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Primary care principles and community health centers in the countries of former Yugoslavia

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ABSTRACT

Background: Many countries implement primary health care (PHC) principles in their policies. The community-oriented health center (COHC) has often been identified as an appropriate organizational model for implementing these ideas. The countries of former Yugoslavia have a long tradition of health centers which have been part of their official policies, but they face the challenge of reforming their health care systems. The aim of the study was to describe the extent of the principles of primary care in these countries and the new role of medical centers.
Methods: This qualitative study was carried out between 2010 and 2011. A questionnaire was sent to two key informants from each of the six former Yugoslavian countries. The set of questions encompassed the following categories: organization and financing, accessibility, patient/community involvement, quality control and academic position of primary care.
Results: Primary care is officially declared as a priority and health centers are still formally responsible for implementing primary care. Different organizational approaches to primary care were reported: predominant independent practices, health centers as an exclusive form and forms health centers and independent practices coexist. We could not find a unique pattern of covering primary care principles in different organizations.
Conclusion: Formally, health centers still play an important role in the countries of former Yugoslavia, but major differences between PHC policies and their implementation have appeared. A consensus about an appropriate delivery of medical care to cover the primary care principles no longer exists.

1. Introduction

The organization of healthcare delivery is of utmost importance for the post-modern world [1]. Scientific research has provided evidence on benefits of well-developed primary care systems, in the field of better coordination and continuity of care and better opportunities to control costs [2,3]. Current tendencies that shape conventional health systems include a disproportionate focus on specialist and tertiary care, fragmentation, and commercialization of health care in unregulated health systems [4].

Although many countries agree on the importance of primary care, its goals have largely not been achieved [5]. In 2008, a new declaration was launched by the WHO [4] in order to implement the PHC principles of justice, accessibility, patient/community involvement, quality care, safety

Abbreviations: BiH, Bosnia and Herzegovina; CME, continuous medical education; COHC, community oriented health center; FYR, Former Yugoslav Republic; GP, general practitioner; HC, health center; PHC, primary health care; USA, United States of America; WHO, World Health Organization; Wonca, World organization of family doctors.

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and efficiency in everyday medical care at the primary level [6–10]. The declaration stresses the importance of person-centredness, comprehensiveness, integration and continuity of care with a regular point of entry into the health system. Many countries look for appropriate organizational forms to implement these ideas. In the USA, the idea of a community oriented health center has recently re-emerged as a concept of a medical home [11–14]. In Europe, community oriented medical practices are increasingly seen as a method of ensuring that patients have access to the right care at the right time in the right place [15,16].

The countries of the former Yugoslavia have a long tradition of a similar concept which has been considered successful and the most efficient organizational model for implementing these principles [17–19]. They followed Andrija Štampar's ideas on community oriented primary care, which was first implemented in 1920s and became a national policy of organizing primary care after the Second World War. According to this policy, primary care centers were established in every commune with the aim of covering a defined area and a defined population. The role of primary care centers was to ensure primary care service, prevention and public health service. There was a free access for all people and some population groups (e.g. children, pregnant women) were given special attention. This system was very effective in solving some of the important health care issues in the first half of the 20th century, but confronted problems by the end of the century [20–26]. Yugoslavia claimed that their health care system was as original as their political system and that it was neither private nor state-run [27].

Since the beginning of the 1960s the policy of primary care faced serious problems. The core problems were: inadequate education of health professionals about health promotion and disease prevention, unsatisfactory economic and social status of primary care professionals and low interest of citizens taking care of their own health through disease prevention [28]. On the other side costs were rising, especially as the volume and intensity of hospital-based care increased. The Yugoslavian system as nominally universal in coverage, health services still were used more by the better-off, and efforts to reach the poor were often incomplete. The 1990s was a decade of major reforms in national health systems. All countries were struggling to develop adequate prevention models to reduce the burden of disease that can bankrupt a national health system [29]. This process coincided with the collapse of political system, when important changes have taken place which is apparent from the economic and political situation (Table 1).

In the new circumstances dilemmas about the appropriateness of the concept of health centers have arisen. Furthermore, in many countries reforms introduced new policies in this field. So far there have been only a few articles/documents describing the situation in primary care in these countries after the collapse of socialism [30–40].

To our knowledge, no studies have dealed with these countries in a systematic way. The aim of study is to describe the new role of medical centers and to what extent the principles of primary care are present in ex-Yugoslavian countries.

2. Methods

2.1. Study design

This qualitative study was conducted between 2010 and 2011. The key informant method of obtaining data from persons whose professional and/or organizational roles imply they have knowledge about specific characteristics of the population being studied as well as potential pathways and constraints for community change, was used [41,42]. The informants were suggested by Wonca (World organization of family doctors) national representatives in these countries, except for Montenegro, which was not a Wonca member in the time of the study. In this case, the informants were suggested by the Ministry of Health of Montenegro. The people we asked for suggestions were informed about the nature of the study and asked to name experts and leading specialists in the field of primary care. Two key informants from each of the six countries of former Yugoslavia were invited to participate in the study. They were considered to correspond to the characteristics of the most ideal key informant: they had adequate knowledge of the topic, were willing to participate, were impartial and were able to communicate [43]. They were all general practitioners with academic background.

2.2. Data collection

The informants were given a semi structured questionnaire covering the areas of primary care described in the WHO documents: organization and financing of primary care, accessibility, equity and patient/community involvement. We asked for their opinion on planning and financing the contents and extent of contractor's work in health care related to the health needs of the community in balance with available resources. Quality control and academic status of primary care were also included as well as the role of health centers. The questionnaires, written in English, were sent by e-mail. The terminology used in questionnaire was clear enough to be understood by chosen informants.

2.3. Analysis

After the information had been received, the records were transcribed verbatim and organized thematically. In the first data analysis, the answers from both informants from each country were compared by the two authors (D.K. and I.S.) and inconsistencies and discrepancies were identified. In the second stage, the interpretations with a list of inconsistencies were sent back to the key informants with some additional information; in some instances definitions were added (e.g. 'mostly' was over 50%, 'almost all' was more than 80%) and consensus was sought. When consensus was not possible, this was noted and described later in the paper. In the third stage, the informants were given a draft version of the results and asked to clarify the remaining dilemmas. The final version of the results was then sent to the informants for confirmation. All the informants approved the final version of the results.