Community-based health care services: indispensable in comprehensive and responsive health care systems

Workshop 'Reimagining health care delivery in the Russian Federation'

Creating a platform for improved health care outcomes

Moscow, 28 june 2017

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Why do many countries in the WHO Region of Europe more focus on Primary Care*)

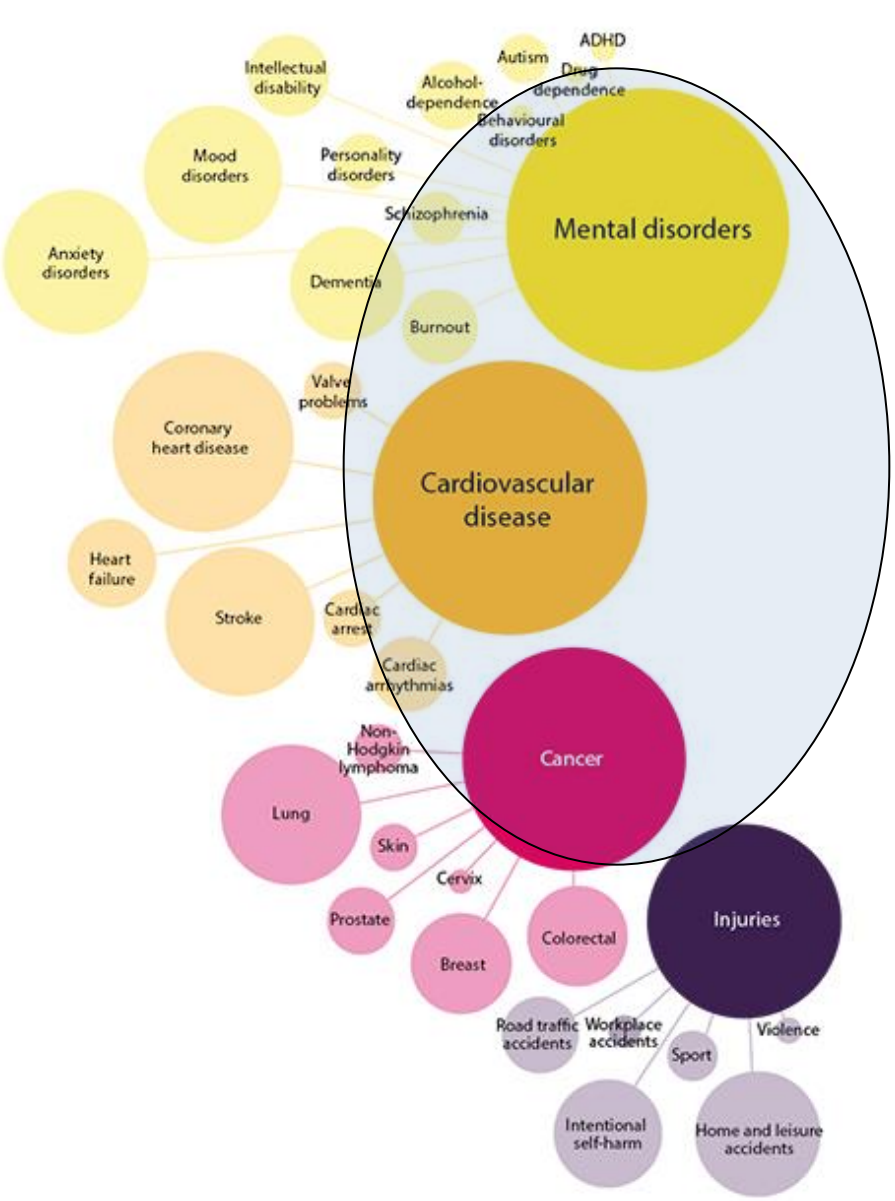
(because the evidence suggests it is an answer to challenges)

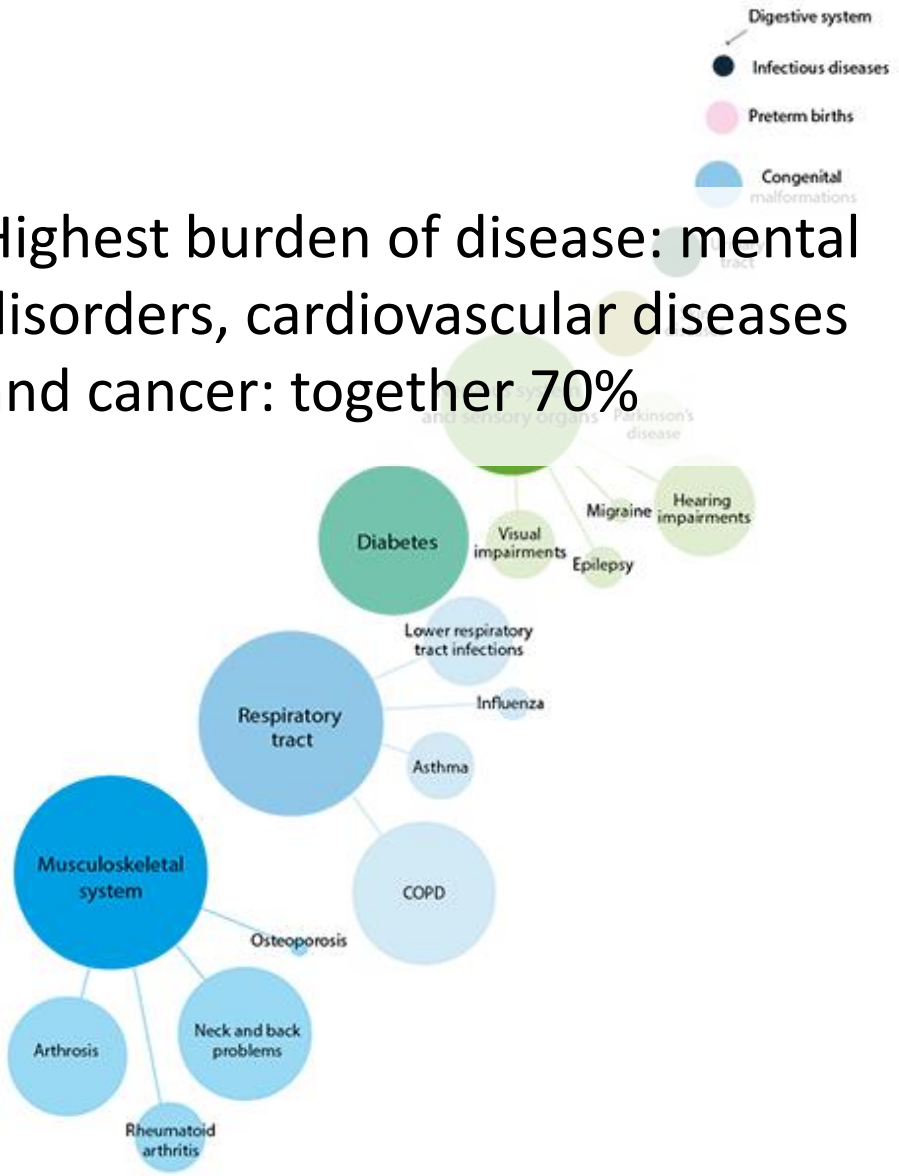
*) Definition: primary care is directly accessible care, prevention and health education provided to people living at home.
It i.a. includes family medical care; home nursing; personal care; pharmaceutical care; general mental care; physiotherapy; social work.

Healthcare-related challenges in the WHO Region of Europe

- Demographic developments (ageing)
- Changing health risks (lifestyle related NCDs)
- More complex care demand (multiple chronic diseases)
- Growing demand for outpatient and home-based care
- Patients have better access to health information
- Rising expenditures
- Developments in medical and pharmaceutical technology
- Diminishing 'returns' on health investments
- Some shortage in health human resources
- …….

Burden of disease in The Netherlands

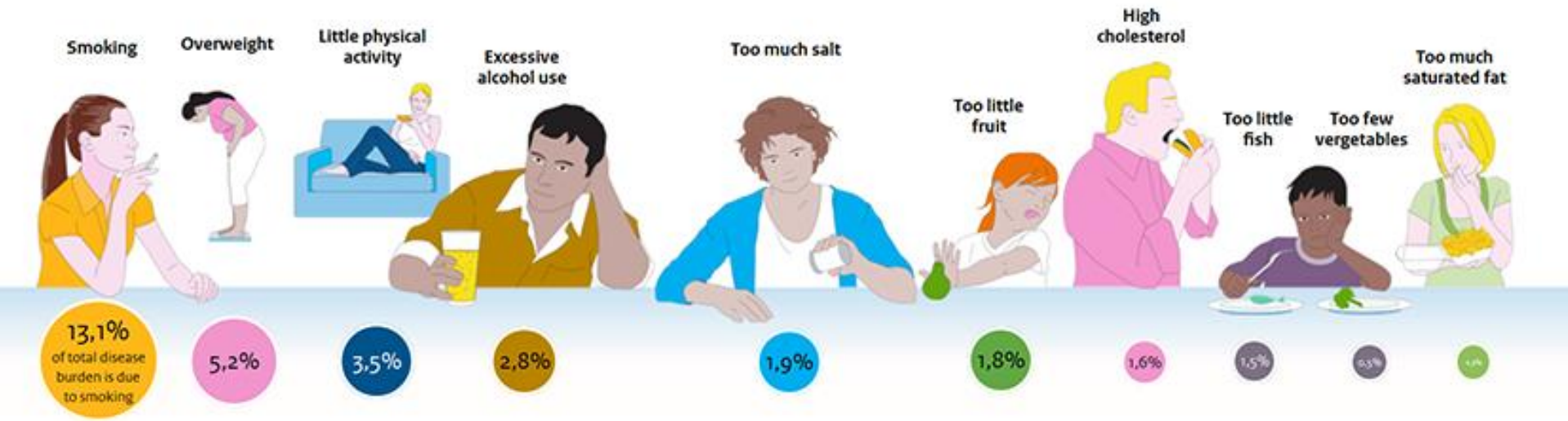




Highest burden of disease: mental disorders, cardiovascular diseases and cancer: together 70%

Source: Volksgezondheid Toekomst Verkenning 2014

Health risks

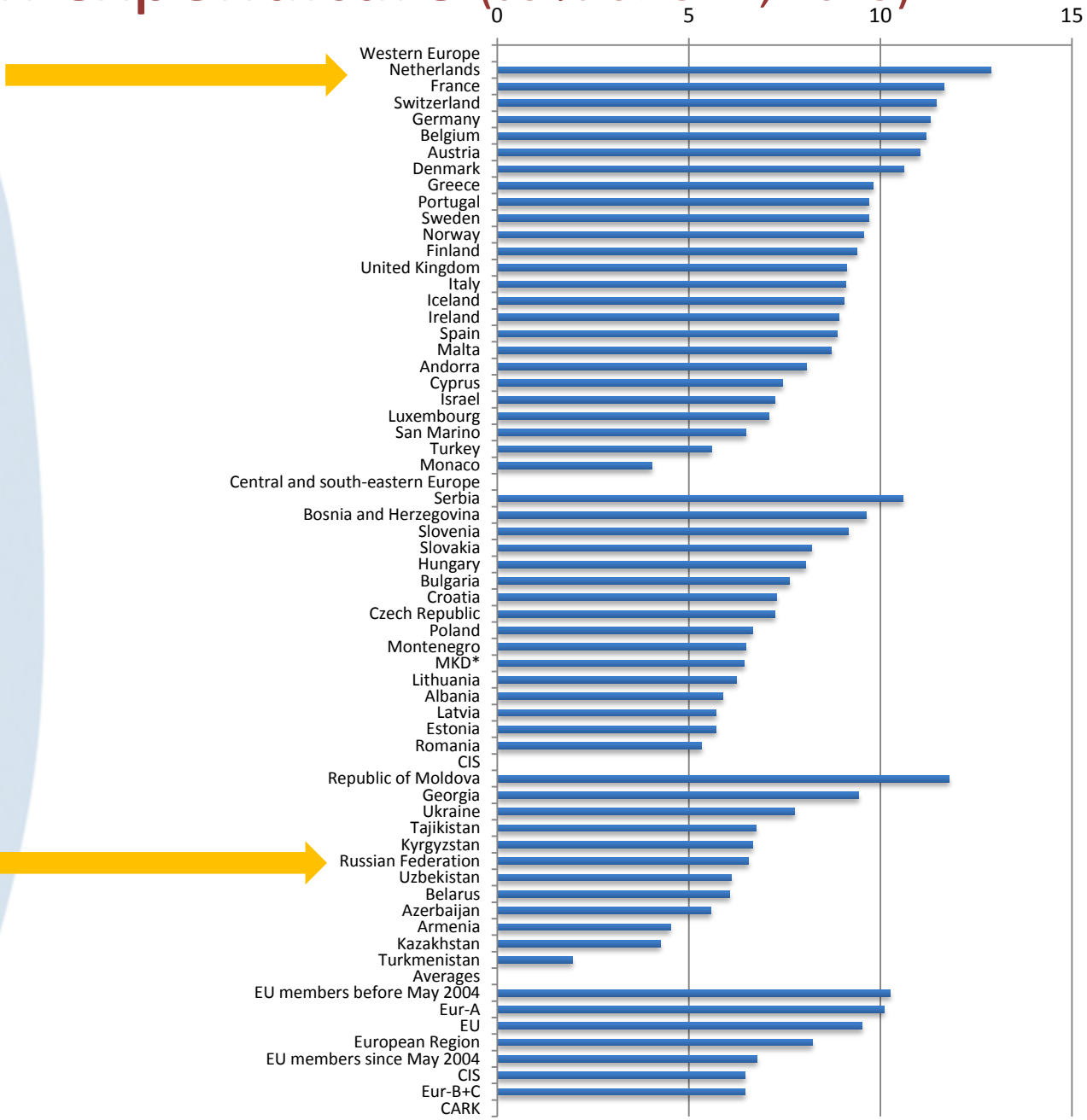


- 13% of total burden of disease caused by smoking
- 5% of total burden of disease caused by overweight

Note. % not to be added together

Source: Volksgezondheid Toekomst Verkenning 2014

Health expenditure (as % of GDP; 2015)



How to cope with the challenges?

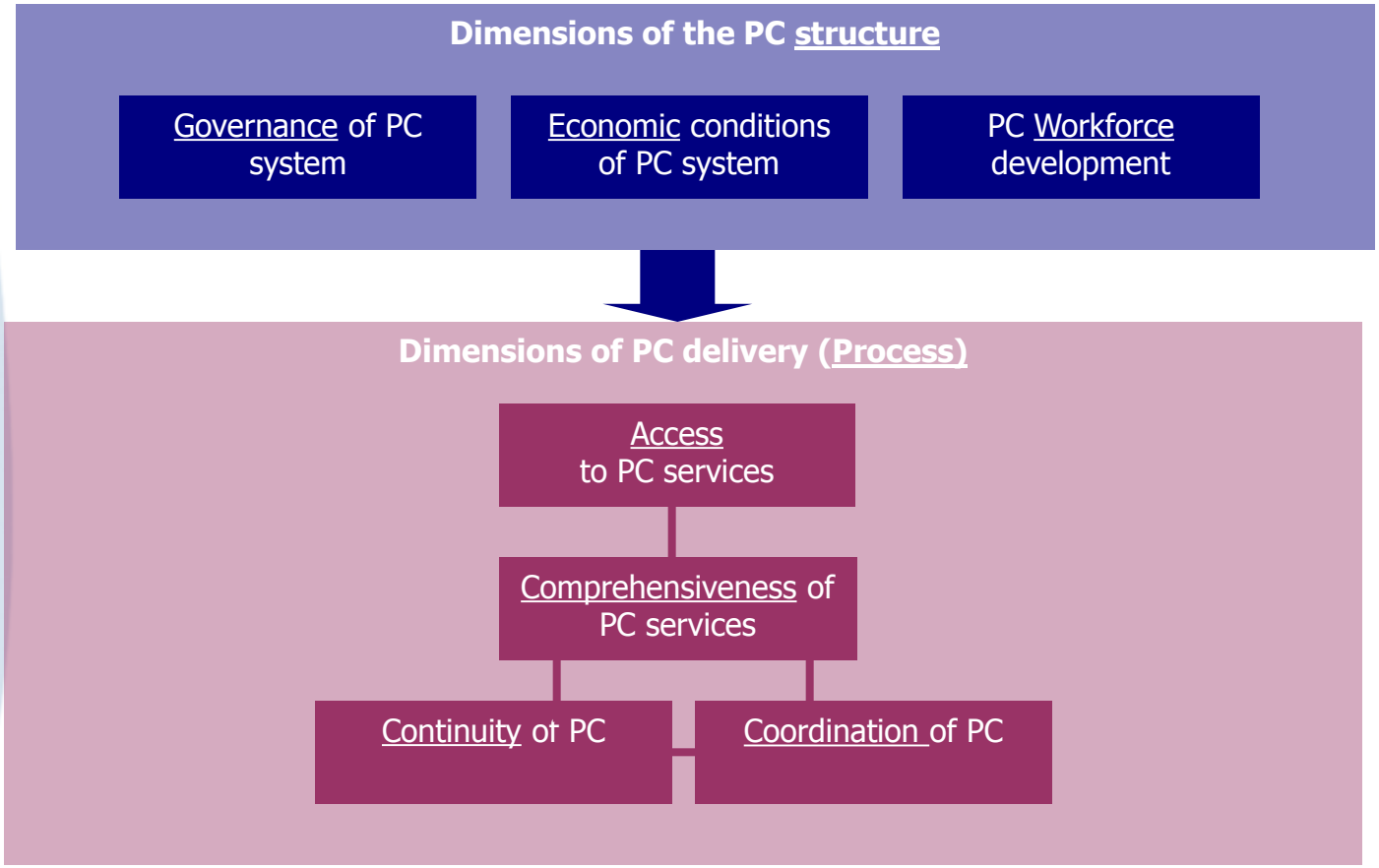
- More patient/person-centred care *(rather than disease-centred)*
- Pro-active and population-based approaches *(in addition to and combined with individual 'reactive' care)*
- Re-design of tasks (e.g. *delegation within multidisciplinary teams; bringing down traditional walls by 'transmural' care chains*)
- More focus on care coordination (between primary care and hospitals and public health)
- Better use of information and new technology

Can this be realized by strong primary care?

What is strong primary care?

indicators based on a systematic literature review

Specific functions of primary care



Kringos et al. BMC Health Services Research 2010, 10:65
http://www.biomedcentral.com/1472-6963/10/65

What strong primary care offers the health care system

- Triage and first contact care close to where people are living (community-based and small scale)
- Cost effective treatment for most conditions
- Both individual + population approaches (prevention)
- Coordination of care provided at different points in health care (less duplication)
- Accountable providers responsible for an identified population ('personal doctor')
- Limiting unnecessary – secondary – care (by a referral system)

Evidence: 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

But also:

- **Patients are not more satisfied** (less freedom of choice)
- **No lower health expenditures**

By Dionne S. Kringos, Wienke Boerma, Jouke van der Zee, and Peter Groenewegen

DOI: 10.1377/hlthaff.2012.1242
HEALTH AFFAIRS 32,
NO. 4 (2013): 686–694

Europe's Strong Primary Care Systems Are Linked To Better Population Health But Also To Higher Health Spending

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Wienke Boerma is a senior researcher at NIVEL, the Netherlands Institute for Health Services Research, in Utrecht.

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Peter Groenewegen is the director of NIVEL.

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.[1] Strong primary care is believed to contribute to high-performing health care systems, a belief that is supported by evidence to some extent.[2–4] 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.[5,6]

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.[1–4] 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?

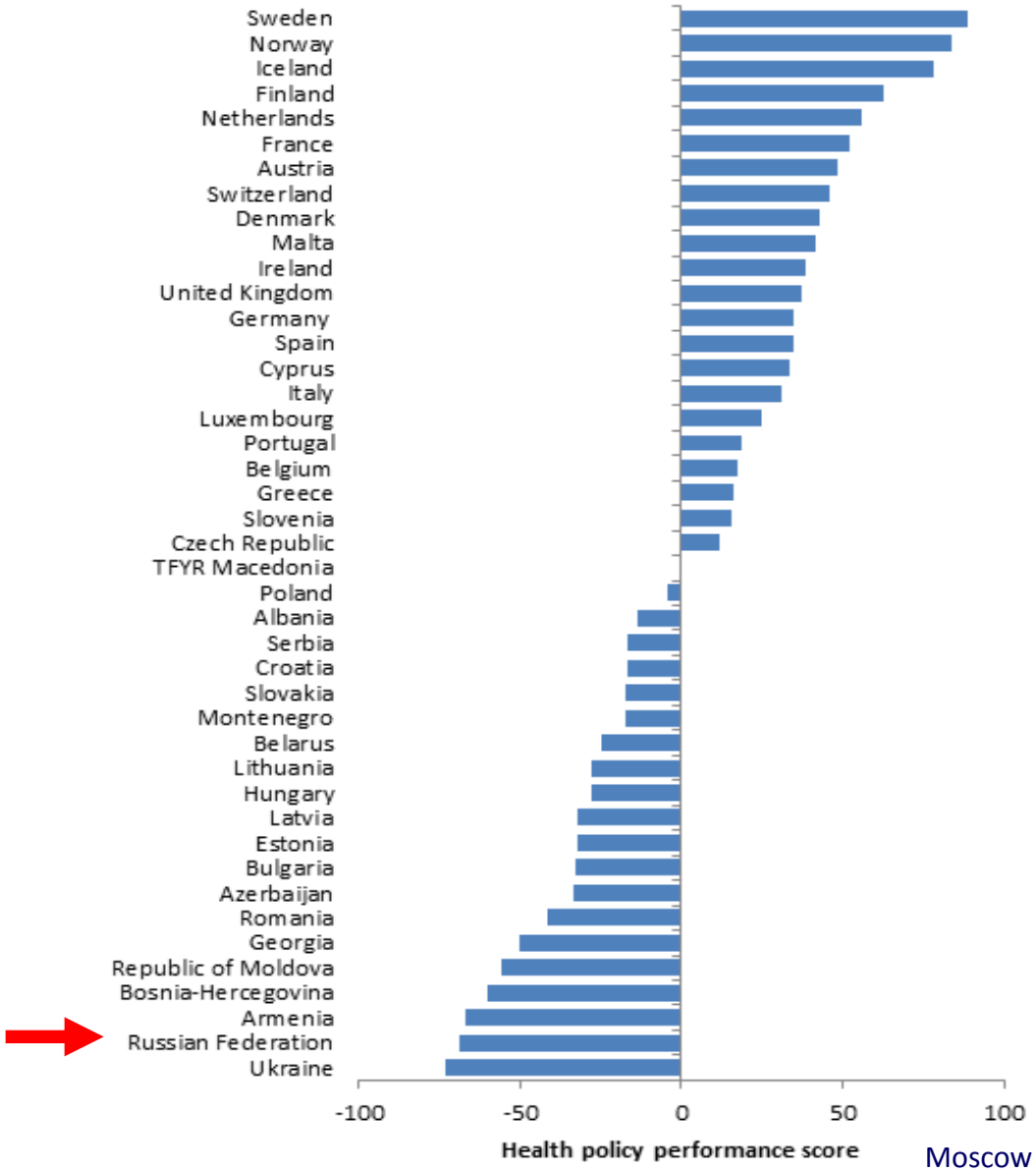
In 2009–10, as part of a European Union–funded project, the Primary Health Care Activity Monitor for Europe, we performed a systemic literature review to derive seventy-seven indicators. These measured five key dimensions of primary care: structure, access, coordination, continuity, and comprehensiveness.

Strategies to strengthen primary care

- Establish PC facilities close to where people live
- Promote continued patient-doctor relationship (personal doctor system)
- Comprehensive services provided in primary care (curative; acute and chronic; preventive)
- Teamwork and integration of services (link with hospitals)
- Adequate skill mix and medical equipment
- Specific education for PC providers (specialisation Family Medicine)
- Evidence-based practice (guidelines)
- Implement proper incentives (financial and other)
- Effective information (electronic patients records; networking with hospital and pharmacy)
- Referral system (as a condition for coordination)
- Better organized primary care out of office hours

How effective are governments in doing so?

Success of governmental prevention policies in 43 countries (source: Mackenbach & McKee, 2013)



Mackenbach & McKee (2013) A comparative analysis of health policy performance in 43 European countries. *European Journal of Public Health*

Strengthen primary care implies changing roles of actors in health care

- Governance

Showing leadership in pro-PC measures

Actively involving stakeholders (e.g. more self regulation)

More focus on 'steering' (rather than 'rowing')

- More active care purchaser / payer

Demanding better value for lower cost

Creating incentives (e.g. through selective contracting; funding outcomes rather than services

- Providers

Taking up new roles; skill mix; teamwork; networking

- Patients

More active; empowered; health literacy

Monitoring primary care with the PCET

Primary care evaluation tool (WHO)

Moscow 28 June 2017

PCET methodology

Multilevel

National governance

Documents, stakeholder survey

Stewardship
Resource generation
Financing

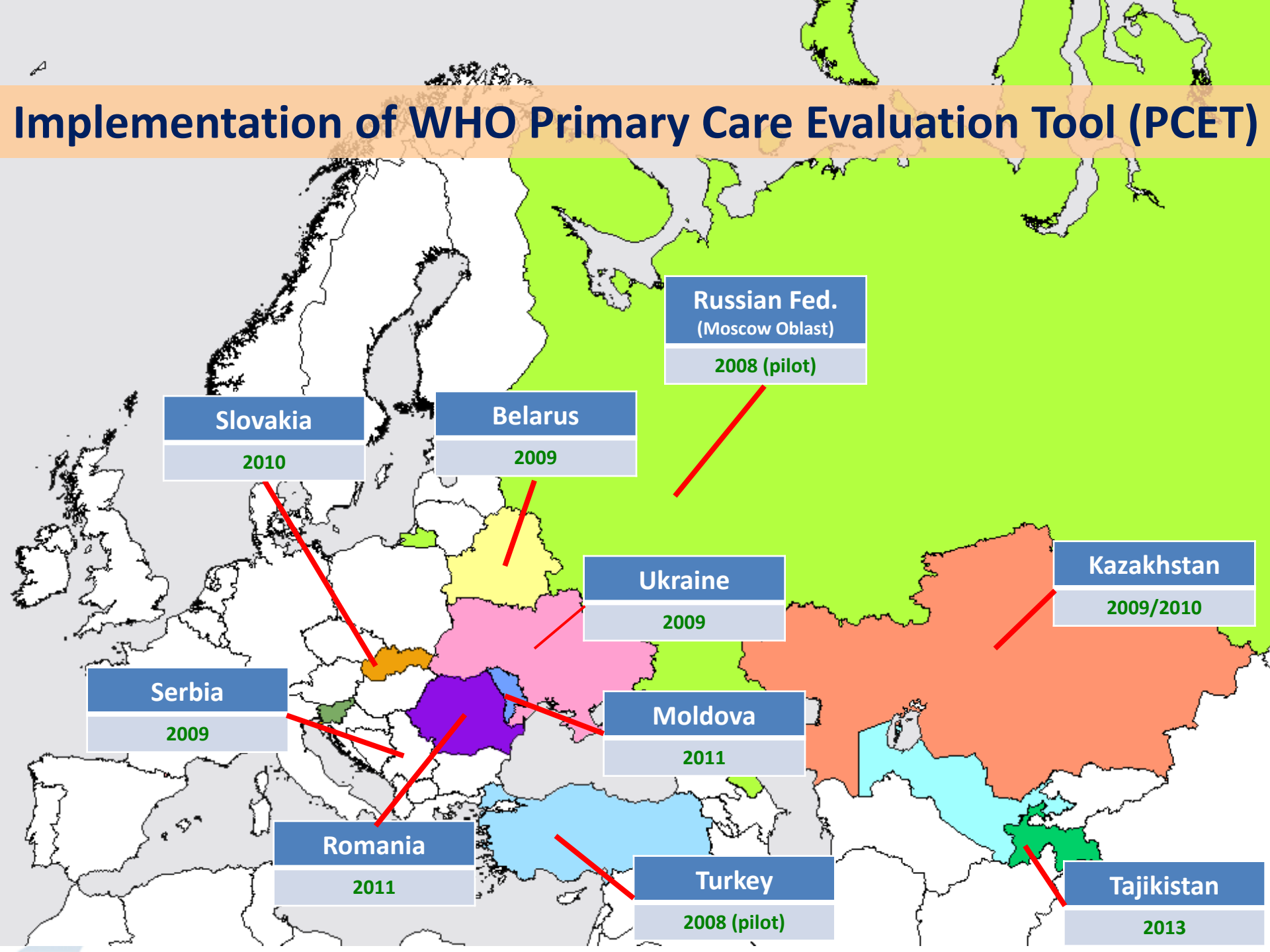
Service delivery

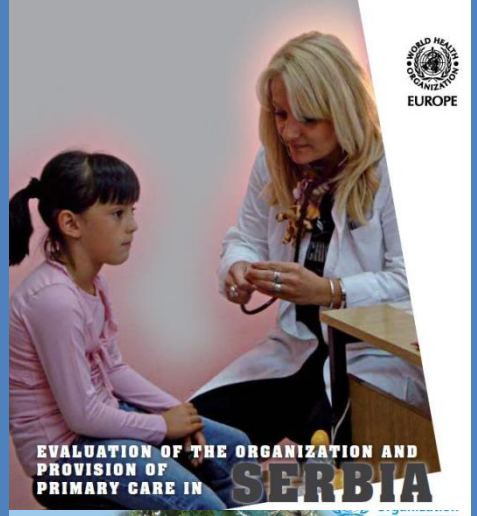
GPs, nurses, patients surveys,

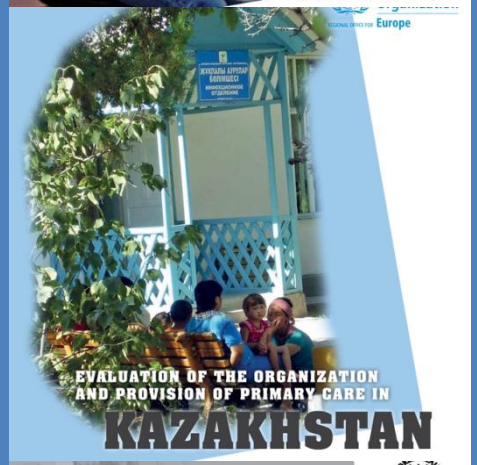
Access
Continuity
Coordination
Comprehensivenes

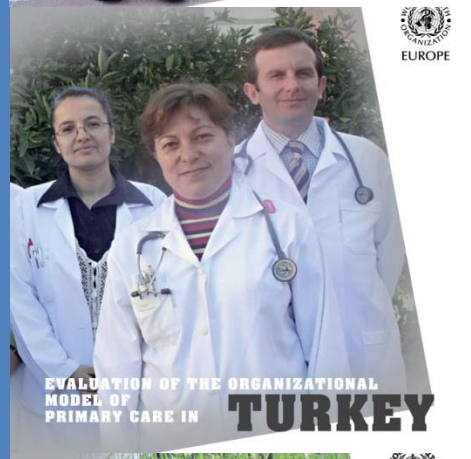
Patient experiences

Implementation of WHO Primary Care Evaluation Tool (PCET)







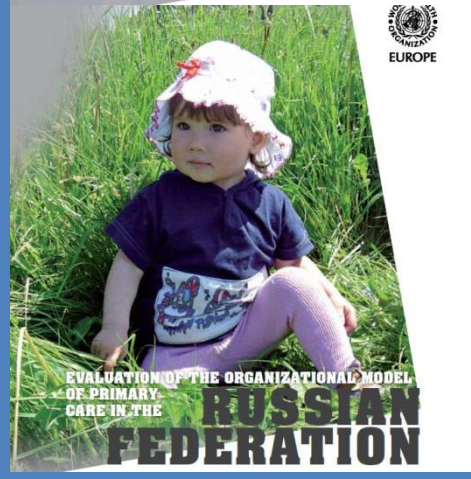


A tool to evaluate PHC in transitional countries

The PCET

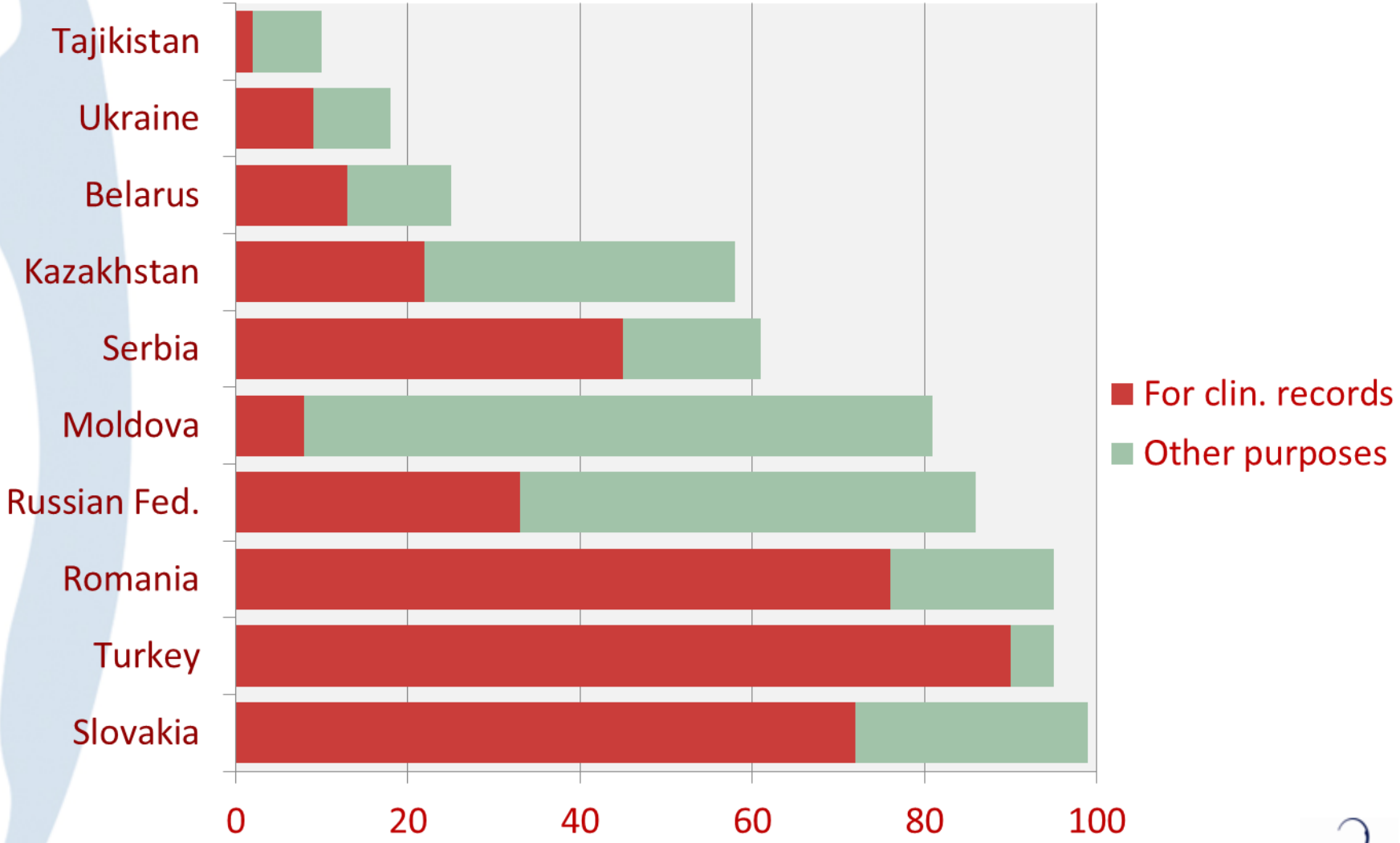
Developed for WHO Europe by NIVEL

Moscow 28 June 2017



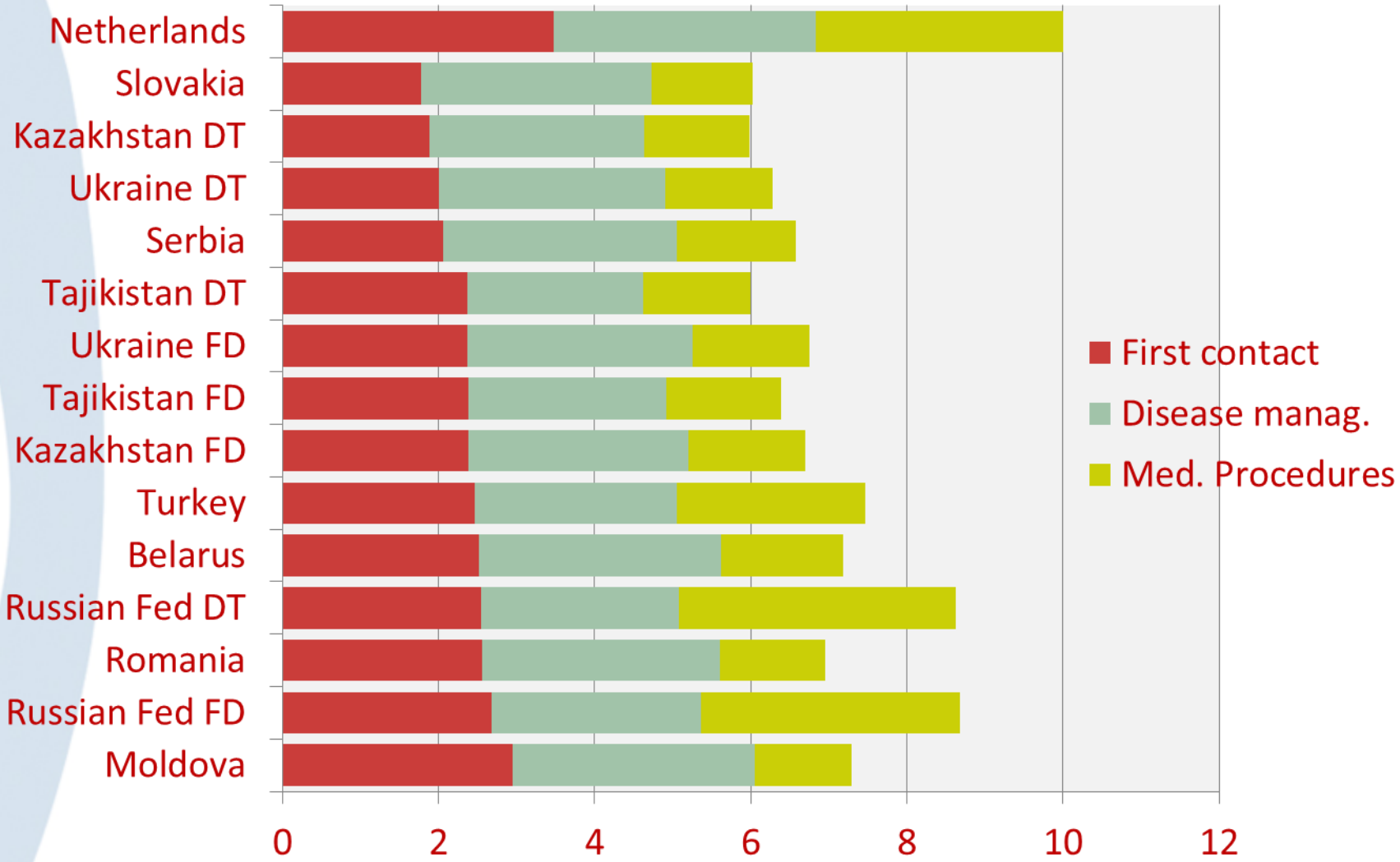
IT in PHC practice

availability and use of computers by FDs/GPs (%)



Clinical service profiles of PHC physicians

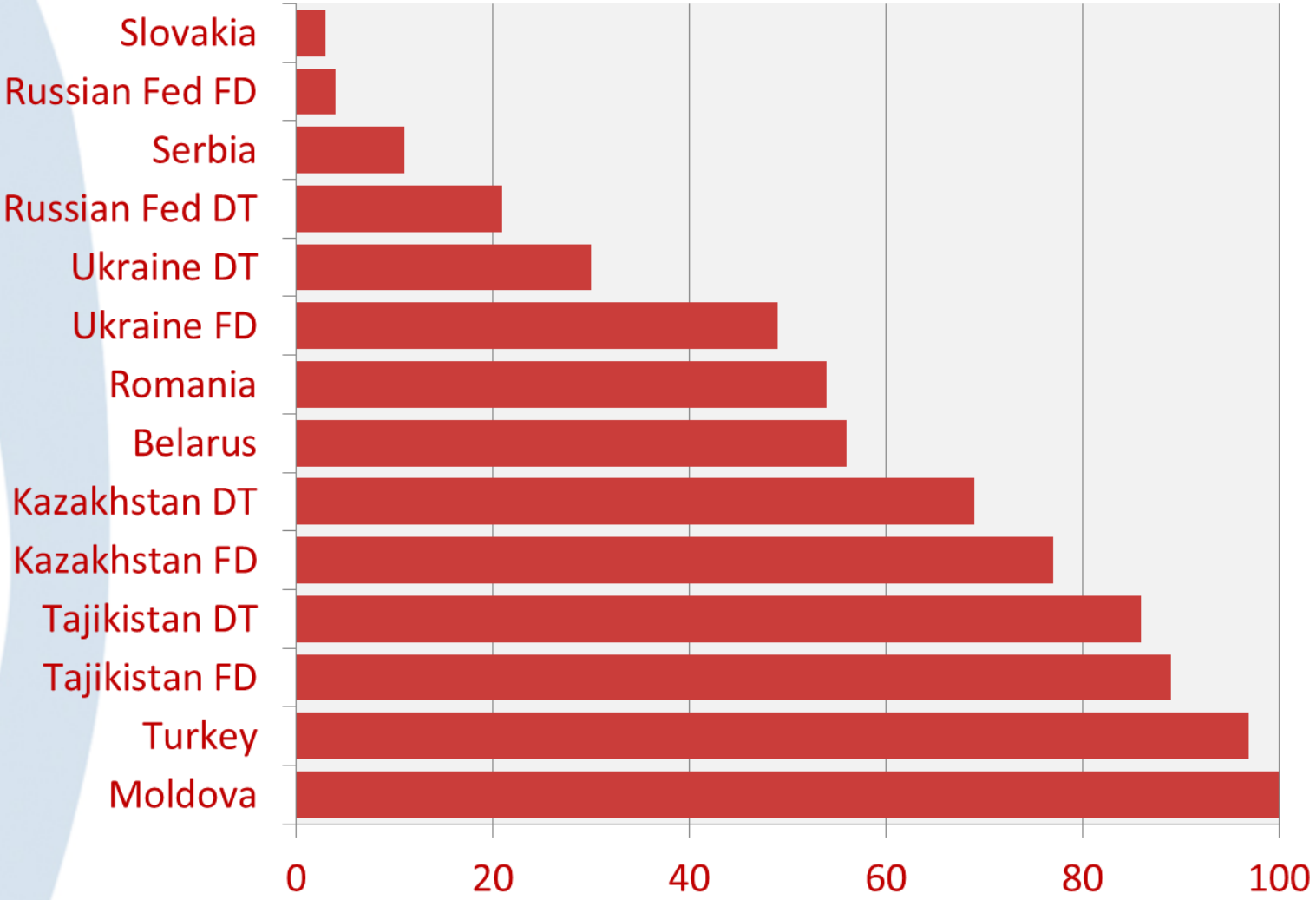
A. First contact – B. disease management – C. medical procedures



DT = Not retrained physician (e.g District Therapist)

FD = Family Doctor (retrained)

% PHC physicians involved in family planning



DT = Not retrained physician (e.g District Therapist)

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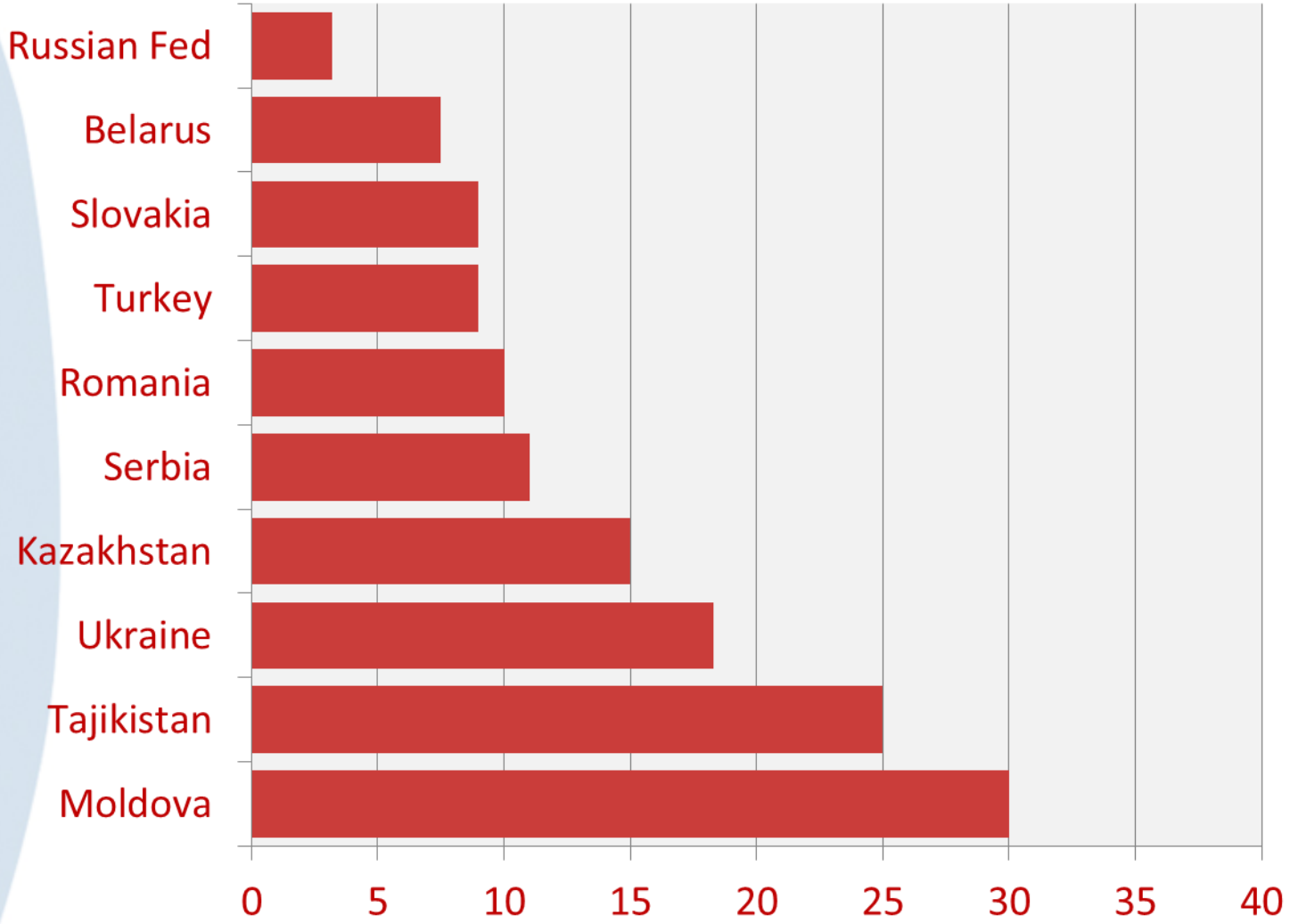
Financial barriers for patients to access PHC



% patients reporting to have delayed or abstained from a PHC visit for financial reasons (e.g. not being able to pay for prescribed medicines)

Burning issues after PCET in 10 countries

- GOVERNANCE: lack of consistent vision; weak leadership; no priority for primary care; inability to turn policies into practice; no stakeholders involved; no incentives for quality
- WORKFORCE: staff insufficiently trained for new tasks; resistance from medical universities; rural shortages; potentials of nurses insufficiently used
- MEDICAL EDUCATION: family medicine not recognised in most countries; obsolete methods, also in CME
- PROFESSIONALS: poorly organised; lack of leadership
- SERVICE DELIVERY: only limited task shifting from secondary to primary care; lack of skills and equipment; poor coordination
- INFORMATION: no practice information software available that facilitates quality of care; so, no data; no tradition and no infrastructure for monitoring/evaluation of health services
- PATIENTS: lack of trust; health litteracy under developed

Thank you

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NIVEL, The Netherlands Institute for Health Services Research

- Since 1965
- Independent, not-for-profit research institute
- Annual turnover 14 m€
  - 30% Ministry of Health
  - 70% projects
- Staff: approx. 170
- Double mission: scientific and societal
  - Links with universities
  - Links with stakeholders in health care
- WHO Collaborating Centre since 1987