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Commentary – Alma Ata

Comprehensive Primary Health Care: a new phase?

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In the first commentary on Alma Ata in this edition of the *London Journal of Primary Care*, Exworthy describes how, in 1978, 134 countries and 67 international organisations committed themselves to develop a social model of health, to complement the biomedical model that was dominant at the time. It aimed to engage all citizens and organisations in a shared effort for health. They called it 'comprehensive primary health care'. It emphasises participation, inter-sectoral collaboration and equity. In the second paper Macdonald laments the failure to achieve this ambitious model. He concludes 'it is time to either treat seriously the term 'Primary Health Care' or abandon it, to avoid the situation where general practitioners think they are doing it merely by encouraging life-style change'.

But with hindsight, 1978 was not the right time to move forward this ambitious vision. Alma Ata did put its finger on the things a society needs to be healthy. But it forgot to say how difficult these things are to achieve. As Exworthy mildly put it 'the rhetoric has been comparatively easy compared to the implementation'.

Here is the nub of the problem, we lack adequate theories and models of how to make participation and inter-sectoral collaboration for health and equity the norm. A subtle, encouraging approach is likely to be needed. But the dominant theory used to get people to do what we want is instrumental and direct, focused on discrete projects and short-term objectives. It has been enshrined in the soundbite – 'Carrots and Sticks' – a metaphor made to move donkeys short distances.

1978 was not the beginning, but the end of an era. Big Politics were about to take an abrupt change. McNulty and Ferlie remind us that those days witnessed a 'taxpayers revolt' against the cost of governing the extended social democratic State, demanding a curb of State growth and stimulation of markets.[1] This led to the election of Margaret Thatcher as UK prime minister in 1979 and Ronald Reagan as president of the USA in 1980. Their 'new public management' message of 'markets and targets' has been a dominant mantra ever since, including the Blair/Bush years.

Thatcher brought the market/target mantra to the NHS in 1990 (I was once told that senior civil servants fell of their seats when they heard her say she was going to 'reform the NHS' – they thought she had flunked her lines and was supposed to say 'the hospital service'). Models of the time that facilitated multidisciplinary participation in general practice and cross-organisation strategic support (such as the Health Education Authority Teambuilding Workshop Programme) were swept away, in favour of medical, market-focused initiatives, such as GP fundholding.

Along the way, many started to think that Primary Health Care was the same thing as general practice. Perhaps this came from the success in highlighting the extraordinary (unachieved) potential of general practice. Barbara Starfield showed that health systems based on primary medical care are more effective and efficient than those based on specialist care.[2] Iona Heath argued that general practitioners handle the interface between illness and disease.[3] Julian Tudor-Hart argued for a new kind of general practitioner skilled at both personal care and public health.[4] General practice can only ever be one part of comprehensive Primary Health Care. But it could develop a pivotal role, because it has feet in both the biomedical and social models of health.

Big Politics is again valuing collaboration, participation and equity. Exworthy quotes the desire of Margaret Chan, director general of WHO, to return to the principles of Primary Health Care. Macdonald cites the Australian government's commitment to self help. Several countries are progressing the idea of a community development agency that 'sees health as a "citizen" not a "profession" issue'.[5] Four of the 'World Class Commissioning Competencies' required of PCTs are skills of collaborative working. And Lord Darzi made it absolutely clear to the *London Journal of Primary Care* that he supports 'bottom up', multidisciplinary, and equitable practice.[6]

So what about an adequate theory of change? Targets give focus to effort. Markets encourage people to raise their game to out-perform others. But as sole

tactics they do not help local people to solve problems for themselves. They often fragment relationships, demotivate people and create new inequities. They cause people to ignore other important local priorities and particularly the connections between different aspects of health.

What we need are techniques that help us to face both ways – or rather to face multiple ways. We need to encourage competition and target-driven progress, while also encouraging participation, team-building and cross-sectoral innovation. We need to nurture individuals AND communities, develop organisations AND systems, promote personal care AND public health, treat diseases AND promote health. There has since been a significant increase in understanding how to do these things, and explanations of why targeted approaches alone will never be able to achieve these more complicated tasks.[7]

From the heartland of science, it is now recognised that the predictable effect of a 'cause' as witnessed within a laboratory (and underpins the idea of targets) does not apply in everyday society. Instead complex adaptation of diverse factors is a more powerful determinant of outcome.[8] This non-linear relationship between past and future behaviours is predicted by complexity theory[9,10] and observed in empirical organisational research.[11] Successful strategies for inclusive participation use this natural tendency of different factors to adapt to each other as a force for local ownership, consensus and coordinated system-wide change.

Learning Organisations[12,13] offer a way to think about this task. We can embed service redesign within a structured process of shared learning. People from all parts of the system can share their experiences about the system as a whole, and reflect on the meaning of data. Repeating this process at intervals reveals unexpected consequences of actions and new opportunities that can be shaped into locally-agreed targets, guidelines and protocols. Tenders can stimulate pilot projects that test the value of new insights. Multidisciplinary teams can lead these and at the same time nurture relationships between organisations.[14] This deceptively simple process is a powerful way to embed the three pillars of Primary Health Care. It provides a mechanism for broad participation in service redesign and ongoing inter-sectoral innovation. Data can be generated to reveal old and new inequities. Participation of marginalised groups provides a platform for non-dominant perspectives to be aired.

A research methodology has been developed in London primary care that uses a learning organisation approach to harness diverse insights into evolving stories. It is called 'whole system participatory action research'.[14] It involves repeated cycles of reflection and action of people from all parts of a system. It reveals data about glitches in the system and facilitates consensus about what they mean. This kind of approach can also be used to develop local leaders. It can integrate health care effort in both horizontal and vertical directions. It could, for example, be used to develop a polyclinic.

Practice based commissioning (PBC) provides a perfect environment to apply the theories and models arising from the organisational learning literature. PBC can work with Primary Care Trusts, local authorities and others to build environments that facilitate communication and trusted relationships – these in turn will enable participation and collaboration for whole system improvements. Through a similar process PBC could facilitate participation and collaboration between different practices and different disciplines in the extended primary care team. This could focus on urgent issues for the care of vulnerable people including continuity of care, shared guidelines and patient empowerment.

PBC does not have to do all this. But it does have to signal to others a preparedness to do it – to work towards a shared vision, using shared systems and developing win-win ways forward. A climate of shared learning must stimulate reflection, inquiry and collaborative action within PBC geographic area. PBC needs to fund whole system events and cross-organisation work groups to examine the issues that arise.

There is another thing. Many years ago Macdonald argued that one of the great obstacles to achieving the vision of Alma Ata is medical practice itself.[15] This is in large part because medicine relies on a science of the laboratory. This science is excellent at understanding the behaviour of discrete parts but does not have the power to recognise the interplay of multiple factors that are essential to being a healthy person within a healthy society. We general medical practitioners and other members of the primary care team deal with these complexities all the time. We sit at the interface between medical science and the multiple factors that affect health. For this reason we are well placed to lead a new way. We must continue to value medical science and practice medical care, but we also must become more skilled at the science of multiple insights and working with whole systems of care. We need to test the ideas arising from learning organisations, including participatory and action approaches to inquiry, and from this contribute to a new phase in implementing the idea of comprehensive Primary Health Care.

With hindsight 1978 was not the right time to move forward the ambitious vision of Alma Ata. The right time is NOW.

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