

Commentary – Alma Ata

Reflections on Alma Ata, and 60 years of the NHS

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New occasions teach new duties
Time makes ancient good uncouth
They must upwards still and onwards
Who would keep abreast with truth

Lowell JR, *Boston Courier*, 11 December 1845

The verse refers to our need to re-discover truth and moral direction at times of social and cultural change. Nowhere are the words truer than in the changing world of the medical profession, which has had to adapt to new diagnostic techniques and new treatments that, perhaps more than in any other profession, interface with major ethical and religious dilemmas.

Let's look at the extent of this change. At the start of the health service in 1948, my father was a GP in Birmingham. Prescriptions were free, and although, as today, there were waiting lists for hospital beds, and long delays in outpatients, hospitals seemed less crowded and free from the atmosphere of crisis and collapse that is a common feature today. Doctors were regarded with uniform awe and respect, and nurses held in great esteem. Visiting hours were much more restrictive than today. Prolonged exposure to relatives, was not considered a good thing, for either patient or hospital staff.

At the time, the new miracle drug was penicillin, used, with little thought given to long term bacterial resistance. Polio, or infantile paralysis as it was then commonly referred to, existed in endemic proportions. A popular brand of cigarette was advertised as 'good for your throat'. Widespread spraying with newly discovered DDT almost helped eliminate malaria, but as we have learnt since, almost, is not good enough.

It is important to look to the recent past, to understand and appreciate the massive changes in scientific progress, and the huge advances in clinical techniques which medical practitioners patients and wider society have had to take in their stride since the start of the NHS: whole families of new drugs, scanners and new imaging techniques, transplants and lasers to name just a few new aids to our continuing quest for a longer and healthier life.

Rapid scientific advance in medicine inevitably gives rise to new ethical dilemmas. In serving as lay

member of the BMA Medical Ethics Committee, I was amazed at the constant stream of complex, major ethical issues arising out of new discoveries and new procedures, particularly in the field of genetics and transplant surgery. Alongside major medical advances, there have also been huge changes in society itself, and it is impossible to understand the problems, challenges and opportunities of today's health service, without looking at and understanding the nature and magnitude of these social changes, and building them into the equation of our quest for better health for all.

The start of the Health Service coincided with a post-war baby boom that has now become a generation at the end of economically active life. The labour shortage of the early 1950s, led to the arrival, by invitation, of then youthful immigrants, now in retirement. These factors combined with better medical techniques have resulted in a steady growth in the proportion of the elderly in the population; a growing segment of the population that is not only economically inactive, but also a larger than average consumer of NHS resources. Many of the new advances in treatment and care are enormously expensive, with the effect that the care of the elderly takes up a growing proportion of the healthcare budget.

In the past, the important nursing aspect of the care of the elderly would often have been absorbed within the family unit. But here also, there have been major social changes, which impinge directly on national resources. Perhaps the most important of these has been the change in family structure and long assumed family responsibilities.

Cohabiting and extra-marital relationships are nothing new, but the contraceptive pill has made such relationships more common and no longer subject to general social or moral censure. This has had a major effect on the family unit, with more transient and frequently, less dedicated relationships. It's not a moral judgement but a statement of fact, that both within and outside marriage, a sense of responsibility to partner, parent, grandparent or even children, has shown a marked sense of decline in the last half century. Obsession with personal happiness: *my* life, *my* right

to do *my* own thing, has become central to the life of many.

It has also become more common today, for both parents to go out to work, making it physically impossible to care for an infirm family member. Responsibility then passes to the state – at a monetary cost and reduction in the funding available for other things. There is also a real cost arising from a weakening of family ties and responsibility. Family care at minimal cost has now been widely replaced by state or private nursing homes – and with this the trauma of means testing or selling one's home to meet the cost of care. For others, particularly the mentally sick, 'care in the community', often becomes total social abandonment.

Another area of concern is the growing disparity between the healthcare available to the wealthier and the poorer extremes of society. We are frequently reminded that poor families in Britain have some of the unhealthiest children in the developed world, destined to grow up as illness prone adults. Infant mortality in Britain is higher than in most of Europe.

While Britain may lag behind much of Western Europe in certain areas of health provision, no such criticism can be made of our country's pioneering work in many areas of medical research such as IVF, cloning techniques and much else. To the layman, the advances in medical research have been truly breathtaking, bringing us to a point where we can now play with the very building blocks of life in attempts to eliminate many genetically inherited disorders. We are now on the brink of spare parts farming with animals to provide spare parts for arteries, heart valves, skin grafts and other body parts.

But, to the layman, and many within the medical profession, there is also a slight sense of unease. It's a feeling that we may be being too clever for our own good and that we are moving too fast to understand the full moral, ethical, social and even scientific implications of our discoveries. There is a sense of unease that society is being led into uncharted waters by a powerful combination of science and market forces, beyond the shoreline and safety of ethical and moral understanding.

One such area lies in our ability to keep people alive against their apparent wish on the grounds of diminution of quality of life. While, in my view, it is clearly wrong to artificially prolong the life of a person in a vegetative state with no chance of recovery, the argument that, 'it's my life and I should be free to decide when to end it', ignores the reality of no man being an island. We are all part of the mainland. Our actions have a ripple effect on others, particularly those close to us.

Some of the new medical advances now available, or on the horizon, will be enormously expensive, and ethically questionable. But at least for the more

wealthy, there is the increasing prospect of a considerably longer and disease free lifespan. But how far do we want to go down this road at the expense of basic health provision for the many? And at the expense of quality of life?

While we would all like a normal healthy lifespan, and perhaps a little bit more, I feel most people would agree with the Sikh teaching that it's not the number of years we live, but what we do in them that is important. Some people die at an old age, but have barely lived. Others have lived to a much greater degree, but die at a young age. Each religious tradition has its prophets, its gurus, who died young but left a lasting impression, Jesus Christ is an example; he was in his 30s when he was crucified. Guru Arjan, author of much of the Sikh holy scriptures and founder of the Golden Temple was martyred in his 40s.

I do not mean to glamorise youthful death. I mean only to suggest that every moment is precious and full of potential. Being alive means paying attention to the breadth of things that matter and interacting creatively with them. From this comes humility as we recognise how small we are and also empowerment as we see how to make a difference. Good health means being alive in the moment. The spiritual dimension of health involves seeing and actually feeling the dynamic interactions between multiple things. Each faith community has its own way of describing 'the spirit that binds'. Different faith communities, and indeed secular groups, use different languages to describe this spirituality. Fritjof Capra, famous for drawing comparison between complexity science and Eastern mysticism, says: 'Spirituality is an experience of aliveness of mind and body as a unity'.¹ He concludes this from his study of relativity science.

Different spiritual traditions and secular groups use different techniques to improve the ability to be alive in the moment (it is a very difficult thing to achieve). Primary care practitioners of all disciplines can improve health by helping people to find ways that are meaningful to them to do this – to become alive. Here is another interface at which generalists act – the interface between medicine and spirituality.

Today we are all lured by the siren call of materialism which says that we can buy happiness, health and contentment, by, pandering to self. We are told that we can do this by having a larger home or a bigger car, or other material goodies, because 'we're worth it'. It doesn't work, and our different religions have long warned us about this. Christianity warns us about greed and half a dozen other deadly sins. Incidentally, Sikhs list only five!

As we all know rising affluence in the West has been paralleled, with remarkable correlation, by increasing family breakdown, alcoholism, crime, particularly violent crime, drug abuse, record teenage pregnancies and a discernable fracturing of social structures. There

has been a vast increase in suicide rates and in problems of mental health. Today, in our world of comparative plenty, it's common to say we're 'stressed'. It's worth reflecting that the phrase hadn't been invented at the start of the Health Service 60 years ago in the clearly more austere and difficult post Second World War period.

The lesson of all this is that while we all want to live comfortably, selfish pursuit of material comforts, or quick fix solutions through drugs or alcohol abuse, do us no good and cause hurt to those around us. Society is very much like a ship on which we are all afloat; it's the social environment in which we live, and its wellbeing is inextricably linked to our own.

Is this not what Alma Ata was saying? – that the social environment matters. It impacts on the health of individuals all the time, and individuals impact on it all the time. A social model of health does not deny curative care or individual pain. But it sets it within a bigger concept of the health of families, communities and the entire social order.

There are other external and seemingly unconnected factors that impinge on healthcare. The first is a growing lack of respect for those in authority and the second is increasing expectations of what may be possible, arising from media obsession with new discoveries; with research and theory being misinterpreted as cure or treatment which in reality may be many years way

Revitalising the vision of Alma Ata means recognising how inter-twined are medical, ethical, social, and I believe spiritual factors, and how they all affect healthcare today: We must pay attention to the social, medical and spiritual needs of the elderly, the poor, the mentally ill and other vulnerable people. We must do this in ways that value low-tech solutions and our own personal resources, using sparingly expensive drugs and techniques. This requires local participation and collaboration for the common good – two of the Alma Ata pillars. We need to develop many ways, new and old, to share the job of improving health and healing sickness.

The third pillar of Alma Ata – equity – forces us to face hard realities. The reality of Health Service funding today is that there is nowhere near enough money available to meet the basic costs of healthcare, let alone

heightened public expectations. Painful though it may be, the way to meet current shortfalls is through higher taxation, increasing efficiency, and where necessary, a system of rationing based on priorities

A system of priorities, or priority categories or age groups, in some ways appears to cut across the ethos of healthcare being equally available to all. But it already exists and I believe it has become a necessity. What is important is that provision is equal throughout the country and that the poor are not disadvantaged. Rather, provision, particularly of public health measures, must be weighted in their favour to reduce an intolerable level of sickness and poor health. Of course it is also important that national policies work to reduce the extremes of wealth all too visible today.

At the same time we need to set boundaries about what is ethically acceptable in new treatments. This to my mind is the greatest challenge of all.

The use of human embryos, to produce stem cells for treating genetic disorders, is an example of this ethical dilemma. The possible benefits are obvious; but so too is the fact that manipulation of potential life decreases, at least marginally, our respect for life. Nothing is for nothing.

We are all aware of the slippery slope that can easily take us from promising new treatment, to a trivialising of life. The boundaries of what is acceptable are constantly being tested, and it is important that in defining them, and assessing their continuing validity, we use the surprisingly common, ethical values of our different faiths to help us move forward with compassion and understanding to an exciting future.

REFERENCE

- 1 Capra F. *The Hidden Connections*. 2nd ed. St Ives: Flamingo, 2003.

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