Profiles of general practice in Europe : an international study of variation in the tasks of general practitioners

10 Summary and conclusions

Introduction

The study reported in this book fulfils the need for comparable information about the provision of primary medical care services in Europe. Individual variation in tasks delivered by general practitioners (GPs) is a well-known phenomenon, but little is known about the effect of the characteristics of health care systems on the work of GPs. In this study, the involvement of GPs in a range of curative and preventive tasks has been related to these system characteristics at national level, as well as to the possible effects of the local situation of the practices and the individual GPs. There is increasing international interest in this information, since a strong base of primary care services is considered to be a means of improving coordination and cost control in health care.

This final chapter summarises the previous nine, discusses the results and draws conclusions for the scientific community, general practice and health policy-makers.

Background to the study

The study attempts to describe and explain the variation in the range of services that GPs deliver to patients. These services may vary within countries, due to differences in GP characteristics or the organisation and circumstances of the practice, such as location in rural areas or cities, teamwork, available supporting staff and medical equipment. When countries are compared, variation is expected to be related to specific differences in the formal position of and payment systems for GPs, the mode of access for patients to health services and whether or not the country's health care system is undergoing profound changes, such as in the post-communist countries.

The design of the study is a cross-sectional survey in 32 European countries, using a multi-level design. Data on the provision of services and the situation of the practice were collected from samples of individual GPs by means of a questionnaire and a 7-day workload diary in the national languages. Information on the health care system resulted from desk research. The study was coordinated by NIVEL and implemented in collaboration with a network of contacts in the countries involved. A total of 7,895 GPs participated in the study, which is a response of 51%. Data entry, data processing and analyses were carried out at NIVEL, using the SPSS and MLwiN software. The involvement of GPs in major task areas was measured by means of questions with answers on a four-point scale. Individual scores on the position of GPs in these areas were calculated using a scale construction procedure and the

activity scores were examined in relation to characteristics of the health care systems relevant to general practice (whether or not the GPs' had a gatekeeper role, the GPs' employment status and whether or not the country was in post-communist transition) and with characteristics of the GP and the practice situation.

Summary of results

Chapters 2 to 9 inclusive of this book comprise published work from the study. In this section, the aims, research questions and results of each chapter will be reported briefly.

Overview of service profiles of GPs in Europe

Chapter 2 provides a general description of the comprehensiveness of the services that GPs in Europe provide to their patients. It examines differences between groups of countries on the basis of the formal position (gatekeeper or parallel access to medical specialists) and payment (salaried, capitation payment or fee-for-service) of GPs. Countries differed considerably in the range of services that GPs' provide to their patients. Four broad groups of services were considered, viz. first contact with patients' health problems, the application of medico-technical procedures, the treatment of disease, and preventive care. Four sub-groups were identified within first contact care and labelled as follows: acute problems, children's health problems, women's health problems and psychosocial problems. Where the point of first contact was concerned, the GPs reported a major involvement in acute health problems and a relatively limited involvement in the first contact with psychosocial problems (patients may possibly more often contact other care providers in connection with this latter type of problems). First contact with women's health problems and children's health problems was a normal GP task in some countries, but was scarcely provided at all in other countries, where these problems are more frequently presented directly to gynaecologists and paediatricians respectively.
Concerning the medico-technical procedures large differences were found, particularly between countries in northern and western Europe and those in southern and eastern Europe.
There was a greater similarity between European GPs with regard to GPs' involvement in the treatment of disease than in the other areas of service. Preventive services consisted of screening, health education and child health surveillance. Most GPs were involved in hypertension screening, while in most countries only minorities systematically screened for blood cholesterol and

cervical cancer. The sharp contrasts found in the role of GPs in child surveillance and immunisation of children indicated different organisation of these services, in which GPs may or may not be involved. Health education in groups did not appear to be a regular task of GPs.

Groups of countries were compared on the basis of three characteristics, viz. whether or not the GPs' had a gatekeeper role, the GPs' employment status and whether or not the country was in post-communist transition. In countries where GPs were gatekeepers, they had a much more comprehensive role as the doctor of first contact than GPs in other countries. Where GPs were not gatekeepers, the first contact position was apparently shared with ambulatory medical specialists. Countries with gatekeeping GPs did not differ from the other countries in the other areas of service.

The employment status of GPs made a difference in disease management. In countries where GPs were mainly self-employed, they were more involved in the treatment of diseases than in the other countries where GPs were mainly employees. No other differences were found between countries with self-employed and salaried GPs.

The contrast was greater when the post-communist countries were compared to 'western Europe'. GPs in western countries had a more comprehensive role in most areas of service, i.e. they had a more exclusive role in the first contact with health problems, they applied more medico-technical procedures, they screened more frequently for blood cholesterol and were more often involved in paediatric prevention than GPs in the former communist countries. No differences between east and west were found with regard to the GPs' involvement in the treatment and follow up of (chronic) diseases and the screening for hypertension and cervical cancer.

Urban and rural general practice compared

The subject of this chapter is the differences in the curative task profiles of GPs working in cities, semi-urbanised areas and the countryside. Three hypotheses were formulated on the basis of previous studies. Firstly, it was expected that GPs in rural areas would have more comprehensive service profiles than GPs in urban practices, particularly those in inner city practices. Secondly, it was hypothesised that GPs working closer to a hospital would have more limited service profiles, irrespective of the degree of urbanisation of the practice location. Thirdly, differences between urban and rural task profiles would be smaller in countries with gatekeeping GPs (where the flow of patients is more controlled).

A simple comparison of urban and rural practices showed that they were differ-

ent, as were the GPs working there. In rural areas for example, practices were more often single-handed and had more medical equipment available. Social deprivation was more common in urban practice populations. More GPs in inner city practices had not completed a postgraduate (vocational) training programme. Rural practices and practices more than 5 kilometres away from a general hospital were found to show consistent differences with other practices. Rural GPs and those working far from hospitals had more comprehensive task profiles in relation to the three task areas considered, although the differences in treatment tasks were smaller than in the other two task areas. GPs in inner city practices appeared to be less involved in technical procedure tasks than suburban and rural GPs.

The urban-rural dimension was not the only source of difference. GPs generally reported delivering a more comprehensive set of services in practices with many elderly people and many socially deprived people. Specifically favourable practice conditions for the provision of medico-technical procedures appeared to be the availability of medical equipment and allied staff, and a GP who had completed postgraduate training. In addition, male GPs provided more of these procedures. The GPs' tasks in the treatment of disease were more related to indicators of demand. There was more involvement in treatment tasks in practice populations with many elderly people (although practice equipment and time spent on keeping up-to-date played a role as well).

The comparison of groups of health care systems confirmed the earlier findings on the first contact role of gatekeeping GPs and GPs in the western countries, the contrast between eastern and western Europe in the use of medical techniques, and the greater involvement of self-employed GPs in the treatment of a range of specific (chronic) diseases. Furthermore, there was evidence of 'erosion' of the gatekeeper role in inner cities in western countries; gatekeeping GPs working in inner cities had a more limited role in the first contact with health problems than other gatekeeping GPs.

It can be concluded that GPs in rural practices and at a longer distance away from hospitals provided more comprehensive services in all health care systems, mostly in the first contact with health problems and medico-technical procedures. This strongly confirmed our first and second hypotheses, stating that rural GPs have a more comprehensive service profile than urban GPs and that GPs working close to a general hospital have a more limited service profile than those at larger distances. The third hypothesis was not confirmed; differences in service profiles between urban and rural practices occurred equally in gatekeeping systems and other systems.

The first contact with patients' psychosocial problems

This chapter focuses on GPs as the first contacted health care professional for patients with psychosocial problems. Influences on this role as first aid in mental health care were hypothesised to be located in the health care system, in the practice and in the person of the GP. GPs in health care systems in which patients are registered with a (gatekeeping) GP were expected to be more involved in this kind of care than GPs in other health care systems, where patients have more direct access to medical specialists. The expected influences at practice level were: pressure of work and time available for patients, as well as knowledge of the patient's situation (through a comprehensive record system) and professional skills (acquired through education and from cooperation with social workers).

Large differences in GPs' first contact care with psychosocial problems were found, not only between GPs in the same country, but also between the national averages. Comparison of types of health care systems in this respect showed the effect of GPs as gatekeepers with a list of patients. In countries with a gatekeeping system, GPs' role as the first aid in mental health care is much stronger than in other countries, which was consistent with the hypothesis. Furthermore, pronounced differences were found between the post-communist countries and western Europe. GPs in the western countries were more involved in the first contact with psychosocial problems than those in central and eastern Europe.

A number of features of the organisation of the practice favoured a stronger involvement in first encounters with non-medical problems. GPs were more involved if the daily flow of patients was regulated by an appointments system and if the time allocated for a consultation was not very short when appointments were being planned. GPs with intermediate time slots per patient in the appointments diary were most involved in psychosocial first contacts. Being busy, in terms of a high patient workload, did not seem to be an obstacle however, because GPs with many patient contacts per day were even more involved in first contacts with psychosocial problems than GPs who saw fewer patients. Knowing the patients had an effect, as expected, because GPs who kept comprehensive patient medical records were more involved in this first contact care. The hypothesis on the effect of professional skills was supported by the finding that vocationally trained GPs and those who had regular meetings with social workers fulfilled a more comprehensive role in this type of care than GPs without postgraduate training and no such working relationships with social workers. Additionally, personal characteristics of GPs made a

difference. Older GPs, in the age group of 40 to 50 years, and male GPs more often reported being the doctor of first contact for patients with psychosocial problems than the other age groups and women. The usual difference appeared when GPs were compared by location of practice, with the lowest involvement in inner city practices and the highest in rural practices.

In general, most assumptions were confirmed by the results. The GPs' position as the first contact with mental problems was more comprehensive in systems with gatekeeping GPs and registered patients than in other systems and also more comprehensive in the western countries than in the post-communist countries. More comprehensive roles in the first contact with mental problems were found among GPs who routinely keep medical records (and thus may be better informed about their patients), who had completed vocational training and who have regular meetings with social workers (which may enhance skills for dealing with mental problems).

Female and male GPs compared

This chapter described differences between male and female GPs in their personal and work-related characteristics. Their curative and preventive service profiles were related to characteristics of the health care system and the practice. As suggested by many national studies, gender differences were expected in work preferences, the organisation and setting of the practice, and the provision of services. The international comparison was expected to show less gender difference in curative services in countries with a gatekeeping system where patients are normally registered with a GP; there may be less freedom to see a doctor of the same gender in these countries. In countries with self-employed GPs, little or no difference by gender was expected in the provision of preventive medicine and health education. In these countries the overall involvement of GPs in prevention and health education is expected to be low, because such services are rarely eligible for payment in these systems.

The gender distribution in general practice differed substantially across Europe. Male GPs outnumbered female GPs in most countries, but the situation was usually the other way around in the post-communist countries. Female GPs were certainly younger than male GPs and more often worked part-time in groups or partnerships, and in cities (but not in deprived areas). Female GPs had different working arrangements; they made fewer home visits and did less work outside office hours. Differences relating to the workload, that female GPs had fewer office contacts a day for example, appeared to result from female GPs' working part-time.

No overall gender differences were found in the involvement in first contact care, but there did appear to be differences in two subgroups of problems. Female GPs in western Europe were more involved in the first contact with women's health problems. In contrast, they were less involved in the first contact with psychosocial problems (although not in countries with gatekeeping GPs). When other curative services were taken into consideration, all health care systems showed a general trend of lower involvement of female GPs in the application of medico-technical procedures and the treatment and follow up of a range of specific diseases. In most types of health care systems, however, involvement in health education (smoking cessation, alcohol consumption and diet) was higher among female GPs than among male GPs. Few differences were found where the screening of patients at risk was concerned, apart from the fact that female GPs in the former communist countries were more active in screening for serum cholesterol and cervical cancer. Finally, family planning was a service in which female GPs in western countries and in countries with gatekeeping GPs were less involved than male GPs.

As expected, the gender differences in the provision of curative services were smaller among gatekeeping GPs than in other health care systems. The expectation that little or no gender difference would be found in preventive services in countries with self-employed GPs was only confirmed for health education and cervical cancer screening.

Differences within central and eastern Europe

The health care systems of the former communist countries are often perceived as a homogeneous group. This chapter aimed to find out whether this was true or not. Variation in the task profiles of GPs in these countries were investigated and related to the different - historical - backgrounds of the health care systems. Three hypotheses were formulated, based on information on primary care in the communist era and the recent start of the transformation of health care in these countries. Firstly, that the variation between task profiles of GPs in the post-communist countries would be less than the variation between the western countries. Secondly, that the variation in GP task profiles within the post-communist countries would be less than the variation within western countries. Thirdly, that the stronger the influence of the former Soviet Union had been in a country, the more limited the task profile of GPs would be.

Considering all post-communist countries as a whole, there was an evident gap between them and the western countries regarding the role of GPs. Western GPs clearly delivered a much more comprehensive set of services than the GPs in

the central and eastern countries. The greatest difference was the involvement in the first contact with health problems and the application of medical techniques. The differences were much smaller where preventive services were concerned. The supposed homogeneity among the post-communist countries was found neither in curative care nor in prevention. Despite some exceptions in both directions when specific services were considered, the general variation in GP task profiles between the central and eastern countries was no more limited than the variation between the western countries. Closer examination of the post-communist countries revealed that the variation between GPs within those countries was even greater where most curative services were concerned than it was within the western countries. The results for preventive services were mixed: with some services the variation between GPs was greater than in western countries and with other services it was the other way around.

It was possible to identify three sub-groups within the group of post-communist countries, on the basis of the comprehensiveness of GP curative tasks, viz. the former Yugoslavian countries, the countries which entered the communist sphere of influence after the second World War and the countries that used to be part of the Soviet Union. GPs' involvement in all curative tasks was highest in the former Yugoslavian countries, except in the treatment of a specified diseases. GPs occupied an intermediate position in countries of the second group, which had previously had a social health insurance system before the Soviet 'Semashko system' was introduced. GPs were less involved in curative care than in the former Yugoslavia, but they had a stronger position in first contact care (particularly relating to children's problems and psycho-social problems) than GPs in the third group, viz. countries formerly belonging to the Soviet Union.

The pattern was different for preventive care. GPs were relatively strongly involved in prevention in former Soviet countries, in contrast to the GPs in the countries of the former Yugoslavia, who were less involved in two of the five examined prevention tasks.

Home visits to patients by GPs

This chapter contains a description and comparison of the home-visiting practice of GPs in a sub-sample of 18 countries. The variation was examined in relation to relevant characteristics of the health care system, the effects of personal characteristics of the GP, and the type and organisation of the practice. The point of departure for the formulation of hypotheses was the general notion that GPs prefer office encounters while patients prefer home visits. The

comparison of health care systems was expected to find larger numbers of home visits in countries with self-employed GPs and in countries with a relatively high number of GPs (high GP 'density'). Lower numbers of home visits were expected in countries with GPs in a gatekeeping position. Within the individual countries, more home visits were expected in rural practices, in single-handed practices and in practices with larger proportions of elderly people. It was also thought that female GPs would make fewer home visits (because these are younger and are more reluctant to make home visits in less safe situations). Opposing effects were hypothesised for the age of the GP and the presence of many socially deprived people in the practice, so that these were not expected to make a difference overall.

The results showed that, at the time of the data collection, home visits were the normal work of GPs in most countries, but that the number of home visits made varied widely from an average of 2 per week in Portugal to 44 in Belgium. In countries with self-employed GPs, the average number of home visits was much higher than in countries where GPs are usually employees. Fewer home visits were made on average in countries with gatekeeping GPs than in other countries, and the variation between GPs was smaller. These findings were in line with expectations. There was no evidence, however, for the predicted effect of the GP density in a country.

Variation in the frequency of home visiting were greater between countries than within countries. GPs in the same country tended to have comparable levels of home visiting and the differences were generally smaller than expected. The hypothesised larger number of home visits in rural practices and solo practices was only confirmed in countries where GPs were not gatekeepers. Indicators of higher patient demand in the practice population, viz. more elderly people and more socially deprived, were both related to more home visits made by GPs, while this had only been expected for the elderly. Finally, not only the gender but also the age of the GP appeared to be related to home visiting. More home visits were made by male GPs and by older GPs. The age effect had not been expected.

Time use and time management by GPs

In this chapter, results were presented on how GPs use their time and whether there were differences between countries and types of health care system. Variation in the allocation of time was also related to characteristics of the practice population (indicators of differing patient demand), the organisation of the practice and the personal characteristics of the GP.

Contrasts were found in the number of working hours of individual GPs as well as between health care systems. When working hours were divided up into hours spent on direct patient care and hours spent on indirect activities (such as administration and education), the variation appeared to be mainly in the hours for patient care. GPs' working hours, patient load and time for patients were country-specific to a large degree. The average working hours of GPs differed between countries from over 60 to around 40 per week. The number of office contacts GPs had with patients ranged from averages of 15 to 50 per day. These large differences could be explained when the formal position of GPs in the health care system were taken into account. GPs had longer working weeks in countries where GPs were self-employed, but the excess working hours in comparison with employee GPs only referred to direct patient care and not to indirect activities. GPs in countries with gatekeeping GPs and patients who are normally registered with a GP worked fewer hours than GPs in countries where patients can visit medical specialists directly.

Differences in the time spent on indirect activities were found between the post-communist countries and the western countries. GPs in the post-communist countries devoted less time to administration and education than western GPs, although this difference may be attributable to different practice conditions. Many GPs in the post-communist countries were still working in polyclinics in the period that the data were being collected and were usually not involved in administration.

Where the effects of practice organisation were concerned, the use of appointment systems – which differed greatly from country to country - was associated with fewer working hours for direct patient care. The time slots reserved in the appointment agenda for a consultation revealed contrasts between GPs in the time available for patients. GPs in partnerships or group practices reported less working hours overall, irrespective of other arrangements. GPs who kept comprehensive medical records of patient encounters worked more hours, both in patient care and on indirect activities. GPs who used a computer, which was not yet common in 1993, spent more time on indirect activities and less time on patient care. Where personal characteristics were concerned, older GPs tended to work fewer hours than younger GPs and female GPs consistently worked fewer hours than male GPs.

Influence of payment systems on GPs' workload and allocation of time

Chapter 8 deals with the question of whether different payment systems are related to the different ways that GPs allocate their time, if their workload

conditions (the size of the practice) vary. The hypothesis was that GPs would react as follows. The number of working hours was expected to be equal in health care systems with salaried GPs, irrespective of the number of patients served. GPs working in fee-for-service schemes would work more hours if the size of the practice increased. GPs in countries with a capitation payment system were expected to occupy an intermediate position, viz. they would work more hours, but not proportionally more, if the size of the practice increased.
The indirect measure of workload, i.e. the number of inhabitants per GP, varies by a factor of three between countries with high density and low density of GPs. Similar differences exist in direct measurements, such as the number of consultations per day and the frequency of home visits. The time that GPs reserve in the appointments diary for a consultation ranges from 7 to 24 minutes. In some countries, patients usually need to wait two or more days between making the appointment and going to see the GP. The normal working week for GPs showed national averages of between 40 and 60 hours.
The hypothesis concerning GPs working in capitation schemes was confirmed. For GPs in fee-for-service systems the hypothesis was not supported because the expected rise of working hours, time for patients and the number of patients treated was absent in the larger practices. For the salaried GPs it was not expected to find, in the group of smaller practices, an increase in time for patient care and indirect activities, the number of patients treated and shorter times in the appointments agenda with increasing size of practice. We concluded that patients in larger practices receive relatively less care of their GPs than patients in smaller practices, irrespective of the mode of GP payment. We found no evidence that fee-for service payment includes incentives to counteract this effect.

Discussion

After the review of the results of the study by the subjects, this section considers the results in a somewhat wider perspective and comments on methodological aspects. The study has succeeded in producing comparable information on services provided by GPs in European countries. The differences in task profiles between the countries were considerable in many respects. By grouping the countries according to common characteristics relating to the position and payment of GPs, we have been able to better understand the multitude of variation. The method of the study also allowed to take into account a range of characteristics of the GPs, the practice organisation and the practice location, which contributed to a better understanding of the distinct service profiles.

More of the variation could be explained by the characteristics of the health care system than could be explained by effects related to the GPs and the practices. GPs in countries with a gatekeeping system provided more comprehensive range of services, but made fewer home visits and worked fewer hours than GPs in countries with parallel access to medical specialists. GPs in gatekeeping systems provided a more homogenous set of services than GPs in other systems where there was more variation. In countries with self-employed GPs paid per item of service, the GPs were more involved in the treatment and follow-up of disease, made more home visits and spent more working time on direct patient care than GPs in other countries. In countries with salaried GPs, the GPs provided fewer treatment services and made fewer home visits than GPs in countries with self-employed GPs. Although differences were less than expected, GPs' response to varying workloads was related to the prevailing payment system. Working hours and number of patient contacts increased more strongly with practice size in countries with GPs working in a fee-for-service system than in other countries. In general, however, patients in larger practices receive relatively less care than patients in smaller practices.

There was a consistent contrast in GP task profiles between the post-communist countries and the western European countries. In the western countries, GPs had more comprehensive service profiles than in central and eastern Europe, particularly regarding the first contact with health problems and the provision of medico-technical procedures. GPs in western countries spent more time on indirect activities, such as administration and education, than GPs in the post-communist countries. Although the post-communist countries could be regarded as a group in comparison to the western countries, distinctions were actually found within this group - between the countries of the former Yugoslavia for instance, and the countries that had previously belonged to the Soviet Union.

Differences were found within countries, irrespective of the type of health care system. In all countries, there was a contrast between general practice in rural areas, where the profile of services was more comprehensive, and general practice in more urbanised areas and cities, where GPs were less involved in various services. Furthermore, male GPs in general had a more comprehensive task profile than female GPs. And, as might be expected, GPs in practices with more elderly people and a more socially deprived population are more involved in curative tasks (and home visits) than GPs in practices where these categories are less prominent. Finally, diverging task profiles were associated with the organisation of the practice and how GPs allocate resources, such as time.

The implications of the study results will be explained in the sections hereafter, but some methodological reflections would be appropriate first.

The validity of the results may have been influenced by selection bias. A random sampling procedure could not be achieved in all countries. Furthermore, although the response rate was not generally low for surveys of this kind, about half of the sampled GPs did not return a completed questionnaire. Response selectivity may have been reduced, however, by the nature of the questionnaire, which covered a wide range of topics and is therefore less likely to have attracted GPs with a specific interest. Some under-representation of female GPs and GPs in the oldest and youngest age groups was established, which may have affected results in which age and gender effects were relevant, but it is unlikely that the main findings of the study, particularly where the role of the health care system is concerned, are substantially biased.

The dependent variables were based on GPs' perceptions of their involvement in services. The question is how reliable these self-reports are. More precisely, it is difficult to estimate to what extent GPs know if patients present certain health problems to other professionals as well, directly to medical specialists for example. We think that GPs are directly or indirectly confronted with patients' visits to other health professionals, enabling GPs to make a fair estimate of their position in the 'market' for a particular health problem or intervention. In fact, the estimates of gatekeeping GPs may actually be more accurate than those of GPs not in that position. This may have influenced the task profile scores to some extent, but we believe in general that the GPs' perceptions are a good indicator of the real situation.

A problem in some countries was to determine the target population of the study. GPs are easy to identify as a professional group in most countries, even if they are not a well-organised one. General practice was unknown or only starting in a number of post-communist countries and samples were drawn from district doctors instead in these countries, supplemented by a number of newly trained GPs, if available.

In the absence of a feasible international reference point, urban and rural practice have been defined subjectively. We used a simple classification into five categories, which doctors could place within the context of their own national situations. The relevance of urbanisation in the context of this study was the experience of space and environment and the availability of services. Where the subjective component was concerned, a particular type of location in one country may not necessarily be matched by that in another, which is why

we also used the more factual dimension of distance between practice and hospital.

The translation of the questionnaire into the 26 languages was double-checked and so it is not likely that versions were inaccurate. Some connotative loss may have occurred nevertheless, and the interpretation of words may not be identical in all language versions. Our consideration of the results identified only one wrongly translated item in one of the versions of the questionnaire, which was removed from the analyses.

Low rates of GP involvement in services should not be interpreted as a lack of service provision; there will normally be an alternative method of provision when GPs are not involved. Consideration of possible alternatives was not part of this study, nor did the study cover the whole range of possible GP tasks. The focus was not on tasks that were evident GP tasks in all countries, or on very rare tasks. Some areas, such as tasks related to public health and sickness certification, were not investigated.

The associations found in this study suggest causality but do not prove it and it may be difficult to identify cause and effect. The connection between available practice equipment and the provision of services can be interpreted in two ways, and there are also two explanations for the finding that GPs who have regular meetings with social workers are more involved in the first contact with mental problems.

Then, the time that has elapsed since the data were collected should be noted. Changes have occurred in general practice in the past ten years - in the post-communist countries in particular, but in western Europe as well. Measures have been taken to control the cost and improve the quality of health care services and these may have affected general practice to differing degrees. Although changes in professional behaviour are usually limited in scope and take years to become generally implemented, it is unlikely that today's general practice is similar to general practice a decade ago. Preliminary results from Dutch general practice clearly show that contextual changes since the early 1990s have definitively affected the way GPs' understand their job and their professional activities. Only a replication of the European GP Task Profile Study, for which our results would serve as the indispensable pre-test measurement, could reveal the degree of change in general practice in the countries. Less change is to be expected in the explanatory results of the study, compared to the descriptive results. The associations that we have found with the GPs' provision of services are assumed to be much more stable through time.

A final limitation is in the approach of the study. By asking GPs and studying health care systems, this study took an exclusively supply-side position, which meant that patients' preferences and decisions in the use of health services (factors which also influence health care in a country) remained outside the scope of the study. This limitation may have been more significant in countries where the role and functions of health care suppliers like GPs were not yet well-defined, which was probably the case in the post-communist countries at the time of data collection.

Implications

Implications for health services research

The study has produced comparable information that shows the diversity in the organisation and provision of general practice in Europe and the influence of features of the national health care systems. This base of knowledge is a suitable starting point for elaboration in health services research. Detailed questions about the range of morbidity presented by patients to GPs and the interventions, prescriptions and referrals made by GPs, have to be answered by other methods than a survey. Practice *observations* or data collected by means of *registration* are needed to answer such questions. This highlights the importance of a research infrastructure for health services, including a health information system tailored to the needs of GPs and to the requirements of researchers, as these exist in the United Kingdom and the Netherlands, for example. In addition, capacity and resources are needed to make information out of practice data.

Further activity could also concentrate on *regional*, instead of national differences. Health care systems coincided with countries in our study, but variation in the organisation of health care may exist within countries as well. A regional analysis in Spain using data from our study has shown that such regional differences exist in the provision of services (Bolibar et al., 2003). Similar differences are to be expected in other decentralised or federal countries, such as Germany, Belgium and Sweden.

Our study has examined the process of care and does not answer questions on *outcomes* in terms of cost or the health status of the population. Evidence of the process is indispensable, however, in order to be able to understand differences in outcomes or performance of health care systems.

A major added value to this study would be its *replication*. It has been almost ten years since the collection of the data and many things have changed in the health care systems in Europe, particularly in the former communist countries.

Replication would not just provide an update of the situation in general practice, but would also show trends of change in the countries involved, which can be related to the many health reforms and other health policy measures taken in these countries. The resulting information could improve understanding of the practical effects of health policy.

Implications for general practice

In general, *prevention and health education* are less important tasks in general practice in Europe. GPs are heavily involved in curative work and responding to individual demands from patients. An outreaching approach to people who are not ill and giving life style information to groups at risk has no tradition in general practice in most countries. In central and eastern Europe, where prevention gets much attention, the effectiveness may be questioned, however. It is to be expected, however, that the demand for prevention and health education provided by GPs will grow, since primary care is in a favourable position to foster the patients' compliance and follow-up, particularly in systems where patients are on GPs' lists. GP job descriptions could be adapted in such a way as to ensure outreaching and community-based preventive activities receive more recognition as regular tasks, while another point for discussion could be whether GPs and their routinely kept information systems could play a role in the early detection of pandemic outbreaks and environmental threats.

The differences found in the study between services provided in *urban and rural practices* were fundamental. Rural GPs offer a wider range of services to their patients than GPs in cities, and it may be questioned whether qualifications and job requirements are too different to keep them under the same umbrella. Making no distinction, as in the current situation (with the exception of weight factors for capitation payments in rural and deprived practices in some countries), further reduces interest in going into practice in rural areas, resulting in greater inequalities in health services provision. Identifying two strands of general practice is complicated, because of the implications for medical education and the mobility of GPs.

The proportion of *female GPs* is growing rapidly in many countries, particularly in western Europe. Female GPs appeared to have different preferences when going into practice and provided a somewhat different package of services to their patients than male GPs. This situation deepens the problem relating to urban and rural practice, because female GPs prefer to work in urban practice. They also prefer to work in group practices, making it likely that practice conditions need to be adapted to meet these changed preferences. Further

research should clarify the implications of the different services provided by male and female GPs and it may be necessary for training programmes to devote more attention to 'under-served' task areas among female GPs (medico-technical procedures, for example).

There was a sharp contrast between the *post-communist countries* (especially those previously belonging to the former Soviet Union) and the *western* countries. General practice is developing in the transitional countries and it takes time to acquire an established GP position in health care systems. The poor development of tasks in first contact care indicates the inclination of the population to rely on specialist care, even for frequently occurring conditions. GPs will need more communication skills to change this exclusive medical attitude, which is an obstacle to the clarification and effective treatment of vague complaints. Furthermore, additional skills are needed for dealing with new task areas (e.g. children's problems and gynaecological problems) and running a practice efficiently. Being a gatekeeper primarily implies providing a wide range of services yourself, rather than referring patients to other care providers. National and international organisations of GPs can support GP associations in the post-communist countries with their expertise and knowledge. The very limited use of medical techniques and the poor equipment in the transitional countries demonstrates the lack of funds even for essential items. If these become available, GPs will need additional training to work with the equipment.

Results have shown the value of medical records being consistently kept by GPs, particularly in systems with registered patients. Most GPs use a computer nowadays, but its use for medical records is far from general. Computerised medical records are not just a help to GPs in providing continuous care to individual patients, a good practice data base is also indispensable for the systematic screening and following-up of chronic patients, besides being a source of information for epidemiological and health services research. Policy-makers and professional organisations should strongly encourage GPs to maintain record systems appropriate for their professional tasks.

The possible conflict between increasing patient demands and changing preferences of GPs may require changes in the organisation of general practice. Our study has suggested that well-equipped and well-staffed practices, where GPs work in small teams and where the flow of patients is regulated by an appointment system are good conditions for the provision of a wide range of services. Such working conditions may also meet GPs' needs for a private life. The conflict between a GP's private life and his/her working hours, which may

endanger the recruitment of sufficient GPs for the future, might be solved not by organisational measures alone, but by a reshuffling of tasks as well. Countries where general practice is strongly developed may point the way in finding solutions. Tasks in the care of chronic patients are increasingly being transferred from secondary care to primary care, or this care is shared by specialists and GPs. Tasks in general practice are delegated or shared with trained nurses and other staff, which requires a larger scale of practice and a good medical information system.

Implications for health policy

Recurring themes in health care reforms are access to services, equal quality, coordination and continuity of care, incentive structures and definition of professional responsibilities. The post-communist health care systems face a number of additional challenges. The results of our study suggest a number of recommendations for these aspects of health policy.

Access to health care

In countries with GPs in a strong position as gatekeepers, this system is felt to be too rigid in the care of certain categories of chronic patient, who frequently cross the border between primary and secondary care. Countries that do not have a gatekeeping system are trying to introduce one in some form, preferably on a voluntary basis, in order to improve coordination and control the costs of care. This means, in effect, that many countries are looking for flexible forms of GP gatekeeping. Our results do indeed show that gatekeeping GPs are well positioned in the patient flow at the entrance of health care, where they respond to a wide range of daily conditions - medical as well as psycho-social - presented by the patients for whose care they are responsible. This position favours a coordinating role. We also found that there is more homogeneity in the GPs' package of tasks in countries with a gatekeeping system.

Incentives

The mode of employment and payment of GPs should look for a balance between meeting patients' needs and avoiding overtreatment. Self-employed GPs were found to be more active than salaried GPs, both in terms of services and working hours. Services like preventive screening, which are not demand-driven, are unlikely to be provided under simple capitation payment systems, which means that additional target payments are needed in these cases. Situations of oversupply of GPs who are not gatekeepers and are working under

a fee-for-service payment system, often in single-handed practice, most probably contain negative incentives for cost effectiveness and good quality of care.

Expanding responsibilities

Coordination is not the only expanding task for GPs. Hospital stay is becoming shorter and can be avoided if tasks are transferred to primary care. In addition, the favourable position of GPs for case finding and promoting patient compliance with treatments has been discovered in preventive care. GPs are challenged to take up these new tasks. If payment for these services has been organised, the organisation of the practice needs to be prepared for these new tasks. We found that practices with more staff and equipment provided a wider range of services. Working in group practices made no difference in the service profile, but GPs working in groups worked fewer hours and female GPs prefer to work in group practices. Since time devoted to indirect activities is relatively constant, it seems that shortening working weeks for GPs relatively strongly affect time for patient care.

Central and eastern Europe

All post-communist countries are developing primary care and general practice and reducing the hospital sector. They have already learned the pitfalls of a fee-for-service system. There is a need for more coordination and less duplication of services, and the tasks of GPs are limited. Our study would suggest that these problems can be solved by a (voluntary) patient list system, through extending the competence of GPs by additional training, and providing GPs with the equipment to provide the services.

Urban and rural practices

GPs working in rural areas provided a more varied package of services, regardless of the health care system. This situation deserves different contractual arrangements, including payment, for GPs in rural areas.

Self-employed GPs might be preferable in rural practice, because they provide the more comprehensive services that are needed in rural areas. If these conditions are absent, rural practice may lose its attractiveness and staffing problems may arise. The equal distribution of health care manpower and facilities must be secured, in order to prevent services being poorest where needs are greatest.

This also applies to inner city practices, which are becoming less attractive places for GPs to work.

Female GPs

Many countries are seeing a sharp increase in female GPs, which has important implications for health manpower planning, as our study learned. Female GPs preferred to work part-time in group practices in urban and suburban areas and they also provided a more limited range of services than male GPs. Since there is no difference between training to become a part-time GP and training to become a full-time GP, a larger number of GPs will need to be trained in future for an equal number of posts. Practice conditions may need to be adapted to the needs of female GPs (the organisation of out of hours services, for example).

Coordination and continuity of care

Ageing populations mean more chronic patients with longer episodes of care and more complex interventions by different professionals, while continuity of care requires a coordination of various health care inputs in such cases. Our study suggested that a system in which patients are registered with a GP of his or her choice benefits coordination. There is a better chance in such systems that medical information will be stored in one place, than in systems without patient lists of this kind.

Systems with listed patients are also essential for GPs to deliver public health tasks and for researchers to collect data for primary care epidemiology and health services research. A patient list system is not sufficient, however. Individual GPs need to keep comprehensive medical records and maintain good working relations with other health professionals in primary and secondary care, conditions that can be fostered by means of proper incentives.

Samenvatting
(Summary in Dutch)

Huisartspraktijkprofielen in Europa:
een internationaal onderzoek naar verschillen in de taken van huisartsen

Inleiding
Dit boek gaat over een onderzoek naar verschillen in de uitoefening van taken door huisartsen in Europa. Daarbij is vooral gekeken naar de vraag in hoeverre de wijze waarop de gezondheidszorg in een land is ingericht, invloed heeft op de betrokkenheid van huisartsen in dat land bij de verlening van curatieve en preventieve zorg. Invloeden op plaatselijk niveau, zoals praktijkomstandigheden en persoonskenmerken van huisartsen, zijn ook bij het onderzoek betrokken. Het onderzoek, dat financieel werd mogelijk gemaakt door de Europese Commissie en werd gesteund door de Wereld Gezondheids Organisatie, voorziet in een behoefte aan internationaal vergelijkbare gegevens over zorgverlening door huisartsen.
Het onderzoek heeft drie bronnen van informatie. Op grond van literatuuronderzoek en met de hulp van cntactpersonen werd de organisatie en financiering van de gezondheidszorg in de landen van Europa beschreven; deze beschrijvingen leverden de achtergrondinformatie voor het onderzoek. Verder vroegen wij in 32 landen huisartsen, via steekproeven geselecteerd, een vragenlijst (in hun eigen taal) in te vullen. De vragen gingen over de betrokkenheid van de huisarts bij de eerste opvang en behandeling van een groot aantal concreet beschreven gevallen, alsmede over de organisatie en uitrusting van de praktijk, samenwerking en kenmerken van de plaats van vestiging. Bij de vragenlijst was verder een dagboekje gevoegd, waarin de huisartsen gedurende 7 dagen de tijdsbesteding konden bijhouden. In totaal hebben 7.895 huisartsen aan het onderzoek meegedaan; dat is een respons van 51%.
Na het eerste inleidende hoofdstuk van dit boek volgen er zeven, die eerder afzonderlijk zijn gepubliceerd en één dat nog moet verschijnen. Hoofdstuk 10 bevat een uitgebreide samenvatting en de conclusies. Hieronder volgt een bondige samenvatting van de hoofdstukken.

Taakprofielen van huisartsen in Europa
Vier groepen van taken werden onderscheiden, te weten het eerste contact met gezondheidsproblemen van patiënten, het verrichten van medisch technische

handelingen (zoals kleine chirurgische ingrepen), het behandelen van (chronische) ziekten en preventieve zorg. In de rol van de huisarts bij het eerste contact met gezondheidsproblemen werden vooral grote verschillen gevonden waar het gaat om psycho-sociale problemen en om klachten van kinderen en vrouwen. In sommige landen blijkt de huisarts daarvoor niet de eerst aangewezen hulpverlener te zijn. Medisch-technische verrichtingen werden ook in heel verschillende mate uitgevoerd. Bij het behandelen van ziekten waren de verschillen tussen de landen kleiner dan bij de overige aspecten. De betrokkenheid van huisartsen bij systematische preventie was veel geringer dan bij de curatieve taken. Groepen van landen met gemeenschappelijke kenmerken betreffende de positie van de huisarts, werden vergeleken. In landen waar huisartsen een poortwachtersfunctie vervullen naar de specialistische zorg, hadden dezen een veel sterker ontwikkelde rol als arts-van-het-eerste-contact dan in andere landen, waar die rol wordt gedeeld met medisch specialisten. In landen met zelfstandig gevestigde huisartsen waren die meer betrokken bij het behandelen van ziekten dan in landen met huisartsen in loondienst. Tenslotte bleek dat huisartsen in de voormalige communistische landen op de meeste terreinen een beperkter rol vervullen dan hun collega's in de andere landen.

Vergelijking van stads- en plattelandspraktijken

De hypothesen werden getoetst dat bij huisartsen op het platteland een meer omvattend takenpakket zou worden gevonden, en bij huisartsen die hun praktijk vlak bij een ziekenhuis hebben juist een beperkter takenpakket. Bovendien werd verwacht dat verschillen tussen praktijken in de stad en op het platteland kleiner zouden zijn in landen waar huisartsen een poortwachtersfunctie hebben.

Praktijken op het platteland bleken anders te zijn dan die in de stad: huisartsen werken er vaker solo, er is meer apparatuur en sociale achterstand van de bevolking komt er minder voor. Huisartsen op het platteland en in praktijken op meer dan 5 kilometer van een ziekenhuis waren meer betrokken bij de zorg in de curatieve taakgebieden. Huisartsen in binnenstadspraktijken doen minder aan kleine chirurgie en andere technische verrichtingen. Overigens bleek de uitoefening van taken ook verband te houden met de aard van de praktijkpopulatie, zoals de leeftijdsopbouw, de personele bezetting en uitrusting van de praktijk, het voltooid hebben van de huisarts-beroepsopleiding en het geslacht van de huisarts (waarover zo meer). In tegenstelling tot de verwachtingen werd in landen met huisartsen in een poortwachtersfunctie wel een verschil

gevonden in de taakprofielen van stads- en plattelandshuisartsen. Dit zou kunnen wijzen op een erosie van de poortwachtersfunctie in de stad.

De huisarts als hulpverlener in het eerste contact met psycho-sociale problemen
Verondersteld werd dat in landen waar patiënten bij een huisarts staan ingeschreven, die huisartsen een meer omvattende rol vervullen in het eerste contact met psycho-sociale problematiek dan in landen waar dat niet het geval is. Daarnaast werden invloeden verwacht van de werkdruk van de huisarts en de hoeveelheid tijd die hij aan de patiënt kon besteden, kennis van de voorgeschiedenis van de patiënt (uit het medisch dossier) en de beschikbaarheid van deskundigheid (als gevolg van opleiding en door samenwerking met maatschappelijk werkers). Er werden grote verschillen gevonden in de mate waarin huisartsen de eerste opvang verzorgen bij psycho-sociale problemen, zowel binnen landen als tussen landen. Zoals verwacht waren huisartsen in landen waar zij ingeschreven patiënten hebben hierbij beduidend meer betrokken dan huisartsen in andere landen. Ook werd een uitgesproken 'oost-west' verschil gevonden. Huisartsen in de post-communistische landen waren veel minder betrokken bij de eerste opvang van psycho-sociale problematiek. Ook een aantal individuele praktijkomstandigheden was van invloed op genoemde rol van de huisarts. Huisartsen met een afspraakspreekuur en bij wie de gereserveerde tijd per patiënt niet heel kort was, en huisartsen die een goed patiëntendossier bijhouden (en daardoor beter geïnformeerd zijn over hun patiënten) waren meer betrokken bij deze eerstelijns GGZ-taken. Toch bleek een drukke praktijk, in de zin van een groot aantal patiëntencontacten per dag, geen belemmering te zijn. Zoals verwacht had de samenwerking met maatschappelijk werkers en het voltooid hebben van een beroepsopleiding tot huisarts een gunstige invloed. Hierdoor kunnen huisartsen hun vaardigheden in het omgaan met niet-medische problemen beter ontwikkelen.

Vrouwelijke en mannelijke huisartsen vergeleken

Uit de literatuur is bekend dat mannelijke en vrouwelijke huisartsen verschillen in hun voorkeur voor werktijd en werksetting. Verondersteld werd dat er ook verschillen tussen de seksen zouden zijn in de wijze van zorgverlening, maar verwacht werd dat deze verschillen in de landenvergelijking kleiner zouden zijn daar waar huisartsen een poortwachtersfunctie en ingeschreven patiënten hebben. In die landen kunnen patiënten namelijk hun eventuele voorkeur voor een huisarts van hetzelfde geslacht minder realiseren. Wat systematische preventie betreft, werd in landen met zelfstandig gevestigde huisartsen über-

haupt weinig activiteit verwacht, omdat de honorering er daar meestal niet in voorziet. Dus worden in die landen ook geen sekseverschillen verwacht in de betrokkenheid bij preventie.
De man-vrouwverdeling onder huisartsen verschilde sterk van land tot land. Mannen waren doorgaans in de meerderheid, behalve in de landen van Midden- en Oost-Europa. Vergeleken met hun mannelijke collega's waren vrouwelijke huisartsen jonger, werkten vaker in deeltijd, in duo- of groepspraktijken en in de stad (ofschoon niet in achterstandswijken). Ze onderscheidden zich verder door een geringer aantal huisbezoeken en minder diensten buiten kantooruren. Dat vrouwelijke huisartsen minder patiënten zien, bleek geheel toe te schrijven aan deeltijdwerken. Wat de zorgtaken betreft, vonden we dat vrouwelijke huisartsen in West-Europese landen meer betrokken waren bij het eerste contact met gynaecologische problemen Voor alle overige curatieve taken was de algemene tendens dat de betrokkenheid van vrouwelijke huisartsen geringer is dan die van mannelijke collega's. Groepsgewijze gezondheidsvoorlichting, waarin huisartsen in het algemeen overigens weinig actief bleken te zijn, werd meer gedaan door vrouwen dan door mannen. Zoals verwacht bleken de sekseverschillen in de taakverlening kleiner in landen met huisartsen in een poortwachtersfunctie dan in landen met een meer open toegang tot de medisch-specialistische zorg.

Onderlinge verschillen tussen de landen van Midden- en Oost-Europa

Vanuit West-Europa worden de voormalige 'oostbloklanden' vaak als een homogene groep gezien. Wij hebben, voor wat de taakuitoefening van huisartsen betreft, onderzocht in hoeverre dat zo is. In het algemeen was er een flinke kloof tussen de taakbreedte van huisartsen in 'oost' en 'west'. Voor preventie was het verschil kleiner dan voor aspecten van curatieve zorg. Binnen de groep van post-communistische landen vonden wij echter geen grotere homogeniteit in de taakprofielen dan onder de overige landen. Bij de meeste curatieve taken bleek de onderlinge variatie zelfs groter dan tussen de West-Europese landen.
Binnen de groep van Midden- en Oost-Europese landen konden op basis van het takenprofiel van de huisartsen drie subgroepen onderscheiden worden: voormalig Joegoslavië, de voormalige satellietstaten en de landen voorheen behorend tot de Sovjet Unie. Met uitzondering van het behandelspectrum van (chronische) ziekten, was de curatieve zorgverlening van huisartsen het meest omvattend in voormalig Joegoslavië, gevolgd door de satellietlanden, zoals

Polen, Tsjechië, Slowakije, Hongarije. In laatstgenoemde landen werd het communistische zorgstelsel pas na de Tweede Wereldoorlog ingevoerd.
Joegoslavië, onder Tito, heeft door de jaren heen een betrekkelijk zelfstandige koers kunnen varen. Huisartsen in de voormalige Sovjet Unie hadden een erg beperkt pakket van curatieve zorgtaken. Bij preventie was de situatie min of meer omgekeerd. In de voormalige Sovjet Unie maakte preventie een relatief groot deel uit van het takenpakket van de huisartsen (wat overigens nog niets zegt over de effectiviteit ervan).

Huisbezoek door de huisarts

Dit onderdeel ging uit van de algemene veronderstelling dat huisartsen een patiënt liever in de spreekkamer zien, terwijl patiënten meer een voorkeur hebben voor een huisbezoek. Meer huisbezoeken werden verwacht in landen met zelfstandig gevestigde huisartsen en waar een hoge 'huisartsendichtheid' bestaat. In die landen is er een sterkere prikkel voor de huisarts om de voorkeur van de patiënt te volgen, ook als de noodzaak voor een huisbezoek minder sterk is. Minder huisbezoeken werden verwacht in landen waar huisartsen een poortwachtersfunctie vervullen en ingeschreven patiënten hebben. In een dergelijk systeem is er een grotere drempel voor patiënten om van huisarts te veranderen. Op basis van de literatuur werd verder verwacht dat huisartsen op het platteland meer huisbezoeken afleggen dan hun collega's in de stad; in solopraktijken meer dan in duo- en groepspraktijken; in vergrijsde praktijken meer dan in praktijken met een jongere populatie en dat mannelijke huisartsen meer huisbezoeken afleggen dan vrouwelijke. In de meeste landen behoorde het huisbezoek tot de normale taken van de huisarts, maar de gemiddelde aantallen afgelegde bezoeken liepen zeer uiteen, van 2 tot 44 per week. In landen met zelfstandig gevestigde huisartsen lag het gemiddelde beduidend hoger dan in landen waar huisartsen in loondienst zijn. Waar huisartsen een poortwachtersfunctie vervullen met ingeschreven patiënten, legden dezen minder huisbezoeken af en waren de onderlinge verschillen in afgelegde bezoeken kleiner dan bij huisartsen in andere landen. Zo was dat ook verwacht. Het verwachte effect van huisartsendichtheid werd echter niet gevonden. Het verschil tussen stad en platteland en tussen solopraktijken en duo- en groepspraktijken werd alleen gevonden in landen waar huisartsen geen poortwachter zijn. Niet alleen in vergrijsde praktijken werd een groter aantal huisbezoeken gevonden, dit bleek ook het geval in praktijken in achterstandsgebieden. En behalve dat mannelijke huisartsen meer huisbezoeken afleggen dan vrouwelijke, vonden we ook dat oudere huisartsen er meer afleggen dan jongere.

Besteding en beheer van tijd door de huisarts

De gemiddelde aantallen gewerkte uren van huisartsen verschilden sterk van land tot land; van 40 tot 60 uur per week. Die verschillen zaten vooral in de uren die besteed worden aan directe zorg voor patiënten, en veel minder in de uren voor indirecte activiteiten (zoals administratie en scholing). Nog groter waren de verschillen in het gemiddeld aantal patiënten dat een huisarts op een dag in zijn spreekkamer ziet: variërend van 15 tot 50. In landen met zelfstandig gevestigde huisartsen was de gemiddelde werkweek, met name de uren voor directe patiëntenzorg, langer dan in landen met huisartsen in loondienst. In landen waar huisartsen een poortwachtersfunctie hebben en waar patiënten staan ingeschreven bij een huisarts, was de werkweek korter dan in landen waar patiënten niet staan ingeschreven (en dus makkelijker andere artsen kunnen raadplegen). In de post-communistische landen besteedden de huisartsen minder tijd aan indirecte activiteiten dan hun collega's in de overige landen. Wellicht worden in de grotere medische centra in eerstgenoemde landen bepaalde overhead-taken uitgevoerd door daarvoor aangestelde functionarissen. Huisartsen met een afspraakspreekuur, in veel landen zeker nog geen regel, werkten minder uren dan huisartsen met een open spreekuur. De gereserveerde tijd per afspraak liep sterk uiteen. Los van andere organisatorische aspecten werkten huisartsen in duo- en groepspraktijken korter dan huisartsen in solopraktijken. Huisartsen die de patiëntendossiers goed bijhouden, rapporteerden gemiddeld meer werkuren dan huisartsen bij wie dat niet het geval was.

De invloed van het honoreringsstelsel op de werkbelasting en tijdsbesteding

Verwacht werd dat huisartsen verschillend omgaan met een hogere werkbelasting al naar gelang de wijze waarop ze worden gehonoreerd. In landen waar huisartsen in loondienst zijn zouden dezen een ongeveer gelijk aantal uren werken, ongeacht de omvang van de praktijk. Waar huisartsen per verrichting worden betaald, werd verwacht dat het aantal werkuren zou toenemen met het toenemen van de praktijkgrootte. Een tussenpositie werd verwacht bij huisartsen die voornamelijk bij abonnement worden betaald. Zowel voor de indirecte maat van werkbelasting (het gemiddeld aantal inwoners per huisarts in een land) als directe maten (aantal patiëntencontacten en aantal huisbezoeken) werden zeer grote verschillen gevonden tussen de landen. De tijd die huisartsen voor een consult reserveren, varieerde van gemiddeld 7 tot 24 minuten en ook de wachttijd voor de patiënt tussen het maken van een afspraak

en het tijdstip van het consult verschilden sterk. De gemiddelde werkweek van huisartsen in een land liep uiteen van 40 tot 60 uren per week.
Onze veronderstellingen over het verband met het betalingssysteem werden alleen bevestigd voor wat betreft huisartsen met een abonnementshonorarium. In landen met een betalingssysteem per verrichting werd weliswaar een stijging van het aantal werkuren gevonden bij huisartsen met een praktijkgrootte op of onder het gemiddelde, maar niet bij de groep huisartsen met grotere praktijken. Gesalarieerde huisartsen tenslotte lieten, tegen de verwachting in, toch een toename zien in het aantal werkuren in de groep met een gemiddelde of kleinere praktijk. We concludeerden, dat patiënten in grotere praktijken relatief minder zorg krijgen dan patiënten in kleinere praktijken, en dat er van een honorarium per verrichting geen voldoende krachtige prikkel lijkt uit te gaan die dit tegen gaat.

Discussie

Dit onderzoek heeft veel gegevens opgeleverd die de grote verscheidenheid laten zien in de organisatie en verlening van de huisartsenzorg in Europa en de invloed van kenmerken van de nationale zorgsystemen daarop. De verschillen in taakprofielen van huisartsen werden in grotere mate verklaard door die systeemverschillen dan door individuele- en praktijkkenmerken. Waar huisartsen een poortwachtersfunctie bekleden vonden we in het algemeen een breder pakket aan verleende zorgtaken en minder individuele verschillen daarin dan in landen waar medisch specialisten direct toegankelijk zijn. In landen met een betalingssysteem per verrichting zijn huisartsen meer betrokken bij het behandelen van chronische ziekten en het begeleiden van patiënten, leggen ze meer huisbezoeken af en besteden ze gemiddeld meer uren per week aan patiëntenzorg dan in landen met een ander betalingssysteem, vooral landen met gesalarieerde huisartsen. We vonden een duidelijk contrast in de verleende taken tussen de voormalige communistische landen en de overige landen in Europa. Over de hele linie was het takenpakket beperkter in de eerstgenoemde landen, al waren er ook binnen deze groep aanzienlijke verschillen tussen landen van het voormalige Joegoslavië en landen die voorheen tot de Sovjet Unie behoorden.
Naast verschillen tussen landen waren er ook de meer bekende verschillen binnen de landen. Door alle zorgsystemen heen vonden we een breder takenprofiel bij huisartsen in plattelandspraktijken vergeleken met huisartsen in de stad, en mannelijke huisartsen verleenden in het algemeen een breder pakket aan taken dan vrouwelijke huisartsen.

Een aantal methodologische kanttekeningen dient te worden gemaakt. Niet in alle landen kon een representatieve steekproef worden getrokken en bovendien heeft slechts de helft van de aangeschreven huisartsen een vragenlijst ingevuld teruggestuurd. De invloed hiervan op de resultaten valt moeilijk vast te stellen. Voor zover het kon worden achterhaald, waren vrouwelijke huisartsen en heel jonge en oudere huisartsen enigszins ondervertegenwoordigd onder de respondenten. Resultaten waarin leeftijd en geslacht van de huisartsen van belang zijn, kunnen hierdoor zijn beïnvloed, maar in de analyses is altijd rekening gehouden met deze variabelen. De diversiteit aan onderwerpen die in de vragenlijst aan de orde werden gesteld, maakt het niet waarschijnlijk dat huisartsen op een bepaalde belangstelling zijn geselecteerd.
De afhankelijke variabelen zijn gebaseerd op eigen waarneming van de huisartsen. De vraag is in hoeverre een huisarts er weet van heeft dat zijn patiënten voor bepaalde gezondheidsproblemen ook andere artsen consulteren. Wij denken dat huisartsen dit direct of indirect te weten komen en derhalve een redelijke schatting kunnen maken van hun positie in de 'markt' voor bepaalde gezondheidsproblemen of verrichtingen.
In een aantal landen was het lastig de doelgroep van het onderzoek vast te stellen. Vooral in post-communistische landen waren huisartsen zoals wij die kennen vaak niet zo bekend als elders het geval is. In zulke situaties werden, in overleg met de lokale coördinatoren, steekproeven districtsartsen getrokken, die qua functie nog het meest lijken op de huisarts; dit werd soms aangevuld met een steekproef onder artsen die recentelijk waren omgeschoold tot huisarts.
Hoewel veel zorg is besteed aan de vertaling van de vragenlijst in 26 talen, valt het niet uit te sluiten dat sommige begrippen hierbij toch een enigszins verschillende betekenis hebben gekregen.
Hoewel in de resultaten relaties tussen oorzaak en gevolg soms zeer voor de hand liggen, moet niet worden vergeten dat slechts samenhangen zijn vastgesteld.
Waar gevonden werd dat huisartsen, vergeleken met collega's in andere landen, slechts in geringe mate betrokken zijn bij de uitoefening van bepaalde taken, moet niet geconcludeerd dat daar sprake is van een tekort. Vaak zal in die gevallen de zorgverlening door anderen dan huisartsen worden gedaan.
Een ander punt is, dat dit onderzoek zich uitsluitend heeft gericht op huisartsen, de aanbodzijde dus. Voorkeuren van patiënten bij het inroepen van hulp bij bepaalde gezondheidsproblemen, die mede de rol van huisartsen bepalen, zijn dus niet aan de orde geweest.

Ten slotte dient opgemerkt dat nu ongeveer tien jaar zijn verstreken sinds het begin van de gegevensverzameling. In de tussenliggende jaren is er veel veranderd, vooral in Oost Europa. Hoewel professioneel handelen doorgaans langzaam verandert, zullen er veranderingen zijn opgetreden in de taakprofielen van huisartsen. Overigens is het niet waarschijnlijk dat de gevonden samenhangen tussen taakuitoefening en lokale en nationale kenmerken veel zijn veranderd. Een herhaling van deze studie biedt niet alleen de mogelijkheid de omvang van de veranderingen vast te stellen, maar ook deze in verband te brengen met het gevoerde beleid in de achter ons liggende jaren.