ZDRAVSTEVNI DOM: RELIKT PRETEKLOSTI ALI VIZIJA PRIHODNOSTI

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Uvodnik

Izhodišče

Primarno zdravstveno varstvo ostaja še vedno pastorek zdravstvene politike kljub temu, da je o njegovi pomembnosti napisanih veliko člankov in sprejetih veliko deklaracij (1-8). V Sloveniji je primarno zdravstveno varstvo organizirano večinoma v okvirih zdravstvenih domov. Taka organiziranost dejavnosti se dolga leta ni spremenila, čeprav so se občasno pojavljala vprašanja o njeni racionalnosti. Zlasti v zadnjem času je kritikov vse več in pojavljajo se ideje o drugačni organiziranosti primarnega zdravstvenega varstva.

Zgodovina

Družbena dogajanja in razvoj medicinske znanosti v prvi polovici dvajsetega stoletja so močno vplivala na socialno medicino. Družbene razmere po prvi svetovni vojni so terjala zdravstvene reforme. Socialnomedicinska načela v načrtovanju zdravstva so postala neizbežna. Glavni nosilec teh idej v tedanji Jugoslaviji je bil Andrija Štampar (9), v Sloveniji pa Ivo Pirc (10). Temeljna izhodišča Štamparjeve doktrine so pred drugo svetovno vojno in po njej postala doktrina pri razvijanju sistema javnega zdravja v svetu.
Prvi zdravstveni domovi so bili posledica idej: prednost pri reševanju so dobile najbolj ogrožene skupine prebivalstva ter nekatere bolezni. Tak način organizacije primarnega zdravstvenega varstva je kmalu dokazal številne prednosti. Močno se je izboljšala precepljenost prebivalstva, padla je umrljivost otrok, pri zdravstveni politiki pa se je socialno medicinska zavest še dodatno poglobila (10). Zaradi teh uspehov, ki jih je ta sistem uspel zagotoviti ob bistveno manjših sredstvih, kot so jih za zdravstveno varstvo namenile bolj bogate države, je bil zdravstveni dom takrat verjetno ena najbolj inovativnih idej in eden največjih uspehov tedanjega zdravstva. Uspel se je odzvati na potrebe prebivalstva, zagotovil je pravičnost v dostopu do zdravstvene službe, omogočil je izvajanje javnozdravstvene politike države in bil je ekonomsko učinkovit. Pri svojem delu je uporabljal za tisti čas moderne koncepte dispanzerske metode dela in timske obravnave. Zdravstveni dom je bil tudi pomembno gibalo akademskega javnega zdravja.
Program ustanavljanja zdravstvenih domov je v svojih začetkih temeljil na delu osveščenih zasebnih zdravnikov, ki so s pristajanjem na temeljna doktrinarna načela prilagodili svoje delo in včasih delno z državno pomočjo uredili svoje ordinacije. Takih zdravnikov je bilo v začetku malo.

Načela zdravstvenih domov osemdeset let kasneje

Zgodovina osnovnega zdravstva v Sloveniji po drugi svetovni vojni je prinesla celo vrsto sprememb, med njimi tudi sistematično ustanavljanje zdravstvenih domov po populacijskem načelu. V povojnem »herojskem obdobju« so ljudje z navdušenjem zgradili takrat v Evropi verjetno največje prostorske zmogljivosti za osnovno zdravstveno dejavnost in s spoštovanjem sprejemali vanje prve doma izšolane zdravnike, med njimi tudi prve specialiste splošne medicine. Formalistično, birokratsko in politično prevzemanje vodenja teh ustanov je vodilo po letu 1969 v vse večjo nezainteresiranost zlasti strokovnjakov, ki jih tedanji samoupravni sistem ni zmogel preseči (11–13). Nastalo je obdobje krize in sedanji zdravstveni domovi se srečujejo s celo vrsto težav (14, 15). Vprašanje je, v koliki meri so načela prvih zdravstvenih domov preživela preskus časa.

Zdravstveni dom se odziva na zdravstvene potrebe prebivalstva

Primarno zdravstveno varstvo se sedaj sooča z drugačnimi problemi kot takrat, ko so se ustanovili prvi zdravstveni domovi. Ti so jih uspeli razrešiti celo vrsto. Kljub temu, razen uvedbe preventivnega programa za odraslo populacijo, uvedenega v zadnjih letih, preventivna dejavnost zdravstvenih domov še vedno ohranja enake prioritete kot pred osemdesetimi leti. Razumljiva je skrb, da bi se z opuščanjem uveljavljenih programov ponovno pojavili problemi, kot smo jih

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poznali še pred desetletji, manj razumljivo pa je počasno sprejemanje novih vsebin. Reševanje nekaterih potreb prebivalstva se prepušča drugim organizacijam, ki imajo svoj sedež zunaj zdravstvenega doma. Le malo je poskusov, da bi jih organizacijsko uvrstili v zdravstveni dom. Temu je prilagojen tudi način plačevanja, ki je zasnovan na ponavljanju obstoječih programov, ne pa na soočanju z novimi izzivi.
Sedanji zdravstveni domovi se torej ne odzivajo več na zdravstvene potrebe prebivalstva. Potrebno bi bilo resno prevetriti programe in v zdravstveni dom pritegniti vse tiste izvajalce, ki svoje storitve ponujajo zunaj te organizacije, kar bi zanesljivo pomenilo spremembo v organiziranosti.

Zdravstveni dom zagotavlja pravičnost v dostopu do zdravstvene službe

Ustrezno zdravstveno varstvo je temeljna človekov pravica. Zato morata zdravstvena služba in družba posebno pozornost posvečati šibkim in ogroženim po načelu pravičnosti. Klasičnim skupinam s tveganjem so se v zadnjem času postavile ob bok nove,: starostniki, ljudje s potrebo po negi na domu, migranti in predstavniki obrobnih skupin, ljudje brez zdravstvenega zavarovanja, kronični duševni bolniki. V prihodnosti se bomo vse več srečevali z ljudmi iz drugih okolij in kultur.
Novih skupin s tveganjem ne zdravstveni dom in včasih niti zdravstveni sistem ne obravnavata ustrezno in zanje pogosto ne najdeta ustrezne obravnave. Oskrba je ali prepuščena drugim nezdravstvenim področjem (npr. sociali) ali pa ostajajo prepuščeni sami sebi in dobrodelnim institucijam.

Zdravstveni dom omogoča izvajanje javnozdravstvene politike

Vodenje zdravstvenih domov je ena ključnih javnozdravstvenih funkcij v državi. To je bil tudi eden osnovnih razlogov za uvajanje specializacije iz splošne medicine, ki je bila ob svoji ustanovitvi namenjena direktorjem zdravstvenih domov, da so se naučili, kako javnozdravstveno ukrepati. Sedanji čas dodatno zahteva veščino poslovanja, ki večinoma zaposluje direktorje zdravstvenih domov.
S spremembo specializacij bodoči zdravniki v osnovni zdravstveni dejavnosti ne dobijo več znanja s področja javnega zdravja. Politika je razvoj primarne ravni prepustila posameznikom na ravni občin, kar je bilo ob pomanjkanju znanja na lokalni ravni verjetno nepremišljeno. Posamezni poskusi ocene zdravstvenega stanja prebivalstva so uspeli le v večjih centrih ob finančni podpori lokalne skupnosti. V glavnem pa za kaj takega ni niti interesa niti finančnih sredstev. Znanje s področja strateškega načrtovanja v zdravstveni dejavnosti je šibko, zaradi česar se tudi državna politika ne zaveda pomena primarne dejavnosti.
Čeprav s formalnega stališča zdravstveni dom omogoča izvajanje javnozdravstvene politike, postaja ta domena Inštituta za varovanje zdravja in regionalnih zavodov za zdravstveno varstvo, glavno gibalo dejavnosti zdravstvenih domov pa je pogodba z Zavodom za zdravstveno zavarovanje, katerega glavni interes je predvsem ekonomski. Kaže, da se bo v 21. stoletju javnozdravstvena služba kadrovsko in tehnološko okrepila in osamosvojila in prevzela dejavnost, ki jo je doslej delila z zdravstvenimi domovi.

Zdravstveni dom omogoča ekonomsko učinkovitost in kakovost dela

Spremembe zdravstvenega sistema so prinesle v ospredje potrebo po ekonomski učinkovitosti. V zadnjih letih se soočamo z rastočimi stroški, ki jih država namenja za porabo zdravil (16-19). Večino zdravil predpišejo zdravniki v primarnem zdravstvenem varstvu in s tem ustvarjajo velike stroške. Podobno velja za racionalno porabo diagnostičnih postopkov, porabo materialnih stroškov, reševalnih prevozov in racionalno napotitev na sekundarno raven. Ob vsem tarnanju pa se očitno finančne zagate rešijo drugje, saj zdravstvena služba ne pozna presežnih delavcev ali celo stečaja.
Zdravstveni dom ne zagotavlja strokovne in s tem povezane ekonomske kakovosti primarne zdravstvene ravni. Kljub formalnim pozitivnim bilancam ni nikakršnih stimulacij za boljše delo ali učinkovitost. Ukrepi, ki bi jih na tem področju lahko uvajali preko sistema zagotavljanja kakovosti in svetovanja med kolegi, so bolj izjema kot pravilo. Prepuščeni so dobri volji posameznikov, ne pa sistematičnemu izboljševanju kakovosti. Vodstva zdravstvenih domov imajo na voljo zelo malo načinov, s katerimi bi spodbujala boljše zdravnike. Za kaj takega sploh ni spodbud. Sistem mentorstva in svetovanja (20), ki je v tujini priznan in uveljavljen, se v Sloveniji ne uvaja. Tudi sprejete sistemske rešitve se ne uresničujejo. Značilen primer je elektronska kartoteka, ki kljub desetletnim prizadevanjem še vedno ni v uporabi.

Zdravstveni dom dela po dispanzerski metodi

Dispanzerska metoda je značilnost vsakega kakovostnega primarnega zdravstvenega varstva. V Sloveniji jo razumemo kot organizacijsko kategorijo in jo enačimo s preventivnimi programi vodenja ogroženih skupin in bolezni, ne pa kot element rednega dela. Metoda je nespremenjena že osemdeset let. Še vedno ni dovolj jasno, da je to metoda, ki se uporablja pri kurativni dejavnosti ravno tako (ali pa še bolj) kot pri preventivnih programih. Novi populacijski ukrepi na ravni primarnega zdravstvenega varstva (cepljenja, program ZORA) informacijsko prevzemajo druge službe. S tem zdravstveni dom izgublja enega osnovnih razlogov za svoj obstoj.
Dispanzersko metodo bi morali posodobiti in jo uvesti v vseh ambulantah, kar zagovarja družinska medicina (21, 22). To pa pomeni, da bi morali vsi zdravniki in zdravstveni domovi imeti ustrezno računalniško podporo, ki bi omogočila populacijski pristop pri njihovem delu. Temu bi moral slediti tudi model financiranja in opredelitve standardov. S tem bi prenehala potreba po dispanzerjih kot posebni organizacijskih enotah.

Zdravstveni dom omogoča timsko delo

Bivanje različnih služb pod eno streho naj bi omogočalo, da timi delujejo skupaj, kar je nujno za kakovostno delo (23). V praksi se multidisciplinarnost ni obnesla vedno tako, kot je bila zamišljena. Delitev domov na službe je povzročila razdrobitev organizacije, ki je z uvajanjem novih služb, enot in dejavnosti postala nepregledna, zlasti v večjih zdravstvenih domovih. Ker so pogoji poslovanja, dela ter normativi služb različni, je pogosto prihajalo do zavisti in sporov, tako da se sedaj namesto, da bi se pogovarjali o primarnem zdravstvenem varstvu, raje pogovarjamo o krizi pediatrije, šolske medicine, medicine dela in patronaže (15; 24–27).
Zdravstveni dom sicer omogoča timsko delo, vendar je pogosto organizacijsko tako razdrobljen in zbirokratiziran, da je tako sodelovanje skrajno oteženo.

Zdravstveni dom spodbuja akademski razvoj stroke

Dobro primarno zdravstveno varstvo omogoča tudi strokovni razvoj preko raziskovanja in poučevanja (28), kar predstavlja pomembno prednost zdravstvenega doma pred ambulantami posameznih zdravnikov.V Sloveniji je s formalnega stališča urejeno usposabljanje specializantov preko sistema mentorstva, ki je zaživelo kljub velikim težavam v dogovarjanju med zdravniško zbornico in zdravstvenimi zavodi. Zdravstveni domovi večinoma niso registrirani kot raziskovalne skupine, če so, je njihova kakovost slaba. V zdravstvenih domovih je zaposlenih le peščica učiteljev in raziskovalcev, še ti za svoje akademsko delo znotraj doma praviloma ne prejemajo plačila.
Zdravstveni domovi v Sloveniji le deloma spodbujajo akademski razvoj stroke. Sodelovanje z akademskimi institucijami je slabo, tudi zaradi tega, ker ta povezava ni ustrezno urejena.

Možni scenariji

Glede na stanje so v Sloveniji najverjetnejši trije scenariji razvoja primarne zdravstvene dejavnosti v prihodnje.

Prvi scenarij

Po prvem scenariju bi ugotovili, da je javno zdravstvo na ravni zdravstvenih domov v Sloveniji že dolgo mrtvo in ga ni mogoče obuditi. Pokazalo bi se, da je zdravstveni dom konglomerat in predstavlja le priročno obliko neprofitne organizacije, ki na sorazmerno človeški način omogoča delo zdravstvenim delavcem, ki sami ne želijo voditi poslovanja lastnega zavoda ali podjetja in zagotavlja široko paleto zdravstvenih storitev. Po tem scenariju obstoj javnega zdravstvenega doma lahko popolnoma prepustimo tržnim tokovom in konkurenčnosti med zasebnim in javnim načinom organiziranja zdravstvene službe. Z reformo bi prestrukturirali dejavnosti tako, da bi pokazala socialnomedicinske, higienske in epidemiološke vsebine, ki bodo ostale v rokah državnih institucij, in tiste, ki bi jih morale pokriti druge službe. Dejavnosti, ki so vezane na zakonodajo, teritorialno območje in periodične dejavnosti (npr. cepljenje, preventivni pregledi ipd.), bi se izločile iz zdravstvenih domov in organizacijsko pridružile zavodom za zdravstveno varstvo. Ti bi se kadrovsko in prostorsko okrepili, da bi lahko zagotavljali izvajanje javnozdravstvene politike. Od številnih paradnih dejavnosti bi zdravstveni dom obdržal le tiste, ki jih nosilci zdravstvene dejavnosti lahko izvajajo integrirano, tj. ob rednih obiskih bolnikov, računajoč, da se vsak bolnik oglasi pri zdravniku vsaj enkrat v petih letih.
S tako reformo bi se Slovenija priključila številnim drugim državam, ki iščejo ustrezno primarno zdravstveno dejavnost, a doslej ne z najboljšimi rezultati. Ta

scenarij je najbolj verjeten, saj je že na pol poti uresničen.

Drugi scenarij

Po drugem scenariju bi obudili osnovne ideje, na katerih je bil zdravstveni dom zasnovan, in jih prilagodili modernim potrebam. Zdravstveni dom bi tako znova postal ekonomsko učinkovit socialnomedicinski center za krepitev zdravja. Ustanoviteljstvo bi prešlo z občin na državo. Zdravstveni domovi bi se ukvarjali z zagotavljanjem pogojev za čim boljše zdravje ljudi in vsako leto prijavljali nove in drugačne programe po načelih konkurence na razpise. Zdravstvene domove bi organizacijsko preoblikovali v obvladljive enote. Za nekatere ne bi bilo pomembno, ali je nosilec dejavnosti zasebnik ali uslužbenec. Poslovodenje zdravstvenega doma bi zaupali usposobljenim managerjem, ki bi bili interdisciplinarno usposobljeni: poleg poznavanja managerskih veščin obvezno tudi visoka profesionalnost na področju javnomedicinske znanosti. Direktorje in strokovne vodje bi imenovala centralna institucija in zaposleni ne bi imeli bistvene vloge pri soupravljanju, saj bi v vlogi javnih uslužbencev prvenstveno izpolnjevali cilje zdravstven politike. Zasebni izvajalci bi bili po teritorialnem načelu priključeni zdravstvenim domovom. Obdržali bi le delno samostojnost odločanja o obsegu dela, medtem ko bi jim bil program določen centralno. Izločili bi vso specialistično klinično dejavnost, ki ne sodi na primarno raven. Zdravstveni dom bi se glede kakovosti dela naslonil na osrednjo slovensko institucijo, ki bi integrirala javno zdravstvo in klinično medicino ter usmerjala dogajanje in vodenje posameznih zdravstvenih domov glede na lokalne potrebe in zmožnosti za kakovost primarnega zdravstvenega varstva.
Tak sistem bi predstavljal evolucijo Štamparjevih in Pirčevih idej in verjetno ni več izvedljiv.

Tretji scenarij

Po tretjem scenariju bi populacijski preventivni programi potekali kot ločena dejavnost s posebnim vabljenjem uporabnikov. Izvajanje teh dejavnosti bi prepustili centrom za izvajanje preventivne dejavnosti v okviru zavodov za zdravstveno varstvo, ki bi lahko imeli svoje izpostave v sedanjih zdravstvenih domovih in zdravstvenih postajah, kjer bi organizirali tudi laboratorije in fizioterapijo. Preostala kurativna dejavnost bi se izvajala v obliki zasebnega dela. Nosilci dejavnosti v obstoječih javnih zavodih bi se samostojno organizirali in prevzeli odgovornost za poslovanje v obliki novo nastalega zasebnega zavoda ali več posameznih zasebnih izvajalcev. V primeru skupinske prakse bi si zdravniki sami izbrali managerja, ki bi skrbel za vodenje po njihovem okusu. Sedanjo razdrobljeno zasebno dejavnost bi spodbudili k povezovanju s finančnimi spodbudami in predpisi. Vsak nosilec bi bil dolžan skrbeti za izbrano populacijo 24 ur na dan in bi se moral dogovoriti z izvajalci v svojem okolju za pokrivanje preko delovnega dneva in za sodelovanje v nočnem dežurstvu. Sredstva za dežurno službo bi se prerazporedila s sedanjih zdravstvenih domov na nosilce dejavnosti. Službo nujne medicinske pomoči, ki je prav tako nacionalnega interesa, pa bi lahko prevzela sekundarna raven, kot je to običaj drugje po svetu in se načrtuje tudi pri nas. Za razvoj in standarde bi skrbel inštitut za družinsko medicino na državni ravni.

Zaključek

Organiziranost osnovnega zdravstva ne more biti enaka po vsej državi. Delo zdravnikov v mestih je drugačno od tistega na podeželju, zato je drugačnemu slogu dela treba prilagoditi tudi organizacijo službe.
Zdravstveni dom ni skupek ambulant, ampak veliko več. Z združevanjem več služb na enem mestu, njihovim povezovanjem in populacijskim pristopom je sposoben ponuditi prebivalstvu izjemno visoko raven zdravstvenega varstva. Ideološki pozivi k temu, da ga je treba ohraniti, so smiselni, vendar je ohranitev možna le, če se bo zdravstveni dom prilagodil izzivom moderne dobe in izkoristil svoje prednosti pred ostalimi oblikami organiziranja (29, 30). Vztrajanje le na obrambi zgodovinsko pridobljenih privilegijev je zanesljiv pogoj za njegov zaton.

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Literatura

1. Starfield B. Is primary care essential? Lancet 1994; 344: 1129-33.
2. Family practice development strategies. First meeting of an expert network. 1-12. 1995. Copenhagen, WHO.
3. Second meeting of the St. Petersburg initiative for education in general practice and family medicine. 1-14. 1998. Copenhagen, WHO.
4. Third meeting of the St. Petersburg initiative for education and training in general practice/family medicine. 1-20. 2000. Copenhagen, WHO.
5. Fifth meeting of the expert network on family medicine development strategies. 1-13. 2000. Copengahen, WHO.
6. Boelen C, Haq C, Hunt V, Rivo M, Shahady E. Improving health systems: the contribution of family medicine. Singapore: WONCA, 2002.
7. Donaldson MS,.Vanselow NA. The nature of primary care. The Journal of Family Practice 1996; 42: 113-6.
8. Fry, J. What is general practice and primary health care? 1988.
9. Borovečki A, Belicza B, Orešković S. 75th anniversary of Andrija Štampar School of Public Health - What can we learn from our past for our future? Croatian Medical Journal 2002; 43: 371-3.
10. Pirc I. Zdravje v Sloveniji. II. Knjiga. Zdravstvene prilike in delo higijenskih ustanov v Sloveniji 1922-1936. Ljubljana: Higijenski zavod Ljubljana, 1938.
11. Urlep F. Razvoj osnovnega zdravstve v Sloveniji zadnjih 130 let. In Švab I, Rotar Pavlič D, eds. Družinska medicina, pp 18-27. Ljubljana: Združenje zdravnikov družinske medicine SZD, 2002.
12. Košir T. 50 let zdravstvenega doma Škofja Loka. Škofja Loka: Zdravstveni dom Škofja Loka, 2004.
13. Markota M, Švab I, Sarazin Klemencic K, Albreht T. Slovenian experience on Health care reform. Croatian Medical Journal 1999; 40: 190-4.
14. Rauber Z. Privatizacija zdravstva. Isis 2005; 14: 41-2.
15. Bigec M. Celostni pogled na zdravstveno oskrbo otroka. Isis 2005; 14: 114-5.
16. Albreht T, Pečar-Čad S. Poraba zdravil v Sloveniji – socialnomedicinski in socialnofarmacevtski vidik. Zdrav Vestn 2000; 69: I-1-I-4.
17. Bagari N. Recepti v Sloveniji v letu 1999. Racionalna farmakoterapija 2000; 9: 8-16.
18. Furst J,.Samaluk V. Predpisovanje protivnetnih in protibolečinskih zdravil v Sloveniji v letu 1999. Racionalna farmakoterapija 2000; 9: 20-2.
19. Pečar-Čad S,.Oražem A. Ambulantno predpisovanje zdravil v Sloveniji v letu 1998. Bilten ekonomika organizacija in informatika v zdravstvu 1999; 15: 214-8.
20. Royal ST,. Avery AJ. Containing prescribing costs - consider the whole picture and not just the short-term savings. Eur J Gen Pract 2001; 7: 87-9.
21. Allen J, Gay B, Heyrman J, Švab I, Ram P. Evropska definicija družinske medicine. Ljubljana: Združenje zdravnikov družinske medicine, 2004.
22. Allen J, Gay B, Crebolder HFJM, Heyrman J, Švab I, Ram P. The European definitions of the key features of the discipline of general practice: the role of the GP and core competencies. British Journal of General Practice 2002; 52: 526-7.
23. Wright A. People with lon-term mental illness: making shared care work. British Journal of General Practice 1995; 45: 338-9.
24. Kancler K. Dispanzer za otroke danes. Zdrav Var 1994; 33: 149-50.
25. Petrič D. Izbrani osebni zdravniki ali dirigirani zdravniki za otroke? Isis 1995; 4: 41-5.
26. Pretnar Darovec A. Odprto pismo predsedniku Zdravniške zbornice, ministru za zdravje in članom RSK za ginekologijo in porodništvo. Isis 2005; 14: 40.
27. Sušnik J. Ali družinski zdravnik izpodriva zdravnika medicine dela? (Purgatorij medicine dela). Zdrav Var 1994; 33: 151-2.
28. Švab I,.Bulc M. Academic medicine: What does an outsider have to offer? Croatian Medical Journal 2004; 45: 254-5.
29. Švab I. Zdravstveni dom. In Premik M, ed. Primarno zdravstveno varstvo, pp 37-41. Ljubljana: Medicinska fakulteta, Institut za socialno medicino, 1995.
30. Klančar D. Vizija razvoja zdravstvenega doma Cerknica – Loška dolina. Bilten ekonomika organizacija in informatika v zdravstvu 2000; 16: 58-68.

HEALTH CENTRE: A RELICT FROM THE PAST OR A VISION OF THE FUTURE

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Editorial

Background

Despite many declarations and numerous studies stressing the important role played by health centres (1-8), primary health care remains the stepchild of all health policies. In Slovenia, primary health services are mostly delivered in health centres. Primary health care structure has remained unchanged for many years, although the rationality of the concept has been occasionally questioned. Yet, its critics have become increasingly outspoken, and new ideas and organizational concepts have emerged recently.

History

Social processes and the development of medical science in the first half of the 20th century had a strong impact on social medicine. Social conditions after World War I called for health system reforms. Health planning guided by socio-medical principles became the *sine qua non*. These new approaches were pioneered by Andrija Štampar (9) in Yugoslavia, and by Ivo Pirc in Slovenia. The basic concepts introduced by Andrija Štampar were widely adopted, and served as the foundation for the development of health sector during and after the war.

As a result, first health centres began to be set up; priority was given to the treatment of at-risk population groups and some diseases. Numerous advantages of this organizational approach became apparent very soon: vaccination coverage of the population increased, child mortality rates dropped, and the socio-medical element of health policy further gained in importance (10). Thanks to these results, which were obtained with funds that were much smaller than those allocated for health by economically developed countries, the concept of health centre emerged as one of the most innovative ideas, and one of the great achievements of the health system of that time. Health centre managed to meet health needs of the population, and ensured equity of access to health services. In addition, it was economically effective and enhanced the implementation of national public health policy. Health centres used public health dispensary methods of work and team approach -two concepts modern at that time-, and played an important role in the academic public health sphere.

The programme of setting up health centres was pioneered by motivated private doctors, who were highly aware of the demands of health care They chose to work in compliance with the set public health guidelines and adapted their practices accordingly, occasionally with the support provided by the state. The number of such doctors was very small at that time.

Principles of health centres eighty years later

After World War II, primary health care in Slovenia underwent many changes, one of them being the systematic setting up of health centres according to the population principle. The »heroic« post-war period witnessed the construction of probably the largest primary health care facilities in Europe. These were proud to employ the first physicians qualified in Slovenia, including the first specialists in general practice. Yet, after 1969 a formalistic and bureaucratic approach to the management of these institutions led to increasing apathy on the part of health professionals. The self-management system was unable to cope with the arising problems (11–13). A serious crisis which arose in the ensuing period brought along a number of difficulties that affect the functioning of today's health centres (14, 15). Question arises as to whether and to what extent the principles of the original health centres have endured the test of time.

Health centre responds to the population health needs

Primary health care of today is confronted with problems that differ considerably from those that were tackled and, to a great extent, solved by the first health centres. Yet, with the exception of preventive health programmes for adults, initiated recently, the

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priorities of preventive health services in health centres have remained virtually unchanged from eighty years ago. The concern that the abandoning of some well-established programmes would lead to re-emergence of problems known several decades ago is perfectly understandable; it is less easy to understand, however, why new programmes are being adopted so slowly. The provision of certain services for the community was transferred to other organizations, and only few attempts have been made to re-integrate these services within health centres. This situation is reflected in the current payment system, which encourages the perpetuation of old programmes and offers health centres no opportunity to face new challenges.

Health centre strives to achieve economic efficiency and work quality

Along with changes in health care system, priorities have shifted towards an increasing emphasis on economic efficiency. In recent years, the national health care system has been confronted with growing expenses for drugs (16–19) ·which are mostly prescribed by primary health physicians. Another topical issue is judicious use of diagnostic tests, material costs, and ambulance services, and rational referral of patients to secondary level of health service. Yet, health care service knows no redundancies or bankruptcy, which clearly suggests that the financial burden is shouldered by some other sectors.
Health centres do not ensure high professional quality and economic efficiency of primary -level health services. Despite a formally positive balance in primary health care, service providers are not sufficiently stimulated to improve their performance. Taking appropriate action on the results of quality assurance procedures and peer review is the exception rather than the rule. This task was handed over to a few motivated individuals, and does not form part of systematic quality improvement strategies. There are hardly any tools available to the health centre management to motivate physicians to strive to improve their performance. The mentoring and counselling system (20), which has been widely recognized and well-established abroad, has not yet been introduced in Slovenia, neither have the adopted systemic solutions been implemented. A characteristic example is that of electronic medical records system which , despite a decade's efforts, has not yet been introduced into practice.

Health centre offers dispensary services

The use of te so-called dispensary method is characteristic of high quality primary-level health care. In Slovenia, this organization category is not an element of regular health service provision but rather represents preventive programmes intended for high-risk population groups and diseases. It has not yet been made clear enough that this method, which has remained unchanged for eighty years, is applicable to both curative and preventive health programmes. Informational coverage of some recent community primary health care programmes (immunization, ZORA programme) has been provided by other services, and health centre has been gradually losing rationale for the existence.
Family medicine claims that the dispensary method should be updated and introduced in all outpatient clinics (21, 22), which means that a computerized population-based approach to health should be adopted by all physicians and health centres in the country. There should follow the establishment of a financing model and definition of standards. The need for dispensaries as special organizational units would thereby be obviated.

Health centre enhances team work

The idea behind the accommodation of several different services under one roof was to enhance the interaction between teams, which is essential to quality performance (23). This multidisciplinary approach has not always met expectations in practice. Today's health centres no longer respond to the population health problems. There is a strong need to scrutinize current health centres' programmes, to attract health care providers that furnish services outside health centres and to change, accordingly, the organizational structure of health centres.

Health centre ensures equity in access to health services

Access to appropriate health care is a basic human right. Society and its health care services should therefore give special attention to at-risk and vulnerable population groups. Standard risk groups have been recently joined by other specific groups, including the elderly in need of home care, migrants, ethnic minorities, the uninsured and chronic psychiatric patients. The number of people coming from different backgrounds, both geographical and cultural, will be increasing in the future.

Specific needs of these at-risk populations are not met appropriately, neither by health centres nor by the national health system. As a result the provision of health care for these groups has become a domain of other sectors, e.g. social services, or humanitarian agencies.

Health centre is involved in implementation of public health policy

Management of health centres is one of the key public health functions in the country. Specialist training in general medicine was originally devised for directors of health centres with the aim to equip them with the knowledge necessary for the implementation of the adopted public health policies. In recent years, increasing emphasis has been placed on management skills, and directors of health centres spend a large portion of time on managerial tasks.
Because of modifications of the specialist training programme, primary health physicians will not acquire adequate knowledge in public health. The responsibility for the development of primary health care was transferred to individuals at the commune level. Considering the lack of knowledge at the local level, this decision seems to be very inconsiderate. Attempts to assess health status of the population met with success only in large centres, and with financial support provided by local communities. Because of poor knowledge of strategic planning in health care, policy-makers at the national level are not aware of the important role of primary health services.
Although public health policy is formally implementable in health centres, performing this task fas become the domain of national and regional institutes of public health. The agreement between health centres and the national health insurance institute, which pursues mostly its economic interests, has become the mainstay of activities carried out in health centres. In the 21st century, services which have been provided jointly by health centres and public health institutions will most probably be taken over by public health service, which promises to become independent and much stronger in terms of technology and staffing.
The division of health centres into services led to organizational fragmentation, and because of newly established services, units and activities, the organizational structure of large health centres became unclear. Differences in working conditions and standards caused envy and conflicts, and instead of talking about primary health care we prefer to discuss the crisis in paediatrics, school medicine, occupational medicine and district nursing (15, 24-27).

Although services offered in health centres can be provided by a multidisciplinary team, team collaboration is hindered by organizational disintegration and bureaucratic obstacles.

Health centre enhances academic progress and professional development

Because quality primary health care stimulates professional development through research and teaching (28), health centres have an important advantage over individual physicians' surgeries. Specialist training is formally provided through the mentor system, which was established after lengthy negotiations between the Medical Chamber of Slovenia and health care institutions. Most health centres are not registered as research groups, and work of the registered ones is of poor quality. The number of teaching staff and researchers employed by health centres is very small, and as a rule, their academic work in the centre is not remunerated.
Health centres in Slovenia encourage academic progress in medical profession to some extent. Collaboration between health centres and academic institutions is poorly developed, mostly because of weak links between the two.

Possible scenarios

Considering the present situation in Slovenia, there are three most likely scenarios for the development of primary-level health care in the future.

Scenario 1

Public health services delivered at the health centre level have been declared dead long ago, and will never be brought back to life. Health centre has been recognized as a conglomerate and a handy form of non-profit organization, which provides a broad spectrum of health care services, and, relatively humanely, employs health professionals unwilling to run their own centre or business. According to this scenario, the existence of public health centre is purely arbitrary. The principles of market economy can therefore be applied to this institution, and it should therefore enter the competition between the private and public health care sectors. Health centres will be reformed, and their activities will be reorganized and divided into two groups: a group of sociomedical, infection control and epidemiologic services, which will remain in the hands of state

institutions, and other activities which will be carried out by other services. The provision of statutorily regulated services, delivered locally and periodically, such as vaccinations and preventive medical examinations, will no longer be in the domain of health centres, but will be transferred to institutes of public health. To be able to implement the set public health policies, these institutions will increase their capacities with additional staff and facilities. Health centres will keep only activities delivered in an integrated manner, i.e. for patients attending regularly, at least once every five years.
Through this reform Slovenia will become one of many countries seeking an appropriate model of primary health care, which, unfortunatelly, has not yet been found. This is the most likely scenario because Slovenia is already half-way to this goal.

Scenario 2

According to this scenario, the original concepts that served as a basis for the setting up of health centres, will be resuscitated, and adapted to fit the needs of modern health care service. Health centres will become again economically efficient, health promoting sociomedical institutions, founded by the state and no longer by the communes.
Health centres will be committed to providing living and working conditions conducive to health of the population. Every year they will prepare new programmes of activities and submit them to be adopted according to the principles of open competition. Health centres will be reorganized into more manageable units, run either privately or publicly. These will be managed by multidisciplinarily trained professionals with excellent management skills and high level of competency in public health science. Directors and managing staff will be appointed by a central institution. The employees will thus have very little say in the running of their health centre; their main role as public health providers will be to fulfill the goals set by health policy. Private health care providers will be affiliated with health centres according to a territorial principle. They will retain some power to make decisions regarding the scope of work, yet the programme will be created centrally. Specialist clinical services outside the scope of primary health care will be excluded from the programme. Health centres will be offered support by a central national institution responsible for integration of public health and clinical medicine, and for running individual health centres with regard to local needs and capacities in order to establish high quality primary health care.
This system, concieved as an evolution of concepts put forward by Dr Štampar and Dr Pirc, seems to be no longer feasible.

Scenario 3

According to this scenario, population-based preventive programmes will be implemented as separate programmes on the basis of inviting consumer participation. These programmes will be located in prevention centres operating within public health institutions, as well as in their detached units accommodated in the present health centres and health stations, where laboratory and physiotherapeutic services may be founded. Other therapeutic services will be provided on a private basis. Health care providers in the present public health institutions will assume responsibility for the independent organization and management of the newly established private institution or a group of private health care providers. Group practice physicians will appoint their own manager to run the institution in accordance with their wishes. Cohesion of the fragmentated private health care will be encouraged by financial stimulation and new regulations. Every physician will be obliged to deliver health care for the selected population around the clock, and will have to make arrangements for the provision of out-of-hours services and participation in night shifts with other local health care providers. Financing of on-duty services will be transferred from health centres to health care providers. Provision of emergency medical care, which is an area of special national interest, may be transferred to the secondary level of health care. This concept has already been adopted in other countries and is about to be introduced into the Slovene health care system. A family medicine institute at the national level will be responsible for the development and observance of standards.

Conclusion

Organizational structure of primary health care in Slovenia varies from one region to another. Since physician's work in urban settings differs from health care services provided in rural areas, organization of health service has to be tailored to different work styles.
Health centre is not just a random group of clinics, but an institution which, by making different health care services available in one place and by using a population-based approach, can offer very high standard

of care for their patients. There is a rationale to the ideological campaign for the preservation of health centres, yet to achieve this goal health centre has to be changed and adapted to satisfy the requirements of modern health care system, and to make full use of the advantageous position it holds in comparison to other organizational forms (29, 30). Insisting on the defense of privileges granted in the past leads to its definitive collapse.

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Reference

1. Starfield B. Is primary care essential? Lancet 1994; 344: 1129-33.
2. Family practice development strategies. First meeting of an expert network. 1-12. 1995. Copenhagen, WHO.
3. Second meeting of the St. Petersburg initiative for education in general practice and family medicine. 1-14. 1998. Copenhagen, WHO.
4. Third meeting of the St. Petersburg initiative for education and training in general practice/family medicine. 1-20. 2000. Copenhagen, WHO.
5. Fifth meeting of the expert network on family medicine development strategies. 1-13. 2000. Copengahen, WHO.
6. Boelen C, Haq C, Hunt V, Rivo M, Shahady E. Improving health systems: the contribution of family medicine. Singapore: WONCA, 2002.
7. Donaldson MS,.Vanselow NA. The nature of primary care. The Journal of Family Practice 1996; 42: 113-6.
8. Fry, J. What is general practice and primary health care? 1988.
9. Borovečki A, Belicza B, Orešković S. 75th anniversary of Andrija Štampar School of Public Health - What can we learn from our past for our future? Croatian Medical Journal 2002; 43: 371-3.
10. Pirc I. Zdravje v Sloveniji. II. Knjiga. Zdravstvene prilike in delo higijenskih ustanov v Sloveniji 1922-1936. Ljubljana: Higijenski zavod Ljubljana, 1938.
11. Urlep F. Razvoj osnovnega zdravstve v Sloveniji zadnjih 130 let. In Švab I, Rotar Pavlič D, eds. Družinska medicina, pp 18-27. Ljubljana: Združenje zdravnikov družinske medicine SZD, 2002.
12. Košir T. 50 let zdravstvenega doma Škofja Loka. Škofja Loka: Zdravstveni dom Škofja Loka, 2004.
13. Markota M, Švab I, Sarazin Klemencic K, Albreht T. Slovenian experience on Health care reform. Croatian Medical Journal 1999; 40: 190-4.
14. Rauber Z. Privatizacija zdravstva. Isis 2005; 14: 41-2.
15. Bigec M. Celostni pogled na zdravstveno oskrbo otroka. Isis 2005; 14: 114-5.
16. Albreht T, Pečar-Čad S. Poraba zdravil v Sloveniji - socialnomedicinski in socialnofarmacevtski vidik. Zdrav Vestn 2000; 69:I-1-I-4.
17. Bagari N. Recepti v Sloveniji v letu 1999. Racionalna farmakoterapija 2000; 9: 8-16.
18. Furst J, Samaluk V. Predpisovanje protivnetnih in protibolečinskih zdravil v Sloveniji v letu 1999. Racionalna farmakoterapija 2000; 9: 20-2.
19. Pečar-Čad S, Oražem A. Ambulantno predpisovanje zdravil v Sloveniji v letu 1998. Bilten ekonomika organizacija in informatika v zdravstvu 1999; 15: 214-8.
20. Royal ST, Avery AJ. Containing prescribing costs – consider the whole picture and not just the short-term savings. Eur J Gen Pract 2001; 7: 87-9.
21. Allen J, Gay B, Heyrman J, Švab I, Ram P. Evropska definicija družinske medicine. Ljubljana: Združenje zdravnikov družinske medicine, 2004.
22. Allen J, Gay B, Crebolder HFJM, Heyrman J, Švab I, Ram P. The European definitions of the key features of the discipline of general practice: the role of the GP and core competencies. British Journal of General Practice 2002; 52: 526-7.
23. Wright A. People with lon-term mental illness: making shared care work. British Journal of General Practice 1995; 45: 338-9.
24. Kancler K. Dispanzer za otroke danes. Zdrav Var 1994; 33: 149-50.
25. Petrič D. Izbrani osebni zdravniki ali dirigirani zdravniki za otroke? Isis 1995; 4: 41-5.
26. Pretnar Darovec A. Odprto pismo predsedniku Zdravniške zbornice, ministru za zdravje in članom RSK za ginekologijo in porodništvo. Isis 2005; 14: 40.
27. Sušnik J. Ali družinski zdravnik izpodriva zdravnika medicine dela? (Purgatorij medicine dela). Zdrav Var 1994; 33: 151-2.
28. Švab I., Bulc M. Academic medicine: What does an outsider have to offer? Croatian Medical Journal 2004; 45:254-5.
29. Švab I. Zdravstveni dom. In Premik M, ed. Primarno zdravstveno varstvo, pp 37-41. Ljubljana: Medicinska fakulteta, Institut za socialno medicino, 1995.
30. Klančar D. Vizija razvoja zdravstvenega doma Cerknica – Loška dolina. Bilten ekonomika organizacija in informatika v zdravstvu 2000; 16: 58-68.