NATIONAL AUDIT OFFICE
OF THE REPUBLIC OF LITHUANIA

PUBLIC AUDIT REPORT

EFFICIENCY AND EFFECTIVENESS OF THE FAMILY DOCTOR'S WORK

28 February 2013, No. VA-P-10-2-4
Vilnius

Audit started 7 February 2012
Audit completed 28 February 2013

Full audit report in Lithuanian is available on the website of the National Audit Office: www.vkontrole.lt

The speciality of the family doctor (general practitioner) was introduced in Lithuania in 1995 following the experience of other countries. The family doctor is a counsellor consulting on health issues, providing qualified non-specialised assistance and overseeing chronic diseases, as well as a coordinator who help orienting in the health system. The implementation of the Health Care Reform[1] and introduction of the family doctor's institution has involved gradual shift from services provided by internal medicine, children's and other doctors to primary health care provided by family doctors. This care is organised by municipal executive institutions[2], services are provided by almost two thousand family doctors. The Ministry of Health has established the

[1] Lithuanian Health Programme approved by Resolution of the Seimas of the Republic of Lithuania No. VIII-833 of 2 July 1998, paragraph 3.2.
[2] Law of the Republic of Lithuania on the Health System No. I-552 of 19 July 1994, Art. 12(4) (version No. XI-766 of 20 April 2010).

procedure for the organisation of primary outpatient personal health care services and for the payment for these services from the Compulsory Health Insurance Fund. Visits to doctors providing primary health care services account for two thirds of all visits to doctors. The annual amount of funds allocated from the Compulsory Health Insurance Fund to cover primary outpatient health care services totals about LTL 600 million(15 per cent of the expenditure of this Fund). The amount of funds allocated for primary health care over the period 2010–2012 has not been decreasing despite the declining population number in the country; however, there are still persisting problems related to the organisation of this health care, such as patient queues in medical institutions, heavy workload of family doctors, shortage of family doctors in some municipalities.

The main objective of the audit was to assess effectiveness and efficiency of the family doctor's institution answering the following questions:

- does the number of family doctors meet the needs of the population?

- do family doctors properly carry out the duties provided for in the Medical normative standard on the family doctor?

- is the professional competence of family doctors improved in a proper manner?

The audit was conducted in the Ministry of Health, data and information was collected from the National Health Insurance Fund, public and private primary health care institutions (373), Ministry of Education and Science, Vilnius University, Lithuanian University of Health Sciences, Lithuanian Society of General Practitioners, and Lithuanian Nursing Specialists Organisation. Surveys were conducted of family doctors, nurses, managers of medical institutions, municipal administrations, medical students, and resident family doctors. Also, foreign practices and research findings were analysed.

The public audit conclusions and recommendations provided below were drawn upon assessment of the audit findings.

Audit conclusions

1. At present, there is a sufficient number of family doctors in the country, however, they do not completely satisfy the needs of the population due to the following reasons:

1.1. The number of family doctors for 10 thousand people in individual municipalities differs more than three times; as a result, family doctor's services are not equally accessible to all inhabitants.

1.2. No requirements for the distribution of institutions providing primary outpatient health care have been set, which has resulted in uneven establishment of these institutions in municipalities.

1.3. The Medical normative standard on the family doctor has been set on the basis of a single criterion – the number of patients by age groups. When districts are drawn not on the basis of patients' place of residence, family doctors cannot properly conduct community health care. Less than half of family doctors serve the number of patients established in the regulatory document approved by the Minister of Health. 7 per cent of doctors cover very large areas (more than 2000 patients), therefore it can happen that patients receive services of low quality. Patients in small districts have poorer access to family doctors because doctors do not work full-time or every day.

1.4. Not all municipalities properly determine the demand for family doctors because there are no binding criteria to be observed. The Ministry of Health does not have precise data on the number of family doctors and does not perform long-term planning of the demand for family doctors.

1.5. Municipalities have been failing to actively implement measures intended to reduce the shortage of family doctors. Resident doctors lack information about family doctor vacancies. Consequently, more than half of family medicine residency doctors get employed in major cities of the country, rather than in municipalities where there is a shortage of such doctors.

1.6. Family doctors spend almost 22 per cent of their working time for performing functions which do not require doctor's qualification. As a result, they work insufficiently effectively, devoting less time to diagnostic and therapeutic work and failing to fulfil other functions which require doctor's qualification.

2. Family doctors fail to carry out all duties provided for in the Medical normative standard on the family doctor:

2.1. Less than one-third of the surveyed family doctors perform all competencies established in the Medical normative standard on the family doctor, more than half of them perform these competencies only partially. When family doctors do not use the competencies acquired during their professional studies, they fail to hone their skills and, moreover, finally lose some abilities and skills and do not get the experience required for independent diagnosis and treatment of diseases and for the performance of continuous personal and community health care.

2.2. Family doctors sent patients for consultation to specialised doctors without having used all their competencies in the patient examination and treatment area. 30 per cent of the surveyed doctors sent their patients because they do not want to take responsibility for the

treatment and 59 per cent do so at patients' request because they do not want any conflicts with the patients. By sending part of patients to specialised doctors, family doctors try to avoid potential legal disputes.

2.3. Apart from preventive health programmes, a small number of adult patients (according to the data of Sveidra – 5 per cent) get preventive health check-ups for non-infectious diseases. Only 5 per cent of family doctors performed more preventive health checks of adult patients and examined more than one fourth of 18–65 year old patients. Medical institutions do not inform patients about the availability of free preventive check-ups. As a result, opportunities to avoid serious cardiovascular diseases, diabetes and other disease complications are not fully taken up.

2.4. Not all medical institutions provide for allocation of a certain part of funds (in per cent) received for the provision of incentive services and good performance to the medical staff who provided the services in their salary schemes. Therefore, not all family doctors and nurses are encouraged to provide more services.

3. Family doctors' and nurses' qualification improvement has not been organises in a proper manner:

3.1. Family doctors' competencies are not valued and qualification improvement demand is not assessed. Consequently, family doctors do not always properly assess which competencies they need to improve and so fail to choose targeted training programmes.

3.2. Qualification improvement programmes do not meet family doctors' needs: there is a shortage of both targeted and new programmes for family doctors, also, there is very little practical training. Therefore, in order to comply with the requirements of licensed activities, family doctors improve their competencies in courses which have less practical value (such as conferences, seminars).

Audit recommendations

To the Ministry of Health of the Republic of Lithuania:

1. With a view to ensuring that the number of family doctors in municipalities meets the needs of the population:

1.1. to initiate legislative amendments that would set the minimum requirements for the distribution and structure of medical institutions, providing for mandatory observance of these requirements;

1.2. to revise and supplement the criteria for the formation of the family doctor's district and to set a standard for the family doctor's districts on the basis of these criteria;

1.3. to revise the criteria for planning the demand for family doctors, to perform long-term planning of this demand;

1.4. to review and revise legislative provisions so that all mandatory data of the subsystem METAS of the information system Sveidra of the National Health Insurance Fund is registered in a timely and proper manner and is used when planning the demand for family doctors;

1.5. to further develop the database of vacancies of doctors and to ensure its proper functioning.

2. Aiming at better performance of family doctors' competencies, less stressful communication between the doctor and the patient, to initiate revision (amendment and/or supplement) of the Law on the Rights of Patients and Compensation for the Damage to Their Health.

3. Aiming at better improvement of family doctors' professional qualification, to provide for, in the Procedure for the development and financing of professional qualification of health care and pharmacy specialists approved by the Minister of Health, that qualification improvement shall include a certain percentage of practical training.

To the Ministry of Health of the Republic of Lithuania, including other institutions (agencies):

1. With a view to ensuring that family doctors meet the needs of the population:

1.1. in cooperation with municipalities and managers of medical institutions, to apply measures intended to ensure that family doctors' districts are formed in accordance with the established standard;

1.2. in cooperation with schools of higher educations and medical institutions, to expand bases for the placement of medical students and for the training of resident family doctors in regional areas;

1.3. in cooperation with associations of family doctors and nurses, schools of higher education, managers of medical institutions, to review, revise and/or supplement legislation which regulates activities of personal health care specialists providing for transfer of duties and competencies which do not require doctor's qualification to other staff of medical institutions.

2. Aiming at better performance of family doctors' competencies:

2.1. in cooperation with associations of family doctors and other doctor specialities and schools of higher education, to develop methodologies and procedures of diagnostics and treatment to be applied by family doctors, to make a clearer distinction between the competencies of the family doctor and specialised doctors;

2.2. in cooperation with municipalities, managers of medical institutions, associations of family doctors and nurses, to provide for measures encouraging medical institutions and family doctors to perform more active prevention of diseases;

2.3. in cooperation with municipalities and managers of medical institutions to develop measures motivating medical institutions to allocate part of funds received from the National Health Insurance Fund for good performance and incentive services to the employees of the institutions who provided those services as a financial incentive.

3. Aiming at better improvement of family doctors' professional qualification, in cooperation with associations of family doctors, schools of higher education, managers of medical institutions:

3.1. to introduce voluntary assessment of family doctors' competencies;

3.2. to expand bases for the improvement of family doctors' qualification, making it possible to improve the qualification not only in university bases, but also in regional medical institutions;

3.3. to initiate development and update of targeted and practical qualification improvement programmes for family doctors according to areas determined by family doctors as requiring improvement.