

**A PLEA FOR AN INITIATIVE TO STRENGTHEN FAMILY
MEDICINE IN PUBLIC HEALTH CARE SERVICES
OF DEVELOPING COUNTRIES**

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An analysis of standards for the best practice of family medicine in Northern European countries provides a framework for identifying the difficulties and deficiencies in the health services of developing countries, and offers strategies and criteria for improving primary health care practice. Besides well-documented socioeconomic and political problems, poor quality of care is an important factor in the weaknesses of health services. In particular, a patient-centered perspective in primary care practice is barely reflected in the medical curriculum of developing countries. Instead, public sector general practitioners are required to concentrate on preventive programs that tackle a few well-defined diseases and that tend to be dominated by quantitative objectives, at the expense of individually tailored prevention and treatment. Reasons for this include training oriented to hospital medicine and aspects of GPs' social status and health care organization that have undermined motivation and restricted change. A range of strategies is urgently required, including training to improve both clinical skills and aspects of the doctor-patient interaction. More effective government health policies are also needed. Co-operation agencies can contribute by granting political protection to public health centers and working to orient the care delivered at this level toward patient-centered medicine.

Analysis of the poor quality of primary care in the health services of developing countries can take advantage of the experience of some Northern European countries in family medicine. An analysis of standards for best practice of family medicine provides a framework for identifying difficulties and deficiencies in developing countries and offers strategies and criteria for improving primary health care practice.

In order to improve access to modern health care in developing countries, UNICEF and the World Health Organization launched the Bamako Initiative (1) in 1987, in an attempt to render underfinanced public services in developing countries more dynamic. This program involved the financing of revolving funds to be used by health services to purchase essential drugs. It encouraged the active participation of communities in the management of these funds in order to make government services more accessible and to counterbalance the power of health care professionals. In countries where the Bamako Initiative was most successful, utilization rates barely reached 0.5 new cases of sickness episodes per year per inhabitant (2, 3), but this was a major achievement for Guinea, Benin, and Uganda. However, in a number of other countries, utilization rates continued to deteriorate. For example, rates of first-line consultations in the Burkina Faso health services showed a continuously downward slide, from 0.32 new cases of sickness episode per year per inhabitant in 1986 to 0.17 in 1997 (4).

A number of factors account for this worrying trend. The socioeconomic situation in many developing countries has strained both consumers' buying power and care providers' salaries. Continuing budget crises (5) have resulted in reduced priority on spending on social problems. The political appointment of ineffective managers has undermined the effectiveness of existing institutions. These factors, together with the weak capacity of lower social classes to defend their interests within the state administration and political circles, have contributed to a reduced access to health services. Exacerbating these problems is the concentration of health professionals in urban areas.

In addition to these well-documented problems, the poor quality of care is also an important reason for the weak appeal of health services (6, 7), in particular the lack of a patient-centered perspective in primary care practice.

Although first-line health care providers often include pediatricians and gynecologists (in Latin America), medical assistants and nurses (in Africa), and *feldschers* (medical assistants) in Eastern Europe and central Asia, the focus of this article is on doctors who are general practitioners (GPs). The emphasis is not on government-owned facilities per se, but more broadly on health care institutions pursuing a public purpose (government-owned or not), that is, with policies characterized by a quest for equity, social solidarity, well-being, and autonomy (8).

STANDARDS OF BEST PRACTICE IN FAMILY MEDICINE AROUND THE WORLD

Quality of care in general practice remains an ill-defined concept (9). This hampers the organization of health care, strains the professional identity of GPs, and reduces their effectiveness. In England, the following characteristics have been used to define primary care practices and practitioners: "excellence in diagnosing and treating established illness, in preventing the onset of illness, in

enabling patients to understand and make sense of their illness, in meeting patients' wants, and in business efficiency" (10). While this definition applies to all doctors, Starfield (11) offers specific operational criteria to define primary care: the elements of first contact, continuity, comprehensiveness, and a coordination or synthesis function. Another dimension often attributed to good general practice is the improvement of patient autonomy. Clients' demands and satisfaction criteria provide useful insight into the definition of quality. A study undertaken in England, Greece, Yugoslavia, and the former Soviet Union showed that key dimensions of satisfaction with GP care include the nature and quality of the doctor-patient relationship as well as the GP's professional skills (12). A meta-analysis of patients' priorities for GP care revealed that, of a total of 57 options, the most frequently mentioned characteristics were provision of information, a humane attitude, and the competence of the doctor (13). Based on the experience of developing countries, Haddad and colleagues (6) reached similar conclusions and proposed the following taxonomy of perceived quality: technical competence, good interpersonal relations, availability of resources and services, and accessibility and effectiveness of care. Psychological factors are also known to influence consulting behavior (14), and the crucial importance of effective interpersonal relations to primary care patients in developing countries has repeatedly been observed (6, 15), although this appears to be less acute in private practice (16).

Clearly, the inclusion of communication skills in medical training is important, but practices and standards vary markedly throughout the world. Communication skills are better addressed in the United States and in Northern Europe, particularly for doctors in GP training schemes, and gradual progress is occurring in many Southern European countries. Unfortunately, this issue remains largely absent from the medical curriculum in developing countries. Perhaps not surprisingly, there is a corresponding shortage of research on patients' views in the developing world (17, 18). This scarcity probably reflects the marked difference of perspective within health services in different parts of the world (6, 15, 19).

In industrialized countries, family medicine has espoused a patient-centered model of doctor-patient interaction, whereby the doctor actively seeks the patient's point of view (20). This approach has been shown to result in greater patient compliance and satisfaction. Key elements of patient-centered care for European GPs (21) imply the following processes:

- In a continuous process of dialogue with the patient, the doctor assesses the social, family, psychological, and somatic factors that may influence the health problem (22) and its solution, using home visits and information devices such as family files. The doctor may thus eventually achieve a holistic picture of the patient's situation.
- On this basis, the doctor discusses solutions with the patient, and together they agree upon a strategy involving possibly curative, preventive, and/or

health-promotional care appropriate to the patient's specific needs. The GP may also steer the patient toward other professionals (e.g., social worker, community nurse, physiotherapist) or a self-help group (such as for alcoholism or drug abuse), or may refer the patient to a hospital specialist. The GP, however, retains the responsibility for coordinating the teamwork and ensures a proper synthesis of all relevant information.

This process takes place within a context in which GPs are expected to offer their patients tailor-made curative, health-promotion and disease-prevention strategies (23), and specific methods to structure such consultations have been designed accordingly (e.g., SOAP; 24).

In the face of widespread critiques of disease- and doctor-centered models, much progress has been made in developing the problem-solving approach (25) and the patient-centered clinical method (26). Unfortunately, however, in terms of providing standards of good practice in undergraduate medical education, these approaches still remain largely confined to Northern Europe and North America.

PRIMARY CARE PRACTICE IN DEVELOPING COUNTRIES

Very little has been published on the quality of care within the primary care sector of developing countries, and virtually nothing on patient-centered care in this setting. This is in marked contrast to the vast literature on holistic care in traditional medicine. It is difficult to avoid the impression that standards of good practice are more frequently met in industrialized than in developing countries, even if, in Europe and North America, the individual dimension of care is not always sufficiently present (27, 28).

Public sector GPs in developing countries generally concentrate on the sort of preventive programs (prenatal care, under-five child clinics and immunizations, family planning, nutritional rehabilitation, and disease control programs) that were introduced by colonial medicine. This approach is still very much in line with current World Bank guidelines (29). To the extent that they consider disease management part of the GP's clinical responsibility, ministries of health generally play down its importance. The energy devoted to preventive programs, together with poor resource management, resulted in the diminished importance of curative care in public facilities during the 1980s and 1990s. This was in line with the 1993 World Development Report, which stated that in poor countries, public facilities should deliver only "essential clinical services" (29), which meant a curative solution for a few well-defined diseases.

The purpose of this concession to the public service in its competition with the private sector may have been to integrate disease control programs (such as prevention of diarrheal diseases and acute respiratory infections) into the work of

public health facilities. Obviously, patients must be present at health centers if candidates for these programs are to be recruited, but this approach effectively limits the ability of GPs working in government facilities to meet patient demand within the public sector. Although these GPs frequently have their own private practice—part-time employment is widespread in developing countries' public services—this emphasis on preventive programs inevitably undermines GPs' ability to offer a wide array of treatments and individually tailored prevention within the public sector.

Ministries of health tend to define GPs as “good” when they create links between programs, enabling patients to access the right program for their health status at the right time. However, if only five or six preventive programs and “elementary” curative care are available, then the patient-centered principle is of limited relevance. All that is required is a small number of parameters to enable GPs to channel the patient to the appropriate program (Is she pregnant? Does she want to postpone the next pregnancy? Is the child vaccinated?). In practice, GPs in developing countries rarely build generic preventive activities into curative care (with the exception of immunization or the (directly observed therapy) DOT tuberculosis control strategy). Only in exceptional cases do they set up prevention programs that are not part of a national program.

The implementation of prevention programs tends to be dominated by quantitative objectives. Together with the frequent, often inappropriate, use of standardized guidelines, this helps to explain why communication between patients and primary care providers is, on the whole, so poor in clinical practice in developing countries (6, 13). A clear example of this is the use in some Latin American countries of “post-consultation,” during which auxiliaries explain to the patient his or her condition and treatment—which the doctors themselves could do.

In their private practice, GPs show their skills by prescribing treatments that are supposedly tailored to individual need, rather than by addressing psychological and family problems. In addition, prescribing habits are biased by doctors' wish to improve their incomes. In other words, their knowledge is closer to accepted medical standards than is their actual prescribing practice (16). In making diagnoses, the doctor tends to jump on the first major *complaint* the patient presents, without letting the patient explain his or her problem any further. Then, the GP often spends time taking down numerous *signs* and *symptoms* (rarely used thereafter), greatly reducing the time for communication. It seems that in the majority of developing countries, GPs and medical assistants simply assume that psychological problems are for the psychologist, social problems for the social worker, and family problems for the traditional healer.

These examples suggest that GPs in developing countries do not sufficiently take into consideration the individual dimension of care. We need to understand the factors underlying this situation before any solutions can be identified.

REASONS FOR THE LOW PRIORITY OF PATIENT-CENTERED CARE IN DEVELOPING COUNTRIES

In Africa, and to a large extent in Latin America and Asia, health care for the poor has usually been the object of central planning, since few doctors voluntarily choose to live and work in poor and deprived neighborhoods (except in some church-related health care institutions). Fifty years ago, family practice still lacked the necessary legitimacy to be exported from the industrialized world (to the colonies) or imported by independent countries (in Latin America) (30). In Africa and Asia, “colonial” medicine was mainly characterized by hospitals and disease-control programs (sometimes managed in military style, as in French Western and Equatorial Africa). Medical specialists controlled undergraduate medical education, because general practice was considered unscientific (31).

The Alma-Ata conference boosted primary health care without stressing the importance of responding to individually expressed needs. Later, following World Bank policy, ministries of health concentrated their funding on disease-control programs along the lines of selective primary health care (29), criticized for its inefficiency and lack of acceptability in recipient communities (32). Their bureaucratic rationale continued to emphasize guidelines and instructions, in marked contrast to the professional rationale prevailing in the industrialized countries, which promoted individual decision-making (33).

The emphasis on only a few programs was further reinforced by the argument that, with the medical assistants and nurses in charge of primary health care services having such low levels of education, this was all that could realistically be delivered. However, positive experiences with African medical assistants, given appropriate training and supervision (34), suggest that the educational level of medical assistants is not a valid reason for basing first-line health services on just a few programs; rather, this provides an a posteriori justification for program-driven services.

For GPs, their employment structure inevitably reinforces the professional identity forged by training. With members of the employment hierarchy and international experts all stressing quantitative objectives (i.e., coverage) at the expense of nonprogrammed preventive and curative care, the only communication skill required of GPs is the capacity to convince (“Information, Education, Communication”) and to make patients comply.

This is not to deny the impact of some disease-control program—notably those for children under five, where a significant impact on life expectancy can be achieved, and, to a lesser extent, those for expectant mothers. However, the limited scope of such programs is a serious handicap. In Africa, for instance, national diarrhea-control programs saw oral rehydration as the sole therapeutic device, with no reference to the use of antibiotic, anti-amebiasis, or anti-giardiasis drugs, indicated in some cases of diarrhea. Most significantly, the concentration on specific disease-control programs meant that for a vast majority of ministries of

health, other childhood complaints and adult pathologies, including psychosocial problems, were not considered part of primary care responsibilities.

Health service organization can be classified on a continuum according to a program's degree of integration, ranging from a single addressed health problem to a wider range, including specialized vertical programs, multipurpose specialized organizations (the *grandes endémies* in Western Africa), and vertical programs integrated in primary care health services with or without holistic care. Whatever the specific organization, it remains true that on the world map of health care, the borders of the developing world correspond to the area where disease-control programs are pivotal in public health organization.

Vertical programs integrated into first-line health services could have been compatible with a biopsychosocial approach. Even in Europe, GPs could benefit from standards improving their handling of specific complaints and diseases. A lack of vision, however, has undermined program integration. In practice, the integration process has contributed to unsustainable outputs and a deterioration of quality of care. Furthermore, the downgrading of the professional identity of first-line care providers to merely meeting technical standards in narrow domains (35), together with the oversimplification of the definition of primary health care's professional responsibilities, has resulted in low morale among health professionals.

While some level of rationalization is needed to support sound decision-making, excessive rationalization works against individualized patient-centered care. Disease-control programs set ambitious coverage objectives to the detriment of quality, which is less easy to measure. Rationalization affected clinical practice, requiring GPs to be disease-oriented rather than responsive to individual complaints; and the setting of objectives and standards undermined individual quests to improve clinical skills. However, implementation of these policies was not always straightforward. GPs and medical assistants often resisted disease-control norms (although relevant workshops were a source of significant revenue), mostly because these norms were imposed without their participation in the design. Hence GPs went on prescribing expensive drugs (to increase their income) and promoting their skills (16), rather than establishing a genuine dialogue with their patients.

This can be explained by cultural factors affecting doctors' behavior (36). Both GPs in the European countries and traditional healers in developing countries have inherited a tradition of patient-centered care, but this has not been the case with doctors in developing countries (33). The holistic dimension of traditional healers' practice has been played down or even ridiculed. Only recently have medical students in industrialized countries begun to benefit from a conceptualization of general practice that enables them to criticize guidelines and attitudes, taught by specialists, that are incompatible with their task and mission (37).

Clinical education in developing countries followed the old patterns of industrialized countries, with even more detrimental consequences. Undergraduate studies and rotations rarely exposed students to criteria such as efficiency, problem

solving, and use of appropriate technology. Semiology¹ was undermined by relying extensively on radiology and laboratory tests. GPs were not taught to use experience to address health problems caused or exacerbated by psychological and social factors, and therefore were often unaware of the existence of psychosomatic conditions. It is not surprising that many found the work situation outside the university teaching hospital environment so frustrating.

Although intellectual and institutional strategies aimed at strengthening family practice have been markedly absent from developing countries, some changes are now taking place. Recently, in eastern European countries and in Argentina, a strengthening of general practice has been encouraged, although driven more by the need for more effective gate keepers (in order to reduce the pressure on secondary care and thus reduce costs) than by choice and a desire to improve access to holistic care. It is significant that the World Bank favors these moves in countries (Argentina, eastern Europe, central Asia) where primary care is likely to be privatized in the near future.

Another set of factors that has shaped the different situation of GPs in industrialized and developing countries relates to patients' expectations. The difference cannot be entirely explained by a different demand structure, according to which European patients expect more interaction with their doctor than do their counterparts in developing countries. Such a demand could easily be created if GPs in developing countries delivered patient-centered care (19). Social and demographic variables interfere in patient-doctor communication in industrialized countries (38). GPs tend to devote more time to a consultation with a middle-class patient than with a working-class patient (39). Another study suggests that in Australia, socioeconomically disadvantaged patients may not be receiving the health care they require (40). Such variables will have an even greater significance in societies where the social divide is wider and economic differentials between social classes are greater than in industrialized countries. The lack of effective doctor-patient communication is further exacerbated by GPs' social status. In most developing countries, the majority of doctors are of lower-middle-class origin and often experience rejection by higher social classes. In response to this, they are inclined to deny the possibility of effective communication with lower-class patients ("they don't understand anything") in order to emphasize their own middle-class status.

STRATEGIES TO IMPROVE PRIMARY CARE

This article advocates strategies for improving the quality of care in public-oriented services. Public services still represent an important part—probably the most important part—of health care delivery in many developing countries (41).

¹ Semiology is the study of signs and symptoms of a disease, favoring the use of medical history and clinical examination of the patient.

Even in countries with virtually no state-run primary care health services, such as Bangladesh, many nongovernmental organizations (NGOs) operate along the lines of public services. Since public sector health services are unlikely to disappear completely in years to come, they need to develop appropriate strategies for improving the quality of care they provide.

A number of initiatives have already been introduced for private care providers in developing countries, with little or no success. These include dissemination of information and training interventions (42, 43) in situations where overprescribing posed a problem (44). According to Brugha and Zwi (45), such activities are unlikely to yield the desired results (16), because of the “discrepancies between provider knowledge and practice” in the private sector. Governments in developing countries have particular difficulties in controlling and modifying private practice, because they do not control the bulk of the sector’s finances, and experience suggests that dissemination of information and training interventions in the public sector are more feasible (44). A final reason for concentrating on public facilities is the technical difficulty of implementing reform on the supply side. Ministries of health in developing countries rarely have the expertise to contract with and to regulate private providers (46), and civil servants on low salaries may not be motivated to defend the public’s financial interest.

A range of strategies is required, in addition to changes in the undergraduate curriculum, which can take more than 15 years to have an effect (47). The slow rate of introduction of family practice training programs stems from the difficulties doctors face in finding the funding for such training. Only a small proportion of GPs can afford to take on a two-year training program in combination with their work responsibilities. In addition, there is frequently resistance from specialists to the introduction of family practice curricula in universities. Finally, newly trained doctors are unlikely to be employed rapidly by public services.

A number of strategies for improving patient-centered primary health care are set out below. Not all are applicable in every situation, but they can be drawn upon once a diagnosis has been made of the local or national situation. They should be treated as hypotheses to be tested in the context of action research, under the aegis of professional associations, ministries, universities, community representatives, and international agencies.

In-service Development of Patient-Centered Care

General practitioners’ biomedical approach to disease can be modified by sound theories on disease etiology (to enlarge the scope of determinants beyond the biomedical) and by audit-oriented observations (to identify deficiencies in care) (48). One can teach GPs criteria for the quality of care, such as continuity, the quest for patient autonomy, and the need to medicalize a problem (or not). In-service demonstration of patient-centered care should be offered to doctors in pilot facilities.

Strategies to improve the patient-doctor interaction have proved effective in Europe (49) as well as in developing countries (50). Pilot projects have improved it steeply (34). Dialogue can become an intellectual challenge if relevant techniques are taught. Training in communication can rely on a psychiatrist with expertise in the doctor-patient relationship, and *aide-mémoires* of special patients' problems can be designed to systematically explore psychosocial and psychosomatic disorders (e.g., sexual problems, drug addiction, alcohol dependence). Personal experience of one of the authors in Ecuador, based on these strategies, showed changes in the care provider's willingness to deliver holistic care.

Balint groups² permit the exchange of experiences and an analysis of how the doctor's own feelings can interfere with case management. It remains to be seen whether these techniques are applicable to doctors in cultures that are not inclined to introspection, or whether other approaches, building upon traditional knowledge of social relationships, would be more relevant to the context of developing countries. Quantifiable methods of evaluating the quality of the structure, process, and outcome of psychological care are achievable in general practice (51). Problem-oriented medical records, such as the SOAP method, can be used to structure the consultation (24).

Improvement of Clinical Skills

Levels of manual skills are highly variable: in some countries, GPs can perform a cesarean section, while in others they do not know how to insert an intrauterine device, perform a nasal tamponage, or incise a whitlow. Numerous development projects have aimed at improving the surgical skills of first-line health professionals (52–54).

Often, the signs, symptoms, and tests that GPs use are more adapted to the hospital setting than to their own practice: the predictive values of the tests are a function of disease prevalence, which, for serious conditions, tends to be much lower in the GP's case mix than in the hospital's. In addition, the use of these signs and tests is usually taught by hospital specialists on medical faculties.

There are some plans to improve clinical skills in primary care services (e.g., 55). As in Europe (56), their paradigm has often been quality assurance (57–59). However, of 15,354 papers on quality assurance found on Medline for the 1985–1999 period, only about 1 percent concern developing countries. Furthermore, these papers are characterized by efforts to improve practice for known diseases and management resources, usually building on agreed-upon standards. Staff expected to use these standards should be involved in the design or local adaptation of guidelines, algorithms, and decision trees—of the utmost

² Michael and Enid Balint pioneered the use of case discussion groups for GPs that used psychodynamic theory and principles.

importance for medical auxiliaries with GP responsibilities—if they are to use them effectively in practice. It remains to be seen whether the clinical deficiencies of non-doctor staff to whom medical duties are delegated—even though corrected by the use of decision-making tools—will hamper their capacity to deliver patient-centered care. Such shortcomings may impede the process of identifying, analyzing, and correcting links between social, family, and psychological problems on the one hand and somatic disorders on the other (60).

Poor access to up-to-date scientific information has long undermined the efficacy of quality assurance methods in the developing world, although the recent accessibility of the Internet now enables many district medical officers and hospital doctors to access evidence-based medical sites.

Improvement of GPs' Motivation

Much has been said on the issue of salaries and career prospects in improving motivation, and these are indeed important. One way to involve international agencies in paying salaries and operating costs (15) would be by maintaining salaries at the same level during the development project's devolution to national authorities.

Although material benefits and a decent income certainly contribute, these by themselves are not sufficient to improve quality of care (61). Less materialistic issues should also be addressed by district medical officers and GP associations. There should be an open discussion of a political approach to development and the grounds on which the health professional is attempting to get social recognition (as learned by one author from personal experience of the ITM Masters of Public Health Programme in Ecuador). Another avenue for motivating public service staff is to pressure health committees, NGOs, and development projects to use objective criteria for selecting staff, thus counterbalancing political influences and clientage relationships. Health policies—whether privatization, contracting-out, or publicly delivered care—cannot be expected to succeed if factors other than experience and competence dominate the recruitment of civil servants. Finally, professional identity can be enhanced by narrowing the gap between the clinical techniques mastered by the professionals and the available equipment. To achieve this, in-service training should focus on the use of semiology rather than extensive use of lab tests and imaging.

A fundamental objective of all these strategies should be to drive GPs toward adopting reflexive, self-evaluative, and continuing-education practices, but this is not easy given the cultural factors determining work attitudes.

Improvement of the General Organization of Health Care Delivery

In developed countries, improved management of health facilities has a limited relationship to actual performance (62), but this relationship is likely to be more

important in developing countries. Some of the latter have great deficiencies in the equipment of GPs' practices, delegation, patient flow, organization of teamwork, quality assessment, and optimization of workload.

Changes in Health Policy

Ministries of health in developing countries should create national directorates for general practice in order to improve management and steer in-service training and sector planning. This requires a strong political will. When senior ministerial officials are unwilling to promote general practice in public services nationwide, interim strategies can be based on midlevel managers through international projects. At a local level, there are also possibilities for building a community counter-power (health committees in dispensaries and hospitals, mutual health organizations, etc.) to check health professionals and civil servants. This would help tackle the larger issue of the limited control by lower social classes over state institutions and help launch GPs into a dialogue with communities about setting up the public health services.

CONCLUSION

What can we expect from these changes? A better relationship between practitioners and patients could pave the way for a renewed community interest in public primary health care services. In other words, an improved doctor-patient relationship could encourage community involvement in the management of health centers. When GPs understand what patient-centered care is, they will spontaneously improve links between programs. They will experience more job satisfaction as a result of the smoother fit between professional expectations and skills. And patient satisfaction also will improve.

It took forty years of continuous effort to recognize the value of family medicine in industrialized countries, a process involving conceptualization, information and advocacy, professionals' union organization, and staff and curriculum changes in universities. In developing countries, GP associations and academics can build upon these achievements and take advantage of the fact that family practice has now been conceptualized in such a way that it can be taught. Multilateral and possibly bilateral development agencies could contribute to shortening this lengthy process. However, this international involvement must be carefully weighed and designed, since it was inappropriate external influences that first helped to drive general practice into its current corner.

A major effort is needed to halt the current deterioration of public services, which is resulting in inadequate access to care for the majority of the population in many developing countries. GPs must serve as cornerstones of comprehensive primary health care systems (63). Family medicine programs are well established in the Americas and Northern Europe and are underdeveloped in former

communist countries, in India, and in China. However, continuing medical education and managerial strategies that permit doctors to keep working while being trained in family medicine have yet to be formulated. They should now be tested and implemented in health systems.

The integration of disease-control interventions within primary health care services gives these services the political protection of those interested in program delivery at low cost (i.e., donor agencies). Integration often, but by no means always, makes health systems more cost-effective. The integration process should meet a number of basic conditions (64). A poorly integrated program, in the sense of vertical programs that impose their rationale on health centers, can contribute to the deterioration of quality of care (35). Fostering family practice in the public services should help neutralize these detrimental effects. Community participation as an ingredient of public health facilities management, as advocated by UNICEF and WHO, requires a decent level of accessibility to care. On that score, patient-centered care and enhancement of GPs' problem-solving capacity can both improve the public services' response to patients' demand and, indirectly, contribute to funding their activities.

With the Bamako Initiative (1), UNICEF and WHO promoted access to drugs and community co-management of public services in developing countries. Cooperation agencies, by granting political protection to public health centers and working to orient the care delivered at this level toward patient-centered medicine, can contribute, politically and operationally, to promoting GPs' status and the efficacy of first-line care.

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