



PRIMARY CARE QUALITY MANAGEMENT IN

UZBEKISTAN

Primary care in the WHO European Region

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ABSTRACT

This report on Uzbekistan summarizes the main results of the WHO Primary Care Quality Management Tool (PCQM Tool), which was implemented on a pilot basis in Uzbekistan in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Uzbekistan, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherland Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and the Institute of Health and Centre for Evidence-based Medicine of the Tashkent Institute of Postgraduate Studies.

The PCQM Tool focuses on structures and mechanisms intended to control or manage the quality of staff and services in primary care. It examines the existing institutionalized mechanisms and practices in order to find out how Uzbekistan is making use of the available know-how and resources to improve the quality of (primary care) services. The Tool is not about quality of care itself, and therefore quality indicators do not play a prominent role.

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ABBREVIATIONS

| | |
|-------|--|
| CME | continuing medical education |
| GP | general practitioner |
| NGO | nongovernmental organization |
| NIVEL | Netherlands Institute for Health Services Research |
| PCQM | primary care quality management |
| SVP | sel'skii vrachebny punkt (rural primary care unit) |
| WHO | World Health Organization |

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FOREWORD

Primary health care embodies the values and principles that WHO abides by in its world-wide effort to strengthen health systems in an equitable and efficient manner. The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in the recent *World health report 2008*, which urges countries to act on evidence that access to primary care services forms the core of an efficient and appropriate health care system. The title of the report underscores the urgency of its message: *Primary health care – Now more than ever*.

Over the past 30 years, the overall health situation in the 53 Member States of WHO in the European Region has improved considerably despite significant changes in the patterns of and trends in disease occurrence, demographic profiles, and exposure to major risks and hazards in a rapidly evolving socioeconomic environment. There have also been trends towards more integrated models of care and greater pluralism in the financing and organization of health systems. Governments are continuing to rethink their roles and responsibilities in relation to population health and the organization and delivery of health care, thereby changing the context for framing and implementing health policy.

This report on primary care quality management describes the Uzbek governments' efforts to improve service delivery at the first level of care, supplemented with evidence compiled through the development and application of tools tailored to primary care. What does quality care mean at this level and what are the strategies, mechanisms and tools to ensure that it can be maintained, assessed and improved? The report also shows that the involvement not only of national policy-makers but also, and first and foremost, of the stakeholders on the ground who actually provide and organize primary care can result in improvements in quality by an incremental process of creating and adopting a culture of quality control and assurance. This process goes beyond having guidelines, regulations and strategies in place; it entails adopting a transparent approach which acknowledges that only empowered and motivated health care staff working in teams can bring about real improvements, and that all health care workers (family doctors, nurses, midwives and others) are equally important in the drive to attain better health for the population. The centrality of the patient, and of his or her needs and inputs into this process of improving the quality of primary care, should also be emphasized.

We thank the many collaborators who have generously contributed to this novel project with their ideas and insights. We also would like to gratefully acknowledge the financial assistance of the Netherlands Ministry of Health, Welfare and Sport in the framework of the Partnership Programme between the WHO Regional Office and the Netherlands.

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EXECUTIVE SUMMARY

This report on Uzbekistan summarizes the main results of the WHO Primary Care Quality Management Tool, which was implemented on a pilot basis in Uzbekistan in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Uzbekistan, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherland Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and the Institute of Health and Centre for Evidence-based Medicine of the Tashkent Institute of Postgraduate Studies, Uzbekistan.

Introduction

The Primary Care Quality Management Tool focuses on structures and mechanisms intended to control or manage the quality of staff and services in primary care. It examines the existing institutionalized mechanisms and practices in order to find out how Uzbekistan is making use of the available know-how and resources to improve the quality of primary care services. The Tool is not about quality of care itself, and therefore quality indicators do not play a prominent role.

Methods

The Tool consists of three parts: a questionnaire for national-level policy experts, a questionnaire for managers of primary care facilities and a questionnaire for general practitioners (GPs).

The Tool was pilot tested in 2007 in three regions of Uzbekistan: In Fergana, Syrdarya and Tashkent regions, excluding Tashkent city. Questionnaires were completed by national experts from different stakeholder organizations in the health system, and by managers and GPs from the three regions. The results rely strongly on self-reported behaviour rather than on direct observations or registrations.

Results

- *At National level, based on interviews with national experts*
With donor support, quality improvement in primary care is an explicit national priority in Uzbekistan. Many laws, decrees and orders deal with the improvement of (primary) health care services. Reforms also aim to improve health care management. The Centre for Evidence-based Medicine is in charge of the development and implementation of the programme for clinical guidelines in primary care. The Ministry of Health has the final responsibility for the quality of primary care facilities. However, within the Ministry, this responsibility seems to be fragmented between several departments. Despite the dominance of the Ministry, experts reported that there is still some space for regional or local initiatives. However, the position of nongovernmental organizations seems to be weak. The delivery of patient-centred care is not a priority of the current primary care policy. At present, only complaint procedures, patients' informed consent and access to their own medical files are dealt with in the law on patients' rights.
- *At managerial level, based on experiences and opinions of primary care managers*
The level of availability of quality-related documents (e.g. mission statements or budget specification) is clearly better in Fergana than in Syrdarya or Tashkent. In-

ternal assessment instruments are fairly applied. In all three provinces, between 50% and 75% of the managers reported the application of evaluation reports, internal medical audits, GP peer reviews and the existence of quality improvement committees. Patients' needs are infrequently monitored in all three provinces.

In Tashkent, managers generally found that internal resources (e.g. management information, effective support or financial incentives) for quality improvement are not sufficiently available. In Syrdarya, about 60% of the managers judged the situation of the different internal resources for quality improvement to be "fair"; but only few reported them as "insufficient". In Fergana, which has the best reported situation (and most of the donor support), the situation relating to effective incentives for quality improvement was reported to be "good". Overall, there is a need for more (internal and external) support for quality improvement activities. Managers thought that the current attitude of health care staff towards innovation is an obstacle to quality improvement. The majority of managers agreed that there is a clear need to introduce modern management skills and methods to improve performance in primary care.

- *At GP level, based on experiences and opinions of GPs*
GPs were confident that treatment of patients is in line with the latest evidence (while managers were more reserved on this point). Overall, there is a high involvement of GPs in formal and informal quality improvement activities, with little difference between the three provinces, although, on most items, Tashkent scored slightly lower than Syrdarya and Fergana. In Fergana and Syrdarya, almost all GPs said that they used clinical guidelines, while in Tashkent some improvement seemed possible. GPs agreed with their managers about the positive contributions of continuing medical education courses to the quality of care. GPs were more strongly convinced (than their managers) that they spend sufficient time to keep up to date. GPs in general seem inclined to improve many aspects of their clinical care, such as diagnostics and drug prescriptions. Most GPs seem to experience their supervisors' management as a punitive element rather than a stimulating or motivating one.

Recommended policy action

- Further develop and implement a model for comprehensive primary care services especially in cities. Recent reforms have tended to focus on rural areas and the "rural model".
- Reduce the monopoly of the government in the health sector by recognizing the roles of nongovernmental organizations and patient organizations in laws and enhancing their role in health policy development.
- Support the role of managers at the primary care level by training them in modern management techniques, implementing management information systems and providing them with necessary resources.
- Improve clinical information and medical record-keeping among GPs by systematically introducing computers in primary care facilities.

- Continue with the coordinated development, updating and dissemination of clinical guidelines for GPs and introduce systematic evaluation of their use.
- Actively involve patients in the provision of primary care services by systematic monitoring patients' needs and satisfaction.
- Modernize continuing medical education by introducing modern teaching methods and relating the supply of courses to the educational needs of the users.
- Develop human resources management in primary care, including through regular job evaluation interviews and personal development plans.

I QUALITY MANAGEMENT: AN INTRODUCTION

Quality management and primary care

Patients should receive the care they need, that is known to be effective, in a way that does not harm them and does not waste resources. Basic requirements such as effectiveness, appropriateness and safety are of direct relevance to the maintenance of the quality of care from the health care system perspective.

Health care systems should have in-built incentives and mechanisms that allow continuous monitoring (and improvement) of the quality of services. The trend towards improved quality of care at primary care level that can be seen equally in western Europe and the countries in transition results from the general need for more cost-effective health systems. Strong primary care enhances the cost-effectiveness of the system as a whole. Strong primary care means: easy access to first contact services, a comprehensive supply of effective and safe curative and preventive services, continuity of care, coordination with other levels of care and interdisciplinary cooperation. In the absence of review procedures based on explicit and measurable criteria, it is difficult to assess the extent to which primary care systems currently meet these high expectations.

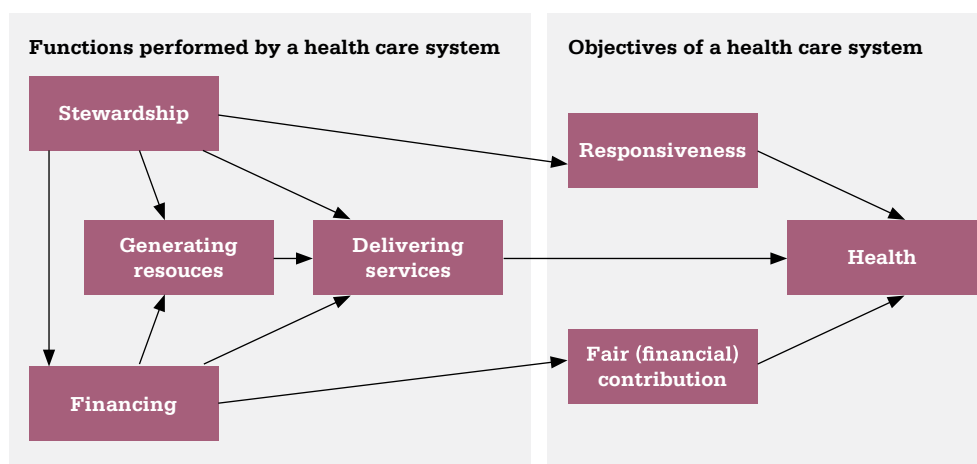
In most countries, assessment of the quality of primary care is much less advanced than that of hospital services. Studies that have been carried out point to large variations in quality of primary care and insufficient maintenance of good care standards (1, 2). Compared to hospitals, there have, to date, been fewer requirements on primary care to demonstrate quality. Primary care is often provided in a fragmented way, and in much smaller units of provision than is the case with hospitals. In addition, hospitals usually have dedicated quality assurance staff and much better information systems, which are essential to generate the performance data needed for quality reviews and to initiate improvement actions.

Quality management and the health system framework

With an increased focus on strengthening (primary) health care systems, addressing structures for maintaining and improving the quality of services will become a key component in health care reforms, since increased resources and know-how do not automatically translate into a higher quality of care. For instance, countries with high levels of health expenditure do not always perform better than countries that have fewer resources available. Making health systems more “quality aware” requires the development of a strategy, an analysis of the current situation, and innovation (that is, the implementation of desired change) (3).

In the WHO health systems framework, performance assessment and consumer protection (both essential elements of quality) are part of one of the health care functions, namely the stewardship function (4). Figure 1 below shows all health system functions and how they relate to health care objectives.

Figure 1: Functions and objectives in the WHO health system framework



The overall objective of a health system is to optimize the health status of an entire population throughout the life cycle. This objective is achieved by means of the functions explained below.

- *Stewardship* is about defining strategic directions in a health care system and setting and maintaining rules (for instance, related to the roles of purchasers, providers and patients). It deals with governance, use of information for feedback and monitoring, coordination, and regulation at various levels. Policy development concerning human/physical resource planning, a regulatory framework for assuring high quality service provision, and consumer protection are part of the stewardship function of the primary care system.
- *Financing* in general, deals with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually or collectively (5). The financing function in health systems is defined by Murray and Frenk (4) as “the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities”. Three subfunctions can be distinguished: revenue collection, fund pooling and purchasing.
- *Generating resources*: providing a balanced variety of resources for health care to function properly. The resources required encompass physical assets (equipment, facilities), consumable supplies, human resources and knowledge/information. Naturally, to ensure quality of care, the skills and knowledge of health providers need to be up-to-date and compatible with developments in technology and evidence-based medicine.
- *Delivering services* involves the mix of inputs needed for the production process within a specific organizational setting leading to the delivery of health interventions (4). It relates to preventive and curative services delivered to individual patients and larger populations (e.g. health education, promotion). Subfunctions of service delivery include the following.



- » *Accessibility*: the patients' ability to receive care where and when it is needed; there may be physical, psychological or financial barriers to access.
- » *Continuity of care*: interventions are tuned to patients' needs over a longer period and cover successive episodes of care/treatment; possible dimensions are informational continuity (referring to the patient's medical history), longitudinal continuity (when more health care workers are involved) and interpersonal continuity (receiving care in an ongoing trustful personal relationship).
- » *Coordination*: a service characteristic resulting in coherent treatment plans for individual patients and an important element in the responsiveness of health services. Coordination is essential at the interface between primary and secondary care, or between curative care and other services.
- » *Comprehensiveness*: the extent to which a full range of services is either directly provided by a primary care physician or specifically arranged elsewhere. In primary care it refers to the fact that services comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention.

Although the quality of health care services is related to all health care functions, the *mechanisms and rules* aimed at maintaining and improving the quality of services are primarily part of the stewardship function (which is exerted at different levels throughout the health care system). Indeed, resource generation (in particular the provision of essential equipment, training and continuing education) and financing (for instance, performance-related payment and other incentives for quality) are important in bringing about good performance.

The PCQM Tool focuses on the “infrastructure” for quality (regulations; mandatory and voluntary mechanisms, procedures and routines; use of information; governance and leadership for quality; availability of support and advisory structures for policy and practice in the field of quality at different levels, etc.), which is primarily related to the stewardship function.

The way in which the stewardship function is implemented and where responsibilities are located in the system may differ according to the type of health care system in a country. This is also true for the position of primary care within a system. In some countries, general practice has a dominant position in the provision of primary care services while, in others, medical specialties provide such services as well. The way primary care is organized determines strongly how quality improvement strategies can be developed and maintained.

The degree of centralization or decentralization is another relevant health system feature in this context. National health systems are usually characterized by a strong role for central and, to a lesser extent, regional health authorities in the financing and provision of services. In the countries of the former Soviet Union, the role of the state continues to be dominant and may have the character of a monopoly, with little or no independent influence of other stakeholders. In contrast, in social health insurance systems, power in health care is usually shared among authorities, health insurers and organizations of providers (usually physicians). To varying degrees, there may be a role for patients' and consumers' organizations. In countries where power in health care is shared, assessment and improvement of quality of care may be more divided among stakeholder organizations. Delegation or self-regulation is usually very weak or absent

in hierarchical state-run health care systems. In strongly centralized systems with a command-and-control style of management in health care, quality assessment and improvement will primarily be top-down, with different incentives for improvement of performance from those in decentralized systems (6).

Different approaches to quality management mechanisms

Mechanisms for quality management can focus on either the structure of care, the process of care or the outcomes of it. This is the well-known framework developed by Donabedian (7). “Structure” refers to physical characteristics (such as premises, equipment, human resources, the organization and management of resources, teamwork). “Process” refers to the actual delivery of primary care (in particular the clinical and interpersonal aspects). “Outcomes” are the results or consequences of the process of care (health status or evaluations by patients). The following examples of quality (management) mechanisms are classified on the basis of this framework.

Related to structure are: safety regulations; activities of a state inspectorate; a system of disciplinary rules for professionals; (re)certification and accreditation schemes; regulations for the establishment of practitioners; human resource training policies in health care organizations; the use of a quality handbook (specifying procedures, safety, privacy, etc., in health care organizations); promotion of (electronic) medical record systems; use of official job descriptions for health professionals; and promotion of teamwork among health professionals.

Process-related activities are: supporting evidence-based medicine; structured peer review among health professionals; implementing clinical guidelines; benchmarking; practice audits; projects aiming at more rational referring and prescribing; promotion of patient information materials; practice visitation; patient complaint procedures; and local (facility-based) quality improvement projects.

Examples of outcome-related initiatives are: patients’ evaluation surveys and structured client consultations.

Producing an instrument to assess the state of quality control and quality management in primary care is complex. Both central and decentralized policies are involved; a potentially wide range of mechanisms and activities, as shown by the above-mentioned examples, at different levels and of different scales need to be taken into account. Furthermore, different actors/stakeholder with different views on quality improvement may be involved (compare: 8).

Focus of this project: institutionalising quality management mechanisms

The focus of the PCQM Tool is on institutionalized mechanisms and routines in (primary) health care systems that aim to ensure that the latest insights and evidence are applied in order to deliver optimum health care services to patients. Know-how and resources will not automatically translate into high quality services; this needs to be organized. The PCQM Tool aims to assess how this has been done.

Hence, the Tool looks mostly at aspects of structure and process – as outlined in the section above – and much less at outcomes, the quality per se. It is important to keep this in mind when implementing the Tool and using the results produced.

Furthermore, in designing the Tool, a number of practical dimensions had to be taken into consideration, since effective institutionalized quality management mechanisms require the activation of a range of different functions, a number of which are listed below.

The *facilitation* and advisory function: an expert structure should be available to facilitate work and advise the Ministry of Health and other health authorities on progress and obstacles regarding the implementation of a quality improvement strategy, and to highlight new insights and trends.

The *advocacy* function: all stakeholders involved in health care quality management need to be sensitized and convinced of the importance and impact of a quality improvement strategy. The advocacy function also includes identifying incentives and disincentives for quality activities and the promotion of motivation.

The *implementation* function: the roles and responsibilities of all stakeholders must be clearly identified to carry out activities such as:

- promotion of evidence-based medicine, including the development and revision of guidelines and protocols and their dissemination/implementation;
- introduction of quality monitoring systems at facility and regional levels, and measurement of national performance indicators;
- facilitation or initiation of facility-based quality improvement projects;
- development of patients' charters (rights and obligations and complaint procedures);
- health technology assessment;
- (further) development of licensing and certification of health professionals;
- (further) development of accreditation of health facilities;
- patient safety programmes and projects.

The *teaching* function relates to training mechanisms (either undergraduate, postgraduate or through continuing medical education (CME)) and the creation of opportunities to build the knowledge and skills needed to carry out quality activities as listed above.

Monitoring and evaluation should be planned with a focus on the implementation processes and results of the quality improvement strategy. Plans should describe successes and failures, analyse their causes, promote reflection among stakeholders and make recommendations.

Research (carried out in research departments and universities) has an important role to play in assessing the effectiveness of quality management policy measures.

Communication between all stakeholders involved in a quality management strategy is essential for its success. Both the content and the channels of communication must be identified.

Stewardship (or leadership, or governance) is the overarching function for the development and promotion of quality management mechanisms. Effective stewardship unfolds a vision and plan in which all the contributing functions mentioned above are coherently described. Stewardship also establishes the rules, sanctions and incentives and enables local leadership, conditions and a climate in which initiatives can develop and individuals are motivated to produce a good performance. Stewardship should aim for the implementation of these functions in an integrated way and on a continuous basis. If that has been achieved, quality improvement can be assumed to be institutionalized into a health system (9).

2 QUALITY MANAGEMENT IN UZBEKISTAN: SOME RESULTS FROM A PILOT PROJECT

2.1. Overview on the implementation of the project in Uzbekistan

The activities of the pilot project began in February 2007 and were completed in March 2008. Project partners of the WHO Regional Office for Europe – besides the Ministry of Health of Uzbekistan – were the Netherlands Institute for Health Services Research (NIVEL) in its capacity as WHO Collaborating Centre for Primary Health Care, and a local partner, the Institute of Health and Centre for Evidence-based Medicine of the Tashkent Institute of Postgraduate Studies, Uzbekistan.

The results and conclusions were discussed at a review meeting with international experts at the WHO Regional Office for Europe in Copenhagen on 14 and 15 April 2008. Experiences in using the Tool during the pilot studies, and comments and recommendations made at the review meeting resulted in a revision of the three questionnaires. A second pilot study was conducted in Slovenia – the results are described in a separate country report. The following two sections give a short overview of the implementation process.

2.1.1. Preparatory phase

Literature review

The first step in developing the Tool was a directed literature review by the researchers at NIVEL. The aim of the literature study was to provide a framework for quality management improvement in (primary) health care that took account of the roles of policy-makers and other possible stakeholders, managers at central and decentralized levels, and providers of health care services. This made it possible to structure the diverse aspects of quality management improvement. The literature study also aimed to identify specific reports from evaluation studies of quality systems in health care. There is a longer tradition of comprehensive quality systems in the hospital sector than in primary care, where only some elements of such systems are being introduced (for instance, peer review, clinical guidelines, benchmarking, patient evaluation studies). The literature review, combined with expertise available at NIVEL, resulted in the identification of relevant fields and topics, ranging from legislation and central regulation to routines in daily practice to maintain and promote quality of care. Topics selected in this way were ordered according to their relevance for the three levels where data collection would take place: at the national level, among managers of primary care, and at the level of providers (in particular, GPs). Since the structures examined by the Tool are usually not visible to patients, it was decided not to add a patient survey as part of the Tool.

Preparatory meeting

An international preparatory meeting was held on 28 and 29 June 2007. The main aims of the meeting were:

- to discuss the first draft of the Tool, consisting of questionnaires for all three levels; the experts present were particularly invited to consider the relevance of the questions to their own health care system, the clarity of the questions and the terms used;
- to exchange information on quality improvement and quality management in primary health care in the WHO Member States represented at the meeting in order to become familiar with the current situation and trends;
- to make first preparations for the pilot implementation of the questionnaires; the general requirements, possible approaches and preliminary timing of activities were discussed and two countries were selected for the pilot studies to take place: Slovenia and Uzbekistan.

Redrafting, validation and translation of questionnaires

On the basis of the information and feedback from the preparatory meeting, the draft versions of the questionnaires were revised. The revised versions were then forwarded to the meeting participants for comment and possible suggestions for change (clarity, omissions, terminology). This revision round also offered for the experts the possibility of involving and consulting with other experts in their country and thus broadening the basis for validation. When all inputs for revision were processed, the final versions in English of the three questionnaires were established. As the questionnaires were tailored to the national situations, the versions developed for Slovenia and Uzbekistan were slightly different. Subsequently, these final versions were translated in the respective countries in a check and double-check procedure. The translations were first made into the local language with inputs from an expert in primary care. Subsequently a back-translation was made and compared with the original version. In Uzbekistan, two translations were necessary: into Russian and into Uzbek.

2.1.2. Implementation phase and field work

Meetings in Uzbekistan

The international project team met twice in Uzbekistan to prepare the implementation of the Tool and to organize the collection of data. The following activities were carried out during these meetings:

- discussion of final details of the questionnaires, resulting in (minor) changes;
- information to and exchange with national working groups that had been established for the guidance of the project and dissemination of results;
- information to central and regional health authorities and managers about the pilot study and the planned activities;
- site visits in the selected regions;
- instruction of those involved in the data collection (for instance, in respect of the confidential nature of the surveys);

- discussion of details of the sampling and recruitment procedure with the national coordinator and others;
- discussion of details of the data collection strategy and logistics;
- preparation for data entry and related instruction;
- leading the meeting with the national experts who filled in the national level questionnaire, in order to achieve consensus on “factual” questions (the “consensus meeting”).

Sampling, data collection and processing

The Uzbek partners suggested including three provinces in the project: Fergana, Syrdarya and Tashkent (excluding the capital). These provinces were selected because they were at different stages of the health care reform. Fergana, a modern, densely populated region, is the most advanced in terms of health sector reforms; there have been many donor-funded activities in health care. In Tashkent, which is a large region surrounding the capital, health reforms are at an initial stage, with support from, among others, the World Bank. Syrdarya is the smallest and least developed of the three regions; health reform activities have so far been at a modest level.

In Uzbekistan, the deputy head doctors in the districts are responsible for the primary care services, and so they were included as the managers in this project. GPs included both those who had completed GP training (either in a postgraduate programme or in a retraining course) and those who had not (yet). All GPs are state employed. In the three provinces, random samples were drawn from alphabetical lists of GPs. In Fergana, a 20% sample was taken (every fifth name from the list); in Syrdarya and Tashkent, 50% samples were taken (every other name from each list). In case of illness or unavailability, the next name from the list was included. All the managers were included. The selected GPs received a questionnaire and a NIVEL envelope from their manager. In the instructions for the managers on how to introduce and collect the questionnaires, freedom to participate or not and confidentiality were stressed. Questionnaires also contained written instructions for the GPs. After the questionnaires had been filled in and put in the envelope, these were sealed and collected in again by the managers who took them to the weekly meeting of managers in each of the provinces. From there, the questionnaires were forwarded to the Institute of Health in Tashkent, where the data was entered.

The consensus meeting with national experts from various health system stakeholder organizations such as the Ministry, health professional organizations, private purchasers, the consumer protection organization and researchers from the Institute of Health took place in October 2007, facilitated by WHO and NIVEL staff. Comments and other additions made by the experts in their questionnaires were translated by the local coordinator into English and later forwarded electronically to WHO. The response to the surveys was excellent, close to 100%. Data entry was done by the local partner, using a data entry programme that had been provided and explained to them. The data files were then transmitted to NIVEL for further processing. Details of the study population, data collection and response for Uzbekistan are summarized in table 1 below.

Table 1: Overview of the implementation process in Uzbekistan

| Features of data collection | Explanation |
|---------------------------------------|--|
| Target groups | <ul style="list-style-type: none"> • GPs • Deputy head doctors in districts (managers) • National experts |
| Locations | <ul style="list-style-type: none"> • Province of Fergana • Province of Syrdarya • Province of Tashkent (excluding Tashkent City) |
| Type of data collection | <ul style="list-style-type: none"> • GPs: surveys using prestructured questionnaires • Managers: surveys using prestructured questionnaires • National experts: prestructured questionnaires and discussion during consensus meeting |
| Period of data collection | 26 November – 3 December 2007 |
| Sampling method | <ul style="list-style-type: none"> • GPs: random procedure • Managers: population (all) • National experts: selected by local partner |
| Sample size / included | <ul style="list-style-type: none"> • GPs: Fergana: 117 (20% of population) Syrdarya: 97 (50% of population) Tashkent: 103 (50% of population) • Managers: Fergana: 16 (= all) Syrdarya: 9 (= all) Tashkent: 15 (= all) • National experts: 11 |
| Response | <ul style="list-style-type: none"> • GPs: Fergana: 106 (91%) Syrdarya: 97 (100%) Tashkent: 103 (100%) • Managers: Fergana: 16 (100%) Syrdarya: 9 (100%) Tashkent: 15 (100%) • National experts: 11 (100%) |
| Instructions | <ul style="list-style-type: none"> • Local partner and provincial health authorities were instructed on details of sampling procedure and recruitment. • Health authorities in the three provinces were informed about the project by the Ministry of Health, the local partner and WHO. • All managers in the three provinces were instructed on the background to the study, requirements for its implementation and the procedure for distribution and collection. • Questionnaires contained instructions on completion. • Local partner was provided with data entry programme and instructions for use. |
| Coordination and support of fieldwork | <ul style="list-style-type: none"> • Managers coordinated the confidential data collection in their district. • Local partner coordinated overall data collection, supported by the international team members. |
| Data entry | By local partner in Uzbekistan, according to agreed guidelines and using the data entry programme provided. |
| Data analysis and reporting | At NIVEL |
| Local partners | Ministry of Health of Uzbekistan Institute of Health and Centre for Evidence-based Medicine of the Tashkent Institute of Postgraduate Studies, Uzbekistan. |

2.2 Uzbek national experts and quality management in primary care: results of the survey

The information presented in sections 2.2.1, 2.2.2 and 2.2.3 is taken from Ahmedov et al (10), from a presentation made by Dr B.Yusupaliev at the international consultation meeting in Utrecht on 28 June 2007, and from local experts during two visits to Uzbekistan. The other sections are based on information provided by 11 national experts from different stakeholder organizations such as the Ministry of Health, professional associations, consumer protection groups and private health insurers in response to a structured questionnaire discussed at the consensus meeting in Tashkent on 5 October 2007.

2.2.1. Primary health care reforms

The 1996 law on health protection was a major first step in the Uzbekistan's health sector reform, since it contains a vision for the future health care system and recognizes a number of principles, such as the universal right to health care, access to services for the whole population, and prevention as a priority for the health sector. Furthermore, it safeguards the confidentiality of patient information and the protection of patients in case of harm resulting from medical intervention. On the supply side of health care, the law defines who may be involved in clinical practice and the responsibilities of physicians.

Two years later, in 1998, a master plan for the period 1998 – 2005 was launched by the Presidential Decree on the State Programme for the Reform of the Health Care System. Important targets included the development of a network of rural and urban medical centres and centres for emergency care, improvements in the health workforce and medical education, including the upgrading of nursing education, and the introduction of privatization in the health sector. The Decree also pointed to the need for a new health financing scheme. Subsequently, in collaboration with the World Bank, the Health I project was developed, with the aim of restructuring primary care. In the context of this project, which ran from 1998 to 2005, new schemes for the financing, delivery and management of primary care were piloted, and facilities such as rural primary care units, known as SVPs, were upgraded. The project also facilitated the establishment of the Institute of Health at the national and regional levels. Training centres for general practice, in which internal medicine specialists, paediatricians and other specialists were trained, were established and teachers trained. General practice became part of the undergraduate programme and CME was restructured. Medical education became subject to accreditation and a licensing scheme was introduced for professionals. Concerning financing, payment in primary care became based on capitation. New (financial) managers in the primary care system could work in a more flexible way and make use of better information systems.

The subsequent World Bank project, Health II, and the "Woman and Child Health Development Project" funded by the Asian Development Bank further strengthened primary care. Pilot schemes were implemented throughout the country and new approaches to maternal and child health, public health, and monitoring and evaluation have been introduced. The educational support infrastructure has been improved by two new

centres, the Centre for Evidence-Based Medicine and the Centre for Continuing Medical Education.

So far, the GP retraining programme, which includes a 10-month retraining course, has produced 2335 newly trained GPs, while 620 are currently being retrained (as of February 2008). With contributions from the United States Agency for International Development (USAID)-funded ZdravPlus project, the GP retraining programme is focusing on continuous quality improvement, for instance by self-monitoring, promoting teamwork and the use of clinical guidelines.

In addition to GPs, 34 professors have been trained in family medicine, as have 14 GP teachers. The medical and other equipment in 2300 SVPs and 29 urban outpatient clinics has been upgraded in accordance with new standards. GP training centres have been established in each of the 14 provinces in the country. These centres serve as educational support facilities for both GPs and nurses.

An important reform aim is to improve health care management. Since training in medical schools does not automatically prepare doctors for running a practice, with the help of ZdravPlus, management skills have now been included in the medical curriculum. In SVPs, new managers (not necessarily physicians) have been introduced with responsibility for the new and more independent financial management (including new payment systems). A new course on health management has been launched in the medical schools.

The latest development is the Presidential Decree issued on 19 September 2007, specifying current challenges and priorities. Continued attention needs to be paid to a number of issues, such as: the effectiveness of prevention, health care management, poorly organized diagnostic services, the monitoring of pregnant women, modern medical training and teaching and a more important role for scientific evidence. As answers to these challenges, the decree promotes the creation of high-level national expert centres, improved retraining for GPs and further facilitation of private practice. The quality of care in SVPs and family polyclinics should be improved by the creation of coordination and support structures at district level.

2.2.2. The delivery of primary care

The transition of the organization and provision of primary care is almost completed; nationwide, more than 3100 SVPs have been established to replace rural out-patient clinics and paramedic points (*feldsher* points or FAPs). The latter were generally primary care facilities in the most remote areas staffed by paramedics (*feldshers*) and midwives but no medical doctors. FAPs provided basic curative primary care services, health promotion, including vaccination, and ante- and postnatal care. The next levels up were the rural out-patient clinics, usually staffed by one or more general internal medicine specialist, a paediatrician, an obstetrician, a dentist and some nurses. In urban areas, the traditional model of primary care provision was (and still is, in many places) provided in polyclinics for children, for adults or for women, linked to a district hospital.

In the new system, the provision of primary care is mainly the responsibility of general practitioners (GPs). The basic unit for primary care is the rural primary care unit (SVP), of which there are four types, depending on the population served. Type 1, with only one GP, serves a population up to 2500; type 4 serves populations of over 4500 inhabitants. Very remote communities with less than 400 inhabitants are served by a branch of the nearest SVP. For each type of SVP, there are standards for staff, premises and equipment. Newly trained GPs are the core of the SVP team, which also include community nurses, whose main responsibility is to conduct home visits to pregnant women, households with young children and elderly people. Internal medicine specialists, paediatricians and obstetricians have been retrained as GPs. In the urban environment, in the future, primary care will no longer be provided by the polyclinics but by family outpatient clinics, also staffed with GPs. Urban family polyclinics have now been established in four cities, including Tashkent. Family polyclinics are linked to a district hospital.

In January 2006, incentives were built into the payment schemes for physicians. Salaries are now linked to the volume, complexity and quality of care provided.

Patients are free to choose their health care provider, and they can either choose public or private services, although the conditions are different. When obtaining primary care services from public providers, no co-payments are charged for diagnostic or laboratory tests. For prescribed medicines, however, co-payments apply (although some categories of patients such as invalids, single pensioners and veterans are exempted from these payments). In urban areas, in particular, private primary care services are available in addition to the regular public services. However, despite the government's support for private practice, visits to private providers have to be fully paid out of pocket.

Current problems in primary care can be summarized as follows. In parts of the country where the Health II project has not yet been implemented, the conditions and quality of primary care services lag behind the regions that are more advanced in the reforms; however, access to care seems to be good in all regions. Although the improved working conditions in primary care have alleviated staff recruitment problems for SVPs, graduates of the medical academies are still reluctant to work in rural areas. However, at present, no understaffing is reported in SVPs. Furthermore, the current 10-month GP retraining programme needs to be upgraded. The course is not yet sufficiently tailored to the new needs for the provision of primary care. Finally, financial and human resources management in primary care leaves much to be desired. This has been set as a health policy priority. However, the situation has not changed much because of lack of management training capacity.

2.2.3 Legislation and regulation

Regulation in the health sector is the almost exclusive domain of the government, which develops and implements policies, finances the system and controls and manages the provision of services. Some budgetary responsibilities have been delegated from the central to the regional authorities, and health care facilities have acquired some more autonomy and flexibility but within centrally determined frameworks and norms. The Ministry of Health controls the implementation of centrally developed planning guidelines.

The previous sections have shown that quality of care has been a point of concern in the past decade. In monitoring and evaluating the quality of (primary) health care, the government currently uses the following sources of information:

- health outcome data (birth rates, mortality, indicators of morbidity, indicators of efficiency of use of facilities and resources);
- monitoring and evaluation data from the World Bank Health II project, for which a special set of indicators has been developed;
- specific studies carried out with foreign support, for instance, the “Sociological evaluation of the reforms in the health care system of Uzbekistan”; and the “Evaluation of the quality of services provided by SVPs”;
- a working group has recently been established to evaluate the efficiency of the health care system; it has set the goals, objectives and implementation mechanisms and is now developing a matrix of indicators;
- a study on consumer rights protection in Uzbekistan was carried out by the State Committee on Demonopolization and Support of Competition and Entrepreneurship;
- evaluation of complaints submitted by the population to local health facilities is carried out on a continuous basis; local managers deal with complaints in line with centrally established procedure.

The government’s continued concern about quality is also reflected in a recently prepared paper on the “National concept of improving the quality of health care”, which gives the following priorities:

- improving the organizational, management and financial aspects of the health care system;
- enhancing the competence level of health care workers;
- strengthening the motivation of health workers to provide better quality services;
- involving the clients in health service quality management;
- introducing new regulatory mechanisms to improve the quality of health care.

Laws and other regulations since 1996

The national experts were asked whether the government had issued any documents explicitly dealing with the improvement of (primary) health care services. They quoted the following list of laws, ministerial decisions, decrees and orders.

- Cabinet of Ministers Decision on a programme for the development of social infrastructure in the regions for the period to 2000 (1996).

- Law on Health Protection of Citizens (1996, with additions in 1999, 2007).
- Presidential Decree DP-2107 on the Government programme of further reforms of public health services (1998).
- Ministry of Health Order on the creation of a working group to develop standard documents for medical insurance (1998).
- Cabinet of Ministers Decision 256 on Measures towards the effective use of a loan and Japanese grant, provided by the IBRD (World Bank) Health 1 project and work from the Health 2 project (2003).
- Cabinet of Ministers Decision 17 on Measures towards further reform of the financing system and management of public health services (2005).
- Cabinet of Ministers Decision 34 on Measures towards realization of the Health 2 project with the participation of the International Development Association (2005).
- Cabinet of Ministers Decision 276 on Improving the system of payment of medical staff (2005).
- National strategy on quality improvement (currently at coordination stage)(2005).
- Strategy on evidence-based medicine (is at a coordination stage) (2006).
- Presidential Decree DP 700 on Measures to improve the organization of activities of medical establishments (2007).
- Presidential Decree 3923 on the Basic directions for the further development of reforms and realization of a governmental programme of public health service development (2007).

The two following documents were primarily devoted to quality improvement:

- Presidential Decision 731 of 19 November 2007 on a Programme of modernization of technical equipment of pharmaceutical enterprises to 2011;
- Ministry of Health orders on the establishment of diagnostic and treatment standards, 2006-2007.

The above-mentioned documents were communicated to stakeholders and the general public via the mass media (television and newspapers), and by distribution to relevant stakeholders (or provided to them on request).

Role of nongovernmental organizations

It was then discussed whether the documents specified any roles for organizations other than the government. Stakeholder groups were considered, as shown below.

- Organizations of primary care physicians

The experts answered that the role of the professional organizations such as associations of physicians, and other public organizations were defined in the Law on Health Protection of Citizens. Associations of GPs, paediatricians and internal medicine specialists were also mentioned.

- Patient organizations

The experts did not know whether patient organizations were mentioned in any of the policy documents. They noted, however, that the Federation for the Protection of Consumer Rights also deals with patients' rights, and that there is close cooperation with the Ministry of Labour and Social Protection

- Other organizations mentioned in the policy documents included the Centre for Evidence-Based Medicine (which is not a nongovernmental organization, however).

Quality-related topics in policy documents

The experts were asked whether a number of topics related to the quality of (primary) health care were explicitly dealt with in the aforementioned policy papers. According to the experts, only two topics were not mentioned in laws or other policy papers: conducting patient satisfaction studies or patient evaluations, and plans to develop medical auditing.

The experts agreed that all the other topics listed below were included in one or more of the documents. Their comments are noted below.

- *Accessibility of primary health care services*

Documents include detailed plans for the geographical distribution of primary care facilities (such as SVPs) in all regions, in relation to the size of the population. Plans also include the stepwise introduction of GPs in primary care.

- *Cost-effectiveness of primary health care services*

An important argument for changing from the multilevel provision of primary care to a two-level system (with the removal of rural hospitals) was cost-effectiveness.

- *Equality in use, treatment or financing of all social groups (equity)*

Equity was an explicit aim of the reforms; the focus was mainly on improving the quality of care for rural populations. For example, the care and provision of medicines for disadvantaged groups (like veterans and invalids) has been improved, as has the quality of food provided to all patients in hospitals.

- *Specification of patients' rights*

The Law on Health Protection of Citizens specifies basic rights in respect of care; preventive medicine was also mentioned as a priority for all.

- *Specification of uniform clinical indicators of quality*

Quality indicators are dealt with in: the Law on Health Protection of Citizens; the Presidential Decree on the Government programme of further reforms of public

health services; Presidential Decree. 700 (2007); Cabinet of Ministers Decision 276 (2005); and the Order on the establishment of the Centre for Evidence-based Medicine.

- *Specification of health improvement targets*
The documents contain improvement targets, for instance in the area of maternal and child health.
- *Establishment of a national centre for quality improvement*
Two centres were established in the context of the Health I project: the Centre for Evidence-based Medicine and the Centre for Continuing Medical Education.
- *Requirements for licensing/accreditation of primary health care facilities and professionals*
These requirements are listed in the Law on Health Protection of Citizens (1996-2007), the Presidential Decree on the Government programme of further reforms of public health services (2007), Presidential Decree 700 on Measures to improve the organization of activities in medical establishments (2007), and Cabinet of Ministers Decision 276 (2005). It was also specified in subsequent documents.
- *Requirement to safeguard the safety of patients*
This is dealt with in the Law on Health Protection of Citizens
- *Promotion of evidence-based medicine, guidelines and standards*
This is included in various documents: Cabinet of Ministers Decision on a programme for the development of social infrastructure in the regions (1996), the Ministry of Health Order on the creation of a working group to develop standard documents on medical insurance (1998), the Law on Health Protection of Citizens (1996-2007), the Presidential Decree on the Government programme of further reforms of public health services (2007), Cabinet of Ministers Decision 276 (2005), and the Order on the establishment of the Centre for Evidence-based Medicine (see above).
- *Performance of policy evaluation studies*
These are promoted in Cabinet of Ministers Decision 217 (2005) on measures for the further reform of the financing and management of health services.
- *Stimulation of research on quality of (primary) health care*
This is related to evidence-based medicine and the promotion of the information base for management and policy-making.
- *Quality systems in health care institutions*
Quality systems are addressed in: Cabinet of Ministers Decision 276 (2005), Presidential Decree 700 on Measures to improve the organization of activities in medical establishments (2007), and the Presidential Decree on the Government programme of further reforms of public health services (2007).
- *Annual reporting on quality of care*
Cabinet of Ministers Decision 276 (2005) and Presidential Decree 700 on Measures to improve the organization of activities in medical establishments (2007).

The state of legislation on patient's rights

Patients' rights were said to be a point of current discussion, as shown in recent publications about sanctions applied when those rights are violated. The experts pointed to the existence of a Law on Patients' Rights (although a law of that name was not reported in the listing above) regulating complaint procedures and patients' informed consent, are regulated as well as the right of patients to access their medical files. Furthermore, it has been legally enshrined that patients are entitled to receive diagnostic, curative and preventive services as specified in the Law on the Health Protection of Citizens (see above).

2.2.4. Coordination and formal structures

The Ministry of Health is responsible for maintaining and improving quality within primary care facilities, in collaboration with regional authorities, the Institute of Health, the Health project and other nongovernmental organizations. Within the Ministry, however, it seems that the responsibility is not concentrated in one department. The management of licensing and quality assurance of medical services, for instance, is the responsibility of the ministerial department for coordination, development and introduction of standards for diagnostics and treatments. But experts in other departments are also in charge of aspects of quality of care. Operational tasks related to quality improvement are entrusted to territorial executives of the health services in provinces, regions and cities. Furthermore, in each province, region and city, societies for the protection of consumer rights observe quality of care from the patients' perspective. In 2006, the Federation for the Protection of Consumer Rights conducted an investigation into the quality of health services.

Observance by primary care facilities of prevailing rules and protocols is formally supervised by the Ministry of Health at the central level, by regional authorities in each province, and by the deputy head in each district. Follow-up to patients' complaints is formally supervised at various levels and by different bodies: the Ministry of Health, regional health authorities and the Federation for the Protection of Consumer Rights. If necessary, the Office of the Public Prosecutor also becomes involved.

The experts were asked whether the following formal instruments or mechanisms existed:

- Supervision of CME activities by GPs
 - » Representatives of the Ministry of Health in each region control whether primary care providers are meeting their CME obligations.
- Formal investigations into shortcomings and significant events in primary care
 - » The experts reported that the Ministry of Health has a central control and inspection system with regional representatives. Inspecting physicians of the Central District Hospitals check the activities of GPs. Other bodies involved in "event monitoring" are the Ombudsman, the Office of the Public Prosecutor, and the Federation for the Protection of Consumer Rights.

- Mandatory licensing (formal external assessment of practices, providers or organizations against predefined standards of competence)
 - » Such licensing exists only for private practices and medical facilities. For the public system, there are norms for premises, equipment and training of staff.
- Benchmarking (systematic monitoring or comparison of performance of primary care facilities, possibly resulting in “performance ranking”)
 - » Performance of medical facilities was subject to comparative analyses randomly conducted by different actors or institutions for a specific purpose or in a specific context (such as evaluation of donor funds), for example, by the Ministry of Health, its regional representatives, the Institute of Health and the Health II project. It was not clear whether these monitoring activities resulted in performance rankings or “league tables” for the general public.
- Contracting of professionals by a purchaser (including specification of aspects of quality as terms of the contract)
 - » No purchaser’s contracts are in place; providers have regular labour contracts.
- Financial incentives for providers and organizations (in particular those that promote good quality of care)
 - » The salaries of providers are related to the complexity of services, and the qualifications and experience of the physician. There are extra bonuses for the level of attestation. Cabinet of Ministers Decision 276 (2005) defined the composition of commissions that can decide on bonuses and related criteria.
- Nonfinancial incentives for the promotion of quality of primary care (such as quality awards, certificates, prizes)
 - » The experts mentioned several awards: the Esteemed Doctor award; several medals; the “Honoured student of public health services” breastplate; the Best GP competition; the Best in Profession competition; and the Best Nurse competition.
- Official (national) programme(s) for the development of clinical guidelines for primary care
 - » The experts reported several laws and decrees that mentioned such a programme (see above). The Centre for Evidence-based Medicine is in charge of developing and implementing the programme for clinical guidelines in primary care.

The experts went on to discuss the existence of the following mechanisms, specifically related to the position of patients. All of the mechanisms were reported to be in place.

- Obligatory procedure on patients’ complaints in primary care settings (detailing the submission, how complaints are dealt with, and how they are reported)

- » The procedure is regulated by the Law on Health Protection of Citizens (see above). The Ombudsman and the Federation for the Protection of Consumer Rights are also part of the procedure.
- Feedback on patients' complaints
 - » Each complaint was reported to be considered and checked according to the procedure. The complainants are generally informed of the outcome.
- Confidentiality of medical information/patient records in primary care
 - » According to the experts, the Law on Health Protection of Citizens contains that safeguard the confidentiality of patients' medical records.
- Access by patients to their personal medical information (files)
 - » The same law also regulates the access of patients to their own medical files.
- Rules on patient safety in primary care.
 - » The experts reported the existence of such rules.
- Rules on informed consent in primary care
 - » The experts reported the existence of such rules.
- Requirements for assessing patients' needs or experiences in primary care settings.
 - » The experts reported that the Ministry of Health, together with the Federation for the Protection of Consumer Rights, had conducted surveys of the population's satisfaction with health services.

In addition to those formal mechanisms, on a more incidental basis health authorities can monitor the quality of health care services and communicate in that regard with stakeholders and the general public. The experts were asked whether the Ministry of Health was involved in such activities. The experts confirmed the involvement of the Ministry in the following activities:

- Commissioning objective external quality assessments of (primary) health services (for instance on access, prescribing drugs, referrals, satisfaction)
 - » The Ministry has ordered various investigations and surveys into the quality of (primary) health care services. The Ministry also uses the results of research undertaken by others, for instance in the context of the Health II project.
- Collecting feedback data on a routine basis using process and outcome measures

- » This refers to the regular data collections by the Ministry and the Institute of Health, routine statistical reports and inspections in health care establishments.
- Communication and discussion of information on quality with stakeholders (e.g. organizations of medical workers or patients)
 - » The experts answered that round tables were organized with the Association of Physicians and the Federation of Consumer Rights Protection. Outcomes of these discussions are communicated to the regions. There were also discussions with representatives of medical staff.
- Reports to the general public about quality performance or possible shortcomings of primary care services.
 - » Reports were given at conferences and via the mass media.

Formal job descriptions can serve as terms of reference for the evaluation of professional performance, practice conditions and obligations related to continuing education. The experts were asked whether such official job descriptions existed for a number of disciplines, and whether certain topics that could be used as references for evaluation were specified.

- Official job descriptions were reported to exist for all the main primary care disciplines and they contained the basic elements that could be used for evaluation of performance. The list of primary care professions for which a job description existed included: GPs, paediatricians, internal medicine specialists, primary care nurses, home care nurses, midwives/birth assistants, physiotherapists and pharmacists. Each of the job descriptions detailed at least the following topics: specified tasks and responsibilities; required level of knowledge and skills; requirements for keeping up-to-date.

Concerning the involvement of professional associations or representatives of professionals in the development of the job descriptions, the experts answered that this had been the case with all job descriptions.

Other structures and voluntary initiatives

A system for quality management improvement in (primary) health care requires not only coordination but also support structures to conduct assessments and evaluation studies and to develop instruments and materials. The discussion among the experts about coordination and support structures pointed to a dominant role of the government, educational institutes and donors. Coordination was exclusively in the hands of the state, with the Ministry of Health at the top and the deputy heads in the districts at the bottom of the coordination chain. Educational tasks have been delegated to the Institute for Postgraduate Medical Education and the Medical Academy of Uzbekistan. Research institutes and the Centre for Evidence-Based Medicine are involved in surveys and evaluation studies and the development of guidelines and other quality promoting materials. From the side of the donors, there has been considerable input from the USAID/ZdravPlus project to improving quality management in primary care,

as well as contributions from the World Bank and the Asian Development Bank. For instance, since 2005, ZdravPlus has supported improvement projects on anaemia in Fergana province.

Beside the formal and institutionalized mechanisms for quality management, local initiatives and other voluntary structures for quality improvement can play an important additional role. The experts were asked about the prevalence of the following voluntary mechanisms:

- Community surveys to receive patient feedback on the quality of care.
 - » It was reported that such surveys did exist. By order of the Ministry of Health, a questionnaire was drawn up to look at patients' opinions; the survey was conducted by the Federation for the Protection of Consumer Rights. Other surveys have been carried out in the context of donor-supported projects.
- Voluntary independent accreditation (the – often mutual – assessment of functions by colleagues from another facility)
 - » Such voluntary accreditation was reported to exist but no further details were given by the experts.
- Local initiatives to improve the quality of primary care, such as: informal mutual practice visitation; local patient surveys; small-scale guideline development, cooperation projects between primary care and a local hospital, etc.
 - » Some of the experts reported that informal practice visitations did occur. Other examples mentioned included the presentation of survey results to local groups of health care providers, and expert-led seminars and discussions on medical topics. Additionally, the experts mentioned mutual visits and exchanges of experiences between primary care facilities.

2.2.5. Education and access to information

Medical education should prepare medical students with skills and tools for monitoring and improving their professional performance – alone or in a team. Relevant techniques need to be learned and then maintained through CME.

Most of the experts thought that current undergraduate and postgraduate medical education and the 10-month retraining course paid sufficient attention to such skills and techniques. Since 2005, methods of quality improvement had been introduced into the curricula.

Concerning CME, experts concluded that current programmes sufficiently addressed the specific needs of health care providers to update their knowledge and skills. CME is provided by several institutes and centres for medical education at different levels and by the central outpatient clinics in the districts. Every five years, GPs need to pass a qualification exam. A national concept for CME was developed and introduced in 2006 for the period to 2010. Under this scheme, CME will be mul-

tifaceted, with the regional branches of the Centre for CME involved and distance learning methods used. The starting point for CME will be the identified educational needs of GPs.

Primary care providers should have feedback information at their disposal to allow them to improve their performance. Experts were asked whether such information was available to family doctors and primary care nurses and whether they had sufficient access to professional guidelines, standards and protocols.

The experts answered that improving the availability of clinical and other information was an essential element of the primary care reform in Uzbekistan. Better access to information was still needed but the situation had already improved considerably.

The managers of health care facilities may play an important role in maintaining and improving the quality of services. Experts were asked whether managers in primary care had sufficient information available for these tasks.

Overall, the experts expressed the opinion that managers had sufficient information for controlling and improving quality. All managers receive feedback data about the performance of their centre or polyclinic. In addition, regular activity reports are published on all primary care centres and polyclinics.

2.2.6. The way forward with quality management

From a list of 23 predefined areas, the 11 national experts who completed the national level questionnaire were asked to indicate their importance (high, medium, low) in strengthening the quality of primary care in Uzbekistan. The activities have been grouped and are described below.

- Policy and planning

Generally, the experts thought that health policy and planning was a relatively well developed area. However, they put high priority on identifying remaining gaps in legislation, for instance, in setting norms and standards of care and in the further development and implementation of clinical guidelines. Medium priority was put on specifying in more detail the goals and values related to quality of care in legal statements and defining quality incentives for physicians and managers. Developing a national programme for auditing and accreditation, and strengthening the position of patients were considered as low priorities.

- Analysis and evaluation

The experts agreed that strengthening the research and evaluation capacity for primary care was important in promoting quality management. They thought that many activities had already been undertaken to identify areas and analyse the causes of poor quality, and to monitor and evaluate policies on primary care quality. Therefore that would not currently need to be given high priority.

- Information

Improving (electronic) medical record systems in primary care and improving electronic access for primary care workers to external sources of information were high priorities. Disseminating information on modern approaches of quality improvement and improving the quality and availability of clinical and management information were judged to be less important.

- Support

The experts felt that there was sufficient political support for quality improvement. Furthermore, since the Centre for Evidence-based Medicine had been established, there was no need for a national steering group or platform. On the other hand, they saw two points as medium priorities: improvement of the current CME programmes; and information to and consultation with stakeholders and the general public about further steps to take in quality improvement.

- Implementation

Regarding the implementation of innovations, the experts pointed to the major importance of finding and allocating resources. Developing pilot projects, rolling out successful interventions and institutionalizing structures for coordination and advice were thought to be less important.

- Perceived obstacles

No items from a list of eight were rated as major obstacles to the improvement of primary care quality management in Uzbekistan. However, four areas were agreed to constitute minor obstacles. These were: the subordinate role of primary care compared to other levels (although that was improving); the current attitude of health care workers; the weak position of patients or users of health care services (these are not well organized); and the lack of nonfinancial resources (such as: information, skills, modern training methods). No problems were seen in relation to the general vision of quality management in health care; available structures for coordination and implementation; the current style of health care management; or available financial resources. No obstacles other than those listed were mentioned by the experts.

2.3. Uzbek primary care managers and quality management: results of the survey

In Uzbekistan, deputy head doctors in the districts are responsible for the quality management of primary care services, and so they were included in this project as the managers, with the total number of managers for all three pilot provinces of Fergana, Syrdarya and Tashkent being 40. The return rate was 100%. Despite the relatively low sample size the results will be presented per pilot region and percentages will be used to allow comparisons between regions – one of the aims of this survey.

2.3.1 Characteristics of the managers and their working environment

Most of the deputy district head physicians in the three provinces are male and well advanced in their forties. In Tashkent, the gender balance is the least skewed, at one third women. In Syrdarya, there was one woman among the nine managers, while in Fergana all were men. The age of the managers was relatively high. In Fergana and Tashkent, the average age was mid-40s and in Syrdarya it was almost 50.

Managers have been working in their position as deputy head physician and in the same location for a relatively long time: between 10 and 20 years. In Fergana, they had on average been working as a manager for 11 years, in Syrdarya for 14 years and in Tashkent for 17 years.

The managers were asked about the type and number of staff they manage. However, only the managers in Fergana answered this question: they are on average responsible for 115 staff, of whom one quarter are primary care physicians (including GPs), 30% are nurses and another quarter are other medical and paramedical staff.

Table 2: Characteristics of the districts

| Type of district | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|-------------------------|----------------|------------|----------------|------------|-----------------|------------|
| | Abs | % | Abs. | % | Abs. | % |
| • Inner city | 3 | 19 | 0 | 0 | 0 | 0 |
| • Suburban | 8 | 50 | 5 | 56 | 5 | 33 |
| • Small town (< 50.000) | 0 | 0 | 2 | 22 | 1 | 7 |
| • - Rural | 5 | 31 | 1 | 11 | 9 | 60 |
| • - Not answered | 0 | 0 | 1 | 11 | 0 | 0 |
| Total | 16 | 100 | 9 | 100 | 15 | 100 |

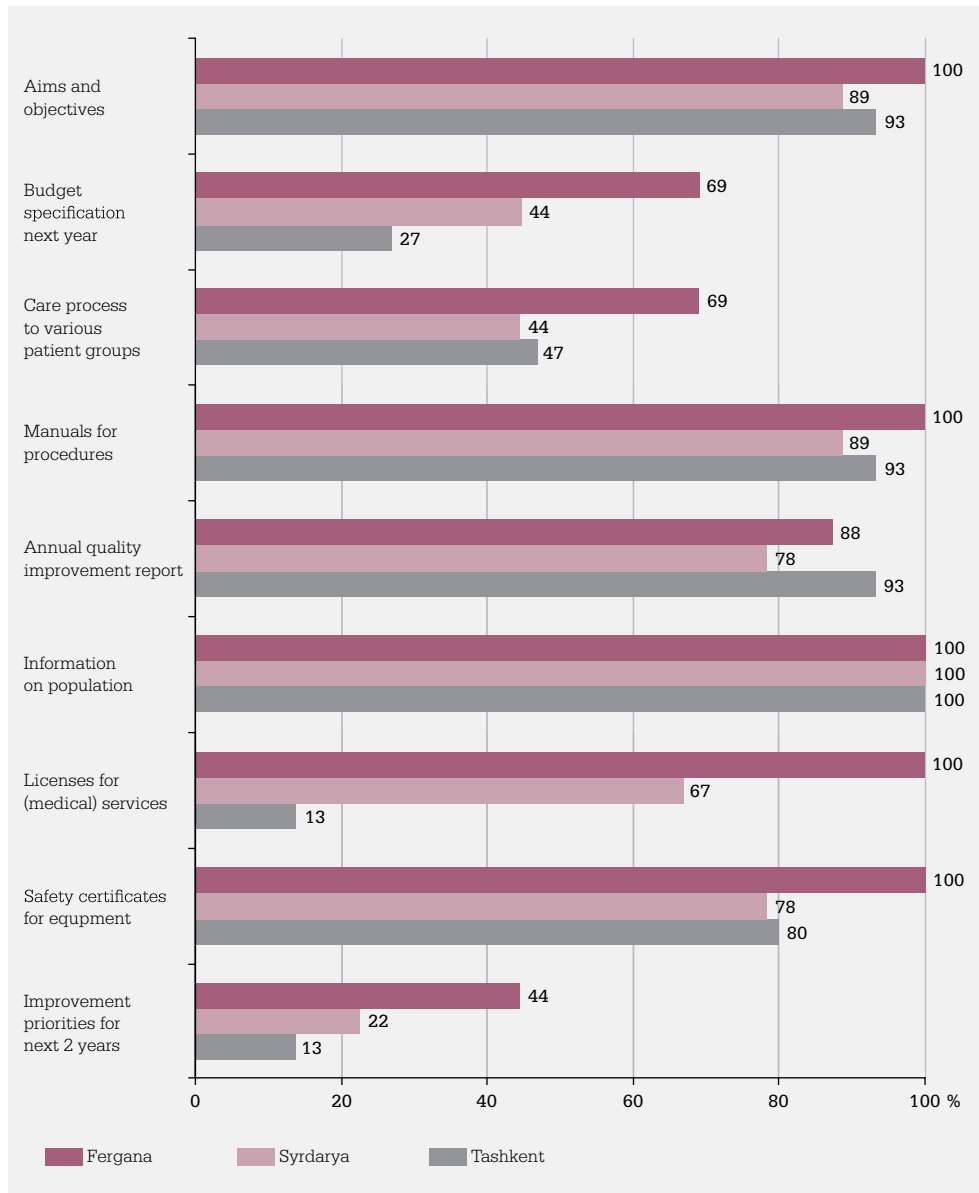
Table 2 shows that there are differences between the districts of the three provinces: In Fergana, which is the most densely populated of the three provinces, more than two thirds of the managers work in the inner city or suburban areas. In Syrdarya, most managers (three quarters) work in suburbs or small towns. In Tashkent, 60% of the managers work in rural districts.

2.3.2 Availability of documents relevant for quality management

Maintaining or improving the quality of services requires references or yardsticks. The services of a health care facility can only be evaluated if aims and benchmarks for services have been established and described, and thus made explicit beforehand. Consequently, managers were asked whether a number of documents, listed in figure 2, relevant to the management of quality of health care services were available in their organization. If not available, managers could indicate that preparations were being

made for their introduction, or that this was a current topic for discussion within the organization. Figure 2 provides an overview of the “availability” only.

Figure 2: Available documents related to quality management (summary)



With five out of the nine listed documents available, managers reported wide or general availability of: the aims and objectives of the organization (the mission statement); manuals for specific procedures; an annual report on quality improvement; general information on the population served; and safety certificates for medical equipment. In particular, the availability of annual quality management reports suggests that, in most districts, in some way, reflection on the quality of services is taking place. However, the policy did not go far as specifying priorities for improvement for the next two years. Only a few managers mentioned that such a document on future priorities was available in their organization. This seems to be in line with the poor availability of another instrument for future (quality) planning: specification of the budget for the next year.

Fergana was best off, with two thirds of the managers reporting that they had such a budget. In Syrdarya however, it was available in less than half of the districts and in only a quarter in Tashkent. Detailed descriptions of the services and care (to be) provided to specific patient and risk groups (such as the chronically ill; mothers and young children; those at cardiovascular risk) were not common in Syrdarya and Tashkent, where less than half of the managers mentioned the availability of such descriptions. In Fergana, the documents were available in two thirds of the districts. There was extreme variation between the provinces in the availability of licenses for medical and other services. Such licenses were reported to be available by all managers in Fergana, by two thirds in Syrdarya and by only 2 (out of 15) in Tashkent.

Managers who reported the availability of a document describing improvement priorities for the next two years were asked to indicate which plans they had. The results are shown in table 3.

Table 3: Priorities for improvement in the next two years, mentioned by managers

| Type of improvement | Fergana | Syrdarya | Tashkent |
|---|--|---|--|
| <ul style="list-style-type: none"> Improvements related to education/qualification of staff:* | Improving qualification of medical workers Continuing education among GPs | Improving qualification of colleagues Team work of family doctor and nurse | Improving staff performance |
| <ul style="list-style-type: none"> Improvements at organizational level:* | Improving quality of medical services Publication of clinical standards | Improving material-technical base of facilities | Computerization Improving quality of medical services in primary care Management Reducing volume of medical reporting Organization |
| <ul style="list-style-type: none"> Improvements related to clinical care / patient groups / prevention:* | Hypertension Diabetes | | Anaemia Maternity and childhood (N=3) Treatment of goitre (N=2) Endocrinologic disease Prevention of disease |

* Priorities were mentioned once unless indicated otherwise

The plans for improvements are grouped into three categories in table 3. The first group contains those related to education and qualification of staff, either in general or specifically related to continuing medical education of GPs or teamwork between GPs and nurses. The second group encompasses improvements in organization or manage-

ment, with specific mention of the dissemination and publication of clinical standards; technical or material improvements; computerization and reduction of unnecessary medical reporting. The third group contains activities aimed at specific aspects of the clinical process, including prevention, and specific conditions or diseases. Managers from Tashkent mentioned improvement priorities for all groups whereas managers from Fergana and Syrdarya focused more on the first two groups.

In table 4, total scores are given for the availability of the nine documents (as mentioned in figure 2). Overall, the level of documentation was clearly better in Fergana than in the two other provinces. This difference was consistent in relation to the availability of all documents for which substantial variation was found between the provinces: licences and certificates; future priority setting; budget specification and description of care processes for specific patient groups.

Table 4: Total scores for documentation related to quality management in the three pilot provinces

| Province | Score* |
|----------|--------|
| Fergana | 85 |
| Syrdarya | 68 |
| Tashkent | 62 |

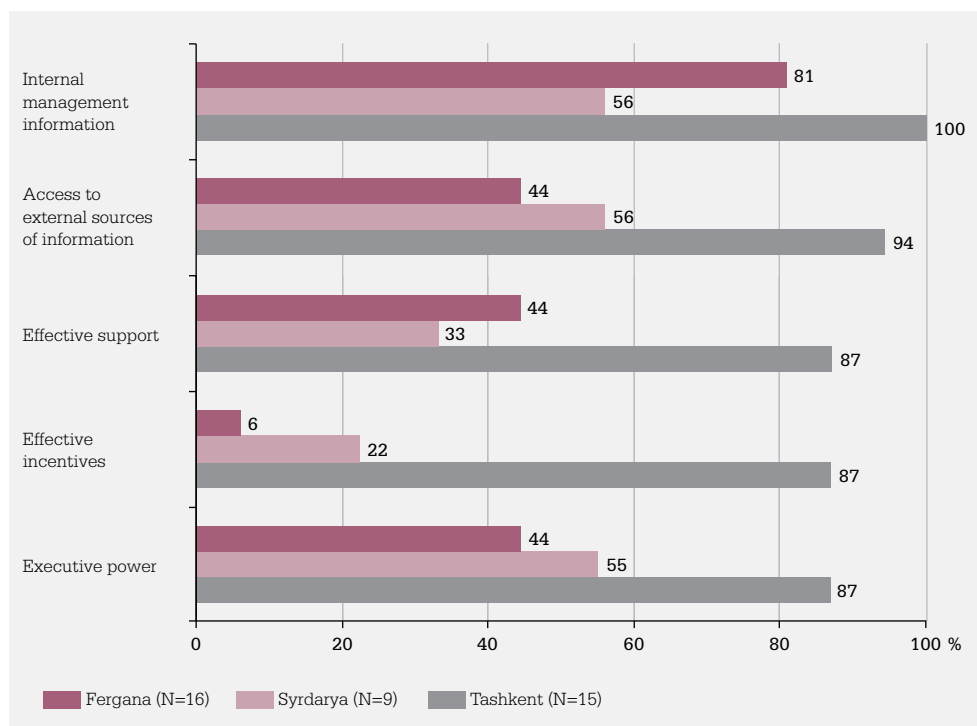
* Maximum score = 100

2.3.3 Conditions and means for quality improvement

Information is the basis for any planned change. Managers need to have information on the internal processes inside their organizations as well as access to external sources of information, for instance for comparisons. Managers may need internal or external support to realize change and introduce incentives to foster good performance among members of their organization. Obviously, managers need to have sufficient executive power to create good conditions for quality management improvements. Managers were therefore asked about these conditions and means. Figure 3 shows the proportion of managers who judged specific conditions and means as “not good”.

In Tashkent, managers generally found that conditions and means for quality management were insufficient. The availability of management information was judged fair by 60% and insufficient by 40%. Two thirds of the Tashkent managers considered they had insufficient access to external information. Concerning support for change, incentives and executive power to implement change, the proportions who answered “fair” and “insufficient” were between 40% and 50% in each case.

Figure 3: Conditions and means for quality management considered as being not good (“fair’ or “insufficient”); summary



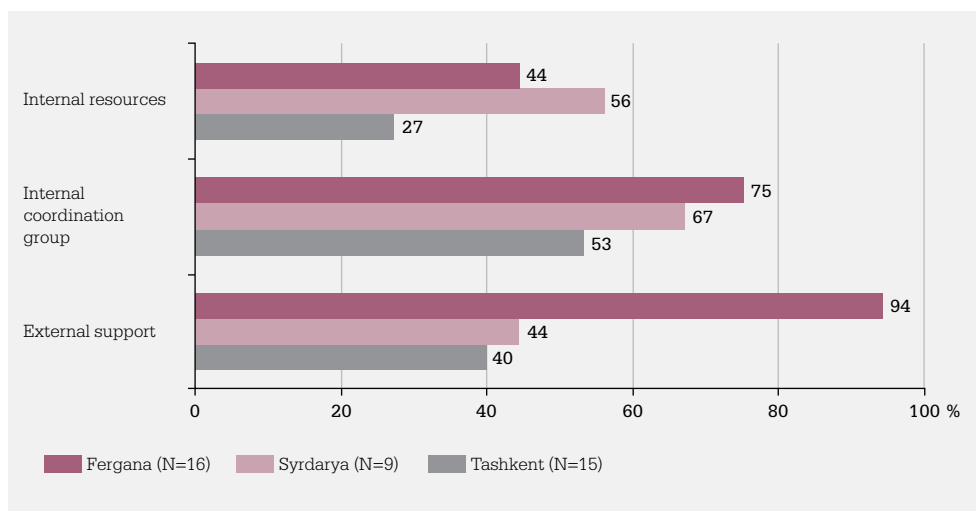
In Syrdarya, conditions and means for quality management were judged more positively by the managers. The percentages in the overview figure mostly referred to the answer “fair”; only a few answered that the situation was insufficient. Nevertheless, conditions and means for quality management can be improved in Syrdarya as well.

Except for the internal management information available and effective support, these conditions and means were best met in Fergana province. Few managers judged the situation for these items to be “insufficient”. Only 2 out of 16 managers found that internal management information was good. A small majority reported that access to external information, support for change and executive power were good. Managers in Fergana were most positive about the availability of incentives for change.

2.3.4 Support for improvement actions

Managers were asked about three specific forms of support for improving the quality management in primary care: the availability of internal resources for that purpose (for instance for the implementation of clinical guidelines), the existence of an internal group to promote and coordinate quality improvement, and the availability of external quality support (for instance, for training of staff). Figure 4 gives an overview on the results. If support was not available it was usually either being prepared or a topic for orientation.

Figure 4: Available support for quality improvement activities; summary



Most managers reported they had no internal resources available for quality improvement activities. In Syrdarya however, a small majority agreed that they did have internal resources available for that purpose, whereas in Fergana, the figure was less than half and in Tashkent only a quarter.

Internal coordination groups have been established in the majority of districts, but there were differences between the provinces. In Fergana, three quarters of the managers mentioned such coordination groups; in Syrdarya, the figure was two thirds and in Tashkent about half.

External support was generally available in Fergana, while in both the other provinces only about 40% of the managers said they could call on external support.

Table 5: Coordination of quality management in primary care organizations

| | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|--|----------------|-----|----------------|-----|-----------------|-----|
| | Abs. | % | Abs. | % | Abs. | % |
| Situation | | | | | | |
| Coordination function clearly established | 16 | 100 | 8 | 89 | 13 | 87 |
| Coordinator:* | Abs. | %** | Abs. | %** | Abs. | %** |
| • The head physician | 13 | 81 | 8 | 100 | 11 | 85 |
| • Another physicians | 4 | 25 | 0 | 0 | 0 | 0 |
| • A quality commission | 0 | 0 | 0 | 0 | 1 | 8 |
| • other | 3 | 19 | 1 | 13 | 1 | 8 |
| * More answers could apply at the same time | | | | | | |
| ** Percentage based on situations with clearly established coordinator | | | | | | |

Table 5 shows that the coordination function for quality management has been clearly established in all provinces. The by far most frequently reported coordination post involved the head physician being responsible for maintaining and improving the quality of services. Four managers in Fergana mentioned that this role was in the hands of one of the other physicians. In Tashkent, a quality commission was responsible for quality-related matters.

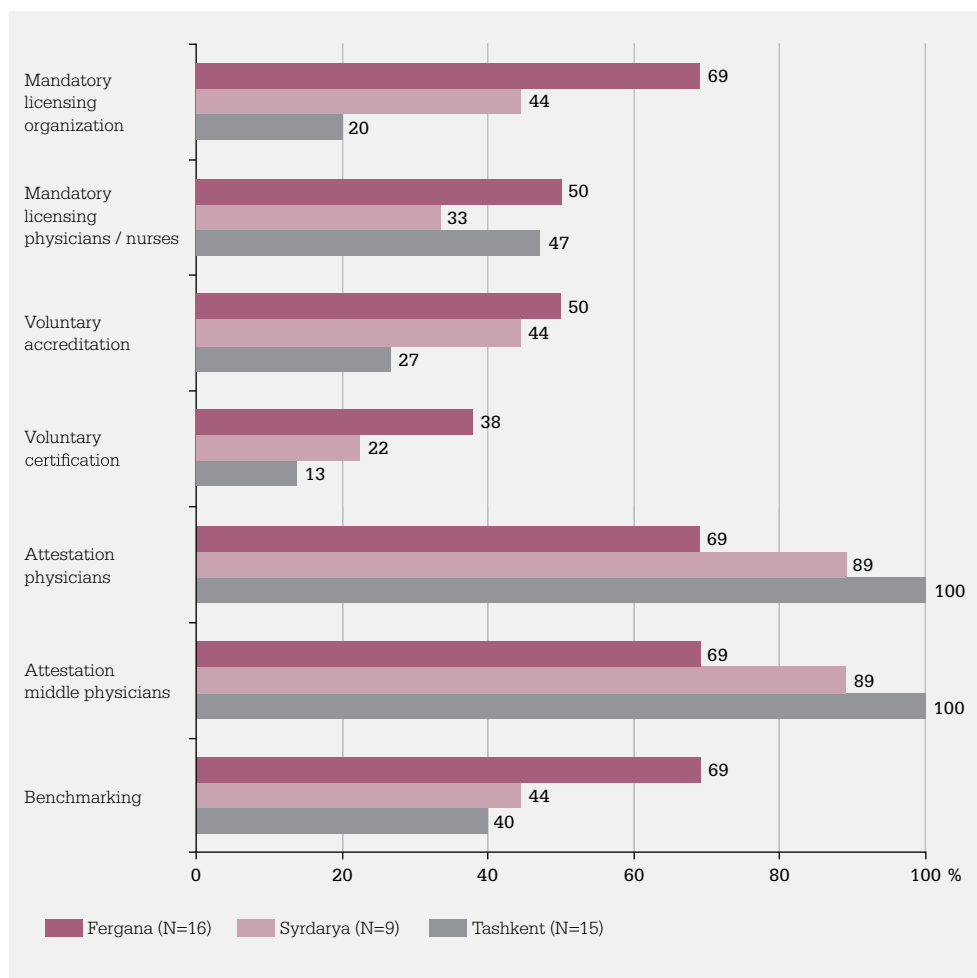
2.3.5 External assessment instruments

An assessment instrument can be characterized as external if the quality of services is compared to predefined criteria or standards set from the outside of the organization (for instance, by the government or by a professional organization). The application of such instruments can either be obligatory, for instance imposed by health authorities, or voluntary. Managers were asked whether the following seven instruments were applied in their organization:

- mandatory licensing (or revalidation) of the organization (compliance with externally set minimum standards);
- mandatory licensing (or revalidation) of physicians and nurses (their compliance with minimum standards of competence);
- voluntary accreditation (assessment of the organization against predefined standards);
- voluntary certification (informal evaluation of the organization);
- attestation of physicians (four- or five-yearly knowledge tests);
- attestation of middle-level medical staff;
- benchmarking (comparing the performance of different organizations).

The overview in figure 5 shows the percentages of managers who answered that an instrument was applied; the other possible responses – ‘preparations are being made’; ‘topic for discussion’; or ‘not available’ – are not shown.

Figure 5: Applied external assessment mechanisms; summary



Overall, the most frequently used external assessment instruments were attestations (of physicians and middle-level staff). It is noticeable that not all managers mentioned the use of attestation, because traditionally this was an obligatory scheme in Uzbekistan.

Concerning the mandatory licensing (or revalidation) of organizations as well as of medical and nursing staff, answers given by the managers were not homogenous, even within provinces. This suggests that districts are, to some extent, free to establish such mandatory schemes in their areas. Mandatory licensing of facilities was mentioned by two thirds of the managers in Fergana, less than half of those in Syrdarya, and one fifth in Tashkent. Mandatory licensing of physicians and nurses was reported by about half of the managers in Fergana and Tashkent and one third in Syrdarya.

Voluntary participation in formal accreditation was reported by around half of the managers in Fergana and Syrdarya and one quarter in Tashkent. Voluntary certification, which is of a more informal nature than accreditation, was mentioned by only a few managers. Benchmarking, finally, was more popular, especially in Fergana, where two thirds of the managers reported being involved in this activity. In both the other provinces, about 40% of the managers said that they used benchmarking.

Total scores on the application of external assessment instruments, as listed in table 6, show Fergana as slightly ahead. If attestation were not taken into account, however, it would be clearer that Fergana is the province where external assessment instruments are applied most widely.

Table 6: Total scores for applied external assessment instruments in three provinces

| Province | Score* |
|----------------------|--------|
| Fergana | 59 |
| Syrdarya | 52 |
| Tashkent | 50 |
| *Maximum score = 100 | |

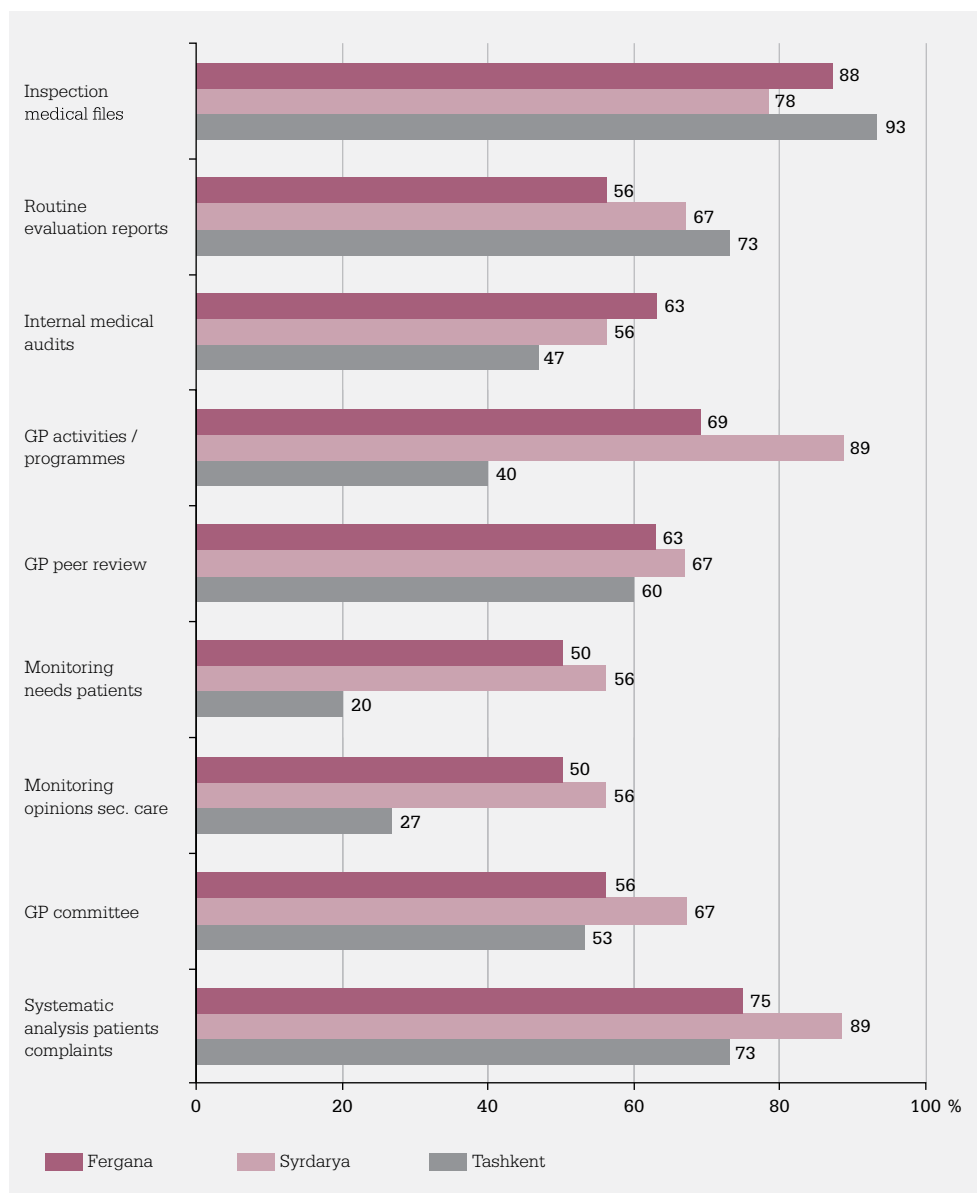
2.3.6 Internal assessment mechanisms

The following nine internal assessment mechanisms were considered:

- regular inspection of medical files by executives;
- routine evaluation reports to management on specific clinical or nonclinical activities;
- internal medical audits;
- quality improvement activities or programmes (using explicit techniques);
- peer review (informal assessment among doctors working in an area);
- monitoring of the needs/satisfaction of patients;
- monitoring of the opinions of partners in secondary care (for instance, medical specialists);
- quality improvement committee(s);
- systematic analysis and follow-up of patient complaints.

Internal modes of assessment usually have more implicit criteria or criteria that are used only within the specific organization. Some internal assessment instruments such as peer review among GPs are of an informal nature, while others, for instance, the follow-up of patient complaints, should be strict and formal. A summary of the answers given by the managers on the use of internal assessment instruments is shown in figure 6.

Figure 6: Applied internal assessment mechanisms; summary



The two most frequently used internal assessment methods in all provinces were the inspection of GPs medical files by (one or more) supervising physicians and analysis and follow-up of complaints submitted by patients. Formerly, inspections of medical files in primary care were carried out, without much coordination, by a range of different medical specialists, each imposing their own criteria and requirements on medical reporting. This resulted in an overload of medical reporting for primary physicians. The managers' answers gave no information about who is currently carrying out the inspections or how frequently. Probably, supervision is now less ambiguous than in the past and it may be the deputy head physicians in each district (the ones who participated in this pilot) who are in charge of these quality checks of medical files.

Analysis and follow-up of patients' complaints were mentioned by three quarters of the managers from Fergana and Tashkent and by all but one from Syrdarya. Patients'

complaints thus seem to be taken seriously in all three provinces. From the perspective of physicians, nurses and other health care workers, the “common denominator” of the strong focus both on inspection of medical files and on patients’ complaints seems to be detecting mistakes made by medical staff. This could point to an organizational culture or style of management which is characterized by control rather than by encouragement and professional development.

Routine evaluations of the management of clinical and other activities were made in three quarters of the districts in Tashkent, two thirds of the districts in Syrdarya and well over half of those in the Fergana province.

Differences in the use of internal medical audits were relatively small in the three provinces. Two thirds of the managers from Fergana and around half of those from Syrdarya and Tashkent reported that such audits were carried out in their district.

All but one of the managers from Syrdarya answered that quality improvement activities or programmes were developed. In Fergana, 11 out of 16 reported improvement activities or programmes, as did 6 out of 15 in Tashkent.

The prevalence of peer review among GPs was almost equal in the three provinces; around two thirds of the managers did mention this.

Monitoring opinions, needs or experiences (either of patients or of secondary care workers) was not widely undertaken. The pattern of answers for the two activities was very similar: around half of the managers from Fergana and Syrdarya and one fifth to a quarter of those in Tashkent said that they carried out such surveys among users and colleagues. Finally, half to two thirds of the managers reported that a quality improvement committee had been established in their district.

Taking all the internal assessment mechanisms together, no large differences were found between the provinces (see table 7). The scores for Syrdarya and Fergana were quite similar; Tashkent was a little behind, mainly because of the relative lack of quality improvement activities/programmes and low prevalence of monitoring patients’ needs and satisfaction.

Table 7: Total score for the application of internal assessment mechanisms in three provinces

| Province | Score* |
|-----------------------|--------|
| Fergana | 63 |
| Syrdarya | 69 |
| Tashkent | 54 |
| * Maximum score = 100 | |

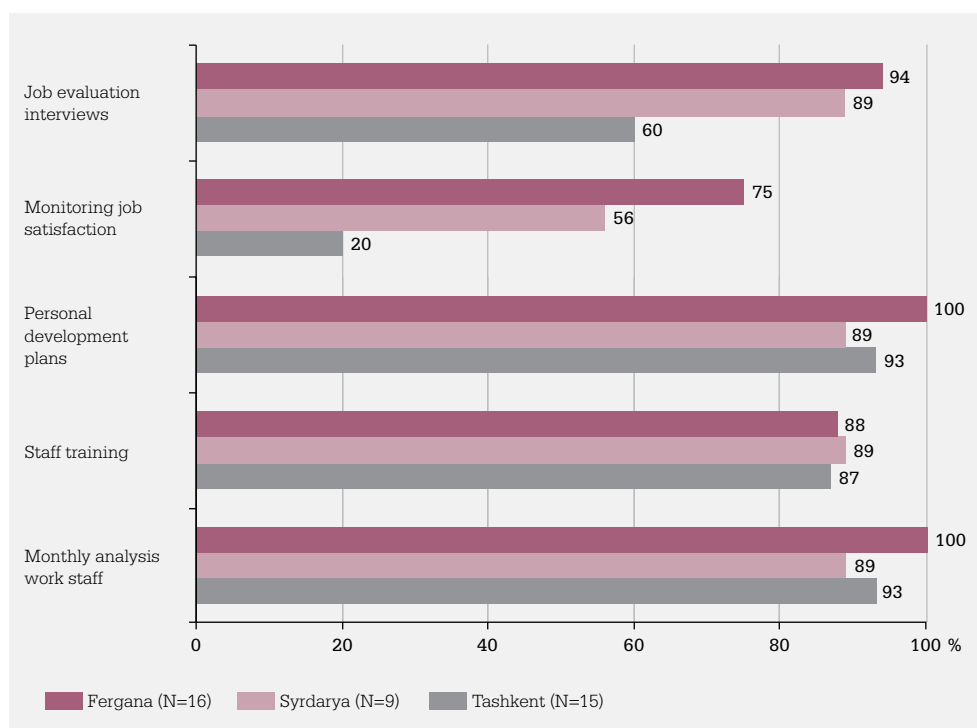
2.3.7 Elements of human resources management

Instruments of human resources management have the potential to provide workers with systematic feedback on their functioning, to identify needs for training and to point to opportunities for improvement and professional development.

Managers were asked whether the following aspects of human resources management applied to their organization:

- regular individual job evaluation interviews with staff
- monitoring job satisfaction of staff
- personal development plans for staff
- staff training for quality improvement of medical services
- monthly analysis and report of medical staff and their work.

Figure 7: Aspects of human resources management; summary



Three elements were reported to be almost general practise in the three provinces: personal development plans for staff; specific staff training for quality improvement in medical care; and regular reports on staff and their activities. Job evaluation interviews were held in almost all districts in Fergana and Syrdarya, but less frequently in Tashkent (60%). Variation between the provinces was largest with respect to monitoring staff job satisfaction. This was reported by three quarters of the managers from Fergana

and well over half of those from Syrdarya. In Tashkent, however, attention to monitoring job satisfaction was low (20%).

Table 8 summarizes the results with the overall rating:

Table 8: Total scores for aspects of human resources management in three provinces

| Province | Score* |
|----------|--------|
| Fergana | 91 |
| Syrdarya | 82 |
| Tashkent | 71 |

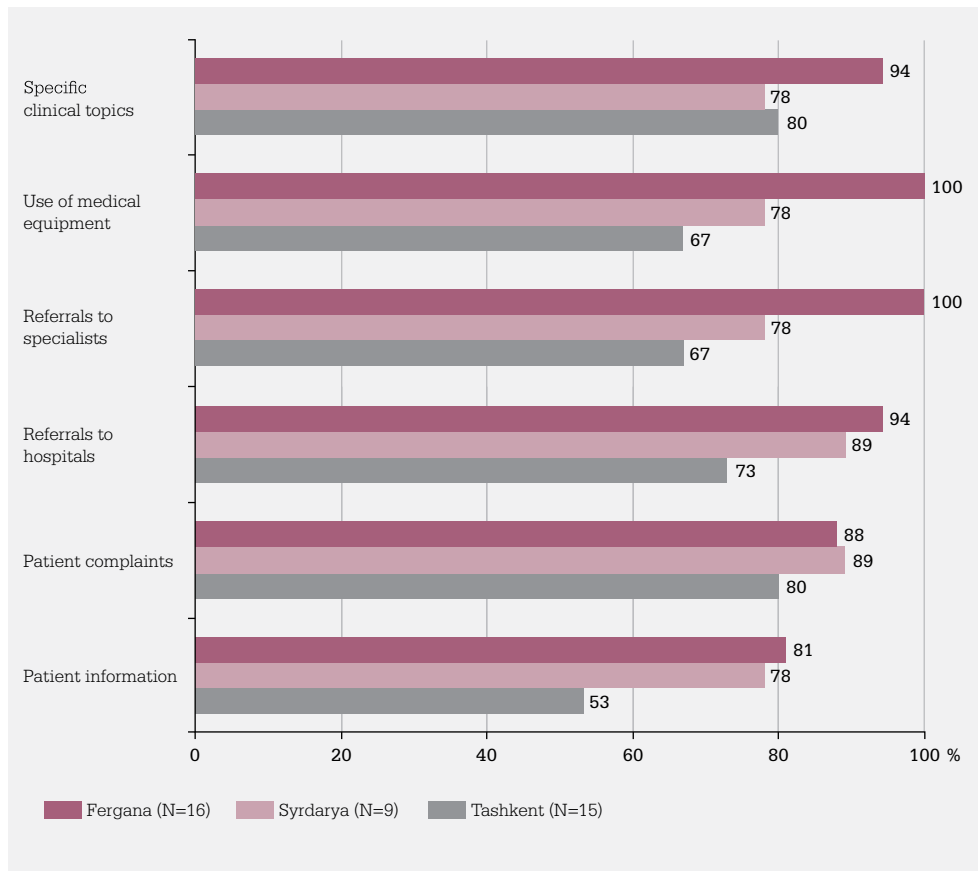
* Maximum score = 100

2.3.8 Use of protocols and guidelines

The use of protocols and clinical guidelines can contribute significantly to the improvement of health care and to the reduction of undesirable variation in the delivery of health care services. Protocols and guidelines can have various subjects. Managers were asked about the following topics:

- guidelines on specific clinical topics (for instance, certain diseases);
- protocols for the use of medical equipment;
- protocols for referrals to medical specialists (for instance, which information to supply to patient and specialist);
- protocols for referrals to hospitals (for instance, which information to supply to patient and specialist);
- protocols for patient complaints (for instance, who deals with complaints);
- protocols for patient information (for instance, what information providers should give to certain categories of patients).

Figure 8: Use of protocols & guidelines; summary



Protocols and guidelines seemed to be widely used. All the types listed in figure 8 were reported to be in use in the districts of most managers. Protocols describing the procedure for dealing with patient complaints were the most frequently mentioned, by more than 80% of the managers in each province. The referral of patients to hospitals was guided by protocols in the districts of all but one manager in Fergana and Syrdarya and three quarters of those in Tashkent. All managers from Fergana, three quarters of those from Syrdarya and two thirds of those from Tashkent mentioned using protocols for referrals to medical specialists in their organization. Use of clinical guidelines was reported by 80% to more than 90% of the managers. Protocols describing the use of medical equipment were available in the districts of all respondents from Fergana, three quarters of those from Syrdarya and two thirds of the managers from Tashkent. Compared to the other items, protocols on patients' information were less prevalent, although still around 80% of the managers from Fergana and Syrdarya and half of their colleagues from Tashkent answered positively.

As a consequence, the total scores on the use of protocols and guidelines were high, and even very high for Fergana province.

Table 9: Total score for the use of protocols & guidelines in three provinces

| Region | Score* |
|-----------------------|--------|
| Fergana | 93 |
| Syrdarya | 81 |
| Tashkent | 70 |
| * Maximum score = 100 | |

Further questions were asked about the use of various norms and standards. Some concerned the service aspects or the rights of patients, while others focused on the conditions for the care process. Table 10 shows the results.

Table 10: Use of norms and standards

| Topics | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|---|----------------|----|----------------|----|-----------------|-----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Waiting times for patients | 11 | 69 | 4 | 44 | 8 | 53 |
| • Treatment of patients at the reception desk/telephone | 12 | 75 | 7 | 78 | 8 | 53 |
| • Access of providers to patient medical records | 14 | 88 | 6 | 67 | 13 | 87 |
| • Storage and confidentiality of patient medical records | 9 | 56 | 3 | 33 | 8 | 53 |
| • Access of patients to their own medical file | 15 | 94 | 8 | 89 | 15 | 100 |
| * Percentage of total number of respondents per region as indicated at top of table | | | | | | |

The use of norms for patients' access to their medical records was generally reported by almost all managers. In Fergana and Tashkent, this was also true for health care providers' access to medical records; Syrdarya lagged somewhat behind in this respect. Norms or standards for the treatment of patients at the reception desk or on the telephone were reported to be used by three quarters of the managers from Fergana and Syrdarya and half of those from Tashkent. Norms for waiting times for patients were best applied in Fergana (two thirds), followed by Tashkent (half of the managers), and by 44% in Syrdarya. Explicit norms for the storage and confidentiality of patient records were not widely applied. Only half of the managers from Fergana and Tashkent and one third of those from Syrdarya reported using such norms.

2.3.9 Managers' future plans for quality improvement

The questionnaire asked managers what plans for quality improvement they had for the somewhat longer term of three years. Possible answers were prestructured in the following three groups:

- plans related to the *process of care* (such as improving staff competence, developing internal or external clinical assessments or projects);
- plans related to the *role of patients* or the population (such as promoting health education or organizing patient feedback);
- plans related to *management* (such as strengthening teamwork, improving the quality of information or aspects of human resources management).

Table 11: Managers' quality management plans related to the care process

| Topics | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|---|----------------|-----|----------------|----|-----------------|-----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Improve knowledge and skills of staff | 16 | 100 | 8 | 89 | 14 | 93 |
| • Improve clinical practice by guidelines and protocols | 16 | 100 | 7 | 78 | 15 | 100 |
| • Improve quality of clinical data/ medical records | 15 | 94 | 8 | 89 | 13 | 87 |
| • Introduce internal assessments or audits | 14 | 88 | 8 | 89 | 14 | 93 |
| • Develop small scale quality improvement projects | 13 | 81 | 8 | 89 | 15 | 100 |
| • Update obsolete clinical guidelines or protocols | 14 | 88 | 7 | 78 | 13 | 87 |
| • Develop peer review among physicians | 13 | 81 | 8 | 89 | 12 | 80 |
| • Introduce protocols for interdisciplinary cooperation | 13 | 81 | 4 | 44 | 10 | 67 |
| • Participation in accreditation or external review | 12 | 75 | 4 | 44 | 10 | 67 |
| • Improve medical-technical and other equipment in SVP | 1 | 6 | 0 | 0 | 0 | 0 |
| • Other plans | 2 | 13 | 2 | 22 | 0 | 0 |

* Percentage of total number of respondents per region as indicated at top of table

Overall, managers had many plans to improve the care process during the coming years. Most of the prestructured answers turned out to match their plans: a large majority and sometimes even all of the managers in the three provinces had the intention to address the competence of their staff; to improve clinical practice by means of guidelines and protocols; to improve quality of clinical information; to introduce internal assessments; and to start improvement projects. Updating obsolete guidelines or protocols and developing peer review among physicians were planned by 80% to 90 % of the managers.

More variation was found in the plans for protocols on interdisciplinary cooperation and to participate in accreditation or external assessment. A majority of more than three quarters of the managers in Fergana, two thirds of those from Syrdarya and less than half of those from Tashkent said they had such plans. The medical-technical equipment in primary care facilities seemed to be at the desired level, as only one manager from Fergana had plans to address that.

Some managers took the opportunity to add other than the listed plans: improving CME; training GPs in self-evaluation and problem analysis; better organization of the supervision of GPs; and organization of practical support for primary care facilities.

In the light of the results described previously, these plans raise some interesting points.

Figure 8 shows that managers indicated the wide use of protocols and guidelines, particularly in Fergana. The table above shows that, at the same time, almost all the managers have plans to improve the guidelines and protocols and to address obsolete elements. This suggests that the managers have serious doubts about the quality of the current guidelines and protocols, or at least part of them.

Most managers had plans to develop peer review in their districts. Results from figure 6, however, show that about two thirds of the managers reported that peer review was already taking place in their district. These – seemingly – contradictory results could point to dissatisfaction among managers about the current state of peer review. This dissatisfaction may relate either to the scale of implementation, which may still be limited, or to the poor functioning of peer review groups.

Concerning the plans for internal and external auditing, results described previously show a strong focus on “one-way’ instruments, like inspection and attestation. There seems to be room for a wider approach, including reviews and audits that provide staff and management with feedback information to improve their performance. That may be what managers meant with their plans to improve the quality of clinical data and records.

Table 12: Managers’ quality management plans related to the role of patients / population

| Topics | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|--|----------------|-----|----------------|----|-----------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Improve health education to patients | 16 | 100 | 8 | 89 | 14 | 93 |
| • Introduce patient satisfaction surveys | 15 | 94 | 7 | 78 | 14 | 93 |
| • Implement a complaint procedure for patients | 14 | 88 | 7 | 78 | 12 | 80 |
| • Involve the population in activities | 13 | 81 | 6 | 67 | 12 | 80 |
| • Other plans | 1 | 6 | 2 | 22 | 0 | 0 |

* Percentage of total number of respondents per region as indicated at top of table

Table 12 shows little variation in the managers' answers with regard to their plans for the role of patients or the population. All the listed items fitted into the plans of most managers. With only one exception, about 80% or more of the managers in all three provinces answered positively on these items.

The other plans mentioned by three managers were actually related to health education: increasing the awareness and feeling of responsibility of the population in health matters.

Given that the needs and satisfaction of patients were not frequently monitored (especially in Tashkent) (see table 3), plans to introduce patient satisfaction surveys would seem to fill a gap. However, a number of managers reported that they conducted such monitoring and still had plans for patient satisfaction surveys. Presumably they were not satisfied with the current methods of monitoring.

A similar point arises with patients' complaints. Table 3 shows that such complaints were analysed by three quarters to 90% of the managers, and around 80% also have plans to implement a complaint procedure. Again, it would seem justified to conclude that current procedures should be improved. However, to have conclusive answers, additional observations would be needed.

Table 13: Managers' quality management plans related to the management

| Topics | Fergana (N=16) | | Syrdarya (N=9) | | Tashkent (N=15) | |
|--|----------------|-----|----------------|----|-----------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Improve human resources management | 14 | 88 | 8 | 89 | 13 | 87 |
| • Improve teamwork | 15 | 94 | 8 | 89 | 14 | 93 |
| • Improve efficiency of work and procedures | 16 | 100 | 8 | 89 | 14 | 93 |
| • Improve quality of statistical data for management | 16 | 100 | 8 | 89 | 14 | 93 |
| • Improve motivation of professional staff for improving the quality of care | 15 | 94 | 8 | 89 | 13 | 87 |
| • Introduce job assessment interviews | 13 | 81 | 8 | 89 | 12 | 80 |
| • Allocate more resources for staff training and development | 15 | 94 | 8 | 89 | 12 | 80 |
| • Other plans | 1 | 6 | 1 | 11 | 0 | 0 |

* Percentage of total number of respondents per province as indicated at the top of the table

As with the previous table, there was very little variation in the answers. Almost all the managers planned to do what was given as an option. The fact that so many managers aim to improve human resources management would seem to reflect dissatisfaction with the current procedures. As figure 7 shows, many human resources instruments were said to be used (job evaluation interviews, personal development plans and

monthly job analyses), but the question remains of what is behind these labels. Surveys are not the right instruments to provide such detailed insight.

Plans to introduce job assessment interviews seem to contradict the results shown in figure 7 that most managers did conduct such interviews. Equally, plans to improve the quality of management data and information, reported by almost all managers, do not concord with plans to improve clinical information, or with figure 3, where managers pointed to the poor situation of management information. All managers from Tashkent, more than 80% of those from Fergana and well over half of those from Syrdarya answered that the internal management information was not good.

Other plans mentioned were: to reduce financial dependence on the central authorities; to increase the autonomy of primary care facilities; and to organize training.

2.3.10 Reflections and expectations concerning quality improvement

A number of questions aimed to explore the current thinking of primary care managers about aspects of quality improvement, the role of staff and their own role. Managers could agree or disagree with a set of statements.

For example, the first statement was as follows: “Current CME courses enable my staff to provide better care to patients”. Overall, it seemed that managers were satisfied with the current CME. They almost unanimously answered that they believe it enables their staff to provide better care to patients. Agreement was strongest among the managers from Tashkent. One manager from Fergana, however, strongly disagreed.

The second and third statements were as follows:

Figure 9: Reflections of managers: “Physicians in my organization spend sufficient time improving their professional knowledge and skills”

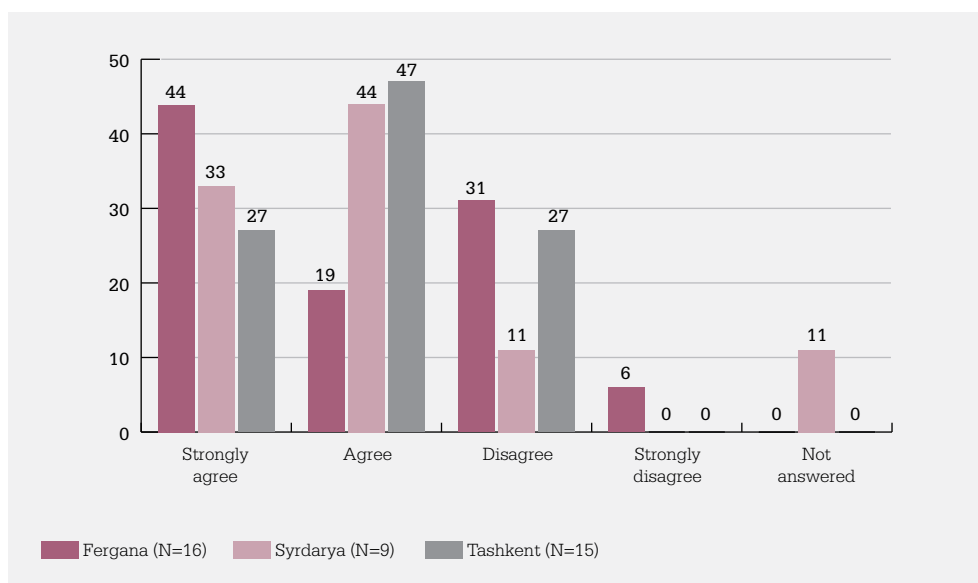
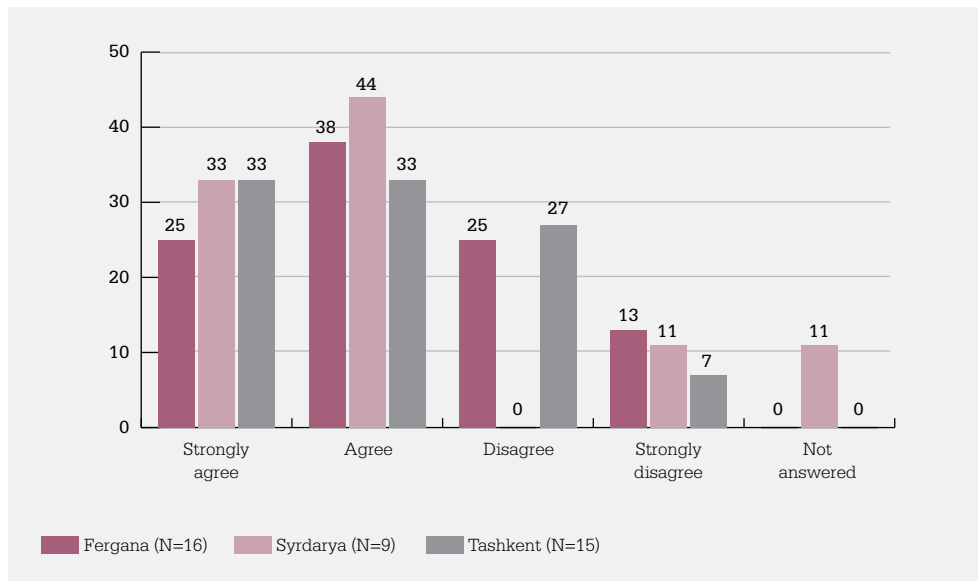
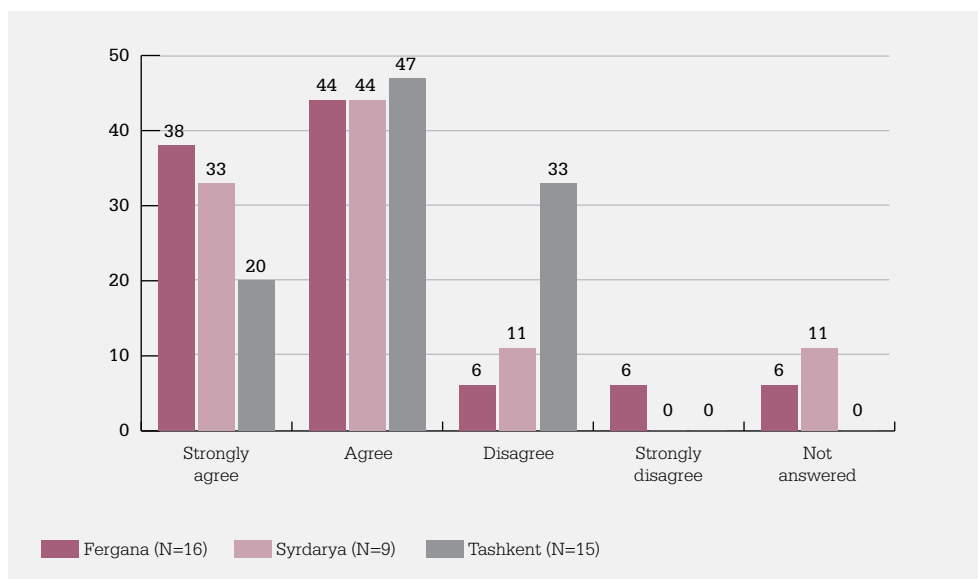


Figure 10: Reflections of managers: “Nurses in my organization spend sufficient time improving their professional knowledge and skills”



Most managers agreed that physicians and nurses in their districts spent sufficient time improving their professional knowledge and skills, but some reservation was evident: about one third of the managers from Fergana and Tashkent disagreed or strongly disagreed with the statement, and slightly more disagreed strongly in respect of nurses in particular.

Figure 11: Reflections of managers “In my organization patients are treated according to latest professional evidence”



Most managers indeed felt that patients in their district are treated according to the latest professional evidence. This conviction, however, is not equally strong among all managers. One third of the managers from Tashkent disagreed.

The outcome on the fifth statement was more homogenous: more than 70% of all managers from all three provinces agreed that “More decentralized decision-making would make my organization more flexible and open to change”. It seemed that Tashkent managers, in particular, felt restricted by the strongly centralized decision-making.

The same or even stronger homogenous agreement among managers was found in response to the sixth statement: “My organization needs a more positive attitude on the part of staff towards innovation”. Managers were quite critical about the attitude of their staff, and – with only one exception – agreed that their organization would need a more positive attitude on the part of staff towards innovation in the future.

Concerning their own role, managers were equally critical. With only one exception, they agreed that they would need more information about modern management approaches to improve the quality of care. The seventh statement was as follows: “As a manager, I need more information about modern approaches to improve my organization”.

In sum, the following can be concluded:

- managers were satisfied about the functioning of CME;
- a minority of managers felt that physicians and nurses should spend more time to keep up to date professionally;
- there was some reservation as to whether patients were treated according to the latest evidence;
- managers felt that more decentralized decision-making would support change management;
- managers thought that the attitude of their staff towards innovation was an obstacle to change;
- lack of information among managers on modern management approaches was seen as an obstacle to better performance.

2.4 Uzbek GPs and quality management: results of the survey

The response among general practitioners (GPs) in the three provinces was excellent (almost 100%). Combined with the random sampling procedure, this has resulted in respondents who are assumed to be highly representative of the population of GPs in the three provinces (the samples were 20% of the GP population in Fergana, and 50% in each of Syrdarya and Tashkent).

2.4.1 Respondents' characteristics

The profiles of the GPs sampled with regard to gender and age in the three provinces were as follows: overall, 42% of the GPs were male and 58% female, but the gender distribution differed between provinces. In Fergana, the proportions between male and female GPs were almost equal, while in Syrdarya and Tashkent, GPs were more often female (two thirds) than male. The average age of the GPs was 43.6 years. In Fergana, GPs were just under this average with 41.6 years and in Tashkent slightly above with 42.5 years. With an average of 47 years, GPs in Syrdarya were the oldest.

With regard to their education, the majority of GPs who responded had completed postgraduate training in general practice: 85% in Fergana, 91% in Syrdarya and 69% in Tashkent. GPs indicated that the duration of their postgraduate training was between 1.3 and 2.2 years. Only a few had completed the (shorter) retraining course (none in Fergana, 8% in Syrdarya and 15% in Tashkent), with an average duration of 17 weeks in Syrdarya and 21 weeks in Tashkent. Nine physicians in Tashkent and one in Syrdarya had not completed any GP training (yet). The question was not answered by 7 respondents in Tashkent and 15 in Fergana, which could mean that they should be added to the numbers not having completed any of the GP (re)training.

Table 14: First specialty of GPs

| First profession | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|------------------|-----------------|------------|-----------------|------------|------------------|------------|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • GP | 14 | 13 | 2 | 2 | 7 | 7 |
| • Therapist | 30 | 28 | 34 | 35 | 36 | 35 |
| • Pediatrician | 57 | 54 | 37 | 38 | 49 | 48 |
| • Gynaecologist | 1 | 1 | 3 | 3 | 2 | 2 |
| • Infectionist | 1 | 1 | 2 | 2 | 1 | 1 |
| • Dentist | 0 | 0 | 11 | 11 | 2 | 2 |
| • Surgeon | 1 | 1 | 3 | 3 | 5 | 5 |
| • Other | 1 | 1 | 5 | 5 | 1 | 1 |
| • Not answered | 1 | 1 | 0 | 0 | 0 | 0 |
| Total | 106 | 100 | 97 | 100 | 103 | 100 |

Since general practice is a relatively recent postgraduate programme, GPs were asked about their first speciality (which could of course also be general practitioner). Less than 10% of the GPs had no previous speciality: 13% in Fergana, 2% in Syrdarya and 7% in Tashkent. This probably represents the younger generation of newly graduated GPs. By far most GPs, more than 70% in each of the provinces used to be either a district physician (internal medicine specialist) or a paediatrician. Paediatricians outnumbered internal medicine specialists. Other first specialties were mentioned infrequently. In Tashkent 5% used to be surgeons and 11% of the GPs in Syrdarya were former dentists

(in the countries of the former Soviet Union, dentistry or stomatology is a postgraduate medical education).

In line with the previous results related to work experience, it appeared that the responding GPs had relatively little experience directly as GPs, but much more as paediatricians or internal medicine specialists. Respondents in Tashkent had about four years experience as GPs and those in Syrdarya six years, usually at the same place as they were currently working. In Fergana, GPs had seven years experience on average and, for some of them, their current working place as a GP was not their first. Before being GPs, respondents had 13 to 18 years of experience as paediatricians or internal medicine specialists.

Table 15: Staff mix

| | Fergana (N=106) | Syrdarya (N=97) | Tashkent (N=103) |
|---------------------------------|-------------------|-------------------|-------------------|
| Type of staff | Mean no. of staff | Mean no. of staff | Mean no. of staff |
| • GPs | 1,6 | 1,3 | 2,6 |
| • Pediatrician | 1,1 | 1,0 | 1,8 |
| • Internal medicine specialists | 1,1 | 1,0 | 1,5 |
| • Nurses | 16,8 | 7,0 | 11,2 |
| • Other (para) medical staff | 3,2 | 2,6 | 2,2 |
| • Other staff | 4,5 | 3,9 | 2,6 |

In terms of total staff, the primary care units were relatively large organizations, varying from an average of 17 in Syrdarya to 28 in Fergana. The number of physicians per unit was between three and four in Fergana and Syrdarya and about six in Tashkent, indicating that primary care units in Tashkent were better staffed with physicians than in the other two provinces. Usually, GPs were (still) working in the same unit as an internal medicine specialist and a paediatrician. We have no information about the division of tasks between GPs, internal medicine specialists and paediatricians. Nurses, who carry out a variety of administrative and nursing tasks, made a substantial part of the teams, from 42% in Syrdarya and 51% in Tashkent to 59% in Fergana.

Table 16: Practice location

| Type of location | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|------------------------|-----------------|------------|-----------------|------------|------------------|------------|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Inner city | 0 | 0 | 0 | 0 | 1 | 1 |
| • Suburban area | 4 | 4 | 3 | 3 | 7 | 7 |
| • Small town (<50.000) | 1 | 1 | 2 | 2 | 0 | 0 |
| • Rural | 101 | 95 | 91 | 94 | 95 | 92 |
| • Not answered | 0 | 0 | 1 | 1 | 0 | 0 |
| Total | 106 | 100 | 97 | 100 | 103 | 100 |

In Uzbekistan, primary care reform started with the introduction of GPs in SVPs, which are in rural areas. So far, only a few GPs have been recruited to the family medicine centres and polyclinics in suburbs and cities. So, with only a few exceptions, respondents were working in rural areas.

2.4.2 Involvement in quality improvement activities

From a list of activities contributing to the improvement of quality management in primary care, GPs were asked to indicate which they had been involved in over the past 12 months. Activities were grouped according to their nature as being more informal and nonobligatory (table 17), or more formal or embedded in the organization of primary care (table 18).

Table 17: Involvement in *informal* quality improvement activities

| Type of activity: | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|---|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Incidental consultation of a colleague when in doubt about diagnosis or treatment | 102 | 96 | 95 | 98 | 101 | 98 |
| • Planning organizational improvements in practice management | 98 | 92 | 96 | 99 | 90 | 87 |
| • Planning improvements in identification, diagnosing, or treatment of disease/category of patients | 102 | 96 | 93 | 96 | 89 | 86 |
| • Reading professional journals (at least 2x per month) | 97 | 92 | 92 | 95 | 92 | 89 |
| • Any scientific research or publication in practical work | 32 | 30 | 66 | 68 | 50 | 49 |
| • Reading professional information on the internet (at least 2x per month) | 18 | 17 | 13 | 13 | 27 | 26 |

* Percentage of total number of respondents per region as indicated at top of table

Incidental consultations of colleagues, or making plans for organizational improvements or improvements in the clinical process were reported as being part of the normal activities of all GPs. Reading professional journals at least twice a month was also routine. Conducting practice-based research and writing publications were mentioned by two thirds of the GPs in Syrdarya, half of those in Tashkent and one third of those in Fergana. For an activity that is not essential to the clinical care process, these percentages are relatively high. It would be worth finding out what the subjects of this scientific work are and what is done with the outcomes. The Internet is only sparsely used as a source of professional information.

As found from the survey of managers, inspection of medical files by a chief doctor was the structured or formal mechanism mentioned most frequently by GPs. However, almost all GPs mentioned more structured activities such as: planning of quality improvement with support from an external institution; regular use of standards for teamwork with a nurse, developing a protocol with colleagues; regular peer review

sessions; and small group discussions with colleagues. Involvement in audits in the past 12 months was mentioned by 72% to 90% of the GPs in Fergana and Syrdarya; in Tashkent, 67% had been involved in internal audits and 54% in external audits. Two thirds to three quarters of the GPs reported having developed a clinical guideline with colleagues. About half of the GPs reported that they attended CME courses at least twice per year. More than half of the GPs had been involved in conducting a patient satisfaction survey.

Table 18: Involvement in structured / formal quality improvement activities

| Type of activity: | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|---|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Inspection of medical files by a chief or executive | 104 | 98 | 94 | 97 | 96 | 93 |
| • Planning of Quality Improvement with involvement of non-medical institution | 96 | 91 | 94 | 97 | 90 | 87 |
| • Regular use of standards for team-work with a nurse | 98 | 92 | 91 | 94 | 86 | 83 |
| • Developing treatment protocol(s) with colleagues from same centre | 94 | 89 | 86 | 89 | 76 | 74 |
| • Regular meetings for peer review | 96 | 91 | 89 | 92 | 78 | 76 |
| • Regular discussion with a small group of colleagues about clinical work | 98 | 92 | 87 | 90 | 79 | 77 |
| • Internal audit (internal assessment of aspects of clinical work) | 88 | 83 | 86 | 89 | 69 | 67 |
| • External audit (assessment of clinical work by external assessors) | 76 | 72 | 78 | 80 | 56 | 54 |
| • Developing a clinical guideline with colleagues from same centre | 76 | 72 | 73 | 75 | 67 | 65 |
| • Attending courses for continuing medical education (at least 2x per year) | 52 | 49 | 55 | 57 | 57 | 55 |
| • Conducting a patient satisfaction survey | 55 | 52 | 56 | 58 | 58 | 56 |

* Percentage of total number of respondents per region as indicated at top of table.

Results on the involvement of GPs in informal and structured quality improvement give a positive picture. Quality improvement is much more than a one-way process of inspection and transfer of knowledge; GPs seem to be actively working on different aspects of the quality of their services. These answers, however, also raise new questions, for instance, about the details of the activities and the GPs' involvement, the time spent on them and the methods used, and, last but not least, their effect on the quality of the care provided.

2.4.3 Use of clinical guidelines

The use of guidelines has the potential to reduce undesirable differences in clinical activities. GPs were asked whether they were regularly using guidelines (defined as scientifically based statements to help to decide about providing good care). For the acceptance and effective use of guidelines among GPs the way they are drafted and introduced are important. Guidelines developed with major (consensus) inputs from practising GPs, and that are implemented in a user-friendly way (for instance, linked to CME, or electronically accessible), and made easily available to GPs appear to be more readily adopted than guidelines developed by medical specialists only and distributed without follow-up. Results on the use and mode of production of clinical guidelines and the way they were introduced in Uzbekistan are reported in the following tables.

Table 19: Use of clinical guidelines

| | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|--------------------------------------|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Regular use of clinical guidelines | 104 | 98 | 94 | 97 | 88 | 85 |

* Percentage of total number of respondents per region as indicated at top of table.

Table 19 reflects a very high percentage of GPs using clinical guidelines on a routine basis in all three provinces – with Fergana and Syrdarya almost reaching a 100%.

All guidelines were issued by the Ministry of Health and are usually scientifically based (see table 20). However, in addition, elements of consensus (either internal or external) were reported to be part of the procedure by a majority of the GPs, especially in Fergana and Syrdarya. There were also guidelines of foreign origin, which were probably implemented in the context of donor-funded projects. Between half and two thirds of the GPs answered that clinical guidelines were imported from abroad.

Table 20: Mode of drafting of clinical guidelines

| Mode of production | Fergana (N=104) | | Syrdarya (N=94) | | Tashkent (N=88) | |
|--|-----------------|-----|-----------------|----|-----------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Issued by the Ministry of Health | 104 | 100 | 92 | 98 | 84 | 95 |
| • By a consensus procedure in your centre | 64 | 62 | 50 | 53 | 39 | 44 |
| • By a consensus procedure outside your centre | 72 | 69 | 68 | 72 | 42 | 48 |
| • By a scientific procedure in your country | 89 | 86 | 83 | 88 | 73 | 83 |
| • Imported from abroad | 64 | 62 | 54 | 57 | 41 | 47 |

* Percentage of total respondents per region who regularly use clinical guidelines. These totals are indicated at top of table.

Table 21 suggests that there is follow-up after the distribution of clinical guidelines. A large majority of the GPs answered that background information was provided and that they were trained to work with the guidelines as well. Moreover, in Fergana and Syrdarya, feedback on performance using the guidelines was usually provided by a supervising physician. Such follow-up was reported by only half of the GPs from Tashkent.

Table 21: Mode of introduction of clinical guidelines

| Mode of introduction | Fergana (N=104) | | Syrdarya (N=94) | | Tashkent (N=88) | |
|--|-----------------|----|-----------------|----|-----------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Provided on paper | 101 | 97 | 89 | 95 | 79 | 90 |
| • Background information on the guidelines was provided | 84 | 81 | 73 | 78 | 63 | 72 |
| • Physicians were trained to work with the guidelines | 97 | 93 | 90 | 96 | 75 | 85 |
| • Supervisor provided feedback to GP on performance on the guideline | 90 | 87 | 77 | 82 | 45 | 51 |

* Percentage of total respondents per region who regularly use clinical guidelines. These totals are indicated at top of table.

2.4.4 Perceived opportunities for improvement

GPs were asked about opportunities they see for improving their work on a large number of aspects, for example, related to the following areas (see tables 22 to 27 structured accordingly):

- delivery of care
- information and communication
- cooperation and teamwork
- service aspects: opening hours and convenience
- general competence and motivation of staff in health care
- quality management structures and procedures in health care.

Table 22: Opportunities to improve the GP's functioning: *delivery of care*

| Aspects of care | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|--|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Diagnostic process | 95 | 90 | 92 | 95 | 99 | 96 |
| • Prescribing medicines | 91 | 86 | 85 | 88 | 91 | 88 |
| • Clinical care for patients with hypertension | 92 | 87 | 89 | 92 | 89 | 86 |
| • Clinical care for patients with asthma | 93 | 88 | 89 | 92 | 92 | 89 |
| • Clinical care for patients with depression | 93 | 88 | 91 | 94 | 88 | 85 |
| • Clinical care for elderly patients | 95 | 90 | 86 | 89 | 91 | 88 |
| • Clinical care for children under 6 | 90 | 85 | 91 | 94 | 95 | 92 |
| • Maternity care | 94 | 89 | 91 | 94 | 94 | 91 |
| • Minor surgical procedures | 92 | 87 | 86 | 89 | 80 | 78 |

* Percentage of total number of respondents per region as indicated at top of table.

Results in table 22 show a general wish among the GPs to improve many aspects of their clinical care, including diagnostics, drug prescriptions, care for various groups of patients and minor surgery. Without exception, the aspects listed in the table were adopted as topics for improvement by almost all GPs in the three provinces.

Table 23: Opportunities to improve the GP's functioning: *providing information and communication*

| Aspects of information/communication | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|---|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Giving information to patients about disease and treatment | 86 | 81 | 86 | 89 | 85 | 83 |
| • Giving information to patients about self care or staying healthy | 93 | 88 | 88 | 91 | 90 | 87 |
| • Communication with patients | 86 | 81 | 82 | 85 | 82 | 80 |
| • Keeping medical records | 81 | 76 | 88 | 91 | 86 | 83 |

* Percentage of total number of respondents per region as indicated at top of table.

Few GPs seemed to be confident with their handling of aspects of information and communication with patients. Most of them would like to provide patients with better clinical information and treatment details and improve health education. Improvement of medical record-keeping was mentioned as a priority by most GPs.

Table 24: Opportunities to improve the GP's functioning: cooperation and teamwork

| Aspects of cooperation/teamwork | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|--|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Referrals to medical specialists | 85 | 80 | 78 | 80 | 78 | 76 |
| • Teamwork with nurses in primary care | 88 | 83 | 91 | 94 | 91 | 88 |

* Percentage of total number of respondents per region as indicated at top of table

The process of referral to specialists in secondary care was an area that could be improved, according to 80% of the GPs in Fergana and Syrdarya and 76% of those in Tashkent. Improving teamwork with nurses in their own practice was a priority for 83% of the GPs in Fergana, 88% of the GPs in Tashkent and 94% of those in Syrdarya.

Table 25: Improve the convenience of the practice building for patients

| Aspects of patient access/service | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|---|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Working times | 78 | 74 | 75 | 77 | 77 | 75 |
| • The convenience of the practice building the patients | 89 | 84 | 93 | 96 | 80 | 78 |

* Percentage of total number of respondents per region as indicated at top of table

GPs seemed to be dissatisfied with service aspects of their primary care unit. Three quarters of the GPs in the three provinces would like the opening hours to be more patient-friendly. Three quarters of the GPs in Tashkent, 84% of those in Fergana and 96% of those in Syrdarya would like their premises to be more convenient for patients. Since these aspects are beyond the responsibility of individual GPs, and come under the competence of the managers or health authorities, it is the latter who need to address them.

Table 26: Opportunities to improve health care services: competence and motivation

| Aspects of staff competence/information | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|---|-----------------|-----|-----------------|-----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Improving knowledge and skills | 106 | 100 | 97 | 100 | 100 | 97 |
| • Strengthen the motivation of professionals for improving care by improving incentives | 99 | 93 | 96 | 99 | 100 | 97 |
| • Allocate more resources for staff training | 104 | 98 | 97 | 100 | 101 | 98 |

* Percentage of total number of respondents per region as indicated at top of table

GPs were asked whether the changes listed in table 26 would help to improve health services. Practically all GPs answered that better knowledge and skills would have a positive impact and that – therefore – more resources should be allocated for training of staff. They also generally seemed to acknowledge that the motivation of health care professionals for care improvement left something to be desired, and that better incentives should be introduced to change the situation.

Table 27: Opportunities to improve health care services: quality management procedures and structures

| Aspects of quality management projects and procedures | Fergana (N=106) | | Syrdarya (N=97) | | Tashkent (N=103) | |
|--|-----------------|----|-----------------|----|------------------|----|
| | Abs. | %* | Abs. | %* | Abs. | %* |
| • Introduction of clinical guidelines and protocols | 103 | 97 | 95 | 98 | 98 | 95 |
| • Introduction of external assessments or examinations | 75 | 71 | 83 | 86 | 71 | 69 |
| • Introduction of internal assessments or audits | 95 | 90 | 87 | 90 | 80 | 78 |
| • Starting small scale quality improvement projects | 99 | 93 | 93 | 96 | 88 | 85 |
| • Updating obsolete clinical guidelines or treatment protocols | 101 | 95 | 94 | 97 | 93 | 90 |
| • Improving and reducing the reporting system | 77 | 73 | 93 | 96 | 100 | 97 |
| • Introduction of protocols for teamwork | 94 | 89 | 90 | 93 | 90 | 87 |
| • Conducting peer review among colleagues | 94 | 89 | 88 | 91 | 94 | 91 |
| • Introduction of patient satisfaction research | 99 | 93 | 95 | 98 | 97 | 94 |
| • Introduction of a complaint procedure for patients | 94 | 89 | 92 | 95 | 93 | 90 |

* Percentage of total number of respondents per region as indicated at top of table

Finally, GPs were asked whether their future care for patients would benefit from the implementation of the procedures and mechanisms as listed in table 27. There were only small differences in the distribution of answers between the GPs from the three provinces – and only very little variation in the priorities set on the different procedures and mechanisms (formal and informal) listed. Overall, GPs voted that more guidelines and protocols should be introduced or updated, as should peer reviews; internal and external assessment mechanisms should be introduced; innovation projects started; and feedback from patients collected systematically by means of satisfaction surveys and complaint procedures. GPs were also critical about the current system of medical reporting. Almost all the GPs from Syrdarya and Tashkent and three quarters of those from Fergana wanted to have a more efficient reporting system.

Comparing these answers to those given in the previous sections, it can be concluded that the quality management procedures and structures that the GPs think are ben-

eficial to health care in general are also those in which they reported being closely involved.

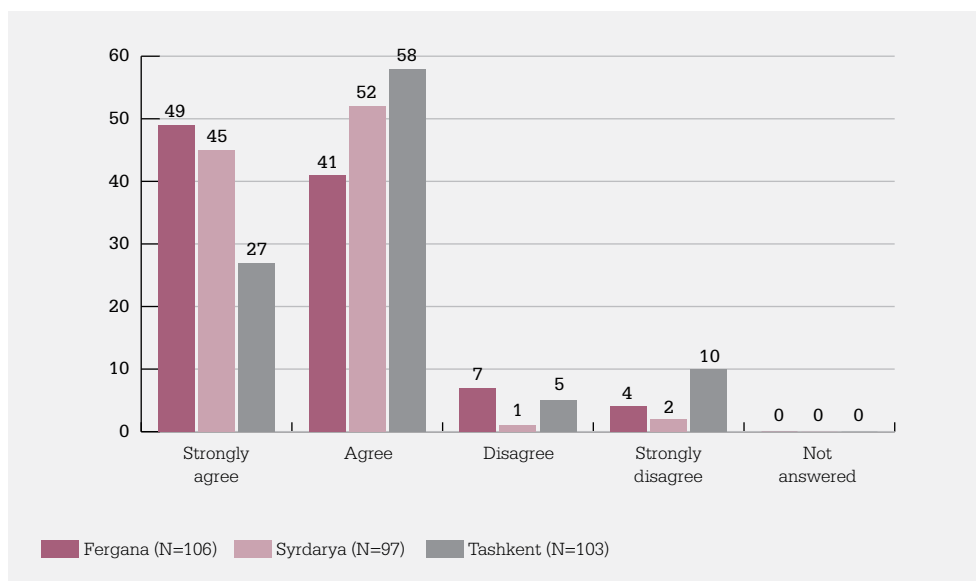
The results given in tables 22 to 27, in particular the lack of variation in the answers, were somewhat puzzling and raised questions that cannot be fully answered on the basis of these data. A large majority of GPs answered they would like to improve almost every aspect of their work, including clinical care; their communication with patients; the referral process; convenience of the facility; their competence and motivation; and various mechanisms and procedures used to assure quality. This is remarkable, since most GPs have many years of medical experience, have completed a postgraduate or retraining programme, are heavily involved in informal and obligatory quality management activities, and generally apply the official clinical guidelines. Further investigation may be needed, but some preliminary interpretation of the results can be made here. Firstly, the answering tendency was too strong to be credibly understood as a general positive attitude on the part of GPs towards change and improvement. A more plausible explanation is that these results point to widespread dissatisfaction among GPs, primarily with the quality of their own work, but also with the facilities and the mechanisms and procedures currently used in (primary) health care. Although the origins of such dissatisfaction are not clear, they can be inferred from the kind of feedback usually communicated to GPs, focusing more on imperfection than on elements of good performance. Furthermore, the lack of balance in the GPs' answers could point to a lack of knowledge and information of what quality and quality improvement are really about and what they means for their professional work. It takes time – and information – to be capable of professional self-evaluation and to distinguish between what is going well and what could be improved. The one-sided way of answering probably showed that the GPs are not (yet) able to set their priorities for improvement.

2.4.5 Reflections of GPs on conditions for quality improvement

A number of questions aimed to explore the current thinking among GPs about aspects of quality improvement and their own role, as well as the roles of patients and supervisors. GPs could express their agreement/disagreement with a given statement by ticking on a four-point scale, as outlined in the following figures. Some of the questions were also put to the managers.

The first statement, which was also put to the managers, was: “Current continuing medical education courses help me to provide better care for my patients”. GPs and managers agreed that CME courses contributed to better care provision. GPs from Fergana and Syrdarya felt the positive effects of the courses more strongly than their colleagues in Tashkent. In Tashkent, there was a discrepancy between GPs and their managers. Among the managers, those from Tashkent were most positive about CME while, among the GPs, those from Tashkent were most reserved.

Figure 12: GPs' reflections: "I spend sufficient time on various activities to improve my professional skills"



Overall, GPs considered that they spent sufficient time improving their skills. The GPs from Fergana supported the statement more strongly than those from Syrdarya. Agreement with the statement was weakest in Tashkent, where 15% of the GPs (strongly) disagreed. Although the statement in the questionnaire to managers was not identical (it mentioned “knowledge and skills”), there is sufficient ground for comparison. The pattern of differences between the provinces found among the managers is more or less similar to the pattern among the GPs, although the general level of agreement was weaker among managers – managers were more often of the opinion that GPs could spend more time on improving their skills. In Fergana, for instance, one third of the managers disagreed with the statement; in Tashkent, the figure was a quarter and in Syrdarya 11%.

In response to the third statement, “My patients are treated by me according to the latest professional evidence”, GPs had little doubt that this is the case and answered accordingly. The agreement was however less strong in Tashkent, where 13% disagreed. Comparison with managers’ answers on the same subject shows them to be less convinced about the evidence-based orientation of their GPs. Fewer managers strongly agreed with the statement. Among the Tashkent managers, one third actually disagreed with the statement.

The fourth statement was: “More decentralized decision-making would make primary care more flexible and open”. Overall, GPs and managers in primary care seem to see decentralization as a mean of enhancing flexibility and openness. In Syrdarya and Tashkent, equally high proportions (around 80%) of both GPs and managers agreed on this. In Fergana, there was some discrepancy between the groups; the agreement among GPs (88%) was higher than among the managers (75%).

The fifth statement asked GPs whether they would be interested in “changing their work according to new insights”. Quite expectedly, less than 10% of the GPs disagreed

with the statement. Agreement was stronger in Fergana than in the two other provinces. These answers seem to conflict with the managers' response to the statement: "My organization needs a more positive attitude on the part of staff towards innovation" (see chapter 2.3.10).

Figure 13: GPs' reflections: "Supervisors in health care should give encouragement rather than opposition or sanctions"

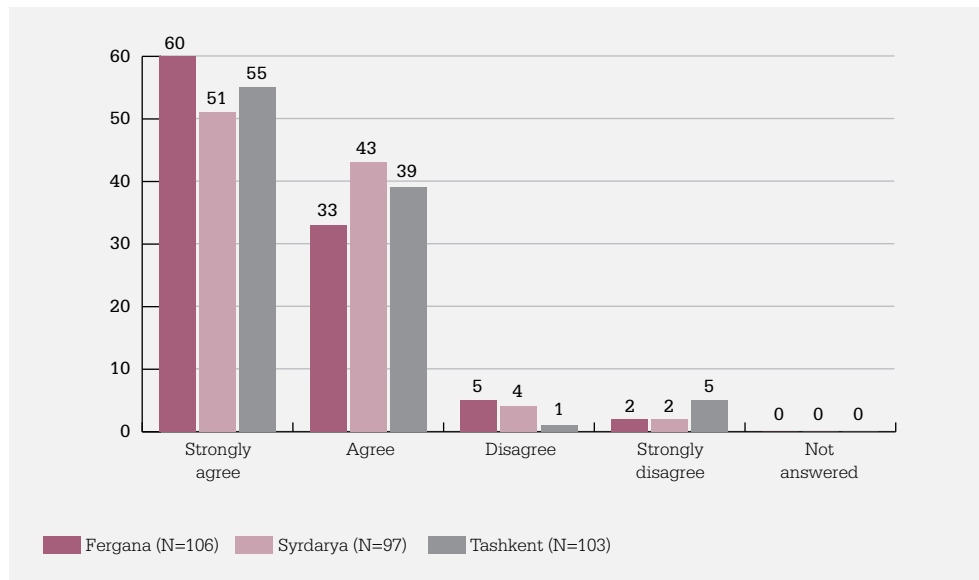
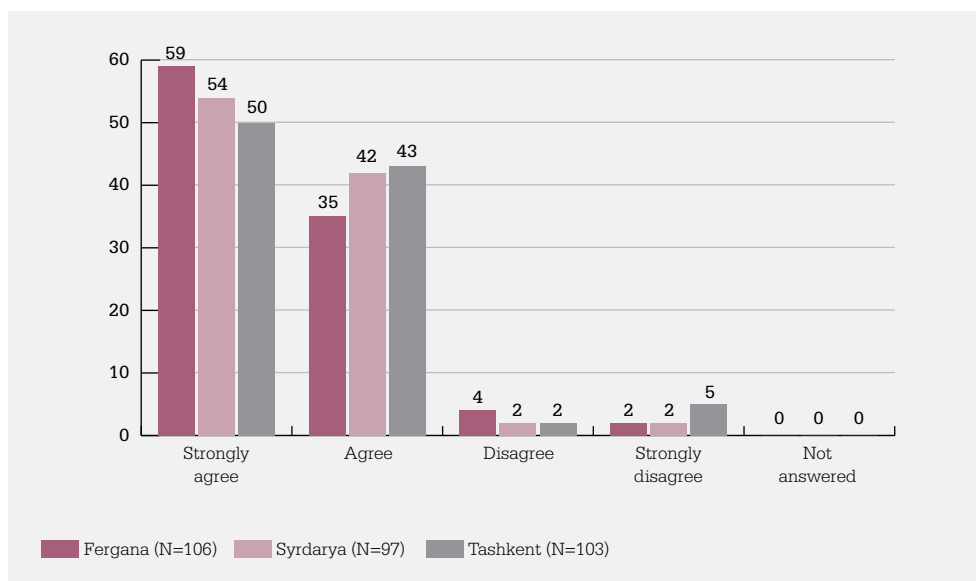


Figure 13 is another issue on which GPs and managers are likely to have different opinions. With few exceptions, GPs agreed, and most of them strongly, that health care supervisors should give encouragement rather than opposition or sanctions. GPs clearly criticized their supervisors' management style, which they seemed to experience as too punitive. Punitive management is not compatible with quality improvement mechanisms, which are based on professional autonomy and individual professional development.

Figure 14: GPs' reflections: "More active involvement of patients will help improve primary care"



The last statement asked GPs about the role of patients. GPs generally see patients as possible partners in quality improvement. More than 90% of all GPs in the three provinces (strongly) agreed that more actively involved patients could help to improve primary care.

In sum, the following can be concluded from the results presented in this section:

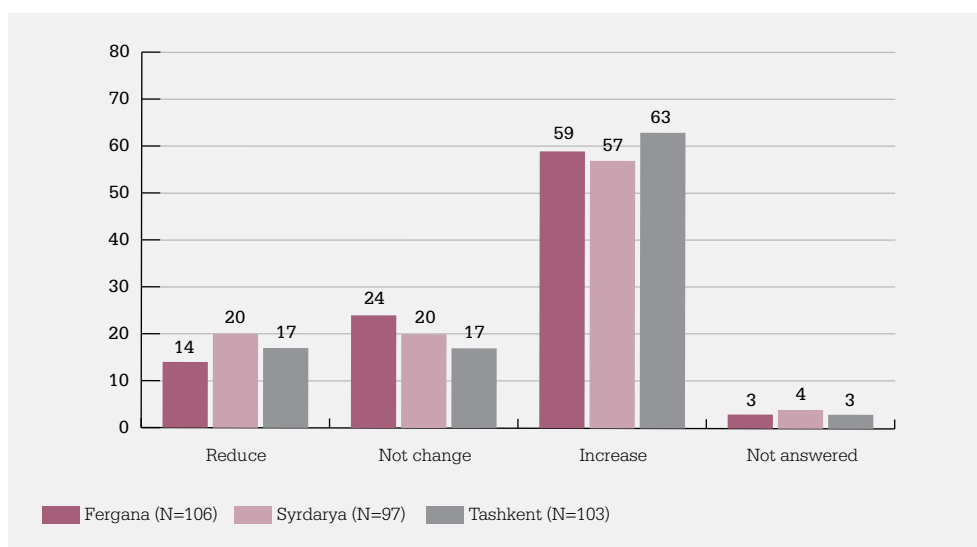
- GPs agreed with their managers about the positive contribution of CME courses to the quality of care;
- GPs were more strongly convinced than their managers that they spend sufficient time on keeping up to date;
- GPs had little doubt that their treatment of patients is in line with the latest evidence; managers were slightly more reserved on this point;
- GPs and managers agreed about the beneficial effects of decentralization on primary care;
- Opinions of GPs and managers clashed on the perceived attitudes of GPs to innovation;
- GPs seemed to perceive the management of their supervisors as punitive rather than as stimulating;
- GPs see more active patients as allies in improving primary care.

2.4.6 Expected effects of quality improvement activities

This last section deals with GPs' answers to a number of statements reflecting possible expectations related to quality improvement activities in their practices.

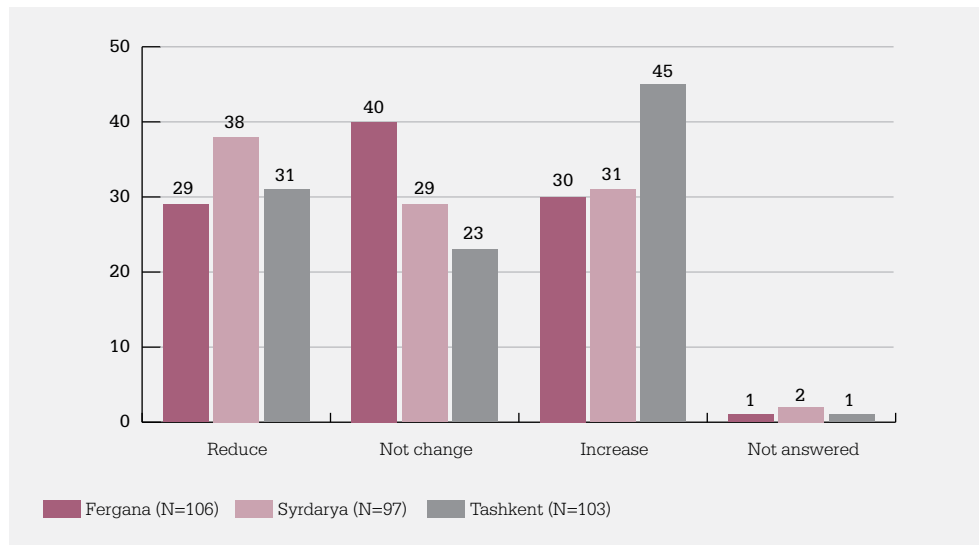
GPs almost unanimously (93%) expected that quality improvement in their practices would result in more satisfied patients. They were almost equally sure (87%) that quality improvement would have a positive effect on their own satisfaction and the satisfaction of other staff in their practices. Concerning the impact of quality improvement activities on the workload of staff, around 60% of the GPs in the three provinces estimated that workload would increase. Between 14% (in Fergana) and 20% (in Syrdarya) said they expected a reduction in workload and the rest expected no change (figure 15)

Figure 15: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, the workload of staff will:"



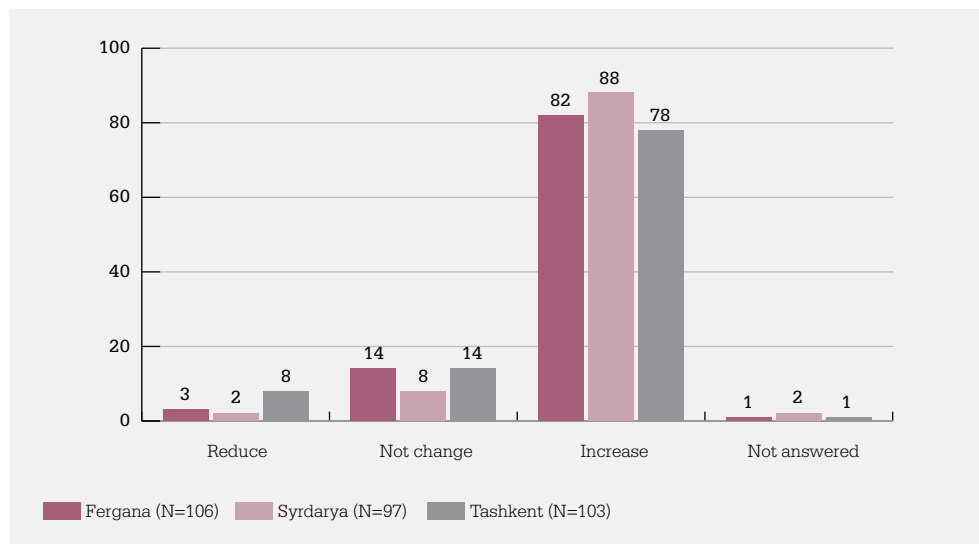
GPs were quite divided in their expectations of the impact of quality improvement activities on the time they spend on administrative work (figure 16). Roughly one third expected it would result in more time spent on administration; another third expected a reduction in that time and the remaining third did not expect any change. The proportion of GPs expecting an increase was higher in Tashkent (45%) than in the two other provinces (around 30%).

Figure 16: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, time spent on administrative work will:"



GPs had high expectations of the possible positive effect of quality improvement activities on their professional freedom (see figure 17). Only very few GPs (8% in Tashkent, 3% in Fergana and 2% in Syrdarya) expected a reduction in professional freedom as a result of the introduction of quality improvement mechanisms.

Figure 17: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, professional freedom of staff will:"



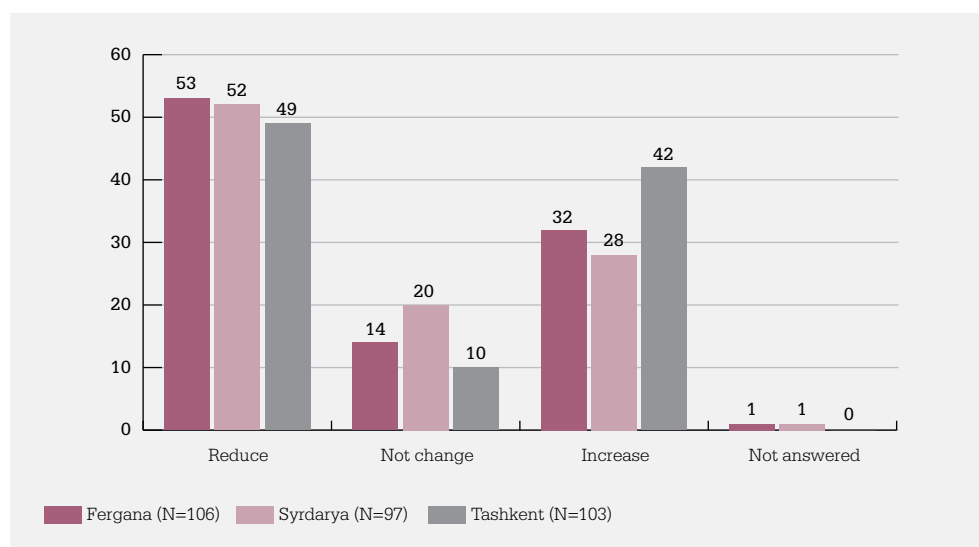
Another very clear expectation expressed by the GPs concerns the impact of quality improvement activities on the reputation of primary care. In Tashkent, 83% of the GPs expect the reputation of their organization to improve as a result of quality improve-

ment activities; in Fergana and Syrdarya, the proportions were 92% and 93% respectively.

Likewise, GPs were very clear and united in their expectations of quality improvement on the population's health outcomes: 95% expect them to improve.

The last statement that GPs were asked to comment on was on the impact of quality improvement activities on expenditure. Here, however, GPs were more divided (figure 18). In each province, about half of the respondents said that they expected a reduction in practice costs as a result of quality improvement activities. On the other hand, there were also substantial proportions who expected an increase in these costs: 28% in Syrdarya, 32% in Fergana and 42% in Tashkent. Between 10% and 20% of the GPs expected quality improvement to have no effect on practice costs.

Figure 18: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, costs will:"



In sum, the GPs' expectations of quality improvement are:

- patients will definitely be more satisfied
- staff will also be more satisfied
- most GPs expected their workload to increase
- GPs were divided on the expected effect on their administrative duties
- professional freedom was generally expected to increase
- the reputation of primary care services was expected to improve
- practically all GPs expected positive effects on the population's health outcomes

- GPs had different expectations concerning the effects on practice costs.

These results show a mix of optimism and realism among GPs. GPs were very optimistic about the effect of quality improvement on satisfaction of patients and staff, and on health outcomes of the population. On the other hand, their expectations concerning their own workload, administrative work and practice costs were balanced and reflected realistic and pragmatic views. Probably the expectations of GPs were more realistic than those of the managers, as reported in chapter 2.3.10.

2.5. Lessons learned from the pilot project

The following observations and lessons learned are based on the experiences of the team members involved in the pilot implementation in Uzbekistan and Slovenia – as well as of the international experts who reflected on the draft report during the review meeting in April 2008 in Copenhagen.

Lessons learned

- Three questionnaires (national level, managers, GPs), which together form the draft Primary Care Quality Management Tool, have been discussed by national experts in Slovenia and Uzbekistan, and subsequently successfully tested in surveys in those countries.
- Based on the experiences from the pilot implementation and the extensive feedback given during the international review meeting in Copenhagen, the following major changes have been made to the Tool for its future use:
 - » in general, questions have been made more factual; questions asking for opinions have been removed or rephrased;
 - » the sequence of topics and questions has been reordered;
 - » the character of the national level questionnaire has been changed from a questionnaire for stakeholders to a questionnaire/template for a background document to be prepared by a small team of experts;
 - » the questionnaires for managers and GPs have been reduced in size, for instance, by removing questions considered to be outside the scope of GPs or managers;
 - » the consistency of terminology and wording throughout the questionnaires has been improved.
- The sensitivity of the instrument could be improved if the quantitative elements (questionnaires) were supplemented with qualitative methods. New sources of information might include group interviews with managers and primary care workers, additional inspection of documents, direct observations and site visits. These additional approaches would help to clarify questions remaining after the quantitative analyses, compensate for possible low rates of response and thus improve the validity of the Tool.
- If the population (and therefore the response) of primary care managers is small in the selected regions, the sample should preferably be extended by including managers from other regions. If, nevertheless, a small number of respondents is expect-

ed, it may be preferable not to conduct a survey but, rather, to collect data in another way (for instance, by means of group interviews).

- In an early stage of the Tool's application in a Member State, a check is needed to determine whether terms and answer categories in the questionnaires are adequate. Possible adaptations need to be made before translation.
- The applicability of the Tool could be further improved by extending the generic core with a variable section that would take the local primary care policy priorities in Member States into account.
- Correct translation of the Tool, using to a check and double-check procedure, is essential. Both linguistic and health care expertise are required.
- In general, the following data collection methods can be identified for the surveys:
 - » postal survey (with or without postal or telephone follow-up);
 - » survey via the internet;
 - » distribution and collection of questionnaires via instructed local health care officials (for instance, chief physicians in districts);
 - » transfer and collection of questionnaires via the appropriate organization in the health administration;
 - » distribution and collection of questionnaires via trained fieldworkers;
 - » distribution and collection of questionnaires via the network of professional associations;
 - » involvement of nongovernmental organizations.
- The choice of data collection method is related to available resources and local circumstances. In Uzbekistan, where health care is hierarchically structured and lines of communication are clear, it was obvious that these health administration structures should be used to implement the surveys (particularly since postal surveys were very unusual there). The Slovene health care system is more loosely structured. Furthermore, postal surveys are not unusual.
- It has an added value if, within a country, the Tool is implemented in contrasting regions or areas. These regions may differ, for instance, in terms of the stage of primary care reform or the model of provision. The choice of regions or areas should be explicitly discussed. The selection of regions for comparison should be driven by relevant questions related to health policy, reform processes, different modes of provision, etc. The formulation (at the beginning of the project) of expected differences between regions may serve as a reference for the interpretation of results and offer a starting point for follow-up activities.
- Successful implementation of the Tool, including the dissemination of results and follow-up activities, depends on the involvement and commitment of stakeholders. Although the ministry of health will usually play a leading role, organizations representing health care professionals, health insurers, patient organizations, donors and others should be involved. The more stakeholders are able to contribute, the richer and more useful the information generated by the Tool will be.

- The pilot studies in Slovenia and Uzbekistan showed clearly that the surveys had a wider impact than simply in terms of data collection. Introduction of the activities at central, regional and local levels involved information transfer and awareness-raising on issues of quality in primary care. The more intensive the approach and the more personal the way in which the surveys were introduced, the stronger the action effect achieved.

Limitations of the Tool

- The Tool relies strongly on self-reported behaviour, rather than on direct observations or registrations. The resulting information may be biased and may not correctly reflect the real situation. Attempts have been made to reduce this bias. Revisions of the Tool have been made with the explicit aim of reducing a positive answering tendency. However, this still cannot be excluded. As a counterbalance, additional observations, checks and interviews have been included in the revised Tool. Quantitative results from the surveys can be validated by these additional measures.
- The focus of the Tool is on structures and mechanisms meant to control or manage the quality of staff and services in primary care. The Tool is not about quality of care itself, and therefore quality indicators have no prominent role in the Tool. Structures examined by the Tool are usually not visible to patients, and for that reason a patient survey is not part of the Tool.
- Since health reforms are much more comprehensive than the topics covered by the PCQM Tool, the results produced should not be considered as a way of monitoring those reforms. Such monitoring would require the collection of much more varied data.

The fundamental revision of the tool and the many suggestions and lessons for its future use are valuable outcomes of the project.

3 MAIN POINTS AND RECOMMENDED ACTIONS

| UZBEKISTAN: main points | |
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| National level / expert group | |
| <ul style="list-style-type: none"> • Primary health care reforms | <ul style="list-style-type: none"> • The 1996 Law on Health Protection set the first guidelines for health sector reform, which were detailed in the 1998 master plan, covering the period until 2005. Its targets were the development of a network of rural and urban medical centres, the improvement of health workforce and medical education, and changes to the health financing scheme. • The Health 1 project (1998-2005), implemented in collaboration with the World Bank, has resulted in a major restructuring of primary care. New schemes for the financing, delivery and management of primary care have been piloted and facilities upgraded. The Institute of Health and training centres for general practice have been established. Medical education became subject to accreditation, and a licensing scheme was introduced for professionals. Payment in primary care became based on capitation. • The Health II project (2005-2010) has made further steps towards strengthening primary care. Pilot schemes throughout the country have been rolled out and evaluation has been introduced. The educational support infrastructure has been improved by two new centres, the Centre for Evidence-based Medicine and the Centre for Continuing Medical Education. • So far, the GP retraining programme has produced 2335 newly trained GPs, while 620 are currently being retrained. Equipment in 2300 SVPs and 29 urban outpatient clinics has been upgraded. GP training centres have been established in all provinces. • The reforms also aim to improve health care management. With donor support, management skills have become part of the medical curriculum. In SVPs, new managers (not necessarily physicians) are being employed with new financial responsibilities. However, financial and human resources management in primary care continues to be an area for improvement. |
| <ul style="list-style-type: none"> • The delivery of primary care | <ul style="list-style-type: none"> • In the new system, GPs are the core of primary care. The basic unit for primary care in rural areas is the SVP. In cities, family polyclinics will be the basic units, but this transformation is still ongoing. • In January 2006, an incentives-based payment schemes for physicians was introduced. Salaries are related to the volume, the complexity and the quality of the care provided. • Public primary care services are available to all without charge. For prescribed medicines, co-payments apply (except in the case of vulnerable groups). Private health services are fully paid out of pocket. |
| <ul style="list-style-type: none"> • Legislation and regulation | <ul style="list-style-type: none"> • Many laws, ministerial decisions, decrees and orders deal with the improvement of (primary) health care services. Regarding the role of NGOs described in these documents, experts answered that the role of the Association of Physicians was defined in the Law on Health Protection of Citizens. They did not know whether a role was defined for patients' organizations or other NGOs. • Experts agreed that the documents provided a broad coverage of quality related topics. • Patients' rights were said to be a point of debate. Currently only complaint procedures, patients' informed consent and access to their own medical files are dealt with in the Law on Patients' Rights. |

UZBEKISTAN: main points

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| <ul style="list-style-type: none"> • Coordination and formal mechanisms | <ul style="list-style-type: none"> • The Ministry of Health has the final responsibility for the quality of primary care facilities. Within the Ministry, however, this responsibility seems not to be concentrated in one department. • The following mechanisms were reported by the experts to be in place: <ul style="list-style-type: none"> • supervision of GPs' CME activities • formal investigations into shortcomings and significant events in primary care • mandatory licensing • benchmarking (comparative analyses of performance of facilities) • financial incentives for providers (performance elements in the salary) • nonfinancial incentives (several awards) • national programme(s) for the development of clinical guidelines (the Centre for Evidence-based Medicine is strongly involved). • Official job descriptions, reported to exist for all primary care disciplines, contain elements that can be used for performance evaluation. Professional associations had been involved in the development of the job descriptions. • Although the Government has a monopoly in coordinating health care, experts reported there was some space for additional (regional or local) initiatives, such as: exchanges between facilities (practice visits), conducting community surveys and organizing expert seminars. |
| <ul style="list-style-type: none"> • Education and access to information | <ul style="list-style-type: none"> • Experts thought the current undergraduate and postgraduate medical programme and the 10-month retraining course paid sufficient attention to quality management-related skills and techniques. Methods of quality improvement were introduced in the curriculum in 2005. • Experts concluded that current CME programmes responded sufficiently to the need to keeping up to date. GPs need to pass a qualification exam every five years. • GPs and nurses need better clinical and other information for feedback on performance. This is a priority of the primary care reform. |
| <ul style="list-style-type: none"> • Way forward and obstacles | <ul style="list-style-type: none"> • Although policy-making was thought to be a well developed area, there are still gaps in legislation: for instance, in setting norms and standards of care and further development and implementation of clinical guidelines. • Electronic medical record systems should be promoted in primary care, as well as electronic access for primary care workers to external sources of information. • It will be important to find and allocate necessary resources for the implementation of innovations. • Although no major obstacles to the improvement of primary care were perceived, the following points may slow down the pace of change: the subordinate role of primary care (compared to other levels); the current attitude of health care workers; the weak position of patients (who are not well organized); and the lack of nonfinancial resources (for instance, information, skills, modern training methods, support). |
| <h3>Primary care managers</h3> | |
| <ul style="list-style-type: none"> • Availability of documents relevant to maintaining quality | <ul style="list-style-type: none"> • The level of documentation was clearly better in Fergana than in the two other provinces. • This difference was also true of the availability of documents, with substantial variations between the provinces in the availability of: licences and certificates; documents on future priority setting; budget specification; and the description of care for specific patient groups. • For documents on: the aims and objectives of the organization (the mission statement); manuals for specific procedures; annual reports on quality improvement; general information on the population served; and safety certificates for medical equipment, managers in all three provinces reported wide or general availability. |
| <ul style="list-style-type: none"> • Conditions and means for quality improvement | <ul style="list-style-type: none"> • In Tashkent, the managers generally considered that the means and conditions for quality improvement were not well met. • In Syrdarya, between 20% and 60% of the managers judged the situation for the different means and conditions to be "fair"; only few reported them to be inadequate. • For three out of five conditions and means, the Fergana managers were the most satisfied. In particular, the situation related to effective incentives for quality improvement was reported to be good in Fergana. |

UZBEKISTAN: main points

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| <ul style="list-style-type: none"> • Support for improvement actions | <ul style="list-style-type: none"> • A majority of managers reported that they had no internal resources available for quality improvement activities. • The percentage of managers reporting that an internal coordination group had been established ranged between 50% and 75%. • Sufficient external support for quality improvement actions was reported in Syrdarya and Tashkent in only a minority of cases. • Almost all managers reported that the coordination of quality improvement was clearly established as a function in their organization. In most cases, the head physician holds this position. |
| <ul style="list-style-type: none"> • External assessment instruments | <ul style="list-style-type: none"> • The widest application of external assessment instruments was reported in Fergana. • Answers relating to the application of mandatory licensing (or revalidation) of organizations and medical and nursing staff were not homogeneous, even within the provinces. • While voluntary participation in formal accreditation was reported by around half of the managers in Fergana and Syrdarya and one quarter in Tashkent, only a few managers said they were involved in voluntary certification. |
| <ul style="list-style-type: none"> • Internal assessment instruments | <ul style="list-style-type: none"> • In general, no major differences were found between the provinces. Tashkent had the lowest score, mainly because of the relatively lack of quality improvement activities/programmes and the low prevalence of monitoring patients' needs and satisfaction. • Monitoring patients' needs and satisfaction was not widely applied in Syrdarya and Fergana either; about half of the managers in these provinces reported such activities, while in Tashkent, the figure was only one quarter. The same pattern was found for monitoring the opinions of secondary care workers. • Inspection of medical files and systematic analysis of patients' complaints were reported to be widely applied in all three provinces. • In all three provinces, between 50% and 75% of managers reported the application of routine evaluation reports, internal medical audits, and a GP peer review, and the existence of a quality improvement committee. |
| <ul style="list-style-type: none"> • Elements of human resources management | <ul style="list-style-type: none"> • Plans for the personal development of workers, offering specific training for improving the quality of medical care, and regular reports of workers and their activities were reported to be widely applied in all three provinces. • Only 20% of managers in Tashkent reported that monitoring of staff job satisfaction took place, while the figures for Fergana and Syrdarya were 75% and 56%, respectively. • Tashkent also had the lowest score for job evaluation interviews: 60% against around 90% for the other two provinces. |
| <ul style="list-style-type: none"> • Use of protocols and guidelines | <ul style="list-style-type: none"> • Protocols and guidelines were reported as being widely used in all three provinces. • Fergana had the lowest total score for the use of protocols and guidelines (70 out of a maximum of 100), mainly because of the relatively limited use of protocols/guidelines on patient information. • The use of norms for patients' access to their medical records was generally reported by all almost managers. • Scores for the use of norms and standards related to other services and patients' rights were lower. In particular, norms and standards for waiting times and for the storage and confidentiality of patients' medical records were often absent. |
| <ul style="list-style-type: none"> • Managers' future plans for quality improvement | <ul style="list-style-type: none"> • In general, there were no large differences between the three provinces concerning future plans for quality improvement reported by the managers. • Almost all of the prestructured answers related to the care process seemed to concord with the managers' plans. An exception was the improvement of technical and other equipment in the SVPs; only one manager (from Fergana) reported having plans for this. • The prestructured answers related to the role of patients/population, and to management also seemed to address the right topics; most of the managers reported having such plans, and only few other plans were mentioned. • The future plans mentioned by the managers seemed to contradict their answers to previous questions, in which they indicated that certain instruments and development are already in place. |

UZBEKISTAN: main points

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| <ul style="list-style-type: none"> • Reflections and expectations concerning quality improvement | <ul style="list-style-type: none"> • Managers were satisfied with the functioning of CME. • A minority of managers felt that doctors and nurses should spend more time keeping up to date professionally. • There was some reservation as to whether patients are treated according to the latest evidence. • Managers felt that centralized decision-making was a restriction. • Managers thought that the attitude of their staff towards innovation was an obstacle. • Lack of information among managers on modern management approaches was an obstacle to better performance. • Managers had very high expectations of quality improvement activities. |
| GPs | |
| <ul style="list-style-type: none"> • Involvement in Quality Improvement activities | <ul style="list-style-type: none"> • Answers concerning the involvement of GPs in informal and structured quality improvement provide a positive picture. There were no large differences between the three provinces, although Tashkent scored slightly lower than Syrdarya and Fergana on most items. • For most activities, between 75% and 100% of the GPs reported that they were involved. There were lower scores for involvement in scientific research/publication and reading professional information on the Internet (informal activities), and for attending CME courses at least twice a year and conducting a patient satisfaction survey (structured/formal activities). |
| <ul style="list-style-type: none"> • Use of clinical guidelines | <ul style="list-style-type: none"> • In Fergana and Syrdarya, almost all the GPs said that they use clinical guidelines; in Tashkent, there was some room for improvement. • All guidelines were issued by the Ministry of Health, and a large majority of them were scientifically based. • Elements of consensus (either internal or external) were reported to be part of the procedure by most GPs, especially in Fergana and Syrdarya. • In general, the GPs' answers showed that the introduction of the guidelines was accompanied by different implementation tools, such as background information or training. Only 50% of managers in Tashkent, as opposed to 85% in Fergana and Syrdarya, reported receiving feedback on their performance in using the guidelines from a supervising physician. |
| <ul style="list-style-type: none"> • Perceived opportunities for improvement | <ul style="list-style-type: none"> • GPs in general seem to want to improve all aspects of clinical care mentioned in the prestructured questionnaire (e.g. diagnostics, drug prescriptions, care for various groups of patients and minor surgery). No differences were found between the three provinces. • The same was true of GPs' perceived opportunities for improving the provision of information to and communication with patients, cooperation and teamwork, access for and services to patients, competence and motivation, and quality improvement procedures and structures. • The lack of variation in the GPs' answers raises questions. It might be because the GPs were not (yet) able to set their priorities for improvement. |
| <ul style="list-style-type: none"> • Reflections of GPs on conditions for quality improvement | <ul style="list-style-type: none"> • GPs agreed with their managers about the positive contributions of CME courses to the quality of care. • GPs were more strongly convinced than their managers that they spend sufficient time keeping up to date. • GPs had little doubt that treatment of patients was in line with the latest evidence; managers were slightly more reserved on this point. • GPs and managers agreed on the beneficial effects of decentralization on primary care. • The opinions of GPs and managers differed on the perceived attitudes of GPs on innovation; GPs felt that they had a positive attitude, while managers felt that there was a need for an improved attitude on the part of staff towards innovation. • GPs seemed to criticize the management of their supervisors as being punitive rather than stimulating. • GPs consider more active patients to be allies in improving primary care. |

UZBEKISTAN: main points

- Expected effects of quality improvement activities
 - GPs expected both patients and staff to be more satisfied as a result of quality improvement.
 - Most GPs expected their workload to increase.
 - GPs were divided on the expected effect on administrative duties; roughly one third thought that time spent on administrative work would increase, one third that it would decrease, and one third that it would remain the same.
 - Professional freedom was generally expected to increase as a result of quality improvement activities, and the reputation of primary care services was expected to improve.
 - Practically all GPs expected positive effects on the population's health outcomes.
 - GPs had differing expectations concerning the effects on practice costs; about half of the GPs in all three provinces expected them to fall, while 30% to 40% expected an increase in costs.

Uzbekistan: recommended policy action

- Further develop and implement a model for comprehensive primary care services in cities.
- Reduce the government's monopoly in the health sector by recognizing the role of NGOs in the development of laws and health policy.
- Support the role of managers at the primary level, by training them in modern management techniques, implementing management information systems and providing them with necessary resources.
- Improve clinical information and medical record-keeping among GPs by systematically introducing computers in primary care facilities.
- Continue the coordinated development, updating and dissemination of clinical guidelines for GPs and achieve their acceptance in practice.
- Actively involve patients in the provision of primary care services by systematically monitoring patients' needs and satisfaction and developing service norms in primary care.
- Modernize continuing medical education by introducing modern teaching methods and link the supply of courses to the educational needs of the users.
- Develop human resources management in primary care, including regular job evaluation interviews and personal development plans.

ANNEX I GLOSSARY OF TERMS FOR QUALITY MANAGEMENT¹

Accreditation: A formal process by which a recognized body, usually a non-governmental institution, assesses and recognizes that a healthcare organization meets applicable, pre-determined standards.

Attestation: Periodic test of knowledge or competence of health professionals (for instance: four- to five-yearly obligatory examinations of physicians in countries of former Soviet Union). Also used in relation to workplaces (with a focus on risk management) (11).

Benchmarking: A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).

Certification: A process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria.

Clinical governance: Framework through which National Health System organizations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish (12).

Clinical practice guidelines: A set of systematically developed statements, usually based on scientific evidence, to assist practitioners and patient decision-making about appropriate healthcare for specific clinical circumstances.

Confidentiality: the right to determine who has access to one's personal health information (13).

Continuity of care: the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional continuity), or are an uninterrupted series of contacts over the long term (longitudinal continuity) (14).

Coordination of care: The mechanisms ensuring that the patient and clinicians have access to, and take into consideration, all required information on the patient's conditions and treatments to ensure that the patient receives appropriate health care services.

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Sources unless otherwise indicated: (18)

Coordination: a service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and necessary and effective interventions, no more and no less. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination means the inter-linkages among staff members and agencies over a longer period of treatment (14).

Effectiveness: The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the patient.

Evidence-based medicine: The wise and careful use of the best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence-based medicine that is best-practice integrates best research evidence with clinical expertise and patient values.

Guideline: Systematically developed statements to help practitioners and patients make decisions in specific clinical circumstances. They essentially define best practice (15); in essence the “right thing to do” (16).

Health outcomes: The effect on health status from performance (or non-performance) of one or more processes or activities carried out by health care providers. Health outcomes include morbidity and mortality; physical, social and mental functioning; nutritional status; etc.

Indicator: A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or the level of quality achieved.

A measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care provided and hence change it (15). Quality indicators infer a judgement about the quality of care being provided. The term ‘performance’ indicator is sometimes used synonymously with quality indicator but it is possible to make inferences about performance without making inferences about quality (16).

Licensing: A process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession.

Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function or process.

Patient safety: Freedom from accidental or preventable injuries produced by medical care.

Performance measure: Provides an indication (e.g., rate, ratio, index, percentage) of an organization’s or provider’s ability to provide care most likely to ensure a good patient outcome.

Process of care: A health care service provided to, on behalf of, or by a patient appropriately based on scientific evidence of efficacy or effectiveness.

Protocol: A detailed plan, or set of steps, to be followed in a study, an investigation, or an intervention, as in the management of a specific clinical condition.

Protocols describe the case-management of a patient with a very specific condition, in a short document (9).

Quality: Quality health care is how well a doctor, hospital, health plan, or other provider of health care keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.

Quality assessment: Determination of how processes and services correspond to current standards, as well as a patient's satisfaction with the care received.

Quality assurance: That set of activities that are carried out to set standards and to monitor and improve performance so the care provided will satisfy stated or implied needs.

Quality improvement: An approach to the study and improvement of the processes of providing health care services to meet needs of clients.

Quality indicator: An agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Quality management: An ongoing effort to provide services that meet or exceed customer expectations through a structured, systematic process for creating organizational participation in planning and implementing quality improvements.

Quality measure: A mechanism to assign a quantity to quality of care by comparison to a criterion. The definition of a quality measure relies on the definition of "Clinical performance," "Clinical performance measure," "Measure," and "Quality of care."

Quality monitoring: The collection and analysis of data for selected indicators that enable managers to determine whether key standards are being achieved as planned and are having the expected effect on the target population.

Quality of care: The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Responsiveness is measure of how the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or non-personal services (not a measure of how the system responds to health needs, which shows up in health outcomes) (13).

Enhancing responsiveness to the expectations of the population, includes: (a) respect for persons (including dignity, confidentiality [of information] and autonomy of individuals and families to decide about their own health); and (b) client orientation (including prompt attention, access to social support networks during care, providing quality of basic amenities and choice of provider) (4).

Revalidation: A periodic evaluation of performance aiming at renewing a qualification or certificate (17).

Standard: The level of compliance with a criterion or indicator (15). A target standard is set prospectively and stipulates a level of care that providers must strive to meet. An achieved standard is measured retrospectively and details whether a care provider met a pre-determined standard (16).

Standard of care: A generally accepted, objective standard of measurement such as a performance standard supported through findings from expert consensus, based on specific research and/or documentation in scientific literature, against which an individual's or organization's level of performance may be compared.

Stewardship: a function of a government responsible for the welfare of the population, and concerned with the trust and legitimacy with which its activities are viewed by the citizenry. It includes the overseeing and guiding of the working and the development of the nation's health actions on the government's behalf. The components of stewardship are: health policy formulation (defining the vision and direction for the health system); regulation (setting fair rules of the game with a level playing field); and intelligence (assessing performance and sharing information) (13).

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SUMMARY

This report on primary care quality management describes the Uzbek governments' efforts to improve service delivery at the first level of care, supplemented with evidence compiled through the development and application of tools tailored to primary care.

What does quality care mean at this level and what are the strategies, mechanisms and tools to ensure that it can be maintained, assessed and improved? The report shows that the involvement not only of national policy-makers but also, and first and foremost, of the stakeholders on the ground who actually provide and organize primary care can result in improvements in quality by an incremental process of creating and adopting a culture of quality control and assurance. This process goes beyond having guidelines, regulations and strategies in place; it entails adopting a transparent approach which acknowledges that only empowered and motivated health care staff working in teams can bring about real improvements, and that all health care workers (family doctors, nurses, midwives and others) are equally important in the drive to attain better health for the population.

The centrality of the patient, and of his or her needs and inputs into this process of improving the quality of primary care, should also be emphasized.