ІМРЕ РУРІК[1], ЛАСЛО КАРАБАЙ[2]
[1]Дебреценський Медичний Університет та [2]Центр Здоров'я, кафедра соціальної медицини, Дебрецен (Угорщина)

ЗМІНИ СТАНУ ЗДОРОВ'Я НАСЕЛЕННЯ ТА НАДАННЯ МЕДИЧНОЇ ДОПОМОГИ НА ПЕРВИННОМУ РІВНІ

Первинний рівень надання медичної допомоги є важливою ланкою у збереженні здоров'я населення у всіх країнах світу. Оптимізація даної системи була основною темою Всесвітньої Організації Охорони Здоров'я на конгресі в Алма-Ата у 1978 році, де були прийняті основні принципи та напрямки щодо оптимізації надання медичної допомоги на даному рівні, і сформульовані у вигляді міжнародної декларації, діючої до сьогоднішнього дня.

В статті наведені результати аналізу власних досліджень щодо змін у системі охорони здоров'я, що стосуються первинної ланки надання медичної допомоги, та зміни стану здоров'я населення у 10 країнах пострадянського простору.

Ключові слова: стан здоров'я населення, первинний рівень надання медичної допомоги, Центральна та Східна Європа

Background. "Health for all by the year of 2000". That was an ambitious vision of the Alma Ata Declaration (AAD) 30 years ago [1, 2]. Under the auspices of the World Health Organisation (WHO) an international conference of health experts declared the pivotal role of primary health care (PHC). Its importance was realized earlier in the more developed (Western) countries. The WHO promoted continuously the orientation toward primary health care, and organized more conferences on this topic [3, 4].

Health care needs money and investment. Many new medical and paramedical disciplines that entered health care in the past decades required a multi disciplinary approach. In the mid-twentieth century the prevailing belief in the ability of science and technology to solve medical needs resulted in increasing reliance on medical technology and more emphasis on training specialist physicians in many countries [5].

Coherence between primary, secondary and tertiary care, curative and preventive services, somatic and mental health care are more difficult to maintain [6]. Transition from a system of hospital services that emphasise curative care and medical specialisation toward a GP/FM (General Practice/Family Medicine)-based health care system is an important component of the reform process and crucial to implementing cost-effectiveness and prevention [5]. Studies have shown that the strong primary care component to a national health system is associated with reduced risks of hospitalisation, shorter length of stay in hospital and decreased costs [7].

The different health systems of different societies have different outputs. There is a sharp divide in life expectancy between Western Europe and the former socialist countries of Central and Eastern Europe, and this gap largely developed in the past two or three decades. High rate of tobacco and alcohol consumption, poor nutrition and increasing social inequalities also contribute to the poor health and low life expectancy of this population [5]. Until the end of 1980s, countries of Central and Eastern Europe were strongly influenced by the policy and the economy of the Soviet Union. Health care in the region was a public responsibility. Organization, management and delivery of care were undertaken by state authorities. General practice, that had had long tradition before the World War II, was almost completely abolished. Nearly all inhabitants were entitled to have access to health care free of charge. Health care was financed from general taxation by the state. Finances were regulated by central and regional state administration. Health care was delivered by public service providers. Patients were allocated to local or regional providers according to their place of residence. GPs were employed by polyclinics/health centres or local municipalities in rural areas. Patients had easy or even unlimited access to most outpatient clinical specialists. Informal payment (tipping) was widespread to obtain better access or higher quality services[3, 5]. District physicians referred a large proportion of them to specialists or hospitals utilising a high number of hospital beds. It was common to find a low quality of care, low patients' satisfactions, rising costs, and medical staff dissatisfied with working condition and salaries [3]. These factors were thought to contribute to the excessive prescription of pharmaceuticals, multiple referrals, overcrowding in hospitals, and increasing costs [5].

With the collapse of communism health care reform started in most Eastern countries at the beginning of the 1990s. Emphasis was on the development of insurance-based financing, decentralization of the organization of health care and perhaps most importantly, the re-introduction of family medicine as a new specialty. New democratic governments of Central and Eastern Europe were forced to seek for more cost-effective health care services that were able to meet society's expectation [3]. PHC reforms toward the general practice/family medicine model were approved by decision makers in all of the countries of the region. Courses for future trainers of new family doctors were organized. English speaking, motivated doctors were selected for training in Western universities. After returning they were expected to develop and conduct training courses for their colleagues in their native language [3,8].

Enthusiastic FPs were involved in international scientific collaboration with WONCA [9] and its network organizations, the European Academy of Teach-

ers in General Practice (EURACT), European Working Party on Quality in Family Practice, European General Practice Research Workshop, later Network (EGPRN) [10]. Specific training in family medicine was introduced, including CME courses, which was a quite new terminology in these counties. Future family doctors were expected to have broader knowledge. New attitudes were needed to change from a disease-centred to a patient-centred approach. Residency-based programmes were established. Family medicine was recognized as an academic discipline. Nearly all university medical schools have departments of family medicine. Professional organisations colleges, scientific associations were established. Quality improvement systems were introduced; guidelines on the management of selected health problems or diseases have been published [3,5,7].

The systems of these countries represent an under researched area in the global PHC research.

The ***aim*** of our study was to present an overview on changes and achievements of primary health systems of these new European Union member countries and to add some demographical, economical facts to make this insight more complex.

Methods. Only widely respected databases were used as source of information which proved reliable data. The main domains and applied statistical data collections were:

Statistics. **1.** Demographic, socio-economic, mortality-based data on health care resources, health care utilization and expenditures were analysed [11]. Characteristic and understandable data were chosen in limited amount, which may reflect the health sector of the respective countries. Although GDP (Gross Domestic Products) is used more widely, Gross National Product (GNP) was chosen reflecting better the economic and historical trends within these countries. Considering their usually lower salaries and prices, Purchasing Power Parities (PPP) was chosen as second economic indicator presented here.

The evaluation's periods within the past 30 years were chosen to compare the stations and grades of development in different countries.

Literature search **2.** Available scientific publications from peer reviewed ranked and indexed journals, where primary care/family medicine and the name of the respective country were both found among keywords or PubMed MeSH terms.

Personal experience **3.** In a short and easy to manage questionnaire [see Appendix] for personal experiences of FPs were asked. They are all practising GPs, many of them in academic job as well and the national representatives of EGPRN [10] well informed and active contributors of other international scientific PC organisations, within the respective countries. An English language questionnaire was constructed, to avoid linguistic errors during translation. There were very simple (mostly open) questions on PC system, educational, scientific, organisational issues, and their personal experiences.

Three questionnaires were sent out (by post or email) to each country (30) and 22 of it were analyzed.

Results &statistical facts. Quantitative (economical and financial) data are presented in this section; qualitative data, analysis and review of the literature were compared in the discussion with the personal experiences of family physicians.

Socio-economic indicators. There was an economical recession and decline in almost every former socialist country in the first half of the past decade. Unemployment, (**Table 1.**) which was unknown in the 'socialist' era, became an important economical indicator and showed a steep increase in the first and a moderate in the second half of 90-ies and decreased only after the Millennium.

Table 2. illustrates that the increase of the GNP and PPP was very slow in the first part of 90-ies, even showing a decrease in some countries. This trend changed only in about 2000, differently in the listed countries.

Health care resources. The hospital based structure of health system has changed markedly (**Table 3**.). The largest reduction was carried out in the Baltic states where one-third to almost the half of hospitals beds were closed. These changes were less drastic in Poland and in Hungary. The number of GPs increased significantly in the Baltic countries and in Slovakia, while it decreased in Romania. According to the available data the percentage of nurses working in hospitals varies between 44-69%. Despite reduction of the hospital sector, the number of nurses increased in the Czech Republic, Hungary, and Slovenia. There were only minimal changes in the other countries.

Mortality-based indicators. The estimated life expectancy improved differently, as seen in **Table 4**. The highest was in the Czech Republic (+6 years in 2005, compared to 1980), lower in other countries (+4-5 year), and the lowest in the Baltic states (+1-2year).

Health care utilization and expenditure. These data were calculated according to the new formula of WHO and presented only as first and last available years in **Table 5**. Total health expenditures increased differently in each country. They doubled in Bulgaria and Slovakia, raised by 60-80% in the Baltic countries and the lowest was in Romania. There was a limited overall change in the percentage of private contribution to all health expenses. This source of contributions increased almost everywhere, in Estonia and Bulgaria a marked increase, in Poland and Romania a slight decrease; in Slovenia a considerable (50%) decrease was reported. Governments spent on average, only 1-2% more than before on health care. From the beginning of the health care reform there was only a limited change (more often increase) in the number of outpatients contact, except in Romania.

Questionnaire. The answers of the questionnaire from respective countries were similar. PC as an academic discipline with opportunity of qualification is accepted in all countries, but till now, no university departments were established in Romania and Lithuania.

CME courses are available in each country, but they are not compulsory for GPs in Estonia.

FPs rated in the questionnaire the gate keeping system of their own countries good only in Bulgaria, Estonia and Slovenia, whereas just symbolic or theoretical in other health systems.

Overworking of GPs was also mentioned in Estonia, Hungary, Lithuania and Slovenia among the answers of the questionnaire. The living circumstances of GPs and that of general population were rated better, than was 15 years before.

Discussion. Human resources, under and postgraduate education. In the former socialist countries, a physician workforce that was often too large, dominated by specialists, and poorly prepared for the transition to primary health care.

At the same time, two methods were employed to rapidly prepare physicians for PHC, retraining of existing physicians for the short-term and the establishment of training programs in the faculties of medicine to train family/general practitioners (GPs) from recently graduated doctors. After more than a decade of independence, there is still a struggle to have a physician workforce with the right numbers, the right specialty mix, and practicing in the right locations [12].

In the Soviet Union a huge number of doctors were educated, 2 to 3-fold higher then in Western Europe [3]. In Romania and the Baltic states a limited number of trained family doctors are a source of existing human resources problems [13,14]. The postgraduate or vocational training lasts 3-5 years in these countries [15]. While number of nurses increased in some countries, the shortage of educated nurses remained characteristic [5]. The skills and practices of nurses in the new role of primary care should be developed [16].

Issues of the future status of polyclinics, children's and female health centres, as well as about the optimal ratio between family physicians and specialists, remain to be resolved in Bulgaria [17].

There is a negative perception of family medicine among Polish students and doctors because of its long work hours, insufficient diagnostic possibilities and monotony and less time for family. FM is chosen because of lack of other possibilities, difficulties in employment and opportunity to become 'a specialist' in short time [18].

Socio-economic, financial changes. Eastern governments were unable to spend more money for health care because of economical recession in the 90-ies. After 2000 a minimal increase could be observed. Structural reforms in PHC, without discernible financial contribution by governments, started only in the second half of the 30 years that had passed away since AAD. Health staff was traditionally underpaid in the socialism. GPs became self-employed because of more rational use of economical budgeting. In Estonia finances were, however, redistributed without substantial increase of PHC budgets [18]. The reform was introduced through the creation of a new funding system for primary care services [20]. Nowadays, state (Beveridge) health system model and one-insurance fund (mostly governmental ruled) are existing in most of these countries, based on the Bismarck model [6]. The Czech Republic and Slovakia are exception, where more insurance companies were established with private investment.

Structural changes in health care. Since the beginning of the 1990s, health care reform projects have taken place in many of the former Communist countries, but these projects have rarely been evaluated systematically [21]. Changes brought about by the recent reform processes are considered generally favourable. The lack of integration of health services under the current system however causes various problems [22]. Health policy and health service planning should reflect the known disparities in health explained by geographical or economical reasons [23]. The utilisation of the private sector remained low in Bulgaria as well [24,25].

Shift from hospital bed-based system toward PC is a detectable achievement of these countries. Nevertheless, encounters by specialist or especially in hospitals mean a change of sector, from private one to state owned (public) level, where only minimal structural changes were reported [3,5,18]. There is no teamwork in PC, praxis communities, group practices practically do not exist. The old style of polyclinics still predominates in Romania, Bulgaria, and Estonia [3,5]. Primary health care centres had been a characteristic in the former Yugoslavian health care system that was introduced widely in Slovenia. Transition brought about poorly managed process of introducing private provision. Furthermore the monopoly position of the Insurance Fund affected their situation. Preserving their public health functions, increasing efficiency and establishing clearly defined relations with private providers are the challenges of the future [26].

Lack of financial interest could be an explanation, why GPs of some countries rated in the questionnaire their gate keeping function just symbolic or theoretical [18]. Incentives for comprehensive services, diverting funds from secondary services, decentralized management, to establish a "gatekeeper" function were declared as purpose of reforms [5]. In most countries patients still have a free access to specialists without referral [3].

There is a consensus between PHC experts of Central and Eastern European countries having similar key areas of concern; atomisation of practices, unsatisfactory payment system, lack of academic infrastructures and unsatisfactory continuous professional development [27].

Changes in morbidity & mortality and population's expectancy. Life expectancies increased, mortality decreased, higher percent of illnesses were discovered in earlier stage with screening, whereas the incidence of preventable diseases decreased minimally in each country we discussed [11]. There is no single reason as explanation for the health gap between countries. Contributing factors include the increasing prevalence of major risk factors in lifestyle and environment, the low efficiency and effectiveness of health care systems [28, 29].

Reorientation towards a primary care system emphasises health promotion and preventive services. Most of the population has not recognised the impor-

tance of healthy life style. The expectation of people to improve their health comes from the health staff. Practically there are no state-financed health-maintaining programs. There is no governmental support for changing unhealthy life style. Although several strategies have been planned to reduce risk of preventable diseases but they are hardly financed [3,5,6]. The bulk of patients who had had a contact with their family doctor were satisfied with his work following the introduction of new PHC systems [30]. The living circumstances of GPs and that of population were rated better in the questionnaire, mainly due to the economic growth of the countries and advantages of self employed status.

Global health provides a special challenge for primary care and general practice, which will become increasingly important in the future as the prevalence of multimorbidity increases with increasing likelihood of survival from acute manifestations of illness, as population's age, and as costs of care increase with increasing availability of technologic interventions. Primary care physicians need to take up the challenge before it becomes a crisis [31].

Governmental initiatives. Obviously, less effort in the Eastern than in the Western Europe has been made to follow the suggestions of the AAD to modify the health structures. Therefore the AAD has been subjected to the ideological clash between communism and capitalism [1]. Almost nothing happened in the Eastern block in the 1980s during the so called "stagnation in the Breshnew era".

Although there are differences between countries, it is general that the implementation of family medicine as part of health care reform is not an absolute priority for decision makers. It is rather a tool for more effective use of resources and not to increase the quality of care.

Unstable political situation and frequent change of decision makers create a long series of problems in the former socialist states. Governments in most countries were a coalition of parties, which were often changed including health ministers.

Abbreviations in all tables:
BUL: Bulgaria, CZR: Czech Republic, EST: Estonia, HUN: Hungary,
LAT: Latvia, LIT: Lithuania, POL: Poland, ROM: Romania,
SKA: Slovakia, SLO: Slovenia

Table 1

Unemployment rate between 1980 and 2005, in countries joining the European Union following 2004

	Unemployment rate (%)			
	1990	**1995**	**2000**	**2005**
BUL	1.7	11.1	17.9	12.7[04]
CZR	0.7	4.0	8.8	7.9
EST	0.8	9.7	13.6	7.9
HUN	1.7	12.0	6.4	7.2
LAT	2.3	6.6	7.8	7.4
LIT	7.3	7.3	16.6	8.3
POL	6.5	17.7	15.1	17.7[04]
ROM	8.4	9.5	10.5	8.0
SKA	1.5	13.8	18.3	16.2
SLO	4.7	13.9	12.2	10.2

[04] : in 2004

Table 2

Gross National Product (GNP) and Purchasing Power Parities (PPP) between 1980 and 2005, in countries joining the European Union following 2004

	GNP (USD per capita)				PPP (USD per capita)			
	1990	**1995**	**2000**	**2005**	**1990**	**1995**	**2000**	**2005**
BUL	2,210	1,330	1,610	3,450	4,700	4,604	5,110	8,075[04]
CZR	2,700[91]	3,870	5,690	11,220	11,531	12,371	13,802	19,408
EST	3,970[91]	2,394	4,070	9,060	6,438	4,068	10,066	14,555
HUN	2,750	4,120	4,650	10,070	7,446	8,976	12,204	16,814
LAT	2,270	2,270	3,190	6,770	6,457	3,297	7,043	11,653
LIT	1,900	1,900	3,170	7,210	4,913	3,843	7,106	13,107
POL	1,700	2,790	4,430	7,160	4,900	7,003	9,529	12,974
ROM	1,640	1,480	1,680	3,910	2,800	4,431	6,423	8,480
SKA	2,200[91]	2,590	3,870	7,950	7,681[91]	8,916	11,279	14,623
SLO	7,612	8,200	10,630	17,440	9,156[93]	12,510	17,367	20,939

[91] : in 1991; [93] : in 1993; [04], : in 2004

Table 3

Health care resources data (number of hospital beds, general practitioners and nurses per 100,000 inhabitants) between 1980 and 2005, in countries joining the European Union following 2004

	Number of hospital beds			Number of GPs			Number of nurses		
	1980	**1995**	**2005**	**1980**	**1995**	**2005**	**1980**	**1995**	**2005**
BUL	885	1037	642	46	80	68	513	607	404
CZR	1085	922	838	68	70	71	731	891	851
EST	1246	837	548	46[92]	58	63	615	634	657
HUN	917	879	785	47	63	65	754[90]	773	877
LAT	1389	1119	768	2[92]	7	55	800	609	545
LIT	1206	1109	812	39	36	86	763	945	742
POL	667	629	523	nd	nd	nd	422	548	468
ROM	877	764	658	nd	74	68	368	432	373
SKA	857	856	689	40	36	43	632	708	631
SLO	695	574	476	28	43	48	442	640	752

[90]: 1990; [92]: : 1992 nd: no available data

Table 4

Life expectancy at birth (in years) between 1980 and 2005, in countries joining the European Union following 2004

	1980	**1995**	**2000**	**2005**
BUL	71.1	71.0	71.6	72.6
CZR	70.3	73.3	75.2	76.2
EST	69.2	67.8	71.0	72.9
HUN	69.1	70.1	71.9	73.0
LAT	69.1	66.3	70.6	71.1
LIT	70.5	69.1	72.3	71.3
POL	70.4	72.0	74.0	75.1
ROM	69.2	69.4	71.2	72.2
SKA	70.5	72.5	73.5	74.3
SLO	72.2[85]	74.8	76.3	77.6

[85] : in 1985;

Table 5

Data on health care utilisation and expenditure in the first and last available years, in countries joining the European Union following 2004.

	Total health expenditure [1]		**Private payment [2]**		**Public sector [3]**		**Outpatient [4]**	
	1998	**2004**	**1998**	**2004**	**1998**	**2004**	**1995**	**2005**
BUL	278	671	31.7	41.6	9.1	11.6	5.5	5.4
CZR	904	1,412	8.2	10.3	13.9	14.6	14.7	15.2
EST	476	752	13.2	21.3	12.3	11.3	5.9	6.9
HUN	774	1,368	22.3	25.0	10.1	11.6	10.4	13.0
LAT	435	852	40.0	42.7	9.4	11.1	4.8	5.2
LIT	490	843	23.0	24.2	14.6	13.8	7.1	6.7
POL	556	814	34.6	28.1	8.1	10.0	5.4	6.1
ROM	331	433	35.0	31.7	8.1	11.1	8.0	5.9
SKA	559	1,061	8.4	10.8	11.6	13.7	12.4	12.5
SLO	1,137	1,815	19.2	9.6	14.3	13.8	7.2	7.2

[1]: Total health expenditures [PPP $/ capita] WHO estimates,
[2]: Private household's out-of-pocket payment on health as % of total health expenditure,
[3]: Public sector expenditure on health as [%] of total governmental expenditures,
[4]: Number of outpatient contacts per person per year

Appendix

Questions
Are there in your country Department(s) of Family Medicine?
Is it an opportunity in your country to be qualified in FM?
Are there in your country compulsory CME courses for GPs?
Have the GPs a real gate-keeper function in your health system?
Are your personal living conditions better than 15y before?
Other comment, remarks:

Conclusions. "Health for all by 2000". The turn of the century seemed too far ahead in 1978. Despite the unimaginable development in health technology and therapy the achievements are not open for everybody, even thirty years later.

After the collapse of Soviet Union that brought freedom and independence to these countries, they had short time and few resources to change their health system. Most of them are still in the midst of transition [32].

Study limitations. Different sources of information and complexity of data try to present the achievements of these 10 countries, but unable to estimate what would happen without the mistakes, pitfalls, political battles and economical crisis. Other limitations are; only those dates are presented which have a common international and validated source, local country-specific scientific publications in their respective languages were not available and analyzable. This paper have more subtitles than usually, to present different issues.

Contributors. IR planned the study, collected and reviewed the literature and corresponded with questionnaire. LK structured the manuscript, made data analysis and some literature search. Both authors contributed in the elaboration of the final version.

Conflict of interest statement. We declare that we have no conflict of interest. Authors did not get any financial support for this study.

Acknowledgements. We are very grateful to the EGPRN National Representatives and other PC experts who answered the questionnaire. Thanks to Éva Belicza PhD, Institute of Health Services Managements, Semmelweis University, for advices in data collection.

REFERENCES

1. Bolden K.J. Training Hungarian primary health care teachers: the relevance of a UK postgraduate course for health educators / K.J. Bolden, S.A. Willoughby, M.T. Claridge, A.P. Lewis // Med. Educ. —2000.— Vol.34.— P.61—65.
2. Declaration of Alma-Ata: international conference on primary health care, Alma—Ata, USSR, Sept 6—12, 1978. Available from.: http://www.who.int/HPr/NPH/docs/declaration_almaata.pdf
3. Haines A. Primary health care comes of age. Looking forward to the 30th anniversary of Alma-Ata / A. Haines, R. Horton, Z.Bhutta // Lancet. — 2007. — Vol. 370, № 9.— P.11—13.
4. Windak A. Primary Care and general practice in Europe: Central and East / A. Windak, P. van Hasselt // Oxford University Press. —2005. — P.70—73.
5. Ljubljana charter on reforming health care // *Br. Med.J.* —1996.— Vol.312. — P.1664—1665.
6. Jack B.Health care reform in Central and Eastern Europe. Family medicine in Hungary / B. Jack, Zs. Nagy, Z. Varga // Eur. J. Gen. Pract. —1997. — Vol.3. — P.152—158.
7. van der Zee J. Health care systems: understanding the stages of development / Zee J. van der, W.G.W. Boerma, M.W. Kroneman // Oxford University Press. — 2005. — P. 52—55.
8. Starfield B. Is primary care essential? / B. Starfield // Lancet. — 1994. — Vol.344. — P.1129—1133.
9. http//: www.GlobalFamilyDoctor.com
10. Lionis C. Establishing academic rural practice: a future and challenging target / C. Lionis, J. Wynn-Jones // *Rural and Remote Health.* — 2007. — Vol.7.— 727p. —Available from: http://www.rrh.org.au.
11. http://www.euro.who.int/hfadb
12. Reamy J. Physician workforce planning and the transition to primary health care in former socialist countries./ J. Reamy, L. Lovkyte, Z. Padaiga // Cah. Sociol. Demogr. Med. — 2005. — Vol.45. — P.307—325.
13. Managing resources in a GP national network: problems and achievements / M. Mărginean, L.Tivadar [et al.] // Stud Health Technol Inform. — 2002. — Vol. 90. — P.665—669.
14. Rabbani F. Medical education and training: responding to community needs / F. Rabbani, B.T Shaikh, Q. Mahmood, K. S. Khan [et al.] // Med. Sci. Monit. —2005. —Vol.1, №10. — P.21—25.
15. Maaroos H.I. Specialist training of family medicine in non-UEMO countries: An Estonian experience / H.I. Maaroos, M. Lember // Eur. J. Gen. Pract. —2007. — Vol.13. —P.246—247.
16. Kalnins I. Starting from a blank page: discovering and creating community health nursing in post-Soviet Latvia / I. Kalnins // Public Health Nurs. — 2001. — Vol.18.—P. 262—72.
17. Popova S. The state of primary medical care in Bulgaria / S. Popova, N. J. Feschieva // J. Public Health Med. —1995. — Vol.17. —P.6—10.
18. Pawełczyk A. Determinants of primary care specialty choice / A. Pawełczyk, T. Pawełczyk, J. Bielecki // Pol. Merkur. Lekarski. —2007. —Vol. 22. —P. 233—238.
19. Boncz I. Financing of health care services in Hungary / I. Boncz [et al.] // Eur. J. Health. Econ. — 2004. — Vol.5.— P. 252—258.

20. Koppel A. Evaluation of primary health care reform in Estonia / A. Koppel, K. Meiesaar, H. Valtonen, A. Metsa, M. Lember // Soc. Sci. Med. — 2003. —Vol. 56. —P.2461—2466.
21. Grielen S.J. Science in practice: can health care reform projects in central and eastern Europe be evaluated systematically? / S.J.Grielen, W.G. Boerma, P.P. Groenewegen // Health Policy. — 2000. — Vol.53. —P.73—89.
22. Holcik J. Primary health care in the Czech Republic: brief history and current issues / J. Holcik, I. Koupilova // Int. J. Integr. Care. —2000. — Vol.1.—106 p.
23. Széles G. A preliminary evaluation of a health monitoring programme in Hungary / G. Széles [et al.] // Eur. J. Public Health. — 2005.— Vol. 15. — P.26—32.
24. Balabanova D. Access to health care in a system transition: the case of Bulgaria / D. Balabanova, M. McKee // Int. J. Health Plann Manage. —2002. —Vol.17.— P.377—395.
25. Borissov V. Health care reforms in Bulgaria: an initial appraisal / V. Borissov, T. Rathwell // Soc. Sci. Med. — 1996. — Vol.42. — P. 1501—1510.
26. Albreht T. Changes in primary health care centres over the transition period in Slovenia / T. Albreht [et al.] // Eur. J. Public Health. —2006.—Vol.16.—P.238—243.
27. Seifert B. Perspectives of family medicine in Central and Eastern Europe / B. Seifert, I. Švab, T. Madis, J. Kersnik, A. Windak [et al.] // Family Practice. —2008.— Vol.25. —P.113—118.
28. Nanda A. Health in the Central and Eastern countries of the WHO European Region: an overview / A. Nanda, A. Nossikov, R. Prokhorskas, M.N. Shabanah // World Health Stat. Q. — 1993. —Vol.46. —P.158—165.
29. Meyer C. Clinical research for patient empowerment-a qualitative approach on the improvement of heart health promotion in chronic illness / C. Meyer // Med. Sci. Monit. — 2008. — Vol.1. — P.358—365.
30. Polluste K. Evaluation of primary health care reform in Estonia from patients' perspective: acceptability and satisfaction / K. Polluste, R. Kalda, M. Lember // Croat Med. J. — 2004. — Vol.45. —P.582—587.
31. Starfield B. Global health, equity, and primary care / B. Starfield // J. Am. Board.Fam. Med. —2007. — Vol. 20. — P.511—513.
32. Liseckiene I. Primary care in a post—communist country 10 years later Comparison of service profiles of Lithuanian primary care physicians in 1994 and GPs in 2004 / I. Liseckiene, W.G. Boerma // Health Policy. — 2007.— Vol.83 — P.105—113.

Стаття надійшла до редакції 15.03.2011

[1]IMRE RURIK, [2]LÁSZLÓ KALABAY

[1]Faculty of Public Health, Medical and Health Science Center, University Debrecen, Hungary, [2]Faculty of Medicine, Semmelweis University, Budapest, Hungary

CHANGES IN THE HEALTH AND PRIMARY CARE SYSTEMS OF THE CENTRAL-EASTERN EUROPEAN COUNTRIES

Primary care as an important tool to improve global health was recognized in many countries a few decades ago. It was a main topic of a WHO promoted conference resulted in the Declaration of Alma Ata, in 1978 where its importance was emphasized.

This study aims to present an overview how the targets of this Declaration regarding primary care were realised in ten countries of the former Soviet block that joined the European Union since 2004.

Some demographic, socio-economic, mortality based statistical dates were presented and scientific publications from respective countries were analyzed, personal experiences of family physicians of these countries were compared.

After the collapse of communist regimes democratic political changes and health reforms started in these countries. There was an economic recession and decline in the first decade.

Life expectancies improved and total health expenditures increased, in different extent by countries, although governments spent barely more for health care. Primary care providers are the main private sector contributors.

Hospital based structure has changed, while number of outpatients contact is nearly the same.

The ratio between secondary care specialists and family physicians remained too high and there is a shortage of educated nurses.

Although new funding systems for primary care services were introduced, budgets were mostly redistributed without substantial increase and improve of outcome. The achievements of reform have rarely been evaluated systematically. There is no teamwork, praxis communities do not exist. Old style of polyclinics still predominates in some countries. The gate keeping system is more often symbolic or dysfunctional. Health promotion and preventive services are rarely supported by governments.

Implementation of family medicine is not an absolute priority for decision makers. Political situation is often unstable. Despite the non-negligible achievements, the health systems in this part of Europe are still in the midst of transition.

Key words: Alma Ata Declaration, Central and Eastern Europe, healthy system, primary care