3: THE TRANSITION TO PRIMARY HEALTH CARE (PHC) IN ECA

Making PHC the Hub of the Health Care Network

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I. INTRODUCTION

Personal health care services (sometimes referred to as curative care services) form the core of any health care system. However, the structure and function of the institutions and organizations that deliver personal health care services to the population differ dramatically around the world. The break-up of the Soviet Union and the dissolution of central planning and funding from Moscow, led to the virtual collapse of the health care systems in many countries of Eastern Europe and Central Asia (ECA). In an effort to respond to the crises of transition in ECA, the World Bank collaborated with client governments and provided loans to shore up the medical care system, to try and avert deterioration of the health status of the population, and to initiate reforms in the health care systems.

Definition and Goals
Primary health care can be defined succinctly as “the level of first professional contact to which a person or family turns when in need of help and advice” (Fry & Horder, 1994). A more lengthy definition that has partly guided health reform efforts by international organizations, donors and bilateral lenders, has been offered by WHO:

“Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of the country’s health system, of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact for individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (World Health Organization, 1978).

“Primary care”, “general practice”, and “family medicine” are frequently used to refer to primary health care. Nurses and general practitioners, also known as family doctors, are the primary providers of PHC. Emergency medical services (EMS) were often included in PHC in ECA, although in a different form from the general definition of EMS, as explained below. The typical definition of EMS is: urgent pre-hospital care of the sick or injured, although it may also include initial stabilization in an accident and emergency department.

The purpose of this paper is to review, assess, and synthesize the World Bank efforts to date in Health, Nutrition, and Population projects in ECA after more than a decade of transition and attempted reform. The emphasis of this cluster paper is on the role of Primary Health Care (PHC) in the Bank’s implemented strategies and activities, the achievements to date of World Bank projects related to PHC, the lessons learned, and the implications for the future. This paper does not attempt to present an exhaustive project-by-project itemization or account of all PHC related activities but attempts to present a “broad brushstroke” of the range of activities undertaken and results achieved.

Methodology
World Bank documents were reviewed for HNP projects in the ECA region that had been approved by the Board of Directors of the Bank between January 1, 1989 and June 30, 2002. All Staff Appraisal Reports (SARs), Project Appraisal Documents (PADs), and Implementation Completion Reports (ICRs) documents for ECA HNP projects from the study period were electronically searched for the keywords ‘primary health care’, ‘general practice’, or ‘family medicine’. For any projects in which SARs, PADs, or ICRs contained the keywords, additional project documents (e.g., Program Status Reports including mid-term evaluation reports, selected Aide Memoires) were obtained. All the captured documents were reviewed independently by a Bank cluster team leader with professional training, clinical practice and teaching experience in Family Medicine,
and by a project consultant. The review attempts to identify, describe, summarize, and synthesize the Bank’s efforts in PHC.

In addition, assessments of key structural and process interventions in support of PHC, were made such as physician and nurse training/re-training and curriculum development; clinical protocol development and quality assurance (QA) systems; and EMS. Areas of inquiry included:

- The original relevant objectives and design of project components and sub-components;
- Any significant revisions to the design of the relevant components and sub-components over the course of the project period;
- Systematic review of the relevant documents using a standard checklist to record details of project activities;
- Accomplishments and outcomes of relevant components and sub-components;
- Lessons learned or evaluations of relevant components and sub-components; and,
- Identification (to the extent possible) of the disbursements made for each of the relevant PHC components, sub-components and activities.

The review and analysis have limitations. Analysis of impact, outcomes, and lessons learned focused largely on completed/closed projects for which project evaluation has been completed. Current active and ongoing projects have not been completed, and thus have not had an opportunity to fully meet objectives or to be formally evaluated. However, PSRs, and selected Aide Memoires did provide some insights into challenges, processes, early results and/or trends. Aide Memoires for supervision site visits were not uniformly available. However, attempts were made to abstract examples, case studies, and operational details from selected Aide Memoire that may not have been included in formal appraisal or evaluation documents. Written documentation frequently lacked sufficient technical detail to adequately characterize the PHC-related activities such as type and length of training; descriptions of curricula developed, models of practice used, detailed line-item budgets/disbursements, and training of nursing staff. The review did not attempt to complete an analysis of all PHC activities by all organizations in the region. Therefore, a description of Bank activities in the ECA region may not provide a complete picture of the status of PHC in the region.

**Brief Reflection: The Soviet Era**

**Primary Health Care in ECA**

The health care systems and the challenges of the transition in ECA have been well described (Chellaraj, 1995; Staines, 1999). The health care systems in most ECA countries were based on the Semashko health care model – the centrally planned, national health service model of the former Soviet Union. There was universal eligibility for all services free of charge, and the budget was derived from the general state budget. All facilities were owned by the state and all health care personnel were salaried, state employees. The systems tended to be under-funded by Western standards since social sectors were given low priority in the state planning process.

Conceptually, the health care system was an integrated, hierarchical structure of feldsher stations, health posts, polyclinics, hospitals, and local, regional and national level institutions in which patients accessed the system through the community-based health centers, the multi-specialty polyclinics, diagnostic departments, hospitals, and industrial health services. Doctors in the outpatient settings (mostly “therapy” a.k.a. internal medicine specialists) were considered to be first contact physicians analogous to primary health care providers in the West. The first contact doctors were supposed to serve as gatekeepers, referring more complicated patients to higher tiers of care. Home visits by physicians at the patient’s request were routine.
Emergency medical services (EMS) is generally taken to mean urgent pre-hospital care of the sick or injured, although it may also include initial stabilization in an accident and emergency department. In the ECA region, EMS was generally under the direct control of the Ministry of Health, although other organizational forms existed, including being attached to emergency hospitals, regional health departments, and other separate services. Before the transition period, EMS was often an integral part of the overall primary care system and ambulances were used to conduct home visits, especially during after-hours when outpatient clinics had closed. This limited their availability for true emergencies. There were however, some specialized EMS teams with equipment for pediatric or cardiac care.

Central planning dictated strict and inflexible norms for staffing patterns, and allocation of facilities and physicians across geographic areas. Incentives encouraged inpatient over outpatient treatment as well as care at the highest, most expensive, levels of the system. The system suffered from both overcapacity – too many physicians, specialists, and hospital beds - and excessive utilization of services and technology, particularly inpatient care. The problems that resulted were - poorly targeted investments, inadequate integration between the different parts of the system, a narrow base for financing, and grossly deficient incentives to efficiency:

“Incentives to efficiency were virtually nonexistent either to motivate patients to maintain good health and use scarce resources judiciously or to encourage health care workers and institutions to provide high-quality care. Doctors working on salaries had an incentive to minimize their workload by referring complex problems up the line.” To protect their global budgets, hospital directors often encouraged staff and physicians to refer expensive diagnoses and treatments to other, higher or more specialized levels of care. “As a result, queues and waiting lists were common even though the number of doctors and beds per capita was higher than in most Western countries” (Chellaraj, 1995).

“Poorly-targeted investment led to a massive but lopsided buildup in acute care hospitals and excessive specialization at the expense of public health services and primary care. The rigid and over-centralized Soviet-style national health services that evolved from this process contained both significant overlaps and significant gaps because different ministries all tried to provide services for their own enterprise-based workers. Surpluses and shortages developed due both to variations in local patterns of use and to political patronage. The compulsory catchment areas and the role of primary care doctors as gatekeepers were unpopular with patients who rightfully felt that they were wasting their time waiting in line to be told that the services they needed were not available at that level of care. Not surprisingly, they were willing to pay substantial gratuities to be referred quickly up the line or to use services outside their official catchment area” (Chellaraj, 1995).

Medical Practice Protocols and Quality Assurance
Quality control and assurance in the health care system were characterized as “top down, command, control, inspect, and punish”. The strict protocols (prikazes) of medical practice had a direct and strong influence within the medical hierarchy, and sporadically external reviews (by the Sanitary Epidemiology System, or SANEPID) were conducted to check for adherence to prikazes, with financial penalties levied for infractions. With limited access allowed with the West, concepts such as controlled trials, randomization, and evidence-based medicine were not widely known or used. Therefore, prikazes were derived largely from expert opinions based on personal experiences and case series, and were reviewed and updated infrequently. Medical practice standards too were frequently determined by arbitrary statistical norms.

Medical and Nursing Education
Undergraduate medical education of physicians consisted of 5-6 years of coursework with students entering directly from high school. Admissions into medical schools were frequently dependent on political factors or on systems of personal patronage. Since medicine was considered a technical skill, doctors and other health
care providers received training provided by Ministries of Health, thereby isolating medical education from the education provided in general universities by Ministries of Education.

Medical universities typically consisted of five specialized faculties: general medicine (“therapy”), dentistry (stomatology), pediatrics, sanitary-epidemiology, and pharmacy — each teaching similar basic subjects such as anatomy, physiology, or biochemistry, but with specialization (e.g., among students in general medicine, specialization into surgery, obstetrics/gynecology, ophthalmology, etc.) and specialty-specific curriculum in the final years. The absence of a broad education and the early development of narrow skills made it difficult for the doctors to adapt to changing circumstances and to an evolving demographic and epidemiological profile of the population. Training of primary health care providers, nurses, and many other auxiliary health care personnel was seriously neglected. In Romania, nursing, as a profession, was actually abolished by Ceaucescu.

The medical curriculum was centrally planned with codification by law or prikazes. Therefore, curricular flexibility and adaptability were extremely limited. Teaching methods emphasized didactic classroom styles with a focus on disease-centered learning. Medical knowledge, therapeutic approaches and methods were usually sourced from proclaimed experts in the specialties. Access to international sources of medical information and research findings was severely restricted. Teaching and medical care were focused on providing most medical services in hospitals or via highly specialized polyclinics. Students had only limited exposure with patients directly, and with real clinical situations. Testing and advancements was based largely on knowledge of prikazes. Clinical skills such as diagnostic acumen, assessment of the undifferentiated patient complaints, recognition of physical signs and symptoms, synthesis of differential diagnosis possibilities was under-developed.

To start a clinical practice, graduates of medical university had to complete at least a one-year “internship” in their specialty. Students with top grades or good personal, family, or monetary relations were offered a 2-year residency – “clinical ordinatura”. During these two years, students were supposed to learn their specialty and also basics of clinical research. For some doctors it was the first step to a PhD (3 year study – “aspirantura”) to obtain a “candidate of medical science” degree and to a successive 4-5 year “doctorantura” to obtain a “Doctor of medical science” (the highest in medical grade system) degree. Doctors of medical sciences could also apply for professors’ positions if they were available.

Postgraduate Medical Education (PGME) was highly specialized and usually occurred under the tutelage of specific physicians in hospitals and/or in polyclinics. Structured or specific clinical curricula was lacking. There was an official system of continuing medical education or structured learning after undergraduate or postgraduate medical education, requiring physicians to participate for 2-3 months and take short-course training every 3-5 years in order to obtain a “qualification upgrade”.

Nursing education was structured similar to Undergraduate Medical Education with strict central planning, specialized faculties, and limited clinical exposure. Girls would enter technical training in nursing at an early stage in their education (e.g., age 15-18), depriving them of a broader educational experience. The development of narrow skills resulting from nursing education relegated nurses to providing minimal nursing support in medical practice or having largely semi-clerical functions.

Medical research was isolated from teaching and financed through non-competitive grants. International isolation in training, research, and technology was rigorously enforced throughout the region, especially in Albania, Bulgaria, and Romania.
II. ISSUES

The Transition
With the collapse of the Soviet system, the socio-economic and medical systems in Eastern Europe and former
Soviet Union came under enormous stress. The overcapitalized and under funded health services outstripped
the financial resources of most countries.

Over the past decade, the health sector in ECA suffered from severe disrepair, excess capacity of physicians,
nurses, feldshers, in-patient beds, and over-emphasis on urban-based specialist care. The first contact
physicians were poorly trained, had limited inpatient and outpatient diagnostic capacities, and obsolete capital
stock in poor condition.

Key health indicators worsened during the mid-1990s with drastically increased mortality from heart disease,
vigonece, injuries, and suicides, particularly among adult males. Economic collapse severely limited the
governments’ capacities to respond to the population’s needs. Low levels of trust in the system developed in
the population resulting in people turning to private or informal sources of medical care and the use of large
proportions of out-of-pocket expenditures for health care. This placed the poor at a special disadvantage,
adding to the vicious cycle of poverty and ill health.

Medical and nursing education were under-funded and largely unreformed, particularly at the undergraduate
level. Medical and nursing education declined in terms of scope and quality. The narrow educational base
made it difficult for the schools and their graduates to adapt to the complexities of the new economic
marketplace, to health system reform, and to the realities of the demographic and epidemiological transitions
occurring in the population, i.e., aging of the population and shift of disease burden away from infectious
diseases towards non-communicable, chronic diseases (e.g., cardiovascular disease and cancer).

With “free market economies”, many private “institutions” offering medical degrees and specialty certification
sprung up without the benefit of educational standards or accountability of results. For example, in Georgia,
privatization of the health sector resulted in the opening of a plethora of medical schools (two in the Soviet era
to fifty two in the post-privatization era) without criteria or procedures for reviewing curricula or criteria for
accrediting the new institutions. The new institutions also added to the problems of oversupply of physicians
and specialists. The schools churn out medical graduates at a pace that exceeds the estimated number of new
doctors needed for the country (in Georgia, 2,000 graduates per year vs. 200 estimated to be needed), that too,
largely in specialties.

Government supported medical and nursing education institutions have little money. Training facilities are in
disrepair, with medical equipment and teaching tools nearly non-existent, and a faculty distracted by the need to
supplement very low salaries. Specialty-based faculties remain parallel and duplicative.

Curricula are virtually unchanged from the Soviet era. Outdated Soviet prikazes (some now over 40 years old)
remain the norm for medical practice guidelines that unfortunately promote ineffective medical practice. The
prikazes continue to be enforced by a Sanitary Epidemiology System that frequently views monitoring of
adherence as an opportunity for salary supplementation. Previous sources of new medical knowledge generated
by research institutes collapsed with the lack of central institutional funding. For example, publication of
virtually all medical journals in FSU ceased during the mid to late 1990s.

There is a basic “disconnect” between the evolution of the health care systems and undergraduate medical
education. As new models of primary health care have been developed and piloted, the curriculum of basic
undergraduate medical education has not adapted. Undergraduate and postgraduate medical education is still in-hospital and specialty focused. Much of the training takes the form of shadowing specialists in hospitals, dispensaries and polyclinics. The structure is vertical, in contrast to a horizontal approach that emphasizes continuity of patient care with the opportunity of following the patient through episodes. Focus is on the disease rather than on the patient. The emphasis is on teaching as opposed to learning, and lacks an explicit assessment of the trainees’ learning needs, early in the program. This means that the delivery of training is predominantly one-way, from teacher to the trainee.

The World Bank’s Response

The Role of Primary Health Care (PHC)
Primary Health Care has taken a prominent role in the World Bank’s efforts, and is mentioned in over half of the Country Assistance Strategies (CASs) in the region since 1990 and cited as a priority or a key strategy in 15 of the 40 CASs adopted since 1996. In 1999, the Health Sector Strategy for ECA promoted several features of a restructured health care delivery system including: “a better match between the care provided and the major patterns of morbidity and death; an expanded primary care system coupled with a leaner and more cost-effective but better equipped hospital sector; a wider range of care alternatives; more professional management of health services and facilities; a preference for evidence-based medical and nursing practices; changes in the mix of general practitioners, specialists, nursing, and paramedical staff, and an expanding role of the private sector” (Staines, 1999).

Completed and closed projects to date represent early efforts of the Bank to respond to the crises of transition in ECA. Fourteen HNP projects were completed or closed in ECA between January 1, 1989 and June 30, 2002. Three of the completed/closed projects (in Bosnia/Herzegovina and Hungary) had no components or sub-components related to primary health care, emergency medical services, PHC physician or nurse training/ re-training, PHC curriculum development, PHC clinical protocols development, or PHC quality assurance systems. The remaining completed/closed HNP projects (in Albania, Bulgaria, Croatia, Estonia, Kazakhstan, Kyrgyz Republic, Macedonia, Poland, Romania, Russian Federation, and Turkey) contained components or sub-components related to primary health care, emergency medical services, PHC physician or nurse training/ re-training, PHC curriculum development, PHC clinical protocols development, or PHC quality assurance systems. Total original loan commitments for completed/closed projects were nearly USD$ 773 million with final disbursements of approximately USD$ 662 million, of which approximately 200 million was targeted to be specifically spent on PHC-related activities.

Active projects represent activities begun later in the 1990s as well as current efforts of the Bank to continue to support health reform in ECA. As of July 1, 2002 there are 15 HNP projects (in Albania, Armenia, Bosnia/Herzegovina, Bulgaria, Croatia, Georgia, Kyrgyz Republic, Latvia, Lithuania, Moldova, Romania, Russian Federation, Tajikistan, Turkey, and Uzbekistan) that contain components or sub-components related to primary health care, emergency medical services, PHC physician or nurse training/ re-training, PHC curriculum development, PHC clinical protocols development, or PHC quality assurance systems. Total loan commitments for currently active projects are nearly USD$ 560 million of which approximately 164 million has been targeted to be specifically spent on PHC-related activities.

Summary of the goals of PHC in World Bank projects
PHC was chosen as a key strategy in the World Bank projects to address many of the ills of the health care system during the transition in ECA. The stated goals of the PHC-related projects have been quite broad and comprehensive, and aim to:
- protect the population, prevent deterioration in health status during the transition, and/or improve the health status of the population;
- increase the equity, access, and scope of health care available to the population;
- improve the quality of basic and essential curative health services;
- improve the efficiency and cost containment of the health care delivery system;
- facilitate the restructuring of the health care system, health sector financing, and/or management;
- modernize the health care system;
- reorient service delivery toward more cost-effective health care;
- integrate prevention and health promotion approaches into personal health care services;
- support high priority disease control programs;
- support the restructuring of the EMS and improve the effectiveness and efficiency of EMS by separating EMS functions from those of the PHC network.

*Varied World Bank approaches to address PHC goals*

Early efforts in PHC in the projects completed/closed to date focused primarily on several individual issues or combination of issues: civil works of facilities that could/would serve as PHC outpatient clinics; procurement and delivery of medical equipment for PHC clinics and for the secondary level of health care; training of physicians and some additional medical personnel in PHC-related topics; and, development of provider payment mechanisms that, in part, supported PHC. Additional types of activities included upgrading of equipment and training for EMS and emergency department personnel, with efforts to rationalize/optimize the number and mix of PHC facilities and development of medical practice guidelines and protocols. Later efforts in currently active projects reflect increasing complexity and sophistication of interventions in PHC.

*Civil works of facilities and medical equipment*

Significant resources (approximately USD$ 500 million) have been or are being devoted to rehabilitation of and medical equipment for PHC facilities and training equipment for PHC training sites/centers. All of the completed/closed projects with PHC related components or sub-components provided significant resources for architectural design, construction, and rehabilitation of facilities that would serve as PHC clinics. Due to the poor conditions during the Soviet era or due to deterioration during the transition, health facilities (particularly in rural areas) required substantial physical upgrading to meet even minimum levels of sanitary and physical standards for structure, water, electricity, and sewage. In several instances, new building and equipment standards had to be developed and adopted by the governments because of antiquated or non-existent standards for PHC clinics. Medical equipment in the facilities intended for PHC were either absent, broken, or obsolete. Therefore, substantial resources were devoted to providing a wide range of medical equipment, furniture, or medical supplies for thousands of PHC facilities. Civil works and medical equipment remain important and necessary priorities in many current Bank projects although the overall emphasis in investments and interventions has broadened considerably.

*Impact and outcomes*

Project evaluations, beneficiary surveys, and social assessments from completed/closed projects have pointed to the significantly improved quality of the work environment for physicians and nurses that, in turn, has improved the attitudes and satisfaction of health staff (e.g. Romania, Russian Federation) and increased their motivation to receive training. For example, in Macedonia, graduates of trainings/CME in PHC received medical equipment as rewards. Better civil works/equipment have increased recruitment of physicians into PHC and into underserved, rural areas. For example in Bulgaria, 26.7% of physicians in project-supported clinics decided to become general practitioners and 2/3 of rural physician vacancies were filled, where 55% of the doctors were previously not working in rural areas – results attributed in the evaluations pointed directly to facility rehabilitation and medical equipment. However, even with rehabilitated and equipped facilities, recruitment of physicians into rural areas remained challenging (e.g. Bulgaria, Georgia, Romania, Turkey).
There is some degree of underutilization of the newly procured equipment by the PHC physicians. For example, there has been a lack of sufficient training in the appropriate clinical indications for use (Armenia), in the operation of the equipment, and at times training occurred at a time too far removed from the actual arrival of the equipment such as in the Russian Federation, where there was a lack of coordination with training curricula. In Croatia, physicians lacked motivation to use the equipment and it was concluded that equipment and training alone could not work without appropriate financial arrangements and incentives for the primary care practitioners (i.e., linkage to a provider payment mechanism with appropriate incentives). In some countries, there was an inappropriate selection of certain types of equipment to be used in PHC clinics. For example, both mammography and cardiology ultrasound acquired for PHC clinics require highly specialized training, which is more relevant to secondary levels of medical care. In addition, diagnostic accuracy and quality of care using mammography and cardiac ultrasound are directly related to operator experience which results from much higher patient volumes than would be anticipated in individual PHC clinics or group practices. In some cases, the specialized equipment ends up being re-deployed at secondary levels of care in the health care system.

There are significant concerns that government technical capacities, motivation, and financial resources will be insufficient for the proper maintenance/repair of rehabilitated facilities and for the quality control, maintenance and eventual replacement of the medical equipment procured under the projects (e.g., Armenia, Georgia, Russian Federation).

Civil works and medical equipment have had some documented impact on efficiency of services. In Bulgaria, a higher proportion of project-supported GPs reported using electrocardiographs procured for the PHC clinics. As a result of the procurement of electrocardiogram machines, only 20% of project-supported GPs reported that they always directed heart problems to specialists compared to 61.9% of non-supported GPs. In addition, project-supported GPs reported greater use of the gynecological chair compared to non-supported GPs. However, no objective assessment was made of actual use of the equipment, the actual referral rates, or the accuracy of interpretation of the electrocardiograms by the GPs. The scientific literature suggests that physicians tend to over-estimate positive behaviors in self-reports.

PHC facility rehabilitation and medical equipment are necessary investments in support of PHC. However, by themselves they do not necessarily result in improved health status, increased access to care by the population, improved efficiency of services, improved productivity, or enhanced quality of care as envisioned by the projects’ goals and objectives. For example in Turkey, “it was assumed that providing additional inputs would automatically trigger health gains. The Project paid too little attention to addressing many systemic, institutional bottlenecks”.

In completed/closed projects, it is difficult to document the degree to which rehabilitation of facilities and procurement of medical equipment have contributed to or achieved health sector goals such as improved health status, quality, equity, access, and cost-efficiency because many of the earlier projects lacked robust monitoring and evaluation activities or indicators which drew direct relationships between project activities and project objectives. In many of the completed/closed projects, evaluation of the success of rehabilitation of the equipment has been measured in terms of procurement or output or by assuming that access, efficiency, and/or quality improved without direct assessment of objective measures or indicators.

In later projects, there may be opportunities to better evaluate the contribution of facility rehabilitation and medical equipment. For example, see Case Study 1:
In other later projects, rehabilitation and equipment represent one part of more complex interventions for which M&E design does not permit the clear determination of the relative contribution of individual sub-components.

Overall, there have been a large number of clinics established/refurbished/equipped by World Bank funded projects in ECA. However, in many countries, only a relatively small proportion of PHC facilities have benefited from the World Bank investments in pilot projects, leaving large unmet capital needs during harsh economic times that threaten the sustainability of the development and scaling up of PHC in ECA.

Training of physicians and other health personnel
World Bank activities related to training of physicians and other health personnel have focused on attempts to meet both short and long-term health personnel needs to support reform and restructuring of health care systems away from specialty care toward outpatient primary health care. These activities include a wide spectrum of training approaches:

− study tours for Ministry of Health (MoH) and professional associations to enhance in-country capacity to develop programs for continuing education, for increasing skills of PHC physicians, and for identifying and enforcing Quality Assurance;

− training of trainers who would then directly train health personnel in short courses, re-training, or postgraduate education programs in PHC (e.g., Armenia, Estonia, Kyrgyzstan, Latvia, Macedonia, Moldova, Russian Federation, Tajikistan, Uzbekistan);

In other later projects, rehabilitation and equipment represent one part of more complex interventions for which M&E design does not permit the clear determination of the relative contribution of individual sub-components.

Case Study 1
Azerbaijan -- Evaluation Design

The project includes investments in facility rehabilitation and medical equipment for a selected group of outpatient clinics in 5 pilot districts. In addition, all outpatient physicians in the pilot districts will be invited to participate in short course trainings on selected outpatient care topics. The monitoring and evaluation (M&E) plan includes baseline surveys and observational studies (i.e., before project implementation) to assess the physical status of facilities, medical equipment, practice behaviors, and health status of the clinic patients of a random sample of outpatient clinics in the 5 intervention pilot districts and in 5 non-intervention districts. At the end of the project, the M&E plan calls for follow-up surveys and observational studies (i.e., after project implementation) to assess the physical status of facilities, medical equipment, practice behaviors, and health status of the clinic patients in: the clinics that received rehabilitation, equipment, and training in the 5 intervention districts; in the clinics which physicians received training but no rehabilitation or equipment from the project; and, in a random sample of outpatient clinics in the 5 non-intervention districts also monitored in the project. The M&E design may help to identify incremental contributions of rehab/equipment/training vs. training alone vs. no project intervention/secular trends related to the project indicators.
establishment of PHC training centers through refurbishment of training facilities and procurement of training equipment such as computers and modern audiovisual equipment (e.g., Armenia, Georgia, Latvia, Romania, Tajikistan);
short courses intended to increase technical knowledge of existing physicians and nurses in the proper operation of the medical equipment that had been procured in the WB project (e.g., Bulgaria, Croatia, Russian Federation);
short courses intended to increase the knowledge of existing specialty-trained physicians to better meet the health needs of the population in outpatient settings related to specific diseases such as immunizations, nutrition, TB, women’s reproductive health, acute respiratory infections in children, integrated management of childhood illnesses, AIDS prevention, essential drugs, and diarrheal disease (e.g., Estonia, Kyrgyzstan, Kazakhstan, Macedonia, Tajikistan, Turkey);
“re-training” of existing specialists for varying lengths of time to receive certificates or other recognition as practitioners of primary care in outpatient settings (e.g., Armenia, Estonia, Kyrgyzstan, Lithuania, Moldova);
establishment of formal postgraduate education (residency) programs to train new medical graduates or practicing physicians to become specialists in General Practice or Family Medicine (e.g., Armenia, Estonia); and,
support of training specifically in PHC/GP practice management (e.g., Bulgaria, Moldova) as opposed to general health management training.

Training in PHC has varied greatly in length from two to eight weeks for short courses, from three months to six months for re-training programs, and from one year to three years for formal postgraduate medical education. Some projects have relied exclusively on short courses or “re-training” in an attempt to increase knowledge to some level (usually not pre-determined) for the largest number of trainees, in as short a time as possible. The objective is to try and meet acute deficits of outpatient or primary health care skills by shifting the emphasis away from hospitals, through structural and financial reforms. At times, the emphasis on re-training is actually driven by clinic refurbishment or equipping schedules of a Bank project, in order to staff refurbished or equipped PHC clinics within the project period (e.g., Russian Federation). Other projects have used combinations of short courses, re-training, and/or post-graduate medical education (e.g., Armenia, Estonia).

The approaches to PHC curriculum development have varied widely - through locally developed curricula based on old Soviet prikazes; through curricula representing “bundles” of disease-specific modules (particularly for short courses) with materials adapted from numerous other sources such as UNICEF, UNFPA, and WHO (e.g., Azerbaijan, Kyrgyzstan); or, more comprehensive, through integrated curriculum development (e.g., post graduate residency) supported by extensive international technical assistance (e.g., Queens College for Bosnia/Herzegovina, DFID/London University for Georgia, Finland for Estonia).

Teaching methods have varied - short, international study tours; training of GPs exclusively by in-country specialists (e.g., Russian Federation); classroom-based lectures only; training fellowships in western training programs; in-country mentoring and clinical supervision by GPs/family physicians fully residency-trained in the West; techniques based on adult learning theory, problem-based learning, diagnosis of the undifferentiated patient complaint, and/or supervised clinical practice; and, combinations thereof.

Impact and outcomes
There is some evidence of favorable impact and outcomes of training of physicians in World Bank (WB) projects on the health status of the population. For example, see Case Study 2:
For many other WB projects, the evaluation of PHC training has emphasized outputs such as number of personnel trained (tens of thousands of health personnel have received some kind of training in WB funded projects) regardless of the length of training or the skills to be acquired. Evaluations have variably included trainee satisfaction with training and/or limited written testing of pre-training and immediate post-training technical knowledge. The evaluation of the influence of training on increasing clinical skills, enhancing the uptake of new clinical practices by direct observation or objective assessments, or the impact on access, quality, or efficiency of care has not been well planned or executed. There is a lack of validated indicators that adequately measure PHC functions (e.g., continuity of care, coordination of care, family-centered care, etc.) and that predict favorable outcomes.

Without funding or reform, the system of undergraduate education has continued to graduate physicians and nurses with narrow and limited knowledge and skills. Curricula in new PHC-oriented post-graduate programs have realized that many students graduating from medical schools are frequently unprepared to begin post-graduate education by learning patient-centered care, where patients present undifferentiated symptoms rather than specialty-focused specific diagnoses. Some projects have discovered the need to devote time to bringing knowledge and skills of entering trainees to a minimum level before embarking on topics and skills for PHC specialization (e.g., Armenia, Georgia, Russian Federation). Most WB projects have not addressed undergraduate medical education but there are some exceptions (e.g., Armenia, Estonia, Georgia, Uzbekistan). Struggles over turf and responsibility are common between the Ministries of Health and Ministries of Education.

In some countries there has been a reluctance on the part of government officials to use loan funds for international technical assistance, study tours, or international training of local physicians (viewed as too costly and/or indefensible given the poor economic status of a majority of the population) even though the knowledge or experience to develop curricula or train physicians in general practice/family medicine generally does not exist in the country (e.g., Croatia, Russian Federation). There also have been challenges for physician and nurses training due to the limited capacity of national institutions to organize and coordinate training programs in-country (e.g., Albania).

In the absence of international criteria, guidelines, or an accrediting body for training or curricula in PHC, approaches, materials and training programs have proliferated. In some countries, the WB PHC project collaborates closely with other partners (e.g., DfID in the Russian Federation and in Georgia) or merely co-
exists with other primary care training efforts supported by international partners or foreign academic institutions that employ equally varied training approaches of variable content/quality.

The quality of PHC training and curricula has been variable and unclear. In many projects, there are no formal or informal pre-assessment of the training needs of the physicians (e.g., existing knowledge and skills) before selecting the length of training/re-training or the type of curriculum to be developed. In addition, in the absence of international guidelines or standards or an international accrediting body for programs in general practice/family medicine, the balance and quality of curricula content and teaching methods are quite variable. There have been limited attempts to assess the content and quality of training programs and curricula developed in Bank projects (e.g., Armenia, Estonia).

Some training programs are based in hospitals or exclusively in sub-specialty outpatient clinics. Trainees in these types of settings have limited or no exposure to primary care as a model of care (e.g., continuity of care, family-centered care, comprehensive care, problems common to outpatients). In other projects, trainees are taught by other GPs/Family Physicians who themselves may have varied levels of training as GPs or training as teachers of general practice/family medicine. Some curricula heavily emphasize theoretical, classroom-based knowledge, or may have little clinically supervised practice such as only written reports by the trainees about patients with selected diseases that they have seen in their clinic (e.g., Armenia). Trainees in these settings will have underdeveloped clinical skills such as abilities to recognize signs and symptoms, to formulate appropriate differential diagnoses, and/or to appropriately judge the need for use of medical technology or referral to emergency or specialty care. Other projects support more appropriate direct clinical supervision and mentoring of trainees by more experienced physicians. Teaching methods or the process of teaching also vary widely from the Soviet style of teaching from protocols, lectures of voluminous amounts of disease-centered information (“heart failure is treated this way”) to a passive, non-interactive audience. And there are examples of more appropriate problem-based learning, patient-centered learning, and assessment of the patient with undifferentiated complaints (i.e., patients usually present symptoms and complaints to the physician, rather than known diagnoses).
Practice Models and Provider Payment Mechanisms

There is wide variation in the scope of practice that defines PHC in WB projects. PHC is being operationalized variably as:

- a “polyvalent” PHC practice model consisting of specialists such as obstetricians, gynecologists, therapists (also known as internists), pediatricians, and sometimes general surgeons -- representing a full spectrum of health services, which can provide a majority of first contact services to a patient population (e.g., Azerbaijan);

- a “monovalent” PHC practice model consisting of a single type of generalist PHC physician with training, skills, and scope of practice (obstetrics, gynecology, pediatrics, internal medicine, minor surgeries and procedures) that includes the diagnosis and treatment of nearly the full range of problems that people bring to their doctors (e.g., Croatia). Referral occur from the generalist to specialists, as needed for patients who have higher levels of difficulty in diagnosis or have complications that exceed the training and expertise of the PHC physician; and,

- a “blended” practice model consisting of a PHC physician with training, skills, and scope of practice in multiple major medical areas (but not all) who can diagnose and treat many of the problems that people bring to their doctors, coupled with specific specialists based in outpatient settings that complement the training and expertise of the PHC physician (e.g. Russian Federation). For example, a PHC physician may be trained and skilled in gynecology, therapy, pediatrics, and minor surgeries, but refer all obstetrical patients in his/her catchment area to an obstetrician whom he/she may be paired with. Other combinations of training and skills of PHC physicians with specialists may also constitute blended practice.

Sometimes, multiple models are employed in the same project or even in the same district (i.e., outside the context of piloting and evaluating the differences between the models). For example, in some projects there is a tendency for the monovalent practice model to be targeted to remote or rural areas where specialists do not want to practice or where population density does not cost-effectively support more than one doctor.
Polyvalent or blended practice models tend to occur in more urbanized areas where demand for services may be higher or where political or professional resistance by specialists to generalist physicians may be strong.

In some projects, the supported/rehabilitated/equipped PHC clinics have been included in the provider payment system on a pilot or ongoing basis largely as capitated or mixed fee/capitated basis (e.g., Estonia), with or without fund-holding or financial risk for general outpatient services or for specific benefits packages. In such cases, the physicians may or may not serve as gatekeepers. In some countries, PHC physicians have been privatized and contracted by the government for services (e.g., Croatia) while others have remained government employees compensated by usually low salaries receiving performance-based bonuses (e.g., Russian Federation, Croatia). In other projects, there was no new provider payment system introduced or no relationship between the provider payment pilots and the project-supported PHC clinics.

Impact and outcomes
Results of WB efforts with provider payment mechanisms are treated elsewhere in the ECA Business Plan. But there are issues and challenges related to practice models. There have been mismatches between project activities related to training and their impact on health service delivery.

Case Study 4
Russian Federation – Limited Scope of Practice

In the Russian Federation, in some urban districts there was strong political and professional support for the concept of a generalist physician, primarily due to shortages of certain specialists (e.g. pediatrics). Therefore, PHC physicians were broadly trained and permitted a broad scope of practice. Yet in other urban districts, generalist physicians were restricted in their scope of practice due to the opposition from obstetricians, pediatricians, and therapists who feared competition and loss of patients in an environment of decreasing birth rates and/or impending capitation and free choice of doctors by patients. The WB project supported training of the generalist PHC physicians with broad scope of practice, only to have the graduates return to some communities where they were prohibited by regulation to practice what they had been trained in.

In addition, it has been difficult to evaluate the direct influence of PHC practices on cost containment/reduction, hospital optimization through bed reduction, hospitalization rates, referrals to specialists, or patient satisfaction due to lack of related evaluation indicators in the project design or the lack of systems to track or capture the information.

Emergency Medical Services (EMS)
EMS components have tended to be fairly large in dollar terms, owing to the high unit costs of vehicles and equipment. There has been considerable interest on the part of donors in EMS (e.g., EU/PHARE). EMS systems were restructured and upgraded in varying degrees with the purchases of ambulances, ambulance equipment, equipment for emergency departments, telecommunications, computer-aided dispatch systems, global positioning systems, and training of EMS staff to use the procured equipment (e.g., Bulgaria, Croatia, Romania, Russian Federation, Lithuania). Restructuring of EMS systems was intended to help separate the functions of EMS from those of the PHC network. With the introduction of concepts such as, making particular PHC physicians responsible for total health care of the patients on their list, and 24-hour non-emergency service it was envisioned that the emergency personnel would focus more on true emergencies and pre-hospital care rather than on home visits, patient transport, or provision of after hours coverage of non-emergency PHC services (e.g., Bulgaria).
Impact and outcomes
Investment in EMS has made a significant impact on some countries. For example, in Bulgaria, ambulance response time shortened from an average of 14.4 min to 11.5 minutes while death rates 6.2/1000 dropped to 2.3/1000. Also, surveys indicated that 10% more patients reportedly turned to GPs in supported villages in an emergency rather than to EMS compared to non-supported villages. In the Russian Federation, at the midpoint of the project in pilot districts, pre-hospital deaths from motor vehicle accidents decreased 10% and pre-hospital deaths from cardiovascular events decreased by 5% while the trend was upward in unsupported districts of the same oblast. In Croatia, it is reported that response times have improved, as has satisfaction of the ambulance doctors, although objective data is not available.

There are still a few challenges remaining. In many projects, the impact and outcomes particularly on issues related to shifting of responsibility and accountability towards PHC, and better utilization of EMS for true emergencies, cannot be evaluated because appropriate project indicators on these topics are not included or because the systems to capture the information are lacking. In some countries, there is an overcapacity of EMS (e.g. ambulances have an average of only 6 to 7 calls per day in Bulgaria). On the other hand in Romania, ambulances are considered to be used intensively but with excessive response times (20-60 minutes) and have an insufficient number of trained staff and equipped vehicles. Additional problems generally center on making the necessary organizational, structural, and management changes to the EMS provider network so as to refocus its activity on emergency pre-hospital care.

Rationalization/Optimization of Outpatient Services
Several projects incorporated a master plan for the consolidation of hospitals and for the network of outpatient facilities with the closure of non-project supported centers and re-deployment or reduction of staff and recurrent budget resources (e.g. Albania, Kyrgyzstan, Latvia, Tajikistan). Other projects rehabilitated and equipped PHC facilities in the absence of a PHC master plan.

Impact and outcomes
The selection of facilities, for inclusion in a PHC project or network, or for rehabilitation and equipment refurbishment, does not necessarily include an objective process for facility master planning, health manpower planning, or facility rationalization/optimization. Even in projects that incorporate a process for facility master planning, the objectives of facility closure, redeployment or reduction of staff, and redirection of budget resources have not been fully met. For example in Albania, “the project designs provided no resources or activities to support a rationalization process and assumed that staff deployment and resource allocation would be automatically implemented by the local authorities. The design under-estimated the level of effort and resources required to achieve a health service rationalization and the technical and political complexity associated with such activities”.

Medical Practical Guidelines and Protocols
There has been a high level of awareness, both on the WB and the client sides, of the need to have quality functions integrated into the health care system. It has also been acknowledged that it is particularly necessary to pay special attention to these functions in times of health system reforms.

A number of quality instruments and methodologies have been transferred, translated, tested, adapted, and implemented as part of quality improvement programs in the region:

- Health professionals and managers have undertaken many study tours and attended conferences, courses and workshops;
- Professional and branch organizations have been supported in setting up and developing new quality functions (e.g. Kyrgyzstan);
− Ministries and health financiers have been supported in developing quality policy and improvement initiatives (e.g. Bosnia/Herzegovina, Russian Federation);
− Educational, scientific and research organizations have undergone an institutional building program and revised their curricula (e.g. Estonia);
− PHC practice guidelines were developed and implemented and evidence based medicine promoted (e.g. Armenia, Latvia, Romania, Tajikistan);
− Accreditation of PHC facilities and certification of PHC practitioners has been set up (e.g. Bosnia/Herzegovina, Kyrgyzstan, Uzbekistan);
− Information management has been reinforced for quality enhancement (e.g. Bulgaria, Kyrgyzstan); and,
− Lots of technical assistance has been provided.

In the completed/closed projects, medical practice guidelines or protocols are developed and are increasingly oriented toward derivation by evidence-based and cost-effective approaches independently or in conjunction with training/re-training of physicians (e.g., Estonia, Kyrgyzstan, Macedonia). Evidence-based medicine has been promoted (mostly through clinical guidelines) to improve health outcomes, and also to improve the organization and management of the medical practice, decrease costs of treatment, and stimulate utilization of cheaper services (e.g., primary or day care instead of hospital care). In later projects, the scope of projects related to quality have expanded to include issues such as: health professional licensing, certification, and re-certification; medical technologies assessment, management, and maintenance; pharmaceuticals licensing, provision, and distribution; facilities planning, licensing, management, and maintenance; quality legislation and regulation; support to professional and branch organizations and associations; and establishment of national agencies for accreditation and quality assurance.

Case Study 5
Bosnia/Herzegovina – Accreditation and Quality Improvement

The Basic Health Project in Bosnia/Herzegovina is supporting a phased approach to the development of accreditation and quality improvement infrastructure in the country. Critical developmental activities have included: formulation of policies on health care quality; development of principles and methods; writing of laws and regulations in support of accreditation and quality improvement; formation of technical working groups to develop clinical practice guidelines for PHC; drafting of accreditation standards for PHC; formation of an independent Agency for Accreditation and Quality Improvement; and, development of strategic and business plans for the Agency for Accreditation and Quality Improvement. Continuing activities for the remaining project period will include: training in modern methods in quality assurance and, development and piloting of criteria for accreditation of health care facilities.

Impact and outcomes
Development of guidelines and protocols using principles of evidence-based medicine and cost-effectiveness has been supported to a considerable extent. In some instances, there has been good integration of the protocol development with physician training, and selection and monitoring of project evaluation indicators (e.g., Kyrgyzstan). Some practice guidelines were developed by the WB projects using systematic reviews of evidence and incorporation of cost effectiveness methods and were issued by the government (e.g., Armenia, Estonia). However, there is frequently a need for a similar process to be mainstreamed into overall medical guidelines and protocol development in the country (e.g., Estonia). It seems that early preference was given to instruments that could be used to solve a number of problems emerging during the reforms, rather than to a balanced development of a more comprehensive quality system within the sector. Some approaches to quality
were used to regulate capacity (planning), sometimes having this as the only quality control and reporting system. It is not clear to what extent new medical guidelines and protocols have been or are taken up in actual medical practices since methods of monitoring and evaluation of medical care and practice (beyond the Soviet command and control model) have been limited.

Health financing reforms (usually from national budget to insurance based systems), initiated as part of these programs, have also managed to raise interest among and involve health care financiers in the quality improvement efforts (e.g. Russian Federation). However, professional (medical, nursing, patient associations) and branch (hospital, health insurers, home care associations) organizations, health management and quality training and research centers at universities, quality institutes (advising, consulting, auditing) are often limited to operationalization and implementation of small scale Government or health insurers-initiated actions.

Other donors and international organizations have managed to support quality improvement activities on all levels of the system and have been able to stimulate a bottom-up approach. A broad range of instruments, often adapted for local use, have been introduced, strengthening local capacity for primarily processes and outcome interventions.

Project Design and Implementation
As always, government “ownership” of the goals and objectives of PHC are critical to the ability to initiate and implement key elements of primary care and family medicine. For example in Estonia, the success of the project was directly attributed to the strong policy environment and the Government’s commitment to implementing PHC regardless of political affiliation. On the other hand in Kazakhstan, there was little Government “buy-in” resulting in the passage of laws and regulations that conflicted with the principles of PHC. There was lack of commitment on the part of project management as well. The project was suspended by the Government at one point and, eventually, cancelled. In Turkey, Parliament did not support the intended reforms and, therefore, did not take the actions necessary to implement them. In other projects, political instability (multiple changes in governments over the life of the project) and armed conflict have hampered efforts to implement PHC.

A common challenge has been insufficiency, or delay, in the availability of counterpart funds for construction (e.g., Turkey). In Armenia, community contribution was reduced from 10% to 2% because of the lack of a cash economy outside the capital city.

Necessary precursors to PHC implementation have been lacking in some projects. Important policies and plans are needed to precede implementation of PHC such as, enabling legislation and regulations (e.g., in the Russian Federation, all activities are prohibited unless specifically allowed by law or regulation). Key system relationships need to be defined e.g., the relationship between primary care providers and secondary/tertiary providers, gatekeeper’s role, financial risk, referral patterns and criteria, etc.

Other projects have attempted to take a comprehensive, integrated approach to the reform of health service delivery in general practice and family medicine.
A consistent theme has emerged when attempting to identify enablers or barriers to PHC implementation – providers and consumers have insufficient knowledge or information about the nature, the potential benefits, or the tradeoffs of the reforms. Western style and models of PHC were unknown to the ECA region during the Soviet era. Transformation of health delivery systems toward outpatient, family centered primary care may face challenges, false starts, mistakes, and unintended consequences. Providers unfamiliar with the principles and practice of PHC may feel threatened professionally or financially. Some stakeholders may also be negatively affected. The general population has little understanding of the objectives of PHC, and of the potential benefits of the PHC transformation. And some principles of PHC management e.g. appointment times, restricted access to specialists, decreased home visits by EMS may be unpopular with the general population. There is a need to manage the changes brought about by PHC implementation – primarily through information sharing and stakeholder consultation and involvement.

Case Study 6
Georgia -- Comprehensive Design for Development of PHC

A new project in Georgia will support the Government’s established national policy and plan for development and implementation of PHC in the country with priority to the rural, high mountain areas where poverty is high and health status is poor. The project envisions a phased approach to development with an initial focus on the foundational elements of PHC such as: development of the legal and regulatory support to enable training, practice, accreditation, and licensing of providers and facilities in PHC/GP/FM; establishment of standards for PHC facilities; health workforce analysis; development of a PHC facility and provider master-plan for the country; and, development of a management structure and plan for PHC. Subsequent activities will establish PHC regional PHC training centers; train additional PHC trainers; train physicians in short courses as well as in post-graduate residency; begin assessment of undergraduate medical education related to educational needs in preparation for PHC; refurbish and equip PHC clinics in one rural area (as a pilot project) with roll out to the remaining rural areas of the country in later phases; and, education and involvement of rural communities in PHC, project planning and implementation. The initial phases of PHC clinic implementation will be linked to a capitated provider payment mechanism for a basic package of services that already exists in the rural areas of Georgia but also needs to be evaluated and revised.
WB projects have been able to complement the efforts of other international organizations and donors when activities have been well coordinated or parallel-financed (e.g., Georgia). However, there have also been challenges such as, incongruence in timing of project implementation by the respective organizations resulting in mismatched activities; depletion of promised resources provided by international partners, leaving WB efforts vulnerable, or, realignment of partner priorities in a particular country, away from PHC.

Case Study 7
Latvia – Implementation of Health Reform Communications Strategy

The Health Reform Project developed a two-year communications strategy to generate a greater sense of awareness of health and health reform issues among the public and stakeholder groups. The objectives of the plan are to: explain health reforms and why they are taking place; identify how the public can most effectively and appropriately access health services and participate in the health insurance program; explain how society as a whole will benefit from reforms; identify the role of physicians and other care providers; build credibility and support for health reform initiatives by replacing misinformation and misunderstanding with practical knowledge; and, build a renewed sense of personal responsibility for health. The plan includes techniques such as optimum timing, sustained messaging, right media mix with appropriate market reach/impact, continual monitoring and evaluation, public opinion polling, gathering of political and stakeholder responses, and campaign adjustments to reflect evolving issues.

However, due to financing related difficulties, all pieces of the communications strategy were not implemented according to plan. Serial surveys indicated that the average index of information level had changed very little from mid-2002 to mid-2001 among the general public and among health professionals. The project intends to more fully exploit the potential of using a professional public relations firm to better achieve the communications goals for health reform.
III. LESSONS FOR THE WORLD BANK

Through its pioneering efforts, the World Bank has demonstrated a strong commitment to primary health care in ECA by provisioning substantial resources and providing technical assistance - representing the largest investments in PHC in the region. Early interventions undertaken in PHC were designed to produce quick, visible results to meet short-term goals related to health reforms. There was an emphasis on inputs over impacts or outcomes. Early efforts also emphasized pilot-approaches with the hopes of “rolling out” or scaling up of successful components. But, over time, the projects have become more complex in recognition of the numerous challenges that impede the full implementation of health reforms.

Have World Bank projects and investments in PHC achieved the intended goals? In many countries, national health status indicators have improved from their nadir in the mid-1990s (particularly in Eastern Europe). However, the influences on health and health status are multi-factorial, multi-sectoral, and heavily affected by socio-economic conditions for which health care services play some, but not an exclusive, role. Improved access and scope of services have been achieved in some countries, particularly where PHC has been targeted in rural areas. Important steps have been taken through protocol development, training, and establishment of assurance mechanisms to try to make quality improvement a permanent and integrated function in the health care system. A variety of provider payment mechanisms and models of practice have been tested. Health care systems have begun to transform themselves (albeit, at times, imperfectly and slowly) toward outpatient orientation.

The Bank’s approach to PHC in ECA lacks a cohesive strategy that should not only addresses the constraints on effective policies, strategies and programs but also lay out concrete actions to resolve such constraints. PHC models, approaches, and priorities vary widely from country-to-country and sometimes within a single country, without clear indications of the analyses or criteria used to select them or the relationships to activities of other international organizations or donors. There are few materials or resources to guide an assessment of the overall status of a primary care system for project preparation, supervision, or evaluation. Overemphasis on “late-stage” interventions in systems development (e.g., refurbishment and equipment) without sufficient attention to the foundational elements of a PHC system (e.g., legislation, regulation, health manpower planning, facility master-planning, strategic planning, human resource development, definitions of roles of PHC in the health care system and functional relationships to secondary and tertiary care, management of change, PHC management structure and function, etc.) threatens the success, replicability, and sustainability of health system development activities. Isolated interventions with narrow focus on single parts of the PHC system (e.g., financing) may be necessary but insufficient to effect change without investment in a “critical mass” of other system components needed for true system functionality. A great deal of operational experience has been accumulated from WB projects with components or subcomponents related to PHC. However, communication of project results, lessons learned, and/or “best practices” have been scant and informal.

There have been insufficient efforts in the identification of health manpower needs for the future, and in the definition of the balance required between primary care and specialty care. Medical professionals well trained in primary care are still in short supply in many countries. There are unanswered questions about the actual performance of specialists, re-trained to provide more primary care-oriented services in outpatient settings. A short term strategy to re-train physicians and nurses for practice in primary health care will be insufficient to meet countries’ long term needs for health care reform and for improving the health of the population through primary care. Restructuring and reform of basic medical, post-graduate medical, and basic nursing education will be critical to long-term sustainability of development and implementation of health systems reform, to primary health care, and to the health care needs of the population.
While the variety and flexibility in training approaches are commendable the ability to evaluate the impact and outcomes of PHC training in WB projects is limited and challenging due to the numerous and different approaches to PHC training being implemented. There is wide variation in length of training, in training curricula, and teaching methods. It is unreasonable to assume or expect that the knowledge, skills, and competence of a physician who has received eight weeks of classroom lectures only will be the same as that of a graduates of a formal 2-3 year postgraduate medical program that included techniques based on adult learning theory, problem-based learning, diagnosis of undifferentiated patient complaints, and supervised clinical practice. Nor is it likely, that the practice styles will be the same for those physicians who received training primarily in the form of “bundles” of disease-centered information, derived from numerous vertically organized programs, when compared to those whose training emphasized the key processes of patient care such as first contact care, longitudinal continuity of care, comprehensive family-centered care including psycho-social aspects, doctor-patient interaction/communication, and coordination of services.

The graduates of the varied approaches to PHC training are frequently interchangeably called general practitioners, family doctors, or PHC specialists. They receive “certificates”, “GP licenses”, or “specialty certification” without clear distinction or acknowledgement of the differing extent of training and the level of knowledge and skills attained. The evaluation of and the expectations of impact and outcomes in terms of improving health status of the population, broadening the scope of services accessible to the population, improving the quality of care, and enhancing the efficiency of health services delivery have been the same without differentiation by level or extent of training. “Lumping” and misclassification of the graduates of various levels of PHC training will only continue to confuse the analyses of the delivery of health care services and obfuscate the potential contributions of PHC to health system reform.

The variety of practice models employed and the scope of practice adopted also will make evaluation of the impact and outcomes challenging. The clinics are frequently referred to as GP practices, Family Medicine clinics or PHC practices without clear distinguishing or acknowledging the difference in practice models or scope of practice adopted. However, analogous to PHC physician training, the expectations of the impact and outcomes, in terms of improved health status of the population, in broadening the scope of services accessible to the population, improving the quality of care, and enhancing the efficiency of health services delivery, have been the same without differentiation of the practice model employed, or scope of practice permitted to, the generalist physicians. Once again, “lumping” and lack of differentiation of the various practice models or scope of practice for generalist PHC physicians will only continue to confuse the analyses of the delivery of health care services and obfuscate the potential contributions of PHC to health system reform.

The ability to directly evaluate the impact and outcomes of WB PHC-related projects on improving the health status of the population as well as on equity, access, quality, and efficiency of primary care services is limited. Assessment and evaluation have been hampered by factors such as (but not limited to): insufficient attention and planning for monitoring and evaluation (M&E) in project design; insufficient resources earmarked in project budgets or in Bank supervision budgets for M&E; lack of collection of baseline data or information by which to assess changes over time; selection of inappropriate M&E indicators that are unrelated to the project activities or objectives; inability to attribute changes in health status or national indicators to project activities because the project is operational in only a small area of the country; selection of unrealistic targets for indicators for which there is little chance of achievement over the short life of a 4 to 6 year project; lack of information systems to capture information needed for M&E; a legacy of non-use of data for policy or management in client countries; and, limited documentation available on project activities and outputs to permit retrospective assessment.

It is important to recognize and acknowledge that development and implementation of health reform, health system development, and specifically primary health care is a long-term process. Systemic change involves
technical detail, policies, as well as politics for which development and implementation of PHC is not immune. The introduction of new concepts and new processes into a previously closed system necessarily results in disequilibrium. This can cause confusion, resistance, stress, misunderstanding, and unforeseen consequences. However, all dynamic systems eventually reach a new steady state. The management of change has been insufficiently addressed in many WB PHC projects.
IV. AGENDA

Over ten years of cooperation in Europe and Central Asia, by the World Bank and its partners, has built a solid basis for supporting health system development in the future towards the creation of a sustainable, integrated primary health care system. However, the next phase of development might require different approaches with greater emphasis on long-term goals and objectives.

Primary Health Care, General Practice, and Family Medicine (PHC/GP/FM) can play an integral and critical role in health care reform and health system development. The World Bank’s emphasis on PHC/GP/FM has been a key intervention in health reform in the region permitting migration of care and services from inpatient to outpatient settings. Continued emphasis on PHC/GP/FM as the foundation of health reform can serve to decrease fragmentation of care and services in systems formerly reliant on narrow specialists and can substantially improve continuity and coordination of individual personal health care services. With proper training and incentives, PHC/GP/FM can further promote enhancements in efficiency in delivery of health services by better serving as a gatekeeper – a role that was under-developed and poorly utilized during the Soviet era. PHC offers an opportunity to better integrate important interventions in public health and disease prevention and to achieve corporate priorities (such as the Millennium Development Goals) rather than to rely on expensive, poorly sustainable, and fragmented approaches that frequently result from a series of vertical, disease-specific or program-specific “silos”. PHC/GP/FM can also enhance the opportunities for developing pro-poor interventions by offering a pragmatic solution to the challenges of providing a broad range of health care services, preventive services, and public health interventions in rural areas where, historically, the prevalence of poverty has been high.

For the next 3 to 5 years, World Bank activities in ECA related to PHC/GP/FM should include:


A PHC/GP/FM strategy for ECA that addresses both short and long-term goals and objectives would provide guidance on effective policies, approaches, and programs to Bank staff and to client countries while acknowledging the diversity of circumstances in the region. A PHC/GP/FM strategy could provide a systematic approach to: health systems assessments vis-à-vis PHC/GP/FM; functional assessments; needs assessments; phased approaches; and, concrete actions to resolve constraints to PHC development and implementation.

2. Development and adoption of operational tools that will enhance development and implementation of PHC/GP/FM.

Key priorities for operational tools include development and testing of an instrument for health systems assessment of the status and functionality of the foundational elements of PHC/GP/FM including (but not limited to): enabling legislation and regulations; practice models in place; undergraduate and post-graduate training approaches used; scope of practice permitted; provider payment mechanisms and financial incentives employed; roles of PHC/GP/FM in the health care system and its functional relationships to secondary and tertiary care; manpower planning for PHC/GP/FM; facility planning for PHC/GP/FM; plans and commitments for sustainability of PHC/GP/FM; PHC/GP/FM management structure and function; relevance of PHC/GP/FM training and scope of practice to disease burden; physical and logistical characteristics of facilities, equipment, and distributional support; plans for management of change and information strategies for implementing PHC/GP/FM; and, roles and activities of other international organizations, donors, and non-governmental organization in PHC/GP/FM.
3. **Enhance knowledge development on PHC/GP/FM through expanded and more in-depth ESWs.**

Critical work is needed to better understand the relationships of key parameters of PHC/GP/FM (such as scope of practice, practice model, type and length of training, and provider payment mechanisms) to each other and to outcomes and impact (such as access to care, equity, efficiency, quality, and health status). There is a need for development and testing of proximal indicators in PHC/GP/FM that are earlier predictors of favorable outcomes and impact on access to care, equity, efficiency, quality, and health status. There is tremendous need for better information to advocate within the Bank and with clients for making primary health care a high priority for the development agenda. Otherwise, there is considerable risk of the health development agenda being overtaken or replaced by disease-specific or vertical-program approaches that are costly, of questionable sustainability, and inherently narrowly focused.

4. **Increase knowledge of Bank staff and of client countries about the technical issues related to development of PHC/GP/FM.**

There are multiple models and approaches to developing and implementing PHC/GP/FM. No one model or approach will necessarily meet the needs of all countries. Approaches should be individualized and customized to the financial, logistical, and political realities in each country. However, the Bank could assist in knowledge management by collation and dissemination of information about PHC/GP/FM such as (but not limited to): developmental phases/cycles of PHC/GP/FM; options for scopes of practice; options for practice models; potential roles of PHC/GP/FM in health systems and relationships to other parts of the system including secondary and tertiary care; options and/or samples of PHC/GP/FM curricula for undergraduate and post-graduate training; management of change strategies and approaches; sample legislation and regulations for PHC/GP/FM; lists of potential national and international consultants and/or centers of PHC/GP/FM excellence; etc.

The Bank should consider development of new knowledge and knowledge management through resources such as: dedicated trust funds for international technical assistance in PHC/GP/FM services development with emphasis on system functionality; and, integration of principles and practice of PHC/GP/FM into a Flagship Course on health sector reform.

5. **Increase emphasis in PHC/GP/FM operations on primary care functions (i.e. first contact care, continuity of care, comprehensiveness of care, family-centered care, coordination of care) in addition to prevention, health promotion, and away from a disease-centered orientation.**

6. **Increase attention and resources to WB project monitoring and evaluation in order to better understand the contributions of PHC/GP/FM to health system reform and to better calibrate the WB responses and activities in ECA.**

7. **Improve health information and surveillance systems to enhance ability to evaluate interventions.**

8. **Enhance partnerships and coordination with other international organizations, donors, and non-governmental organizations regarding PHC/GP/FM.**

Historically, client countries and ministries of health have been weak in donor coordination. There are good examples of close collaboration in PHC/GP/FM between the World Bank and other international organizations, donors, and non-governmental organizations in the region. However, in some countries, lack of communication, coordination, and collaboration between international organizations, donors, and non-governmental organizations has resulted in confusion, fragmentation, duplication, and competition of PHC/GP/FM activities “on the ground” in countries. Roles and responsibilities need to be clearly defined in
order to order to increase the probability of development effectiveness. No one particular organization or donor necessarily should take the lead in all countries. Roles of the World Bank in development and implementation of PHC/GP/FM may vary from country-to-country but should complement and be coordinated with other organizations. The role of the Bank in development and implementation of PHC/GP/FM should be catalytic.

Clearly, the Bank does not have sufficient technical capacity in many areas of development and implementation of PHC/GP/FM and depends on the skills and knowledge of partner agencies, including those in client countries. New partnerships may need to be developed to build the technical support and technical base of knowledge in the Bank related to general practice and family medicine. Nonetheless, the Bank has a comparative advantage that derives from its client focus, country-specific knowledge, comprehensive perspective, potential to integrate across sectors, long-term commitment, convening powers, and ability to work with the public and private sectors. The diversity of roles and functions in primary health care is matched by the variety of instruments at the Bank’s disposal, including not only conventional investment projects but also country assistance strategies (CASs), comprehensive development frameworks (CDFs), poverty reduction strategy papers (PRSPs), and non-lending services.