MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**PRIMARY HEALTH CARE**
Module: 5.2	**ECTS (suggested): 0.2**
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Keywords	Primary Health Care, Public Health
Learning objectives	After completing this module students and public health professionals should: • be aware of principles of primary health care; • recognize; • know ; • improve the knowledge and understanding.
Abstract	Primary health care is essential health care made universally accessible to individuals and families in the community. It is a base and the entrance of the whole health care system, often has the role of gate keeper. It has to be organized according to social realities in which communities live and work. The health system is developed relatively well among the countries in the South Eastern European region. The heath personnel are well-trained and public health services are well established and organized. Around 30% of general practitioners are specialists in family medicine. Health care services in Croatia are organized on three levels: primary, secondary and tertiary. On primary level operate general/family medicine, paediatric, gynaecological and dental practices, public health nursing, diagnostic laboratories and supporting services and pharmacies. The core of primary health services in Croatia are general/family medicine, paediatric services and community nurses. According to the Health Insurance Act in Croatia, there are three main health insurance schemes: basic, supplementary and private health insurance.
Teaching methods	Introductory lecture, exercises, field visits, individual work and small group discussions.
Specific recommendations for teachers	• work under teacher supervision /individual students' work proportion: 30%/70%; • facilities: a teaching room; field visits to at least two types of municipalities (urban and rural) • equipment: transparencies, colour flow masters, overhead projection equipment; computer, LCD projector • training materials: readings, hand – outs;
Assessment of students	The final mark should be derived from the quality of individual work and assessment of the contribution to the group discussions.

PRIMARY HEALTH CARE[1]

Želimir Jakšić, Luka Kovačić

THERORETICAL BACKGROUND

> *Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.*
>
> *Alma Ata Declaration (1)*

Introduction

The strengthening and further development of primary health care is a policy accepted in many countries. The question is how this concept is implemented in practice.

In the difficult economic and social conditions (to mention only increasing unemployment and international debts), there is both a need for adequate, socially sensitive and well balanced primary health care, and also a growing opposition to these ideas. Under financial restrictions the weaker partner usually suffers more. This is a decisive moment for future of primary health care and for the health of people in general. There is no time to delay decisions or wait.

The social aspects of primary health care are essential

Primary health care has to be organized according to social realities in which communities live and work. Because of that, a variety of solutions might be expected. Principles have to be applied with full understanding of conditions and with expectation of changes in the period of dynamic development. The socio-economic relations, community structures, differences in power and interest, existing communication and other social networks have to be taken into account. There are also specific ecological conditions which influence the differences in epidemiological situation, health risks and needs.

The orientation of health care towards the needy and the underprivileged (rural populations, youth, elderly, etc.) is one of the important principles. The growing inequalities in health have to be opposed by an essential change in socio-economic relations. The problem cannot be solved by establishing a second - class service for such groups, as it is often in reality. Primary health care has to be differentiated from "primitive" health care.

Another social aspect of primary health care is covered by **community participation and involvement**. Communities have to decide what they want in the way of health care and how to achieve it. More than in any other field, there are many false and disappointing ways by which this concept is put into practice. Unrealistic expectations are raised, without changing the general social and political conditions.

New approach to the **technology of primary health care** is needed. In some instances it will be sufficient to adapt existing technologies to needs, but many new ones have to be developed. Self-care, group care and community care are few examples. In reality, however "high-technology" approach has suppressed primary health care, considering it only as a vehicle for delivery of services. Primary health care should be developed as a health **discipline in its own right**. Research and education should support this development.

Primary health care is expected to build a **bridge between traditional and contemporary specialized medicine.** Therefore, it should be organized using the

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[1] Adapted from: Jakšić Z, Folmer H, Kovačić L, Šošić Z, eds. Planning and management of primary health care in developing countries. Training guide and manual. Zagreb: Andrija Štampar School of Public Health, Medical School, University of Zagreb, 1996.

intermediate and combined type of technology. It has to be different from haphazard practices of traditional medicine and also from specialist polyclinics, which are regarded as the prototype of medical "industry".

The organization of volunteers and support of free initiative might be examples of success in practice, but continuity of activities should be secured, the reference and communication with other parts of the health system provided and profit making malpractice avoided.

Organizational forms of primary health care

Different **organizational solutions** in implementation of PHC have to be expected under different conditions, i.e. in individual countries and health systems. This does not mean, however, that every solution is appropriate. Integration of health programmes, interaction and coordination of work of health and other sectors, continuity and building of permanent infrastructure are intended principles. In reality, a strong confrontation among different programmes is a common finding. The controversy between **"selective" and "comprehensive"** primary health care reflects deep differences in political interests and social policies.

Primary health care is envisaged as a general solution for all types of communities and all people. It was repeatedly stated that primary health care approach should be the general answer to health needs of all people, regardless whether they live in better developed areas or in poor and underprivileged circumstances, in urban or in rural settings. However, very often primary health care is wrongly conceived as a special project for delivery of health services for poor rural population. Some of these population groups really need to have priority, but they should not be considered in isolation. Primary health care is not a second class service for the underprivileged.

Different intentions are covered under the same name of PHC. For instance, the **role of hospitals** in PHC is a very sensitive point: declarations and realities have to be differentiated.

A system of **community - based health centres** provide a working model, but bureaucratization and over institutionalization have to be avoided. Without strong political commitment and planned intervention under the name of PHC a service will develop with emphasis on medical cure and care.

The community-oriented health workers and family practitioners (volunteers, auxiliaries, nurses, midwives and physicians), their team work and leadership in the health field should be the focus of the system. They should be accepted and close to local culture and because of that accepted by people. In reality their attitudes, interests and training are often far from people's interest and culture. Besides, their power and position in the hierarchy of health services are very low.

The implementation of PHC demands **active support** by the **whole health system**. Among the most important requirements are the appropriate political atmosphere, planning of adequate resources, reorientation of health workers, intersectoral collaboration and networking of the involved institutions.

Verbal support is usually given to these PHC principles but restrictions are imposed. Sometimes, the financial and best human resources are oriented to other parts of the health system. Besides this, PHC is often organized as a special project to other vertical health programmes. The networking is often formal and every sector carefully watches its own resources.

There are differences between intentions and realities in implementation of PHC, but at least intentions are now well formulated. They have to be protected from corruption. Hard work and a long way are ahead.

The question is why the difference, the gap between intention and real practice is still widening in many places. Is it because the economic conditions diminished implementation, simply because not enough was done by responsible groups, or because there is another intention hidden growing a “new vine in old bottles”.

CASE STUDY

Organization of health care in Croatia

Health care services in Croatia are organized on three levels: primary, secondary and tertiary.

Primary level: General/family medicine, paediatric, gynaecological and dental practices, public health nursing, diagnostic laboratories and supporting services, pharmacies. The core of primary health services in Croatia are general/family medicine, paediatric services and community nurses.

Secondary level: county hospitals with specialized policlinics, specialized hospitals for chronic diseases, county institutes of public health.

Tertiary level: teaching hospitals, clinical hospital centres and state's institutes of health (e.g. National Institute of Public Health).

Facilities discharging health activities are either in state, county or private ownership. Teaching hospitals, clinical hospital centres and state's institutes of health are state owned. Health centres ("Home of Health"), polyclinics, general and special hospitals, pharmacies, institutions for emergency medical aid, home care institutions and county institutes of public health are county-owned. Polyclinics, pharmacies, general practice and family medicine units, specialty medicine units, as well as laboratories can be private.

Although the county is responsible for organization of the primary and secondary level, the state for the tertiary level, the most important responsibility for the operation of health care is financial responsibility, which is organized by the Croatian Institute for Health Insurance.

Table1. Health service delivery indicators

Indicators	1992	1995	1998	2001	2003	2006
No. of hospital beds, per 1000 population	6.21	5.75	5.64	5.99	5.62	5.46
No. of physicians, per 100 000 population	197.52	203.58	228.81	237.79	261.78	271.00
Inpatient care admissions, per 100 population	11.73	13.44	14.18	15.79	16.22	16.96
Average length of stay, all hospitals, in days	15.2	13.2	12.6	11.8	11.0	9.94
No of nurses per 100 000 population	444.57	403.52	447.17	499.95	504.16	526.01
No of dentists per 100 000 population	42.49	55.95	67.74	68.08	71.68	74.79
No of pharmacists per 100 000 population	36.53	37.12	45.50	50.37	56.56	59.92

Sources: Croatian Health Service Yearbook, Croatian National Institute of Public Health

The health system is developed relatively well among the countries in the region. The heath personnel are well-trained and public health services are well established and organized. Around 30% of general practitioners are specialists in family medicine.

Table 2. Number of health institutions by type

Institution/Year	2000	2003	2006
Health centre	120	69	47
General hospital	23	23	22
Clinical hospital and clinic	12	12	12
Teaching hospital	2	2	2
Special hospital	30	29	29
Health resort	5	7	6
Emergency care station	4	4	4
Polyclinic	154	257	314
Nursing care institution	102	138	153
Pharmacy	121	163	177
Private practice units (Doctor's offices, laboratories, pharmacies, etc.)	6137	6598	6571
Occupational health institutions	1	12	12
Institutes of Public Health	21	21	21
Health company	6	5	46

Source: Croatian Health Service Yearbook, Croatian National Institute of Public Health

During 2003 and 2004 started a new intensive project of training of primary physicians as family physicians (180 each year) with the financial support from Croatian Health Insurance Institute (CHII). Some of health delivery indicators are shown in table 1, and health services indicators in table 2.

Financing and Reimbursement of Health Care

Two basic acts regulate health care and health insurance: Health Care Act and Health Insurance Act. In accordance with the former, Croatian citizens have health insurance based on the equal entitlement to overall health care with a high level of solidarity.

Health care in Croatia is financed from several sources. A major part of the Croatian health system is financed according to the national health insurance model. The funds are collected from the contributions from employees' salaries that are paid by employers based on salary percentage, from the farmers' contributions, and from transfers from the central government budget or county budget for certain categories of the population. Croatian government budget is providing more than 85% of funding for health care services (Croatian Health Insurance Institute-CHII funds are collected from compulsory health insurance contributions that are paid from salaries of insured persons). In Croatia health care allocations amount 9% of its GDP, which is significantly higher in comparison to the CEE and SEE countries.

According to the Health Insurance Act in Croatia, there are three main health insurance schemes: basic, supplementary and private health insurance.

Basic health insurance is compulsory and is provided by the Croatian Health Insurance Institute (CHII). Supplementary health insurance is also provided by the CHII as well as by private insurance companies. Private health insurance provides higher standard of health services than provided by the basic, obligatory insurance coverage.

The CHII insurance scheme provides basic health services to insured persons through their legal right on the so-called 'package/basket of health services'. This 'package/basket' strictly identifies health care services covered by the CHII, as well as health services that are paid through the supplementary health insurance scheme.

Apart from the participation charge, some health services are paid directly by the patients, such as non - prescription drugs. The citizens pay full price for some health services in private health institutions. This especially refers to dental health care, specialist-consultation service, and some services provided at private polyclinics, special state-owned or private hospitals (4).

Access to health care

Every citizen has right to choose his/her own primary health medical doctor: general practitioner/family physician or paediatrician (for children), and gynaecologist for control of pregnancy and gynaecological problems. Parents can also choose the GP for their children. This is mostly the case for the rural and underserved areas, but recently also for urban areas in the case that GP is family physician specialist. Individuals with chronic diseases are followed-up by general practitioners/ family physician (or paediatrician for children). GP can ask advice from the specialist if she/he can not solve the problem of the patient (diagnostic procedure, recommendation for treatment). Prescriptions for the chronic patient are done by GP.

For acute patients the procedure is the same as for the chronic patient. In the case of emergency, the emergency service is called by the patient or family. Emergency cars (ambulances) are equipped by physician, technician and driver. After health problem is solved by emergency services and hospital (if needed), patient will continue his/her care by his/her own doctor.

Patients with long term care use the health services in the same way, if they stay at home. If they need the nursing care there is community nursing service, what can do nursing services in the home. Patients GP is asked to prescribe such services. If patient needs such services for longer period than health insurance administration should confirm such needs. If patient is not able to live at home there is possibility to be hospitalized in the hospital for long term care, r she or he can go to elderly home. Each elderly home has rooms for bed-ridden patients. Nursing care in such situation is taken by nurses and assistant nurses employed by elderly home. Medical care in the elderly home is provided by GP.

Dental care is at primary level and the access to this care is free for everybody. Te most of dental care practices are private, but they have the contract with the health insurance for free treatment of population.

Physiotherapy is organized at community level; patients need the referral ticket from GP to the specialist (physiotherapist), who can order physiotherapy.

Patients can be seen by GP free of charge (before April, 2008 patients had to pay tax of 10 kunas per visit – up to 30 kunas per month). For the use of specialist service patient have to pay certain amount. This payment is covered by additional voluntary insurance, and patients who have this type of insurance will not pay tax.

EXERCISES

Task 1: Compare of intentions and realities in primary health care

Primary health care is a crucial term for the studies in public health and related specialties. It well known descriptive definition and explanation of meaning is described in the Declaration of Alma Ata (2). There are several layers in the meaning of that term. In this exercise we shall simplify it by speaking about principles and components or elements of primary health care. Dividing these two aspects may help in clarifying the exact meaning as we conceive it in practice.

You should answer the questionnaire individually and then compare the answers with the opinion of others in the group. Individual and group attitudes, estimates and judgements of principles and elements of primary health care as they appear "in theory" and “in practice” will be specified.

In expressing your own opinion in the questionnaire you should consider **real circumstances**. There are **no good or bad answers**, but differences in attitudes and individual experiences. You will find that some questions are ambiguous and general so that it is difficult to answer them. In such situations you should try to think in examples.

If you find differences between your answers and answers of your colleagues, you will discover that speaking in **concrete examples** and pictures contributes to mutual understanding far better than sophisticated abstract discussions. You will also find that, the same example may be judged differently from different points of view.

When summarizing the experience in the group, consider that the most common “miss – interpretations” of primary health care fall in some of the following categories:

PHC = **primitive** health care

PHC = **peripheral (rural)** health care

PHC = **personal** health care, primary **medical** care.

Besides, there are deep ideological controversies hidden under the term of primary health care. Is it meant to be the same as **basic health care**, or is it **selective** or **comprehensive** (integrated) PHC.

Expected outcomes for the task 1:

1. Answered questionnaire (see Annex)
2. Comments to answers, item by item, after consideration in your working group, discussing particularly differences between optimal and actual, and among situations in various countries.
3. Short summary report and suggestions to the plenary session.

Task 2: Comparisons of primary health care under different conditions

During the visits organized to different places in the country many data are collected about different organizational patterns of primary health care services. This was especially true for the old and new part of big urban areas and for rural areas with dense as opposite to scattered populations. This exercise is aiming to summarize your observations.

Table 3. Comparisons of different organizational patterns of primary health care

SPECIFIC AND TYPICAL CHARACTERISTICS	URBAN SETTING OLD	URBAN SETTING NEW	RURAL SETTING DENSE	RURAL SETTING SCATTERED
Population structure, social networks, community organization and participation				
Specific health risks and services needed				
PHC levels and health institutions				
Main organizational problems and dilemmas				

Using notes and impressions as well as results of discussions with colleagues after different visits summarize specific and typical characteristics of visited places in relation to population structure, specific health risks, structure and organization of primary health care. The task has to be fulfilled in small working groups and reported to the plenary session of participants for consideration.

The organization of health services is directly or indirectly dependent on population structure and dominant health problems, but also on tradition and leadership. Consider inter-relations of these factors. What you can learn after comparing the visited places with your own circumstances? Have you identified some elements or details which would be useful for your services? Have you learned some negative experiences to know what has to be avoided?

Expected outcomes for the task 2:

The table 3 has to be completed and compared with observations of colleagues.

REFERENCES

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2. WHO. Alma Ata 1978: Primary Health Care, HFA Sr. No. 1, 1978.
3. Kovacic L, Stipanov I. Optimal Development and Utilization of Primary Health Care in Zadar. European Journal of Public Health 1992; 2(3-4):212-214.
4. Voncina L, Jemiai N, Merkur S, Golna C, Maeda A, Chao S, Dzakula A. Croatia: Health system review. Health Systems in Transition, 2006; 8(7): 1-108.

RECOMENDED READINGS

1. Bjegovic V, Donev D (editors). Health system and their evidence based development. Lage: Hans Jacobs Publishing Company, 2004.

2. WHO. Improving Performance. The World Health Report 2000, Health Systems: WHO, Geneva, 2000.
3. WHO. Health in transition. Series of documents. Accessible at http://www.euro.who.int/observatory/Hits/TopPage

ANNEX: PRINCIPLES AND COMPONENTS OF PRIMARY HEALTH CARE QUESTIONNAIRE

Put cross on each scale:	how it should be	how it is now (Under existing conditions)
	No- -----x-----Yes 0 1 2 3 4 5	No------x-----Yes 0 1 2 3 4 5
1. <u>Principles</u>		
a. PHC makes a part of community development	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
b. PHC satisfies priority needs and demands of all people	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
c. Community participates in the decisions on PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
d. Community participates in health care activities	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
e. The poor people have better attention	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
f. Traditional arts in prevention and healing are included in PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
g. Principle of equity is implemented in allocation of resources	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
h. The self-reliance is the final goal of PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
i. Special programmes (like tuberculosis) are integrated into PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
j. PHC is an intersectoral approach to solving health problems (e.g. in nutrition)	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
k. The PHC is predominantly oriented to rural areas	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
l. Health services are available and accessible	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5

m. Hospitals are oriented to support PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
n. Hospitals are predominantly providing PHC services	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
o. The auxiliaries and voluntary workers make essential part of the PHC	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
p. The supervision of PHC services is strict and authoritarian	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
r. The referral system is well organized	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
s. PHC includes all types of health services and integrates them	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
t. The training institutions should lead services towards PHC goals	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
u. PHC has to get the major part of financial means	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
2. The following are the <u>essential components</u> of PHC:		
a. Education concerning prevailing health problems	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
b. Promotion of food supply and proper nutrition	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
c. Adequate supply of safe water and basic sanitation	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
d. Maternal and child health care including family planning (or birth spacing)	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
e. Immunization against major infectious diseases	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
f. Prevention and control of locally endemic diseases	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
g. Appropriate treatment of common diseases and injuries	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
h. Provision of essential drugs	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5

i. Mental health	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
j. Occupational health	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
k. Programmed care for disabled	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
l. Service for chronically ill persons (hypertension, and diabetes)	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
m. Care for aged	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
n. Dental care	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
o. Provision of emergency services	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
p. AIDS	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5
r. Other (specify)	No----------Yes 0 1 2 3 4 5	No----------Yes 0 1 2 3 4 5

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YOURS COMMENTS: