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GUEST EDITORIAL

General Practice East of Eden: an Overview of General Practice in Eastern Europe

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Aim. To review the status of family medicine in Eastern European countries, specifically the position of the discipline within the health care system, its academic status, and expected trends in the development of the discipline.

Methods. We used available data in the literature and information gathered from personal contacts with members of European Society of General Practice/Family Medicine (ESGP/FM) expert groups, European Academy of Teachers in General Practice (EURACT), and European General Practice Research Network (EGPRN). Personal interviews with key informants from countries that do not have members in these organizations were used. We also performed a Medline search using terms "primary health care" and "family medicine".

Results. It was difficult to get standardized information about the issues addressed. In some countries, contact persons and articles were impossible to find. Because of that, information from some countries is lacking (e.g. Belarus, Ukraine, the Kavkaz states and Central Asian republics). The information from the 14 countries showed that family medicine was formally widely recognized as a specific discipline. In 13 of them, there were some programs of vocational training. In 10 countries, academic recognition has resulted in rapid development in the past two decades, especially after 1989, but in Bulgaria and Moldova we found no evidence of family medicine departments.

Conclusion. The position of general practice in most Central and Eastern European countries is formally adequate, but a lot of effort will still be needed to achieve the desired level of its recognition and quality.

Key words: *delivery of health care; Europe, Eastern; family practice; health policy; primary health care; Turkey*

Europe is characterized by diversity in all areas of society. One of the areas of diversity is the way health care is delivered. There is a powerful movement towards integration in the European Union (EU) and the countries which want to join it. The process is pushing the systems closer in many areas, including health care. But the countries that do not belong to the European Union lack this kind of overall trend towards integration. On the other hand, these countries comprise a bigger population and land area than EU member nations, especially if Europe is defined according to the World Health Organization (WHO) criteria (1,2).

Family medicine has for a very long time been recognized as the key element of a good health care system. This importance is stressed in many declarations, policy papers, and research articles. The countries of Central and Eastern Europe have made significant changes to their health care systems in the last twenty years and have invariably declared family medicine a cornerstone of their new policies. The question remains whether family medicine in these countries has been able to meet the challenges put forward by policymakers and was provided with sufficient resources to meet these challenges. This phenomenon occurred in many countries, but especially in Russia. There are many declarations concerning the importance of family medicine, yet the actual results indicate that family medicine is largely ignored (3-5). Anecdotal information about the actual position of family medicine in these countries gives rise to speculations about large differences.

Family medicine is largely influenced by the context in which it is practiced (6). The issues that are of great relevance to a British general practitioner are not at all relevant to a physician working in Bosnia and Herzegovina. Although the principles are the same, the issues may be tremendously different (7). Countries that want to change their health care systems by raising the importance of primary health care need to take into consideration the actual situation in the country and its potential to carry out the necessary tasks.

The European Society of General Practice/Family Medicine (ESGP/FM) clearly identified the area of Central and Eastern Europe as a priority for the development of the discipline. Although the society represents the biggest and strongest region within the world organization, all of the European countries are

still not members, and some of the members are in great need of support. As part of this strategy, the ESGP/FM executive board has deliberately located its meetings in countries of Central and Eastern Europe (e.g. Sarajevo, Belgrade, Ankara) in order to support the development of the discipline in these countries and to gain clearer information about the actual position of general practice.

Three sets of issues invariably come under consideration when the position of family medicine is discussed:

1) the position of the discipline within the health care system (whether family medicine is officially recognized as a separate discipline with distinct training and a professional society);

2) the academic status of the discipline (the position of family medicine within the universities); and

3) what the existing plans are for the development of family medicine in the future.

The impression from informal contacts is that many very interesting activities are going on in these countries and some of them are of a clear benefit to the development of the discipline. Yet such informal information is hardly adequate to assess the situation of family medicine in a country in order to make policy decisions. Other sources of information would be useful, but there is a lack of good quality comparable data and good quality published papers in this area.

In order to get a clearer picture of the position of family medicine in the countries of Central and Eastern Europe and to create a basis for a clearer policy in this exciting region, an attempt was made to provide an overview of the situation in these countries by focusing on these three issues. This overview is based on the information from resource persons within the society and readily available published information.

Methods

In order to gather the information, we first approached resource persons from two European network organizations that represent their country in either the European Academy of Teachers in General Practice (EURACT) or the European General Practice Research Network (EGPRN). This approach was used for Estonia, Lithuania, Poland, Czech Republic, Romania, Slovakia, and Turkey. The second source of information was used for countries that have no representatives in the European network organizations of general practice (Latvia, Russia, Moldova). In these cases an expert who is running family medicine development programs in these countries (PV) was used as a resource person and co-author of this article. The third source of information were field visits and contacts with local family physicians and representatives of family medicine organizations. This approach was used for Slovenia, Croatia, Bosnia and Herzegovina, Serbia and Montenegro, and Turkey. A semi-structured interview was conducted with each of them, addressing all three issues. In addition, respondents were asked to provide written information about the most relevant issues in family medicine in the countries they were interviewed about.

As a validation, supplemental information about the situation in the countries was sought from other sources. Most of this additional information was obtained by a Medline search of literature describing the development of family medicine in these countries. In the search, the following descriptors and their combinations were used: Primary Health Care; Family Practice; Europe, Eastern; Baltic States; Bosnia-Herzegovina; Croatia; Czech Republic; Estonia; Latvia; Lithuania; Moldova; Poland; Romania; Russia; Slovenia; Slovakia; Turkey; and Yugoslavia. Additional information about these issues was also sought by a simple general Internet search using the same descriptors. The analysis yielded 18 articles when combining the term "family medicine" with the name of a specific country and 57 articles when combining the term "primary health care" with the name of the country. In cases of Czech Republic, Latvia, Lithuania, Moldova, and Slovakia, no articles were found.

Results

Position of Discipline within Health Care System

The position of family medicine in these countries is strongly influenced by the health care systems that have existed in the past (Table 1). Two main systems can be identified, whose legacy has influenced the position of the discipline. Countries that were part of the former USSR (Russia, Estonia, Latvia, Lithuania, Belarus, Moldova, Ukraine, Georgia, Armenia, Azerbaijan, Kazakhstan, Turkmenistan, Uzbekistan, Tajikistan, and Kyrgyzstan) and its satellites (Poland, Czech Republic, Slovakia, Hungary, Bulgaria, and Romania) have had the Shemasko system of health care, based on a system of specialist policlinics. Family medicine was often not officially recognized or promoted, because it was believed that good quality health care could only be delivered by specialists. In addition, basic medical education led to a specialist level degree, and no real generalists existed. In contrast, the countries of former Yugoslavia have had a firmly established position of family medicine, which was (at least formally) considered to be a specialty equal to others. The Yugoslav system also included vocational training for general practice, which was introduced in 1961, although it was not obligatory. The other important reason for the much better position of the discipline within the health care system was the Andrija Štampar School of Public Health, which was a center of expertise and training in this area and the collaborative center for the WHO in primary care (8).

The other factor that has strongly influenced the current position of family medicine was the motivation of policymakers to make changes in society that would demonstrate the shift away from the old systems. In the countries that had a Shemashko system of health care, this motivation was especially strong, as in Estonia (9) and to a lesser extent, Latvia and Lithuania (10). In these countries, most of general practice service was performed by therapists, who are doctors, working in primary care, not specifically educated to be general practitioners. They mostly do not take care of women and children or perform surgical procedures. This practically meant that their main work was largely administrative. The introduction of a new health care system, based on family medicine, was recognized as a priority of health care policymakers and has received strong support from the government, enabling the retraining of therapists into family physicians.

Other countries have been more careful in introducing changes, shifting from the old policlinic system to a new one much more gradually. Some countries made formal changes to their health care system in the past, but have started to introduce change recently (e.g. Bulgaria), while in others there is no indi-

Table 1. Overview of information about the development of family medicine in selected countries. Countries are listed in alphabetic order according to 3 areas of interest: position of family medicine within the health care system, academic status of the discipline, and future trends*

Country	Position within the system	Academic status	Trends and comments
Bulgaria	FM officially recognized ESGP/FM member vocational training exists	no departments	slow development
Bosnia and Herzegovina	FM officially recognized ESGP/FM member vocational training exists	departments exist	external support ending
Croatia	FM officially recognized ESGP/FM member vocational training reestablished after a period of stagnation	departments exist	leading country in FM development in former Yugoslavia
Czech Republic	FM officially recognized ESGP/FM member vocational training exists	departments exist	
Estonia	FM officially recognized ESGP/FM member vocational training exists	departments exist	successful cooperation with Finland
Latvia	FM officially recognized ESGP/FM member vocational training exists	no department	some academic development
Lithuania	FM officially recognized ESGP/FM member vocational training exists	department exists	retraining in progress
Moldova	FM not yet recognized not a member of ESGP/FM no vocational training	no departments	no real development
Poland	FM officially recognized ESGP/FM member vocational training exists	departments exist	many EU-funded programs
Romania	FM officially recognized ESGP/FM member vocational training exists	departments exist	cooperation with The Netherlands
Russia	FM officially recognized not a member of ESGP/FM program of vocational training exists	departments exist	implementation of vocational training not yet properly organized, many programs, great need
Serbia and Montenegro	FM officially recognized applied for membership of ESGP/FM vocational training exist	departments exist	period of a long isolation
Slovenia	FM officially recognized ESGP/FM member vocational training exists	departments exist	
Turkey	FM officially recognized ESGP/FM member vocational training exists	departments exist	

*Abbreviations: FM – Family medicine; ESGP/FM – European Society of General Practice/Family Medicine.

cation that the situation is likely to change in the near future (e.g. Moldova). In Russia, the concept of family medicine was introduced in 1992 by a federal order. Due to problems in its implementation, a new law was passed in 2002 to ratify an official position for family medicine among the medical disciplines and also to define responsibilities of family doctors and nurses in addition to the equipment needed. The big drop-out rate from the profession (according to estimates, only 20-30% of trained and retrained family doctors practice their profession, often because of poor salary) and not enough family doctors' posts are impeding implementation.

Enthusiasm for change also varied greatly among the countries of former Yugoslavia. Some, like Slovenia, have opted for a slow transition from a previous health care system to a new one, and have introduced changes gradually, without abandoning the system of existing health centers. On the other hand, others have experienced dramatic changes. Bosnia and Herzegovina has been faced with the destruction of the entire health care system and has experimented with various models, based on foreign help. The most successful aid program in this country was based on the premise that family medicine has to be introduced from scratch, and that the previous system is of no use. Serbia and Montenegro, however, have not implemented any changes in the system, and have started to consider the possibility only recently.

Turkey has a health care system which does not resemble the ones mentioned above. Currently, primary health care is largely provided by therapists on the primary level, but family medicine as a specialty is recognized and there are plans for its implementation on a larger scale.

Teamwork is one of the important characteristics of family doctors' work, and nurses are supposed to be important team members. The position of nurses and the availability of family and public health nurses' services differ considerably among these countries. In Russia, nurses have not been officially considered as health professionals and understandably this makes team work difficult. The new federal order, issued in 2002, will probably change the situa-

tion for the better. In Baltic countries, the conditions for family doctors' nurses are variable: in Estonia, the family doctor is responsible for providing nurses services within his/her office region. In Latvia, authorities supervise and pay for nurses' services in the rural areas, but not in the cities. The situation in former Yugoslavia was very different, since nurses were always considered as an integral part of the family medicine team, and were hired and paid by the health centers, just like doctors.

Academic Status of Discipline

The key indicator of the academic status of the discipline is its position within the university. The Shemashko system did not recognize family medicine as an academic discipline; therefore no departments of family medicine existed. The transition of systems in the 1990's was marked by a rapid growth of departments of family medicine. Quite often the heads of departments were not family physicians by training, but rather other clinical specialists who had fulfilled the academic criteria for the position. Again, the Baltic States, especially Estonia, were very successful in establishing the position of family medicine within the university. Successes in establishing departments of family medicine were also reported in Lithuania, Poland (11), Romania (12), Hungary, Czech Republic, and Slovakia. Their role and position seems variable. Some are independent, with a strong contribution to the university (e.g. Tartu, Krakow), while some still struggle for proper recognition. On the other hand, there are still countries (e.g. Moldova) that have no departments or teaching of family medicine at the university level. In northwest Russia, there are several recently established departments of family medicine at the university level. Undergraduate level teaching will be provided mainly through optional courses, but postgraduate training has a more formal position within the federally defined curricula (13,14).

The countries of former Yugoslavia, on the other hand, have traditionally had departments of general practice, mainly due to the Andrija Štampar School of Public Health, which was the center of academic development in this region. The department of general practice in Zagreb has existed since 1974 and was involved in undergraduate and postgraduate education. Departments in Rijeka, Osijek, and Split have also been founded in Croatia. General practice was also taught in Belgrade on the postgraduate level. The isolation of Serbia was one of the reasons why the academic development in this country was halted and now faces serious problems due to lack of young experts. The department in Ljubljana, Slovenia, was established in 1995 and has become a major player in the development of the discipline. In Bosnia and Herzegovina, the departments were created as a part of the development of family medicine programs after the war (15).

Reports from Turkey indicate very strong development of the academic position of family medicine, with departments being rapidly established throughout the country (16).

Future Trends

The expected overall trends in family medicine development are positive. All the respondents were positive about the future position of the discipline and its academic development, which seems rather rapid. Nevertheless, some threats were also identified. One of the main threats in the development of family medicine is the political will of policymakers to continue current development programs. Political instability in some of the countries, leading to changes in government policies is also an important issue. Bosnia and Herzegovina, which has relied heavily on support from external sources, is faced with the problem of developing the discipline further while the externally funded projects are ending and the agencies that have supported the development of family medicine are moving to other places. Rapid changes are anticipated in Serbia and Montenegro which are now being introduced to international cooperation after a rather long period of isolation.

The assessment of the challenges facing family medicine in Lithuania seems applicable to the whole region:1) to make all graduate family doctors practice as family doctors, 2) to regard prevention as more important than problem solving, 3) to make family doctors provide the full scope of services, and 4) to create incentives to deliver high quality and comprehensive services using team approach.

Discussion

As in any survey, the validity of our information is of key importance. Because of the nature of our information gathering, bias by informants could be problematic. We have tried to minimize this risk. We have been very careful in trying to select the appropriate informants and decided that the EURACT council members who represent family medicine teachers from every country should have the best insight into the academic position of family medicine in these countries. Although in most cases we had only one informant, we tried to validate the information and to support it with information from other sources: e.g. the Internet and published articles. A Medline search proved a good method of validating information, especially for Estonia, Poland, Croatia, and Bosnia and Herzegovina. However, we were not successful in obtaining informants from some countries of interest (e.g. Belarus, Ukraine, the Kavkaz states, and the Central Asian republics). This clearly limits the scope of this paper, but a comprehensive overview of the situation was never our aim.

We have managed to identify some important and relevant dilemmas.

Relation to Heritage

Primary health care is provided in every health care system, still it differs in the way in which it is provided. The functions of family medicine can be, ideally, performed by well trained family physicians or, in a less favorable situation, by other therapists that do not have adequate knowledge of the discipline and gain some of this knowledge intuitively by working in practice. It seems interesting that our informants often

expressed the view that family medicine did not previously exist in the countries that have been successful in its radical introduction. It seems that the role of former district therapists did not fulfill even the basic requirements of family medicine and that they are now very aware of progress made in recent years. The need to start from the beginning and to reject everything that existed before the reform was most often mentioned in relation to existing therapists, especially in the countries of the post-Shemashko systems. Powerful motivation to give up the Shemashko system has also had less beneficial by-products, e.g. many preventive services were withdrawn for a long time. Nursing as a profession also partly disappeared, and efforts have been put into re-establishing the system. This was probably an indication that the system was not providing adequate results and services. Still there are problems in implementing the family doctor-based health care e.g. in providing adequate posts and resources for family doctors (Moldova, Russia).

The relation to heritage is more complex in the countries of former Yugoslavia (17-19). Although the health care systems at the beginning were almost the same, the approach to change was different. Some have kept the system unchanged, some have made modifications, while the others have totally abandoned it. This probably reflects the quality that the previous system has achieved in the various countries. A similar dilemma is seen in Turkey, where academic family physicians have problems in establishing dialogue with existing therapists, who have a genuine need to further develop their discipline but do not have enough formal training. Cooperation of both groups of therapists would generally be recommended, since it could create a synergy. But, on the other hand, it can also be a cause of problems and may put a stop to the further development of family medicine, and result in the duplication of general practice societies and their unnecessary competition.

In former Yugoslavia, a further dilemma exists, which relates to the former specialization of general practice. Since almost all of the countries have decided to start a new specialty of family medicine, three groups of general practitioners now exist: untrained general practitioners, trained "specialists in general practice" and new "specialists in family medicine." In some countries, family medicine is recognized as a continuum of the previous specialty of general practice (Slovenia), whereas in others (e.g. Bosnia and Herzegovina), it is considered as being completely different and the relation is less clear.

Reliance on Own Sources or External Support?

There are two aspects of this dilemma. The first is how much of general practice development should be left to foreign experts and how much needs to be done locally. There are many good examples of bilateral cooperation: Finland and Estonia, The Netherlands and Romania, Canada and Bosnia and Herzegovina. Foreign experts in most of these cases bring with them the latest expertise in the field of family medicine, but often lack experience and insight into the local situation, which may create problems in implementing suggested solutions in the local setting. One key measure of success of such an approach is whether the changes suggested by the program will be sustainable after the program is over. Sustainability and relevance to the local situation should be strongly emphasized in program planning, performing and also in the phasing-out situation.

The other aspect of this problem relates to the academic position of the discipline. Almost all countries have identified the need for the academic development of the discipline, although the approaches have differed. Some countries have staffed departments with clinical specialists who have fulfilled academic criteria in order to speed up the process of academic development. If the new chairs are able to incorporate the principles of family medicine in teaching and research, this approach is useful. But the danger of introducing a clinical specialist who fails to teach the principles of the discipline, but instead transfers their specialty clinical teaching to yet another department, seems real.

One critical issue is the recruitment of the younger generation of family physicians. In many retraining programs, especially in Russia, professionals near retirement have been the main group interested in retraining to become family doctors. To sustain the family medicine movement, incentives have to be created, especially directed towards the younger generation.

In conclusion, our survey showed that family medicine was almost universally recognized as a specific discipline. Some countries have shown great improvement in the development of the discipline over the last two decades, especially after 1989. Strategies for achieving this position have differed and were full of difficulties. Even if one can be positive about the achievements of the past, the current position of family medicine differs among the countries. Whereas in some countries, family medicine has been clearly established and has a strong academic position, equal to the position in the EU (Estonia, Slovenia, and Croatia), in many countries family medicine is still in its infancy and will need support. This is an important challenge for international organizations of family medicine. The benefits of collaboration are mutual. The role of the European society of family medicine in this respect is to foster communication between general practitioners in the field and the policymakers and to serve as a forum where these successes and challenges can be discussed and learned from.

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References

1 Saltman RB, Figueras J, Sakellarides C, editors. Critical challenges for health care reform in Europe. Buckingham (UK): Open University Press; 1998.

2 Saltman RB, Figueras J, editors. European health care reform: analysis of current strategies. Copenhagen: Regional Office for Europe, World Health Organisation; 1997.

3 Barker LR. Recent trans-European initiatives in general practice. Arch Fam Med. 1999;8:379-81.

4 Boelen C, Haq C, Hunt V, Rivo M, Shahady E. Improving health systems: the contribution of family medicine; a guidebook. Singapore: WONCA (World Academy of Family Doctors), Bestprint publications; 2002.

5 Boerma WG, Fleming DM. The role of general practice in primary health care. Geneva: World Health Organization; 1998.

6 Boerma WG. Profiles of general practice in Europe. An international study of variation in the tasks of general practitioners. Utrecht, The Netherlands: NIVEL; 2003.

7 Allen J, Gay B, Crebolder H, Heyrman J, Svab I, Ram P. The European definitions of the key features of the discipline of general practice: the role of the GP and core competencies. Br J Gen Pract. 2002;52:526-7.

8 Borovečki A, Belicza B, Orešković S. 75th anniversary of Andrija Stampar School of Public Health – what can we learn from our past for the future? Croat Med J. 2002;43:371-3.

9 Lember M. A policy of introducing a new contract and funding system of general practice in Estonia. Int J Health Plann Manage. 2002;17:41-53.

10 Lovkyte L, Reamy J, Padaiga Z. Physicians resources in Lithuania: change comes slowly. Croat Med J. 2003; 44:207-13

11 Okkes IM, Polderman GO, Fryer GE, Yamada T, Bujak M, Oskam SK, et al. The role of family practice in different health care systems: a comparison of reasons for encounter, diagnoses, and interventions in primary care populations in the Netherlands, Japan, Poland, and the United States. J Fam Pract. 2002;51:72-3.

12 Van Es JC. Dutch-Romanian connection on family medicine. Lancet. 2001;357:1713.

13 Toon PD. Reforming the Russian health service. BMJ. 1998;317:741-2.

14 Ministry of Health of the Russian Federation. Order No 350. On improving the out-patient care to the population of Russian Federation. November 20, 2002.

15 Godwin M, Hodgetts G, Bardon E, Seguin R, Packer D, Geddes J. Primary care in Bosnia and Herzegovina. Health care and health status in general practice ambulatory care centers. Can Fam Physician. 2001;47:289-97.

16 Ersoy F, Sarp N. Restructuring the primary health care services and changing profile of family physicians in Turkey. Fam Pract. 1998;15:576-8.

17 Hebrang A. Reorganization of the Croatian health care system. Croat Med J. 1994;35:130-6.

18 Hrabač B, Ljubić B, Bagarić I. Basic package of health entitlements and solidarity in the Federation of Bosnia and Herzegovina. Croat Med J. 2000;41:287-93.

19 Hebrang A, Henigsberg N, Erdeljic V, Foro S, Turek S, Zlatar M. Privatization of the Croatian health care system: effect on indicators of health care accessibility in general medicine [in Croatian]. Lijec Vjesn. 2002;124: 239-43.

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