The legacy of Alma-Ata:
Thirty years on

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Thirty years ago, in September 1978, the World Health Organization (WHO) launched its global primary health care strategy at a conference in Alma-Ata in South Eastern Russia. The non-binding Declaration of Alma-Ata proclaimed that primary health care is the key to the attainment of a level of health sufficient to permit people to lead socially and economically productive lives – *'Health for All by the Year 2000'*. This ambitious vision of 'Health for All' was a powerful motivating idea and rallying call for people concerned about continuing inequity, injustice and general lack of fairness in the delivery of health care.[1]

The Alma-Ata meeting was planned as a global launching pad for WHO's primary health care strategy which had been in development for over a decade. Prominent in the genesis of these ideas was Kenneth Newell, a New Zealand public health physician who spent his immediate and formative postgraduate years as a general practitioner embedded in Maori communities on the East Coast of the North Island. It was in this environment that Newell came to realise that the social determinants of health are of prime importance and that health services are not purely a way of delivering health care interventions to people, but are something important to individuals and communities in their own right and are linked to qualities such as power, sovereignty, ownership, equity and dignity. In his later work with the WHO Newell went on to develop the concept of 'health by the people' and to have this embodied in the spirit and the principles of WHO's evolving primary health care movement.[2] This link between New Zealand Maori and the origins of WHO's global primary health care strategy is not widely known or appreciated.

The strategy received a mixed reception internationally. Poor countries with few health resources welcomed the strategy but could afford only limited cost-effective interventions, often delivered by poorly trained, supervised and paid community health workers. Most wealthy countries on the other hand saw little relevance in the primary health care concepts and strategies. There was little immediate impact in New Zealand. Early interest was shown by the public health community – especially public health nurses – by Maori, and by some emerging women's groups. Mainstream medical practice was largely indifferent.

Over the last 30 years, interest in primary health care concepts has grown in New Zealand and abroad, but progress here has been made in fits and starts. Public health nurses, Maori, nursing groups and women have maintained or expanded their interest. Interest by organised medicine, particularly in general practice, has grown with the activities of Healthcare Aotearoa, academic contributions, activities of the Royal New Zealand College of General Practitioners (RNZCGP) and that of the Independent Practitioner Associations (IPAs). But it was not until the introduction of the New Zealand Health Strategy in 2000, the Primary Health Care Strategy in 2001, and the roll-out in 2003 of Primary Health Organisations (PHOs) that the pace of change quickened markedly.

Research in demonstrating inequities and injustices in the allocation of health resources and in the delivery of health services first came to public and professional attention in the mid-1970s.[3] Steady progress has been made in more recent times, culminating in the work reported by Professor Tony Blakely and the team working out of the Department of Public Health at the Wellington School of Medicine, the department in which Ken Newell was the foundation professor.[4]

Turning now from the past to what could be the future. First it needs to be recognised and accepted that the scope and the reach of primary health care is greater than that of traditional general practice medicine. Further we need to accept that the face of general practice and primary health care in New Zealand could be very different even five years into the future. Historically general practice has recognised the social influences on health and disease, but has intervened and invested most heavily in the physical and biological dimensions of care – medical technologies, biologicals and pharmaceuticals. This has brought great gains and will continue to do so. But evidence, both in New Zealand and internationally, is accumulating to suggest that social

factors in the care of patients and of populations are the prime determinants of health and longevity.[5] It is here that the major changes in primary health care are likely to come in the years ahead.

What New Zealand needs is a well articulated, widely known and understood, forward looking primary health care strategy – one which positively embraces the changing social and economic conditions of our society. There is cross-national evidence to show that current health sector development in New Zealand is at least the equal of that in other countries with which we traditionally compare ourselves.[6] We should seek to build, not rest on, this advantage. What is needed is greater creativity and innovation in primary health care – particularly in its social dimensions.

Major political disturbance aside, current incremental changes in keeping with the current primary health care strategy are likely to continue, but will that be enough?[7] More radical or disruptive change may be needed. Many of our current organisational structures, systems and processes had their origins in the industrial conditions of the nineteenth century. Do they serve us well today? Do we need radically new approaches?

For instance, do we have the workforce in primary care with the capability and the capacity to meet changing needs and demands, especially for care in areas where social knowledge and skills and interdisciplinary teamwork are prime requirements? In the area of social intervention, the workforce is our principal effector agent. More creative innovation and investment in workforce development is surely warranted.

The workforce is not the only area requiring creative innovation. Complex human systems like health stand to benefit from creating not discouraging diversity. The demographic characteristics, the health needs and wants and the resources available, both within and outside the health system, vary enormously across the country. Of course national policy and accountability requirements must be met but, within these constraints, well-led front-line teams, working with the available resources, should have the authority and the capacity to tailor services to meet local needs and conditions. Quite apart from other gains, this could greatly enrich the job satisfaction of front-line health workers and perhaps help to resolve the current workforce crisis.

To benefit from this diverse creativity, innovation, and empowered local leadership, ways should be found to share experience and learning. People with promising ideas and good track records of achievement should have access to the support needed to develop those ideas. Experience should be documented and shared in the spirit of shared learning. Technical and other help should be available to enable innovators to share and to scale up successful innovations.

To do all this the health sector needs to function more as a flat cooperating network rather than a hierarchy of command and control. It is encouraging seeing this beginning to happen with the evolution of regional arrangements for service provision and for workforce development. The New Zealand health system is made up of many relatively small elements which can only function effectively and efficiently by managing risk and working closely together. Trust develops across supportive networks that work well together for collective benefit. It rarely develops or is required in command and control environments.

Contracting and funding arrangements are keys to much health sector development. The spirit in which such contracting is done is vitally important. Narrowly prescribed short-term contracts with tightly targeted funding and auditing requirements do not encourage creativity and innovation, do not exploit the benefits of diversity or networking, and do not encourage the creation of trust or good will. Contracting should really be about the building of effective and sustainable working relationships.

For this to succeed, greater capacity must be built for what is called 'relational contracting'. This seeks to cultivate positive relationships, good shared experience which encourages joint enterprise and trust between contracting partners. Reported experience in a variety of organisational settings now shows that relational contracting can create more positive work environments and greatly improve the performance of all parties.[8] To succeed, this may involve major changes in the organisational culture of all involved. For some this might require radical change and the introduction of new ways of thinking and working.

These are but a few of the legacies that could come from the further embodiment of the spirit and the concepts first voiced globally at the Primary Health Care Conference at Alma-Ata 30 years ago, but first intellectualised by Ken Newell as a consequence of his work with Maori communities on the East Coast of the North Island more than 50 years ago.

References

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