Mental Health and Family Medicine: between Scylla and Charybdis

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Abstract

Background: Since 1999 the Romanian health insurance system shifts to a Bismarck model where primary care is provided by family medicine physicians, in private practices, under contract with local insurance houses. Family doctors are supposed to have a Gatekeeping role, ensuring that patients see specialists only for conditions that could not be managed at this level and are referred to an appropriate specialist. Aims: To explore the opinions of the family doctors on the interventions needed for a better management of the psychiatric cases. Method: A survey was conducted among 43 family doctors from Galati county (Romania). Results and Discussion: Despite a formal gatekeeping role, Romanian family doctors do not have a pivotal role in coordinating psychiatric care. Direct access to a specialist is possible for certain pathologies and there is evidence of overuse of ambulance services, hospital services and outpatient care setting bypassing primary care. Conclusion: Rather than focusing on the "gatekeeping" we should focus on more collaborative work between family doctors and psychiatrists with patients. An improved communication and cooperation between the family doctor and the psychiatrist plays an essential role for proper care processes and thus the overall quality of care for the psychiatric patient.

Keywords: Primary Care, Family medicine, Gatekeeping, Psychiatric Training

1. Introduction

Due to the changes in the political regime, family medicine in Romania had a special evolution.

In the interwar period, family medicine existed mainly as private practice, even though there existed a health insurance system, the "Central Social Insurance House". Between 1943 and 1978, primary care was organized territorially in "plase" (nets) and consisted of "circumscriptii" (rural sanitary constituencies for one or more communes with an average population of 5,000 inhabitants).

The district was headed by a rural health-care district physician who was the hierarchical chief of the health and care staff in its constituency, with the exception of specialized hospitals and protective settings, and was subordinated to the net hygiene physician and county chief physician.

The district doctor was responsible for initiating and executing all necessary measures in connection with hygiene and preventive medicine including compulsory vaccination [1,2,3], the health police and the medical care of the population within its constituency. He was helped by health care staff: a nursing sister and a health care provider ("agentul sanitar") for an average population of 3,000-5,000 inhabitants and one midwife for each commune. Medical dispensary had a day care center for children, home for a doctor and a nurse, a popular bath and deworming resort (Law no. 189/1943 for the state health organization).

Since 1999 the health insurance system shifted to a Bismarck model (Law 145/1997) and primary care has been provided by family medicine physicians, mainly in solo practices, under contracts with the DHIHs. Healthcare is purchased through contracts between the district level health insurance branches and providers, following a standard Framework Contract. Primary care physicians own their practices and receive payments based on a mix of age-weighted capitation and fee-for-service.

However, despite a formal gatekeeping role, they do not play a pivotal role in coordinating care. Direct access to a specialist is possible under certain conditions and there is evidence of overuse of ambulance services, bypassing primary care.

Fragmentation is increased by the fact that specialized ambulatory (or outpatient) care is provided through a network of hospital outpatient departments and polyclinics, specialized medical centers for diagnosis and treatment, and individual specialist physician offices. The health system is characterized by a lack of integration between different sectors (primary, hospital and public health) and by the underdevelopment of care continuity [4].

Family medicine physicians are not required to assure provision of primary care out of hours, at weekends or during public holidays, but they do on-duty calls in continuity care centers.

Primary care physicians own their practices and derive income from that earned by their practices, through contracts with the DHIHs.

Although strengthening of primary care has been on the policy agenda since 1990, primary health care services remain underfunded and there is overutilization of hospital services. The state no longer sustains salary payment for primary care workers, GPs finding themselves thrown “in deep water” and undergoing forced privatization: 14000 GPs had to become managers, hire 40000 nurses, make a list with at least 1000 patients in order to make a contract with Health Insurance Houses.

Insufficient income did not allow keeping the initial medical and auxiliary staff so that out of 3 nurses on average only one nurse remained employed, and this generated an increase in the workload.

If the medical office spaces were initially made available free of charge by the local authorities, they were gradually leased at market value.

Being forced to function not only as a doctor but also as an owner of a medical business without having the experience of private practice, the Romanian GP was forced in antagonistic, conflicting roles.

Table I – conflicting roles of GP

doctor	**a commercial business owner**
patient’s best interest	own business interest
refer patients to specialists more than needed	less
being a good colleague	fighting competition
I have to keep my business	I have my own life
complying to insurance rules not to be punished	patient interest first

Over time, bureaucracy and punitive administrative rules, as stated in the framework contract for primary care, grew to a level hard to understand. If in 1999 the framework contract had 15 pages, in 2018 it has (together with its application norms) 660 pages. The number of penalties stipulated in the contract for administrative misconduct outreaches the letters of the alphabet.

Moreover, administrative limitations have appeared that restrict the prescription of compensated medicines by the family doctor. In some medical areas, these restrictions are so limiting and include basic meditation that limits the role of the family doctor to resolving only simple cases and sending patients unnecessarily to the secondary healthcare segment.

Psychiatry is one of the medical fields where GPs are almost excluded from the healthcare team. Holistic view, even if the patient with mental disorder should be seen from a bio-psycho-social perspective for an appropriate therapeutic plan [5] and the family doctor approaches that take into account social consideration in a holistic view.

2. Methods

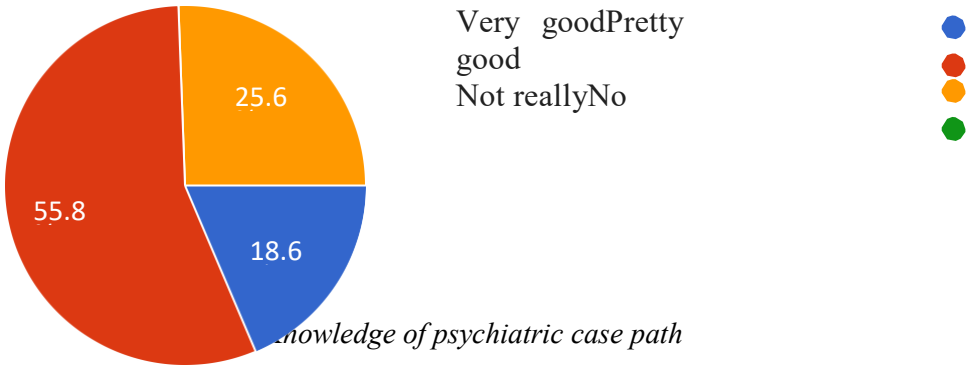
A study specific online survey instrument was developed using google forms and pilot tests. The final survey instrument link was sent by mail to all 248 family doctors from Galati county, Romania.

The response rate obtained in the trial was 17.33%, comparable with other surveys and lower than those from the general population. The sample is representative for the GP population in this area and the distribution of the respondents was as expected taking into account age, location and number of patients. The rural-urban distribution of praxis location is 58.1% and 48.9%; 55.9% of the respondents were over 45 years old and 39.5 percent had a praxis between 1500 and 2000 patients.

Data were analyzed by descriptive statistics using Excel software from Microsoft Office package and for a population proportion of 3%; the confidence level was better than 95% (confidence interval 3% ± 4.64%).

3. Results

Asked about the understanding of the regulatory process involving a psychiatric patient ("When to treat on his own practice? When to refer to a psychiatric consult? When to indicate hospitalization? When to refer the patient to a psychologist? When to contact social services?"), over one quarter of family doctors admit that they do not really know the optimum path.



nowledge of psychiatric case path

This shows that the administrative hyperregulations in the contract with the health insurance houses do not have the role of improving the quality of the medical act in the case of psychiatric patients at the level of primary care.

Asked about the usefulness of standardized psychiatric questionnaires in family medicine, only 2.3% of family doctors consider them unnecessary, 34.9% would accept them unconditionally and the rest under certain conditions (only for screening, paid additionally, integrated in their medical software)

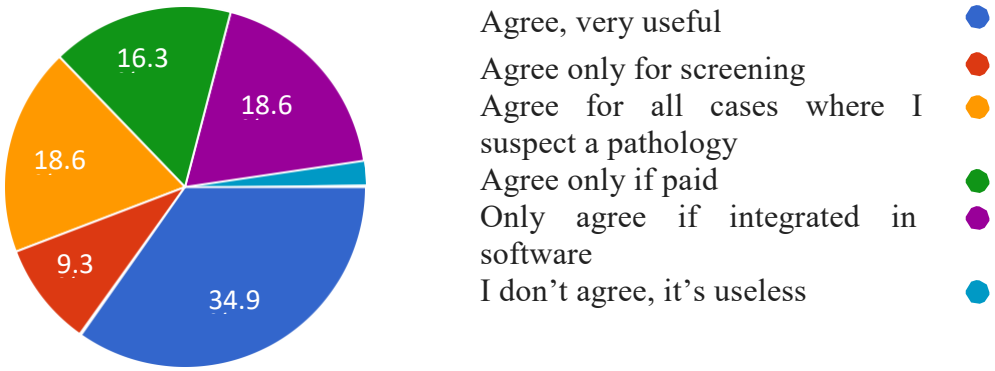
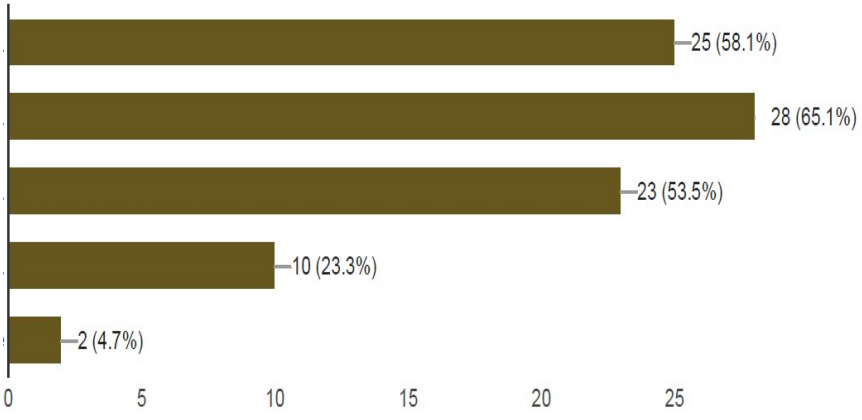


Figure 2. Opinion about psychiatric questionnaires adapted for primary care

The main barriers to the optimal management of psychiatric pathology at the level of primary care were:



Poor communication with psychiatrist

Not enough time

Lack of knowledge

Patients have more important diseases

Other problems

Figure 3. Major barriers treating a psychiatric case at the primary care level

65% of family doctors consider the lack of time one of the major obstacles to optimal patient management at primary care level. Psychiatric counseling is time consuming and the number of consultations settled by the health insurance house is limited to 20 daily for physicians with under 2000 patients.

23.3% of surveyed family doctors consider the better management of psychiatric cases in their cabinets an obstacle, given that they have to prioritize somatic conditions with a potential threat to the life of the patient.

58% of family doctors blame poor communication with the psychiatrist. This is a consequence of both lack of time due to overworking, but it is also a product of defective regulation, the medical letter being an administrative tool in the first place.

The lack of necessary knowledge in the field of psychiatry is admitted by 53.5% of physicians questioned as one of the causes.

This is a consequence of the need to prioritize consultations according to the ability to complete them. A completed consultation involves both the ability to diagnose and prescribe the treatment. Prescription limitations for psychiatric medications decrease the physician's interest in this area of pathology, preferring to improve their medical knowledge in areas where this knowledge can be used resolving the case at the family medicine cabinet level.

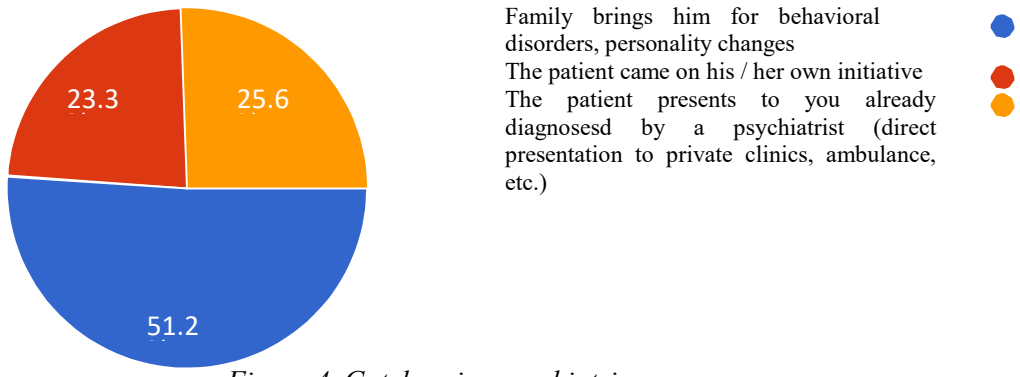


Figure 4. Gatekeeping psychiatric cases

One of the free comments to this question very well synthesizes one of the main barriers: "The lack of certain skills in psychiatry, from the health insurance agency's point of view, which deprived us of our doctor quality and competence and transformed us into civil servants, mere transcribers of medical letters. We don't have the liberty of judging by skills and training each medical case anymore, all of them are in line with the contract's implementing regulations, thus amputating our profession… and the rest of the specialties were affected similarly, it has ripped them from the medical trunk and left them as branches at best, or leaves into the wind...".

26.5% of family doctors say that, most often than not, a new psychiatric patient comes to a family doctor already diagnosed by a psychiatrist (taken by the ambulance, direct address to the private cabinet, addressing directly emergency room, etc.), bypassing the GP filter. This percentage shows that the role of the GPs as gatekeepers is mostly formal and psychiatric diagnosis, primary and secondary prevention are not done early by GP as would be desirable.

Questioned whether they prescribe psychotropic drugs on simple prescriptions without reimbursement as an act of their own will and knowledge, without the treatment initiated by a psychiatrist,

the majority of family doctors (53.5%) stated they never prescribed psychiatric medicines without reimbursement, at their own will. However, 18.6% of family doctors are prescribing psychiatric drugs on their own rarely and 27.9 % frequently.

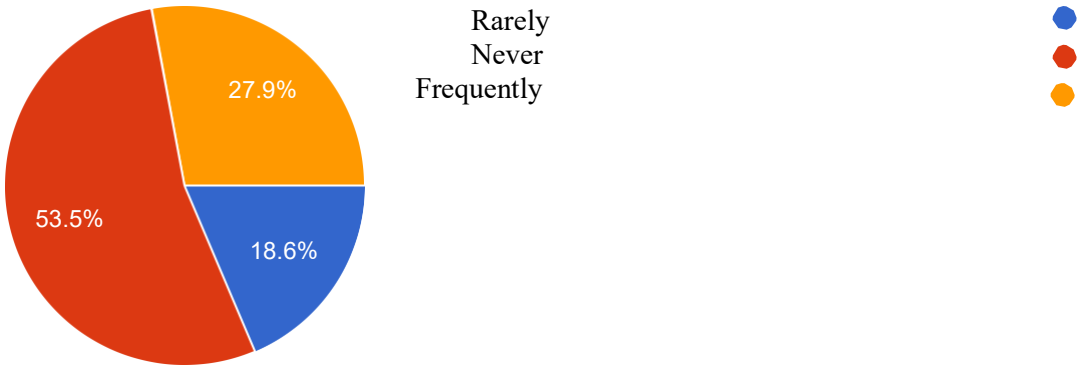


Figure 4. Psychiatric drugs initialization

These data should be taken into account as there are differences in the status of rural, urban and suburban doctors [6]. In remote rural areas, the family doctor is the only health care provider. It is important to keep in mind that the rural population is pauper and that the psychiatric patient generally has limited financial resources and access to the psychiatrist as for the rural patient that is more difficult and costlier, and there are also transportation costs. In this situation, the family doctor is more likely to assume psychiatric treatment, especially in cases where the necessary medication is not expensive.

This explains the polarization between physicians who do not initiate psychiatric medication at all and those who are doing it frequently.

79.1% of the surveyed doctors considered that giving up the need for medical letters and granting the right to initiate psychiatric compensation in cases like mild depression, panic attack, and insomnia would be better for their patients. However, almost one third of questioned family doctors do not agree to this transfer of responsibility, considering it the psychiatrist's job.

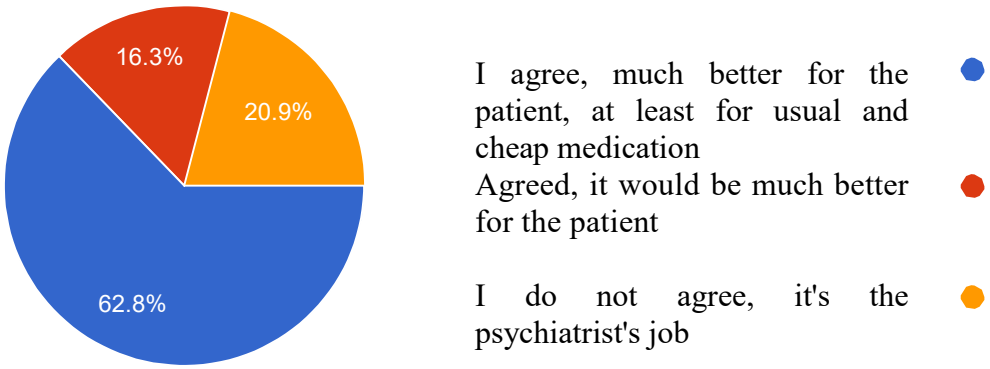


Figure 5. Giving up restrictions

4. Discussion

The level of gatekeeping is a health system decision and varies widely between countries. It ranges from free access to specialists, a need to obtain a referral from a GP to access a specialist (such as in Australia), or an option to skip the GP by paying a private specialist. In the U.S., gatekeeping inaccess to specialists has been common for many years, and the Affordable Care Act introduced in 2010 did not change any gatekeeping policies.

In general, in medical systems where family doctors do not have a gatekeeping role, the only option in their relation with the psychiatrist is either competing or collaborating.

In case GPs benefit from the presence of specialists, the services provided by these health professionals can be considered as complementary. When GPs are harmed by the presence of specialists, competition for patients seems to dominate the interaction between the health providers [7].

In Romania, direct access to secondary level medical care is possible for some pathologies, including psychiatric ones as stipulated in the "List containing the diseases that allow direct presentation to the specialist physician in the specialized ambulatory. 22. Psychiatric illnesses (schizophrenia diagnosis group, schizotypal and delusional disorders, mood disorder, autism, ADHD, mental illness in children)" of the implementing rules of the framework contract.

Gatekeeping ensures that patients see specialists only for conditions that could not be managed by a GP and are referred to an appropriate specialist, hence saving specialists time for more complex cases (Greenfield, et al, 2016).

There are no cited cases in medical literature to analyze what happens if doctors (GPs in our case) are excluded from an entire therapy field and that makes us think that such a situation never happened before.

We found only one study in which short term effect of reimbursement restriction in benzodiazepines (to help the switch for modern SSRI) seem to lower the rate of anxiety and sleepy disorder diagnoses [8].

Romanian MDs could neither gatekeep nor compete psychiatrists because they could not manage a case alone as they do not have the knowledge, motivation and possibility to prescribe psychiatric medication.

Particular strengths of this study were not only the sample size, but the comprehensive coverage of information about health policy regulatory limitations, possible by using open questions and commentaries in questionnaires.

The study had some limitations: despite the response rate, the sample may not be entirely representative even for Galati county as internet related activity is not favored by doctors after a certain age. Older doctors are not very well represented in this research, only 7% in 55-60-year category and 2.3% over 60 years responded, even if official statistics shows that the average age of a Romanian GP is 55 years.

Even if the situation is general and we do not see any reasons why it would differ in the other regions of the country, an assessment at the level of the other counties is necessary to extend the conclusions at national level.

5. Conclusions

Lessons learned from the evaluation of the effects of pharmaceutical policies in one country may provide important information for policy makers and regulators in other countries.

Long term effects on hyper - restrictive pharmaceutical reimbursement policy in an area leads to deprofessionalization of the targeted doctors, lack of knowledge and interest in prevention, underdiagnosis, unnecessary referrals and overuse of hospital services finally affecting the patient.

A possible solution is that, rather than focusing on the "gate" (who controls it and to what extent), we should switch to focus on more collaborative work between GPs and specialists with patients, as the most important stakeholder, taking ownership of their health. An integrated work environment between GPs and specialists may generate a common sense of purpose [9].

6. Conflicts of Interest

The author declares no conflict of interest.

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