Sophia Schlette, Kerstin Blum, Reinhard Busse (eds.)

Health Policy Developments 11

- Primary Care
- Appropriateness and Transparency
- National Strategies

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Focus on Primary Care, Appropriateness and Transparency, National Strategies

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Preface

Dear readers,

In this series, we have been reporting on the latest health policy developments in the 20 partner countries of the International Network for Health Policy and Reform ever since 2003. In order to allow you to express your opinion of our twice-yearly publications, we included a reader questionnaire with issue 10. We would like to thank all those who have already provided us with feedback and would like to invite all others to follow their example.

A bridge between academic study and policymaking

The feedback we have received has been most encouraging. It is especially pleasing to note that *Health Policy Developments* is considered of interest to and helpful for a very varied readership which includes policy-makers and members of staff from the political arena as well as representatives from the worlds of self-management, journalism and academic disciplines. It is our goal to present health policy developments and approaches in an objective, impartial and comprehensible manner and thereby to build bridges between the worlds of academic study and politics. According to our readers, this series of book publications makes a significant contribution toward this goal. Some of our readers would find compact booklets on individual topic areas useful. We intend to incorporate this idea, together with your suggestions for topics, in our project work in the near future.

Now more than ever

The main focus of *Health Policy Developments 11* is on primary care. In this, we are in good company. In its 2008 World Health Report, published 30 years after the declaration of Alma-Ata, the World Health Organization (WHO) has re-examined the concept of primary health care as defined at that time and emphasized

that the 1978 declaration has lost none of its relevance in the intervening years. On the contrary, primary care is now more vital than ever before.

A subject area which for so long has been neglected and even disparaged by physicians and politicians alike is therefore becoming more and more important in the current climate of demographic change and the changing needs of older and chronically ill patients. Primary care is much more than general medical care. Ideally, it overcomes the divide between the outpatient and inpatient sectors and crosses the borderline to other medical disciplines by coordinating services and service providers from different sectors. Its integration into the care and service systems operating outside the health service and a clear focus on prevention and support for self-management are already key components of primary care in a number of developed countries.

Primary care reform as a work in progress

The trend today is clearly in favor of strengthening primary care. In many countries, more resources are being allocated to research in this area, new university chairs are being set up and model projects are being promoted. Primary care is currently a highly dynamic area of ongoing reform and is subject to constant development, integration and expansion. In this publication, we present the latest developments from nine countries.

Appropriateness, fairness and transparency

Under the heading "Appropriateness, Fairness and Transparency" we turn our attention to a further topic which is of great concern to health policymakers and experts all over the world. How can the benefits of medicine be evaluated with a view to ensuring that available resources are allocated based on need, effectiveness, cost-effectiveness and appropriate use? How can suitable evaluative procedures be developed that are both transparent and comprehensible to all concerned? How can the quality of health care provision be measured in a way that is both reliable and conducive to transparency? Our examples from nine partner countries show how different healthcare systems are addressing these issues. Part and parcel of this subject is the concept of Health Technology Assessment, which is being applied in an increasing number of countries. This is a process of systematic assessment of medical technologies, procedures and resources, but one which also extends to the organizational structures in which medical services are provided. This involves analyzing a

number of criteria ranging from effectiveness, safety and cost factors to social, legal and ethical aspects.

Reporting period autumn 2007 to spring 2008

As always, the sources of information for this book were the expert reports of the International Network for Health Policy and Reform. The current volume presents the results of the eleventh half-yearly survey which covers the period from October 2007 to April 2008. From the 81 reports of reforms received, we have selected 26 for inclusion in this volume.

Our special thanks are due to Susanne Werner, freelance journalist and consultant (of the agency 'Kommunikation • Gesundheit • Netzwerk'), for her help in compiling the first draft of the German issue of this book, to LinguaServe Language Services for the English translation and to Ines Galla (Bertelsmann Foundation) for her organizational assistance in preparing this publication.

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We are grateful for any comments and suggestions you may have regarding issue 11 of *Health Policy Developments* and these may be addressed to the editors. We look forward to receiving your suggestions for improvement.

Sophia Schlette, Kerstin Blum, Reinhard Busse

Strengthening Primary Care

Primary care is a key instrument of control for an effective and efficient health service. Countries with a well-structured system of basic health care usually perform better in terms of selected health indicators. Evidence-based studies from England show, for example, that each additional GP per 10,000 inhabitants reduces the mortality rate by six percent (Starfield et al. 2005: 462). The World Health Organization (WHO) has emphasized the importance of primary care in a number of policy statements. The 1978 Declaration of Alma-Ata, which today still holds valid as a guiding principle and which has been confirmed by the WHO as its goal in the organization's 2008 World Health Report, defines primary care as

Primary care in the Declaration of Alma-Ata

"… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. […] It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (Declaration of Alma-Ata, Section VI).

The WHO's vision of an integrated health sector

In the WHO's 1998 program entitled *Health21: Health for the 21st Century*, the Target 15 is the vision of an integrated health sector in which primary care takes on a more important role. In this concept, it is envisaged that patients should be able to turn as their first point of contact within the health service to a well-trained "family health nurse" and a "family health physician."

Working together with local community structures, this team would then coordinate the subsequent stages of care (Health21 1998: 25).

Primary care is always part of a chain of health care

To date, there is no universally agreed definition of the concept of primary care. For this reason, most attempts to approach this topic commence with a discussion of terminology and definitions. At a meeting of the WHO Regional Office for Europe on "Primary Care and General Practice/Family Medicine: Definition and Link to other Levels of Care" in Barcelona in 2002, the experts taking part agreed to regard primary care as being always a part of the overall provision of health care services. It can not therefore be seen in isolation from other services. Unlike the firmly established concept of general practice provided by a family doctor, primary care is a much wider concept which also includes supplementary services provided outside the health service for the care of an (ailing) population as a whole and which extends the narrow concept of treating individual patients to a much broader notion of providing care for an entire population. In the absence of a binding, unequivocally and universally accepted definition, primary care can therefore be defined by any country, health system or profession according to levels of care, roles and activities or even by reference to organizational structures.

Primary care is always the first point of contact

In view of the vagueness of the term, it seems wise to take a pragmatic approach on the basis of actual developments that have long since taken place in all industrialized countries. In most health services, primary care is the initial point of contact for the patient. It embraces diagnosis, therapy, rehabilitation and palliative medicine but also covers preventive measures. It sees the patient in the entirety of his or her personal and social context and guarantees continuity of treatment (Saltman/Rico/Boerma 2006: 14, cf. also Starfield/Shi/Macinko 2005: 465). Primary care is therefore able to unite a number of different professions such as private practice physicians, general practitioners, family doctors and pediatricians but also internists and gynecologists. In a wider sense it also includes nonmedical health professions such as nurses and coordinates its own services with those of local social services.

Coordination and communication

In theory, therefore, it is more than just a matter of providing general health care; in theory, primary care overcomes the highly

fragmented nature of the relationship between the inpatient and outpatient sectors found in many places and bridges the gap to other medical disciplines by coordinating services and service providers from different sectors. Its integration into care systems outside the health service and a sophisticated system of coordination and communication with these sectors are already key components of primary care in a number of developed countries.

Professional roles are in need of revision

In view of the initiatives being promoted by policymakers in many countries to strengthen primary care, it is apparent that in spite of all the evidence which documents it, this concept is still in need of further practical experience, positive results and a more solid theoretical basis. Many healthcare systems need to be restructured before primary care can have a beneficial effect on the system as a whole. Here, it is not only a matter of innovative forms of care, organization and control, but also of professional self-image and new cooperations within and outside the health service.

Variety of initiatives to strengthen primary care

In this chapter on primary care, we are therefore dealing with a field of activity which is currently in a state of flux. Primary care—an area which has long been much neglected and even disparaged by physicians and politicians alike—is gaining in importance in the present climate of demographic change and the changing needs of older and chronically ill patients. In many countries, therefore, more resources are being allocated to research into concepts of care, new university chairs are being set up and model projects are being sponsored. In some places (in Germany, for instance), health policy initiatives are running ahead of medical practice; in others, such as in the United States, it is the service providers themselves who for pragmatic reasons are taking the initiative in order to tackle the shortcomings in care and coordination confronting their patients, the practical effects of which they encounter in daily practice. At the present time, primary care is therefore a highly dynamic area of reform which is subject to ongoing development, integration and expansion.

This chapter considers three aspects:

– Local primary care in the context of regional and local structures: Denmark, Finland, United Kingdom, Estonia and Austria

– Health professions, new professional skill mixes, division of labor and distribution of roles: New Zealand, France and Japan
– Primary care and the chronically ill: Denmark and Singapore

A diversity of approaches with similar goals

Irrespective of whether the reforms are concerned with organizational structures, the professional mix or care for the chronically ill, the expectations are always the same. It is hoped that the activities, tasks and services of primary care will make the health service more efficient and secure the long-term future of health care. The initiatives presented in this chapter not only illustrate the diversity of the various strategies being adopted in developed countries to strengthen primary care, but in part at least also highlight the parallels between these initiatives.

Sources and further reading

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Organization, competence and levels of care

The following sections deal first of all with the way that care is organized in the context of regional and local structures. The strengthening of primary care is not infrequently bound up with the expectation of relieving the inpatient sector and thereby making the whole system more cost-effective.

Denmark: More responsibility for GPs

In Denmark, specialized care in hospitals became more centralized in 2007. This means that GPs are expected to take on additional responsibilities, to become case managers for their patients and thereby also to achieve a high quality of care at as low a cost as possible. This is to be achieved by creating larger group practices with a mix of professionals (see the report on Denmark, p. 16).

Finland: Larger units of primary care

In Finland, primary care has so far fallen within the remit of local health centers, owned and run by the municipalities. Since these have a median population of only 5,000 inhabitants each, most of them are too small to guarantee high-quality, efficient care. A law enacted in 2007 decreed that primary care centers should be responsible for at least 20,000 inhabitants. This was initially greeted with protests from local authorities but in the meantime, the law has given rise to new cooperative initiatives (see the report on Finland, p. 20).

UK: Closer integration of health and social services

In addition to greater efficiency, the goal of structural changes can also be improved coordination of health care and social services in the sense of a more comprehensive concept of primary care. In July 2008, the United Kingdom enacted a new law on health and social care (Health and Social Care Act 2008). The most important innovation here is the setting up of an intersectoral quality commission charged with promoting closer integration between the health service and the social services (see the report on the United Kingdom, p. 21).