Reflections on Alma-Ata

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Upon an examination of the development of health services in India, it is evident that the primary health care strategy was a logical outcome and justification for health policies that were (and are) antithetical to the principle of social justice. Thirty years down the line, the village health worker has metamorphosed into the Accredited Social Health Activist, but the health situation cannot be significantly improved without challenging the exploitative social structure.

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The Alma-Ata conference of 1978, convened by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), is considered a historical turning point in healthcare provisioning for the developing world. The declaration adopted, with its rallying cry of "Health for All by 2000 AD", captured the imagination of the public health community in no uncertain way. Though the promises made by the political leadership of the 134 member countries to the people of the world remain largely unrealised, it continues to resonate even 30 years after the event. This year's report of the WHO (2008), entitled "Primary Health Care: Now More than Ever", hopes to affirm that the concept is still valid. While social justice, universal access to healthcare, self-reliance, and self-determination, enshrined in the declaration are values to aspire to, the question today is why the goals were not achieved. Is it only because of a shift to "selective" primary health care under the influence of donors and the western nations, the most commonly stated critique among public health scholars, or, was the problem more generic? Halfdan Mahler, the then Director General of the WHO, credited with the success of Alma-Ata, has acknowledged that the Indian experience substantially contributed to the development of the concept of Primary Health Care (PHC), the central tenet of the declaration (Banerji 2007). By examining the development of health services in the country, I would argue that the PHC strategy was a logical outcome and justification for health policies that were antithetical to the principle of social justice and the assertion of health as a fundamental human right.

The Alma-Ata declaration came when India, free from direct colonial rule, was three decades into health planning. In 1947, when the country gained independence, half the population was dying before the age of 10 years, the life expectancy was less than 30 years and the major cause of death was communicable diseases, with "fevers" accounting for more than half of the deaths (Bhore Committee 1946). Independent India opted for a multi-party democracy and development planning with the intention of promoting economic development with an accent on distributive justice. This period saw the state plan unlike its colonial predecessor, to provide its people with basic services, including healthcare (Qadeer 2005).

Healthcare – Elitist and Urban Biased

As part of its welfare policy, the Indian government adopted the central guiding principle of the Bhore Committee that no individual should be denied medical care because of his/her inability to pay for it. This was in response to the pressure from below to fulfil the promises made during the freedom struggle on the one hand and the needs of capitalist development on the other which required state interventions in areas in which private capital was not equipped to enter or did not find it attractive to do so (Phadke 2004). One of the first health measures was the passing of the Employees State Insurance Act, 1948 which provided compulsory social security benefit, including medical care, to workers in the organised sector.[1] This, in effect, divided the working class by providing healthcare security to a small privileged section of workers, leaving the majority of the workforce who formed the unorganised sector with no legally enforceable health rights.[2] Though, for this population, "free medical service" was to be provided through a tiered system of health facility along the lines of the recommendations of the Bhore Committee, this was not a "justiciable" right.

The next critical issue related to the choice of cadre of health workers who would man the services. At the time of independence, the country had two categories of doctors, the "Licensed Medical Practitioner" (LMP) who had undergone a three-year training, numbering 29,870, and the "Graduates" who had undergone a five-year training, numbering 17,654. The

Bhore Committee's recommendation was to abolish the "Licentiate" course and train only the "Graduates", whom they termed "basic doctor". Though they agreed that this would mean that it will take longer to meet the country's needs, a more highly trained doctor who could meet international standards was, according to them, the best use the country's scarce resources could be put to. They foresaw that the bulk of the non-recurring costs would go into the setting up of the health infrastructure and professional education and the bulk of the recurring costs into salaries; the single "largest proportion" of the recurring costs was to be spent on the salaries of the health staff, with other heads, drugs for instance, receiving a negligible amount. In short, for all their radical sounding recommendations, almost the entire budget of the health services was to be spent on the maintenance of a large cadre of employees who were to be provided all benefits, including accommodation and social security (pension, leave allowance, etc).

After independence, taking the cue from the Bhore Committee's majority members' recommendations,[3] largely due to the political clout that the medical community enjoyed even then, the Indian government decided to abolish the Licentiate course and train the one "highly trained" basic level doctor. By appealing to the patriotic sentiments, the country was thus seduced into accepting a doctor-centred, technology-oriented, costly model of medical care to the exclusion of all other alternatives.

The choice of modern medicine meant that the health services would need to rely totally on those trained in this system and with this, the ball was set rolling to create a virtual monopoly and control by the medical professionals trained in modern medicine. Further, despite the state's avowed intentions of providing healthcare for all, the Bhore Committee's (1946) recommendation that the government should apportion 15% of its budget for the health sector as a "statutory obligation" was never implemented. In fact, public spending on health in 1950-51 was abysmally low at 0.22% of gross domestic product (NCMCH 2005).[4] But this did not result in changing the plans in keeping with the low allocation. In the following years, emphasis continued to be placed on establishing a health infrastructure and in training a cadre of medical manpower, both matching international standards. But insufficient public funding meant that the expansion of public services could not proceed as planned and the high cost, doctor-centred, hospital-based medical care began to be concentrated in urban centres leading to a large section of the population, particularly in rural areas, being deprived of state-provided modern medical care. Soon, gross rural/urban and regional disparities in the availability of health services could be discerned.

In 1959, as part of the planning process, the government appointed a committee under Dr A L Mudaliar to review the health services and make recommendations. The committee (1962) observed that rural services were not popular among the doctors, and that, "…where the positions are not actually vacant, the incumbents with rare exceptions look upon it as a period of forced labour until they can manage to find their way to a more congenial posting in a city hospital or the health department". But contrarily, they recommended the setting up of more medical colleges to solve the manpower crisis! They concluded that since it would not be feasible to provide primary health care to the whole of the rural population, the scarce resources would be better spent on strengthening the district hospitals. Even if it is argued that the Bhore Committee members and the political leadership of post-independent India wanted the best, as defined by international standards, for their people, when it was clear, within the first decade itself, that the health infrastructure created was elitist and had an urban bias, policy changes could have been made for providing a more equitable distribution of healthcare; instead the first important review of the government consolidated the inequitable direction health services were to take in the future.

Enter the Village Health Worker

The 1960s and the 1970s were marked by a series of uprisings and people's movements in the country which threatened to destabilise the political situation. It was not only in the health sector that inequalities had become noticeable; the economic policies of the government had, rather than alleviate poverty, increased disparities and the fruits of development were being cornered by a small upper class/caste minority. This was well reflected in the health statistics of that time. For instance, by 1970, while the Infant Mortality Rate (IMR) had declined from that recorded in 1951 (146/1,000 live births), almost all of the decrease was confined to the urban population which recorded 90 in contrast to the 136 in rural areas.

In terms of healthcare, in keeping with the earlier trend, the urban bias and regional disparities in the availability of health services had escalated over the years. It was clear that the expensive and highly trained medical professionals, on whom so much of the country's resources and the health budget had been spent, were unwilling to serve in rural facilities, which in any case were poorly budgeted and equipped, and were settling down in urban areas or migrating to the west. For instance, in 1972, the doctor population ratio in the country was 1 per 4,200 population (this was apart from the number that had migrated abroad) and Bombay, Delhi and Calcutta had 1 doctor for 500 persons (Mejia et al 1979: 283-85). Though the larger proportion of the doctors who did not migrate abroad was still in the public sector, this was the beginning of the shift in growth towards the private sector.

The Shrivastav Committee set up in 1974 to review medical education and support manpower observed that "in spite of the substantial investments made and impressive results obtained, particularly in the production of medical manpower, the health status of the Indian people is still far from satisfactory". For the first time medical technology was looked at critically and there was talk of deliberately deciding to abandon this model of healthcare. Health was seen essentially as an individual's responsibility and the committee stated that, "if an individual cannot be trained to take proper care of his health, no community or state programme of health services can keep him healthy. The issue is therefore, basically of education." While this committee recommended

that no new medical colleges be set up and the number of seats in existing colleges be reduced, they reiterated that the standard of training should continue to be high and that financial considerations should not be allowed to reduce academic standards in medical education. For the rural areas, they perceived that, "...at the community level what (was) needed most (was) not professional expertise so much as nearness to the community, its confidence, emotional rapport with the people, willingness to assist, low cost and capacity to spare the needed time". Without in any way questioning the rationale for spending public money on training doctors who were not meeting the country's needs, for the first time a dual policy, one for the urban (rich) and another for the rural (poor), of healthcare provisioning was articulated explicitly by a government review committee. Enter the Village Health Worker to solve the problems of the doctors' refusal to go to the villages!

Differential Systems of Healthcare

In 1975, the Indian state reacted to the growing discontent in the country, by imposing an Internal Emergency to contain civil unrest leading to the widespread suppression of democratic rights, including the right to procreate. The coercive nature of public health became apparent when health workers were turned into agents of the state in realising its targets for controlling the numbers of the poor. The Family Planning Programme budget jumped from Rs 270 million in 1961-66 (the Third Five-Year Plan)[5] to Rs 3,150 million in 1969-74 (the Fourth Five-Year Plan), and further to Rs 5,160 million in 1974-79 (the Fifth Five-Year Plan) and public healthcare in rural areas became synonymous with population control programme.

Political turmoil, in other parts of the world as well, was leading to consternation in the west. Growing inequalities and its attendant unrest raised the spectre of revolution, and healthcare, with its potential for allaying distrust, became a commodity for buying peace. It was in this context that in January 1975, the executive board of the WHO observed, "…we are on the edge of a major crisis which we must face at once as it would result in a reaction which could be both destructive and costly. There appears to be a widespread dissatisfaction of populations about their health services for varying reasons". It was to respond to this crisis that the 30th World Health Assembly met in Alma-Ata in 1978.

The conference observed that the existing gross inequality in the health status of the people, both within a country and among countries, was unacceptable and therefore a common concern to all countries. In keeping with the "New International Economic Order" and in a spirit of technical cooperation, all governments, international bodies, bilateral and multilateral agencies, and donors were urged to pool in their support for the promotion and protection of the health of the "people", particularly in developing countries which was essential for development and world peace.[6]

It was to answer the problems of non-availability of modern medical care to the marginalised that the concept of "Primary Health Care" was born. Primary health care was defined as "essential healthcare, 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 that the community and country could afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". And what was the "universal" package to consist of? It was to include "at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". These were in fact not very different from the content of the earlier programmes. No wonder that, barely had the ink dried, metaphorically speaking, UNICEF launched its GOBI (Growth Monitoring, Oral rehydration, Breastfeeding, and Immunisation) programme, with the later add-ons of FFF (Female education, Family spacing and Food supplements), to efficiently translate into actions the several components of the "at least" care.

The caveat, "at a cost that the community and country could afford to maintain at every stage of their development", thus meant not the same "universal" package for all, but a selective one based on a country's resource availability, and within that, differential care depending upon socio-political location of a population.

This went well with the subtle shifting of responsibility of healthcare into the hands of the "people" even while declaring that the health of the people was the responsibility of governments. By using the term "people", social stratification was sought to be discounted as a determinant of heath status and healthcare access. In lieu of self-determination, the term "community participation" was coined and the villages were idealised by treating its members as a homogeneous entity, living more or less harmoniously, waiting passively to be catalysed by an external agent of "change".[7] In effect, without calling for a rationalisation of the highly trained medical manpower which absorbed the lion's share of the health budget, that the third world countries were supplying cheaply to the west, Alma-Ata gave global political consent to a policy of differential systems of healthcare, and obfuscated the duality by glorifying the persona of the Village Health Worker (VHW).[8] While social control of the VHW was debated passionately, there was no discussion on the social control of doctors.

False Claims

In India, with the change in government, and in the euphoria of having overthrown an oppressive regime through the ballot, a VHW[9] programme (healthcare in people's hands) along with a rural health scheme with the involvement of medical colleges (Reorientation of Medical Education Scheme, popularly known as ROME scheme) was launched. However, this government fell within a brief period, and these efforts, including training of the VHW, also dwindled off. The expansion of health infrastructure continued and alongside the private

health sector began to grow, catering to the interests of the doctors, the pharmaceutical companies, and the small proportion of the elite.

Though the Indian government abandoned the idea of VHWs, the "voluntary" sector took up the VHW scheme with great enthusiasm as funding was more likely for a "community health programme" than hospital-based services, even if they were an essential part of the tiered system of care. The impact of VHWs on the morbidity and mortality profile was exaggerated with non-existent data. Requests for data were scoffed at and anecdotes became the cornerstones of "authoritative" pronouncements. Internationally renowned community health programmes in the country brought out "evidence" to demonstrate that in "their" villages, they had achieved an IMR comparable to Cuba merely through their VHWs' programme, the role of the other development related inputs, including feeding programmes, being conveniently glossed over. Such programmes provided "proof" that there was no need to act on the larger determinants of health and improvements in health could be brought about by appropriate medical technologies (e g, the Oral Rehydration Solution for diarrhoeal deaths) without having to bring about any structural changes in society. This, notwithstanding the Alma-Ata's assertion, that health could not be achieved without action on "many other social and economic sectors".

The Alma-Ata declaration has been upheld as a national and international commitment to providing health to the most disadvantaged of people and with the subordination of technology and administrative services to the needs of the people (Banerji 2007). However, the declaration was also an assertion of the position of the western world which viewed the improvement of primary health services as the "key" to achieving health for all by the year 2000 when ample historic evidence existed that most improvements in health have been due to changes in economic, social and political structures rather than in the health sector (Navarro 1984). It was this contradiction between the stated philosophy and formulation of strategy in the Alma-Ata declaration that led to its being a document with little possibility for bringing about a real change.

Thirty years down the line, the world is a different place – little structural transformation but a lot of "structural adjustment". Medical technology has come to dominate the practice of medicine. Today, with market failure in healthcare, countries are being asked to shell out their public funds on healthcare products that are not required, all in the name of commitment to primary health. Hence the pressure to increase budget allocation on health. The policies propounded by the WHO, particularly those linked to vaccines and contraceptives, show clearly that the organisation is promoting the interests of transnational capital. There are new players on the scene – the World Bank, the Global Alliance for Vaccines and Immunisation, the Global Fund for Children's Vaccines, and International AIDS Vaccine Initiative – with direct links to the industry.

Yet some things have not changed. India continues to export its skilled medical personnel (for instance, 60% of the graduates from the All India Institute of Medical Sciences leave India following graduation), now with the sanction of the government. "Community participation" has been replaced by "communitisation"; the VHW concept has metamorphosed into the ASHA (Accredited Social Health Activist) programme; and "evidence" is being gathered to prove that the health situation can be improved without challenging exploitative structures in society.[10] The report of the WHO's Commission on Social Determinants of Health, published this year, entitled "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health", seeks to bring back into the global public health agenda issues of social justice which are "killing people on a grand scale". But without a call for bringing about structural changes, it has little chance to materialise.

NOTES

1 In 1954, the Central Government Health Scheme was introduced to provide comprehensive medical care to central government employees. The Armed Forces and the Railway employees also have their own health services.

2 It is only now that, after a protracted struggle, a social security scheme for unorganised workers has been enacted.

3 Six members dissented as they felt that the Bhore Committee had been unduly influenced by the Goodenough Committee of the UK and what was needed for India was not such a highly qualified doctor (Bhore Committee 1946).

4 This increased to 1.05% in the mid-1980s and stagnated to around 0.9% in the later years.

5 The Mudaliar Committee (1962) had suggested stringent measures to control population.

6 "Using" healthcare as a tool for containing dissent and buying peace was quite an old strategy. In fact, during the setting up of the regional centre of WHO in south-east Asia, Jawaharlal Nehru had stated that the political conflicts of the world were caused mainly by fear and that the solution to the political and economic problems could be assisted by greater international cooperation in matters like health where there was no reason for any kind of conflict (WHO 1967).

7 Terms like "animators" (to animate – to bring alive), catalysts, were the development jargon of that time, depicting the village communities as passive and inert.

8 The Chinese "barefoot doctors" being the prototype.

9 Later the term was changed to Village Health Volunteers as the VHWs began to unionise.

10 For instance, it is being claimed that the presence of a new state-level cadre of village-level health workers is the cause for a fall in rural IMR in Chhattisgarh from 85/1,000 live births in 2002 to 65/1,000 births in 2005, due to better health-seeking behaviour and childcare practices although the author admits that the programme has not been evaluated for its contribution to the reported reduction in IMR (Sundararaman 2007).

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