FIFTH MEETING OF THE EXPERT NETWORK ON FAMILY MEDICINE DEVELOPMENT STRATEGIES

Report on a WHO Meeting

Tartu, Estonia
14–16 October 1999
EUROPEAN HEALTH21 TARGET 15
AN INTEGRATED HEALTH SECTOR

By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The Expert Network on Family Practice Development Strategies was established to give its participants, who are drawn from countries that are reorganizing their primary health care services, the opportunity to share their experience and learn from each other. The Fifth Meeting of the Expert Network considered collaboration between primary and secondary health care professionals in the light of target 15 of the HEALTH21 strategy and recent strategy development both internationally and nationally. Other issues were the remuneration of general practitioners/family medicine (GP/FM) teams according to different types of contract and the benefits and disadvantages of GP/FM status either as an employee, self-employed person or employer. The Meeting adopted 10 recommendations based on the discussions. Participants received in-depth knowledge about the education of general practitioners/family doctors and the primary health care system in Estonia through presentations and site visits.

Keywords

PRIMARY HEALTH CARE – trends
PHYSICIANS, FAMILY
STRATEGIC PLANNING
SALARIES AND FRINGE BENEFITS
INTERPROFESSIONAL RELATIONS
EUROPE, EASTERN
EUROPE
ESTONIA

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Introduction

The Fifth Meeting of the Expert Network on Family Medicine Development Strategies was held in Tartu, Estonia, from 14 to 16 October 1999. The host was the University of Tartu, Department of Polyclinic and Family Medicine. Dr Mårten Kvist, Technical Adviser, Primary Health Care Unit, opened the meeting on behalf of Dr J.E. Asvall, WHO Regional Director for Europe. Dr Üllar Kaljumäe, Vice-Chancellor, made an opening speech on behalf of the Ministry of Social Affairs, Estonia. Professor Teet Seene, Vice-Rector, University of Tartu, welcomed the participants.

The Meeting was attended by 14 participants from 11 countries, a representative of the European Society of General Practice/Family Medicine (ESGP/FM) and two staff members from the WHO Regional Office for Europe. The majority of the participants, appointed by the ministries of health in the Network countries in central and eastern Europe, were new to each other, but a few had attended previous meetings of the Network in Ljubljana (1995), Warsaw (1995), Istanbul (1997) and Zagreb (1998). Reports from previous meetings can be requested from the Primary Health Care Unit, WHO Regional office for Europe, Copenhagen, Denmark.

Professor Heidi-Ingrid Maaros, Estonia, was elected Chairperson and Dr Margus Lember, Estonia, Rapporteur for the Meeting.

Scope and purpose

Dr Mårten Kvist gave a short review of the past meetings and the topics previously dealt with. The participants at the last meeting had proposed a number of topics for discussion at this Meeting. The following had been chosen from among them:

- collaboration between primary and secondary health care professionals in the light of target 15 of the HEALTH21 policy document;¹
- remuneration systems for general practitioners/family doctors; and
- the employment status of the general practitioner/family doctor.

An important part of Network meetings has always been to learn about recent developments in general practice education in participants’ countries and to get acquainted with the general practice in the host country through site visits.

The objectives of the fifth Meeting of the Network were thus to:

- discuss collaboration between primary and secondary health care professionals, in the light of target 15 of the HEALTH21 strategy;
- discuss the principles of remuneration of general practitioners/family medicine (GP/FM) teams according to different types of contracts;
- discuss the benefits and disadvantages of the GP/FM status either as an employee, self-employed or employer, and
- get acquainted, through site visits, with developments in family practice in the host country.

¹ WHO. HEALTH21: the health for all policy framework for the WHO European Region. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).
Country reports

Albania

Dr Llukan Rrumbullaku described recent developments in Albania: the establishment of the Health Insurance Institute, capitation payment for family doctors and opening of a Family Medicine Department at the Medical Faculty in Tirana.

Bosnia and Herzegovina

Participants from Bosnia and Herzegovina described health care development and different training programmes in primary health care. As there is a lot of international help for the country, coordination of the projects is especially important.

Croatia

Dr Mladenka Vrcic-Keglevic gave an overview of changes in Croatia. Although general practice is not a new specialty in Croatia, only 40% of GPs are vocationally trained. Nowadays 60% of GPs are independent contractors in the Health Insurance Scheme. The payment is based on capitation, with double payment for pre-school children and people over 65 years of age. About 30% of GPs provide comprehensive care for all age and gender groups; the rest limit themselves to either adults or children, or do not take care of gynaecological problems.

Czech Republic

Dr Libuse Valkova outlined the current situation in general practice. The concept of different GPs for adults and for children is still followed in the Czech Republic. About 97% of GPs are independent contractors. Their payment system changed in 1997: instead of fee-for-service it is now capitation, but GPs have no gatekeeper function. The change in the payment system resulted in a 20% fall in the number of visits. General practice is considered as a separate specialty requiring its own postgraduate education and exam.

Estonia

Dr Margus Lember described changes since 1998 in the organization of general practice in Estonia: the introduction of a list system with a combined payment system (mainly from capitation, with the addition of a basic practice payment, fees for service and extra payments), the introduction of a partial gatekeeping system, and independent contractor status for GPs. The first research results have confirmed the positive effects of the changes. Academic family medicine, a strong professional society of GPs, and close cooperation with secondary care, the Sickness Fund and the Ministry of Social Affairs, have all been important factors in successful reforms.

Hungary

Dr Gabor Selmeczi described the primary care reforms in Hungary, which was one of the first countries in the WHO European Region to introduce a list system and capitation payment for GPs and to privatize practices.
Latvia

Mr Ainar Civics described the steps taken in primary health care: implementing compulsory health insurance, centralization of financial resources and, at the same time, decentralization of health care services. Now Latvia is attempting to change the payment model for GPs (from fee-for-service to capitation), introduce a gatekeeping function of GPs and develop academic professional training and retraining for GPs.

Lithuania

Professor Julius Kalibatas described the educational system for GPs in Lithuania, which is leading to a new kind of relationship with secondary care. A new quality assurance system is based on a new committee of state audit, revision of the job description of GPs and development of new guidelines. A new PHARE project is to support the retraining of former district doctors for adults and district paediatricians as GPs.

Slovakia

Dr Zuzanna Cervenakova gave an overview of the current situation in general practice: there are still separate GPs for adults and for children – the concept is supported by the educational system and by legislation. About 95% of GPs are self-employed and paid a capitation fee. The main tasks for the future are to establish a College of General Practice and develop a new educational system for general practice both at pre- and postgraduate level.

Slovenia

Dr Josip Car described developments in his country. General practice with a special training system has existed since the 1960s. The health care reform in 1992 introduced a health insurance system for payment and private practice. Although the vast majority of GPs still work in health centres, there is a trend towards independent contracting.

The former Yugoslav Republic of Macedonia

Dr Pance Arsov and Dr Svetlana Grlickova described the situation in their country. The biggest changes have occurred in the introduction of private practice. This is putting new demands on GPs, especially the demand for managerial skills. Big hopes are laid for the future on GPs, especially to guarantee the cost-effectiveness of care.

Discussion

In the ensuing discussion, participants paid most attention to organizational changes, types of remuneration, employment status and education in general practice. There seems to be a common trend towards insurance-based funding, independent contracting of GPs, list systems with mainly capitation payment, and development of academic departments of general practice/family medicine at medical schools.

Collaboration between primary and secondary care

Professor Heidi-Ingrid Maaroos introduced the topic “Collaboration between primary and secondary health care professionals in the light of target 15 of the HEALTH21 strategy”. This was
followed by a discussion of the similarities and differences in rural/urban conditions, emergency care and home visits, referrals to specialists in different European countries, the influence of job description and the influence of funding organizations on tasks of GPs and on the interface between primary and secondary care. The different communication methods used by family doctors for cooperation with specialists were illustrated by Table 1.

Table 1. Different communication methods between GPs and secondary health care specialists

<table>
<thead>
<tr>
<th>Method</th>
<th>Clinical value</th>
<th>Educational value</th>
<th>Feedback</th>
<th>Preferred by FD/GP</th>
<th>Preferred by secondary health care doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation by patient: FD/GP together with secondary health care specialists</td>
<td>++++</td>
<td>++++</td>
<td>++++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Regular visits of secondary health care specialist to FD/GP facilities</td>
<td>++++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Referral with referral letter</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>++++</td>
<td>++++</td>
</tr>
<tr>
<td>Telephone consultations</td>
<td>+++</td>
<td>++++</td>
<td>++++</td>
<td>+</td>
<td>?</td>
</tr>
</tbody>
</table>

The Working group on collaboration between primary and secondary health care professionals discussed the problems in, and possible solutions for, improving collaboration. The group made nine proposals. It is important to:

1. invite secondary care professionals into the practices of primary care;
2. define clearly the responsibilities of primary health care;
3. improve equipment in primary care doctors’ offices;
4. take more account of people’s health care needs in planning primary and secondary health care;
5. improve quality of primary health care; possible areas of activities are, for example, continuing medical education (CME), practice guidelines and access to hospitals for primary care doctors;
6. develop personal contacts between providers of primary and secondary health care services;
7. plan human resources more carefully: the numbers of medical students and of primary and secondary health care doctors;
8. plan a network for public health;
9. develop multiprofessional teams (doctors, nurses, social workers, psychologists, teachers, the media, etc.).

Remuneration of general practitioners

Professor Pertti Kekki introduced the second main topic, the remuneration of GPs, by giving an overview of different options for contracting and financing health care. Based on the literature, he presented Table 2 which shows the effect of different remuneration systems on cost-containment, quality and administration.
Table 2. Comparisons of different remuneration systems

<table>
<thead>
<tr>
<th>Payment system</th>
<th>Cost containment</th>
<th>Quality</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Very poor</td>
<td>Very good</td>
<td>Very difficult</td>
</tr>
<tr>
<td>Case payment</td>
<td>Good</td>
<td>Fair</td>
<td>Difficult</td>
</tr>
<tr>
<td>Bonus payment</td>
<td>Good</td>
<td>Good</td>
<td>Easy</td>
</tr>
<tr>
<td>Flat rate</td>
<td>Good</td>
<td>Good</td>
<td>Easy</td>
</tr>
<tr>
<td>Capitation fee</td>
<td>Very good</td>
<td>Fair</td>
<td>Very easy</td>
</tr>
<tr>
<td>Salary</td>
<td>Fair</td>
<td>Poor</td>
<td>Easy</td>
</tr>
<tr>
<td>Budget</td>
<td>Very good</td>
<td>Fair</td>
<td>Easy</td>
</tr>
</tbody>
</table>


In the following discussion, Dr Mårten Kvist also provided data from recent research projects conducted by the Ministry of Health and Social Affairs, Finland, with the Social Insurance Institution.

The Working group on remuneration of GPs/GP teams according to different types of contract emphasized three main points in their discussion:

- fee-for-service payments generally guarantee GPs higher incomes but do not support continuity in care (no list) or prevention (if the preventive services are not listed and priced);
- a capitation-based system guarantees cost-control, offers more freedom in work organization and guarantees more continuity through the patient lists; the disadvantages are possibly too long lists, higher referral rates and a lesser effect on quality of services;
- doctors’ organizations can influence the payment level with arguments from the studies they have carried out.

The status of the general practitioner/family doctor

Dr Nick Freemantle presented the benefits and disadvantages of the GP/FD either as an employee, self-employed or an employer, basing his lecture on examples from the United Kingdom NHS. In the United Kingdom, health policy changes have regularly made an impact on the organization of family medicine, which is currently once again in the midst of a major reorganization. He considered and contrasted the manner in which the NHS developed with evidence from other health systems in which other solutions have been found, and particularly mentioned the RAND Health Insurance Experiment in the United States. This complex social experiment randomized 2000 families to different insurance plan models. Differences were found among doctors depending on their employment status. The results suggested that changes in employment status and management structures towards a salaried position may reduce the overall volume of services provided but not the mix of services. Finally, Dr Freemantle considered the factors that health policy-makers might wish to consider when planning the organization of a service.

The presentation was followed by an interesting general discussion, mainly focusing on the status of self-employed GPs in public systems, the recent development of primary care groups, quality assurance (clinical governance) and cost–benefit analysis.

The *Working groups on the status of the GP, either as an employee, self-employed or an employer* emphasized a number of aspects in their discussions.

The groups drew up a list of possible **elements for a contract**: length of list (with and without defining minimum and maximum sizes), age structure, structure of services, volume of services, financial procedures and working time. Social security for self-employed GPs was important, requiring regulations on health insurance and pensions, occupational diseases and injuries, and malpractice insurance.

When GPs are self-employed, the following aspects should be covered: patients’ needs and rights, public funding, needs of the practice/organizational or functional units, employees’ needs and the doctor’s own needs. When the doctor is an employee, the important aspects for consideration included the labour market situation, contracting with insurance, professional organization/union and personal characteristics.

**Site visits**

One afternoon was devoted to visiting three different practices. The first was located in an area of blocks of flats, separate from a bigger polyclinic. This was a group practice with three GPs and one trainee, and was the first new family practice in Tartu (opened in 1993) with the doctors working as independent contractors. The practice provides a full range of GP/FP services and the lists includes patients of all ages. The health records are fully computerized and the practice equipment is good.

Two other practices were located at the Maarjamõisa Polyclinic, which is a new polyclinic belonging to the University Clinic of Tartu. The doctors work as independent contractors in office space rented from the Polyclinic. They use many of the services provided by the Polyclinic but run their practices completely by themselves. The records are computerized and connected to a common polyclinic network and full lists were shown of FD services for all age groups on the lists. They employ one family nurse to assist them who also takes care of their autonomous tasks.

The participants in the Meeting also visited the Department of Polyclinic and Family Medicine at the University of Tartu, which was established in 1992. The development of the Department was one activity in the World Bank Health project for Estonia since 1995. The Department takes care of undergraduate teaching (2nd year and 6th year medical students), specific training in family medicine (3-year programme coordination), retraining of primary health care physicians and continuing medical education. The Department also has responsibilities in research and development of primary health care in Estonia. In spring 1999, an international peer review was carried out and the Department was recognized as a centre of excellence for family medicine, with all necessary modern facilities.
Final session

Participants decided to draw up 10 recommendations, covering job description, education, management training, manpower planning, associations of GPs, payment systems, financing systems and contracts.

The evaluation of the Meeting was high and most participants reflected on the usefulness of the network meeting. They had received up-to-date information, and appreciated the high level of the presentations by the invited speakers. Some problem areas were also identified, such as lack of continuity of the membership of the group and the non-availability of reports from previous meetings of the network. The next meeting would probably take place in September 2000 in Budapest, Hungary, and the suggested topic was continuing medical education.

Conclusions

1. Training in collaboration between primary and secondary health care professionals is important and should be encouraged at all levels of medical education. Through training it is possible to enhance smooth cooperation between the sectors and thus increase the quality of care and improve its cost-effectiveness. Fruitful collaboration needs a continuous dialogue between the partners and their associations.

2. Payment and funding systems in primary health care need to be carefully considered, as they influence the types of service delivered and the quality of care. The changing status of a general practitioner/family doctor, whether employee, self-employed or an employer, also requires new skills in management and leadership, which should be reflected in training programmes.

On the basis of these conclusions, the Meeting decided to make ten recommendations.

Recommendations

1. In all countries a job description (synthesizing terms of reference) should be developed for GPs. Job descriptions should reflect the interface between GPs and specialists. Their content should be relevant to their purpose (whether an educational guide, professional recommendation or part of the contract with payers of health care) and the country’s needs.

2. Curricula for medical students should cover topics of cooperation between primary and secondary health care. Problem-based learning would provide opportunities for this kind of education.

3. Training in management and leadership, adjusted for the appropriate level, should be part of GPs’ education, with the main focus on those who have management responsibilities.

4. Human resources should be planned with regard to the needs of primary and secondary health care. This would permit medical schools to plan their educational activities better.

5. Encouragement should be given to the development of personal networks between GPs and specialists, to enable better communication and thus higher quality of care for patients.
6. GPs’ associations should have an active role in discussions with associations of specialists on the division of tasks in different health care systems. Governments should encourage self-regulation in the profession.

7. Mixed systems of payment, mainly based on capitation, are most appropriate for primary health care. Several incentives should be built into reimbursement schemes to direct providers’ behaviour in the desired directions.

8. Limiting the number of funding sources in primary health care would support the development of higher quality services, cost-containment and equity in health care.

9. The following items should be included when contracts for GPs are being planned with funding bodies: elements for promoting quality, the requirements of the process, and protected time and guaranteed funding for continuing medical education which would improve quality of care.

10. Flexible systems should be encouraged in the devising of emergency care. GPs should have the possibility of separate contracts to participate in emergency care, if this is found to be useful.
Annex 1

WORKING PAPERS AND BACKGROUND MATERIAL

| EUR/ICP/DLVR040302/1 | List of working papers and background documents |
| EUR/ICP/DLVR040302/2 | Scope and purpose |
| EUR/ICP/DLVR040302/3 | Agenda |
| EUR/ICP/DLVR040302/4 | Provisional programme |
| EUR/ICP/DLVR040302/5 | Provisional list of participants |
| EUR/ICP/DLVR040302/6 | Collaboration between primary and secondary health care professionals, in the light of target 15 of the HEALTH21 strategy. *Heidi-Ingrid Maaroos, University of Tartu, Estonia* |
| EUR/ICP/DLVR040302/7 | Principles of remuneration of general practitioners/family medicine teams according to different types of contracts. *Pertti Kekki, WHO collaborating centre for primary health care, University of Helsinki, Finland* |
| EUR/ICP/DLVR040302/8 | Benefits and disadvantages of the GP/FM either as an employee, self-employed or an employer. *Nick Freemantle, University of York, United Kingdom* |

Background material

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Target 15 – an integrated health sector (related to PHC). Extract from *HEALTH21: the health for all policy framework for the WHO European Region.*
Annex 2

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