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14 – An International Comparison of the Role of the Family Doctor in Different Countries and its Consequences on the National Health Outcomes and Expenditures: What has Changed in More than 10 years?

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In the 2002 WONCA Congress (London) Alberto Donzelli, Maria Enrica Bettinelli and I delivered the presentation "An International Comparison of the Role of the GP in Different Countries and its Consequences on the National Health Outcomes and Expenditures".

The authors are MDs, with clinical and organizational specializations, working for the NHS in the continuing education and management of >1000 GPs, in Milan, Italy. We addressed some issues about the organization of primary care in industrialized countries, looking at the available evidence.

The GP is the health professional closest to the greatest number of citizens and the only professional who can provide personalized/comprehensive care, including prevention, at reasonable costs.

In order to fully accomplish this task, GPs must coordinate and filter the market-driven increasing technological suggestions, be the patients' advocate in order to avoid unnecessary medicalisation, as well as consider the community's needs and attempt to influence the physical/social environment components of the disease.

The main issues regarding the GPs' role, how to finance them and organize the health service are:

- GPs (mainly) gate-keeper vs. direct provider of services
- GPs paid by capitation vs. fee-for-service
- Public NHS vs Health insurance-based

We considered the economic point-of-view of the NHS and the community's wider opinion, highlighting the more effective and cost-effective options on the basis of the available health and economic indicators. We chose the reliable, updated Organization for Economic and Cooperation Development/OECD Health database (2001), comparing it now with the 2013 OECD database (1) and others (2).

To measure the effectiveness and cost-effectiveness in producing health, we chose some proxy health and economic available indicators. Health indicators were life-years lost before 70 years for avoidable mortality; infant mortality; and rates of selected surgical interventions. The main economic indicator was the percentage of the Gross Domestic Product/GDP spent for health in every country, as total and public expenditures. We differentiated the countries according to the different GPs' role,

payment and health system model, with special interest for Italy, where the GPs are gate-keepers, paid mainly by capitation with some incentives, in a NHS. There is still political pressure towards more market and privatization, supposedly more cost-effective.

In 2002, with the exception of Portugal, the USA had the highest quantity of life-years-lost before 70 among the examined developed countries; in 2013 their life expectancy is still lower than the average of the 34 OECD countries (78.7 vs 80.1 years) and much lower than Italy, second-best within the whole evaluation (82.7 years).

The infant mortality pattern has not changed, with Nordic countries experiencing the lowest rates (2/1000 live births) and around 4/1000 in the other Western European countries and 6.1/1000 in the USA. The reduction in infant mortality has been slower in the USA than in most other OECD countries, with socio-economic/ethnic inequalities playing a significant role.

In 2002 the rates of some surgical elective procedures showed regional variations not consistent with any epidemiological pattern, but strongly correlated with the different method of payment of doctors and with the health systems' organizational structure. This is still valid today.

We addressed the question whether a GP is more effective and efficient when he/she is mainly a gate-keeper or a direct provider of services, even when these functions are compounded in the work of European GPs.

The Total Health Expenditure was higher in countries without a gate-keeping GP and with direct access to the specialist (i.e. USA, Switzerland, France, Belgium…). The countries with gate-keepers (i.e. Italy, UK, Spain…) spent less and achieved better health results. Since 2002 the European economic situation has deteriorated and health expenditure has abruptly decreased in some countries (Greece), but the main findings seem still valid.

If the main source of income and gratification comes from the direct provision of services, especially if highly technological, this could divert GPs from the fundamental role of gate-keeping. Under these circumstances, they must question the appropriateness of many prescriptions or suggestions coming from hospitals or university specialists. The gate-keeping task often makes the doctor-patient relationship problematic, especially if it has not been included in the education and training and is not seen as important or valued by the health system and community. The public should be educated on the value of the gate-keeping function and its ethical significance for a better use of available resources.

The direct provision of additional services is usually linked to fee-for-service payments and where they are used the per-person total and public expenditures are higher than where capitation or salary are preferred. Doctors seem to provide the best rewarded services, even if they are aware of their questionable health value (3).

The capitation payment should also be preserved for ethical reasons, being more suitable to comprehensive care, prevention included, according to the patient's needs. It should evolve towards an age-weighted capitation formula with a progression by age, weighted more towards the elderly (and infants) than the young (4). It could be integrated by incentives based on results/levels-of-result, especially in crucial areas such as the anti-smoking and breast-feeding counselling in Italy.

The General Medical Contract/GMS for GPs with its related Quality Outcome Framework/QOF, introduced in 2004 in the UK and continually readjusted, showed that the P4P was more expensive than expected because most GPs have reached the fixed goals, concentrating their efforts on the targeted areas only. Our model with a strongly age-weighted capitation is more comprehensive and should avoid the latter.

The role of GPs is also preventative; increased financial reward for older patients should encourage every evidence-based preventative efforts to ensure a healthy old age for their patients, avoiding unnecessary diagnostics and treatment, recently defined as "quaternary prevention" (5). To sum up: "A system that pays for health and not for disease".

Comparing Insurance–based and NH services, the *total* health expenditures are obviously not contained by the former, and such systems are not able to contain the *public* expenditure, both in the non-profit version ("mutuel", "Krankenkassen"…) and in the profit ones (private insurance companies) which also have the worst health outcomes.

Take Home Messages

- National health services are still the more effective and efficient health systems
- Within them, GPs should have a strong role as gate-keeper
- GPs should be paid by a weighted capitation system, integrated by outcome-based incentives
- Fee-for-service payments and other systems paying for disease (disease management…) and for processes (pay-for-performance/P4P…) should be dismissed in favour of a system paying for health (and for a long healthy life of the citizens)

Original Abstract

http://www.woncaeurope.org/content/419-international-comparison-role-general-practitioner-gp-different-countries-and-its

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