In 1978, world leaders assembled in Almaty (formerly Alma Ata) in Kazakhstan to sign an international declaration highlighting the importance of primary healthcare services around the world. The result was a landmark document in the history of public health: the ‘Alma Ata Declaration’ – an agreement of WHO member states to implement ‘health for all’ by the year 2000.

Many have regarded the Alma Ata Declaration as the most important public health document to be agreed upon in the last century. The Declaration not only indicated states’ commitment to health access in a global context, but also used the broad World Health Organization definition of health, as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. The definition affirmed health as a human right, including socioeconomic well-being as part of health, and stated that health equality was a major goal of member states, identifying governments as responsible for protecting their citizens’ health with the support of the international community.

The Alma Ata Declaration defined ‘primary care’ comprehensively, stating that its purpose was to address ‘the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly,’ based on ‘the application of the relevant results of social, biomedical and health services research and public health experience’. Primary care included ‘education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally
endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs’. Primary health care ‘should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need’.²

While this landmark document set out a bold vision for the future, it was unfortunately followed by decades of disappointment. In spite of the progressive agenda outlined in the Declaration, it was later revealed that representatives from five wealthy nations, including the United States, had met secretly during the conference to define a ‘real’ agenda, consisting of the promotion of maternal and child health at the expense of comprehensive care.³ This was thought more realistic and would avoid excessive commitments of funds from donor to recipient countries. In line with this narrower focus, over the next few years the comprehensive definition of primary care adopted in the Alma Ata Declaration evolved into a ‘minimum package’ of ‘essential’ services and goods.⁴ The list of essentials was codified in World Health Organization documents, reducing broad arrays of services, pharmaceuticals, and patient support systems to much shorter lists of very basic, cheap and often sub-standard medications and medical protocols, excluding numerous common diseases, conditions and public health needs.

The quest to build new primary care infrastructure after Alma Ata was therefore largely unsuccessful. As part of the initiatives created after Alma Ata, numerous ‘health posts’ appeared in poor countries, typically single-room shacks staffed by untrained members of the community conscripted as health assistants. Limited coverage of local diseases, and limited or improper treatment of patients, produced few significant benefits in terms of morbidity or mortality. Many posts lasted for short periods of time; others were related to worsening health outcomes as untrained providers misused medications or even turned public facilities into private clinics. Some countries did, thankfully, experience reductions in crude death rates and improvements in life expectancy over the past few decades since Alma-Ata; however, this appears more related to general improvements in living conditions and income among the populations, rather than enhancements in actual primary healthcare delivery systems.⁵

An undemocratic framework

In the years following Alma Ata, limited investment in primary care was accompanied by the public health community’s creation of aggregate measures of disability and disease (disability-adjusted life years and quality-adjusted life years). These measures of public health programme efficacy were used to
assess the health or economic returns to be expected from investments in various health programmes. However, such analyses often resulted in limited investments in comprehensive primary care health services. As a result of their focus on immediate benefits and costs, cost-effectiveness analyses failed to account for the down-stream consequences of disease, or of the failure to make needed public health investments – consequences in the shape of the transmission of diseases to others (for communicable diseases) or in terms of the social and economic consequences of leaving diseases untreated until a public health problem became more severe (and potentially more costly).

Critical assessments of the new field of cost-effectiveness analysis in public health also revealed that the aggregate measures used in these analyses, subject to numerous assumptions and subjective judgments, were difficult to calculate with reasonable reproducibility by different analysts, and usually had weak statistical validity. Nevertheless, these ‘metrics’ became the basis for an industry of theses by international development banks, academic groups and government agencies, giving aggregate measures of health system impact greater political weight than direct measures of population health and health system efficacy (such as waiting times for essential treatments, the availability of qualified doctors in rural populations, or the number of households with access to clean water).

Assessments using aggregate indicators and cost-effectiveness measures meant that communities were often unable to engage with the evaluation of their own health systems. The assessment of health system quality was conducted through convoluted but not validated models produced primarily by American market analysts whose previous experience was in designing privatised health systems. Aggregate indicators often produced nonsensical results, such as a WHO health system ranking method that rated China’s as equivalent to Haiti’s, or that gave high ratings to systems in which health outcomes and patient evaluations indicated very poor access and service quality.

Key discussions in public health became divorced from community concerns. Rather than discussing the serious failure to implement the Alma Ata mandate, debates were focused on such things as whether donor funding would generate inflation, though there was no economic evidence to support the inflationary targets adopted, and public health spending was often decreasing or stagnant, rather than increasing. Much of the concern was about providing ‘returns on investment’ for rich-country donors, often by accelerating mineral extraction or labour supply from poorer countries.
The emergence of HIV

While these discussions preoccupied the public health community, governments failed to react urgently to what was to become the greatest public health catastrophe of our time, the AIDS pandemic, and the resurgence of tuberculosis that has followed in its wake in many parts of the world.\(^{14}\) By the early 1980s it had become clear that a new public health challenge had emerged, targeting those most socially marginalised. Gay men had been reported to have ‘Gay-Related Immune Deficiency’ (GRID), later renamed ‘Acquired Immune Deficiency Syndrome’ (AIDS) as Haitians and injection drug users were added to the cluster of the feared and ostracised members of society who were thought to be vectors of this pathology.\(^{15}\) Gay men, already mobilised from earlier fights for civil rights, and with relatively more social and economic capital than other affected groups, created new activist organisations to advocate for health care, argue against stigmatising and pathologising rhetoric that surrounded their association with this disease, and influence the course of medication development to treat it. They protested until they were accepted into the US Food and Drug Administration’s committees, creating a new mechanism to allow experimental drug access for dying patients.\(^{16}\) They also joined forces with anti-apartheid activists as it became evident that migrants and women in many regions of sub-Saharan Africa were heavily affected.\(^{17}\)

While some in Hollywood would characterise AIDS as a disease that could ‘strike anyone’, the reality was that the human immunodeficiency virus (HIV) causing AIDS targeted those who were poorest, and who led the least socially stable lives. Academics struggled to find biological explanations for this highly skewed distribution of disease, finding that those with poor treatment for prior sexually-transmitted infections were at high risk, and attributing differences in HIV risk to differences in a variety of nutritional, sexual, regional or other factors.\(^{18}\) But these proximal explanations failed to explain the full extent of variation in the disease’s incidence; the focus on ‘behaviour’ neglected the economic and social determinants of infection.

In reality, the top epidemiological predictor for HIV infection around the world was low income. This meant that those most vulnerable to HIV infection did not significantly benefit from a model focused exclusively on education,\(^{19}\) which assumed people living in poverty were sufficiently able to control the circumstances of their lives to avoid infection. Numerous surveys have established that those most at risk for HIV often do know how the virus is transmitted, and even the highest prevalence areas have sexual partnership rates lower than in many regions of the US and UK.\(^{20}\) Sex was not as much the issue as the context in which sex occurred. In the South African
mining sector, for example, a group of psychologists recently declared that the norm of ‘masculinity’ (expressed through soliciting prostitutes) in South African ‘culture’ increased the risk of HIV transmission among miners.\textsuperscript{21} But to identify ‘culture’ as the problem would ignore the perspective of the miners themselves. In the context of a 42 per cent injury rate, it would be natural to think that catching a disease that could kill a person ten years in the future would be less pressing than trying to gain some control over life – or perhaps just enjoying life in some minor way (e.g. through alcohol or sex) before getting crushed by falling rock. But the scientists labelled miners as ‘in denial’, asserting that miners’ ‘low self-esteem’ could be responsible for their increased risk of HIV infection. A similar survey among prostitutes labelled them ‘liars’ (in ‘denial’ of their agency) when they attributed their prostitution to lack of education and job opportunities, and to coercion.\textsuperscript{22}

The error involved in seeing the issue as ‘cultural’ soon became clear from the failure of ‘educational’ solutions. Even after messages were adapted to ‘local norms’, ‘providing information about health risks changes the behaviour of, at most, one in four people – generally those who are more affluent and better educated’ according to a systematic review of evidence in the \textit{British Medical Journal (BMJ)}.\textsuperscript{23} Even if the best-performing education initiatives had covered the entire globe by 2005, such programmes would still have left a rate of transmission equivalent to 1.5 million new cases a year, according to the public health community’s most advanced models.\textsuperscript{24}

What the public health community ignored is that the background of increasing HIV transmission was one of neo-liberalism – a context where short-term financial gains through deregulated trade agreements were privileged over long-term investment and the ability of most people to secure a decent livelihood. The increased rates of HIV transmission across southern Africa, East Asia, Eastern Europe and Latin America were strongly correlated with increases in forced migration, which most often occurred when rural agricultural sectors were destroyed following the liberalisation of markets and the subsequent drop in primary commodity prices, leading (mostly male) labourers to find work in urban centres and leave their families behind.\textsuperscript{25} In sectors of southern Africa, miners housed in all-male barracks for months at a time worked six days a week, were given alcohol to ‘keep them happy’ (or keep them from rebelling) on the seventh – when intoxication and depression lead to the solicitation of prostitutes.\textsuperscript{26} When sick with AIDS-related infections, the men were sent home to die, and found that either their wives had left them to find a better source of income and support, had entered prostitution or other risky professions to generate income, or were waiting for their husbands to return home (and infect them
with HIV). The ‘rural women’s epidemic’ of HIV – that is the sub-epidemic of women in rural zones who were infected by their migrant male husbands – is not so surprising in this context, even though it was considered a public health puzzle for years.

Today, HIV remains a disease of the least powerful. We often describe it as focused on Africa, but it is not all Africans who are at risk, or all non-Africans who are not at risk. Indeed, nearly one in twenty citizens of Washington D.C. have HIV, and the concentration of HIV among and within African states varies widely, primarily according to income level. The dramatic reduction in mortality resulting from HIV in the US and Europe has been due to the rapid expansion of antiretroviral drug access since the late 1990s, and the integration of these highly effective medicines into primary care systems; the rate of new HIV infections remained stable while mortality from HIV plummeted in the late 1990s, while it was rising exponentially in other nations.

Civil society movements

Although the WHO and other international agencies, as well as domestic ones in the US and elsewhere, were resistant to responding to the epidemic, ordinary men and women in South Africa, Thailand, Brazil, the US and Europe did react, creating a community-based movement that forced a major shift in public health funding, health system infrastructure, and notions of accountability in public health. Facilitated in part by improved Internet access and related communications resources, a massive movement of ‘AIDS activists’ was formed, primarily advocating that HIV-infected people themselves should have a say in how they are treated by their communities and the public health system. While this was initially a push for AIDS services, the populations hardest hit by the disease were often also ill-served by health systems because of who they were: drug users; men who have sex with men; racial minorities; women without social, educational or employment opportunities; and the poor. AIDS activists began a large movement to call for the expansion of health services in general, focused on those most marginalised, and for health systems to meet the specific needs of the communities who used them. The idea was that HIV was not a special disease, but a symbol of neglect and inequality – the most recent, and worst, manifestation of undemocratic decision-making about who should have access to health services and what it means to have a right to health.

With a focus on human rights, and with a large public movement embarrassing public officials at meetings, international economic conferences, and presidential election campaign stops, the institutional global health
agenda shifted from a ‘minimum package’ of health services to determining how best to use a public health approach to scale-up services and meet the grave need for care that was highlighted by the millions of HIV-related deaths between the late 1980s and the turn of the century. In the past 10 years, the most representative instance of this shift was the debate on antiretroviral access in poor countries. AIDS activists returned to the Alma Ata definition of primary care, indicating that the control of locally endemic or epidemic diseases was part of primary care. Given the astoundingly high prevalence of HIV in many communities (over 1 in 5 adults in much of South Africa), this would assuredly include HIV treatment. But the calls for wider availability of AIDS treatment encountered the same reaction from those who favoured ‘selective primary care’ in the years after Alma Ata.

A number of arguments were advanced to indicate that antiretrovirals should be available only to the wealthy. The first was that prevention approaches would be more cost-effective than treatment, and a dichotomy was established between the two. But it soon became evident that prevention initiatives were of limited benefit in many regions, as people perceived the disease as a death sentence, and had little motivation to present themselves to health centres that would not help them but simply provide patronising safe sex messages, often too late to change health outcomes. Furthermore, the interventions often assumed that people lived in circumstances in which ‘behaviour change’ was a simple matter of education, rather than a complex set of constraints involving gender, race and class inequality, including migrant labour, sex work, and other conditions of survival that limited people’s priorities and control.

A second argument was that the pharmaceutical industry could not reduce drug prices, as this would discourage research and development. Yet the activist movement revealed that the prices of pharmaceuticals were several times larger than their production cost, and that much of the research was taxpayer-funded. The industry was spending 27 per cent of its profits on marketing and 11 per cent on research and development, even as it ranked highest in the world in terms of profits as a percentage of revenue (three times the Fortune 500 average).

A final argument was that poor countries had such limited infrastructure, or the intellectual capacities of their citizens was too low, to permit the successful implementation of medication. In 2001 the director of the US Agency for International Development, Andrew Natsios, said that antiretroviral medicines were inappropriate in Africa because Africans ‘don’t know what Western time is… Many people in Africa have never seen a clock or a watch their entire lives. And if you say, one o’clock in the afternoon, they
do not know what you are talking about.\textsuperscript{37} Pilot programmes, spearheaded most prominently by the non-governmental organisations Partners in Health and Doctors Without Borders, soon contradicted these ignorant and racist assumptions. People living with HIV in the poorest settings were able to adhere to medications at rates far better than most patients in the US or Europe, had sustained success in their treatment, and could be treated through public health approaches such as the delivery and monitoring of care by community healthcare workers, which also enhanced overall primary care delivery, besides HIV care.\textsuperscript{38}

Because AIDS activists pushed themselves into government meetings, international development conferences, and medical research boards, a shift occurred in what was considered prudent and possible. The resulting ‘3-by-5 Initiative’, a WHO programme to initiate antiretroviral treatment of 3 million people living with HIV by 2005, galvanised this shift. What was remarkable about the 3-by-5 initiative was its support for expanding beyond a ‘minimum package’ to programmes that would support the expansion of healthcare facilities and greater access to Alma Ata-like primary care in resource-denied settings. The 3-by-5 programme focused on concrete operational guidelines and high-quality management, transparency and accountability to the community, which not only meant that attention to a disease-specific problem was realized in effective protocols and care, but that this initiative would lead to broader improvements to the general health system. This involved building medical schools in poor countries, developing new hospitals, training providers in general primary care, and ensuring strong systems for manufacturing and delivering medications. The move brought previously defunct health centres back into reliable service.\textsuperscript{39} The Global Fund for AIDS, Tuberculosis, and Malaria and similar initiatives galvanised by AIDS activists harnessed the attention brought by HIV/AIDS to expand the type of primary care called for at Alma Ata.\textsuperscript{40}

Furthermore, a system was established whereby civil society could actively monitor progress or corruption, often by creating large email listservs from which community members could report to distant activists about problems in their local healthcare system. When health delivery systems failed, advocates were able to address the issues immediately and get the attention of the highest levels of administration to rectify failing systems and protect human rights. The recent failure to deliver medications to rural clinics in Africa, for example, was reported to listservs in the US and UK, resulting in an overnight massive lobbying effort in Washington DC; this resulted in improvements in the design of a pharmaceutical distribution programme that affected not only HIV drugs, but all general clinic medications,
which had been previously mismanaged for years.\textsuperscript{41} A comparable level of transparency and accountability, resulting from public scrutiny, has not been seen elsewhere in public health.

\textit{Conflict over control – the creation of an AIDS backlash}

The galvanising power of 3-by-5 and related initiatives has been unwelcome to those keen on returning to the ‘minimum package’ approach. Focusing on HIV/AIDS, and in particular on HIV treatment, has been declared unwise and unsustainable. The argument has been that HIV ‘competes with’ other public health priorities, taking funding away from other health problems. This is said to funnel investments into a ‘bottomless pit’ of HIV treatment, when greater funding for HIV prevention would be a more cost-effective and strategic choice. The fact that HIV funding commitments are extensive, and have increased rapidly in recent years (including but not limited to support for anti-retroviral therapy), is used as a basis for these arguments.\textsuperscript{42}

Empirical data analyses, however, have found the opposite—that HIV has brought in new funding, rather than diverting resources from other diseases; that the increase in funding for HIV corresponds to the burden of disease in an appropriate manner that is highly consistent and actually conservative with respect to other conditions in terms of morbidity and mortality per capita; that much funding has been displaced \textit{from} HIV/AIDS to other causes (indeed, HIV-related fundraising nearly tripled overall health system funding, which was previously stagnant); and that improvements to health systems have often occurred through the comprehensive approaches of HIV programmes.\textsuperscript{43}

Many critics of AIDS programming and funding refuse to acknowledge the dire state of public health in aid-recipient countries before this wave of public scrutiny,\textsuperscript{44} when services were not transparent, frequently inefficient, and sometimes outright corrupt (with only $0.37 of every donated $1.00 going into actual healthcare delivery among African countries, on average).\textsuperscript{45} While AIDS programmes suffer from deficiencies as well, the heightened role and capacity of civil society in providing oversight and scrutiny of the HIV/AIDS field has cast a bright light on many of these problems as they occur. Recent detailed reports, including both a systematic study of funding streams and case studies from Argentina, Brazil, Dominican Republic, Uganda, Zambia and Zimbabwe, have found that HIV initiatives have successfully expanded systems of reliable health supplies, trained and retained skilled workers for general public health benefit, and improved infrastructure as well as governance.\textsuperscript{46} Improvements in HIV programmes have corresponded to declines in out-of-pocket expenditures for patients
and a rise in per capita health funds for general health around the world. Each 1 per cent increase in funding to the US President’s Emergency Plan for AIDS Relief corresponds to a 10.1 per cent increase in the rate at which out-of-pocket health expenditures have declined in affected countries, after correcting for changes in per capita income. Each 1 per cent increase in Global Fund funding has also corresponded to a 7.9 per cent increase in the rate at which out-of-pocket health expenditures are declining and a 16.5 per cent rise in the rate at which per capita funds for general health are increasing after correcting for changes in per capita income, suggesting a magnified impact of HIV funds in terms of general system benefits.\textsuperscript{47}

Many HIV programmes have often also offered transparent, accountable, and measurable results, with community-based structures for needs assessment and resource delivery, whereas many other areas of health and development have been plagued by a dearth of clear plans, accountability structures, and measurable targets, and have a history of poor management and weak support for infrastructure development. In terms of the relative balance of funding within AIDS, HIV prevention has had far more funding since the beginning of the epidemic; the World Bank has invested nearly twice as much in prevention as in care and treatment.\textsuperscript{48} Yet antiretroviral therapy has shown more dramatic effects on national mortality levels in the countries hardest hit by the epidemic.\textsuperscript{49} Furthermore, in the absence of a safe and effective vaccine or microbicide, AIDS treatment has itself been modelled as an HIV prevention intervention, because it can suppress viral load, which effectively curtails transmission,\textsuperscript{50} disrupting the false dichotomy between treatment and prevention that has been the hallmark of current debates. Data indicate that where AIDS treatment has been introduced, more people have come forward to learn about their serostatus and about personal protective measures, and that HIV funding has been effectively used to build the first medical schools and health centres in regions previously devoid of trained local providers and services.\textsuperscript{51}

It is understandable, however, that the attention received by HIV has been met with resentment, and the concern that health programmes have become, or will become, excessively focused on HIV. This has led to a call to move to ‘SWAps’, or ‘sector-wide approaches’ to public health. The acronym refers to the idea that it is best for donors to support the ‘general public health system’, and should in theory be a more comprehensive approach to advancing primary care as conceived in Alma Ata. This call appeals to people with positive and progressive agendas. But the term has been manipulated to support a political agenda that can often actually undermine public health programmes, reducing donor commitments over time and returning to an
era of economic development theory that compromises public health. The reality is that comprehensive care, driven by community needs, has been a priority for HIV/AIDS advocates, as for global health advocates generally, from early calls in the 1980s and 1990s for a national healthcare system in the US to current demands from leading advocates in the field to renew the global call for ‘health for all’. SWAps, by contrast, have been programmes devised and supported by international development banks, directing funds from donors directly to ministries of health. This approach sounds more targeted to population needs, and is intended to address issues of fragmented aid and avoid favouring issues that happen to be popular with donors by giving more power to aid recipients. In reality, however, such shifts in power have not been found to occur in practice. The national plans are actually constructed largely by donors, with a focus on the management of health ministries, not the health burdens experienced by communities. The plans often involve initiatives to privatise or limit health programmes. Ministries of Health continue to be divided from the communities who receive their medical and public health services, often as a result of class divides between elite government ministers and poorer community members. The actual content and results of SWAps have not been transparent and have excluded civil society participation. These factors have resulted in significant diversions of funds away from service provision to vague administrative activities, resulting in troubling medical system failures.

This data indicate that extreme ‘horizontal’ projects (programmes for the ‘general health system’, or a ‘basic minimum package’) can be just as ineffective as extreme ‘vertical’ (disease-specific) initiatives. SWAps unfortunately have yet to set clearly transparent targets that can be monitored and critiqued by outsiders, and there are no data on their effectiveness, while we do have data on the risk they pose to actual on-the-ground medical services when they divert funds from tangible existing medical care programmes. Many funds claimed to be for ‘health system’ uses are diverted into ineffective, inefficient funding streams, which are often misused for poor educational initiatives, bureaucratic events, and salaries for those who operate development consulting programmes, rather than for training local healthcare workers, building infrastructure, and providing needed community-based services.

Those advocating a retreat from the HIV-style of programme construction and calling for general health system development are also often concerned about ‘sustainability’. Arguments about the sustainability of healthcare financing have not been met, as they well might, with the rebuttal that the living standards of rich countries would often be ‘unsustainable’ without the labour and resources of the poorest nations. The reality is that poor health
systems will not be ‘sustainable’ at any level until we address critical issues of health worker training and retention, comprehensive public health and medical services, and reliable and affordable supplies and pharmaceuticals. We are in truth faced with the choice of expanding the HIV effort to continue developing comprehensive care systems, or regressing to an era in which the idea of ‘sustainability’ is used to justify minimal or no services. It is not ‘sustainable’ for societies to avoid treating major diseases that can lead to social collapse and result in turmoil and ruin.

The sterile dichotomy that pits HIV/AIDS policies against general health systems development fails to realise that all health systems need both focus and breadth. Without continued and sustained focus on disease-specific standards of care and treatment, many millions of the poorest and most marginalised will die due to substandard medical management, inadequate measures to meet resource allocation needs, training demands, and detailed assessments to evaluate the critical bottlenecks and failures in health systems. This has already occurred with the transfer of funds from tuberculosis programmes to SWAps in Zambia, for example, resulting in grave health outcomes for the population. It is also manifest in the significant epidemics of drug-resistant tuberculosis resulting from medical mismanagement and inadequate resource allocation to achieve sufficiently high standards of medical practice in many poor communities. The need is for both vertical protocols and stronger primary care across the board. We will miss a historic opportunity to build functioning health systems in some of the poorest countries in the world if HIV is not recognised as a social indicator to redistribute capital and healthcare decision-making power to those actually affected by the greatest burden of disease.

Plans for the Future

A critical lesson from HIV/AIDS has been that community mobilisation and attention to global health is capable of dramatically expanding the availability of funds and their appropriate use, as well as what is considered ‘possible’ in resource-denied settings in terms of public health and medical delivery programmes. This can move us from an era in which disease advocates compete for the scraps that are left after development consultants and ministries have filtered away the majority of funds, to an era in which advocates can jointly demand that funds, and the strategies for using them, meet actual patients needs. We have learned from many programmes that disease-specific protocols are necessary from a medical perspective, to ensure proper training of healthcare workers and monitoring of performance, to produce efficient budgets and supply chains, and to keep track of outcomes,
all while improving fundamental services such as nutritional support, medical education, and physical infrastructure.\textsuperscript{62} We have also learned that the ‘minimum package’ approach has marginalised large numbers of sick people, favouring the lives of groups considered, by religious or moralistic standards, as ‘more worthy’ of care (particularly young children) and removing care for those who are socially marginalised and at most risk of disability and death.\textsuperscript{63} Finally, we have learned that common conceptions of health promotion and prevention are often based on assumptions made too quickly: in particular, the idea that education alone is sufficient when people have little real ability to act on the sources of risk in their lives;\textsuperscript{64} and the idea that prevention rather than treatment saves healthcare dollars. In reality, prevention generally can reduce suffering, but by extending life does not save money; there is the false belief that somehow diseases and risks will be prevented and people will live long lives, but their bodies will magically fall apart at an old age without getting ill and costing health systems money. The reality is that deaths averted from infectious diseases or heart conditions in working-age adults result in costlier deaths from cancer or neurological diseases in old age.

Our goal is not simply to avert death, nor to save money for its own sake – it is to reduce human suffering. Hence, we should orient medical care to reduce suffering (sometimes saving costs by focusing on palliation rather than chemotherapy in old age, for example), and improve living conditions to minimise the likelihood of suffering and allow for enjoyable lives to be lived for reasonable durations. Such a goal would return to the original Alma Ata definition of health. To achieve a reduction in suffering and determine what patient priorities are for reducing suffering, and how to redistribute funds from rich areas with a plethora of options to avoid suffering to people with few options, we should ask the affected persons themselves what their priorities are. This has been among the most valuable lessons of the HIV activism movement: that those most likely to suffer should be intimately involved in determining how public health systems should reduce their suffering.

The recent call for the withdrawal or redeployment of AIDS funds essentially repeats the mistakes of history, proposing to retrace the path of Alma Ata’s failure rather than taking the opportunity to achieve Alma Ata’s mandate. The call to limit and shift funding would in reality allow governments to renege on their prior commitments to global public health.\textsuperscript{65} Recent analyses have shown that in difficult financial times, public health funding for major epidemic diseases must be maintained to avoid disastrous resurgence.\textsuperscript{66} In the current financial crisis, the temptation will be strong for governments and funding agencies to simply raid AIDS funding to sustain
initiatives that appear more general but may have questionable population impact; the goal should be sustaining and increasing resources for community-based health programmes overall and community-based decision-making in particular. Even if no monies are diverted from AIDS, donors are already cutting back on promised resources to public health programmes, while increasing evidence indicates that deficit spending on health in times of economic downturn actually produces greater social protections and less economic destabilisation than cutting budgets for short-term savings.67

It is often said that the health of the global economy is dependent on the health of its people, and no one can expect strong economies without healthy workers and with an avoidance of the rising tertiary health costs resulting from poor primary care access and excessive services for the elderly, or when diseases have been allowed to progress to expensive end-stages requiring hospitalisation.68 This is true, but the other question is what we want our society to look like: is having a good economy the end result, or is this part of a larger effort to make life more enjoyable? If the latter, then good health must be seen as its own end, and it should be seen as perverse that we must appeal to financial gain as a reason to fund health.

The time is now for a ‘new deal’ on global health, which builds upon the successes in AIDS to revive the movement for comprehensive primary care focused on patient decision-making. We have the basis for civil society participation to achieve a form of direct democracy in bringing patient communities into planning and debates about what health services should look like. Realigning our focus around an agenda to prioritize health and allow it to be patient-based, rather than based on development theories that have demonstrably failed the poorest and least powerful, should be our mandate.

In looking at concrete examples of how HIV programmes have been successful at achieving this goal, we can see common trends in the design and implementation of successful programmes. First, the most successful HIV programmes have critically involved community decision-making (not just ‘participation’), particularly the involvement of affected patients in constructing programme logistics.69 Analogously, the programmes that have been least oriented towards community voices and priorities seem to be ineffective. For example, a recent World Bank funding offer called for programmes to reduce HIV-related stigma in western Nepal. Community groups were excluded from the meeting, but a coalition of public health workers and NGOs discussed the proposal and observed that many patients in the region did not agree with the central premise that stigma-reduction programmes should be the point of focus of new healthcare programmes.
Rather, they argued in a series of community meetings that HIV stigma-reduction programmes, rather than focusing on renovating a local hospital to care for both HIV and non-HIV-infected patients, were actually pathologising HIV and focusing so much on HIV patients that the public had the misperception that only HIV patients could receive care at local clinics. Furthermore, the stigma-focused programmes were making it harder for HIV-infected persons to receive treatment, as the publicity around HIV on billboards and radio stations made it ironically more embarrassing and shameful to enter testing centres. While the World Bank ignored this information and proceeded with their programme, a group of local healthcare providers and members of the public have worked to renovate the local hospital and to ‘mainstream’ HIV as one of many diagnoses that are treated as a primary care condition in general health clinics.

Similarly, programmes in Haiti which have involved community healthcare workers, or lay members of the public trained to provide services to those who are distant from central clinics and hospitals, have allowed for a greater patient voice in priority-setting. The HIV programmes in the central plateau of Haiti have thus been able to expand into programmes that address fundamental systemic causes of HIV infection – particularly women’s lack of access to credit for their own businesses, which resulted in dependency on men to provide them with basic income, sometimes in exchange for sex. Creating a local ‘pro-poor’ bank has helped reduce the risk of HIV among women by facilitating their access to credit. Programmes in nutrition, reducing indoor air pollution and respiratory diseases from wood-burning stoves, and providing local jobs to avoid migrancy, have similarly resulted from community-based HIV initiatives in other settings.70

The common principle is to remove power from those who have traditionally harbour ed it in ministries and institutions far from actual health problems, and allow patients to identify the greatest risks in their daily lives and conceptualise their own health system approaches. Sometimes this will involve extensive HIV programmes, sometimes not; communities must be allowed to decide what their local problems are, receive the technical assistance they need to execute improvement programmes, and create systems to protect the most marginalised of community members. The process of building a civil society that protects the most marginalised members of a community often results in ideas that are not focused on traditional public health methods of simply expanding particular education or discipline-specific programmes (e.g., ‘maternal child health’ or ‘infectious disease’), but address daily household risks and problems of access to health services, from road conditions to clinic locations and costs of care that are specific to the poor.
Moreover, the practical implementation of this approach involves measures that do not require extensive financing: community meetings, focus groups with patients, training local providers as mobile roving community health workers, and improved access to reporting and feedback avenues among those most affected by public health programmes.71

In addition, successful HIV programmes appear to have set clear targets that have population benefits which can be monitored. The programmes declare which people they will reach, how they will do so, and what intended outcomes are sought over what time-scales. Such an approach relies on data that are straightforward to collect (percentage of people reached, waiting times, etc.), rather than requiring economic modelling by outside consultants to produce metrics highly subject to manipulation (such as quality-adjusted life-years). It also permits the public to identify weaknesses in the programme. Some of the weaknesses in HIV treatment programmes that are not very successful appear to be due to an excessively narrow focus on medications alone, rather than support for adherence to the medications (general public training and community coordination on issues of side-effects and family support), nutrition (malnutrition programmes including access to therapeutic foods), transportation support (coordinating with ministries responsible for road development and public transport), and programmes to directly address poverty (job training and credit).72 The current sector-wide approaches to public health that are being presented as alternatives to HIV programmes have lacked definitive targets; even if targets cannot be quantified because they are inherently qualitative (such as the improvement in organising skills of local health ministers), the health system improvement process should involve priority-setting with community members, and the results should be reported to the public, such that the class (and often gender and racial) divide between the elite ministers of health and the poorest of patients can be breached. HIV programmes in Latin America, East Asia, and elsewhere have been notable for their ‘open source’ approach to tracking and publishing the actual expenditures and outcomes of public health programmes, often via posting all of their development materials, epidemiological statistics, and logistical manuals on the Internet – a practice that was previously unheard of in public health.73

As we expand the field of ‘global health’, we must recognize that the debates we construct and respond to are intimately tied to our power to define what is relevant and not, what is appropriate and not, what is sustainable and not, and what is worthy and not. The HIV activism movement has taught us about democratising this process, such that who makes these declarations is as important as the declarations themselves; we risk losing the power of
this lesson if we attempt to return public health to an activity that is focused on elite economic theories devised in distant centres (however sensible they may seem rhetorically), rather than community-based programmes decided by patients. Elites everywhere will often assume that particular initiatives are ‘impossible’, too involved, not basic enough, and not sustainable; in reality, this reflects their failure to appreciate that resource-denied locales are also denied resources by this very language, and that they will never gain more resources or health improvements unless we move beyond the idea that certain places will always be poor and undeserving of more than ‘basic’ needs. If we always focus on the most minimum care, the most basic and cheapest services, then the poor will always remain so; the fundamental principles of redistribution require that we abandon this rhetoric, which is devised to preserve current inequalities, and instead create both the language and systems to redistribute the power of decision-making from traditional public health decision-makers to patients.

NOTES

2 Ibid.
10 Ibid.
12 Eleonora Cavagnero, et al., ‘Development assistance for health: should policy-


16 Ibid.


25 Bello, Siamese Tragedy.


30 Epstein, Impure Science.


33 Justin Parkhurst, “‘What worked?’: the evidence challenges in determining the causes of HIV prevalence decline’, AIDS Education and Prevention, 20(3), 2008,

34 Ibid.

35 Gellman, ‘A Turning Point’.


41 Gonsalves, *HIV/AIDS Response and Health Systems*.


47 All of these findings are significant at the p<0.05 confidence level, after regression upon the USAID *Health Systems 20/20* dataset.


52 Epstein, *Impure Science*. 


56 Ibid.


59 Ooms, ‘Health development versus medical relief’.

60 Bosman, ‘Health sector reform and tuberculosis control’.


63 Cueto, ‘The origins of primary care’.


65 Cohen, ‘The great funding surge’.

66 Stuckler, ‘International Monetary Fund programs and tuberculosis outcomes’.


71 Farmer, Pathologies of Power.
