

## G2H2 #AA40 Commemoration

### Reflections on Alma-Ata, forty years on David Legge<sup>1</sup>

#### History

Community health took off in Australia in 1973. After a 23 years of conservative rule the Australian Labor Party was elected to power and one of their first initiatives was to appoint a health services commission which was headed up by Dr Sidney Sax. Dr Sax was a refugee from Apartheid South Africa where he had been a junior colleague of Drs Sidney and Emily Kark, famous for their work at the Pholela Health Centre (Kark and Cassel 1952, Kark and Kark 1999).

Dr Sax created the Community Health Program (Interim Committee of the Hospitals and Health Services Commission 1973) under which there was a flowering of community health centres (CHCs), particularly in my home state of Victoria. This early generation of CHCs provided comprehensive primary health care through a multidisciplinary team and were managed by locally elected committees of management.

I was an enthusiastic supporter of CHCs from the beginning, in particular through an educational program we developed for newly elected members of these committees of management ('Health Feedback', later reinvented as [Talking Better Health](#)).

The Indigenous health movement in Australia had in fact established the first community controlled Aboriginal health service in 1971 (Foley 1991), the year before the Labor government was elected but they were quick to pick up on the new funding stream under the Community Health Program. Six years later, one of the pioneers of Indigenous health in Australia (Shane Houston) was part of the Australian contingent at Alma-Ata in 1978.

In 1984 a newly elected State Labor Government established a system of 'district health councils' (DHCs) in Victoria to support community involvement in health promotion and health planning and to strengthen health system accountability (Legge and Sylvan 1990). As part of the District Health Councils Program we established a support agency, the Centre for Development and Innovation in Health which undertook research, produced resources and provided support to DHCs and CHCs. Some of the publications produced through CDIH are still accessible online at [www.cdinhealth.org](http://www.cdinhealth.org).

Much of what was established in those early years has since been demolished by the neoliberal onslaught. The exception is the Indigenous sector. Community controlled health Aboriginal health services remain a beacon for comprehensive primary health care in Australia (Fredericks and Legge 2011).

The Alma-Ata Conference took place *after* the first explosion of community health centres in Australia but in the years following Alma-Ata generations of primary health care practitioners in many different settings have been inspired by the Declaration and have used it in their advocacy around health development. I certainly have been inspired and re-inspired each time I have gone back to the Declaration.

#### Reflections on Alma-Ata

Reflecting on the Alma-Ata Declaration 40 years on, I highlight three issues:

- the references to a New International Economic Order (NIEO) in the Declaration;
- the collection of case studies put together by Kenneth Newell in 'Health by the people' (1975) which was very influential in shaping the Alma-Ata Declaration; and

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1. David Legge lives in Melbourne. He has been an active member of the People's Health Movement since its foundation in December 2000 – the year which passed without 'Health for All'.

- the expectations, which arose from the Declaration, that PHC practitioners, including community health workers, would/should take a leadership role in their communities in health promotion including community mobilization, intersectoral collaboration and policy advocacy to address what we now refer to as the social determinants of health.

## NIEO

There are several references to a New International Economic Order in the Alma-Ata Declaration, as one of the necessary conditions for achieving Health for All by the Year 2000. Unfortunately the significance of this reference has not been given due attention in subsequent comment on the Declaration.

The call for a New International Economic Order was sponsored by the G77 and adopted by the UN General Assembly in 1974 (Sneyd 2005). In many ways the NIEO was the mirror opposite of the Washington Consensus, a term which was introduced in 1989 to rationalize the brutality of structural adjustment and provide a cover for the emergence of neoliberalism in the 1990s (Ocampo 2001).

Where the Washington Consensus argues for trade liberalization and export oriented 'development', the NIEO argued for the legitimacy of infant industry protection and for a non-reciprocal approach to trade regulation; for a global economic regime which was positively tilted in favour of the poorest countries; which would promote redistribution towards equity as well as providing new pathways to economic development.

The inclusion of the NIEO in the AA Declaration signifies the importance for the 'Health for All' project of understanding the dynamics of the global economy and the governance structures which at this time continue to drive the neoliberal agenda.

One of the tragedies of Alma-Ata was that within two years of the Declaration, the Debt Trap was sprung when US interest rates were taken to 20%; within a few years health policy in the Global South was being dictated by the IMF and the World Bank under structural adjustment<sup>2</sup>. While it was the Rockefeller Foundation and UNICEF who sought to replace comprehensive with selective PHC, it was structural adjustment which drove the demolition process.

## The Newell collection

The Newell collection ('Health by the people', [here](#)) was an important input to the design of the AA Declaration.

In part as a consequence of the advocacy of the Christian Medical Commission in the lead up to Alma-Ata both Newell and Mahler were very aware of the work of the Aroles at Jamkhed in Maharashtra and the Nugros in Solo in Indonesia and other case studies of PHC. Indeed the way Litsios tells it (Litsios 2002, Litsios 2004), it was the Christian Medical Commission that helped to bring Jamkhed to the attention of Newell and Mahler.

It may be that Newell and Mahler under-estimated the challenge of (what the Bank likes to call) 'scaling up' such projects. The Aroles and the Nugros were social entrepreneurs. The achievements of those models depended on the leadership and the autonomy of those enterprises. Not only is it hard to scale up to national coverage but the (completely justified) celebration of these models can create the impression that universal access to primary health care might be achieved through a replication of these quite unique models.

The Newell collection also included a chapter on China (by Vic and Ruth Sidel) which celebrates the role of community health workers ('barefoot doctors') in addressing the environmental determinants of health, in particular, through the Great Patriotic Health Campaign.

The Chinese experience since 'opening up' from the 1980s carries quite somber implications for PHC. Under Mao the Chinese established a system which provided universal coverage of a limited range of essential services to be

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2. The background to the 1980s debt crisis needs to be better known in public health. Key factors include the oil price hikes of the early 1970s and the flurry of predatory lending which followed; the economic slow-down of the late 1970s with the combination of recession plus inflation ('stagflation'); and the 'fight inflation first' slogan of Thatcher and Reagan which meant a dramatic increase in interest rates, designed to break the unions, but which precipitated the Third World debt crisis as well. This was the moment for the IMF and structural adjustment.

delivered by the 'barefoot doctors'. However, with the turn to a market economy the funding base for PHC was rapidly undercut and health care agencies were encouraged to fund themselves through user charges. This had a devastating impact on access, efficiency and quality. From the 1990s the Chinese people have increasingly demanded access to providers who can deploy all of the tools of modern medicine. The transformations, driven by these two developments, has been traumatic; one of the costs has been the dismantling of the primary health care infrastructure.

## The expectation that CHWs would/should provide the local leadership for health development

The Alma-Ata Declaration implies that primary health care practitioners, including community health workers, should provide leadership in health development in relation to the social determinants of health, including community mobilization, intersectoral collaboration and policy advocacy. From the inspiration of the Aroles and the Nugros and the achievements of the Patriotic Health Campaign in China emerges an expectation that this kind of leadership will be projected by primary health care workers in a wider range of settings.

At this distance there are grounds for some caution in over-loading community health workers with such leadership expectations. It is beyond doubt that the Jamkhed model can deliver this kind of leadership within the boundaries of such a project but the challenge of 'bringing it to scale' to the national level remains. The achievements of the Great Patriotic Health Campaigns in China were not just the work of the barefoot doctors; they had the enthusiastic support of the Communist Party of China and the Party committees in work units throughout the country.

## Conclusion

I have been and remain inspired by the Declaration of Alma-Ata and believe that its principles and assumptions remain relevant and indeed critical for the achievement of health for all. In particular I underline the emphasis in the Declaration on PHC as a whole of health system approach; a whole of government approach. I fully endorse the importance of PHC practitioners, including community health workers, in contributing to the struggle over the social determination of health.

However, the struggle to bring the vision of Alma-Ata to reality is not just about how we deliver health care; it is also about economic development, equity and social justice, democracy and human rights. In the era of neoliberal globalization, when the national polity is hostage to transnational corporate power, it is also about creating a new international economic order.

In the context of debates about the rising power of the transnational corporation vis a vis the nation state, the US sociologist, William Robinson (2004) posits a transnational capitalist class, comprising both the corporate elite and the political elites from the dominant capitalist economies. The transnational capitalist class is organized, coherent and self-conscious of itself as a class; it controls vast resources but numerically it is tiny, less than the 1% denounced by the Occupy Movement. However it is confronted by an incoherent assemblage of national middle classes, working classes and marginalized classes, divided by language, ethnicity, religion, nationality and gender.

The project of PHC, including a new NIEO, will require a convergence of these subaltern classes, a new listening across difference, a new solidarity, a new collective self-consciousness. This convergence is being driven by social and political movements within countries and increasingly across countries, including the global 'Health for All' movement.

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