Policy Brief №18
General Practice Centers: Access and Efficiency

This policy brief summarizes key research results on the efficiency and accessibility of health services in General Practice Centers established in 2006-2007 years in rural and remote regions with population less than 25,000 people.

General Practice Center (GPC) is a new form of health care organization established by merging territorial hospital and its affiliates with primary health care organizations.

Table 1. Characteristics of GPC

#	Name	Number of population*	Type of merging
Jalal-Abat oblast			
1	Kok-Jangak	10 314	TH + FMC
2	Toguz-Toro	19 112	TH + FMC
3	Chatkal	21 835	TH + FMC
4	Karakul	23 460	TH + FMC
5	Shamaldy-Sai	9 947	TH + FGP
Batken oblast			
6	Samarkandek	20 649	TH + FGP
7	Aidarken	22 649	TH affiliate + FMC
Osh oblast			
8	Cho-Alai*		TH + FMC
Chui oblast			
9	Suusamir	6 208	TH affiliate + FGP
Naryn oblast			
10	Min-Kush	5 004	TH affiliate + FGP
Issyk-Kul oblast			
11	Barskoon	6 511	TH affiliate + FGP

Note: *as from the date of the research GPC was not established. TH: Territorial Hospital; FGP: Family Group Practice; FMC: Family Medicine Center

1. Introduction

The objectives of the establishment of GPC's included (a) optimization of the health service delivery system in remote areas and (b) effective use of financial resources by merging primary care and hospital care. On the whole, these changes were supposed to contribute to better efficiency and access to good-quality health care.

2. Research methodology

This research project was conducted in order to assess whether the establishment of GPC's contributed to better efficiency and access prior to making a decision about replicating this organizational form in other remote areas. Both quantitative and qualitative research methods were used. Qualitative methods included collection of medical-statistical and financial information about performance of GPC's. Quantitative methods included semi-structured interviews with managers of GPC's, their deputies and representatives of local government administrations as well as focus-groups with involvement of administrative personnel, doctors and middle-level health personnel at primary and secondary levels and also the population.

3. Research results

The experience of GPC's showed that in the context of limited financial and human resources, **merger of primary and secondary health organizations may contribute to better efficiency and accessibility of the health services in remote and difficult-to-access regions.** However, the research **has also revealed a number of weaknesses with respect to the regulations governing the activities of GPC's.**

The key benefits from the establishment of GPC's are the following::

- **Better performance of the emergency care service (EC).** It has been noted that previously the FMC's did not have sufficient resources to serve emergency calls and the population had to pay gas costs themselves for the ambulances. Following the establishment GPC's, supply with gas improved and doctors started to respond to emergency cases (Toguz-Toro, Minksuh, Suusamir, Kara-Kul).
- **Better continuity between PHC and hospitals.** Various managers mention that better continuity is facilitated with joint staff-meetings, meetings, reviews of patients, emerged opportunity to make collegial decision by PHC and hospital doctors about treatment policy for patients at the outpatient level (Kok-Jangak, Aidarken, Chatkal, Toguz-Toro, Samarkandek, Kara-Kul).
- **Better efficiency due to joint use of equipment, laboratories and CSU (centralized sterilization unit).** As following the GPC organization, available physical infrastructure became joint, outpatient doctors obtained an opportunity for more frequent referrals of their

patients for laboratory-diagnostic tests (Kok-Jangak, Aidarken, Shamaldu-Sai, Toguz-Toro).

- **The human resource shortage has been partially addressed**, as far as there is an interchangeability of doctors working at primary and secondary levels in GPC's.
- In respect to GPC, **supply with drugs and medical products has improved** (Toguz-Toro, Suusamir, Minkush).

Nevertheless, there were **issues revealed which require further attention** prior to making decision on this extension of this experience to other remote areas:

- **There are incentives for increasing unnecessary hospitalizations.** Managers mentioned that before the GPC establishment FGP doctors aspired to serve patients themselves (i.e. at PHC level) and didn't refer them to the hospital. With the establishment of GPC's, hospitalization procedure has simplified and the organization can increase its revenues by admitting more patients under the case-based payment method.
- **In certain cases, more attention is paid to development of hospital services as compared to PHC services.** Where GPC operates as a former CRH, there is a dominating role of the hospital, poor PHC service and practically lack of preventive profile in medical service.
- **The quality of PHC services can decline due to attraction of FGP doctors to night shifts in the hospital.** Actually, in all GPCs (Shamaldu-Sai, Kok-Jangak, Min-Kush, Toguz-Toro, Kara-Kul, Barskoon) there is a broadly started practice of attracting FGP doctors to night shifts in the hospital. Part of doctors are happy and perceive this as an opportunity to earn, as for another part this is unwanted additional working load which causes decreased quality of PHC services. There are considerably fewer examples when hospital doctors deliver outpatient consultations.
- **There is uneven motivation of personnel.** Part of GPCs mentioned increased salary as one of the benefits of the new organizational form (Chatkal, Toguz-Toro). There is an opportunity to pay quarterly bonuses out of saved funds (Toguz-Toro, Suusamir). However, such a possibility is not available for all GPCs. For example, in one of them it was mentioned that «there are no conditions for motivation, if only owing to increased treated case». This circumstance may impact problem of HR supply in the framework of GPC.
- **There is no common approach for ILD (Index of Labor Distribution) calculation**. Interviews showed that the former incentive system has undergone changes and not always in a better way (lost coefficients, cancelled or not imputed some ILDs etc.). There are no new developments which could efficiently operate in the framework of GPC. «ILDs of FGP and hospitals are done separately» (Toguz-Toro, Aidarken, Suusamir).

4. Recommendations

1. Review the regulations governing the operation of GPC's including staff terms of reference, calculation of remuneration, and optimization of medical-statistical and financial reporting.
2. Discuss changing the payment mechanisms of GPC's potentially moving away from the current mix of capitation and case-based payment to a global budget with volume targets. This would reduce incentives to over-hospitalize.
3. Specific management training needs to be organized for managers of GPC's;
4. Prior to making a decision about rolling out this organizational form to other remote areas, it is recommended to repeat this analytical work in order to understand whether the weaknesses have been resolved.

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