BMA

International models of general practice

British Medical Association
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Contents

Introduction

The BMA supports an NHS that is publicly funded and free at the point of delivery and opposes charging patients for services including GP appointments.[a,b] However, in response to concerns[c] of the current pressures facing general practice in the United Kingdom (UK), this paper explores how our health system compares to health systems across the world and how they fund and organise general practice. Alongside this it looks at what evidence exists to compare how sustainable and effective different models of general practice are.

This paper looks at what characterises different approaches to general practice internationally and what conclusions can be drawn about the advantages and disadvantages of different systems. It focuses on five key areas:

1. How funding for healthcare is raised before point-of-use
2. How money is allocated to general practice
3. What patients are expected to contribute at point-of-use for general practice
4. Workload pressures
5. The role and status of the GP

Methodology

To ensure a manageable study size we have focused on general practice in a subset of countries. These have been chosen because of their similar level of economic development to the UK, the varying range of general practice systems used, the wide range of geographical areas covered as well as the availability of data and evidence. The countries focussed on are:

- Australia
- Canada
- France
- Germany
- The Republic of Ireland
- The Netherlands
- New Zealand
- Sweden

Information on the general practice systems in these countries was gathered from desk-based research including a review of available literature, analysis of available international data, surveying international medical associations and data obtained by the European Union of General Practitioners.

This review has two key limitations. Firstly, as outlined above it focuses on a relatively small subset of countries. Secondly, a lack of robust comparable international data makes it difficult to draw firm conclusions about the differences in health systems.

a ARM 2011 (Resolution 1437) That this Meeting still believes in the NHS, universal, comprehensive and free at the point of delivery and demands that the government categorically states its agreement with this principle.
b ARM 2017 (Resolution 549) That this meeting opposes charges for patients: i) to see a GP; ii) if an appointment is missed.
c LMC Conference May 2017 (Resolution 501) That conference instructs the GPC to produce a discussion paper outlining alternative funding options for general practice, including co-payments.

Definition of general practice

The definition of general practice differs across countries and the role of family medicine varies. Due to these differences, this review has taken a broader definition of general practice as *'the first level of professional care where people present their health problems and where the majority of the population's curative and preventative health needs are satisfied'* (Primary Care Health Activity Monitor for Europe).[1]

The mix of disciplines that make up the general practice workforce differs from country to country. For example, in Germany, secondary care specialists such as orthopaedics, gastroenterologists and paediatricians, can be based in the community rather than hospitals. However, general practitioners and family practitioners are the most common providers of care in this review.

Differences such as these can make it difficult to make direct comparisons of models of general practice across different countries. However, this review explores lessons that can be drawn from the different international approaches to funding and organising general practice.

How is funding for healthcare raised before point-of-use?

UK

The NHS in the UK is publicly funded mainly through general taxation, and a smaller proportion from national insurance (a payroll tax). Additional elements such as prescription charges and hospital parking charges also go towards the NHS. Around 11% of the population also buy supplementary cover for more rapid and convenient access to services; however much of this will not be comprehensive. Private insurance will not cover A&E care and is unlikely to cover general practice, mental health and maternity care.[2]

In all the countries we reviewed, the public are asked to contribute funding for universally available healthcare before the point at which they use services – either through national or local tax revenue or statutory health insurance (which can be funded through a number of sources). PHI (private health insurance) systems also run alongside publicly funded health services in all the countries we reviewed, with their use varying between countries.

Table 1: International healthcare funding models

	General tax revenue	Statutory health insurance	Private health insurance
Australia	✔		✔
Canada	✔		✔
France		✔	✔
Germany		✔	✔
Republic of Ireland	✔		✔
Netherlands		✔	✔
New Zealand	✔		✔
Sweden	✔		✔

General tax revenue

Many countries raise funding for healthcare, including general practice, through general tax revenue. This is generally considered to be broadly equitable, where general taxation is drawn from the whole population, regardless of health status, income or occupation. For example, Canada's Medicare universal system is funded in each province through general taxation, where GP appointments are covered and free for all if the practice opts to remain under the public system.[3]

The level of funding raised through general taxation for public health systems varies across countries. For example, Sweden's health system is primarily funded through taxation (mainly raised through local county councils), with 84% of the country's health spending being publicly financed. These levels are slightly lower in Canada with 70% of total health spending coming from public sources.[4]

However, not all health services are covered by funding raised through general taxation. In the Republic of Ireland, general taxation is used to offer comprehensive publicly funded health services to low-income groups and universal public hospital coverage, but there is no universal general practice cover.[5]

Statutory health insurance

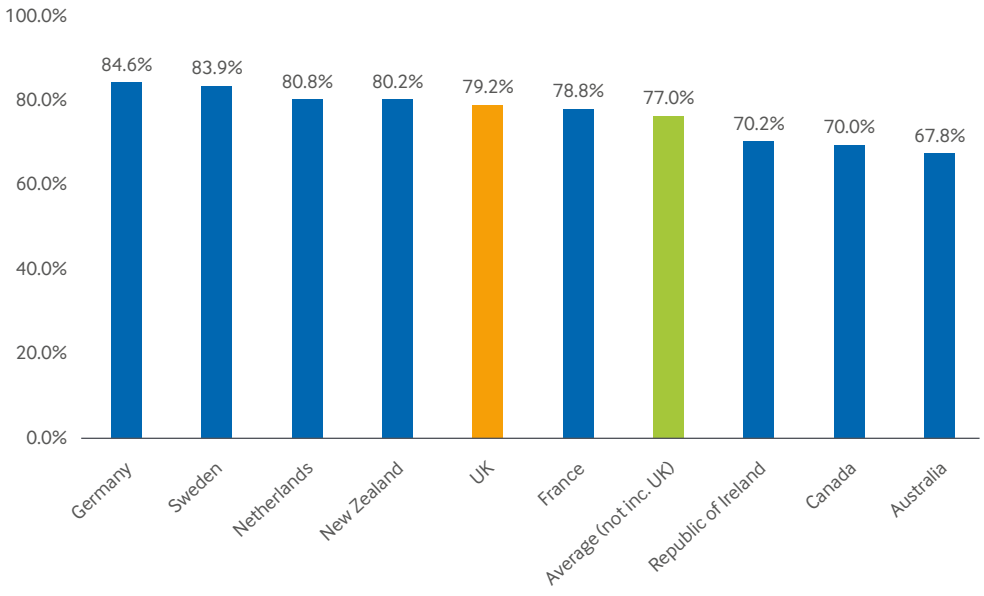
Another means through which health care systems can be funded is through statutory contributions that are deducted from an individual's salary for health insurance. Like general tax revenue, ensuring equity and universal access based on clinical need is a principal objective of SHI (statutory health insurance) systems. Those registered as unemployed can apply for state-funded health insurance.

Unlike general tax revenue, people tend to have a choice of provider for their SHI. This choice varies between countries. For example, in the Netherlands in 2016 four insurer groups dominated 90% of the insurance market.[6] However, in Germany, statutory contributions fund the government health scheme, which is administered by over 100 competing SHI insurers. This covers primary care, some secondary care[d], hospital care and basic dental treatment.[7] Proponents of this approach argue that a more diverse market of insurers tends to bring increased competition and leads to reduced premiums and a broader offer of extra benefits and bonus programmes for the public.[8]

SHI systems are mainly financed through employer/employee contributions. However, other sources such as general tax revenue also help to fund these systems. In France 50% of SHI is financed by employer and employee payroll taxes. However, other sources include a national earmarked income tax (35%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and private health insurance companies (13%); and state subsidies (2%).[9]

For all countries researched in this paper, the majority of healthcare is publicly funded, either through general tax revenue or through SHI. However, the proportion of health spending that the public contributes through private health insurance or private provision varies considerably.

Figure 1: proportion of health expenditure by public schemes (2016)[10]



Source: OECD (accessed October 2017)

d This includes elective secondary care and secondary care consultations with specialists that are based in the community.

Private health insurance

Private healthcare systems also run alongside publicly funded systems in most countries. This is mainly used to complement or supplement statutory cover,[e] as in France where around 70% of doctors' fees will be reimbursed through their SHI system.[11] Therefore, the remainder must be paid for either by the patient or through supplementary private health insurance (some out-of-pocket payments will be capped by state-sponsored complementary insurance).

Table 2: Estimated prevalence of PHI in international populations[12]

France	~95% buy or receive government vouchers for complementary coverage
Netherlands	84% buy complementary coverage for benefits excluded from statutory package
Canada	~67% buy complementary coverage for non-covered benefits
The Republic of Ireland	~56% of the population have PHI[13]
Australia	~47% buy complementary and supplementary coverage
New Zealand	~33% buy complementary coverage and supplementary coverage
Germany	~ 11% opt out of statutory insurance and instead buy complimentary and/or supplementary coverage. It is a legal requirement to have some form of insurance.
Sweden	~10% of all employed individuals aged 15–74 get supplementary coverage from employers for quicker access to specialists and elective treatment

The Australian Government actively encourages enrolment in PHI through reforms including a 30% rebate for premiums and, above a certain income, a penalty payment for not having PHI. In 2016 47% of the population had private hospital cover and 56% had general treatment cover.[14] This is an increase from 2006 when around 43% of the population had cover for both of these services.[15]

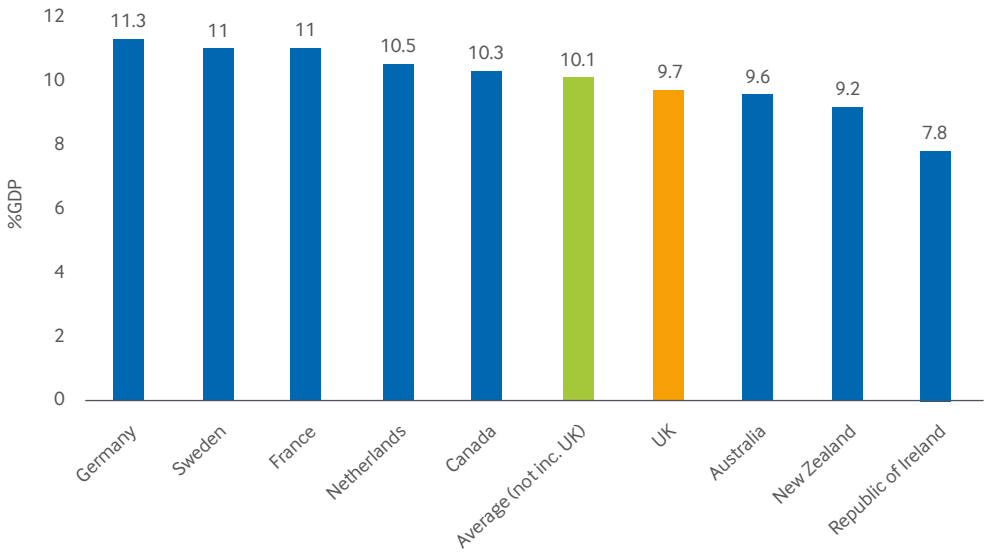
Variation in funded provided by government

Having looked at the different means through which funding for healthcare is raised, it is also worth noting that there is considerable variation in the percentage of national income that different countries dedicate to healthcare.

BMA analysis of OECD data on health spending has shown that the UK continues to lag behind comparable European countries in the proportion of GDP it dedicates to healthcare.

e **Complementary PHI:** private health insurance that complements coverage of statutory insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., cost-sharing, co-payments). **Supplementary PHI:** private health insurance that provides coverage for additional health services not at all covered by the statutory insurance scheme.

Figure 2: Health expenditure as a proportion of GDP (2016)



Source: OECD stat (accessed October 2017).

Key points:

- In all the countries reviewed the public fund the health system either through general tax revenue, SHI or PHI or a combination of these sources.
- The majority of healthcare is publicly funded, either through general tax revenue or through SHI.
- The proportion of health spending that the public contributes through purchasing PHI or private provision varies considerably.
- There is considerable variation in the amount of national income that is dedicated to health across the countries, with the UK spending a smaller proportion of GDP on healthcare than the average of the countries reviewed.

How is money allocated to general practice?

Internationally there are a variety of approaches for allocating money to general practice including capitation, payment-for-performance and fees-for-service.

UK

Within the UK, the capitation model is used to determine core funding for general practice.[1] The model is uncommon however outside of primary care, although this could change in England with the development of new models of care,[2] ICSs (integrated care systems) and ACOs[3] (accountable care organisations).

Elements of payment-for-performance are used in primary care through the QOF (quality and outcomes framework) in England and Northern Ireland. QOF provides funding to GP practices for achieving performance indicators such as managing chronic diseases and implementing preventative measures. A small number of CCGs in England have recently begun exploring local alternative incentive schemes. Scotland has ended QOF and is planning new payment arrangements for general practice and Wales has agreed to fundamental reforms to QOF. In addition, practices in England, Northern Ireland and Wales receive fee-for-service payments for the provision of a limited number of services, such as some immunisations and local enhanced services.

The BMA has publicly called for a greater proportion of NHS funding to be allocated to general practice.[16]

As Table 3 shows, most of the countries we reviewed use capitated payments combined with fee-for-service elements, with some countries also using pay-for-performance mechanisms.

Table 3: Funding models for general practice in state subsidised healthcare

	Capitation	Fee-for-service	Pay-for-performance
Australia		✔	
Canada	✔	✔	✔
France	✔	✔	✔
Germany	✔	✔	
Republic of Ireland	✔	✔	
Netherlands	✔	✔	✔
New Zealand	✔		✔
Sweden	✔		✔

Capitation payment systems

Capitation payments are made to care providers based on the number of patients in a target population.[f] In general practice this population is usually the registered patients at a practice. Crucially capitation payments are not linked with how much care is provided but rather the characteristics of the target population, such as age or number of patients with chronic conditions.

In the Republic of Ireland for example, the main system of allocating money to general practice is through an annual capitation payment. The payment covers the registered practice population who have a medical card or GP card.[g] The registered population is then weighted for age and gender. Additional allowances are also available to general practice. These can cover out-of-hour fees, rural practice and remote area payments. The average payment to GPs for the capitation payment per eligible person was €226.07 in 2015[17] (£168.71[h]). This amount has been reducing over the last five years.

Pay-for-performance

Pay-for-performance is an arrangement where providers are financially rewarded for achieving high performance or quality. Each scheme rewards providers in a unique way. In New Zealand, PHOs (primary health organisations) coordinate primary health care as well as receive additional funding from the government to improve access and promote health.[i] Pay-for-performance is used by PHOs to provide additional funding to GPs who reach targets for cancer, diabetes, cardiovascular screening and vaccinations.[18]

Fee-for-service payment systems

The fee-for-service system is based on general practice being paid for specific activities. It is also known as 'payment-for-activity'. For many state funded health services, the government will set a fee for a service and this is then claimed back by the patient, general practitioner, or by private health insurance companies. In France for example, most doctors have a signed contract with the French healthcare system to provide medical services at a nationally agreed rate. These rates may vary depending on whether it is an evening, weekend or home visit.[19] In Germany, the value of fee-for-service points is capped by a global budget constraint.[20]

Some healthcare systems allow general practitioners to add an additional amount above the nationally state funded agreed fee. In Australia, GPs can claim fees-for-service through an electronic system with the Government; this is a reimbursement of the fees negotiated between the Government and general practice. In addition, GPs can charge on top of the Medicare fee, which the patient or their private health insurance is responsible for. The charge on top of the Medicare fee is at the discretion of the individual GP practice. In 2014-15 about 83% of GP appointments were provided without this additional charge.[21] *(More information on patient charges can be found in the next chapter.)*

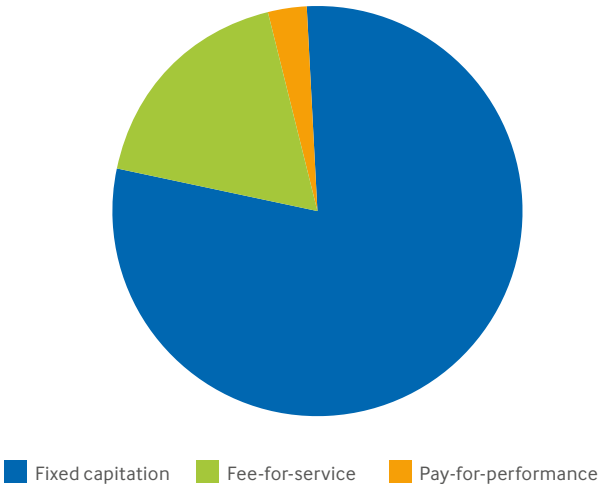
Combining two or more payment systems

Most of the countries focused on for this paper use two or more payment systems. This reflects the diverse characteristics of each country's payment system, and how they can be used to achieve different objectives. For example, in 2015, the Netherlands introduced a new model for how general practice was funded based on three systems: capitation (representing about 75% of spending); fees-for-service (representing about 15% of spending); and, additional funding negotiated directly between individual GPs and insurers (represents about 10% of spending).[22]

f A target population will vary depending on the healthcare system and the priorities of a particular government.
g Waged citizens earning under a certain amount are entitled to a medical card or GP visit card. This allows the holder to receive certain services, including GP appointments. Generally, a dependent spouse or partner or children are also entitled to free services.
h Currency converted into pounds using average 2015 exchange rate: Euro 1.34. Source: UK foreign exchange services.
i There are 31 PHO across New Zealand. These are networks of self-employed primary care professionals.

In Sweden healthcare providers, including general practitioners, are paid using a number of payment systems. Providers are paid a combination of fixed capitation for their registered individuals (80-95% of total payment), fee-for-service (5-18% of total payments) and often pay-for-performance related income (0-3% of total payments) as well.[23] This variation in the use of payment systems in general practice is increased further by the devolved character of the Swedish healthcare structure. Each of the 21 Swedish county councils are individually responsible for organising primary healthcare in their area. Subsequently each county council chooses how it wants to remunerate primary care. This has created regional differences in how general practice is funded.

Figure 3: Payment systems used in Sweden for primary care



Canada's decentralised system also results in increasing variation of payment methods for general practice amongst provinces and territories. This variation is growing with capitation and pay-for-performance becoming more common. For example, in 2014/15 fee-for-service payments made up 45% of payments to GPs in Ontario, compared to 68% in Quebec and 84% in British Columbia.[24]

A decentralised payment system brings flexibility for local variation but at the same time it can create challenges in terms of national performance reporting.

Key points:

- Capitated payments, fee-for-service payments and pay-for-performance payments are the main ways that funding is allocated to general practice.
- Capitation payments are made to care providers based on the number of patients in a target population, such as the registered patients in a practice.
- Pay-for-performance is an arrangement where providers are financially rewarded for achieving high performance or quality.
- The fee-for-service system is based on general practice being paid for specific activities.
- Most countries use a combination of two or more of these systems. Capitated payments combined with fee-for-service elements is the most common combination.

What are patients expected to contribute at point-of-use for general practice?

In many of the countries covered in this paper patients are expected to make some form of contribution to general practice at point of use. The following describes the different systems used and the variation in patient contributions.

UK

In the UK, patients are not expected to pay any upfront costs for visiting their GP. In England there are some charges for prescriptions. Whereas in Scotland, Wales and Northern Ireland they are free of charge for all patients.

Full upfront payment with exemptions

In some countries patients are expected to pay the total cost of GP services upfront, unless they qualify for exemptions.

This is the case in the Republic of Ireland, although there are exemptions for children under the age of six and adults over the age of 70. Those receiving social welfare, on low incomes or who have serious/long-term illnesses may be granted a Medical Card which entitles them to more free services, such as GP appointments. People not qualifying for a Medical Card may qualify to obtain a GP Visit Card, which is also based on a means-test but has higher income thresholds.[25] The majority of people (c.60%) do not have these cards and must pay for GP appointments.[26]

There are no set fees for a GP visit in the Republic of Ireland. Costs are set by local surgeries, typically around €50-€60 per visit.[27] Those with private health insurance can, depending on their plan, have their GP costs paid or refunded, either fully or partially, by the insurance company.

Co-payment with exemptions

Patients in some countries pay part of the cost for GP services at the point of care, with the remaining funding provided by government.

In New Zealand, capitation payments make up approximately half of practice income with the rest coming from patient charges. Practices are mostly run as small businesses and retain the right to set the levels of co-payment to fit their business models, with no upper limit. As in the Republic of Ireland, there are exemptions for low-income areas and socio-economic groups. For around a third of the population, co-payments are capped at NZ$17.50 (£9.72) per visit and primary care is mostly free for children aged 13 and under, and subsidised for older people over the age of 65.[28]

A similar model is used in Sweden, with regional councils rather than practices setting co-payment rates. Nationally, annual out-of-pocket payments for healthcare visits are capped at SEK 1,100 (£100.27[j]) per individual. In all county councils, patients under the age of 18, as well as some other targeted groups, are exempt from charges for visits.[29]

j Currency converted into pounds using average 2017 exchange rate: Swedish Krona 10.97. Source: UK foreign exchange services.

Subsidised payments

In some countries where SHI dominates patients might have to pay upfront for GP appointments, but are reimbursed the majority of their fees later.

For example, in France patients pay upfront for visiting their GP but are then automatically reimbursed a percentage of the medical fee by the state-run health insurance provider, leaving a small amount still to pay. The current cost of a regular visit to a GP is €23 (£20.17[k]) and patients are reimbursed about 70% of this. The rate varies depending on whether it is an evening, weekend or home visit. The remaining costs are either paid for by the patient or through supplementary private health insurance.[30]

In Australia, the universal health system funds primary care services and GP visits are subsidised at 100% of the Medicare fee (AU$ 36.30/ £21.74[l]). However, GPs can choose whether to charge above the Medicare fee and, if they do, patients have to pay the difference. Fees are not regulated and GPs are free to amend their fees as they wish. In 2014/15, about 83% of GP visits were provided without a charge to the patient.[31] Whether patients have to pay upfront or not depends on individual practice billing policies. Some practices will 'bulk bill' patients, meaning Medicare directly pay the practice, while others directly bill their patients, with patients paying the costs upfront and subsequently receiving the rebate.[32]

No upfront cost

In other countries with SHI systems in place, such as the Netherlands, insurance covers GP visits and there are no upfront costs to patients.[33]

Key points:

- Patients are expected to make some form of contribution to general practice at point of use in many of the countries reviewed.
- This is through:
  - **Full upfront payments** – patients are expected to pay the total cost of GP services upfront, unless they qualify for exemptions.
  - **Co-payments** – Patients pay part of the cost for GP services at the point of care, with the remaining funding provided by government.
  - **Subsidised payments** – where SHI dominates patients might have to pay upfront for GP visits, but are reimbursed the majority of their fees later.

k Currency converted into pounds using average 2017 exchange rate: Euro 1.14. Source: UK foreign exchange services.

l Currency converted into pounds using average 2017 exchange rate: Australian Dollar 1.67. Source: UK foreign exchange services.

What is the role and status of the GP?

This section explores some of the differences in the way the role of the GP is fulfilled across health systems and different expectations placed on GPs as a result.

UK

Characteristics of the role and status of GPs in the UK include:

- Practice list – patients must register with a GP practice as an NHS patient to receive NHS care, with practices offering continuity of care to a defined patient list.
- Gatekeeping role – in most cases, patients in the UK must see their GP in order to access specialist care.
- Autonomy – most GPs are independent contractors, or work as salaried doctors employed in practices run by GP partners. This gives general practice a unique role in the NHS, enabling them to act as independent advocates for their patients within the system. It also provides a direct incentive to work efficiently and to respond quickly to change.

These characteristics are, of course, not static. The development of new models of care across the UK will potentially impact on the role and status of GPs, as different parts of health systems are encouraged to work together more closely in multidisciplinary teams.

Patient registration

In most of the countries covered in this paper patients are not required to register with a GP, although in some systems there are financial incentives to encourage patient registration. For example, in France patients must register with their GP to claim full fee reimbursement[34] and in New Zealand GP care is subsidised if you are registered.[35] In the Republic of Ireland, if a patient has a medical card they must register with a practice that provides services covered by the Health Service Executive to receive free GP care.

However, in some countries registration is not required or incentivised and patients are able to see any GP. For example, in Australia there is no requirement for patients to register. Patients can choose what practice they attend on any particular day and GPs are paid for services given. This facilitates greater choice, but it may also limit continuity of care and could create additional issues relating to the sharing of patient records.[36] It can also lead to 'prescription shopping' where some patients visit many doctors without telling them about their other consultations to access the same prescriptions, or receive a large amount of medications well in excess of their prescribed dosage.[37]

Allowing patients to go to any GP surgery can also cause instability in practice income. In Australia, because patients can go to any practice on any day, practice income is typically more variable. Practices can increase their income by seeing more patients and providing more services, meaning working harder with longer hours is likely to generate more income. Practices could though, potentially limit the amount of work they have, as they do not have responsibility to care for a specific population.[38]

In terms of patient experience, in countries where registration is not required GPs may be motivated to improve access and availability for regular patients but if they are popular they can become overbooked with appointments. Although neighbouring GPs may be able to manage the extra workload there is a loss of continuity and medical records can become fragmented.

Gatekeeper role

GPs act as gatekeepers to access secondary and specialist care across many countries. However, in most countries there is no formal gatekeeping role. In Sweden, GPs are often the natural first point of contact but patients are free to contact specialists directly. In Germany, GP referral is not required to access specialist care, which is free for patients with statutory health insurance.

Table 4: International GP gatekeeping systems to access specialist care[39,40]

	Do GPs have a gatekeeper role to specialist services?
Australia	Yes, incentivised
Canada	Yes, incentivised. In most provinces, specialists receive lower fees for patients not referred.
France	Voluntary, incentivised (although referrals not needed to see certain specialists.)
Germany	No
Republic of Ireland	Yes, incentivised
Netherlands	Yes
New Zealand	Yes
Sweden	No

In some countries, as with patient registration, although there is not a requirement to go through the GP there are financial incentives to encourage patients to do so. For example, in the Republic of Ireland, if patients are referred by a GP for an out-patient appointment, an x-ray or blood test or to an emergency department they will not be charged. If patients go directly without a GP referral there is a charge for these services.[41] In Australia, a referral is needed for a patient to receive the Medicare subsidy for specialist care. Patients can go direct to specialist care but will need to cover the cost themselves.[42] This is similar to the process in France, although referrals are not needed to see a gynaecologist, a paediatrician or an ophthalmologist.[43]

Employment status

In most countries, the independent, self-employed model is still by far the most common. This is the case in the Republic of Ireland, New Zealand, France and the Netherlands. In these countries, GPs run their own surgeries, hire clinical and administrative staff and generally function like a small business. In Australia, there is a similar model but over the last few years' practices have been getting larger and are increasingly owned by corporations rather than GPs.[44] In contrast, in Sweden all GPs are salaried and employed by the regional councils.[45]

Key points:

- Patients do not have to register with a GP in most of the countries reviewed.
- However, many countries have implemented financial incentives to encourage patients to register with a GP.
- In most countries reviewed, GPs act as gatekeepers to access secondary and specialist care. In those countries where this role is not mandatory, patients are financially incentivised to obtain referrals from GPs for these services.
- The self-employed model for general practitioners is still by far the most commonly used model in the countries reviewed.

Workload pressures

The following section explores what evidence exists relating to workload experienced by GPs across different health systems. Due to a lack of reliable data it can be very difficult to quantify workload levels and compare them across countries. However, in general it seems GPs in many countries experience some similar workload challenges.

UK

Workload in general practice is rising. For example, there was a 38% increase in the number of consultations in England between 1995 and 2008,[46] although reliable data has not been collected since then. Data from Northern Ireland shows that consultation rates have increased by 63% between 2003/4 and 2013/14.[47]

In addition, many GPs in the UK report the need to do administrative work during evenings, weekends, or days off.[48] A BMA survey of GPs in England in 2016 found that 84% reported workload as excessive.[49] However overall, there is very little other quality data available on GP workload levels in the UK.

Table 5 sets out some available information about differences in general practice workload levels across countries, based on a BMA survey of international medical associations in September 2017.

	Average appointment length	Average GP working week
Australia	15 mins	38 hrs
Canada	15 mins	49 hrs
France	–	–
Germany	–	50 hrs
Republic of Ireland	–	–
Netherlands	11 mins	43 hrs
New Zealand	15 mins	35 hrs
Sweden	20 mins	40 hrs
UK	8-10 mins	45-50 hrs[50]

Table 5: Indicators of workload in general practice

Key workload pressures

The following sets out some of the most commonly cited pressures impacting on workload that are experienced internationally.

Administration

Anecdotal evidence across countries suggests that administrative tasks contribute significantly to increased GP workload. In Sweden, GPs reportedly spend around 1.5 hours a day on administration work[51] and physicians in Germany spend one-third of their working time on tasks such as writing reports and referral letters, case conferences and practice management.[52] In a 2011 survey of GPs, the Australian Medical Association reported that *'30% of GPs were spending up to or more than the equivalent of a full day's work doing Government paperwork, seeking telephone authorisations, or performing other bureaucratic tasks that kept them away from patient care'*.[53]

Workforce

Shortages of GPs is cited as an issue contributing to increases in workload levels across many countries. A lack of specialists in general medicine has been identified as the main issue that impacts workload in Sweden.[54] In New Zealand, 44% of GPs intend to retire in the next 10 years. Thirty-two per cent of these have already reduced their hours and another 25% intend to reduce their hours in the next two years. Although the number of younger GPs is growing, there is a significant gap of mid-career GPs.[55]

In addition to the number of GPs working, the distribution of the workforce can impact workload. Workload can be significantly increased for those GPs working in rural areas, particularly in Australia[56] and New Zealand,[57] as well as in Germany where they not only work longer hours than colleagues in urban areas, they also have to carry out more home visits.[58]

Alleviating workload pressures

Although readily comparable evidence is not available, there are some examples of countries acting to address workload pressures.

Workforce diversification

One initiative that is currently being promoted, is the diversification of workforce in general practice to include other health professionals. For example, in Sweden, investment in nurses is high in primary care and the number of doctor consultations per person is low.[59] This may be explained by the fact that nurses and other health professionals such as physiotherapists, occupational therapists and psychologists, play an important role in primary care centres.[60] Australia has also adopted a GP led team based model of care, including the use of practice nurses, with over 12,000 practice nurses now working in primary care.[61] In addition, some provinces in Canada such as Ontario and Alberta have put in place new primary care delivery models that provide capitated to the practice to enable the hiring of other practitioners such as nurses, pharmacists and mental health coordinators.[62]

Models of care

The consolidation of practices into larger practices has become common in Australia, one of the aims of which is to address workload issues. The proportion of GPs working in a practice with six or more doctors has increased from 47% in 2008 to 61% in 2015.[63]

Alternative ways of seeing patients have also been implemented to help alleviate workload pressures. For example, telehealth has been implemented in many countries.[64]

Case study: Healthcare Home Model of Care Requirements

There is an increasing move towards the 'Healthcare Home Model of Care Requirements'[65] in New Zealand, launched in 2011.

This model aims to address challenges of rising demand and an ageing workforce through principles such as offering alternative options for patients via email and telephone; targeting of face to face consultations to those that need them most; shifting general practice from a reactive service to one where all 340 are planned with the patient; moving to a shared, cloud-based patient information system to enable timely care and effective co-ordination of activity; and removing waste in practice systems and processes that add no value to the patient, the practice or the system.[66]

This model has been positively received in those practices where it has been implemented. For example, over 12 months, one practice estimated a saving of 44.45 working weeks of patient time. This was a result of effective GP triaging and offering alternatives to face to face care in the surgery.[67]

Key points:

- Although a lack of reliable data makes it difficult to directly compare the workload levels of general practice across countries, it is evident that many similar workload challenges are experienced.
- These challenges include high levels of administration work and workforce shortages.
- Diversifying the workforce in general practice has been used by some countries to help overcome workforce shortage issues. This includes investment in nurses and other allied health professionals.
- Other methods such as consolidating practices and using telehealth to see patients are also being used to address workload pressures.

Discussion

It is evident that the UK's health system is in many respects unique compared to the countries examined in this paper. i.e. the NHS is funded mainly through general tax revenue, patients are not expected to pay for care at the point of use and only a small proportion of the population has private health insurance. Other countries in this review have health system that are either predominantly funded through SHI, expect patients to pay for care at the point of use or have a large proportion of the population purchasing PHI.

This, along with the difficulty in comparing international evidence due to the different context and structures of healthcare in different countries, can make it difficult to draw firm conclusions about advantages and disadvantages of different systems. However, the following section sets out some of the reported benefits and challenges of the systems used across the limited subset of countries researched for this paper.

Funding healthcare

Most countries covered in this paper use multiple sources for funding healthcare. There are benefits and challenges experienced with most funding models. For example, SHI is often considered to be a transparent way of funding healthcare. Funds can be kept separate from other government-mandated taxes and charges, providing increased transparency and certainty about funding levels for health in the medium term. However, SHI systems are relatively expensive. Costs are pushed up as these systems tend to be administratively complex. The existence of multiple health insurance funds and fragmentation in healthcare purchasing can further drive up costs.[68]

It has been argued that PHI reduces the burden on public finances by taking some people out of the state system; although this is not guaranteed. For example, the reforms in Australia where government offered reductions in premiums and issued penalties for not having private health insurance did result in enrolment to private health insurance schemes increasing. However, it did not achieve their aim of easing financial and demand pressures in the public system and have been criticised for disproportionately benefiting higher earners and diverting government funds away from the public system.[69]

A country's context, history, and social values can often impact its healthcare model's effectiveness. There are high costs associated with a transition in funding methods. Therefore, many countries rarely make major changes to their established primary way of paying for health care.[70]

Allocation of funding to general practice

There are a wide variety of payment models for general practice, both internationally and within individual countries. Each model brings both advantages and disadvantages, and shapes the role and impact of the GP within that health service. There is no clear model that works best for general practice. For example, the Australian fee-for-service system has been criticised for being inflexible. It has also done little to promote integration of care.[71] Cost containment for general practice can also be problematic in fee-for-service systems, since budget setting is difficult.

It could be argued that a capitation model encourages a more integrated approach to care, and there is evidence that professionals work more closely with each other under a capitated budget.[72] At the same time however, there is evidence from Dutch capitation models[73] that it creates a negative incentive to provide as little care as possible to minimise costs. The model has also been criticised for capitation being inflexible to changing levels of demand. Increasingly there is a trend of single health systems using a number of payment models. This allows flexibility. It also means that payment models can better fit the population they serve and the objectives of individual health services. However, this can also lead to inconsistencies in health systems. For example, having 21 different health systems in Sweden each run by the local council can lead to constant changes to care.[74]

Patient contributions

Charging patients for GP services has been a topic of debate within the NHS, with the BMA's Representative Body recently reaffirming its position that the Association opposes charging patients for services including GP appointments.

Two advantages usually put forward by proponents of GP charging are that it is an effective way to generate extra income either for the NHS or for practices and that it could help with workload by deterring patients with trivial complaints from seeing a GP – at a time when NHS finances are precarious and practices are under unprecedented pressure. However, our research finds that there is little robust comparable evidence in this area, and the implications of introducing charges for GP services are likely to be complex and would bring additional administration costs and new bureaucracy at a time when many GPs want to see this reduced.

Impact on patients

In countries where there is a charge for GP appointments, there is a growing concern about creating a two-tiered health system and exacerbating health inequalities.

Entitlements under the various private health insurance plans vary but the main benefit is faster access to treatment. For example, although the USA was not covered by this review, it is widely reported that disparities exist between uninsured and insured patients. More than 67% of U.S. residents receive health coverage through private voluntary health insurance.[75] However, it has been found that uninsured people receive worse care and more delayed care than privately insured people.[76]

In addition, in the Republic of Ireland around half of the population have private health insurance. Those patients that have medical cards or pay upfront for public services are often deprived of timely access to GPs and treatment.[77]

> *"I remember seeing an 87 year old patient whose full medical card was downgraded to a GP Visit Card because her income was €13 over the threshold. This meant that she would have to pay the full price for her medicines as opposed to the €2.50 per item charge which everyone with a full medical card pays."*
>
> ***Dr H Siddiqi, GP working in Republic of Ireland 2016/17, BMA survey 2017.***

There is also a significant difference in number of consultations between those who are exempt from charges because of holding a medical card and those who have to pay upfront in the Republic of Ireland.[78] However, although this may lead to fewer unnecessary appointments, it can also lead to fewer necessary appointments. For example, a cross sectional study[79] of general practice patients found that reduced appointments were most pronounced amongst younger adults, over 40% of whom had a medical problem but did not see the GP because of cost.

Medical cards in the Republic of Ireland are strictly means tested and can result in those patients that fall just outside of the threshold paying the full cost for services.[80] This can prevent patients seeking much needed health care due to the inability to pay.

In France, the proportion of people reporting unmet health needs due to financial reasons among the low-income population increased by more than 50% between 2008 and 2014.[81] In Australia between 1996 and 2003 the affordability of GP fees declined, with the average cost of visiting a GP increasing and the percentage of appointments with co-payments also increasing. This coincided with a reduction in demand for general practice and a high-level of unmet health needs recorded.[82] These trends have been central to the debate in Australia around health inequalities and the fees-for-service payment system. In addition, lower use of primary care services because of financial burdens can lead to increased hospital stays.

Impact on funding

Some countries attempt to manage health inequality concerns by having exemptions for vulnerable groups, as is the case for prescription charges in England. In England 90% of all prescriptions are dispensed free of charge.[83] If the same boundaries were applied to GP appointments, this would severely restrict the amount of money GP charging could raise. For example, there are approximately 340 million GP consultations in England per year.[84] If a £10 charge per consultation was in place £3.4 billion could in theory be raised (if no exemptions were applied and assuming no reductions in consultations). However, if the same proportion of exemptions currently used for prescription charges in England was applied and only 10% of these consultations were charged for, this represents just 3.5% of England's investment in general practice in 2016/17.[85]

The likely drop in demand for consultations seen in other countries that have introduced charges would bring this figure down further. In addition, when combined with the associated administration burden of implementing a new system, this would mean that such a system is unlikely to be cost effective. These are very rough estimates but provide a sense of the scale of costs that could be recouped through charging for appointments.

Impact on demand

The argument that charging patients for GP appointments restricts 'unnecessary' visits is also far from clear and seems a crude mechanism for resolving complex demand issues. There is a lack of comparative evidence across countries to show a direct link. However, given the likelihood of a high number of exemptions and the question of whether low fees would be enough to act as a deterrent it seems unclear that charging for GP appointments would lead to significant reductions in workload. A study in the Republic of Ireland found that the deterrent effect of the consultation charge was most evident in patients in the middle of the income range. For those with higher incomes, the cost is a relatively weak disincentive while those with lower incomes are protected by the exemptions safety net.[86]

Charging for GP appointments might also conceivably lead to increasingly consumer-minded patients concerned about ensuring they get their money's worth. For instance, it has been reported that there is often over-consumption in France, with patients expecting general health check-ups and often arriving to consultations with a 'shopping list of tests'.[87] In addition, the administration required to process patient fees would likely become another activity taking doctor's time away from seeing patients.

General practice workload

Due to inconsistencies in data and differences between countries, such as population size and geographical spread of a population, it can be difficult to compare the workload levels across countries. However, many countries cite workload as being unmanageable in general practice and experience the same pressures that impact workload as the UK, such as a shortage of workforce and administrative burdens.

Although there are many similarities between the UK and the countries discussed in this paper, there are differences in workload between the UK and other EU countries. The European Union of General Practitioners[88] has identified key differences in the types of patients that GPs see across EU countries that can significantly impact workload levels. For example, GPs in many countries do not see children under four years of age as they are instead seen by paediatricians. In addition, maternity patients are instead referred to obstetricians. Patients with mental health issues are seen by psychiatrists and elderly patients in nursing homes are seen by the community geriatrician or in the Netherlands, a "Nursing Home Doctor".

This raises questions over whether removing or reducing the 'gatekeeper' role of GPs in the UK could lead to reduced workload.

Role of the GP

In the UK, gatekeeping was initially developed as a response to a desire to control healthcare spending and to compensate for a shortage of specialists.[89] There are valid arguments both for and against gatekeeping, some of which are included in the table below:

For GP gatekeeping	Against GP gatekeeping
Lower use of more expensive health services	Increased costs from delayed diagnosis
Reduces waiting times	Takes control away from patient
Ensure specialists only see complex cases	Can preserve primary-secondary divide
GPs see variety of cases	Increases GP workload

There is some evidence that relinquishing the gatekeeping role for specific groups, as is done in France, can relieve some of the burden on GPs. In certain cases, it has been shown to be cheaper to allow easier access to certain specialists, as well as providing clinical benefit. For example, self-referral for people with musculoskeletal problems has been shown to cut waiting times and costs, increase patient satisfaction, and reduce long term pain and disability.[90] A trend towards 'segmentation' in general practice has been noted in England, with an increased emphasis on offering relatively healthy patients faster access to GP services – and the implications this has for the traditional 'medical generalist' model of general practice.[91]

There have been some ethical concerns raised around gatekeeping and the GP's role as both a patient advocate and a commercial business. For example, although Norway is not a country that is discussed in this paper, one study found that in fee-for-service models in Norway, GPs can earn more by treating patients themselves, so refer patients less often.[92]

Conclusion

The unprecedented pressures that general practice in the UK is facing have yet to be appropriately addressed by Government. Therefore, alternative ways of organising and funding general practice that take place internationally have been examined.

Research does suggest that there are some similarities in the pressures experienced in general practice in other countries. However, the international evidence and evaluation of different funding models in general practice is mixed and complex. This makes it difficult to draw firm conclusions on preferred models of general practice. There is no clear definitive model that provides a single solution to the challenges that general practice faces, both within the NHS and internationally. A lack of comparable data also makes international comparisons difficult.

Although the way that general practice is organised may impact the pressures experienced, the levels of funding and resources provided, as well as workforce numbers are likely to be the most important factors impacting services. As outlined, the UK spends less on health as a proportion of GDP than the average of the eight countries covered by this paper.

Finding new ways to support GPs to manage their very heavy workloads is an important task for the governments of the UK if health services are to remain sustainable, and international examples may provide some guidance in this area. However, this cannot be a replacement for adequately staffing and resourcing general practice and the NHS.

The BMA's view is that the NHS remains the best system for providing healthcare to all in the UK. It is a unique model of healthcare that is proven to work and has a proud record of providing safe, effective and equitable healthcare to patients across the UK. The UK has been found to be one of the top performing health systems when comparing indicators such as health outcomes and access to care with other countries, with primary care provision significantly contributing to this.[93] Therefore, it is crucial that government addresses the pressures facing general practice and provides sufficient funding to ensure the sustainability of the NHS.

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