Building Primary Care in a changing Europe
Contributions from research

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EFPC, European Forum for Primary Care

EFPC Webinar 19 May 2015
In memoriam

Janko Kersnik
Building Primary Care in a changing Europe

Contributions from research

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Current challenges in health care

• Demographic developments
• More complex care demand (multi-morbidity)
• More demand for home-based care
• Greater diversity of patients (migration)
• Changing health risks (more related to lifestyle)
• Patients have better access to health information
• Rising expenditures
• Diminishing returns on health investments
• Technological developments
• Developments in health human resources
• ..........etc
What adaptations are needed?

- More person-centred care *(rather than disease-centred)*
- Pro-active population based approaches *(in addition to and combined with individual ‘reactive’ care)*
- Re-design of tasks *(e.g. delegation within teams)*
- More explicit care coordination
- Innovation of care processes *(e.g. transmural care chains)*
- Better use of information and technology
- Innovation in medical and nursing education *(e.g. for new functions)*

Is there evidence that stronger primary care is an answer?
What should primary care contribute?

“The essential role of primary care is to provide people with first contact care, health promotion and basic treatment, as well as to facilitate adequate access to other health care and related services for those who need this”.

(Starfield B, Shi L, Macinko J. 2005)
“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

Primary health care is the key to attaining this target as part of development in the spirit of social justice.”
Primary care development requires research and evidence

... although that is not enough
What the PHAMEU project contributed: measuring the strength of PC systems in Europe

- NIVEL (leader) (NL)
- University of Tartu (EE)
- IRDES (F)
- Heinrich Heine University / University Witten/Herdecke (D)
- Bocconi/CERGAS (I)
- University of Tromsø (N)
- Jagiellonian University (PL)
- University of Ljubljana (SI)
- IDIAP Jordi Gol (ES)
- ScHARR (UK)
- University of Leicester (UK)

- WHO Europe
- EGPRN
- European Forum for PC
- EUPHA
- European Commission

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De PHAMEU studie 2008-2011

Data collection in 31 countries (EU27+4)

Procedure:

• Defining dimensions and indicators for primary care
• Using available data sources and information
• Expert panels in each country for information not available from accessed sources
• For analyses, using data from the European Social Survey and the Eurobarometer

Kringos et al. 2010 BMC Fam Pract
First question of the PHAMEU study:

’What are the essential features of primary care?’
Answer based on the international literature

**DIMENSIONS OF PRIMARY CARE**

**Dimensions of the PC structure**
- Governance of PC system (12)
- Economic conditions of PC system (11)
- PC Workforce development (16)

**Dimensions of the PC Process**
- Access to PC services (12)
- Comprehensiveness of PC services (10)
  - Continuity of PC (9)
  - Coordination of PC (7)

**Dimensions of PC outcomes** (e.g. efficiency; patient evaluations)

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PRIMARY CARE STRUCTURE & PROCESS

Dimensions of the PC structure

- Governance of PC system
  - System goals
  - Equity in access policies
  - Collaboration policies
  - (de)Centralization
  - Quality management
  - Patient advocacy
  - Total: 12 indicators

- Economic conditions of PC system
  - PC expenditures
  - PC coverage
  - Employment status
  - Remuneration system
  - Income of PC workers
  - Total: 11 indicators

- PC Workforce development
  - Profile PC workforce
  - Professional status
  - Supply and planning
  - Academic status
  - Prof. associations
  - Total: 16 indicators

Dimensions of the PC Process

- Access to PC services
  - Density PC workforce
  - Geographic availability
  - Access at practice level
  - Affordability of services
  - Patient satisfaction
  - Total: 12 indicators

- Comprehensiveness of PC services
  - First contact care
  - Disease management
  - Sole GP contacts
  - Medical procedures
  - Preventive care
  - Health promotion
  - Medical equipment
  - Total: 10 indicators

- Continuity of PC
  - Longitudinal continuity
  - Informational continuity
  - Relational continuity
  - Total: 9 indicators

- Coordination of PC
  - Gatekeeping system
  - Skill mix
  - Collaboration of care
  - Public health integration
  - Total: 7 indicators
What we have learned from PHAMEU
Mapping the relative strength of Primary Care

Source: Kringos et al, 2011

© NIVEL, 2011
Evidence from the PHAMEU study

**Stronger PC is associated with:**

- Better health outcomes, in terms of:
  - Fewer potential life years lost
  - Less social inequity in self-reported health
- Better opportunities for cost containment
  - E.g. fewer avoidable hospitalisations
- Political situation and dominant values
  - Social Democrats in power

**But also:**

- Lower patient satisfaction (less freedom of choice)
- No lower health care expenditures (as % of BNP)
Europe’s Strong Primary Care Systems Are Linked To Better Population Health But Also To Higher Health Spending

By Dionne S. Kringos, Wieke Boerma, Juke van der Zee, and Peter Groenewegen

ABSTRACT Strong primary care systems are often viewed as the bedrock of health care systems that provide high-quality care, but the evidence supporting this view is somewhat limited. We analyzed comparative primary care data collected in 2009–10 as part of a European Union-funded project, the Primary Health Care Activity Monitor for Europe. Our analysis showed that strong primary care was associated with better population health; lower rates of unnecessary hospitalizations; and relatively lower socioeconomic inequality, as measured by an indicator linking education levels to self-rated health. Overall health expenditures were higher in countries with stronger primary care structures, perhaps because maintaining strong primary care structures is costly and promotes developments such as decentralization of services delivery. Comprehensive primary care was also associated with slower growth in health care spending. More research is needed to explore these associations further, even as the evidence grows that strong primary care in Europe is conducive to reaching important health system goals.

Primary care is the first level of professional care, where people present their health problems and where most therapeutic and preventive health needs can be satisfied. Strong primary care is believed to contribute to high-performing health care systems, a belief that is supported by evidence to some extent. Decision makers have trusted this evidence and invested in primary care reforms, such as the Affordable Care Act in the United States, as well as in numerous charters and statements made by nongovernmental organizations worldwide.

Several studies that compare primary care internationally and within the United States have provided evidence of the benefits of strong primary care, in terms of better opportunities to control costs, improved quality of care, better population health, and less socioeconomic inequality in health. These studies have shown the potential of primary care to improve the health of populations and the performance of health systems, and they suggest directions for further research.

In Europe these studies have evoked an increased interest in the great variation among health systems and the different roles assumed by primary care. The question that we believed needed to be answered was whether results from previous studies about the benefits of strong primary care systems would still be valid using more recent data and more tailor-made measures. Also, we wondered, could the results be generalizable if many more European countries were considered?

In 2009–10, as part of a European Union-funded project, the Primary Health Care Activity Monitor for Europe, we performed a systematic literature review to derive seventy-seven indicators. These measured five key dimensions of primary care: structure, access, coordination, continuity, and comprehensiveness.
Is gatekeeping essential?

- **YES**, for cost containment in health care
- **NO**, not for coordination.

For coordination is essential:

- Accountability and responsibility for a defined practice population (the so-called list system which is often but not necessarily coupled with gatekeeping)
- So that the coordinating physician for any patient is known
Obervations from the PHAMEU study

- PC systems in Europe strongly vary in strength
- There are common themes to improve PC (e.g. vision, inequity in access, incentive systems, workforce shortages, coordination)
- There is no one best way to achieve efficient PC, but countries should use comparable benchmarks.
- PC system management requires improved PC information systems at the national level
- Availability and quality of PC data for research is poor in most countries
Building primary care in a changing Europe

Edited by
Dionne S. Kringos
Wenke G.W. Boerma
Allen Hutchinson
Richard B. Saltman

Volume 2:
Structured country reports
(available on-line only)
The PHAMEU database accessible at

www.nivel.nl/en/dossier/country-information-primary-care
### PHAMEU: primary care data availability

- **ranking of countries** -

<table>
<thead>
<tr>
<th>Indicators at level:</th>
<th>Ranking of countries on data availability for indicators by level of primary care system</th>
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**Conclusions from PHAMEU:**

- too many data are missing
- too little data are based on scientific research
Based on the PHAMEU groundwork

Next steps being made in the QUALICOPC project
The QUALICOPC study: 34 countries

2011-2014

26 EU Member States
+ Norway
+ Iceland
+ Switzerland
+ Turkey
+ Macedonia (fyr)
+ Australia, New Zealand, Canada,

Consortium: 6 partner institutes
Coordinated by NIVEL

Linked data set: ± 7,000 GPs / ± 70,000 patients

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De QUALICOPC studie 2011-2014

Data from 3 levels

- Countries – from the PHAMEU study
- GP practices: surveys in 200 practices in 34 countries
- Patients: surveys among 10 patients per participating GP practice

Schäfer et al. 2011, BMC Fam Pract
From international evidence

↓

to national evidence

↓

to action
Purposes of evidence

• **International** studies: to improve the body of knowledge

• **National** studies: to provide feedback to policy makers and stakeholders (*what is the situation and how to move forward*)

• *(Providing feedback alone is not enough for action)*
Action: strategies for PC strengthening

• Personal doctors / (voluntary) gate keeping
• Integration and teamwork (skill mix change)
• Involvement of empowered patients
• Evidence-based medicine (guidelines)
• Electronic medical records / medical IT
• Targeted incentives structures
• Accountability / clinical governance
• Better organized primary care out of hours
• Monitoring Primary care reform processes
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30 August / 1 September 2015

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