The promise and pitfalls of generalism in achieving the Alma-Ata vision of health for all

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Defining the ideal generalist medical practitioner is essential to effective primary care

It is 30 years since 3000 delegates from 134 governments, 67 international organisations and many non-government organisations gathered in Alma-Ata, Kazakhstan, to agree upon a declaration about how primary health care could achieve "health for all by 2000".[1] The conference was convened by the World Health Organization and the United Nations Children's Fund (UNICEF) in response to the growing inequality among large sections of the world's population. The conference was influenced by global political and social change in the preceding decades and a strong desire to move away from medical dominance and elitism,[2] to focus on developing countries rather than dominant Western nations, and to propose a model of health as a tool for economic development.[1] The leadership of WHO Director-General Halfdan Mahler (1973–1988) was crucial to the direction of the declaration, as he had been impressed by developments in China, India, Africa and Latin America that provided health care via local community-controlled services using lay participation, and he envisioned such programs addressing health inequalities across the world.[3] The resulting Declaration of Alma-Ata consisted of 10 sections (Box 1).

Anniversaries often prompt reflection, and as the Alma-Ata Declaration reaches its 30th birthday, it is clear that implementing the Declaration has been more difficult than creating the vision.[4-7] Many commentators argue that the Alma-Ata experiment failed;[5] others say it has never been tried.[8] Some highlight the influence of the Declaration on policy agendas in developing countries (eg, Mozambique, Nicaragua) and on the development of community health workers.[4] However, many programs that evolved were disease-focused, and critics would say that the community health workers, rather than being agents of change, became civil servants.[8]

So what is the relevance of a WHO declaration made 30 years ago to the Australian health care system? Some may see the Declaration as applying mainly to developing countries, but on reflection there is much we can gain from considering it in our own context. As a population, we desire health for all, and yet we continue to see health inequities. The rise in chronic disease and the ageing population means that multiple morbidities are the most common reasons for presentation to primary care,[9-12] yet Australia, like many countries, continues to focus on single-disease-led health care linked to relative disease burden, often via treatment guidelines.[13] This approach encourages specialisation, leads to fragmentation of health care, and affects our ability to deliver the goal of "health for all".

The fragmentation in so many health initiatives goes against the spirit of the Declaration. Perhaps governments, the health professions and wider society did not fully understand or truly value the kind of health care proposed. The Declaration called for a dramatically different approach to health and health care, but it failed to articulate the attributes required of the health care workers. The essential role and inclusion of *primary medical care* in the conceptualisation of primary health care was poorly articulated. Perhaps the desire to reject medical dominance, combined with a poor understanding of primary care,[14-17] explains why there was no definition of what a "suitably trained physician"[1,18] would need to be like to deliver the ambitious goals. Even though there was increasing focus on the need for a team of professionals to provide primary health care,[19,20] there was little systematic gathering of evidence to inform the roles and values of various team members.

What kind of physician could contribute to achieving the Alma-Ata vision?

We propose that a generalist primary care medical practitioner is a vital component of primary health care. Australia has a well trained general practitioner workforce, yet most GPs continue to practise mostly reactive, consultation-based medicine with little time for planning, monitoring, teamwork, community involvement, and networking or integration activities. As a nation, we face a medical workforce crisis in that general practice struggles to attract and maintain high-quality graduates. The policy response is to shift the work of GPs to non-medically qualified practitioners and assistants. Interestingly, there has been little public involvement in debate of this issue. Our recent review, commissioned in 2007 by the Australian

1 Summary of the Declaration of Alma-Ata[1]

The 1978 Declaration of Alma-Ata formally adopted primary health care as the means for providing a comprehensive, universal, equitable and affordable health care service for all countries. Consisting of 10 sections, in summary it declares:

I: health as the state of complete physical, mental and social wellbeing;

II: the unacceptability of health inequalities, especially between developed and developing countries;

III: the necessity of economic and social development for health;

IV: the right and duty for lay participation in planning and implementing health care;

V: the responsibility of governments for providing primary health care and for measuring health and social wellbeing;

VI: the role of primary health care as the local, universally available, essential, first point of contact with the health system, based on practical, scientifically sound and socially acceptable methods and technology at a cost the community and country can afford;

VII: the essential elements of primary health care (culturally relevant; addresses the main health problems; provides preventive, curative and rehabilitative care; provides health education; includes a multisectoral approach; community participation; integrated functional referral systems; consists of physicians, nurses, midwives, auxiliaries, and community workers trained to work as a health team);

VIII: the need for government policies on primary health care;

IX: the need for international cooperation for health; and

X: the need for better use of the world's resources and a policy for peace and disarmament. ◆

Primary Health Care Research Institute (APHCRI), provides, for the first time, a conceptual model of a primary care generalist based on a systematic narrative review of the literature (Box 2). A full description of the review methods and findings is available from the APHCRI website.[21]

The generalist ideal encapsulated in our model can bridge the inclusive vision of who should be involved in promoting health for all, with the much more narrowly and often specialty-focused health care found in many countries, such as the United States. The type of generalist role proposed is sophisticated and requires interpretive skills, a broad approach, excellent networks and supports.

We conceptualise generalists as exhibiting compassion, tolerance, trust, empathy and respect (virtues). They reflect carefully on each clinical interaction, recognise its complexity, and acknowledge their prejudices (eg, towards obesity, unsafe sex practices, single parenthood, substance misuse, poverty, violence, religion). By acknowledging and dealing with their feelings (being reflexive), generalists can begin to fully engage with each patient. The generalists spend time gathering information from the biopsychosocial and cultural domains, rather than focusing solely on physical symptoms and signs.

Each interaction requires biotechnical expertise, and the generalist needs to use the best available evidence to manage health. This is likely to be facilitated by access to independent evidence-based guidelines and reliable information systems. The generalist knows how to access appropriate technology to achieve health (this will range from familiarity with accessing online evidence to knowing how to access a magnetic resonance imaging scan to being aware of how to get patients from a remote area to a district hospital during the rainy season). In addition, the generalist will exhibit a high index of suspicion for medical, psychological and social "complications" and awareness of the complex interaction of morbidities and social factors.

A fundamental role of the generalist is to balance the biotechnical with the biographical. The generalist must know and understand how each life story and social context are constantly influencing and being influenced by physical and emotional health. To achieve the balance between the biotechnical and biographical aspects of each interaction, the generalist must have the skills to reach a mutual understanding of the priorities and challenges that individual patients face when managing their health.

The ideal generalist would be easily accessible and knowledgeable about other services to arrange appropriate and timely referral. The generalist would balance individual needs against those of the population, and consider the whole person and what they know about each to provide comprehensive care, dealing with areas such as sexual health with as much knowledge, interest and respect as diabetes. They will be comfortable working with both mental and physical health problems (flexible), and able to negotiate a plan for health care that suits each person (patient centred). This might be as simple as ensuring that single parents can get appointments that suit their work schedule and childcare requirements. The generalists would work in a system that allows them to ensure that each person receives all the health care they need regardless of their ability to pay for it, and the generalists would have the potential to guard against fragmentation in the delivery of care.

Such a generalist embodies the medical practitioner role for primary health care that has the potential to deliver health for all. Like the Declaration, it is an ideal, but striving towards this goal is likely to have far-reaching health benefits.

2 A conceptual model: essential dimensions of a primary care generalist medical practitioner

Ways of being (ontological frame)

Virtuous character: holds ethical character traits of compassion, tolerance, trust, empathy and respect.

Reflexive: interdependent; reflects on judgements and biases; lifelong learner.

Interpretive: uses processes of interpretation to understand patients, with an emphasis on the contextual factors; use of multiple health systems languages; active listener; autonomous decisionmaker; has good communication skills.

Ways of knowing (epistemological frame)

Biotechnical: uses scientific and rational evidence; high index of suspicion; biomedically driven; technically focused; uses advanced information systems.

Biographical: concentrates on lived experience and life story; family, carers, community and social knowledge all provide evidence.

Ways of doing (theoretical frame)

Access: accessible; first-contact point; gatekeeper; provides referral.

Approach: balances individual versus population needs; consultation-based; holistic; comprehensive; flexible; adaptable; acts across clinical boundaries; provides early diagnosis; interdisciplinary team approach; negotiates and coordinates services; integrates knowledge; promotes health through education; prevents disease; is culturally sensitive; provides patient-centred care; minimises service inequities; reduces service fragmentation.

Time: provides continuity of care over whole of life cycle.

Context: community-based; uncertain; complex; deals with undifferentiated multiple problems of patients; acute and chronic care. ◆

Generalism and the Alma-Ata Declaration

The generalists' character, reflexive and interpretive ways of being, biographical ways of knowing, and accessible, longitudinal, contextual approach place them at the crux of the social, economic and community sectors that are the focus of the Alma-Ata Declaration. The generalists' biotechnical focus is the link to medicine, but also a way of bridging the gap between medicine and the personal, social and cultural circumstances of individual patients.

This vision of generalism responds to the Alma-Ata Declaration and can inform primary care practice in developed or developing countries. There is a strong synergy between the Declaration and the conceptual model of generalism, especially around the importance of incorporating biopsychosocial aspects in the delivery of health care and the focus on first contact, locally accessible health promotion, prevention, cure and rehabilitation (section VII of the Declaration). The virtuous character in our model is in keeping with the spirit of social justice required in the Declaration (section V). The community focus of the generalist is critical to integrating the social and economic sectors into the promotion of health (section I), to bringing health care as close as possible to where people live and work (section VI), and to getting the kind of work done that the Declaration called for (section VII).

The promise of generalism

We have identified a conceptual model of generalism that could underpin a *new* primary health care approach, building on the bold vision of the Alma-Ata Declaration. We have argued that a major limitation of the Declaration was its failure to consider the kind of physician and the health care relationships needed to deliver health

for all. Having control over resources, participating in health care and ensuring communities are equipped and empowered to deal with their health needs are important ideals. But someone must integrate health care within a relationship context, continue that care, and support promotion of health, prevention, diagnosis and treatment. Health for individuals, let alone health for all, cannot happen without access to health care practitioners able to promote health, prevent disease, diagnose, treat, and follow up. This will require more than one health professional, but acknowledgement of the important central role of the generalist is missing from the Declaration.

Few studies have explored whether generalist approaches to primary care are cost-effective. No randomised trial of generalism has ever been conducted, nor is it ever likely to be undertaken. But there is observational evidence that generalist primary health care contributes to achieving the goals of Alma-Ata.[22]

The potential pitfalls in achieving generalism

Generalism alone is not the answer. The issues of sustainability, war, terrorism, well planned cities, public transport, affordable housing, secure employment, quality childcare and education are just as important to health as the common physical and emotional health problems that consume most of the health dollars. The generalist offers a bridge between the biomedical and the social, but within limits. To truly realise the potential that generalism offers will require that generalists work closely with others with an expanded view of health and health care.

In Australia, this would require us to reconsider the way GPs work and the infrastructure support required to enable them to undertake preventive, curative and rehabilitative health care as a core component of the primary care team. If this is made possible, generalists may find themselves not only providing physical and mental health care, but playing a role in a team that focuses on keeping individuals in their community safe from harm, finding them work for a living wage, advocating for a child-friendly environment, changing the gaming laws, or introducing a cervical cancer vaccination program. The generalist is *a* part of the wider health care and social system and the generalist role is inherently adaptable to local needs and grounded in local relationships. To avoid the pitfalls of fragmentation in health care and interprofessional rivalry that may stand in the way of achieving generalism and the ideals of Alma-Ata, this role will increasingly need to pay attention to the broad partnerships called for in the Declaration.

Conclusion

Critics may argue that our literature-based model encompasses an ideal that is impossible to achieve. But, much like the Declaration, if it is not an aspiration, it will never be achieved. One major challenge remains — whether the community as a whole will value the concepts of generalism and the Declaration made at Alma-Ata 30 years ago over the more seductive promise of specialism and high-tech, high-cost intervention. If health for all is the goal, governments, health care professions and individuals need to carefully consider the central role of generalism and the components set down at Alma-Ata, and will need to invest in making sure that they can happen.

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Competing interests

None identified.

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