The spirit of Alma-Ata

by **Francesco Carelli**

Thirty years ago, the Declaration of Alma-Ata defined health as a "complete physical, mental and social wellbeing and not merely the abssence of disease or infirmiy" and also stated that the access to basic health services was a fundamental human right.

What is the meaning of going back to Alma-Ata now? It leads to an enhancement of the provision of primary care because the challenge for medicine in the third millennium is to achieve the right balance between modern technologies and interpersonal relations. A shift was made, which is characteristic for Family Medicine, from patient to person, from treatment to care given in a network of relationships.

EURACT is stressing the Alma-Ata philosophy, promoting high levels of teaching and health promotion, and looking for mandatory specific training.

Doctors are involved in rational decisions, and during their undergraduate and vocational training they need to consider the interrelationships between health and social care, the impact of poverty, ethnicity, inequalities, and the structure of the health care system in which they live and in which they work[1].

Thirty years ago, the Declaration of Alma-Ata defined health as a "complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" and stated that the access to basic health services was a fundamental human right. The model adopted to provide healthcare services was "primary health care" (PHC). This means universal, community-based preventive and curative services, with a great community involvement. We could surely say that the definition of health as complete wellbeing is not realistic, but it is now time to rediscover the spirit of Alma-Ata, developed in 1978 in the Soviet Union, when the Cold War was still ongoing and when Internet was still unheard of.

It is worth remembering the context of the 1970s which faced policy-makers and general practitioners alike. The 1973 oil price crisis and the resulting 'new economic order' precipitated a series of social reforms including in the health sector, one of which was the International Conference on Primary Health Care in September 1978, in Alma Ata (the former capital of Kazakhstan and now known as Almaty). It was organised by the World Health Organisation and UNICEF and brought together 134 countries and 67 international organisations. The conference culminated in the issue of a declaration which defined and gave international recognition to the concept of PHC: the Alma-Ata Declaration.

Two really important documents have tried to make the Alma-Ata ideals a practical reality for patients. The WONCA Europe Definition has set out the range of skills required to practise the kind of primary health care envisaged in the Alma-Ata declaration. The EURACT Educational Agenda seeks to equip future generations of doctors in the same way.

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What is the meaning of going back to Alma-Ata now? It leads to an enhancement of the provision of primary care which implies the reaffirmation of the role of family doctors and nurses. The growth of PHC and Family Medicine, which represents a major part, is of great importance, because the challenge for medicine in the third millennium is to achieve the right balance between modern technologies and interpersonal relations. Such a commitment implies rethinking the issue of humanization/dehumanization, with all its underlying physical, psychological, cultural and relational aspects. Family doctors are in a privileged position, because Family Medicine is the place where medical sciences merge with other disciplines, in particular sociology, economics, philosophy and jurisprudence. The Alma-Ata declaration that health is not merely the absence of disease renewed the meaning of the concept of care, transcending a restrictive view of care simply as treatment. A shift was made, which is characteristic for Family Medicine, from patient to person, from treatment to caregiving. As a fact, in Family Medicine the human being is viewed as a part in a network of relationships. Treatment thus becomes more of a social process, attention is given to circumstances, such as diseases affecting children, the elderly and women. Of course, these tasks are determined to a considerable extent by the health care system in which family doctors work and by the changing needs and demands of the patients. Family practice has always proved very good at adapting and responding to changing needs and demands of patients, much more than hospital doctors. Simply because we, as family doctors, are closer to the patients.

Gay considered the disease as the result of organic, human and environmental factors[2], a concept like the biopsychosocial model of Engel in his "holistic" model[3]. Efficiency as illustrated by Gay refers to the cost efficiency as a characteristic feature of well-developed family health care systems[2].

Again, if we want to promote health and wellbeing by applying health promotion and disease prevention strategies appropriately, we could use a comprehensive approach, that is often in contrast with the specialist approach in treating each problem separately. Throughout Europe, we are seeing many family doctors handling risk factors whilst promoting self-care, thus limiting the impact of patients' illnesses on their wellbeing, by taking into account the patients' personalities, families, daily life, physical and social surroundings, and, also, their backgrounds, cultural and religious beliefs.

This is why EURACT is stressing the Alma-Ata philosophy, promoting high levels of teaching and health promotion, and looking for mandatory specific training.

Society has changed over the years and there has been an increasing role for the patient as a determining factor in health care and its provision. We must now organize an approach to care which has to ensure a balanced use of technology and support systems in providing care, to implement a social model truly consistent with the human nature and its needs. Putting forward such a model entails a significantly different educational-training dimension, which would foster an increased interaction between healthcare providers and patients and between the different professionals involved in the treatment and care who intend to work for the good of the single person and the community.

Also here EURACT values were formed by the Alma-Ata Declaration, taking strong consideration of the community orientation. This is because family doctors have a responsibility for the community in which they work and must understand the potentials and limitations of the community.

As in all societies health care systems are being rationed and doctors involved in such initiatives, as well as in ethical and moral decisions, are in the best position to try and influence the health policy in the community. How? It could be by reconciling the health needs of individual patients and of the community, in balance with readily available resources.

To be able to do so, they need to learn in their undergraduate and vocational training the interrelationships between health and social care, the impact of poverty, ethnicity, inequalities, the structure of the health care system in which they live and in which they work[1]. How to learn this? With case-discussions, record reviews, visiting health and social care institutions and practice audits. This paper is, as all political documents, an indication, a way, to be integrated in each member states' reality. In fact, advocacy is a big point, helping the patient take an active part in the clinical process and working with the government and other authorities to maximise equitable distribution of services to all members of society.

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