POLICY BRIEF 2

ACCESS TO A SPECIALIZED HEALTH CARE WORKFORCE

...for diabetic patients

INTRODUCTION

This policy brief outlines information about the availability of a specialized health care workforce for diabetes treatment in Kosovo. The brief provides some key facts regarding the current state of affairs and some ideas for how to deal with such situations in the future.

The main aim of the KOSANA Project is improvement of the health and social security of the population of Kosovo through support of active participation by civil society in the development and implementation of a health insurance system in the country.

The KOSANA Project empowers the CSO-s representing citizens and patients to create advocacy positions based on facts, information, and the needs of the people. This process requires a long-term effort and commitment by organizations that represent citizens' interests.

This policy brief outlines information about the availability of a specialized health care workforce for diabetes treatment in Kosovo. The brief provides some key facts regarding the current state of affairs and some ideas for how to deal with such situations in the future.

Patients with diabetes are treated at all three levels of care: primary, regional hospitals, and tertiary care centers. The system of care is characterized by poor diagnostic ability, inadequate supplies of medication and testing equipment, and lack of a specialized health care workforce.

Services for diabetic patients are generally available; however, patients have to visit different doctors located in various places to get these services. The travel required to reach physicians and medical services is easy, but may be costly. The waiting time to see the doctor is not very long normally, but it can be at times, especially in the public sector.

People's trust in doctors, nurses, and medical staff is known to suffer at times. Disinterest or unprofessionalism on the part of the doctor or medical staff can be present, although patients report positively about the professionalism of doctors and medical staff on most occasions. Discriminatory or inappropriate behavior by medical staff is rare, but it does occur.

In general, there is a perception that there is no state-of-the-art treatment for type 2 diabetes. There are some efforts in the provision of good care, but they are limited. European guidelines for diagnosis and treatment are not part of the national effort to deal with situation, although there is talk about integrating them.

However, there are national guidelines and other standard procedures that are being used by different institutions. These are based on guidelines developed in the United States and Europe. The guidelines address both the diagnosis and treatment of the disease.

There have been efforts to develop the capacity for better treatment of diabetic patients, but there is still a long way to go before we see serious improvements in care. An important aspect of the problem is the working conditions for the medical staff. The equipment in the public clinics and hospitals is generally quite poor, though there are exceptions to this rule, and there are facilities that operate well and are well equipped.

The aim of this policy brief is to provide an assessment of the availability of the health professionals that provide treatment for diabetes in the country and to suggest possible policy measures that could improve the current situation.

KEY FINDINGS

Several interesting facts were revealed by a survey performed in 2013 with the support of the KOSANA Project and are listed below.

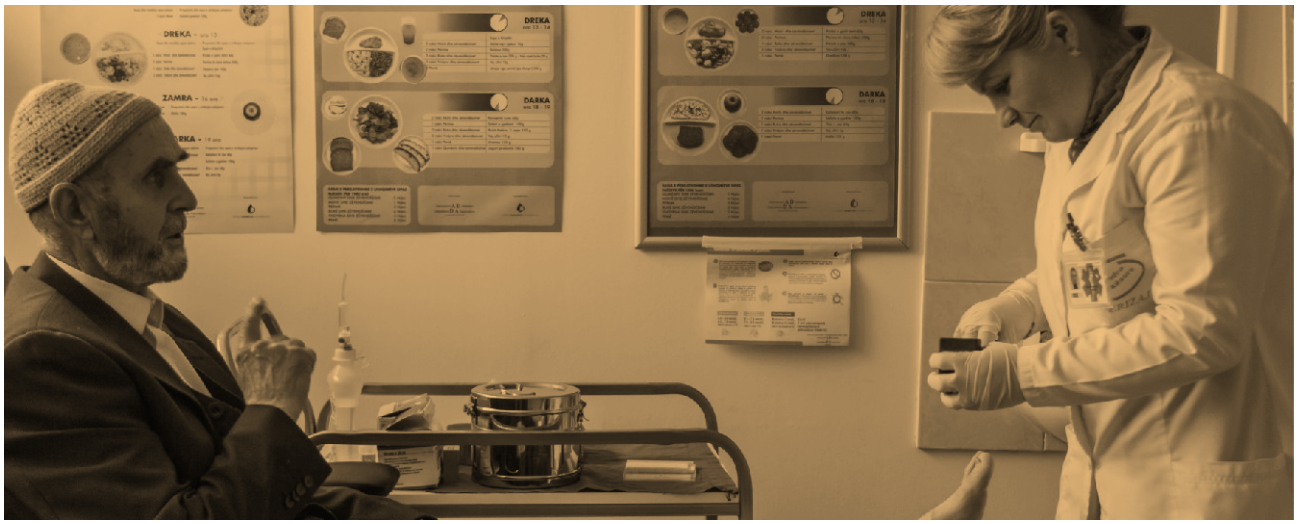
1. Most diabetic patients seem to have visited some kind of health professional to treat their disease. 59% of people with diabetes have visited a family doctor. A much higher percentage has visited an internist (70%) and/or a diabetes specialist (68%). Only 39% of people with diabetes have visited an endocrinologist. The total percentage of patients visiting either a diabetes specialist or an endocrinologist is 82.3%. 24% of people have visited both a diabetes specialist and an endocrinologist.

2. Diabetic patients are most satisfied with visits to diabetes specialists and endocrinologists. They tend to be less satisfied with visits to other health professionals, such as family doctors and internists.

3. A visit to a family doctor is positively correlated with a visit to an internist, while it is negatively correlated with a visit to a diabetes specialist or an endocrinologist. Visiting a family doctor does not seem to have a significant effect on visits to other health specialists.

4. A visit to an internist seems to be positively correlated with a visit to another health specialist.

5. A visit to an endocrinologist is positively correlated with visits to other health specialists; it is not significantly correlated with visits to family doctors, internists, diabetes specialists, or pediatricians.



DISCUSSION AND RECOMMENDATIONS

Data from the survey show that a larger percentage of people with diabetes visit an internist, endocrinologist, or diabetes specialist compared to a family doctor. This confirms that the primary care system is slightly less engaged in the provision of care for diabetic patients, while specialists are more involved.

One important aspect of measuring diabetic patient visits to health professionals is to see whether visiting one type of health professional tends to encourage or discourage visits to others. The correlations between visit rates among specialists could suggest that family doctors tend to refer diabetes patients to internists but not to diabetes specialists or endocrinologists. These findings could also indicate that patients who visit diabetes specialists and endocrinologists are not encouraged to have regular visits to a family doctor.

There are several important directions that policy discussions should take to address the workforce issues related to diabetes treatment. They are listed below.

1. Countries that deal successfully with diabetes have managed the lack of diabetes specialists by empowering family doctors and training them so that the health care services they provide to diabetic patients are as comprehensive, high-quality, and professional as possible. Due to the large number of people with diabetes and the frequency of their visits to health care institutions, even the most advanced societies with advanced health systems do not have a sufficient number of diabetes specialists and endocrinologists to fulfill the increased demands of this group of patients. To compensate for this, they use additional capacity in the primary care system.

2. The first step toward empowering family doctors is achieved by implementing the concept of family medicine in which the flow patients is improved by the primary health care provider taking the role of a "gatekeeper". This would result in a lower burden of routine and ambulatory cases on secondary and tertiary care systems, allowing them to focus on the provision of advanced care for sicker patients rather than ambulatory care.

3. Increasing the specialization of the workforce in matters that are important for the treatment of diabetes (i.e., treatment of specific complications, modern approaches to disease control, etc.) should warrant special consideration. This would reduce the need for treatment abroad, saving money and effort from patients, their families, and the health care system in the country.

4. Organization of care, guidelines for practices within each level of care, and determination of referral patterns to higher levels of care will be important determinants of the success of efforts to improve care for patients with diabetes. The concept of line services provides an opportunity to address such efforts.

Photos by Vedat Xhymshiti for Solidar Suisse Kosova 2014