# Health Systems and Young Family Doctors

A report from the facilitators at the World Café workshop at the 2nd Vasco da Gama Forum in Dublin in 2015: The Best and Worst of Contemporary Health Systems in Europe.

With young family doctor participants and music from across Europe and beyond, the 'world café' format workshop on Health Systems kicked into action at the 2nd Vasco da Gama Movement's Forum in Dublin earlier this year.

The World Health Organization's 'Health System Building Blocks' provided a framework to three discussion rounds at six tables, each covering a different health system building block and facilitated by a VdGM member. The WHO's framework offered a structure under which participants were able to exchange knowledge and experiences of their own health system. Discussions were lively and dancing between discussion rounds was of the finest quality!

This article provides each facilitator's original report of discussions that took place with the aim of sharing the experience and inspiring other young family doctors across the WONCA network to think about their health system and how they can contribute to improving it considering the various 'building blocks'.

Reports follow from:
Service Delivery - Kalle Saikkonen (Finland)
Health Workforce - Eline Dekker (Netherlands)
Financing – Nina Monteiro (Portugal)
Information – Elena Klusova (Spain)
Medical Products, Vaccines and Technologies - Amy Morgan (Ireland)
Leadership & Governance - Claire Thomas (United Kingdom)

Service Delivery - Kalle Saikkonen (Finland)

In the three rounds of discussions we managed to delve into most of the pre-given possible stimulating questions and occasionally wandered out of bounds to touch upon issues and questions more closely associated with the other tables and themes. We had participants from Croatia, Denmark, Ireland, Netherlands, Portugal, Slovenia, Spain and UK.

We found out that although consisting of many of the same elements, the way health services are organized, financed and run varies quite a bit in different countries. In most countries access to health care services is at least on paper universal and relatively free of charge. Yet still, concerns were raised in our discussions over inequity in accessibility to services in many countries. Urban-rural, well off – deprived were the most common dividing lines.

We discovered that sometimes people's access to quality primary health care services is determined by sheer luck. Long waiting lists to public secondary care due to poor organizing, lack of communications, inadequate funding and shortage of workforce are a cause of distress and suffering for many a patient but also a real issue for system wide patient safety and cost-effectiveness in some countries. Out-of-hours and emergency services were quite universally considered to be inappropriately used as an overflow valve for the demand of PHC services or speed lane to the secondary care. In many countries there are deeply rooted customs valuing personal relations and connections that can drastically affect an individual's access to services. Some systems seem to exhibit embedded cronyism or clear corruption that drive inequity in accessibility to services on all levels. We also lively discussed the discontent of GPs in some countries with their limited role in service delivery and lack of recognition from their secondary and tertiary care colleagues and the general public.

We did discuss the good things about health care service delivery in our countries and systems as well. Free and universal access, at least in principle, was seen by many as the best feature in their respected systems. The Dutch and the Danish colleagues were happy about the relatively well established and clear division of roles and the smooth running of processes connecting PHC and specialist care in their systems which helps them to deliver proper service.

Discussions were lively and dancing was of the finest GP/FD-quality.
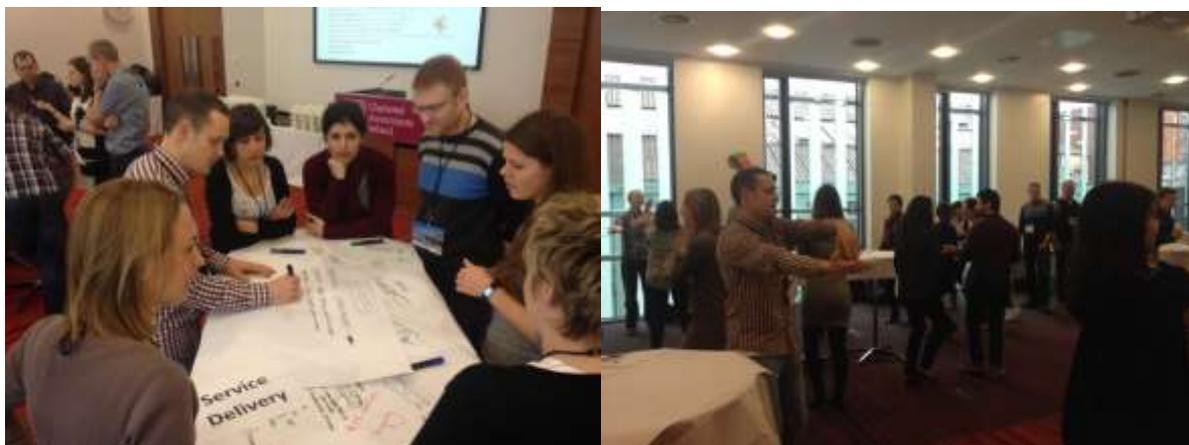
Health Workforce - Eline Dekker (Netherlands)

'Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country's health workforce consists broadly of health service providers and health management and support workers. This includes: private as well as public sector health workers; unpaid and paid workers; lay and professional cadres. Countries have enormous variation in the level, skill and gender-mix in their health workforce. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes.'(WHO 2007)

In the global health café workshop on the 2nd Vasco da Gama forum (21st February 2015) we discussed with GP trainees and young GP's from all over Europe about this topic. We discussed the differences in traineeships, organization of primary care in each country and what we could improve if we were the minister of health in our country. We had participants from France, the Netherlands, Denmark, Croatia, Spain, Ireland and Portugal. We faced a lot of differences between all the countries. For example length and content of the GP traineeship. In some countries (f.e. Croatia) a residency in General practice/Family medicine is not obligatory to work as a GP. Also the number of patients per GP varied widely from 1200 in France to 2150 in the Netherlands. The organization of primary care and use of allied professionals in the field (like practice nurses, social workers etcetera) varied widely. Each country faces its own problems that would like to be solved if we had more political influence. Of course budget of primary care was one of the core items but also health illiteracy (f.e. in Portugal) is a big problem.

As a summary of the discussion we concluded that when you have a happy and efficient healthcare workforce in your country this will lead to happy patients! (and of course improved quality of care)
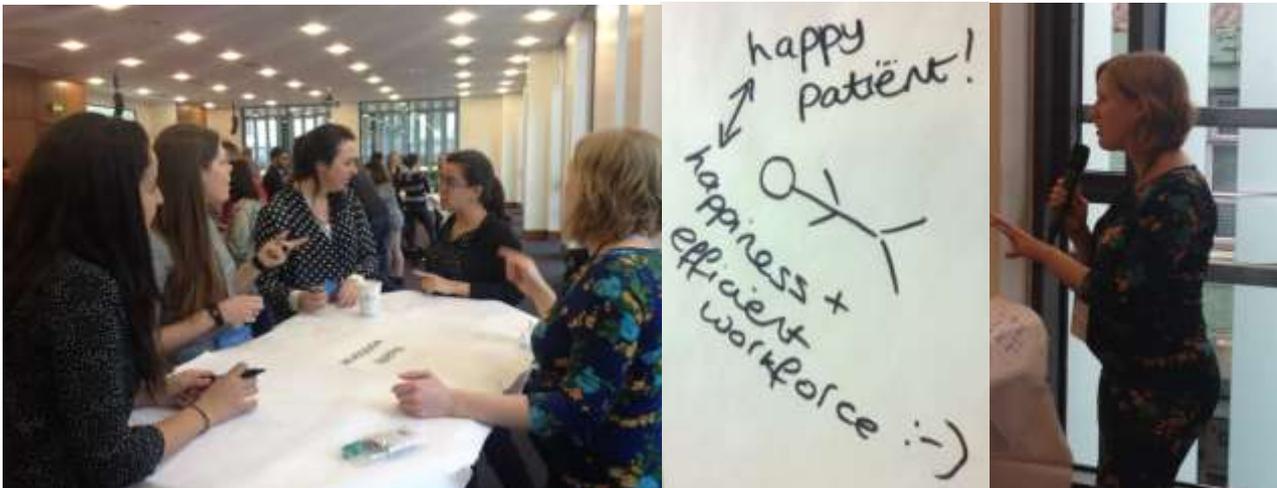
Financing – Nina Monteiro (Portugal)

In order to ensure a forceful Health System we need a financing system that is able to raise adequate funds for health. This was one of the topics discussed at the 2nd VdGM Forum's Global Health Café.

In the three discussion groups we always talked about how the money was collected in each of the participants' countries, ranging from general taxation in the UK to national insurance in The Netherlands. Everyone knew, more or less, how was the procedure in their working countries and we all agreed that the problem would be more on how the money is spent and not to so much on how it is collected. A common factor was that dental care is, in most realities, totally private, contributing to most of the out of the pocket money, as well as the payment for medication.

Another topic was how doctors are paid. There was a discussion regarding pay for performance, which may lead to a service quality improvement. However, that would be very much related to who makes the goals and what are the underlining objectives. On another hand, fee for service may change behaviours on medical staff and eventually lead to unnecessary treatments. There was a general agreement that capitation would probably be the most fair way of payment, though it has a risk of decreasing doctors' motivation.

Of course we also spoke about the economical crisis and the impact it has been having on health, in some countries more that others. And although current reality seems less brilliant, we concluded that there is hope. Primary Care, with effective preventive care and education to health, is a way to save money in not such a long period of time. So the policy makers should do incentives to Primary Care development, in a way of financing and others.
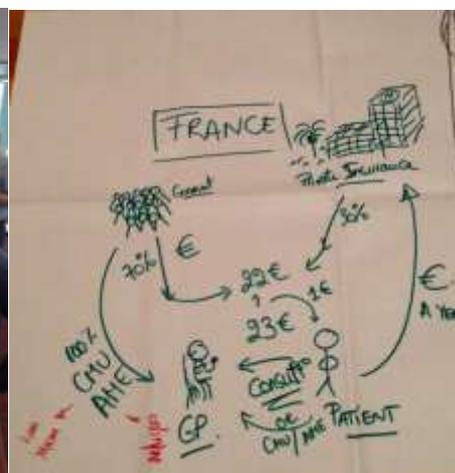
Information – Elena Klusova (Spain)

"One system bordering on perfection" A project of information structure for the Health System.

Health card with chip information:
- A part of usual details of social security number/mutuality/health insurance, document of identity and major personal data, the chip must contain an updated photo of whole body of the patient with glasses, cane, wheelchair and other information of the actual physical state.
- Real or virtual image of the patient with schematic and visual indication of major diseases and involvement of target organs to appreciate most relevant problems of the health of the patient in 1 second. (Stroke, IAM, DM, heart bypass, anticoagulant therapy, history of digestive bleeding, renal failure, rheumatoid arthritis, liver transplantation, prosthesis, deafness, HIV...) to be able to make quick but cautious decisions in emergency situations.
- Electronic Chip readable for workers in areas with permission adapted: medical specialty and primary care, hospitals, health centers, hospital emergency services and ambulances,.
- Access of pharmacists to the chip information relevant to their work with patient medication automatically updated.
- Access to some information on the health, diagnoses and treatments for the governmental agencies with special permits that are dedicated to statistical records.

Information, tools and ethical aspects
- Automatic transfer of data of the pathologies and treatments of patients relevant to the programs of studies and research.
- WEB 2.0
- Easy and intuitive community medicine network for the population with the continuously updated information on the - health education, - telephone numbers and addresses of neighbourhood associations, alcoholics anonymous, social aid, psychological support groups, information on homehelp, help for the care of children and the elderly, purchase and sale of articulated beds, wheelchairs, canes ... second-hand and other useful information for the economically unprotected.
- Programs of sanitary education for students of the schools and adult population
- Connection online between   the patient, physician, nurse and social worker.
- Direct and immediate information exchange between health care provider and pharmacist.
  Ease of advice on undesirable interactions and contraindications of the drug
  combinations.
- Alarms installed in the health care programs on undesirable interactions of drugs when advertising the treatment.
- Knowledge is power! Easy fast and intuitive access to guides, manuals, protocols and classifications from the medical program.
- Data protection and security of patient
- Keeping patients in the dark o give the access their own records? What must the patient know about his own illness and case history?

Other Questions not to forget although they had not been commented:
- Is there feedback on family doctors' performance? What is measured? Who is this shared with? The individual? Local doctors? Regional policy makers? Nationally? Publicly with patients? Anonymously or named (practice or individual level)?
- Can patients give their doctor a rating (like on Amazon)?

- Is there information on disease outbreaks easily available to you, guidance on what to do and easy mechanisms to report e.g. influenza, measles or even ebola?
- Is there information on inequities in health in your country or on the social determinants of health? Can you use this information to inform your work?
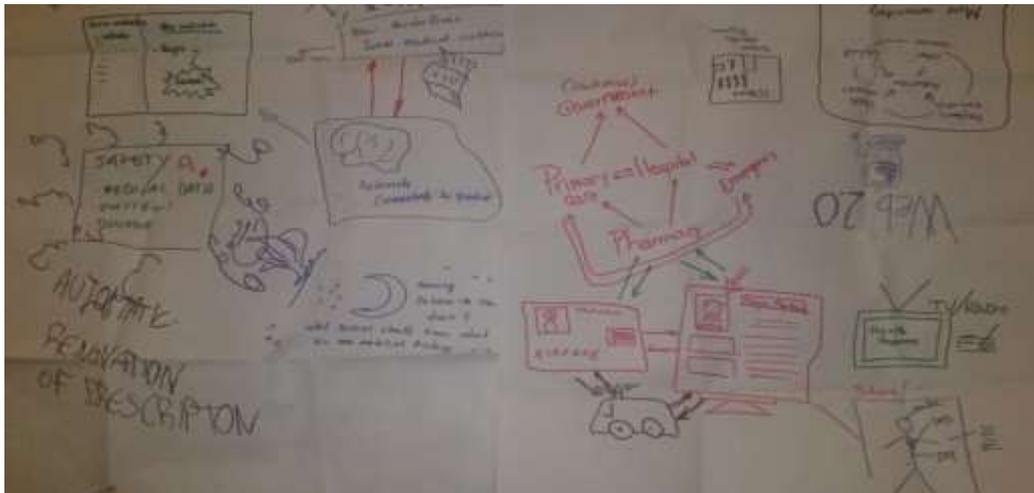
Medical Products, Vaccines and Technologies - Amy Morgan (Ireland)
We had such an energetic bunch of contributors! This is a broad area, with lots of scope across all areas of primary care delivery but some common themes emerged throughout the discussion with participants

Those themes were broadly as follows:
Prescribing; Control & Autonomy: All the delegates had some form of prescribing authority in their country, be it regional or local. There was a commonality for generic prescribing, & whilst the doctor still had autonomy over prescribing practices, there was generally an onus to prescribe generic medications. In some jurisdictions, there was legislation in place to ensure that pharmacists could supply generic form of medications, & if a GP wished to override this, a substantiating reason would have to be supplied. We discussed the pros & cons of such a system: Pros: reducing total pharmaceuticals spend, thus potentiating efficiencies across health system & health budget, possible potential to divert extra funding into primary care. Cons: incurring upon doctors autonomy of practice, 'Watchdog' effect, will budgetary gains really be spent wisely or diverted into secondary care.

The issue of prescribing data registries also came up: several countries had such a system in place to monitor prescribing practices for drugs such as BZ's, hypnotics (Ireland, Denmark) PPI's (Spain) for example. We felt that positive outcomes of this would be improved safety in prescribing practices, reduced drugs bill, & a greater awareness amongst primary care physicians about their own prescribing trends/habits & an ability to be able to react appropriately.

Pharmacists Emerging Role as Community Care Providers: all delegates acknowledged that health resources in general practice is a key concern within their own countries due to factors such as an aging population, & increasing comorbidities, against a backdrop of unfavourable health budgets due to austerity/ global recession. Therefore there appears to be an emerging trend by various governments & pharmacists across Europe to transfer certain aspects of care to the community pharmacy; e.g blood pressure monitoring, blood glucose testing, weight checks, prescribing emergency contraception etc with the goal to relieve the work burden of GP's, increase healthcare access to the public etc. We discussed that in some instances, far from reducing GP's work burdens, it may have the effect of increasing them, due to the inability of pharmacists to be able to initiate treatment & refer for appropriate investigations. We questioned whether in instances like a pharmacist prescribing emergency contraception, there may actually be a lost opportunity for GP/patient contact to provide screening for STI's, discussing contraceptive choices etc.

Emerging Technologies: Unique Patient Identifiers, 'all your data on a barcode?' This is an exciting time for emerging medical technology & we discussed the differences between various countries in adopting different methods into how family medicine is practiced on a daily basis. Canada, for example we learned has a unique patient barcode identification, stored on a card that the patient can swipe when collecting a prescription, attending a doctor etc. This code stores details such as the patients current prescription medications, medicines previously prescribed (including over the counter medicines), hospital records. We discussed that this would be of huge benefit to the patient & physicians, pharmacists as all healthcare providers would have up to date, accurate records, thus reducing prescribing errors such as duplication of prescriptions, & increasing awareness of drug interactions such as warfarin & certain antibiotics. It could also cut down on the need for other healthcare professionals to face delays in attempting to communicate others in order to receive up to date information & be able to make clinical choices safely & efficiently. We discussed that there needs

to be a consistent encouragement of developing safe, reliable medical information systems with proper resourcing for both implementation & integration of such systems (ie IT supports) & education of GP's & allied health professionals in order to adequately use them.

Vaccination Programmes: All the delegates generally agreed that in their own respective countries there existed a comprehensive childhood vaccination programme with no significant difference in terms of resources/vaccine allocations between rural & urban districts. Renumeration & staff resources (ie practice nurses) were largely deemed adequate for provision of such services & we all agreed that this was an example of where collaboration between GP's & Government can provide a successful health programme to a population at a relatively low cost, with largely good success rates/uptake across the various populations. We also discussed how optimization of a IT systems & electronic records in family practice can achieve better results in terms of vaccination targets due to facilities such as electronic reminders, automatically sending patient notifications of overdue vaccinations etc.

Leadership & Governance - Claire Thomas (United Kingdom)

During our dialogue it emerged that key to our understanding of the leadership and governance of our health systems was where we felt the power and influence lay; whether we felt that GPs were very far removed from the locus of control in a health system, or if they were well positioned to hold influence over policy and service development.

For many countries the healthcare leadership governing the delivery of Primary Care seemed to come from higher up the food chain, at national and governmental levels, thus sitting outside the average GP's perceived sphere of influence.

There was a sense that the power lay too heavily in the hands of politicians, subsequently leaving healthcare vulnerable to political agendas such as austerity. For many nationalities who joined us, including Portugal, UK and Spain, there was anger at perceived moves by political forces towards privatisation and away from universal health coverage. The pervading fear was that our health systems are subsequently increasingly vulnerable to corruption; that external parties may be benefiting inappropriately from the marketisation of health services.

Driven by these concerns we shifted our perspective to constructive solutions, including the role of strong professional bodies in creating a unified voice for our profession. We heard inspiring examples of healthcare professionals working together to attempt to reclaim power and influence over the direction of health services development... such as the "White Tide" (Marea Blanca) movement in Spain. In addition, we reflected that enhancing GP engagement could be aided by incorporating leadership & governance into GP training programs.

In conclusion, control and influence over health services often feels distant to the primary care doctor. However, the redressing of the power balance is best achieved when we work together, alongside other healthcare professionals and the public, to lobby for change.