

1. Introduction

This report is a summary compilation of the feedback and responses to a survey launched in December 2010, among the current membership of ACOPC, with the aim to;

- a. Garner information about the need and appetite for a network/alliance and the profile of current [and potential] membership, and
- b. Commence collecting thoughts that can inform the definition and the development of a framework for community oriented primary care in Europe

2. Key Messages

Community oriented primary care

- a. Current international environment highlights health reforms in many European countries, with policy direction favouring the development of first level of care
- b. There is currently a lack of agreed definition, framework and up to date comprehensive and comparable information on community oriented primary care in Europe, therefore an opportunity for ACOPC to develop one.
- c. There are features that can be employed to characterise community oriented primary care.
- d. Respondents to the survey broadly describes community oriented primary care as incorporating personal care, health promotion, prevention, community development and involvement, access and intersectoral collaboration that encompasses all determinants of health.
- e. Community oriented primary care requires practitioners input as they are mostly organised by professionals
- f. Achieving a standardised understanding of community oriented care enables production of comparable data and information, improves understanding and creates opportunities for shared learning and knowledge trends

Developing ACOPC

- g. Respondents expects ACOPC to provide opportunities for personal and professional development, create a learning environment, and have a voice and policy function/role
- h. Members want to be involved in the alliance in a meaningful way, contribute to knowledge and practice and share skills and capacities

3. Introduction to ACOPC

The Alliance for Community Oriented Primary Care services (ACOPC) is a Working Group (WG) of the European Forum for Primary Care (EFPC) as a group of national and regional associations of Community Oriented Primary Care services in Europe.

The WG was formed in 2010 to strengthen the lobby for and facilitate the development of new regional/national associations for Community Oriented Primary Care services. It was felt that a much stronger voice was needed to ensure that European populations receive the health service they deserve. The Working Group started with a meeting at the 3rd biannual EFPC conference in Pisa (August 2010) with 9 representatives of regional/national associations. All of them are members of the EFPC.

The objectives of ACOPC are, to;

- Define and sustain the development of “community oriented primary care services” in Europe
- Share experiences / ideas / definitions about COPC and how to sustain it
- Strengthen the lobby for Community Oriented Primary Care at regional, national and European level
- Stimulate the development of new national/regional associations of Community Oriented Primary Care services in Europe

4. Background & Context

Primary care is the first level of professional care in Europe where people present their health problems and where the majority of the population's curative and preventive health needs are satisfied. Therefore, one could argue that community oriented primary care services should be available close to where people are living with no obstacles to access (Kringos. et. al. 2010)

Community oriented primary care is also described as 'generalist care', focused on the person with a health needs, in his or her social context, rather than on the optional diseases. The mixes of disciplines which make up the primary care workforce do differ from country to country, but general practice or family practice is often considered as the core of primary care. (Kringos. et. al. 2010)

Within the United States, for example, evidence has been provided that highlights the benefits of well developed primary care systems, in terms of better coordination and continuity of care and better opportunities to control costs (Kringos. et. al. 2010). In Europe, however, there exists a variety of models of organisation and health care provisions, alongside diversities of regulatory mechanisms, funding and financial models, formal and informal incentives and a rich demographic mix of service users. These make Europe a favourable environment to undertake comprehensive studies on community oriented primary care and a platform to amass good practices.

Although the current membership of ACOPC has a broad agreement about the merits of community oriented primary care systems, current knowledge about a common definition and features is inconclusive. There is therefore a realisation that international comparative data and examples of good practices will provide information about the drivers of good community oriented primary care. With ongoing health reforms in many European countries, coupled with a common aim to further develop the first level of care, one could conclude that there is a demand for comparative information and a need to learn from other experiences.

5. Working definitions

Academics and practitioners have argued that there is currently a lack of agreed definition, framework and up to date comprehensive and comparable information on community oriented primary care, coupled with a lack of knowledge of structures and strategies conducive to strengthening primary care in Europe [Kringos, et. al., 2010].

Attempts have been made, for example, by the EC funded project - Primary Health Care Activity Monitor for Europe (PHAMEU) - aiming to fill this gap by developing a Primary Care Monitoring System (PC Monitor) for application in 31 European countries, with the aspiration to make possible and to create an alternative model for holistic analyses of primary care. The model developed – *PC Monitor* - approaches primary care in Europe from three multidimensional lenses: structure [i.e. governance, economic conditions, and workforce development]; process [i.e. access, comprehensiveness, continuity, and coordination]; and outcome [i.e. quality, and efficiency] [Kringos, et. al., 2010].

A definition adopted by the Primary Health Care Research Information Service (PHC RIS), describes it as incorporating “...personal care with health promotion, the prevention of illness and community development”, with an underpinning philosophy that includes “... the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health” [Keleher, 2001].

The WHO definition¹ defines primary health care as: “...socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health...includes health promotion, illness prevention, treatment and

¹ This definition encompasses the WHO's Declaration of Alma Ata (WHO 1978) and recent Primary Health Care: A Framework for Future Strategic Directions (WHO 2003), and further developed by the Australian Primary Health Care Research Institute (APHCRI). This definition was also cited in *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy* (September 2009)

care of the sick, community development, and advocacy and rehabilitation.”

As a respondent explains it: “[It]...is created by health professionals...they work and organise themselves...to offer the population continuous primary health care. Their actions are patient centred, integrating cure and prevention. [It is]...a place close to the populations they work with, where they can find social and medical information. The teams are involved in prevention campaigns, and activities that reach further than simple care delivery: it articulates its work around community participation and the autonomy of the patients in taking responsibilities in their health...”

6. Features that characterise a community oriented primary care service

The responses from the survey can be broadly categorised under the following headlines:

- a. Community development and public involvement
- b. People centred with evidence of maximisation of self care
- c. Holistic care
- d. Integrated service with multidisciplinary collaboration
- e. Public health focus, including prevention and health promotion
- f. Cost effective services that achieves value for money
- g. Accessible, provides and promotes choice
- h. Driven by quality and high level of care

Some comments from respondents:

Community development and public involvement

“Community oriented with defined population...action at community level”

“[There is] dialogue with community based organisations”

“Its providers are selected among the service receivers in order to increase clients' trust”

“... must have a social interest and a particular attention for non-discrimination. The centres should not have personal enrichment interests and should have...community based interests...”

“Patients' involvement stands for patients' participation, even taking decisions for their centre, therefore going further than care delivery. Involvement can take different forms, either individual or collective, can be initiated by professionals or patients themselves...patients can take part of it...modify it, even refuse it”

People centred

“I see a community oriented care to which I can go and have my chronic conditions taken care of by a multidisciplinary team, and where I could have acute diseases (colds, flu and vaccines) taken care of”

“A service that is characterised mainly by being client-oriented...based on the evaluation of people needs; It has been designed and presented by people”

“Patient centeredness includes health with social matters; it looks at the patients problems not only in a physiological way, but also organic, family, social, psychological, economic or cultural. Patient centeredness is necessary not only to have a correct diagnostic but also to find the way to solve the case. It gives consideration to the human being, the person, beyond the disease/symptom”

Holistic care

“Holistic consideration of all determinants of health and wellbeing not just those amenable to health care e.g. police, housing, health, social care, community and voluntary services, education”

“The delivery of the service does not bring any kind of dissociation to the delivery of other healthcare services”

“... the health centres are polyvalent: they are an entrance in the system for any patient whatever his age, sex, diseases or social status”

Integrated service with multidisciplinary collaboration

“Consultation with all organisations that deliver projects and interventions in the local area Knowledge of who those organisations are, there will be more that you think!”

“An ideal community oriented primary care service is characterised by health professionals working together and the patient will experience that she/he is the important one. This is very essential in order to achieve the best and the cheapest primary health system”

“Multidisciplinary work...presented as a quality criterion of its own. It creates [opportunities for] exchanges, comparison, and non-isolated work. Even if the whole team doesn't take part in each of the project, it sustains it by the different points of views that are shared in an open way”

Public health focus, including prevention and health promotion

“Care for the 9 parameters expressed by Wilkinson & Pickett: level of trust, mental illness including alcohol and drugs, life expectancy and child mortality, obesity, children's educational performance, teenage births, homicides, imprisonment rates, social mobility”

“Preventive, curative, health education & rehabilitation matters being taken care of in the same centre. We shouldn't forget the importance of health promotion that should be done in association with existing (national) programs”

“Action on social determinants in health...everything that can shape people's health without being directly linked to health services. (Factors such as socio-economics, environment, culture, work...)”

Cost effective that achieves value for money

“It is accessible to people, at the lowest cost...delivery at local level in a cost effective way”

“The quality also includes efficacy...and cost effectiveness.”

Accessible, provides and promotes choice

“...I value to have important tests done at the time of the meeting which would be convenient for me and for my doctor who would be able to act without delay”

“High quality care, closer to home...”

“It is accessible to people with the lowest cost and trouble; it is safe and does not endanger patient safety”

“... and is not the only choice of receiving the service in the community”

“If it is delivered freely to people, people have the right to criticise the service qualitatively and quantitatively”

“Services provided close to or at patient's home, easy access, no waiting list, minimal hand offs”

“Accessibility which should be understood as: financial, geographical, good conditions (acceptability)...acceptability means the best match possible between the practice and social norms, ethical and cultural matters according to the patients and their families”

Driven by quality and high level of care

“It is delivered by the best and knowledgeable providers...”

“High quality care with opportunity to always improve”

7. Expectations of respondents from an European alliance for community oriented primary care

There are 3 main areas of expectations from respondents

- a. Personal and professional development with mutual support
- b. Learning environment, knowledge and practice exchange, that influence practice
- c. The alliance having a voice and policy function/role

As respondents expressed it;

Personal and professional development

“Working in a network to articulate all our work with other partners of the health system”

“Facilitate meetings between primary care services and professionals of these services, to learn from each other...to sustain each other”

Learning environment, knowledge and practice exchange

“Strengthen roles - as GP or nurse - and provide education and framework for such...to be organised and funded...”

“Ability to share best practice with others and to design services with other groups”

“Foster and stimulate the development of COPC across the community...provide networking and sharing of ideas and best practice”

“Knowing how to implement certain concepts and principles (patient centred care, multidisciplinary etc.) at service level and also how we, as regional organisations, can promote, assist and develop that kind of primary care services”

“Delivering the statement and definition of a community oriented primary care”

“To provide the health professions with tools that enables them to work together and to provide evidence for the benefits of collaboration”

“Sharing experiences in reorienting health systems and strengthening capacity”

“The alliance needs...to present its achievements to other countries and use the experience of employment of the services”

“To define and sustain community oriented primary care services...share experiences, different ways of practicing, new ideas”

“Support the development of COPC services and associations...in Europe”

Voice and policy function

“Locally but also regionally and even on a more global scale...this can help us in achieving the goals we set up previously”

“Sharing ideas and networking impact on local policy making, strengthening primary care in countries where primary care is less developed and lacks support”

“I think that the alliance needs to improve worldwide communication and contact and try to use other countries healthcare systems' programmes in providing primary healthcare services”

“A special place [to be] given to patients organisations to bring their special view on the objectives and quality of the services”

“Advocacy for COPC: strengthen the lobbying for Community Oriented Primary Care at regional, national and mostly European level”

8. What respondents can offer and/or contribute to an European alliance for community oriented primary care

These fall into 3 key areas;

- a. Involvement – with a purpose
- b. Contributions to knowledge and practice - in specific areas
- c. Sharing – of skills and capacity

As respondents put it;

Involvement

“To participate in meetings...for exchange of knowledge and experiences”

“I would like to be involved, especially in understanding of primary care, specifically urgent and unscheduled care

“Carrying out studies”

Contribution to knowledge and practice

“I can provide easy to use accurate and cost effective diagnostic tools”

“Interested to participate in a project to prove the benefits of point of care testing”

“Evaluation of the impact on wellbeing”

“Own experience and model of a rural clinic extending membership”

“Research on patient safety”

“The perspectives of the pharmacies”

Sharing...of skills and capacity

“Experience, contacts, research”

“Best practices and evidence based practices [e.g. in Canada]

“Scientific evidence”

“Experiences in designing the services”

“Offer our location for some meetings; up to 30 people [in Brussels]

“Link to existing network e.g. SEPSAC (European secretary of community oriented health practices)

9. Limitations of this report

- a. The selection of features and indicators were subject to country specific dimensions and practices.
- b. There is limited literature underpinning the survey.
- c. The research strategy was limited to an online questionnaire only
- d. Numbers of respondent were 25 and not balanced, regarding country of operations, size of their network/membership etc, therefore not exhaustive – see appendix

10. Conclusion

Respondents broadly agree that there is a need for a European network that they can contribute to and have expectations of.

Most agree that community oriented primary care are often organised around people’s needs, integrates public health, is inclusive and multidisciplinary with clear line of sight on quality and cost effectiveness.

From the survey, it appears that a standardised framework for describing community oriented primary care systems needs to be developed, based on practice evidence and consensus among practitioners [and academics].

Achieving these, will enable the production of comparable data and information, the potential to improve the understanding of community oriented primary care delivery in different national contexts and the creation of opportunities for shared learning and knowledge trends [Kringos, et. al., 2010].

11. Appendix

List respondent organisations

- Fédération des maisons médicales et collectifs de santé francophones
- JvEI
- HemoCue
- TIABARI FOUNDATION
- Vereniging van Wijkgezondheidscentra
- West Norfolk PBCConsortium
- Badger Group
- Mastercall
- NHS North Somerset
- Lodex Ltd
- Uttlesford Commissioning Consortium
- NHS Blackburn with Darwen
- TIABARI FOUNDATION-NGO
- Radboud University Medical Centre
- Canadian Nurses Association
- WONCA Europe
- Tehran University of Medical Sciences
- Centre for Research in Primary and Community Care
- Derbyshire Health United Ltd
- EuroPharm Forum
- Federation of primary health care centres & French health groups, non-profit-making organization
- ACSS, IP (Central Health System Administration, Public Institute)

Countries of operation of respondents

- Belgium [x3]
- Netherlands [x2]
- Sweden
- Romania, Transilvania, Oradea
- UK [x9]
- Romania
- International
- Canada
- Europe
- Iran
- Denmark
- Portugal

Main objectives of respondent organisations

- Marketing of diagnostic point of care accurate tests
- Developing the rural health services in rural area
- Support of the wijkgezondheidscentra (community health centres) Representation of the wijkgezondheidscentra Development of new wijkgezondheidscentra and support of starters Advocacy for the model of wijkgezondheidscentra (11 criteria)
- Service redesign and improvement
- Out of Hours Services
- Provision of safe, effective, patient focused healthcare
- Improve the health of the population of North Somerset by commissioning health care services that reflects their need.
- Helping community projects to evaluate the impact their projects have on the wellbeing of participants
- Take forward and develop the commissioning agenda with the development of locality services and closer integration with others involved in providing and receiving health and social care in this area
- To improve health and wellbeing of our population
- Developing integrated health service delivery in rural communities' health promotion and education CME for GPs, primary care workers improving the quality of PC in rural areas
- To strengthen capacity for systemic approaches of population health. This implies capacity to treat health effects, reduce risks, but also better understand and address the underlying, immediate and structural causes of increasing health inequalities within as well as between countries.
- In pursuit of the vision and mission, CNA has established the following goals: To promote and enhance the role of registered nurses to strengthen nursing and the Canadian health system. To shape and advocate for healthy public policy provincially/territorially, nationally and internationally. To advance nursing leadership for nursing and for health. To broadly engage nurses in advancing nursing and health. To transform CNA governance structure and processes.
- Science
- It aims to provide both educational and research development to country through educating expert and skilful healthcare providers. In addition, through supervising teaching hospitals, it brings primary and well as specialised healthcare to people.

- The hospitals and research institutions affiliated to the university try to make a connection between people needs to suitable and safe healthcare services and new knowledge and technology.
- Out of ours primary care, Urgent Care Prison, Health Care, Care in Police Custody, Forensic Examination
- The aims of the Forum are: to improve health in the WHO European Region to support the implementation of WHO policies in the European region to formulate policy statements on health issues identified at the General Assembly of the Forum to promote the integration of appropriate aspects of policies of WHO policies into basic, postgraduate and continuing pharmaceutical education to strengthen contact between the national pharmaceutical associations and between the national pharmaceutical associations and the WHO.
- The Federation of primary health care centres is in movement towards a society that stands together, more equitable & with a social justice. It's main aim is promoting health policies based on primary health care in general and particularly our multidisciplinary health care centres who are looking forward to work like Integrated health centres.
- Propose and administer strategies in the field of financing, human resources, IT...

Types of membership of respondent organisations

a. Individual memberships

- i. Employees
- j. individual members

b. Service centres

- k. Community health care centres (wijkgezondheidscentra)
- l. GP practices
- m. Primary Care Trusts
- n. Hospitals
- o. Community Nursing

c. Civil Society

- p. Charities
- q. NGO

d. Professional Associations

- r. Nursing associations
- s. Regulatory bodies.
- t. Scientific
- u. Pharmacy organisations

e. Others

- v. Local Authorities
- w. Mental Health Trusts
- x. Social Care
- y. Independent Contractors
- z. Academic, research and education
- aa. Teaching Hospital

Membership size of respondent organisations

- Below 10: 1 respondent
- Between 11 and 100: 6 respondents
- Over 100: 3 respondents

Some given contacts

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- Professional Secretary Kirsten Holme euro@europharmforum.org
- Hubert Jamart, MD, general practitioner in a multidisciplinary primary health care centre (Liège) & politic permanent in the federation of primary health care centres (Brussels).

12. References

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