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Review Article

Family Medicine Development in Bosnia and Herzegovina

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Abstract

Bosnia and Herzegovina is a country in Southeastern Europe located on the Balkan Peninsula. During communist rule, the health care system in the former Yugoslavia was centralized. Primary medical care was provided by specialists in centralized polyclinics or health centers, and in smaller community-based clinics called ambulates, staffed by general practitioners (without formal residency training) and nurses. With the end to the war in 1995, the BiH government, with support from international organizations and multilateral agencies such as the World Bank, began a health care reform program to restructure its health system. The reforms aimed to develop a new model of PHC centered on family medicine. The Family Medicine Development Project in Bosnia and Herzegovina was an initiative funded by the Canadian International Development Agency (CIDA) that was sparked by a visit to Queen's University by the Dean of the Medical School in Sarajevo in 1995. He came specifically to encourage the Department of Family Medicine to look into the possibility of helping our country establish an effective primary care infrastructure based on the Canadian family medicine model. The project introduced family medicine into undergraduate curricula, established three-years long program of residency in family medicine in 1999, created departments of family medicine in all medical schools, helped with the process of establishing a professional college of family doctors, worked with ministries of health to establish supportive policies for these activities, and regularly provided continuing medical education programs for family practitioners during the 13 years of the project.

Keywords: Primary health care; Family medicine; Health systems; Bosnia and Herzegovina

Country in Context

Bosnia and Herzegovina (BiH) is a country in Southeastern Europe located on the Balkan Peninsula. Sarajevo is the capital and largest city. With the dissolution of the Yugoslav Federation, Bosnia-Herzegovina sought international recognition, which was achieved on 6 April 1992 following an internationally supervised referendum in which the great majority of its population voted in favor of independence. This caused the civil war that took place between 6 April 1992and 14 December 1995. The most recent figures suggest that around 100,000 people were killed during the war and over 2.2 million people were displaced making it the most devastating conflict in Europe since the end of World War II [1,2,3]. In 1995, the political divisions of Bosnia and Herzegovina were created by the Dayton Agreement, which recognized a second tier of government in Bosnia and Herzegovina, comprising two entities: the Federation of Bosnia and Herzegovina (FBiH), with mostly Bosniaks (Muslims) and Croats (Catholic), and the RepublikaSrpska (RS) with mostly Serbs (Ortodox Christians), each governing roughly one half of the state's territory [4].

Health Care System in Bosnia and Herzegovina before Independence

During communist rule, the health care system in the former Yugoslavia was centralized. Each municipality had its health centre (a DZ), which coordinated a network of smaller PHC community facilities (DZ outposts). There were 109 DZs, located in the main cities or towns — each covering a commune of 30 000 to 50 000 inhabitants — with clinics in smaller communes and villages. The DZs coordinated 900 doctors' offices, staffed by a doctor and a few nurses, which provided basic first line services to local populations. Within the DZ, PHC was divided into seven distinct functions: (a) general practice, (b) occupational medicine, (c) pre-school paediatrics, (d) school paediatrics, (e) gynecology and obstetrics, (f) laboratory/X-ray, and (g) hygiene and epidemiology. The PHC system was coordinated by the Ministry of Health and Social Affairs, and included health clinics that served special groups such as the police and military personnel and large companies, which organized their own health services. General medicine clinics often functioned essentially as triage centers. Patients were not registered with one GP and appointment system did not exist, so the patients were mainly served by different doctors depending on their current availability. Most conditions were referred to specialists at the health centers or hospitals and treatment was usually based on orders from a specialist. Although, the standards and skills of the specialists in former Yugoslavia were mostly satisfactory, majority of GPs had only basic undergraduate education and very poor skills. Majority of GPs also did not see their future career in general practice and they were waiting for different residency posts, mainly in internal medicine, gynecology and surgery.Very few physicians pursued residency

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program in general practice which was completely conducted in inpatient settings, by the specialists of public health or hospital doctors [5, 6].

Beside the level of training of physicians, this situation reflected several factors, restrictive regulations, inadequate equipment, many years of a specialist-based health care system that did not value primary care, and the expectations of patients who had received care in this system [5].

The Primary Health Care Strategy after 1992

The foundation of the primary health care (PHC) Reform program of the Bosnia and Herzegovina is the Declaration adopted at the international conference on PHC, which was held in Alma Ata in September 1978 under the auspices of the World Health Organization and UNICEF. The Declaration of Alma Ata views PHC as follows: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. At the same time, it forms and integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" [7,8,9].

During the time of Yugoslavia, there had been several, not very successful attempts to reform PHC. When the civil war finished, the studies and analysis of the World Bank demonstrated widely spread, both absolute and relative poverty in Bosnia and Herzegovina and other countries in the region. The war had resulted in lower socioeconomic statuses of Bosnia's citizens, raised new health concerns, caused epidemiological changes, and changed the focus of the community. Many PHC physicians emigrated to neighboring counties or to Western Europe and South America, while large percentage of PHC facilities was destroyed. The spread of infectious diseases, the consequences of alcohol and drug misuse, high incidence of posttraumatic stress disorders (PTS), shortage of health care providers in certain geographic areas, large percentage of uninsured population and the occurrence of violence and crime led*to marked health inequity and inequality.*

Poverty represented a challenge for ensuring conditions for a long-term and sustainable economic development that would significantly contribute to the reduction of poverty. Better health markedly depended on the efficiency and success of a health system, however, the former health care system was not effective [10]. Here of, with the end to the war in 1995, the BiH government, with support from international organizations and multilateral agencies such as the World Bank, began a health reform program to restructure its health system. The reform aimed to develop a new model of PHC centered on family medicine. In 2001, a new model of PHC, piloted in both entities (the Federation of Bosnia and Herzegovina [FBiH] and Republika Srpska [RS]), proposed to simultaneously introduce changes in the health systems elements: namely, organizational structure and stewardship, financing, provider payment systems, service provision and resource generation [11,12].

Key health care issues to be considered by the BiH PHC reform program were unequal access to health care, inefficient delivery of health care services, inadequate health care financing, inadequate structure of human resources and ageing population [12].

Unequal access to health care was caused by a high number of individuals with no health care insurance. The level of direct payment for health services ("out-of pocket" payment) was quite high, thus constituting an additional barrier to the access and aggravating inequality, which rendered individuals more vulnerable to the effects of a disease. A better protection of the most vulnerable groups of the population from health risks, and dealing within equality in access to health care was the key to poverty reduction and enhanced social cohesion [12, 13].

The PHC we inherited focused on disease and therapy, episodic care and passive admission of patients, a higher utilization rate of consultative-specialist and diagnostic services and hospital treatment. The first level of contact of individuals with the health system was fragmented, where the gate-keeping role was limited and insufficient attention was paid to the continuity of health care. At the PHC level, in the majority of health centers, services were delivered according to age, gender or type of disease, by specialized departments or services, which did not constitute the most efficient way of utilization of available resources. Inefficiency of health services delivery was evidenced by health expenditures, where an emphasis remained on the secondary and tertiary health care to the detriment of primary health care [5, 12].

In the BiH health system, not a single strategy dealt with human resources. It was necessary to develop such a strategy, which will identify the current and future needs, implementation plans, as well as financial implications of its application. The current number of doctors and nurses/medical technicians at the PHC level did not suffice for the implementation of the family medicine-based PHC reform. At the PHC level, there were a large number of doctors - specialists in various areas of medicine, which was a legacy of the previous system. Such a profile of doctors at the primary health care level impeded the implementation of the reform and introduction of the family medicine model [5, 12]. Also, with the rapidly ageing population, the burden of disease continued to grow. The control of outbreaks of mass non-communicable diseases was the main public health challenge.

The health care reform in the BiH aimed to: introduce the family medicine model, establish an efficient entry point into the health system, rehabilitate the PHC infrastructure, allow a free choice of a doctor, establish new mechanism for health care resource allocation and introduce new provider payment mechanisms, enhance the organization, planning and management of health institutions, develop and implement national health policies, strategies and programs [12, 13].

The Family Medicine Development Project

The Family Medicine Development Project in Bosnia and

Herzegovina was an initiative funded by the Canadian International Development Agency (CIDA) that was sparked by a visit to Queen's University (Kingston, Canada) by the Dean of the Medical School in Sarajevo in 1995. He came specifically to encourage the Department of Family Medicine to look into the possibility of helping our country establish an effective primary care infrastructure based on the Canadian family medicine model. Two years later, after much work and effort by Director of the project, and with the support other professors from Queen's University, the project became a reality. The project involved establishing family medicine teaching centers in the five medical schools in Bosnia and Herzegovina: Foca, Sarajevo, Tuzla, Mostar, and BanjaLuka. It introduced family medicine into undergraduate curricula, established three-years long program of residency in family medicine, created departments of family medicine in all medical schools, helped with the process of establishing a professional college of family doctors, worked with ministries of health to establish supportive policies for these activities, and regularly provided continuing medical education programs for family practitioners during the 13 years of the project.

The Family Medicine Development Project in Bosnia and Herzegovina was the contribution of the Canadian Government through the Canadian International Development Agency (CIDA). The primary objective of CIDA's health programming in BiH was to support health care policy reform by ensuring that the partner country has the capacity to develop and implement health policies that support efficient and effective primary health care. The project's ultimate goal was to establish, with the help of the local physicians and medical faculties, an effective family medicine educational infrastructure that continued after the project finished.

The Queen's Family Medicine Program, as well as programs of other international health aid agencies introduced new concepts and approaches to health care that are challenging and at times difficult for individuals to incorporate into their understanding of what it means to be a health care consumer or provider [14].

Further Expansion of Family Medicine

Changes to the stewardship function and organizational structures included the creation of a Federal Ministry of Health with decentralization of health services to entity (in the case of the RS) and canton levels (with 10 cantons in FBiH, each with a minister of health). At operational level, family medicine was established as a medical specialty and introduced into municipality health centers as gatekeepers and providers of PHC services. Autonomous family medicine teams (comprising a family physician and one or two family medicine nurses) were created. These could contract directly with the municipality health centers or through them with the newly created health insurance organizations (one in RS and one in each of the 10 cantons of the FBiH) to provide health care services: a shift from salaried employment. At PHC level, users were given the right to choose their family physicians [15].

Budget funding was replaced with a mixed financing system, with the introduction of health insurance to complement budget transfers from the state and local government. Provider payment systems for PHC changed from budgets to simple per capita in order to slow the growth of heath care spending and give the entities impetus to find creative ways to provide services more efficiently. Changes in service provision were driven by the introduction of service contracts between health insurance organizations and PHC providers, which defined the scope of services delivered, and specified use of evidence-based guidelines set the quality standards, which were used for the accreditation of PHC providers, and prescribed the essential equipment used to deliver services. The family medicine model extended the scope of services delivered in the PHC setting by family physicians and family medicine nurses to include health education, promotion, disease prevention interventions, expanded diagnostic and curative services thus enabling the family medicine team to act as a gate keeper while providing more comprehensive and continuous health care services to its registered population. The new family medicine centered PHC service model had a major impact on professional identity, inter-professional relationships and organizational routines [15,16].

While many transition countries have struggled with the introduction of family medicine centered PHC reforms, in spite of considerable resource constraints and a challenging post-war context, within 18 years, BiH has managed to scale up multifaceted reforms to cover over 80% of the country. Although many rural PHC centers adopted reform, generally, the success of it was weaker in rural compared to urban settings. Very often, rural PHC centers employed older doctors, specialists with additional training in family medicine who are quite reluctant to the changes or young physicians who are looking for the other post or hospital career. On the other hand, the lack of employment opportunities in *rural areas* is hindering economic revival and local community is not able to participate in its development.

The study conducted in 2004–05 over 18 months analyzed PHC reforms in a transition country from an innovation lens, provided empirical evidence on PHC reforms in BiH, a particularly complex post-war setting. Most of the respondents interviewed perceived family medicine to be beneficial to users, health professionals working at PHC level and the health system. Key perceived advantages of the new family medicine model were identified as greater emphasis on holistic and user-centric health care with expanded services, especially health promotion and prevention. Family medicine was seen as a "more human, friendly health care model", with a "holistic approach to the population's health needs", which gave the users simultaneously more "choice" and "responsibility with health decisions". The family orientation of the model allowed "personal problems to be seen in a broader context". Health needs", which gave the users simultaneously more "choice" and "responsibility with health decisions". The family orientation of the model allowed "personal problems to be seen in a broader context". Perceived benefits for the users included "improved access to the system", "improved doctor-patient relationship" and "an increased individual responsibility for the health professionals towards the user", and "respect for one's time". For the health professionals, as many informants explained, the family medicine model and the accompanying organizational/financing changes led to a "more meritocratic payment system" with the introduction of "performance related pay", which created "an opportunity for promotion of those who perform well". Whereas, for the health system, the perceived benefits related to improved productivity and equity, as family medicine was seen to be "more

rational and cost-effective", introduced "gate keeping" to reduce unnecessary hospitalizations, and increased accessibility to health services which improved equity in the system [15]. However, further research on the effectiveness of PHC in Bosnia is needed.

Conclusion

Family medicine centered primary health care reform was a complex innovation, involving organizational, financial, clinical and relational changes. An important factor influencing the adoption of this complex innovation in BiH was the perceived benefits of the innovation: benefits which accrue to the users, family physicians, nurses and policy makers. With political commitment, an enabling economic environment and equitable distribution of resources, comprehensive PHC has proved to be a better strategy in achieving the goal of health for all. However, although family medicine passed through long journey from imposition to partnership, there is still largeplace for the improvement.

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