# Inverting the Pyramid: Strengthening Primary Care in Central Asia

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The health care system in the Central Asian Republics can be pictured as a pyramid, with the hospital sector forming the base and primary care the apex. Hospitals consume more 70 percent of health spending compared to 30 percent for public health and primary care.

ZdravReform, a USAID-funded project of US-based Abt Associates, is working to change this imbalance. The project helps the governments of Kyrgyzstan, Kazakstan, and Uzbekistan to improve the efficiency of their health care systems by shifting clinical care and resources from expensive hospital care to cost-effective primary care, which can best address the principal causes of mortality and morbidity. Improving the system of primary care requires an integrated approach to health reform that combines changes in organization of care with new methods of financing.

Abt has introduced this approach health reform demonstration projects in Issyk-Kul Oblast, Kyrgyzstan; ZhezkAzgan and Semipalatinsk Oblasts, Kazakstan, and Fergana Oblast, Uzbekistan. At the core of the reform process in all three countries is: 1) re-organization of primary care into Family Group Practices (FGPs), 2) clinical training, 3) new incentive-based payment methods, and 4) free choice of providers by the population.

Historically, primary care services were fragmented into separate polyclinics (outpatient health centers) for children, adults and women seeking gynecological and pregnancy-related care. Patients had no choice of the polyclinic they went to nor their primary care physician. And rather than treating a range of age groups and illnesses, as do family physicians, primary care physicians specialized in a particular population: internists served adults, pediatricians treated children, and gynecologists served women--all in different locations. These first-contact primary care physicians had limited clinical capabilities due to inadequate equipment and insufficient training.

For example, a primary care physician frequently referred children with an ear infections to a specialist, because the physician did not have an otoscope or clinical training in the diagnosis and treatment of ear infections. Furthermore, since polyclinics were financed on budgets based on the number of staff and visits, there was no incentive not to refer, and primary care physicians functioned as indifferent dispatchers.

To remedy these problems, ZdravReform set a goal of providing comprehensive primary care with free choice of provider. This led to a strategy of combining the separate polyclinics for adults, children and women into independent FGPs, which consist of a small number of pediatricians, internists, gynecologists, nurses, and a practice manager. With free choice and competition in mind, a large number of FGPs have been formed, some within polyclinics and others dispersed throughout the community. The FGPs have been provided with necessary equipment, such as otoscopes, and intensive clinical training so that the practices can improve and expand their scope of clinical services. New treatment protocols are also being implemented, such as World Health Organization guidelines for acute respiratory infections and diarrheal diseases, and modern methods of family planning.

The formation of FGPs is only the first step in shifting to a system of family medicine. In the FGP, primary care is provided by the three traditional specialties working as a group. The goal, however, is to transform these narrow specialists into family practitioners. This is a long-term process that requires far-reaching changes in the medical education system in all three countries. For example, in Kyrgyzstan, the Post-Graduate Training Institute, with the

assistance of American family physicians, has established a one-year clinical program to retrain existing specialists into family practitioners.

The formation of FGPs and the training of family physicians is closely tied to the introduction of new payment systems that create an incentive to improve the productivity of primary care. The first step has been to give independence to FGPs so that they have their own bank accounts and management autonomy to run their practices. FGPs now function more like small businesses, and this has created a need for a new specialist who can manage the new financial systems--the FGP practice manager. ZdravReform is providing assistance in training these managers. The FGP is paid by capitation (specified amount per person) based on open enrollment. Total health care spending is divided by the population to create an amount per person (capitated rate). Patients have free choice to enroll in any FGP, and the number of patients enrolled determines the FGP's budget.

Free choice of providers by the population is one of the most dramatic reforms that has been introduced. During the enrollment campaign, the population is given detailed information on all of the FGPs and is given the right to choose their primary care provider. In Issyk-Kul, Kyrgyzstan and in Zheskesgan, Kazakstan, the open enrollment campaigns were so successful that over 90 percent of the population turned out to choose one of the various FGPs. Open enrollment creates competition among primary care providers and this has led to far-reaching changes in FGPs. For example, in Zheskesgan many of the FGPs are now open at night for patient convenience. The enrollment process is a method for actively involving the population in their health care, and promoting democracy at the grass roots level.

The next step in payment reform is the introduction of "fundholding." The idea is to give FGPs financial control over referrals for specialty consultations and hospital services as a way to create a stronger incentive to decrease referrals and expand the scope of clinical services. The introduction of fundholding is a long-term goal and many reforms must be put in place, such as a comprehensive information system. In Zheskesgan, partial fundholding will soon be implemented. In the first phase, the capitation rate to FGPs will be increased to cover specialized ambulatory services, such as consultations with specialists. FGPs have the right to purchase these services from any outpatient provider. If they decrease their referrals, they will be able to use the money they save to reinvest in their practice.

Although the central thrust of health reform is primary care, the resources needed to fund primary care must come from savings generated in the hospital sector. ZdravReform has helped the health insurance funds in Kazakstan and Kyrgyzstan introduce a new hospital payment system that encourages competition and efficiency. In Issyk-Kul and Zheskesgan, hospitals are being paid per treated case using a simplified system analogous to Diagnosis Related Groups (DRGs), used by the United States Medicare program. Hospitals are paid the average cost for each clinical group regardless of length of stay. FGPs have the right to refer to any hospital. This creates incentives to decrease the historically long hospital stays and increase turnover. In addition, it creates stable payments for hospital care which are needed to introduce hospital fundholding.

These demonstration projects in Central Asia have created a working model for health reform that is being used as the basis for national health reform in all three countries. World Bank support is now helping replicate the projects on a national basis. The demonstrations show that even under the constraints of chronic under-financing, it is possible to improve significantly the health system by using existing resources more effectively. Already one can see significant improvements in patient satisfaction because of more responsive and clinically enhanced primary care. Meanwhile, the hospital sector is decreasing in size and increasing its efficiency. As FGPs increase their clinical capabilities, health resources will flow into primary care, thus inverting the pyramid.

*The authors work with Abt Associates' ZdravReform program in Central Asia.*