Health service production: primary care

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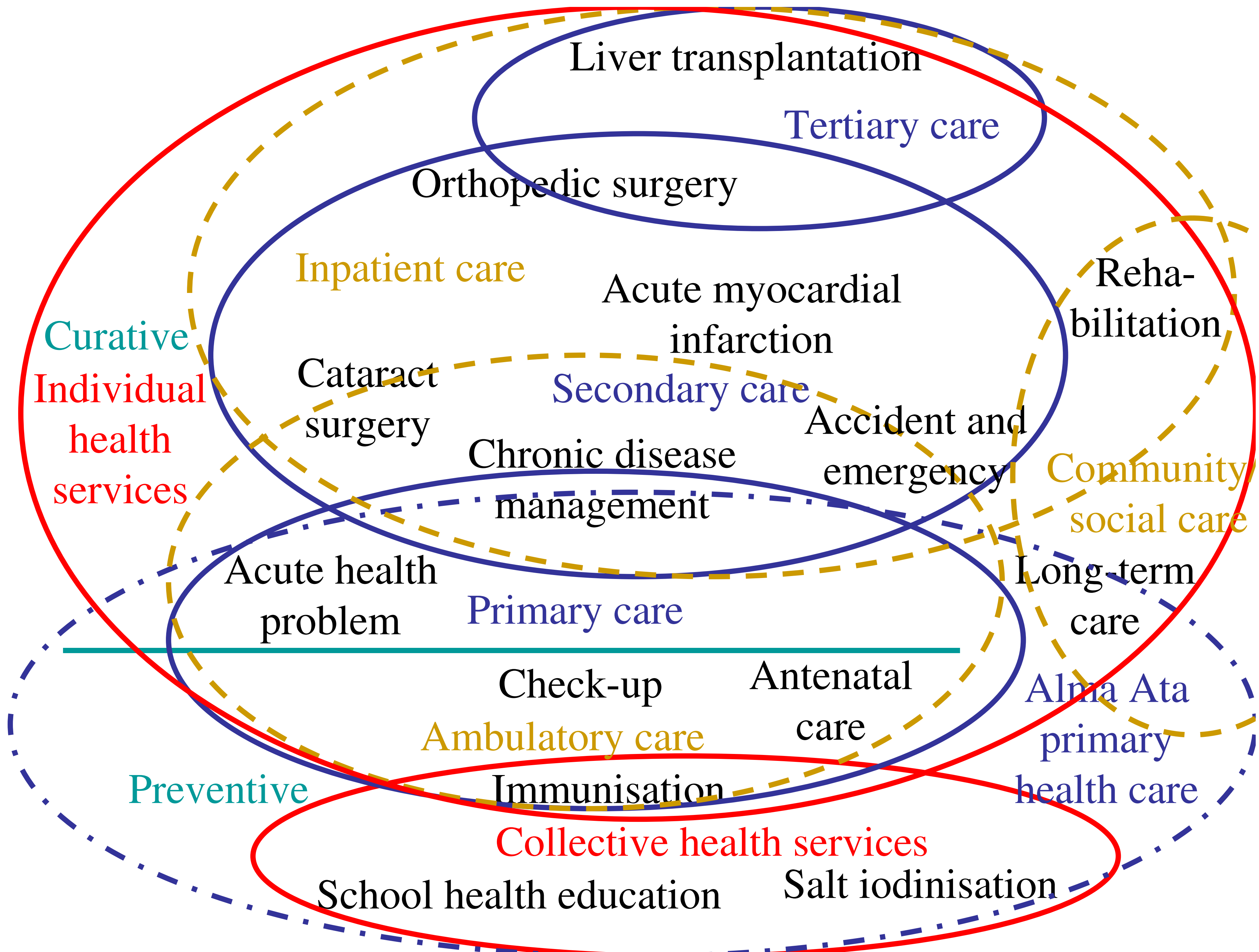


Liver transplantation
Tertiary care
Orthopedic surgery
Inpatient care
Acute myocardial infarction
Reha-bilitation
Curative
Individual health services
Cataract surgery
Secondary care
Accident and emergency
Chronic disease management
Community social care
Acute health problem
Primary care
Long-term care
Check-up
Antenatal care
Alma Ata primary health care
Ambulatory care
Preventive
Immunisation
Collective health services
School health education
Salt iodinisation

4.2 Primary/ ambulatory care

Here primary health care refers to the first point of contact of the health system with the individual consumer and includes general medical care for common conditions and injuries. Health promotion and disease prevention activities, also part of primary health care, are described under public health services.

Note: If secondary care specialists are mainly organized around a private practice model (rather than in hospital), they may be included here under “ambulatory care”.

Position of GPs in system

- Number of GPs per population
  high: B (1/600), I , F (<1/950)
  low: S (1/2900), NL (1/2300), D (1/2100)
- Percentage of female GPs
  high: EST (94%), LIT (89%), RO (74%)
  low: CH (7%), A, ICE (12%)

Table 10.1 Characteristics reflecting regulation of the market for GPs' services (employment status, payment system, personal list system and gatekeeping) by type of health care system

Country	*Percentage of GPs self-employed*[a]	*Payment system*[b]	*Personal list*	*Gatekeeping*
National health service				
Denmark	100	capitation + fee-for-service	yes	yes
Finland	2	salary	no	no
Greece	30	salary (if self-employed, fee-for-service)	no	no
Iceland	25	salary + fee-for-service (if self-employed, capitation + fee-for-service)	no	yes
Italy	98	capitation	yes	yes
Norway	58	fee-for-service (if employed, salary)	no	yes
Portugal	1	salary	yes	yes
Spain	4	salary	yes	yes
Sweden	1	salary	no	no
United Kingdom	99	capitation + fee-for-service	yes	yes

Social insurance				
Austria	99	fee-for-service	no	no
Belgium	97	fee-for-service	no	no
France	97	fee-for-service	no	no
Germany	100	fee-for-service	no	no
Ireland	91	capitation	yes (lower incomes)	yes
Luxembourg	98	fee-for-service	no	no
Netherlands	93	capitation + fee-for-service	yes	yes
Switzerland	99	fee-for-service	no	no

Transitional countries[c]				
Belarus	0	salary	no	no
Bulgaria	1	salary	no	no
Croatia	0	salary	no	yes
Czech Republic	33	salary (if self-employed, fee-for-service)	no	no
Estonia	1	salary	no	no
Hungary	12	salary (if self-employed, capitation or fee-for-service)	no	no
Latvia	3	salary	no	no
Lithuania	0	salary	no	no
Poland	0	salary	no	no
Romania	6	salary	no	no
Slovenia	1	salary	yes	yes
Ukraine	0	salary	no	no

[a] The percentage of GPs who are self-employed was established in a European survey in 1993 and 1994 (Boerma and Fleming 1998).
[b] Predominant payment system; if more than 25 per cent but less than 50 per cent has a different payment system, this is noted in brackets.
[c] Since the collection of these data, there have been considerable changes in the transitional countries, particularly the Czech Republic, Estonia, Hungary and Poland.

Sources: Boerma *et al*. (1993, 1997), Boerma and Fleming (1998)

GP + actual first point of contact (for acute problems, children, women, psychosocial problems)

- high: NL, UK, DK, IRL (= gatekeeping)
  medium high: N, CRO, ICE, E, P, I (g), F, A, B (no g)
  low: BG, LIT, LV

Table 10.2 Characteristics indicating the chances of professional social control (percentage of GPs with postgraduate training and partnership size or group size) by type of health care system

Country	*Postgraduate training (%)*[a]	*Single-handed practice*	*2–5 in practice*	*6–10 in practice*	*More than 10 in practice*
National health service					
Denmark	99[b]	30	56	14	0
Finland	34	8	38	28	27
Greece	67	45	24	15	17
Iceland	82[b]	15	39	37	10
Italy	11	86	12	1	1
Norway	45	25	64	7	4
Portugal	65	12	28	25	35
Spain	27	24	28	21	28
Sweden	96[b]	2	63	28	7
United Kingdom	71[b]	16	55	27	2

Social insurance					
Austria	54[b]	93	7	0	0
Belgium	71	69	28	2	1
France	16	59	40	0	1
Germany	75	67	33	0	0
Ireland	45	54	43	3	0
Luxembourg	35	61	39	0	0
Netherlands	66[b]	46	51	3	0
Switzerland	86	73	27	0	0

Transitional countries					
Belarus			No data available		
Bulgaria	15	10	8	15	67
Croatia	57	37	37	9	17
Czech Republic	90[b]	43	30	9	18
Estonia	12	25	21	9	45
Hungary	33	56	33	8	3
Latvia	49	17	51	6	26
Lithuania	16	33	51	2	14
Poland	19	78	21	1	0
Romania	26	32	55	6	8
Slovenia	45	21	27	23	30
Ukraine	unknown	22	20	23	35

[a] Percentages are based on answers to a survey questionnaire; they do not necessarily refer to a regular postgraduate training programme for general practice.
[b] Postgraduate training for general practice is obligatory.

Sources: Boerma *et al.* (1993), Boerma and Fleming (1998)

Workload and practice facilities

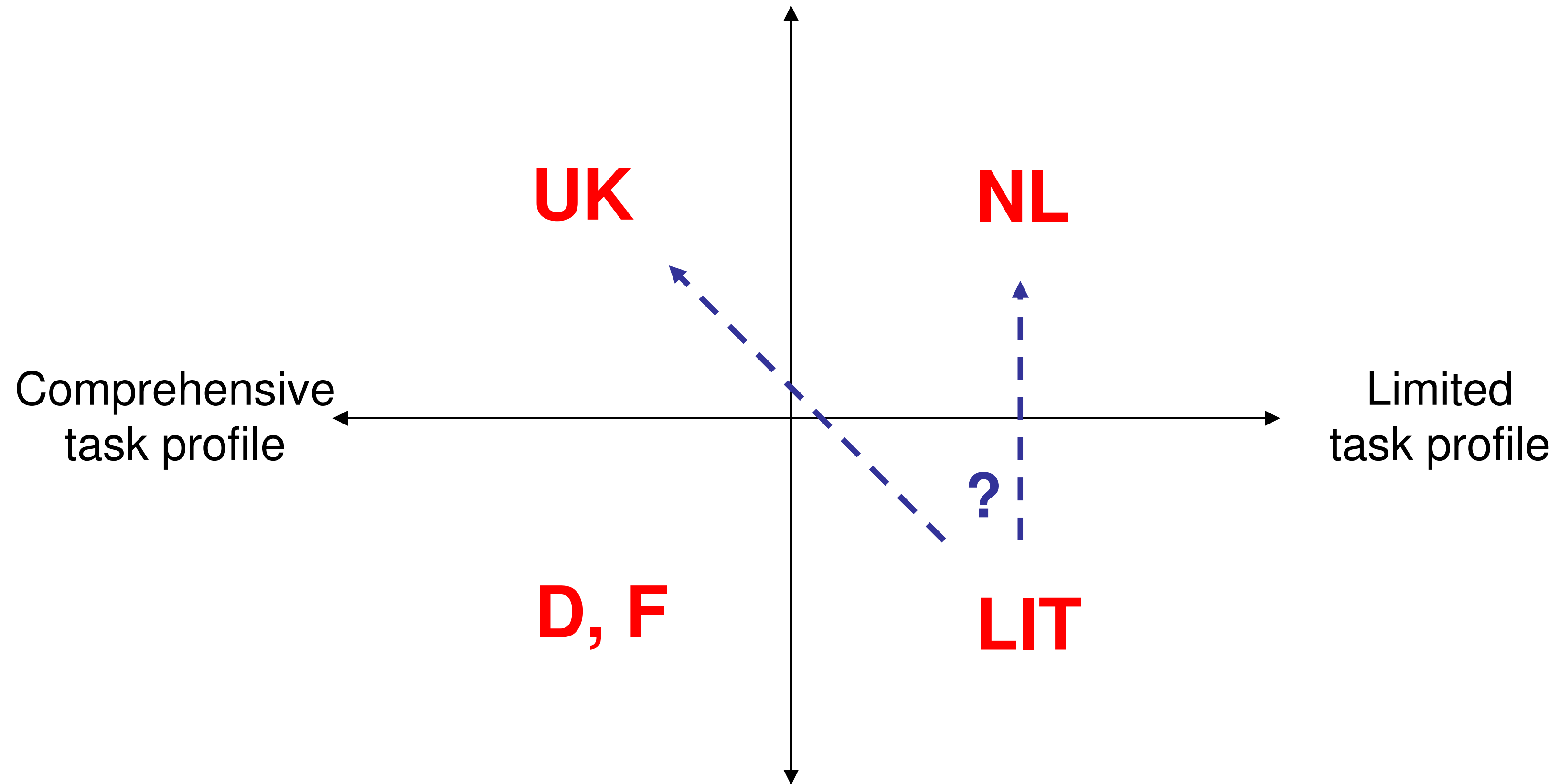
- Working hours/ week
  high: D, F (54), L, B, CH
  low: RO (29), H, LV
- Patient contacts/ day
  high: D (50), A, H, CZ, CRO, E (>40)
  low: LV (13), S, EST, F, LIT, ICE, B
- Home visits/ week
  high: B (46), D (34), A, F, H
  low: P, S (2), FIN, DK, CRO
- Practice equipment
  high: FIN, ICE, N, S
  low: CZ, PL, RO, I

GP task profile - preventive

- Group health education
  comparatively high: P, SLO, UK, D
  low: NL, CZ, LV, L
- Family planning
  high: DK, IRL, UK (99%)
  low: LIT (14%), CZ (19%)
- Antenatal care
  high: DK, IRL, UK (90-99%)
  low: D, SLO, L (ca. 40%)
- Child surveillance/ immunizations
  high: DK, F, ICE
  low: CZ, LIT

GP task profile - curative

- Routine blood pressure measurement
  high: F (99%), P, L, UK, B, PL
  low: NL, S, N (ca. 40%)
- Routine assessment of blood cholesterol
  high: E, D (ca. 80%)
  low: NL, RO (ca. 15%)
- Involvement in procedures such as wound suturing, fundoscopy …
  high: FIN, ICE, NL, N
  low: BG, LIT, PL, EST, I
- Involvement in diseases such as hyperthroidism, menigitis, depression …
  high: UK, N, F, D
  low: BG, RO, CZ, LIT, NL, SLO, E


All patients access system through GP
UK
NL
Comprehensive
task profile
Limited
task profile
?
D, F
LIT
Nobody accesses through GP

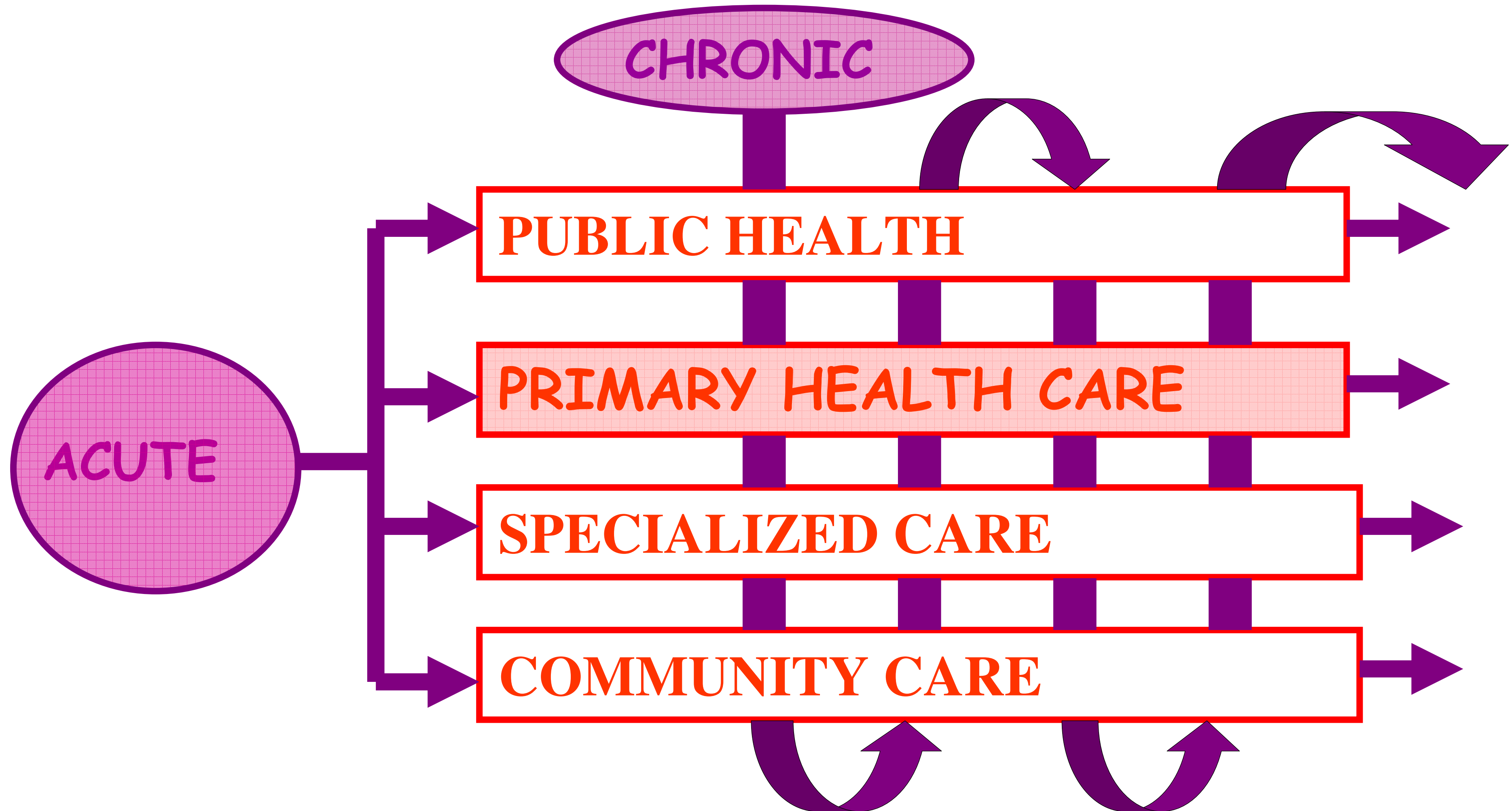
PRO-COORDINATION REFORMS IN EUROPEAN HEALTH CARE: The role of primary care

TWO TYPES OF REFORMS WHICH EXPAND THE ROLE OF PHC

1. GPs AS COORDINATORS
   a. Purchasing
   b. Other (gatekeeping, commissioning, etc.)
2. EXPANDING TASK PROFILES
   a. Total substitution (eg minor surgery)
   b. Partial substitution (eg shared care)

→ BOTH IMPLY A CHANGE IN SYSTEM COORDINATION MECHANISMS

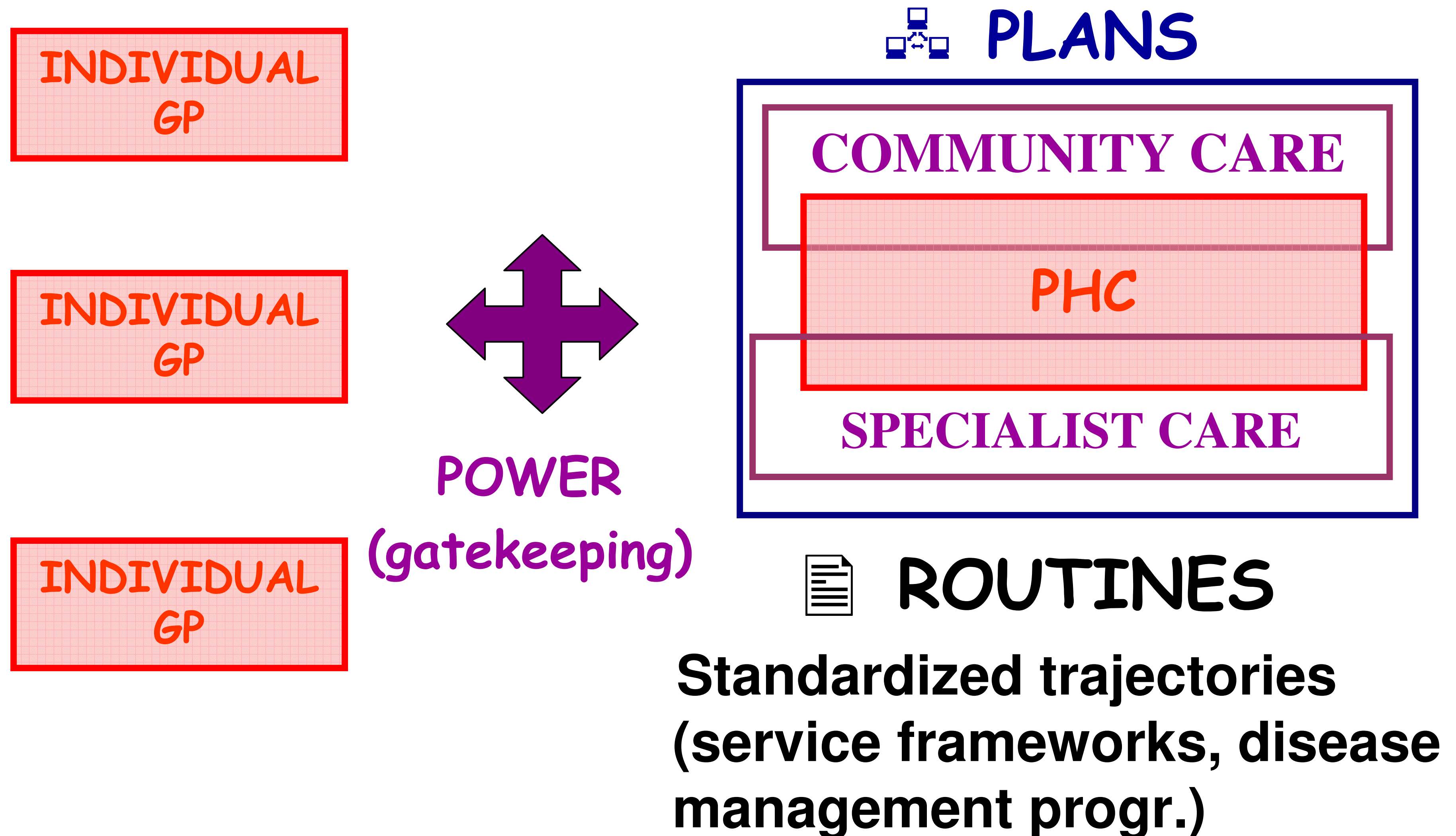
MAIN DRIVERS OF PRO-COORDINATION REFORMS



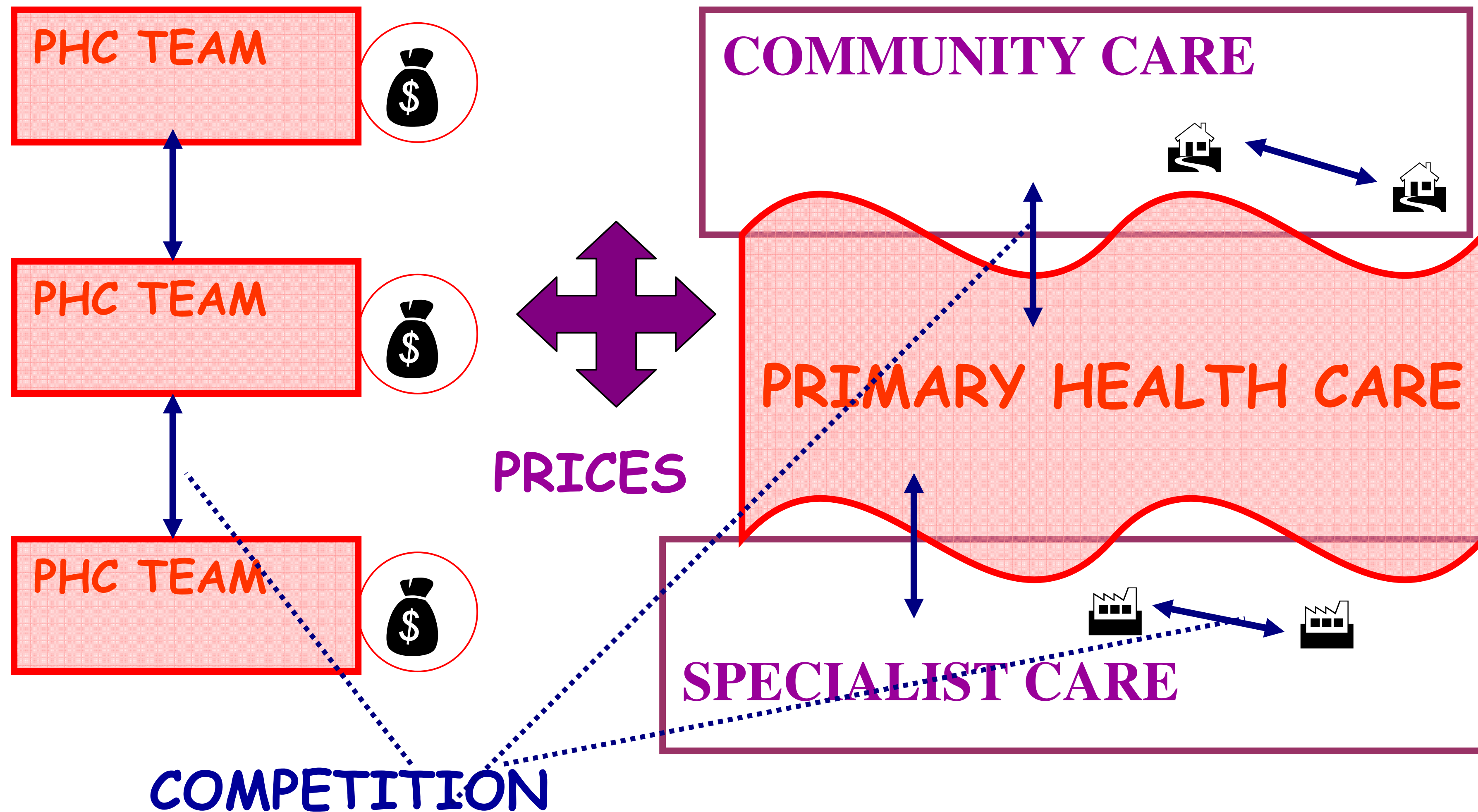
MECHANISMS OF COORDINATION

	COORDINATION	CONTROL
MARKET	Prices COMPETITION	Ownership
HIERARCHY	Plans & routines PLANNING	Power
NETWORKS	Collective decision-making COOPERATION	Social sanction

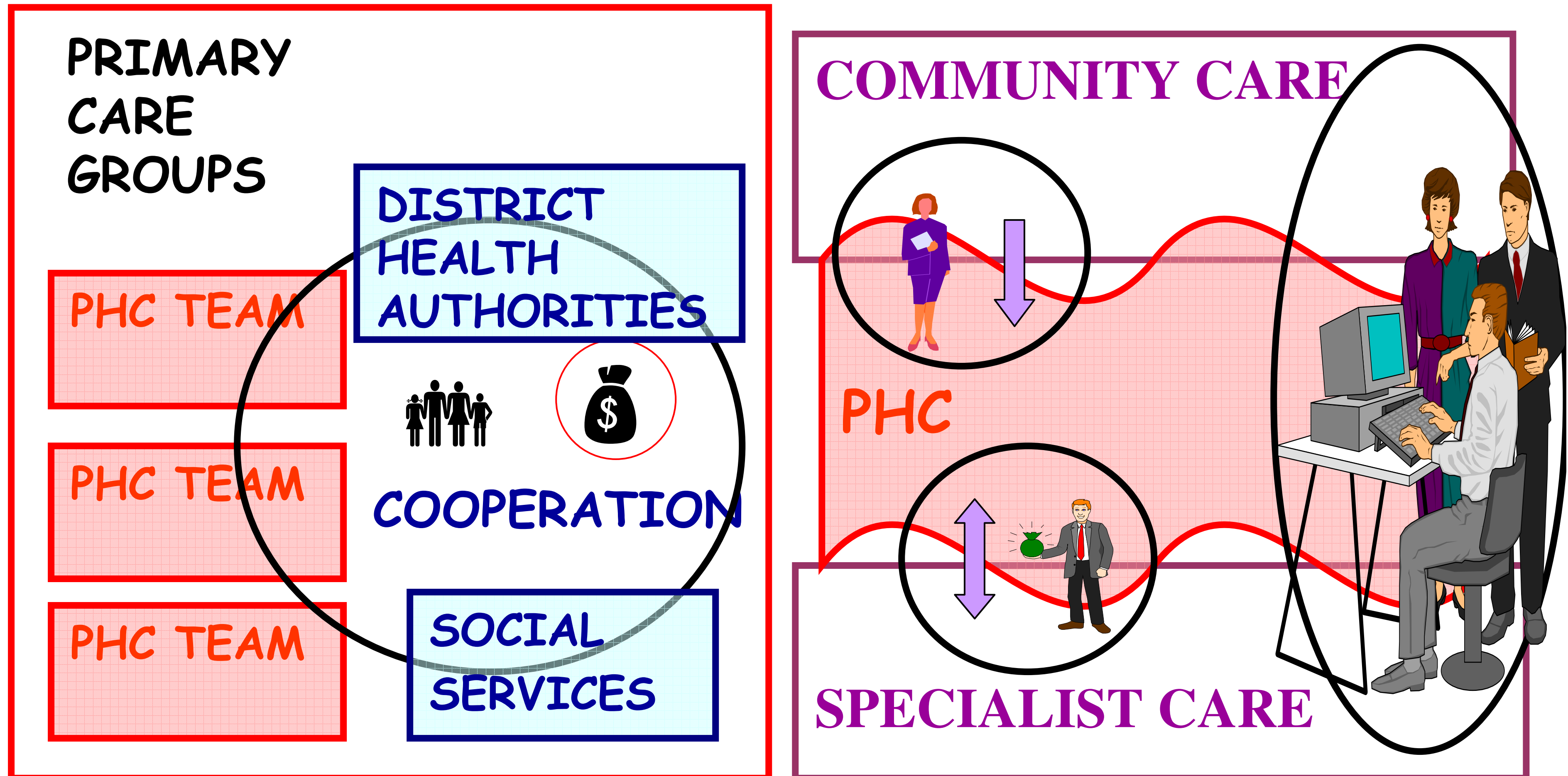
PRO-COORDINATION REFORMS: HIERARCHICAL MECHANISMS



PRO-COORDINATION REFORMS: MARKET MECHANISMS



PRO-COORDINATION REFORMS: NETWORK MECHANISMS

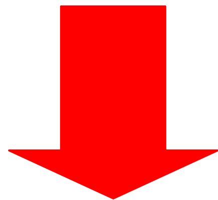


OTHER PHC REFORMS IN EUROPE

INPUTS

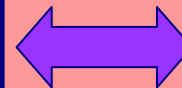
TECHNOLOGY
- Telematics
- Other

HUMAN RESOURCES
- Training
- Skill-mix

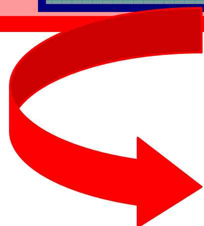


CONTROL MECHANISMS
- ✓ Transfers of ownership
- ✓ Contracts & payment systems
- ✓ Governance systems
- ✓ Accreditation & certification
- ✓ Quality control systems
- ✓ Team work & scale

PROCESS



COORDINATION MECHANISMS



OUTPUTS

Information on primary care in the HiTs (Health Care Systems in Transition)

4.2.1 Organizing and delivering primary/ambulatory care

How are primary health care services organized? Describe the model of provision of primary health care services including settings, nature of providers and functions. Consider:

- Settings and models of provision – independent/single-handed practices, group practice, health centre, hospitals;
- Are primary health care providers directly employed or contracted?
- Public-private ownership mix;
- Health care personnel involved (e.g. general practitioners (GPs), family physicians, specialists, nurses, feldshers, paediatricians, social workers, dentists, pharmacists, midwives).
- Give a brief indication of the roles and functions of each category of health care personnel.

4.2.1 Organizing and delivering primary/ambulatory care (cont'd)

- If available, give the average number of patients per general medical practitioner.
- Provide an indication of the range of services provided. Consider the following categories: general medical care (including the adult population and elderly), care of children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, dispensing of pharmaceutical prescriptions, certification, 24-hour availability, home visits, preventive services (e.g. immunization, screening), health promotion services (e.g. health education).
- Is there freedom of choice of primary health care physicians (e.g. general practitioners)? What restrictions are there, if any, with respect to changing physician?

[Standard Figure D Outpatient contacts per person]

4.2.1 Organizing and delivering primary/ambulatory care (cont'd)

Access to secondary care:

- Is there direct access to specialist (ambulatory and hospital) services?
- Is there a GP gatekeeping role?
- Discuss the referral process, if any. Can patients choose hospital and/or physician.
- Comment on the geographical distribution of primary health care facilities/practitioners. How do rural areas compare with urban ones? If possible, provide figures illustrating geographical differences.

Comment on the quality of services and facilities. Include if available indications from official quality assurance reports and an indication of the level of patient satisfaction with services and facilities (e.g. based on consumer surveys).

Describe major changes that may have occurred in recent years in any of the above areas.

Discuss main problems or challenges associated with current practices relating to the above areas.

What expectations or reform plans, if any, are there regarding future developments?

4.2.2 Paying for primary/ ambulatory care

Consider the following payment methods:

- *Fee-for-service*. A specific amount is paid for each act/treatment provided. Physicians itemize services on an invoice after the completion of care whereupon the third-party payer reimburses the physician or the patient. This is common for self-employed doctors, both for ambulatory and in-patient services.
- *Capitation fee*. Every patient is on a list of general medical practitioners or specialists. The third-party pays the physician a fixed amount per year for each subscriber, regardless of the services provided.
- *Salary*. Physicians are paid a fixed amount for time at work. The physician is paid on a time basis regardless of the quantity/type of services provided or the number of patients treated. This system is mainly associated with direct employment by an organization.
- *Case payment*. Physicians are paid a fixed amount for providing all necessary care to each patient. This can be based on a single flat rate per case or on a schedule of payment by diagnosis.
- *Mixed formulae*. Often payment of professionals is based on a mix of methods (i.e. capitation plus fee-for-service for some services). Similarly, systems can be supplemented by bonus/target payments as an incentive for achieving certain objectives.

4.2.2 Paying for primary/ ambulatory care (cont'd)

Describe how physicians are being paid at present. Distinguish between general medical practitioners and specialists (in ambulatory and in hospital settings). What role if any do out-of-pocket payments play in paying for services? If available what proportion of total payments do these out-of-pocket payments represent? Which groups, if any, are exempt from any out-of-pocket payments?

Comment on methods of deciding the rates (e.g. negotiation, rate regulation, payer dictation, etc.) What is the extent of government regulation in this process?

In systems where physicians hold budgets, e.g. in the capitation fee system, what financial incentives if any are provided to encourage specific treatment/prescription patterns?

Are there incentives for physicians to undertake minor surgical and other procedures which would typically be performed within a secondary care setting?

Have there recently been any changes in methods of payment? Indicate problems that triggered such change.

What problems are associated with the present forms of physician payment (e.g. lack of regard for cost effectiveness, low quality of services, low professional satisfaction, morale, etc.)?

4.2.2 Paying for primary/ ambulatory care (cont'd)

If new payment mechanisms have been introduced:

- How widespread has their use been to date?
- Have there been any problems or difficulties with implementation (i.e. rapidly increasing physician remuneration leading to payment difficulties in view of resource constraints)?
- How extensive are black market (under-the-table or envelop) payments to physicians estimated to be?
- Are there any reforms on payment systems being planned? What is the prevalent thinking and expectations in this field?