PROPOSED MODALITIES AND DIRECTIONS

FOR SYSTEMIC SOLUTIONS TO REDUCE THE BARRIERS TO ACCESSING REPRODUCTIVE HEALTHCARE OF WOMEN

IN THE REPUBLIC OF MACEDONIA

Focus on the Human Resources in the Health Sector

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Abbreviations

CME
Continuous Medical Education

HERA
Health Education and Research Association

HIF
Health Insurance Fund

IPH
Institute of Public Health

MISA
Ministry of Information Society and Administration

MMS
Macedonian Medical Society

MOES
Ministry of Education and Science

MOH
Ministry of Health

PAP
Papanicolaou smear

PHC
Primary Health Care

UNFPA
United Nations Population Fund

UNICEF
Nations International Children's Emergency Fund

WHO
World Health Organization

Introduction

As a result of the barriers identified in the access to reproductive healthcare of certain women categories, especially women from socially vulnerable groups and as a result of the country's poor indicators connected to this segment of the population's health for a long period of time, in 2017, the civil society organization HERA performed a Situational analysis of the reproductive healthcare in Macedonia with a focus on human resources. The aim was to make an objective assessment of the situation in the country from various aspects in order to contribute to the process of evidence-based informed decision making in this segment of the healthcare. The involvement of a consultation expert group, composed from members from various profiles, representatives of all stakeholders in the society, provided additional value to the situational analysis. A focus group was also realized with specialists in gynecology and obstetrics in order to get a broader knowledge base from the pool of professionals which bears most of the burden in the provision of reproductive healthcare services.

This analysis focused on the problem from several main aspects:

- Country's capacities regarding available healthcare professionals involved and potentially involved in provision of reproductive healthcare services: number, competences, education and in-service training;
- Health records system;
- The system of financing of the reproductive healthcare.

The analysis provided several findings based on facts and comparisons. A comparative review of certain quantitative elements with the situation in the developed countries, primarily European Union countries was provided and also, examples and experience from several developed countries ware used. Additionally, certain time trends, especially with regards of the number of healthcare professionals, were presented.

Considering the findings of the situational analysis, the consultative group also performed a participative process for development of directions that the country should follow in order to achieve systematic solution of the problems, improvement of the indicators over long term and sustainable removal of the existing barriers. For certain aspects, few modalities were proposed.

The conclusions derived from the situational analysis of the reproductive healthcare in Macedonia with a focus on the human resources, which were the main principles in the development of the proposed modalities by the consultative group include:

› The main threat for the country relates to the fact that the **average age of the health-care professionals**, especially of the specialists in gynecology and obstetrics, as well as midwifes, is growing rapidly which poses a great danger for this segment of the healthcare **in the near future**.

- The number of **midwifes and nurses with higher vocational education**, especially the number of those recognized and employed by the healthcare system as highly educated staff is very low.
- The physicians – specialists in gynecology and obstetrics have unified **specialization** with duration of 60 months and acquire the same competences, regardless of the health-care level in which they are referred to work. Most of the reproductive health services are provided in **all three healthcare levels**. Neither the Law on Health Protection, the evidence-based medicine nor the practice, provide clear distinction of the healthcare level responsible for the provision of certain services.
- The **higher-vocational education** system for **midwifes** is not harmonized with the situation on the labor market or with the Council of Europe flexibility recommendations. There is no efficient professional protection of the midwife profession such as chamber and licensing and relicensing system as well as continuous medical education system.
- The territorial **distribution** of the healthcare professionals in the country, especially of gynecologists and midwifes is especially uneven with huge discrepancies in the availability of healthcare professionals for the women in various regions.
- The **health records system** is very poor with unclearly regulated responsibilities in this segment. The data collected for the health workers are only a fraction of all data which according to the global standards and recommendations should be collected for the purposes of assessments and policy formulation, taking into account that the healthcare staff costs are the largest portion in the total healthcare expenditures.
- The primary healthcare currently engages 40% of the specialist gynecologists. Capitation is the **provider payment method,** which was introduced more than 10 years ago and since then it has not been adapted to the developments in healthcare and society and there are no indicators showing its efficiency. This system represents a payment method which is not conductive to quantity or quality of services, is unacceptable to the service provides and has been identified as one of the direct causes of the increase of the barriers to accessing reproductive healthcare services.

In line with these main conclusions, the consultative group created objectives, directions i.e. modalities to be followed by the state, for systematic and sustainable resolution of the identified problems in line with the goals and provisions of the "Global Strategy on Human Resources for Health: Workforce 2030"[1]. Certain proposals were provided for short/mid and long term measures which might be undertaken in order to realize the goals.

It is necessary to emphasize that the realization of the proposed measures requires joint efforts by all stakeholders, establishment of interdisciplinary work groups, adaptation of the relevant laws and bylaws etc. The responsible stakeholders include the Government of RM through the Ministry of Health, the Health Insurance Fund of Macedonia (HIF), the Institute of Public Health (IPH), the Electronic Healthcare Directorate, the Health Home - Skopje through the Institute of Mother and Child Health, the Agency for Quality and Accreditation of Healthcare Institutions , the Ministry of Education and Science (MOES), the Ministry of

Information Society and Administration, the specialists in gynecology and obstetrics, represented by their associations, the midwifes and nurses, represented by their associations, the Doctors' Chamber of Macedonia, civil society organizations, international agencies (WHO, UNFPA, UNICEF).

Primarily it is necessary to perform a financial analysis for short/medium term, but also for the long term proposed measures for transformation of the healthcare services payment methods.

It is also necessary to analyze the necessary regulatory changes.

It is necessary to establish a separate organizational unit in the Ministry of Health for the promotion of the reproductive health in Macedonia, which will be responsible to coordinate the activities related to the reform processes in this area.

1 *WHO. Global Strategy on Human Resources for Health: Workforce 2030. WHO, Geneva 2016.*

Utilization of the scarce resources in a best possible way

... and ensuring that they will be strategically engaged through adoption and implementation of policies for healthcare professionals, based on evidence and adjusted to the context of the national healthcare systems at all levels.

Physicians Specialists in Gynecology and Obstetrics

- Develop a plan and realize a long term strategy to maintain the total number of specialists in gynecology and obstetrics at the current level through relevant long term determination of the number of **specializations** on an annual basis considering the workforce aging rate. The specializations which will be issued should maintain the old model of unified specialization in gynecology and obstetrics where the curriculum will cover all the competences. The practice of 2016 to organize specializations in gynecology specifically for primary healthcare should be abandoned.
- **Redefine the national demographic standards** provided in the Regulation on the Network of Healthcare Institutions with reference to the number of gynecology teams in relation to the geographic coverage (increasing of the norm of 3,000 women per primary gynecologist to a norm which is realistic depending on the local needs – around 5,000 women per primary gynecologist) – taking into account the **total capacities at primary and secondary level** combined, changing the regional organization and establishing a new network with a defined number of gynecologists.
- **Expand the competences of the specialists in gynecology and obstetrics**, who currently work on primary healthcare level through additional training and work protocols (e.g. medical abortion, cardio screening, prevention and management of gender-based violence...).
- Introduce a system of **professional cooperation** between the institutions which realize the gynecology and obstetrics activities at primary – secondary – tertiary level in all directions, with a defined criteria and conditions for realization thereof.
- Strengthen the **quality management and control** system of the gynecology and obstetrics activity primarily through 1) adoption and practical implementation of the Standards for Accreditation of Specialist Offices in Gynecology and Obstetrics, prepared by the Agency for accreditation; 2) adoption of evidence-based guidelines which are not yet adopted (Guidelines for Safe Abortion, Contraception Guidelines); 3) adaptation of all guidelines/protocols to the local context; 4) strengthening of the degree of application of the evidence-based guidelines; 5) preparation/defining a set of primary level healthcare quality indicators with a focus on the reproductive healthcare, based on internationally adopted indicators.

- Regular training for primary gynecologists – prepare a plan for **continuous medical education** (CME) which will be mandatory, involving the Professional Association of Gynecologists and Obstetricians, the Professional Association of Private Gynecologists, MOH, Doctors' Chamber, Macedonian Medical Society (MMS). In certain areas, the gynecologists should receive training abroad and transfer their knowledge through cascade trainings to the gynecologists of the lower levels of healthcare. Encourage the mentoring system. The secondary level physicians should be trained at the University Clinic for Gynecology and Obstetrics as a tertiary healthcare institution, and apply the acquired knowledge in order to reduce the burden of the tertiary level gynecologists. The plan for mandatory CME of the primary gynecologists should include real needs based contents, with a special emphasis on the application of the existing clinical guidelines.
- **Strengthen the current capacities of the secondary healthcare in the domain of gynecology and obstetrics.** Introduce mobile teams (gynecologist and anesthesiologist) for assessment and strengthening of the capacities of the hospital departments based on the identified needs (professional competence and professional capacity, availability of equipment, medications and medical materials).
- **Regionalize the gynecology departments/maternity wards** by defining 3 levels of competences for provision of services in the domain of gynecology, obstetrics and neonatal care, according to criteria regarding the space, type and number of specialists, their expertise/training, organization, working hours, necessary equipment, geographic position and distance etc. The regionalization should be realized based on situation analysis with recommendations about the method of regionalization. The goal is to enable provision of relevant healthcare for the pregnant women and newborns depending on the existing health risk.
- **Change the payment method for the out-patient gynecologists** in order the remuneration amount to be influenced by the type and quantity of services, not only by the number of registered patients. To realize this objective several modalities are proposed:

Modality 1

· Defining a package/s of services which would be covered by the capitation point; envisaging differences in the capitation point coefficient as well as the content of the services depending on the woman's age as well as whether she is pregnant or not. Define the service packages for ante-natal care which will be exempted from co-payment which would encourage women to realize all envisaged and necessary health examinations (according to the guidelines).

Modality 2

· Application of a combined model of capitation and pay-per-service.

Modality 3

- Application of the pay-per-service method which is currently applied in the specialist-consultative healthcare. This should consider addressing certain threats during the implementation of this reform, through: 1) measures for direct access of the women to gynecology specialist healthcare, as an exception from the current method of access to specialist-consultative services through the referral system; 2) measures for discouraging of irrational demand for gynecology care; 3) measures for provision of control over the budgets (limits, controls etc.); 4) a good model of co-payment in which some of the services would be exempted from co-payment, according to the Government programs.

> **Introduce a health technologies assessment system** (HTA) as a mechanism to determine the type and scope of services which will be covered with the health insurance in any of the modalities.

Family Medicine Specialists

> Encourage the family medicine specialists which are involved in the primary healthcare level, to realize certain reproductive health services. To achieve that, it would be necessary to envisage financial incentives through **change in the payment methodology** of the primary healthcare. The current model of payment according to registered patients (capitation) should be transformed into combined model of capitation and pay-per-service i.e. pay-per-service package.

> Define **reproductive healthcare services/packages**, which will be covered by the family medicine specialist at primary level and paid by the HIF. This should envisage defining of a special (minimal package) for ante-natal care, which would be in the domain of competences of the family medicine specialists with defined coverage of services and their prices.

> When defining the payment methodology of the primary healthcare in the area of family medicine, a **difference in the payment level** should be envisaged **for family medicine specialists versus general practitioners** as an incentive for the general practitioners to continue their education through specialization in family medicine.

> Develop the healthcare services **quality monitoring and control system** with a focus on the primary healthcare which should be based on preparation of guidelines/standards/norms for practicing of reproductive healthcare services specifically by the family physicians and plan for their implementation.

> Envisage incentives for involvement of the family physicians in **population education and awareness rising** activities in the reproductive health area.

Midwifes/Nurses

- Strengthen **midwifes'** role at all healthcare levels.
- Prepare a **National Program for Education** for promotion of higher education of midwifes and nurses.
- Envisage measures for **encouraging midwifes' higher education**: 1) flexible duration of the specialized university programs for midwifes (one to three years) depending on the previous professional practice as nurse, according to the recommendation by the Council of Europe; currently the duration of the higher education for midwifes is fixed at 36 months; 2) providing scholarships through the Health Home, MOES, MOH, foreign funds according to the mapping/field findings.
- Strengthen the **role of the nurse/midwife in the primary healthcare** in the selected doctor – nurse team in order to ease the burden of the gynecologists through: 1) defining the services which may be provided by the midwife/nurse in the PHC offices (contraception counseling, nutrition, physical activity, breastfeeding, harmful effects of tobacco, drugs, alcohol, prevention of sexually transmitted infections, prevention and management of gender-based violence, identification of risk signs through measurement of blood pressure, body mass etc., inviting patients which do not come for regular health checks, for example for PAP test, pregnant women etc.); 2) financial incentives based on the number of midwifes/nurses and their education degree.
- **Revise the jobs descriptions** of the public healthcare institutions in the part of the competences of the midwifes and nurses, to differentiate between job positions for midwifes with high school and midwifes with higher education, thus making relevant changes in the MISA Catalogue of Jobs in the Public Sector, which currently does not contain any job positions in the areas of midwifery and patronage which require higher education.
- Prepare g**uidelines/standards/norms** for practicing reproductive healthcare services by midwifes and nurses and plan for their implementation

Modality 1 – midwifes as independent stakeholders in the private primary healthcare

- Enable "concession arrangements" for **midwifes** through primary healthcare level **independent private healthcare organizations** which would sign contracts with HIF and realize stationary and outreach work and would be paid through combined model of pay-per service and capitation.

Modality 2 – strengthening of the preventive healthcare in the public healthcare sector

- **Strengthen the current system of polyvalent patronage** within the Health Home through: 1) investments in technical and technological work conditions of the patronage activity; 2) enabling selection of patronage nurse by the patients according to a model of "primary/selected patronage nurse" (midwife or nurse); 3) changing the payment method into combined pay-per-service package method + incentive for the selected patronage nurses (capitation).
- **Open counseling centers for pregnant women within the health homes** in which 1) so called "family midwifes" with higher education would be engaged, 2) stationary (office) activity will be performed with a possibility for home visits (optional – combination of both); 3) will be paid by combined model – pay-per-service package + incentive for the selected patronage nurses (capitation); 4) standards and norms will be prepared for the work of the counseling centers.

Reducing the inequalities in the access to healthcare professional

- Establish a **National Coordinative Mechanism** for reduction of the inequalities in the access to reproductive health professional who, among the other, will work on setting targets/indicators about the degree of reduction of the inequalities in the access, which will be used to measure the country's achievement in that direction. Optionally, this activity should be recognized as a special priority in the activities of the existing National Committee for Safe Motherhood.
- **Amend the Regulation on the Network of Healthcare Institutions and the demographic standards** through: 1) revising the network of specialists in gynecology and obstetrics; 2) establishing demographic standards and network of specialists in family medicine, midwifes and nurses/patronage nurses (in preventive healthcare) in line with the international recommendations, but considering the current situation and the differences between urban and rural areas (ex. 1 family doctor per 1,000 population; 1 polyvalent patronage nurse per 5,000 – 6,000 urban population/2,000 – 4,000 rural population etc.)
- Establish a **mobile – outreach service** adapted for provision of gynecological services, through: 1) defining packages of mobile services, finances through the MOH preventive programs; 2) involvement of the capacities of the civil sector and Roma health mediators for counseling and referral; 3) hiring the Roma health mediators and their more active engagement.
- Encourage **mobility of the specialists in gynecology and obstetrics** through defining mobility packages for the areas in which poor accessibility to gynecologist is identified.
- The plan of specializations in gynecology and obstetrics as well as the advertisements for studies for nurses and midwifes should envisage incentives for the healthcare professionals which will work in certain regions.
- **The greater involvement of the family medicine specialists, midwifes and patronage nurses in provision of reproductive healthcare services will provide greater territorial coverage with primary care services.**

Strengthening of the health records system, relating to human resources

... for relevant planning and programing, monitoring and responsibility for the implementation of the national and regional strategies as well as the Global Healthcare Sector Human Resources Strategy.

- Reach consensus between the public healthcare institutions, healthcare institutions and scientific community about the **urgency of the need** to solve the problems with healthcare sector records.
- Clearly **define the competences** of the various state institutions in this segment.
- **Expand the scope of information about the healthcare professionals** which will be collected and systematically processed in accordance with the international recommendations and will include comprehensive review of the workforce characteristics (public and private practice); modalities for payment thereof (from several sources, not only from the public sector payroll); workers' competences (ex. the role of the healthcare professionals divided by staff and various care levels); absences from work and main causes; workforce dynamics and mobility (rural versus urban, public versus private, international mobility); attacks on the healthcare professionals; and performances of the healthcare sector human resources management system (average time to fill in the vacancies, rate of disappearance during education and employment, results of the accreditation programs etc.)
- **Invest in information technology** and its networking in order to perfect the current national health sector electronic record system. Pay special attention to and remove the weaknesses in the healthcare staff data recording (registry) as well as the method of recording the healthcare services/checks at primary and secondary level.
- The information collected in the national electronic system should be made available to relevant institutions for **analytical and scientific purposes** for relevant planning, programming and decision making in the health sector.
- Promote the electronic **records of the health examinations** on primary healthcare level and remove the current weaknesses through establishment of a work group with all stakeholders.

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