Reflections on Alma Ata

Green, Andrew

Empfohlene Zitierung / Suggested Citation:
Green, A. (2008). Reflections on Alma Ata. *Global Social Policy*, *8*(2), 155-157. https://doi.org/10.1177/1468018108008002020204

Navarro, V. (2007) *Neoliberalism, Globalization and Inequalities: Consequences for Health and Quality of Life*. Amityville, NY: Baywood.

BIOGRAPHICAL NOTE

VICENTE NAVARRO is Professor of Health Policy at the Bloomberg School of Public Health, The Johns Hopkins University, and Professor of Political Sciences at Pompeu Fabra University. Please address correspondence to Vicente Navarro, Department of Health Policy and Management, The Johns Hopkins University, Bloomberg School of Public Health, 624 N. Broadway, Room 448, Baltimore, Maryland 21205, USA. [email:vnavarro@jhsph.edu]

Reflections on Alma Ata

ANDREW GREEN
Leeds University, UK

I started working in the international health field in the early 1970s and remember well the build up, and subsequent events related to Alma Ata. The Declaration made absolute sense to me and, though clearly idealistic, was seen by many as a genuine turning point in how health and development was viewed. Under the leadership of Halfdan Mahler, the World Health Organization (WHO) Director General, primary health care (PHC) became in the early 1980s a guiding strategy for many countries towards the goal of Health For All 2000. During that period there was particular emphasis on initiatives such as essential drug lists, maternal and child health services and community health workers.

However, we were not long into the 1980s when challenges to what became called the comprehensive approach to Alma Ata appeared in the guise of 'selectivism'; this foreshadowed one of the themes of the 1990s reforms and beyond in the Millennium Development Goals (MDGs) – the prioritization of health based on largely 'technical' (as opposed to social or democratically set) grounds. And by the end of the 1980s the early optimism of the PHC movement had been replaced, in donor agencies at least, with a belief that the answer to continued poor health lay in much more structural reforms, based on a market ideology. This reflected a wider New Right neoliberal ideology that was then in the ascendancy in countries such as the UK and the USA. The vacuum in international health leadership caused by the then weak WHO coincided with a growth in power and influence of the World Bank with its particular ideological commitment to the market. The international language of health and development became dominated by concerns about increasing private sector roles, contracting, downsizing the public sector, and emphasis on individualized rather than collective health financing through user charges.

The key themes of Alma Ata were largely lost in this: equity seemed to be overtaken by pursuit of efficiency; the focus on health care structures left little space for consideration of the wider determinants of health; and while decentralization of health care governance was a common policy agenda item, participation of communities in decision-making was not seen as a key component of this (in economic parlance, it was a supply-side, rather than demand-side, driven agenda). The very approach to the reforms themselves was often internationally driven with little bottom-up engagement. The focus on a particular approach to service structures also ignored a number of key policy issues in this area – most notably the growing crisis of a shortage and maldistribution of professional health care workers, but also issues such as the malfunctioning of referral systems and the relationships between the increasingly prioritized vertical disease programmes and the wider primary care services. In some ways these sins of omission were a natural sequitur of the market approach and the downplaying of the public sector and its policy leadership role. These policy gaps illustrate that health system structures *did* need attention, but that the basic values and ideology on which such systems should be designed will affect greatly the type of structures.

The new millennium did not bring Health For All; instead it brought a new set of global goals – the MDGs. While they had a political role in raising awareness about development – indeed health professionals are often reminded that three of the goals are health-related – they have (as targets have the ability so easily to do) focused attention – and resources – on the 'killer' diseases, at the expense of other 'neglected' health problems (such as mental illness). This narrow disease focus has parallels with the selectivist movement of the post Alma Ata period, raising questions again about how prioritization is done, and by whom. Furthermore, it has the danger of swinging the pendulum away from health *system* issues.

What then, 30 years on, is the relevance of the Alma Ata Declaration today? First, I still believe, as I did 30 years ago, that the broad principles that underpin the declaration are universal both in time and space. However, I also recognize that this is based on a particular set of values that are not universally shared. In particular the underlying commitment to a social, rather than solely an individual, set of responsibilities for health is largely (though not purely) ideological, reflecting a particular view of the world and the role of society and in particular government. Indeed, I believe that health policy analysts need to pay greater attention to the legitimate role of values in policy making, alongside the calls for more evidence-informed policies.

While Alma Ata does provide a solid base of principles for the pursuit of just and equitable health, these need to be contextualized to time and place. The theme of community participation illustrates this well with two different examples. First, the pursuit of community (and individual) participation in health decisions is likely to be very different in an increasingly information

literate society fed, and influenced, by the Internet, compared to that of 30 years ago. Second, the locus of many decisions on health systems has moved outside the national arena with multinationals and Global Public–Private Partnerships often more significant policy actors than even the multilaterals, reducing further the democratic space for national, let alone community involvement in such decisions. Development of accountable and effective global governance in the health field is a critical priority.

Second, it is clear that the principles running through Alma Ata remain as unmet challenges to the health system. Three in particular stand out. Inequity remains endemic, and we continue to witness the many forms in which it manifests, including most pervasively, gender. However, the plundering of low-income countries as sources for health professionals has brought to the fore the wider issue of global inter-regional inequity.[1]

Second, health systems remain professionally dominated, with little space given for democratic participation in how resources are used. This remains a challenge for health systems throughout the world, through there are examples, such as in Brazil, of interesting attempts to open up decision-making to communities.

Last, health (service) systems still struggle with looking upstream towards the root causes of ill-health, preferring to focus on dealing with the results. In the same year that Alma Ata's 30th anniversary is celebrated, the Commission on Social Determinants of Health will produce its report. If this report can politically refocus attention on what Alma Ata called multisectoralism, it will be an appropriate way to celebrate.

NOTES

1. Regarding the dimesions of inequality, consider: every year, half a million women die in childbirth – the majority of deaths being preventable; these unnecessary deaths are very unevenly distributed with the lifetime risk of dying in pregnancy being 1 to 12–16 in Africa compared to 1 in 4000 in Europe. Currently, whilst around 95% of births are attended by a skilled attendant in high income health systems, the average for Africa is half of this. The 2006 World Health Report identifies a need for a leap in professional staffing levels with an extra 334,000 midwives by 2015. The USA has a ratio of over 950 nurses/midwives to 100,000 population, compared to Ghana with approximately 80.

BIOGRAPHICAL NOTE

ANDREW GREEN is Professor of International Health Planning and Head of Centre at Nuffield Centre for International Health & Development, Leeds Institute of Health Sciences. Please address correspondence to Andrew Green, Nuffield Centre for International Health & Development, Leeds Institute of Health Sciences, University of Leeds, Charles Thackrah Building, 101 Clarendon Road, Leeds LS2 9JL, UK. [email: a.t.green@leeds.ac.uk]