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Commentary

Redefining Global Health; Integrating an Alma Ata Declaration Retrospective

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Commentary

A recent inspiring, yet provocative expedition to South Georgia Island ("Resurrection Island") in the distant South Atlantic, a former world center for whale and seal harvesting slaughter, and the Antarctic Peninsula, where evidence of global warming sears one's consciousness, motivated me to draw attention to profound threats to the place we call home, our planet Earth.

South Georgia Island has successfully intervened for wildlife to flourish from near annihilation resulting from relentless human predation and profound environmental degradation [1]. Antarctica presents a more complex scenario. Its massive size and remote inaccessibility make it difficult for most people to grasp that its massive glaciers are shrinking, as evidenced by widespread melting and giant iceberg calving, due to global warming. Consequentially, serious world-wide, water-related threats have emerged related to climate change. Rising sea levels portend extensive coastal flooding with many population centers at risk [2]. Pacific Islanders, residing on remote, low elevation atolls and islands, are in jeopardy of being displaced from their homes by rising seas, thus becoming climate-related refugees. Reports of glaciers diminishing in the Himalayas, New Zealand [3], the Arctic, and South America presage grave danger because fresh water resources that sustain the lives of multi-millions of people across the globe are expected to decline or potentially disappear.

How best to incorporate my recent observations and experiences? By integrating this commentary with an appeal - an imperative - to redefine what we call global health. We must expand the narrative to include strategies to counteract the multitude of environmental factors that threaten all of us.

Lesotho, a small landlocked country in Southern Africa, offers a greeting of relevance in the Sesotho language: "*Khotso, pula, nala*… peace, rain, prosperity." In keeping with this commendable expression, I propose changing the World Health Organization (WHO) definition of health to "peace, prosperity, and health for all people and our planet...," the home we all share. Without a global environmental health perspective, how can health truly be achieved and protected?

To endorse this appeal we should honor the 1978 Alma Ata Declaration [4], "to protect and promote the health of all the people of the world." While this international proclamation achieved demonstrable successes in some parts of the world, it should also encourage requisite reflection about critical contemporary issues. "Health for all by the year 2000," based on the WHO definition of health, was and remains impacted by social, political, economic, ethical, and importantly, adverse environmental realities that have impeded sufficient progress at many regional and national levels in both rich and poor countries.

The 1978 Declaration proclaimed the need for urgent action by governments, health and development workers, and the world community, reaffirming the WHO definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" [4]. The gross inequalities in health status between industrialized nations and politically, socially, and economically stressed developing countries were highlighted; health asserted to be a human right. While this was the first international affirmation emphasizing the importance of Primary Health Care (PHC), the WHO definition seemingly failed to address a much broader issue: environmental health threats to the Earth on which we all reside.

The World Health Organization should take a leadership role by adopting an expanded mandate inclusive of protecting environments. Efforts shouldn't just be about preventing or responding to pandemics and specific maladies. Whether by direct causation or close associations, the numerous environmental threats we face are responsible for enough disease entities to populate heavy medical textbooks! Compellingly, according to the WHO, more than 4 million people die annually from air pollution-related illnesses [5].

Of grave concern, contributing to ongoing environmental degradation, are the irresponsible use and disposal of pesticides and other agricultural chemicals; industrial pollution; greenhouse gas emissions; deforestation; occupational hazards and lax/absent worker protections [6]; excessive reliance on fossil fuels with attendant carbon dioxide emissions; electronics waste [7]; sub-standard housing; dirty air; unpotable water [8]; inadequate basic sanitation and solid waste disposal [9], including gross overuse of plastics; expanding vector-borne disease geographical zones; vulnerable agricultural productivity compounded by prolonged drought and depleted soils; and the unsustainable demands of excessive populations [10]. These circumstances are magnified by the ramifications of climate change, conflict, displaced persons, and competition for finite, insufficient government resources and private funds. Should priorities focus on procuring weapons or providing health care, social services, and environmental protections - the 'guns versus butter' debate?

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Primary health care models, envisioned by the "health for all people" Alma Ata Declaration, included basic curative and preventive services. The early focus centered on infectious diseases (malaria, tuberculosis, smallpox eradication, schistosomiasis, and other parasites) [11]; vaccine preventable diseases (polio, measles, diphtheria, pertussis, tetanus); and maternal/child health strategies through "GOBI" (growth monitoring, oral rehydration, breast feeding, immunizations) - and an overall strategy of community participation. Ideally, patients would have access to local or rural clinics, staffed by trained village health workers. Referrals would be made to nearby district, regional provincial, or central hospital centers, depending on the complexity of medical problems [12].

Integrating health education into the PHC vision was deemed essential: human resources development; first aid training; village pharmacies; anti-sickness campaigns; exploration of local problems with attendant solutions; and enhanced hygiene and sanitation programs [13]. Implementation included improved allocation of limited resources, enhanced training programs, clinical practice guidelines, and community participation [14].

Sponsorship and implementation of global health programs over decades have generally been based upon donors' agendas without sufficiently engaging local communities to allow them to define their own needs. Encouraging local ownership of projects would offer a greater likelihood of sustained success [15]. A new paradigm is needed because foreign aid, historically, was generally designed to support home country aid industries and their non-government organizations. Many operated as businesses, typically tied to the purchase of goods and services from donor countries. Aid without local participatory infrastructure development has perpetuated recipient dependence.

Despite the advocacy of the People's Health Movement [16], a broad global network of grassroots health activists, private society organizations, and academic institutions, much work remains to achieve quality health care objectives. A combination of clinical and public health strategies and respectful cultural immersion are essential in lower resource settings, as described at the Schweitzer Hospital in Gabon [17]. *The Struggle for Health* [18] offers an excellent historical foundation of this complex subject. The Global Conference on Primary Health Care, celebrating the 40th anniversary of the Declaration of Alma Ata, endorsed a new declaration emphasizing the critical, worldwide role of PHC for people to enjoy the highest attainable standard of health [19]. However, without a firm global commitment to counter environmental health threats PHC ideals will remain compromised.

During the same year as the 1978 Alma Ata conference, a seminal paper, *Health Service Coverage and its Evaluation* [20], provided a framework for evaluating efforts to implement effective and equitable health care, a concept distilled as the "3 A's": Available, Accessible, and importantly, Acceptable resources. This analytical tool examined the extent of interaction between provided health services and the people for whom services were intended. Ultimately, success would be measured by the percentage of patients who actually sought those services.

The Millennium Development Goals [21] have been superseded by Sustainable Development Goals, which expand the Declaration's original global imperatives with a call for action by all countries - poor, rich, and middle-income - to promote prosperity, while protecting the planet [22]. Water and sanitation concerns and non-communicable diseases [23] have finally gained justifiable attention, including cancer, diabetes, mental health, lung and cardiovascular diseases, and now a focus on the environment.

Not a priority of earlier agendas, the serious need for access to quality surgical services has also been acknowledged. This includes surgeons, obviously, but also clean operating rooms, proper equipment, *and* anesthesiologists. Moreover, low-tech diagnostic methods remain necessary in locales where electricity is unreliable or diagnostic tools are lacking or poorly maintained. Rapid diagnostic tests for malaria and tuberculosis are valuable technological advances. Yet, with the facility of modern day, international transport, potential infectious disease pandemics still loom. Ebola in West Africa and avian flu in Asia are contemporary examples.

Structural Adjustment Programs (SAP), instituted in the 1980's and 1990's, imposed by the World Bank and International Monetary Fund, adversely impacted the vulnerable PHC model, hindering "health for all" ideals. Subsequent fiscal hegemony had serious adverse social and economic consequences among numerous developing nations in East Asia, Latin America, and sub-Saharan Africa. Many poor countries were pressured to repay loans, which often proved difficult; loans that should not have been provided in the first place. Monetary transfers should have been offered as development grants.

Ministry of Heath budgets were slashed, resulting in poorly maintained and ill-equipped health facilities; inadequate transportation; deficient communications infrastructure; and limited access to pharmaceuticals. An already inadequate health care workforce witnessed declining numbers, influenced by global brain drain pressures, low salaries, and poor morale. Food insecurity and malnutrition exacerbated, while infant mortality rates increased.

Withdrawn social subsidies harmed people in many countries. Health care became unaffordable or inaccessible for populations already living below poverty levels. Public health programs were compromised, including tuberculosis control and the response to the emerging HIV-AIDS pandemic. Primary school enrollment in southern Africa declined substantially [24]. Illustratively, in Zimbabwe school tuition was raised, while school uniform subsidies for poor families were discontinued [25]. Without affordable, required attire many children were not permitted to attend school.

University of Chicago SAP architect and economist Milton Freedman's neoliberal views [26] were re-iterated in the New York Times: "…there is one and only one social responsibility of business: to use its resources and engage in activities designed to increase its profits, so long as it stays within the rules of the game…" [27] A deep contradiction evolved between SAP and social policies to improve the health of populations and human resource development [28]. *Shock Doctrine: The Rise of Disaster Capitalism* provides a critical narrative of the neo-liberalism model, SAP repercussions, and multinational corporate complicity [29].

Reconciling the Alma Ata Declaration economics agenda [4] with SAP-motivated economists, who seemed to express no societal compass by not integrating social responsibility and health care policy into their calculations, was problematic. Expenditures for health-related programs, despite economic and political obstacles, should have been viewed as investments in the future, not simply costs. Healthy people are more productive.

Perhaps, U.S. President Jimmy Carter said it best [30]: "…There is a growing chasm between those…who are rich, powerful, and healthy and those who are weak and suffering from preventable diseases. If we are to improve health, we must concentrate on existing disparities in opportunities, resources, education, and access to health programs. Only to the extent that we can eliminate these inequities will…global health in the 21st century be realized…" Without question, eliminating disparities related to income inequality and preventable diseases must also include remedial and protective, global scale environmental policies and actions.

In conclusion, the original Alma Ata Declaration focused on health care for all. However, without a transparent, clearly articulated, and inclusive global commitment to protect the world's environments - a fundamental social determinant of health [31] - the welfare of the entire planet, which provides sustenance for everyone, is in jeopardy. When confronted by the multitude of environmentally-related health problems, the most effective health professionals should ask not only "what" the problem is, but "WHY." Unequivocally, redefining global health is an essential part of this process.

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