Policy Brief

Protocols on non-Communicable Diseases and Elderly People Care for Family Medicine in Albania

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Background

Clinical guidelines and protocols (CGP) are an essential element of evidence-based modern healthcare practice. They are intended to provide concise, yet effective instructions on how to provide healthcare services. The most important benefit of clinical practice guidelines is their potential to improve both the quality and process of care and patient health outcomes[1].

Recent World Health Organization analyses report on different aspects of primary health care (PHC) in Albania including governance, infrastructure, equipment, human recourses and organization of services[2]. However, the issues related to clinical guidelines & protocols in Albania have not been analyzed thoroughly, to date. Hence, this comprehensive inventory related to clinical guidelines and protocols in the PHC area aimed at filling this void.

Key Findings (Facts)

(based on the newly compiled Inventory of existing CGPs on NCDs and elderly people care for family medicine, December 2019)

Development of the Clinical Guidelines and Protocols in Albania

The CGPs were mainly developed from 2004 to 2019 in various phases and at different stages of health care system reforms in Albania but, most commonly, in the framework of internationally-supported projects.

All CGPs have been approved or endorsed by the main public responsible agencies in Albania, i.e. the Ministry of Health and Social Protection (MoHSP), the Compulsory Health Care Insurance Fund (CHCIF), or the National Centre for Quality and Accreditation in Health Care (NCQSAHI). Specifically, to date, 57 CGPs on NCDs and older people care have been established in the context of Albania.

Typically, professors of the University Hospital Centre in Tirana have been involved in the development of most of the available CGPs documents. On the other hand, PHC professionals have been rarely and only occasionally involved in the process of CGP development.

Of note, the existing CGPs in Albania have not been specifically designed for family doctors (PHC professionals).

Furthermore, CGPs have not been developed in a properly planned and systematic manner, with participation and coordination of all major stakeholders and parties concerned. In particular, the current CGPs have only scarcely involved PHC professionals and their potential contribution has been neglected.

In addition, the existing CGPs are not accompanied by training manuals which would explicitly frame and foresee a proper implementation and the respective monitoring mechanisms.

As a matter of fact, most of the existing CGPs have not been made available to family physicians for use and application in their daily practice.

Inventory of the Clinical Guidelines and Protocols on NCDs and older people care

The inventory specifically covering CGPs on NCDs and older people care consists of 57 documents (guidelines and accompanying protocols), which have been organized in seven categories:

i) cardiovascular diseases; ii) diabetes; iii) chronic respiratory disease; iv) mental health conditions; v) elderly people; vi) other NCDs, and; vii) CHCIF's drug protocols.

Of all the 57 CGPs included in this Inventory, only three of them have been developed by CHCIF (two new CGPs: one on Diabetes and the other on Hypertension and the CHCIF's drug protocols). The 54 CGPs have been developed by NCQSAHI (with only two exceptions, when IPH led the process) and subsequently approved by MHSP.

Likewise most of the other existing CGPs, only few of the NCD and/or older people care CGPs are used sporadically by family physicians in their routine clinical practice.

Compatibility with CHCIF drug protocols

In addition to the above mentioned CGPs, there are a series of protocols elaborated by CHCIF that include 430 drugs (all the drugs reimbursed fully or partially by the health insurance scheme). While clinical guidelines provide only recommendations to be followed based on physician's judgment, the CHCIF drug protocols are mandatory requirements based on strict contractual basis. However, clinical guidelines and the CHCIF drug protocols are pretty much in line with each-other and, based on the current comprehensive review, there is no evidence of any important incompatibility.

Of note, typically, the formulation of evidence and the recommendations stated in clinical guidelines, do not contradict the CHCIF drug protocols. Furthermore, almost always, during the development of CGPs, NCQSAHI has systematically involved CHCIF experts in the working groups to avoid discrepancies and assure a reasonable level of consistency.

Nonetheless, there are some differences between CGPs and CHCIF drug protocols, as they have different aims; CHCIF drug protocols have been developed to monitor PHC practice vis-à-vis the planned funds allocated on yearly basis for reimbursable drugs.

Furthermore, CGPs have been developed mainly by university hospitals focusing especially on hospital care and overlooking the specificities and peculiarities of the PHC practice. In most cases, the protocols lack a clear-cut division of clinical tasks for PHC and other levels of care, thereby providing no specific criteria on referral procedures from GPs to narrow specialists. Contrary to this, most CHCIF drug protocols require for specific examinations and referrals to narrow specialists as core criteria for drug prescription, prioritizing generic drugs.

Another problem is the lack of simultaneous update of drug recommendations in CPGs and CHCIF drug protocols. NCQSAHI CGPs for PHC in particular, have not been updated since 2010; the revision process started in 2018 was limited to guidelines about University Hospital Care.

In 2019, CHCIF has started for the first time development of its new clinical guides about diabetes and high blood pressure, adapting them to PHC settings and assuring consistency with its drug protocols. Yet, the process remains uncoordinated with NCQAHI and the newly established Operator of Health Care Services.

Issues related to use of clinical protocols in PHC practice

PHC physicians are very familiar with the CHCIF drug protocols and apply them vigorously in their routine clinical practice. Actually, the correct implementation of CHCIF drug protocols is assured through a continuous monitoring system including explicit financial mechanisms.

On the other hand, PHC physicians are not familiar with the other CGPs. Even in cases when PHC physicians are aware of the existing CGPs related to NCDs or older people care, such protocols are used sporadically (mostly driven by personal interests) and by no means in a systematic manner.

Main reasons for not using the CGPs are as follows:

- PHC physicians often are not aware about the existing of such protocols;
- PHC personnel believe that the current CGPs are not designed according to the context, needs and specificities of PHC services, as well as the limits and restrictions experienced in the PHC realm.
- The existing CGPs do not specify neither the roles of different health care levels, nor the referral procedures or tasks and responsibilities of doctors/nurses/other specialists.
- GPs, especially the senior ones, perceive time-pressure and lack of sufficient time for reading through the voluminous documents pertinent to the current CGPs.
- Continuous medical education not always has been coordinated with implementation of clinical protocols in the PHC routine practice.

- Lastly, PHC physicians feel neither obliged nor motivated to use the protocols in practice. CHCIF, NCQAHI and the Operator of Health Care Services have not established any systematic monitoring mechanisms or supportive supervision instruments in this regard.

Key Messages

- The recently established 'Inventory' of 57 existing CGPs for family medicine with special focus on NCDs and elderly people care should be considered as a dynamic and comprehensive reference to be checked during every future effort aiming at enforcing the implementation of effective guidelines and protocols in PHC practice. The recommendations and models of care these CGPs contain can serve as a solid basis for the development of more concise and refined practical guides for the general practitioners in Albania.

- The most important health conditions amenable to PHC services should be selected and revised/updated accordingly from this newly developed Inventory. Subsequently, particular efforts should be made to include these protocols into family medicine (PHC services) as easily and concisely as possible, which could serve as an educational tool for Peer Groups too.

- The PHC manual and protocols developed in 2005 by 'Proshendetit' Project, which were updated in 2008 by NCQSAHI, and endorsed by MoH, constitute a good example which should be revised and developed more concisely for PHC practice. Such a manual is the best model combining the main NCDs and care for the elderly in the PHC context and routine practice.

- The priority health conditions for which the PHC personnel need to have effective CGPs for the standardization of care include the following NCDs: HBP, ischemic heart disease, other circulatory problems, diabetes, dyslipidaemia, COPD, asthma, and mental health issues.

- Two CHCIF protocols about diabetes and high blood pressure, prepared during 2019 are also good examples of PHC friendly guidelines. To increase the chances for effective implementation, the CHCIF should involve in this process the Operator of Healthcare, which has currently legal responsibility in this area. The NCQSAHI should be also involved, which can assure procedural consistency and coordination with the process of accreditation of health centers. Finally, MoHSP should always endorse all the documents according to the existing health care law in Albania.

- Clinical guidelines should cover all the pathways from PHC services to narrow specialists and backward, with specific tasks at every level. They should adapt to PHC time limits, laboratory requirements and other resource constrictions. CGPs need also to include clear follow-up recommendations or criteria for long term clinical decision taking in the field of chronic conditions. It will help avoiding misunderstanding during collaboration of GPs with narrow specialists. A comprehensive PHC clinical practice guideline should consider specifying tasks for nurses as well as physicians at health centre.

- Effective protocols should be very concise and simple, specifying standard procedures for each health professional at PHC settings. In-depth clinical aspects and scientific basis for the content of the protocols should be inserted into separate documents for potential use only by those professionals who need extensive scientific information, mostly the younger physicians.

- CGPs should serve as a basis for the facilitation and accreditation of PHC institutions by the NCQSAHI and assessment of potential malpractices by the Chamber of Physicians in Albania. Hence, CGPs should not be meant only for the inspection of obligatory financial and contractual restrictions imposed by the CHCIF.

- The Operator of Healthcare Services and its local units of healthcare should coordinate with CHCIF and NCQSAHI to facilitate the formal introduction of CGPs to PHC personnel, before applying systematic supportive supervision of their application. The Health Operator and its local units should plan and support making CGPs available to PHC providers and capacitating selected PHC teams in provision of training on implementation of CGPs among colleagues via peer groups.

- Lastly, family physicians, through their representatives should be part of the working groups for the design and updating of the CGPs. It is recommended to involve associations of patients in this process as well.

THE WAY FORWARD

- There is an urgent need to develop and/or update CGPs in PHC services focusing on the most frequent NCDs and issues and problems pertinent to older people care.
- In all cases, the establishment of new protocols and/or the revision/update of the existing CGPs should be geared toward PHC environment, its context, specificities and peculiarities, as well as limitations and restrictions faced in the daily PHC practice.
- Equally importantly, development of new protocols and/or update of the existing ones should fully involve PHC professionals, as a main prerequisite for sustainable use and effective application of CGPs in routine PHC practice.

1 Woolf SH, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines. BMJ. 1999;318(7182):527–530. doi:10.1136/bmj.318.7182.527.
2 World Health Organization. Primary health care in Albania: rapid assessment. Copenhagen, Denmark WHO, 2018.

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