

External relationships

Whatever the pattern of primary health care practice, from the solo practitioner to the multispecialty polyclinic, it has to relate to other parts of the health care system through referral, and maintain lines of communication with financing agencies, licensing bodies and other agencies. In addition to these basic and essential relationships, there are many others resulting from and depending on the scope and nature of the services provided and the position of primary care, not only within a particular health service but also within the whole sociopolitical setting in which it operates.

No aspect of primary care organization could be discussed without reference to relationships with other institutions or agencies. These relationships have been discussed in earlier parts of this book in the context of the range of services, staffing patterns, teamwork, information systems, policy and decision-making, the administrative structure, relations to the community, and inevitably also financing mechanisms. The basic theme, in fact, in the concept of primary care as it emerged from Alma-Ata and the strategies for health for all by the year 2000, is one of the integration of primary care into the broader social fabric of the community as well as into the other levels of the health care system.

What remain to be discussed are merely some specific arrangements, observed here and there among primary care establishments, that aim to facilitate the necessary communications and make the ensuing relationships operative. A WHO working group listed the relationships between the primary health care team and other health and personal social services (*1*). The group concentrated on relationships arising from the fact that primary care is only part of the health care system—albeit a central part or, as expressed by the Alma-Ata Conference, the key to achieving an acceptable level of health. The working group emphasized the mutual obligations of contact: “they work in both directions, and there must be a constant feedback from one service to another”. This cannot be too strongly underlined, because in much of the European Region the feedback to primary care from hospitals, specialists, laboratories, etc. leaves much to be desired; it may not occur at all, or it may be incomplete or not timely. The working group discussed the

subject under the four headings of hospitals, specialists, public health services, and social welfare services.

Regarding relations with the hospital services, the group noted, first of all, that the primary care team should have access to appropriate diagnostic facilities and, as far as possible, their diagnostic findings should be accepted by the hospital and not duplicated after the patient's admission. One can go further by noting that such access to diagnostic facilities may obviate the need for hospital admission. The working group also stated that the primary care team ought to be able to visit patients in hospital so as to maintain contact and preserve some element of continuity of care or concern. This also leaves much to be desired in many European countries because of the often sharp distinction between primary and hospital care.

When discharged from the hospital, the patient should be referred back to his primary physician or primary care team, who should be informed of all treatment given in hospital. One might add that this should be done promptly and also include any instructions for after-care.

Regarding relations with specialist services, the working group listed three important factors:

- the primary physician should know and accept his therapeutic limitations
- the specialist must accept the coordinating and integrating role of the primary physician
- there must be close cooperation between the primary physician and the specialist.

Relations with public health services are discussed here on the assumption that there are separate public health facilities for such preventive personal services as maternal and child care, immunizations, etc. It is important that the work of the primary care team be integrated with that of the public health services, so that in effect they join forces in the care of individual patients. Close personal relations between the two services must be built up.

As to relationships with social welfare services, an undesirable separation is caused in many countries by the fact that the social services, covering a different spectrum from that covered by the health services, often have a different and separate organizational structure. It is important, therefore, for a social worker to be a member of the team. Since this single social worker cannot provide all the social services a patient may require, he must serve to establish and maintain contact between the team and the social services as a whole. It is stressed that this contact at the working level should be supported by parallel coordination at the administrative and planning levels. It may be added that it is particularly important also to overcome problems posed by separate financing mechanisms for the two services where no joint financing exists.

In his review of primary health care in Europe, prepared in the context of the Alma-Ata Conference (2) the Regional Director discussed

the relationship between the providers of primary care and the consumers or the community. Only in a few countries does primary care "spring from the community" but there is no clear evidence that this affects the populations concerned in any significant way. The development of an effective relationship is seen as a testing ground for much of the future approach to primary care. There are signs in the European Region, however, of increasing consumer participation either as observers, guardians or advocates of consumer interests or, less often, sharing in the formulation of policy and running the services. The Regional Director also deplores the separation of health and social care since the distinction between medical and social need is rapidly becoming an artificial one, especially in regard to the care needs of the elderly, the handicapped and the mentally disturbed. As a consequence of the widespread separation of primary from hospital care, the relationship between the two sectors is not clear; functions often overlap and "the notion of integration is lost".

Highly structured relationships exist, of course, among primary care, other levels of health care, and a range of other agencies under the various forms of national health service. There is, first of all, the hierarchical structure within the health service system itself, a number of connections to be maintained with other government agencies, and particularly also statutory links with a variety of local administrative and service organizations. Authorities other than those concerned with health may be directly involved in the operation and management of a primary care facility. This may apply to matters relating to the premises of a health centre and even to personnel management. In some European health service systems there is a division of administrative and financial responsibility for health professionals on the one hand and administrative personnel on the other. In Iceland, for instance, physicians, nurses and midwives are appointed and paid by the state, whereas all other staff are employed and paid by the local authority. In Czechoslovakia, administrative personnel are not specifically assigned to particular primary care facilities but form part of the establishment of the Institutes of National Health.

If primary care cannot be considered as a self-contained system because of its links with other parts of the health care system and with other agencies, so the health care system as a whole has links with many other parts of the overall system, including all aspects of national endeavour. These relationships are paralleled at the global level by the links that WHO has come to maintain with other international organizations in technical fields as well as in broader social and economic aspects: the Alma-Ata Conference itself was the result of WHO and UNICEF collaboration.

The socialist countries of eastern Europe

Referral within the primary care sector, i.e. from local to more central units, and referrals from primary to secondary or tertiary levels

of care, are most clearly seen in the highly structured and strictly regionalized systems of the USSR and other socialist countries. At the local level, the feldsher or feldsher-midwife refers to the *učastok* doctor who, in turn, may pass instructions on to the feldsher; he also visits the post regularly and whenever required.

The *učastok* hospital-polyclinic has links with other health services available at that level, such as pharmacies, physiotherapy services, the sanitary and epidemiological station, kindergartens and nurseries. Relations between ambulatory and inpatient care are facilitated by periodic exchanges of medical staff, thus lessening the separation between these two sectors that exists in other health care systems of the European Region.

One of the functions of the polyclinic is the provision of outpatient services for the hospital. It is part of the streamlining of the services and efficiency of operations that pre-admission investigations are carried out as far as possible by the polyclinic. On referral from a polyclinic to the hospital, a case summary is sent to the hospital and on discharge a report from the hospital is sent to the referring polyclinic. To maintain an effective relationship between patients and the primary care facility for purposes of screening, follow-up, etc., volunteers are appointed to maintain contacts with patients residing in their area (3).

Reference was made in an earlier part of this book to the cooperation of primary care establishments with other health facilities such as the sanitary and epidemiological stations, as well as among the various primary care establishments themselves such as services for the general adult population, maternal and child care facilities, and the occupational health services in the area. Relations must also be maintained with the various community organizations supporting the health services, and especially voluntary organizations such as the Red Cross and Red Crescent (4).

In Czechoslovakia a strictly regionalized system requires and permits linkage between all levels of the system. In such a system the primary physician is either able to manage the diagnosis and treatment of the case himself or has the right and duty to use the consultant services and, in more serious cases, to refer the patient to the appropriate specialists at the hospital polyclinic. The main task of the specialist services at the hospital polyclinic, on the other hand, is to help physicians of first contact to cope with the whole spectrum of prevention, diagnosis, treatment and assessment of work incapacity in their communities. First contact physicians, together with the specialist of the hospital polyclinic, form a team able to solve most local health problems. Those that cannot be dealt with within the district are referred to the regional hospital polyclinic; only very exceptional cases have to be referred beyond the region. First contact physicians can readily consult specialists but the usual procedure is a referral in writing from the first contact physician to the specialist, without the former being present at the consultation. The specialist then enters his information on the patient's record for use by the first contact physician. Physicians working outside the premises

of a polyclinic (e.g. in territorial health centres or industrial health centres) generally contact specialists in writing or by telephone. After discharge of a patient from hospital or at the termination of spa treatment, the first contact physician receives from the hospital or spa a detailed report on the course of treatment of his patient.

The first contact physician also collaborates closely in questions of prevention, origin of infectious diseases and environmental health with personnel of the District Hygiene Station, and he refers patients to spas. Other relationships of the primary care services are those with industrial establishments, the Works Trade Union Council and the social welfare authorities, regarding medical assessment of work incapacity due to illness, pre-employment fitness examinations and assessments for purposes of disability pensions. Contacts with social welfare authorities also concern patients' needs for domiciliary care, including the need for home help to assist with the activities of daily living. First contact physicians, especially the health community paediatricians, also maintain contact with the education system by providing school medical services. The appropriate health community physician completes the medical certificate for the purpose of death registration.

In Czechoslovakia the primary care service is organized by the appropriate District Institute of National Health, and there are plans to create a post of district physician to manage these services. Relations with the population served are facilitated through citizens' committees, through voluntary organizations such as the Red Cross and, in the case of the industrial health service, through the respective trade union organizations.

In the German Democratic Republic too, it is the organization of medical care on a regional basis that facilitates cooperation between the primary care sector and the remainder of the health care system (5):

All specialties participating in outpatient and inpatient treatment are involved in providing primary medical care. Outpatient and inpatient treatment are fully integrated to allow for the coordination of preventive medicine, diagnosis, treatment, follow-up care and rehabilitation.

Medical care is organized on a regional basis. The district territorial unit of primary medical care is supplemented (particularly in the field of outpatient treatment) by factory health centres. Teamwork between physicians of municipal institutions and factories organized on the same administrative lines, joint utilization of diagnostic and therapeutic capacities of local medical facilities, and factory health centres make it possible to provide effective medical care in the residential areas and in factories.

The central facilities of the districts (district hospitals and polyclinics) give systematic guidance to all smaller facilities and organize postgraduate education for all persons working in their districts.

The periodic exchange of physicians between the primary care sector and the hospitals not only serves the purpose of continuous education but also facilitates effective relations between the two sectors.

The Hungarian Ministry of Health also refers to the integrated

network of outpatient and inpatient facilities, i.e. dispensaries, polyclinics and hospitals, all of which form a hierarchical organization with its line relationships. The general practitioner service is subordinate to the professional authority of the director-general of the hospital. This organizational arrangement ensures effective professional relationships since the district health service polyclinic and hospital are all part of the same organization, so that referrals, admissions, transfers, etc. are part of the regular communication system without requiring special provisions. If a patient requires specialist treatment or care in a special institution, the immediate superior of the general practitioner (i.e. the group leader or hospital consultant) may refer the patient to a regional hospital or a specialized national institute. In urgent cases these referrals can be made by the general practitioner himself. The Ministry considers these relationships not at all as external to the primary care facility but as closely integrated levels of one and the same system.

Since all local health and social services in Hungary are linked to the local council—or in cities to the municipal health body—the general practitioner can readily contact other agencies such as the social services or the school health service. Separate school health services are provided only in towns and cities as a youth health service. Primary school children are cared for in larger towns and cities by the district paediatrician, while in the villages the general practitioner looks after every type of school. There is regular reporting by the general practitioner to the appropriate health authority and, in turn, he is provided with the information he requires from other sources. There are regular meetings with the health board of the local council. The industrial physician, besides his immediate contact with management and the sanitary and epidemiological station, is also in contact with the National Institute of Labour Hygiene.

While integration of all levels and branches of the health service has been a guiding principle since the Second World War, increasing specialization and differentiation of institutions rendered the task more complex, especially in the city of Budapest where some institutions have nationwide functions. Paediatric services present special problems of their relationship to other sectors in the capital, and particular attention has therefore been paid to the integration of all branches of the health services and communications among them (6).

If health services for children raise particular problems in their relationship to other agencies, health services for the elderly also require that attention be paid to the need for expanding relationships between the health and other community organizations. This is illustrated by the example of a rural community in Romania that has recently become industrialized. Not only does this development necessitate establishing effective relations with the social services, but it also means establishing effective communication with families and the community at large to cope with the broader social and psychological problems, including those arising from the generation gap, to which primary medical care must relate (7).

Any effort at a truly effective relationship between primary care and the hospital, and therefore complete integration, must overcome the traditional separation between those two sectors. When this became a problem in the city of Zagreb in the 1960s, it could still be observed that integration existed mainly only on paper: "though repudiating any dualism theoretically, we nevertheless tolerate it in practice" (8). Part of the remedy was to create a programme of specialty training in general practice that brought the status of the general practitioner up to that of his specialist colleagues at the polyclinic and hospital. Plans for hospitals in Yugoslavia to have a general practitioner on the staff to do the work of general medicine at admission and screening developed slowly, if at all. The organization of primary care in medical centres was found to facilitate the desired relationships. Integration would not only improve medical care, it was postulated, but would also have financial benefits by pooling certain equipment and administrative services, as well as by avoiding the duplication of diagnostic procedures. Relationships between primary health care, other sectors of the health services and other community activities are framed by the social agreements or compacts that regulate the functions of primary care institutions in accordance with the community social insurance agency, local industry and trade unions, and other community institutions (9, 10). Relations between primary health care and such organizations as the Socialist Alliance of Working People of Yugoslavia, the Conference for the Social Activity of Women, the Confederation of Yugoslav Trade Unions and others facilitate campaigns for blood donors, mass immunization and screening, sanitary measures, etc. Similarly, primary care receives support from the Yugoslav Red Cross and other voluntary organizations. Health education is promoted by the relationship between primary health care and the local school system.

Many of the features found in the health services of the socialist countries also exist to different degrees in other European countries with a national health service. This applies most generally to the vertical relationships within the system, necessarily characterized by hierarchical elements inherent in a national organization with a differentiation of functions between the central, regional and local. Perhaps what distinguishes the socialist systems from their counterparts in other countries is the close integration of the health care system into the framework of central or regional socioeconomic planning, and the consequent lateral relationships at the primary level, as at each other level, with the corresponding civic and political structures.

Other European countries with a national health service

Vertical relationships of primary care with other levels of the system, lines of referral, and the flow of communications are, as mentioned above, essentially similar to those in the socialist countries. There are

differences in detail, however, and with regard to the flow of information the actual practice is often at variance with the established rules; this applies particularly to the flow of information from the specialist or hospital back to the referring primary physician, a flow which is frequently inadequate in terms of content or timing or both. Primary and secondary care are distinctly separated and access by the general practitioner to his patients in hospital is limited to certain conditions. He may be permitted to visit his patients in the hospital, but the treatment stays in the hands of the hospital doctor.

Here again, the health centre organization favours more structured relationships, within both the health care system and other community organizations, than could be maintained by a single-handed practitioner without the logistic support built into the health centre. Also, the very process of erecting a new health centre, and the consultations connected with it, will bring about a closer relationship between the centre and other community organizations than could exist between a general practitioner and the community.

The establishment of some of the health centres in Sweden, which were monitored by academic research institutions and the Swedish Planning and Rationalization Institute of the Health and Social Services (SPRI), involved broad representation of the communities to be served by the centre. An example is the creation of the new centre in Tierp Municipality. The objective of that project was stated as the application of the "totality concept" to the experimental activities and "thereby contributing to the coordination of social welfare, public health, medical care and student care" in the municipality (11). A close relationship between the future centre and the various sponsoring organizations was established as early as the planning stage. A "collaboration committee" contained representatives from the municipality, the county council and the National Board of Health and Welfare. A "reference group", responsible for the research and development of the project, comprised members from the research organizations observing the project and from the National Board of Health and Welfare. A "coordinating group" consisted of the head of the local social service office, the registrar of the health centre and the local chief education officer. Collaborative relationships in the operation of the centre between the medical services, social services and student care services were formalized in the above mentioned "coordinating group" as well as in four "area groups", each responsible for a geographical-administrative area within the municipality. These groups comprised a social welfare officer, district nurses and medical officers, home care officers and a school representative, with representatives of other organizations co-opted as required. The social welfare officer of each group was to act as its coordinator and chairman at meetings. To ensure collaboration in the care of individual patients, joint social-medical teams were set up. Early experience with this new type of organizational structure brought out some of the difficulties that became apparent in its operation.

Ideally, all of the units in the organisation would work under conditions of harmonious co-operation. Such co-operation is difficult to achieve in well-established organisations, and in young organisations special problems may often arise. Channels of information have often not been clearly established, various units in the organisation get under way at different times, and there is an uncertain allocation of responsibility, etc. In spite of the fact that the organisational changes in Tierp were relatively well prepared, numerous problems of this nature were encountered during the introductory period. In addition, large sections of the organisation's environment were inadequately informed on the new work forms.

This illustrates the teething troubles inherent in any restructuring of established relationships. Such a formalized inter-agency organization introduced a new note into community life and it was uncertain how people would react to it.

How are these difficulties to be overcome? Smooth working relationships must evolve from experience and mutual recognition.

Such questions must be solved within the organisation and its environment (municipal and county bodies, etc.) and in pace with the need and willingness of the organisation to subject the matters to discussion.

As for the conditions for effective collaboration among the primary care team itself, discussed in an earlier part of this book, inter-agency collaboration must also be based on mutual awareness of the distribution of functions and responsibilities; this can be stimulated and supported by a suitable organizational, administrative and financial structure.

Guidelines such as those given in Denmark through the Ministry of the Interior and the Ministry of Social Affairs, and parallel recommendations by the Municipal Councils Association, for planning, cooperation and communication within and between primary and other health care levels, are intended to ensure and stimulate the achievement of a truly comprehensive service at the local level. In particular, this also helps to ensure smooth and effective relationships between the social and health services where both are needed.

Inadequate coordination between the health and social services is a recurrent theme in most countries. In Sweden, social services are the responsibility of the local community, while health services fall under the authority of the county. But there are other problems arising from the dichotomy of social and health care services, some of which are described by the Finnish Ministry of Social Affairs and Health (12): personal social services are subject to a wide variety of regulations, are implemented by different organizations, and have remained underdeveloped in comparison with health care due to a lack of adequate planning and funding. All this impedes the care of chronically ill patients, alcoholics, the physically and mentally handicapped, etc. Common regulation and funding of the social and health services would

achieve closer cooperation between the two. Another factor hampering the relations between branches of the health services, and between these and other community services, is frequently the lack of coterminous borders (13). Regarding the relationship of primary care centres in Finland, it has been the policy to increase ambulatory services provided by hospitals, decentralize them as needed, and coordinate them with the activities of the health centres. Implementation of this policy has enabled one health centre to make specific arrangements for various services with a number of hospitals. In another centre it was found that community based projects, such as the North Karelia project, are instrumental in bringing general practitioners into regular contact with hospital doctors.

The matter of information exchange between a health centre and other health care institutions regarding referred patients is regulated in paragraph 18 of the Finnish Public Health Act of 1972. The Act also provides for health centres to assist the police in carrying out forensic examinations and, if so requested, to examine those eligible for military service. In its general argumentation leading to the introduction of the Act, the government allowed for agreements to be entered into between communes and schools or places of employment for the provision of health care to students and employees. Such services, except for routine school health services of a supervisory nature (paragraph 14.5 of the Act), should not be obligatory for the commune, and payment should be fixed in any agreement.

Further external relationships of Finnish health centres may arise from agreements between the National Board of Health and a commune maintaining a health centre, regarding the care at the centre of patients from certain institutions.

Special care facilities, such as those for maternal and child care, the mentally ill and tuberculosis, must maintain relationships with other agencies according to the requirements of such special services. The Helsinki City Tuberculosis Dispensary, for instance, lists the following among external bodies with which contact is maintained: the central sanatorium, polyclinics of other hospitals, the city health centre, the city welfare authorities, the police (for inspection of persons refusing treatment), and address bureaux and registers (to help locate patients). These contacts are in addition to those maintained routinely with specialists and hospitals, social welfare authorities, municipal school health services and registration offices.

In the United Kingdom, general practitioners are not employees of the National Health Service but contract with the service to provide their services to patients registered with them. The pattern of practice—solo, group or health centre—is up to the individual practitioner, and consequently there is a wide variety of arrangements by which he may relate to other agencies. Under these circumstances a recent Royal Commission stated that “it would be foolish and unprofitable to try to force general practice into one particular mould” (14). The same applies to dentistry in the United Kingdom. Some general practitioners have

periodic sessions in hospitals, and it is thought that the introduction of a hospital practitioner grade will increase hospital work by general practitioners. Consultants from the hospital, on the other hand, may visit patients of general practitioners, and they are even more likely to hold consultant sessions in health centres. There is, as the Commission observed, little cross-boundary work between community and hospital work by other categories of health personnel, although some liaison posts exist and in some local hospitals nurses work both inside and outside the hospital. General practices may employ nurses or they may be employed by the health authority and "attached" to a health centre or group practice.

The relationship between hospitals and the primary care services in the United Kingdom still leaves much to be desired, although their integration was one of the objectives of the reorganization of the service in 1974. The Royal Commission found "frequent criticism of communications across the hospital/community boundary". While there are established procedures for referral back and forth, communications are often inadequate.

Another link maintained by some of the independently practising general practitioners in the United Kingdom is that with a commercial deputizing service, which sometimes raises questions of quality and continuity of care. Special problems exist in regard to the relationship between primary medical care and the social services, since each is administered by a different authority (except in Northern Ireland). Joint consultative committees and overlapping representation on the respective authorities, as well as the availability of (albeit limited) joint financing, aim to overcome the difficulties inherent in this separation.

Sharp separation between general practice and the hospital has been a long-standing feature of the British health care system and it is slow to change. The exclusion of the general practitioner from the hospital "where most of the more spectacular advances in medicine have been made" was deplored by the British Medical Association in 1970 (15) and recommendations for improvement were made. "Feelings run high on this question", the report states, "largely because the general practitioner has been excluded from any part in the care of his patients in major hospitals since the inception of the National Health Service, and, indeed, until recently, has had difficulty in gaining access to ordinary diagnostic facilities". These complaints relate largely to the major district hospitals; there are smaller hospitals, general practitioner hospitals, and particularly maternity facilities to which the general practitioner has access. Another point of dissatisfaction among primary care physicians in the United Kingdom is the difficulty in communication with the hospital: "close liaison is essential between the members of the primary health care team and the hospital service, but at present this liaison is frequently negated by the prolonged interval which can occur between the patient being seen at a hospital as an out-patient or being discharged from hospital and the arrival of the consultant's report in the hands of the family doctor" (16).

Possible relationships between hospital and community health services in the setting of the British National Health Service were explored, and respective advantages and disadvantages reviewed, in a study on health centres (17). The alternatives mentioned are:

- all medical care being incorporated into the hospital service;
- all health services being based on the site of the district general hospital;
- limited duplication in all health centres of services traditionally provided at hospitals (e.g. diagnostic equipment, outpatient sessions, day surgery facilities);
- selective application of the foregoing alternative;
- overlap of personnel, but not of services, between health centres and hospitals; and
- health centres as general practice teaching units.

Advantages and disadvantages, including acceptability to those involved of each of these possible models, make it clear that, apart from policy issues, practicability will depend largely on local circumstances.

A number of health centres in the United Kingdom, especially those sited in proximity to a hospital, are already being used by specialists for their outpatient clinics. Specialists and general practitioners should have the occasion to discuss individual patients or policy regarding the management of certain types of case (18). A policy statement by the Department of Health and Social Security established criteria for the siting of health centres in association with a hospital (19). In any case, there should be consultation with the community health council. A central location well served by public transport would favour such siting, certainly in the case of a general practitioner hospital. It should be made clear, however, that the centre is not part of the hospital, so that patients will not lose the feeling of coming to their family doctor. Practitioners must be fully informed of future plans for the hospital. Regardless of their siting, health centres should have accommodation for local authority social workers connected with the primary care team.

Pluralistic health care systems

A very loose form of organization and external relationship exists in those countries where the primary care physician, often in solo practice, operates as an independent professional, creating his own relationships with other professionals and agencies. He may, on occasion, request the services of a community nurse employed by a public agency, he may refer a patient to one of the social service stations, or he may refer him to a specialist practising within or outside the hospital. Austrian experience with using the services of a community nurse led to the conclusion that such arrangements may often work well, especially in small communities, but communications may be time consuming and sometimes break down (20). Relationships of the general practitioner

with the hospital vary not only from country to country but also within countries according to local conditions and personal arrangements, for instance regarding a general practitioner's visit to his hospitalized patients even though their treatment may be entirely in the hands of the hospital doctor. In general, however, the general practitioner's access to the hospital is limited at best.

Regarding some form of relationship with the community, there is—especially where health centre-like institutions exist—some vague awareness that some rapport with the community should be aimed at for the sake of health promotion but, as the Belgian Ministry puts it, such rapport is difficult to achieve because the population has become accustomed to a passive role *vis-à-vis* the health establishment. Nevertheless, some centres have evolved a variety of relationships ranging from patient committees to informal meetings, distribution of health educational material and some preventive activities, but rarely amounting to participation in management such as organization of the centre, priority setting, programme planning, etc.

There are also charitable and other voluntary groups in these countries that cooperate with and support the activities of public health bodies, centres for social assistance and other community care, or institutions for the care of the elderly. While in the Federal Republic of Germany there is not the clear dividing line as in other countries between the work of the general practitioner and that of the specialist, there is a sharp separation between those practising outside and inside the hospital, with the former having no access to the hospital. Treatment after admission is conducted entirely by the hospital staff.

Doctors at health centres in France, or other primary care physicians, are not normally allowed to see their patients in hospital, but they may refer patients to the hospital of their choice. Referral to hospital or a specialist may be made by a letter of referral, or by sending a photocopy of the patient's record. It should be noted here that some centres, such as the *mutuelles* or L'Institut prophylactique in Paris, have a number of beds at the centre for selected inpatient care. The centres usually maintain good relations with the various public health agencies in their community, including dispensaries, as well as with the social services, which have workers in many of the centres. They also make their services available to other physicians in the community. In most cases, however, liaison with the school health services leaves much to be desired.

In the Netherlands most specialists can admit patients to hospital, and they use hospital facilities for the care of their outpatients. General practitioners may admit maternity cases but they do not work in the hospital, except for visits to their patients who may have been admitted.

With the variety of organizational forms of primary care existing in this group of countries, the relationships with other parts of the health system and other agencies also vary considerably in their nature and extent. This applies in particular to any structural relationship with the community served, however this may be defined. Personal motivation

and initiative on both sides play a major role here. The referral system follows the basic pattern existing elsewhere, except for the general absence of the more-or-less strict regionalization prevailing in countries with a national health service. Also, the general practitioner may not necessarily be the first access doctor in the pluralistic systems. Since most countries in this group have insurance systems of one kind or another, the relationship between the primary care establishment and the insurance carriers assumes greater importance and may in some situations affect the pattern of practice.

Primary care and the larger system

Relationships of any form of primary care facility are conditioned by its role within the system, i.e. the health system as well as society in general. This corresponds partly, though not necessarily entirely, with vertical and horizontal dimensions. Vertical relationships are generally those with other levels of the health service, such as from the primary level to a specialist and/or hospital. Horizontal relationships for the most part extend to other community services and agencies at the local level. Especially for the more peripheral primary care facilities, this distinction often goes hand in hand with communication and referral outside the local community for secondary or tertiary services, or inside the community for other locally provided services.

In both respects, there are differences in relationships among the three broad groups of health care system reviewed here, i.e. the socialist systems of eastern Europe, others with national health service systems, and the pluralistic systems. If this book clarifies any of the issues inherent in the organization of primary care in the European Region, it should be the fact that primary care cannot be discussed and understood without the context of the systems of which it is a part, i.e. the broad societal system and its subsystem concerned with the provision of health services.

The most highly structured relationships are found in the socialist systems with their strict regionalization and defined populations served by the facilities at the various levels. Under these systems the relationship within the health sector is a strict line relationship in an essentially hierarchical organization. Lateral relationships within the local community, on the other hand, are clearly defined by the central planning system, which deals with the health service as an integral part of total societal activity at each level of administration.

Similarly structured vertical relationships within the health care system prevail in those other European countries that have a public national health service. Exceptions are those countries where general practice is an independent profession, so that relationships with other parts and levels of the system are of a contractual rather than a hierarchical nature. Horizontal relationships, however, lie outside the organizational framework provided by the national health service. In some countries, such as Northern Ireland and Poland, health and

personal social services are administratively combined, facilitating the coordination of the two. Great Britain has joint consultative councils intended to bridge the gap between the still separate (and largely also separately financed) health and social services. A beginning has been made with joint funding.

Other countries may have the two services combined at the central level in one ministry, but not at the local level where the social services may be administered by the local authority and health services by the larger county administration, thus rendering working relations between the two more difficult. But even the tenuous ties provided by a combined central health and welfare ministry have no parallel in respect to other community agencies and services that bear on the health of the people, so that the primary medical service and the community at large are left to their own devices regarding any relationship they might develop. That such relationships have nevertheless been established here and there is evidence of a felt need.

In the pluralistic systems there exists neither the hierarchical structure within the health care system nor, generally speaking, a built-in link with other sections of community affairs. The relationships within the health services are confined to unstructured referrals, and rare links with other parts of the community emerge only as a result of local and often personal initiative. They do exist, however, and again they reveal the need for and advantages of the kind of relationship that complements community orientation of the primary care facility with primary care orientation of the community.

The full integration of primary care into the remainder of the health care system (or, vice versa, restructuring of the health care system to fully and most effectively support the primary care services) leaves much to be desired in many countries of the European Region. There is a growing awareness that the development of the concept of primary health care as an integral part of community life, as envisaged at Alma-Ata, is desirable, if not essential, if health for all is to be achieved. All this, however, means building up new relationships and ensuring the will not only of policy-makers but also of those who will have to establish relationships, for which they must be conditioned by their training. Society at large must also be made aware that physical, mental and social wellbeing are indivisible, and that it must do as much as possible to maintain health before relying on medical care to cure or alleviate illness.

Primary care, for its part, must be equipped not only to dispense medical service passively but also to establish and maintain the relationships necessary to play its broader role. The European Region shares this challenge with other parts of the world where the idea of health centres is gaining ground. Several years before the Alma-Ata Conference, a study sponsored by the Canadian government concluded that a health centre must maintain the vertical as well as horizontal relationships described above, i.e. "form part of a responsive and accountable health service system" and "in turn, the health services must be closely and

effectively co-ordinated with the social and related services to help individuals, families and communities deal with the many-sided problems of living" (21). The health centres established in the United States under the auspices of the Office of Economic Opportunity are conceived as integral parts of developing socially and economically deprived areas. As in many other countries, health services in Japan have been seen as wanting in the past in several respects: too categorical, separation of curative and preventive services, and too one-sided planning from the administrative and professional points of view. Future needs are described as strengthening of community based health activities, promotion of comprehensive health care, and active participation of the people in health planning (22).

The Declaration of Alma-Ata (23) describes the highest possible level of health as a social goal "whose realization requires the action of many other social and economic sectors in addition to the health sector". Primary care, the Declaration further states, "involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors".

An integrated, functional and mutually supportive referral system is needed to enable primary care to discharge its functions. The joint report for the Alma-Ata Conference by the Director-General of WHO and the Executive Director of UNICEF (23) emphasizes the need for coordination: "primary health care, as an integral part of the health system and of overall social and economic development, will of necessity rest on proper coordination at all levels between the health and all other sectors concerned". And, in turn, primary care must be supported by other sectors of the health system and all the other social and economic sectors. Other sections (86-90) of the joint report describe more specifically the liaison mechanisms and referral system required for primary care to fulfil its functions regarding the relationship to other sectors.

To ensure the necessary two-way support and referral process between the various sectors, the Executive Board of WHO states that "a system needs to be devised that links the various institutions involved" (24). This is part of the strategy for achieving health for all by the year 2000. It requires primary health care to maintain multidirectional relationships which, in many countries of the European Region, are as yet only poorly developed or nonexistent. To enable primary care to live up to the role expected of it, it needs two things: the proper orientation and the necessary resources.

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