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Primary health care in Kosovo[a]: rapid assessment

WHO European Framework for Action on Integrated Health Services Delivery

[a]In accordance with United Nations Security Council Resolution 1244 (1999).

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Primary health care in Kosovo[a]: rapid assessment

WHO European Centre for Primary Health Care
Health Services Delivery Programme
Division of Health Systems and Public Health

[a]For the purposes of this publication, all references to "Kosovo" should be understood as "Kosovo [in accordance with United Nations Security Council Resolution 1244 (1999)]".

WHO European Framework for Action on Integrated Health Services Delivery

Abstract

This report describes the main findings and recommendations of a rapid assessment of primary health care (PHC) in Kosovo (in accordance with United Nations Security Council Resolution 1244 (1999)). As part of the health sector strategy for 2017–2021, the Central Health Authorities of Kosovo seek to strengthen family medicine–based PHC and to enforce a gatekeeper and coordinator role for family medicine teams. Currently, people often bypass PHC services and tend to address health problems directly to narrow specialists. There is mismatch between PHC capacity in terms of team composition, competencies and available equipment and the health needs and expectations of the population. Governance, funding, health workforce planning, health information systems and reimbursement of medicines require alignment to better support PHC.

Keywords

PRIMARY HEALTH CARE
HEALTH SERVICES
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Abbreviations

PHC	primary health care
PHC-IMPACT	primary health care tool for monitoring impact, performance and capacity

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Background

As part of the health sector strategy for 2017–2021, the Central Health Authorities of Kosovo[1] seeks to strengthen family medicine–based primary health care (PHC) and to enforce a gatekeeper and coordinator role of family doctors *(1)*. In alignment with the regulatory framework, PHC in Kosovo provides quality and safe health services, based on the principles of family medicine and led by the needs and requirements of individuals, families and communities with the final aim at promoting, preserving and improving health for all *(2)*. This definition is in accordance with the WHO vision of Health 2020 for people-centred health systems that extend the principles of equity, social justice, community participation, health promotion, the appropriate use of resources and intersectoral action *(3)* and the European Framework for Action on Integrated Health Services Delivery *(4)* for making progress towards universal health coverage while contributing to improved outcomes, economic and social development and wealth creation *(5)*.

In Kosovo, fewer people than in other European countries are satisfied with their visits to PHC *(7,8)*, and studies indicate that patients' expectations for PHC services in Kosovo have not been met. PHC capacity in terms of team composition, competencies and available equipment does not match the health needs and expectations of the population, which leads to decreasing prestige and bypassing of PHC services.

In this context, the Central Health Authorities requested WHO support to assess the current state of PHC. A WHO mission took place from 6 to 10 August 2018 and from 3 to 5 April 2019 to complete a rapid assessment on PHC. The assessment included an analysis of the patient flows, transitions to specialized and hospital care, links with public health services and identified policy options to strengthening PHC.

[1] In accordance with United Nations Security Council Resolution 1244 (1999).

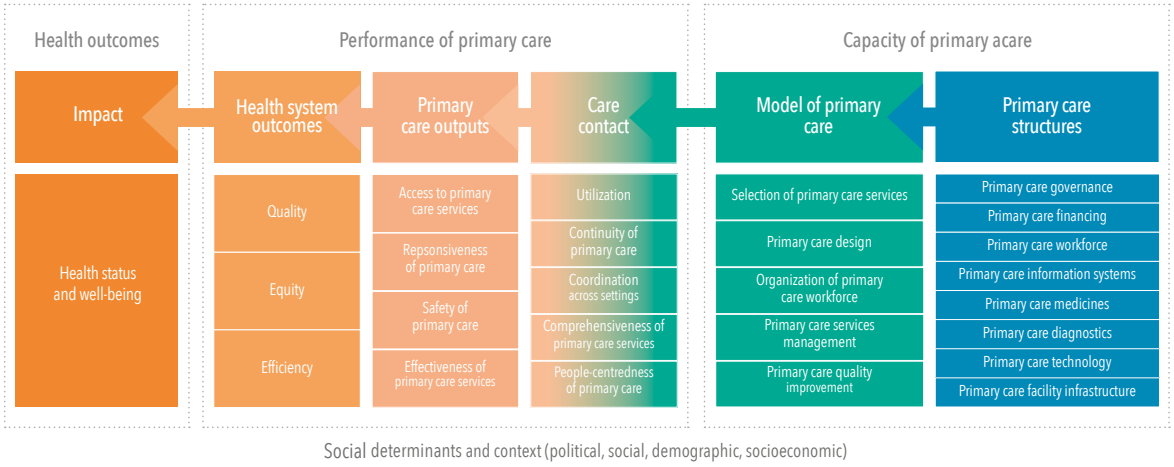
Methods

The following methods were used for the rapid PHC assessment:

- desk review of the main PHC-related documents, strategies and orders of the Central Health Authorities and reports of international partners;
- bilateral meetings with PHC managers, general practitioners, nurses and specialists of the Central Health Authorities and institutions responsible for PHC governance;
- direct observation during visits to family medicine centres of different types by geographical areas – one urban area in Pristina, two urban or suburban areas and one family medicine centre far from Pristina with an affiliated medical post; and
- discussions of key findings and recommendations with representatives of the Central Health Authorities, health administrators of municipalities, PHC professionals and international partners during a roundtable that took place in April 2019.

Guiding questions for semi-structured interviews during the bilateral meetings and a list of items for observation and questions during the desk review, were developed in the approach of WHO European Framework for Action on Integrated Health Service Delivery and its monitoring tool *(9)*. This policy framework was developed under the leadership of WHO European Centre for Primary Health Care and its accompanied monitoring tool has recently undergone a piloting phase.

Fig. 1. Components of the tool for monitoring impact, performance and capacity of PHC (PHC-IMPACT)



Source: WHO Regional Office for Europe *(9)*.

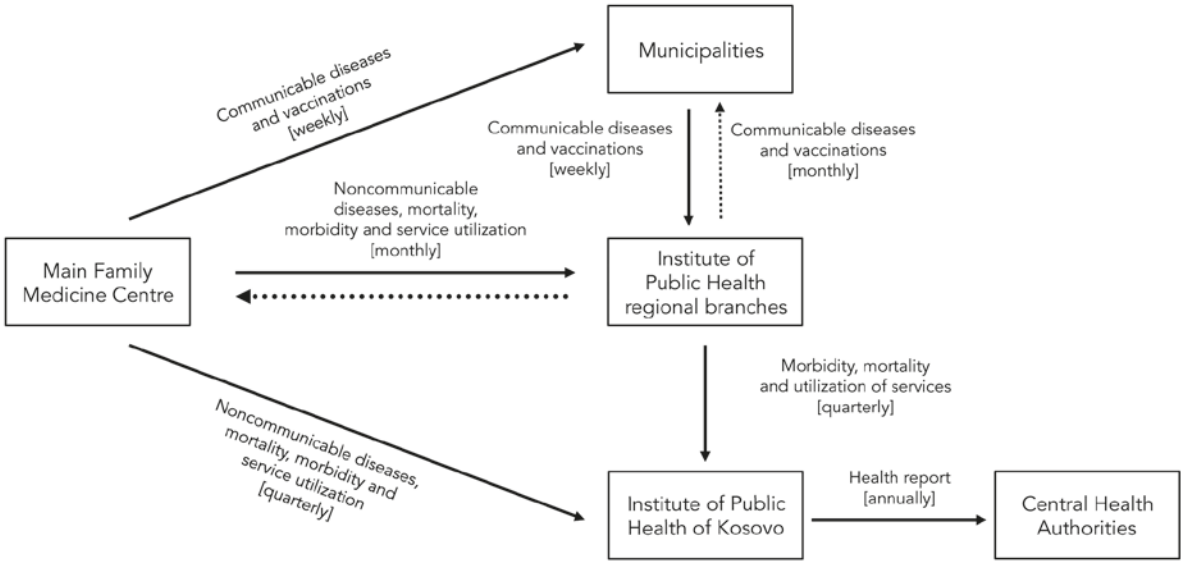
The PHC tool for monitoring impact, performance and capacity (PHC-IMPACT) includes a wide scope of questions and measures for selected tracer conditions. The process of developing questions for PHC rapid assessment in Kosovo was guided by the logic of PHC-IMPACT, and all main components and subdomains of PHC-IMPACT were accounted for (Fig. 1). However, the questions for the rapid assessment were tailored according to what is already known from the desk review prior to the mission, aiming to cover selected features and indicators that inform about key gaps in the PHC system. The results of the assessment should enable policy recommendations to be developed on features within all subdomains that require improvement.

Population health needs and PHC performance

Health needs and setting priorities

Family medicine centres collect data on morbidity, mortality and service utilization and submit them monthly to the regional institute of public health and every three months to the Institute of Public Health of Kosovo. The incidence and prevalence of communicable and noncommunicable diseases follow different reporting flows (Fig. 2).

Fig. 2. Reporting flows of data



Source: author.

The affiliated family medicine centres report data on communicable diseases and vaccinations every week to the main family medicine centre. The latter submits to the municipality, which reports to the regional institute of public health. The regional institute of public health reports monthly back to the municipalities and family medicine centres. The regional institute of public health reports on the incidence and prevalence of communicable and noncommunicable diseases, mortality and on the utilization of services to the Institute of Public Health of Kosovo every three months. Feedback to municipalities and family medicine centres on health needs is limited. Family medicine centres do not stratify the population according to risk.

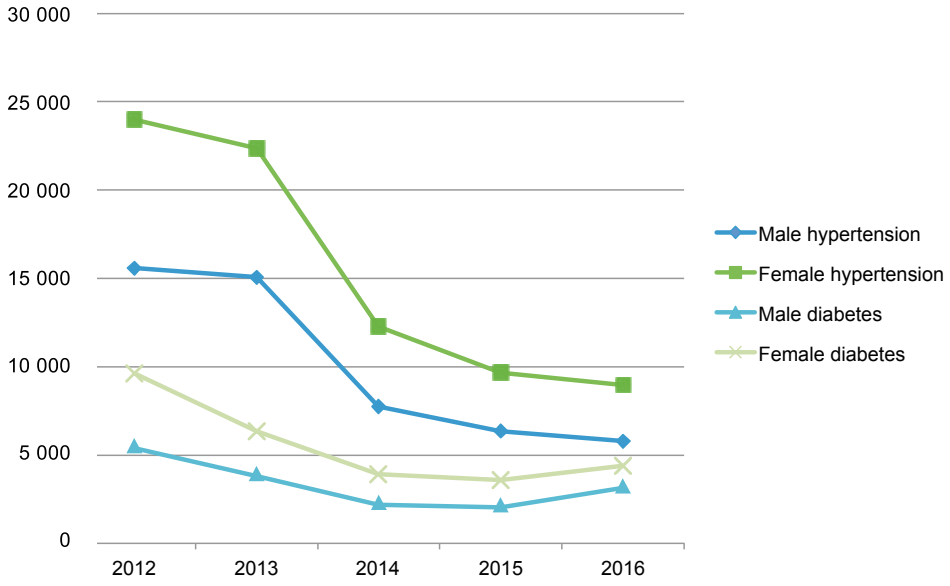
During the roundtable, there was agreement there is need to prioritize data collection and analysis to support population health management and strengthen people centredness. Opportunities are envisaged through an ongoing e-health project, supported by the Government of Luxembourg. The project envisages to introduce a web-based health information system in all family medicine centres by the end of 2020. Three pilot family medicine centres already benefit from this

information system. The web-based information system will allow the centres to analyse morbidity data of the population that they serve and to manage selected chronic conditions through a set of clinical indicators.

PHC performance

Monitoring PHC performance focuses on inputs, such as the number of visits to PHC doctors and nurses. Data on the outcomes and outputs, such as hospitalization for ambulatory care sensitive conditions, are not disaggregated by PHC centre or analysed. During the mission, the Institute of Public Health of Kosovo provided data on hospitalization for diabetes and hypertension in seven regional hospitals. The number of hospitalizations for diabetes and hypertension is decreasing, with a more intensive decline from 2012 to 2014, especially for hypertension (Fig. 3). Hospitalizations for diabetes since 2014 are more stable, with a slight increase for both sexes in 2016. The hospitalization rates per 100 000 inhabitants for both sexes are 776 for hypertension and 396 for diabetes. This is higher than the average of 33 OECD countries in 2015: 131 and 174, respectively. For asthma, the rate is 24 versus the average 69 in OECD countries in 2015 *(10)*.

Fig. 3. Hospitalizations for diabetes and hypertension by sex, 2012–2016, absolute numbers

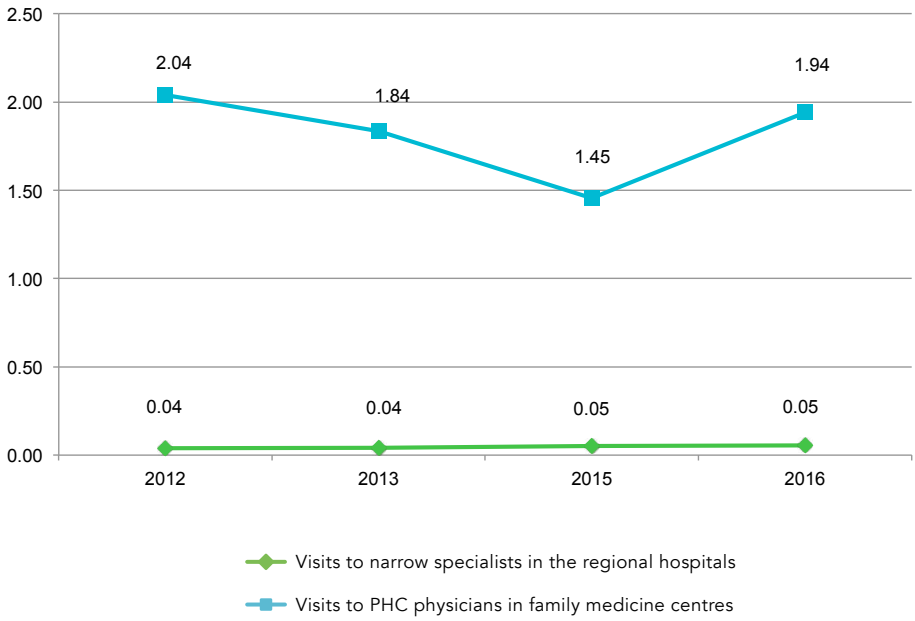


Source: Public Health Institute of Kosovo, 2012–2016.

Utilization of PHC services

Analysis of outpatient visits in public facilities data shows an average of 1.99 visits per inhabitant per year in 2016, of which 1.94 visits per inhabitant are to PHC physicians. The rate is less than one third of the average of the countries in the WHO European Region – 7.4 in 2014. The utilization of outpatient services has changed little since 2012 (Fig. 4). However, these data seem to contrast with information gathered during the visits to the family medicine centres. For example, Fushe Kosovo family medicine centre, with 34 000 inhabitants in the catchment area, reports an increase of visits to from 84 000 to 140 000 visits, and Pristina family medicine centre, with 200 000 inhabitants in the catchment area, reports that visits doubled from 600 000 to 1 200 000.

Fig. 4. Outpatient visits for physicians' consultations per inhabitant at family medicine centres and regional hospitals, 2012–2016



Source: Public Health Institute of Kosovo, 2012–2016.

Low rates of utilization of outpatient services could partly be explained by data not being included from the university hospital and from private practices. During the site visits, it was found that patients tend to increasingly address health problems directly to narrow specialists in private practices. For example, Elez Han family medicine centre, serving 10 000 people, reported that about 90% of children seek care directly from private paediatricians available 35 km away in Fereci. There is one private practice in Fereci with two paediatricians and some other private practices that totally have one tuberculosis specialist, five otolaryngologists and one cardiologist. There are no data from private practices, and no data are available on the share of outpatient visits in the private sector. The results of a population-based study from 2016 on access to health care in Kosovo indicated that 32% of the adults in Kosovo prefer private clinics, primarily because of the quality of care offered *(11)*.

Access to PHC services

The President of the Association of Family Physicians of Kosovo reported that PHC services are easy accessible without appointments in advance. This is in line with the results of a survey done by the Association in Gjilan Family Medicine Centre from 2017 revealing that the average waiting time to get a physician consultation after entering a family medicine centre is approximately 5 minutes. This is a short waiting time, even compared with countries with an appointment system.

During site visits, the main family medicine centres had higher patient flows than affiliated ones.

Family medicine centres do not operate with an appointment system.

All family medicine centres are open at least seven hours per day, from 8:00 until 15:00, five days per week. All main family medicine centres provide 24/7 services, with one doctor on duty from 15:00 to 8:00. Doctors on duty report a high workload:

for example, a doctor on duty in Elez Han family medicine centre consults about 100 patients during a shift of 17 hours.

Transitions and referral system

Formal referral from general practitioners is needed to consult narrow specialists. The assessment revealed that self-referrals to narrow specialists in regional public hospitals are infrequent. Nevertheless, narrow specialists from regional hospitals report increasing flows of patients with referrals for minor health problems that could easily be resolved at family medicine centres. Hospital specialists consider that general practitioners do not actually act as gatekeepers and patients often tend to consult narrow specialists, even for minor problems. General practitioners easily issue referrals when patients demand it. According to the narrow specialists, general practitioners are increasingly just referring and prescribing.

The mission could not comprehensively analyse existing pathways and patients' transitions to hospital care. Available statistics do not provide data on the proportion of people from the catchment area visiting a family medicine centre. A survey of adults showed that 54% of respondents had never had a general health check-up in PHC *(10)*. During a roundtable held in April 2019 to discuss the preliminary results of the assessment, representatives of Central Health Authorities, international partners and patients' associations agreed upon the need to include data on population coverage, referrals and self-referrals in the set of PHC reporting system and performance evaluation.

Site visits to the family medicine centres and interviews with family doctors showed a lack of tools for standardizing practice, supporting clinical decisions and patient pathways. There are only 10 clinical guidelines used at the PHC level which are only partly implemented. There are no protocols with defined roles for family doctors, PHC nurses and narrow specialists in the management of particular clinical conditions. The chair of the committee for evaluating clinical guidelines and protocols informed that 20 clinical guidelines and protocols planned to be developed and implemented by the end of 2019. Family medicine centres in five municipalities, which are pilots of the Accessible Quality Healthcare project funded by the Swiss Agency for Development and Cooperation, have implemented the WHO Package of Essential Noncommunicable disease intervention protocols. UNICEF has supported the implementation of HEADSS (home, education, activities, drug use and abuse, sexual behaviour, suicidality and depression) assessment tools and trained 1–2 family doctors from every family medicine centre. Family doctors and general practitioners from family medicine centres said that clinical guidelines and protocols for the main clinical conditions, such as diabetes, hypertension, bronchial asthma and chronic obstructive pulmonary disease, are highly needed. The Accessible Quality Healthcare project of the Swiss Agency for Development and Cooperation has recently implemented protocols for bronchial asthma, diabetes and hypertension in all family medicine centres in 12 pilot municipalities.

According to representatives of municipal health administrations, the people consider that the co-location of narrow specialists in family medicine centres improves the quality of PHC services. On the other side, some family doctors fear that this may jeopardize the further development of a family medicine-based PHC. The Central Health Authorities ensured that the family medicine approach remains a policy priority and highlighted the need to align health services with people's needs and expectations. At present, the response capacity of PHC remains low and people address their health problems directly to the narrow specialists. The

possibility of narrow specialists providing regular consultations in family medical centres was appraised in the context of improving access to specialized services while enhancing family doctors' and PHC nurses' competencies. The need for a proactive approach in PHC with extended access to preventive services was also discussed as an option for decreasing the need of specialized care.

PHC organization and scope of practice

Network of PHC facilities and licensing

PHC in Kosovo is organized through a network of family medicine centres owned by local municipalities. Kosovo has 430 family medicine centres – 20–22 in three northern Kosovo municipalities and 408 in the remaining 35 municipalities. Each municipality has a network of family medicine centres – one main family medicine centre and several affiliated centres (with family doctors and nurses) or medical posts (only nurses). An increasing network of private outpatient practices also provides first-contact care. The number of licensed private institutions reached 1307 in 2015 (1069 in 2014), of which 549 are dental clinics, 126 laboratories, 95 gynaecological ambulatories, 79 polyclinics, 67 internal medicine clinics and 49 paediatric ambulatories. No private practices of family doctors were reported.

Private PHC providers need to get a licence. The division of accreditation of the Central Health Authorities are responsible for assessing and licensing private facilities. The Central Health Authorities have recently discussed whether public health institutions should also be accredited. The initial consideration is to have public health institutions accredited on a voluntary basis. None of the 38 main family medicine centres has initiated an accreditation process so far.

PHC workforce and professional development

PHC in Kosovo is based on family medicine, and family doctors are the main PHC professionals. Family doctors evaluate the care provided by the family medicine team, identify problems and lead the team members in resolving them. Kosovo has 379 family doctors trained through three years of residency. Incentives for specializing in family medicine are low since physicians can work as general practitioners without any specialization. The only requirement to be employed as a general practitioner is six months of practice: four months in a hospital and two months in a family medicine centre *(6)*. Annex 1 presents the differences in defined administrative and team tasks for general practitioners and family doctors. General practitioners have the same responsibility for determining the final diagnosis and prescribing treatment but follow patients under the supervision of family doctors. General practitioners are not required to have a list of patients and only assist family doctors in medical audits.

Kosovo has 552 general practitioners and thus 931 PHC physicians, both family doctors and general practitioners, for 1.9 million inhabitants. This averages 2040 inhabitants per PHC physician versus 1612 in the WHO European Region *(11)*. The strategy target of 1540 people per physician by 2020 would require employing additional 300 physicians. This is difficult for many reasons.

Physicians have little motivation to specialize in family medicine during their residency. Interviews with the President of the Association of Family Physicians of Kosovo and with young doctors who had just graduated from the medical university informed about difficulties in getting young family doctors to work in PHC. Most family doctors with specialization are very close to retirement age. Undergraduates

who do not succeed in becoming residents in a narrow specialty temporarily work as general practitioners in PHC. Physicians without any specialization can be employed as general practitioners in PHC with only €50 difference from the monthly salary of a family doctor with residency.

The migration of doctors and nurses abroad is increasing. Young doctors interviewed during the site visits estimated that about half the graduates left Kosovo within the first year after graduation. There is also internal migration and a lower density of physicians in remote areas.

The interviews with national stakeholders and PHC doctors confirmed that nurses have potential to improve PHC practice. Kosovo has 2183 nurses employed in PHC, more than three nurses per physician. Nurses are often the only staff available on a permanent basis in family medicine centres in remote areas, and a physician visits once or twice per week. Nurses have more sustainable, longitudinal contact with the population in the catchment area, especially in remote areas, where permanently employed physicians are lacking, and general practitioners work temporarily until they enter a residency for narrow specialization. Although many PHC nurses are employed, there are fewer than 2 nurses per physician working. The migration of nurses is also a challenge. For example, Pristina family medicine centre has 65 nurse and 35 doctor vacancies. Nurses do not have any specialization in family medicine or PHC. In recent years, attention to the professional development of PHC nurses has increased. The Central Health Authorities organized training on communication skills and motivational counselling through a training-of-trainers approach for almost all PHC nurses.

Kosovo lacks a strategy on human resources for health that addresses challenges related to migration, distribution of medical specialties among graduates, education, specialization and professional development of family medicine nurses and more equal geographical distribution of PHC professionals.

The Chamber of Physicians of Kosovo is responsible for licensing and relicensing family doctors. The relicensing cycle is five years. During the five-year cycle, family doctors must obtain 100 credits of continuing professional development, of which 70 credits must be obtained only from courses accredited by the Association of Family Physicians of Kosovo.

Scope of PHC practice

PHC provides quality and safe health services based on the principles of family medicine, led by the needs of individuals, families and communities with the aim of promoting, preserving and improving health *(2)*. This definition is in accordance with the vision put forward by Health 2020 for people-centred health systems *(3)*. The Central Health Authorities have recently established a working group for reviewing a draft decree that defines a package of services and the organization of PHC. The draft decree highlights the need to enhance the organization and management of PHC and defines PHC as first contact and coordinating point for accessing other health services. The draft decree does not touch upon scope of practice or quality improvement mechanisms.

The site visits show that PHC provides reactive services, resolving the health problems presented, focusing on prescriptions and referrals to narrow specialists. No proactive and preventive people-centred strategies were reported, such as addressing the health needs of vulnerable population groups. In family medicine centres with several general practitioners or family doctors, neither doctors nor

nurses have any assigned population. An administrative task for family doctors, but not for general practitioners, is establishing a list of patients, including information on age and sex. There are no patient lists, so patients can consult any doctor in the family medicine centre or even in other centres and other districts, which creates a challenge for continuity of care.

During the site visits, nurses demonstrated that they can provide motivational counselling for people with noncommunicable diseases. However, there is no systematic approach to follow up with patients. Family medicine nurses also provide comprehensive services. The same nurse makes intravenous and intramuscular injections in the procedure room. A challenge is that nurses rotate among services and take care of any patients who entered the family medicine centre at any moment and need specific services. Continuity remains a challenge in this case: to better learn about patients' problems and be able to apply a more holistic approach and provide more patient-centred care, nurses should be in charge of a patient list. Supporting material such as for individual risk assessment and educational for patients is not widely available. Individual risk assessment is provided only in family medicine centres, piloted by the Accessible Quality Healthcare project funded by the Swiss Agency for Development and Cooperation.

There is no systematic screening of population for cervical, breast or colon cancer. Doctors reported that they encourage women to undergo preventive screening and refer them to mammography. Nevertheless, a population-based survey informs that only 14% of women 50–65 years old underwent mammography once in the past five years *(10)*.

Health system enablers for PHC

The Central Health Authorities give high priority to strengthening PHC, thereby aiming to improve the efficiency and sustainability of the health system. The administration recently sought to define the main gaps in the PHC organization and performance and to outline priority areas for improvement. The administration is highly committed to strengthen the people-centredness of the health system and include disease prevention in the health service delivery model. There are plans to develop a PHC development strategy and a strategy for Health Promotion and Health Education. There are also plans to enhance governance capacity of the Central Health Authorities.

Municipalities own the family medicine centre facilities, and the family medicine centre directors report to the municipalities. Municipal administrations play a role in finding investment for restructuring PHC facilities. The size and structure of family medicine centre facilities are comparable to the average of other European countries, but they need to be made more attractive and comfortable for people. The main family medicine centres are better renovated and equipped than the affiliated family medicine centres due to unequal investment done by the municipalities for renovating the premises. The Central Health Authorities are considering measures to increase the interest of local administrations to improve the conditions of the family medicine centres while compensating with investment in equipment and strengthening of the PHC health workforce competencies.

In contrast to the attention paid to rehabilitating premises, municipalities often neglect their role in contributing to human resource planning and retention in remote areas or in designing the model of care to optimally address priority health needs. So far, there have been no examples of PHC development plans at the municipal level. The Accessible Quality Healthcare project funded by the Swiss Agency for Development and Cooperation aims to increase the responsibility of municipalities for people's health and to empower them for health planning. Project activities include building the capacity of family medicine centres and municipal administrations for developing master plans for PHC facilities in 12 pilot municipalities. The Central Health Authorities aim to enforce health planning in all municipalities by the end of 2019 using a simplified template for the action plans.

PHC is funded through grants from the Central Health Authorities submitted through municipalities. Grants are distributed under five budget lines: capital investment, salaries, goods, subventions and water supply and heating, with strict fiscal rules and limited autonomy to move funds between the budget lines. The site visits showed that the grants from the Central Health Authorities comprise about €30 per capita. Co-payments from patients are €1 for any visit to a family medicine centre and €4 for a basic set of laboratory tests. Blood glucose tests for people with diabetes receiving insulin therapy are free of user charges. Co-payments are required for people with diabetes but not receiving insulin therapy and for people with other diseases.

Salaries comprise about 65% of the total budget. The salaries of family doctors are the same as those for narrow specialists, about €630 per month. The salary is about €50 less for general practitioners and €200 less for family nurses. Despite the same salaries for narrow specialists, family doctors reported better opportunities for narrow specialists to earn additional money from private practice.

Municipalities often provide additional funding for medicines, laboratory tests and dentistry, about €15 per person per year. Twenty municipalities have benefited since 2014 from the performance-based capitation project funded by the World Bank. All family medicine centres from 20 municipalities received an additional annual €2.5 per person who has visited PHC at least once. The project should contribute to improving the population coverage with PHC services. Nevertheless, because of limitations of the health information system, the project was not able to collect evidence on improved PHC performance.

The health information system does not adequately support PHC practice and the monitoring of PHC performance. Kosovo currently has two different health information systems – one under the development of an e-health project funded by the Government of Luxembourg and another under the responsibility of the Public Health Institute of Kosovo. Since 2017, the Public Health Institute of Kosovo have solely been responsible for collecting data on health utilization, while the e-health project is developing processing and analysis capacity, funded by the Government of Luxembourg. E-records are already available at three pilot family medicine centres where the e-health project introduced the web-based health information system. During the site visit to the family medicine centre in Drenas, it was shown how family doctors and nurses enter clinical data and diagnosis codes into the e-records. The system allows them to analyse data of patients who visited family medicine centre, at least once but not the whole population served.

Medicines from the essential medicines list approved in 2015 are purchased centrally and distributed among family medicine centres. If a doctor prescribes medicine, patients can get it free of charge. Demand for medicine is higher than supply, so not all medicines are available, which often limits the affordability of long-term treatment for noncommunicable diseases. Nevertheless, family doctors reported that the supply of medicines from the Central Health Authorities has improved since January 2018. The main family medicine centres had sufficient medicines available, but affiliated family medicine centres have limited access to medicines. This was reported as one reason why patients often bypass the affiliated family medicine centres and address health problems directly to the main family medicine centres.

Recommendations

Improve the reporting and feedback system to manage population health and measure PHC performance

The intensive communicable disease–focused reporting and feedback cycle should be revised and should better account for needs related to noncommunicable diseases.

Municipalities' role in assessing health needs and setting priorities with the engagement of other stakeholders such as public health specialists, PHC professionals and representatives of other sectors should be enhanced.

Trained or retrained public health specialists from regional public health directorates should play a key role in analysing health statistics data collected by PHC and technically support the process of assessing health needs and stratifying population risk.

PHC performance measurement should include more output and outcome measures, such as avoidable hospitalizations of ambulatory care sensitive conditions, early stage of diagnosis of cancer and control of high-risk patients and complications.

It is recommended:

- to revise the PHC data reporting and feedback cycle to better inform the health needs related to noncommunicable diseases;
- to enhance the role of regional public health institutes in providing methodological support to municipalities and family medicine centres in assessing health needs and setting priorities; and
- to include more output and outcome measures in PHC performance measurement and to integrate them into the reporting and accountability system.

Improve patients' choices and clinical governance to optimize patients' pathways

People should be assigned to a preferred PHC team to benefit from better-coordinated and continuous care.

Visits of narrow specialists to family medicine centres could be organized to improve access to specialized care. These visits will also serve to enhance the competencies of family doctors and PHC nurses.

PHC teams should be supported by clinical guidelines and protocols with guidance on managing specific conditions, referrals and the role of patients.

Patients with complex needs need to be addressed through a case management approach, including shared care plans.

It is recommended:

- to use population awareness campaigns for promoting the benefits of coordinated, person-centred PHC (examples from best practices) and to encourage people to choose family medicine centre as first-contact care;
- to introduce patient lists so that every individual has the right to choose his or her own physician within the municipality in which he or she lives;
- to disaggregate data reporting by family medicine centre and to include performance data on self-referrals, coverage and referrals;
- to increase access to consultations of narrow specialists for patients in need by (1) introducing rotational visits of narrow specialists to PHC and (2) strengthening the gatekeeping system by increasing fees for self-referrals to narrow specialists;
- to develop and implement clinical guidelines and protocols for the main clinical conditions with clear referral criteria; and
- to introduce shared care plans for patients with multiple conditions and complex health needs.

Strengthen a people-centred approach in PHC services

People-centred, proactive PHC requires integrative approaches with public health. The potential of regional public health institutes should be used for the defined or redefined model of integrating PHC with public health. Through integrative approaches with family medicine centres, public health specialists should contribute to community empowerment and lead community interventions for addressing priority health problems. Further assessment is needed to better learn about the capacity and opportunities of regional public health institutes in this regard.

A strategy for human resources for health should be developed to address gaps and challenges related to doctors and nurses specializing in family medicine, migration and the geographical distribution of staff.

More investment in the capacity of nurses is needed, since they are more equally distributed geographically, are more often retained at the same family medicine centres and have more continuous relations with the same patients and people in the community. Evidence supports that, through a more holistic and patient-centred approach, appropriately trained nurses can be efficient in individual risk stratification, health education and behavioural change communication for patients with noncommunicable diseases.

Based on clinical protocols and guidelines, the diagnostic and laboratory equipment recommended for PHC tests should be available at family medicine centres. Diagnostic tests and prescribed medicines should be accessible and easy affordable for patients. Rotation of mobile diagnostic services could be organized to improve accessibility in the remote areas.

It is recommended:

- to develop standards and criteria for accrediting family medicine centres;
- to redefine the model of cooperation with public health to strengthen proactive people-centred care;

- to address gaps related to specializing in family medicine, migration and the unequal distribution of health workforce;
- to redefine the role of the PHC team and assign responsibility for a defined population;
- to define a compulsory set of laboratory tests to be delivered at the point of care at every family medicine centre and a set of tests provided only at the main family medicine centres but taken at the point of care and transported; and
- to introduce mobile diagnostic services that can be provided at remote family medicine centres through rotation.

Strengthen governance, revise payment schemes and align other health system enablers to sustain PHC development

PHC governance by municipalities creates good opportunities to make health policy a priority of local communities. Municipal administrations need to focus on population health goals. This requires responsible leadership, engaging the public and mobilizing intersectoral action in addressing defined and mutually agreed priority health needs.

Community health committees could be established as advisory bodies to the municipal councils, connecting representatives of the administration, community, nongovernmental organizations, PHC, public health specialists from regional public health institutes, education sector, social care among others. Such committees could act as discussion panels on priority health needs and an advisory body on policy solutions and the expected results of implemented local health policies. Establishing health education committees is a good project initiative in the pilot municipalities of the Accessible Quality Healthcare project funded by the Swiss Agency for Development and Cooperation.

The Central Health Authorities should empower municipalities by providing tools for developing a PHC plan. The experience of the Accessible Quality Healthcare project pilot municipalities in developing master plans for PHC facilities could be used. Municipal PHC development plans also should anticipate the investments needed from the Central Health Authorities and from the municipalities.

PHC payment schemes need to be revised to encourage higher performance. Health information systems should be strengthened and provide evidence of PHC performance and improved health outcomes. Collected and demonstrated evidence on improved outcomes for population health and health system efficiency from best practices is an especially important aspect of a successful change management strategy.

It is recommended:

- to strengthen PHC governance capacity;
- to establish community health committees in municipalities;
- to develop municipal PHC development plans;
- to revise payment schemes for family medicine centres, introducing incentives for improved performance; and
- to identify and promote the best family medicine centre practices and use them as demonstration initiatives for implementing changes.

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Annex 1

Tasks of general practitioners and family doctors

General practitioner	Family doctor
Administrative tasks	
Creating a list of patients by age and sex and completing regular and accurate medical records, including regular appointments for patients	Not applicable
Keeping records and reporting cases of infectious diseases, noncommunicable chronic diseases and malignant diseases to the Institute of Public Health of Kosovo	Not applicable
Acting in a professional manner, respecting the regulations for the PHC and acting in accordance with all applicable regulations, procedures and policies of the Central Health Authorities	Acting in a professional manner, respecting the regulations for the PHC and acting in accordance with all applicable regulations, procedures and policies of the Central Health Authorities
Determining the final diagnosis and describing the therapy	Determining the final diagnosis and describing the therapy
Attending the Kosovo programme of continuing medical education	Attending the Kosovo programme of continuing medical education
Ensuring the confidentiality of the patients	Ensuring the confidentiality of the patients
Following up patients with diseases	Under the supervision of a family doctor, following up the health situation of the patients
Identifying special risk groups	Identifying special risk groups
Participating in consultancy physician groups and making joint decisions on disease management	Participating in consultancy physician groups and making joint decisions on disease management
Actively participating in drafting clinical protocols	Not applicable
Developing medical audits in the respective institution	Assisting a family doctor in developing medical audits in the respective institution
Participating in meetings and conferences and showing interest in developing strategies for improving a high level of patient care and clinical interventions	Participating in meetings and conferences and showing interest in developing strategies for improving a high level of patient care and clinical interventions

Team tasks	
Encouraging teamwork (general practitioners, dentists, family nurses, community nurses and dental assistants)	Encouraging teamwork (family doctors, family nurses and nurses in the community)
Evaluating the care activity provided by the family medicine team, identifying the problems and leading the team members in resolving them	Not applicable
Determining team members in accordance with patient needs and the skills and qualifications of staff to meet the needs of the institution	Not applicable
Participating in training, appraising competencies and orientation and education for young employees	Participating in training, appraising competencies and orientation and education for young employees
Communicating clearly and accurately and creating a good working environment that enhances employee satisfaction	Communicating clearly and accurately and creating a good working environment that enhances job satisfaction
Serving as a source of knowledge and skills for other team members to share clinical experiences	Not applicable

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