Report

"Assessing Primary Healthcare Services in the Republic of Moldova as to the integration of mental health services into PHC"

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CONTENTS:

Abbreviations
PHC – Primary Healthcare
TMA – Territorial Medical Association
FMC – Family Medicine Center
NHIC – National Health Insurance Company
HC – Health Center
MoF – Ministry of Finance
MoH – Ministry of Health
FDO – Family Doctor Office

Introduction

Upholding people's health is a must for sustainable development of any nation. Reforming and consolidation of the PHC is a distinct example of accomplishing Government programs aiming at curbing inequities and improving the accessibility of health services.

The health systems of many countries were primarily focused on providing technology-intensive hospital care services before.

In 1978, the Alma-Ata conference (Kazakhstan) drew people's attention to PHC issues. The Alma-Ata Declaration set forth that health is a fundamental human right and that governments are responsible for ensuring this right to their citizens and for designing appropriate strategies required to attain such goal.

"PHC is essential healthcare, universally accessible by all individuals and families at large alike, is provided by means endorsed by those, while fully involving those, at a cost that the community and the country can afford" *(Alma-Ata, 1978).*

The conference *stated* PHC development as a priority; *stressed out* involvement in planning and implementing measures meant to provide population with healthcare; *invoked* the need to use evidence-based medical technology based on social and economic factors and *highlighted* the need for cross-sector coordination of public health activities.

Pursuant to the Alma-Ata Declaration from 30 years ago, PHC was recognized as a key strategy to be achieved by 2000, "Health for All".

Jointly with other countries, the Republic of Moldova committed to back up the values laid out in the Alma-Ata Declaratoin at all commitment levels.

Likewise, the WHO Conference on Health System Reforms from Ljubljana, Slovenia, during 17-20 June 1996 emphasized the fundamental role of PHC in reaching the major objectives of health system reforms, i.e. improving the health of the whole society.

Hence, the alighment of the Alma-Ata Declaration, the outcomes of the WHO Conference on Health System Reforms from Ljubljana, Slovenia and courtesy of the political support both at the country level and internationally made Moldvoa undertake more measures to consolidate PHC.

Pursuant to the provisions of the Government Decision no.668 of 17 July 1997 'on the endorsement of the Health Care System Reform Concept in the Republic of Moldova under new economic conditions 1997-2003', changes were suggested to the organizational and functional layout of the PHC by establishing family physician positions....' and by 'designing bylaws required for setting up and developing a PHC sector'.

Pursuant to the Government Decision no.1134 of 09 December 1997 'on the development of PHC', there was general care physician (family doctors) positions set up, while implementing

the principle of free choice of family doctors by population, 'Nursing', PC-based and data systems, setting up a system for standalone budgets for PHC providers through a per capita based system etc. Local pulbic authorities were delegated the task of PHC management.

At the same time, we would like to reiterate that, pursuant to all the efforts bent, family medicine has become a specialty by law, while recogning PHC as a priroty and is topping the health system. PHC provides accessibility and continuity and it has the highest impact on health indicators of all other.

Chapter I

Prospects for Integrating Mental Health into Primary Healthcare

The burden of mental disorders is high. Mental disorders prevail in all societies. They make up a significant burden for affected people and their families, causing significant economic and social hardship, affecting the society as a whole.

Mental health disorders and somatic conditions are associated and cross-linked. Intregration of mental health services into PHC provides for a comprehensive treatment of patients, catering to the mental health needs of people with physical disorders, as well to the physical needs of people with mental disorders.

There are significant gaps in the treatment of psychiatric conditions. There is a significant discrepancy between the prevalence of psychiatric conditions and the number of people getting treatment and care in all countries. Getting mental health services integrated into PHC may bridge this gap.

Integration of mental health services into PHC facilitates the access of people to quality health care services. Whenever mental health is embedded in PHC, mental health services are closer to the patient, one's residence, upholding family integrity and not interfering with daily activities of the beneficiaries. The integration process shall also facilitate community mobilization, mental health advocacy, monitoring and management of the status of affected people in the long run.

By integrating mental health services into PHC, one advocates for the observance of human rights. Mental health services delivered within the PHC are minimizing stigma and discrimination. Moreover, it eliminates the risk of human right violations, which might happen in psychiatric hospitals.

Integration of mental health services into PHC is cost-efficient and affordable. If part of the PHC, mental health services are less expensive than in psychiatric hospitals for the patients,

community and Government alike. Moreover, patients and families avert the indirect costs incurred when seeking specialized care in remote locations.

Integration of mental health services into PHC yields good health results. Most people with mental disorders treated in PHC have good results, in particular when are linked to a network of community-based specialized services.

At all levels of health care delivery, a number of mental health services may be provided through PHC facilities, which may be topped up with access to services provided by specialists, such as education, consultations, assessments with hospital admission and specialized treatment. This "link" with specialists is of particular importance, as most of the ordinary mental health conditions are noticed within the PHC, with limited options for detecting and managing usual mental health conditions, e.g. depression. Streamlining the training of PHC clinicians requires a mix of several strategies – including access to data and correlation with the feedback of other health care professionals (Gilbody et al., 2004).

PHC system reforms aim to strengthen the quality of health services, including mental health services. Integration of mental health services into PHC shall significantly reduce the burden and costs associated with specialized care, whereas the resulting savings may be spent to heighten the quality and ensusre continuity of care provided to people with mental health conditions in particular and to lay population in general.

PHC physicians shall be capable of preventing, detecting and diagnosing mental health conditions that the population they serve is facing, including in children and adolescents, while setting up a referral system shall allow physicians to redirect patients with severe impairment to relevant specialists. One task of the PHC system is to monitor the status of the patients who benefited or are still benefiting from specialized care.

Chapter II
Legal Framework

Listed below in chronologic order are the relevant policy papers and bylaws related to PHC, starting in mid 1990's to date.

1995

- ***Law on Healthcare Delivery, no.411-XIII***

  Key points: Article 2 h): Government guarantees standing up for public interests in healthcare through a mandatory health insurance system, primary healthcare delivery by family doctors, pre-hospital emergency healthcare delivery, hospital care delivery, within

the prescribed load and range; Article 2 i): patient has a free choice to select a family doctor and a PHC facility they want to be enrolled with.

1998

- ***Law on Mandatory Health Insurance, no.1585-XIII***

  Key points: Article 5. (4) Coverage of the uninsured: pre-hospital emergency healthcare, PHC provided by a family doctor and specialized inpatient and outpatient care for the socially determined conditions with high impact on public health are paid with mandatory health insurance funds.

2007

- ***National Health Policy, Government Decision no.886***

  Key points: para 24 e) All health advocacy and prevention of diseases related policy papers, strategies and laws shall draw upon PHC as the key element of health system;

  181. Shift in healthcare delivery away from a treatment-centered policy towards a health promotion and disease prevention focus. System efficiency is to be ensured by priority development of PHC, nursing and by turning the hospital care sector into a flexible and performance-based network of providers based on population needs and funds available.

- ***Health System Development Strategy 2007-2017, Government Decision no.1471***

  Key points: Section 3, 65-e) In order to provide for integrated healthcare and to ensure the continuity of healthcare in dealing with population health issues, the following is planned: heighten the role and boost the authority of PHC within the national health system, with priority accent on disease prevention measures.

- ***Government's Activity Program "European Integration: Freedom, Democracy, Welfare" 2012-2015***

  Key points: Flatten discrepancy between rural and urban areas by redirecting investments towards rural area through:

  - Construction and refurbishment of rural health centers (providing those with medical equipment and transportation means);

  - Complete institutional autonomy within the PHC system, including through direct contracting of family doctor offices by the National Health Insurance Company.

2010

- ***Primary Health Care Development Strategy 2010-2013, MoH ordinance no.460***

  Key points: the goal of this strategy is to uphold and further improve the health status of people through ongoing development and strengthening of family medicine; to ensure equitable access to quality and cost-efficient PHC services focusing on meeting the basic health needs of communities; to support and accomplish health prevention, promotion, treatment and oversight interventions over the health status of individuals and their families.

- ***Joint MoH and National Health Insurance Company ordinance no.627/163-A***

  Key points: endorse the Regulations on the enrollment of population with a health care facility providing PHC services within the basic package of mandatory health insurance.

- ***MoH ordinance no.695 on PHC in the Republic of Moldova***

  Key points: Endorsement of a number of regulations on the PHC layout, namely: Rules governing the PHC in the Republic of Moldova; terms of reference for the family doctor; terms of reference for the PHC nurse; PHC facility staffing norms, while setting forth four different lines inclusive of the standards for management and administrative staff of Family Medicine Centers and autonomous Health Centers, for physicians, nurses, orderlies, and ancillary staff.

- ***MoH ordinance no.816 on amendments and addenda to the MoH ordinance no.404 of 30 October 2007)***

  Key lines: endorsement of the framework regulations for public healthcare facilities, family medicine centers and health centers.

2011

- ***MoH ordinance no.861***

  Key lines: endorsement of legal delimitation of health centers.

- ***Joint MoH and NHIC ordinance no.1021/206-A 'on the approval of Methodological Norms for Use in 2012'***

  Key lines: Methodological norms set forth the terms for all types of health care delivery; list of paraclinical investigations, payment methods and criteria for contracting eligible providers under the mandatory health insurance system based on

the financial parameters as set forth in the Law on mandatory health insurance funds for any given year.

2012

- ***Joint MoH and NHIC ordinance no.302/70-A on the approval of the Regulations on the validation of performance indicators***

  Key lines: It stipulates the procedure for performance indicator validation for the providers enrolled in the mandatory health insurance system.

- ***MoH ordinance no.252 on the 'boosting of preventative measures within the PHC'***

  Key lines: it sets forth actions to prevent diseases by means of preventive medical examinations.

- ***MoH ordinance no.957 on amendments and addenda to the MoH ordinance no.404 of 30 October 2007 'on the legal delimitation of PHC at district level'***

  Key lines: endorsement of the framework Regulations for the Public Healthcare Facility – Health Center.

- ***MoH ordinance no.962 on amendments and addenda to the MoH ordinance no.695 of 13 October 2010 'on the PHC in the Republic of Moldova'***

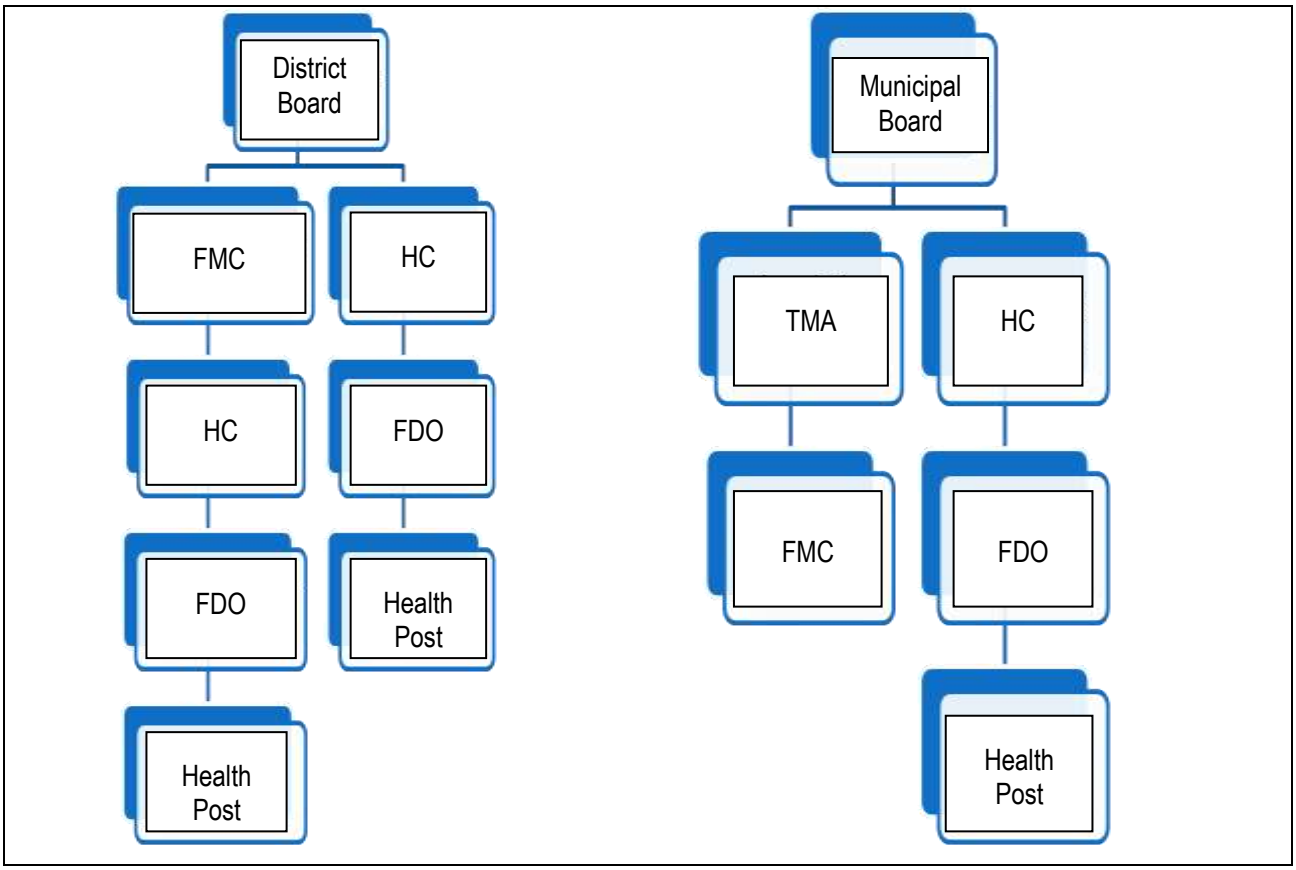
  Key lines: endorsement of the PHC staffing norms, defining the positions that may be used by adding it to the PHC public health care facility staff, as per the Roster of Positions of the RM.

Chapter III
Layout of PHC Services

Network of healthcare facilities providing PHC as of 1 January 2012 consists of 5 Territorial Medical Associations (TMA) in the municipality of Chisinau with 12 family medicine centers (FMC) operating inside.

According to the National Center for Health Management data, there were 37 Family Medicine Centers (FMC) and 60 autonomous Health Centers (HC) operating in the Republic of Moldova at the beginning of 2012. In order to ensure the autonomy of PHC facilities, a gradual HC legal delimitation was started – a process which is ought to be completed by 2014 (MoH

ordinance no.861 of 10 November 2011 on the endorsement of the HC Legal Delimitation Program).



PHC facilities provide PHC services to the patients enrolled with a PHC of their own choice, based upon a written application, irrespective of someone's insurance status (insured or uninsured), including from other facilities in case of medical and surgical emergencies, or under any other situations justified from a medical standpoint.

Irrespective of their legal form of setup, PHC facilities are part of the Roster of public health facilities duly endorsed by the Ministry of Health.

The overarching goal of PHC facilities is to improve the health of people through continuous development and strengthening of family medicine, with priority focus on measures aiming at preventing diseases within a defined population.

PHC facilities are classified based on the following criteria:

a) by location they operate in;

b) by population size they are servicing;

c) by legal form of setup;

d) by complexity of PHC services they provide;

Based on the aforesaid criteria, PHC is provided in:

a) Family Medicine Centers (FMC);

b) Health Centers (HC), including the autonomous ones;

c) Family Doctor Offices (FDO); and

d) Health Posts (HP).

Family Medicine Centers

FMC are set up in urban areas and at the place of residence of local public authorities and are directly contracted by the NHIC. A FMC consists of rural PHC facilities – HC, FDO and HP – as per the provisions of the Roster of public health care facilities, holding premises and other fixed assets, medical equipment and gear, transportation means etc.

At the FMC place of residence, there is one or several family medicine stations, depending on the population size they service and the number of primary care physicians.

FMC are classified as follows:

1) FMC of category III – up to 40,000 people;

2) FMC of category II – between 40,001 and 80,000 people;

3) FMC of category I – 80,001 people and more.

Health Centers

HC are usually set up in rural areas and subject to their legal form of setup, one may distinguish:

1) Autonomous (public or private) directly contracted by the NHIC;

2) Subdivisions of the aforesaid FMC.

HC are servicing at least 4,500 inhabitants.

HC are classified based on the population size they service, including that of their FDO and HP as follows:

1) HC of category IV – between 4,500 and 6,000 people;

2) HC of category III – between 6,001 and 9,000 people;

3) HC of category II – between 9,001 and 11,500 people; and

4) HC of category I – 11,501 people and more.

HC as subdivisions of FMC

HC is a subdivision of a district-level FMC that is subordonate to the FMC director, providing basic PHC services to people in a certain location, including to the population serviced by its subdivisions, as prescribed and in the amount set forth in existing bylaws, while ensuring, if needed, the referral of patients further up to the FMC to perform the lab and instrumental

investigations it does not have locally. HC is set up in rural areas, preferably located within standardized buildings, equipped with lab facilities, transportation means etc., having a convenient geographic location to ensure easy access for residents from adjacent communities.

The population size covered in a HC location together with all its FDO and HP may not be lower than 4,500 residents. HC is coordinating the work of its FDO and HP.

When streamlining the PHC layout, one has to make allowance for the geographic location, easy access to the HC location, material and technical supplies, and staffing.

Autonomous HC

A HC is autonomous when it complies with the criteria as endorsed by existing bylaws, including when the former presents specific justification, as coordinated with the head of the FMC and/or local public authority (LPA) as to their capacity to operate as autonomous entities.

Autonomous HC is the PHC facility that is set up as per the decision made by LPA and is ensuring basic PHC delivery to people from the respective HC location and surrounding settlements, as per the healthcare delivery agreement concluded with the NHIC, as duly set forth in existing bylaws.

HC, including the autonomous ones, may have a population size under 4,500 given that its geographic location allows easy access of people to healthcare in a designated HC, having informed the MoH first and having submitted justification, coordinated with LPA beforehand.

Autonomous HC may partner up to create associations in order to provide services and/or share certain resources, possibly under the aegis of a FMC.

Family Doctor Offices and Health Posts

FDO and HP are subdivisions of FMC and HC set up in rural areas based on defined criteria.

Streamlining the layout of HC in line with the classification criteria aims at optimizing and streamlining their work, in particular as autonomous entities, towards ensuring direct contracting by the NHIC.

FDO are set up in rural areas with a population size between 901 and about 3,000 inhabitants, with one or two family doctors operating as prescribed by the staffing norms.

HP are set up in rural communities with a population size under 900 inhabitants, with only family medicine nurses operating, as prescribed by the staffing norms.

Whenever two or more communities with HP located within the same coverage area together have a population size between 900 and 1,500 people, they are entitled to one family doctor.

PHC Services provided within PHC Facilities

PHC services include entry-point healthcare and ongoing follow-up of patients, no matter whether sick or healthy. PHC services are delivered by a family doctor and family nurses, which make up a family medicine team and which are delivered within PHC facilities – either public or private – and are set up in urban and rural communities alike, as per existing bylaws.

PHC services are delivered by a family doctor and family nurses, which make up a family medicine team.

A family doctor is the physician who graduated from the family medicine track following graduate (university) or postgraduate education in family medicine and by conversion of general medicine physicians, internal medicine physicians and pediatricians following primary specialization in family medicine; it is the physician providing for and coordinating the primary and continuous healthcare of individuals and their families; it secures comprehensive biological and psychosocial healthcare for both genders and for all age-groups.

PHC facilities provide PHC services to the patients on their roster based upon a written application filed based on a free-choice of PHC principle, irrespective of one's health insurance status (insured or uninsured), including from other facilities for medical or surgical emergencies or under other circumstance justified from a medical standpoint.

PHC facilities carry out the following activities:

1) Preventive measures and health promotion actions, healthy life-style advocacy;

2) Curative medical activities;

3) Speical medical activities;

4) Organizational, methodological and management related activities;

5) Education activities in the field of family medicine, including as trainers;

6) Research activities;

7) Other medical activities in line with any bylaws on additional professional education;

8) Support activities; and

9) Pharmaceutical supply to population.

PHC facilities provide basic PHC services, as well as extended healthcare or additional healthcare services.

Basic PHC services are those services that are defining the PHC area of expertise, as per the terms of reference set forth for family doctors, and which are to be provided by all family doctors during a medical consultation.

Listed below are the basic PHC services:

1) First-aid interventions in medical / surgical emergency, including at home;

2) Preventive healthcare services, as well as: education of population to advocate for healthy lifestyles, accomplish the immunization program, active detection of people at high risk of getting sick with specific conditions, based on evidence, active follow-up of asymptomatic adults and children with normal or heightened risk, by sex and age-groups;

3) Monitoring of chronic conditions: active follow-up for the most often chronic conditions, starting up and maintaining support therapy, periodically run clinical, instrumental and lab tests and specialized consultations;

4) Medical consultation services for pregnant women, children, adolescents, elderly, socially vulnerable, disabled and terminal patients;

5) Family planning;

6) Oversight of pregnant and breastfeeding women and infants;

7) Some minor surgery procedures; and

8) Medical / social services: healthcare at home, palliative care to terminally-ill, be part of a multidisciplinary team, as per existing bylaws.

Additional health services are those services that a PHC facility may deliver and which are beyond the traditional package of PHC services, requiring additional skills and special equipment/gear. These are additional services required for the diagnosis of diseases at PHC level, rehab therapy and pharmaceutical care setup, support services etc. Building up additional services is regulated by existing bylaws.

PHC services Serviciile are delivered by family doctors and family nurses, which together make up a PHC team. While delivering services, a family doctor is collaborating with all other medical specialties, complying with specific features of that specialty and abiding by existing bylaws on healthcare delivery within the mandatory health insurance system.

Mechanisms to evaluate the quality of PHC services: within-office internal control; office inspections by supervisors or health authorities; periodical mandatory testing of knowledge and professional skills of physicians and nurses.

Sometime one may also use: external clinical auditing (by using patient cards).

There are process and outcome indicators usually used by the MoH to monitor PHC progress, such as:

- Accessibility: number of family doctor visits per inhabitant
- Efficacy:
  - Monitoring of pregnant women at 12 weeks gestation and follow-up in line with prescribed standards;
  - Follow-up of infant during first year of life;

- Infant mortality at home;
- TB case notification and follow-up;
- Hyperhension notification and follow-up;
- Preventive gynecological examination and cytology test;

- Satisfaction degree: surveys on public satisfaction with services provided

Evidence-based Medicine and Clinical Guidelines

There have been about 164 national clinical protocols designed and endorsed through MoH ordinances in the health system overall, including all levels of healthcare delivery. All protocols are posted on the MoH website. With the support of the EU project "Strengthening the PHC", there have been 2,300 copies of 47 standardized clinical protocols for family doctors developed and shared free of charge in all PHC facilities. Three of those protocols deal with high blood pressure in adults; uncomplicated diabetes mellitus; and community-acquired pneumonia in adults.

Currently, the development of clinical protocols for family doctors is going on with the World Bank support within the framework of the Health Care and Social Assistance Services project. In this context, at least 60 standardized clinical protocols for conditions common for family medicine are ought to be developed.

All protocols are developed and updated by a group of authors (family medicine and healthcare experts) created by MoH ordinance.

Moreover, one has to highlight two key publications:

- Family doctor's guidelines: developed by a group of authours (family doctors and other experts) and shared within other facilities by MoH ordinance;
- Family doctor's guidelines to palliative care: developed by a MoH working group made up of family medicine and palliative care experts; it was copies with the support of the Soros Foundation and shared free of charge in PHC facilities.

Chapter IV
Human Resources in Primary Healthcare

Moldova's coverage with family doctors is 38.8% lower than in the EU. This is one of the factors that impact the quality of healthcare at PHC level undermining people's health status today, in particular, the burden of non-communicable diseases: cardiovascular conditions, diabetes, cancers etc.

There are 1,877 family medicine physicians working all over the country today, caring for about 1,896 people per physician on average. Primary care physicians account for about 15% of all physicians in the Republic of Moldova. The number of PHC nurses is almost three times that of physicians.

Bylaws prescribe 1,500 people per family doctor, as set out in the MoH ordinance no.100 of 10 March 2008 'on Health Staffing Norms'.

PHC Professionals (as of January 2012)

Working PHC providers	*Absolute*	*Population size per staff*
Family doctors	1,877	1,896
Family nurses	5,362	664

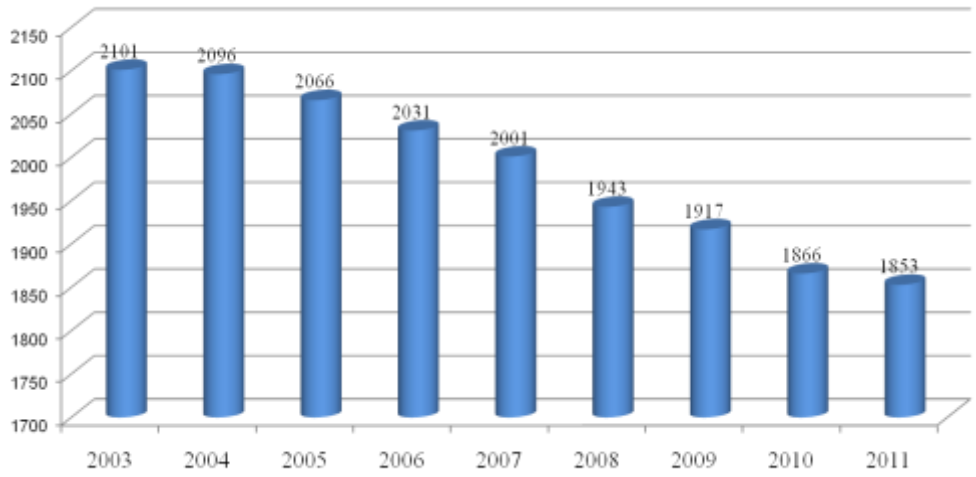
Total number of working physicians: 12,905 (2012; source: MoH)

The health system in Moldova is facing the same challenges specific for most of the Western European countries today, namely: uneven distribution of health workers, with understaffing in rural areas and overstaffing in urban areas.

There is an uneven distribution of family doctors and family nurses in the country – with 2,500 people per physician on average in the South versus 1,900 people per physician on average in the North. The highest density of family doctors is reported in Chisinau, where a family doctor is catering to 1,450 people on average. Given the average population-to-physician prescribed rate of 1,500, all regions of the country, except Chisinau, significantly exceed the prescribed rate, which is indicative of severe understaffing with family doctors in the country.

According to the MoH data, 290 family doctors should further be hired to cover the current gap of physicians in all PHC facilities, which is, for instance, approximately the number of medical residents graduating in one year at the Medicine and Pharmacy State University "Nicolae Testemitanu". But given that only 25 of the 60 family medicine graduates do ultimately get a job in rural areas, it would take some 12 years to cover this gap, provided that nobody would retire and would not leave in the meantime.

Trends in the total number of family doctors, 2003 – 2011



Source: National Center for Health Management

Licensure and (re)accreditation

There are formal requirements one has to comply with in order to work within the PHC sector. Pursuant to Article 10 (2) of the *Law on Healthcare Delivery* no.411 of 28 March 1995 and Article 4 b) of the *Law on Working as a Physician* no.264 of 27 October 2005, for one to work as a physician, they have to prove to have completed postgraduate medical or pharmaceutical education in the universities and postgraduate education facilities. Pursuant to the *Law on the Mandatory Health Insurance*, the basic package of mandatory health insurance, and the Joint MoH and NHIC ordinance no.522/207, there are equal conditions for both public and private entities for getting contracted for PHC services. Standard equipment is prescribed for all PHC facilities.

Accreditation

All physicians, including family doctors, have to undergo accreditation once every five years. The following official criteria apply:

According to the law, clinicians have to systematically improve their knowledge and skills. In order to evaluate the professional competency of practitioners, the latter have to pass an accreditation test once every 5 years.

The formal criteria for physician accreditation are set forth in the MoH ordinance no.75 § 1 of 2 June 2011 'on the Accreditation of Physicians and Pharmacists' (*http://ms.gov.md/_files/8892Ordin%2520Atestare%2520medici%2520si%2520farmacisti%25202011%2520Usatii_20.06.pdf*)

Nurses have to go through the same accreditation procedures as physicians once every 5 years.

The formal criteria for reaccreditation of secondary education health workers are set forth in the MoH ordinance no.59 § 2 of 4 May 2011 ‘on the Accreditation of Secondary Education Health and Pharmaceutical Workers’ *(http://ms.gov.md/_files/8891Ordin%2520atestare%2520lucratori%2520cu%2520studii%2520medii%25202011_final_20.06.pdf).*

Professional Associations and Magazines

Family doctors are organized in an Association of Family Doctors of the Republic of Moldova, which is an extensive organization for defending their material interests, professional development, training and research. It has 1,800 members, which in practical terms means that basically all family doctors are members of this assocation. It seems that this association is the only professional organization for family doctors.

There is no periodical for family doctors being published in the Republic of Moldova.

Medical Training

There are six education facilities in the Republic of Moldova (medical university and medical colleges) training people in this area. The Medicine and Pharmacy State University “Nicolae Testemitanu” in Chisinau is the only one of the above six providing family medicine postgraduate education. Training lasts three years.

Training of family doctors has two stages: 6 years of graduate medical education in the field of general medicine, and three years of postgraduate specialization in family medicine, followed by a final exam and issuance of a license diploma.

In 2011, 17% of all medical graduates got enrolled into a postgraduate education program for family doctors. The number of family medicine graduates is considerably dropping each year. There were 66 graduates in 2009 versus 45 in 2010 versus 30 in 2011. The number of graduates basically halved in two years only.

Chapter V
Financing of the Primary Healthcare

The package of health services is comprehensive, with the Government baring the costs of such services, but the cost of pharmaceuticals is not fully covered. About 30% of the whole health budget is spent on PHC.

Starting in 2003, the self-financing and not-for-profit policy is guiding the operations of

public healthcare facilities within the mandatory health insurance system. Therefore, a Government Decision set forth the way the payroll is calculated based on the principles for payroll payment by financially autonomous entities. Each year, the MoH, NHIC and health workers' trade unions set the payroll thresholds for each category of physicians, including coefficients for the record of work and bonus payments.

Family doctors are eligible for the following bonuses to top up their baseline salary:

- Category (degree) of qualification

  The bonus of a qualification category (degree) is paid on a monthly basis, including to physicians with administration tasks, specialized secondary medical education workers, physicians with management tasks and account for 50% of the baseline salary – for the higher category, 40% - for category I, and 30% - for category II;

- Record of work

  The bonus for the record of work is paid on a monthly basis, computed as share of baseline salary for family physicians and family nurses alike. The bonus payable for the record of work is more generous for the family doctors and nurses working in rural areas than for urban areas;

- Working hours are split in two

  This is an additional payment to workers the working hours of whom are split into two parts based on certain working hours, and a break of over two hours in-between and which is not part of the ordinary appointment hours. Such payments may account for only 30% of the baseline salary for the hours actually worked during specific days.

- Research title;
- Honorary title;
- High efficiency in work, labor-intensive work and performance of works of special importance or urgent works.

Chapter VI

PHC Challenges and Reform Trends

PHC is currently facing a number of challenges, such as:

- Incomplete autonomy;
- Discrepancy between the PHC layout in districts and in the municipality of Chisiau;
- Over-concentration;
- Low efficiency of PHC providers;
- Inadequate motivation of health staff;

- Poor management of PHC facilities;
- Cumbersome data flow;
- High demand for the specialized hospital care services

Reform trends focus on PHC consolidation and development, emphasizing the need to improve people's access to PHC services, higher quality and the continuity of care. PHC reforms required to redirect the health system to ensuring Health for All aim at developing along four lines:

Better management reforms

- Build the stewardship capacity at local level – training heads of health care facilities in organizational and financial management;
- Full autonomy for all HC before the end of 2013, including PHC reform in the municipality of Chisinau;
- Turn FMC into HC;
- Improve the management of PHC facilities (full-scale implementation of appointments, delegation of responsibilities, team work with nurse, setting up triage rooms, "patient's school", including health education etc.)

Resource Generation Reforms

- Make working in rural areas for medical doctors more attractive by implementing mechanisms to provide incentives to family doctors: salary raise; performance-based payments; provide more incentives for freshmen to work in rural areas;
- Implement the protocols on the family doctor's workplace;
- Improve the technical and material supply of facilities;
- Provide them with vehicle, medical devices;
- Develop data systems

Service Delivery Reforms

- Change the paradigm of PHC to carrying out prophylactic measures to prevent diseases and advocate for healthy lifestyles;
- Make PHC providers responsible for the health status of population;
- Strengthen the role of PHC provider as a focal point for interaction with other levels of care (vesting them with administrative powers and purchasing capabilities);
- Improve the mechanism for patient referral to consultations and investigations in healthcare facilities of a different level, making it easier, more autonomous and flexible;
- Cut down the number of referrals to specialized physicians;
- Integrate mental health services into PHC;

- Fix most of the patients' health related issues at PHC level, whenever possible, avoiding unjustified hospital admissions.

Policy Reforms

- Shift the burden from tertiary health care to PHC;
- Increase the share of funds earmarked for PHC;
- Build efficient mechanisms to monitor PHC activities (design and approve priority indicators etc.)

Chapter VII

Examples of International Good Practices in Integrating Mental Health into Primary Healthcare

There are good practices of integrating mental health into primary care worldwide.[1] For instance, the diagnostic, treatment and rehab services for patients with severe mental disorders form Argentina are integrated into PHC. Patients benefit from outpatient therapy within their own communities. Psychiatrists and other mental health specialists are vested with powers to examine and provide consultations on difficult mental disorders. A community-based rehab center provides care that is complementary to the clinical one and is the teaching site for general medicine residents and for PHC practitioners. This program increased the demand for mental health care and made it possible for people with mental disorders to stay within their communities and remain socially integrated. As psychiaytrists are used less and for fewer cases, thus avoiding institutional care, costs are lower and access to required services is better.

Mental health services have been integrated into PHC for the elderly in the general practice of Innercity Sydney in Australia. A general medicine physician provides primary care for mental conditions, while counseling and support are provided by community nurses, psychologists and geriatrics psychiatrists.

In Brasil mental health services have been integrated into primary care in the city of Sobral. PHC practitioners perform physical and mental health evaluations for all patients. They prescribe therapy to patients or request consultation by a specialized mental health team, which is paying regular visits to health centers. There are joint consultations carried out by mental health specialists and PHC practitioners. Not only such model ensures good quality of mental health care, but it also is a training and follow-up tool for PHC practitioners.

[1] Integrating mental health into primary care, A global perspective, WHO and WONCA, 2006

In Great Britain PHC provides mental health services to the disadvantaged communities of London. A practice of primary care in eastern London led to an innovative modality of also including vulnerable groups, including migrants and homes, providing a holistic PHC for physical and mental health, early detection of diseases and co-morbiditites, less stigma and more social inclusion. This practice also showed significant progress in providing psychosocial support to rehab patients. An essential feature of this good practice was the close link with community health services, as well as a bunch of organizations and services dealing with housing, legal and employment issues.

Recommendations

1. One may facilitate the integration of mental health services into primary care not only through good mental health policy, but also through general health policy, focusing on mental health services at primary level. MoH policy and plans shall include PHC for mental disorders, which is the cornerstone of a successful concept;

2. Advocacy efforts, e.g. campaigns, should be started up to change the attitudes and behaviors of lay public and PHC professionals alike. Advocacy is an important aspect of integrating mental health into primary care;

3. National and local political leadership, health authoritieds, local public authorities and PHC workers shall be made aware about the importance of mental health integration. Some important justification for this are the prevalence estimates of mental disorders, the burden associated with mental disorders if left untreated, human rights and violations often reported within psychiatric hospitals, as well as the availability of efficient PHC;

4. Adequate training of PHC workers is critical. Training PHC workers in mental health issues is essential for mental health integration. Nevertheless, PHC workers shall be guided over time by mental health specialists. One has to set up collaboration or joint models of care, whereby consultations and interventions would be carried out by PHC and MH professionals together;

5. The mental health tasks of PHC shall be well-defined. Decisions as to the specific areas of competency shall be made in consultation with various community stakeholders,

assessment of human resources and funds available, and careful consideration of strengths and weaknesses of the actual health system by addressing mental health;

6. There is need to set a concrete plan for gradual integration of mental health services into PHC, design clinical protocols for integrated diagnosis, build within and cross-sector referral mechanisms etc. based on WHO recommendations[2]. Usually, PHC is efficient in mental disorders when the tasks and responsibilities are defined and international practices prove it by having at most 2 integrated diagnosis a year within PHC reforms;

7. Mental health specialists shall be available to provide support to PHC practitioners. Integrating MH services into PHC is essential, but shall be accompanied by additional services, special secondary components of care to be approached by PHC workers for recommendations, support and oversight. Such support may be provided by community-based mental health centers or by appropriately skilled practitioners;

8. Patients must have access to essential psychotropic medicines within PHC. Access to basic psychotropic drugs is essential for the successful integration of mental health into PHC. It implies direct distribution of psychotropic drugs by PHC facilities and not through psychiatric rooms or hospitals;

9. A coordinating committee or board shall be put in place for the integration of MH into PHC. Integrating MH into PHC may be timely, may revert or shift the focus of reforms, and any unexpected problems may threaten at times the results or the mere survival of reforms;

10. It requires human and financial resources. Although integrating MH into PHC is cost-efficient, funds are needed to set up and uphold such services. One has to cover the training outlays and certain suppliments required by PHC staff and MH specialists.

[2] mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 1.0, 2010, WHO