Primary health care comes full circle

WHO/C Black

Dr Halfdan Mahler

Dr Halfdan Mahler served three terms as director-general of the World Health Organization (WHO) from 1973 to 1988. He joined WHO in 1951 as a senior officer attached to the National Tuberculosis Programme in India. He came to WHO headquarters in 1962 as chief of the tuberculosis programme, a post he held until 1969. From 1969 until 1970, he served as director of project systems analysis. From 1970 until 1973, he served as assistant-director general of several divisions. After retiring from WHO in 1988, he directed the International Planned Parenthood Federation until 1995. He obtained his medical degree at the University of Copenhagen in 1948 and holds a post-graduate degree in public health.

Thirty years ago last month 134 Member States of the World Health Organization gathered in the former Kazakh capital, Alma-Ata, against a backdrop of the Cold War, at an international conference to reach a landmark agreement: to adopt primary health care as the key strategy for achieving 'health for all' by the year 2000. Dr Halfdan Mahler, who was director-general at the time, talks to the *Bulletin* about why primary health care lost its way and his hopes for its renewal today.

Q: Initially, you didn't think it was a good idea to hold an international conference on primary health care, why was that?

A: My colleagues and I in the Conference Secretariat were convinced we needed more time to prepare background documents, but that was rejected by the Executive Board when it agreed the conference should take place in 1978. In retrospect, it was a good thing that they shot us down in flames.

Q: Where did the initiative for more of a health systems-oriented approach come from?

A: From many countries. A lot of documentation came from nongovernmental organizations (NGOs). A WHO publication *Health by the people* based on feedback from individual countries, NGOs and institutions was also important. After its creation, the World Health Organization (WHO) had for many years a strong communicable-diseases focus. That was during the Cold War, when there was always competition among the superpowers to be first. Malaria eradication was supported by the United States of America, and the Soviet Union took on smallpox eradication. Many in the WHO Secretariat were big communicable-disease characters. Then, in the 1960s, Member States started telling WHO that it had failed to support them with their health services. In the 1970s, WHO's Secretariat at last began to search for a balance between the vertical (single disease) programmes and the horizontal (health systems) approach.

Q: There was conflict between the grassroots, community-based approach to primary health care, supported by NGOs and some at WHO, and the centralized health-systems approach espoused by the Soviet Union. Is it true that you favoured the community approach?

A: You can't have one approach without the other, they go hand in hand. Not only the Soviet Union but many Member States supported a centralized health-systems approach. Primary health care will not succeed unless we can generate participation from individuals, families and communities, but this community participation will not work unless there is support from the health system.

Q: What was the atmosphere at Alma-Ata like 30 years ago? What were your expectations of the conference, and were those fulfilled?

A: I expected it to become the most decisive conference WHO had organized after its foundation [1948]. But the Secretariat was anxious about getting a consensus, which was vital. That did not mean trying to convince our adversaries they were wrong, but trying to unite ourselves with them at a higher level of insight. This was exactly what happened in Alma-Ata. It was almost a spiritual atmosphere, not in the religious sense, but in the sense that people wanted to accomplish something great. There was a lot of fighting during the months of preparation and at the conference itself. But there was an overwhelming feeling that 'we must arrive at a consensus'. It wasn't easy. For example, to include 'family planning' alongside 'maternal and child health care' in the Declaration virtually caused the whole thing to break down. But because of a willingness to make a sacrifice for our shared objectives, we reached a spiritual consensus. It's amazing how much this consensus was criticized afterwards. Each time I asked those critics: "Have you actually read the Alma-Ata declaration and report?" most said: "Who would read such rubbish?" Even among WHO staff, only a few really went to town in reading and re-reading it.

Q: Is there a single moment at the conference that sticks in your mind?

A: There is one moment I shall never forget. At the end of the conference, a young African woman physician in beautiful African garb read out the Declaration of Alma-Ata. Lots of people had tears in their eyes. We never thought we would come that far. That was a sacred moment.

Q: What did it mean for people? What was the immediate impact of the Declaration, both in terms of WHO's operations, and in the wider international context?

A: For most, it was a true revolution in thinking. Health for all is a value system with primary health care as the strategic component. The two go together. You must know where you want your values to take you, and that's where we had to use the primary health care strategy. There was a kind of jubilation immediately afterwards. Some suggest nothing was done after that, but that is grossly unfair if you see what WHO regions and Member States did in the first few years afterwards. For

instance, several WHO Member States made quite extraordinary progress. But they had more resources. Africa too had some of the most amazing examples of primary health care in action, for example in Mozambique, while other countries' efforts were slowly eroded by the prevailing political and economic climate. Years later, WHO recorded and continued to implement the Alma-Ata consensus with diverse positive results in different regions and countries.

Q: Selective primary health care, i.e. focusing on single issues or single disease programmes, is the opposite of the Alma-Ata primary health care consensus that called for health for all. Why did primary health care lose its way?

A: The 1970s was a warm decade for social justice. That's why after Alma-Ata in 1978, everything seemed possible. Then came an abrupt reversal, when the International Monetary Fund (IMF) promoted the Structural Adjustment Program with all kinds of privatization, and that drew scepticism towards the Alma-Ata consensus and weakened commitment to the primary health care strategy. WHO regions kept on fighting in countries, but there was no support from the World Bank and the IMF. And the biggest disappointment was when some United Nations agencies switched to a 'selective' approach to primary health care. That brought us right back to square one. We had started with selective health-care programmes, single diseases such as malaria and tuberculosis in the 1950s and 1960s. Then we had this spiritual and intellectual awakening that came out of Alma-Ata, and suddenly some proponents of primary health care went back to the old selective approach again. Perhaps, paradoxically, Alma-Ata had in such instances the opposite effect to the one intended, as it made people think too much about selection, rather than following the Alma-Ata gospel of health for all.

Q: Did the Declaration of Alma-Ata live up to your expectations?

A: The Declaration more than lived up to my expectations and went way beyond the expectations of the governments, NGOs and individuals involved. Never has health been made so important. Health is only complete for those who see it in a complete light and is fragmented for those who see it in a fragmented light. This truism was ever-present in the deliberations at Alma-Ata. The immediate impact of the Declaration was tremendous because people left Alma-Ata with the conviction that they had participated in a health revolution.

Q: Is primary health care as much of a pressing priority now as it was then?

A: Primary health care is more urgently needed now than ever before, not least because you have to find ways of bridging what happened during the first few years after Alma-Ata and what now exists. There is still a memory of primary health care in WHO's regions and Member States, and among NGOs supporting WHO that can be re-awakened.

Q: Health for all seems a Utopian goal, what did you mean by that?

A: The goal was not to eradicate all diseases and illnesses by 2000; we knew that would have been impossible. Our goal was to focus world attention on health inequities and on trying to attain an acceptable level of health, equitably distributed throughout the world.

Q: Are you disappointed that the health for all goal was not achieved and that primary health care is seen as a failed attempt to provide universal health care? How can WHO revitalize primary health care now and what is your involvement?

A: WHO is starting something very important. It goes right back to WHO's wonderful definition of health. If only people had been more respectful of this, that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" – a definition that was ridiculed by many medical professionals. I strongly support what WHO is doing now. I find it exceptionally courageous of WHO's Director-General [Dr Margaret Chan] to have started the discussion with Member States on how to revitalize primary health care. I say this as an old guy who was disappointed that things went the way they did, but now I see that WHO is ready to take a serious look at where we are today and where we want to go beyond selective primary health care. It may cost a lot, not only for converting vertical programmes, but for health systems based on primary health care concepts. It will take all the synergies that can hopefully be generated between the vertical and the horizontal. I am very happy that all of this is beginning to happen now. ■