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HEALTH FOR ALL

Beyond the Alma-Ata Declaration

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IT IS WELL KNOWN TO ALL concerned persons, that the call "Health for All by 2000 AD" was given in the international conference on primary healthcare at Alma-Ata (the capital of Kazakhstan of erstwhile USSR) in 1978. The conference was organized by the joint committee on WHO and UNICEF and was attended by almost all the member states.

The Declaration of Alma-Ata adopted primary health care (PHC) as the means for providing a comprehensive, universal, equitable and affordable healthcare service for all countries and it was unanimously accepted by all participants. The draft resolution of the conference stated :

The Conference strongly reaffirms that 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 and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

Access to basic health services was affirmed as a fundamental human right by the Declaration of Alma-Ata in 1978. It can be said that the conference and the subsequent declaration led the foundation stone of "Right to Healthcare" for the people of all countries, more so for the downtrodden mass of the developing nations, the governments of which were the signatories in the historic declaration.

The declaration further stated: Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

PHC envisaged universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. The emphasis

changed from the larger hospital to that of community-based delivery of services with a balance of cost-effective preventive and curative programs.

National governments throughout the world adopted PHC as their official blueprint for total population coverage with essential PHC services. Goals and targets were set for Achieving Health for all by the Year 2000. Some of these goals were that:

- at least 5% of gross national product should be spent on health;
- at least 90% of children should have a weight for age that corresponds to the reference values;
- safe water should be available in the home or within 15 minutes' walking distance, and adequate sanitary facilities should be available in the home or immediate vicinity,
- people should have access to trained personnel for attending pregnancy and childbirth; and
- Child care should be available up to at least one year of age.

The conference rightly suggested that political and economic overhauling are essential preconditions for achieving such goals :

An acceptable level of health for all people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share .

The 1960s and 1970s were, for many developing countries, an era of newly won independence from former colonial powers. This independence was accompanied by an enthusiasm to provide high-standard healthcare, education and other services for the people. It must be stated here that in the 1960s and 1970s, the socialist countries like China, Tanzania, Sudan and Venezuela initiated successful programs to deliver a basic but comprehensive program of primary health care services covering poor rural populations, which was hailed by the WHO also.

During the 1970s, a synthesis of these concepts was undertaken by the World Health Organization (WHO) and UNICEF. It addressed the need for a fundamental change in the delivery of healthcare services in developing countries, with an emphasis on equity and access at affordable cost, and emphasizing prevention while still providing appropriate curative services. This took place in an era where the pre-eminent role of government in the provision of health, education and welfare services was taken for granted in most developed countries, and when there still existed large countries with socialist economies, such as the USSR and China.

The co-operative healthcare delivery system of socialist China won the praise of international agencies and the slogan " Learn from China " was also raised by WHO itself.

The World Bank Report, 1993

Changes in political and economic philosophy in the late 1980s and 1990s marked a major change in how government services were delivered throughout the world. Emphasis was placed on reducing government involvement in all aspects of society. Market forces became the dominant model for service delivery.

The fall of the socialist eastern European bloc and China's adoption of many aspects of liberal economics were major features of this period.

Governments in resource-poor countries, which had already reduced their expenditure on health as their foreign debt mounted in the 1980s and 1990s, now had to contend with the new economic philosophy. International donors insisted these governments adopt the market-driven economic reforms if they were to receive foreign aid and debt relief.

It was against this background that the World Bank's World Development Report of 1993, "Investing in Health", was undertaken. It reflected a marked change in the orientation of how healthcare services in resource-poor countries would be delivered. The report makes little use of the term "Primary Health Care". It considers the delivery of healthcare services in terms of the economic benefit that improved health could deliver, and sees health improvement mainly in terms of improvement of human capital for development, rather than as a consequence and fruit of development. The report is mostly about healthcare sector activities in improving health, and gives scant recognition to the role of other sectors, which contrasts with the original PHC's multicultural approach.

This World Bank approach became known as Health Sector Reform. This heralded an emphasis on using the private sector to deliver healthcare services while reducing or removing government services. User pays, cost recovery, private health insurance, and public-private partnerships became the focus for delivery of healthcare services. Since the 1993 report, the World Bank and other similar agencies have made little reference to PHC as endorsed at Alma-Ata. However, WHO continued to use the terminology throughout the 1990s.

The "World Health Report 2000, Health Systems: Improving Performance" marked the end of WHO'S use of PHC as the means for the delivery of health services in the resources poor countries.

Indian perspective

The National Rural Health Mission (2005–2012) document has depicted the state of public health in India:

- Public health expenditure in India has declined from 1.3% of GDP in l990 to 0.9% of GDP in 1999.

- The Union Budgetary allocation for health is 1.3% while the State's budgetary allocation is 5.5%.
- Union Government's contribution to public health expenditure is 15% while States' contribution about 85%.
- Various Health and Family Welfare Programs have limited Co-ordination at operational levels.
- Lack of community ownership of public health programs impacts levels of efficiency, accountability and effectiveness.
- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.
- There are striking regional inequalities.
- Population Stabilization is still a challenge, especially in States with weak demographic indicators.
- Curative services favor the non-poor: for every Re 1 spent on the poorest 20% population, Rs 3 is spent on the richest quintile.
- Only 10% Indians have some form of health insurance, mostly inadequate.
- Hospitalized Indians have to spend on an average 58% of their total annual expenditure.
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses.
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses.
- 83% expenses incurred by Indian population are out of pocket.

There is wide gap between the recommended numbers of different types of health centers with respect to population size, rural hospitals, beds, equipments, manpower infrastructure in the form of general and specialist cadre of doctors, nurses, technicians and other healthcare attendants. Without going into the details, it can be said in a nutshell that the public heath and medical care service is grossly inadequate, pro-rich, urban bias and inequitably distributed in the country.

In this situation it is clear that India can hardly afford to follow the path of market economy in case of health and medical care. The recommendations made in the Alma-Ata are no less relevant in these days of so-called liberal economy. More public spending and development of government infrastructure is the necessity of the day.□□□

The following tables give some more statistical data from different government sources

TABLE 1

Disease	Total Patients	Annual mortality	World position

Tuberculosis	15 million	0.5 million	First
Diarrhea	5.5 million	2 million	First
Malaria	2.2 million (annually)	25000	First
Leprosy	4 million	-	First
Blindness	3.5 million	-	First
Rheumatic heart disease	1 million	?	First
Pneumonia	4 million	0.8 million	First
HIV/AIDS	30 million	?	First/Second
Other STD	5 million	-	First
Deficiency diseases	250 million	?	First

TABLE 2

Anemia in pregnancy	57.9%
Home delivery by untrained Dai	52%
Infant mortality rate	54 per 1000
Under 5 mortality	72 per 1000
Low birth weight	32%
Anemia in children (6 months to 3 years)	74%
Maternal mortality rate	301 per 1 lac
Severe malnutrition in children	21 millions

TABLE 3

Health indices	USA	CHINA	CUBA	INDIA
IMR/1000	07	10	05	54
Under 5 mortality/1000	08	13	07	72
MMR/ lac	21	48	12	301
Life expect	75	72	75	64
Allopathic doctors/1000	2.56	1.5	5.5	0.7