New Deal Survey

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Introduction

The New Deal of Minister Vandenbroucke aims to develop a new organisation- and financing model for general practice. A reflection group consisting of delegates from doctors' unions, health insurance organisations, GP professional organisations and academics convened to develop such a model from September 2022 up until January 2023. As part of this development process, a quantitative survey among Belgian GPs was set up in order to explore the current set-up of general practice in Belgium and how GPs would like their practices to evolve in the future.

Methods

The survey was conducted online using Qualtrics, in either French or Dutch depending on the respondents' preference. Ethical clearance was provided by the ethical committee of KU Leuven (reference number G-2022-6054-R2(MIN)) on 5th January 2023. The survey was subsequently launched on 6th January 2023 using advertisements on social media, the RIZIV/INAMI website, newsletters of professional GP organisations such as Domus Medica, Artsenkrant/Journal du Medecin, and via the members of the reflection group. The survey was closed on 5th February 2023.

To ensure the survey was completed by GPs, the RIZIV/INAMI number was requested at the start of the survey but excluded from further analyses to safeguard anonymity.
The survey consisted of the following topics:

- Demographic data: age and gender;
- Type of practice: solo, network, group, multidisciplinary in the fee-for -service financing model, multidisciplinary in the capitation financing model; size of the practice;
- Current set-up of the practice: number of doctors, receptionists, nurses, etc. either salaried by the practice, self-employed, or through an external collaboration agreement, in number of people and full-time equivalents (fte);
- Future set-up of the practice: number of doctors, receptionists, nurses, etc. either salaried by the practice, self-employed, or through an external collaboration agreement, in number of people and full-time equivalents;
- Barriers for hiring receptionists and nurses;
- Time spent outside the individual patient consultation;
- Satisfaction with current financing model, reasons for (dis)satisfaction, satisfaction with job as general practitioner;
- Willingness to change to another existing financing model or to a new financing model, reasons for willingness;
- Discrete choice experiments: 6 scenarios in which two practices were compared and the respondent had to choose between either of the two. Practice A is identical in each scenario and represents the status quo, practice B varied on one or more parameter as listed below.
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Table 1: discrete choice parameters and values

Parameters	**Values**
Consultation length	10, 15 of 20 minutes
Total number of working hours per week	-5 hours, no change
Personal yearly income	-10%, no change , +10%
Delegation of tasks to a practice nurse	Yes, No

Collaboration with other health care professionals such as a psychologist or social worker	Yes, No
Number of patients enlisted in the practice	-10%, no change , +10%

Results

In total, 2453 respondents started the survey. Of those 601 were excluded from the analyses: 458 because they left the survey completely empty, 41 because they entered an invalid RIZIV/INAMI number and 102 because they had entered a valid RIZIV/INAMI number but left the survey otherwise empty. As a result, the analyses were conducted on 1852 respondents, 835 French speaking (45.1%) and 1017 Dutch speaking (54.9%).

More women than men completed the survey: 56.2% female versus 43.5% male (0.3% opted not to disclose their gender). The median age of the respondents was 40.0 years (minimum 23 years and maximum 83 years). The age distribution is shown below.

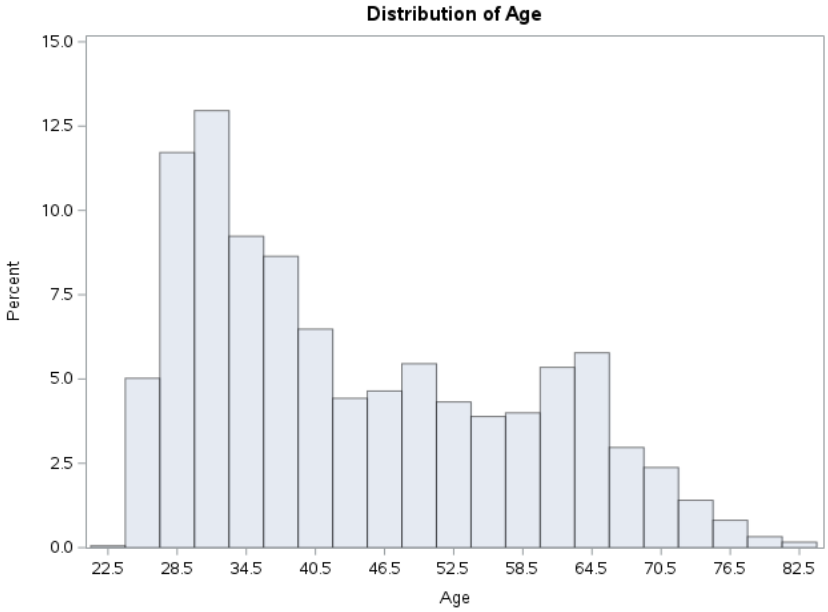

Figure 1: Age distribution of analysed respondents

The most common type of practice was a group practice (41.0%), followed by a solo practice (23.0%), a multidisciplinary practice with fee-for-service financing (17.6%), a multidisciplinary practice with capitation financing (11.8%) and a network practice (3.6%). In 3.1% of cases, respondents indicated they worked in a different type of practice, mostly because they did not have a practice of their own (e.g. working as a locum doctor or in retirement). The median age of respondents working in solo practices is markedly higher see table 2.

Table 2: median age of respondents by practice type

Practice type	**Median age (Years) + IQR**
Solo	57.0 (24.0)
Network	43.5 (22.0)
Group practice	36.0 (18.0)
Multidisciplinary, fee-for-service financing	37.0 (17.0)
Multidisciplinary, capitation financing	38.0 (16.0)

IQR: interquartile range

The median number of GPs per practice was 3.0 who are almost all self-employed (median of 2.5 self-employed GPs per practice). The median number of GPs-in-training was 1.0; combining GPs and GPs-in-training, the median fte per practice is 3.0. The median number of doctors per practice type and the full-time equivalents they work is presented in table 3.

Table 3: Median number of doctors per practice type (+fte)

Practice type	**Median number of GPs (IQR)**	**Median FTE (IQR)**
Solo	1 (0)	1.0 (0.5)
Network	3 (2)	3.0 (3.0)
Group practice	3 (3)	3.5 (2.5)
Multidisciplinary, fee-for-service financing	4 (3)	4.5 (3.0)
Multidisciplinary, capitation financing	5 (3)	4.5 (3.0)

IQR: interquartile range

The number of patients with a registered therapeutic relation with a GP (GMD/DMG) in the respondents' practice is shown in Figure 1. Almost 30% of respondents indicate their practice holds between 2001 and 4000 GMDs/DMGs; only 17% of practices hold less than 1000 GMDs/DMGs. The proportion of practices that hold at least 1000 GMDs/DMGs is 36.9% in solo practices, 65.2% in network practices, 76.5% in group practices, 73.9% in multidisciplinary fee-for-service practices and 71.1% in multidisciplinary capitation practices. The median number of unique patients that are treated per year, regardless of GMD/DMG status, is 3000. Respondents indicate they work a median of 8 hours per week outside direct patient contacts.

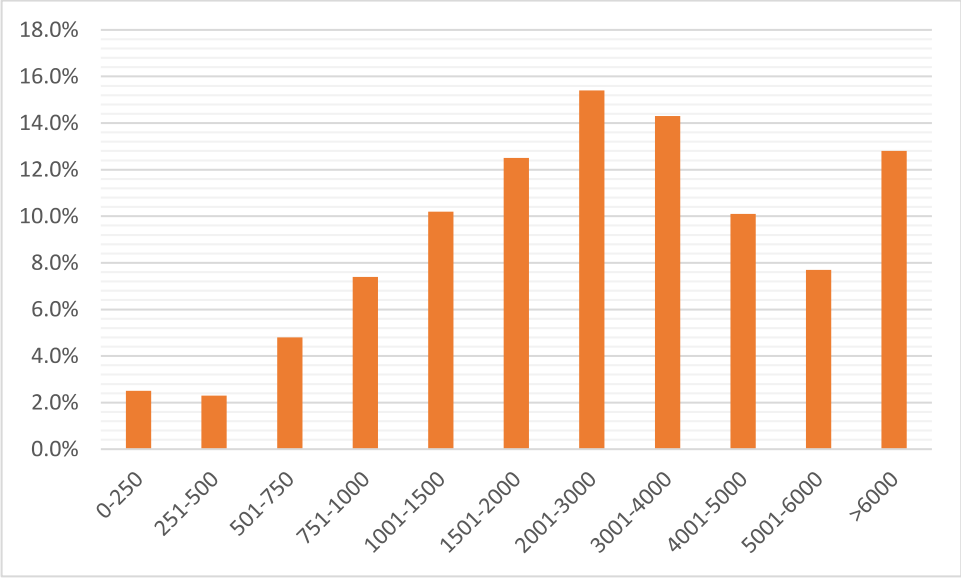

Figure 1: number of GMDs in the respondents' practice

Current set-up of the practice

Overall, the majority of respondents indicated their practice included either salaried personnel, non-salaried team members or external collaborators.

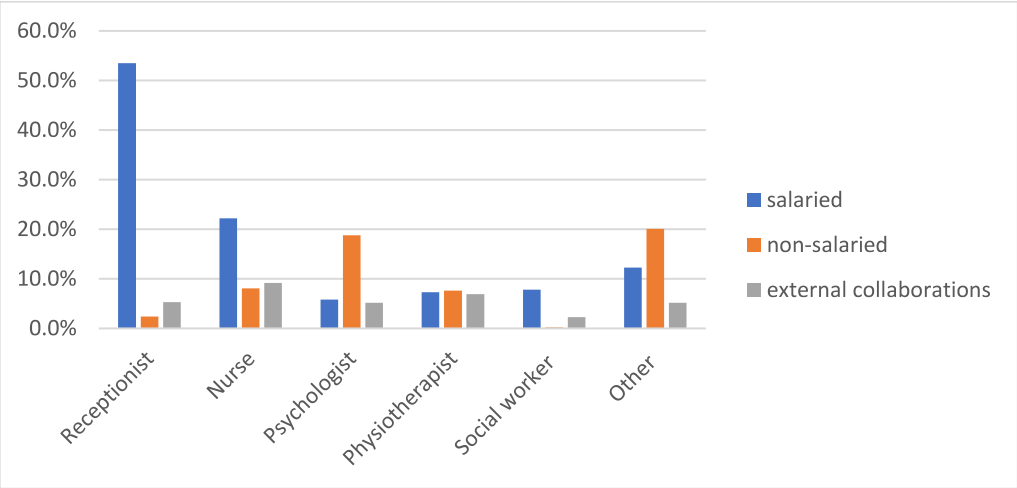

Figure 2: Overall set-up of current GP practices

In terms of salaried personnel, more than half of respondents indicated they employ a receptionist in their practice (53.5%%), with a median number of 2.0 receptionists totalling a median of 1.0 fulltime equivalents (fte) suggesting most practices employ 2 part-time receptionists. Salaried nurses are present in the practices of 412 respondents (22.2%), with a median of 1.0 nurse and 1.0 median fte. Other salaried personnel are far less common (5.8% for physiotherapists, 7.3% for physiotherapists, 7.8% for social workers). There are marked differences according to practice type, with solo practices having the least salaried personnel and multidisciplinary practices the most. Other personnel include cleaners/logistics (12.8%), practice managers/coordinators (4.0%), dieticians (2.9%) and health promotion (2.3%) – only categories mentioned by >1% of the respondents are listed here. For further details, see table 4.

Table 4: Salaried personnel

	Receptionist	**Nurse**	**Psychologist**	**Physio-therapist**	**Social worker**	**Other**
Practices with ≥1 (%) Median n (median fte)	53.5% 2.0 (1.0)	22.2% 1.0 (1.0)	5.8% 1.0 (0.5)	7.3% 3.0 (2.0)	7.8% 1.0 (0.7)	12.3% 1.0 (0.5)
Solo	15.3% 1.0(0.6)	1.2% 1.0 (0.5)	-	-	-	3.3% 1.0 (0.5)
Network	39.4% 1.0 (1.0)	4.5% 1.0 (0.8)	-	-	-	4.5% 1.0 (0.2)
Group	62.3% 1.0 (1.0)	11.9% 1.0 (0.5)	0.9% 1.0 (0.2)	0.7% 2.0 (2.0)	0.4% 1.0 (0)	7.8% 1.0 (0.3)
Multidisciplinary fee-for-service	74.6% 2.0 (1.0)	61.4% 1.0 (0.5)	8.0% 1.0 (0.2)	5.5% 2.0 (1.0)	4.9% 1.0 (0.5)	12.3% 1.0 (0.3)
Multidisciplinary capitation	78.0% 4.0 (2.5)	77.5% 3.0 (1.6)	31.6% 1.0 (0.5)	50.5% 3.0 (2.3)	54.6% 1.0 (0.5)	51.8% 3.0 (1.0)
Practice with ≥1000 GMDs/DMGs	30.3% 2.0 (1.0)	30.4% 1.0 (1.0)	7.8% 1.0 (0.5)	9.5% 3.0 (2.3)	10.4% 1.2 (0.6)	16.4% 1.0 (0.5)

Team members that are working within the practice but are not on the practice's payroll are summarized in table 5. The largest group are psychologists, who are present in 18.8% of respondents' practices, followed by nurses (8.1%). The median number of psychologists and nurses

are 1.0 in both cases, and both represent a median of 0.3 fte. In 20.1% of cases, other team members are present which include (again limited to those mentioned by at least 1% of respondents): dieticians (10.8%), cleaners/logistics (15.8%), podiatrists/medical pedicurists (3.8%), physician-specialists (2.4%), speech therapists (2.1%), coaches (1.7%), midwives (1.7%), osteopaths (1.7%), and spouses/parents/partners (1.2%).

Table 5: Non-salaried team members (self-employed or outsourced)

	Receptionist	**Nurse**	**Psychologist**	**Physio-therapist**	**Social worker**	**Other**
Practices with ≥1 (%) Median n (median fte)	2.4% 1.0 (1.0)	8.1% 1.0 (0.3)	18.8% 1.0 (0.3)	7.6% 2.0 (1.0)	0.2% 1.0 (0.3)	20.1% 1.0 (0.2)
Solo	3.8% 1.0 (0.8)	3.3% 1.0 (0.4)	4.5% 1.0 (0.2)	3.8% 1.0 (0.8)	0.2% 2.0 (0.3)	10.1% 1.0 (0.0)
Network	3.0% 1.0 (1.0)	9.1% 2.0 (0.2)	18.2% 1.0 (0.0)	6.1% 1.5 (0.5)	-	12.1% 1.0 (0.0)
Group	1.8% 1.0 (0.5)	8.6% 1.0 (0.2)	13.3% 1.0 (0.3)	4.1% 1.0 (1.0)	-	15.0% 1.0 (0.2)
Multidisciplinary fee-for-service	1.8% 1.0 (1.0)	17.5% 1.0 (0.3)	51.8% 2.0 (0.5)	23.0% 2.0 (1.0)	0.6% 1.0 (0.3)	48.2% 2.0 (0.2)
Multidisciplinary capitation	1.8% 2.0 (0.7)	2.7% 1.5 (0.6)	20.2% 1.0 (0.5)	16.0% 2.0 (1.9)	0.5% 1.0 (0.5)	20.2% 1.0 (0.1)
Practice with ≥1000 GMDs/DMGs	3.0% 1.0 (0.9)	10.5% 1.0 (0.3)	25.1% 1.0 (0.3)	9.3% 2.0 (1.0)	0.3% 1.0 (0.3)	25.6% 0.0 (0.0)

Finally, respondents indicated they collaborate externally mostly with nurses (9.2%) and physiotherapists (6.9%). Other people with whom they collaborate (by at least 1% of respondents) are tele-secretariat (2.6%).

Table 6: Collaborations outside the practice

	Receptionist	**Nurse**	**Psychologist**	**Physio-therapist**	**Social worker**	**Other**
Practices with ≥1 (%) Median n (median fte)	5.3% 1.0 (1.0)	9.2% 2.0 (0.0)	5.2% 2.0 (0.0)	6.9% 3.0 (0.0)	2.3% 1.0 (0.2)	5.2% 1.0 (0.0)
Solo	7.3% 1.0 (0.0)	13.4% 2.0 (0.0)	9.6% 2.0 (0.0)	12.0% 3.0 (0.0)	2.8% 1.0 (0.0)	4.9% 1.0 (0.0)
Network	9.1% 1.0 (0.1)	9.1% 1.5 (0.3)	3.0% 1.5 (0.0)	4.5% 2.0 (0.0)	-	7.6% 0.0 (0.4)
Group	6.2% 1.0 (1.0)	6.2% 3.0 (0.0)	3.3% 2.0 (0.2)	4.6% 3.0 (0.0)	1.7% 1.0 (0.0)	5.0% 1.0 (0.0)
Multidisciplinary fee-for-service	2.8% 2.0 (1.0)	9.2% 2.0 (1.0)	3.4% 1.0 (0.5)	5.8% 3.0 (1.0)	3.1% 1.0 (0.6)	4.0% 1.0 (0.3)
Multidisciplinary capitation	0.5% 1.0 (1.0)	13.3% 2.0 (0.2)	7.3% 1.5 (0.3)	8.2% 3.0 (0.3)	3.7% 2.0 (0.3)	7.4% 1.5 (0.0)
Practice with ≥1000 GMDs/DMGs	5.6% 1.0 (1.0)	10.3% 2.0 (0.2)	5.2% 2.0 (0.2)	7.3% 3.0 (0.2)	2.6% 2.0 (0.5)	6.4% 1.0 (0.0)

Figure 3 provides an overview of the current set-up of practices by practice type. This graph clearly shows that receptionists are by far the most commonly employed staff in all practice types except in

multidisciplinary practices with capitation financing (where nurses are equally common as receptionists). Solo practices have the least salaried and non-salaried personnel. Multidisciplinary practices with capitation financing employ the most personnel of all types.

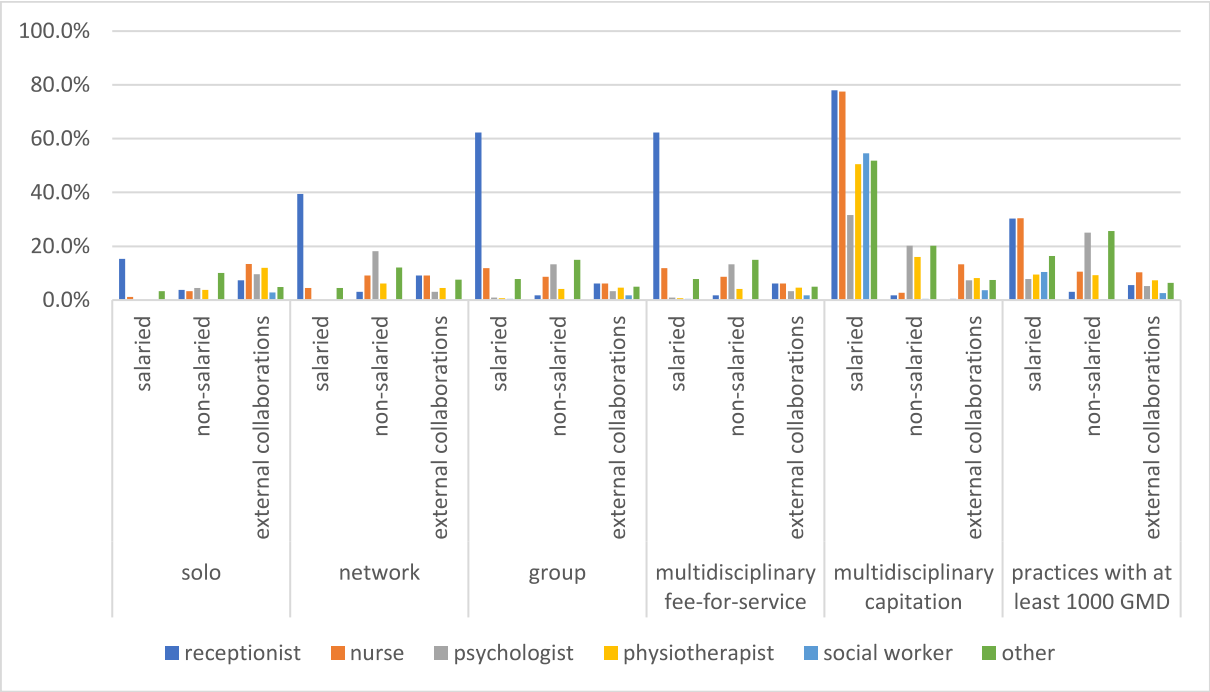

Figure 3: Overview of current practice set-up by practice type

Future set-up of the practice

In the future, 27.4% of respondents would like to employ a receptionist. Of those who currently do not employ a receptionist, 30.2% would like to employ one in the future. Even more practices would like to recruit a nurse (35.7%), rising to 39.0% in respondents who currently do not employ a nurse. The median fte is 0.5 (IQR 1.0) suggesting most respondents intend to hire a part-time nurse.

Most common other personnel are dieticians (5.5%), physician-specialists (1.3%), cleaners/logistics (1.1%), podiatrists/medical pedicurist (1.1%) and speech therapists (1.0%) – list restricted to those listed by at least 1% of respondents.

Table 7: future personnel

	Receptionist	**Nurse**	**Psychologist**	**Physio-therapist**	**Social worker**	**Other**
Practices with ≥1 (%) Median n (median fte)	27.4%	35.7%	27.8%	11.4%	19.8%	12.6%
Solo	26.8%	21.6%	13.8%	8.0%	10.3%	8.0%
Network	42.4%	34.8%	31.8%	9.1%	12.1%	18.2%
Group	34.5%	50.7%	33.6%	12.1%	21.0%	12.1%
Multidisciplinary fee-for-service	22.4%	39.6%	32.5%	14.7%	16.2%	17.8%
Multidisciplinary capitation	9.2%	10.5%	28.9%	13.7%	23.0%	15.1%
Practice with ≥1000 GMDs/DMGs	31.1%	44.9%	35.2%	14.7%	27.1%	16.0%

The most common barriers for hiring a receptionist or a nurse are insufficient financial means in both cases (15.8% and 16.6% respectively), followed by a lack of space in the practice (13.4% and 14.7% respectively). Insufficient financial support from the government and financial means insufficiently guaranteed over time have also been cited as a barrier by >10% of respondents. In addition to the barriers suggested in the survey, respondents also listed other barriers but only 'unclear legislation' for hiring a nurse was cited by >1% of respondents (1.3%). All barriers are displayed in Figure 4.

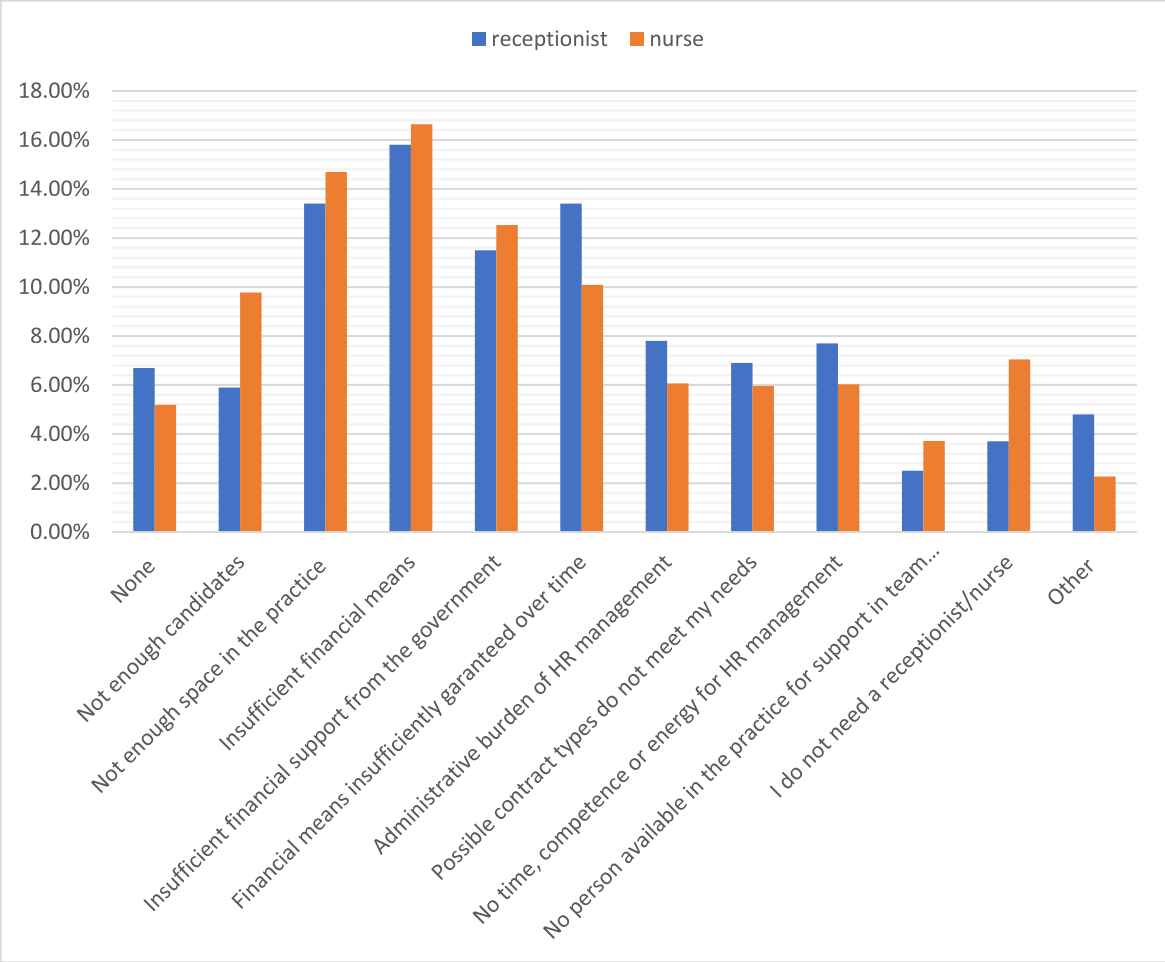

Figure 4: Barriers for hiring a receptionist or nurse

Additional premiums

In the past, most respondents have received additional premiums related to their professional activity as a GP.

Below all premiums are displayed graphically in Figure 5.

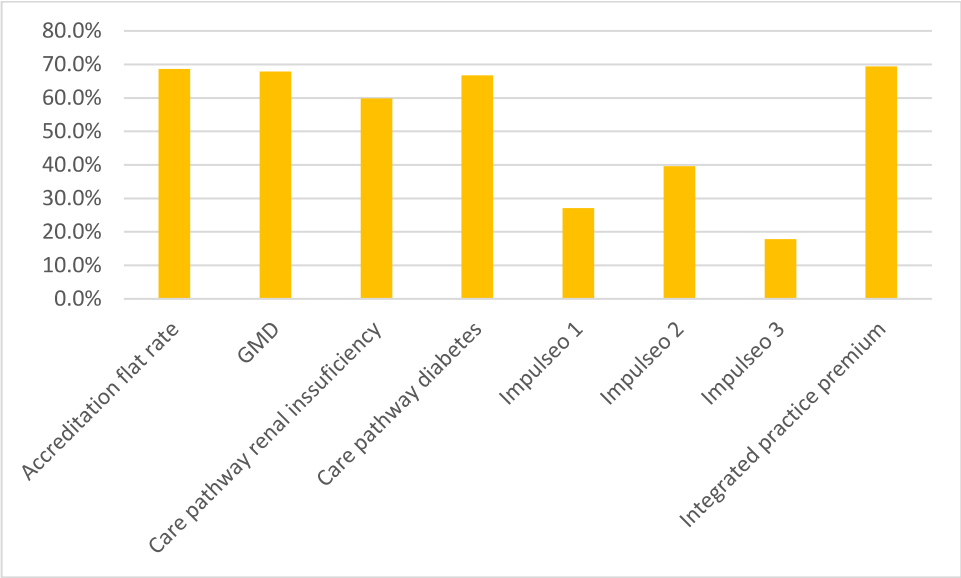

Figure 5: premiums received in the past

In addition to these premiums, 147 GPs indicated they had received other premiums, mostly money for personal protective equipment (5.4%) and a lump sum for primary care during the COVID-19 pandemic ('Oxygen for care', 3.9%).

Professional satisfaction

Most respondents expressed high satisfaction with their job as a GP. On the VAS scale of 0-10, the median satisfaction was 7.0. In total, 82.4% of respondents indicated a satisfaction of 6 or more on the VAS scale. Satisfaction was similar in all practice types (median 7.0) except in multidisciplinary practices with capitation financing where the median satisfaction was 8.0.

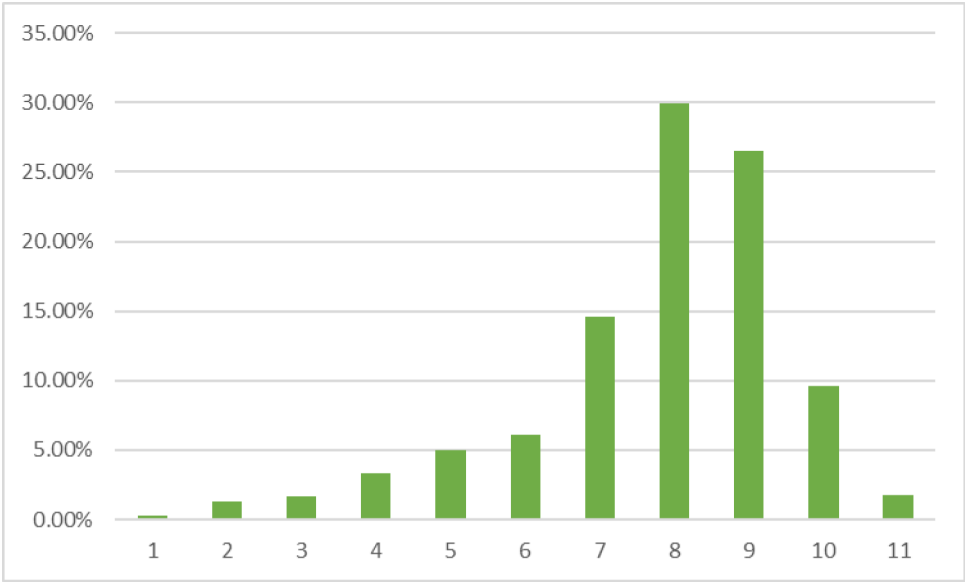

Figure 6: satisfaction with their job as a GP on a 0-10 VAS scale

Overall, most GPs are satisfied or very satisfied with their current financing model: 57.3% are satisfied and 14.7% are very satisfied. Satisfaction is broadly similar across the different practice types, although satisfaction is slightly lower in GPs working in a multidisciplinary practice with fee for service financing (64.2% satisfied or very satisfied) and GPs working in a solo practice (68.5% satisfied or very satisfied) whereas satisfaction is slightly higher in GPs working in a multidisciplinary practice with capitation financing (83.3% satisfied or very satisfied). See figure 7 below.

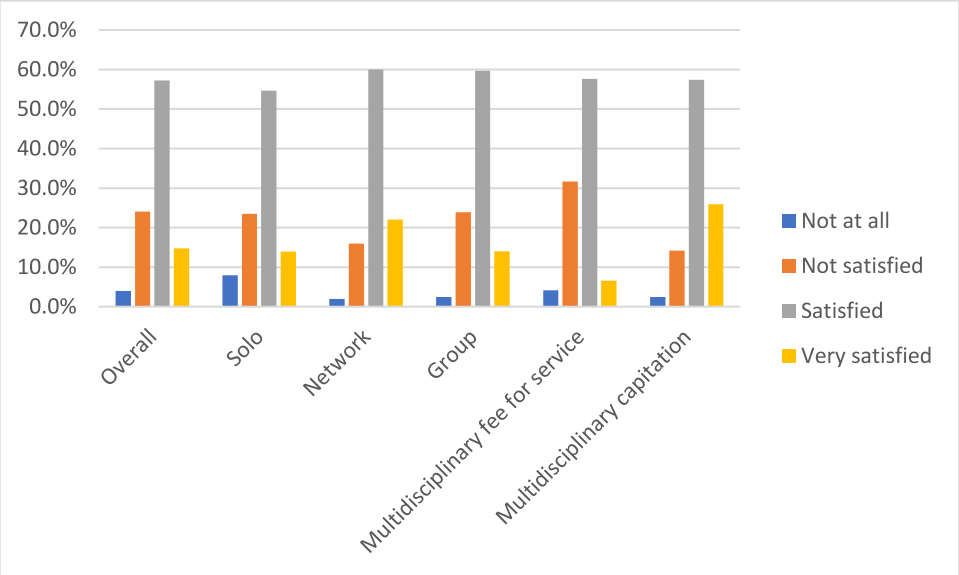

Figure 7: Satisfaction with current financing model

Satisfaction was slightly higher in GPs younger than 40 years of age (74.6% versus 69.5% respectively).

Factors contributing to satisfaction levels are displayed in figure 8. Remuneration and autonomy are the most important factors contributing to satisfaction; administrative obligations, the possibility to employ other team members and remuneration of additional tasks the least.

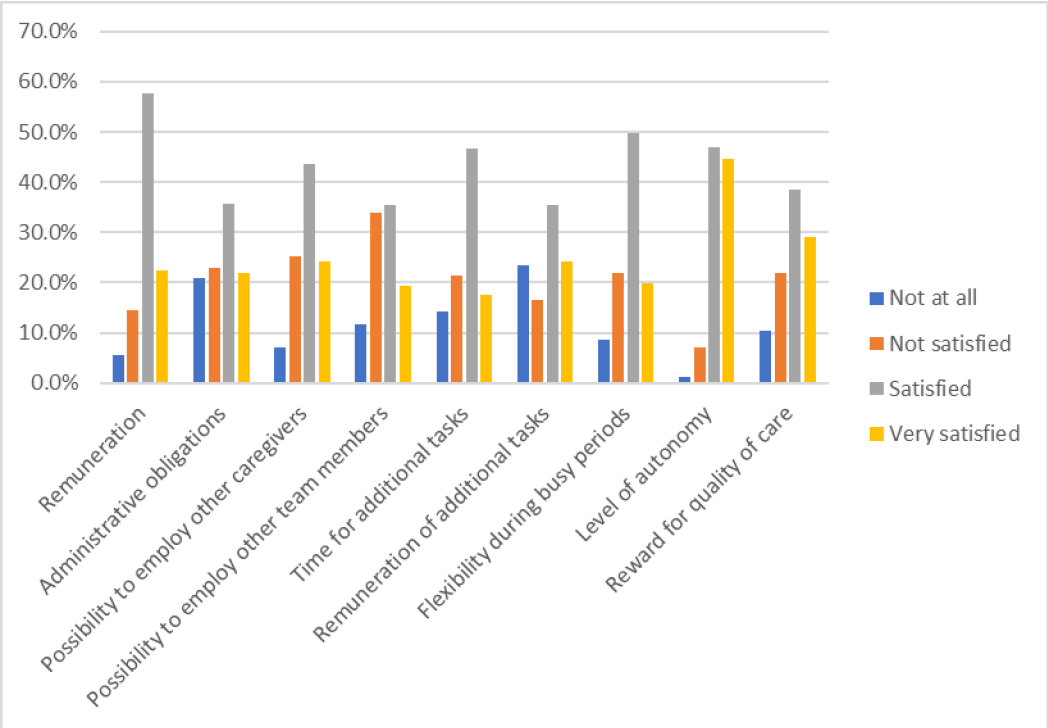

Figure 8: Factors contributing to satisfaction with financing model

Willingness to change

Asked whether they would like to change to another existing financing model, 81.2% of respondents said *no* and subsequently only 18.8% said *yes*. There are, however, marked differences between respondents by practice type: only 8.6% of respondents working in a solo practice would be willing to change, compared to 13.6% in multidisciplinary practices with capitation financing, 16.0% in network practices, 20.3% in group practices, and 32.1% in multidisciplinary practice with fee for service financing. Respondents younger than 40 years of age are more willing to change than older respondents (21.2% versus 16.6%).

The most common reason for not wanting to change to another financing model is knowledge: 18.3% of respondents indicated they are not sufficiently familiar with the other financing model. Second is administrative burden. Other reasons include (limited to those listed by at least 1% of respondents): wishing to remain independent from the government or maintain autonomy (1.5%).

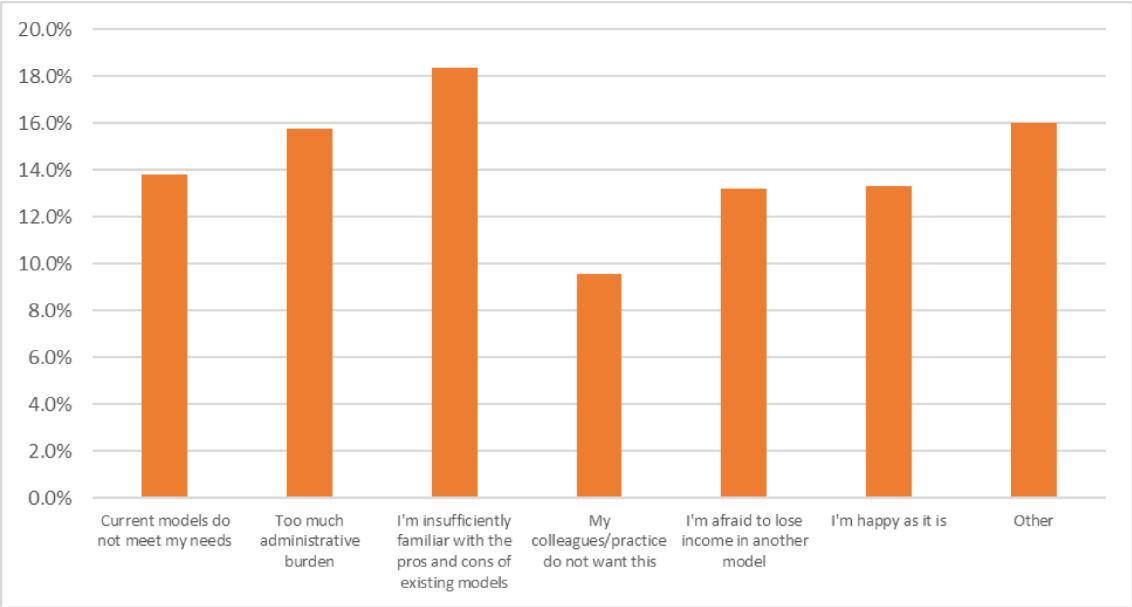

Figure 9: Reasons for not wanting to change to an existing financing model

Asked whether they would consider changing to a new financing model, if appropriate, 70.0% of respondents answered *yes*. This is again slightly different by practice type: 59.0% solo, 66% network, 73.3% group, 81.1% multidisciplinary with fee for service financing and 61.1% multidisciplinary with capitation financing. There is more willingness to change among younger GPs than older GPs: 75.6% in <40 years versus 64.2% in >40 years. Respondents working in a practice with at least 1000 GMDs are willing to change to a new financing model in 71.9% of cases. The most common reason for not wanting to change is fear of losing income (25.6%), followed by administrative burden (18.6%). No other reason reached the 1% threshold.

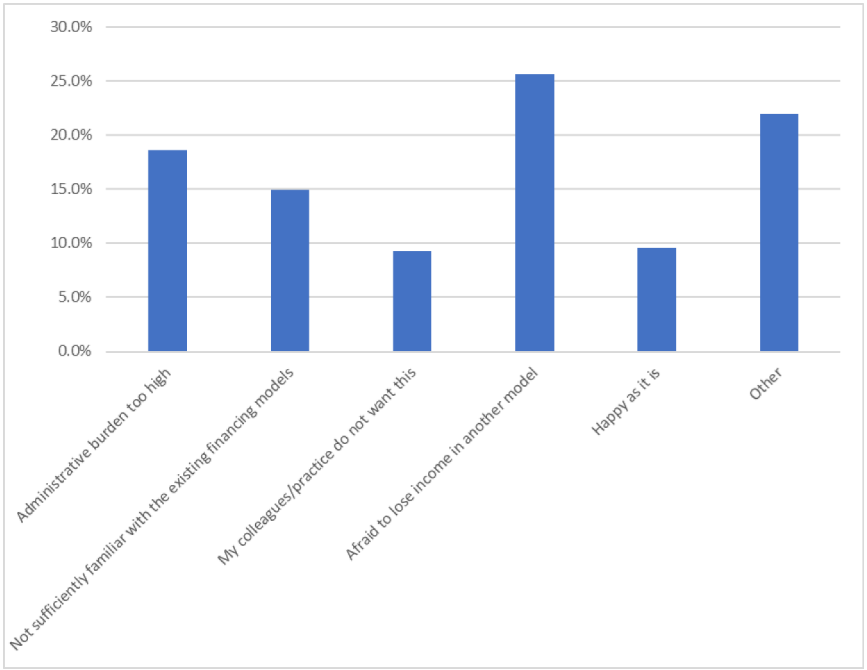

Figure 10: reasons for not wanting to change to a new financing model

Consequences of changes in practice organisation

In 6 scenarios, respondents indicated their preferences as regards to the consequences of changes in practice organisation. In each scenario, changes and their consequences were compared to the status quo (practice A).

In the first scenario, GPs were asked to compare the status quo with a new practice in which consultations would last only 10 minutes (rather than 15 minutes in practice A) leading to a shorter working week by 5 hours. Only 10.4% of respondents would prefer this new practice over the status quo.

In the second scenario, the status quo practice was compared to a new practice in which task delegation to a nurse led to a 10% increase of the patient population and a 10% increase in income: 72.4% of respondents preferred the new practice.

Thirdly, the status quo practice was compared to a new practice in which task delegation to a nurse led to a shorter working week by 5 hours: the latter was preferred by 80.1% of respondents.

In the fourth scenario, the status quo practice was compared to a new practice in which task delegation to a nurse and to other healthcare professionals would lead to longer consultations of 20 minutes. This was preferred by 74.5% of respondents.

In scenario 5, the new practice delegated tasks to a practice nurse and to other healthcare professionals leading to a shorter working week by 5 hours but also to a 10% decrease in patient population and a 10% decrease in income. This was preferred by only 41.9%.

Finally, in scenario 6, task delegation to a practice nurse and to other healthcare professionals led to consultations of 20 minutes and a 10% decrease in income (without changes in the patient population): 34.3% of respondents preferred this practice over the status quo practice.

Table 8: Preferences by frequency

Scenario	**Preference frequency**
Task delegation to a nurse leading to a shorter working week	80.1%
Task delegation to a nurse and other healthcare professionals leading to longer consultations	74.5%
Task delegation to a nurse leading to a larger patient population and higher income	72.4%
Task delegation to a nurse and other healthcare professionals leading to a shorter working week, a smaller patient population and a decrease in income	41.9%
Task delegation to a nurse and other healthcare professionals leading to longer consultations and a decrease in income	34.3%
Shorter consultations leading to a shorter working week	10.4%

Discussion

This survey was competed by >1800 respondents, of whom 56% were female, the median age was 40.0 years and 41% worked in a group practice. The median number of GPs per practice was 3.0 and 83% worked in a practice with >1000 GMDs/DMGs. More than 53% of respondents employ a receptionist and 22% employ a nurse. In the future, 27% would like to employ a receptionist and 36%

a nurse. The most common barriers for hiring a receptionist or nurse are insufficient financial means and space restraints.

Respondents are mostly satisfied or very satisfied with their job as a GP (median 7.0 on a 0-10 VAS scale). Remuneration and autonomy are the most important factors contributing to this satisfaction. Less than 20% of respondents would like to change to another existing financial model. Reasons for not wanting to change are insufficient knowledge of the financing models and administrative burden. In contrast, 70.0% of respondents would like to change to a new financing model, if the model would be appropriate. The most common reason for not wanting to change is fear of losing income and administrative burden.

Task delegation to a nurse leading to a shorter working week was the most popular scenario of changes in practice organisation, followed by maximum task delegation to a nurse and other healthcare professionals leading to longer consultations and task delegation to a nurse leading to a larger patient population and subsequent higher income. Scenarios leading to lower income or shorter consultations were preferred by less than half of the respondents.