World Nutrition

 **Volume 5, Number 5, May 2014**

 **Journal of the World Public Health Nutrition Association**

 **Published monthly at www.wphna.org**

 *World Health Assembly. Primary health care*

 Health for All: The vision

 whose time has come again



 **María Hamlin Zúniga**

 **People’s Health Movement, Managua, Nicaragua**

 **Email: maria.hamlin.zuniga@gmail.com**

 **Claudio Schuftan**

 **People’s Health Movement, Ho Chi Minh City, Vietnam**

 **Email: schuftan@gmail.com**

 Editor’s note

 This is the month of the WHO World Health Assembly. The authors, two leaders of the social medicine movement, call on representatives of WHO member states to speak out at the Assembly, and to insist on renewed policies and programmes in which people come first.

 Since the 1980s, public goods have been progressively privatised. One result has been the betrayal of the *Health for All* principles agreed by WHO member states in Alma Ata in 1978. These affirm public health as a public good. The privatisation of public health is proved to be a catastrophe. Malnutrition persists. This now also takes the form of rocketing rates of obesity and diabetes including among impoverished populations. The current prevailing political and economic monetarist ideology that is still driving world health programmes must be stopped and reversed. What is needed is the restoration, protection and strengthening of *Health for All*, in principle and practice, belatedly beginning now, and in the decades ahead. The authors here summarise how primary health care should be seen in 2015 and beyond, and explore

 what it would take to reduce the millions of maternal and child deaths each year.

 Primary health care as a basis of democracy



*The principle of publicly funded health care is embedded in the UK National Health Service, whose 65th birthday is celebrated here by Labour politicians currently in opposition to the UK government*

We know now that history was not kind to the *Alma Ata Declaration* (1). Primary health care was never comprehensively applied towards fulfilment of the vision of Alma Ata, namely: ‘Health for all by the Year 2000’ – ‘health’ including healthy nutrition

The failures and successes of the current health and nutrition system to protect the lives, health and nutrition of impoverished mothers and children have shown how 'magic bullet' technologies have saved lives, but have not responded to the key question. This is: survival at what cost, and for what type of a future? The ultimate aim for mothers and children is not only to survive, but to be healthy and well nourished in the fullest sense of well-being.

Now is the time to ensure that the right to adequate and nourishing food is made a central part of primary health care. This commentary is published in the month of the World Health Organization’s World Health Assembly. Its purpose is to affirm that universal publicly funded primary health care, with all this implies for good personal and population nutrition, is essential for the health, welfare and well-being of nations.

***Primary health care is much more than the extension of basic health services***

Universal, comprehensive primary health care is not a novel concept. In partial and simple forms it has been a feature of many societies, partly for practical, utilitarian reasons – healthy populations are more able. It inspired the UK National Health Service (NHS), created in 1948 as part of a general plan to ensure that the British people could afford decent housing, gain publicly funded education, and enjoy adequate nourishing food, as well as being offered health care on request.



*Margaret Chan, WHO director-general, says that she is committed to the principles and practice of publicly funded universal public health care, and most of all in less resourced countries and settings*

Among others, it also inspired the creation of the SUS (*Sistema Único de Saúde*), the Brazilian unified national health service, after the period of military rule, as specified in the current 1988 Constitution that envisions Brazil as a participatory democracy. But both the NHS and the SUS have become increasingly dominated by curative interventions as distinct from prevention, and both are under increasing pressure from the private medical sector. Nevertheless, both still protect the people of the UK and Brazil against the inequalities and inequities of a mainly mixed or wholly private system of health care, of the type that is endured by the people of the US.

Primary health care is not an aged or ageing concept, in the sense of being outdated. Here is what Margaret Chan, the current director-general of the World Health Organization, said in 2011, in the USAID journal *Frontlines* (2). She was asked, what is the best way for communities in impoverished parts of the world to get quality health care? She said:

In my view, the best way is to go back to basics: the values, principles, and approaches of primary health care. Abundant evidence, over decades of experience, supports this view. Countries at similar levels of socioeconomic development achieve better health outcomes for the money when services are organised according to the principles of primary health care. A revitalisation of primary health care is the smart move to make.

To be frank, a smart move, in this case, is not an easy move. We are almost starting again from scratch. Over the past three decades plus, health systems in large parts of the developing world have crumbled from neglect. Countries and their development partners have failed to invest adequately in basic health infrastructures, capacities and services, including staff education and training, setting up a working regulatory capacity, procurement systems, and statistical services…

Many health systems are just barely able to cope with outbreaks of infectious illness. They are totally unprepared to cope with the onslaught of demands on staff, budgets, medicines, supplies, and hospital beds for referrals that come with the rise of chronic non-communicable diseases. In an alarming trend, developing countries now bear nearly 80 percent of the burden of deaths from diseases like cardiovascular disease, diabetes, and cancer – on top of the burden of infections an infestation by parasites. In groups rendered poor and disadvantaged, patients with these diseases fall sicker sooner and die earlier than their counterparts in wealthier societies. Primary health care has been identified as by far the best framework for preventing and managing key aspects of these chronic conditions at both the population-wide and the individual level.

What Margaret Chan is indicating, is that primary health care is meant to cure, prevent, promote and rehabilitate. But this should not be by means of a series of top-down vertical programmes, as are now ubiquitous. The whole process of democratic decision making has been missing. This was at the basis of the Alma Ata Declaration, but since then it has been bypassed.

‘Politics is medicine writ large’. This statement made by the politician, pathologist and founder of social medicine Rudolf Virchow was quoted in David Werner’s commentary on *Health for All* in the April issue of *WN* (3). Rudolf Virchow also stated that epidemics are symptoms of sick societies

When Margaret Chan and so many others write and speak about the protection and improvement of public health at national or international level, in the context not of curative health care, but of the prevention of disease and promotion of well-being, they are necessarily upholding the principle and practice of universal primary health care. There is no other model that does or could work. If there ever was any doubt about this, the events of the last thirty years have proved the point.

.

 *Box 1*

 Maria Hamlin Zuniga

 Maria Hamlin Zuniga of the People’s Health Movement grew up in the US and has lived in Central America since 1968. She resides in Nicaragua. She is a health educator and activist with a MPH from the University of Minnesota.

 She is the founder and president of the board of directors of the Center for Information and Advisory Services in Health, a Nicaraguan non-governmental organization founded in 1983. This health education organisation is known for its participatory education methodologies involving children and youth as well as advocacy for women.

 She is the founder and member of the coordinating commission of the regional committee for the Promotion of Community Health, a network of primary health care programmes in Central America, Mexico and the Caribbean. Established in 1975, the network is responsible for advocacy and capacity building in the region. She is the founder of the Guatemalan Association of Community Health Programmes, established in 1978. This is now the largest national health organisation with workers active in communities throughout the country.

 She was also the founder and coordinator of the International People's Health Council, the politics of health organisation established in 1991, and one of the networks that organised the First People's Health Assembly in Bangladesh in 2000. She helped to establish the People's Health Movement in 2000, and is now a member of its global steering council and of its Latin American coordinating committee.

The uncontrolled epidemics of obesity and diabetes are now global pandemics afflicting low-income countries and impoverished populations within higher-income countries (4). They are not phenomena that can be isolated from other evidence of societal failure, as a medical approach based on treatment implies. The same applies to the persistence of food and nutrition insecurity, under-nutrition, deficiency diseases and hunger throughout many Asian and African countries, and within many other countries. These will remain intractable for as long as their root political, economic and social causes are not recognised and addressed. Impoverished people become sick, and sick people become impoverished.

States of population nutrition cannot be meaningfully separated from states of public health. Also, states of population health cannot be meaningfully separated from states of national and international health and well-being in the broadest sense. This includes the quality of personal, family, social, professional and political life, and relative states of autonomy, security, trust, respect, peace, freedom, creativity, and all the other qualities that can and should make human life a joy. Societies that are sick are sick societies – and this is the state of affairs we are living in now.

For those of us who are relatively very privileged, as almost all those who discuss and agree public policies are, this reality does not impinge on our daily lives. We therefore need to live and work in solidarity with those who are living in poverty. They include middle-class people in high-income countries whose basic security is shattered by layoffs, or evictions, or violence, or storms – or medical bills.

The state of public health in any country or community is a sure sign of personal and community health and well-being. The public provision of primary health care services, which can take simple forms in the least resourced communities, is an undeniable human right. It is also the duty of governments at all levels, international, national, municipal and in villages and communities. Any government that has ratified UN human rights covenants but which evades this responsibility, is at best irresponsible and at worst in violation of international human rights law

 *Health for All* asserted

Not so long ago universal publicly funded primary health care, as a human right and a duty of government, was not merely a concept. In 1978, well within the lifetimes of many if not most health professionals, it was the agreed policy of all UN member states. Here follow the first five clauses of the 1978 World Health Organization - UN Children’s Fund Alma Ata Declaration, also known as the *Health for All* declaration (1). [*The full text can be accessed here.*](http://wphna.org/wp-content/uploads/2014/05/1978_WHO_Alma_Ata_Declaration.pdf)  The Declaration affirms the fundamental and essential importance and value of universal primary health care. It was agreed by all 134 member states at the end of the meeting.

The final discussions at the meeting, held in the capital of the Kazakh republic within the USSR, followed a series of Resolutions agreed at the WHO World Health Assembly in 1975 and 1976. They also followed a series of national and regional meetings held in 1977 in which the principles and scope of the statement were drafted and debated. Examples of primary health care successes in Bangladesh, China, Cuba, India, Niger, Nigeria, Tanzania, Venezuela and Yugoslavia were noted (5). The process of creating the Declaration is described in a 1978 joint WHO-UNICEF report printed in full at the end of this commentary, [*whose text can be accessed here*.](http://wphna.org/wp-content/uploads/2014/05/1978_WHO-UNICEF_Alma_Ata_report.pdf)

**I**

Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right. The attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many social and economic sectors in addition to the health sector.

**II**

The existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

**III**

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

**IV**

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

**V**

Governments have responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

The messages of the Declaration were summarised some years ago as follows (6). The general principles of *Health for All* remain the same, before and after Alma Ata, as well as for the future. Thus:

The importance of health as a fundamental human right that should be achieved through collective action by societies, and is a responsibility of governments.

The unacceptability of the gross inequalities in health status, especially those between poor and rich countries.

The understanding that good health for all will advance social and economic development and world peace.

The importance of people’s participation in health care as both a right and duty.

The fact that primary health care should be universally accessible in a manner the community and country can afford and should bring health care as close as possible to where people live and work and should include ‘promotive, preventive, curative and rehabilitative’ services .

The fact that achieving health for all will require coordinated efforts from all sectors that have an impact on health.

The fact that its implementation will require political will to mobilise resources for primary health care.

The interdependence between countries, and that the attainment of health by people in anyone country directly concerns and benefits every other country.

The fact that armaments and military conflicts take away resources from achieving health for all, and that peace and disarmament will release resources for social and economic development.

Therefore, we state that primary health care is the cornerstone of health care for the future. That is what member states must keep in mind in their deliberations at the WHO World Health Assembly this month.

 The framework for WHO action

It is tempting, especially in the periods like this month when the WHO World Health Assembly is held, merely to press WHO to adopt such crucial principles as these above. But WHO is under all sorts of pressure, and can do little more than articulate what its member states agree.

What is needed is an increasingly strong push from public interest civil society and movements, as has happened with the environment and with HIV-AIDS, and in our own field, with breastfeeding. What is also needed is a careful and constant review and renewal of the core principles of the Alma Ata Declaration, which are of *Health for All*.

Here we present some suggestions. To begin with, it has to be recognised that the negative aspects of globalisation, which include the progressive privatisation of public health, are the main block facing *Health For All.* Somebody in the Society for International Development once said: ‘Money has rained on jungles, plains and deserts for 40 years, but in the end only poverty has grown’. The bottom line here is that poverty, rather than any microbe, parasite or worm, is the vector of preventable ill-health, preventable malnutrition and preventable deaths.

Globalisation has brought with it the dominance of the ‘market economy’ in health. This has undermined public sector health systems, eroded ethical standards among health workers, and damaged trust between communities and the health system.

We go further. Minimising inequalities in society will do more to reduce high morbidity and mortality rates than all preventive measures put together, nutrition included. Inequality and poverty must not just be accepted as unalterable facts.

Selective, vertical health care and nutrition programmes remain dominant. These fragment the issues. They also draw away scarce human and financial resources from wider primary health care services. They treat mothers, children and patients as passive recipients of care or services, and ignore the social, economic and political determination of disease, health and well-being. There is a need for focused programmes, but always integrated into comprehensive primary health care.

Primary health care and public health nutrition need to be embedded in the social and political processes in each specific context where they are applied. For that, primary health care should:

* Never be limited to just providing primary level of care and prevention, which is to say, merely providing a ‘basic package’ of care and of health and nutrition surveillance for those who are poor.
* Include comprehensive public health and nutrition interventions, as well as a working referral system to secondary and tertiary (that is, higher) levels of care.
* Be financed through public sources, so as to ensure universal and equitable access.
* Address the socio-economic injustice underlying a system of health care that does not provide equitable access to health care, and supply nutritional services according to need.
* Confront the social, political, economic and environmental determinants of preventable ill-health, malnutrition and death.
* Address global water shortages, global warming and related natural disasters, as well as the changing patterns of disease associated with these.
* Raise consciousness about the current outrageously unfair international economic order, including the militarisation that is its cause and consequence.
* Empower communities, especially, the most disadvantaged, so that they can act as protagonists and claim holders and actively demand improvements of their health, their nutrition and livelihoods;
* Use technology in ways that are sensitive to local needs and contexts;
* Combine traditional and modern medicine to maximise benefits to patients
* Embed policies and interventions in the human rights framework, supporting beneficiaries as claim holders with the right to hold to account duty bearers
* Make all these demands in all relevant venues where the post 2015 development agenda is being discussed.

There is more to say and do, given the world’s present ominous circumstances.

Given the looming health and nutrition human resource crisis, and as a core primary health care principle, community health workers should have more responsibility. As well as health, sanitation and nutrition coverage at the local level, they should also be social mobilisers in the empowerment of communities. The social and other determinants of states of health need to be addressed.

Always to be remembered: the training curricula of young professionals need to be changed, to give comprehensive primary health care a more central role in education.

Primary health care requires universal access to essential medicines, with most of them made available as generic drugs. Patents in this field need to be confronted, because they are primarily market-oriented. Drugs must be available to all who need them either free or at affordable costs.

The institutions involved in primary health care will need to change their focus. But this is not a time to blame. It is a time to move forward.

 The revival of *Health for All*

It is now 36 years after Alma Ata. Times and circumstances have changed, but the core principles of the Alma Ata Declaration remain as valid now as they were then – indeed, more so.

We are committed the principles and values of the UN system and of its agencies. We all should look to WHO to provide not only technical analysis and recommendations, but also moral and political leadership. WHO needs to reclaim its legitimate position as the global leader in promoting policies that lead to a world with healthy and well-nourished populations.

Specifically, WHO must actively support member countries to adopt policies that promote primary health care as an integral part of their national policies. This support needs to be given not only in the area of health systems development, but also in promoting policies that more resolutely address the issues related to the social and other determinants of health.

Happily there is support for *Health for All,* then and now, in a high place. WHO director-general Margaret Chan has so come out publicly. She believes in universal and comprehensive primary health care provision in the face of the overwhelming evidence that privatisation of public health is a catastrophe. We end simply by quoting from the statement she made in her own country of China (7).

 *Box 2*

 Public health, and China

 *This is an extract from the address given by WHO director-general Margaret Chan in Beijing at the International Seminar on Primary Health Care in Rural China, November 2007(9).*

 The highest duty of public health is to protect populations from risks and dangers to health. This duty belongs to government. It includes the performance of basic public health functions, such as ensuring the safety of food, water, and blood supplies. It also includes a responsibility to ensure that populations have the information and the means to protect their health. It includes regulatory functions and requires the investment of public funds.

 *The ethics of public health*

 The highest ethical principle of public health is equity. This can be expressed in simple terms. People should not be denied access to life-saving or health-promoting interventions for unfair reasons, including those with economic or social causes. The greatest power of public health is prevention. Medicine focuses on the patient. Public health seeks to address the causes of ill health in ways that provide population-wide protection.

 Never before has medicine possessed such a sophisticated arsenal of tools and technologies. Yet every year, more than 10 million young children and pregnant women have their lives cut short by largely preventable causes. Poverty contributes to poor health, and poor health anchors populations in poverty. Better health allows people to work their way out of poverty and spend household incomes on something other than illness.

 Governments have failed to invest adequately in basic health infrastructures, regulatory frameworks, and the health workforce. The gaps between wealth and poverty, between good health and avoidable ill health, grow ever wider. Gaps between the health status of privileged urban populations and that of marginalised rural populations; gaps between households with health insurance and households driven below the poverty line by out-of-pocket payments for medical care. The best care tends to go to those who need it least.

 Many low-income countries have, with efficient policies and high-level political commitment, achieved health outcomes comparable to that in much wealthier nations. Think of China in the 1970s. This country’s health achievements were legendary. The health system, achieving 90% coverage of a vast population, was the envy of the world.

 Equity is vital as a policy objective. Low-income countries with policies that emphasise equitable access to essential care have achieved greater life expectancies than wealthy countries with no such policy objective. Better health outcomes can be achieved when equitable access to care is an explicit policy objective.A commitment to equity is also a mark of good governance. The political will to take care of society’s most vulnerable and deprived citizens also speaks of the value a society gives to each and every human life, regardless of whether that value has religious, cultural, social, or economic dimensions. A commitment to equity is also a promise of solidarity and shared responsibility in the pursuit of better health

 A primary health care approach is the most efficient and cost-effective way to organise a health system. International evidence overwhelmingly demonstrates that health systems oriented towards primary health care produce better outcomes, at lower costs, and with higher user satisfaction.

*References*

1. World Health Organization – UN Children’s Fund. *Declaration of Alma Ata.*International Conference on Primary Health Care, Alma-Ata, USSR, 6-12

September 1978. [*Access pdf here*](http://wphna.org/wp-content/uploads/2014/05/1978_WHO_Alma_Ata_Declaration.pdf)

1. Anon. Exclusive interview with WHO’s Dr Margaret Chan. *Frontlines* April-May 2011. Washington DC: USAID. <http://www.usaid.gov/news-information/> frontlines/global-healthiraq/exclusive-interview-whos-dr-margaret-chan
2. Werner D. World Health Assembly. Primary health care. The return of Health for All. [*Commentary*]. *World Nutrition*, April 2014, **5, 4**, 336-365. [*Access pdf here*](http://wphna.org/wp-content/uploads/2014/05/WN-2014-05-04-336-365-David-Werner-Primary-health-care1.pdf)
3. World Bank. *Towards a Healthy and Harmonious Life in China. Stemming the Rising Tide of Non-Communicable Diseases.* Washington DC: World Bank, 2011
4. Cueto M. The origins of primary health care and selective primary health care. *American Journal of Public Health* 2004, **94**, 11, 1864-1872.
5. Baum F. Health for all now! Reviving the spirit of Alma Ata in the twenty-first century. An introduction to the Alma Ata Declaration. *Social Medicine* 2007, **2**, 1, 34-41. [*Access pdf here*](http://wphna.org/wp-content/uploads/2014/05/2007_Social_Medicine_Fran_Baum_Alma_Ata.pdf)
6. Chan M. Keynote address. International Seminar on Primary Health Care in Rural China, Beijing, China, 1 November 2007.[*Access pdf here*](http://wphna.org/wp-content/uploads/2014/05/2007_Margaret_Chan_PHC_Beijing.pdf)

|  |
| --- |
|  Status  |

 Readers may make use of the material in this commentary if acknowledgement is given to the Association, and *WN* is cited. Cite as: Hamlin Zuniga M, Schuftan C. *Health for All*. The vision whose time has come again. [*Commentary*]. *World Nutrition*, May 2014, **5, 5**, 446-456. All *WN* contributions are obtainable at www.wphna.org.

 *World Nutrition* commentaries are reviewed internally or by invitation. All contributions to

 *World Nutrition* are the responsibility of their authors. They should not be taken to be the

 view or policy of the World Public Health Nutrition Association (the Association) or of any of

 its affiliated or associated bodies, unless this is explicitly stated.

|  |
| --- |
|  How to respond  |

 Please address letters for publication to wn.letters@gmail.com. Letters should usually respond to or comment on contributions to *World Nutrition*. More general letters will also be considered. Usual length for main text of letters is between 350 and 1000 words. Any references should usually be limited to up to 10. Letters are edited for length and style, may

 also be developed, and once edited are sent to the author for approval.