

# The Spanish Primary Healthcare by a Group of Portuguese Residents—Vasco da Gama Movement Experience

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**Abstract:** BACKGROUND: The Vasco da Gama Movement (VdGM) is a European working group for young and future Family Doctors. It aims to improve the quality of Family Medicine, by holding preconference exchange programs amongst other activities. GOALS: To report and critically analyse the experiences of the medical conference exchange program in Spain as Portuguese GP residents and highlight the main differences in primary health care between the two countries. METHODS: Descriptive report and critical analysis. Preconference exchange promoted by VdGM, lasting for one week. One resident attended the Palma de Mallorca exchange (III Balearic Meeting of European Residents and Young General Practitioners) and the other three participated in the Madrid exchange (XVIII Conference of Family and Community Medicine Residents). The programs included: attending a Spanish Family Doctor practice, visiting the hospital emergency department, attending the medical conference and giving a presentation about their National Health System. CONCLUSIONS: This experience was a great opportunity for young family doctors to overview different approaches on primary healthcare, to interact with their peers and know more about other cultural settings. The authors believe that participating in such programs has increased their social and intercultural competencies, which will lead to better communication skills and improve patient-physician relationship. The authors hope to encourage other colleagues to participate in similar programs.

**Key words:** Family practice, family medicine, primary health care, communication.

## 1. Introduction

The Vasco da Gama Movement (VdGM) is a European working group for young and future Family Doctors, also called General Practitioners (GP). It aims to encourage new ideas for the improvement of general practice, by holding preconference exchange programs amongst other activities [1]. Before us, others have shared the benefits coming from VdGM preconference exchange, highlighting values as self-discovery, friendship and innovation amidst diversity and uncertainty [2].

As globally stated on the Declaration of Alma-Ata,

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primary healthcare can be defined as “essential health care”, based on scientific and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community. Therefore, it is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination [3]. Based on that, it is accepted that the primary care system in Portugal performs well. Recent primary care reforms have been successful in improving accessibility, efficiency, quality and continuity of care, as well as increasing the satisfaction of both professionals and citizens [4]. The Portuguese population enjoys good health and increasing life

expectancy, though at lower levels than other western European countries [5]. Considering that, one can say there is room for improvement. For instance, as stated in the World Health Report (WHO, 2000), the first of this kind involving 191 countries, the overall performance of the Spanish health system has ranked better than the Portuguese (no. 7 vs. no. 12), being also cheaper (no. 29 vs. no. 27, stated as the most expensive healthcare system *per capita*) [6]. This article aims to report and critically analyse the experiences of medical conference exchange programs in Spain, based on the personal view of a group of four Portuguese Family Medicine residents.

## **2. Methods**

Medline® was searched on September 2016 for English-language articles about VdGM, healthcare systems and family medicine models of learning. Relevant articles were included. Internet search on institutional information concerning technical aspects of both Spanish and Portuguese Primary Healthcare was also performed (search engine-based).

Each author produced an individual descriptive report of the exchange activities. By using the information collected, a summary of the main aspects was performed and a brief comparison of their experience followed. Based on their field experience, the authors also performed a critical review on clinical practice aspects. That led to a brief comparison of Portuguese and Spanish Primary healthcare systems, on the scope of the personal view of four Portuguese residents.

## **3. Vasco da Gama Movement Experience**

### *3.1 Description of the Preconference Exchange Program*

The preconference exchange was promoted by VdGM, lasting for one week. One resident attended the Palma de Mallorca exchange, on September 7-12th of 2015, around the III Balearic Meeting of European residents and Young GPs. Other three residents

attended the Madrid exchange, on March 14-20th of 2016, around the XVIII Conference of Family and Community Medicine Residents.

The program included: (1) attending a Spanish Family Physician practice (*Centro de Salud Coll D'En Rabassa*—Palma de Mallorca; (2) *Centro de Salud Ángela Uriarte* and *Centro de Salud Alpes*—Madrid), visiting an hospital emergency department; (3) participating in the medical conference and giving the presentation regarding “What you must know and do to practice in my country” during the International Session and (4) several optional cultural activities.

The main activity was attending a Spanish Family Physician practice for several days, either at the clinic or home visits. The performance was merely observational, although some have performed basic tasks, namely cardiac and pulmonary auscultation and abdominal exam.

### *3.2 About the Two Neighbouring Countries*

First of all, Spain has more inhabitants than Portugal (47.2 vs. 10.5 millions), longer life expectancy at birth in both genders (82.8 vs. 81.1 years old), but also higher infant mortality rate (3.5% vs. 3.0% per capita). (WHO, 2015) [7]. As stated before, data from 2000 showed that Spain health system had a better ranking position than the Portuguese, at less expenditure per capita [6].

As in Portugal, the Spanish healthcare consists of both private and public healthcare. In Spain, the statutory National Health Service (NHS) is universal coverage-wise (including irregular immigrants), funded from taxes and predominantly operates within the public sector. Provision is free of charge at the point of delivery with the exception of the pharmaceuticals prescribed to people aged under 65, which entail a 40% co-payment with some exceptions. Health competences were totally developed at a regional level (called autonomous communities) as from the end of 2002; this decentralisation resulted in 17 regional health ministries with primary jurisdiction over the

organization and delivery of health services within their territory. The Spanish Ministry of Health and Social Policy holds authority over certain strategic areas, such as pharmaceuticals' legislation and as guarantor of the equitable functioning of health services across the country. The highest body for NHS coordination holds responsibility over the 17 regional ministers of health, chaired by the national minister [7-9].

In Portugal, healthcare is universal although it is not free of charge—user fees have been implemented to protect the sustainability of the service. All residents have access to health care provided by the Portuguese NHS, financed mainly through taxation. Out-of-pocket payments have been increasing over time, not only co-payments, but particularly direct payments for private outpatient consultations, examinations and pharmaceuticals. The level of cost-sharing is highest for pharmaceutical products. Between one-fifth and one-quarter of the population has a second (or more) layer of health insurance coverage through health subsystems (for specific sectors or occupations) and voluntary health insurance [5, 10]. Although the primary care system in Portugal performs well, the geographical distribution of healthcare services and human resources shows asymmetries, resulting in a greater supply along the coast compared to the interior [11]. The 2007 Primary Health Care Reform led to the establishment of innovative Family Health Units, aimed at encouraging more multidisciplinary team working and at achieving greater co-ordination between providers. Portugal has also an impressive depth of available primary care information, with systematized collection of a large number of indicators linked to the payment system. Together, these sophisticated approaches to delivery, organization and payment suggest that Portuguese primary care is well advanced in measuring, assuring and improving quality. Strategic reflection around the balance between traditional Primary Health Care Units and the innovative Family Health Units is now needed in order

to ensure that high quality care can be accessed by the whole Portuguese population. Efforts are also needed to ensure optimal use of the primary care workforce, to fully exploit available data in quality monitoring and improvement, and to ensure that primary care takes the lead in preventing and managing chronic diseases [4, 12].

Considering the formal aspects of Family Medicine residency, the authors found them globally similar in both countries (4-years program) and it is beyond the scope of this paper. The following critical analysis was primarily focused on the clinical practice.

### *3.3 Focusing Now on the Clinical Practice—Our Top 5-Selected Differences*

#### *3.3.1 Electronic Records and Informatics System*

In both countries, electronic health records and online prescription are widely implemented, despite small regional differences. One important difference between both countries is that in Portugal the electronic health records are included in one integrated national online-based platform, allowing sharing of information between primary and secondary care in the entire country. On the other hand, in Portugal mainland the prescription is valid in the entire territory, while on Spain the prescription is only valid on each autonomous region, becoming less practical.

Spanish informatics system is user-friendlier. Only one login and password is required, as all programs are combined in one: (1) patient records, (2) diagnostic test results, (3) prescription in general, (4) referral to secondary health care (hospital) and also included the (5) possibility of editable fields (e.g. for genogram writing, mapping skin lesions on human body, etc). It should be remarked that diagnostic test results from public reference hospitals are automatically updated to the primary care informatics system, requiring only validation by the family doctor.

In Portugal, we understand that family doctors struggle with their current informatics systems on a regular basis, being that a point of discontentment.

Being rather slow and with occasional crashes, usually 4 programs (*SClínico*®, *PEM*®, *SiiMA Rastreios*®, *Alert PI*®) are required for the consultation, each using individual credentials (login and password). Above that, all the diagnostic test results have to be manually introduced, taking several minutes of the actual consultation.

### 3.3.2 Duration and Planning of the Consultations

Regarding some consultation technical features, the authors verified that consultation length (in minutes) was significantly shorter on Madrid and Palma than in Portugal. The scheduled medical appointments lasted around six minutes in Spain against fifteen to twenty minutes in Portugal. In Spain, typically one patient problem is addressed per consultation, whereas in Portugal rarely only one problem is addressed. Although in both countries, doctors and nurses work as a team, the authors considered that the Spanish Nurses showed more autonomy, in accordance to the European standard, particularly monitoring diabetic and high blood pressure patients, which facilitated the medical consultation. Also interesting was the planning and scheduling of the consultation, which is done mainly by the patient or the administrative personnel, saving time for the medical consultation. In Portugal, the scheduling can be done by the patient, nurse, family doctor or administrative personnel, but is usually done by the family doctor.

### 3.3.3 Preventive Medicine

Regarding Preventive Medicine, the authors verified that both in Madrid and Palma there are no population-based cancer screening programs on primary care to the date of the exchange programs. In Portugal, there are several cancer screening programs implemented, mostly under the regulation of regional entities, namely for breast, cervical and colorectal cancers, executed in general by family doctors themselves. Spanish nurses also have a critical role in patient education, regarding preventive measures and care (diet, exercise, hygiene, etc), whereas in Portugal such task is usually shared amongst family doctors and

nurses.

In Spain, patient information, like bulletins and handouts, were globally provided on their informatics system and elaborated by Public Health Department, which allowed them to be standardized for the population.

### 3.3.4 Children's Health

With respect to Children's Health, the exchange residents verified that both Madrid and Palma had permanent Paediatricians at the Primary Health Center, who give assistance to children and teenagers up to age 14 years old. In Portugal, Family doctors provide continuity of care since birth to adulthood, referring to Hospital only when needed. There are some exceptions, namely some Primary Care centers where Paediatricians (mostly residents of Paediatrics) work on ambulatory level—it occurs on a minority of centers and it is not the standard. As the authors understand, no studies were found about the cost-benefit related to this strategy.

### 3.3.5 Pregnancy Care

Concerning the follow-up of pregnant women at primary Care level, in Madrid and Palma they had specialized Nurses allocated at the health center several—midwives (“*Matronas*”)—who did the follow-up. Sporadic visits of an assigned obstetrician also occurred for selected cases. In Portugal, the follow-up is done by the family doctor and the nurse, who work as a team to provide assistance, doing referral to Hospital only when presenting medium-high obstetric risk or any complication, as well at pregnancy term.

## 4. Discussion

There are significant differences in the way that Healthcare systems are organized and Family Medicine is practiced throughout Europe. The authors regard the differences between Portugal and Spain as learning opportunities. The authors hope the brainstorming started by VdGM contributes to the development of a better Primary Care system, at least on the FHU of the

residents.

Regarding GP residency, the possibility of an abroad fellowship is also an asset for the residents CV and helps building peer networking and communication skills, helpful for our daily practice. Thus, the conference exchange program offers the possibility to present research work (as long as it is accepted at the attended medical conference) and sessions on their country health system and GP residency.

The identifiable threats are the cost of the exchange program and the need of absence from work at our FHU. The participation in the exchange program is free, although there are no stipends for the travel arrangements. In the case of the resident in Palma, she managed to stay at the home of one of the program organizers, but the residents who stayed in Madrid had to take care of their sleeping arrangements. About leaving their work in their FHU, the GP residents in Portugal have 15 days allowed for attending medical conferences, courses and workshops—a careful management on the total of these days is required, as this was a week exchange program. Furthermore, a special requirement signer by the residency coordinator is needed, as the fellowship is abroad.

Regarding clinical care, the authors liked the fact that each consultation addressed only one medical problem. However, they felt uncomfortable with having only 6 minutes per consultation and wonder what kind of doctor-patient relationship is possible in such conditions? It is known that in Family Medicine a strong doctor-patient relationship is crucial for good health care practice.

## 5. Conclusions

Overall, the authors conclude that the Vasco da Gama Movement preconference exchange program is an excellent experience, thus recommending it to other GP residents. It allowed not only a reflection on the differences and similarities between the two neighbouring countries, as well an opportunity to improve the authors' communication skills and peer

networking, which will contribute to better patient-doctor relationship.

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