Evaluation of Primary Health Care in Slovak Republic

Recommended policy action
on the basis of the PCET

Launch meeting, Vysoké Tatry , 11 October 2012

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Recommended policy action

4 groups of recommendations

1. Governance and regulation

2. Education & professional development

3. Financing and incentives

4. Service delivery

1. Governance and regulation

- ***Primary care policy development***

"A coherent PHC/GP policy should be developed, reflecting changing population health needs and current challenges in the health care system. Central and local leadership would be required to implement this policy."

Weaknesses and challenges identified in the report point to the need for a vision for PHC and for leadership to deliver the vision in collaboration with stakeholders. This might include: providing a more comprehensive package of PHC services and reducing high referral rates; improving coordination for patients with chronic conditions; and achieving a more systematic approach to prevention in PHC. This demands for well-defined roles and domains, clear norms and proper conditions and resources. Points like these were included in the Concept of Health Care, but have not yet been addressed effectively.

- ***Primary care at the MoH***

“Consideration should be given to organizing responsibilities for PHC at the Ministry of Health more effectively”.

Four departments are currently involved with PHC, while general medicine for adults and general care of children and adolescents have their own chief specialists. This fragmentation may pose an obstacle for integrated policy-making. An option could be to establish a special unit for PHC in the Health Section of the MoH to coordinate all issues related to PHC

- ***Referral system***

“The re-introduction of a referral system in PHC should be considered”.

GPs’ high referral rates suggest inefficiencies and underuse of PHC’s potential. The current task profile of GPs provides sufficient grounds for seeking improvement. Removal of the obligatory referral system seems to be a move in the wrong direction; international evidence has shown that strong PHC, including a referral system, is better able to control the cost of health care and maintain quality of care.

- ***Human resources for PHC***

"A human resource planning strategy for GPs and nurses in PHC should be developed with education plans to ensure sufficient doctors and nurses to meet future needs, based on established norms. Obstacles to becoming a GP should be removed".

Only 19% of all active physicians are working in primary care. The rising age profile of GPs is alarming, with many due to retire in the near future. Although official norms for GP establishments do not exist, a quarter of GPs in the survey reported shortages in their area. The inflow of new GPs is stagnating and insufficient, probably because the profession is not sufficiently attractive to potential recruits. Fifteen per cent of graduates take positions outside primary care. Migration of health personnel is another unfavourable factor.

- ***Practice information system***

“The use of computers for medical records and exchanging information with other health care workers should be strongly encouraged”.

The survey showed that many GPs are neither using their computer for keeping medical records nor for sending referral letters to medical specialists.

- ***The voice of patients***

“More opportunities to hear the voice of patients in PHC should be created. Complaints procedures should be formalized and coordinated and other forms of feedback from patients in the GP practice should be encouraged”.

Complaints are dealt with at central level by various bodies and agencies but without much coordination, and the survey showed an absence of complaints procedures in most GP practices. The central handling of complaints should not replace a complaints procedure in GP practices. In addition, systematic feedback from patients (other than in the form of complaints) can serve as a powerful tool for GPs to improve the quality of their services. The survey suggests that most GPs do not investigate the satisfaction of their patients.

- ***Premises in primary care***

“Norms for the quality of PHC practice facilities should be maintained and expanded, if necessary”.

Patients were critical about accessibility of practice premises for disabled people and wheelchair users, which is a formal requirement. Many patients found waiting rooms unsatisfactory. Results from the GP survey pointed to the absence of medical equipment that should be available according to official norms.

- ***The role of self-governing regions***

"An investigation should be mounted into whether self-governing regions have sufficient competencies and resources to control the distribution and quality of services".

Regions are largely responsible for supply of PHC in line with local needs. There are indications of inequities between regions and between districts within regions. No information was available on the activities that regions undertake to control health care services (such as inspections of practices and publication of audit results) and explanations as to why some regions are more active in this respect are lacking. Regions and health insurance companies could work together to maintain good local PHC services.

2. Education and professional development

- ***GP Clinical guidelines***

"Clinical guidelines specifically for GPs should be promoted. Guidelines should have a practical focus, be produced with inputs from practitioners and implemented along professional lines".

While directives are produced and distributed by the MoH, there is no structure for the production and updating of GP clinical guidelines. The survey showed that fewer than half of the GPs indicated that they used guidelines frequently. For practical reasons, the use of foreign clinical guidelines in cooperation with a GP association in that country, such as the Czech Republic, offers a feasible option.

- ***Postgraduate training in GP***

"An investigation should be mounted to establish to what extent the inflow of new GPs is hampered through no payment being available for the 36 months of specialization to become certified as a GP".

Payment during the three-years specialization period is not stipulated in law. Trainees may be paid by their future employer, such as a hospital, but this is not an option for GPs, who are independent entrepreneurs. Those who cannot find a sponsor for the training period are unlikely to become GPs. Strategies aiming to address the expected shortage of GPs in the near future may fail because of this structural obstacle.

3. Financing and incentives

- ***Role of health insurance companies***

"Health insurance companies should be enabled and encouraged to use their role as contractors and purchasers of health services to improve efficiency, quality and responsiveness in PHC and to avoid geographical inequalities in service provision".

Health insurance companies play a marginal role in maintaining and promoting quality of care. The current framework agreement is a not binding recommendation. They nevertheless have an opportunity, in principle and in collaboration with regional authorities, to use (variable) contracts to stimulate the provision of services for which there is a need in defined geographic areas. Obstacles to developing this role should be removed.

- ***Payment system for GPs***

"GPs' capitation payment should clearly define the services included. Additional payment should be available for specific services provided within PHC".

The package of services under the capitation fee is not currently sufficiently defined. Certain services, such as those focusing on care for chronic conditions or prevention, are not provided due to financing being unavailable or unclear. The definition of services could include quality indicators.

4. Service delivery

- ***Comprehensiveness of GP services***

"The scope of GP services for patients with chronic conditions, minor surgery and population-based prevention should be expanded. Opportunities and parameters for expansion should be investigated and coordinated with stakeholders. Expansion should then be implemented in a stepwise fashion".

The survey showed high referral rates of GPs and a limited service profile. Legal barriers that prevent GPs from providing certain services (e.g with chronic care, prevention and minor surgery) should be removed. Foreign experiences show that provision of a broad range of services to the population is possible with a good skill mix and coordinated care. GPs' service profile should be the reflection of a comprehensive PHC vision. The MoH, the regions, educators and other stakeholders should be involved in implementation.

- ***Coherence in primary care***

“Teamwork and networking in primary care should be actively promoted.”

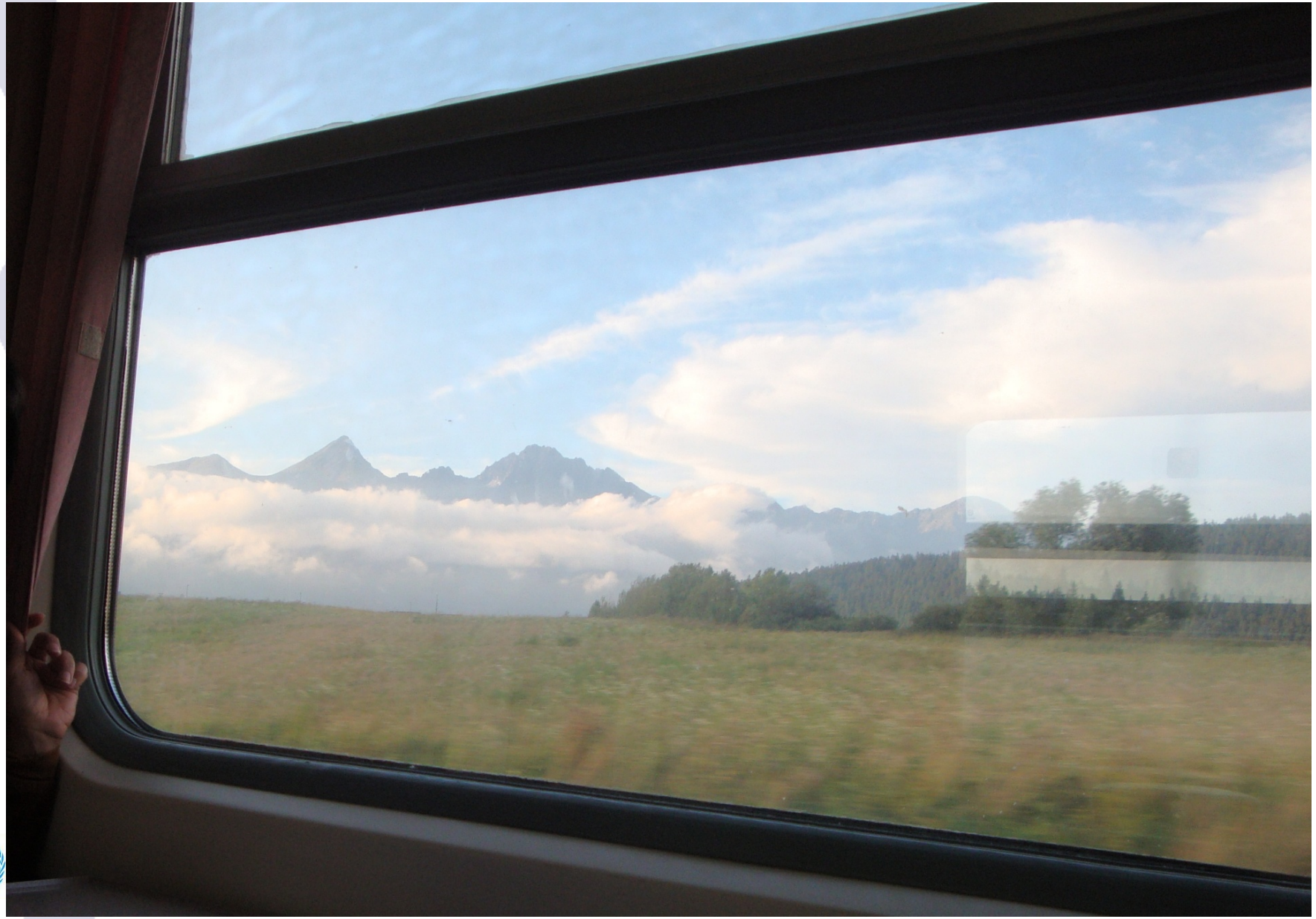
Many GPs work in shared premises with other GPs and health care workers. The opportunities for effective cooperation and teamwork are not used. On a voluntary basis, GPs should be stimulated to develop forms of cooperation with a focus on integrated care and quality assurance. The contract with the health insurance companies could be a framework in which this could be promoted.

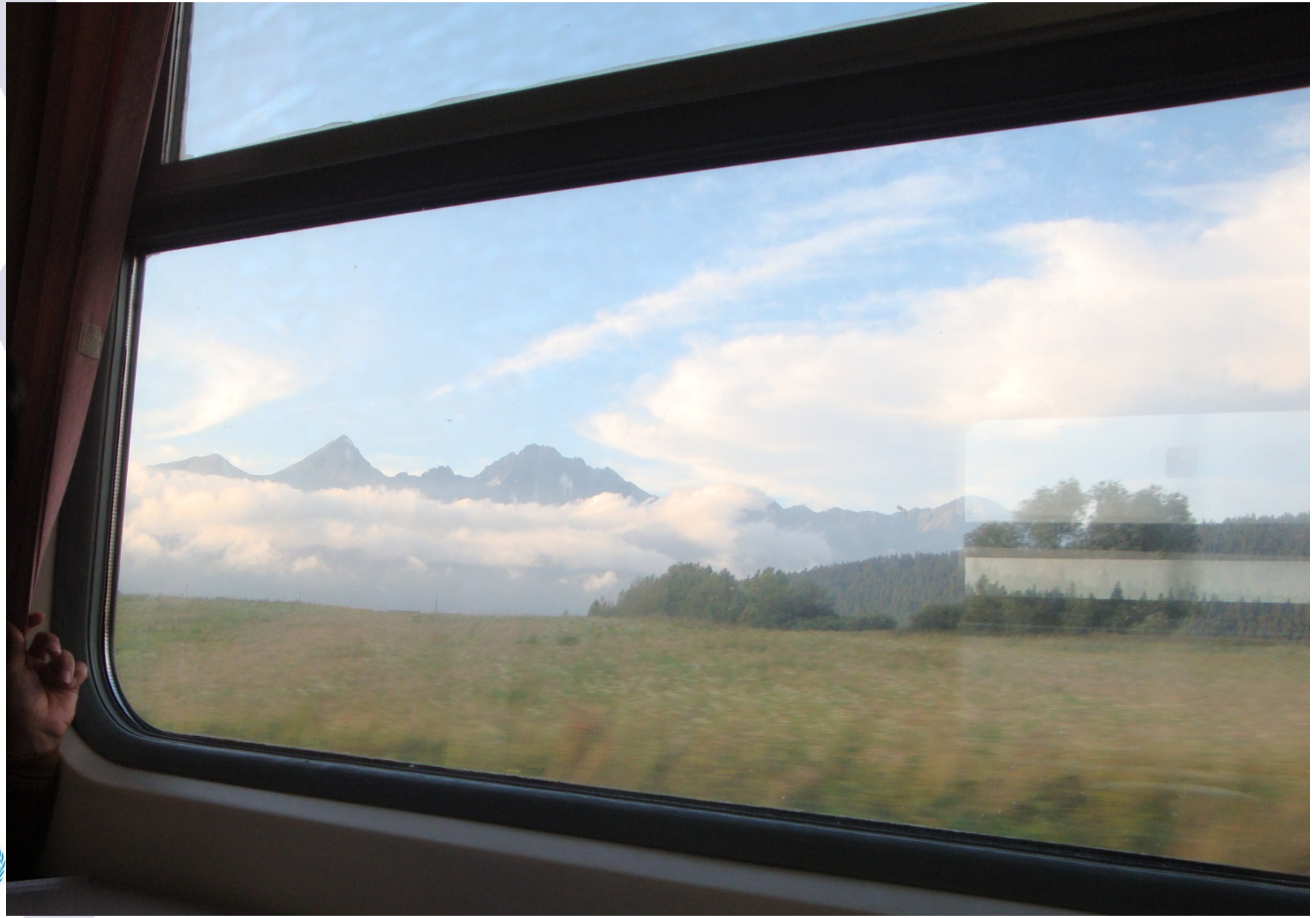
Conclusion

…. Led by an articulated vision of the government on health care and PHC,

…. stakeholders should work in a coordinated and balanced way

….. towards further development of PHC in the Slovak Republic.





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