

Hippokrates Exchange Final Report

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Introduction

My name is Amber Janjua and I am a GP based in Hertfordshire in England. In September 2011 I took part in the Hippokrates Exchange Programme run by the Vasco de Gama movement, visiting the USF Unidade de Saúde Familiar - Family Health Unit in Leiria, Portugal. Leiria is a city of approximately 50,000 halfway between Lisbon and Porto. The city is not a usual tourist destination and this made it an interesting place to visit. While speakers of English were not common this was not a problem as I found the people of Leiria very friendly, and they seemed to really appreciate my efforts to try and speak Portuguese. The local culture was particularly vibrant, with many public activities.



Above: Leiria

I spent the majority of my time shadowing a GP at the Unidade de Saúde Familiar, Dr Denise Alexandra. I was struck when I first arrived at the layout of Denise's office: it was decorated with pictures of the children on her patient list, painted orange, and had a grinning donkey on the door reminding people to smile! This made me feel instantly relaxed and true to expectation Denise was a wonderful host who was very willing to answer all my questions.



Above: Dr Denise Alexandra

As I was preparing to leave for Portugal I had this report in mind and so I sat down and had a think about the different ways in which general practice in Portugal might differ from that in the UK. After a little research, I came up with a short list, which included things like consultation style, differences in the patient cohort, training and the like. However, at the same time I was also reading up on the development of the Health and Social Care Bill 2011 (which, as I write, has moved to the House of Lords). This highly contentious proposed law will, if passed, have far reaching ramifications for all doctors and will change the landscape of the NHS. For young doctors such as me it may mean that we practice in a radically different environment to those who trained us.

Yet, when I tried to get to the bottom of what effect the changes would have, it soon became apparent to me that the Health and Social Care Bill is a highly politicised issue and unbiased information is hard to come by. Supporters of the bill present it as a positive change which will sweep away bureaucratic red tape, place GPs at the centre of decision making and empower patient centred healthcare. Opponents present a different picture, suggesting that the bill is a combination of crude money saving techniques, will lead to disorganised and fractured healthcare provision, and will place GPs in the unenviable position of having to ration health provision to a degree unheard of to date. Those most bitterly opposed to the bill believe that the Health and Social Care Bill, with its

provision that any willing provider may tender for the provision of healthcare, amounts to a partial dismantling of the NHS and the creation of a two-tier health system.

I do not propose to be an expert on the possible effects of the Health and Social Care Bill 2011. Without wishing to express an opinion one way or the other on these issues, it is self-evident that private health provision will have a greater role in the delivery of healthcare should the bill become law. I realised that looking at the current Portuguese model of healthcare, the interplay between primary and secondary healthcare and the interplay between the public health system and private provision would be interesting and informative in the current climate in the UK. As such in this report I hope to set out the differences that I noticed, both positive and negative, in the hope of identifying perhaps some of the problems and opportunities GPs and other medical professionals may have in the UK in the future.

The Portuguese Health System

By way of background, I begin with some general comments about healthcare in Portugal. The first difference I noticed is that it is very decentralised, with local government areas administering health centres directly. There are currently five regions: North, Centre, Lisbon and Tejo Valley, Alentejo, and Algarve. As such the organisation of NHS provision is very variable and, it seems, not always rational or efficient. Healthcare in Portugal has been extensively reformed in the 2000's and is currently provided by three separate means. Low-cost, public 'NHS' provision exists for those who contribute to Portuguese social security (IE, those in employment) and their families as well as those that are unemployed. This provision is supplemented by 'health subsystems', a form of health insurance through employers, and also by private treatment when patients individually contract with a practitioner.

A particular reform to the health system in 2006 introduced the family health centre model, through which you get to choose the team you work with and have to meet demanding targets. It is not mandatory for a health centre to be a family health centre; rather groups of GPs will put forward an application to convert their health centre to adopt the model. The Unidade de Saúde Familiar, where I was placed, is a family health centre (as you might have guessed from the name!). As such, my observations of Portuguese health care were viewed through the lens of this specialised experience.



Above: The Doctors

General Practice - Administration

The core of Portuguese General Practice is the family list. At a family health centre like USF a single GP will have the entirety of a given household on his or her patient list, and each time the patient attends they will see this doctor. Whenever a patient's notes are accessed the doctor can see information on all family members, and not just health records: living arrangements, occupation, social situation and a range of other risk factors. All this information was really useful in informing treatment decisions and the continuity of care implicit in family lists seemed to me to do a lot to build relationships between doctors and patients, based on what I saw. As to whether a similar system would work in the UK, there might be additional practical problems here: in many families the parents are unmarried and surnames differ and people move around a lot more than in Portugal.

The Unidade de Saúde Familiar has six GPs who maintain a one-to-one ratio between doctors and nurses. However, I noticed a marked lack of support staff and secretarial work was done directly by the doctors while I was there – I was surprised how much data entry Portuguese doctors did. Similarly, the centre has no practice manager or the equivalent. There is a unit co-ordinator, a doctor who acts as a spokesperson, but I was told in no uncertain terms that he is no-one's boss: he doesn't manage, he co-ordinates. In effect there was no clear leadership in the health centre, and 'human resource' issues are left unattended. For example, each doctor's family list is supposed to have a

nurse assigned to it but the nurses do not nurture this and there is no one in a position to arrange so that things are otherwise.

For this new family health system, access for the patients that are registered with GPs it is not a problem. Targets are set, and if these are met a financial bonus is awarded. I can only assume, however, there is a degree of local variation in this regard. GPs are all public employees, with fixed salaries. To advance salary wise more exams have to be taken, although at the moment pay is frozen due to the financial crisis.

General Practice - Consultation

Consultation times vary between health centres but at the USF Santiago Family Health Centre the standard time was 15 minutes, with child health surveillance appointments being 20 minutes. Another health centre I visited had 15 minutes for acute appointments and 18 minutes for planned appointments. There was apparently less time pressure on both doctors and patients and appointments would frequently overrun.

Doctors were able to take a break when they needed to and have up to an hour for lunch, patients running up to an hour late were still seen and doctors would even see patients for impromptu appointments in the corridor (this I noted during my one day visit at a traditional health centre in Coimbra). Doctors were happy to deal with multiple health problems in one consultation and also deal with multiple members of the family in one consultation. This did of course lead to significant problems in keeping to time. Patients did not seem to mind being kept waiting but would also often be late themselves. Overall, I got the impression that both doctors and patients are more laid back about timing and the use of resources, in the form of a doctor's time, in Portugal. I do not think we could adopt a similar attitude in the UK because of our more resource pressured environment, with 5 – 10 minute appointments and, also, higher patient expectations.

There were some ways in which doctors were stricter with patients in Portugal. In Portugal visits are for the elderly, paralysed and newborns and the like, people who really cannot get into the surgery – this is very different to my experience in England. The problem of non-attendance is common but dealt with directly by some doctors and Denise at least penalises non-attendees by barring them from booking another routine appointment for another month.

Due to the law regarding sick leave in Portugal, appointments for doctor's notes are very common. Even a single day off requires a doctor's note, including a day off school for children! On the other hand, acute admissions are rarely made by GPs in Portugal. I did not see one for the whole duration of my stay and the Portuguese GPs I spoke to were surprised how frequently I had to make acute admissions in the UK.

Generally, the flexibility with appointment times and lengths, and the enhanced continuity of care afforded by family lists, seems to have a good effect on the doctor patient relationship, at least from what I saw. For example, I got the impression patients are very honest with the doctor and they do not try and hide things about their lifestyle. At the same time doctors do not medicalise every problem and are able to be more direct. It seems the trust of the patients is not reliant on

performing multiple investigations for “reassurance”. Overall it made me feel regret for the fact we are moving away from continuity of care in England.

An apparent side effect of this is that it is very rare for patients to make a complaint against a doctor, or to try and take grievances further. However the lack of complaints is also due to an impression that investigating bodies are reluctant to apportion blame for mishaps in treatment and legal cases will rarely succeed in court as judges almost always take the word of doctors over those of patients. This lack of accountability is obviously concerning and the GP I was shadowing certainly felt that this should be addressed. This lack of concern over medical negligence cases seemed markedly different to the litigation-averse mentality prevalent here in the UK.

Health Care Team

Despite the one-to-one ratio between doctors and nurses, the role of the nurse was restricted compared to that in the UK. For example, diabetic clinics are jointly held by a doctor and a nurse, but the doctor handles all the medical treatment. Similarly, all the smears are done by the doctors. When I mentioned in the UK we let nurses run diabetic clinics and do smears, prescribe and do other clinical roles the trainees I was speaking to were outraged and said that would never happen in Portugal. According to them, doctors would feel very insecure about relinquishing aspects of their role and so would resist these suggestions at a local level, it was suggested that the nurses would not be keen to take the extra workload either.

There are no health visitors or district nurses in Portugal, and this role is filled by GPs and the practice nurses. I got the impression that the doctors really cherished this, as it meant that they were seeing their patients when they were well. In UK we tend to only see people, particularly children, when there is a concern and this is often when they are unwell. We have little opportunity to build relationships outside of such situations.

The Patient Cohort

Obesity is a significant problem in Portugal, particularly in the under fifties. Stroke is the leading cause of death. There is a significant problem with patients being on lorazepam and olprazolam, and these drugs have often been taken from a young age, including many who began when they were under fifty.

A lot of couples will have no children, or have children late, due to the lack of state assistance for children. I was told having children is thought to be a burden people really think about. Incidentally any assistance provided by the state is closely monitored to the point where they will even try to get information from their GPs to catch them out.

Child Health Surveillance

There is a focus in Portuguese medicine on paediatric care. For example, all children nationally get oral vitamin D for the whole of the first year of their life, although I am not sure this is evidence based.

I was very impressed with the excellent child health surveillance programme in Portugal however. Children are seen very regularly: at 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 – 6 years, 8 years, 11 – 13 years, 15 years and 18 years. This ensures a thorough overview of a child and young adult's health. At each appointment the child will see the nurse first, who takes age appropriate measurements.

The child then comes to see the doctor who examines them including looking at the child's teeth. I saw Denise ask quite a wide range of questions to ascertain the child's health. I was impressed by how much attention was paid to what the child's hobbies and interests were in order to discover if the child was active, and also how much attention was paid to diet. Acquired scoliosis is an issue: there are no lockers at school and children have to carry heavy books around, in their rucksack, often doing so with only one strap. This is also addressed in the consultation.

From a grass roots level Portuguese GP's are looking after children and educating them as to their health – it was perfect in terms of preventative medicine. They are clearly aware of the problems obesity can cause and want to nip them in the bud. With that in mind, if children are overweight and fall into the obese category are sent to a paediatrician who works with them to help lose the weight with an MDT approach.

Relationship between Secondary and Primary Care

What was immediately apparent was that the relationship with secondary care was poor. Hospital consultants rarely send clinic letters, the exception being A&E doctors, who will do a letter for the patient to bring in to their doctor. However these letters are so vague and give little information as to what actually happened. Generally the GPs just have to rely on the patient's understanding and recall of what was told to them. I could barely believe this was actually thought of as normal! It really brought home to me how lucky we are in the UK that we have such tight articulation between primary and secondary care, and how valuable high quality clinical referrals and the letters back are. I appreciate this is not the case across the country however it is not considered the norm and would likely be discussed at the LMC. In Portugal there is basically a one way relationship, GPs referring patients to hospital consultants and getting no concrete information back.

Waiting lists for scans and hospital referrals are significant in Portugal. For example, ophthalmology, ENT and dermatology have a wait of between 6 months to 2 years.

Clinical tests, for example blood tests, are done in private laboratories. Some providers will return results direct to the GP, others to the patient who must bring in the results to their GP to discuss them. Doctors must input the results manually, a process which is time consuming and prone to human error. It is also very uncommon to have ECGs done in the surgery and they too are done by private clinics.

Costs of NHS Medical Treatment

The Portuguese NHS is generally not free at the point of delivery. Most patients have to pay a heavily subsidised contribution towards their NHS provision, although pregnant women and the elderly are exempt from this. These charges are small, e.g. €2.20 for a consultation with a GP and €8 for visiting the hospital. A CT scan might cost the patient €19. These sums should be compared to the monthly minimum wage of €475. I did not hear patients complain at any stage about these contributions and they seemed to be accepted as a fact of life. I also did not see many “worried well” appointments, which I have found are not infrequent in the UK!

Prescriptions provide a subsidy for drugs, but the cost of each drug varies. The costs paid by a patient vary between a few Euros to tens of Euros depending on the drug prescribed and the brand given. This means the variation can be quite significant and I was surprised to learn that pharmacists are under no obligation to advise NHS patients with a view to minimising their expenditures and in practice pharmacists will try and sell patients them the most expensive brands. The onus is on patients to ask for the cheapest drugs, and some doctors, such as the one I was shadowing, try and educate them in this regard.

Contraceptives are no longer free due to the financial crisis. They can be prescribed for free by an NHS GP but only for those that are registered with a GP. Unlike in the UK, children do not get free prescriptions in Portugal, payment being the responsibility of parents. Notably, prescriptions for chronic diseases are not exempt from charges, so for example an epileptic child can be a real financial burden, particularly if private treatment is relied on in order to bypass the NHS waiting list.

Relationship between NHS and Private Treatment

Portugal's current model of national health provision is recent and the NHS is far from as comprehensive as in the UK. NHS provision is still in practice incomplete. 2 million people are not on the list of an NHS GP and many of these people have to go to a private GP. Private practice remains a supplement to the NHS healthcare system and many NHS doctors will do private practice on the side. Private consultations are done on the basis of a contract between a patient and an individual practitioner.

I was surprised to learn that it is common practice for private consultants who do NHS work to feed their private patients into NHS lists for scans and the like ahead of NHS patients, in order to maintain a good relationship with their private patients and so retain them for the future. For example, a pregnant woman being treated privately by an obstetrician will have her scans on the NHS, at NHS rates, and will jump into the queue ahead of NHS patients. Clearly this can only increase the already problematic waiting times for NHS patients. Similarly, GPs who have both private and NHS patients sometimes also prioritise their private list. I must point out Dr Alexandra does not do private GP work.

Nursing homes in Portugal are private and very expensive. They usually have their own privately employed doctor. Some nursing home patients are registered with an NHS doctor as well and in such

cases the nursing home doctor will communicate with the NHS doctor, but it is unusual for NHS doctors to visit nursing homes and decide on management. Some doctors refuse flatly to have contact with these doctors and it seems that nursing homes are generally thought to be outside the scope of NHS general practice. That said, most old people do not go into nursing homes as they cannot afford them.

GP Training

Portugal has a really thorough GP training system which I think in some aspects compares favourably to the UK. It lasts 4 years and the first 8 months is mainly observational, the “shoulder to shoulder” time, the trainee sitting in with a trainer, and only seeing patients occasionally. The trainee then does hospital rotations for 16 months during this time trainees continue to spend 2 sessions a week in general practice which I think is a real bonus, as it stops trainees losing touch with what they are training for. Finally, the trainees spend 2 years in general practice. The nice thing is that throughout the whole training period the trainee has the same trainer, building up an excellent relationship such as that I could see between Denise and her trainee. Assessment is done at the end of each attachment in the form of a written report, and a viva at the end of every rotation. Although trainees do not have to pay for their exams, having discussed this with Denise, it was clear that a lack of standardisation between examinations was a significant issue.

In Portugal GP trainers don’t need to go on any courses to get accredited, instead they just need to have practiced for 3 years, preferably in the same practice so that they know their patient population. Both in GP training and subsequent employment a lot of the emphasis is placed on connecting and getting to know the patient population, I saw an example of this first hand when the trainees went through their assignments with me, the first year trainee had to study a 100 patients and the final year student 300 patients. I do not think sufficient weight is given to similar considerations in the UK, with the main emphasis being towards financially led targets that are not necessarily specific to the practice population served.

Unlike in the UK there is no trainer’s workshop and no day release for trainees. The equivalent of the VTS was if I am honest not very impressive, the facilities were old fashioned with all the trainees behind tables in a traditional classroom setting and the delivery of learning was similarly very archaic, taking the form purely of a dry lecture. I gathered that this was usual and in fact there has been resistance to proposals for updating learning methods.

Overall it seemed professional development and collegiate learning is less valued than in the United Kingdom, with the focus being much more on the trainee/trainer relationship. This I think has both positives and negatives.

Reflections

My trip to Portugal has made me rethink some of my ideas on the Health and Social Care Bill. I have seen firsthand a decentralised health system. The truncated role of nurses in Portugal might not be something we are at risk of returning to in the UK, but it does show what can happen when a vested

interest is left unchecked – in this particular case, the vested interest of Portuguese doctors in maintaining their position despite the potential resource savings. Top down organisation is one way to initiate change, and this capacity will be reduced by the Health and Social Care Bill. However, perhaps the greater pressure on GPs to maximise resources as part of consortia will help to initiate efficiency savings. That said, I am uncertain as to what will drive change for better patient care, as opposed to (financial) efficiency savings, against the default inertia of the status quo.

I have also, as mentioned, come to appreciate how tight a relationship GPs have with secondary care in the UK, and now realise this need not be a given. I would hope that this relationship would be maintained with any “willing provider” commissioned under the new system in the future. Certainly a degree of standardisation in terms of reporting will help maintain the quality of treatment in this regard.

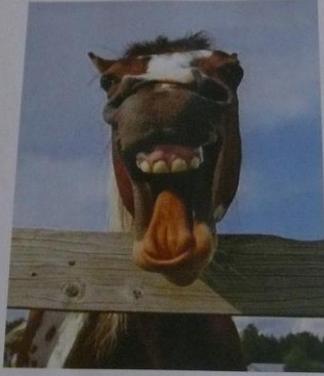
I really admire the strong relationship that Portuguese doctors maintain with their patients and the strong element of continuity of care built into both the family health centre model and GP training generally. Continuity of care is something that appears to be receding as a goal in the UK and it was interesting for me to see a possible economic argument for it, in the form of the trust that Portuguese patients hold for the doctors they know so well reducing the need for expensive investigations to confirm the GP’s original opinion. Similarly, this trust stopped investigations being unnecessarily repeated as a result of doctor shopping within a practice, something I have seen in the UK. At the same time I am aware that familiarity between doctor and patient may lead to occasional missed diagnoses arising out of complacency and an inability to share heart sink patients. It has to be said that overall, I was very impressed with the family health centre model and I do think it really does help a GP to provide health care from a fully informed starting position.

Upon seeing a system where NHS care is subsidised but not free at the point of delivery, I think perhaps I am more comfortable with this idea than I was before going to Portugal. If the costs per consultation are kept reasonable it seems they might have a positive effect in making sure resources are not wasted on pointless appointments.

The biggest wakeup call for me was, I think, the way in which private healthcare interacted with NHS provision, particularly the way private patients were given preferential treatment even in the NHS system, solely to serve the interests of those patients and the doctors treatment them for financial gain. This is quite frankly, in my view, wrong. I was surprised this was allowed to happen and I suspect that, due to a lack of oversight. While, again, this is not something that will happen in the UK it is a reminder that any profession can act in an undesirable way if there are not firm, enforceable guidelines in place, which are regulated properly.

Under the Health and Social Care Bill GPs will increasingly be torn between their duties to their patients and their duties to the public purse and also, indirectly, their own financial position. They will be faced with a diverse healthcare environment and much of the standardisation of the past will be gone. It will be important for GPs to develop skills to manage healthcare cost effectively but it is important also that GPs do not lose sight of their primary professional duty, that to their patients, and do not let that duty be watered down by other considerations.

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