Opinion and analysis

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Primary health care in the Region of the Americas: 40 years after the Alma-Ata Declaration*

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ABSTRACT *This article reviews the evolution of regional proposals and agreements from the Declaration of Alma-Ata (1978) to the Universal Health Strategy, highlighting how the core tenets of the primary health care strategy have come to be reflected in proposals to strengthen the primary level of care and establish integrated health services networks. Contextual aspects of implementing the strategy within the framework of complex national scenarios are also noted, through a review of some of the milestones of the last 40 years. Factors that hinder implementation of primary health care are described, as well as the advances and the emerging challenges that health systems face in several countries. This article reaffirms the need for a strong primary care level—with coordination and response capacity, close to and involved in the community, and accessible—in order to advance towards realizing the right to health for all. It also advocates for practical proposals to relaunch the primary health care strategy 40 years after the Declaration of Alma-Ata.*

Keywords Primary health care; health systems; health policy; universal coverage.

Health, understood as a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (1), is a complex social phenomenon dependent on the interplay of multiple social, political, economic, cultural, and scientific factors. Given this complexity, it is not surprising that the leaders of the nations gathered at the International Conference of Alma-Ata (Union of Soviet Socialist Republics, 6-12 September 1978) (2) concluded that the basic tool for achieving that state of well-being and making the right to health a reality was primary health care (PHC), involving comprehensive action that transcends reductionist disease-centered approaches.

Unfortunately, many interpreted PHC as "poor services for poor people", which could not be farther from the spirit of Alma-Ata. Indeed, some of the conference participants and regional public health officials since then have voiced their frustration at the misunderstandings and distortions surrounding the issue (3), directly calling attention to the "erroneous interpretation of the terms" (4). The conditions that gave rise to the social and political goal of "health for all" intensified as time went by—given the persistence of vast inequities, the predominance of the curative medical approach, and limited social participation in health systems—leading to important actions and resolutions (5–9). In September 2014, the 53rd Directing Council of the Pan American Health Organization (PAHO) approved the Strategy for Universal Access to Health and Universal Health Coverage, later shortened to the "Universal Health Strategy," which implies "that all people and communities have access, without any kind of discrimination, to comprehensive,

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appropriate, and timely quality health services …" (10). The resolution adopted expressly states that the strategy is "framed by the values and principles of primary health care in the spirit of Alma-Ata." Its intent is therefore to transform the organization and management of health services by developing models of care centered on the needs of people and communities—with greater capacity at the first level of care, connected through integrated health service delivery networks (IHSDNs) (11), and based on primary health care. Finally, Goal 3 of the Sustainable Development Goals is to "ensure healthy lives and promote well-being for all at all ages." To accomplish this, one of its targets is to achieve universal health coverage, especially financial risk protection and access to safe, effective, quality, and affordable medicines and vaccines for all (12), clearly supporting the Alma-Ata proposals (13).

All the discourse and declarations appear to support this, but, in our view, when the time comes for decision-making, countries continue to give preference to a hospital-centered model, advanced technology, and curative medicine. When drafting policies, governments do not prioritize investment in infrastructure, human resources, and technologies or social and public health strategies designed to work effectively with communities to address the social determinants of health and bring health to where people live. (14). Nevertheless, given the historical path of each country in the 40 years following the Declaration of Alma-Ata (Figure 1), PHC continues to appear to be key to making the right to health a reality.

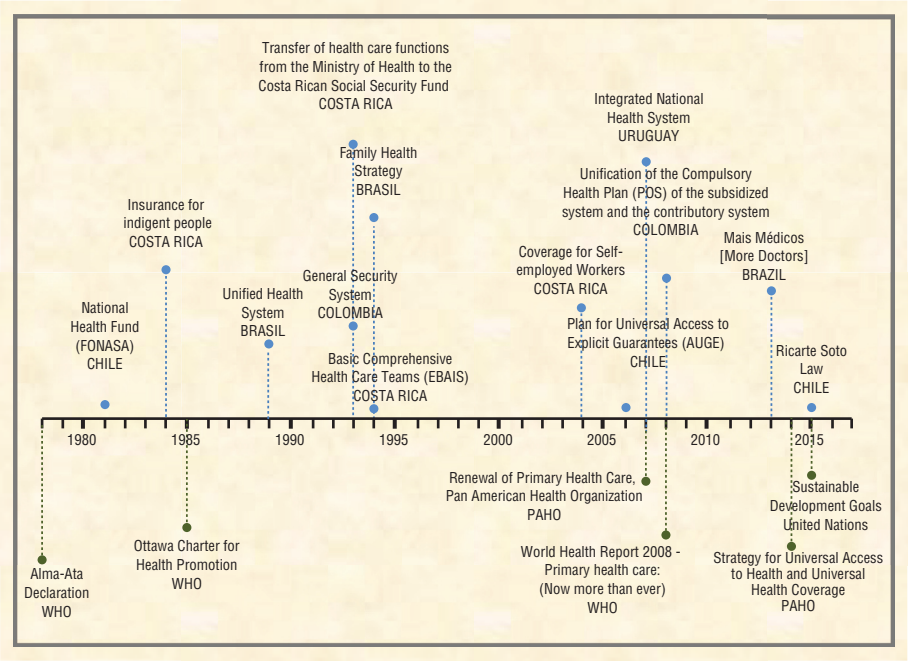
It is worth considering whether, underlying the lack of coherence between discourse and action, powerful interests and values are prioritizing the medical industrial model in which health is a business and not a right. In addition to perpetuating the social determinants of health, this model continues to make efforts to honor the spirit of Alma-Ata an uphill battle.

In the historical and sociopolitical context of Latin America, countries have shown varying degrees of concern about social issues, the alternation of democratic and authoritarian governments, military dictatorships, democratic transition and recovery processes, structural adjustments and State reform processes, health sector reforms, the introduction of cost-containment models, and the development of social protection systems, among other sometimes divergent processes. These sociopolitical phenomena have not always furthered the implementation of PHC (15). Some economic models have focused on efficiency in public health expenditure, often putting the explicit needs and demands of communities on the back burner. In other cases, populist relationships between States and civil society have stressed short-term action that fails to have a real impact on the health of the population. Furthermore, the trend toward top-down planning has put the brakes on political and administrative decentralization processes that promote intersectoral participation in local planning with a sustainable strategic approach. Even though the stated intent of some initiatives is to shift the focus of health action from the individual and care standpoint toward collective action, disease prevention, and health promotion, they have been insufficient to alter the traditional biomedical approach and health care practice in PHC (16).

However, progress has been observed despite these problems (Table 1). Immunization rates in the Region remain high, antiretroviral therapy coverage has substantially increased, per capita health expenditure has doubled, and infant and maternal mortality and mortality from preventable causes have fallen. The health policies of recent decades aimed at expanding health coverage in the Region of the Americas have been adopted in a context of redemocratization and economic growth, which has led to an increase in financing, the reduction of catastrophic health expenditures, better health indicators, and the reduction of inequalities. These policies have increased health coverage for more than 46 million Latin Americans over the past 25 years (17). Countries that have implemented PHC-based policies and programs, among them Chile, Costa Rica, and Uruguay, report lower infant and maternal mortality (18–20). These countries also show an increase in the use of cervical and breast cancer prevention services, contraceptive use, prenatal check-ups, and deliveries attended by skilled personnel (17).

By way of example, since the creation of its National Health Services in 1952, Chile has gradually and continuously strengthened primary care, especially in recent decades with implementation of the family and community health

FIGURE 1. Chronology of Milestones: from Alma-Ata to Universal Health



model (21) and a significant increase in public funding (22). This path has consolidated PHC as a successful State policy with broad-based consensus. This is seen in the fact that different stakeholders in the country recently signed a position paper reflecting the opinions of over 10,000 people who participated in 387 discussions on increasing the social value of PHC during the period 2016-2017 (23, 24). Several countries in the Region have made serious attempts to include civil society and local communities in different forums for dialogue on health; create formal bodies for the representation of social and community-based organizations such as local health committees or health councils (Bolivia, Brazil, Chile, Colombia, Mexico, and Peru, among others) with different degrees of influence in the design, implementation, and evaluation of health policies; make the health authorities accountable through participatory public accounts; use participatory budgeting as a deliberative exercise for influencing the use of public health resources; and introduce different forms of dialogue and citizen consultations (in-person or through participatory digital platforms) on changes of a legal nature (food labeling, explicit health rights and guarantees, the production and distribution of medicines) or technological changes that can affect the health of the population (25, 26).

One of the major challenges identified for health systems, which should be met largely in primary care, is the increase in noncommunicable chronic diseases and their associated risk factors in every socioeconomic group in every country (17). Primary care has an essential role to play in reducing

TABLE 1. Demographic and economic indicators, and others related to the health system, risk factors, and mortality in Latin America and the Caribbean, 2000–2015

Indicators	2000	2005	2010	2015
Demographic				
Total population	524 829 251	560 677 885	596 479 937	631 062 661
Population growth (annual %)	1.45	1.28	1.21	1.08
Population ≥ 65 years (men, % of the total)	4.87	5.37	5.94	6.72
Fertility rate (births per woman)	2.60	2.40	2.20	2.10
Life expectancy at birth (years)	71.53	72.98	74.22	74.22
Economic				
Unemployment (% of total working population)[a]	10.61	8.00	7.26	6.57
Poverty incidence rate (% of the total population)[b]	11.70	9.80	6.00	4.50
Per capita GDP, PPP (current international dollars)[c]	8635.1	10422.6	13280	15238.2
Current health expenditure (% of GDP)[d]	6.10	6.52	6.87	7.39
Current health expenditure per capita, PPP (current international dollars)[d]	536.70	677.49	894.78	1 081.34
National health expenditure per capita, PPP (current international dollars)[d]	236.94	300.07	439.73	556.71
Out-of-pocket expenditure (% of current health expenditure)[d]	42.07	42.36	33.95	31.27
Health system				
Immunization with DTP vaccine[e]	90.73	93.61	93.21	90.09
Measles immunization[e]	93.58	92.73	93.28	92.66
Antiretroviral therapy coverage[f]	10.40	20.80	33.86	53.09
Risk factors				
Prevalence of malnutrition based on age[g]	18.40	15.70	13.40	11.40
Prevalence of overweight[g]	6.80	6.80	6.90	7.00
Prevalence of malnutrition (% of total population)	11.95	8.99	6.93	6.58
Mortality				
CVD, cancer, diabetes, or CKD (ages 30-70, %)	20.42	28.58	17.29	15.99
Suicide (per 100 000 population)	6.82	6.94	6.93	7.05
Mortality in children < 5 (per 1 000 live births)	33.43	26.19	24.62	18.07
Infant mortality rate (per 1 000 live births)	27.72	21.97	18.79	15.33
Maternal mortality rate (per 100 000 live births)	99.00	88.00	81.00	67.00

[a] Based on the model of the International Labor Organization.
[b] Based on $1.90/day (2011 PPP).
[c] Gross domestic product (GDP) per capita, based on purchasing power parity (PPP), is the gross domestic product converted to international dollars using purchasing power parity rates and divided by the population at mid-year. The data for Latin America and the Caribbean are calculated using the weighted average.
[d] Aggregation method: weighted average.
[e] Percentage of children aged 12-23 months.
[f] Percentage of people living with human immunodeficiency virus.
[g] Percentage of children under 5.
CVD, cerebrovascular disease; CKD, chronic kidney disease. DPT; diphtheria, whooping cough, and tetanus.
Sources: World Development Indicators, World Bank (http://databank.bancomundial.org/data/reports.aspx?source=world-development-indicators). World Health Organization. Global Health Expenditure database (http://apps.who.int/nha/database). Organización World of the Health. Global Health Observatory Data Repository (http://apps.who.int/ghodata/).

chronic diseases and risk factors. Investment in boosting the capacity of primary care in disease prevention, early diagnosis, and risk-factor detection is one of the key pillars of the Declaration of Alma-Ata and the Universal Health Strategy. One of the recommendations regarding preventive health services for adults is to provide at least one health check-up per year. However, despite the steady increase in noncommunicable chronic diseases, the average annual percentage for health check-ups is 20%, far from an ideal model of preventive care (17). Hospitalization for conditions manageable on an outpatient basis is still high, as are the associated costs. A study published in 2012 puts the number of avoidable hospitalizations in several Latin American countries at 8.1-10 million, at a cost representing 2.5% of the total health expenditure in these countries (27). These findings show that better response capacity in primary care could prevent many hospitalizations, reducing costs and improving the quality of life of the population.

Given the progress and pending issues, it must be reiterated that PHC is essential health care accessible to all individuals and families in the community through acceptable means, with their full participation, and at an affordable cost to the community and the country. "Essential" should be understood as the basic, most important services that should be accessible to all comprehensively, in the multiple sense of the word: 1) promotion, prevention, treatment, rehabilitation, and palliative and long-term care, 2) throughout the life course, 3) along the entire continuum of care, and 4) in the diversity of family and community settings, without any discrimination in attaining the highest quality of life possible. It is a strategy that not only cuts across the health sector, but across all policies. Thus, it is essential to have a robust and quality first level of care with good response capacity, supported by specialized services organized in a network. The PHC strategy requires active social participation and the inclusion of aspects such as the intercultural and gender approach, with the strengthening of activities such as those indicated above in some countries of the Region. PHC is definitely not "poor services for poor people" but the best investment for achieving health for all.

Expanding access to health services means increasing accessibility and response capacity in ambulatory settings (beyond the walls of the traditional hospital), which involves building trust among people and communities and increasing their satisfaction. "Ambulatory services" are understood as the first level of care or contact with the user community; as health facilities with human competencies and technological capacities specializing in relatively less frequent health problems, together with diagnostic, therapeutic, or logistical support at the first level; and as the various health and social-sector mechanisms in the community that work in a coordinated network to meet the needs of people and communities without hospitalization (28).

Anticipatory health care and, thus, improvement in the quality of life, requires an integrated social response. This change cannot be effected solely by the health sector or a particular public health mechanism, but implies a shift in the organizational paradigm, in how we intervene from a population standpoint, in the way health systems are modeled, and in how the necessary resources for meeting that objective are provided (28).

PHC response capacity includes having trained interdisciplinary health teams with incentives and attractive working conditions, especially in areas where access to health care is difficult—for example, in poor, marginalized, and scattered rural areas or urban and peri-urban areas. These workers should have sufficient and appropriate health technologies (laboratories, drugs) at their disposal, as well as the effective support of specialists. The changes in the first level of care are designed to forge health teams capable of taking intersectoral action on the social determinants of health, working with the community in promotion and prevention, managing acute and chronic problems (including sequelae and disabilities), and providing home-based palliative care to maintain close, seamless, relevant, and permanent relationships with the community in its geographical setting. In a current reading of the spirit of Alma-Ata, participation is more than a mere formality; it is the means for endowing people and communities with real power and agency. The intercultural approach is a paradigmatic shift more than a complementary approach and implies respect for diversity in our practices. Proximity implies the absence of geographical, economic, cultural, and other access barriers, as well as: 1) physical proximity and the ease with which people establish stable ties with health workers, request appointments, receive reports, and are involved in understanding and meeting their particular needs (related to age, sex, ethnicity, or other characteristics); 2) linkage with local stakeholders and realities (including the media) to ensure that services are an integral part of community life, using modern communication technologies, home visits, mobile brigades, community health agents, partnerships with civil society groups, among many other options, to strengthen linkages with local communities; and 3) progress in developing participatory local planning processes within the expanding framework of political and administrative decentralization, a focus on equity and the cultural relevance of health activities, a cross-cutting approach to rights, and the active exercise of citizens' rights in the development of an agenda for sustainable inclusion and social protection (28).

The first level of care is not only the gateway to the entire system but the linchpin in its organization and the primary source of data for case management information systems (supported by the creation of a network of electronic files), for monitoring care processes, appointments and case management, and referral and back-referral systems, among other things. This means that the services' human resources, infrastructure, and technology must be organized in a way that guarantees a first level of care capable of action with and for the people and the community, making it possible to solve people's main health problems comprehensively and in their own settings.

By all indications, 40 years after the Declaration of Alma-Ata, this is a good time not only to consider a situation analysis but to propose concrete practical solutions born of dialogue, close listening, and rigorous research. If primary care is not strengthened by intersectoral and community participation, it will not be possible to achieve social well-being or universal access to health.

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La atención primaria de salud en la Región de las Américas a 40 años de la Declaración de Alma-Ata

RESUMEN

En este artículo se reseña la evolución de las propuestas y acuerdos regionales desde la Declaración de Alma-Ata (1978) hasta la Estrategia de Salud Universal y se destaca la vigencia de los planteamientos esenciales de la estrategia de atención primaria, que hoy se expresan en las propuestas de fortalecimiento del primer nivel de atención y la generación de redes integradas de servicios de salud. Se recuerda, también, el carácter contextual de la implementación de la estrategia en el marco de situaciones nacionales complejas a través de algunos hitos de los últimos 40 años. Se describen los factores que frenan la implementación de la atención primaria de salud (APS), así como los avances y desafíos emergentes que hoy en día enfrentan los sistemas de salud en varios países. Se reafirma que solo mediante un fuerte primer nivel articulador y resolutivo, cercano, inserto en la comunidad y accesible, es posible avanzar hacia el ejercicio del derecho a la salud para todos y se aboga por la generación de propuestas prácticas para relanzar la estrategia de APS a 40 años de la Declaración de Alma-Ata.

Palabras clave Atención primaria de salud; sistemas de salud; política de salud; cobertura universal.

Atenção primária à Saúde na Região das Américas 40 anos após a Declaração de Alma-Ata

RESUMO

Este artigo apresenta a evolução das propostas e acordos regionais a partir da Declaração de Alma-Ata (1978) até a Estratégia de saúde universal, destacando a vigência das perspectivas básicas da estratégia de atenção primária, atualmente expressas nas propostas de fortalecimento da atenção primária e formação de redes integradas de serviços de saúde. Salienta-se o caráter contextual da implementação da estratégia em cenários nacionais complexos, ilustrando-se com os marcos alcançados nos últimos 40 anos. São descritos os fatores que freiam a implementação da atenção primária à saúde (APS) e os avanços e desafios emergentes atualmente enfrentados pelos sistemas de saúde em vários países. Enfatiza-se que, somente com um nível de atenção primário que seja forte, articulado e resolutivo, que esteja próximo e inserido na comunidade e de fácil acesso às pessoas, é possível progredir no direito à saúde para todos. O artigo defende a elaboração de propostas práticas para relançar a estratégia de APS após 40 anos da Declaração de Alma-Ata.

Palavras-chave Atenção primária à saúde; sistemas de saúde; política de saúde; cobertura universal.