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## **The story of Primary Health Care : from Alma Ata to the present day**

The idea of primary health care (PHC) emerged in the 1960s, in recognition of the shortcomings of the health systems inherited by developing countries after independence. The urban, centralised and curative-oriented health systems were poorly matched to the needs of their people.

### **Health for all**

By the time of the Alma Ata conference in 1978, a consensus had emerged placing fresh emphasis on preventive, rural, peripheral and 'appropriate' services, integration and inter-sectoral collaboration, and participation of local communities. The conference itself affirmed the right to health – and its definition as a state of complete, physical, mental and social wellbeing.

The Conference demanded 'an acceptable level of health for all the people of the world by the year 2000' or 'Health for All 2000', implying an emphasis on equity as well as effectiveness and efficiency.

Fissures in the consensus appeared almost immediately. In 1979, the paper 'Selective Primary Health Care' proposed a limited list of cost-effective interventions to respond to most health needs in low-income countries, especially those of children. It prompted a host of critical responses which argued that cost-effectiveness did not ensure a universal health system or give sufficient space to equity, and that the holistic notion of health espoused in the Alma Ata declaration had given way to one of avoiding disease. They argued that the strategy provided a short-term fix rather than a long-term solution and that this implicitly medical notion ignored the need for collaboration and integration.

### **Affordable primary health care?**

A cornerstone of the initial consensus was that a PHC system would be affordable to low-income countries. The Rockefeller Foundation published the 'Good Health at Low Cost' case studies in the mid 1980s, which showed that some places such as China, Costa Rica, Sri Lanka and the Indian state of Kerala, had achieved affordable and effective health systems. All had dramatically improved health outcomes, despite economic constraints within widely differing political systems, but all emphasised PHC within an overall social welfare-oriented development model.

### **PHC delivery system ignored**

However, others argued that PHC is not cheap and that simple interventions require a delivery system that is frequently lacking in practice and ignored in the debate. The realities of PHC delivery systems failed to match up to the ideal. Services intended for poor people were often perceived as cheap and second class. Governance issues affected the delivery of services in a number of settings. Political commitment voiced at Alma Ata was often not followed up through implementation.

By the 1990s, proposals looking for alternatives to over-stretched public sector budgets emerged from international agencies. Increased debt levels were undermining the credibility of increasing public expenditure and there was a growing emphasis on markets as the basis of public sector reform. The World Bank's Agenda for Reform promoted centralised user fees, insurance mechanisms and greater involvement by the private sector. And the Bamako Initiative proposed local revenue-generating mechanisms alongside measures to strengthen the delivery of PHC.

These approaches, however, undermined access by the poorest people, threatening the universal principle enshrined in Alma Ata. User fees were widely implemented and equally widely maligned: evidence emerged, for example from Ghana, which resulted in reduced use of health services and exclusion of poor people.

Several new approaches have emerged in the last decade, whilst those of the 1980s and 1990s continue to inform current thinking. Conflict between new aid modalities, most notably the sector wide approach – where aid effort in each sector is brought under a single management framework governed by national government and bilateral and international agencies – and international mechanisms with specific disease focus such as the Global Fund to fight Aids, TB and Malaria has similarities with the dispute between selective and comprehensive PHC.

Should local ownership, integrated service provision and system development be emphasised, or measurable outcomes, specific objectives, and short-term efficiency?

'Essential packages', itemising a limited set of priority cost-effective interventions, are now everywhere in aid dependent countries but raise the same questions that selective PHC did 30 years ago. How does a health system based on an essential package respond to a patient with a condition not covered by the package? What are the equity implications of allowing the private sector to fill the less cost-effective gap?

It is possible to argue that PHC 'failed', in the sense that 'Health for All 2000' was not achieved. Advocates of comprehensive PHC have critiqued advocates of more selective approaches for their tendency to prioritise 'technical fixes' over larger social development processes. Nevertheless, if it is recognised that a more comprehensive PHC vision is more than a longer list of technical fixes, PHC failure can only be addressed in the same terms as those that evaluate wider development processes. These in turn perhaps can also be seen to have largely failed over the same period, owing to global economic and political forces and national failures of governance. These are likely to be the critical factors that determine success with PHC and other elements of social development over the coming decades.

Source(s):

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