Policy Brief # 8
Evaluating Manas Health Sector Reform (1996-2005): Focus on Primary Health Care

This Policy Brief is based on a detailed study evaluating primary health care reforms (PHC) implemented in the framework of the Manas Health Sector Reform (1996-2005)[1].

1. Why reform primary health care?

Reform of primary health care was an important reform component for the following reasons:

- The health service delivery system inherited from the FSU was oriented to high cost inpatient care;
- Primary care did not have independent legal and administrative status;
- The distribution of resources was inefficient and inequitable;
- Primary care services were fragmented due to narrow specialization of doctors;
- There were no incentives to increase efficiency and quality of the delivered services ;
- Regional distribution of human and other resources was inequitable;
- There were limited opportunities for patients to choose their own doctor and to make decisions regarding their own health.

2. Primary Care Reforms in the Kyrgyz Republic

Primary health care reform became a key area of the Manas Reform with the following main directions:

- Primary care has been organizationally and financially separated from hospital care. Independent family group practices (FGP's) have been set up. The population is required to enroll with an FGP of their choice.
- Human resources training was overhauled aimed at institutionalization of family medicine training at three levels: (1) undergraduate training; (2) postgraduate training – two-year clinical internship for graduates of medical higher education institutions; (3) continuous training on following programs – training of trainers (doctors and nurses) in family medicine; retraining of doctors and nurses in family medicine; qualification upgrading of practicing specialists and trainers on family medicine. Most family doctors and nurses (60-70%) participated in retraining in the fields of family- and evidence-based medicine on different programs supported by ZdravPlus,,STLI, Swiss Cooperation Office and World Bank.
- 162 clinical protocols on the most prevalent diseases were developed on the basis of evidence based medicine and introduced;
- The State Guaranteed Benefit Package (SGBP) was introduced specifying health care benefits and payment obligations of the population. Within the framework of the SGBP, all citizens irrespective of their insurance and enrolment status are entitled to free health services at the primary health care level;
- Additional Outpatient Drug Benefit Package was introduced which entitles insured individuals to primary care sensitive drugs at reduced prices;
- Primary health care began to receive additional funding from payroll tax through the MHIF;
- New provider payment methods have been successfully introduced for FGP's based on per capita financing including partial fund-holding for medicines in the ADP. Capitation payments are more equitable way of distributing resources at PHC level as compared to line-item financing based on historical performance;
- Activities have been undertaken to improve relations with population and local communities' involvement into the decision-making process relating to PHC service.

1 Rifat Atun. «Evaluating reforms undertaken in PHC Service in the framework of Manas Program (1996 – 2005). You may see full Russian and English versions of the documents on website: http://hpap.med.kg.

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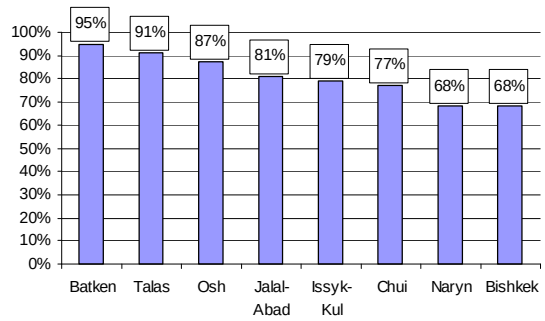
3. Impact of Primary Care Reforms on service delivery and health system objectives

The main achievements of PHC reforms are: good access to services at primary level; reduced referrals for hospitalization; extended range of services delivered by family doctors; better management of chronic diseases at primary level; and greater population involvement in health promotion issues. These results contributed to increased efficiency and improved quality of the delivered services.

Improved access to PHC service

Access to PHC service has improved. Currently, citizens of the KR have free access to primary health care services under the State Guaranteed Benefit Package. The share of population enrolled with an FGP increased quickly and is about 80% of population (Fig.1).

Figure.1. Percentage of population enrolled with FGP by oblasts in 2003

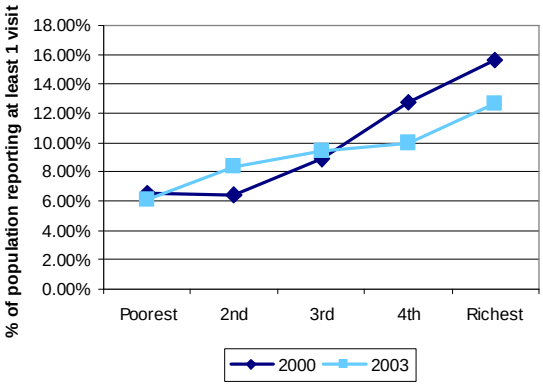


Source: Rifat Atun. «Evaluating reforms undertaken in PHC Service in the framework of Manas Program (1996 – 2005).

The smallest percentage of enrolled population is noted in Bishkek although there is no problem of geographic access in the capital. A recent study of the WHO-DFID Health Policy Analysis Project showed that this is likely to be related to the big number of internal migrants residing in so called *"Novostroiki"* who are reluctant to enroll with an FGP for a variety of reasons. Relatively low enrolment in Naryn oblast requires further investigation. Probably, role of geographic and financial barriers for travel expenses are important factors in this poor oblast.

Evaluation of visits to outpatient care by different socio-economic groups of the population shows improved equality in health services utilization (Fig. 2).

Fig.2. Distribution of visits (primary health care + outpatient specialist)



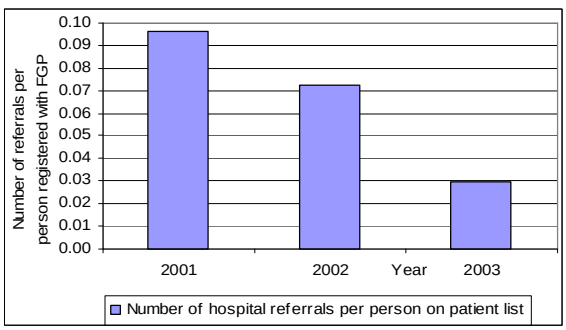
Source: WHO/DFID. Health Policy Analysis Project

The dark line shows distribution of outpatient visits (primary care + outpatient specialized care) by quintile of household consumption. In 2001, the richest 20% of the population used outpatient services two times more frequently as compared to 20% of the poorest population. By 2003, the rate of visits decreased among the richest. The poorest quintile group did not experience any changes in the rate of visits while we see a significant increase for the second quintile group. Thus, the poor capture a greater share of public expenditures than before the reforms.

Reduction of referrals for hospitalization

Analysis of referral patterns and unnecessary hospitalizations indicate improvements in the first contact and gatekeeping functions of FGP's as a result of introduced family medicine. This has significantly shifted health care provision from secondary to primary level. Over 2001-2003, the number of hospital referrals reduced among enrolled citizens and this could be partially due to the improved gate-keeping function of FGP's and their broader practice patterns. (Fig.3).

Figure 3. Number of hospitalizations per a citizen enrolled to FGP



Source: Rifat Atun. «Evaluating reforms undertaken in PHC Service in the framework of Manas Program (1996 – 2005)".

Increased volume and content of health services at primary level led to the reduction of referrals and unnecessary hospitalizations and consequently to increased efficiency and rationality of the health care system.

Extending the scope of services delivered by family doctors

As the recent study on "Evaluating family medicine reforms in the Kyrgyz Republic" showed, many functions which are performed by family doctors in European and other developed countries, are performed by narrow specialists in the Kyrgyz Republic, such as ENT-doctors, surgeons, surgeons-orthopedists, ophthalmologists and other. (R.Atun, World Bank Report, 2005)

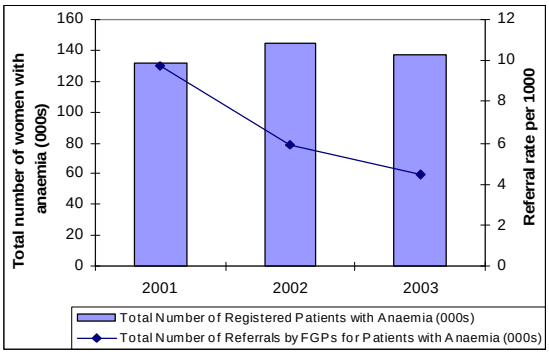
Comparing the practice patterns of family doctors across the country, FGP's in Issyk-Kul oblast have the most expanded practice pattern and this is where the primary health care reforms have the longest history and depth. FGP's in Issyk-kul increasingly take on functions of narrow specialists. They make decisions more frequently than their counterparts in Osh and Bishkek cities regarding the 27 most frequent diseases and manage the 17 most prevalent chronic conditions. Also, they are more likely to engage their patients in discussions on healthy life-styles and to use more medical equipment.

Improved management of chronic diseases at primary level

Family doctors increased the volume and scope of services to manage prevalent chronic diseases such as hypertension, insulin-dependent diabetes, bronchial asthma, duodenal ulcer and anemia. To manage these chronic diseases, evidence-based clinical protocols have been developed and implemented that allowed to improve continuity and comprehensiveness of primary care.

For example, the number of hospitalizations with anemia, most prevalent among pregnant women, reduced by more than half despite total increase in anemia incidence (Fig.4.).

Figure 4. Number of hospitalizations per a citizen with anemia



Source: Rifat Atun. «Evaluating reforms undertaken in PHC Service in the framework of Manas Program (1996 – 2005)".

Similarly, the number of hospitalizations under other chronic conditions also decreased.

Greater involvement of the population into health promotion

Encouraging examples of community initiatives to solve health problems have been implemented. For example, the Kyrgyz-Swiss Health Reform Support Project supported by SDC has successfully developed a model of health promotion (Jumgal model), which encourages rural communities to analyze their own health care priorities and to create health committees based on voluntary involvement to improve health in their villages.

4. Key recommendations for further reforms

All necessary preconditions for further reform have been established at primary level. Next steps for further development of primary health care could include the following:

- Improving the funding situation for primary care especially in rural areas and improving equity in financing and in access to services;
- Further extending the role of FGP's as well as the scope of primary care services;
- Introducing more flexible contracts for FGP's based not only on capitation but also on other criteria of performance such as providing incentives for quality improvement, for delivery of additional services (e.g. health promotion and disease prevention). However, introduction of such contracts will require considerable analytical and executive potential of the MHIF and MoH, as well as improvement of the stability in health financing;
- Increasing the salaries for family doctors and nurses to attract qualified specialists, to improve the prestige of family medicine, and

to motivate FGP's to increase the quality of their services;

- Focusing on the modernization of FAP's in order to improve equity in access to care for remote populations;
- Improving access to health services for internal migrants living in Novostroiki in Bishkek;
- Addressing the long-overdue issue of narrow specialists. Presence of narrow specialists in FMC's is a source of inefficiency impeding first contact, gatekeeping functions and continuity in observation. This is a key barrier in PHC service development. Ideally, all FMC's should be reorganized into FGP centres and narrow specialists should be either transferred to hospitals or retrained as family practitioners.

To get more detailed information and complete report on the study, please contact HPAP team
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