19th November 2018,
Skopje, Republic of Macedonia

SUMMARY REPORT

On the

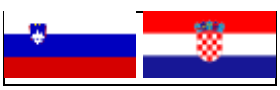
Expert Meeting on the Value of Primary Healthcare System Strengthening in the South-eastern European Region

Ljubljana, Slovenia

6–7 November 2018

SEE HEALTH NETWORK MEMBER STATES

SEE HEALTH NETWORK PARTNER STATES



Family photo: Ljubljana, 6 November 2018

ABBREVIATIONS

ALB	Albania
BiH	Bosnia and Herzegovina
BUL	Bulgaria
CDs	Communicable Diseases
COPD	Chronic obstructive pulmonary disease
CRO	Croatia
EIB	European Investment Bank
EHN	EuroHealthNet
European Observatory	European Observatory on Health Systems and Policies
EU	European Union
FFS	Fee for service
LMICs	low- and middle-income countries
MDA	Republic of Moldova
MKD	Republic of Macedonia
MNE	Montenegro
MOH	Ministry of Health
MS	Member States
NHIF	National Health Insurance Fund
NCD	Non communicable Disease
NGO	Non-Governmental Organization
OECD	Organization for Economic Cooperation and Development
PHC	Primary Health Care
RHDC	Regional Health Development Centers
SDG	Sustainable Development Goals
SEE	South Eastern Europe
SEEHN	South Eastern European Health Network
SRB	Serbia
WHO	World Health Organization

CONTENTS

SUMMARY REPORT

1. INTRODUCTION

The Expert Meeting was jointly organized by the National Institute of Public Health, the Ministry of Health of the Republic of Slovenia, the South-eastern Europe Health Network, and the WHO Regional Office for Europe, and is financially supported by the Ministry of Foreign Affairs of the Republic of Slovenia through the Slovenia's Development Cooperation funds. The event took place in Ljubljana, Slovenia on 6-7 November 2018.

The event was attended by representatives of the governmental sector (from the SEEHN ministries of health, institutes for public health and health insurance funds, as well as Austria, Croatia, Slovenia) and public health professionals from SEEHN member states (Regional Health Development Centres (RHDC) who are, as key actors, involved in the activities at the national level aiming to strengthen primary health care. European Union, OECD, EuroHealthNet representatives as well participated within the workshop.

The purpose of the meeting was to present and discuss the mechanisms that support strengthening of primary healthcare and improving its quality. Primary healthcare (PHC) is a comprehensive and complex system that requires coordination at several levels. The commitment of political decision-makers to strengthen primary healthcare is clearly required, as are cooperation among numerous experts in order to ensure proper governance, organization and management of the system, sustainable financing, an appropriate and adequate network of providers with a balanced and fair geographic distribution, an efficient payment model, strategic personnel planning and development, adequate IT support, and systematic, pre-planned monitoring and evaluation of the performance of primary healthcare.
The Final Agenda of the event is presented in Annexes 2 of this Report.

The expert meeting has been underpinned by a mapping exercise on the PHC systems in all the SEEHN countries. In this respect the SEEHN Member States and partner countries have been asked to fill out a short online questionnaire on "Primary Healthcare" in their respective country, whose aim was to create a snapshot of current primary health-care models in the SEE Health Network member states and partners.
The questionnaire is presented in Annexes 3 of this Report.

The initial results of the survey were presented during the expert meeting. However, the Institute of Public Health will continue thorough analysis of the collected data in the next half a year. It is expected the results to be compiled into a publication on the current PHC operational models in the SEE Health Network member states and partner countries.

Additionally, the participants had the opportunity to visit the Community Health Center Ljubljana, the Šiška Unit and have first-hand experience on the organization and service delivery model of one of biggest Slovenian PHC provider.

2. DISCUSSIONS

1. The expert meeting aimed at presenting and discussing mechanisms that support strengthening and ensuring the quality of primary health care as a comprehensive and complex system that requires coordination of action at different levels. In addition, it

intended to foster cooperation between a number of experts in the SEE Region, thus, on a later stage, to enhance the political commitment of decision makers to strengthen primary health care. More efforts are needed to ensure proper management of the PHC system, sustainable sources of financing, an appropriate coverage of the network of operators with a uniform geographical distribution, an appropriate model of service payment, personnel, definition of services in the framework of primary health care, systematic and update information technology support, pre-planned monitoring and evaluation of the performance of the PHC system.

2. The topic of the expert meeting is extremely important both within and outside the region, as research proven that health systems based on strong primary health care contribute significantly to improving the health of the population, greater equity in health services access and more effective health care.

3. With the WHO Declaration from Alma-Ata, countries committed forty years ago to build their health policies primarily focused on primary health care, which was already recognized as the cornerstone of a successful healthcare system that offers the most comprehensive response to the population demands ensuring accessibility, cost-effectiveness, treatment and user involvement. In Ljubljana, at the WHO Ministerial Conference on Health Systems in the European Region in 1996, the Ljubljana Charter was adopted, which emphasizes the importance of primary health care and its key role in preventing and early detection of chronic diseases and conditions. The 2008 Tallinn Charter summarizes the Ljubljana Charter and further emphasizes that it provides primary health care between the health, the community, individuals and families, and provides an interdisciplinary approach and consequently a greater commitment of the societies to strengthen and preserve human health. In its Health 2020 Strategy, the WHO, as an important goal of developing healthcare, highlights, while ensuring universal accessibility and the right to health, to reduce health inequalities. This in the local settings, in cooperation with other stakeholders, can best address primary health care.

4. The topic of Primary Health Care regain space and the country leaders of the world just have endorsed Declaration of Astana a week ago. The Declaration reaffirms the commitments expressed in the ambitious and visionary Declaration of Alma-Ata 1978 in the aim of Health for All, towards Universal Health Coverage and the Sustainable Development Goals. The Astana Declaration affirms to focus on:
    - ✓ Knowledge and capacity building.
    - ✓ Human resources.
    - ✓ Technology.
    - ✓ Financing.
    - ✓ Empower individuals and communities.
    - ✓ Align stakeholder support to national policies, strategies and plans.

    However, we shall keep *the pulse* and ensure PHC commitments are followed within the next UN General Assembly in 2019 in New York.

5. The European Observatory on Health Systems and Policies (European Observatory) and the OECD, in their analyses of health systems, also highlight as a key part of health systems to ensure the full and quality care of patients with chronic diseases and for the sustainability of health systems primary health care.

6. The European Observatory's analysis also confirms that, from the perspective of society, preventive programs and health promotion programs are more cost-effective than the

treatment of diseases, and preventive healthcare activity must be a fundamental task of primary health care for the improvement of people's health and well-being.

7. For several years, the OECD has been monitoring in the Member States the proportion of potentially preventable admissions to the hospital due to the complications of certain chronic diseases. This is a good indicator of the quality of health care at the primary health care level. A high degree of hospitalization due to complications of chronic illnesses such as asthma, pulmonary emphysema, chronic bronchitis, heart failure and diabetes that can usually be successfully monitored at the primary health care level, otherwise may indicate shortcomings at this level.

8. Ministry of Foreign Affairs of Slovenia since 2004, when Slovenia joint EU and became a donor country, channelled its foreign aid towards strengthening the expert professionals' resources, especially for Balkan Region. Promotion and support of the Regional Cooperation is one the foreign policy priorities, particularly health sector is one of the beneficiaries for already a couple of years. The funds provided to the healthcare area based on the competition bases allow to consolidate Regional partnerships, develop new ones' and identify tailored solutions for the SEE Region countries health system challenges.

9. In Slovenia, primary health care has retained a central role in the health system. Since 2000, this role has been upgraded by the introduction of preventive services for the management of cardiovascular diseases and related risk factors, by introducing the model of the reference clinic for family medicine, preventive health promotion centers and screening programs for early detection of cervical cancer, breast, colon and rectum cancers. Slovenia has great access to quality and efficient treatment and the systematic implementation of preventive health care at the PHC level. Another distinctive feature worth to mention is that the customer is placed in the center and all the services shall be organized around customer's needs to ensure people-centred approach.

10. Currently, Slovenia is developing the National Strategy for Development of PHC. The strategy is grounded on the process of identifying solutions based on good practice and selected priorities. Slovenia has a long tradition of a strong PHC, with community-level health centres first established in the beginning of 20th Century. Today, PHC is mostly provided by a network of health care centers, owned and managed by municipalities; this covers around 76% of physicians and 42% of dentists working in primary care. In addition, publicly funded PHC services are delivered by contracted, office-based physicians in private practices, that have contracts (concessions) with the National Health Insurance Fund (NHIF).

11. Slovenia operates a gatekeeping system whereby patients require a referral from their primary care doctor in order to access specialist care. Patients can choose their physician (changes are possible once a year) and for the visit there should be no waiting time. However, in case of no immediate emergency, the nurse in the practice can make an appointment for the visit within the week. There are no out-of-pocket payments for primary health care services, except for medicines and some of the services in dentistry and gynaecology.

12. Comparing with other countries, Slovenia is below the average in number of physicians per 100.000 population. On the average a family physician has more than 1800 patients. Those, providing services to homes for elderly only, have on average much less patients due to the complexity of care and thus higher capitation per patient (about 300 per physician). Nurses, working at primary level, can be either nursing assistants, registered nurses and midwifes,

working in a primary health care team, community nursing or Health Education Centre. The income of GPs in comparison of average hospital specialist incomes is almost the same.

13. Compulsory insurance is covering most of the services in PHC. PHC services provided by personal physicians (GPs/family physicians, primary-level gynaecologists and paediatricians) are paid through a combined system of capitation and FFS (fee for service) payments. For preventive services and coordination of care of chronic patients delivered by a registered nurse in a so called „model practice", additional flat rate budget is paid to the GP's/family physician's team. Capital investments in Health Care centres are responsibility of municipalities which sometimes presents a problem due to different financial capacities. Investments in private practices of concessionaires are mostly covered by a PHC physician. Often concessioners for practical reasons hire premises at the local health care centre.

14. Slovenia identified several issues to be addressed in future:
    - Shortage of physicians in some of the regions and rural areas
    - Lack of incentives to drive more efficiency and efficacy
    - No systemic quality monitoring and improvement mechanisms
    - Lack of time per patient
    - Rising administrative burden
    - Dental care organization and financing.

    Improvements are needed in cooperation among professionals and providers, continuity of care and comprehensiveness of care.

15. Preventive services that are delivered at PHC level include health care of woman performed by gynaecologist and health care of children and adolescents by paediatricians. Strong community nursing is also a tradition and presents important potential to access vulnerable groups of population including elderly and poor. It also assures nursing of mothers and a new born child. In early 2000 Health Education Centres were developed within most of PHC Centres offering smoking cessation and healthy life style counselling.

16. PHC system performance is assessed through potentially avoidable hospital admissions indicator for some more prevalent diagnoses. OECD comparisons show that Slovenia is improving in care at primary level in COPD, which could at least partially be contributed by the introduction of additional nurse in model practices. Also, monitoring showed improvements in diabetes care and in particular in the management of chronic hard failure and hypertension.

17. National Strategy on Development of Primary Health Care in Slovenia 2016 to 2025 is based on introducing good practices. In the large, consultative, consensus process it was also agreed that it will build on already developed and recognized good practices. Few of them are as follow: Model practices with registered nurse; Health promotion centres within PHC to better focus on reducing inequalities in health; Comprehensive approach to obesity in PHC Centre involving the whole family; Cooperation of community nursing with social services through consultations and common meetings; Introduction of pharmacists into the PHC team to evaluate pharmacotherapy in patients with multi-morbidity are the most prominent. In addition, national strategy priorities for action are: the introduction of e-referrals (already implemented)), e- prescription and e- health records; institutionalization of quality monitoring, research and of support to further development of PHC (development of a new PHC Institute); a new payment model introducing payment for performance.

18. The National strategy is financed from: EU and Norwegian grands which amount is around 40 million euros and National Budget specifically earmarked taxes from tobacco sails. Another target is to have earmarked alcohol/sugar/trans-fat tax.

19. In the aim of controlling the burden of NCD's and tackling health inequalities Slovenia strengthened cooperation between public health, primary healthcare and local communities through a new paradigm implemented since 2011. The model focuses on the integration of prevention of all NCDs at PHC settings („model practices"), integrated trained nurse practitioner in the PHC team who took over: primary and secondary prevention of NCDs and follow-up of stable chronic patients, life style intervention given by practice nurse in model practices and in health promotion centers; clinical guidelines, standards and protocols are integrated in preventive practices to ensure quality control. At this stage 85% of all PHC practices are functioning by the „model practices".

20. SEEHN has established in Montenegro the Regional Health Development Center (RHDC) for NCDs since November 2011. The recent regionally implemented initiatives are as follow: salt intake reduction programs, scaling up colorectal cancer screening programs, NCDs registries (cancer), common set of indicators on NCDs to be M&E at the SEE Regional level.

21. Austrian PHC was depicted as a model and best practice presented within the Regional Meeting. Current Austrian PHC challenges are: little possibility for flexible and integrated forms of work, no structured form of collaboration, 74 % of contracted GPs will be 65 years until 2030, little interest of medical students to specialise in General Practice and changing expectation of their future professional career (feminisation, team-work, etc.). Currently, Primary Health Care in Austria became a priority in health policy following international best-practice and building on international expertise. Since June 2017 a dedicated health care law was under development, coordination and is on the way to be approved. The main concept relies on a network of 75 primary health care units until 2021. The core pillars to addressed under the Start-up philosophy are:
    - Financing and Funding,
    - Care concept,
    - Supportive measures for founders,
    - Attractiveness of the primary health care sector.

22. Austria launched the SRSS project as start-up initiative for primary health care units in the period June 2018 - end of 2019, funded by EIB. Main areas covered:
    − Preparation of a start-up guide for primary health care units (building on previous work)
    − On-site support for primary health care units (founding process)
    − Development of web platform and information campaign
    − Raising the attractiveness of the primary health care sector and support in local coordination (Partner: European Observatory on Health Systems and Policies).
    The preliminary conclusion is than financial challenges are common issues even in developed countries and is worth to explore funding opportunities even within banking system.

23. EU mainly focuses its work on health area through EU Expert Group on Health Systems Performance assessment, European Commission's State of Health Report, Steering Group on Health Promotion and cooperation and development. The report mapped 7 essential elements when building primary care performance assessment:
    - Improve primary care information Systems.
    - Embed performance assessment in policy processes.

- Institutionalize performance system.
- Ensure accountability.
- Consider patients experience and values.
- Take advantage from adaptability.
- Support goal-oriented approach through a better use of professional and contextual evidence.

24. State of health in the EU Companion Report 2017 came up with 5 key conclusions:
    - health promotion and disease prevention pave the way for a more effective and efficient health system: NCDs accounts for 80% of health care costs, yet only 3% from health budgets are spend on health promotion;
    - strong primary care guides patients through the health system and helps avoid wasteful spending: 27% or ¼ of the visits to an emergency department because of inadequate primary care, thus ¼ avoidable spending;
    - mandatory PHC referrals indicate strong gatekeeper systems in half of the Member States;
    - Integrated care tackles a labyrinth of scattered health services to the benefit of the patient
    - The patient is at the centre of the next generation of better health data for policy and practice: better health data contributes to patient outcomes whilst reducing wasteful spending in health care.

25. EU supports health system strengthening through: providing knowledge resources on-line, EU Programs; Multi-country – financial assistance under IPA II, TAIEX, TWINNING, assessment (Reports- Action-Plans, Sub-committee meetings ENLARG.

26. OECD built a strong case for investing in PHC. There are several common core priorities countries have to focus on to strengthen their primary health care system:
    - Greater prevention efforts are needed in primary care settings
    - Developing new team-based models and develop new role for health personnel
    - Implementing innovative payment systems that reward preventive activities and coordinated care
    - Develop information systems that monitor outcomes and quality of primary care

27. WHO is advocating for the last 40 years for a strong role of the PHC in achieving universal health coverage for everyone, everywhere. Age-standardized overall premature mortality rate in people aged 30–69 years for four major NCDs in all SEEHN Member States except State of Israel are well above average EU 15 average. One of the spotted challenges is quality of the provided care. The gap between the quality of care on the planet and the quality of care could be enjoyed by the people in low and middle income countries, based on best available practices, pictured in the annual toll in deaths alone globally, is between 5.7 and 8.4 million deaths (annually). Those are deaths attributable to the gap between the quality that is delivered and the quality that could be delivered technically. To translate that number, even at the lower limit, that is more than all the deaths in the world from HIV, tuberculosis and malaria combined. More than 830 million people with a diagnosed NCDs are not being treated, and more than 4 million avoidable quality-related deaths each year are attributable to ineffective care for NCDs. Hospitalizations in low- and middle-income countries (LMICs) lead to 134 million adverse events each year, and these adverse events contribute to more than 2.5 million deaths annually.

28. WHO promotes PHC as a strong foundation to be set firmly and confidently that can provide protection in order to ensure the needs, wants and expectations of individuals, families and communities. The global agenda 2030 objectives strive as well for people-centred health systems while systematically influencing how health professionals and health administrators respond. Human resources availability, coverage is an issue to focus within SEEHN. Nurses shall benefit a special attention in the aim to expand their qualifications and contribution to the PHC unmet needs.

29. PHC as an enabler to other SDGs. Most of the SEEHN countries are in the middle of the way to achieve SDGs, Slovenia being well ahead. A solution to strengthen PHC is to expand UHC from all 3 angles: services, financing, and coverage. One of biggest challenges in the SEE Region countries are the catastrophic out-of-pocket payments.

30. Policy accelerators identified by the WHO to strengthen PHC are as follow:
    - Realize a population health approach
    - Adopt a community care model
    - Coordinate with social care
    - Invest in the competencies of practitioners
    - Establish quality improvement mechanisms at practice level
    - Ensure the responsible use of medicines
    - Meaningfully engage the public and civil society
    - Optimize services with data driven transformations
    - Align provider payments
    - Promote inclusive entitlements

31. Discussions were held around the imperative of the wide consultation in the policy development process. In SLO example everybody was consulted including nurses and GPs. In Austria there is a very strong voice of Chamber of the PHC. Many rounds of consultations have been held and also through this process a commitment has been secured for further policy implementation. Although, many countries from SEE Region still have to include the specialists into the policy development, as well as patient associations has to participate into the dialogue as customers and direct beneficiaries.

32. PHC governance has enjoyed particular attention. Detailed stakeholder mapping along with accountability, motivation and incentives that would be applied to drive the most performance at the PHC level were reviewed.

33. Some of the PHC challenges SLO decided to solve through implementation of a new financing model. The proposed model has simpler design, more transparent and evaluated for each enrolled persons assigned, according to the realization of all doctors who performed examinations and provided services. Existing funds for preventive care are reallocated among providers. Additional fundraising is expected from partners' side to pledge additional resources. The aim is to reach the average doctor's salary at 1200 euros and to have supplementary employment for teams' needs.

34. Mental health organization and functionality system were widely discussed on the SLO example, as well as SEE countries models. Despite, well distributed and accessible PHC centres SLO is facing many common challenges for the SEE Region: increased number of mental health disorders in all age groups; insufficient network of mental health services at PHC level; shortage and overload of family doctors and paediatricians; lack/insufficient systematic renewal/upgrade in paediatricians and family doctors` knowledge and skills; shortage of clinical psychologists, child psychiatrists; lack of cooperation and integration

among professionals/services provision; shortage of services for the treatment of persons with severe/chronic mental disorders on primary level in the community.

35. SLO solutions to strengthen mental health developed National Mental Health Programme for the period 2018-2028. One of the document priorities is to upgrade the existing primary level mental health services with 25 Centres for mental health that will function within PHC centres. The centres are expected to ensure an equal, accessible and comprehensive interdisciplinary and intersectorial care in the field of mental health in defined areas (app. 80,00.0 residents).

36. BiH presented their model of Community Mental Health focused not only on treatment but also on recovery and social inclusion. The policies focused comprehensively on several components: legislation, human resources, quality of care, human rights, new services (introduced occupational therapy), strengthening management capacities, strengthened user capacities. It is important to mention the huge complementary work done by the nurses. Worth mentioning are the additional preventive programs as: Suicide prevention, Gambling prevention, Prevention of Psychosomatic Disease, Cooperation with schools in prevention of violence.

37. Romania has a different PHC model mainly based on privatized 11,200 GP practices. The initial strategy from 2014 aim to change towards PHC and community care by 2020. PHC in Rom is seen only like family care. The provided service range include: acute care, management of chronic diseases, preventive care, home care activities, palliative care, counselling, support activities, complementary activities – ultrasound etc., other: education, research, though no integrated care, dental care, school care. Since, most are single privatized practice it is very difficult or near impossible to implement the best practice examples presented in SLO. Electronic prescription is implemented since May 2015; e-referrals are still expected to be implemented. In terms of quality assurance, the biannual evaluation by the National Insurance House is the functional mechanism at the moment. It will be replaced by an accreditation scheme in a 5 annual cycle that contains also monitoring and quality improvement mechanism. The planned reforms are expected to be led by the National Authority of Quality Management in Health (accredited by ISQua). The standards of care are already developed at this stage, although the fear of bureaucracy make primary care physicians reluctant in accepting it.

38. Current payment system of the PHC in Romania is a mixed form of: 50 % capitation, 50% fee for service. No pay for performance is applied in Rom. Some preventive services are payed within a separate contract for vaccinations, cervical cancer screening. Primary care delivers 70 % of all medical services for only 5,8% of the National Insurance House funds.

39. Romania faces a huge challenge related to health personnel. It includes several phenomenon as aging: the doctors (1/3 are over 60 years), migration, nurses' shortages due to low wages and no motivation schemes.

40. Strengthened cooperation between PHC and secondary care was widely acknowledged important part to achieve better health outcomes. Deliberations identified several areas for possible improvement as: communication with using modern technologies/innovative ways, one day a month GP to visit Local Hospital /Secondary Care Team to have an external consultation, common events for GP and secondary care Doctors to develop personal and group relations and focus on task sharing in the patients' case management.

41. Health information technology has been seen by MNE authorities to have the potential to improve coordination by making information electronically available. Montenegro implemented an Integral Information system which includes: Health Insurance Fund, Primary health care (PHC) - health centers, Pharmacies of Montenegro "Montefarm", general hospitals, special hospitals, Institute for Emergency Medical Assistance of Montenegro, Blood Transfusion Institute of Montenegro, Institute for Public Health of Montenegro, Agency for Medicines and Medical Devices, Health Center of Security Forces of Montenegro, private dental clinics that are part of the health care network, private pharmacies that are part of the health care network, private health institutions that are part of the health care network, and partially: Clinical Center of Montenegro.

42. PHC sector is small but raising in ISR. The total health expenditures are 7.5% which is below the OECD average at 9%, though Israeli Health System is ranked first according to Bloomberg Efficiency score and most important the public satisfaction rate with the system is around 90% on average. The Israeli Healthcare System is based on the Health Insurance Law-1994 and includes: Community care (primary, specialists); Hospitals - Government, HFs, non-profit Public; Private sector - small but rising; Public Health Services: preventive services supplies by Ministry of Health. The distribution of expenditure is 35% for community care and 45% for hospital care. The information technology is an example of innovation in Israel. Almost 100% of the health records are electronic. Nevertheless, there are major obstacles with the flow of information as the patient is moving from the community to the hospital and back, and even when switching between centers. Every hospital group and community center use different electronic health record system which challenges information flow, a flow that is essential for patient safety. Tele-Health Center (MOMA) is an excellent example of people-centred care being a complementarity between hospital and community based healthcare system. It provides:
    - ✓ Nationwide support network for home/remote care management
    - ✓ Innovative platform for chronic care management (Tele-monitoring and interventions)
    - ✓ Multi-disciplinary center with Primary physicians and nurses
    - ✓ Fully coordinated with patients.

    The Tele-Health Center (MOMA) achieved: better diabetes control, 40% decrease in depression rate, decreased hospitalization & successful homecare, over 7,000 current patients & 11,000 treated.

    Another proposal only vociferated within the SEE countries is successfully implemented in ISR the virtual incorporation of the primary care physician into hospital ward morning rounds.

43. ISR efforts to improve interactions between primary and secondary care achieved decreasing length of hospitalization, increasing community base services (day-care centers, small surgical procedures), integrating GP's with hospitals clinical decisions, ensure continuum sequence of care, fruitful interchange of ideas. There still challenges to be addressed as:
    - ✓ Inherited conflicts of interest
    - ✓ Bilateral frustration and lack of cooperation
    - ✓ Uncontrolled competition between secondary HCS
    - ✓ GP as a financial gatekeeper
    - ✓ Constant difficulties receiving approvals and reimbursement.

44. Moldova on the national example pictured the current challenges the PHC workforce is facing in the SEE Region. Thus, more than 20 % of MDs and 15 % of PHC nurses are needed currently in the health system of Republic of Moldova. There are even bigger disparities if looking into rural-urban distribution, or South-North differences. The main

identified barriers for choosing rural practices were mentioned: lack of infrastructure in rural areas, high workload, administrative work pressure, low income, insufficient expected professional growth in the career, higher opportunities while moving to other sectors of economy and migration outside the country (brain-waste and brain-drain phenomenon). Several solutions have been implemented in MDA to overcome the workforce shortage including: financial incentives (bonus for young specialists who accept working in rural areas receive 2300 euros in the first 3 years of practice, nurses - 1850 euros), along with non-financial support from the government and local public administrations (housing, commodities, etc.). Recently adopted measures for graduated persons impose mandatory 3 years' term of in-country practice or to refund all training costs.

45. Preliminary analysis of the questionnaire sent in advance to all SEEHN Member States have been presented. It pictured first results related to the Governance of PHC and policy implementation, primary healthcare system model, financing model, communication between primary and secondary care professionals, structure of health professionals (by basic education and specialisation), PHC efficiency and quality control. Though, SEEHN countries requested additional time for revising the information provided.

46. Slovenia as partner and SEEHN Secretariat encouraged countries' representatives to commit and engage in the following moths in order to complete maximum in 6 months to publish the results of this workshop.

3. CONCLUSIONS AND RECOMMENDATIONS

Several priorities for future work have been highlighted aimed to strengthen PHC in different countries:

1. To strengthen Human resources, human capital, through different motivation incentives as pay for performance mechanisms, by continuously updating postgraduate training and improved working conditions. Health workforce sent to geographically remote areas shall benefit from additional incentives to ensure equal access and quality of care.
2. To strengthen referral system to guide patients through the health system, as well as ensure proper communication between primary and secondary care, avoid duplication of examinations;
3. To ensure greater prevention effort needed at the PHC level, to enable better and closer cooperation between Public Health and PHC, but also with social care;
4. To revise the payment system thus to encourage the preventive activities and coordinated activities;
5. To encourage Team base model of the PHC that demonstrated in OECD countries to better address the needs of chronic patient conditions, multi-disciplinary practice with social worker and other specialities as occupational health on board;
6. To increase the role of community;
7. To reduce administrative burden on health professionals to have more time for patients;
8. To enable rich information infrastructure as essential to improve quality of PHC;
9. To enhance PHC research and development;

10. Countries shall explore additional financing mechanisms as EU, Norwegian Grand funds etc.
11. At the national level earmarked taxes for tobacco/alcohol/trans fats products commercialization could be used as additional sources of financing to the PHC preventive measures.

Annex 1 Final Agenda

Expert Meeting on the Value of Primary Healthcare System Strengthening in the South-eastern European Region

M Hotel, Ljubljana (Slovenia)
6–7 November 2018

AGENDA

Monday, 5 November 2018

Afternoon	*Arrival of participants*

Tuesday, 6 November 2018

8:30 – 9:00	*Registration*
Opening of the expert meeting *Moderator: Ms Špela Vidovič, National Institute of Public Health, Slovenia*	
9:00 – 9:30	***Welcome addresses*** • *Assist Pia Vračko, MD, MSc, State Secretary, Ministry of Health, Slovenia* • *Dr Mira Dašić, Head, SEE Health Network Secretariat* • *Mr Uroš Vajgl, Acting Head, Department for Development Cooperation and Humanitarian Assistance, Ministry of Foreign Affairs, Slovenia* • *Dr Darina Sedlakova, Head, WHO Country Office in Slovenia* • *Prof Dr Ivan Eržen, Head, Centre for Analysis and Development of Health, National Institute of Public Health, Slovenia*
9:30 – 10:00	***Introduction to the programme of the workshop and brief presentations of participants***
Break for group photography	

Opening plenary session: The role of primary healthcare in addressing changing population needs *Moderators: Prof Dr Ivan Eržen, National Institute of Public Health, Slovenia* *Dr Kiril Soleski, Macedonian Medical Association*	
10:10 – 10:25	***The role of strong primary healthcare in achieving universal health coverage for everyone, everywhere*** *Dr Juan Tello, WHO European Centre for Primary Healthcare*
10:25 – 10:40	***National strategy for primary healthcare development in Slovenia*** *Ms Vesna-Kerstin Petrič, MD, MSc, Ministry of Health, Slovenia*
10:40 – 10:55	***Controlling the burden of NCD's and tackling health inequalities – cooperation between public health, primary healthcare and local communities*** *Mr Rade Pribaković Brinovec, MD, National Institute of Public Health, Slovenia*
10:55 – 11:10	*Break*
11:10 – 11:25	***Opportunities for strengthening comprehensive care at primary healthcare in context of changing population needs*** *Assist Pia Vračko, MD, MSc, State Secretary, Ministry of Health, Slovenia*
11:25 – 11:35	***NCDs and PHC prospects in general*** *Dr Milica Stanišić, SEEHN Regional Health Development Centre on NCDs, Montenegro*
11:35 – 11:50	***Primary healthcare reform in Austria*** *Mr Stefan Eichwalder, Ministry of Health, Austria*
11:50 – 12:05	***European Commission activities to leverage primary healthcare systems strengthening in member states*** *Mr Gerhard Steffes, European Commission*
12:05 – 12:25	***How can primary care improve population health outcomes? Learning from OECD countries*** *Dr Caroline Berchet, OECD*
12:25 – 12:40	***Reflexion on European Union member states' activities in primary healthcare aimed at achieving universal health coverage*** *Doc Dr Mojca Gabrijelčič Blenkuš, MD, PhD, EuroHealthNet, National Institute of Public Health, Slovenia*
12:40 – 13:00	***Steered discussion***
13:00 – 14:30	*Lunch break*
Expert group work session: Mechanisms for PHC strengthening	

Introduction to expert group work: Mr Rade Pribaković Brinovec, National Institute of Public Health, Slovenia	
14:30 – 16:00	- ***Expert group 1: Primary healthcare governance and management*** *Moderator: Dr Aleksander Stepanovič, Primary Health Care of the Gorenjska Region, Slovenia* - ***Expert group 2: PHC purchasing and payment model*** *Moderator: Ms Karmen Petrič, Health Insurance Institute of Slovenia* - ***Expert group 3: PHC organization and services*** *Moderator: Prim Dr Goran Čerkez, Federal Ministry of Health, Federation of Bosnia and Herzegovina, Bosnia and Herzegovina* *Co-moderator: Ms Mejvis Kola, Ministry of Health and Social Protection, Albania* - ***Expert group 4: Approaches to improve cooperation between the primary and the secondary levels of the healthcare*** *Moderator: Prof dr Zalika Klemenc-Ketiš, Slovene Association of Family Medicine Physicians* - ***Expert group 5: Human resource development and management for strengthening Primary Healthcare*** *Moderator: Dr Tatiana Paduraru, SEEHN Secretariat* *Co-moderator: Ms Nataša Pilipović Broćeta, MD, MSc, Faculty of Medicine Banja Luka, Republic of Srpska, Bosnia and Herzegovina* - ***Expert group 6: PHC performance – monitoring and evaluation, quality assurance*** *Moderator: Dr Nebojša Jokić, Ministry of Health, Serbia* *Co-moderator: Dr Milica Stanišić, Regional Health Development Centre on NCDs, Montenegro*
16:00 – 16:15	*Break*
16:15 – 17:30	***Visit to the Community Health Centre Ljubljana (Šiška)*** *Derčeva ulica 5, Ljubljana*
19:00 – 21:00	*Dinner* *(Departure from the hotel – by bus – at 18:45)*

Wednesday, 7 November 2018

Plenary session with expert group reporting: Mechanisms for PHC strengthening *Moderators: Mr Rade Pribaković Brinovec, National Institute of Public Health, Slovenia* *Dr Asher Salmon, Ministry of Health, Israel*

9:00 – 9:30	***Opportunities and challenges in PHC governance in Slovenia*** *Ms Vesna-Kerstin Petrič, MD, MSc, Ministry of Health, Slovenia* ***Group 1 reporting*** ***Discussion***
9:30 – 10:00	***Objectives of PHC financing model update in Slovenia*** *Ms Karmen Petrič, Health Insurance Institute of Slovenia* ***Group 2 reporting*** ***Discussion***
10:00 – 10:30	***Organization of mental health services at primary healthcare in Slovenia*** *Prim Nuša Konec Juričič, MD, National Institute of Public Health, Slovenia* ***Mental health services at primary healthcare in Bosnia and Herzegovina*** *Prim Dr Goran Čerkez, Federal Ministry of Health, Federation of Bosnia and Herzegovina, Bosnia and Herzegovina* ***Primary healthcare organization and service provision in Romania*** *Dr Andrea Neculau, Romanian Society of Family Medicine* ***Group 3 reporting*** ***Discussion***
10:30 – 11:00	*Break*
11:00 – 11:30	***Cooperation between primary and secondary levels of healthcare in Montenegro*** *Dr Nebojša Kavarić, Primary Health Centre Podgorica, Montenegro* ***Cooperation between primary and secondary levels of healthcare in Israel*** *Dr Asher Salmon, Ministry of Health, Israel* ***Group 4 reporting*** ***Discussion***
11:30 – 12:00	***Human resource development and management for primary healthcare strengthening in Republic of Moldova*** *Dr Ghenadie Curocichin, State University of Medicine and Pharmacy, Moldova* ***Group 5 reporting*** ***Discussion***
12:00 – 12:40	***Opportunities and threats for primary healthcare IT support in Slovenia***

	Mr Dalibor Stanimirović, PhD, National Institute of Public Health, Slovenia ***Group 6 reporting*** ***Discussion***
12:45 – 13:00	***Wrap up of the meeting and conclusions*** *Dr Mira Dašić, Head, SEEHN Secretariat* ***Closure of the expert meeting*** *Dr Darina Sedlakova, Head, WHO Country Office in Slovenia* *Assist Pia Vračko, MD, MSc, State Secretary, Ministry of Health, Slovenia*
13:15 – 14:00	*Lunch* *Departures*

Annex 2 PHC Questionnaire

PHC Questionnaire is attached separately beside this document ("pdf_vprasalnik").

Annex 3 PHC Questions for Discussion

PHC Questions for Discussion are attached separately beside this document ("SEEHN - PHC - QUESTIONS FOR DISCUSSION - 05 November 2018").