is it possible to present one and the same problem at different levels (for example, for various primary health care professionals)?

Some more "PROBLEM" projects should start relatively soon, because the number of authors will be small. The authors woudl perhaps feel more secure, if there were more of them. The greatest difficulty in creating is artificial and false presentation of one`s own experience. This is true both of the video and computer technology.

b. "EXAMPLES". These are presentations from the practice, suitable almost only for video technology. Potentially, this is also a specific, important and successful video educational approach. Our experience reveals the following elements as important :

- conciseness
- directness
-"imperfectness"

In order to achieve that, creative improvization is needed. Experience shows that too extensive work out and technical perfection sometimes negatively influence the final effect. The effect of incompleteness and the feeling "that something is missing", especially if it is possible to create the atmosphere of spontaneity, seem to be better. In order to achieve that, one should maybe try recording without the previous notice, with smaller team. "Perfect" examples should by all means be avoided. Difficulties, motives and human, not organizational aspect of activities should be insisted upon. Incompleteness and imperfectness are important for accepting other people`s examples. Finding out the disadvantages of the particular example should be made possible, because this initiates discussion and acceptance. This is however related to the ethical problems. A larger number of examples should diminish the sensitivity of those showed in them. Besides, the examples that refer to a smaller part of the entire work tend to be accepted, remembered and compared more easily. Examples of some better organizations can be fractioned in series. The span of institutions presented should be large. Several questions have remained unsolved, like the following :

how to emphasize the main message?
how to present negative experience and behaviour?
how to make sure that we get discussion and feed-back?
how to solve legal aspects (who is the author and what is his relation to those he presents?)
is it possible (and to which extent) that some groups record presentations of themselves?

True work should be presented as much as possible; manifestations and celebrations should by all means be avoided. It should be aimed at viewing the institution with the eyes of those for whom the presentation is intended. People from the practice and recipients (students, etc.) could formally serve as interviewers and reporters.

c. "PRESENTATIONS" (DEMONSTRATIONS). These are materials which present procedures and relations (useful models for the practice) by means of video technology. In computer technology, relatively simple decisions and analyses of schematic situations should be exercised. Emergency states, relationship between the physician and the patient, physical therapy, diagnostic procedures which can be seen, etc. are very suitable for video materials, whereas emergencies, diagnostic procedures, drug choice etc, are suitable for computer technology. Although we have no experience, we suppose that no greater problems should occur, if the preparations (script), recording and elaboration are done well enough and in a professional manner. Script writing (professional and pedagogic work out) require here full attention.

d. "LESSONS" (INSTRUCTIONS) are materials with the similar task as the previously mentioned ones, although the possibilities of direct illustration are not simple. It is mostly a transfer of knowledge and information, according to the system of programmed education. Video materials will mostly depend on the recorded spoken message. Authorities and practitioners should here deal with the same topics. Repetitions and illustrations by means of pictures, schemes and animation are supposed to go along with the presentations. Being clear is very important. Accompanying texts with the tape are also important. Computer materials are of the CAI type.

The team has practically no experiences with the last two types of work. Although no greater difficulties are expected, small projects should serve for gaining experience. There is a considerable number of practical problems :

- length of a unit,
- dividing from the rest within the monthly (how do people react to "STOP" during one disc?)
- how much is enough during one application (differences between individual and group application) ;
- combination of speech and written text on video screen, i.e. of written texts and schemes in computer technique ;
- the use of jokes and similar forms of expression, etc.

A lot could be learned from the already existing commercial tapes and discs within educational TV programmes. Linking of the computer and video technology is a real challenge.

3. The experiences gathered so far, which can be considered rules already, are the following :

3.1. The amount of material within one teachnig unit is very limited. Therefore, one should : proceed directly towards the target, avoid too much playing with details and side-effects.

3.2. The level of presentation should be high, regarding the contents (as high as possible). The authors should feel free, but also responsible. They should be the top-people in their branches. Facts which have not been proved and repetition of generally known phrases and stereotypes can by no means be allowed.

3.3. The described types of teaching units (problems, examples, presentations and lessons) can be mixed, but only if necessary. There is a great danger in wishing to say everything (problem, presentation, example and lesson), because the result is often - nothing.

3.4. Active participants are the most valuable people for the Project. Video and computer possibilities should be provided for the interested professionals and potential authors to gather. Collecting of opinions expressed by passive participants by means of opinion polls is of limited validity, although it is necessary in the process of elaboration of the materials.

3.5. Scientific approach, as described in the Project materials, is an integral part of the procedure,not something special. That is why every member of the team must be well acquainted with all of the Project targets (and they are indeed ambitious). The following hypotheses are now important :

- possibilities of group continuing education "on distance" ;
- on the theories of specific contents of work in primary health care ;
- on the characteristics of video medium in education
- on expert system, "jewel digging" methods in the experience of experts ;
- on the methods of evaluation.

In this regard, the teams cannot be divided into the ones who think and the ones who operate. The theoretical background must be mutual for all the participants in the project, for all the experts.

3.6. In the beginning of the Project, the "exit towards the outside world" is very important; regarding the field work, gathering of experts, communication with the widest spans of public, etc. It should be well coordinated. To the greatest possible extent one should take into consideration the Project as a whole and its prestige.

Proposal for Sample of Users

Sample size, dynamics of Spreading by stages

— second revision —

解題：　本プロジェクトのユーザーの組織について
対象ユニットの選定方法（選定規準）と，
年次毎のユニット設置計画を明らかにした
もの。
本資料最終頁（p.130）にユーザーユニット
の配置計画図が掲載されている。

"A.ŠTAMPAR", SCHOOL OF PUBLIC HEALTH,
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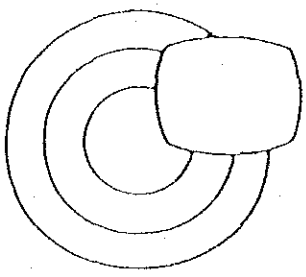
Z A G R E B

INSTITUTE FOR ORGANIZATION AND
ECONOMICS OF HEALTH
Z A G R E B

ASSOCIATION OF ORGANIZATIONS OF
ASSOCIATED LABOUR IN HEALTH OF
SR OF CROATIA

as members of

CENTRE FOR HEALTH COOPERATION WITH
NON-ALIGNED AND DEVELOPING COUNTRIES
Z A G R E B



Project: "CONTINUING EDUCATION FOR PRIMARY HEALTH CARE"

PROPOSAL FOR SAMPLE OF USERS

Sample size, dynamics of spreading by stages

- Second revision -

Zagreb, April 1986

INTRODUCTION

This study is based on the needs of the Socialist Republic of Croatia, but there is a possibility to be extended also to the other parts of Socialist Federal Republic of Yugoslavia. Two kits are required for each of other seven Republics/provinces (one in the center and the other in rural region, connected with the center) what makes totally fourteen.

SAMPLE IN SOCIALIST REPUBLIC OF CROATIA

1. Gradual spreading of the new system of primary health care is anticipated.
Sample in two stages may be chosen. In final stage of complete realization the system is expected to include almost all users. It is very important to determine precisely the first stage, when a small number of users is included. In this first stage the following conditions should be satisfied:

1.1. One part of the system, for experimental purposes, to be located in Zagreb, being the center of the study: in Medical School, Institute for Organization and Economics of Health, "Andrija Štampar" School of Public Health.

1.2. To set up a network of users in the field in such a way that all regions of Socialist Republic of Croatia are included (the inland and the seaside, main regional centers as well as rural areas). In this first stage it is advisable to choose the most cooperative and advanced teams for cooperation locations, in order to introduce and set up the system.

2. When passing to the third stage - in which the whole sample - maximum number of users is included, we had in mind the

the following determinative factors:

2.1. According to statistics for 1982 there were 107 "working organizations" in primary health care (26 Medical*) Centers and 81 Primary health care centers)* while the number of video recorders is 70 or even 60. That means that each Primary health care unit can not be supplied with its own system. It is important to emphasize that Primary health care Units which are supplied "gratis" with necessary video equipment will be motivated to subscribe to video journals.

2.2. When working on the pattern and trying to determine the best locations for video equipment the following factors most be taken in consideration:

1. territorial areas set-up (groups of communes) .
2. four regions
3. regional centers and rural areas to be included
4. communication problems (in some areas the system can be distributed and transfered to neighbouring educational units, while some areas are in a certain sense isolated - the islands)
5. in which premises the equipment will be installed (according to some information the Medical Association premises, health and/or medical centres, schools etc. will be used)
6. number of health workers who will use the system, in each educational unit
7. number of inhabitants - users of health care

* Health Centre is out of hospital
* Medical Centre is intercrated health institution which consists of Health Centre and Hospital.

8. corrections which are to be made (some distant educational units should be supplied with the equipment, although the size of the unit is small; in some areas the natural gravitation must be taken into account when choosing the most suitable location)

9. mobile systems to be anticipated, which will be transfered according to agreed skedule (two months here and two months there)

10. stimulate the users' not included in the sample to purchase the video recorder which are not so expensive, through Selfmanaging Community of Interest (Republic Selfmanaging Community of Interest, Associated Selfmanaging Community of Interest and local Selfmanaging Community of Interest) and get them to subscribe.

3. Primary health care includes:
   1. medical part
   2. stomatological part
   3. pharmaceutical part

3.1. Medical part includes:
   1. General medicine
   2. Emergency care
   3. Health care for infants and preschool children
   4. Health care for school children and youth
   5. Occupational health (for employced)

Obviously, different reactions can be expected from all above mentioned profiles of health workers and probably there were no closer relations between them so far. At the same time, a well organized communication system is now expected to be set up among all branches of primary health care by means of video/computer equipment.
The following system of vertical communication is expected to be realized:

childrens' health care	school health care	general medicine, occupational health

and exchange of information on below stated levels:

emergency	childrens' health care
emergency	school health care
emergency	general medicine
emergency	occupational medicine
and general medicine	occupational health

Such communication system would surely contribute to more efficient treatment of patients, specially when families are in question.
Medical Centers are considered particularly suitable locations, disposing also with hospital wards, what means that almost complete health peronnes of the area would be exposed to programme.

3.2. STOMATOLOGIST sometimes seem to be forgoten (different school, indipendent job, etc.), although their job is of enormous importance in primary health care (discovering of pathological chauges including carsinoms in oral cavity, prevention of deformities and caries).
Since dentist ambulances, if any, are always located in Primary Health Care Centers (they are never isolated units), they will cetainly have a chauce to use video recorders, located in Primary Health Care Centers, but it is important to make the programmes interesting for them.

3.3. The situation is completely different with pharmacists, since pharmacies are often indipendent units, in relation to Primary Health Care Centers and Medical Centers. Anyway, it is expected that professionals from pharmacies and all similar

indipendent health stations are invited by Primary Health Care Centers and Medical Centers to join a new system and to start using video recorders.
There will be no problem in realization of such sollaboration, specially in middle sized towns with Medical Centers and in smaller towns with Primary Health Care Centers.
Naturally, in video journals a special column should be aticipated, dealing with matters interesting for them (medicines, lists, magisterij).

4. Some dilemmas and suggestions for their settlement

to each part of this study certain dilemmas have been outlined.

4.1. Dilemmas to be solved are the following:

DILEMMA No 1: IMPLEMENTATION STAGES:

a) whether to start the system with a small number of users and spread it little by little, or

b) try to include soonest possible all of them.

From the expert point of view the first version is better since it enables the feasibility and being pilot, but for financial needs subscribtions) the others should be included soonest possible. That means, pilot I should be applied only for 4-5 numbers of video journal, when it is necessary to pass to pilot II, and then the system should be gradually spread within one year. All users are expected to be included until the second year of project.

IMPLEMENTATION STAGES IN RELATIONS TO THE SAMPLE

4.1.1. The first stage - pilot I

1. To test ways and methods of accepting information; main reactions to the offered forms, topics, etc.

2. To develop models of team-work. Not only when exchanging interesting experiance, but also when represhing

of knowledge in various subjects such as from the emergency care; it is advisable to work in a team, including the experts for emergency care (general medicine, Occupational Health and Child Health Care), what means those working in a big center (Zagreb), dealing with the emergency cases in their everyday job, and those who rarely meet such cases special attention to those in PHC, who are in isolated distant locations and have to deal with emergency care although they may even be rarely exposed to it.

The f i r s t s t a g e - pilot I (11-13 recorders)

The system to be locate- primary in Zagreb, in the following institutions:

	Number of recorders
A) ZAGREB	
1. Medical School, "A.Štampar" School of Public Health, Institute for Organization and Economics of Health	4
2. Primary Health Center (in Novi Zagreb, Trešnjevka, Zaprešić)	3
B) OUT OF ZAGREB	
3. Selected unite in the field:	
Benkovac	1
Labin	1
Pazin	1
Županja	1
Zadar	1
Varaždin	1

4.1.2. The s e c o n d s t a g e - pilot 2 (8 recorders)

To include all region units, i.e.:		Number of recorders
1. Region centers:	Osijek	1
	Split	1
	Rijeka	1
2. Centers of microregions:	Zadar	1
Periphery (rural area):	Senj	2
	Makarska	

4.1.3. The t h i r d s t a g e:

Gradual inclusion of all planned units in the Republic. See page No

DILEMMA No. 2: Spreading through Socialist Federal Republic of Yugoslavia

Whether to distribute all recorders, or keep 2 systems for each republic and 1 for each Autonomous province. Concerning the ambitious plans for spreading the project it results necessary to keep them from technical and financial point of view. It means 14 recorders should be kept aside.

4.3. Pattern with regard to the users

Pattern can be applied in several levels, depending on the structure of users (in wider sense), what will surely influence the way of making and the use of video journal.

1. Big centers with faculties: beside primary health workers also the following structures actively participate in making video journals:

- university professors (Medical school, School of dental medicine, Pharmaceutical school and Higher medical school)
- students
- postgraduate students (not only in primary health care - proposed tape "Primary health care to colleagues of other specialities")
- specialists in other branches of medicine
- nurses and other allied health personnel
- population (various clubs for protection: blood pressure, sugar, alcoholism, etc.)

That means, three levels can be defined:

1. inside primary health care: present and future health care workers (students and postgraduate students).

2. messages to the other specialists for better collaboration and distribution of work (it would have been ideal to develop certain parts of video journal jointly to be them used by secondary care).

3. for the purpose of health education of population

Besides, when making choosing locations decision on the sample, the number of physicians in primary health care was taken into account. There are 10 areas (groups of communes) in Socialist Republic of Croatia with different numbers of health units, physicians, stomatologists and pharmacists in primary health care. Total number of physicians in this regions was also considered, as well as the number of inhabitants using health care. Anyway, final goal of the Project always remains to improve services offered to population and to make them actively included into the mechanism of joint protection (table No.1).

Table No. 1

ANALYSES OF THE NETWORK OF HEALTH UNITS IN COMMUNITY ASSOCIATION IN.1982 REQUIRED FOR MAKING PATTERN FOR CONTINUING EDUCATION IN PRIMARY HEALTH CARE*

List of Areas (Group of Communes)	Number of communes	Number of Health working organizations	Number of primary health care units	Physicians in primary health care	Total number of physicians	Stomatologist	Pharmaceuts	Inhabitants
1. Bjelovar	10	13	65	125	482	103	86	370.916
2. Gospić	5	7	18	27	69	28	15	90.336
3. Karlovac	6	12	42	68	253	58	59	172.144
4. Osijek	14	21	142	257	1096	219	237	867.646
5. Rijeka	19	36	141	253	1244	220	214	540.485
6. Sisak	6	8	36	72	302	55	54	199.790
7. Split	22	60	168	322	1399	286	287	882.050
8. Varaždin	5	12	53	95	428	80	78	303.590
9. G.Z. Zagreb	14	51	133	348	2722	498	507	855.568
10. Zagreb	12	20	63	124	353	93	87	318.944
		240	861	1691	8348	1640	1624	4,601.469

* Acoording to statistics from 1981, Statistics Annual

Information resource: Indicators of health status of population and the work of the health care system of SRH in 1982, Institute for Public Health of SRH in 1984

Table No. 2

HEALTH CARE INSTITUTIONS NETWORK IN AREAS (GROUPS OF COMMUNES) (in 1982)

List of areas (Group of communes)	Primary health care	Secondary health care	Institutes	Others
1. Bjelovar	4 6 1	2		
2. Gospić	1 3 2	1		
3. Karlovac	2 3 2	1		
4. Osijek	7 6 1 1 1 4			1
5. Rijeka	2 7 1 5	1 1 6 1	2	2
6. Sisak	3 3 2			
7. Split	4 16 8 12 12	1 6	1	
8. Varaždin	2 3 1 4	2		

List of areas (Group of communes)	Primary health care	Secondary health care	Institutes	Others
9. GZO Zagreb	13	4		
	5	3		
	2	11		
	1	2		
	3		2	10
10. Zagreb	1			
	11	3		
	2			
	3			

Information resource: Indicators of the situation and quality of work in health system of SRH in 1982 Institute for health protection of SRH in 1984

3. The t h i r d s t a g e: Distribution of the remaining recorders. Each area should be supplied with one recorder, that is:

Table No. 3 DISTRIBUTION OF VIDEO RECORDERS PER AREAS (GROUPS OF COMMUNES)

Area - groups of communes	Supplied with recorders in stage 1 or 2	Recorders to be supplied in this stage
Bjelovar	-	1
Gospić	-	1
Karlovac	-	1
Osijek	+	
Rijeka	+	
Sisak	-	1
Split	+	
Varaždin	+	
Zagreb, city	+	
Zagreb area outside the city	-	1
In 3rd stage required total of		5

Since some of areas (groups of communes) are bigger than the others, and some of them would be supplied in the second stage, what means that they are better equipped than the others (with regard to the number of physicians - users of video journal and regional distribution) it is suggested to continue distribution of the recorders until all medical centers in Socialist Republic of Croatia (26 of them) are supplied. If medical centers and health center have indipendent health stations or pharmacies on their territory they are expected to include them in the use of video journal for continuing education in primary health care. See table No. 4.

Table no. 4

LOCATIONS OF VIDEO RECORDERS IN AREAS (GROUPS OF COMMUNES) AND MEDICAL CENTERS WITH INDICATION OF TOTAL SAMPLE, RESULTING FROM STAGES 1,2 and 3

Area (groups of communes)	Health organization	No. of health workers	No. of video recorders
BJELOVAR			4
	1. M.C.* Emilija Holek, Bjelovar ZS Željezničar	573	1
	2. M.C. Virovitica	440	1
	3. M.C. Tomislav Barlek, Koprivnica pharmacy	654	1
	4. M.C. Pakrac	298	1
GOSPIĆ			1
	1. M.C. Gospić	200	1
KARLOVAC			2
	1. M.C. Duga Resa	135	1
	2. M.C. Dr. D. Dragulić-Puba Karlovac	856	1
ZO OSIJEK			9
	1. M.C. Našice	244	1
	2. M.C. Dr. A. Štampar, N.Gradiška	364	1
	3. Medical Faculty, Osijek	-	
	4. DZ/MC** Osijek -pharmacy Osijek -emergency station -polyclinic	558	
	5. M.C. Slavonska Požega -pharmacy S.Požega	443	
	6. M.C. Slavonski Brod ***ZS Đ. Đaković	859	1
	7. M.C. Vinkovci	622	1
	8. M.C. Vukovar	556	1
	9. DZ/MC Županja	118	1

*M.C. = Medical Center

**DZ/MC= Primary Health Care Center

***ZS = Health Station - PHC Unit

continuation - table 4

1	2	3	4
RIJEKA			8
	1. Medical Faculty Rijeka	-	
	2. DZ Rijeka		1
	-ZS Željezničar		
	-pharmacy Jadran		
	-emergency station	1042	
	3. MC Pula		1
	-pharmacy Pula		
	-Institute for health protection	1006	
	4. MC Ogulin		1
	-pharmacy Ogulin		
	-ZS Željezničar	316	
	5. DZ Labin	125	1
	6. DZ Pazin	95	1
	7. DZ Umag		
	- pharmacy Umag	115	1
	8. DZ Senj	47	1
ZO SISAK			3
	1. MC Glina	113	1
	2. MC Petrinja	279	1
	3. MC Sisak	815	1
SPLIT			10
	1. DZ Benkovac		
	-pharmacy Benkovac	59	1
	2. MC Dubrovnik		1
	-ZS Babin Kuk		
	-pharmcy Dubrovnik	591	
	3. MC Knin	340	1
	4. DZ Korčula		
	--regional stations		
	ZS Blato		
	ZS Smokvica		
	ZS Vela Luka		
	ZS Orebić		
	Pharmacy Korčula		
	Pharmacy Blato	113	

continuation - table 4

	5. DZ Makarska -pharmacy	132	1
	6. Medical Faculty Split		1
	7. DZ Petar Vilerica, Split -ZS Brodosplit -Town pharmacy	1069	1
	8. MC Šibenik -ZS Boris Kidrič -Pharmacy -ZS Željezničar	844	1 1
	9. MC Zadar -ZS Vinilplastika -ZSVlado Bagat -ZS Boris Kidrič -Pharmacy Zadar	1058	
	10. Movable types for the islands		1
ZO VARAŽDIN			2
	1. MC Čakovec -pharmacy Čakovec	605	1
	2. MC Varaždin -pharmacy DR Gaj -ZS Varteks -ZS Željezničar	1084	1
ZAGREB CITY*			9
	1. DZ Željezničar + ambulance Hanuševa 6 and Square of F. Republic	154	1
	2. DZ Novi Zagreb	344	1
	3. DZ Trešnjevka	314	1
	4. DZ Zaprešić	125	1
ZO ZAGREB OUTSIDE CITY			2
	1. MC Cvijeta Huis, Zabok + pharmacy Zabok ZS Zabok	246	1
	2. DZ Krapina - pharmacy -regional stations Pregrada/Straža/	133	1

*for details see table 5: Summary of Zagreb

Table 5 SAMPLE - SUMMARY BY AREA WITH INDICATION OF COVERAGE

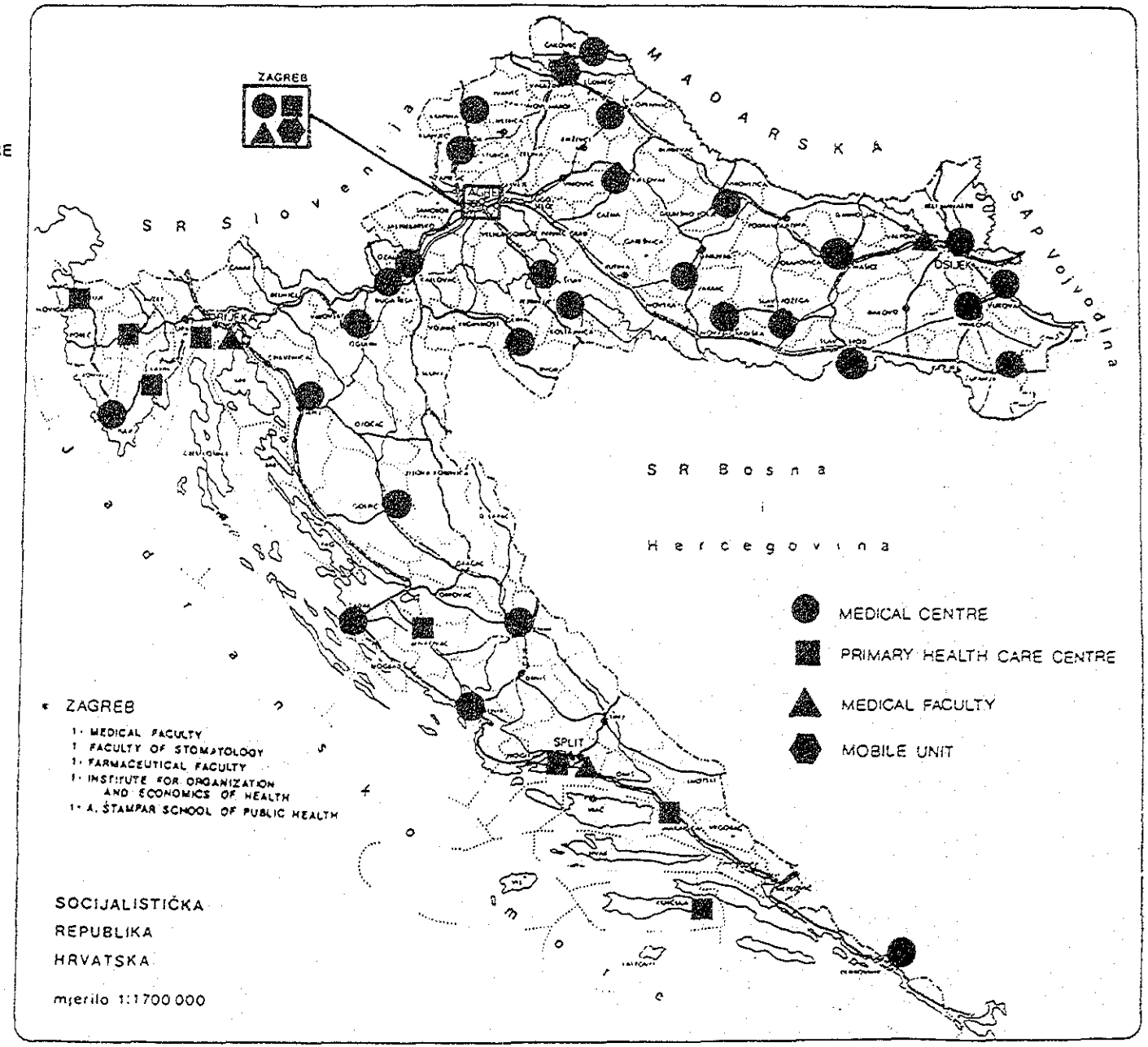
AREA	Included health organization	No.of health workers	Health workers included	%	No. of video recorders
BJELOVAR	4	2494	1965	79	4
Gospić	1	420	200	48	1
Karlovac	2	1279	991	77.5	2
Osijek*	9	5790	3646	65.01	9
Rijeka*	8	5931	2555	44	8
Sisak	3	1391	1207	87	3
Split	9	7049	4207	60	10
Varaždin	2	2373	1689	71.2	2
Zagrebcity**	9	12582	-	-	10
Zagreb out of city	2	1968	246	19.2	2

* Comment
(Osijek, Rijeka, Split get another recorder for the Medical faculty. The number of helath professionals covered that way has not been calcultated. The assumption is that it would raize the percentage significantly. It is important to emphasize that in Rijeka practically 85% of PHC workers are already covered by including major PHC Centre.

**
Zagreb city is another specificity. It has 14 major PHCC, one smaller PHCC, 4 Primary health care units, several public health research and other institutes etc. Sea summary for Zagreb, table 6.

PROJECT :
CONTINUING EDUCATION
FOR PRIMARY HEALTH CARE

NETWORK OF VIDEO RECORDERS IN
SR CROATIA



WHAT IS EXPERIMENTAL PHC UNIT

解題：　Dr. Pavlekovic（パヴレコヴィッチ）をリーダーとするＡＶグループは，すでにトライアル・ヴィデオ・プログラムの製作を始めているが，その過程で，いくつかのＰＨＣユニットを選び，プロジェクトの志向する生涯教育の方法論に対する反応を観察し，あるいはそれらヘルス・ユニットから作品製作への共同参加を募るといった試みを行っている。

本ペーパーは，そのようなExperimental Unit の趣旨を説明するとともに，その一つであるZapresic（ザプレシッチ）のヘルス・センターの概要を述べたものである。

なお，本センターの訪問記録については本文（pp. 7－8及びpp.14－15）を参照されたい。

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May 1986

Project: Continuing Education for Primary Health Care

NETWORKING
EXPERIMENTAL PHC UNIT
ZAPREŠIĆ

WHAT IS EXPERIMENTAL PHC UNIT

The experimental PHC unit is chosen as a way of establishing closer contact with user of video-continuing education programmes, to get their active participation, to get review and initial evaluation, as well as joint development of programm. At the same time such a unit is essential to develop the optimal model for use of programmes is a small group.

The main obstacle of various programmes of continous education is reffered to be poor collaboration of those who created it and those who use it. In this project one of the tasks is to avoid it. Many steps are taken to gain the interest and create active participation of users. The main group of users are primary health care workers in primary health care units: Health centres and Medical centres. Therefore it was decided that one Health Centre would be chosen as an experimental PHC unit.

WHY ZAPREŠIĆ?

When developing the scheme for network of this project several health centres were identified, and Zaprešić is quite representative of majority of them. Neither too advanced and in the middle of the city nor very isolated. Far enough to include in dally activities many

intervention and thus build up a lot of selfreliance. No hospital locally, but hospitals are not too far away. Besides it has mixed population (rural and urban), and it is not far away, which is physicially and financially beneficial.

WHAT DO WE NEED THEM FOR?

1. To be a part of editorial board-wider one and help us finalize our tapes-esp. the ones which are ment as series.

2. Review and evaluation: professionaly sound
   interesting
   balanced (not too much or too l little)
   visually interesting
   provocative

3. Develop the optimal model for use of video-ways of funkcioning of a small group.

HOW DO WE DO IT?

It is too early to be able to give a complex analysis of achieved, but short description only:

We started with

1. Initial contacts to explain the project
2. and then meeting them regularly, each time agreeing about the amount of time spent, show the film, first and second part of series on Hypertension, have a discussion to express their professional standpoint and fill in multiple purpose questionnaire (for evaluation, to include in the next issue of a series).

Making notes and collecting suggestions regarding the main goals (see above 1,2, and 3).

HEALTH CENTRE ZAPREŠIĆ

The administrative set up of our country is such that Republics are divided into communes. By decentralization process most of decision takes place in communes. Communes are further divided into local communitites (neighbourhoods) but they can also get together and form the association of communes. Zagreb is such an association of 13 communes.

The commune of Zaprešić is the youngest, the newest commune to joint the city. It is one of development, housing areas. It used to be a set of villages, between rivers Krapina and Sava, to the west of the city spreading all the way to Slovenian border, and having some industry. In seventies it was one of sites to which the city started to expand with a big project of housing development.

Health related specificities of Zaprešić

area surface: 225 km2
population: 45 000, all insured
structure of population: peasants, craftsmen, workers of all types, retired.

- Population is growing fast by migration. Most of new settlers are young and middle aged, (which means there are a lot of children) most of them commute daily to the city (cca 7000).

- There is public transportation bus or train (it takes cca one hour to get to the place of work by public transportation). Beside houses, schools, kindergardens, and chaine of shops (mainly food) is built. There is water,sewage and electricity in a new settlement while gas and telephones are still to come. In the rest of a commune water and

electricity are available, sewage not in all parts of the commune, food supply is good, gas is to come telephones partially, there are primary schools and kindergatens/

- There are 7000 daily commuters to the city. By law they are supposed to use PHC at the place of work, but due to distances, most of them use it locally as well.

- The area surface is quite large, dwelings are dispersed, some areas can not be reached by public transportation, roads are only recently better, but still not all of them, which raizes the cost of and its access.

Organization of health care

Primary health care and some of polyclinical secondary health care is organized at the level of commune, while for the more sofisticated polyclinic and hospital care inhabitants use Zagreb hospitals and minor part of population at the far west part use the nearby hospital in Brežice (Slovenia).

Development of Health centre Zaprešić

1945: 25.000 population, mostly rural or unsemiskilled workers in nearby factories: two general practice offices and 1 dental care

1955: Health station

1963:it became Health Centre

1986: Health Centre Zaprešić

Personnel: There is a total of 195 employed in Health Centre Zaprešić, out of whom 149 health manpower: 44 physicians, out of whom

20 specialyst

18 other high level stomatologysts, pharmacysts, and biochenical engineers

89 nurses, technicials, medical sisters, physical therapeuts

44 other: drivers, clercs, cleaning and maintenance;

Physical facilities: one main complex with offices, dispensaries laboratories, rehabilitarion unit, polyclinical part and pharmacy

- 8 locally spread offices

The structure

- 11 teams of general practice, which includes 10 visiting nurses,
- 4 teams of occupational health and one dispensary for occupational health. Dispensary is involved in preventive activities only i.e. specific health care of workers (examination prior to employment, systematic examinations etc.), while teams are located in local working organizations (industry).
- dispensary for preschool children with 3 pediatric teams.
- dispensary for school childred with 3 teams of school health for primary schools children
- 11 teams for dental care (stomatologysts), out of whom 8 for grown up population 2 for school children and 1 for orthodontics.
- Not for hygienic and epidemiology departement (HE) led by epidemiologyst, orriented mainly for control of contagions diseases.
- Emergency care and the centre for home-calls (visits). This service operates 24 hours a day, teams on all consist of 1 physician, 1 nurse, and a driver. There are special cars and radio connection.

Paralel to this there is a service for transport of patients to and from hospitals and policlinics which are not urgent.

Beside primary health care there are laboratories and polyclinics. The diagnostic laboratories are:

- X - ray
- chemical laboratory (blood, urin)
- ECG laboratory.

Polyclinical part consists of

- antituberculose (ATD) dispensary
- skin/veneral dispensary
- mental health dispensary
- ginecological dispensary

all of them are led by specialists

Specialist offices for:
- internal medicine
- otorinolaringology (ear-throat-nose)
- eyes
- rheumatological with physical therapy department with 5 physical-therapeuts.

A pharmacy in Zaprešić with a officer in another village - Bistra - in which there are 8 pharmacysts and 5 technicians.

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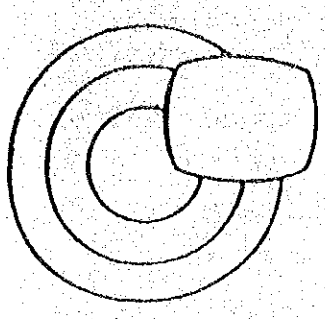

PROJECT: "CONTINUING EDUCATION FOR PRIMARY HEALTH CARE"

INITIAL STUDY ON THE STATE AND DEVELOPMENT OF CONTINIUING EDUCATION FOR PRIMARY HEALTH CARE

by

the Working Group of the
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WHO Collaborating Centre for PHC
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Zagreb, December 1985

STUDY ON THE STATE AND DEVELOPMENT OF CONTINUING EDUCATION IN SOCIALIST FEDERATIVE REPUBLIC OF YUGOSLAVIA

Initial study on the state and development of continuing education for primary health care

1. Continuing education is part of the general system of education, which comes after the regular education obligatory to gain professional skills to perform a certain job. Since in health professions it is usually possible to gain higher qualifications sequentially during the work, it is difficult to separate some forms of graduate and postgraduate training and specialization. This study will concentrate on continuing education as that part of education acquired after the final qualification, because it is believed that this part is the most important for maintaining the quality of work of the professional.

   In order to concentrate on the main purpose of the Study, only certain forms of education were taken into consideration. The following forms of continuing education were not taken into account (except when specifically mentioned): general professional congresses and other similar meetings, information through mass media without a clearly defined educational goal; irregular publications of different kind including journals, monographies, etc.; regular routine meetings of teams and groups of workersin primary health care except in cases when they have specifically stated their educational function. All these forms have a very important role in continuing education but they are not included in general considerations of continuing education (CE) because in this Study emphasis is given to planned and formally organized group acrtivities with a clearly defined educational goal. All activities are included regardless of who is carrying them out: health organizations, professional associations or educational institutions. The group tried to include in their assessment all forms of education and qualification directed towards certain professional groups as well as those forms directed towards teams of different professionals and disciplines. Unfortunately, the first analysis did not include stomatologists and other dental-health workers.

2. The system of training and development of health manpower in Yugoslavia has its characteristics which derive from the general social system which is based on decentralization and self-management. Health and educational organizations are independent, and not financed through a fixed budget. They generate income

through programmes of work which have to be accepted and paid after implementation by the users of their work. For health educational institutions the role of users has the health service. For health service organiyations the users are ensurees - workers, farmers and members of their family, as well as other groups of working people and citizens. Relations between users and providers of services are regulated either through their directrelationships or through "self-managing communities of interest". Self-managing communities of interest are constituted of delegates of users and delegates of providers of services who, organized in two chambers, jointly decide about the programmes of work and plans of development. Health manpower development is the responsibility of health work organizations (health centres, hospitals etc.). They have to plan their overall development, including needs for manpower training. They have the right to fix the number of needed manpower of different profiles, but also, through self-managing communities of interest and certain other mechanisms, to influence the content and form of education. Employing of new health workers goes through public announcement of needs ("open parts") by health organizations according to their plan of development and financial possibilities. Further training i.e. postgraduate and continuing training, specialization etc.) goes also according to plans (and possibilities), worked out by the work organization.

In this way, there is no question of a free "labour market", or centrallz planned development and secured budget. Income distribution within work organizations is determined by regulatins enacted by referendum, so that relationships, positions and wages of workers are different in different work organizations.

In that way the essential role in continuing education is played by the work organizations (basic organizations of association labour).

Since the system is decentralized, federal laws offer only fundamental solutions, while most of the health legislation is on the republical level and important part in resource distribution is played by the self-managing communities of interest in communes. Therefore, the focus of activities important for continuing education for PHC is at the local or regional level and less at the republican level. It stands to reason that there exist variations in the way different republics and regions organize and implement continuing education.

3. Description of the existing continuing education

Continuing education of all workers is enacted by the Law on Associated Labour on the level of the whole country (articles 178 and 179). Based on this, most laws on health care in republics and autonomous provinces state, for instance, that "Health workers have the right and obligation to continuing education according to the needs of work" . The same provision is given to social workers according to laws on social care, etc.

Continuing education is regulated by the plan of vocational training of workers, drawn up by work organizations. They also have to organize training by establishing relationships with corresponding educational institutions.

Besides, it is important for continuing education how quality

control is regulated. According to regulations, health organizations have an essential role in this matter, because they are responsible for the quality of work. They carry out internal quality control (besides external quality control which is carried out by other public authorities).

Legislation has gone through interesting changes in the last decades. At the time public services were centralized, there existed regulations which prescribed to what extend and in which period should a worker complete his/her vocational training. There are considerably less of such regulations nowadays and the decisive, final word is given to needs and agreed upon plans of work organization.

Resources for continuing education are ensured from four types of sources: from health work organizations themselves (an obligatory fund in all organizations), from self-managing communities of interest, from individuals (registration fees and tuition fees), and from other sponsors who have an interest (e.g. Red Cross, the Government, pharmaceutical industry, professional associations, etc.). There exist differences between certain parts of the country, but as a rule mos of the resources come from self-managing communities of interest, or through funds of organizations of associated labour specially allocated for vocational training (including continuing education).

The organizers of continuing education are also vary and they could be identified as follows:

- health organizations (different systems of regular professional meetings, courses, working groups) for their members and other health organizations;
- professional organizations and associations for certain specialist disciplines, their members and others;
- educational institutions (high, higher and graduate schools) providing various short courses, seminars, symposia, workshops;
- scientific institutes, institutes of public health, administrative bodies, etc. providing usually various specialistic courses, with specific objectives.

The number of programmes and activities varies according to areas, subjects and forms, but overall it should be considered significant. While programmed activities of health organizations include on the average a relaively big number of health workers, it is very difficult to assess, due to differences, the actual coverage by programmes of continuing education. If programmes were equally distributed among all workers, it could be estimated that at the most 1/3 has satisfactory coverage. The coverage is paralell to the general level of development of health services. Besides, there are also differences in coverage as to the type of health workers. It is estimated that there is a wider coverage of physicians and medical specialists than other profiles of health workers. One may estimate the reasons why primary health care is in a relatively unfavourable position. It might be because of smaller organizations,limited availability of resources and partly because of organizational difficulties (such as dispersed working places,needs for temporary replacement of health workers during their training et similar).

4. Planning and programming of continuing education

The working group has assessed, on the basis of the present condition, that despite relatively substantial resources and energy allocated for continuing education, its degree of organization is poor. This weakness is felt in all phases of planning, implementation and evaluation of continuing education. The need to orient and improve continuing education has been noted a relatively long time ago (10-20 years ago), so that there are several ongoing projects (especially within certin republics and professional associations) whose main goal is to link the activities of continuing education with needs, to coordinate and evaluate them. The dispersion of interests and resources have limited such attempts, so that they finished as analyses of the situation and general proposals. Since the focus of the manpower policy lies in basic health organizations, and that continuing education is there elaborated in plans and programmes, the situation depends on circumstances and interest found in organizations. If workers working in those organizations show personal interest, if there exists a collective interest to master advanced technology in order to satisfy the expectations of users and to carry out programmes

which generate income, and if health units are adequately managed, these organizations will are able to carry out vocatonal training in a satisfactory way. An estimate of the group of experts is that around 1/3 of organizations have such a situation. However, in other organizations the plan is subjected to either "private interests" of individual experts or to "demands" of secondary health care and the current fashion, so that continuing education is inadequate and wrongly oriented. It is estimated that perhaps as much as 50% of organizations should undertake urgent measures to initiate, and improve continuing education. These estimates are based again on the assessment of experts in the working group. However, the general assessment reached in various projects, symposia and surveys is that continuing education is:

- widespred but still inadequate
- poorly organized and not sufficiently effective
- not subjected to evaluation.

The system works successfully when it is adequate to local needs and interests, and coordinatd with health service management.

5. Relation between continuing education and specific needs of primary health care

It is impossible to give a reliable overall assessment of the orientation of continuing education towards the needs and goals of primary health care because programmes differ as to where and who is carrying them out. In continuing education the orientation towards technology and narrow specialized topics is pronounced and a widespread belief exists that continuing education should in fact be spreading knowledge from the centre to the periphery. Thus, most of the programmes of continuing education carried out by schools and special institutes include contents whose starting points are new medical technologies and the narrower interest of an institute. Similar are the programmes initiated and organized by certain professional associations and groups, although some of them are related to certain projects in practice and have more often a multidisciplinary approach. Programmes organized by work organizations and professional associations related to primary health care, also very often resort to technological issues, although priorities in primary health care are better emphasized in accordance with the health objectives of the work organizations.

Contents are being defined and programmes planned according to a free assessment of priorities, and occasionally based on a survey conducted among users. There also exists an influence of a health-political character, based on formal documents such as the "Programme of health care measures". This document is prepared by self-managing communities of interest as an expert document for planning health activities in a certain period. However, generally, it is a weak link between defining contents of continuing education and the wider goals of planning, reorientation of health technology for primary health care needs and especially with findings of quality control.

According to studies carried out for needs of other forms of

education (especially organized postgraduate training as part of specialization in primary health care disciplines), it could be concluded that typical contents of primary health care are not adequately represented in continuing education. there is not enough scientific research and understanding of actual experiences and work in primary health care. In this way, continuing education, like other forms of education transfers on a large-scale paradigms of work of secondary health care and information on special technology which predominates at secondary level of services Primary health care workers by that type of continuing education do not add to new experiences but to their feeling of inadequacy is being intensified. The fact is that recommended procedures are not feasible in primary health care.Recommended type of work does not correspond or is very far from the needs of the existing practice. Emphasis is given to diagnostics, isolated diseases, standards and criteria developed in specialized institutions, somatic aspects of diseases outside the context of psychic and social, treatment by drugs, "dangers" of procedures. Preventive and rehabilitative aspects are neglected or only formally mentioned (as being the responsibility of "someone else"). Relatively little is said about typical activities in the sense of work with healthy people, maintenance and improvement of health, health education, follow-up and continuity of care ,home treatment, team work, etc. Emphasis is given to examples of bad work in primary health care, and little to positive examples. Only recently some work organizatins have made an effort to change this approach and to include more people from PHC practice in the process of continuing education, i.e. projects led by practitioners themselves (Balint groups,education in workshops in some health centres etc.).

6. Methods of continuing education

As can be concluded from the previous description there exist different forms of education. Methods, however, are predominantly traditional and are based on courses and weekend-seminars. The methods are one-way and didactic with little possibility for active participation, with little or no use of advanced audiovisual (or computer) techniques, and regularly without the possibility of practical work. Often the groups are big, sometimes even very big with several hundred listeners.

A positive practice is to print texts: some as manuals, some as general instructiones, some just as proceedings.It is now known how much they are actually used afterwards.

Most of the organized activities practice some forms of evaluation which are usually carried out in the form of a survey conducted among participants about their opinions on the performed teaching and their suggestions for new subjects. There is practically no programme in which its effect is assessed by testing the actual knowledge of participants, especially in solving problems in practice. Sometimes, only, questionnaires with multiple choice of answers before and after the activity have been used. Both instruments (questionnaires and opinion surveys) regularly, of course, show positive assessments.

Education through mass media emphasizes usually the importance of highly sophisticated technology in medicine, which is true

especially for most of the TV programmes.

Certain printed bulletins (e.g. those on drugs) are showing a good effect in some parts of the country. However, the distribution of journals and publications (including also WHO publications) is limited, especially in PHC units. There are not enough libraries in PHC work organizations.Inadequate knowledge of foreign languages is an additional limiting factor, as is also the price of journals, so that regular reference to literature is objectively hindered.

7. Motivation and interest

It should be pointed out that the general level of education in PHC in Yugoslavia is relatively high, especially among physicians. After basic education, intership and practice many take up organized formal postgraduate training. About 30 (GP) to 60 and more percent of physicians working in PHC disciplines have the status of specialists in general practice, occupational health, school health, pediatrics, which means at least an additional three-year vocational training. It should also be stressed that studies have shown a relative stability of these cadres in their jobs. There is significant difference between the present situation and the one-two decades ago, when high fluctuation was one of the main reasons for low quality of work and poor interest for vocational training in PHC. Today, such a situation can be found in less developed regions and among workers who are working in PHC by statutory obligation.

In the last ten years the number of professional and scientific papers has increased as well as the number of people who have obtained academic degrees. The same is true for professional meetings, research projects and publications.

There exists an interest among health workers for active participation in continuing education. There are two main motives. The first stems from an inner interest, feeling of responsibility and positive desire for improvement of one's own work. The second motive is imposed by general conditions, "competition", low employment rate, etc. Since all changes of jobs and promotions are linked with public application for employment, it is necessary to "objectively" show one`s professional advancement. This motive is evident in the fact that participants like to collect "certificates" of attendance to certain short courses. The other motives are less pronounced.

The effect of various forms of compulsion and obligation is relatively small, so that they are often proclaimed but infrequently implemented. According to observations, very strictly undertaken disciplinary measures (one of the ways in which some work organizations conceive these obligations) permanently move not more than 60-70% of workers, and this is not far from the results obtained in well organized programmes without formal compulsion. Formal compulsions cause resistance in one part of the workers.

According to "public opinion" of PHC workers continuing education is a privilege, so that competition exists for participation in courses, resources for tuition fee, travel expenses, job replacements etc. All these conditions are decided upon by the self-managing bodies in a work organizations. Individual and group motives, as well as the process of decision-

making in organizations, balance utilization of various forms of education by different profiles of health workers. Of course, there are few extreme examples where resources are spent inadequately (e.g. only for participation in congresses for a few priviledged experts in the organization, and the like).

8. Assessment of the situation and perspectives

8.1. The level of technical education and training in PHC in Yugoslavia is relatively high. Postgraduate training is especially well developed. Continuing education is not adequately evaluated, but it is estimated to be probably the weakest link in the chain of manpower education.

8.2. The need for continuing education has been realized and a considerable interest exists for various forms of such education.A legal framework exists and stimulates continuing education as well as internal quality control organized by health organizations and the active participation of the community inn health care. Continuing education like other forms of education are conceived as the right and duty of health workers, along with the needs and plans of health organizations.

8.3. In practice there exist numerous multicentric programmes implemented by health work organizations, professional associations, educational institutions and scientific and other institutes. Medical schools and educational institutions could and should have a more accentuated role in continuing education. Organization and coordination of activities is poor. There is no general evaluation system of these activities.

8.4. Considering the health policy "Health for All" and the contents of work in PHC the greatest deficiency of present programmes of continuing education are that they are more oriented towards particular problems and medical technology rather than planned tasks and essential PHC activities. Since the system of continuing education is decentralized and depends on the basic work organization which is responsible for manpower development, there exist great differences in the policy of implementing continuing education. These differences also express the contrast between the interest of individuals for their own training and the general interest for the development of a health care system. The priority of actions for further improvement of continuing education should be in changing the orientation and contents. Similar is necessary in other forms of education. By strengthening continuing education the contents of other parts of education could be better oriented, giving health PHC workers the possibility to improve their function as teachers and researchers and developing advanced units as teaching bases.

8.5. Resources allocated for continuing education in PHC and directly controlled by work organizations are relatively

scarce. There exist, however, great differences in resources available between work organizations. The existing methods of continuing education are traditional and the modern means of communication and information are not sufficiently used which would be especially important and attractive for PHC units. Present methods emphasize the mechanical approach to education (education in one way direction from powerful centres of knowledge and technology in medicine to periphery). The possibilities of information and education of the entire population are also not put to profitable use.

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Annex

STUDY ON THE STATE AND DEVELOPMENT OF CONTINUING EDUCATION IN SELECTED EUROPEAN COUNTRIES

Members of the Working group

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PRIMARY HEALTH CARE

(SUMMARY)

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Dr Simunic, M.

Introduction : Dr Skupnjak, B.

Zagreb, 1986

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Zagreb, April 1986

P R E F A C E

In the early seventies of this century, the world was in a doubt, even a turning point: new, independent states, mostly in the southern hemisphere, found themselves in economic and social difficulties. The crises which were getting deeper (oil, energy, raw-materials, monetary and population crises) brought those countries to the edge of poverty. The industrially highly developed countries did not remain untouched either, so that the mankind faced the question whether the existing economic and social order guaranteed its further development. Ideology items, as well as items related to political concepts were discussed, regarding the man's vital, existential needs (nutrition, habitat, health, water supply, etc.). These events are mentioned in this book as well. They are so extremely important because they influenced originating of the primary health care concept, which is the essence of this edition.

It is emphasized, that the decade of conceptualization, i.e. the decade of the seventies, has passed.

In that decade, some very important worldwide conferences were held, sponsored or originated within the United Nations System and regarding practically all development sectors of modern society.

Mostly the official delegations of governments from all over the world participated in the conferences. Plans of actions were made in order to carry out the standpoints and concepts formulated at the conferences as soon as possible.

Fifteen such conferences (on economy, ecology, food-supply and proper nutrition, habitat, basic sanitation, etc. - see the enclosure) were held in that decade, some of them being rather important for the sector of health (although practically all of them had a high degree of relevance to the health sector).

The most significant ones were:

United Nation Conference on TCDC (Buenos Aires - 1978)
WHO UNICEF Conference on Primary Health Care (Alma Ata - 1978)

The procedure of initiating and launching the greatest and (in its ultimate goal) the noblest idea of the century is connected with that decade;

"Health for All by the Year 2000" (determination in 1977 and strategy formulation in 1979).

Thus a coincidence happened between the organization of specific concepts on water, habitat, food, the role of women, environment, etc. At first sight that was a strange coincidence culminating in the last quarter of the decade with the conferences on TCDC and primary health care and the determination for (plus the formulation of) the strategy "Health for All by the Year 2000".

The conferences held in that decade reflected a certain symbolic meaning, because they involved the development sectors, deeply connected with the so-called "eight essentials" of the primary health care, i.e. relating to water, sanitation, habitat, industrial production (of drugs, among other things), food supply and proper nutrition, etc.

Therefore, that decade, along with its conferences of conceptualization, provided all the prerequisites for operationalization of ideas.

Unfortunately, this has not been carried out in all sectors. This decade, i.e. the eighties, are characterized by imballance between conceptualization and operationalization.

This imballance is probably avoided to the largest possible extent in the primary health care concept, adopted by the Alma Ata Declaration and the related resolutions of the World Health Assembly in 1979.

The imballance between conceptualization and operationalization is less expressed in our country and this is something we are rather proud of. The probable reason for that is the fact that our general socio-political system implies the main determining factors of the primary health care concept: intersectoral approach and people's involvement. This has by all means made the application of the concept faster and easier.

There are, however, some additional factors which contributed to the implementation of the primary health care concept in this country.

Immediately after the II World War, Andrija Štampar, President of the Interim Committee and first Chairman of the World Health Assembly, founded health centres, actually institutionalized forms of primary health care (which was then, of course, not so called).

At the "Peasants' University" which be founded before the war in the School of Public Health (today named after him), the peasants from all parts of the country came to exchange experiences and to get instructions on all items influencing health status and disease, particularly on agricultural production, sanitation, etc., which was actually a promotion of the so-called intersectoral approach.

In the villages near Zagreb, the selfreliance principle was demon-

strated in a very illustrative manner; the peasants provided sanitation and water supply by themselves and also carried out many health sanitation and health education measures, taking over the full responsibility for their health.

After the War, in another part of Yugoslavia, SR Srbia, the village of Ivanjica was treated as a demonstration area and used as "case study" in an already classical study, ordered by the World Health Organization in the mid-seventies, related to alternative approaches to the health care organization; the study was worked out by dr Djukanović and dr Mah.

In that period, the first in the world specialization in general practice was introduced in Yugoslavia. The purpose was to make the major carrier of primary health care, i.e. the general practitioner with his team, adopt public health views of health and disease phenomena, thus improving the level of his professional competence and his social status (by professionally and in terms of status becoming equal to the specialists from hospitals and keeping at the same time his socio-medical and public health approach towards solving health problems).

In the education, the principle prevailed, that educational bases should be as similar as possible to the future working places of physicians. Here, the Medical Faculty in Zagreb had the leading position with its School of Public Health. The education was spread (probably to the largest extent in whole Europe), to non-hospital institutions and field work, particularly health centres, where primary health care was demonstrated to the future physicians. It should again be noted that it was not called that way in those times.

In many parts of the country, the primary health care was organized in such a way that it almost foresaw the main postulates of the Alma Ata Resolution (although it all happened a long time before Alma Ata).

Several communes in Istria are a good example (it should be noted, that it was not just an isolated area, but something practiced by the majority!). In those communes primary health care was organized again with the main determining factors of the concept, later formulated in Alma Ata: intersectoral approach and people's involvement.

In one of those communes - Pazin - the director of the Health Centre, dr Bartolić, a native of Pazin, organized health services in a way which is very similar to the modern concept of primary health care almost 20 years ago, based on the "ideology" basis acquired during medical studies and through the knowledge of public health tradition (of which Andrija Štampar was the leading personality). In the course of 20 years long evolution of that health care, such results have been achieved, that it seemed worthwhile to present them in a separate edition issued by our Centre*.

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* "Pazin - the Site of the Field Work of the Brioni Colloquia on Leadership Development on TCDC for Health for All", Zagreb, 1986

Dr Bartolić, the person who initiated numerous primary health care activities, connected his practical experience with theoretical background provided by the second author prof. Šimunić. This constructive connection with the assistant professor of the "Andrija Štampar" School of Public Health , Medical Faculty in Zagreb, (the School being the second in the world and the first in Europe "WHO Collaborating Centre for Primary Health Care), resulted in this edition. Dr Šimunić himself spent a few decades in developing communes of our country, working on primary health care, so that they prepared the book on primary health care in Yugoslavia together.

This edition was published by the Institute for Health Organization and Economics in Zagreb, which is at the same time a service institution of the Centre for Health Cooperation with Non-Aligned and Developing Countries and one of its members. That is the first such book in our country, and probably on of the first such books in the world. It is especially attractive because it actually represents an interesting and successful compound of practice and theory, concept and operationalization, based on primary health care application experiences in a commune in our country and relying upon health and legislative background of the regulations in the republic in which the commune is located (SR Croatia). It reflects very extensive knowledge of the problems, which resulted in practical experience and theoretical build up.

Since the Centre for Health Cooperation with Non-Aligned and Developing Countries represents an association of 25 institutions from health and health related fields, which associated in order to make their appearance at the international health scene as successful as possible, insisting upon the technical cooperation concept, the Centre thought it necessary to ask the authors to prepare an extended summary (although the term itself represents "contradictio in adjecto"). In that extended summary, they touched the majority of items which are to be found in the original book ("Primary Health Care in Yugoslavia", Institute for Health Organization and Economics, Zagreb, 1985), thus making some of the attitudes and postulates expressed in the book accessible to the readers outside Yugoslav language area.

It is especially important that the Centre for Health Cooperation with Non-Aligned and Developing Countries is at the same time a WHO Collaborating Centre on TCDC for Health Development. As such, it is the organizer of numerous activities, dominated by the Brioni Colloquia, edicated to the "Health for All by the Year 2000" strategy by means of primary health care.

For that purpose, resource materials are prepared in a special way. The participants - recognized actual and potential leaders from the developing countries - mainly produce them, thus showing a great deal of selfreliance. In spite of that, we thought is necessary to make the summary of the mentioned book accessible in English, so that it was made a part of the "TCDC for Health for All Series" in form of a special edition which offers insight into primary health care concept in our country.

We hope that the primary health care concept applied in this country will thus be accessible for those who either participate in the mentioned colloquia, or visit Yugoslavia for other reasons. They will be in a position to compare it with the situation in their country. It will all contribute to the promotion of the concept and as successful as possible implementation of the "Health for All by the Year 2000" strategy in the whole world.

Director of the Centre:

Dr Berislav Skupnjak

I CHAPTER

DEVELOPMENT OF THE PRIMARY HEALTH CARE CONCEPT IN THE WORLD AND IN YUGOSLAVIA

In the first chapter the development of the primary health care concept in Yugoslavia and in the world has been described. At the end, there is a definition of primary health care according to the Declaration of the First International Conference in Alma-Ata and a definition given by the authors who adapted it to the Yugoslav conditions and organization of primary health care implementation.

The short review of the development of primary health care concept starts with efforts of WHO to initiate changes in health round the world during the last decade. This action started with Djukanovic's and Mach's study and the proposition for more efficient organization of health in the world by as minimal resources and expenses as possible, and was continued by series of expert meetings on primary health care prior to Alma-Ata conference.

Some more important reasons for organizing First International Conference on Primary Health Care in Alma-Ata have been mentioned. The primary health care concept has been described in accordance with the Declaration and Recommendation. The short review has been given of professor Andrija Stampar's role in establishment of WHO and of cooperation between SFR of Yugoslavia and WHO.

Yugoslavia was one of the founders of WHO. From the very beginning cooperation with this Organization has been very successsful. Great confidence was expressed to Yugoslavia by establishing Centre for technical cooperation among non-aligned and developing countries in the field of health, particularly in improving primary health care. The one entrusted with it was the Institute for Organization and Economics of Health in Zagreb, while the Collaborating centre for primary health care has been established within the School of Public Health "Andrija Stampar", also in Zagreb.

In the part concerning the development of primary health care concept in Yugoslavia, prof. Andrija Stampar is mentioned as deserving credit that from the time Yugoslavia was established in 1918, the development of health was being based on the ideas of integral medicine. The first health centre was founded in 1923. Štampar's health centres, clinics for specific diseases, school polyclinics and public health institutes were the basis for the post-war organization of health

In the period after the War the primary health care was provided in health stations, health centres and medical centres by general practice teams and health workers from a number of different clinics (tuberculosis clinic, clinic for mother and child care, occupational health clinic, clinic for school medicine, clinic for venereal diseases, malaria clinic,etc.).

At the beginning of 1960 in the School of Public Health "Andrija Stampar"in Zagreb, as first in the world started the specialization in general practice. The aim of introducing this specialization was to strengthen general practice and its functioning on the principle of comprehensive medicine. The post-war health legislation was based on the same principles. By introducing the self-management system on the territory of Yugoslavia in the 50-ties health, health insurance and self care have been put in function of associated labour and of the whole population. At the same time, health and health care have become mutual concern of all subjects within society, and not only of health. By this, the process of decentralization in health started.

The central position in providing primary health care is given to general practice. A general practitioner with his team provides the majority of health care for the whole population. A health team consists of at least one general practitioner, a nurse and a community- health nurse. Beside of general practitioners, primary health care activities are also provided by physicians in occupational health, school medicine, emergency service, epidemiology or hygiene with their collaborators, as well as by pediatricians.

In preparations for the First International Conference on Primary Health Care, the Federal Committee for Labour, Health and Social Welfare organized several expert meetings and a consultative conference in Bled at which a Federal Executive Council's platform was proposed for discussion of the official delegation at the Alma Ata Conference. Most important items from the report of the Yugoslav delegation at the conference have also been presented. To conclude, words of Dr.Skupnjak, the member of the Yugoslav delegation in Alma-Ata, are worth quoting: "Maybe the most impressive thing about this presentation was that it pointed out that Yugoslavia had been practising primary health care already for many years exactly in the way now recommended by everybody, i.e. that primary health care is to be organized in a local community, that all the factors of the commune participate in it but that the strongest influence should come from users and providers of health services, and that from the very beginning our model of primary health care had the character of comprehensive health care".

At the end of this chapter a comment is given in the definition of primary health care which reads: "Primary health care is a care which is provided in a planned and organized way on the territory of the commune, where people live, work and get educated and is provided jointly by health and numerous social factors outside health, such as individuals, families, local communities, organizations of associated labour, social welfare, education, Red Cross, sports and recreation organizations and other subjects as performers of certain measures and actions aimed at improving and keeping of health, disease control, treatment and rehabilitation, with regard to social needs and economic potentials of the population.

Primary health care directs some of the users, particularly more serious cases, to higher care levels - polyclinic-consiliary and stationary- for diagnosis and rehabilitation, but afterwards providing them the continuous health care.

II CHAPTER

ORGANIZATION

In the chapter ORGANIZATION the concept of primary health care has been described in the context of the health care system, with particular reference to the way of providing health care - by active participation of working people and citizens , role of health services and organizations, duties of health workers and other workers in health, communication between users and providers of health care services and methods of work of health workers in health and in communities where working people and citizens live and work. After a general description of the concept for the reform of health and health care system in the world, a presentation is given of health and health care development in SR of Croatia until 1980 and of the reform started in the same year (graphs).

Conditions for accepting and implementing primary health care concept in SR of Croatia and SFR of Yugoslavia are based on the generally accepted concept of primary health care within the World Health Organization and actual socio-economic relations based on self-management when stimulates primary health care development. The basic principle of the concept of primary health care development is that health workers and working people and citizens mutually make plans of health care measures, that health care users participate actively in implementation of all health care measures and activities. Therefore, primary health care teams organize and provide activities in places where people stay (infant nurseries, kindergartens, schools), work (factories and work organizations), live (local communities), or are permanently accomodated (homes for adults and elderly people). Each team has its own programme of work in accordance with actual needs and priorities in health care of these places. Each programme includes needs of individuals or groups of individuals, as well as needs of the community as a whole.

Primary health care teams consist of teams for health care of preschool children, school children, workers, other users according to the place of living, emergency service and pharmaceutical service. These teams are working in an integrated way, organized in activities of general medicine, pediatrics, school medicine, occupational health, hygiene and epidemilogy emergency service and drug-supply service.

The basic work organization for the primary health care is the health centre. It puts all the above mentioned activities together. The development of health centres passed a 60-years period. Their organization and functions changed according to changes of health needs and priorities. Manpower development and resources

Conditions concerning facilities and equipment for certain primary health care activities, as well as for the work of a health centre, station for emergency service and pharmacies are determined by law. They represent guidelines and criteria for constructing and equipping of premises, as well as criteria for providing agreement by the republic health authorities for starting particular activities. In SFR of Yugoslavia the proportion between the number of inhabitants and the number of general practitioners is not balanced, ranging from one physician per 500 inhabitants (in bigger cities) to one physicians per 5000 inhabitants in smaller settlements and villages. There is also a difference between republics, provinces and districts.

The task of the general medicine is to plan, organize, direct, coordinate and implement primary health care measures by itself and in co-operation with other services which provide special health care measures for certain groups. The principle of work is a comprehensiveness and uniformity of care, sharing of work with other primary health care activities in a team work and close cooperation with bodies, organizations and communities in which it is acting.

Child care - provides care for pre-school children through mother and child guidance centre, and through organization for pre-school education (infant nurseries and kindergartens with over than 250 children). This team works part of the time in Health Centre and part of the time in institutions for small children. As a type of health worker, a pediatrician does not participate obligatory in primary health care service. A pediatrician in a health centre, acts in principle in a capacity of primary health care physician.

In Yugoslavia, health care for small children is provided in 1200 places by 1873 physicians, among which 1006 pediatricians. In small institutions for children, teams of child care include also nurses, kindergarten teachers, psychologist and hospital nurses. Educational programmes include also programmes of health education, monitoring of psychomotor development of children, nutrition and environmental hygiene.

School health care - is organized in schools and school centres with over 1500 pupils by specialists in school medicine or general practitioners. Primary health care of school children in smaller schools is provided by general practitioners who provide comprehensive health care in smaller settlements and villages. In 1983, 1370 physicians were acting in school health care, of which 646 were specialists. Health care programmes for school children, are mostly focused on protective measures, improvement of health, prevention and early detection of disease, and are organized as a part of educational-instructional programmes in schools, as activities mutually organized and implemented by schools, pupils' homes and primary health care teams, and as activities provided by health workers at the request of pupils or their parents.

Occupational health care includes measures and activities which are being planned, organized and implemented in work organizations. They are provided by primary health care teams (general practice) and specific health care teams of specialists in occupational health according to the place of work. In 1983, on the territory of Yugoslavia there were 3168 physicians of which 1265 were specialists. While the activity of teams of primary health care for workers is to a great extent oriented towards prevention, that of specific health care teams is exclusively concentrated on it. Since they are physically mostly situated in work organizations, they are supposed to cooperate directly with workers' councils, hygienic-technical service and social services (organization of nutrition and recreation of workers) and trade unions.

Hygienic-epidemilogical service is being organized for an area of about 50 000 inhabitants. Within health centres covering a smaller population some physicians and technicians are particularly in charge of organizing this activity including administrative monitoring of protective measures against infectious diseases, improvement of nutrition, water supply, as well as of keeping files of diseases of social importance. This service cooperates with local sanitary inspection service, veterinary service, work organizations, kindergartens, schools as well as with authorized regional Publich Health Institutes.

Dental care service is orgnaized in such a way that this service makes part of primary health care teams in schools, work organizations and local communities. In prevention activities, they provide dental care directly in work organizations of users, but when there is a need for treatment users are asked to come for interventions. In SFR of Yugoslavia, there are 7423 stomatologists working in public sector on 3709 places.

Emergency service is being organized in each commune. This service is provided by physicians on duty in smaller settlements within separate units with adequate premises, vehicles and communication system or by bigger units with regular team work, or by special organizations in bigger cities. This service operates 24 hours daily, cooperating with other primary health care teams and public security services. These service includes general practitioners, health technicians and drivers.

Drug-supply service is provided by teams of pharmacists in pharmacies or by a pharmaceutical service within health centres. Usually, this service has its branch-offices in smaller settlements (drug depots in which, beside pharmacist, pharmaceutical technicians are also employed). In 1983, in Yugoslavia there was 4255 pharmacists, i.e. one pharmacist per 4518 inhabitants. Teams of pharmacists cooperate in their work with other primary health care teams.

Organization and provision of health care measures are implemented through active participation of health care users. Participation in planning, management and organization of health care and health service is realized through following features:

- self-managing communities of health and health insurance of workers and farmers where delegates of users and providers make decisions on needs, programmes of work and organization of services on an equal basis;

- local communities where users, within assemblies and other bodies of these communities, and primary health care teams make decisions on an equal basis on all needs concerning provision of primary health in their surroundings;

- work organizations where workers, through their workers' councils, appear as users, and their primary health care teams as providers of health services;

- Councils of schools and Teachers' councils in educational organizations;

- various kinds of associations (of retired persons, for recreation, association of women, of war-veterans, etc.);

- clubs and groups of patients suffering from various chronic diseases:

- bodies of the assembly of a commune.

The above mentioned represents possibilities and places of communication of users and providers of health care services directly or indirectly. In this way, primary health care activities get included into communities and health care becomes part of life and work in function of development and progress.

In the period immediately after the World War II, Yugoslavia faced lack of health personnel, particularly in out-patient service. At the beginning, it was covered by small number of physicians, semiskilled male-nurses, midwives and nurses, assistants of physicians, disinfectionists, dentists and semiskilled laboratory technicians.

Nowadays, in Health centres the following profiles of health personnel are providing primary health care services:

- workers with health-oriented education: physicians, stomatologists, pharmacists, medical biochemists, sanitary technicians, senior nurses, nurses, X-ray technicians, dental technicians, physiotherapists, health statisticians and informaticians;

- workers with education other than health: social workers, psychologists, logopedics, nutritionists;

- workers who by instructions and under the control of health workers perform simple skilled jobs: health assistants, assistants in laboratories, etc.

Beside general practitioners, teams of general practice include also stomatologists, community-health nurses, social workers, home nurses.

Teams for health care of pre-school children, beside general practitioners or pediatricians, include also nurses and stomatologists, as well as personnel from organizations for pre-school upbringing and education: kindergarten teachers, nurses, psychologists.

Teams of school health care include specialists in school medicine or general practitioners, nurses pedagogues, psychologists, social workers, physical training teachers and others.

Teams of occupational health, beside specialists in occupational health or general practitioners, include nurses, social workers, psychologists, industrial psychologists, engineers of safety at work, etc.

In teams of hygiene and epidemiology, beside specialists in hygiene and epidemiology, there are also sanitary technicians, nurses, etc.

In teams of emergency service there are general practitioners, health technicians, nurses and ambulance drivers.

In drug-supply service, beside of pharmacists, there are also pharmaceutical and laboratory technicians.

After finishing school education, health workers are obliged to serve oneyear preparatory service (rotating intership) according to the established programme and guided by a mentor. At the end of it, health workers are supposed to pass an exam consisting of the general part (organization and regulations from management law) and professional part.

Methods of work of primary health care are:

- team work method., meaning that certain workers work together, redistributing tasks among themselves aimed at achieving planned objectives;

- dispensary method is characterized by such approach that each health problem of an individual, a family or a community is treated from the preventive, social or currative aspect;

- epidemiological method is used in research of causes, prevalence and sequels of diseases and other factors concerning health;

- social-medical method is used for studying relevant factors in social environment having an impact on health;

- statistical-informatic method is used for collecting, processing, distribution of data necessary for planning and evaluation.

III CHAPTER

PARTNERS IN PROVIDING PRIMARY HEALTH CARE

The third chapter is dealing with partners from other than health sectors, participating in providing primary health care.

The function of contemporary primary health care, as the first level in providing health care, is to join, organize and develop mutual cooperation of certain social subjects outside health in planned implementation of health care of the whole population. Without these social factors, health alone would not be able to provide, in a planned and organized way, enough preventive aspects of health care, efficiently control current morbidity paterns or meet other health needs and problems of the population.

Theoretically seen, if it would be possible to fully activate all the existing social factors or subjects outside health in implementation of certain health care measures through health self-care and mutual care, comprehensive health prevention would be initiated in all places where people live, work and get educated, namely in all the communes in Yugoslavia. Implementation of the planned health care measures would include about 13 000 local communities, about 120 000 organizations of associated labour, about 137 000 classes from primary and secondary schools, about 500 centres for social work, the same number of local Red Cross organizations, dozens of thousands of sports organizations, about 6 million household and a great number of other social subjects.

Through such activity, primary health care workers get in touch with the environment they live in and with potentials which can implement certain measures and actions aimed at improvement and protection of health, disease control, treatment and rehabilitation.

In the first part of this chapter an individual health care user is described, as well as his role in health self-care and mutual care, regarding the three aspects:

First, a health care user can deal alone with certain measures and actions aimed at improvement and protection of his health, treatment and rehabilitation of his diseases and injuries. Second, the user can be a partner or collaborater of teams of health workers or patients in his surroundings. Third, the single user as the basic subject of self-management is in position to participate in decision-making in his work organization of associated labour, local community or self-management bodies on functioning and development of health, not only in the area where he lives and works but also wider-on the territory of a sub-region, a region or even the Republic.

The second part of this chapter referes to the family in providing certain measures and actions of self-care not only to its members, but

also as to an important partner of primary health care in planned environmental control actions as well as in other preventive health care measures.

A team of general practitioners in charge of health of a family according to the place of living should cooperate with occupational health, school health with other activities of primary health care as well as with numerous other actors outside health field in providing health care for the whole family. This type of a more comprehensive cooperation between the team of general practitioners and all other subjects mentioned above points out the difference from the activity of a classic family doctor who used to provide mostly only the curative aspect of health care.

The third part of this chapter gives a description of a local community and its role in primary health care.

Working people and citizens in local communities are obliged to define and specify their health needs in cooperation with health workers who are in charge of providing health care for that particular area. Many health care measures have been mentioned which can be taken on the level of a local community and examples are given of successful implementation of health self-care and mutual care on that level.

As basic and independent subjects for production of goods and services, organizations of associated labour are important partners and cooperaters of primary health care. Organizations of associated labour and the health centre or medical centre of the commune should jointly try to meet health problems of their workers.

Problems of modern chronic diseases have been described too. Regarding the course and duration of the majority of registered diseases, they can be divided into three groups: urgent or life threatening diseases, acute and chronic ones. It has been estimated that there is about 1% of urgent, about 20% of acute and approximately 80% of chronic, mostly incurable or life-long diseases. The first two groups are treated more or less succesfuly, while the final result of chronic life-long diseases is to the great extent influenced by a patient himself, his family, conditions in which he lives and works, i.e. by subjects outside health.

A very important non-health sector in implementation of health care is education, particularly primary and secondary (specialized). About 27 000 classes of primary and secondary schools on the territory of SR of Croatia and about 137 000 of them on the territory of Yugoslavia should elaborate their health self-care and mutual-care programmes which would primarily be concerned with prevention of health. These programmes would include about 4 million of pupils, their teachers, parents and health workers. Classes in schools are very suitable places for implementation of programmed preventive health measures. Such units represents

groups of pupils of the same age spending together about nine months a year on an average.

Social welfare and health are two social sectors coping with many problems that could be solved only by their mutual approach to it. Any isolated try of solving common problems by only one side would be incomplete and deficient so therefore, their cooperation and joint action is more than necessary and of their mutual interest. Cooperation of these two sectors could be provided through pre-marriage guidance centres and family planning, through pre-natal care, care of new-born children and infants, care of pre-school children and of women, up to the care of elderly.

Both sectors have been declared by the Constitution to be of particular social interest.

Implementation of health care in social welfare institutions has been described too.

The Red Cross, an international humanitarian organization, has been established on the territory of Yugoslavia in 1876, and it can be said that for almost about hundred years it has also been implementing some health care measures. Therefore, the Red Cross organization can be considered as a very experienced cooperating partner of health in different health activities.

Examples of implementation of certain health activities by the Red Cross organization, either by itself or in cooperation with health and other partners are quoted too.

In conclusion, it has been stated that the future activity of the Red Cross organization in health care of the population in a commune will make an integral part of the primary health care plan.

Physical culture is also very close cooperating with primary health care. Both sectors cover the whole population aiming at the improvement of health at disease control and at improvement of health, working and protective capabilities of the whole population. In sport and recreation activities as many population as possible should be involved in an organized and planned way, making part of a communal health care plan, of workers, their recreation and rehabilitation. In provisions of the Constitution, of the Associated Labour Act and Act on Health Care and Health Insurance the emphasis is given to the recovery programmes.

The primary health care should be well informed on everything

concerning planned implementation of physical culture on the territory of a commune. Annual programmes of physical culture on the territory of the commune should be brought in under the control of the health sector.

Another partner of primary health care has also been described - Croatian League on defeat or cancer, - which has been successfully active on the territory of SR of Croatia for almost twenty years.

On the territory of Yugoslavia, for several years there has been registered about 2 million of disabled persons, of which some 500000 in Croatia. The great majority of disabled persons are the members of their associations which form alliances on the level of districts, republics or the Federation. Cooperation of primary health care with associations of disabled persons and their alliances is of particular importance, as for the health condition of disabled persons, so also for the community as a whole.

At the end of this chapter the cooperation of primary health care with the Organization of Veterans of the II World War has been described in providing health care of veterans. The model of such type of care has been described on the example of the commune of Pazin.

IV CHPATER

SOCIO-ECONOMIC RELATIONS

The socio-economic relations imply the complex of relations between health care users and providers, organization, management of health services and financing of health care.

The development of these relations and systems in Yugoslavia, after the II World War, could be divided in some periods:

a) Early post-war period (1945-1952)

This period was characterised by domination of the state. Health service was centralized and organized as:

- public health service (health centres, out-patient clinics, hospitals, public health institutes, polyclinics) financed through the budget and partly through health insurance funds and through users paying for the services.

- social insurance health services

- private practice of physicians, midwives and dentists.

Health authorities (the ministry of health) were planning the work and development of health, expenses and education of health workers and placements of health workers in an administrative way.

b) Period of de-etatisation of health services and self-financing of health activities (1953-1960)

This period was characterised by the transition of competences of federal and republic health authorities to communes. Health institutions became independent and health insurance was separated from the governmental authorities. Health institutions were ruled by management boards consisting of health workers, representatives of citizens and of social security services. Members of the management board were nominated by work organizations and people's councils of the communes. Health institutions began to form prices for their services on their own. In that period (1959) private practice was abolished.

c) Period of introducing and developing of self-management in health (1961-1973)

By introducing self-management in health, health institutions were becoming more and more independent. They elected workers' councils and management boards among their own members and citizens of the commune and formed health councils from representatives of health institutions, delegates and other people. Health institutions, health councils and health insurance associations were bringing in health care plans. Health institutions became more and more independent in providing and financing in accordance with the elements of prices set up by social agreements. Rights to be provided from health insurance were extended, while compulsory forms of solidarity were introduced into insurance.

d) Period of organization and development of self-managing communities of interest and introducing free exchange of labour (1974-1980)

This was the period of further development of self-magament in health care, health and health insurance. On the basis of the newly established socio-economic relations, self-managing communities of interest in the field of health and health insurance were organized. They assemblies were formed by the delegates of health users (workers and citizens) and of health providers. Within these communities formed at the level of local community or work organization (as a basic unit), commune (communal self-managing communities), several communes (association of communities) and republic (association of health and health insurance communities), needs in health care were identified, as well as programmes brought on the principle of solidarity. The basic principle is that health care is a mutual concern and in accordance with this, working people, citizens and health workers should jointly and directly make decisions on needs and possibilities. In this way free exchange of labour is developing between users and providers of health care services, which means that working people and citizens pool their means for certain programmes, while relations between their organizations and health self-managing community of interest are being arranged according to self-management agreements. Every such agreement has a corresponding programme established mutually by users and providers of services.

In such self-managing system in health and health care, a socio-political community (commune) plays a coordinating role streamlining and monitoring the functioning of health and is only partly engaged in setting-up of programmes for some of the affairs of common interest (ecology, informatic system, emergency service on main roads).

V CHAPTER

PLANNING

In the period immediately after the II World War governmental authorities were in charge of planning. In the next period planning became right and duty of health itself, with a significant assistance of socio-political communities (communes and districts). Since the 80-ties, planning was the responsibility of health care users together with health workers, within communities of health and health insurance. Today, planning is a right and duty of workers in their organizations of associated labour, citizens in local communities, workers and citizens associated in health self-managing communities of interest.

Planning in primary health care reflects needs of individuals, families, workers' associations, local communities expressed through their active involvement in planning, aiming at improvement of factors of living and working environment influencing health. So, needs are being identified mutually by users and providers of health care services. Once the needs are identified according to certain indicators (demografphic data, morbidity patterns of population, factors of living and working environment), workers' councils in work organizations and assemblies of self-managing communities set-up programmes of work for teams of health workers acting in these communities. Each programme is being annually mutually evaluated by users or their delegates and members of primary health care teams in order to start setting-up plans for the next planning period. For the needs of setting-up plans of work of primary health care teams, a standard nomenclature of services with the corresponding standards of time are used. Each programme has also be evaluated in terms of costs and resources, expressing as much as possible needs of a particular group of users in certain surroundings (school, work organization, local community), including measures and activities for health care and improvement of health, control and early detection of diseases, treatment and rehabilitation. In these programmes particular attention is payed to health education, to factors of living and working environment, nutrition, control of mass diseases, work with chronic patients. Programme of health care measures for the commune is set-up by the self-managing community of interest in health and health insurance, while programmes of local communities, work organizations and schools are set-up by them, so that programmes reflect to the maximum all the local needs.

VI CHPATER

EVALUATION

Evaluation as the way of determining of what was achieved in relation to what was put as an aim, by using certain indicators, should become a part of practice of the primary health care. An evaluation of health care and health services should be provided by:

users of services (health care, way of providing primary health care measures, health care expenditures),

providers of services (fulfilment of needs, organization, utilization and features of work of health services, financial plans),

social community (balance of needs and possibilities, contribution of health to the general development, legal and professional surveillance and quality assurance of health services).

This chapter is also describing the following: way of estimating general health status, objectives to be achieved in health care, programmes of health education, self-care and mutual care, maternity care, mother and child care, school children and youth care, care of workers and of other users. Separately, indicators have been described for evaluation of dental health care, of control of vector-borne diseases, of conditions of human living and working environment, as well as of emergency service.

Process of evaluation of work is based on indicators of quantity and quality for each primary health care activity. The example is also given of questionnaries suitable for practical work, as well as for self-evaluation of work within each team. In this way, one can get an overlook of goals achieved and tasks accomplished, as well as of the quality and quantity of work provided by the primary health care.

VII CHAPTER

CONTENT OF WORK

This chapter describes practical tasks and activities of the work of primary health care, as follows:

- way of organizing and providing ambulatory treatment, home care treatment and help,

- way and organization of work of a community health nurse,

- work and procedure with patients suffering from chronic diseases, desribing ways and procedures for keeping their files,

- way of determining temporary disability and evaluation of temporary disability (sick-leaves),

- way of evaluating work capability,

- procedure for evaluating disability

- way of organizing and providing quality assurance,

- surveillance provided by primary health care in order to determine and supervise hygienic conditions in places where people work and live, surveillance of food and water supply and control of people employed in these and other public services,

- ways of organizing and keeping obligatory records, providing documentation and information,

- coronership service.

The chapter on quality assurance in primary health care describes methodological approaches and organizations of its provision, as well as types of quality control according to the law on health care and health insurance.

The first, type of quality assurance is a control from the outside, performed by the Republic Committee for Health and Social Welfare through their experts - physicians. This type of control is made at least once in four years.

The second type is the internal control within each health organizations provided by nominated experts within the health organization concerned. These two types of control should complement eazc other.

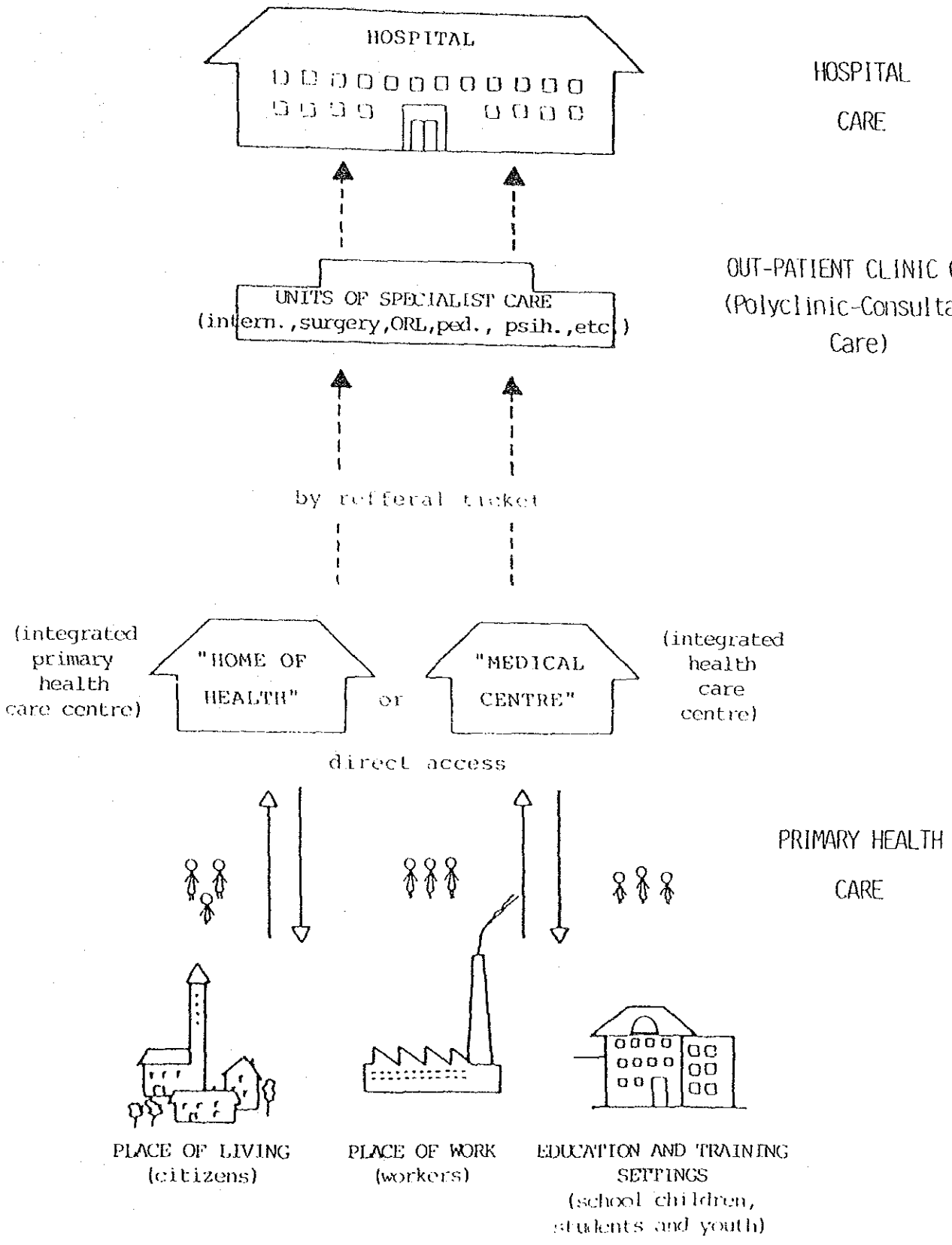
The third type of control could be initiated at the request of a single health care user, health and health insurance self-managing community of interest, work organization of users, or others.

The fourth type of control concerns work of single health workers, in case that some good reasons exist for initiating it.

A draft of a catalogue of skills in primary health care care is presented too. The draft was outlined a-cording to the Catalogue of skills of the Medical Faculty of the University of Zagreb and the Catalogue of Knowledge of the Medical Faculty of Ljubljana. Skills refer to medical check-ups, diagnostic-laboratory procedures, relation towards a patient and use of drugs. Particularly, the list is given of skills of physicians who are working in general practice, health care of children and youth, occupational health, hygienic-epidemiological service, social medicine, organization of health care, health informatics and emergency service.

There is also a list of skills related to some specialities which primary health care physician should be familiar with, such as surgery, urology, orthopedics, war surgery, gynecology and obstetrics, otolaryngology, ophthalmology, rehabilitation, general pathology and forensic medicine.

THREE LEVELS OF HEALTH CARE



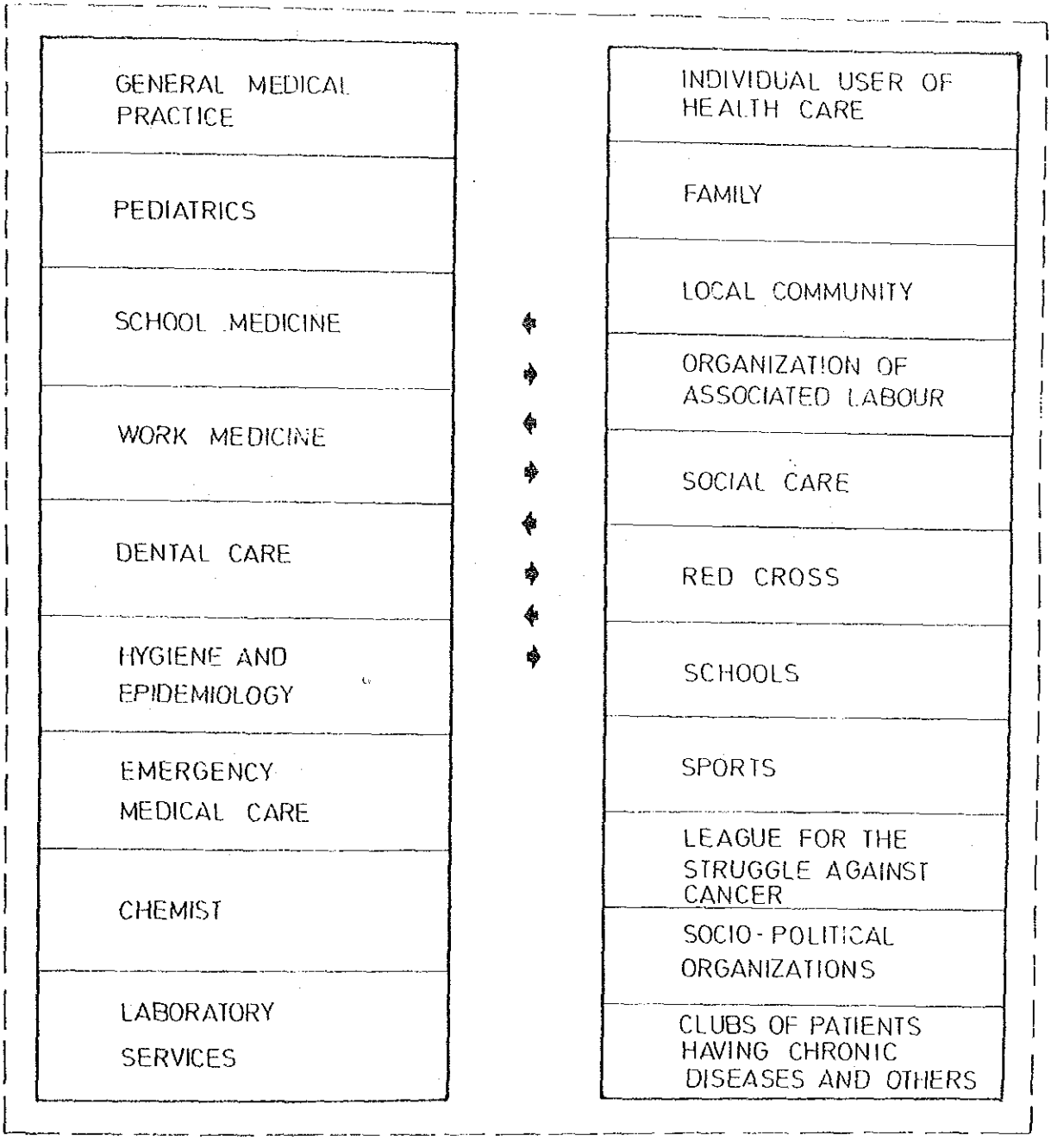
PRIMARY MEDICAL CARE

CARRIED OUT INDIVIDUALLY BY EXPERTS HEALTH PROFESSIONALS OF HEALTH HOMES OR MEDICAL CENTERS THROUGH FOLLOWING ACTIVITIES

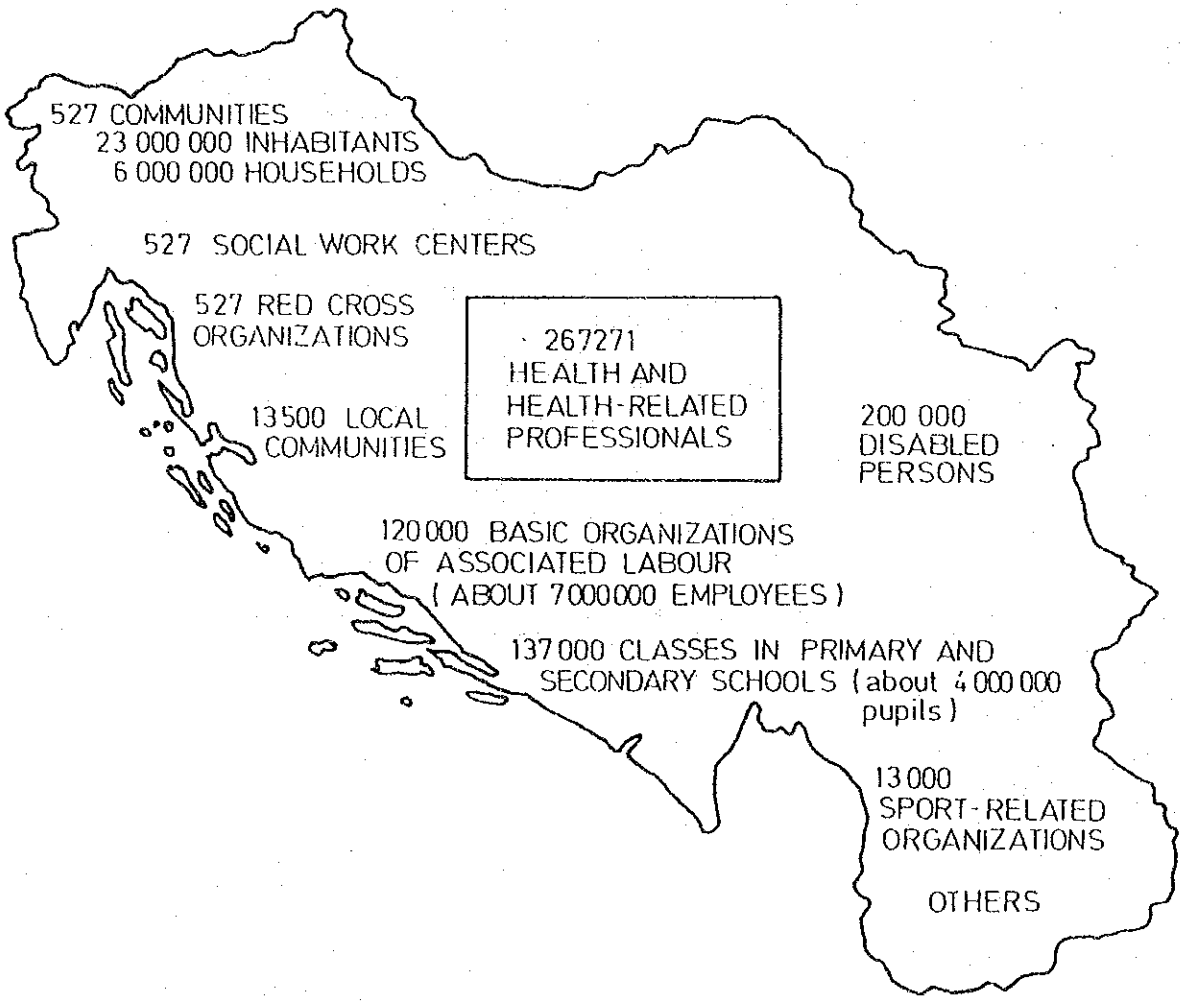
- GENERAL MEDICAL PRACTICE
- PEDIATRICS
- SCHOOL MEDICINE
- WORK MEDICINE
- DENTAL CARE
- HYGIENE AND EPIDEMIOLOGY
- EMERGENCY MEDICAL AID
- CHEMIST
- LABORATORY SERVICES

PRIMARY HEALTH CARE

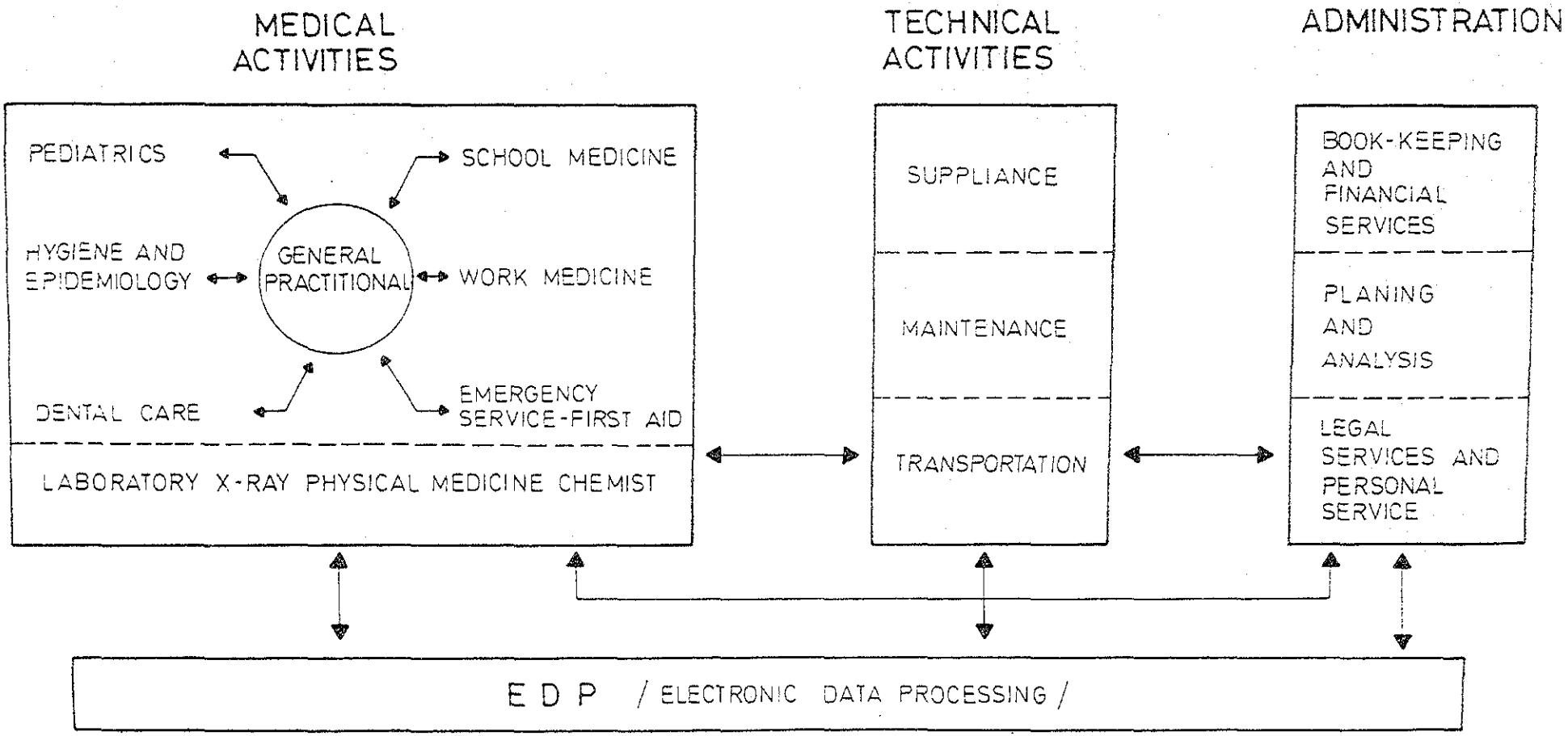
CARRIED OUT BY JOINT EFFORTS OF HEALTH HOME HEALTH PROFESSIONALS OR MEDICAL CENTRE HEALTH PROFESSIONALS AND PARTICIPANTS OUTSIDE HEALTH SECTOR ON THE TERRITORY OF A PARTICULAR COMMUNITY WHERE THEY LIVE, WORK OR ATTEND SCHOOLS WITH PARTICIPATION OF THE ENTIRE POPULATION



HEALTH AND POTENTIAL PARTICIPANTS IN CARRYING OUT HEALTH CARE IN THE TERRITORY OF SFRY



A MODEL HOME OF HEALTH ORGANIZATION

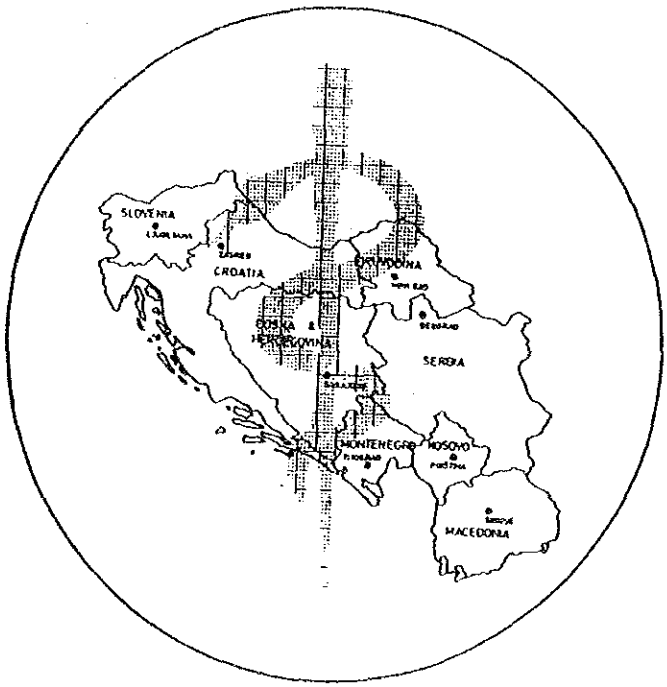


Prevailing Health Problems

TCDC FOR HEALTH FOR ALL SERIES

CENTRE FOR HEALTH COOPERATION WITH NON-ALIGNED AND DEVELOPING COUNTRIES

PREVAILING HEALTH PROBLEMS IN YUGOSLAVIA



ZAGREB, 1985

Centre for Health Cooperation with Non-aligned and Developing Countries

Prof.dr Slaven Letica and Dr. Berislav Skupnjak

PREVAILING HEALTH PROBLEMS IN YUGOSLAVIA (1980-1985) AND STRATEGY FOR THEIR SOLUTION BY THE YEAR 2000

(with Appendix: Approach and methodology for defining prevailing health problems and the strategy for their solution - experiences and lessons from SR Croatia - Yugoslavia)

Zagreb, 1985.

1. INTRODUCTION

1. The main purpose of this paper is to give readers out side Yugoslavia a general view of the main social and health problems which confront health and social policy in Yugoslavia, and to present methods by which we in Yugoslavia are attempting or planning to solve these problems.

The paper includes a critical review of our main health problems, a review of basic long-term health development objectives as well as a description of general and specific health strategies and policies oriented towards achieving developmental objectives (i.e. solving health problems).

2. In order to make this paper more comprehensible, we will use as much as possible the professional terminology found in the WHO studies in the "Health for All" series. It is important to point this out because in the Yugoslav political system and even in the field of public health a specific terminology is very often used. If this terminology were used in this text, it would needlessly diminish its comprehensibility.

2. MAIN PUBLIC-HEALTH PROBLEMS AND PRIORITIES IN YUGOSLAVIA

3. To clearly and precisely define the main public - health problems and priorities is a very complex task. The success of the entire managerial process for health development depends on the successful completion of this task. In order to tackle public-health problems of the local community, commune, region or the whole country, we need scientific research and analysis by professionals, such as sociologists, physicians, economists, etc.

Research on public-health problems should take into consideration broader political, social, living and working conditions and circumstances. In other words, many problems in the field of health and health care very often have their roots in the broader economic, social and political system.

4. In presenting basic public-health problems of modern Yugoslavia, we are not restricting ourselves to purely health problems. However, we will single out only those problems which are common for the country as a whole. This is especially important to point out because health problems in certain regions of Yugoslavia are very different due to the different general development of every region as well as their health development. To illustrate these differences, we will mention only one datum: the GNP per capita in the most developed republic of Slovenia is about 7 times higher than that in the least developed autonomous province of Kosovo.

5. In addition to presenting health problems, we will also present basic social problems which have a direct influence on the health and quality of life of the entire population.

These problems, of course, cannot be solved through health policy alone. For the successful resolution of these social and economic problems, it is necessary to conceive an optimal social and economic policy and to achieve a collaboration among different political decision-makers.

2.1. Main economic and social problems significant for the health and quality of life of the Yugoslav population

6. In presenting the main economic and social problems which have an essential influence on health and quality of life, we will restrict ourselves here to only a few indicators of the level of satisfaction of basic life needs of the individual or family: nutrition, housing, employment, education and life in a healthy environment.

7. Nutrition. Three groups of problems dominate:

a) Malnutrition and qualitative nutritional deficiencies. With regard to energy consumption, the nutrition status of the Yugoslav population is very close to that found in Common Market countries (about 3100 calories

versus 3400 in developed countries). Classic diseases caused by nutritional deficiencies are very rare (serious forms of malnutrition in children and youth are found only in 1-2% of cases, while mild forms of malnutrition in 5-10%). More frequent are qualitative nutritional deficiencies, especially vitamin and mineral deficiencies (iron and calcium deficiency is found in 15-40% preschool and schoolchildren and in 20% of workers). The food consumption pattern indicates that the consumption of some biologically valuable foodstuffs (milk, fish, meat, fresh vegetable and fruit) may represent a serious problem because it is not only less than in developed countries but is even below the standard for healthy nutrition.

b) Hyperalimentation and obesity. Epidemilogical screening clearly shows that inadequate nutrition causes situations where 20% of the male and about 35% of the female adult population have body weight over the standard, and that 60% of obese people have symptoms of hypertonia or hypercholesterolemia (or the combination of these two diseases). Obesity is very often found also in preschool (10-12%) and schoolchildren (15-20%).

c) Problems of food hygiene and contaminated foodstuffs.

Even though the system of food control and measures for improving hygienic and nutritional food standards have improved considerably, there are still some significant problems. Microbiological contamination problems (spoilage of food) are still present, although their number has decreased considerably. However, the main problem today is contamination caused by modern technology in food production, distribution and processing. The most frequent contaminators are: pesticides, herbicides, heavy metals and micotoxins.

The present economic crisis, accompanied by a higher cost of living and increased food prices, makes nutrition of the population a signification social and health problem.

8. Housing. There are 2 main problems regarding adequate housing:

a) quantitative deficit of apartments. The numerical

deficit of apartments, according to the 1981 census, is relatively small (about 150,000). However, due to an inadequate distribution of the population and apartments (surplus of apartments in rural areas and shortage in cities), the real deficit is considerably higher (600-800,000).

b) inadequate quality of housing. The existing apartments do not satisfy basic spatial, hygienic and communal standards (on the average - 15 m^2 per person). Only 0.5% of apartments do not have electricity, while the percentage of apartments without an inside water supply is very high (31.1) and the percentage of those without bathroom and toilet even higher (47.3).

9. Employment. We will point out only the basic among the many problems of employment directly linked to health and quality of life:

a) unemployment. Registered unemployment at the end of 1983 was exceptionally high 910,000 (i.e., about 9,3% of the active working population).

b) latent-hidden unemployment. Estimates of hidden unemployment range between 20-30% (i.e. 1,200,000 to 1,800,000) of the number of gainfully employed.

c) emigration - employment abroad. Specific health problems are related to the 700,000 Yugoslav workers and approximately 250,000 members of their families working abroad.

d) "Double (hidden employment). About 500,000 farmers working in the public sector are engaged in their "free" time on their own properties. At the same time, another 2 million workers are also engaged in some sort of work in their "free" time. This form of activity has a specific and mainly negative effect on this population's health status (since they work, on the average, 10-12 hours a day).

10. Education. The percentage of illiterate people is still relatively high (according to the 1981 census it was 9.5% (4,1% for males and 14,7 for females.). Primary school, which is compulsory, is still not completed by about 20% of the population. Illiteracy and non-completed primary school are basic problems of educational and health policy.

2.2. Main Public-Health Problems

11. In presenting the main public-health problems of Yugoslavia, we will restrict ourselves to those problems which should have, in the authors' opinion, a priority place in defining long-term health development strategies and policy. Since the presentation of the problem affects the determination of optimal long-term health development strategies, we will group all the problems according to specific fields of health development policy:

1. The population's health status - policy of defining health priorities,
2. Financing problems and financial policy,
3. Employment problems,
4. Education problems,
5. Technological and scientific policy problems,
6. Problems of the position and rights of health care users,
7. Health care utilization policy problems.

12. The population's health status- fundamental problemms

The population's health problems are very specific in every Yugoslav republic, province and region. There are,however, a certain number of common problems which deserve a priority place in defining long-term health development strategies. The problems are as follows:

- relatively high (compared to developed countries) infant mortality 31.7% in 1983.)
- high rate of total work disability: around 45-50%

of pensioners are work invalids (retired before the regular age limit)

- a high rate of partial work disability: every employee is absent from his/her work (21.0% working days every year (1982 data) 15.6 days due to illness and 5.4 due to pregnancy or birth)

- considering the indicators of mortality, total and temporary work disability and morbidity (hospital, PHC morbidity and that determined by screenings), the top list of current public health priorities in one Yugoslav republic is as follows:

1. diseases of the circulatory system
2. diseases of the respiratory system
3. accidents, poisonings and violence
4. cancer and neoplasmas
5. diseases of the digestive system
6. perinatal morbidity and natality
7. diseases of the urogenital system
8. infectious and parasitic diseases
9. endocrine, metabolic and nutritional diseases
10. diseases of the nervous system and organs of senses.

13. Problems of financing and financial policy. There are two main problems in this field:

1. problem of insufficient resources
2. problem of inadequate structure of resources

a) The basic problems of health care financing policy are a relatively high and an absolutely low (and insufficient) health expenditure. In 1978, for instance, personal health expenditure was 5.7% of the GNP. In 198.3 it was less, only about 4,3%. Expenses for sick pay and social aid amounted to 3.0 of GNP, while expenditure for scientific work in the field of health and for education of health workers was about 0.3%. In all, as 9-10% in 1978 and 7.5-8% in 1983 of the GNP is spent on health care. The main problem of health care financing policy is how to solve the disproportion between a relatively high expenditure and an even higher demand

from health institutions and the population for expenditures. This problem is very hard to solve because health expenditure despite its high proportion in the GNP, is still absolutely low. Per capita health expenditure in Yugoslavia amounts to about US$ 100 while in the US, for instance, it is US$ 800-1000.

b) the other basic financing policy problem is the inadequate structure of allocated financial resources: preventive and sanitary care take up only 4.5% of total resources, while 25.5% is spent of primary health care and 70% on stationary care.

A long-term financial policy objective is the redistribution of resources to the benefit of primary health care.

14. Main problems of employment policy. From the great number of problems related to employment, unemployment and emigration of health workers, we will point out those which should be given priority in employment policy until the end of the centruy:

- a rapid increase in the number of persons employed in health services is a problem of manpower policy. With 86 inhabitants per health worker and 528 per physician in 1982, Yugoslavia is already today much closer to developed countries despite its lower general level of development. (1980 data for some countries Austria 398, Belgium 440, Sweden 490, England and Wales 750, USA 480).

A relatively high number of employed physicians and other health workers and limited financial resources increase the proportion of expenses for manpower in the total health expenditure. This situation hinders scientific and technological progress in medicine as well as the quality of health care.

- Problems of unemployment is the second basic employment policy problem. The number of unemployed physicians and stomatologists is estimated today at 5000-8000, while there are about 1000 unemployed pharmacists. Every year about 2500

(in 1982, 2854) students graduate from our medical schools, 650 from our stomatology schools, and 450-500 from our pharmacy schools, so the risk of unemployment is greater among young health workers. If the present policy of enrollment continues, every year about 30% of graduates will remain without work. The problem of unemployment of physicians and other highly skilled workers is especially dramatic in large university cities such as Zagreb, Belgrade, Ljubljana, Sarajevo, etc.

- Emigration problem: It is estimated that today about 2500 physicians and 10,000 other health workers from Yugoslavia are working in European countries and the US. This problem becomes a limiting factor in some of the types of health care in Yugoslavia. In other words, emigration is especially intensive among hospital intensive care personnel which is very hard to find nowadays.

- Problem of "dequalification" (underemployment). There is much evidence showing that many health workers, especially those with university degrees and specialist training, are even "over" qualified for the jobs they are doing.

- Inadequate structure of physician-specialists. The structure of physician-specialists shows a shortage of specialists in medicine and surgery, while there are too many specialists in neuropsychiatry, pneumoftiziology, pediatrics, and gynecology.

15. Basic problems of education policy.

- too many candidates for secondary and medical schools is the first education policy problem. In secondary schools the number of candidates is 50-100% higher than the number of enrolled, while in medical schools it is even 300-400% higher.

- inadequate professional orientation of schoolchildren and students. Surveys on professional ambitions of students show that most of them look down upon work in primary health care 15% and

rural areas and prefer to work in big cities and clinical medicine (85%)Such a professional orientation of schoolchildren and students represents a serious obstacle in running an active employment policy and stimulating the geographical mobility of manpower.

- Low educational effectiveness. About 20-30% of the candidates who have enrolled after meeting strict selection criteria ever graduate, and another 30% study several years longer than is necessary to graduate.

- Quality of teaching and professional knowledge. The great number of students relative to teaching and financial possibilities of higher education essentially decreases the quality of teaching, especially in its practical work (work in clinics and PHC units).

16. Scientific and technological policy:

- Medical equipment and techniques are usually imported. Since a planned import policy and control had not been introduced, existing equipment was imported from different countries and manufacturers. This creates a serious problem of servicing.

- Sophisticated technology is unsufficiently or irrationally used since the capacities of superspecialized technology often exceed the local needs of the population for whom this equipment was imported and installed.

- Scientific-research capacities are used mostly for teaching purpose and not for solving basic public health problems.

- Coordination and collaboration between scientific workers in planning and financing research programmes is insufficient, so that similar or identical research programmes are often conducted by several research teams and institutions.

- The system of financing scientific work does not stimulate either creative research or that which is most necessary for medical practice, since the number of published scientific papers is often the only criterion used in allocating funds.

17. Position and rights of health care users

a/ Basic problems of the earlier health insurance system were quite large differences in the scope of rights for different population categories:

- about 8 -10% of the population was not included in any type of health insurance so that they had to pay directly for most of the health services,
- insurees-farmers had only minimal rights to health insurance,
- insurees-craftmen had special insurance funds which guaranteed them many rights to health care but no right to sick pay,
- those employed in the public sector had a special health insurance system and the greatest number of rights.

b/ Users´participation in the health development system is relatively high compared to developed countries. However, since the information system and the health care planning system were monopolized, health workers, health organizations and government authorities had a much greater influence on almost all decision-making in health development.

The problem of democratization and decentralization of health policy has thus become a priorit problem in the further development of health policy.

18. Health care utilization. Free choice of physician and free access to a great number of health workers and institutions were the main characteristics of the earlier health care system. Free flow of patients through the health care system led to different forms of irrational health care utilization. For

instance, the same patient could satisfy the same health need in several places at the same time. Primary health care should have been in the centre of the health care system but free access to superspecialized care often puts its central role in question.

A consequence of such a situation was an exponential growth of all types of health services:

- the number of visits to nurses and related personnel rose to 2000 visits per workers per year,
- the number of visits to GPs in consulting rooms averaged 10 000 visits annually per GP (meaning nine minutes per visit),
- the number of visits per physician specialist (in polyclinical-consultant care) amounted to 14,000 per specialist per year (or seven minutes per visit).

On the average, every inhabitant annually used about 20 different services. If we know that all potential demands were by far not fulfilled, it is easy to conclude that a reform of the health care utilization system was badly needed.

3. CHOICE OF MAIN HEALTH DEVELOPMENT STRATEGY AND PROBLEMS IN ITS IMPLEMENTATION IN HEALTH POLICY BY THE YEAR 2000

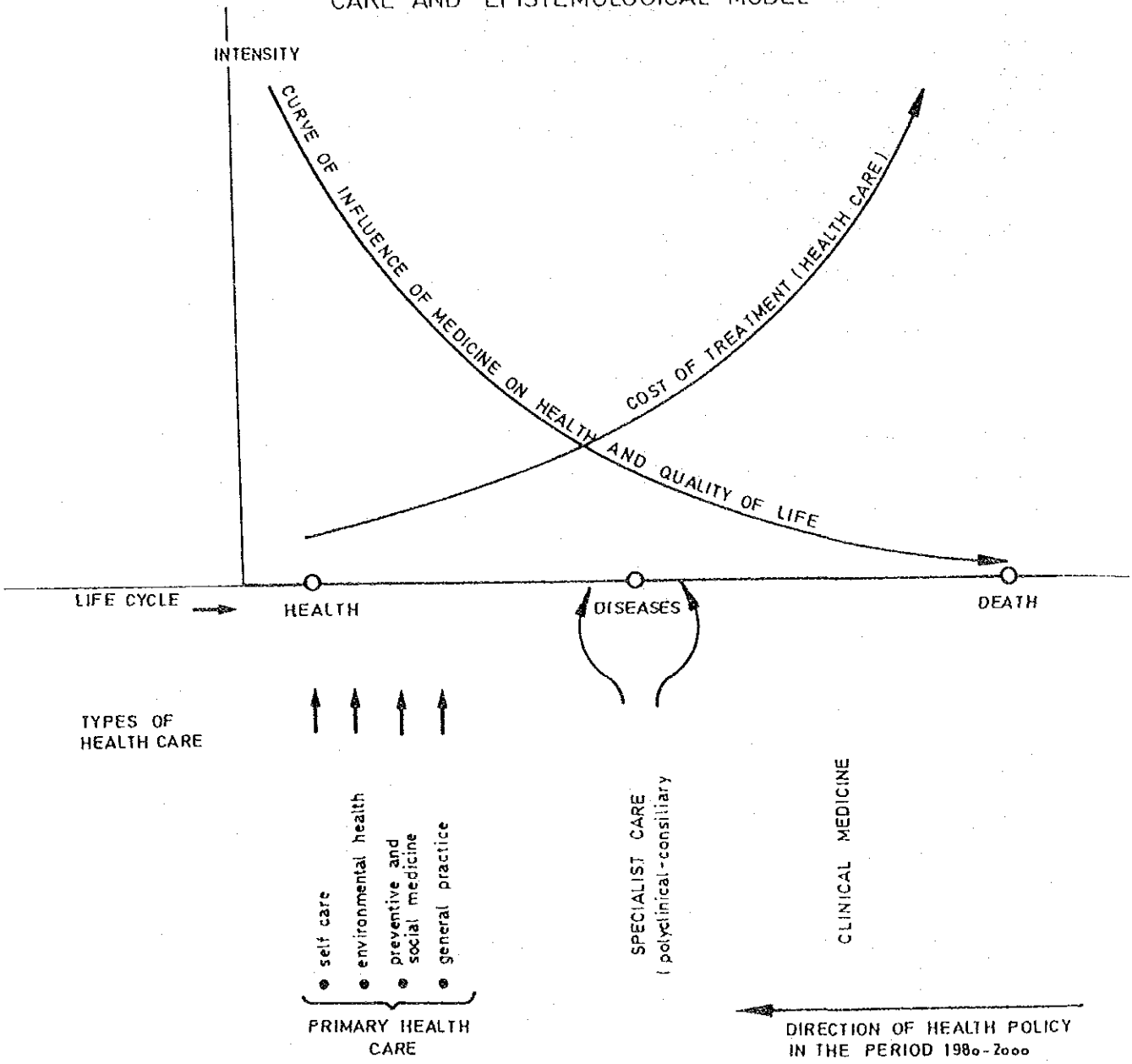
19. The general health development strategic objective declared in the popular WHO strategy: "Health for all by the year 2000" has been put into practice in Yugoslavia in its consitutional act by which all citizens under the same conditions have the same rights to health care and health insurance.

20. In order to successfully attain this strategic objective, Yugoslavia has accepted the(WHO) policy of developing primary and preventive health care as its own statutary and political orientation.

Reasons (economic and medical-public-health) for accepting the strategy of developing primary and preventive health care are shown in Figure 1.

FIGURE 1

RELATION BETWEEN COST AND BENEFIT OF HEALTH CARE AND - EPISTEMOLOGICAL MODEL



21. As can be seen in Figure 1, those branches of medicine (and health care) which have the greatest influence on health and quality of life (PHC: self-care, environment health, social medicine, community medicine, GP, etc.) have the lowest cost - expenses. By directing health policy towards primary health care, a twofold positive result should be achieve: "better health for less money". However, problems of implementing this global development strategy within the health system as well as outside of it are quite numerous.

22. Yugoslavia is an example of a country which has attempted to bring primary health care into the centre of its health system. Namely, primary health care has had a priority position in the Yugoslav health system for more than 40 years. The general health-political orientation of health care towards social and preventive medicine and primary health care was already accepted in the 1930s (primarily due to theoretical and political actions of Andrija Štampar). After Štampar's death, the tradition of this orientation was publicly advocated by the School of Public Health in Zagreb which bears his name. This concept ("PHC is the basis of the health care system") was given full support in the health legislation and health doctrine of new Yugoslavia.

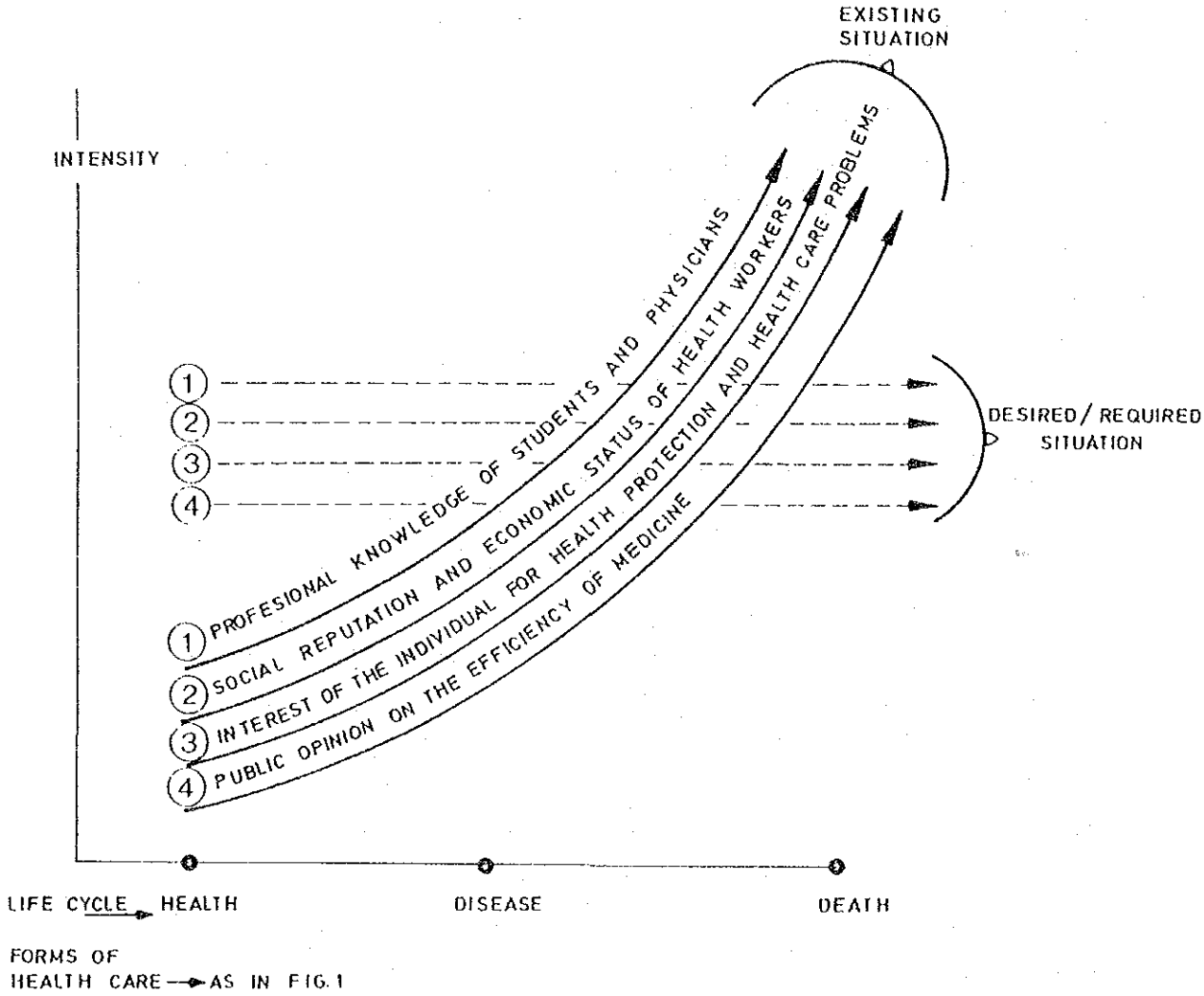
23. Immediately after World War II, significant results were achieved by applying the "ideology of PHC and social medicine" in the health care practice of new Yugoslavia. However, since the beginning of the 1960s, implementation of the policy of developing primary health care as the "centre of the system" has faced very serious problems. These problems started to arise about the time that health expenditure rose to 5% of the GNP (or US$ 500 per capita). A special study should be conducted in order to analyze the relationship between social development, health development and primary health care development problems.

24. However, even without detailed research it is possible to precisely define the basic problems facing the strategy of developing primary health care as the "centre of the system" in Yugoslavia today.

To illustrate these problems, we will use the model shown in Figure 2.

FIGURE 2

SOCIO-DYNAMICS OF THE HEALTH SYSTEM



25. In developing countries*, the success of the strategy of developing primary health care as the "centre of the system" functionally depends on the various factors which are presented in Figure 2. Placing primary health care in the centre of the system pre-supposes a change in a whole set of factors:

1. change in the structure of education and knowledge of health workers,
2. improvement of the economic and social status of health professionals in primary health care,
3. higher interest of the individual for problems of disease prevention and improvement of one´s own health,
4. change in the public´s attitute towards the efficacy and value of medicine.

26. Curves in Figure 2 marked as "existing situation" mean the following:

- curve 1.: the system of regular and additional education of health workers in developed countries is oriented more towards the needs of clinical medicine than to primary health care; professional knowledge of health professionals deals with disease - its symptoms, detection and treatment;
- curve 2.: the payment policy is such that health workers in secondary and tertiary care have higher salaries and a higher social status than those in primary health care;
- curve 3.: the interest of the individual and the population for health problems is increasing, as a rule, proportionally with age and higher risk of morbidity and death;
- curve 4.: the public has created a myth about the enormous power and efficacy of superspecialized and technologically intensive medicine, on the one hand, and about the modest possibilities of general practice and primary health care, on the other hand.

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* We think that problems of primary health care development in developed and developing countries are very different; we are referring here mostly to developed countries.

27. Basic problems of every long-term primary health care development policy could be defined as the search for answers to 4 fundamental practical-political questions:

1. How to increase the knowledge of health professionals about disease prevention and improvement of health (without diminishing their existing knowledge on detection and treatment of diseases, prolongation of life and delay of death);

2. How to improve the economic position of health workers in the primary health care sector;

3. How to motivate citizens to care for their own health through preventive activities (and how to make them use as many self-care curative procedures as possible);

4. How to change the general public opinion on the true value of nedicine; that is, how to demystify the scientific-technological myth of medicine by developing a preventive-socio-medical "myth".

Of course, it is by no means enough simply to answer these questions intellectually-philosophically and theoretically; they should be answered pragmatically-politically through a whole set of precisely scientific, manpower, educational, financial and other policy measures.

The way in which modern Yugoslav social and health policy is trying (or could try) to find"answers" to the above mentioned questions and the way it does solve the problems stated in chapters 2 and 3 will be explained in the following chapter.

4. HEALTH POLICY MEASURES TO THE YEAR 2000

28. Different health policy measures whose purpose is to solve the basic health problems presented in chapter 2,are presented in this chapter. These are based on two fundamental laws which define health policy in Yugoslavia today: the Law

on Associated Labour and the Law on Health Care and Health Insurance*.

It should be pointed out right away that the word "law" should be understood in the specific sense the term is used in Yugoslavia. In the Yugoslav self-managing system every law has three functions. First, there is the classic function which law has in civil rights systems to establish norms of behaviour and the mechanisms of coercive measures for maintaining the law. Second, some enactments determine only main common principles, while more specific regulations are set up by self-managing acts and decisions. Third, some legal norms have a strategic nature; in this sense, these legal norms are determined by a long-term development programme.

4.1. Policy of individual rights to health care and health insurance

29. In Yugoslavia the most important part of the policy "Health for all by the year 2000" is related to the policy of equalizing individual rights to health care and health insurance. The new health insurance system considerably diminishes differences in the rights between basic social groups in the population: workers (i.e. those employed in the socialized sector), farmers, private craftsmen and "others".

30. The system of individual rights to health care and health insurance is extremely complex. Nevertheless, the political-legal basis of the individual rights concept can be described in a very simplified way:

a/ the whole population is insured against all basic health risks, i.e. workers, craftsmen and farmers have the right to use all types of health care at the level of the general practitioner and his/her team in the local community;

* With ratification of 1974 Constitution, the right to promulgate laws in the field of health care and health insurance was totally transferred from the federal level to the level of republics and provinces. Here we are analyzing the Law on Health Care Health Insurance of Croatia, but basic statements are valid for the whole country.

b/ workers and working people (all gainfully employed persons) have guaranteed rights at a standard level to use the so-called "specific health care of workers, which is a condition for work and production" (this is mainly preventive health care);

c/ the whole population has the right to stationary health care;

d/ the following persons have the right to use poly-clinic-consultative care:

- children until the age of 15 years and youth until completion of compulsory education;
- women in relation to pregnancy, birth, motherhood and family planning;
- all citizens suffering from chronic diseases which have to be reported;
- all persons suffering from mental diseases which represent a danger to their life, the lives of other citizens and property;
- persons suffering from distrophy and related muscular and neuromuscular diseases;
- all persons suffering from malignant diseases, endemic nephropathy and diabetes.

e/ workers (gainfully employed) have the right to 100% sick pay at the expense of health insurance for all diseases for which sick leave does not exceed 30 days. For occupational diseases, a sick child under 7, maternity leave, hospital treatment and some other cases, the health insurance allocated sick pay from the first day of sick leave. In all other cases of sick leave up to 30 days,sick pay is provided by the work organization.

f/ besides the mentioned rights workers also have the right to travel allowances, rehabilitations, etc.

g/ members of the family have, as a rule, the same rights as the insuree, with the exception of sick pay.

31. Quality of health care is defined by law by the following attributes: adequate, accessible and timely health care. The responsibility of health workers for high quality health care is especially emphasized.

32. The right to health care regardless of its general content and quality (imposed by the possibilities of the community) always pre-supposes the EQUALITY OF USERS.

The application of this axiom (on the absolute equality of users) is today and will be tomorrow the basic problem of fulfilling the right to health care in Yugoslavia. In other words, the disproportion between the possibilities of health care and users´demands is generally present to the disadvantage of possibilities. For more complex procedures such as highly sophisticated technology, therapeutic procedures and rehabilitation, this disproportion is quite dramatic. In such a situation, the problem of selecting users becomes a complex necessity. The choice of selection criteria and selection practices are especially complex from the ethical point of view for those procedures and measures dealing with the dilemma of life and death (and there are ever more such dilemmas in modern medicine and health care).

33. Given awareness of the problem of (actual and potential) inequality of users, the new Law on Health Care and Health Insurance for the first time tries to legally establish a "standard right to health care", that is, "standard level of health care".

The intention of the legislators is quite clear. In a situation where the disproportion between needs and possibilities is growing, at least a temporary solution would be to guarantee (optimal and minimal) average rights to using health care.

The health standard is established by law as a self-managing-legal category. It is set in plans (for a medium-term period) which specify the quantity and quality of use of legally established types of health care and other rights in health care utilization.

4.2. Changes in the organization of the health care delivery system

34. The purpose for changing the organization of the health care system is to place primary health care in the centre of the entire health care system. The general practitioner's team in the local community (i.e. in residential areas), on the one hand, and the team of physicians of general practice and occupational health in the work organization, on the other hand, are given the exclusive right (in collaboration with patients) to make all essential medical and health legal decision: whether the patient needs a physician-specialist, stationary (hospital) treatment, or a sick leave; which drugs and therapeutical aids, etc.

35. Basic changes in the organization of health care delivery with regard to the place and function of primary health care are shown in Figure 3 (the old system) and Figure 4 (the new system).

FIGURE 3

SCHEME OF THE HEALTH CARE SYSTEM
IN THE PERIOD 1945-1980

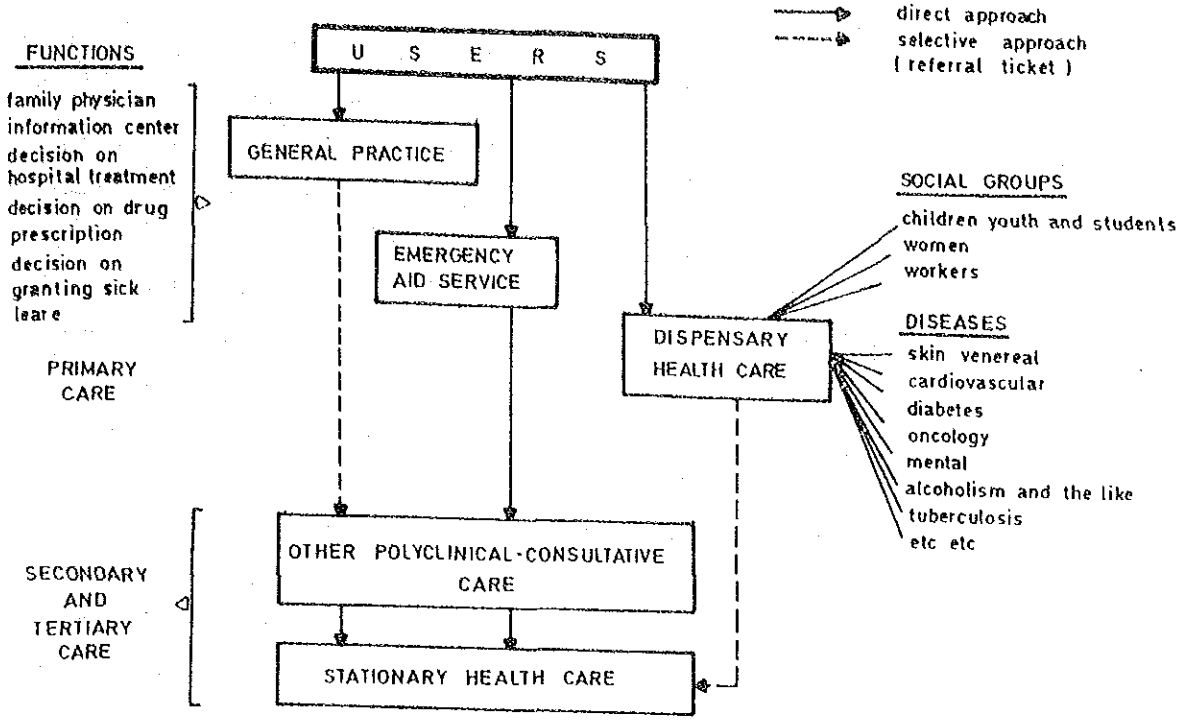
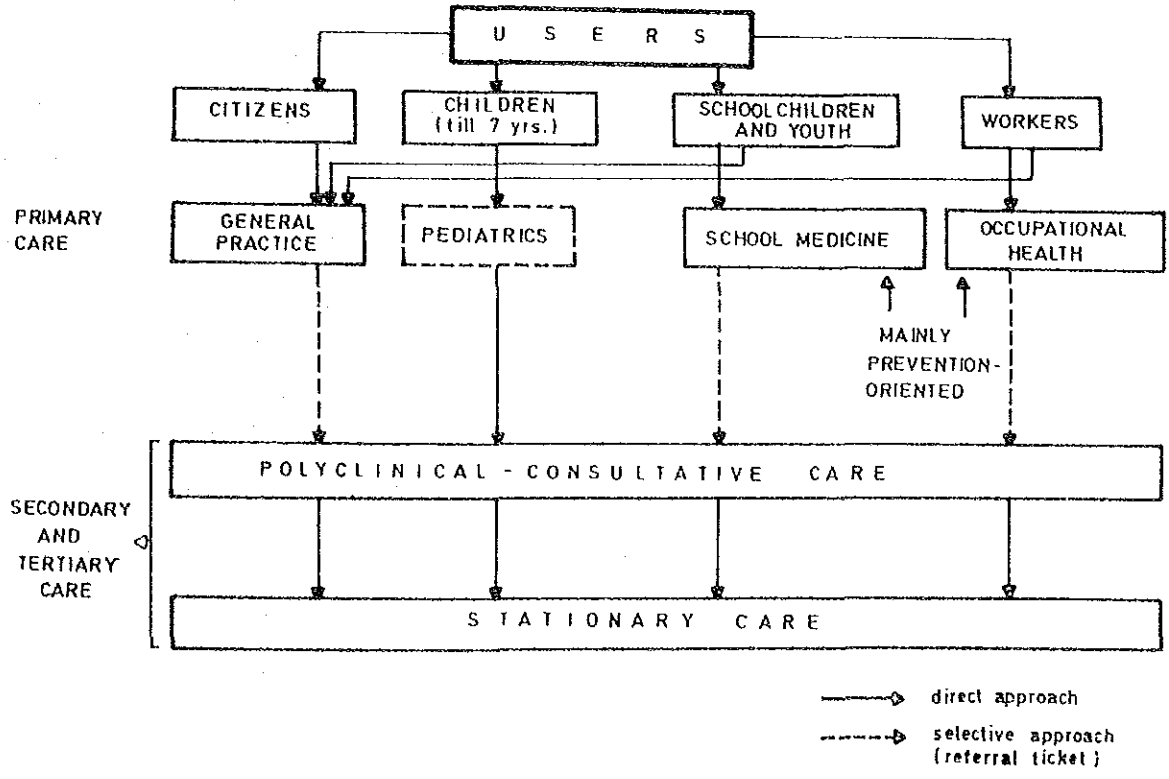


FIGURE 4

SCHEME OF THE NEW HEALTH CARE ORGANIZATION (after 1980)



36. The tasks of primary health care of the population and specific (preventive) health care of workers which have all the strategic, investment and other priorities in the health development system, are precisely prescribed by law.

37. Primary health care tasks are to:

- participate in increasing psychophysical and working capacities of workers, schoolchildren and students, youth, sportsmen and other people, carry out health care measures, take care of the health status and improvement of health, ensure and assess their capability for work , schooling and sport;
- participate in carrying out preventive and especially hygienic and epidemiological health care measures;
- carry out health care measures of preschool children, take care of their health status and improvement of health and participate in increasing their psychophysical capacities;
- provide pre-natal, natal and post-natal care and other health needs of women;
- carry out health care measures and take care of the improvement and maintenance of the health status of War Veterans;
- carry out health care measures for retarded persons;
- point out the unfavourable influence of the environment on the health status and working capability of users;
- provide emergency medical aid;
- carry out treatment in consulting rooms, or in the patient´s home;
- follow-up the implementation of preventive, curative and rehabilitation measures;
- carry out measures of prevention and treatment of the mouth and teeth;
- organize drug supply;
- refer users to consultative-specialist examinations and to stationary and other care;
- coordinate and carry out necessary diagnostic and therapeutical procedures.

38. Specific (preventive) health care of workers - tasks are:

- medical examinations for determining general and special health capabilities;
- systematic examinations (check-ups) of workers according to sex, age, working capacities and occupational diseases, accidents at work and chronic diseases;
- examinations of workers which are compulsory because of environmental sanitation, protection of consumers (users) and other compulsory examinations;
- examinations for determining health capabilities of workers for carrying out particular jobs or responsibilities of organizations of associated labour regarding regulations of protection at work;
- assessment of working conditions in particular jobs (effects of dust, noise, light, etc.) for protection against occupational diseases;
- providing on site first (medical) aid to a worker who becomes ill or is injured at work;
- health education of workers;
- improvement of hygienic conditions in certain jobs and workers´nutritional and housing conditions;
- assessing the need to refer workers to take organized active rests in order to improve their health and working capabilities and determining their health status after these rests;
- arranging organized active rests for workers including measures and procedures of early rehabilitation;
- other preventive measures (optional vaccinations, optional systematic examinations, etc.).

39. It was expected that changes in the organization of contents and provision of certain types of health care would have the following immediate positive economic and health consequences:

- the pressure of patients on superspecialized health care would decrease,

- temporary and total disability for work would decrease (since priority was given to preventive health care of workers);

- a rational division of labour in primary health care among auxiliary medical personnel, nurses and physicians would develop.

40. The period in which the new system has been functioning has shown certain positive effects but not to the extent the political decision-makers and creators of the new system had expected. Very briefly, the effects are as follows:

- the pressure on clinical and preclinical specialist medicine has not decreased although the pressure on primary health care has significantly increased;

- absenteeism due to illness has not diminished but the long-term trend of its growth has been stopped;

- certain communication problems have appeared in determining users' (patients) rights to drugs, specialist examinations, sick leave, etc.

4.3. Democratization and decentralization of health policy

41. Although in the earlier health policy system there was a high degree of different types of community participation in decision-making on health development, the new system of self-managing health policy has increased the significance of local authorities and especially the population in health policy formulation.

42. Ever more rights and responsibilities for originating and carrying out health policy have been transferred from government authorities to new institutions, the so-called self-managing communities of interest for health and health insurance. These institutions, as a rule, are set up on the territory of every commune (in Yugoslavia there are about 500 communes) and

sometimes even on the territory of a local community. Self-managing communities of interest make almost all the decisions on financing health care, users' rights and the mode of using health care, and the construction-location of health institutions.

43. Delegate-representatives of health care users (delegated by self-managing bodies in firms), delegate-representatives of health institutions as well as delegates of political and government authorities participate on an equal footing in the management and decision-making processes in self-managing communities of interest.

4.4. Changes in the health care financing system and policy

44. There are two basic objectives which we are trying to achieve with the introduction of changes into the health care financing system and pilicy:

1. improving the financial position of primary health care
2. restraining further expansion of health expenditure.

45. In order to ensure the priority position of primary health care in the financing policy, the system of financing primary health care has been changed as well as the manner of settling contributions for health insurance. In short, changes introducedin the financing system have made investment into preventive and primary health care very attractive to firms because investment in this type of health care is free of all taxes and contributions.

46. The system of financing health institution construction is also stimulating health development. In other words, the greatest part of funds for the construction of facilities is provided through public subscription taxes which are decided

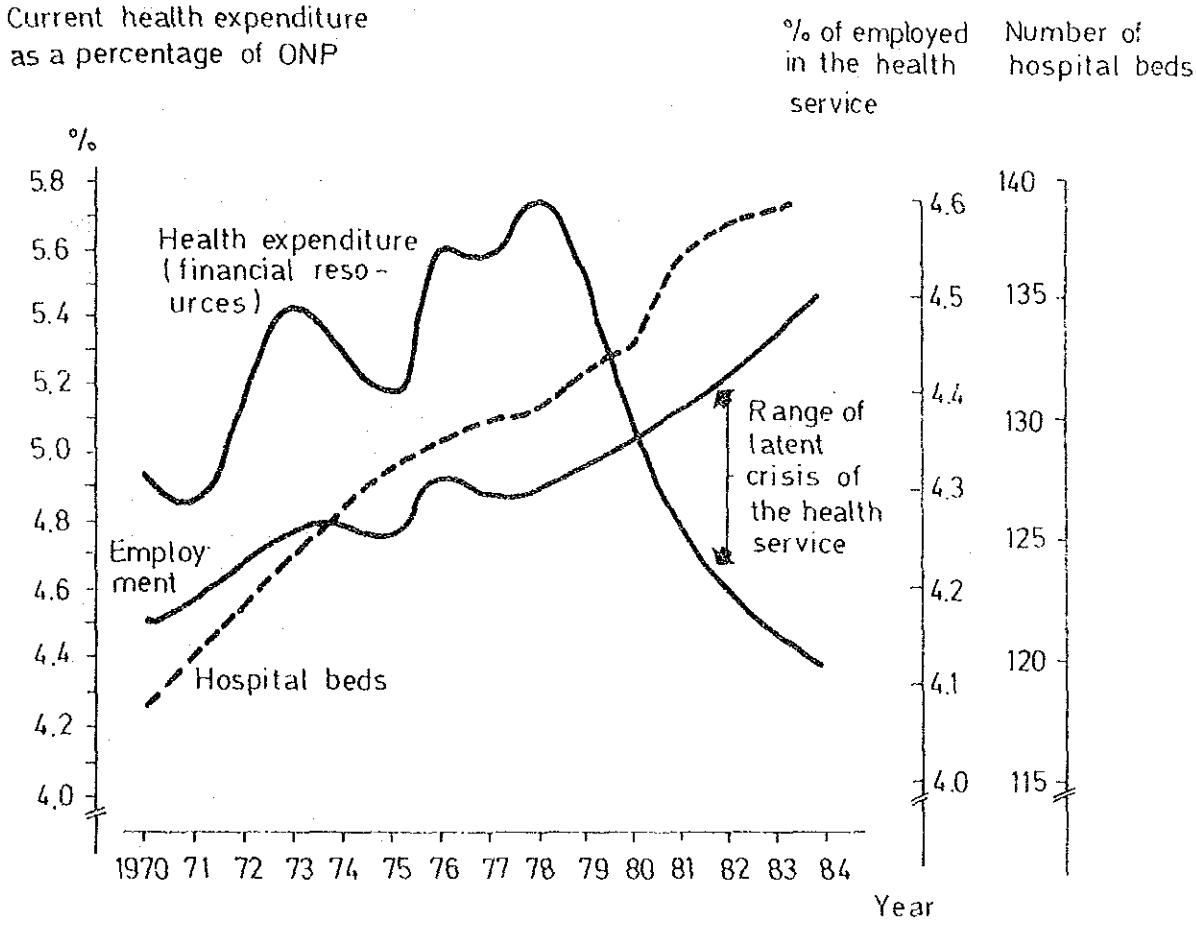
by the population in communal and municipal referenda. This financing system shows obvious advantages because the local population is actively participating not only in decision-making on the amount of resources but also on the purpose and location of new institutions.

47. The policy of decreasing health expenditure is very hard to implement. The fact is that due to a low flexibility of demands for clinical services the development of primary health care does not only decrease but but often even increase health expenditure.

The fact is that after 1979-1980 the Yugoslav health services has entered a period of permanent financial crisis. This financial crisis is the consequence of purely administrative limitations in the current and capital health resources almost no changes have been made in the structure of the health sector, nor has the input of health care (health manpower, hospital beds, medical technology, etc.) been slowed down. For these reasons a real danger exists that the present financial crisis of the health sector migh become its general crisis. The relation b tween "expenditure potentials" and the actual financial resources of the health service is shown in Graph 5.

Graph 5

RELATION BETWEEN "EXPENDITURE POTENTIALS" AND ACTUAL FINANCIAL RESOURCES OF THE HEALTH SERVICE IN YUGOSLAVIA IN THE PERIOD 1970-1984



In the situation where there exists a restrictive financial policy in the health sector a change occurs in the composition of expenditure: the proportion of the so-called non-elastic (i.e. hospital) expenditure increases while the proportion of the "elastic" (PHC) expenditure decreases.

Composition of current health care expenditure by types of health care services in Yugoslavia in 1979 and 1984

	1979	1984
Specialist and primary health care outside hospital	33.1	31.0
Hospital care	57.6	62.1
Other	9.3	6.9
TOTAL	100.0	100.0

Due to a strong interdependence between various factors (causes) which influence the rising of health expenditure, it is very difficult to precisely quantify the influence of each of the factors-causes.

48. In the ample macro-economic study on factors of increased health expenditure (carried out in 1984*) in Yugoslavia in the period 1960-1981 I used the following conceptual theoretical model:

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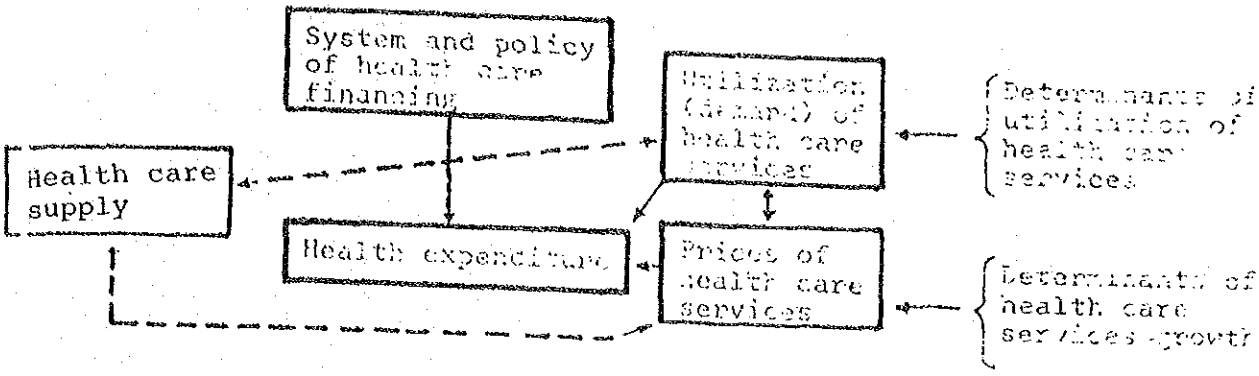
*see S. Letica, Kriza i zdravstvo (Crisis and Health) Stvarnost, Zagreb, 1984.



On the basis of the mentioned study on cause of rising costs in health care services it is possible to roughly quantify the influence of different factors in the following way:

a) causes related to the "supply side" of health care:

increased scope and amount of service provided, i.e. increased personal costs, inflation, increased cost of new medical technology etc. - 70%

b) causes related to the "demand (utilization) side" of health care, i.e. increased number of population and increased utilization of health care, changes in case-mix etc.- 20%

c) causes related to the system and method of financing of health care - 10%.

4.5. Employment and education policy

With the aim of developing primary health care many actions were set into motion to define the optimal employment and education policy. We will mention only a few activities.

49. We are trying to coordinate the number of students at medical schools with long-term needs for manpower. The selection of candidates is carried out through an entrance examination system. The maximum number of students admitted each year is determined through negotiations with the self-managing community of interest for education.