HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Reorientation of Health Services**
Module: 1.5	**ECTS: 0.5**
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Key words	health service, health service reform, primary health care, health promotion
Learning objectives	After completing this module students should: • recognize the importance of re-orientation of health service in order to foster health promotion and to achieve better health situation in the population; • differentiate between comprehensive and selective health care models; • understand that the process of re-orientation of health services, implementation itself as well as development and evaluation is an extremely complex task where all partners need to be fully involved and where new working methods need to be introduced.

Abstract	Health promotion is from one point of vision defined in terms of the several action areas among others comprising re-orientation of health services toward health promotion. According to this concept, health services were encouraged to move increasingly from predominantly curative approach to more preventive approach. The idea of comprehensive primary health care was launched. The paper is presenting problems related to application of comprehensive primary health care in practice in the period after adoption of Alma Ata Declaration. The case of Slovenia health care system and characteristics of its transition is presented as an example. Presented are current situation as well as broader context and possible solution in the future.
Teaching methods	Teaching methods include introductory lectures, exercises, and interactive methods such as small group discussions. Students after introductory lectures first carefully read the recommended papers on comprehensive and selective models of health care. Afterwards they discuss the concept of comprehensive health care with other students, and identify the pressures contemporary health systems are facing and the challenge of re-orientating health services towards comprehensive health care and health promotion.
Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 30%/70%; • facilities: a computer room; • equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases; • training materials: recommended readings are mainly available in the internet; • target audience: master degree students according to Bologna scheme.
Assessment of students	Assessment is based on seminar paper and oral exam.

RE-ORIENTATION OF HEALTH SERVICES

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Theoretical background

Basic definitions and explanation of terms

Re-orientation of health services

According to World Health Organization (WHO) (1, 2), re-orientation of health services is defined as a process which is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded. In this context the health needs of the individual as a whole person are in the central position, balanced against the needs of population groups.

This definition is strongly related to several relevant concepts among which the following are important for understanding of this module:

- the concept of health explanatory models;
- the concept of health needs, since the re-orientation of health services should lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person (1); and
- the concept of investment for health.

Health explanatory models

There exist several perspectives or approaches on what health is. Contemporary approaches in health promotion are (3):

- medical or biomedical approach – this approach views health as an absence of diseases or disease-producing physiological conditions. In this approach the centre of orientation is disease and selective disease treatment the key strategy;
- behavioural approach – this approach views health in terms of the behaviour and lifestyle of individuals. In this approach the centre of orientation is individual's behaviour;
- socio-environmental or bio-psycho-social approach – according to this approach health is being influenced by internal and external environment and therefore this is the most comprehensive approach. In this approach health is the centre of orientation and comprehensive influence on health determinants the key strategy.

Health needs

Among definitions of health need the most simple is a desire of people to remain healthy. However, health need is extremely complex entity and when it is related to the individual as a whole person it is composed of several components which include medically defined need or medical need, socially determined need and perceived need (4).

There exist several perspectives on health needs: a citizen (a »consumer«) perspective, health professional (a »provider«) perspective, and a payer perspective. In this context along with the expression "a need" the expression "a demand" is used.

The definition of these two terms is not unified since it depends on our stand-point perspective. For example, medical need is mostly defined as medically modifiable morbidity burden while medical demand is defined as the request of the citizen, this time in the role of patient (a »consumer«) for medical care services (5). This definition is primarily related to payer's perspective.

Investment for health

Investment for health refers to resources which are explicitly dedicated to the production of health and health gain (1).

Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies.

Investors could be public or private agencies as well as people as individuals or groups (communities).

Health services, health needs and a need for re-orientation of health services

Traditionally, health services are intrinsically oriented in disease (biomedical approach) and consequently in satisfying medically defined needs. In most but not all cases (e.g. vaccinations or screenings) satisfying these needs coincides with satisfying self-perceived needs of patients. On the other hand, health services are mostly not interested in considering social needs. If we sum up these characteristics, traditional health services hardly meet the demands of comprehensive approach to serve the health of the citizens.

As health care costs have skyrocketed in last half of a century, health services started to face enormous financial and ethical problems. On one hand this happened owing to improvements in medical technology, which made it possible to treat distinct diseases and disabilities with increasingly sophisticated equipment, for both diagnostic and therapeutic purposes. Since recent advances in clinical medicine improved prognosis of people with acute and chronic diseases, there is an increased need for specific training of health care providers. Rehabilitation and long-term care are in particularly important, which eventually leads to higher costs for health care.

How to solve the problem

Health care system with its health services has an important influence on health of the population. Nevertheless, we should keep in mind that it represents only one, although very important determinant of health. It is the interaction between the environment in which people live, work and play (natural and social environment, including economic, and cultural environment) and individual factors or inner environment (inherited factors e.g. genetics or acquired factors) have a marked influence on health status of an individual and of a population.

Beside health care system, one of the extremely important determinants of health is an economic system. Health care and economic systems are not independent (6). In fact they are closely related: healthier populations are more productive populations. Thus, from the economy perspective, the process of continuous, progressive improvement of the health status of individuals and groups in a population should be of enormous importance. Finally, both systems have enormous influence on health of the population.

The interrelationship of health, health care and the economy is one of the major themes of WHO's Health for All Strategy (2). The concept of investment for health that requires health to be put at the core of social, economic and human development was introduced (2, 7).

Although important, these two determinants are still not enough to achieve good health of a population. For achieving it (either, good health of individuals or a population as a whole) several determinants of health should be addressed and responsibility for health issues needs to be shared between many partners including individuals and communities.

Regarding health services this will require an expansion in health promotion and disease prevention action to achieve an optimal balance between investments in different types of health services: health promotion, disease prevention, diagnosis, treatment, care, and rehabilitation (1).

Whatever the process, it is necessary to keep in mind that health inequalities should be avoided and great attention on social responsibility for health should be emphasized.

Health promotion and re-orientation of health services

The basic WHO health promotion document, The Ottawa Charter (8), in 1986 defined health promotion in terms of the several action areas include beside building of healthy public policy, creation of supportive environments, strengthening of community action and democratic planning processes, developing of personal skills, re-orientation of health services toward health promotion as well. This last action area in fact means that health services were encouraged to move increasingly from predominantly curative approach to more preventive approach. The process of re-orientation of health services to health promotion was understood as a core element of a comprehensive approach to maximize the health capacity of a community (8, 9).

Historical perspective

The Ottawa Charter actually was not the first WHO document to introduce the idea of comprehensive primary health care[1]. This in fact was the core idea of The Alma Ata declaration (10). According to this declaration:

- everyone should have access to primary health care, and everyone should be involved in it. In another words, people have the right and duty to actively participate, individually and collectively, in the planning and implementation of their health care (1);
- people were treated as subjects and not merely as object in the health care process.

Primary health care was in this context seen as set of activities addressing the main health problems in the community, providing comprehensive approach and pointed out promotive, preventive, curative and rehabilitative role of health services. The key components of primary health care should be equity, community involvement and participation, intersectorality, appropriateness of technology and affordable costs (1).

But in opposition to the comprehensive primary health care approach, the selective health care approach was posed (11). Both approaches are distinctly different. The selective health care approach, for example, is basing on medical interventions and is oriented in curing the disease (basing on biomedical model of health) while the comprehensive approach rests on engagement with local communities, involvement of many sectors and dealing the underlying health determinants (basing on bio-psychosocial model of health). In fact, the selective health care approach could be understood more as primary medical care than primary health care. Since the adoption of Alma Ata Declaration the struggle between these two approaches is present and over time the selective approach started to prevail.

The First International Conference on Health Promotion with its sound document Ottawa Charter (8) could be understood as the first visible response to this departure from the Alma

1 According to WHO, primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (1).

Ata vision. The comprehensive approach has got new impulsion. But unfortunately, in few years after launching the concept of health promotion, the selective approach became again more powerful than comprehensive.

The next response in WHO European Region was The Ljubljana Charter on Reforming Health Care (12), which was adopted in 1996. This Charter addresses health care reforms in the specific context of Europe and is centred on the principle that health care should first and foremost lead to better health and quality of life for people. It was stressed that health services are important, but they are not the only sector influencing peoples' wellbeing. Other sectors also have a contribution to make and responsibility to bear in health and intersectorality must therefore be an essential feature of health care reform. This Charter was characterized by 5 principles of re-organization of health care services: health care reforms should be driven by values, targeted on health, centred on people, focused on quality, based on sound financing, and oriented towards primary health care. The later should ensure that health services at all levels protect and promote health, improve the quality of life, prevent and treat diseases, rehabilitate patients and care for the suffering and terminally ill, and they should promote the comprehensiveness and continuity of care within specific environments. For a while, this was fresh impetus to comprehensive approach. The same was again repeated in the Jakarta declaration adopted in 1997 (13).

In following years, the idea of "investing in health" strengthened. This idea, unfortunately, meant new departure from comprehensiveness of health care, being driven by profits gained by investing in health (not for health) (11). This resulted in disadvantageous health phenomena in many countries. By the end of the twentieth century, for example, it was evident that Health for All by the Year 2000 would not be achieved and that for some countries life expectancy and some other health indicators were going backwards. As a response to this unfavourable trend the People's Health Movement was raised (14). This Movement draws its inspiration from Alma Ata declaration. The First People's Health Assembly was held in Bangladesh in December 2000, and the People's Health Charter was adopted there (15). It calls for a people cantered health sector that is based on comprehensive primary health care.

What could be done

Certainly, there is a strong need for health care services reforms. Greater investment for health implies re-orientation of existing resource distribution within the health sector towards health promotion and disease prevention. A significant proportion of investments for health should be undertaken by people in the context of their everyday life as part of personal and family health maintenance strategies. This was realized in many different countries (5, 16-20).

There are several reasons for going this direction. They include the rise of new public health challenges anticipated for new millennium, like aging of the population in developed countries associated with higher prevalence of chronic non-communicable diseases (e.g. cardiovascular diseases and cancer), or emerging infectious diseases (e.g. BSE, SARS, avian influenza), as well as strengthening the ability of societies to reduce inequities in health.

Despite the need for re-orientation of health services, most of the previous reforms had been oriented in higher efficiency of services (the supply side of the health care) and only few considered the demand side (improving health of the population by investments for health)

(5). Nowadays, the situation remains similar. The process of re-orientation of health services to be more supportive of health promotion evidently should be strengthened (16).

SWOT analysis of re-orientation of health services

Strengths and opportunities

One of the main opportunities of health care services in their role to serve to the health of the population in the future, it will be to take over the key role in supporting inter-sectoral action for health. Achieving equity in health could not be possible without coordinated intersect oral activities.

Weaknesses and threats

The process of re-orientation of health services into the direction of health promotion has its weaknesses. It is definitely not easy since it requires an increase in the capacity of the health service staff themselves and of the organization (16). This fact presents certainly one of the major weaknesses and limitations to health care systems to go this direction. It is the well known fact that health care systems all over the world are getting more and more expensive. The growing cost of care is associated with higher levels of chronic diseases and disability, the increased availability of new medical treatments and technologies, and rising public expectations. Going the direction of re-orientation to health promotion definitely would increase the costs. Although this would only be of temporary nature, we should be aware of it.

Also, an expanded role of primary health care services could not be achieved only through an increase in direct health system activity. Action by sectors other than the health sector may be more effective in achieving improved health outcomes. This could be seen as another weakness. Health services have only a limited impact on the health status of a population without other activities directed in health of the population since key determinants of health lie outside the health sector (21). Policies in areas such as education, employment, and agriculture often have even greater impact on population health than medicine. Therefore, cooperation of primary health care with other sectors is strongly needed.

An important threat to this process is the fact that in 1990s WHO lost its leading position in the field of international public health and World Bank became the major player. »Investing in health« becomes the well known slogan of this organization at that time. The basic problem in this context is that achieving good population's health seems not to be the main goal of World Bank (11). Organizational arrangements that had originally been meant to improve equity in access to health have increasingly been constrained by the concern for effective cost containment. A lot of countries responded with a series of measures to control cost pressures. The economic aspect prevailed over the moral imperative of maintaining solidarity and the social good character of health care.

Recent findings

Historically, the struggle between comprehensive and selective health care approach seemed to be more in favour of the later yet recent findings probably show opposite. Comprehensive health care approach was considered to be too idealistic and expensive and in many respect defeated by selective approach. Consequently, the later prevailed whilst recent studies indicate that it has not been effective (22). On the contrary, comprehensive

health care including health promotion and disease prevention can save money. How much, it depends on the programme, demographic and other characteristics of the population, the diseases structure, and whether short-term or long-term community outcomes are considered. In these times, when costs of medical care are escalating, especially high technology medical care, this fact should not be overlooked. The only time when prevention could be more expensive than treatment is when disease or injury is infrequent and moves quickly to death before major expenses are incurred. But we need to be aware that the argument for prevention in the frame of comprehensive health care cannot - and should not - be made primarily on economic grounds.

It is encouraging, that the re-orientation of health services to more comprehensive approach including health promotion is coming again on the agenda of global health policy rethinking (17, 18, 22).

Case study - primary health care in Slovenia and its orientation

Slovenia and health care reforms

In Slovenia the need for reforming health care system was realized immediately after it became independent. The process started in 1992 by adopting new legislation (23-25). The reasons were political (to open the health care system to private initiative and a more diverse organizational approach) and economic (cost-containment, multiple contributions - national insurance and voluntary insurance fees- and a mixed public and private health care system) (24). It is sill going on.

Since the emphasis in comprehensive health care systems is on primary health care services the SWOT analysis on this segment of health care system is presented.

Primary health care services in Slovenia

Strengths

Traditionally, in Slovenia primary health care has a long and firm tradition. Community health centres were providers of primary health care before independency of Slovenia. Today, more than 15 years later, they are still the main providers of this kind of health care, though they were subjected to the radical changes soon after Slovenia attained its independence (26). The process is still ongoing.

Community health centres are the institutions which bear traditions from the ideas of Andrija Štampar, a distinguished scholar in the field of social medicine, born in Croatia. The first community health centre in Slovenia was established in 1926 (23, 25, 27, 28). The original idea was to deliver primary health care to the population at the level of the local communities and to provide various types of care in an integrated approach, especially to endangered population groups e.g. children, women, etc. For this purpose community health centres had special units, called dispensaries (27, 28).

Today, by law and in practice, community health centres are institutions that provide both, preventive and curative primary health care for different target population groups (many of them are from a public health standpoint at higher risk). The types of care include (23): emergency medical aid, general practice/family medicine, health care for women, children and youth, home nursing, laboratory and other diagnostic facilities, preventive and curative dental care for children and adults, health aids and appliances, pharmacy services, physical therapy, and ambulance services.

In 1999, Slovenia had 64 community health centres and 69 health stations. A primary health care facility (health care centre or health care station) is available within 20 kilometres from almost all locations. In rural areas, a physician's practice is more that of a family physician and a physician may have as many as 3000 patients, whereas in Ljubljana, the capital, a physician may have as few as 750 patients. The average number of patients per general practitioner is about 1800 (which normally includes only up to 10% of all children since their care is usually organized through primary care paediatricians) (23).

In the past, different types of care were facilitated, as previously mentioned, by the organization of dispensaries. The important characteristic of dispensaries was orientation not only in curing individuals with the disease but, at least at the very beginning, mainly in preserving good health of endangered groups of individuals as well as that of communities. The natural and social environment was considered as important determinant of health.

After the independency of Slovenia, in community health centres the era of transition started, which is still in a process. Today, some of dispensaries are still existing, e.g. for children and youth, but their role is slowly changing from more preventive orientation to more curative one.

We could conclude that in Slovenia the comprehensive primary health care approach was launched even before it was encouraged by the WHO. Unfortunately, the transition went in opposite track than it was proposed by WHO.

Weaknesses

As mentioned above, as the years passed by, the dispensaries were starting to disappear as an important part of health care at the primary level, and the selective approach prevailed over the comprehensive approach. Some of dispensary services are still organized, mostly as purely supplementary outpatient specialist services.

Another weakness is that actually many community health centres collapsed in the recent years and functionally ceased to exist in several parts of Slovenia while still developing and being well integrated into the new concepts in other parts of the country. This resulted in disparities in physical access for people in different parts of Slovenia. Part of this problem was also the long unsolved issue of publicly owned premises and their availability for (potential) private providers of health care. As no national guidelines were prepared for this problem until late in the process, many providers left the publicly owned premises and started developing their own as private providers.

Threats

Community health centres are still the main (public) providers of primary health care in Slovenia. Apart from public health care providers, the number of private providers is increasing. Private care is provided by either individual health professionals acting as providers or by group practices with various combinations of services and specialties. The self-governing community grants concessions for private primary health care providers (based on the consent of the Ministry of Health). Such a concession is a public contract, which ensures inclusion into the network of publicly financed health care providers. In the private sector material gain is one of the most important driving forces and this fact should be considered as an important threat to the further development of the comprehensive health care at the primary level (29).

Opportunities

It is undeniably that private sector could have many positive impacts on quality of health care (29). They are market orientated and therefore they need to take into consideration all key business operation with special emphasis on quality and economy of the working process.

Private provision also introduced competition, until then mainly unknown phenomenon in Slovene health care. Although private practitioners with contracts with the Health Insurance Institute of Slovenia work alongside the publicly employed physicians, competition arises by virtue of the competitive process associated with winning a contract.

Possible future alternative in Slovenia

Regional institute of public health as a central regional primary health organization

Features of health systems that encourage collaborative partnerships are those where there is:

- an environment that encourages trust;
- a common purpose among the key players;
- a supportive external environment;
- practical projects to work on;
- organizational stability;
- commitment from staff throughout organizations;
- willingness to commit resources;
- evidence that change is likely to improve outcomes for users, and
- an organizational environment in which learning from past experience is encouraged.

A number of constraints and tensions that work against introducing a greater emphasis on re-orientation of health services and collaboration within the system should be addressed and discussed, including tensions between central funding and health care management, experts and the reform fatigue which is underlined by increasing cynicism among staff resulting from continuous change. Against the chaotic background of contemporary health service reform it is very difficult to bring about genuine reform to achieve a shift to more emphasis on comprehensive approach in health care.

During last few decades the most important mission of Slovenian Regional Institutes of Public Health has been to identify the hazards that are threatening the health of population and proposing and introducing measures to avoid the threats and to preserve health, especially on population level.

In the last years, since it is very clear that privatization in primary health care in Slovenia is an ongoing process possible alternatives have been discussed to find ways how order to preserve and further develop programmes on primary prevention on individual level which have been started many years ago and are proven to be successful. Among the options, there is a serious consideration that Regional Institutes of Public Health get a new mission - development and coordination of preventive programs on the primary level. This model enables private sector to take over an important sphere of activity, which till now was in the competence of health centres. On the other hand, as developers and coordinators, public health institutions will be able to preserve public health interests.

The advantages of the Regional Institutes of Public Health when applying for the »coordinator« role in the development process of re-orientation of health services are:

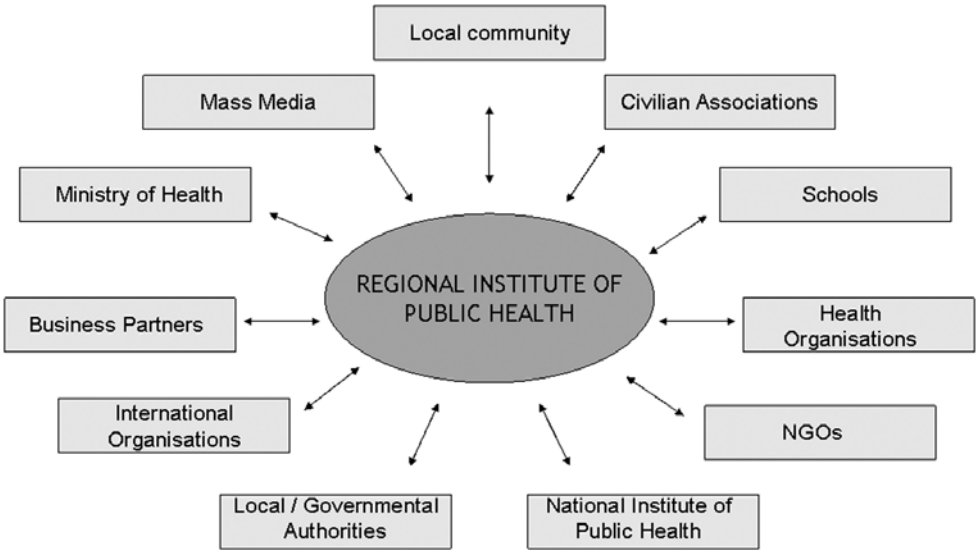
- wide scope of connections made with various social subsystems and their organizations;
- variety of communications skills;
- variety of professions, tasks and working methods used and thus more open for successful introduction of new forms of work;
- awareness and understanding of the importance and possibilities of re-orientation of health services.

Numerous connections, both from the institutional as well as territorial aspect, fostered for the purpose of performing various professional tasks, have enabled the formation of an extremely rich network of adapted means of communication. These organizations have the distinction of great flexibility and are, more than others, able to seek paths not yet trodden and to create new social network, required in the implementation process of health promotion strategy.

Figure 1 shows the complexity of connections made by e.g. Regional Institute of Public Health. The interconnections among individual organizations are not shown, although rich in number as well.

Besides all previously mentioned characteristics, the Regional Institutes of Public Health are state owned and are therefore programme and not profit oriented.

Figure 1. An example of different communications and connections held by the regional re-orientation



The tool

Re-orientation of health services is not possible without radical changes in approach to and method of work. As this is the case of intervention in several social subsystems, the project method which is becoming the most important tool for performance of new, complex tasks is considered the most adequate tool for in the process of re-orientation of health services.

This kind of approach to work was initially characteristic only for profit oriented enterprises, whereas it can currently also be observed in non-profit organizations. My be the best prove that this approach is the right one is the fact that the international health promotion movement uses project method as a fundamental approach to task performance and is anticipating the use of this tool for implementation of health promotion in various settings e.g. business enterprises, schools, hospitals. Project management has proven to be successful also in performance of programmes, focused on changing lifestyles and improving ecological conditions. It is only through the project approach that interdisciplinary co-operation can be implemented, which is regarded as essential to the performance of new tasks in re-orientation of health services.

Key features of a project dealing with re-orientation of health services are:

- it is a type of organization to perform complex, new tasks of various sectors within a single organization or among various organizations;
- it is an instrument to introduce changes planned in an organization;
- it mobilizes and redirects resources from one or more systems to new tasks;
- it evaluates and verifies the efficiency of new forms of co-operation and integration among individual departments and organizations;
- it gives the participants the opportunity to acquire fresh experience and skills to be later incorporated in their everyday activity;
- it exerts positive influence on the entire organization or other organizations, taking part in the project.

Development and interaction of knowledge among professionals is an integral part of project management. New tasks usually require new expert knowledge as well as different application of knowledge with experience (30).

Institutes of Public Health have, due to their role in the society of today, developed various kinds of knowledge and skills to facilitate the implementation of project work. They are closely connected with several social subsystems so they stand a real chance of undertaking the role of co-coordinators in the process of health services re-orientation.

Exercise

The main aim of the exercise is to get the students acquainted with the importance of re-orientation of health service in order to foster health promotion and to achieve better health situation.

Task 1:

Carefully read the papers:

Magnussen L, Ehiri J, Jolly P. Comprehensive versus selective primary health care: lessons for global health policy. Health Affairs 2004;23:167-176. Available at URL: http://content.healthaffairs.org/cgi/reprint/23/3/167.pdf (Accessed: August 10, 2007).

and

Baum F. Health for All Now! Reviving the spirit of Alma Ata in the twenty-first century: An Introduction to the Alma Ata Declaration. Social Medicine 2007;2:34-41. Available at URL: http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/76/187 (Accessed: August 10, 2007).

Task 2:

Identify the pressures contemporary health systems are facing and the challenge of re-orientating health services towards comprehensive health care and health promotion in specific environment.

Task 3:

Discuss the process of re-orientation of health services in your environment and try to evaluate the achievements in this field as well as factors that stimulate or hinder this process.

At the end of the module students should understand that the process of re-orientation of health services, implementation itself as well as development and evaluation is an extremely complex task where all partners need to be fully involved and where new working methods need to be introduced.

References

1. World Health Organization. Health promotion glossary. Geneva: World Health Organization, 1998.
2. World Health Organization, Regional Office for Europe. Health 21: the health for all policy framework for the WHO European Region. Copenhagen: World Health Organization, Regional Office for Europe, 1999.
3. Laverack G. Health promotion practice. Power and empowerment. London: SAGE Publications, 2004.
4. Kalimo E. Health service needs. V: Holland WW, Ipsen J, Kostrzewski J (editors). Measurement of levels of health. Copenhagen: World Health Organization, Regional Office for Europe, International Epidemiological Association, 1979. p.64-72.
5. Fries JF, Koop CE, Sokolov J, Beadle CE, Wright D. Beyond health promotion: reducing need and demand for medical care. Health Affairs 1998;17:70-84. Available from: URL: http://content.healthaffairs.org/cgi/reprint/17/2/70 (Accessed: August 10, 2007).
6. Zöllner H, Stoddart G, Selby Smith C. Learning to live with Health Economics. Copenhagen: WHO Regional Office for Europe, 2003.
7. Roberts JL. A glossary of technical terms on the economics and finance of health services. Copenhagen: WHO Regional Office for Europe, 1998.
8. World Health Organization. Ottawa Charter for Health Promotion. First international conference on health promotion: The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada. Ottawa: World Health Organization, 1986. Available from: URL: ttp://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (Accessed: August 10, 2007).
9. Lopez-Acuna D, Pittman P, Gomez P, Machado de Souza H, Fernandez L. Reorienting Health Systems and Services with Health Promotion Criteria. Technical paper prepared for the Fifth International Conference on Health Promotion, 5–7 June 2000, Mexico City. Geneva: World Health Organization, 2000. Available online at URL: http://www.who.int/hpr/conference/products/techreports/indextechreports.html (Accessed: August 13, 2007).
10. World Health Organization. Declaration of Alma Ata: International Conference on Primary Health Care, Alma Ata, USSR, 6–12 September 1978. Available from: URL: www.who.int/hpr/NPH/docs/declaration_almaata.pdf (Accessed: August 10, 2007).
11. Baum F. Health for All Now! Reviving the spirit of Alma Ata in the twenty-first century: An Introduction to the Alma Ata Declaration. Social Medicine 2007;2:34-41. Available from: URL: http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/76/187 (Accessed: August 10, 2007).
12. World Health Organization. The Ljubljana Charter on Reforming Health Care, 1996. Available from: URL: http://www.euro.who.int/AboutWHO/Policy/20010927_5 (Accessed: August 30, 2007.

13. World Health Organization. The Jakarta Declaration on Leading Health Promotion into the 21st Century. Geneva: World Health Organization, 1997. Available from: URL: http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf (Accessed: August 10, 2007.
14. People's Health Movement. Available from: URL: http://phmovement.org/ (Accessed: August 10, 2007.
15. People's Health Charter. Available at URLs: http://www.healthwrights.org/static/nl44-charter.PDF; http://www.phmovement.org/pdf/charter/phm-pch-english.pdf (Accessed: August 10, 2007.
16. Yeatman HR, Nove T. Reorienting health services with capacity building: a case study of the Core Skills in Health Promotion Project. Health Promotion International 2002;17:341-350. Available from: URL: http://heapro.oxfordjournals.org/cgi/reprint/17/4/341.pdf (Accessed: August 10, 2007.
17. The Verona Initiative. The Verona Challenge. Investing for health is investing for development. Verona: World Health Organization, Regional Office for Europe, 2000.
18. Hall JJ, Taylor R. Health for all beyond 2000: the demise of the Alma Ata Declaration and primary health care in developing countries. MJA 2003;178:17-20.
19. Green A, Ross D, Mirzoev T. Primary health care in England: the comming of age of Alma Ata? Health Policy 2007;80:11-31.
20. World Health Organization, Regional Office for Americas. Renewing Primary Health Care in the Americas. A Position Paper of the Pan American Health Organization/World Health Organization (PAHO/WHO). Washington: PAHO/WHO, 2007.
21. Saltman RB, Figueras J. Analyzing The Evidence On European Health Care Reforms. Health Affairs 1998;17:85-108.
22. Magnussen L, Ehiri J, Jolly P. Comprehensive versus selective primary health care: lessons for global health policy. Health Affairs 2004;23:167-176. Available from: URL: http://content.healthaffairs.org/cgi/reprint/23/3/167.pdf (Accessed: August 10, 2007).
23. Albreht T, Česen M, Hindle D, Jakubowski E, Kramberger B, Kerstin-Petrič V, Premik M, Toth M. Health care systems in transition: Slovenia. Copenhagen: European Observatory on Health Care Systems, 2002.
24. Markota M, Švab I, Saražin Klemenčič K, Albreht T. Slovenian experience on health care reform. Croat Med J 1999;40:190-4.
25. Albreht T, Delnoij DMJ, Klanzinga N. Changes in primary health care centres over the transition period in Slovenia. Eur J Pub Health 2006;16:237-42.
26. Premik M (editor). Expert conference: Primary health care; public and private sector (in Slovene). Ljubljana: Univerza v Ljubljani, Medicinska fakulteta, Inštitut za socialno medicino, 1995.
27. Urlep F. Primary health care services in Slovenia in the last hundred years (in Slovene). In: Premik M (editor). Expert conference: Primary health care; public and private sector (in Slovene). Ljubljana: Univerza v Ljubljani, Medicinska fakulteta, Inštitut za socialno medicino, 1995.
28. Premik M. Primary health care and community health centre (in Slovene). In: Premik M (editor). Expert conference: Primary health care; public and private sector (in Slovene). Ljubljana: Univerza v Ljubljani, Medicinska fakulteta, Inštitut za socialno medicino, 1995.
29. Česen M. Developmental obscurities of public-private mix in health care (in Slovene). In: Premik M (editor). Expert conference: Primary health care; public and private sector (in Slovene). Ljubljana: Univerza v Ljubljani, Medicinska fakulteta, Inštitut za socialno medicino, 1995.
30. Eržen I. Project management in health promotion. In: Semolič B, Hauc A, Kerin A, Kovač J, Rozman R, Škarabot A (editors.). SENET 1st South East Europe Regional Conference on Project Management, November 9-11, 2000, Ljubljana. Proceedings and final programme. Ljubljana: Slovenian Project Management Association, 2000. p. 120-125.

Recommended Readings

1. Baum F. Health for All Now! Reviving the spirit of Alma Ata in the twenty-first century: An Introduction to the Alma Ata Declaration. Social Medicine 2007;2:34-41. Available from: URL: http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/76/187 (Accessed: August 10, 2007).
2. Fries JF, Koop CE, Sokolov J, Beadle CE, Wright D. Beyond health promotion: reducing need and demand for medical care. Health Affairs 1998;17:70-84. Available from: URL: http://content.healthaffairs.org/cgi/reprint/17/2/70 (Accessed: August 10, 2007).
3. Magnussen L, Ehiri J, Jolly P. Comprehensive versus selective primary health care: lessons for global health policy. Health Affairs 2004;23:167-176. Available from: URL: http://content.healthaffairs.org/cgi/reprint/23/3/167.pdf (Accessed: August 10, 2007).
4. World Health Organization. Declaration of Alma Ata: International Conference on Primary Health Care, Alma Ata, USSR, 6–12 September 1978. Available from: URL: www.who.int/hpr/NPH/docs/declaration_almaata.pdf (Accessed: August 10, 2007).

5. World Health Organization. Ottawa Charter for Health Promotion. First international conference on health promotion: The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada. Ottawa: World Health Organization, 1986. Available from: URL: http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (Accessed: August 10, 2007).
6. World Health Organization. The Ljubljana Charter on Reforming Health Care, 1996. Available from: URL: http://www.euro.who.int/AboutWHO/Policy/20010927_5 (Accessed: August 30, 2007).
7. Yeatman HR, Nove T. Reorienting health services with capacity building: a case study of the Core Skills in Health Promotion Project. Health Promotion International 2002;17:341-350. Available from: URL: http://heapro.oxfordjournals.org/cgi/reprint/17/4/341.pdf (Accessed: August 10, 2007).