Hippokrates Exchange Programme Report

I did a Hippokrates Exchange in Aarhus, Denmark, for two weeks between the 2nd of October and the 13th of October. This report focuses on comparing key areas between the Danish and Portuguese health system, especially between primary care, and on my reflection about the exchange and the differences between countries.

On the first week I went to the Research Unit for General Practice/ Center for Global Health in Aarhus University with Dr. Per Kallestrup and the next days I visited the practice of Bodil Lyngholm and Christian Sandvej - Lægerne Sandvej og Lyngholm. In the second week I went to the Jacob Laurberg clinic, I also visited a general practice emergency service, 3 nursing homes and SANO Rehabilitation Center. In these weeks I had the opportunity to see the practice of different health professionals in two clinics, including home visits and going to a nursing home, helping me gain a wide perspective on how the health system/primary care is structured and organized in Denmark, the services, and resources available and how it works.

- **Health System Organization and Funding**

Portugal and Denmark have both universal healthcare systems funded by taxation, but their healthcare organization and governance structures differ. Portugal's healthcare system is more centralized in terms of governance, with the Ministry of Health overseeing national health policy, while in Denmark there is a division into regions, each one with a high degree of autonomy in managing healthcare services. The main difference noticed between both countries is the fact that General Practice (GP) clinics in Denmark are private, but they enter into agreements with regional governments and provide services to patients under the covered healthcare system, while in Portugal the health centers belong to the Ministry of Health. Both clinics of this exchange were private clinics, the patients did not pay, but the expenses of the services were accounted and reimbursed by the government.

Danish and Portuguese primary care clinics are usually the first point of contact for patients seeking medical care and they act as gatekeepers in both countries, meaning patients typically need a referral from their GP to access specialized care, such as consultations with medical specialists, hospital treatment or diagnostic tests. Despite this, in Portugal, not everyone has a GP due to insufficient number of family doctors in some regions and emergency services are generally readily available, so, in some cases, the emergency department is the first point of care. This results in another variation, patients in Denmark have the freedom to choose their preferred GP, they can select a GP in their local area, allowing for some flexibility in primary care access.

- **Accessibility**

As said before, in Portugal and Denmark GPs are the first contact with the health system. Danish primary care clinics strive to provide timely access to care, with same-day appointments often available, while in Portugal long waiting times for appointments with primary care physicians can be an issue, especially in some regions. Additionally, in Denmark, medical care outside regular working hours is provided by a regional medical service known as "lægevagten", with rotation of the GPs from that area, whereas in Portugal people go directly to emergency departments in hospitals.

Danish primary care and secondary care seem to have a closer relation than the Portuguese, communication by email between the GP and other specialists is a common practice. The waiting time for specialists' appointment after referral is variable in both countries.

- **GP Clinics**

GPs in Denmark play a critical role in providing preventive care, managing acute and chronic conditions, and coordinating patients' care, as in Portugal.

The exchange took place in two clinics, which have different organizations. In the first one, there were two doctors, two nurses, one midwife, one trainee and two medical students, while on the second one there were 2 doctors, 1 GP trainee, 1 nurse, 1 secretary and 2 medical students. The schedule of the clinics I visited was organized between 8-3pm and in Lægerne Sandvejog Lyngholm there was one day from 8-5pm. In both, there was a team-based approach to healthcare, with the involvement of nurses, medical students, and administrative staff, however the arrangements differ between the clinics. In Lægerne Sandvejog Lyngholm they started appointments at 8 am till 3 pm, with an interruption in the middle of the day of 30 min for supervision and clinical cases discussion with the trainee. In this clinic the role of the med students was to answer the phone and do the administrative work and collecting blood samples; the midwife took care of almost everything related to children and women's health, including the family planning. In the Jacob Laurberg clinic every day started with 1h of telephone consultation/video consultation, after, there was time for programmed consultation and consultation of acute diseases. Most consultations were 15 mins, if it was a complex patient, they scheduled a 30 min appointment - when patients scheduled the consultation, they also said the motive why they did so, allowing the doctor to know the purpose of the appointment beforehand. In both clinics I had the opportunity to do home visits.

There are some significant differences between Danish and Portuguese health centers. To begin with, in Portugal the clinics have doctors, nurses and secretaries, if possible, in the same number, the patients have a family team, including a family doctor and a family nurse, being the health care provided preferably by this team. Also, the number of health workers working in a clinic is usually higher in Portugal. Secondly, the schedule is longer, the clinics are usually open between 8am-8pm, with consultations during these hours with a duration of 20 min each, in most clinics. Moreover, the responsibilities of each professional class differ between both countries, in many ways, in Portugal, medical students can not work in a clinic, here in Denmark they are responsible for a variety of tasks – phone contacts, doing some consultations, collecting blood samples, etc.., also there are no midwifes in Portugal. In Denmark doctors do not have nursing support in children's health and women's health consultations, so doctors administer vaccines and make anthropometric measurements. Home visits are similar in Denmark and in Portugal, with similar criteria, but it was interesting to see the differences between the houses of the countries, reflecting cultural distinctions.

The clinics in Denmark belong to the doctors so the rooms seemed more personalized, with paintings and other decorations besides the medical material. Furthermore, there were much more devices available than in Portugal and a little laboratory in each clinic. ECG, blood tests and pulmonary function tests are done in the clinics. Moreover the software used is chosen by the professionals, however all the information is available independently of the software. There is integration of all the patient information, including results of exams, appointments with specialists, prescribed medication -accessible to every health professional in Denmark.

- **Being a family doctor in Denmark**

The GP trainee role between both countries is similar, but there are some differences during the training years. Specific general practice training includes internship and runs for 4 years, but in Denmark the first 2 years consist of different hospital internships and then the last 2 years are spent in GP clinics – in two different clinics. During the training years there are also curricular courses but there are no exams in Denmark, but a list of competencies the trainees have to accomplish.

After specialty graduation, the GP can buy and start a clinic or be employed by another doctor in a clinic; When a GP's list reaches 1600 persons, the doctor is allowed to close the list to new patients, but the list can have more patients. GPs' annual income is about 120.000€. The number of patients per doctor is like Portugal, but the income is significantly higher in Denmark.

- **Research Unit for General Practice/ Center for Global Health in Aarhus University**

The Research Unit for General Practice in Aarhus is one of four Danish research units that conduct research in general practice and the interface between primary and secondary care. The Research Unit for Global Health addresses health problems that transcend national boundaries and have political and economic significance globally, focusing on population health in a global context and emphasizing on improving health for all, reducing inequalities, and protecting against global threats. Visiting these research units was a unique and inspiring experience. In Portugal there are no research units for general practice and investigation in primary care settings is challenging, with lack of government incentives and support (financial and technical).

- **SANO**

SANO center offers rehabilitation for people with rheumatological diagnosis, from preventive team training to intensive rehabilitation stays of several weeks, targeted precisely for physical and psychological needs. The visit to this center was inspiring. The plan is adapted to individual needs and individual goals of each patient, with an interdisciplinary team including Rheumatology, occupational therapist, psychology and physiotherapists. There is a special attention on making people feel like home and doing rehabilitation to focus on the daily life of the patient. In Portugal there are no rehabilitation centers like this, so it was really rewarding to have the opportunity to visit this center.

Positive points of GP practice in Denmark and comparison to Portugal

The primary care structure and organization in Denmark allow the GP and the other health professionals to have more autonomy, allowing them to respond to their population health needs. Moreover, with this kind of structure of family practice clinics there is no shortage of material and there is a possibility to invest in devices that help doctors make more informed decisions, contrasting with Portuguese health centers, dealing with common shortage of material and scarcity of updated devices, not only because of lack of public investment of the government but also because of dependence of the ministry of health to buy and replace materials. Additionally, in my point of view, the work autonomy makes professionals feel more fulfilled, and patients happier, because they can adapt their practice to their individual, team, and population's needs. They are also more aware of health costs, contributing to less unnecessary spendings. However, this autonomy can result in differences between clinics, which can result in less uniformity in the way healthcare is provided. Also, the clinic usually has quite

small teams, unlike Portugal, in which teams are larger and there is always at least a weekly moment in which all the professionals of the clinic are together, with exchange of ideas. This plurality can benefit clinical practice.

The used software integrates the information recorded from the consultations, the information sent from hospital specialties, the results of diagnostic tests requested from the laboratories/ radiologist, referrals to specialties and prescription, all of which is accessible across Denmark. In Portugal, almost everything is computer based but there are many different software programs, the results of all exams are not integrated automatically, and some hospitals have different programs that are not accessible by GPs, resulting in unnecessary work by health professionals. Moreover, this lack of integration of health information is also disadvantageous for the patient.

The availability of complementary exams in clinics in Denmark including blood test, in my opinion, have many benefits, it contributes for patients satisfaction and compliance because they only have to go to the family medicine clinic and do not have to go to various clinics, like in Portugal, and this results in more efficiency in GP work – there is no need for new appointments because patients forgot to do the blood tests or the ECG. In addition, it can be useful in acute consultations to have some fast exams to make some clinical decisions, sometimes avoiding the referral to emergency.

The division of responsibilities between the GPs, nurses, secretaries, and med students in Danish clinics makes the daily work distribution more even, which in my point of view vastly contributes to a happier workplace.

The communication between primary and secondary care is better in Denmark, making the healthcare less fragmented and contributing to patients' satisfaction.

Finally, the balance between work and personal life as well the GPs remuneration makes Denmark an attractive place to work, it results in more satisfied professionals, facilitates the engagement in research and other kinds of clinical activities, contributing to being a better doctor.

- **Exchange's reflection**

The Hippokrates exchange provides the opportunity to observe primary care in other countries. I choose Denmark not only because the Danish healthcare system has consistently been recognized as one of the best in the world, but also because healthcare is mostly provided by a publicly financed health system, available for the entire population, sharing similarities with the Portuguese public health system. The expectations were very high for this exchange, and they were exceeded.

First, every professional I had contact with was really considerate, available to respond to all my questions and doubts, explaining particularities of the Danish health system and also about cultural aspects. Furthermore, I had the opportunity to explain the Portuguese health system organization with a presentation (in the first clinic) about the Portuguese national health system and my health center. This was a really rewarding experience, allowing the sharing of ideas and reflecting on problems and solutions about both countries. Visiting two clinicals made this exchange richer, besides having contact with various professionals, it allowed me to see "this autonomy" referred before in practice and see differences in organization of GP clinics.

Secondly, some differences found were connected to social and cultural aspects: in Danish society there is more trust, allowing the doctors to have more autonomy; people are more literate, with a higher quality of life, reflecting in patients more preoccupied with their own health. These make me reflect on my role as a GP in Portugal – I can contribute to health literacy in my daily work and adopt a less paternalistic approach to empower patients to be more responsible for their health and use the healthcare system more effectively. About the "trust" as a society, it is difficult to achieve, but if each of us maintain an assertive and correct approach as a doctor and as a citizen, individually we can make a difference, and hopefully one day grow to a more trusty and equal society.

Finally, the working conditions of Danish GPs are distinct from Portuguese doctors, with better remuneration and work life balance, making me realize how important these aspects are in our everyday life to be a good doctor. Portugal is experiencing difficult times, doctors are losing quality of life, with low remuneration and many extra hours of work which reflect on the quality healthcare provided in Portugal. It was productive to see another reality of work.

This experience was transformative. Numerous aspects of this exchange, on top of those already mentioned, helped me grow as a doctor and as a person. It was inspiring to see the Danish health system and experience the living of Aarhus, encouraging me to change some aspects of my clinical practice and as an individual and working for a better future for health in Portugal. I highly recommend this experience to all colleagues who have that possibility.

Learning Objectives

Original Learning Objectives in Primary Care Management
To know the organization of primary care services in another country and reflect on the differences between them. Also, to observe how Danish GPs monitor, assess and improve quality of care.
Actual Learning Outcomes in Primary Care Management
With this exchange I had the opportunity to understand the organization of the Danish Health system and the role of primary care. Besides that, I have also learned about primary care clinics structure, management and work, including how they assessed quality of care.

Original Learning Objectives in Community Orientation
Get to know the Danish culture, particularly the perspective on health issues.
Actual Learning Outcomes in Community Orientation
Living in Aarhus for two weeks and visiting different places, two different clinics, including home visits, SANO rehabilitation center, nursing homes and the research centers, allowed me to know more about danish cultures and particularities about their perspective on health issues.

Original Learning Objectives in Specific Problem Solving Skills
To observe medical practice in a different epidemiological context.
Actual Learning Outcomes in in Specific Problem Solving Skills
I was able to observe GPs in a distinct epidemiological context and observe their way to manage the most common health problems.

Original Learning Objectives in Comprehensive Approach
To observe how danish GPs reconcile the health needs of individual patients and health needs of the community in which they live in balance with available resources.
Actual Learning Outcomes in Comprehensive Approach
Denmark has a lot of different resources in the community, like nursing homes and hospices available if necessary. In the GPs clinics there are a variety of health professionals and they all collaborate in health care of patients - there is a shared responsibility and services provided are adapted to the person's needs. In primary care there is an actual coordination of patient care. I consider I have reached the learning objective with this exchange.

Original Learning Objectives in Person Centred Care
To observe other forms of approach on general practice's medical appointments: how multiple complaints and comorbidities are managed and how health promotion is integrated.
Actual Learning Outcomes in Person Centred Care
In both clinics I observed consultations of different GPs and had the opportunity to understand how they manage complex patients and other health needs in their daily practice.

Original Learning Objectives in Holistic Modelling
To know a different context of primary care practice, see the difference and how it influences the approach to patients in their individuality. To understand how danish health system provides the continuity of health care
Actual Learning Outcomes in Holistic Modelling
Every Danish has a family doctor that is responsible for her/his healthcare, providing the continuity of care. This exchange provided me the opportunity to understand and reflect how different structures and services available at primary care level influenced the approach to patients and the management of their health.

Original Additional Learning Objectives
To know other types of general practice training.
Actual Additional Learning Outcomes
I met GPs trainees and medical students in both clinics, letting me know how general practice training worked in Denmark.