Position paper on the shortage of GPs and the perspective of primary care medicine

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1. Introduction

Primary Care:

As future health professionals, we will have face a major challenge: to ensure a constant quality of care for an aging population, while at the same time experiencing a reduced supply of general practitioners.[1]

This **shortage of general practitioners is extremely significant**, currently:

- **one fifth of them already are of retirement age**
- **more than one third are 60 years old or more**
- of this third, 71,3% admit they have no successor for their practice[2]

In their role as health promoters, GPs are at the forefront of preventing the onset of disease. **Increased provision of care in this specialty has been highly correlated with reductions in mortality** from cardiovascular, oncological and respiratory causes. **This reduction is much more significant for general practitioners than for specialists[3].**

The aspects of prevention and early management of risk profiles are fundamental, both for the well-being of the population and for limiting the increase in health care costs. Indeed, this last point has recently been brought to the forefront of the media following an increase in premiums between 3,5% and 9,5% depending on the cantons this autumn 2022 (average increase:6,6%).[4]
It is important to mention a study made by MFE in Zurich where **GPs and pediatrician's offices solved 94.3% of their patient's health problems themselves while their practice generated only 7,9% of the costs.[5]**

Polypragmasis:

Umbrella organisations such as santésuisse (a private body representing a large proportion of Swiss **insurance companies**) **calculate the average cost per patient for each physician**. If the average cost of a doctor is higher than the average cost of other doctors, the insurers apply pressure to reduce the average cost of the doctor, who is often a GP.[6,7,8] Doctors

considered "too costly per patient" are in a situation of polypragmasis (could be summarized by "overtreatment") and must pay a sum corresponding to the "surplus" they have costed. Many of these statistics are inaccessible to the accused doctors, who must pay an external business to analyse their data, and then, defend themselves.

Thus, **to keep the average cost as low as possible and avoid problems with the insurers, patients are more often redirected to hospitals and specialists**. These measures are considered favorably by the statistical calculation method of santésuisse[6,9,10,11]. However, **they are counterproductive for the health system given the higher prices charged by hospitals and specialists**. Apart from their excess over the calculated average, doctors who are accused by santésuisse receive no additional information and are given two options.

An accused doctor can either take the case to court, with little chance of winning, or haggle a confidential settlement of often less than half of the initial sum demanded by the insurers (these initial sums were often found between 100'000 and 200'000 frs for one year). In court, the doctors in question will have to justify statistically the reasons for their average extra cost and the particularities of their practice. Insurance statistics alone are sufficient to establish polypragmasis and if the practitioners fail to prove otherwise, they will have to repay the entire sum. This last option is rarely chosen. [6,7,8]

This practice is undignified and degrading for the profession: **it provides a strong incentive to lower the average cost per patient for the following year**. As a result, a decrease in the average cost of a GP will lower the overall average cost of all GPs. In this way, the **following year, other doctors whose practice is now considered "too expensive"** in relation to this new, artificially lowered average will be confronted by santésuisse. **Unfortunately, it is neither effective nor fair**: it is passed on to other parts of the health system [7,9] and doctors who mainly perform intellectual and lower cost procedures (such as primary care physicians) are disadvantaged.[6]

The negative consequences of the use of the statistical method by insurers are manifold: patient care is more fragmented, more expeditious, and polymorbid patients are less often treated as outpatients and more often hospitalized. Physicians, for their part, are constantly under pressure to be economical, which can even hinder good practice[6,9]. The resulting **moral conflicts put the practitioner at greater risk of burn-out** and may discourage practice.

2. Call to Action

The swimsa recognises that...

1. …primary care, prevention and interprofessional collaboration are essential concepts for the resilience of the health system and for cost containment.

2. …attractive conditions for career choice as a general practitioner must be created at faculty, hospital and state level.
3. …the current control methods and retrocessions charged to physicians do not promote cost reduction in the health care system, nor do they promote good practice or good patient care.
4. …pressure from insurers on primary care physicians reduces the attractiveness of the profession and its effectiveness.

The swimsa demands...

...from educational institutions…

1. that the training of doctors includes prevention and primary care based on a standardized federal model, and that they ensure the unification and good promotion swiss-wide.

2. …to continue to upgrade the academic research and training of primary care physicians.

3. …to identify factors that inhibit postgraduate choice of primary care medicine

4. …to systematically include courses in practice management and fee systems in the studies.

...to hospitals and health system providers…

1. …that they encourage and train the patient to make earlier and more frequent use of the GP and to self-limit certain procedures and underline the value of GPs.

2. …that they emphasize to their residents the importance of the work GPs do when the opportunity arises.

...to the federal government and the cantons :

1. …that they proclaim prevention as one of the main means of saving money and adopt the appropriate legislative and executive measures to benefit the whole population.

2. …that they perpetuate the new medical school places created and continue to create more.

3. … that they create more incentives in remote locations lacking GPs.

...to insurers :

1. …that they systematically integrate an analytical method by expert physicians into the statistical control method currently used and any future ones..

2. …that this analytical method :

a. Favours overall cost reduction instead of delegation to other health actors b. Considers quality time with the patient as a factor in prevention, compliance and change.
b.strengthens the role of GPs in primary care by allowing them to provide comprehensive care and reduce patient delegation to hospital or specialists.

The swimsa undertakes that:

1. Medical students are informed about the issues of being a GP during their studies and encouraged to become more involved in improving the health care system.

2. Solutions from other European health care systems that have proven to be successful are highlighted.

3. Main Text

Primary Care:

Some measures have been taken to address the predicted shortage of practitioners, such as the Bernese AIM (Allgemeine Innere Medizin = General Internal Medicine) program involving BIHAM (Berner Institut für Hausarztmedizin = Bernese Institute of General Practice) and the University Clinic for General Medicine[12], or the special program for human medicine approved in 2016 (Sonderprogramm Humanmedizin/programme spécial en médecine humaine). The latter aims to increase the number of doctors trained each year in Switzerland by almost 50% by 2025. With these funds, particular attention has been paid to improving postgraduate training in primary care medicine.[13]

However even with these last measures, counter efforts such as the pressure of the insurers may accelerate the decline in the number of existing GPs (many of whom are beginning to reach the age of retirement[12]). Furthermore, it may also discourage medical students who have completed their training from embarking on the path of primary care medicine. This will additionally be accentuated by the shortage of teacher doctors from the branch, following a general decline in the number of GPs. In short, although laudable efforts are being made to increase the attractiveness of primary care medicine at the academic level, it would also be necessary to remove some of the disincentives to its practice and add other incentives.

Some countries are good examples of what is possible, such as **Denmark**, which has managed to control the costs of the healthcare system and make the profession of general practitioner attractive. **The GPs account for around 70% of the country's doctors and are slightly better paid** (around 160,000 chf/year) **than their specialist counterparts**.[6]

In addition to that, in many European countries such as France, Danemark, Netherlands and Germany, basic medicines are reimbursed based on the **reference price system**. This system is designed to reduce the price of drugs and promote generic usage, which are 81,4% of the drugs used in Germany vs 27% in Switzerland). **The implementation of this system was recommended by a Swiss federal commission of enquiry in 2018**, it diminishes costs for society and promotes lower drug prices but with no advance since .[13]

Polypragmasis:

Currently, the Art. 56, para. 6 of the LAMal (Health Insurance Act) states: "The providers of (health) services, such as **doctors/nurses, and the insurers shall agree on a method** for monitoring the economic nature of the services".

From this control imposed by the law came the Swiss term "**polypragmasis**", which refers to the **practice of a doctor who costs significantly more than his colleagues and requires reimbursement from the doctor to the health insurers.**

Ms JUNOD, lawyer and professor of pharmaceutical law at the Geneva Law School, and associate professor at the HEC in Lausanne, summarised the situation factually in her analysis: "Polypragmasie, Analyse D'une Procédure Controversée":

*"There is an **obligation to "reimburse" at the expense of the doctor** in private practice as soon as it is established that his fee notes at the expense of the funds "are on average significantly higher than those of other doctors", provided that:*

1) *these other doctors practice in the same region,*
2) *these other doctors have a similar clientele,*
3) *there is no justification for the difference in cost.*[6]

In order to determine whether a doctor has indeed overcharged or wrongly prescribed, 2 methods currently exist:

The analytical method consists of giving certain files drawn at random from the patient base of the allegedly offending doctor to a group of doctors mandated by the court who will analyse whether the costs in this file are indeed justified. For example: is it right to send this patient for an MRI according to the available history? Or is it right to prescribe a certain medicine in a certain situation? The doctor under suspicion can also justify himself and explain why he gave a particular treatment or took a particular step.

"The statistical method consists of comparing the average annual cost per patient of the doctor concerned with the cost of all his colleagues in the same FMH speciality and practising in the same canton. The doctor must justify his costs if they are 30% higher than those of his colleagues. If he fails to do so, he must "reimburse" the part that exceeds the tolerance margin. Thus, the statistical method does not require the examination of individual patient files; there is no need to examine whether the treatment of a particular patient was appropriate. " [6]

"Despite the almost unanimous criticism of doctors and some of the doctrine, the Federal Insurance Court (FIC) regularly reiterates its confidence and preference for the statistical method. Indeed, this method allows "a standardised, broad, rapid and continuous examination of the economic impact". In contrast, according to the FAT, the analytical method is so costly as to potentially discourage health insurance companies. " [6]

Some inconsistencies and problems with this method :

➢ The statistical method is very opaque. The details of these statistics, necessary for the defence, are not available to those who are incriminated.[6,10]

➢ **It is up to the doctor to prove his innocence**, the statistics given by the insurance company are sufficient to establish the presumption of "guilt". The degree of proof required is that of a **preponderance of probability**. This means that **the court does not need to be sure that the doctor is guilty of polypragmasis to order him to pay**. It only needs to consider that he is more likely to be "guilty" than innocent. Santésuisse therefore only has to present its statistics to incriminate a practitioner.[6]

➢ **General practitioners, already a profession with a low profile in the medical profession, are particularly affected by these accusations** of polypragmasis, even though their work has the greatest population impact. Specialists have a much greater margin in the statistical calculation of their costs despite the obvious shortage of GPs.[9,10]

➢ **The cost in reputation, lost time and money of the proceedings for doctors under attack is extremely high**. It is also worth mentioning the emotional distress and acute stress resulting from this procedure. The impact on personal fulfillment is significant when the remaining choices are either to reduce the quality of care offered or to undercharge for their work.[7,8]

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