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Perspectives of family medicine in Central and Eastern Europe

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Introduction. In the last decade of the 20th century, the countries of Central and Eastern Europe (CEE) have experienced rapid changes in health policies. This process was largely supported by international grants. After this support has ended, it is important to keep up with the development, developing its own strategies and priorities.

Aims and methods. The aim of the paper is to make a proposal for the future development of the discipline in CEE countries. The proposal is based on reports on an invitational conference that was organized for the key representatives of family medicine from CEE countries. For the purpose of this paper, additional information about the situation was gathered from literature reviews, country visits and personal interviews.

Results. Information shows that although family medicine has been formally recognized and introduced in university curricula, there is a very big difference in its academic position. Postgraduate training has been established in all CEE countries, according to the European Directive. Quality measures such as the development and implementation of guidelines and the recertification procedure have also been formally introduced, but its quality varies. The key areas of concern are atomization of practices, unsatisfactory payment systems, lack of academic infrastructure and unsatisfactory continuous professional development. On the other hand, examples of good practice exist and need to be promoted.

Conclusion. There is a need for continuous exchange of expertise within the countries. The paper will serve as a discussion paper for the next meeting of experts from CEE countries.

Keywords. Family medicine, international comparisons, postgraduate education, practice management, undergraduate medical education.

Introduction

The importance of good primary care is very well recognized by many declarations, starting from the Alma-Ata conference,[1] and later by the Ljubljana Charter, the World Health Organization (WHO) programme 'Health for All' and others.[2,3] Regardless of that, the health care systems of countries of Central and Eastern Europe (CEE) were largely focused on specialist and hospital care. The importance of primary care and family medicine was low.[4–7]

In the end of the 20th century, most of these countries have undergone rapid political changes, also by putting more emphasis on primary care and modern family medicine. This development has been supported by European projects, such as Human Resources Development Programme Foundation and the World Bank. Most of the countries have become members of the world organization of family doctors (World Organization of National Colleges and Academies in GP/FM) and its networks. Although the academic position of family medicine has improved considerably, it still has not reached the standards of the developed Western Europe.[8] Although the academic institutions of family medicine in CEE countries actively participate in international arena, they

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have their own problems that need to be addressed. It is still unclear to which extent family medicine in these countries fullfills the needs of the European definition of general practice/family medicine (GP/FM)[9,10] and what is its academic position.

Further, the countries of CEE are not a homogeneous group as often perceived. There are considerable differences in organization of health care services, GP task profiles and development of training programmes.[11,12]

The aim of this article is to describe the critical aspects concerning the current development of GP/FM in CEE countries in order to influence the development within the discipline.

Methods

This article is based on the analysis of reports and discussions at the first international symposium on family medicine in CEE countries, which was initiated and hosted by the Czech Society of General Practice. The conference was organized in order to exchange experiences on health policy, education, research and quality of care in family medicine in these countries. The participants at the conference were 112 GPs from 10 countries (Lithuania, Estonia, Hungary, Czech Republic, Slovakia, Poland, Slovenia, Latvia, Romania and Bulgaria). All of them had leading positions in medical societies, associations and academic departments.

In the first stage of the analysis, the structured reports provided by country representatives and reports from group sessions were analysed in a qualitative way. Two independent investigators have used the standard qualitative methods:

(i) identification of quotations and assignment of codes;
(ii) connecting codes into reasonable contents;
(iii) review of codes; and
(iv) final creation of themes.

In addition, validation of the information in the reports was done from the following sources:

(i) background materials for the conference: reports from international studies,[11,12] surveys presented during conferences,[13] articles[14–16] and materials from textbooks;[17–19]
(ii) literature reviews;
(iii) country visits; and
(iv) personal interviews with other key informants.

Finally, the results of the analysis were discussed in a group of experts and the final conclusions were agreed.

Results

The transcripts from the conference were gathered around the following themes:

Health policy issues

Theme 1: general complaints. Although all countries reported that family medicine is officially recognized, most of the transcripts included quotes about the problems in the processes of adaptation and recognition of the new or re-established speciality. Main complaints concerned insufficient funding, low recognition of family medicine, ageing of GPs, poor clarity of GP role within health care models and finally a non-existent gatekeeping, etc. In all countries, GPs/family physicians (FPs) are the first respondents to patients' needs.

Table 1 gives an overview of main challenges and trends.

Theme 2: conservatism versus radical changes. Although family medicine is being politically recognized as a key element for effective health care systems, in some countries, only formal changes have been done to develop primary care and to establish a general practice; policy makers have been conservative in introducing changes. This conservative policy is demonstrated by keeping paediatricians and gynaecologists as primary care physicians (Slovenia, Slovakia and Czech Republic), although specialization training in family medicine has been introduced. Other countries have been eager to introduce GP/FM according to its principles; this can be seen in Poland, Estonia and less in other Baltic countries, where district paediatricians were offered to retrain and establish themselves as family physicians.

Theme 3: decentralization and privatization. Many CEE countries experienced a drastic change of many doctors who have left the existing polyclinics and rented or built their own facilities. The process of privatization has concluded in a high number of individual practices, which account in some countries for 90%. Self-employed family physicians have overtaken responsibilities of premises, equipment and supporting staff and for the management of the practice. Family physicians have also been forced to learn about management. This trend is in contrast with modern concept of family medicine, which demands sharing responsibilities through teamwork.

In Lithuania, the disintegration process of polyclinics started in 1996, and at the time of the conference, 40% of the population was reported to be served by former polyclinic teams. Estonia, Czech Republic and Slovakia are having family physicians working as private entrepreneurs, while Slovenia opted for a rather slow transition, using gradual changes, and thus has not left the health centers system.

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TABLE 1 *GP/FM discipline development in CEE countries*

Country	VT/organized by	Retraining programmes	Trends and critical issues	Challenges
Estonia	3 years since 2003/University departments	Systematic 3-year in-service retraining courses since 1991 for paediatricians and internists	Quality indicators established, incentives introduced	Prevention, quality improvement
Slovakia	3 years since 2005/ Postgraduate Medical School, MoH	Programmes available for doctors from other specialities, the duration depends on prerequisites	New job description, implementation of quality system	Ageing of GPs, role definition in a system
Czech Republic	5 years since 2005 (VT introduced in 1978)/ Postgraduate Medical School, MoH	Programmes available for doctors from other specialities, the duration depends on prerequisites	Quality assurance, quality indicators, accreditation, grouping of practices	Ageing of GPs, low interest in GP, atomization of practices
Poland	4 years/University departments, MoH	1-year retraining in transition period, now 3-year programme for internists, paediatricians, surgeons or gynaecologists	Quality assurance, accreditation	Competence, referrals, role definition in a system, insufficient funding
Latvia	3 years since 1993 Latvia Academy of Medicine, University of Latvia	Systematic 2-year in-service retraining courses since 1992 for paediatricians and internists	Quality assurance system established, Scientific Research Centre	Low financing, low academic status
Hungary	5 years since 1992 (VT introduced in 1974)/National Institute of Primary Health Care, MoH	Individual programmes available for doctors from other specialities, the duration depends on prerequisites	National Institute of Primary Care: research, quality projects	Gatekeeping not functioning low academic status
Slovenia	4 years (VT introduced in 1961)/University departments, MoH	Individual programmes available for doctors from other specialities, the duration depends on prerequisites	Quality indicators established, including accreditation	A lack of doctors, work overload, 'polyclinic thinking'
Lithuania	3 years/University departments	Individual programmes available for doctors from other specialities, the duration depends on prerequisites	FPs' teams planned to work from 2010, retraining to family medicine	Hard adaptation and recognition of new speciality
Romania	3 years/University departments, MoH	Not specified	Quality projects	Equipment, competence improvement, appointment system
Bulgaria	3 years/MoH	Not specified	Quality indicators established, incentives introduced	Competence improvement

Differences in duration and organization of VT and retraining in GP/FM in CEE Countries. Current trends and challenges as perceived by experts from CEE countries. MoH, Ministry of Health and VT, vocational training.

Theme 4: attractiveness of family medicine. Due to economical and managerial freedom and the promising future of the discipline of family medicine, it has been attracting both young graduates for vocational training and other doctors for retraining since the mid-90s. Yet, the former enjoyment of working on a private basis has been largely replaced by disappointment. The support for primary care has not continued throughout the whole transition process nor has the workload been reduced. Thus, most of representatives reported that the discipline has lost its attractivity during recent years.

Quality of care

Theme 1: equipment. All the groups have agreed that the quality of care has been raised.

Practices are nowadays better equipped (with electrocardiographs, spirometres, rehabilitation, office-based laboratory tests or even ultrasounds) and family physicians can offer more services and have a better choice of drugs. Most of the practices are computerized.

Education

Comparison of academic development in GP/FM in CEE countries is illustrated in Table 2.

Theme 1: undergraduate education. CEE countries have taken different approaches to developing academic family medicine, with variable success. For example, there are courses on family medicine as a part of undergraduate curriculum, which are hosted by other departments (Slovakia, Lithuania, Latvia and Hungary), or there are established family medicine departments (Estonia, Slovenia, Poland and Czech Republic). Excellent progress was reported from Estonia and Slovenia, where family medicine departments

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TABLE 2 *Academic status of GP/FM in CEE countries*

Country	Academic status	PhD programmes	Professor's chair
Estonia	Departments exist in the Faculty of Medicine, University of Tartu since 1992	In function (nine finished)	Yes
Slovakia	Course on general practice in undergraduate curriculum	Some	No
Czech Republic	Departments exist in all seven medical schools (Prague since 1997)	Some	No
Poland	Departments exist in all 12 medical schools	Some	No
Latvia	Course on general practice in undergraduate curriculum	In function (Research Centre)	No
Hungary	Course on general practice in curriculum since 1983	Some	No
Slovenia	Departments exist (in Ljubljana since 1995)	In function	Yes
Lithuania	Departments exist (Kaunas, Vilnius)	Some	Yes
Romania	Departments exist	Some	Yes
Bulgaria	Course on general practice in undergraduate curriculum	Some	No

Academic status of GP/FM in CEE countries: Comparison of academic development and career in the discipline of GP/FM obtained from national reports of CEE countries participating at International Symposium of GP/FM in Prague 2006.

have been functioning since 1992 and 1992, respectively. PhD programmes in family medicine are also available for students in Estonia, Slovenia, Poland and Latvia. There are also other countries with family physicians who have received PhD degree in other branches, such as public health or social medicine. Yet, an academic career path remains complicated for family physicians in most countries; requirements have not been established with regards to primary care; and the research experience is low.

Theme 2: specific training. Specific training in family medicine has been established in all CEE countries, according to the European Directive. Differences in duration and organization of vocational training and retraining are illustrated in Table 1. The duration varies from 3 years (Estonia, Lithuania, Latvia and Romania), to 4 years (Slovakia, Poland and Slovenia) and to 5 years (Czech Republic and Hungary). A trainee spends almost half of his time in trainer's surgery. Some countries have offered a transition period to retrain paediatricians, internists, surgeons or gynaecologists to become family doctors (Poland and Baltic countries). The specificity of the training, in terms of organization and financing, has caused problems, and in some countries (Czech Republic and Slovakia), it seems to have become a barrier in choosing family medicine as a future job. However, in Slovenia, family medicine often attracts the best medical graduates.

Theme 3: continuing professional development. Family physicians are, to a large extent, influenced by systematic, quality improvement initiatives. In all the CEE countries, legislation concerning continuing medical education (CME) exists. All doctors are expected to take part in different activities in order to maintain an adequate standard of knowledge and competence. In the majority of countries, participation in CME is obligatory, but only in Slovakia and Lithuania sanctions for failure are also predicted. In Poland, participation is entirely voluntary. Successful participation in CME, according to the announced and published criteria, leads to a re-certification or other formal confirmation of satisfying CME requirements.

Theme 4: re-certification. Family doctors in Latvia, Lithuania and Slovakia have to prove that they have been working in general practice for at least for 3 years to be re-certified. Re-certification or equivalent CME assessment is done periodically, usually every 5 years; yet, in Poland, it is done every 4 years. Lack of re-certification usually does not lead to any serious consequences. Restrictions and incentives are weak, yet most of physicians do it. CME rules are usually made by government, but chambers of physicians, colleges or other professional associations play various roles in the process. In Slovakia, all of them jointly have created Slovak Accreditation Council for CME, which approves educational activities to be recognized for CME. In the Czech Republic, a GP Society runs the register of events and credits. In Poland, the College of Family Physicians runs a comprehensive programme recognized by the chamber, which is responsible for CME for all physicians. In all the countries, educational activities hoping to be recognized as a part of CME have to be conducted in collaboration with the university or the scientific college or in association with family physicians. Re-certification in most of the countries is based mainly on a collection of credits, confirming passive or active participation in various educational activities like conferences, courses, seminars, etc. Self-education, e.g. regular reading of professional journals (confirmed by subscription), is also widely recognized. Internet-based and other distance learning activities are part of CME in Estonia, Poland, Slovakia and Czech Republic. In Latvia, GPs are expected to conduct performance analysis in order to be re-certified. Similarly, in Estonia, patient profile and practice analysis are required.

Re-certification, if desired, can be easily achieved upon passive participation in various courses and conferences. Education is rarely driven by real educational needs, which has been established through

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results of the quality assurance activities. In countries where current rules have existed for a longer time, there is a common impression about their ineffectiveness and also a need for change.

Theme 5: research. Primary care research has been developing in Estonia and Slovenia, but less so in other Baltic countries, and in Hungary, Poland and the Czech Republic. In Estonia and Slovenia, research method training is included in their postgraduate programme. Also, a collaborative initiative for international research projects has been undertaken recently by Hungarian colleagues. Yet, such research continues to need a more active, international, encouragement.

Theme 6: common standards. The need for 'context-specific approach' has been recognized by the participants and from international surveys. Country representatives increasingly reported the problem that a 'European standard of family medicine' is unlikely to be developed due to big differences.

Discussion

Although there is a general trend of harmonization and improvement in family medicine in CEE, which can be seen in areas of formal recognition, academic development, research and quality of care, there are several new and specific issues for this part of Europe that need to be considered.

Health policy issues

It is obvious that the evidence for efficiency of health care systems, based on strong primary care, has not had enough impact in Eastern Europe. Although it is known that the full benefit of such care cannot be achieved unless all the fundamental characteristics of up-to-date primary care are in place,[3] policy makers prefer to implement only some attributes of primary care.

The process of privatization and disintegration of polyclinics has concluded in a high number of individual practices which goes against the European trend to grouping of practices. We are hoping that the trend will be reversed and that a process of joining existing solo practices in group practices on a voluntary basis will be implemented. This process should be actively supported by government policies, because it improves continuity of care, and sharing of professional knowledge,[14] which is until now not the case.

Education

The development in undergraduate education has been very promising. Family physicians have established themselves as successful teachers, with excellent evaluations given by students.[19]

The interest towards family medicine varies. In some countries, the low appeal of family medicine can influence the provision of primary health services in future. In these countries, family medicine needs to be even more actively promoted through renumeration and other health policy strategies.

The re-certification process in most of CEE countries is still unsatisfactory. Although the countries have formalized the re-certification of family medicine, the content of these strategies is usually not addressed at all. In the future, education should be driven by individual educational needs established through results of the quality assurance activities rather than by central desicions[20] and modern approaches like personal development plans need to be discussed and implemented.[21–23]

Primary care research in CEE countries is less developed and should be enhanced by international collaboration and by the support of European General Practice Research Network and of other primary care-oriented networks.[24,25]

Strengths and limitations of the work

Although the paper is based on reports and opinions of experts, we have tried to reduce the subjectivity of the findings. Our informants were carefully selected among the key representatives from participating countries. We have also validated their information through independent sources (mainly articles and reports on family medicine in WHO documents and European Union of General Practitioners papers). The authors of the paper have also served as the second key informants in order to maximize the objectivity of the findings.

Conclusion

The following action plan for the development of family medicine in CEE countries is proposed:

(i) The international platform for cooperation and an exchange of information on GP/FM development in CEE countries should be maintained. We propose a formation of a permanent working party that would continue with monitoring of the development. This party should be in regular contacts with other international organizations from this area, mainly with WONCA, UEMO and the European forum for primary care.
(ii) More promotion of successes of family medicine is needed. This is the role of national colleges and academic departments which should display the achievements to policy makers, insurance authorities and academic leaders.
(iii) The academic development of family medicine should be supported by international collaboration.

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(iv) Modern methods and approaches in teaching and re-certification should be promoted to national colleges.

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