Out of Hours

International primary care snapshots:

Armenia and South Africa

MAKING STRIDES TOWARDS FAMILY MEDICINE IN ARMENIA

Primary health care (PHC) has come a long way since Armenia gained independence in 1991. The former Soviet health service had to face the problems of transition to a market economy. A reform programme was launched in 1997 to move from the polyclinic system to family medicine (FM) with the programme aiming to create a strong and skilled PHC sector and a Basic Benefits Package for all citizens.

Family medicine academic capacities were created in Yerevan State Medical University and the National Institute of Health. From 2000–2010 around 1500 polyclinic PHC doctors were retrained through 1-year conversion courses to become family physicians (FPs) in a race to build the workforce. The curriculum and training modules were created through the support of international experts and training courses in Western university clinics. Novel clinical teaching methods were introduced and clinical preceptors were trained countrywide to be involved in the retraining process, creating a cohort of modern-thinking professionals.

The shift to FM has been uneven. In the cities, the old polyclinic system persists, perhaps because of the abundance and power of specialists and administrative staff. As in Soviet times, PHC in urban polyclinics is provided by therapeutists for adults and paediatricians for children working alongside specialists such as general surgeons, gynaecologists, and ENT specialists. The scope of the PHC practitioners work however, is severely constrained by the polyclinic specialists.

In the villages progress towards FM has been more successful. FPs work in new-style ambulatories alongside specially-trained PHC nurses and midwives, providing comprehensive primary care to the population. Most FPs work in state-provided centres. Income consists of a basic allowance (scaled according to experience and qualifications), capitation and various bonuses such as hitting targets. Capitation is designed to encourage medium-sized lists typically between 1500–2000. Pay is low, about £200 per month. A British GP sitting in would find the scope and complexity of the FPs' work familiar. They would also recognise the pride and enthusiasm many FPs have for their work. Revalidation is through accumulation of sufficient continuing medical education (CME) credits over a 5-year period.

Patients must register with a state PHC provider to receive the Basic Benefits Package. Under the previous system, fees were a barrier to access, especially for the poor whose numbers were rising following the end of the Soviet era. The package consists of free consultations and investigations in primary care but not medication. This, and the availability of many drugs without prescription, may explain why some adults self-medicate with what would be prescription-only drugs in the UK. Certain groups, such as older people, children, the indigent, and those with some chronic disorders, are entitled to free prescriptions. Patients have to pay for secondary care services but private medical insurance and the Social Package for the state sector covers the costs for some.

Preventative medicine and long-term management of non-communicable diseases (NCD) are assuming greater importance as long-term conditions increase in frequency. High rates of smoking among males and an increasingly first-world lifestyle drive the changing pattern of chronic diseases. Free health checks for NCDs have been introduced in the past year with training and guideline development for managing NCDs being rolled out throughout the country through CME sessions, as well as supporting documents and guidelines.

Crucial to the progress of PHC has been the development of an academic discipline. The Yerevan State Medical University, Armenia's only state medical university and provider of the FP qualification, hosts a FM department actively supported by its rector, himself a respiratory physician.

Currently, a 2 year residency (vocational training) programme and an exit examination are mandatory for entry into FM. While FM is now considered a specialty, a mere 3 weeks' allocation in the 7-year undergraduate curriculum of the Yerevan State Medical University suggests its status remains low. The Family Medicine Academic Society, a professional association open to all FPs, significantly contributes to CME and the raising of standards and status of FM.

While the benefits of universally-accessible PHC (greater effectiveness, efficiency, and equity) are officially recognised, old attitudes and new commercial pressures put up hurdles. In just 15 years and with <3% of GNP spent by the state on health, the progress of PHC in Armenia is truly impressive. Problems that still need addressing are: lack of trust in FM in the cities; the low status of FPs; and the too-short undergraduate exposure and brief specialist training programme for FM. Building strong FM organisations with continued official support are vital to tackling these problems and continuing progression.

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SOUTH AFRICA: A 20-YEAR STRUGGLE FOR PRIMARY HEALTH CARE

With the end of Apartheid in 1994, the new government announced that primary health care for all South Africans would form the cornerstone of health policy. They inherited a system deeply fragmented along racial and geographic lines and in many communities, completely absent. Nelson Mandela announced almost immediately that primary care would be free to mothers and children, placing additional pressure on services. Health managers realised that the only way to offer primary care at scale was for it to be driven by nurses and supported by doctors.[1] Today 80% of all consultations in public sector primary care are with nurses.[2]

The HIV/AIDS epidemic followed swiftly on the heels of the political transition with prevalence rising from 0.7% in 1990 to 24.5% among pregnant mothers by 2000.[3] The burden of disease facing primary care remains dominated by HIV and tuberculosis (TB), both of which are still largely treated in vertical programmes, and South Africa now has the dubious honour of having the greatest number of people on antiretroviral treatment in the world.

South Africa has a quadruple burden of disease with interpersonal violence and trauma, maternal and child health, and non-communicable diseases making up the other quadrants.[4] A primary care morbidity survey in the public sector in 2012 found that hypertension, upper respiratory tract infection, HIV/AIDS, type 2 diabetes, and TB were the five commonest conditions seen.[2] Interestingly, the survey also showed that mental and social health problems were rarely recorded, indicating that our primary care lacks a 'broad and holistic perspective to the patient's problems', which is a hallmark of medical generalism.[5]

South African society remains one of the most unequal in the world and the healthcare system continues to mirror this inequity. Although the country spends around 8.6% of the GDP on health, 60% of this is spent in the private sector for only 16% of the population.[6] The more affluent and employed section of the population have health insurance and through this can access primary care from private (largely in a fee-for-service system) GPs. As a colleague put it recently, a mother with a sick infant will see a qualified doctor with 8-years of basic training in the private sector and have easy access to specialist care, while a mother in the public sector will see a nurse with 1 year of training in primary care. Doctors are a scarce resource with only 3.7 medical practitioners per 10 000 population (excluding specialists) and 70% of them are likely to be in the private sector.[7] Similar inequities are seen between rural and urban areas.

In response to these challenges the government announced plans to ensure universal coverage through national health insurance within the next 15 years.[6] The initial plans require the quality of public sector primary care to be significantly improved and the resources in the private sector to be shared in a more integrated system. Several initiatives have been implemented including; district clinical specialist teams (dyads of clinical specialists and specialised nurses in the three disciplines of family medicine and primary care, obstetrics and midwifery, and paediatrics and child health), to improve health outcomes for mothers, newborns and children; enhanced school health services to focus on prevention and health promotion; and ward-based outreach teams. These are teams of community health workers and nurses, supported by doctors, who take responsibility for a specific group of households, in a model similar to Brazil.[8] This initiative, if successful, will transfer the health service from being reactive, curative, and facility-based, to being more proactive, preventative, and community-based. A further government initiative is that of the Ideal Clinic, which defines the norms and standards expected of all clinics in the country: access to a doctor now being one of these standards. An initial attempt to integrate resources from the private sector has been a drive to contract with GPs in the national health insurance pilot districts so that they can offer a service at local clinics in the public sector.

Student doctor prepares injection. **Photograph by Estelle Coetzee — courtesy of Van Schaik Publishers.**

Universities responded to the country's needs by incorporating exposure to primary care in all undergraduate medical curricula. The Health Professions Council of South Africa also mandated that the obligatory internship include 3-months in primary care. After a 2-year internship, doctors are required to offer a year of community service, which may be in the district health services. Following this, no further training in primary care is required, and any doctor who has satisfactorily completed undergraduate training, internship, and community service will be registered as an independent practitioner and can enter general practice. However, in 2007 the speciality of family medicine was recognised and 4-year postgraduate registrar programmes to train family physicians were established at all medical schools. Family physicians are trained to work in districts (of which there are 52 in the country), at both district hospitals and their associated primary care facilities.[9]

Through the representative bodies, the South African Academy of Family Physicians and the College of Family Physicians, the discipline of family medicine in South Africa developed a partnership with the Royal College of General Practitioners in 2014 to improve the quality of clinical trainers and to bring the national postgraduate exit examination to an international standard.[10] Currently the number of family physicians is very small (only 545 on the register or 0.1/10 000 population) and the short-term goal is to train 1000 family physicians, which would allow each community health centre, sub-district, and district hospital in the public sector to have a family physician.[9]

A final initiative being spearheaded by the discipline of family medicine is to introduce a 2-year national postgraduate diploma in family medicine to reorientate and upskill the pool of primary care doctors that are unlikely to train as family physicians.[10]

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