**Medicine Journal**
2014; 1(5): 38-42
Published online November 30, 2014 (http://www.openscienceonline.com/journal/med)

# The Alma Ata declaration and the 10/90 paradox in global health resources utilization

Inegbenebor Ute[1, 2]

[1]Department of Health Education, Texila American University, Georgetown, Guyana
[2]Department of Physiology, Faculty of Basic Medical Sciences, College of Medicine, Ambrose Alli University, Ekpoma, Nigeria

## Email address

druteinegbenebor@yahoo.com

## To cite this article

Inegbenebor Ute. The Alma Ata Declaration and the 10/90 Paradox in Global Health Resources Utilization. *Medicine Journal*. Vol. 1, No. 5, 2014, pp. 38-42.

## Abstract

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is therefore of common concern to all. This was part of the Alma Ata Declaration in 1978. Against the background that only 10% of the global resources is used for research on the health problems of 90% of the world people, notably those who live in the developing countries, how well has this declaration been implemented after thirty-five years? Do the member countries of the United Nations have the political will to implement this declaration? This article highlights the gross inequalities in the global health status, allocation of resources, access and utilization of health facilities and discusses the mutual benefit that can be realized by donor industrialized and recipient developed countries in the event of adjusting the 90/10 disequilibrium.

## Keywords

Alma Ata Declaration, Global Health, Resource Utilization, Paradox

## 1. Introduction

Health provision varies around the world. Almost all wealthy nations provide universal health care. The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them and this according to WHO [1], requires a strong, efficient, well-run health system, a system for financing health services, access to essential medicines and technologies and a sufficient capacity of well-trained, motivated health workers. Shah [2], reported that health provision is challenging due to the costs required as well as various social, cultural, political and economic conditions. The provision of universal health care by wealthy industrialized nations was in response to the Alma Ata Declaration in 1978, which stated among other things that health, which is a state of complete physical, mental and social wellbeing and not just the absence of disease or infirmity is a fundamental human right and that the attainment of the highest possible level of health is the most important worthwhile social goal, whose realization requires the action of many other social and economic factors in addition to the health sector [3]. It was also noted that the existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is therefore of common concern to all countries. However, the inequalities have continued over thirty years after the declaration due to socio-economic, cultural and political reasons.

Nigeria is a prototype of developing countries. The existing inequality in the health status of her inhabitants in urban and rural areas as well as in the six geo-political zones is no doubt due to social determinants of health such as those reported by Shah [2]. This is evident in the recent Nigeria Demographic and Health Survey (NDHS) where wide margins still exist between the North and South as well as between the rural and urban dwellers. Although previous surveys collected data at the national and zonal levels, the 2013 report collected data on key indicators from the six geo-political zones of South-South, South-West, South-East,

North-West, North-East, and North-Central as well as the 36 states and the Federal Capital Territory (FCT). The 2013 NDHS is the fifth in a series of Demographic and Health Surveys conducted in Nigeria; previous surveys were conducted in 1990, 1999, 2003, and 2008. Although the recent NDHS report shows some health burden to be reducing compared to previous reports, the indices of health burden are still high considering the country's status in the globe. Thus, Nigeria still has a long way to go in achieving the targets of the Millennium Development Goals. Nigeria has high maternal morbidity and mortality rates secondary to preventable pregnancy related causes, high fertility rate, and threat of population explosion, high infant morbidity and mortality rates, and low life expectancy. According to the 2013 NDHS, there is a wide disparity between the urban and the rural parts of Nigeria with respect to provision of sanitary facilities, educational facilities and curative health facilities. The burden of disease, ignorance and poverty weighs heavily on the rural areas when compared to the urban areas. In addition, employment facilities are more readily available in the urban areas with consequent rural–urban migration and its attendant problems of congestion in facilities meant for the urban areas, urban poverty and increased crime rates.

This article therefore highlights the gross inequalities in the global health status, allocation of resources, access and utilization of health facilities and discusses the mutual benefit that can be realized by donor industrialized and recipient developed countries in the event of adjusting the 90/10 disequilibrium.

## 2. Causes of Inequality

According to Shah [2], some of the major causes of inequalities in health status include inverse care, impoverishing care, fragmented care, unsafe care and misdirected care;

a *Inverse care:* This is a phenomenon where people with the most means, whose needs for health care are often less, consume the most care, whereas those with the least means and greatest health problems consume the least. In other words, public spending on health services most often benefits the rich more than the poor in high-income and low-income countries alike. Regardless of the fact that great advances have been made in the biomedical sciences coupled with the effective technologies for all levels of disease prevention and cure [4], different scenario present in various countries depending on their type of economy. In the free market economies, the cost of health care determines what is accessible and affordable to individuals, families and communities. In the welfare states that have in their constitution the policy to care for their citizens from birth to death, health care is expected to be available to all citizens irrespective of political or economic status. In many countries with mixed economies, the government provides some health services at low cost to all willing citizens and others at high cost to those who can afford them. Whatever the type of economy, there is a price to pay in terms of money expended or time wasted in long queues. In the countries with free market economy, the price individuals and families are able and willing to pay, determines accessibility and facility utilization of the available health care. In welfare states, services provided are based on rationing so that some people may have to waste time in coming to the health care facility several times before they can utilize available facilities.

Primary Health care can minimize the problems encountered by individuals, families and communities because of the geographical spread and the simple and user friendly nature of primary health centers. Health education accessed at such centers can reduce the burden of disease so that only a few persons would need health care services at the secondary and tertiary levels of health care. A number of developing countries such as Chile, Sri Lanka, China and Cuba have devised and managed highly successful health programs with limited resources. No doubt, their models for achieving good health at low cost have provided worthy examples for other countries to follow [4].

b *Impoverishing care:* Over 100 million people annually fall into poverty because they have to pay for health care [2]. Wherever people lack social protection, and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. In industrialized capitalist countries, poverty secondary to payment for health care is prevented by using health insurance. However certain persons may be excluded from this scheme if they are unemployed, under-employed, visitors or tourists. In most developing countries, health insurance is generally lacking. Where it exists, it is an exclusive preserve of employees of large corporations or government service and so called contributors. In a typical developing country such as Nigeria, healthcare providers under the National Health Insurance Scheme [6], provide the following benefit package to the contributors:

- Out-patient care, including necessary consumables,
- Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the National Essential Drugs List and Diagnostic Test Lists;
- Maternity care for up to four live births for every insured contributor/couple in the Formal Sector Programme;
- Preventive care, including immunization, as it applies in the National Programme on Immunization, health education, family planning, antenatal and post-natal care;
- Consultation with specialists, such as physicians, pediatricians, obstetricians, gynecologists, general surgeons, orthopaedic surgeons, ENT surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists, physiotherapists, etc.;
- Hospital care in a standard ward for a stay limited to cumulative 15 days per year. Thereafter, the beneficiary

and/or the employer pay. However the primary provider shall pay per diem for bed space for a total 15 days cumulative per year.

- Eye examination and care, excluding the provision of spectacles and contact lenses;
- A range of prostheses (limited to artificial limbs produced in Nigeria); and
- Preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

Note: All Providers are expected to provide counselling as an integral part of quality care.

Considering the above list therefore, there is a limited protection offered by this type of insurance scheme even if it is carried out as intended in the guidelines. A major defect in this type of insurance scheme is that it does not take care of majority of the population who are either small or medium scale sole proprietors or subsistence farmers. This scheme started over fourteen years ago and there has been no attempt to extend the benefits of the scheme to the rural dwellers and the urban poor, who form 90% of the population. Hence, it only cares for the elites who are about 10% of the population.

To get quality treatment, individuals and families must pay out of pocket and be impoverished further. The insurance scheme in developing countries may therefore not prevent inequality in health care as expected.

c *Fragmented and fragmenting care:* The excessive specialization of health-care providers and the narrow focus of many disease control programs discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. By implication, according to Shah [2], health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation. This is additionally worsened by the reality that many primary health centers are understaffed coupled with the situation where many primary health centers have no doctor. In addition, the state of the doctor-patient ratio in developing countries is contributory. Although staffing has been improved through the midwives service scheme in medically underserved areas in Nigeria [7], from personal observation, the threat from terrorist groups, flood disasters and cultural discrimination is hindering some midwives from taking up appointment in the scheme or forcing them to seek alternative placement.

d *Unsafe care:* According to Shah [2], poor system design that is unable to ensure safety and hygiene standard has led to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health. In fact, hospital acquired infections have been shown to include malaria, Lassa fever, serum hepatitis and other blood borne diseases. Many hospitals in malaria endemic regions are not regularly sprayed with insecticides. In spite of the introduction of insecticide treated mosquito nets (ITN), many hospitals are yet to imbibe the culture of regular usage for patients. This is further compounded by the often epileptic electricity supply, so that unscrupulous health workers may carry out poor sterilization of hospital equipment resulting in hospital acquired infections. 'Out of stock' is a common phenomenon in many hospitals in developing countries. This encourages patients to source medicines from poorly controlled medicine vendors, who may sell expired and substandard drugs to unsuspecting patients. It is not uncommon for hospital management to source drugs from corrupt political contractors who can deliberately import substandard drugs in order to maximize profit. The method of employment of chief executives of the health organizations in some developing countries, which is based on god-fatherism rather than meritorious management expertise, contributes immensely to this health hazard in health care systems.

e *Misdirected care:* Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health [2]. In fact, in many developing countries including Nigeria, the government spends most of her health budget on tertiary care leaving with little for primary care [8,9]. It is common to find large complex teaching hospitals, with a high concentration of the medical and paramedical personnel in cities. The user fees for most of these hospitals make them unaffordable by over 70% of the population. This creates inequality in distribution of health resources as facility accessibility and utilization by the poor leads to catastrophic expenditure and impoverishing care

## 3. Advocacy for Equity in Health Care

Implied in the Alma-Ata declaration is equity, which is seen as fairness and justice in the health status of individuals, families, community groups and communities, allocation of resources and access to and utilization of health facilities. Differences in health status are strongly associated with poverty. Allocation of resources is expected to be done in a fair manner. However, if large differences already exist in the health status in the community, equal amount of resources, horizontal equity, to each individual will worsen the disparity that already exists [4].

## 4. Vertical Equity

Vertical equity can be attained, if resources from the most affluent sector of the community are used to cater for the lower income individual and families. Regional international treaties have brought nations into union. International travel

through the air and the sea bring people from one country into the other within hours. The world is now a 'global village', and the previous geographical gap between developing and developed countries has been bridged by international travel. This implies that diseases with longer incubation period than the duration of travel can be transferred from a developing country to a developed country. The reverse is equally true when one consider the recent Ebola tragedy in Nigeria by a US Citizen. Another good example is the 1–3 week incubation period of Lassa fever, which implies that an infected person in an endemic area in West Africa can travel to a developed country within the incubation period and cause an epidemic. There is therefore a need for reinforced international collaboration between multinational agencies and developing countries in order to eradicate this fatal disease [10].

International cooperation has become a necessity in an attempt to promote international health. The health activities that used to be done for fear of introduction of diseases from foreign lands, or on compassion in terms of providing relief for the needy during emergencies, are now done for mutual benefit. There is now a broader appreciation of international health as providing mutual benefits for all the participants, both developed and developing countries, both rich and poor, both the giver and the recipient of aid. Rather than a donor recipient relationship, the modern concept of international health is of cooperation and partnership based on mutuality and reciprocity. Partnership implies investment of effort towards achievement of a common goal and an equitable sharing of products. International cooperation based on the realization of mutual benefit is likely to be more enduring and sustainable than actions based solely on fear, compassion or both.

Researches, carried out in the industrialized countries, have greatly benefited people in the developing countries. Research carried out in developing countries may also be of benefit to the industrialized countries. There is evidence that research done on supervised ambulatory care for tuberculosis in India, a developing country, gives similar results to the traditional care in a sanatorium [4]. Developed countries may benefit from the public health procedures used recently for the prevention of Ebola fever in Nigeria.

## 5. Mechanisms of Global Health Cooperation

This can be achieved through bilateral agreements between nations, which involve financial and technical support, exchange of scientific information and other forms of assistance. Cooperation may also be in form of multilateral cooperation involving many governments. Examples of such bilateral aid programs include Department for International Development (DFID), Swedish International Development Agency (SIDA), United States Agency for International Development (USAID). Multilateral aid agencies include World Health Organization (WHO), United Nations Children's Fund (UNICEF), World Bank and European Union [4]. Some non-governmental agencies are also giving aid to developing countries. These include Ford Foundation, Bill and Melinda Gates foundation and Carter foundation.

## 6. The 90/10 Disequilibrium

This summarizes the inequity that exists in Global health care. Research on problems affecting poor people in developing countries has been relatively neglected. According to the Global Forum for Health Research (1999) only 10% of the $50-60 billion that is spent every year on health research is used for research on health problems of 90% of the world's people [11]. In virtually every country, especially those operating the free market enterprise, the 10/90 paradox occurs as the elites are able to influence the use of most health resources to their own health care leaving very little for the majority of the population. In developing countries, the political class spends millions of dollars for health care overseas while the poor cannot afford cheap anti-malaria and antimicrobial drugs.

## 7. Conclusion

Though it has been said, that equity should be the watchword in global health promotion, that the primary health care should be the first contact between the patient and health care delivery system and that primary health care should not be seen as a second best meant for the less privileged, there is no evidence that all these dreams will come true in the near future as most countries operate an elite model of governance that will influence 90% of the health resources for the use of the elites and 10% for the less privileged. Thus the 10/90 paradox will continue to operate in most parts of the world in the near future except urgent action is taken by United Nations and its member nations' governments.

## Recommendations

For Nigeria to achieve the expectations of the Alma Ata Declaration of 1978, the health care delivery system should be reorganized in such a way that the primary health centers are actually the first point of contact between individuals, families and communities and the health care delivery system. The numerous doctors in the large hospitals should be redistributed to the primary health centers to re-enforce the success being archived by the Midwives Service Scheme. Each primary health center should become a functional comprehensive health center with midwives, nurses, community health extension workers (CHEW), laboratory assistants/scientists and medical doctors. This will no doubt reduce the health burden of Nigerians whose ailments are then nipped in the bud.

In addition, decentralization of Government ministries and agencies will facilitate even development of Nigerian geopolitical regions and prevent rural urban migration and

economic dualism and achieve horizontal equity in health and economic status.

Local government chairmen should be encouraged to develop rural roads and ambulance facilities with the aim of facilitating transfers to district and tertiary health facilities when necessary.

## Author Contributions

Dr Inegbenebor, Ute conceptualised and designed this article. He was also involved in the final approval of the version to be submitted and any revised version.

## References

[1] WHO. Universal Health Coverage. www.who.int/iuniversal health coverage/en/ Accessed 13/07/2013. 2013.

[2] Shah, A. Health Care around the World. Global Issues. www.globalissues.org Accessed on 14/07/2013. 2011.

[3] International Conference on Primary Health Care (ICPHC). Declaration of Alma Ata. 1978, www.who.int/publications/almaata_declaration_en. Accessed on 13/07/13.

[4] Lucas A.O.; Gilles H.M. A Short Text Book of Preventive and Social Medicine for the Tropics. Revised 4th Edition. London: Book Power, 2006, 283-284, 363-374.

[5] Park, K. Models of Health Education. Communication and Health Education. Park's Textbook of Preventive and Social Medicine. 19th Edition. Prem Nagar Jabalpur. M/s banarsidas Bhanot Publishers. 2007, 712 -713.

[6] National Health Insurance Scheme (NHIS). Operational Guidelines.www.nhis.gov.ng Accessed 15/07/2013. 2013.

[7] National Population Commission (NPC) [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International. 2014. 1-282

[8] Abimbola, S.; Okoli, U.; Olubajo, O.; Abdullahi, M.J.; Pate M.A. The Midwives Service Scheme in Nigeria. *PLoS Med*. 2012, 9(5), e1001211.

[9] Lerberghe, W.V.; Béthune, X.; Brouwere, V. Hospitals in sub-Saharan Africa: why we need more of what does not work as it should. *Trop. Med. Inter. Health*. 2003, 2(8) 799 – 808.

[10] Pate, M.A. Nigeria: Why Health Care Delivery Should Target Rural Dwellers. International Planned Parenthood Federation (IPPF). 2009.

[11] Inegbenebor, U.; Okosun, J.; Inegbenebor, J. Prevention of Lassa fever in Nigeria. *Trans R. Soc. Trop. Med Hyg*. 2010, 4(1):51-54.

[12] Currat, L.J.; Hyder, A.A.; Nchinda, T.C.; Carey-Bumgarner, E. The 10/90 Report on Health Research. Global Forum for Health Research. Geneva. 1999, 27-157.