Out of Hours
International primary care snapshots:
Sweden and Lebanon

PRIMARY CARE IN SWEDEN ON THE MOVE — AHEAD AND BACKWARDS!

Primary care in Sweden is delivered through around 1200 primary healthcare centres (PHCs), almost all of which are group surgeries containing more than one doctor. The largest one, situated in a suburb of Stockholm, has more than 30 GPs plus registrars. The surgeries also have nurses, secretaries and laboratory staff. Where I have worked for 33 years there are 4 senior doctors sharing 3 positions, a registrar, 2.5 surgery nurses, 1.5 district nurses, a lab nurse, and one secretary. We have contracts with physiotherapists, occupational therapists, a psychologist, social worker, and a dietician.

The government owns about half of the PHCs; the other half being private practices. The latter are more common in the cities and the former more ubiquitous in rural settings. The economic conditions are the same for both type of ownership through contracts with the local county council. The average Swede sees the doctor three times per year, and 50–70% of this constitutes visits to GPs. The rest of the visits are to secondary care doctors, at hospitals or outside.

However, Sweden does not have a common system for reimbursement. All GPs (in practice surgeries) have lists of citizens who have actively chosen their doctor. Sweden has 22 counties and each decides on its payment. The reimbursement (payment) amount per visit is highest ('pay per visit') in Stockholm but the payment per visit consists not only of what the patient pays but is also a payment per visit from the county itself. The variation, of course, provides different incentives: with 'pay per visit' it tends to be 'one diagnosis per visit', but with better access, while 'high capitation' (capitation: the amount the practice receives annually for a listed patient who has chosen the surgery, irrespective of whether they actually visit the GP), lends to a more 'holistic', traditionally family medicine-oriented approach. The balance reflects only partially the political pattern in the county, but of course a high 'pay per visit' is more common in 'right-wing' counties.

After the recent national and county election we now have a 'left-wing trend' and we can expect fewer quick-fix scenarios and more holistic working conditions. On the other hand, this probably means that private practice will be less profitable for the entrepreneurs, often doctors, but sometimes (unfortunately), venture capitalists. The most extreme left-wing party wants to forbid all private practice, but they will most likely not succeed.

Öregrund, Sweden, in the snow.

For rural areas in the four most northern counties, covering about one-third of the country, where there are always problems recruiting doctors, there are a few lights at the end of the tunnel! For the first time there seems to be a common action plan for the development of rural medicine, covering a wide range of aspects including a specially-designed training programme for residents heading for a rural job.

Another important activity is the development of 'academic primary health care centres'. Up until recently there have been university departments in family medicine at the seven universities, but there is a strong desire both from the universities and the county councils to develop specially-designed academic PHCs; for example, eight (out of around 200) in the Stockholm area.

Opportunities for teaching, research, development — and a possibility for GPs with a PhD to get an academic position in the same way as our hospital colleagues — are in sight! As usual, there is a lack of money for this new system, and the financial resources compared to the university hospitals are minimal, but we must start somewhere if we are to develop academic primary care.

Also of concern are the European rules on obtaining a GP licence. In Sweden the time it takes to become a GP is around 5 years, while those training to be GPs in the rest of Europe train for only 3 years. This creates a risk of less qualified doctors practising in Sweden, particularly since doctors from abroad are more or less allotted to rural practices due to the higher number of vacancies there, and must start their career without a more senior supervisor to guide them.

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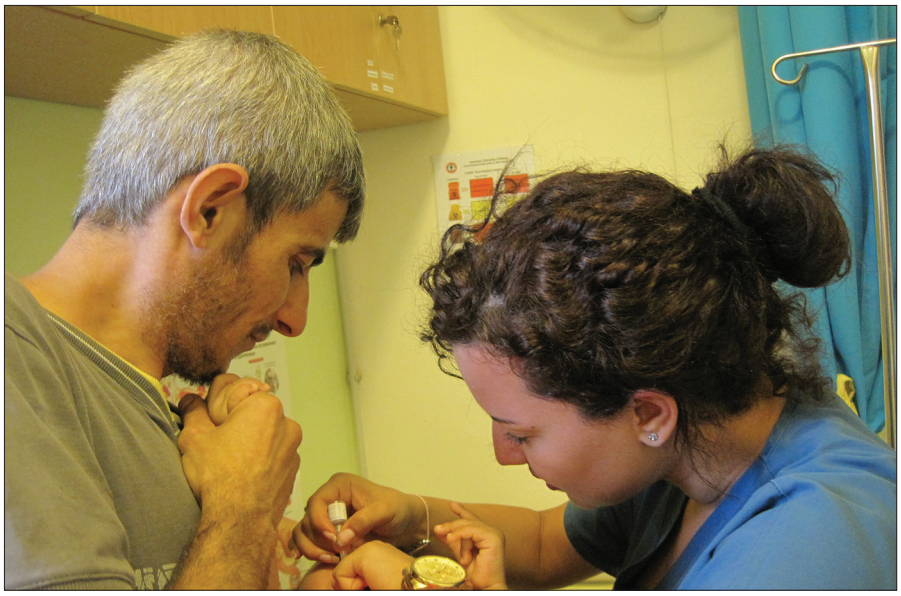

A clinic in Sabra camp, Lebanon.

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FAMILY PRACTICE IN LEBANON — AN ABANDONED TREASURE

Eighty per cent of ambulatory care in Lebanon is provided by the private sector, which is unregulated and fragmented.[1] Such fissuring and inefficiency of care is also seen at the government level, which has six public funds.[2] The Ministry of Public Health tries to alleviate the burden of more than 50% of the population not covered by health insurance. This is done by providing primary health care in centres operated by the government and non-governmental organisations (NGOs). There are around 900 ambulatory clinics that charge £2–5 per visit.[1]

One-third of these dispensaries are owned by the government, with the rest operated by NGOs, many of which have political and/or religious affiliations.[1,2] The trust in these centres is low as less than 20% of the population (estimated at 4 million) uses them.[2]

There are 11 450 registered physicians in Lebanon and 70% of these are specialists.[2] Doctors in Lebanon finish their undergraduate medical studies in more than 75 countries. Once you receive an MD degree you can work as a GP without any vocational training. In Lebanon there are seven medical schools of which only two private universities graduate less than 12 family physicians a year (there are less than 200 family physicians practising in Lebanon). A major drawback is the absence of family practice training in the only governmental university, pointing to a lack of commitment to graduate enough family physicians.

The health system in Lebanon allows patients to see specialists without having to go through a GP first, making all physicians potential primary care physicians. An over-supply in the amount of doctors results in unethical practices, tension between GPs and other colleagues, and in decreased income. One study reported that 90% of physicians earn less than $2000 a month.[3] The Lebanese authorities have been trying to enforce a continuous medical education (CME) programme. However, this has not yet materialised and thus the dictum 'once a doctor always a doctor' still holds.[4] The majority of CME activities are financed by the pharmaceutical industry.

Drug representatives in Lebanon have unrestricted access to physicians, which partly explains the high amount spent on brand drugs. More than 25% of the health expenditure goes on medications.[2] Generic medication constitutes only 2% of the pharmaceutical market.[1] These facts explain the high bill paid by the Lebanese people for medicinal products; expenditure on pharmaceuticals as a share of the GDP in Lebanon is 3.1% compared to 1.0% and 2.1% in the UK and US, respectively.[5,6]

Poor control on the quality of medical laboratories also makes the task of physicians difficult; of the 230 free-standing laboratories, 50% are not licensed.[2] When shown a lab result, some doctors make a point of telling patients their judgement is based on the *assumption* that the lab tests are correct.

In conclusion, Lebanon has a surplus of specialists and a shortage of competent primary care physicians. Major savings on the health bill are possible if the several health funds can be operated by one administration, generic medications are promoted, and the government works on training an adequate number of competent primary care physicians.

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