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From Alma-Ata to Astana: the path of Primary Health Care in Portugal, 1978-2018 and the genesis of Family Medicine

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Abstract *Throughout the twentieth century, the profound changes that have taken place in Medicine can only be wholly explained if observed from a historical perspective, for they have always occurred in response to external influences, some scientific and technological, others of a social nature. Modern Family Medicine is one of the many new disciplines that have developed during medical history, and we critically discuss the last 40 years of primary health care in Portugal, which started in 1971, long before the Alma-Ata Declaration (1978). Along the way, in 2005, the Primary Health Care Reform emerges in Portugal, along with the new family health facilities, which until September 2019, attended about 94 % of Portuguese citizens, i.e., 9,5 million people. At the end of this course, in solidarity and voluntarily, this Reform inspired another one in Brazil, in Rio de Janeiro, in 2009. Finally, we present the challenges pointed out in the 2018 Astana Declaration, among them, the issue of the workforce in primary health care as an essential factor for the performance and sustainability of health systems.*

Key words *Primary health care, Family Medicine, Universal health coverage*

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Introduction

In his book "A textbook of Family Medicine", McWhinney, the father of Family Medicine in Canada[1,2], states that the profound changes that have occurred in Medicine can only be explained entirely if observed from a historical perspective, as they have always emerged in response to external influences, some scientific and technological, some social. Modern Family Medicine is one of many new disciplines that have developed throughout medical history.

In 1910, the Flexner Report[3] described significant deficiencies in the U.S. Medical School education system and even led to the closure of many for lack of scientific credibility. The impact of that report had repercussions not only in the United States but in Europe. The rigorous criteria and requirements that have been demanded of medical schools have turned them into teaching and research centers. It also created the conditions for the development of a highly specialized technological Medicine, albeit less sensitive to the social role of the medical profession.

In the United Kingdom, for the first time, in the so-called Dawson Report of 1920[4], a position of the British government emerged which, on the one hand, sought to counteract the curative Flexner model founded on biological reductionism and, on the other hand, to establish a reference for the organization of the British health care model, which at that time was marked by high costs, medical complexity and low resolution of citizens' problems.

The Dawson Report advocated the organization of services in health centers and hospitals, home services, complementary services, and university hospitals. Health centers and home-based services should be organized as per a regional model in which most health problems should be solved by physicians trained in General and Family Medicine. Only cases that family doctors could not solve should be referred to hospitals.

This organization is characterized by the hierarchy of care levels and integrality, that is, the strengthening of the relationship between curative and preventive actions, and influenced the organization of health systems around the world.

Over the next three decades, the rapid technological progress, the development of applied research, and increasing specialization, a source of prestige in medical practice, did not favor General Practice. After World War II, the place of General Practice was held by medical intervention resulting from the fragmentation of significant specialties into sub-specialties. This decline has been noted even in the United Kingdom, where general practitioners held an essential position in the health system, reinforced after the establishment of the National Health Service (SNS) in 1948.

The response of general practitioners manifests itself in the creation of academies and colleges designed to boost the practice of Family Medicine. Namely, the creation of the American Academy of Family Physicians in the United States in 1947, the Royal College of General Practitioners in the United Kingdom in 1952, and the College of Family Physicians of Canada in 1954.

The point is that the ultra-specialization process of modern medical exercise has generated a tendency toward depersonalization of the doctor-patient relationship that leads to the loss of the total perception of the human person, now divided into systems, apparatus, and organs while relegating to the background or ignored the psychosocial dimension of the individual.

All of these elements had a decisive influence on the process of social awareness regarding the need to revive the old general practitioner, the physician who followed the history of the person and family from birth to death.

When the field of specialization seemed to have reached its peak, a movement arises in the U.S. against care fragmentation, advocating the reemergence of general practitioners, now different from 'old general practitioners', by playing a very different role in their performance as a medical professional. McWhinney[1] argues that this movement begins with two key documents: "The Graduate Education of Physicians: Report of the Citizens Committee on Graduate Medical Education"[5] and "Meeting the Challenge of Family Practice: Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education"[6].

While the first – the Millis Commission Report – discredited fragmented health care and stated, *it is time for a revolution, not a few patchwork adaptations*, the second – the Willard Commission Report – advocated the formation and training of a new specialist: the family doctor[5,6].

Three years later, the American Board of Family Practice gives rise to the 20th Medical Specialty Board, with the formal recognition of Family Medicine as a medical specialty. Interestingly, the first with required six-yearly recertification. This development was so vigorous in the U.S. that, in 1971, the American Academy of General Practice changed its name to the American Academy of Family Medicine.

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From the 1970s, albeit of different dimensions and with their particularities, similar movements occurred in parallel in Canada, the United Kingdom, the Netherlands, Norway, Australia, Portugal, Spain, and other developed countries. Moreover, following this international movement, the World Organization of Family Doctors (WONCA) is created, whose first conference is held in 1972 in Melbourne. Six years later, an even more decisive event takes place: The Alma-Ata Conference.

In the twentieth century, the history of Family Medicine became intrinsically linked to the history of Primary Health Care (PHC), understood as the first level of care in the health system.

The Alma-Ata Conference

In this context, in 1978, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) held the 1st International Conference on Primary Health Care in Alma-Ata, Kazakhstan (former Soviet Union). At this conference, WHO proposes to achieve the "Health for All by 2000" goal through the implementation and development of "Primary Health Care" worldwide.

This is defined as *essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process*[7].

The Alma-Ata Declaration, namely, the agreement signed among the 134 WHO member countries, calls for the establishment of local health services focused on the health needs of the population and based on an interdisciplinary perspective, involving doctors, nurses, midwives, assistants, and community workers, as well as social participation in the management and control of their activities.

The document also describes the minimum actions required for the development of primary health care in different countries: health education, focused on prevention and protection; food distribution and adequate nutrition; water treatment and sanitation; maternal and child health; family planning; vaccination; prevention and control of endemic diseases; treatment of common diseases and injuries and, finally, supply of essential medicines.

More than that, the Alma-Ata Declaration points to the need for universal health systems, that is, it conceives of health as a human right. Although the Alma-Ata goals were not fully achieved, they became an essential reference for health system reforms in several countries in the 1980s and 1990s, including Portugal, which, as we shall see below, initiated this process of changes in the 1970s.

The foreshadowing of the first health centers in Portugal in the path of primary health care

In 1971, the Health System and Care Reform (Decree-Law No. 413/71)[8] led to the reorganization of the Ministry of Health services (established in 1958), with the so-called "first generation health centers". This Decree introduced significant changes to the system by restructuring central and regional and local services. For the first time, attempts were made to counteract the dominance of hospitals and guide care delivery to primary care. Also, these health centers were endowed with many skills, including, of course, the provision of primary and nursing care. Mainly, it aimed to provide some protection for the population (with particular emphasis on two especially vulnerable groups, such as women and children) and to prevent major infectious diseases through vaccination.

The April Revolution of 1974 led to profound changes in the country and state institutions, including Health. The end of the overseas war and the independence of the colonies meant the return of thousands of Portuguese in a short time. Many former college doctors who were previously required to go overseas stayed in the country. Many of them chose the General Practice, which allowed the establishment of "medical services to the suburbs" in 1975, which took newly licensed doctors out of large urban centers and created the opportunity to improve health care in health centers, including rural and inland areas.

The birth of the National Health Service (SNS) in Portugal

The creation of the National Health Service (SNS) occurs a few years later, in 1979, with António Arnaut, known as the "father" of the SNS. Funded and guaranteed by the state, the SNS was conceived as a universal, general, and free service, regardless of the economic capacities of the citizens. Article 64 of the 1976 Portuguese Constitution states, first, that *everyone has the right to health protection and the duty to promote and defend it*[9]. Secondly, it states that *the right to health protection is realized by establishing a universal, general and free National Health Service* (…)[9].

In this context, the implementation of General Practice as a medical specialty started in the 1970s and is undergoing a vigorous development with the establishment of the General Practice Institutes in the North, Center, and South between 1981 and 1983, given the relevance of general practitioners in the SNS. One of the priorities of these Institutes – which were under the supervision of the Directorate-General for Primary Health Care (created by Decree-Law No. 74-C/84 of March 2)[10] – was the training of health care physicians, under two different models, namely, the General Practice Complementary Internship and the Specific In-Service Training. The latter was a groundbreaking experiment – analyzed years later by other countries, which adapted it to their reality – as it was intended for doctors who were already working as General Practitioners at health centers. It integrated the "oriented service", the "classroom training", that is, in traditional ways, and the hospital internship. Through this in-service training model, General Practitioners could obtain the General Practitioner Assistant degree, and, consequently, entry into the General Practitioner career.

The General Practice career emerges in 1982 (Diploma of Medical Careers, Decree-Law No. 310/82)[11], and, in the following year, the so-called "second-generation health centers" were established (Normative Order N° 97/83, of April 22)[12]. These health centers derive from the merger of the Social Security Pension Fund Posts (created by the Second Republic) with first-generation health centers.

The General Practice College of the Medical Association is created that same year. In 1983, the Portuguese Association of General Practitioners (APMCG) was established, which in the following years would become the largest non-compulsory medical professional association.

In the 1980s, the SNS management and the need to contain rising health costs was now a priority for governments. The revision of the Constitution in 1989 makes health "tendentially free", and the Basic Health Law[13,14] is approved a year later. Generally, this critical document states that health becomes the responsibility not only of the State, but of each individual, and allows the increase of the SNS contracting services from the social and private sector. That same year, for the first time, moderating fees are introduced in health centers and hospitals. The payment of these moderating fees or reimbursement exempted people in particular situations, such as those with relevant clinical situations of higher health risks or situations of economic insufficiency.

The organization of primary health care around the so-called second-generation health centers, without administrative and financial autonomy, has, in practice, kept them dependent on the Health Sub-regions (SRS) and the Regional Health Administrations (ARS). The need to change this state of affairs and bring the decision-making center closer to the field, and the professionals led to a series of organizational experiences in 1996 led by APMCG family doctors.

The 1990s and mid-2000s: The Alfa Projects and the creation of third-generation health centers

The Alfa Projects[15] emerged in 1996 and 1997 in the Lisbon and Tagus Valley Region. Mostly, they aimed to encourage organizational solutions from the initiative of health professionals, which would enable them to make better use of existing capacity and resources in health centers. The model built on two fundamental principles: on the one hand, improving the accessibility and quality of primary health care and, on the other, the establishment of small multidisciplinary teams responsible for providing health care to a given population, as per well-defined principles, objectives, and goals agreed with the Administration through a contracting process.

The positive evaluation of these projects led to the approval of the Experimental Remuneration Model (RRE) for GPs in 1998. The RRE was regulated by Decree-Law N° 117/98 of May 5[16], which not only enshrined changes in the organization of work similar to those of the Alfa Projects but also introduced a form of remuneration for doctors associated with the amount of work performed and the professional quality. The innovative model shook up a bureaucratic and

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immobile central administration. For the first time, good clinical performance was positively discriminated against, and the establishment of the Outsourcing Agencies in 1997 and 1999 contributed to the separation of funding and health care delivery. Discussions on program contracts with hospitals began in 1998, and later on with health centers.

The debate on the decentralization of primary health care management from health sub-regions (SRS) to health centers culminates in 1999 with the legislation on third-generation health centers (Decree-Law No. 157/99, May 10)[17]. These health facilities are legal entities with administrative and financial autonomy, and should be organized into functional units with technical autonomy and interlinked as per a multi-professional and networked work model. The objective was to make management more flexible, bringing it closer to the professionals who were in the field, and, therefore, more knowledgeable of the population's needs, such as enhancing proximity with users and improving access. However, despite all the efforts and work over the years, third-generation health centers have not yet left the drawing board, primarily because of the resilience of the Health sub-regions, which would see their power transferred to health centers once they had administrative and financial autonomy. Its extinction was predetermined, and indeed it happened.

The second half of the 2000s and the 2010s: From the Primary Health Care Mission to the Health System Reform

The 17th Constitutional Government Program (2005-2009), in the area of Health, mainly focused primary care and its importance in connecting with users, as it is their first access to health care. It explicitly referred that health centers would be restructured with the creation of new facilities called "family health units" (USF)[18]. In general terms, these new units should abide by the following principles: (i) small multi-professional and self-organized teams; (ii) functional and technical organizational autonomy; (iii) contracting an essential portfolio of services; (iv) decentralized diagnostic means; (v) remuneration system that considers productivity, accessibility, and quality.

After the establishment of the Government Program in September 2005, the Council of Ministers[19] created the "Primary Health Care Mission" (MCSP) directly under the then Minister of Health Correia de Campos, with the nature of mission structure, to conduct the overall primary care reform project in Portugal. The MCSP was extended for two years and then another year, ending its mandate on April 14, 2010, after four and a half years of activity. It has published, among others, an important document entitled "Priority Action Lines for the Development of Primary Health Care"[20].

Its main objectives for Primary Care Reform were to obtain more and better health care for citizens, increase accessibility, and consequently achieve a higher satisfaction of service users. It also intended to increase the satisfaction of professionals by creating good working conditions, improving the organization, and rewarding good practices. At the same time, it planned to improve efficiency and promote cost containment by eliminating structural competition and achieving economies of scale.

During 2010, hundreds of USFs were opened nationwide, and dozens of health centers were transformed into USF. In 2019, more than 9.5 million Portuguese citizens had been assigned a family doctor (5,765 nationwide), which corresponded to about 94% of the total resident population. If all doctors accepted the contest positions that provide for 400 General and Family Medicine vacancies, the percentage of Portuguese with a family doctor could reach 98%[21]. It is also important to highlight that in the same decade, in a long process of partnerships with Brazil, the primary health care model served as a source of inspiration in the period 2009-2016, for the Primary Health Care Reform carried out in the city of Rio de Janeiro[22,23].

The Astana Declaration and the challenges for the future of primary health care

On the second day of the Astana Conference, held on October 25-26, 2018, The Lancet magazine published a special issue dedicated to primary health care[24], highlighting that *strong primary health care, rooted in community participation and action, is the foundation of the entire health system, and no country can achieve health for all without them*.

Moreover, if we return to this October 2018[24] Lancet Editorial, we can see that *primary health care is in crisis*. That is, there are enormous challenges, since, at the first level of health care, this care is underdeveloped in many countries, underfunded in others, and faces an essential mission of recruiting and retaining its workforce.

Half of the world's population has no access to essential health services. However, 80 to 90% of people's health needs throughout their lives could be met within an essential primary care framework – from maternal and child health care, disease prevention, vaccination, to chronic disease management and palliative care. As populations age and multimorbidity becomes the norm, the role of primary care professionals becomes increasingly important, and so a revival of primary care is essential to providing health for all, especially for the most vulnerable.

Investing in primary health care across four platforms (community-based care, health centers, first-level hospitals, and population-based interventions) is one of the Lancet Commission's messages on "Investing in Health"[25].

The Astana Declaration[26] may mark the beginning of a better future for primary care, which, as we have seen in Portugal, started in a timeline that began in 1971 (Figure 1).

The health workforce (and for most reasons in primary care) is a crucial factor in the performance and sustainability of health systems. The World Organization of Family Doctors (WONCA) has stepped up its efforts to train doctors in developing countries, but an insufficient investment in primary care professionals has been noted over the past 30 years. Multi-professional teams focused on people's needs can be an essential way to introduce innovations.

Fortunately, Portugal is among the countries with a primary healthcare-oriented health system worldwide, with one of its leading indicators – the child mortality rate – declining sharply in the last 40 years (Figure 2).

In Portugal, the road from Alma-Ata to Astana is practically overlapping the path of the National Health Service. At the 40-year celebration, Pizarro[27] writes that we are currently aware of the countries with the best results in most indices that evaluate health outcomes. We achieved excellent results in child mortality, and almost eradicated maternal mortality. We treat cardiovascular disease and cancer at the best level. We lead in the complex area of organ transplantation. The mean life expectancy at birth has increased considerably to over 80 years. For this reason, the SNS is felt by most Portuguese as one of the great achievements of our democracy. However, to overcome the challenges of the present and to continue to improve, we cannot but fight. Celebrating the SNS is, therefore, doing what has not yet been done.

In the same vein, on the occasion of the official celebrations of the 40th anniversary of the SNS, Minister of Health Marta Temido[28] states that despite the relevance of the path taken and its achievements, the most important way to commemorate SNS 40th anniversary will be to prepare it to the future. Three priorities have been identified: the SNS must improve the quality of access, motivate health professionals, increase their productivity, and strengthen investment. The SNS is and should remain, above all, an instrument for combating inequalities and strengthening social cohesion.

It would be crucial that the new Basic Health Law, enacted in 2019[29], bring the improvements we all want, and help us meet the current challenges of the National Health Service, with great solidarity and cooperation among all service providers to the benefit of all Portuguese citizens.

1143	Independent nation
1910	Implementation of the Republic
1971	Community Health Centers
1974	Democratic Regime
1978	Alma-Ata Conference
1979	**National Health Service**
1982	General Clinic Career
1986	Member of the European Union
2005	Primary Health Care Reform
2009	Primary Health Care Reform in Rio de Janeiro
2018	Astana Conference

Figure 1. Timeline of primary healthcare in Portugal: From Alma-Ata to Astana, through Rio de Janeiro.

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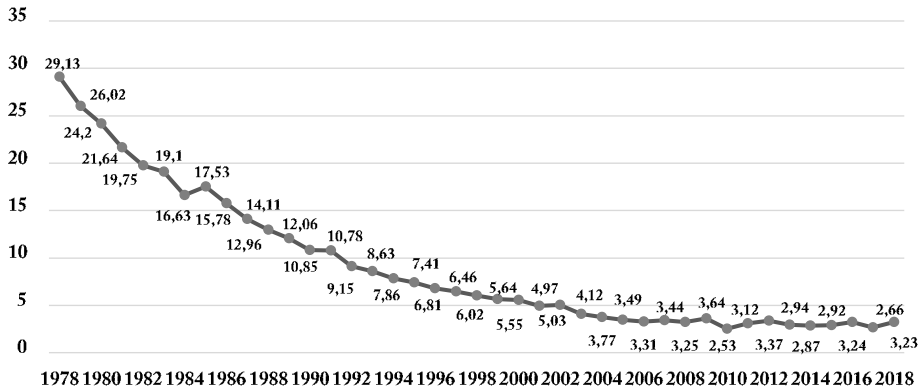

Figure 2. Child mortality rate trend - Portugal – 1978-2018.

Source: National Institute of Statistics (INE), Portugal.

Collaborations

LA Pisco and LF Pinto participated jointly in all stages of paper elaboration and final review.

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