The spirit of Alma Ata

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

Other international documents, as Health for All, and WONCA in 1991, and WHO Euro-Region 21 in 1995, and WHO Europe Framework in 1998 are important, but dealing with professional activity in the health care system, not about the discipline as a medical activity with a specific process.
Two really important documents have tried to make the Alma Ata ideals a practical reality for patients. The WONCA Europe Definition has set out the range of skills required to practise the kind of primary health care envisaged in the Alma Ata declaration. The EURACT Educational Agenda seeks to equip future generation of doctors in the same way.

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

Comprehensive care is a crucial aspect of general practice, **as a people based discipline as opposed to pathology** or organ based, and as normality orientated as opposed to abnormality orientation of secondary care, but, at the same time, family doctors meet and manage serious illness at an early and undifferentiated stage, with an incidence of illness, signs and presentation that is absolutely specific.
Gay considered the disease as the result of organic, human and environmental factors, a concept like the bio psychosocial model of Engel (11) in his " holistic " model.

Efficiency is a further statement by Gay which refers to the **cost efficiency** as a characteristic feature of well developed family health care systems and WONCA Definition indicates that family doctor has a role in resource management in health care systems.
Again, if we want to promote health and well being by applying **health promotion and disease prevention** strategies appropriately, we could use a **comprehensive approach**, that is often in contrast with the specialist approach in treating each problem separately.
Through Europe, now we can see how many practices and family doctors handle risk factors **promoting self – care** so to limit or minimise the impact of their patients' symptoms and reactions on their well being by taking into account their personalities, families, daily life, physical and social surroundings, and, also, their backgrounds, cultural and religious believes.
In this way **EURACT** is stressing so much the Alma Ata philosophy promoting high levels for **teaching and learning** health promotion, looking for mandatory **specific training**, and **undergraduate curriculum** and early exposure to clinical experiences within the primary care setting and **clear selection** for teachers and practices.

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

Also here EURACT values were informed by Alma Ata Declaration, taking strong consideration of **the community orientation**. This is because family doctors have a responsibility for the community in which they work and must understand the potentials and limitations of the community.
As in all societies health care systems are being rationed and doctors are involved in the rationing decisions, also **ethical and moral responsibilities** are on GPs' shoulders and they could try to influence health policy in the community.
How ? It could be by reconciling the health needs of individual patients and of the community, in balance with really available resources. To do this, GPs have to be **allowed contractually to act as advocate** for all their patients and community health promotion.
To be able to do so, they need to **learn** in the basic curriculum and in the Vocational Training the **interrelationships between health and social care**, the impact of poverty, ethnicity, inequalities, the structure of the health care system in which they live and in which they work (Educational Agenda 2004).
How to learn this ? With case – discussions, record reviews, visiting health and social care institutions, making audit of practice. This one is, as all political documents, an indication, a way, to be integrated in each Country's reality.
In fact, advocacy is a big point, helping the patient take an active part in the clinical process and working with the government and other authorities to maximise equitable distribution of services to all members of society.

Considering holistic as the **bio – psycho – social model**, we could focalise that one's own health beliefs and life experiences contribute to make a person the entity that he/she is now, and are among the health – maintaining factors in a person, like the understanding of events, the acceptance of meaning, the autonomy that leads to the persuasion that life is manageable.
Health remains for all, primary care has to consider populations, and this is important in teaching and health education, but really it is a public health responsibility.

Challenges are much, or more, now than then.

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