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PRIMARY CARE REFORM IN MONTENEGRO

REFORMA OSNOVNE ZDRAVSTVENE DEJAVNOSTI V ČRNI GORI

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Abstract

Background: *Montenegro is a newly independent state. As with many countries of that region, the country was faced with the need to reform its health care system. The overall aims of the reform were to improve the quality of services. This paper describes the process of implementation of the reform and its first achievements in patient satisfaction and quality of services since it has been introduced.*
Methods: *The ministry of health introduced a series of steps that included changes to legislation, financing and manpower structure. Investments in primary care have been made and informatics support was developed. Educational interventions at the undergraduate and postgraduate levels were also introduced.*
Results: *The initial results show that the changes have improved the quality of care provided: the composition of professionals in primary care has improved; preventive activities have remained high. Primary care is more accessible and organization of services is better, which can be seen in reduced waiting times for consultation in primary care and improved satisfaction with health care.*
Conclusions: *The initial results show some progress since the reform was put into place. New measures aimed at raising the level of health care to reach European Union standards are still to be introduced.*

Key words: health policy, primary care, Montenegro, South East Europe, health centres

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Izvleček

Izhodišče: *Črna Gora je na novo neodvisna država. Kot veliko držav v regiji se je morala spopasti z nujnostjo po reformi zdravstvenega sistema. Cilj reforme je bil izboljšati kakovost zdravstvenih storitev. Članek opisuje proces uvajanja reforme in prve izsledke. pri doseganju zadovoljstva bolnikov ter kakovosti zdravstvenih storitev.*
Metode: *Ministrstvo za zdravje je uvedlo vrsto aktivnosti, med katerimi so spremembe v zakonodaji, financiranju in v kadrovski strukturi. Narejene so bile investicije v osnovno zdravstveno dejavnost in informatiki. Uvedene so bile spremembe v izobraževanju na dodiplomski in podiplomski ravni.*
Rezultati: *Prvi izsledki kažejo, da so spremembe izboljšale kakovost zdravstvenih storitev: kadrovska struktura na osnovni ravni se je izboljšala, preventivne aktivnosti so ostale na visoki ravni. Osnovne zdravstvene dejavnosti so postale dostopnejše, organizacija oskrbe je boljša, kar se vidi v skrajšanih čakalnih dobah na pregled v osnovni zdravstveni dejavnosti in izboljšanem zadovoljstvu.*
Zaključki: *Prvi izsledki kažejo na napredek po uvedbi reform. Izzivi, kako dvigniti raven zdravstvene oskrbe na tisto, ki jo je postavila Evropska unija, še ostajajo.*

Ključne besede: zdravstvena politika, osnovna zdravstvena dejavnost, Črna Gora, jugovzhodna Evropa, zdravstveni dom

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1 INTRODUCTION

Montenegro is a country that covers an area of 13,812 km^2 and has a population of 631,536. Its GDP by expenditure approach at current prices €2980.9 in 2009 [1]. It proclaimed its independence in 2006. Its health care system was based on the principles of the Bismarck social health care insurance and was financed from the contributions of employers and insured citizens. Primary care was based on the principles of community-oriented primary care, which was common in the former Yugoslavia [2, 3]. The predominant organizational form was a primary care center ("dom zdravlja"), located in municipalities that provided both primary and some specialist services [4]. According to the Health Statistical Yearbook for 2005 [5], out of 2,569 health care workers in primary care, 563 of them were physicians: 105 general practitioners without specific training, 74 on residency and 384 were different specialists, including specialists in general medicine.

This kind of organization of primary care had several difficulties. From the structural point of view, the following problems were identified:

- **Regulations**: The roles and equipment of primary care institutions were inadequate. The role of health centres was unclear. Although they were created as primary health institutions, they provided a mix of primary and secondary care [6]. The health centres were often not adequately equipped for delivery of quality primary care. The informatic support of primary care was not based on modern IT technology.
- **Economic conditions**: The financing of primary care was inadequate. Even though primary care was officially declared as a priority in official documents [7], this was hardly the case: the majority of resources were directed towards secondary and tertiary levels, and 60% of health care services were done at these levels. The budgetary financing of primary care did not stimulate personal continuity and responsibility of primary care teams.
- **Human resources**: The primary care professionals were inadequately trained, and their structure did not reflect the needs of the population. The number of other health care workers per one doctor was large. The vast majority of these professionals were employed in administration and not in delivering care. The level of expertise of health professionals was another problem. Although a specialty of general practice was established, it was not an obligatory requirement for independent practice, and many doctors were working without specific training. The specialty training for this discipline was conducted in hospitals and not in primary care. Family medicine was not considered an academic subject and students received no information on primary care at the undergraduate level.

This kind of system did not fulfil the requirements of modern health care. The standards of care were low, and there was dissatisfaction among patients and providers. The primary care system could not provide the services that were formally available to the population, and these services were often provided at secondary and tertiary levels. It was obvious that the health care system required a change that would improve the position of primary care, which should gradually take over its role.

The aim of this paper is to describe the implementation of health care reform in the country based on the changes to legislation, financing and improvement of human resources and some effects of the reform on quality of care, mainly in the areas of quality of services and acceptance by patients.

2 METHODS

In September 2003, the Ministry of Health prepared the Strategy for Health Care Development [8]. The strategy was detailed in the Master Plan for Development of the Health System in Montenegro for the period 2005-2010 [6], and the Master Plan for Development of the Heath Care System of Montenegro for the period 2010-2013 [9].

The implementation of the reform was financed by a loan from the World Bank.

2.1 Changes to primary care institutions

The legislative changes introduced new roles and responsibilities of primary care teams and new roles of primary care institutions.

The reform created a new profile of a personal doctor. The term was used in order to stress the personal responsibility of the provider for the patient. Several categories of personal doctors were defined. Two of them were based on the age of patients (doctors for adults and doctors for children), and two additional categories of personal doctors were created for specific pathologies (doctors for female population for gynaecological problems, contraception and pregnancy and personal dentists for dental problems).

The responsibilities of doctors towards their patients were re-defined. One of their main roles was to be a gatekeeper to the specialist level. Every inhabitant

had to register with one personal doctor of his or her choice. Those doctors were responsible for curative care and preventive care, and they also had public health responsibilities. These doctors were supposed to work within a team in a health centre. The other professionals in primary care were considered either as specialist services within health centres, providing support to personal doctors, or were supposed to be retrained to become personal doctors.
The health centers were re-defined as the institutions that organize support for primary care teams. The specialist services in health centres were organized as "support units" of primary care teams with the purpose of providing consultations with specialists at the primary care level (e.g. pulmologist, psychiatrist) or diagnostics(e.g. laboratory, ultrasonography, x-ray diagnostics). Other units of health centres included community nursing and home care, preventive attendance to risk groups and public health units. Smaller centres were merged and now cover more than one municipality. In addition, regional centres were organized for several municipalities for specific health problems: mental health, children with special needs, reproductive health, TB and pulmology.
These changes required changes in legislation and a series of new laws had to be passed in order to change the position and the role of primary care institutions (the Law on Health Care[10], the Health Insurance Law [11], the Law on Health Inspection [12], the Patient's Rights Act [13], the Law on Data Bases in Health Care [14], the Law on Protection of the Population from Infectious Diseases [15], the Nursing Law [16], the Law on Drugs [17], the Law on Taking and Using Biological Samples [18], etc.). The new responsibilities of doctors were defined by the Rulebook on specific conditions in terms of standards, norms and ways of exercising the right to primary care [19].
All the outpatient departments in Podgorica have been renovated and equipped according to new standards of care. IT based informatics support was developed for the entire country in 2008 through a project "The Implementation of IT support on PHC reform."

2.2 Financing

The new model of financing primary care was introduced. All funds for health care services were managed by the Health Insurance Fund (HIF), which then paid all public health care providers based on a contract. The contract for primary care was based on a combination of capitation (roughly 50% of income), fees for services and adjustments according to geographical location. The chosen (personal) doctors achieve half of their revenues (50%) through capitation, while the other half (50%) by billing pre-defined services [20].
The health centres and their managerial structure were responsible to the HIF for fulfilling the contract and to the Ministry of Health for quality of services.
The new method for financing was established starting in 2007.

2.3 Human resources

A series of different educational CME interventions for primary care staff at various levels were introduced.
Three obligatory courses were developed for primary care teams:

- **Use of computers**

A one-month course inbasic use of computers was organized for all primary care teams, which was followed by a one-week applied course on the practical application of computers and electronic medical records in practice.

- **Basic skills course**

Since the basic package of services identified a range of new skills as well as diagnostic and therapeutic procedures, a shorter course was organized for all doctors in primary care and their teams based on a regional principle. This type of training was organized so that teams in primary care can adequately rely on equipment that has been acquired at all clinics. Courses were organized during 2008 and constituted training for ECG and spirometry, defibrillation and surgical skills.

- **Advanced course for primary care teams**

An advanced course of four months was organized for primary care teams as well. Its aim was to raise the level of expertise of the primary care staff to the same level so that the basic package could be implemented. The course for doctors consisted of 222 contact hours, with a theoretical part of lectures and discussions aimed at new approaches to diagnostics and treatment in primary care. The course also included a practical part, which consisted of training skills, individual work under the supervision of educators and auditing of practices. The module for nurses was shorter, consisting of 178 hours, with a similar structure. The course was held twice a year. It was piloted in Podgorica but was later extended to the whole of Montenegro.

- **Other developments in education**

During the reform, the first steps were taken to introduce family medicine topics tothe curriculum at the Medical Faculty in Podgorica. Family medicine was introduced

as an elective subject for the 8th and the 10th semester of undergraduate study. The education took place at the health centre of Podgorica, which received the status of a teaching unit of the medical faculty.
The programme of specialization of family medicine was also developed and accepted by the new Healthcare Law. It is planned to last for four years. However, the programme has not been implemented yet. The new bill also made professional development a mandatory activity for both healthcare and managerial staff.

2.3.1 Measuring the effects of change

The success of the primary health care system reform is monitored by the Ministry of Health through routine data collection and by surveys assessing the views and attitudes of patients and health care workers that are conducted in two-year intervals starting from the planning and announcement of the reform in 2004.

3 RESULTS

3.1 Structural changes

The total HIF expenses for health care increased from nearly €105 mil. in 2006 to €168 mil. in 2009, and the proportion of costs for primary care has slightly decreased (Table 1).

Table 1. *Proportion of money allocated to different levels of health care 2004-2008 (in percents)*.*
Tabela 1. *Deleži denarja, namenjenega različnim ravnem zdravstvenega varstva 2004-2008 (v odstotkih).*

Care Level (Raven)	2004[21]	2005[22]	2006[23]	2007[24]	2008[25]
Primary care (Primarna raven)	38.94	38.15	38.02	37.40	33.65
Secondary care (Sekundarna raven)	33.85	35.84	33.72	35.36	36.30
Tertiary care (Terciarna raven)	8.12	8.81	8.30	8.69	8.91
Other health care services (ostale zdravstvene usluge)	19.09	17.20	19.95	18.54	21.14
Total (Skupaj)	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

The proportion of costs for primary care slightly decreased from 2004 to 2008.
A total of 11 advanced courses were held that were attended by all the chosen doctors' teams. So far, 222 chosen doctors and 248 nurses successfully completed the required courses.
The reform improved the personnel structure at the primary care level (Table 2).

Table 2. *Structure of professionals employed in the primary care, 2005 and 2009.*
Tabela 2. *Struktura zaposlenih v osnovni zdravstveni dejavnosti, 2005 in 2009.*

	Year/Leto 2005 [5]	2009[26]
Doctors without specific training Zdravniki brez specializacije	105	106
On specialisation Specializanti	74	91
Specialists in primary care Specialisti	384	393
Total doctors Vsi zdravniki	**563**	**590**
High school level health workers Visokošolska izobrazba (sestre itd.)	1663	1408
College level health workers Višješolska izobrazba	84	100
Total medical professionals Vsi strokovni delavci	**2873**	**2688**
Non medical staff Nemedicinski kader	673	603
Total Skupaj	**3546**	**3291**

The reform has improved the personnel structure in the primary care level. The number of doctors has increased, and the number of nurses with only a high school degree has decreased, and the higher education (college level) has increased. The number of non-medical staff has decreased.

3.2 Indicators of quality

3.2.1 Quality of services

According to a survey done in Podgorica, utilization rates for primary care have increased (Table 3).

Table 3. *Quality of care indicators.*
Tabela 3. *Indikatorji kakovosti.*

Indicator Indikator	**2004**	**2008**
Overall utilization per year Odstotek populacije z obiskom letno	11,4%	34,7%
Romani people utilization Odstotek romske populacije z obiskom letno	21%	39%
Waiting time for consultation>21 min Čakanje na obisk več kot 21 minut	57%	34%
Consultations time >11 min. Čas obiska več kot 11 minut	30%	65%
Immunization rate DTP Preceplenost DTP	86%	94%
Immunization rate MMR Precepljenost MMR	82%	92%

According to a survey done in Podgorica, utilization rates for the primary care are increased. Primary care utilization for the Romani people, who represent a population at risk, has also increased. Waiting times for consultation in primary care have decreased and duration of a consultation (more than 11 min) has increased. Immunization rates for diphtheria, tetanus and pertussis (DTP) and for mumps, morbilli and rubella (MMR) have increased from 2004 to 2008.

3.2.2 Patient satisfaction

The data on patient satisfaction can be seen in Table 4. Overall, satisfaction increased.

Table 4. *Change of the health care characteristics (%).*
Tabela 4. *Spremembe v značilnostih zdravstvenega varstva.*

Patient satisfaction parameter **Kriterij zadovoljstva**	**Improved (in%)**	**Worsened (in%)**	**No change (in%)**
Overall quality of services Splošna kakovost uslug	58,3	11,5	30,2
Better relationship with the doctor Boljši odnos z zdravnikom	61.6	3.8	34.6
Waiting times for patients to be seen by the doctor Čakanje na zdravnika	53.5	13.3	33.2
Time available for conversation with the doctor Čas obiska pri zdravniku	49.0	8.7	42.3
Time available for examination Čas pregleda	46.5	9.2	44.3
Crowds in the waiting room Gneča v čakalnici	42.9	14.7	42.4
Equipment of facilities Oprema	40.5	4.2	55.3
Doctor's competence Zdravnikova usposobljenost	31.5	3.7	64.8
Motivation of doctors Motivacija zdravnikov	28.3	11.7	60.1

The data on patient satisfaction can be seen in Table 4. Overall, satisfaction increased.
According to the majority of responders, overall quality of services increased as well as better relationship with doctor. Waiting times for patients to be seen by a doctor is reduced. However, the respondents did not perceive changes in doctors' motivation.
The characteristics that have improved in relation to the period before the reform, according to the respondents, were the following: a more qualitative relationship with the doctor, which results in better awareness of the patient's health condition and medical history, and waiting times for patients to be seen by the doctor, which was reduced by introducing compulsory appointments in advance. However, the respondents did not perceive changes in doctors' motivation and competence.

4 DISCUSSION

The challenge in reforming health care is common among many countries [29-31]. It is a difficult and a long term process that involves compromise between the policy declarations and local realities. In Montenegro, the government made some interesting decisions that merit attention.
Due to the potential political problems and pressure from the public, the government decided not to re-train all of the primary care teams according to the principles of family medicine. Hence, it kept in place the primary care paediatricians and primary care gynaecologists since they already provided their services relatively well. The current situation seems to be in favour of further development of family medicine, where both specialties will coexist and the provision of services by one or the other specialty will depend on the availability

of resources and many other factors. This decision was also made by other countries in the region (e.g. Serbia, Croatia, and Slovenia) [20,32-34].

The government has also decided to keep the infrastructure of the health centres and to restructure them instead of replacing them with solo practices, managed by independent contractors, which was the case in some neighbouring countries (e.g. Croatia) [33,34]. This kind of system is easier to manage. Keeping community-oriented medical centres at the local levels seems to be a good idea, since they are able to provide organized care and are traditionally accepted as local sources of health care. Also, community oriented health centres seem to become an increasingly interesting option for policymakers in more developed parts of the world [35-37]. This task in Montenegro is not over yet. The formal restructuring is finished, but there is still a lot of work to be done in refurbishment of premises. The World Bank project has provided resources to refurbish the health centres in Podgorica but not in other parts of Montenegro.

With respect to most teaching activities, the goal was to teach all the teams in one course and to enable the teams to work together. This is a rather innovative approach, but experience shows that doctors and nurses can learn together, especially if there are topics of common interest (e.g. organization of care).

Results also show that during the five-year period since the beginning of the reform, patient satisfaction with primary care is slowly increasing and there are enough indications that the quality of care is improving. The results are not spectacular, but the trends are favourable and are an indication that many elements of primary care have been improved through structural changes

There is still a lot of work to be done in the area of education in the future, such as the implementation of full specialty training for family medicine, a program of formal re-training for doctors in primary care to reach the formal qualification of a specialist that can work in primary care and the further development of Montenegro's academic primary care. Key problems of the health care sector still remain, such as dissatisfaction with health care worker salaries, lack of motivation among doctors and waiting and queuing.

4.1 Limitations

The authors are aware that the paper is far from presenting a comprehensive approach to assessment of health system performance or even the performance of primary care. In a recent review of the literature on primary care, as many as ten dimensions can be identified [39]. We were limited by the scarcity of comparable data at the beginning and during the reform, therefore our paper represents only a limited insight into a very complex area.

The data on which we present do not have the same scientific rigor as data gathered for research projects. Nevertheless, since statistical data used for primary care purposes is still being developed, this is the best information available.

4.2 Keypoints

- In contrast to some other countries in the region (e.g. Macedonia, Croatia), Montenegro has not privatized primary care.
- Montenegro has kept the institution of the health centre as the cornerstone of primary care, where teams are responsible for comprehensive community oriented primary care.
- The country has not decided to re-train all primary care doctors into family medicine specialists but has decided to introduce the institution of a "personal doctor" based on the majority of existing profiles in primary care.

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