MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**STRATEGIES FOR DEVELOPMENT AND STRENGTHENING OF GENERAL PRACTICE/FAMILY MEDICINE AS PART OF PRIMARY HEALTH CARE**
Module 4.1	**ECTS: 0.2**
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Keywords	General Practice, Family Medicine, Primary Health Care, Organization of Health Services
Learning objectives	After completing this module students and public health professionals should: • be aware of different strategies in development of general practice/Family medicine; • recognize needs for health care reforms in primary health care; • know the characteristics of different models of organization of general practice/family medicine; • improve the knowledge and understanding of the of function of the health care system.
Abstract	The health reforms went diverse ways in different countries, but everywhere under powerful influence of political, economic and social changes. The market principles were proposed (and not very successfully applied) to a situation of poor and apparently egalitarian systems. The importance of primary care was underlined, but it was often disintegrated, overspecialized and inadequately supported. Facing a burden of social problems the centralized state solutions as well as participatory social movements had only momentary effects, so that strengthening of local and family capacities, supported by a team of generalist professionals emerged as the best choice. It was advocated by empirical results in most of developed countries. Based on experience from Croatia and other countries the strategies were identified for implementing the generalist professional approach as a basis of PHC services. Firm political decision, vocational training and development of professional identity of general practice/family medicine (physicians and nurses) were essential starting points. Organizational arrangements, academic/scientific support, and international relations have to stabilize further development.
	Independent contractual relation of professionals with financing institutions and group practice in form of integrated small health centres, appear to be the best nucleus of primary health care.
Teaching methods	Introductory lecture, exercises, individual work and small group discussions.

Specific recommendations for teachers	• work under teacher supervision /individual students' work proportion: 30%/70%; • facilities: a teaching room; • equipment: internet; PC and LCD projection; • 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.

STRATEGIES FOR DEVELOPMENT AND STRENGHTENING OF GENERAL PRACTICE/FAMILY MEDICINE AS PART OF PRIMARY HEALTH CARE

Želimir Jakšić

THEORETICAL BACKGROUND

Recent health care reforms and primary health care

The rapid changes in type of health needs, visible ageing of populations, social problems such as migrations, unemployment, growing social divisions and insecurity, more knowledgeable patients with higher expectations, hopes in technological panacea, mounting costs of health services, all of them together, triggered the new wave of health reforms in all countries. It is under strong influence of deep turn from egalitarian to libertarian views. High expectations are associated with market principles and free enterprises in economics, what is reflected in social, health and other public services (1).

The effectiveness, efficiency and equity in health care, quality and satisfaction of people with services are the essential goals of reforms. As an important factor emerged the general/family practice which according to experiences may influence radically the health system in the desired direction.

The evaluation studies in most developed countries showed that both rational use of resources and satisfaction of people may be influence by services in which a considerable role is plays general/family practice (2-4).

According to circumstances and traditions the countries have diverse positions and stress different expectations. The economic and cost-containment concerns where at the top in most countries, followed by equitable distribution of services. Many others follow, like implementation of subsidiary principle, involving families and local communities, substitution of institutionalized care by home care etc.

Essential intentions in developing primary health care for 21st century

The great change from egalitarian to libertarian paradigms in economics, social and health policies is still influencing tensions inside health sectors. The big international organizations from the same UN family have conflicting views (e.g. WHO and World Bank) stressing different approaches to further development. The World Health Report "Life in the 21st century - A vision for all" (5) and the new global policy "Health for all in the 21st century"(6) stress social problems and poverty as main contribution to ill health, still follow the predominantly egalitarian approach and build on successful experiences of growing acceptance of primary health care strategy.

> *"Building on primary health care, health systems should be: community based and comprehensive, including promotive, preventive, curative and rehabilitative components; available continuously; closely linked at all levels to social and environmental services; and integrated into a wider referral system".*

"Maximum freedom should be sought for local services…Long-term care should be primarily provided in the community through non-hospital institutional care and home-based services".

However, no specific organizational form of care is envisaged and less stress is given to participation and economics, now popular in health reforms. Contrary, the social aspect is stressed: a decentralized, sustainable and scientific evidence based care, meeting the social, cultural and spiritual needs of different groups, is recommended. Fostering innovation and human resources for health are among essential health system functions.

In the proposed new European WHO policy document (7) the targets are more specific, as e.g. Target 19: "Primary health care with a family-oriented health services at its core":

"By the year 2010, at least xx% of people in Member States should have access to a physician and a nurse of their choice, both specialized in family health, as a first level of care and to other specialist services when required.

This target aims at:

- *By the year 2005, all countries having adopted the basic concepts of integrated primary health care services, based on professional team work and adequately supported by secondary and tertiary hospital services;*
- *By the year 2005, the principle of family health physicians and family health nurses working at the core of this integrated primary care service having been accepted by all countries; …"*

For better understanding it is also important to quote a WHO document, named "Framework for professional and administrative development of General Practice/Family Medicine in Europe" (8a). It comes as a result of a contribution of several WHO collaborating centres for primary health care in Europe, first as a draft of a "Charter for General Practice/Family Medicine in Europe" in 1992. After wide discussions in over 200 international and national associations and professional organizations of physicians and of general practitioners, as well as other health professionals contributing to primary health care in Europe, the revision of the draft Charter was produced in a consultation meeting in Copenhagen 1998. In the section on purpose of the document one of conclusions is:

"General practice can thus contribute to an effective and efficient primary health care service of high quality, which should positively affect the workload and quality of specialized and hospital care".

In the following section the characteristics of General Practice are described, and as the main titled "general" one can read:

"General practice addresses the unselected health problems of the whole population; it does not exclude certain categories of the population because of age, gender, social class, race or religion, or any category of complaint or health-related problem. It must be easily accessible with a minimum of delay; access to it is not limited to geographical, cultural, administrative or financial barriers".

Under section on conditions for the development of GP/FM the structural conditions (discrete general population, working environment close to patients and referral system), organizational improvements and professional development are mentioned.

Very important issues are described under professional development, such as:

- specific education and vocational training required for all those to become a family physician;
- quality development through audit carried out in peer groups;
- role and function of academic departments of general practice;
- research;
- development of effective professional organization.

The essentially same political statement was repeated 10 years later (8b).

Summing-up, one may conclude that the experiences gained from health reforms are becoming a realistic input for health policies on turn of centuries. The simplified traditional libertarian solutions of individualism and free enterprise, introduction of health market corrected by high moral standards and charity, are not a guarantee against growing social problems and weakening of social networks. As answers are offered two traditional lines of understanding what is most important for primary health care:

- the first, technical, stressing evidence based medicine, high standards of quality, efficiency and professionalism (a line closer to libertarian philosophy and to traditional public health);
- another line stressing the need of equity in health as basic right of people, subsidiary, community participation and empowerment, strengthening of primary groups, like neighbourhoods and families (a line closer to egalitarian philosophy and to so called "new public health").

Both separately are a try against dominant social currents and practices, appealing to human rationality, tolerance, social concern and solidarity, an important hope, but without final proof.

The new pragmatic policy, as presented in quoted documents are recognizing need of unifying both approaches, as it is presented in a new attitude towards generalist professionals (GP/FM) at roots of the health system. Facing this orientation, practically all countries have to revise their practices, developed, developing or new established states. Many different ways could be envisaged, increasing diversity of practical solutions in different circumstances.

Reflection on experiences

A new approach to general/family practice

A new approach to GP/FM was considered in all European countries CCEE (4,9,10). The situation was different: in some countries even the clear notion was not present about what is and what should be the GP/FM; in others the long tradition petrified some approaches inappropriate to new tasks. The different strategies were necessary, but essentially they may be defined in several groups of elementary strategies. Their relative importance might vary according to different phases of development. The particular elements were installing or reforming training (vocational training, different forms of continuous education and participation of practitioners in undergraduate training), changing the financing of health care ("privatization", contractual relations of professionals with the financing agencies, self-contribution by patients), the reorganization of services (individual and group practices, changes in division of work at the primary level, different types of managed care), raising the social and professional status of GP/FM (9).

Unfortunately the feeling of urgency has influenced some mechanical shortcuts and contra-productive impositions of health administrations: the destruction of entrepreneurial self-confidence instead of flexible supporting of its development.

The transitional phase is far more complex than it was expected. Models are less transferable among countries. Propositions and perspectives are not quite understood and seemingly undesirable. Population is conservative and threatened by changes. The new challenges are not welcomed by the "silent majority".

The enthusiastic minority might be confronted with many difficulties, needs support and the strategies have to be specified and thoroughly carefully thought about.

The major strategies are similar, but their form and timing will differ

Although many experiences already exist, simplification and schematization may lead to errors. This general consideration should primarily serve as a frame for consideration of every individual strategy and a way to exchange experiences and not as a proposed prototype. However, the moves triggering change are similar.

Table 1. Choice of major strategies in different phases of development

MAJOR STRATEGIES : Constructing support by	PHASE 1 Start and initial growth	PHASE 2 Positioning in the system	PHASE 3 Building int. strength	PHASE 4 Sustained empowerment
PUBLIC IMAGE AND PATIENTS'SATISFACTION				
INTERNATIONAL RELATIONS				
RE-INTEGRATION OF PRIMARY SERVICES				
COLLABORATION, RATIONALIZATION				
POLITICAL RECOGNITION AND SUPPORT				
VOCATIONAL TRAINING, NEW IDENTITY				
PROFESSIONAL EMPOWER-MENT AND ORGANIZATION				
ACADEMIC ROLE AND POSITION (R&D)				
REFLECTIVE EXCHANGE OF EXPERIENCES				
PERSONAL CARE AND QUALITY PRACTICE				

The table 1 is combining a choice of elementary strategies, of which the first five are predominantly based on “external” activities originated by governments, health administration etc., while the second group of five are predominantly "intrinsic", i.e. initiative is expected by profession itself.

The most important long-range strategy is reliable provision of personal high quality cars and patient satisfaction.

The triggers pushing the change are usually political recognition of GP/FM as important and unavoidable element of health system and vocational training leading to technical self-confidence and entrepreneurship.

After these first steps the "intrinsic" strategies were usually essential for further development: professional empowerment, taking over academic positions and tasks, and gaining managerial skills.

These strategies could hardly be successful without open communication and close collaboration with partners and finally institutionalization of integrated primary care services. Described strategies depend on circumstances, but to become successful have to be based on a proactive, flexible and open-minded behavior of the GP/FM profession.

Beyond correction of poor practices

The greatest gap between intentions and real achievements of PHC and GP/FM was the wider outlook on care in community and collaboration with all partners, sectors and services. The major role in choosing proper solutions has to be given to people them, but a technically informed advice is necessary. An important strategy in developing GP/FM is to continue and further develop the traditional role of general practice to be advocate and consultant to people, even to protect them in case of insulting marketing of health and medicine.

However, it cannot be achieved if regarded only as a superficial correction of accustomed behavior learned during administratively lead system. It also depends of a deep rooted insecurity and ambiguity learned by vague overall definition of primary care. There is poor understanding and differentiation of certain "kinds" of primary health care, using similar and familiar terms, but with opposite meaning, i.e.: comprehensive, selective, community or family oriented primary health care. The comprehensive or integrated primary health care is the choice, because it has growing role confronting the contemporary problems in developed countries: elderly, poor, and chronically ill and those with psychical problems. It is more complex and difficult than selective approach, it stresses the need for team work, consultations and collaboration, all what is making troubles and regularly hated and avoided by independent practitioners. How to combine the personal care with that broader open-mindedness is a real challenge (3,4).

Building up awareness of the new role, independent thinking based on practical experience, establishing a self-confident professional organization will certainly in most new-comers be a sign of mature achievements.

Obstacles and what one can do about them

Unfortunately in many of older and quite a few younger professional organizations the internal tensions are inevitable and common. This tensions and conflicts may considerably weaken development. Majority of obstacles to development are "imported" obstacles actually reflecting conflicts of the wider system. These may be grouped in two clusters:

(a) One predominantly reflecting general social and political situation, e.g.

- Double face of health politics (verbal support and financial deprivation);
- Remaining concepts of "selective primary care" and "primary medical care";
- Demanding patients and aggressive bureaucrats in health administration.

(b) Another reflecting the relations within the wider medical profession, e.g.:

- Power structure inside health services and among medical professions;

- "Closest neighbours, worst enemies" (generalist versus specialists, like internists, public health specialist, nurses, paramedical);
- Traditional approach to training in medicine and vocational training.

A hidden conflict is more difficult to solve between the group of "pioneers" and the group for which is GP/FM only a "second job" (some successful "managers", overloaded women and similar groups).

The one of most important resistance are related to stimulation of the "silent majority". The leading group should not loose the touch with the far larger group proclaiming "Do not shake the boat". Many different reasons and in some countries the learned obedience, discipline in front of authorities, fear and insecurity might be explanation for choosing waiting as the best solution, because "GPs will always somehow survive". Training, concrete joint activities, technical project proper information and networking should be the uneasy but important solution.

Fragmentation inside profession among generations, rural/city groups, academic and others GPs, different market coalitions, because of small issues among neighbours, etc. is usually not dangerous, but needs timely deliberation.

Strengthening professionalism

The building of professional consciousness, understanding of needs for professional solidarity and long-range thinking about far reaching common interests with patients, other professionals and community, development of own dignity, self-confidence and adequate social position is a long process (11).

Successful strategies for development and strengthening the profession may be summarized as follows:

- Networking, professional solidarity and organization of activities;
- Outspoken technical and ethical standards;
- Patient mobilization and support;
- Clever tactics inside professional and political circles;
- Relying on own strengths. Forwarding "own" technical and administrative support;
- Development of own academic basis and influence on training programs;
- International relations: world wide perspectives.

The time has been nearly forgotten when views related to primary health care were against medical establishment. Opinion existed that it would be possible to implement ideas of PHC without participation of professional practitioners. Similarly, at the other end, a belief dominated that general practice is responsible only for personal care on request of individuals, not necessarily taking into account the community in which they work and live. It was a history of love and hate, trust and mistrust, but better understandings are now prevalent. It may look as a rather long search for obvious, although it may be even now a reason for dispute.

General practice/Family Medicine (GP/FM) is developing as an interface between clinical medicine and public health (community medicine), an example of people oriented integrated medicine. It is a potent bridge between science and human care, prevention and treatment, biological, psychological and social understandings, individuals, families and communities, a science and an art of living (12).

The process has not yet been settled. A realistic approach to participation of people and of different other sectors in PHC has to overcome tempting ideas that free market will

automatically empower people to participate and influence health care. The awareness is maturing of growing costs and limitations of free medical practice in a society divided by richness and opportunities. The right behavior has to be accepted by practitioners of all kinds, to secure long range mutual interests, beyond their particular immediate interest.

However, we may accept with satisfaction that the basic mutual understanding is present and collaboration accepted by all sides. This should be the starting point in discussing strategies for strengthening general/family practice. A "win/win" solution was rediscovered by professionals and all other participants.

The game is not finished: the main influences are coming from socio-political issues

Nevertheless, the gap between intentions and realities seems to be as great as ever. The main support to primary health care policy was "for all" strategy in development, declared in Alma-Ata 1978. However, after economic recession in early 1980, and downfall of "egalitarian" ("socialist") political systems in 1990, the neoliberal and free market philosophy as the main engine of global development.

The confrontation of those powerful and wealthy with those suppressed and poor become evident not only in terrorist attacks and military revenges, but also in diminished solidarity among and between countries. Under emerging socio-political condition heal care was one of offers in structural adjustment policies imposed by World Trade Organization, World Bank and particularly International Monetary Fund (13-15). Although some international organizations such as World Health Organization, UNICEF, and UNESCO further supported "for All" policies in health and education, they were weakened and the situation in the field started to alarm United Nations. At the turn of centuries (and millenniums) United Nations developed Millennium Declaration and later through Millennium Project and Global Fund tried to reach targets in 2015 ("(1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empowerment of women, (4) reduce child mortality, (5) improve maternal health, (6) combat HIV/AIDS, malaria and other diseases, (7) ensure environmental sustainability, and (8) global partnership for development") (14).

However, it is already clear that Millennium targets will not be achieved, and some of the issues are understood in different ways (16,17). The old fight between promoters of genuine comprehensive (horizontal) primary health care and selective (vertical) programs of primary care become visible particularly in conflicts about funding. How it is in a destructive way attacking General/Family Practice in Europe is well seen from an address of the Organization of Family Doctors (WONCA) and a number of other international organizations called Strengthening primary health care "15 by 2015" (18):

> *"…we propose that by 2015, 15% of the budgets of vertical disease-oriented programs be invested in strengthening well-coordinated, integrated local primary healthcare systems and that this percentage would increase over time. Such an investment would improve developing nations' capacity to address the majority of health problems through a generic, well-structured, primary health care system."*

Summary

1. The GP/FM in the context of primary health care has an important role, next to people, complementary to other services and often as a conductor of the orchestra. The existing experiences show movements in all countries. Most of them are in good direction to improve relevance, efficiency, equity of services and satisfaction of people, but still needs time to evolve or reform themselves.
2. There is a gap between general solutions and real practices. The type of organization of PHC is not successfully recognized so that further evaluation of practices and experiments are needed. The problem of "privatization" as a tool for change and the old problem of health centres and integration of primary services are presented, based on experience in Croatia.
3. Essential elementary strategies for development of general/family medicine are identified as:
   - long-range: relevance and quality of personal services and satisfaction of people;
   - starting: vocational training, development of identity and political support;
   - strengthening: professional organization and academic developments;
   - institutionalizing: reorganization of service management;
   - sustaining: national and international networking, evaluating experiences.
4. Diversity and different dynamics in combination of elementary strategies and different ways of development should be expected. Proactive approach and flexibility are most important. Possible internal and external obstacles are identified. Among them the passive expectant majority from inside and the vague governmental support and aggressive health administration from outside are considered as most threatening.
5. The role of the recently issued WHO document "Framework for professional and administrative development of general practice/family medicine in Europe" is important to present the intentions of GP/FM and introduce them to other partners, as well as to strengthen their internal homogeneity.

CASE STUDY

Experiences from Croatia

Croatia shared many of the worst experiences of violence, power struggle and unsolved economic, social and political problems during the last years. It can be illustrated by quantitative data. The social problems (19) of war victims, unemployment, elderly and poor are described in Table 2.

Table 2. Selected indicators of social problems in Croatia 1995 and 1996

ACTIVE AND SUPPORTED INHABITANTS (1995) (in thousands)			
Population	4,600		
Employed	1,377		
Unemployed	**249**	(est. 280)	**15.3%** (17%)
ALL ACTIVE	1,626		Ratio:
SUPPORTED (?)	~3,000		**1.87 ++**

DIRECT WAR VICTIMS (1995) (in thousands)			
Killed	**9,208**	Expatriates	191
Injured	**28,309**	Refugees	207
Missed	2,853	Repatriates	7+
TOTAL	**404** (1996:**100**?)		

PENSIONERS (1996)	(in thousands)	(receiving Kuna/monthly)
"Retired": Aged	410	900
Invalids	180	930
Family members	185	900
"Independent entrepreneurs"	18	724
"Peasants"	53	276
"From other republics"	30	400-700
Total	**876**	

POVERTY (1996)		
Receiving material support from social services		**~106 000**
Structure:	employed	14%
	unemployed	29%
	retired	27%
	peasants	6%
	others	24%

Source: Žaja B. Revija za socijalnu politiku 1996;3:313-8.

A comparison with Macedonia and Slovenia in Tables 3 and 4 shows some similarities but also striking differences. Some of indicators in comparison with those before 1990 show the widening gap between Croatia and Slovenia, and some of closer formal similarities with data from Macedonia.

The situation is described as a "Croatian paradox" that with worsening of general conditions the usual health indicators have shown so far a tolerable degree of health indicators (20). However, one of the overlooked reasons explaining beneficial outcome might be the tradition of a decentralized system, strong and independent primary health care and great personal contribution of professionals during the war. Until now the decisive contribution of primary health care, and especially general practitioners, is not well recognized, because more attention was given (as it is usual) to specialized and hospital services.

As it is well known and documented, the importance of generalists and primary care was well conceived in Croatia rather early in comparison with other countries. The significance of integrated (preventive/curative) health centres was important, in spite of lately over-managed or bureaucratic organization of fat-headed "Health homes" or policlinics (21,22).

Table 3. Comparison of social indicators for Croatia, Macedonia and chosen neighbouring countries for 1994 and 1995

COUNTRY	**Inhabi-tants** millions , 1995	**GDP** $ 1995	**PPP** $ 1994	**Unemp-loyment** %, 1996	**Elderly 60+** %,~2000	**War 1991/ 1995**	**First govern-ment**	**Natio-nalism**
CROATIA	4,78	3250	3960	15,90	21,2	+++	One-party	Present
MACEDONIA	1,94	…	3965	39,80	…	0	Coalition	Low
SLOVENIA	1,98	8200	10404	14,40	19,4	0	Coalition	Low
BULGARIA	8,41	1330	4533	12,50	22,8	0	…	…
HUNGARY	10,23	4120	6437	10,50	20,9	0	…	…

GDP - Gross Domestic Product (UNDP), PPP - Population Purchasing Power (World Bank), Unemployment (ECE,UN), Elderly (World Bank), War, First government, Nationalism according to SP Ramet, Erasmus 1998;(24):2-14.

Table 4. Comparison of health indicators for Croatia, Macedonia and chosen neighbouring countries for 1994 and 1995

COUNTRY	**Physicians Per 10000 1994**	**Nurses Per 10000 1994**	**Hospital beds Per 1000 1994**	**Health exp. % GNP 1995**	**Infant mortality 1995**	**Live exp. Years 1994**	**Hm. Dev. Index 1994**
CROATIA	20.1	41.2	5.9	9.0	16.3	73.3	0.760
MACEDONIA	22.1	54.4	…	8.8	22.6	72.3	0.748
SLOVENIA	28.2	59.8	5.8	7.8	5.5	74.9	0.886
BULGARIA	33.3	76.2	10.2	4.7	16.3	70.8	0.780
HUNGARY	34.0	30.0	9.9	6.9	10.6	69.9	0.857

Sources: HFA Database (WHO/EURO), all except Hm.Dev Index - Human Development Index (Life expectancy, Education, GDP. UNDP)

The reform started with changes in financing and some reorganization (23). The health fund was centralized and organized as the Croatian institute of health insurance in the closest possible way collaborating with Ministry of health. The resources have in one period diminished to one third of those immediately before the new Croatia started to exist. Public health was re-organized as a centrally administered separate service, including institutes of public health but also peripheral units previously working as part of health centres. Medical centres were "dissolved" into original parts: hospitals, health centres and institutes of public health.

The case of "privatization"

The "privatization" of primary care physicians was proclaimed as a major health policy, but continued with hot/cold tactics in support of "free" private practices and of strict administrative and financial control of services. The positive move was insisting on free choice of physicians by people, although the actual implementation was limited protecting existing services and some powerful groups of professionals. The important next step was introduction of contractual relations between primary care physicians and the health insurance. Under condition of restricted resources and threat of loosing job, the contracts

have been largely dictated by health insurance administration. The resources have been limited, but the proclaimed rights of people further covering complete care as before. The "rationing" of prescriptions given to individual practitioners was standardized to the averages (by definition half of people having less than it was usual, mostly in urban areas, and half more than enough). If some demands of patients have not been fulfilled, professionals were regularly found responsible. Administrative measures and material punishments were implemented for those who exceeded the standardized rate of patients on sick leave. This has put majority of professionals in an insecure position, derogating their technical competence and humiliating them publicly.

On the other side, many short-sighted tactics and "children diseases" of privatization were common among most ambitious 5-10% of "completely private practitioners": advertisements promising impossible, unnecessary additional medical interventions, complementary and alternative procedures, misuse of technology etc.

For all physicians in primary health care, from 1997, the planned, mandatory leasing of premises from health centres was introduced, as a kind of limited fund-holding and semiprivate position.

To co-ordinate and protect interest of physicians the Chamber of physicians started to exist, but still has many problems and tensions defending political independence and accommodating very different interests inside profession.

Tables 5 and 6 may illustrate forms and quantities of health services' staff and institutions, especially regarding the most important element - manpower.

Table 5. Health workers permanently employed in state/county institutions, and in private institutions, and private practices (December 31, 1996.)

Health workers (by education)	**State/county institution**	**Private health institution**	**Private practices**	**Total**
Medical doctors	9,384	39	687	10,110
Structure (%)	*92,8%*	*0.4%*	*6.8%*	*100.0*
Stomatologists	1,617	5	1.025	2,647
Pharmacists	1,454	134	257	1,845
Other, univ. degree	683	2	3	688
College	5,697	71	170	5,938
High school	20,512	458	694	21,664
Semi-skilled	688	9	9	706
TOTAL	**40,035**	**718**	**2,845**	**43,595**
Structure (%)	*91.8%*	*1.6%*	*6.5%*	*99.9%*

Source: Croatian Health Service Yearbook 1996, Croatian National Institute of Public Health, Zagreb, 1997.

Until the end of 1996 about 92% of health workers were employed in institutions owned by state or counties. Regarding physicians in primary health care the ratio of number of public teams and registered private practitioners was the highest among stomatologists (~1:0,63%), followed by gynecologists (~1:0,61), and in general/family practitioners just above 10% (ratio ~1:0,13).

One should be careful in interpretation because different sources of data vary in definition of different forms of private practices. Therefore, based on data one may just conclude that number of primary care professionals in two years were growing rather fast, mostly in form of contractual relations with premises on lease among general/family practitioners, while among specialists there prevailed units based on own premises.

Table 6. Number of primary care physicians offered lease of premises

PRIMARY SERVICES	December 31, 1996.		Leasing premises				March 1998
	Teams	Private	- 1996	1997	5.98	Total	Private
Gen/family practice	2,111	274	0	303	232	535	687
Est. percentage		*~13%*				*~23%*	*~30%*
Stomatology	1,617	1,028	3	269	200	472	1485
Gynecology	171	109	0	34	21	55	124
Pediatrics	300	41	0	20	19	39	75
Other	…	25	0	227	139	366	…

Source: For 1996 - Croatian Health Service Yearbook 1996. Croatian National Institute of Public Health, Zagreb, 1997. For Leasing - Ministry of Health, 1998. For Private 1998 - Association of Private Employers in Health: Health Private Practice Bulletin (Bilten Privatna praksa u zdravstvu) 1998; 2.

Qualitative appraisal of gained experiences

The main objectives regarding the individual practitioners, quality of their work and their position in the health system is described as having mixed, positive and negative traits. It is estimated that most of positive traits are in stimulation of professionals, not yet clear final impact in technical aspects of work, and a changing situation regarding the position in the health system.

Unfortunately even the most positive aspects are not fully developed by giving chance to technical, economic and human initiatives, because the liberty is limited by strong centralization in management and control. In Table 7 the so far gained qualitative estimates are summarized.

There are good prospects of conflicts in the system built on tensions between central authorities and accumulated interests in the primary level, but also dangerous developments when the common goals are submitted to immediate political needs. The essential unity, namely, has to grow up through an independent, democratic, ethically and technically safe process, and not by authoritarian central guidance.

A narrative description of events and processes in essays of 72 leading general practitioners and their teachers is published in a book: Jakšić Ž, ur. Ogledi o razvoju opće/obiteljske medicine. Zagreb, Hrvatska udružba obiteljske medicine, 2001. (312 str.) (The essays on development of general/family medicine).

OBJECTIVES	POSITIVE (+) TRAITS	NEGATIVE (-) TRAITS	IMPACT (+) (-)					
Stimulation	**Greater push and satisfaction**	Inefficient efforts, wrong direction						
Liberty (centrally "guided")	Local initiatives + service adequacy	**Administrative power and arrogance**						
Quality of technical work	Answering to needs/demands	**Neglected prevention & social issues**						
Economic concern	Rationality in use of resources	Profit by "saving" on account of patients						
Patient/people-orientation	Personal care and continuity	**Mechanical "kindness"**						
Personal responsibility	**Building own "trade-mark"**	Frustration and/or de-moralization						
Organized professionalism	Constructive solidarity	Individualism and/or power-struggle						
Coherent strategy	Critical attitude + entrepreneurship	**"New start": nobody before or after Me**						

Table 7. Estimated impacts of reforms

EXERCISES

Task 1

1. Compare data from your country with those presented in Case study about Croatia. What are the similarities and what are differences?
2. Discuss in small group described elements of different strategies and their relevance and expected efficiency.

Task 2

1. Propose sequence and intensity of different activities to achieve best results in present situation in your country
2. Is public health in your country supporting the idea of general/family practice or vertical programs?

Task 3

1. Discuss in small group the statement that general/family practice is in theory the basis and main coordinator in providing comprehensive primary health care and in practice just a servant in vertical programs lead by clinical specialists.
2. Describe differences among group practices of genera/family practitioners, health centres and policlinics.

Task 4

1. Answer the following questions:
2. Is primary care lead by private general practitioners more socially sensitive than the system of public hospitals and specialist clinical consultations? Which system is promising the best equity in health care?
3. How management should assure best quality and safety in providing primary health care?
4. How risky is the clinical autonomy of doctors in primary health care and is there a difference with autonomy of clinicians working in out-patient departments of hospitals?

REFERENCES

1. European Health Care Reform. Analysis of current strategies. Copenhagen, WHO/EURO, 1997.
2. Starfield B. Is primary care essential? Lancet 1994; 344: 1129-33.
3. World organization of family doctors. The role of general practitioners/family physician in health care systems. A Statement from the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. London, WONCA, 1991.
4. Goicoechea J, ed. Primary health care reforms. Fifth forum on primary health care development in Southern Europe and its relevance to countries of Central and Eastern Europe - the way forward. Copenhagen, WHO/EURO, 1996.
5. The World Health Report 1998 "Life in the 21st century - A vision for all". Geneva, WHO, 1998.
6. Towards Health for All, WHO Document 1998: http://www.who.ch/hfa/policy
7. Health for all for the twenty-first century. The health policy for Europe. Working draft. EUR/RC47/11. Copenhagen, WHO/EURO, 1997.
8. a. Framework for professional and administrative development of General Practice/Family Medicine in Europe. WHO/EURO: EUR/ICP/GPDV 94 01/PBO1/Rev.1, 1998. The same standpoint was repeated by WHO in 2008; 8. b.Chan M. Report to the WHO Executive Board January, 21. 2008. WHO News, 2008.
9. Jakšić Ž. Restrukturiranje hrvatskog zdravstva. Bitna uloga stručnjaka je pretpostavka dobre organizacije (Restructuring of Croatian Health Care System. The Role of Health Professionals). 10. Kongres Hrvatskih liječnika (10^{th} Congress of Croatian Physiscians), Zadar 1996. Lij. vjes.
10. Report on the first meeting of an expert network on family practice development strategies. Ljubljana 26-28 January 1995. Copenhagen, WHO/EURO, 1996.

11. Petric D, Tiljak H. Strukovno organiziranje/stvaranje profesije (Professional Organizations/Development of Profession). Medicina familiaris Croatica 1995; 3(1): 39-42.
12. Fugelli P. General practice in the megazone. 3rd European Congress on Family/General Medicine, WONCA, Stockholm 1996. Family Practice 1997; 14(1): 12-6.
13. Maciocco G, Italian Global Health watch. From Alma Ata to the Global Fund: The history of international health policy. Social Medicine 2008; 3(1): 36-48.
14. United Nations Millenium Declaration 2000. http://www.eoearth.org
15. Sachs J. End of poverty: Economic possibilities for our time. NewYork, Penguin Press, 2005.
16. Schoen C, Osborn R, Huynh PT, Doty M, Peugh J, Zapert K**.** On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, And Views in Seven Countries: Country variations in primary care practices indicate opportunities to learn to improve outcomes and efficiency. Health Affairs 2006; 25: http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w555/DC1
17. Starfield B. Pathways of influence on equity in health. Soc Sci Med 2007; 64: 1355-62.
18. De Maeseneer J, van Wheel Ch, Egilman D, Mfenyana K, Kaufman A, Sewankambo N. Strengthening primary care: addressing the disparity between vertical and horizontal investment. BJGP 2008; 58: 3,4.
19. Žaja B. Revija za socijalnu politiku (Social Policy Review) 1996;3:313-8.
20. Okvirni temeljni dokument za pristup reformi sustava zdravstva i sustava zdravstvenog osiguranja u Republici Hrvatskoj (Basic Documents for the Health Care and Insurance System Reforms in Republic of Croatia). Zagreb, 1998.
21. Zaključci rasprava na Danima primarne zdravstvene zaštite u Labinu: Iskustva i mogućnosti domova zdravlja u primjeni novog zakona o zdravstvenoj zaštiti (1993) i Racionalizacija i "privatizacija" u primarnoj zdravstvenoj zaštiti (1994) (Conclusions of the Conference “Days of Primary Health Care Labin”). Zbornik Dani primarne zdravstvene zaštite u Labinu 1994 (Proceedings of the Conference “Days of Primary Health Care Labin”). Labin, Dom zdravlja, 1995: 357-67.
22. Izvješće o razvoju zdravstva od 1990 do 1995 godine te stanje u zdravstvenom sustavu Republike Hrvatske. Zagreb, Vlada Republike Hrvatske (Report on the Development of the Health Care System 1990-1995, Government of the Republic of Croatia), 1996.
23. Izvještaj radne grupe Svjetske zdravstvene organizacije. Razvoj opće medicine u zemljama srednje i istočne Europe (Report of the WHO Working Group. Development of General Practice in Countries of CEE). Benešov 1992. Medicina familiaris Croatica 1993; 1(1): 7-10.

RECOMMENDED READINGS

1. Mintzberg H, Ahlstrand B, Lampel J. Strategy safari. London; Financial Times/Prentice Hall, 1998.
2. United Nations Millenium Declaration 2000. http://www.eoearth.org
3. Framework for professional and administrative development of General Practice/Family Medicine in Europe. WHO/EURO: EUR/ICP/GPDV 94 01/PBO1/Rev.1, 1998.