From GP list size to practice configurations

A quantitative study protocole – *European Forum for Primary Care-* Ljubljana 17/09/2024

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Introduction

- Workforce crisis in primary care with rising demands :
  - Complexity
  - Multimorbidity (1)
  - Aging population
  - Comprehensive care including home hospitalisation
  - Relative shortage : more doctors but… less GPs (2)
- In Belgium same observations
  - Stop new patients for 20% of GPs
  - Majority of older GPs vs young GPs + Work life balance (3)
- Do we have enough GPs? How many patients can be handled by a GP?

(1) Damarell RA, Morgan DD, Tieman JJ, Senior T. Managing multimorbidity: a qualitative study of the Australian general practitioner experience. Fam Pract. 2022;360–368. doi: 10.1093/fampra/cmac096. Cited: in: : PMID: 36063437

(2) OECD (2020), Realising the Potential of Primary Health Care, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/a92adee4-en

(3) Beersmans A, Euben T, & Gils M. (2023). Rapport : analyse de l'emploi du temps des médecins généralistes par ordre du ministre de la Santé publique et du Service Public Fédéral Santé publique, Sécurité de la Chaine alimentaire et Environnement. Avril 2023.

Practices and patient lists

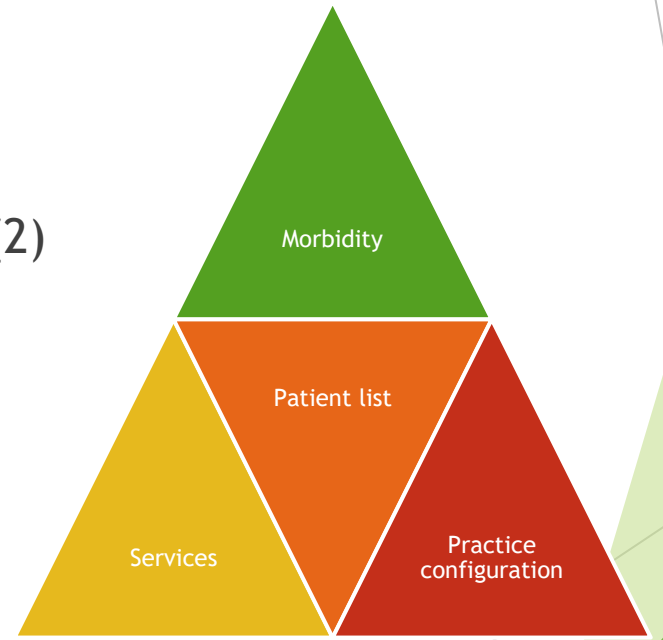
Literature shows a wide range of variations in practices designs (1)

From solo to multidisciplinary, heterogenous compositions

Link to a GP can be mandatory to fully freedom of choice(2)

Different sort of services and patient morbidity profiles

->International comparisons difficult



(1) Saint-Lary O, Gautier S, Le Breton J, Gilberg S, Frappé P, Schuers M, Bourgueil Y, Renard V. How GPs adapted their practices and organisations at the beginning of COVID-19 outbreak: a French national observational survey. BMJ Open. 2020;10:e042119. doi: 10.1136/bmjopen-2020-042119. Cited: in: : PMID: 33268433.
(2) Anderson M, Pitchforth E, Edwards N, Alderwick H, McGuire A, Mossialos E. United Kingdom: Health System Review. Health Syst Transit. 2022;24:1–194. Cited: in: : PMID: 35579557

Situation in Belgium

- Freedom of choice for:
  - Design of practice : solo -> multidisciplinary
  - Size of practice list
  - Patients chose their GP and vice-versa
  - Financing system
    - Fee-for-service – FFS (94,5%)
    - Capitation-fee - CF (5%)
    - New-Deal : mix of CF and FFS (pilot practices; 0,5%)
  - Link to patient?
    - Global Medical Record (patients' choice)
    - Registration in CF-practice
    - Registration in ND-practice

Assessing patients to a GP : why chose CF-practices?

Different options to evaluate patient lists :

- Counting patients through the number of GPs Global Medical Records
  - Geographical heterogeneity
  - Not mandatory
- Belgian Health Care Knowledge centre (KCE) : du *Usual Provider Continuity Index ou Usual provider of care* (UPC)
  - Links a patient to the GP mainly seen on a period of two years (e.g. 2015 -2016 68% of patients saw their preferred GP 3 times out of 4 (UPC >= 0,75)
- **CF-patients list : mandatory link -> patient list much better defined**

Research question

What determines the ratio between patient list and professionals in CF-practices in Belgium?

$$\frac{\text{Patient list size}}{\text{Professionals team size}}$$

Bias & limitations

- Population in CF-practices are on average more deprived and vulnerable (1)
- 5 to 10% patients don’t subscribe (numerator)
- Only 5 to 10% of belgian population in CF-practices -> not generalizable
- More urban than rural model
- Discussion on workforce of GP trainees

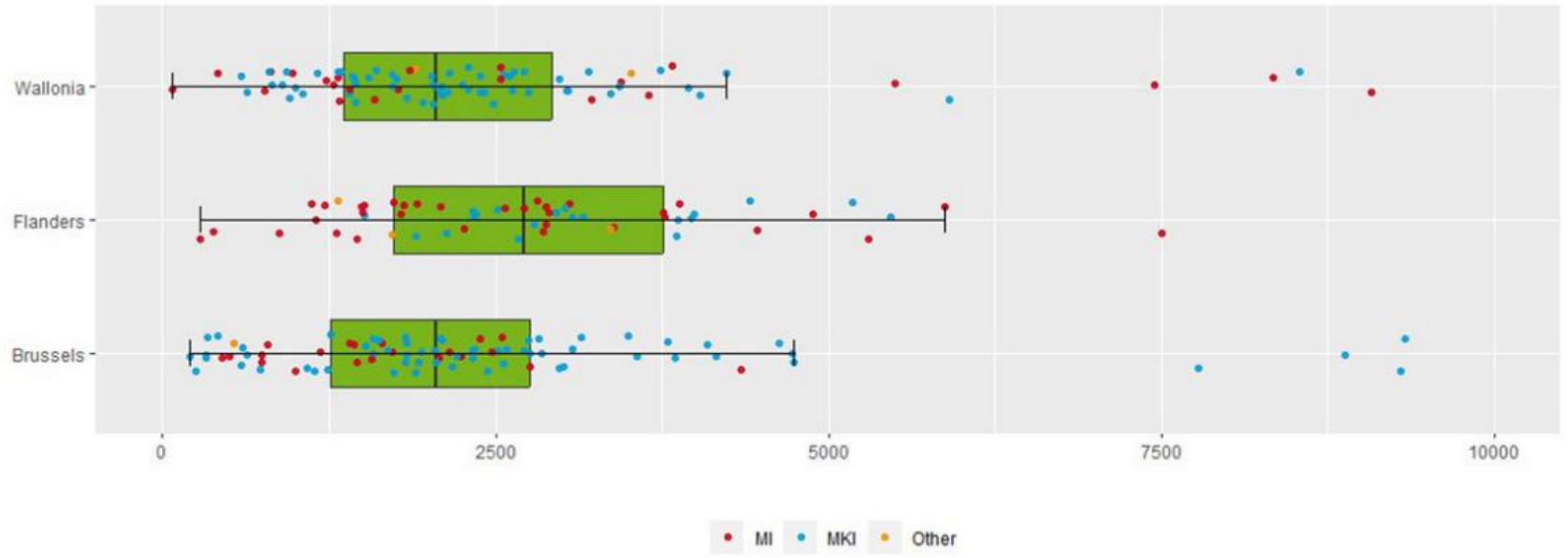
(1) Boutsen AM, Camilotti G, Zinno T Di, Pirson A, Cutsem P Van, Vervoort K. Comparaison des coûts et de la qualité de deux systèmes de financement des soins de première ligne en Belgique : une mise à jour. 2017;1–126

Data mining

- National study : Flanders – Brussels – Wallonia
- Different reports of various origins : KCE, sickfunds alliance (IMA), KPMG, Fédération des maisons médicales (FMM)
- 227 CF practices in 2022
- National Institute for Health & Disability Insurance (NIHIDI) and **CF-practice annual reports**

Data mining

Figure 8 – Number of registered patients per community health centre, by region and type of centre (2022)



MI = GPs and nurses; MKI = GPs, physiotherapists and nurses
Boxes are drawn from first quartile to third quartile with the median as inside line, whiskers are drawn from the box to the most extreme point that is less than or equal to 1.5 times the IQR, and dots represent community health centres.
Source: RIZIV-INAMI

Figure 8 : Van de Voorde C, Lefèvre M, Detollenaere J, Bouckaert N, Jonckheer P. Data requirements for risk-adjusted capitation payments for community health centres in Belgium. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2024. KCE Reports 385. D/2024/10.273/37 pp

CF-practice annual reports

- Dependent variable :
  - Ratio between CF-Practice list + out-of-list patients and professionals
- Independent variables (team) :
  - Team composition : professions & FTE (curative and non-curative time)
  - GP trainees
  - Urban/rural/semi-rural
  - Region
  - Age of practice
- Independent variables (patients characteristics)
  - % >65 yo
  - % BIM
  - % diab
  - Mental health
  - Palliative care
  - KATZ-score

Hypothesis

1. The ratio Patient list/professional will decrease with morbidity variables
   A. average age of patients
   B. Social status of patients
   C. Katz-score
   D. Other : diabetes, palliative care, mental health
2. Ratio will increase in rural contexts
3. Ratio will increase if GP trainees
4. Ratio will increase with age of practice

Take-Home messages

1. Importance to measure -> plan the future of primary care
2. Help to organize health system on populations needs basis
3. Natural evolution in Belgium (freedom of choice) towards multidisciplinary team-based practices
4. Future research after quantitative exploration -> interview CF-practices to understand their choices (team members profile, list-size…)

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