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Appropriateness of gatekeeping in provision of reproductive health care for adolescents in Lithuania: general practitioners' perspective

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Abstract

Background

Adolescents' address to primary health care services remains problematic despite factual accessibility of these services. Researchers pay a lot of attention to adolescents' reproductive health services seeking behavior: still little is known how this behavior is influenced by gatekeeping system. This study aimed to explore general practitioners' perceptions on the appropriateness of gatekeeping in adolescents' reproductive health care.

Methods

Twenty in-depth interviews regarding factors affecting adolescents' reproductive health care were carried out on a diverse sample of general practitioners (GPs) and analyzed using grounded theory.

Results

The analysis identified several factors that shaped negative GPs attitude to gatekeeping in adolescents' reproductive health care. Appropriateness of gatekeeping in this field was questionable due to lack of GPs' willingness to provide reproductive health services for teens, their insufficient training, inadequate equipment of offices and low perceived support for reproductive health services provision.

Conclusions

Since struggling factors for improvement of adolescents' reproductive health concern not only physicians, but health system and policy levels as well, complex measures should be designed aiming to overcome these barriers. Discussion of flexible model of gatekeeping, encompassing both coordination of care provided by primary health care physician and possibility of patients' self-referral, should be included into political agenda. Adolescents tend to under use reproductive health services; therefore, every effort should be made to eliminate barriers to accessibility of these services.

Introduction

Adolescents' address to primary health care services remains problematic despite factual accessibility of these services (1). Efforts made to identify the factors affecting teenagers' decisions to seek health care are valuable in tailoring existing health services to the adolescents' needs (2-4). Researchers pay a lot of attention to adolescents' reproductive health services seeking behavior: still little is known how this behavior is influenced by gatekeeping system.

Gatekeeping, according to Starfield (5), is the first patient's contact with the health care system. Then, gatekeeper is responsible for primary health care services provision as well as for care coordination by referring his patients to the specialists. Gatekeeping is intended to reduce health expenditures and improve health outcomes (5). Martin et al. (6), assessing the data of randomised trials, made a conclusion that gatekeeping, incorporating incentives and penalties for primary health care physicians, can reduce the cost of ambulatory services by limiting specialist visits. Clancy et al. (7) demonstrated that gatekeepers order fewer tests for the patients

comparing with those physicians working in the fee-for-service system. Franks et al. (8) concluded gatekeeping to be a critical strategy in minimizing overtreatment and developing optimal health care system.
Other studies, however, demonstrated minimal changes in utilization of specialists after gatekeeping was replaced by system with open access to all specialists (9; 10). Moreover, Forrest and al. (11) study on child and adolescents referrals to specialty care revealed that gatekeeping arrangements result in increased referrals to specialty care. No evidence was found that overall medical care expenditures were lower in gatekeeping system (6; 12; 13). In contrast, research identified negative gatekeeping consequences on patients' confidence, trust in their primary health care physician and satisfaction with health care provided (14-16). Negative gatekeeping effects on physician-patient relationship were admitted by physicians as well (17; 18).
Ability of primary health care physician to coordinate medical care efficiently is a crucial prerequisite for the effectiveness of gatekeeping system (5; 6). Some studies addressing reproductive health services delivery in primary health care acknowledge general practitioners' efficiency in providing these services for adolescents (19; 20); however, a great deal of papers emphasize the urge for proper primary health care providers' training as well as for their attitudes changes towards adolescents' reproductive health needs (21-25).
In Lithuania gatekeeping system was adopted in 1997; since then, general practitioner is nearly the only health care provider whose services are free of charge and whom adolescents can address their concerns about reproductive and sexual health related issues. The survey performed in Lithuania revealed, however, unwelcoming teens' attitude towards general practitioners as reproductive health care providers: only 4 % of 13-18 year old estimated general practitioner as the most appropriate reproductive health care provider (26). Although there were some attempts to explore Lithuanian primary health care providers' involvement in adolescents' reproductive health care (27), there is lack of evidence on suitability of gatekeeping system for adolescents' reproductive health care. Thus, the aim of this study was to explore general practitioners' experience in adolescents' reproductive health care and their perceptions of appropriateness of gatekeeping in adolescents' reproductive health care.

Lithuanian health care – the context of transition

Lithuania, the largest of the three Baltic States, re-established its independence from Soviet Union in 1990. The inherited Soviet health system was grounded on the biomedical model, emphasizing technical facilities and underestimating the patient's role. The health system transition process started in the early 90-ties has deeply affected technological features of health system as well as its management. Development of the primary care network, involving free access to primary health care services and the gatekeeping function of GPs, went along with the establishment of compulsory state health insurance schemes and decentralization of services. These most pronounced achievements of the Lithuanian health care reform (28) were the key issues of transformation of health system from highly centralized and specialized into an economically sustainable system.
During the Soviet time primary health care services were segmented by the age of patients as well as by health problems. District pediatricians took care of persons less than 16 years of age; district internists provided health services for persons more than 18 years old; adolescents' cabinets in the outpatients departments were designed for 16 – 18 year old adolescents. Reproductive health services were provided by

gynecologists working in the Women's consultations (29). Geographical distance was among the main barriers to apply for secondary and tertiary health care services. Since general practice did not exist in the highly specialized Soviet health care system; an extensive training of general practitioners was introduced in 1992. Two distinct patterns of training were developed for newly graduated and already experienced physicians, some of whom were at pre-retirement age. The residence program of general practice lasted for 3 years; the retraining of physicians was scheduled to be accomplished within 33 weeks. In 2002, 50% of primary health care services were provided by general practitioners (30). Debates on privatization of general practice initiated in 1998 were followed by a rapid increase in private primary health care centers; those with agreements of Sickness Funds constituted 25% of the total number of primary care institutions in the fall of 2002 (30).

Provision of health services specially designed for young people are not intended in the current framework of health system. Adolescent cabinets established in polyclinics at the end of Soviet époque were gradually reduced since the declaration of independency and were totally closed by 1997. Few youth clinics providing youth friendly reproductive health services have been opened in Lithuania since 1997. Most of them have received sponsorship from international foundations, private institutions and Health Fund of Municipalities (31). Young people from big cities have occasional opportunity to address these clinics. However, sustainability of their activity is weak due to lack of appropriate policy and instable financing.

General practitioner's services are free of charge and available for every minor patient of Lithuania, since persons less than 18 years of age are among those insured by the state. Legal framework of Lithuania emphasizes the importance of considering minor patient interests in health care provision. The legal age of consent is 18 years (32), for abortion 16 years (33).

The patients have the right to choose the health care setting as well as the primary health care provider. Gatekeeping system in Lithuania was adopted in 1997. As reproductive health services officially are stated being an integral part of primary health care (34), general practitioners are responsible for reproductive health services provision. Direct and free of charge access to gynecologists or urologists (traditional providers of reproductive health services for men) without the referral of general practitioners is feasible nearly exclusively in some private primary health care centers working with the contract of Sick Founds.

The general practice was institutionalized ten years ago and the primary health care settings have experienced dramatic urge for different sort of equipment. Since gynecological equipment was probably the most costly, an idea to equip each general practitioner's office with them failed. Instead separate rooms, called "room for female examination" or "room for gynecologic examination", were set up in primary care centers, both in private and governmental, to be used by all GPs working there. Physicians who do not have such opportunity are supposed to use gynecological equipment disposed in gynecological departments.

Sexual and reproductive health related issues are perceived as deeply private aspect of human being in Lithuania. Traditionally health sector practically had not his place into the guidance of people towards healthier sexual live, however, it was involved into the management of outcomes of sexual behavior as in the provision of pregnancy care, treating of STDs or termination of unintended pregnancies. The threat of AIDS has had a major impact on attitudes changes; however, society as well as medical practitioners is still reluctant to more open approach towards sexual and reproductive health issues.

Methods

This paper reports one component of a larger project on Adolescent Reproductive Health Promotion Policy in Lithuania. The study was carried out between July and November 2003 in Kaunas, the second city of Lithuania. According to the Register of National Sickness Funds, free primary care services were delivered in Kaunas by 35 private and 46 state practices in the fall 2002 (30).

General practitioners provided primary care services for 60% of the population of Kaunas in the fall 2002 (30). Since the delivery of reproductive health care is the responsibility of GPs rather than of other primary health care providers, the final sample comprised 20 GPs: fifteen females and five males. Nine of them practiced in state primary care settings, eight in private primary care centers, and three practiced in both state and private institutions. One physician refused to take part in this study giving the reason of experiencing urgent family problems. Eight of the GPs selected had completed the general practice residency and twelve had become GPs after vocational training (retraining program). The age distribution of participants was as follows: aged 26 – 39(n=10), aged 40 – 54 (n=8) and aged 55 and over (n=2). Selection of participants was performed aiming to achieve diverse representation of thoughts and experiences of general practitioners from different ages and having diverse training and working experience.

Qualitative methods are beneficial in investigating complex health issues. Individual in-depth interviews were selected as a method for this study since they provide more privacy exploring personal attitudes towards sexual and reproductive health. All participants were informed of the purpose of the study – exploration of GPs' own experience, thoughts and attitudes towards adolescent reproductive health care. Participants were acquainted with the scheduled publications as well as with the idea of improving reproductive health care for adolescents. Confidentiality issues were discussed as well; confidentiality was warranted to participants.

The principal investigator, a GP, acted as the interviewer after completing introductory training in performing in-depth interviews. Non-structured in-depth interviews were held in the offices of participants at the time they had chosen themselves. Physicians were invited to describe actual cases by asking them: "Could you tell me about some of the latest adolescents' consultations that were related with sexual or reproductive health issues?" Then the interviews were based on topics revealed by the physicians themselves. The interviews lasted from 50 minutes up to 2 hours (mean time between 1 and 1hour and a half). We think that the fact the interviewer was a general practitioner could favorably affect getting into contact with participants. Still during the interviews, some of the physicians were prone to inquire the interviewer about his own experience or use him as a source of "correct information". After revealing their own thoughts on discussed issue, some participants asked: "How should we proceed in such a situation?" or "What are you doing in these circumstances?"…. The interviewer was reluctant in providing his own view explaining to the physician that various opinions exist. This approach was adopted seeking strengthen participant's confidence in himself and avoiding influence from the interviewer.

The interviews were tape recorded, fully transcribed and then analyzed using grounded theory. Each element was coded; codes akin to each other were gathered together as main topics (e.g. gatekeeping, confidentiality, contraception, abortion…) and summarized to enable a description of GPs' views of adolescents' reproductive health care issue. All views were included in the coding process. Identified key factors

were labeled and illustrated by selected interview quotes. This paper deals only with aspects related to gatekeeping in adolescents reproductive health services provision.

Results

The analysis identified several factors that shaped negative GPs attitude to gatekeeping in adolescents' reproductive health care. Appropriateness of gatekeeping in this field was questionable due to lack of GPs' willingness to provide reproductive health services for teens, their insufficient training, inadequate equipment of offices and low support for reproductive health services provision.

Willingness to provide sexual and reproductive health services to adolescents

The data have shown that some factors decrease general practitioners' willingness to access sexual health matters during the consultations, such as: discomfort felt by physicians in discussing sexuality related questions, low prioritization of sexual and reproductive health issues in the primary health care as well as legal uncertainty of physicians-teenage patient-parents' relationship.

Primary health care providers have a feeling that conservative social attitudes towards sexuality shape their medical practice and they experience some discomfort while approaching sexual health matters.

"It's a certain stupid feeling […] that this is […] domain, well […] not a taboo, but […] some sort of dark and it makes me feel like shamed… and it's awkward to speak about and so on..." (GP5M).

It seems that behavioural aspects of sexual health are experienced by general practitioners as the most intense trouble, since they *"don't perceive any inconvenience to talk about the medical side" (GP15M)*. "Medical side" related with the sexual behaviour outcomes management is "privatized" by health care providers from the previous time; moreover, this realm of sexual and reproductive health is socially attributed to the physicians. In contrast, general practitioners seem to be more reluctant to access sexuality health matters in the prevention aspects, since they do not want *"to look ridiculous"(GP16F*) going to the field that is already covered by others.

"I remember when I was a school girl, […] our teacher told us about physiology and […] menses […] and what should be done during the periods […]. I think that the same practice exists currently… I don't know […] I think that majority of teachers speak about that… At least I believe that…" (GP14F).

General practitioners acknowledge that medical guidance often is critical to their young patients – *"I know that these issues are at the first place in adolescence as well as in older age" (GP2F).* Still physicians seem to be very cautious in discussing sexual and reproductive health matters with their minor patients. One of the problems is that adolescent is a minor patient, then, the duty of health care provider belongs to his parents or legal guardians. Consequently, parents should be involved in sexual and reproductive health care decision making process. These circumstances force physician to grip between adolescent's reproductive health needs and their parents' preferences.

"These nuances between parents and kids […] are very delicate; moreover, this age (of adolescence) is always so risky; so you are at risk to lose the trust of both of them - parents as well as their kids…" (GP7F).

Adolescent's demands seem to be the least important component in the triangle of physician - teenage patient - parents comparing with legal rights of parents and professional uncertainty of physician.

"*I think that …if I prescribe contraceptives, let's say, without informing parents […] a lot of misunderstandings could rise […] not in the medical plan, I am not talking about side effects, but in relationship… It might be that parents are very religious or… very conservative and… they forbid their daughter to go on a date… with some boy… I think that I would be…I don't know… I would become a very bad doctor and I would be… stigmatized […] since (my intervention) can be understood… as an inflammation of some sort of green light to her." (GP5M).*

Physicians are afraid that performance of their professional duties can be interpreted as an element of promotion of promiscuity or as a pressure to early sexual activity. On the other hand, sexual health seems to be too far from the top priorities of general practice. Thus, physicians, gathering health history of the patient, seek to pass through all bodily systems, still they usually avoid reproductive system since it *"isn't such relevant […] as it could cause something bad" (GP9F).* Holistic approach is still rare in general practice and primary health care providers assume their responsibility to address sexual and reproductive health issues only if adolescent himself reveals existing problem.

"Why should I ask them? Let's say […] if a person doesn't have pain in the liver or diarrhea and she/he doesn't complain about that, then I don't ask her/him: "How is your stomach or intestines?"… So, I suppose, the same is with sexual issues…" (GP17F).

Then, general practitioners seem to have willingness to access sexual and reproductive health issues. Social uncertainty around the subject aggravated by uncertainty in the physician-minor patient-parents relationship, encourage physicians to avoid sexual and reproductive health issues when providing primary care for their adolescents patients.

Training issues

According to general practitioners, sexual and reproductive health issues were included in residency program of general practice as well as in retraining program of already practicing physicians. However, participants of the study emphasized their inadequate formation in sexual and reproductive health care provision.

"I think that […] in the context of sexual revolution… physicians need to receive more knowledge in this field (sexual and reproductive health)" (GP7F).

General practitioners who completed full residence program were prone to complain that sexual and reproductive health issues during undergraduate as well as postgraduate studies were "*excised" (GP11F), "escaped, […] not scheduled […], not emphasized" (GP9F)* topics. Retraining of general practitioners lasted several times shorter than residency of general practice; still these physicians were more likely to value highly the knowledge obtained during the retraining process.

"All my life I was a pediatrician […] and I was happy about these studies […]. I studied hard […], I wanted to absorb all lectures […], everything was interesting to me […]. Currently I feel plenitude, I am happy. […] I don't know a lot, that's a tragedy… I perceive deep gaps still I can catch on to some of the problems at least" (GP20F).

Regardless of the positive evaluation of general practice program, it seems that training in sexual and reproductive health was helpful to expand personal physicians' horizons, but it was not consistent enough to ground their activity in reproductive services provision. The majority of interviewed general practitioners admitted their low competence in reproductive health matters. Gaps in knowledge disturb general practitioners' confidence as reproductive health providers; consequently, they become more reluctant to discuss reproductive health issues.

"Which contraception is the best choice? […] How much is reasonable to decrease (estrogens), what is permitted after delivery? […] For example, I wouldn't know exactly […]. We don't discuss such questions" (GP12F)

Lack of specific knowledge is worsened by difficulties faced in performing gynecological examination – *"every time performing gynecological examination, I feel tension" (GP11F)*. Insufficient gynecological examination skills were reported as a major problem to reproductive health services provision by majority of informants, especially by those completing vocational training program of general practice.

"…to perform […] gynecological examination […] I don't know, I haven't skills […] I can't… I can't be ready for that morally. What's the use of my gynecological examination if I haven't had any experience? So what of my examination if I couldn't detect anything… I'm not confident in myself…" (GP17F).

The area of expertise of general practitioner is wider comparing with those of previous primary health care providers – internists or pediatricians. Development of

competence in any new domain was not easy for physicians; still it seems that integration of reproductive health care in everyday practice is the most challenging for general practitioners.

"In my hart I remain as an internist […]. Internal diseases I face differently […] I feel stronger […] in this area. And all those (others areas of general practice) […] were added later and gynecology – the last. Neurology – it might be that knowledge was given earlier (during previous studies), well, there everything is clearer and we perform better in this field. And, for example, in gynecology, really very little…" (GP13F)

According to general practitioners, gaps of training in reproductive health can hardly be filled in everyday practice since the patients do not show willingness to "sacrifice" to the training needs of their doctors.

"In the beginning of my general practice I had a lot of enthusiasm. You [….] say to her: "I'll make a gynecological examination". You know already what kind of pathology she has, so you can look (practice your skills). But they (patients) are really reluctant… They say – "Well, it's an additional gynecological examination, I don't want to" […] It is possible to persuade some of them, but majority of them say "No, no, no" […]. So, my enthusiasm declined at the end of the first month […]. Actually I am really very little involved in that" (GP7F).

Perceived professional incompetence forces general practitioners to avoid reproductive health care issues. Primary health care physicians are not eager to embroil into an issue problematic for them. Still when they face reproductive health problem, the strategy applied the most frequently is referral to gynecologist.

"Sometimes I get nervous when […] I explain anything. Everything is clear, but the patient wants somebody (physician-specialist) […]. But when she wants to go to a gynecologist… I let her go… It's better that she would be seen by a gynecologist if there is something wrong […]. When there is no full confidence in myself, then […] it's better to let the patient go to the specialist"(GP13F).

Consequently, the professional incompetence of general practitioners in reproductive health area seems to be one of the key issues of very weak gatekeeping performance in this field.

Lack of equipment for reproductive health care provision

Primary health care providers' access to gynecological equipment seems to be a critical aspect of reproductive health care delivery; still the majority of general practitioners is unable to perform gynecologic examinations in their surgeries. According to the physicians, "geographic" remoteness of the gynecologic consulting rooms is related with several inconveniences. General practitioners are always in short of time, still the consultation and examination performed in two offices are a loss of time. Moreover, various organizational constraints make it even longer.

"…this room isn't always open […]. Midwifes (who practice in this room), well, they used to be there few hours per day […]. Of course, it's possible to find the key […], but usually you lack time" (GP15M).

General practitioners believe that is not acceptable for the patients in the middle of the consultation to go trough the lobby of health care setting to another room to have gynecological examination.

«It may seem strange: the family doctor goes to another office and says: "now I'll examine you"» (GP11F).

According to GPs, adolescents can be especially disturbed with this requirement since the privacy of consultation could be violated. This patient's move from the GP's surgery to the place named "room for gynecologic examination" can be easily observed by other patients waiting to see the doctor. Taking into account that primary health care facilities are usually located in small communities, it is likely that there is someone knowing the girl in the waiting room. Consequently, the reason of her consultation can be disclosed easily. The same doubts bring the idea to use gynecological equipment in gynecological departments. It is even more time consuming for physician and embarrassing for adolescent patient. Moreover, it seems not to be a highly possible alternative because of negative gynecologists' attitude towards general practitioners.

"We can't go to gynecologists since they accept us extremely unkindly as […] we would be completely clueless" (GP15M).

Then, "geographic" remoteness of gynecologic examination area, raising awkwardness for physicians as well as for their patients, can be evaluated as an impediment for reproductive health services provision in primary health care.

Perceived GP's support for reproductive services provision

Integration of new services in routine primary health care requires a lot of efforts from health care providers as well as support from the environment. General practitioners' perceived support or rather lack of support for adolescents' reproductive care provision from policy level, patients and colleagues affects their performance in gatekeeper role.

Lack of defined policy on adolescents' reproductive health care in general and on general practitioners duties particularly facilitates ignorance of teens' reproductive health needs. General practitioners tend to escape from these issues supposing that other specialists take care of them. Eventually, response to adolescents' reproductive health needs in such circumstances seems to be assumed by general practitioners as a benevolent and charitable mission, but not as an essential responsibility of primary health care provider, performing the role of "gatekeeper".

"…nobody provides these services… Well, it might be some single […] enthusiasts who deal with that […]. Really, I don't know who should do that… It may be […] that physicians, more precisely, […] family physicians… should carry […] one more stone on their back" (GP5M).

Patients seem to be uninterested in the changes of professional responsibilities of health care providers. Prior to the health care reform, reproductive health services were provided by gynecologists.

"Yeah… they do not ask me something in that style […], gynecologist is still in the mind of people […], it might be unusual for them, that family physician […] could talk about this sort of matters" (GP9F).

Primary health care physicians working in the private facilities that provide opportunity for direct access to gynecologist admit teenagers striving to avoid general practitioners consultation when facing sexual and reproductive health problem.

I (interviewer): Do adolescents address you for sexual health problems?
GP: It happens sometimes, but not abundantly. Somehow they address gynecologists mostly, usually they are clever enough.
I: Clever enough?
GP: Well, I mean, we have gynecologists (who can be addressed without referral), so, they practically discharge this load entirely… (GP10F).

General practitioners from the public health care settings also stress adolescents' preferences to obtain a consultation with a gynecologist. Still patients address general practitioners at first, they can not take advantage of the opportunity of the direct, free of charge gynecological consultation. The sexual and reproductive health problem is presented as: "*doctor, I would like to go to gynecologist*" (GP12F) and primary health care physicians learn about it as he *"needs to write something into the referral list"* (GP1M).

General practitioners as gatekeepers are put in a dramatic situation because of:

- ambiguity of social attitudes towards adolescents' sexual and reproductive health care needs and lack of explicit policy on this issue
- self perceived professional incompetence in reproductive health care
- lack of equipment.

They do not have willingness to perform these services; moreover, their patients are reluctant to address reproductive health problems with them. It seems that the only support that general practitioners receive in this field comes from their colleagues, other general practitioners who face the same problems. Although this physicians' support is vital psychologically, its impact on the delivery of reproductive health services is rather negative.

«I saw, nobody does this work […] as a family physician, nobody does not provide reproductive health services. They (other GP) said me "Are you crazy?"» (GP7F).

Discussion

The findings of this study suggest that GPs do not feel adequately trained, equipped and supported for adolescents' reproductive health care provision. Moreover, primary health care providers, as gatekeepers of health system, were reluctant in becoming highly involved in this field and indicated a preference to refer the minor patient to physician-specialist while facing sexual and reproductive health problems. The study results are relevant to the Lithuanian health care system since they question the suitability of gatekeeping system in reproductive health care provision for adolescents.

De jure, reproductive health care services for adolescents are accessible for adolescents in Lithuania since every minor patient can address his general practitioner. However, experience of primary health care providers'/gatekeepers' reveals that sexual and reproductive health issues tend to be avoided by them in adolescents' consultations because of miscellaneous reasons ranging from their personal embarrassment and lack of training or equipment up to legal uncertainty of triangulation of physician-minor patient-parents' relationship. Moreover, if the reproductive health problem emerges during consultation, the general practitioners seem to have little impact on identifying serious pathologies that require specialist consultation. Research data underline the sensitivity of adolescents to various sorts of struggles that could impede their access to reproductive health services (35-38). Then, it is reasonable to suspect that gatekeeper handling poorly with sexual and reproductive health issues can be seen more as a barrier and not as a facilitator in the health seeking process of adolescent. Eventually, accessibility of reproductive health services for adolescents can be evaluated as being compromised *de facto* because of gatekeeping.

The findings of the study that suggest deep problems in adolescents' reproductive health care are consistent with abundant research data from other countries that indicate difficulties experienced by GP's in delivering sexual and reproductive health services for teenagers. The participants of our study voiced considerable concern regarding lack of knowledge and skills in reproductive health services provision for adolescents. The need for proper training of primary health care providers is widely emphasized as an urge issue to respond to young people's needs (39-41). Since there are serious doubts that GP's perceptions of knowledge in areas of common practice indicate adequately their actual knowledge, Tracey (42) argues that the self directed learning activities of primary health care providers can be misdirected. Then, the development of training curriculum tailored to the needs of health care providers and integrated into a postgraduate training as well as in continuing medical education seems to fulfil the expressed demands of general practitioners the best (43;44). Existing evidences allow expecting that educational interventions in adolescents health care specifically designed for GPs are an effective way to achieve improvements in knowledge, skills as well as in self perceived competency (45). Although professional competence of general practitioners is essential in improving the adolescents' reproductive health care, structural changes oriented towards fulfilment of basics GPs' needs for equipment is also important. Previous study performed in Lithuania underlined the equipment for gynecological examination being the major factor shaping physicians' activity in adolescents' reproductive health care (46); the data from other countries confirms that physicians' participation in

family planning is consistent with their possibilities to provide gynaecological examination (47). Taking into account the relatively low primary health care providers' access to gynecological equipment (46) – the need for adequate equipment of gatekeepers' offices becomes evident seeking for better performance of their duties.

Additionally to the personal and structural factors that need to be addressed in improving adolescents' reproductive health care, study revealed an urge for the development of adolescent reproductive health policy with explicit role of primary health care provider. Political involvement seems to be relevant stimulating GP's interest in this field as well as wider patients' recognition of GP's as reproductive health providers. Moreover, adolescents' reproductive health promotion strategy might become a substantial ground in the elaboration of incentives showed to be effective in the provision of preventive services (2).

These conclusions, however, are the first attempt to address the crucial question of suitability of gatekeeping in adolescents' reproductive health care in Lithuania. This study aimed to explore GPs' perceptions on appropriateness of gatekeeping in adolescents' reproductive health care and did not intend to provide the comprehensive evaluation of gatekeeping effect neither on adolescents' reproductive health seeking behaviour, neither on the health outcomes. The relatively small sample of general practitioners that was a convenience sample rather than a random sample was appropriate to the needs of this explanatory study. On the other hand, the views and experiences of participants may not have been representative of those of the wider general practice community since the study included GPs practicing in only one town, the views of physicians from other urban and, especially, rural areas may have been different on this issue.

Future research should test and prove the findings of this study looking on the broader context and conclusions should be triangulated with a quantitative approach. Studies are required to assess appropriateness of gatekeeping from the adolescents' point of view. Estimation of economical impact of gatekeeping in adolescents' reproductive health care would be helpful in improving health services provision design for minor patients in Lithuania.

Although conclusions made are tentative, our findings are still sufficient to begin the wider reassessment of gatekeeping in adolescents' reproductive health care in Lithuania. GP's views and experience explain partly the reasons of low adolescents' satisfaction with GP's as reproductive health providers, revealed in previous studies (26). Since struggling factors for improvement of adolescents' reproductive health concern not only physicians, but health system and policy levels as well, complex measures should be designed aiming to overcome these barriers. Developing new models of reproductive health services delivery for youth, establishment of adolescents' friendly health settings should receive a particular consideration (48-50). Even though they are certainly necessary, general practitioners still play a major role in reproductive services provision for youth (51). Then, discussion of flexible model of gatekeeping, encompassing both co-ordination of care provided by primary health care physician and possibility of patients' self-referral (15; 52), should be included into political agenda. Adolescents tend to under-use reproductive health services. Eventually, every effort should be made to eliminate barriers to accessibility of these services.

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