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The health centre concept in primary health care

Robert Kohn

*Formerly Professor of Community Health
London School of Hygiene and Tropical Medicine
University of London*

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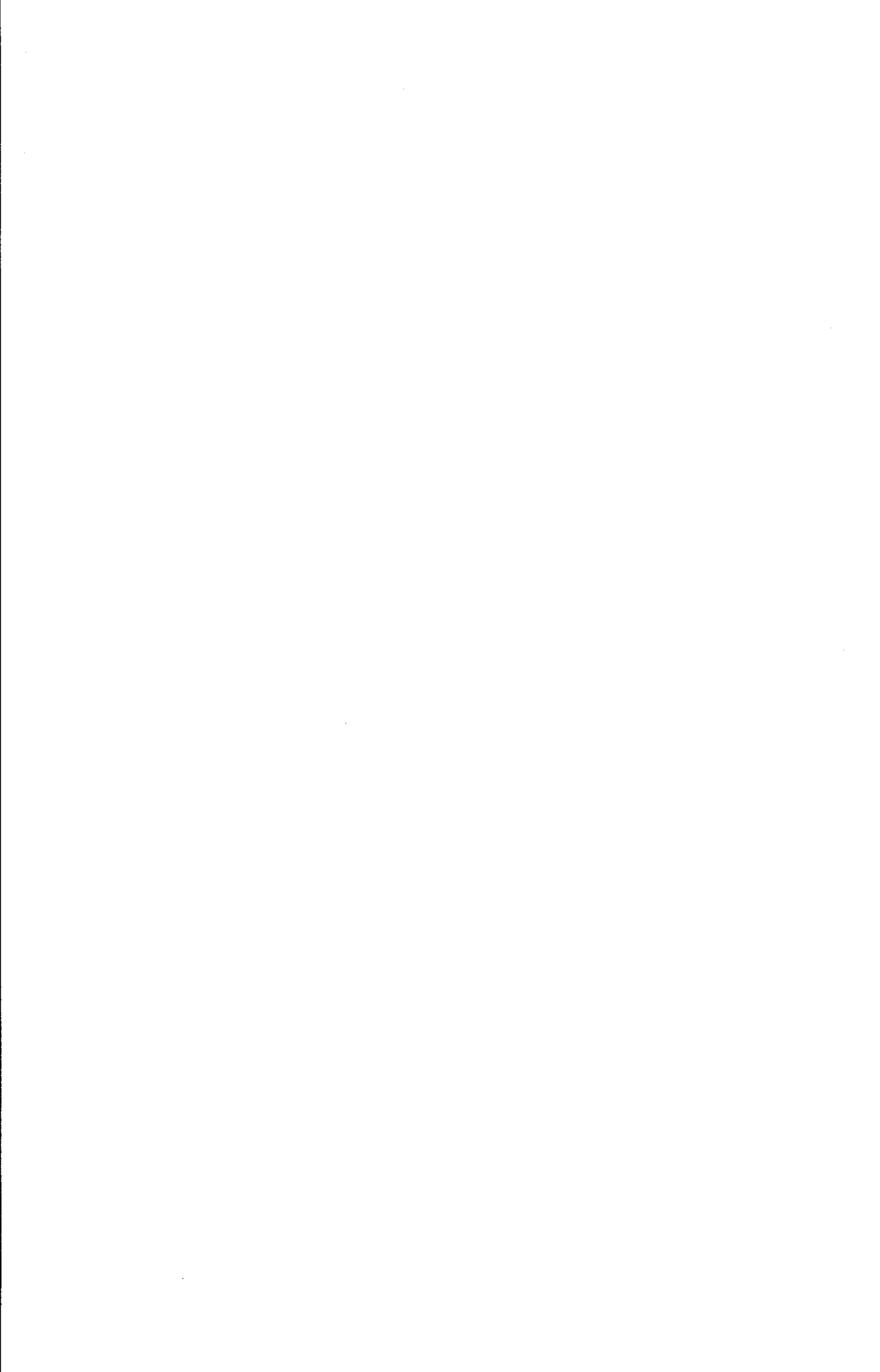
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General observations

What are the best possible health services? There is no universally applicable answer to that question simply because of the dynamic nature of the concept of health, and variations in health needs and the resources to deal with them. What is "best" must be determined in the light of existing knowledge and technology; what is "possible" is dictated not only by financial constraints but also by the time-lag inherent in the production of new types of personnel or the changing of existing types, as well as in the creation of new facilities or equipment. This time-lag tends to impart a certain degree of rigidity into any health service system and, unless the functioning of the system is reviewed periodically, there is the danger either that it will become fossilized or, when change becomes imperative (as, for instance, in times of financial cutbacks), that it will be implemented on the basis of expediency and without regard to its implications for the whole system.

Not so many years ago, general practice was considered obsolete in an era of rapidly advancing medical knowledge that could be mastered only by specialists concentrating on smaller and smaller areas of medical science and skill. The hospital with its sophisticated equipment became the logical place to be, when sick; the faith in an infinite ability to cure disease diminished concern with prevention. More recently, however, the recognition grew of the human being as something more than just an assembly of parts, of the need to coordinate various specialized approaches, and of certain potential disadvantages arising from avoidable hospitalization. The limited ability of medicine to cure chronic and degenerative disease rekindled interest in prevention and health maintenance, which had proven so effective with regard to communicable diseases. Primary care began to come into its own again, but not as something based on the traditional solo practitioner. General practice broadened into becoming a specialty of its own, and it soon became recognized that, to be fully effective, the physician must be supported by other professionals and particularly by those who could cater to people's personal and social needs.

All these changes have occurred to a different extent and over different periods in different parts of the world. Poorer countries have

seen too many sophisticated resources concentrated in too few places. More affluent countries have suddenly been made aware of limitations even to their resources, and it is this sudden economic squeeze rather than the earlier recognition of real health needs which is bringing about a reappraisal of the role of primary care.

Between the resistance to change of a rigid system and the urge to change because of sudden economic constraints, there is the danger of precipitate solutions being attempted without balancing the needs of various population groups and the potential supply and use of health resources.

Those studying the health needs of populations and of particular high-risk groups have been aware for some time that the physician, however well qualified, and the hospital, however well equipped, are no longer sufficient to provide the care many patients require and modern medicine can provide. Physicians have become increasingly specialized and thus able to provide better care for specific health problems. Facilities and equipment also have become more sophisticated, permitting successful intervention in cases where this was previously unknown. These advances are likely to continue and, to the extent that they do, will bring about new and more efficacious ways of diagnosing or treating particular illnesses. All this leads to health services of greater complexity but it also contains the danger of increasing fragmentation unless deliberate steps are taken to coordinate proliferating activities. General medicine, which had lost some of its status to the more spectacular specialties, is coming into its own again, not to replace the specialties but to permit their fully effective application, which depends on the recognition of the need to see people as wholes and not just in terms of isolated episodes. A new understanding of the effects on health of people's lifestyles and of the environment has led to new approaches to health maintenance and the prevention of illness. The possibilities of physical and mental rehabilitation and the recognition of the substantial social needs of certain categories of patients have broadened the range of activities that constitute an effective modern health service. This broadened recognition of health needs has led to new categories of personnel, new procedures, and the addition of new equipment to the armamentarium of the health services. The result has been the concept of the health team – long accepted in the hospital setting where doctors, nurses, therapists, technicians and often social workers, as well as administrators, have come to work together. This cogwheel concept has been extended to health services outside the hospital, and many countries have long and substantial experience of various ways of organizing such services.

These services have been variously designated as primary, ambulatory, or community services but none of these terms is quite appropriate, since the services in question are of both a primary and a continuing nature and the hospital is, or should be considered as, part of community resources. Moreover, there is no clear dividing line between the hospital and other institutions for the care of, for instance,

the elderly or handicapped. The term "community services" is also often used to cover residential institutions other than the hospital, and the patients may not be ambulant but bedridden, even though not in hospital.

What this report is about is the organization of services that are outside institutions and provide ambulatory care and care in the patient's home. This constitutes "primary care" as the term is used in this report. Emergency services, although a form of primary care, will be dealt with only to the extent that they are part of an organization designed to provide general primary care, but not where they are independent or attached to a hospital.

If the range of services referred to above is to be made available to the ambulatory as well as the homebound patient, some form of organization is required to provide the necessary personnel and equipment; the term "health centre", as used in this report, is intended to cover the variety of organizational patterns adopted for this purpose in different countries and within countries.

Such organizational forms have developed in different countries to a varying extent because they have been recognized as essential to good health care. In some countries certain forms of health centre are part and parcel of the national health service system, in others they are experimental or have been set up as demonstration projects.

If this development originated in the recognition of health needs in the community, it has of recent years been powerfully reinforced by the critical examination of health service costs. Economic considerations have in many countries led either to cuts in the health budget or to strict limitations on future increases. Since, in most places, the hospital has been the most costly component of the health services, it has become the main target of cost constraints. There is, of course, the likelihood that, apart from the elimination of obvious waste, financial constraints bring about a corresponding deterioration in services, unless at least equally good alternatives for providing the services are found. In the case of the hospital, the alternative now frequently proposed is a strengthening of the primary care sector. This is an area in which planning directions in both industrialized and non-industrialized parts of the world coincide, even if the cost levels are still very different. A passage from a WHO document^a aptly summarizes the many proposals that have emerged in various countries:

On the international forum attention has been redrawn to the concepts of primary health care and simplified health technologies which could be effectively applied in preventive, curative and restorative health care. The concept of primary health care is not restricted to developing countries. The need to strengthen "front-line care" has been discussed for many years in industrialized countries, and some of them have remarkable achievements in

^a Kleckowski, B. M. et al. *Comments on causes and possible cost containment measures*. Geneva, ILO and WHO, 1977 (unpublished document RCMC/1977/D. 5).

this field. The appropriate technology for such health care has also been debated and tried. Some countries are providing it through dispensaries, some through general practitioners or group practice, and yet others through integrated and regionalized health services in which allocation of various medical technologies can be achieved even in a more rational and economic way.

Thus, for once, concepts of good care have been found to coincide with the aims of cost-conscious administrators, the result being the development of a great variety of organizational technologies, each influenced by priority needs, the available resources, and traditional health service patterns.

Because many countries are still searching for suitable ways of organizing primary care services, it should be helpful to them to have an account of alternative approaches to a basically similar problem. The European Region of WHO comprises countries at widely different levels of industrialization, with climates ranging from the arctic to the subtropical. Findings from the various parts of the European Region should therefore have applications in corresponding situations in the other WHO regions.

To summarize briefly the objectives of this report, it will be found that in most, if not all, countries there is a need to strengthen primary care services and broaden their scope beyond that of the services that a general practitioner can provide single-handed. This arises from an assessment of what constitutes good patient care, as well as from the necessity of providing good care as efficiently as possible, specifically by limiting costly hospital services to those services that the hospital is best suited to supply.

Sources of information

Two methods of gathering information were used. First, a letter was sent to all Member States in the Region, asking them to describe the forms of primary care organization existing in their country. Second, some countries in the Region were visited to obtain more details on the structure and operation of organizations of the health-centre type. The selection of countries was bound to be arbitrary to some extent, because no one health care system can be said to be exactly typical, but the countries selected do represent two broad categories of system, i.e. the pluralistic system with a public as well as a substantial private sector (as in France and the Federal Republic of Germany) and the largely public and centrally planned and/or operated systems such as those in the eastern European countries, Scandinavia and the United Kingdom.

Both the circular letter sent out by the Regional Office and visits followed the same line of enquiry, but the specificity of the information obtained varied considerably, as was bound to be the case, in both approaches.

This report is not a complete review of the forms of organization of primary care existing in the European Region; this was not possible with

the time and resources available. Consequently, some interesting approaches to the health centre concept may have been omitted and the Regional Office would appreciate it, if such instances were brought to its attention for future reference. For the present, however, it is hoped that sufficient variations on the theme are described here to arouse interest and stimulate further study and discussion, thus placing health administrations in a better position to evaluate the situation in their own countries.

Organization of health care outside the hospital

That the hospital requires an increasingly complex organization has been taken for granted. The hospital is the repository of sophisticated equipment, it is the field of activity for a wide range of health professionals, it provides various hotel services in addition to medical care, and by its very nature it requires administrative and maintenance services. To ensure the smooth interaction of these various cogwheels, a definite organizational structure is necessary and has indeed evolved.

Health services outside the hospital—variously but inadequately referred to as primary, ambulatory, or community services—have however remained largely fragmented in most countries. In as labour-intensive an industry as the health services, the distribution of manpower reflects the differing degrees of organization. In the health service of an industrialized country one may expect to find, for every physician, about 15 other workers, but these have until recently been concentrated in the hospitals so that the comparative distribution may be something like this:

	<i>Personnel per physician</i>	
	<i>In</i>	<i>Outside</i>
	<i>hospital</i>	<i>hospital</i>
Nursing and midwifery staff	12	1.1
Technicians	2	0.3
Administrative and other staff	11	
Total	<u>25</u>	<u>1.4</u>

As the emphasis shifts from care in the hospital to primary care outside, it becomes obvious that primary care must be equipped to perform its new tasks. The revival of primary care and the consequent shift in the distribution of tasks in many parts of the world is a phenomenon of the last decade or so, and in 1970 Roemer (1) observed that "from a global perspective on health service, we seem to be entering a period when the major social focus is shifting from hospital care to care of the ambulatory patient". In his worldwide review of the primary care scene, Roemer observed five types of organization: (1) separate dispensaries for treatment of the sick; (2) hospital outpatient departments; (3) specialized preventive clinics under public health agencies, industries, or schools; (4) private group medical practice, and (5) health centres of either preventive or integrated preventive-curative scope. This

has remained a useful categorization, but all attempts at strictly classifying human services necessarily result in oversimplification because of the continuum presented by human needs and the variations in their recognition by society. Terminology is another confounding factor especially when different languages are involved; but, even in the same language, terms such as "health centre", "dispensary", "group practice" or "polyclinic" may mean different things in different countries.

Nor is the distinction between hospital care and outside care always clear-cut. Hospitals may have day or night patients, while health centres may have beds for some of their patients, and the dividing line between medical care on the one hand and social and custodial care on the other is often blurred. This is one of the things that makes it difficult to agree on a precise term for the kind of activity or organization discussed in this report. "Primary" or first access care may be limited to the general physician and his supporting staff, but in other situations it may involve internists, paediatricians, gynaecologists and, in some health care systems, any specialist. "Ambulatory" care, strictly interpreted, excludes the bedridden patient at home. "Community" care, meaning care outside the hospital, would be the most appropriate term for the purposes of this discussion, but it conveys the unfortunate notion that the hospital is not part of the community and not integrated with other community resources. "Outpatients" are generally understood as those using the outpatient department of a hospital. The *Glossary of health care terminology* published by WHO (2) illustrates those semantic difficulties. Where the above terms are used in the following text, they should be considered as interchangeable and as referring to services other than those provided to inpatients at a hospital.

It would be just as detrimental to effective and efficient health care to develop primary care services in isolation from the hospital as it would be to plan hospital services without regard to primary care needs and resources in the community. Many health problems require a continuum of services: progressive or regressive patient care, as the case may be, should not stop at the gate of the hospital but be allowed to extend freely beyond it. While McKeown's balanced hospital community is designed to provide complementary hospital services "for all classes of patients" (3), the broader concept of progressive patient care envisages centres combining not only hospital facilities but also doctors' surgeries for the care of ambulatory patients, housing for the aged, offices for public and voluntary health agencies, and personnel and equipment for the home care of patients (4). Resolution (77)3 of the Council of Europe conceives of the hospital as providing comprehensive care to both inpatients and outpatients.

It is in countries with a substantial private health care sector that, because of the lack of direction, the greatest fragmentation of primary care services may be expected, but the existence of a public health service is no guarantee that the services will be organized in the most desirable way. Nevertheless, where a substantial public sector health service—as distinct from health insurance—has existed, as in the

Scandinavian and later in the eastern European countries and the United Kingdom, there has been a greater tendency towards organized forms of primary care than in other European countries. By 1975 it could be observed that "throughout the world there is a growing emphasis on the establishment of health centres which aggregate physicians so that they can provide patient care in a comprehensive way utilizing the gains in medical technology and diagnostic aids, and with the support of a variety of health workers" (5).

In some countries, however, the collective practice of physicians was, and in some cases still is, hampered by legal restrictions or at least by concepts of professional ethics held by professional associations of physicians.

Three examples from diverse social systems may suffice to illustrate the worldwide recognition of the need for a better organization of primary care. In the USSR, the Tenth Five-Year Plan assigns particular importance "to the development of the network of units belonging to the polyclinic-outpatient system" (6). This implies the transformation of every ambulatory unit into a highly qualified prophylactic, diagnostic, and curative centre with the equipment and supporting services necessary to raise the efficiency of the district physician.

In the United States, with its pluralistic system, a Committee on the Costs of Medical Care recommended as early as 1932 "that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel" (7), a concept that has recently been broadened to that of the Health Maintenance Organization, which may assume a variety of organizational forms.

Like other less industrialized countries, India with its National Strategy for Health and National Health Scheme for Rural Areas aims at increasing the number of primary care centres and subcentres, adequately staffed and equipped (8).

A similarly wide range of social and health care systems exists within the European Region of WHO, and here too new forms of organizing primary care have developed and traditional forms have been adapted to meet the requirements of modern health services. Here too are countries with universal national health service systems and with pluralistic ones; here too are countries with substantially lower resources than those found in the more highly industrialized societies.

With such wide differences among countries in their socioeconomic-political fabric and their respective health services, can they benefit from the knowledge of the situation in other countries? Certainly countries with similar institutions can profitably examine one another's experience and, for the health services anywhere and for primary care in particular, some considerations are more or less universal. This is true of one of the basic requirements of primary care, i.e. accessibility, and it holds good for the basic component resources (personnel, equipment, facilities) and their availability and coordination.

Thus there are certain similarities in the structure of primary care

organizations everywhere, although the ways and means of organizing them may differ widely, as may their methods of financing and accountability, as well as the source of the incentive to organize, e.g. government, the medical profession, insurance carriers, or consumer groups. Where there is a public national health service, the government may decree (with varying degrees of consultation) forms of organization of primary care, as is the rule in the eastern European countries and the tendency in others such as, for example, Finland. This approach may also be encouraged where, as for instance in the United Kingdom, primary care physicians and dentists retain some degree of independence. Of primary care organization in New Zealand, it has been said that the primary care physicians themselves are alone responsible for the way they develop their service and that they are also the most appropriate people to develop it on a collective basis (9).

Where there is a national health service, a greater degree of standardization, though not necessarily uniformity, exists in the way primary care is organized, in contrast to the variety of public and independent private agencies found under pluralistic systems. The latter, on the other hand, with France and the Federal Republic of Germany as prominent examples, offer the advantage of a much greater variety of organizational forms, providing more opportunity for experimentation and study, an opportunity of which greater advantage should be taken. In countries with a national health service the health centre, as the hospital, is an integral part of the system and administered very much like other public utilities by the central or local government. In mixed systems, privately initiated and operated centre-like establishments frequently exist side by side with centres operated by municipalities or non-profit organizations such as religious or other charitable institutions. In the latter case, professional staff may be employed on a part-time or sessional basis while otherwise maintaining their private practice.

In any case, any form of organization implies bringing together several providers, types of service, and/or equipment. Depending on the objectives of a particular organizational form, it may emphasize a combination of different types of personnel (e.g. the primary care team consisting of physician, nurse, and social worker), or of personnel with similar functions (e.g. several general practitioners), or it may combine features of both forms by accommodating several primary care teams or by extending the concept of primary care to include certain specialties.

One may thus distinguish horizontal or vertical associations of health professionals, depending on whether they combine similar categories of personnel (e.g. general practitioners) or different ones (e.g. the primary care team, or general practitioners and specialists). Most frequently one finds combinations of these two forms. The reference above to specialties illustrates one of the difficulties in delineating primary care. Internists, paediatricians, gynaecologists and obstetricians, for instance, frequently appear as members of the primary care establishment; other specialties may be represented, particularly where there is direct access to specialists. In Canada and the United States it is the multispecialty

group that has been most strongly promoted: "groups of doctors with different skills, organized ideally, so that each ailment of each of their patients can have the care of an expert" (10). This must be seen, of course, in the context of a system of freely practising specialists as opposed to hospital employees.

The degree of standardization in the organization of primary care resources will vary according to the degree of socialization of the health care system. Standardization will be greatest where all health resources are owned, operated, and financed by one central agency, notably the state, and where all health workers are employees of that agency. Under these circumstances, primary care services are automatically an integrated part of the larger system and its organization. They are also apt to be organized within themselves, since all personnel and physical resources are administered under common auspices. One remaining problem may be that of an organizational framework to coordinate services provided by different government departments, such as health and personal social services where these are separately administered and financed. That central planning and a consequently greater degree of standardization do not mean uniformity has already been observed. Variations in the environment within a country will affect patterns of health and disease and, "the density of the population, its distribution over the area concerned, the state of the roads, transport facilities, communications, etc., play a large part in determining the forms of medical care provided" (11). Thus, for example, "a high population density may make it possible to set up curative and prophylactic, and sanitary and epidemiological, establishments that are larger in size and more economical and thus to increase the degree to which health establishments perform specialized functions; as far as medical personnel are concerned, this situation makes it possible for them to be distributed and utilized in a more rational manner".

These observations indicate the variety of criteria determining the optimal size of population covered by a health centre. Foremost among those criteria are population size, health status and demographic characteristics, the range of services provided, the availability of alternative sources of care, and the nature of the centre, i.e. whether oriented towards primary care or also specialist services of the kind available in the polyclinics. The issue is largely one of balancing accessibility with the objective of providing the desirable full range of primary care services and considerations of economies of scale. In an urban setting it seems that the optimal population base for a health centre, as the exclusive source of primary care, is about 20 000. The "učastok" model in the USSR is based on the community unit serviced by a physician in urban areas where, as in other eastern European countries, parallel streams of primary care exist. Thus the population covered by one physician ranges from about 1000 to 2000 for each of the therapeutic, paediatric, obstetric/gynaecological, and industrial "učastoks" (11). Thus, one of these units may serve a population of about 4000, whereas a polyclinic in one of the larger cities may cover a

population of up to about 50 000. While the Finnish system of health centres envisages units for populations between 10 000 and 15 000, this is based on a combined catchment area of from about 35 000 to 50 000 population, in which individual units would rely on the same laboratory and X-ray facilities.

The unifying force of central planning is absent in a pluralistic system—occasionally, with some exaggeration, referred to as a non-system—where at least a large part of the resources are in the private sector so that each hospital and every health professional may act as an individual agent. In this situation, any stimulus towards organization, i.e. integration of several components of the system, must come from the providers or consumers, either directly or through their elected representatives. An intermediate position exists where a substantial part of the financing of the services is through social security or insurance, in which case the carrier may offer incentives or impose conditions relating to organization.

Such pluralistic systems exist in the European Region. They have their counterparts in North America, and it is there that much of the research into the organization of care and its performance has been carried out. In many cases this will be applicable to similar phenomena elsewhere, though one major difference must be borne in mind, i.e. the difference in the relationships between doctors and hospitals. Another special feature of the North American scene is the combination of organized provision of services and financing mechanisms, i.e. the “prepaid group practice”. This feature has relatively little relevance to the situation in Europe, where most countries have either substantial national health services or financing mechanisms covering at least substantial parts of their populations.

Health centres or similar organizations in many countries stress preventive services such as immunization, counselling, and maternal and child care. Especially if the centre is responsible for a defined population (defined geographically or as members/subscribers), it may have screening programmes and follow-up procedures, widely practised by “dispensaries” which function as ambulatory care facilities for patients with specific diseases such as tuberculosis or venereal disease. There are other elements of “outreach” aimed at high-risk groups. However, the concept of assuming responsibility not only for the care of the sick but also for the maintenance of optimal health in a given population is as yet limited to isolated experiments or demonstration projects. One of the early examples was that of the relatively short-lived Peckham Pioneer Health Centre in London. Even its creators looked on it as an experiment, based on broad biological principles rather than medical science in the conventional sense. It was labelled as an experiment in living, and the unit of living was seen not as the individual but the family. Living, in the view of the Centre’s founders, meant health which, if not synonymous with life, was seen as “the factor of primary importance for human living” (12). Here, then, is an example of family orientation considered as an important attribute of health care, such

care being more than immunization and screening for disease which, while operating efficiently as a sieve for the detection of disease and disorder, "is ineffective as a health measure in the absence of 'instruments of health' providing conditions in and through which the biological potentiality of the family can find expression". The Centre, first established as a "family club" in 1926, took on its full family- and health-oriented approach in 1935, but owing to wartime disruption its activities were suspended in 1939. One condition for the successful functioning of an institution thus oriented is, of course, its whole-hearted acceptance by the population covered. It was concluded that, "given suitable circumstances, there were families who would welcome a Health Service distinct from any sickness service and without being urged by any sense of impending sickness". This statement may be found even more valid today, a generation later, when there is so much more emphasis on changing life-styles in order to preserve health. The Centre was revived after the Second World War but by 1951 had to be closed because the project was seen "to be contrary to the policy" of the Government, which by then had instituted a universal National Health Service.

Among services based on similar ideas were the Pholela Health Centre in South Africa (13) and the project carried out in the 1950s by the Montefiore Medical Group in New York (14). If Peckham was an experiment, Montefiore was a "demonstration" of family health maintenance. Both were strongly family-oriented, the former serving as a study ground for biologists, the latter emphasizing sociological aspects.

For the establishment of similar programmes elsewhere it may be as revealing to know why earlier experiments eventually failed, as it is to see the results of their studies. As regards the Peckham experiment, it was indicated very clearly why it could not survive as part of the recently established National Health Service in the United Kingdom. The reasons why it could be considered as "irregular" in such a service were stated as follows (15):

- (1) It is concerned exclusively with the study and cultivation of health: not with the treatment of disease.
- (2) It is based exclusively on the integrated family: not on the individual.
- (3) It is based exclusively on a "locality": it has no "open" door.
- (4) Its basis is contributory (2/- per week per family): not free.
- (5) It is based on autonomous administration, and so does not conform to the lines of administration laid down by the Ministry.

Not all of these points would be seen as "irregular" today, if the principles of health maintenance and family orientation were to be adopted on a national scale. Peckham, at the time, had to be based locally and to be contributory and autonomous, because there was no alternative national service. But, even today, how many health services are prepared to aim at maintaining health as much as they are committed to the treatment of disease? How many are ready to accept the integrated family rather than the individual as the unit of care?

Immunizations produce quick and readily demonstrable results. They are also easily identifiable as applications of medical science and technology and therefore as appropriate functions of the health care agency responsible for the health of a given population. The promotion of healthy living, potentially more effective in the long run, is more difficult to specify in operational terms and hence more difficult to view as a function of the medical services. It is being attempted, however, as for instance in the North Karelia Project in Finland, where an intensive health education programme has been built into health centre activities (16). Elsewhere, as for example in Canada and the United Kingdom, governments have formally stated a policy of promoting healthy lifestyles among the population but as yet with little indication of how such a policy is to be made operational.

In concluding this general review of concepts of organized primary care, it may be well to point out that the component parts do not necessarily have to be under one roof and that a single building is not essential to the concept of a health centre. This is brought out very clearly in the recent establishment of a health centre system in Finland, and has been proposed as one solution to the fragmentation of a health care system as pluralistic as that of Canada, where services provided under a wide variety of auspices could be coordinated by a central agency (17). An early proposal for a health maintenance project in the United States described the concept as follows: "co-operative but not unified services were envisioned: nursing and social work from Community Service Society, out of their own offices; medical care from a medical group center in some other place—no single location for the combined services, no single unit for health and welfare services" (14). Such loosely knit coordinating arrangements will be partially effective where no coordination whatsoever exists as yet among agencies under different auspices, but they will fall short of bringing about integrated teamwork and the team approach to health problems.

In short, Hogarth's remark on the term "health centre" holds good: "a term which means different things in different countries, and may therefore require to be defined in the context of a particular discussion" (2).

Primary care and health policy

General health goals do not vary much, if at all, even among countries with widely different social and economic systems. All subscribe to the goal, set by WHO, of attaining the best possible health for their people, although countries do vary in the place assigned to health in the order of national priorities. There is a high degree of similarity in the human and physical resources used in different countries to attain health goals. Well trained health workers can, apart from language difficulties, function effectively in any country, as attested by their high mobility where there are no administrative barriers, and a good hospital is a good hospital anywhere. The availability and accessibility of these resources to the population they are to serve can readily be observed.

The often repeated statement that health systems, or certain of their features, cannot be transplanted is therefore at best of limited validity and applies mainly to the way the services are financed.

The question of the leverage a government requires to implement changes that may seem desirable is another matter. To what extent national or autonomous regional policy affects health policy and, in turn, its impact on the health services depends on the extent of the public sector's control over health resources. A greater degree of public funding and of direct public sponsorship will lead to a greater degree of standard-setting and control, though this will not necessarily be the same for all sectors of the health services. Hospitals have a longer tradition of being in the public sphere than has the practice of medicine. In all countries, the provision of hospitals has traditionally been accepted as a community responsibility, whether it is a public initiative or a non-profit private one, although not necessarily to the exclusion of private ownership. Some form of health insurance or social security coverage is more likely to be found for inpatient hospital care than for care outside the hospital. The practice of medicine, on the other hand, and that of the other health professions, particularly outside the hospital, is more likely than the hospital to be free from public control.

Independent practitioners will tend to organize their services to suit their needs and the needs of their patients as they perceive them. It follows that countries will display greater variation in the way that primary care is organized than in the manner in which their hospitals operate. It should thus be possible to develop a typology of organizational forms in primary care, according to the degree of public or quasi-public control. Four broad categories of primary care situation emerge:

- countries with a unified state health service system, where institutions are publicly owned and operated and all personnel are employees of the system (e.g., the eastern European countries);
- countries where most medical practitioners, at least those outside the hospitals, and other health professionals are independent (e.g. France, the Federal Republic of Germany and other central European countries);
- countries where health professionals are formally independent but bound by uniform contracts to the public system (e.g. the United Kingdom); and
- countries that would fall into one of the above three groups but present special problems because of their lack of resources compared with the more industrialized countries in the Region (e.g. some of the countries bordering the Mediterranean).

Such a classification has some merit because it shows at a glance the basic differences between unified, centrally planned and operated systems and pluralistic systems with only a limited public sector. The former, as expected, show a greater degree of standardization, whereas the latter

offer a greater variety of approach. For an analytic appraisal, however, this typology constitutes as misleading an oversimplification as do such other dichotomies as socialist/capitalist, eastern/western, developed/developing. Factors such as population density, rural-urban distribution of the population, climate and topography, communication and transport, the nature of the major health problems and, last but not least, the resources available will affect the way primary health care is organized, even within a given political structure.

Other typologies could be devised, for instance, on the basis of parallel situations within countries. For certain purposes it would be particularly useful to compare, for example, the provision of primary care in metropolitan, other urban, and rural areas within countries with different health systems. Comparisons of the provision of primary care in sparsely populated or isolated areas by countries in the North African part of the European Region and by countries extending into the sub-arctic or arctic zones might also be of interest. The latter were briefly considered by a WHO-sponsored conference in 1962 (18), but more intensive and up-to-date studies in these areas could be of considerable interest to the countries concerned. Ministries of health in all European countries agree on two points:

- that there is a need to strengthen primary care and relieve the hospital of demands that are better and possibly more economically satisfied elsewhere; and
- that primary care can accordingly no longer be adequately provided by the practitioner single-handed, but that supporting staff and facilities must be provided whose coordination requires some sort of organization.

Common to all types of centres or clinics is the idea of a combination of resource components. This may mean different categories of personnel working in close relationship with one another—the team—or increasing the effectiveness of the professionals by making various types of equipment readily available, in some cases even providing beds. The two forms usually go hand in hand, but the scope of the team and the extent to which it is supported by physical facilities vary considerably.

A policy involving organized forms of primary care on a national scale has been the rule in the eastern European countries for many years and what has been said of the German Democratic Republic (19) applies to other countries as well: "Polyclinics and the so-called ambulatoria are seen as the corner stones of socialist health protection in the DDR". The primary care teams in the rural ambulatoria and nurses' stations provide the link between population and physician.

While government policy may be equally oriented towards the health centre concept in countries where primary physicians are essentially in the private sector (though largely paid through public or semi-public insurance systems), the implementation of government policy is difficult

because physicians are generally free to practise as and where they like. There is some variation, however, in the extent to which the governments of these countries provide leadership and incentives. In countries with a federal constitution, there is the additional factor of responsibility for health and health services being primarily under regional jurisdiction, with the central government assuming at best a guiding role whose influence is largely determined by the size of its financial contribution.

The approaches adopted by governments of countries with a substantial private sector vary. In France, the social security agencies establish and operate polyclinics and centres of various kinds, mainly in major urban centres; these are linked with services in the private sector through a two-way referral system, especially for more sophisticated technical and specialist services. Finland emphasizes coverage of the rural areas in implementing its health centre programme, also maintaining links with the private sector, which in this case is relatively small. Scotland has promoted its policy by extra payment to practitioners working in groups, by direct reimbursement of rent, and partial but substantial reimbursement of the salaries of ancillary staff (20). Although similar incentives for collective practice exist in the other regions of the United Kingdom, practitioners there seem to have been more reluctant to work in health centres, initially under the auspices of the local authorities (21) and, since the 1974 reorganization, under the Area Health Authorities.

The Federal Republic of Germany introduced new incentives for the organized practice of primary care as one of the measures in its cost containment programme of 1977, echoing a renewed emphasis on health centres and similar forms of practice in a British Government document outlining priorities in the health and personal social services at a time of severe financial constraints. The stress on cost containment is a pervasive one. The Austrian Federal Ministry of Health and Environmental Protection has also declared its intention to lend material and ideological support to the idea of group practice, partly to counter the rising cost of hospitalization (22). Possible approaches to the implementation of this policy, based largely on experience in Austria itself and in other European countries with pluralistic systems, are discussed in a publication of the Austrian Federal Institute of Health (23). While the problem of cost containment lends urgency to the search for new approaches and may be the prime motive for political action in this sense, concomitant improvement of the services is not entirely lost from view. The chain of traditionally available services often leaves gaps inhibiting the continuity of care that patients require. Also, traditional services are essentially passive, i.e. they wait for the patient to consider himself in need of care, with the result that any prevention is largely relegated to its secondary stages (24). In countries where health services belong essentially to the private sector, there are quasi-public forms of organized primary care such as clinics operated by insurance carriers or the *mutuelles* in France, which operate for the benefit of their members

who carry the basic public insurance. A means of linking the various existing health and personal social services and, on the other hand, bridging the gap between the public and private sectors is provided in France by the Union nationale interfédérale des Œuvres et Organismes privés sanitaires et sociaux.

Countries with unified health systems under public auspices have clearly defined concepts and specific standards for their health centres at different levels. The provision of such centres to serve the entire population may, however, be hampered by limited resources, and in such cases priorities are established, usually in favour of the generally less well-served rural areas. The United Kingdom, for instance, in view of severe economic constraints, is prepared to compromise in regard to its standards for health centres by encouraging the adaptation of existing premises rather than waiting until funds become available for the construction of centres as envisaged at the creation of the National Health Service, and the government is considering even greater flexibility in the application of health centre policy (25).

Countries where general practice is largely in the hands of private practitioners are generally willing to support various forms of collective practice initiated by the physicians. In the Netherlands the Ministry of Health and Environmental Protection, also very much concerned with the effective organization of primary care, does not commit itself to any specific form of organization pending the development of ideas about primary health care through discussions of such basic questions as the content and scope of primary care, the respective roles of the public and private sectors, and the role of the population as the consumer of health care.

In all this, the boundaries of what constitutes primary care remain blurred where specialists are available in health centres (in some cases directly accessible to the patient) and where limited numbers of patients may be admitted to beds attached to the centre. Primary care, therefore, as indeed the health centre, must be seen and defined in the context of a particular health system. The three levels of care—primary, secondary, tertiary—may reflect increasing degrees of specialization or, as in the Netherlands for instance, depend on the place where care is provided, e.g. primary care being ambulant, extramural, or in the home; secondary care being given by specialists to out- or inpatients in general hospitals; tertiary care being generally provided in institutions for long-term care.

It is essential, therefore, to observe primary care, its organization, functions, and objectives in the context of the health system as a whole. To view it without regard to the provisions for secondary and tertiary care would be as unsatisfactory and narrow as attempting to understand hospitalization merely by studying patients between admission and discharge. Most people require care both inside and outside the hospital, at least at the extremes of their life span and frequently also in between. The systems approach is implicit in the concept of progressive patient care in its broadest sense, ranging from intensive to ambulatory and home care (26). In the light of the broad range and the continuum of

human need, it would be artificial to maintain a sharp dividing line between in- and outpatient care; these must not be considered as mutually exclusive alternatives but as stages in a process whereby "the choice of any particular type of medical care must be governed by the condition of the patient and by economic considerations" (10).

It is primarily the medical condition of the patient that determines the type of medical care he needs but his social condition also plays a part. Not only is the concept of medicine being extended to cover such behavioural "diseases" as the addictions, social disease in the narrower sense, and even delinquency, but there is growing recognition of the interrelationship between health and the social environment and between health services and the personal social services.

The Peckham and Montefiore projects mentioned earlier were directed towards positive and complete health. Some forms of integration or at least coordination of health and personal social services in selected European countries have been described by the WHO Regional Office for Europe (27). These may involve formal or informal arrangements for contact between the health and social services, or social service personnel may be actually attached to the primary health care team, the social service thus serving as an arm of the health service. That this relative position can be almost reversed is illustrated by the neighbourhood health centres established in the United States under the antipoverty programme. These centres, under the sponsorship of the Office of Economic Opportunity, address themselves very directly to the social problems of their communities. Thus, it has become one of their functions to provide employment opportunities, especially by training and employing the so-called neighbourhood health workers who are recruited from the population served by the centre. These workers provide simple medical, social, and preventive services and facilitate communication between the centre and the community (28). Another special feature of these centres, resulting from their broader role, is the high degree of community participation and often control. As a result, the health centre becomes a tool not only for providing medical care but also for the social and economic betterment of the community. Going even farther beyond traditional concepts of medical care, some see the effective organization and use of primary care as a possible means "toward bringing change in the socio-political structures which now prevent movement toward health" in its broadest sense (29). Generally, however, the immediate aims of health policy are stated as equitable distribution and optimal accessibility of health resources.

Because health services—and, most directly of all, primary care services—fill a universally recognized basic human need, they constitute a societal activity that, like certain public utilities, may be wholly or largely "socialized" even in otherwise "free-market" societies, which makes the international study and comparison of such services particularly pertinent. It is of interest, therefore, to compare the ways in which health centre policy, once adopted, is implemented. In some countries health centres are already part and parcel of the social and

political fabric; in others the policy is implemented gradually, and often very slowly; while yet other countries have not progressed beyond experimentation and statements of policy. Finland's approach merits attention as an example of policy, once adopted, being systematically implemented. Since Finland may be described as a pluralistic society, some of the features of its implementation of policy may have relevance to other pluralistic societies – bearing in mind, however, that in Finland, as in other Nordic countries, the provision of health services has traditionally been accepted as a societal task to a greater extent than in some central and western European countries. Subject to this proviso, Finland's experience with health policy provides a valuable case study.

The problems of Finland's health services over the last decade or so have been similar to those in many other countries: emphasis on hospital care to the neglect of primary care, including prevention and rehabilitation; the rising cost of hospital care; unequal distribution of existing primary care resources, both public and private; and lack of long-range planning on a population basis. Sickness insurance, introduced in 1964, alleviated the financial burden of sickness but did not improve the distribution of resources. Resources were needed also on the social service side to care for long-term patients, particularly the elderly. There was general agreement that the goal should be to improve primary care services, but there were conflicting views on how this should be achieved. There was the question of the respective roles of the local and regional authorities and that of the possible reactions of health professionals to the introduction of the team concept which would alter their traditional differentiated roles and relatively independent status (30).

The solution to these problems was the Public Health Act of 28 January 1972 incorporating the principle of centralized planning and decentralized administration, a principle that would have to be applied *mutatis mutandis* in constitutional frameworks of a federal nature. This Act made it possible “to coordinate the development within the national resource constraints through a centralized planning system” and at the same time to ensure that “the traditional local democracy and the independence of the local decision-making was maintained by the decentralization of the administration” (30). It should be added that local authority is upheld also through its participation in the national planning cycle and its share in the financing of health services. In introducing the bill, the government of the day stated the objective in now familiar terms: “to transfer the centre of gravity in our public health policy to health care and extramural medical care by creating the administrative and financial conditions for a rapid and organized development of the communal system of primary medical care”^a.

The problem of local autonomy versus central power is the ever-present one of the right balance between centralization and decentraliz-

^a Government's General Argumentation, Public Health Act (No. 66) of 28 January 1972 (undated).

ation. In the case of primary care services, there is the added complication that primary health care, on the one hand, is attuned to local needs and relies on other local community services but, on the other, constitutes an integral tier (with secondary and tertiary services) of the regional or national health care system. The extent to which the financing of primary care services is the responsibility of the local community or is undertaken at a higher level also is an important factor in determining the respective authority and responsibility. These are among the political and administrative considerations determining primary health care policy.

There is also the human element, which is all-important, since the system can be fully effective only if it satisfies both the recipients and the providers of services. Where a system of health centres fills an earlier void, there will be little question of its being welcomed by the population served. Where it replaces existing services, any advantages of a new health centre may be recognized only after it has been in operation. Studies carried out in Sweden by the University of Uppsala and the Swedish Planning and Rationalization Institute of the Health and Social Services regarding the establishment of the Tierp centre and others have investigated these phenomena.

As for the providers, the replacement of traditional independent practice by health centres can prove very traumatic for them if it means not only changing the venue of practice but also altering general working conditions. The latter was the case in Finland following the Act of 1972. The role of the physicians, as well as their relatively high income compared with that of other health professionals, had given rise to some debate. The Act changed the status of health centre physicians in several ways, i.e. they were no longer accorded voting rights on the local boards of health, contracts for senior positions were given for 4 years only, and local councils were given power to dismiss a doctor even without consulting the National Board of Health. Concurrent legislation furthermore put doctors on a fixed salary based on a 37-hour working week, with extra pay for overtime (31). Paying health centre doctors by the same method as other health professionals also helps to put team members on a more equal footing and fosters a non-hierarchical relationship among them.

The loss of independent status in the new team approach, changing working conditions, and involvement in such managerial functions as planning and evaluation has created difficulties for some professional health workers, and the innovation has in some cases been perceived "as a danger to the professional status" (30). Nevertheless, the changes appear to be on the whole acceptable to the physicians, and the coverage of rural Finland by health centres has been progressing rapidly. With a population of 4.7 million, of whom about 3.4 million live in areas with less than 100 000 population, Finland had 269 health centres by the end of 1974 (32), fulfilling the objective of a health centre for every 10 000–15 000 population in the rural areas. As early as 1972/73, the health centres' share of all primary contacts had risen to 51% in the southern and western areas of the country with their large urban

conglomerations, and to 66% in northern and eastern areas (30). In the case study of policies for innovation just referred to, flexibility is stressed as "one of the most obvious features", being reflected in the gradual implementation of the new system subject to adjustments in the planning procedure as they occur. This flexibility is vividly illustrated by the fact that it is still possible to encounter an elderly rural general practitioner who prefers to practise in his old office, even though there is a modern health centre building only a few metres away obviously waiting for a new incumbent.

The report on the introduction of the new system (30) singles out the training programme as the most important technique of change, an opinion confirmed by those in the field. It is felt that younger physicians, more exposed to the tenets of social and community medicine, will be more ready than those of the older generation to practise in centres, a tendency also noted in other countries. The undergraduate education of all categories of personnel has been adapted to the new requirements. For those already occupying a position in the new system, training courses of several weeks are provided. The salaries of health centre personnel compare favourably with those of hospital staff.

The years of preparation for the new system provided ample time and opportunity for a full discussion of its objectives and implementation among politicians, administrators, and provider and user organizations.

Finland thus offers an example of the introduction on a national basis of a new system of primary care, albeit in a country with a long tradition of considerable societal responsibility for the health care of its population. Nevertheless, the change required broad acceptance by all concerned. There is still a strong private sector (though it is largely publicly financed), especially in the larger urban areas, where private health centres are to be found. A similar symbiosis of public and private health care organization can be observed in other European countries, notably (as already mentioned) in France, except that there the health centres under public auspices are concentrated in the large population centres.

A different situation exists where the maldistribution of resources is aggravated by their general shortage and the inability of large segments of the population to sustain needed services financially. Under such circumstances the state has to supplement the private sector by centrally provided and financed services similar to those found in the unified systems of the eastern European countries, except that the nationalized services are provided on a selective basis where the private sector fails. An example is the organization of *ocaks* (health centres) and health stations in Turkey, covering about a third of the country's population. However, maternal and child health centres are also operated by the government in areas not covered by the nationalized health services.

In short, it is apparent that countries in the European Region generally have accepted the desirability of the organization of primary

care in health centres of various kinds. The pros and cons of health centres will accordingly not be further discussed here, but reference can be made to the substantial literature on the subject. A report by the Council of Europe (33) summarizes the advantages and disadvantages of the related forms of group practice and health centres. But the report repeats the often voiced criticisms that health centre care is impersonal and detrimental to the desirable physician-patient relationship, that "the very idea of a family doctor is irrelevant", that "there are virtually no home visits", and that the appointment system generally practised in health centres may discourage immediate attention when needed. But surely these are not matters inherent in the nature of the health centre, and many centres exist where, for regular appointments, the patient can see his own physician, where there is no ban on home visits, and where provisions for walk-in patients ensure ready access. It has also been said that, where several physicians are involved in the care of a patient, none of them is apt to accept the basic responsibility and that "the individual doctor thus feels less committed to his patient" (34). This again is not necessarily an attribute of health centre practice and, in fact, shared judgement and responsibility may well benefit the patient.

It has been observed earlier that, in European countries with pluralistic systems, the problems of organizing primary care are much the same as they are in North America, where a good deal of research on the subject has been going on. One Canadian study of group practices (35) draws attention to the potential contribution of group practice organization to the regionalization of health services, an important consideration in the rationalization of hitherto largely unplanned health services. Policy considerations in many of the European countries are echoed in the way a report on health centres commissioned by the Canadian government summarizes the issue: "In summary, community health centres are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society wishes to establish for health care in the future" (36).

Community interest in the development of the health centre model in the provision of primary care should be seen against the attitudes of those staffing the centres. For most categories of staff, a health centre represents a source of employment very much like that of the hospital. However, in health systems where the medical profession maintains an independent status with the ability to choose the working environment, the balance between the pros and cons of work in centres under public auspices will determine the success of such institutions. There is then, first of all, an ideological issue of working in the public versus the private sector. In either sector, the participating doctor in a health centre practice has the advantage of a regular schedule, usually with provision for holidays and time for continued education. There is ready professional contact with colleagues and often greater incentive and opportunity for research. Diagnostic and therapeutic equipment and

supporting staff are more likely to be available in a health centre than in single practice, and there is usually a more structured relationship with the hospital. Especially for the younger doctor, entering health centre practice eliminates the financial and logistic problems connected with establishing a new practice. On the other hand, while many, and especially younger, doctors welcome the opportunity for teamwork with colleagues and members of other professions, the more individualistically oriented will find it difficult to make the inevitable adjustments required. Impressions gained during medical education and training play a role here.

Organizational structures

The meaning of the term "health centre" or any of its variants must be understood on two levels: first as a physical facility accommodating the health team and its equipment, and second as an administrative concept encompassing any arrangement whereby a variety of services are integrated to provide comprehensive primary care; in the latter case, the component services may be at different locations and even under different auspices. It follows that the concept of a health centre as an integrating, or at least coordinating, agency will be particularly applicable in pluralistic systems where indeed various services may be provided under different auspices.

Even where each practitioner, institution, visiting nursing service, laboratory, and other agent or agency of health or personal social service has been working independently of the rest, it is possible to establish a coordinating centre with direct lines of communication to each of the practitioners and agencies concerned, so that all services existing in the community can readily be mobilized when needed. This could relieve the physician, for instance, from the need to maintain liaison with a multiplicity of agencies and he could refer patients for specific services—diagnostic, curative, or rehabilitative—to the coordinating centre just as he would refer them to a hospital for inpatient care (17).

Another version of this system is the *Anlaufstelle* in some communities in the Federal Republic of Germany. The United States concept of the Health Maintenance Organization also comprises not only group practices functioning under one roof, but also other forms of association among otherwise independently operating practitioners, with the aim of providing comprehensive services under a common plan of financing. One legal form taken by such an association may be that of a medical care foundation, sponsored by a local or state medical society with the objective of assisting member physicians towards providing quality care, and financed through private prepayment plans or categorical public plans.

Another situation in which the health centre concept is not confined to services provided from the same premises is when a health centre extends the geographical area it serves by establishing subcentres, often

themselves referred to as health centres although they are administered, supervised, and supported by the larger centre.

Thus, a health centre may be:

- a coordinating agency, which may or may not provide services to patients:
- an integrated system of primary care facilities comprising subcentres; or
- a facility where a variety of primary care services is provided under one roof.

While the last type is perhaps the one most frequently found in countries where the organization of primary care is left largely to the initiative of independent providers of care, or where there are no remote areas to be served by satellite centres, the existence of subcentres is found where a policy of regionalization of health services exists and where services have to be extended to outlying areas. But teamwork and coordination do not necessarily require a common physical base: “good premises do not necessarily produce good team-work, and a well integrated team can provide first rate primary care from accommodation which is inconvenient or unsuitable” (37). Whether first-rate care can be provided from unsuitable facilities may be questionable, and indeed the report just quoted goes on to say that, “other things being equal, the effective functioning of a team is likely to be promoted if it operates from a common base and is supported by adequate facilities”

Once again, the categories listed are not clear-cut ones into which primary care facilities can be readily fitted. One additional element for distinguishing among the various forms of centre is provided by the fact that there are centres or centre-like facilities that do not accommodate the complete primary care team or all the supporting activities available in the community.

Free-standing laboratories constitute an extreme example, perhaps altogether beyond the range of the health centre concept since they may not even provide direct services to patients or be directly accessible to them. They may, however, serve one or more health centres and possibly independent practitioners, thus constituting an essential adjunct to the primary care centre for all, or at least the more complex, laboratory procedures.

A similar relationship exists in what, in the Federal Republic of Germany, is called an *Apparatgemeinschaft*, where physicians or groups of physicians use common diagnostic and therapeutic equipment, not necessarily situated in the same area as the users. Like a common laboratory, this arrangement reduces costs by pooling relatively expensive equipment, but it may entail additional travel for the patient to be examined or treated.

Inherent in the health centre concept, whatever its form, is the notion of a primary care team, generally including a physician. However, there are variations even on this theme, and there are centre-like organizations

that combine services by some, but not all, members of the team, in some cases even leaving out the physician. For example, the *Sozialstationen* (social service stations) in Rheinland-Pfalz, Federal Republic of Germany, provide a broad range of nursing and personal social services, including the loan of equipment, to ambulant and homebound patients, but not physician's services, although there is a physician on the executive committee. These services are provided, on referral, by a physician in the community. Like some health centres in Belgium and the Netherlands, these stations, are sponsored by religious organizations, in some cases on an ecumenical basis, i.e. sponsored jointly by both the Protestant and the Catholic churches in a community.

Another example of a centre-based team being supplemented by outside sources is to be found in the very frequent reliance of the primary medical team on personal social service resources available from other public or private agencies.

The degree of a health centre's dependence or independence varies fundamentally according to the health system of which it is a part. In a socialized system with strict regionalization, the primary care centre is a link in the hierarchical organization of the system with upward accountability and structured paths of referral and channels of consultation, combined in some situations with a horizontal relationship to the health committee of the local council. The extent and intensity of this relationship varies according to the local community's responsibility for the organization and especially the financing of primary care services within the area.

Under other systems this relationship will be transferred to whatever kind of sponsoring agency there may be, e.g. an insurance carrier, religious body, consumer group, or trade union.

Where, as for instance in Turkey and other southern European countries, the central government assumes complete responsibility for that part of the health system that is nationalized, lines of authority and accountability will be strictly from the centre to the periphery and vice versa.

Here again the dilemma of primary care makes itself felt, i.e. on the one hand its services are primarily directed to a more or less defined local population and it relies heavily on other local community services, but on the other hand it must remain integrated into the secondary and tertiary levels of the health system.

In countries with an independent medical profession, at least as far as primary care is concerned, the external relationships of a health or group practice established by practitioners themselves is analogous to those of single practitioners. Collective practices, however, sometimes have difficulty in obtaining payments from insurance agencies whose accounts may be with individual physicians only.

A health centre in a regionalized system may, in turn, assume authority over one or more subcentres. In all instances where health services must be provided for scattered populations in rural or remote

areas, health-centre-like institutions are found at several levels. In a socialized and regionalized system, these are highly standardized in regard to their services, staffing, equipment, and channels of referral and communication.

Such a hierarchy is clearly evident in the Finnish system of primary care centres with subcentres and dispensaries. Turkey has its *ocaks* and health stations. Eastern European countries utilizing the experience of the USSR have well defined steps in their organization of primary care, especially in rural areas, usually related to the size of the populations to be served. Thus, Bulgaria has "branch (village) polyclinics" for one or several areas with over 6000 inhabitants, a "village public health service" for areas with over 4600 inhabitants, a "medical assistant's health centre" for about 1500 to 4600 inhabitants, and a "central district physicians' office" for communities with more than one or two general practitioners, and its "physician's office" for one or two general practitioners in smaller communities. Romania has a hierarchy of "dispensaries" staffed and equipped according to population size. Similar gradations exist in other eastern European countries, especially where there is still a substantial agricultural population in the rural areas. Poland, for example, has its community centres, village centres, and clinics, particularly in the rural areas.

Also characteristic of the organizational structure of primary care in the eastern European countries are the parallel strands of general medical care, occupational or industrial health services, maternal and child health services, and *sanepid* (sanitary and epidemiological) stations. The respective categories of medical staff are variously referred to. For example in Czechoslovakia there are the "territorial health community physician" for the adult population who cannot use health services at their place of employment, the "factory health community physician" for those employed in industry, the "health community obstetrician-gynaecologist", and the "health community paediatrician" for children up to the age of 15 years. Dental services are provided by stomatologists. Depending on population size and corresponding staffing patterns, the different types of service may be accommodated in the same place or separately housed. For an adult employed person, the criterion for using either the general or the industrial health service is usually whether he is ambulant (in which case he would go to the industrial doctor) or not (in which case he would be cared for by the general physician).

A distinction must be made in socialized health systems between the strictly hierarchical relationship in all matters relating to management and administration, and the staff relationship, which also involves an element of supervision and surveillance but mainly takes the form of consultation, usually between the medical staff of the health centre and that of a more central polyclinic.

Arrangements for the transport of patients vary. Sometimes ambulances are attached to health centres, sometimes they are operated

on a regional basis. In countries with pluralistic systems they may be administered by such public agencies as the fire brigades, by voluntary nonprofit organizations, or by commercial enterprises.

In pluralistic systems, in which physicians are independent agents, there is an almost infinite range of organizational arrangements whereby physicians may be associated in their work. The pooling of laboratory services or equipment has been mentioned already. There may be formal or informal arrangements for substituting or deputizing. Physicians may establish themselves in a common building and share certain maintenance costs while keeping their medical practices strictly separate. They may pool office staff, equipment, and facilities such as reception desks, waiting-rooms, etc., they may form a loose partnership or a more structured group practice, or they may organize their practices in the form of a health centre with a central records system, pooled staff and equipment, and common accounting.

Policy regarding the inclusion in health centres of beds for inpatient care varies. Finland follows the principle of having beds (some for acute, some for chronic patients) in its health centres. Czechoslovakia, on the other hand, also as a matter of principle, has none. Elsewhere the practice varies; some centres maintain a few beds, mainly for observation. Others, like the Institut prophylactique in Paris, a voluntary nonprofit institution, maintain a hospital annex for short-stay patients.

The merits of having inpatient facilities attached to a health centre must be judged in the context of the particular centre and its function within the health care system. If there are to be beds incorporated in a centre, there arises the question of the kind of beds best suited to circumstances. The problems are due in part to the hitherto generally too rigid separation between outpatient and inpatient care, or the so-called community care versus institutional care, or simply the vertical and horizontal posture of the patient. There has been a movement towards integration from the institutional end by making the hospital the centre for the entire range of primary, secondary and even tertiary care. Thus, primary care centres or multispecialty clinics are located in the hospital or in physical proximity to it. This has the advantage of facilitating communications and of pooling capital investment in plant and equipment. A possible disadvantage is the effect on consumer acceptability because of the institutionalized and impersonal character of the entire facility and the impression it may create among some patients that they are "going to the hospital" rather than "just to see their doctor".

Until recently considerations of economies of size have led to increasing the bed capacity of general hospitals, which consequently served larger populations than would be covered by a primary care facility. The hospital also became farther and farther removed from the health centre, nursing station, or dispensary, thus making transport and communication more difficult. It meant furthermore that patients, in order to be hospitalized, had to be removed from their local community.

As a result, we witness the renaissance of the once shunned cottage hospital and/or the attachment of beds to a primary care facility. This provides a clue to the type of such beds. They would be either short-stay beds for diagnostic procedures, minor surgery and perhaps normal deliveries or, on the other hand, long-term beds for chronic patients requiring minimal nursing care and medical supervision but enabling the patient to retain his local ties.

One of the difficulties of attaching beds to a centre, rather than a centre to a hospital, is that in many situations the licensing provisions for inpatient facilities are such that staffing and building standards would very substantially raise the cost of building and operating the primary care facility. Another obstacle to combining primary care and inpatient facilities exists where the two operate under different auspices, e.g. public/private or national/local sponsorship and funding.

The degree of usefulness or appropriateness of a health centre incorporating beds depends also on the centre's location. Beds will be more useful where distance and transport difficulties render a transfer to a hospital difficult and risky, and where the patient would be removed from his social contacts and environment.

Since the term "health centre" covers a wide range of facilities—from the outlying post manned by an auxiliary, perhaps only once or twice a week, to the multispecialty polyclinic attached to a tertiary care hospital—there can be no general rule regarding the advisability of attached beds. But in a fully-fledged centre, serving a population of about 10 000 to 15 000, where round-the-clock staffing is available, beds for the specific purposes outlined above will be advantageous to both patients and providers of services.

Especially in countries where industrialization and urbanization are on the increase, there is a tendency to consolidate smaller centres and for several small communities to join in maintaining a common, larger, and better equipped centre. This tendency goes hand in hand with the consolidation of other community services such as schools and churches, and in Czechoslovakia, for instance, it has accompanied the trend towards combining agricultural cooperatives into larger units.

If any broad pattern emerges from the variety of organizational structures for health centres existing in the European Region, it is the distinction between socialized and pluralistic systems already noted. In the former, as a result of planned regionalization, there is a hierarchy of highly standardized types of health centre based on the size of the population served and staffed accordingly. Health centres in these countries are an integral part of the health system with clearly defined channels of authority, accountability, and referral. The health centres produced by pluralistic systems, on the other hand, are largely free-standing and vary widely in organizational structure. Since several governments have emphasized the need for further study of the problems of primary care organization, the experience available should prove most useful, especially in view of the current emphasis on the need for strengthening primary care services.

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