Policy brief #5
Policy issues in providing outpatient specialist care

This policy brief summarizes the findings of a detailed study implemented by Health Policy Analysis Project (HPAP) in the period from October 2003 to March 2004. The study was completed with the participation of MHIF, Department of Reform Coordination and Implementation (DRCI), MOH Department of Health Care Organization and Licensing, HA KR, FGPA KR and Primary Care Development Project (Human Resources, DfID).

1. Background

For the past two years, outpatient specialist care has been provided at both primary and secondary levels. At the primary level, outpatient specialist care is provided at Family Medicine Centers (FMCs) at rayon and oblast levels. At the secondary level, outpatient specialist care is provided at Ambulatory Diagnostic Departments (ADDs) under Territorial Hospitals. While there is variation across the country in the work and performance of FMCs and ADDs, there are commonly experienced concerns that prompted this study. The level and distribution of specialists is inefficient and inequitable, there is significant duplication of specialties, there is large variation in the availability of medical equipment and supplies, and working conditions vary. Furthermore, the concern has been raised that the availability of narrowly defined specialist care at FMC level has stunted the further development and strengthening of primary care. In response to these concerns, the MOH initiated a study with the objective of identifying the appropriate location and role for narrow outpatient specialist care in the health care system.

2. Study methodology

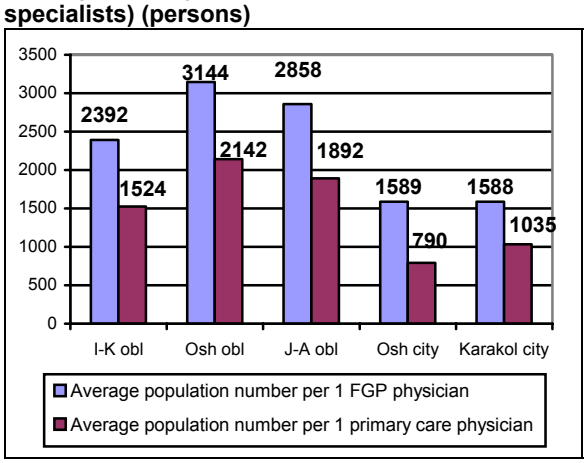
The study covered 4 rayons in three oblasts (Issyk-Kul, Jalal-Abad and Osh) and in two cities (Karakol and Osh). A number of qualitative and quantitative indicators were selected to assess performance of narrow specialists in ADD and FMC:

- Brief description of catchment area;
- Description of organizational structure and material-technical equipment of ADD and FMC;
- Staffing levels and mix;
- Workload per day and per hour (with and without preventive examinations);
- Service-mix and duplication;
- Patient -mix by diagnosis;
- Structure of outpatient visits and hospitalizations.

3. Total number of physicians at primary care level

Description of general characteristics of catchment areas revealed that staffing levels at primary care level show large inequality between urban and rural areas: urban areas are close to the normative of 1500 people per FGP physician while rural areas experience a great shortage of physicians. Looking at FGPs and narrow specialists in FMCs together, the geographic inequality in the distribution of physicians shows a similarly unequal pattern. (Figure 1).

Figure 1. Number of population per FGP and primary care physician (FGP + narrow specialists) (persons)



To highlight some extreme situation, we found that in some remote areas of the country, the number of population per FGP physician comes to 7,000-12,000. Such large number of population and reporting requirements make it difficult for FGP physicians to ensure quality of provided care.

4. Findings on the performance of FMC and ADD narrow specialists

- Currently, the list of narrow specialists at rayon level includes 36 profiles in FMCs and 14 profiles in ADDs. The corresponding figures for oblast levels are 15 and 26 profiles.
- There is duplication of specialities, combination and overlap of positions

Manas Health Policy Analysis Project ♦ 1 Togolok Moldo Street , 720405 Bishkek, Kyrgyz Republic
Phone: 996 (312) 660-438 ♦ Fax: 996 (312) 663-649 ♦Email: moh@manas.elcat.kg

between FMCs and ADDs. Duplication is often observed for such specialities as surgeon, cardiologist, otolaryngologist, ophthalmologist, neuropathologist, endocrinologist and physicians of laboratory – diagnostic services. These positions are often held by the same physical person due to lack of specialists.

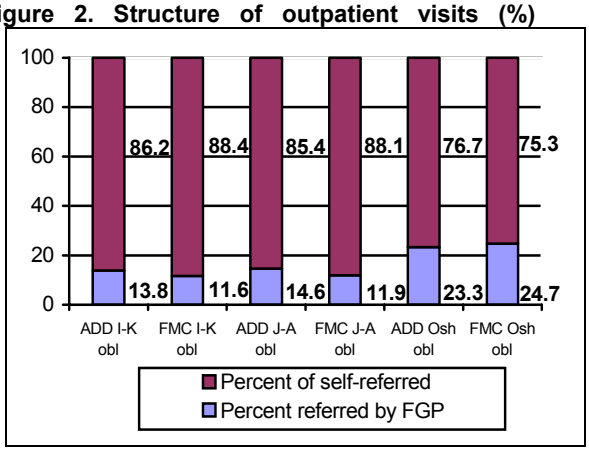
- On the whole, narrow specialists in FMCs and ADDs at rayon level have low actual workload. The normative for therapeutic and surgical profile specialists is 4 and 6 patients per hour respectively. However, actual workload averaged to 1 to 3 patients per hour (often for otolaryngologist, ophthalmologist, traumatologist, surgeon, neuropathologist, etc.) and in some cases less than 1 patient per hour (for juvenile physician, oncologist, infection disease doctor, etc) (Table 1).

Table 1. Workload of narrow specialists at rayon level (per day and per hour)

Narrow specialists	Workload per occupied post per day, per hour					
	ADD		FMC+Prev.ex.		FMC-Prev.ex.	
	per day	per hour	per day	per hour	per day	per hour
Dermatologist-venereologist	.-	.-	50.4	6.3	10.1	1.3
Infection disease doctor	2.3	0.3	32.7	4.1	14.5	1.8
Cardiologist	4.8	0.6	7.2	0.9	3.6	0.5
Narcologist	.-	.-	22.3	2.8	6.4	0.8
Neuropathologist	10.8	1.4	32.5	4.1	10.6	1.3
Oculist	5.8	0.7	42.0	5.2	9.3	1.2
Oncologist	.-	.-	30.8	3.8	3.3	0.4
Otolaryngologist	6.5	0.8	33.3	4.2	6.9	0.9
Pediatrician	6.5	0.8	.-	.-	.-	.-
Psychiatrist	.-	.-	19.3	2.4	4.1	0.5
Therapist	12.2	1.5	.-	.-	.-	.-
Traumatologist	5.3	0.7	32.2	4.0	6.3	0.8
Urologist	7.6	0.9	9.6	1.2	7.5	0.9
Surgion	5.4	0.7	26.2	3.3	3.5	0.4
Endocrinologist	7.4	0.9	28.8	3.6	3.9	0.5
Ultra-sound physician	16.0	2.0	.-	.-		
Functional physician (ECG)	28.8	3.6	9.3	1.2		
Laboratory physician	145.5	18.2	164.5	20.6		
Roentgenologist	15.9	2.0	85.9	10.7		
Physiotherapist	.-	.-	5.9	0.7		
Endoscopist	.-	.-	0.4	0.0		

- Workload of FMC at rayon level is higher as compared to ADD but this happens because of preventive examinations. The most widespread pathologies found through preventive examinations are endemic goiter, iron-deficient anemia and caries. Detection rate of other conditions under preventive examinations is low (under 2.8% of total number of examined). Major organizational difficulties arise in conducting medical examination of conscripts (soldiers).
- ADDs are equipped with medical equipment significantly better than FMCs. Lack of medical instruments in FMCs as well as inability to undertake biochemical and serological examinations are the main cause of redirection of patients flow from FMC to ADD.
- In most areas, the referral system is not observed. In all FMCs and ADDs, most specialist consultations takes place without referrals. (Figure 2). Non-observance of referral system results in high percentage of non-profile consultations, provision of primary care at secondary level and violation of continuity between ADD, FMC and FGP.

Figure 2. Structure of outpatient visits (%)



- Study of work of FMC and ADD at rayon level revealed cases of irrational organization of work and irrational use of occupied premises. Individual ADD managers do not have a clear idea about their functional responsibilities.
- In cases when specialists combine their job in FMC, ADD and TH they get incentives in increasing the number of hospitalizations. Not all admission departments in TH register patients by type of referral (from FGP, FMC or ADD).
- Study of performance of FMC at oblast level and ADD in oblast merged hospitals showed that ADD specialists have higher workload than FMC specialists. Structure of outpatient visits in oblast ADDs also shows the prevalence of self-referred patients, primarily rural population (i.e., population from oblast), whereas in oblast FMCs it shows prevalence of urban population with referrals from FGPs.
- Lack of unified registration-reporting documentation in ADD is a problem. Some facilities fill out CIFs, others fill out registration journals where entered information is different. FMC and ADD do not observe single registration system of outpatient visits and calculation of workload of laboratory service is done of different methods, etc. These factors make it difficult to undertake comparative analysis and control of FMC and ADD performance.

5. Recommendations

The following recommendations on rationalization of FMC and ADD performance were developed based on study results.

On organization of FMC work

- There should be only one FMC per rayon; and it is possible to establish affiliates in other settlements to ensure accessibility to medical care;
- FMC should be well equipped with laboratory-diagnostic equipment necessary for provision of primary health care;
- Total number of primary care physicians (FGP physicians + narrow specialists) should be brought into line with fixed normatives (1 physician per 1500 mixed population) and the problem of geographic inequality should be addressed by attracting a large number of physicians to rural regions;
- Salary of FGP physicians should be increased and an incentive system should be developed; source for salary increase can be savings resulted from staff reduction; Ministry of Finance and its oblast departments should guarantee preservation of savings within health system budget;
- Complete elimination of narrow specialists in FMCs should be done on phased basis. As the first phase, it is recommended to reduce the existing list of 36 narrow specialists down to 7: otolaryngologist, oculist, neuropathologist, psychonarcologist, dermatologist-venereologist, TB specialist, and surgical profile physician (surgeon, traumatologist, urologist, oncologist);
- All narrow specialists should be retrained into family doctors. At the transitional phase besides provision of family medicine care they will have to perform training-methodic function to FGP physicians on the profile of their former specialization. This function should be remunerated additionally.

On preventive examinations

- Consider transfer of function of preventive and medical examinations (schools, etc.) to FGP physicians;
- Preventive examinations of working collectives should be done by FMC and/or ADD specialists based on choice of the organization/facility itself and on contractual basis;
- Ministry of Health together with Ministry of Defense is recommended to revise the procedure of medical examination of conscripts (soldiers).

On organization of ADD work

- All structural subdivisions of ADD (laboratory, medical equipment, admission unit, consultants rooms) should be concentrated in one building to ensure convenience for patients;
- Considering existing low workload of ADD consultants at rayon level it is inexpedient to provide rooms for each specialist. Consultants may use 1 – 2 examination rooms and be invited to ADD as patients arrive;
- Situation when one and the same physical person combines work in ADD and FMC should be discontinued;
- With a view of ensuring high qualification consultations ADDs should involve physicians whose primary employment is in hospital (TH. OMH, etc.); ADDs should not have independent staff of narrow specialists;
- Combination of admission department with ambulance (if within the TH structure) should be excluded since such combination as a rule facilitates increase in emergency hospitalizations;
- Patients should be admitted only with referral from FGP and/or FMC, which will ensure provisions of consultations by profile.

On ensuring continuity and succession of medical services

- To ensure observance of referral system, it is required to consider introduction of economic incentives.

On management of registration-reporting documentation in FMC and ADD

- To ensure correct collection of statistical data and further monitoring of FMC and ADD performance it is recommended to revise existing reporting forms and take for basis matrixes (tables) developed and approved during the implementation of current study.

To receive detailed information and complete report on the study please contact the HPAP team:

Murzalieva Gulgun
gulgun@manas.elcat.kg
Kojokeev Kanat
kanat@manas.elcat.kg