

Editorial

Integrating prevention and primary health care: everywhere on the agenda

Most contributions in this IJIC issue discuss efforts to link health promotion, disease prevention and curative primary health care. H.H. Duba and D. Sanders show the importance of these efforts for poor people in Kenya and South Africa. Vienonen gives a detailed overview of developments in the Russian Federation to design a nation-wide health system in which disease prevention and primary health care are the main points. However, this type of integration is not only on the agenda in poorer countries. In the United Kingdom, the health debate concentrates on the creation of so-called primary care groups that are responsible for preventive services, family medicine and home care. Goodwin gives in his paper the state of this debate.

The success of integrated primary health care depends on three factors, as Eijkelberg shows in her qualitative case study. The program should be adequate, its managers mission driven and skilled and the local and political context supportive. In theory, integrated programs are often excellent and full of promise. In practice, the management of them is complicated. Doctors, nurses and health workers are often separately educated, with their own paradigms, standards and objectives of interventions. A manager has to translate and mix these, sometimes creating new values and sometimes compromising the old ones. The local and political context is often a big restraint for the integration processes. Regulation and power distribution often functions as a brake and seldom as an accelerator.

There are many ways to start integration of preventive services and primary health care. The IJIC contributions from north, south, west and east of the world show these. Professor Sanders shows a 'bottom up'

approach with charismatic leadership, trying to give a good example. In the United Kingdom the entrance to integration is a national debate from which detailed implementation is derived. This is a 'top down' approach. The Russian Federation receives visits from many policy advisors from Western Europe, who advise to implement social insurance within the so-called Bismarck model. This is an 'outside in' approach. On the contrary, Eijkelberg shows the working of an 'inside out' scenario: existing small-scale integrated care projects are merging themselves to one larger scale disease management program.

Which implementation approach is adequate depends again on the local and political context. If the national and political context is unfavourable for integrating health services a 'bottom up' approach is preferable. Is the local context chilly, then maybe a central, 'top down' approach might prove to be an easier way.

What catch the eye in this IJIC issue are the references of all contributions: The article on Kenya has Kenyan footnotes and the contribution from the United Kingdom refers to British sources. The same is the case for other articles. For the IJIC editors this is a signal that there is a need for this journal. We offer a platform for international exchange of knowledge on integration of prevention, cure and long term care, as well as on integration within one and the same sector, for instance between hospitals and nursing homes. We invite all readers to become authors and to inform each other about successes and pitfalls of their integration efforts.

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