Position, remuneration and income of General Practitioners in Germany, England, The Netherlands, Belgium and France

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Version 2010

General structure of the lecture

PART I

- 2 families of health care systems
- gate-keeping or free access: that's the question

PART II

- GP incomes and remuneration 1975-2005
- Recent update of GP-incomes in D, UK NL, F, B 2005-2009

PART I

- 2 families of health care systems:

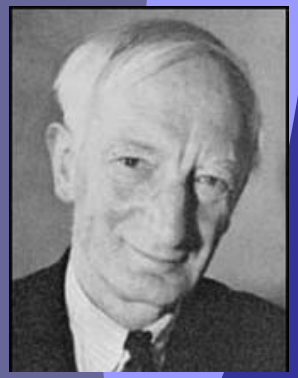
  Health care systems in Europe can be subdivided into 2 ‘families’:

  – Bismarck systems (German family)

  – Beveridge systems (UK family)

Characterization:

- Bismarck:
  - ‘Family’ of social security based healthcare systems (SHI)
  - German health care system belongs to and is founder of this type of systems



- Beveridge
  - ‘Family’ of National Health Systems (NHS)
  - Founder: United Kingdom

Differences Bismarck/Beveridge

	SSH	NHS
Funding	•Earmarked premiums	•General taxation
Organisation	•Far less strict organisation	•Strictly hierarchical (pyramid)
Role of state	•Legal conditions, supervision	•Funding, spending and regulating
	•no provision of health care	•Often providing health care
Role of GP	•No gatekeeper	•Gatekeeper
	•No listed patients	•Patients listed
	•Remunerated fee-for-service	•Often salaried

Bismarck versus Beveridge:

- Ok, these are the differences, but…….. so what?

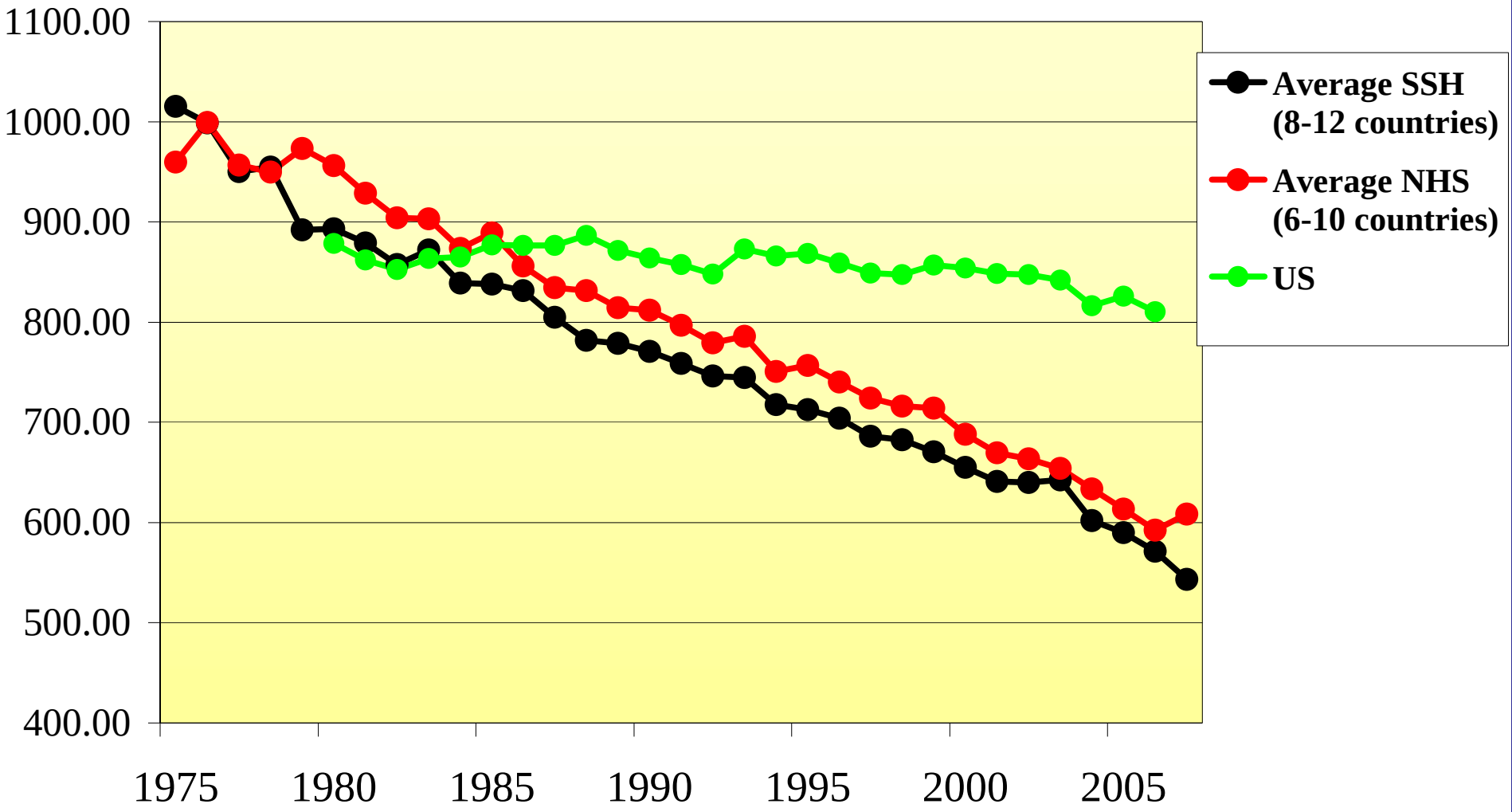
- Van der Zee and Kroneman studied differences between Bismarck (SSH), Beveridge (NHS) in Europe* versus USA in:
  1. health outcomes
  2. health care utilization
  3. health care expenditure
  4. user evaluation

*J van der Zee, M Kroneman. Bismarck or Beveridge: a beauty contest between dinosaurs, BMC Health Services Research, 2007, 7:94

Health indicators

Mortality

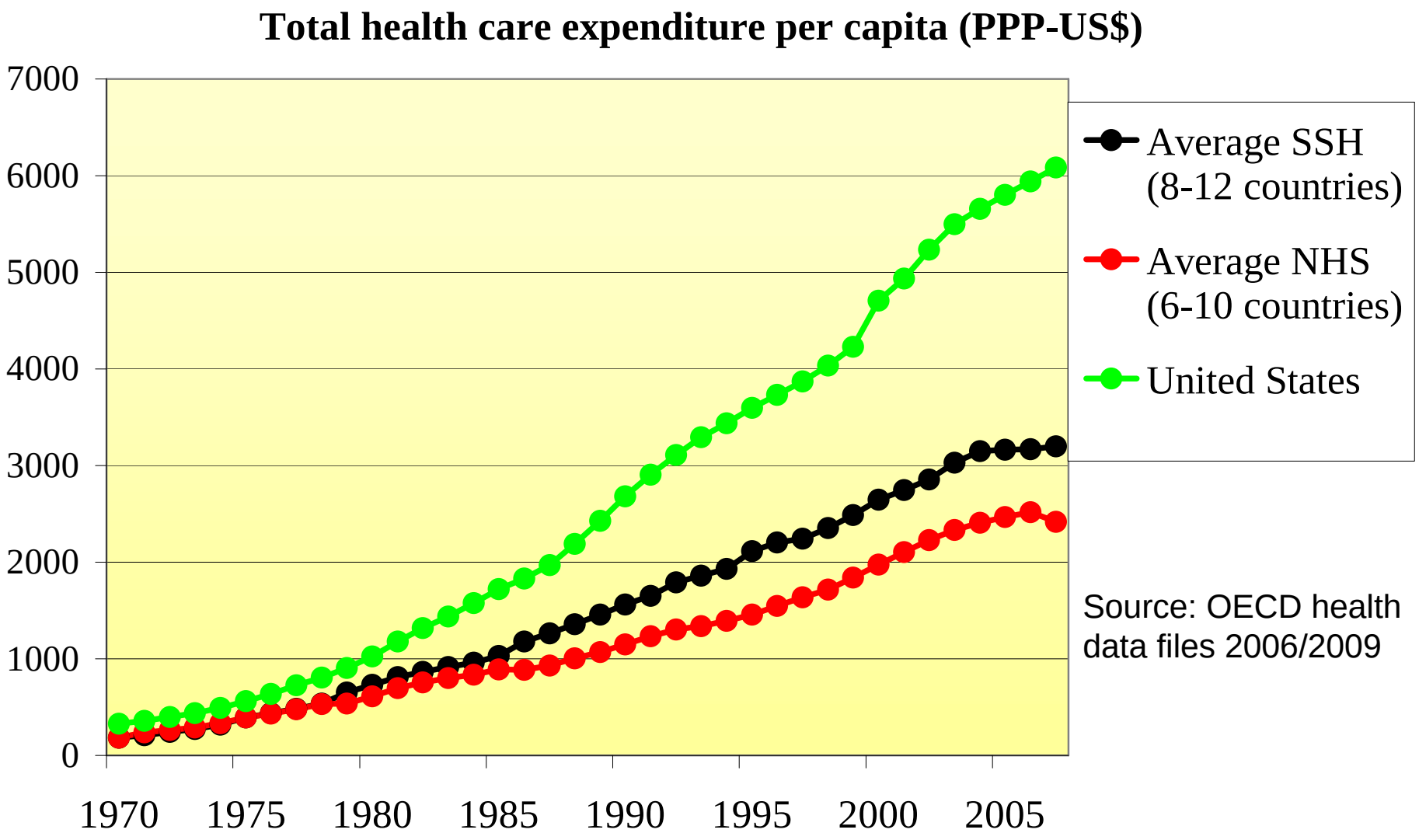
Standardized death rates per 100,000



Source: WHO Health For All database 2006/2009, US: Heron, M., Hoyert, D.L. e.a. Deaths: Final data for 2006, National Vital Statistics Reports, 57 (14) 2009

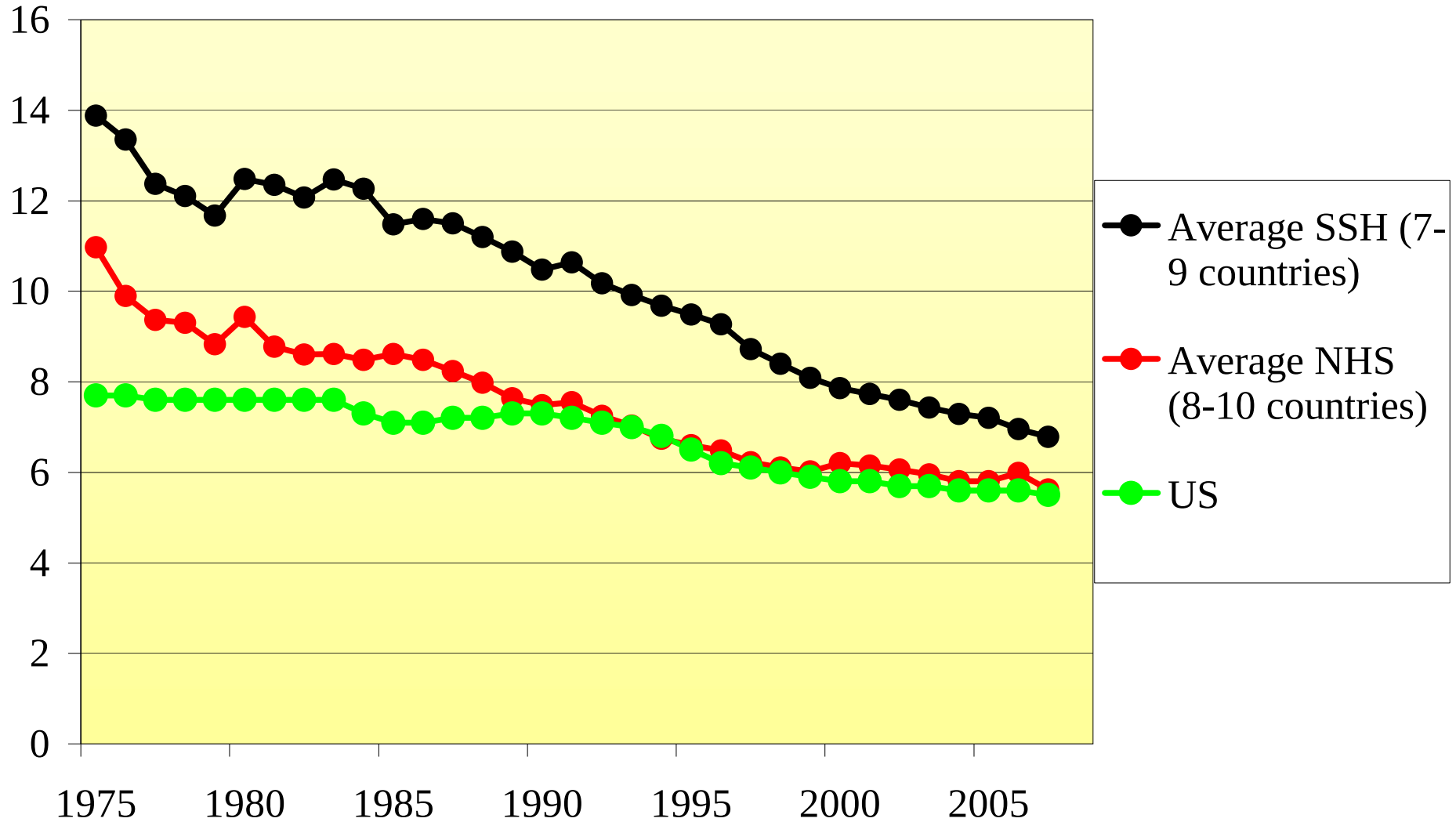
Health care expenditure

Total health care expenditure per capita (pppUS$)

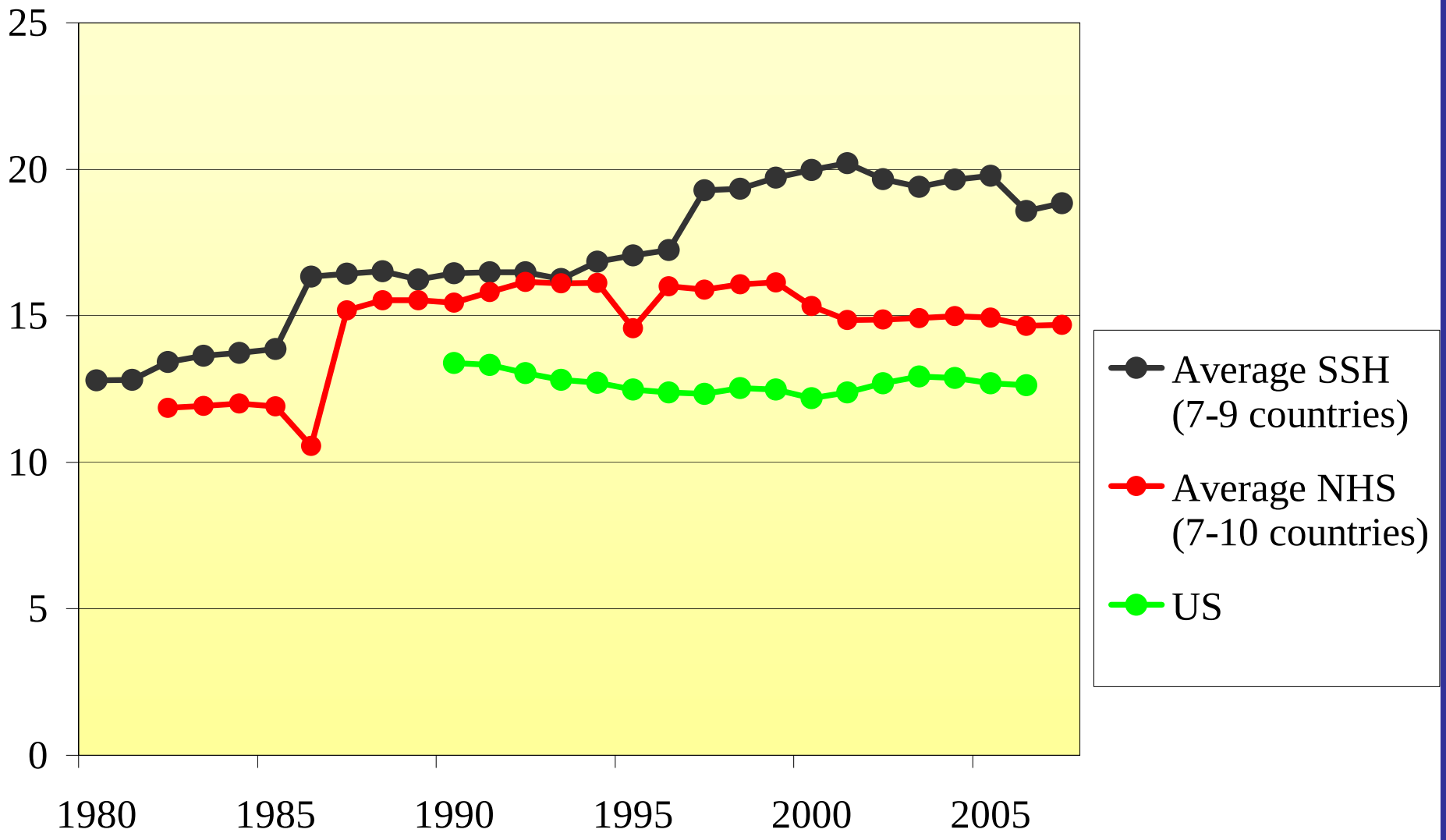


Health care utilization

Average length of stay in acute care hospitals (days)

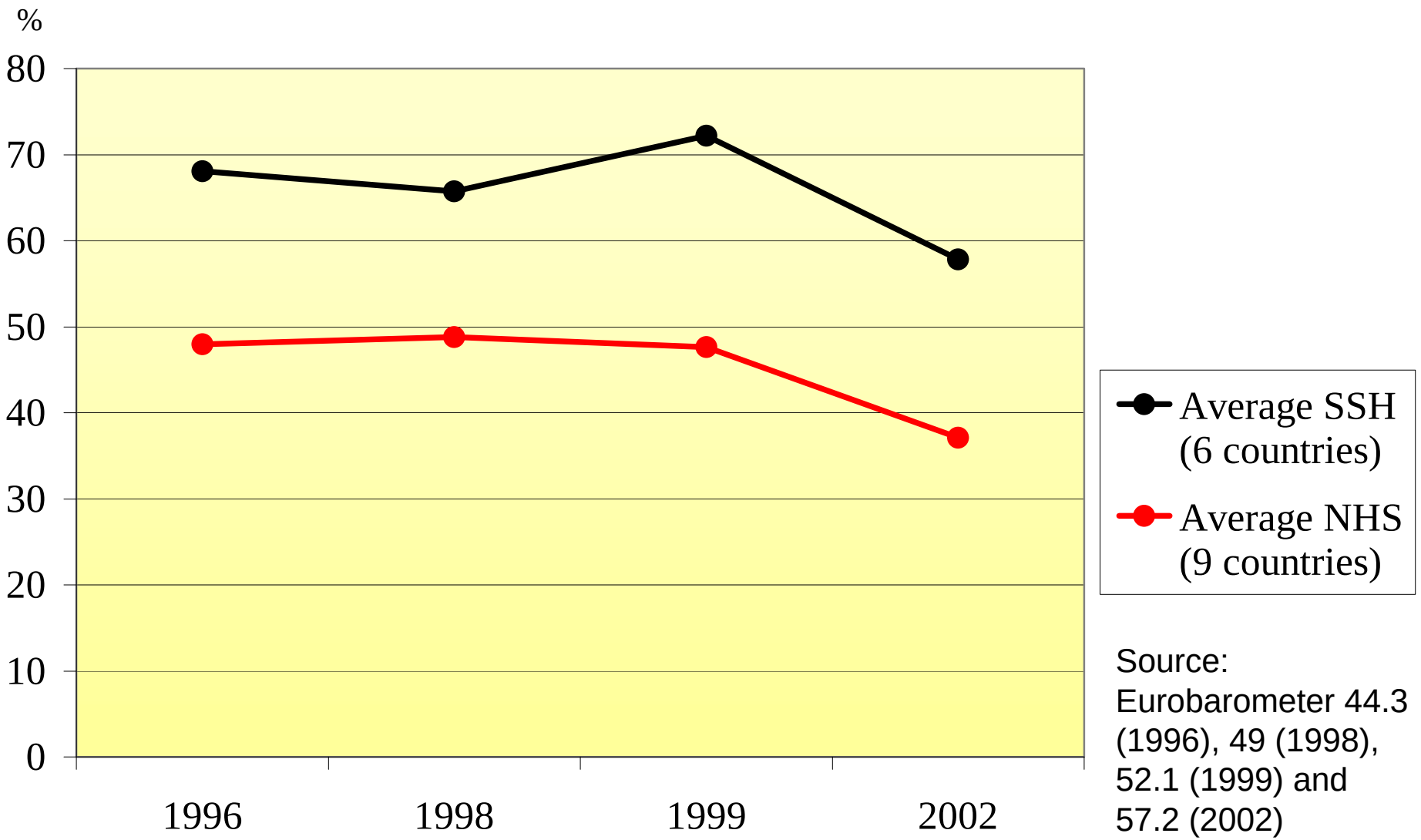


Hospital discharges per 100 inhabitants



User evaluation

Consumer evaluation of health care system (% satisfied)



Source: Eurobarometer 44.3 (1996), 49 (1998), 52.1 (1999) and 57.2 (2002)

Conclusions SSH versus NHS

- Neglectable (hardly any) differences in health outcomes
- Higher utilization rates in Bismarck/SSH systems
- Lower costs and better cost containment in Beveridge/NHS
- Higher user satisfaction in Bismarck/SSH
- Both Bismarck and Beveridge perform far better than USA

- In short: trade off between user satisfaction and health care expenditures

Part I

- Gate-keeping or free access:
  - What is the key to the lower satisfaction scores for Beveridge/NHS health care systems?
  - Could it be the gate-keeping position of GPs?

Some results of an explanatory study

Direct accessibility and patient evaluation

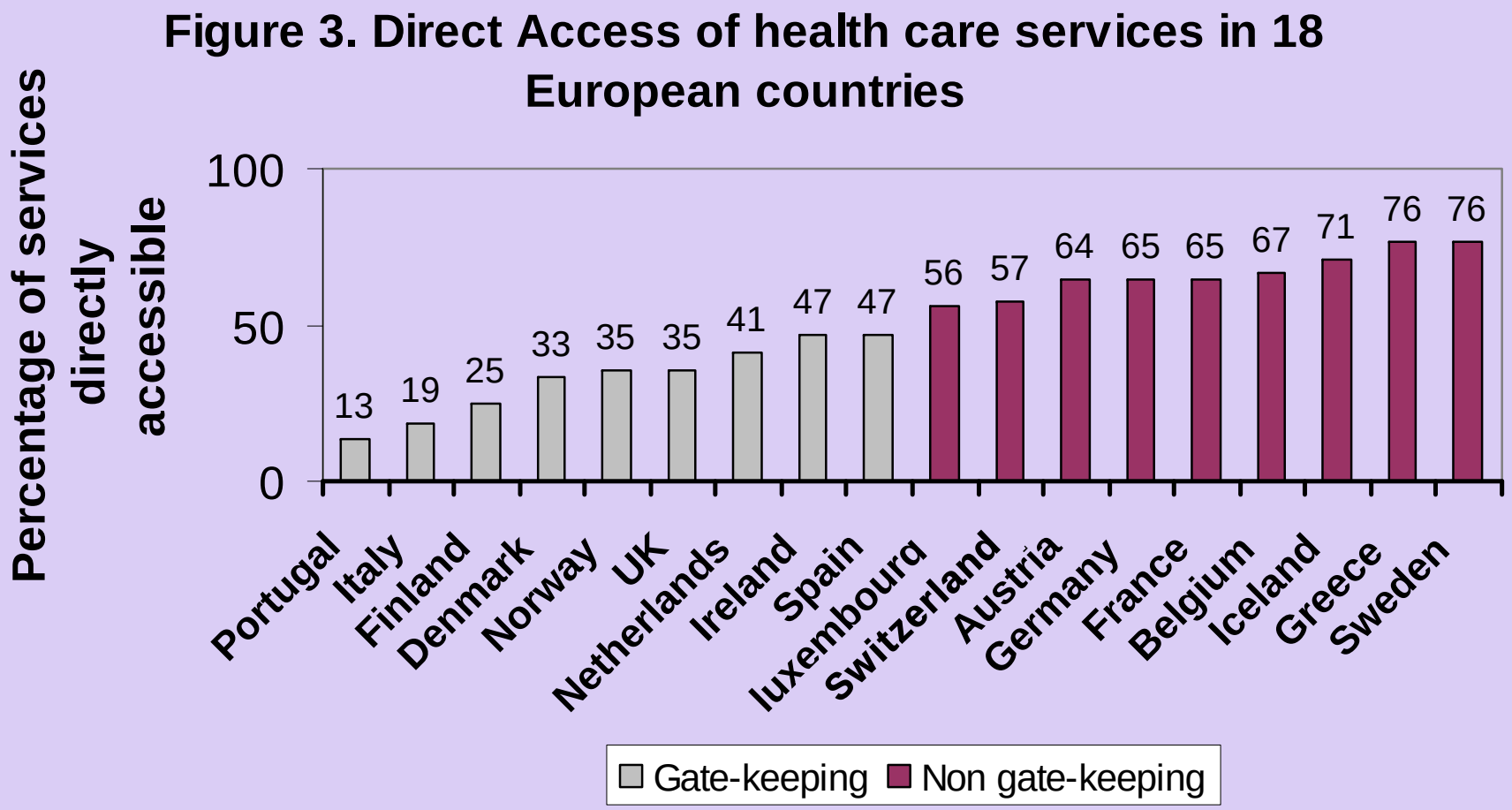
- Establish relationship between accessibility of specific health services in EU and the evaluation of (GP-)care by the population

M.W. Kroneman, J.A.M. Maarse, J. van der Zee.*Direct access in primary care and patient satisfaction: A European study,* Health Policy, 76 (2006) 72-79

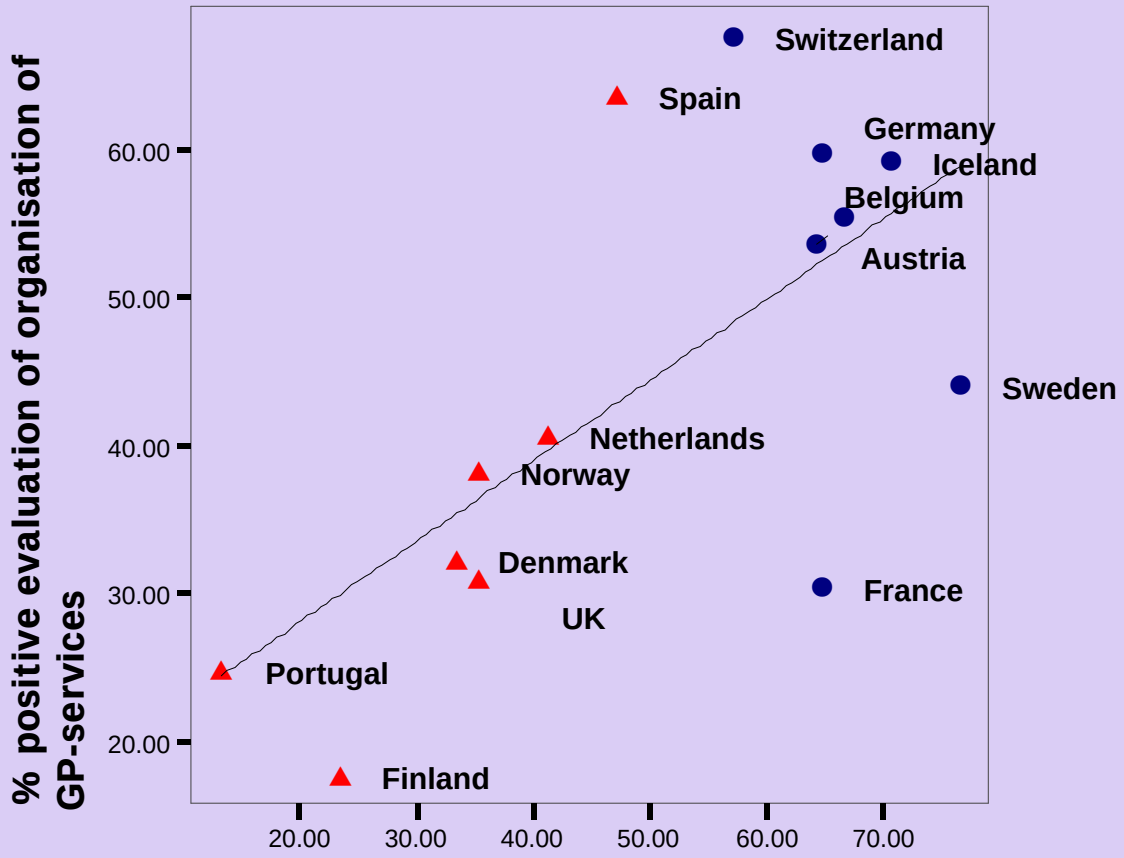
Methods

- E-mail questionnaire about accessibility of 17 health care services (in 18 countries), resulting in scale of direct accessibility varying from 0% to 100% of the services
- Data from EUROPEP-study into patient evaluation of GP-care (14 countries) (Grol R, Wensing M. Nijmegen: Mediagroup KUN/UMC, 2000)

Direct accessibility and gate-keeping



Direct access and organisation of GP-services



accessibility of the service = 17.16 + 0.55 * percda

R-Square = 0.45 **(r = 0.67, p=0.01)**

Satisfaction with specific aspects of medical care (summary)

- Satisfaction with:
  - patient physician communication and
  - medical technical content

  NO RELATIONSHIP with direct accessibility
- Satisfaction with:
  - Accessibility of GP services:

  SIGN. correlation with direct accessibility
  (r = 0.67, p=0.01)

Discussion

- So gate-keeping by GPs versus free access to health services seems to be a sensitive element in satisfaction of health care users

PART II

- Summarizing part I:
  - Bismarck/SSH systems are less strictly organised than Beveridge/NSH:
    - GP less dominant/powerful
    - No gate-keeper in most cases
    - GP-services compete with other health care services
- Fee-for-service remuneration is typical fro Bismarck/SSH; Salary or capitation fee typical for Beveridge/NHS
- These features influence health services utilisation (previous slides) and health care expenditures....

- Question for Part II: **Do these elements influence GP-incomes in Europe?**

Incomes of General Practitioners 1975-2005 a study in eight European countries

Introduction

Sources:

- Data for 1975-1991:
  - Delnoij 1994*
- Data for 1995-2005:
  - Kroneman, Van der Zee, Groot ,2009**
  - Kroneman, Meeuws, Van der Zee, Groot, 2009***
- For this conference: preliminary data for 2005-2009

*Delnoij DMJ. Physician payment systems and cost control. Utrecht: NIVEL, PhD thesis Utrecht University, 1994.

**Kroneman M, Van der Zee J, Groot W. Income development of General Practitioners in eight European countries from 1975 to 2005, BMC Health Services Research, Vol 9, 2009, nr. 26 and

***Kroneman M, Meeuws P, Van der Zee J, Groot W. The calculation of the Belgium General Practitioner revised. 21 april 2009. Comment

Introduction

Research question:

- How is the development in GP income over time in several European countries?

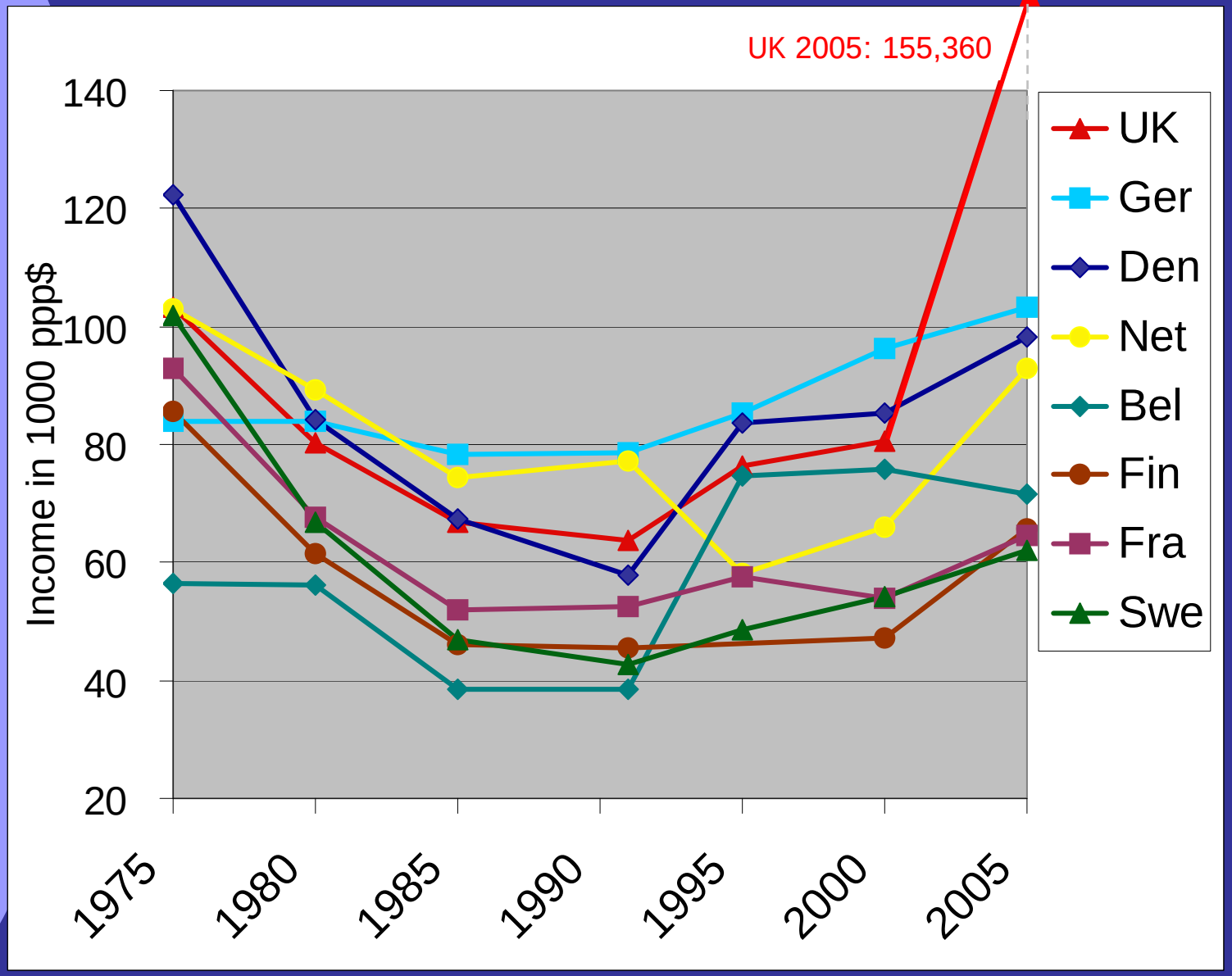
Methods (1)

- Countries: Belgium, Denmark, Germany, Finland, France, The Netherlands, Sweden and the United Kingdom
- Data sources: internet, written sources, country experts (by tailor made questionnaires)
- Data collection:
  - for 1995 and 2000: in 2004/05
  - For 2005: in 2006/07
- Yearly income:
  - for salaried GPs: yearly salary before taxes
  - For service related remuneration systems: based on data on health care utilization and tariff structure

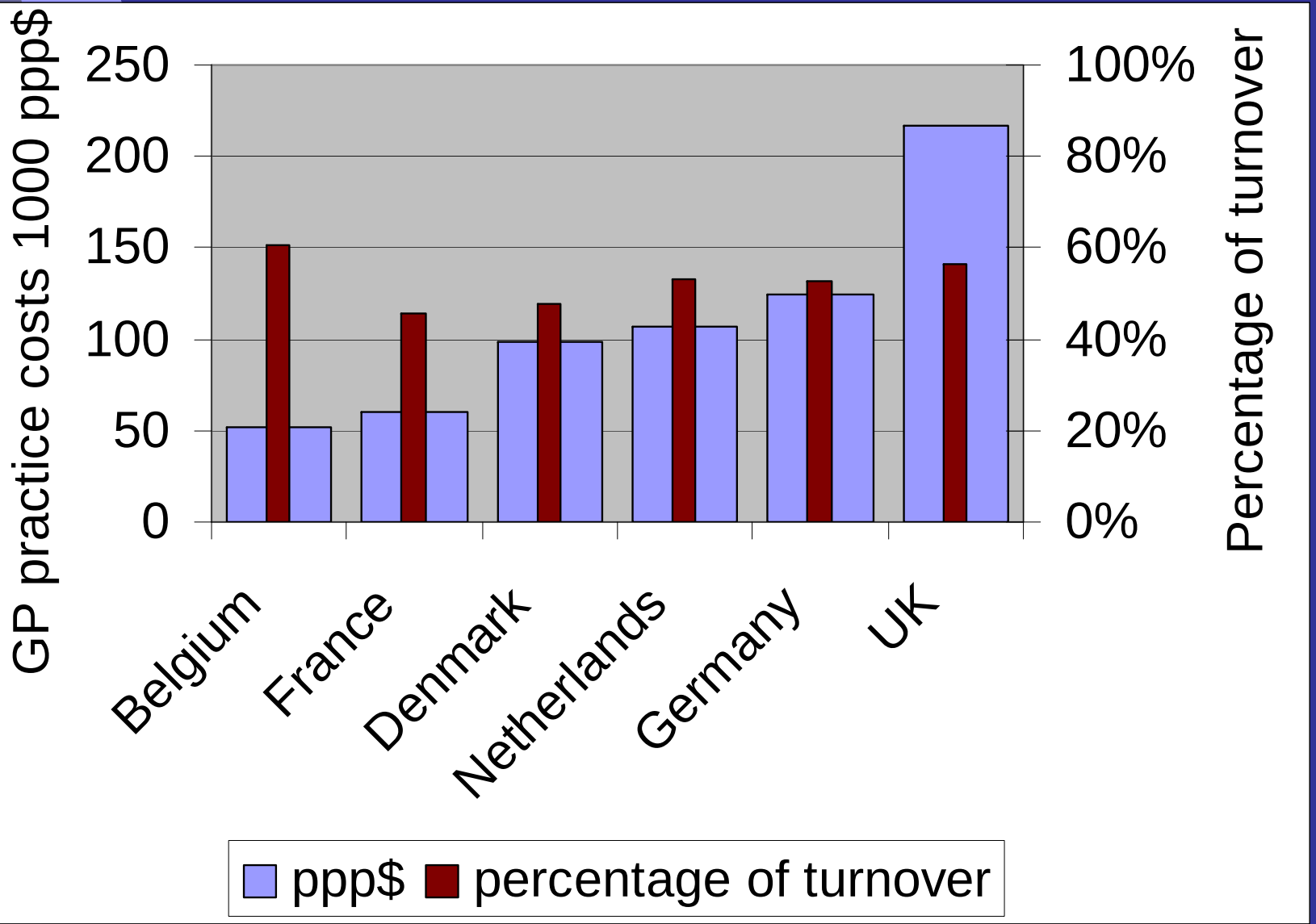
Methods (2)

- Comparability of the data:
  - Data were corrected for international differences in purchasing power and inflation

Annual GP income over time in ppp$, corrected for inflation, index year = 2000



Practice costs for ffs countries 2005



Conclusions

- GP-incomes going down 1975-1990/95; increasing from 1995 again;
- Dramatic increase in 2005 in UK due to quality target based income construction;

- What happened around 2005?
  - (Changes in) the remuneration system in UK, Netherlands, Germany, Belgium and France

Changes in GP remuneration

- Netherlands 2006: drastic change in remuneration system :
  - Former system:
    - Sickness fund patients: capitation fee,
    - Private patients: fee-for-service (mainly consultations and visits);
    - 35-40% of population privately insured
  - New system:
    - all patients: capitation fee + additional fee-for-service per contact
    - fee for special services (e.g. minor surgery, substitution secondary care) in negotiation with health insurers

NEW

- Effects in the Netherlands:
  - Declarations to health insurers necessary for all patients
  - More long consultations (>20 min) declared then expected (in 2006 17% increase)
  - Extra income from special services varies per health insurer (32 in 2008) and per practice, depending on negotiation outcomes
  - Formerly private patients go more often to GP (is now free of charge)
  - Expenditure on GP care higher than expected: discussion on tariffs
  - In short: private patients started to behave like sick fund patients

Changes in GP remuneration

- United Kingdom 2004: drastic change in remuneration system
  - Before 2004:
    - Basic allowance per GP (age dependent)
    - Additional income from a.o.
      - number of patient on the list
      - demographic characteristics of patients
      - out-of-hours and emergency visits
      - several preventive activities
  - After 2004:
    - Practice based allowances, based on characteristics of patients on the list
    - Additional income from reaching quality requirements
    - Option to opt out for out-of-hours services (90% of GPs took this option)

NEW

Effects in UK

- Dramatic increase in income, British GPs become best paid in Western-Europe
- Targets: almost all practices satisfy all targets
- Almost all GPs opt out for out-of-hours services (decreases income with 6000 euro per year)
- Government freezes income
- Targets are adjusted

Changes in GP remuneration

NEW

- Belgium:
  - Fee for service
  - General Medical Record allowance (since 1999), large increase in price in 2003
  - Several (relatively small) allowances (accreditation, settlement, GMF lumpsum, informatisation)
- No fundamental changes in remuneration system since 2000

Effects in Belgium

- Increase results mainly from additional income via GMF (since 2003)
- Increase in 2008 result of enlargement of insurance coverage (self employed now included)

Changes in GP remuneration

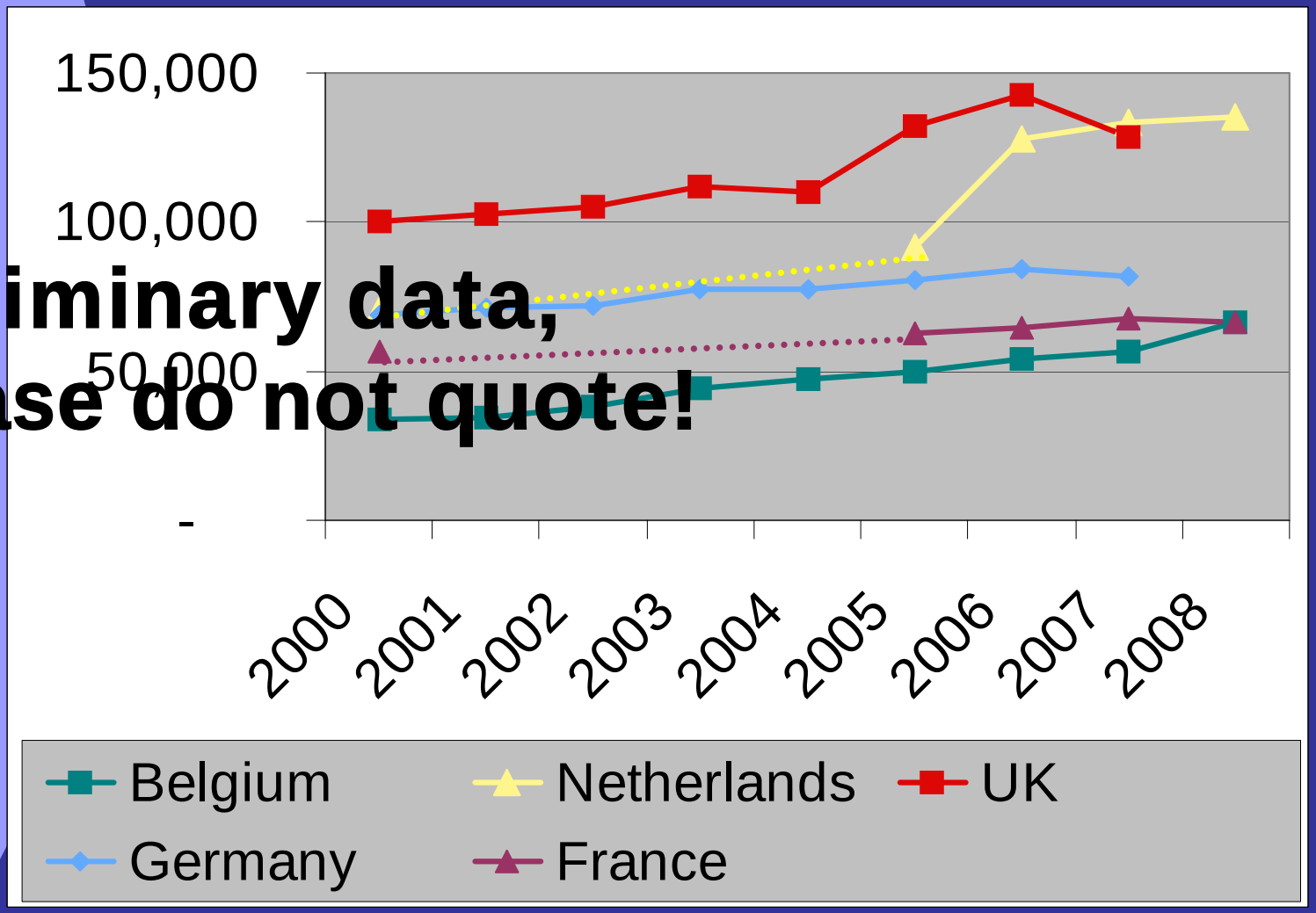
- France:
  - Fee-for-service system
  - 2005 changes:
    - Basis of calculation of value of service changed. From 2005 fixed fee per consultation.
    - *médecin traitant:* patients first visit their GP for referral to medical specialist. For registered patients with chronic conditions, GPs receive 40 euro per year (2005)

NEW

Changes in GP remuneration

- Germany:
  - Fee-for-service system, based on value points
  - 2009 changes (data on income not yet available):
    - Fee-for-service based on monetary value, volume related caps, for volume above budget: lower monetary value
    - Case related compensations increase in importance

Development in GP income
based on 2000 price level, corrected for purchasing power (preliminary data!)



Preliminary data, please do not quote!

Conclusions

- German reforms; effects cannot be shown yet (2010 earliest year) but effects will not be spectacular and if that was the case; curbing measures will be inevitable;
- German GP incomes have been in the top range since 1975.
- Increase in NL due to abolition of private patients (started to behave like sick fund patients);
- Governments don't like income increases and try to curb these (harder work for the same tariff or just higher targets).

General conclusion

- GP gate-keeping:
  - sensitive element
  - influences satisfaction with health care system.
- However:
  - listing of patients in a practice plus
  - remunerating the GP for record keeping and coordination:

  promising way of strengthening the (income) position of GPs in FFS based remuneration systems
- All in all:
  - Bismarck based health care systems perform quite well
  - But: there is a price attached to satisfied users.

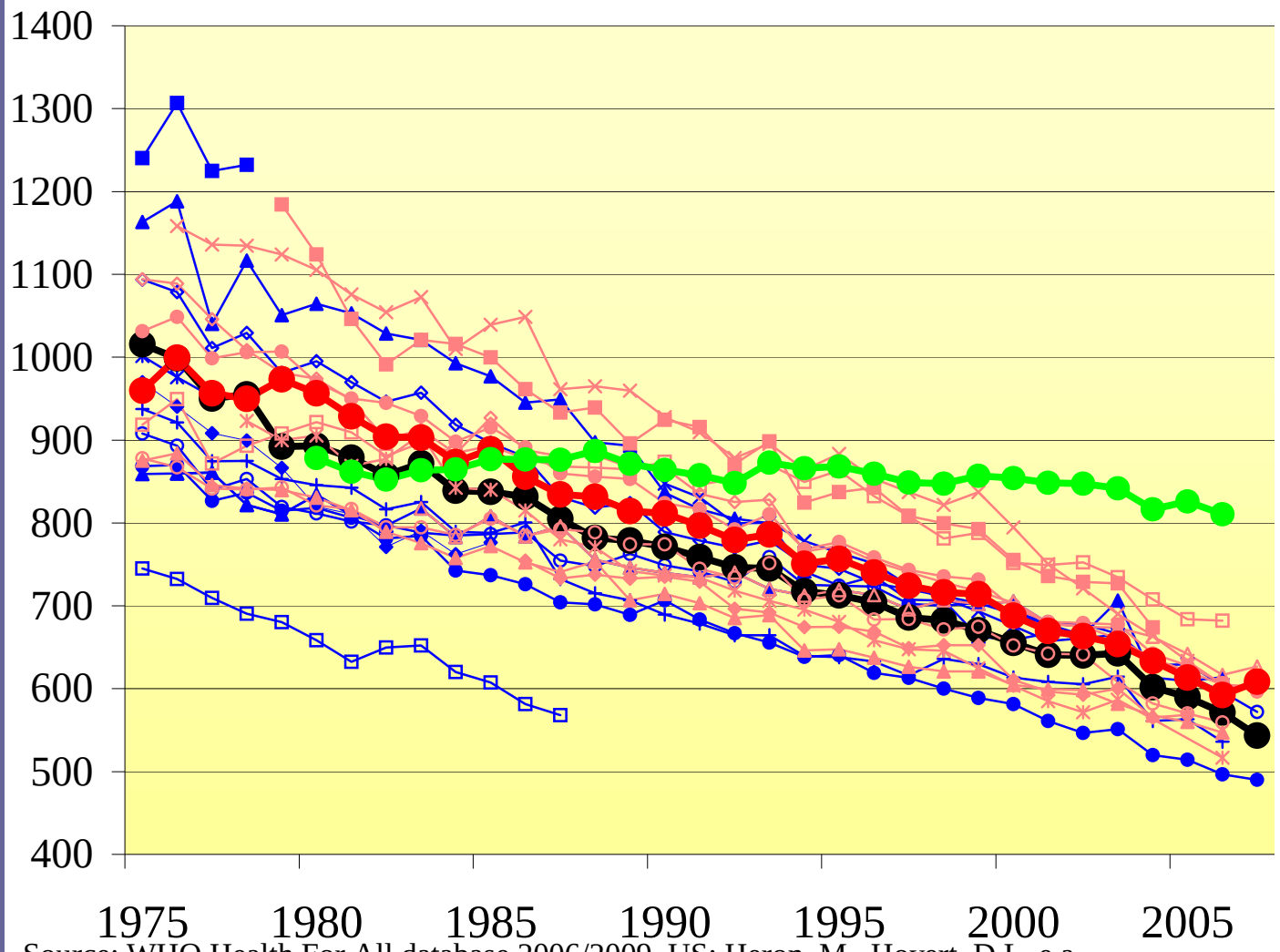
Additional information

- Detailed results of comparison between SSH, NHS and USA

Health indicators

Mortality

Standardized death rates per 100,000



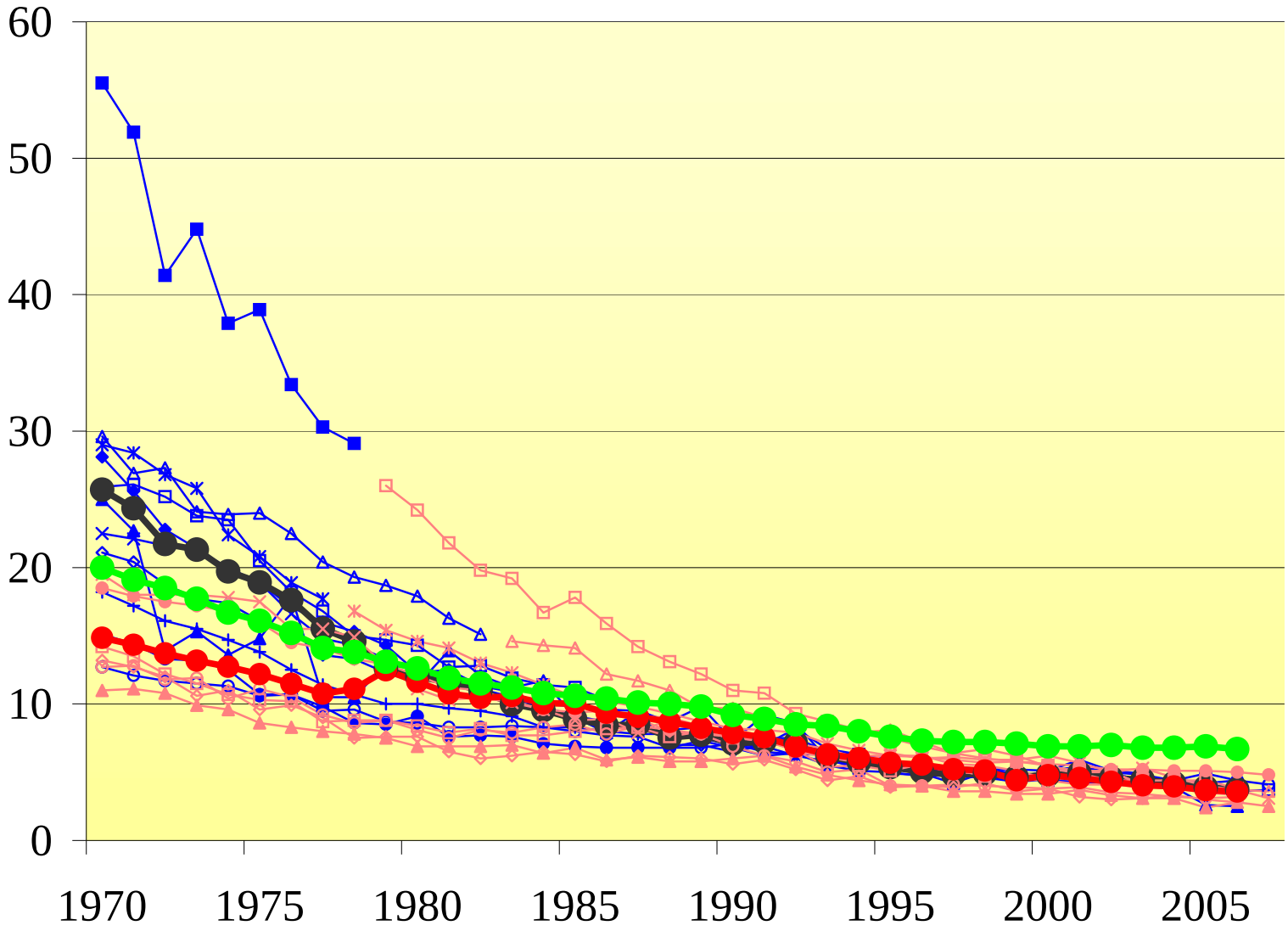
Austria
Belgium
France
Germany
Greece
Luxembourg
Netherlands
Switzerland
Greece -1982
Italy -1977
Portugal -1978
Spain -1985
Average SSH
Denmark
Finland
Greece 1983-
Ireland
Italy 1978-
Norway
Portugal 1979-
Spain 1986-
Sweden
United Kingdom
Average NHS
US

Source: WHO Health For All database 2006/2009, US: Heron, M., Hoyert, D.L. e.a.
Deaths: Final data for 2006, National Vital Statistics Reports, 57 (14) 2009

Version 2010

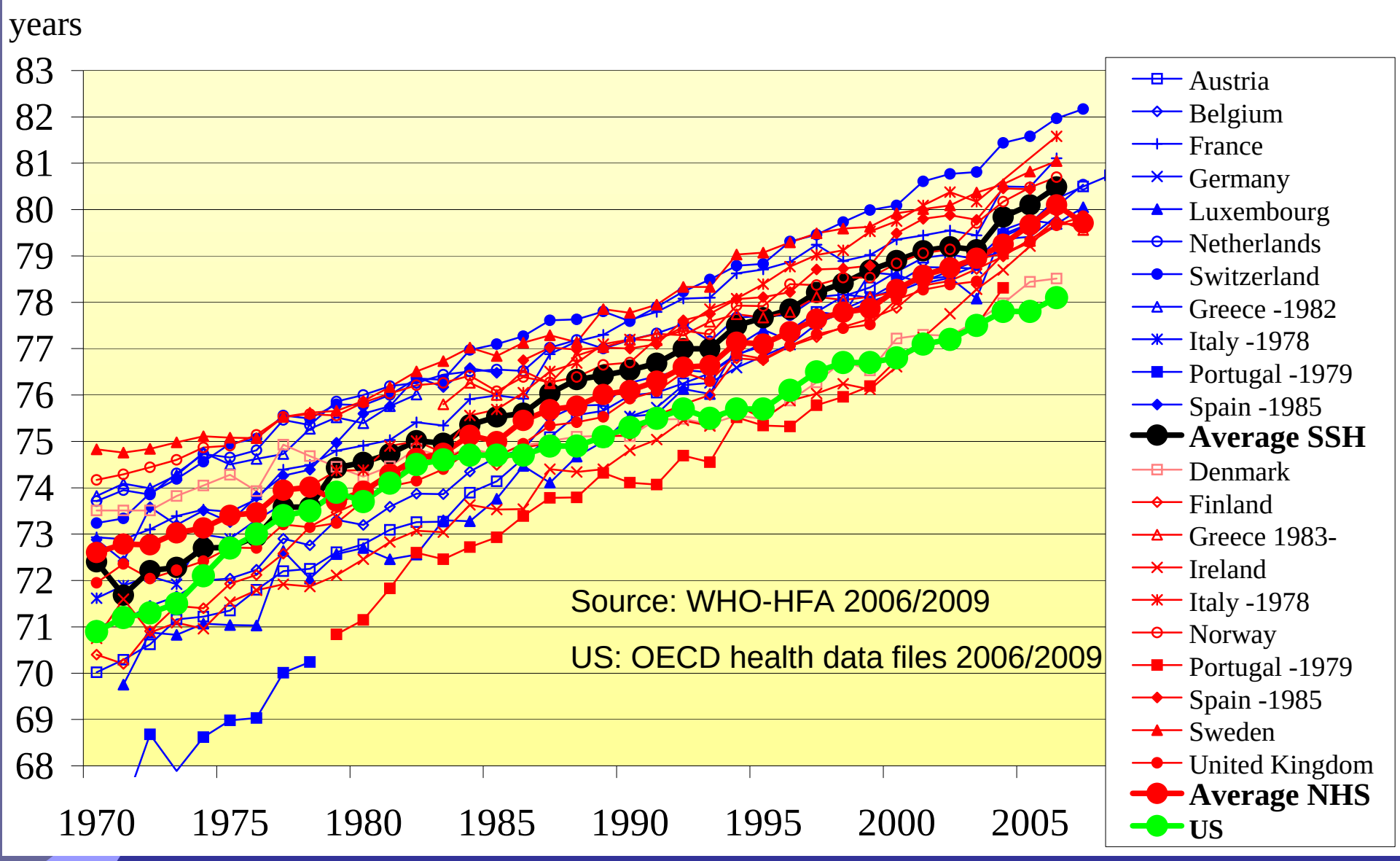
Infant mortality rates

Deaths per 1.000 life births



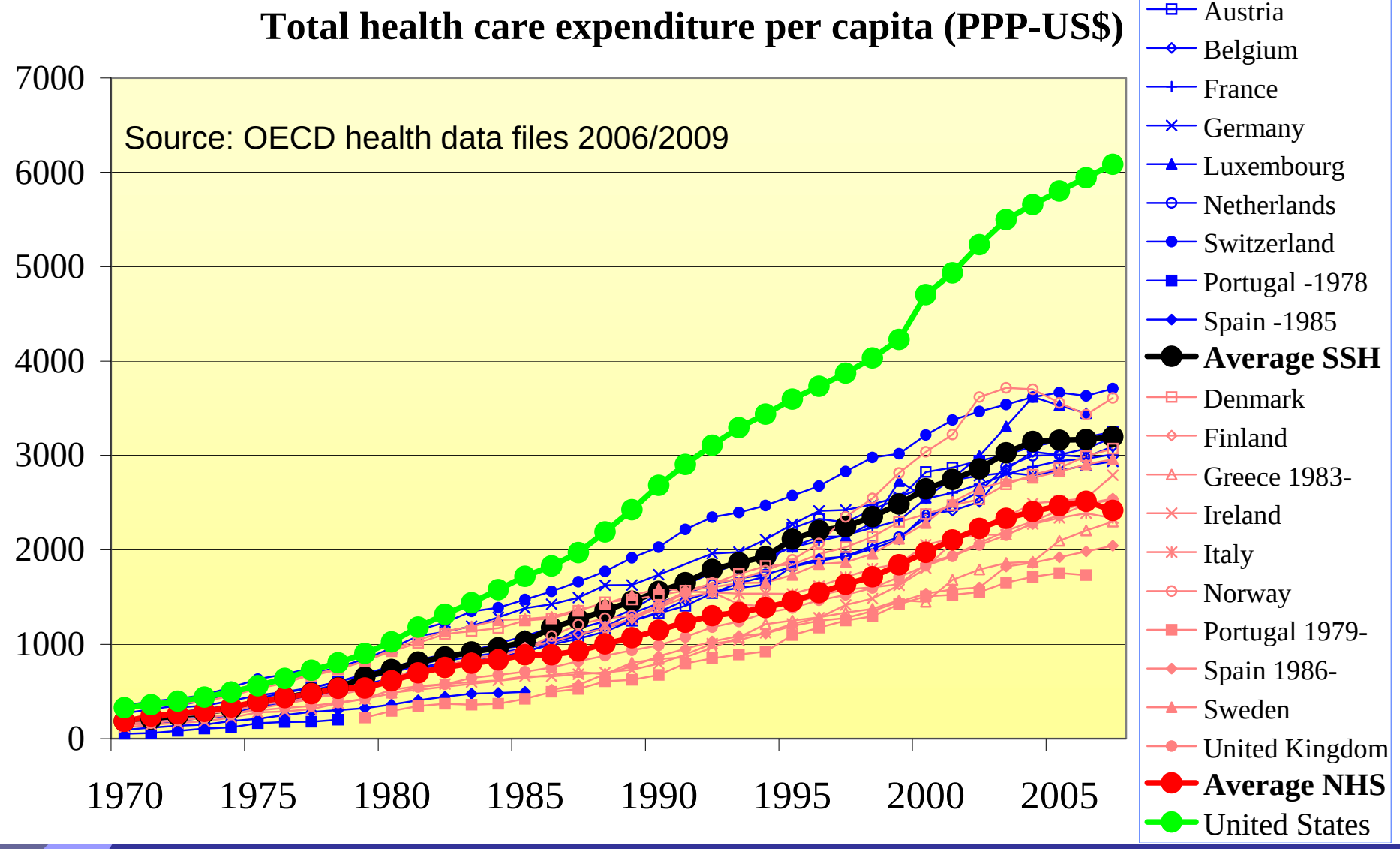
- Austria
- Belgium
- France
- Germany
- Luxembourg
- Netherlands
- Switzerland
- Greece -1982
- Italy -1977
- Portugal -1978
- Spain -1985
- **Average SSH**
- Denmark
- Finland
- Greece 1983-
- Ireland
- Italy 1978-
- Norway
- Portugal 1979-
- Spain 1986-
- Sweden
- United Kingdom
- **Average NHS**
- US

Life expectancy at birth

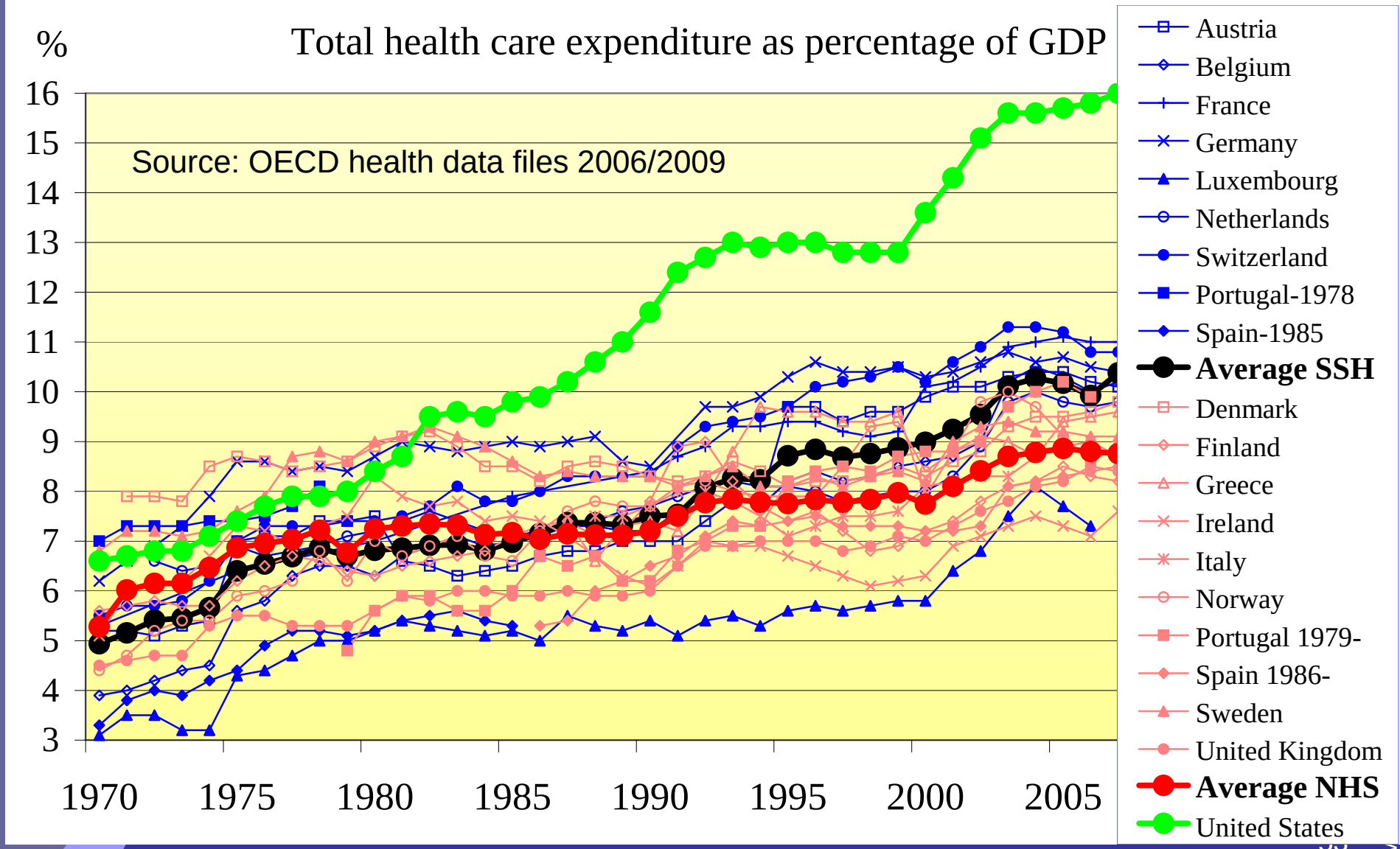


Health care expenditure

Total health care expenditure per capita (pppUS$)

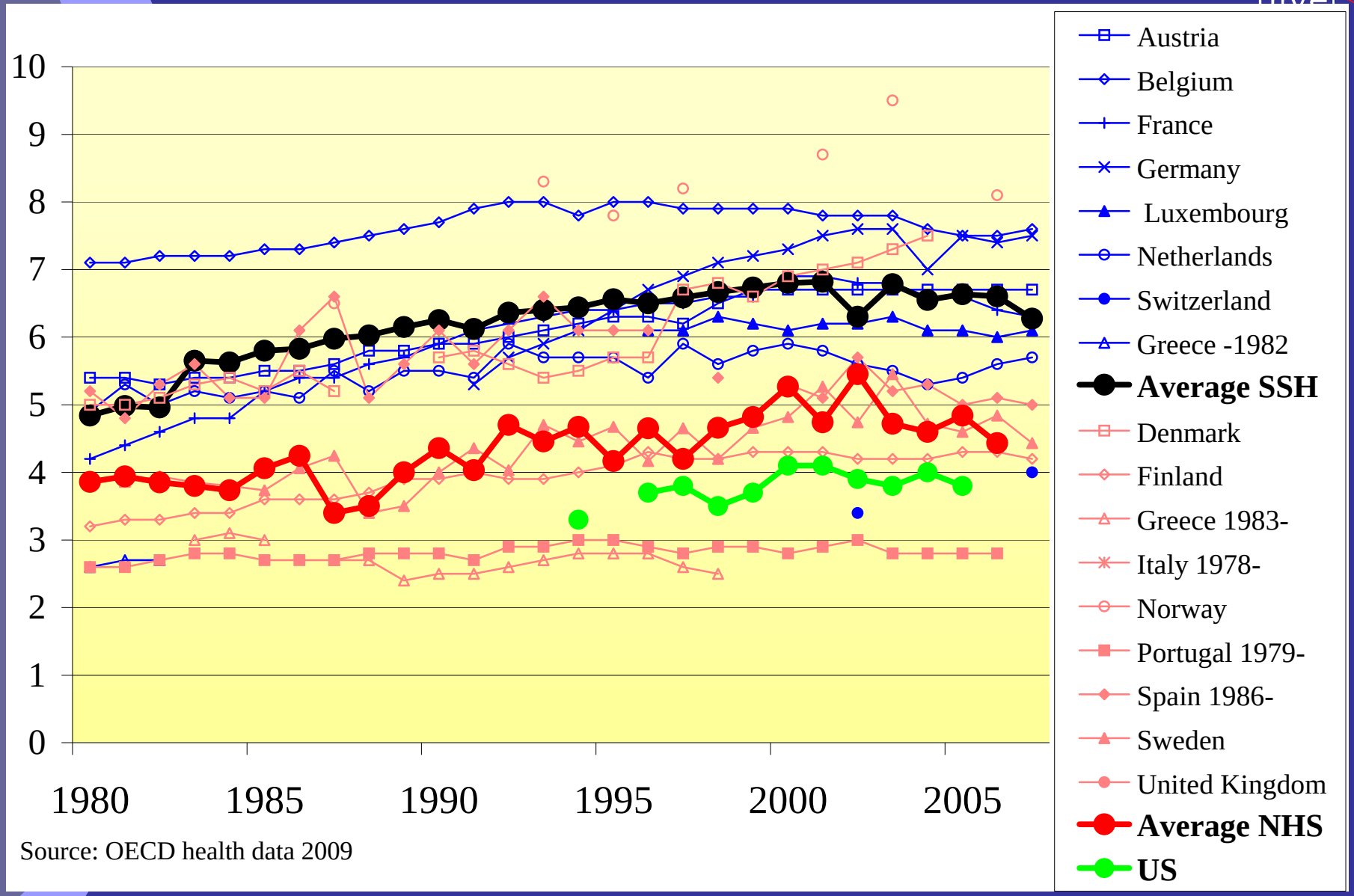


Total health care expenditure as percentage of GDP



Health care utilization

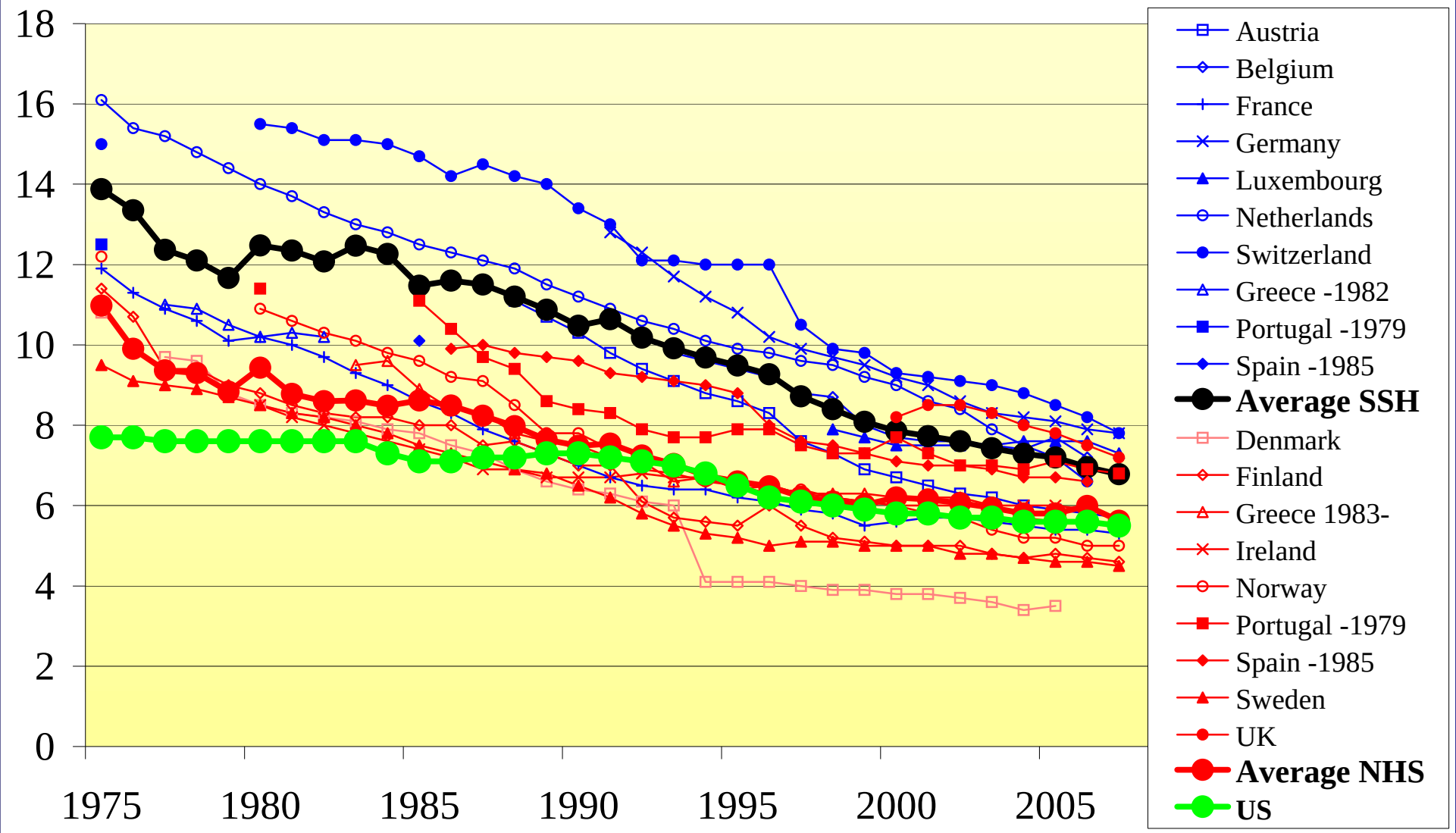
Doctor's consultations per capita



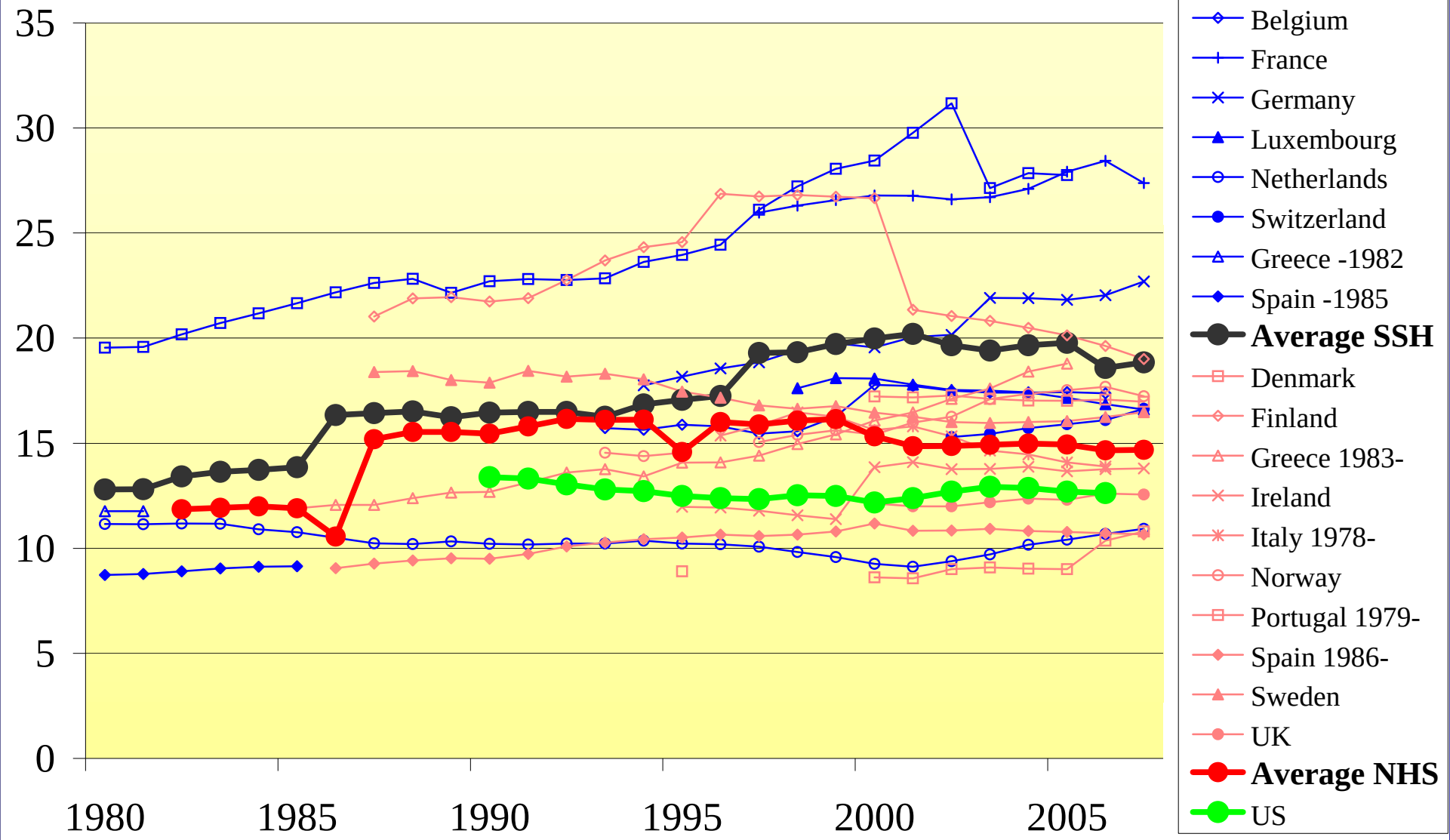
Source: OECD health data 2009

Version 2010

Average length of stay in acute care hospitals



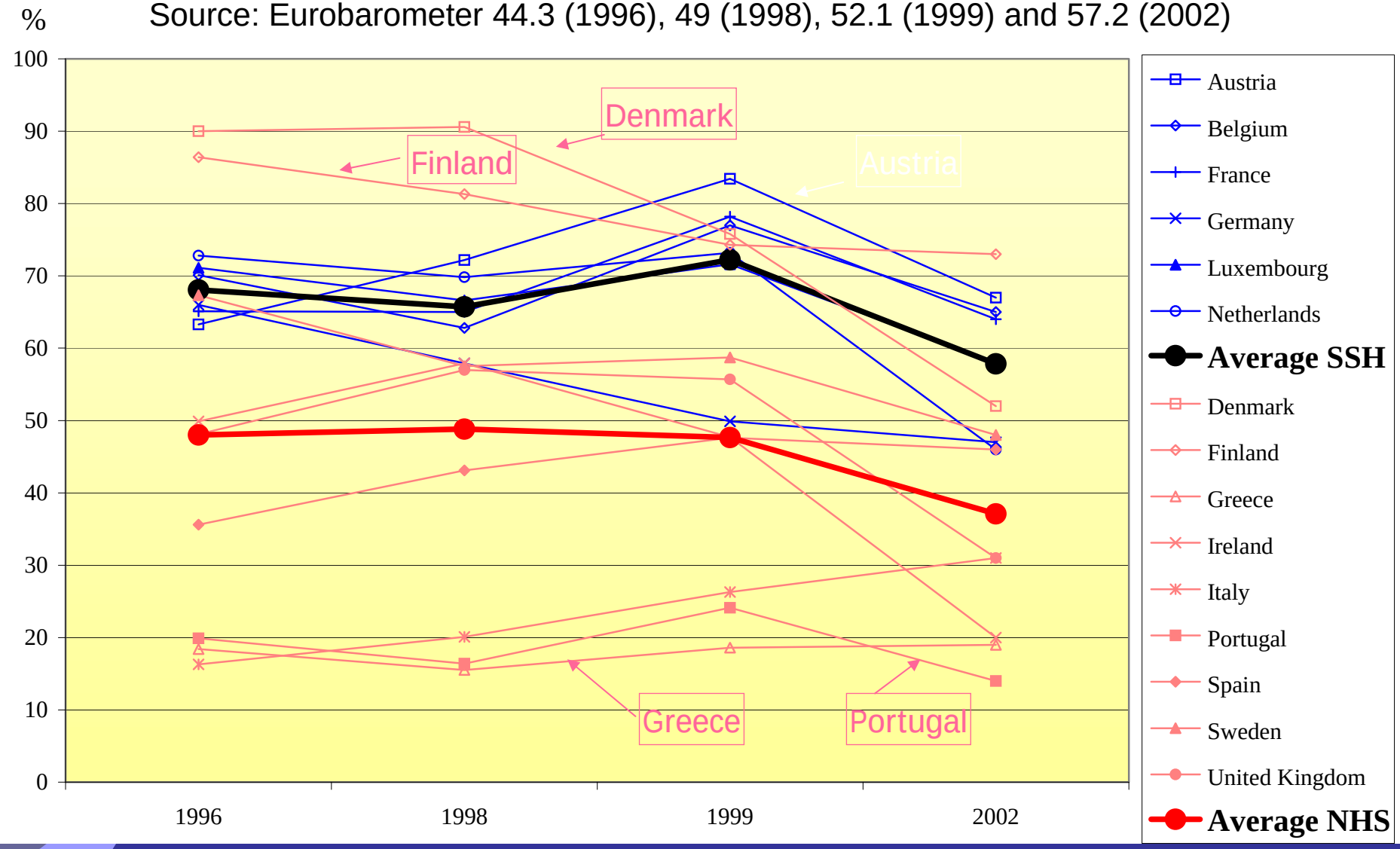
Hospital discharges per 100 inhabitants



User evaluation

Consumer evaluation of health care system (% satisfied)

Source: Eurobarometer 44.3 (1996), 49 (1998), 52.1 (1999) and 57.2 (2002)



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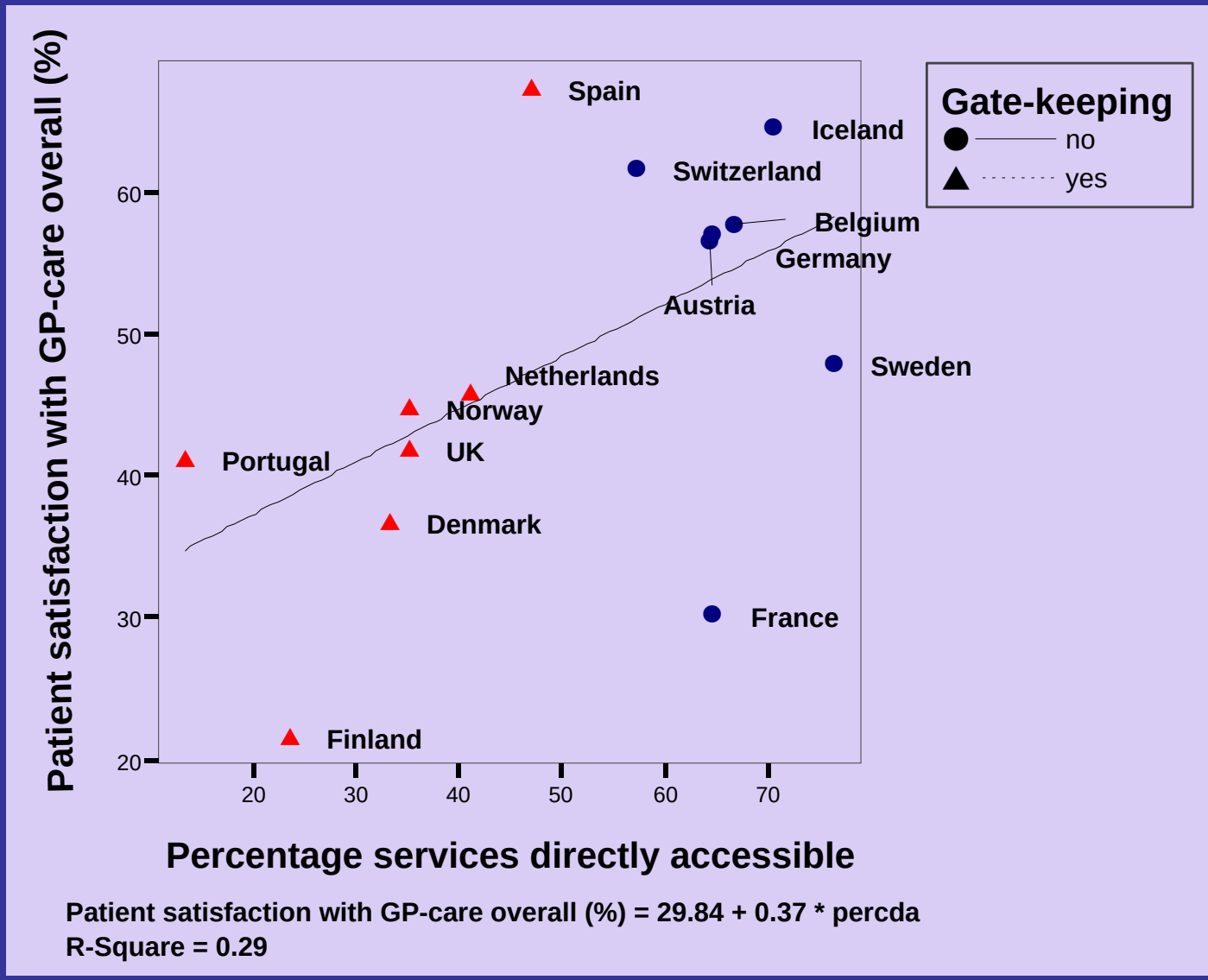
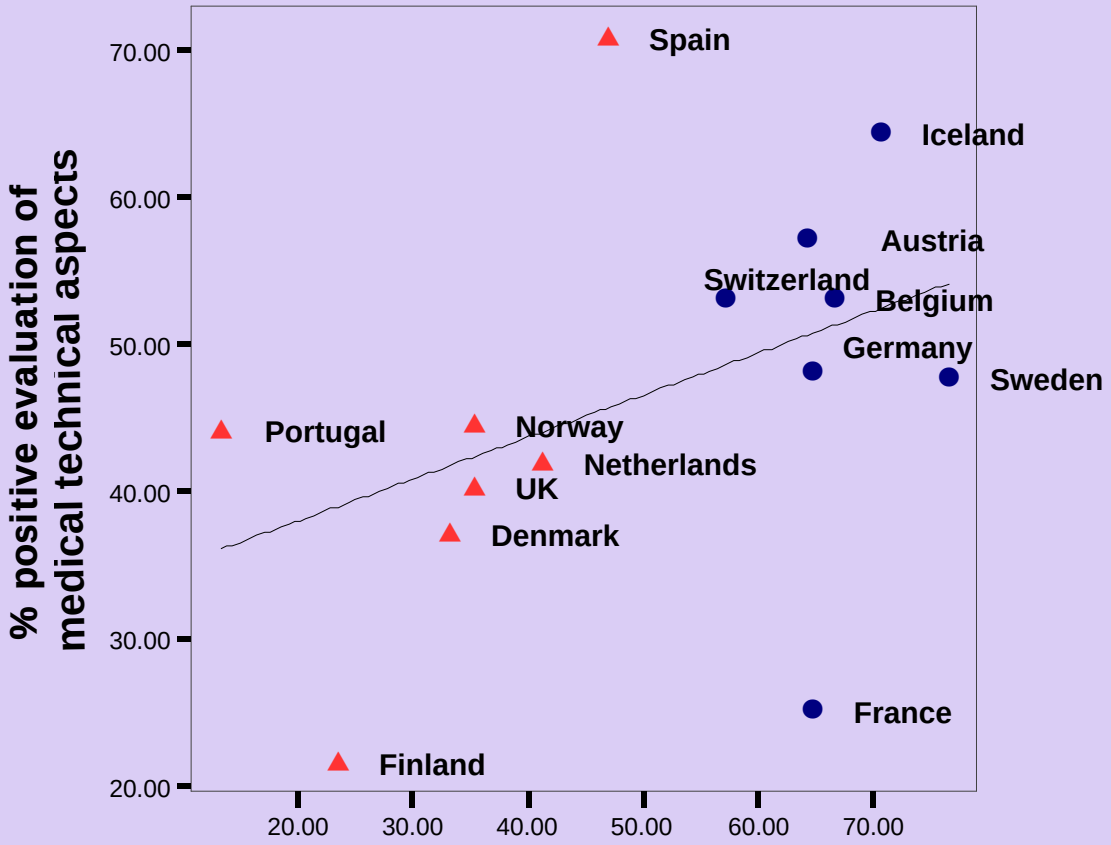
Direct access and overall patient evaluation of GP services



Patient satisfaction with GP-care overall (%) = 29.84 + 0.37 * percda
R-Square = 0.29

Direct access and evaluation of medical technical aspects of GP care



Percentage services directly accessible

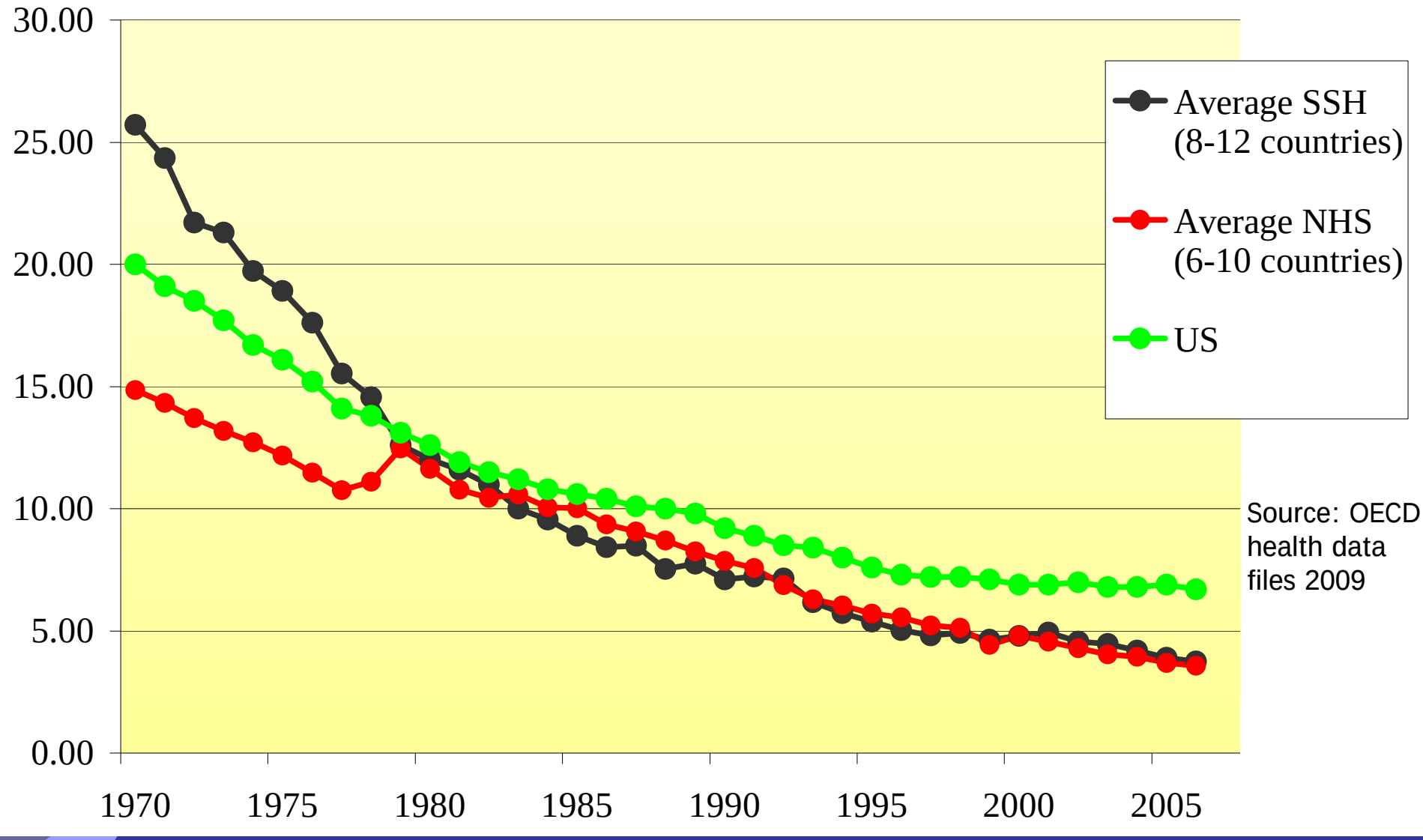
medical technical aspects = 32.28 + 0.29 * percda

R-Square = 0.17

Bismarck-Beveridge

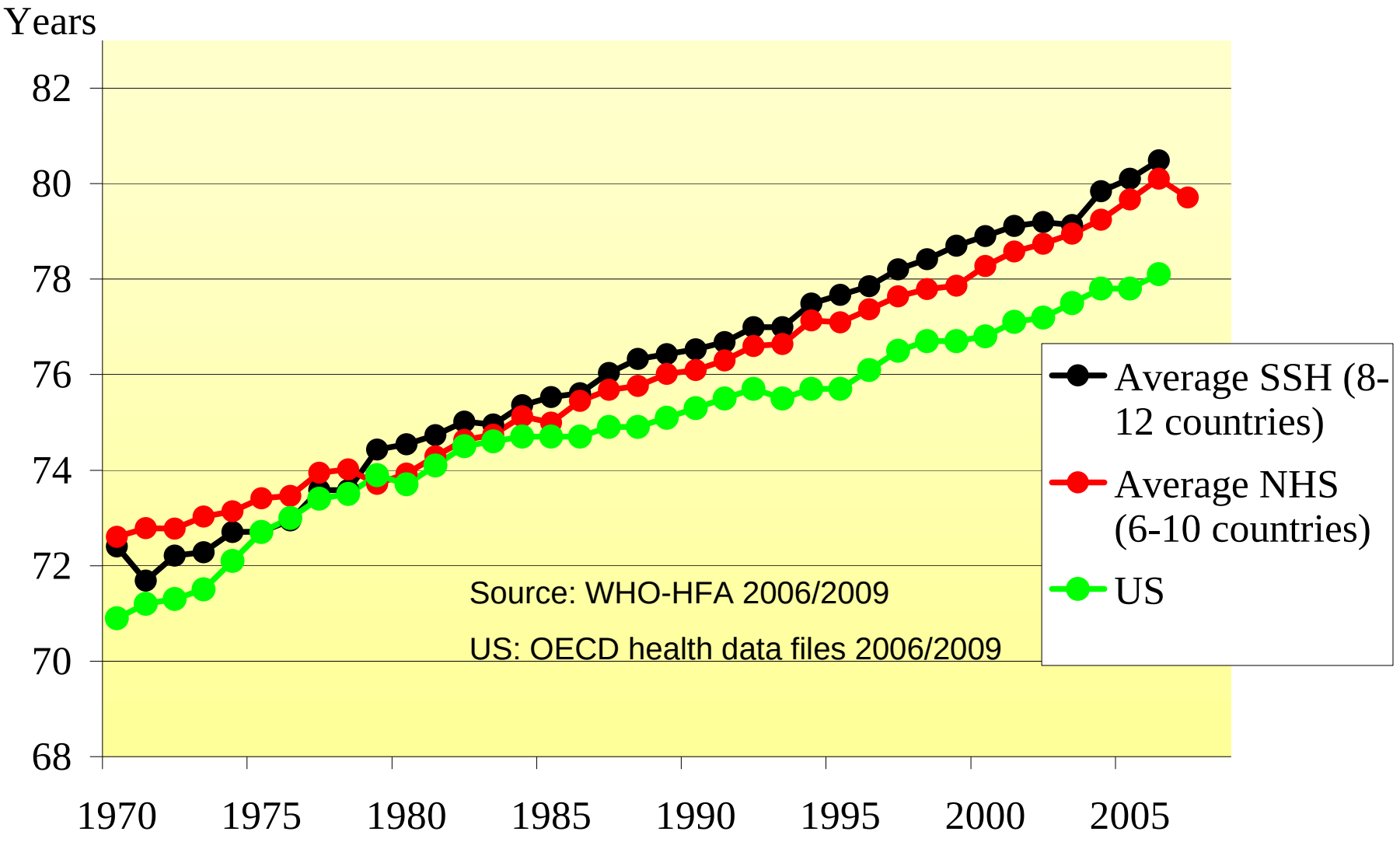
Infant mortality rates

Deaths per 1.000 life births

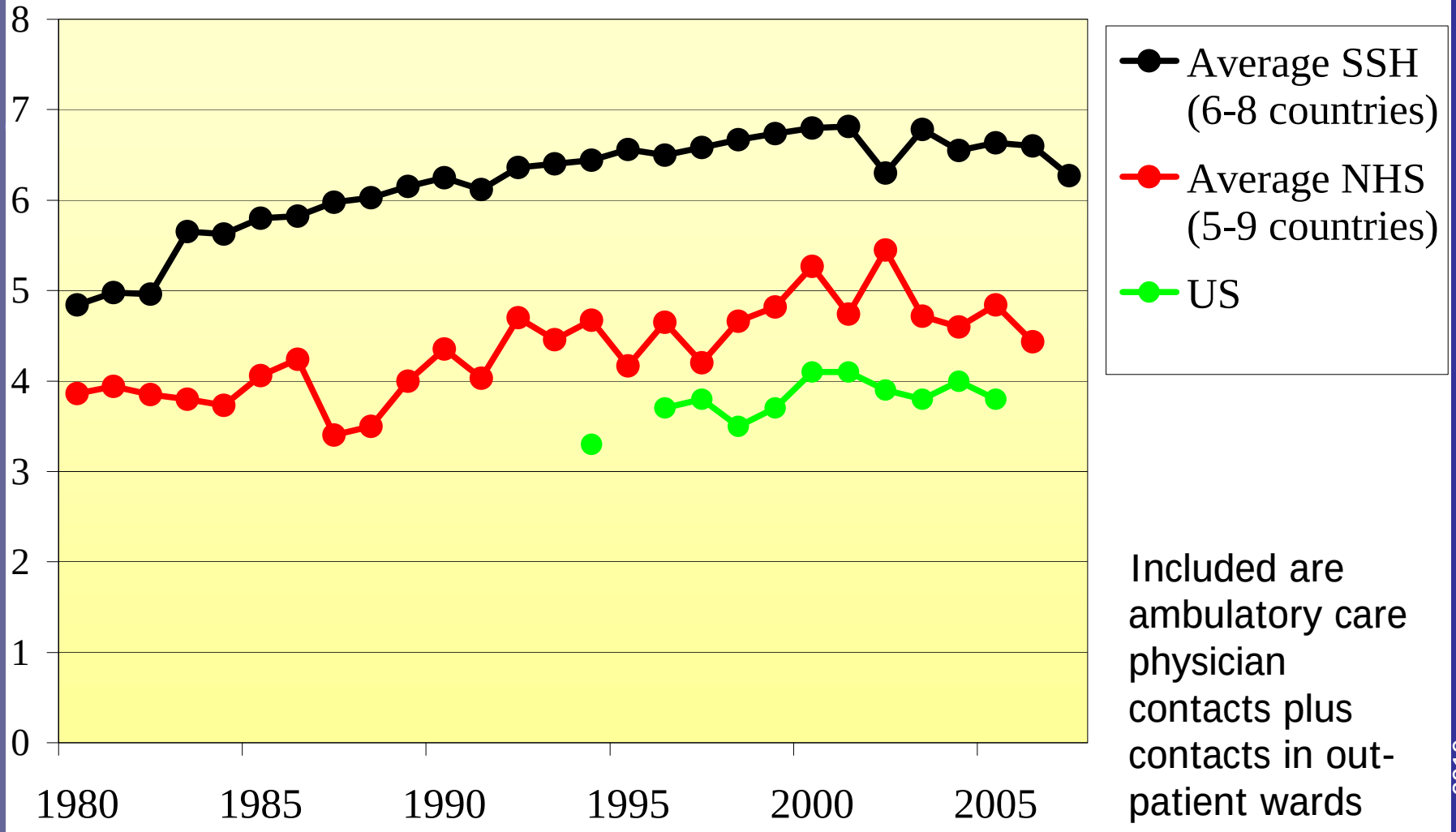


Source: OECD health data files 2009

Life expectancy at birth



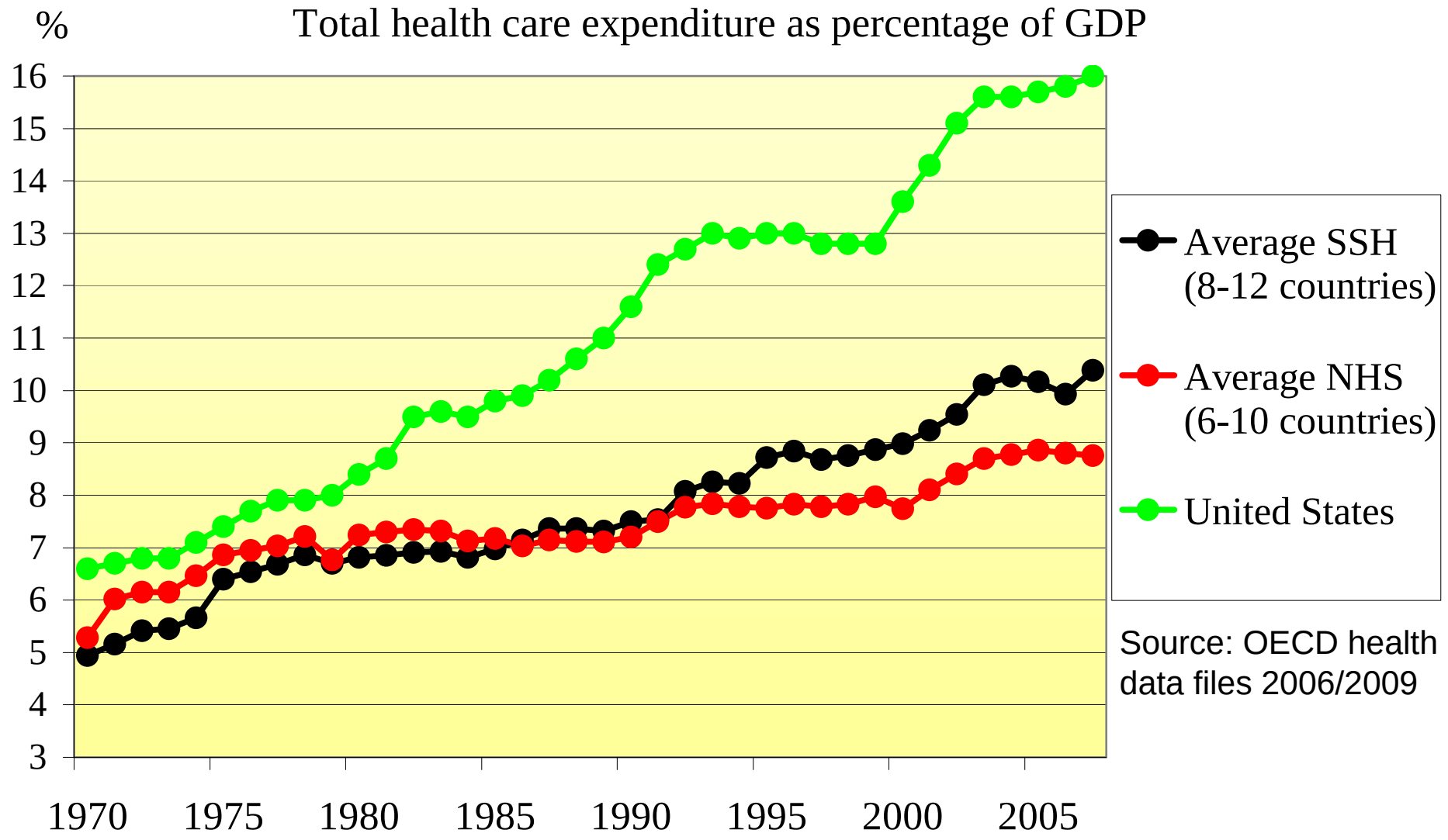
Doctor's consultations per capita



Source: OECD health data 2009

Included are ambulatory care physician contacts plus contacts in out-patient wards (excl. US)

Total health care expenditure as percentage of GDP



Source: OECD health data files 2006/2009