EUROPE AND EURASIA: EXPERIENCE IN INTEGRATED PRIMARY HEALTH CARE AND FAMILY MEDICINE ASSESSMENT

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DISCLAIMER
The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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<td>ADB</td>
<td>Asian Development Bank</td>
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<td>AIHA</td>
<td>American International Health Alliance</td>
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<td>ASTP</td>
<td>Armenia Social Transition Program</td>
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<td>BBP</td>
<td>Basic Benefit Package</td>
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<td>CAR</td>
<td>Central Asian Republics</td>
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<tr>
<td>CEE</td>
<td>Central and Eastern Europe</td>
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<tr>
<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<td>CME</td>
<td>Continuing Medical Education</td>
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<td>DFID</td>
<td>UK Department for International Development</td>
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<td>DHCPR</td>
<td>Department of Health Communication and Public Relations</td>
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<tr>
<td>DRG</td>
<td>Diagnosis related group</td>
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<tr>
<td>E&amp;E</td>
<td>Europe and Eurasia</td>
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<td>EBM</td>
<td>Evidence-based medicine</td>
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<td>ECG</td>
<td>Echocardiogram</td>
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<td>EHIF</td>
<td>Estonia Health Insurance Fund</td>
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<td>EU</td>
<td>European Union</td>
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<td>FAP</td>
<td>Feldsher-midwifery post</td>
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<td>FD</td>
<td>Family medicine doctor</td>
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<td>FGPA</td>
<td>Family Group Practice Association</td>
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<td>FM</td>
<td>Family medicine</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FSU</td>
<td>Former Soviet Union</td>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>GDP</td>
<td>Gross domestic product</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<tr>
<td>GHTech</td>
<td>Global Health Technical Assistance Project</td>
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<tr>
<td>GOBI</td>
<td>Growth Monitoring, Oral Rehydration, Breast Feeding, and Immunization Strategy for Child Survival</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HA</td>
<td>Hospital Association</td>
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<tr>
<td>HC</td>
<td>Health center</td>
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<tr>
<td>HIF</td>
<td>Health Insurance Fund</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HIMS</td>
<td>Health Insurance Mediation Service</td>
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<td>HMIS</td>
<td>Health Management Information Systems</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<td>IPHC</td>
<td>Integrated Primary Health Care</td>
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<td>IT/IS</td>
<td>Information Technology/Systems</td>
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EXECUTIVE SUMMARY

BACKGROUND

In 1993, the U.S. Agency for International Development (USAID) began supporting efforts to implement the Integrated Primary Health Care/Family Medicine (IPHC/FM) model in Eastern Europe and Eurasia (E&E), starting with projects in Kazakhstan, Kyrgyzstan, the Russian Federation, Ukraine, and Uzbekistan. USAID extended this work to Albania, the Caucasus countries, and Romania in the early 2000s. After 17 years of sustained effort, the USAID/E&E Bureau has commissioned an assessment of the approach.

The three objectives of this assessment were to: (1) document the experience of E&E countries in implementing the IPHC approach based on the FM framework and Health Systems Strengthening (HSS); (2) assess the strengths, weaknesses, opportunities, and threats (SWOT) of the IPHC approach, taking into account the effectiveness—or ineffectiveness—of the approach in achieving health outcomes and building health systems capacity; and (3) provide recommendations to E&E Missions, host countries, and development partners on how they can more effectively implement IPHC programs in the future. The E&E Bureau will also use the assessment report to guide future programming and to support President Obama’s Global Health Initiative (GHI).

A project team was assembled to conduct the assessment, and part of their workplan included an extensive Literature Review and Analysis (Annex 4) of general trends in primary health care (PHC) and the history of PHC in the E&E region. This literature review included important individual country information, which is incorporated into individual Country Assessments (Annex 3). The more general material contained in the literature review is repeated in the main body of this report as important background to the regional analysis that follows it. The regional analysis itself is built on the team’s review of key informant interviews, the two countries visited (Armenia and Albania), the personal experience of one team member (George Purvis) working directly with other countries in the region, and the insights gained from the Literature Review and Analysis.

The project team also interviewed key informants in person or by phone with USAID staff, development partners, other representatives of the United States in the countries, and representatives of host country governments including Ministries of Health, health care providers, contractors, and other relevant individuals and organizations. To augment these individual interviews with group perspectives, a roundtable discussion between representatives of key development partners was held in Washington, DC.

Field visits were made, each lasting a week or more, to two of the currently most active IPHC/FM countries in the E&E region (Albania and Armenia), and the project team prepared a Country Assessment for each.

Country Assessments were also written for all other countries considered but not visited: Azerbaijan, Belarus, Estonia, Georgia, Kyrgyzstan, Moldova, Romania, the Russian Federation, and Ukraine. All eleven Country Assessments can be found in Annex 3.

A complete list of all contacts made by the project team is found in Annex 2.

Building on the Country Assessments and the background information collected, a Regional Analysis was developed. The Regional Analysis discusses key issues related to IPHC/FM in E&E; analyzes the strengths, weaknesses, opportunities, and threats (SWOT) to IPHC/FM in E&E;
presents lessons learned and regional best practices; and provides recommendations for the future.

The Country Assessments in Annex 3 contain significant detail that, while specific to the individual countries, is critical to understanding wider regional concerns. The reader is urged to carefully review these Country Assessments, which have been placed in Annex 3 largely because of space constraints posed in the Statement of Work.

KEY FINDINGS OF THE ASSESSMENT

It is possible to reform elements of the traditional Soviet-style health system model toward a modern IPHC system based on FM and HSS principles and techniques.

1. The greatest strengths of the IPHC/FM approach in the E&E region have been the sustained efforts of development partners, working cooperatively across a broad range of health system fronts with a flexible approach that accounts for the conditions and needs of different countries and areas (e.g., rural versus urban areas). These efforts should be continued, and USAID should “stay the course.”

2. Major weaknesses include the inadequate attention of donors to the role of public health institutions in the reform process and limited success in coping with four major challenges facing the region’s health systems, namely lack of political commitment, weak capacity to improve provider skills, dysfunctional relationships between family doctors and “narrow specialists,” and corruption.

3. In a number of countries in the region, the progress made to date has led to significant opportunities, including the potential for breakthrough achievements in IPHC/FM, and for further assisting academic institutions and professional organizations in upgrading the quality of medical practice and “evidence-based” medicine.

4. Major potential threats—beyond uncontrollable externalities—include the decreased availability of health sector funding and declining political and social commitment to health sector reform.

5. The conflict between generalist physicians (e.g., general practitioners and FM doctors) and the Narrow Specialists (NS), especially in the urban polyclinics, is a complex and difficult issue, not easily resolved without complete health system reform.

Health finance reform is critical to changing the incentives for both patients and providers. A “single payer” system is an effective vehicle for reimbursement of providers.

Reform in one subsector (primary care) impacts other subsectors (public health, secondary, and tertiary care), and comprehensive reform throughout the system is needed to achieve lasting benefits.

Continuing the restructuring and rationalization process at the secondary and tertiary levels is most important for reallocating scarce funds to the primary care sector.

A combined approach of USAID and the World Bank (WB), with USAID implementing various HSS activities and the WB handling the investment component, produces more effective and lasting reforms. Both technical assistance in HSS and improvements in facilities, instruments,

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*A “Narrow Specialist” is a term used in the E&E region to describe a “subspecialist” or all certified specialists except pediatricians, general internists, OB/GYNs, and family medicine specialists. Narrow specialists, particularly in polyclinics, are specialists who cannot be seen directly, but only on referral from the primary specialists referred to above, or from the general practitioner.*
equipment are necessary to implement lasting QI and continuing reform of the primary care system.

KEY RECOMMENDATIONS OF THE ASSESSMENT

1. USAID should continue its efforts on health reform in the E&E region, with continued support of and enhanced funding for IPHC/FM programs and activities.

2. USAID should significantly increase the focus on improved quality of medical education, training, and practice for IPHC.

3. USAID should focus on comprehensive health systems reform (primary, secondary, and tertiary) in the region, bringing polyclinics, hospitals, and Sanitary Epidemiology Services (SES) fully into the reform process.

4. USAID should implement health finance reforms through expanded HSS assistance to Health Insurance Funds (HIFs) in the region, thus developing more effective incentives and disincentives at the provider level.

5. USAID should assist the SES (the traditional Soviet-style prevention and public health service, isolated from health promotion and related clinical activities) with transition into a Modern Public Health Service.

6. USAID should help governments introduce effective, integrated Monitoring and Evaluation (M&E) systems at all levels.
I. ABOUT EUROPE AND EURASIA INTEGRATED PRIMARY HEALTH CARE/FAMILY MEDICINE AND THE GLOBAL HEALTH INITIATIVE

The Global Health Initiative (GHI) is based on seven key programmatic principles, listed below. Following each principle is the team’s assessment of the fit and relevance of the E&E IPHC/FM approach to that principle:

1. **Implement a woman- and girl-centered approach:** Building PHC systems with a family focus of care would seem an obvious approach to strengthening health services for women, girls, and children in general. This is especially true in rural areas or underserved urban areas where such services have been generally lacking or difficult to access. The E&E IPHC/FM effort, with both its accomplishments and challenges, is an important model to consider in this regard.

2. **Increase impact through strategic coordination and integration:** Though it is not entirely clear among whom “coordination and integration” is referred to in the GHI principle, there has been much IPHC/FM experience in national-level coordination and integration that should be examined, as well as some important successes.

3. **Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement:** In the opinion of the assessment team, one of the impressive accomplishments of the E&E IPHC/FM over the last decade is the complementary, effective relationship that it has demonstrated with the World Bank, and in some cases with other bilateral donors. In terms of private sector engagement, the E&E experience is more mixed, in large part due to the embryonic nature of the private sector in most E&E countries and the prevalence of corruption within both private and public sectors.

4. **Encourage country ownership and invest in country-led plans:** Again, despite many obstacles, E&E activities have consistently focused on this principle and have produced a large body of experience in working within it.

5. **Build sustainability and HSS:** Across-the-board efforts in HSS (with the notable exception of the Public Health apparatus and activities) are a key feature of the E&E IPHC/FM program. The relatively long timeframe (for country health projects) also makes this program an especially relevant laboratory for understanding the complexities of this key GHI principle.

6. **Improve metrics, monitoring, and evaluation:** Although there has been considerable investment by E&E in these activities, progress in actually creating integrated monitoring and evaluation systems and using the data collected and analyzed has been modest. Perhaps this is an important, if cautionary, finding of relevance for the GHI.

7. **Promote research and innovation:** Innovation in both PHC/FM areas has been an important feature of E&E work. Formal research, especially disciplined operations research, has been a somewhat neglected area. More work in this regard might make the E&E effort very useful to GHI development in the years ahead.

One critical area this report stresses but appears missing, at least in direct form, in the GHI key principles is the importance of fostering substantive improvement in quality: quality of education and training, and quality of competence in the delivery of health services.
With all the positive and negative elements, as described in the regional SWOT and in the Country Annexes, of the E&E IPHC/FM effort, it seems obvious to the assessment team that this program has, in addition to its own direct value, important implications for the wider USAID community as it looks to the GHI over the years ahead. This is one reason why this report has repeatedly urged that USAID continue its work on IPHC/FM in the E&E region.
II. ASSESSMENT OBJECTIVES

The three-person project team, joined by local consultants in Armenia and Albania and working on contract to GH Tech, consisted of Stephen C. Joseph (Team Leader), George P. Purvis, and Timothy Ryan. The team met in Washington, DC for the first time in September 2010 and completed the first draft of their report in early November 2010. During field visits to Albania and Armenia, the team was joined by a local consultant (Dorina Toca in Albania and Knarik Toomasyan in Armenia), each a physician native to the country visited.

There were three objectives of this assessment, as set out in the Statement of Work (See Annex 1):

1. Document the experience of E&E countries in implementing the IPHC development approach based on the framework of FM and HSS.
2. Assess the strengths, weaknesses, opportunities, and threats of the IPHC approach, taking into account the effectiveness—or ineffectiveness—of the approach in achieving health outcomes and building health system capacity.
3. Provide recommendations to E&E Missions, host countries, and development partners on how they can more effectively implement integrated PHC programs in the future.

A summary of these objectives was stated by the E&E Task Manager: “Assess the adequacy, effectiveness, and/or ineffectiveness of the USAID E&E approach to IPHC, FM, and HSS.” The E&E Bureau will use the assessment report to guide future programming and support President Obama’s Global Health Initiative (GHI).
III. ASSESSMENT METHODOLOGY

APPROACH

The first challenge the project team faced was the vast amount of relevant information and data that needed to be considered. The USAID IPHC/FM effort in E&E has entailed sustained involvement throughout the region since 1993. This work has included more than a dozen projects involving a wide range of technical and national partners.

HOW THE INFORMATION WAS COLLECTED

First, the team conducted a broad analysis of the IPHC/FM efforts in E&E through a literature review and multiple key informant interviews. Second, the team conducted extensive interviews during weeklong visits to two of the countries (Albania and Armenia) where E&E Bureau IPHC/FM projects were currently active. Finally, the team met with and interviewed representatives from key development partners in the field and in Washington, DC, and facilitated a roundtable discussion between representatives of development partners. The names and affiliations of all persons interviewed can be found in Annex 2.

HOW THE DATA WERE ANALYZED

Information from all of the above sources was assessed using a standard set of criteria, developed by the project team, that reflected major factors in implementing the IPHC/FM “development approach based on the framework of family medicine and health systems strengthening (HSS).”

These six criteria included:

1. Political and Social Commitment

The project team defined Political and Social Commitment as the presence of sufficient leadership and governance mechanisms to achieve effective health system programs countrywide. In addition to the presence of informed and active political leaders in the country, such national mechanisms include, for example, strategic policy frameworks with effective oversight, coalition building, legal and regulatory processes, and ownership.

2. National Capability, Sustainability, and Replication

National Capability is the overall capacity of the country to implement nationwide IPHC/FM programs and maintain them after donor funding is reduced or eliminated. Examples of this include country ownership of, financing for, and control over implementation of modern management HSS tools and techniques.

3. Human Resources and Management Systems

Human Resources and Management Systems indicate the presence of leadership and management structures that ensure sufficient qualified and responsive personnel who will work effectively to achieve the best health outcomes for patients. This includes both management and medical personnel at all levels. Mechanisms include adequate compensation, training and other rewards/incentives, and evaluation systems to motivate and maintain the quality of technical and managerial staff.

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b Because of limitations of time and cost, only two countries were visited.
4. Cost-Effective and Appropriate Technology

Cost-Effective and Appropriate Technology is the presence of appropriate infrastructure, processes, and systems to efficiently provide safe and effective health care services at all levels. Examples include equipment, laboratory services, pharmaceuticals, training and outreach, quality control processes, and information technology.

5. Health System Linkages and Integration

Health System Linkages and Integration refers to the presence of mechanisms to ensure coordination and cooperation between elements and among partners of the health system, combined with the requisite leadership for coalition building, which can bring about synergy between both horizontal and vertical programs and clinical and public health services countrywide.

6. Monitoring and Evaluation

Monitoring and Evaluation (M&E) is the presence of mechanisms to ensure that the health and management information necessary for analysis and decision-making is routinely collected, reported, analyzed, and employed to improve health outcomes, health status, and health system performance.
IV. BACKGROUND (PRIMARY HEALTH CARE, HEALTH SYSTEMS IN EUROPE AND EURASIA, TRENDS IN THE REGION)

PRIMARY HEALTH CARE

There are many definitions for primary health care (PHC). This reflects its different uses:

- As a **strategy** to “maximize health and well-being.”
- As a **structure** created within a health system to enable that end.
- As a **process** for delivering health care services to patients within a community.

Strategically, PHC aims to guarantee access to “basic health care for all people” in a country. Equally important to the strategy is the approach taken to ensure access. As described in the 1978 Declaration of Alma-Ata, which first elaborated the strategy, PHC “is based on the principles of equity, participation, inter-sectoral action, appropriate technology and a central role played by the health system.” Within a national health system, the PHC strategy provides “universal, community-based preventive and curative services, with substantial community involvement.”

There are many reasons why the PHC strategy appeals to the international community. It addresses “basic diseases that constitute most of a developing nation’s disease burden,” which are often ignored by disease or condition-specific campaigns. Other assessments have concluded that “there are advantages for health systems that rely relatively more on primary health care and general practice, in comparison with systems more based on specialist care, in terms of better population health outcomes, improved equity, access and continuity and lower cost.” Because of these and other factors, developing countries are often encouraged “to focus their resources at [the PHC] level of health services.”

The appeal of this strategy is founded in history. During the late 1960s and early 1970s, the vertical approach used in malaria eradication came under considerable criticism: “Large numbers of the world’s people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have… the most serious health needs cannot be met by teams with spray guns and vaccinating syringes.”

Structurally, PHC is “the basic level of health care provided equally to everyone,” manifesting at “the first point of health care contact.” Often represented as the base of a pyramid of health care, services provided at the PHC level address “the most common problems in the community” by providing “practical, scientifically sound and socially acceptable methods and technology… at a cost that the community and the country can afford to maintain.”

Although the term primary care was coined in the early 1970s, the model for delivering PHC services drew upon and was inspired partially by preexisting practices, such as found in Indian rural medicine and the “barefoot doctors” of rural China.

Following this model, problems that require more specialized medical expertise are addressed in secondary care, while especially challenging cases are treated in tertiary care. In other words, PHC providers are most often “distinguished from their secondary and tertiary counterparts by the variety of problems” they encounter and treat.

Practically, PHC often refers to the health care services themselves, which may be delivered in a physician’s office, health post, health center, or even the outpatient department of a hospital. The physician provider may be a general physician or trained and certified as a specialist in one
of the so-called primary specialties such as pediatrics, internal medicine, gynecology, or FM. In many countries, nonphysician auxiliaries (e.g., nurse practitioners, physician assistants, clinical officers, medical assistants, feldshers) may be the actual providers of care. PHC may be delivered during initial encounters or follow-up visits and may include health promotion and disease prevention activities, as well as clinical services. Thus, PHC is often defined not so much by the nature and credentials of the provider, or in general by the complexity of the specific care provided, but rather by the location and nature of the site in which it is provided.

SELECTIVE AND INTEGRATED PRIMARY HEALTH CARE

Although originally intended to be a comprehensive approach to delivering health care for all, many experts argued that “limited funding, personnel and weak health systems” in countries made it impossible to implement PHC at such a scale. As a theoretically more effective, realistic, and measurable alternative, some experts in the late 1970s advocated a different model: Selective Primary Health Care.

Selective Primary Health Care (SPHC) aims to tackle the main disease problems of poor countries by delimiting the services rendered in the PHC setting to the most important disease conditions in a community. It does this by deploying a limited package of specific, low-cost technical interventions in PHC settings.

Since its introduction, several SPHC “packages” have been implemented, such as UNICEF’s Growth Monitoring, Oral Rehydration, Breast Feeding, and Immunization Strategy for Child Survival (GOBI, 1982); the African Child Survival Initiative (1981–1993); and Integrated Management of Childhood Illness (IMCI, 1990s). The SPHC approach “guided much of the efforts over the past three decades” against generalized disease epidemics (e.g., HIV, malaria, TB) and “addressed childhood illnesses, such as pneumonia, diarrhea, malaria, measles and malnutrition.” Simultaneously, bilateral and multilateral donors have worked to strengthen the capacity of Ministries to implement universal PHC systems, so as to improve the results of these targeted interventions.

Over time, more technical areas were added to country health programs, raising questions about how they could be better coordinated and managed. Many felt that “it is at the entry point of the system, where people first present their problem, that the need for a comprehensive and integrated offer of care is most critical.”

The IPHC model was developed to integrate PHC services at the point of contact, thus ensuring that “the delivery system is designed to meet the holistic needs of an individual when they go to a health facility,” while at the same time “capturing the... advantages of joint programming” among donors, governments, and other institutions. Some argue that in order to be effective, PHC must be integrated “around the particular needs and situations of individuals - along with systems of care that can take into account the needs of particular communities and populations.”

Operationally, IPHC refers to a one-stop service delivery model “in which an individual or family visits its local, primary care unit or general practitioner as the first point of encounter within the health care system.” The PHC provider (the gatekeeper) “either treats the patient or refers the patient to a specialist, if necessary.” If this function is well established, a patient cannot access a specialist unless referred by the gatekeeper.

Experience in countries (e.g., Canada, the United Kingdom, and the United States) with general practitioners, FM specialists, and nurse practitioners has demonstrated that they can effectively diagnose and manage a wide variety of health problems, serving as gatekeepers to more specialized care.
There are similarities between IPHC and SPHC. IPHC can refer either to a setting in which PHC is provided to a wide range of patients (children, adults, pregnant women, and so on) or to a combination of traditional PHC services with services intended to address specific health issues of special importance (e.g., HIV/AIDS, TB)—or to both.

In cooperation with partners, USAID helped introduce the IPHC model in Central Asia, Russia, and the Ukraine (among other countries) in the mid-90s, and extended it to Albania, Romania, and the Caucasus countries in the early 2000s. USAID has supported IPHC initiatives through bilateral projects (buy-ins to Bureau for Global Health Field Support projects) and through the American International Health Alliance (AIHA) Health Partnerships Program.

From the work of USAID, its partners, and cooperative governments there has been “promising, although limited evidence on the effects” of such strategies. “Integration is intended to reduce differences in access and use of health services between geographical and socioeconomic groups, but this can only be expected to the extent that it is targeted at disadvantaged populations and is effective.”

Several identified risks of integrating PHC services include the possibility of overworked or unskilled health workers or the inability to deliver specific services. To minimize these risks, USAID and others have implemented the IPHC model within the framework of FM and HSS, sometimes referred to as diagonal approaches, which “aim for disease-specific results through improved health systems.”

**FAMILY MEDICINE AND HEALTH SYSTEMS STRENGTHENING**

FM is a medical specialty devoted to comprehensive health care for the individual and family across all ages, sexes, diseases, and parts of the body. The aim of FM is to provide personal, comprehensive, and continuing care for the individual in the context of the family and the community.

FM physicians are trained and certified to practice with a perspective on all members of the nuclear family (father, mother, children). However, “the definition and role of the family physician vary by country.” Although most likely to be found in PHC settings, FM physicians in many countries admit and care for patients in hospitals, conduct deliveries, and may even perform surgery.

IPHC is often implemented within the framework of FM because “health system performance can be enhanced if a strong FM-centered primary health care (PHC) level is present.” In such cases, “family physicians play an important gate keeping role, with the family physician being the first point of contact in the health system, with the exception of some emergencies.”

Depending on the needs of patients, however, the composition and organizational model of FM can change over time. In some cases a single FM physician may deliver IPHC/FM services, while in others it is “a group practice which collectively responds to the local family’s health care needs.”

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6 In North America and Western Europe, the term “GP” generally refers to a physician with a single year of postgraduate clinical training, usually a rotating internship. FM refers to a more recent specialty connoting a 2–3 year postgraduate training period, which may vary in amount of time spent in specific fields (e.g., more or less surgery, obstetrics, pediatrics, or psychiatry), but which produces a physician focused on the entire family—adults and children—who is thus certified as a specialist in FM. In the E&E region, GP more generally refers to a physician who enters practice without postgraduate (“residency”) training, and FM to a former GP who has undergone 1–2 years of FM-oriented residency training.
Many factors can influence the quality of care delivered by family physicians in PHC settings, ranging from training in FM, to organizational arrangements (e.g., management capacity and approaches, resource availability, enforcement of the gatekeeping role), to financing and provider payment systems. Cultural factors, such as the characteristics of physicians and the relationships between doctors and patients also contribute to the quality of care.

Underpinning successful efforts to integrate PHC through FM is the functioning of the overall health system in general. Since the early 21st century, leading global health financing institutions and donors have recognized that “strong and effectively functioning health systems are considered a prerequisite to scaling up cost-effective interventions for reducing disease burden and for achieving the health MDGs [Millennium Development Goals].”36 Put simply by the World Bank Strategy for Health, Nutrition, and Population Results, “well-organized and sustainable health systems are necessary to achieve results.”37 HSS is now regarded by many as a “first-order” goal to “create the necessary enabling institutional and systemic environment to achieve and sustain” longer-term goals.38

USAID augments its support for IPHC/FM in most countries with HSS efforts, through multiyear bilateral activities or projects negotiated through umbrella projects managed by the Bureau for Global Health. USAID’s approach to HSS typically includes “intermediate results” in project designs such as improving the legal and regulatory environment for PHC, increasing the generation and allocation of resources for PHC health, improving the quality of PHC care, and empowering individuals and communities to assume greater responsibility for their health. More recently, USAID has emphasized the World Health Organization’s (WHO) six “building blocks” of health systems: “Service Delivery; Health Workforce; Information Systems, Medical Products, Vaccines, and Technologies; Health Financing, and Leadership/Governance, plus Consumer Empowerment.”39

HEALTH SYSTEMS IN EASTERN EUROPE AND EURASIA 40

Prior to 1990, the health systems of most countries in E&E were based on the Semashko model developed in the Union of Soviet Socialist Republics (USSR) in the 1920s. This model led to “publicly funded, centralized . . . health systems with universal or close to universal entitlement to free health care.”41

Health systems based on the Semashko model had some success in dealing with wide-scale public health issues, such as TB and malaria; however, they tended “to neglect primary care.”42 To meet the health and medical needs of the population, these systems “emphasized hospital care” provided by specialized medical doctors. In urban areas, primary care “was provided in policlinics [or] at community facilities, often of poor quality” by a Narrow Specialist (NS) who often added little to the diagnosis or treatment of the patient. Primary care in rural areas consisted of ambulatory services or, in many cases, services delivered in often under-resourced health posts “by feldshers (paramedical workers), nurses, and midwives.”43

This focus on infectious diseases and epidemic control, combined with a culture of politicized investment decisions, resulted in systems that were “inefficient and unresponsive to patients’ demands and needs” and ultimately led “to an imbalance in the overall structure of healthcare provision.”44 The primary care sector was particularly weak, both in terms of physical infrastructure and human resources. “Low prestige and poor pay reduced the quality of entrants into the primary care sector and also encouraged the de facto privatization of services via moonlighting or the levying of informal charges for supposedly free services.”45

As a result, by the 1990s, the health care systems of most countries in E&E had eroded and generally consisted of “overstaffed, overspecialized hospitals, [which] countries were unable to
These systems had “profound inefficiencies,” none more so than the “imbalance between the hospital and primary care sectors. Hospitals consume[d] more than 70% of the health care budget [in 1999]. The health delivery system inherited from the Former Soviet Union can be likened to an inverted pyramid. The hospital sector at the top of the pyramid is overdeveloped and the primary health care sector which should serve as the broad base of the pyramid is underdeveloped, underfinanced, and underutilized.”

The countries of Central and Eastern Europe face major obstacles as they seek to “reform their health systems by moving from a centrally planned system driven by planning to a pluralistic model, increasingly funded by social insurance.” Some of the most serious challenges include fewer public resources available for health care, growing health care costs, and rising poverty. At the same time, the movement from a planned economy to a market-based economy provides new opportunities for private health services and entrepreneurship in the health care system.

There are also serious professional and clinical challenges in the primary care sector. Historically, PHC was provided by primary care physicians “with incentives to refer quickly to specialists.” However, in the region, education and training of physicians is often inadequate. As a result, medical “conditions that should be effectively treated in the primary care sector are treated in the hospital or by specialists at polyclinics.” In addition, many of the extensive vertical programs that exist “also should eventually be integrated into primary care.”

In nearly all of these countries, “the long-term vision of primary care is the development of family medicine.” This is seen as particularly important because of the problems faced in providing health care in rural areas. In such areas, “primary care clinics [increasingly] have only one physician. This means that an internist, by necessity, is forced to become a family physician and see women and children also, even though she was only trained to see adults. . . . However, to create a sustainable system of family medicine one cannot only train family physicians to work in rural areas. Physicians would not likely to choose this specialty if they could only work in rural areas.” In the urban polyclinics in the region, integrating the new concept of family medicine specialists into the strongly established system of narrow specialists and primary specialists in medicine, pediatrics, and OB/GYN is very much a work in progress, and it remains to be seen how effective and acceptable such a change will be.

**EMERGING TRENDS IN HEALTH IN EASTERN EUROPE AND EURASIA**

Although health conditions vary across the E&E region, there are several generalized trends that should be accounted for in approaches to improve PHC. Some of the most important ones include:

- The populations of many countries in the E&E region are both shrinking and experiencing increased life expectancy. This leads to fewer economically productive people “to support a growing number of older dependents in future years.”

- Mortality rates vary significantly between countries, stagnating in some cases and increasing in others. Mortality is generally much higher among males than females. Both trends are “associated with lifestyle and behavioral factors, especially male alcohol consumption and smoking patterns. . . . Non-communicable diseases produce the largest burden of mortality.” However, the rapid rise of HIV/AIDS and tuberculosis epidemics, particularly in association with intravenous substance abuse, are producing devastating short and long-term effects, particularly in Russia and the Ukraine.

- The mortality rate of children under 5 in most countries has dropped significantly, indicating that living conditions and access to health care have generally improved. However, some countries have rates that are more than five times higher than others, “suggesting possible socioeconomic problems that particularly affect newborns.”
There is insufficient public expenditure for health, and the cost of health care is rapidly increasing. “Several countries, including Albania, Georgia, Russia, and Uzbekistan, have seen a decline in health expenditure as a percentage of gross domestic product (GDP) since 2002, while others, such as Serbia, Slovenia, and Turkmenistan, have seen a fall in the amount of public sector funding as a percentage of GDP. Azerbaijan and Tajikistan have among the lowest public health expenditure levels in the world. Overall, however, the picture shows continued growth in health care spending per capita across the region, more than doubling between 2002 and 2006. Health care costs are projected to increase by several percentage points of GDP by 2050. Corruption—amenable to corrective action when the political commitment exists—is a primary impediment to the use of health funds and success of health systems in the E&E region. Out-of-pocket health expenditure as a percentage of private expenditure on health is more than 80% in the region and has been climbing steadily between 2002 and 2006. Closely linked to the goal of financial protection is the goal of equity in finance, which means that people with lower incomes should not pay more as a percentage of income for health services than people with higher incomes. Effective health services are one crucial element in addressing the relationship between the social determinants of health and inequity in health and in counteracting the rising inequity in health in both high-income and low/middle-income countries in the region.”

There is a need for a “more systematic collection of health and socioeconomic data of greater accuracy and reliability.” Routine, standardized collection of reliable health-related data is poor or nonexistent in many countries. Vital statistics and epidemiologic, socioeconomic, health service delivery, risk factor, and health service information is often inadequate to confirm trends or plan interventions. In several countries, capacity to conduct analysis is inadequate even should such data be made available.
V. INTEGRATED PRIMARY HEALTH CARE/FAMILY MEDICINE EUROPE AND EURASIA REGIONAL ANALYSIS

Based on the information collected from literature, interviews, and visits to countries, the project team identified key issues associated with implementation of the IPHC/FM model within the E&E region.

KEY ISSUES

What is the Region?

About the Region

Until recently, the USAID E&E region encompassed 29 countries, 14 of which currently receive USAID health sector support. Together, these countries cover a substantial part of the world’s inhabited land, ranging from southeastern Europe in the west, to the Baltic countries in the north, to the Caucuses in the south, to the far eastern border of Asia.

Each country and its population evolved differently, adjusting to the conditions and demands placed on them by their environment and incorporating cultural elements picked up through contact with others. Their individual experiences have shaped them differently. As such, the region is one of the most culturally diverse in the world, with hundreds of ethnicities, varying approaches to government and education, distinct alphabets and languages, unique architectural and artistic styles, diverse cuisines, and different religions.

One thing that nearly all E&E countries have in common, however, is their recent experience as members of the USSR throughout most of the 20th century with the heavy handed influence of its Communist system, which permeated nearly every aspect of society, including health care.

Although the foundation of the USSR was laid with collapse of the Imperial Russian government in 1917, actual unification of the Soviet states took place in 1922. The USSR was formally legitimized in 1924 with its establishment of a Soviet Constitution.

Among the early Russian statesmen was Nikolai Semashko, People’s Commissar of Public Health until 1930. Under Semashko, a model of health care was established (the Semashko model) that became common among all Soviet Republics during the 20th century. The Semashko model is “characterized by a strong position of State, who guarantees free access to health care for everyone. This is realized by state ownership of health care facilities, by funding from the state budget, and by geographical distribution of services throughout the country. The state-dominated Semashko model is funded by taxation. Health services are hierarchically organized. They are provided by state employees, planned by hierarchical provision, and organized as a hierarchy of hospitals, with outpatient clinics (polyclinics) as the lowest level of entrance.”

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According to a 2000 census, 109 languages were spoken in Estonia alone.

Armenia was the first state to adopt Christianity as its religion, early in the 4th century; Islam was the predominant religion of Albania from the 15th to the early 20th century.

There are some exceptions (e.g., Albania).
Semashko model intended to provide health care services for “all members of society, leaving little or no choice to the user but seeking to achieve a high level of equity.”

During the 20th century, nearly all countries in the E&E region implemented a Semashko-style health care system, and the legacy of this system continues to be felt in the delivery of health care today. Key features of this legacy include the relatively limited amount of GDP that is dedicated to health care; centralized planning and management of services; inequitable access with under-the-table payments; exclusive privileges for the more well-off; and a poorly motivated, highly specialized, poorly paid oversupply of physicians and nurses and an emphasis on unregulated, hospital-based, inpatient care—with poor quality of publicly provided first-line services as a result.

As countries in the E&E region seek to improve their health care systems, perhaps one of the least obvious but most encumbering results of the Semashko-style system was that it lowered patients’ expectations and deprived them of control over the quality of care. In the Soviet system, “the population was not involved in decisions about their health care. They had limited rights as well as limited responsibilities. They were unable to choose their primary care provider and their health care provider did not provide them with information about their condition. Provider payment systems funded the infrastructure of the health sector not the health services received by the population, and as the state provided everything, people did not take responsibility for their own health.”

While there are many challenges to improving PHC systems in E&E countries, apathy and the lack of demand from the general population for substantial, appropriate reform remains a significant barrier in many countries. Of course, this mutually reinforces the problems of creating sufficient political and social commitment to accomplish health system reforms.

The Integrated Primary Health Care/Family Medicine Model

The social benefits to providing high-quality essential health care at an affordable cost are well documented. Although the ideal model for delivering such care is less universally agreed upon, there are many examples to draw from. Furthermore, the benefits to “customizing” the approach to best function within each country’s socioeconomic, cultural, and geographical setting has been established, particularly given the many factors that must be harmonized in-country en route to successful delivery of high quality care. The combination of national structures, economic conditions, academic settings, cultural perspectives, and health issues demand that a country-by-country approach to designing a PHC delivery model be not only respected but insisted upon.

Nonetheless, as described above, the general IPHC/FM “concept” has benefits that transcend country circumstances and, when calibrated appropriately, have a place in countries regardless of circumstances.

The challenge of appropriately calibrating the IPHC/FM model and timing its introduction within countries remains a central issue. The model must be customized in each country, taking into account the country condition and external factors. In some cases, rapid, countrywide implementation of the IPHC/FM model may be most suitable. In others, a slower approach, targeting specific areas of the country, may be most appropriate.

External Factors

Successful integration of PHC and the institutionalization of FM can be influenced by a number of factors. As a fundamental piece of national infrastructure, its implementation and operation benefits from (and can contribute to) a well-organized and sustainable health system. Thus, establishment of the IPHC/FM model is frequently tied to national efforts to strengthen health systems. In addition, however, progress and effects of IPHC/FM can be slowed or expedited by a
number of external factors. War and civil strife, such as that experienced by many countries in the E&E region, can hamper efforts to reform national systems, including health systems. As described to greater extent below, institutional change relies on political commitment and resources, which can be distracted and defrayed when higher priority issues take the stage (such as, for example, the South Ossetia crisis between Georgia and Russia or conflicts within a country’s borders between different ethnic groups). The accurate estimation of resources needed and available, also a critical component of any planned transition, can suddenly become inaccurate when large populations emigrate from, within, or into a country (a phenomenon which can be seen across the region), and it was not clear to the assessment team whether this movement is adequately taken into account by policymakers and planners in the region. In short, dynamic situations make long-term planning and implementation difficult, and the E&E region during the past decade has been fraught with dynamism.

**Political and Social Commitment**

**Leadership**

The issue of political and social commitment is the single most important criteria in the development of health reform and institutionalization of the IPHC/FM approach. In the team’s interviews with various counterparts (e.g., USAID, World Bank, WHO) both in and out of the countries visited, everyone agreed this is the most important variable. Political commitment is about leadership and involves the exercise of power, control, and the requisite energy to implement reforms and stand fast when problems occur. With all of the difficulties of the last 15 years in developing and implementing the IPHC/FM approach, leadership has been the deciding factor in the successes or failure of individual projects and programs in the region. While there have been many success and many failures, the key element was often the Minister of Health and/or a group of relatively young reformers who stuck together to foster and protect the reforms when needed (with strong donor support).

Two early success stories in the region were Estonia and Kyrgyzstan. For various reasons (described in their Country Assessments, Annex 3) both countries were able to assemble health reformers who understood the work that was required and, with donor assistance, were able to coordinate the technical assistance and resources needed for reform. In the case of Estonia, the approach was to “throw out all that is Soviet” and start fresh with Western ideas and concepts. In Kyrgyzstan, leaders slowly reformed the system both from the bottom up and the top down, with both successes (primary care) and failures (secondary and tertiary care, and SES reform).

**Legal and Regulatory Framework**

After the breakup of the Soviet Union, these new countries had to transition from planned to market-based economies. In most cases the legal and regulatory systems were Communist or Socialist-oriented with few guidelines or legal frameworks for reform. In essence, the last 15 years have been ones of “country building”, developing a legal system from the ground up, with few lawyers familiar with market-based legal principles. The ideas of democracy, political parties, and related activities were unfamiliar, and there were few precedents to build upon.

Despite the examples of Estonia and Kyrgyzstan, the overall experience in the region with implementing and sustaining (as opposed to legislating) legal and regulatory reform of the health system has generally been unsuccessful. In many countries, it has been difficult or impossible to change existing norms, “priказ”, and regulations. The process of developing and implementing new IPHC/FM tools and techniques has often been hampered by frequent, lengthy debate and the demand for repeated submissions of documents, proposals, or suggested regulatory changes. One example from Armenia is drawn from the University Medical School, where the FM curriculum was developed and revised a number of times over the years and used to teach new
physicians about FM. However, the Medical School has still not adopted, to date, the curriculum or the concept of FM, as they were not in its original regulations.

**Strategic and Policy Development, Ownership, and the Status Quo**

In the region, the management concepts of strategic planning or strategic development are well understood. Consultants for the World Bank, WHO, USAID, and others made early and frequent attempts to work with Ministries of Health to develop their own plans and processes to ensure effective management of the health system. In general, there have been some successes. Most countries have an overall Health Plan—usually for five years—and many countries have a Health Policy Unit in the Ministry of Health. Planning has been comparatively successful, as a result of technical assistance (TA) from partners that facilitated the process. Less successful have been attempts to establish national ownership of the plan and then execute that plan. This disjoint between planning and execution is a legacy of the Semashko-style system employed by the Former Soviet Union (FSU), in which government officials regularly prepared five-year plans that were data driven, highly unrealistic, and soon forgotten. In many countries, there are few, if any, incentives and a decreasing number of “champions” for FM reform (or for effective health reform in general). Many of the remaining champions appear tired and increasingly less effective. There are plentiful opportunities to abuse public power, including through graft and informal payment for services, and there are few jobs outside the system that are as lucrative as those within.

Reform efforts are impeded by frequent—sometimes annual—changes in ministerial leadership, each of which sets priorities according to its own agenda. New strategic plans are often required to reflect these new priorities, and they are often incongruent with previous plans. In some instances, donors have assisted ministries in strategic planning, decreasing incentives for the government to develop its own strategic planning capacity and expertise. In Kyrgyzstan, after ten years of effective health reform, progress has slowed due to political changes and the reduced influence of health reformers. A reform movement in Albania appears to have gained momentum, and leaders (many of them Western-trained) have emerged who are eager for reform, although much work remains to be done. Georgia has begun major restructuring, including an attempt to privatize nearly all health services, potentially reducing the influence of the Ministry of Health over management and oversight of health care delivery. It is unclear if this approach will continue, however, as many of the leaders responsible for these reforms are no longer in power, and much of their planning and implementation is now being reconsidered.

One early problem faced by countries in the region was the lack of effective managers who were trained in strategic and policy skills. This condition has been somewhat corrected over the last 15 years, as more human resources with those skills (many trained abroad) are becoming available. Increasingly, however, the problem is that trained managers do not have incentives to work in a Health Policy Unit; there is little possibility for financial gain, and donors and technical agencies offer better pay for more rewarding work. The real problems are how to retain talent in Ministries of Health, how to foster the development of these agencies, and how to develop a group of health reformers who can grow and effectively execute in the present environment.

During the assessment, the team heard anecdotal stories about ineffective leadership, poor management, and corruption in the Ministries of Health. Finding and attracting effective leaders and managers is a difficult task in the present environment in the region. Overcoming the status quo requires committed leaders who prioritize reform; few countries in the region have this type of leadership on any consistent basis or for a sufficient length of time.
Health Care Financing

Health financing changes in the countries in the E&E region were one of the earliest health reform areas various governments undertook. These early financing changes were necessary as a result of the Semashko model (described above) and the unaffordable legacy of the FSU policy of providing “free” health care for all, paying for health care through the general budget allocations, and funneling most of the funding for health through the Ministry of Health. All countries in the region have struggled with these changes, but many are making progress. Kyrgyzstan was an early adapter and a successful model for other countries in this regard, as discussed at length in Annex 3 of this document. Another major innovator was Estonia. However, health financing reform is dependent on external factors (such as economic changes) and cannot be done in isolation from other reforms, such as in the organization and management of service delivery and the development of human resource capacity through medical education and training.

Separation of Purchaser and Provider

An early financing reform several countries pursued was the separation of purchaser from provider, usually by establishing a Health Insurance Fund (HIF) and developing and implementing the various health insurance mechanisms required. These new HIFs were often part of or related to larger social insurance and pension reform programs. An example of this was in Armenia, where an early USAID health reform project was linked to larger pension reform efforts. The process of developing and implementing these new HIFs often presented considerable political and organizational problems, especially for the Ministry of Health. As control of resources allows influence over their use, taking resources away from the Ministry of Health and putting them in a separate organization led to significant political concerns. To alleviate these concerns, many countries in the region chose to organize the HIF either directly under or proximate to the Ministry of Health. Examples of this are Armenia and Kyrgyzstan. More recently, countries have begun to separate the two bodies further, as in the case in Kyrgyzstan. This is also being considered in Armenia and Azerbaijan.

The various countries in the region that have set up HIFs have moved forward with the development of modern health insurance system payment mechanisms, which usually involve some type of capitation program for primary care and some type of case-based payment for secondary care. Some countries, like Kyrgyzstan, have introduced more sophisticated Diagnosis Related Group (DRG) payment systems for secondary and tertiary care. These changes were necessary to move from a funding system based on input capacities (e.g., beds, visits, staffing) to an output-based system more focused on results (e.g., numbers of cases). While these efforts have had some success in the region, the results are mixed and the progress is slow.

Pooling of Funds and the Single Payer System

A major issue in health financing reform is the development of accounting policies and mechanisms to allow flexible spending of funds at the provider level. This is related to improved levels of autonomy at the provider level. Such reform requires cooperation from Ministries of Finance in these counties, as existing systems have historically been inflexible about moving funds between budget lines. Countries in the region are making some progress with this change, but the results have been mixed. Another major problem in the region, observed in field visits to both Albania and Armenia, is the issue of providers receiving multiple sources of funding. In most cases, the Family Group Practice (FGP) or health center receives funds from the HIF, the Ministry of Health, and local governments, usually intended to fund specific items (capital equipment, operating expenses, programs or services provided). However, there is still significant confusion among providers and funders about how funds can be spent, and the process of pooling and managing pooled funds—as is being done in Kyrgyzstan—is still in the early stages of implementation. In general, there has been limited success in the region in developing a single payer system.
Informal Payments

One related health finance reform issue is the problem of informal or under-the-table payments from patients or families to the provider. This issue is another legacy of previous systems. Not only can informal payments reduce access but they are a large source of concern (and fear) to families seeking care (especially from hospitals), as they do not know in advance how much out-of-pocket money they will be asked to pay. In various countries in the region it is estimated that as much as 50% to 70% of the money in the health care system is “black money” or under-the-table payment. There is little reliable information about this issue, however, and it clearly remains a significant problem for health system reformers.

Attempts to address the problem of informal payments in the region have met with relatively little success. Kyrgyzstan has had the most success, by implementing a clear policy of copayments, especially for large copayments at the hospital level, and publishing established copayments for various services. There is some evidence in Kyrgyzstan (via patient surveys) that implementing copayments at the secondary level may have reduced the number of informal payments. It appears that published copayments, secured upfront upon admission, are seen as more transparent and, as they are often combined with financial counseling, reduce the patient’s and the family’s fear of not knowing how much will have to be paid. Although the issue of informal payments has been well studied, there has been a lack of political commitment (and ability) to implement solutions. Such solutions are especially difficult to implement because the issue is tied to historical, cultural, and ethical beliefs as well as organizational, tax, and financing policies.

Privatization and Private Practice

With the breakup of the USSR, one of the early reforms in moving from a planned economy to a market-based economy in health was the privatization of various components of the old system. Privatization of pharmacies came first, followed by the privatization of stomatologists. While some countries continue to privatize public pharmacies and dental services, most countries have moved to other privatization activities. Early efforts to privatize hospitals (e.g., in Kazakhstan) have had little success. Some countries, like Georgia, have attempted to privatize all health providers, but the lack of regulation and adequate planning have caused significant disruptions in the system, and many of the early efforts are being reconsidered. Most countries in the region are moving towards a mixed model of public and private care in health.

Most (but not all) countries allow physicians from the public sector to conduct private practice outside of public facility hours. Some only allow private practice in a private facility (e.g., Armenia) and others (e.g., Albania) are still in the midst of discussion of the best ways to organize these activities. There is much variation between countries and no commonly accepted policy, possibly because it remains unclear if the advantages of this approach outweigh the disadvantages.

Basic Benefit Package and Financial Allocations to Primary Care

Significant efforts have gone into the process of establishing and funding a Basic Benefit Package (BBP) for PHC. Countries in the region have established guidelines and lists of services that are included and not included in this BBP. Usually the list is too extensive and cannot be funded out of the available funds. There has been some initial success with this issue but the results in the region have been mixed.

An important health financing issue in the region concerns the percentage of GDP allocated to the health sector. Within the region, this percentage was low to begin with and has remained static or declined in virtually all cases. Similarly, attempts to “invert the pyramid” have been relatively unsuccessful in allocating more funds to primary care. Even where funding for secondary care has decreased, this has generally not led to the increase in funding for primary care that was anticipated.
Management Systems and Human Resources

Improvement in management systems and human resource development were two areas that initially benefited from assistance from USAID and other donors during the process of implementing the IPHC/FM approach. Both of these areas were in a poor state after the collapse of the USSR, when the countries in the region had chaotic health systems management.

Management Systems

Historically, management systems in the USSR were highly autocratic, with little or no decentralization of authority for decision-making. There were few trained managers; those in management positions were almost all physicians with little or no management training. As discussed previously, most health systems in the region were based on the Semashko model, which was highly specialized, normative-based, and provided a rigid and inflexible management environment. Very little real capital investment had gone into health facilities for decades. Little if any Continuing Medical Education/Continuing Professional Development (CME/CPD) was conducted, with no continuing education for primary care practitioners. Primary care was either poor or nonexistent in most countries in the region, and primary care practitioners were underpaid and the lowest status practitioners in the health care system. Ministers of Health changed frequently and few countries had continuity of leadership. In sum, there was a lack of effective management and leadership within the health system.

Within a Semashko-style, specialist-oriented health care system, most management personnel were technically focused and could only work in a very specific area of expertise. As a result, overstaffing existed at every level of the system. Salaries were generally low compared to other professions, and working conditions suffered due to limited capital investment. The old Soviet adage, “We pretend to work and they pretend to pay us,” was the norm.

Achievement of effective health reform obviously depends in many ways upon positive changes in these archaic, ineffective, and often corrupt management systems, and E&E efforts have devoted significant attention to positive changes, especially through training. But, in the face of deeply embedded organizational and cultural styles and expectations, it is slow work.

Human Resources Management

Some progress has been seen in all areas of human resource development in recent years. Doctors and nurses have been trained (and retrained) in a variety of clinical areas. Management training programs have been attended by large numbers of physicians and technical managers from a variety of institutions (e.g., Family Group Practices (FGPs), Family Medical Clinics, hospitals, polyclinics, the SES). Most of projects sponsored by USAID and other donors emphasize training and management systems development. This effort led to successes during the period covered by this assessment. During interviews, personnel brought up the importance of training and its impact both on them personally and their on-the-job performance. This is well documented in the country reports and evaluations of the various projects over the 17 years of IPHC/FM development. In general, the training, which has focused on management needs in the areas of budgeting and finance, laboratory and pharmaceutical management, M&E, information management, and various aspect of QI and evidence-based practices, has been effective.

Significant effort has been made to help nurses become more effective and professional members of the health care team and demonstrate improved job performance.

Once again, Kyrgyzstan was an early leader in programs to develop FGP managers and chief doctors, as well as in providing training for hospital managers, especially financial managers. The World Bank has supported many training courses for senior Ministry of Finance personnel on various aspects of health reform, leadership, and management. This training has had some success in developing not only medical personnel, but health care managers at all levels of the system. There has been some success in the region in other areas of human resources.
management training and in the improvement of working conditions. As outlined below, granting health care practitioners more autonomy has been surprisingly beneficial.

**Management Autonomy for Providers**

Management autonomy for providers has been a central objective of the IPHC/FM approach in the region. Increasing levels of autonomy for doctors and nurses, especially in rural areas, leads to improved performance and job satisfaction (contributing to retention of skilled personnel). It was apparent during the assessment team’s visit to rural facilities in both Albania and Armenia that there has been some increase in the levels of autonomy of chief doctors, allowing them more control over both planning and resources, including equipment, supplies (e.g., drugs), and their budget. It was also observed that the payment systems for staff in Albania had an “incentive” (Payment for Performance [P4P]) that was tied to individual performance on a number of clinical management indicators; individuals could (to some extent) improve their salary by up to 15%. Armenia plans to launch a similar system in 2011. The introduction of such techniques represents a significant change in the management environment within a relatively short period of time.

Progress has also been made in establishing and documenting the respective roles and responsibilities of health care workers and the government that employs them. For example, written contracts in Albania for staff in rural ambulatories explain the quantity and quality of work expected, performance objectives, the process of performance evaluation, and various other management items. This change in the working environment is expected to contribute to better management and improve employee satisfaction.

Two areas of human resource management in IPHC/FM reform have failed to date. The first area is the role, performance, and effectiveness of narrow specialists working in the PHC system. Not enough has been done to involve this group in the reform process. Although the need to do so has been considered in a number of countries in the region, no solution has yet been found. The second area that has seen too little progress is the development of human resource and management capacity in what might be called the “strategic support” field, such as information analysis, policy, planning, finance, and economics. If Ministries of Health are to adopt more long-term, strategic perspectives, they require more and better-trained human capacity in these areas.

**Donor Coordination and Infrastructure Development**

As discussed in other sections of this report and in the country sections, informal partnerships between USAID, other development agencies, and the World Bank have proven to be highly effective and efficient over many years. In Kyrgyzstan, through two World Bank projects and three USAID projects across Central Asia, the collaboration convinced the government what needed to be done and how to finance it. The donor collaboration in Kyrgyzstan eventually led to the present Sector Wide Approach (SWAp) arrangement in which various donors collaborate on the areas they want to fund or not fund. The positive effects of donor cooperation have also been apparent in Albania, Armenia, Azerbaijan, Georgia, and other countries.

**Health Services Delivery**

**Delivery of Clinical Services**

With few exceptions, the quality of primary health care delivered in the region during the period of this assessment has generally been low, especially in rural facilities staffed by GPs. Undergraduate medical education (typically six years duration in a university setting) is overly didactic, lacking adequate “hands-on” clinical exposure and progressive assumption of patient care responsibilities. Upon graduation, doctors are placed in rural areas as GPs without further
Even if there were sufficient and appropriate equipment, supplies, and access to pharmaceuticals, it would be unreasonable to expect that such physicians could do an adequate job of patient care. Many of the countries, operating in the model of the Semashko-style polyclinic staffed by narrow specialists, formally restrict the scope of care rendered by the GP, requiring them to refer patients to a polyclinic specialist for conditions that GPs are able and authorized to care for in other parts of the world. This system fosters inconvenience, delays patient care, introduces additional cost to the system, and is enmeshed in the problem of under-the-table cash payments for care and specialist referrals. In those countries where there is an oversupply of physicians and nurses, productivity is low. Quality of care at the secondary level (i.e., the polyclinic or the district-level hospital) is generally better than in the rural or urban health center or health post, but this varies. At the tertiary care level, medical expertise is generally much better among specialist physicians with postgraduate training. However, the severe problems in nursing, which are quite similar to those described for physicians above, reduce the overall quality of care significantly.

As might be expected, GPs have low status among both patients and specialist physicians. The movement to replace these GPs with FM specialists (who have postgraduate training that includes greater clinical involvement and recognizes the principles of evidence-based medicine) is an appropriate response to these problems and has begun to make significant change in a few countries in the region. However, lack of financial incentives and constraints in producing sufficient numbers of skilled physicians and nurses in a reasonable time frame have limited the success of these efforts. There has not, in general, been effective development of professional associations, such as an Association or Academy of Family Practice, within the region.

Nevertheless, there has been real, if limited, progress in most countries of the region on improving PHC systems. This should be encouraged and continued, and it might be useful to take an analytical look at the tradeoffs of moving away from GPs toward FM specialists on the one hand and, on the other hand, of major sustained efforts to improve the education and training of GPs.

Quality of care in both urban and rural areas is also negatively impacted by the scarcity of trained managers (whether physicians or non-physicians) and over centralized control of health centers and polyclinics by central Ministries of Health or Health Insurance Agencies, which allows little local autonomy over budget, program, and staffing decisions. In many countries of the region, there is little effective quality assurance (QA) through licensing, accreditation, and continuous quality improvement (QI).

Public Health, Prevention, and Health Promotion

Modern public health approaches in the region are poorly developed, especially with respect to their integration with clinical services. This has a negative impact in E&E countries, where the major causes of morbidity and mortality are chronic diseases, diseases of older persons, and diseases mediated by lifestyle and/or environment. In many countries, the Soviet SES no longer functions effectively, but has not been replaced by a more appropriate focus on public health, prevention, and health promotion. Both clinical care and approaches to traditional public health concerns suffer from a lack of emphasis on the quality of the “mother sciences” of epidemiology and biostatistics, which are indispensable for the effective management of any health system. The efforts of both USAID and the World Bank in IPHC/FM and health reform have not placed much focus on the issues of quality and relevance of public health services, nor on their important relationship through health promotion and disease prevention with clinical services (especially PHC). This is an important area that deserves much more direct attention in the future.
Health Indicators and Health Systems Strengthening

Given the inadequate epidemiology and health statistics described above, without rigorous research it is difficult to show (particularly in the short-term) quantifiable improvements in population health brought about by IPHC/FM. Efforts to do so are further confounded by other factors that have significant impact on population health (e.g., nutrition, economic conditions, status of women and disadvantaged groups, and education). There is, however, significant literature showing that well-implemented PHC itself can have measurable positive effects on morbidity and mortality and that, further, a Basic Services framework that includes a PHC underpinning can enhance the positive impacts of individual categorical services (e.g., family planning, adequate antenatal care, Directly Observed Therapy Short-course [DOTS], GOBI).

Demonstrating the measurable health effects of HSS is even more complex, although the idea that a more efficient and effective health system enables improved health outcomes is intuitively acceptable. These issues provide a strong argument to support strengthening (and using) better health management systems and M&E approaches.

Based solely on a set of simple indicators of national health status, presented in the table below, countries in the region that have vigorously implemented the IPHC/FM approach are generally less vulnerable than the ones that did not, while spending less on public health (as a percent of GDP).65 As described above, however, the varying contexts of countries and challenges they face make it impossible to clearly ascribe these directly (and certainly not solely) to implementation of the IPHC/FM approach, although its contributions cannot be discounted.

Readers who are not familiar with USAID’s approach to ranking countries in a health vulnerability analysis should view, especially, references 65 and 66 in the Bibliography in Annex 5.

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy</th>
<th>Adult mortality</th>
<th>Under-5 mortality</th>
<th>TB incidence</th>
<th>HIV incidence</th>
<th>Public health expenditure</th>
<th>Final outcomes</th>
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<tr>
<td>Albania</td>
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E&E countries that have not vigorously implemented the IPHC/FM approach

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy</th>
<th>Adult mortality</th>
<th>Under-5 mortality</th>
<th>TB incidence</th>
<th>HIV incidence</th>
<th>Public health expenditure</th>
<th>Final outcomes</th>
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<tbody>
<tr>
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<td>28</td>
<td>12</td>
<td>20</td>
<td>25</td>
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<td>16</td>
<td>19</td>
<td>26</td>
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Based on similar indicators of national health status over time,66 countries implementing the IPHC/FM approach likewise generally demonstrate higher rates of improvement between 1990–2008.
Table 2. Change in Key National Health Indicators, WHO, World Health Statistics 2010

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<tbody>
<tr>
<td>E&amp;E countries in which the IPHC/FM approach has been vigorously implemented</td>
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<tr>
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<tr>
<td>E&amp;E countries that have not vigorously implemented the IPHC/FM approach</td>
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<tr>
<td>Russia</td>
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<td>65</td>
<td>68</td>
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<td>309</td>
<td>273</td>
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<td>257</td>
<td>277</td>
<td>21</td>
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Expectancy at birth has increased slightly (by 1–4 years) in all three of the countries where IPHC/FM has been implemented vigorously. It has declined slightly (by 1–2 years) in Russia and Ukraine. The adult mortality rate has decreased significantly in two of the IPHC/FM countries (Albania and Armenia). In Kyrgyzstan and the two countries where IPHC/FM was not implemented vigorously, it has increased significantly. The three countries where adult mortality rate has increased also have a comparatively high incidence of TB/HIV. Under-5 mortality was halved in all three countries where IPHC/FM was implemented vigorously. It also declined (less so) in Russia and Ukraine, although it was significantly less in those two countries to begin with.

More recently, in the years 2000 to 2008, life expectancy in Albania, Armenia, and Kyrgyzstan increased slightly or remained the same. Life expectancy in Russia and Ukraine declined or remained the same. Adult mortality rate declined in two countries: Albania and Russia. In Armenia, Kyrgyzstan, and Ukraine, it increased. Under-5 mortality declined in every country. Its decline was most significant in Albania, Armenia, and Kyrgyzstan. The least decline was in Ukraine, although Russia and Ukraine had the lowest under-5 mortality rates among all five countries in 2008.

The assessment team would like to stress that, given the complex relationships between health services, improved health outcomes, and other social and economic factors, a rigorous definition of the direct influence of IPHC/FM activities in the region upon improved health outcomes must be rather speculative. This is particularly true given the weaknesses in available and reliable epidemiologic and biostatistical information, and the absence of carefully designed and carried-out research.

**Relationships Between Vertical (Categorical) and Horizontal (PHC) Approaches to Health Care Delivery**

Rather than being an IPHC/Basic Health Services approach, the Semashko-style system is, in effect, a system of closely stacked vertical silos—representing diseases, organization of services, organization of facilities, and types of subspecialist care. Its greatest defects are in its inadequate horizontal underpinnings—for more comprehensive attention and skills, interchange of information, convenience, and efficiency of care. These are major cracks for silos to fall through. As countries in the region move to develop better PHC and its horizontal structures, one can confidently predict that even the vertical silos will become more effective, leading to earlier detection and diagnosis, more effective and more continuous treatment, and smarter referrals when necessary for issues “outside the silo.”
Better training and support of GPs/FMs, improved organization and management of more autonomous facilities, refined financing, enhanced and more evidence-based M&E systems and national policies, and more attention to the integration of clinical services and modern public health activities—all of these can be expected to contribute to increased access to effective care and better health outcomes. They can also be expected to improve the effectiveness of individual vertical activities, which are also necessary, but not sufficient, within a well-functioning health system.

Major problems in the region remain, however, in the inefficiencies and oversupply/low productivity of the polyclinic and hospital facilities that currently dominate the national systems, and in the archaic and unintegrated public health components.

STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

In the Country Assessments (Annex 3) in this report, the project team describes the SWOTs of the IPHC/FM approach, as they appear within individual countries. The diversity across these countries makes it difficult to generalize in many instances (e.g., what might have been a success in FM training in one country could have been a failure in the next country). Therefore, in looking for strengths and weaknesses related to specific aspects of IPHC/FM or HSS projects, one would do well to also carefully review the individual Country Assessments in Annex 3 of this report.

Strengths

1. There has been a long, continuous, sustained USAID E&E effort, with significant successful attention to development partners’ collaboration and coordination.

2. The program has “worked across the board” of the clinical health sector in a coordinated way, from lending by the World Bank for physical infrastructure (including equipment), to USAID technical assistance applied at many levels (from senior levels of the Ministries of Health to rural health posts).

3. There has been significant flexibility of approach to fit national and local settings. In some cases urban health centers are staffed with FM physicians, while in other cases they are staffed by a combination of primary care specialists, depending upon the needs of the country as reflected in the proposal of the contractor selected for the work.

The three strengths outlined above have played a significant role in the ability of the countries in the E&E region to achieve, among other signs of progress, the following:

1. There are, in a significant proportion of the countries in the region, positive and concrete steps toward health financing reform, leading to better access, better management systems, and more effective and efficient use of available resources. Examples of this include work in Albania, Armenia, and Kyrgyzstan. These have usually taken the form of a national health insurance program, often run by an agency other than the Ministry of Health. Payment is usually capitated for outpatient care and case-based for hospital care.

2. In a number of countries in the region, FM is being formally developed as a medical specialty and there is greater emphasis on the development of PHC systems, both rural and urban. Guidelines for evidence-based practice have been developed and are in use, academic postgraduate and FM training has begun, and FM specialists produced. Perhaps the best examples of such developments in FM are in Albania and Kyrgyzstan.

3. Particularly in rural areas, health facilities have been constructed, renovated, and equipped with basic diagnostic instruments. This has improved both the image and, to some extent, the performance of PHC and rural health services.
4. To some extent, the sustained and broad activities of the IPHC/FM effort have begun to change mindsets in the population and are legitimizing the program concepts.

**Weaknesses**

1. In some cases, a focus on the development of “FM as a medical specialty” may have diverted attention from the need to significantly improve the quality of undergraduate medical education and support and improve the quality of practice of the large numbers of general practitioners who staff the rural health facilities. Thus, other options (such as increasing the competence of GPs doing PHC) may not have been adequately explored. This may have added a degree of difficulty to the acceptance of the development of PHC networks. It may be useful for E&E to give some disciplined thought and critical analysis to the tradeoffs that are possible in the region between substituting FM specialists for GPs or improving the competence for practice of GPs. In any case, a focus on the improvement of quality and relevance of undergraduate medical education, and the development of postgraduate training in primary care, need to be seen as absolutely necessary foundations for effective IPHC and health reform.

2. There has been limited success in dealing with four difficult, yet fundamental, problems of the region’s health systems:
   - Lack of effective political commitment to health system reform.
   - Poor quality of education, training, and practice of doctors, nurses, and managers.
   - Dysfunctional relationships between GPs and narrow specialists and the corresponding dysfunction between the primary and secondary (especially polyclinic) levels of care.
   - Corruption at all levels.

   These four are difficult problems to combat, but, nevertheless, they must be viewed as having limited the success of the IPHC/FM approach in the region.

3. Failure to reform the SES, develop a modern public health approach, and closely link disease prevention and health promotion to clinical services are major obstacles to improvements in health outcomes and strengthened health systems. These failures have unfortunately combined with inadequate investments in health information management—particularly reliable epidemiology and biostatistics—and M&E for quality improvement.

**Opportunities**

1. Even in countries that have had more modest success to date with IPHC/FM, many lessons have been learned and progress has been made in establishing the foundation for improved outcomes from IPHC/FM in the future. If USAID can stay the course, there are significant opportunities over the next few years for breakthroughs in countries experimenting with IPHC/FM. Many of these countries are at the tipping point for sustained reform, which, once achieved, could have wide-ranging implications within, and even beyond, the region.

2. Current efforts to implement the IPHC/FM approach and increase the competency of GPs and FM specialists could be amplified by developing and supporting national, regional, and international collaboration among academic institutions and professional organizations.

3. As described above and in the Country Assessments (Annex 3), many country initiatives are handicapped by a lack for capacity in key management areas at all levels, and in a wide range of fields. There is the potential for substantial improvements in health care quality through greater support for education and training in program planning, analysis, management, and finance.
Threats

1. Current and future threats to successful implementation of IPHC/FM include unexpected political instability, conflict, epidemics, and decreased availability of financial resources for the health sector.

2. Another concern is the inability to stimulate and sustain appropriate political and social commitment for health system reform via IPHC/FM and HSS.

LESSONS LEARNED

1. It has been possible to assist in the transformation of a rigid, vertical (categorical), inefficient, overstaffed, low productivity health care system (the Semashko model) toward an IPHC system based on the framework of FM and HSS, but it is a long, slow, and difficult task.

2. The four most critical obstacles to such an effort (inadequate political and social commitment; poor quality of education, training, and practice of health professionals; the dysfunctional relationships between GPs and the narrow specialists; pervasive corruption) are very resistant to change. Of these, the first and the last are most difficult for an outside development partner to reach; thus, traction is perhaps best gained by emphasizing the middle two. This might very well have positive effects on all four.

3. In all countries in the region, factors external to the health system frequently interrupt action and progress.

4. The approach and timing of implementation needs to be flexible and sensitive to differences between countries and within them (e.g., between rural and urban areas).

5. Implementing FM as a new medical specialty allows wider acceptance of FM among the medical and surgical community as well as with patients.

6. FM appears to work best in rural areas, but it can work in urban areas if adjusted to meet the characteristics of the urban delivery system.

7. Continued improvements in the quality of FM care can only come through improved education and training and a widely recognized increase in the scope of FM practice.

8. Sustained and continuing medical education, training, and retraining of physicians, primary care nurses, community health nurses, midwives, and other medical professionals is critical to long term QI of services.

9. There are different approaches to implementing family medicine and there is little clear evidence that any one approach is better than another. What is clear is that the approach (whether it be to retrain specialists as family doctors or to package specialists within a family group practice) should be carefully considered and based on an analysis of the environment of the population being addressed. In some cases, retraining has failed because it was not the appropriate approach, while in other cases it has had more success.

10. The development and support of professional medical societies, especially in FM, is an important QI technique.

11. The conflict between FM and the narrow specialists, especially in the urban polyclinics, is a complex and difficult issue, not easily resolved without complete health system reform.

12. A combined approach of USAID and the World Bank, with USAID implementing various HSS activities and the World Bank handling the investment component, produces more effective and lasting reforms than stand-alone projects. Both technical assistance in HSS and improved facilities, instruments, and equipment are necessary to implement lasting QI and continuing reform of the primary care system.

13. The implementation of licensing and accreditation programs for health professionals and health facilities is an effective tool for QI.
14. Health finance reform is critical to changing the incentives for both patients and providers. A single payer system is an effective vehicle for reimbursement of providers.

15. The development and implementation of a National Health Account (NHA) system has been successful in identifying the proportion of the public and private sector funding going to primary care. Informal payments are a complex and difficult issue for patients, families, and the health finance system. Some progress in this area has been made by using copayments to reduce these informal payments.

16. The process of decentralization and increasing levels of autonomy at the ambulatory provider level can significantly increase productivity and improve quality.

17. Continuing the restructuring and rationalization process at the secondary and tertiary levels is most important for reallocating scarce funds to the primary care sector.

18. Reform and improvements in one sector (primary care) impact other sectors (public health, secondary care, and tertiary care), and comprehensive reform throughout the total system is needed to implement lasting reforms.

**BEST PRACTICES**

A number of best practices are described below, mostly related to the enhancement of the quality of medical (and, to some extent, nursing) education, training, and practice, and to improvements in health care financing. Some of these are not so much “best practices” in the traditional sense of the term (representing a “best of breed national, regional, or global standard practice”), but rather are tangible efforts and accomplishments that demonstrate significant overall progress and are worthy of being singled out, replicated, and emphasized for continued and expanded support.

The nascent implementation of a P4P system, which rewards improvements in quality, will very likely prove a best practice in both Albania and Armenia.

The establishment of the Independent Family Medicine Ambulatory in rural areas, particularly with two or three physicians with high levels of autonomy, has been identified as a best practice in Albania, Armenia, and Kyrgyzstan.

The implementation of a payment system with penalties for “self-referrals” is an important improvement to the referral system and a best practice in Albania.

The implementation of a “hands-on” FM Training Center, where patient care and teaching occur simultaneously within an urban polyclinic, has been identified as a best practice in Albania, Armenia, and Kyrgyzstan.

The establishment and support of quasi-independent professional medical associations (i.e., Family Group Practice Association, Hospital Association, or Medical Accreditation Commission) that can look out for the interest of their constituents and can lobby the local and national governments for effective change has been identified as a best practice in Kyrgyzstan.

The implementation of an Accreditation Institute in Albania that supports the licensing process for health professionals through an effective CME Accreditation program is a best practice in Albania.

The implementation of a National Health Account (NHA) Program that can report on expenditures in various health sectors and more accurately identify the amount of expenditures in each sector of the health care system is a best practice in the E&E region.
The concepts of patient choice of physician and “Open Enrollment” Programs are a force for improved quality of care and improved competition between physicians, and have been identified as a best practice in Armenia and Kyrgyzstan.

The establishment of a system of copayments, with prices clearly presented, along with counseling patients on financial issues, may reduce informal payments and improve access and utilization of primary and secondary care facilities. This is a best practice in Kyrgyzstan.

The coordination of donor activities through a SWAp process is an effective method for allocation of scarce donor funds and is a best practice in Kyrgyzstan.

The reported practice of rural FM physicians making regular (monthly) visits to surrounding villages for health promotion and disease prevention, particularly in maternal and child health/reproductive health/family planning (MCH/RH/FP) services has been identified as a best practice in Armenia.

The concept of merging urban polyclinics with hospitals, which allows improved assignment of NS to both facilities, is a best practice in Albania.

The emerging establishment of FM as a specialty medical discipline, within the wide range of professional medical and surgical specialties, is a regional best practice.

The implementation of national HIFs to oversee and manage reimbursement of medical providers is a regional best practice.

The implementation of a rational referral “gatekeeping” system from primary care to various specialists at the primary/secondary levels, with strong disincentives for bypassing the system via self-referral, is a regional best practice.

The implementation of written contracts between health institutions and the HIF and contracts between health institutions and their employees is a regional best practice.

The implementation of an incentive/bonus payment system for medical staff (based on key performance indicators) is a regional best practice.

RECOMMENDATIONS FOR THE FUTURE

Based on this assessment, including its individual Country Assessments, the project team has identified six important recommendations for USAID Missions, countries, and partners, each of which implies a number of actions for the future. These recommendations are listed below.

1. **USAID should continue its efforts on health reform in the E&E region, providing continued support and enhanced funding for IPHC/FM programs and activities.**
   - In addition to its own direct value, the E&E IPHC/FM effort has an important value for the wider USAID community as it looks to U.S. President Obama’s GHI.
   - USAID should maintain ongoing collaboration regarding planning and programming with international development partners. The World Bank SWAp is a good example.
   - Development partners should establish significant pre-conditions for funding appropriate to program objectives. The establishment of Health Policy Units in the Ministries of Health and the placement of effective deputy ministers in key positions, as well as financial commitments of more funds to primary care, are a few examples.
   - Where possible, vertical activities and their funding should be integrated into a horizontal (IPHC) base.
USAID should support a series of regional forums (similar to the St. Petersburg Initiative) in order to scale up country successes across the region.\(^h\)

USAID should continue to strengthen the commitment and capacity of country Ministries of Health to implement all aspects of national IPHC/FM strategies by, among other things, incorporating it more broadly in USAID health-related activities and literature.

2. **USAID should significantly increase its focus on improved quality of medical education, training, and practice.**
   - Reforms should encompass undergraduate medical education, postgraduate training (including FM), and CME, in order to increase the competencies of GPs and medical and surgical specialists.
   - Reform should include curriculum development, modern teaching techniques and methods, hands-on clinical education and training, and evidence-based practices.
   - Regulatory reforms should expand the “scope of practice” of FM physicians, develop effective licensing and accreditation programs, and put guidelines for standards of practice in place.
   - USAID should continue to assist and strengthen professional medical associations, both in countries and regionally.
   - All of the above recommendations are also applicable to nursing development activities in the region.

3. **USAID should focus on total health systems reform (primary, secondary, and tertiary) in the region, bringing polyclinics, hospitals, and SES fully into the reform process.**
   - Selected pre-conditions and a memorandum of understanding should be carefully designed, incorporating both incentives and disincentives, and tied to key areas of reform.
   - Polyclinic reform should increase the scope of practice of FM physicians and reduce the role of the narrow specialists to more appropriate numbers and thus higher productivity.
   - Hospital reform should increase productivity, reduce surplus beds, and move toward more ambulatory care, with closer coordination of out and in-patient services.
   - USAID should assist countries in developing Modern Public Health Services, modernizing or replacing SES as appropriate.

4. **USAID should implement health finance reforms through expanded HSS assistance to Health Insurance Funds (HIFs) in the region, developing more effective incentives and disincentives at the provider level.**
   - Stimulate decentralization and increased autonomy for providers.
   - Accelerate reform of payment mechanisms and information management systems.
   - Improve coordination and cooperation between the Ministry of Health, HIF, and Ministry of Finance.

\(^h\) In the mid-1990s, a series of regional conferences among high-level health reformers and academicians was held in St. Petersburg to discuss the issues surrounding, and prospects for, HSS and health reform. The activity dwindled, and the assessment team believes its possible rebirth should be investigated as a potential stimulus to continued progress across the region. This would follow appropriately from the 2008 Tallinn Charter, in which 52 Countries in the WHO Euro Region committed to HSS.
5. **USAID should assist the SES to modernize itself into a Modern Public Health Service.**
   - SES services and programs should be rationalized and restructured, or carefully replaced with another Public Health Services form of organization.
   - Information management should generate useful epidemiology and biostatistics.
   - USAID should consider establishing, within the region, a modern school of public health. This might be a single “magnet” school serving a number of countries in the region, or a school within and for a particularly interested country.

6. **USAID should help governments introduce effective, integrated M&E systems at all levels.**
   - Establish standards and systems for performance monitoring of quality levels in PHC.
   - Systematically collect and analyze data to demonstrate changes in key reform objectives.
   - Develop the IPHC/FM approach “story” in clear and concise language so that policymakers and the public can understand the impact and importance of continued funding for IPHC/FM.
ANNEX 1. STATEMENT OF WORK

Global Health Technical Assistance Project
GH Tech
Contract No. GHS-I-00-05-00005-00

STATEMENT OF WORK
(Revised: 08/06/10)

I. TITLE
Activity: E&E: Assessment of Europe and Eurasia (E&E) Experience in Integrated Primary Health Care and Family Medicine
Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD
On/about mid-August – before or no later than December 31, 2010

III. FUNDING SOURCE
USAID/E&E Bureau funds

IV. PURPOSE AND OBJECTIVES
The objectives of this assessment are to:
1. Document the experience of E&E countries in implementing the integrated primary health care (IPHC) development approach based on the framework of family medicine and health systems strengthening (HSS);
2. Assess the strengths, weaknesses, opportunities, and threats of the IPHC approach, taking into account the effectiveness—or ineffectiveness—of the approach in achieving health outcomes and building health systems capacity; and
3. Provide recommendations to E&E Missions, host countries, and development partners on how they can more effectively implement integrated PHC programs in the future.

The E&E Bureau will use the assessment findings and recommendations to guide E&E Missions in implementing future health assistance programs and responding to key tenets of President Obama’s Global Health Initiative. The assessment should also benefit E&E countries and other development partners in guiding future health reform initiatives.

V. BACKGROUND
“Integrated primary health care” is defined in many ways. Simply defined, it describes a “one-stop” service delivery model in which an individual or family visits its local, primary care unit or general practitioner as the first point of encounter within the health care system. The PHC “gatekeeper” either treats the patient or refers the patient to a specialist, if necessary. Annex B includes several general references that document the programmatic and historical experience with integration.

Within the E&E context, USAID Missions, host countries, and development partners implement integrated primary health care within the framework of family medicine and health systems...
strengthening. Also referred to as the family medicine model, E&E and its partners introduced the IPHC model in Central Asia, Russia, and Ukraine in the mid-90s, and extended it to Albania, Romania, and the Caucasus countries in the early 2000s.

The “results” frameworks for IPHC programs typically aim to improve the health of the population by increasing the utilization of primary health care services. “Intermediate results” are usually defined in health systems contexts such as improving the legal and regulatory environment for PHC, increasing the generation and allocation of resources for PHC health, improving the quality of PHC care, and empowering health care individuals and communities to assume greater responsibility for their health. E&E Missions typically implement IPHC initiatives in five-year increments over several years, recognizing the sustained effort and flexibility these programs require. Close collaboration and leveraging of resources with development partners are other key features. Funding of these programs is relatively small, $4 million to $8 million annually, compared to the much larger sums USAID allocates to countries in other geographic regions, typically for disease/condition-specific interventions. Nonetheless, the E&E Bureau and Missions believe the potential for system wide impact on population health and systems strengthening can be substantial. See Attachment A for a list of USAID-funded IPHC projects, past and present, in the E&E region. E&E continues to assist countries in implementing the approach in Albania, Armenia, Azerbaijan, and Georgia.

At the same time, the activities targeted U.S. Government “priority services,” particularly those linked to the congressional “directives” funding the activity. In recent years, this approach has become known as the “diagonal” health systems strengthening approach. The IPHC model contrasts with the U.S. Government approach that targets U.S. Government priority services or conditions—HIV/AIDS, TB, Malaria, MCH, RH/FP, and other public health threats—or integrates two or more of these services (e.g., MCH and FP/RH or HIV/AIDS and Prevention of Mother to Child Transmission).

The following excerpt from the document “Conceptual Foundation of Health Reform in Central Asia” explains the rationale for the IPHC approach. The rationale applies to most E&E countries as they all inherited the highly centralized, vertically structured Semashko health care system prevalent throughout the Former Soviet Union.

“One of the most profound inefficiencies in the health care system is the imbalance between the hospital and primary care sectors. Hospitals consume more than 70% of the health care budget. The health delivery system inherited from the Former Soviet Union can be likened to an inverted pyramid. The hospital sector at the top of the pyramid is overdeveloped and the primary health care sector which should serve as the broad base of the pyramid is underdeveloped, underfinanced, and underutilized. Solving this problem requires complete restructuring and strengthening of the primary health care sector through the creation of new primary care practices.

There are also clinical obstacles to the development of the primary care sector. Primary health care has been inadequately provided in the past through catchment area physicians with incentives to refer quickly to specialists. Training of primary care physicians, by Western standards, is inadequate, and thus conditions that should be effectively treated in the primary care sector are treated in the hospital or by specialists.

The terms “primary health care,” “primary care,” “general practice,” and “family medicine” are often used interchangeably. See the following link for short descriptions of how each is defined by WHO: http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/primary-health-care/main-terms-used.

In 2008, USAID transferred management of programs in Central Asia to the Asia Bureau.

at polyclinics. Solving this problem requires introduction of general or family practice and upgrading of clinical skills. There are also clinical areas such as reproductive health and infectious diseases which should be incorporated into primary health care (see the two papers in this ZdravReform series covering this topic). In addition, the Soviet system maintained extensive vertical health programs for tuberculosis, sexually transmitted diseases, oncology and psychiatry, which also should eventually be integrated into primary care.

Efforts to restructure the primary care delivery system in the countries of Central Asia have focused on creating a network of primary care entities (FGPs) that are physically, financially and administratively independent from higher level facilities. The ultimate goal of these restructuring efforts is to increase the managerial autonomy and internal control that primary care providers have over their resources, so they can better adapt to the needs of their populations."

USAID has supported IPHC initiatives through bilateral projects, “buy-ins” to Bureau for Global Health “Field Support” projects, and through the American International Health Alliance (AIHA) Health Partnerships Program. This assessment will focus on the non-AIHA programs but will take into account the findings and recommendations of the 2008 evaluation of the AIHA primary health care partnerships experience. See: the “Program Evaluation Report: AIHA Primary Healthcare Partnerships in the New Independent States” at: http://dec.usaid.gov/index.cfm?p=search.getCitation&CFID=110905&CFTOKEN=93579214&id=s_C1CEDDFC-D566-FC5C-D19CFE00BF0BBAC7&rec_no=144388

Future E&E health assistance will be guided by President Obama’s Global Health Initiative (GHI), which follows the following key programmatic principles:

- Implement a woman and girl-centered approach.
- Increase impact through strategic coordination and integration.
- Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement.
- Encourage country ownership and invest in country-led plans.
- Build sustainability through health systems strengthening.
- Improve metrics, monitoring, and evaluation.
- Promote research and innovation.

E&E IPHC activities have incorporated most of these principles, and the assessment will take them into account in examining past performance and recommending future directions.

The E&E Bureau believes it is timely to assess its experience with the IPHC approach because (1) E&E physicians practicing specialty medicine continue to resist family medicine, especially in urban centers; (2) little literature exists that examines the effectiveness of the IPHC approach in E&E; and (3) President Obama’s Global Health Initiative (GHI) places much emphasis on implementing more integrated health assistance programs and health systems strengthening. This assessment will help inform E&E Missions on how to design future PHC interventions, will contribute valuable knowledge to the scarce literature on the effectiveness of the IPHC approach, and will strengthen E&E Missions’ capacity to respond to the GHI.

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VI. SCOPE OF WORK

The assessment team will produce the following deliverables:

- Produce a literature review of E&E countries and development partners’ (World Bank, WHO, EU, DFID, etc.) experience to date in implementing the IPHC/family medicine approach. This “desk review” will identify the key constraints that E&E countries face and the strategies they are using to address them. Illustrative key word searches will include integrated primary health care, family medicine, family doctors, family nurses, health sector reform, health sector rationalization, health systems reform, etc.

- Produce an assessment report that:
  - Identifies the strengths, weaknesses, opportunities, and threats (SWOT) of E&E Missions’ experience in implementing the IPHC approach, describing the extent to which IPHC activities have contributed to improvements in population health status and health systems capacity. See SWOT analysis template in Attachment C. The Contractor will examine the magnitude of results achieved at the community, regional, and national levels, recognizing the contributions of the host government and other development partners.
  - Assesses when it is more appropriate to support a more narrow integrated approach, integrating two or three disease/condition priorities (HIV/AIDS and TB; child health, maternal health, reproductive health and family planning; and noncommunicable diseases and injuries) or focus solely on one disease/condition priority.
  - Assesses the sustainability and replication of the IPHC approach.
    “Sustainability” is the capacity of the IPHC approach to continue successfully after foreign assistance ends. Sustainability includes financial and institutional dimensions. Financial sustainability refers to the capacity of the host country to replace withdrawn donor funds with funds from other, usually domestic, sources. Institutional sustainability refers to the capacity of the host country, if suitably financed, to assemble and manage the necessary non-financial resources to carry on successfully the IPHC approach.
    “Replication” is the expansion of the IPHC model to other regions within the country. How many people are affected by these changes—what percentage of the local, regional, and national populations? The Contractor will identify actual and planned replications.
  - Includes a matrix that summarizes the outcomes, sustainability, and replication of the IPHC approach beyond the initial pilot sites.
  - Identifies 3–5 major lessons learned and 3–5 best practices that USAID can apply in E&E countries.
  - Draws 3–5 summary conclusions on the effectiveness or ineffectiveness of the IPHC approach in E&E and makes 3–5 recommendations on how E&E can more effectively implement IPHC programs in the future.

VII. METHODOLOGY

The principal methodologies will include document reviews, key informant interviews, field visits to two E&E countries—Albania and Armenia—videoconferences, roundtable discussions, and focus group interviews, as appropriate.
The assessment team will:

- Hold a team planning meeting and produce an assessment work plan as described below.
- Research and produce a review of the professional literature relating to implementing the IPHC/family medicine approach in the E&E region, including relevant E&E country, USAID, and development partner documentation, particularly evaluation studies.
- Produce an assessment report that takes into account the literature review and USAID project documentation for IPHC activities, including the activity contract or cooperative agreement and modifications, quarterly and annual progress reports, work plans and project management plans, earlier evaluation studies, technical reports, websites, etc. Host country documentation will also be researched, including government laws and decrees, implementation strategies, technical documents, etc.
- Visit Albania and Armenia to assess the IPHC implementation experience on-the-ground. The countries selected must have supported IPHC programs for at least five years. Countries meeting this criterion include Albania, Armenia, Azerbaijan, and Georgia. The assessment team will arrange videoconferences with the Missions not visited to discuss their experiences. Although Central Asia now falls under USAID’s Asia Bureau, the Contractor will take into account the Kyrgyzstan experience, given the prominent role it has played in advancing IPHC in Central Asia and the E&E region.
- In preparation for the site visits, videoconferences, and roundtable discussion, prepare and send a list of key questions in advance to the Missions and roundtable participants.
- Hold a Washington, DC roundtable discussion that invites key USAID, World Bank, and implementing partners that have been directly involved in supporting E&E IPHC initiatives.

Below are illustrative questions the assessment team will address:

- What are the strengths, weaknesses, opportunities, and threats of the IPHC approach in terms of:
  - Increasing the utilization of PHC services?
  - Addressing the country’s leading causes of death and disability—and U.S. Government priority services: family planning/reproductive health, maternal and child health, HIV/AIDS, TB, and other public health threats?
  - Strengthening health systems in the areas of Health Finance; Information Systems; Human Resources; Service Delivery; Medical Products, Vaccines, and Technologies; Leadership/Governance; and Community Participation and Health Communications?
- To what extent has the IPHC approach been successful—and unsuccessful—to date in responding to the following principles of the Global Health Initiative:
  - Implementing a woman and girl-centered approach?
  - Increasing impact through strategic coordination and integration?
  - Strengthening and leveraging key multilateral organizations, global health partnerships, and private sector engagement?
  - Encouraging country ownership and investment in country-led plans?
  - Building sustainability through health systems strengthening?
  - Improving metrics, monitoring, and evaluation?
  - Promoting research and innovation?
- What are the “opportunity costs” of implementing the comprehensive, IPHC approach versus the more selective, disease/condition-specific intervention approach—in terms of capacity-building, lives lost, and illness averted? Does existing evidence exist that suggests the tradeoffs?
Can differences in health systems performance and health be observed in E&E countries that have more vigorously implemented the IPHC approach (Armenia, Albania, and Kyrgyzstan) than those that have not (e.g., Russia and Ukraine)?

E&E physicians sometime resist being retrained as family doctors. Should pediatricians, OB/GYNs, and doctors of internal medicine be retrained to practice as family doctors? Should they retain their specialties but practice within a "one-stop" family group practice? Should both organizational forms be promoted?

What role do nurses and specialists play in the IPHC and family medicine model? How can their roles be leveraged? What are the barriers to increasing their involvement?

Some critics question the capability of the family doctor to diagnose and treat the wide range of health problems facing rural and urban communities. Is it realistic to expect the family doctor to diagnose, treat, and make good judgments in referring patients to specialists?

It is often challenging to retain family doctors in underserved areas due to competing higher salaries offered in neighboring countries or in urban centers. How can financial and non-financial incentives be strengthened to attract family doctors to work in underserved rural areas? Are incentives adequate for promoting private sector PHC group practices?

Family doctors sometimes do not use the evidence-based practices in which they were trained. What explains this and how can it be addressed?

To date, attempts to introduce the family medicine model into urban centers have met strong resistance from specialists who do not want to become family doctors and feel threatened by family doctors. Should E&E countries introduce the family medicine model into urban areas? If so, how?

Institutionalizing IPHC requires a strong government commitment. Is the IPHC approach in the E&E region donor driven or country driven?

Over the long term, based on experience to date, can E&E countries impact health status more effectively through the comprehensive, IPHC approach or through more selective, disease/condition-specific interventions—or both?

VIII. DELIVERABLES AND PRODUCTS

Team Planning Meeting

The assessment team will start their work with a two-day planning meeting with the team members prior to the onset of meetings and work with the USAID E&E Bureau. The purpose of this meeting will be to clarify team roles and responsibilities; to develop the interview instruments, workplan, and methodology; and to create a timeline and action plan for completing the deliverables. In the meeting, the team will specifically:

- Share background, experience, and expectations of each of the team members for the assignment.
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities.
- Agree on the objectives and desired outcomes of the assignment.
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
- Review the assessment timeline and strategy for achieving deliverables.
- Finalize the assessment timeline and strategy for achieving deliverables.
- Develop and finalize data collection methods, instruments, tools, and guidelines.
• Develop a preliminary outline of the team’s report and assign drafting responsibilities for the final report.
• During the team planning meeting, an in-briefing with USAID/E& E Health Team will be held to discuss expectations of the assessment.

**Workplan, Methodology, and Status Reports**

The assessment team will develop an assessment workplan, methodology framework, and field visit and interview schedule in consultation with the USAID E& E Health Team. The Assessment Team Leader will submit a 3–5 page workplan and methodology framework to Forest Duncan, the Activity Manager, and GH Tech no later than five days after the TPM. The workplan will outline the steps and methodology the assessment team will take to produce the deliverables described in sections VI and VII, finalize the key questions and interview instruments, propose an implementation schedule with target dates for producing each deliverable, and include a rough draft outline for the report. The E& E Health Team and E& E Missions to be visited will review the proposed workplan and submit comments within two working days. The assessment team will then revise the workplan, incorporating E& E comments. The workplan and methodology must be finalized and approved prior to the initiation of the interviews and site visits. The Assessment Team Leader will also provide biweekly status reports on workplan implementation to the Activity Manager and GH Tech.

**Roundtable Presentation**

The assessment team will conduct a roundtable discussion in Washington, DC with key stakeholders that have been directly involved in supporting E& E IPHC initiatives. The main findings will be summarized and included as an annex in the draft assessment report.

**First Draft of Assessment Report and USAID Presentation**

The Assessment Team Leader will submit the first draft report to Forest Duncan, the Activity Manager, and GH Tech within 30 working days after returning from the field visits. The report will include the literature review as an annex. The Activity Manager will distribute the draft report to the E& E Health Team, USAID/Albania, and USAID/Armenia for comment. The E& E Health Team, USAID/Albania, and USAID/Armenia will review the draft report, and the Activity Manager will submit combined USAID comments within five working days.

**Presentation of Findings**

The assessment team will present the draft report findings and recommendations to a wider audience of USAID, development, and implementing partner “stakeholders” on a date to be agreed upon with USAID. The PowerPoint presentation will be shared with GH Tech prior to the USAID and stakeholder debriefing.

**Second Draft Report**

The Assessment Team Leader will submit the second draft of the report to Forest Duncan, the Activity Manager, approximately 10 days after receiving written USAID comments. Forest Duncan, the Activity Manger, will collect comments from the E& E Health Team and E& E Missions and submit them within five working days to GH Tech to revise/finalize/complete the report (G. below).
Final Assessment Report and Literature Review

GH Tech will submit 50 copies of the edited and formatted final document to the Activity Manager approximately 30 days after USAID provides final approval of the report content and sign off. The final report will be approximately 25 single-spaced pages in length, excluding the executive summary and attachments. The report will include the literature review as an annex. Procurement sensitive information will be removed from the final report and incorporated into an internal USAID Memo. The remaining report will then be released as a public document on the USAID Development Experience Clearinghouse (DEC), http://dec.usaid.gov, and the GH Tech project website, www.ghtechproject.com.

IX. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

The assessment team will be composed of a Senior Public Health Specialist, a Senior Health Systems Analyst, and a Research Analyst. The Senior Public Health Specialist will be the Team Leader.

The **Senior Public Health Specialist** must have at least an MA degree and academic training in health policy, public health, or a social sciences field related to health. S/he should have extensive experience applying health systems analysis in program and project design, implementation, and/or evaluation in developing or transitional countries. Experience managing HSS projects that also target disease/condition-specific programs using the “diagonal approach” is highly desirable. In-country experience in the E&E region is preferable.

The **Senior Health Systems Analyst** must have at least an MA degree and academic training in health, public health or a social sciences field related to health. S/he should have extensive experience applying health systems analysis in program and project design, implementation, and/or evaluation in developing or transitional countries. Experience managing HSS projects that also target disease/condition-specific programs using the “diagonal approach” is highly desirable. In-country experience in the E&E region is essential.

The **Research Analyst** must have an MA degree and at least five years of experience researching and synthesizing key findings of literature reviews. Strong writing and analytical skills required.

The assessment will be completed according to the following Level of Effort (illustrative).

<table>
<thead>
<tr>
<th>Task</th>
<th>LOE (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect and review documents/prepare for Team Planning Meeting</td>
<td>TL/TM/RA=5</td>
</tr>
<tr>
<td>Conduct Team Planning Meeting</td>
<td>TL/TM/RA=3</td>
</tr>
<tr>
<td>Finalize workplan and methodology</td>
<td>TL/TM/RA=3</td>
</tr>
<tr>
<td>Conduct literature review (RA)</td>
<td>RA= 28</td>
</tr>
<tr>
<td>Conduct key informant interviews</td>
<td>TL/TM=10</td>
</tr>
<tr>
<td>Visit two E&amp;E countries (TL/TM)</td>
<td>TL/TM=18</td>
</tr>
<tr>
<td>Prepare for/facilitate roundtable discussion (send advance questions to Missions and E&amp;E Bureau)</td>
<td>TL/TM/RA=4</td>
</tr>
<tr>
<td>Analyze results and write first draft of assessment report</td>
<td>TL/TM/RA=11</td>
</tr>
<tr>
<td>Prepare for/present initial findings to USAID and key stakeholders</td>
<td>TL/TM/RA=2</td>
</tr>
<tr>
<td>Task</td>
<td>LOE (Days)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Write second draft of assessment report and PowerPoint presentation</td>
<td>TL=5 RA=3</td>
</tr>
<tr>
<td>with key findings and recommendations</td>
<td>TM=3</td>
</tr>
</tbody>
</table>

| TOTAL CONSULTANT LOE                                               | Team Leader=61                |
|                                                                  | Team Member=59                |
|                                                                  | Research Analyst=59           |

A six-day work week is approved when team is working during country site visits (e.g., Armenia and Albania).

X. RELATIONSHIPS AND RESPONSIBILITIES

GHTech will conduct and manage the assessment and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the assessment team.
- Provide all administrative, logistical, and secretarial support services (e.g., local translators, interviewers, data processors, availability of office space, cars, laptops, tape recorders, hand calculators, and other needed equipment).
- Respond to all points included in the SOW, including the submission of the final report.

USAID/ E&E Bureau will provide overall technical leadership and direction for the assessment team throughout the assignment and will undertake the following specific roles and responsibilities:

- Consultant conflict of interest (COI): To avoid COI or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding any potential COI.
- Background documents: Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.
- Key informant and site visit preparations: Provide a list of key informants (with contact information) and site visit locations (including suggested length of field visits) for use in planning for the roundtable, phone interviews, and in-country travel. Provide accurate estimation of in-country travel line items costs (i.e., number of in-country travel days required to reach each destination and number of days allocated for interviews at each site).
- Lodging and travel: Provide information as early as possible on allowable lodging and per diem rates for stakeholders that will travel/participate in activities with the assessment team. Also, provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics.
- Mission Point of Contact: Ensure constant availability of the Mission Point of Contact person(s) to provide technical leadership and direction for the consultant team’s work.
- Meeting space: Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available or other known office/hotel meeting space).
- Meeting arrangements: Support the consultants in coordinating meetings with stakeholders. Arrange key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings). Introduce the team to project partners, local government officials, and other stakeholders,
and—where applicable and appropriate—prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

- Timely reviews: Provide timely review of draft and final reports and approval of the deliverables.

**XI. CONTACT INFORMATION**

The USAID Activity Manager for this work is Forest Duncan. Mr. Duncan is the E&E Bureau Health Team’s Senior Health Systems Advisor. In Mr. Duncan’s absence, contact Ms. Susanna Baker, Public Health Advisor.

Contact information for Mr. Duncan and Ms. Baker follows:

**Forest Duncan**
Senior Health Systems Advisor  
Bureau for Europe and Eurasia  
U.S. Agency for International Development  
Street Address: Federal Center Plaza, 400 C St SW, Room 220 i  
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Washington, DC 20523-5700  
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E-mail: fduncan@usaid.gov

**Susanna Baker**
Public Health Advisor  
U.S. Agency for International Development  
Street Address: Federal Center Plaza, 400 C St SW, Room 220 k  
Mail Address: 1300 Pennsylvania Avenue, NW  
Washington, DC 20523-5700  
Tel (202) 567-4008; Fax (202) 567-4259  
Email: sbaker@usaid.gov

In carrying out the scope of work, the Contractor, under Mr. Duncan’s guidance, will interact with all members of the E&E Health Team (which includes staff from the Office of Regional and Country Support, Bureau for Global Health), other staff from the Bureau for Global Health, and staff in USAID Missions in the E&E region. Close collaboration with technical experts from E&E, Global Health, and the Missions will be critical to gathering information in the limited time available.

**XII. COST ESTIMATE—TBD**

**XIII. REFERENCES**

Attachment A: Selected USAID-funded projects  
Attachment B: Selected References  
Attachment C: SWOT Analysis Template
## ATTACHMENT A: ASSESSMENT OF EUROPE AND EURASIA EXPERIENCE IN INTEGRATED PRIMARY HEALTH CARE AND FAMILY MEDICINE

### Selected Projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Years</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALBANIA</strong></td>
<td></td>
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</tr>
<tr>
<td>Enabling Equitable Health Reforms in Albania</td>
<td>2010–2015</td>
<td>To strengthen the Albanian health sector’s capability through the implementation of equitable health reforms, moving from strategies into implementation action plans, by providing instruments and tools and testing those in selected districts. Implementer: TBD</td>
</tr>
<tr>
<td>PRO Shendetit (Improving Primary Health Care)</td>
<td>2003–2009</td>
<td>To improve health for Albanians through primary health care—basic maternal and child health care that reaches all of Albania. Implementer: University Research Co. LLC (URC)</td>
</tr>
<tr>
<td>Partners for Health Reform Plus Project Albania</td>
<td>2002–2005</td>
<td>To carry out a pilot test of primary health care reform in four pilot sites in Berat and Kuçova districts. The pilot is intended to move the country towards a more efficient health care system and to deliver higher quality care. Results of the pilot are expected to inform a proposed model of primary health care provision that will replicate pilot reforms across Albania. Implementer: Abt Associates</td>
</tr>
<tr>
<td><strong>ARMENIA</strong></td>
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<tr>
<td>Armenia Health Care System Strengthening Project</td>
<td>2010–2015</td>
<td>Will address key constraints in health financing, leadership and governance, human resources, and information systems that impede access to and delivery of quality Maternal and Child Health (MCH), Reproductive Health and Family Planning (RH/FP), Tuberculosis (TB) and preventive services. Implementer: TBD</td>
</tr>
<tr>
<td>Primary Healthcare Reform Project</td>
<td>2005–2010</td>
<td>To support health sector reforms designed to increase utilization of sustainable, high-quality, primary health care services—contributing to the improved health of all Armenian families and to a more productive workforce. Implementer: Cardno (Emerging Markets Group)</td>
</tr>
<tr>
<td>Armenian Social Transition Program</td>
<td>1999–2003</td>
<td>To mitigate the adverse social impacts of the transition, to strengthen and make sustainable key social and health systems, and to provide urgently needed services to the most vulnerable in selected regions. In the health sector, STP sets out three strategic objectives: Increase access to, and the quality of, primary health care services in selected regions. Establish the foundations for implementing a sustainable health insurance system. Address the immediate health needs of vulnerable groups. Implementer: Planning and Development Collaborative International</td>
</tr>
<tr>
<td>Project</td>
<td>Years</td>
<td>Project Objectives</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<tr>
<td><strong>AZERBAIJAN</strong></td>
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</table>
| Primary Health Care Strengthening Project, Phase II                    | 2007–2010 | 1) Improve mobilization of health care resources.  
2) Establish policies and a legal framework with an increased focus on community-based health care services.  
3) Improve quality of health care services.  
4) Better inform the population about healthy lifestyles and personal health care rights and responsibilities.  
5) Integrate TB and PHC to make services more accessible, especially for vulnerable and less mobile populations.  
6) Strengthen maternity, neonatal, and child health services.  
Implementer: Abt Associates                                             |
| Primary Health Care Strengthening Project, Phase I                     | 2005–2007 | To improve the supply and demand for better PHC services by strengthening clinical care and launching programs that educate the population about key health issues and healthy lifestyles. The Project uses a four-pronged approach to achieve these objectives:  
Increase public expenditures for health and improve resource allocation for PHC.  
Create a policy and legal framework that defines PHC services and the delivery system.  
Improve quality of PHC services and Individuals and Families.  
Promote personal responsibility for health among individuals and families.  
Implementer: International Medical Corps                                |
| **GEORGIA**                                                            |           |                                                                                                                                                                                                                     |
| Health Systems Strengthening and Reform Project                        | 2009–2014 | To support the Government of Georgia’s health reform efforts aimed at improved population health status, access to, and satisfaction with the quality of health services. The new project will contribute to these efforts by achieving the following three objectives over a five year period. Objective 1: Strengthen insurer capacity to provide quality health insurance services. Objective 2: Strengthen provider capacity to manage and deliver quality health care services. Objective 3: Strengthen government capacity to guide and monitor health reforms.  
Implementer: Abt Associates                                              |
| Cooperation in Health System Transformation Project                    | 2005–2009 | To improve Georgia’s health care financing system, support reproductive health and family planning policy, and provide organizational development support to the Ministry of Labor, Health and Social Affairs and relevant affiliated agencies.  
Implementer: Abt Associates                                              |
| **ROMANIA**                                                            |           |                                                                                                                                                                                                                     |
| Romanian Health Care Reform Program                                    | 2006–2007 | To actively address and implement activities for health care reform, reallocating resources to the PHC system, and to strengthen and improve services. Project components were:  
1) Health policy reform and implementation.                             |
<table>
<thead>
<tr>
<th>Project</th>
<th>Years</th>
<th>Project Objectives</th>
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<tr>
<td><strong>2) Strengthening the quality of PHC.</strong>&lt;br&gt;3) Rationalizing pharmaceutical management.</td>
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<td><strong>RUSSIA</strong></td>
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<tr>
<td>ZdravReform (Russia, Kazakhstan, Kyrgyzstan, Uzbekistan, and Ukraine)</td>
<td>1993–1997</td>
<td>To improve the health of the population in support of economic and democratic development by increasing economic efficiencies, quality of care, and provider choice in the Russian Federation through market-oriented reforms of the health financing and service delivery systems, while protecting universal access to health care. Implementer: Abt Associates</td>
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<td><strong>UKRAINE</strong></td>
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<tr>
<td>ZdravReform Program-Ukraine Option Period</td>
<td>1998–1999</td>
<td>In 1997, ZRP began to target its work in three areas: (1) financial management, (2) system restructuring, and (3) family medicine/primary health care. In 1998, ZPR began to focus increasingly on primary health care at both the local and national level. Implementer: Abt Associates</td>
</tr>
<tr>
<td>ZdravReform (Russia, Kazakhstan, Kyrgyzstan, Uzbekistan, and Ukraine)</td>
<td>1993–1997</td>
<td>To help increase economic efficiency, quality of care, access, and provider choice in the NIS through market-oriented reforms to the health finance and service delivery systems. Implementer: Abt Associates</td>
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<tr>
<td><strong>CENTRAL ASIA</strong></td>
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<tr>
<td>Health Improvement Project for Central Asia</td>
<td>2009–2014</td>
<td>To improve the capacity of the public health systems of Central Asia to better meet the health needs of vulnerable groups. The project’s strategy for achieving this goal is to introduce or institutionalize QI methodologies at all levels of health services management and empower the community to respond to health needs. Implementer: TBD</td>
</tr>
<tr>
<td>Increased Utilization of Quality Health Care in Select Populations/Quality Public Health and Primary Health Care in Central Asia (ZdravPlus II)</td>
<td>2005–2009</td>
<td>To ensure the provision of quality public health and PHC by improving both health systems and services in the five countries of Central Asia. The project efforts include working at the policy level to promote health reform (finance reform and the promotion of evidence-based medicine), as well as building capacity for QI and evidence-based medicine at the facility level. Implementer: Abt Associates</td>
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<td>Project</td>
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<tr>
<td>ZdravReform (Russia, Kazakhstan, Kyrgyzstan, Uzbekistan, and Ukraine)</td>
<td>1993–2000</td>
<td>To collaborate with local leaders to introduce and adapt to the NIS new ways of thinking and operating based on Western market-oriented principles which offered promise for improving the efficiency and effectiveness of the outmoded centrally planned and controlled Soviet-style health care system. Implementer: Abt Associates</td>
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</table>
ATTACHMENT B: ASSESSMENT OF EUROPE AND EURASIA EXPERIENCE IN INTEGRATED PRIMARY HEALTH CARE AND FAMILY MEDICINE

Selected References

General


Albania


Armenia


Azerbaijan

“Azerbaijan Health Systems Performance Assessment 2009.” Health System Reform Project, IDA Credit: No.: 4210-AZ.


Georgia


Moldova


Romania


Russia


Ukraine


CENTRAL ASIA


RFP HE176-09-005. “Health Improvement Project for Central Asia.” April 2009. https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=5b6f46e31d6683549569948ca16f467&cview=1
## ATTACHMENT C: SWOT ANALYSIS TEMPLATE

### IPHC and Family Health: E&E Experience

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<tr>
<th>Criteria Examples</th>
<th>Strengths</th>
<th>Weaknesses</th>
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<td>Capabilities?</td>
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<td>Competitive advantages?</td>
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<td>Processes, systems, IT, communications?</td>
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<td>Effects on core activities, distraction?</td>
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<td>Management cover, sustainability?</td>
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Many listed criteria can apply to other quadrants, and the examples are not exhaustive. You should identify and use any other criteria that are appropriate to this assessment.
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M. Rashad Massoud, Director, USAID Health Care Improvement Project, Senior Vice President, Quality and Performance Institute
David D. Nicholas, Senior Vice President
Carol Shepherd
ANNEX 3. COUNTRY ASSESSMENTS

Information below comes from a variety of sources: country visits, key informant interviews in person or by telephone, and extensive review and analysis of existing literature. Time and resources permitted field visits to only two countries: Albania and Armenia. Concerning the other countries, the project team has analyzed and presented as full an assessment as was feasible, and in those cases, the reader will notice that the analysis is abbreviated.

REPUBLIC OF ALBANIA

Social and Political Commitment at National Level

Although Albania has had a later start (compared to many other countries in the region) with health reform and the development of IPHC/FM, the Ministry of Health, with assistance from the donor community, has made a good effort to get FM and IPHC working in both rural and urban areas. The spirit for health reform is still high among counterparts, which in general appear to be a younger group, many who have had training abroad. The Ministry of Health, despite many false starts and general chaotic implementation of new programs and services, is focusing on getting FM and HSS actually working at the primary care level. The most obvious manifestation of this is the establishment of quasi-autonomous Health Centers or mini-polyclinics in both the rural and urban areas, which have improved levels or autonomy, a capitation-based budget mechanism, and some flexibility in spending and resource utilization. Health center chief doctors are overwhelmingly positive about the increased level of autonomy, the new instruments and equipment, renovations of physician areas, and general increases in funding for primary care activities and services.

On the negative side are the still highly centralized Ministry of Health structures and bureaucracy impeding getting things done. There is little decentralization of responsibilities, and authorities and the general structures are still rigid and not adequately flexible for the operational managers. There is confusion between the roles of the Ministry of Health and the Health Insurance Institute (HII), and overlapping responsibilities and conflict in authorities. Approvals of changes in laws and regulations are slow and cumbersome. While FM has been made a specialty, the new FM curriculum, which has been in existence for many years, has still not been approved as part of the overall medical school curriculum. While progress has been made in the urban areas by combining the polyclinics and hospital organizationally (still not in Tirana), thus allowing more rational utilization of specialists, the chief doctors have had little management education and training on improving human resources and other efficiencies in operations. While progress in urban areas is most apparent, the rural areas have not had as much attention, and are still lacking basic instruments and equipment in many health centers.

National Capability, Sustainability, and Replication

Albania has made excellent progress in developing and implementing a number of key organizational structures, which are necessary for QI in the health sector. The development and implementation of the Institute for CME, which oversees accreditation of Continuing Medical Education programs, as well as administering the licensing and recertification of physicians, dentists, and pharmacists, is a major first step toward QA. The development and implementation of the National Centre of Quality, Safety and Accreditation of Health Institutions, which has developed facility standards for both hospitals and primary care, is another excellent start toward QI.
The separation of the HII from the Ministry of Health and the creation of a single payer system is an excellent development, and although it is still using some outdated budget guidelines, it is moving toward capitation-based and eventually case-based payment. The development of autonomy for the health centers and chief doctors of the HCs is a major step toward the implementation of autonomous or quasi-autonomous institutions with full responsibility and authority for patient care activities within a specified catchment area.

**Human Resources and Management Systems**

Albania was less constrained by the old Soviet norms and capacity-based budget than most other countries in the region. Some of this is no doubt due to the undersupply of physicians and narrow specialists, and the existence of GPs in the old system, which was in direct contradiction to the Semashko model. As GPs are an accepted way of practice, which has been improved by FM training, the model of a general practice doctor is well accepted. The Ministry of Health, with the help of the donor community, has made good strides in retraining GP into FM doctors, but with 1500 GPs, the task has not been completed and large numbers of rural doctors have not received training in FM methods and practices. Large numbers of nurses and midwives have been trained but retraining of these groups has not been a priority and more resources need to go into education and training, and especially improvement in the roles of the nursing professionals.

One major very positive development is the process of written contracts been the HII and the HCs and the resulting written contracts between HCs and their employees. With the help of the new HII, a bonus arrangement of up to 15% of compensation is being implemented to allow bonuses based on performance on key indicators. This is a major step in effective human resources management. However, salaries are still low, especially in more expensive urban areas, which leads to demands for under-the-table payments, which often confuse patients with health insurance, although it appears to be a widely accepted practice. It is unclear whether there are differences in human resource practices in rural versus urban environments, but with the large shortage of physicians, especially specialists in the rural areas, it is felt that the rural areas need even larger amounts of education and training of physicians, nurses, and midwives.

**Cost-Effective and Appropriate Technology**

With the assistance of World Bank funding there have been improvements in facilities, instruments, and equipment throughout the country. However, the urban areas have gotten more and better equipment, and the rural areas still need basic instruments and equipment in some areas. There are still no echocardiogram (ECG) machines in HCs, which should now be a basic piece of medical equipment. Ultrasounds are not readily available. The HCs are becoming small polyclinics, have specialists in obstetrics/gynecology and cardiology, and need improved equipment. As highlighted in the above section, the need for more training and education of physicians of all specialties, and nurses and midwives training, should be a higher priority.

An excellent example of cost-effective technology is the rationalization of the referral system between primary and secondary care. The HII, along with support of the Ministry of Health, has implemented a penalty system for patients who self refer themselves to secondary care specialists without going to primary care physicians first. This practice has significantly increased the demand for health insurance registration booklets and increased the participation in the HII system. Another cost-effective technique is the capitation-based payment system for primary care, which is based on populations of the catchment areas. While this is still being refined, and in many cases is still based on old normatives, it is moving toward more focus on outputs (patient visits) and not inputs (capacity). The system is most effective at the HC level, as the cost of specialists is covered by the capitation rate (many larger HCs have pediatricians and
cardiologists on staff) and the HC-budgeted capitation rate covers the specialist cost as well, resulting in more cost-effective services at the primary care level.

Another example is the development of a performance-based bonus system for employees based on quality performance indicators, whereby an employee can receive a bonus up to 15% of total compensation based on performance. One especially cost-effective practice, which generally is not found in the region, is the organizational integration of the polyclinics and hospitals in the urban areas (not in Tirana due to lack of a secondary hospital), which allows more effective and more efficient assignment of specialists based on need.

Health Systems Integration and Linkages

There is a large variety of health education information in the form of brochures and wall charts (mostly USAID Health Education Program materials, MCH/RH and FP) in the various HCs visited. There does not appear to be strong connectivity between clinical care and health promotion/disease prevention or the use of tools and techniques of a modern Public Health System. However there are a number of PH specialists within the Ministry of Health management system, so it is hoped their education and training is being utilized.

Monitoring and Evaluation

There was much evidence in the HCs visited that various data and information was being collected and reported, as forms, computer input systems, software, and hardware were apparent and functioning. In the large urban HCs visited there were at least two staff, an “economist” and IT/IS person, with large quantities of data forms and other information available. It was not possible to verify if this was utilized for QI or cost-effectiveness, but M&E systems were in place. Most all staff complained about excessive amounts of paperwork and not having enough time for patients. Unfortunately or fortunately, we all live in an information age but getting it efficient as well as effective is most important in developing health care systems that are patient friendly and allow sufficient time for health promotion and education with patients.

Strengths, Weaknesses, Opportunities, and Threats

Strengths
1. There exists a somewhat optimistic atmosphere of “possible reform” throughout the system.
2. Despite some discouragement with the pace and reality, significant corruption, and the difficulties that lie behind and ahead, there is a palpable sense of forward movement, gains achieved (which is indeed realistic), and of system and national cohesiveness. There are quite a few younger professionals among those in positions of responsibility, and the energy level is high.
3. Albania has designed, and is in an early, but active, stage of implementing, a FM model for both rural and urban areas. Such developments (though far from mature, and beset by issues of the low quality of current medical practice) as autonomy for the budget and management of health centers, a capitation model for PHC, concrete moves toward licensing and accreditation, and QI of medical practice using a FM model are highly positive.
4. There is not an oversupply (in fact there is an undersupply) of physicians.
5. The health system, and the individuals within it, is less rigid and more flexible than in other countries of the region. There is significantly less hangover of the Soviet normative encasing.
6. In a few areas (urban), there is an early development of integration and combined management of polyclinic and second tier hospitals.
7. There seems to be, perhaps more than elsewhere in the region, a closer connection between clinical services and Modern Public Health promotion and prevention. A good number of the middle and senior managers of the clinical system have public health training.

8. There is an organized and somewhat well functioning referral system (health center to polyclinic to hospital), with financial incentives and disincentives for avoiding the prescribed stream.

9. There is a flexible attitude and practice, in urban clinics, for either (or in some cases, both) a FM or a primary specialty (internal medicine, pediatrics, gynecology) organization.

10. A single-payer system of capitated payment for PHC is rapidly increasing in terms of the percent of population covered.

**Weaknesses**

1. There is a very significant and critical lack of a Strategic Health Development perspective in the Ministry of Health. Critical skills in finance and health economics, planning, and management are absent or in short supply.

2. The Ministry of Health is overcentralized.

3. There is a lack of effective coordination and mechanism of purpose between the Ministry of Health and the Health Insurance Institute. Relationships are not good; each agency seeks to take on significant functions of the other. HII is overly control-centric; the Ministry of Health lacks the information systems with which to plan and manage key functions. The strengths of each are withheld from the other, and vice versa.

4. The training and education of physicians, most of whom (1500 out of approx. 2000) have or will go straight into health center practice directly from an overly didactic, non-hands-on medical education system that leaves them without the experience of a supervised progression of responsibility for patient care, is of low quality, especially at the rural GP level. There are similar quality issues in the education of nurses, of whom very little clinical skill is expected. An ambitious, but very difficult, approach to upgrading GPs to family physicians via on-site “continuing medical education” is in its very early stages, and about 50–100 FM specialists have been trained via a postgraduate 2-year program, but the ability to take these efforts to scale, with quality results, will be very difficult. There is also a serious question as to what extent the postgraduate family medicine specialty training, and certainly the Continuing Medical Education (CME) program, is actually adequately focused on the kind of practicum and patient care involvement that is so necessary, and is so lacking in undergraduate medical education in Albania.

5. Politically, the Ministry of Health is regarded as not very important, and its direction is usually given to a less-powerful political party.

6. Health center and hospital directors (MDs) have little training in management.

7. There is pervasive corruption in the system, from under-the-table cash payments to physicians to skewing of national priorities.

8. The focus of the HII is control, rather than a management focus. There is a heavy and duplicative burden on physicians for reporting, but the data systems are not used effectively for QA, nor well shared between HII and Ministry of Health.

9. Concepts of a mixed economy in health are not well developed; such privatization as exists (e.g., diagnostic and laboratory systems and pharmacies) is poorly regulated.

10. Patients, though eligible for coverage by a national insurance system, are within a catchment-area system, without opportunity for open enrollment. There is little or no meaningful QA derived from the information management systems in place.
Opportunities

1. There is a very significant opportunity to push forward the Quality of Medical Practice envelope, in family practice. The leadership of the FM faculty at the University is expert, innovative, and forward-looking. Excellent modules for FM continuing education have been developed (with very significant USAID support) and are in early use and constant improvement. All sources report that rural GPs are very positive about the opportunity for self-improvement. The difficulties will lie in the scale and pace, and how to balance full-time FM specialty-training with CME on-site for the GPs. But the opportunity, the leadership, and the early advances exist. There is an opportunity here to make a major leap forward whose effects could be felt across the entire region.

2. A new USAID health program is about to begin. The previous efforts have indeed been effective within the reality limits, and are valued and appreciated by the Albanians. The quality in the delivery system has been improved at the peripheral (health center) and tertiary levels (a visit to the University Pediatric Service at the tertiary Teaching Hospital was extraordinary in its demonstration of patient, nursing, and medical specialty care). Highest-value targets for the next phase of USAID assistance in health may be (a) continuation of support for medical quality education and training enhancement at the health center level, (b) support of quality enhancement at the polyclinic level, and (c) support in the development of a Strategic Health Development Perspective and improved coordination between Ministries of Health and HII.

3. All sources report that the FM Professional Association is a virtually absent player. Support to raise the level of involvement of this group in quality of training and practice efforts is an opportunity to work directly with family practitioners, perhaps through a twinning-type arrangement with a European or North American Academy of FM.

4. Albania’s aspirations for the next stage of accession to membership in the EU may provide a leverage point to raise the awareness of the importance of improvements in the health system.

5. As has been done elsewhere within the region, the World Bank might be encouraged to come in with renovation and equipping of polyclinics and specialty clinics, behind which USAID might strengthen this middle layer of the system with the efforts described in 1 and 2 above.

Threats

1. A failure to continue efforts at quality and system reform, especially in the areas described above, would lead to stagnation and a loss in the significant gains already made. USAID needs to stay the course.

2. The efforts at curriculum change, licensing, and accreditation are not yet solidly functional, and might flounder, or prove not sustainable.

3. Political change of parties, and various kinds of upheaval, are always possible.

4. Corruption at all levels, as elsewhere in the region, is endemic. While all observers of the health system have recognized the importance of this factor, no obvious solutions are apparent.

Lessons Learned

1. FM as a specialty is compatible with further development of the Albanian health system, as the basis for the rural health centers. At the mid-level of the system, there is openness to pluralism: some clinics being staffed with family doctors, some with combinations of primary care specialists (internal medicine, pediatrics, gynecology). This is a healthy approach.

2. General Practice, especially in rural areas, can devolve toward FM. But there is an extensive need for education and training to upgrade quality of practice and effectiveness. How to
achieve scale, and how to strike the balance between CME on-site and more formal full-time postgraduate training, are major dilemmas.

3. The sustained assistance by USAID at the education/training and demonstration/pilot service delivery areas has been a significant, and appreciated, success. But it is still early, and USAID needs to stay the course.

**Best Practices**

1. Even in their embryonic states, the creation of the CME and the Accreditation Institutes are significant advances.

2. The referral system, with incentives and appropriate disincentives for breaking the HC-clinic-hospital chain, is likewise a major achievement.

3. The capitated insurance system with incentives (including some bonuses for practitioners) and disincentives (e.g., significant financial cost for services without being a member of the insurance system) is, with all its early problems, a major success.

4. The few instances of “mergers” (which are mostly in management terms, not physical proximity or provider dual-functions) are a step in the right direction.

5. The presence of FM specialists and other primary care specialists in the same urban polyclinic (including at least one instance in Tirana where the director of the polyclinic was an FM doctor!) demonstrates a certain openness and ability to innovate in the Albanian system.

6. This open, less rigid, more flexible approach, along with a displacement of the Soviet normative-bound system, is perhaps the best of the best practices.

**Recommendations**

1. The Ministry of Health needs to “stay the course” with FM/IPHC health reform and HSS, in both the rural and urban areas, and continue the process of implementing health centers with a high degree of autonomy in operations and management.

2. The Ministry of Health, as well as donors, needs to continue to allot significant funds for education and training of nurses, midwives, and GP/FM physicians in order to improve quality of practice as well as improving patient satisfaction. This should be combined with the process of retraining all GPs as FM physicians. The Ministry of Health needs to push for the full integration of the FM curriculum in the overall medical school curriculum to ensure acceptance of FM methods and practices.

3. The Ministry of Health, with assistance from donors, needs to develop and implement mass media programs to improve the acceptance by the population of FM practice in both rural and urban areas.

4. The Ministry of Health needs to continue the process of decentralization of authority/responsibility for health activities—health management and operations—to ensure effective performance by health managers. This should be combined with improved levels of management training, at all levels, but especially for head doctors of health centers and polyclinics, to make them better managers of resources, especially human resources.

5. The Ministry of Health and the HII need to work more effectively together to define in writing the responsibilities and authorities of each organization, in order to ensure effective implementation of programs and to effectively utilize resources.

6. The Ministry of Health and HII, together, need to develop incentives for improved performance of health workers at all levels to ensure a focus on improving levels of quality and patient satisfaction.

7. The Ministry of Health, with the assistance of the donor community, should continue to strengthen the professional medical associations, especially the Family Practice Association,
to get them more involved in improving CME activities and the quality of practice for family physicians.

8. The Ministry of Health, with assistance from the World Bank, should continue to improve the availability of medical instruments, equipment, and renovations of health centers, especially rural health centers. The Ministry of Health may want to consider development of a new investment program, with the support of the World Bank, to focus on polyclinic development and rationalization, along with hospital rationalization and restructuring. The investment program would work to improve the quality of facilities, equipment, instruments, and services combined with a rationalization/restructuring effort for excess personnel, with the focus of improving productivity, workloads, and income. Excess staff would be retired, reassigned to rural areas needing various specialists, or bought out of existing employment contracts; retained personnel should be assigned given workload and patient requirements as part of a new employment contract process.

REPUBLIC OF ARMENIA

Social and Political Commitment at National Level

After an initial burst of activity and a strong start in IPHC/FM development in the 1997–2002 period, the health reform progress has slowed significantly in the 2005–2010 period. Progress has been much better in the rural areas, but has slowed or stopped in the cities, especially Yerevan. Following the original Armenia Social Transition Program (ASTP [Padco]) project, and with the assistance of World Bank financing, the rural ambulatories and feldsher-midwifery posts (FAPs) were renovated, refurbished, and equipped and large numbers of FM doctors (FDs) and nurses were trained in FM methods and practices. FM became a specialty medical category and the job description of the FD was approved by GoA, the only job description so approved in Armenia.

The progress in the rural areas has been significant and a notable success. With well-equipped facilities, trained FDs and nurses, and with heat, hot water, emergency drug supplies, medical supplies, laboratories, and equipment including otoscopes and other key instruments, patients have returned to the FAPs and rural ambulatories and utilization has increased. The regional Tavush Marz Chief Doctor stated that “FM has been accepted in the rural areas and has changed the mentality of patients and families toward FM (i.e., they go to FD first before going to NS, as well as FM now being a buffer for the polyclinics and hospitals).”

The progress in IPHC/FM in the major cities has been mixed and the situation in Yerevan has had little or no progress. Some cities have tried, with limited success, to merge the polyclinics with the hospitals, thus moving some of the NS into the hospitals. Most polyclinics in the cities have a large surplus of NS doctors, while there is a general shortage in the rural areas. There are some conflicts between FM and the NS as well as some competition between the FDs and the gynecologists. There is pressure for the FDs to refer patients to the NSs as income is based on number of patients seen as well as the potential for informal payments. Most FDs in the city polyclinics are working as pediatricians or therapists (internal medicine specialists) and not as FM. The problem between FM and the NS is a complex one and involves competition for patients and referrals (and thus income—usually informal payments), some lack of respect for FM skills in the broader diagnosis and treatment areas, and some professional jealousy about the attention FM has received with new equipment, training, and renovated facilities.

There appears to be pervasive corruption at every level. Interviews with personnel in the Ministry of Health, NIH, State Health Agency (SHA), World Bank, and WHO all mention that informal payments are at least half of the money spent on health care in Armenia. It is said that
most personnel (especially in hospitals) receive a large majority of their monthly income from informal payments. At the primary care level informal payments appear to be less.

While there were many “champions” of IPHC/FM in the early period of reform (1997–2002) there appears to be no available “champion” in the new environment to push, pull, market, praise, and change the attitudes of the population and the medical community toward FM. The Ministry of Health does not appear to be fully engaged any longer in the health reform process, seems to lack a strategic focus toward ongoing reform, and appears to have let the donor community do the strategic thinking for the country. The existing “status quo” with modest reform has become much too comfortable.

National Capability, Sustainability, and Replication

Armenia has made good progress in the “rural” IPHC/FM development with WB assistance in the implementation and improvement in various physical conditions and equipment and USAID providing the necessary technical assistance (TA). FM doctors and nurses have been training in QA and QI and data collection and reporting systems, the Health Management Information System (HMIS), mainly through a number of USAID projects (ASTP and Primary Health Care Reform Project [PHCR]; the Nova Project has also helped to train Community Health Nurses in MCH/RH/FP, etc.). Some of the city FDs and FM nurses have had some QA training, but most city FDs are not working in FM, so the exposure has been limited, and with the “practice conflict” between the FDs and the NSs, the development of a quality culture has not occurred. The primary care NSs have had little or no training in QA and QI tools and techniques.

There are problems in the quality of medical care education and training (especially postgraduate training), the quality of medical care delivery, the quality of management and administration, and while QA (5 tools and 10 performance indicators) is discussed and there have been training and data systems to collect and report information on quality (HMIS), there is an absence of any deeply embedded culture of quality which is the basis of modern medical education and practice.

Human Resources and Management Systems

The system under the FSU was a “normative” and “specialty-oriented” health system, with the majority of resources in the secondary and tertiary care levels. By any international standards, the staffing ratios were high, the productivity low, patient utilization low, and salaries low (especially for primary care physicians). Considering where they started (Soviet system norms), the Armenian health system has made some progress, especially in primary care. There have been positive changes in such areas as clinical and management training and partial success with data systems implementation, catchment area “open enrollment” and choice of primary care doctor, MCH and reproductive health training, etc. Significant numbers of physicians have been trained (or retrained) in FM, though the larger percentage of these are not working as family doctors (FDs), especially in the urban areas. There is oversupply of physicians and nurses especially in the cities (Yerevan by far the worst), geographic misdistribution (shortage in rural areas with surpluses in cities), and generally low workloads and poor productivity. Regarding much of the health system, there is a “Potemkin Village” character with large differences between what is claimed and what is actually present and functioning effectively. In FM there are low salaries and low morale, as many FDs cannot practice FM in their daily practice activities, and opportunities for informal payments are less. Management styles (polyclinic head doctors) are basically authoritarian and hierarchical, with little premium placed on innovation, decentralization, worker involvement, and other modern management methods and techniques.

Cost-Effective and Appropriate Technology

Many, but not all, rural IPHC/FM outpatient ambulatories and FAPs have been renovated and equipped countrywide, and FDs and nurses, as well as community health nurses, have been
trained and retrained on various quality and cost-effective methods and techniques. However, this is not the case in the polyclinics as most polyclinic physicians and NSs have not been trained or retrained and have had little or no funds for renovations, instruments, or equipment. The city polyclinics, especially in Yerevan, have been left out of the reform. National Health Accounts have been implemented to allow accurate capture of health funds at the different health system levels, but it is unclear if they are being used effectively to allocate funding to primary care.

While some QA programs have been piloted, and Performance-Based Reimbursement (P4P) is scheduled to be introduced into the system in the near future, little has been done to improve QA and QI processes. It has been reported (see 2008 WHO report) that multiple and disparate data systems for QA and monitoring have been introduced into the overall system with little coordination or standardization. Community health nurses have had training in MCH/RH/FP, but the sustainability of this training and improvement is seriously questioned by the Nova Project Director. There is a problem regarding inadequate training and permitted span of practice of FM doctors. While there is frequent reference made to “evidence-based medicine” (EBM), there is no indication of its introduction on any wide scale. There is inadequate evidence of the practice of health promotion and disease prevention methods and other modern public health practices within the Ministry of Health.

Health Systems Integration and Linkages

While there is a large variety of health education information in the form of brochures and wall charts (mostly USAID Health Education Program materials) in the rural ambulatories, there was little evidence of this in the city polyclinics. There appears to be very poor connectivity between clinical care and health promotion/disease prevention tools and techniques of a modern public health system. There was some evidence that various USAID projects (PHCR and Nova) were working together. There was little evidence of other health projects or programs working at the FM level. While it appears that the organizational foundation for a good referral system is available, it is currently distorted and dysfunctional. There is little “gatekeeping” at the primary care level (except possibly in rural areas), and FDs are pressured for making referrals to the NSs, especially those in the urban polyclinics. This is evident in Yerevan, as FDs are generally not permitted to utilize FM methods and practices (clearly evident in Polyclinic #17), and FDs must work as a pediatricians or therapists (internists) rather than FDs. The result is unnecessary referrals and higher utilization of the NSs and polyclinic services (e.g., lab, radiology), resulting in more informal payments and higher cost to the health system.

Monitoring and Evaluation

There was evidence in the rural ambulatories that significant amounts of data and information were being collected and reported, as forms, computer input systems, software, and hardware were apparent and functioning in all facilities observed. In the city polyclinics, including Yerevan, there was little evidence of data systems and collections, but the FM head doctor (Polyclinic #17) said she needed a computer for various practice issues including data reporting, immunization records, and various other functions. While the information systems were apparent, they were focused on data collection, but it is uncertain if these were used in decision-making or feedback to the local level in order to improve performance.

Strengths, Weaknesses, Opportunities, and Threats

Almost 15 years of TA in support of the Armenia's Health System, with an emphasis on the development of primary health care, FM, and Health Services Strengthening, have led to significant advances and “strengths,” both structural and functional, within the system. However, many of these strengths are more apparent than secure, and there are also inherent “weaknesses” in major aspects of the system, most of them stemming from inherited inflexible and compartmentalized structures. But weaknesses offer opportunities, as do strengths, and all
these factors create new threats to the system, both internal and external to health care per se. Armenia’s position on the Health System Reform scale is best thought of as very much a work-in-process.

**Strengths**

1. The creation and countrywide implementation of a rural system of FM, based on renovated and equipped facilities that are quasi-independently budgeted, connected, and accessible to a defined catchment area and its population, with service fees capitated, is a major achievement. It provides a solid base, despite its significant problems with quality and efficiency, for further development.

2. Likewise, the establishment of a recognized and officially authorized specialty of FM, with a nascent education and training system for this specialty, and staffing the rural facilities with these physicians, must be regarded as another major accomplishment.

3. At the national level, the development and early implementation of Health Systems Strengthening components has shown some successes, such as a movement toward open enrollment for competition, capitation (though marred by under-the-table cash payments considered by the population and providers alike as the norm), QA data systems (however partial and accurate), and early notions of using QA for appropriate monitoring, evaluation, and provider incentives.

4. Likewise, moving toward health care financing in a mixed public/private payment system, with capitation for primary care (but with some fee for service) and case-based hospital payments, can become a powerful force for system reform, especially if combined with effective QA.

5. A mixed public/private system could lead, again if linked with appropriate QA, to the benefits of true competition between, and incentivization of, providers.

**Weaknesses**

1. Pervasive corruption at all levels of the system, top to bottom, is perhaps the single most important barrier to further health system reform.

2. There is a lack of “strategic perspective” within the Ministry of Health that makes both adequate policy/planning and sustainable efforts over time problematic or appear half-hearted and less than comprehensive.

3. Health reform efforts to date have had their greatest visibility, and most obvious tangible rewards, in bricks, mortar, refurbishment, instruments, and equipment, especially in the rural areas. This has exacerbated tensions between FM and the NSs located in urban polyclinics, especially in Yerevan. It may be time to focus more attention on reform and the rationalization and restructuring of the polyclinic.

4. Second only to corruption within the system, overproduction and oversupply of physicians and nurses, and misdistribution of them, is a critical weakness. In urban areas, Armenia has about three times the ratio of physicians to population as does Western Europe; in rural areas, it has only half as many. When combined with a very inefficient workload, and a high ratio of physicians to patient utilization, this is the second most detrimental factor in the health services economy.

5. There is widespread and deep conflict between FM and primary care specialists*/NSs. Much of this is due to the relationship between referrals and cash payments, but there is also a deeper antipathy, based on questions of professional status. A corollary of this is that FM physicians are constrained from performing many of the functions that would optimize their effectiveness in the system (*pediatricians and general internists).

6. Education and training (especially postgraduate training of physicians) is generally of poor quality and relevance. Hands-on clinical training with progressive increase over time in
supervised responsibility for patient care is notably lacking in the system. This has obvious detrimental effects upon the quality of later practice.

7. Though there has been some small increase in recent years, a very low percent of GDP (estimated at 1.5%) is spent (officially) on health. Estimates are that at least an equal amount, and possibly several times that amount, is spent on “cash under the table,” other informal payments, and wasteful expenditures (e.g., oversupply of doctors with low productivity and low patient loads).

8. There is a virtual absence of health promotion and prevention within the clinical system. The Ministry of Health has neither the organization, the personnel, nor the programs to carry out modern public health.

9. There is neither effective licensing nor accreditation, nor is there a continuing education system for providers, health care facilities, or health professional education institutions.

Opportunities

1. Engaging the Ministry of Health in a permanent process of strategic development would build on the advances already achieved, place them in a more sustainable context, and allow building upon them for greater gains and for diminishing system weaknesses in the future.

2. An investment in urban polyclinics, similar to that which was done with the rural ambulatories, if combined with support for QI in education, training, practice, and decreased inefficiency, could “cement” the system together from primary to tertiary levels. In a sense, the polyclinic is the glue that holds both ends of the system together, and if major advances could be made at the polyclinic level, the entire system would benefit. Any investment in the polyclinics should be tied to staff reductions and productivity improvements, especially with regard to NSs.

3. Perhaps developing and supporting key professional associations, most notably the Association of Family Practice, may be a key to the improvement of both quality standards of practice, continuing education, and the morale of FM practitioners. One way to consider going about this might be developing a “twinning” relationship (such as in the former American International Health Alliance [AIHA] project) between the Armenian FP Association and the American Academy of Family Practice.

4. Is it possible to deal directly with the oversupply of physicians and nurses? There are schemes in other countries and industries that have been devised in similar situations for the progressive buyout of near-retirement, less-active, less-productive, and then less-quality-performing providers.

Threats

1. Pervasive, entrenched graft and corruption at all levels of the system has been described in every analysis of the Armenian health system. Its persistence is the most significant threat to continued HSS.

2. While perhaps of much lower probability, the possibility of political upheaval or stress in the region or country must be considered a potential threat.

3. An acceleration of the current population decline (through falling birth rate or out-migration) would exacerbate the provider oversupply problem.

4. Any significant increase in the current pattern of post-industrial morbidity and mortality pattern (chronic disease, environmentally mediated illness, trauma), which this system is particularly ill equipped to deal with, would worsen quality, productivity, and effectiveness.

5. Failure to continue reform and globalize the system, rather than reinvigorating the process, would bring this system near functional collapse. There is no turning back.
Summary
The critical “drivers” which must be addressed in order to maintain and enhance the progress that has been made are:

1. Stay the course of health reform.
2. Reduce and redistribute the oversupply of health care providers.
3. Reduce corruption through health finance improvements.
4. Improve substantive quality of provider education, training, and practice.

Lessons Learned
1. FM was developed as a medical specialty within the Armenian health system, and was recognized by the government and the medical profession as an important addition to the medical specialties in Armenia.
2. FM was implemented in both rural and urban areas, but experience has shown that FM works best within the ambulatory facility in the rural areas of Armenia.
3. The competition for patients between the various NSs and primary care doctors (including FM) is particularly severe in the urban polyclinic, especially in Yerevan.
4. The development and implementation of a National Health Account (NHA) system over the past few years has been successful in identifying the proportion of the public sector funding going into primary care.
5. Informal cash payments (“under-the-table”) for health services create major distortions in any attempts to achieve rational financing of the health sector. Patients and family want to know “upfront” what health services will cost rather than being asked repeatedly for unknown amounts of informal payments as they move along the referral and treatment process.
6. Improved quality of care, and an increased approved scope of practice, via relevant training and education, is an important need for the success of FM.

Best Practices
1. The reported practice of rural FM Doctors making regular (monthly) visits to surrounding villages for health promotion and disease prevention, particularly in MCH services, has been identified as a best practice in Armenia.
2. The setting up and operation of a teaching and patient care FM clinic, within an urban polyclinic (Polyclinic #17, Yerevan), where patient care and teaching occur simultaneously, has been identified as a best practice in Armenia.
3. The establishment of the Independent Family Medicine Ambulatory in rural areas, particularly with two physicians with high levels of autonomy, has been identified as a best practice in Armenia.
4. The concept of patient choice of physician and “open enrollment” as a force for improved quality of care and improved competition between physicians has been identified as a best practice in Armenia.

Recommendations
1. The Ministry of Health needs a new vision for health reform in Armenia. This should be done as part of a strategic planning process, which would develop the key ingredients required, including the need for improved governance, stewardship, and ownership by the Ministry of Health of the goals, objectives, strategies, and action plans as outputs of the process; donors need to give preconditions to the Ministry of Health for supporting new
programs and projects based on implementation of various policy frameworks and new vision requirements.

2. The Ministry of Health should develop and implement an Institute of QI within the Ministry of Health which would focus on various aspects of QI development in all sectors of the health system. The new Institute should begin to focus on “accreditation” of facilities and services, both in the public and private sectors, as well as EBM tools and techniques.

3. The local NGO/PVO professional organizations (e.g., Associations of FM) should begin the process of being responsible for the quality of medical practitioners through a combined effort with the Ministry of Health to developed improved licensing standards, CME requirements, and related professional development activities.

4. Assistance to rejuvenate and support the existing academic program to provide postgraduate medical education for the new specialty of FM should be a priority for ongoing USAID assistance.

5. In order to improve FM and IPHC in the urban polyclinics, a new investment program, with the support of the World Bank, should be developed to focus on Polyclinic Development and Rationalization. The investment program would work to improve the quality of facilities, equipment, instruments, and services combined with a rationalization/restructuring effort for excess personnel, with the focus on improving productivity, workloads, and income. Excess staff would be retired, reassigned to rural areas needing various specialists, or bought out of existing employment contracts; retained personnel should be assigned given workload and patient requirements as part of a new employment contract process.

6. A new public health function, separate from the existing SES, should be developed that would focus as a modern Public Health Department using modern PH tools and techniques.

REPUBLIC OF AZERBAIJAN

Social and Political Commitment at National Level

Like many other countries in the E&E region, “Azerbaijan inherited an extensive and highly centralized Semashko system at independence”67 with an “extensive network of health facilities both in hospital and ambulatory care.”68 After gaining independence in 1991, however, Azerbaijan did not immediately reform the health sector and subsequently, “because of the war with Armenia in the mid-1990s…coupled with social and economic transition, reforms were [further] delayed.”69

Currently, noncommunicable diseases, such as cardiovascular diseases, “cancers, and other ‘lifestyle’ diseases[,] are the leading causes of morbidity and mortality”70 in Azerbaijan, although “the prevention of communicable diseases, particularly tuberculosis (TB), remains a significant health issue.”71 Infant and maternal mortality are also high.

In recent years, political pressure “to reform the fundamentals of the health system [has been] growing in Azerbaijan.”72 The Government of Azerbaijan has stated that it is committed to improving “primary care” 73 and, in 2008, the Government’s commitment to reform was reaffirmed with the approval of a “Health Financing Concept for a single payer and new provider payment mechanisms.” 74

However, the political environment in Azerbaijan “does not favor changes if they could be accompanied by significant social tension.”75 Furthermore, the opportunity for care in other systems (such as from private providers) and the significant financial resources “potentially available for the health sector”76 may have reduced the sense of urgency for change. This combination of risk-avoidance in the political environment and a lack of urgency have made
reform slow, especially drastic reform (such as to health care finance systems), and instead change “is sought over the longer term.”

Although the government publicly states that FM is the future direction for PHC, to be implemented first in rural areas, the pace of introduction is slower than desired. Most efforts to introduced FM have been limited to pilot projects, such as those conducted “in several rural districts targeted by the World Bank-supported Health Sector Reform Project” with plans to someday roll these out to the entire country if successful.

Financial resources are not a barrier to health care reform in Azerbaijan, a country that “has considerable mineral wealth, including oil and gas reserves.” Despite this wealth, however, public health expenditures (0.9% of GDP) were the lowest in the E&E region in 2008. Out-of-pocket expenditure that year was approximately 73% of total health expenditures, “a level that imposes huge and sometimes catastrophic burdens on the population.”

Azerbaijan receives significant support from international development partners, and since independence has received loans of more than $55 million from the World Bank for health reform and for the strengthening of health care system functions, such as stewardship, health financing, service delivery, and human resource development. USAID has funded projects to improve family planning services and “to assist the government in implementing health financing reform, developing solid health policies, improving the quality of services and strengthening Ministry of Health capacity in health communication.” This support has been complemented by a range of financial and/or technical contributions from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Global Fund), GAVI, and several United Nations agencies (WHO, UNICEF, UNDP, UNFPA) and others. “Including the new World Bank-assisted project that began in 2006, total international assistance in health could be estimated at US$ 20 million annually, which would represent approximately 2% of total health expenditure in the country.”

In general, this support has had mixed results. For example, although USAID-funded pilot projects to improve primary health care during the late 1990s and early 2000s “failed to achieve sustainable or systemic changes, they stimulated a national policy dialogue about the future directions of health reforms and led to an improved understanding and acceptance by the government of a need for serious reforms in the health sector.”

From 2005–2010, USAID has conducted a “Primary Health Care Strengthening” (PHCS) project in Azerbaijan, implemented by Abt Associates, Inc. “The PHCS project provides technical assistance to the Ministry of Health on primary healthcare reforms. It focuses on increasing healthcare financing and improving resource allocation for primary health care, redefining and restructuring primary health care community-based services, improving the quality of primary healthcare services, and promoting personal responsibility on the part of individuals and families for their own health care.” This project, among other things, contributed to approval of the National Health Financing Concept 2008-2012 mentioned above. USAID support complemented contributions from the World Bank and others to develop a new concept for health reforms in 2006 (and revised in 2008), which is a valuable step forward even though the systemwide Health Care Reform Concept has not been formally approved.

Historically, “lack of commitment from the Ministry of Health to replace the existing fragmented system of primary health care….with an integrated model based on FM/general practice…was another reason why the reform of primary health care services did not take root.” Although recent developments appear to indicate greater commitment, and some progress made toward reform, it remains to be seen if progress will continue and if new systems will be sustained after international support ends.
National Capability, Sustainability, and Replication

Many of the key features of the health care system that Azerbaijan inherited on independence remain. “The formal structure of the health system is highly centralized and hierarchical and most decisions about key health policy initiatives are made at the national level.” However, although official health planning in Azerbaijan is undertaken by the Ministry of Health and Ministry of Finance, and the Ministry of Health is ultimately responsible for management of the health care system, “it has limited means to influence health care providers at the local level as they are financially dependent on the local district health authorities or the village authorities for smaller rural services.”

Furthermore, a growing number of health services provided in Azerbaijan fall outside the sphere of its responsibility, namely providers that “are subordinated to and financed through other line ministries or state enterprises.” Although the private sector is licensed by the Ministry of Health, it is “otherwise completely independent” and service provision through the private sector is increasing. “There is licensing for health facilities in the private sector, but no licensing or accreditation for facilities in the state sector regardless of whether they are under the control of the Ministry of Health or parallel state structures.”

Even where the Ministry of Health has influence over PHC planning (such as in the preparation of a National Master Plan for health facilities), this planning is fragmented and does not always translate into action. Although plans may be approved by the Ministry of Health, for example, they rely on District Health Authorities (each of which is “responsible for planning and delivery of health services in their districts”) to implement those plans. The Ministry of Health has little recourse if plans are not followed.

Human Resources and Management Systems

Like many countries in E&E that offer low wages for medical staff, the number of doctors and nurses in the public health care system per capita has fallen since independence, although this decrease has slowed in the past decade. “The Ministry of Health has found it difficult to obtain the right mix of medical specialties in the state sector and an adequate geographical distribution of staff.” It is unclear the extent to which this decrease has reduced the overall national capacity for health care, as there is no national register of physicians in Azerbaijan, and it is likely that many continue to operate in the private sector: individual practitioners are not formally licensed in Azerbaijan.

The government of Azerbaijan has done comparatively little to develop systems that can replace departing medical staff with new staff with improved training. Investment in health care in Azerbaijan has been focused on physical infrastructure development projects, such as construction of hospitals and diagnostic facilities, and procurement of high-technology systems. Such short-term, highly visible capital has been more attractive “during the time of economic boom than engaging in more long-term investments, for example in improving the knowledge and skills of medical staff.”

Although there are plans to increase the level of budget allocations to the health sector, the health system needs to improve its capacity to use the money effectively. The national education system is not equipped to quickly provide this capacity. “The Azerbaijan Medical University is the only provider of undergraduate medical education in the country. Several unlicensed private medical schools used to function in the late 1990s and early 2000s but they were all closed by the Ministry of Education by 2005.” One of the private universities provides a master’s degree program in public health.

Doctors required six years of undergraduate training. In addition, all physicians undergo a one-year practical internship under the supervision of senior physicians. However, there is vicious
cycle in the structure of this education: because the health care system “for adults and children in Azerbaijan is still divided, providers for each system are trained separately in treatment–prevention and pediatrics departments, respectively.”94 This makes it much more difficult to introduce an IPHC/FM model in Azerbaijan, which in turn makes it difficult to reform the educational system.

In recent years, the Ministry of Health and other stakeholders in Azerbaijan, with support from donors such as USAID, have invested in building the capacity of management and clinical staff in the country. The Azerbaijan Physicians’ Advancement Institute provides education for physicians, “who are required to attend refresher training courses in their respective areas of medicine every five years.”95 Other training sessions for physicians and nurses have been piloted, curricula for FM training have been developed, “and the first master-trainers for the retraining of primary care physicians”96 has been carried out. However, training programs have not been institutionalized and “failed to become part of the national system for postgraduate education of health personnel.”97

In reality, “improving the quality of care remains the most pressing problem [in Azerbaijan] to address and reflects the fact that until (July 2009) insufficient attention had been paid to improving the system of pre- and post-diploma education and to human resource planning.”98 There is also a need to invest in staff that can utilize the new public infrastructure (such as high-technology equipment) effectively, perhaps by building on the experience of the private sector.

Cost-Effective and Appropriate Technology

As described above, there has been a significant investment in infrastructure in Azerbaijan, using both government funds as well as funds from the World Bank and other development partners. “Revenues from the recent oil boom have been used to fund large capital investment projects such as the building of new hospitals with the latest technology and the import of modern equipment.”99 The hospital system clearly remains the priority, while the primary care network receives “little attention and fewer resources.”100

There is no health technology assessment agency operating in Azerbaijan and evaluations of technology performance “do not feed into the policy-making process.”101 As such, the selection and procurement of technology is ad hoc, and does not follow any national rationale or planning process.

Health Systems Integration and Linkages

There is “a lack of an effective gatekeeping function at the primary care level” and “a subsequent unlimited access to any specialist or secondary/tertiary care facility.”102 “There is no formal system for patient pathways in Azerbaijan. Weak gatekeeping at the primary care level means that any patient can start from any level of care (primary, secondary, or tertiary) depending on their place of residence, personal connections, and ability to pay…As there is no gatekeeping function and a disrupted referral system, patients can bypass primary care and go directly to the upper levels of care.”103

Monitoring and Evaluation

One area where progress has been made in Azerbaijan has been the development of national clinical protocols based on clinical efficacy and cost–effectiveness. This progress was significantly buoyed by the USAID PHCS project, which assisted the Ministry of Health “to institutionalize the concept of evidence-based medicine; establish a national process for approving clinical practice guidelines and protocols; and train more than 3200 PHC providers on approved guidelines.”104
However, because of the “split between the funding of services by local government and their regulation by the Ministry of Health at the district level has serious implications for the flow of information on the activities of providers at the local level. The Ministry of Health does not receive timely information with sufficient detail from the local level as reporting systems need improvement and are not yet computerized. Despite efforts to improve information systems, there is no single information system in place for the collection, reporting and analysis of data on activity, services and quality. Fragmentation in the system means that potentially useful information from different parts of the system is not shared and there is a reluctance to report adverse results lest individual staff incur penalties. The reliability of health data acts as a further constraint on the Ministry of Health’s ability to monitor health care quality and population health.”

This lack of information is further hampered by payment systems in Azerbaijan. “The payment of providers according to line-item budgets does not motivate them to collect and analyze data for better planning; providers do not see how they could benefit from improvements in the health information system.” Furthermore, much information is missing “as a result of the weak enforcement of reporting procedures for private and parallel health care providers not under the Ministry of Health. The rapid expansion of the private sector and strength of parallel state service providers means that this is not an insignificant part of the overall health system.”

**Strengths, Weaknesses, Opportunities, and Threats**

**Strengths**

1. The establishing of the PHRC with its Department of Health Communication and Public Relations (DHCPR) in 2007 helped the Ministry of Health to ensure better oversight and coordination of health promotional activities carried out by a number of governmental and nongovernmental agencies. This department is closely supported by international organizations, strengthening its capacity through training, exchange visits, and technical assistance in the development of a national health communication strategy.

2. Successes thus far have been confined to specific areas, such as the establishment and institutionalization of evidence-based medicine in the development of national clinical guidelines, the development of family medicine as a specialty, the strengthening of pharmaceutical regulation and the development of a formulary system for rational drug use.

3. In 2008, the Concept on Health Financing and Introduction of Mandatory Health Insurance was drafted by the Ministry of Health and approved by the President. In 2009, the Cabinet of Ministers approved the Action Plan to Introduce Health Financing Reforms.

**Weaknesses**

1. There are 11 specialized research institutes. However, there are no formal mechanisms for integrating the findings of their research into policy-making or health technology assessment.

2. The planning efforts of the Ministry of Health are not always effective in ensuring a balanced mix of medical specialties or their rational geographic distribution throughout the country. First, the Ministry of Health loosened its planning functions during the 1990s, which resulted in an oversupply in certain specialties such as obstetrics-gynecology and surgery. Second, the ministry ceased having a mandatory three-year assignment for medical graduates to work in rural areas, which existed during Soviet times. Finally, the flourishing private sector in Baku attracted many experienced health care professionals, thus draining the public sector. The Ministry of Health is trying to address this problem through the stricter control of specialization by new doctors and restoring a system of mandatory rural assignments for graduates. However, such measures are unlikely to succeed unless supported by substantial economic or other stimuli for young physicians.
3. There are major disincentives to increasing the efficiency of the health sector in the current health financing and service delivery system. Insufficient data and analysis of technical efficiency in the system also limit the development of planning for efficient resource allocation.

4. Despite significant increases in public health expenditure in recent years, Azerbaijan is still characterized by relatively low levels of public health expenditure both in absolute terms and as a share of GDP.

5. The burden of financing health care is on the health care users, with out-of-pocket expenditure reaching almost 62% of total health spending in 2007 (World Health Organization, 2009).

6. The payment mechanisms for the state-owned providers are based on inputs (beds, staffing), which does not foster the efficient use of resources. Moreover, the government, through the treasury system, controls how the money is spent within the health facilities by applying strict limitations for spending along budget line-items, which leaves health providers with little managerial and financial autonomy.

7. Azerbaijan inherited an extensive network of health facilities both in the hospital and the ambulatory sector, and the excess capacity has been retained. However, Azerbaijan also has a very low admission rate, which may indicate access problems.

8. Recruitment and retention of medical staff in rural areas are long-standing issues, and the flourishing private sector in Baku has also attracted many experienced health care professionals, thus draining the public sector.

9. The country’s political environment, with an emphasis on social stability and political harmony, and the absence of strong opposition were also not favorable for radical changes.

10. Household surveys indicate that health services utilization among low-income groups was lower than among richer households, suggesting that the utilization of health services is related to socioeconomic status more than need.

11. The current allocation of resources for health care favors the hospital sector over primary care. International evidence suggests that this is not the most efficient allocation of resources. Similarly, the reliance on high-cost diagnostics as standard and the weak gatekeeping function of primary care providers would indicate, on the basis of international experience, that the current system does not provide good value for money.

12. TB services are provided through a vertical system of specialized facilities with little integration into primary care.

Opportunities

1. In order to address the broader issues of data collection and data quality within the information system as a whole, the Ministry of Health has been actively developing its Integrated Health Information System Concept. With the introduction of new provider payment mechanisms, this has the potential to radically improve the health information system.

2. The Ministry of Health and the Ministry of Finance have agreed on new health financing reforms that will centralize funds and make room for greater provider autonomy and the introduction of contracting as the basis for new payment mechanisms, such as per capita payments in primary care and case-based payments for hospitals. These reforms will underpin the proposed introduction of mandatory health insurance.
Threats
1. The basic benefits package guaranteed by the state is being discussed and is not due to be in place until 2012. Most services and pharmaceuticals are paid for out of pocket at the point of access. The high level of out of pocket payments relative to prepaid government funds (2:1 in 2007) indicates that health revenue collection remains predominantly regressive.
2. The lack of risk pooling in direct private payments means that many households are under threat of catastrophic health care costs in the face of serious illness.

GEORGIA

“Georgia has undergone a profound demographic transformation since independence. According to official figures, the population has shrunk by nearly a fifth to 4.4 million. Civil war, rapid marketization and hyperinflation following independence left Georgia in a state of economic collapse, but from 1994 the economic situation improved rapidly. Nevertheless, a large proportion of the population... is still living in poverty. While data must be interpreted with considerable caution, overall health status in Georgia following independence fell and only began to recover at the beginning of the 21st century. While still high in international comparison, maternal and infant mortality rates have been falling as socioeconomic conditions in the country improve. However, infectious diseases... are very significant public health problems.”

“The central budget is the only source of official funding [for health care] in almost all of the former Soviet Union countries (except Georgia). A radical process of devolution took place in the late 1990s in Georgia as responsibility for major public health functions was shifted to local municipalities, with central oversight.” A share of the private health insurance as an official source of health care funding, though still relatively small, has significantly grown in Georgia during recent years.

“Primary health care (PHC) service providers are differently configured in each region... As a result there is a variety of PHC service providers across the country. Family medicine was introduced as a specialty in 1997 and many of the PHC services are staffed by general practitioners offering a broader range of services, but some are staffed by generalist physicians, general pediatricians and NSs. Primary care doctors only act as gatekeepers for patients covered under relevant private health insurance schemes, because patients mostly pay out of pocket for services and are free to self-refer to inpatient services. For many patients, this is the preferred option, as the quality of PHC services is still perceived to be low.”

In 2002, the World Bank provided a loan to the Government of Georgia for a development project to “to improve the coverage and utilization of quality primary health care (PHC) based on the model of family medicine/general practice, with an emphasis on reaching the poor and disadvantaged. In the long run, strengthening PHC services is expected to have a beneficial impact on the health status of the Georgian population through prevention, early detection and the treatment of diseases responsible for a high burden of disease in the population (e.g., cardiovascular diseases, tuberculosis, and acute respiratory infections). Implementation of PHC is also expected to have a positive impact on the quality, cost-effectiveness and efficiency of health service delivery in Georgia.”

“In October 2003, DFID launched the Primary Health Care (PHC) Project II, which ended in 2008, that built on the previous DFID project supporting reforms in the health sector. DFID project covered the majority of TA requirements identified by the Government of Georgia and within the World Bank project providing long term assistance to the Ministry of Health. WB, EC, DFID, USAID, WHO, UNFPA and Ministry of Labor, Health and Social Affairs are willing to sign a Memorandum of Understanding in order to harmonize activities in support of the PHC reform. The DFID project had three main areas of work: 1) Effective implementation of the
new PHC model; 2) Building capacity in key ministry departments and associate structures; 3) Support to health and social policy development.”

“The main principles of health care reform since 2006 were to make the transition towards complete marketization of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. The basis for these decisions was rooted in the country’s economic policy, which was to ensure economic growth based on liberalization and private sector development. Mandatory social health insurance, which was introduced in the 1990s, was abolished and private health insurance has been promoted as its replacement.”

“The most recent marketization reforms in the Georgian health system have bold objectives, have achieved some successes and should only be measured in the fullness of time. Nevertheless, experience shows that any bold privatization of service purchasing has many associated risks. First, international experience shows that the administrative costs of private insurance largely exceed the costs when public expenditures are administered by a public purchaser, and these administrative costs have risen significantly since the scheme was introduced in Georgia. Second, the regulation, reporting and accountability instruments to supervise the private insurance function in the framework of the state health programs remain weak. This is a very complex reform package that is difficult to understand, has many different actors and relies heavily on relatively small private insurers to purchase health services and inexperienced state agencies to regulate the purchasing process. The strategy has raised serious concerns about the equity and sustainability of the health system, as well as issues relating to quality and efficiency.”

There is also apparently a lack of awareness among beneficiaries as to their entitlement, which can lead to underutilization of services.

“[In 2010,] Georgia’s health and social services sectors are struggling to overcome the ill-effects of low government spending in these areas since independence in 1991. Health facilities have not been well maintained and maternal and child mortality rates are high. Despite this, Georgia has managed to keep its life expectancy rate stable and keep vaccine preventable diseases in check. In the years following the Rose Revolution, the government has undertaken major reforms of its social sectors. A top priority of USAID’s assistance is to support these reforms while addressing the priority areas of reproductive, maternal and child health and control of infectious diseases such as tuberculosis, and HIV.”

USAID provided more than $1 billion in humanitarian/development aid to Georgia, beginning in 1992. USAID/Georgia has, in addition to health, a large economic growth portfolio and education portfolio.

The government of Georgia has become privatization-minded, moving this direction for past 4–5 years. Government hospitals are in the process of privatization, with very few exceptions. There are plans to further privatize by, for example, selling the current government health centers to the physicians who work in them.

The Government of Georgia has been focusing on the most disadvantaged groups, by identifying which households are poor; those who qualify receive comprehensive health insurance coverage. More than one million people have their care paid by government. There are also private insurance companies, who pay providers directly. Since 2005, about 70% of total health spending was made out-of-pocket, the highest percentage in the former Eastern Bloc.

The previous system of coverage was not universal; what was on paper was limited in practice and not fully implemented.

Like many other former USSR countries, Georgia inherited an extensive/very centralized system. There was an oversupply of health care infrastructure and an excess capacity of facilities
and manpower. Because of resource constraints in the early years after independence, there was significant contraction of the system.

Early reforms focused on building a nationwide PHC network. This did not meet expectations, with weak government leadership and inadequate donor coordination. In 2006, after the Rose Revolution, a new strategy was adopted, which relied upon market mechanisms to improve access, upgrade infrastructure, improve quality of services, and increase efficiency.

Now the country is facing many challenges/difficulties with PHC. Most health care is provided by the private sector. Hospital infrastructure has been sold to private investors (except some hospitals in Tbilisi), who are supposed to refurbish and operate them. Economic crisis is straining this. There is a plan to transfer ownership of PHC clinics to medical staff.

Mandatory Social Health Insurance was introduced in 1990s, but now is being replaced by private health insurance as the mechanism for pre-payment of health services. Private insurance for people living below poverty line is paid by the government; everyone else is expected to purchase coverage on their own. Out-of-pocket payments are still high, as is reduced access to services, especially the availability of drugs.

Overall, health services regulation and planning are weak. The government is not allowed to fully monitor service provision by private providers. Decisions about quality and guidelines need to be more consistent and evidence-based: there are approved National Practice Guidelines for some specialties, but not all, and these are only recommended, not mandatory; hospitals sometimes follow different standards/protocols.

There are high numbers of doctors, but significant problems in recruiting and retaining doctors and nurses in rural areas. PHC is organized differently from place to place, with a variety of configurations. Some are run by GPs, some by specialists. Gatekeeping is not strong and exists only for certain health insurance schemes. Patients can self-refer to inpatient services. There are generally low utilization rates, which, combined with the extent of infrastructure, seem to imply low productivity, poor access features, and barriers to care. Privatization without strong regulation/reporting poses a risk—regulation and oversight of the system is perhaps the biggest challenge to the health system. Health care reform is said to be one of top priorities of change that population is demanding from government. Privatization of the health system in Georgia has faced a lot of challenges, because of crisis, because of war. But improvements may be starting to pick up again. In each district, there is a commitment to build a district level hospital. Construction/refurbishment has started and USAID helping them through the Loan Guarantee program to help cover the costs for people who want to borrow money to build/refurbish. Also, there is a new Ministry and health leadership, and the sense is that they want to be more involved in regulation of the market; they are not moving radically away from privatization, but it appears that the pendulum is swinging back toward more government regulation.

USAID has had several projects in Georgia, such as: the CoReform Project 2005–2009, Health Management Education Project, Loan Guarantee Project, and programs to improve priority health services, like HIV/TB. Most recently, USAID has conducted the Health Systems Strengthening Project. A medical interventions classification system is being developed through the CoReform Project in partnership with the insurance industry, health service providers, and MoLHSA representatives. A new draft law on pharmaceuticals, developed with the USAID assistance and aiming to reduce costs through fair competition, is awaiting approval by the parliament.

For example, the Health Insurance Mediation Service (HIMS), created for out-of-court resolution of disputes between insurance companies and insured, has helped to lower costs for insurance companies and clients and has increased customer satisfaction.

Insurance companies and clients can resolve disputes in a less costly, yet satisfactory way. The mediation service is widely praised by all stakeholders, though its functioning still relies heavily on U.S. funding.

CoReform is assisting insurance companies and providers to develop the medical interventions classification system and facilitate the creation of model contract agreements between insurers and providers. CoReform has further plans to support health care providers through management training for PHC physicians. CoReform is enhancing the capacity of the MoLHSA to set premiums and interact with private health insurance companies through the provision of a part-time consultant.

Health Management Education Project

“Responding to the growing demand in qualified health managers in Georgia, USAID partnered Georgian and U.S. universities to offer to the private health industry graduate degree and professional short training courses in health insurance and health service management.”116

Loan Guarantee Program

“In order to address hospital investors’ limited access to credit to fulfill their new hospital construction obligations, USAID is planning to use a Development Credit Authority (DCA) mechanism. A partial loan guarantee will be offered to qualifying hospital investment companies for amounts borrowed from privately-owned banking/financial lending institutions as determined by USAID/Caucasus.”117

Programs to Improve Priority Health Services

“USAID provides assistance to help control the spread of TB, HIV/AIDS and STI, as well as to expand and improve reproductive health services. These projects recognize the need for targeting specific diseases and strengthening health systems to achieve better health outcomes.”118

Based on Experience with Past Projects, What Factors Influenced Success?

Successful: Model of targeting resources for poorest groups, how to move with limited resources, and government decided to move in that direction. Established a health insurance mediation service, between people getting services. Whenever disputes, the service mediated it, tried to resolve it out of court. Was initially NGO, now is part of Ministry, and they look at is as a tool that can be used to ensure access.

Less successful: Accreditation was in a somewhat advanced stage, and then government asked USAID to stop its work in this area. There were some small initiatives, too. Training for medical classification of medical interventions and surgical interventions, and these trained many providers, but the government asked to delay adoption, government did not think the “system was ready.”

Strengths and weaknesses of the approaches taken: Factor that contributed to success: was flexibility of government counterparts, who were ready to adjust activities to emerging needs. This was a key factor for success. Also, the projects employed, as much as possible, local technical experts who are familiar with situation, rather than international people who need to get familiar with situation. Ad hoc requests make it very difficult to plan ahead for a year or so. Unexpected changes, new initiatives by government make it difficult to plan and deliver, in one year; never mind five years.
In summary, what was learned from the work? The need for flexibility with the host government and recognizing the potential role of the private sector. Recognizing them as equal partners, which is appreciated by the private sector. Also, the potential use of some vertical programs in HIV, TB, maternal health, which are also very important and have shown dramatic improvements. PHC has been not very much involved in those vertical programs, but is planning to move all these activities to PHC.

KYRGYZ REPUBLIC

Social and Political Commitment at National Level

“Since independence in 1991, Kyrgyzstan has undergone dramatic economic and political change, transforming itself from a Soviet republic with a command economy into an independent state with a more democratic and market-oriented system. The country witnessed a severe recession and poverty increased markedly. These fundamental changes led to reforms in all sectors of society in order to adjust to the changing environment and to manage the challenges of transition. The drastic contraction of funding for health had a negative impact on the quality of health services, which is likely to have contributed to the deterioration of the health status of the population. This macroeconomic context has driven health care reform in Kyrgyzstan.”

“From 1992, the Kyrgyz Government introduced key legislations to create an enabling environment and establish platforms for systemic, comprehensive and multifaceted health reforms with objectives of reducing inefficiencies, enhancing equity and access (financial and geographic), and improving quality.”

Kyrgyzstan has a long history of successful social and political commitment at the national level. Beginning with the Manas project in 1992 working with WHO, and later USAID, the World Bank, and other donors (e.g., DFID, Kreditanstalt für Wiederaufbau [KfW]), a group of health reformers were able to accomplish significant change over many years. The work on PHC/FM has been supported by all levels of government over the life of the three USAID projects (1994–2009) and three World Bank projects, as well as other donors which provided significant investments and infrastructure. Previous governments as well as the recent interim government were supportive of these reforms, and while the new government is just being formed, it is believed they will also be supportive of this ongoing effort toward health reform. Although little has been accomplished within the last year or so, due to the social unrest, significant gains were made over the last 15 years.

“In 1994, USAID funded ZdravReform, the first in a series of three projects to help the CAR to reform their health care systems. The goal of this assistance has been the same since 1994: to assist the governments of Central Asia to restructure their primary care delivery systems and budgets to provide more support for primary health care and improve health status through a strengthened system of primary care.”

“Health care reform in Kyrgyzstan has taken place in the difficult context of political and economic transition and severe economic pressures. In 1996, the country, with the support of external donors, embarked on a comprehensive 10-year health sector reform programme.”

National Capability, Sustainability, and Replication

Kyrgyzstan has a long history of successful health reform and implementation of PHC/FM. Many of the methods, techniques, models, and practices developed in Kyrgyzstan have been utilized in other country projects by USAID and other donors. Kyrgyzstan was an earlier implementer of PHC/FM using a Family Group Practice (FGP) model. This model allowed the three primary care specialists (pediatrician, therapist/internal medicine, and OB/GYN) to be retrained as FM physicians. FM became a specialty and extensive training and retraining of these new FM specialists was conducted with the help of USAID and other donors. Kyrgyzstan
was also one of the early implementers of health finance reform and set up one of the earliest Mandatory Health Insurance Funds (MHIF) in the NIS/CIS countries. Kyrgyzstan was one of the few countries that had good success in downsizing the secondary care sector, primarily in the rural areas. An FM training center and training programs, using “hands-on” clinical training in a FM practice setting was a high priority and has been most effective. Kyrgyzstan was also one of the early implementers of EBM methods, practices, and techniques and has been working on clinical protocols and guidelines in FM for a number of years, which is discussed in more detail in a later section.

“Nevertheless, more remains to be done. The restructuring of health care delivery needs to be continued, with an emphasis on the hospital sector and the sani-epid service. It is also necessary to develop the concept of QA. Activities to stop the spread of communicable diseases, in particular tuberculosis, malaria, and HIV/AIDS, must be continued and strengthened, and the population should be encouraged to take greater responsibility with regard to its own health. Although life expectancy has improved again in recent years, it is still lower than it was in 1991, and infant and maternal mortality continue to be very high.”

“The successes of the Kyrgyz health reform process to date have been achieved through domestic political support, the effective coordination of donors’ efforts, continuity in health reform management and a step-by-step approach, linking pilot projects to national health reform. It will be necessary to ensure the continued support of all stakeholders for the implementation of further reforms. The country is facing the challenge of achieving a good performance in the health sector in the context of a difficult macroeconomic and political situation.”

Human Resources and Management Systems

The Kyrgyzstan health system, as with others in the E&E region, under the FSU was a “normative” and “specialty-oriented” health system with the large majority of resources going to the secondary and tertiary care levels. The staffing ratios were high, productivity low, patient utilization low, and salaries low (especially for primary care physicians), which resulted in demands by providers for informal payments. Through a variety of USAID projects providing technical assistance (TA) and the World Bank providing funds for infrastructure improvements, significant progress has been made in reducing the number of facilities and the number of personnel, combined with improvement in training, instruments, and equipment, as well as improving patient utilization. This process has helped in reducing the funds going to secondary care and reallocating some of these funds to primary care.

Kyrgyzstan has been a leader in the E&E region with USAID support of the establishment of professional societies, especially for FM. The first USAID project assisted with the establishment and operation of the Family Group Practice Association (FGPA), which includes most of the new FGP/FM physicians. This new association gave the FGPs a forum for discussion of primary care issues, as well as forming a lobbying group for FM programs and activities. ZdravReform has continued to support this organization, as well as a Hospital Association and a Medical Accreditation Agency over the life of the three USAID funded projects.

“The private health sector has developed since the 1990s. Starting with pharmacies, it later expanded to include the provision of health services. In 2003, the Ministry of Health issued 254 licenses for private medical practices, of which 49 were for legal entities and 205 for individuals. Private health facilities can bid for contracts from the public sector and participate in the State Benefits Programme. So far, this has mainly been seen in relation to drug supply.” NHAs have been implemented to allow accurate capture of health funds at the different health system levels and are being used effectively to allocate funding to primary care sector as needed. “There has been some progress in the reform of medical education. Training and retraining programs in
family medicine have been set up, a school of health management established, and curricula of
the State Medical Academy revised. What is lacking so far is a comprehensive system of human
resources management. At present, human resources are very unevenly distributed, with an
oversupply in northern and urban areas of the country and a lack in southern and rural parts.
The salaries of health care workers are still low, even though they have improved under the
single payer system.”

“The presence of narrow specialists at FMCs, which can be accessed directly by patients, is a
source of inefficiency and a key barrier to developing PHC. This leads to fragmentation of the
first contact function; fracture of the gate keeping function; adverse impact on continuity of care;
hindrance to practicing integrated and holistic family medicine and extended PHC; duplication of
hospital OPDs; and creation of false and potentially destructive perception of separate rural and
urban models of PHC. This source of inefficiency should be eliminated by converting all FMCs to
FGP centers. The narrow specialists who work in FMCs should be either gradually transferred
to hospitals or retrained as family physicians.”

“A high level of self-referred hospitalizations in recent years has indicated that the population was forgoing primary care in seeking health services. To solve this problem, family group practices are expected to function as gatekeepers by referring patients to higher levels of health care according to clinical protocols. Under the single payer system, incentives to encourage the use of the referral system have been designed and built into the State Benefits Package. Without a referral from a family group practice, patients have to pay higher levels of co-payment.”

“Within the countries of the former Soviet Union, the Kyrgyz Republic has been a pioneer in
reforming the system of health care finance. Since the introduction of its compulsory health
insurance fund in 1997, the country has gradually moved from subsidizing the supply of services
to subsidizing the purchase of services through the ‘single payer’ of the health insurance fund. In
2002 the government introduced a new co-payment for inpatients along with a basic benefit
package. A key objective of the reforms has been to replace the burgeoning system of unofficial
informal payments for health care with a transparent official co-payment, thereby reducing the
financial burden of health care spending for the poor. The analysis shows that there has been a
significant improvement in financial access to health care amongst the population. The
proportion paying state providers for consultations fell between 2004 and 2007. As a result of
the introduction of co-payments for hospital care, fewer inpatients report making payments to
medical personnel, but when they are made, payments are high, especially to surgeons and
anesthetists. However, although financial access for outpatient care has improved, the burden of
health care payments amongst the poor remains significant.”

“A key achievement is the Single Payer System, which has enabled pooling of all sub-national
budget funds for health care...in a ‘single-pipe funding’ to the State Guaranteed Benefits
Package...New provider payment methods have been successfully introduced in the pilot
regions for FGP’s based on simple per capita mechanism. Direct and indirect contracts have been
introduced for FGP’s, including partial fund holding for pharmaceuticals.”

“Prior to recent reforms, the health care system was fragmented into four levels of government administration: republican, oblast, city and rayon, serving overlapping populations. Furthermore, many national programs, such as immunization schemes, were operated through separate vertical systems. The fragmentation of health care budgets was one of the major challenges to the reform of health care financing and of the health care delivery system. One of the key elements in the reform of health financing in the initial pilot oblasts (Chui and Issyk-Kul in 2001, and now extended nationally) was the centralization of financing at the oblast level to enable better risk-pooling and to break the integration of finance and provision that contributed to excess physical capacity. A complementary reform was the granting of more autonomy to health facilities to manage their budgets. With the introduction of new provider payment methods (capitation for primary care
and case based payment for secondary care), especially co-payments by patients, health facilities have been given greater flexibility in the internal allocation of resources."131

Other improvements included “introducing formal ‘above-the-table’ user fees” to “limit informal payments. The Kyrgyz Republic pursued this as part of a broader reform of the health system’s collection, pooling, and payment functions. The ‘single-payer reform’ introduced a basic benefit package providing free primary care through GPs, with whom each insured person must enroll. It required copayment for inpatient care, as long as the patient was referred, to increase copayment transparency and improve resource flow to providers. Analysis of the 2001 and 2004 Kyrgyz Household Health Financing and the 2007 Household Budget Survey showed that the reform succeeded most for inpatient care, by curbing informal payments for the purchase of medical supplies and drugs that were supposed to be provided free. By 2004 fewer than half of hospitalized patients paid anything above the copayment threshold, taking food costs into account—a result sustained into 2007. But households still provide family members with many products and services that health facilities should officially provide. The reform was evaluated as an overall success, but some policies may be difficult to sustain. The percentage of patients reporting informal payments fell during 2004–2007, but the median amount of these payments increased.”132

Cost-Effective and Appropriate Technology

During the first USAID project it was identified that setting up a new primary care system in Kyrgyzstan would require not only organizational and clinical changes, but also additional resources to refurbish and equip the new FGPs. In the early stages this was funded by USAID, but later the first World Bank project was established, which provided funds to equip these FGPs and provide heat, hot water, instruments, and equipment. USAID then was free to focus more on TA and other issues of health reform. Early in the first project an FM training center and training programs, using hands-on clinical training in a FM practice setting was a high priority and has been most effective. Kyrgyzstan was also one of the early adapters of EBM methods, practices, and techniques and has been working on clinical protocols and guidelines in FM for a number of years. Under the second USAID project, a Medical Accreditation Commission (MAC) was established after an earlier failure of attempting to do licensing and accreditation together. Licensing of facilities became a function of the state and the accreditation process became a quasi-independent organization. This MAC has been highly effective in setting up a hospital and health facilities accreditation program for both private and public providers. The focus of the accreditation program is to develop facility standards, to ensure providers are following standards, and to conduct ongoing CME for the hospitals and FGPs in the area of standards and QI. The MAC works closely with the FGPA and the Hospital Association to ensure programs and services meet the needs of these two large constituencies.

Under the new USAID project, “expected outcomes included the introduction of modern clinical protocols, the implementation of new provider payment methods, and increasing consumer choice. With the design of ZdravPlusII in 2004, USAID sought to address the need for medical leadership to accept and promote changes in clinical practices to improve both the quality and the scope of primary health care. The project broadly promoted evidence-based medicine (EBM) to medical leaders and the development and implementation of new clinical practice guidelines in addition to continuing support for family or general practice and specific service delivery improvements in priority program areas. In its second and third contract periods, Zdrav implemented quality improvement programs to demonstrate best practices for specific medical interventions.”133

“One of the primary objectives and core functions of the HIP is to improve the quality of health services throughout the CAR. The HIP will support CAR health systems to adapt modern QI approaches to their needs and priorities. The project will seek to directly improve
health care processes in order to improve health outcomes. Much of this work is expected to focus on Congressionally-mandated health priorities, but also to contribute to a broader strengthening of health systems. The program should take a top to bottom approach for QI that includes improving the quality of care, resulting in improved clinical outcomes (EBM is one pillar of improved outcomes); improving quality of services (patient satisfaction is one dimension); improving quality of resource use (from stewardship of the system to cost-effectiveness of individual interventions); and improving quality of the health workplace (including compensation and supportive supervision). Development programs in the Central Asian Republics (CAR) have experienced varying levels of success at addressing each of these components; as a result, more remains to be accomplished in some countries than in others. EBM and evidence based practices are key components of improving the quality of clinical outcomes. One lesson learned from USAID’s work on health reform is that EBM is not simply the development of guidelines and standards using reviews of literature and analyses of scientific studies, although this approach can help guide national policy and provide tools for health providers. EBM is also the practice of making decisions about health care at the service delivery level, based on the best available, current, valid and relevant evidence, clinical experience, and ultimately, the patient’s values and wishes.”

Health Systems Integration and Linkages

“High-level support for FM reforms has been strong; the Ministry of Health has a clearly articulated health reform strategy and has succeeded in coordinating donor agencies to ensure alignment of inputs to reduce duplication and optimize value added by multilateral and bilateral organizations actively involved in the health sector; namely, WB, WHO, ADB, USAID, UNICEF, UNDP, DFID, SDC and JICA.”

“The successes of the Kyrgyz health reform process to date have been achieved through domestic political support, the effective coordination of donors’ efforts, continuity in health reform management and a step-by-step approach, linking pilot projects to national health reform. It will be necessary to ensure the continued support of all stakeholders for the implementation of further reforms. The country is facing the challenge of achieving a good performance in the health sector in the context of a difficult macroeconomic and political situation.”

The third World Bank project was conducted on a SWAp joint financiers arrangement working closely with USAID and UN agencies and other bilateral projects implemented under a Manas Taalimi/SWAp funding umbrella. This SWAp arrangement has provided benefits to both the funders and the recipient, allowing funders to choose which items in the reform project they would like to focus upon.

“USAID/CAR has worked to strengthen PHC for fifteen years, and is committed to solidifying the gains made by this investment. HIP was designed to incorporate aspects of traditionally vertical programs (HIV and TB interventions) with an overall systems strengthening approach that prioritizes capacity at the primary care level. In this way, it is expected that the capacity of horizontal health structures will be developed, not detracted from, through the integration of what are now considered to be vertical programs. HIP activities are expected to be implemented simultaneously at two levels: policy assistance and capacity building of national institutions for supervision and planning; and interventions to demonstrate best practices and tailor activities to the Central Asian context.”

Monitoring and Evaluation

Kyrgyzstan has been a leader in the development and implementation of M&E systems, methods, and practices. Beginning with the first USAID project, data and information systems were built into the early pilot projects with FGP. This began with the use of the international physician’s ordering form (which captures procedures, tests, and ICD-10 diagnosis data) and then rolled out into a national data system for all FGP and primary care facilities. These early data systems were later computerized using modern IT and eventually were integrated with the Mandatory
Health Insurance Fund (MHIF) database. These M&E systems were later expanded to secondary and tertiary care under a DRG case-based payment system. With the development of the first World Bank project, extensive data systems and M&E were developed to capture both input and output indicators. This was done with World Bank funding and extensive IT investments were made, which included the MHIF systems and the use of the Internet for data and information exchange. All of these systems resulted in extensive reporting as well as monitoring and analysis of reports, at the World Bank project review meetings.

Close collaboration between USAID ZdravPlus and the WHO Health Policy Analysis Project (HPAP) had been an early effort which resulted in improved technical input to the M&E framework. The collaboration provided clinical input to various research studies used to document progress or non-progress on health reforms. One example of this collaboration, was the assistance of the ZdravPlus/STLI physician consultants (Western FM physicians working in Kyrgyzstan) assisting with a process to identify inappropriate hospital admissions. The collaboration and M&E process identified as many as 30% of the admissions as inappropriate or better managed on an outpatient/ambulatory level. Additional M&E has also been utilized effectively in the safe motherhood, hypertension, and asthma programs.

Strengths, Weaknesses, Opportunities, Threats

Kyrgyzstan has been a leader and innovator in the E&E region in health reform, and has had more than fifteen years of TA support from a variety of international donor organizations as well as significant investment through the World Bank. Every aspect of the health system has been reviewed, analyzed, and improved wherever possible. Major efforts on the development of PHC, FM, and Health Services Strengthening have led to significant advances and “strengths”, both structural and functional, within the system. However, there are also many inherent “weaknesses” in the system and the reform is still fragile. While much has been done there is still much to do in Health System Reform in Kyrgyzstan.

Strengths

1. The early development and implementation of independent FGPs in rural areas provided the model for later expansion to the rest of the country. Although this independent model had to be adjusted to fit the urban environments, this process clearly proved that the FM model needs to be altered to fit different situations, rural and urban. These early developments also led to a mix of private and public providers in PHC, which improved competition between providers. Over the last few years utilization of both the primary care and hospital care has been increasing.

2. The establishment and support of the FGPA, the HA, and the MAC as new quasi-independent professional medical organizations provided a basis for later influence on governments, both national and local, to implement regulatory changes required to improve IPHC/FM.

3. The establishment of a group of health reformers, who were strategically placed in key positions within the health system (Ministry of Health, MHIF, FGPA, etc.) and who were able to influence key decisionmakers, assisted the process of keeping the health reforms alive and growing in a difficult political and economic environment. The continuity/longevity in office of senior Ministry officials that were inclined to support reform in office also facilitated change.

4. The early establishment of health financial reforms, and the separation of payer from provider, with the implementation of the MHIF, provided the basis for developing new payment systems (capitation and case-based payment) for PHC as well as for hospitals. The later establishments of copayments assisted the process of reducing the informal payments and allowed better access of the poor. The availability of the additional drug benefit in rural...
areas has improved. The patient’s financial burden has reduced and lower out-of-pocket expenditures have been recently documented. The primary care health system continues to receive an increasing share of the State Guaranteed Benefit package (SGBP).

5. The development of open enrollment programs and patient choice of their provider developed healthy competition within the primary care system and helped to break up the old bureaucratic catchment areas.

6. The implementation of a FM Training Center, with hands on postgraduate and CME training, provided the early recognition of the need for QI and evidence-based practices, leading to the development of protocols and guidelines in FM and PHC.

7. The early collaboration between donor groups, and especially the coordination between USAID and the World Bank, led to effective use of funds, allowing each organization to do what they do best. This eventually led to the SWAp, which has become a model for effective donor collaboration worldwide.

8. At the national level, the development and early implementation of M&E systems provided the basis for the collection and reporting of information on health status and health outcome indicators, as well as leading to studies on patient satisfaction, informal payments, and other key indicators which helped to document the impact of these IPHC/FM changes. Progress continues on the development of Clinical Practice Protocols and Guidelines and EBM development.

9. The new USAID project in CAR will continue to provide significant support and help to push the envelope in the utilization of vertical program funds into an integrated horizontal environment as well as continuing evidence-based programs. The World Bank continues to support the implementation of an integrated approach.

Weaknesses

1. The political situation is still very fragile, and the frequent and often violent changes in government could disable the health reform process.

2. The slow economic growth and the relatively small portion of the overall governmental budget and low percent of the GDP that goes into health and especially into primary care is a continuing concern.

3. The changing leadership within the Ministry of Health and the MHIF, combined with existing levels of corruption at all levels, means less funds allocated to primary care activities and programs in an already underfunded system.

4. The failure to continue the rationalization and restructuring process for the hospital sector (both secondary and tertiary) especially in the major cities, means more funding going to hospitals and less funds going into primary care.

5. The failure to continue reforms of the SES and the inability to establish a modern public health system within the Ministry of Health is a lost opportunity for change and improvement.

6. The inability to restructure and rationalize the polyclinic structure and to reduce the number of excess NSs means less effective primary care. There is a continuing conflict between FM and the NSs, which is due to the relationship between referrals and informal cash payments, as well as professional jealousy and ongoing role definition.

7. The human resources situation, especially in the rural areas, remains a real concern and is due to continued out-migration from rural areas. This results in larger workloads for PHC doctors and eventually could affect access to and quality of care.
Opportunities
1. The establishment of a new government with hopefully fresh thinking and new effective leadership may lead to continued strong support for health reform.
2. The establishment of new senior leadership at the Ministry of Health and the MHIF could produce a new environment of cooperation and collaboration and a reduction in attempts to subvert and destroy the successes of the last 15 years.
3. The continued combination of USAID and the World Bank, along with other donors who are in the SWAp arrangement, continued to provide opportunities for more effective collaboration.
4. The initiation of the new USAID project for Central Asia, with a strong focus on integrated horizontal programs and continued development of evidenced-based practices in all areas will continue to enhance development in these areas.
5. The continuing development of the FGPA, the HA, and the MAC as strong quasi-governmental agencies who can lobby the Government of Kyrgyzstan effectively for changes in policy and regulation can be a significant force toward continuing sustainability of health reform.

Threats
1. The possibility of continuing social and political unrest and possible change in governments is a major concern.
2. The slow growth or no growth economy continues to be a major concern as well as the regional inequities in health funding.
3. The ongoing process of graft and corruption that exists at all levels could continue to reduce the funds flowing into the primary care system thus endangering access and quality.
4. An acceleration of the out-migration (doctors and nurses) from rural areas could add to the workload problems of FGPs and reduce access and quality.
5. The failure to continue the rationalization and restructuring process of the secondary and tertiary care sectors and the SES would only ensure the continued status quo.

Summary
The critical “drivers” which must be addressed in order to maintain the tremendous progress over the last fifteen years are as follows:
1. Stay the course of health reform with assistance and collaboration of donors and the World Bank.
3. The reduction of corruption through continued health finance policy and operations improvements with increased levels of transparency.
4. Continued work in QI through evidenced-based methods and techniques and support for integrated programs.
5. Continued focus upon Human Resource Management improvements at all levels of the health system to ensure retention of key personnel in all areas.

Lessons Learned
1. FM as a specialty, and the development of the FGP model, proved to be the catalyst for improvements in the primary care system. The use of HSS methods and techniques provided the necessary tools to improve care through a variety of TA activities and programs. Effective PHC needs both professional and clinical training for doctors and
nurses, as well as instruments, equipment, and capital improvements to ensure the environment for quality of care is available.

2. FM was implemented in both rural and urban areas, but experience has shown that FM works best within the Ambulatory facility in the rural areas and works less well in the urban areas.

3. The competition for patients between the various NSs and primary care doctors (including FM) is particularly severe in the urban polyclinics.

4. Health finance reform is critical in order to change the incentives for patients and providers and to reduce the distortions in the payment system. The development and implementation of a NHA system over the many years has been successful in identifying the proportion of the public sector funding going into primary care.

5. Informal cash payments (“under-the-table”) for health services can be reduced by the initiation of copayments. Patients and family want to know “upfront” what health services will cost rather than being asked repeatedly for unknown amounts of informal payments as they move along the referral and treatment process.

6. Improving the quality of care and an increased approved scope of practice, via relevant training and education, is an important ingredient for the success of FM.

7. Continuing the restructuring and rationalization process at the secondary and tertiary levels is important for reallocating scarce funds to the primary care sector.

8. Attention must be given to building stakeholder participation and consensus for any effective change to occur over a long period of time.

9. There is no “magic bullet” or “quick fix” to system problems, and only comprehensive implementation of multiple reforms in all health sectors can lead to effective sustainable health reform.

**Best Practices**

1. The establishment of a system of copayments, with prices clearly presented, along with counseling of patients on financial issues, can reduce informal payments and improve access and utilization of primary care and secondary care facilities.

2. The setting up and operation of a teaching and patient care FM Training Center, within a family group practice setting, where patient care and teaching occur simultaneously, has been identified as a best practice in Kyrgyzstan.

3. The establishment of the independent FGPs in rural areas, particularly with two to three physicians, with high levels of autonomy and financial control, has been identified as a best practice in Kyrgyzstan.

4. The concept of patient choice of physician and “open enrollment” as a force for improved quality of care and improved competition between physicians has been identified as a best practice in Kyrgyzstan.

5. The establishment and support of quasi-independent professional medical associations (Family Group Practice Association [FGPA], Hospital Association [HA], Medical Accreditation Commission [MAC]) that can look out for the interest of their constituents and can lobby the local and national governments for effective change has been identified as a best practice in Kyrgyzstan.

**Recommendations**

1. The new Government of Kyrgyzstan needs to “stay the course” of health reform and continue the process of improving the effectiveness and quality of PHC and FM.
2. The Ministry of Health, with the assistance of various donors, especially USAID, needs to continue the QI process through more attention to evidence-based techniques, including the implementation of clinical practice guidelines and protocols.

3. The Ministry of Health, with the assistance of donors and the SWAp process, needs to continue the pressure to rationalize and restructure the secondary and tertiary sectors, especially in the two major cities.

4. The Ministry of Health, with the assistance of donors and the SWAp process, needs to continue to reform the SES and move toward a modern public health system.

5. USAID needs to find accounting, finance, and operational methods to utilize funds from vertical programs to continue to strengthen integrated horizontal programs and services.

OTHER COUNTRIES IN THE EUROPE AND EURASIA REGION

Although the extent of experience with the IPHC/FM approach varies among other countries in the E&E region, some lessons can be drawn from them and are described below.

Republic of Belarus

In December 1991, the Republic of Belarus declared independence from the Soviet Union and was recognized by the U.S. government. Over time, however, “U.S.–Belarus relations deteriorated as [its government] become increasingly authoritarian” and in 1997, the United States announced that it would have “very limited dealings” with the country. As a result, only modest U.S. aid to Belarus has been aimed at “promoting economic reforms and assisting the country's health and education sectors.”

Belarus’s economy is considered one of the most unreformed in Europe, and health expenditure, like nearly all aspects of its health care system, has not changed significantly since independence. “Levels of total health expenditure and public sector expenditure [have] remained relatively stable. Social health insurance has not been introduced in Belarus, and the system is mainly funded by the State through general taxation and some out-of-pocket payments.”

The Ministry of Health controls the health system, and sets standards for care and services. Decision-making in regions and districts is limited. Purchaser and provider functions are integrated. Top-down policy development and implementation does not engage stakeholders. Monitoring, evaluation, and analysis of health systems is weak and is not used to inform policy and planning.

Although attempts have been made to reduce hospital capacity (“through financing mechanisms that are based on the number of residents at the district and regional levels, rather than the number of beds”), the number of hospital beds per capita is still higher than other countries in the region. Capital investment is primarily in the hospital sector and specialized care. There is an increasing overcapacity of doctors and nurses focused on inpatient and specialist care, unevenly distributed geographically across specialties. Low wages and new career choices for health workers have led to recruitment problems for key health workers in rural areas and PHC—with overcapacity in cities and hospitals. Integration of PHC into the remainder of the health care system and control of referrals through gatekeeping is virtually nonexistent in urban areas, where patients can self-refer. In rural areas, gatekeeping functions because patients have a limited set of health facilities from which to choose.

Although some attempts have been made to strengthen PHC in rural areas and introduce new methods of health care financing (“based on per capita financing and contracting for primary
care doctors‖), they have been limited to pilot projects. Despite the limited, incremental nature of reforms, "there have been significant improvements in some key indicators, most notably in the falling maternal and infant mortality rates." Nonetheless, "the growing dissatisfaction of the population with the overcrowded and impersonal primary care services and with the busy and burnt-out PHC doctors‖ makes it likely that reforms will continue, albeit likely at the slow pace seen to date.

Republic of Estonia

Extensive reforms in PHC/FM took place in the 1990s and at the beginning of this century. Reform has been facilitated by the stability of the political environment and continuous annual economic growth, above the EU average. These included user choice of family physicians, new payment methods, university training for FM, increased PHC services, and national, evidence-based guidelines. Reforms have contributed to improved health conditions, as evidenced by several key health indicators (such as infant mortality rates, which are third best in the region) and improved management of key chronic conditions and reduced hospital admissions. As part of the health care system, PHC/FM is mainly funded by the government through mandatory health insurance contributions; however, private expenditure is high (approximately a quarter of all health expenditure) and increasing. Overall health expenditure per person is consistently high, supported by a conservative fiscal policy and balanced public budget policy. Estonia has received a significant amount of external funding to support reform, including loans from the World Bank and bilateral donors.

Reforms have been supported by extensive political commitment and strong leadership, which effectively managed the contributions and interests of many at both the political and operational level. There is increasing emphasis on quality of care, including initiatives for voluntary accreditation of professionals by associations, introduction of better quality handbooks in hospitals, and the development of evidence-based, clinical guidelines. In addition to professional training, top managers and health care professionals must attend management training every year.

When health care reforms began, there was an oversupply of doctors, a shortage of nursing personnel, and an uneven distribution of specialist services across the country. Long-term plans were made to increase training for nurses and doctors. Specialist training of family doctors significantly broadened the scope of services delivered in PHC settings. While the situation has improved, Estonia still faces a lack of human resources in the health care sector. The accreditation of health care workers is voluntary, but health care professionals must undergo training related to their profession each year. Hospital supervision has not achieved its full potential. In recent years, Estonia received grants from the European Economic Area (EEA) and related Norwegian financial mechanisms for (among other infrastructure development) the training of health protection specialists.

When reform began, Estonia’s geographically decentralized hospital system resulted in excess capacity. Since then, the number of hospitals and the number of beds has fallen dramatically. External funding, including two World Bank loans and other bilateral and multilateral donor financing, supplemented by national resources, have been used to expand and improve educational facilities in the country (such as new buildings for the University of Tartu Faculty of Medicine) and purchase high-technology hospital equipment. Nonetheless, care involving high technology has been centralized to fewer institutions.

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m Ibid.
Family doctors exercise a partial gatekeeping function and control most access to specialist care. Patients need a referral in order to see most specialists and to be admitted as a non-emergency inpatient. Patients are still free to access several types of specialists directly. Initially, there was resistance to the requirement for referrals to specialists, from both specialists and patients. However, after the Government introduced regulations concerning specialist visits without family doctor referrals, the situation changed and specialists have come to understand the role of the family doctor. Chronic illnesses are increasingly managed in the PHC setting and management of these illnesses has improved.

Estonia is considered one of the leading countries in terms of “e-health” in Eastern Europe. Health sector information systems have developed significantly and now cover almost the entire population and all health providers. Providers must report health care data according to national standards, and this data is used for monitoring and surveillance of communicable diseases and other health risk factors, as well as for registering data of births and deaths, cancer incidence, strokes, and heart failures. Adverse events of medicines must be reported. Providers are also required to report changes in medical staff. In addition, data on waiting times are monitored routinely and the government conducts annual population satisfaction surveys, which are accessible to the public.

The extensive reforms made in Estonia that have led to a health care system now built around nationwide PHC though FM, with specially trained doctors/nurses, is a significant achievement. The quality of health care has improved largely and remains among the highest in the region. Estonia has successfully reduced the size of the hospital sector and expanded the number of private providers, while introducing a system of social health insurance. Popular satisfaction with the PHC system is high.

Although major reforms have occurred, systems and policies are still relatively new and must be maintained and further improved. EU accession in 2004 led to a temporary migration increase of doctors and nurses to other EU countries, and although educational systems have helped, a shortage of qualified professionals in the health care sector remains a challenge. In addition, there are significant issues that must be addressed. For example, there is no standard procedure for purchasing medical equipment, guidance for product costs, or oversight of purchases, yet there is growing pressure and strong incentives to introduce high-cost technology. Hospitals invest in expensive apparatus and information technology developments without clear evidence of value-for-cost.

The Estonian health care system has introduced several fundamental reforms upon which it can build. The current reforms support the widening of the scope of primary care, in terms of more involvement of nurses on individual consultations and setting incentives for practices in general. Further expansion and increased coordination of care at the primary level, combined with the development of additional nursing and rehabilitation services, would make the delivery system even more patient-centered. The existence of national health information standards and their adoption by providers nationwide offers an opportunity for Estonia to increase the performance of the health system.

Although public health expenditure is high, the increasing portion of total health costs that is private may in the future limit access for low-income population groups. The sustainability of government funding for PHC/FM is also at risk because of the country’s small and open economy, persistent account deficit, and rapidly expanding gross external debt. Human resource issues also pose a significant threat to the ongoing excellence of the PHC system: the number of doctors and nurses remains a major area of concern. The combined effect of three factors (drop-out from the health care sector, migration to other EU countries, and retirement) will inevitably reduce the numbers of doctors and nurses in Estonia in the near future, as the growth in numbers of new health care workers is below the replacement level. There are also threats
to the quality of management, particularly in the hospital sector. The selection of hospital supervisory board members is mostly based on politics, rather than competence. As a result, members often lack experience in governing large organizations, and thus pose a threat to hospital performance if it affects the selection of hospital managers and brings instability to the whole organization. The situation can only be improved by offering systematic training to supervisory board members, which is currently lacking.

Reforms in Estonia began with a period of rapid, radical policy changes, which were then—after some testing—refined and instantiated as national legislation, followed by a period of refinement that continues to today. This approach created opportunities to learn from best practices during implementation.

The introduction of a national health insurance system, for example, did not wait to be prepared down to the very last detail, allowing space for fine-tuning and regional innovation. It was particularly advantageous that the country began reform by establishing a sustainable and fully operational health financing system, an inevitable prerequisite for later reforms.

The Government of Estonia took a carefully considered, multifaceted approach to reform that was critical to success: development of evidence-based guidelines for management of acute and chronic conditions encouraged family doctors to manage these conditions and reduce referrals to specialists. Early investment in training established a critical mass of health professionals that enabled new policies to be rapidly employed. A careful change-management strategy, including an encircling approach to the roll-out of reforms that avoided direct confrontations opposing stakeholders, avoided health reforms being politicized too early in the process.

A practical approach to implementation, emphasizing simplicity of interventions, was easily understood by potential adopters. Strong leadership and good coordination between policy and operational level were vital to reform.

**Republic of Moldova**

Moldova inherited a health system based on the classic Soviet Semashko model. There was rapid economic decline after independence, accompanied by substantial decrease in funding for the health sector and worsening of population health indicators. Despite resource constraints, Moldova achieved significant PHC reform by privatizing health services, developing PHC based on FM, and successfully introducing mandatory social health insurance, which also reduced the level of informal payments in the system. This was generally supported by political commitment for health reform in Moldova, although some claim that lack of political commitment was a main reason why reforms to the Soviet pension system were delayed. Reform ideas were passed into law early in the transition period, although socioeconomic hardship and a high turnover of health ministers were barriers to the reform process. Allocations for health care only stabilized with the introduction of social health insurance. Health care coverage is provided through a combination of mandatory social health insurance and government/internationally funded programs targeting specific priority health issues. Employed residents must contribute a portion of their wages through a payroll tax or a flat rate lump sum. The government pays contributions for the rest of the population.

Governance/regulation of the health care system is the responsibility of the Ministry of Health; however, the regulatory function is underdeveloped and there is limited capacity for strategic planning in the country. Planning is often not based on need, but rather by line-item budgeting or formulas. Planning and management capacity at all levels of the health system are insufficient to effectively implement planned reforms. National-level policies and strategies exist, such as the National Health Policy for Moldova, 2007–2021, but these do not include strategic plans for the operational level. Where such plans exist, they do not adequately link activities with national
objectives/targets/metrics. Most institutions operate in isolation from the plans of others, although there is a desire to improve planning. Improving the quality of health services is promoted as a priority in the country and, although systems to measure quality are not yet in place, a new national strategy on health quality management was approved in 2008. Much work remains to be done to implement QI efforts, such as increased human resource capacity. Nevertheless, there is evidence that reforms have had a positive impact on the perceived quality of services, particularly in PHC (Shishkin et al. 2006).

In 1997, Moldova had one of the most extensive networks of health staff in E&E (World Bank 2000). There was extreme overcapacity in the supply of doctors in the Moldovan system. Since then, emigration, increased career opportunities, and low wages have led to the loss of key health workers, particularly for PHC in rural areas. PHC medical staff receive financial incentives to work in rural areas, but this is insufficient to retain them. There is a general lack of management and medical capacity at the health system level. Following recent reforms, training of family doctors and health care managers has received particular attention, and training programs have developed considerably. The focus on developing PHC and the substantial investment in training/retraining has begun to build capacity in the PHC system. Overall, however, the health system is still led by specialists, and FM has low status. This, with low salaries, discourages doctors from entering residency or retraining programs in FM, despite the demand. At the national level, recruitment and training efforts have not kept pace with the technical demands of reform. For example, the National Center responsible for health monitoring cannot analyze data because of a shortage of people with appropriate technical skills.

After independence, Moldova was faced with extreme overcapacity in the hospital sector. Economic challenges made it impossible and undesirable to maintain the health system at that scale. By 2000, Moldova had drastically reduced the number of beds for hospital acute care and consolidated secondary care hospitals. Specialized and high-technology tertiary care providers, most of them in the capital (Chisinau), were not consolidated. The PHC system is extensive, and geographical access to services is good. Hospital and PHC infrastructure is poor, except for those refurbished with international support or World Bank loans (Doganov and Araujo 2003). Most new investment has been in PHC centers throughout the country, but routine maintenance has not been a priority. Local governments allocate few resources to infrastructure and equipment (Atun 2007). A significant portion of Moldovan health care centers reportedly contain obsolete equipment. As with the infrastructure, much of the equipment dates back to Soviet times and needs to be replaced. Technologies are outdated even in tertiary care institutions. Throughout the 1990s, investment in and maintenance of medical equipment did not occur and equipment purchased or received through donations more recently has not always corresponded to national priorities.

Moldova has made efforts to shift focus from inpatient, hospital-based care to primary care. Secondary care has been reorganized and dramatically consolidated. The primary care sector is now based on a general practice model with family doctors, and patients are free to choose their family doctor. Family doctors act as gatekeepers to secondary care, providing referrals for specialist and inpatient care and diagnostic investigations. There are flaws in the system, however. Choice of doctors is limited by geography in rural areas. Poor gatekeeping allows patients to directly access the secondary care level and specialized care professionals without referral from the PHC level.

The Moldovan health system has data collection systems, and many institutions regularly collect and provide data, but M&E systems are generally paper-based, produce excessive data at the operational level, fragmented with poor linkages, and rely on multiple agents for data collection and analysis, resulting in duplication of effort. Delays in routine reporting and an inability to analyze data for policy/operations means that information is not useful for decision-making.
There is no systematic monitoring of the quality of services provided in primary care. Formally, health institutions/professionals are responsible for the safety of medical treatment, but mechanisms to monitor risks and prevent the poor functioning of health services, medical malpractice, and errors do not exist.

Despite a resource-constrained environment, Moldova has made significant reforms to its PHC system upon which it can build long-term. Mandatory Health Insurance with copayments has been introduced, thus creating a transparent environment for payments to providers. Key laws have been passed that will enable further FM and PHC reforms, such as recognition of FM as a specialty. PHC services have been articulated in law and defined in the State Guaranteed Benefits Package. The hospital sector has been rationalized extensively (more than any other FSU country), and Moldova’s network of PHC centers has been expanded and (in some cases) refurbished. The former system of pediatric, women’s, and adult clinics have been consolidated into unified PHC centers providing services for all citizens. Users have been given the freedom to choose their family physicians, and the role of family doctors is beginning to be understood. Evidence suggests that both users and health professionals welcome the new model of PHC.

Although impressive, Moldovan achievements are fragile. Government funding for health continues to decline. Much of the infrastructure is outdated, as well as the medical technology, and funding to improve both is primarily through international support and loans. Moldova is one of the most heavily indebted countries of the Former Soviet Union. Private expenditure as a portion of total health care spending is high; much of this reflects the cost of pharmaceuticals, which are not generally not covered by national insurance. Coverage by national insurance is incomplete, particularly for rural subsistence farmers. Insufficient human resource capacity is an enormous constraint for reform, as is the lack of any technology assessment or evidence-based approach to medicine. All three are needed to ensure efficient use of resources and improve the quality of care, which is often substandard. Although Moldova is not among the poorest performing health systems in E&E, it still ranks quite low, and TB and HIV incidence are high.

National plans and strategies are in place to address some of the health system’s weaknesses. There is much political support for continued reform: the need to achieve greater health insurance coverage, for example, is well recognized by the Government of Moldova, as is the need to increase human resource capacity at national and health delivery levels. While financing remains a challenge, Moldova can make significant additional advances in reform by strengthening the capacity of its Ministry of Health, which will support the implementation of all other aspects of national strategies.

Involving all stakeholders in further reform planning has been weak in the past and will be key to future reforms. A lack of motivation among health personnel to support change also contributes to the departure of personnel from an already shallow health care system. Without greater involvement from more skilled management staff at all levels, reforms will continue to be challenging: experience from many countries confirms the importance of adopting a systemic approach to reforms and combining bottom-up and top-down approaches, with simultaneous developments at both policy and operational levels to create shared ownership, to reduce resistance, and to enable lesson-sharing at different levels of the health system.

Introducing mandatory social health insurance can be highly effective where it is used as a means of initiating other reforms of the system, such as by using contracting as a mechanism to improve accountability, transparency, and quality.

Legal sanction of reform ideas can be valuable even if implementation of reforms is not immediately possible. In fact, delays provide the time to work closely with international and national partners and refine initiatives before implementation, thus avoiding some of the pitfalls encountered in other countries.
Although national policies and strategies can be agreed upon, successful implementation requires not only firm political commitment, effective and visible stewardship, and adequate resources, but also sufficient management and planning capacity and an effective, integrated M&E system at all levels.

**Romania**

Since its revolution in 1989, the population of Romania has been declining (5% from 1992–2006) because of emigration, decreased birth rate, and increased mortality. Health status is poor, with life expectancy significantly shorter (for both men and women) than other European countries and among the highest infant and maternal mortality rate in the European region. Noncommunicable diseases, particularly cardiovascular diseases, are the greatest cause of death.

The health care system in Romania has been reformed significantly since independence. For example, “by 1998, the centralized, tax-based system had been transformed into a decentralized and pluralistic social [mandatory] health insurance system with contractual relationships between purchasers, the health insurance funds and health care providers.”

The mandatory health insurance scheme, which covers the entire population, entitles patients to a “complete” package of basic benefits, ranging from health services to medicines and medical devices. Patients have their choice of providers, thus increasing their participation in decision-making.

PHC is provided by family doctors that are independent practitioners contracted by DHIFs (District Health Insurance Funds). Family doctors are the main points of entry into the health system. Their gatekeeping role was “strengthened in 1999 by introducing direct payments for hospital admission without a referral from a family doctor.” In other words, patients are charged if they visit a specialist without a referral from a family doctor. The integration between PHC and secondary care is further strengthened by the requirement for specialist doctors to send a “medical letter” to the family doctor who provided the referral.

Shortly after independence, different payment mechanisms and decentralization plans were piloted through support from the World Bank, as well as pilots of changed provision and payment for general practitioner services. These pilots were stopped in order to introduce the new national insurance scheme.

The major objectives of reform were “universal and fair access to a reasonable package of health services, control of costs of health services and efficient delivery and allocation of resources. To date, the objectives have not been reached, due to the scarcity of resources, lack of experience and ongoing changes in the political and economic environment.”

However, recent developments suggest that health is a government priority. Moreover, because of the European Union accession process, Romania has been required to harmonize legislation with European Union requirements. However, there still is a gap between the legal developments and actual implementation on the ground, mainly a result of poor administrative capacity, lack of accountability mechanisms at the local level, inadequate communication between public institutions and insufficient management skills among elected officials at the local level and administrative personnel.”

The role of USAID in Romania has primarily been to support “training programs and the development of specific curricula for the health sector and also in efforts to reform the reimbursement of hospitals through the diagnosis-related group project; a US$5 million program has been dealing with the reproductive health issues in Romania since 2000.”

“In 2001, USAID…implement[ed] the Romanian Family Health Initiative (RFHI) with the goal of scaling up integrated family planning nationwide, focusing on rural areas.” The RFHI
“expanded access to family planning services and supplies by integrating family planning” into PHC. As a result of this project, “contraceptive prevalence increased significantly, and there was a concurrent and dramatic decrease in abortion rates.” Most recently, the USAID Romanian Health Care Reform Program (2006–2007) “was designed to actively address and implement activities for health care reform, reallocating resources to the primary health care (PHC) system and to strengthen and improve services.”

**Russian Federation**

The Russian Federation is the world’s sixth most populous nation. Although the Russian Federation has a higher level of economic performance compared with other E&E countries, it is one of the five most vulnerable countries in the region. It had the highest adult mortality in the E&E region in 2007, as a result of severe communicable and noncommunicable disease epidemics. Alcohol-related accidental deaths and HIV and TB incidence (and drug-resistant TB) combine to place an extraordinary burden on the health system. “In terms of sheer numbers, [the Russian Federation] is experiencing the most striking case of population decline in the region.”

Historically, there were positive elements to the Russian health care system. “During the Soviet period basic health services were made accessible to the population at large, including rural dwellers. Easy access to specialists was a particular feature of the system as developed.” Like other countries in the region, however, lack of financing for these systems led to their deterioration and suboptimal service for patients. Because of the increasing specialization of polyclinics, physicians were unable to “coordinate the treatment and prevention activities of his/her clinic, or constantly monitor the condition of patients and their families.”

Near the beginning of the 21st century, physicians “account[ed] for 37% of health workers in the Russian Federation, and nurses for 63%, while in the economically developed countries the corresponding figures [were] 14–25% and 75–86%, respectively.”

After the USSR divided, the new Government of the Russian Federation attempted to reform PHC by replacing its polyclinic model with general (i.e., family) practitioners with little success. Nonetheless, in recent years PHC has increased its status. The National Project on Health identifies PHC as a priority, and as a result, in 2006, salaries for those working in PHC were raised drastically.

Although the GP model has not succeeded in the public sector, it has gained traction in the private sector. New private clinics typically employ FM doctors, paid more in recognition of their broader skills, “because of a perception that such doctors will increase efficiency.”

Efforts to replicate this in the public sector have generally failed, because of the significantly higher salaries expected by such doctors. Like many other countries, such as the Ukraine, existing specialized staff and the general population also resist such changes. Many fear that, because FM physicians/GPs do not receive extensive training in a particular area (such as gynecology or pediatrics) they will be unable to adequately detect and/or manage more complex health issues.

In 2010, “cooperation on health continues to be a positive area of collaboration between the U.S. and Russia... USAID-supported activities help strengthen the health and social welfare systems by training practitioners in international best practices, management and policy skills, developing interventions and adapting guidelines appropriate for Russia. USAID focuses on improving access to family planning, promoting women’s and children’s health, controlling infectious diseases such as HIV and TB, and promoting individual responsibility to health. The portfolio has transitioned to a stronger focus on institutionalizing best practices in centers of
excellence at the federal and federal district level to disseminate lessons learned to surrounding regions.”

**Ukraine**

The Ukraine, which became independent from the USSR in 1991, is the second largest country in Europe, second only to the Russian Federation. Since independence, the health status in the Ukraine has deteriorated. The main causes of death in the Ukraine are diseases of the circulatory system, although communicable diseases (primarily HIV and tuberculosis) are becoming increasing problems: the Ukraine has one of the fastest growing and most severe HIV/AIDS epidemics in Europe.

Like Belarus, the PHC structure in the Ukraine has changed very little since independence. Unlike Belarus, health care sector reform was a high priority on the national agenda shortly after independence, and progress was made in establishing legislative support for change. “The 1992 Principles of Legislation on Health Care in Ukraine established the principles of health system organization and the procedures for financing, of state control and supervision of health care, of organizing health services and drug supply and of ensuring healthy and safe living conditions for the population as well as the general conditions for medical interventions and safeguarding patients rights, protection of mother and child health, general principles of medical examinations, medical and pharmaceutical activities and professional rights and obligations of health personnel.”

Some significant, necessary steps toward implementation of the IPHC/FM model have been made. The Principles of Legislation state that PHC “based on the (territorial) principle of family medicine/general practice” would be the main mechanism for delivering health care in the country. Medical schools subsequently established departments of GP/FM to provide postgraduate training and, in 1997, FM was declared as a physician’s specialty. Practical implementation of these reforms has been inhibited, however, by debates about how best to administer, finance, and monitor and evaluate PHC services. These lengthy debates, however, are in reality simply a symptom of the key barrier: the lack of “acceptance of the specialty and its practitioners in the eyes of the government and secondary care” and by the general population.

Because of a lack of acceptance of FM, progress has not been made toward addressing these practical issues, and as a result the status quo has remained. The lack of respect for FM as a scientifically respectable specialty, combined with the drastically low wages of FM physicians, handicaps efforts to recruit and retain FM doctors. “Fifty percent of trained family doctors leave the service on a yearly basis, often pursuing careers in more lucrative work such as the pharmaceutical industry or even in the retail industry.” Specialists frequently refuse to be retrained as general practitioners/FM physicians. Patients generally demonstrate “little confidence in the family doctor” and prefer to seek care elsewhere.

Efforts to demonstrate the “value” of FM, which would be a useful tool to help change cultural perceptions of the field, are hampered by the lack of evaluation and analysis of the impacts of IPHC/FM: “Although family medicine is present, a longitudinal approach to its development predominates. This approach allows some change to occur, but the lack of any evaluation or research, which then informs further development in a cyclical manner, limits its usefulness.”

The USAID ZdravReform programs (1993–1997 and 1998–1999) attempted to facilitate implementation of the IPHC/FM model. USAID has also “supported health partnerships between American and Ukrainian health care providers to further the capacity of recently established family medicine clinics to provide high quality primary care service.” Despite these efforts, it seems likely that “in the foreseeable future the major strategy for restructuring the
health care system in Ukraine will consist of improving the management of the existing system."\textsuperscript{179}
ANNEX 4. LITERATURE REVIEW AND ANALYSIS

Assessment of Europe and Eurasia (E&E) Experience in Integrated Primary Health Care and Family Medicine

Literature Search, Review, and Analysis

THIS DOCUMENT

An independent team of consultants has been recruited to assess the experience of the USAID Europe and Eurasia (E&E) Bureau with Integrated Primary Health Care (IPHC) and Family Medicine (FM). According to the workplan for this project, one product the assessment will be a literature search, review, and analysis (LSRA). This document is that LSRA.

Project Objectives

According to the Statement of Work for this GH Tech project, the project is an “Assessment of Europe and Eurasia (E&E) Experience in Integrated Primary Health Care and Family Medicine.” The objectives of that project are to:

- Document the experience of E&E countries in implementing the IPHC development approach based on the framework of FM and health systems strengthening (HSS).
- Assess the strengths, weaknesses, opportunities, and threats of the IPHC approach, taking into account the effectiveness—or ineffectiveness—of the approach in achieving health outcomes and building health systems capacity.
- Provide recommendations to E&E Missions, host countries, and development partners on how they can more effectively implement integrated PHC programs in the future.

About this Document

The LSRA will describe the experience to date of E&E countries and development partners in implementing the IPHC/FM approach. It will identify the key constraints that E&E countries face and the strategies they are using to address them.

The material in the LSRA is organized in three chapters:

- Trends in IPHC/FM
- Experience of IPHC/FM in E&E Countries
- Factors related to the success of IPHC/FM Programs

TRENDS IN INTEGRATED PRIMARY HEALTH CARE/FAMILY MEDICINE

Introduction of Primary Health Care

There are many definitions for PHC. This reflects its different uses:

- As a strategy to “maximize health and well-being.”
- As a structure created within a health system to enable that end.
- As a process for delivering health care services to patients within a community.

Strategically, PHC aims to ensure access to “basic health care for all people” in a country. Equally important to the strategy is the approach taken to ensure access. As described in the 1978 Declaration of Alma-Ata, which first elaborated the strategy, PHC “is based on the
principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system.” Within a national health system, the PHC strategy provides “universal, community-based preventive and curative services, with substantial community involvement.”184

There are many reasons why the PHC strategy appeals to the international community. It addresses “basic diseases that constitute most of a developing nation’s disease burden,”185,186 which are often ignored by disease- or condition-specific campaigns. Other assessments have concluded that “there are advantages for health systems that rely relatively more on primary health care and general practice in comparison with systems more based on specialist care in terms of better population health outcomes, improved equity, access and continuity and lower cost.”187 Because of these and other factors, developing countries are often encouraged “to focus their resources at [the PHC] level of health services.”188

The appeal of this strategy is founded in history. During the late 1960s and early 1970s, the vertical approach used in malaria eradication by U.S. agencies and the World Health Organization (WHO) came under considerable criticism:189 “Large numbers of the world’s people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have…the most serious health needs cannot be met by teams with spray guns and vaccinating syringes.”190

Structurally, PHC is “the basic level of health care provided equally to everyone,” manifesting at “the first point of health care contact.” Often represented as the base of a pyramid of health care,191 services provided at the PHC level address “the most common problems in the community” by providing “practical, scientifically sound and socially acceptable methods and technology…at a cost that the community and the country can afford to maintain.”192

Although the term “primary care” was coined in the early 1970s, the model for delivering PHC services drew upon and was inspired partially by practices that had existed for many years, such as found in Indian rural medicine193 and the “barefoot doctors” of rural China.194

Following this model, problems that require more specialized medical expertise are addressed in secondary care, while especially challenging cases are treated in tertiary care.195 In other words, PHC providers are “distinguished from their secondary and tertiary counterparts by the variety of problems”196 they encounter and treat.

Practically, PHC often refers to the health care services themselves, which may be delivered at a physician’s office, a health post, health center, or even in the outpatient department of a hospital. The physician provider may be a general physician, or trained and certified as a specialist in one of the so-called primary specialties such as pediatrics, internal medicine, gynecology, or FM. In many countries, non-physician auxiliaries (nurse practitioners, physician assistants, clinical officers, medical assistants, and so on) may be the actual providers of care. PHC may be either initial encounters, or follow-up visits, and may include health promotion and disease prevention activities, as well as clinical services. Thus, PHC is defined not so much by the nature and credentials of the provider or in general by the complexity of the specific care provided, but by the location and nature of the site in which it is provided.

**Selection and Integration of PHC**

Although originally intended to be a comprehensive approach to delivering health care for all, many experts argued that “limited funding, personnel and weak health systems” in countries made it impossible to implement PHC at such a scale.197 As a theoretically more effective, realistic, and measurable alternative, in the late 1970s, some experts advocated for a different model: Selective Primary Health Care.
Selective Primary Health Care (SPHC) aims to tackle the main disease problems of poor countries by delimiting the services rendered in the PHC setting to the most important disease conditions in a community. It does this by deploying a limited package of specific, low-cost technical interventions in PHC settings.

Since its introduction, several SPHC “packages” have been implemented, such as the GOBI strategy for child survival (1982), the African Child Survival Initiative (1981–1993), and Integrated Management of Childhood Illness (IMCI, 1990s). The SPHC approach “guided much of the efforts over the past three decades” with generalized disease epidemics (e.g. HIV, Malaria, TB) and “addressed childhood illnesses, such as pneumonia, diarrhea, malaria, measles and malnutrition.” Simultaneously, bilateral and multilateral donors have worked to strengthen the capacity of Ministries to implement universal PHC systems, so as to augment and improve the effect of these targeted interventions.

Over time, more technical areas were added to country health programs, raising questions about how they could be better coordinated and managed. Many felt that “it is at the entry point of the system, where people first present their problem, that the need for a comprehensive and integrated offer of care is most critical.” The Integrated Primary Health Care (IPHC) model was developed to help accomplish this by integrating PHC services at the point of contact, thus ensuring that “the delivery system is designed to meet the holistic needs of an individual when they go to a health facility,” while at the same time “capturing the...advantages of joint programming” among donors, governments, and other institutions.

Some argue that in order to be effective, PHC must be integrated “around the particular needs and situations of individuals—along with systems of care that can take into account the needs of particular communities and populations.”

Operationally, IPHC refers to a one-stop service delivery model “in which an individual or family visits its local, primary care unit or general practitioner as the first point of encounter within the health care system.” The PHC provider (the gatekeeper) “either treats the patient or refers the patient to a specialist, if necessary.” If this function is well established, a patient cannot access a specialist unless referred by the gatekeeper.

There are similarities between IPHC and SPHC. IPHC can refer either to a setting in which PHC is provided to a wide range of patients (children, adults, pregnant women, and so on) or to a combination of traditional PHC services with disease entities of special importance (e.g., HIV/AIDS, TB)—or to both.

Among others, USAID and its partners have helped introduce the IPHC model in Central Asia, Russia, and Ukraine in the mid-90s, and extended it to Albania, Romania, and the Caucasus countries in the early 2000s. USAID has supported IPHC initiatives through bilateral projects, “buy-ins” to Bureau for Global Health “Field Support” projects, and through the American International Health Alliance (AIHA) Health Partnerships Program.

From the work of USAID, partners, and governments there has been “promising, although limited evidence on the effects” of such strategies. “Integration is intended to reduce differences in access and use of health services between geographical and socioeconomic groups, but this can only be expected to the extent that it is targeted at disadvantaged populations and is effective.”

One risk of integrating PHC services that has been identified is that it could result in overworked or unskilled health workers or the inability/incapacity to deliver specific services. To minimize this risk, USAID and others have implemented the IPHC model within the framework of FM and Health Systems Strengthening, sometimes referred to as diagonal approaches—which “aim for disease-specific results through improved health systems.”
The Family Medicine Framework and Health Systems Strengthening

FM is a medical specialty devoted to comprehensive health care for the individual and family across all ages, sexes, diseases, and parts of the body. The aim of FM is to provide personal, comprehensive, and continuing care for the individual in the context of the family and the community.

FM physicians are specially trained and certified to practice with a perspective on all members of the nuclear family (father, mother, and children). However, “the definition and role of the family physician vary by country.” Although most likely to be found in PHC settings, in many countries they admit and care for patients in hospitals, conduct deliveries, and even perform surgery.

IPHC is often implemented within the framework of FM because “[h]ealth system performance can be enhanced if a strong FM-centered primary health care (PHC) level is present.” In such cases, “family physicians play an important gate keeping role, with the family physician being the first point of contact in the health system, with the exception of some emergencies.”

Depending on the needs of patients, however, the composition and organizational model [of FM] can change over time, in some cases manifesting as a single FM physician, while in others as “a group practice which collectively responds to the local family’s health care needs.”

Many factors can influence the quality of care delivered by family physicians in PHC settings, ranging from training in FM, to organizational arrangements (e.g., management capacity and approaches, resource availability, enforcement of the gatekeeping role), to financing and provider payment systems. Cultural factors, such as the characteristics of physicians and doctor-patient relationships also contribute to the quality of care.

Underpinning the success of efforts to integrate PHC through FM is the functioning of the overall health system in general. Since the early 21st century, leading global health financing institutions and donors have recognized that “strong and effectively functioning health systems are considered a prerequisite to scaling up cost-effective interventions for reducing disease burden and for achieving the health MDGs.” Put simply by the World Bank Strategy for Health, Nutrition, and Population Results, “well-organized and sustainable health systems are necessary to achieve results.” HSS is now regarded by many as a “first-order” goal to “create the necessary enabling institutional and systemic environment to achieve and sustain” longer-term goals.

USAID augments its support for IPHC/FM in most countries with HSS efforts, through its Bureau for Global Health’s (GH’s) Global Health Systems Program. USAID’s approach to HSS combines “field-level assistance with technical leadership” with an emphasis on six “building blocks” of health systems: “Service Delivery, Health Workforce, Health Information, Pharmaceutical Management, Health Financing, and Leadership/Governance.”

Health Systems in Eastern Europe and Eurasia

Prior to 1990, the health systems of most countries in E&E were based on the Semashko model developed in the Union of Soviet Socialist Republics (USSR) in the 1920s. This model led to “publicly funded, centralized…health systems with universal or close to universal entitlement to free health care.”

Health systems based on the Semashko model had some success in dealing with wide-scale public health issues, such as TB and malaria; however, they tended “to neglect primary care.” To meet public health needs these systems emphasized hospital care by specialized medical doctors. In urban areas, primary care “was provided in polyclinics [or] at community facilities, often of poor quality” in urban areas. Primary care in rural areas consisted of ambulatory...
services or, in many cases, services delivered in often under-resourced health posts “by
feldshers (paramedical workers), nurses, and midwives.”

This focus on infectious diseases and epidemics, combined with a culture of politicized
investment decisions, resulted in systems that were “inefficient and unresponsive to patients’
demands and needs” and ultimately led “to an imbalance in the overall structure of healthcare
provision.” The primary care sector was particularly weak, both in terms of physical
infrastructure and human resource capacity. “Low prestige and poor pay reduced the quality of
entrants into the primary-care sector and also encouraged the de facto privatization of services
via moonlighting or the levying of informal charges for supposedly free services.”

As a result, by the 1990s, the health care systems of most countries in E&E had eroded because
of underinvestment and generally consisted of “overstaffed, overspecialized hospitals, [which]
countries were unable to sustain.” These systems have “profound inefficiencies,” none
more so than the “imbalance between the hospital and primary care sectors. Hospitals
consume[d] more than 70% of the health care budget [in 1999]. The health delivery system
inherited from the Former Soviet Union can be likened to an inverted pyramid. The hospital
sector at the top of the pyramid is overdeveloped and the primary health care sector which
should serve as the broad base of the pyramid is underdeveloped, underfinanced, and
underutilized.”

The countries of Central and Eastern Europe have been faced with major challenges as they
sought to “reform their health systems by moving from a centrally planned system driven by
planning to a pluralistic model, increasingly funded by social insurance.” Some of the most
serious challenges faced include “diminishing public resources available for health care, increasing
user charges and rising poverty levels.”

There also serious clinical challenges faced in the PHC sector. Historically, PHC was provided
by physicians “with incentives to refer quickly to specialists.” Training of physicians has been
inadequate and, as a result, “conditions that should be effectively treated in the primary care
sector are treated in the hospital or by specialists at polyclinics.” In addition, many of the
extensive vertical programs that exist “also should eventually be integrated into primary
care.”

In nearly all of these countries, “[t]he long-term vision of primary care is the development of
family medicine.” This is seen as particularly important because of the problems faced in
providing health care in rural areas. In such areas, “primary care clinics [increasingly] have only
one physician. This means that an internist, by necessity, is forced to become a family physician
and see women and children also, even though she was only trained to see adults. . . . However,
to create a sustainable system of family medicine one cannot only train family physicians to work
in rural areas. Physicians would not choose this ‘specialty’ if they could only work in rural
areas.”

**Emerging Trends in Health in Eastern Europe and Eurasia**

Although health conditions vary across the E&E region, there are several generalized trends that
should be accounted for in approaches taken to improve PHC in that region. Some of the most
important ones include:

- The populations of many countries in the E&E region are both shrinking and experiencing
  increased life expectancy. This leads to fewer economically productive people “to support a
growing number of older dependents in future years.”

- Mortality rates vary significantly between countries and subregions, stagnating in some cases
  and increasing in others. Mortality is generally much higher among males than females. Both
  factors are “associated with lifestyle and behavioral factors, especially male alcohol
consumption and smoking patterns and failed control policies. Noncommunicable diseases produce the largest burden of mortality."  

- The under-5 mortality rate in most countries has dropped significantly in most countries, indicating that living conditions and access to health care have generally improved. However, some countries have rates that are more than five times higher than others, “suggesting possible socioeconomic problems that particularly affect newborns.”  

- There is insufficient public expenditure for health, and the cost of health care is increasing. Several countries, including Albania, Georgia, Russia, and Uzbekistan, have seen a decline in health expenditure as a percentage of GDP since 2002, while others, such as Serbia, Slovenia, and Turkmenistan, have seen a fall in the amount of public sector funding as a percentage of GDP. Azerbaijan and Tajikistan have among the lowest public health expenditure levels in the world. Overall, however, the picture shows continued growth in health care spending per capita across the region, more than doubling between 2002 and 2006. Health care costs are projected to increase by several percentage points of GDP by 2050. Corruption—amenable to corrective action when the political will exists—is a primary impediment to the use of health funds and success of health systems in the E&E region. Out-of-pocket health expenditure as a percentage of private expenditure on health is more than 80% in the region and has been climbing steadily between 2002 and 2006. Closely linked to the goal of financial protection is the goal of equity in finance, which means that people with lower incomes should not pay more as a percentage of income for health services than people with higher incomes. Effective health services are one crucial element in addressing the relationship between the social determinants of health and inequity in health and in counteracting the rising inequity in health in both high-income and low-/middle-income countries in the region.”  

- There is a need for a “more systematic collection of health and socioeconomic data of greater accuracy and reliability.” Routine, standardized collection of high quality health-related data is poor or nonexistent in many countries; vital statistics, epidemiologic, socioeconomic, health service delivery, risk factor, and health service information is often inadequate to confirm trends or plan interventions. In several cases, capacity to conduct analysis is inadequate even should such data be made available.

EXPERIENCE OF INTEGRATED PRIMARY HEALTH CARE/FAMILY MEDICINE IN EUROPE AND EURASIA COUNTRIES

Material from the country-specific literature review and analysis is included in the narrative of each Country Assessment, including its bibliographic reference (See Annex 3).

For convenience of the reader, only the bibliographic references of this country-specific material is included here as part of the Literature Review and Analysis.

Factors Related to the Success of IPHC/FM Programs

This section describes seven factors that the assessment team considers to be essential to successful integration of PHC/FM and provides recent examples, from E&E countries, of how these factors contribute to (or hamper) integration:

- Social and Political Commitment at National Level
- National Capability, Sustainability, and Replication
- Human Resources and Management Systems
- Cost Effective and Appropriate Technology
- Health System Linkages and Integration
• Monitoring and Evaluation

Social and Political Commitment at National Level

• “In the immediate aftermath of the collapse of communism, each country faced a major economic shock, with falling economic output and rising inflation…expenditure on health services began the 1990s at a low level and has declined further in real terms in most countries due to the fall in economic output.”243

• “All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country’s resources, and to use available external resources rationally.”244

• “Implementing PHC reforms is a complex strategic change process and there is insufficient managerial capacity to accelerate the pace of development. It is necessary to rapidly develop a critical mass of middle and senior level managers and health professionals to act as change agents along with local capacity to deliver training programs. Moving out of ‘pilot’ and ‘experiment’ mode is critical to institutionalize and systematize changes by timely update of laws and regulations to sustain the momentum.”245

• “While it is necessary to invest in key individuals to develop champions of reform, this must be balanced with efforts to widely engage stakeholders to achieve consensus on reform objectives. The experience of the five countries studied confirms the importance of combining bottom-up and top-down approaches with simultaneous investment in key individuals, institutional development at different levels, and institutionalization through appropriate laws and regulations.”246

• “PHC did not achieve its goals for several reasons, including the refusal of experts and politicians in developed countries to accept the principle that communities should plan and implement their own healthcare services.”247

• “Finally, the key groups necessary in industrial relations negotiations in a modern industrial state, be they employers, trade unions, or professional associations, are still very weak. Under communism it was not possible to develop these elements which are necessary for a functioning civic society. Indeed, the growing evidence that such a society, based on trust, participation, and cooperation, leads to sustained improvements in health and wealth is of special relevance to the process of political reform in this region.”248

• “In countries which receive technical assistance from different international agencies, the coordination of donor assistance is vital in improving investment efficacy and avoiding redundant activities.”249

• “Although the general environment may have become more favourable towards reform in recent years, more attention may be needed to create a process of policy design and implementation that is effective at changing established structures….In addition, strategies to work with other government sectors and to involve stakeholders from the implementation and local community level more systematically appear critical for reaching broad political consensus and for making reform proposals operational, that is, moving from reform proposals to implementation.”250

• “Problems in the development and implementation of reforms in the mid-1990s occurred rather more as a result of a lack of shared vision and political will than factors such as poor infrastructure or administrative skills. An example of positive conditions for successful reform is the introduction of the scheme for financing and regulating family medicine in 1997. Although this reform was initiated on the basis of a ministerial decree alone, it was seen as necessary by important stakeholders such as leading players in the Ministry of Social Affairs, the Estonia Health Insurance Fund (EHIF), the county doctors, the newly trained..."
family doctors and the University of Tartu Faculty of Medicine. The joint efforts of these groups made the preparation and implementation of the reform possible within a 9-month period.”

National Capability, Sustainability, and Replication

- “[T]he health reform process in Central Asia is redefining how information is collected and used in the health sector. New health management information systems are generating better quality information that can be assembled and analyzed in a way that is useful to health managers and policymakers for improving clinical practices, the management of resources, and other aspects of health facility performance. Linking this information into a system of health policy evaluation extends the generation and feedback of information for continuous quality improvement of the health system as a whole as an inherent part of the process of health reform.”

- “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 specialty. 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.”

- “Moving out of ‘pilot’ and ‘experiment’ mode is necessary to institutionalize and systematize changes to sustain health system reform. Continuing development in a pilot mode, with multiple projects, result in sprinklings of pockets of innovation without coherent systemic change.” (Review of Experience of Family Medicine, World Bank, 2005)

- “International agencies have played an important part in changes that have taken place. However, their role often concentrated on the transfer of ideas rather than on building domestic capacity for policy analysis and planning. Inevitably, foreign experts who had prominent roles in the early days often had little insight into local situations. Furthermore, assistance often bore little relation to the major health challenges faced by each country.”

- “Evidence of the effect of health reforms from the past two decades is unfortunately sparse. Moreover, little sharing of available evidence took place. This situation might be changing as countries become increasingly interested in assessment of their reforms.”

- “Gillam notes that most developing countries have failed to provide even basic primary healthcare packages. Weaknesses in primary healthcare services often result from a variety of forces, including economic crises and market reforms, which limit the range and coverage of services and thus their effect on health. On the positive side, between 1997 and 2002, financial support to improve health care in developing countries increased by about 26%, from $6.4bn (£3.3m; €4.4m) to $8.1bn. However, most aid was allocated to disease specific projects (termed ‘vertical programming’) rather than to broad based investments in health infrastructure, human resources, and community oriented primary healthcare services (‘horizontal programming’).”

- “In low-income settings PHC is cost-effective… Even in resource-poor settings, it is possible to implement and sustain key PHC services…. Shifting care from narrow specialists to family physicians and from secondary to primary care has been shown to be cost-effective, without adverse effects on health outcomes.”

- “The necessary data for assessing the technical efficiency of the system objectively are not available, but the reliance on high-cost diagnostics as standard practice and the weak gatekeeping function of primary care providers would indicate, on the basis of international experience, that the current system does not provide good value for money. There are
major disincentives to increasing the efficiency of the health sector in the current health financing and service delivery system.”

- “The ‘single payer’ system gives the MoH very good strategic potential to use health financing policy as a lever for improving the health system. It makes possible implementation of a single policy in terms of determining financing priorities and the structure of health care provision, as well as effective purchase of medical services from providers that have managerial and financial autonomy. Those countries which have achieved substantive reforms—such as major service reconfiguration, more equitable distribution of resources, and improvement in quality—have almost always used provider payment and contracting reforms as a major driver of change.”

- “Since budgets are calculated based on the number of beds rather than the quantity and quality of services actually provided (outputs), productivity is not encouraged and it may be lucrative to maintain or even expand physical capacity (number of beds and staff) regardless of actual use. In addition, rigid line-items and the loss of unspent funds do not provide incentives for hospital administrators to contain costs. The health financing reform approved by Presidential Decree in 2008 foresees a shift towards contracting and performance-related payments in the fullness of time.”

- “The quality of service provision is hampered by insufficient upgrading of the skills of health staff through continuous medical education and, to some extent, by poor equipment and supplies. Incentives that motivate medical personnel to systematically provide the best possible quality of care remain weak in the current system.”

- “The challenge lies in making the delivery system more patient-centered and coordinating care at the primary level, with the development of additional nursing and rehabilitation services. The current reforms support the widening of the scope of primary care, in terms of more involvement of nurses on individual consultations and setting incentives for practices in general. Further expansion would enable more efficient use of resources and ensure better access to and quality of care.”

- “Per capita payment is the payment of a fixed amount each month or year to PHC providers for each enrolled individual, regardless of input use or utilization. Per capita payment has been introduced in the region to address the inequities of historical budgeting patterns; facilitate the shift of resources from the hospital sector to PHC; and set in motion an ongoing cycle of strengthening PHC, reducing unnecessary hospital services, and thus freeing up additional resources to continue to strengthen PHC (Cashin et al. 2009).”

- “There is some evidence of effective strategies for improving quality of care in the private for-profit sector. In view of the importance of this sector in many low-income and middle-income countries, these approaches could be worth pursuing. However…there are important questions regarding the weight to be given to investing in strengthening the private sector versus strengthening the public sector. Whatever choices are made, governments need to develop capacity to ensure effective, efficient, and equitable health care delivery, since this stewardship role cannot be left to the market alone.”

**Human Resources and Management Systems**

- “The overall goal is to create a single unified undergraduate/pre-service curriculum, which would create a single profile physician, known as a family physician, also sometimes called a general practitioner. A feasible scheme would be that after completing a general internship, this doctor would then be able to practice medicine. After her internship, she could opt for further training through a residency program to become a family medicine specialist. These residency programs would be developed to train hospital-based specialists like surgeons and cardiologists, but there would also be a new residency program for family medicine specialists. This would create a medical education system similar to Western countries like
the United States and Great Britain. The first step in the process is developing a cadre of family medicine trainers based in the medical institutes who will become the agents of change in developing family medicine. The critical point to understand is that since there is no system of family medicine, there are no family medicine trainers.”

- “One of the major challenges in implementation of family medicine was training family doctors. This training often lagged behind the introduction of new employment and payment systems. Many countries tried to transform specialists into generalists with short courses. However, this strategy has had little success, raising questions about the ability of some former specialists to provide care beyond their specialty area. In addition to concerns about the qualifications of many retrained family doctors, which have also been raised in western Europe, the new training programs have struggled to meet demand.”

- “The development of family medicine through the medical schools is a long-term process. In the best scenario, the first graduating class for newly trained generalists from medical school will not occur for another five years and this does not even include any possible residency programs. Therefore, the changes in the medical school system must be complemented by an extensive re-training program of existing physicians, to complement on-going health reforms.”

- “The evidence showed that the supply of family physicians and their geographic distribution, consultation length, type of after-hours primary care arrangement, waiting time, and targeted service provision are critical features of access that affect primary care outcomes.”

- “In the conditions of decentralized management of health care organizations, selection and appointment of managers of health care organizations is an essential factor for effective system functioning and quality service provision.”

- “Overcapacity in urban areas with severe undercapacity in rural districts is also still a feature of the system, despite many schemes to improve efficiency.”

- “Primary health care was neglected and, by the 1990’s, health services were delivered in dilapidated facilities by low paid staff….Health services were concentrated in relatively expensive hospitals which took most of the health budget and encouraged excessive medical specialization, while primary health care services were neglected…typically staffed by low status doctors offering very poor quality services.”

- “These countries ‘have an over-supply of doctors with 4.1 per 1000 population compared to the established market economies with 2.5. There is considerable variation in the region, however, with high ratios in the countries of the former Soviet Union.’ ‘Income is difficult to estimate as doctors can earn bonuses of up to 50% over their standard wage as well as gratuities….For example, some specialist doctors in Albania can increase their income five times through ‘presents.’”

- “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.”

- “Throughout the region there is an urgent need to tackle the imbalance between doctors and nurses (and other skilled staff). This will be very difficult, especially in the former Soviet countries, where there are large numbers of poorly trained doctors who have received very little continuing education and whom it will be difficult to retrain.”
• “A small proportion of the health care workforce in these countries is highly qualified, such as some doctors, but most have only low levels of training. Each country faces major challenges in moving medical education away from a highly didactic teaching method concentrating on factual knowledge of specialized topics that are frequently of little relevance to the population they will treat. Doctors need a greater level of practical training with a reorientation towards common conditions and the broader societal aspects of medicine.”

• “New training programmes will have little effect if working conditions are so poor that trained staff leave the service, moving either to the private sector or abroad.”

• “Licensing standards and clinical quality guidelines are enforced partially and are not obligatory. Most hospital doctors’ income is informal. Both public and private hospital specialists seem to combine some form of employment with a low salary from government budget, with informal fees-for-service negotiated with patients and informal payments to hospital directors for admission privileges to particular hospitals. It is vital to bring these arrangements into the formal economy, and make them more transparent in Armenia.”

• “Continuity of care presents another challenge: bringing outpatient care and high-quality hospital services close to patients without long waiting lists. All this hinges on the availability of human resources, particularly nurses, who for several years have been migrating to neighboring countries or leaving nursing for jobs outside the health sector.”

• “Primary care services are equitably distributed across the country, with financial incentives in place to encourage family doctors to work in rural areas. However, there is concern regarding how to motivate doctors and nurses to work closer to the client in rural areas. To build relations in terms of prevention and promotion, the quality bonus system was introduced for family doctors and a number of screening programs are in place.”

• “To reduce excess capacity in the health system, shift from hospital services to more cost-effective PHC, provide incentives to modernize outdated clinical practice and be more responsive to consumers, provider payment systems must move toward reimbursing health providers for actual health services delivered rather than physical infrastructure, and must allow consumer choice of provider.”

Cost Effective and Appropriate Technology

• “Medical technology in terms of techniques, drugs, equipment and procedures are crucial in the delivery of primary care. Appropriate development and use can be stimulated at governmental level by developing a national policy or strategy concerning the application of ICT in primary care, and by organizing guidance to government and providers on technology appraisal on the use of new and existing medicines and treatments.”

• “The principle of community participation and the use of appropriate technology have proved to be effective strategies in combating some diseases. For example, the eradication of guinea worm in African countries was accomplished without new drugs or vaccines, but through grassroots public health interventions on the modest budget of about US$ 225 million for a 20-year campaign.”

• “The increase in capital investments, primarily in the renovation or construction of hospitals, in new expensive diagnostic equipment, and to some extent in the health information system, is expected to increase the range and quality of services provided. However, as the state recognizes, significant investments in human resources are needed to ensure effective use of the new equipment. Since the mid-1990s, there has been an insufficient adjustment of human resource capacity to demand with regard to skill mix and geographical distribution. The modernization of the medical education system has been slow and this has had a negative impact on the level and scope of knowledge and skills obtained by graduates. For
this reason, in July 2009 after the passing of the Law on Education, the Ministry of Health was directed to revise the entire medical education curriculum.”

- “The prices of pharmaceuticals are currently not controlled, indicating that the potential of government-negotiated price reductions and facilitation of the import of generic drugs may be underexploited (see Section 6.6 Pharmaceutical care). A recent study revealed significant problems with rational drug use (Analytical Expertise Centre for Medicines, 2009). To address this, the Ministry of Health started the development of evidence-based clinical practice guidelines and took measures to strengthen the system of prescriptions. In practice, however, pharmacies still sell prescription drugs over the counter, with the exception of controlled drugs. Moreover, the high share of out of pocket payments also increases the influence of patients and doctors on the choice of diagnostics and treatment, which may not always follow criteria of rational use and cost-effectiveness.”

- “Regulation and oversight of the system probably remains the biggest single challenge as it affects all aspects of health care in Georgia, including the production of human resources for health and the quality of care. Actively building the regulatory environment will involve more stringent and transparent enforcement of laws and regulations. Transparency is an essential prerequisite for increasing accountability in the system and building public trust, indeed, transparency in decision-making is a part of the stewardship function. Greater transparency and accountability are necessary to avoid conflicts of interest, particularly in a marketized system. Developments in the regulation and oversight of the system could support improvements in the rightsizing of service provision; improvements in quality and efficiency; speeding up the fulfilling of investors’ obligations to the public and the government; and increasing the accountability of insurance companies.”

- “Modern, centralized acute and high-technology care increases the need for attention to geographical access and the development of outpatient services close to the patient(s).”

- “There is evidence that user fees reduce the use of necessary (as well as non-essential) health services and drugs, thereby further disadvantaging poor populations. However, removal of user fees needs to be accompanied by policies to remunerate health workers adequately, as well as alternative means of financing health care. Other financial mechanisms to improve access to health care need to be assessed, including community-based health insurance and social health insurance schemes. Evidence of the effects of community-based health insurance, particularly on poor populations, remains weak.…In general, the removal of financial barriers to essential medicines and services should be considered. Some form of risk sharing is needed, although how best to do this will differ across contexts. A systematic approach is needed for the design, monitoring, and evaluation of alternative models, and should include a description of how revenue is collected (eg, through general taxes, health insurance, donor funding), the type of organization that collects revenues (eg, public, private not for-profit, private for-profit), who and what is covered, how funds are allocated, from whom services are purchased, and how service providers are paid.”

### Health System Linkages and Integration

- “Political commitment at all levels is vital and is seen in the support for the reforms that are addressing some aspects of the rationalization of health services. Integration of vertical programs has not been accepted as a necessary and cost-effective use of limited funds.”

- “The subject of this book is not the broad societal strategy of primary health care as laid out at Alma Ata, but rather the more limited area of primary care as a subset of functions or services delivered specifically within the context of health care systems.”

- “In countries such as Denmark, the Netherlands and the United Kingdom, GPs have a central position in the health care system. This is mainly based on their role as ‘gatekeepers.’…To sum up, two gatekeeping roles can be identified. First, their control of
the use of specialist, hospital or other expensive services, is meant to reduce or restrict health care costs, i.e., GPs act as a mechanism for rationing services. Secondly, they are expected to improve or maintain quality of care through their coordinating role. In this way, GPs are considered as the coordinators of the whole packages of care that is received by a patient, which could improve continuity. Therefore gatekeeping can be seen, at least in theory, as an organizational mechanism to promote integration, although problems can exist in implementing this mechanism."

- “In the United Kingdom in the NHS system, the principal focus has been on problems of coordination across the primary/secondary care (hospital) interface, particularly poor communication due to professional rivalry between hospital doctors and GPs. Several causes for these problems can be identified. One is the organizational boundary between (generalist) primary and (specialist) secondary care. Furthermore, the two core disciplines of primary care—general practice and home care—are organized and financed separately. These boundaries are now the main obstacles to the provision of integrated care tailored to the needs of individual patients (see De Roo et al., 2004).”

- “An additional problem is the broad range of tasks that GPs perform (Moll van Charante et al., 2002). It includes preventive activities, acute curative care, care for patients with chronic conditions and sometimes emergency care (out of office). It is difficult to coordinate all these tasks inside and outside the general practice, especially with an average list size of 2250 patients. Therefore, workload is considered a threat to the position of GPs as gatekeepers in the Dutch health care system.”

- “In other systems general practice has not played such a central role. For example, in the French health care system patients have traditionally had a choice of provider. In central and eastern European (CEE) countries, common practice has involved a shift towards dispensers—specialized clinics for specific health problems. In the late 1980s, before democratization, this approach resulted in two basic types of Primary Health Care (PHC) settings. One is known as ‘home of health’ or PHC centers, which could correspond to group practice in western European countries. These centers mainly consisted of a group of PHC professionals: GPs and other PHC specialists (pediatricians, gynecologists), as well as other specialist: internists, oculists, dermatologists, etc. In the former Soviet Union, three PHC practitioners served as the basic PHC structure of so-called ‘threeplets.’ Their education would be similar to education of internists, pediatricians and gynecologists, but they worked together as a basic team responsible for PHC service. A slightly different system was created in ex-Yugoslav countries, where GPs were recognized as basic PHC practitioners. Most of them worked in PHC centers together with other specialists and they played a gatekeeping role within that context. The GPs role included a personal list of patients, keeping individual medical records of those patients and other administrative responsibilities.”

- “These structures prevented PHC practitioners from becoming individual practitioners offering personal care. Instead, the public perception of PHC practitioners was quite low. The 1990s transition in CEE countries was characterized by two parallel pathways: (1) recognizing PHC practitioners, mainly as GPs, as a basic element of the PHC service; and (2) privatization of health care. Both movements led to the disintegration of the existing PHC structure and put the GP in a new situation. The GP became the symbol of PHC overall in the professional, medical perspective and at the same time the GP became a private entrepreneur. The coordination role became more evident, but at the same time GPs were allocated important new tasks. Moreover, the coordination role was strongly related to other tasks: financial and organizational, professional development, obligations derived from contractual commitments, and medical educational preference.”
• “The structure of these new PHC settings suggests a broad collaboration, a great amount of teamwork and consequently a need for coordination. However, in the absence of a basic medical professional, the role of coordination was usually allocated to the health care manager or the local health care authority. These managers/co-coordinators were not always medical professionals. This system developed a paradoxical situation in which a group of PHC practitioners worked together but did not collaborate and coordinate their work.”

• “A stronger professional association of doctors, exercising leadership in professional ethics and internal discipline of the profession, could play a constructive role in helping to re-build the good reputation of the medical profession in the eyes of citizens, and in providing a reasonable partner for the MoH to consult and negotiate with regarding future health development strategy.”

• “Reforms in the health care system are closely linked to the social welfare system. The systems of health care and social welfare are relatively separate from each other, which causes problems in terms of the transfer of people between the different systems (Ministry of Social Affairs, 2005). The accessibility and quality of nursing care services is limited, due to the fact that the welfare and health care systems are financed from different sources….Many social care home residents also need nursing care, but the amount of care provided is constrained by limited resources of municipal budgets. As the target group of nursing care and welfare services is largely overlapping, integration and better coordination of services are required to respond more effectively to the varying needs of elderly and chronically ill people. Strategies to optimize integrated care in Estonia are developed by interdisciplinary working groups but at the time of writing have not yet been implemented. For successful implementation, consensus between the different care sectors is required, along with legislative support from state bodies. Changes are also needed in financing: both combined financing from the EHIF, municipalities and personal resources; and at the service organization level, in terms of descriptions of minimum requirements and quality requirements for all nursing and social care.”

Monitoring and Evaluation

• “Health reform efforts in the countries of Central Asia are well into implementation and are generating lessons to guide future reform strategies in the region and beyond. The experience gained from implementing health reforms should be analyzed and evaluated in a systematic way to determine whether the goals of reform are being met, and how implementation should be modified to improve the effectiveness of the reform programs. The function of health policy evaluation, however, has not historically been part of the Ministries of Health (MOH) of the countries of Central Asia, and there is very limited research and analysis capability in the MOH structure. The elaborate reporting systems in the government health sector generate large amounts of data, but this data is mainly used for compiling aggregate statistics and is not fed back to the system to be used to improve performance. There is limited capacity to carry out effective evaluation of health reform initiatives in the countries of Central Asia, and therefore evaluations of the reforms are often highly subjective and politicized. Future donor-assisted health reform efforts should build the capacity for health policy evaluation within the MOH, and establish a process for formative health policy evaluation, which provides feedback to the implementation process.”

• Research in this area [human resource issues that arise from the economic aspects of health care reform] is challenging because “accurate information systems on staffing trends and conditions are often not in place….Indeed, the one conclusion of the study is that the shortage of information presently available limits” its ability “to examine in detail the
situation in each country….The task of monitoring trends in employment is becoming more complicated with a greater diversity of employers.”  

- “A reasonable criticism of PHC is that it did not establish whether it was actually bringing about a quantifiable change in the health of populations in the early 1990’s.”  
- “In reality, very little emphasis is placed on regulating the quality of care and there is limited scope within the current health care system to monitor and implement such regulations…so it is not possible to provide evidence on the quality of services provided by public, private or parallel service providers.”
- “It is always challenging to disentangle the impact of socioeconomic transition and the contribution of the health system to health improvement. However, in Azerbaijan it is particularly difficult because of problems with the reliability of demographic and health data (see Section 1.4 Health status). Data quality issues also place limits on the extent to which health services can contribute to overall population health, because the government’s ability to adequately measure the impact of health service interventions on health outcomes is central to the development of evidence-based policy-making.”
- “…the performance of the health system (and its various components) has been assessed by both national and international organizations over recent years. However, the clear challenge is how to transform the monitoring and evaluation results into effective actions to increase the performance of the health system.”
ANNEX 5. BIBLIOGRAPHY

Bibliographic references marked with an asterisk (*) are resources that the project team found particularly informative during their assessment, and would be valuable for those interested in IPHC/FM and health reform in the E&E region. Note that references are only marked with an asterisk on their first appearance in the list below.


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