DANISH REGIONS

HEALTH FOR ALL
VISION FOR A SUSTAINABLE HEALTH CARE

A VISION FOR GENERAL PRACTICE

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Citizens must be provided with attractive, efficient, continuous and accessible generalist care across the country

In the coming years resources will be scarce in the Danish healthcare system. We are at the beginning of a period of demographic changes with an ageing population. The demographic changes will place enormous pressure on the public sector. Shortage of labour will present immense challenges in the years to come.

The development of new therapies and technologies and higher expectations from citizens contribute to raise the quality of healthcare. At the same time, it will strengthen the pressure on healthcare resources.

We are living longer and therefore often require healthcare services for a prolonged time. The growing number of people with chronic disease enhance the need of resources for diagnosis and treatment of chronic diseases. Treatment of chronic disease requires long-term and continuous care, rather than an acute and episodic one. At present, specialised healthcare is largely geared to providing the latter.

At the same time, the healthcare system is under pressure to provide citizens with continuity of care across the system. The healthcare system has not been good enough at providing continuous and integrated care - yet we know that this is something citizens want and need. For many citizens integration between health and social services will be crucial as well.

A new approach

To meet these enormous challenges we need to look at our healthcare system and see it from a new perspective. There is need for innovation in relation to how we view the population and the needs and wishes of the population. We need to innovate the way we work together to promote health and reduce the risk of disease among citizens. We need to develop the way we organise healthcare and plan healthcare services according to their value for the patients, the population and their economic efficiency at a societal level (cf. Triple Aim).

In a Danish context, we must develop a population-based focus, taking the needs and wishes of specific population groups into consideration. We must focus on prevention and early detection of disease aiming initiatives at different population groups. We have to change the prevailing "one size fits all" approach.

We need to become better at seeing healthcare as an integrated economy in which all stakeholders contribute to ensuring that services are organised and placed where they create most value for the citizen and the society.

Furthermore, we need to enhance incentives for all stakeholders to focus on quality, continuity of care and personalised care.

General practice as part of an integrated healthcare system

General practice plays a crucial role and function in the Danish healthcare system contributing to the overall efficiency and quality of healthcare.

An accessible and community-based provision of generalist care is one of the cornerstones of the Danish healthcare system. General practice's expertise lies in their holistic view, their ability to navigate and understand the interplay of medical issues and assess and treat symptoms or, where necessary, refer patients to further investigations by specialists.

In Denmark, general practice functions as a gatekeeper to the specialised health system. They play a crucial role in relation to diagnosis and treatment. Nine out of 10 medical consultations are finished or remain in the care of general practice.

The Regions are responsible for providing local generalist care for Danish citizens. The general practitioners, working under agreement with the Regions, provide a 100 per cent publicly funded health service for all Danish' citizens. In some areas of Denmark, there is a challenge to provide local access to general practitioners. In these areas, the Regions will procure provision of generalist care via tender or regional clinics, at which doctors specialised in general medicine are employed to provide consultation for registered citizens in need of general medical care in the daytime.

General medical expertise is a scarce resource. For this reason, it is relevant to look at how general practice services can be sustainably organised - professionally and financially - and which solutions are necessary in order to provide citizens with an attractive, efficient, continuous and accessible generalist care across the country.

The Regions will develop and invest in general practice. The pointers for development will be rooted in a population-based approach, as explained above.

In the future, general practice will take the primary role in meeting citizens' general medical needs. Furthermore, general practice will be an integrated part of the healthcare system and help meet the general challenges it faces.

The future general practice must be equipped to handle a variety of tasks, especially in relation to patients with chronic diseases. This requires optimising the use of resources in general practice, strengthening of the general expertise, enhancing general practice's use of data in the work of quality improvement etc., and that general practice commit to take on and carry out services within an integrated health system.

In the following, the Regions' vision for general practice will be set out. Including how the Regions will support general practice in the development of the future general practice.

A vision for general practice

New roles and new tasks

The Regions will support general practice to work population-based. The future general practice should aim to provide health for all the citizens registered within their practice

In the future, it will be necessary that the healthcare system focus even more on the population groups, which are at high risk of experience deterioration in their health status. There are many reasons a patient can be at risk of developing illness. Risk factors may include social marginalisation, a limited social network, stress, high blood pressure, a history of heart attacks etc. The care should be differentiated depending on the individual's risk of developing an illness or worsening of illness.

A population-based approach aims at improving the health of an entire population assuring the highest possible level of health among the given population. The approach will promote a more systematic approach to targeting the resources in general practice for the groups of the population that are most in need.

The approach does not suggest that we should cease to focus on individual patients as a basis for care. Rather, it is an approach, which entails general practice to be more proactive and personalise care for their patients depending on their risks instead of waiting for the patients to present themselves. Risk stratification is an important tool for this. In this way, citizens who do not typically visit their general practitioner will become more visible to the general practitioner.

The general practitioner must take on the overall responsibility of the patient's care, as the patient-responsible doctor. This includes a proactive approach to patients registered with their practice.

The population-based approach entails a shift in focus from viewing general practice as a gatekeeper for specialised healthcare, to seeing the future general practitioner

as responsible for promoting the best possible health for the registered patients. This new focus does not change the fact that citizens' needs must be met based on the LEON principle. As a consequence, the general practitioner's role as gatekeeper will include a more long-term dimension and a more proactive focus.

The population-based approach will strengthen the need for a strong and integrated primary sector in which there is close interaction between the municipality and general practice – especially concerning vulnerable citizens in need of both healthcare and social services. The population-based approach will make it possible to create joint initiatives that target those citizens who are highly at risk of developing an illness or experiencing the worsening of an illness.

The future general practice should together with the Regions and the municipalities and by the use of data increase the focus on early detection. For instance, there will be a greater focus on specific population groups as for example vulnerable patients suffering from both diabetes and mental illness who for one reason or another do not visit their general practice regularly.

Example

A region, a municipality and the municipality-based general practices have started a joint initiative targeted at citizens with diabetes. As part of the initiative, the region extracted data about the number of citizens suffering from diabetes, as well as specific data about the proportion of citizens who had received a foot examination either at hospital or at their general practice. The numbers showed that about half of all persons with diabetes had undergone a foot examination either at hospital or at their general practice.

For a person with diabetes untreated foot ulcers can have major consequences, and in the worst-case lead to amputation of the foot, with a resultant deterioration in quality of life. Thus, there presents a great opportunity for prevention and reducing the costs for the society.

The region, the municipality and general practice agreed to increase the focus on persons with diabetes. It was agreed that municipal employees in the future will check the feet of persons with diabetes frequently and ongoing. At signs of redness or ulceration, they will contact a nurse specialised in care of wounds. In addition, it was agreed that nurses in general practice would increase focus on foot examinations at general practice

The Regions will support general practice with the treatment and care of people with chronic disease

In order to continue to have a sustainable healthcare system that delivers a high standard of care, it is necessary to take a systematic approach to the planning and organisation of healthcare services. This includes identifying which tasks patients are able to carry out themselves. The goal is to guarantee value and a high quality of care for citizens and to identify the most cost effective solutions to problems, with a focus on improving citizens' health.

The future general practice should provide more care for people with chronic disease. In the future, the general practitioner will be the primary caregiver for people with chronic diseases and primarily handle all aspects of assessment, treatment, monitoring and control. This will include people with diabetes, COPD or heart disease. Elements of these tasks are already handled in general practice, but in some areas, it will be necessary to move tasks from outpatient clinics to general practice. This will improve citizens' access to local healthcare services of high quality.

The Regions will support general practice in carrying out these tasks by providing systematic and easy access to specialist advice etc.

The Regions will ensure collaboration between general practice, regions and municipalities with the aim of creating an integrated health service. It requires a more binding collaboration between stakeholders

Continuity of care is one of health care's biggest Achilles heels. For some citizens, it is equally important that there is integration throughout the health and social services.

Regional hospitals, general practice and municipality services must to a higher degree act as an integrated unit working towards a shared goal: achieving the highest possible level of health and quality of life in the population. It entails working together to prevent illness and the worsening of patients' illnesses. General practice should be an equal and committed partner fulfilling the roles and tasks, which are agreed upon centrally and locally.

The Regions will ensure that general practice is supported by the hospitals in the delivering of care. General practice should have access to the expertise at the hospitals. This requires further development of standards and easy access to communication between general practice and the hospitals. The communication can take place by telephone or via e-mail correspondence. The communication must be formalised, making the possibilities the individual general practitioner has clear for consultancy from the specialists at the hospital.

One of the core elements of a strengthened collaboration will involve strengthening the formal framework. There is a need to strengthen the formal agreements between stakeholders. All stakeholders should be guaranteed that the provision of services would be solved with an adequate level of professionalism, quality and financial efficiency at a societal level, whether it is hospitals, general practice or municipalities who are responsible.

In line with the above, it should become increasingly possible for the various stakeholders to "order" services from each other. At the same time, it is crucial that the stakeholders keep each other informed. Care provided at one setting should not be viewed as separated from follow-up care at another setting. In other words, we need to further develop health agreements, and different patient programmes and pathways as well as patient rights, and assess whether they are binding, such that the patient's programme of treatment is always followed-up on when a patient is transferred from one setting to another.

Communication between sectors must be structured, rapid and streamlined. This also applies to electronic communication, including discharge summaries and referrals. A review must be carried out to assess whether we have adequate facilities to electronically share patient data between sectors. We must assess the usability of the present electronic communication tools and their ability to share relevant patient information. The flow of information and data between sectors is a prerequisite for continuity of care across the healthcare system.

The Regions will create incentives for all stakeholders to ensure that patients, to the degree possible, return to their everyday-lives

All stakeholders must be motivated to ensure that patients are able to return to their everyday-live. All stakeholders should have this as a shared goal. Tools to motivate this goal may include bundled payment or value-based management. This indicates a need to develop the current financial models and incentives in general practice. New models need to promote and support efficiency, continuity of care and value of care for the patient and the society. The models need to support the way general practice should work, including their overall responsibility for the care of their registered patients.

Example

In 2015, The Netherlands introduced a new funding model for general practice comprising three segments. Segment 1 funds core primary care services and consists of a capacitation fee per registered patient, consultation fees and fees for ambulatory mental health care. The fees are determined nationally. Segment 2 covers fee-for-services in relation to multidisciplinary care for people with diabetes, heart disease, asthma and COPD. Segment 3 gives general practice the opportunity to negotiate additional contracts with insurers for pay for performance or innovation initiatives.

The health authorities in the Netherlands predict that segment 1 will represent 75 per cent of a general practitioner's salary, while segment 2 will represent 15 per cent and segment 3 will represent 10 per cent.

Medical professionalism and documented quality

The Regions will contribute to enhance the expertise in general practice and support the development of structures supporting ongoing quality improvements

The future general practice will be better equipped to work proactively and to examine and treat patients suffering from chronic illness. This require that the expertise in general practice is continuously updated and supported. Furthermore, it is crucial to develop and promote the framework for quality improvement and data-driven work.

One way to strengthen the quality and the medical professionalism in general practice is to introduce clusters, professional groupings of general practices. Clusters can help improve quality by encouraging general practitioners to take part in quality improvement activity within their units. The organisation of general practice into clusters can also enable and support general practices to hire a greater number and variety of personnel.

An example from the Netherlands

In the Netherlands, various forms of organisation exist including networks and partnerships between a large amount of doctors and other other professions. There is no requirement for general practitioners to form networks or partnerships, and the formation of such organisations are voluntarily. These organisations take various forms ranging from cooperation based on cooperation agreements to private companies with a manager and shared profits between the owners.

Some general practitioners are part of cooperatives of up to 100 general practitioners. These cooperatives provide treatment of chronic illness. By grouping together in this way, the general practitioners have the opportunity to specialise in the treatment of selected chronic illnesses. The cooperative can help to support and improve the quality of care for the chronically ill provided by individual doctor via accreditation and systematic training. In addition, the cooperatives can have an administrative function responsible for contracts with insurance companies, accounting, communications, etc.

An example from Scotland

The Scottish Government and the Scottish General Practitioners Committee decided to introduce a formalised cluster structure. From 2016/2017, all general practice will be part of a cluster. A typical cluster will include four to eight general practices with approximately 20,000 to 40,000 registered patients. The clusters will function as drivers for quality improvement and will be involved in improving the quality of each practice and of other health and social services in the local area. Each general practice will have a practice quality lead who will meet regularly with the other practice quality leads to discuss the quality of care in the cluster. Each cluster will also appoint a cluster quality lead who will have protected time to participate in the development of the overall regional and local health services. The cluster quality lead will in addition have a coordinating role within the cluster. Furthermore, the cluster quality lead will participate in meetings chaired by a regional leader. At these meetings, training and quality will be discussed. The cluster quality lead is responsible for ensuring focused and data-driven quality work within the cluster.

The quality improvement work must be supported by data, including data about activity and quality indicators for each general practice. The plan is that in the long term, it should be possible to benchmark the clusters in relation to number of referrals, prescriptions, access and use of unscheduled care in order to identify areas of variation, learning and areas of improvement.

The Regions will contribute to support general practice to work in a more data-driven and populations-based manner by contributing knowledge, data and methods for stratifying and identifying citizens who are at risk of developing illness or experiencing a deterioration of current illness

Quality improvement, research, healthcare decisions, planning and management in the health system require data of high quality. Activity, provision and quality in general practice must be documented - without compromising the security of the citizens' personal data.

General practice can use patient-reported outcomes as a basis for quality assessment and improvement. This can provide each doctor with an understanding of the individual patients' experience of their illness, the effect of a treatment and patients' experience of healthcare services. At the same time, it can be used as a tool to learning and quality improvements in clusters or serve as a tool to identify which citizens require particular attention.

There is a need for transparency with respect to quality and performance in general practice. Both the authorities and the public should have easy access to relevant data.

The Regions will ensure that all citizens have easy access to local generalist care

All Danish citizens should have the opportunity to choose generalist care close to where they live. Accessibility is essential for the provision of acute care, which is one of general practice's core tasks.

Accessibility is also increasingly important for municipalities that need guidance from general practice in relation to care and prevention targeted citizens who receive treatment from both sectors.

Improved robustness will serve to improve public accessibility to general practice. Accessibility should be interpreted broadly. Accessibility applies to geography meaning the opportunity to choose a general practice close to where they live. As well as it applies to virtual accessibility meaning access to medical care provision via various technologies. It applies in relation to opening hours where the opening hours should be adapted to the patients' needs. Moreover, it applies to physical accessibility meaning easy and equal access for all - including citizens who have difficulties walking.

Example

In parts of Denmark it has proven challenging to provide generalist care for citizens. This challenge will grow in the future, as an increasing number of general practitioners retire and it becomes more difficult to recruit new general practitioners. Currently, the Regions provide generalist care via tender or regional clinics where doctors specialised in general medicine are employed to provide services for registered citizens in need of general medical services during daytime. The ambition of the Regions is that all citizens have a choice between at least two general practitioners within a 15-kilometre radius of their homes.

General practice has utilised electronic health records for many years now. The future will bring many new digital solutions, some of which may be key to increasing the robustness of general practice. Technologies may serve as tools to ensure that resources in general practice are targeted at those citizens who need it most. At the same time, technology provides citizens with more flexibility concerning accessibility to generalist care. Digital tools may also serve to relieve administrative burdens.

Example

A group of general practitioners in the United Kingdom use a "click-first" approach to treating patients in deprived areas. When patients need generalist care, they are encouraged to fill in an electronic questionnaire found at their doctor's website.

The questionnaire allow patients to choose whether they want to help themselves by acquiring information about their condition (e.g. back pain), whether they want advice on over-the-counter medicines to treat their condition, whether they need to contact emergency service or whether they request an e-consultation with their general practitioner.

An evaluation showed that more than a third of patients dealt with their problems themselves via the information provided. Eighteen per cent of these patients had initially intended to contact their general practitioner directly. Of the enquiries in which the patient requested an e-consultation with the doctor, the e-consultation leaded in 40 per cent of cases to a later physical consultation. The remaining consultations resulted in the prescribing of medicine or a phone consultation. In total, 60 per cent of all consultations carried out via "click-first" were resolved without any need for the citizen to meet up physically at the general practice.

Patients are very satisfied with the "click-first" approach. 95 per cent of patients believe that "click-first" is "good" or "excellent". The click-first approach is currently being rolled out to meet the needs of more than one million patients in the United Kingdom, and it is expected to be further extended.

Another way to improve the robustness is to expand the use and the scope of other generalist care professionals. For example, some professionals can be employed by multiple general practices. A better use of other professionals can contribute to improved accessibility, efficiency and quality.

Working as a general practitioner should be an attractive and challenging job for the individual doctor. There should be room for flexibility in relation to the needs each doctor has in different periods of their careers. For this reason, the scope of general practice shall be developed such that it is possible to accommodate the needs and wishes of both young and old doctors. This will promote recruitment and retention of staff.

It may be considered whether the task of running general practice can be organized in a way that ensures that the general practitioner spends the maximum amount of time with patients instead of on paperwork. The Regions will support general practice in improving the organisation and provision of services, which the general practitioners currently are responsible of, though the services do not comprise general medical core tasks.

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