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From Alma-Ata to Astana. Primary health care and universal health systems: an inseparable commitment and a fundamental human right

De Alma-Ata a Astana. Atenção primária à saúde e sistemas universais de saúde: compromisso indissociável e direito humano fundamental

De Alma Ata a Astaná. Atención primaria de salud y sistemas universales de salud: compromiso indisociable y derecho humano fundamental

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The *Brazilian National Constitution* of 1988 acknowledges the link between economic and social development and environmental conditions in the determination of the health-disease process and defines "*health as the right of all and the state's duty*". The 1988 *Constitution* creates a universal public health system, the Brazilian Unified National Health System (SUS), with a 30-year history in pursuit of the principles of universality, comprehensiveness, equity, and social participation.

The 1988 *Constitution* and the SUS are thus aligned with the spirit of the *Declaration of Alma-Ata* (1978) on primary health care (PHC), which called on governments to formulate national policies, strategies, and action plans to implement PHC as part of comprehensive national health systems and in coordination with other sectors to confront the social and environmental determinants of health, mobilizing the necessary political determination and resources.

The Conference of Alma-Ata occurred in the wake of a series of conferences held by United Nations agencies during the 1970s, and that debated an expanded agenda for a new international economic order aimed at reducing the disparities between the central countries and the so-called Third World nations [1]. World Health Organization (WHO) Director-General Halfdan Mahler contended that it was impossible to dissociate economic and social development from health, expressed precisely in the ideals of comprehensive PHC and health for all in the *Alma-Ata Charter*.

In the years following Alma-Ata, with the rise to power of conservative leaders in Europe and the United States, neoliberal policies were implemented with their "one-size-fits-all" recipes. Based on proposals by the United Nations International Children's Fund (UNICEF) and the Rockefeller Foundation, the GOBI strategy was conceived (Growth monitoring of young children, Oral rehydration therapy, promotion of Breastfeeding, and Immunization), a form of selective and targeted primary care focused on childhood health, clashing with the broad ideals of equity and health as universal rights in the *Alma-Ata Charter* [2,3].

In Latin America in the 1980s and 1990s, accompanying the World Bank's structural adjustment programs and impositions, minimal packages of services were disseminated, targeted to specific groups such as mothers and children or populations in extreme poverty, prompting Mario Testa to question whether the intent was primary health care or primitive health care [4,5].

The 2000s, with re-democratization and the inauguration of Latin American governments committed to social justice, the continent witnessed processes of revitalization of PHC from a comprehensive approach, reaffirming the principles of the *Declaration of Alma-Ata* [5]. The Pan American

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Health Organization (PAHO), pressured by the region's governments, promoted a renewal of the PHC strategy, emphasizing social inclusion, equity, and comprehensiveness [3].

In the celebration of the 40 Years of the *Declaration of Alma-Ata*, at the initiative of the WHO, the UNICEF, and the government of Kazakhstan, the Global Conference on Primary Health Care convened in Astana in October 2018 with the purpose of renewing the commitment by PHC to achieving universal health coverage (UHC) and meeting the Sustainable Development Goals (SDGs) [6].

The Astana Conference took place in a different international context from that of Alma-Ata, with austerity policies, a migratory crisis, and threats to democracy. The conference limited the meaning of comprehensive PHC from Alma-Ata and the scope of the right to health by subsuming it within universal health coverage. UHC, shaped in the last decade with a strong influence from the Rockefeller Foundation and the World Bank, combines guidelines from pro-market reforms such as the reduction of state intervention, demand subsidies, selectiveness, and targeted health policies.

The UHC proposal, as approved in the WHO resolution on financing in 2011 and as one of the targets in the 2030 Agenda (3.8), has been widely publicized by international agencies with a focus on financing via the combination of funds (pooling) managed by private or public insurance companies, coverage by different insurance modalities, and definition of a limited basket of services [7,8]. By emphasizing financial coverage, the proposal merely expresses formal entitlement under some type of private or public insurance, but without a guarantee of access and use when needed [9]. Insurance policies cover specific interventions and dispense with designing a comprehensive and integrated health system. Thus, the right to health becomes restricted to coverage of a limited basket of services to be hired, thereby reediting selective PHC.

The UHC proposal thus results in segmented coverage by differential insurance schemes according to specific social groups based on their income, with service packages that perpetuate inequalities. This is quite different from guaranteeing the universal right to health [10].

Unlike segmented insurance coverage, acknowledgment of the rights in universal health systems funded by tax revenues means the guarantee of access and use according to individual and collective needs. There is robust empirical and analytical evidence that universal systems are superior in quality, efficiency, and equity when they are based on the following pillars: the organization of comprehensive PHC, financing and services provision that are predominantly public, and effective state regulation to guarantee universal access, subordinating the fragmented market logic to the vision of health as a public good [11,12,13,14].

By transmuting the universal right to health into the right to universal health coverage, there is a transposition from one public order to another, of the right to coverage. In UHC, the concept of the right to health, based on the egalitarian principle of social justice, which can only be guaranteed by the state, was transposed to a principle of coverage, exempt from financial difficulties, which introduces the notion of billing by market agents for the provision of health services, corresponding to a narrow liberal vision of citizenship [15].

In this sense, UHC runs counter to the spirit of Alma-Ata and SDG 3: to ensure healthy lives and promote well-being for all at all ages.

The UHC proposal was not validated by PAHO, which adopted "Universal Health", as defined in *Resolution CD53/5* of 2014, which attempts to meet the demand by South American countries to incorporate (on this topic) the guarantee to the right to health and access to health services [16].

The Global Conference on Primary Health Care in Astana: the declaration and its negotiation and commitments

The *Declaration of Astana* presented in the Global Conference on Primary Health Care was submitted to public hearings and to the negotiating process with WHO member states in which Brazil, represented by its diplomatic corps in Geneva (Switzerland), made key contributions with the technical support of the Ministry of Health, Oswaldo Cruz Foundation (Fiocruz), and the Brazilian National Health Council (CNS) [6]. The first drafts of the *Astana Charter* received heavy criticism, since they differed significantly from the principles of Alma-Ata and completely subsumed PHC to UHC. The drafts prioritized participation by the private sector, reduced government responsibility, and

fragmented services with no reference to the organization of an integrated universal system with coordination of care by PHC.

The priority issues submitted by Fiocruz and the CNS featured the following: reaffirmation of the principles of the *Declaration of Alma-Ata*, the defense of the universal right to health, strengthening of universal public health systems, governments' prime responsibility in guaranteeing the right to health, social justice, equity, and non-commodification of health, adequate and sustainable financing, and emphasis on the economic, social, and environmental determination of health. In the document, drafted by researchers from Fiocruz with support from the Technical Chamber on Basic Health Care of the Ministry of Health and backed by the CNS, PHC was highlighted as the backbone of universal public systems with quality, an efficacious and efficient model for guaranteeing health as a human right and a condition for implementation of the path laid out in the 2030 Agenda to "leave no one behind" [15,17].

Along the same line, PAHO Director Carissa Etienne, in a speech to the final plenary session of the Conference, reaffirmed that health is not a commodity but a fundamental human right and the duty of governments [18]. She called for a new "health for all", not limited to access to health services with quality, but also a driving force for sustainable development, promoting equity and social justice.

The *Declaration of Astana* was presented in the first plenary session and approved by acclamation. This was followed by plenary and parallel sessions on PHC and specific topics such as integrated provision of services, access to medicines, training human resources for PHC, mental health, palliative care, noncommunicable diseases, etc., with participation by government representatives, international agencies, civil society, the private sector, and academia.

PHC with quality was reiterated as the most effective and efficient way to apply resources, and there was an alert on the need for greater public investments for health and more efficient use: "*more money for health and more health for money*".

The Brazilian experience with PHC, led by the Family Health Strategy, a structuring and inseparable part of the construction of the country's universal health system (SUS), was cited by several authorities in the opening plenary session and in various other sessions as a successful model based on its relevant impacts in improving the population's access and health. With its 41,000 multidisciplinary teams caring for 130 million Brazilians, the Brazilian example of PHC, the basis of a universal system, was presented together with other examples of expanded coverage by social insurance and community-based health insurance in low-income countries.

Over the course of the three days, participants examined PHC in the context of the 2030 Agenda. Health was highlighted as a central theme, a key indicator, and the best evidence of success in the implementation of the 2030 Agenda. Despite the conceptual limits of UHC, dealing jointly with the themes of the 2030 Agenda and PHC may be a promising approach. It involves: social, economic, commercial, and environmental determinants of health; access to health services with quality; and research, development, and innovation to provide new health technologies oriented by the health economic-industrial complex to respond to the population's needs and confront the enormous challenges of a more equitable standard of development and global health [19].

The *Declaration of Astana* is an international reference, but it does not supersede that of Alma-Ata with its principles of social justice and the conception of comprehensive PHC, inseparable from economic and social development. The *Declaration of Astana* has ambiguities and gaps. An analysis of the declaration's wording and the meanings between the lines reveal what is in dispute in the global health arena [20]. Unlike Alma-Ata, it refers to justice without the "social" adjective. Social justice necessarily means a redistribution of wealth. The emphasis on coverage in UHC may undermine the comprehensive, integrated approach of PHC and limit the population's access to the first level of care or to the supply of basic packages based on persons' ability to pay. Comprehensiveness may be compromised both in its promotion and prevention components and in the guarantee of needs-based access to specialized and hospital care [20]. A comprehensive approach in PHC, in the spirit of Alma-Ata, with its components of health promotion and equity in confronting social determinants, is crucial for guaranteeing the right to health and synergistically meeting the SDGs [21].

Nevertheless, the *Declaration of Astana* affirms the commitment to every human being's fundamental right to health, acknowledging that the persistence of health iniquities is unacceptable. The declaration identifies PHC as the foundation of sustainable health systems, the first effective and

efficient point of contact and the conceptual framework for what should be done to make progress in health and well-being. It aspires to governments and societies that prioritize health and well-being and promote and protect health through solid health systems. It reiterates PHC with quality with person-centered care in comprehensive and integrated health services, with a more inclusive, efficacious, and effective focus to improve health. It affirms PHC as the cornerstone for sustainable health systems with universal coverage [22].

Astana acknowledges that the success of primary health care will depend on: adequate and sustainable financing, well-trained human resources organized in multidisciplinary teams with decent, valued work, integrated care for all, promotion, prevention, cure, rehabilitation, and palliative care, and with a referral system to other levels, confronting fragmentation.

To achieve such success, primary health care and health services should be *"high quality, safe, comprehensive, integrated, accessible, available, and affordable for everyone and everywhere, provided with compassion, respect, and dignity by health professionals who are well-trained, skilled, motivated, and committed"* [22]. It further aspires to guarantee environments that foster good health, in which individuals and communities are engaged in maintaining and enhancing their health and well-being [22].

The declaration's gaps include lack of mention of the following: the health sector's enormous economic importance and the resulting conflicts of interests in the UHC proposal, the economic and commercial determinants of health, and the restrictions imposed by austerity policies. It is necessary to acknowledge that the unviability of Health for All resulted largely from lack of consideration for health's economic dynamics and the need for regulation and strategic orientation of the industrial and innovation complex in health to respond to social needs, all inherent dimensions of development strategies and the structural viability of universal access [19,23].

The People's Health Movement, a global "network of networks" of social movements in health, published an alternative declaration by civil society based on the first draft of the Astana Declaration, denouncing the growing and extreme inequalities, unmasking neoliberal policies and their harmful effects on social rights, and calling for Health for All Now! [24]. The Brazilian National Health Council supported this declaration [25].

The *Declaration of Astana* still requires efforts by those who join in defense of comprehensive PHC and the universal right to global health. The declaration may possibly inform a proposal for a Resolution to be submitted to the World Health Assembly in Geneva in 2019. Finally, the theme will be examined by the United Nations General Assembly in the High-Level Meeting on UHC in September 2019.

To move forward in the spirit of Alma-Ata, it is crucial to recognize social rights, affirm the state's duty, universal access, orientation and regulation of the economic dynamics based on public and social needs, involving decentralized governance coordinated at the national and global levels and with strong social participation [26].

It is necessary to continue building universal public health systems, free and with tax-revenue financing, with comprehensive PHC as the backbone for the network of care, as Brazil's SUS is intended to be. Its population focus requires promoting inter-sector and crosscutting public policies to deal with the social, economic, commercial, and environmental determinants of health, materializing the most effective and efficient path to promote equity and the universal right to health, "leaving no one behind".

Alma-Ata mobilized, and for 40 years has continued to mobilize, hearts and minds in defense of the universal right to health. Will the *Declaration of Astana* have the same force to orient the necessary challenges in consolidating this right?

Contributors

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1. Pires-Alves FA, Cueto M. A década de Alma-Ata: a crise do desenvolvimento e a saúde internacional. Ciênc Saúde Colet 2017; 22:2135-44.
2. Cueto M. The origins of primary health care and selective primary health care. Am J Public Health 2004; 94:1867-74.
3. Birn AE. Back to Alma Ata, from 1978 to 2018 and beyond. Am J Public Health 2018; 108:1153-5.
4. Testa M. Pensar em saúde. Porto Alegre: Editora Artes Médicas; 1992.
5. Giovanella L, Almeida PF. Atenção primária integral e sistemas segmentados de saúde na América do Sul. Cad Saúde Pública 2017; 33 Suppl 2:e00118816.
6. World Health Organization. Global Conference on Primary Health Care. https://www.who.int/primary-health/conference-phc (accessed on 27/Oct/2018).
7. Giovanella L, Mendoza-Ruiz A, Pilar ACA, Rosa MC, Martins GB, Santos IS, et al. Sistema universal de saúde e cobertura universal: desvendando pressupostos e estratégias. Ciênc Saúde Colet 2018; 23:1763-76.
8. Sengupta A. Universal health coverage: beyond rhetoric. Ottawa: Municipal Services Project/International Development Research Centre; 2013. (Occasional Paper, 20).
9. Noronha JC. Cobertura universal de saúde: como misturar conceitos, confundir objetivos, abandonar princípios. Cad Saúde Pública 2013; 29:847-9.
10. Laurell AEC. Políticas de salud en pugna: aseguramiento frente a sistemas universales públicos. Rev Latinoam Enferm 2016; 24:e2668.
11. Wagstaff A. Social health insurance vs. tax-financed health systems-evidence from the OECD. Washington DC: Development Research Group, World Bank; 2009.
12. Schneider EC, Sarnak DO, Squires D, Shah A, Doty MM. Mirror, mirror 2017: international comparison reflects flaws and opportunities for better U.S. health care. New York: The Commonwealth Fund; 2017.
13. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005; 83:457-502.
14. Kringos DS, Boerma WGW, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res 2010; 10:65.
15. Fundação Oswaldo Cruz; Conselho Nacional de Saúde. Atenção primária e sistemas universais de saúde: compromisso indissociável e direito humano fundamental. Saúde Debate 2018; 42(n esp 1):434-51.
16. Organização Pan-Americana da Saúde. Estratégia para o acesso universal à saúde e a cobertura universal de saúde. Washington DC: Organização Pan-Americana da Saúde; 2014. (CD53/5, Rev. 2).
17. Conselho Nacional de Saúde. Resolução nº 600, de 11 de outubro de 2018. Diário Oficial da União 2019; 14 jan.

18. Etienne C. PAHO Director Dr. Carissa Etienne's closing remarks at Global Conference on Primary Health Care, October 2018. https://www.paho.org/hq/index.php?option=com_content&view=article&id=14760:dr-carissa-etienne-director-paho-closing-remarks-at-global-conference-on-primary-health-care&Itemid=2270&lang=es (accessed on 09/Jan/2019).
19. Gadelha CA, Temporão JG. Development, innovation and health: the theoretical and political perspective of the Health Economic-Industrial Complex. Ciênc Saúde Colet 2018; 23:1891-902.
20. Vance C. De Alma-Ata a Astana: la Declaración que muestra lo que está en disputa. http://isags-unasur.org/es/de-alma-ata-a-astana-la-declaracion-que-muestra-lo-que-esta-en-disputa/ (accessed on 09/Jan/2019).
21. Hone T, Macinko J, Millet C. Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals? Lancet 2018; 362:1461-72.
22. World Health Organization; United Nations Children's Fund. Declaration of Astana. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf (accessed on 05/Jan/2019).
23. Asociación Latinoamericana de Medicina Social. Declaración de ALAMES frente al intento de absorber la APS en la, muy cuestionada, Cobertura Universal de Salud (UHC). Saúde Debate 2018; 42(n esp 1):431-3.
24. People Health Movement. Alternative Civil Society Astana Statement on Primary Health Care http://phmovement.org/alternative-civil-society-astana-declaration-on-primary-health-care/ (accessed on 09/Jan/2018).
25. Conselho Nacional de Saúde. Resolução nº 609, de 13 de dezembro de 2018. Diário Oficial da União 2018; 31 dez.
26. Fleury S. Brazil's health-care reform: social movements and civil society. Lancet 2011; 377:1724-5.

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