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EDITORIAL

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Primary health care 'From Alma-Ata to Astana': Fostering the international debate through the experiences of Portuguese-speaking countries

1 | FROM ALMA-ATA TO ASTANA: DIFFERENT NARRATIVES ON THE UNIVERSALITY OF PRIMARY HEALTH CARE

The way in which states ensure the health and well-being of their populations is influenced by diverse factors such as: political regimes; economic capacity; degree of social cohesion and the population's trust in their health services; installed capacity in terms of infrastructure, technologies and human resources dedicated to training, management, research and care; and capacity for social mobilisation.

Regardless of differences resulting from these factors, health systems are usually anchored on a discourse of universality and predominance of primary health care (PHC). However, this discourse hides different perspectives that can, simply speaking, be divided into those who defend universal health systems and those who associate universality with selective health care services.[1–4]

The tensions underpinning these perspectives are well illustrated by the narratives on PHC that evolved from Alma-Ata in 1978 to Astana 40 years later.[5]

1.1 | Alma-Ata: From integrative to selective approaches to PHC

The International Conference on Primary Health Care was held in Alma-Ata in September 1978 under the auspices of the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). It challenged governments to make profound changes to their health systems in order to achieve the goal of "Health for All by the Year 2000".

However, this innovative proposal was immediately contested by multilateral organisations, including the Rockefeller Foundation, the World Bank, and even UNICEF. About 2 years later, they were already making joint attempts to limit the scope of PHC to a few procedures and treatments mainly for the most vulnerable population groups. This came to be referred to by some authors as Selective Primary Health Care.[5,6]

1.2 | The agenda of international financial organisations

The debates around PHC became polarised between those focussed on implementing vertical disease programs and those defending holistic health programs.[7]

International financial organisations, such as the International Monetary Fund, the World Bank, and regional development banks aligned closely with selective approaches to PHC. Over the past 40 years they have conditioned health policies, mostly in developing countries, with 'structural adjustment' programs. Free-market policies aimed at limiting spending on the social sector, including health, have often been used as bargaining chips in low- and

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middle-income countries, with widely known consequences. PHC was turned into second-rate services for poor populations at the expense of a narrow definition of desirable health outcomes.[8,9]

Because of what the World Bank saw as 'systematic constraints that served as obstacles to providing more comprehensive, efficient and equitable health services, it restructured its approach to health sector funding', and in 1986 introduced user charges 'as a means to equalise access to government-run health services in developing countries'. They argued that user charges could help make health systems more equitable, considering that the richest of those who benefited from public services would have to pay. This would theoretically free up government resources that could be used in programs and facilities for the poorest. WHO's and UNICEF's Bamako Initiative, with the introduction of user charges, led to a further widening of health inequities in many contexts in the global south. Its results were at odds with the policy's intentions.[10]

The World Bank's agenda for reforms in the health sector has not changed substantially over the years. It advocates, among other things, the strengthening of the role of the state as a regulatory agent; the introduction of competition between public and/or private health service providers; and the development of state subsidies and incentives—mainly fiscal—to support for-profit private initiatives. This position has led several authors to argue that the agendas of the financing entities did not benefit those most in need,[11] but reinforced the role of national health systems as systems for the poor,[12] conditioned access to health care through people's own ability to pay, and denied health as a human right.[3,5,7,13]

1.3 | The Ljubljana Charter: Reaffirmation of the principles of Alma-Ata

Despite the controversy over the implementation of the Alma-Ata Declaration, the WHO adopted a list of principles for building the basis of PHC in the Ljubljana Charter (1996), including: respect for the values of human dignity and ethnic, cultural, religious and gender diversity; equity, solidarity and professional ethics; entitlement to disease protection and health promotion at all stages of life and for all types of illness; people-centeredness by enabling citizens to participate and influence health care delivery; and quality-oriented, properly financed services to allow all citizens access to all necessary care. This statement, however, caused concern about cost-effectiveness issues that had not been explicitly addressed in Alma-Ata, and that were associated with some of the arguments from those who stood for selective PHC.[14]

1.4 | World Health Report 2000: Universalism in market-driven societies

But WHO soon shifted its position, adopting what its World Health Report 2000 called the 'new universalism'. The definition was not 'all possible care for everyone, or only the simplest and most basic care for the poor', but rather the 'delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability'. It implied the explicit choice of priorities among procedures, which required respect for the ethical principle that it might be necessary and efficient to ration services, but that it was inadmissible to exclude whole groups of the population. The effects were the transformation from centrally planned to market-oriented economies, reduced state intervention in national economies, fewer government controls over service delivery, and more decentralisation. Ideologically, this shift 'meant greater emphasis on individual choice and responsibility'; politically it meant limiting promises and expectations about what governments should do.[15]

1.5 | Astana: Universal access rather than universal systems

In celebration of the 40th anniversary of the Alma-Ata conference, the Global Conference on Primary Health Care took place in Astana, Kazakhstan in October 2018. Although building on the same starting points, Astana resulted in a very different attitude to the central elements in the Alma-Ata Declaration 4 decades before.

There was a continued understanding that PHC should be the cornerstone of health systems.

There was no more emphatic insistence on states' responsibility to guarantee the right to health, nor was there talk of public universal health systems, but rather of a new concept: that of universal health coverage (UHC), which, for many scholars, represented a movement away from health as a human right.[16]

The 'new universalism' associated with UHC points out that guaranteeing access to health services should not necessarily be a state prerogative and that health services would also be expanded through commodified social protection, that is, a substantial increase in shared funds and prepayment mechanisms.[5]

Furthermore, by transmuting the universal right to health into the right to UHC, there is a transposition from one political order to another: from the right to health to the right to coverage. The latter reinforces the notion of charging for the provision of health services by market agents, corresponding to a liberal concept of restricted citizenship.[17] In this regard, UHC goes against the spirit of Alma-Ata.

It is worth mentioning that the UHC proposal was not validated by the Pan American Health Organization which, pressured by South American countries, adopted 'Universal Health' in Resolution CD53/5 of 2014 as the key term for guaranteeing the right to health and access to health services.[18]

2 | PRIMARY HEALTH CARE IN CPLP MEMBER STATES

In the midst of this evolving reality, strengthening PHC has been a concern around the globe, including the Community of Portuguese-speaking Countries (CPLP).[19]

The eight CPLP member states (Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal, São Tomé e Príncipe, and East Timor) are spread over four continents. They reflect the geographic, political, administrative, social, and epidemiological diversity in which PHC has evolved.

After a long period of discussions, the CPLP finally included a commitment to strengthen PHC systems in their Strategic Plan for Cooperation in Health—PECS (2018–2021).[20]

This document reiterates one of the principles of Alma-Ata: 'All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors'.[21] To achieve these objectives, the PECS addresses the need for bi and/or multilateral cooperation to strengthen PHC models, in order to guarantee their universal nature.[20]

In view of the international tensions involving Alma-Ata and Astana, experts from the eight CPLP member states were invited to a seminar at Universidade Nova de Lisboa in October 2021. The participants were asked to reflect on the evolution of PHC in their countries since the publication of the Alma-Ata principles.[22]

In general terms, all the CPLP countries were clearly sensitive to the principles defended in Alma-Ata, and sought to adopt the paths set out there, within their means and specificities. Brazil and Portugal are key examples of holistic Alma-Ata PHC. On the other hand, although initially guided by the Alma-Ata principles, most of the Portuguese-speaking African countries—Cape Verde,[23] Guinea-Bissau[24] and Mozambique[25,26]—, showed signs very early on of opting for more selective approaches. This resulted in policies clearly aligned with the new universality adopted in Astana. East Timor[27] tried to maintain a relatively holistic stance in its approach to PHC.

A comparison of the CPLP member countries' presentations of their PHC systems results in a set of generalisations that are not easy to synthesise, but identify similarities and differences that are worth noting:

a) the importance of understanding the specificities of each country's culture, economy and politics in relation to health systems
b) the importance of not losing sight of health, regarded as a fundamental human right
c) ensuring community involvement via diverse participation and empowerment mechanisms
d) the importance of stable political cycles that allow for continuity of health policies and innovation of health systems
e) the need for resilient PHC systems that articulate well with community health systems and specialised and hospital care, particularly important in dealing with non-communicable and recurring communicable diseases
f) the importance of trusting, well-informed public opinion
g) a significant increase and rationalisation of the number and nature of health units over time
h) an increase in population coverage by PHC and access to medicines and essential technologies
i) provision, to a greater or lesser extent, of services by the for-profit and not-for-profit private sectors
j) the continuing existence of national health services that are free of charge at the point of consumption
k) the wrongful perception that PHC is the base of a pyramid, disregarding its central position in healthcare networks
l) ongoing vertical programs, with different degrees of integration in PHC services
m) in all countries, PHC is generally provided by multidisciplinary teams in which either doctors or nurses play a central role
n) the warning that without a relevant workforce there is no PHC, and also that without adequate functional or structural investments, professionals cannot positively impact the people's health
o) community-based workers (village health workers, informal care givers), with different jobs in different national contexts—health promotion and prevention, treatments and first aid, ongoing care, palliative care—are re-emerging as a workforce subset that requires professional recognition and adequate financial compensation
p) the clear advantages of the family health approach in the countries that have adopted it, whose good results in terms of disease prevention, health promotion and improvement of indicators are already well demonstrated in existing publications
q) the unresolved information gaps, financial and structural difficulties of some countries that still managed to advance in the organisation of PHC and coverage of the population
r) the persistent fragility of systems in the face of pandemic threats
s) recognition by all of the importance of international cooperation for the development of resilient PHC systems

3 | ARGUMENTS TO FOSTER INTERNATIONAL DEBATE ON THE EVOLUTION OF PHC

Over the past 40 years, the principles of Alma-Ata have been compromised by political, economic, and legal transformations that we called neoliberalism, even before they were enshrined in most countries. Once again, it was the peripheral countries in the international order that lagged farthest behind in the construction of integrated, articulated, universal PHC systems. This situation is well illustrated by the experience of the CPLP member states.

The tensions that markets cause in the definition of universal policies have been and will continue to be common to innumerable countries. What differentiates countries is the way in which universality is defined, rights and entitlements are or not assured, and the impact that these options have on social inequalities and health outcomes.[28,29] In a market economy, the functioning of democratic regimes will be decisive in counteracting harmful impacts of restrictive approaches to universality. By functioning of democratic regimes, we mean science, universities,[30] a free press[31] and freedom of association.[32]

The political interpretation performed here is necessary because it shows how far the times in which Alma-Ata emerged diverge from the current times in which Astana took place. It also shows that, despite the differences, an idea of extended protection persists in the minds of decision-makers, even though the tone of its definition and scope has changed. Today, there are fewer guarantees of universal protection, so the risk of widening the gap between the haves and have-nots has increased.

What we must recognise is that countries do not have the resources to deal with this situation on an equal footing. Therefore, in a comprehensive approach as set out in the Sustainable Development Goals (SDGs), the reaffirmed appeal is to: resist change that creates poverty (SDG 1) and preventable diseases (SDG 3); strengthen emancipatory, disinterested international cooperation, as reflected in the PECS (SDG 17); and enable international policy guidelines that do not further accentuate the marginal condition of peripheries, be they countries or communities (SDG 9).

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