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ORIGINAL PAPER

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Workplace Violence and Sanctioning of Family Medicine Physicians Due to the Rules of Health Insurance Funds in the Western Balkan

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ABSTRACT

Introduction: After family medicine's famous beginnings in the early 60's through introduction of the world's first family medicine specialization, with transitional changes and war also come changes in former Yugoslavia's healthcare systems. **Aim:** The primary aim of this article is to analyze frequency and causes of sanctioning of family physicians by Health insurance funds in the countries of former Yugoslavia. The secondary aim is to evaluate frequency and types of workplace violence family physicians experienced due to insurance boundaries for patients. **Methods:** The comparative, cross-sectional survey was carried out from October 2017 to February 2018. Study participants were general practitioners' (GPs), family physicians (FPs) and those without a specialty designation but providing family medicine services in one of the five Western Balkans countries: Croatia, Slovenia, Serbia, Macedonia and Bosnia and Herzegovina (B&H). The questionnaire was designed for the purpose of the study. **Results:** Forty-nine percent of participating physicians have been sanctioned by Health Insurance Fund and 77.5% has been exposed to workplace violence. The most common type of violence was verbal (76.6%). Financial penalties according to the scale had the highest rates in Macedonia (73.9%) and Slovenia (43.9%). **Conclusion:** It is necessary to educate creators of healthcare policies, doctors and patients for the purpose of establishing partner relations which would lead to strengthening of primary healthcare, but also to a more efficient healthcare system.

Keywords: family medicine, public insurance, penalties, maltreatment.

1. INTRODUCTION

According to the Alma Ata Declaration, Primary healthcare plays a critical role in the overall healthcare system (1). As the prevalence of noncommunicable disease (NCD) increases, primary care physicians take more responsibilities in the process of gate management of healthcare expenditures (2, 3). Although scientific data identified better health outcomes for population in the countries with strong family medicine models, many health care systems around the world still have weak primary care, mainly oriented toward economic issues, less toward a patient (4). European countries are still trying to find the best model for financing primary healthcare (5-7).

Before 1992, the Yugoslavian healthcare system was the closest to Siemaszko's model (8). To improve the quality of care and implement internationally accepted core values of patient-centered primary care, School of Public Health "Andrija Stampar" in Zagreb, Croatia introduced vocational training in general/family medicine in the 1960s (9, 10). With the dissolution of Yugoslavia, poverty and ineffectiveness of the former healthcare system imposed a need for health insurance reform. While the majority of countries in Eastern Europe introduced several insurance choices for patients (via a combination of public and private insurance), countries of former Yugoslavia kept the model of one national insurance company with a very modest share of private insurance, restrictive

toward patients' rights (7, 11-16). Very little is known if this insurance model influences the work-related safety of family physicians.

2. AIM

The primary aim of this article is to analyze frequency and causes of sanctioning of family physicians by Health insurance funds in the countries of the former Yugoslavia. The secondary aim is to evaluate frequency and types of workplace violence family physicians experienced due to insurance boundaries for patient care.

3. METHODS

3.1. Study participants

The comparative, cross-sectional survey was carried out from October 2017 to February 2018. Study participants were general practitioners' (GPs), family physicians (FPs) and those without a specialty designation but providing family medicine services in one of the five Western Balkans countries: Croatia, Slovenia, Serbia, Macedonia and Bosnia and Herzegovina (B&H). Bosnia and Herzegovina comprised of two entities: The Republic of Srpska (RS) and the Federation of Bosnia and Herzegovina (Federation B&H) with two independent national Health Insurance Funds in place. Although the primary goal was to recruit in each country at least 120 physicians, the number of physicians approached diverse between countries. Data were collected through a self-distributed questionnaire.

3.2. Measurement

The questionnaire was designed for the purpose of the study. Development of the questionnaire consisted of the selection of relevant questions and the pilot survey.

The investigators evaluated the questions in five consensus rounds and determined their relevance as well as potential problems in obtaining responses. The group of colleagues was consulted to evaluate a preliminary version of the questionnaire regarding questions comprehensibility and any misconstrues the responders might encounter.

To decrease variation in the answers to be obtained between countries, the questions not suitable for international comparison, questions expected to be unreliable or difficult to understand were excluded, two new included and three rephrased.

The final version of the questionnaire consisted of two parts. The first part included standardized questions to collect data regarding physician's gender, age, professional education, length of service, practice type, practice setting (urban or rural) and distance between family practice, and the nearest hospital. The second part summarized the presence, types and causes of two multi-item dimensions: sanctions of Health Insurance Funds toward family physicians and workplace violence. The questions were constructed as dichotomous (5), multiple-choice (6), open-ended (5) and mixed (1).

The questionnaire was developed in Bosnian-Croatian-Serbian language, but prior to being distributed in each participating county was translated to other languages (Macedonian and Slovenian). After translation, the text underwent review by two independent reviewers. No major differences were found.

During the pilot testing phase, Cronbach's alpha coefficient was calculated to assess the internal consistency for the two multi-item dimensions. The value of the coefficient >0.5 was considered acceptable.

3.3. Procedures

All procedures were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2008. Research assistants in each participating country were responsible for coordinating the data collection. The questionnaires were sent either by mail (Bosnia and Herzegovina), or delivered directly during conferences (Serbia, Macedonia) or distributed via Google docs (Croatia and Slovenia), along with a short description of research purpose and objectives. Physicians were informed that by completing the questionnaire, they agreed to participate in the study. To increase participation, regardless of the method of questionnaire distribution, four reminders were sent at an one-week interval to no respondents.

The survey took approximately 10 minutes to complete. The information was compiled and a database of physicians' characteristics was created. To avoid any risk potentially involved in participating in this survey, the investigators assured that participants' responses will not be identified. No physician identifiers were collected and responses were used only in the generation of statistics. Financial and non-financial incentives have not been used as a way to encourage physicians to take part in the study.

3.4. Statistical analysis

Statistical analyses were performed using SPSS package (SPSS, Chicago, IL, Version 20). Descriptive statistics were used to summarize demographic and practice characteristics of participating physicians. Differences between countries in single variable were assessed using non-parametric Hi square or Kruskal-Wallis test. P-values less than 0.05 will be considered significant.

4. RESULTS

The demographic and practice characteristics of study participants are shown in Table 1. A total of 1562 FPs completed the survey. Majority of them were female (76%), belonged to the age group between 50 and 59 years (32.5%), practiced medicine in public sector (54.6%), rural area (51.9%) and in a place with the distance to the nearest hospital less than 19 kilometers (39.8). Physicians from Slovenia were overrepresented (38.6%)

FPs in Macedonia and Croatia were significantly more sanctioned compared to physicians from the Republic of Srpska, Serbia, Slovenia and Federation of Bosnia and Herzegovina ($p < 0.001$). Statistically significant difference between countries were found by type of sanctioning ($p < 0.001$). In Serbia and Croatia, the most frequent type of sanctioning was financial penalty according to the damage (55.3 % and 53.1, respectively).

Financial penalties according to the scale had the highest rates in Macedonia (73.9%) and Slovenia (43.9%), while the warning was the most common type of sanctioning in both entities in Bosnia and Herzegovina, RS (74.3 %) and Federation B&H (100 %). In Croatia, FPs were more exposed

Variable	N	%
Gender		
Female	1187	76
Male	372	23.8
Age, years		
25-29	128	8.2
30-39	363	23.2
40-49	381	24.4
50-59	507	32.5
60-69	181	11.7
Practice type		
Public	853	54.6
Private	689	44.1
Length of service		
0-5	231	14.8
6-10	226	14.5
11-15	358	22.9
16-20	222	14.2
21-30	316	20.2
31-40	194	12.4
>40	11	7
Professional education		
Doctor of medicine	776	49.7
Certified FP/GP	780	49.7
Practice setting		
Rural	811	51.9
Urban	745	48.1
Distance to the hospital (kilometers)		
< 5	622	39.8
5-19	518	33.2
29-49	339	21.7
59-99	73	4.7
>100	6	4
Country		
Macedonia	438	28
Serbia	134	8.6
Republic of Srpska	148	9.5
Federation of B&H	70	4.5
Croatia	169	10.8
Slovenia	603	38.6

Table 1. Demographic and practice characteristics

to workplace violence compared to physicians in other participating countries ($p < 0.001$). Exposure to the violence was the lowest in Federation B&H (95.9%).

Differences by type of violence between the countries were not found ($p = 0.317$) (Table 3). FPs who experienced sanctioning were also more exposed to workplace violence ($p = 0.001$).

Male physicians ($p = 0.001$), physicians with the length of service between 11 and 15 years or 31 and 40 years ($p = 0.001$), working in private clinics ($p = 0.001$) experienced sanctioning more frequently compared to their female colleagues and those employed by the government. Relationship between professional education and sanctioning was not significant, however, certified family physicians were exposed more to workplace violence ($p = 0.004$) compared to physician with vocational training (Table 4).

5. DISCUSSION

In this paper, we have attempted to display the problem of frequent sanctions of family physicians by health insurance funds on the one hand, and their exposure to patient violence caused by holding up to insurance stan-

Variable	N	%
Sanction causes		
Medication prescribing against HIF guidelines	103	6.6
Orthotics prescribing	65	4.2
Sick-leave	194	12.4
Travel costs	27	1.7
Medication prescribing during hospitalization	4	3
Referral letters against HIF guidelines	66	4.2
High costs of prescribed medications	25	1.6
Care	37	2.4
Other	46	2.9
Multiple reasons	191	12.2
Sanction types		
Financial penalty according to the damage	223	29.7
Financial penalty according to the scale	373	47.5
Warning	179	22.8
Violence types		
Verbal	1164	76.6
Verbal and physical	54	3.6
Physical	2	0.1

Table 2. Distribution of study participants according to sanction and violence types

dards on the other. During data analysis, we encountered a significant number of dilemmas and questions open to further research.

The differences in the organization of family medicine between the former Yugoslavian countries are minimal and mostly related to the type of practice (public versus private) (11–14). Concessionary contracts refer to private practices (family physicians manage healthcare budget themselves). This practice type is partially present in Slovenia (a minor percentage) and Croatia, and entirely in Macedonia. Vocational training is not mandatory to practice family medicine.

Slovenian (17) and Croatian (18) healthcare funds display rules and regulations in regards to patient's rights on websites. The Fund of the Republic of Srpska is the only institution explaining to the patients that family physicians do not have to prescribe a medicine which was previously recommended by a clinical specialist if the recommendation is not in accordance with the clinical guidelines (19). In Serbia, Macedonia and Federation of Bosnia and Hercegovina many medication can't be described by family physicians without specialists' report (20). In Croatia, Fund encouraging the prescription of cheap generic medication.

In all countries, governments control family physicians on several levels, mostly in terms of medicine expenditures (quantities), number of referrals given out, sick leaves days and orthopedic tools. Slovenia, as a member of OECD, follows specific prescribing guidelines for antibiotics, proton pump inhibitors and polypharmacy (21). Antibiotics expenditure is regulated in Croatia, not according to the indications, but by the number of boxes or price. The physicians

Variable	Macedonia n (%)	Serbia n (%)	RS n (%)	Federation n (%)	Croatia n (%)	Slovenia N (%)	p
Sanctioning							
Yes	280 (63.9)	48 (35.8)	39 (26.4)	3 (4.3)	146 (86.4)	249 (41.6)	0.001
No	158 (36.9)	86 (64.2)	109 (73.6)	67 (95.7)	23 (13.6)	350 (58.4)	
Type of sanction							
*	37 (12.5)	26 (55.3)	2 (5.7)	0	76 (53.1)	92 (35.1)	0.001
**	318 (73.9)	6 (12.8)	7 (20)	0	27 (18.9)	115 (43.9)	
***	40 (13.6)	15 (31.9)	26 (74.3)	3 (100)	40 (28)	55 (21)	
Workplace violence							
Yes	317 (73.5)	102 (76.1)	120 (81.1)	44 (69.8)	162 (95.9)	465 (79.9)	0.001
No	114 (26.5)	32 (23.9)	28 (18.9)	19 (30.2)	7 (4.1)	117 (20.1)	
Type of violence							
Verbal	303 (95)	96 (94.1)	118 (97.5)	45 (100)	161 (95.3)	441 (95)	0.317
Verbal and physical	16 (5)	6 (5.9)	2 (1.7)	0	8 (4.7)	22 (4.7)	
Physical	0 (0)	0	1 (0.8)	0	0	1 (0.2)	

Table 3. Differences between countries in sanctioning and exposure to workplace violence *Financial penalty according to the damage; **Financial penalty according to the scale; ***Warning

are mostly sanctioned for prescribing medications differently than advised by Funds. National prescription guidelines often differ from international guidelines, and hospital physicians frequently do not follow Funds rules. It would be interesting to examine whether and by how much medication expenditure would increase if the funds would be using international treatment guidelines.

Health insurance Funds rigorously control family physicians in terms of sick leave days prescribing. The percentage of sick leave days per family practice is determined by the number of employed patients, without taking into account other factors related to the economic and social outcomes of sick leave day (22–24).

If we look at the survey results, we can see that almost 50% of participants were sanctioned for one or several reasons. This kind of behavior from the Funds infuriates family physicians who, as a result, do not feel valued as partners of the funds (25). It is interesting that sanctioning is more frequent in countries having a concessionary type of practice.

Physicians understand that the healthcare system has limited resources, but the question is whether these rigorous controls will drive young family physicians away from family medicine as a future career. Due to the problems mentioned above, many experienced family physicians emigrate to other EU countries. Available literature found that there were attempts to “cheat” the funds to secure more significant budgets. However, the family physician enrolled in the current study were sanctioned for trying to help their patients, not for achieving personal material benefits.

Documents of the World Bank show that all former Yugoslavian countries experience problems with financing family physicians and establishing quality control over them. No papers explored the relationship between the World Bank and family physicians so far. It would also be interesting for future research to explore if family physicians (but also decision makers) are acquainted with indicators of work quality in primary healthcare introduced by the

Variable	Sanctioning			Workplace violence		
	Yes n (%)	No n (%)	p	Yes n (%)	No n (%)	p
Gender						
Male	227 (61.4)	143 (38.6)	0.001	280 (76.7)	85 (23.3)	0.596
Female	537 (45.3)	648 (54.7)		928 (80.1)	231 (19.9)	
Length of service						
0-5g	75 (32.5)	156 (67.5)	0.001	178 (78.4%)	49 (21.6)	0.097
6-10g	109 (48.2)	117 (51.8)		181 (81.9)	40 (18.1)	
11-15g	213 (59.7)	144 (40.3)		258 (81)	67 (19)	
16-20g	104 (46.8)	118 (53.2)		170 (78.3)	47 (21.7)	
21-30g	146 (56.5)	168 (53.5)		234 (76.7)	71 (23.3)	
31-40g	108 (56)	85 (44)		152 (79.6)	39 (20.4)	
40+g						
	7 (63.6)	4 (36.4)		7 (63.7)	4 (36.4)	
Practice setting						
Private	487 (70.1)	206 (29.9)	0.001	520 (77)	155 (23)	0.560
Public	283 (33.3)	567 (66.7)		678 (81.1)	158 (18.9)	
Professional education						
Certified FP*	471 (56.1)	369 (43.9)	0.058	693 (83.1)	141 (16.9)	0.004
Doctor of medicine**	436 (53.3)	379 (46.5)		633 (79.7)	164 (20.6)	

Table 4. Differences in sanctioning and exposure to workplace violence according to demographic characteristics*Completed residency training in family medicine; **Without vocational training p< 0.005 is bolded and considered significant

OECD and the World Bank and, how that knowledge could reinforce balance between quality of care and national healthcare budget (26-29).

Following previous studies, there is considerable exposure to violence due to upholding to funds’ regulations (30–36). Data are showing that male doctors and hospital specialists are more exposed to violence. It would be interesting to compare other traits of healthcare and social systems as well as differences in rates of workplace violence over family physicians in other European countries. The far

higher level of patient education on their rights and obligations is needed. Patients need to be aware of the fact that family physicians do not limit their rights and that majority of the decisions in regards to diagnosing and treatment depend on health insurances' regulations.

6. CONCLUSION

Financing of the healthcare system is one of the greatest challenges all countries face. This challenge is more difficult in middle- and low-income countries due to a lack of resources for providing optimal healthcare. In former Yugoslav countries, within the current organization, physicians are exposed to considerable control by healthcare funds and great demands made by patients, who are ill-educated of the possibilities of their healthcare systems. Therefore, it is necessary to educate creators of healthcare policies, physicians and patients in the future. Their partnership could lead to strengthening of primary healthcare and more efficient healthcare system. Further research is needed to explore the consequences of physicians' sanctions, as well as the reasons why patients are so aggressive toward family physicians.

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