Quality in Primary Care 2013;21:269–73

Guest editorial

The impact of the financial crisis on the quality of care in primary care: an issue that requires prompt attention

Christos Lionis MD PhD FRCGP(Hon)
Professor of General Practice and Primary Care, Clinic of Social and Family Medicine, School of Medicine, University of Crete, Greece

Elena Petelos BSc (Hons) MPH PhD
Research Associate, Clinic of Social and Family Medicine, School of Medicine, University of Crete, Greece and Research Fellow, Faculty of Health, Medicine and Life Sciences and Maastricht Graduate School of Governance, University of Maastricht, the Netherlands

Health systems have transitioned, over the past few decades, from an era of expansion to an era of cost-containment and, more recently, an era of outcomes.[1] Scarce resources and an ever-increasing number of healthcare innovations have resulted in the introduction of evaluation methods and mechanisms to prioritise the adoption of more effective interventions for achieving the desired outcomes. For primary care outcomes, it is more relevant to assess effectiveness jointly with quality. To that effect, the Institute of Medicine (IOM) has defined quality as 'the degree to which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge'.[2] This emphasised the central role of the patient and expanded upon the notion of desirable outcomes two decades later:

> the health care system should define safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity using measures determined by the outcomes patients desire, although clinicians should not be asked to compromise their ethical values. Desirable personal health outcomes include improvement (and prevention of deterioration) of health status and health-related quality of life, and management of physical and psychological symptoms. Desirable outcomes also include attention to interpersonal aspects of care, such as patients' concerns and expectations, their sense of dignity, their participation in decision making, and in some cases reduced burden on family and caregivers and spiritual well-being. Such outcomes can be described at both the individual level (e.g. improvement in individual health status) and the population level (e.g. reduced aggregate burden of illness and injury in a population).[3]

It is apparent from this expanded definition of desirable outcomes, that quality in healthcare can only be achieved through integrated care-delivery models, with a strong focus on promotion and prevention and well-developed, interdisciplinary primary care, and with general practice serving as the 'bedrock' of the healthcare system.[4] In addition to IOM, the World Health Organization (WHO) has highlighted the importance of focusing on health systems as a whole, and on the quality of the outcomes they produce, further noting that the principles of quality management are largely identical, independent of the country in which they are applied.[5] For this very reason, *Quality in Primary Care* has embarked on publishing a series of papers in which frameworks and tools for quality improvement in primary care are being critically examined;[6] various aspects, such as the quality components of clinical governance, including evidence-based practice, clinical audit, risk management, mechanisms to monitor the outcome of care and lifelong learning, were recently highlighted, when the political dimension for quality improvement was reported upon in the last Editorial of *Quality in Primary Care*.

Quality in primary care at a time of crisis: an existing or foregone opportunity?

We are living in an ever-changing world in which the effects of the financial crisis that has taken over Europe during the past few years raise questions about its impact on quality in primary care. There have been many papers in the literature reporting on the various

effects of the global financial crisis of the last 10 years as the loss of operational financial resources, combined with increasing unemployment and a steep rise in the cost of medicines, placed unprecedented pressure on healthcare systems.[7–12] There are even papers assessing whether the crisis may be a good thing: a comparison of health-compromising versus health-promoting behaviours stemming from the crisis in the case of Iceland highlights the increase in health-promoting behaviours, such as a reduction in alcohol and tobacco consumption, noting, nonetheless, that these effects are largely determined by price increases.[13] Thus, despite a number of reports, numerous questions remain on how quality improvement could be achieved in the context of austerity and within the rapidly changing sociopolitical and economic environment and the highly divergent cultural and contextual factors at play in many European countries, including those that the crisis has affected more gravely: Greece, Spain, Portugal, Italy and Ireland. Despite potential commonalities in these countries, where primary care was underdeveloped to varying degrees in comparison with countries like the United Kingdom (UK), the Netherlands and Scandinavia, it is important to note that the effect of the crisis can vary greatly depending on the degree of development of existing care and support structures and mechanisms; for example, whether outreach efforts utilising community and human resources for prevention and promotion had already been established, or whether national illness prevention and health promotion programmes were already implemented, in other words, the point in time when the crisis 'hit' a particular country and the corresponding, existing, degree of reform its primary care system had already undergone modulated the effect of the crisis.

Primary care physicians and the clinical practice of primary care comprising first contact, longitudinality (care over time), comprehensiveness and co-ordination have also been considered an effective means to reduce health inequalities.[14] The financial crisis has had a serious effect on all the fundamental components of primary care and a major question is how equity can be served. The financial crisis has also had a serious impact on disadvantaged groups across Europe, in Greece for example, the period of austerity has led to incidents of hostility, racism and violence against immigrants.

It is a period during which many voluntary actions have appeared in an attempt to alleviate the burden of disadvantaged groups, while the voices of scientific consortia, like that of the RESTORE project consortium, have been raised to protect the right to healthcare for all.[15] There is ample evidence suggesting that, coupled with the impact on social life and the increase in unemployment, and more particularly in youth unemployment, access inequalities will lead to increased morbidity and early mortality along with a steep rise in mental illness and suicidality, particularly in vulnerable groups.[8,16,17] We can also safely assume that these effects are not transient, but rather longer lasting, and measures to address them should take this into consideration.

General practitioners (GPs) could be instrumental in counteracting the particular effects of the crisis in these groups, but they face additional challenges at times of crises as familial discord, divorce rates and violence also increase. There is strong evidence to suggest that training and supporting primary care physicians to recognise and treat depression result in decreased suicide rates.[17,18] Consequently, mental healthcare, a sector in which resources are extremely limited and inequitably distributed in most low- and middle-income countries, could be substantially supported by well-developed primary care.[19] Mental health risks also increase greatly in high-income countries at periods of economic crisis, with some researchers suggesting that the only way to effectively prevent mental health consequences is through 'accessible and responsive primary care services support[ing] people at risk';[20] further reports indicate that expanding mental health services in primary care settings may help in coping with the increasing number of mental health disorders in areas strongly hit by the recession.[21]

Apart of the impact of the financial crisis on quality in primary care, there have recently been a strong focus and heated debate on how compromised quality of care results in serious patient safety issues, as highlighted by the Francis report.[22] More evidence is needed on the measures to be adopted and there is a need for greater transparency in procedures for greater safety. The National Patient Safety Agency in the UK National Health Service (NHS) reported on the seven steps to patient safety in general practice, the first being to build a safety culture that requires leadership, teamwork accountability, understanding, communication, awareness of workload pressures and safety systems.[23] A recent report from Cretan GPs serving rural areas highlights the impact of financial crisis on the quantity and quality of healthcare services and the threats to patient safety.[24]

The primary prevention of cancer, which is also tied to primary care and general practice, can be used as an example of where the long-term impact of the financial crisis should be examined in more detail. Researchers emphasise the importance of primary and preventive care for this leading cause of mortality, but go further, indicating that long-term planning can lead to reduced costs only through the provision of comprehensive cancer care in an integrated fashion, with screening programmes, and by utilising synergies and shared infrastructures at times of crisis.[25,26] This implies the existence of a basic network for the provision of integrated care, hopefully, benefiting from national screening programmes.

Similarly, communicable diseases, which are often neglected during periods of economic crisis, should be given particular attention. Vulnerable people represent a much larger portion of the general population during an economic downturn, and carry a disproportionately high burden of infection,[27,28] exacerbating inequalities and reducing the overall quality of care of any particular care system.

Researchers further emphasise an element of quality that is often neglected, that of sustainability in terms of both financial and human resources.[27,28] According to a recent report from the King's Fund, sustainability should be considered 'an essential dimension of quality akin to equity or accessibility, with mechanisms to monitor and hold the system to account for its environmental performance. Transformation [needed] should also involve services organized in new ways, with different components of care integrated more closely'.[29]

How do all of these factors interact to affect the quality of healthcare services? It is known that uninsured people consume fewer primary care services and this leads to a lack of continuity of care. Poor disease management thus exacerbates inequalities in healthcare provision. Barriers in access, either to healthcare services or medicines, can result in inappropriate treatment, thus compromising patient safety. Research from Italy indicates that there are commonalities, despite regional heterogeneity: priority should be given to promoting actions to counter reduced care demand and compromised access to prevention in vulnerable or uninsured groups.[30] The economic crisis also compromises the physician response to the increasing health needs of the population because it reduces the financial incentives provided, disproportionately augments workload and adversely affects professional or academic careers. Physicians and patients turn to more opportunistic and acute healthcare consumption and provision with greater use of urgent services; patient behaviour can inadvertently become a central theme in the patient consultation.

How can all of these impacts and effects of the financial crisis be discussed and addressed? Barbara Starfield's work supported focusing on meeting people's needs as expressed in their own terms and by them, rather than by professionals.[14] Patient experience is of paramount importance for high-quality outcomes. The voice of both patients and physicians appears to be neglected under the pressing conditions imposed by the financial crisis. Greece presents such a situation, where primary care remains fragmented and general practice lacks support, the necessary financial and human resources and an absence of standards, even prior to the financial crisis.[31,32] It is important to remember, however, that although the patients' own assessment of quality is essential to measuring primary care quality, it cannot replace the need for records-based measures of good clinical practice.[33]

This Editorial raises questions on a number of issues that have been brought about by the financial crisis and its implications for quality delivery. The extent to which this painful period may ultimately prove to be an opportunity for the introduction of interventions that will achieve high-quality integrated primary care remains to be seen. However, all the ingredients to build and implement standards of quality and patient safety, and to establish the right indicators to measure the successful implementation of interventions, are lacking in most European settings affected by the financial crisis. A final question, which has been much less examined, is how feasible is it to change the existing practice culture to respond to the crisis and the challenges it poses? A recently published paper, with a focus on the Greek case, discusses the essential elements of a primary healthcare reform that should follow the economic crisis, but more research focusing on the transferability of interventions and evidence-based reform measures are required.[34]

A shift in the healthcare system to primary care is also a frequent political statement, but there are many questions to be answered when such a policy is intended for implementation in countries where, even prior to the crisis, primary care was underdeveloped and often ineffective, with lack of continuity and integration being majors issues. Decision-makers and politicians should, of course, be informed by relevant research and scientific expertise; the mix of primary care and high technology is bound to keep changing as the two become more intertwined, making health technology assessment and appraisal much more complex.

Patients and physicians can do a lot to contribute towards a professional and public mandate in the direction of improved quality. A fundamental shift in the level of public engagement in health is key for people to learn how to use primary care and self-care more effectively and efficiently, and to allow for large gains to be made in the longer term by refocusing health services towards prevention, health promotion and early detection, as recently highlighted by the Wanless report.[35] It is clear that the financial crisis requires the voice of both GPs and patients in a concerted effort to establish and maintain standards of quality of care. It is, therefore, perhaps more relevant than ever before to reflect upon the words of Avedis Donabedian:[36]

> I believe, with a passion, that, at heart, the best interests of healthcare practitioners and consumers are congruent and that the political system will be the most responsible to quality enhancement when healthcare professionals and consumers present a united front. It is, therefore, necessary that individual practitioners be always completely open and truthful with their patients about the ways in which public policy shapes what they are able to do. How else could patients act intelligently in their other role: as citizens in a democracy?

REFERENCES

1 Relman AS. Assessment and accountability: the third revolution in medical care. *New England Journal of Medicine* 1988;319(18):1220–2.

2 Institute of Medicine. Lohr KN (ed) *Medicare: a strategy for quality assurance*. Volume I. National Academy Press: Washington, DC, 1990.

3 Institute of Medicine. *Crossing the Quality Chasm: a new health system for the 21st century*. National Academy Press: Washington, DC, 2001.

4 Baker R. King's Fund report on improving the quality of care in general practice. *BMJ* 2011;342:d1932. doi: 10.1136/bmj.d1932

5 Bengoa R, Kawar R, Key P, Leatherman S, Massoud R and Sturno P. *Quality of Care: a process for making strategic choices in health systems*. World Health Organization Press: Geneva, 2006, pp. 1–50.

6 Gilam S and Siriwardena AN. A primer for quality improvement in primary care. *Quality in Primary Care* 2013;21:1–4.

7 Suhrcke M, Stuckler D, Suk JE *et al.* The impact of economic crises on communicable disease transmission and control: a systematic review of the evidence. *PLoS One* 2011;6(6):e20724. doi: 10.1371/journal.pone.0020724. Epub 2011 Jun 10.

8 Kentikelenis A, Karanikolos M, Papanicolas I, Basu S, McKee M and Stuckler D. Health effects of financial crisis: omens of a Greek tragedy. *The Lancet* 2011;378(9801):1457–8. doi: 10.1016/S0140–6736(11)61556–0. Epub 2011 Oct 9.

9 Sargent-Cox K, Butterworth P and Anstey KJ. The global financial crisis and psychological health in a sample of Australian older adults: a longitudinal study. *Social Science & Medicine* 2011;73:1105–12. doi: 10.1016/j.socscimed.2011.06.063. Epub 2011 Jul 27.

10 Notara V, Koulouridis K, Violatsis A and Vagka E. Economic crisis and health. The role of the health care professionals. *Health Science Journal* 2013;7:149–54. E-ISSN: 1791–809x.

11 Karanikolos M, Mladovsky P, Cylus J *et al.* Financial crisis, austerity, and health in Europe. *The Lancet* 2013;381(9874):1323–31. doi: 10.1016/S0140–6736(13)60102–6. Epub 2013 Mar 27.

12 Portela C and Thomas S. Impact of the economic crisis on healthcare resources: a European approach. *International Journal of Healthcare Management* 2013. doi: http://dx.doi.org/10.1179/2047971913Y.0000000038

13 Asgeirsdóttir TL, Corman H, Noonan K, Olafsdóttir T and Reichman NE. Was the economic crisis of 2008 good for Icelanders? Impact on health behaviors. *Economics & Human Biology* 2013. doi:pii: S1570–677X(13)00032–4. 10.1016/j.ehb.2013.03.005 [Epub ahead of print].

14 Starfield B. Primary care and equity in health: the importance to effectiveness and equity of responsiveness to people's needs. *Humanity and Society* 2009;33:56–73.

15 O'Donnell C, Burns N, Dowrick C *et al.* The hidden impact of austerity on migrants: health care for migrant populations in Europe. *The Lancet* 2013;382(9890):393.

16 Ifanti AA, Argyriou AA, Kalofonou FH and Kalofonos HP. Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care. *Health Policy* 2013. pii: S0168–8510(13)00154–1. doi: 10.1016/j.healthpol.2013.05.017 [Epub ahead of print].

17 Economou M, Madianos M, Peppou LE, Theleritis C, Patelakis A and Stefanis C. Suicidal ideation and reported suicide attempts in Greece during the economic crisis. *World Psychiatry* 2013;12(1):53–9. doi: 10.1002/wps.20016

18 Mann JJ, Apter A and Bertolote J. Suicide prevention strategies: a systematic review. *JAMA* 2005;294:2064–74.

19 Saxena S, Thornicroft G, Knapp M and Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet* 2007;370(9590):878–89.

20 Wahlbeck K and McDaid D. Actions to alleviate the mental health impact of the economic crisis. *World Psychiatry* 2012;11(3):139–45.

21 Gili M, Roca M, Basu S, McKee M and Stuckler D. The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. *European Journal of Public Health* 2013;23:103–8. doi: 10.1093/eurpub/cks035. Epub 2012 Apr 19.

22 Francis R. *Report of the Mid Staffordshire NHS Foundation Trust, Public Inquiry – Executive summary*. The Stationery Office: London, 2013.

23 National Health Service National Patient Safety Agency. *Seven Steps to Patient Safety in General Practice* 2009. www.nrls.npsa.nhs.uk/resources/?entryid45=61598

24 Tsiligianni I, Anastasiou F, Antonopoulou M *et al.* Greek rural GPs' opinions on how financial crisis influences health, quality of care and health equity. *Rural and Remote Health* 2013;13:2528.

25 Martin-Moreno JM, Alfonso-Sanchez JL, Harris M and Lopez-Valcarcel BG. The effects of the financial crisis on primary prevention of cancer. *European Journal of Cancer* 2010;46(14):2525–33. doi: 10.1016/j.ejca.2010.07.048

26 Martin-Moreno JM, Anttila A, von Karsa L, Alfonso-Sanchez JL and Gorgojo L. Cancer screening and health system resilience: keys to protecting and bolstering preventive services during a financial crisis. *European Journal of Cancer* 2012;48(14):2212–18. doi: 10.1016/j.ejca.2012.02.060. Epub 2012 Mar 15.

27 Rechel B, Suhrcke M, Tsolova S *et al.* Economic crisis and communicable disease control in Europe: a scoping study among national experts. *Health Policy* 2011;103(2–3):168–75. doi: 10.1016/j.healthpol.2011.06.013. Epub 2011 Aug 4.

28 Stuckler D, Basu S, Suhrcke M, Coutts A and McKee M. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *The Lancet* 2009;374(9686):315–23. doi: 10.1016/S0140–6736(09)61124–7. Epub 2009 Jul 7.

29 Naylor C and Appleby J. *Sustainable and Social Care: connecting environmental and financial performance*. The King's Fund: London, 2012.

30 de Belvis AG, Ferrè F, Specchia ML, Valerio L, Fattore G and Ricciardi W. The financial crisis in Italy: implications for the healthcare sector. *Health Policy* 2012;106(1):10–16. doi: 10.1016/j.healthpol.2012.04.003. Epub 2012 Apr 30.

31 Lionis C, Symvoulakis EK and Vardavas CI. Implementing family practice research in countries with

limited resources: a stepwise model experienced in Crete, Greece. *Family Practice* 2010;27:48–54.
33 Sbarouni V, Tsimtsiou Z, Symvoulakis E *et al.* Perceptions of primary care professionals on quality of services in rural Greece: a qualitative study. *Rural Remote Health* 2012;12:2156.
33 Rao M, Clarke A, Sanderson C and Hammersley R. Patients' own assessments of quality of primary care compared with objective records based measures of technical quality of care: cross sectional study. *BMJ* 2006;333(7557):19.
34 Kousoulis AA, Symvoulakis EK and Lionis C. What Greece can learn from UK primary care experience and empirical research. *British Journal of General Practice* 2012;62(603):543.
35 Wanless D. *Securing Good Health for the Whole Population*. HM Treasury: London, 2004. www.hm-treasury.gov.uk
36 Donabedian A. The Lichfield Lecture. Quality assurance in health care: consumers' role. *Quality in Health Care* 1992;1:247–51.

CONFLICTS OF INTEREST

None declared.

ADDRESS FOR CORRESPONDENCE

Professor Christos Lionis, Clinic of Social and Family Medicine, School of Medicine, University of Crete, PO Box 2208, 71003, Heraklion, Crete, Greece. Email: lionis@galinos.med.uoc.gr

Received 26 July 2013
Accepted 30 July 2013