Attempt at reforming duty and on-call services

Country: Slovenia

Partner Institute: Institute of Public Health of the Republic of Slovenia, Ljubljana

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Health Policy Issues: System Organisation/ Integration, Political Context, Remuneration / Payment

Current Process Stages

1. Abstract

The MoH of Slovenia decided to restructure duty and on-call services in health care. There would be a reduction in the salary bonuses for those who perform these services. In some cases the physical presence of doctors would be replaced by stand-by arrangements. One of the controversies of the present system are the differences in payments for comparable posts in comparable specialties, where in some cases these were 30 to 40 per cent higher than in others. The original reform attempt failed.

2. Purpose of health policy or idea

The purposes of this attempted reform were the following:

1. Reduction in the number of posts with continuous presence of medical doctors (24/7/365)

2. Institution of more stand-by posts, especially for non-critical medical specialties

3. Reforming salary bonuses and supplements for duty and on-call services by standardising these posts

4. Introduction of the possibility to organize duty services during daytime hours (6.00-22.00) shifts as well.

The idea behind the proposed changes was to provide room for optimization of on-call and duty services. This would mean that some of these posts in the smallest departments would be abolished. In addition, some of these services would be abolished entirely in some of the smallest hospitals.

Main objectives

Objectives/characteristics of the new policy:

1. Equalising incomes of all medical doctors performing on-call and duty services in health care who are comparably qualified
2. Reducing the number of on-call posts for medical doctors
3. Preparation of a new network of on-call and duty posts for the entire country, taking into account improved physical accessibility of most general hospitals.

Type of incentives

Financial incentives actually are disincentives as the key policy objective was to reduce the total workforce costs for these services by 11 million Euros.

Non-financial incentives included a reduced workload for doctors performing these services in bigger centers, attracting additional doctors to perform them, and limiting the workload of senior medical doctors.

Groups affected

Medical doctors, Hospitals, Primary care providers

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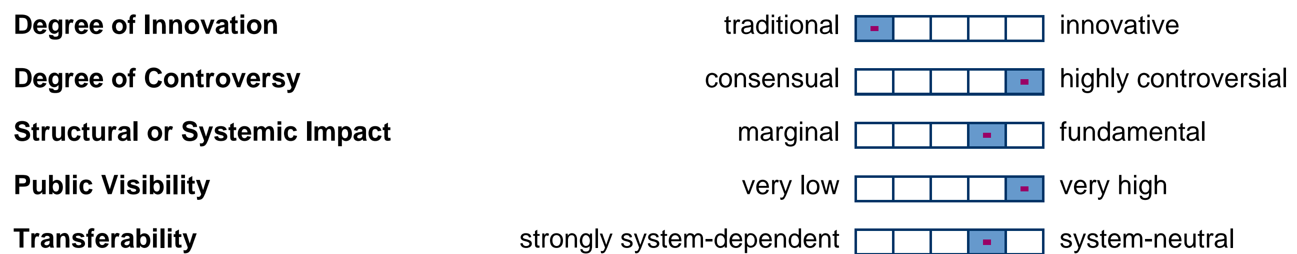
3. Characteristics of this policy



This policy's approach is traditional as it approaches a complex issue through reductions in costs through reduced salary expenses (which, of course, are a major contributor to health care expenditure). It raised huge controversies, leading to a strike of physicians that only could be diverted through a significantly reduced concept of the new arrangements. This process gave the policy a very high public visibility that later obscured some of its intended positive effects.

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4. Political and economic background

The present Government (elected for the term 2008-2012) has committed itself to a comprehensive health care reform as the present system is the result of a specifically placed reform process of the period 1990-1992. This earlier reform was prepared in a long process, but implemented in a rather hasty manner, due to different circumstances .

The promise that the on-call and duty posts would be revised and reformed was given by the organised medical profession (The Medical Chamber and the Medical Trade Union) after the end of the medical doctors' strike in 1996 (agreement between the two parties and the Government, later amended and revised in 1999). However, this part of the agreement never got implemented and the issue remained largely unresolved.

The main issues were the following:

1. Costs of on-call and duty services increased, as there was a growth in salaries.
2. The network of these posts, especially on the secondary level, became exaggerate given the changed setting of changes in care, in the road infrastructure, etc. While there is an excessive density of the number of on-call posts throughout Slovenia, there is also, in part, a maldistribution. While acces to on-call medical services is very easy in some parts of the country, especially in the cities, access in the countryside is very limited. In cities, the number of medical doctors simultaneously working in different duty services is relatively large,

especially given the clear definition of the gatekeeping role of primary care physicians.

3. Differences in payments for these services increased as the hourly rate depended on the specific doctor's salary and not simply on the type of service he/she was supposed to secure and/or deliver.

Consequently, there were increasing differences in salaries bonuses across different medical specialties, and even among providers, which created imbalances. In a setting of continuing shortage of medical doctors, it was hard to find doctors who are available for delivering these services at all.

Complies with

Other - the declared goals and objectives of the health care reform and the changed salary system for civil servants (including all employees in the publicly owned health care in Slovenia)

5. Purpose and process analysis

Origins of health policy idea

The idea derives from the estimates from the early 1990s that on-call and night services in Slovenia are too expensive under the changed circumstances. The services have already become more expensive because doctors are paid for these services not in terms of the generic tasks they are expected to provide but based on their basic salary. This means that an on-call trauma surgeon who is also a professor and a consultant will be much more expensive on on-call duty than a recently qualified specialist, although they will, when emergency cases occur, basically perform very similar tasks and duties.

In addition, costs of these services soared because of the combined effect of increasing physicians´ salaries and bonuses on additional working hours. This has led to an unsustainability of these services, both financially and organisationallly in some environments, especially in middle-sized and smaller hospitals. This situation got even more complicated through the shortage of medical doctors, which made a smooth planning process almost impossible.

Therefore, it was necessary to address the issue of on-call services from the viewpoint of their rationality, as well as from the viewpoint of ensuring equal access to all medical services for all citizens of Slovenia.

Initiators of idea/main actors

- Government

Stakeholder positions

The approach was top-down, as the Ministry of Health (MoH) decided to go for a reform of on-call services, which are a point of frequent discussion and pressure. On the one hand there are those medical professionals, who see these services as a source of additional income, on the other hand there is an increasingly bigger group of doctors who would prefer more spare time for their private lives rather than additional income generated by additional workload from on-call services. In any case, there was fierce opposition of the medical profession to the execution of any changes, especially to those changes that would significantly influence the income generated by these services.

Actors and positions

Description of actors and their positions

Government

Medical doctors	very supportive	▭▭▭▭■	strongly opposed
Hospitals	very supportive	▭■▭▭▭	strongly opposed
Primary care	very supportive	▭■▭▭▭	strongly opposed

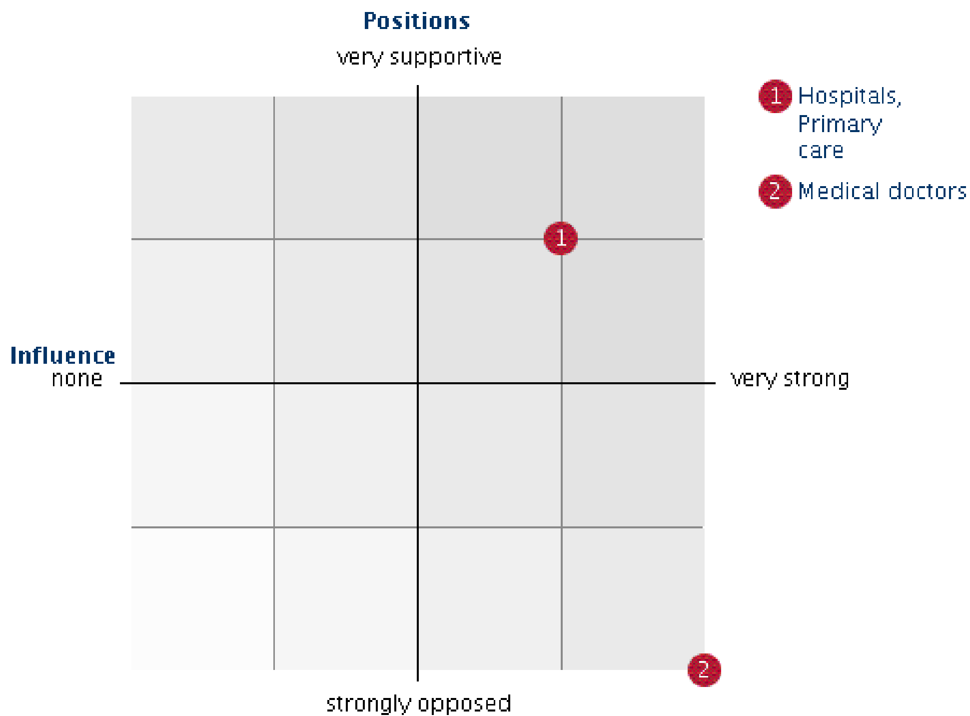
Actors and influence

Description of actors and their influence

Government

Medical doctors	very strong	■▭▭▭▭	none
Hospitals	very strong	▭■▭▭▭	none
Primary care	very strong	▭■▭▭▭	none

Positions and Influences at a glance



6. Expected outcome

The policy could not achieve its objectives as it was blocked by the organised medical profession at its very beginning, and had to be significantly modified in order to divert a widespread strike by medical doctors. This became imminent

when doctors started withdrawing consent forms, which are required when doctors work more than 48 hours a week. Without a written consent nobody can constrain a medical doctor to performing services in excess of 48 weekly working hours. Around 70% of the doctors in hospitals withdrew these forms, which had only two possible effects - either a complete halt to on-call and duty services, which is impossible given the risks, or a reduction in all those services which depend on the real availability of medical doctors (including their on-call services!). This led to long negotiations in which the Government decided not to change the present system at once, but committed itself to prepare and implement changes over the next two years.

Therefore, the government postponed the implementation of a new structure and distribution of on-call and duty posts which it had meant to reduce significantly. Currently, there is also process going on which is meant to stratify hospitals and their departments into several categories. After this process is completed, not all departments will keep 24-hour services but some will continue only as day hospital with some diagnostic and out-patient services. It was agreed that this process runs in co-ordination with the different medical colleges which are responsible to determine the specific standards and requirements for the different medical specialties. This will then also be revised by the MoH and the two chambers, the Medical and the Nursing Chamber.

Quality of Health Care Services

Level of Equity

Cost Efficiency

The proposed policy would have had a rather marginal impact on the quality of health care services as it would generally not influence the standard delivery of care.

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