



EQuiP **25** Years:  
**1991-2016**

# A visual history of EQuIP

2005, Berlin



2005, Berlin



2005, Kos



2006, Barcelona



2006, Istanbul



2006, Istanbul



2006, Istanbul



2006, Istanbul



2011, Zagreb



2012, Stockholm



2014, Ljubljana



2014, Tallinn



2014, Tallinn



2014, Tallinn



2015, Zagreb



2015, Fischingen



2015, Fischingen



2015, Fischingen



2015, Fischingen



2016, Prague



2016, Prague



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# Preface



(Source: <https://sites.google.com/site/someambassadors/1wordforfamilymedicine>)

What does it mean to be a General Practitioner? The "One Word for Family Medicine" (#1WordforFamilyMedicine) initiative was launched by #SoMe Ambassador Kyle Hoedebecke and serves to explore the identity of General Practitioners (GPs) and Family Physicians (FPs) by allowing the international Family Medicine community to collaborate on advocating for the discipline via social media.

Participants answer the questions "What is your favourite part of GP/FM?" in their native tongue. Afterwards, the words for each country are collected into a list and turned into a word cloud image. Completed images can be seen on the map below.

The #1WorldforFamilyMedicine project was promoted by WONCA (World Organization of Family Doctors) and multiple countries across the globe to help celebrate the 2015 World Family Doctor Day on 19 May. To date, over 100 images have been created in 75 different countries on six continents and were viewed 37.000 times from across 120 countries.

Please visit the fullscreen map [here](#):

It is hoped that this initiative will help inspire current and future GPs worldwide. Please send an email to [1wordforfamilymedicine@gmail.com](mailto:1wordforfamilymedicine@gmail.com) if you want to collaborate in bringing #1WordforFamilyMedicine to your country.



# A short history of EQuIP: The Establishment (1989-1990)



## I. Introduction and background

At the WONCA Council Meeting prior to the 12th World Congress held in Jerusalem in 1989, the Improvement of Quality Working Party was set up as a result of the acknowledgement of the growing significance and importance given to this issue by Family Doctors world-wide and to the work that many of WONCA's member institutions were carrying out to develop initiatives on the subject in their own countries.

The work group was created as a sub-committee of the Permanent Medical Education Committee with the following objectives:

1. To revise the current state of quality indicators and standards in General Practice in the member countries
2. To take measurements
3. To get to know the capacity of the member countries to improve them
4. To draw up methods by way of which WONCA could promote the set-up of quality improvement strategies

At Jerusalem, Dr. Marwick from New Zealand was proposed as Chairman of this work group. The incentive group emerged at subsequent meetings, counting among its members on Prof. Richard Grol, title professor of Quality Assurance at Nijmegen University (Holland), and Chairman of the European group.

In 1990, the Chairman of EQuIP sent a letter to the different Family Medicine associations in the WONCA member countries, introducing EQuIP and inviting them to join by appointing two delegates.

## II. Aims

This European group held its first meeting at the WONCA European Region Congress in Barcelona in 1990 and set down its objects:

1. To promote collaboration between the organisations, associations and Family Practice colleges of General practitioners/family doctors in Europe on the topic of Quality Development.
2. To promote the exchange of experts and experience in quality development by organising workdays, drawing up positioning documents, distributing reports and creating collaboration projects.
3. To enhance the creation of national networks of family doctors, educators and researchers in each country to aid in promoting and implementing EQuIP's results.
4. To give an impulse to tuition on quality development during the pre-graduate period, continuous medical education and vocational training scheme.
5. To initiate, support and supervise specific concerted actions concerning quality development.

The EQuIP incentive group was formally established with aims, objectives, and up to two national delegates per WONCA member country in 1991.

## III. The structure of EQuIP

EQuIP consists of an assembly and an executive council.

The EQuIP executive is formed by the President, the Honorary Secretary, the Honorary Treasurer and the delegate in WONCA Europe Executive and 1-3 members at large. It is entrusted with the structure, relations with WONCA, budget, quotas and social aspects.

The assembly is formed by the delegates in representation of the different national organisations members of WONCA Europe. The maximum number of representatives per country is two.

At the assembly meeting in Turkey in the spring of 2006 a decision to work on an EQuIP constitution was taken. A group of delegates were appointed to draw up a draft constitution. Drafts were discussed at and altered after four consecutive assembly meetings in Spain 2006, the Czech Republic 2007, France 2007 and Norway 2008 until it finally was adopted by the EQuIP assembly at a closed meeting in Bucharest, November 8, 2008.

*José Miguel Bueno Ortiz*



(c) Thanks to Anna Maria Pedro, Juan Maria Rodma, OSATZAN group and Victor Quesada.



## National Reports (2006-2008): Austria



*In Austria accreditation was introduced based on self-audit. 7% receives external audit each year. Common patient record over all professions was established. 50% doctors do not work under the contract with the insurance companies. There are too many doctors on the market.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Austria mandatory practice assessment is running. It is based on electronic self-assessment and 7% random external check-ups. They introduced 3 grades prescribing lists (permitted, permitted only in defined situations, permitted only after approval by a "control" doctors.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Austria they will apply EPA programme on organisational quality. Several GP practices had to be closed down due to lack in the premises or equipment. Health care reform will weaken the Medical Chamber.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*



(c) Thanks to Patrick Reichel.

# Quality improvement (2006): Austria



## **Electronic social insurance card**

At the end of 2005 all Austrian citizens will have to use an e-card to access medical care. The card contains administrative data about the cardholder, but no health data at the moment.

Further extensions are in preparation: electronic prescription, extension to a European-wide accepted health insurance smart card, integration of social security registration procedures, application of the e-card as a key card for the transmission of sensitive data on the health sector (i.e. secure transmission of diagnostic findings).

One consequence of the introduction of the e-card will be the computerization of every medical practice at the end of the year.

## **Evaluation of practice standards**

National standards for medical practices are still developed and negotiated by the doctors-chamber and the ministry of health. Attainment of a minimal standard will be pre-condition for office-based medical activities.

The assessment procedure will consist of an obligatory self-assessment process followed by a random external audit procedure (approximately 10% of practices will be audited).

## **New control system for cost-effective prescribing**

A new control system for cost-effective prescribing was established in January 2005. Expensive medications have to be justified by a detailed documentation in a medical report.

Every three months a doctor gets an evaluation of his prescribing behaviour. If his prescription rate is higher than an age-quantified average of the prescription level of doctors in a comparable setting an external audit will take place.

## **Disease Management Programmes**

DMP-programmes will start in the second half of the year. Patients can choose to participate on a voluntary basis. The first will be a DMP for Diabetes mellitus, the second this for Hypertension. In the Austrian out-patient sector general practice is in competition with specialist care.

The DMP-programmes will hopefully bring a better understanding of the role of General Practitioners. A different type of DMP is a new quality improvement programme for substance misuse replacement therapy which is currently being implemented.

Benchmarking, improvement in education of doctors, documentation, communication, networking and financial incentives will be the corner stones of this concept.

By *Reinhold Glehr*



# Interview with Reinhold Glehr (Austria)



Interview with Reinhold Glehr, MD, GP (RG)

### What is the first thing that comes to your mind, when you think of EQuIP?

RG: Richard Grol and the special leadership experience by him: To lead with a clear goal but to give the group the feeling that they did find it themselves.

### What was your first EQuIP experience?

RG: My first important impression where GPs of whole Europe having a similar mindset towards the profession family medicine/ general practice in spite of working in very different health systems.

### What major achievements do you know EQuIP for?

RG: The Quality Circle Method was the reason for me to join. The knowlege we got by EquiP helped to establish the method for GPs in Austria.



**“The Quality Circle Method was the reason for me to join.”**

### How would you describe the current world of quality improvement and patient safety in primary care in your country and in Europe?

RG: Quality improvement is now characterised by a rivalry with quality assurance. The first is a dynamically approach, the second is more statically, restricting. The non-medical professions in the governments see their task - needless to say - in monitoring and ensuring which interferes very often with development.

### How would you predict the future for quality improvement and patient safety in primary care in your country and in Europe?

RG: The future will be orientated to efficacy and efficiency factors. What is promoting, what is impeding. e.g. too sophisticated actions for patient safety have sometimes contra-productive effects. It will be necessary to reveal and to bring recommendations in balance.



(c) Thanks to Patrick Reichel.

## National Reports (2004-2009): Belgium



*Dominique Paulus gave a wonderful overview of Belgium and the Belgian health system. Based on a national insurance system, operationalise through health insurance companies, centralised, large number of physicians fee for service, 75% solo practices, direct access to specialists, consultation rate 6.5/year, 1/3rd home visits (but reducing rapidly), consultation time approximately 20 minutes. Main quality improvement initiatives based around peer review circles, guidelines and prescribing feedback. The presentation was followed by a lively question session, focusing on determinants of quality.*

*(26th Assembly Meeting, Brussels, 10-11 November 2004)*

*Belgium had elections in trade union. Accreditation based on competence (lessons, 4 times a year attend peer review group) not on the performance. If accredited you get 25 % higher remuneration. Local peer review groups are working. Local rota groups for weekend shifts are established.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Belgium patients have free access to health care; they face low interest of students in entering GP. They struggle for better remuneration. A quality award was introduced.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Belgium they had 16 workshops on quality. They are working on professional health.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*In Belgium more than half of GPs do not have any practice assistants to help. Government subsidises opening of new practices in underprivileged areas and half of the salary of practice assistants. Clinical pathways are being developed. Diabetes mellitus and kidney failure are developed across the interface between primary and secondary care. They were working on projects Maturity Matrix and EPA practice assessment. Quality development in Belgium slowly moving up?*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

*Luc Lefebvre, Belgium – INAMI awards, clinical pathways on chronic renal failure. They introduced Practice Support Programme (EPA + 3 years of coaching)*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*



*(c) Thanks to Indra Van Hoorick.*

# Quality Improvement: Belgium



## (2009) Belgian Quality Improvement

A global approach to quality? A national policy working group on quality priorities starts in June.

Aim: Advising the national health service, setting priorities and pointing out implementation strategies.

### Questions remaining

Who will influence the agenda? The minister of health already proposes and finances prevention/dementia/urinary incontinence.

A contract with the scientific organisations (Domus Medica en SSMG) for participation, support and implementation.

### Other projects and initiatives

Practice Support Programma (POP) in 30 practices in Flanders (EPA-visit+ 3y coaching).

The national council on quality improvement agreed on a recommendation for the use of the medical record. The organisation of one global feedback report.

By *Luc Lefebvre*  
Belgian EQuIP delegate

## (2008) Belgian Quality Improvement

### Government

- Impulse 2: 50% funding of a practice-assistant to group-practices or practices which cooperate
- Clinical care pathway regulation for diabetes will start in 2009
- KCE (federal knowledge center)

### NRKP/CNPQ (national advisory committee on quality)

- Burn-out report and recommendations gets support
- A quality platform to set national priorities is planned
- Feedback campaign to all GP

### Scientific organisations

- Domus Medica:  
Praktijk ondersteunend programma (POP) practice support program (EPA + coaching)
- Domus Medica + SSMG:  
Pilotting Maturity Matrix  
New recommendations: ec depression,...

By *Luc Lefebvre*  
Belgian EQuIP delegate

## (2004) Belgian Quality Improvement in Family Medicine

### Guidelines from the Scientific Societies of General Practice

Both Belgian Societies of Family Practice follow a common scientific method for the development of the guidelines. This includes a test on the field by GPs and specialists. The latest guidelines were externally validated by the Belgian Cochrane Collaboration Centre, called CEBAM.

### Projects of the Belgian centre for health care knowledge (KCE)

The new KCE conducts several projects in relation with best practice, health technology assessment and organisation of care. Several projects are in relation with quality indicators.

A first project concerns the quality and organisation of care of diabetes. This encompasses three parts:

- First a broad search for evidence-based QI in multiple guidelines and QI databases yielded a set of evidence-based quality indicators.
- Secondly a systematic literature review identified different models for the organisation of care with their conditions and effects.
- Thirdly a broad description of the organisation of care in 9 countries analysed the strengths and weaknesses of those health care systems. Some EQuIP members actively contributed to the validation of its content.

A second project aims at reviewing the literature on the development and use of QI with the potential implications for the Belgian health care system.

A third project compares the quality and costs of fee for service and capitation GP. In this context all potential clinical QI were identified and selected if they could be measured in administrative databases.

A last project will begin on quality indicators in GP, encompassing the EPA project and a new data search of QI.

By *Dominique Paulus & Luc Seuntjens*  
Belgian EQuIP delegates, Brussels, November 2004

# Interview with the new president of EQuIP (2015-Now): Piet Vanden Bussche



## 1) Why did you run for president?

*I was candidate for presidency of EQuIP because some members who I value highly repeatedly asked me to do so.*

*This gave me the self confidence to go for it. And apparently a majority of the assembly members thought I could do it.*

*It would not be possible to do it without the support of the faculty of the university where I work, the support of my colleagues in the practice and the support of Domus Medica, the organizational member for whom I am the representative (Belgium).*

*I hope I can meet the expectations of the members of the assembly and continue the very important work Tina started. I want to emphasise the importance of her presidency. She led EQuIP through a very crucial transition period in a brilliant way.*

*Now, it is a stimulating, enthusiastic group of people from all over Europe and it is a great honor to become their president.*

## 2) What tasks will you focus on right away?

*The months to come are for me a very important 'learning' phase. Tina is still in the lead and I can watch how she does it and learn a lot from her. I think it will be very important to support ongoing projects as much as possible.*

*The board is planning a strategic weekend in the months to come. This is good to be able to know each other a little bit better and to stimulate the team spirit. There we will try to set priorities for the next years and present them to the assembly in Switzerland.*

## 3) What challenges does EQuIP face now and in the future?

*The challenges for EQuIP in the future may be: can we manage to keep overview and bring together all aspects of Quality in Primary care, emphasise how they are interconnected and show what the basic underlying vision and knowledge is?*

*Can we stay and become more influential by cooperating with other networks and take up a leading role when the theme of Quality is at stake?*

*How can we spread the quality virus in primary care all over Europe by teaching, in CME and highlighting good practices?*

## 4) What is your vision for EQuIP in the near and the distant future?

*Personally I think it is important to open the network, gather as many people and organizations who are interested in Quality in primary care as possible, and convince them to become member.*

*I think it will be crucial to strengthen the networking by realising a modern communication system and continue the effort of interesting, stimulating open meetings every spring.*

*The Summer Schools are also very important to learn young people about Quality and EQuIP. They are the future of our organization.*

## CV

- Born in 1961 as the first son of a quality controlling engineer
- General Practitioner since 1985, working in a multidisciplinary group practice in Lichtervelde (semi-urban village in the western of Flanders)
- 1999- 2006: President of Flemish Parliament of General Practitioners
- 2006 -2008: President of the College of Flemish General Practitioners (Domus Medica)
- Since 2008 part-time lecturer on quality of care and chronic care in the Department of Family Medicine and Primary Care at Ghent University (Belgium)
- Member of the Council on Quality Promotion of the Belgium National Institute for Health and Disability insurance (NIHDI)
- In 1997 participant at the Equip Summer School Maastricht
- Since 2008 Equip member, as Belgian representative and coordinator of the Equip Teaching Quality Project
- Special interest in translating quality into day to day practice management, seamless care, teaching quality and equitable care
- Co-author of the book "Dokteren met kwaliteit" (Quality in medicine)





# Interview with Interview with Luc Seuntjens (Belgium)



**Interview with**

*Luc Seuntjens, MD,  
GP (LS)*

**What is the first thing that comes to your mind, when you think of EQuIP?**

*LS: A concentration of knowledge and experience on quality work in everyday practice.*

**What was your first EQuIP experience?**

*LS: The Summer School in Maastricht, where we learned to set up loco-regional projects to improve quality in GP practices. Also, writing the book Tools and methods for quality assurance in GP in Finland with Marjukka Makela.*

**What major achievements do you know EQuIP for?**

*LS: EQuIP presents a clear framework to work on in quality assurance. EQuIP realises a firm European research network. EQuIP realises an European fostering network implementing the principles of QA.*

**What is your best EQuIP experience?**

*LS: Organising the Brussels EQuIP conference "From theory to practice", where we welcomed 150 experts and GPs from over Europe to discuss in an interactive way.*

**How would you describe the current world of quality improvement and patient safety in primary care in your country and in Europe?**

*LS: We really need firm leadership on quality assurance in Belgium. For more than a decade the tools and methods are in place, there are numerous small projects in local quality groups, but there is still no coherent plan to integrate these continuously in the local practices.*

**How would you predict the future for quality improvement and patient safety in primary care in your country and in Europe?**

*LS: QI and patient safety work can only succeed as team-work. We need to find care programs where nurses, practice support workers and social work come together and work out practice patient care improvement initiatives.*

*QI and patient safety work will not only rely on data, but embrace any improvement initiative from the start on, to create a culture of caring for quality. We need specific coaching to foster this caring for QA.*

*QI and patient safety should be strongly rewarded on specific outcome criteria like prevention of readmission of severely ill patients, correct prescription rates of antibiotics, and statins... where research evidence shows that these rewarding really affect outcomes.*



*Luc Seuntjens, MD, GP*



# Quality Improvement (2009): Croatia



## **Reform of the Health Care System in Croatia**

The new Health Care Law introduced in January 2009 brought substantial changes in organization of the primary health care in Croatia.

New organizational and quality standards have been introduced, including better recognition and validation of preventive work of family doctors promoted by incentives for specific preventive programs, stimulation of group practices, introduction of fee-for-service in addition to existing capitation-based model of payment, and other changes.

These changes are being gradually introduced and evaluated according to the expert opinion of Working Group for Coordination, Monitoring and Steering of Health Care Reform in Family Medicine, formed at Ministry of Health and Social Welfare, that includes prominent experts in the field of family medicine, as well as according to opinion of the Croatian Medical Chamber and Croatian Medical Association.

## **Projects aimed at improving quality of care in family medicine in Croatia**

*Improving quality of care in family medicine in Croatia – assessment of outcomes of care* is a project led by Professor Milica Katiz, MD, PhD, Department of Family Medicine, «Andrija Stampar» School of Public Health, Medical School University of Zagreb.

The aim was to investigate the quality of interpersonal care in general practice in Croatia using patient enablement as a consultation outcome measure and its association with patient, physician, and practice characteristics.

Consultations in general practice in Croatia resulted in a relatively high average level of enablement compared to previous studies in UK and Poland; research has confirmed the strong positive relation between continuity of primary care in Croatia and patient's ability to understand and cope with his life and illness

Publication: Ozvacic Adzic Z, Katiz M, Kern J, Laziz D, Cerovečki Nekiz V, Soldo D. Patient, physician, and practice characteristics related to patient enablement in general practice in Croatia: cross-sectional survey study. *Croat Med J.* 2008 Dec; 49: 813-23.

*Care for the Diabetic Patients in General Practice in Croatia* is a project led by Associate Professor Biserka Bergman Markoviz, MD, PhD, supported by Department of Family Medicine, «Andrija Stampar» School of Public Health, Medical School University of Zagreb, and Association of Teachers in General Practice/Family Medicine.

Diabetes mellitus (DM) represents one of the prominent risk factors for cardiovascular diseases (CVD) and is associated with early disablement of the individuals as well as with higher total and specific, CVD related, mortality rates. Quality of care for DM patients depends upon general practitioner's (GP's) professional knowledge, working conditions and organization of preventive activities on the primary health care level. To improve quality of care for DM patients, systematic and early detection and adequate treatment is required.

The aim of the study is to investigate the quality of care for DM patients in Croatia. Specific aims include antropometric measurements in DM patients (weight, height, BMI, waist and hips circumference, waist-hip ratio (WHR)); rate of overweight and obese DM patients; average blood pressure level; average blood level of glucose, HbA1c, total cholesterol, LDL, HDL, triglycerides and uric acid levels; presence of developed micro- and macrovascular complications; comorbidity of DM patients. Attitudes of GPs regarding obstacles related to initiation of insulin treatment in type 2 DM patients will be investigated. Differences between regions (coastal and continental part of Croatia) in the investigated variables will be tested.

The study is designed as a multicentric, cross-sectional study. Sample of 500 randomly assigned GPs is taken from Register of the Croatian Institute for Health Insurance (CIHI), year 2007. Every GP will include convenience sample of 20 DM patients aged  $\geq 40$  years who will meet the inclusion criteria and visit the GP during one month period.

The patient's inclusion criteria are: age  $\geq 40$  years, DM diagnosis (IDF criteria), DM treated with oral hypoglycaemic drugs in the last three years (minimum), signed informed consent to participate in the study. Exclusion criteria are also defined (patients with iatrogenic DM and other defined disorders of endocrine system, patients with diseases that affect life span of red blood cells, terminally ill patients with life expectancy  $< 6$  months, reluctance to participate in the study).

Project's final aim is contribution to improvement of quality of care for patients with DM type 2 in general practice through implementation of intervention model primarily based on adequate treatment of diabetic patients (oral hypoglycaemic drugs and as insulin).

## Quality Improvement (2009): Croatia



### Projects aimed at improving quality of care in family medicine in Croatia

*Cardiovascular Risk and Intervention Study in Croatia-family medicine (CRISIC-fm)* is a project led by Associate Professor Biserka Bergman Markoviz, MD, PhD, supported by Department of Family Medicine, «Andrija Štampar» School of Public Health, Medical School University of Zagreb, and of Association of Teachers in General Practice/Family Medicine. Project is registered at International database of controlled clinical trials in March 2009. (RCS ISCTN31857696).

Cardiovascular diseases (CVD) represent leading cause of death in Croatia and worldwide and great economic burden for the health care systems. There is a need for implementation of international and national guidelines on CVD primary prevention in general practice setting in Croatia, resulting in systematic intervention on CVD risk factors. CVD prevention should include proactive approach to all with additional care for high risk groups.

This project aims to investigate the efficiency of general practitioner's systematic intervention in the population of patients aged 40+ years regarding reduction of the total risk for coronary heart disease and cerebrovascular disease, as well as decrease in the incidence of the metabolic syndrome.

Additionally, regional distribution of the 10-year total risk for fatal outcome in CVD (SCORE) and cerebrovascular disease (Framingham risk-chart), individual risk factors, metabolic syndrome, participants' nutritional status, attitudes towards preventive activities and changes in these attitudes at the end of the research period, will be investigated.

The study is a multicentric, prospective, randomised, cohort one. Sample of 64 general practitioners (GP) will be stratified into two groups: 32 GPs in intensified intervention group (IIG) using measures (pharmacological and non-pharmacological) recommended by professional guidelines (European Society of Cardiology Guidelines 2007), and 32 GPs in conventional intervention group (CIQ), using present, non-systematic, single-factor approach. Every GP will include systematic random sample of 55 patients aged 40+ years who will meet inclusion criteria and visit GPs practice during two months period for whatever the reason.

Project's final aim is to contribute to improvement of quality of care in CVD primary prevention by presenting successful implementation model of existing professional guidelines in routine general practice consultations.

*Opportunistic screening for detection of impaired glucose regulation and diabetes mellitus in Croatia* is a project coordinated by Assistant Professor Marija Vrca Botica, MD, PhD, Department of Family Medicine, «Andrija Štampar» School of Public Health, Medical School University of Zagreb. Associates: Assist Prof Ivana Pavliz Renar, MD, PhD; Prof Milica Katiz, MD, PhD; Assoc Prof Biserka Bergman Markoviz, MD, PhD; Goranka Petriček, MD; Ines Zeliz, MD; Ivana Katiz Milošević, MD.

A dramatic increase in the prevalence of type 2 diabetes mellitus in Croatia has been noted. There is 6.1% of patients with type 2 diabetes in the age group 18 to 65 years in Croatia and it is estimated that there is a total of 9.1% people with diabetes. Previous research showed that diabetes mellitus already lasted 7 to 12 years when it was first clinically detected and 30% of complications developed during that period.

Effective primary detection of impaired glucose regulation and change of lifestyle can delay onset of diabetes mellitus. Effective primary detection of diabetes mellitus can prevent complications of diabetes. General practitioner (GP) is the right person to perform this opportunistic screening program.

The aim of this study is to evaluate prevalence of newly diagnosed type 2 diabetes mellitus and impaired glucose regulation in the patients aged 45 to 70 years in Croatia. Specific aims: to establish how to form risk groups for opportunistic screening for type 2 diabetes in Croatia. (problem of collecting relevant data); to determine which are known risk factors for making a decision about the opportunistic screening process; to find out what is the response of patients to the screening process; to investigate attitudes of patients and GPs to the screening process; to investigate the attitudes of patients after being advised to change their lifestyle.

The study is designed as a prospective study. In the first year patient's status will be detected, followed by three years of preventive program for patients with impaired glucose regulation. Opportunistic screening will be performed by 100 randomly selected GPs in patients aged 45-70 years with existing risk factors but without established diagnosis of diabetes. Measurements: «gold standard for opportunistic screening».

By *Zlata Ozvacic Adzic*  
Croatian EQUIP delegate



# Improving the Quality of Work (2014): Croatia



## Improving the quality of work

The present health care reform that started in 2013. introduced some positive changes to primary care.

From 2013. it is possible for primary care physicians to form group practices, which is leading to strengthening of family medicine profession. Fellows are finally turning to each other, sharing their problems, learning from experience and finding mutual solutions.

We started with the introduction of some diagnostic algorithms which facilitate the work of the GP's.

According to the contract with the CHIF, five family practices can now employ an additional nurse who can, according to practices' mutual agreement, take some administrative tasks or be engaged in some specific aspects of health care, e.g. patient counseling, etc.

From our point of view, the most important thing that has made a positive change related to the quality of work in family medicine was the introduction of chronic disease panels and peer groups.

From 2014 there is a stimulation of work in small groups (called "peer groups"), with additional financing for the doctors involved in it. During one meeting, a group of professional peers discuss the issue with which some have met (a case report or different professional topic), compare experiences and try to find the best possible solution.

The meeting and the conclusions are documented in the meeting minutes and validated by the Croatian Medical Chamber as CME activity.

This method of work actually resembles quality circles, facilitating professional communication among health care professionals with great potential for improving quality of work.

The introduction of "chronic disease panels" represents a starting point for systematic preventive activities as well as programmed care for the most prevalent chronic conditions (hypertension, COPD, DM).

It consists of software platform incorporated to the patient's electronic health record that facilitates recording of different parameters used as quality indicators (e.g. BMI, HbA1c, FEV1, etc.).

These indicators can be used for self-audit, with the possible intention to make external assessment based on these data. Nevertheless, from what is known from the research, it should be carefully decided which process and outcome measures should be monitored and even more carefully how to set the expected standards. The complexity of assessing quality of care based on quality indicators has been well described in the literature.



The complex nature of primary care consultations, the need to keep holistic approach in our daily work, and the context of care that can highly moderate outcomes of care (the patient, physician, setting and system factors) call for caution when trying to interpret such results.

As a conclusion, we would like to mention that after many years we see a shift towards valorization of higher quality of care in family medicine, as well as increase in satisfaction of family physicians due to the fact that they are able to display and evaluate their work.

Family doctors are keen to strengthen their role in the society, are willing to take responsibility for their work and are willing to work well and to acquire new skills that will enable them for better quality of work.

*Dijana Ramic Severinac*

*Zlata Ozvacic Adzic*

## National Reports (2006-2010): Czech Republic



Czech Republic has a new minister who is more supportive to primary care. They introduced e-learning in medical education.

(30th Assembly Meeting, Barcelona, 23-24 November 2006)

Petr Struk and Bohumil Seifert presented the situation in Czech Republic. It has 10.000.000 population with 10.000 Euro per capita GDP. There are 9 health insurances. 7.17% of GDP is spent on health care. 34,242 doctors, average income 1,500 Euro, 82,000 nurses, 750 Euro income. GP is recognised as speciality in 1978 and only in the last decade of previous century recognised as a core in health care system. There are GPs for adults and GPs for children and adolescents. Average list of 5,100 GPs for adults is 1,551 patients, 2,200 GPs for children have lists with 970 patients. In 96% are private contractors. Primary care has 70% of all contacts and uses less than 5% of the budget. There are more than 6 contacts with GPs per year. GP is run as a private business. The reimbursement is a mixed model of capitation + fee for service payment. After 15 years in private practices the GPs look for possibilities to work together. Vocational training consisted of 30 month curriculum, since 2005 has changed to 60 months. New suggestion is 48 months. Several quality projects are in place. Among others a great emphasis is on the guidelines development and implementation. They produced 35 guidelines in the most important fields. They performed several research studies (EUROPEP, medical record audit...). They introduced e-learning last year.

(31st Assembly Meeting, Prague, 26-28 April 2007)

In Czech Republic they introduced "regulative fee" 1 euro for a consultation. They manage to diminish the consultation rates under 6 visits per year. Patient safety – new regulation issued this year. Ageing of GPs and few newcomers are becoming an important problem. They are developing accreditation for GP.

(34th Assembly Meeting, Bucharest, 7-9 November 2008)

Bohumil Seifert, Czech Republic presented quality developments in his country. Clinical Guidelines have been produced which include sections of guidance for non medical people in the Appendix. Topics include critical incidents and medical error. 50% of the budget for postgraduate education now goes to education in general practice. New criteria for quality assessment have been introduced with 28 standards each with between 4 and 8 criteria. Practices are assessed by visiting auditors (there are ten trained auditors taking part in practice assessments).

(37th Assembly Meeting, London, 29 April-1 May 2010)



(c) Thanks to Kristyna Kozouskova.

# Quality Improvement (2006): Czech Republic



General practice is recognised as a speciality with own post-graduate curriculum since 1978 in the Czech Republic. Currently, 5100 general practitioners are working independently as private providers in primary care and are fully qualified in general practice.

An average number of patients registered with one GP is 1,600. The reimbursement of GPs is mixed capitation and fee for service payment. Primary care is provided in outpatients clinics with groups of doctors or more often by individual GPs.

The concept of family medicine does not exist and children up to 15 or 19 are registered with practising pediatricians. GPs do not play the strict gate-keeping role but the most of patients seek for health care first in general practice.

## Education

General practice is a part of curriculum in all seven medical schools, but not all faculties have established GP chair. 60-months postgraduate programme was established by new law in 2004.

It is structured to a hospital part (internal medicine, surgery, gynaecology, psychiatry) and ambulant part with a dominant training in general practice. The management of postgraduate training, obligatory and facultative courses, regular meetings for trainees and methodological support of GP-trainers is provided by Department of General Practice of Postgraduate Medical School.

Currently, all teaching practices have to pass through a process of accreditation. The continuous medical education is supervised by Medical Chamber via a credit system. The dominant role in CME has The Society of General Practice.

The offer of educational events of different character is rich, including regional CME, national conferences and special educational programmes on leading actual topics (colorectal cancer screening, cardiovascular prevention, pain management, palliative care, etc). The attendance of annual GP conference in November 2006 exceeded 1000 of participants.

New practical guidelines were presented and new modules such as original EQUIP workshop on uncertainty were successfully performed.

Another source of information are peer reviewed journals and internet. A project of EUNI (e-university) has been recently launched. Project EUNI including e-lecture prepared by general practitioner on Proteins of acute phase was presented during EURACT meeting in October in Prague.

## Quality Initiatives

Czech Ministry of Health established „Committee for Quality in Health Care“ in 2000. The purpose of this committee is to prepare system of quality management closely related to the European health care quality management activities and the relevant programmes of WHO/EURO, putting the main accent to the comparison of key indicators, parameters and evaluations.

The committee initiated proposals of four general programmes:

- Health Care Quality Programme Policy
- Measurement of Care Efficiency and Introducing of Standard and Special Clinical Classifications
- Standardization of Health Care Delivery
- Quality and Availability of Health Care – roles of the state and regions

The committee settled frame to create global policies for programmes of quality and efficiency of health care delivery programmes.

First project following these programmes were prepared and accepted in 30th October 2000 and subsequently submitted to the Governmental Committee for Quality and confirmed. Originally, quality management activities were initiated by Czech Medical Chamber in the beginning of 90's in the Czech Republic.

The first projects was almost completely focused on the hospital care and partly to the clinical laboratory services. General practice and primary health care were slightly delayed in the QM process. However, there were many various projects supporting the field of general practice from the middle of 90's (further information follows) and, at the present, the process of accreditation of general practices is to be tested and introduced.

Since autumn 2001 The Czech Society of General Practice (scientific) and The Association of Czech General Practitioners (professional) have established a Centre of Primary Care in Prague. It was followed by developing of regional primary care centres as an alternative to previous administrative management and in order to coordinate activities in education, research and in quality initiatives. All Society members were offered to enter the e-network.

In 2002 Primary Care Research Fund was founded to support research and quality improvement projects in primary care and to enable independence in education, quality and research projects. Practical guidelines development project is supported via this Fund.

The Society of General Practice has received several grants since 2001: Harmonizing tools for research and quality improvement. This project consisted of:

- ICPC-2 translation procedure
- ICPC-2 study on referrals from general practice
- Patient Satisfaction Questionnaire (EUROPEP) translation procedure
- EUROPEP study in 20 practices
- International Glossary of Primary Care – translation

## New organisation of Czech Young GPs (CYGP)

In a period 2003-2006 thirty five practical guidelines for general practitioners were prepared by specialists and practitioners under the umbrella of Czech Society of General Practice. CME programmes were organized as a part of guidelines implementation process. Informed Selfcare as a tool for process of standardization in health care.

The aim of this project was to explain the EBM guidelines to patients and prepare written and internet information for patients. There are other particular quality and research projects have been conducted in general practice:

- Monitoring of Colorectal Cancer Screening
- Study on cardiovascular prevention in general practice
- Screening of depression in primary care
- Reflux disease management in primary care
- Audit of antibiotic therapy in general practice
- Audit on chronic pain management and opioid treatment.

The first comprehensive Textbook on General Practice was published in 2005. It includes a chapter devoted to quality issues. The Czech Society of General Practice organized The International Symposium of General Practice/Family Medicine as an invitational conference for leading colleagues in 11 countries of Central and East Europe. The conference was held in Prague in March 2006. Topics concerning quality and continuing professional development were also discussed.

*Bohumil Seifert and Petr Struk,*  
Czech Republic EQUIP delegates



# Quality Improvement (2011): Czech Republic



## Basic Figures

General practice has been recognised as a speciality with own postgraduate curriculum since 1978 in the Czech Republic. Currently 5100 general practitioners (GP) are working independently as private providers in primary care; 92% of them in single-handed practices, the others in group practices or in outpatients clinics. The average age of GPs is 53 years.

An average number of patients registered with one GP is 1600. The reimbursement of GPs is mixed capitation and fee for service payment. The concept of family medicine does not exist and children up to 15 or 19 are registered with practising pediatricians (n=2150).

GPs do not play the strict gate-keeping role but the most of patients seek for health care first in general practice. GPs consult in average 160 patients and do 4 house calls a week. 80-90% contacts are handled solely by GPs without referrals to other provider.

94% GPs have computer in practice and 77% of them use electronical medical records.

## Education

General Practice/Primary Care is a part of curriculum in all 7 medical schools, but only two faculties have established GP chair. The extent and structure of curriculum varies but all medical schools ensure that students visit general practice before they leave school.

The postgraduate programme was shortened to 36 months in 2009. The reasons were imminent lack of doctors and limited potential to cover expenses of residency programme.

The programme includes a common hospital trunk (Internal medicine, Surgery, Gynaecology, Pediatrics, Neurology), outpatient part (ENT, Ophthalmology, Psychiatry, Hygiene and Epidemiology, etc) dominated by training in General Practice. There are obligative and facultative courses. All teaching practices have to pass through a process of accreditation. The final assessment before specialization is guaranteed by the Postgraduate Medical School.

The continuous medical education is supervised by Medical Chamber via a credit system and dominated by The Society of General Practice. The offer of educational events of different character is rich, including regional CME, national conferences and special educational programmes on leading actual topics. The attendance of annual GP conference exceeded 1200 participants in 2010.

The Society of GP in cooperation with other specialities introduces or updates 5-10 practical guidelines yearly. An information for lay persons is a part of each guideline. Another source of information are peer reviewed journals and internet. A project of EUNI (e-university) has been successfully developed and has been actively used by third of GPs around the country.

The Primary Care Research Fund has been established in 2001 to support research and quality improvement projects in primary care. Practical guidelines development project has been supported from this Fund. The Society of General Practice has also received several grants during last years. The ethical issues concerning cooperation with Pharma Industry are carefully considered by the GP Society.

## Quality Initiatives

General practice is represented in „Committee for Quality and Safety in Health Care“ at the Ministry of Health. The purpose of this committee is to prepare system of quality management closely related to the European health care quality management activities and the relevant programmes of WHO/EURO, putting the main accent to the comparison of key indicators, parameters and evaluations.

The projects concerning primary care quality have been completed recently:

- Accreditation standards for general ambulances
- Reporting on critical incidents and medical errors in primary care

The awareness on quality issues in primary care, which was slightly delayed compare to hospitals, is now rising and becoming a very important topic. The GP representatives also negotiate the inclusion of quality aspects in the system of reimbursement in primary care.

Another examples of quality and research projects form primary care:

- Management of diabetic patients of the 2nd type.

Diabetic patients 2nd type were managed by specialists for years in the Czech Republic. Nowadays GPs are ready to overtake the care for non-complicated patients with diabetes 2nd type. This change needs a careful interdisciplinary management, economic considerations and rises a lot of quality issues.

- Study on cardiovascular prevention in general practice
- Early diagnostics and treatment of peripheral ischaemic disease

Studies about risk factors intervention in primary care. A kind of electronically driven and monitored research in practices.

- Monitoring of Colorectal Cancer Screening

New design of Colorectal Cancer Screening Programme has been introduced since 2009. It has brought new challenges and possibilities for primary care physicians. The monitoring covers the gaps in the process of data collection on screening with particular focus on GP performance.

## New organisation of Czech Young GPs (CYGP)

In January 2010 an organisation of Czech Young GPs (CYGP) was established. The organisation pays attention on actual issues of young GPs as well as international cooperation and improving of quality in general practice.

The CYGPs arranges international exchange programs in collaboration with similar groups abroad. It takes part in negotiating with authorities especially about education and take-over of practices. It is a new platform for introducing quality improving programs and bringing them to life.

*Bohumil Seifert and Jan Kovar,*  
Czech Republic EQiP delegates



# Interview with Interview with Bohumil Seifert & Jan Kovar (Czech Republic)



## Interview with

Bohumil Seifert,  
MD, GP, PhD (BS)  
& Jan Kovář, MD,  
GP (JK)

### How would you sum up the last 10 years of Quality Improvement (QI) and Patient Safety (PS) efforts in General Practice?

*BS: I see progress both in systemic way and in bottom-up initiatives. We have a new legislation, which includes quality and safety requirements, insurance companies motivate GPs to improve organization of their work, College produces guidelines and implement them and organises CME on quality assurance. We still see a variability in quality in general practice but also a lot of improvement.*

*JK: I am in practice for 5 years so far. In this short era I witnessed the introduction of guidelines as major tool of QI/PS systemic effort. Also there has been move towards broader GPs competences in drug prescription, chronic care, POCT lab and diagnostic devices. Still, I do not feel the will for change of attitude amongst "peripheral" GPs.*

### How is General Practice (especially Quality and Safety work) organised and supported

*BS: All the measures and initiatives described above contribute. Although presently we have no program particularly oriented to support quality and safety in GP.*

*JK: Guidelines are introduced regularly on local meetings or national congresses. As the majority of GPs are single-handed, acting as doctors, employers, semi-managers, QI/PS has - especially due to a time shortage - unfortunately a low priority in organising practice.*

### Which tools and methods are currently in use?

*BS: The National College offers different instruments: EURO-PEP, Critical Incident registration and analysis, accreditation standards. All these instruments were piloted in the Czech Republic and they are part of instrumentarium for accreditation standards. But they are not widely used. Quality circles exist, but are not formally established.*

*JK: Honestly and shamefully, I have not used any tool so far.*

### Are GPs and Trainees formally trained in QI and Patient Safety?

*BS & JK: No.*

### Which IT and communication technologies are being used in General Practice?

*BS: Different software GP-specific systems. Internet is available in almost all practices. Software includes modules, which supports QI/PS in chronic disease management, e.g. diabetes.*

*JK: Several secured communication channels are working between GPs, specialists, labs, hospitals.*

### Which role should EQuIP play now and in the years to come?

*BS: To continue to be an inspiration and source of information. In addition, international project participation and collaboration would be helpful. They always push the progress.*

*JK: The same! I know, I will not be able to run a project on my own, but I believe, I can gather quality data for someone else.*

### What do you expect from the future of QI and Patient Safety work in General Practice?

*BS: Increasing patient safety culture, particularly in my country. Wish to show that I do things well and my practice is safe. Increasing role of patients.*

*JK: Perception and acceptance of the QI/PS policy as a regular, or even better: A natural part of daily practice. Tools for smooth introduction of the topic to mistrustful and skeptical colleagues.*



Bohumil Seifert,  
MD, GP, PhD



Jan Kovář, MD, GP

## National Reports (2006-2010): Denmark



**In Denmark counties are fusing into regions. Patients are risk stratified, especially diabetics, in order that GPs focus on most ill ones. Emphasis should be on long term care of chronic patients. GPs will be paid additional money for each diabetic patient in his/her office. Data will be captured electronically directly from the medical records. They will be stimulated to go into the community to the patients, who are not well controlled. All GPs use electronic patient record.**

(30th Assembly Meeting, Barcelona, 23-24 November 2006)

**In Denmark they are introducing a new fee system for chronic care, as a part of a chronic care model. They create common general practice specific data-base for reporting indicators.**

(31st Assembly Meeting, Prague, 26-28 April 2007)

**In Denmark the emphasis is on organisational quality.**

(33rd Assembly Meeting, Bergen, 22-24 May 2008)

**In Denmark in a population of 5,5 million, there are 3,500 in 2,400 practices. In DAK-E project they have data-capture/benchmark and feed back, indicator development, implement ICPC2, coordination of sectors, DANPEP implementation. They will introduce new accreditation system similar to EPA and EUROPEP.**

(34th Assembly Meeting, Bucharest, 7-9 November 2008)

**Ynse de Boer, Denmark presented problems with contract negotiations in GP in Denmark. The government passed the law on reporting on unintended events. They use disease "packages". For example cancer package describes all the steps from raising a suspicion to follow up for all common cancer diseases.**

(36th Assembly Meeting, Bled, 5-9 November 2009)

**Still no contract between GP-organisation and Regions Board for wages and tariffs. There is a threat to central quality unit (DAK-E) and paralysis of development of prospective QI initiatives. Preparing for testing a Danish Quality Model for General Practice. Data-capture not longer limited to special agreement on control for diabetic patients. Law on reporting Unintended Events, now includes primary health care. We should report: Problems appearing in transfer between sectors, with medical equipment, infections as complications to treatment, and unintended events with serious consequences. Are we doing the right thing? It is the general practitioners task to help the people seeking his help in solving their health problems based on professional basis in a continuous doctor-patient relationship and in collaboration with other health services.**

(38th Assembly Meeting, Malaga, 4-6 October 2010)



(c) Thanks to Christina Svanholm.

# Quality Improvement (2006): Denmark



## The structure reform

The organisation of the Danish health care sector is being reformed currently, and 13 counties that previously took care of the organisation of health care in Denmark is fusing to 5 regions. The fuse takes place now and should be in place by 2007.

At the same time the municipalities have fused to larger units that in the future will take over the responsibility for preventive care and rehabilitation.

## The chronic care model & risk stratification

The health care systems were designed to handle acute illnesses and thus provide episodic rather than continuous care, transfer responsibility rather than share responsibility between sectors and actors and take responsibility for patients rather than stimulate self care.

The age composition – longevity and changed lifestyle of populations leads to chronic disease. >30% of the Danish population suffer from one or more chronic diseases and >70% of resources in the Danish health care system are spent on care for chronic disease. Moreover there are numerous new possibilities to treat such conditions.

Therefore the National Board of Health (Sundhedsstyrelsen, SST) has set out to change the health care system accordingly, with numerous implications for the primary sector.

A **new contract** between the National Health Insurance and the General Practitioners' Organisation in Denmark with a new concept for fee combined with quality measurement of diabetes care should be seen as the start of a more basic reform of the sector. The aims are to integrate the care of chronic patients in general practice in a collective strategy for the national health care service of chronic patients.

Diabetes was selected as "model disease" and if the system proves successful, other chronic diseases, e.g. COPD, will be included.

## GPs as the central professional figures: MAIN COORDINATORS OF CARE

This new contract introduces a new type fee – the annual fee for diabetes care to be introduced in January 2007. It is a fixed annual fee for diabetes care including quality measurement, irrespective of the numbers of diabetes care consultations

## GPs quality indicators for diabetes

- HbA1c 6-monthly (yearly in 2. sector)
- HbA1c less than 8% (same)
- Blood pressure 6-monthly (yearly in 2. sector)
- Blood pressure less than or equal to 135/85 mmHg (same)
- Lipids yearly (every 2nd year in 2. sector)
- Albuminuria yearly (every 2nd year in 2. sector)
- Eye examination every second year (same)
- Foot examination yearly (every 2nd year in 2. sector)
- Life style and self care discussion with patient yearly
- Agreed treatment plan yearly

Enrolment is voluntary and involves a 3-year period 2007 – 2009. Comprises all diabetics managed in the practice (mainly type 2. diabetes). The practices are now obliged to use electronic patient records. An automatic data capture module must be installed and all diabetes patients have to be coded (ICPC – T90). Data on quality indicators and risk stratification will be sent to a central database. The risk stratification criteria are developed as well as the indicator set for diabetes care.

The "old" contract with partly capitation fee and fee for services continue but now extended with specific preventive consultations also useful for chronic care patients but without claim for documentation of the quality. The contract will be gradually adapted to meet society's increasing demand for chronic care (more older and chronic patients) and the increasing workload in general practice.

The main annual diabetes consultations includes a specified content (guideline), common planned goals (between GP and patient) of treatment in the coming year and planned number of controls in the coming year. The fee is independent of numbers of controls.

The practice will receive feedback of results 6-monthly (quality indicators and risk stratification). The results are anonymous on practice level but public on group level – perhaps on the municipal level

## Necessary reform of the Danish primary sector

Because a relative shortage of GPs and physicians at large and because of the increased workload in general practice, it will be necessary for GPs to organise differently, to employ more staff, to increase practice size and to delegate work.

## The DAK-Unit

A new unit – the DAK-Unit is taking over from the DAK-project and is being established currently. The aims will be to support the QI development on a national level, main focus on IT developments, and development of national quality indicators and elements of shared care.

## EQuIP related developments

DanPEP is being established as a national project based in Århus, after Hanne Hejes successful implementation of the system in Denmark.

Maturity Matrix is popular in Denmark, a Danish version of the tool has been developed and named "Praksis Matrix". The project includes 3 counties, 11 GP facilitators and 70 practices.

*Tina Erikson*  
Danish EQuIP delegate

# Quality Improvement (2014): Denmark



At the end of 2011 the Danish Organization (PLO) and the Danish Regions finally agreed on a new contract. The negotiations had been going on for about 3 years. The new contract is interesting from a quality improvement perspective:

- All GP's are to include the data capture program before the end of 2012.
- All GP's are expected to start using ICPC codes for chronic diseases from the 1st of April 2011.
- GP's should start reporting quality data for diabetes, heart failure, IHD, stress, anxiety en depressive disorder, as soon as they are connected to the data capture system.
- All practices should perform some kind of patient evaluation survey every 3 years.
- The developmental parts of the central Danish Quality Unit DAK-E has been cut away

Furthermore it is agreed, that a Danish Quality model for General Practice should be developed, and be ready for pilot test in autumn of 2011. This task is given to the Danish Institute of Quality and Accreditation in Healthcare (**IKAS**). The chosen standards and indicators are inspired by different existing indicator sets, and should include indicators on health performance, organizational issues and patient satisfaction.

Indicators on health performance are almost ready and can be collected by the data capture program. The patient evaluation tool DANPEP (much like EUROPEP) still needs some adjustments, and there is ongoing work with choosing and customising the organizational indicators.

In the future general practice will be accredited, as hospitals already are today.

It yet has to be decided, in what way participating practices can be assisted and supported in working with quality plans and feedback.

The Danish Organization and especially the Danish Regions have the impression that research, CME and QI-activities should be integrated in order to support and inspire each other better. Until now there have been 3 separate funds to support GP activities in these areas, and it is decided to analyse in what way the funds can be integrated.

Especially the Danish Regions have been unsatisfied with the number of practices that have implemented the data capture program and other QI initiatives. They have decided, they want to concentrate resources in QI and CME on broader implementation of the use of ICPC-coding, indicator reporting through the data capture model, and stimulation of GP's on reflecting on and working with quality reports in areas where sets of indicators for family medicine have been developed (e.g. diabetes, COPD, IHD).

In this process, unfortunately, the funding of the Central Quality Unit (DAK-E) has been reduced. As a consequence the Unit will have to focus on maintaining and supporting the data capture model, and there are limited resources for developing indicators in new areas. Until now this work has been done in DAK-E, and there yet is no organisation, that can take over.

**To conclude:** There is a very good opportunity for spreading known and respected methods of QI, but there is a need to establish a new structure that can inspire and develop new areas and new methods.

By Unse de Boer,  
Danish EQuIP delegate



# Interview with Christina Svanholm (Denmark)



## Interview with

Christina Svanholm,  
the VdGM-EQuiP Li-  
aision Officer & GP  
Trainee (CS)

### What is the first thing that comes to your mind, when you think of EQuiP?

CS: Summer Schools and Quality Circles.

### What was your first EQuiP experience?

CS: The 43rd EQuiP Meeting in Paris 5-6 April 2013, where EQuiP opened for membership.

### What major achievements do you know EQuiP for?

CS: The PECC-WE project (Patient Empowerment in Chronic Conditions, WONCA Europe) and the Summer Schools.

### What is your best EQuiP experience?

CS: The 2014 joint EQuiP-VdGM Summer School in Denmark, which I also co-arranged, but that is not the only reason, ha ha.

### How would you describe the current world of quality improvement and patient safety in primary care?

CS: A bit fragmented, but emerging, dedicated, inspiring and contagious.

### How would you predict the future for quality improvement and patient safety in primary care?

CS: With increasingly greater focus on quality improvement in Europe and in the World, I think we will see a shift towards more fundamental, relevant and bottom-up quality work, where the GPs take ownership of minor quality improvement project in Primary Care. Patient Safety will be a collective undertaking for primary care and there will be emphasis on sector transitions between primary and secondary care.



# Interview with the Immediate Past President of EQuIP: Tina Eriksson (2007-2015)



## 1) What was the most interesting task during these years?

*Eight years is a long time, and your view on a task like this one will naturally change over time. At the very first period, chairing EQuIP was a rescuing action - there were conflicting interest between researchers and developers of the instruments for QI that had been developed in EQuIP. Before I took over, the instruments EUROPEP, EPA and International Family Medicine Maturity Matrix were taken out of EQuIP and placed in a parallel network for the researchers involved, the TOPAS association. That created tension, as EQuIP members felt that they had contributed and that the legacy of EQuIP was at stake.*

*In the following years, the innate vision of the early EQuIP as creator of a European center of a uniform practice accreditation proved unrealisable, as politicians and administrators in the different countries were not prone to leave this important task to an international GP organisation. Therefore, EQuIP had to develop a new vision. For me, that vision was to develop a generous and vital network of ideas and exchange of views among GPs and researchers working in this field.*

*It was important for EQuIP to develop legal grounds. We needed to be a legal body, to set organisational rules. After 2010, opening EQuIP gradually to individual and organisational membership was the vision. In order to do that the constitution had to be changed.*

*Now the network has very good projects, a good economy and a very good new leadership.*



## 2) Are there any particular milestones you want to highlight?

- *The Leonardo da Vinci project - EQuIPs first EU project and the intellectual basis of structuring thoughts on QI in the future.*
- *The opening of EQuIP for individual and organisational memberships and the new constitution in 2013.*
- *Winning the anniversary project of WONCA Europe in 2012 was another achievement, brought about by the energy, insight and creativity of the group. I am looking forward to witness the completion of that project in 2015.*
- *New valuable projects on Quality Circles and on the quality aspects of inequality.*
- *EQuIP summer schools on QI and safety regularly in the last 5 years.*

*Recently, TOPAS has again joined forces with EQuIP. For me, that completes a circle. It shows that stressing EQuIP as a collaborative network of sharing ideas and views on QI and Safety is indeed a simple, but strong vision.*

## 3) You are still full of energy - still going strong - what will you do next?

*In the field of quality and safety, I will dedicate my efforts to fulfill my personal ambitions for quality work in my own practice. I bought a practice very late in life - in 2010 at the age of 53. I have 2.000 patients on my list.*

*To my disappointment, I have found it difficult to organise the quality work in my own clinic. There is always something that compromises the processes: the nurse falls ill, the secretary finds another job, a colleague suffers from stress, the premises are being renovated etc.*

*I have been involved in QI work as a consultant for 10 years at Danish national and regional levels. In those 10 years, QI developed from almost scratch to a large field. Indicators, automatised data capture, large databases, decision support etc. has been developed.*

*This have led to conflicting interests between those GPs, who embrace this development, and those who see this as a threat to the personal doctor patient relationship as well as a tool for external control of the GPs and clinics.*

*Some GPs feel that they are drowning in administrative work. Conflicts between administrators, politicians and GP organisations started in association with the negotiations of a new contract in 2013, and they are still as open and bleeding wounds in the flesh of Danish general practice. I do not see any easy ways to solve those conflicts.*

*QI has to do with data, making use of data to improve care. However, data on health as well as other aspects of life is being accumulated and used now in ways I did not at all foresee 8 years ago. Whistleblowers have opened our eyes to the surveillance we are all prone to in virtually all fields of life.*

*I feel uncertain: How will "big data" on health affect primary care in the years to come? How will it affect health insurance practices? Will the Europeans embrace the idea that data on their health is being accumulated or will they try to avoid registration? Will they demand control of their own health data? Moreover, are the GPs and the authorities willing - and able to grant them that?*

*I have left my job as a quality consultant because I do not feel that I know the way to follow. Eventually I decided that I'll demonstrate my ability to perform QI and safety measures to my own satisfaction in my own clinic before taking on more tasks in this field. I hope I will succeed before I need to retire.*

*I am grateful for the opportunity to be in EQuIP. It has been a great experience. I thank all those wonderful and dedicated people that comprises the network.*

# Interview with the Immediate Past President of EQuIP: Future of EQuIP

Tina Eriksson (2007-2015)



As previously mentioned, quality and safety in primary health care is on the agenda of all stakeholders; policy makers, administrators, insurance companies, patient groups etc.

The themes are central in the discussions about all aspects of the organisation of the sectors, work modes, financial incentives etc. As GPs, we need our own networks of researchers and GPs working in the fields of quality and (patient) safety.

The issues of quality and safety are not straight forward, as the work of GP/FM is complex and many patients have several conditions to take into account. There is a growing knowledge on measuring quality and safety, but many questions remain to be asked:

- Does the focus on measurement change the consultation process itself with the individual patient, and is it for the better?
- Does quality measurement change the focus on the measurable parts of the consultations?
- Does quality measurement and pay-for-performance enhance or decrease equity of health care?
- What is really measurable, and to which extent are the results valid?

In a situation, where GPs all over Europe are faced with increasing demands for measurement of quality of care and transparency, EQuIP becomes increasingly important and a knowledge exchanging and generating network based on GPs and researchers in the field.

The most recent example hereof is the open letter to the OECD review team on Health Care Quality in Denmark, **Errors and Omissions on Danish GP** (20 April 2013), which was authored by the president of EQuIP.

*Tina Eriksson*

# Quality Improvement (2013): Estonia



From 2006, a pay for performance (P4P) system was introduced in Estonia by starting to use some quality incentives to evaluate clinical quality in family medicine. That was built up by Estonian Society of Family Doctors (ESFD) and the Estonian Health Insurance Fund (EHIF). Systems development is ongoing. In 2011 85% of family doctors are interested to take part of clinical quality assessment.

The system consists of 3 parts:

- Prevention (pre – school age children vaccinations and follow-up, prevention of cardiovascular disease at the age of 40 – 60)
- Management of chronic diseases ( type2 diabetes, arterial hypertension, myocardial infarction and hypothyreosis)
- Professional competence – CME (resertification, competence of the family nurse), follow up pf pregnancies , gynaecological and surgical activities.

After the process indicators within last year are assessed, family doctors who reach the criteria at the level of 100% or 80% can get paid in two levels. Nevertheless the P4P at maximum level makes 1,2% from family doctor s income.

Family Medicine Centers (and doctors) get their income on the basis of contract with Estonian Health Insurance Fund (EHIF).

In 2009 ESFD decided to describe the standards for good practice. So The Quality Guide for Estonian Family Doctor Practices was published. The manual describes how to organize the work in family medicine practice in a best way. The book was published in estonian and russian language and was also translated and digitally available in english (added as pdf).

## Contents of manual:

- Availability of family doctors help and access to the practice (standards – access to practice and informig the patients)
- Organisation of the practice standards – working order of the practice, managing the medical information, work-rooms and access to them, medical accessories and devices, clinical supproting processes.
- Quality of the treatment work: Standards – promoting health an preventing diseases, diagnosing and solving individual health problems, consistency of medical care, cooperation with the patient, safety and quality, education and training.
- Practice as an educational – scientific base: Standards – practice as an educational base, practice as a base for scientific work)

On the basis of The Quality Guide for Estonian Family Doctor Practices the development of practice accreditation system was launched. The ESFD has used an intranet "Svoog" ([www.perearstiselts.ee](http://www.perearstiselts.ee)) for digital practice accreditation assessment. Family doctors may fill up the table about quality indicators of the practice work and get scored from C to A (maximum).

This is voluntary and open only for doctors who are members of ESFD. Still – on the first year (2009/2010) 79 practices and 2010/2011 109 practices wanted to analyse themselves (total number of practices in Estonia is 468).

The board of ESFD has decided to audit the best practices (A- level) and therefore the voluntary auditors visited all A- practices. The auditing protocol was filled and signed by both sides ( the auditor and the practice representative).

As our system is unique – down to top organized, voluntary, without any P4P for practice quality incentives – we have the only possibility to use the honouring and positive public attention to those practices as motivator.

At 2011 the president of Estonian Republic Toomas – Henrik Ilves specially acknowledged the practice – holders of the A-level practices. They also get an award from ESFD – the wall – hanging pennant (photo added), wonderfully designed by textile – artist Ene Pars.

Estonian Society of Family Doctors declares the quality- aspects its first interest. The work with these aspects is going to continue.

By *Katrin Hartinson*,  
Estonian EQuIP delegate



# Quality Improvement (2014): Estonia



## Continuity of the care and e-health

The quality of care over time is linked to the continuity of care. There are two important perspectives on this. In the patient's ideal experience continuity of care is like a „continuous caring relationship“ with a certain health care professional. As patients' health care needs can rarely be met by a single professional, for health care providers the ideal of the continuity is the delivery of a service through integration, coordination and sharing of information between different providers. Continuity in the experience of care relates to patients' satisfaction with both the interpersonal aspects of care and the coordination of care.

Moreover, continuity is related to important aspects of services such as „case-management“ and „multidisciplinary team working“.

One of the bigger challenges of the nowadays health care is the fragmentation- it is usual that in the same time period different providers from different health care levels, or outside of the health care (social service, unemployment agency etc) take episodic care for a person. Each of them has different rights and responsibilities and each of them needs and at the same time produces huge amount of information related to the person's health. E-health is an efficient way to collect and share information such as prescriptions, test results, investigations etc.

One of the best working innovations in Estonia's e-Health-care system is e-Prescription, which is a centralized, paperless system for issuing and handling medical prescriptions. When a doctor prescribes medicine using the system, he or she does so electronically, with the aid of an online form. At the pharmacy, all a patient needs to do is present an ID Card. The pharmacist then retrieves the patient's information from the system and fills the prescription.

All family doctors, hospitals and pharmacies in Estonia are connected to the system. Patients have a possibility to follow the log attached to every prescription and see who and when has accessed the data. There is a Patient Portal application which allows citizens to view their medical data and related information.

The another well working e-system, which allows easy access to patients health data is the nationwide Picture Archiving and Communication System.

Since 2007, more than 80% of radiological studies in Estonia have been stored in the system. Electronic Health Record and Digital Registration which serve an important role in care coordination, information sharing and improved continuity of care are not working so efficiently as it was hoped some years ago, because not every health care provider send information to the E-health system.

Other important attempt in e-health, implementation of which needs time and more hospital willingness, is e-consultation. There are good examples of e-consultation between some specialists and family doctors in Tallinn and North-Estonia, no achievements in other areas of Estonia.

Some hopes for future developments in e-health in Estonia are related to electronic clinical decision support systems which generate patient-specific advice, warnings about potential drug interaction effects and generate reminders regarding screening and lifestyle modification. Possible developments in taking care of the chronically ill patients can be M-health services.

This is using the mobile Technologies in communication, sharing and exchanging the information, images and data among healthcare professionals, and with the patient, wherever they are located. One pilot study of the diabetes patients was provided in 2011-2013 in Estonia and this had generally positive feedback from the patients side.

*Ruth Kalda, Estonia*



# Interview with Katrin Martinson (Estonia)



**Interview with**

*Katrin Martinson,  
MD, GP (KM)*

## **What is currently going on in QI field in primary care in Estonia?**

*KM: The auditing of best (A-level) practices for 2013 is just about to begin – the auditors are ready to go to visit practices. The system is working from 2009/10 (see below) and now there is the fourth season of accreditation. Auditing has been taking place once a year. The criteries have been modified yearly, but first time the practices which have got nomination of A-level for 3 years are going to be audited in season 2014/15, until this they automatically are counted as A-level practices. Regarding to this we have 31 practices to audit.*

## **Who are the auditors and how do they work?**

*KM: Auditors are family doctors, the leaders of well-organized practices, the members of the board of Estonian Society of Family Doctors (ESFD). Outside of ESFD there are important guest-auditors this year - Tanel Ross (director of Estonian Health Insurance Fund - EHIF), Maivi Parv (head of EHIF Tartu branch), Margus Tsahkna (head of the Social Affairs Committee, the parliament of Estonia), Pille Saar ( Estonian Health Board, head of department of Family Medicine) and - last not least , our foreign guest- Paula Vainiomäki (Turku University, Finland, Department of General practice). We are very glad to have their view to accreditation process as feedback.*

*Auditors work in pairs, there is a protocol to be filled by practice representative before auditing, the auditors visit practice for appr. 2 hours and after that the practice gets peer-review from auditors.*



(Photo: WHO/Kadri Kont-Kontson)

*Katrin Martinson*

## National Reports (2006-2010): Finland



**In Finland they have problems with shortage of doctors in GP. Government force local communities to organise public health care services on the population base of minimum 20,000 inhabitants.**

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

**In Finland small health centres are forced to unite in bigger units under one administration. Young doctors are reluctant to work in only one place. In bigger centres GPs are sometimes specialising in endoscopies or cardiology. 9% of practices are not occupied. Finnish primary health care centres join in the Finnish Quality Networks. They achieved better results of prevention of vascular disease for every year. They face problems with the preventive activities in the field of smoking, alcohol consumption or osteoporosis, because the patients are not asked. Private sector is emerging with 20% of visits, mainly by clinical specialists.**

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

**In Finland national institution helps with analysing quality problems. The government encourage GPs to work more on prevention and counselling smoking cessation and lower alcohol consumption.**

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

**Klas Winell, Finland presented Finnish developments. One third of the health centre personal took part in yearly measurements.**

*(36th Assembly Meeting, Bled, 5-9 November 2009)*

**In Finland, 8% of GP positions are vacant. Population of 5.5 million. Government forces small health centres to merge to unite. The minimal population size should be 20,000. Young physicians work in private companies, which sell their services for health centres. Specialised care and hospital put the emphasis of QI on harm reduction. Finnish quality network grows and covers 2/3 of the population. 70% of patients are below target value for LDL cholesterol level (2,6 mmol/l). They proved that in the regions where feet of diabetics are examined, there are less amputations.**

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

**Klas Winell, Finland, described the unemployment rate in Finland is risen to 9.1% with paper industries continuing to close. The basic unit of licensing is 5-10,000 population in size. Government has decided that the municipalities must now have a minimum size of 20,000 inhabitants, Private companies (for example like foreign financial companies) have entered the marketplace with competition and have attracted many younger doctors who are then no longer available to work in the general health system. In working with the chronic care model, nurses may become care managers.**

*(37th Assembly Meeting, London, 29 April-1 May 2010)*



# Quality Improvement (2009): Finland



## The Economy and the Health Care

The economical recession and the growing number of unemployed people have strongly influenced the tax flow to the municipalities. Because these are responsible for organising health care to the inhabitants, the situation has led to diminished budgets in health centres. Year 2010 will be very tough for the primary care in the country.

At the same time several governmental programmes promote development in health care. The government forces small health centres to unite. Each health centre should serve a population of at least 20 000 inhabitants. This has caused turbulence in small health centres.

GPs have left for this reason many well functioning centres that are too small to qualify for the new legislation. 8 % of the GP positions are now vacant. It has become very popular for the young physicians to work in private companies, where they can dictate their own working conditions. The companies then hire physicians to health centres. The young physicians stay often a very short time in each centre, which again causes more turbulence.

## Combining the resources of R&D units

The ministry of health and welfare united the human resources of Stakes and National Public Health Institute from the beginning of 2009 to a new administrative unit, THL – the National Institute of Health and Welfare. Rohto, which is a governmental programme that promotes rational use of medicine is under governance of THL since the beginning of 2009.

The programme takes place in many health centres and involves now about one fourth of GPs in the country. Rohto uses the working method of workshops. They are of high quality and they promote process building. In 2009 Rohto has started a breakthrough project (IHI method) with 15 health centres in developing the updating of medicine lists.

## Patient Security and Harm Reduction

The ministry of health and welfare started a new programme in 2009 on patient security and harm reduction. The programme is very much quality based. It has a strong support from the specialised care, which now seems to find its aspect in QI – adverse event reduction.

Most of the cases concern mistakes in ordering and delivering medicines. Nurses have been very active in this new programme. Time will show if the doctors use the possibilities of harm reduction in larger scale. So far the programme has very limited connections to ambulatory care and there is a concern that this programme can put a side the positive development in chronic disease management and quality development in primary care.

## Current Care Guidelines and Evidence Based Handbook

96 national evidence based guidelines are available. An English summary of 63 of them can be read on [www.kaypa-hoito.fi](http://www.kaypa-hoito.fi). Many of the guidelines have already been rewritten with the new evidence included. Maximum time before rewriting is three years.

Implementation of the guidelines is the tough part of development. There is no organised way of doing that so far. Some research is done on implementation, mainly on guidelines of hypertension.

The Finnish Quality Network (FQN) is doing that so some part and Rohto to some part. The evidence based hand book that is used in electronic form by most physicians in Finland is now been translated several other countries like Germany, Switzerland and Portugal.

## Indicator development

Several bodies have shown their interest to develop indicators. The Guideline office intends to develop indicators to follow up how the guidelines are implemented. At the same time there is a goal to get indicators to support process development on health centre and hospital level.

Rohto people have also started indicator development. Their first intention is to get indicators for good ordering praxis for prescriptions and maintenance of medicine lists for chronically ill. THL has also shown interest for indicator development. Instead of having only national indicators for performance there is now a goal to get indicators for hospitals and health centres.

The Finnish Quality Networks have developed indicators mainly for primary care, but to some extent also to specialised care. The latest development work has been on dementia care indicators.

## The Finnish Quality Networks

There are four quality networks in function: The Quality Network of Prevention of Cardiovascular Diseases, the Quality Network of Reducing Risk Use of Alcohol, the Quality Network of Osteoporosis and Fracture Prevention Network and the Quality Network of Memory Dysfunction.

Conmedic is running the networks. The networks have in total over 70 health centres joining. These cover more than 60 % of all GPs in Finland.

The activities of networks are yearly measurement of quality and intermediate outcomes, network meetings and campaigns for good care. Local quality meetings in health centres are organised 1-3 times a year. In these meetings the results are analysed, processes developed and quality thinking is taught. Health centres get the bench marking results from Conmedic in power point presentations which are easy to use in local quality meetings.

The GPs at the health centres have also the possibility to get help from the quality facilitators, if they so wish. More information is available on [www.conmedic.fi](http://www.conmedic.fi). The networks are developing material that is available for all members from the data ware house. The data ware house on the web site of Conmedic possess bench marked models of good clinical care, examples of good instructions for different working models and patient leaflets.

Examples of quality indicators and bench marking analysis are easily available. Conmedic has developed a web audit instrument for quality measurement. It is easy and fast to use and secures high quality of data collection in quality measurements.

By *Klas Winell*

The Finnish Association of General Practice

# Quality Improvement (2012): Finland



## **The New Law of Health Care from May 1st 2011**

The new law strives to support primary health care, promote patient's central position, increase health promotion and co-operation of primary and secondary care. It also emphasizes the access and effectiveness of health care.

The new law enforces every health care unit to make a plan for developing patient safety and quality. Experiences of this exercise are still scarce. It will be interesting to see if this will be found as a positive development in health care, and not only as an extra task.

## **Treatment plan**

The ministry of health and welfare urges to make treatment plans for every patient with a chronic illness. Planning is on the way in most health centres. This seems to increase the work load a lot, but on the other hand everyone believes patient care will improve with the plan.

## **Ministry Supports the Chronic Care Model**

The responsibility of organizing health care services lies on municipalities. The ministry of welfare and health intends to point the direction of health policies with project money. For the time being, the ministry wants health centres to strengthen the care of chronic diseases.

The framework of chronic care model is promoted with extensive national development program Kaste. In many cases the participating health centres want to follow up the results. This again can lead to increasing use of quality improvement methods.

The model emphasizes the need to write a treatment plan for every chronically ill patient. The aims of treatment plan of the chronically ill are patient centeredness, empowerment, continuity of care, use of electronic patient records in promotion of self care. In the model GPs see chronically ill patients less often, but instead they will write a treatment plan that will be followed up by nurses.

## **Ambulatory care work registered**

The ministry of health and welfare forces health centres to register all visits with ICD10 codes and codes that cover the work done. This coding could open doors for good statistics and even quality follow up, but that would require accurate data collection. Time will show if this can take place in real life with the tough work load.

## **Shortage of physicians in primary care**

6.5% of the GP positions are vacant in health centres. Many young physicians work in private companies, where they can dictate their own working conditions. The companies then hire physicians to health centres.

The young physicians stay often a very short time in each centre, which results in bad continuity of care. 6.7% of vacancies in health centres are now run by private companies

## **Obligatory vocational training was removed**

Finland removed obligatory vocational training in general practice May 1st 2011. Since then a physician can autonomously practice after graduation from medical school. This has caused problems for Finnish medical students who have studied in other Nordic countries, where they have to finish the studies including the practical part in the end of the studies before moving back to Finland.

Finnish GPs, who wish to work in other European countries, have to fulfill their specialist examination in GP before moving to another EU country.

# Quality Improvement (2012): Finland



## Patient Security and Harm Reduction

The ministry of health and welfare started a new program in 2009 on patient safety and harm reduction, the Finnish National Programme on Patient Safety. The program is strongly linked to quality improvement. It has a strong support from the specialized care, which now seems to find its part in QI – adverse event reduction.

Most of the cases concern mistakes in ordering and delivering medicines. Nurses have been very active in this new program. Time will show if the doctors use the possibilities of harm reduction in larger scale.

So far the program has very limited connections to ambulatory care and there is a concern that this program can overlook the positive development in chronic disease management and quality development in primary care. A new Society of Patients Security was started in 2010.

The programme has established a [website](#). The website is a national e-Library on patient safety and includes for example information, tools, reports, best practices, innovation paths. An e-learning package has been developed.

## Current Care Guidelines and Evidence Based Handbook

102 national evidence based guidelines are available by Duodecim. A short English summary of 91 of them can be read [here](#).

About one third of the guidelines are been rewritten every year. Implementation of the guidelines is the tough part of development. To help implementation various versions of the guidelines are published: html, pdf, lay person versions and abstracts.

In addition, power point sets and e-learning courses are developed. Interactivity of the guidelines has been developed as well. Some research is done on implementation, mainly on hypertension guidelines. Two quality networks (The Finnish Quality Network (FQN) and Rohto) facilitate implementation to some part.

The evidence based hand book that is used in electronic form by most physicians in Finland is now been translated in several other countries like Germany, Switzerland and Portugal. All health centres have electronic version of the hand book available.

This is important when thriving for evidence based medicine. Duodecim produces also electronic programs for testing medicine interactions and use of medicines during pregnancy or nursing.

## The Finnish Quality Networks

The quality networks have in total about 60 health centres joining. These cover over a third of all GPs in Finland. The activities of networks are yearly measurement of quality and intermediate outcomes, network meetings and campaigns for good care. Local quality meetings in health centres are organized 1-3 times a year.

In these meetings the results are analyzed, processes developed and quality thinking is taught. Health centres get the bench marking results from Conmedic. The GPs at the health centres have also the possibility to get help from the quality facilitators, if they so wish.

The networks are developing material that is available for all members from the data ware house. The data ware house possesses bench marked models of good clinical care, examples of good instructions for different working models and patient leaflets. Conmedic has developed a web audit instrument for quality measurement.

It is easy and fast to use and secures high quality of data collection in quality measurements. Quality measurements can now be done on diabetes, hypertension, coronary disease, fracture prevention, smoking cessation, mini-intervention on risk use of alcohol, dementia and treatment plan.

## Indicator development

Several bodies have shown their interest to develop indicators. The Current Care office has started to develop indicators to follow up how the guidelines are implemented. The guideline groups are urged to plan the indicators as part of their writing activity.

The Finnish Quality Networks (FQN) have developed indicators mainly for primary care, but to some extend also to specialized care. The latest development work has been on indicators for dementia care and care of chronic respiratory disease. Since 2011 the FQN is developing indicators for occupational care as well.

By *Klas Winell & Raija Sipilä*  
Finnish EQuIP delegates



## National Reports (2006-2009): France



*Teacher doctors are on strike in France. Worse position for academic GPs. Doctors do not choose GP in the same rate as other disciplines. Mandatory quality assessment and organisations are accredited.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In France there is one GP for 1000 patients, vocational training is running from 1977. GPs are not so good socially recognised. They run projects on quality on drug prescriptions, diabetic clinics, etc. Electronic health records should diminish unnecessary lab tests and use of drugs. Doctor and patient key card allows access to common data-base on patient data. They face visits from insurers with the emphasis on rational prescribing.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In France there is gradual improvement in academic status. Each citizen has to choose his/her doctor.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*Hector Falcoff, France – 50% of GPs are working in solo practices. 40 % of doctors after specialist training do not work as GPs. All private doctors have to be assessed every 5 years from 1999. CAPI (contracts to improve individual practices) is introduced by insurance companies using quality indicators.*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*



*(c) Thanks to Hassna Errami and Loïc Masson.*

# Quality Improvement (2006): France



Last June, we wondered whether effective and relevant political decisions would be made. As often, the answer is mitigated. Two important laws were voted in August by the Parliament, bringing about some changes in the organisation and funding of French Healthcare system.

The health insurance system is becoming more and more complex. Patients have to choose a "treating doctor" which has to refer them to other specialists if they want to get re-funded. This doctor might not necessarily be a GP, but might be a specialist in case of chronic disease.

This can be interpreted as an introduction of some kind of gate keeping, but with no patient list. Patients can change "treating doctor" anytime they want, no changing in the payments system for doctor that means no capitation.

In fact there is no recognition of the central role of a primary care doctor in the system:

- A very confusing funding system that might open big opportunities to private insurers for wealthy people and might bring difficulties for lower middle class people and some elderly.
- A co-payment of One Euro per contact with a doctor, even in primary care.
- A centralised and computerised medical file for every patient is also planned, but up to now no money has been put on the table, and it is not sure that the project is feasible.

## **Creation of a High Authority in Health Care replacing ANAES**

This body is now not directly linked to the Health Care minister but chaired by a group of eight prominent persons designated by different major political bodies. This new body's mission will be to give independent advice to policy makers, professionals and patients about the quality of health services, and provide information as to products and services that should be paid by health insurance systems.

**Mandatory practice assessment for all doctors** Some kind of practice assessment and quality improvement activities is now mandatory for every doctor working either in hospitals or ambulatory care. The responsibility for assessment of procedures of quality improvement methods is also devoted to the "High Authority in Healthcare".

It is too early to say what these procedures will be, and to what extent the professionals will be associated to the process. General Practice recognised as a full academic speciality. Vocational training last six semesters and is under the responsibility of the University. The last semester can be spent by students as registrars, in well organised GP practices, but it is not mandatory.

This new process, where students work as registrars in a GP practice, seems very promising. Some practices may now organise as a real training facility, where medical students still spend most of their practical training.

The National College of teaching GPs (CNGE) is working hard to organise and make this new curriculum successful, as it is undoubtedly a significant improvement of the training of GPs in France. The status of academic GP's is still not the same as the specialist status in the University.

*By Marianne Samuelson and Hector Falcoff*  
French EQuIP delegates

# Quality Improvement (2014): France



There is a paradox about our health care system. From one side it has been classified by Barbara Starfield as a weak primary care system, and from the other side it has been ranked first by WHO in 2000.

This good ranking was probably linked to three elements:

- We had a universal health insurance system. And we still have it. Even if during the last 15 years the average out of pocket money increased for minor health problems, the patients are totally covered for major diseases (diabetes, cancer, etc).
- The supply of primary care was not at all organized, but it was abundant.
- We had a really big secondary and tertiary care sector. For example, there were as many dermatologists in Paris than in England.

During the last years there were some important changes in primary care:

- General practice became an academic discipline (2004) : titular professors, lecturers, PhD students...
- Patients had to choose a doctor and to register in his list, and GPs became gatekeepers (but gatekeeping is "soft" and often it is shunted by patients without big penalties).
- In 2009 the law defined the specific role of GPs, particularly in coordination and continuity of care and patient record keeping.
- In 2010 we managed to create a national college which federated the GP unions, scientific, academic and CME organizations. Today general practice has one face, and it is easier to participate to the policy debate with the other stakeholders.
- Until 2011 we were paid only by fee for service. Today there are new types of payment with a small capitation fee and we get some money with P4P, according to clinical indicators. The total amount does not exceed 10% of the GP's earnings.
- One of the most striking changes is the development of PC team work in structures called "Maisons de santé pluriprofessionnelles": Multi-professional health homes. They are private initiatives, but they receive specific funds from the government. These teams developed first in rural areas as a response to shortage of GPs, and now they are also developing in cities. They fit young doctors expectations, that are team work and personal quality of life, and they represent a new way to deliver preventive and chronic care. In a few years probably 25% of GPs and nurses will work in these teams in primary care.

Of course we still have many quality issues. Today we want to focus on equity of care and safety of care.

## Equity in care

Equity is an important issue in France, where there are major social health inequalities, and where the "inverse care law" applies. To improve equity of care it is necessary to measure it in daily practice.

To achieve this, the first step is to characterize the social situation of individual patients. Within the french college of general practice, a working group, including GPs and epidemiologists, developed a guideline entitled "Why and how to register social information for an adult patient in general practice"?

The guideline describes what are the most useful social informations to collect, how to register them in a standardised way, and how to use them in daily care and in quality improvement.

# Quality Improvement (2014): France



## A first step to measure equity of primary care

Life expectancy for french at thirty five years old has been increasing in the last thirty years. But, among men, executives live nearly seven years more than manual workers. This difference remains stable in the time. There is also a difference of three years among women.

This difference is associated with more years of disability before death for manual workers. We call this the "double punishment". There is a gradient, the health in each social group is better than in the group below and worst than in the group above it.

This is mainly the result of social processes and the so called social determinants of health, and probably the health care system has little influence. But it is unfair and it is not acceptable. Equity of care means "equal care for people with equal health needs" and "more intensive care for people with more health needs".

The aim is to get outcomes as similar as possible across the different social groups. Today we do not deliver equitable care. In many surveys we observed that we follow "the inverse care law" which says that "the availability of good medical care tends to vary inversely with the need for it in the population served".

For exemple in a national survey diabetic patients with a low education level, compared to those with a high education level, have more macrovascular complications, and, at the same time, they receive less recommended procedures, like ophthalmologic exams.

As we cannot improve what we cannot measure, we consider that the first thing to do is to measure equity in our daily practice. Within the college of general practice, a working group, including GPs and epidemiologists, developed a guideline entitled "Why and how to register social information for an adult patient in general practice"?

The group made a literature review and a delphi procedure. The guideline was published in march 2013. It describes what are the most usefull social informations to collect, how to register them in a standardised way, and how to use them in daily care and in quality improvement.

This guideline is a first step in the field of equity of primary care in France. Next steps will be to test the faisability and the acceptability of the social data collection, to disseminate nationwide the guideline to GPs and software companies, to implement templates in the electronic medical records, to develop equity indicators, to discuss with policy makers about how to incentivise the routine data collection, and finally to start with plan-do-study-act cycles.

## Patient safety

Patient safety in primary care is a very new topic in France with scarce knowledge. The first epidemiologic data on incidence of adverse events (Aes) in ambulatory sector are known since december 2013. We observed 22 Aes/1000 contacts (visits – home visits – phone contacts) and no harm for ¾ AEs. 2% were serious AEs.

The main types of risk situations identified by the ESPRIT study are organization problems in medical practice, precriptions writing, communication with patients and lack of proper knowledge and skills mobilizing.

On the field, there are some local initiatives being developed either in primary care practices as morbi-mortality review, or in peer groups or quality circles where GPs can analyze AEs together and design improvement actions. Unfortunately, there is not yet any process set up to spread the information gathered in such groups.

## Patient safety in primary care: What's going on in France?

In France, as in many other countries, particular attention is paid by the government to the issue of patient safety, as evidenced by the national plan for patient safety 2013-2017. This comprehensive program covers both ambulatory and hospital sectors.

Until 2013, most of the collected data on medical errors and harms to patients were coming from Hospitals. The ENEIS study showed that 4.5% of hospitalizations were due to adverse events (AEs) occurred in ambulatory sector. And the EVISA study, in it's qualitative side, provided information in the causes of the AEs. The immediate failures were mainly:

- Therapeutic errors
- Monitoring failures
- Therapeutic delays

Most cases were adverse drug events, related to anticoagulant drugs, neuroleptics and diuretics. However, there was scarce data about patient safety in primary care, so that the Government asked for an epidemiological study about AEs in primary care.

In last december we got the results of this ESPRIT study. It brought two major contributions :

- The study led to a consensus definition of AEs in primary care.
- It was the first national study on the incidence of AEs in primary care.
- 22 Aes/1000 contacts (visits – home visits – phone contacts)
- Quite frequent: 1 AE/2days/GP
- No harm for ¾ AEs
- 2% were serious AEs

They most often result from organization or communication failures, such as task interruptions (phone calls, computer malfunctions, entanglement of medical and administrative tasks) and excessive flows of unsorted information. The main types of risk situations identified by the ESPRIT study are:

- Organization problems in medical practice
- Prescriptions writing
- Communication with patients
- Lack of proper knowledge and skills mobilizing (which account for 20% of the total)

There are some local initiatives being developed:

- The « Maisons de santé pluriprofessionnelles » (see above)
- Practice exchange groups (peer groups - quality circles) where GPs can analyze AEs together and design improvement actions they could implement in their own practice to prevent AEs.

Unfortunately, there is not yet any process set up, to spread the information gathered in such groups. Moreover patients are not involved at any level in this sort of approach. Obviously there is still a lot to do, and a lot of questions to be addressed. Proibly the core issue is to develop a safety culture among health providers.

A lot of GPs today still don't know exactly what is an adverse event. They often confound it with adverse drug reaction or they mix up error and fault. There is a lot of guilt around these issues and french GPs are not comfortable with the notion of "learning from error". Thus we have collectively to understand why and how reporting an AE is necessary and useful.

By *Isabelle Dupie & Hector Falcoff*  
French EQuIP delegates



# National Reports (2006-2010): Germany



*In Germany they got emphasis on certification of doctors using EPA. 600 family practices were certificated in this way. They developed EPA for paediatricians and assessed 200 of them and 100 dentist offices.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Germany there was a major health care reform in this April. A lot of hospitals are closing down (30% closed in the last 10 years). There is a 50% of hospital stay reduction in the last 10 years. Hospitals are allowed to perform more ambulatory care. Many health care decision functions became centralised. They will set up a new national agency for quality indicators. There are at least four independent agencies working on quality indicators at the moment. 50-60% of diabetics are in a disease management programmes. There is development of health care card on the way with a lot of resistance among doctors. EPA is developing well.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Germany there is a tendency to marketing and competition. There were many disease management programmes. There were some improvements in indicators. The sick funds will introduce American companies for case management using telemedicine. Next year institute of measurement will be established as independent organisation.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*In Germany disease management programmes in diabetes care proved to be successful. Publication: Szecsenyi J, et. Al. German diabetes disease management programs are appropriate for restructuring care according to the chronic care model. Diab. Care 2008; 31: 1150-4. Nurses in primary care are providing case management.*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

*Jochen Gensinchen, Germany presented the development in quality research in Germany. He presented systematic guideline review. Advisory Council on the Assessment of Developments in the Health Care System – Coordination and integration in health care – Health in a long living society.*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*

*Antonius Schneider and Jochen Gensinchen from Germany added comments about the Quality Indicators used in Germany. Practices participate voluntarily, also out of professional pride. Many GPs present the findings of their quality assessment to the patients as certificates they display in their practices. 38,000 are accredited with KREP (checklist type of assessment, easier to do) and 1.700 are accredited with EPA, where the assessment is done with a practice visit by an external person and is more formative.*

*(37th Assembly Meeting, London, 29 April-1 May 2010)*



(c) Thanks to Christian Rechtenwald.

# Quality Improvement (2006): Germany



## Relevant quality projects in the field of general practice

The German health care system is in a painful reform process with currently a lot of frictions between government, payers and providers. Some relevant quality projects in the field of general practice are:

- Guideline development: The German College of General Practitioners (DEGAM) has recently published its 7th problem-oriented guideline ("ear-pain"). In the year 2007 there are 3 more guidelines to come. More information on the guideline programme can be found [here](#)
- European Practice Assessment (EPA): There are about 700 GP practices involved in EPA so far. In 2004 the government issued a law which makes the introduction of quality management for all practices mandatory until 2009. More information about EPA can be found [here](#). In the meanwhile a special set of indicators and instruments form an EPA for pediatricians and an EPA for dentists. Practices, which have performed well in EPA can obtain a certificate from "Stiftung Praxissiegel", a joint effort of TOPAS Germany and the Bertelsmann-Foundation. More information [here](#).
- Medical errors: The Frankfurt department of general practice ([here](#)) has established an internet-based critical incident reporting system for general practice teams. This system is working quite successfully under the title "Jeder Fehler zählt" ("every error counts"). More information [here](#).
- Practice based research networks and indicators: The departments of general practice in Göttingen and Heidelberg with the support of the Federal ministry of Research and Education (BMBF) have established practice based networks to analyze data from medical records based on [ICD-10](#) and [ICPC-2R](#).
- Quality circles on rational prescribing: These multifaceted interventions have been introduced in different projects the states of Lower-Saxony, Saxony-Anhaltina and Hesse. In Hesse there is currently a project with more than 1.700 practices running in the context of a programme for primary care coordinated health services. More information [here](#).

General information about the German health care system (in English and German) can be found [here](#).

By *Joachim Szecsenyi*  
German EQuiP delegate

# Quality Improvement (2015): Germany



## Relevant quality projects in the field of general practice

*Guideline development:* The activity of the German College of General Practitioners (DEGAM) regarding the development of guidelines has further increased in the last years. Currently 33 guidelines, many of them including patient information are available. Due to the demand a new category of guideline has been developed.

The S1 guidelines deal with a specific and often actual problem where GPs are in need of support. The first S1 guideline was developed during a nationwide outbreak on EHEC infections, due to the high acceptance and feedback from the medical community many more S1 guidelines have been developed since.

In contrast to 'full' guidelines the topic is much more focused, resulting in a faster development process. New guidelines are being prepared on issues like multimorbidity and protection from over- and under supply. More information on the guideline programme can be found [here](#).

Based on international experience with practice visits by peers the German college (DEGAM) has started a campaign for practice visits. The aim is to offer a structure for and contact to practices who are interested in an intercollegial exchange based on a peer visit.

In contrast to models often used DEGAM aims to include participation of visiting colleagues during actual patient encounters to give an opportunity for feedback on patient communication as well. Practices interested may use the material provided and can register at the DEGAM homepage.

Beside this national initiative physician chambers in different federal states have started similar initiatives. In Lower-Saxony a peer review with a focus on patient safety and the inclusion of visits by doctors assistants is being piloted, in Schleswig-Holstein hospitations based on the DEGAM model are being offered.

The Advisory Council on the Assessment of Developments in the Health Care System has published a new report with a focus on Needs-based Health Care: Opportunities for Rural Regions and selected Health Care Sectors – the future role of General Practice and Safety regarding medical devices as well as disparities in medical care are among the topics being analyzed in the report. An online version is available [here](#).

By PD Dr. *Guido Schmiemann*, MPH  
German EQiP delegate

## New Impulses for GP Centered Health Care

In Germany, political will to support primary care, namely GP-care, started in 2004 with the establishment of a legal framework for GP centered health care programs.

Still based on the general principle of free physicians' choice for patients and the so induced competition between physicians, statutory health insurance funds (SHIF) were encouraged (since 2004) respectively obliged (since 2007) to offer contracts to GPs in order to implement incentives for more and better GP-coordinated health care, and to patients to benefit from the program by choosing one specific GP whom they commit to consult before seeing a specialist in return.

The concrete elements of those contracts are to be set between the contract partners which normally are the SHIF, the regional association of statutory health care physicians and the regional association of GPs.

There are two different types of contracts:

- 'Full' contracts leave the regular remuneration system, and build their own system for all GP-services.
- 'Add-on' contracts are built on top of the regular remuneration system.

After the full contract of the SHIF 'AOK' in the federal state of Baden-Württemberg has been evaluated with positive results, now, the results of the first scientific evaluation of an add-on contract of the AOK PLUS in the federal state of Thuringia have been presented at the IHEA-conference 2015 in Milan and the DEGAM-conference 2015 in Bozen.

The economic and care coordination outcomes may be interpreted as first cautious evidence of intensified and better coordinated care for older, multimorbid patients, going along with no statistically significant rise in total direct cost (not regarding intervention costs).

Namely patients enrolled in the program more often consulted only one GP during an observation period of 18 months and more often had referrals when consulting a specialist.

There was a higher rise in GP-consultations, laboratory tests, home-visits, enrolments into disease management programs, medication adjustments, and a slower rise in drug costs in the intervention group compared to a control group.

By *Jochen Gensichen* MD, MA, MPH (Professor and Chair)  
German EQiP delegate

## National Reports (2006-2008): Greece



*In Greece funds from abroad invested in private health services which compete for public resources for health care provision. The investments are mainly in hospital sector. They are waiting for the reforms on reorganisation of primary care.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Greece they started educational programme on management of CV risk factors. Due to lack of doctors and public demand on full coverage many doctors have to work over their working hours. They increase the vocational training positions. They established monitoring of the performance of doctors in private PHC including GPs. They face problems in communication with Ministry of health and reluctance in establishing GP departments at Universities.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Greece they introduced a new law which has foreseen certification of practices.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*In Greece EPA and Maturity Matrix tools were introduced.*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*



(c) Thanks to Vicky Garmiri and Maria Bakola.





# Quality Improvement: Ireland



## (2012), Head of Quality and Standards

In Ireland, in 2010, a significant Quality Improvement initiative was introduced by the Irish College of General Practitioners (ICGP) which has been welcomed internally within College and has been supported by college members, general practitioners.

The position of Head of Quality and Standards was created for the first time in July 2010 providing a leadership role in the ICGP encompassing Training, Education, Research, Professional Competence and Quality activities of the College.

Oversight, co-ordination/integration and support at strategic and operational levels, both internally and externally, are provided by the Head of Quality and Standards as appropriate, whilst working closely with the ICGP Directors in each of these areas.

The Head of Quality and Standards takes a lead role in re-accreditation of the ICGP as a training organization and as a professional competence scheme provider.

The ICGP is responsible for setting national standards of general practice specialist training under the auspices of, and accredited by, the Medical Council; and the College is the body responsible for the overall accreditation of GP training programmes.

The ICGP is formally recognised by the Medical Council under section 91 (4) of the Medical Practitioners Act, 2007 such that it may assist the Medical Council to perform its duty to satisfy itself as to the ongoing maintenance of professional competence of registered medical practitioners.

From May 1st 2011, all doctors registered in Ireland are subject to the requirements of Part 11 of the Medical Practitioners Act 2007 which governs the reaccreditation of every registered medical practitioner as an individual.

The ICGP through its professional competence scheme supports doctors working in general practice/primary care to meet these requirements.

At a strategic level the Head of Quality & Standards has a role in the promotion of general practice and contributes to health policy through interaction with external agencies including – The Minister for Health, the Department of Health & Children, the Health Services Executive, the Health Information & Quality Authority, the Medical Council, the Forum of Postgraduate Training Bodies, the Irish Medical Organisation, the National Cancer Control Programme and Patient Representatives.

By *Dr. Andrée Rochfort*  
Director, Health in Practice Programme & Irish EQuIP delegate

## (2009), ICGP Health in Practice Programme - Promoting Healthy Practices

The ICGP set up the Health in Practice (HiP) programme in March 2000 as a system of health education, health information and to promote quality improvement in personal healthcare and occupational health for GPs in Ireland.

In May 2001, the programme launched its first publication "Managing Occupational Health and Safety in General Practice" which has since been updated into the 2nd Edition (2007) which is an online publication. Regular articles and reviews are published in Forum, the monthly journal of the ICGP.

In November 2001, the ICGP HiP launched its Healthcare Service for GPs and their families as a national programme provided by 150 health professionals. This service coordinates a confidential system of primary healthcare, psychological therapy, psychiatric assessment and occupational health advice.

This enables GPs and their families to have direct access to confidential formal healthcare in the same way that non medical patients do. Doctors on the specialist training programmes for general practice, and in the newly establishing GPs group (NEGS) may also access the service.

"Doctors Health Matters" is an established programme of educational activities (lectures, workshops, seminars) for GPs, specialist training programmes, medical students as delivered by the ICGP Health in Practice (HiP) programme. New topics are added annually and on request by discussion with the Director.

This education programme for doctors has developed links with the European Association of Quality in General Practice, **EQuIP**, which is a Wonca Europe network organisation, and also with the recently established European Association of Physician Health, **EAPH**. HiP upholds the ethical standards of the Medical Council in service delivery and education. For further information see [here](#).

## ICGP Partnership with Patients

This project was set up in 2009 as one of the core strategies of the ICGP and it is consistent with the patient-centred approach of our national health strategy. The projects 'Vision' is to enhance the College's awareness of the needs of patients and to foster a partnership between patients and the College.

This reflects the need to involve the knowledgeable patient in building a safer health system. Further details on the aims of this project can be read [here](#).

## The National General Practice Information Technology (GPIT) Project

The Irish College of General Practitioners and the Health Service Executive came together at the end of 2006 to restructure and reactivate the National General Practice Information Technology (GPIT) Group. There are two parts to the group, an educational section headed with 10 GPIT facilitators around the country, and a projects section.

Each of the two sections have a project manager. GPIT provides practice based support, training and advice to GPs with Information Communication Technology issues. It is also involved with certification of GP Practice Software Management Systems, developing electronic referral systems and promoting interoperability. More information [here](#).

## E-Learning Education for Quality

The ICGP E-learning Unit goes from strength to strength in providing education for GPs in order to keep up to date with current standards of patient care, with developing particular interests and services in their practices and with supporting GPs throughout their professional career. Further information from [www.icgp.ie/go/courses/e\\_learning](http://www.icgp.ie/go/courses/e_learning).

By *Dr. Andrée Rochfort*  
Director, Health in Practice Programme  
& Irish EQuIP delegate

## National Reports (2006-2009): Israel



**In Israel they had a difficult time during the bombardment during the summer. They produced 50 national indicators all over several clinical fields, mainly chronic diseases. There are many cross-cultural differences in risk profile of the patients in Israel. A quality programme on mental health was introduced.**

(30th Assembly Meeting, Barcelona, 23-24 November 2006)

**In Israel they showed the quality indicator system which has now 50 quality indicators nation wide and the data include the whole Israeli population. The data shows that the access to care the process of care and the outcomes of care is similar for the low socioeconomic stratum of society as for the rich. This was shown in primary prevention of cardiovascular diseases, cholesterol check up and control.**

(31st Assembly Meeting, Prague, 26-28 April 2007)

**In Israel they set several indicators, there is not any penalty for not reaching the targets. They are drawing a list of quality indicators in geriatrics. They established a service for doctors' health.**

(33rd Assembly Meeting, Bergen, 22-24 May 2008)

**In Israel due to high computerisation of GP the doctors are heavily scrutinised for their activities. The pop up menus warn doctors which quality indicators for reaching the targets. You have to answer to the questions why you have not fulfilled the proposed measures or you have to take actions. Monitoring of prescribing is very important issue.**

(34th Assembly Meeting, Bucharest, 7-9 November 2008)

**Gordon Littman, Israel presented development on quality indicators. He was critical about the indicators which do not have EBM ground. The indicators at the moment do not have financial consequences, they are merely used to compare competing health care founds.**

(36th Assembly Meeting, Bled, 5-9 November 2009)



(c) Thanks to Jonathan Orrelle and Ronen Brand.

# Quality Improvement: Psychosocial indicators



I have been the representative of the Israel Association of Family Physicians to EQuIP since 2007 and have had the privilege to meet and work with many outstanding physicians from all over Europe. My recollection of EQuIP relates to the subject of quality indicators.

When I first joined EQuIP, quality indicators were beginning to play an important part in our everyday lives as family doctors, but many doctors felt that they interfered with the interaction between them and their patients on a daily basis and did not truly measure the "quality" of the work family doctors do.

Why did (and even today, do) many doctors feel a degree of antagonism towards the quality indicators? The main reason seemed to be that most of the indicators measure only the "bio" part of the consultation while we work with our patients using a bio-psycho- social approach, as described by Engel in his paper "The clinical application of the biopsychosocial model" that was published in the American Journal of Psychiatry in 1980.

With this idea in mind, together with two colleagues from EQuIP, Adrian Rohrbasser from Switzerland and Kees in't Veld from the Netherlands, I arranged a workshop on quality indicators at the WONCA conference in Malaga in 2010 as a presentation on behalf of EQuIP.

The goal of the workshop was to request the participants to take the part of management, family doctors and patients and to recommend indicators that each sector might introduce as a way of measuring the psychosocial part of the consultation. The workshop did not consider the method that would need to be employed in order to measure the specific indicators.

40 doctors participated in the workshop and the indicators that were recommended are listed below, according to the three sectors. Those that are in italics are indicators that the three sectors agreed upon.

GROUPING	PATIENT	DOCTOR	MANAGEMENT
<i>Structure</i>	Structure of the practice	Doctor's surroundings / structure of the practice / staff	Co-workers / teams
<i>Process</i>	Access to the practice / telephone access / ease of obtaining appointments	"Process" indicators	
<i>Structure of the consultation</i>	Privacy	Respect	Privacy (data protection laws)
	"Enough time" for the patient	Length of the consultation	Length of the consultation
<i>Communication skills</i>	Continuity of care	Continuity of care	Continuity of care
	Communication skills – "active listening"	Communication skills – expectations (ideas, concerns, expectations)	Communication skills
	Ability to solve conflicts	Level of agreement	
	Patient centred (not guidelines centred)		
<i>Enablement</i>	Empathy	Empathy	
	Trust	Trust	
	Patient enablement	Patient enablement	Patient enablement
<i>Quality of life</i>	Quality of life	Quality of life (? also of the doctor)	Quality of life
		360 degree assessment	
<i>Outcome</i>	Outcome		Prescriptions – antidepressants, overall prescribing / measurement of a number of "soft" diagnosis
<i>CME</i>	Medical competence	Education / CME	Education / CME
<i>Tools</i>			Structured interview forms



At the conclusion of the workshop there was broad agreement among the participants that the main problem with this list of psychosocial indicators is that they are not easy to measure. The "bio" indicators are easily measured by the computer: By pressing one key, one can obtain measurements of HbA1C or blood pressure in a practice very easily, very quickly and extremely cheaply.

The measurement of psychosocial indicators requires thought regarding the best method for the measurement, time, and expense. We all knew that it would not be easy to integrate them into our everyday working environment but today, there are health organizations that already measure some of them.

In conclusion, if these psychosocial indicators could be added to the "bio" indicators that are already widely used, together, they may represent a more accurate assessment of our work as family doctors.

*Gordon Littman*  
 Israel Association of Family Physicians  
 EQuIP delegate



## National Reports (2006-2009): Italy



*In Italy there is a big variety of regional organisation of health care system. The GPs have to cover their services over the whole day from 8 a.m. to 7 p.m. in order to diminish pressure to hospital emergency departments.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Italy there is a new policy to promote a further development of primary care units with the aim of increasing accessibility to the practices (in Emilia Romagna the Regional Agreement established a minimum of 7 hours opening per day, 5 days a week). In Emilia Romagna the SOLE project was started, i.e. GPs on line network. It will be used for the exchange, by internet, direct information on patients between GPs and Local Health Units (hospitals, specialists and secondary care level booking services) and among GPs. Health Authorities, at local and regional levels, regularly monitor the prescribing habits of GPs.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Italy there is a tendency to connect single independent practices in networks. There are some ongoing projects: Oral anticoagulant treatment, diabetes 2 management, cardiovascular risk assessment. In 56 million population there are 50,000 GPs, 8,000 general paediatricians and 18,000 deputy doctors running on call and night services. Due to small proportion of generic medicine prescribed by GPs, there are several strategies to promote prescription of cheaper drugs.*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

*Gianluigi Passerini, Italy – Ministry of Health a month ago declared to establish University GP Departments. Diversity of the developments in health care organisation. Specialist training is well on the way, but it has still a long run to go.*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*



(c) Thanks to Jacopo Demurtas and Stefano Celotto.

# Quality Improvement (2008): Italy



In Italy (56 million population) we are about ( free contractors with the N.H.S.):

- 50,000 GPs
- 8,000 General Pediatricians
- 18,000 doctors working in the national Deputising Service ( on call overnigh and on Sundays).

So far we haven't any possibility of University based career nor half time job.

The evolution of the Italian GE, in the N.H.S is towards a more aggregated way of delivering care. This is what new GP's contracts aim at, to limit the access to hospitals, facing themselves with problems of resources' limitation. The problem of GP is actually different in large/ medium size cities, compared to small ones/ villages, where many GPs still work single- handed.

## Different options are offered

- Net Practice: single- handed GPs operating in different surgeries, but in internet connection with others, so that they can enter other GP patients' computerized clinical records while patients can consult a GP, other then theirs, in out of consultation hours of their GP.
- Group Practice: as above, but practicing in the same surgery and with Staff.
- Primary Care Centres: open at least 8 hours per day, involving more GPs with staff (Secretaries and Nurses), with availability of first level instrumental tests ( ecg, spirometry, audiometry etc).
- Territorial Unit of Primary Care: open 24 hours a day, including staff ( Secretaries and Nurses), firs level Pathology Lab and Ultrasound Services, as well as Specialists directly working in between the same TUPC.

At the moment PCC and TUPC are only very few and experimental.

With the aim of reducing the burden of First Aid& Casualty Hospital Depts, currently overloaded of work, and mainly used and forced to increase the number of admittances, some proposals have been set in the Agenda of the next Contract for GPs.

The main one deals with the possibility of returning ( it was abolished in 1980) to the system in which out of hours ( night-time and Sundays) calls be dealt with by GPs in the near future.

## Others proposals

- Creating a closer continuity ( by Internet connection) between GPs and Doctors working in the N.H.S. Deputising Service.
- Involving GPs in First Aid& Casualty Hospital Depts ( to treat lower risk cases after triage). (In larger cities) Creating GP Centres, where GPs ( on a rota system) could operate 24 hours per day, including Sundays, on a free access system.
- Some experiences could start in 2009 ( in the New Contract). Only GPs in First Aid& Casualty Hospital Depts have already been experienced, with positive results, in a few little areas ( the first ones in the Piemonte Region).

On the national level the organization and running of GPs depends more and more by Regions than from the Central Government, so different policies are applied in different Regions.

## Some ongoing projects

In some Regions agreements have been signed among Local Health Authorities, Regions and GPs' trade Unions to involve GPs in care programs. The philosophy is that, if GPs help limiting overall expenses in some specific field, a part of saved money is redirected to them.

OAT (Chronic Oral Anticoagulant Treatment):

- In Italy OAT is still mainly carried out in Hospitals, in the so called Anti Coagulation Centres, mainly located in Clinical Pathology&Laboratory Departments.
- In the Emilia Romagna Region an agreement has been signed between the Region and GPs.

Each GP ( the participation is not compulsory) can accept to follow up Chronic OAT ( quick strip aouthomatized system). The agreement consists of:

- Preliminary Teaching Course ( one full day)
- Yearly periodic re-evaluation of results ( days in range) and refresher course
- Payment of € 214/ pt/ year ( plus strips supplied by the region) Provided that the whole project reaches the aim of reducing overall expense ( including indirect expenses depending on the intervention of Hospital based Anti coagulation Centres ( very frequent in Italy) from € 4 to 1 million/ year.

During the first 6 months an evaluation has been done on the percentage of days in range, comparing Anti Coagulation Centres vs Participating GPs. The result is: 57% for the former and 61% for the latter.

## Diabetic Care ( type 2) Integrated Management

Diabetic Care is carried out in very different ways in Italy: in some Regions it's totally carried out in Hospitals, where as in others it's shared between GPs and Hospital Diabetologic Centres. In some Regions ( Lombardia, Campania, Emilia- Romagna, Marche) projects ( with free possible participation) of Integrated Care of Diabetes have been carried out.

The agreement consists of ( with differences either in protocols and tasks or in payments and payments):

- Preliminary Teaching Course
- Yearly periodic re-evaluation of results ( quality indicators, mainly HbA1c and BP, but with differences)
- Yearly ( or biennial) overall re- evaluation by Hospital based Diabetologic Centres, for heart/ kidney/ eye/ etc supervision and instrumental tests, where/ if required
- Payment of € 200-250/ pt/ year. Global c-v Risk Measuring with High Risk People Detection and Intervention Programs

In some areas ( different places in various Regions) GPs have been involved in filling in data- bases with the aim to detect high risk patients.

In a second phase these have been followed to help reducing their global risk ( giving up smoking or reducing weight or treating BP or DM etc).

## Quality and drug prescription in the Italian NHS

A strong effort has been made by Local health Authorities to force GPs to prescribe generic drugs ( it's not compulsory). The problem of quality has been advertised by The Ministry of Health, stating that generic means equivalent.

Official figures declare that 12-17% of all prescribed drugs are generic. The main reason for the shift to them has been a matter of prices.

During a first phase drug companies didn't lower the price of the branded drug, so patients had to pay the difference ( sometimes € 5-10 or more per box) between it and that of the generic. For this reason the some patients asked GPs to prescribe generics.

In a second phase drug companies lowered prices, at most just a little ( usually less than € 1), of branded drugs. This balanced the shifting to generics.

By G. Passerini & A. Campanini,  
Italian EQUIP delegates



# Quality Improvement (2009): The Netherlands



General Practice in the Netherlands (16 million inhabitants) holds a strong position in the health care system. The 8.500 GPs in the Netherlands, working in 4.500 practices, have listed patients and are goalkeepers for hospital based, specialised care.

- More and more female colleagues are joining GP-practices
- The number of single-handed practices is steeply decreasing. The most recent figure (2008): 20%

From 2006 onwards a new insurance system with a key role for Health Care Insurers is effective. A more market-oriented health care approach is meant to improve quality and that for a better price:

- Health insurance is mandatory for everyone
- Insurance companies 'purchase' care
- Transparency on performance indicators will enable patients to make their choice

## Results

The system changed less than some expected, for better or for worse. Purchasing care proves to be difficult, indicators are not that easy to denominate.

The Netherlands College of GPs (NHG) tries to improve the quality of primary care by formulating guidelines, preparing methods and materials for continuing professional development ('life-long learning') and by endorsing practice visits (NHG-Practice Accreditation).

Cost containment: some medication is no longer insured, e.g. benzodiazepins, oral contraceptives, paracetamol, while in other cases just the generic drugs are refunded, e.g. statins: simvastatine, pravastatine, PPI's: omeprazol.

There are initiatives to refund chronic care (Diabetes, Asthma/COPD, Depressive disorder, Heartfailure) as a Diagnosis-Treatment combination, so for every patient with diabetes the health care provider gets in a fixed amount, regardless the provider of care. Fragmentation of care could be the result of this approach. Both College and Association strongly endorse a generalistic approach from General Practice.

P4P might be a new way of remunerating professionals depending of the level of their care provided.

The first preliminary results of an experiments show an improvement of the quality of care, but there are also reports from other countries where ticking the boxes proves to be the way of performing.

## Patient safety

A new way of looking towards Quality: Safety is an aspect of Quality! Government efforts are put into making a Safety Management System obligatory for each Health Care Institution, for each practice delivering Primary Care.

'Safe' reporting of incidents and accidents is promoted, although there is a tendency towards listing bad performers on the internet and increase the severity of punishment, which is not a very safe environment to experiment!

## Indicators

The Netherlands College and Association of GPs co-operated in the preparation of a set of indicators for Primary Care to be tested (feasibility) in the Autumn of 2009.

## Practice assessment

The Practice Assessment Programme (NPA) is slowly gaining ground amongst the professionals. More than 2000 of the 8500 GPs are participating in the scheme, over a 1000 GPs are accredited.

The GP teaching practices will be enrolled. That gives thrilling expectations for the improvement of General Practice!

The improvement plans of practices enrolled in the NPA cover a wide range of subjects.

## Practice management

Looking at practice management the top three consists of introducing Protocols in daily practice, for instance on improving hygiene in the practice, Improving the accessibility of the practice by telephone and the institution of structured practice meetings. But the top three only makes up for 34 % of the plans.

In the medical domain the top three is for nearly 80% directed towards improving the care for the chronically ill.

By C.A. (Kees) in 't Veld,  
Dutch-EQUIP delegate







## National Reports (2005-2008): Norway



*There is a lot of stress in Norway. They have the biggest per capita health care expenditure, long waiting list, high hospital costs. They lack representation of GP in the negotiations and as a partner in politics and decision. The patient in GP can wait between one day and two weeks.*

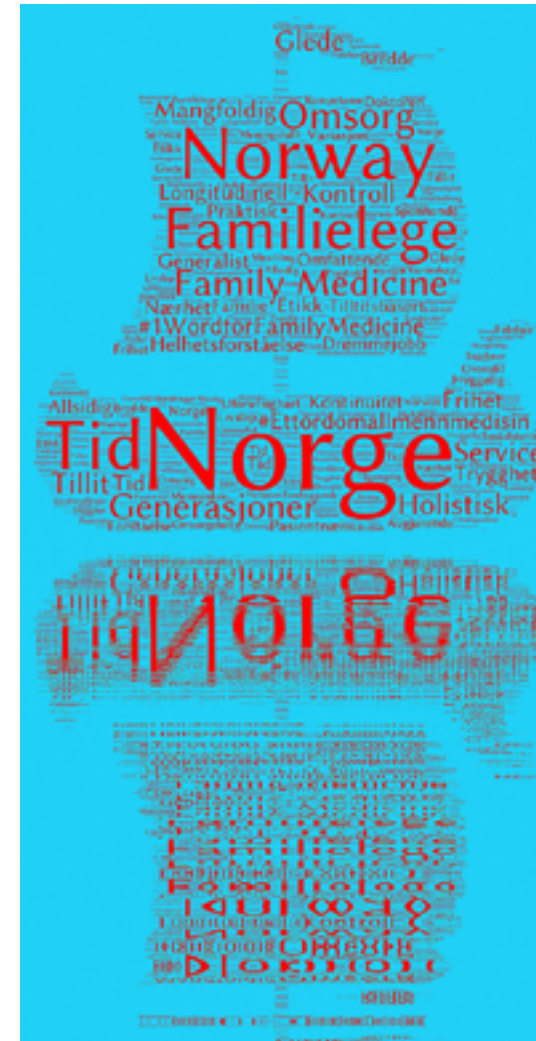
*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Norway they use a list system. The population is less satisfied with the accessibility in spite of better in practice accessibility. They succeeded to diminish night calls. They introduced an electronic textbook of medicine for daily practice.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Norway they are facing inverse health care system organisation with a rapid development of secondary health care and stagnation in number of GPs and reimbursement of primary care services.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*



(c) Thanks to Elisabeth Stura.

# Quality Improvement: Norway



## (2008) Players on the quality scene

In Norway, local and regional authorities are absent players on the quality scene in primary care. The Norwegian Medical Association (NMA) has been the most active agent in stimulating Quality Development (QD).

They have organized and funded separate and large national quality projects, and they have made a framework where it is easy to integrate quality development with Continuing Medical Education (CME). This is largely due to the Norwegian rule of recertification as specialist in General Practice every five years based on specified CME activities.

Because of this, funding is allocated: Approximately €4.9 million is spent every year by NMA; this corresponds to approximately €1.330 per General Practitioner.

National strategies for Quality Development have mainly concentrated on specialist services, and a set of national quality indicators have been constructed and must be published by the hospitals.

However, the exclusive focus on specialist services is changing with the new quality strategy that is being developed. Data from electronic patient records will be extracted in a national project - SEDA - for the purpose of developing a database for primary care. In Norway, more than 90% of doctor's use electronic patient records.

The database can be used as reference data for quality development activities, and for research, development and governing purposes. The new strategy also establishes that user input is compulsory in QD, and every doctor's office must be able to document that they collect and use such input in the future.

## Quality development seen from the doctor's office

Although there are many "carrots" and opportunities for doing QD in the NMA framework, you really did not have to do it up till now as an individual doctor. But the "sticks" are moving closer. The authorities use systematic revision visits, focusing on professional quality and patient safety, and the local newspapers have access to the reports.

The primary care quality committee (KUP) is developing tools to stimulate and help doctors in QD work: a **quality web site**, quality programs that run you through risk assessments, quality processes and produce your quality handbook (TRINNVIS), and a quality indicator project to establish useful quality indicators for QD in primary care.

A sensible combination of sticks and carrots might move QD forward in Norway, and infuse primary care with enthusiasm for this way of working and for improving the services we offer our patients.

## (2006) New National Strategy for QI

A new National Strategy for Quality Improvement is being developed these days. It is hoped that this strategy will make it possible for people to get down to working with the areas for improvement that they experience in their everyday life.

In the strategy we combine research, evidence-based practice and quality improvement work, in order to make a more comprehensive effort for high quality and predictable services possible.

The strategy has been developed in cooperation with professional groups and authorities that represent main ideas and choices of direction. Plans of action will be developed for each target area that is presented in the strategy. These plans will also be developed in cooperation with the services.

## The Norwegian RGP Reform

In June 2001 Norway reformed its primary health services and introduced the Regular General Practitioner (RGP) scheme. It is a contractual system based on listing and capitation.

In Norway the municipalities (the lowest level of government) have responsibility for the general practitioners (GPs). Most GPs are self-employed on a fee-for-service basis. The fees are partly paid by the patients themselves, partly by the National Insurance Scheme.

In addition, the GPs receive a contribution from the municipality. This used to be a practice allowance depending on the number of auxiliaries, but with the RGP Reform it was replaced by a capitation component depending on the number of inhabitants on the RGP's list.

Approximately 30 % of the income is expected to come from capitation and 70 % from fee-for-service. A few GPs, mostly in rural districts, are municipal employees on a fixed salary. Most GPs work together in small group practices.

The RGP Scheme is continually evaluated through administrative data delivered to the Ministry by the National Insurance Administration and Statistics Norway. In addition, The Research Council of Norway was given the task of organising a scientific evaluation, covering a period of five years ending in 2005.

This scientific evaluation was not targeted towards medical management of individual patients, but concentrated on four main service areas that were designated for this evaluation:

- Coverage of doctors
- Accessibility
- Continuity
- Effectiveness

The Research Council invited scientists to submit project applications, and a total of 15 large-scale and 15 smallscale projects received funding. Large-scale projects were mostly conducted by academics working in university departments or independent research organisations.

Small-scale projects were mostly conducted by nonacademic GPs who received scholarships for 1 - 3 months, under the guidance of university departments of general practice.

## Conclusion

Parallel with the RGP Reform the coverage of doctors improved considerably, and the stability among RGPs is high. However, there are still problems with doctor shortage in some remote and rural areas.

In addition, some local authorities have hesitated to apply for new practice licenses, and as a consequence the inhabitants have no real option to change RGP. Although the reform prepared the ground for a strengthening of public medical work, this has not happened so far.

Accessibility has improved, but patients are less satisfied with waiting times and telephone accessibility than with most other aspects of the RGP Scheme. There is no indication that accessibility is dependent on list size, but RGPs who experience patient shortage seem to have better accessibility and time for their patients.

Most patients are very satisfied with the personal relationship they have with their RGP. Doctors are humble to have been chosen by their patients, and they may have become more service-minded. But they also feel that the patients have been empowered by the reform and are more demanding.

Both doctors and patients value continuity, and this was the most important consideration when the inhabitants made their choice of RGP. They wanted to keep a GP they already knew. In 2005 98.5 % of the population have been assigned to an RGP, and there are indications that continuity has improved, especially in rural areas.

However, for many doctors and patients with established relationships, the reform did not make any significant difference. Approximately 2.5 % of the population change RGP every quarter, but less than half of the changes are due to dissatisfaction.

There are indications that the gatekeeper role has been weakened by the RGP Scheme, and an increasing number of patients are referred for secondary care. The most important reason for this, however, is probably increased availability of specialist services. Both RGPs and their partners in primary and secondary care appreciate that the responsibility for patients has been clearly defined.

However, there is a potential for improving co-operation between RGPs and others. Local authorities are generally satisfied with the service provided. They have low ambitions for controlling the RGPs and have few other means of governing than dialogue and collaboration.

By *Janecke Thesen*,  
Norwegian EQUIP delegate

# Quality Improvement (2011): Norway



## **"The coordination reform" - TCR - in Norwegian healthcare**

In Norway, the authorities have been working for several years with "The coordination reform" - TCR. It is supposed to build on General Practice (GP) as a foundation for health care services, and it will be implemented from 01.01.12.

We really hope that TCR will be an effective and sensible follow-up by the Norwegian authorities of a mounting research evidence, based mainly on studies by the late Barbara Starfield, that the health services of the world should be based on GP as the foundation.

But we lack indications of this in real world Norwegian politics. We have not received any indications that the authorities will increase the number of GP's for instance, or try to resolve the problem that we are an ageing profession who will decrease in numbers if some central actions are not taken.

We fear that these are mostly rhetorical exercises, strengthening the economic focus, the power of bureaucrats and the specialist services. We also fear age discrimination of patients.

Quality is a central concept in the reform, but to this date, less than a month from the implementation date of the TCR, the law regulations of quality have still not been revealed by the authorities.

I will not be surprised if other EQuIP members have similar experiences.

Partly as a result of long time work with quality in GP, and partly as a response to the TCR, Norwegian GP's in close collaboration with the Norwegian Medical Association have been working on developing and establishing SAK (Centre for quality in general practice and family medicine).

The aim of SAK is to establish an organisation, most likely a legal and financially independent unit, which should support quality work in Norwegian GP practises. Quality work should be an integrated part of the medical activity in every GP practise. The following issues are important elements in the work of the quality centre SAK:

### **Support quality work done locally**

- Develop quality tools
- Educate quality facilitators
- Contribute to the development of EPR (electronic patient records) as a flexible tool that will improve GP work flow, communicate well with other EPR's in the health service, and deliver dependable data for both local quality work and Regional and National quality indicators
- Strengthen the role of and support practise consultants/ Coordinators working to improve collaboration between hospitals and GP's
- Work on strengthening the leadership of GP's - both in the local practises, and in the local municipalities

There are different models for how to organise quality systems for general practise. A top down model can be based on sets of quality indicators with or without a pay for performance system. A bottom up model can consist of locally initiated quality projects, for instance learning networks of GP surgeries supervised by GPs specially trained in quality work and supported by a national or regional board.

Norwegian GP's hope for a fruitful combination of bottom-up and top-down approaches in the TCR, in order to make reflective General Practise survive.

By *Janecke Thesen*,  
Norwegian EQuIP delegate

# Interview with Elisabeth Stura (Norway)



## Interview with

Elisabeth Stura,  
MD, GP Trainee (ES),  
VdGM representative  
Norway

### What is the first thing that comes to your mind, when you think of EQuIP?

ES: Quality

### What was your first EQuIP experience?

ES: The EQuIP Summer School in 2014 held at Brogården in Denmark.

### What major achievements do you know EQuIP for?

ES: Developing tools like EuroPEP, Maturity Matrix and of course the Summer Schools.

### What is your best EQuIP experience?

ES: The Summer School in 2014 provided inspiring new knowledge and unforgettable memories with amazing people.

### How would you describe the current world of quality improvement and patient safety in primary care?

ES: I feel it becomes more and more relevant. It's high on the health political agenda, and many colleagues are opening their eyes to the importance of quality improvement to keep high standards in our field of work.

### How would you predict the future for quality improvement and patient safety in primary care?

ES: The future will be bright if we work together. It's important to not focus on patient safety in a way that makes patients feel unsafe and stop trusting their primary care provider. We are good today. We just want to become better tomorrow.





## National Reports (2005-2009): Poland



*Zbigniew and Tomasz gave a interesting and informative overview of Poland and the Polish health system. Capitation system with GPs as gatekeepers. Health care system in transition. Polish College of Family Doctors established 1992. 11 universities. Vocational training in Family medicine since 1994. Over 7,500 physicians with diploma in family medicine – need 20,000. In Krakow average list 1066, but up to 3,000 in rural areas in Poland.*

*(27th Assembly Meeting, Krakow, 15-17 April 2005)*

*Guideline on influenza is a most recent achievement. 8 guidelines developed on hypertension, asthma in adult and children, back pain, Helicobacter Pillory...*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Poland, College of FD guidelines development – hypertension, smoking cessation, diabetes mellitus, and influenza. They are in the process of accreditation of family practices. They introduced training for leaders in QI.*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

*Tomasz Tomasiak, Poland presented developments on accreditation process. National College will be able to purpose one member of the accreditation board. Refreshing training for tutors for peer review groups.*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*



(c) Thanks to Donata Kurpas.



# Quality Improvement: Poland



## **(April, 2011) Peer-review groups**

In 2009 a new project has been developed, aimed at activation of peer-review groups. The College of Family Physicians in Poland has designed the working programme for peer-review groups and found potential external sponsors for it.

The sponsors were recruited mainly from pharmaceutical companies. However, they had neither impact on programme contents or on actual performance. The sponsors gave the grants to the whole programme not to the particular interventions. All the groups were free to make their own choices and realize meetings according to their needs.

In 2009 – 2010 altogether 40 groups were started all over Poland with 331 doctors belonging to them. Again, physicians, the College and the sponsors positively evaluated the experience. Currently the efforts have been undertaken to continue the programme and to increase the number of groups and participating in their work physicians.

## **InGPinQI Project**

A new project "Innovative lifelong learning of European GP/FPh in Quality Improvement (QI) supported by information technology" (InGPinQI) granted by the Polish Leonardo da Vinci Agency started in the beginning of 2011.

The aim of the project to improve the existing training programs for both, general practitioners/family physicians (GP/FPh) and teachers in family medicine in the field of QI by implementing new innovative didactic tools and methods in existing educational systems (with support of IT).

6 Partners from 5 countries participate in this project, which will last till the end of 2012.

The most important project results will be:

- Internet tool to identify individual, educational needs of GPs in QI
- Guidebook containing guidelines on effective development and implementation of QI programmes
- Innovative VET program for GPs teachers
- Distance-learning module for GPs on QI
- New guidelines for the management of arterial hypertension and diabetes mellitus for Polish GPs
- Coverage of doctors
- Accessibility
- Continuity
- Effectiveness

## **(November, 2008) Quality Improvement Guidelines development**

College of Family Doctors (FD in Poland with association of other specialists' association):

- Hypertension
- Smoking cessation
- Diabetes mellitus
- Influenza

## **Accreditation of FD Practices**

- College of FD in Poland in cooperation with National Center of Quality Monitoring and Polish Chamber of Physician
- 17 practices accredited in 2008

## **School of Tutors**

- Training for leaders in quality assurance
- 27 alumni

## **Leonardo da Vinci Project**

- "Educational Tools for Quality Improvement across Europe"

## **Local level**

- Peer review groups
- CME Quality Assurance training in a few branches of the College of FD in Poland
- Assessment of GP competences in hypertension management – research project in Jagiellonian, Univ. in Krakow

## **Conclusions**

- There is no support of government and local authorities for quality activities in Poland
- Still educational activities (CME) are the most popular amongst GP
- Quality activities are interested only for people involved.

By *Tomasz Tomasik and Beata Modlińska*,  
Polish EQuIP delegates



# Quality Improvement (2011): Portugal



## Country profile

Portugal has approximately 10.6 million inhabitants, according to the census from 2011. The Portuguese population enjoys good health and an increasing life expectancy, though at lower levels than other western European countries. Through the National Health Service (NHS) established in 1979, all residents have access to health care.

The NHS is mainly financed through taxation, and it has a wide range of primary care centres and hospital care units, the last ones being mediated by a gatekeeping system. In the last decade, some measures have been implemented to increase the performance of the health system, such as public-private partnerships for new hospitals, pharmaceutical reforms, the reorganization of primary care and the creation of long-term care networks.

After the severe economic crisis that started in 2009, the NHS budget has been severely reduced and many services are expected to close or to be reorganized. The focus on rationing costs has been mainly on secondary care, on generic prescription and to implement guidelines that reduce the variability of clinical practice and to enhance the adoption of a more evidence based approach in the health system.

## Primary Health Care Reform

A reform in Portuguese Primary Care started in 2006, led by the Mission for the Reform of Primary Health Care. This taskforce was coordinated by Luis Pisco, the former Portuguese EQuIP delegate. In the 1970's, Portugal was one of the first European countries to create a vast network of health centres, at a number of approximately 350.

The startup phase of the Reform was dedicated to the creation of Family Health Units (FHU) that are "small multi-professional teams, formed voluntarily, self-organized, and composed by 3 to 8 family doctors, an equal number of family nurses and administrative professionals, encompassing a population between 4.000 and 14.000 people".

These primary care teams have technical, functional and organizational autonomy. They exist inside a health centre, that usually has two or three primary care teams (whether FHUs or Personalized Health Care Units).

The payment system in the FHUs is composed by salary, with capitation and also according to performance. These units tend to have good accessibility and continuity of care, in high proximity with the served community. They are assessed yearly according to several health indicators that are discussed and contractualized with a local contractualizing team.

The nation-wide implementation of electronic health record systems in the NHS since 2006 and the generalized use of ICPC2 to code health problems gives professionals and authorities a more thorough and realistic approach to the current health indicators in primary care. Although there is no national quality network that performs systematic analysis of the health indicators, there are Regional Support Teams for the FHU that accompany regularly (twice a year) the organizational development and motivation of these primary care teams. Each team usually defines their own strategy for quality improvement, according to the data extracted and their perceived needs.

Quality Improvement Strategy of the Ministry of Health  
The Department of Healthcare Quality (DQS) in the General Directorate of Health (DGS) is the governmental body which is responsible for the Quality Improvement National Strategy (2009), in primary and secondary care. However, they're main focus is primary care teams according to the fact that the electronic health record is fully adopted and more than 95% of the prescriptions are done electronically. The current action points of the DQS regarding primary care are:

- Clinical and organisational quality
- Patient safety
- Integrated disease management and innovation
- International mobility of patients
- Qualification in health
- Infections related to the provision of healthcare
- Violence against health professionals.

## Guideline development

The General Directorate of Health (DGS), in close cooperation with the Portuguese Medical Council, has been assigned by the Health Minister in August 2011 as the responsible organism to create guidelines and to develop a systematic assessment of their implementation in the Portuguese health system.

The Portuguese Association of General Practitioners signed an agreement to cooperate in the guideline development since its very start. Thirty guidelines have been produced until the third trimester of 2011, and another set is expected until the end of 2011. Portuguese GPs are involved in the guideline development and appraisal by using the AGREE (Appraisal of Guidelines Research and Evaluation) assessment tool, which is available [here](#). Guidelines are distributed electronically, free of charge and are available for [download](#) (in Portuguese).

## Accreditation of FHU

There is a voluntary accreditation process for FHU since 2009, but until now only 3 units have been accredited. It has been developed by the DQS from the DGS and it's based on the Agencia de Calidade Sanit ria de Andalucia (ACSA) model. The main accreditation areas are process, competence and clinical management.

The Accreditation Manual is divided in the following topics according to the 112 indicators:

- Patients: satisfaction, participation and rights (17)
- Accessibility and continuity of care (13)
- Clinical records (6)
- Processes of Care (5)
- Health promotion and chronic care programs (7)
- Practice management (11)
- Professionals, education and development (14)
- Structure, equipments and suppliers (11)
- Health information systems (9)
- Quality systems (12)
- Key results of the organization (7)

By *Alexandre Gouveia*  
Portuguese EQuIP delegate

# Interview with David Rodrigues (Portugal)



## Interview with David Rodrigues, (DR)

**What is the first thing that comes to your mind, when you think of EQuIP?**

*DR: I think about WONCA, quality and a friendly forum.*

**What was your first EQuIP experience?**

*DR: The conference in Fisingen, Switzerland last year on quality circles.*

**What major achievements do you know EQuIP for?**

*DR: The QUALICOOP project, reference in quality education.*

**What is your best EQuIP experience?**

*DR: Multicultural team work, dynamic discussions, and great ideas about quality in primary care.*

**How would you describe the current world of quality improvement and patient safety in primary care in your country and in Europe?**

*DR: In my country I think it's a hot topic right now. Our primary care system is based in small teams so quality improvement is getting a lot of attention. In Europe my main and young perspective tells me that it should an even "hotter" topic than it is today.*

**How would you predict the future for quality improvement and patient safety in primary care in your country and in Europe?**

*DR: In my country - as I mentioned - it is a very discussed issue nowadays. The future seems inspiring and it seems that both professionals and authorities want to develop and invest in these topics.*







## National Reports (2006-2009): Slovenia



**In Slovenia nationwide project on quality assessment of hypertension management was finished showing a great variation in practice.**

(30th Assembly Meeting, Barcelona, 23-24 November 2006)

**In Slovenia independent national agency for quality development, introduction of quality systems in health care settings. Under new legislation for health care management surveys of patient and staff satisfaction became regular yearly procedure in the majority of health care organisations.**

(31st Assembly Meeting, Prague, 26-28 April 2007)

**In Slovenia they produced a manual for the doctors and patients on diagnostic procedures.**

(33rd Assembly Meeting, Bergen, 22-24 May 2008)

**In Slovenia guideline on diminishing burden of diabetes mellitus is under development, which will involve lay public and several society structures to improve lifestyle of the population in order to postpone the onset or to avoid diabetes at all.**

(34th Assembly Meeting, Bucharest, 7-9 November 2008)

**Marija Petek Ster, Slovenia presented the project on CVD prevention programme.**

(36th Assembly Meeting, Bled, 5-9 November 2009)



(c) Thanks to Barbara Ifko.

# Quality Improvement (2006, 2010): Slovenia



## (2010) Strategy of quality and safety in primary care

### Aims

- To summarize the existing state of primary health care quality in Slovenia and offer the proposals for the improvement
- To implement the system for quality monitoring on local and national level
- To promote quality improvement projects in primary health care
- To facilitate knowledge transfer by education and guidelines
- To assure basic working conditions

### Obstacles

- Shortage of doctors in primary health care
- Inappropriate decision making on programmes
- Inappropriate system of financing
- Inapplicable management

### Proposals

- Development of systematic management of quality and safety
- Encouragement of projects on quality on the level of health care providers
- Establishment of quality and safety education system
- Development of approach for the improvement of health care
- Establishing the preconditions for development of a quality system

## Action plan of diabetes control in primary care

### Aims

- To identify individuals with great risk for the development of DM
- Structured management of individuals with great risk for DM type II and follow-up
- Early detection of pre-DM and DM type II
- To provide conditions for the successful management of the patient with DM at primary health care level
- Research and development
- Quality monitoring

## Action plan of diabetes control in primary care

The course in 2010 was dedicated to learning and teaching about the impact of new information technologies in medical education in general practice/family medicine. The course is aimed at educators in primary care who are involved in teaching at the university or practice level. We expect experienced teachers and also those on the beginning of their educational careers.

### Aims of the course

- To know the new forms of information technology (IT) used in teaching family medicine
- To understand the roles that these new methods play in education and practice
- To know how to use some of these methods in teaching
- To value the use of new technologies in education
- To appreciate the limits of the use of these tools and their appropriate use in education
- In September 2011, the course will be again held in Bled, Slovenia.
- The topic will be teaching and learning about professionalism general practice/family medicine.

By Zalika Klemenc-Ketis,  
Slovenian EQuIP delegate

## (2006) Quality Improvement

Quality developments in Slovene family practice Slovenia is a small country with population close to 2 million. Slovene family medicine society as part of Medical association is responsible for the CME and quality developments in family practice.

### Guidelines

Slovene family medicine society will finally launch translated and adopted Finish EB guidelines in June this year.

### National indicators project on management of hypertension

Web based data gathering process on core indicators on management of hypertension based on English protocol: three measurements before the initiation of drug treatment, starting value, disease register, regular of check-ups, mean value of the last three measurements, referral in the case of difficulties in reaching target values. Each participant receives feedback with own results tabulated to the rest of participants.

### Practice evaluation – Visotool

Slovene family medicine society is a member of TOPAS collaboration. We decided to use Visotool as a web tool in future practice evaluations in FP.

### Teaching QA

One module (i.e. 2 days and 3 week exercise) in vocational training curricula for FP is dedicated to QA. Students have one session on QA during their FP curricula.

## Community orientation in FP

Bled course in 2006 (September 19-23) is dedicated to Community orientation in FP. The meeting is aiming at the educators in primary care who are involved in teaching at university or practice level.

The aim of the course is to work on a fifth core competence of a FP/GP as adopted by EURACT Educational agenda, which encompasses the ability to reconcile the health needs of individual patients and the health needs of the community in which they work in balance with available resources.

TO KNOW the methods for needs assessment of the individual patients and the community and the resources of the community.

TO UNDERSTAND the balance between the needs of the patients and the community and resources available.

### TO KNOW HOW

- To assess the patients' social and existential needs
- To assess the community health care needs
- To relate information on social services and structures to the patient
- To communicate with social services and structures outside health care system
- To keep records on collaboration with other services
- To use available evidence to make management decisions in community oriented care.

TO ACCEPT that community orientation is an important aspect of FP/GP care and the limitation of the available resources in designing community programmes.

TO APPRECIATE the coexistence and support of formal and informal support from the community in managing patients' social and existential problems.

TO VALUE the role of broader teamwork in managing the patients' social problems and TO VALUE reflection in the community oriented work.

### Patient satisfaction

We developed and validated patient evaluation forms for nursery home patients, emergency room patients and for the emergency services patients.

# Quality Improvement (2011): Slovenia



In 2011, the pilot project entitled "Model family practices" started in Slovenia under the umbrella of Slovenian Ministry of Health. This is a new model of working in chosen health-care centres' units. The project is available at <http://www.referencna-ambulanta.si/>.

## Definition

Model family practices are the existing family practices in which family physicians are already working and are assessed for high quality based on some quality indicators. Their management of patients is based on practice guidelines. Their key features are:

- protocols for managing patients with chronic diseases
- making registers of patients with chronic disease,
- implementing prevention programmes,
- achieving standards of quality based on quality indicators,
- implementing skills on managing family practice patients.

The innovative approach introduced by model family practices is the involvement of nurse practitioner in management of patients with chronic disease.

## Aims

The main aim of this pilot project is to develop a model which will define the primary healthcare centre family practices in future based on:

- Contents of work (protocols for management of patients with chronic diseases, making registers of such patients)
- Organisation of work (distribution of activities and competences, integrated healthcare)
- Staff strategies (working teams with proper competencies' distribution inside teams),
- Financial model (we have to suggest a change of financing, which should be higher when someone is doing more work (higher number of defined population) and has higher quality indicators).

## Other aims are:

- Providing healthcare for defined population of a single family physician,
- Assessing the needs of defined population for health services according to sex, age, the presence of predefined diseases, risk factors for chronic diseases,
- Less complaints from patients,
- Uniform distribution of workload,
- Planned management of patients,
- Reducing the frequency of patients' visits,
- Equal access to healthcare,
- Higher patient satisfaction,
- Higher satisfaction of healthcare providers.

## Organization

### Working team

1 FTE family physician, ½ FTE nurse practitioner and one nurse with secondary school

### Roles of nurse practitioners:

- Management of stable patients with chronic diseases,
- Team work,
- Preventive actions.

### Registers:

- Healthy people without risk factors,
- Healthy people with cardiovascular and other risk factors,
- Patients with common chronic diseases.

### Organisation of work:

- Active management of family practices' defined population.

### Motivation, leading:

- Promotion of professionalism, ethical principles, common goals.

### Work quality control

- Making standards and monitoring of quality indicators,
- Benchmarking of patient management with defined standards of care
- Developing suggestions for improvements.

## Vision

- Achieving 90% optimal values of quality indicators until 2015.
- Approximately 20% more patients with arterial hypertension, asthma, COPD and diabetes mellitus type II will achieve target values when compared to the existing family practices.
- Better screening of healthy population (each year 10% more newly discovered people with risk factors).

*Zalika Klemenc Ketis*





**Interview with**

Zalika Klemenc Ketiš,  
MD, GP, PhD (ZK)

**What is the first thing that comes to your mind, when you think of EQuIP?**

*ZK: Quality in Family Medicine.*

**What was your first EQuIP experience?**

*ZK: I attended the meeting in Bled, Slovenia, in 2009. It was a very positive experience.*

**What major achievements do you know EQuIP for?**

*ZK: Different projects, such as EUROPEP, Maturity Matrix, inGPinQI (EU funded Leonardo da Vinci project).*

**What is your best EQuIP experience?**

*ZK: Meeting people from different countries interested in quality and safety.*

**How would you describe the current world of quality improvement and patient safety in primary care?**

*ZK: In Slovenia, there is an increased awareness of the importance of this subject at primary care level. I was invited by the Ministry of Health to develop quality indicators. Also, a project on quality improvement for family medicine practices is currently running.*

**How would you predict the future for quality improvement and patient safety in primary care?**

*ZK: I think and hope that it will become a standard part of working in family practice.*



## National Reports (2006-2009): Spain



*In Spain there are 17 different health care systems, 47 Million citizens, each year the population is growing by 0.5 million. Immigrants are mainly coming from Morocco, Ecuador, Romania and Peru. Nearly 99% of services are free access. 7.6% GDP invested in health. Health system is financed directly by indirect taxes. Family doctors are gate-keepers from 1979 when the speciality was introduced in the health system. There is 4 years postgraduate vocational training in family medicine. Multidisciplinary teams are working in primary health centres. Employees are salaried. Patient satisfaction, accessibility, prescription rates, sustainability of the planned budget are included in the payment system. Each practice has to perform at least one quality project per year. They use integrated electronic medical record for the region. Data can be accessed by any professional not only by attending physician. There levels of access to data stored. They use virtual forums to discuss the performance. Family physicians have to work under objective budget constraints and under restrictive political power. Managers of the health care organisations are under pressure of these. Family practices keep practice lists and patients have to wait from 2 days to up to 6 weeks to see a family physician.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Spain the gate keeping system in Catalan, Spain is very much accepted as a form of interaction between doctor and patient. In Catalan they created a virtual forum for the discussions between professional, patients, regulatory bodies and payers. Clinical records are on line. Indicators can be monitored permanently. They include case management elements in the health care system. GPs are coordinators of case management supported by IT.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Spain they produced a virtual practice environment where they can contact doctors and consult. They are producing quality indicators for the primary care teams. The nurses develop towards physician assistants.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*In Spain they use gate-keeping system. Health care system is decentralised on country level. Patient empowerment is encouraged. Each of 17 regional governments can develop their organisation of health services in their own way. In Catalonia disease management was introduced. Several projects are in place: CHF, diabetes, COPD, depression, fibromyalgia, early cancer detection pathways... IT with unique electronic clinical record enables web based shared system for primary care and hospitals. Pay for performance system has been introduced. Specialist training takes 4 years.*

*(34th Assembly Meeting, Bucharest, 7-9 November 2008)*

*Toni Dedeu, Spain presented National Health System Model in Spain. Doctors are salaried. There are several developments going on. Vertically integrated brought compatible software between PC and hospitals. QA initiatives – accountability through quality indicators, pay for performance initiatives. 25 % of income from Budget Management and 75 % Quality of Care. They introduced fast pathways for some severe diseases.*

*(36th Assembly Meeting, Bled, 5-9 November 2009)*



*(c) Thanks to Anna Maria Pedro, Juan Maria Rodma, OSATZAN group and Victor Quesada.*

# National Reports (2006-2010): Sweden



*Sweden had elections recently, privatisation on the way in group practices.*

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

*In Sweden the government changed to a conservative alliance, 4 parties. They have announced an intention to privatise GP-practices during the next 4 years. We already have 35% private practices, and the goal is is not set yet, but it will differ in the separate counties. The government is convinced that private practices are more efficient, have greater control of the quality of care, and a greater access. Today 75% of the revenue will consist of capitation and the rest out of different fee for service items. There will be a movement of a smaller capitation, and larger fee for service, in a hope to incentivise access.*

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

*In Sweden counties are paying for health care and after election in 2006 wanted to make change in patients have to choose doctors. There is demand on reporting achievements regarding indicators.*

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

*Sven Engstrom, Sweden, described the reform to the free choice that was available in primary care. There is a shortage of GPs. Pay for Performance activities were inspired by QoF in Uk, for example being paid to measure Hba1c. Sweden thought they could measure quality. However, five indicators cannot indicate total quality. In recent years indicators have been introduced on telephone access to the practice, on access to the GP, on nurses activity. It has been described that measuring data is very good for improvement in quality in those areas measured but not good for assessment of quality generally. Many other factors are important influences on quality, like social factors and poverty, so that we must be very careful about how we interpret results because GP work is very complex.*

*(37th Assembly Meeting, London, 29 April-1 May 2010)*



# Quality Improvement (2014): Sweden



GPs in Sweden have undergone 5 years of specialisation after 5½ years of University studies + 18-21 months of internship. About 15-20% of all specialists are GPs. Three consultations with a specialist per inhabitant and year is average; half of these are with a GP. Consultations with GPs are, on average, 20 minutes.

In Swedish GPs often work at health care centres in close collaboration with district nurses and other health care personnel, however there are also a few single doctor practices. Most appointments with the PHCC are preceded by a telephone call to a nurse who decides whether to schedule the patient to see a GP, a nurse, or whether advice by telephone will be sufficient.

There are roughly 1200 health care centres (or GP practices in Sweden). Almost all primary health care is publicly financed through taxes. Around 40 % is privately produced and 60% publicly produced. The reimbursement systems differ between the 21 county councils (regions) in Sweden but in each region the reimbursement is by law the same for privately and publicly produced health care.

The most common system is reimbursement mainly in proportion to the number of patients linked to the health centre (capitation) and a smaller share related to visits and achieved quality goals. The capitation is often related to age, ACG and CNI of the listed patients. The patients are free to choose any health care centre and the patient fees are low and the same for privately and publicly produced primary care

Main organisations are:

- The Swedish Association of General Practice, **SFAM**, (the scientific organisation for GPs) (English summary [here](#)), part of the Swedish Society of Medicine, Svenska Läkaresällskapet, [www.SLS.se](http://www.SLS.se)
- The Swedish Union of GPs, **DLF** (the labour union for GPs), part of **Swedish Medical Association**

There is more information to be found under the following links:

- The Swedish Association of Local Authorities and Regions ([link](#))
- The National Board of Health and Welfare ([link](#))
- The Swedish Institute; Health care in Sweden ([link](#))

By *Eva Arvidsson*,  
Swedish EQuIP delegate

## (April, 2006) Quality Improvement

There are 5.523 GPs, who have undergone 5 years of specialisation after 5½ years of University studies + 2 years of internship. There are roughly 1000 general practices, most owned and run by the County Councils, but an increasing part are becoming privately owned.

Except for a very few single-DR practices, most are group practices run by 3-8 doctors, working together with the same amount of nurses, 2 laboratory technicians, 2 secretaries. Primary care is mainly financed by capitation, with a goal of 1600 patients per doctor, but presently an actual amount of more than 2000.

By *Per Stenström*,  
Swedish EQuIP delegate





# Quality Improvement (2009): Switzerland



## Quality Improvement (October, 2009)

Switzerland is one of the richest countries in the world. It has one of the best health care systems, but also one of the most expensive. The country faces major problems in financing the increasing expenditure in health care.

The split reimbursement of hospital care between the local government and the insurances favors hospital based health care. Reducing hospitals would imply less job facilities, which makes it impossible for any politician to close hospitals, apart from the emotional factors this would cause in the local population.

In order to optimize the facilities, the ambulatories are extended. Ambulatory care at any hospital is entirely reimbursed by the insurances and not regulated.

Hospital care and costs of ambulatory care units have therefore substantially increased.

Institutes for Primary Care/Family Medicine have been established at the University of Basel, Zürich, Bern and Lausanne, which is a milestone in the history of family medicine in Switzerland.

However, primary care has decreasing appeal (1), especially among young physicians. Many reforms have been undertaken, such as a revision of the reimbursement of lab testing which led to a significant decrease in the income for GPs. The sale of drugs to the patients, which is allowed for GPs in many cantons (states), is also under criticism and the new regulations lead to another decrease in the income for GPs.

Unfortunately, all these interventions and reforms in the health care system are politically motivated and lack any evidence. This is due to the fact that valid data about the health care system are not available, including studies assessing the role of the GP. Switzerland has previously focused – and still does so – on clinical research more than any other country.

However, there is not any awareness that health service research is needed to enable evidence-based decisions for all stakeholders.

The focus is still on what (new diagnostics and therapies for example) should be provided and underestimates the potential that lies in how the care is provided. OECD data, as well as other research data, have provided quite strong evidence that a better Primary Care orientation of a health care system is associated with lower costs and most probably with better care and higher quality of life for its patients.

Unfortunately, Switzerland has never participated in these data collections and, consequently, politicians and other stakeholders are completely unaware of these facts. Not only politicians underestimate the importance of health service research but also GPs in Switzerland, who complain about the fading importance of their specialty.

There exist many potential threats to Swiss family medicine. Regulations given by the National Administration of Health continually decrease the attraction of the profession for young doctors.

This dangerous approach of the government endangers the care of a growing number of chronically ill people. On the one hand, Swiss family doctors struggle with the shortage of young doctors like everywhere else; on the other they have to cope with absurd political guidelines increasingly restricting Family Medicine.

As a response, the three formerly autonomous Swiss associations of primary health care (general practitioners SGAM, general internists SGIM and paediatricians SGP) have decided to unite for political issues in a corporate, professional association called "Swiss Family Doctors".

Therefore, a single and powerful contact can be established for all issues of Family Medicine in terms of "one voice – one structure". The new association will represent all family doctors in all political and media related activities, whereas the pure specialist duties remain with the particular associations. Further, the association aims for a title in Family Medicine that is accredited throughout Europe.

Quality improvement is an ongoing issue because it is expressed in the federal regulations but not set into practice yet. A system that shows and monitors the quality of care given is mandatory according to the regulations.

So far, the different groups of doctors have not managed to achieve consent as to which system they want to use. Different specialists have their own preferences as a result of which there is a vast amount of different systems used. EPA, apart from a variety of other indicator sets for organisational quality, is only used by few general practitioners.

A project led by the Swiss Medical Association will provide an overview of what is in use at present.

(1) Thomas Rosemann, Department of General Practice and Health Services Research, University of Zurich, Switzerland Wonca Europe and its input on the Family Medicine research in Zurich; Primary Care 15, p272

By *Adrian Rohrbasser*,  
Swiss EQuIP delegate

# Quality Improvement (2012): Switzerland



In 2012, Swiss physicians in ambulatory care published their activities to improve quality in healthcare for the second time. The aim was to uncover all the endeavours and to find out what actions were more likely to improve quality of care in different contexts. Once more, there seemed to be lack of a general view and insufficient networking of various quality activities.

However, physicians developed an awareness of quality improving and assessing which led to the foundation of the Swiss Academy of Quality in Medicine. The academy consists of delegates representing the different specialties and aims to improve all aspects of quality concerning patients, their families and the physicians themselves. It serves as an umbrella organisation for all the committees that deal with quality improvement in different specialties. It sets standards for data collection and assessment of projects concerning quality in medical care.

The academy is also concerned with vocational training and continuous professional development in quality in medical care. It will support research projects and coordinate knowledge translation and dissemination. The academy will serve as a platform for networking and exchange of ideas. The Swiss Association of Family Physicians (SAFP) plans on collaborating closely with the new academy to increase the impact of their efforts in this field.

The Swiss Academy of Quality in Medicine ensures the legal requirement of transparency of their members' daily work and serves as a stakeholder for patients, their relatives and the physicians opposite to the institution that is planned by the Federal Office of Public Health which represents the government and health insurance companies as many parliamentarians are involved in these companies.

Finally, it also serves as a stakeholder in the Institute of Innovation and Valuation where health technology assessments will take place in the future. This institute should guarantee "a broad technology focus at a national level involving the different stakeholders".

However, looking at the structure, pharmaceutical representatives and stakeholders of health care insurance companies are too powerful in this concept and it may be difficult to strengthen the patients' position.

Primary objectives of the Swiss HTA Consensus Project are to complement the existing but fragmented Swiss HTA initiatives currently in place, notably by the Federal Office of Public Health (for new technologies in the context of reimbursement and pricing decisions), as well as the more recent initiative of the Zurich Medical Board (primarily assessing established technologies), and to contribute to the development of a refined and integrated approach at the national level.

The project was accepted by the Swiss Medical Association (FMH), the Swiss Academy of Medical Sciences (SAMS/SAMW), and by the Federal Office of Public Health (FOPH/BAG, with observer status).

Stakeholder participation should be guaranteed as the Swiss HTA processes and evaluation criteria tend to be fully transparent. Accordingly, timelines and key documents relevant to HTAs (such as key documents of assessments, appraisals, and decisions including their rationales) should be made available to the public.

**ReMed** is a supporting network for physicians in medical needs, ensuring patient safety and improving the quality of medical care. Medical professionals' health is a matter of particular concern to the Swiss Medical Association FMH.

This is why it launched a programme under the title ReMed 2007 focussing exclusively on this important topic. Since its launch, a large number of people have sought advice, demonstrating that the support network is on the right track and has been able to establish a basis for confidence.

Even though ReMed is funded by the FMH, the professional organisation has no access to personal and support files at any time. ReMed is bound by professional medical confidentiality. Medical and administrative tasks are clearly separated. The parent organisation and various partner organisations of the medical profession are represented on an advisory committee. A national steering committee is responsible of the support network.

ReMed help primarily doctors with FMH membership. They can also assist people associated with physicians such as family members and colleagues. The experienced consulting team can be contacted by phone or e mail. They aim to report back within 72 hours to discuss the situation. ReMed arrange for physicians to benefit from knowledge and experience in health promotion and prevention.

They support physicians in critical situations with a wide range of services: crisis intervention, mentoring and coaching. ReMed give advice to physicians who turn to the programme because they or regulatory bodies want to assess whether they meet current quality standards.

The organisation is now represented in the whole country in three different languages and helps more than 140 people a year.

The committee of quality improvement of the Swiss Association of Family Medicine has completed several projects: quality circles / peer review groups are recognized as main means of increasing and disseminating knowledge among primary care physicians.

As patients and their needs are the focus of primary health care, a validated patient survey is at everybody's disposal. Regular staff appraisal is crucial and therefore, the committee has developed a standard procedure for small practice units.

To reinforce successors, different systems were developed to encourage tutors and mentoring physicians and to promote vocational training programs for future family physicians at reasonable pay. Unfortunately, these systems are different in different states of Switzerland and a fitting system for rural areas is missing.

## Quality Improvement (2013): Switzerland



At a national level, there is an on going discussion about the future of Family Medicine. Although it is acknowledged that family medicine basis forms the basis of health care in Switzerland, there is still no agreement on how future colleagues should be encouraged to work in that field.

The popular initiative concerning the support of family medicine was signed by far more than 100 000 people within short time forcing the politician to either develop a legal framework around this initiative or generate an own proposition.

The Federal Assembly are drawing up a road map on future health care and they promise better working conditions in the future for people working in primary health care.

Physicians developed an awareness of quality improving and assessing which led to the foundation of the **Swiss Academy of Quality in Medicine**.

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*Adrian Rohrbasser*  
Swiss Delegate for EQUiP  
Family Physician  
MSc in Evidence Based Health Care





# Quality Improvement (2001): Turkey



## A few Words About Family Medicine in Turkey

Family medicine exists as a specialty in Turkey since 1983. Most of the advances have been achieved during the last years, resembling a geometrical growth rate. Today there are 26 family practice departments in 39 medical faculties, serving to a population of around 65 million people. Beyond the departments at the faculties, there are nine other teaching hospitals with family practice residency programs.

The first residency program started in 1985. Today there are around 1000 graduated family physicians and 500 residents. Being aware of the need for postgraduate education, also the untrained GP's (who are more than 57 thousand in number) have established an institute (The Institute of General Practice) and started their own program.

This institute lacks any support or supervision of the universities. Although this makes their programs inofficial, the Turkish Medical Association insists on this institute. The main reason for this seems to be their political disagreements with the Turkish Ministry of Health.

## First Turkish National Family Practice Days Performed

National congresses of family medicine are performed every 2 years in Turkey. The fifth congress, which was expected to be in 2001, was postponed to March 2002. This caused family physicians to start organizing family practice days after each congress.

The first Turkish national family practice days were performed during 2-5 November 2001 in Edirne. Topics important for family physicians were discussed during the four days with over 150 participants.

Dr. Janko Kersnik from Slovenia, Dr. Bodossakis Merkouris and Dr. Athanassios Simeonidis from Greece, and Dr. Deborah Ulmer and Dr. William Kerns from USA were invited lecturers from other countries.

## New Designation Places for Family Physicians

As every new specialty, family practice fights its way in the definition of its tasks and responsibilities. Until recently, family physicians who decided to work for the state had only one choice: the mother-child health care and family planning centers.

With the new arrangements, family physicians gained new positions at the state hospitals as well as the district polyclinics of the state hospitals. As the next step, family physicians want to be charged at the small health centers in the health districts where they will be able to give primary care service.

## First Professor of Family Medicine

The number of family physicians with academic titles increases from day to day. Until recently there were more than 30 assistant professors, 6 associate professors, and 2 professors (residency made in public health).

The academic title of the first family medicine professor was celebrated during the national family practice days. This event was a strong motivator for family physicians throughout Turkey.

## EUROPEP Translated Into Turkish

EQUIP's instrument for the evaluation of primary care physicians and their practices by the patients is translated into Turkish. For statistical evaluation, the instrument was applied to 1160 patients of 33 doctors.

Although there is no law obligating patient feedback and the family practice board is not active yet, family physicians are willing to apply EUROPEP to their patients for self-evaluation.



(c) Thanks to Seda Coşkun

# Quality Improvement (2001): Turkey



## **Patient Records: Efforts for Standardization Started**

Although it is obligated by law to keep patient records, the details of the record system are not defined. In the current state polyclinics of the state and university hospitals keep their records by just writing down the name, age, diagnosis and medication of the patient.

For inpatients, an unstandardized, source oriented record system is used. And many of the physicians working in private offices don't use any record at all. One of the workshops during the family practice days focused in this issue. A core group was established, priorities were defined and a work plan was developed.

This group will continue to work with the aim to develop a well structured, standardized, and flexible problem oriented record system meeting the needs of the primary care physicians. Eventually, a record system will be developed for the use of Turkish family physicians.

## **Core Curriculum Development Discussed**

One of the problems of Turkish family physicians is the lack of a core curriculum for family practice residency. The curriculum accepted by the Ministry of Health is composed of rotations in different wards (internal medicine, emergency ward, pediatrics, gynecology and obstetrics, and psychiatry) at the hospital.

Currently primary care places are not involved in the residency education. Family practice departments try to overcome this problem by personal dialogue with the involved departments. On the other hand, also the content of the rotations at the different wards is not defined.

As many of the family practice departments have developed their own curriculum for residency education, it was decided to bring the present work together in order to establish a common core curriculum. Family physicians from different places in Turkey came together to establish a group dealing with this issue. First results of the work are expected to be available during the national congress in March 2002.

## **New Criteria for Associate Professor Exam**

Associate professorship is an important position in the Turkish academic system. Candidates for associate professorship have to pass an oral exam, which is done by a jury of five professors. The candidates have also to convince the jury to their competency with regard to published work.

Until recently there were no standards for this examination. With the last arrangements done by the higher education council, candidates are requested to have published at least three articles in journals listed at the Science Citation Index. In at least one of the articles, the candidate has to be the first author.

In addition, the professors who want to be jury members need to have certain qualifications. They need to have at least one citation to their work published in one of the biomedical journals listed at the Science Citation Index.

There was a lot of debate during the re-organization process of this issue. Political pressure was applied to remove family medicine from the associated professorship list. Fortunately, family physicians throughout Turkey tightened together and prevented this campaign.

In front of this drive being again the Turkish Medical Association, advocating for the Institute of General Practice as a substitution for family medicine.

By *Süleyman Gönpeliotlu & Zekariya Aktürk*  
Turkish EQUIP delegates

# Quality Improvement (2006): Turkey



## News from the Health Transition Project

Supported by the World Bank, the Health Transition project is continuing. Since most of the new regulations are related with primary care, family physicians follow the course very closely and try to make positive influences.

### *Pilot Implementation*

The new primary care health system mentioned in our previous **reports** is being applied in Düzce, the first pilot city. Repeated inspectory visits of Turkish Association of Family Physicians demonstrated a sustained increase in physician as well as public satisfaction.

However, despite the many advantages of the new system, especially to mention the increased income of family doctors, there are still some areas to be improved. Among these are the regulation of health services to frequently migrating populations and the IT system used for electronic medical records.

### *New pilot cities*

On March 2006, the ministry of health declared 10 more pilot cities to implement the health transition project. Right after this announcement vocational trainings of the untrained practitioners started in these cities too. Previous educations in the first pilot city Düzce have demonstrated a substantial contribution of these educations to the physicians.

### *Second phase trainings*

The transitional education of the practitioners consists of two phases. A short (10-day) phase one course will be followed by a one-year on-site training. Several workshops have been done previously to collect the views of trainers in general practice. A team consisting of national and international members has been established to prepare a curriculum for the second phase of the trainings.

## National Family Practice Core Curriculum Ready

Although, not officially announced, the Turkish Board of Family Medicine (TAHYK) has finished the preparation of the new national family practice residency curriculum. After sharing the draft document with the academic departments, it will be released and sent to the ministry to be applied in the residency education.

## Social Security System Changed

Radical changes are happening in the social security system of Turkey. Three big social security organizations were abolished and a new organization was established to cover all citizens leading to standardized services for everybody related to retirement and health financing.

This change was followed by a separation of retirement funds and the health care security system. Health care security premiums of all citizens below 18 are now covered by the government.

## ICPC-2R Book Available in Turkish

With the supervision and support of Dr. Inge Okkes and Dr. Marc Jamouille from the Wonca International Classification Committee (WICC) a Turkish team translated and adopted the ICPC2-R Book into Turkish.

Copyrights to publish and distribute five thousand copies of the book were recently obtained from Wonca. Printing procedure is planned to be finished before the seventh national congress of family medicine in Izmir on 22-26 May 2006.

## TAHUD Continues to Support National CME Activities

Continuous Medical Education activities are an important means to increase the quality of health services provided. TAHUD is determinedly striving to support such activities. Despite its limited budget TAHUD managed to organize more than 8 regional meetings spread throughout the country within the last 6 months.

Among these are the national family medicine days in Van, Kartal, Adana, Mersin, Antakya, Kahramanmaraş, and Şanlıurfa. A skills-course on chest x-ray interpretation was applied to all primary care physicians in Edirne.

## Drug Financing Rules Changed in Favor of Family Physicians

Family physicians are currently the most advantaged physicians in Turkey regarding prescription privileges. With the active cooperation of TAHUD executive, the Ministry of Health revised the regulations on prescription privileges of doctors. Formerly family physicians were not allowed to prescribe SSRI's and proton pump inhibitors beyond some other medications. This change led to an improvement of the image of family physicians.

On long term, such positive changes are expected to effect the preference of medical students to enter family medicine residency.

## Academic News

The number of academic departments of family medicine has increased to 38. There are currently 5 full professors and 11 associate professors and 35 assistant professors. The department of family medicine at Trakya University launched its center for family medicine and healthy living.

## Two Turkish FM Departments Joined the Socrates Primary Health Care Europe Network

Last year Departments of Family Medicine at Kocaeli and Antalya Universities were invited to introduce themselves at the Socrates Primary Health Care Europe Network Meeting in Vienna. There is mutual ongoing student exchange between Kocaeli and Nijmegen Universities. At the last meeting of the network in Ljubljana Kocaeli was officially accepted to the network.

By *Zekariya Aktürk & Nezihe Dağdeviren*  
Turkish EQUIP delegates

# Quality Improvement (2009): Turkey



## **Federation of Family Physicians' Associations Established**

The health transition project is giving birth to new constitutions. Practitioners who made contract with the new health system are establishing their own organizations. Family physician organizations from over 20 pilot cities joined recently under the umbrella of *Federation of Family Physicians*.

## **ICPC Trainings Started**

The Ministry of Health took the initiative to implement ICPC coding in primary care. Trainings of the core trainers were done during August-September 2008.

Trainings are conducted all over the country targeting the more than 25 thousand practitioners and around the same number allied health staff. Countrywide implementation is hoped to begin by the end of 2009.

## **Upcoming Scientific Events**

The following upcoming scientific activities supported by TAHUD are in the agenda of the Turkish Family Physicians:

- National family medicine days: 4-6 June 2009
- Rhinocamp meeting: 20-24 May 2009
- Kartal family medicine days: 7-10 May 2009
- Academic geriatrics conference: 20-24 May 2009

## **Turkish Cabinet Revised: Minister of Health Reappointed**

After the local municipality elections in March, the Turkish prime minister Recep Tayyip Erdoğan made a revision in the cabinet. 19 members were released from their positions including the minister of education.

However Prof. Recep Akdağ, the minister of health preserved his place. The health transition project is one of the most popular projects of Prof. Akdağ. Despite of some criticism from the doctors' side, the public seems to be happy with his activities.

## **Difficult Decision: Should Family Physicians be Gatekeepers?**

Family physicians are the central actors in most of the health systems worldwide. Also academic definitions define the family physician as the "chief of the orchestra". Although "gate keeping" function is increasing the importance of family physicians and seemingly empower them, it is not a standard practice in developed countries.

As a result of long debates, decision was taken to implement gate keeping role of family physicians during the health transition project in Turkey. A regulation for this purpose was put to action in November 2008 to start gate keeping in four pilot cities.

Although this change lead to daily savings of 400.000 Turkish Liras (185.000 EUR) and a decrease in the patient load of hospitals, according to some figures, a second regulation issued on 1th of January 2009 postponed the implementation to July 2009.

Reasons for postponing of the gate keeping regulation were complains from both patient and doctors sides. The patients don't want to lose the freedom of using all available resources while family physicians started to complain of the increased patient load. Interestingly, even the hospital doctors were not happy with the situation; most probably due to a decrease in their fee for service incomes. Time is passing fast and the next deadline is approaching.

A difficult decision is waiting for the politicians: academic and economic benefits of gate keeping on one side – patient and doctor satisfaction on the other...

By *Zekeriya Aktürk & Nezih Daşeriren*  
Turkish EQUIP delegates



# Quality Improvement (2011): Turkey



## Turkish Delegates are Conducting Quality Courses

In accordance to EQuIP's mission to spread quality in the member countries, Turkish delegates took the initiative to conduct quality related courses and workshops during national events.

Two courses were conducted in March and April 2010 with the title "Use of Quality Tools in Family Practice" during the First Trakya Family Medicine Conference and the Fifth Istanbul Family Medicine Conferences respectively.

A third course will be conducted during the 10th National Family Medicine Conference in May 2011 with the title "Quality in Family Practice". Subtopics of the course are as follows:

- What is quality?
- ISO and JCI
- Audit
- Quality Circles
- Patient and employee satisfaction
- QALY, DALY, cost effectiveness, cost efficiency
- Processes, procedures, flowcharts
- Quality indicators

In case of enough funding, the delegates are planning to make the courses an EQuIP activity with contributions from abroad.

## Health Transition

Project Reached an important Goal: Nationwide List-Based Family Practice Available Since January 2011 As mentioned in our earlier reports, one of the main objectives during the Health Transition Project in Turkey was to convert from a geographically based primary care health system to a list-based system together with a change in the payment system.

As to 13th of December, 2010 this goal seems to be accomplished. Citizens in all 81 provinces have now a dedicated family physician. As to the current figures, 20.183 family physicians (out of them about 80% non-specialists) are serving a population of 72.560.510 people (3.595 people per GP) in 6.330 family health centers and 986 Population Health Centers. The Ministry of Health intends to have 1 GP per 2.000 citizens by the year 2023.

## Ministry of Health Succeeded in Obliging Turkish Doctors for Fulltime Work

According to the previous regulations, physicians working in the public sector could choose to work on a part time basis. Besides being the only profession in the public sector having this privilege, the shortage of doctors was claimed to be a necessity to shift to full-time work for doctors.

As to 1st of March, 2011 doctors working in the public sector are obliged to work on a full-time basis. Although many physicians running a private office had already decided to shift to the public sector due to other financial influences, some high ranking professors especially in the university hospitals are not happy with the new regulation.

## Turkish EQuIP Delegates Conducted the Third Study Evaluating

Current Opinions of Family Physicians Started in 2008, Turkish EQuIP delegates are conducting yearly surveys to collect opinions of Turkish family physicians about issues under discussion. Last report in this series was published in March 2011.

One of the discussions is about the gate keeping function of family physicians. Currently it is not applied in Turkey but discussed to be implemented. Opinions about gatekeeping function of GPs

Another hot topic in the agenda of family physicians is the paw on full time service. Most of the GPs seem to be supporting full time service in government facilities.

## Upcoming National Scientific Events for Family Physicians in Turkey

6th Istanbul Family Medicine Conference will be conducted during 28-30 April 2011 in Swiss Hotel The Bosphorus.

10th National Family Medicine Conference will be conducted during 18-22 May 2011 in Lykia World, Fethiye

The Second Conference of the Federation of Unspecialized Family Physicians will be conducted during 28 September and 2 October 2011 in Cyprus Acapulco Hotel.

By *Zekariya Aktürk & Nezih Da deviren*  
Turkish EQuIP delegates

# Quality Improvement (2012): Turkey



## **The Status of Electronic Health Records in Turkey**

After implementing the family medicine system nationwide, all the family practices are now using electronic health records (EHR) connected to a central server. Effort continues to integrate the EHR with hospitals and pharmacies.

The system enables family physicians to access patient information from any computer connected to the Internet. All the information entered by the GP is ready to download for clinical as well as research purposes. The physician can filter his/her patients according to disease status or any other search criteria such as contraceptive usage. Given that the GP feeds the relevant data, most software used also supports decision-making.

For example, one can easily catch a case of growth hormone deficiency and take action with the help of the EHR. All the patient processes including registering, prescriptions, and laboratory procedures are managed using the unique identifier numbers or barcode readers.

There are currently around 20 EHR software in the market with accreditation from Ministry of Health, 10 out of these being more popular among family physicians. Some programs also support web-based services such as taking appointments and mobile applications.

## **Tuberculosis Follow-up System**

Still being a big health threat worldwide, tuberculosis (TB) receives attention from Turkish authorities. Current country-wide family medicine 2/3 implementation system allows close follow up of TB patients by the family physicians. After showing that the patient has no active TB by sputum examination, patients are discharged from chest disease clinics. Each patient is followed up by his/her family physician.

Family physicians provide coordination and continuity of care from the perspective of person centered approach. Patient adherence to given pharmacotherapy is an important issue in the management of TB. The treatment process is long and often ends up with exhaustion.

Thus, majority of patients discontinue therapy if there is no strong control system or incentives. The system is claimed to have many advantages from economic savings to patient adherence and improved quality of care.

## **War Against Smoking Continues: New Anti Tobacco Legislations**

Although there is a trend to decline, prevalence of tobacco usage was 31.2% according to a study in 2001. Although Turkey now ranks fourth in in quitting rates according to the WHO report, there is still a long way to go.

With the support of all political groups in the national assembly, legislations with strong precautions have been established prohibiting the advertisement of tobacco products and smoking in public places.

Additionally, medications such as bupropion and varenicline are covered by the social security organization. According to Prof. Recep Akdağ, the minister of health, new regulations are on the way making it even more difficult to access and use tobacco. According to a press release, the new regulations will prohibit using tobacco brands for even other purposes and also the size and type of warnings on the packages will be changed.

## **Obesity Control Activities**

Obesity prevalence among adult males and females was found as 21.2% and 41.5% respectively. Due to the increasing burden and epidemics of obesity, the Ministry of Health established a "Department of Nutrition and Physical Activity".

The Ministry of Health requests family physicians to record relevant information in order to deal with the obesity epidemics. Family physicians find it important to be involved in the action plan in fighting against obesity.

## **>100 % Success Rates in Childhood Vaccination**

Immunization services in Turkey are mainly provided by family physicians. With the recent campaigns also children who couldn't immunized before are included. Hence, immunization rates exceed the 100% target in some areas. 3/3 Hepatitis B is in the immunization schedule since 1998.

In 2005 the schedule contained 7 antigens, namely diphtheria, tetanus, pertussis, oral polio, BCG, measles, and hepatitis B. Hemophilus influenza type B was added in 2006 followed by changing the diphtheria, measles, and tetanus with a more developed vaccine and adding conjugated pneumococcal vaccine in 2008.

There is also another campaign to combat influenza and pneumonia among patients with diabetes. Objectives are declared as immunization rates of 75% and 50% for influenza and pneumonia respectively.

## **Home Care Services**

According to the Ministry of Health figures, around 100 thousand patients are living bedridden in Turkey. In order to cover the needs of home care dependent patients the Ministry of Health implemented a nationwide project with the inclusion of family physicians.

Patients and relative now can access the home care services coordination center by dialing 444 38 33 from all over Turkey to get services from basic examinations and renewal of health reports up to intravenous fluid therapies.

By *Zekariya Aktürk & Neziha Deviren*  
Turkish EQUIP delegates

# National Reports (2006-2010): The UK



**In the UK there are slide differences in the legislation regarding health care. There are some private providers emerging form the USA with the support from the politicians. There is a tendency in forming bigger group practices. There are issues on data confidentiality, data gathering, ownership of data, data warehousing. "The computer is full of better care."**

*(30th Assembly Meeting, Barcelona, 23-24 November 2006)*

**Devolution is increasingly leading to different health policies in the four countries of the UK (England, N Ireland, Scotland and Wales). One GP contract still exists and the QOF is still the dominant mechanism for quality in primary care. There is no real wish to do practice accreditation. In England, there is support for patient choice of provider at the hospital level – so called Choose and Book – but there have been problems with its implementation. There is also much interest in referral management and referral assessment as a means of demand management. These two strands of development are in potential conflict with each other.**

*(31st Assembly Meeting, Prague, 26-28 April 2007)*

**The government in UK yearly changes a few indicators to make the job of GPs harder. With financial contracts government changes provision of health care. USA commercial organisations are buying UK GP practices and GPs going employed.**

*(33rd Assembly Meeting, Bergen, 22-24 May 2008)*

**General comments from the floor included the fact that with QOF UK measuring 1.000 indicators that the IT systems are bursting with data. Another contribution was that there are two main incentives for measuring data, one is professional pride and the other is financial, but that financial incentives should not simply be given for measuring data but for producing improvement plans in connection with the data. Another delegate emphasised the importance of defining the terminology we are using as it can be interpreted differently in different countries, for example "private health care", "acute health care" and "surgery" can refer to a whole range of standards of care. Terms like "incentives" can mean very different concepts in different health systems and cultures.**

*(37th Assembly Meeting, London, 29 April-1 May 2010)*



(c) Thanks to Claire Marie Thomas and Zalan Alam.

# Quality Improvement (2011): The UK



Since 2007 the RCGP has established a leadership position in the UK medical community by way of its innovative Continuing Professional Development (CPD), Revalidation and Practice Quality Development programmes for GPs.

These have focused on improved patient outcome and quality of service through supporting and developing the individual and the practice. Much of this work has been undertaken through the RCGP Professional Development Board (PDB).

In the last three years key achievements have been the development of a CPD Strategy and Scheme with supporting eLearning and other components, which are an integral part of the appraisal, updating and revalidation for all doctors.

Under UK legislation all doctors will be required to revalidate every five years from 2012 and this will require them to demonstrate that they are up to date and fit to practise in the field in which they work.

The RCGP has worked with the General Medical Council, the Departments of Health and other key stakeholders including our sister royal colleges to develop and pilot a standards and evidence framework, and quality assurance support which is a legislative duty on all of the royal colleges, the PDB is developing the supporting CPD and tools which include addressing policy issues on standards of the annual appraisal.

As well as supporting the individual GP the Board's work has also included quality development of the practice team. Some specific areas of interest are highlighted below.

## **CPD Credits Scheme**

The Scheme has now been finalised after piloting and internal and external consultation. The innovative aspect is that it is based not just on learning hours but on the impact of the learning on the GP and their patients.

So one hour of education is one learning credit, however, if that education leads to changes for patients, the doctor or the practice, the GP can claim two learning credits for each hour of such education. The Scheme links in with ongoing work on appraisal, the Revalidation ePortfolio, Essential Knowledge Updates and Essential Knowledge Challenge, integration of PEP and e-Learning developments including the new on Line Learning platform

## **Essential Knowledge Updates (EKU)**

Now in its third year, the Essential Knowledge Updates (EKU) programme has established itself as the Royal College of General Practitioners' premier online educational tool. It is a six monthly synthesis of the new and changing knowledge that all GPs should know in an on line learning package of modules. It is accompanied by a podcast of discussions with the authors.

## **Essential Knowledge Challenge (EKC)**

The Essential Knowledge Challenge (EKC) is a voluntary multiple choice test which yields a downloadable certificate on completion, it is based on the content of its associated Essential Knowledge Update (EKU) and released approximately 6 months after the associated EKU. EKC 5 was released in October 2010.

## **On Line Learning Environment (OLE)**

The On Line Learning Environment has been developed over the last three years using a MOODLE based learning management system, it has enabled us to deliver the EKU and EKC programmes in exciting and accessible eLearning formats and also to develop a range of other eLearning programmes.

## **Revalidation ePortfolio**

The RCGP has developed a Revalidation ePortfolio, the first phase of this was released in December 2010 and, by March 2011, over 7,500 GPs had used it. It has been designed as a member benefit and enables GPs to collect all their information for their annual appraisal, including CPD.

If their primary care organisation has signed up for the tool it can also be used for the appraisal itself and, when further phases have been developed, it will enable delivery of revalidation information. A newly established and dedicated Helpdesk supports it.

## **Personal Education Planning (PEP)**

PEP is a formative tool, which enables GPs to clearly identify their learning needs for their Personal Development Plans, thus laying the foundation for appraisal and providing a key support tool in preparing for revalidation.

The new version of PEP includes an evaluation/research functionality, which will allow the extraction of learning needs information across all user groups and all UK deaneries and faculties.

## **Practice Accreditation**

The RCGP Practice Accreditation is a voluntary quality improvement scheme that will support the organisational development of practice teams across the United Kingdom.

The scheme provides a framework to measure primary care services recognises the achievements of practice teams and reflects the multidisciplinary approach to primary care.

The scheme will support practices to prepare for their registration with the Care Quality Commission, which will be a requirement for them from 2012 onwards.

We are working to ensure synergy with the well-established RCGP Quality Practice Award, to ensure that we have schemes which can support practices at all levels and encourage them to become engaged in continuous aspirational quality improvement cycles.

## **Quality Practice Award**

Quality Practice Award (QPA) is a criterion-based quality accreditation process undertaken by Primary Health Care Teams across the United Kingdom.

The purpose of the award is to improve patient care by encouraging and supporting practices to deliver the highest quality care to their patients. It is aimed at practices, which wish to achieve the highest level of quality improvement.

By Professor Nigel Sparrow  
UK EQUIP delegate