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Primary care in the **driver's seat?**

Organizational reform in European primary care

Edited by
Richard B. Saltman
Ana Rico
Wienke Boerma

chapter one

Coordination and integration in European primary care

Wienke G. W. Boerma

A book on stronger primary care

The title of this book appears to imply that the current driver of the health care system is not doing a satisfactory job and should be replaced by primary care. Indeed, it may be that in a number of European countries the provision of health care to patients is inadequately steered, but this is likely due to the fact that, too often, there seems to be nobody behind the wheel. This situation is not new. In the 1970s and 1980s, countries sought with varying degrees of success to make health services more efficient and more coherent (Abel-Smith and Mossialos, 1994; Maynard and Bloor, 1995; Saltman and Figueras, 1997). Several decades later, insufficient coherence and coordination in health care are still considered the main causes of lack of responsiveness to the needs of the population. Experience in several countries indicates that this problem can be tackled at the point where patients normally enter the health care system, where the scope of the patients' health problems is examined and where decisions are made about other possible providers to involve: that is, in primary care (WHO, 2002). Strengthening primary care by extending the skill mix or giving primary care control over other levels of care is often mentioned as key to the solution (Starfield and Shi, 2002). How feasible are these ambitions in the current health care context in Europe, which is extremely heterogeneous, particularly with regard to primary care? What are the conditions for strong primary care and what is known about effective measures and strategies? Although the organization and provision of health care are still largely a national affair, European integration has led to higher interest in foreign experiences in the field of health system development as the basis of policy-making (WHO, 2002).

The aim of this book is to consider the extent to which strengthening primary care can be a suitable strategy to improve the overall coherence in health care and to explore the conditions and instruments that fit into this strategy. The

"driver's seat" in the book's title refers to the coordination and navigation function, for which primary care may have considerable potential. After completing our exploration we maintain the question mark in the title, however, because the answer is not unequivocal. The character and conditions of primary care in Europe are so diverse that a general judgement about the suitability of primary care for coordination and navigation is hard to make.

This volume explores the different approaches to primary care found across Europe and examines the success of different strategic alternatives in its design and operation. In this introductory chapter, we set the conceptual stage for the more detailed assessments that follow. We begin by examining the central issue of health system coherence and coordination, and assessing the role that primary care might play in resolving this dilemma. Drawing on this analysis, we then develop a working definition of primary care, which, in turn, serves as the basis for Chapter Two's subsequent mapping of primary care resources across the European region.

The problem

Despite constantly rising health expenditures in European countries, the health needs of growing subgroups of the population, such as the chronically ill, the elderly and those in need of hospice services in their homes, are not well met (McKee and Healy, 2001). Over the past years these needs have changed quantitatively and qualitatively and they will continue to do so, as a result of the epidemiological transition related to the ageing of populations and the general increase in wealth in most countries. Larger proportions of patients suffer from more than one disease and receive a mix of health (and social) care provided by several workers from different disciplines at the same time (Van den Akker *et al.*, 1998; Menotti *et al.*, 2001; Westert *et al.*, 2001). Such complex needs often are not adequately dealt with by a health care system which itself has also become much more complex. The inadequacy may result not only in unmet needs, but also in unnecessary treatments, medicalization and other threats to patients' safety. The increased system complexity is a side effect of specialization and subspecialization in health care, by which professional "inward-directedness" has tended to grow at the expense of attention to integration with other disciplines. The implementation of new care arrangements, such as those based on shared care, substitution and teamwork, is hampered by this fragmentation. More coordination will be needed to offer users of complex care the guidance and navigation to find their way through the system. Problems of coordination are likely to arise at key interfaces: between primary and secondary care, between curative care and public health services, and between specialities within particular subsectors (Renders *et al.*, 2001; Faulkner *et al.*, 2003; Rat *et al.*, 2004).

Another development that underlines the need for more coherence and coordination is the growing importance of anticipatory medicine and prevention. These are expected to bring further population health gain in terms of quality of life and life expectancy. Health care may be increasingly asked to look actively and systematically for conditions in their early stages and to identify factors that are known to be health risks. Screening, monitoring and follow-up,

which are still relatively new tasks in primary care, can only be carried out effectively by the coordinated the efforts of various professional groups on the basis of information concerning the population they serve (Isles *et al.*, 2000; Murchie *et al.*, 2003; Oakeshott *et al.*, 2003; Campbell, 2004). Where preventive interventions already go beyond the boundaries of standard health care, extended coordination will be needed to include other sectors such as social services or education.

The pressures for change originate not only from public dissatisfaction about poor responsiveness of health care and the need to find effective ways of promoting health and preventing disease. Policy-makers, financers and others responsible for health care expenditure have long worried about the growing costs of health care (Abel-Smith, 1992; OECD, 1995). They are looking for incentives and mechanisms to enhance accountability and the awareness among health care providers of the common goal of efficiency. Currently, there is demand for reform measures that can improve coordination across health systems as well as stimulate a more efficient use of resources. Thus, current pressures go beyond the more targeted cost-containment measures that were dominant in the 1990s (OECD, 1995; Paton, 2000).

Although analysts tend to view health care as an integrated system, existing arrangements do not always provide a well-organized response to the health problems occurring in a society. The relevant characteristics of a system are not evident: operational goals are not always shared, the division of labour is far from perfect and, due to lack of coordination, the various elements of health care lack coherence (Van der Zee *et al.*, 2004). Poor communication between primary care, hospitals, and medical specialists has been well documented in many health care systems for decades. Similarly, curative health care and public health services are usually worlds apart. Furthermore, status and domain problems may prevent good working relations between doctors and nurses, in particular if the latter are working in separate organizations, such as independent practice and home care organizations (Poulton and West, 1993; Mur-Veeman *et al.*, 2001). Removing these barriers, for instance by creating incentives for teamwork, may improve the quality of care at the individual and facility levels of health care, but may not be sufficient to bring about increased coordination among levels and sectors of care. Other specific measures will be needed to establish new forms of supply that guarantee seamless interfaces, such as chains of care or integrated care networks.

Primary care: features and disciplines

Definitions of primary care are numerous and either more descriptive or normative, depending on the purpose they serve. The normative approach has been closely connected with the WHO Alma Ata Declaration in 1978 on Primary Health Care, in which the focus was on solidarity and equitable access to care; on the protection and promotion of health rather than on curing illness; on more influence of the population on health care instead of professional dominance; and on broad intersectoral collaboration in dealing with community problems (WHO, 1978).

Although the concepts of "primary care" and "primary health care" are often used as synonyms, they represent different aspects of the development and articulation of first level care. The subject of this book is not the broad societal strategy of primary health care as laid out at Alma Ata, but rather the more limited area of primary care as a subset of functions or services delivered specifically within the context of health care systems. Of course, a well-designed primary care sector can also serve broader primary health care goals as well. In the current European context of health care, the concept of primary care can be understood in the following ways: as refering to a level of care between informal care and hospital care; or to a set of functions and activities; or to a means of performing those functions and activities; or to a set of characteristics for the organization of health services (Starfield, 1992, 1998). One consistent thread within these variations is that primary care consists of the professional response when patients make first contact with the health care system. This approach to primary care is considerably broader than the care delivered by a general practitioner or a family doctor, yet is considerably more restricted than the intersectoral concept of primary health care promulgated at Alma Ata. It is precisely this intermediate category, however, which is at the centre of ongoing primary care development in many European countries (see as examples the four boxes in this chapter and Chapter Two) and which is the focal point for efforts to improve coherence and coordination in health care service delivery. For the purposes of this book, we will refer to this intermediate category as 'extended primary care.' As an initial step in the formulation of a working definition, we will address the functions or attributes of extended primary care, since they help identify which patients need adequate help, once they have taken the step to seek professional health care services.

The primary care process

Although the manifestations of primary care in Europe are diverse and the disciplines involved differ, its functions can be identified in most health care systems, although to differing degrees (Boerma, 2003; Raad voor de Volksgezondheid en Zorg, 2004). The most evident primary care function is serving as the point patients receive *first contact* professional care. This point lies at the transition from lay care to professional care, where a general identification of the problem takes place. Information about the previous visits of this patient and his or her medical history is taken into account. It may be necessary then to *clarify the demand:* what does the patient (actually) expect from health care and what are the patient's own options for dealing with the problem? At this stage already, large proportions of demands appear not to need further intervention and it will suffice to give *information, reassurance or advice*, sometimes combined with a follow-up appointment. For other patients a *diagnostic procedure* may be required. Diagnostic examinations will focus particularly on the identification or exclusion of severe illness. The diagnostic phase may be followed by *treatment*. Decisions on treatment are taken together with the patients because their motivation and possibilities are determinants of success. Depending on the kind of treatment it may be necessary to *involve other disciplines*, either in primary care

or in secondary care. Involvement may vary from asking for advice to complete referral. If more than one health professional or health care facility is involved in the treatment, *coordination* is needed to avoid duplication and safeguard the *continuity* of the treatment. Closely related to the functions mentioned so far, which mainly apply to curative care, is *prevention* in primary care, which may start from knowledge about patients and their living situation and observations (weight or blood pressure, for instance) made during curative contacts. The preventive function may also extend to groups in the community.

The attributes or functions of primary care have been concisely summarized in the definition of the American Institute of Medicine (Donaldson *et al.*, 1996) referring to "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community". Needless to say, the functions attributed to primary care may also apply to varying degrees to other levels of care.

Other dimensions

As a *level of care*, primary care is often represented as the base of the pyramid of health care. The middle layer is secondary care while tertiary care is situated at the top of the pyramid. Informal care is an unspecified area below the pyramid. Primary care is the response to unspecified and common health problems accounting for the vast majority of the population's health needs. Problems that require more specialized medical expertise are dealt with in secondary care, in hospitals or the outpatient context, while rare and very complex cases are treated in tertiary care (Fry, 1972). By the *characteristics of their services*, primary care is the kind of care that is ambulatory and directly accessible to patients, with a generalist character, situated in the community that it serves and with a focus on the individual in his or her home situation and social context (Van der Zee, 1989; Gervas *et al.*, 1994). Starfield has defined primary care more in the *content and the range of care*, including its integrative function: those services addressing the most common problems by providing a mix of preventive, curative and rehabilitative services; integrating care when more than one health problem exists, dealing with the context of illness; organizing and rationalizing the deployment of basic and specialized resources (Starfield, 1991).

Primary care is not a discipline itself, but it is provided by professionals with specialized training. Examining health care systems, disciplines can be listed which are, to varying extents, involved in the provision of extended primary care.

Primary care and general practice

A core discipline in primary care is general practice or family medicine. Primary care started to develop in medical territory not occupied by (medical) specialists. As specialization expanded and the number of specialties grew in the second half of the twentieth century, these "residual activities" became labelled as

primary care and further developed to become its own specialty. In the Netherlands, for example, primary care was officially identified as a separate echelon in 1974 with the publication of a white paper on the structure of health care. The paper concluded that health care was not coherent, the financing fragmented and that too much emphasis was placed on the inpatient sector. (Ministerie van Volksgezondheid en Milieuhygiëne, 1974). In 1980 another paper, exclusively devoted to primary care, described the features of this echelon, the health professions involved, and launched measures to strengthen primary care (Ministerie van Volksgezondheid en Milieuhygiëne, 1980).

In Europe, primary care is not easily conceptualized without general practice, but these two concepts are not equivalent. The concept of extended primary care, as already noted, encompasses considerably more than general practice alone. How much more varies from one country to another. In those countries where general practice is well developed, the functions and characteristics of primary care largely overlap with those of general practice, and general practice may have a preferred position in primary care. In other countries, directly accessible primary medical care is also provided by specialists, such as paediatricians, gynaecologists, specialists in internal medicine and cardiologists. A definition of the general practitioner (GP), set out more than 30 years ago by the British Royal College of General Practitioners, covers many of these elements. According to this definition, a GP is

> . . . a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their own homes, in his consulting room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in a single-handed practice, he will work in a team and delegate when necessary. His diagnosis will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health.
>
> (RCGP, 1972)

From this and the many definitions that came after, the following key characteristics of general practice or family medicine can be synthesized. First, it is *generalistic care*, meaning that it deals with the full range of unselected health problems and with all categories of the population, without exclusion on the grounds of age or gender. Second, as the provider of *first contact care*, services are available at all times and at a close proximity, in patients' homes, if necessary. Third, the *orientation to the patients' context* implies that the individuality of a patient is taken into account in the treatment as well as social network and living circumstances. Fourth, the focus is on *continuity*: the interventions are not limited to one episode of care but cover patients' health needs longitudinally. Fifth, *comprehensiveness* refers to the fact that services comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention. Finally, coordination means that patients are referred to other health

professionals if necessary and that health care resources are properly allocated (Leeuwenhorst Group, 1974; WONCA, 1991, 2002; Boerma and Fleming, 1998; Van Weel, 1999; Olesen, 2002; Boerma, 2003). From this characterization, it follows clearly that general practice requires teamwork and collaboration with other disciplines.

Other disciplines in primary care

As in other sectors, the professional division of tasks and specialization have resulted in an increasing number of disciplines working in or with primary care. Obviously, not all characteristics of primary care – for instance the direct accessibility or a general approach – apply equally to all disciplines in every health care system in Europe. Furthermore, disciplines may be involved in primary-care-style activities but in hospitals or nursing homes as well. The typical profile of involvement of various disciplines in primary care is a distinguishing feature of the health care system in a country. In addition to general practice, the health professions outlined below can be regarded as the major providers of primary care (Boerma *et al.*, 1993; Bower and Sibbald, 2004; Pringle and Irvine, 2004; Raad voor de Volksgezondheid en Zorg, 2004).

Nursing is a crucial profession, which currently appears in primary care in various forms (Kinnersley *et al.*, 2000; Temmink *et al.*, 2000; Pringle and Irvine, 2004). The longest tradition involves *community nurses* (or district nurses), who care for patients in the home situation, mostly the very young, the elderly and those with chronic conditions. Examples of this type of care include washing patients, caring for wounds, administering medicines, giving information and support, and technical interventions after hospitalization or in a terminal phase. Psychiatric patients living at home are the target population of *community psychiatric nurses*. Activities of *practice nurses* include health promotion, perinatal care, vaccinations and routine monitoring of the chronically ill in the context of general practice. There is a tendency to involve practice nurses more in patient management (Shum *et al.*, 2000). In addition to the activities of practice nurses, *nurse practitioners* do certain diagnostic procedures and treatments including administering some medication. In addition, other *nurse specialists* are working in primary care teams for particular categories of patients, such as those with diabetes, asthma and coronary heart diseases (Calnan *et al.*, 1994; Vrijhoef, 2002).

The core task of *pharmacists* is to prepare and distribute of medicines prescribed by physicians. The density of pharmacists (and so their competition) varies greatly among European countries. In a number of countries, especially those where patients are usually registered with a pharmacy, providing patients and general practitioners with information has become an important task for pharmacies. Potentially, pharmacies are in a good position to develop a drug-prescribing policy with GPs in their area and to keep a careful watch on the safety of prescriptions (Hughes and McCann, 2003; Muijrers *et al.*, 2004; Silcock *et al.*, 2004). In the Netherlands cooperation between GPs and pharmacists has been strongly promoted since the early 1990s. Nowadays 71% of Dutch GPs have an explicit agreement with a pharmacist concerning their prescription

policy. On average, Dutch GPs have meetings with pharmacists for 19 minutes per week (Braspenning *et al.*, 2004).

Physiotherapy is a rapidly growing profession in some countries, particularly in north-western Europe. Physiotherapists treat patients with musculoskeletal problems and they may work in institutions or in the community. In some countries patients may need a referral from a physician to see a physiotherapist (Koster *et al.*, 1991).

Midwifery is usually practiced in a clinical setting, where midwives are involved in prenatal care and deliveries under the supervision of obstetricians. In some countries midwives also work in the community (Page, 2001). In the Netherlands they have a unique position: midwives are responsible for about 40% of all deliveries most of which are at home (Wiegers *et al.*, 1998).

Finally, there are some disciplines with primary care functions although these workers are not always classified as primary care. Most important are *home helpers*, who give personal and domestic assistance, often in situations where community nurses also are involved (Hutten and Kerkstra, 1996). The deployment of the necessary mix of professional knowledge and skills for the specific needs of patients requires cooperation between professionals to ensure that their efforts match recipients' needs. The demand for better coordination in health care refers not just to increased cooperation between sectors or levels of care but also to the situation within primary care, which is considered to be too fragmented.

Vignette 1.1 The Almere experiment[1]

In 1968, the first steps were taken on the newly reclaimed land of "Zuidelijk Flevoland". In a part of this vast new polder, not far from Amsterdam, a new town was planned. In 1978, the first inhabitants entered their houses. Now, Almere has 165,000 inhabitants, with an average annual increase of 6500.

In the time that Almere was on the drawing boards, white papers were published about the urgent need to strengthen the Dutch primary care system to meet changing patient demand and to reduce the need for secondary care. There was a lack of coherence and coordination between specializations that led to fragmentation in primary care. At that time, GPs were private entrepreneurs mainly working in solo practice. Although the concept of integrated multidisciplinary health centres had been implemented in new housing estates, large-scale systemic change appeared to be very difficult.

Almere became a challenge to design a well-developed coherent system of primary care with a minimum amount of secondary level facilities. Supported by the authorities, a group of young health care workers, in collaboration with groups of active citizens, took the initiative in 1979 to start the Almere health care experiment, with the objective of avoiding the problems and shortcomings of the existing Dutch arrangements. Instead of care provided by individual private practiotners, integrated

health centres would have a variety of professionals working in collaboration for the benefit of the population within well-defined catchment areas. Since the traditional combination of entrepreneur and caregiver was seen to be potentially confusing, a foundation was created to employ all GPs, physiotherapists, pharmacists, dentists, midwives and auxilliary staff. Later, social workers and community nurses were also employed by this foundation. GPs provided comprehensive services including first aid, minor surgery, child health care and major parts of ophthalmology. The goal was to reduce referrals to medical specialists. The use of antibiotics, particularly by children, was to be reduced, as were tonsillectomies. Furthermore, it was mandated that there would be at least one female GP in every health centre, so that patients who so wished could choose a female doctor.

From 1983 until 1992, the experiment had the legal status of a formal project, with special funding and regulations intended to establish new types of health care workers. One result of the Almere philosophy was that a small hospital was not opened until 1991. In the course of those years the use of hospital services was indeed lower. GPs and hospital specialists developed an intensive collaboration in a structural working group. A similar working relationship was established with a psychiatric centre that opened in 1997. In 1999, the foundation for primary care in Almere (EVA) merged with the organization running the nursing home and homes for the elderly.

The experiment has been successful in many regards as it has created a strong local network of health centres. Evaluation has shown that referral rates were lower than the national average, particularly when the age structure of the population was taken into account. Citizens of Almere are satisfied with the services and more than elsewhere health centres are involved in public health.

On the other hand, there have also been some setbacks. Most inhabitants of Almere previously lived in the old quarters of Amsterdam. They brought with them a pattern of expectations and health care consumption that was not always in line with the ideals of their new GP. These ideals may have suffered in the negotiation of this new healthcare strategy. The experiment also evolved in other respects as time went by. Those who subsequently worked for the Almere experiment were less idealistic and more pragmatic. They achieved an umbrella organization in Almere with working conditions that were still hard to realize elsewhere in the country.

There were three priorities that were central to the Almere experiment: teamwork, working part-time and delegation of tasks. In the Netherlands most professionals are not well prepared for teamwork because each profession fears losing their independence. In Almere, teamwork is the core of primary care provision and for many health care workers this was a reason to choose to work there. Newly attracted staff need to be trained for the working arrangements in the health centres. There has been much

resistance in general practice concerning working part-time because it was seen as a threat to the concepts of personal, integral and continuous care. However, with the expanding proportion of female GPs in the Netherlands, there was a growing need for part-time work. At an early stage, these conflicting needs were reconciled in Almere. The result is that now 50% of the GPs in Almere are female, whereas the national proportion is 28%. Task delegation has also been well developed in Almere. Substitution has been realized between secondary care and primary care, but also within primary care. Some traditional GP tasks, for instance in care for the chronically ill and elderly, are now being delegated to newly introduced nurse practitioners and other staff. In Almere these changes have been implemented without fear of losing status in the health care market.

Recently, there have been additional innovations. GP service during evenings, nights and weekends has been reorganized. There is a better-equipped and staffed central GP facility for out-of-hours services for the city. Physiotherapy is becoming increasingly involved in guidance and follow-up with patients at risk of heart disease, the overweight and those with chronic diseases. Most physiotherapists have specialized in manual therapy, child physiotherapy or sport injuries. The supply of social services work has been extended with the introduction of primary care psychologists.

Almere is no longer an experiment, nor is it mainstream primary care in the Netherlands. Due to its special structure and its special population of health care workers, it is easier to implement changes, such that it will continue to be a model within the Dutch health care system.

Continuity of care

Continuity is the degree to which a series of discrete health care events is experienced as coherent and connected, and is consistent with the patient's medical needs and personal context (Haggerty *et al.*, 2003). Essential in this definition is the personal perspective of the patient: continuity is what patients perceive. Coordination and teamwork is what providers do for the benefit of continuity. In primary care, continuity is usually seen as the continued relationship between a patient and a particular provider – rather than a team – beyond care episodes. This is also referred to as personal continuity (Hjortdahl and Borchgrevink, 1991; Hjortdahl, 2004). However, the sense of affiliation between patient and caregiver is stronger in general practice than in some other professions, such as nursing, where a consistent approach is emphasized by the transfer of information. In addition to the personal perspective of a single patient, the second key element of continuity is longitudinality (Schers, 2004). The time frame may be relatively short, for instance an episode of care, or much longer, such as a long-standing relationship between patient and GP. Depending on the type of provider and the context of care, Haggerty *et al*. (2003) distinguish three types of continuity: informational, managerial and relational.

Informational continuity is the use of information, either documented or in the memory of providers, on past events and personal circumstances, to make current care appropriate for the individual. Information links care from one provider to another and from one event of care to another. *Managerial* continuity is the consistent and coherent approach of several professions to the management of health conditions (especially if chronic or complex) that is responsive to a patient's changing needs. Continuity is achieved if services are delivered in a complementary and timely manner, for instance by means of protocols. *Relational* continuity is the ongoing therapeutic relationship between patient and provider(s). Continuity is a quality relevant to care at different levels: in the relationship between patient and provider; among providers of one discipline; between disciplines and between organizations, levels or sectors of care. In the context of this book, informational continuity and managerial continuity are most relevant.

Coordination, teamwork, integration

When more than one provider is involved in administering care to an individual patient, some form of coordination will be necessary to realize continuity. The degree of coordination needed in specific situations depends on the complexity of the case and the options open to the patient. The conceptual framework developed by Boon *et al.* (2004) has distinguished seven models of care provision on the continuum between strict solo provision on the one hand and full integration of disciplines for the provision of curative, rehabilitative and preventive services on the other. In the non-coordination model, called *parallel practice*, practitioners work independently and carry out a formally defined set of services. In *consultative practice*, information concerning particular patients is shared informally and on a case-by-case basis. In the *coordinated* model, the communication and exchange of patient records is related to particular diseases or therapies and is based on a formal administrative structure; a case coordinator monitors the transfer of information. More articulated, more formalized and usually more numerous is the *multidisciplinary team*, led by a team leader and possibly sub-teams and sub-team coordinators. When members of a team start making group decisions or developing shared care policy, facilitated by regular face-to-face meetings, the multidisciplinary team has become an *interdisciplinary team*. Finally, the model of *integrative team care* is reached if the interdisciplinary team, based on a shared vision, provides 'a seamless continuum of decision making and patient-centred care and support' (Boon *et al.*, 2004).

A major reason why health care and primary care are still neither very coherent, nor very cost-effective, and why curative and preventive services are still too separate, is that coordination and teamwork are difficult to achieve. The success of new arrangements – such as shared care or several forms of substitution within primary care or between primary and secondary care – depends on cooperation and teamwork. The extensive literature on multidisciplinary collaboration has described the obstacles that have to be overcome. In addition to basic problems, related to differences in social status, employment, education,

power and gender (Mur-Veeman *et al.*, 2001), there is little evidence on what the optimum model of collaboration looks like and how effective teams should be led. And even if teams work effectively it should not be assumed that it is automatically cheaper (Wolters *et al.*, 2004). It may be concluded that improving the collaboration and teamwork in primary care requires a multifaceted approach from decision-makers, management and health care workers (Poulton and West, 1993; West and Slater, 1996; Winkler, 2000). Health care systems in Europe differ considerably as far as the degree to which this has been successful is concerned (Boerma and Fleming, 1998). Not surprisingly, in countries with strong primary care systems there has been relatively greater attention paid to the development of collaboration and teamwork in primary care and to the smoothening of the interface between primary care and secondary care (Van Weel, 1994; Busby *et al.*, 1999; Temmink *et al.*, 2000; Iliffe *et al.*, 2002; Brown *et al.*, 2003; Rummary and Colemen, 2003). These experiences may be useful to further developing primary care in other countries.

Working definition

In the previous sections, primary care has been considered from several points of view. This has clarified the type of care provided in extended primary care and the disciplines potentially involved. We have seen why continuity is an important requirement and how collaboration, teamwork and other methods of coordination can promote the continuity of care for different categories of patients. Our working definition summarizes the features of extended primary care that are important in the context of this book. Primary care:

- refers to directly accessible, first contact ambulatory care for unselected health (related) problems;
- offers diagnostic, curative, rehabilitative and palliative services in response to the bulk of these problems;
- offers prevention to individuals and groups at risk in the population served;
- takes into account the personal and social context of patients;
- is provided by a variety of disciplines, either within primary care, secondary care or related sectors;
- assures patients continuity of care over time as well as between providers.

This definition can serve as a yardstick in the examination of primary care systems across Europe. The wide diversity in primary care in European countries, as discussed below, points to different conditions for the provision of primary care. For instance, continuity of care is not readily achievable if the organization of primary care is small scale and fragmented, or if there is no single point of entry to the health care system. Structural characteristics of health care, such as the mode of financing, determine possibilities for the provision of primary care. Financing arrangements influence not only how and where patients enter health care, but also the opportunity to establish a longer term relationship between patient and primary care provider, for providers to keep patient records routinely, to maintain adequate professional education and quality of care, or to foster cooperation between providers at different levels. How such conditions

emerge and what strategies are effective to support primary care in particular countries depends on the prevailing national governance and health care structure.

Potential of primary care

There is considerable agreement, especially among international organizations and academics, that a strong primary care system is the linchpin of effective health care delivery and that it can help resolve the lack of continuity and responsiveness in health care in general (Saltman and Figueras, 1997; WHO, 2002). There is indeed considerable logic in thinking that the entrance point to the system is the obvious place where improved coordination should take place. Although there are critics who question the evidence for these arguments (Maynard and Bloor, 1995; Sheaff, 1998), studies have suggested that strong primary care based systems are cheaper to operate than more "open" systems and that their health outcomes are better (Starfield, 1994; Doescher *et al.*, 1999; Shi *et al.*, 2002; Macinko *et al.*, 2003). One study conducted in OECD countries found that systems with gatekeeping GPs were better able to control the costs of ambulatory care (Delnoij *et al.*, 2000). It therefore could be concluded provisionally in the European context that primary care-based systems are more cost effective. At meso and micro level there have been many studies on the effectiveness of collaborative, team and "shared" approaches to care, either within primary care or involving various levels of care, showing that these can promote continuity of care and be effective in dealing with new tasks (although they are not necessarily cheaper) (Poulton and West, 1993; Vierhout *et al.*, 1995; Calnan *et al.*, 1996; Shum *et al.*, 2000; Temmink *et al.*, 2000; Renders *et al.*, 2001; Brown *et al.*, 2003; Faulkner *et al.*, 2003; Murchie *et al.*, 2003; Oakeshott *et al.*, 2003; Vlek *et al.*, 2003; Campbell, 2004; Rat *et al.*, 2004; Wolters *et al.*, 2004). There is no direct evidence available about continuity of care, although greater cost-effectiveness may have resulted from better cooperation and coordination mechanisms.

Reservations

The positive expectations among policy-makers for a more central coordinating role of the primary level of health care, however, are in contrast to the diversity of opinions about the organizational mechanisms best suited to achieve that aim. This is due to the fact that health care functions are similar in any country, but the organizational system and the providers involved are quite diverse. This reflects the European reality, with quite different situations of primary care, as explained below. At present some health care systems are already formally based on primary care, including a referral system to secondary care and gatekeeping general practitioners (GPs) with broad task profiles, while others are based more on specialist services with a less exclusive domain for GPs (Boerma and Fleming, 1998). Other differences that create incomparable conditions relate to the financing structure, the mode of governance and the role of

professional organizations. A more centralized NHS system, like in the UK, offers quite different conditions for policy-making and coordination than a social security environment, for example in Germany or France, where more parties are involved in decision-making (Saltman *et al.*, 2004).

Another issue, however should, probably precede questions about whether primary care *could* be installed in the driver's seat, how that could be realized, and whether it is *desirable* to do so. The delegation of coordination powers to providers in primary care, for instance GPs, may entail a dual role as both coordinators and providers of care. This may create a conflict of purpose (also discussed in Chapter Four). The important question is whether primary care has the capacity to handle new, complex tasks without losing hold of its main responsibility as the provider of care. First and foremost, GPs are the agents of their patients with professional values that require investing as high a level of resources as possible in those patients. However, to become efficient coordinators, they must incorporate "higher level concerns", and may therefore find themselves divided between these different responsibilities. Vice versa, one may even wonder about the influence of "coordinating doctors" on their professional values. A good division of tasks within primary care teams could potentially offer a solution to this conflict.

And what about the decision-makers: are they in favour of strengthening primary care? In their analysis of reforms in primary care systems in OECD countries, Macinko *et al.* (2003) found that only a few countries have been able to improve essential features of primary care since 1970. Does that reflect the stubbornness of health care reform or the absence of reasons for profound changes? Policy-makers, professionals and the public in countries where primary care is not well developed may not feel strongly attracted to the idea. They may come to see primary care as useful for cost containment, yet generally consider it a lower grade service compared to specialist care. In Central and Eastern Europe, countries had little choice but to change fundamentally their health care systems. Their experiences have taught us about the impact of radical reforms and the time it takes before the reformed system finds stability again.

Different possibilities

For most countries in Europe, the conclusion that neither extended primary care nor general practice specifically serve as the firm basis of health care is justified. Instead, primary care and GPs offer a heterogeneous set of services, often in competition with specialist services (Boerma and Fleming, 1998). In countries where it is hard to identify clear boundaries between levels of care, coordination and continuity of care is difficult to achieve, and possibilities for a steering role of primary care are obviously limited. But even in countries where citizens are on the list of a gatekeeping GP, primary care is usually not the most powerful echelon of health care. This creates a paradoxical situation: the tension between the relative weakness and unattractiveness of this level of care versus the intention to assign critical strategic functions to it. This *primary care paradox* is a basic concern that runs throughout this volume. Available strategies

need to be considered that could tip the balance of the health care system towards primary care.

The three chapters that follow in Part One seek to provide a range of perspectives on the context for this central paradox. Chapter Two maps out the existing distribution of key primary care resources across Europe and examines in close detail the type and form of activities in which primary care personnel engage. Chapter Three analyses the process of governance in primary care, detaching the ways in which it has evolved and providing a framework for thinking about how it might develop in the future. Lastly, Chapter Four draws together the central themes that tie the volume together, exploring in particular the major challenges that primary care currently faces.

In Part Two, the chapters utilize both conceptual theories as well as national experience to probe more deeply into a number of key aspects of primary care raised in Part One. Chapters Five, Six, and Seven explore the changing institutional arrangements in European primary care, assessing the issues of coordination, purchasing, and the public-private mix. Chapters Eight, Nine, and Ten review changing work arrangements, including task profiles, training, and financial incentives. Finally, Chapters Eleven and Twelve examine changing quality standards, assessing efforts to emprove quality of care as well as to introduce new information and communication technologies. Taken together, the eight chapters in Part two are intended to provide the detailed case-based depth that can help amplify and reinforce the conceptual perspective and analysis presented in the four chapters of Part One.

Note

1 This vignette was written by Bert Groot Roessink, GP and Director, Curative Care, Almere, the Netherlands.

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