

GROUNDWORK FOR PRIMARY CARE IN SLOVAKIA

Report from an EC/Phare project

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PREFACE

This is a report of the project 'Primary Health Care Financing in the Slovak Republic', which was funded by the European Union in the framework of the Phare programme. It was carried out from the end of January to the end of November 1997 by a multidisciplinary team of consultants from the Netherlands, directed by NIVEL, and in close collaboration with a team of Slovak experts.

This report contains a detailed description of the aims of the project, the resulting activities and the conclusions and recommendations. As a background there is information on the Slovak health care system and its current urgent problems. The project was commissioned primarily from the need for cost containment in the Slovak health care system. More specifically, the four areas in which activities were undertaken were given by the Terms of Reference made by the Slovak Government which served as the input to the proposal. Since a major proportion of expenditures in health care directly result from decisions taken in primary care, the focus was on that segment of health care. In addition to developing financial instruments and incentives we focused on quality improvement and training. As suggested in the title of this publication, the outcomes of the project require to be tested and implemented on a wider scale. A continued project is foreseen later in 1998.

The achievements of this project are a product of the quality of the cooperation of those involved. We are grateful to the local partners Dr. Eva Durechova and Dr. Jan Goljer from Bratislava, who have been quite valuable liaisons and who did a lot of preparatory work to meetings and workshops. Furthermore Dr. Zora Bruchacova from the Ministry of Health should be acknowledged as the coordinator of the Phare programme, and Dr. Lubos Pinter and mr. David Simpson, for their contributions from the Project Management Unit (PMU) in Bratislava *.

* A list of experts to this project has been added as an annex.

1 INTRODUCTION

The reform process in the Slovak health care system started in 1990 when the country was still unified in the federation with the Czech Republic. Major changes have been the shift from a tax based state monopoly to a decentralised health insurance system, increased choice for the patients and important privatisations in primary care. Despite these efforts, the health care system still faces symptoms of imbalance. Urgent symptoms are in the financial situation: so far, acceptable and effective means to control health care costs are lacking. Deficits with the health insurance funds resulted in slow or partial payments of health care providers and institutions. In a number of cases this has created acute situations. Given these and other challenges, the Slovak government in collaboration with the European Union, has launched a Phare programme focusing on four key areas: health financing and control; health care management; primary health care services and privatisation.

The project at issue, has specifically addressed remuneration and financial control in primary health care, containing costs of pharmaceutical prescriptions, improving quality of care and competence of doctors in primary care and generating the information which is needed to realise these goals.

Strengthening the effectiveness and efficiency in primary care, so that the volume of specialist and hospital care can be reduced, is a major strategy in controlling health care costs. This requires qualified and sufficiently equipped doctors in primary care working in collaboration with other professionals. In a situation where physicians are independently established an exclusive top-down quality control is no longer adequate. Modern methods, more decentralised and based on grassroots level, are more effective in addition to central regulation. Tasks in the maintenance of quality assurance can be delegated to a certain extent to professional organisations, such as the Medical Chamber. In other countries self-control from within the profession has proven to be quite effective.

This report has been structured as follows. As a description of the context of this project the next chapter will deal with the health care and health care reform in Slovakia. Chapter 3 also contains background information; results from a European study show the position of Slovak primary care doctors in comparison to their colleagues abroad. Chapter 4 specifies the goals, means and conditions of this Phare project. The following four chapters deal with an explanation of the activities and results in each of the four areas of the project. Chapter 5 is about the remuneration system and financial control; chapter 6 is on pharmaceutical cost containment; chapter 7 is on quality of care and chapter 8 is on the provision of information on the shorter and the longer term. Conclusions and recommendations are made in chapter 9. The final chapter 10 is a formal evaluation of the process and outcomes in relation to the planned programme.

2 THE CONTEXT OF HEALTH CARE AND REFORM

After the tax-financed and state-run system was abolished, in 1992, a decentralised system developed, which was financed through compulsory health insurance. Nowadays, primary care, dental services and pharmacies have been completely privatised, while hospital facilities have got a semi-autonomous status as legal entities supervised by the Ministry of Health. The ownership of the spas is being transferred to private owners. Formally, health care provision is still free at the point of delivery, although this is increasingly threatened by acute funding problems. Particularly, in primary care various forms of co-payment are not rare.

2.1 Planning and management

Overall health care planning and management has been delegated to the Ministry of Health by law (Act on Health Care nr. 277/1994). This Act contains minimum requirements for health care facilities, e.g. on manpower, equipment and the range of services. Within this legal framework, management of the health care facilities has been largely delegated to the health authorities in the 8 regions and 79 districts which were created in 1996 by the Act on a New Territorial-Administrative Division. Although municipalities can own local health centres since the early 90s, this opportunity has not yet been used. In a similar way most hospitals are still state-owned. There are three exceptions: one hospital is run by a district, one by the church and one by an industrial company. It is expected that an increasing number of, mainly smaller hospitals will be under the supervision of districts. State hospitals are semi-autonomous bodies with a director appointed by the Ministry of Health and an advisory board consisting of the hospital's deputies or heads of departments. In addition an administrative board has been introduced with representatives of the Ministry, the municipality, health insurance companies and the local industry (as potential sponsor).

2.2 The financing system

The National Insurance Company, founded with the 1992 health care reform, was the first legal basis for the operation of the Health Insurance Plan. Until 1994 the company was to finance not only health care, but also sickness and pensions; financial resources were still from the state budget. In 1994 health insurance was split from sickness and pensions and became formally independent from the state budget. The Act nr.273 on Health Insurance in 1995 created the possibility for a diversity of health insurance companies. Nowadays there are 10 of them, the biggest of which is the General Health Insurance Company. GHIC covers about two-thirds of the population, among which the economically inactive. Besides, there are three sectoral insurance companies, with slightly different coverage, respectively for the ministries of Internal Affairs, Defence and Transport&Communication. Finally, there are six more - private - insurance companies, whose solvability has not been guaranteed by the government. Legal requirements put restrictions on the establishment of new insurance companies. For instance, these need at least 300.000 insurees and a certain amount of financial reserves. Services covered by the compulsory insurance are specified in the Health

Insurance Plan. Some competition among insurers is possible in offering voluntary additional coverage. Health insurance premiums are income related with an individual upper limit. The self-employed pay 13.7% of their 'premium income'. Employees pay 3.7% themselves, while their employer contributes the remaining 10% of their 'premium income'. The system is completely individualised; the insurance plan does not cover family members. Premiums for the benefit of children, pensioners, persons caring for children or disabled, soldiers, prisoners and refugees are paid by the state (originally 13.7% of the legal minimum wage; later sensibly reduced). The Employment Fund pays for the unemployed. This situation implies that, at present, indirectly most of the health care budget is still from the state.

The financial situation of the GHIC is very difficult. Its insurees are the lowest paid in the country and are among the highest users of health care. Besides, the state contribution on behalf of the economically inactive (two-third of the population) was reduced: the contribution was no longer 13.7% of the minimum wage, but 13.7% of a fraction (80% in 1996) of the minimum wage. The resulting deficits with the health insurance funds in turn resulted in delayed payments to health care providers and facilities. In 1995 debts of insurance companies and health care facilities were compensated by the state. In the same year a redistribution system for health insurance premiums was introduced to compensate for the unequal age and income distribution of insurees among insurance companies.

Hospitals are paid by the health insurance companies on the basis of contracted bed-day prices. Health personnel in the hospital sector are all salaried. Primary care has been privatised and the remuneration system changed several times in a few years time. Nowadays doctors are remunerated by a mix of capitation fees (about 60% of their income) and fees for items of service. Patients can change from one doctor to another once per 6 months. Details of the declaration system, both the description of the services to be remunerated and the level of payment, vary from one insurance company to another. Remuneration is based on a so called point system; in an official list a number of declaration points is attached to each item of service. One point equals a certain number of Crowns (usually established afterwards). So, the number of points that a doctor makes in a period of time determines the sum to be paid. The insurance company of the Ministry of Interior has simplified the point system by defining groups of activities instead of separate details. Ambulatory specialists are also paid per item of service.

Due to the low level of payments and delay or reductions from the side of the health insurance companies many forms of co-payment seem to occur nowadays, such as additional 'subscription fees' and surcharges per treatment. In this way many practices have made their own additional price policy. It is unknown to which extent this has replaced the under-the-counter payments which were usual, especially in dental care and various specialties.

2.3 The delivery system

Primary care is provided by privatised 'general practitioners', paediatricians and gynaecologists/obstetricians, each for their specific segment of the population. Secondary care providers are the medical specialists, either working in an outpatient setting (polyclinic) or in a hospital. Specialists in polyclinics are largely privatised.

There are several types of hospitals: local hospitals, part of these do not offer all of the four basic wards (internal medicine, gynaecology/obstetrics, surgery and paediatrics); district hospitals, with basic and some specialised departments; regional hospitals, with

a full range of specialties and the national categorial institutes.

In terms of manpower and facilities the volume of the (formal) Slovak health care system shows a decreasing tendency (see table below).

Table 1 Volume of in-patient and out-patient supply in the Slovak Republic 1992-1994

	1994	1993	1992
Inpatient (84 hospitals):			
beds	37,962 (-9.5%)	41,926	n.a
beds/10,000	70.9	78.9	n.a
bed occupancy (%)	76.6	74.2	n.a
length of stay	11.4	11.6	
Out-patient:			
establishments	1,673 (-7.2%)	1,803 (-6.1%)	1,920
physicians	8,606 (-7.4%)	9,293 (-2.3%)	9,508
geriatric nurses (home care)	604 (+5.8%)	571	n.a
Patient populations:			
adults per district doctor	2,084 (+14.1%)	1,827 (+24.5%)	1,467
<18 per district paediatrician	1,451 (+4.1%)	1,394	n.a
women per distr.gynaecologist	7,110 (+7.0%)	7,642	n.a

Bed supply, both in absolute numbers and relatively, reduced by almost 10% from 1993 to 1994. Bed occupancy rate and average length of stay in hospital improved slightly. The number of polyclinics and health posts throughout the country decreased from 1992 to 1994 by almost 13%. In the same period of time the number of doctors in outpatient care diminished by 902 which equals to minus 9.5%. Consequently the population-doctor ratio increased; most dramatically with district doctors whose average patient population rose in two years time by 42%. Obviously the reduction of doctors in outpatient care was sharpest among the general district doctors. The statistical information does not give clues about the current activities of the doctors who left the job. They say most of them are working in the private sector related to health care (e.g. in pharmaceutical companies). It is unknown if they are still 'on the market', for instance as doctor for private patients only or that they are no longer in medicine at all. An exception to the trend in the table above was the almost 6% increase in the number of geriatric nurse, who care for the elderly and the chronically ill in their homes. Despite this increase, however, there is one nurse available on an average 65+ population of 950, which practically means that in many districts these home nurses are not available at all.

The geographical distribution of outpatient care is unequal. In cities, for instance, there is (at least theoretically) one outpatient doctor on an average of 400 population while in rural areas and small towns primary care doctors are responsible for an average population of 1150. Nowadays, after the privatisation, primary care doctors usually work in single handed practice. Many rent one or more rooms and equipment from the polyclinic where they used to work and in the premises of which they continued to

work. In addition to the general physicians also specialists are attached to polyclinics; e.g. ophthalmologists, neurologists, psychiatrists, otorhinolaryngologists, surgeons, diabetologists and cardiologists. Polyclinics have their own diagnostic facilities (laboratory and X-ray). General physicians in primary care only provide a legally limited range of examinations and interventions. For investigations and treatment the patient is usually referred to a so-called 'narrow specialist'. With a few exceptions patients are not allowed to address a specialist without a referral.

In addition to curative tasks primary care paediatricians are involved in immunisation and screening activities and gynaecologists in family planning. The first contact with health services may also be with a company doctor. The network of occupational medicine focuses on protection against occupational diseases, accident prevention and first aid. It also includes regular check ups of people working in high risk working places. Many company doctors now work in a general practice; sometime with an additional contract to one or more companies for occupational tasks.

2.4 Hospital key figures in international comparison

In table 2 reference is made to a number of key statistics of western european countries (reference year 1992; Slovak Republic 1994).

Table 2 International comparison of key figures

	In-patient beds/1000	Acute beds/1000	Length of hosp.stay	Physicians 0/00 of pop.
Austria	9.7	5.5	11.1	2.3
Denmark	5.1	4.2	7.5	2.8
France	9.5	5.0	11.7	2.7
Germany	10.1	7.2	15.8	3.2
Ireland	5.4	3.4	7.7	1.7
Netherlands	11.4	4.0	10.1	1.5
United Kingdom	5.4	2.2	12.3	1.5
Slovak Republic	11.3	7.1	11.4	3.1

Slovak Republic is higher than most western european countries in the table with respect to the four key statistics. However it cannot be concluded that there is a real gap. Variation among the countries is large. Ireland and the United Kingdom, for example, have relatively very small hospital sectors, while bed supply is twice as large in Germany, which is comparable to the Slovak situation. The average length of stay in hospital in Slovakia, which cannot be interpreted easily because of the unknown variation, does not deviate from the other countries. The relative number of doctors is high; in several countries the population per doctor is twice that in Slovakia. But, here again, the same goes for Germany.

2.5 Some process and outcome measures

In polyclinics and rural health posts 1238 examinations/treatments per 100 population have been done in 1994. If we understand that no episodes of treatment are counted here, the annual average contact rate in outpatient care is 12.3. This is similar to the german contact rate with any physician in 1992, but very high as compared to the other countries in western Europe (e.g. Austria 6.0; France 6.1; United Kingdom 5.8; Ne-

therlands 5.7). The highest attendance rates in Slovakia were with paediatric/adolescents care, general medicine, gynaecology, internal medicine and dental (stomatological) care. From the contacts of general practitioners/district doctors 30% was in the patient's home as first medical aid. Gross mortality rate in 1994 was 9.61 per 100.000. Highest mortality was for disorders of the circular system (5.25), followed by tumors (2.01). Third group of mortality is formed by injuries, poisoning and other consequences of external causes (.69). The average life expectancy at birth in 1994 was 68.3 years for men and 76.5 years for women. Compared to countries in western Europe life expectancy in Slovakia is still behind, about 5 years for men and 3 years for women.

3 SLOVAK GENERAL PHYSICIANS IN A EUROPEAN PERSPECTIVE

3.1 Introduction

In the European Study on Task Profiles of General Practitioners data have been collected with about 8,000 primary care doctors in 34 European countries on the range of curative and preventive services they provided, the practice organisation and available equipment, patient contacts and workload and job satisfaction. The study was funded by the European Commission in the BIOMED1 programme. Data collection took place in 1993 and 1994, except for the Slovak Republic where about one-third was collected in 1994 and two-thirds in 1996. In countries where more than one type of GP is operative in primary care, like in the Slovak Republic, district doctors, which are sometimes called GP for adults or therapist, were taken as target population. In this chapter a number of key figures will be presented, thus offering an international comparison of the position of Slovak 'GPs' in comparison to colleagues in both central/east and western Europe. (For more details see Boerma et al., 1997) The following subjects have been selected here for consideration:

- The role of the GP in the **first contact** with health problems of the population (i.e. the point of access to health care).
- The application of **minor surgery** and some other medical techniques.
- The degree of involvement of GPs in **treating (chronic) diseases**.
- The medical **practice equipment** that GPs have at their disposal for diagnostic and treatment purposes (the availability of 25 items of equipment).
- The number of **working hours** of GPs normally make per week (excluding night shifts etc.).
- The number of hours GPs normally spend on **keeping up-to-date** (i.e. continuing medical education).
- The number of **face-to-face contacts** with patients (per average working day).
- The (estimated) average number of **home visits** per week.

Results have been presented in a series of diagrams, followed by a conclusion. Scoring values are explained in a technical note at the end of this chapter.

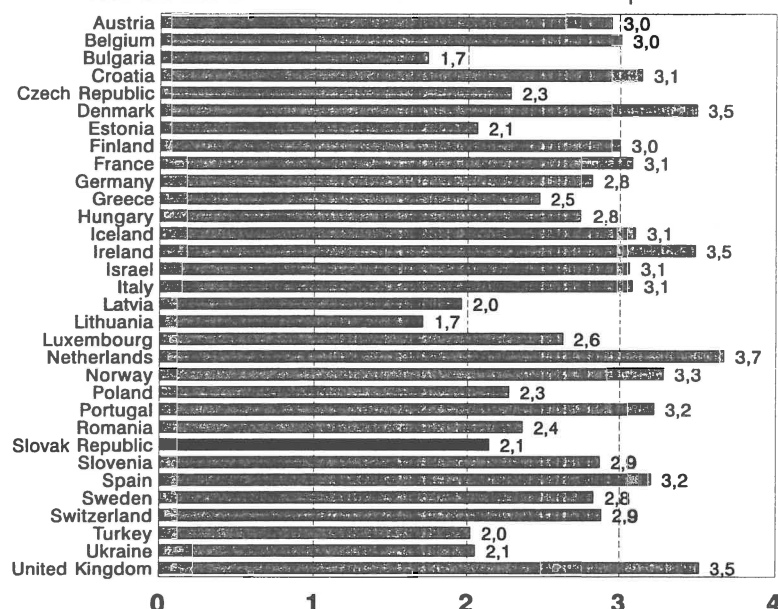
3.2 Profiles of services

The figures 3.1, 3.2 and 3.3 show results on the first contact position, the application of medical technical procedures and treatment of a range of diseases *.

* Explanation on scorings in figure 3.1, 3.2 and 3.3.

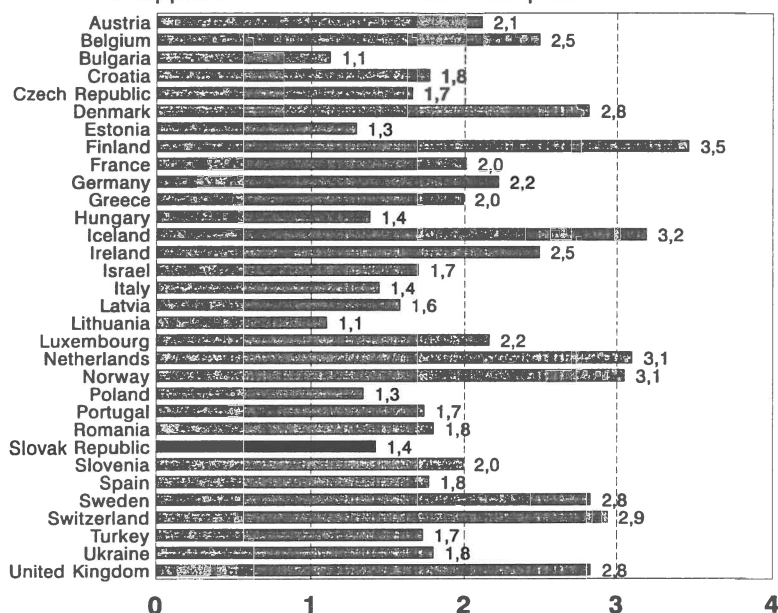
Scorings in these figures are the averages of doctors in the countries on a scale on the three task aspects. Each of these three scales consisted of a list of items on which the doctor was asked to answer to which extent he/she would provide this service when it occurred in the practice population. In this way a score in the low side of table 3.1 means that, the GPs in that country had a small role in the first contact with a range of 27 specific health problems, including severely coughing child, confirmation of pregnancy, stomach pain, chest pain, burn of hand, polyuria, first convulsion, relationship problems. The maximum score is 4, implying that the doctors are (almost) always the first contacted doctor with these health problems. Similarly, in figure 3.2 scores express the involvement of GPs when 13 medical technical procedures are needed in the practice population, such as: wound suturing, excision of warts, fundoscopy and taping an ankle. Figure 3.3, finally, expresses the involvement in treating a list of 17 diseases in the practice population; for instance: chronic bronchitis, peptic ulcer, acute CVA, pneumonia, salpingitis, uncomplicated diabetes type II, myocardial infarction. A low score means that these diseases are usually treated by specialists; a high score means that the GP is usually the one

Figure 3.1 GPs' role as the doctor of first contact with health problems



GPs in the Slovak Republic have a relatively weak position as the point of entry to health care (see figure 3.1). Only Bulgaria, the Baltic States, Ukraine and Turkey have lower scores. This means that more than in most other countries there are other doctors with whom patients have the first encounter in health care. This position is strongest with GPs in the Netherlands, United Kingdom, Ireland and Denmark.

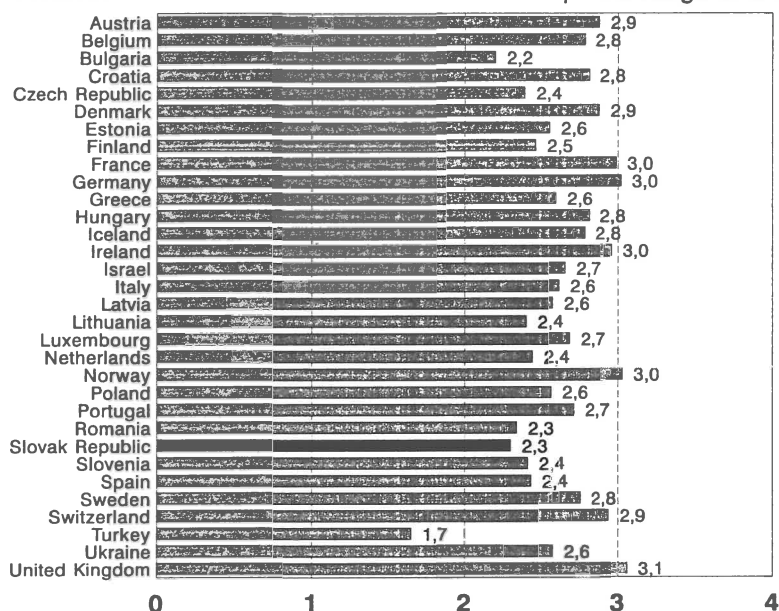
Figure 3.2 The GPs' application of medical technical procedures



Involvement of Slovak GPs in medical technical procedures is low (see figure 3.2). Most probably in the Slovak Republic, many patients of GPs who need a simple surgical operation or some other technical application, are referred to specialists. Countries where GPs do many technical procedures themselves are the Scandinavian countries, the Netherlands, Switzerland and United Kingdom.

who is providing these services.

Figure 3.3 Involvement of GPs in treatment and follow-up of a range of diseases

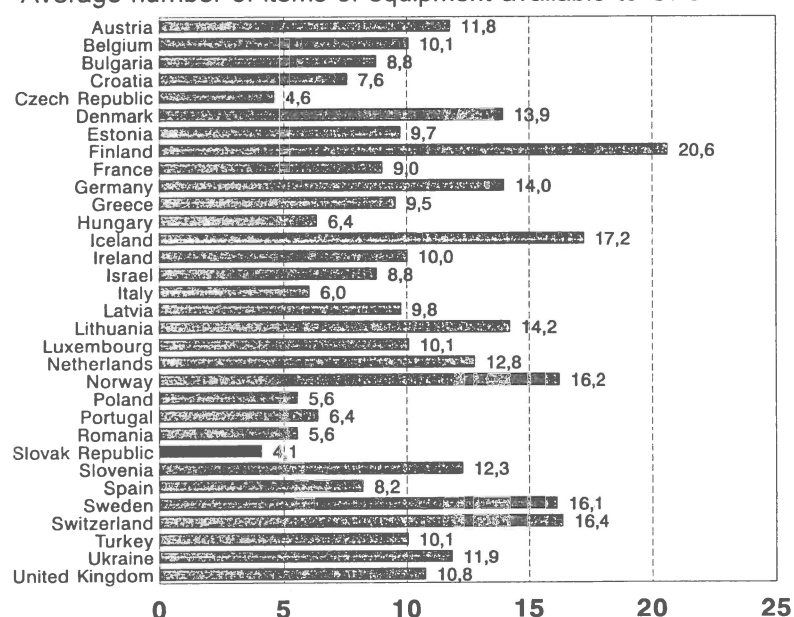


Differences between countries are smaller here than with both other task aspects (see figure 3.3). Nevertheless, Slovak GPs have comparatively low scores, with only Turkey and Bulgaria in lower positions. Countries with GPs highly involved in treatment and follow-up of diseases are France, Germany, Ireland, Norway, Switzerland and United Kingdom. Again, low scores probably point to a high level of referrals.

3.3 Practice equipment and workload

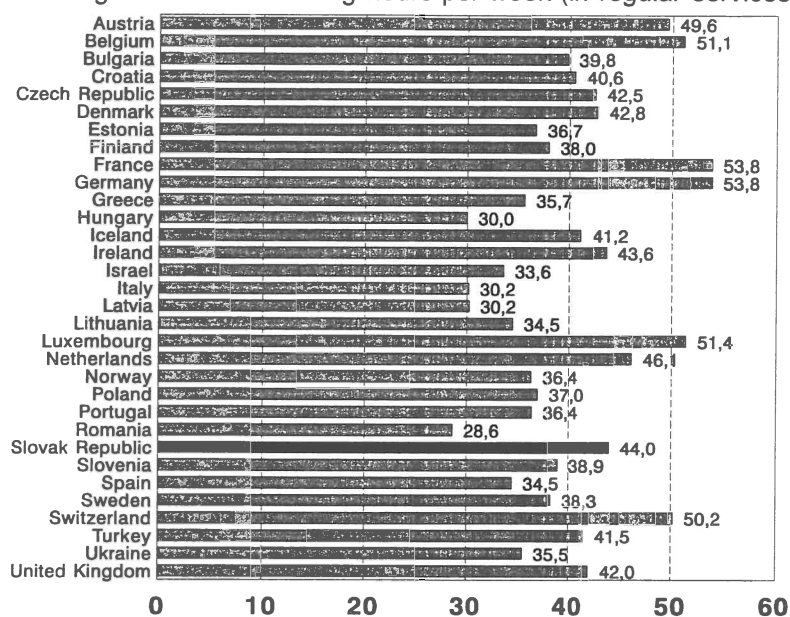
Figure 3.4 shows the availability of practice equipment (the average number of items from a list of 25). Aspects of working hours and patient workload are explained in the figures 3.5-3.7.

Figure 3.4 Average number of items of equipment available to GPs



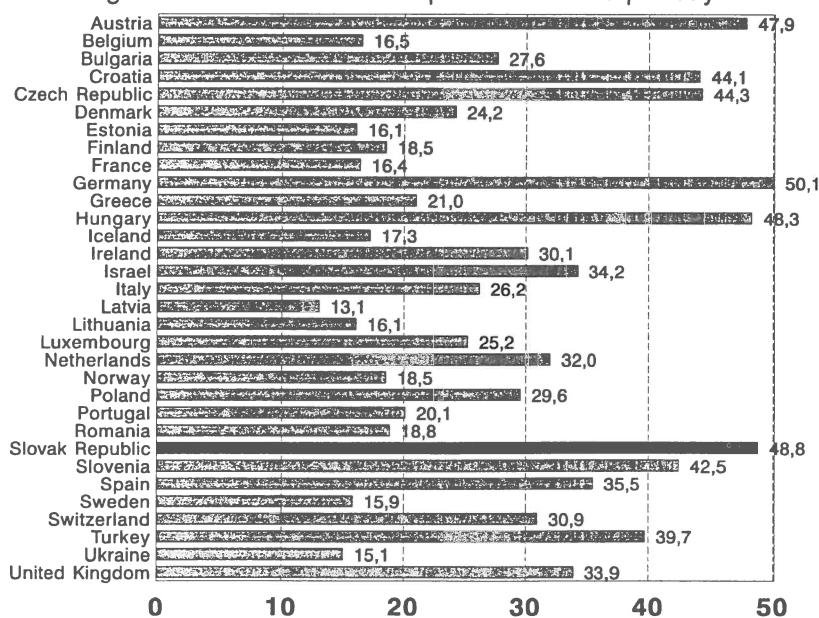
Countries vary enormously in the equipment GPs have at their disposal (see figure 3.4). Finland is leading, which will not be surprising after the high score on application of medical techniques. In the other Scandinavian countries and Switzerland, GPs are also well equipped. In Italy, Portugal and the countries of central and eastern Europe, there is not much equipment in general practice. GPs in the Slovak Republic rank lowest among the European countries.

Figure 3.5 Average number of working hours per week (in regular services)



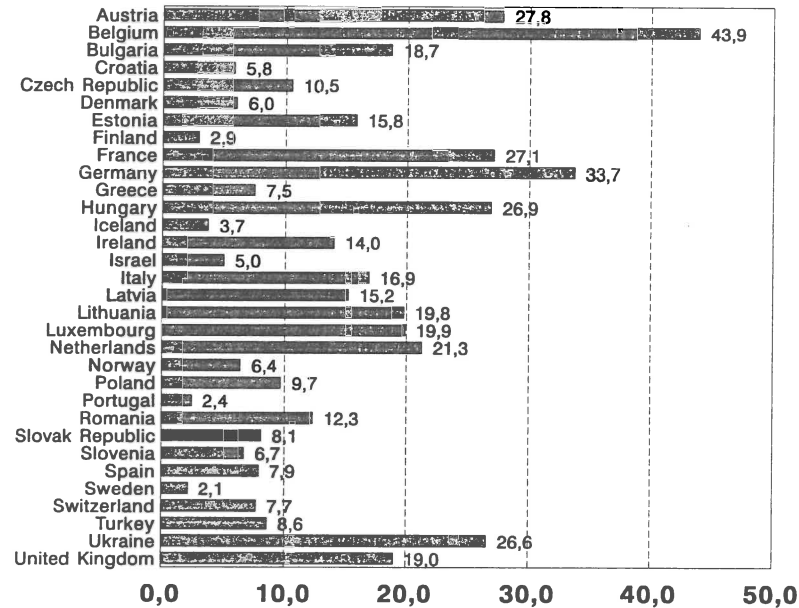
GPs in France, Germany, Luxembourg, Belgium and Switzerland make longest working weeks with averages of at least 50 hours (see figure 3.5). With 44 hours on an average Slovak GPs are well above the average. With these results it should be taken into account that two years ago, before the privatisation when data were collected in the other countries, the average working week of GPs in Slovakia was considerably lower and probably more in line with the other countries in the region. As a general phenomenon in the study we found self-employed doctors to have longer working weeks than salaried colleagues.

Figure 3.6 Average number of face-to-face patient contacts per day



German doctors see 50 patients per day, which is almost fourfold the Latvian number (see figure 3.6). Slovak GPs are also among the highest. Comparison is difficult because the number of contacts is expected to have strongly increased since the privatisation. It is interesting to note that a strong position of GPs not necessarily includes seeing large numbers of patients every day.

Figure 3.7 Average number of home visits per week



There are many countries with a stronger pattern of home visiting GPs than Slovakia (see figure 3.7). In Belgium GPs make many home visits, which is largely the result of competition among the many doctors in that country. Slovakia is in the middle range. It would be interesting to know what the effect of the reforms has been on the home visiting rate. Although home visits can often be reduced by efficient practice management and patient education, it remains an essential element in a system of home care.

3.4 Conclusion from the international comparison

The position of Slovak GPs in the health care system is comparatively weak. Their position as the point of entry to health care, including a possible coordinating role, can be much improved. Many cases in which medical technical procedures are required or continued treatment of diseases is needed, seem to be referred to medical specialists or are never seen by the GP. Whether it is a cause or the result of the weak position, it is a matter of fact, that GPs have very few medical equipment at their disposal: an average of only 4 from a list of 25. These results are all the more alarming since data in Slovakia have been collected more recently than in any other country. In the working hours and the number of patients seen per day the impact of the privatisation and features of the current remuneration system are evident. It may be questioned, however, if this has helped the quality of the doctor's performance.

4 THE FOUR PROBLEM AREAS

Major problems of primary care in Slovakia, as they were addressed in this project are described in this chapter. The description has been ordered according to the topics mentioned in the Terms of Reference to this project and the report from the inception phase. Throughout the project, activities have been structured according to these four areas.

4.1 Financing and remuneration

The payment system for primary care physicians was changed several times. The fee-for-service system, in which a number of declaration points were determined per item of service, was replaced in 1994, only one year after the introduction, by a flat capitation system (except for the dentists who chose to continue the point system). With the Act on the Therapeutic Order in 1995, the remuneration system was changed again into a mixed system, in which about 60% of the income is from capitation fees and the remaining 40% from points per item of service. In order to stimulate the transition to private practices, privately contracted doctors receive a kind of bonus per point (0.2 to 0.4 Slovak Crowns, depending on the insurance company; this is a reason for some doctors to ask patients to change to an insurance company which pays the higher bonus. Still one is not satisfied with the current payment system. First of all, the point system does not provide health insurance companies with means to control costs. For doctors it is too complicated, in itself and because applications differ from one insurance fund to another. So it is felt as an unreasonable administrative burden on primary care doctors. Besides, the system lacks the right incentives to strengthen the position of primary care. Somewhat disrespectful one could state that the current payment system invites doctors to be 'lonesome gate-watchers' instead of a 'teamworking gatekeepers'. This is probably enhanced by the widespread opinion of doctors that the level of payment is inadequate. Many of them have invented their own additional payment schemes e.g. yearly subscription fees; own price calculations for items of service; surcharges. This is a threat to the equity of access which was one of the principles to be maintained in the reform. As a matter of fact, doctors should be stopped being preoccupied with their survival. Positively, they should be encouraged to higher involvement in cost-effective diagnostic services, treatment and prevention. (Evidently the payment system is not the only instrument to achieve this goal). It should be realised, however, that more cost-effectiveness and higher quality has its price. In contrast to the current situation, a new payment system should take into account compensations for time spent on continuing medical education and costs made for an efficient practice management.

4.2 Pharmaceutical prescribing

Excessive consumption of expensive drugs has been one of the causes of health care financing problems. This resulted partly from the destruction of the domestic drug production capacity, which accounted for 80% of the drug market in the old days. After the 'Velvet Revolution' this dropped to about 10%. Although there is some improvement, still most drugs have to be imported. Imported drugs are three to five times more expensive. In addition, the country's system of drug regulation seems to be liberal in connection to the available health care budget. In 1996 26% of this budget was for drugs (56% for inpatient care; 13% for outpatient care). The list of fully reimbursed drugs seems to be relatively extensive. Only a small fraction of the allowed drugs are

not reimbursed at all. There seems to be agreement that many prescriptions are not necessary from a medical point of view. Nevertheless, solutions are complicated in a field where pharmacies and primary care doctors are privatised; the latter mostly working single handed. For that reason the introduction of a drugs budget for primary care doctors can not be considered as a possible solution; the basis of the individual practice is too small, the risk too large. Solutions should include a combination of measures with various parties involved, including doctors and pharmacies.

4.3 Quality of care

A negative side-effect of the privatisation is the loss of former structures for quality assurance. Doctors have few incentives for keeping up-to-date. At the same time expectations as regards primary care are rising. The health care system should become more primary care based, with a considerable decrease of referrals. So much more skills and expertise will be needed for these new tasks. In the new situation, with self-employed doctors, the traditional top-down approach is less and less effective. New quality assurance structures should be developed. This requires new attitudes of practitioners and learning new methods. Although the government and other parties in health care, like health insurance funds and postgraduate institutes, also have tasks in this process, it should be carried by non-governmental organisations of professionals and particularly by those working in daily practice. NGOs may collaborate with governmental organisations: governmental tasks can be delegated to NGOs, with the government in a inspectorate role on the background. Still, quality assurance is seen as quality control, which is a top-down approach. Adequate top-down measures should be supplemented by grassroots initiatives, such as peer review. Development of professional guidelines should be a joint activity of professional organisations and the government, with the government in a facilitating role. Inherent to private practice is that financial incentives appear to be more effective than rules and direct inspection. There is a tendency to consider professional guidelines as the modern versions of the orders from the ministry in former days, rather than as the products of a self confident profession.

4.4 Information systems

Doctors in Slovakia have many administrative duties, resulting from the complicated health insurance system, the obligatory information to be delivered to the Institute for Health Information and Statistics (UZIS), the Institute for Hygiene and Epidemiology and, last but not least, the administrative consequences of being a private entrepreneur. Although much information (even at contact level) is being collected, there is still a lack of primary care data on subjects like epidemiology, interventions, referrals, practice management and doctor's workload. Data collected at practice level, are only used at aggregate level in the yearly health statistical reports. Data are not fed back to the doctors themselves. Although most doctors still work with the paper forms, computer systems are also available and in use. These offer the opportunity not only to provide the ministry with the obligatory information, but also use it for other purposes. Motivation for collecting data is low. Among practical doctors a tradition of practice research or other forms of systematic reflection seems to be absent. Clinical research is carried out at the university, usually in one of the highly specialised areas. The benefits of primary care research or health services research still need to be explained. In the current situation where research is not (financially) rewarded, it has a very low priority. At central level there is probably one exception; there are plans to develop manpower planning (not just for primary care) as an instrument to control the number of health personnel. Thus there is an interest in setting up registers and carrying out

studies on estimated future needs for health care providers. Although interest in research is not high, other computer applications have a warm attention, especially if it helps with the insurance matters, financial management, budget control and provides quick reference to medical information and expert systems.

5 SPECIFICATION OF GOALS, MEANS AND CONDITIONS

This chapter deals with the planning of the project: from the general aim of the project to the more specifically formulated operational goals and the resources and activities which are meant to bring about the desired outcomes. In the plan of work, resources and activities are specified for each operational goal. In the course of the project the applied resources may deviate from the initially planned resources. In the planning of the project an estimation is also made of the internal and external conditions which influence the realised outcomes.

5.1 General goal

The general aim of the project is:

'Contributing to the improvement of cost-effectiveness and quality of primary health care services in the Slovak Republic.'

This general aim resulted from the core problems identified earlier:

- Low morale of physicians, which is an obstacle to realising a stronger primary care system.
- Current physician payment methods place an unreasonable burden on providers and lack proper incentives.
- The costs for pharmaceutical prescriptions are high and still rising.
- Health care providers and managers currently lack systematic feedback on their activities.
- Primary care physicians provide a narrow range of curative and preventive services; many patients are referred to specialists.
- Participation in continuing medical education is low; supply of courses and methods used are not suitable to the situation of privatised doctors.

In this project the following resources will be applied to tackle the problems: deployment of local expertise; deployment of external expertise; workshops, meetings and conferences; written information and documentation; training; study tours; research and feedback; publicity; equipment; project coordination.

The intermediate step between the general goal and the plan of work are the operational goals, each of which address one of the four project areas: (1) remuneration and financial control; (2) pharmaceutical cost containment; (3) quality of care and (4) information system. Below, for each of these areas the problems/challenges will be summarised, the operational goal will be specified and the planned means will be described.

5.2 Goal 1: remuneration system / financial control

Specific problems:

- low income of doctors;
- remuneration system includes incentives for quantity rather than providing quality of care;
- high patient doctor contact rates;
- unnecessary referrals to secondary care;
- the existence of unofficial payments, which cannot be estimated;
- a high (and expensive) drug prescription rate.

Operational goal 1:

'Changing the doctors' remuneration system in order to provide proper incentives for quality of care and cost-effectiveness.'

Means:

- review of the current remuneration system;
- elaboration of a preliminary plan developed by local experts;
- drafting a blueprint for a new remuneration system;
- identification of resulting information needs related to this remuneration system;
- calculating possible consequences of the new system with available data;
- testing in pilot practices (without financial consequences);
- collection/analysis of practice data needed for feed back/monitoring;
- study tour on fundholding and other payment schemes;
- evaluation of the system / recommendations for future implementation.

5.3 Goal 2: pharmaceutical cost containment

Specific problems:

- an explosive growth of the proportion of the health budget spent on drugs;
- no incentives for physicians to prescribe cheaper (equivalent) drugs; little cost-awareness;
- price legislation, controlled by the Ministry of Finance, does not contain mechanisms for cost control on drugs; this allows importers of drugs to set prices at their discretion;
- no incentives for the pharmacist for cost containment;
- prescribing drugs seems a routine in finishing a patient contact. Almost all diagnoses are related to a drug prescription, which is high in comparison to western european countries.

Operational goal 2:

'Providing incentives and other conditions for doctors in order to stimulate cost-effective prescribing of drugs which contributes to cost containment in pharmaceutical care.'

Means:

- review of current system of pharmaceutical prescribing and distribution;
- planning/recommending a system with proper incentives;
- calculating effects/consequences with available data;
- estimating possible savings;
- planning/recommending implementation on a larger scale;
- providing documentation;
- study tour;
- evaluation of results.

5.4 Goal 3: quality of care

Specific problems:

- Doctors lack incentives for spending time on keeping up-to-date.
- Former structures for continuing medical education are no longer adequate; new learning methods are needed.
- Level of competence of primary care doctors should be improved; referral rates to secondary care are too high.
- Maintaining quality is too much considered as a top-down control matter; this

should be supplemented by coordinated grassroots initiatives.

Operational goal 3:

'Introducing modern methods of peer review and guideline development and making recommendations for an infrastructure for quality assurance.'

Means:

- recommending a new system of GP recertification;
- information on the use and content of an official GP job description;
- introducing peer review as a modern method of quality assurance;
- professional guideline development as a contribution to the 'body of knowledge' of family practice;
- collecting/analyzing practice data for feedback in peer review;
- small scale implementation of a developed guideline;
- identifying needs for practice management;
- provision of literature and information;
- study tour;
- identifying policy implications;
- evaluation of results.

5.5 Goal 4: information system

Specific problems:

- Doctors have many administrative data collection duties.
- Many data are collected but there is a lack of data for epidemiology, primary care interventions, referrals, practice management and manpower planning.
- Information is not available to providers.
- Priority for research is low; there is no tradition of research in primary care.

Operational goal 4:

'Improving the availability of collected practice data for the benefit of the project activities and formulating future options for a primary care information system.'

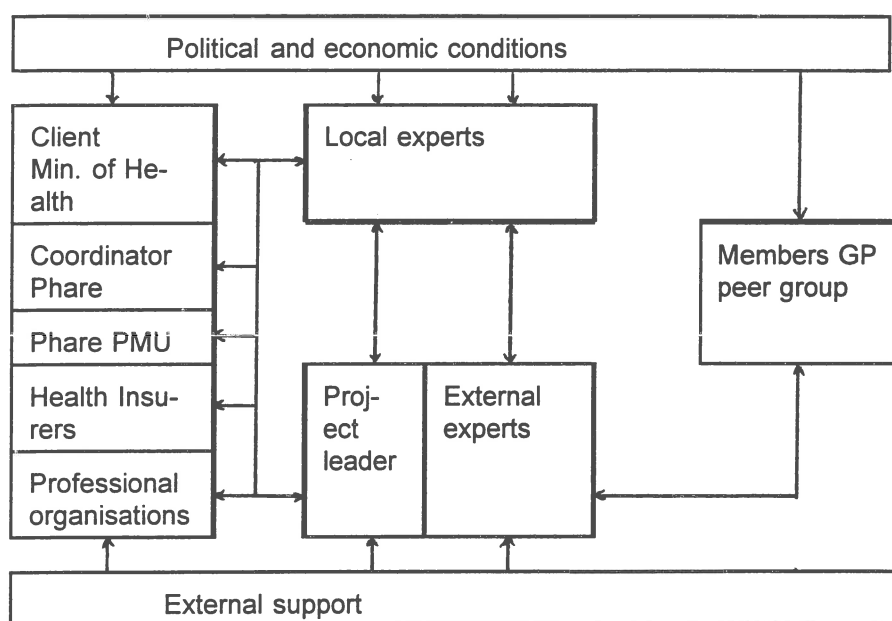
Means:

- reviewing/comparing currently used practice information systems;
- assessing information needs for various purposes (remuneration, pharmaceutical cost control and quality of care);
- developing/adapting software/ selecting hardware;
- testing/implementing in pilot practices;
- purchasing necessary hard- and software;
- supporting development of research environment;
- recommending/planning implementation on a larger scale;
- evaluation.

5.6 Conditions and relations of the project

Core players in the implementation of this project are the Ministry of Health, who commissioned the Phare programme, the local experts appointed to this project and the team of external experts managed by the project leader whose proposal was selected in the tender procedure. Relations between persons and institutions involved in this project have been visualised in the scheme below.

Scheme 1



Local experts and the team of **external experts**, particularly the project leader, together make most of the practical work and organisation of the project. It is essential that they collaborate and communicate very well and that external experts make visits according to the needs. Exchange of information with the **Coordinator Phare** programme is another essential condition. And the **Ministry of Health** needs to be well informed about the activities and progress of the project to guarantee that these remain in line with the official policy. This implies a mutual interaction between policy makers and project staff; local experts and project leader are responsible for communication between these two levels.

Since small scale testing and practical implementation is part of the project activities, involvement of this 'test group', which is indicated as the **members of the peer group** in the scheme above, is obvious. Logistic tasks will be carried out mainly by the local experts, while the external experts are in charge of the training and coaching.

The **Health Insurers** are involved for two reasons. Firstly they can help providing background data needed for making theoretical calculations to estimate possible effects of a new remuneration scheme. Secondly, like the Ministry, Health Insurance Companies need to be involved in the process of testing and implementing a new system of payment in primary care.

Professional organisations, like the Associations of primary care doctors and the Postgraduate Medical Institute, are the intended partners both in the acceptance in the medical world of the project outcomes and in carrying on and continue developments.

External support, finally, are all those inputs resulting from needs for information, documentation, communication, computer hard- and software and mobility. This is a major responsibility of the project leader.

6 REMUNERATION AND FINANCIAL CONTROL

This chapter is the expression of the process of development of a new remuneration system. After the description of preliminary considerations the new model is described and consequences are calculated on the basis of available data.

6.1 Preliminary considerations

As a solution for the doctors' remuneration problem in first instance a system of GP budget holding, which was proposed by local partners, has been considered. Although it provides the right incentives for the provision of cost effective primary care based health care, it was rejected as a feasible solution in the shorter term because we thought that Slovakian GPs are not yet able to meet the professional and managerial requirements of budget holding. This opinion was supported by our conclusions made during the study tour on this subject to England.

We concluded that it would be more successful to develop a remuneration system which could be introduced and extended gradually, depending on the progress in primary care development. The following new elements of this payment system were identified:

- Reduction of the current fee-for-service element in the income of doctors and an increase of the proportion from capitation fees (this would also reduce the administrative burden).
- Introduction of a differentiation in the capitation fee with, for instance, a higher fee for the elderly patient groups, and for doctors working in sparsely populated areas.
- Changing the remuneration system from a retro- to a prospective system.
- Introduction of official co-payments for patients (for which the low income groups can be excluded) in order to give them opportunities for countervailing power (a disadvantage is the additional administrative work).
- Incorporating financial incentives for the provision of quality and cost-effective care; the repertory of these incentives can be extended in the future.

We were aware of the fact that some of these measures could be realised more easily than others. For a change to a higher proportion of capitation fees, for instance, the law has to be changed. Another difficulty was to get insight in the elements constituting the doctor's turn-over, such as the expenses which together make the practice costs, and the sources of the doctor's income. The available information from only one practice was too sketchy to be used for the calculations. Information on income and turnover, however, is needed to provide a base line from which income effects of a revised remuneration system can be established.

We also concentrated on elaborating the incentives and came to the formulation of a number of 'reference groups' or 'targets', for which a doctor can earn a bonus on his capitation fee if he or she succeeds in keeping under the target limits in a certain year. Targets can be agreed prospectively or can be set retrospectively. Per target bonus levels can be introduced; a higher bonus is earned by doctors who exceed the target limit with a higher percentage. The establishment of the targets has to be done carefully and taking into account practice characteristics, such as age composition of the practice population and distance to secondary care facilities.

6.2 Blueprint of a new remuneration system

In the short term, we think targets could be experimented with respect to:

- **Drug prescriptions**
Overprescribing has been identified as an important problem. Targets ('ideal' prescription profiles) are possible both on volume of pharmaceutical prescriptions and on the costs. Earnings can be realised by lower prescription rates, less drugs per prescription and by more generic prescribing (see also the next chapter on Pharmaceutical cost containment).
- **Referrals to specialists**
General targets can be set as a percentage of the number of patients or as a percentage of the patient contacts. On the basis of practice registration data, targets can also be set related to categories of patients or specific diagnoses.
- **Diagnostic laboratory tests**
It was suggested that in many cases routinely the extensive test (amounting 930 declaration points) is ordered where the smaller set (430 points) would be sufficient. So, targets could be set for the proportion of orders for small and large tests respectively and probably the total number of ordered tests.
- **Continuing Medical Education**
This is an important condition for providing quality of care. As a target could be taken a certain minimum number of hours per year that a doctor needs to spend on courses and other educational activities to be eligible for a bonus. Courses and activities that count for this target should be officially acknowledged or accredited to guarantee its quality (see also the chapter 8 on Quality of care).

Scheme 6.1 Framework of the recommended remuneration system

Income components (in kind or restituted):	amount
1. Capitation fees (differentiated per age/sex category of the practice population)	
2. Fees for services (prospectively or retrospectively)	
3. Co-payments by patient	
4. Possible bonuses from targets (% on top of capitation fees):	
4.1 Pharmaceutical prescriptions	
- meeting target = capitation +P%	
- target plus X% = capitation +PP%	
4.2 Referrals to specialists	
- meeting target = capitation +R%	
- target plus X% = capitation +RR%	
4.3 Laboratory tests ordered	
- meeting target = capitation +L%	
- target plus X% = capitation +LL%	
4.3 Participation in Continuing Education	
- meeting number of hours = +C%	
4.4 Other targets (to be determined)	
Total income	

In the scheme per target two bonus levels have been distinguished: one for meeting the 'normal' target and another for meeting the 'extra' target; meeting the 'extra' target makes the doctor eligible for a higher bonus. Distinction of these two levels is not essential to the system.

The remuneration system can be introduced in phases. However, one should be aware that the right mix of measurements is introduced in a certain phase. Effects on income and on quality of care should be well monitored. This requires the availability of relevant practice data (see chapter 8). The income problem of the doctors can gradually be solved by increasing the amount of the capitation fee step by step, according to the available primary care budget. The proportion of the doctor's income from capitation fees and from fees for services has to be determined. Services for which fees are paid should be those which are specific for certain conditions, so that

unnecessary provision will be avoided as much as possible. Although preventive services do not belong to the first priorities in the new payment system, targets can be set later, for instance on screening, vaccination, check ups and other items.

The volume of fees for services can be determined prospectively, which means that GP and health insurance companies agree beforehand upon the number of points for these services in a year (a fixed budget). In the scheme the mode of payment to the GP has not been specified yet. In the current system fees and capitation payments are transferred directly from insurance companies to the doctor (provision in kind). Especially in primary care a restitution system is also possible; the GP is paid by the patient who is subsequently restituted (completely or - in case of co-payment - partly) by the insurance company.

6.3 Calculation of key figures

For the elaboration of this remuneration system practice data were needed. Since these were not available at individual practice level on patient contacts, referrals to medical specialists, drug prescriptions, and diagnostic laboratory tests ordered by the GP, we initiated a data collection in a number of practices in different parts of the country. These were practices of GPs who participated in the peer review group^{*}.

For the main part of the data collection we made use of the system of declaration data of the health insurance companies, which has been computerised in part of the Slovak primary care practices. By this system every month doctors declare their points according to the detailed fee for services scheme. For our purpose, the data base was extended to include orders for diagnostic laboratory tests and drug prescriptions. In collaboration with the largest health insurance company the software was adapted consequently. Our data provide an insight in the 'production' of GPs (e.g. patient contacts, GP orders for diagnostic tests, referrals to secondary care services) and in the variation between GPs. They are helpful in estimating the targets of the remuneration system. The data have also been used in other project areas.

On the basis of the collected data we calculated the following key figures on an annual basis (we calculated with 230 working days per year).

Table 6.1 Some GP 'production' figures on an annual basis

items	average per practice/yr	average per patient/yr	average per contact
patient contacts	13,416	7.6	n.a.
diagnoses	17,174	9.4	1.3
declared services	18,821	10.4	1.4
service points	1,953,857	1085	146
referrals:			
- for treatment	2,292	1.3	0.17
- for diagnostics	942	0.5	0.07
- total	3,234	1.8	0.25
prescribed packages of drugs	24,314	13.3	1.8

On an average GPs see their patients 7 to 8 times per year, which is high, even if we take into account that part of the contacts are (also) with a nurse or are for administrative purposes. The average contact frequency in the Netherlands and the United Kingdom is between 3 and 4 per year per patients. During a patient contact 1.3 diagnose has been made and 1.4 declarable services are applied, which make 146

^{*} The content of the database, such as the number of registration days per doctor and the number of contacts with patients, have been specified in chapter 8.

service points per contact. With a total rate of 0.25 the proportion of referrals is very high; every fourth patient is referred to a specialist, mostly for treatment. The high patient contact rate in combination with the high referral rate make a very high absolute number of referrals in the Slovak primary care practice. The high consumption of pharmaceutical drugs is confirmed in these statistics: on an average more than one package of drugs is prescribed during a patient visit; which here also results in a boosted effect on expenditures by the high contact rate.

Table 6.2 Yearly prescribed pharmaceutical drugs (in Sk)

	per practice/yr (in Sk)	per patient/yr (in Sk)	per contact (in Sk)
turnover	3,118,091	1,537	256

The costs for prescribed drugs is well over 3 million Slovak Crowns (Sk) per practice per year, which equals to 1,537 Sk per patient and 256 Sk per visit.

Table 6.3 GP turnover from capitation payments and fees for services on an annual basis

income elements	per practice/yr (in Sk)	per patient/yr (in Sk)
capitation fees*	292,176	144
fees from services**	338,778	167
total	630,954	311

* Average practice size: 2034

** Calculated as follows: $18,821 \times 100 \times 0.6 \times 0.3$ Sk

Extrapolation of our data to annual statistics shows that the proportions of these two income elements amount 54% from declared fees for items of services and 46% from capitation payments. In addition to these two sources of income doctors are assumed to receive an unknown income from cash private payments.

These GP income data are interesting when considered in combination with the produced costs for pharmaceutical drugs. Per year a GP prescribes for drugs five times the amount of his/her own income both on capitation payments and fees for declared services. (For comparison: in the Netherlands the costs for drugs prescribed by GPs is about 2.5 times the income from patient care).

6.4 Links to other areas

Experimenting and implementing this revised remuneration system needs support from and has consequences for other areas within this project as well as for external institutions and persons. The following links have been identified:

- Setting targets and monitoring effects and achievements cannot be done without an adequate practice information system. So far we have worked with data from an information system that was adapted for this purpose. It has provided information which is much better than what was available before, but which is still imperfect.
- A revised payment system urges doctors to change their professional behaviour. This can only be realised in a responsible way if better alternatives are offered. It has to be avoided that this behavioral change (e.g. lower referral rates or prescription rates) results in a loss of quality of care. So there are obvious links between the remuneration system and the existence of a coherent national structure on 'quality of care'.

- Prerequisite for the implementation of a revised remuneration system is the acceptance by the government, health care financers, the doctors and the patients. To some extent these are allies: the government and the health insurance companies may expect that it also helps solving the problem of high health care costs. Doctors may expect that it helps improving their income situation. Patients expect better, more personal care.
- The way GPs are remunerated cannot be isolated from the payment system of other health care providers, and in particular medical specialists and pharmacists. Since the payment system of the former has been subject of another Phare project on Privatization of Secondary Ambulatory Health Care, coordination is needed for further implementation.

7 PHARMACEUTICAL COST CONTAINMENT

7.1 Starting point

As a result of our analysis of reimbursements and distribution in the pharmaceutical sector we concluded that pharmacists could better be reimbursed by a system consisting of, at least, three components:

- a fixed fee per delivery for their service as a distributor;
- a full compensation of the real (net) wholesaler price of the drug;
- a bonus for delivering cheaper equivalent drugs.

This should be sustained by an official government policy for promoting generic prescribing. Solutions for the problems in the area of pharmaceutical distribution and prescriptions should be identified and implemented in a coherent way; various sections of health care are involved. GPs and pharmacists are closely linked in their activities and their financing and payment systems should be well coordinated. However, it is beyond the scope of this project to further elaborate activities on pharmacies and pharmacists.

Concerning the primary care doctors, solutions should try to reduce the total volume of prescribed drugs as well as the price per unit of drug. Reduction of the volume asks for change of the doctor's professional routines. This can be achieved primarily by providing information and training to doctors about other treatment options which do not (or do less) rely on drugs. Financial incentives, as described in the proposed new payment system may be effective support, but cannot do without proper information. The price per unit of drug can be reduced by introducing systematically a system of generic prescribing. This only requires a marginal change of the doctor's routines. Financial incentives are effective helps. This can only be realised if pharmacists are obliged, by an official policy measure, to deliver the generic drug the doctor has written on the prescription. Another option is doctors to prescribe names of substances only and pharmacists deliver the cheapest product. In that case there should be an incentive in the pharmacists' remuneration system to deliver these cheaper products.

7.2 Testing possible effects: two pilot studies

It was decided to carry out two pilot studies to demonstrate possible effects of the policies of preferred prescribing of generic drugs and increase the rationality of prescribing habits. Possible savings have been calculated on the basis of data collected in the pilot practices of this project^{*}. Data have been collected on patient contacts, diagnoses, prescriptions, type of drugs, volume and prices. The following two studies have been carried out:

- a. What savings could be realised if prescribed drugs would be systematically substituted by the cheapest possible equivalent (often a generic).
- b. What savings could be realised if, in a number of specific diagnoses, doctors would consequently follow an official prescription guideline.

These two questions will be dealt with in the sections 7.3 and 7.4.

7.3

^{*} Although we consider here particularly the financial consequences of more rational prescribing it has to be stressed that the aim of guidelines is broader: improving the quality of care.

Savings from cheaper prescribing

We limited this exercise to the top 20 of (groups of) drugs which were most frequently prescribed by the doctors in the pilot practices. For comparison, differences of dosages had to be eliminated by calculating per drug a price per unit (usually 1 mg). In the extreme right hand column of table 7.1 the resulting savings have been expressed as a percentage of the current costs. Obviously, if no cheaper equivalent was available, there is no saving.

Table 7.1 Possible savings with 'Top 20' of ATC groups of drugs prescribed in 6 pilot practices*

ATC DRUG CODE	prescribed packages	current costs	cheapest option**	possible saving (%)
C01DA02 (Glyceryl trinitrate)	2,341	113,734	43,023	62.2%
M01AB05 (Diclofenac)	1,959	169,247	109,160	35.5%
C02EA02 (Enalapril)	1,311	149,686	88,842	40.6%
B01AC06 (Acetylsalicylic acid)	1,277	12,875	11,153	13.5%
C04AD03 (Pentoxifylline)	1,021	88,186	56,173	36.3%
C05CA (Bioflavonoids)	900	58,477	38,042	34.9%
C01AA05 (Digoxin)	862	11,138	10,563	5.2%
C04AX09 (Cinnarizine)	834	46,411	26,064	43.9%
A11AH03 (Multivitamins)	755	25,603	18,821	26.5%
C02DE02 (Nifedipine)	716	28,565	23,262	18.5%
M01AE01 (Ibuprofen)	690	32,819	30,107	8.3%
C04AX (Other peripheral vasodilators)	673	160,681	160,681	0.0%
N02BE01 (Paracetamol)	625	5,969	5,974	0.0%
N05CD03 (Flunitrazepam)	587	16,436	16,436	0.0%
C01DA08 (Isosorbide dinitrate)	582	33,347	25,393	23.9%
A12CC (Magnesium)	580	48,100	48,100	0.0%
N05BA01 (Diazepam)	553	10,728	8,309	22.6%
N06BX03 (Piracetam)	551	57,259	31,728	44.6%
A09AA (Enzyme preparations)	477	52,697	49,830	5.4%
A11HA02 (Pyridoxine; vit.B6)	451	5,372	3,424	36.1%
TOTAL	17,745	1,127,329	805,086	28.6%

* An ATC group unites drugs of the same substance from different manufacturers and dosages.

** For all drugs in this top 20 we calculated a 'standard price per unit' (usually mg). In this way the cheapest option could be calculated taking into account different dosages.

If GPs would have a consequent policy on prescribing the cheapest available product, in the top 20 of most frequently prescribed ATC groups (groups of drugs from different manufacturers with identical substances), this would result in a reduction of well over 28% compared to the current level of costs. In four categories, savings are not possible but, in contrast, in the category with the highest frequency of prescribed packages, a reduction is possible with almost two-thirds.

7.4 Savings from rational prescribing

For this calculation a list of 16 diagnosis-related 'model prescriptions' has been made, derived from professional guidelines developed and published in the Netherlands by the Dutch College of GPs. In table 7.2 the selected diagnoses are described (with the ICD10 codes), the preferred prescriptions (NL) and the Slovak equivalent (SLK), which was taken for comparison with the price in Slovak Crowns.

Table 7.2 Selected diagnoses, NL recommended pharmaceutical prescription and SLK equivalents and prices*

diagnosis	NL 'model' prescription / SLK equivalent	
cystitis / urinary tract infection (N30)	Trimethoprim 300 mg tabl no.III S 4 dd 1	NL
	Trimethoprim not in the list; replaced by Cotripharm 480 20x480 mg (ATC J01EE01) Price: Sk 31,30	SLK
pharyngitis (J02)	Paracetamol 500 mg tabl no.XX S 4 dd 1	NL
	Paracetamol K 10 x 500 mg (ATC N02BE01) Price: Sk 2 x 7,30 = 14,60	SLK
crural ulcer (I83.0;I83.1;I83.2)	Oleum arachidis 30 ml Ungt Zinci Oxydi 10% 30gr	NL
	Oleum arachidis not in list; replaced by Oleum Helianthi CSL 50 gr (ATC D02A) Price: Sk 12,70	
	Ungt Zinci Oxydati 1 x 20 gr (ATC D02AB) Price: Sk 1.5 x 12,70 = 19,05	SLK
hypertension (I10)	Hydrochlorothiazidum 25 mg tabl no XXX S 1 dd 1	NL
	Hydrochlorothiazid Leciva 20 x 25 mg (ATC C03AA03) Price: Sk 1.5 x 7,90 = 11,85	SLK
hypercholesterolemia (E78.0)	Simvastatine 20 mg tabl no XXX S 1 dd 1	NL
	Zocor 28 x 20 mg (ATC B04AB01) Price: Sk 1793,30	SLK
asthma/chronic obstructive pulmonary disease (J43;J44;J45)	Salbutamol diskhaler 400 mcg no LX (60 doses) S 2 dd 1	
	Beclomethason diskhaler 400 mcg no LX (60 doses) S 2 dd 1	NL
	Ventodisk 15 x 8 x 400 mcg (ATC R03AC02) Price: Sk 0.5 x 517,50 = 258,75 Becodisk 15 x 8 x 200 mcg (ATC R03BA01) Price: Sk 2 x 930,- = 1860,-	SLK
acute diarrhea (gastro-enteritis) (A09)	No medication	NL
	id.	SLK
influenza (J11)	Paracetamol 500 mg tabl no XX S 4 dd 1	NL
	Paracetamol K10 x 500 mg (ATC N02BE01) Price: Sk 2 x 7,30 = 14,60	SLK
gastric complaints (K29;K30)	Suspensio algeldrati et magnesii hydroxidi (Antagel) 1000 ml S 4xdd 15 ml or: Cimetidine 800 mg tabl no XV S 1xdd	NL
	Maalox 30 x 15 ml (ATC A02AD) Price: Sk 2 x 139,30 = 278,60 or:	

	Primamet 100 x 200 mg (ATC A02BA01) Price: Sk 0.6 x 129,40 = 77,64	SLK
angina pectoris (I20)	Atenolol 50 mg tabl no XXX S1 dd 1 Isosorbidedinitrate tabl 5 mg no XXX S sn	NL
	Tenormin 28 x 50 mg (ATC C07AB03) Price: Sk 94,70 Wesorbide 5 100 x 5 mg (ATC C01DA08) Price: Sk 0.3 x 76,30 = 22,89	SLK
hay fever/allergic hyperreactive rhinitis (J30)	Budenoside nasal spray 100 mcg per dose no CXX S 1 dd 2 doses D et S	NL
	Beconase nasal spray 200 x 50 mcg (ATC R03-BA01) Price: Sk 1.2 x 127,50 = 153,-	SLK
heart failure (I50)	Furosemide 40 mg tabl no XXX S 1 dd 1 Enalapril 5 mg tabl no LX S 2 dd 1	NL
	Furanthril 50 x 40 mg (ATC C03CA01) Price: Sk 0.6 x 37,70 = 22,62 Enalapril Lachema 5 30 x 5 mg (ATC C02EA02) Price: Sk 2 x 127,40 = 254,80	SLK
low back pain (M54.5)	Paracetamol 500 mg tab no LX S 4 DD 1	NL
	Paracetamol K10 x 500 mg (ATC N02BE01) Price: Sk 6 x 7,30 = 43,80	SLK
radicular syndrome (M51.1;M51.2;M54.4)	Paracetamol 500 mg tab no LX S 4 DD 1	NL
	Paracetamol K10 x 500 mg (ATC N02BE01) Price: Sk 6 x 7,30 = 43,80	SLK
epicondylitis (M77.1)	Paracetamol 500 mg tab no LX S 4 DD 1	NL
	Paracetamol K10 x 500 mg (ATC N02BE01) Price: Sk 6 x 7,30 = 43,80	SLK
anxiety disorders (F41)	Diazepam 5 mg tabl no LXXXX S 3 dd 1	NL
	Seduxen 20 x 5 mg (ATC N05BA01) Price: Sk 4.5 x 11,50 = 51,75	SLK

* Under the following assumptions:

1. In case of chronic diseases prescriptions are for one month
2. Prescriptions are for 'average' adult patients with 'average' severity of disease

In table 7.3 prices of the real prescriptions made in the pilot practices with the 16 diagnoses have been compared with the prices of the preferred prescriptions according to Dutch GP guidelines on these diagnoses.

Table 7.3 Comparison of drugs prescribed with 16 selected diagnoses in 6 pilot practices and 'model prescriptions' according to Dutch College Guidelines (in Slovak Crowns)

ICD code	packages	real (Sk.)	model (Sk.)	difference R - M (%)
N30	356	37,324	11,143	-70.2%
J02	432	51,178	6,307	-87.6%
I83.0/.1/.2	216	13,929	6,858	-50.9%
I10	6,627	987,200	78,530	-92.0%
E78.0	476	67,140	853,611	+1172.1%
J43/44/45	398	34,990	843,263	+2309.4%
A09	170	8,800	no presc.	-100.0%
J11	518	19,229	7,563	-60.8%
K29/30	70	5,017	12,783	+155.3%
I20	173	26,050	20,343	-21.9%
J30	271	39,757	41,463	+4.3%
I50	46	3,296	12,761	+28.7%
M54.5	2,082	177,710	91,192	-48.7%
M51.1/.2/.4	600	57,389	26,280	-54.2%
M77.1	158	10,954	6,920	-36.7%
F41	4	39	207	+430.7%
total	12,597	1,540,001	2,019,224	+31.1%

In 10 out of 16 diagnoses, the model prescription is cheaper than the currently prescribed drugs. At the aggregated level, however, prescribing drugs according to Dutch guidelines would not result in savings. Costs would be 31% higher than the current expenditures. In particular with asthma and hypercholesterolemia Dutch GPs prescribe different drugs, which are much more expensive, than their Slovak colleagues. Here again, we want to stress that the aim of professional guidelines is to improve the quality of care, which is not necessarily equal to cost reduction.

7.5 Links to other areas

What was mentioned under the payment system is applicable to the pharmaceutical area as well. The prescription behaviour of GPs is an explicit aim of the payment system, in which involvement of the government, health insurance companies, providers and patients cannot be missed. Attention also needs to be paid to acceptance by the population, so there are obvious links to health education. For monitoring and evaluation a constant stream of information has to be available.

8 QUALITY OF CARE

Although conclusive information was not available, serious doubts about the quality of the primary care services in Slovakia were the starting point of our activities in this area. Doctors see many patients per day with little time available per patient, and the level of equipment is low compared with colleagues abroad. Since former structures for continuing medical education are no longer working effectively, there is an urgent need for modern methods of quality assurance which are adequate for privatised doctors. Instead of the traditional 'top-down' quality control by the government, we set out for a more decentralised model in which practice audit and peer review are the essential elements. It was concluded that improving the quality of primary care and developing a proper support structure in the longer term would be a condition for success of the new payment system. The achievement of a more powerful primary care system largely depends on a nationwide quality improvement effort. Since we had to start from scratch we realised that this will take more time than the period of this project.

8.1 The peer review group

A peer review group of eight GPs was started as a central activity. Evidently this was a completely new phenomenon in the Slovak health care. Coached by two external experts, participants learned to reflect on quality by expliciting their practice routines and give each other feedback in a structured way. The awareness of variability in professional work was an important experience. Altogether five group sessions have taken place; the first one in April and the final one in November. The group members have been recruited in an informal way. One of the criteria was their use of a software package which allowed to collect practice data for feedback. (This could not be realised in all cases). Participants were paid for each group session they attended. As a way of 'learning by doing' the group developed a Slovak version of a professional guideline. The essential difference with previously published guidelines was that this one was developed by primary care doctors themselves, based on their own experiences and as a result of mutual discussion. This relevance to the doctor's daily work increases the acceptance and applicability. Hypertension was selected as the subject of this first exercise. The group agreed on the differential diagnosis of primary versus secondary hypertension. Subsequently other aspects of the guideline were systematically covered: definition, anamnesis and physical examination, additional examinations, therapy and follow-up and monitoring. As homework participants prepared case descriptions of newly diagnosed hypertensive patients. The guideline has been published in a Slovak medical journal not just to support its dissemination nationwide, but also to provoke discussion which may result in an improved version. The publication also included a short explanation of the aim and method of working in a peer review group. The outcomes sofar are both this guideline and, even more important, the process leading to this end.

8.2 Current practice and the new guideline

Unfortunately the time of the project was too short to be able to perceive changes in the practice routines on hypertension resulting from the adopted guideline. It is expected that the diagnostic process and treatment of hypertensive patients will be more in line with the agreed guideline than before. However, it will take time before these effects can be seen. For patients with a stable medication for a long time, there is no use to change the medication immediately now that this guideline has been

adopted. Feed back information on the current practice on hypertension was produced in order to see what should be changed in the doctor's prescription routines to be in line with the hypertension guideline.

Table 8.1 Ten most frequently prescribed drugs for hypertension (ICD codes I10-I15) during 4 weeks in 6 pilot practices (prior to participation in a peer group on hypertension)

slovak drug code	substance	% prescriptions (n=2192)
62596	Enalapril	10.9%
99334	Nifedipin	5.8%
94629	Nitroglycerin	4.0%
04367	Trimecryption (b-blocker)	3.8%
01328	Methyldopa	3.6%
94321	Diltiazem	2.8%
94810	Hypopytylin (other anti-hypert.)	2.5%
04063	Cavinton (vasodil.)	1.8%
99295	Anopyrin (ac.salic.)	1.6%
02622	Stugeron (vasodil.)	1.4%
total		38.2%

According to the guidelines agreed in the peer review group pharmacological treatment of hypertension should preferably consist of:

- monotherapy;
- in order of preference: beta-blockers, diuretics, ace-inhibitors, calcium-antagonists and vasodilators.

The current pattern of prescribed antihypertensive drugs is clearly not in conformity to this guideline. Methyldopa is not mentioned at all in the guideline. Nitroglycerin and Anopyrin are, strictly speaking, not anti-hypertensive drugs, but have probably been prescribed as medication for heart problems occurring in addition to the hypertension. Also the rank order is not according to the guidelines. With regard to the future prescription pattern, after the agreed work style with hypertension has been incorporated in the daily routine, we expect that:

- the frequency of methyldopa will be lower (or completely disappear);
- the ranking order of drugs will be more in agreement to the guidelines.

A second measurement will be needed to assess possible effects of this intervention.

8.3 Towards a professional platform

The original working time of the project was extended with 3 months. This allowed us to complete the development of the guideline, including its publication, and making plans for the future. The group has discussed further steps to be made. At least three group members intended to start a peer review group in their own region, using the experience from this project. At the same time one or more new training groups would be needed to spread peer review more over the country. The role of external experts will be in coaching the leaders of the peer review groups, training new group leaders and advising on the national infrastructure for the coordination of activities on quality assurance. As a general strategy we recommended to expand peer review at local level as an informal voluntary activity with GPs who are motivated for it. After some time, for instance one year, there should be an evaluation on the speed of expansion,

the resulting products, satisfaction with this method of working, and the willingness and ability of participants to continue by starting new groups.

In the final meeting by the end of November, a number of points have been addressed with a broader impact than peer review alone. These are:

- The consensus guideline on hypertension will be sent to all members of the Slovak Medical Association, with the information that this was a first step towards quality assessment and re-certification.
- A draft procedure for re-certification of GPs (see also below) was presented (a system of rating points for educational activities).
- The group has the intention to be the starting point for a GP section in the Slovak Medical Chamber and the Slovak Medical Association.
- In this respect the group wants to be involved in a continued PHARE project with the aim to develop an institute for primary care and a college of GPs.
- Translation of textbooks regarding primary care and quality improvement in the Slovak language is a priority.

8.4 National infrastructure for quality assurance

In addition to the ambitions of the Slovak peer review group, we formulated the following requirements concerning a national infrastructure for quality assurance:

- availability of educated teachers (preferably recruited from interested GPs) and teaching practices;
- organised development of professional guidelines for general practice in Slovakia;
- policy measures aiming at the recruitment of GPs for peer review and to ensure a nationwide coverage of 'quality circles';
- proper incentives for GPs to involve them in activities of quality assurance; this may be part of the remuneration system (as recommended) and the system of re-certification. Of particular importance are: refunding of costs made for continuing medical education, arrangements for practice replacements during absence and organisation of the courses convenient to the GPs.

As a general strategy quality assurance should start with highly relevant topics with easily measurable outcomes (e.g. prescription of drugs; referrals to secondary care). This approach will motivate other parties (e.g. health insurance funds; government) to support continuation of these developments. Furthermore, it is strongly recommended for a continued Phare project to allocate sufficient resources for this subject and to involve actively an organisation that has the capacity to take up a national coordinative role. The Postgraduate Medical Institute could be supported to take up this role.

8.5 Accreditation of training and courses

Information was provided on the need for an accreditation system for continuing medical education (CME). Improving quality of care implies setting criteria for continuing medical education courses. One of the targets in the recommended remuneration system is related to the doctor's effort in following courses for keeping up-to-date. Since not all supply on continuing medical education meets the quality standards, there should be an accreditation board which certifies a course or other educational activity. This board should also assign the number of hours (or points) attached to specific CME activities. An accreditation system has not been initiated in this project because the organisational embedding still was not clear. Accreditation is not necessarily a task for the Ministry of Health; it could probably better be delegated to an organisation run by the profession with marginal state (inspectorate) control, or it could be a task for a (renewed) Postgraduate Medical Institute.

8.6 Certification and re-certification

The need for a system of certification and periodical re-certification of GPs was discussed as another condition for quality improvement. Information from the Netherlands was provided. Certification and re-certification may start as a simple and basic instrument for quality assurance, which may be sophisticated in due course. It regulates the inflow of doctors: new doctors are only certified to become a GP, if they have completed a GP vocational training programme. And as regards re-certification, as a start the only requirement for re-certification can be that the doctor has really worked as a GP during the past period (e.g. five years). This is to exclude physicians who have not completed the specific GP training. This is a protection to both patients and GPs. Later on, requirements for re-certification may become sharper, including practice visits and even tests of skills and knowledge.

We have not started implementing a certification and re-certification procedure, partly for the same reasons as mentioned with continuing medical education, but also since the vocational training for primary care doctors in Slovakia is not yet modernised into a real GP vocational training. Furthermore, the current job description, which is still from the pre-privatisation period, is not up to date and cannot be the frame of reference. Only if an infrastructure for GP education and quality assurance is in place is it realistic to implement these instruments. Yet it is useful to explain the principles of a (re-)certification procedure and announce its introduction in the future. This will push doctors to engage in education and training for keeping up-to-date.

8.7 GP job description

The need and use of an agreed job description (or 'GP package of duties') for Slovakian GPs was explained. A job description specifies in detail the tasks and functions of the GP, not only regarding curative and preventive services and health promotion aspects, but also the role of the doctor with special groups of patients, the organisational aspects and accessibility.

The Basic Job Description of GPs in the Netherlands identifies the following groups of duties:

- Introductory duties (e.g. being receptive for requests for help; working according to current professional and scientific insights).
- Duties derived from the process of care (diagnostics, planning actions, follow-up duties).
- Duties in respect of the plan of action (e.g. adopt a waiting attitude, advise self-care, information/advice, drug therapy, minor surgery, counselling, consultation and referral).
- Follow-up duties (critically reviewing and - if necessary - adjust the GPs working hypothesis/diagnosis).
- Duties related to certain categories of patients (e.g. pregnant women and newborns; infants, children and adolescents; the working population; the aged; terminally ill; the bereaved; chronic patients; patients in need of emergency care).
- Supporting duties (increasing/maintaining professional knowledge; collaboration; coordination; maintaining practice facilities; organisation of the practice; keeping the medical and financial administration).
- Other duties (imposed by government; drawing attention to factors in the community that influence health; contributing to the professional organisation and health care; contributions to health care training).

Furthermore information was provided on how a job description procedure can be developed in a combination of bottom-up activities and central support and coordination. At central level preparatory work can be done, which subsequently is discussed

and amended at local level by (groups of) GPs. A job description can be used as a reference profile of the profession for education (including continuing medical education), training and negotiations with health insurance funds. Adaptation of the current job description in Slovakia should be a joint effort of the government, professional organisations and educational institutes.

9 PROVISION OF INFORMATION

Our involvement in the provision of primary care information had both a short-term and a longer term perspective. As explained in the previous sections of this report, data were needed to provide baseline information for the targets in the remuneration system, evidence about possible savings in the prescriptions of pharmaceutical drugs and feedback to the peer review group on quality of aspects of care. We started a review of current information systems in Slovakia, with the aim to make the required information available in a short term and with few adaptations of the software. One of the more sophisticated information systems currently being used in primary care in Slovakia, was selected and seven practices using this system were recruited as pilot practices for several activities of this project, among which peer review^{*}.

9.1 Data for short term purposes

The software package was extended to include pharmaceutical prescriptions and external diagnostic orders. Doctors were instructed for these new elements in the information system. It was organised that, on a monthly basis, data were recollected on diskettes from the practices all over the country. Since also declaration data were included, the largest health insurance fund was also involved. The chief statistician of this fund has been an adviser to the project for the analysis of the data. Data were also transferred to the project leader for analyses. For practical reasons in most practices we have not been able to recollect the intended amount of data. Below, the number of registration days per doctor have been summarised on which the analyses are based.

Table 9.1 The database: registration days and contacts per GP¹

doctor	days	contacts
A	58	3,947
B	91	4,984
C	83	3,443
D	62	2,969
E	46	2,169
F	89	4,648
Total	429	22,160

¹ Data from two doctors of the peer review group have been excluded; one was not a GP but a gynaecologist, the other did not use the same software

Results of the analyses that we have made so far, were presented in previous sections. They should be interpreted with caution because data only refer to a limited period of time, and to a limited number of practices, which are not necessarily representative of the situation in the Slovak Republic. Furthermore the information system was not specially designed for this purpose, so that the resulting information still lacks detail and articulation. But still, we defend this pragmatic approach: in our opinion it is better to work with imperfect data than have none and wait in ignorance. Even the rough information presented in this report, has not been available previously. An important effect has been that it has pointed to the value of information and research in running a health care system and the need for a carefully planned information system.

^{*} On the other hand, there was one member of the peer review group who used a different information system.

9.2 Towards a (primary) health care information system

In addition to the satisfaction of short term needs for information, the need for a structured approach in the development of a future information system was discussed and demonstrated. This approach implies identifying current and future needs for information and setting priorities in data collection. It must be clear what information is to be collected for which purposes and by which persons. This discussion has to be continued in a wider group of representatives of professional organisations to get national support.

The following categories of data were identified:

- * Data for the Government:
 - on health manpower (yearly);
 - on infectious diseases (a list of 90 diseases has to be notified);
 - on influenza (weekly in January).
- * Data for the Health Insurance Companies:
 - practice data (for the capitation payment: number of registered patients per company monthly);
 - patient contact data (date; patient identity code; company code; ICD diagnose code; process code; code for prescribed drugs; referral code).
- * Data for the new remuneration system (in general, a fee for service system requires a lot more data to be collected than a system based on capitation payments):
 - specified referral data;
 - specified prescription data;
 - specified data on diagnostic tests;
 - participation in continuing medical education.
- * Data for (financial) practice administration:

These data depend on the way the practice is managed and on the position of the GP and the working conditions (e.g. sending bills to patients for certain services or co-payments; fiscal information; maintenance of - shared - premises etc.).
- * Data for quality assurance:

The information system should be flexible to include various needs for information, resulting from (local) activities on quality assurance. In this project hypertension has been selected as a topic for developing a guideline, but many other subjects are thinkable.
- * Data on morbidity and interventions in general practice:

At present there is no such registration. If it is decided that this will contribute to professional development in general practice and the future position of GPs, it should be implemented.

The last mentioned category of data is meant to provide information on the position of GPs in the health care system, e.g. related to the position of medical specialists and hospitals. Obviously, the questions to be answered, determine which data should be collected with what instruments and during which period of time. Some questions defining the position of GPs are:

- What are the reasons why people visit the GP?

Rather than presenting diseases in diagnostic terms, especially in primary care they contact their GP with more or less vague complaints and health (related) problems. Knowing these reasons for contact, related to the working diagnoses and the final diagnosis, gives insight in this transformation from lay concepts into professional categories. This is relevant not only to GP education purposes but also to learn about health and health related behaviour in the population. It may also clarify the backgrounds of high contact rates in primary care.
- What morbidity is seen in general practice?

Answers on this question will show the wide variation of morbidity in general practice. This should be in contrast with the morbidity spectrum of the specialist. If not, this could imply that specialists deal too much with 'primary care problems'. If relevant practice information is available for the epidemiological denominator,

morbidity data also provide important epidemiological information. Evidently, also morbidity data are crucial for GP education and training.

- What interventions do GPs do?

This will provide information on the treatment of GPs. What kind of therapies are used; what kind of patients are referred to medical specialists or sent to the hospital.

This is particularly important if linked to the diagnoses.

If all three questions are to be answered, which obviously gives a most complete insight in the typical function and process of primary care, the information system should be able to identify episodes of illness, repeated contacts and interventions for one underlying health problem or disease. If episodes are not identifiable, the continuity of care, which is typical in primary care, cannot be understood well.

9.3 A centre for information and research

Discussions on the information system resulted in questions on what to do with the data and who should do that. Current mistakes, collecting data without using them, should be avoided in the future. Data have to be collected and processed and information has to be reported and disseminated. This requires a proper organisation and infrastructure. The more data are collected by individual organisations who need it, the higher the probability of duplication: of work and thus waste of resources. In coordinating information needs and data collection in health care, an independent institute should be preferred. Sophisticated data processing and analysis, which are essential components of doing research, is a specialty in itself and can better be delegated to professionals working in organisations made for this purpose, in which the quality of the work can be well monitored. The structure and position of such an institute deserves careful attention. It should be strictly independent and preferably not for profit. This position can be guaranteed by creating a board of governors, in addition to a professional management, in which relevant parties in health care are represented, like the Ministry of Health, Health Insurers, various professional organisations and, ideally, patients/consumers. The independence should also be elaborated in the bye-laws of the institute. The task of such a central institute is to collect, process and analyse data for the benefit of parties in health care, such as policy makers, epidemiologists, professionals and health insurance funds. In addition, the institute has a role in documentation and publishing for the general public. Possibly the institute provides a broader range of services, e.g. development of health education materials; design of practice premises; financial and legal advice; management and organisational advice.

9.4 Networking

Related to ideas of a centralised data and information facility (the institute for information and research), we discussed the creation of networks. The term 'network' in this context can be understood in two ways: as a network of collaborating GP practices or as a computer network.

First steps towards a network of collaborating practices have been made with the GPs in the peer review group who participated in the pilot study. Important questions for the extension of such a network are:

- who is participating?
- for which period of time?
- who is responsible?
- will there be meetings?
- how will data be used?

Answers to these questions should make up the plan of work for such a network. If there will be a central facility (e.g. an institute) the management of the network could

be located there.

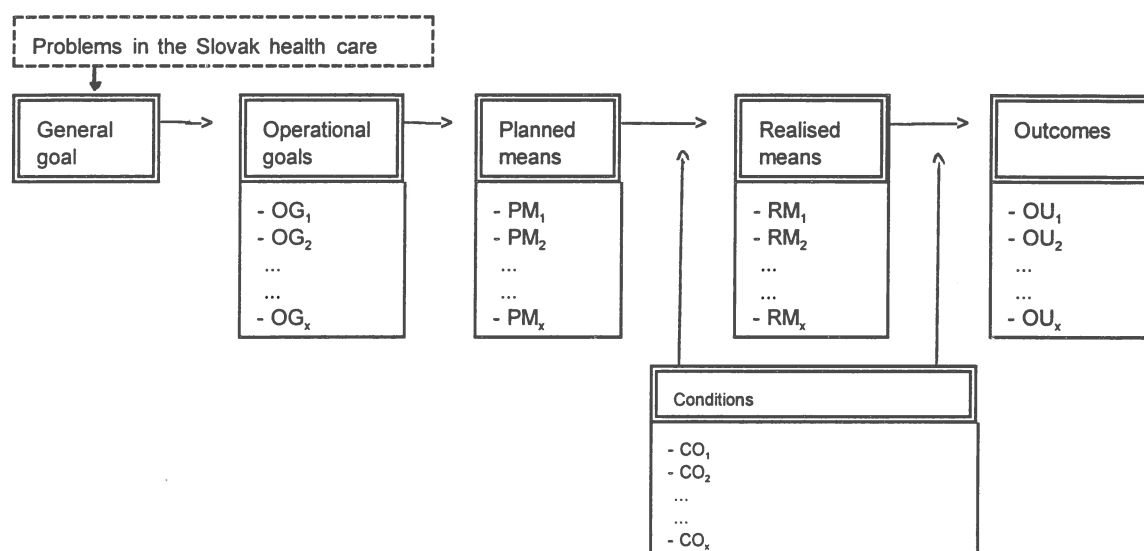
As regards computer networks, two options should be distinguished: an in-house network, for instance within a larger medical centre, or a network covering a number of practices scattered over the country. The aim of an 'internal' information network is the use of one identical information system by all workers in an organisation (e.g. health centre or polyclinic). The design of a network of collaborating practices depends on the exchange needs in the group. Should every member be able to communicate with every other member? Is one practice the focal point for the whole network, or will there be a central office? As an option to start with, the computer in the Medical Centre in Bratislava, which was a focal point in this project, could serve as the central computer for the network of pilot practices with connections by modem to the peripheral computers. Agreements need to be made with all participants on the conditions for use of the network, delivering data, the hardware and software to be used, the costs and the management of the system.

10 EVALUATION OF THE PROJECT

10.1 Introduction

Apart from the outcome of the project, we aimed to clarify the elements of the process and the conditions which led to success or failure. This requires a structured approach of the evaluation in which the contribution of planned and not planned activities to the achievement of operational goals are specified, as well as the facilitating or hampering role of foreseen and unforeseen conditions. This step by step specification, which is the framework for this chapter, has been outlined in the scheme below.

Figure 10.1 Framework of the evaluation (adapted from a model by Stake, 1967)



The general goal has been derived from an analysis of the current problems in the Slovak health care system, and in particular primary care. A number of working areas have been defined as priorities and for each of these areas, the general goal has been specified in operational goals. For the attainment of each operational goal a plan of work specified the resources to be applied and activities to be undertaken; these are the planned means. However, the intended plan of work may be adapted in the course of the project and that is why we distinguished the realised means as well. Changes between planned and realised means are often related to conditions that influence the process, and that cannot always be foreseen. Conditions may be external, like the economic and political developments or closer to the field of the project, such as time constraints, recruitment problems or logistic problems. Conditions are also crucial for the final outcomes of the project. Acceptance and dissemination of results require positive (external) conditions. On the other hand the absence of such conditions may hamper implementation and follow up. The operational goals, the planned means and the expected conditions form together the planned programme. The realised programme consists of the realised goals, means and conditions. The planned goals of the project were operationalised in the following way: the planned means point to the distinctive steps that need to be made in order to reach the goals. We will determine the degree of success of the project by assessing to what extent the different steps of a goal were realized.

The decision to evaluate the project was taken after the start of the project. An

evaluation study, however, requires a more formal structure in the organisation, reporting and management of a project. In the practice of this project these requirements could not completely be met. In the project a data collection in pilot practices was initiated. The evidence from this data collection has been presented in previous chapters. Although we aimed to use these data also for evaluation we failed to do so because of logistic difficulties and resulting time constraints. For the evaluation we have therefore relied mainly on qualitative methods. We made use of the following sources:

- terms of reference formulated by the Slovak government;
- project proposal as submitted by NIVEL;
- the project's Inception Report;
- the Progress Summary Report of the project;
- internal notes and reports of meetings and workshops, made by local and external experts;
- final evaluation interviews made with all local and external experts.

The structure of the rest of this chapter is based on the distinction between the planned and the realised programme. In the next section the planned goals and estimated conditions are described; in section 10.3 to what extent the planned means were put into practice and the results in each of the four working areas. Then the realised conditions of the project will be specified in section 10.4. This chapter will be concluded by a (preliminary) judgment of the success of the project.

10.2 Planned programme

The general aim of the project has been formulated as: 'Contributing to the improvement of cost-effectiveness and quality of primary health care services in the Slovak Republic', which then was specified in operational goals.

The operational goals of the project

- (1) *Changing the doctors' remuneration system in order to provide proper incentives for quality of care and cost-effectiveness.*
- (2) *Providing incentives and other conditions for doctors in order to stimulate cost-effective prescribing of drugs which contributes to cost containment in pharmaceutical care*
- (3) *Introducing modern methods of peer review and guideline development and making recommendations for an infrastructure for quality assurance*
- (4) *Improving the availability of collected practice data for the benefit of the project activities and formulating future options for a primary care information system.*

Although not formulated beforehand, two groups of expected conditions can be distinguished: pre-conditions, such as the political and economical situation, and the conditions which can be influenced from the project. We identified six conditions. Political and economical situation are a limiting condition; if these change drastically this may even result in cancellation of all plans, because financial resources are no longer available or priorities for health care no longer comply with the aims of the project. A second condition is the Slovak public opinion, which should accept the new role of the GP, without being oriented too much towards specialist- and hospital care. Thirdly, consent from both the Slovak GPs and from other doctors working in a primary care setting, (e.g. the ambulatory specialists) is essential. Strong unexpected opposition against the reforms is possible from the Slovak population as well as from other professions in health care. Fourthly, GPs have to be competent for their new coordinating role between primary and secondary care; this implies they should have an adequate skills level. The fifth condition is the time available. A (too) short time span will influence the results that can be achieved. Our final condition is the regularity of the visits of the team of external experts. It is expected that regular visits are needed in

order to keep the implementation process of the project at a certain speed.

10.3 Realised programme

Operational goal 1:

'Changing the doctors' remuneration system in order to provide proper incentives for quality of care and cost-effectiveness.'

<i>planned means:</i>	<i>realised?</i>
- reviewing current remuneration system and alternatives	++ ¹
- making outline plan for new payment system	++
- making final detailed plan (together with the parties involved)	+
- identifying information needs for the plan	++
- communicate these to sub-project information systems	++
- implementation of (part of) plan on limited scale	0
- collection/analysis of practice data	+
- study tour	++
- evaluation of activities/recommendations for further implementation	++
<i>not planned means:</i>	<i>realised?</i>
- 'testing' the new system with the available data	++
- 'theoretical' implementation in pilot practices	++

¹ ++ = completely / + = partly / 0 = not realised

The results in this area can be summarised as follows:

- analysis of the problem;
- blueprint for a new payment system;
- first registration data obtained in the pilot;
- acceptance by the professional group;
- favourable attitude of Ministry of Health towards implementation of the new payment system.

The current remuneration system was reviewed and several alternatives were considered. In order to detail the designed plan, the level of the targets had to be determined on the basis of production data from primary care practices and agreed quality criteria. For the purpose of this data collection, the information needs were communicated to the information expert. The external experts for the peer review group should define criteria for referring, prescribing, ordering lab tests and hours to be spent yearly on continuing medical education. This could not be realised for several reasons. Firstly, a very practical point was the delay in the data collection. Secondly, the peer review group was too much involved in the process that resulted in the guideline and making plans for the future, to be able to discuss the targets (even though the project time was extended with three months). More in general, we also realised that applying incentives should be done very carefully, hand in hand with activities to increase the GPs' competence, in order to prevent financial gains at the expense of quality of care. We also need to have better insight in the practice costs to be able to judge the effects of the new remuneration system on the income. (A loss of income as a result of the new system would not be acceptable).

So, as parameters for the incentives had not been defined, it was not possible to start the experimental implementation of the new payment system in the pilot practices. From both representatives of the doctors and the Ministry of Health the plan for the payment system was received positively.

Operational goal 2:

'Providing incentives and other conditions for doctors in order to stimulate cost-

effective prescribing of drugs which contributes to cost containment in pharmaceutical care.'

<i>planned means:</i>	<i>realised?</i>
- reviewing the current system	++
- recommendations for a more rational and economic system	++
- creating opportunities for implementation	+
- implementation on experimental basis in the 3 pilot practices	0
- providing documentation	++
- study tour	++
- evaluation of results/recommendations for implementation on a larger scale	++
<i>not planned means:realised?</i>	
- 'theoretical' implementation in pilot practices	++
- estimating possible savings	++

¹ ++ = completely / + = partly / 0 = not realised

Summary of results in this area:

- analysis of the problem;
- recommendations towards distribution of pharmaceutical drug and remuneration of pharmacists;
- creation of incentives for more 'rational' and cheaper prescribing in the blueprint of the new payment system;
- pharmaco-economic pilot study:
 - a. calculation of theoretical savings by: prescribing according to (Dutch) guidelines and systematic substitution by cheapest equivalent product;
 - b. effect of peer review on prescription of GPs.

The current system of registration, pricing, reimbursement, prescribing and distribution of drugs was reviewed. Creating opportunities for implementation was elaborated in a pilot study, in which effects were simulated on the basis of the data collected in six pilot practices: theoretical savings, achieved by prescribing according to (Dutch) guidelines and by substituting branded drugs for cheaper products were calculated. The transformation of the data that were collected, turned out to be complicated. In the blueprint for the new payment system, incentives for more rational and cheaper prescribing were created. The calculation of possible savings has provided good arguments to stress the important role of primary care and general practice in a cost-effective health care system. Moreover, it shows that prescription behaviour is one thing, but the delivery of drugs is another. This points to the relevance of changes in the rest of the pharmaceutical distribution system. The pilot also gave the possibility to glimpse at possible changes in prescription behaviour to take place after an intervention -implementation of a newly developed Slovak guideline for hypertension- in the peer review group.

Operational goal 3:

'Introducing modern methods of peer review and guideline development and making recommendations for an infrastructure for quality assurance.'

<i>planned means:</i>	<i>realised?</i>
- formulating recomm. for an improved system of re-certification	+
- introducing peer review in theory and in practice	++
- creation of more 'circles' in different parts of the country	0
- developing/adapting the official task description of GPs	0
- first introduction of professional guidelines	++
- provision of literature and information	++
- study tour	++
- identifying policy implications	++
- evaluation of results	++
<i>not planned means:</i>	<i>realised?</i>
- collecting/analyzing practice data for feed back	++
- small scale implementation of guideline	++
- identifying needs for practice management	+
- start developing practice management course	+

¹ ++ = completely / + = partly / 0 = not realised

Summary of results in this project area:

- analysis of the current situation described in the Inception Report;
- setting up a first peer review group;
- teaching the method of peer review;
- developing a Slovak 'bottom-up' professional guideline;
- publishing the guideline;
- planning initiatives for expansion of peer review groups;
- implementation of the guideline for hypertension in 7 practices;
- monitoring behavioural changes;
- recommendations for implementation of a system of re-certification and accreditation of CME;
- getting support from the Medical Chamber;
- impulse to a scheme for re-certification;
- impulse to accreditation system of CME courses.

In the beginning of the project, it was obvious that taking measures for re-certification was not yet feasible, mainly because other essential elements in the infrastructure for education and quality assurance are not up-to-date. A preliminary result is the awareness of the Slovak partners about the role of re-certification in the context of quality assurance. Re-certification can only be fully implemented if certain other conditions are met. The principal activity in this project area was the establishment of a peer review group. This was a quite new experience, which caused some difficulties in the recruitment phase. Candidates invited to participate in this activity were insufficiently informed about the objectives and the activities. The first introduction of modern guideline development took place in this peer review group; a Slovak guideline on hypertension was developed and published. Certainly as important as the guideline itself was learning the process that led to these results: participants learned to explicit their practice routines and give each other feedback in a structured way. Another aim was trying to create more quality circles in different parts of the country by participants then becoming peer group leaders themselves. At the moment no new quality circles have been set up, although some initiatives for the future were taken. The impression is that at least three participants are willing and able to do this. Further coaching of these new group leaders would be needed.

The need for developing an official GP task description was discussed and information was supplied. Such a description has not been drafted effectively, because of the lack of organisation of GPs in Slovakia that could sustain and carry on this work. Recommendations for future policy were formulated at different moments in time during the project. An evaluation of the activities took place during the last peer review session.

Operational goal 4:

'Improving the availability of collected practice data for the benefit of the project activities and formulating future options for a primary care information system.'

planned means	realised?
- reviewing the various information systems in Slovak republic	+
- describing and prioritizing the needs for information	++
- developing software/adapting available software	++
- selecting hardware for the 3 pilot practices	++
- testing and implementing the information system in the pilot practices	++
- supporting the establishment of a research environment	+
- making recomm. for the implementation on a wider scale/evaluating the results	++

¹ ++ = completely / + = partly / 0 = not realised

Summary of realised results:

- adjustment of the selected practice information system;
- data collection in 6 pilot practices;
- analysis of the production figures of the GPs;
- availability of background data via Health Insurance Company;
- start of the discussion about future information priorities and strategy;
- research with the collected practice data;
- discussion on national information and research centre.

It was not necessary to review extensively the various information systems that are in use in Slovakia, because in an early stage local experts had already decided to use one of the information systems in place. After consulting the other experts, decisions were taken to adapt this information system. For this purpose the software in the pilot practices was extended to include drug prescriptions and orders for diagnostic laboratory tests. Hardware was purchased for participating practices in the project. Supporting the research environment, the other goal of the information system, took place in a limited extent. The discussion focused on future needs and priorities for the information system in relation to the position of General Practice in Slovakia. The discussions that were needed for the needs and priorities on a longer term were started. Data collection was logistically difficult and the analysis was hampered by starting problems.

10.4 Realised conditions

In section 10.2 we estimated the following conditions to be influential:

1. The economical and political situation in the Slovak republic
2. Support by the Slovak population
3. Consent from the GPs and other professions within the primary care setting
4. Competence and skills level of the Slovak GPs
5. Time span available
6. Regular visits of the team of external experts

The conditions 2 and 4 have not been relevant, because outcomes have not been implemented on a large scale. The conditions 1,3,5 and 6 have played a role. First of all, the political and economical situation. The role of the Ministry of Health, who was the commissioner of the project, cannot be underestimated. After all, it was the wish of both the local and external experts that the Ministry would be more involved in the project. We think the results of the project were received with goodwill at the Ministry of Health, but there might have been more mutual exchange and feed back. This will even be more crucial in the future, with the stepwise implementation of the remuneration system. This requires real commitment at the highest level in the ministry. The same applies to the follow up of our activities in the field of pharmaceutical prescribing and cost control.

Secondly, the opinion of GPs and other professions within the primary care setting. Right now consent about the proposed reforms does not seem to exist, but this might stem from a lack of an 'organized opinion' at all. This could be related to the absence of a tradition of organisation in the private sphere (e.g. in clubs, associations). Furthermore GP organisations are relatively weak in the Slovak Republic. Strengthening non-governmental organisations to become partners in health care should be addressed in the near future. A third condition was the time span available for the implementation of the project. Important decisions have to be made by the Slovak authorities, often at political level. These processes take time and cannot be accomplished in only ten months time. Fourthly, it was estimated that regular visits from the team of external experts would be needed. This turned out to be indeed an important condition for the project. The visits were very important for the continuity of the activities in the identified working areas. It was a deliberate policy to have frequent but short working visits. By experience this approach -in which local and external experts do 'homework' following a visit- appears to be more effective than long stays.

As regards the role of the local coordinators, these have been very important for the success of the project. According to the external experts, indeed the Slovak way of working sometimes seemed to be ad hoc, as could be noticed in the organisation of meetings and unexpected decision making. The local coordinators effectively worked as the intermediaries between these two 'cultures'. Sometimes it was felt that the local experts appointed to the project were no experts in all areas. In the peer review activities this could be compensated by delegating the coordination to one of the participants of the peer review group. In the area of the information system the focus was largely on short term goals and a thorough reflection on future needs did not really happen. In a future project it could be considered to involve various local experts coordinated by one principal local coordinator which serves as a link to the external project leader. Finally, an unforeseen condition were the logistic difficulties related to data gathering in the seven pilot practices and the subsequent analyses. This has especially influenced the results obtained with the payment system and pharmaceutical prescribing and -to a lesser extent- in the field of quality assurance. It caused some delay in final reporting and the fact that targets could not be defined in more detail.

10.5 Conclusion

We conclude that the implementation of the project fitted closely with the planned structure of the project, but most proposed changes could not be implemented. Important reasons for this were: (1) the time process needed for reforms of this kind, especially in the field of quality of care (2) the dependency of reforms in the remuneration system and pharmaceutical cost containment on the quality activities (3) the complex and politically laden contents of some reforms, (4) the lack of organization of the Slovak GPs and (5) the logistic difficulties in the data collection.

To what extent have the planned goals of the project been achieved? We have shown in this chapter that the four operational goals have only been partly achieved. The question is how successful the project has been. This is a difficult question because the criteria for success of projects like this one are not obvious. The planned goals, as formulated in the Terms of Reference and the Inception Report, were not very realistic for the duration of the project. However, there may have been good reasons to do so. Apart from this, it is essential to take into account the turbulent context of these kind of projects; very often crucial prerequisites for success, like sound preparation, efficient working time and good structuration in advance cannot be safeguarded. In a final judgement the strict conclusions of the evaluator should be accompanied by those of the client and the experts who were involved. Both client and experts appear to be reasonably satisfied with the outcome. So, we conclude that not all goals of the project have been realised; but taking into account the context and the conditions, much more could not have been achieved.

11 CONCLUSION AND RECOMMENDATIONS

11.1 Conclusions

Meaningful contributions have been made in the four areas of the project:

- A new remuneration system for primary care doctors
- Measures for pharmaceutical cost containment
- Introduction of a system of quality assurance
- Information system in primary care.

However, progress has remained below the ambitions as described in the inception report and the workplan. In particular less implementation could be realised than was promised before. While working in this project, local and external experts have learned the details and the scope of the problems, the obstacles and the conditions for solving the problems. Relieving the burden of financial problems in the Slovak health care system without seriously threatening the quality of care, takes much more time and effort than could be given in the context of this project. New methods and infrastructures have to be developed and implemented for continuing medical education, re-certification, improvement of professional organisations and related legislation. Bringing down the pharmaceutical costs partly results from measures to replace wrong incentives. In a relatively short term, major savings can be achieved here by measures aiming at systematically prescribing and delivering cheaper equivalent drugs (e.g. generics). The newly developed remuneration system has the potential both to contain health care costs and to improve the quality of care. Obviously, this requires that doctors engage in programmes for continuing education. At present, it must be admitted that it is difficult to motivate doctors for continuing education and other aspects of quality improvement in an environment where income and payment are such dominant issues. Another problem is related to delegation of tasks, which do no longer obviously belong to the domain of the government. Organisations of (privatised) professionals and other non-governmental organisations are not yet sufficiently developed for these roles. Finally, the importance of an information system in the provision of data for defining problems in the health care system and monitoring change, has been well demonstrated.

Our pilot studies with data from 22,000 patient contacts in 6 practices provided useful information for further action.

- We found a high contact rate of 7 to 8 visits per year of which a quarter is referred to secondary care. It seems possible to bring down both rates by improving the competence of GPs and patient education.
- We found indications that the quality of prescribing is not optimal; the net result of improving this quality, however, will not necessarily result in a cost reduction, although it may result in lower referral rates and costs in secondary care.
- In every contact almost two packages of drugs are prescribed; further research should clarify whether drugs are prescribed unnecessarily in order to improve rational prescribing.
- If doctors would systematically prescribe the cheapest available product this would result in a cost reduction of 25 - 30% on pharmaceutical prescriptions, in addition to possible savings from reducing unnecessary prescriptions.
- In the weeks immediately following the agreement of the guideline on hypertension, we could not yet assess effects in the prescriptions of the GPs. This is not surprising, because the new treatment policy will be implemented particularly with newly diagnosed patients; it would even

be undesirable to change medication of the known population of hypertensives. Nevertheless, on the basis of the data, desirable longer term effects were formulated.

- Results of the referral patterns, which will be available later, will provide information on possible reductions in referrals to secondary care.

Data from these pilot studies fitted well in the earlier results from the European Study of GP Task Profiles about the position of Slovak GPs in comparison to their colleagues in other countries. These results show:

- The weak position as the doctor of the first contact in health care
- The limited range of services provided
- The low level of practice equipment
- The long working days of doctors.

Altogether, the research data provide a good basis for the activities that have been initiated and that need to be continued in the areas of quality improvement, practice management development, remuneration including proper incentives, cost control measures and related policy. Below, we will draw lines to the future for each of the four project areas and formulate a number of recommendations concerning conditions and the role of stakeholders.

11.2 The way ahead

* Remuneration system

- Level of capitation fees have to be determined for the 8 pilot practices, on the basis of past income levels and the estimated income from services which are remunerated per item and other sources of income.
- Services to be remunerated per item have to be determined.
- Targets for referrals, prescriptions and lab tests are to be set for the pilot practices. Proportions of reduction should be set on the basis of practice data and after discussion in the peer group; the reduction targets may not necessarily be equal for all practices.
- Possible co-payment by patients has to be decided upon, aiming at a decrease of the contact rate of patients).
- Ministry of Health and health insurers commit themselves with the system and guarantee the GPs at least no loss of income during the experimental implementation.
- For monitoring purposes, data need to be collected, analyzed and fed back.
- Larger scale implementation is to be prepared.

* Pharmaceutical cost containment/prescribing

- Stimulate cost effective prescribing by GPs (see remuneration)
- Continue development of (prescription) guidelines and other quality improvement efforts in primary care.
- Change remuneration of pharmacists.
- Incentives for pharmacists to deliver cheap equivalent products/generics.
- Consider co-payment for certain drugs; or limitation of the drugs list.
- Initiate cooperation between pharmacists and GPs at local level for improving the quality of pharmaceutical care.
- Collect and analyze data for monitoring and feed back.

* Quality assurance

- Continuation of peer group activities by starting new groups by GPs.
- Start training of GPs who want to be peer group leaders.
- Continuation of 'production' of guidelines on other relevant urgent primary care topics.
- Recruitment of active and capable GPs for training, teaching etc.

- Further develop network of practices for teaching and research (using the available list of doctors who showed their interest).
- Start national coordination of continuing medical education and accreditation of courses; the Postgraduate Institute could play a role.
- Start of a scheme for re-certification which is to be implemented gradually.
- Develop retraining programme for doctors to become certified GPs 'new style'.
- Draft GP Job Description to be discussed and agreed nationwide.
- Involvement of relevant professional organisations (Medical Chamber; Slovak Medical Association).
- Organise/institutionalise documentation, information, research in (primary) health care.
- Work on harmonisation of education and (re)certification with EU directives.
- Develop necessary policy and legislation for developing and enforcing primary care.

*** Information system**

- Continue discussion on future information needs at national level.
- A more in-depth orientation on different registrations in general practice
- Primary care research priorities are to be formulated
- Selection of software on the basis of specified needs.
- Develop manpower register for planning.
- Start network of registration practices (see also above)
- Create infrastructure for coordination, data handling and service, e.g. a primary care information and documentation centre.

Furthermore the experts suggest to include the following relevant related subjects in a future project:

*** Training and education**

- Identifying retraining needs
- Developing (short term) re-training course
- Testing/implementing this course on a small scale
- Coordinating with peer review groups
- Adapting postgraduate curriculae
- Introducing international organisations (e.g. EURACT)
- Evaluation of achievements

*** Professional organisation and infrastructure**

- Identifying needs of existing organisations
- Reviewing possibilities of existing organisations for new tasks
- Advise/support transforming organisations
- Supporting the creation of a PHC section in one of the medical journals, serving as a publication and discussion forum
- Introduction of international organisations
- Evaluating achievements
- Implementing academic chairs for general practice/family medicine

*** Research**

- Education in primary care research
- Formulation of research programmes
- Developing a surveillance system for health of the Slovak population
- Embedding primary health care research in an academic environment

11.3 Further recommendations

* Broadening the basis for expansion

This project predominantly had a technical focus: problems have been investigated, models and solutions have been developed and, sometimes, tried out on a limited scale. Although this technical work will not stop now, there needs to be a shift towards the decision makers and other stakeholders in health care. Experimenting with the remuneration system requires a much greater commitment of, at least, the Ministry, the health insurers and representatives of the doctors such as the Association of Private Physicians. Expansion of peer review, drafting an official GP job description and implementation of (re)certification also requires active and formal involvement of professional and educational organisations, such as the Medical Chamber, Slovak Medical Society and the Postgraduate Institute.

* Coordinated policy making

Modernisation of the health care system requires new legislation and policy making. For strengthening primary care it will not be enough to improve the competence of GPs. The position of GP should have a legal basis. For instance, various specialists are still accessible without referral by a GP (e.g. ophthalmologists, psychiatrists, and all specialists for check ups with chronic patients). The gatekeeping role of GPs should be well defined, established and maintained. Explicit policy development is also needed on the future of primary care gynaecologists and GPs for children. Should this GP-trio be kept in the future or gradually reduced to one GP for all age groups and both sexes? Are options different for cities and rural areas? Policy making should also be coordinated. During this project, while working on a guideline for hypertension, we were confronted with a policy measure on the drug formulary which reduced the range of drugs (also anti-hypertensives) that primary care doctors are allowed to prescribe. Coordinated policy making is a condition for stability in the health care system.

In respect to **future Phare projects** we recommend to make the right 'mix' of activities in one project and coordinate well between projects. As we have explained extensively remuneration and quality assurance are closely linked; we recommend to include this in one project. Projects in the hospital sector should be carried out in coordination with primary care projects. Health promotion activities should take into account possibilities and opportunities of primary care; and primary care should be prepared for health promotion tasks.

* Coherent financing

a.hospital - primary care

Another aspect of coordinated policy making relates to financing. Strengthening primary care implies and allows the reduction of the volume of secondary (hospital) care. This - more or less spontaneous - process of reduction is already well underway in Slovakia. Resources should be reallocated to give primary care the possibilities to take up its more comprehensive tasks.

b.pharmacists / drugs

It is strongly recommended to change the remuneration of pharmacists from a percentage of the turnover to, for instance, a fee per prescription. As a transitional measure the current level of income could be guaranteed by recalculating it to the number of prescriptions. Adaptations of the Price Law may be necessary as well to attain cost containment goals.

* Embedding GP in primary care

Primary care includes more than just general practice; other health professions should play complementary roles. Caring for elderly and chronically ill patients, who at present often occupy hospital beds, can often be transferred to the community, if home nursing services and home help services are available. Community nursing is absent in most parts of the country. This profession should be developed in a similar way as the

doctors. Regional and/or local organisations should be created with a proper funding system (e.g. by block contracts) to provide these services. At present nurses can only make home visits ordered by the doctor, from whose budget it is paid. Teamwork of primary care professionals is important to prevent gaps and double work. Collaboration can take place in various forms. One option is the small scale integrated health centre in which, for instance three GPs, four community nurses and four auxiliaries work together in one building for a population of 5000 to 6000 patients. One of the advantages of making group practices of three to five GPs is the greater possibility to purchase equipment and use it more efficiently. These structural aspects of primary care can be the subject of a primary care stimulating policy. It should be taken into account, however, that the public opinion is against any structure which reminds of the former polyclinic.

*** GP Education**

Quality assurance and education and training are closely related. An official GP job description can serve as a frame of reference to both. It is recommended that the reorientation of a GP curriculum 'new style' will get an impulse; on the short term this should focus on a retraining course for improving the competence of current doctors who want to be certified as a new style GP. This is urgent since nowadays there is no longer an effective training scheme for primary care doctors. These used to be trained in hospitals, but since primary care has been privatised, hospitals prefer the education of future hospital doctors.

*** Practice management**

Primary care doctors have not been prepared for their new position after the privatisation. Most probably, many doctors still would need support as private entrepreneur. Making the health care system more primary care based, increases the need of GPs for practice management tools: the lay out of the practice, organising practice routines and prevention, access in evenings and weekends, delegation of tasks to the practice assistant etc. These subjects should be addressed in CME courses and in the retraining programme for doctors who want to become a GP. The remuneration system should also be designed to include separate components for premises, practice equipment and practice assistant.

*** National organisations for GP**

The power of the government in the Slovak society has considerably decreased, but there is a lack of structures to take over (parts of) this role. GPs are weakly organised and do not feel strongly committed to 'their' organisations. As we have experienced, this is an important obstacle to mobilising persons and ideas and disseminating fruits of new activities. National organisations with regional and local branches can play an important role in the necessary modernisation of health care, improving the position of professionals and building the 'body of knowledge' of general practice. These non-governmental organisations should be supported to become a well developed counterpart in the health sector, that can carry out tasks which do not necessarily need to be done by the government. There is no need seeing these organisations as a threatening factor; the government should create a positive environment for these organisations to develop.

*** Changing routines**

Changing practice routines is difficult and not just an educational challenge. Patients are also used to the doctor's routines. The expectations of the patient may be an obstacle to giving up routines (see also below on the role of the public opinion). Besides, the influence of medical specialists on primary care should be considered as an important factor to take into account in changing professional behaviour of GPs.

*** The public opinion**

Modernisation of health care needs approval and commitment of all parties involved. This includes acceptance by the patients. For many years the population has believed that primary care is inferior to secondary care. It is strongly recommended that the population will be informed about the changes which are underway in primary care, so that the negative attitude towards primary care can change.

*** Harmonisation with EU**

Although membership of the European Union is not expected in a short term, where possible, policy measures and legislation should be harmonised with those of the EU. This can also be taken in a broader sense. For instance, the relatively very low payment (or: the social esteem) of doctors in Slovakia, like their colleagues in other countries of central and eastern Europe, is in sharp contrast to the one in western Europe. Reliable information on these incomes is hard to get, since an unknown proportion is from informal cash payments of patients. Those who can pay more, sometimes have better access to care. Although currently these issues are no subject of explicit EU policy, they can be an obstacle to a smooth integration of Slovakia in the future.

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ANNEX 1

Experts involved in the project

Coordination

Phare MUDr. Zora **Bruchacova**
(Ministry of Health, Bratislava, SR)

Main local experts

MUDr. Jan **Goljer**
MUDr. Eva **Durechova**
Director and vice director of a medical centre in Bratislava

Team of external experts

Project leader: Wienke G.W.**Boerma** (MSc, psychologist, health services researcher and consultant; NIVEL, Utrecht, NL).

Team members (alphabetic order):

Vic E.**Dubois** (MD, PhD, GP trainer, peer review and communication; Maastricht, NL)

S.Martin **van Geel** (MSc, economist, consultant in organisation and financing of pharmaceuticals, Utrecht, NL)

mrs. Saskia J.**Grielen** (MSc, sociologist, project assistant; NIVEL, Utrecht, NL)

Joep **Heesters** (PhD, health economist, financing of health care, payment systems; GGZ Netherlands, Utrecht, NL)

Job F.M.**Metsemakers** (MD, PhD, GP, GP trainer, director registration network; Maastricht University, NL)

François **Schellevis** (MD, PhD, GP research and information systems, quality systems; Free University, Amsterdam; NIVEL, Utrecht, NL)

Koos **van der Velden** (MD, MPH, epidemiologist, primary care consultant, primary care information systems; NIVEL, Utrecht, NL)

Supporting consultants:

mrs. Diana **Delnoij** (PhD, political sciences, health care financing and payment systems; NIVEL, Utrecht, NL)

Prof. P.P.**Groenewegen** (PhD, sociologist, health care policy and organisation, research; NIVEL and University of Utrecht, NL)

Prof. Jouke **van der Zee** (PhD, sociologist, health system comparisons, health policy development, director of NIVEL; Maastricht University, NL).

Research assistance / data processing

Harald **Abrahamse**, (BA, NIVEL, Utrecht, NL)

ANNEX 2

CHRONOLOGY OF PROJECT MEETINGS AND EVENTS

Start meetings/introduction	28-29 January	Bratislava
Workshop/ planning of activities	17-19 February	Bratislava
Planning/inception report/ practice visits	4-6 March	Bratislava, Cicov, Presov
Seminar	7 March	Bratislava
Workshops 'payment system'/ 'pharmaceutical costs'	24-25 March	Bratislava
Study tour I Netherlands	31 March-4 April	Netherlands
Workshops 'payment system'/ 'pharmaceutical costs'	21-22 April	Bratislava
Workshops 'information system'/ 'peer review group'	28-30 April	Bratislava, Cicov
Int.conference; practice visit	7-8 May	Svidnik, Presov
Progress meeting	9 May	Bratislava
National conference	10 May	Bratislava
Practice visits; Workshop 'peer review group'	21-23 May	Presov, Bratislava
Study tour II Netherlands	26-30 May	Netherlands
Workshop 'information system'	11-12 June	Bratislava
Workshop 'peer review group'	1-2 July	Bratislava
Workshop 'payment system'; progress meeting	7-9 July	Bratislava
Workshop 'pharmaceutical costs'	4-5 August	Bratislava
Workshop 'payment system'	18-19 August	Bratislava
Study tour United Kingdom 'fund holding'	26-29 August	London
Workshop 'peer review group'	28-29 August	Bratislava
Workshop 'pilot studies'	29 September	Bratislava
Phare PMU Conference	30 September	Bratislava
Workshop 'peer review group'	25-26 November	Bratislava