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REGIONAL OFFICE FOR EUROPE

THE ROLE OF GENERAL PRACTITIONERS IN THE PROVISION OF COMPREHENSIVE PRIMARY HEALTH CARE

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EUR/HFA TARGET 27

This document presents the results of a study undertaken for the WHO Regional Office for Europe by Professor Z. Jaksic of the Andrija Stampar School of Public Health, Zagreb. The work is aimed at achieving the following target in the health for all strategy.[a]

TARGET 27

RATIONAL AND PREFERENTIAL DISTRIBUTION OF RESOURCES ACCORDING TO NEED

By 1990, in all Member States, the infrastructures of the delivery systems should be organized so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.

Index terms

PRIMARY HEALTH CARE
PHYSICIANS, FAMILY
COMPREHENSIVE HEALTH CARE
PHYSICIAN'S ROLE
YUGOSLAVIA
EUR

[a] *Targets for health for all.* Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series, No. 1).

CONTENTS

Introduction

In view of the variety of attitudes, controversy, present dynamic circumstances and different cultural traditions in Europe, it is worth while at this juncture in European history to reconsider the profiles and roles of professionals who provide or participate in primary health care (PHC).

The economic situation in Europe today and the sociopolitical transformations taking place are the main reasons for reopening this question. A broad philosophical and historical perspective, which takes into account the global ecological situation, technological progress and the growing shortage of care-providing professionals (and other people involved in providing care), also points to the need for a re-evaluation of the situation.

The European targets for health for all (HFA) provide the general framework for this exercise, and a direct mandate is laid down in targets 27 and 29. The regional HFA targets stress the central role PHC plays in health care systems. It is therefore clear that the gap between expressed expectations and actual practice is considerable and demands immediate attention.

As the subject is complex, it is necessary to limit the scope of the analysis. This paper will consider only a part of the problem: the role of general (family) practitioners in the provision of comprehensive PHC. It will also focus on preventive aspects of care.

This re-evaluation was initiated at the meeting of WHO collaborating centres held in Utrecht, December 1988. At that meeting one topic of discussion was complementing and reorienting PHC providers and facilities. A draft questionnaire was developed to collect views on the situation and perspectives in providing comprehensive PHC by general practitioners and family physicians in Europe.

Factors influencing the role of general practitioners in primary health care

Different standpoints and ideologies

The role of general practitioners in PHC has been discussed on many occasions during the last decade.

Immediately after Alma-Ata the role of general medical practitioners in PHC was not regarded as promising or prominent. Rightly, the role of communities and other sectors in health care was stressed. New profiles of PHC workers were introduced in many countries, although sometimes PHC issues were oversimplified. Traditional ways of treatment and care were rediscovered. However, general practitioners, together with other professionals, were regarded in some circles more as obstacles than as partners who could help. Medicalization was regarded as a great danger to the primary care revolution. It was easier to be antimedical than find ways to collaborate successfully. Existing primary medical care in more developed countries was clearly distinguished from PHC and explicitly criticized. Good experiences were rejected along with the bad.

In centrally planned countries - where the number of health workers was high and services, even in the front-line, were specialized - the system was defended as proper primary health care, and it was felt that there was no need

for change. The formal involvement of communities through representatives in different councils was defended as characteristic of PHC, and the bureaucratization of the whole system was overlooked. The dissatisfaction of people and professionals, together with low quality of care and impersonal relations, was denied until recently.

In many eastern European countries general practitioners have been regarded as obsolete, following the belief that early and complete specialization guarantees quality. Moreover, general (family) practitioners have been regarded as unacceptable in many cases on ideological grounds. (In the same way as the solution of social problems through social measures was unacceptable because this might strengthen the role of the family, a role that was highly controversial.) This was particularly seen in towns where services developed as polyclinics (combined specialized clinics). Although they were called "health centres" in some countries, treatment was the main activity. Prevention was also "medicalized" and reduced to the screening of early defects and long-term "control" (dispanzerization). General practitioners were formally put in the centre of the system, but this was practiced only in remote rural areas. In urban areas they were increasingly pushed into administrative and control functions, trivial medical interventions and home visiting. Only a few countries started vocational training (specialization), e.g. German Democratic Republic, Yugoslavia, later Hungary and some others, but even that was not enough to regain social and technical prestige for general practitioners.

The medical profession was sceptical of or openly against the new PHC system, either in the name of protection of scientific values of medicine or owing to their independent position and profits gained in private practices. PHC concepts were rejected because of their strong and predominant social values, emphasis on communities, not individuals, fear of state control of health care and relation between physicians and people. The possibility that services would be "socialized" and organized in institutions, physicians turned into administrative clerks, resources controlled and activities planned was and remains frightening to many general practitioners; they are still suspicious of PHC ideas.

Meanwhile, during the last decades profound changes have been taking place, and a clear tendency of convergence from all sides has begun. The Leeuwenhorst group* included in its definition of the general practitioner in Europe his or her concern and care for the community besides the family and individuals. The vocational training of general practitioners spread throughout the eastern Europe; two years ago even the USSR declared the change and introduced family physicians as a new PHC profile. The orthodox PHC approach has also retreated under the pressure of practices and split into two groups: one around the flag of health promotion movements, and other around integrated comprehensive primary health services built around general practitioners and organized as a complete system up to district level.

However, even in the second group one may recognize two extreme ideologies: one views the medical profession in the traditional way as the healing profession, combining the art and science of healing, and the other as

* Leeuwenhorst Group. The general practitioner in Europe, 1974. (Professor C. Spreeuwenberg, Chairperson of Leeuwenhorst Group, Nieuwegein, Netherlands.

a "modern", "scientific", technically oriented profession dealing with biomedical processes and not with people as human beings. According to this second attitude the medical profession is regarded as an "engineering" and "paternalistic" profession that can be understood only as being in contrast with the picture laypeople have of a doctor caring for ill people or advising on health promotion.

Contrasting characteristics of the two extreme viewpoints regarding the medical role in health care

	"Health promotion"	"Scientific medicine"
Approach	Emotional	Rational
Moving energy	Solidarity	Technology
Social	Fluid, social movement	Structured centre of power
Institutional	Sparse Underdeveloped	Strong Hyperdeveloped
Internal relations	Charismatic leadership	Paternalistic
Positive endpoint	Self-reliance	Effectiveness
Negative practices	Antiprofessionalism	Inequity

These two extreme standpoints need to be reconciliated by the PHC approach, which can combine the positive characteristics of both viewpoints and avoid the negative ones. The creative PHC approach has to be:

- both rational and emotional;
- such that the energy should come from community involvement;
- flexible but structured, and adapted to local circumstances;
- such that experts should be leaders and teachers, understanding both social interactions and scientific facts;
- effective and able to stimulate self-reliance.

The question is who can properly respond to this formidable task. From the standpoint of the conflicting ideologies the answer is, on the one hand, a radical solution that people themselves should respond and, on the other, that a number of highly technically specialized professionals respond to the call: for every problem a new specialist, or a specialized service with a number of "outreach workers".

Not one of these extreme solutions has satisfactorily survived the test of being extended to a whole system and lasting long enough without external support. Empirical middle solutions that follow specific cultural traditions might be the best.

Diversity of practices and organization of services

Long-standing practices in European countries show a diversity of practical solutions. All kinds of the systems coexist, among which the most pronounced are:

- specialized medical services, polyclinics (often connected with hospitals)
- health centres (small and big)
- group practices of different size and membership
- variety of parallel public and voluntary initiatives, and
- private practitioners.

Diversity is also reflected in the type of PHC team. Although the variety might be considerable there are some prevalent types, as follows.

(a) Office-based practitioners

Practitioner(s)	*Team member(s)*
- general practitioner	- limited number of helpers
- group of general practitioners	- an extended team: receptionist, nurses, laboratory technicians, physiotherapist
- mixed group of specialist and practitioners	- an extended team: unstructured or structured in a health centre
- group of specialists	- a limited team related to every specialist office, or structured team in a polyclinic
- specialized services (e.g.physiotherapists)	- various

(b) Home and community-based services

Practitioner(s)	*Team member(s)*
- specialized solo practitioners	- depending on discipline
- organized specialized services (selective or comprehensive)	- team member for home treatment, help at home and social services

In the front-line of health services a team of professional health workers have to fulfil all the required tasks. They obviously have to combine appropriate medical technology with social and psychological skills. Organizational forms may differ greatly. However, the essential question

remains: how to ensure that services dealing closely with people are continuous and comprehensive, and serve as a permanent interface between professionals and primary groups (such as families, neighbourhoods and other communities in which people personally know each other). In addition to being continuous and comprehensive, several additional requirements also need to be satisfied:

- economical rationality and development of self-reliance
- flexibility and guaranteed free choice for both professionals and people
- technical adequacy, acceptable and reliable quality.

For the time being, no completely satisfactory solution exists in practice, although there are some good examples. The closest would be a team centred around a general (family) physician who, in most circumstances, could provide a change in scope and work style.

Different work styles

Technically there are many possibilities, styles and forms of PHC provision. Surprisingly, the literature on that issue is scarce and the search for appropriate typology only beginning. Moreover, healers will be appreciated by both the general population and patients, if their professional style corresponds to the existing culture and if they express a real concern for the people they are caring for.

The different working styles and types of general practitioner can be illustrated in the following way. They are distinguished by differences in attitudes (a) towards the practice of medicine, generally, (b) towards prevention, specifically and (c) towards ways in which present practice may be improved:

Scientist	general: application of scientific methods and knowledge to presented problems; objectivity;
	prevention: a rationally chosen better way of dealing with problems;
	improvements: advancement in science and technology; better distribution of knowledge and information.
Engineer	general: following pragmatic technical instructions and rules; somatic and disease orientation;
	prevention: stressing systematic examinations, early detection and provision of "technical service" to whom it is necessary;
	improvements: standardization of procedures, legal obligations.

Craftsman	general: a skilful service to those who ask for it, tailored according to individual requests;
	prevention: a possible part of the offered services; cautious advice on request;
	improvements: complete liberty of individuals, and a guaranteed free choice and privacy.
Artist	general: restoring harmony between people and nature, through the sublime help and leadership of the physician;
	prevention: an art of balance (a combination of virtue, pleasure and grace);
	improvements: strengthening human potentials, broad cultural betterment; strong position and powerful role of the physician in the community.
Pastor	general: support of person and relying on ability; spiritual and psychological orientation;
	prevention: support in development of self-esteem and self-reliance;
	improvements: holistic and spiritual movements and mutual support of members.

A combination of different styles is most common. However, traditions and general conditions of services influence the distribution of particular styles. Although these concepts should not be oversimplified, it is a commonly held belief that in centrally controlled public institutions the "engineer" style predominates (e.g. in large systems in some eastern European countries); that among individual private practitioners the "craftsman" style is typical (e.g. in some countries of central and western Europe); that the "artist" style is more frequent in southern Europe; that the "scientist" approach prevails in northern Europe; and that the "pastor" is typical for voluntary charitable organizations (e.g. in some countries of western Europe).

Factors influencing the occurrence of different styles are:

- cultural and traditional influences
- general social and health policy and system
- economic factors
- institutional policies and administrative factors
- preconditioning factors such as medical education.

Changes in these and other factors may produce overall change, but only if they point in one direction. For instance, modern technology supports the engineering style, but also allows more time and energy for social and psychological support. Moreover, some of the changes may only be temporary and follow certain fashions.

Changes in these factors may only mean that a certain style will then be accepted and provided by other healers. The vast number of quasi-traditional healers have adopted a style that is rare in narrowly specialized professions. However, that should not cause these professionals to hastily abandon traditional styles. As experienced practitioners know, some of those approaches are technically necessary and very effective. Many components, on the other hand, have not be proven scientifically and are not even well understood. Those who are closest to it are general practitioners.

It is important to realize that every style may be open to change towards comprehensive PHC. A style that corresponds to local culture and expectations will be most productive, and current styles should not be changed abruptly but complemented with additional procedures and skills. Some of them are open to intervention, but changes may only come about slowly as a result of steady efforts. As has happened in other areas, different styles become more and more convergent. The whole issue has to be regarded as building a science and an art of PHC, a new PHC culture. Although not the only ones, the most important builders are naturally those people who are most involved, i.e. general practitioners and district nurses.

Difference between the ideal model and actual practice

PHC is a complex of processes and relations among people and professionals, and represents a specific human activity. The professionals and services represent just a part of it. Because of that it is most important to define the expectations of individuals and communities, and how professional activities would best fit into that system.

Individual users expect the following factors to characterize appropriate PHC:

- great technical ability
- human concern and privacy
- free access and easy communication
- continuity of care
- a comprehensive approach
- comfort.

On the other hand, the broader community expects:

- no complaints from people
- effective care for prevalent needs
- reasonable costs
- prevention of major health problems
- diminishing of social consequences of illness in handicapped, vulnerable, and underprivileged groups.

When these expectations are compared with the actual situation, it is obvious that at present, in most circumstances, these expectations are not met, and that several skills are lacking or in short supply among professional teams providing PHC.

It is most urgent and important to try to fill the gap. It is likely to grow because because of further change in population structure, growing concern about health matters and wellbeing, growing social inequalities and limited public resources.

One may follow general needs, tendencies and good experiences. The elementary PHC team may differ in the following variables and in each of them good practices exist.

* Does the PHC team work for a certain population (defined territory or defined practice population), or is there an "open door" policy?

  For comprehensive PHC a defined population is needed.

* How big should a PHC team be (solo practice or an extended membership)?

  There is a tendency towards group practices and extended teams, but with a limitation of 4-6 teams working together, and a core team of 3-5 people.

* Who is a member of the team (only professional of one level and one discipline, or also volunteers, professionals of different levels and different disciplines)?

  One has to expect great flexibility, experimentation and innovation in building the team. It appears, however, that the two key professionals are the general practitioners and the home-visiting (district, patronage) nurse.

* Who is the leading technical decision-maker?

  It appears that a generalist has to take over that task, but in order to do so he or she will in most cases need additional training, especially in epidemiology, social skills, prevention and management.

* Should a PHC team (or a group of teams) be an independent organizational unit or an inseparable part of a larger institution?

  The broader support might be needed and new types of health centres might be developed. It is, however, important to keep in mind that they easily develop administrative power, as has happened in many places, destroying the essential conditions for creative and high quality PHC.

* What are the best financial arrangements (source of financing, distribution of funds and way of payment)?

  Great changes and many different forms may be expected. The sources have to remain essentially based on solidarity, so that equity can be assured, but all kinds of private/public mixtures might be present to stimulate work and initiatives, and to avoid dull administrative budgetary financing.

In view of traditions in Europe and experiences in many countries, present and future health needs and resource limitations, and the need to avoid unrealistic extremes, the appropriate solution would be a group of teams of practitioners, nurses and a few other care workers (physiotherapists, social workers, etc.), providing that the style of work of the generalists is improved and some new skills added.

Improvements and new skills are needed, especially in human concern and continuous care, communication and understanding, prevention and resocialization, and the rational use of resources.

It is our task now to examine the present situation and consider the potential and willingness for change in some detail. For that purpose a survey of opinion of practitioners and organizers of services has been designed.

The questionnaire on activities for general practitioners with special concern for the provision of preventive care

The survey design and organization

The survey was designed to collect opinions on the organization and provision of health care from various experts and those involved in general practice in different countries, as well as to collect a number of recent reports and research results on the same subject. The intention was not to collect hard data or compare existing statistics, but to survey the judgements and opinion of well informed experts.

From each country 2-6 persons were asked to respond, covering the different aspects of the problem.

The elements of the questionnaire were specified at the meeting of representatives of WHO collaborating centres in primary health care, held in Utrecht, December 1988. The collaborating centre in Zagreb took the responsibility of proposing the final design of the questionnaire and all the collaborating centres took on the obligation of collecting data.

The questionnaire is presented in Annex 1. The purpose and structure can easily be understood based on the instruction sheet.

Responses

The questionnaires were completed and returned to Zagreb by the following collaborating centres:

Granada (Spain)	4
Kuopio (Finland)	1
Bucharest (Romania)	1
Lisbon (Portugal)	1
Antwerpen (Belgium)	1
Zagreb (Yugoslavia)	32

The collaborating centres in Berlin and Utrecht sent literature but did not reply to the questionnaire.

The data also included answers to the questionnaire by one expert from the Netherlands and one from Norway, as independent and well informed experts from these countries.

The answers were processed in Zagreb. The means were calculated as a simple average of all answers expressed in numbers. In the case of "other" (except Yugoslavia) countries, a weighted average was calculated: first the average for 4 answers from Spain and, using that result, the average for all "other countries" was determined.

WARNING! It is obvious that the quantitative processing of data was limited by the kind and number of responses, and the following presentation of results should be regarded only as what it is: a survey of opinion to stimulate further thinking, but not an objective estimate of the existing situation, especially not in real values.

This was confirmed by the analysis of data from Yugoslavia, where it was shown that there is great variability in quantitative assessments, reflecting the attitudes of those who answered the questionnaire rather than the facts. For instance, in many quantitative assessments the answers practically covered the whole range of possibilities and were not on the same level as data from other sources.

However, the average assessments and the internal relations between answers to different questions were close to assessments made by other sources, although on average more optimistic.

It is therefore possible, though with due caution, to accept the data as an illustration of attitudes, and this is the scope and meaning of the following presentation of results.

Results

The quantitative results are presented in the following figures (see also Annex 2). They show the answers obtained from Yugoslavia (N 32) as well as the responses from all the other countries (N 10).

The first group of figures is related to estimated percentages of general practitioners performing different kinds of preventive measures in Yugoslavia. These estimates are shown separately for practitioners working in urban and rural areas. The expected desirable percentages are compared with those performed.

In the second group of figures the same data are compared with answers received from other countries.

The third group of figures describes answers from Yugoslavia and from other countries on additional general questions: "vehicles" for application of preventive measures by general practitioners; position and felt power of general practitioners in relation to other parts of the health system and other institutions; factors involved in preventive activities; and support general practitioners get in trying to implement comprehensive services.

The abbreviations describing variables in all those figures are listed in Annex 3.

Estimated percentage of general practitioners performing preventive work in Yugoslavia

Because of the sample and differences in organization of work in different parts of the country, the results correspond mostly to Croatia, because the majority of replies came from that Republic (29 out of 32) (see the map in Annex 2). The majority of answers came from experienced general practitioners and only a few from other experts in health care (6 out of 32).

The smaller groups were first presented separately, but because there was no evidence of a difference (actually the differences were greater between some parts of the same Republic than between Republics), all the results were processed together.

Fig. 1 shows the estimated percentage of preventive measures performed by practitioners working in urban areas. The estimates vary between 25% and 33% for activities related to maternal and child health. The highest estimate is for immunization and the lowest for family planning. Among activities in health counselling and education, the highest estimate for individual counselling of patients is 66% and about 25% for group work and public educational efforts in the community. The assessment of working capacity, mostly certifying temporary absenteeism from work, reaches the highest estimate, 75% of all practitioners.

Screening procedures for breast and cervical cancers are estimated at the level of 20%, and for hypertension and diabetes around 50%. There were also a number of answers that mentioned other initiatives. Comprehensive work with groups at risk because of social circumstances or handicaps is more frequent in the case of elderly people and people with chronic diseases (estimates about 30%) while with others it is much less frequent.

Fig. 2 shows that the pattern for practitioners working in rural areas is different, especially in relation to preventive measures undertaken for children and to a certain extent also to mothers. Fig. 3 shows the comparison between data obtained for practitioners working in urban and those working in rural areas. There is a slightly higher estimated percentage in nearly all preventive activities carried out by practitioners working in rural areas, but the difference is pronounced only in a few categories: immunization, well baby clinics and school health programmes. In urban areas the existence of other specialized services probably contributes to lower percentages of general practitioners performing preventive activities.

This attitude is also reflected in the estimated level of "needed" (expected, desirable) preventive activities in urban and rural areas, as presented in Fig. 4 and Fig. 5. The majority of expectations are at the level 80-90 %, except for two groups of measures. One is maternal and child health, estimated at about 70% for those general practitioners who work in urban areas. The other lower estimate is for both urban and rural general practitioners and is related to continuous care for groups at risk, such as adolescents, immigrants, the unemployed, lonely people and the mentally retarded. The need for those activities is felt to be somewhere around 40-50%.

Although in practically all preventive activities the individual estimates vary from 0% to 100%, a consistent pattern emerges when averages are calculated. Moreover, the result is slightly over-optimistic in relation to the real situation recorded in official statistics.

It is interesting to observe the attitudes of respondents towards different groups of preventive activities. One group of proposed activities is traditional and mostly related to maternal and child health (antenatal care, immunization, well baby clinics), a field in which special maternal and child health services and general practitioners compete. In rural areas generalists have to undertake these duties but not in urban areas, where other

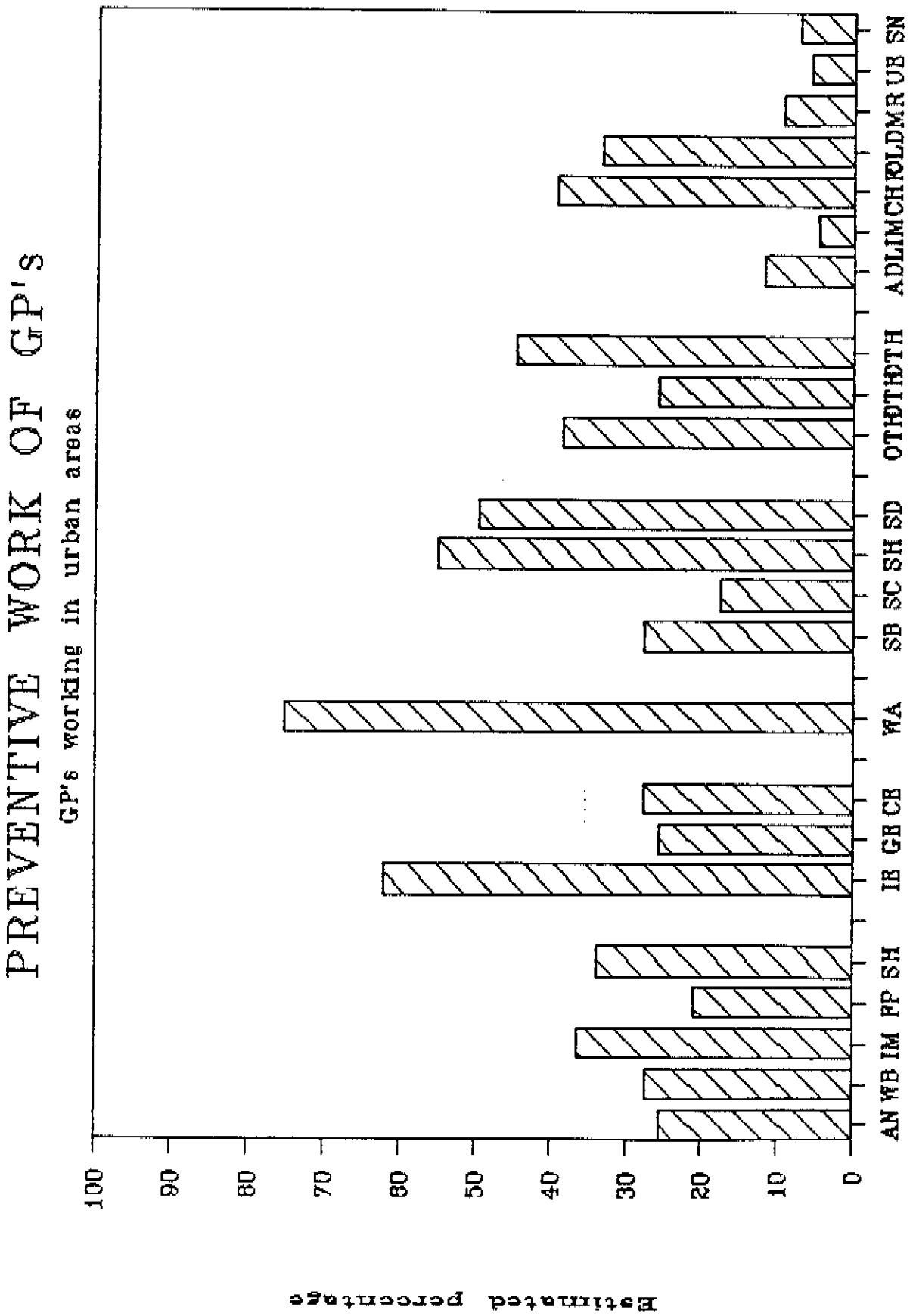
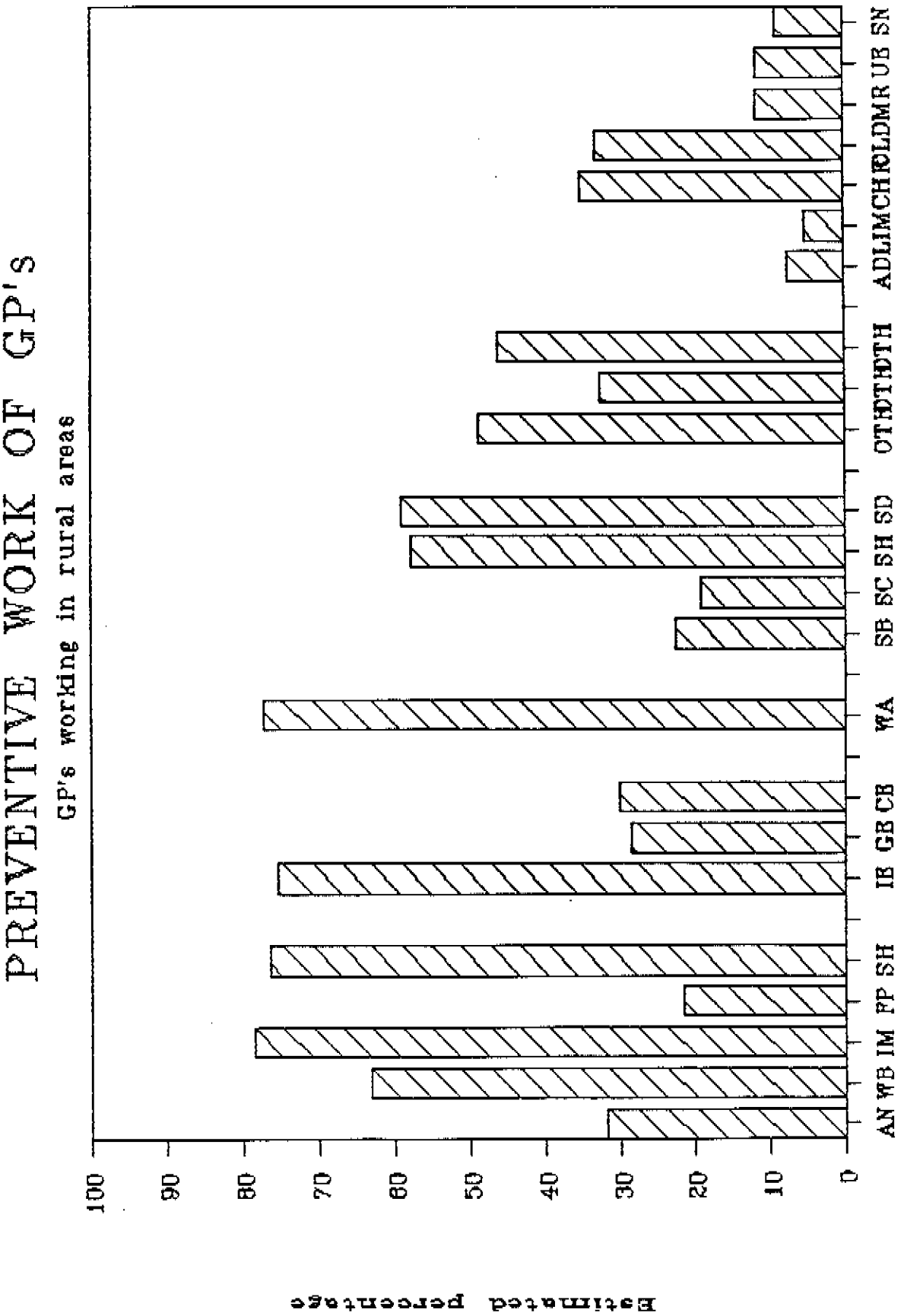

PREVENTIVE WORK OF GP'S
GP's working in urban areas
Estimated percentage
100
90
80
70
60
50
40
30
20
10
0
AN WB IM FP SH IB GB CB WA SB SC SH SD OTHDTHDTH ADLIMCHRDLDMR UB SN

Fig. 1

Fig. 2


PREVENTIVE WORK OF GP'S
GP's working in rural areas
Estimated percentage
100
90
80
70
60
50
40
30
20
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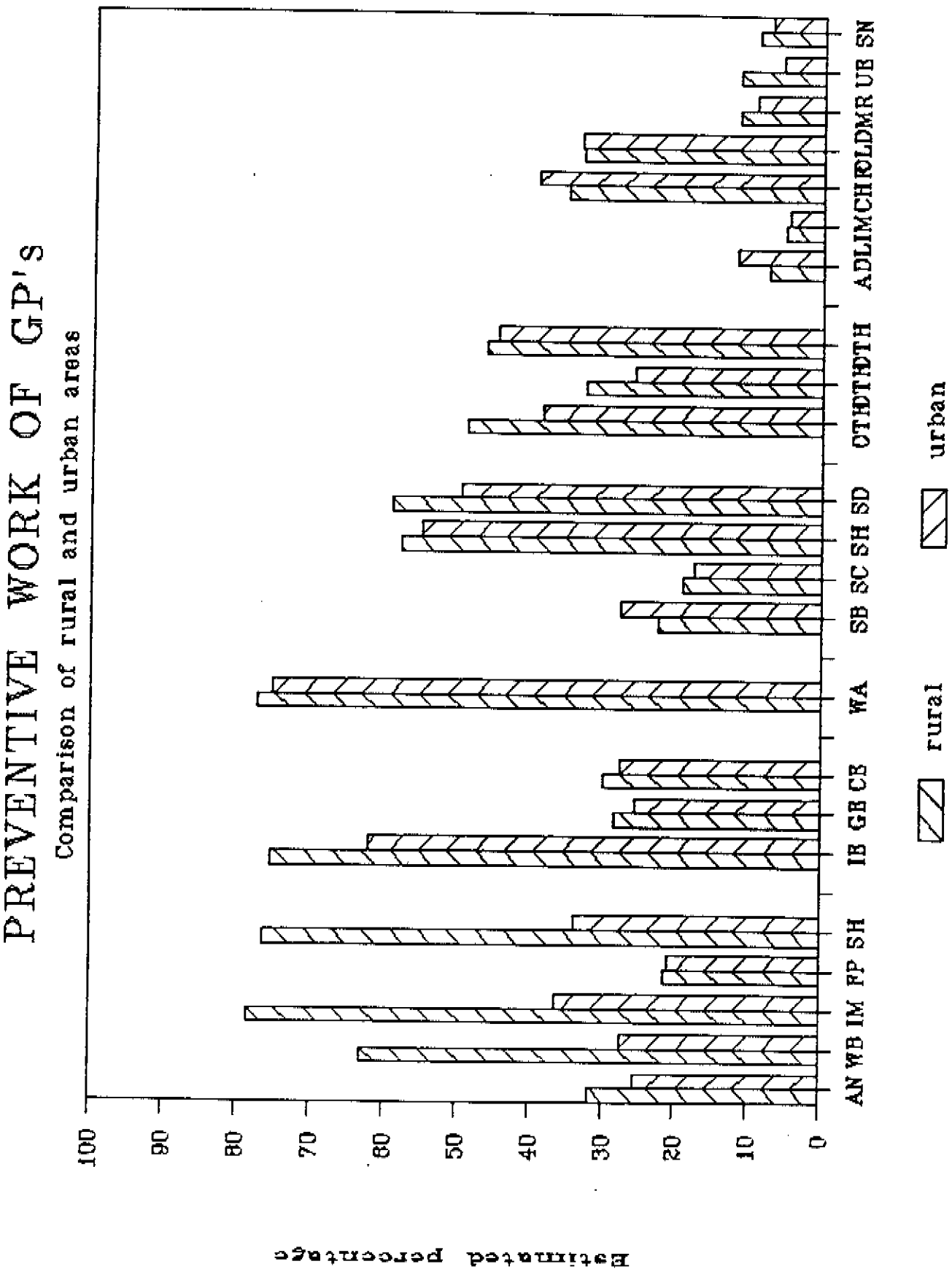
0
AN WB IM FP SH IE GB CB WA SB SC SH SD OTHDTHDTH ADLIMCHOLDMR UB SN


PREVENTIVE WORK OF GP's
Comparison of rural and urban areas
Estimated percentage
100
90
80
70
60
50
40
30
20
10
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AN WB IM FP SH
IB GB CB
WA
SB SC SH SD
CTHDTHDTH
ADLIMCHRØLDMR UB SN
rural
urban

Fig. 3

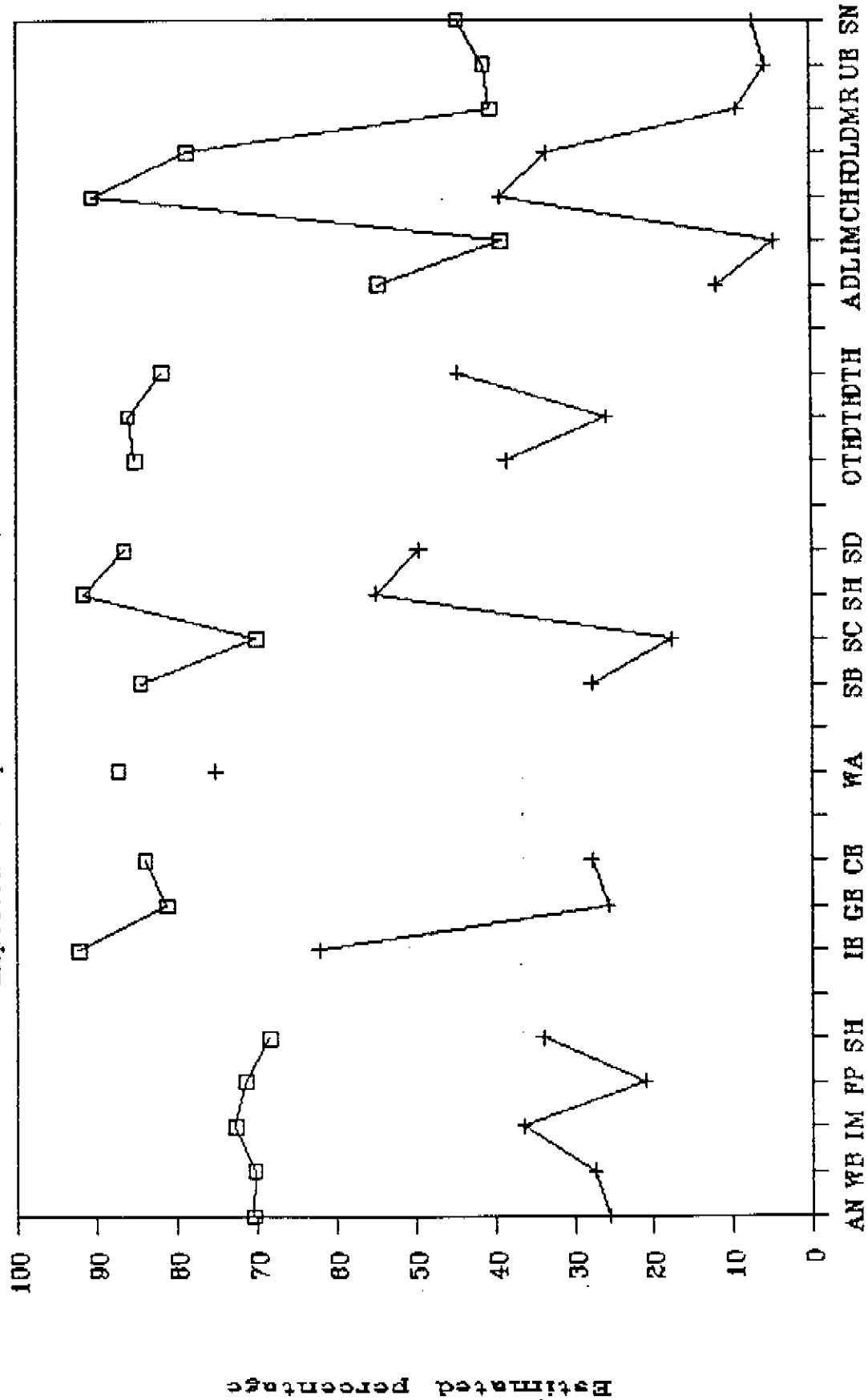

PREVENTIVE WORK OF GP's
Expected and performed work, urban area
Estimated percentage
100
90
80
70
60
50
40
30
20
10
0
AN WB IM PP SH IB GB CB WA SB SC SH SD OTHDTHDTH ADLIMCHRDLDMR UB SN
□ Expected
+ Performed

Fig. 4

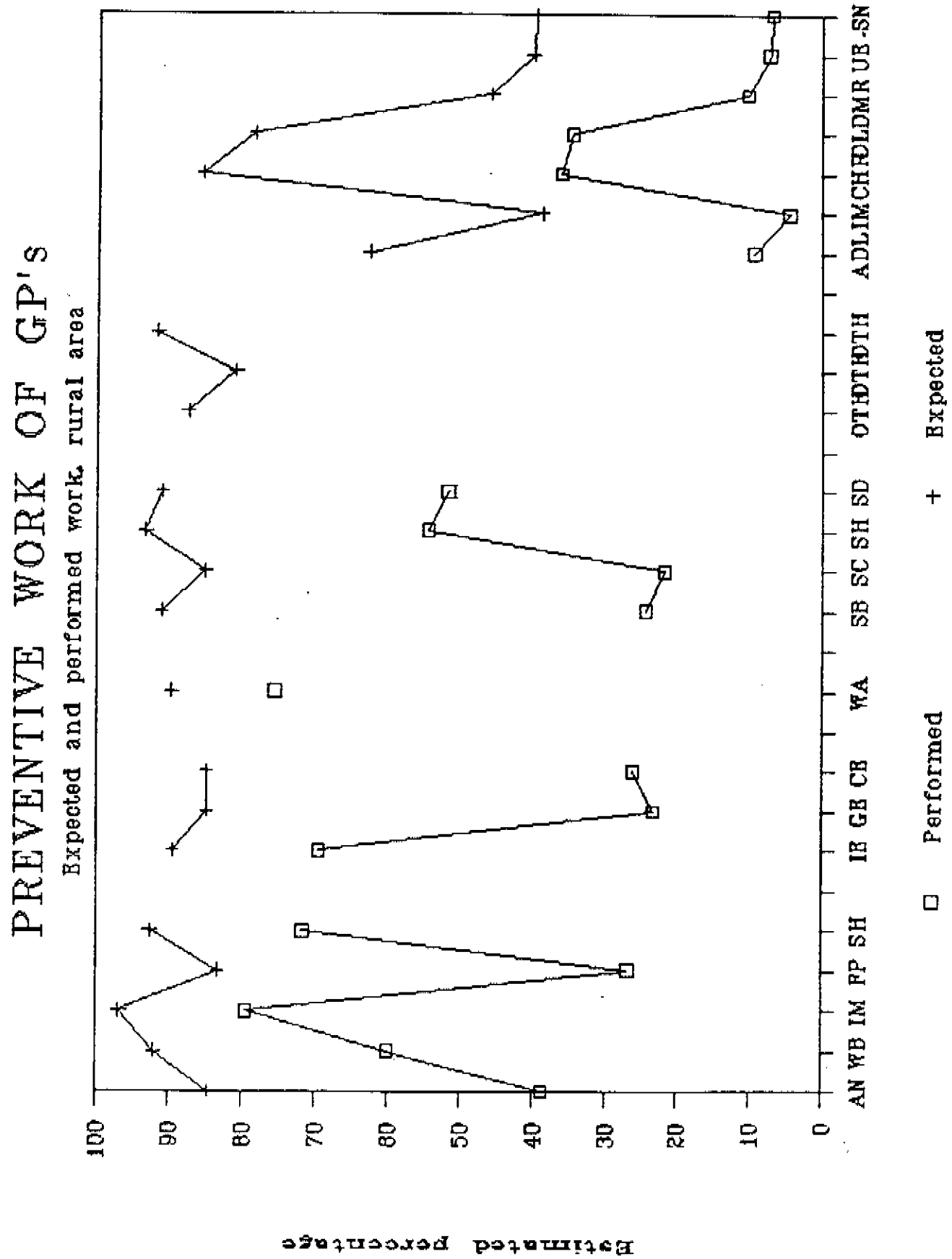

PREVENTIVE WORK OF GP'S
Expected and performed work, rural area
Estimated percentage
100
90
80
70
60
50
40
30
20
10
0
AN WB IM FP SH IE GE CB WA SB SC SH SD OTHDTHDTH ADLIMCHRDLDMR UB-SN
Performed
Expected

Fig. 5

services exist. Other vulnerable groups which have not yet standardized "obligatory" programmes also became general practitioners' centre of interest and concern. In this field, screening procedures are most popular, representing a conventional medical approach to prevention. The positive sign is that experiments are in progress and many initiatives exist.

However, risks peculiar to women have somehow been removed from the scope of generalists, who either have been pushed out or left this field, which has been taken over by gynaecologists. (The same trend is visible in family planning and even in antenatal care.)

The important observation, one that should also serve as a warning, is that psychological and social risks have so far not been viewed in terms of prevention needs, which must come within the purview of general practitioners in the same way that transitional physical diseases and risks do.

Comparing answers from Yugoslavia with those from other countries

The averages of all answers received from Yugoslavia were compared with those received from other countries. The limitations of the comparison have been mentioned; any interpretation therefore has to be done carefully. However, again it seems that a general pattern exists, as well as some striking differences. Unfortunately, because of technical reasons, a part of questionnaire was not answered by more than half of the respondents, so that one part (preventive activities and continuous care for risk groups) cannot be presented.

Estimates on preventive work of practitioners in urban and in rural areas are shown in Fig. 6 and 7. In both cases the general pattern of answers is similar, but with several striking differences:

- for antenatal care and family planning programmes the estimates are higher in "other" countries;

- screening of breast cancer and cervical cancer is estimated at a lower level in answers from Yugoslavia;

- the assessment of working capacity is consistently lower in estimates from "other" countries.

It is interesting that the results were somehow not accepted by respondents from Yugoslavia, because their answers about the "needed" (desirable) level of performance were definitely higher in all cases, but especially in those in which the differences in estimated levels of performance level between Yugoslavia and "others" is pronounced. Results are shown in Fig. 8 and Fig. 9. These figures also show that expectations are higher in Yugoslavia, both for urban and rural areas. However, in the opposite case, i.e. the assessment of working capacity, there was no greater difference between performed and expected activities in "other" countries, which may be interpreted as being "normal" for those countries.

Fig. 10 is a comprehensive overview of all the results obtained on estimated performed activities, Fig. 11 on expected activities and Fig. 12 on differences between performed and expected activities. The presented average answers are similar overall. The unanimously estimated highest expectation is related to individual counselling and health education, and closely after that screening procedures for common chronic diseases.

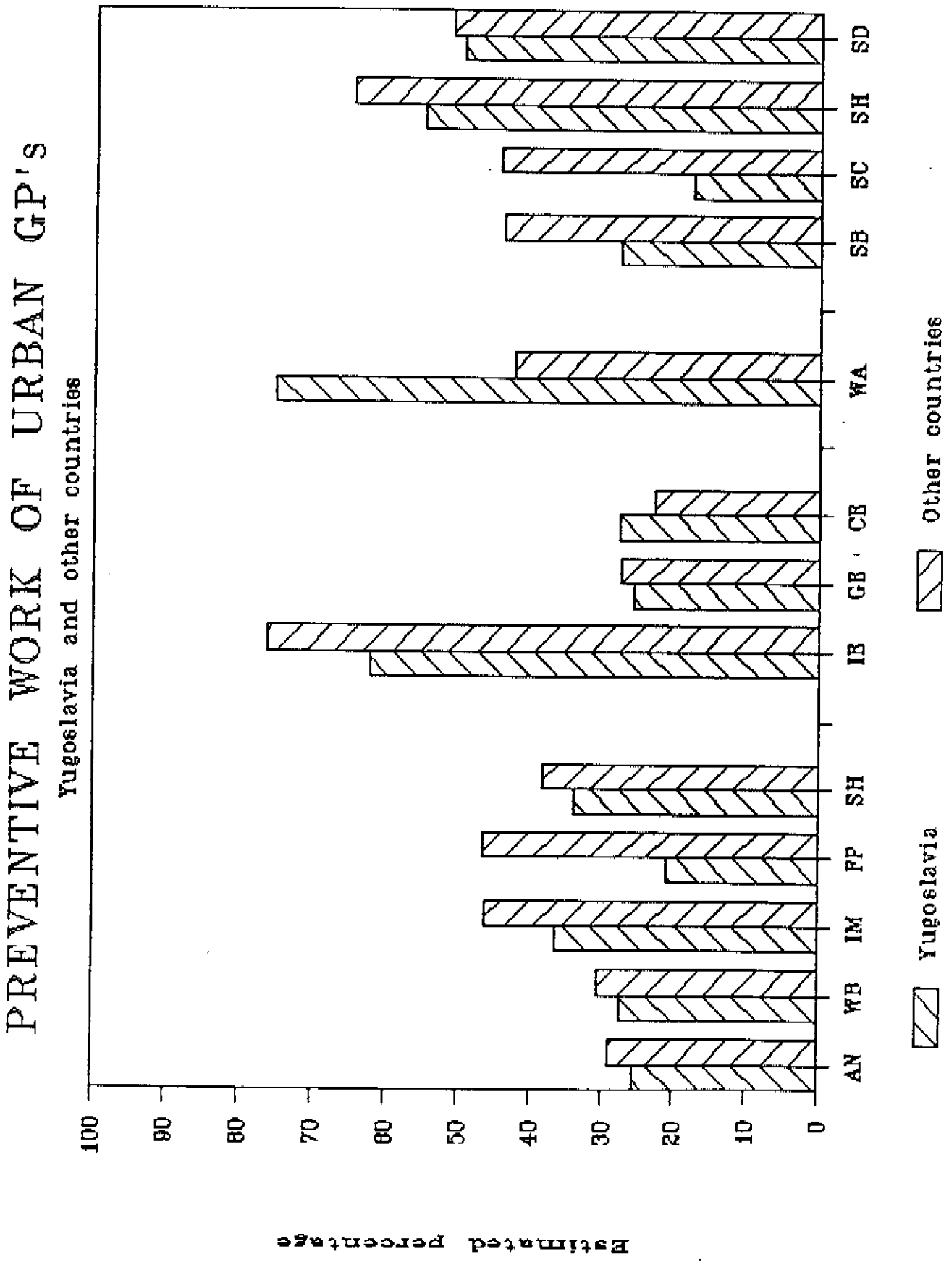

PREVENTIVE WORK OF URBAN GP's
Yugoslavia and other countries
Estimated percentage
100
90
80
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IB
GB
CB
WA
SB
SC
SH
SD
Yugoslavia
Other countries

Fig. 6

Fig. 7

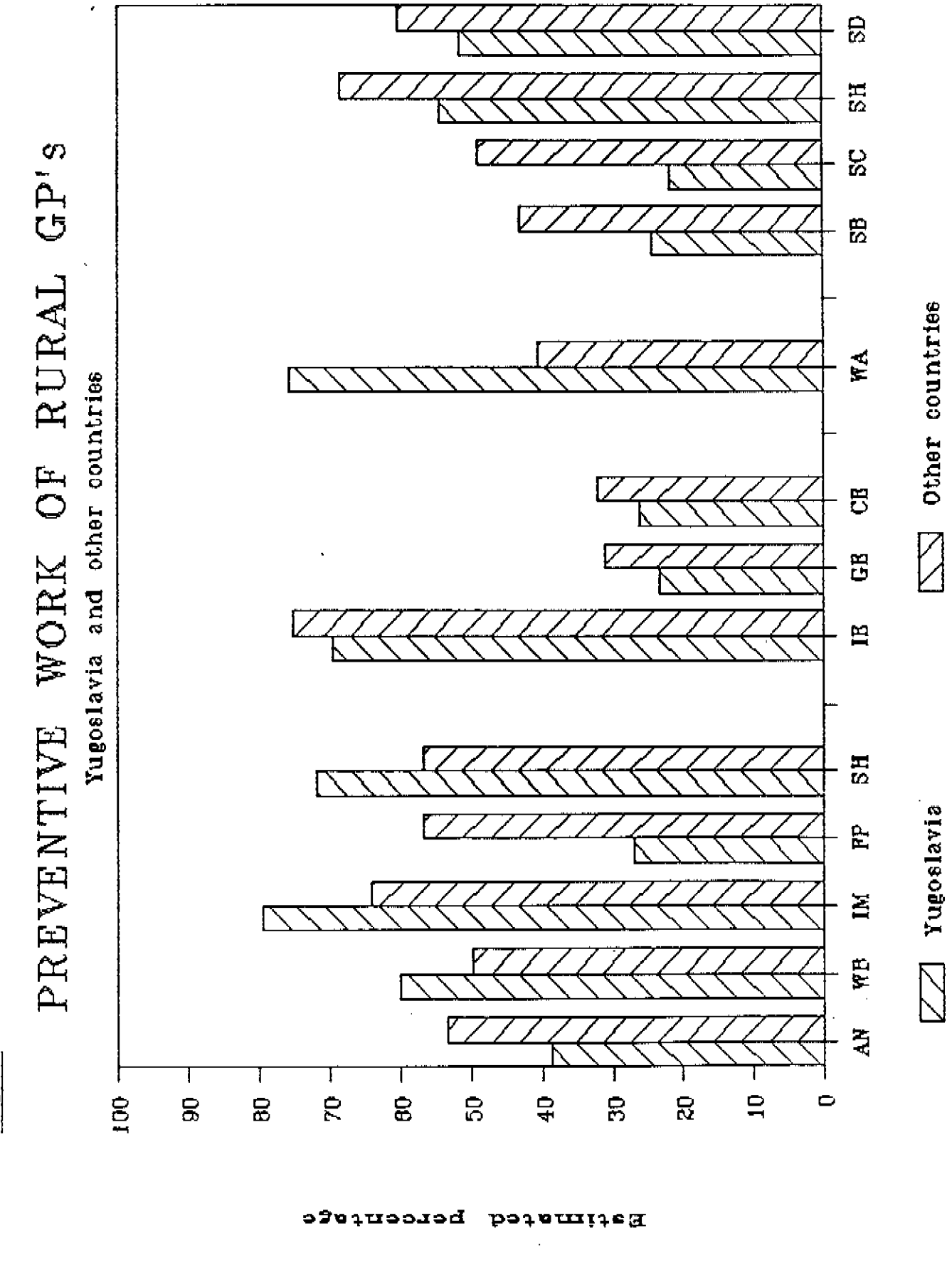

PREVENTIVE WORK OF RURAL GP's
Yugoslavia and other countries
Estimated percentage
100
90
80
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IB
GB
CB
WA
SB
SC
SH
SD
Yugoslavia
Other countries

Fig. 8

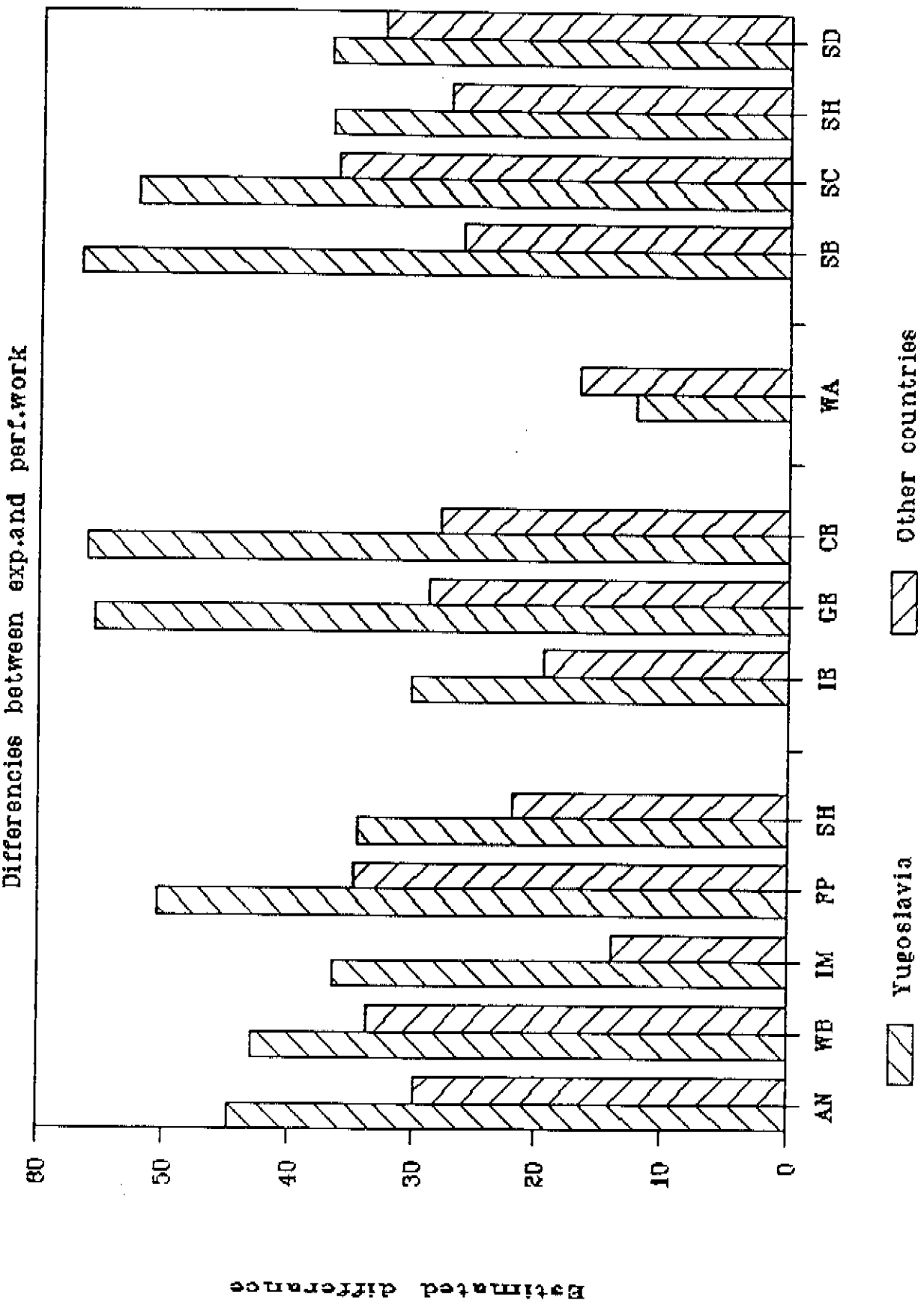

PREVENTIVE WORK OF URBAN GP's
Differencies between exp.and perf.work
Estimated difference
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IB
GR
CR
WA
SB
SC
SH
SD
Yugoslavia
Other countries

Fig. 9

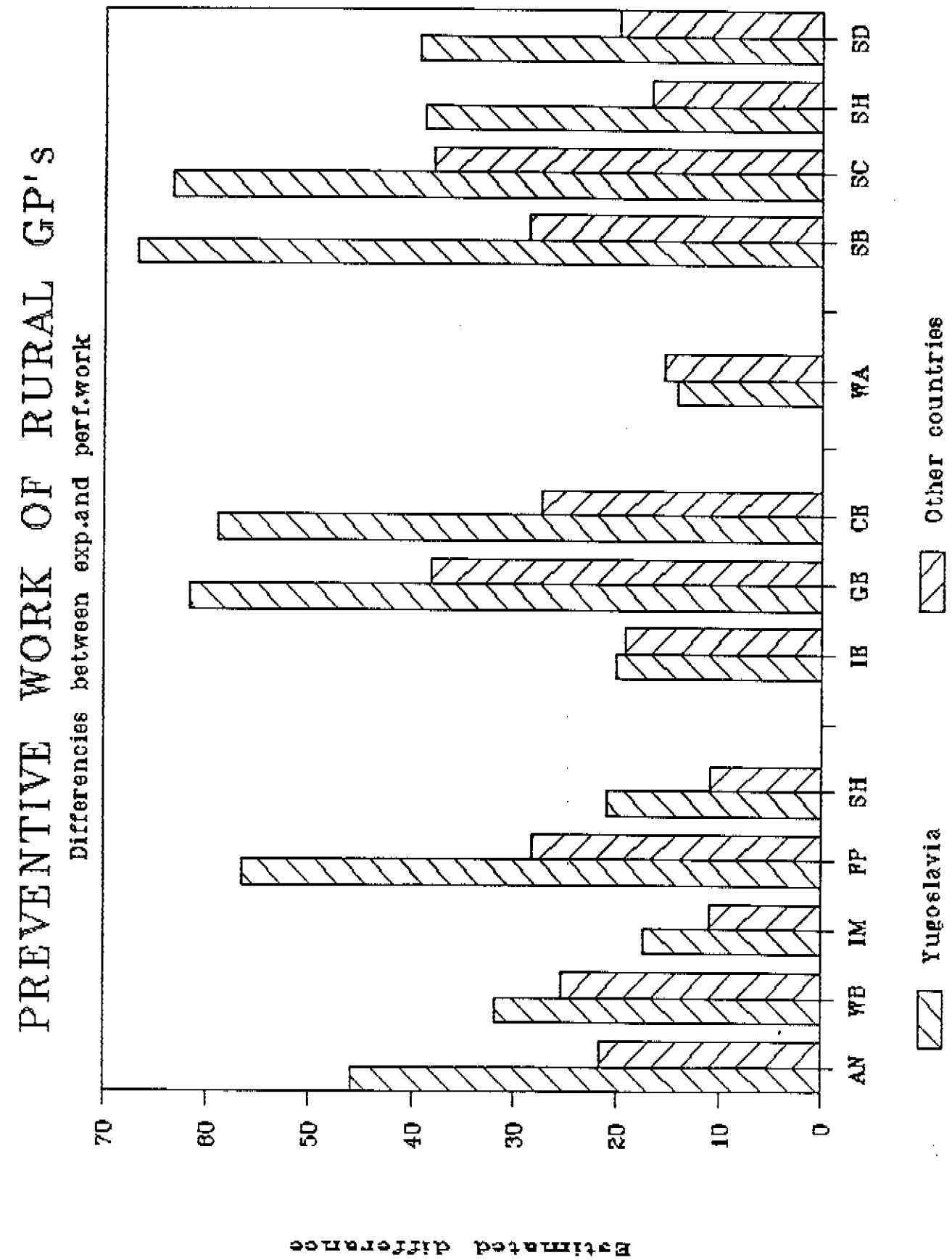

PREVENTIVE WORK OF RURAL GP's
Differencies between exp.and perf.work
Estimated difference
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IE
GB
CB
WA
SB
SC
SH
SD
Yugoslavia
Other countries

Fig. 10

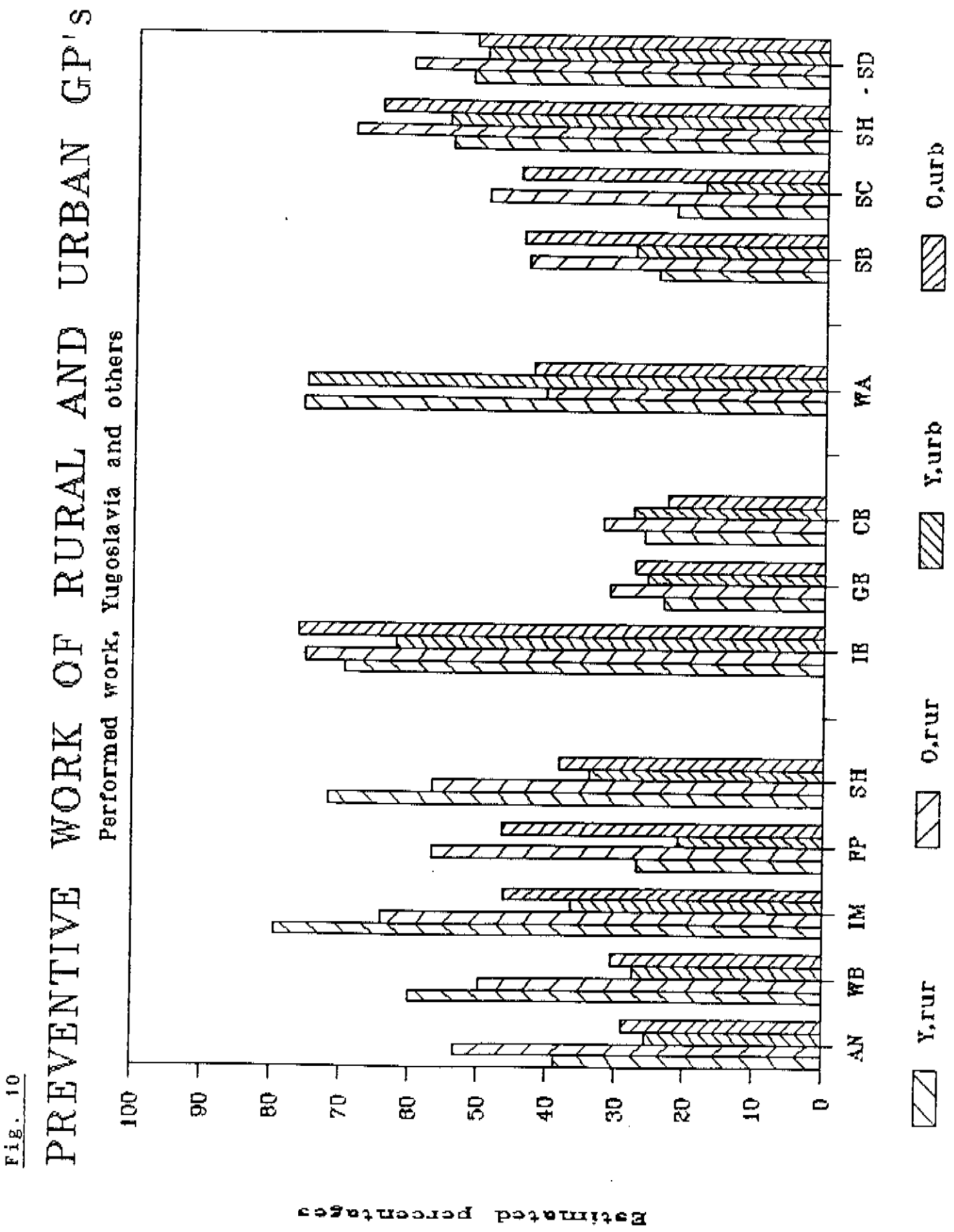

PREVENTIVE WORK OF RURAL AND URBAN GP'S
Performed work, Yugoslavia and others
Estimated percentages
100
90
80
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IE
GB
CB
WA
SB
SC
SH - SD
Y,rur
O,rur
Y,urb
O,urb

Fig. 11

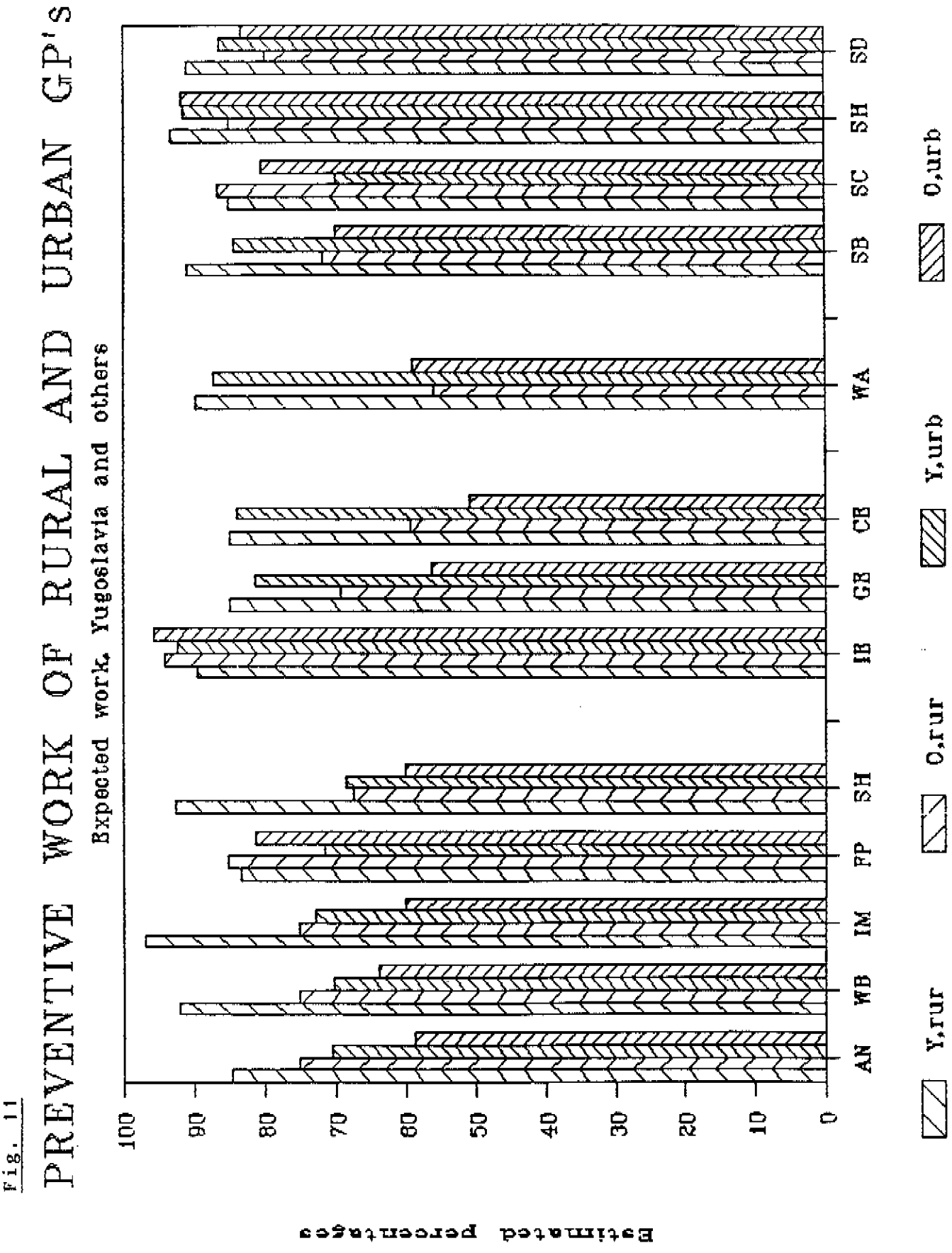
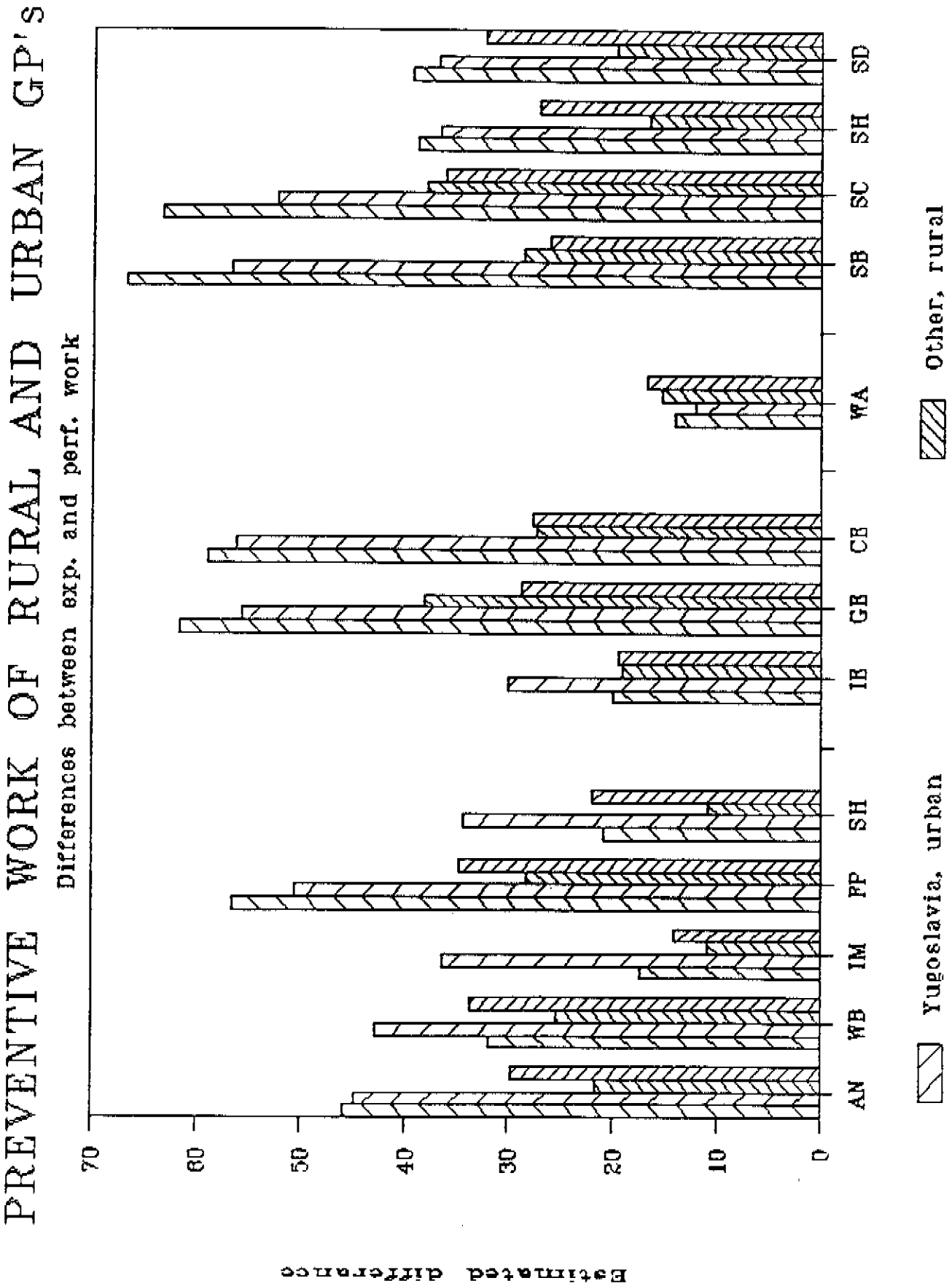

PREVENTIVE WORK OF RURAL AND URBAN GP'S
Expected work, Yugoslavia and others
Estimated percentages
100
90
80
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IB
GB
CB
WA
SB
SC
SH
SD
Y,rur
O,rur
Y,urb
O,urb

Fig. 12


PREVENTIVE WORK OF RURAL AND URBAN GP's
Differences between exp. and perf. work
Estimated difference
70
60
50
40
30
20
10
0
AN
WB
IM
FP
SH
IE
GE
CE
WA
SB
SC
SH
SD
Yugoslavia, urban
Other, rural

The paradigm is traditional. The expectation in maternal and child health is high in rural areas and less so in urban areas. The health education activities in groups and in communities are on the same level as maternal and child health for urban areas: 50-60% in other countries and somehow higher 60-70% for rural areas. In some countries it might be the consequence of attitudes and traditions that the prime interest of practitioners is the individual, followed by the family, and less pronounced interest for the neighbourhood or community. It also could be the consequence of a common situation that other (specialized or voluntary) services have taken over the care of families and groups and of communal aspects of health prevention and promotion.

The presented data indicate differences in attitudes of those who answered the questionnaire. The comparison of data from Yugoslavia and other countries is to a certain extent artificial and the consequence of a limited number of answers from some countries. If it is possible to judge on the basis of the replies from Yugoslavia, one may expect great differences in opinion inside the countries, but also between different countries and regions of Europe. It would not be justified, because of that, to regard Yugoslavia as a special case, but to understand the comparison only as a tool to indicate existing differences.

It is also clear from the individual descriptive answers from countries that there are pronounced differences in attitudes in countries with centrally planned services (e.g. German Democratic Republic, Romania), and those having a pluralistic approach (e.g. Belgium, Netherlands). It is also an impression of new trends in new, young circles of practitioners in some countries in southern Europe (e.g. Portugal, Spain).

Unfortunately, all these observations are incomplete and unreliable, because the sample and the responses have not covered all the relevant parts of Europe and have been limited by small numbers and subjective estimates. On the other hand, these results contribute to the conclusion of other studies that in spite of differences there is a convergent "European attitude", which may enrich PHC experience and further thinking about future PHC strategies.

Analysis of the data identified several alternative strategies, of which the most important are:

- the relation between "comprehensive general practice" and "community health" in the framework of PHC policy: division of work and collaboration and, consequently, organization of health centres and their position inside a district;

- the relation between "family medicine" and "occupational health": profound changes in work characteristics in the postindustrial era (work at home, stress and chronic diseases as major health problems, work and free time, etc.);

- the balance of "medical" and "other" aspects (social, educational, behavioural) of prevention and, consequently, the type of core team and integration of health and social services.

The present position and support needed in changing the situation

Fig. 13 presents the answers on the estimated degree of power of general practitioners, namely answers to the question: How strong is the position of general practitioners in relation to other parts of the health system and social sector? If the answer was "poor", the mark was 1, if "very strong", the answer was marked 5. All the other answers were quantified in-between. The question was asked in two forms: first, what is the actual situation and, second, what would be desired. Because the average results have been parallel (with the difference that estimates related as "desired" were on a higher level), only estimates given for "actual" situation are presented. The results are again given for Yugoslavia and "other" countries separately.

The estimated results obtained from "other" countries were on a higher level, nearly all above 3 (good). Average estimates from Yugoslavia are above 3 in only two categories: position of general practitioners inside a PHC setting and inside their own team. However, one may observe some major similarities because estimates from "other" countries were highest in the same categories.

With regard to hospital care, the estimate from Yugoslavia is the lowest, but in this category there is also the largest gap between estimates from Yugoslavia and "other" countries.

The other similarity is that the influence on the political system is low for both Yugoslavia and other countries, and is lowest among estimates from "other" countries. The estimated influence on local communities is among the higher estimates and in answers from "other" countries immediately after estimated influence on PHC and own team.

The other interesting difference between answers from Yugoslavia and "other" countries is in comparatively higher estimates in Yugoslavia concerning power in relation to social services, establishments (companies and firms) and other sectors, but a lower estimated power to influence the ecological situation. Although the differences are not big, the findings are worth further consideration.

An analysis of the position of general practice in the power structure inside the social system might be one of the most important further studies with regard to implementing PHC. It would also be interesting to compare attitudes not only among different countries and systems, but also among different profiles of medical and health professionals.

A similar attitude is reflected in different ways (or vehicles, channels) with regard to the implementation of prevention activities. The results are shown in Fig. 14. The estimates are given twice, under different categories. The first is under the category "general awareness of practitioners" and the second represents the opinion of the respondent "is it needed to be used by practitioners" or "are the practitioners aware of their role". The distinction between those two questions was not quite clear, which led to comparatively small differences between answers. The pattern again is clear and quite similar for answers from Yugoslavia and from "other" countries, except in relation to establishments.

Fig. 13

POSITION OF GENERAL PRACTITIONERS

IN RELATION TO OTHER FACTORS

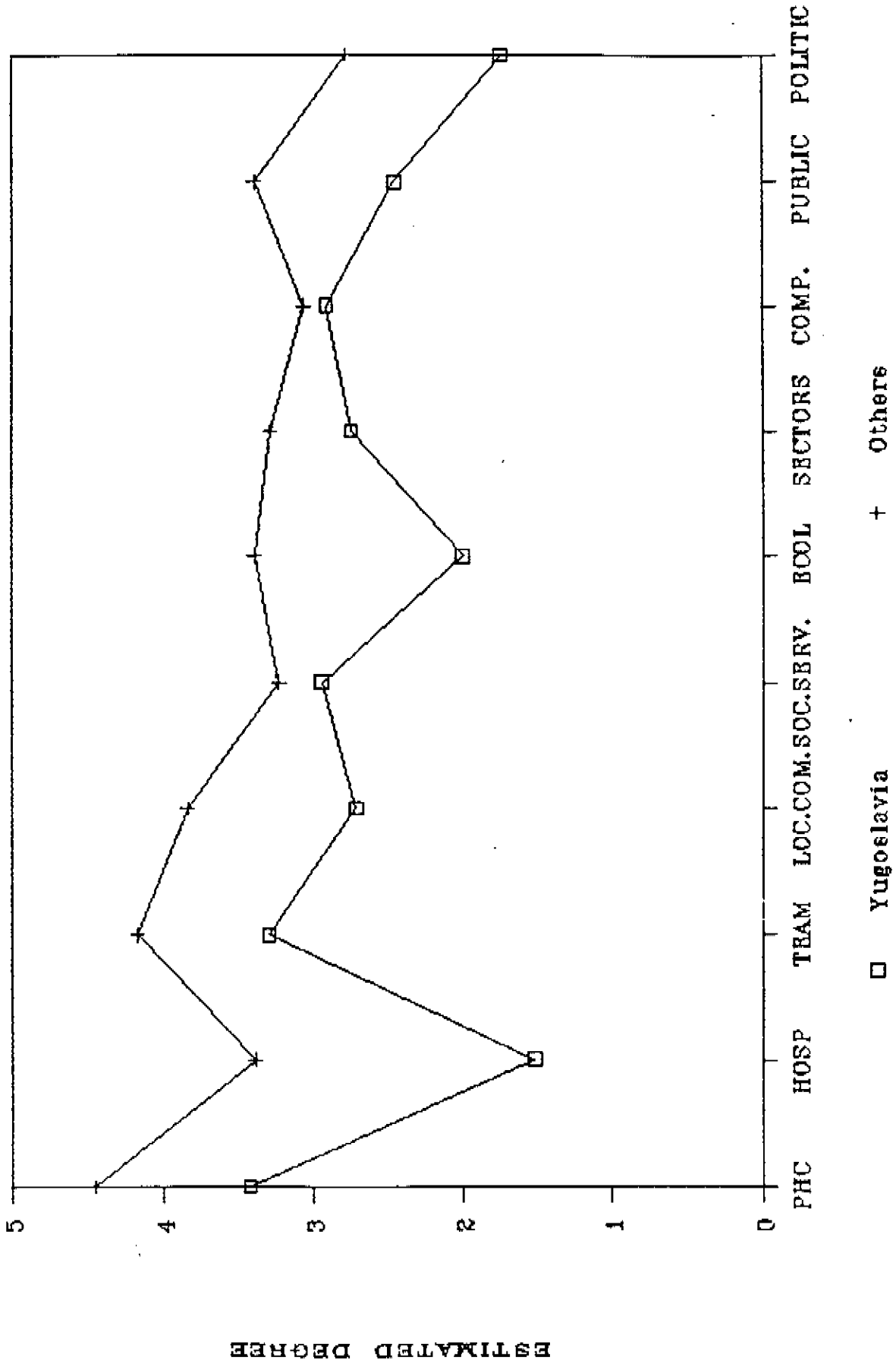
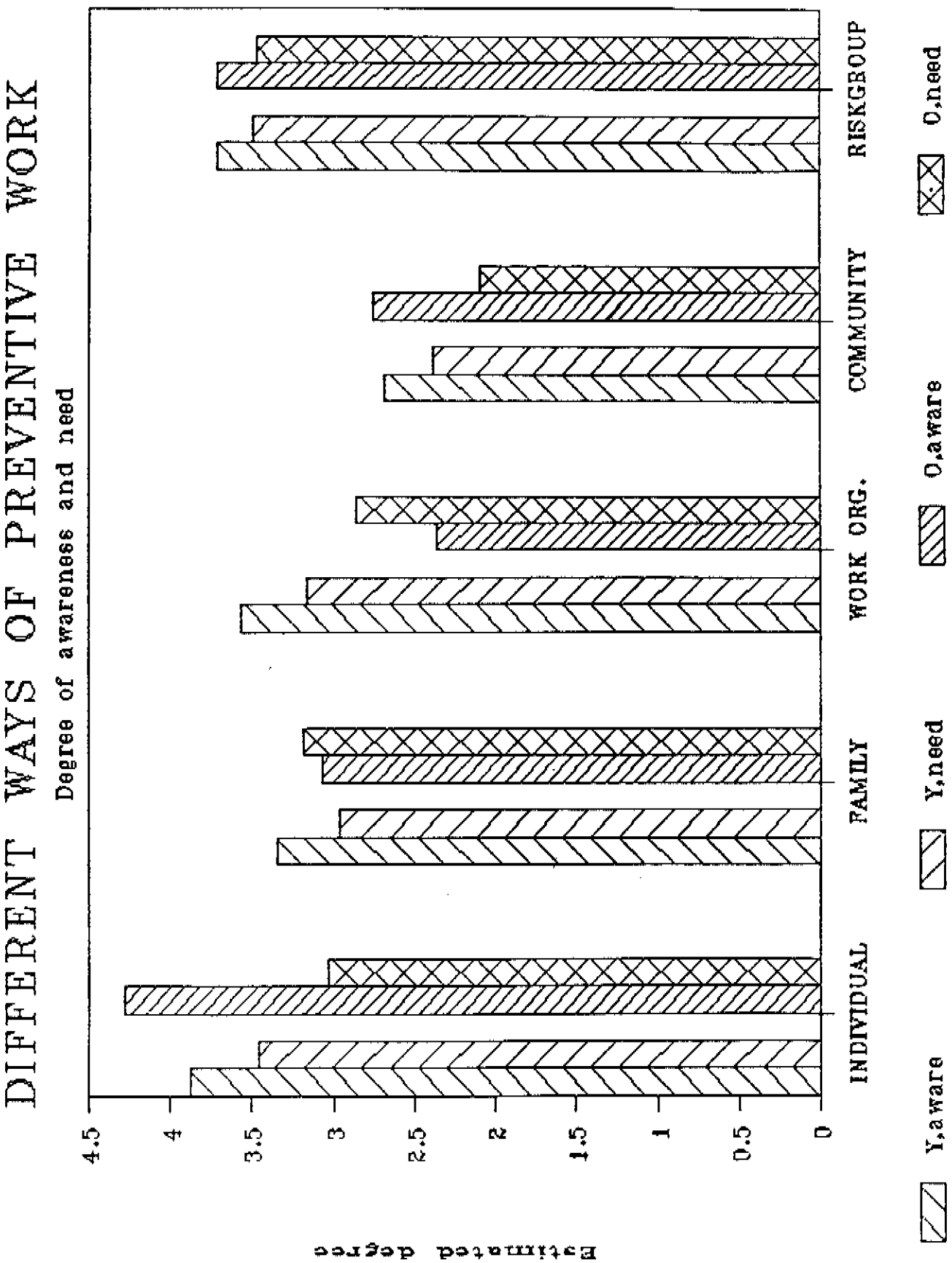


Fig. 14


DIFFERENT WAYS OF PREVENTIVE WORK
Degree of awareness and need
Estimated degree
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
INDIVIDUAL
FAMILY
WORK ORG.
COMMUNITY
RISKGROUP
Y,aware
Y,need
O,aware
O,need

The common ranking of different ways (vehicles) in implementing prevention activities by general practitioners is:

- individuals
- risk groups
- family (and establishments, Yugoslavia)
- community (and establishments, "other" countries).

This is an expected ranking and in agreement with previous answers. The question arises as to whether that ranking be changed.

Fig. 15 presents the estimated degree of satisfaction with different factors that influence the status and practice of prevention activities and comprehensive PHC. Again, it is surprising how similar the pattern of estimates is. The ranking of factors and circumstances supporting prevention activities of general practitioners is estimated as follows:

- postgraduate education;
- personnel they work with in teams;
- premises;
- transport, information and organization of services (communication devices and home treatment tools for "other" countries; personal income for "other" countries);
- personnel they work with in the community
- basic medical education;
- equipment (except for computers and educational equipment for Yugoslavia);
- necessary local institutions;
- financial and other stimulation for preventive work.

The biggest differences between answers from Yugoslavia and from "other" countries were in different types of equipment and in personal income.

Further explanation and elaboration can be found in the comments that have been added to the quantitative estimates. There were more than 200 remarks, of which only the most frequent are mentioned here. Detailed reports from the German Democratic Republic[a] and Netherlands[b] are available.

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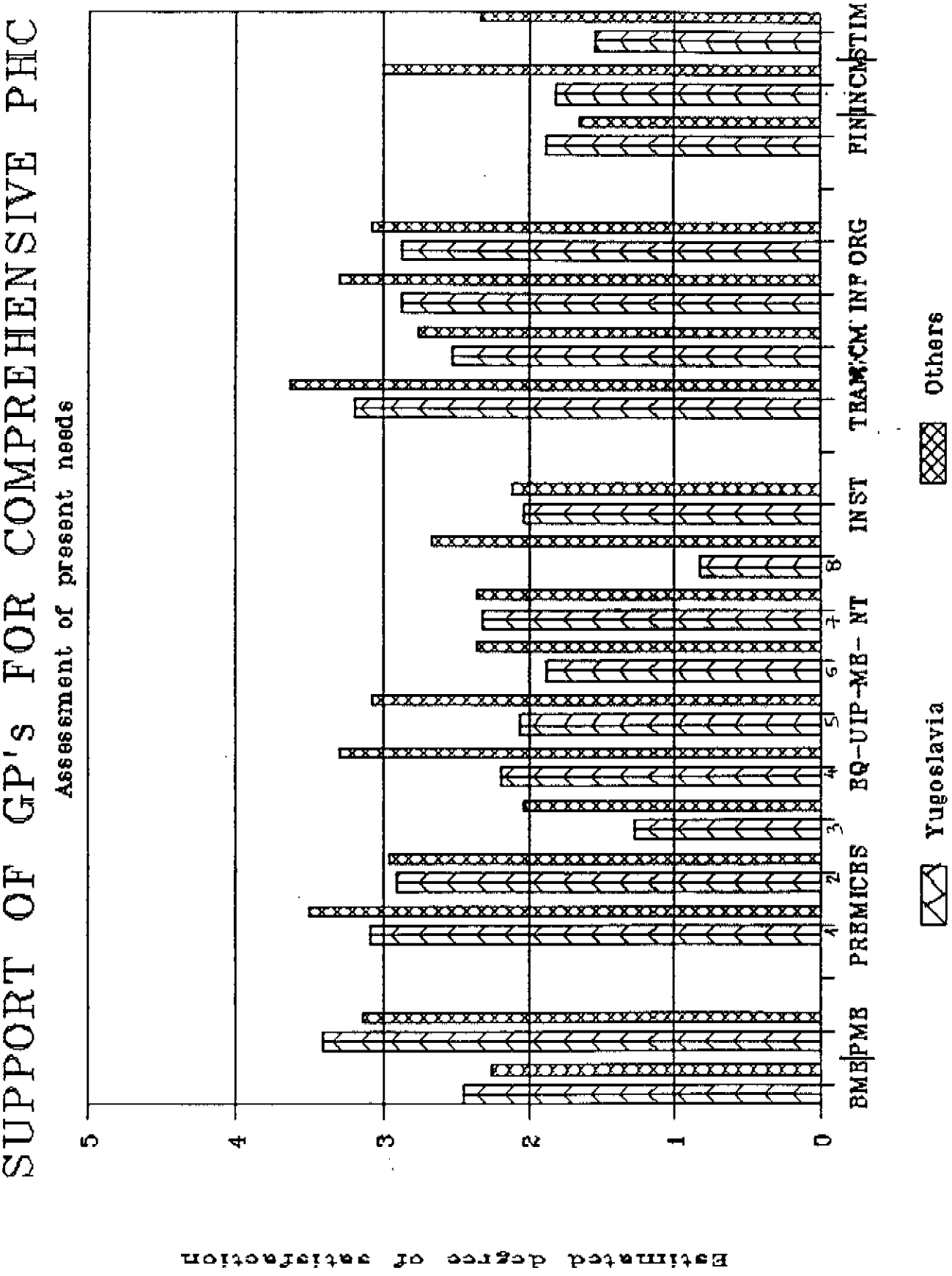
[a] Weiss, O. & Huttner, H., ed. Analyse zur hausarztlichen Betreung in der DDR. Institut fur Sozialhygiene und Organisation des Gesundheitswesens, Berlin, 1987.

[b] van Eijk, J. Health promotion in general practice (unpublished working paper).

Fig. 15


SUPPORT OF GP's FOR COMPREHENSIVE PHC
Assessment of present needs
Estimated degree of satisfaction
0
1
2
3
4
5
BMB
PMB
PREMICES
BQ-UIP-MB-NT
INST
TRAM
CM
INF
ORG
FIN
INCM
STIM
Yugoslavia
Others

Constraints and obstacles, strategies for change

Constraints and obstacles

The experiences in implementation of comprehensive PHC, in which an important part is also prevention and health promotion, varies according to circumstances. However, it is significant that many major obstacles and some constraints are similar. This similarity may to a certain extent also be superficial, because similar wordings may have different meanings and connotations under dissimilar circumstances.

The following are the most prominent constraints:

- general position of prevention activities: poor and late visibility of consequences, inadequate elaboration of programmes (except for some measures, such as immunization and maternal and child health), inadequate preparation of professionals, suppression by curative tasks, etc.;

- no local population census, overlapping of services; poor information of practitioners about their practice population, epidemiological situation, general health policies and alternative demands and practices by people;

- disintegrated and medically oriented health services, incapable and unwilling to implement comprehensive approach; often bureaucratic administration, conservative and destimulating; dominating hospital services, no special institutions supporting prevention activities, no vigorous district PHC concept;

- lack of incentives and financial resources for preventive activities; limited budgetary sources and poor interest of health insurance and other agencies in financing preventive services;

- in some southern and eastern European countries, as well as in Yugoslavia, there are shortages and restrictions in needed materials, number and kind of personnel;

- worsening of general health situation (especially degradation of environment in which people work, live and recreate), prevalent unhealthy living habits (addiction, smoking and alcoholism), and inappropriate information through public media.

In the face of all these constraints PHC practitioners feel powerless.

Major obstacles are:

- specialized medical programmes and separate vertical services; prevention and health promotion formally planned but not adequately supported;

- generally poor motivation of practitioners, their isolation, turnover, inadequate working conditions; little concern for psychological, social and preventive aspects of patients, their demands and population health needs; possible negative selection and inappropriate education;

- nihilistic and cynical approach towards prevention, especially towards health needs and preventive measures effective in adults and the elderly; inadequate technical elaboration, standardization and evaluation of programmes; physicians frequently disloyal;

- inadequate number of professionals with experience in interdisciplinary and intersectoral work; low level of collaboration and teamwork;

- health services separated from voluntary and lay people's initiatives.

Existing and new strategies

The existing strategies, already formally declared internationally and in particular countries, are regarded as positive but generally not sufficient. Among them are:

- PHC policies, some new laws and regulations;

- population census, geographic delineation of territories for prevention activities;

- postgraduate training and permanent education of health workers;

- technical information and plans for prevention activities of PHC practitioners, their monitoring and quality assurance;

- better information systems inside health services;

- different experimental forms of involvement of patients and people in self-help groups.

The answers from Yugoslavia are different in the sense that they are more critical. Many of existing policy documents have been criticized as being unrealistic, mere declarations without the support of financial, organizational, material and educational measures. There are several requests for legal changes guaranteeing the freedom of choice of people, deregulation of PHC activities and forms of work.

There were an additional number of proposals for new strategies.

1. Economic stimulation of preventive activities both by innovative approaches to finding and mobilizing new resources (but guaranteed essentially by public funds and the state budget), and by distribution and efficient spending on prevention activities. The method of payment of personnel and incentives also have to be considered in new ways, opening competition between practitioners and quality control measures.

2. Social, professional and all other possible measures to increase the status, prestige and real capabilities of PHC teams, general practitioners and nurses. Their involvement in decision-making, stimulating career structure and ways of promotion, publicity, open door to continuous education and research, etc.

3. Radical change in all forms of education, especially in basic medical education, particularly in balancing and, when possible, integrating the social and psychological aspects of health practice with dominating technical

and biomedical sciences. The multiprofessional training of health professionals through joint training of students learning different disciplines.

4. Strong public information on scientifically based prevention activities and education through all possible channels (public media, schools, voluntary actions, self-help groups, "third age" universities, etc.).

5. Organization of autonomous group practices and health centres having "horizontal" health promotion programmes and continuously working in small local communities. It would also be their responsibility to integrate all vertical programmes and coordinate their work with local voluntary groups. They have to have some formal possibilities for involving local communities, without monopolizing or imposing their own way but rather as an equitable partnership.

6. Consideration of possible new role or organization of district or regional public health centres providing technical support to PHC teams in dealing with health promotion, protection of the health environment, health propaganda and quality assessment of services.

7. The intensification of research: epidemiology, intervention studies, technology assessment, health economics and operations research. The PHC practitioners should be stimulated to join.

8. Influencing political and other activities in support of healthy environment and healthy living in an organized way.

Obviously, each proposal contains some problems that have not yet been solved, but some proposals have unanimous backing as a solution to primary health care.

One of main dilemmas is how to combine the technical standardization, quality control and joint planning of prevention actions with freedom of choice, free support of all initiatives, and so forth. The question may be summarized as: is more regulation or more deregulation needed?

On the other hand, some of the old dilemmas, at least in the group of those who answered the questionnaire, apparently disappeared: integrated or specialized approach; vertical or horizontal programmes; the area planning and the district type of arrangement, yes or no? The most common response was an integrated, horizontal service and district system. Only one opinion and two remarks questioned this type of solution, although many complained that real practice is far from the desired solutions.

Another important impression is that although there was probably an over-optimistic estimate of the present situation, expressed in estimated percentages, solutions and new proposals have been made in a realistic tone and with real concern. There is no doubt that developments are moving in the right direction and that a general practitioner, a (district) nurse and new types of health worker will form the backbone of a future team providing comprehensive PHC. It appears that their concern for community health affairs is growing, and a convergent synthesis can be envisaged, combining personal care, prevention and rehabilitation for individuals but also caring for families and other groups in which people live and work.

Conclusions

1. A PHC team (with a general practitioner and a home-visiting nurse as core members) is emerging as the essential and integrating element of PHC services providing continuous and comprehensive care.

2. A convergent development, based on different cultures, social and health systems and organization of services, is showing a need for complementary additions to the skills and experience of general practitioners, especially communication, prevention, management.

3. The survey of opinion of practitioners and public health experts show differences but also a common pattern of preventive practices provided by general practitioners. The essential one is a transition from traditional forms of prevention, individual and medical, to participation in health promotion and changes in lifestyles.

4. The power of general practitioners to influence different factors important in the provision of comprehensive PHC has been analysed. The strongest relations are inside the settings of PHC, and the very lowest in relation to hospitals and the political sphere.

5. A list of obstacles and constraints was made based on responses, among the most important being poor technical and material support and the low self-confidence and prestige of general practitioners.

6. The existing strategies are regarded as positive but insufficient. Among the most significant at present are postgraduate and continuous education, the team with which the practitioner will work and financial support.

7. A rich list of suggestions and proposed new strategies is given in the report, and some existing dilemmas revealed, especially in the economic field and in ways to reach a desired balance between the free choice and initiative of people and professionals and planning, standardization and quality assurance of services.

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Annex 1

QUESTIONNAIRE ON THE SITUATION AND PERSPECTIVES OF GENERAL PRACTITIONERS AND FAMILY PHYSICIANS IN EUROPE WHO PROVIDE COMPREHENSIVE PRIMARY HEALTH CARE

Purpose

The purpose of the survey is to better understand the circumstances in which general practitioners and other physicians in PHC work, and what the strategies and opportunities are to broaden and reorient some of their activities towards provision of comprehensive PHC.

General practitioners and district the health nurses are regarded as major professional resources interested in PHC.

The result of the survey will be used for further consideration of strategies and exchange of experience in fostering the development of PHC oriented towards general practice, i.e. family practice.

Instructions and explanations

The questionnaire is meant to be answered by general practitioners, health service organizers and users of services or other lay people.

They will be asked to try to answer the questionnaire in relation to a particular urban or rural area (a district or region, for example).

The replies should refer to general practitioners or family physicians. In many countries, physicians from various specialized disciplines work as practitioners; this should be indicated separately and a separate questionnaire should be filled in, keeping in mind all the PHC-practising physicians.

The questions are general and mostly require educated guesses or personal opinion. It is an attitudinal questionnaire. If some data (research paper) exist, it would be appreciated if they are added to the questionnaire.

The most important questions are found at the end of the questionnaire and concern strategies, obstacles, and so on. This part is even more important then the first one, which is on the description of work at the present moment.

GENERAL DATA

Respondent

Age

Sex

Profession

Direct involvement in PHC

Circumstances

Date

Individual or group answers

Answers related to the area:

urban
rural

The local name of that type of practitioner:

Are some other types (disciplines) of physician practising in PHC in the area?

Other comments or explanations:

Further information can be obtained:

1. Are general practitioners in your country involved in preventive activities?

   Estimate the percentage of those who are working in these activities and the (desired) percentage that should be working in these activities, for urban and rural areas respectively.

	Rural areas		Urban areas	
	Work	Should work	Work	Should work
Antenatal care				
Well baby clinics				
Immunization				
Family planning				
School health programme				
Individual health counselling				
Programmed health education in small groups				
Health education in the community				
Working capacity assessment				
Screening of breast cancer				
Screening of cervical cancer				
Screening of hypertension				
Screening of diabetes				
Other				

2. How much do general practitioners contribute to the continuity of care?

Assess whether this contribution is satisfactory or not and give examples of typical problems.

Relation with the hospital (before, during and after hospitalization)	SATISFIES:	YES	PARTLY	NO
Example:				
Home treatment	SATISFIES:	YES	PARTLY	NO
Example:				
Occupational health (workers' health care)	SATISFIES:	YES	PARTLY	NO
Example:				
Specialists' consultation	SATISFIES:	YES	PARTLY	NO
Example:				
Medical records	SATISFIES:	YES	PARTLY	NO
Example:				
Knowledge about the health situation of a community with a certain population	SATISFIES:	YES	PARTLY	NO
Example:				

3. Are general practitioners aware of the preventive needs of the population and their role in preventive activities?

Assess the situation by using a 1-5 scale, 1 equals no and 5 equals completely.

(a) Aware of:

preventive needs in individuals	/__/
preventive needs through family	/__/
preventive needs through work organizations	/__/
preventive needs of the local community	/__/
preventive needs of certain at-risk groups	/__/

Specify the needs which they are not aware of:

(b) Aware of the role of:

prevention in individuals	/__/
prevention through family	/__/
prevention through work organizations	/__/
prevention through the local community	/__/
prevention of certain at-risk groups	/__/

Specify in what sense the role is not clear?

4. How strong is the position of general practitioners in relation to other parts of the health system and social sector.

   Assess the actual position and the one to be desired within the existing general system.

	ACTUAL	DESIRED
Influence on organization of health services:		
- within primary health care	/__/	/__/
- in relation to hospitals	/__/	/__/
Teamwork	/__/	/__/
Role in the local community	/__/	/__/
Influence and relation with social care	/__/	/__/
Influence on solving ecological problems	/__/	/__/
Influence on other institutions (e.g. schools)	/__/	/__/
Influence on firms and companies	/__/	/__/
Influence on public opinion	/__/	/__/
Influence on the political system	/__/	/__/

Comments

5. What preparation and support is required for general practitioners to actively participate in comprehensive primary health care?

From 1 (poor, not satisfactory) to 5 (excellent, completely) assess the support which general practitioners have in:

Basic medical education		/__/
Postgraduate education		/__/
Equipment of working sites:	consulting rooms	/__/
	transport	/__/
Technical equipment:	computers	/__/
	communication devices	/__/
	home treatment tools	/__/
	rehabilitation tools	/__/
	equipment for health education and propaganda	/__/
	other	/__/
Institutions (or possibilities) for residence and gathering of the population, elderly, youth patients		/__/
Personnel they work with:	in the consulting room	/__/
	in the community	/__/
Information, contact with colleagues, continuing education		/__/
Organization of work (time, responsibility)		/__/
Financial support for programmes of preventive work		/__/
Personal stimulation:	personal income	/__/
	other stimulations	/__/

If you think that in certain areas there is no adequate support given to general practitioners in their effort to implement comprehensive primary health care, specify:

6. List basic difficulties and obstacles in achieving the role of general practitioners in health care prevention within primary health care.

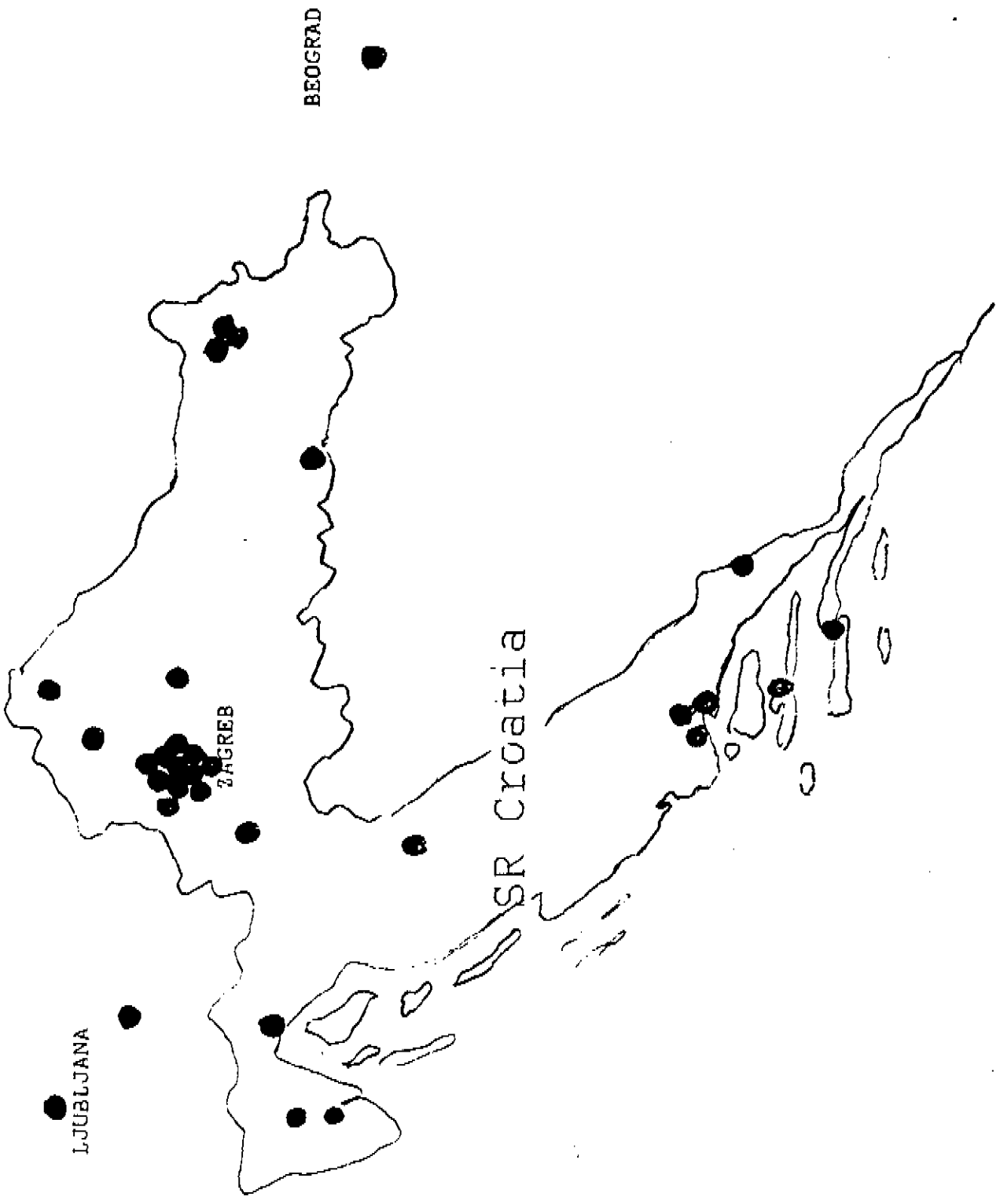
7. List existing and suggest new strategies for the improvement of work and reorientation of general practitioners towards the concept of comprehensive primary health care, especially its preventive activities.

Existing strategies:

Suggestions for new strategies:

Annex 2

DISTRIBUTION OF RESPONDENTS IN YUGOSLAVIA



Annex 3

ABBREVIATIONS OF VARIABLES PRESENTED IN THE FIGURES

(A) Preventive work - measures

AN	Antenatal care
WB	Well baby clinic
IM	Immunization
FP	Family planning
SH	School health programme
IE	Individual health counselling
GE	Programmed health education in small groups
CE	Health education in the community
WA	Working capacity assessment
SB	Screening of breast cancer
SC	Screening of cervical cancer
SH	Screening of hypertension
SD	Screening of diabetes
OTH	Other

Continuous work with different at-risk groups:

ADL	Adolescents
IM	Immigrants
CHR	Chronic patients
OLD	Elderly
MH	Mentally handicapped
UE	Unemployed
SN	Alone, isolated - social networking

(B) Position of general practitioners - other factors involved

PHC	Influence on organization of primary health care services
HOSP	In relation to hospitals
TEAM	Own team
LOC.COM.	Role in the local community
SOC.SERV.	Influence and relation with social care
ECOL	Influence on solving ecological problems
SECTORS	Influence on other institutions (e.g. schools)
COMP.	Influence on firms and companies
PUBLIC	Influence on public opinion
POLITIC	Influence on political system

(C) Support of general practitioners for comprehensive primary health care

BME	Basic medical education
PME	Postgraduate medical education

Premises and equipment:

1	Consulting room
2	Transport
3	Computers
4	Communication devices
5	Home treatment tools
6	Rehabilitation tools
7	Equipment for health education and propaganda
8	Other

INST	Institutions (or other possibilities) for gathering of population, the elderly, youth, patients
TEAM	Personnel they work with in the consulting room
CN	Personnel they work with in the community
INF	Information, contact with colleagues, continuing education
ORG	Organization of work (time, responsibility)
FIN	Financial support for programmes of preventive work
INCM	Personal incentives: personal income
STIM	Their incentives