

From Alma-Ata to Almaty: a new start for primary health care

On Oct 14, *Now more than ever*, the World Health Report for 2008, was launched at Almaty, a city formerly called Alma-Ata and well known for the 1978 WHO declaration on primary health care.¹ Although many countries tried to put primary care into practice, the declaration's goal of Health for All was not achieved. Will all countries now establish strong and efficient primary care as an integral component of their health systems? Is 2008 different from 1978?

Both the 1978 declaration and the 2008 report are underpinned by social justice, equity, and solidarity, although these values are increasingly under pressure in a context of globalisation and a growing gap between rich and poor nations. The most important difference between 2008 and 1978 is that today there is more evidence about the effectiveness and efficiency of primary health care. This evidence may inspire action at different levels with greater safety, effectiveness, efficiency, patient-orientation, timeliness, and equity of health services.

Evidence at the macro level (eg, policy, payment, regulations) is now overwhelming: countries with a strong service for primary care have better health outcomes at low cost. Systems that explicitly distribute resources according to population health-needs (rather than demands), that eliminate co-payments, that assume responsibility for the financing of services, and that provide a broad range of services within the primary care sector are more cost effective.² The evidence is robust across time and place, including middle-income countries and countries of the Organisation for Economic Co-operation and Development (OECD), with similar findings in more limited studies in developing countries.

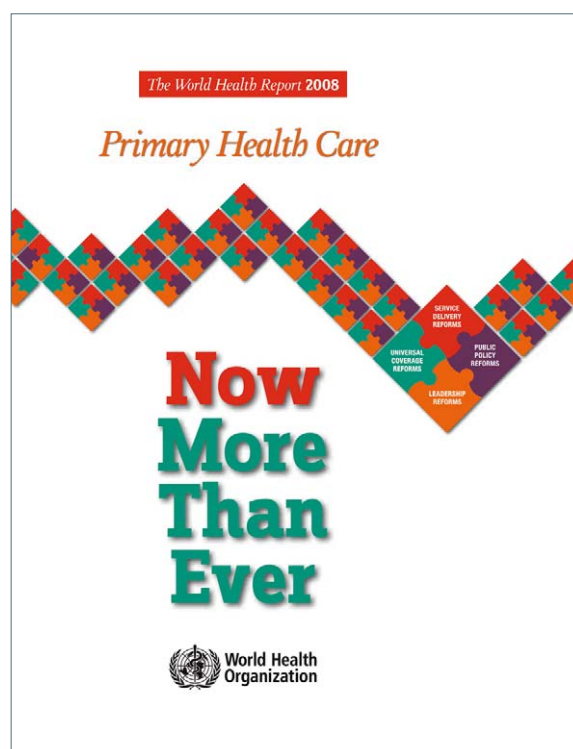
Essential features of a strong health system led by primary care are: accessibility (with no out-of-pocket payments), a person (not disease) focus over time, universality, a broad range of services in primary care, and coordination when people do have to receive care elsewhere. There are large variations, even among developed countries, in exposure to primary care services.³ Focusing on just a few diseases or health problems interferes with the development of local services for primary health care through the inefficiency and duplicated effort of competing personnel and facilities.⁴

The multiple interacting health problems that are intractable cannot be dealt with without a person-focused population-oriented approach. Vertically oriented and externally funded services interfere with the responsibility of the state to improve its own health services.⁵

The need for integration of health services by primary health care was emphasised by a workshop in May, 2008, in Geneva.⁶ The 15by2015 campaign (launched in March, 2008, to strengthen health systems led by primary care) asked donors to invest 15% of their funding in local primary health care.⁷ A system with a list of patients, mixed capitation, and no co-payments is more cost effective (through less use of secondary care, medical imaging, and laboratory testing, and more cost-effective prescribing) and of better quality (better performance in prevention) than most current approaches.⁸

The report⁹ by WHO and the Commission on Social Determinants of Health emphasises the importance of health systems based on primary care principles that take into account the range of social determinants, where prevention and promotion are in balance with investment in curative interventions and where there is

Published Online
October 14, 2008
DOI:10.1016/S0140-
6736(08)61524-X



an emphasis on the primary level of care with referral to higher levels only when justified by need.

At the middle level, the gap between primary health care and public health must be bridged by intersectoral actions for health to address social and health determinants. There are clear indications that primary care reduces social inequalities in health through empowerment of individuals and communities and social cohesion.¹⁰ A primary care approach combines care of chronic illnesses with care for the acute illnesses that both predispose to and complicate the chronic illnesses. In the UK National Health Service, over 95% of contacts with patients for acute and chronic conditions occur in primary care. With 82% of all problems managed at this level, patients' satisfaction is high and at a relatively low cost to the health system.^{11,12}

At the micro level, *Now more than ever* places special attention on the importance of local health services that put people, not diseases, first. The commitment of all health workers to primary care is essential. Although the type of health worker will vary by local circumstances, common features are patient-orientation with continuing care provided over time, universality, and comprehensiveness.¹³

Participation of the citizen-patient and the local community in primary health care is essential. Prevention should take a population orientation with explicit consideration of attributable risks, the setting of priorities on the basis of reduction in illness, avoidance of adverse effects, and the imperative to reduce inequities in health.¹⁴ Strategies such as Community Oriented Primary Care¹⁵ involve the local community in a continuous process of information gathering, including the design of health-need assessments, planning, and intervention and monitoring of local outcomes.

Some countries have shown the way. Thailand has shown how the introduction of a family physician contributes to accessibility, patient-orientation, and cost-effectiveness of care.¹⁶ Brazil's national primary care policy has improved outcomes for important health indicators.¹⁷ Cuba has achieved levels of health commensurate with those of OECD countries through its commitment to primary health care over 20 years. Oman's investment in a health system led by primary care and accessible to the whole population yielded health indicators similar to those of European countries.¹⁸

Now more than ever encourages partnerships. The goal is that by 2028 the world's population will have equitable, good-quality, and cost-effective primary health care with referral to secondary and tertiary care only when appropriate. Expanding the range of problems that can be dealt with in primary care and improving the quality of services have both been greatly advanced by developments in information and communication technology since 1978. In the UK, for example, most primary care practices now use electronic patients' records and have access to online educational resources, which in many cases are also accessible to patients and the public. Ensuring effective use of these new technologies and online resources will be a key priority for health-care systems.

A worldwide global plan for primary health care is needed, and WHO should set the agenda for this development, by creating a specific high-level unit for primary health care that cuts across the programmes oriented vertically to diseases in the organisation. *Now more than ever* sets ambitious challenges for primary health care. Now, by contrast with 1978, we know more about how to meet these challenges.

**Salman Rawaf, Jan De Maeseneer, Barbara Starfield*
WHO Collaborative Centre, Wandsworth Teaching PCT,
London SW19 3RU, UK (SR); European Forum for Primary Care,
Ghent University, Ghent, Belgium (JDM); and Johns Hopkins
University, Baltimore, MD, USA (BS)
srawaf@sgul.ac.uk

We were among the six global reviewers of *Now more than ever*. SR and JDM were also involved in the early meeting in preparation for the report.

- 1 WHO-UNICEF. Declaration of Alma-Ata: international conference on primary health care, Alma-Ata, USSR, 6–12 September 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed Sept 5, 2008).
- 2 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83**: 457–502.
- 3 Bindman AB, Britt H, Crampton P, Forrest CB, Majeed A. Diagnostic scope of and exposure to primary medical care in Australia, New Zealand and the United States: results from three national surveys. *BMJ* 2007; **334**: 1261–64.
- 4 Chan M. Return to Alma-Ata. *Lancet* 2008; **372**: 865–66.
- 5 Brown A. Integrating vertical health programmes into sector wide approaches—experiences and lessons. July, 2001. http://www.sti.ch/fileadmin/user_upload/Pdfs/swap/swap044.pdf (accessed Sept 5, 2008).
- 6 WHO. Maximizing positive synergies between health systems and global health initiatives. 2008. http://www.who.int/healthsystems/hs_&_ghi.pdf (accessed Sept 5, 2008).
- 7 De Maeseneer J, Van Weel C, Egilman D, et al. Funding for primary health care in developing countries: money from disease specific projects could be used to strengthen primary care. *BMJ* 2008; **336**: 518–19.
- 8 Annemans L, Closon JP, Closon MC, et al. Comparison of cost and quality of 2 financing mechanisms for primary health care in Belgium. 2008. http://www.kce.fgov.be/index_nl.aspx?SGREF=5268&CREF=11494 (accessed Sept 5, 2008) [in Dutch].

- 9 WHO-Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. 2008: 12. http://www.who.int/social_determinants/final_report/en (accessed Sept 11, 2008).
- 10 De Maeseeneer J, Willems S, De Sutter A, Van de Geuchte ML, Billings M. Primary health care as a strategy for achieving equitable care: the literature review commissioned by the Health Systems Knowledge Network. http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf (accessed Sept 11, 2008).
- 11 Pereira-Gray D. Dozen facts about general practice. London: Department of Health, 2006.
- 12 National Audit Office. Patient choice at the point of GP referral. London: The Stationery Office, 2005.
- 13 Mash R, Downing R, Moosa S, De Maeseeneer J. Exploring the key principles of Family Medicine in sub-Saharan Africa: international Delphi consensus process. *S Afr Fam Pract* 2008; **50**: 62–67.
- 14 Starfield B, Hyde J, Gervas J, Heath I. The concept of prevention: a good idea gone astray? *J Epidemiol Community Health* 2008; **62**: 580–83.
- 15 Rhyne R, Bogue K, Kukulka G, Fulner H. Community-oriented primary care: health care for the 21st Century. Washington: American Association for Public Health, 1998.
- 16 Pongsupap Y. Introducing a human dimension to Thai health care: the case for family practice. Brussels: VUB-Press, 2007.
- 17 Ministerio de Salud del Brasil. Evaluación para la mejoría de la calidad de la estrategia salud de la familia. Ministerio de Salud, Serie B: Textos Básicos de Salud, 2006.
- 18 Sultanate of Oman. Second primary health care review mission. Geneva: WHO, 2006.