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The renewal of Primary Healthcare from the doctor's surgery

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THE RENEWAL OF PRIMARY HEALTHCARE FROM THE DOCTOR'S SURGERY

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THE RENEWAL OF PRIMARY HEALTHCARE FROM THE DOCTOR'S SURGERY

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CHAPTER 1

Introduction: the necessary "bottom-up" renewal of Primary Healthcare from the doctor's surgery. Innovative vigour *vs.* routine and the "complaints culture"

Juan Gérvas and Josep Casajuana

Three fundamental points that support clinical practice

Human beings are born and die free. The environment can restrict human freedom at birth, during life and death. To the extent possible, we healthcare professionals help humans to be born, live and die with freedom, we eliminate and alleviate pain, suffering and death, and as professionals we are free to do so using science, awareness and courage.

Science

Science based on enhanced knowledge used appropriately in clinical practice, adapted to health issues, patients and their cultural and social environment. Science to help provide maximum quality, minimum quantity and suitable technology by the proper professional, at the right time and place and as close as possible to the patient's home.

Awareness

Awareness of the patient's preferences and society's demands which supports and sustains the healthcare system, showing compassion towards human variability, having respect for and an understanding of matters that cannot be found in textbooks but which are prolific in life. Awareness with regards meeting the ethical, social and professional demands that lead to a commitment to patients' suffering and death.

Courage

Courage to not throw in the towel, to go against the tide if necessary, to seek the truth with determination, sometimes without even knowing which truth to look for, to change

established routines, to introduce ethics of negation and ignorance into daily clinical practice, to adopt exactly the right stance and to adapt to situations, balanced between "technical irrationality" (all for the organisation) and "romantic irrationality" (all for the patient). Courage from our student days (the first hour of the first day in the first year of Medicine, Nursing, Pharmacy, Psychology, Social Work, Clinical Assistant, Laboratory Technician, etc.) until retirement (the last hour of the last day of the last month of the last year).

Three grievances of our Primary Healthcare

In Spain, there are three basic problems in Primary Healthcare and these problems are also usually present in countries with public financing and provision, such as Portugal and Brazil: deprofessionalisation*, an inferiority complex and poor team leadership.

Deprofessionalisation

Salaried professionals are tempted by the worst of bureaucracy in the sense that they strictly comply with minimum duties and hold the belief that "I'm not paid to do this". Many Primary Healthcare teams are not teams as such, rather they are personnel without shared common objectives who have patients' general well-being at heart. The patients can become the "dynamite of the system", as they can be irritating, especially those who fail to comply with procedures and appointments and these people are usually those most in need of care.

Professionals therefore lose their commitment to patients, the population and to their profession. The "complaints culture" takes hold and many people suffer from burnout. Simply turning up for work is enough and there are no implications involved. In this bureaucratic environment, ignorance and routine comfortably take hold. Hiding behind complaints and burnout means that the challenges of Primary Healthcare are not being faced: managing uncertainty and time with complex patients at the doctor's surgery and at home, providing highly-accessible, extremely versatile life-long services for many problems and coordinating care given by third parties.

Inferiority complex

Training predominantly takes place at hospitals and has a strong hidden curriculum. It teaches us how to provide care that is mainly biological, fragmented and technological. Together with the decentralisation of Primary Healthcare resources (to bring them closer to patients' homes), professionals develop an inferiority complex *vis à vis* their colleagues at the hospital, which is considered the ideal place to be and which contrasts sharply with Primary Healthcare that lacks "technological sparkle" and innovation.

* Translator´s note: "deprofessionalisation" in this publication is used with the Spanish term "funcionarización", which refers to the reducing of healthcare professionals to a passive, administrative civil servant role.

GPs finally become resigned to the fact that specialists know more about their specialty, while GPs should be specialists in frequent issues, in the complexity of each patient. Patients are defenceless in the face of uncoordinated care, if they do not have a doctor that "adds, subtracts and raises to the umpteenth power" the care received from specialists. Specialists are competent in their specialty, but are dangerous if uncoordinated.

Our inferiority complex makes us accept protocols, guidelines and the "consensuses" of specialists relating to different illnesses and situations on an illness and risk-factor basis and we end up doing what the computer, charts and activities included in the incentives package tell us to do.

Poor team leadership

Primary Healthcare teams "select" a member as director or coordinator, but their clinical leadership or specific training in management issues are not usually taken into consideration. In fact, the post is often occupied by someone who simply offers themselves up for the role, acting as a mere "communications channel" for upper management whilst preserving the status quo. The team members feel that the hierarchy is absurd without leadership or autonomy.

There is an evident lack of leadership in the eyes of students working at health centres, which leads to the rejection of bureaucratic jobs in an environment plagued with inferiority complexes that lacks the challenges of complexity and multimorbidity. This is exacerbated by the fact that "technological sparkle" in Primary Healthcare is virtually non-existent.

Not surprisingly, resident medical interns (MIR) are not overly attracted by the Family and Community Medicine specialty and, consequently, it is chosen mainly by those who obtain the lowest grades. Students often give it up and adopt another specialty or end up working in the casualty department, at the opposite end of the spectrum to Primary Healthcare, where there is less longitudinality.

Three basic principles to change our practice

We need to convince ourselves that the solution largely depends on our decisions. It is not the patients (unnecessary and exaggerated use of healthcare resources, especially time, and excessive demand), it is not the specialists (excessive tests, appointments and rescheduled appointments, prescriptions imposed on GPs), it is not the managers (who ignore life in the "trenches" and burden the system with more and more bureaucracy), it is not the politicians (who are vote-hunting, think in the short-term and are populist), or society (eager and demanding, manipulated to ask for eternal youth, medicalized until they fall ill, worshippers of technology and miraculous medicines), or the media (with their dramatic news, their lack of rigour). Rather than "passing on" the blame, it should be about searching for solutions. It is ultimately up to us, the professionals, who must and can change the situation.

How do we change from the bottom up? How do we renew Primary Healthcare from the doctor's surgery? First and foremost, we must identify the issues discussed above and foster enthusiasm and faith in our own strengths. If we want to, we can do it.

After recognising the problem, we must find solutions. International comparison allows us to understand what is being done "out there", which often surprises us. A calm analysis of the impact of the economic crisis is also surprising, as it shows that health can be improved by an organised and rational response. The outside perspective of those analysing the MIR and the choice of Family and Community Medicine is also surprising, as is the attitude of those in the field in relation to all the work that still needs to be done in Primary Healthcare.

In order to change from the bottom up, from the doctor's surgery, three basic principles must be respected:

Primum non nocere

In the twenty-first century, this continues to be the fundamental cornerstone of healthcare activities. This is achieved when we work with quaternary prevention, i.e. when we seek to prevent the damage caused by healthcare actions, to prevent all that is unnecessary, since this never justifies the harm it causes, and to prevent, decrease and alleviate the damage also caused by necessary activities.

All healthcare procedures have adverse effects; even simple words and advice can of course cause harm, as shown by the advice that children should sleep face down in order to prevent sudden death syndrome (it actually increases as a result of this recommendation). Prevention must lose its aura of "innocence", because preventive actions have already caused too much harm (and death). One such example is the impact of hormone replacement therapy on the menopause (thousands of cases of breast cancer, embolisms, strokes and myocardial infarctions).

Equity

In terms of access and healthcare processes. Services must be provided on the basis of the needs of individuals and populations, not in accordance with their ability to pay, contrived demand and/or manipulation of the healthcare system. Vertical and horizontal equity to provide more care to those who most need it and the same care for similar needs.

Equity in terms of access, with flexibility to overcome the obstacles faced by those who work or those who are "inconsequential" (the poor, prostitutes, drug addicts, the homeless, etc.) and equity in processes, so that once contact is made with the healthcare system, professionals are capable of providing appropriate treatment, irrespective of culture, language, sexual orientation or race, etc. It is about minimising the impact of the "inverse care law" (those who need the most services receive the least) and this is achieved to a greater extent when the healthcare system is more focused on the market.

Generalism

Professionals should "revolve" around the patient (and not the other way around), to provide maximum services at a given time. This requires great accessibility, flexibility,

versatility, longitudinality, and the ability to coordinate (intra-team and with other levels and sectors). The appropriate use of certain technology is also required *(know-how) as well as an environment* that limitlessly and responsibly broadens the autonomy and fieldwork of each professional. In view of the unstoppable growth of multimorbidity, generalism is becoming increasingly important.

Multimorbidity is usually treated by multiple activities, including polymedication, multiple referrals and fragmented care. This concoction leads to serious risks and exposure to adverse effects which eventually become a public health issue. The mixture of biological, mental and social problems and their handicaps cannot be dealt with by macro teams of mini specialists, but rather by generalist professionals providing a multitude of services at the same moment of care. We therefore need more generalism.

In Spain we already have trained Primary Healthcare professionals, patient lists and a monopoly (to a certain extent) for the first point of contact. All we need is responsible autonomy and accountability. Renewal is possible and desirable. In the following chapters we try to explain how.

CHAPTER 2

The renewal of Primary Healthcare from the doctor's surgery

Josep Casajuana

Introduction

Primary Healthcare requires significant changes which go beyond simple evolution. We may not go as far as a revolution, but we at least need to witness a re-birth. Professionals should be the initial drivers of these changes. Let us focus on issues inherent to Primary Healthcare professionals, which we have referred to as internal grievances (described in the first chapter) and which we have the power to deal with and change, irrespective of whether the winds around us (society, managers, politicians, etc.) are blowing in the right direction. There are three issues which are closely intertwined:

1. Deprofessionalisation.
2. Inferiority complex vis à vis secondary care.
3. Low leadership profile of Primary Healthcare managers.

As a result of these grievances, Primary Healthcare self-imposes a number of limitations: 1. The perception that attendance is exogenous, 2. The perception that prescriptions are imposed upon GPs and 3. The lack of decision-making capacity.

The perception that attendance is exogenous

Aside from defending what others should do for us, it is essential that we start doing what is within our control and there is a lot we can do. Separate the wheat from the chaff, eliminate excessive follow-ups, and excessive therapeutic and preventive treatments. Useful low-complexity activities (low or zero need for a doctor) and excessive follow-ups can be reassigned to other team professionals. Sometimes, it may also be a good idea to place the control in the hands of patients ("expert patient"). By eliminating useless, low-complexity tasks, we can focus more attention on high-complexity consultations

and distinguish between those which must be on-site and those which can be virtualized (telephone, email and SMS), which also favours accessibility and proactivity. Bodenheimer's proposal to classify patients' demands in accordance with their need for a doctor is a clear example (figure 2-1).

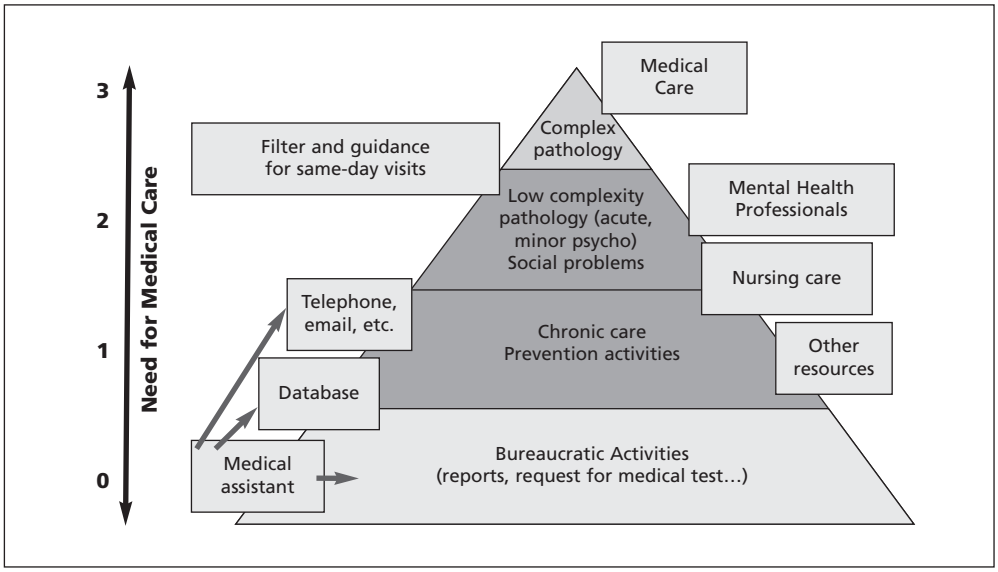

Figure 2-1. Proposal to classify patients' demands in accordance with their need for medical care. Source: Adapted from Bodenheimer.

The perception that prescriptions are imposed upon GPs

This imposed prescription is partly exacerbated by the lack of decision-making capacity and both these elements are a result of (to some extent) the inferiority complex. The transition from this "imposed prescription" approach to the "healthcare agent" role implies that hospital professionals recommend, consider, etc. and that it is the Primary Healthcare doctors –speaking to their patients, analysing the pros and cons– who make the decisions. Being more resolute will reduce unjustified "annual check-ups" by many patients with different hospital specialists and the implementation of actions, especially with polymedicated patients, that are often highly inappropriate. This means managing the patient's prescription, free of our inferiority complex, and assuming the difficulties that may arise.

From poor decision-making capacity to quaternary prevention

This, inter alia, prevents patients from receiving secondary care when they do not need it, involving actions that are much more invasive and unnecessary. All issues that should be resolved by Primary Healthcare and are referred to others are poorly resolved.

However, this is also true for matters not involving referrals, where appropriate care is not being received. Conversely, issues that should be and are referred are well-resolved by Primary Healthcare, while those that should be referred and are not are poorly resolved. The computerization of consultations (referrals, population receiving care, variability of a single process) enables these issues to be researched. Poor decision-making is probably influenced by all three problems previously mentioned: deprofessionalisation, an inferiority complex and the lack of leadership. It is therefore essential for each team and professional to have updated and comparable information on their situation in this respect, in order to be able to act in accordance with their results.

This is not easy, the environment is unfavourable but is also going to change significantly as a result of the current economic crisis. If we have already taken the first steps, our ability to influence changes in the environment will undoubtedly be much greater.

CHAPTER 3

A practical proposal for clinical renewal at the Primary Healthcare surgery

Juan Gérvas and Mercedes Pérez Fernández

What can GPs and other Primary Healthcare professionals do in order to revamp their own clinical practices, improve their performance and productivity and use science, technology and time in order to provide more services that are better? How can the professional, organisational and social context help?

What society appreciates about GPs is accessibility, versatility and longitudinality. A particular doctor, capable of "resolving" a myriad of problems and of "responding" to all of them, becomes a type of civil "hero" that people long for. GPs should share this social prestige with other Primary Healthcare professionals, who help them achieve a considerable amount of their decision-making capacity and responsiveness. This means that the right professional must provide services free of barriers (geographical, administrative, monetary, cultural and others) and be capable of "responding" to a diversity of situations, be equipped with adequate knowledge, skills and attitudes and make a life-long commitment to patients, families and communities. The objective is to obtain maximum quality and minimum quantity using the appropriate technology at the right place and time, by the right professional as close as possible to the patient's home.

Accessibility should be adapted to patients' needs and characteristics, with particular emphasis on those who have greater difficulty in meeting appointments, such as employees, drug addicts, the homeless and other marginalised people, adolescents, etc. Schedules should be cleared out and their use by "big users" reviewed in order to adequately resolve their issues and ensure that they do not clog up the schedules of different professionals to facilitate "effective" accessibility, depending on their needs. The delegation of functions (knowledge, skills, time and power) frees up professionals from tasks that reduce their "status of eminence" (and their self-esteem), and improves Primary Healthcare performance.

Versatility depends especially on overall material resources (technology), on the skills to use them and relevant regulations, complemented with well-organised access. The versatility of GPs and other Primary Healthcare professionals depends on the text (science, technical and values of the GP) and the context. Therefore, "usage and customs" and the

scope of power are essential. Today in Spain, few patients expect the Primary Healthcare nurse to insert an IUD or for the GP to take a vaginal sample and examine it under the microscope to look for Trichomoniasis. Of course, accessibility is necessary to ensure that versatility helps increase productivity. Some areas have been "abandoned" by Primary Healthcare, which should be recovered through a renewal movement seeking to bridge the gap between efficacy and effectiveness, allowing services to be rendered based on needs, close to the patient's home. These areas include surgery services (removal of skin cancers, treatment of gluteal abscesses and infarcted haemorrhoids, etc.), gynaecology and obstetrics (monitoring of pregnancies and treatment of Bartholin's cysts, etc.), infectious diseases (care for patients with AIDS or tuberculosis, etc.), paediatrics ("from the cradle to the grave"), dentistry (diagnosis and treatment of tooth decay, etc.), ophthalmology (diagnosis and monitoring of ocular hypertension and the removal of foreign bodies from the cornea, etc.), orthopedic surgery (infiltrations and immobilisation of sprains and fractures, etc.), mental health (provision of care to drug addicts, etc.) and the terminally ill (home palliative care).

Longitudinality is the provision of various services over a lifetime by the same professional with whom a relationship of trust is established, and recognition by the population and patients of the GP as a "source of care", who is consulted from the very start. The management of partly "regulated" information (medical history, physical examination and the result of various diagnostic tests, for example) and partly informal information, which we call "soft" and which sometimes becomes "etched" on the professionals' memory without their realisation, has a huge impact on their clinical decisions. A high level of longitudinality can only be achieved if the professional remains in his or her post for decades and if they provide multiple services (versatility) with easy access. Longitudinality is broken by "monthly" (sometimes, "weekly, daily and even hourly") contracts in Spain for public GP posts which do not require public state exams. Longitudinality is also reduced for those who do not have an "assigned" GP. When colleagues are absent, priority should be given to taking care of their patients (i.e. during the holidays, doctors should alternate so that patients are cared for, in general, by an "assigned doctor" who they already know and not just by a doctor who "happens to be available"). Doctor "rotation" (transfer), which reduces longitudinality to zero, is more frequent in the public provision systems, such as in Spain and in Brazil, and is less common where doctors have to "build" their portfolio of patients, like in Germany, Denmark and Norway. Longitudinality also favours capitation payments (which always involves patient lists and the role of the filter), like in Denmark, Norway, New Zealand and the United Kingdom.

Longitudinality means coordinating the care provided by other specialists, both outpatient and at the hospital (including casualty), in the private and public sectors and using community pharmacists and other services (social services, home helps, shelters, kitchens, police, etc.). Longitudinality facilitates coordination between clinical practice and public health, enabling the relevant public health actions to be "transferred" to patients, families and communities through its "natural professionals", who they trust and know, with the power to transfer information and change behaviour (if applicable).

Practices exist which are "clearly improvable": from the use of antibiotics and their resistance to the management of heart failure in Primary Healthcare, from improved care to prevent hospital admissions arising from health situations and issues that could be

preventable by Primary Healthcare to avoiding or postponing serious complications in diabetics, from the correct management of axial skeletal pain (avoiding excessive diagnostic methods that have no scientific basis, surgical and pharmacological therapeutics and guidelines for ineffective rehabilitation) to providing better care to terminal patients who wish to die at home.

We need more curative and less preventive care with scant scientific basis, and this also implies an ethical problem, especially with regard to the principle of "fairness", because resources are generally transferred from the elderly to the young, from the sick to the healthy, from the illiterate to the educated and from the poor to the rich. Curative activities end up being rejected, leading to the harsh reality of uncertainty and suffering.

CHAPTER 4

Learning from other European countries

Josep Casajuana and Marc Casajuana

Introduction

Family and Community Medicine in Spain has characteristics that are not very usual in Primary Healthcare in other European countries: doctors are public civil servants who work in multidisciplinary teams and earn a fixed salary. Professional dissatisfaction is becoming increasingly prevalent and explicit. Certain characteristics of our organisation are not at all consistent with what we want from Primary Healthcare. In Spain doctors defend a maximum of 25 visits per day, while in France, professionals aim for a minimum of 25 visits. Here, we want to limit our quota (guaranteed) to 1,500 or 1,200 patients, while in Norway, professionals seek to attract clients in order to have an "adequate" quota. In Spain, our aim is to land a morning shift while in most countries, professionals work both mornings and afternoons.

Logically, none of this meets clinical or medical practice criteria. They are "easy" ways of suiting individual and professional interests and the health system's organisational model. It is true that in Spain, our model tends to encourage us to work less, meaning that many professionals prioritise certain employment-related matters over basic professional matters in their objectives.

It is obvious that incentives work, that the type of remuneration has important implications regarding professional performance, as it indicates interests or the value placed on different aspects of the work by the employer. The fact that German GPs are paid on the basis of the number of patients treated over the last three months for example, means that this is the "standard" control period for patients with high blood pressure or diabetes, etc.

We cannot be indifferent to this reality, which is an important conditioning factor. Therefore, the objective of this chapter is to analyse the various organisational methods in some of our neighbouring countries and to see what we can learn with regards encouraging the positive aspects and minimising the aforementioned problems.

The National Health System (SNS) or Social Security (SS) model do not seem to have a direct influence *per se* on the perception of quality. Instead, the differences observed are

particularly influenced by other aspects of the organisation, such as being self-employed professionals, having patient lists, or playing the role of gatekeeper.

Self-employed or salaried doctors/individual or team work

The perception of quality in countries where doctors mainly work alone at privately-owned centres is 87.8%, those in small groups in private centres is 89.3%, while those in publicly-owned centres is 75.4%. Large teams, often composed of more than 40 people, trained through Spanish public state exams, probably have an unfavourable "benefit/harm ratio", because it is not unusual for the purported benefits of these teams (mutual empowerment, ongoing on the job training, etc.) to be merely incidental or wishful thinking whereas, conversely, the secondary effects of these teams are clearly visible: reduced responsibilities, low involvement, "I'm not paid to do this", and this leads to deprofessionalisation, i.e. the reducing of healthcare professionals to a passive, administrative civil servant role, leading to frequent burnout, whether as a health problem (less common) or as an excuse (more common).

Remuneration model

GPs who are remunerated on a service basis will logically worry if their schedule is empty. Those who are salaried will complain that their schedule is too full. Those who are remunerated by capitation make efforts to increase their patient list. Without a doubt, rather than encouraging the assumption of a greater workload, salary payments do the opposite. Professionals who have a "good reputation" among their patients will usually have a heavier workload and as "compensation", there will be a delay in obtaining appointments. Professionals who tend to "churn out patients" will have a more organised quota, without any impact on remuneration. A good incentive for civil servants.

Patient lists/quotas

Patient lists or quotas where the doctor gives the referral, favour longitudinality, which is particularly relevant in the case of chronic or pluri-pathology patients. In most countries with capitation payments, the client portfolio, or quota, is something the professional must "earn". This is not guaranteed nor simply "handed" to them. In addition, a long patient list restricts the professional's mobility because if the patients leave, their income will be considerably reduced. The patient list was established to improve equity (the response to needs with no discrimination), in exchange for a relative loss of freedom. In countries with patient lists, equity is more important than freedom, the GP is more important than the specialist and Primary Healthcare is more important than the hospital. Of course, all of these elements are necessary in the right dose, but in countries with no patient lists, society values freedom more than equity, the specialist more than the GP and hospitals more than Primary Healthcare.

International comparison shows that countries with patient lists (a "monopoly for the first point of contact" and capitation payment) have better control over the increase in

health spending and have better health. In fact then, the decision to establish a patient list was correct.

The Primary Healthcare doctor as a point of entry to the healthcare System

In some countries GPs are honoured for being the patient's healthcare agent and the specialists' pay depends largely on the GPs' role. In Spain however, the fact that it is virtually impossible to influence referrals due to a lack of choice, service quality and the referring GPs' level of satisfaction having no impact on the payment received by the specialist or hospital, and the low prestige of GPs because of the way they are treated as system secretaries by the government, means that the role of gate-keeper is more often seen as a problem rather than a solution.

Workload: quota size, number of visits and hours worked

Workload is another component that varies significantly from one country to another, following a pattern that we can consider "logical", depending on whether we refer to public employees or self-employed professionals and the existing remuneration model. In Spain, the difference in remuneration between having 1,500 and 2,000 patients is purely "incidental" and services are used in a frenzied, consumerist way since there is nothing to moderate this behaviour. This takes place in an environment with scant flexibility (employment-related, of course, while also mental, in our opinion), because the possibility of working with a bigger or smaller workload and more or fewer hours, as happens in many of the countries analysed, is very restricted in Spain.

Competences of a Primary Healthcare doctor: techniques, medical care for children and women

The competences of GPs include all issues that arise frequently enough for them to keep their skills up to date and which do not require specific technology. One of the core characteristics of GPs is versatility, which forms part of their "essence". A low competency level reduces professional versatility and is an additional component of deprofessionalisation, which helps maintain an inferiority complex. Versatility implies greater work diversity, which is professionally desirable, and also a heavier workload. This could result in poor motivation levels in our environment.

Professional autonomy and remuneration that acknowledges different workloads, greater involvement and a broadening of the services portfolio are characteristics which seem to be increasingly and urgently required.

CHAPTER 5

How do GPs respond to daily clinical issues in European countries with capitation payments and patient lists?

Juan Gérvas, Mercedes Pérez Fernández and Roberto Sánchez

Public healthcare systems with universal coverage

Each country in the European Union has a public healthcare system with universal coverage. However, there are important differences under this common "umbrella" that protects the population against bankruptcy arising from illness and against suffering, disease and death that are medically avoidable. These differences are more heightened with respect to Primary Healthcare and the GP. This is understandable, as Primary Healthcare adapts to the culture and idiosyncrasies of societies, whereas hospitals "impose" their organisational model in a manner that is virtually homogeneous and universal. Public financing of over half of health expenditure does not "demand" the public provision of Primary Healthcare services. In fact, there are few countries in the developed world with publicly provided Primary Healthcare: Spain, Finland, Greece (rural), Portugal and Sweden.

Public financing and public provision, salaried GPs and public civil servants

In these countries, GPs are salaried employees in a strict hierarchy and are not independent professionals. They are public employees or civil servants, who work in a publicly-owned building ("health centre"), whose colleagues are also salaried employees that have not been personally selected by them (a "workforce" usually called a "Primary care team" including nurses, clerical and other personnel), with publicly-owned production resources. Salary-based remuneration, which makes up the majority of their income, "segregates" GPs from the population and patients, meaning that Primary Healthcare can become bureaucratic and distant, and professional mobility common. In Spain, everybody has an "assigned" GP (ex-officio, which in practice, can change). This involves

dividing the entire Spanish population into "quotas" or patient lists and assigning a GP to each quota, ensuring "equitable" division throughout the country. The patient list means that there is a monopoly for the first point of contact and capitation payment. In Spain salary payments are the highest percentage of GPs' income and capitation payments account for between 5% and 10%. There are other payments, such as annual bonuses for meeting quality objectives, inter alia.

Public financing and private provision

The private provision of Primary Healthcare services is the most common in EU countries, where contracts exist between GPs and the financing organisations that establish the employment and remuneration terms and conditions. They work in private practices, either alone or in small groups. Generally speaking, GPs work without the help of nurses and have highly versatile auxiliary clerical staff with problem-solving skills. Primary Healthcare nurses usually work "in the field" (in homes and elsewhere) and depend on public community services.

Public financing and private provision, "refundable" fee-for-service payment

GPs see patients, charge them and issue an invoice based on the service rendered ("fee-for-service payment"). Patients submit the invoice to the financing organisation and eventually recover the amount (generally less than 100%). In these countries, Primary Healthcare is weak because patients can go directly to the specialist. There are no "quotas" or "patient lists", although there are incentives to encourage the role of point of entry, informal lists (chronic patients), etc. Since "client portfolios" are eventually built up over the years, transfers are uncommon.

Public financing and private provision, "non-refundable" fee-for-service payment

GPs see patients and money is not exchanged. The invoice is also "service-based" (based on the services provided at the practice), but it is sent directly by the GP to the financing organisation. Primary Healthcare is also considered weak since it favours direct access to specialists. In some cases, there is no training programme for specialisation in General/Family and Community Medicine. "Client portfolios" are also built up over the years and transfers are therefore uncommon.

Public financing and private provision, capitation payment (patient lists)

GPs have contracts with financing organisations and receive emoluments through a mixture of capitation payments, various incentives and maintenance payments (for the surgery, hiring auxiliary and other staff), etc. After a number of years, the "patient list" explains why transfers are uncommon. Primary Healthcare is strong if measured in terms of its enormous scientific production in General/Family and Community Medicine and by the existence of a "first point of contact monopoly". Referrals from GPs "drag" the care budget over to hospitals. Capitation payments include a desire to take Primary Healthcare resources over to where they are most needed and to reverse the Inverse Care Law. The Netherlands is the exception (patients pay a monthly fee to the financing organisations), where capitation has very low co-payments.

In the last part of the chapter, various GPs respond to clinical cases (specifically, clinical situations), in accordance with their usual daily practice. It endeavours to simply and briefly explain the most likely response on any particular day. We do not expect them to provide an answer as to what should be done, but rather what is being done. For further details, we refer the reader to the original publication.

CHAPTER 6

Relaunching Family and Community Medicine through what we are learning about medical specialty choices*

Beatriz González López-Valcárcel and Patricia Barber Pérez

Introduction

Family and Community Medicine has been sliding down the preference scale and is at the bottom of the league table of specialties. The opposite occurred in the case of Paediatrics, one of the other most sought-after Primary Healthcare medical specialties on the rise. The economy carefully influences people's motivation to decide what they want do with their lives, how much effort they dedicate to work and how they manage the trade-offs between sacrifice and reward. It also acknowledges the role of intrinsic motivation and how employees identify with an organisation. The role of GPs and the manner in which they develop their practices vary greatly between countries, even between European countries that have patient lists and capitation payments where GPs hold the "the first point of contact monopoly". The range of tests and procedures that GPs can directly request for their patients without validation by the specialist is very restricted, particularly in certain autonomous regions. This could diminish the specialty's appeal in an environment where technology is everything. However, the low popularity of the specialty is not a problem that is exclusive to Spain. A considerable number of studies are available on the decline of Family and Community Medicine and Primary Healthcare specialties in a market of medical specialisation, particularly in the case of the United States.

How is the economic crisis affecting recruitment and retention of candidates as Primary Healthcare doctors?

One possible effect of the economic crisis is the decline in the number of abandoned Family and Community Medicine residential posts, since the recession has

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worsened employment prospects in the field of medicine, increasing the risk and cost of giving up a residential post. As a result of the crisis, the MIR programme is becoming a goal in itself, a poorly-paid but secure job for four or five years, which offers more than most jobs do. 50% of medical professionals who re-train in a specialty are GPs who have already been trained. Furthermore, Spanish doctors are sought after in international markets, and countries such as the United Kingdom became the second choice for young Spanish doctors enabling them to hang on to their employment and professional development expectations. Nonetheless, the crisis is also an opportunity. Job security is the attribute that has the greatest impact on medical specialty preferences. We have estimated that every 10% increase in the probability of finding work in a specialty increases the *odds ratio* of choosing that specialty by 33.7% (CI 95%: 27.2- 40.5%). Job security is 4 times more important than remuneration expectations in private practice (CI 95%: 1.7-6.8). Therefore, one measure that would have a huge influence on increasing Spanish doctors' entry into Family and Community Medicine would be to guarantee employment in the years after they have completed the specialty.

Spain in Europe. Comparing ourselves to France

Unlike in Spain, medical specialties in France are more desirable than surgical specialties. The increasing regional mobility of young doctors for the purposes of specialisation contrasts sharply with Spain. General medicine is not badly positioned, although vacancies exist due to the large number of posts on offer (52% of the total; 28% in Spain). Conversely, Paediatrics, one of the most popular choices in Spain, is almost at the bottom of the league table in France.

Choices affected by grades that have policy-related consequences. University ranking

In the MIR, you do not choose what you want; you choose what you can get. The fact that students with the worst grades end up in Family and Community Medicine does little to boost morale or overcome their inferiority complex. Medical schools vary in terms of "quality" and these differences remain unchanged over time. Year after year, the same university (Universidad Autónoma de Madrid) ranks number one, and year after year, two or three take turns at the bottom of the league table. A new phenomenon has emerged in recent years; Spanish medical schools at the bottom obtain worse results than foreign universities overall. We`re seeing a phenomenon of spatial segregation of family doctors in Spain that is biased towards certain origins (worst-performing universities and foreign universities). Changes in current policies (a minimum number of correct answers to be awarded a post) seek to improve the performance of candidates at the bottom of the league table in order to prevent their exclusion from the training programme.

Factors affecting the choice of MIR programme and the impact of policies on them

Various studies, particularly for the United States, have analysed the impact of so-called *controllable lifestyles* (convenient timetables, possibility of achieving a work-life balance) when choosing specialties. In Spain, medical students have well-defined preferences before they graduate. However, 46% of our young doctors change their mind a year after qualifying, when they opt for a place in the MIR programme. We see an imbalance between supply and demand. In the hypothetical scenario of being able to choose a specialty without any restrictions, as if each applicant came first in their exams, there would be more Family and Community Medicine posts available than those sought after. The academic position of Family and Community Medicine in Spain is very shaky compared to other countries. Only three universities include compulsory Family and Community Medicine in their curriculum (pre-Bologna process). Financial remuneration and the possibility to work in a private practice are the least influential factors, both for those who have chosen Family and Community Medicine and for others. Conversely, of those who do choose Family and Community Medicine, the likelihood of finding a job, job stability, a convenient timetable and the proximity of the workplace to the home are considered to be extremely important. In addition, the technological prestige of the hospital significantly influences the choice of certain specialties.

We have evaluated and quantified the imbalance between supply and demand of the specialities in MIR 2012 from the already mentioned survey made to residents (demand: which specialty would you choose if there were no grade restrictions?) and the data coming from official call (offer of announced posts by specialty). The results from this exercise are conclusive. Family Medicine and Paediatrics, the two medical specialities of Primary Healthcare, appear exactly at both ends.

12% of the MIR had chosen Paediatrics, but only 6.3% of all offered positions were actually for that specialty, having a "deficit" of 383 all places. In the case of FM only 7% of the candidates chose it as the first option, leaving surplus of 28% equivalent to 1.376 vacant posts.

To achieve a better understanding of this issue, we refer the reader to the original research publication in Spanish: Descriptive report on the MIR R1 survey in May 2012. Eco Salud ULPGC Group and Directorate-General for Professional Regulation February 2013. Available at: http://www.msssi.gob.es/profesionales/formacion/necesidadEspecialistas/doc/Infor meMIR2012.pdf and the chapter ¿Por qué los médicos huyen y rehúyen la Medicina de Familia? Datos y claves sobre el problema en busca de soluciones (available at: http://www.upf.edu/catedragrunenthalsemg/_pdf/Cap_3.pdf).

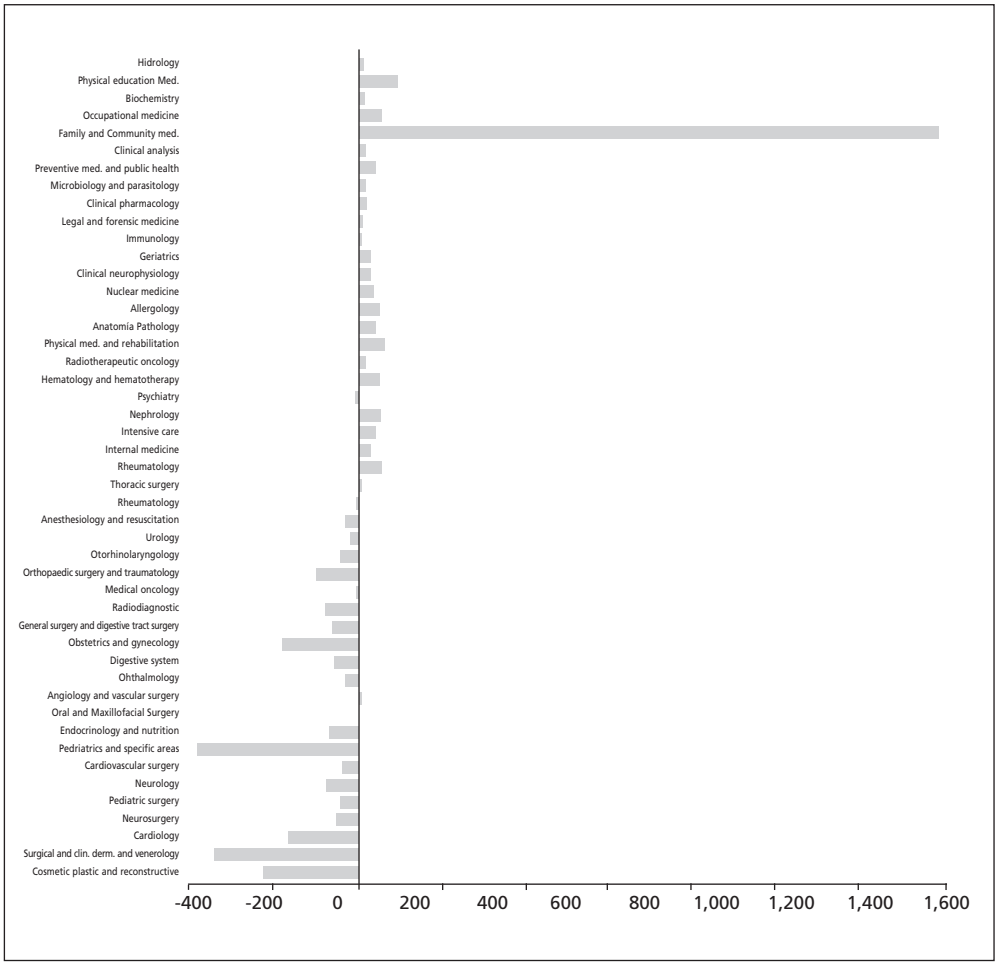

Figure 6-1. Imbalance between supply and demand MIR 2012.
Source: MIR survey in May 2012. Available at: http://www.msssi.gob.es/profesionales/formacion/necesidadEspecialistas/doc/Infor meMIR2012.pdf

CHAPTER 7

Do we receive too much healthcare? Is it unnecessary? Some issues to avoid getting lost in the reassignment debate

Francisco Hernansanz Iglesias

Our health system depends too heavily on the false belief that it is the main factor that conditions health and, consequently, it favours the "consumption" of too many health services. In view of the strong correlation between the use and availability of resources, the consequences of more services lead to a never-ending spiral of expenses, with dubious effectiveness. The problem is that healthcare policy is not focused on demystifying technology, it does not promote self-care and it does not curb people's expectations regarding health issues and synergies between health and industry professionals. There seems to be an unbreakable link between the doctor's surgery and the prescription, where the benefits of medication are measured excessively by society with no attention paid to their risks. The increase in risk factors, which involves an increase in preventive medicine, favours therapeutic regimes that are extremely difficult to manage and have unpredictable adverse effects. What is most concerning is that the consumption of medication has become a health issue: the burden of illness associated with the use and abuse of medication is the runner-up to heart disease and cancer; these are examples of how abruptly the scenario changes from the health production phase (To Cure) to the "To Hurt" phase (figure 7-1). It is wrong to seek health exclusively from health services. Matters such as housing, work, lifestyle, education, water quality, sanitation and habits should be taken into account since they are important factors that affect health. For many developing countries, sanitation and housing have involved low-cost investment with huge achievements in health indicators. In the EU15, the public healthcare expenditure of each country was above their GDP, but the Spanish race towards a "more is better" attitude was dramatic: from 1999 to 2009 the actual public expenditure per capita grew by more than 49%, 4 times faster than our GDP. Such was the case even though we acknowledge that we are unaware of the effectiveness of a myriad of modern medical procedures, and this lack of awareness does not seem to change over time.

If the debate continues to focus on the fact that we earmark a lower percentage of GDP to healthcare compared to our neighbours, that demand exceeds supply (illustrated for example by waiting lists) and that we have an ageing population, we will continue to

make the same mistakes and will find ourselves on a slippery slope. In a National Health System like Spain's, where no money is exchanged upon administration of treatment and the best quality care is provided to everyone in all areas, it is easy to envisage infinite demand. This is worrying if mixed with a hedonistic generation of irresponsible consumers. Spending more wisely implies acknowledging that what we are doing is wrong and that we are unaware of the effectiveness of more than half of our actions. In order to judge the quality of any healthcare system, figures are required: use, morbidity, mortality, complications, etc. This data can be compared and the submission of these figures is a transparency exercise that is still poorly developed. Even though we have evidence of the lack of effectiveness of certain practices, it is sometimes impossible to fight against the recommendations made by governments or world organisations, whose conflicts of interests have not been made known. The ethics of negation (politely and firmly saying "no" to the demands of patients and authorities) and of ignorance (sharing with patients and authorities the curative and preventive limits of medicine) should not only form part of the clinical ethics of our healthcare professionals but also of those to whom the responsibility of healthcare policy is delegated.

When more is better if Primary Healthcare is desired and solvent

Willing to divest and reassign, one option to consider is the reinforcement of Primary Healthcare. However, a higher budget (reassignment) has to go hand in hand with a Primary Healthcare service that is obliged to demonstrate its solvency and social desirability, a healthcare service that is obliged to win back all the groups that have been gradually lost over the years and adopted by substitutes from other healthcare levels, obliged to provide quality healthcare services that are needed, close to patients' homes. Working independently with other professionals or otherwise, capitated financing, focusing on important tasks rather than the mundane, highly trained nursing staff, improving end-of-life care and avoidable hospitalisation are examples of robust Primary Healthcare. This should go jointly with public healthcare in order to achieve a dynamic and almost complete overview of a population's health, its social, economic and environmental conditioning factors and the initiatives that must be adopted to improve it. If possible, we need the support of the community itself, so that we can use the word "community" in our specialist title with pride.

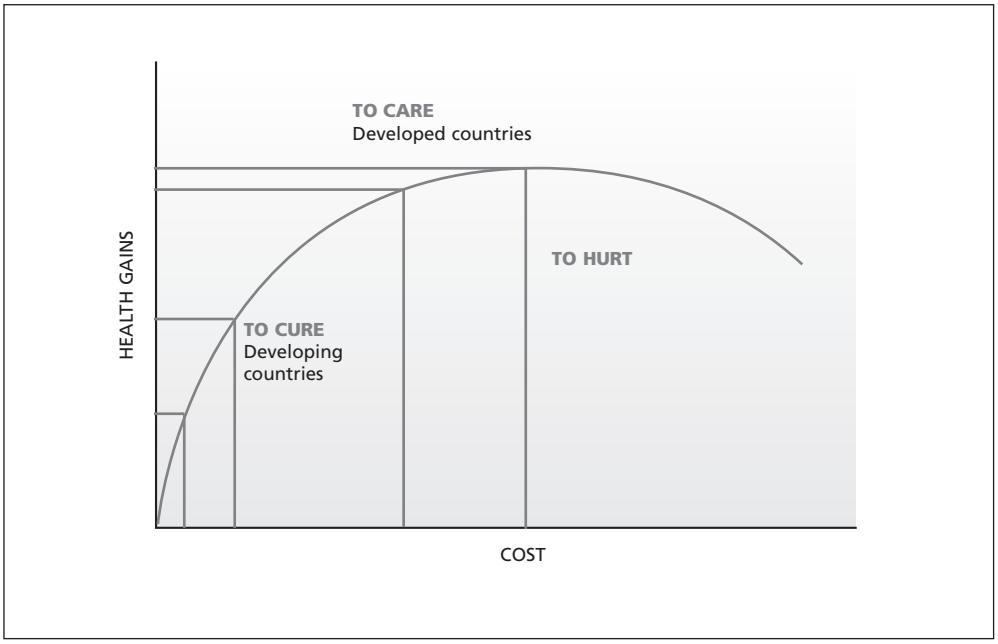

Figure 7-1. Concern about the evolution of healthcare expenditure: marginal productivity derived from the investment in health.
Source: own production.

CHAPTER 8

Crisis in Spain: how can we renew healthcare services?

Vicente Ortún and María Callejón

The factors determining health and the impact of healthcare services during an economic crisis

The economic crisis places public health in the spotlight and the notion of health in all policies. With no light at the end of the tunnel, the basic factors determining the state of the population's health emerge and risks that we thought long gone have reappeared, as a result of poor nutrition, unemployment and declining environmental and lifestyle conditions. We shouldn't forget that healthcare services are still newcomers to this constellation of factors that determine our health, and actions taken within the healthcare sphere cannot make up for the deterioration of some of the most basic fundamentals such as income or education. The economic crisis has returned income, education, environment and lifestyle to the top of the list as factors that influence health.

The healthcare component of the Spanish welfare state

In Spain, the decrease in public revenue has brought about changes in healthcare with varying degrees of success and legitimacy. Recovering the distinction between the main health insurance recipients and their beneficiaries could adversely affect social cohesion (exclusion of groups). The delimitation of benefits (portfolio of services) and co-payment reform appear to be necessary.

Improving productivity and having a Welfare State (WS) are not incompatible. The problem is not the WS itself but rather the type of WS and this is where Spain must continue to do its homework because the manner in which its WS is organised is neither equitable nor efficient, compared to European standards. Obligatory insurance has proven to be better in both theory and practice than a market with competing insurance companies. This does not mean that a single public insurance body is necessarily the

best organisational option. If coverage is provided on a needs basis and incentives are offered to prevent risk selection by insurers, then there is room for other forms of organisation. In order for the WS to continue to be a blessing for the healthcare system, attention must be focused on what and how we spend, on how we decide and how it is financed.

Selective public financing paying for the interests of society

It is good and cheap to use knowledge and practices that have been scrutinised in other countries, where compared efficacy and cost-effectiveness criteria in financing decisions and price setting are commonly used. The impact of health cutbacks can be minimised, provided that linearity is avoided: the instrument to be used is the doctor's scalpel, not the budget manager's scissors. Public revenue should be supplemented by co-payments, which despite their numerous flaws, can be designed more efficiently and fairly.

Integrated systems (where all social and health levels are effectively or virtually addressed) allow for better prevention, greater orientation towards Primary Healthcare, lower hospital admission and readmission rates, enhanced compliance of treatments by patients, incentives to avoid technology with dubious benefits and stimuli to tackle problems in the chain with greater decision-making capacity (clinical expression of efficiency). Two types of innovation are of particular interest: innovation that saves money and innovation that considerably and additionally improves quantity and the quality of life, in accordance with the incremental costs of existing technologies.

Planning, bridging the gap between efficacy and effectiveness, trimming the fat and reassignment

Healthcare usually uses mortality and morbidity as indicators that highlight need, especially when they measure the use of resources as a result of supply and demand. Supply affects use and expenditure but not results in terms of health, and professionals adapt easily to the availability of diagnostic tests and therapeutic resources at their disposal. The planning of human resources and materials facilitates specialisation, the obtainment of economies of scale and the use of technology that improves welfare, by preventing iatrogenesis and waste. This requires:

- Bridging the gap between efficacy and effectiveness, which involves turning knowledge into practice.
- Trimming the excess fat, the harmful fat, from healthcare services that are not worth what they cost, whether globally or in the case of a specific individual (inappropriateness).
- Eliminating financing, in whole or in part, for medication, devices and procedures with zero or low clinical value, promoting those with higher clinical value, enabling them to be financed by freed up resources.

Responsible autonomy, yardstick competition and reassignment of functions among healthcare personnel

Guaranteeing immortality to organisations and individuals is an infallible recipe for stagnation and debilitation. Innovation arises partly from need. Yardstick competition does not involve the market. It is not about price competition (sacrificing the qualities not perceived by users) or performing failproof experiments in the interest of making policy developers look good, but about introducing the idea that a minimum portion of the resources received by a healthcare organisation will depend on the quality provided compared to its peers. Prestigious clinics and experienced civil servants, both equipped with clinical and management skills, also explain improved performance in healthcare organisations as a result of better communication, greater credibility and authority. As far as the doctor's surgery is concerned, a division of work is required to address decision-making capacity and avoid guildism in order to achieve the essential economies of scale, range and learning required when caring for chronically- and acutely-ill patients.

It will be very difficult to improve public management or introduce healthcare reforms that notably enhance our productivity if there is no improvement in the quality of the policies and institutions affecting them. Better healthcare governance, including, inter alia, transparency, accountability, regulating conflicts of interests and professionalising the system's executive functions, is an important step in the right direction.

CHAPTER 9

The renewal of Primary Healthcare. Views from the field

Ricard Meneu and Salvador Peiró

Introduction

Like many of the buildings erected during the property bubble, the construction of Primary Healthcare in the SNS has been plagued with construction problems. Cracks, leaks, imperfections and filtrations have emerged in various ways, such as tolerance of the bureaucratisation of professional timetables, the commitment to a somewhat disproportionate concept of "prevention" that is inefficient and of questionable effectiveness, the abandonment or neglect (suicide) of "intrinsic" and "strategic" Primary Healthcare areas (such as home visits or the care of terminally ill patients), the inability to manage core aspects of activity (demand, prescriptions, time and work management), and the self-perception of being "Cinderella" –if not the "Ugly Duckling"– of the SNS, which accompanies what is defined in another chapter of this book as "profiting from burnout". As we witness the changes that are occurring at a rapid and dizzying pace in society, in illness patterns, technologies and in the healthcare organisation as a whole, we continue to be puzzled by –what in another chapter has been labelled - Primary Healthcare's "resistant climate".

Let us focus on the three issues that we felt required the most critical analysis: 1) the organisational redesign of Primary Healthcare; 2) the availability of comparative information and other matters affecting transparency; and 3) a change in the method of assessing quality flaws, defined as the difference between the processes and results observed in clinical practice and those that are potentially achievable.

Organisational redesign of Primary Healthcare

Rather than being standard, the modular structure of most healthcare centres is antiquated and has hardly changed over the last twenty-five vertiginous years, with no assessment of their original suitability, hardly any adaptation to the current environment and

with similar GP, paediatrician and nurse ratios. In addition, as shown in another chapter, emphasis is placed on giving the title of "team" to a group of professionals who have not chosen to form such a team and who have been "thrust" into almost lifelong professional marriages. Since these organisational surroundings are a foreseeable source of dissatisfaction, the limited interest in alternative designs is surprising: self-organisation or freelance working under contract /agreement with the SNS. Maintaining the *statutory status quo* leads to condemning these alternatives as "mercantilist" or "neoliberal", hindering management by corporate professionals and favouring administrative concessions given to business conglomerates to which Primary Healthcare is entrusted.

It would seem appropriate to considerably relax the assignment of patients to what is defined as "their area", which would facilitate greater control between centres and professionals. Reassigning functions within the team seems to be even more essential, to prevent the waste of knowledge and to allow administrative IT tasks to be assigned to less qualified personnel. Lastly, the tradition of meetings, of elected coordinators who are more concerned with "raising" professional complaints than "grounding" organisational strategies and the proliferation of managers, directors and deputy directors of medicine, nursing, administrative management and other procedures relating to specialised hospital care, now labeled as "Primary Healthcare", should be regarded as a threat to clinical management and desirable professional autonomy.

The transparency and comparative information shortfall

Basically, we consider that there are three particularly urgent issues:

— Improved patient information, from two perspectives: to choose among alternative suppliers and to explicitly include patients' preferences and expectations with regard to decisions concerning the care they receive. Furthermore, the system discourages professionals from attracting patients, making them an excessive burden which is unrewarded and even penalised.

— The availability of comparative public information on the different results of centres, teams and professionals, where relevant. Not only is this information easy for all citizens to understand, it is also used by the healthcare community in their work on benchmarking, mutual learning and quality improvement. There is a huge democratic shortfall when our governors "hijack" the information that allows their judgement to be measured.

— The transparency required in terms of conflicts of interest faced by all professionals in their relationships with the healthcare industry, with the ambitions of the government they serve, their own values and users' demands.

The quality shortfall

The quality and efficiency problems within Primary Healthcare can be divided into 4 large groups:

1) The underuse of efficient procedures and therapeutic failure, which increase "preventable" morbidity and mortality.

2) The overuse of unnecessary procedures including Primary Healthcare visits, referrals for specialised care and the massive surge of "non-urgent" patients towards hospital casualty services. Overuse implies unnecessary use and, therefore, the direct squandering of resources, but it also entails harm and indirectly, further waste.
3) Safety.
4) Waste: treatments (more expensive than others that are similarly effective), lack of care coordination (especially for chronic or weak patients), duplicity of diagnostic tests, engaging doctors and nurses in performing bureaucratic or administrative duties which could be performed by less qualified professionals.

The good governance shortfall and the pressing need to improve collective decisions

Public administrations attempt (or should attempt) to ensure that collective decisions adopted in relation to planning, financing, insurance and the purchase and production of services maximise results (effectiveness, safety, efficacy, budgetary control) for patients and populations (over and above customer yields or the electoral benefits of the governors in power). It is possible to include foolish benefits in the services portfolio that are not subsequently used, but it is more reasonable to exclude them. It is possible to have different prices for equivalent products and request professionals to use the cheaper ones, but it makes more sense to use the policies (benchmark prices, co-payments, exclusions) so that these products have similar costs for the healthcare system (not necessarily for the patients). It is important to significantly reduce coexistence between the industry and professionals, especially with regard to ongoing training, students and doctors in training, and institutional messages and acts.

In our opinion, three key concepts should guide us towards a renewal process that meets the "urgent need to improve" Primary Healthcare. Firstly, restructuring from the doctor's surgery upwards (as discussed in various chapters). Secondly, organisational redesign that requires profound reflection on prevailing procedures rather than huge structural changes. Thirdly, and perhaps the most difficult of all, the launch of tenders to manage public healthcare in a way that provides healthcare with maximum efficacy and efficiency and not only to achieve "savings", and which is governed by the same transparency, accountability and responsibility criteria that we expect from professionals.

The renewal of Primary Healthcare from the doctor's surgery

This book and the previous book, *The re-birth of Primary Care,* are based on a variety of experiences and knowledge, allowing coordinated healthcare to be provided at a time when society needs it the most. Although important functions need to be reassigned among the members of the healthcare symphony orchestra, the doctor will continue to be a benchmark, the leader whose prestige and social recognition must help tune the entire orchestra.

This is a partial translation but it paints a sufficiently clear picture of the current situation. We refer the reader to the original publication for more in-depth detail of the contents set forth herein. This summary will please healthcare professionals, citizens, managers and researchers of healthcare services by informing them and equipping them with the tools required in order to first of all understand and secondly, improve.