



Original Article

Managing the Performance of Family Physicians in the Portuguese National Health System

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Abstract

A key aspect of current reforms in Europe is an increased focus on the first line health services, with a central role for the “general practitioner/family physician” (FP). The introduction of family practice as a specific discipline in Portugal goes back only to the early 1980’s, following the introduction of a National Health Service (NHS) in the 1970’s.¹

This paper explores the awareness, among health system managers at various levels, of problems with performance, as well as their perception of what is being done and what could be done to improve it. The first step was to interview senior NHS managers at regional and sub-regional health authority (RHA and SRHA) level. The second step was to interview directors of health centres (HC), the place where FPs work. The final phase of the study included an interview with the national sub-director of health in charge of FP and HC.

This study shows that performance management is a poorly developed part of the management *armamentarium* of public sector managers in the Portuguese NHS. Health services managers appear aware of the need to find mechanisms for performance management at the institutional level, but show little concern for performance management at the individual or sub-institutional level. Moreover, they apparently focus on evaluation of process and structure, and make little or no mention of assessing production of health.

Key words: Family Physician, Performance, Public Sector, Public Health Administration

Introduction

A key aspect of current reforms in Europe is an increased focus on the first line, with a central role for the “general practitioner/family physician”. Family medicine is “emerging from being a field of medicine practised by professionals with little specific training, to become a discipline with its own distinctive features, area of professional practice and corpus of knowledge”⁽¹⁾. The WHO Regional Office has recom-

mended principles and characteristics for the development of general practice in European countries⁽²⁾.

The introduction of family practice as a specific discipline in Portugal goes back only to the early 1980’s, following the introduction of a National Health Service (NHS) in the 1970’s.¹ NHS family practitioners (FP) work in Health Centres (HC), where they have an increasingly central role, and act as gatekeepers for the

1 This research was conducted in the context of the project “Measuring and monitoring staff performance in reforming health systems”, INCO-DC programme of DGXII, European Union, contract number IC18*CT970239



system. District hospitals and health centres represent two pillars of the *Sistemas Locais de Saúde* or district health networks. Under the ongoing reforms, these *Sistemas Locais de Saúde* are to be funded through contracts with five regional purchasing bodies, the *Agências de Contratualização*. These contracts will specify the objectives as well as the criteria and indicators for assessing the performance obtained with the budget accorded under the contract. Hence there is an interest in the performance of HC and FP, and in the way their performance can be assessed and enhanced.

Published research provides little guidance. A literature search with the keywords performance, human resources, motivation, job satisfaction and patient satisfaction produced no original articles on methods of assessing individual performance in the Portuguese setting. Some work on the evaluation of technical performance of FP in particular areas through the analysis of clinical files (e.g. child and maternal health, hypertension) has been published⁽³⁻⁵⁾. Although Portuguese FP have opportunities for private practice, the articles reviewed exclusively refer to the public sector. When the private health sector is mentioned, it is as a reminder that human resources are shared by both sectors and that the relationship between the two is not transparent⁽⁶⁾. The impact of this overlap on the performance of the health personnel has, so far, never been reported upon in Portugal. Imbalances and maldistributions in the public sector are described⁽⁷⁾ as well as the professional risks health professionals are exposed to⁽⁸⁾, including stress at work⁽⁹⁻¹²⁾. The literature reports on some attempts to use teamwork to improve professional and user satisfaction⁽¹³⁻¹⁶⁾. The various papers mention high levels of job dissatisfaction related to insufficient salaries, inadequate incentives, inadequate work environment, low level of skills of the health centre managers and self-perceived low status of family practitioners. Many papers claim that continuing education and teamwork increase job-related satisfaction^(9-11,17-20). None of the articles reported on interven-

tions to correct the problems described. This paper explores the awareness, among health system managers at various levels, of problems with performance, as well as their perception of what is being done and what could be done to improve performance. It is based on interviews with health care managers at various levels, whose objective was to identify to what extent performance management is part of the management *armamentarium* of public sector managers in the Portuguese NHS.

Population and Methods

In Portugal there are 5 health regions divided in sub-regions (1 to 6 per region). The region chosen by convenience for this study includes one of the two largest metropolitan areas in Portugal, with a population of 3,222,200 people (about 30% of the Portuguese population), 22 hospitals (2,942 beds) and 84 HC. In 1998 open-ended questionnaires were applied to 9 members of the management boards of regional and sub-regional health authorities (RHA and SRHA), with a response rate of 7/9.

While conducting interviews with the managers of the RHA and the SRHA one of the researchers obtained a list of the 20 HC considered the “best” and the 20 considered the “the least good” (based on RHA/SRHA judgement, without attempt to provide them with criteria). From this list 10 HC in each of the categories were selected using a simple random sampling strategy. The 20 HC, all falling under one of the sub-regions, with a catchment population of 2,050,700, include urban, peri-urban and rural communities. The twenty directors of these health centres (usually family practitioners, with a three year appointment) were interviewed, with a response rate of 90% (18/20). The response rate of the “best” group was 100% and of the “other” group was 80%. All information on the identification of the Region, Sub-Region, HC and interviewees was kept confidential. This material was subsequently complemented by an interview with the official in charge of family

practice and health centres at national level.

The interview material (notes and tapes) was analysed blindly regarding the identity of the respondents and their health centres. The analysis was conducted by repeated listening to the tapes, identifying themes and re-exploring these themes in the many tapes and interview notes. No attempt was made to quantify the data: the focus was on identifying the range of issues considered important by the respondents, and possible different patterns between the two groups of Health Centres. The small number of managers interviewed certainly did not constitute a representative sample of public sector managers in Portugal. Nevertheless, they provide an indication of the environment in which performance management mechanisms in Portugal would have to operate.

Views of Performance Management

On most topics RHA, the SRHA and HC directors provided basically similar views. Table 1 summarises what they consider to be “good performance” for a Family Practitioner. Table 2 lists formal and informal tools and criteria used for performance management at Health Centre level as reported by the interviewees. Table 3 presents the views of the interviewees on possible means of improving on the current situation.

Presentation of this material to the senior official in charge of FP and HC at the national level illustrates the difference in perspective between the policy making and the operational management levels. There was a definite sense of frustration with the professional culture and practices of the managers. It was the “management attitude” of the RHA that did not allow them “to assume the organisation in a different way”, although this “different way” was possible under existing public administration legislation. The same applied to the HC directors: although they have no legal authority, they “could do much more to approach their managerial practise differently in term of work organisation,

interpersonal relationships, local dynamics, motivation and the like. A “more entrepreneurial approach” would give them more legitimacy to demand new tools, changes and means to change.

The interviews confirm the impression given by the literature review: a health care sector where *individual* performance management has not been explicitly acknowledged. Managers pointed out several processes that have been used to plan *institutional* performance, monitor it and encourage good performance. These processes have not been standardised and have not been constituted as official policy. But the fact that they are acknowledged and used, form the core around which explicit performance management is already evolving.

A “well performing” FP is essentially described by the interviewees in terms of process or inputs rather than in terms of health outcomes. “Good” FPs “manage their patient list correctly”, “make efforts to continue their education”, “participate in community-oriented activities”, “have an empathic relationship with their patients and colleagues”, and “monitor the results of their practice”. They have (and make use of) “clear good-practice guidelines”. Performance management consists of the use of incentives (“educational opportunities, promotion”, “extra resources for the best health centre”, “support for innovative projects”, “new remuneration policies”) and formal monitoring of waiting lists, complaints books and expenditure statements. Formally, the evaluation of performance is based on an analysis of strategic plans and associated objectives, budgets and associated action-programmes and the terms of reference for project teams. Indicators used are professional satisfaction, patient satisfaction, and number of consultations per clinician, profile of prescriptions, absentee rates, number of complaints and accessibility to health care. Interviewees also mention informal evaluation criteria that include “the degree of participation of professionals in objective-setting and decision-making”.

Although all HC directors used some for-

mal mechanisms for monitoring institutional progress towards programmatic objectives, formal performance management of individual family practitioners was non-existent, “for lack of the necessary culture” and because there are no formal “norms and guidelines to manage the difference” - i.e. to reward the best performers.

Nevertheless, interviewees acknowledged that they had the latitude to formalise systems of individual performance management, including local incentive policies to reward the best performers, if they so wished. If they did not do so, this was partly because of “the local professional medical culture”.

Table 1 Managers’ perceptions of what is considered good performance of a family physician.

Focus on mission of the HC

- Is committed to solving community level problems
- Participates in community-oriented activities
- Is committed to improve the health indicators of the patients on his list
- Participates in all HC activities
- Feels responsible for his patients in all phases of the life cycle
- Is knowledgeable of the patients on his list
- Fulfils his objectives

Focus on personal development

- Continues education efforts

Adherence to quality standards

- Has clear “best-practice” guidelines
- Monitors his/her individual practice results

Relational more than a technical focus

- Has a empathic relationship with his/her patients
- Has a empathic relationship with his/her colleagues
- Has an empathic and therapeutic relationship with his patients
- Has a good relationships with all members of the health team
- Is committed to team work not always looking to assume the role of team leader
- Is humane
- Likes people
- Motivates other fellow workers
- Is committed to continuing care

Committed to efficiency

- Plans his or her work
- Uses resources efficiently
- Is punctual
- Is assiduous
- Is productive
- Contributes to reduce unnecessary demand
- Manages well his/her patient list (administratively and ensuring the necessary access)
- Is accessible
- Shares information with colleagues

Committed to effectiveness

- His work has technical quality
- Responds to health problems in a humane and technically competent manner

Maintains ethical standards

- Ensures confidentiality

There was a major overlap of the opinions of the Directors of both groups of HC (the “best” and the “worst”). It is, nevertheless, important to emphasise some of the differences between them.

The Directors of the “best HC” identified the “current context of change in the country” as a window of opportunity to further improve the existing services. They also acknowledged that the prevalent “medical professional culture”

Table 2 Formal and informal tools and criteria used for performance management at HC level.

Tools for performance management	Criteria for performance evaluation
<p>Needs identification Health information system Waiting lists Complaints books Users’ office Feedback from the hospitals Regular auditing of quality of the clinical records Special surveys: e.g. patient satisfaction surveys</p> <p>Use of incentives Educational opportunities Promotion extra resources for best performing HC support for innovative projects new remuneration policies</p> <p>Expenditure statements for each cost-centre Analytical accounting</p>	<p>Formal:</p> <p>Regularity and comprehensiveness Formal monitoring at all levels (quarterly at RHA level and yearly reporting at HC level)</p> <p>Accountability Existence of strategic plans and associated objectives Existence of programmatic plans and associated objectives Existence of budgets and associated action-programmes Existence of terms of reference for project teams</p> <p>Existence of indicators for needs identification and to monitor progress towards objectives Namely: Agreement on a set of standard indicators Professional satisfaction Patient satisfaction Number of consultations per clinician Profile and cost of prescriptions Absenteeism rates Punctuality Number of home visits Number of complaints Ratio of booked to unbooked consultations Acute diseases as % of the total New diagnosis as % of the total Coverage rates Number of patients per physician Number of consultations per clinician Profile of prescriptions Accessibility to health care</p> <p>Informal: Degree of participation in objective-setting and decision-making Degree of participation of in non-clinical activities Participation in meetings of the HC Absence of dysfunction associated with defective or lack of information</p>

is an obstacle to maximise the potential benefits that could be derived from this “culture of change”. They went beyond what was explicitly spelt out as their duties and obligations: in the words of one of them “I make use of the little autonomy given to me and then I stretch it to the extent I feel it is necessary...” (a flexibility that is actually expected by senior management

Table 3 Means of improving on the current situation.

Exert external pressure
 Greater contention on central demands implies better centrally defined priorities
 Improve on the existing strategies

Restructure and adequate resourcing of the HC
 Improvement of HC infrastructures
 Greater accessibility to regional managers
 More nurses, doctors and administrative personnel
 Downsizing HC²
 Financial and administrative autonomy
 Greater autonomy for HC hiring and firing of all personnel
 Terminate part-timers and short terms-contracts
 Better co-ordination with hospitals
 Better financial incentives
 Better remuneration

Integrate the performance management system (PMS) in the overall management of the HC
 Increase the focus on individual as well as team performance while ensuring the continuing management of institutional performance
 Greater emphasis on team work
 More participatory management
 Regular analysis of productivity and quality statistics

Relational focus (focus on people)
 Investment in training FP in communication skills
 Remembering special dates such as birthdays
 Use coffee breaks as a means for developing a HC spirit
 Informal support for special request of leave for off-duties, conferences, continuing education, etc
 Penalise users if they miss consultations or if they lose requisitions

Focus on development
 Invest in continuing education
 Move away from a project mentality
 Introduce regular peer-reviews

Explicit and formal quality and performance criteria
 Introduction of good practice/performance codes
 Link future development to explicit rules, criteria and consequences (incentives)
 Formalise and standardise performance evaluation processes - internally and externally

Focus on need identification
 Developing and formalising existing evaluation mechanisms in order to be able to apply them in a systematic and standardised fashion

Focus on accountability
 Evaluate the evaluations
 Strengthen the link between quality of performance and supplementary budgets

2 Health centres in the Portuguese NHS vary greatly in their dimension. The HC collaborating in this study varied from HC with 7 FP to HC with as many as 86 FP.

at policy level). These Directors made use of a greater variety of tools and criteria to evaluate the performance of the FP in their HC. A good FP was someone committed to “high technical quality with a human face”. The “best HC” were also those that most frequently recognised complaints, feedback from the referring hospitals, auditing and quality of the clinical processes and clinical discussions as important means of managing the performance of FP.

The need to increase the management autonomy at HC level, to improve infrastructures and to increase salaries was acknowledged. The “best” HC focused more on the importance of better co-ordination with hospitals, on personalised attention to all personnel in the HC, in greater availability of local incentives and on greater emphasis to continuing education, with special attention to communication skills.

All the directors refer to the degree of participation of professionals in non-clinical activities and in HC meetings as informal elements they consider in the evaluation of FP performance in their health centre. The indicators mentioned as formal evaluation cover a somewhat larger scope in those HC that are considered to be the best performing by the RHA/SRHA: it is only in those centres that the notion of population coverage is mentioned.

Suggestions for improving performance are, as could be expected, wide-ranging. They include requests for better infrastructure, more personnel and better salaries, to training in communication skills, continuing education, regular peer-reviews, “introduction of good practice/performance codes”, “greater emphasis on teamwork”, “more participatory management” or ‘remembering birthdays’, ‘use coffee breaks as a means for developing a health centre spirit’, and ‘informal support for special requests of leave’. Some HC Directors see a potential to improve FP performance by ‘penalising users if they miss consultations or if they lose requisitions’.

Apart from these ready-made recommendations, it is interesting to note the insistence,

by nearly all interviewees, on ‘strengthening the link between quality of performance and supplementary budgets’, on more autonomy in hiring and firing of personnel, but also on clearer definition of service objectives and evaluation criteria by the central level (“linkage of future development to explicit rules, criteria and incentives” or “standardisation of the existing evaluation mechanisms”). Perhaps most surprising is the fact that only one of the interviewees mentioned the need for explicit job descriptions, although they are lacking in most health centres.

The Portuguese NHS is changing: an Experimental Remuneration System of FP (*Regime Remuneratório Experimental*) started, on a voluntary basis, for a small number of FPs that make a commitment, as a team, to a health programme to achieve explicit objectives for their catchment population. For their work the payment is on a mix of a basic salary, complemented by capitation-linked payment and a fee-for-(some) services; the new HC law which removes some of the obstacles mentioned by RHA and SRHA interviewees; the computerisation of the HC information’s system; the introduction of tools for quality assurance, including auto-evaluation, cross-evaluations, external-evaluations and tools for monitoring patient and doctor satisfaction. In the view of the national level interviewee the recently introduced RHA based Purchasing Agencies (*Agências de Contratualização*) are “forcing health centres to adopt a more analytical culture and to reflect about the most appropriate management to ensure the achievement of objectives spelt out in the contracts with the Purchasing Agencies”. “Once they are operational, all these tools and changes will reinforce team work”.

Nevertheless, many of these changes are still being rolled-out, and clearly meet with resistance from the labour unions, the civil servants in the ministerial departments and from the public administrative system in general. At the same time, the tools that are already available are not organised in an integrated performance management system .

Although FP, as civil servants, are legally and culturally protected (it is almost impossible to fire them or to initiate any kind of disciplinary process against them) and the legal framework for career progress is based on curriculum evaluations without performance and productivity criteria, most managers seem to be aware that the performance of FP working in public sector health centres is an “issue”. Mostly, however, this awareness does not lead to active intervention into performance management.

In the context of the current legal framework of human resources in the public sector in general and in the absence of requirements for formal or informal management training as a condition to be appointed to a health management board, it is legitimate to question the managers’s capacity to effectively manage the performance of FP.

Managers have been using several processes to plan *institutional* performance, monitor it and encourage good performance, even when there have not been standardised and have not constituted official policy. These processes constitute a core around which explicit performance management systems are already evolving.

These trends in the Portuguese public sector NHS are in line with the development in Europe of a “new public administration” approach⁽²¹⁾, namely managerial autonomy, the use of incentives and disincentives and focus on performance measured as outputs and outcomes. Of these only the first two are explicitly mentioned by the interviewees. The use of incentives and disincentives requires a legal framework that is presently evolving. The interviewees, however, leave the impression that public sector managers feel without contextual support and without the tools necessary to influence the performance of family practitioners. They are ready to accept cultural, legal, infra structural and procedural reforms as long as these are associated with the necessary resources to reward good performance. They do not feel either motivated

or competent to improvise and to risk non-formal means of *individual* performance management.

Conclusions

The managers interviewed certainly did not constitute a representative sample of public sector managers in Portugal. Also, the small sample and the qualitative nature of the study limited the process of scientific induction and the value of presenting numbers. Nevertheless, these studies may provide an indication of the context of opinions and circumstances that will have to be considered to implement management performance mechanisms in Portugal.

The literature reviewed and the interviews reinforced our perception of a health sector where *individual* performance management has not been explicitly acknowledged.

Health services managers appear aware of the need to find mechanisms for performance management at institutional level, but show little concern for performance management at individual or sub-institutional level. Managers do not feel either motivated or competent to improvise and to risk non-formal means of individual performance management.

Of more concern is the absence of the translation of the notion of performance in terms of production of health: of outputs and outcomes, in contrast to the insistence on getting all the ingredients - well trained and well paid staff, who are punctual and work hard - in place. Financial incentives for getting the right inputs is not the same as paying for results -which is what new public management is about.

This study may serve as a base to understand, in a couple of years, how has performance management (individual and institutional) evolved after a more extensive implementation of the current package of reforms in the NHS. It can also serve as the base to another exploratory work of understanding how to link doctors performance to the production of health.

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References

1. Asvall JE. Foreword. In: Boerma WG, Fleming DM. **The role of general practice in primary health care**. WHO Regional Office for Europe, 1998:ix-x.
2. World Health Organization Regional Office for Europe. Annex I. Framework for professional and administrative development of general practice/family medicine in Europe. In: Boerma WG, Fleming DM. **The role of general practice in primary health care**. WHO, Regional Office for Europe, 1998:107-16.
3. Baía H, Martins ML, Lopes T, Vieira R. Avaliação da qualidade dos registos em saúde infantil-Primeiro ano de vida. *Saúde Infantil* 1995;17:33-39.
4. Baltazar J, Natario A. Avaliação da qualidade dos cuidados médicos em hipertensos. *Acta Médica Portuguesa* 1993;6:431-38.
5. Costa AM, Silva EB, Machado MC. Avaliação da competência técnico-científica dos profissionais do Centro de Saúde de Almada no âmbito do tabagismo. *Revista Portuguesa de Clínica Geral* 1996;13:167-80.
6. Campos AC, Carvalho R. Remuneração dos médicos de clínica geral: otimizar recursos, clarificando ambiguidades. *Revista Portuguesa de Clínica Geral* 1987;20:33-7.
7. Giraldes MR. Caracterização dos principais recursos humanos de saúde em Portugal - sua evolução de curto prazo e desigualdades na respectiva distribuição. *Revista Portuguesa de Saúde Pública* 1995;13:5-19.
8. Uva MS, Faria M. Riscos **Ocupacionais em Hospitais e outros Estabelecimentos de Saúde. Ano Europeu de Segurança, Higiene e Saúde no local de trabalho 1992**. Lisboa: Sindicato Independente dos Médicos e Federação Nacional dos Médicos.
9. Nogueira JMR. "Stress" e exaustão na actividade profissional do clínico geral. *Revista Portuguesa de Clínica Geral* 1989;6:141-47.
10. Hespanhol AP. "Stress" no dia a dia do clínico geral: um estudo piloto. *Revista Portuguesa de Clínica Geral* 1994;11:20-48.
11. Hespanhol AP. Condições do Exercício da Clínica Geral no Norte de Portugal. Dissertation submitted in partial fulfilment of the requirements for a PhD at the Faculdade de Medicina da Universidade do Porto, Portugal; 1996.
12. Pereira MMC. Satisfação e stress profissional dos médicos de família dos centros de saúde. *Revista Portuguesa de Saúde Pública* 1998; 16:57-64.
13. Diniz JAB, Ortiz MC, Page P. Trabalho em equipa no centro de saúde de Almeirim - efeito de moda? *Cadernos-Santarém* 1988;2:19-24.
14. Leitão JAM. Atendimento por equipas multidisciplinares versus atendimento nos moldes clássicos - estudo do grau de satisfação na Óptica dos doentes. *Cadernos-Santarém* 1991; 5:5-10.
15. Nogueira F, Cunha G, Martins M, Costa N. Trabalho em equipa. *Cadernos-Santarém* 1991; 5:11-17.
16. Marques JMB. **Avaliação da Satisfação de Utentes e Profissionais num Contexto de Mudança Organizacional, o Projecto Alfa**. Lisboa: Escola Nacional de Saúde Pública, Universidade Nova de Lisboa; 1997.
17. Pires B, Cerdeira F. Satisfação profissional de clínicos gerais num centro de saúde. *Revista Portuguesa de Clínica Geral* 1989;6:6-13.



18. Vieira D, Viegas I. Satisfação profissional do clínico geral. *Revista Portuguesa de Clínica Geral* 1991;8:210-15.
19. Vieira D, Viegas I, Furtado N. Satisfação profissional em médicos da carreira de clínica geral. *Acta Médica Portuguesa* 1995;8:531-35.
20. Mourão, JN. **Incentivos aos Profissionais Prestadores dos Cuidados de Saúde no Hospital Público Português.** Lisboa: Escola Nacional de Saúde Pública, Universidade Nova de Lisboa; 1997.
21. Hunter DJ. The changing roles of health care personnel in health and health care management. *Soc Sci Med* 1996;43:799-808.

