Hippokrates Exchange Programme- Final Report

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There are many similarities between the primary health care system in Slovenia and that of Scotland. I spent two weeks observing the primary health care system in the Ravne na Koroskem area of Slovenia. My observations of the differences between the systems have emphasised for me some of the qualities within my own health care system and also allowed me to identify areas in which it could be improved. I hope to outline these in the following report.

Organisation of the primary health care system
The infrastructure and financing for health care is run by the Ministry of Health. There is compulsory health insurance which allows all emergency health care to be provided free and a voluntary health insurance (which most Slovenian citizens also have) paid to the government. Following payment they receive a health care card with which all health care is free, similar to the NHS. On the health insurance card is also stored information on the patients' prescriptions and there is a central computerised database on which is stored laboratory results and radiology. All other health records are currently not computerised however there are plans for changing this. I think having all medical records computerised as in the UK allows easier access to past records and results. It is also easier to input information and record relevant information within set templates such as are used for chronic disease monitoring.

The Slovenian government employs local health directors for each region in Slovenia, appointed by the local municipality. These health

directors are in charge of the budget for primary health care in these areas including employing healthcare workers. This is comparable to the Primary care trusts in England and the Health boards in Scotland which manage the NHS budget within a local region. However the budget allocated per GP and associated clinical team (nurse, equipment, and laboratory) is the same despite variables in patient demographics. I think this may put health care centres with an elderly patient population or those with many chronic diseases at a disadvantage.

In this particular area in Slovenia the local health director covers four 'health homes' each in a different town in which there are four, three, two and one GP respectively. Together these make up the health centre for this region. Within these four 'health homes' there is one central centre which also contains a laboratory department, a radiology department and a pharmacy. The advantage of having a laboratory service specifically for primary health care within the area is that blood samples are processed very quickly. This allows clinical decisions to be made following the results of a blood test within a couple of hours of first seeing the patient. I have found in general practice in the UK, where the laboratory is within the local hospital and there is only one blood collection from the health centre per day, that the results are often not available until the evening or seen the following day. Within the central 'health home' in the Ravne na Koroskem area are also offices for the district nurses and clinical psychologists and clinics for community gynaecology and paediatrics (which are also part of the primary care system). There is also the emergency department which works closely with the out of hours general practice area. Within the local nursing home there is a physiotherapy department which serves the four 'health homes' in the area.

Undergraduate training

Medical school in Slovenia is six years with the first three years mainly pre-clinical and the last two years primarily based in rotating through different hospital specialties. Once qualified there are six months of postgraduate training prior to specialisation. This is comparable to the two foundation years in the UK.

General Practice training and continuing professional development

Doctors pay monthly to be a member of the Medical Chamber which protects and represents the interests of the medical profession, issues the code of medical ethics and monitors doctors conduct, participates in undergraduate and postgraduate training and provides legal assistance. General practice training is four years in total. This comprises of two years working in general practice followed by two years rotating around different hospital specialties. These include six months of internal medicine, three months of surgery, three months of paediatrics, two months of infectious diseases, two months of obstetrics and gynaecology, two months of psychiatry and one month of each of orthopaedics, oncology, dermatology, neurology, ophthalmology and ENT. I think this has a significant advantage over

the current GP training scheme in the UK where we are not able to cover such a wide variety of specialties over the course of the training leaving our knowledge in some areas lacking. During the two years in general practice for GP trainees in Slovenia there are two training days per month held in Ljubljana. Each GP trainee is supposed to have one day per week with their GP trainer however due to staff shortages this is not always possible. GP trainees work independently within a health centre sometimes having their own patient lists inherited from a retiring GP or seeing those of their GP trainer. Their GP trainer is sometimes within a different 'health home' and is available by telephone for advice.

Within Slovenia there is a network of continued education for all doctors including monthly lectures on 'hot topics' of which individual doctors must attend a certain number within a seven year period. GP trainers must demonstrate educational activities over and above that which is normally required in the seven year period to maintain their status as a trainer.

Role of the GP

Each individual GP has their own patients of around 1700 to 2000 and work very much as individual practitioners. This contrasts to General Practice in the UK where patients belong to a practice in which they can see any doctor, although they may be arbitrarily assigned to a particular doctor or and often choose to see the same doctor. The only exception to this may be in a very rural practice where there is only one doctor. If one doctor is on sick leave or on holiday another doctor in the same 'health home' cross covers. The advantage of the Slovenian system is that when the patient sees the same doctor there is better continuity of care and less opportunity for diagnoses to be overlooked. The disadvantage is that there is less opportunity for discussion and sharing of knowledge and expertise between GPs working in the same health centre. I think this collaboration including regular meetings to discuss challenging patients, current evidence and any significant events is important for self reflection, peer teaching and continuing professional learning and development.

The working hours are usually 7am to 3pm although some GPs also work late sessions from 1pm to 8pm (once a week). Appointment length is usually 15 minutes for patients booked in to see the doctor and then patients in need of an urgent appointment and telephone calls are fitted in around this. At the end of surgery repeat prescriptions are written and home visits done. This is different from my own GP practice where one GP within the health centre is on call during the morning or afternoon takes the telephone calls and sees 'on the day' patients with more urgent problems, whilst the other GPs within the practice see pre-booked patients. I think this makes the working day flow more easily as it may be difficult to fit in urgent appointments and phone calls between regular appointments and causes a more stressful and time restricted working environment. Around 50-60 patients are usually seen by one GP in a day. From my experience this is more than is usual within one working day in the UK and is largely due to the current shortage of GPs in Slovenia.

There are fewer home visits done in Slovenia, usually one to two a week. In Ljubljana there are usually no home visits done at all. This seems to be due to patients not expecting to be visited at home. I think it is debatable as to whether this is better practice or not as many home visits does use up resources, particularly time. However sometimes I think it is of value to visit patients in their own home as it provides a better assessment of their social situation and how well they are managing activities of daily living and therefore aids holistic care.

The role of the GP in Slovenia as in the UK is as the first point of call for patients seeking health advice. However in Slovenia all patients have their own gynaecologist who provides all gynaecological care on an out patient basis. The GP therefore only sees patients with gynaecological problems out of the normal working hours. In central health care centres there are also community paediatricians who patients can attend directly without referral and therefore GPs only see children when working in 'health homes' further away from the central centre or out of hours.

There are screening programs similar to the UK within Slovenia, some of which are managed by the GP. For example GPs provide primary prevention for cardiovascular disease where men age 35-65 and women age 45-70 are screened using a scoring system for calculating cardiovascular risk similar to the one used in the UK. This is done opportunistically as is also the case in the UK. There are national screening programs such as FOB for colorectal cancer (SVIT), mammography for breast cancer (DORA) and cervical screening (ZORA) the last of which is carried out by the out patient gynaecologist rather than within general practice as is the case in the UK. Other additional services such as minor surgery are provided according to the individual training and ability of the GP. Some chronic disease management is managed by the GP and some by hospital specialists. For example patients with CKD3 or hypertension are reviewed on a 6 monthly basis by the GP where as patients with diabetes are monitored by the endocrinologist on an OP basis and those on warfarin by the cardiologist as an OP. However this does vary between health districts. I think this is an area where primary care in the UK provides a good service probably partly due to the current contract providing funding for 'enhanced services' and the quality and outcomes framework. There is also no specific recall system for reviewing patients with chronic disease with patients being given an appointment for the next review at the time of review. I think this is another area where it is useful to have all patient records computerised as it allows easy identification and automatic recall of patients on a disease register who are due review.

Palliative care is currently only a very small speciality in Slovenia with only one specialist in the country. There are very few hospice beds and therefore most palliative care is provided in the community by the GP and district nurse. There is no national guidance such as the Liverpool Care Pathway currently available to GPs to aid GPs in helping the patient achieve 'a good death'.
Individual GPs often also provide the health care for the local nursing home usually visiting several afternoons per week. For example

the local nursing home in the Ravne na Koroskem area is visited by an allocated GP three times per week and on an as required basis. The nursing home houses both physically disabled elderly patients and also those with dementia.

GPs are obliged to take part in the out of hours service which in the Ravne na Koroskem area is based in the central health care centre. This is closely linked to the A&E department within the health centre. During the day there is the '1st emergency team' comprising of an anaesthetist and two paramedics and one of the GPs in the health centre is 'on call' with a specialist nurse as a '2nd emergency team' and only called to emergencies when the 1st emergency team is already occupied. During the night the 1st emergency team and the 2nd emergency team may both be staffed by GPs and therefore in Slovenia the GPs are more skilled in emergency care than GPs in the UK. I think this regular work within the emergency department carried out by GPs in Slovenia allows them to keep up their skills in emergency care where as in the UK as we do not often attend emergencies we may easily become de-skilled.

Role of other members of the clinical team

Each doctor works with a practice nurse who is responsible for managing and triaging patient appointments and phone calls to the health centre. She also provides wound care and is able to give IM and SC injections. This differs from primary care in the UK where more and more the practice nurses are taking a greater role in management of chronic disease and primary prevention.

The biochemist within the laboratory works closely with the doctors and phones with any abnormal results.

The districts nurses each cover patients in an area within the region and take part in chronic disease management such as monitoring of blood pressure. They also take part in primary prevention for example all patients over 65 years are visited twice a year by the district nurse for screening for hypertension. They provide wound care and are able to give IM and SC injections. There is good communication between the district nurses and the general practitioners as in primary care in the UK.

The clinical psychologists within the central health centre provide diagnostic services, counselling, CBT and group therapy and the GPs from the health centres within the area are able to make referrals directly to them. They also take referrals from social work and schools, paediatricians and hospital specialists such as neurologists.

Patient expectations

A recent survey carried out in Slovenia suggested that patients trust their GP more than hospital specialists and as with the UK many patients attend their GP for reassurance and support. However patients do often attend seeking referral or expecting antibiotics as is the case in the UK. In Slovenia the waiting times following referral to secondary care is dependant on the region and the speciality. For example in the Ravne na Koroskem area to see a surgeon there is usually three weeks wait, for gastroscopy two months, ophthalmology three to six months and one month for 24hr tape, ECHO and ETT.

Relationship between primary and secondary care and how GP is viewed by society.
Usually around 20% of patients seen within primary care are referred to hospital specialties. Referrals are written to hospital specialties with the priority of referral specified as within twenty-four hours, two months or routine. For acute admissions the patient is again given a written referral and it is not necessary to contact the admitting team by phone. I think it is of benefit in the UK to have direct contact with the admitting team at the hospital as this provides better communication between primary and secondary care and facilitates continuity of care. Communication between the hospital specialties and the GP following review of the patient by secondary care is by letter given to the patient and not directly to the GP. I think this again can cause a barrier in communication between primary and secondary care.
Currently there are not sufficient general practitioners mainly because of the high work load in general practice due to staff shortages. There is still some feeling that general practitioners are not respected as much as secondary care doctors.

Summary
In summary there are many similarities between primary care in Slovenia and in the UK. I think the main advantages of Slovenia and therefore areas in which we could improve in the UK are:

- Providing more opportunity for exposure to a wider variety of specialties in GP training,
- Better access to laboratory services,
- More training and exposure to emergencies to maintain our skills in this area.

I think the main advantages of the UK primary care system lie in:

- The sharing of knowledge and regular discussion of complex patients and analysis of significant events between the GPs within a practice and other members of the clinical team providing mutual support and aiding professional development.
- The organisation of primary prevention and chronic disease management enabled partly through QOF and having computerised patient records.