Salaried general practice in Czechoslovakia: personal observations and impressions

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SUMMARY. In 1991, a visit was undertaken to the former Czechoslovakia, during which discussions were held with general practitioners. Some personal observations and impressions from the visit are presented. For four decades, salaried general practice was a feature of the Czechoslovakian health care system. Primary health care comprised three strands: paediatric services, an occupational health service and community general practitioner care. The main point of service delivery was the polyclinic which, although being large and impersonal, provided easy access to other primary and secondary services. General practitioners, over half of whom were women, had regular leave entitlement and predictable hours of work, out of hours work being provided through separate contracts based on primary care emergency centres. However, doctors were poorly paid compared with industrial workers. Following the 'velvet revolution' in 1989, all aspects of the health service have been subject to major review, and salaried general practice is likely to give way to a more entrepreneurial system.

Keywords: workload; salaried general practice; patterns of work; GP services; professional status; Czechoslovakia.

Introduction

THE former Czechoslovakia was one of the most industrialized countries within the former Soviet bloc. It has a population of 15.5 million people, 65.5% of whom are in urban areas.[1] Following the 'velvet revolution' in November 1989 most of Czechoslovakian society, including the health service, has been subject to review. The re-evaluation has extended to salaried general practice which has been a feature of the system for four decades.

In the United Kingdom many general practitioners have shown renewed interest in a salaried general practice option.[2] It therefore seems appropriate to see what lessons can be learned from the Czechoslovakian experience.

In September 1991 I spent a week in Czechoslovakia discussing some of these experiences with working general practitioners and local health administrators in Hradec Kralove (an industrial city in the northern Czech province of Bohemia), Trutnov (a small industrial and mining town close to the Polish border) and Brno (the capital city of the southern Czech province of Moravia). This paper is the product of these conversations and observations. Any conclusions are solely my own.

Health and health care

Following the second world war, the British National Health Service served as a model for the Czechoslovakian health care system. However, by 1951[3] amendments resulted in the emergence of a system which closely resembled that in the Union of Soviet Socialist Republics where 'ambulatory [non-inpatient services] and public health establishments were integrated with hospitals on a territorial basis' thus giving rise to the polyclinics, which were the main focus of primary care provision in Czechoslovakia.[4]

The service was mainly funded from general taxation, and consumed up to 6% of total state income.[5] This compares with the percentage of gross national product spent on health in the UK in 1989, which was 5.8%.[6] Below central government control, the health care system was administered by regions which were in turn responsible for local districts. Primary care and outpatient services were organized at a district level to cover populations as small as 4000 people. There were three tiers of hospital care — local hospitals covering populations of 50 000, district general hospitals (with catchments of 200 000 people) and teaching hospitals/regional centres (with catchments of 1.5 million people). In many instances, polyclinics were attached to each of these types of hospital.[4]

Prior to the 1989 revolution Czechoslovakia was facing growing health problems. In the early 1960s the country was ranked 13th for life expectancy but two decades later its position had slumped to 41st.[7] The infant mortality rate in 1987 was 13.1 per 1000 live births and life expectancy for men was 67.4 years and for women 74.8 years.[1] The infant mortality rate in 1987 in the UK was 9.1 per 1000 live births and the life expectancy was 72.9 years for men and 78.4 years for women.[5] Prevalence of cardiovascular and oncological diseases was particularly high[7] which is perhaps not surprising as the consumption of alcohol and cigarettes was much higher than in western Europe.[8] Forty per cent of men were smokers, alcohol related mortality doubled between 1984 and 1989 and the typical diet was characterized by a high animal fat and salt content (Public health policies and child health in Czechoslovakia seminar, 1990). Also, Czechoslovakia suffered from the general environmental pollution which characterized much of eastern Europe's industrial legacy (Public health policies and child health in Czechoslovakia seminar, 1990).

Structure of general practice

There were three, largely separate, strands of primary health care: paediatric services, factory health care and community general practitioner care.

Paediatric services cared for patients up to 18 years old and were almost totally staffed by women doctors who provided both acute and preventive services. There were no health visitors. There was virtually 100% immunization and developmental screening uptake apart from uptake by the indigenous Traveller Gypsy population which remains on the margins of society. Patients were called/recalled by letter, using manual systems.

Factory health care catered for the employees of larger enterprises and for clusters of smaller places of work. This form of health care was the initial point of contact for almost all the adult population at a time when there was full employment. If employees were too ill to attend work, they were seen at home by the factory doctor if they lived nearby. Otherwise, they were seen by the community general practitioner who was expected to submit a report to the factory doctor. The factory general practitioner service was the key agency for adult preventive health services, providing health checks and supervising work conditions.

The general practitioner based in the community cared for the remainder of the population. All patients in a defined geographi-

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cal area were looked after by a designated general practitioner. This, in effect, meant that the community general practitioners looked after chronically ill and retired people.

Delivery of services

Primary care services were provided by polyclinics and their branch district health centres. The former offered primary health care services and a wide range of specialist services within one building while the latter generally had only primary care staff. There were laboratory, x-ray, rehabilitation and pharmacy departments in each polyclinic, as well as at many of the bigger health centres. Paediatric and community general practitioner services were usually provided by polyclinics while factory services were provided by health centres. However, this division was not rigid and depended on local circumstances.

General practice was the initial point of contact for all health services except for major medical emergencies and road traffic accidents.[9] The general practitioner treated most patients, only a small minority (up to 10%) being referred to a specialist. Referral at a polyclinic to a specialist could be immediate, the patient taking the general practitioner's letter to the appropriate department. In other instances, the patient could book an appointment for two weeks ahead. Some patients seen at a health centre had to travel to the central polyclinic for their specialist referral.

There was approximately one general practitioner per 1800 patients.[9] Each general practitioner worked about 40 hours per week, community based doctors starting at between 0700 hours and 0800 hours and finishing by mid-afternoon. Some worked a more variable rota. Evening surgeries were not routinely provided as adult patients were seen at work. However, with a liberalization in work patterns and increased unemployment, change is likely. Typically, up to 60 patients were seen per day, with consultations lasting between three and six minutes. The consultation was usually reactive to the presenting symptom, and preventive action and advice were seldom offered.

General practitioners usually worked with nurses. Nurses' clinical work included duties such as measuring a patient's temperature and blood pressure and giving injections. However, a large proportion of their time was spent on administrative tasks, such as fetching patients' records, and filling in forms.

Home visits were carried out after surgeries but in larger areas special teams undertook home visits. This allowed surgeries to continue without interruption. When not undertaking surgeries and home visits, the work of the general practitioner varied, depending on the branch of the service in which they worked. For example, paediatric general practitioners held clinics or carried out school visits, while factory doctors offered preventive services or undertook workplace visits.

Out-of-hours cover was arranged separately from daytime work but was mainly carried out by a roster of daytime doctors. Separate payment was received for this which helped to supplement the doctor's basic income. The service was run from a special primary care centre which had overnight accommodation for duty doctors. The centre was staffed by a telephonist with a doctor present to give advice and to decide on priorities. Other doctors on duty carried out the home visits and were provided with cars to take them to the patients' homes. There was one doctor on call for every 20000 to 40000 patients and each doctor would carry out up to 20 home visits per night.

Professional issues

Though medicine was a fairly high status profession in Czechoslovakia, it was not well paid. Coal miners and skilled industrial workers received the highest wages, with general practitioners earning about 60% of their rates. This disparity between status and payment was an inheritance from the former regime and was a constant source of grievance within the medical profession.

Over 70% of general practitioners were women which is slightly higher than the percentage of women in medical school. The reasons for the high percentage of women in general practice are complex. The better academic achievement by young women entitled more women than men to enter medical school. General practitioner contractual arrangements were often more attractive than other areas of medical work to women with domestic commitments. Furthermore, men doctors tended to be over-represented in the medical specialties and in other, better paid, non-medical work compared with women.

Doctors' immediate line management was upwards to professional colleagues. The chief general practitioner supervised colleagues and responded to patients' complaints. Despite reports to the contrary[10] many managerial doctors felt they had little power to influence the practice of their colleagues who retained a large degree of professional autonomy in their day to day work.

After six years in medical school, newly qualified doctors spent up to three years working in relevant specialties to obtain the necessary accreditation for a career in a particular field of medicine. For general practice, the training doctors spent most of their time in hospital posts. Three months were spent in the community with a general practitioner trainer. There was a general consensus that this was woefully inadequate and there were plans to extend this to at least six months. If one wished to make any further career advancement or become a head of department further postgraduate qualifications were necessary.

Postgraduate education was run at various levels and in various forms, the Czechoslovakian Medical Association having a major role. It carried out its general practitioner duties through the Association of General Practitioners. Further work was carried out by the trade union, the Union of Czech Physicians. The recently established Medical Chamber (equivalent to the General Medical Council) was having an increasingly important role in the accreditation process.

There was a general feeling that many general practitioners were not highly motivated to improve standards, and that the existing contractual arrangements provided little incentive. Improvements which did occur were a result of persuasion by general practitioner managers, financial incentives and peer pressure.

Problems and future prospects

Morale within the health service was not high. Low pay, large, impersonal buildings, lack of equipment, and low levels of resources contributed to this malaise. In the immediate post-revolution period, it was thought that lifting the heavy hand of the former regime would solve all problems. Time has shown the situation to be more complex.[7,11]

Most of the health premises I visited seemed to be well maintained. Many of the buildings, particularly the polyclinics, were big and consequently were too impersonal to be patient friendly. In an attempt to overcome this, many of the larger buildings are being divided into smaller functional units centred on the general practitioner and nurse.

General practitioners' surgeries had a similar range of equipment to surgeries in the UK, although most of it looked dated. However, there was ready access to x-ray and pathology services especially when these services were in the same building as the general practitioners. The problems with equipment were felt more acutely at the secondary level where doctors were frustrated by their inability to provide optimal investigation and treatments, owing to technological deficiencies. Most of the English language medical books on display, even on primary care, were

from North America. This probably reflected the desire to look to free enterprise health care systems for future models.

Payment was a particular source of discontent. Doctors felt that their relatively low rates of pay reflected society's estimate of their value. Most thought that a shift towards a market based economy was an essential prerequisite to achieve Western living standards.[11] There seemed little interest in British developments, not least because the NHS was seen to be established along public service lines, and free care had come to be associated with substandard care.[8]

The proposed solutions to these problems are 'decentralization, pluralism, market incentives and consumer choice.'[11] The new system will be financed from various sources, and consumers will have greater choice. People will subscribe to a mandatory health insurance scheme. Each community (individual or amalgamations of towns or districts) will be responsible for the delivery of a 'basic guaranteed standard'[7] of health care to all its inhabitants. The community, or business enterprises, will have the option of adding to the central health allocation and individuals will have the opportunity to augment their personal insurance cover.

In the medium term, major hospitals will remain under state control but most other health care services and utilities will either be leased or sold to market oriented care providers. Pharmacists, dentists, general practitioners and many community specialists are expected to be in the front line of the privatization process. As these groups and institutions become more autonomous, they will have to become more competitive as they seek to attract patients and payments in the new health market.

The widespread professional support for this strategic shift may obscure a number of concerns. Many personnel, who have worked all their lives in a public health service, fear they do not have the necessary entrepreneurial skills to survive. General practitioners would have two roles, their traditional role of providing clinical care, and their new role of making a success of their fledgling enterprises. These concerns were heightened when the initial experiments in pricing general practice activity failed to produce a sufficient increase in income to meet the growing cost of professional expenses (Bradacova, personal communication).

Conclusion

The Czechoslovakian experience with salaried general practice has produced a number of interesting features. It has provided decent working hours and other employment benefits for doctors which have facilitated a wide involvement of women in the discipline. A separate daytime and out-of-hours service is central to this. The integration of acute, preventive and occupational health into primary care and its link with community based specialist services through the polyclinics had a number of advantages for patients and doctors. These gains, however, were achieved at the expense of patient choice and the continuing personal relationship between patient and doctor which is a feature of British general practice. In general, the system stands discredited.

The medical profession hope that the planned reforms will attract more finance and resources into health care. This should increase incomes and raise working conditions to place doctors on a par with their colleagues in western Europe and North America. On the other hand, the government hopes that economic liberalization through the health insurance system will be the 'instrument for the revitalization of the health services, the introduction of rational feedbacks, the restriction of demand and the control of the cost of health dare delivery.'[7] Neither of these contradictory impulses sees a future for salaried general practice. It remains to be seen who will be the winners and who will be the losers following its demise.

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