



**European Forum for Primary Care**

**Conference 'Primary Care: Interdisciplinary and Community Oriented'**

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## **New Experiences with Chronic Care Delivery**

### **An invitation to Rethink the Organisational Frameworks for Integrated Primary Care**

#### ***Introduction***

In this lecture, I will be exploring new horizons for cooperation in primary care in the Netherlands. Firstly, I will look back briefly at the adventures of the health centres in the past decades. I will focus on the roots of the health centres and the standard set-up that developed over time. Then I will look at current developments in organised chronic care. These current developments are exiting from a health systems point of view, as they might provide us with some useful insights in reasons to seek cooperation.

Firstly, I want to introduce myself shortly. I am a senior policy adviser with the L VG, the National Association of Organised Primary Care, one of the founding members of the European Forum. Currently, we represent approximately 200 health centres, the twenty primary care support organisations, and, since last year, also a number of chronic care provider groups. I will focus on this last group, as they represent an interesting innovative development in organisational frameworks for primary care.

We, the L VG, have developed from - I have to be honest - a rather narrow association of health centres to a branch organisation that stands for all organisations that foster cooperation in primary care. So, we have broadened our scope.

I myself have been trained as health scientist and as a historian. I have worked in health care and policy research for over 15 years now. But, I have also been a board member of a community health centre. So, I have some practical experience as well.

Recently, I have seconded for 1½ day per week to the Netherlands Organisation for Health Research and Development ZonMw. This organisation promotes quality and innovation in the field of health research and health care, initiating and fostering new developments; e.g. by committing considerable research funds. We are very happy that the Ministry of Health has commissioned ZonMw to develop a programme to further support the development of integrated health care with action oriented research. The research grants amount to a total of some €18½ million.

## ***The Establishment of Primary Care Centres***

Well, where are we with integrated primary care now? For those who were not present at the first conference of the European Forum in Utrecht in 2006, and for those who might have forgotten some details, I will briefly paint the historic picture.

### **The Roots**

Approximately 35 years ago, the first community health centres were established. Looking back, we can say that this was primarily ideology driven. The main reason being the strong conviction that health professionals should primarily focus on addressing the community's and patients needs and that the health care facilities had to be accessible for all population groups.

The establishment of the health centres was a reaction on the traditional and rather conservative organisation of primary health care. Up until then this was largely provider driven. Patient needs were, so to say, never heard of. In those days primary care was only provided by solitary working private health professionals. Cooperation with other health professionals was nearly not existent, let alone cooperation with other social services. Moreover, there was a sharp distinction between privately insured patients (the lucrative first class patients with a higher socio-economic profile) and the second class ones who were paid for by the sickness funds.

### **The Formation of Health Centres**

The professionals who established the health centres sought cooperation. The aim of this cooperation was to accommodate to both the patients' and to the community needs. Working according guidelines was daily practice. Even more shocking, the health professionals were employed by the health centre foundation; even the GP's and the pharmacists. In those days this all was fairly revolutionary. To the traditional professional

interest groups, this all was gruesome. Although their resistance caused some inconveniences and delays, they were not able to halt this development. At that time of polarisation in society, this resistance might even have stimulated the zeal of the dedicated young health professionals with strong convictions.

Many centres were established in the old deprived inner-city neighbourhoods, often with active support from the municipality. For the municipality a health centre was an attractive partner because they were easier to work with than the traditional soloists. Besides, the health professionals and social workers were committed to improve the health and living conditions of the deprived groups, and willing to address their social problems. The nature of these problems made multi- and interdisciplinary cooperation necessary.

Newly built suburbs were another environment where health centres were realised, and even actively planned. The health centres were considered as a privately run public service, just like primary schools. These health centres in newly developed areas could, therefore, receive additional grants in order to get themselves properly established.

In the course of thirty years, a kind of blue print for health centres was developed. Nowadays still only approximately 15% of the GP's work in the health centres. But no-one doubts any longer that the future model for primary care will be dominated by organised primary care facilities in one form or another.

A typical health centre provided primary health care and social services for a neighbourhood with some 10.000 inhabitants. The variety and number of services provided can be broad; up to more than twenty. Often a pharmacy was part of the health centre. Its profits were used for additional services and projects. But in any case there were GP's, midwives, physiotherapists, community nurses, and social workers. These five disciplines even became a prerequisite for additional funding. Different from the traditional soloist professional was the presence of trained medical support staff.

Because of the community orientation many health centres developed specific tailor made multi- and interdisciplinary programmes to address the most pressing issues; e.g. programmes for psycho-social problems and clinical pathways for chronic conditions like diabetes, COPD or heart failure. For the successful implementation, organisational innovations proved to be necessary. Various types of support staff were introduced, next to the already present medical assistants: nurse practitioners, advanced nurses, diabetic

nurses, mental health nurses. It would be fair to state that the health centre practitioners were bearers of primary care innovation. The others follow with some delay ...

The funding of the 'extras' of the health centres was arranged in a rather odd financing mechanism that grew incrementally over time. The existing health centres felt themselves comfortable with it. At the same time, this financing mechanism petrified in such a way that it was impossible to establish a health centre that did not fit the blue print. You will understand that the needs of the various communities differed and that the services needed differed too.

One of the general weak points of Dutch primary care that was not sufficiently solved by the health centres, was the lack of attention for prevention and health promotion. I am happy to say that these themes are high on the agenda since two years now.

### ***New Financing Arrangements***

After more than 30 years of discussions and various plans, in 2006 a new health care financing system was put in place. It is a hybrid system: it is public system that is executed by private health insurance companies. Some of them are heirs of the old non-profit sickness fund co-operatives, others are part of commercial insurance companies. Most parts of the health care system are now considered and treated as regulated markets and negotiations between health care providers and the insurance companies are an important integral part of the system.

With these enormous system change, all the former arrangements were halted; including some that were important for the health centres. A real revolution was the repeal of the familiar subsidy scheme for health centres after two decades. This was a real shock for many health centres as the certain grants had become essential to balance the budget. After a while, the fixed ('easy') grants have to be replaced by extra funding that has to be negotiated with the health insurance company. This implies that the health centres have to have their houses in order. They have to negotiate on the basis of an offer of additional services that suit the health profile of the community.

Understandably, this was quite a shock to the health centres. How to go about this? On the other hand, the repeal of the subsidy scheme gave a lot of room to entrepreneurship. The grant conditions were grown quite restrictive over the years. Not many health

centres to be were able to meet them. To be honest, the conditions had become an obstacle for many new and enthusiastic initiatives. In spite of a stimulus for cooperation and innovation, it had become an obstacle. For the existing health centres, however, the old framework was rather convenient.

You can imagine that that for a branch organisation, this was not always easy. We had to balance between the vested interests of our members that were affected by the new financing schemes, and the wish to promote cooperation in primary care through a more stimulating financial set-up. In fact, to date the new arrangements are not yet clear. This is indeed worrying. But I will not further elaborate on this now.

## ***New Dynamics and Innovations***

The preparations of the implementation of the new health care financing system took a lot of effort. As a result, there was little attention on content related issues. All focus was on D-Day, January 1, 2006.

### **A New Agenda**

With a new cabinet and a new Minister of Health in 2007, however, a new agenda was to be set. Despite continuing attention for financing, the focus shifted towards content related issues again, to name a few:

- Patient demand versus supply induced demand
- Chronic conditions, including prevention and self-management
- Prevention in primary care
- Patient safety and quality management
- Transparency and performance indicators
- Promotion of primary care as the backbone of the health care system
- Entrepreneurship as a driving force of innovation
- Substitution of care from hospitals to primary care

Before you become over-enthusiastic, I have to put this in perspective. These, in itself important, issues were addressed on a more abstract level, on a system's level. Practical implications, including the financing of innovations, were far less well-thought out.

Nevertheless, from a primary care angle we could consider these developments

positively. Moreover, the combination of the new health insurance, attention on content, and more room for entrepreneurship unleashed new dynamics for cooperation in primary care. Dynamics that were not really planned or foreseen.

## **Chronic Care**

I will elaborate a little on the development of the chronic care programme providers. As this development is still in its initial phase, I can only draw a few rough lines, let alone drawing conclusions.

The epidemiological transition has left us with an ever ageing population. An important part of the elderly suffer from chronic conditions, diabetes, COPD, heart failure, dementia and depression. These chronic conditions weigh heavily on the patients, but they are also responsible for an important part of the health care demand and, thus, are quite expensive. From the perspective of quality of care and the costs involved, we, as a health system, could do better.

## **Diabetic Chain Care Experiments**

Diabetes is a rapidly growing disease with a large burden on health. The Netherlands Diabetes Federation has developed a golden (multidisciplinary) standard that is supported by both professionals and patients. According to that standard, only one third of all patients received proper treatment. This implies that ½ million patients did not receive proper treatment and therefore had a high risk of developing unnecessary complications; e.g. foot amputations. Meanwhile it has shown that nearly none of patients that are treated according to the golden standard have foot amputations. These differences were no longer acceptable, not from a patients perspective, nor from the limited resources available, but it was no longer acceptable from a professional's point of view either.

This situation led to an experiment with research grants from ZonMw. Ten chronic care provider group with varying organisational designs were to experiment with the provision of the prescribed multidisciplinary care according to the golden standard. The groups had to organise all care needed, all along the chain of care; from GP and dietician to an internist, podiatrist and ophthalmologist. They have to make arrangements with all care providers involved. The groups receive a lump sum per patient for all necessary care. This was quite a new approach. The experiment started back in 2005. It should lead to conclusion how the diabetic care could be best organised and paid for. Results were to be expected in 2009.

## **The Rise of Diabetic Care Groups**

Well, the practice of chronic care delivery has meanwhile changed dramatically. The ZonMw experiment has meanwhile been taken over by reality. What has happened?

Over the last two years, primary care professionals have organised themselves in diabetic care provider groups; similar to the experimenting ones. They have negotiated lump sum contracts committing themselves for the complete chain of care according to the golden standard. The vast majority of the initiatives was initiated by GP's, mostly organised in cooperatives with typically some 75 GP members. These cooperatives subcontract other health and allied health professionals for their part in the care provision. Most GP's have delegated a considerable part of their routine jobs to nurse practitioners and other support staff.

Performance indicators will have to show if the performance of the new groups is satisfactory. According to the contracts, payment will be made dependent on the performance. We do not yet know in what degree the promises will be fulfilled.

## **The Significance for Integrated Primary Care**

When looking at this recent development, I am still astounded to see these developments unfold in such an amazing speed. It all fell in its place only in the last two years. In that period nearly all GP's have become part of a cooperative and have committed themselves to care provision according to the multidisciplinary golden standard. By this they acknowledge that they cannot work as soloists any more. They have to be part of networks or organisations.

This movement will gain even more momentum because it is expected that a functional financing mechanism will be put in place for chronic chain care for, probably, four chronic conditions.

If we look at this phenomenon from our perspective - the promotion of collaboration in order to enhance the quality of care delivered - it is even more astounding. Our members and ourselves have promoted cooperation for over decades now. Sure, with some success, but the pace of the current changes is really overwhelming. What happened? Which forces were at work?

The drivers for these change are various. Of course, the suboptimal quality of care could

no longer be denied. But that is probably not the most important driver. My assumption would be that smart entrepreneurship from the GP's is predominant. The new financing system and a central position of the health insurance companies caused serious concern among the GP's. Would their strong position survive under the new circumstances, or would it erode? By the formation of the GP cooperatives they increased their market power vis-à-vis the the health insurance companies, but the allied health professionals became increasingly dependent as well.

We can conclude that the formation of the chronic care provider groups is a double edged solution. It will definitely increase the quality of care, but it also strengthens the GP's position, partly at the expense of the allied health professional. At the same time none of the GP's will deny that cooperation, and task shifting, both horizontally and vertically, contribute to a better quality of care. They will also admit that they are taken up in a formal network of health care provision. At the same time they will admit that they lost very little autonomy, despite the necessary group management.

## ***Conclusion***

How should we weigh all this? Well, I think it is worthwhile to reflect on the rapid growth of the diabetic care provider groups vis-à-vis the rather slow growth of the health centres. What can we learn from this for the causes of integrated primary health care and the interdisciplinary approaches of health issues?

The old 'believers' might argue that the establishment of a full fledged health centre is something completely different and far more complicated. This is certainly true. They might argue that multi- and co-morbidity should be addressed in an appropriate holistic way. This Is also true.

These refutations are true, but they are besides the point if we look at it from the angle of change management. It is apparent that in the case of chronic care provider groups, the levers of quality of care and entrepreneurship were working in the same direction and were thus reinforcing each other.

If we look more closely at the chronic care groups, we can observe quite a variety of ambitions. Whereas some are mainly interested in the strengthening of the position and the income of the GP's, others are mainly interested in delivering up-to-standard care, in doing this together with other health professionals and the patient. In such a

configuration they largely keep their autonomy as a professional and as an entrepreneur. At the same time they are an integral part of a network organisation that is on its way to new forms of integrated primary care.

We do not know how things will develop, but we know for certain - and that is valid for everyone in Dutch primary care - that the tendency to more cooperation, to more integration, and to more task shifting and task delegation is inevitable and will thus continue.

Last weekend Professor Guus Schrijvers, whom you might remember know from the first EFPC congress in Utrecht, was very enthusiastic when he wrote his weekly newsletter. He saw fresh green pastures everywhere, full of flowers, and dancing sheep, so to say. And he might have been exaggerating a bit while observing the establishment of a thousand new health centres on its way. I am not sure if he is right in this one. But, he might be right in observing a new enthusiasm among primary care practitioners, especially among GP's. Their significant income rise might also contribute somewhat ... Anyhow, this new enthusiasm is precious and should be fostered and used to the right ends.

I want to conclude that, in my opinion, we should consider the recent developments in the organisation of chronic care as an invitation to us to reflect and rethink our familiar strategies to promote integrated primary care. In the end it is not the organisational framework that counts, but the quality of care delivered and the patient satisfaction.

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Arthur Eyck MA MSc

Senior Policy Advisor

National Association for Organised Primary Care LVG

eyck@lvg.org

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