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GP attitudes towards health, prevention and poverty in deprived communities: does working with capitation or fee-for-service make a difference?

by

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Abstract

Objectives: *To explore general practitioners' attitudes towards health, poverty and prevention and to examine if payment system or practice setting plays a role.*

Design: *a qualitative study using semistructured interviews.*

Setting: *two neighbouring deprived inner-city areas in Ghent, Belgium.*

Participants: *20 general practitioners.*

Main outcome measures: *practice and payment type. Respondents' definitions of health and poverty, attitudes towards poverty and preventive medicine. Reasons for not practising preventive medicine.*

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Results: *Concerning the definition of health and disease, illness provoking factors, attitudes towards other cultures, identifying thresholds in access to primary care, no differences were noted between the different payment systems or practice settings. Attitudes towards poverty did show differences. Preventive medicine was viewed as an important part of general practice, although solo GPs were more negative about their own role in prevention. A gradient was found in the extent to which preventive medicine was practised from single-handed practice over group to health centre.*

Conclusions: *The findings of this small sample study suggest it does make a difference whether you work alone or in group as a GP, in order to fulfil the complex task of primary care in a deprived city area. Whether working in group has a positive effect on your attitudes or vice versa remains unclear. Working with capitated or fee-for-service reimbursement seems less important.*

Keywords: attitude, capitation, fee-for-service, poverty, preventive medicine, primary health care

Introduction

Primary healthcare in Belgium is mainly financed by fee-for-service (FFS), with 25% cost-share. Almost 1% of the population is registered in a capitation system and receives primary health care without cost-share. Most of the GPs who work in these settings, work in community health centres, generally located in deprived communities in the cities. Here, inhabitants can seek primary care in both types of practice.

The health gap that still exists between social classes can be partially explained by preventable differences in lifestyle. Tackling health inequalities as well as promoting preventive medicine are priorities to many (national) health institutions and general practitioners are expected to contribute to the solution.

Previous reports suggest that the payment system in which a general practitioner operates, may be related to the GP's attitude towards health, healthcare, illness, prevention, etc. (1-3). Results of studies on the impact of working in a FFS versus a capitation system on actual patient outcomes are few and conflicting (4-6). Attitudes towards health promotion and preventive activities have been explored by means of a postal questionnaire (mainly in the UK (7)) but the relation between these attitudes and the payment system has not been investigated in Europe. In this study we explore the differences in attitudes towards health (care)

of Flemish GPs working in deprived communities in different practice settings and payment methods.

Setting

Ghent is a city with 230,000 inhabitants where primary care is provided by 190 GPs. The most deprived communities are all situated outside the city centre, in the '19th century belt' characterised by bad housing, cultural diversity and an income and education level lower than the city's mean. Belgian cities have difficulties attracting young GPs. In Belgium 50% of GPs are older than 53 (8).

Method

Systematic data on practice characteristics (single-handed versus group, monodisciplinary versus multidisciplinary, FFS versus capitation) and their relationship with the medical outcome of patients visiting primary-care services, are unavailable in Belgium. It is also unknown if a difference in attitudes exists among GPs working in different settings. This qualitative study was designed to explore the domain, returning to some questions that were left unanswered in a previous study (9). Semi-structured interviews with all GPs of two adjacent neighbourhoods, in which the different settings of family practice are available, were used to collect data. This method was preferred since it is advocated as being well suited to explore sensitive and personal matters in detail (10). A postal questionnaire can reach more GPs, but lacks the ability to go into detail, whereas interviewing is very time-consuming, both in doing the actual talking as in analysing the data afterwards. A published, validated instrument to conduct the interview was not found.

At the time of the study 25 trained GPs were active in the selected region. Six trainees in family medicine were not included in the study. Two GPs (BA, JDM) were not included because of their involvement in the study.

A pilot interview was conducted with a GP from another deprived area in Ghent, leading to small changes in the original questionnaire. All 23 GPs were contacted by telephone and were informed about the aims of the study. Three GPs did not want to participate citing time restraints and objections related to the study objective.

Twenty GPs were included in the study and were visited by the researchers (CS and BM). The interviews were audiotaped and typed out. Each researcher analysed the interviews independently using a 'cut and paste' technique and considering every question separately,

followed by an interview-transcending approach. The results were discussed resolving differences in interpretation. When needed BA was asked to help with the interpretation.

Participants

The characteristics of the GPs are summarised in Box 1.

BOX 1

GP characteristics	Total	Single handed	Group Capitation	Group FFS
Number	20	8	7	5
Mean age	43	49	38	40
Number of women	8	2	4	2

All single-handed practices are FFS, all capitation practices are groups. Only two of the single-handed practices have a professional part-time secretary (the others get support from their spouses), versus all of the group practices. The self-reported workload did not vary much between capitation or FFS-practices. The FFS-GPs see 15 to 30 patients per day, and spend 15-30 minutes per patient. Some of the GPs working fee-for-service see 10 patients per day, whereas others see up to 45 patients per day. The time spent per patient varies from 15 to 30 minutes.

GPs working on a fee-for-service basis reported that about 35% of their patients are ‘poor’, the health centres reported 57% of poor patients. These percentages reflect subjective perceptions based on the experience of the daily encounters and were not compared to the actual social situation of the populations they serve. All GPs were graduates from the University of Ghent or the Catholic University of Leuven and were equally divided over the different groups.

Results

Some differences in attitudes seem to exist between the interviewed GPs. For many issues raised in the interview, the general practitioners’ views were largely similar. Questions covering the definition of health and disease, and illness provoking factors led to similar answers. Attitudes towards other cultures and towards thresholds to primary care did not show many differences.

However, attitudes towards poverty, prevention, working with other health-care professionals did differ between GPs. In general the

differences did not appear between the two payment systems, but between single-handed and group practices.

GPs working in group unanimously appreciated the benefits of a preventive approach and reported on making efforts to implement preventive activities in the consultations as well as on the practice level. GPs working single-handed had more negative thoughts about preventive actions by a GP. Half of them stated that it was a useless, frustrating, (financially) unrewarding and time-consuming task. They felt there were not enough incentives for them to engage in such activities. GPs working in group also mentioned frustration and sometimes despair when investing in preventive activities for their impoverished community, while still acknowledging their importance.

> "To me preventive medicine happens mainly during a consultation for example talking about smoking. Sometimes the attention is drawn via information in the waiting room. We can also invite our registered patients for screening" (CAP1)

> "The administrative support we have in our practice makes it easier to engage in preventive activities" (FFS-G1)

> "I think you have to choose between curative and preventive medicine. I myself refer patients to other doctors for preventive care, for example for vaccinations" (FFS-S1)

> "I notice there is a lot of talking about preventive care, without something actually being done" (FFS-S2)

> "Preventive care is important, although mostly overrated. I am a curative doctor myself" (FFS-S3)

Another area of difference was the GP's attitude towards poverty. Whereas all GPs working in group (capitation and FFS) and some of the GPs working solo used a 'socio-cultural' explanation for the situation and behaviour of their poorest clients, five out of eight interviewed solo-GPs cited individual factors, some of which might be called 'guilt-inducing'.

> "Some people are poor because they are born that way. However, half of the poor only have themselves to blame. Poverty in this group is due to drinking or drugs and to spending money in a stupid way. Those people should not count on my sympathy" (FFS-S4)

> "I think a lot of the problems of poverty are due to family and education. We do what we can in our surgery, but an important role is to be played by schools" (FFS-S5)

"Poverty is a swamp in which somebody sinks due to relational, financial or social situations and cannot get out of" (FFS-G2)

"Poverty means a lack of possibilities to live in welfare. There can be a lack of financial, social or educational opportunities." (CAP2)

The different domains relating to poverty cited by the interviewed GPs are largely the same as in the previous study (9) conducted in Ghent.

A third area in which differences were observed was the co-operation in the framework of a health-care network to provide primary care. Obviously, GPs working in multidisciplinary groups have a network in the same team, but even so these GPs were more likely to mention the collaboration with other health professionals (outside their own team) as an added value to the service they provide. GPs from the group practice also use networks but to a lesser extent and only a few of the single-handed practices had more than a 'preferred nurse' to (net)work with.

"I do not have enough time to involve in networking, and I am not being paid to do so" (FFS-S6)

"We refer to local psychologists and physiotherapists and we work with self-employed nurses. Of course people are free to choose their caretakers" (FFS-G4)

Finally, although every GP said he tried to make access as easy as possible for the patients, the way in which this objective was put into practice, varied widely between practices. On the one hand, GPs working within the system of capitation cited the absence of any financial threshold as an important strategy, as well as working in group (continuity) and being open-minded to all population groups. GPs working alone stressed the importance of being able to consult the same doctor at any moment as contributing to a lower threshold, as well as handing out medication samples. The FFS-group-practice GPs acknowledged the financial threshold and offered 'free' (third party payment) consultations for those in financial need.

Having a good physical accessibility and facilitating opening hours, as well as prescribing cheap medication were cited by almost every GP.

"We give a lot of free samples to our patients in financial need. I also sometimes ask a specialist to indulge third-party payment" (FFS-G5)

"We are open a lot of hours and the attitude of the doctors is contributing to a lower threshold" (CAP4)

"When I go on a home-visit and several people are sick, I charge only one person..... I think doing a lot of home-visits helps me to know my patients very well, which helps the patient" (FFS-S7)

"Prescribing generic medication is very important to me. I do not see a difference between neighbourhood health centres and my surgery. We are both primary-care practices and therefore have a low threshold" (FFS-S8)

Discussion

One could hypothesise that GPs working within the capitation system and GPs working with FFS would have different attitudes towards the health and diseases of the deprived population they serve, as well as towards the importance of preventive medicine.

The perceived differences in this study appear not to relate that much to the payment system as they relate to the practice organisation.

In this small sample, GPs working in groups seem to have similar ideas and attitudes concerning the subjects investigated, regardless of the way they are paid. The differences we found were mostly situated between single-handed and group practices.

In our sample, GPs working in group reported seeing relatively more deprived patients than their single-handed colleagues. It is unclear how this relates to the difference in attitudes towards poverty.

Finding time, money and motivation to engage in health promotion and preventive activities appears to be a problem for GPs across Europe (11) and the world (12), and Belgium is no exception. It is remarkable that working in a group seems to make these activities more feasible (mostly due to time and administrative support) for Flemish GPs, as it has been reported in Spain (13), but in contrast to a UK study where solo GPs appear more positive towards health promotion (7).

Single-handed practitioners in this study were mostly male and older than the average GP in the area. They regard their primary-care service as a valuable alternative to the other practice forms in a deprived area because of its great personal continuity and willingness to do home visits. This is consistent with earlier findings (14). Relatively more female and younger GPs worked in the capitation system. This may explain part of the differences (4,15).

Without doubt working in deprived communities influences attitudes on health, prevention or poverty. One observational study suggests that it is more difficult to deliver high quality preventive care in deprived

communities (16), but that 'a good team climate' improves diabetes care and staff satisfaction. Since the solo working GPs included in this study really work alone, there is no team climate, good or bad.

This study has some serious limitations: the sample selected (25 GPs in two deprived areas in one city) is obviously too small to generalise conclusions. It can therefore not be the ambition to draw any conclusions from this study other than that there seem to be differences between Belgian GPs' attitudes and that it appears that – from a qualitative approach - these differences cannot be attributed to factors related to the payment system in which the GP works, but rather relate to practice-setting. Since the GPs were not randomly chosen from the whole city, the results may be biased. Since all results are based upon self-reported data, conclusions can only be drawn with caution, as in previous reports (17).

The question whether a single-handed GP's attitude differs from his colleagues working in a group setting before he starts his professional career, is unanswered. Up until now, 70% of Belgian GPs work single-handed. Many of the group practices working in deprived areas originate from the 1970s which implied a clear vision towards urban health promotion, whereas during the 1980-2000 period no incentives existed to start a group practice. Both the evolution of primary and secondary care in Belgium, as well as expectations from GPs, patients and government, and international evolution in the Netherlands and the UK (18) show a clear trend towards more GP-partnerships. Many different reasons to work alone still exist among Belgian GPs in spite of this pressure to form groups (19).

Negative or reluctant attitudes (such as guilt-inducing attitudes towards poverty) lead to more frustration with GPs, and potentially to lower quality of care. The origin of these attitudes needs more research, as do the methods to change them in the GP workforce or in medical training.

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