National Dissemination Workshop Discusses Results of the Albania Baseline Health Survey

Results of baseline health surveys engendered discussion at a PHRplus/Albania-sponsored workshop on “Evidence for Policy Dialogue” held in May. Sixteen health professionals from throughout Albania, as well as representatives from the USAID mission attended the workshop.

The surveys, which gathered information on the availability and utilization of curative primary health care (PHC) as well as reproductive and preventive health services, and on the financing of PHC services, were carried out in the pilot districts of Berat and Kuçova and the control site in Fier. The baseline data are intended to serve both the national and local levels in understanding health care and health insurance needs, to develop information useful to policy and system improvements, to evaluate the success of the improvements, and to indicate areas where future reforms are needed.

The surveys contribute to an important project strategy: to provide intensive research and demonstration in pilot project sites. In addition to the surveys, PHRplus has carried out technical assistance and training, most of it in four health centers in the demonstration districts.

Workshop Goals

1. To provide a brief overview of the health reform context in Albania and, more specifically, describe the interventions in Berat and Kuçova and the monitoring and evaluation activities associated with the interventions.

2. To provide baseline survey results for sampling areas in the health sector: availability of services, management, information systems, quality assurance; service utilization, choice of provider, out-of-pocket payments, perceptions of quality for chronic and acute problems, and preventive and reproductive health.

3. To provide opportunity for discussion and sharing experience based upon the recent survey.

4. To provide input and advice on potential future project activities and the national health care reform agenda by discussing the implications of the survey findings and other activities in the pilot sites.

Workshop Results Support Using Evidence for Policy

As the workshop name implies, the theme of the workshop was the use of quantitative evidence in policy dialogue. Albania has passed many health sector laws and amendments, and established new institutions. However, these reforms were designed and legislated without consulting hard data, and without effecting changes that are perceptible to providers and patients. In contrast,
Albanian Physicians Receive Training in Family Medicine and Clinical

Continuous Quality Improvement (CQI) of health care services is a major objective of PHRplus/Albania. Clinical Practice Guidelines (CPGs) and training in Family Medicine (FM) are two major activities under this objective.

Family Medicine Training

Background

When it began work in Albania, PHRplus found an obsolete health system that specialized service from the first point of patient contact with primary health care (PHC). Similar to health systems of many Eastern European countries, the Albanian system did not acknowledge PHC as a single service based on Family Medicine; instead, it adopted the goal of putting facilities that offered a “trio” of services – internal medicine, pediatrics, and obstetrics/gynecology – in every corner of the country. It failed to achieve this widespread coverage. Many of these specialty polyclinics still exist, unfunded and inefficient. The need for reform became evident as low quality and high costs led to failure of the system. The advent of free movement of the population and migration of doctors from rural areas toward towns and cities was the final blow.

Purpose

The integration of the Family Medicine approach into PHC services is intended to improve the quality of services already offered and to introduce new services.

Training Program Principles

A careful assessment of the PHC environment and resources was done before setting up the PHRplus training program, which is based on the following principles:

▲ Introducing the philosophy and methodology of contemporary Family Medicine.
▲ Increasing and improving the knowledge and clinical skills of doctors in the pilot health centers.
▲ Using primary care CPGs as the basis for training and the key to the success of Family Medicine for two reasons:
  ▪ CPGs were set up based on concepts of a proven Family Medicine model.
  ▪ CPGs are scientific approaches to clinical diagnoses and treatment. The guidelines are accepted worldwide and represent the shortest way to achieve standardized, high quality, cost-effective PHC.

Expanding physicians’ clinical skills in patient examination and diagnosis through use of technology and tools such as the otoscope for ear examinations and ophthalmoscope for eye examinations considerably improves general practitioners’ success at treating acute illnesses, managing long-term cases, avoiding over-use of more costly specialty care by making appropriate referrals to other levels of the health care system – and achieving better patient outcomes.

Clinical Practice Guidelines

Background and Purpose

According to the Albanian Institute of Medicine, CPGs are “Systematic works to assist the doctor and patient in decision-making for appropriate health care in certain clinical conditions.” As noted above, their utilization ensures an optimal quality of health care, standardizes service, and ensures better control of the scientific job quality. In addition to the clinical improvements, use of CPGs will enhance:

▲ Control of the functioning of the health system and identification of the quality of service through audits.
▲ Definition of official standards of quality of service and a future system of quality assurance through accreditation.

Implementation of CPGs

CPGs have been developed for 21 clinical conditions deemed most important based on their frequency, gravity, and risk, and the feasibility of clinical management at the PHC level. The CPGs were worked out by PHRplus in collaboration with Albanian health experts and health clinic physicians. The adoption of Family Medicine and the continued need for standardization requires frequent updating of CPGs in parallel with Family Medicine training.

Training Results

Training was given to the following numbers of health care providers and community members:

<table>
<thead>
<tr>
<th></th>
<th>Numbers</th>
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<tbody>
<tr>
<td>Doctors</td>
<td>18</td>
</tr>
<tr>
<td>Nurses</td>
<td>40</td>
</tr>
<tr>
<td>Midwives</td>
<td>10</td>
</tr>
<tr>
<td>Women*</td>
<td>212</td>
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</tbody>
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* participating in Awareness Campaign on Reproductive Health

Future Goals: Family Practice and Standards of Care

A future goal is the introduction and integration of Family Medicine into a health system where self-regulation and self-function are the core principles. The following elements are needed for success:

▲ Review and update the Family Medicine training program.
▲ Introduce Continuous Medical Education; this ensures the PHRplus CQI objective.
▲ Frequently update the CPGs and Continuous Medical Education.
Health Information Systems: A Model Component and Monitoring and Evaluation Tool

A new Health Information System (HIS) is an integral component of the primary health care model that PHRplus is introducing in the four pilot clinics in Berat and Kucova. The purpose of the HIS is twofold: first, as famous physician and writer Sir Arthur Conan Doyle said, “It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts.” In other words, we need to have all the necessary information so that we can make sound decisions. Second, the same information is used as a monitoring and evaluation tool to measure project effects.

PHRplus implemented the HIS in the four facilities in July 2002. A meeting with all the stakeholders introduced the HIS and its purpose, and built a consensus on which further activities would take place. The HIS collected valuable data till the end of 2002. By that time some project activities, focusing on provider training, had already commenced. However, this was the “pre-intervention” period, and activities had not had time to produce a measurable effect. The second period, starting in January 2003 and continuing today, is the “intervention” period. The HIS continues to collect information about facilities, doctors, nurses, patient demographics, reasons for patient visits, diagnoses, referrals, lab tests, and medications. More than 50,000 encounters have been registered since July 2002.

The data is collected each time a patient is encountered in the facility. A nurse uses the Patient Encounter Form to register the data during or after the visit. Completed forms are then sent to the PHRplus office in Berat and entered into the Microsoft Access database by optical scanning. Generic reports can be produced in both English and Albanian. (Illustrative graphics produced by the HIS accompany this article.)

The reports generated are discussed with facility staff and with other local health authorities like the Public Health Directorate, Primary Health Care Directorate, and Health Insurance Institute. A Technical Assistance office is scheduled to be inaugurated in early autumn at the Public Health Directorate of Berat Qarku. This office will assume responsibility for all the information collection, processing, and sharing duties now carried out by PHRplus. This transfer of duties is part of the capacity building of the Albanian health authorities. A PHRplus staff member will also assist the technical assistance staff with all the issues related to the HIS till local health authorities are comfortable in doing so.

PHRplus’ approach is to work at the facility, community, and national levels to introduce reforms to improve PHC based on evidence.

Conclusions

As mentioned repeatedly in closing remarks by the directors of the Health Insurance Institute, the Ministry of Health’s PHC department, and the Public Health Care office in Berat, the workshop demonstrated that, after a year-and-a-half of collaboration, discussion and dialogue among health agencies has become the accepted practice. Evidence-based discussions allow the various health sector actors to go beyond opinion and anecdotal evidence as input into policy dialogue. Participants expressed an urgency to push forward with project activities and especially to work with government leadership to apply pilot approaches to health care financing using insurance mechanisms.

If you would like a copy of the workshop proceedings, please contact the PHRplus office in Tirana or download it from www.PHRplus.org.
Determining the Cost of Primary Health Care

The type of information most demanded by Albanian stakeholders in the current health reform process is no doubt the costs of services. In accordance with its goal of providing solid evidence for policymaking, in early 2002 PHRplus implemented in the pilot sites of Berat and Kuçova a facility-based Health Information System (HIS) to measure utilization, visit characteristics, and costs of visits. Currently, the HIS database contains information from more than 50,000 visits to the health clinics.

In addition, in July 2002, PHRplus initiated an expenditure tracking system for the four pilot health centers. These expenditure data are fed into a costing model that calculates fixed and variable costs of visits at the centers. In this way it is possible to relate costs to volume of patients, to measure the cost of different services offered at the visits, and to simulate results under various assumptions. The costs of different services will be defined with the help of Clinical Practice Guidelines (see preceding article). The model is being developed together with the Quality Improvement system in the clinics.

All the costs incurred are classified in four categories: personnel, facility costs, supplies, and equipment. The Directorate of Primary Health Care and the Health Insurance Institute provide the monthly expenditures for personnel and supplies. No historical data are available for facility costs and equipment and hence shadow prices are used to estimate such costs. The current market value of the facilities was appraised and a monthly cost equal to the rental value was calculated. A system was built to also appraise the equipment cost and calculate a monthly depreciation value.

The project has now collected cost data regarding the facilities for more than a full year (July 2002-August 2003). These cost data combined with the great number of visits recorded can serve very useful purposes in cost analysis. The model details the impact of different factors such as personnel, space, or supplies on the total cost of services provided by the PHC delivery sites. Using break-even analysis and simulations we can capture the relationship between volume and costs under the current service delivery model and get numbers for important costs like average cost and marginal costs. Along with improved services and the added cost for such services it will be possible to forecast the financial consequences of improved services provided on a national basis.

Results

▲ Out of doctors’ total time, the time spent with patients ranges from about 9% in one center to almost 35% in another, reflecting variations in efficiency between doctors in different environments.

▲ Due to variation in efficiency between health centers, the average cost per visit varies greatly, ranging from 163 Leke per visit at one center to 814 Leke per visit at another.

▲ Personnel represents the highest cost category – about 87% at one urban center, for example – leaving very little funding for supplies and equipment.

▲ An increase of funds in medical supplies is an immediate need for the health centers.

For more detailed information about the costing system and analysis, contact PHRplus office in Tirana.