Policy Brief

Work time allocation patterns at Primary Health Care level in Albania

Background

Albania has embraced the Universal Health Coverage Policy giving Primary Health Care (PHC) priority as the gateway towards the system[1]. However, over the last years it got increasingly clear that there are important workforce shortages in Albania to deliver essential health services at PHC level. These shortages are further aggravated by poor human resource management practices, large imbalances in the geographical distribution of the health sector workforce and migration[1]. Thus, there is a need to better understand the nature and size of these problems, including the relation between shortages and the productivity of health workers (in terms of human resources management).

A motivated and well performing workforce is a crucial input to equitable and efficient health service delivery. Although efficiency and quality improvements have been a major concern in the context of health sector reforms, few countries have systematically addressed performance improvements. More generally, health sector reform in the past decade has tended to focus on reshaping institutional relations and changing methods of health system financing. Little attention has been paid to human resources. It is therefore an important goal of health policy and practices to identify approaches for improving the productivity, performance and the motivation of HWs.

This policy brief examines the productivity and work time use of HWs at district level and analyses the relationship between productivity and various potential determinants such as individual characteristics of workers and urban-rural differences. The document also discusses productivity improvements as a possible way for reducing human resources shortages.

Methods

This brief is based on the findings of the study "Work time allocation patterns at Primary Health Care level in Albania", which combined two different approaches. The first approach consisted of direct observation of PHC staff to assess the allocation of time during their daily working routine. 18 doctors and 30 nurses from health centers and health post ambulances of Diber and Fier regions were followed for five consecutive days during the period 7th January 2020 – 28th January 2020. The second approach was a qualitative one, with in-depth interviews to better understand work time allocation patterns as seen by three different types of health stakeholders: (1) health providers, (2) director of health centers and (3) policy makers. 13 interviews were conducted during the period November- December 2019.

Main findings

General time allocation findings

- Health providers (doctors and nurses) in PHC work less hours than assumed in both regions. Only 76.3% of required working time was observed and recorded (1216.7 hours in total), while during 6.7% of required working time no observations were obtained due to logistics constrains of the study and 17% of required working time accounted for absenteeism in work place. Absenteeism in the workplace was a consequence of several actions: i.e. coming late to the workplace (4.4 %), leaving earlier (4.9%) and being absent for full working days (7.7%). Most of the time the absenteeism was justified as lack of logistics to come and get back from work, rotation and replacement within health services, participation in meetings/ trainings, personal reasons.

- The study found significant variations of work-time allocation patterns across doctors and nurses. The work-time allocation patterns were similar between the two regions under review as well as urban and rural facilities, except for the time nurses of rural and urban settings allocated on direct patient care and administrative activities. The patterns of work-time allocation while away from the facility differ to some extent.

- Doctors and nurses worked on average 5.6 hours per day and were consulted by a daily average 11.4 patients. They spent 40.7% of their overall working time at the facility unproductively (36.8% of which was spent on waiting for patients and only 3.9% on breaks), 29% on administrative activities, 15% on direct patient care and 12.7% on outreach activities. The rest of the time was allocated to activities that took less than 2% of the overall working time: continuous medical education (1.6%) and meetings (1%).

- These findings contradict some of the qualitative ones, where health providers were perceived as having a high workload. The need for better management of human resources in PHC, in terms of distribution of health resources and increasing the interest of doctors to work as family doctors, is perceived by policy makers and family doctors.

- Administration work occupies a great amount of time for PHC providers as one of their main activities (34.9% for doctors and 25.8% for nurses). *In terms of this study administration work includes dealing with health information (6.4% for doctors and 12.1% for nurses), patient administration (consultation forms, recommendations, patient forms - 20.6% for doctors and 4.7% for nurses), and other administration tasks (7.9% for doctors and 9.0% for nurses).* The effort required for the administrative tasks is illustrated by the fact that there are 58 registers and forms of CHCIF and of MoHSP which are to be filled by staff of PHC facilities[2] and in addition contain repetitive information. Furthermore, the health staff of PHC reports separately to two different institutions: the regional entities of the CHCIF and the local health care entities of the Health Operator.

Thirdly, most of the documentation is paper-based (at the time that our study was being conducted e-consultation forms were yet to be implemented).

- Findings from qualitative survey suggest that clinical practice was considered a priority toward other tasks, although administration tasks were perceived as a burden for achieving work performance in PHC, by health providers and policy makers.

- Very little time is spent on health promotion (HP) by both doctors and nurses (0.2% of the overall working time at the facility), mostly limited to HP during consultations. Findings from qualitative suggest that insufficient budget and insufficient efforts to improve the HP in the higher levels of organization are the main reasons for this limitation. In Albania as in other countries, nurses' constrains to offer HP are further related to the general practice settings and their educational information[3,4].
- Findings from the qualitative part suggest that motivation among the interviewed health providers was not optimal. Except for higher salaries, the interviewees said that trainings, having equipment and good working conditions would increase their motivation.

Findings on work time allocation patterns along cadres

- Main groups of activities where PHC doctors spent their time were: administration (34.9%), unproductive time (29.4%, mostly waiting for patients) and direct patient care (24.5%). As for nurses, main time-consuming activities were unproductive time (46.9% of their working time, mostly waiting for patients), administration (25.8%), outreach (15.8%, home visits included) and direct patient care (9.7%).

- Family doctors are responsible for most of activities in the PHC services in both regions, while nurses are underused although in high numbers (224 family doctors versus 1130 family nurses, in Diber and Fier). Albania, as other countries[5], has a long tradition of doctor-centered health care with limited scope of nurse practice. Looking at the job contract between every HW and the CHCIF, it becomes clear that doctors are a key element for the functioning of the PHC system as they are the only ones responsible for conducting clinical consultations with patients, prescribing medication, referring patients to a specialist, filling out the patient form and updating the patients' registers. The study found out that family doctors visited 18.2 patients on average per day, compared to national data of 13 patient per day[6]. The rate of patients visited by nurses was 7.4 patients per day. The same perception was expressed in the qualitative part of the study, where doctors were perceived as busier than nurses as they have more responsibilities including clinical and financial responsibilities.

- Doctors spent more time on direct patient care (24.5%) than nurses (9.7%). *If patient administration tasks would be considered as part of direct patient care category and as exclusive tasks for the family doctor in Albanian PHC system, 20.6% more time would be spent on this category: in total PHC doctors would have spent **45.1%** of their time on direct patient care*. Nurses spending almost three quarters less time than doctors on clinical activities can be attributed to: Firstly, HW-patient ratio, with doctors being responsible to cover six times more patients than nurses (one doctor: 2500 patients, one nurse: 400 patients)[2]. Secondly, lack of nurses' competences and training to conduct certain activities, especially the ones involving complex nursing skills and clinical reasoning[3,7]. Thirdly, the Basic Package of Care (BPC) despite outlining the required skills for family doctors and nurses at PHC facilities, does not give a clear description of their roles.

- Findings from qualitative part, perceive nurses as an underused work force, to which a rather secretarial role is imposed by doctors.

- Continuous medical education (CME) takes a small part of nurses time (1.3%), while doctors spent 2.2% of their time on CME.

- Doctors spent less time on outreach than nurses (7.2% versus 15.8%), especially on home visits (0.7% versus 4.4%). The BPC describes offering home services with or without the presence of the doctor for almost all of the seven main services as a responsibility of nurses. Thus, nurses go on more home visits than doctors and consequently spend more time on home visits.

Comparison of findings between urban and rural facilities

- PHC family doctors in urban facilities spend more time than doctors in rural facilities on direct patient care 27.4% versus 23.9% (*if patient administration is considered as a direct patient care task it would be 54% versus 41.2%*), followed by administration tasks 36.3% versus 34.6% (*if patient administration excluded, it would be 9.7% and 17.3%*) and unproductive time is almost the same for both settings (*30% in urban versus 29.3% in rural*).

- Nurses in rural settings spend more time than those in urban settings on direct patient care (16.3% versus 10.2%) and unproductive time (49.4% versus 44.6%), but less time on administrative work (21.6% versus 35.3%).

- Doctors in rural settings spend 10.7% of their overall working time away of their facility, compared to 1.2% of the working time of doctors in urban settings. While nurses in rural settings spent more time away of their facility compared to nurses in urban ones (RHC nurses spent 12.6% of their time, while UHC nurses spent 9.1%, and RHPA nurses spent 24.4% of their time, whereas UHPA nurses spent 18.3% of their time). A lot of time is spent on transport (walking or driving), especially in rural areas because of the large catchment area that the staff of the rural facilities has to cover to provide the service away from the facility.

Main recommendations for addressing these findings

- Better management of PHC services in terms of planning of doctors and nurses' activities is needed. It is recommended to train HWs in work-time organization as this is an important skill that PHC staff should develop in order to use the time efficiently.
- Implement an appointment system for patients. Prior studies have reported benefits in scheduling the daily work, better planning of services and better care[8,9].
- Improve the HIS practices for PHC (doctors and nurses as primary users), through better coordination between central institutions, more investment in digitalization, and training of staff on gaining skills on such digitalized health services.
- Empower nurses in PHC through training and education programs that are based on the evaluated needs of nurses, system and population. Extend nurses' area of work by granting them more responsibilities, enabling them to perform new tasks with responsibility and professionalism and ensuring more equilibrated shares between family doctor and nurses.
- More investment in PHC related to improving health facility infrastructure, working conditions and increasing motivation of health workers (increased salaries and professional development opportunities, as well as improved logistics of health providers conditions).

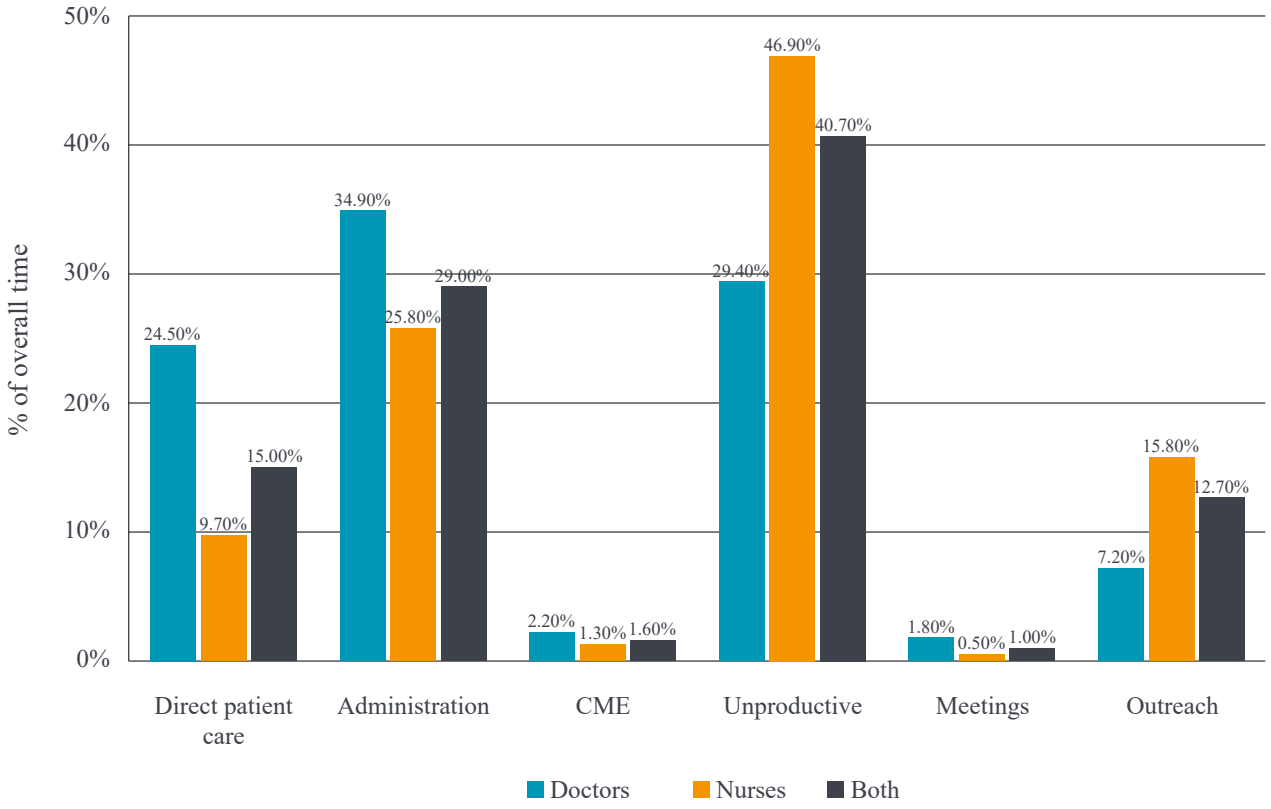

Figure 1: Overall time allocation on main categories of activities by health workers category at the facility

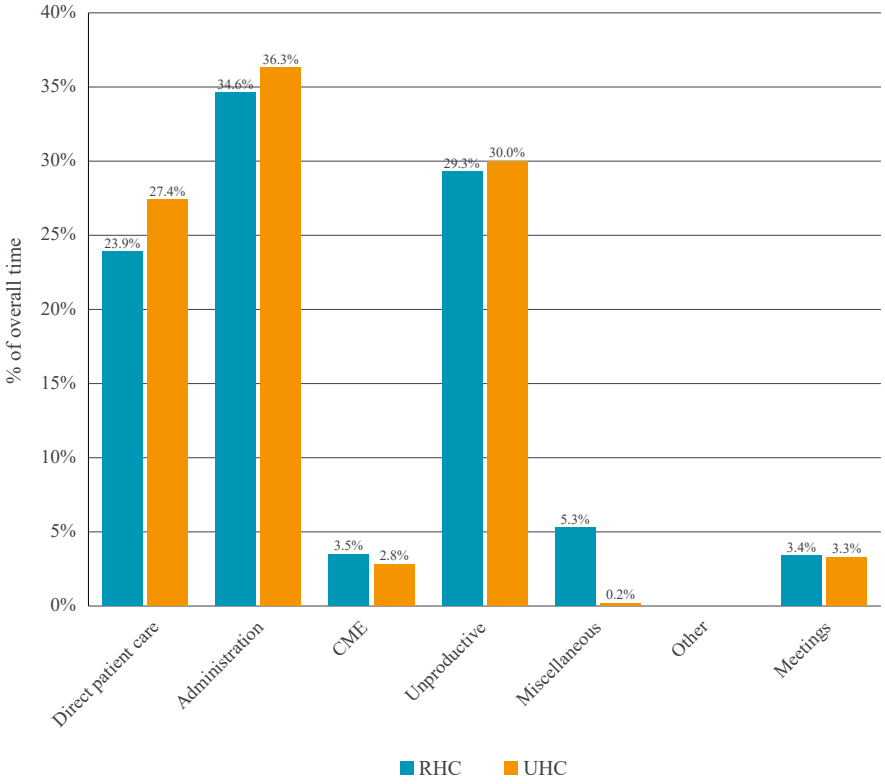

Figure 2: Percentage of overall time allocation (including outreach time) by doctors at different facility types on main categories of activities

% of overall time of nurses in different Health Centers

Main Category	RHC	RHPA	UHC	UHPA
Direct patient care	16.1%	16.8%	9.9%	10.4%
Administration	24.0%	17.4%	35.0%	35.6%
CME	2.1%	0.6%	1.2%	0.5%
Unproductive	49.0%	50.2%	48.1%	40.7%
Miscellaneous	6.6%	12.9%	4.4%	12.5%
Other	1.6%	1.2%	0.1%	0.0%
Meetings	0.6%	0.9%	1.2%	0.3%

Figure 3: Percentage of overall time allocation (including outreach time) by nurses at different facility types on main categories of activities

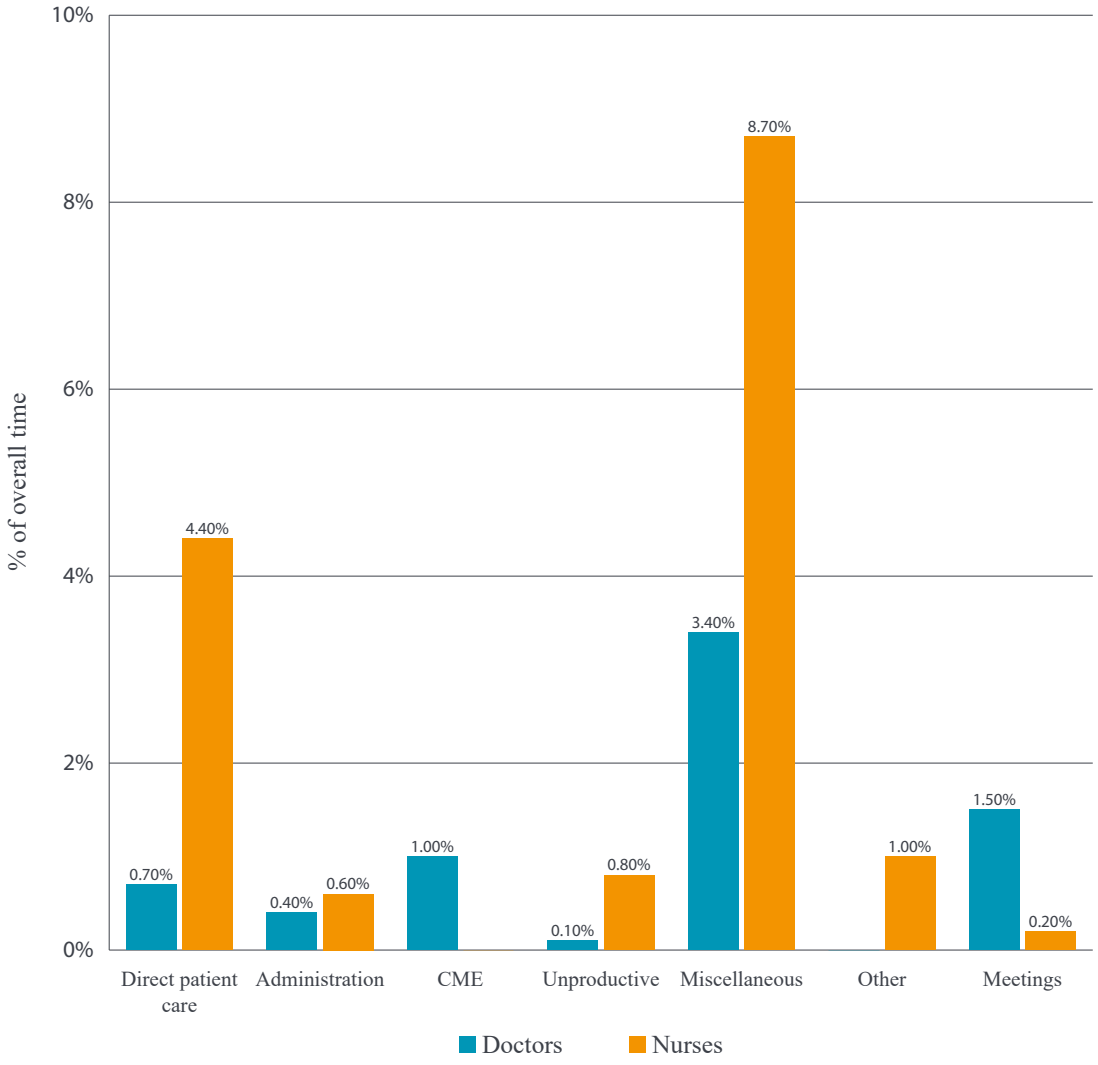

Figure 4: Percentage of overall time allocation by health workers category while away from facility

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