International Health Congress
KRG – Iraq Ministry of Health
Erbil, 4th February 2001

The role of Family Medicine in Health Reform: some international perspectives

Dr. Egbert Sondorp

Senior Lecturer

Department Global Health & Development

London School of Hygiene and Tropical Medicine

Family Medicine

Family medicine is the medical specialty which provides continuing, comprehensive health care for the.

It is a specialty in breadth that integrates the biological, clinical and behavioral sciences.

The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity.

Health Reform

"sustained, purposive change to improve the efficiency, equity, and effectiveness of the health sector"

"with the objective to improve population health, improve health-system performance (cost-effectiveness), enhance risk protection, and heighten public satisfaction"

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Typical Health Reform elements

- Separation of functions
  - policy-setting, health care provision, financing, and regulation not necessarily in one hand
  - ‘purchaser-provider splits’
- Enhance role for non-State organisations
- Strengthening of market approaches
- Decentralisation
- Clinical packages, evidence-based medicine, explicit prioritization
- Integration of vertical approaches
- Shift in funding approach
  - e.g. user fees, social insurance

Transitional Contexts

- Accelerated reforms
- Window of opportunity for (positive) change.

But beware:

- All transitional contexts are different
- All health systems are different
- All reform processes are different.

Example of health reform in (extreme) transitional context

Afghanistan 2001/2002

- Prolonged war
- Poor health status of population (25 M)
- Wide-spread poverty
- Government health system collapsed
- Pre-existing system: urban bias; hospital based
- The limited services that were provided were run by NGOs

The “Afghan Model”

- Health Policy (‘what’)
  - Delivery of BPHS to all Afghans
    (BPHS=Basic Package of Health Services)

- Implementation model (‘how’)
  - Government sets policy, regulates, procures and monitors
  - Contract partners (NGOs) provide the BPHS
  - Largely financed by the international community

Transitional contexts with introduction of family medicine

Central and Eastern Europe (after fall of Berlin wall)

- Extensive reforms of health systems in all countries in the ‘post-Soviet’ era
- Against a backdrop of major political and socio-economic change

Two examples of lessons learned:

1. Kosovo
2. Review of reforms in central and eastern Europe

Kosovo (1999)

- Tax-based ‘Semashko’ model of health care delivery
- Primary care through ‘polyclinics’, with general practitioners, paediatricians, dentists, gynaecologists, physiotherapy, laboratory
- Functioned relatively well, but deteriorated during the long conflict

Kosovo Health Reforms

Emerging health policy (after 1999):

- Strenghten primary care through the development of family medicine teams
- Specialist care through referral
- Facility plan (size and location linked to catchment areas of typically 10,000 people).
- Training of doctors and nurses in family-medicine

Kosovo Primary Care

- To treat 80-90% of presenting health problems
- Diagnosis &curative care, incl. minor surgery; emergency care; maternal and child health; reproductive health
- Prevention (health education, immunisation), home visits; community mental health; palliative care
- Individuals to choose family doctor, who should coordinate specialist care
- Financial penalty for bypassing referral system

Kosovo Reforms: progress

Mixed progress:

- Family medicine was endorsed and accompanied by well established training programmes
- But no great enthousiasm, rather tolerated or resented (by family doctors + specialists)
- Gate-keeping role underdeveloped.
- Poor capacity of MoH to fully implement
- Poorly regulated private practice (and payments)

Review of health reforms EE

Three key elements in reform:

1. Establishment of health insurance systems
2. Growing reliance on out-of-pocket payments (both formal and informal)
3. Strengthen primary health care through a family medicine model

Primary health-care reform EE

- Away from pre-exisiting emphasis on hospital care
  - General practice instead of polyclinics
- (Re-)train physicians as general practitioners
  - Training quite minimal; still low status and prestige
- Isolated elements of reform
  - Need for more comprehensive model of care
- Evidence base for family medicine as being superior to the polyclinic model weak
  - Few rigorous assessments of results

Some key lessons

1. Implementation is bottleneck and usually much more cumbersome than anticipated
2. Need for Government/MoH capacity to implement
3. Need for capacity in policy analysis and planning
4. Health needs of populations to be taken into account
    1. Demograpic and epidemiological transitions
    2. Care that is better equipped to deal with co-morbidities and chronic diseases

Key references

1. Percival V, Sondorp E
   A case study of health sector reform in Kosovo
   Conflict and Health, 2010, **4**:7

2. Rechel B, McKee M
   Health reform in central and eastern Europe and the former Soviet Union
   Lancet 2009; **374**:1186-95