

Call for papers – the Alma Ata Declaration at 40: reflections on primary healthcare in a new era

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The Declaration of Alma Ata was a watershed moment in global health. Indeed, in the four decades since its launch, there is a sense in which all declarations or communiques issued at global health conferences have been aiming for comparable historical impact. Launched in 1978 at the International Conference on Primary Health Care, the declaration called for ‘Health for All by the Year 2000’¹ and promoted comprehensive primary healthcare as the preferred backbone of national health systems alongside a number of other key elements including an emphasis on global cooperation and peace; a new economic order to underpin it; acknowledgement of the social determinants of health; involvement of all sectors in the promotion of health; community participation in planning, implementation and regulation of primary healthcare; and a focus on achieving equity in health status. In totality, these elements—which became known as the ‘primary healthcare approach’—flagged a paradigm shift away from the medical model of health planning and service delivery and towards a ‘social model’ with an emphasis on addressing social determinants of health via intersectoral public health and preventive strategies based on local ownership and community participation.

Convened by WHO and UNICEF, the International Conference on Primary Health Care was held in Alma Ata (presently called Almaty, in Kazakhstan), in the Union of Soviet Socialist Republics, during the Cold War; a battle between the worldviews of Western capitalist democracies and the Eastern socialist bloc. Despite the galvanising vision of the declaration, however, just one year later in 1979, ‘selective’ primary healthcare was presented as a more economically feasible alternative at a Rockefeller Foundation-hosted conference in Bellagio, Italy. The concept of selective—not comprehensive—primary healthcare was designed to ensure more rapid improvements

in health outcomes by targeting specific areas of health—notably those affecting children under age five and women of reproductive age with low-cost technological interventions.² Contrary to the vision of the Alma Ata Declaration which had emphasised the development of health systems as a platform for improved front-line health services *and* a citizenry empowered to improve their own health, moreover, selective primary healthcare was operationalised as a series of stand-alone, vertical programmes designed as classic public health ‘interventions’. This pattern of targeting specific diseases via stand-alone or vertical programmes continues today, justified and bolstered by similar arguments regarding the need for clear and attainable targets with primary consideration given to rapid results and (short term) cost-effectiveness.^{3,4}

The world of the late 1970s and early 1980s in which UNICEF and WHO promoted selective primary healthcare seems familiar in 2018. The early 1980s saw the increasingly apparent failure of centrally planned socialist economies, the rise of neoliberal governments in the UK and the USA, economic recessions in several high-income donor countries and debt crises in many low-income and middle-income countries.^{5,6} The period also gave rise to receding national investments in strengthening health systems as the World Bank and International Monetary Fund introduced structural adjustment policies, which emphasised public sector restraint and market-driven reforms.^{5,6} The world of 2018 presents some similar challenges—the fall in commodity prices is slowing the economies of many low-income and middle-income countries⁷—there are concerns that foreign aid may drop significantly or will become more explicitly self-interested,^{8–11} and relations between Russia and the USA are reminiscent of the Cold War era.¹² So too does the unavoidable tension between idealism and pragmatism evident in the debate on selective versus comprehensive primary healthcare continue 40 years on, in the

tensions between proponents of more specific goals, such as those of global health security, versus the extensive vision of advocates for Universal Health Coverage.¹³

2018 is an appropriate year to reflect on the legacy and relevance of the landmark Declaration of Alma Ata as we mark 40 years since its launch. In the intervening period between 1978 and 2018, and despite the prominence of selective primary healthcare, the vision outlined in the original declaration has retained its currency. In 2008, the WHO used its World Health Report: *Primary Health Care: Now More than Ever* to reassert the case for (comprehensive) primary healthcare, stressing the need to reorient global and national efforts towards building health systems that 'put people at the centre of health care'.¹⁴ That 2008 report was published against a backdrop of increased health spending globally, but accelerating rates of health inequity and the rapid rise of disease-specific global health initiatives that were placing enormous pressure on weak health systems of low-income and middle-income countries.¹⁵ In 2015, WHO published its Framework on Integrated People-Centred Health Services, further drawing on the principles outlined in the Alma Ata Declaration.¹⁶ And most recently, in 2015, Sustainable Development Goal (SDG) 3, which seeks to 'Ensure healthy lives and promote the well-being for all at all ages', also channels the Declaration. Meanwhile, debates regarding the inclusion, definition and measurement of Universal Health Coverage as an explicit target under SDG 3 also arguably represent a contemporary extension of the vision of comprehensive primary healthcare.¹⁷

Notwithstanding the recent decade of widespread rhetorical support for the principles of primary healthcare, what progress in policy, practice or health outcomes has been made? Is the primary healthcare of the 21st century the same as what was first envisioned in 1978 and built on in the Ottawa Charter's recommendation of 'health in all policies'? How are the principles of primary healthcare, or aspirations for Universal Health Coverage, to be reconciled with the political economy of global health security, or the disease-specific targets still embraced by donors? Do the persistent inequities between countries and growing inequities within countries mean that the vision of Alma Ata is already dead? And in what ways could a primary healthcare approach help to address the concurrent rise of non-communicable diseases and re-emergence of many communicable disease worldwide? *BMJ Global Health* welcomes commentaries, analysis and practice papers, and original research papers from low-income, middle-income and high-income countries, addressing these or other questions of relevance to the theme: *The Alma Ata Declaration at 40: reflections on Primary Health Care in a new era*. While submissions will be accepted throughout 2018, accepted manuscripts already published as part of the themed series will be officially launched online between 6 and 12 September 2018 to coincide with the 1978 anniversary of the conference.

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