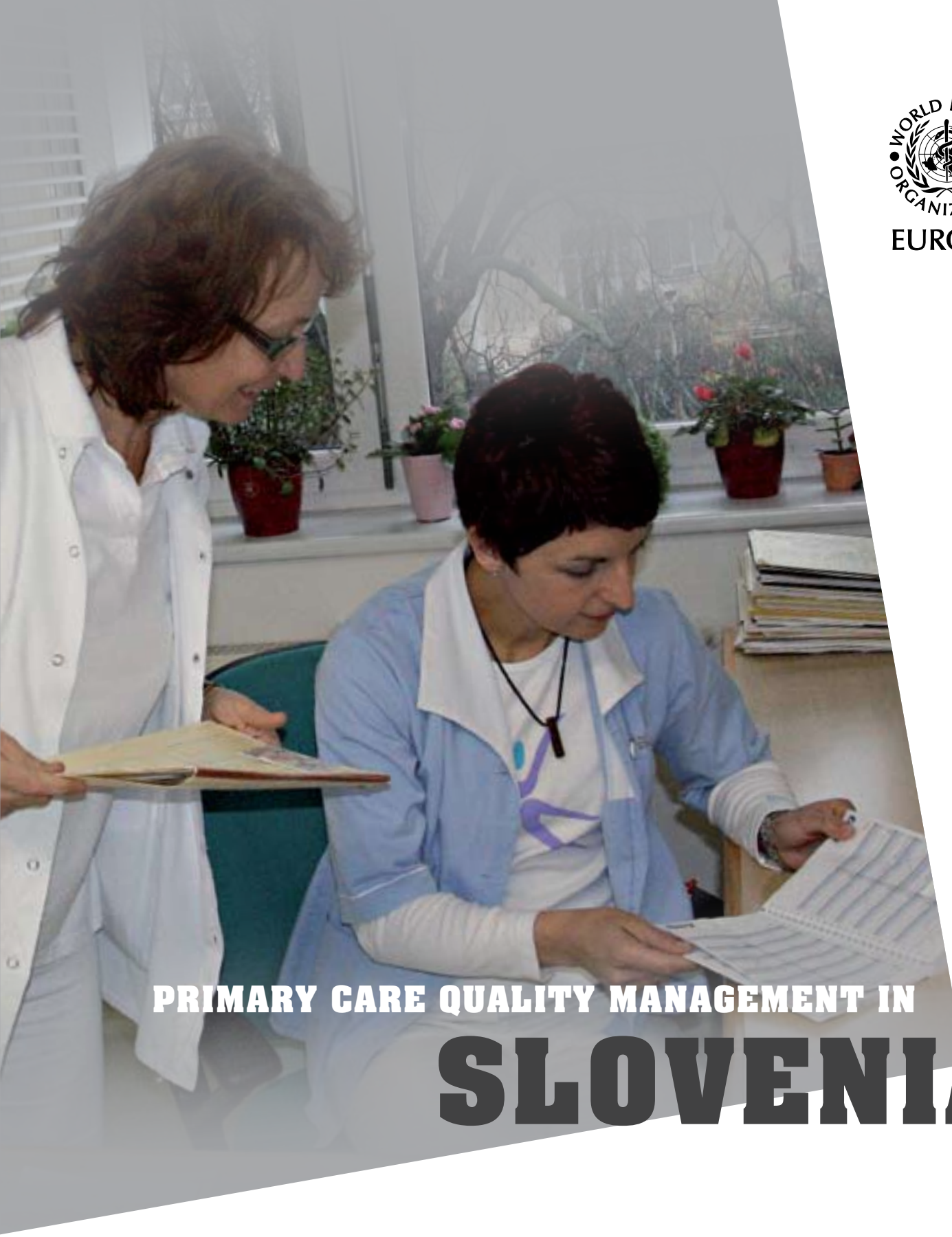

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PRIMARY CARE QUALITY MANAGEMENT IN SLOVENIA

Primary care in the WHO European Region

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PRIMARY CARE QUALITY MANAGEMENT IN SLOVENIA

ABSTRACT

This report summarizes the main results of the WHO Primary Care Quality Management Tool (PCQM Tool), which was implemented on a pilot basis in Slovenia in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Slovenia, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherland Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and the Department of Family Medicine, University of Ljubljana, Slovenia.

The PCQM Tool focuses on structures and mechanisms intended to control or manage the quality of staff and services in primary care. It examines the existing institutionalized mechanisms and practices in order to find out how Slovenia is making use of the available know-how and resources to improve the quality of (primary care) services. The Tool is not about quality of care itself, and therefore quality indicators do not play a prominent role.

Keywords
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ABBREVIATIONS

BCA	biennial collaborative agreement
CME	continuing medical education
EBM	evidence-based medicine
GP	general practitioner
IVZ	Institute of Public Health, Slovenia
MS	Member State
NHS	national health system
NIVEL	Netherlands Institute for Health Services Research
PC	primary care
PCQM	primary care quality management
PH	public health
PHC	primary health care
QA	quality assurance
QI	quality improvement
QM	quality management
RHA	regional health authority
SHI	social health insurance
WHO	World Health Organization
ZZV	Regional Institute of Public Health, Slovenia
ZZZS	Health Insurance Fund, Slovenia

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FOREWORD

Primary health care embodies the values and principles that WHO abides by in its world-wide effort to strengthen health systems in an equitable and efficient manner. The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in the recent World health report 2008, which urges countries to act on evidence that access to primary care services forms the core of an efficient and appropriate health care system. The title of the report underscores the urgency of its message: Primary health care – Now more than ever.

Over the past 30 years, the overall health situation in the 53 Member States of WHO in the European Region has improved considerably despite significant changes in the patterns of and trends in disease occurrence, demographic profiles, and exposure to major risks and hazards in a rapidly evolving socioeconomic environment. There have also been trends towards more integrated models of care and greater pluralism in the financing and organization of health systems. Governments are continuing to rethink their roles and responsibilities in relation to population health and the organization and delivery of health care, thereby changing the context for framing and implementing health policy.

This report on primary care quality management describes the Slovenian governments' and health system stakeholders' efforts to improve service delivery at the first level of care, supplemented with evidence compiled through the development and application of tools tailored to primary care. What does quality care mean at this level and what are the strategies, mechanisms and tools to ensure that it can be maintained, assessed and improved? The report also shows that the involvement not only of national policymakers but also, and first and foremost, of the stakeholders on the ground who actually provide and organize primary care can result in improvements in quality by an incremental process of creating and adopting a culture of quality control and assurance. This process goes beyond having guidelines, regulations and strategies in place; it entails adopting a transparent approach which acknowledges that only empowered and motivated health care staff working in teams can bring about real improvements, and that all health care workers (family doctors, nurses, midwives and others) are equally important in the drive to attain better health for the population. The centrality of the patient, and of his or her needs and inputs into this process of improving the quality of primary care, should also be emphasized.

We thank the many collaborators who have generously contributed to this novel project with their ideas and insights. We also would like to gratefully acknowledge the financial assistance of the Netherlands Ministry of Health, Welfare and Sport in the framework of the Partnership Programme between the WHO Regional Office and the Netherlands.

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EXECUTIVE SUMMARY

This report summarizes the main results of the WHO Primary Care Quality Management Tool, which was implemented on a pilot basis in Slovenia in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Slovenia, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherlands Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and the Department of Family Medicine, University of Ljubljana, Slovenia.

Introduction

The Primary Care Quality Management Tool focuses on structures and mechanisms intended to control or manage the quality of staff and services in primary care. It examines the existing institutionalized mechanisms and practices in order to find out how Slovenia is making use of the available know-how and resources to improve the quality of primary care services. The Tool is not about quality of care itself, and therefore quality indicators do not play a prominent role.

Methods

The Tool consists of three parts: a questionnaire for national-level policy experts, a questionnaire for managers of primary care facilities and a questionnaire for general practitioners (GPs).

The Tool was pilot tested in 2007 in two regions of Slovenia: Gorenjska region and Ljubljana city. Questionnaires were completed by national policy experts from different stakeholder organizations of the health system, and by managers and GPs from the two pilot regions. The results rely strongly on self-reported behaviour rather than on direct observations or registrations.

Results

- *At National level, based on interviews with national experts*
  Quality assurance is not a priority in primary care in Slovenia but leadership and a clear vision of quality improvement strategies could help to change that. Legislation is proceeding slowly. In 2007, three laws with relevance to quality in health care were waiting to be adopted. The current system does not permit full accountability; for example, external quality assessments and inspections commissioned by the Ministry of Health are rarely used. Beyond the formally arranged inspection and supervision in health care, supervision of quality in primary care is fragmented and poorly coordinated. The current continuing medical education system is based on credit points and is insufficiently driven by the educational needs of physicians. Better access to guidelines and protocols can improve the management of quality. Independently produced guidelines are only available for purchase. Those provided by the pharmaceutical industry are free but are less suitable for use in primary care.

- *At managerial level, based on experiences and opinions of primary care managers*
  Quality reports are rarely made (33% of managers in Ljubljana and 60% in Gorenjska made routine evaluation reports). There are formal instruments for assessing quality, such as attestation of physicians, voluntary certification and accreditation,

and mandatory licensing of physicians or nurses and organizations, but they are not broadly or well used. Neither region uses a human resources management plan for general quality improvement. Only around 20% of the managers in Ljubljana and 40% in Gorenjska reported that they provide staff training for quality improvement, apply personal development plans and monitor job satisfaction. Protocols and guidelines are not generally implemented - only in about half of the centres. Managers expressed their intention to invest in further implementation and to update obsolete practices. Managers in both regions were confident that patients are treated according to the latest professional evidence.

- *At GP level, based on experiences and opinions of GPs*
  GPs are more involved in unofficial and ad hoc forms of quality improvement than in formalized procedures. Improvement would seem to be possible with regard to the use of clinical guidelines. These are not drafted in a uniform way but, rather, using a mix of approaches. In both regions, GPs were positive about continuing medical education courses that help them to provide better care for their patients. About 75% of the GPs in both regions recognised that it would be possible to improve teamwork and cooperation within primary care with nurses, and between primary and secondary care with medical specialists. More than 80% of the GPs in both regions acknowledged that the motivation of health care workers to provide better care left something to be desired and that better incentives could help to change the situation.

Recommended policy action

- Develop leadership and clinical governance at national level by effectively establishing the planned National Institute for Quality Improvement and empowering the Quality Department in the Ministry of Health.

- Improve the legislative basis for quality assurance by speeding up the progress of pending laws (including the law on patients' rights).

- Develop an effective national platform consisting of the Ministry of Health and stakeholders in health care to draw up and implement joint plans for structured quality assurance at primary level.

- Develop an integrated plan to modernize the management of primary care facilities, including education of managers, improved management information and the introduction of quality procedures and routines to improve accountability.

- Coordinate nationwide implementation of measures to strengthen the position of patients, including uniform complaint procedures, a patient charter, etc.

- Revitalize the system of continuing medical education by making it more needs-driven (focusing on knowledge and skills that are lacking); creating incentives for (voluntary) periodical assessments; and reducing the current dominant role of the pharmaceutical industry.

- Promote the use of computers for medical information and expertise, clinical record-keeping and practice-based research.

- Coordinate updating and expansion of the use of clinical guidelines by GPs.

- Develop human resources management in primary care, including regular job evaluation interviews, personal development plans and increased efforts in the area of staff training.

1 QUALITY MANAGEMENT: AN INTRODUCTION

Quality management and primary care

Patients should receive the care they need, that is known to be effective, in a way that does not harm them and does not waste resources. Basic requirements such as effectiveness, appropriateness and safety are of direct relevance to the maintenance of the quality of care from the health care system perspective.

Health care systems should have in-built incentives and mechanisms that allow continuous monitoring (and improvement) of the quality of services. The trend towards improved quality of care at primary care level that can be seen equally in western Europe and the countries in transition results from the general need for more cost-effective health systems. Strong primary care enhances the cost-effectiveness of the system as a whole. Strong primary care means: easy access to first contact services, a comprehensive supply of effective and safe curative and preventive services, continuity of care, coordination with other levels of care and interdisciplinary cooperation. In the absence of review procedures based on explicit and measurable criteria, it is difficult to assess the extent to which primary care systems currently meet these high expectations.

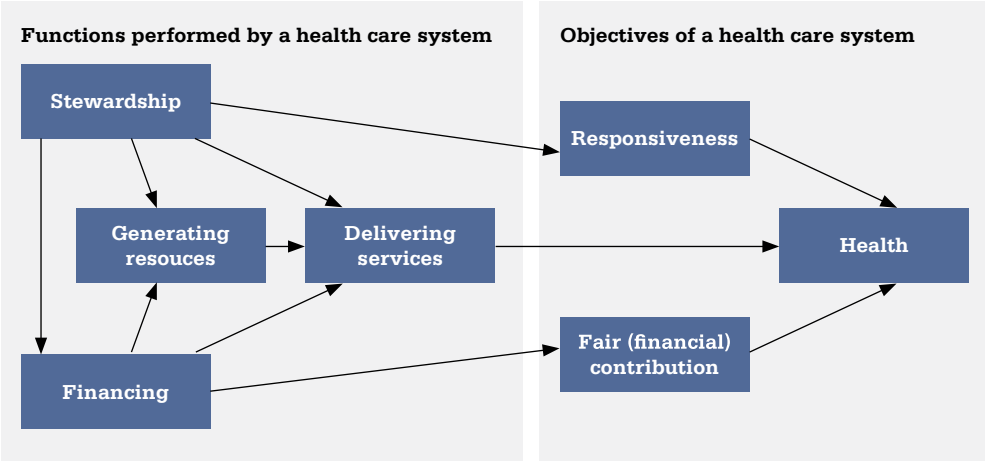
In most countries, assessment of the quality of primary care is much less advanced than that of hospital services. Studies that have been carried out point to large variations in quality of primary care and insufficient maintenance of good care standards *(1, 2)*. Compared to hospitals, there have, to date, been fewer requirements on primary care to demonstrate quality. Primary care is often provided in a fragmented way, and in much smaller units of provision than is the case with hospitals. In addition, hospitals usually have dedicated quality assurance staff and much better information systems, which are essential to generate the performance data needed for quality reviews and to initiate improvement actions.

Quality management and the health system framework

With an increased focus on strengthening (primary) health care systems, addressing structures for maintaining and improving the quality of services will become a key component in health care reforms, since increased resources and know-how do not automatically translate into a higher quality of care. For instance, countries with high levels of health expenditure do not always perform better than countries that have fewer resources available. Making health systems more "quality aware" requires the development of a strategy, an analysis of the current situation, and innovation (that is, the implementation of desired change) *(3)*.

In the WHO health systems framework, performance assessment and consumer protection (both essential elements of quality) are part of one of the health care functions, namely the stewardship function *(4)*. Figure 1 below shows all health system functions and how they relate to health care objectives.

Figure 1: Functions and objectives in the WHO health system framework



The overall objective of a health system is to optimize the health status of an entire population throughout the life cycle. This objective is achieved by means of the functions explained below.

- *Stewardship* is about defining strategic directions in a health care system and setting and maintaining rules (for instance, related to the roles of purchasers, providers and patients). It deals with governance, use of information for feedback and monitoring, coordination, and regulation at various levels. Policy development concerning human/physical resource planning, a regulatory framework for assuring high quality service provision, and consumer protection are part of the stewardship function of the primary care system.

- *Financing* in general, deals with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually or collectively *(5)*. The financing function in health systems is defined by Murray and Frenk *(4)* as "the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities". Three subfunctions can be distinguished: revenue collection, fund pooling and purchasing.

- *Generating resources:* providing a balanced variety of resources for health care to function properly. The resources required encompass physical assets (equipment, facilities), consumable supplies, human resources and knowledge/information. Naturally, to ensure quality of care, the skills and knowledge of health providers need to be up-to-date and compatible with developments in technology and evidence-based medicine.

- *Delivering services* involves the mix of inputs needed for the production process within a specific organizational setting leading to the delivery of health interventions *(4)*. It relates to preventive and curative services delivered to individual patients and larger populations (e.g. health education, promotion). Subfunctions of service delivery include the following.

- *Accessibility:* the patients' ability to receive care where and when it is needed; there may be physical, psychological or financial barriers to access.
- *Continuity of care:* interventions are tuned to patients' needs over a longer period and cover successive episodes of care/treatment; possible dimensions are informational continuity (referring to the patient's medical history), longitudinal continuity (when more health care workers are involved) and interpersonal continuity (receiving care in an ongoing trustful personal relationship).
- *Coordination:* a service characteristic resulting in coherent treatment plans for individual patients and an important element in the responsiveness of health services. Coordination is essential at the interface between primary and secondary care, or between curative care and other services.
- *Comprehensiveness:* the extent to which a full range of services is either directly provided by a primary care physician or specifically arranged elsewhere. In primary care it refers to the fact that services comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention.

Although the quality of health care services is related to all health care functions, the *mechanisms and rules* aimed at maintaining and improving the quality of services are primarily part of the stewardship function (which is exerted at different levels throughout the health care system). Indeed, resource generation (in particular the provision of essential equipment, training and continuing education) and financing (for instance, performance-related payment and other incentives for quality) are important in bringing about good performance.

The PCQM Tool focuses on the "infrastructure" for quality (regulations; mandatory and voluntary mechanisms, procedures and routines; use of information; governance and leadership for quality; availability of support and advisory structures for policy and practice in the field of quality at different levels, etc.), which is primarily related to the stewardship function.

The way in which the stewardship function is implemented and where responsibilities are located in the system may differ according to the type of health care system in a country. This is also true for the position of primary care within a system. In some countries, general practice has a dominant position in the provision of primary care services while, in others, medical specialties provide such services as well. The way primary care is organized determines strongly how quality improvement strategies can be developed and maintained.

The degree of centralization or decentralization is another relevant health system feature in this context. National health systems are usually characterized by a strong role for central and, to a lesser extent, regional health authorities in the financing and provision of services. In the countries of the former Soviet Union, the role of the state continues to be dominant and may have the character of a monopoly, with little or no independent influence of other stakeholders. In contrast, in social health insurance systems, power in health care is usually shared among authorities, health insurers and organizations of providers (usually physicians). To varying degrees, there may be a role for patients' and consumers' organizations. In countries where power in health care is shared, assessment and improvement of quality of care may be more divided among stakeholder organizations. Delegation or self-regulation is usually very weak or absent

in hierarchical state-run health care systems. In strongly centralized systems with a command-and-control style of management in health care, quality assessment and improvement will primarily be top-down, with different incentives for improvement of performance from those in decentralized systems *(6)*.

Different approaches to quality management mechanisms

Mechanisms for quality management can focus on either the structure of care, the process of care or the outcomes of it. This is the well-known framework developed by Donabedian *(7)*. "Structure" refers to physical characteristics (such as premises, equipment, human resources, the organization and management of resources, teamwork). "Process" refers to the actual delivery of primary care (in particular the clinical and interpersonal aspects). "Outcomes" are the results or consequences of the process of care (health status or evaluations by patients). The following examples of quality (management) mechanisms are classified on the basis of this framework.

Related to *structure* are: safety regulations; activities of a state inspectorate; a system of disciplinary rules for professionals; (re)certification and accreditation schemes; regulations for the establishment of practitioners; human resource training policies in health care organizations; the use of a quality handbook (specifying procedures, safety, privacy, etc., in health care organizations); promotion of (electronic) medical record systems; use of official job descriptions for health professionals; and promotion of teamwork among health professionals.

Process-related activities are: supporting evidence-based medicine; structured peer review among health professionals; implementing clinical guidelines; benchmarking; practice audits; projects aiming at more rational referring and prescribing; promotion of patient information materials; practice visitation; patient complaint procedures; and local (facility-based) quality improvement projects.

Examples of *outcome*-related initiatives are: patients' evaluation surveys and structured client consultations.

Producing an instrument to assess the state of quality control and quality management in primary care is complex. Both central and decentralized policies are involved; a potentially wide range of mechanisms and activities, as shown by the above-mentioned examples, at different levels and of different scales need to be taken into account. Furthermore, different actors/stakeholder with different views on quality improvement may be involved (compare: *8*).

Focus of this project: institutionalising quality management mechanisms

The focus of the PCQM Tool is on institutionalized mechanisms and routines in (primary) health care systems that aim to ensure that the latest insights and evidence are applied in order to deliver optimum health care services to patients. Know-how and resources will not automatically translate into high quality services; this needs to be organized. The PCQM Tool aims to assess how this has been done.

Hence, the Tool looks mostly at aspects of structure and process – as outlined above – and much less at outcomes, the quality per se. It is important to keep this in mind when implementing the Tool and using the results produced.

Furthermore, in designing the Tool, a number of practical dimensions had to be taken into consideration, since effective institutionalized quality management mechanisms require the activation of a range of different functions, a number of which are listed below.

The *facilitation and advisory* function: an expert structure should be available to facilitate work and advise the Ministry of Health and other health authorities on progress and obstacles regarding the implementation of a quality improvement strategy, and to highlight new insights and trends.

The *advocacy* function: all stakeholders involved in health care quality management need to be sensitized and convinced of the importance and impact of a quality improvement strategy. The advocacy function also includes identifying incentives and disincentives for quality activities and the promotion of motivation.

The *implementation* function: the roles and responsibilities of all stakeholders must be clearly identified to carry out activities such as:

- promotion of evidence-based medicine, including the development and revision of guidelines and protocols and their dissemination/implementation;
- introduction of quality monitoring systems at facility and regional levels, and measurement of national performance indicators;
- facilitation or initiation of facility-based quality improvement projects;
- development of patients' charters (rights and obligations and complaint procedures);
- health technology assessment;
- licensing and certification of health professionals;
- accreditation of health facilities;
- safety programmes and projects.

The *teaching* function relates to training mechanisms (either undergraduate, postgraduate or through continuing medical education (CME)) and the creation of opportunities to build the knowledge and skills needed to carry out quality activities as listed above.

Monitoring and evaluation should be planned with a focus on the implementation processes and results of the quality improvement strategy. Plans should describe successes and failures, analyze their causes, promote reflection among stakeholders and make recommendations.

Research (carried out in research departments and universities) has an important role to play in assessing the effectiveness of quality management policy measures.

Communication between all stakeholders involved in a quality management strategy is essential for its success. Both the content and the channels of communication must be identified.

Stewardship (or leadership, or governance) is the overarching function for the development and promotion of quality management mechanisms. Effective stewardship unfolds a vision and plan in which all the contributing functions mentioned above are coherently described. Stewardship also establishes the rules, sanctions and incentives and enables local leadership, conditions and a climate in which initiatives can develop and individuals are motivated to produce a good performance. Stewardship should aim for the implementation of these functions in an integrated way and on a continuous basis. If that has been achieved, quality improvement can be assumed to be institutionalized into a health system *(9).*

2 QUALITY MANAGEMENT IN SLOVENIA: SOME RESULTS FROM A PILOT PROJECT

2.1. Overview on the implementation of the project in Slovenia

The activities of the pilot project began in February 2007 and were completed in March 2008. Project partners of the WHO Regional Office for Europe were the Netherlands Institute for Health Services Research (NIVEL), in its capacity as WHO Collaborating Centre for Primary Health Care, and a local partner, the University of Ljubljana, Slovenia.

The results and conclusions were discussed at a review meeting with international experts at the WHO Regional Office for Europe in Copenhagen on 14 and 15 April 2008. Experiences in using the Tool during the pilot studies, and comments and recommendations made at the review meeting resulted in a revision of the three questionnaires (see also chapter 2.5 on lessons learned). A second pilot study was conducted in Uzbekistan – the results are described in a separate country report. The following two sub-chapters give a short overview on the implementation process.

2.1.1. Preparatory phase

Literature review

The first step in developing the Tool was a directed literature review by the researchers at NIVEL. The aim of the literature study was to provide a framework for quality management improvement in (primary) health care that took account of the roles of policy-makers and other possible stakeholders, managers at central and decentralized levels, and providers of health care services. This made it possible to structure the diverse aspects of quality management improvement. The literature study also aimed to identify specific reports from evaluation studies of quality systems in health care. There is a longer tradition of comprehensive quality systems in the hospital sector than in primary care, where only some elements of such systems are being introduced (for instance, peer review, clinical guidelines, benchmarking, patient evaluation studies). The literature review, combined with expertise available at NIVEL, resulted in the identification of relevant fields and topics, ranging from legislation and central regulation to routines in daily practice to maintain and promote quality of care. Topics selected in this way were ordered according to their relevance for the three levels where data collection would take place: at the national level, among managers of primary care, and at the level of providers (in particular, GPs). Since the structures examined by the Tool are usually not visible to patients, it was decided not to add a patient survey as part of the Tool.

Preparatory meeting

An international preparatory meeting was held on 28 and 29 June 2007. The main aims of the meeting were:

- to discuss the first draft of the Tool, consisting of questionnaires for all three levels; the experts present were particularly invited to consider the relevance of the questions to their own health care system, the clarity of the questions and the terms used;

- to exchange information on quality improvement and quality management in primary care in the WHO Member States represented at the meeting in order to become familiar with the current situation and trends;

- to make first preparations for the pilot implementation of the questionnaires; the general requirements, possible approaches and preliminary timing of activities were discussed and two countries were selected for the pilot studies to take place: Slovenia and Uzbekistan.

Redrafting, validation and translation of questionnaires

On the basis of the information and feedback from the preparatory meeting, the draft versions of the questionnaires were revised. The revised versions were then forwarded to the meeting participants for comment and possible suggestions for change (clarity, omissions, terminology). This revision round also offered for the experts the possibility of involving and consulting with other experts in their country and thus broadening the basis for validation. When all inputs for revision were processed, the final versions in English of the three questionnaires were established. As the questionnaires were tailored to the national situations, the versions developed for Slovenia and Uzbekistan were slightly different. Subsequently, these final versions were translated in the respective countries in a check and double-check procedure. The translations were first made into the local language with inputs from an expert in primary care. Subsequently a back-translation was made and compared with the original version.

2.1.2. Implementation phase and field work

Meetings in Slovenia

The international project team met twice in Slovenia to prepare the implementation of the Tool and to organize the collection of data. The following activities were carried out during these meetings:

- discussion of final details of the questionnaires, resulting in (minor) changes;

- information to and exchange with national working groups that had been established for the guidance of the project and dissemination of results;

- information to central and regional health authorities and managers about the pilot study and the planned activities;

- site visits in the selected regions;

- instruction of those involved in the data collection (for instance, in respect of the confidential nature of the surveys);

- discussion of details of the sampling and recruitment procedure with the national coordinator and others;
- discussion of details of the data collection strategy and logistics;
- preparation for data entry and related instruction;
- leading the meeting with the national experts who filled in the national level questionnaire, in order to achieve consensus on "factual" questions (the "consensus meeting").

Sampling, data collection and processing

For Slovenia, it was decided to include the directors of primary care units and the heads of the GP teams in the primary care facilities into the survey as "managers". The managing directors of health centres (which are large umbrella structures) were excluded because they have hardly any direct responsibilities related to quality in primary care. The GPs included both those working in the public facilities and those in private practice. Private GPs make up 18% of all practising GPs in the country. Data were collected by means of a postal survey, supported by telephone calls. Given the availability of resources and past experiences, this was considered to be the best feasible approach. Since the whole population of GPs and managers in Ljubljana city and the Gorenjska region was included, no sampling procedure applied. Overall, the response in Slovenia was disappointing. Only 41% of GPs returned a completed questionnaire, even after they were reminded by telephone. Half of the managers responded. Of the national experts invited, just 59% returned the questionnaire and only half of those attended the consensus meeting. More details on the implementation are summarized in the following table:

Table 1: Overview of the implementation process in Slovenia

Features of data collection	Explanation
Target groups	• GPs (both public and private, 18% being private) • Directors of PHC Units + Heads of GP teams in PHC • National experts
Locations	• Gorenjska region • Ljubljana city Justification: Little variation in quality strategies in primary care were expected between the regions in Slovenia, but the situation in the capital of Ljubljana could differ from that in other regions. Therefore, the national working group decided to collect data in the Ljubljana region and in the northern region of Gorenjska.
Type of data collection	• GPs: postal surveys using prestructured questionnaires • Managers: postal surveys using prestructured questionnaires • National experts: prestructured questionnaires and discussion at consensus meeting
Period of data collection	15 October – 15 November 2007
Sampling method	• GPs: population (all) in 2 regions • Managers: population (all) in 2 regions • National experts: selected by local partner

Features of data collection	Explanation
Sample size / included	• GPs: Ljubljana: 130 (= all) Gorenjska: 70 (= all) • Managers: Ljubljana: 14 (= all) Gorenjska: 13 (= all) • National experts: 17
Response	• GPs: Ljubljana: 63 (48%) Gorenjska: 18 (26%) • Managers: Ljubljana: 9 (64%) Gorenjska: 5 (38%) • National experts: 10 (59%) of whom 5 (29%) attended the consensus meeting
Instructions	• Local partner was instructed on details of sampling procedure and recruitment. • Questionnaires contained instructions on completion. • Local partner was provided with data entry programme and instructions for use.
Coordination and support of fieldwork	• Local partner coordinated the postal survey according to guidelines. • Telephone follow-up by was organized to increase the level of response.
Data entry	By local partner in Slovenia, according to agreed guidelines and using the data entry programme provided.
Data analysis	At NIVEL
Local partner	Department of Family Medicine, University of Ljubljana

2.2 Slovene national experts and quality management in primary care: results of the survey

The following results are based on the answers given in the national level questionnaire completed in by 10 national experts from different stakeholder organizations such as the Ministry of Health, professional associations, patient and consumer protection groups and health insurers. The first section, in particular, reflects the discussion during the consensus meeting held with 5 of the 10 national experts who completed the questionnaire and is meant to give the reader an impression of how the management of quality in primary care is approached and perceived in Slovenia (approach to a culture or quality management).

2.2.1. General attitude to quality management in primary care

The relatively low rate of response to this pilot project in Slovenia raised the question of whether this could point to a lack of interest in the subject as such; this issue was therefore the starting point for the consensus discussion with national experts. The group agreed that the management of quality was, indeed, not perceived as a burning issue in primary care in Slovenia, and that leadership on quality improvement at all levels was lacking.

Experts agreed that the Ministry of Health, the National Health Insurance Institute and the professions all have a responsibility in quality improvement, and shared leadership was therefore clearly necessary. However, instead, there is a lack of mutual trust that

is probably linked to the new relations in health care. The professions seem to be defensive as a result of the growing influence of the purchaser (and, more indirectly, the user) of health care services. The Quality Department within the Ministry of Health is very small and does not as yet have a coordinating role.

The National Health Insurance Institute is a relatively new player with ambitions in terms of quality improvement. Its focus is now on more evidence-based prescribing and it aims, in the future, to introduce more quality incentives for both physicians and managers.

Managers at the intermediate level, who usually have a purely medical background, also need to adapt to a situation in which accountability, competence, incentives, evidence and communication are becoming keywords.

The experts found that only few GPs see quality improvement as a core task. As they are fully taken up by direct patient care, they have no time for quality improvement. Moreover, they also lack awareness of the need for systematic improvement of the quality of their services.

In addition to a general lack of a "quality culture" and insufficient leadership, the experts also concluded that the infrastructure for quality in health care is deficient. Legislation is proceeding slowly; there are currently three laws with relevance to quality of health care going through the parliamentary procedure. Furthermore, a national institute for quality improvement, originally planned for 2006, has not yet been established. Finally, performance information in terms of feedback to clinicians and managers was felt to be missing.

The meeting concluded that probably all of these factors contribute to the rather neglected position of quality improvement in primary care in Slovenia.

The question remains, however, of why implementation of innovation stagnates. It is not because problems have not been identified or the diagnosis is new. International projects and several policy workshops in Slovenia have resulted in similar lessons. For instance, the World Bank Health Sector Management Project, which finished in 2004, addressed many issues related to quality of health care services (such as an incentive framework for improving productivity and quality at all levels; strengthening of health care management, guidelines for guidelines, clinical pathways and implementation of information systems) and institutional arrangements were proposed accordingly but no decisions have yet been taken. Another much smaller project, "Needs in PHC in Slovenia", completed in 2001, addressed peer review and clinical guidelines in pilot health centres, a procedure for patient complaints, teamwork and coordination of care, and a research programme for primary care. Both projects experienced difficulties in implementing changes. The World Bank project reported that the "impression among stakeholders that the Slovene health system is better than in most other countries" could be a root cause *(10)*. Indeed, compared to other countries in transition, the starting point of the Slovene health care system was more positive. Therefore, a possible root cause could indeed be the lack of urgency and a feeling of self-satisfaction that hampers progress in primary care development.

2.2.2. Legislation and regulation

At present, the Law on Health Care and the Law on Medical Services are most relevant for quality in health care; they deal with quality systems in institutions, licensing, working conditions in health institutions, medical auditing and medical education.

Patients' rights are generally addressed in the Law on Health Care and aspects of patients' rights are addressed in the Law on Health Institutions (delivering complaints by patients) and the Law on Personal Data Keeping (access to medical files). A new comprehensive Law on Patients' Rights has been submitted to the Parliament and was approved after the project had ended. It was announced in February 2008 and enforced on 26 August 2008.

Additionally, the national experts reported that the following policy documents deal explicitly with monitoring and improving the quality of (primary) care:

- *Development and implementation of quality management systems in health care* (1997);
- Recommendation No R (97) 17 and memorandum, Medical Chamber of Slovenia, University Clinical Centre, Council of Europe;
- *National health care programme: Health for all to 2004* (2000);
- *Slovene manual for guidelines development*, Delovna skupina C13, Ministry of Health (2003);
- *Strategy for e-Health in Slovenia 2010*, Ministry of Health (2005);
- *National strategy for quality development in health care* (2006);
- *Methodological recommendations for clinical guidelines development and implementation* (2006);
- Recommendations of the Council of Ministers, European Union, Ministry of Health (2006).

These documents are distributed by the Government to relevant stakeholder organizations (such as the Medical Chamber of Slovenia) and communicated to the general public via the mass media. They specify the roles of organizations other than the Government, such as the National Health Insurance Institute, the Medical Chamber and patients' organizations. However, some experts stress that this is not always sufficient; in particular, the role of primary care is poorly defined compared to that of the hospital sector.

The group of experts looked at the content of these policy documents and noted that the following 10 topics (from a list of 12) are addressed:

- accessibility of primary care services (note: only in general terms)

- equality in use, treatment or financing of all societal groups (equity)
- specification of patient rights
- specification of clinical indicators
- specification of health improvement targets
- establishment of a national centre for quality improvement
- specification of requirements for licensing of primary care facilities
- requirements to safeguard the safety of patients
- promotion of evidence-based medicine
- stimulation of research in quality of (primary) care

The group of experts could not, however, confirm whether the documents considered either the cost-effectiveness of primary care services or the performance of policy evaluation studies.

2.2.3 Formal structures

Formal supervision of compliance with rules and regulations in primary care is well organized. The Law on Health Care specifies the main supervisory control responsibilities of the medical profession and the roles of the Ministry of Health (management), the National Health Insurance Institute (financial and administrative control) and the Medical Chamber (professional control).

More specifically, the role of the Ministry of Health covers the areas noted below.

- Commissioning external quality assessments of (primary) health services (for instance, on access, prescribing drugs, referrals, patient satisfaction). Although the experts reported that the Ministry only rarely commissions such assessments, the following three points should be mentioned:
  - » the assessment of new practice(s) or health centre(s), in particular, the certification of premises before the start of health care services: practices, providers or organizations are formally assessed against predefined standards of competence;
  - » the Ministry audits cases of unexpected events (for instance, the unexpected death of a patient);
  - » there is ministerial involvement related to drugs: market inspectors supervise the implementation of the Law on Drugs and regulations on drug prices; the Ministry supervises the National Drugs Agency; and a more prominent role is planned for the National Health Insurance Institute in this area.
- Routinely collecting feedback data using process and outcome measures

» The national and regional public health institutes collect data but these are not used by the Ministry for quality improvement. Health statistics used by the Ministry do not address the quality of services. The ambitious e-health system which is being developed in the context of the strategy for e-health in Slovenia by 2010 may change this situation. For the time being, collecting feedback data is very much a small-scale affair.

- More or less regularly communicating and discussing quality information with stakeholders.

  » Although the Ministry participates in activities related to quality in health care, there is no standing committee or regular events for such communication and discussions with stakeholder organizations. The indicators on which such communication should be based do not exist.

- Reporting to the general public about quality performance or possible shortcomings of primary care services.

  » The Ministry regularly provides information to the general public on its website. However, there is very little emphasis on quality issues and shortcomings are usually not reported.

Other stakeholders are active in the areas noted below.

- Mandatory licensing.

  » Implementation of the licensing scheme has been delegated to the Medical Chamber. In November 2007, the Chamber started a new mandatory assessment scheme for primary care practices and GPs. The Chamber's visiting committee uses a special assessment tool (the Visatool developed by the World Association of Family Doctors-Europe, educational wing and network (WONCA Europe/EURACT)) for this purpose.

- Formal supervision of CME for GPs.

  » This is part of the licensing/re-licensing scheme mentioned above, under which GPs receive "credit points" for courses and other CME activities. The re-license criterion is 100 points over a period of seven years.

- Formal investigations into shortcomings and significant events in primary care.

  » In addition to the health centre where the event occurred, the Medical Chamber and sometimes the Ministry of Health are involved in "reactive" investigations. Physicians nominated by Medical Chamber visit health care institutions to identify possible shortcomings or to investigate incidents.

- Formal supervision of the follow-up given to patients' complaints by primary care facilities.

» Although a complaint procedure does formally exist in health care, there is no countrywide supervision of its implementation or the way that complaints are dealt with.

- Contracting of professionals (including the specification of aspects of quality in the terms of the contract).

  » The contract or agreement between the National Health Insurance Institute and providers of primary care does not seem to contain any elements of quality improvement (this refers to 2007). This applies equally to private GPs (independent contractors) and the community health centres where different types of physicians are employed. The contracts are the same for both situations.

- Financial incentives for providers and organizations (in particular for the promotion of good quality of care).

  » Negative financial incentives for GPs do exist: for example, for excessive referrals to medical specialists and hospitals (exceeding two standard deviations from the national referral rate); for not achieving the agreed number of preventive check-ups; and for over-prescription of drugs. However, there are no positive financial incentives such as bonuses.

Official job descriptions can serve as terms of reference for the evaluation of professional performance, practice conditions and obligations related to continuing education. It was asked whether such official job descriptions exist for a number of disciplines and whether they specify certain topics that could then be used as references for evaluation.

» The existence of job descriptions was checked for the following PHC team members: GPs; primary care nurses; district nurses, physiotherapists and pharmacists (there has not been a separate category of "midwives" in PHC in Slovenia for about 10 years, since district nurses are classified as "polyvalent", that is, having multiple responsibilities). There are job descriptions for all of these disciplines, including specific tasks and responsibilities, and requirements in terms of knowledge, skills and education. Most job descriptions also contain requirements for continuing education; for the nurses, however, this is still at a preliminary stage. The experts added that job descriptions also exist for occupational therapists and social workers. They commented that job descriptions in general should be more detailed and should specify the context of the function (for instance, teamwork) in order to be suitable as references for evaluation.

The experts were asked whether professional associations or representatives of professionals had been involved in developing job descriptions.

» The usual procedure in Slovenia is that job descriptions for (primary) health care professionals are developed by the Ministry of Health; there is no formal involvement of organizations representing the professionals.

2.2.4. Coordination and voluntary mechanisms

Beyond formal inspection and supervision in health care, the situation for quality management can be described as fragmented: quality management of primary care in Slovenia has not been entrusted to a particular body or structure that could coordinate activities and initiatives. The Quality Department of the Ministry of Health, established in 2000 with two staff and a yearly budget of € 180 000, has been involved in the issue and is in the process of developing plans.

The National Institute for Public Health has certain duties related to collecting monitoring data but there are no clear users for them. At present, quality of care activities are undertaken by different stakeholders with different interests, and thus limited scope; for instance, by the Medical Chamber and medical faculties and departments. The 2006 National Strategy for Quality Development in Health Care included the establishment of a National Institute of Quality Improvement. So far, however, no such institute has been established. Moreover, the Society of Family Physicians and the Department of Family Medicine have insisted that an Institute for Family Medicine be set up within the Faculty of Family Medicine. The experts agreed that the existing institutes could play an important coordinating role.

The group of experts was also asked about the prevalence of a number of voluntary mechanisms.

- Community surveys to receive patient feedback on the quality of care.

  » Each GP or health centre has (theoretically) the possibility to organize a community survey. In practice, this does happen, but only sporadically, for instance as part of a project or a specific training research programme. There have been public opinion surveys with questions on health care. However, surveys aimed at receiving feedback at community level or from users of primary care services are practically unknown. Therefore, such data are not available for quality improvement.

- Voluntary independent accreditation (meant as: assessment of predefined functions by peers from outside the person's own facility or organization).

  » Reportedly, such voluntary accreditation does not exist in Slovenia.

- Local provider initiatives to improve the quality of primary care, such as: informal mutual practice visitation; local patient surveys; guideline development on a small scale; cooperation projects between primary care and a local hospital.

  » Such initiatives are extremely rare. Some GPs are involved in what is known as "inter-vision", which invovles informal discussions and reflections on aspects of their work, sometimes on a regular basis. Some communities are eager to improve the quality of local health care services but the PHC level usually lacks the executive power to do so. The pharmaceutical industry sometimes takes initiatives with patient groups to promote patient information. The expert group pointed out that the population's perception of the quality of health care ser-

vices has been influenced negatively by the media, which, for example, tend to "blame" rather than inform.

- Benchmarking (that is, the systematic comparative monitoring of performance in primary care, possibly resulting in "performance ranking").

  » Benchmarking has been proposed but not implemented because of the lack of available resources. The expert group would prefer to have a mandatory system of benchmarking.

- Non-financial incentives for the promotion of quality of primary care, such as quality awards, certificates and prizes.

  » The expert group had no knowledge of the existence of any such incentives.

- Official (national) programme(s) for the development of primary care clinical guidelines.

  » There are no official national programmes supported by the Government. The Finnish family medicine guidelines have been translated and adapted, on the initiative of the professional organization (Society of Family Physicians), as have the Scottish and German guidelines, in the context of a World Bank project. In the past (around 2001), guideline development was supported in two pilot locations in the context of a Slovene-Dutch project on primary care development.

2.2.5. Education and access to information

Reflection on one's own work and being able to monitor and improve professional performance, alone or in a team, are skills that must be learned. The medical curriculum should prepare medical students for these tasks, for instance, by including peer review techniques, teamwork and patient information.

According to the expert group, in general, the undergraduate medical curriculum does not pay sufficient attention to quality of care and patient safety. In the postgraduate programme in family medicine, the situation is more positive, since communication skills, quality and research are major subjects.

Later, these skills need to be further developed in the context of CME.

The expert group concluded that the choice of courses for CME is large but focuses mainly on clinical subjects with medical specialists as teachers. Quality of care and methods for improving performance are not very popular among suppliers of courses. The expert group pointed to weaknesses in the current CME system, which is more driven by the "credit points" that all practising doctors need to gain rather than by real educational needs or professional shortcomings based on regular (self-) assessment. Physicians are free to choose any topic for CME. The expert group thought that innovation in the area (towards continuing professional development) is hampered by the current dominant role of the pharmaceutical industry in CME.

In nursing education, the situation has improved recently. Courses on quality of care are available now for graduate nurses.

Information and feedback are enabling factors for primary care professionals to improve their performance. The expert group was asked whether family doctors and primary care nurses in Slovenia have sufficient clinical information available to enable them to improve their services, and whether they have sufficient access to professional guidelines, standards and protocols.

The expert group was divided about the clinical information available to professionals. However, when focusing on clinical information for individual feedback, they agreed that this seems to be too fragmented. One major obstacle was the insufficient use of computers in primary care, especially for medical documentation. Although every family medicine practice in Slovenia has a computer, the software programs are usually not user-friendly and serve only national health statistics and financial purposes. There is no software package or informational support such as expert programs or a coordinated info-way platform tailored to primary care. Each provider has to find information independently. Another problem was that sources that are available are not well used (for example, the recommendations on clinical pathways by the Ministry of Health).

Concerning professional standards and protocols, most experts initially thought these were sufficiently available. Many admitted, however, that access to them could be better. Independently produced guidelines are only available for purchase. Those provided by the pharmaceutical industry are free but they are not drawn up by GPs for specific use in primary care. Materials published by the Ministry of Health (such as the guidelines manual and methodological recommendations for clinical pathways) are not suitable for use in primary care. Since the supply of professional guidelines is fragmented, it is not easy to gain an overview of the situation. These are some of the important tasks to be dealt with by the intended National Institute for Quality Improvement.

As leadership is important for keeping organizations and professionals up-to-date, managers of health care facilities have an important role to play in ensuring the optimum quality of the services. Here, the question to the expert group was whether managers in primary care in Slovenia have sufficient information to do so.

The expert group was of the opinion that the availability of management information is less of a problem than its proper use. Most managers have had only a medical education; they lack managerial and communication skills and do not use the available information properly. Quality management is still not an issue and it is not considered as an important part of their job. They are not evaluated on performance or quality criteria, but only on financial performance. The expert group considered that developing managerial skills in primary care and raising awareness of quality issues would contribute to the effectiveness of quality improvement strategies in primary care.

2.2.6. The way forward with quality management

From a list of 23 predefined areas, the 10 national experts who completed the national level questionnaire were asked to indicate their importance (high, medium or low) in strengthening the quality of primary care in Slovenia. Overall, the experts judged that the importance or priority of all of the areas was medium or high. Five items were rated "low" by one expert; two items were rated "low" by two experts and one item was rated "low" by three experts. The activities have been grouped and are described below.

- Policy and planning

  In the area of policy-making, experts rated as most important:

  » issuing legal statements specifying the goals and values related to quality of care
  » identifying priorities for legislation and interventions
  » drafting a strategic plan to promote quality of care
  » allocating financial resources for innovation
  » defining specific financial and nonfinancial incentives to promote quality (among both providers and managers).

  Developing plans to strengthen the position of patients (for instance by means of complaint procedures, safety incidents reporting and informed consent) was rated slightly less important. Developing a national programme for auditing and accreditation was rated lower, although still a high priority according to four experts. Even though other items were considered more important in the short run, current schemes for auditing and accreditation still need to be updated.

- Analysis and evaluation

  » The experts strongly agreed on the need to identify areas of poor quality and to analyse the causes of poor quality as the basis of a strategic plan. They concluded that policy measures on quality improvement in primary care need to be monitored and evaluated on a routine basis, and that research capacity in primary care needs to be strengthened. Experts added that critical events, observation of patient safety rules and patients' complaints should also be monitored systematically.

- Information

  » One of the top priorities was to improve the (electronic) medical record system in primary care. Experts expected that this would improve the information basis for quality improvement and also enable family doctors to work more efficiently and thus reduce their workload. Furthermore, it was felt important to promote and disseminate information on modern approaches to quality management in (primary) health care. It was also expected that electronic access to external information would improve when the use of computers in primary care increased.

- Support

  - » To create support for quality management at the national level, experts thought it would be helpful to establish a national steering group or platform with representatives from professional organizations, patient organizations and the Government.
  - » Improving the current CME system was rated as a medium to high priority. The starting point for CME should be the individual needs for training and education. Physicians should follow programmes tailored to their educational needs and the effects of the programmes should be assessed.
  - » Although the experts were in favour of the establishment of a National Institute on Quality Improvement, as mentioned above, some did not give it the highest priority but thought that existing expertise and structures should be better used first.
  - » Informing and consulting with the public and stakeholders on priorities and progress in quality improvement was given a relatively low rating.
  - » The expert group added the following points to the list: the further development of a coherent set of clinical pathways and professional guidelines; and better use of international expertise and platforms on quality of healthcare (for instance in the context of the European Union, WHO and international professional organizations).

- Implementation

  - » It was considered important that positive results from smaller scale interventions and pilot studies be implemented on a larger scale and become "institutional". This would require a coordinating function that does not currently exist. Developing new pilot or demonstration projects was not seen as very important.

  The expert group added the following points here:

  - » the systematic involvement of patients by means of satisfaction surveys, complaint procedures and participation in local health care facilities; as well as education of patients on their rights and responsibilities in health care;
  - » facilitation and encouragement of small-scale activities among primary care providers, including peer review in family medicine, supervision and inter-vision;
  - » improved quality of health care management at different levels through training of managers and the introduction of a system of management supervision and control.

- Perceived obstacles

  From a list of eight items, the following three were rated by at least half of the experts as perceived major obstacles to the improvement of quality management in primary care:

  - » existing values and general vision in terms of health care and quality improvement;

» the relatively subordinate role of primary care compared to other levels of health care (especially with regard to funding);
» the lack of structures for the promotion, coordination, implementation and control of quality management initiatives.

Asked about other possible obstacles, the expert group mentioned the following:
» the current (at the time of the project implementation in 2007) lack of interest on the part of the National Health Insurance Institute in becoming an active player in improving the management of quality;
» the current strict norms for GPs that result in a very high patient workload and little time for education and professional exchange.

2.3. Slovene primary care managers and quality management: results of the survey

The "managers" sample included the directors of primary care units and the heads of GP teams in primary care facilities in the two regions, Ljubljana and Gorenjska, with the total number of managers being 27. Only about half of the managers contacted completed the questionnaires (9 in Ljubljana and 5 in Gorenjska). Nevertheless, since this was a first pilot study, the results will be presented for each pilot region. In the tables and figures, despite the small numbers, percentages will be used to allow easy comparison of the results.

2.3.1 Characteristics of the managers and their working environment

In both pilot areas, the gender of the managers was well balanced, with a small majority of female managers. The age of the managers ranged from mid-thirties to mid-sixties. In Ljubljana, the average age was 56, while in the Gorenjska region, managers were younger, with an average age of 44.

A marked difference was found in the managers' working experience. The managers had been working in their current position and place between 1 and 36 years. In Ljubljana, they had been working much longer in the same position than their colleagues in Gorenjska. The average in Ljubljana was 27 years and in Gorenjska 13 years.

The managers were asked about the number of staff they supervise in their districts: those in Ljubljana were responsible for 176 staff on average, while in Gorenjska region, which is a more rural area, the managers supervised an average of 43 staff. Of the 176 staff that managers in Ljubljana were responsible for, 45% were (para)medical staff, 16% were nurses, 9% were GPs, and 30% were other staff. The 43 staff in Gorenjska consisted, on average, of 53% nurses, 23% (para)medical staff, 19% GPs, and 5% other staff.

Table 2: Characteristics of the working areas

	Ljubljana (N=9)		Gorenjska (N=5)	
Type of working place	Abs	%	Abs.	%
• Inner city	7	78	0	0
• Suburban area	2	22	0	0
• Small town (< 50.000)	0	0	5	100
Total	**9**	**100**	**5**	**100**

Table 2 shows clear differences between the managers' working areas in the two regions: Most managers in Ljubljana were working in the inner city, while a minority was working in suburban areas. In Gorenjska, all managers were working in small towns.

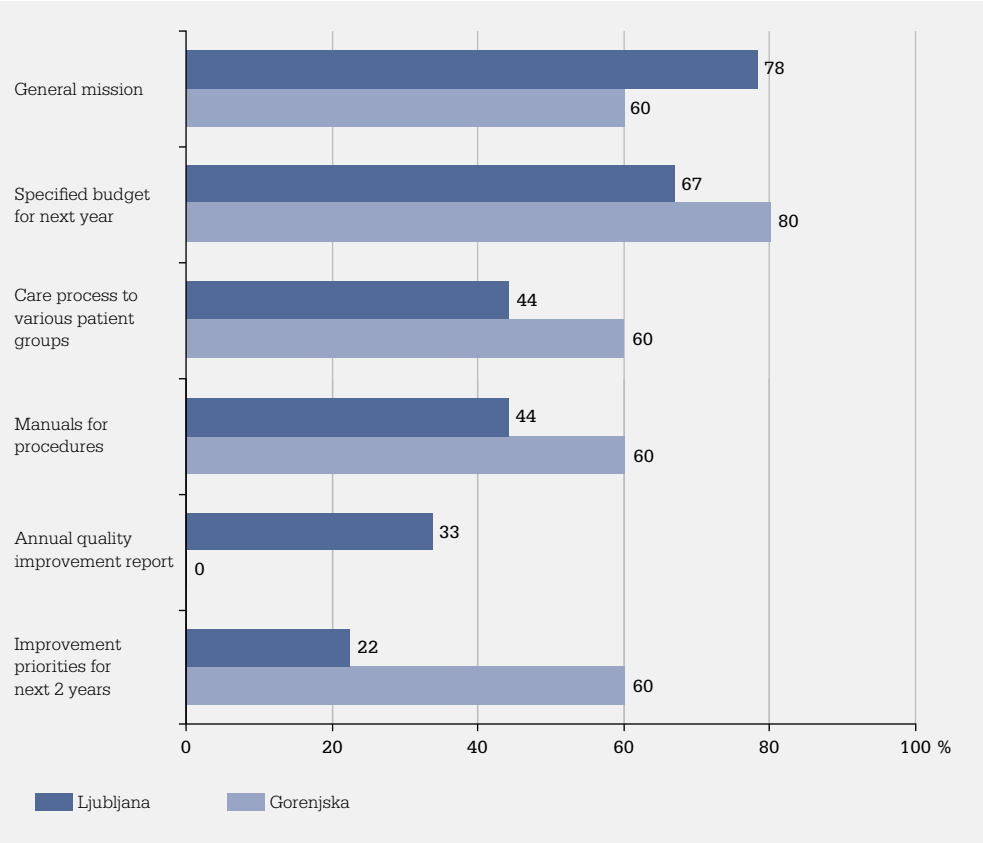
Additionally, the managers were asked to characterize their current position. The responses were very similar in the two pilot areas: in general, they were either head of a GP department or manager of a primary care unit.

2.3.2 Availability of documents relevant for quality management

Maintaining or improving the quality of services requires references or yardsticks. The services of a health care facility can only be evaluated if aims and benchmarks for services have been established and described, and thus made explicit beforehand. Consequently, managers were asked whether a number of documents, listed in figure 2, relevant to the management of quality of health care services were available in their organization. If not available, managers could indicate that preparations were being made for their introduction, or that this was a current topic for discussion within the organization. Figure 2 provides an overview of the "availability" only.

Overall, in Gorenjska, two thirds of the managers reported the availability of five of the six listed documents, while in Ljubljana this was only the case for two types of document: the general mission statement and a financial budget specification for the coming year. These two types of documents were also generally available in Gorenjska, in addition to documents providing a detailed description of the care process for various patient groups; manuals describing specific procedures; and reports on future improvement priorities. Annual quality improvement reports were not available in Gorenjska, and their availability in Ljubljana was low. In Gorenjska, managers answered this was still a topic for discussion, while in Ljubljana 44% reported that preparations were being made for their introduction.

Figure 2: Available documents related to quality management (summary)



However, even though no annual reports were made in Gorenjska, priorities had been set for the improvement of services over the next two years, including annual budgetary planning. In Ljubljana, the status of implementation of priorities was diverse. Only two managers (22%) reported the availability of such a document, while three (33%) reported that it was not available. Two thirds of the managers mentioned that a specified budget for the next year was available. Detailed descriptions of the services and care (to be) provided to specific patient and risk groups (such as the chronically ill; mothers and young children; cardiovascular risk groups) and manuals for the performance of specific procedures were common in Gorenjska, but not very common in Ljubljana.

Managers who reported to having a document describing improvement priorities for the next two years were asked to indicate which plans they had. Results are shown in table 3.

Table 3: Priorities for improvement over the next two years, mentioned by managers

Type of improvement	Ljubljana (N=9)	Gorenjska (N=5)
• Formalised quality improvement activities:*	Introduction of a quality certificate Practice audits Establishing quality registration and control Application of quality indicators Annual reporting on quality assessment	
• Patient safety:*	Prevention of hospital infections	
• Patient access and services:*		Renovation of practice premises and laboratories (N=2)

* Priorities were mentioned once unless indicated otherwise

Plans for improvements were grouped into three categories. The first group covered those related to formalized quality improvement activities in Ljubljana. Those specifically mentioned were: the introduction of a quality certificate; practice audits; establishing registration and control; applying quality indicators and introducing annual reporting on quality assessment. The second group encompassed prevention of hospital infections to improve patient safety. The third group contained a priority expressed by two of the managers from Gorenjska concerning renovation of practice premises and laboratories.

In table 4, total scores are presented on the availability of the six documents mentioned in figure 2. Overall, the level of documentation in Gorenjska region was somewhat better than in Ljubljana.

Table 4: Total scores for available documents related to quality management in two pilot areas

Province	Score*
Ljubljana	48
Gorenjska	53

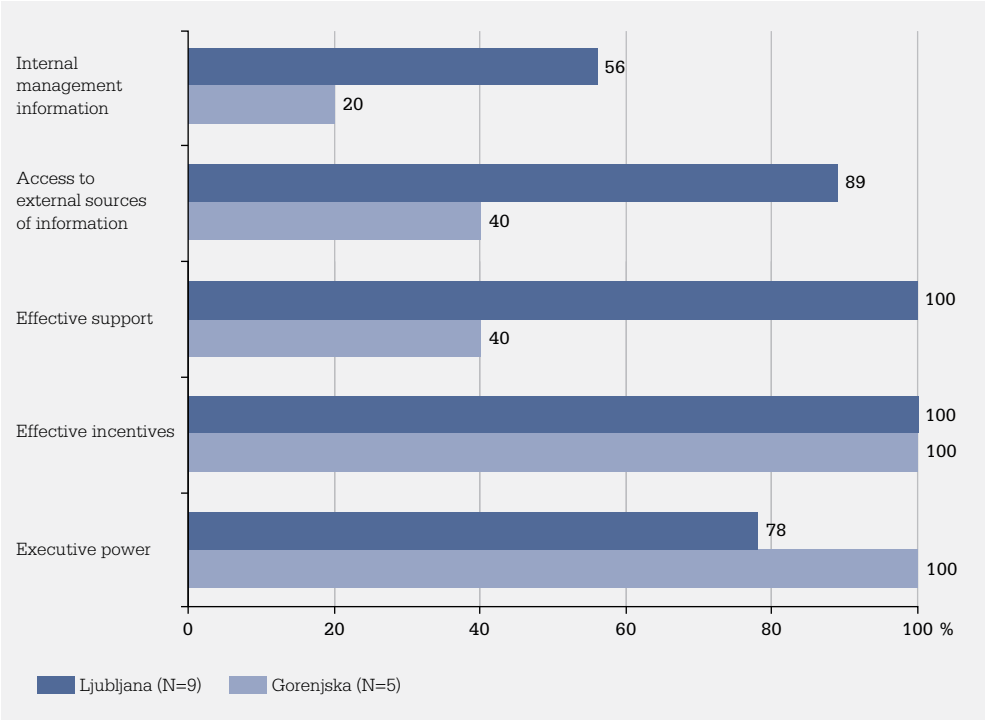
* Maximum score = 100

2.3.3 Conditions and means for quality improvement

Information is the basis for any planned change. Managers need to have information on the internal processes that take place within their organizations as well as access to external sources of information, for instance, for comparisons. Managers may need internal or external support to achieve change, and incentives to foster good performance

among members of their organization. Obviously, managers need to have sufficient executive power to create good conditions for quality management improvements. Consequently, managers were asked about these conditions and means. Figure 3 shows the proportions of managers who considered that specific conditions and means were not good.

Figure 3: Conditions and means for quality management considered *not* good ('fair' or 'insufficient'); summary



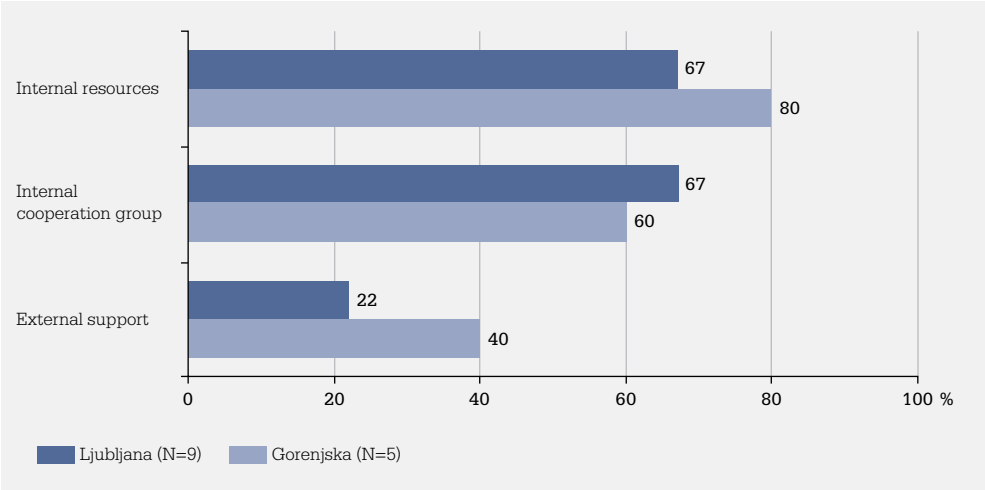
In contrast to their colleagues from Gorenjska, managers from Ljubljana generally found these conditions and means to be inadequate. They were least dissatisfied with the availability of management information, which was judged good by 44% and fair by 56%. However, for the other conditions and means, three quarters of all the managers in Ljubljana indicated that these were either fair or insufficient. For instance, two thirds answered that they had insufficient effective incentives for realizing change. Concerning access to external sources of information, external support and executive power to implement change, around 70% of respondents rated them 'fair' and 20% rated them 'insufficient'.

In Gorenjska, the managers judged the conditions and means for quality management much more positively. The majority considered that they had 'good' access to internal management information and external sources of information and received good support for implementing changes in the organization. Only with regard to receiving effective incentives and executive power did a majority of managers in Gorenjska indicate that the situation was only 'fair'.

2.3.4 Support for improvement actions

Managers were asked about three specific forms of support for improving quality management in primary care: the availability of internal resources for that purpose (for instance, for the implementation of clinical guidelines); the existence of an internal group to promote and coordinate quality improvement; and the availability of external quality support (for instance, for training of staff). Figure 4 gives an overview of the results. If support was not available, it was usually either being prepared or was a topic for discussion.

Figure 4: Available support for quality improvement activities; summary



Most managers in both Ljubljana and Gorenjska reported that they had internal financial resources at their disposal, and internal coordination groups had been established for the promotion and coordination of quality improvement activities. Only about 20% reported that these two provisions were not in place.

External support seemed to be somewhat better available in Gorenjska than in Ljubljana. In Gorenjska, 40% of the managers reported that it was available, another 40% reported that it was a topic for discussion and 20% said it was unavailable. In Ljubljana, almost half of the managers answered that preparations were being made for organizing external support, while 22% mentioned that it was already available, 11% rated it unavailable and 22% said it was a topic for discussion.

Table 5 shows that the coordination of quality management had been established as a function for about half of the managers in the centres of Ljubljana and Gorenjska. The most frequently reported coordination post involved the director or chief manager being responsible for maintaining and improving the quality of services. One of the managers in Ljubljana mentioned that a quality commission was responsible for quality-related matters.

Table 5: Coordination of quality management in primary care organizations

	Ljubljana (N=9)		Gorenjska (N=5)	
Situation	Abs.	%*	Abs.	%*
Coordination function clearly established	4	44	3	60
Coordinator	Abs.	%	Abs.	%
• The director / chief manager	2	50	3	100
• A multidisciplinary commission	1	25	0	0
• Other	1	25	0	0
* Percentages based on situations with clearly established coordinator				

2.3.5 External assessment instruments

An assessment instrument can be characterized as external if the quality of services is compared to predefined criteria or standards set from the outside of the organization (for instance, by the government or by a professional organization). The application of such instruments can either be obligatory, for instance imposed by health authorities, or voluntary. Managers were asked whether the following six instruments were applied in their organization:

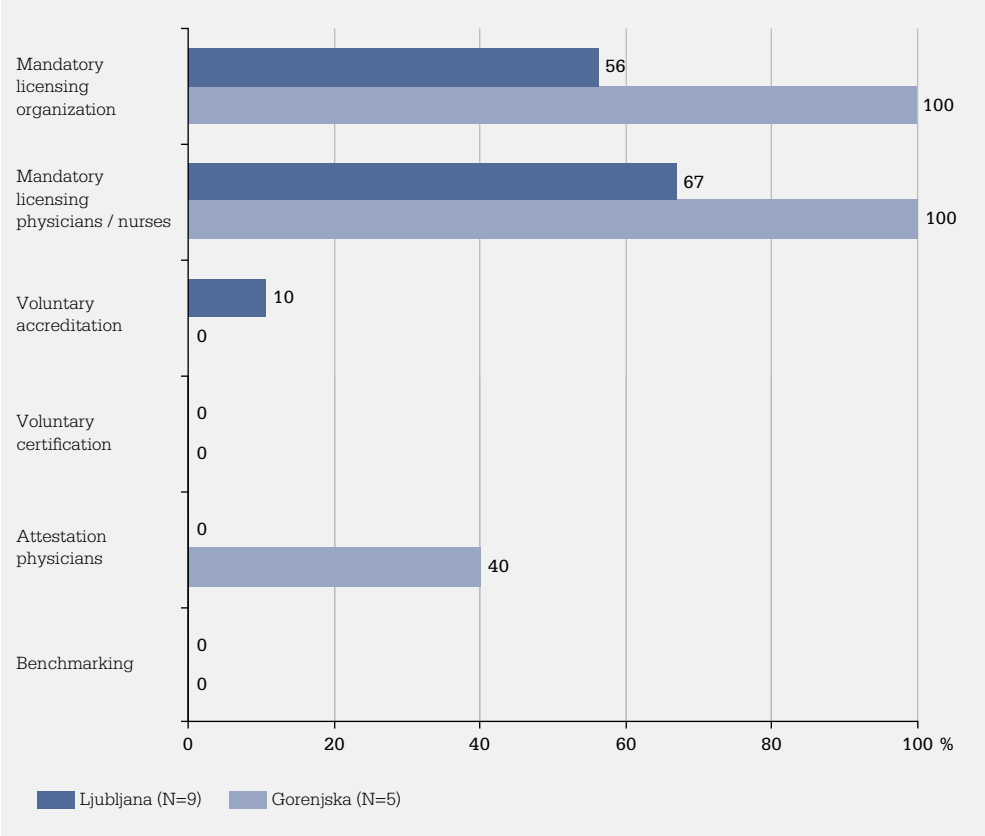
- mandatory licensing (or revalidation) of the organization (compliance with externally set minimum standards);
- mandatory licensing (or revalidation) of physicians and nurses (their compliance with minimum standards of competence);
- voluntary accreditation (assessments of the organization against predefined standards);
- voluntary certification (informal evaluation of the organization);
- attestation of physicians (four- or five-yearly knowledge tests);
- benchmarking (comparing the performance of different organizations).

The overview in figure 5 shows the percentages of managers who answered that an instrument was applied; the other possible responses – 'preparations are being made'; 'topic for discussion'; or 'not available' – are not displayed.

Overall, very few of the listed external assessment instruments were used in the two regions. Only mandatory licensing was mentioned by the majority of the managers but, despite its mandatory character, it did not seem to be implemented uniformly in the two regions. Mandatory licensing of organizations as well as of physicians and nurses was generally implemented in Gorenjska, while it was only reported by a small majority

of the managers in Ljubljana. This suggests that primary care facilities in Ljubljana had (or took) more freedom to join such mandatory schemes.

Figure 5: Applied external assessment mechanisms; summary



Voluntary participation in formal accreditation was reported by around half of the managers in Fergana and Syrdarya and one quarter in Tashkent. Voluntary certification, which is of a more informal nature than accreditation, was mentioned by only a few managers. Benchmarking, finally, was more popular, especially in Fergana, where two thirds of the managers reported being involved in this activity. In both the other provinces, about 40% of the managers said that they used benchmarking.

Total scores on the application of external assessment instruments, as listed in table 6, show Fergana as slightly ahead. If attestation were not taken into account, however, it would be clearer that Fergana is the province where external assessment instruments are applied most widely.

Table 6: Total scores for applied external assessment instruments in two pilot areas

Province	Score*
Ljubljana	22
Gorenjska	40
*Maximum score = 100	

The total scores for the application of external assessment instruments given in table 10 show a greater level of implementation in Gorenjska region. The overall low scores are, however, in line with the low level of application of the external assessment instruments that have been described.

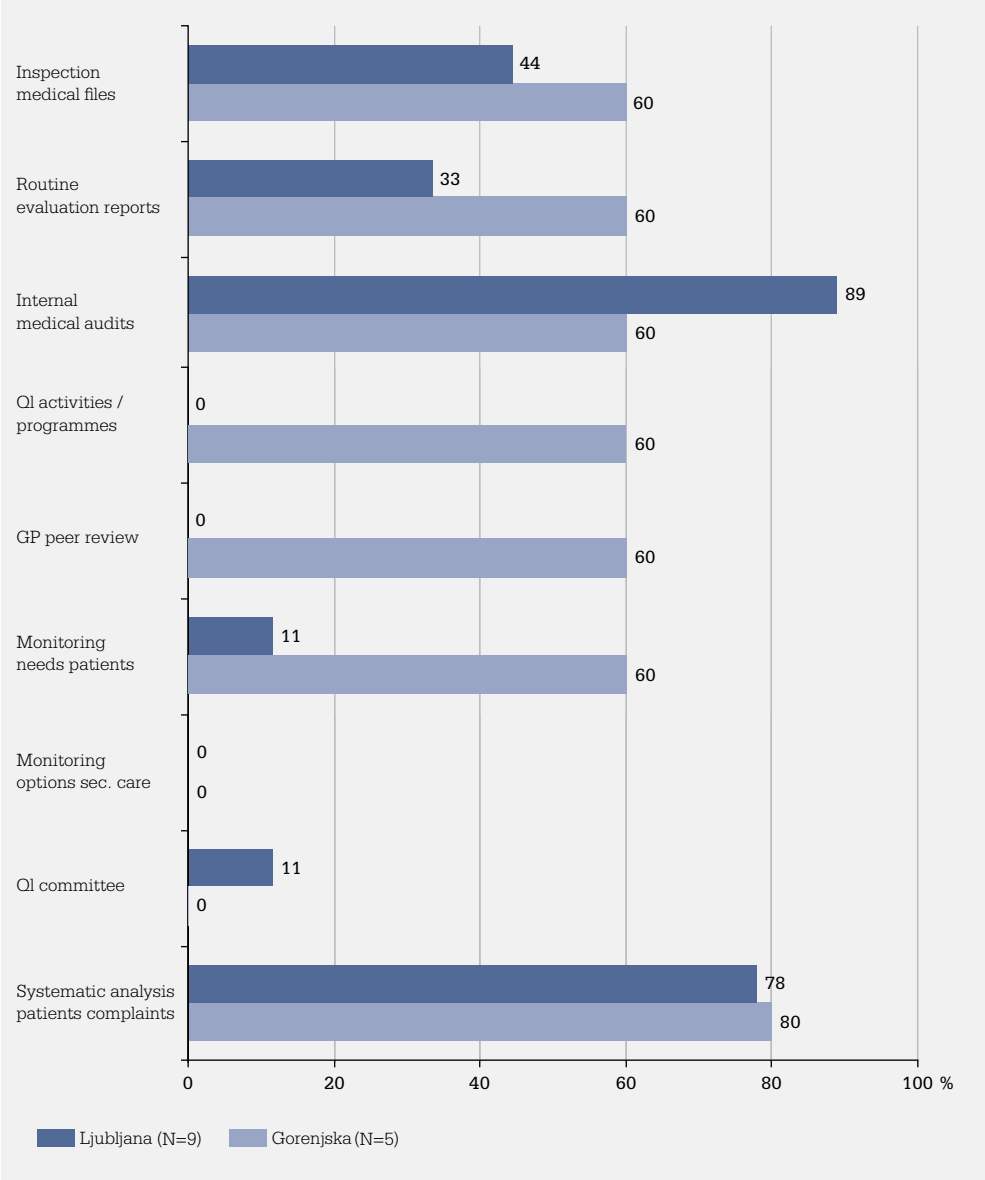
2.3.6 Internal assessment mechanisms

The following nine internal assessment mechanisms were considered:

- regular inspection of medical files by executives;
- routine evaluation reports to management on specific clinical or nonclinical activities;
- internal medical audits;
- quality improvement activities or programmes (using explicit techniques);
- peer review (informal assessment among doctors working in an area);
- monitoring of the needs/satisfaction of patients;
- monitoring of the opinions of partners in secondary care (for instance, medical specialists);
- quality improvement committee(s);
- systematic analysis and follow-up of patient complaints.

Internal modes of assessment usually have more implicit criteria or criteria that are used only within the specific organization. Some internal assessment instruments such as peer review among GPs are of an informal nature, while others, for instance, the follow-up of patient complaints, should be strict and formal. A summary of the answers given by the managers on the use of internal assessment instruments is shown in figure 6.

Figure 6: Applied internal assessment mechanisms; summary



Most internal mechanisms were more prevalent in Gorenjska than in Ljubljana. All mechanisms listed in the diagram, except two, had been implemented, according to two thirds of the managers in Gorenjska. The following were in place: inspection of medical files by executives; routine evaluation reports to management on (non)clinical activities; internal medical audits; quality improvement activities and programmes; informal assessments among doctors; monitoring patient needs; and systematic analysis of patients' complaints. Only the monitoring of the opinions of secondary care workers and the establishment of internal quality committees had not been implemented.

In Ljubljana, internal medical audits and systematic analysis of patients' complaints were reported to be widely implemented. Others such as quality improvement activities and programmes had not been implemented but had been prepared for, according to a small majority of the managers. Informal assessment among physicians and

monitoring opinions in secondary care were mentioned as topics for discussion by four managers (44%) in Ljubljana.

The results further show that there seemed to be good awareness of patient dissatisfaction. In both regions, the follow-up given to patients' complaints was mentioned by about 80% of the managers. The more general monitoring of patients' needs and satisfaction was reported by two thirds of the managers in Gorenjska, while in Ljubljana, the majority stated that preparations were being made for its implementation. Overall, taking into consideration the implementation of all internal assessment mechanisms, Ljubljana stayed clearly behind Gorenjska (see table 7).

Table 7: Total score for the application of internal assessment mechanisms in two pilot areas

Province	Score*
Ljubljana	30
Gorenjska	49
* Maximum score = 100	

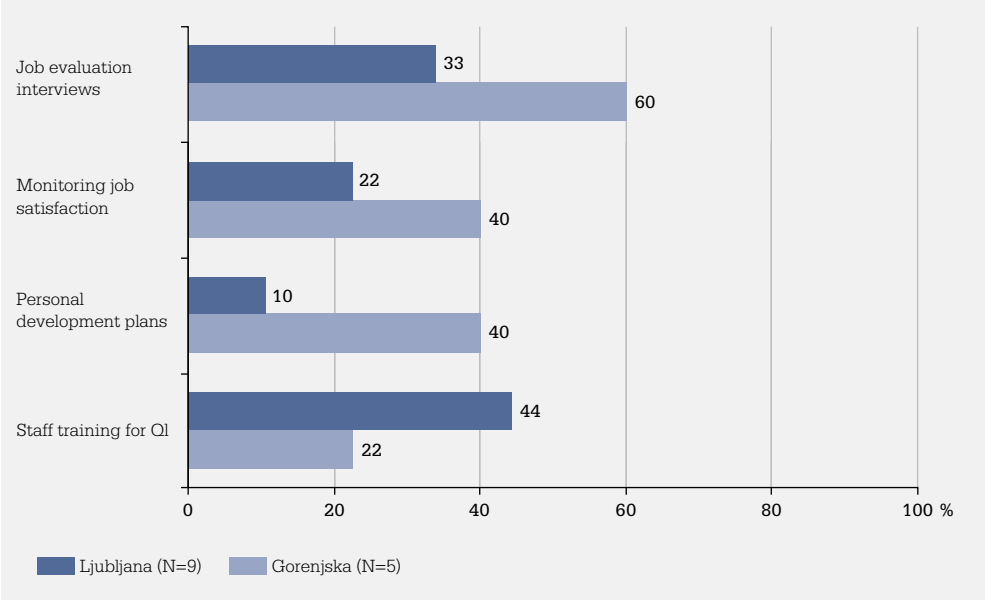
2.3.7 Elements of human resources management

Instruments of human resources management have the potential to provide workers with systematic feedback on their functioning, to identify needs for training and to point to opportunities for improvement and professional development.

Managers were asked whether the following aspects of human resources management applied to their organization:

- regular individual job evaluation interviews with staff
- monitoring job satisfaction of staff
- personal development plans for staff
- staff training for quality improvement of medical services.

Figure 7: Aspects of human resources management; summary



In both regions, the listed elements of human resources management were applied, although on a limited scale. Only in Gorenjska were job evaluation interviews reported to be held by the majority (60%) of the managers. In Ljubljana, only three managers (33%) reported that such evaluation interviews had been conducted, while two (22%) stated that preparations had beenmade for implementation and four (44%) said that job evaluation interviews were still a topic for discussion. Monitoring the job satisfaction of staff was mostly a topic for discussion. It was only reported as actually in place by two managers (40%) in Gorenjska and two (22%) in Ljubljana. The difference between the two regions was greatest in respect of personal development plans for staff. This was reported by two (40%) of the managers in Gorenjska, and only one (11%) in Ljubljana. Staff training for quality improvement was reported by one manager (20%) from Gorenjska and four (44%) in Ljubljana. It was mentioned as a topic for discussion by 60% of the managers.

Table 8 summarizes the results by displaying the overall rating: Despite the overall rather low scores, Gorenjska region again scored better than Ljubljana.

Table 8: Total scores for aspects of human resources management in two pilot areas

Province	Score*
Ljubljana	28
Gorenjska	40
* Maximum score = 100	

2.3.8 Use of protocols and guidelines

The use of protocols and clinical guidelines can contribute significantly to the improvement of health care and to the reduction of undesirable variation in the delivery of health care services. Protocols and guidelines can have various subjects. Managers were asked about the following topics:

- guidelines on specific clinical topics (for instance, certain diseases);
- protocols for the use of medical equipment;
- protocols for referrals to medical specialists (for instance, which information to supply to patient and specialist);
- protocols for referrals to hospitals (for instance, which information to supply to patient and specialist);
- protocols for patient complaints (for instance, who deals with complaints);
- protocols for patient information (for instance, what information providers should give to certain categories of patients).

All types of protocols and guidelines mentioned above were reported to be in use by more than half of the managers from Ljubljana. In Gorenjska, this was true for all but two of the topics mentioned; the exceptions were protocols for referrals to hospitals and protocols for provision of patient information. According to the answers shown in figure 8, both regions scored best on the availability of protocols dealing with patients' complaints (80% in Gorenjska and 100% in Ljubljana). Protocols for the provision of patient information were not used in Gorenjska but they were well in place in Ljubljana (reported by 78% of the managers). Clinical guidelines, protocols on the use of medical equipment, and protocols guiding referrals to specialists were reported to be used by a small majority of the managers in both regions. Protocols for referrals to hospitals were only used in Ljubljana, as reported by 56% of the managers. Consequently, the total scores for the use of protocols and guidelines were high in Ljubljana, and just below mid-scale in Gorenjska (table 9).

Figure 8: Use of protocols and guidelines; summary

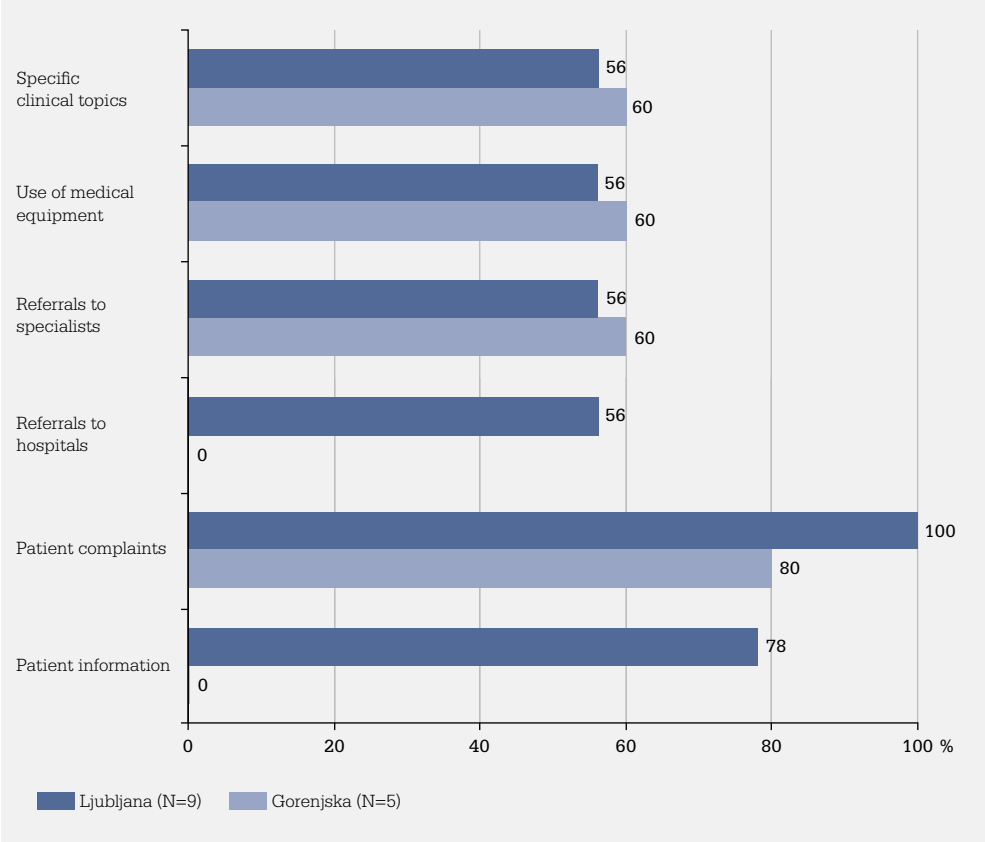


Table 9: Total score for the use of protocols and guidelines in two pilot areas

Region	Score*
Ljubljana	67
Gorenjska	43
* Maximum score = 100	

Further questions were asked about the use of various norms and standards. Some concerned the service aspects or the privacy of patients, while others focused on the conditions for the care process. Table 10 shows the results.

Table 10: Use of norms and standards

	Ljubljana (N=9)		Gorenjska (N=5)	
Topics	Abs.	%*	Abs.	%*
• Waiting times for patients	9	100	4	80
• Treatment of patients at the reception desk/ telephone	6	67	4	80
• Access of providers to patient medical records	9	100	4	80
• Storage and confidentiality of patient medical records	9	100	4	80

* Percentage of total number of respondents per region as indicated at top of table

There was high reported use of norms and standards guiding the patient care process in both regions. In Ljubljana, all managers reported the use of norms for waiting times for patients, access of providers to patient medical records, and norms for the storage and confidentiality of patient medical records. Norms for the treatment of patients at the reception desk or by telephone were reported by only three quarters of the managers in Ljubljana. In Gorenjska, four out of five (80%) of the managers reported to applying each of the listed norms and standards.

2.3.9 Managers' future plans for quality improvement

The questionnaire asked managers what plans for quality improvement they had for the somewhat longer term of three years. Possible answers were prestructured in the following three groups:

- plans related to the *process of care* (such as improving staff competence, developing internal or external clinical assessments or projects);
- plans related to the *role of patients or the population* (such as promoting health education or organizing patient feedback);
- plans related to *management* (such as strengthening teamwork, improving the quality of information or aspects of human resources management).

Table 11: Managers' quality management plans related to the *care process*

	Ljubljana (N=9)		Gorenjska (N=5)	
Topics	Abs.	%*	Abs.	%*
• Improve knowledge and skills of staff	9	100	5	100
• Improve clinical practice by guidelines and protocols	9	100	5	100
• Participation in accreditation or external review	8	89	4	80
• Improve quality of clinical data/medical records	7	78	5	100
• Develop small scale quality improvement projects	7	78	5	100
• Update obsolete clinical guidelines or protocols	7	78	4	80
• Introduce internal assessments or audits	7	78	2	40
• Develop peer review among physicians	6	67	5	100
• Introduce protocols for interdisciplinary cooperation	7	78	1	20
• Other plans	6	67	0	0

* Percentage of total number of respondents per region as indicated at top of table

Overall, managers had many plans to improve the care process during the coming years. Most of the prestructured answers turned out to match their plans: a large majority and sometimes even all of the managers in the two pilot regions had the intention to address the competence of their staff; to improve clinical practice by means of guidelines and protocols; to participate in accreditation or external review; to improve quality of clinical information; to start improvement projects; and to update obsolete guidelines or protocols.

More variation was found in the plans to introduce internal assessments or audits. Three quarters of the managers in Ljubljana reported having this intention, against 40% of the managers in Gorenjska. All managers in Gorenjska and two thirds of those in Ljubljana had plans to develop peer review among physicians. Protocols for interdisciplinary cooperation seemed to be desirable according to all but one manager in Gorenjska. This was however not the case in Ljubljana where three quarters of the managers were planning to improve interdisciplinary cooperation through the use of protocols. Some managers used the opportunity to add other than the listed items. They mentioned, among other things, increasing the currently limited resources available for quality improvement activities.

In the light of the previously described results, these intentions reported by the managers raise some points. The plans to improve knowledge and skills of staff were in line with the earlier reported results. Little effort, so far, had been put into personal development plans and staff training for quality improvement (figure 7). Managers reported

that they had insufficient executive power (and probably resources) to implement these and other changes (figure 3).

Figure 8 shows that protocols and guidelines on various topics had been implemented in about half of the centres. Managers also expressed their intention to invest in further implementation and to update obsolete elements. A surprisingly low level of interest in introducing protocols for interdisciplinary cooperation was reported in Gorenjska, with managers there reporting that no protocols were available for referrals to hospitals and only a few of them answering that protocols for referrals to specialists were available. This suggests that managers are either satisfied with the existing level of cooperation or that there is little awareness of the potential quality and efficiency gains that can be achieved when improving cooperation across levels of health care.

Even though about half of the managers reported regular inspection of medical files (figure 6), they seemed to be dissatisfied with the quality of medical record-keeping, given their high score on improvement plans.

Results concerning plans on the role of patients or the population are listed below in table 12.

Table 12: Managers' quality management plans related to the *role of patients / population*

	Ljubljana (N=9)		Gorenjska (N=5)	
Topics	Abs.	%*	Abs.	%*
• Introduce patient satisfaction surveys	7	78	5	100
• Improve health education to patients	8	89	4	80
• Involve the population in activities	7	78	4	80
• Implement a complaint procedure for patients	8	89	2	40
• Other plans	2	22	1	20

* Percentage of total number of respondents per region as indicated at top of table

In Ljubljana, all the items listed fitted into the plans of at least three quarters of the managers. This was also the case in the Gorenjska region, with the exception of one manager. Although complaints procedures had been implemented in both regions (see figure 6), managers in Gorenjska may not be satisfied with the existing ones, since they reported that they had plans to introduce complaints procedures.

Even though a small majority of the managers reported that they regularly monitored the needs of patients, they clearly felt they could improve the quality of care by implementing the plans listed in table 12.

The last group of plans in this section is those related to management. Table 13 provides an overview of the results.

Table 13: Managers' quality management plans related to *management*

	Ljubljana (N=9)		Gorenjska (N=5)	
Topics	Abs.	%*	Abs.	%*
• Improve teamwork	9	100	5	100
• Improve efficiency of work and procedures	9	100	5	100
• Improve motivation of professional staff for improving the quality of care	8	89	5	100
• Improve quality of statistical data for management	7	78	3	60
• Introduce job assessment interviews	7	78	3	60
• Allocate more resources for staff training and development	6	67	2	40
• Improve Human Resources Management	6	67	2	40
• Other plans	1	11	1	20

* Percentage of total number of respondents per region as indicated at top of table

Nearly all the managers reported having plans to strengthen efficiency, teamwork and staff motivation. A large majority also aimed to improve the quality of their management information. Human resources management was not a high priority, as shown in figure 7, except for the aspect of job assessment interviews. Three quarters of the managers in Ljubljana and a small majority of those in Gorenjska had plans to conduct such job interviews. Finally, allocating more resources for training and development was reported as an intention by two thirds of the managers in Ljubljana and two (40%) of those in Gorenjska.

2.3.10 Reflections and expectations concerning quality improvement

A number of questions aimed to explore the current thinking of primary care managers about aspects of quality improvement, the role of staff and their own role. Managers could either agree or disagree with a set of statements.

For example, the first statement was as follows: "Current continuing medical education courses enable my staff to provide better care to patients". Overall, it seemed that managers were satisfied with the current CME. They almost unanimously answered that it enabled their staff to provide better care to patients. Agreement was strongest among the managers from Ljubljana. One manager from Gorenjska disagreed with the statement.

The second and third statements were as follows:

Figure 9: Managers' reflections: "Physicians in my medical organization spend sufficient time improving their professional knowledge and skills"

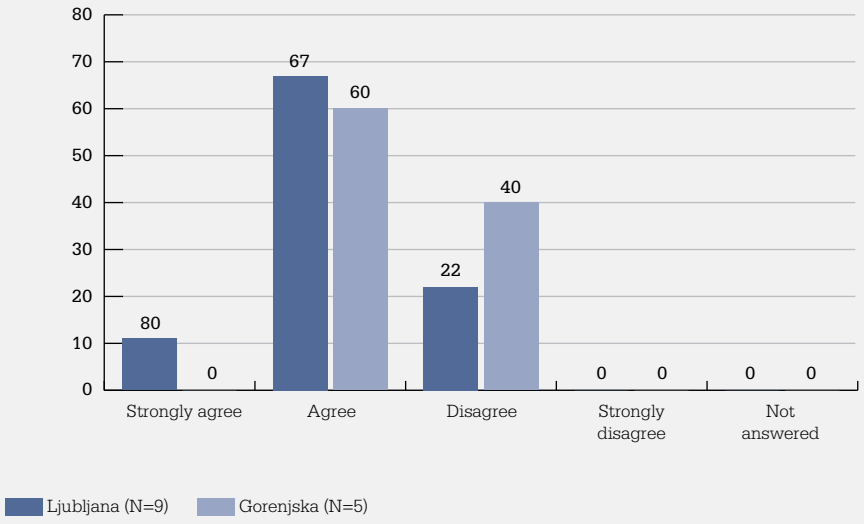
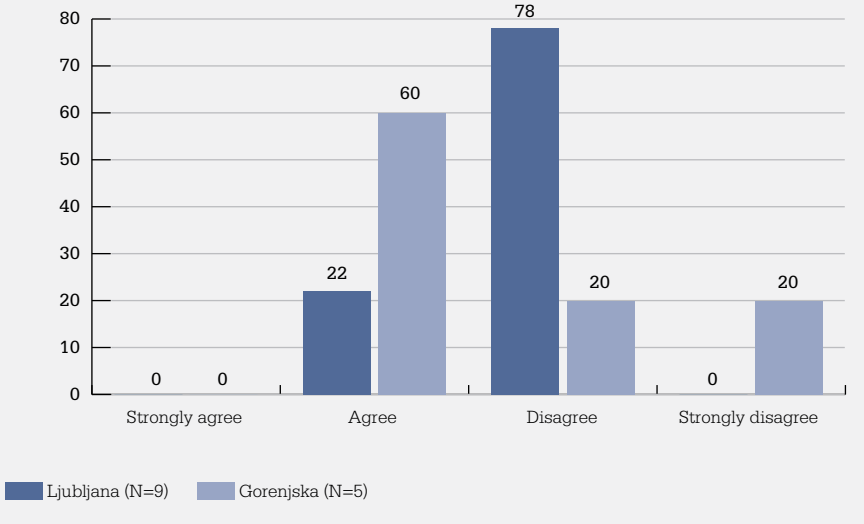


Figure 10: Managers' reflections: "Nurses in my medical organization spend sufficient time improving their professional knowledge and skills"

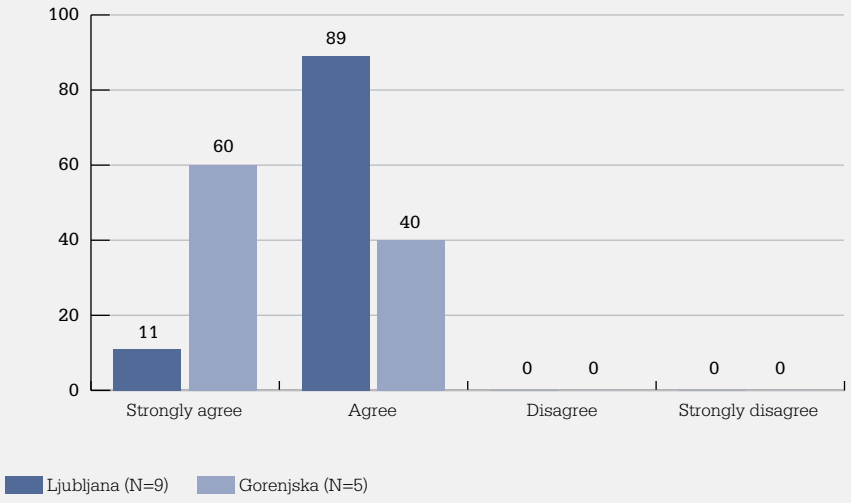


Most managers agreed that physicians in their region spent sufficient time improving their professional knowledge and skills but some reservation was evident, especially among those from Gorenjska (figure 9). Only one manager, from Ljubljana, strongly agreed with the statement. Two out of five managers in Gorenjska (40%) even thought that physicians should spend more time on keeping up-to-date.

Concerning the statement on nurses keeping up-to-date with professional skills, disagreement was stronger, especially among the managers from Ljubljana. Three quarters

of the managers from Ljubljana and 40% of those from Gorenjska (strongly) disagreed with the statement; in other words, they felt that nurses should spend more time improving their professional development. Managers from Gorenjska, however, seemed to be more satisfied. Three out of five (60%) agreed with the statement.

Figure 11: Managers' reflections: "In my medical organization, patients are treated according to the latest professional evidence"



All managers felt that patients in their area were treated according to latest professional evidence. This conviction, however, was stronger among the managers from Gorenjska than in those from Ljubljana.

The outcome on the fifth statement was equally homogenous: All managers, except one working in Ljubljana, agreed that "more decentralized decision-making would make my centre more flexible and open to change".

All managers, except two working in Gorenjska, agreed to the next statement: "My medical organization needs a more positive attitude to innovation on the part of staff". And finally, concerning their own role, managers were equally critical. With only one exception (and another who did not answer), they all agreed that they would need more information about modern approaches to improve their organization. The seventh and last statement was as follows: "As a manager, I need more information about modern approaches to improve my medical organization"

In sum, the following can be concluded:

- managers were satisfied with the functioning of CME;
- managers felt that physicians spent sufficient time on keeping up-to-date with their professional skills;
- managers, especially in Ljubljana, thought that nurses did not spend sufficient time on keeping up-to-date;

- managers were convinced that patients were treated according to the latest evidence;
- managers felt that centralized decision-making was an obstacle to more flexible primary care;
- managers perceived the attitude of staff towards innovation as an obstacle;
- managers felt that they needed more information on modern management to perform better.

2.4 Slovene GPs and quality management: results of the survey

Background information on the survey and details about the selection of pilot areas and GPs are described in chapter 2.1.2 of this report. Overall, the response rate among GPs in the two pilot regions was low. Only half (63) of the GPs sampled in Ljubljana and a quarter (18) of those sampled in Gorenjska completed the questionnaire. The results will be presented by pilot region. Despite the low response rate, percentages will be displayed in the tables and figures in addition to the absolute numbers to allow easy comparison of the results in the two regions.

2.4.1 Respondents' characteristics

The two pilot regions showed similar respondent characteristics. Three quarters of the GPs were female. The age of GPs ranged from 32 to 62 years, with an average of 48 years in Ljubljana and 47 years in Gorenjska.

With regard to their education, about three quarters of the GPs - 79% in Ljubljana and 72% in Gorenjska - had completed, in addition to their first speciality as general practitioner, a postgraduate training in general practice and family medicine. Of the remainder, 13 physicians in Ljubljana and 4 in Gorenjska had not yet completed this training.

In line with their advanced average age, respondents had substantial experience as GPs. On average, they had between 20 and 21 years of working experience, mostly at the same place as they were currently working.

Table 14: Staff mix

	Ljubljana (N=63)	Gorenjska (N=18)
Type of staff	Mean no. of staff	Mean no. of staff
• GPs	14,2	29,7
• Nurses	21,2	47,6
• Other (para)medical staff	14,7	18,3
• Other staff	6,4	26,1

In terms of total staff reported, the primary care units were very large organizations, varying from an average of 56 in Ljubljana to 122 in Gorenjska (Gorenjska is less densely populated than the Ljubljana region). Given these large sizes and the large degree of variation reported within the regions, it is reasonable to assume that some GPs reported the total number of primary care staff working in the whole pilot area, while others reported the number of staff working in their own primary care unit - the way the question was intended.

In terms of other GPs working in the same facility, respondents indicated numbers between none and 50 for Ljubljana (with an average of 14 GPs) and for Gorenjska between 2 and 63 (with an average of 30 GPs). Nurses made up more than one third of the primary care staff, and paramedical staff represented 27% of primary care staff in Ljubljana and 15% in Gorenjska.

Table 15: Practice location

	Ljubljana (N=63)		Gorenjska (N=18)	
Type of location	N.	%	N.	%
• Inner city	47	75	12	67
• Suburban area	11	17	4	22
• Small town (< 50.000)	1	2	1	6
• Rural	1	2	1	6
• Not answered	3	5	0	0
Total	**63**	**100**	**18**	**100**

In the Ljubljana pilot region, three quarters of GPs were working in the inner part of the city, 17% were working in suburban areas and only 4% in surrounding smaller towns or rural areas. The allocation of GPs in Gorenjska was similar to that in the Ljubljana region. The majority of GPs work in the inner city, 22% in suburban areas, and only two in small towns or rural areas. It may be assumed, however, that 'inner city' and 'suburban' has been understood somewhat differently in Ljubljana and Gorenjska.

2.4.2 Involvement in quality improvement activities

From a list of activities contributing to the improvement of quality management in primary care, GPs were asked to indicate which they had been involved in over the past 12 months. Activities were grouped according to their nature as being more informal and non obligatory (table 16), or more formal or embedded in the organization of primary care (table 17).

Table 16: Involvement in *informal* quality improvement activities

	Ljubljana (N=63)		Gorenjska (N=18)	
Type of activity	Abs.	%*	Abs.	%*
• Incidental consultation of a colleague when in doubt about diagnosis or treatment	57	90	17	94
• Reading professional journals (at least 2x per month)	60	95	14	78
• Planning specific improvements in practice management	55	87	15	83
• Planning improvements in clinical work	48	76	10	56
• Reading professional information on the internet (at least 2x per month)	45	71	11	61
• Any clinical or epidemiological research	27	43	8	44

* Percentage of total number of respondents per region as indicated at top of table

Incidental consultations of colleagues, reading professional journals (at least twice a month) and planning improvements in practice management were reported as being part of the normal activities of all GPs. Planning improvements in clinical practice and reading professional information on the internet (at least twice a month) were mentioned by around three quarters of the GPs in Ljubljana and around 60% of the GPs in Gorenjska. About 44% of GPs in both regions had been involved in research over the previous 12 months.

Table 17: Involvement in *structured / formal* quality improvement activities

	Ljubljana (N=63)		Gorenjska (N=18)	
Type of activity	Abs.	%*	Abs.	%*
• Attending courses for continuing medical education (at least 2x per year)	57	90	17	94
• Regular use of a protocol for teamwork with a nurse	38	60	10	56
• Conducting a patient satisfaction survey	36	57	7	39
• Regular discussion with a small group of colleagues about clinical work	21	33	10	56
• External audit (assessment of clinical work by external assessors)	14	22	6	33
• Developing treatment protocol(s) with colleagues	12	19	3	17
• Developing a clinical guideline with a colleague	10	16	3	17
• Regular meetings for peer review	13	21	2	11
• Inspection of medical files by a chief or executive	5	8	4	22
• Internal audit (internal assessment of aspects of clinical work)	10	16	2	11

* Percentage of total number of respondents per region as indicated at top of table

In contrast to their involvement in informal activities, the participation of GPs in formal activities, as listed in table 17, was far from being part of routine activities. The only exception was attending CME courses, which was reported by almost all the GPs.

Only half of the GPs said that they used protocols for teamwork with nurses on a regular basis. Equally low involvement of GPs was reported in developing protocols and guidelines: this seems to be in line with the managers' plans to improve teamwork as well as the implementation and use of protocols.

In Ljubljana 57% and in Gorenjska 39% of the GPs were involved in patient satisfaction surveys: managers intended to improve the quality and the degree of implementation of the surveys.

Furthermore, the GPs' answers show their lack of involvement in audits. Only one fifth of the GPs in Ljubljana and one third of those in Gorenjska were involved in external audits. Involvement in internal audits was even lower: 16% in Ljubljana and 11% in Gorenjska. Where the managers reported the inspection of medical files as routine, it was notable that most GPs said they were not involved in such inspections. In Ljubljana, 8% reported that they were involved in the inspection of medical files; in Gorenjska, the figure was 22%.

Participation in regular small group discussions on clinical topics was mentioned by one third of the GPs from Ljubljana and well over half of those from Gorenjska. Involvement in more structured peer reviews, however, was lower and reported by only one fifth of the GPs from Ljubljana and 11% of those from Gorenjska.

Comparison of tables 16 and 17 suggests that GPs were much more involved in unofficial and ad hoc forms of quality improvement than in more structured and formalized procedures.

In sum, the results in table 17 showing the rather low level of involvement of GPs in formalized structures conform to the overall earlier findings among the managers that quality management mechanisms were poorly implemented, especially in Ljubljana (see figure 6). But even then, there are clear discrepancies between the answers of the managers and those of the GPs. Most managers (89% in Ljubljana and 60% in Gorenjska) reported using internal medical audits, while only 16% of the GPs in Ljubljana and 11% of those from Gorenjska said they were involved in such audits. This may raise questions about the effectiveness of those mechanisms as well as the ability of the management to enforce a quality management policy.

2.4.3 Use of clinical guidelines

The use of guidelines has the potential to reduce undesirable differences in clinical activities. GPs were asked whether they regularly used guidelines (defined as scientifically based statements to help to decide about providing good care). For the acceptance and effective use of guidelines among GPs, the way they are drafted and introduced is important. Guidelines developed with major (consensus) inputs from practicing GPs, and that are implemented in a user-friendly way (for instance, linked to CME, or electronically accessible), and made easily available to GPs appear to be more easily ad-

opted than guidelines developed by medical specialists only and distributed without follow-up. Results on the use and mode of production of clinical guidelines and the way they were introduced in Slovenia are reported in the tables 18 to 20.

Table 18: Use of clinical guidelines

	Ljubljana (N=63)		Gorenjska (N=18)	
	Abs.	%*	Abs.	%*
• Regular use of clinical guidelines	51	81	12	67
* Percentage of total number of respondents per region as indicated at top of table				

In both regions, but especially in Gorenjska, some improvement seemed to be possible with regard to the use of clinical guidelines. In Ljubljana 81% and in Gorenjska 67% of the GPs answered that they used clinical guidelines regularly.

Overall, clinical guidelines were not drafted in a uniform way, but rather using a mix of approaches (see table 19). The most frequently mentioned modes were guidelines imported from abroad and guidelines drafted using a scientific procedure. Half of the GPs mentioned that guidelines were also drafted using a consensus procedure outside their centre. In Gorenjska, 58% also mentioned that the Ministry of Health drafted clinical guidelines. In Ljubljana, this was rarely mentioned by the GPs.

The results shown in table 20 suggest that the distribution of clinical guidelines could be improved. Only half of the GPs answered that background information was provided with the guidelines distributed. Two thirds of the GPs mentioned that guidelines were presented as part of a course. However, in Gorenjska only 17%, and in Ljubljana 49% of the GPs stated that they were trained to work with the guidelines. Less than 10% mentioned that feedback on performance on the guidelines was provided by a supervising physician.

Table 19: Mode of drafting of clinical guidelines

	Ljubljana (N=51)		Gorenjska (N=12)	
Mode of production	Abs.	%*	Abs.	%*
• Issued by the Ministry of Health	14	27	7	58
• By a consensus procedure in your centre	10	20	2	17
• By a consensus procedure outside your centre	29	57	6	50
• By a scientific procedure in your country	31	61	9	75
• Imported from abroad	34	67	9	75
* Percentage of total number of respondents per region who regularly use clinical guidelines. These totals are indicated at top of table				

Table 20: Mode of introduction of clinical guidelines

	Ljubljana (N=51)		Gorenjska (N=12)	
Mode of introduction	Abs.	%*	Abs.	%*
• Provided on paper	40	78	10	83
• Background information on the guidelines was provided	29	57	6	50
• Physicians were trained to work with the guidelines	25	49	2	17
• Guidelines were integrated in a course	32	63	8	67
• Supervisor provided feedback to GP on performance on the guideline	5	10	1	8
* Percentage of total number of respondents per region who regularly use clinical guidelines. These totals are indicated at top of table				

2.4.4 Perceived opportunities for improvement

GPs were asked about opportunities they see for improving their work on a large number of aspects, for example, related to the following areas:

- delivery of care
- information and communication
- cooperation and teamwork
- service aspects: opening hours and convenience
- general competence and motivation of staff in health care
- quality management structures and procedures in health care.

Tables 21 to 26 show the results. Answers have been put in order of (perceived) high opportunity to low opportunity for improvement.

Table 21: Opportunities to improve the GPs' way of working: *delivery of care*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of care	Abs.	%*	Abs.	%*
• Diagnostic process	51	81	15	83
• Prescribing medicines	39	62	15	83
• Clinical care for patients with depression	41	65	14	78
• Clinical care for patients with hypertension	39	62	14	78
• Clinical care for patients with asthma	39	62	12	67
• Minor surgical procedures	24	38	14	78
• Clinical care for elderly patients	23	37	9	50
• Maternity care	11	17	5	28
• Clinical care for children under 6	8	13	1	6

* Percentage of total number of respondents per region as indicated at top of table

Equal proportions (over 80%) of GPs in Ljubljana and Gorenjska answered that they would like to improve their diagnostic process. For the rest, however, GPs in Gorenjska more frequently answered they would like to improve aspects of care as listed in the table, compared to GPs from Ljubljana. In Gorenjska, about 80% of the GPs would like to improve prescription of medicines, care for patients with depression and hypertension and minor surgery. Two thirds would like to improve clinical care for patients with asthma and half the GPs mentioned care for the elderly. In Ljubljana, two thirds wanted to improve prescriptions and clinical care for specific patient groups. Just over one third would like to improve minor surgery and clinical care for the elderly. Both in Gorenjska and Ljubljana, maternity care and care for young children were least mentioned as aims for improvement.

Table 22: Opportunities to improve the GPs' way of working: *providing information and communication*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of information / communication	Abs.	%*	Abs.	%*
• Giving information to patients about disease and treatment	35	56	17	94
• Giving information to patients about self care or staying healthy	36	57	16	89
• Keeping medical records	39	62	11	61
• Communication with patients	37	59	13	72

* Percentage of total number of respondents per region as indicated at top of table

In respect of opportunities to improve information and communication (table 23), GPs in Ljubljana seemed to be more satisfied than those in Gorenjska. About 60% of the GPs in Ljubljana reported that they perceived improvement opportunities for all aspects mentioned in the table. In contrast to this, in Gorenjska, almost 100% of GPs wanted to improve the clinical information to patients and health education, and almost three quarters wanted to improve their communication with patients. Equal proportions of GPs (around 60%) in both regions answered that they would like to improve their medical record-keeping.

Table 23: Opportunities to improve the GP's way of working: *cooperation and teamwork*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of cooperation / teamwork	Abs.	%*	Abs.	%*
• Teamwork with nurses in primary care	48	76	14	78
• Cooperation with medical specialists	47	75	13	72
• Referrals to medical specialists	38	60	13	72
* Percentage of total number of respondents per region as indicated at top of table				

The improvement of teamwork and cooperation within primary care, with nurses, and between primary and secondary care with medical specialists seemed to be an important topic for GPs: all areas of cooperation were mentioned as points for improvement by three quarters of the GPs in Ljubljana as well as Gorenjska. A specific aspect of the cooperation with medical specialists, the referral process, was mentioned as an opportunity by three quarters of the GPs in Gorenjska and 60% of those in Ljubljana.

Table 24: Opportunities to improve the practice: *opening hours and convenience*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of patient access / service	Abs.	%*	Abs.	%*
• Opening hours of practice	30	48	10	56
• The convenience of the practice building for patients	9	14	5	28
* Percentage of total number of respondents per region as indicated at top of table				

About half of the GPs in both regions would like the practice opening hours to be more patient-friendly. Concerning the convenience of the practice building for patients, GPs seemed to be satisfied, since only few aimed to improve on that. Managers in Gorenjska thought differently about this; they wanted to improve the premises (see table 3).

Table 25: Opportunities to improve future patient care: *competence and motivation*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of staff competence / motivation	Abs.	%*	Abs.	%*
• Improving knowledge and skills	53	84	16	89
• Strengthen the motivation of professionals for improving care by improving incentives	53	84	16	89
• Allocate more resources for staff training	49	76	15	83
* Percentage of total number of respondents per region as indicated at top of table				

GPs were asked whether the changes listed in table 25 would improve their care for patients in the future. They believed that all three aspects of competence and motivation of health care workers would contribute to better care. Around 85% of the GPs answered that better knowledge and skills would have a positive effect and that, as a consequence, more resources should be allocated for training of staff. They also seemed to acknowledge widely that the motivation of health care workers to provide better care was not up to the desired level and that better incentives may help to change this situation.

Table 26: Opportunities to improve health care services: *quality management procedures and structures*

	Ljubljana (N=63)		Gorenjska (N=18)	
Aspects of QM projects and procedures	Abs.	%*	Abs.	%*
• Updating obsolete clinical guidelines or treatment protocols	49	78	16	89
• Introduction of clinical guidelines and protocols	51	81	15	83
• Starting small scale quality improvement projects	48	76	14	78
• Conducting peer review among colleagues	45	71	12	67
• Introduction of internal assessments or audits	38	60	11	61
• Introduction of protocols for teamwork	37	59	11	61
• Introduction of patient satisfaction research	31	49	9	50
• Introduction of a complaint procedure for patients	21	33	2	11
• Introduction of external assessments or examinations	16	25	3	17

Finally, GPs were asked whether their care for patients in the future would benefit from the implementation of procedures and mechanisms as listed in table 26. There were only small differences in the distribution of answers between the GPs in Ljubljana and Gorenjska. Overall, GPs seemed to prefer supporting mechanisms rather than mechanisms that include assessment or aim to identify poor performance. The highest priori-

ties were on guidelines, protocols and local projects. More than three quarters of the GPs answered that introducing guidelines and protocols, updating old ones and starting small-scale projects would help to improve their care for patients. Most GPs also expected positive effects from developing peer review with colleagues. Furthermore, between half and 60% of the GPs answered that internal audits, protocols for teamwork and surveys on patient satisfaction would help them to provide better care in the future. Relatively small proportions of GPs expected such benefits from the introduction of a patient complaint procedure or external assessment or examinations.

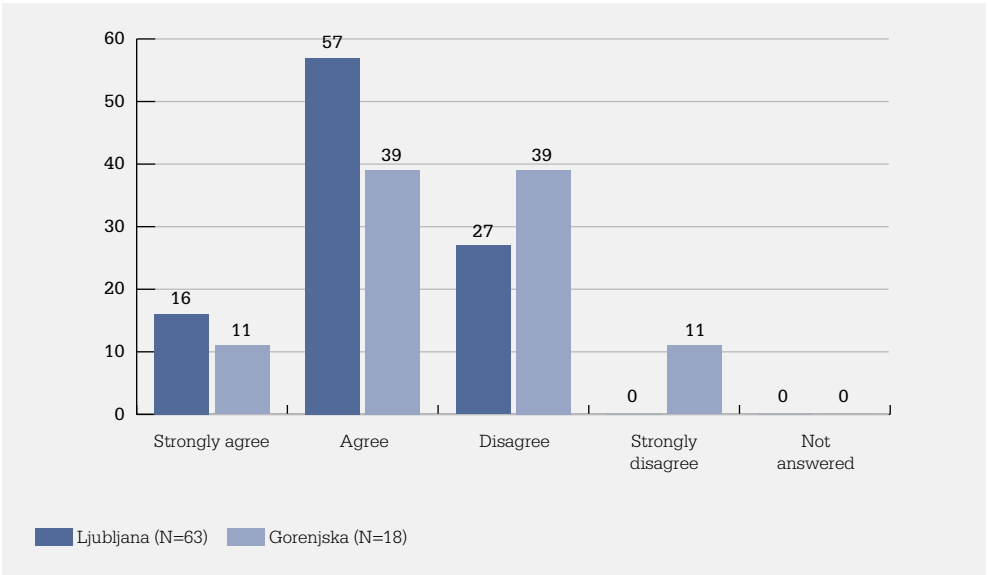
2.4.5 Reflections of GPs on conditions for quality improvement

A number of questions aimed to explore the current thinking among GPs about aspects of quality improvement and their own role, as well as the roles of patients and supervisors. GPs could express their agreement/disagreement with a given statement by ticking on a four-point scale, as outlined in the following figures.

The first statement was as follows and has also been asked to managers: "Current continuing medical education courses help me to provide better care for my patients". All GPs but one from each region agreed that continuing medical education courses help them to provide better care for their patients.

Figure 12 shows that 50% of the GPs from Gorenjska are spending (or have) insufficient time to improve their professional skills, whereas GPs from Ljubljana were more positive: three quarters agreed that they spend sufficient time on improving their skills. When comparing this with the results of the managers' survey, managers in Gorenjska were slightly more positive than their GPs. In Ljubljana, the answers of the managers and the GPs were similar.

Figure 12: GPs' reflections: "I spend sufficient time on various activities to improve my professional skills"

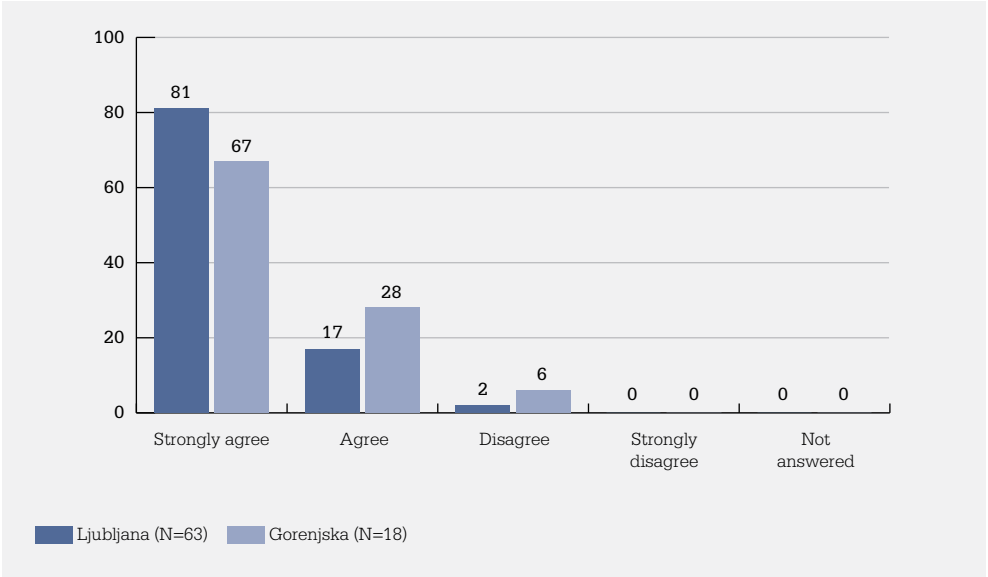


For the third statement: "I treat my patients according to the latest professional evidence", GPs had little doubt that this is the case and 91% of GPs answered accordingly. This confidence was however less strong among the GPs from Gorenjska, which is in line with the overall picture given in figure 12.

The forth statement was reading: "More decentralized decision-making would make primary care more flexible and open". Overall, the majority of GPs and managers in primary care seem indeed to see decentralization as a mean to enhance flexibility and openness. However, over 20% of the GPs from Ljubljana disagreed or preferred not to answer to this question.

Answers to the fifths statement "I am interested in changing my work according to new insights'" were generally positive. Only 14% of the GPs in Ljubljana and 11% of their Gorenjska colleagues disagreed and, thus, did not have a positive attitude to innovation. Overall, this picture seems to contradict the earlier results and opinions of managers that GPs were not motivated to improve quality of care (see chapter 2.3.10).

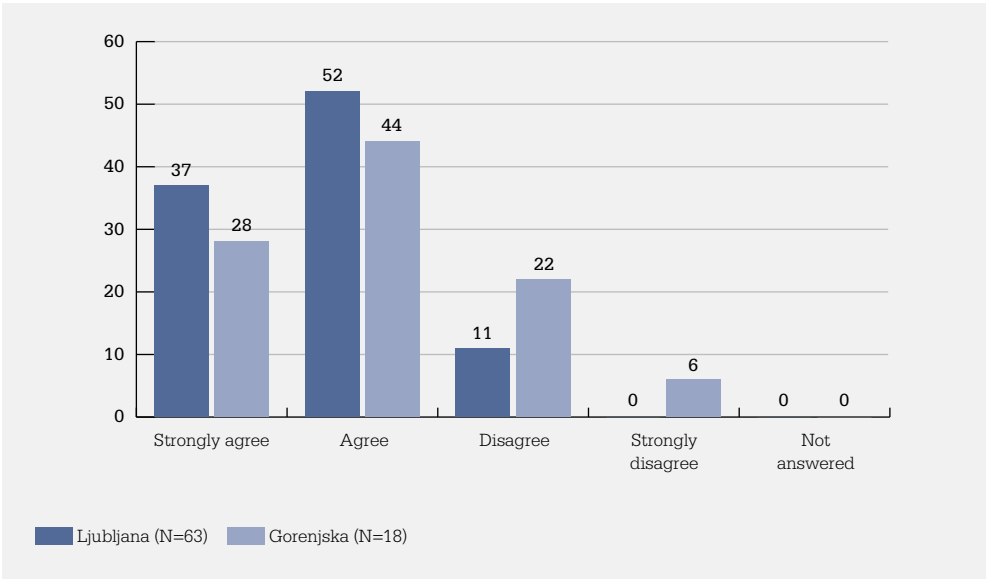
Figure 13: GPs' reflections: "Supervisors in health care should give encouragement rather than opposition or sanctions"



A majority of GPs agreed that supervisors in health care should have an encouraging and supporting approach (figure 13). Most GPs even strongly agreed with this statement, and this may point to the GPs' experiences that the management was not always motivating.

The final statement in this section reads: "more active involvement of patients will help improve primary care' (figure 14). Despite some reservation, especially among the GPs in Gorenjska, GPs generally agreed on the importance of actively involved patients in improving primary care.

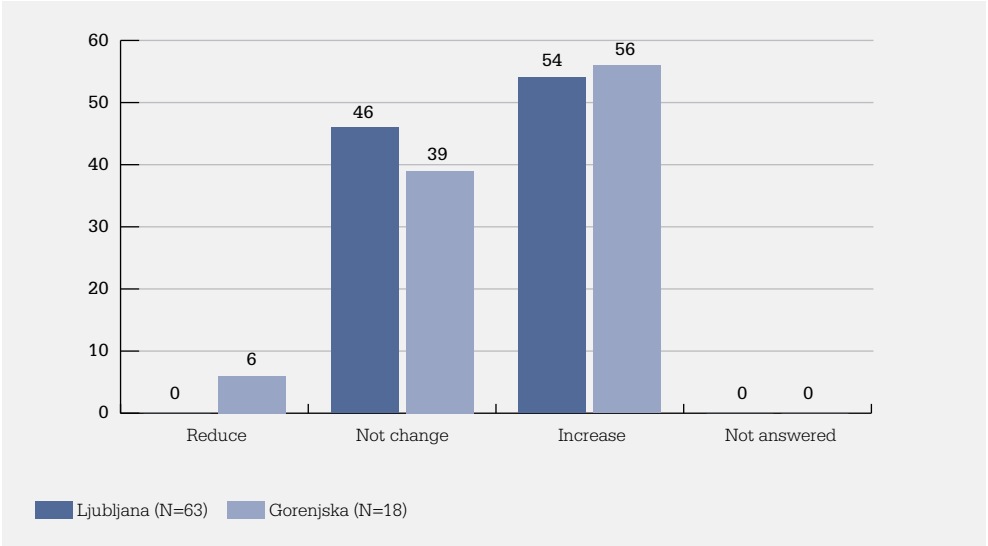
Figure 14: GPs reflections: "More active involvement of patients will help improve primary care"



2.4.6 Expected effects of quality improvement activities

This chapter gives a short overview on GPs expectations from potential quality improvement activities. GPs were asked about the impact they expect on several aspects of their work, based on given statements.

Figure 15: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, patient satisfaction will:"

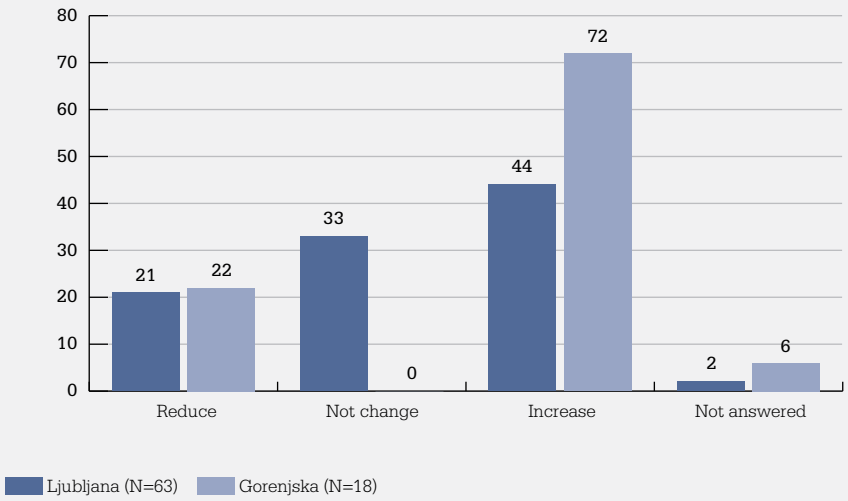


Overall, GPs had difficulties in determining the impact of quality improvement activities on the satisfaction of patients: about 55% expected that it would lead to more satis-

fied patients; however, almost half of the GPs in Ljubljana and 39% of those in Gorenjska expected it to have no effect on patient satisfaction.

In contrast to this, GPs were more confident about the positive impact of quality improvement on staff satisfaction and motivation. About three quarters of the GPs expected staff satisfaction and motivation to increase, while one quarter expected no change at all. A reduction in staff satisfaction was only expected by four GPs in Ljubljana.

Figure 16: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, the workload of staff will:"



GPs were divided about the expected impact of quality improvement activities on the staff workload but only few (about one fifth) expected a reduction (figure 16). In Gorenjska, three quarters of the GPs expected their workload to increase while, in Ljubljana, only 44% had this expectation and one third did not expect any change in workload.

However, quality improvement activities were expected to result in an increase in administrative work (figure 17). Almost two thirds of GPs in Gorenjska and 37% in Ljubljana believed that it would rise. Around 30% of GPs from both regions however expected that quality management activities would result in less administrative work.

Figure 17: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, time spent on administrative work will:"

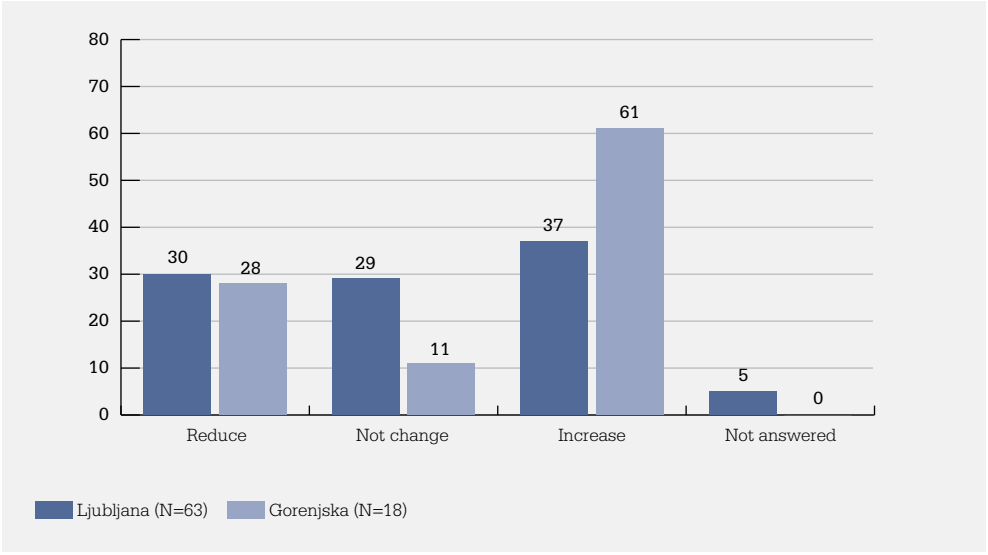
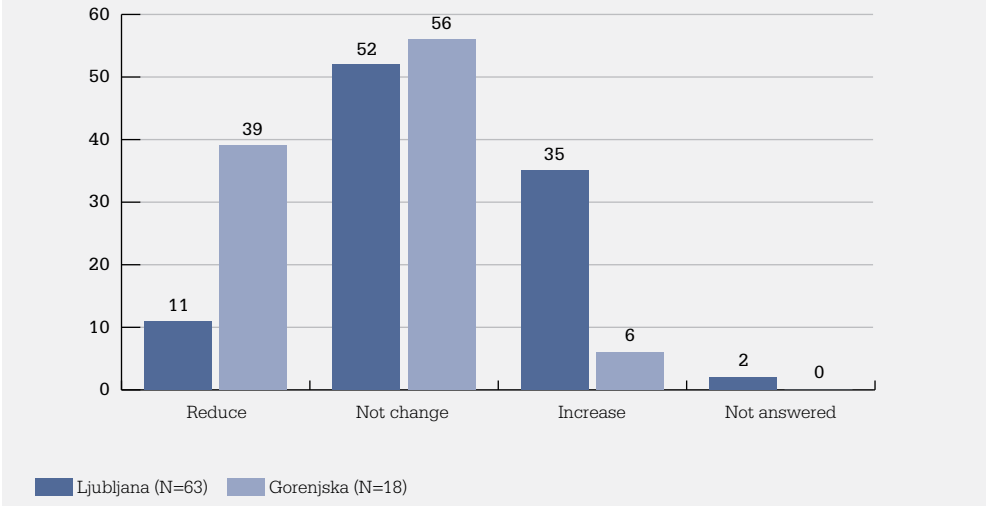


Figure 18: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, professional freedom of staff will:"



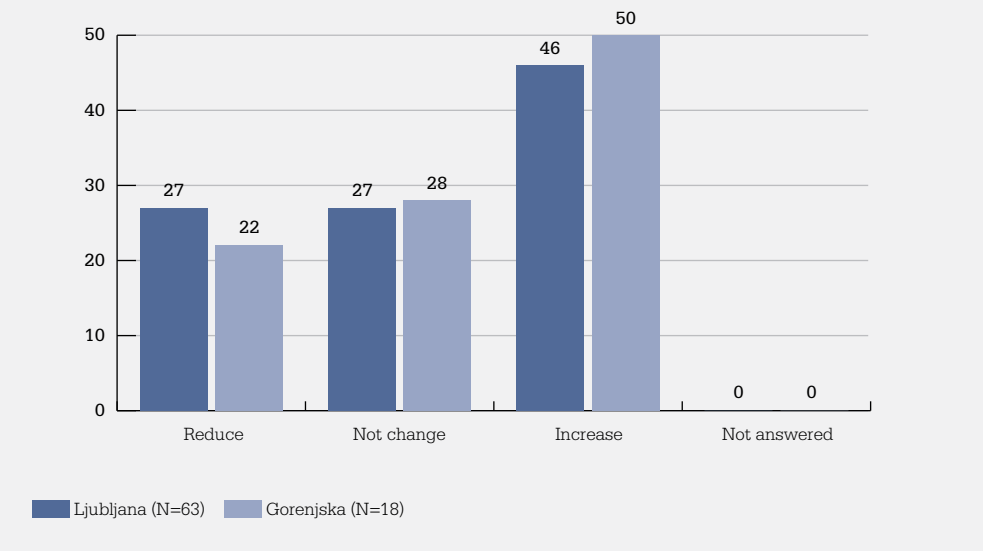
In both regions, a small majority of GPs thought that quality improvement activities would not alter the professional freedom of staff (figure 18). The remaining GPs had contrasting opinions: in Gorenjska 39% expected a reduction in professional freedom as a result of quality management activities, while in Ljubljana 35% expected freedom of staff to increase.

More unanimous were answers received for the following statement: "As a consequence of quality improvement activities in my practice, the image or reputation of my organization will either a) reduce; b) not change; c) increase; d) not answered". A small

majority (around 60%) of the GPs in both regions expected that the reputation of their organization would improve as a result of quality improvement activities, while around one third expected no change in their reputation.
Likewise, GPs were fairly convinced that quality improvement activities would result in better health outcomes. Three quarters of the GPs in Ljubljana and two thirds of those in Gorenjska had that expectation. Practically all the remaining GPs expected no effect of improved quality management on the health outcomes of their patients.

The final statement presented to the GPs looked at the relationship between quality management and costs: overall, GPs were not sure what the impact of quality improvement activities would be on the practice costs, but about half of the GPs expected an increase in costs (figure 19). About one quarter expected no effect on costs, while another quarter expected a cost reduction.

Figure 19: GPs' quality management expectations: "As a consequence of quality improvement activities in my practice, costs will:"



2.5. Lessons learned from the pilot project

The following observations and lessons learned are based on the experiences of the team members involved in the pilot implementation in Slovenia and Uzbekistan - as well as of the international experts who reflected on the Tool and the draft report during the review meeting in April 2008 in Copenhagen.

Lessons learned

- Three questionnaires (national level, managers level, GPs level) – together forming the draft Primary Care Quality Management Tool – have been discussed among national experts in Slovenia and Uzbekistan, and subsequently successfully been tested in surveys in these countries.

- Based on the experiences from the pilot implementation and the extensive feedback given during the international review meeting in Copenhagen, the following major changes were made to the Tool for its future use:

  » in general, questions have been made more factual; questions asking for opinions have been removed or rephrased;
  » the sequence of topics and questions has been reordered;
  » the character of the national level questionnaire has been changed from a questionnaire for stakeholders to a questionnaire/template for a background document to be prepared by a small team of experts;
  » the questionnaires for managers and GPs have been reduced in size, for instance, by removing questions considered to be outside the scope of GPs or managers;
  » the consistency of terminology and wording throughout the questionnaires has been improved.

- The sensitivity of the instrument could be improved if the quantitative elements (questionnaires) were supplemented with qualitative methods. New sources of information might include group interviews with managers and primary care workers, additional inspection of documents, direct observations and site visits. These additional approaches would help to clarify questions remaining after the quantitative analyses, compensate for possible low rates of response and thus improve the validity of the Tool.

- If the population (and therefore the response) of primary care managers is small in the selected regions, the sample should preferably be extended by including managers from other regions. If, nevertheless, a small number of respondents is expected, it may be preferable not to conduct a survey but, rather, to collect data in another way (for instance, by means of group interviews).

- In an early stage of the Tool's application in a Member State, a check is needed to determine whether terms and answer categories in the questionnaires are adequate. Possible adaptations need to be made before the translation.

- The applicability of the Tool could be further improved by extending the generic core with a variable section that would take the local primary care policy priorities in Member States into account.

- Correct translation of the Tool, using to a check and double-check procedure, is essential. Both linguistic and health care expertise are required.

- In general, the following data collection methods can be identified for the surveys:

  » postal survey (with or without postal or telephone follow up);
  » survey via the internet;
  » distribution and collection of questionnaires via instructed local health care officials (for instance, chief physicians in districts);
  » transfer and collection of questionnaires via the appropriate organization in the health administration;
  » distribution and collection of questionnaires via trained fieldworkers;

» distribution and collection of questionnaires via the network of professional associations;
» involvement of nongovernmental organizations.

- The choice of data collection method is related to available resources and local circumstances. In Uzbekistan, where health care is hierarchically structured and lines of communication are clear, it was obvious that these health administration structures should be used to implement the surveys (particularly since postal surveys were very unusual there). The Slovene health care system is more loosely structured. Furthermore, postal surveys are not unusual.

- It has an added value if, within a country, the Tool is implemented in contrasting regions or areas. These regions may differ, for instance, in terms of the stage of primary care reform or the model of provision. The choice of regions or areas should be explicitly discussed. The selection of regions for comparison should be driven by relevant questions related to health policy, reform processes, different modes of provision, etc. The formulation (at the beginning of the project) of expected differences between regions may serve as a reference for the interpretation of results and offer a starting point for follow-up activities.

- Successful implementation of the Tool, including the dissemination of results and follow-up activities, depends on the involvement and commitment of stakeholders. Although the ministry of health will usually have a leading role, organizations representing health care professionals, health insurers, patient organizations, donors and others should be involved. The more stakeholders are able to contribute, the richer and more useful the information generated by the Tool will be.

- The pilot studies in Slovenia and Uzbekistan showed clearly that the surveys had a wider impact than simply in terms of data collection. Introduction of the activities at central, regional and local levels involved information transfer and awareness-raising on issues of quality in primary care. The more intensive the approach and the more personal the way in which the surveys were introduced, the stronger the action effect achieved.

Limitations of the Tool

- The Tool relies strongly on self-reported behaviour, rather than on direct observations or registrations. The resulting information may be biased and may not correctly reflect the real situation. Attempts have been made to reduce this bias. Revisions of the Tool have been made with the explicit aim of reducing a positive answering tendency. However, this still cannot be excluded. As a counterbalance, additional observations, checks and interviews have been included in the revised Tool. Quantitative results from the surveys can be validated by these additional measures.

- The focus of the Tool is on structures and mechanisms meant to control or manage the quality of staff and services in primary care. The Tool is not about quality of care itself, and therefore quality indicators have no prominent role in the Tool. Structures examined by the Tool are usually not visible to patients, and for that reason a patient survey is not part of the Tool.

- Since health reforms are much more comprehensive than the topics covered by the PCQM Tool, the results produced should not be considered as a way of monitoring those reforms. Such monitoring would require the collection of much more varied data.

The fundamental revision of the Tool and the many suggestions and lessons for future application are valuable outcomes of the project.

3 MAIN POINTS AND RECOMMENDED ACTIONS

SLOVENIA: main points and conclusions	
National level / expert group	
• General context on quality management improvement	• There was agreement that quality management was not a burning issue in primary care in Slovenia. At all levels, leadership in quality improvement was said to be fairly developed. • National guidelines on quality management have been adopted but they are abstract and not ready for implementation. • The national institute for quality improvement was planned for 2006 but has not been established yet. • Probably as a result of new relationships in health care, there is a lack of trust between the Ministry of Health, the National Health Insurance Institute and the professions. This is perceived as a major obstacle to (shared) leadership in quality of care. • Health care managers, usually with a medical background, need to adapt to a situation in which accountability, competence, incentives and evidence have become key words. • Only few GPs see quality management assessment and improvement as a core task. They feel that their time is fully taken by patient care, so that no time is left for those tasks; moreover, they lack awareness of ways of systematically improving their services and support in doing so.
• Legislation and regulation	• The current infrastructure for quality is not sufficient. Legislation is proceeding slowly (for example in 2007 there were three laws with relevance to quality of health care waiting to be adopted). • Coordination and support for quality programmes is weak, and performance information for feedback to clinicians and managers is missing. • The Law on Health Care and the Law on Medical Services deal with quality systems in institutions, licensing, working conditions in health institutions, medical auditing and medical education. • Patients' rights have been generally addressed in the Law on Health Care, and aspects of them are also addressed in the Law on Health Institutions and the Law on Personal Data Keeping. • A new comprehensive Law on Patients' Rights has been submitted to the Parliament and was accepted in 2008 after the project was concluded.
• Formal structures	• The Ministry of Health has instruments to commission external quality assessments but these are not well used. • Data collected by the public health institutes are not used by the Ministry for quality purposes. • The implementation of licensing (including supervision of CME) has been delegated to the Medical Chamber. • A complaint procedure for patients does formally exist but is not supervised nationwide.
• Coordination and voluntary mechanisms	• Beyond formal inspection and supervision in health care, the situation is fragmented, and coordination between stakeholders in assuming different responsibilities could be improved. The Quality Department in the Ministry of Health is very small and cannot yet play this role. • Different groups undertake activities only to a limited extent. Voluntary local initiatives, such as community surveys, voluntary accreditation or benchmarking, are rare.

SLOVENIA: main points and conclusions	
• Education and access to information	• Quality assurance is given little attention in the undergraduate medical curriculum. However, in the postgraduate programme for family medicine, communication skills, quality and research are major subjects. • CME focuses mainly on clinical subjects. The management of quality of care and methods for improving performance are hardly addressed. • The current CME system (based on "credit points") is insufficiently driven by educational needs. Physicians are free to choose topics. No regular (self-)assessments take place. • Most GPs use computers but usually not for medical documentation or for professional expert systems. • Access to guidelines and protocols could be improved. Independently produced guidelines are only available for purchase. Those provided by the pharmaceutical industry are free but are less suitable for use in primary care. • Concerning modern management information, availability may be less of a problem than proper use. Managers often lack a managerial background. Moreover, quality management is still a low priority and an aspect on which managers are not yet evaluated.
• Way forward and obstacles	• Slovene policy-making experts mentioned as priorities: shaping leadership by formulating basic legal statements on goals and values of quality of care; setting priorities and drafting a strategic plan; and allocating resources in line with the plan. • Areas of poor quality management need to be identified on a routine basis; causes of poor quality should be analysed and serve as the basis for a strategic plan. • Specific incentives should be introduced to promote quality management of care (for both providers and managers). • Electronic medical record-keeping should be promoted. • The CME system should be based on established individual training needs of primary care professionals. • Planning and coordination at national level should be promoted by a steering group or platform, consisting of representatives from the professions, patients and the Government. • Experts mentioned the continued development of a coordinated set of clinical pathways and guidelines as a priority. • International expertise on quality management in healthcare should be better used.
Primary care managers	
• Availability of managerial documents relevant for maintaining quality of care	• Annual quality improvement reports are rarely available. • The level of managerial documentation on maintaining quality of care was somewhat better in Gorenjska than in Ljubljana. The majority of managers in Gorenjska mentioned availability of five out of the six listed documents, while a small majority of managers in Ljubljana responded negatively on the availability of four out of the six listed managerial documents. • Among the priorities for improvement over the next two years, the following were mentioned: introduction of a quality certificate; performing practice audits; establishing registration and control; applying quality indicators; and introducing annual reporting on quality assessment; prevention of hospital infections; and renovation of practice premises and laboratories.
• Conditions and means for quality management	• In Ljubljana, the conditions and means for quality management were perceived as only fair: managers had insufficient effective incentives for realizing changes, little access to external sources of information, insufficient external support, and little executive power to implement change. • In Gorenjska, the means and conditions were rated more positively. Points for improvement were: effective incentives and an increase in executive power.
• Support for improvement actions	• Support for quality management activities is perceived as suboptimal. The most critical point for improvement was the amount of external support that managers received for realizing quality improvements. In addition, it was felt that internal financial resources and the effectiveness of internal cooperation for the promotion and coordination of quality management should be increased. • No clear coordination function has been established. Quality management is mostly the responsibility of the director or chief manager of a primary care facility.
• External assessment instruments	• Managers apply few external assessment instruments for quality appraisal. The following instruments were almost completely absent: voluntary accreditation; voluntary certification, attestation of physicians; and benchmarking performance against different organizations.

SLOVENIA: main points and conclusions	
• Internal assessment instruments	• In both Gorenjska and Ljubljana, efforts have been made to implement internal assessment mechanisms. However, the uptake and scope of instruments is still very limited, particularly in Gorenjska. • Improvements can be made with regard to monitoring opinions of secondary care workers; the introduction of a quality management committee; the monitoring of patients' needs; inspection of medical files; GP peer review; setting up quality management activities and producing routine evaluation reports.
• Human resources management	• Both regions put little effort into human resources management. Little staff training in quality management is provided; personal development plans are rarely made; job satisfaction is only occasionally monitored; and job evaluation interviews are held infrequently.
• Use of protocols and guidelines	• Protocols and guidelines on various topics had been implemented in about half of the centres. Nevertheless, managers expressed their intention to invest in further implementation, and to update obsolete elements. • About half of the managers reported that protocols were not yet in use on the following subjects: specific clinical topics; use of medical equipment; and referrals to specialists. In Gorenjska, there were no protocols on referrals to hospitals or on patient information. • There was high reported use of norms and standards guiding the care process for patients.
• Future plans for improving quality management	• The managers had many plans for improving the care process over the coming years. These included: addressing the competence of their staff; improving clinical practice by means of guidelines and protocols; participating in accreditation or external review; improving the quality of clinical information; starting improvement projects; and updating obsolete guidelines or protocols. • Furthermore, managers seemed to be dissatisfied with the quality of medical record-keeping. • Managers had several plans related to the role of patients in improving the quality of care. These included the introduction of patient surveys, improved health education, and increased involvement of the population in quality improvement activities. Managers were also planning to improve complaint procedures for patients. • Managers felt that certain aspects of human resources management such as teamwork and staff motivation could be improved. However, these were not a high priority for managers.
• Reflections and expectations concerning quality management	• Managers were satisfied with the current medical education and the competence of physicians. • Managers, especially in Ljubljana, thought that nurses did not spend sufficient time on keeping up-to-date. • Patients were treated according to latest professional evidence. • Managers felt restricted by the strongly centralized decision-making. • Managers in Ljubljana felt that a more positive attitude on the part of staff towards innovation was needed. • Managers felt they needed more information on modern management in order to perform better. • Managers had high expectations for the impact of quality management activities on improved primary care.
General practitioners (GPs)	
• Involvement in quality management activities	• GPs were more heavily involved in unofficial and ad hoc forms of quality improvement than in structured and formalized procedures. • Results showing poor involvement in structured/formal quality management activities agreed with findings among managers that quality mechanisms were not well implemented, especially in Ljubljana. But even then, there were clear discrepancies between the answers of the managers and those of the GPs: most managers reported using internal medical audits, while only 16% of the GPs in Ljubljana and 11% of those from Gorenjska said they were involved in them.
• Use of clinical guidelines	• In Ljubljana, 81% of the GPs and 67% of those in Gorenjska said that they used clinical guidelines regularly. • Only half of the GPs answered that background information was provided with distributed guidelines. Two thirds of the GPs mentioned that guidelines were integrated in a course. However, only 17% of the GPs in Gorenjska and 49% in Ljubljana stated that they were trained to work with the guidelines. Fewer than 10% mentioned that feedback on performance on the guidelines was provided by a supervising physician.

SLOVENIA: main points and conclusions	
• Perceived opportunities for improvement	• GPs in both areas saw opportunities to improve their functioning related to the delivery of care, specifically with regard to: diagnostics; prescribing medicines; and clinical care for patients with depression, hypertension and asthma. GPs in Gorenjska also wanted to improve minor surgical procedures and clinical care for elderly patients. • GPs in Ljubljana were reasonably satisfied with their communication skills and provision of information to patients. In Gorenjska, GPs saw more opportunities for improvement. They were not satisfied with their information provision about disease and treatment, about selfcare and staying healthy, and with their communication with patients. • Many GPs wanted to improve the teamwork and cooperation within primary care, with nurses, and between primary and secondary care with medical specialists. • About half of the GPs in both regions would like the practice opening hours to be more patient-friendly. Concerning the convenience of the practice building for the patients, GPs seemed to be satisfied, since few aimed to improve on that. Managers in Gorenjska thought differently about this; they wanted to improve their premises. • GPs acknowledged that the motivation of health care workers to provide better care was not adequate and that better incentives could help to change this situation. • Introducing guidelines and protocols, updating old ones and starting small-scale projects would help to make patient care better. Most GPs also expected positive effects from developing peer review with colleagues. Furthermore, between half and 60% of the GPs answered that internal audits, protocols for teamwork and surveys of patient satisfaction would help them to provide better care in the future.
• Reflections on conditions for quality management	• Managers in Gorenjska were slightly more positive than their GPs on whether GPs spend sufficient time on improving their professional skills. In Ljubljana, the answers of the managers and those of the GPs coincided and showed satisfaction. • Like the managers, a large majority of the GPs were confident that their treatment was in conformity with the latest clinical evidence. • Most GPs agreed that more decentralized decision-making would make primary care more flexible and open. • In general, GPs seemed to have a positive attitude to innovation. This result seems to be in conflict with the opinion of managers that GPs were not very motivated to improve quality of care. • GPs seemed to have experience that the management was not always encouraging. • Despite some reservation, especially among the GPs in Gorenjska, GPs agree on the importance of the role that active patients can play in improving primary care.
• Expected effects of quality management activities	• GPs were not sure about the possible impact of quality improvement activities on the satisfaction of patients. They were more confident about the positive effect of quality improvement on staff satisfaction and motivation. • GPs were divided about the expected effect of quality improvement activities on staff workload but only a few expected a reduction. • Quality management activities were expected to result in an increase in administrative work, in particular by the GPs from Gorenjska. • In both regions, the majority of GPs thought quality improvement activities would not alter the professional freedom of staff. The opinions of the remaining GPs differed between the two regions • A small majority of the GPs in both regions expect the reputation of their organization to improve as a result of quality improvement activities. • GPs were fairly convinced that quality improvement activities would result in better health outcomes. • GPs were not sure what the impact of quality improvement activities would be on the practice costs, but about half of the GPs expected an increase in costs.

Slovenia: recommended policy actions
• Develop leadership and clinical governance at national level by effectively establishing the planned National Institute for Quality Improvement and empowering the Quality Department in the Ministry of Health.
• Improve the legislative basis for quality improvement by speeding up pending laws.
• Develop an effective national platform consisting of the Ministry of Health and stakeholders in health care to draw up and implement joint plans for quality management at primary level.
• Develop an integrated plan to modernize the management of primary care facilities, including education of managers, improved management information and the introduction of quality procedures and routines to improve accountability.
• Coordinate nationwide implementation of measures to strengthen the position of patients, including uniform complaint procedures, a patient charter, etc.
• Revitalize the system of continuing medical education by making it needs-driven; creating incentives for (voluntary) periodical assessments; and reducing the current dominant role of the pharmaceutical industry.
• Promote the use of computers for medical information and expertise, clinical record-keeping and practice-based research.
• Coordinate the updating and expansion of the use of clinical guidelines by GPs.
• Develop human resources management in primary care, including through regular job evaluation interviews, personal development plans and increased efforts in the area of staff training.

ANNEX 1 GLOSSARY OF TERMS FOR QUALITY MANAGEMENT[1]

Accreditation: A formal process by which a recognized body, usually a non-governmental institution, assesses and recognizes that a healthcare organization meets applicable, pre-determined standards.

Attestation: Periodic test of knowledge or competence of health professionals (for instance: four- to five-yearly obligatory examinations of physicians in countries of former Soviet Union). Also used in relation to workplaces (with a focus on risk management) *(11)*.

Benchmarking: A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).

Certification: A process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria.

Clinical governance: Framework through which National Health System organizations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish *(12)*.

Clinical practice guidelines: A set of systematically developed statements, usually based on scientific evidence, to assist practitioners and patient decision-making about appropriate healthcare for specific clinical circumstances.

Confidentiality: the right to determine who has access to one's personal health information *(13)*.

Continuity of care: the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional continuity), or are an uninterrupted series of contacts over the long term (longitudinal continuity) *(14)*.

Coordination of care: The mechanisms ensuring that the patient and clinicians have access to, and take into consideration, all required information on the patient's conditions and treatments to ensure that the patient receives appropriate health care services.

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1 Sources unless otherwise indicated: *(18)*

Coordination: a service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and necessary and effective interventions, no more and no less. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination means the inter-linkages among staff members and agencies over a longer period of treatment *(14)*.

Effectiveness: The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the patient.

Evidence-based medicine: The wise and careful use of the best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence-based medicine that is best-practice integrates best research evidence with clinical expertise and patient values.

Guideline: Systematically developed statements to help practitioners and patients make decisions in specific clinical circumstances. They essentially define best practice (15); in essence the "right thing to do" *(16)*.

Health outcomes: The effect on health status from performance (or non-performance) of one or more processes or activities carried out by health care providers. Health outcomes include morbidity and mortality; physical, social and mental functioning; nutritional status; etc.

Indicator: A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or the level of quality achieved.

A measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care provided and hence change it *(15)*. Quality indicators infer a judgement about the quality of care being provided. The term 'performance' indicator is sometimes used synonymously with quality indicator but it is possible to make inferences about performance without making inferences about quality *(16)*.

Licensing: A process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession.

Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function or process.

Patient safety: Freedom from accidental or preventable injuries produced by medical care.

Performance measure: Provides an indication (e.g., rate, ratio, index, percentage) of an organization's or provider's ability to provide care most likely to ensure a good patient outcome.

Process of care: A health care service provided to, on behalf of, or by a patient appropriately based on scientific evidence of efficacy or effectiveness.

Protocol: A detailed plan, or set of steps, to be followed in a study, an investigation, or an intervention, as in the management of a specific clinical condition.

Protocols describe the case-management of a patient with a very specific condition, in a short document *(9)*.

Quality: Quality health care is how well a doctor, hospital, health plan, or other provider of health care keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.

Quality assessment: Determination of how processes and services correspond to current standards, as well as a patient's satisfaction with the care received.

Quality assurance: That set of activities that are carried out to set standards and to monitor and improve performance so the care provided will satisfy stated or implied needs.

Quality improvement: An approach to the study and improvement of the processes of providing health care services to meet needs of clients.

Quality indicator: An agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Quality management: An ongoing effort to provide services that meet or exceed customer expectations through a structured, systematic process for creating organizational participation in planning and implementing quality improvements.

Quality measure: A mechanism to assign a quantity to quality of care by comparison to a criterion. The definition of a quality measure relies on the definition of "Clinical performance," "Clinical performance measure," "Measure," and "Quality of care."

Quality monitoring: The collection and analysis of data for selected indicators that enable managers to determine whether key standards are being achieved as planned and are having the expected effect on the target population.

Quality of care: The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Responsiveness is a measure of how the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or non-personal services (not a measure of how the system responds to health needs, which shows up in health outcomes) *(13)*.

Enhancing responsiveness to the expectations of the population, includes: (a) respect for persons (including dignity, confidentiality [of information] and autonomy of individuals and families to decide about their own health); and (b) client orientation (including prompt attention, access to social support networks during care, providing quality of basic amenities and choice of provider) *(4)*.

Revalidation: A periodic evaluation of performance aiming at renewing a qualification or certificate *(17)*.

Standard: The level of compliance with a criterion or indicator (15). A target standard is set prospectively and stipulates a level of care that providers must strive to meet. An achieved standard is measured retrospectively and details whether a care provider met a pre-determined standard *(16)*.

Standard of care: A generally accepted, objective standard of measurement such as a performance standard supported through findings from expert consensus, based on specific research and/or documentation in scientific literature, against which an individual's or organization's level of performance may be compared.

Stewardship: a function of a government responsible for the welfare of the population, and concerned with the trust and legitimacy with which its activities are viewed by the citizenry. It includes the overseeing and guiding of the working and the development of the nation's health actions on the government's behalf. The components of stewardship are: health policy formulation (defining the vision and direction for the health system); regulation (setting fair rules of the game with a level playing field); and intelligence (assessing performance and sharing information) *(13)*.

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SUMMARY

This report on primary care quality management describes the Slovenian governments' and health system stakeholders' efforts to improve service delivery at the first level of care, supplemented with evidence compiled through the development and application of tools tailored to primary care.

What does quality care mean at this level and what are the strategies, mechanisms and tools to ensure that it can be maintained, assessed and improved? The report shows that the involvement not only of national policy-makers but also, and first and foremost, of the stakeholders on the ground who actually provide and organize primary care can result in improvements in quality by an incremental process of creating and adopting a culture of quality control and assurance. This process goes beyond having guidelines, regulations and strategies in place; it entails adopting a transparent approach which acknowledges that only empowered and motivated health care staff working in teams can bring about real improvements, and that all health care workers (family doctors, nurses, midwives and others) are equally important in the drive to attain better health for the population.

The centrality of the patient, and of his or her needs and inputs into this process of improving the quality of primary care, should also be emphasized.

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