ABSTRACT

Healthcare as a Fundamental Human Right:

The Alma Ata's Role in Shaping Health Policy in Three North American Countries

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The World Health Organization's Alma Ata Declaration set a new world standard for human rights following its publication in 1978. By declaring health and healthcare as fundamental human rights, it pushed the boundaries of social safety nets provided by most of the world to one that was cognizant of the complexity of wellbeing and social determinants of health. The following is a review of the Alma Ata Declaration that explores its theory and application. It unpacks the political, philosophical, and ethical elements of the Alma Ata, and it conducts a comparison among three North American countries – Canada, The United States, and Mexico in the post-Alma-Ata era. The review ends with a few concluding remarks about the future of U.S. health policymaking and implementation. Overall, the review aims to provide a comprehensive understanding of the Alma Ata Declaration by exploring its intended goals, ideals in action, and impact on future health policy.

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HEALTHCARE AS A FUNDAMENTAL HUMAN RIGHT:
THE ALMA ATA'S ROLE IN SHAPING HEALTH POLICY IN THREE NORTH
AMERICAN COUNTRIES

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TABLE OF CONTENTS

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CHAPTER ONE

The Alma Ata Declaration

> The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (International Conference on Primary Health Care, 1978).

The world found itself in a dramatic geopolitical realignment when the Alma Ata Declaration entered the international conversation, contributing to the subsequent rise of more progressive attitudes towards global health. World War II left large parts of the world and many colonial-era governments with broken systems, poor infrastructure, and instability. These circumstances shifted global powers and global priorities. Among these priorities was an effort to ensure peace, health, and wellbeing to all global citizens using modern technology, science, and established health systems. Ultimately, the need for a centralized transnational governing body led to the establishment of the United Nations in 1945 and the World Health Organization in 1948. In the paper, "Health for Some: Global Health and Social Development Since Alma Ata," the political environment of global health in the 1970s was characterized by "a growing trend towards social regulation, and emphasis on equality and expansion of health and welfare provision, operated by agencies with a Keynesian or reformist bias like the WHO, over whom developing countries were exercising a growing influence" (Carpenter, 2000). In other words, there was a recognition among the international global powers that targeted action was needed to address the growing pains of a new and reformed global society.

Today, the Alma Ata and its ambitious goals are still far from achieving the progress promised by the original document. This has mainly been the consequence of misinterpretation and perhaps naivete on behalf of the World Health Organization and governing partners. The downfall of the Declaration is articulated in the paper, "From Health for All to Universal Health Coverage: Alma Ata is Still Relevant," by noting that the Declaration's "idealism failed at the crosswinds of global political economy" (Pandey, 2018). Past failed idealism and recognition from leaders of the global political economy on the economic advantages of a healthy and productive global society have led to the revamping of current Health for All efforts.

Addressing global health inequality is a natural steppingstone and challenge toward improving the livelihood and wellbeing of all people in the world. How exactly do we get to that point, and are our current efforts leading us in the right direction? These are questions I aim to explore through the assessment and breakdown of the Alma Ata document. There is a lot to learn from past failures and successes, and it is ultimately this process of reflection that will get the global health establishment closer to meeting the shared goals of a global society. In the following chapter, the historical, political, and ideological context of the Alma Ata will be described to discuss the implications of the document for health policy legislation. In the next chapter, I will focus in specifically on three North American countries.

Historical Context

The Declaration of Alma-Ata came onto the global stage during the September of 1978 International Conference on Primary Health Care in Almaty (formerly Alma-Ata), Kazakh Soviet Socialist Republic (present-day Kazakhstan). The conference came at a time of global economic upheaval, a consequence of the post-World War II economic boom, and a united effort to eradicate disease caused by the end of the war. In addition to the aftermath of the war, political hostility between the United States and the Soviet Union led to a growing recognition of a need for global unity in the New International Economic Order. Given that health advocacy was a common goal for many nations in the 1970s, the culmination of conflict and a desire for cooperation led to a commitment to "protect and promote the health of all the people of the world" (International Conference on Primary Health Care, 1978). This was an effort that became increasingly complex as experts and officials came to understand the impact of factors such as education, safety, and social stability on health and wellbeing.

Political Context

The Alma Ata is as much a vision statement as it is a political statement on health. It arguably is responsible for the early stages of "a shift in the nature of collective action concerned with health" that has led to the birth of the interdisciplinary field of global health politics (Khazatzadeh-Mahani et al., 2018). Through its assertion of health and healthcare as fundamental human rights, it extenuates the weight and responsibility of health onto governments, leaders, and international governing entities. Furthermore, the

document through its assumption of global health politics recognizes that politics is "necessary and integral to effectively addressing global health challenges" (Khazatzadeh-Mahani et al., 2018). The Declaration widens the safety net provided by the infrastructure and systems of a society, and therefore all governing parties of that society must work together to achieve a cohesive strategy to ensure wellbeing.

In addition to serving as an inspiration for countless charters and declarations, the Alma Ata and its successors are actively taking a larger role on the United Nations Sustainable Development Goals (UN SDGs). These efforts "include specific targets, but additionally emphasize broader interlinked aspects, such as sustainability and social justice, promoting a more integrated development agenda" (Hone et al., 2018). By proposing an agenda, providing an understanding of human health in a global context, and establishing a need for global health politics, the document has become a catalyzing force in the wider global health conversation. And, given the weaknesses in both national and international health systems that the recent COVID-19 pandemic has revealed and further exhausted, it is now more relevant and pressing than a few decades ago.

Philosophical Foundation

A focus on social justice is at the very core of the Alma Ata. This has become increasingly evident as areas of study such as the social and economic determinants of health have revealed large implications when it comes to health at both an individual and population level. Socially, factors such as discrimination, inequality, famine, and war have large negative effects on health that can yield generational consequences. Environmentally, factors such as climate change, natural disasters, and pollution have

displaced thousands from their homes and exposed communities to unsafe living environments. In "Revisiting Alma-Ata: What is the Role of Primary Health Care in Achieving the Sustainable Development Goals?" the present ecological situation is described in stark terms: "[e]nvironmental factors (such as pollution and the built environment) contribute to a fifth of the global burden of infectious, parasitic, neonatal, and non-communicable diseases, and actions to address these factors lie outside the health sector" (Hone et al., 2018). The Alma Ata, in declaring that health and healthcare are fundamental human rights, assumes that to achieve the vision set forth, all possible etiologic factors implicated in the origins of disease and illness must be addressed, including and especially those external to the human body. The Alma Ata, and the documents inspired by the declaration, argue that to reach global health and healthcare equity, social and environmental determinants of health must first or simultaneously be addressed.

Many scholars have suggested that the document's greatest contribution was to shift the status quo of healthcare from one dimensional to holistic, equitable, and cognizant of social determinants of health (e.g., Rifkin, 2018). In other words, the document sought to validate that socioeconomic status and health are interwoven at their very core. This outlook remained largely ignored, this is in part due to the element of complexity it adds to global health efforts. Nonetheless, awareness of such factors is increasingly a part of the broader conversation on global public health.

The late physician and humanitarian Paul Farmer, in his book *Pathologies of Power* illustrates how the assault on the human dignity of individuals is ultimately the

cause of many pathologies. Highlighting the connection between economic and health disparities, Farmer states that "as a physician to the poor, [he has] seen what has happened, and what continues to happen, to those whose rights and freedoms— particularly freedom from want—are not safeguarded" (Farmer, 2005). Farmer points out that documents such as the Alma Ata must address issues of inequality and justice to achieve its goal of ensuring health and wellbeing. It is imperative to be aware of how "human rights abuses are best understood (that is, most accurately and comprehensively grasped) from the point of view of the poor" (Farmer, 2005). The sick and poor are not necessarily separate populations; they often are the same people or groups of people. Cognizance of this reality should inform efforts to mitigate the impact of poverty on health.

Ethical Framework

In examining the ethical framework of the Alma Ata, it is important to understand the basic function and goals of public health ethics, which are distinctive and have different goals and applications than clinical medical ethics. In *Public Health Ethics*, the authors explain that "public health ethics helps guide practical decisions affecting population or community health based on scientific evidence and in accordance with accepted values and standards of right and wrong" (Barrett et al., 2016). It achieves this level of proactivity and utility by providing "a systematic process to clarify, prioritize, and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders, and scientific and other information" (Barrett et al., 2016). In other words, public health ethics codifies and translates all these considerations into a

formula that can be used to get closer to the fundamental ethical problems or dilemmas in each setting. Although this description is not new, it facilitates and breaks down the tedious vetting that many public health efforts must endure, which is essential in establishing credibility and trust among individuals and communities.

Public health ethics also provides a framework from which stakeholders in public health initiatives can organize themselves and function in unison. It is crucial to understand the scope of the mission of the public health sector, notably its advocacy of social, political, and economic interventions. Barrett and colleagues (2016) seek out one of the more widely accepted definitions of public health and describe it as "the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts … and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health." A distinguishing characteristic of public health in comparison with medicine is a focus on the population as a whole instead of on the individual. These foci often overlap but understanding differences in priorities should be used to inform decision-making in a public health context.

Further framing public health as an idea, Barrett and colleagues (2016) identify four distinguishing features of public health practice: "the pursuit of the collective good, a focus on prevention, the use of government or collective action, and an emphasis on an outcome-based (utilitarian) approach—[these] generate most of the ethical challenges public health practitioners typically face" (Barrett et al., 2016). It is also worth noting that a significant role of public health is to serve as advocates for communities, working to

groups achieve specific population goals while helping accomplish other goals (e.g., voting rights and gender equity). And, because these population-specific goals may require unique and diverse approaches, they must have equal weight and relevance as any other public health effort.

Public health is a broad and encompassing field, and accordingly ethical implications stretch beyond what is apparent on the surface. This is in part due to the complexity of human health and its determinants, which is sensitive to and highly adaptable to environmental circumstances, yet at the same time not well equipped to withstand systemic health stressors for long periods. In their book, Barrett and colleagues do a great job of summarizing the fascinating influence and impact of social networks on the health of individuals and groups. Such "network[s] of relationships and emotional bonds between people sharing a life in common organized through a political and moral order" carry significant weight (Barrett et al., 2016), and it is vital when working with and for communities to keep in mind these are networks of people, and not just numbers and statistics. By considering the social context of the lives of people they seek to help, public health leaders can consider broader macro-level forces that may work for or against their campaigns, and therefore learn how to better mitigate issues within respective communities or populations. The authors assert that "ideally everyone should have a fair opportunity to attain their full health potential" and "no one should be disadvantaged from achieving this potential, if it can be avoided" (Barrett et al., 2016). This is a sentiment that may be universally shared among public health scientists and policymakers, yet understanding how to achieve this is complicated and often disputed.

What does achieving one's full health potential look like, for example, among individuals with congenital or chronic disabilities? What does it look like in respective regions of the world? Questions such as this animate debate in public health circles, and if there is one aspect of this conversation that has reached consensus, it is that "achieving [health] equity ultimately will depend on the cooperation of government and civil society" (Barrett et al., 2016). This is where policy statements such as Alma Ata come in, motivated by an earnest desire to construct a framework to guide such cooperation.

A critical conversation to have when discussing determinants of health and healthcare, is the idea of an implicit right to not have one's health harmed as a result of circumstances outside of one's direct control. Who is responsible for keeping such influences in check and who and how does one petition when one has been harmed? Are their legitimate claims to a right to health or healthcare, and how are such rights defined and enforced and against whom? As stated in *The Oxford Handbook of Public Health*, "the implicit, and undefended, presumption is that only state agencies are capable of choice-limiting actions or 'coercion,'" but the reality is that there are many influences that can deter someone from making their own decisions regarding their health (Schrecker, 2019). Inequality, for example, is a significant deterrent to personal decision-making and thus a significant determinant of the health of people and populations. While choices and individual liberties are often thought of as entirely up to each individual person, in actuality these choices may be limited by social-structural, political, and economic realities, so it would be irresponsible for public health policymakers to not acknowledge these realities.

A challenging part of any public health campaign or effort is identifying the problem at its root. For example, "often implicitly, life expectancy is treated as the 'absolutist core' of human wellbeing" (Venkatapuram, 2019). And while life expectancy is an important metric, just as important is the quality of life that those individuals or the given population are experiencing. How we measure health affects our understanding of the actual status of individuals, how we quantify the issues, and how we identify what the problem is. Correctly identifying the root or core problems underlying population health issues is a challenge that public health leaders and organizations have always had to face, but especially in recent decades as especially intractable public health problems have arisen. An example is the initial global response to the AIDS epidemic in the 1980s, which faced major setbacks due to a lack of collaboration from members countries. How global health entities communicate with their partners, whether it be governments or non-profits, is key to ensuring a shared agreement on the desired outcomes and pathways to get there. The public health sector has come to understand that "health is instrumentally valuable" because it (health) "determines what one is practically able to be and do daily, as well as one's ability to make and realize long-term life plans" (Venkatapuram, 2019). Because health is a valuable state, it is imperative to target root problems and mitigate them aggressively and with an eye to the widest possible context.

This ongoing conversation in public health has by necessity focused as well on the delicate balance between personal freedoms and state protection. The *Handbook* states, "[P]olicymakers in many countries have tried to balance between protecting the population from harm while allowing personal freedoms" and "these trade-offs require

ethical considerations of beneficence, dignity, and justice" (Anderson et al., 2019). There is no perfect formula for achieving this balance while determining the best approach for mitigating health disparities, but these ethical frameworks serve as guidelines from which to navigate the decision-making process.

In the context of COVID-19 these debates have played a significant role in discussing how governments have addressed the pandemic. It is a tricky topic because, on the one hand, the state trusts individuals to make decisions about their health. At the same time, they recognize that mass public intervention is necessary to address the issue at hand. COVID-19 is just one example of this. Every day, individuals decide what they consume, the habits and lifestyles they believe they should live, and whether to be immunized against the most common communicable diseases. This freedom is valued by many, yet it leads many others to chronic illnesses such as obesity, lung cancer, and antibiotic-resistant tuberculosis. The *Handbook* provides an exciting outlook on the dichotomy of freedom versus choice: "this ethical argument over capability divides individual freedom into two aspects: one that pertains to the opportunity of the individual's 'ability to achieve,' and another that pertains to the 'process of choice itself'" (Anderson et al., 2019). Although this remark was made in the context of health as an object to be obtained or chosen, it foreshadows the many external influences that may make it significantly challenging to achieve health (e.g., fast food and a lack of access to preventive medicine). The challenge implicit in balancing between state-mandated health measures and personal freedom will most likely remain a contested topic within public health, and reminds us of the responsibilities of the state and the duties of the individual.

Implications of the Alma Ata

The ideals of the Alma Ata Declaration are complex and larger than the document itself. This reality is due in large part to the interwoven societal components and determinants of health just discussed. To unpack these issues a key is to understand and distinguish what the document claims and entails. Specifically, it would be helpful to deconstruct the differences and ideals between two competing perspectives that animate discussion and debate, still, nearly half a century after the Declaration: namely, the ideas of healthcare and even health as fundamental human rights. This section reviews this discussion and touches on some of the socioeconomic implications of the document.

Health as a Fundamental Human Right

Health as a human right is a vague statement, given that human health is the result of multiple forces many of which are still unknown to science. Factors such as socioeconomic status, genetic and chronic conditions, as well as social environment, influence an individual's health to a certain degree, and seeking to address each of these forces is challenging, and perhaps unfeasible. The intention behind the statement is a noble attempt to ensure a result that may ultimately be outside the capability of a single entity, such as a government or international governing body.

Yet so many nations and world entities include this language in principal documents. Aiming to offer some clarity, Krennerich (2017) directly elaborates on what is meant by health as a human right by noting that "the human right to health as it is enshrined in the CESCR entitles every person to enjoy the highest attainable standard of physical and mental health to lead a life in human dignity". Therefore, reaching this

highest attainable standard of health includes vital instruments such as social security and healthcare services. Additionally, it is crucial to understand that this is not simply a legal guarantee to be healthy. No state could meaningfully claim to be able to provide such a guarantee (although politicians often do). They do not claim this because "health alone is dependent on factors which the state is unable to control or which it should not be controlling for good human rights reasons" (Krennerich, 2017). This definition or clarification helps make the goal of health as a human right one that may be more attainable through different points of measurement and effectiveness.

Krennerich remarks that "the human right to health is mentioned more often in programs from the Global North, such as involving cooperation among multiple development agencies, than in those countries that have the most pressing health problems" and limited access to financial and institutional resources. This begs the question of whether the human right to health is a utopian ideal or goal, and whether it is solely a wealthy nation problem (Krennerich, 2017). Perhaps, it is a matter of meeting the needs and demands of any given community. At times, these needs, and directions may consist of Band-Aid solutions or providing access to at least simple primary care healthcare services. Regardless, it is essential "that medical facilities and medical care are appropriate and of an adequate quality from a scientific and medical point of view" (Krennerich, 2017). In health for all is to be attained in emerging nations, then healthcare should not solely consist of "hand-me-downs" from the developed world, but instead be ensured by access to a more resource-rich medical and public health infrastructure.

Krennerich also states that "since the health of an individual person is dependent on a variety of contingents and therefore factors which can be influenced, the conditions for a healthy life can, in principle, always be further improved" (Krennerich, 2017). This raises the question of what is the end goal? Ensuring health for individuals in a population is a basic statement, but clarifying what is meant by this, specifically, in a particular nation, determines how far the nation, state, or global entity is willing to go to ensure that state's health. Another question the statement poses is whether innovation should continue to be prioritized throughout the wealthiest nations in the world? In a country that heavily emphasizes technological progress and innovation, the United States, it is easy to become cynical at the specific and minute solutions we aim to solve when the rest of the world is still attempting to contain tuberculosis and malaria outbreaks. As voiced by Krennerich, "all members of society – individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector – have responsibilities regarding the realization of the right to health" (Krennerich, 2017).

Healthcare as a Fundamental Human Right

As with health as a fundamental human right, the similar but distinctive ideal of healthcare as a human right remains vague and is often misunderstood. The two putative rights are not the same. This complexity is heightened when you consider the social, political, and ethical implications of the latter idea. As has been noted, "[T]he World Health Organization (WHO) set out already in the preamble to its 1946 constitution that each person has a fundamental right to the enjoyment of the highest attainable standard of

health" (Krennerich, 2017). The backstory here is interesting and provides some context as to who began the conversation around health as a human right and when, and more importantly, with what aim. Krennerich (2017) shares, "UDHR identifies medical care as a central but not the only element of this right. Also, social security, especially in cases of illness and invalidity, as well as access to healthy living conditions (food, housing, etc.) play an important role." When woven into the conversation of social and financial security, healthcare as a human right takes on what appears to be a central role in efforts to ensure wellbeing among the population of respective nations. Krennerich (2017) points out that the Alma Ata and follow-up documents "not only [point] to a strong link between the right to health and the right to social security," but deem them the one and the same. The fusion of both economic and health disparities changes how economists and public health experts approach and mitigate life-threatening issues while simultaneously breaking down avenues of solutions into bite-sized pieces that are more amenable to addressing.

Primary Care

What the WHO terms primary health care (PHC) is the Alma Ata's weapon of choice when combatting health inequality. Two additional advantages of PHC in underdeveloped health systems are the increased opportunity for decentralization and sustainability. Both advantages are key given that they "improve efficiency and bring services closer to communities," which in turn reduce hospital treatments and greater medical expenditure (Hone et al., 2018). PHC is a cost-effective approach to addressing global health needs through the value and emphasis on preventive care. Although the

implementation of PHC can be challenging to undergo, the results of successful campaigns have been remarkable and noteworthy.

Conflicts

Although the Alma Ata has been revered for its providing a guiding framework to influence global health politics, it has sparked criticisms from experts and politicians worldwide. Criticisms for the Alma Ata have mainly revolved around the Health for All statements made in the document. It is important to note that this criticism comes not from opposition to the idea of Health for All—after all, who can truly be opposed to health for all people?— but rather the methods required to attain and ensure this as laid out in the document. The disagreement originates in "the misinterpretation arising from the perspective that primary care should be responsible for addressing broader determinants of health and advancing social justice, far beyond the remit of health services" (Hone et al., 2018). In other words, attaining this utopian vision would seem to require nations' health ministries to usurp the authority of most of government agencies and domains, and, in any event, attaining true "health for all" may still be elusive. In summary, this criticism of Alma Ata is not based on opposition to health or healthcare for all, but rather in the practically of attaining either or both of these visions.

The Alma Ata and its Influence on Policy

As a standalone document, the Alma Ata was a revolutionary vision statement for what governing bodies, both national and international, ought to strive for. Since the Alma Ata's release, countries and governing entities have developed similar documents

sharing the ideal of health, or healthcare, as a fundamental human right. It is fair to say

that the Alma Ata became a policy inspiration and catalyst for many of today's domestic

and international health policies; how countries adopted these policies has varied. Most

countries adopted a nationalized health system model, but others sought a mixed model

of nationalized, subsidized, and privatized systems.

How nations address healthcare has significant effects on healthcare equity and

overall population health. Health policies have life or death consequences, so

understanding their influence on an individual's life is key to making a better and more

resilient policy. Furthermore, contextualizing policy to meet regional or community

needs is a vital step at addressing local problems, rather than offering universal solutions.

This section reviews some of the most influential pieces of legislation written and ratified

following the publication of the Alma Ata Declaration.

The Ottawa Charter for Health Promotion (1986)

> Health promotion is the process of enabling people to increase control
> over, and to improve, their health. To reach a state of complete physical,
> mental and social well-being, an individual or group must be able to
> identify and realize aspirations, satisfy needs, and change or cope with the
> environment. Health is, therefore, seen as a resource for everyday life, not
> the objective of living. Health is a positive concept emphasizing social and
> personal resources, as well as physical capacities. Therefore, health
> promotion is not just the responsibility of the health sector, but goes
> beyond healthy life-styles to well-being (World Health Organization,
> 1986).

Chartered during the November 17th to 21st first International Conference on

Health Promotion in 1986, the Ottawa Charter is a notable piece of legislation that sought

inspiration from the Alma Ata and transformed Canadian healthcare. The charter's

emphasis on "complete physical, mental and social well-being" spearheaded the adoption

of the ideals set forth by the Alma Ata. It proposed logistical and practical solutions to

addressing health equity through a five-part health promotion action plan: build health

public policy, create supportive environments, strengthen community action, develop

personal skills, and reorient health services. Lastly, the charter committed Canada to

radical health promotion that called the world to view health as an altruistic means to care

for oneself and others (World Health Organization, 1986).

The Tallinn Charter: Health Systems for Health and Wealth (2008)

> All the Member States of WHO in the European Region share the
> common value of the highest attainable standard of health as a
> fundamental human right; as such, each country shall strive to enhance the
> performance of its health systems to achieve the goal of improved health
> on an equitable basis, addressing particular health needs related to gender,
> age, ethnicity, and income (The World Health Organization, 2008).

Approved during the June 25th to 27th WHO European Ministerial Conference on

Health Systems in 2008, the Tallinn Charter aimed to address health equity in Europe

through an emphasis on building and maintaining resilient health systems. Given that the

charter was targeted at the European Union, a generally wealthy region of the world, the

Tallinn Charter used the vision and wording from the Alma Ata in a way that was

relevant and appropriate for a region with greater health, access to healthcare, and an

existing healthcare infrastructure. They acted according to the belief that "investing in

health is investing in human development, social well-being and wealth," three desirable

outcomes for any nation or governing body (The World Health Organization, 2008).

The Rio Political Declaration on Social Determinants of Health (2011)

> Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels (World Health Organization, 2011).

Declared on October 21st, 2011, the WHO's Rio Political Declaration on Social Determinants of Health was one of the first and principal global health documents to affirm the government's role in ensuring the health of its citizens and recognize social determinants, such as socioeconomic status and justice, to have an impact on health and wellbeing. The declaration adopts three principal goals to target social determinants of health: improve daily living conditions, tackle the inequitable distribution of resources, and assess the impact of the action (World Health Organization, 2011). It also sets the groundwork for practical steps to improve governance for health and development, promote policymaking and implementation, and participate in global collaboration.

The Declaration of Astana (2018)

> We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence (World Health Organization, 2018).

Declared during the October 25th and 26th Global Health Conference on Primary Care in 2018, the Declaration of Astana is the WHO's most recent reaffirmation of its commitment to ensuring the fundamental human right to health and access to healthcare. Building off its predecessor, the Alma Ata, the document emphasizes justice and solidarity, and it shifts the conversation and verbiage to match the needs and concerns of the present world. The Declaration of Astana recognizes the emerging threat of climate change on health and wellbeing. Most notably, it acknowledges the undeniable failures of modern healthcare, mainly the growing cost of care. By first affirming its goals for healthcare equity and recognizing the challenges ahead, the Declaration of Astana commits itself to prioritize policy-making across all sectors and developing sustainable primary health care (World Health Organization, 2018).

The Alma Ata Declaration: In Summary

Chapter One has examined one of the most influential, perhaps revolutionary, documents in public health history, the Alma Ata Declaration. Although its ideals were not entirely new to the world, the document fleshed out the health implications of what was termed the New International Economic Order, renewed interest in global health, and provided a means to an end to achieving health equity worldwide through PHC. Despite its shortcomings and criticisms, the document has inspired charters, declarations, and legislation that have shaped the lives of many. The Alma Ata and its successors will continue to evolve and engage the world in a conversation that is complex and everchanging. As we look toward the future, it is helpful to observe and question whether

these catalyzing forces achieved the goals set forth, and, if they did, to ask are we better for it?

There is no simple solution to ensuring that every individual attain perfect health or that there is perfectly equitable access to healthcare. But there are proven strategies that have been successful in improving people's lives, and other strategies that have been unsuccessful or harmful. As prefaced at the beginning of this chapter, this thesis aims to assess the Alma Ata and its impact and role in mitigating global health disparities in order to better inform future campaigns and decision-making. Chapter Two will describe how the themes and foundational ideals of the Alma Ata have been translated into national legislation across three neighboring North American countries: Canada, the United States, and Mexico. Given these countries' geographic proximity yet differing governmental approaches, the approaches of these three countries will be compared and contrasted in order to depict the diverse effects of the Alma Ata on public health policy.

CHAPTER TWO

The Alma Ata Declaration: Three Case Studies

Healthcare expenses have skyrocketed since the mid to late 20th Century. As countries grappled with post-War expenses and an increase in population size, nations large and small found themselves with a growing need for adequate and cost-effective healthcare reform that served all citizens. Canada, the United States, and Mexico are three North American countries that have experienced similar challenges in ensuring healthcare access to their citizens. Yet they have addressed these challenges through different practical and ideological solutions. Three dimensions of the overall challenge of healthcare that have remained consistent in all three countries are access, care, and costs.

Healthcare access refers to the ease of accessing medical care and services by the individual (Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services, 1993). It includes everything from transportation solutions to and from a medical facility to the presence of a hospital or clinic. It is one of the most important dimensions of care because regardless of the quality and costs, without such access patients cannot acquire the best of care even if it is otherwise available. Healthcare access, among other understandings, most directly translates to an established infrastructure of healthcare providers that can provide care for patients. Infrastructure can include physical infrastructure (e.g., hospitals and clinics), technological infrastructure (e.g., electronic health records), and personal infrastructure (e.g., the availability of trained and skilled nurses, doctors, and technicians).

Healthcare quality refers to the measured value provided to the patient by medical care and services (Agency for Healthcare Research and Quality, 2020). It includes metrics from a patient's experience receiving care, the timing and relevance of their care, as well as their case-specific outcomes. Quality of care is the dimension of healthcare that is responsible for establishing a standard for clinician conduct (e.g., code of ethics and bedside manners), technical expectations (e.g., sanitization and proper use of medical equipment, patient privacy), and clinical ethics.

Healthcare cost refers to the monetary value of medical care. Cost is determined by internal and external factors of the healthcare sector, and, regardless of the financing agent (e.g., patient or state), this often trickles down to patients via budget reassessments or out-of-pocket costs. Healthcare costs include any financial obligations incurred from receiving medical care; this can extend from a primary care visit, treatment, and medications. Increased healthcare costs are one dimension that persistently is a challenge for the three nations, mainly due to the global trend in rising costs of medical care, as well as the growing demand for that care.

Together, access, quality, and costs shape the medical care that patients receive at any scale. These dimensions can make or break a situation, which can lead to preventable chronic conditions, complications, and even death. In the following three case studies, historical context, political context, and an overview of the nation's most current health policy are provided to assess the impact of the Alma Ata document on policy and determine their efficacy and sustainability.

Health as a Human Right in Canada

Among the three North American nations, health as a human right as a driving ideology in national health policy is most visibly observed in Canada's healthcare system. Through a series of reforms, Canada transitioned from a mixed model of health care to a government subsidized and province-run health system. Achieving health for all is spearheaded by the country's basic principle of "universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay" (Canada.ca, 2019). Medicare achieves these results both through extensive public health efforts and by providing healthcare.

Political Context

Canada is a constitutional monarchy and a parliamentary democracy, which acts in the name of the Crown through the authority of the Canadian people. Canada's parliamentary system "consists of the Crown, the Senate, and the House of Commons, and laws are enacted once they are agreed to by all three parts. Since Canada is a federal state, responsibility for lawmaking is shared among one federal, ten provincial and three territorial governments. The judiciary is responsible for the interpretation and application of the law and the Constitution and for giving impartial judgments" (Parliament of Canada). The governmental arrangement originates from the Canadian constitution, which provides fundamental laws and a framework of governance, both at the federal and provincial level. It also prescribes executive, legislative, and judicial powers, and limits to the respective offices in the Canadian government.

Historical Health Policy Context

To resolve issues within a country's political context, policy makers must first look at the source of power and funding established in their constitution. For Canada, their constitution sets out the powers of the federal and the provincial and territorial governments. Under the Constitution Act of 1867, "the provinces were responsible for establishing, maintaining and managing hospitals, asylums, charities and charitable institutions" (Canada.ca, 2019). The federal government oversaw providing national standards through its Department of Agriculture until 1919 when the Department of Health was established.

Prior to World War II, healthcare in Canada was a private enterprise. In fact, the movement towards providing a state sponsored health plan began in one of the nation's 13 provinces and territories, Saskatchewan. In response to provinces adopting this model of social security, the federal government passed the Hospital Insurance and Diagnostic Services Act in 1957, which offered to "reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services" (Canada.ca, 2019). The federal government then responded to the widening coverage of patients in the provinces through renewed policy. In 1966 it passed the Medical Care Act, which offered to "reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals" (Canada.ca, 2019). It was not until 1984 that the federal government became a large player in funding and coordinating healthcare in Canada, a shift in funding and protocols as a result of the Canada Health Act. This comprehensive legislation ultimately shaped the Canadian system set in place today.

Health Policy

　　Canada has a universal health coverage funded through its Medicare health system. A product from the 1984 Canada Health Act, Medicare has a public contract model, which means it is "publicly financed with private provision" (Columbia Public Health, n.d.). It also must comply with the Canada Health Act's five pillars: the system must be universal, be publicly administered, have comprehensive coverage, be portable across provinces, and be accessible to the population (Columbia Public Health, n.d.).

　　In this model, "[p]ublicly funded health care is financed with general revenue raised through federal, provincial and territorial taxation, such as personal and corporate taxes, sales taxes, payroll levies and other revenue. Provinces may also charge a health premium on their residents to help pay for publicly funded health care services, but non-payment of a premium must not limit access to medically necessary health services" (Canada.ca, 2019). This translates to a tax-financed system that is "decentralized to the provinces and provides universal coverage" (Coady et al., 2012). Additionally, the Medicare management roles "are divided among the federal and the provincial and territorial governments. The federal government, as the big regulating body, oversees establishing universal guidelines for the system that align the Canada Health Act, providing financial support to the provinces and territories, and assuring the equitable distribution of healthcare resources to groups of people who fall outside the regular governing bodies" (Canada.ca, 2019).

Although far from perfect, Medicare has managed to exist and expand mainly through strict cost management practices that have limited the growth of healthcare spending in the nation. Medicare physicians are primarily funded based on a fee-for-service basis, "nearly all hospitals and physicians…are financed by federal funds," and there is a national limit on enrollment in medical schools both of which has allowed for efficient supply constraints and budget caps (Coady et al., 2012). It is through these strict practices that "Canada has maintained a predominantly tax-financed public system since the 1960s, and gatekeeping by primary care physicians is a central element" (Coady et al., 2012). In addition to providing care, Medicare also carries out other national wide health initiates. For example, "public health, which includes sanitation, infectious diseases and related education, is shared between the three orders of government: federal, provincial/territorial and local or municipal. However, these services are generally delivered at the provincial/territorial and local levels" (Canada.ca, 2019). Overall, Medicare is a one-stop solution to managing preventing disease, education the population, and managing medical care needs.

Health as a Human Right in The United States

The idea of a right to healthcare in the United States is widely disputed both at the present and throughout the country's history. The inability to reach a consensus, due in part to competing political, have led to a relatively small social safety net for the American people. Currently, the U.S. does not have universal health insurance coverage, leaving approximately 8.5 percent of the population without any coverage (Berchick et al., 2018). However, a heightened focus on healthcare access and equity in the past two

decades has led to momentum building legislation such as the Affordable Care Act and an overall trend in a decreasing number of uninsured citizens. A shift in ideological framework, as well as a need to address an increasing rise of health disparities, medical care costs, and crumbling infrastructure are pushing legislators to act quickly and swiftly.

Political Context

The U.S. is a federal republic of fifty partly self-governing states. The Constitution divides the federal government into three branches: legislative, executive, and judicial (USA.Gov, 2022). The legislative branch, or Congress, comprises the House of Representatives and the Senate and is responsible for making and ratifying laws. The executive branch includes the President, Vice-President, Cabinet, and federal agencies, and is responsible for carrying out laws. Lastly, the judicial branch includes the Supreme Court and lower court system and is responsible for vetting laws in their relationship to the Constitution. Regardless, of their preserved responsibilities, each branch can influence and check the actions from the other branches. For example, the President can veto legislation, Congress can confirm or reject presidential nominees as well as impeach the President, and the justices in the Supreme Court can interpret the constitutionality of a law and overturn laws they deem unconstitutional.

Historical Health Policy Context

Healthcare reform and health policy in the United States have been subject to debate since the early 18th Century. Beginning with the 1864 Bill for the Benefits of Indigent Insane, legislation brought existing disputes to the federal level and the bill was

vetoed by Franklin Pierce, the 14th President, who argued that "the federal government should not commit itself to social welfare" (Manchikanti et al., 2017).

Following the Bill for the Benefits of Indigent Insane, the federal government involved itself in designing and administering the first medical care system in the post-Civil-War South. These efforts led to the construction of 40 hospitals and the federal employment of 120 physicians (Manchikanti et al., 2017). It was not until the early 20th Century, including passage of the 1911 National Insurance Act in the United Kingdom, that American politicians began to take notice of global progressive ideals about national healthcare that were appearing in other Western nations. The first effort to achieve universal health coverage in the U.S. was initiated by President Theodore Roosevelt during his presidency from 1901 to 1909 (Manchikanti et al., 2017). In 1933, President Franklin D. Roosevelt went a step further and incorporated publicly funded healthcare into his drafts of the Social Security legislation, setting precedence and procedure for future Presidents to come. The move toward universal coverage also incited an organized opposition by the medical establishment (Manchikanti et al., 2017). In 1949, President Truman and the Democrats pushed for universal healthcare legislation through various policy proposals, such as the Wagner-Murray-Dingell bill, the Taft-Smith-Ball bill, a National Health Program, and the Hill-Burton Act. Some of the bills, such as the Hill-Burton Act, managed to pass and become law, but many failed to pass (Kaiser Family Foundation, n.d.).

Following decades of stagnation, both Democrats and Republicans struggled to foster support for universal healthcare and other government-subsidized health programs.

The most significant change in U.S. healthcare policy was in 1965 when President

Lyndon B. Johnson signed into law Medicare and Medicaid (Manchikanti et al., 2017).

Additionally, the passing of this historical law began the growth in U.S. public healthcare

expenditure (Coady et al., 2012). The 1970s witnessed an array of efforts to both

strengthen and weaken Medicare and Medicaid, challenging the strategies of Presidents

Richard Nixon and Jimmy Carter. In the 1980s, the only major legislation was the

"Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA, that amended the

Employment Retirement Income Security Act of 1974 (ERISA) to give some employees

the ability to continue health insurance coverage after leaving employment" (Manchikanti

et al., 2017).

In 1993, President Bill Clinton signed laws implementing the State Children's

Health Insurance Program (SCHIP) and Health Insurance Portability and Accountability

Act (HIPAA), which were pieces of the comprehensive but mostly unsuccessful Health

Security Act. Legislation passed under President Clinton consisted of public management

and coordination reforms that supplemented the existing healthcare infrastructure. It did

this by designating specific resources for some vulnerable populations (e.g., children) and

setting national standards to protect patient privacy (Manchikanti et al., 2017).

Developments of 1900s reforms also aimed to control the growth of government health

care expenses (Coady et al., 2012). Reforms such as SCHIP and HIPPA indicated a

notable shift in the ideological and strategic frameworks used before the passing of

Medicare and Medicaid. They stressed legislation aimed at improving the resilience and

economic sustainability of the programs rather than expanding them.

The 2000s saw passage of the Medicare Modernization Act (MMA), proposed by President George W. Bush, which sought to expand Medicare coverage of prescription drugs (Manchikanti et al., 2017). By the end of the decade, Congress passed President Obama's Affordable Care Act of 2010, "arguably the most consequential and comprehensive health care reform since Medicare was introduced" (Manchikanti et al., 2017). A federal strategy to ensure near-universal health coverage, the Act was modeled in part after earlier state legislation in Massachusetts introduced by Governor Mitt Romney, a Republican. The Act was passed by both houses of Congress and signed into law by President Obama. Arguments have been made against the Act and its effectiveness in ensuring wider access to affordable and quality care. Yet despite these criticisms, and ongoing efforts to repeal it, the Act remains the law of the land in the U.S. and the centerpiece of the federal healthcare system as currently organized.

Health Policy

As the largest global spender on healthcare, the U.S. healthcare system consist of a hybrid model, providing both private insurance and provider health care to its citizens (Coady et al., 2012). Most Americans receive their healthcare via employment sponsored insurance plans, which provide healthcare through privately run insurance firms and hospital networks. However, two public programs exist: Medicare and Medicaid. Medicare is a government health insurance plan for individuals 65 and older, and specific populations (e.g., disability, end-stage renal disease, or Lou Gehrig's disease). Medicaid is a joint federal and state program that helps cover medical costs for low-income individuals. Although individuals can occasionally qualify to receive coverage from both

programs, they usually serve their specific and respective populations. The U.S. has come to address cost constraints mainly through the adoption of managed care, which is a "health care delivery system organized to manage cost, utilization, and quality" (Medicaid.gov, n.d.). Like Canada's tight grip on healthcare expenses, managed care is used as a gatekeeper to more expensive and non-routine medical care. Much more work and diligent efforts are required, however, to combat the growing cost of healthcare and to address healthcare disparities such as those related to the social determinants of population health.

Health as a Human Right in Mexico

Healthcare access and quality has increased in Mexico throughout the past two decades. Mexico has a "segmented social health insurance system" which consists of insurance for the "private sector, salaried workers, government employees, and oil company workers and the Popular Health Insurance (PHI) for the rest of the population" (Coady et al., 2012). This means that while all citizens theoretically have a social safety net to fall back onto, some fall further down the net or simply are never caught. While wealthy and well employed individuals opt for private insurance plans and providers, the remaining individuals are left waiting outside of overcrowded clinics for proper care. Recent healthcare reform seeks to change the country's historical battle with ensuring access to cost-effective and quality care to its most vulnerable populations. However, there is little to no data yet to support the efficacy of recent healthcare reform.

Political Context

The United Mexican States is a Federal State composed of 32 states. The Federation is rooted "on the principle of division of powers among the Executive, Legislative, and Judicial Branches" (Instituto Nacional Electoral, n.d.). The Federal Executive power consists of the nation's president, and the governors of the 31 states (Mexico City is the exception). The Federal Legislative Branch consists of Congress, which is split into an Upper and Lower Chamber. The Judicial Branch consists of the Supreme Court of Justice of the Nation, which is held by eleven justices, or ministers, for 15-year periods. In addition to the division of power by states, the Constitution also establishes that "all the states of the federation must adopt the municipality as the basis for the territorial, political, and administrative division" (Instituto Nacional Electoral, n.d.).

Historical Health Policy Context

Since adoption of its constitution in 1917, Mexico has developed "a deep social orientation towards the policies of education, work, and health" (Columbia Public Health, n.d.). And, although an effective healthcare system was not adopted until 1943, it established three major institutions: the Ministry of Health, the Mexican Social Security Institute (IMSS), and the Mexican Children's Hospital. With three distinct goals and procedures set in place, the role of the Ministry of Health is to cover individuals who do not qualify for health insurance through social security or private insurance. The Mexican Social Security Institute (IMSS) is the social welfare institution of the country, which covers medical and public health expenditures for a large majority of the population.

Lastly, the Children's Hospital is the first national health institute in the country, which offers "highly specialized services, seeks to increase knowledge through research, and has a high impact both nationally and internationally" (Columbia Public Health, n.d.). Most recently, in 1960, "(c)overage was…expanded to public sector employees with the creation of the Institute of Security and Social Services for State Workers (ISSSTE)" (Columbia Public Health, n.d.).

Rural health disparities became a larger area of focus in the 1930s, which is when the "President at the time opted to demand that all medical students spend a set of amount of time working and living among the poorest indigenous Mexicans," a practice that was amended into the constitution and remains in place today (Columbia Public Health, n.d.). In addition to required medical service, the Program for Social Protection of Marginal Groups (COPLAMAR) "took a community-based approach to health services by training local people such as midwives and traditional healers to provide primary care to local communities" (Columbia Public Health, n.d.). This is a similar to what other countries, such as the Republic of China, have adopted and has rendered positive public health results (Huang et al., 2018).

It was not until 1981, three years after the Alma Ata Declaration, that the "Mexican Political Constitution was reformed to recognize health as a universal right," which required a reorganization of the country's health institutions to ensure equitable access to health to all (Columbia Public Health, n.d.). The shift in policy took two decades to affect the lives of ordinary Mexicans, who in 2003 witnessed implementation of the General Law of Health, which led to the rollout of Popular Health Insurance, or

Seguro Popular (Columbia Public Health, n.d.). The 2004 System of Social Protection in Health sought universal access to health care, improving the allocation of resources, making the distribution of resources among states more equitable, increasing competition among service providers, protecting the funding of public health interventions, and protecting families from excessive health expenditures. Prior to the early 2000s health policy initiatives, "central fund allocations to the states continued to be based on historical budgets and, as a result, funding disparities persisted and even increased as the wealthy states increased their own allocations," setting a precedent for the national healthcare system at large (Coady et al., 2012). To this day, the Mexican states remain limited in their roles in expanding healthcare access and increasing public health efforts. Instead, they must rely on federally allocated funds to enact programs or build new healthcare infrastructure.

Seguro Popular was Mexico's response to universal healthcare, and it sought to cover poor citizens and individuals with no formal employment. In 2020, this was replaced by the Institute of Health for Welfare, a decentralized body of the Ministry of Health (Columbia Public Health, n.d.). The hope being that the newly implemented program would "move away from a system of vertically integrated insurance/provider institutions toward a more universal system" (Coady et al., 2012). It remains too early to determine whether the 2020 reform to the Mexican health system will address some of the previous downfalls of its predecessors, but it exemplifies the country's effort to move toward achieving the ideals of Alma Ata and of its own constitution.

Health Policy

　　Mexico has a fragmented healthcare system composed of three principal service providers: the Mexican Institute of Social Security (IMSS), private insurers, and government-sponsored social programs. The IMSS, which includes the Mexican State's Employees' Social Security and Social Services Institute (ISSSTE), is the largest health insurance provider in the country; it covers all medical expenses for both employees in the private sector as well as those who work in the public sector. Private insurance, which is often run exclusively in private hospitals and clinics, is voluntary and usually requires premiums from the individual. Although some employers offer private insurance, it often requires some out-of-pocket expenses from the patient. With this subset of the population in mind, it is important to note that "[t]he private sector is heterogeneous, in terms of both the size of care institutions and the quality of care provided, and is weakly regulated" (Coady et al., 2012). Lastly, social programs are federally funded programs such as the Institute of Health for Wellbeing (INSABI). They cover individuals who do not qualify for the IMSS such as unemployed individuals–nor those who can afford the premiums of private insurance–such as low social-economic status individuals.

　　Together, the IMSS, private insurers, and government-sponsored social programs provide avenues for people to receive medical care in Mexico, most of it free of charge for patients (Columbia Public Health, n.d.). Nonetheless, despite the ambitious goals set forth by such reform, Mexico's healthcare system remains one of the least efficient in the OECD (Coady et al., 2012). Part of these inefficiencies originate from "(f)ragmentation and lack of competition" (Coady et al., 2012). Furthermore, "(s)ocial security institutes,

private insurers, and federal and state health services each have their own vertically integrated service providers with no access to the others' services…[which] has resulted in a costly duplication of health administration and infrastructure, curtailment of patient choice, and lack of competition between providers" (Coady et al., 2012). These inefficiencies ultimately lead to greater healthcare spending, and a decrease in medical resources.

Summary of Cases

Access, quality, and costs are three dimensions of healthcare that Canada, the United States, and Mexico have and will continue to consider when establishing health policy. Ensuring health and access to healthcare is not an easy and affordable task; let alone establishing a solid infrastructure from which to provide care. With similar goals, but disproportionately different access to resources, and outcomes, these sovereign nations differ due to their history and respective constitutions. Factors such as the division of power, the historical role that the federal government has played in ensuring a robust safety net, and their willingness to intervene in national markets, have ultimately impacted the response to the Alma Ata document in respective nations.

The Alma Ata Declaration: In Summary

Chapter Two examines the health policy approaches of three North American Countries (Canada, U.S., and Mexico), provides political and historical context to their respective approaches, and outlines their responses to the Alma Ata Declaration. The Alma Ata, although profoundly influential on foreign health policy, does not set forth

specific protocols for how to ensure health and/or healthcare as a human right. As made evident by Canada, the U.S., and Mexico, healthcare can be packaged as universal healthcare coverage, privately ensured healthcare coverage, or a hybrid of both. And two of the same type (e.g., Canada and Mexico's universal healthcare coverage) can differ in efficacy and cost-effectiveness, ultimately leading to poor quality care or lack of resources. Overall, health policy is a complex problem that demands focused scrutiny and continued attention from national governments, no matter their financial solvency or any ongoing political contingencies.

      Moving forward, Chapter Three will summarize how the Alma Ata Declaration has impacted on national healthcare policies. It will also assess the Alma Ata's sustainability and efficacy at improving health outcomes through a review of statistical data from Canada, the U.S., and Mexico. Lastly, the chapter will conclude with health policy recommendations, personal opinions on the Alma Ata and its role in health policy, and a recognition of the limitations of this present analysis.

CHAPTER THREE

Implications of the Alma Ata

> The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (International Conference on Primary Health Care, 1978).

In 1978, the Alma Ata Declaration set out a vision, and a framework, on how to mitigate the growing demand for healthcare and address population health disparities and inequities. It sought to "protect and promote the health of all the people of the world" (International Conference on Primary Health Care, 1978). Health, defined as a state of complete wellbeing and as a fundamental human right, became an ideal not solely for the few nations who could dream and afford it, but for all nations to aspire to adopt as an ideal. The document recognized that health was not solely about the absence of disease but also is a function of structural factors such as political, economic, and social determinants of health, justice, and autonomy. The Declaration also provided a framework, spearheaded by PHC, from which to begin the process of achieving Health for All. Today, the Alma Ata Declaration is a document that has by now inspired countless domestic and international health policies and is the document recognized by public health leaders, scholars, and students—as well as politicians and government workers—as the primer and template for modern-day global public health initiatives focused on a variety of systemic and more specific concerns.

Alma Ata and the COVID-19 Pandemic

The COVID-19 pandemic has revealed the weak spots in the existing healthcare systems both domestically, within various nations, and in the global health infrastructure. This is a problem that persists at the time of this writing. Although some nations have fared better than others, perhaps resulting from disproportionate wealth distribution and better pandemic readiness, throughout the world people in all nations have experienced the results of healthcare systems unequipped to deal successfully with the pandemic. Until this situation changes for the better, citizens of the world will continue to see the ill effects of the pandemic not just on COVID-19 morbidity and mortality, but on parameters of healthcare in general especially among the most vulnerable populations who most rely on robust safety nets, even as the rest of the world transitions out of the crisis.

The Alma Ata Declaration, ratified in 1978, continues to impact on the world's health and wellbeing through providing a vision of healthcare equity. The document, and the many other subsequent health policy documents, policies, and legislation, continue to challenge governing institutions and experts to do better and strive toward a goal that is perhaps not fully attainable. The elusiveness of Health for All as an ideal nonetheless serves to summon nations, political and public health leaders, and society as a whole to strive progressively toward something much more focused and inclusive than what has been the norm up to now. If research in public health and health policy remains a priority for the world's governments, then humanity has the tools to think through how to become better prepared for the next pandemic.

Public health is the science of preventing disease, prolonging life, and promoting health through organized efforts. Health policy, on the other hand, is the legal tool and action plan—utilized by public health experts, national governments, and international governing bodies—to bring about systematic changes to health, and the delivery of healthcare (Columbia Public Health, 2021). Alma Ata both created a vision and identified practical tools to bring about population health through greater access to healthcare. Accordingly, Canada, the U.S., and Mexico have adopted some of the solutions suggested by the Declaration. But the outcomes have led to different approaches and different outcomes.

For example, Canada adopted an entirely federally and provincially subsidized healthcare system. The U.S. adopted a hybrid model, where a majority of its citizens pay to be covered by health insurance. And, Mexico has launched a series of attempts to provide a public solution to healthcare insurance and delivery. The success of such models is in part yet to be fully evaluated, especially in the U.S. and Mexico.

General Policy Recommendations

In general, Canada, the U.S, and Mexico would do well and curb expenditures if they shifted their public health approach from a reactive model to a preventive model. A preventative model significantly increases the number of resources used to prevent disease in their population and better manage patients with chronic illnesses to avoid costly health treatment and complications. The three countries are experiencing increasing healthcare costs, also a global trend resulting from rising populations, greater

41

access to care, increased demand for care, and greater availability of innovative healthcare treatments. In other words, in some developed countries the healthcare cost spiral has seen respective nations become the victims of their successes in developing effective medical care.

In some counties, higher healthcare costs are augmented due to the lack of supply, meaning lower availability of healthcare providers, facilities, and infrastructure. In countries that fully subsidize the care of their citizens, the toll on the patient may not be the cost of care, but rather limited access to high-quality care. By shifting the logistical and procedural framework of their healthcare systems to a preventive model, some of this burden may be ameliorated. Healthcare systems at any scale can invest in preventive care, such as through routine screening (e.g., for cancer, cardiovascular disease, and diabetes), access to basic healthcare treatments and resources (e.g., essential drugs, family planning), and greater patient agency (i.e., empowerment).

Policy Recommendations for Canada

As a government-subsidized healthcare system, Canada's Medicare utilizes several strategies to regulate healthcare costs. One of the avenues through which Canada maintains lower expenditures is by heavily regulating the supply of their healthcare staff, including the supply of physicians. Medicare sets national and provincial quotas for how many medical students are accepted into medical programs. By keeping the number of physicians low, Medicare controls how much it is spending on hiring and maintaining a physician. Although this method has allowed the system to work efficiently, it has also led to unintended consequences.

If you ask any Canadian about their most pressing concern regarding healthcare, care wait times are the top concern (Brandts-Longtin, 2021). Because of the limited number of physicians available to patients, wait times can often translate to long waits for primary care visits, chronic health maintenance, and surgical procedures. Canadian wait times directly impact patient outcomes and patient satisfaction. A policy proposal for Canada, and its respective governing provinces, would be, first, to reassess the numbers of students accepted into medical programs, and, seconds to address the issue with other health professions providers (e.g., nurses, nurse practitioners, physician assistants) and the increased role and agency of these other non-physician practitioners. The logic behind the recommendation is that Canada is also dealing with an increasingly aging population which will need more specialized care in the coming years and therefore more physicians if they are to maintain a sustainable healthcare system.

Policy Recommendations for the United States

The U.S. spends the most money per capita on healthcare worldwide. This is despite over 50 percent of its population utilizing private insurance to fund most of their healthcare costs. One of the main contributors to the country's exponential rise in healthcare costs, is the plethora of perverse incentives influencing the way patients are treated and billed by their healthcare providers.

In the U.S., an important culprit of such incentives is the fee-for-service payment model, which is the most utilized payment method in the U.S. healthcare system. Fee for service, as its name implies, means that healthcare services are paid for one at a time, separately, on a rolling basis as such services are used, like most commodities. The

payment of individual services is facilitated using Healthcare Common Procedure Coding System (HCPCS) codes, which break down each patient visit and treatment into multiple individual services that are billed separately. A fee-for-service model fragments the delivery of care–providing friction to an already highly inefficient system–and introduces key distortions, such as by incentivizing physicians to provide and bill for more treatments than may be necessary given that their compensation will be dependent upon the quantity of care, and not the quality of care. Accordingly, policymakers are advised to adopt alternative payment models with health-promoting incentive structures in mind.

Policy Recommendations for Mexico

Mexico's healthcare system is severely underfunded. This is due, in part, to a rising demand for healthcare among a rapidly growing population coupled with a highly inefficient healthcare system. The Ministry of Health must plan for a sustainable and cost-effective healthcare system that is not have stifled by supply constraints (e.g., healthcare infrastructure, healthcare providers), and that can provide consistent managed care. In Mexico, the greatest sources of morbidity and mortality are obesity and, concomitantly, cardiovascular diseases (OECD, 2019). This situation is made worse by poorly managed care practices underwritten by public insurance providers. Mexico's healthcare system needs to scale up to match its demand, and it needs to resort to sustainable and cost-effective practices in order to be successful.

Mexico would be well advised to consolidate the IMSS and other government-sponsored social programs. Under the current model, the federal government, through the assistance of the state governments, is simultaneously running large "universal" health

insurance and healthcare service providers, as well as smaller programs that target

specific populations. Consolidating the programs would allow for the planning and

resources needed for one truly universal healthcare coverage and system. This would

enable the federal government to record, identify, and regulate the areas of inefficiency

found within the entire public healthcare system. By identifying where problems arise,

and then targeting identified areas of inefficiency, the Ministry of Health could begin

testing practical solutions to scaling up the Mexican healthcare system.

Limitations

The primary aim of this paper has been to provide an understanding of the

downstream impact of the Alma Ata Declaration, in theory and practice, through a review

of how three North American countries have responded to the document in evolving its

national healthcare policies. Although careful consideration and research were dedicated

to covering the theoretical components of the document, as well as the economic and

political contexts of the three nations, a few limitations of this analysis were present.

First, there is an extensive backstory to the Health for All movement that predates

Alma Ata, and this was only briefly touched on in Chapter One. The overall ideology of

government-funded healthcare existed both in theory and practice, such as the

establishment of the National Health Service in 1948 by the United Kingdom, and, before

that, the experience of Weimar Germany (Thaler, 1996). Nonetheless, the growth of the

Health for All idea was sporadic and not widely applied or debated until Alma Ata, and

the subsequent documents reviewed earlier. Thus, while some of these ideas were already

in circulation, the Alma Ata Declaration was the first document to bring these ideologies

to the global stage, and it served as a foundation and guide for other nations to build upon.

Second, the national profiles in Chapter Two, organized by political context, historical health policy context, and current health policy, are by necessity limited in their scope. That is, whether the Alma Ata Declaration directly impacted the evolution of healthy policy since its ratification can only be inferred and not "proven," and this differs by country. In part, this is due to limited information available about and from particular countries. The case studies, it is hoped, facilitate an understanding of how Alma Ata might have and appears to have influenced domestic policy in three nations, encouraging leaders to adopt a more robust and progressive safety net for citizens that relies on a government-funded healthcare option or mandate.

Third, the policy recommendations made in Chapter Three are a based primarily on the author's delimited comprehension of Alma Ata and of relevant information about the healthcare policymaking process in the three nations. More advanced scholars might have more detailed insights. The recommendations serve, simply, as examples of how the Alma Ata may continue to shape policy both domestically and globally. Therefore, the country-specific policy recommendations are meant to seed future talking points in the larger conversation on global healthcare rights and national healthcare policy.

Concluding Thoughts and Remarks

The Alma Ata Declaration was more than just a vision statement when it was published in 1978; it was a new framework around which to organize a modern society. The WHO recognized the need to address population health disparities throughout the

globe, and it sought accordingly to encourage large and dramatic changes to the international governing order. Although not all countries recognized nor accepted the ideals of the document, the world has moved unilaterally towards a future where health–defined as "a state of complete physical, mental and social wellbeing"—and healthcare are as accessible and attainable as any other human right (International Conference on Primary Health Care, 1978). Human rights, especially those we deem "fundamental," obtain their stature from recognition of innate human dignity. Human dignity, the ethical, philosophical, and political belief that humans garner value simply for the sake of existing, is reliant on certain principles, one of them being health and wellbeing. If individuals and societies deny the ability of people to achieve their greatest degree of health, then they are denying them their rights as humans as well as their dignity.

The Alma Ata Declaration sets forth a goal that some may deem too ambitious for current governments and economic systems to sustain. There may be truth behind that assertion, as achieving health and healthcare for all is what policymakers call a wicked problem, one that requires a wicked solution (Rittel, Horst W. J. & Webber, 1973). Realistically, the solution to addressing the world's most pressing health equity problems will not be one perfect action plan, but rather multiple action plans that may be imperfect at first but will eventually make progress in ensuring the dignity of all people.

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