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EDITORIALS

Alma Ata and primary healthcare: back to the future

After 40 years, global health is returning to the vision of the Alma Ata declaration

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In 1978, when the world looked different geopolitically, the Soviet Union hosted a landmark international conference on primary healthcare. Organised by the World Health Organization and Unicef, the conference took place at Alma Ata (now Almaty) and considered the role of primary healthcare in population health. It finished with a declaration that promised “health for all by the year 2000.”¹

The Alma Ata declaration was signed by 134 countries and 67 international organisations and was groundbreaking in several ways. The declaration promoted a holistic definition of health “as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” The 10 statements of the Alma Ata declaration stressed the large inequality in health and its social determinants and recognised primary healthcare as integral to achieving health for all by 2000.

The conference and declaration also espoused three important principles. Firstly, primary healthcare is an integral part and central function of health systems. Secondly, it is essential to social and economic development. Thirdly, primary healthcare must be universally accessible through full community participation and based on practical, scientifically sound, and socially acceptable methods and technologies.¹

Although the response to the declaration was generally enthusiastic, its implementation met with many challenges. For some countries, the model of primary healthcare proposed was “poor care for poor people, a second-rate solution for developing countries.”¹ Others had fundamental misgivings about the principles of universality and social justice championed by the declaration, which they thought seemed impractical and smacked of radicalism.¹

Indeed, the declaration lacked a pragmatic plan to translate its laudable goals into meaningful actions and results. Within a year of the declaration, a conference hosted by the Rockefeller Foundation in Bellagio, Italy, debated universal versus selective approaches and recommended interim measures of selective primary healthcare, focusing on a narrow set of high impact and cost effective strategies to tackle major causes of death and ill

health.^{2 3} The outcome was a package for reducing child mortality based on growth monitoring, oral rehydration, breastfeeding, and immunisations (GOBI). Once expanded to include food supplementation, female literacy, and family planning, GOBI-FFF became a rallying cry for Unicef and other agencies for more than a decade.

Hence, although some countries in Latin America—notably Brazil, Cuba, and Nicaragua—introduced a new model of comprehensive primary healthcare inspired by the Alma Ata declaration,¹ the vision lost momentum in most countries. Instead, a more selective version of primary healthcare gained prominence—a vertical or disease specific approach proposed by some development agencies, notably USAID, and supported by development economists at the World Bank.

Implementation of robust primary healthcare strategies was hindered by a view that the burden of disease in less developed nations was socially and economically sustained, requiring political will to tackle social determinants.⁴ Another alternative to primary healthcare was to focus on technological solutions to reduce poverty and improve living conditions.⁵

Despite the competing claims of selective and comprehensive approaches,⁴ most settings had ample scope for both strategies to coexist and deliver integrated care.¹ Some countries implemented these combined strategies successfully with a “diagonal” progression of healthcare.⁶ Nonetheless, the millennium development goals reinforced the argument for selective programmes as the best approach to reducing maternal and child mortality. The Global Fund to Fight AIDS, Tuberculosis, and Malaria, Gavi (the vaccine alliance), and the President’s Emergency Fund for AIDS Relief (PEPFAR) continued this trend by financing global initiatives targeting large scale immunisation programmes, HIV, tuberculosis, and malaria diagnosis and treatment.⁷

While these selective and vertical efforts were intended to create positive synergies to strengthen health systems,¹ and the principles of equity and gender equality were picked up early, they did not extend beyond their target conditions—for example, by mobilising community health workers⁸ or financial support

mechanisms.⁹ The conclusion from the experience of the millennium development goals was that targeted programmes alone were not enough. Countries needed universal health coverage as now envisaged by the sustainable development goals: strong health systems, underpinned by comprehensive primary healthcare and multisectoral approaches to reduce inequalities and ill health.¹

Much has changed since the Alma Ata declaration, although the world is still grappling with socioeconomic disparities, health inequalities, and preventable deaths.¹⁰ Alma Ata's vision of health for all by 2000 proved to be a mirage. Yet hope remains alive. The principles are as fresh and relevant today as they were 40 years ago. A renewed commitment by WHO and the United Nations to universal health coverage means that decades after its introduction, the approach championed by the Alma Ata declaration remains an enlightened and forward thinking blueprint for countries striving to achieve health for all.

In support of these principles and to further the debate, *The BMJ* is creating a special collection of content on the progress and future of primary healthcare (www.bmj.com/primaryhealthcare). We will add relevant articles and multimedia as we publish them.

At its 40th anniversary, revived by the impetus of the sustainable development goals and universal health coverage, the principles of Alma Ata must be translated into firm actions to achieve equitable health, wellbeing, and sustainable development for generations to come.

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