



BALKAN PRIMARY HEALTH CARE POLICY PROJECT



Dear Readers,

Issue No. 7/8 of the BPHCPP Newsletter is focusing on organizations of health professionals, regulation and quality of practice. It brings you informative articles, project news and a useful tool for practitioners to ensure that clients are in the centre of their care.

It opens with an article on professional organizations of health workers by Djenana Jalovcic, followed by the article by Ruth Wilson on association and chambers of primary health care practitioners. Newsletter also brings you a report on business planning activities for Serbian professional chambers written by group of authors that includes the directors of professional chambers, both Serbian and Canadian consultants and the director of BPHCPP. Ivanka Franjic in her article places nursing in focus. There is another useful tool that we would like to share with you: a Guide for Client/Patient Centred Health Care.

Finally, you will find regular highlights of the past events in Serbia and Bosnia and Herzegovina as well as the announcement for the Third Regional Conference of the BPHCP project which is the final activity in the BPHCP project.

Even though we provided you with a lot of bedtime reading for this summer, we hope that you will still enjoy it.

BPHCP Project Team

Professional Organization of Health Workers:

Associations, Chambers and Unions

Health workers in this region have the long tradition of organizing professionally. Medical Associations or specialists associations with big membership base, research tradition and significant programs of continuing professional education are good examples.

In 2007 the Balkan Primary Health Care Policy Project gathered information about 118 active professional organizations in Bosnia and Herzegovina and Serbia who responded to the questionnaires sent by the Project. Out of the total number of organizations, 71 were registered in Bosnia and Herzegovina and 47 in Serbia. Professional associations were the most common way of organizing health professionals. There were 43 professional organizations in BiH and 43 in Serbia.

The main characteristics of the voluntary organizations of health workers in Bosnia and Herzegovina is absence of organizations at the state level, that prevents health workers of a specific profession or specialty to join international organizations as full members. Members of the international organizations such as the International

Council of Nurses or the World Confederation for Physical Therapy, accept only one member organization from one state with the biggest membership and which functions on the territory of the whole country.

While voluntary associations of health workers are well developed and have good reputation and long history, the chambers of health workers are of recent date. In the survey conducted in 2007, the Project collected information about 28 chambers of health professionals, out of which five were in Serbia and 23 in Bosnia and Herzegovina. There were 20 chambers in Federation of Bosnia and Herzegovina and three in Republic of Srpska, which is the reflection of administrative and political organization of Federation BiH, where the jurisdiction over health is divided between Federation BiH and ten cantons.

Existing Laws on Health Care Protection in entities of Bosnia and Herzegovina, and the Law on Chambers of Health Workers in Serbia, have introduced chambers as the mandatory form of professional organization of health workers.

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The main goal of chambers is self regulation of the professional practice through licensing of individual professionals giving them the permission to practise in the specific profession. Licensing is firstly a way to protect the patients and users of health services and secondly to protect the profession. Incompetent health workers or those who breached ethical code chambers can give disciplinary measures or revoke the license for practice in extreme cases. These measures prevent license professionals from harming the users, destroying the reputation of the whole profession and ruining the trust that users have in the profession. However, the current regulations which guide Chambers do not place emphasis on protection of the public.

Although laws regulated forms of mandatory and voluntary organizations of health workers as well as their distinctive roles, sometimes it happens in practice that their roles are overlapping in some instances, the mandate prescribed in the Law leads to conflict of interest. There are examples that chambers function as unions or associations advocating and protecting the rights of health professionals and neglecting their primary role of protecting the public. For example, the current legal framework allows chambers to financially support a licensed health professional to defend himself or herself from complaint filed by the patient. This situation represents the conflict of interest, because chambers which should protect the rights of users, in this case protect the profession neglecting their primary role.

As it is mentioned earlier, sometimes chambers and professional associations implement the same activities, the example of which is continuing education. However, the most important difference between chambers and associations are that chambers have legal mandate given to them by the Government, and they are accountable to the Government for their operations, to the public and to their licensed members. At the same time, professional associations have more flexibility in the definition of their mission, goals and activities and they are accountable to their membership only.

The Survey conducted in Dom zdravljas by the Institute of Public Health of Federation BiH and

the Institute of Public Health of Republic of Srpska as part of the Project, demonstrated that a majority of doctors of medicine and dentistry have the license issued by their respective chambers. In Federation BiH, 82% of medical doctors and dentists who are employed in Dom zdravljas have licenses, while in RS almost all medical doctors and dentists have licenses (97%). The situation with licensing of nurses and medical technicians is somewhat different and more complex. In Federation BiH 65 nurses and medical technicians reported to have a license for practicing their profession. In RS there is no Law that prescribes mandatory licensing for nurses and medical technicians, therefore only 3% of surveyed nurses and medical technicians reported to have the license. In the last couple of years, and particularly during 2007, representatives of Unions of Health Professionals were often guests in the media because of the strikes in the health institutions. Unions function according to the Law that defines their activities. Unions negotiate contracts which define salaries, benefits and working conditions and assist their members in protection of their rights given in the contracts. Unions complement the role of chambers by ensuring that working conditions support safe practice and advocate for their members in the situation when their rights are violated.

In addition to associations that are voluntary organizations, chambers that are mandatory organizations, unions are the third way of organizing health professionals. Although obvious, the differences in the roles and goals of each type of organization are not always reflected in the roles that these organizations play in practice. Recently, there is a trend of combining the roles of different organizations, namely associations and chambers, and associations with unions. Generally speaking, professional associations are weaker because the membership in them is voluntary. In the combination with chambers or unions, professional associations benefit from a bigger membership and become more efficient in implementing their mandates. Combining the role of unions and chambers is not recommended because it can create a situation of conflict of interest. It becomes very difficult to protect and advocate for users of services and individual rights of registered members at the same time, as it was described in the example above.

By Djenana Jalovcic

Associations and Chambers of Primary Care Practitioners

Associations and Chambers of health professionals both have vital roles to play in the advancement of primary care for patients and communities, as well as continuously improving the standards and quality of care provided. I have just concluded a term as President of the College of Family Physicians of Canada, which have given me some perspectives on the roles of these bodies.

The College of Family Physicians of Canada is a national voluntary organization of family physicians that makes continuing medical education of its members mandatory. Members choose whether or not to join, but if they join they pledge to keep up-to-date in their knowledge and skills.

The College strives to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

As the voice of family medicine in Canada, The College of Family Physicians of Canada champions quality health care for all people in Canada, supports its members in providing quality patient care through education, research and the promotion of best practices, and ensures that the role of the family physician is well understood and widely valued. The CPFC is funded mainly by voluntary dues paid by its members, as well as receiving funding from government

and other agencies wishing to carry out projects which involve family physicians. It is governed by a board of elected family physicians, along with three elected public (non-physician) board members.

Chambers have a different function, which involves regulating the practice of medicine or other health profession to protect and serve the public interest. The functions of a chamber can include issuing certificates of registration or licences to doctors or other health profession to allow them to practise; monitoring and maintaining standards of practice through peer assessment and remediation; investigating complaints about health professionals on behalf of the public; and conducting discipline hearings when health professionals may have committed an act of professional misconduct or incompetence.

The public and the professions are well-served by having two kinds of organizations. Associations focus on raising standards by promoting education, research, life-long learning, and voluntary meeting of standards. Chambers regulate health professionals and protect the public in doing so. Both are required for a vibrant primary care sector.

*By Ruth Wilson MD CCFP
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THE BUSINESS PLANNING PROJECT FOR SERBIAN PROFESSIONAL CHAMBERS - IN A PERIOD OF BEGINNING AND UNCERTAINTY

"Would you tell me, please, which way I ought to go from here?" asked Alice.

"It depends a good deal on where you want to get to." said the Cat.

"Alice in Wonderland" /Lewis Carroll.

On February 3, 2006, the Canadian Society for International Health and Queen's University in Canada, signed a contract with the Canadian International Development Agency to work collaboratively on the design and implementation of the Balkans Primary Health Care Policy Project (PHCPP). The Project began in September 2006 and will be completed in September 2009. The Project aims to contribute to the achievement of responsive and accountable Primary Health Care (PHC) systems in Serbia and Bosnia and Herzegovina (BiH). One of the actions that was approved for project implementation was aiding in the development, establishment and sustainability of professional self-governing Health Chambers in Serbia. In this regard, improving the capacity of each Chamber to undertake business planning was identified as a critical element in their development.

Serbia has the goal of integration in the European Union (EU) and has started on the long process of preparation towards formal negotiations. In keeping with this direction the country is building new institutions and is reforming the health care system in a manner that is consistent with EU standards. The PHCPP focused in Serbia on PHC stewardship and delivery. The Project's expected results are:

- Improved capacity of government to lead cost-effective PHC policy development and to introduce appropriate regulation and tools for governance;
- Improved capacity of decision-makers for evidence-based practice and quality management in PHC;
- Increased capacity of providers to participate in formulation, monitoring and implementation of more effective, equitable PHC services;
- Opportunities and mechanisms for public participation in PHC policy development for improved services.

To achieve these results the Balkans Project Team worked with the MOH and other stake-holders to implement an interrelated set of activities: Policy Development, Quality of PHC Services, Role of Providers and Voice of Consumers. Throughout the Project five cross cutting themes were addressed regarding each of the activities: vulnerable groups, public sector competence, private sector, EU accession and gender equality. The business planning process that was undertaken by the Chambers has taken into account each of these activities and themes. The following explains the process that was undertaken to develop the First Business Plan for each Chamber.

What is a Business Plan and What are its Uses

A business plan is a written description of a Chamber's financial future. It describes what the Chamber plans to do in an operational and financial sense, and how the Chamber plans to do it. A business plan can be used by a Chamber to convey a vision of the organization to the Ministry of Health, to donors, to its own members, etc. It can also be used to attract support for new services, and to aid in dealing with suppliers. A business plan conveys a Chamber's operational and business goals, the strategies that meet the goals, potential problems that may arise and ways to solve them. It can also provide information on the culture, organizational structure and the amount of capital required to finance future activities and how the Chamber will function until it breaks even. In essence, a business plan is a set of management decisions about what an organization will be doing to be successful. To be a useful tool, a business must reflect the total essence of an organization - where it is now, where it is planning to go, what specific challenges must be addressed, how it will execute the plan, and how it will know and communicate its success.

An effective Chamber business plan focuses on four key areas:

- Focuses Resources to Priorities
- Identifies Activities to Perform Priorities
- Measures Success
- Gives an Indication of Resources Needed

A Chamber Business Plan can be used as a tool to improve accountability to the public, funders and regulatory agencies. In addition, it may be essential in negotiations with funders and regulators to raise funds, change governance protocols and attract talented employees to the Chamber. In other words, an effective Business Plan helps to sell what a Chamber does in a convincing manner.

There are six key sections of a business plan:

1. Executive Summary
2. Health System Strategies – Goals and Objectives
 - Achievements for Past Year
 - Policy Priorities for New Year
3. Business Description - Activities to Support Priorities
 - Activities to Support Priorities and Cost
4. Trends and Issues Analysis - Resource strategies
 - Risk Assessment and Management
5. Financial plan - How to Finance the Business Plan
6. Communication and Negotiation of Business Plan

Note that there is logical progression in the development of the business plan as noted by the arrows.

Development of Business Plans for Serbian Chambers

Each Business Plan must be designed for a specific audience. If the audience changes the Business Plan must be changed or altered to meet the needs of the new audience. For example, a business plan will have a very different focus for a donor vis-à-vis a Department of Health. The focus of the Business Plan for each of the Chambers in this project was the general membership of the Chamber. This focus was picked as all Chambers had recently begun operations for the first time and this allowed the membership to get an understanding of the scope of activities, and cost and revenue structure of the Chamber, as well as some insight into future organizational and financial issues and trends.

The first step in the process of developing business plans for the Chambers was to develop a more detailed report for each section. In each case, consultants worked with a number of individuals from each Chamber, including Directors of each Chamber, chief financial official - economist, other senior staff, board members and members of Chambers.

One of the objectives of developing the first business plan is that it can then be used by Senior Officials and Management and Supervisory Boards to make further decisions and approvals during the 2008 year and become the framework for business planning for the 2009 year. This recognizes that financial impacts on the Chamber will be continual in the future and the steps that were undertaken to develop the first 2008 business plan provides a process for members of Chamber to follow in the future.

While the process of developing the 2008 Business Plan for each Chamber was being undertaken, the Balkans Primary Health Care Consultants in concert with Orvill Adams, Director of the BPHCP, suggested that each Chamber develop a Poster on their Business Planning process and results to date for the 2nd Regional Conference to be held in Belgrade in September 2008. All the Chambers agreed and with the assistance of the Balkans Primary Health Care Consultants each Chamber developed a poster.

After the posters were developed and presented at the annual conference, the process of completing the business plan 2008 was completed, and preparation and planning for the 2009 business plan was undertaken in each Chamber.

The final business plan for each Chamber provides more detail and depth of Chambers operations, financial statements and data, and analysis of trends and issues. The reports vary in length from 25 to 35 pages.

Evaluation of Business Plan Planning Process and Outcomes for Each Chamber

After the 2008 Business Plan was completed the consultants undertook an evaluation of the process of completing the 2008 business plan and assessment of outcomes of the project. An interview questionnaire was prepared and interviews were undertaken in each Chamber with a variety of individuals that included, Directors of each Chamber, chief financial official - economist, other senior staff, board members and members of Chambers. A brief summary is provided below.

All Chambers found the 2008 business plans and the process of developing and completing the plan very useful in their operations. A number noted that the plan "opened communication doors to banks because we could talk the same language." All noted that risk analysis needed to be given more time and consideration in the future and that risks related to expense projections for branch offices needed special emphasis. Many noted that there needs to be information available from the Ministry of Health in preparing projections and assessing decisions that the Chamber will have to make. Some noted that a six month rebalance of budget and business plan be undertaken to keep the Chamber plans up to date with Ministry of Health decisions.

A number of responses noted that the process of developing the 2008 business plan forced careful consideration and reconsideration of Chamber Head office and Branch relations, regarding autonomy and financing of Branches, centralized versus decentralized auditing and legal services, and, information flows and data recording. Many noted that in the future, computer programs that could aid in developing future business plans was needed, and, that expertise and assistance was needed in some cases to continue the development of business plans. In addition, the Boards of Chambers needed to be oriented to an understanding of business planning process and outcomes, and, to improve financial and organizational skills to improve effective governance.

All felt that a continuation of developing the business plan for 2009 was important. All noted that the process of preparing the 2008 Business Plan provides Staff and Members of Boards a sense of business vision of Chamber and the strategic direction and future activities of the Chamber. Many noted that developing the 2008 business plan was useful as it provided a new way of thinking about future plans because the plans always had to be connected to planned activities and revenue and costs. The business plan was a good process to set and refine priorities.

Closing Note

Throughout the process of developing the 2008 Business Report two issues seem to stand out that will confront the Chambers in the next two or three years.

1. The first one is that the health care system in Serbia will undergo a significant change in the next two to three years. This will be led by internal Serbian changes in governmental health care policy, funding, regulations, laws, clinical practice, cost constraints, etc. Some of the changes that will be required will also be driven by forces external to Serbia such as the European Union, WHO, World Bank, IMF, worldwide and European professional Chambers and associations, etc.
2. The second one is the impact of the Global Financial Crisis on the Chamber's operations and financial structure and priority setting.

Both of these forces will create uncertainty and have an impact on strategic and operational sustainability factors for Chambers. As a result, risk analysis will play an increasing role in future Chambers Business Planning. As one participant in the business planning process noted "In our first year of our Chamber operation, the key issue was location, location, location. In the next year (2009), the key issue will be change, change and change." Business Plans are an effective tool for Chamber to have to expedite the change process. As Louis Pasteur noted "Change favours the prepared mind."

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NURSING IN FOCUS

Competencies of Nurses with Different Levels of Education

Report for discussion

Ms. Ivanka Franjic, Senior Officer for Nurses/Technician, Federal Ministry of Health

1. Competencies of Nurses with Different Levels of Education

Nurses constitute the biggest group of health professionals and their role in health sector is essential. In case nurses receive adequate education, and are distributed appropriately respecting realistic needs, number and type, they will be able to offer full potential. Contribution of nurses to health of population is immeasurable. They are low-budget human resources providing safe, available, continuing health care of good quality or so called „health care without stitches“.

In order to realize their full potential, nurses need appropriate knowledge and skills, which enable them to appropriately respond to users needs, to help everyone to live healthier life, and to provide appropriate health care in case of need. Also, it is necessary for them to be prepared to timely face challenges put before nurses in future.

(WHO, Medical nurses and midwives for health; WHO Strategy for Europe-Education for medical nurses and midwives)

„To respond to needs and challenges nurses must be competent to develop and perform functions promoting maintenance of health status of population and preventing diseases. Also, they need to assess, plan, provide and evaluate their professional care during the course of disease and rehabilitation process, which includes physical, mental, and social aspect of life that affect health and occurrence of disease, handicap or death. They can work both in hospitals and communities. They are competent to work independently or as equal members of medical or multidisciplinary team.

The above mentioned requires understanding and application of specific knowledge and skills in practice, which whenever possible are based on professional research. It absorbs knowledge and techniques from humanistic sciences, physical, biological, behaviouristic sciences, management and leadership theories, and education theories.“

Competencies of nurses trained at different levels of education in health system are not defined in many countries, including Bosnia and Herzegovina. In the Federation of Bosnia and Herzegovina the Rule Book on internal organisation and systematisation of working positions of each health institutions defines working posts and provides respective job descriptions. Currently, the aforementioned Rule Book defines job description for medical nurse with secondary education and two year-faculty qualification, while medical nurses who graduated at four-year faculty have no job description or description of respective competencies. The Rule Book is used as a guide by employers in the determination of salaries and responsibilities.

In practice we meet medical nurses with completed secondary school training performing head nurse duties (in health centres, departments, and clinics, while medical nurses with high school and higher education qualifications work at card-files office or out patient clinic i. e. invite patient to doctors office and make records in protocol. This is consequence of inadequate job descriptions/competencies for different levels of medical nurses' education.

Curricula of education institutions have job descriptions for respective profiles regulated at level of canton, without agreed national standards that would incorporate international or European standards for medical nurses and midwives

2. Their duties and responsibilities in different environments of PHC; secondary and tertiary health care

Functions and role of medical nurses engaged at different levels of health care (PHC, secondary and tertiary level) are not defined.

Neither of entities have harmonised definitions for medical nurse role and scope of work that is incorporated in the law. This omission is an obstacle for advancement of the medical nurse profession.

There is no special law that regulates profession of nurses and midwives, although draft laws on nursing profession is in the adoption procedure. (NAP, EU/WHO 2005)

Most, if not all roles currently performed by medical nurses and midwives are not well defined and adjusted to current needs of health sector and health care. A significant part of the working time of medical nurses and midwives are spent on administrative duties, and not direct patient care. Even less time is dedicated to health promotion and prevention of diseases. (NAP, EU/WHO 2005)

Role of medical nurses

There is no harmonised use of modern terminology in local languages which additionally complicates description and planning of medical nurses' work. (NAP, EU/WHO 2005)

Medical nurse-general: Medical nurses at secondary and tertiary level of health care provide health care to patients and execute medical doctors' instruction in hospitals. Administrative duties include typing anamnesis, medical findings, collection and processing of statistical data, keeping and analysis of consumption register on drugs and other consumable material; escorting patients to different exams, tests (blood, different scanning, etc.); work at reception desk, etc. consume majority (state percentage) (no survey was performed in this area thus it is not possible to indicate ratio between these activities and their working time) Medical nurses work in many other institutions e. g. lead advisory service for diabetes patients, AIDS/HIV and nutrition; in daily care of mental health centre, vaccination centre, consultancies for mother and child, old peoples home, kindergartens, schools and schools for children with hearing impediment. (NAP, EU/WHO 2005)

Midwife: cares and advises women during pregnancy, birth and during the period after the birth; performs birth and cares about newborns, including prevention. At secondary and tertiary level of health care they provide care in maternity wards, gynaecological departments and clinics, where they take care of newborns and mothers. There is no special education for midwives. Knowledge in respective area is obtained upon completion of secondary medical school. At the level of primary health care, medical nurses of general specialisation usually perform midwife duties after completion of additional education in area of protection of mother and child health. (NAP, EU/WHO 2005)

Health promotion is an important component in nursing practice. It is mode of thinking based on a philosophy of wholeness, benefit and wellbeing. Health promotion includes programmes changing environment and behaviour of an individual. Example of health promotion include improvements in nutrition, prevention of alcohol and drug addiction, reduction of smoking, maintenance of body condition and exercising, etc. As health promotion is dynamic process aimed to enable people to have better control over determinants influencing health, and consequently enhance their health. Currently, role of medical nurses in public health sector is directed only towards patients registered with family doctor. We have no valid data on to what extent medical nurses working in family medicine teams perform activities related to health promotion and prevention of diseases.

Many determinants influencing health are placed outside health sector, therefore health professionals have to cooperate with other sectors. Such cooperation can not be established in full capacity if medical nurse provide services for patients registered with family doctor. (Note: in order to be registered one has to have health insurance. The issue is what happens with those not medically ensured and those belonging to vulnerable groups, etc).

Although reforms in health sector have lasted number of years, there still have not been developed or established nursing services in the community, which would ensure health promotion and prevention of diseases for entire (living, working, playing, learning, resting) population in the community. Also, health promotion and health prevention re not provided for vulnerable groups, such as poor, elderly, handicapped persons, and minority groups. Health promotion is important element for fostering better health for all age groups and society in general. Role of nurse in health promotion is to work with people not for them, i.e. to react as mediator in the processes of assessment, evaluation and understanding of health. Nurses can take the role of counsellor, teacher, promoter or coordinator of services. Medical nurses in community should ensure health promotion, prevention of disease, rehabilitation, and treatment for entire population in the geographically defined community.

In line with the Primary Health Care Strategy it is necessary to establish nursing service in a community, which will ensure health promotion, prevention of diseases, rehabilitation and treatment for entire population, all age groups in the community (micro level). It is necessary to strive to eliminate or reduce determinants influencing the health of population in cooperation with other sectors.

Nurse in community. Before the war there were well developed services in the community. Some of them still exist in areas in which the new model of "family medicine" is introduced. According to tradition, each health centre has home care and patronage service. Nurses involved in home care work in mobile teams composed of a doctor and medical nurse, where treatments are performed according to doctors instructions. Role of "polyvalent patronage nurses" is based on working in community and is primarily related to health promotion and raising of health awareness in communities and families. These medical nurses, with high school degree are not involved in treatment and have no role in provision of care and curative services in some parts of the country. Old model of health work in community is replaced with "family medicine" model (promoted by donors, such as the World Bank, in five pilot regions in FBiH and tri in RS). Upon completion of additional education, medical nurses from community health care service become family medicine member.

Medical nurse in mental health institutions: Before the war mental health services were located in psychiatric hospitals and small departments for acute conditions in general hospitals, some services are placed in health centres in community. During the war great number of such institutions was destroyed and morbidity rate for mental illnesses at the same time dramatically increased (WHO estimates that more than one million people suffer from mental disorders caused by stress caused by the war). A radical political decision was made in FBiH in regard of transfer of psychiatric services in community and awarding a key role to primary health care. Around 40 new centres for mental health in FBiH, operating on community based activities and 20 centres in RS, responsible for prevention and treatment. New policy foresees expanded and independent role for medical nurses. However, currently education of nurses in mental health area is not organised. (NAP, EU/WHO 2005)

Medical nurse for work with patients with learning difficulties: There are medical nurses employed in hospitals, nursery homes, and institutions for persons with special needs, but who did not participated in special training. (NAP, EU/WHO 2005)

Paediatric medical nurse: Work in paediatric health facilities at the level of primary health care, in departments of secondary health care and clinics at tertiary level of health care. Some secondary medical schools in FBiH organise courses for paediatric medical nurses, but most of hospitals and health centres employ medical nurses of general specialisation who haven't attended additional education. Medical nurses employed in centres for children vaccination attended special education after completion of secondary school. (NAP, EU/WHO 2005)

Expanded role: Medical nurses can work as technicians or assistants for different specialities, but there is no expended or "advanced" role in terms of care. (NAP, EU/WHO 2005)

Quality and continuity of health care is also negatively impacted by low level of communication between primary and secondary health care services (especially hospitals and health centres). Better systems are necessary, including new documentation in order to ensure continuity of care of released inpatients provided by medical nurses and midwives from primary and secondary health care. (NAP, EU/WHO 2005)

3. Their relation with other care providers

Relation of medical nurses with other disciplines: Medical nurse cooperates with number of different colleagues and participates in Multisectorial cooperation. However, her role is mainly role of assistant who executes orders given by doctor and has subordinated role in medicine. There is no concept of medical nurses' profession or advancement in carrier; medical nurses have low wages and adverse status, and for the last couple of years very little has changed in that regard. (NAP, EU/WHO 2005).

Although reforms in health sector have been ongoing for several years, nursing was never adequately included in the reform.

Approach to reform of nursing is selective and based only on additional education of medical nurses engaged in family medicine.

Current „low“ status of nursing and obstetrics is partly because no interest of medical nurses and midwives in major changes that are necessary for these professions. In addition, other professionals in health sector and society provide inadequate support to enhancement of the status of these professions in health sector.

As stated in the National Action Plan (NAP) challenges we are currently facing include:

- inadequately defined roles and functions;
- inadequate basic education;
- lack of postgraduate and continued education ;
- lack of regular courses in major specialities such as work of midwives, care for mentally ill patients and persons with learning difficulties;
- lack of adequate standards, regulations and laws;
- slight possibilities for carrier advancement;
- lack of carrier flow (thus, advanced medical nurses can perform managing functions, but not advanced clinical roles);
- exclusion from process of creation of health policy (NAP, EU/WHO 2005)

4. Current classification and duties and responsibilities of nurses and technician

As stated in NAP, in Bosnia and Herzegovina there are approximately 15 types of professional qualifications for non-medical staff. This includes professions of medical nurses (general), midwives, geriatric nurses/ technician, senior nurses/technician, Physiatry technician, lab technician, pharmaceutical technician, dental technician, dental nurses, sanitary technician, and radiology technician. Currently, these groups are not differentiated and usually treated as one group in terms of training and planning. (NAP, EU/WHO 2005)

Standard classification of occupations ("Official Gazette FBiH No: 22/04) from 24. 04. 2004 is used in Federation of Bosnia and Herzegovina. Structure of the Standards classification of occupations is developed based on the structure of ISCO-88, with no major difference. There are variations in cases when specifics of needs in Federation of Bosnia and Herzegovina required so. Institutions are recommended to identify and correlate codes for working positions in the respective systematisation of working places or Rule Books on Labour based on occupational codes set in the Standard Classification of Occupations (SCO). SC. This nomenclature is not in use for now.

USEFUL TOOLS

Guide for Client/Patient Centred Health Care

Introduction

The improvement of quality and patient safety are goals of many Primary Health Care Facilities. In addition they have begun to pay particular attention to how they interact with their consumers and are adopting approaches that can be characterized as 'Patient and Family Centred Care'. The Institute for Family-Centre Care (IFCC) describes this approach as follows: "Patient and family-centred care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families and health care providers"¹ The IFCC argues that studies increasing show that the involvement of patients and families directly into planning, delivery and evaluation contribute to the improvement of quality, safety and a reduction in health care costs. The approach is based on the following principles:

- Dignity and respect
- Information sharing
- Participation
- Collaboration

Moving an organization towards patient centred care will require in many cases a change in its culture, education of the providers and consumers. This will take time, but health care systems in Serbia and Bosnia and Herzegovina are clearly moving in this direction. Initiatives to promote client/patient centred practices have already been taken by professionals and at the organization level. Contributions like this should serve as another resource, reference and a reminder for health care providers and their practices.

The components of patient centred care:

- explore the disease and the patient's illness experience (communication)
- understand the whole person
- find common ground (partnership)
- incorporate prevention and health promotion
- enhance the doctor patient relationship
- be realistic

The connection with evidence based medicine:

Sackett's definition of EBM:

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. (Sackett, DL, et al, BMJ 1996;312(7023):71-72)

¹ Institute for Family-Centred Care, Strategies for Leadership, 2004. www.familycenteredcare.org

Client/Patient Centred Care Guidelines

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INITIATING THE SESSION

Establishing initial rapport

1. **Greets** patient and obtains patient's name
2. **Introduces** self, role and nature of interview; obtains consent if necessary
3. **Demonstrates respect** and interest, attends to patient's physical comfort

Identifying the reason(s) for the consultation

4. **Identifies** the patient's problems or the issues that the patient wishes to address with appropriate **opening question** (e.g. "What problems brought you to the clinic/hospital/consultation?" or "What would you like to discuss today?" or "What questions did you hope to get answered today?")
5. **Listens** attentively to the patient's opening statement, without interrupting or directing patient's response
6. **Confirms list and screens** for further problems (e.g. "so that's headaches and tiredness; anything else?")
7. **Negotiates agenda** taking both patient's and physician's needs into account

GATHERING INFORMATION

Exploration of patient's problems

8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)
9. **Uses open and closed questioning technique**, appropriately moving from open to closed (open ended e.g.: Tell me about your pain?, closed ended: Is the pain still present?)
10. **Listens** attentively, allowing patient to complete statements without interruption and leaving time for patient to think before answering
11. **Facilitates** patient's responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation
12. **Picks up** verbal and non-verbal cues (body language, speech, facial expression, affect); **asks and acknowledges** what these mean
13. **Clarifies** patient's statements that are unclear (e.g. "Could you explain what you mean by light headed")
14. **Periodically summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.
15. **Uses** concise, **easily understood questions and comments**, avoids or adequately explains jargon
16. **Establishes dates and sequence** of events

Additional skills for understanding the patient's perspective17. Actively **determines and appropriately explores**:

- patient's **ideas** (i.e. beliefs about meaning of symptoms)
- patient's **concerns** (i.e. worries) regarding each problem
- patient's **expectations** (i.e., goals, what help the patient had expected for each problem)
- effects: how each problem **affects** the patient's life

18. **Encourages patient to express feelings****PROVIDING STRUCTURE****Making organisation overt**

19. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section

20. Progresses from one section to another using **transitional statements**; includes rationale for next section

Attending to flow

21. Structures interview in **logical sequence**

22. Attends to **timing** and keeping interview on task

BUILDING RELATIONSHIP**Using appropriate non-verbal behaviour**23. **Demonstrates appropriate non-verbal behaviour**

- eye contact, facial expression
- posture, position & movement
- vocal cues e.g. rate, volume, tone

24. If reads, writes **notes** or uses computer during interview, does this **in a manner that does not interfere with dialogue or rapport**

25. **Demonstrates appropriate confidence**

Developing rapport

26. **Accepts** legitimacy of patient's views and feelings; is not judgmental

27. **Uses empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly **acknowledges patient's views** and feelings

28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; partners with patient

29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

30. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is....")

31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs

32. During **physical examination**, explains process, asks permission

EXPLANATION AND PLANNING

Providing the correct amount and type of information

33. **Chunks and checks:** gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed
34. **Assesses patient's starting point:** asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information
35. **Asks patients what other information would be helpful** e.g. aetiology, prognosis
36. **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely

Aiding accurate recall and understanding

37. **Organises explanation:** divides into discrete sections, develops a logical sequence
38. **Uses explicit categorisation** (e.g. "There are three important things that I would like to discuss. 1st..." "Now, shall we move on to.")
39. **Uses repetition and summarising** to reinforce information
40. **Uses concise, easily understood language**, avoids or explains jargon
41. **Uses visual methods of conveying information:** diagrams, models, written information and instructions
42. **Checks patient's understanding** of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patient's perspective

43. **Relates explanations to patient's illness framework:** to previously elicited ideas, concerns and expectations
44. **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately
45. **Picks up verbal and non-verbal cues** e.g. patient's need to contribute information or ask questions, information overload, distress
46. **Elicits patient's beliefs, reactions and feelings** re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making

47. **Shares own thinking as appropriate:** ideas, thought processes, dilemmas
48. **Involves patient** by making suggestions rather than directives
49. **Encourages patient to contribute their thoughts:** ideas, suggestions and preferences
50. **Negotiates a mutually acceptable plan**
51. **Offers choices:** encourages patient to make choices and decisions
52. **Checks with patient** if accepts plans, if concerns have been addressed

CLOSING THE SESSION**Forward planning**

53. **Contracts** with patient re next steps for patient and physician
54. **Safety nets**, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure

55. **Summarises session** briefly and clarifies plan of care
56. **Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

OPTIONS IN EXPLANATION AND PLANNING (includes content)**IF discussing investigations and procedures**

57. Provides clear information on procedures, eg, what patient might experience, how patient will be informed of results
58. Relates procedures to treatment plan: value, purpose
59. Encourages questions about and discussion of potential anxieties or negative outcomes

IF discussing opinion and significance of problem

60. Offers opinion of what is going on and diagnoses if possible
61. Reveals rationale for opinion
62. Explains causation, seriousness, expected outcome, short and long term consequences
63. Elicits patient's beliefs, reactions, concerns re opinion

IF negotiating mutual plan of action

64. Discusses options eg, no action, investigation, medication or surgery, non-drug treatments (e.g. physiotherapy, walking aides, fluids, counselling, preventive measures)
65. Provides information on action or treatment offered
 - name
 - steps involved, how it works
 - benefits and advantages
 - possible side effects
66. Obtains patient's view of action, perceived benefits, barriers, motivation
67. Accepts patient's views, advocates alternative viewpoint as necessary
68. Takes patient's lifestyle, beliefs, cultural background and abilities into consideration
69. Encourages patient to be involved in implementing plans, to take responsibility and be self-reliant
70. Asks about patient support systems, discusses other support available

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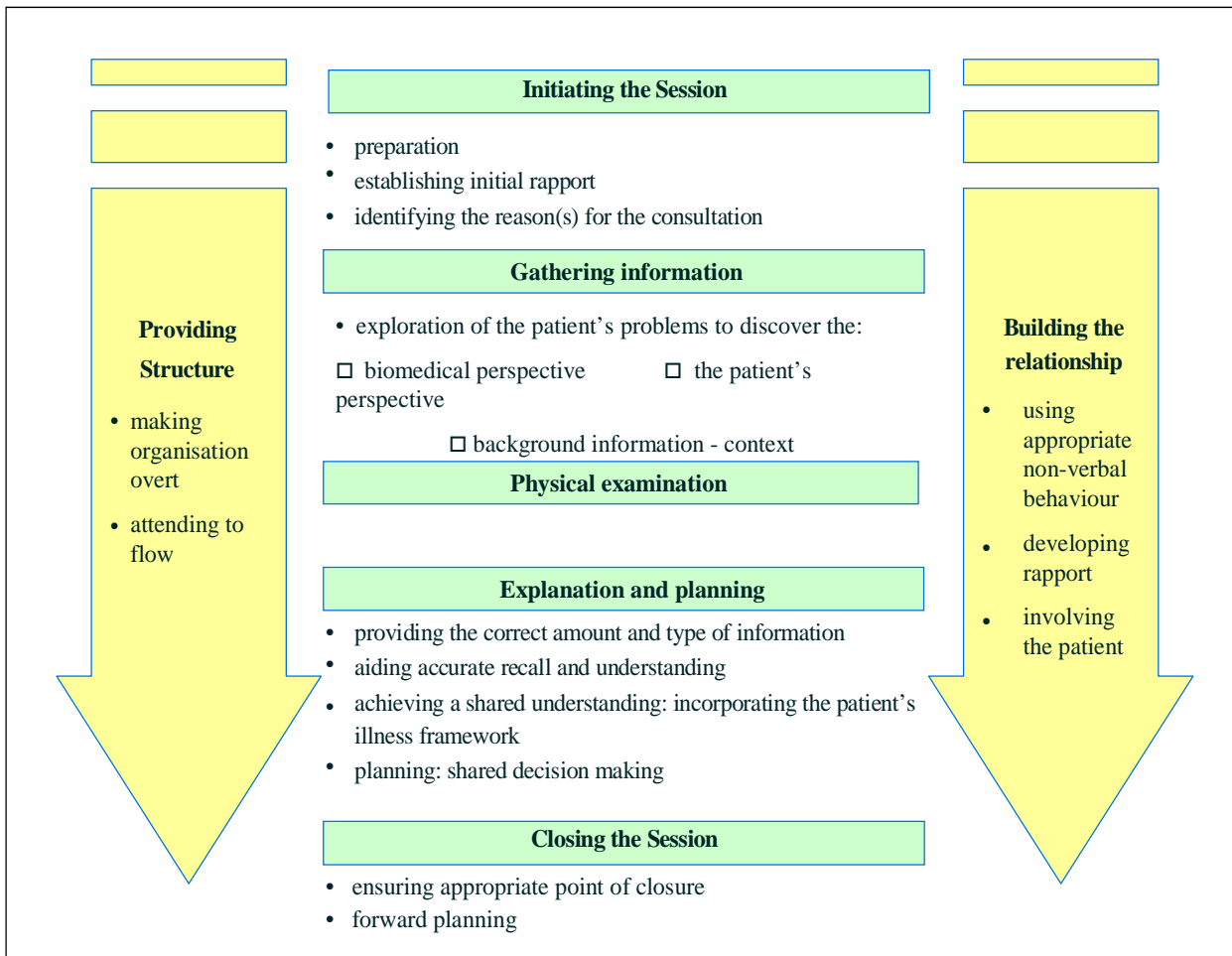
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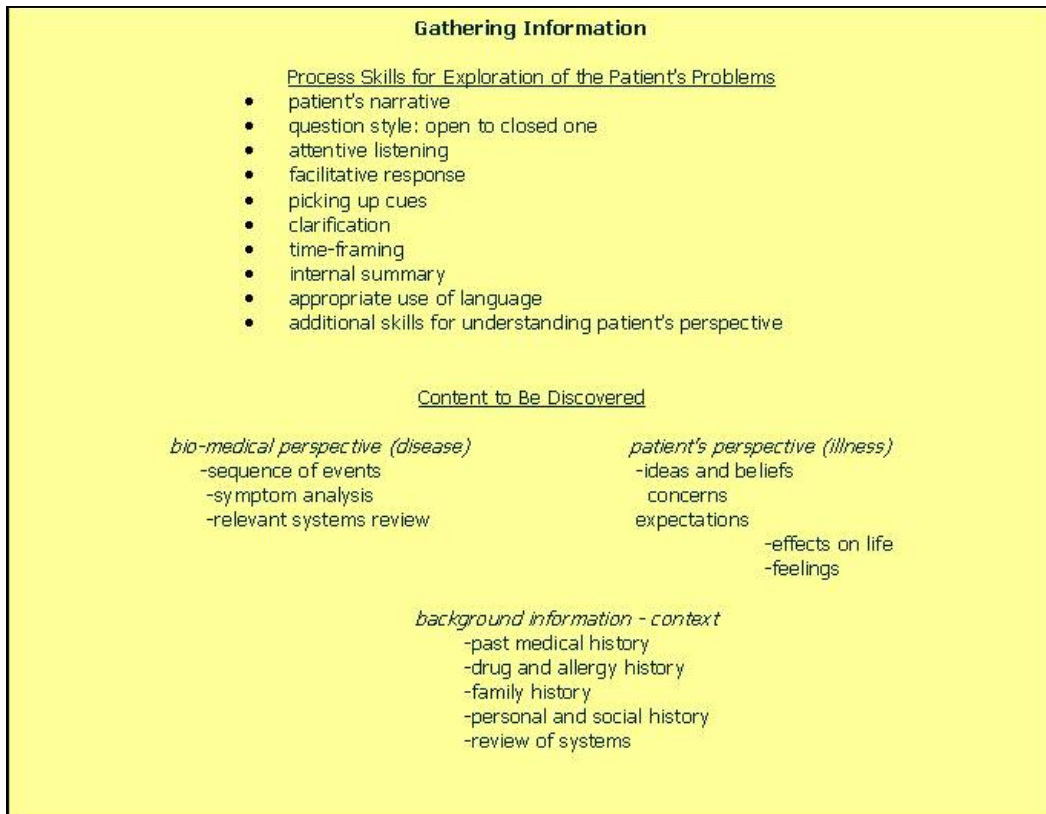
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Integrating content with the patient-centred approach



Summary of The Patient-Centred Medical Interview



Past Events

SERBIA

PHC Policy Dialogue in Serbia

Fourth PHC Policy Dialogue, dedicated to further development of PHC Policy Paper for Serbia took place in Subotica, on February 5th and 6th, 2009. Tomica Milosavljevic, Minister of Health of the Republic of Serbia took place in the work of the Dialogue, supporting the process and presenting the overall strategic development directions for PHC and the whole health sector in Serbia. This PHC Policy Dialogue was attended by 76 persons, including representatives of the Ministry of Health, Local Self-Governments of cities and municipalities (including Standing Conference of Cities and Municipalities of Serbia), PHC providers' institutions (project demonstration sites PHC centers and other representatives of "dom zdravljas" and institutes in PHC), health services consumer groups, Chambers of health professionals in Serbia etc. Representatives of donor institutions (CIDA, World Bank, European Commission) and international partners in health sector (EU funded Project "Support to the Implementation of Capitation Provider Payment System in PHC in Serbia") also participated in the work and had the opportunity to get familiar with the document, comment and make suggestions.

Following the presentation of the Draft PHC Policy Paper for Serbia to the Minister, State Secretaries and Assistant Ministers of Health, four public presentations and discussions on the Draft Paper have been organized in Belgrade, Novi Sad, Nis and Kragujevac. All public events have been organized in collaboration with Project Demonstration Site PHC Center (dom zdravlja) in respective cities for key stakeholders from above mentioned regions. These were another opportunity for representatives of health services providers and consumers, local governance, other relevant public sectors (e.g. Center for Social Work) and other key stakeholders to have discussion on PHC policy for Serbia. Officials of the Ministry of Health, City Secretary of Health, PHC Center Director and Project team made introductory presentations at public meetings.

Demonstration Sites

Training Module 7, on Measuring Quality and Performance in Primary Health Care Centers, within the Strengthening Management Capacities of Demonstration Sites Program, took place in Nis, on March 2nd and 3rd, 2009. The training was delivered to participants from Project Demonstration Sites in Serbia. Training was delivered by Snezana Simic, Professor at the Institute of Social Medicine of the Medical School in Belgrade, Orvill Adams and Predrag Zivotic.

Module 6 of the Strengthening Management Capacities of Demonstration Sites Program on Change Management was organized for 5 representatives from each of project Demonstration Sites took place in Subotica on November 10th and 11th, 2008. Training was delivered by "BONEX Inzenjering".

BOSNIA AND HERZEGOVINA

Within the Program Strengthening Capacities of Chambers and Associations of Health Professionals, Module on Communication was organized on May 5th in Banja Luka and on May 7th in Sarajevo as a final module for chambers and associations of health professionals in both entities.



Human Resources for Health
June 2, 2009, Banja Luka and June 4, 2009, Sarajevo

The beginning of June was marked by the launch of the Reports on Human Resources prepared by the Institute for Protection of Health of Republic of Srpska and the Federal Institute of Public Health. Meetings with over 160 participants were held in Banja Luka on June 2, 2009 and Sarajevo June 4, 2009. Representatives of District Brcko took part in both meetings.

With the support from the Project comprehensive data on human resources have been collected and used for workforce planning and policy making. An agreement on the type and scope of data to be collected was reached in order to avoid duplication and provide new information to complement the health statistics that are collected on a regular basis. Launch of the reports was the end of a technical exercise which was an example of excellent collaboration and coordination among the numerous stakeholders from the institutional, cantonal and regional, and entity levels.

Sex disaggregated data were collected to describe age, education, experience, employment status and work patterns of over 30,000 workers employed in 212 health care facilities, health sciences

students in 30 educational institutions and unemployed health workers registered at 11 employment bureaus in Bosnia and Herzegovina. In addition, the data included managers' views on reward systems, secondary employment and professional mobility in Republic of Srpska as well as basic information on the workforce employed in the private health institutions in District Brcko.

In parallel with this complex undertaking, a series of capacity strengthening sessions and policy discussions were implemented to ensure the use of this data for policy and planning purposes. This process raised awareness among the different levels of government about a greater need for a comprehensive approach to human resources planning and management and their role in the process. Data on health human resources in the public sector in Federation BiH, primary health care in Republic of Srpska, and both private

and public providers in District Brcko, provide a common base for planning health human resources in a process which brings together providers, public health institutes, and government players. This echoes the message of the World Health Report devoted to human resources for health: Working together for health.



Results of three studies conducted in two entities and District Brcko: The Survey of Human Resources in Primary Health Care in Republic of Srpska, the Study of Human Resources in Health Sector in Federation of BiH and the Study of Human Resources in Public and Private Health Sector in District Brcko were used to develop draft plans of human resources for each entity and District Brcko. The Project consultants Vern Hicks and Orvill Adams presented the draft plans of human resources for each entity and District Brcko.

Third Regional Conference
“Health in All Policies and Primary Health Care”
September 23 to 24, 2009
Holiday Inn, Sarajevo, Bosnia and Herzegovina

This is the final conference of the Balkans Primary Health Care Policy Project which is funded by the Canadian Government through the Canadian International Development Agency. The Canadian Society for International Health and Queen's University implement the project with the Ministry of Health of Federation of Bosnia and Herzegovina, the Ministry of Health and Social Welfare of Republic of Srpska, and the Department of Health of District Brcko under coordination of the Ministry of Civil Affairs of Bosnia and Herzegovina.

The health of the population is more than the responsibility of the health sector. This theme is at the heart of Health for All (Alma Ata, 1978) and The Ottawa Charter on Health Promotion, “Build Healthy Public Policy” which calls for health to be on the agenda of policy makers in all sectors and administrative levels. It suggests how different instruments of policy such as, legislation, fiscal measures, taxation and organizational change can be used in strategies to improve the health of populations (Leppo, 2007). “The main principle behind the slogan ‘Health in all Policies’ is really very simple: Health is greatly influenced by life-styles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly decision influencing people’s health do not concern only health services or ‘health policies’, but decisions in many different policy areas have their influence on these health determinants”, Puska (2007).

Article 152, ‘Health in All Policies’ of the Treaty of the European Union, (as agreed in Amsterdam, 1997), provides an obligation that all Community actions and activities shall contribute towards a high level of health protection. This requires that policies are designed such that they work together to protect health.

Countries in the Balkans as in other regions are engaged in reforms in many sectors, such as; health, education, agriculture, macroeconomic, transportation, judicial, etc. Policies in these different sectors if they are not complimentary can act to make more difficult the policy intentions of other sectors. For example, a policy designed to stimulate macroeconomic by lowering requirements for environmental controls may act to increase health hazards. There are also policies in which are reinforcing of each other. An example; is that of policies designed to improve transportation safety which has a direct impact on injury due to road accidents.

The Conference will aim to bring together policy makers, consumers and practitioners to discuss the different forms of intersectoral action that is taking place in the Region and to examine ways of strengthening them in-order to increase their effectiveness in improving the health of their populations. The Third Regional Conference is expected to:

Provide an opportunity for participants to see and discuss the intersectoral nature of the different policies that are being developed in the Region with respect to their impact on health of populations;

1. To examine ways in which “health in all policies” can be strengthened;
2. To discuss the results and lessons learned in the Balkans Primary Health Care Policy Project;
3. To strengthen the relationship between actors facing common challenges.

The Conference will be organized to allow for dialogue between the stakeholders in sectors that have an impact on the PHC sector. The Conference will use a mixture of key note presentations, panel and round table discussions and poster presentations.

The invited participants will include representatives of the governments from Serbia and Bosnia and Herzegovina, as well as neighbouring countries, representatives on non-governmental organizations, service providers and users, project partners and other stakeholders.