Quality in Primary Care 2009;17:133–43

International exchange

The organisation of primary care in Europe: Part 1 Trends – position paper of the European Forum for Primary Care

Geoffrey Meads PhD MA(Oxon) MSc(Tech)
Hon Professor of International Health Studies, Institute of Health Sciences Research, Warwick Medical School, UK

ABSTRACT

Aim To describe and classify contemporary organisational developments in primary care across Europe.
Method Ten case studies have been undertaken at local sites which are exemplars of organisational practice nominated by national leaders and international experts. The selection is informed by a comprehensive literature and documentary review, with expert advice from members of the European Forum for Primary Care.
Results A profile of organisational development trends is indicated, confirming the status of the extended general practice, the growth in managed care enterprises and the omission of service models prominent in other continents.
Conclusion The risks as well as the opportunities arising from the enlargement of Europe, with its vulnerable polyclinic and medical cabinet models, are highlighted, with further discussion and analysis to follow in Part 2 of the position paper.

Keywords: Europe, organisation, policy, primary care

Introduction

This paper is an edited version of a position paper produced for the European Forum for Primary Care (EFPC). Its aim is to examine a representative range of organisational developments across Europe and to identify the contemporary position of primary care in relation to these. In Part 1 the focus is a series of case studies that exemplify current trends in national policies. In Part 2 a detailed analysis and discussion follows.

The need for an EFPC position statement arises from the accelerated and radical nature of recent organisational changes across European primary care settings. The scale of these has increased during the period that followed the assumption of public health responsibilities in Article 152 of the 1999 Amsterdam Treaty, and the resultant first European Union and the World Health Organization (WHO) regional health strategies.[1,2] Making sense of such changes is important if they are to be understood not just in terms of their economic determinants, but also as organisational developments with the potential to either reinforce or undermine a particular philosophy of service. The values inherent in this philosophy have meant that primary care has signified in the past more than simply a literal first point of health services contact, albeit one that is outside of hospital. Rather it has meant a generalist and personalised approach which is both comprehensive and longitudinal and which appreciates presenting individual illness as something more than just formal disease. As a result, its effective practice has required negotiated interventions which are based on a sensitive awareness of a patient's context and relationship patterns, as much as they are on data derived from scientifically labelled conditions and specialist clinical procedures. A fundamental organisational issue today is whether or not the contemporary innovations to organisational structures and processes will permit such practice to continue. How this issue is addressed may help decide whether or not, at the continental level, new policy initiatives are considered either necessary or even desirable to combat alternative emergent service philosophies for primary care.

Approach

This paper has drawn on the database resource for international 'transferable learning' at the University of Warwick (UK). This consists of 320 relevant reports and articles, covering the period from 1997 to 2006, on global primary care developments.[3] For the present paper this has been augmented by a review of subsequent publications, and individual country profiles from the European Observatory on Health.[4] Of these, the most significant is the December 2006 volume entitled *Primary Care in the Driver's Seat*.[5] This authoritative book reviews contemporary reforms in primary care. Its thematic analysis addresses three principal organisational developments arising from different countries' new institutional arrangements. These are the emergence of new public–private provider combinations; the growth in primary care-based commissioning agencies; and innovations in cross-boundary collaboration for more integrated service delivery.[6–8] The observatory text was produced by 31 national and international experts, and this paper seeks to build on its analysis.

A number of the chapters in *Primary Care in the Driver's Seat* contain interesting illustrative case studies.[9,10] The second source of data for the present paper is, similarly, sets of interviews and observation visits to local country sites deliberately selected for the purpose of preparing case studies. These are intended to accurately indicate the scope and direction of modern organisational developments in European primary care. These case study accounts, in abbreviated form, are set out below and the interview topic guide is summarised in Box 1. There are ten in number, which is in line with the number originally selected this year by the WHO in its commemorative publications for the 30th anniversary of the seminal *Alma Ata* declaration.[11] Significantly, only one of the final 12 sites chosen by the WHO is in Europe.[12]

Each site was nominated as an exemplar of modern organisational practice in primary care by the national policy and professional leaders interviewed in the research done either for this paper or for its preceding articles.[13] The countries covered through case studies are: Finland, Portugal, Greece, the Czech Republic, the Macedonian Republic, Ireland, Poland, Italy, Hungary and England, with the profile of countries determined in conjunction with EFPC expert advisors. The studies are evenly spread across eastern, central and western European sites. The intention is to reflect the notion of shared learning that is important even at the stage of methodological development. This is especially pertinent in 2008 when the challenge for western European states is to extend their majority middle class service models of primary care to marginal and minority population groups, while for eastern and central European countries it is precisely the other way around.

Box 1 Topic guide: the organisation of primary care in Europe

1 *Organisational philosophy*: ideas, concepts, values, ethics
2 *Organisational form*: structures, processes, markets, systems
3 *Organisational relationships*: interprofessional, inter-agency, generalist/specialist, public/private
4 *Policy*: decision-making forums/actors, central/local/international, formative influences – internal and external
5 *Research*: priorities, applications, deficits, participants
6 *Europe*: influences, benefits, opportunities, disadvantages, obstacles, issues, prospects

The theoretical stance of this paper favours contextual forces as the decisive variable in the organisational development of primary care. This stems from earlier international research which, for example, emphasised how critical 'sense of place' is in converting health policies into primary care practice,[14] and how the long-term 'enabling influences' of local civic cultures prevail over shorter-term 'predisposing' and 'precipitating' factors, such as management restructuring exercises and political crises, as prerequisites for major change in community settings.[15]

Organisational framework

The earlier Warwick research identified a global classification of six primary care organisations, distinguished from each other conceptually by their separate forms of governance, their different ethical underpinnings and service orientations, and their distinctive physical premises and vocabularies. For example, the extended general practice typically has a simple structure of professional partners for its governance, with services geared to its registered patients and a classic normative value base of public obligation. By contrast, the reformed polyclinic, is usually structured around medical specialists with a private business orientation that connects its commercial value base to its clients. Similarly, the competitive modern managed care enterprise has a structure that accommodates many investors calculating the dividends to be derived from particular performance targets, while the district health system is a bureaucratic collaboration in pursuit of overall population benefit. Table 1 provides a summary of the alternative models.

Table 1 Categories of primary care organisation

Organisational type	Structure and process	Value base	Service focus	Location (examples)	Endpoint	Countries (examples)
Extended general practice	Simple, partnership	Normative	Registered patient list	Health centre	Patient	Finland, Portugal, Greece
Managed care enterprise	Complex, stakeholder	Calculative	Target groups	Physicians' group	User	Ireland, Italy, England
Reformed polyclinic	Coalition, divisional	Commercial	Medical conditions	Multi-specialist clinic	Client	Macedonian and Czech Republics
Medical cabinet	Self-employed, independent	Professional	Maintenance	Municipal premises	Attendees	Hungary
District health system	Hierarchic, administrative	Executive	Public health improvement	General hospital	Populations	N/A
Community development agency	Association, network	Affiliative	Local populations	Health stations	Citizen	N/A
Franchised outreach	Quasi-institutional, virtual	Remunerative	Payers	Private, hospital premises	Customer	Poland

The six organisational types are: the extended general practice, the managed care enterprise, the reformed polyclinic, the outreach franchise, the community development agency and the district health system. Table 1 provides a summary of their main characteristics, which are then explained in turn in more detail at the beginning of the case studies themselves. The summary includes an additional seventh organisational model which is prevalent in European settings: the medical cabinet. In practice, of course, there is often an overlap between the different organisational types within individual countries. In Europe, nevertheless, the interaction between the different models between 2002 and 2009 is largely confined to the first five in the list. By contrast, the organisational mode of the WHO's ten chosen case studies in 2008 is overwhelmingly that of the community development agency or the district health system, which prevail in Latin America and sub-Saharan Africa.

Organisational developments

The studies that follow are snapshots that seek to represent the organisation of primary care between 2002 and 2009 in Europe. The ten exemplar sites selected are three extended general practices (from Finland, Portugal and Greece), three managed care enterprises (from Ireland, Italy and England), two reformed polyclinics (from the Macedonian and Czech Republics), one medical office (from Hungary) and one outreach franchise (from Poland). The descriptions are presented, initially by type, with a local examplar that represents the particular organisational model, and then in the chronological order of their studies. Each account is a synthesis of standardised interview data derived from a minimum of six interviews with a central policy maker, two lead professionals and an academic expert, and two local practice directors. While every effort has been made to ensure accuracy, inevitably all will have details that will be out of date by the time of publication. They are largely written in the present tense for literary effect and consistency. As their variety and energy indicate, the organisational developments of modern primary care in Europe are nothing if not dynamic.

Kangasala (Finland): extended general practice

Arguably a world best,[16] the Kangasala Health Centre is the extended general practice writ large. In this partnership model of a primary care organisation, the defining characteristics are a site-based interprofessional team in which the general medical practitioners and their demand-led registered lists of individual local patients are the pivotal points, around which services are accumulated. The healthcare approach is holistic and contextual, taking into account especially family circumstances, offering a personal and longitudinal service that includes social care and local therapists.

Accordingly at Kangasala, in central Finland, the 28 GPs practise in partnership with groups of social workers, psychologists and physiotherapists. The registered lists total over 30 000 and the local imagery of 'service circles' and 'care chains' captures the emphasis laid on good co-ordination between health and social care professionals. This applies particularly to the management. On the partnership board, the GP director and lead nurse are joined by seven elected councillors with social services responsibilities, from five of Finland's 481 municipalities. Three are from the host municipality which owns the centre and provides 70% of the funding and the staff contracts. As a result leadership is strategic. Primary care is the entrance to both community health and community contributions. The centre holds the main local occupational health contracts. It attracts people's charity tax contributions and co-payments, plus research funds from the nearby Tampere University. Staffing includes six environmental and animal welfare officers and no fewer than 16 oral health staff and 36 public health nurses. The GPs themselves are the only doctors, and firmly generalist, but their range of specialties extends from paediatrics to orthopaedics, allowing them to provide the specialist medical cover themselves for 82 attached inpatient beds, which have a norm of 2–3 days' length of stay. The quality of care is safeguarded through the 'knowledge' facilitation of STAKES, the national research and development institute which upholds its independence from the Helsinki government through multi-municipality and private funding sources.

In terms of Finland's post 2002 'modernising' nationwide Health Project, Kangasala seems to have it all. Of course there are other agendas as well. Not all of the country is as well provided for as Kangasala, with deficits in the number of general practitioners (GPs) indicating the weakness of the municipality as a management unit in rural areas. Consensus change also requires long lead-in times and, even with these, in Helsinki primary care remains very much the junior partner for the university's medical faculties and political elites. Nevertheless, it is this Nordic experience of organisational development in primary care that sets the pace for Europe.

Dublin (Ireland): managed care enterprise

The performance management of market mechanisms to improve both cost and clinical effectiveness defines the essence of managed care. These mechanisms include independent regulation of separate purchaser and provider functions, the application of evidence-based medicine techniques, and a total resource management approach which disregards sectoral and professional boundaries. The managed care enterprise enhances value by locating primary care within a general management context, which then acquires the commissioning responsibilities for secondary and, in some instances, social care.

South of Dublin's city centre, in a temporary building, is the new Liberties Primary Care Team. Adjacent to it, in the converted wing of the old Meath Hospital are the offices of the Inner City Primary Care Partnership. Down the road is the Local Health Office of the central Health Service Executive (HSE), which commissions both the team and the partnership, and operates itself at strategic level in 'social partnership' agreements with other service ministries, following the abolition in Ireland of intermediate-tier regional health boards in 2005. The HSE also pays for all public hospital services covering the whole population. Its 2003–2006 primary care strategy was designed to control this burgeoning expenditure, and the 'liberties' initiative was one of ten national pilots. In a country where all GPs and 65% of patient registrations are private, its aim was to combine independent primary care practitioners with National Health Service staff into community-based integrated care services, and to diminish the future public expenditure commitment.

The HSE commissioning of the relationship between the Liberties Primary Care Team and the Inner City Primary Care Partnership brings together two separate general medical practices totalling six GPs and three practice nurses under a common administrative umbrella with the Inner City Partnership's public health nurses, psychologists, physiotherapists, occupational therapists, planners and care staff. For the partnership this brings access to the registered patient lists and medical skills; for the general practices the partnership brings opportunities to expand and attract both more capitation payments and HSE local 'quality' contracts and fees. The result is a shared database for HSE commissioning purposes and new community-based diabetes, wound, rehabilitation and day treatment clinics that substitute for previous hospital care.

In 2008–2009, four further managed care enterprises are in the pipeline, covering 140 000 Dubliners. The next in the disadvantaged Piers Street area does not have to rely on recycling an old public hospital. A local charity, the Baggot Trust, is supplying the premises. At the local health office the commissioning manager describes the change as a 'transformation'. Up the road at the Grafton Medical Centre, the GPs are not so sure. For them a managed care enterprise is still a small surgery with lucrative travel health facilities and multiple private registrations. Down the road at the National University of Ireland, the facilitation of the HSE proposed new multiprofessional teams is gaining a mixed response. Nurses and therapists attend the workshops, but many local GPs do not. A differential market is emerging.

Skopje (Macedonian Republic): reformed polyclinic

With its roots in the Soviet *Semashko* model, this organisational development has witnessed the unexpected conversion of the multi-medical specialist service model, geared to acute service interventions, into multi-healthcare practitioner direct access units with a general primary care remit, in unexpected places. Sydney and Santiago can be counted amongst these: 10 000 miles away from the original Muscovite designers.[17] Nowadays the polyclinic offers governments the scope to prescribe specific packages of preventive health care and clinical risk management, and to ensure their delivery to targeted population groups through both private contractors and public service professionals.

For the economic development of the Republic of Macedonia, reforming the polyclinics of the traditional and heavily bureaucratic city-wide Health House offers a way into the creation of a commercial business sector. The Aerodrom Health Home in Skopje is still national government owned and managed, but since 2004 it has accommodated three GPs who, by 'concession' have private status. The home has a 120 000 population catchment area and three tiers of professions accredited by the national medical chambers. The 20 old specialist clinics in the home are all at level two: dermatology, neurology, ophthalmology, radiology, etc. At this level, all clinicians are state employees still and salaries are depressed. Aerodrom now has co-leadership from a financial as well as a medical director, and most of the current monetary incentives are directed deliberately at level one, including capitation payments for the first time for GP-registered patient lists.

The results are becoming apparent across Skopje. There are now 700 Macedonian GPs with concessionary independent status in contract with the National Health Insurance Fund. As their numbers grow, so do their terms of service to include preventive roles previously confined to the ten centrally underfunded institutes of health protection. Direct access to specialists is still formally an entitlement at Aerodrom, but here, as in the city's other health homes, 'curative' GP/nurse practitioner pairs are being formed to offer new level one alternatives to specialists' consultations in terms of 'patronage' outreach services and chronic disease-management programmes. One consortium of 20 GPs has been formed, and at the Nevro Health Home a private venture has meant GP facilities now include computed tomography (CT) scans and ultrasound on site.

The official aim of 80% of health contacts in primary care is becoming achievable. Paediatricians and gynaecologists are the other medical professionals at level one. They are also entitled to independent registered lists, but take up is relatively low and there is a cascade of applicants from these professions and others to retrain in general medical practice. In the Macedonian Republic, the entrepreneurial organisational changes in primary care are seen as a way of both retaining and reshaping patient choice and using the potential of multi-specialist provision to promote professional competition: all still within the particular cultural legacy of the health home and its polyclinic format.

Budapest (Hungary): the medical office

The vast majority of Hungary's 6650 practices in 2008 are either solo or of two GPs. Primary care is practised, but in Europe this is the bottom line of primary care, hopeful of progressing to extended general practice status but apprehensive of a possible slide into an outreach franchise position. Between 160 and 300 practices stand vacant and specialist large paediatric practices for under-14 year olds are on the increase. In the rural areas and the poorer districts of northeast Hungary, GP access is especially limited. University departments of family medicine are committed but small. The two largest at Semmelweis and Debrecan are headed by doctors who indisputably lead the scientific life of family medicine in Hungary but whose 'science' began in internal medicine and urology. There are now fewer than 100 GP residencies nationally per annum, and the mean age of practising doctors is 57 years, with 25% of the total due to retire by 2013. With government ministers having a short shelf-life and the national Health Insurance Fund riddled with inefficiencies, public and professional confidence in the political leadership of the health system is low. In such a context the medical office is a sanctuary, the source of a subsistence income and the only reliable unit for any development.

In the 17th district of Budapest at Rakoskeresztúr, all of these features are apparent. The national norm for a patient list size is 1500, but to make a decent living here the GPs have either ~3000 registered patients or alternative incomes. Neither individually nor together, can the doctors afford to purchase the building from the proprietor municipality, and conditions remain clean but claustrophobic. Capital investment, as with medical offices elsewhere in Europe, is in short supply. The four practice nurses have to spend too much time checking patients' uncertain insurance status and there are no computerised networks to either payers or other providers. External data demands are heavy and GP surgeries are required to be of a minimum four hours' length.

But local people do come in, and in large numbers. They support the medical office, and in a 2007 national referendum rejected fee-charging proposals that could have led to an alternative model of health care, just as they had earlier hospital privatisation political initiatives. The Hungarian GP is properly trained, after three-year post-MD residencies, and both call-in and appointment times are offered during the extended opening times. There is something to lose and there is an awareness that such countries as the Ukraine and Slovakia have sacrificed the medical office to market forces, without achieving a satisfactory organisational replacement in primary care. Central regulations continue to preserve GPs' initial diagnosis and secondary care referral rights. At present, the only sign of the extended group practice or managed care enterprise is in the emergence of cost savings and clinical data-sharing consortia amongst GPs, and interprofessional initiatives are few. But these collective initiatives are a start, and with EU membership there is a hope amongst those leading primary care that Hungary might yet move into the mainstream of European developments.

Lodz (Poland): outreach franchise

In countries where governments lack coherent or explicit strategies for primary care for at least parts of their populations, as in China and the Philippines,[18] primary care services may happen opportunistically, often more by default than design. In such instances the franchise is likely be taken up by the main hospital to ensure it has a ready intake of patient referrals, although in the Philippines, for example, gaps are filled frequently by aid and religious mission societies for which the provision of health care has a charitable and evangelical purpose. External sponsors can also be corporate bodies, and the use of doctors on short-term electives, volunteers, and product loss leaders are all characteristic of the outreach franchise.

Polish policymakers do not admit to this model, pointing outside observers typically to the national 1991 primary care strategy as evidence of a different and more coherent approach to the organisation of primary care. Seventeen years later, however, the fieldwork evidence is of a hiatus in planned developments, following failures to achieve portability between 16 sickness funds, to ratify national health targets, to establish computerised systems and clinical protocols for chronic disease management in general practice, and to effectively maintain the educational curriculum for the latter in more than 50% of the 12 university departments of general practice designated in 1991. Gynaecologists and paediatricians continue to substantially outnumber family doctors in local clinic settings.

Although there is much to admire regarding civil regeneration in the once Jewish city of Lodz, these settings are much more likely to be commercial multi-specialist centres than general practice-based primary care. At one end of the main Piotrkowska street, there are no fewer than four large private clinics, with pharmacies and commercial insurance companies close by, billing clerks at the reception, and 20-plus advertised medical specialties on offer. The adverts also highlight dermatology as being a (solitary) service that attracts funding from the National Insurance Fund. There is no sign of a general practice, or at least not until the relatively downbeat Paradnia Lekarzy Rodzinnya neighbourhood is reached, with its three socially conscientious family doctors for 3900 patients. Here the offers of specialist sessions are resisted with support from the University of Lodz Department of Family and Community Medicine. But the different levels of investment between the different services is apparent, as strong American and other foreign investment at Piotrkowska contrasts with the lack of either the municipal or charitable supplementary funding legally permitted since 2002 obvious in the Paradnia practice. This has had to abandon its small minor surgery facility, while in the nearby academic department there are only five staff, including just a single academic GP. Its office is in an old hospital above a pitted car park, and the state of Ministry of Health-sponsored services may help to explain why other government departments continue to fund and manage their own separate health facilities. These again are hospital dominated.

The diversity and inequity of provision reflects the historic Polish principle that supports rights of autonomy under *Voivodship*. Tourists to Krakow can see this in action when they visit the Nafta Galeria shopping mall. There are signs for 32 private healthcare clinics and companies. The profile is remarkably similar to the names of the medical specialisms at the university hospital campus behind the Galeria. Primary care does not figure in either, although there is a small university general practice 20 minutes' walk away – managed by the internist director of the acute inpatient general

medicine service on the hospital wards at Oddzial Kliniczny Kliniki Chorob. In Poland there has been a custom in rural areas of giving doctors monetary gifts as tokens of gratitude. Now top-up payments, of both the official and unofficial kind, appear to apply almost everywhere.

Crete (Greece): extended general practice

Out-of-pocket payments, and payments in kind, are also a major feature of the Greek health system, which has Europe's most complex funding arrangements. The unique mixture of social insurance, national and local taxation, differential occupational health insurance schemes, EU grants and private contributions, has, however, been all brought within the responsibilities of the 17 regional health systems which, since 2001, have been charged with establishing 4000 GP-led and multiprofessional health centres nationwide. In cities such as Athens this may merely mean the gate keeping of community polyclinics staffed mostly from academic acute service centres, but in Crete the extended general practice has taken root with a novel and distinctive organisational form.

Anogia is in a largely rural part of the island and has just 9000 patients. There is a chapel at the entrance and a small inpatient ward of five beds at the rear. There are eight GPs on site. Four possess 'specialist' status through their minimum four-year post-qualifying credentials, and in all there are also four grade levels for the doctors. The centre director has associate professor status, and links with the university in Heraklion, the island's capital city, are continuous in terms of extended surgical training and research exchanges. Individual GP specialisms include radiology, emergency medicine and even chemotherapy services. There is a small operating theatre alongside well-equipped consulting rooms with electrocardiograph (ECG) and X-ray machines. Practice nurses are in short supply, but there is a laboratory technician and Anogia has the support of two EU-funded municipal home care teams for its patients, each comprising a social worker, a community nurse and two domiciliary assistants.

In this extended general practice the cultural norm is captured in the phrase 'He is my very good friend'. It applies to everybody. Primary care knows no boundaries in garnering its resources. The Anogia Health Centre is in many ways a classic clinically oriented general practice reflecting the general Greek obsession with formal medical knowledge and qualifications. Yet it also dispenses local herbal remedies, without inhibitions; and the population live longer than anywhere else in Europe. The style of the Greek extended general practice is very much a cultural product.

Pavia (Italy): managed care enterprise

Although officially designated a national primary-managed care pilot, the Pavia Primary Care Group (PCG), south of Milan, is better understood as a provincial product of the post 2001 Italian decentralisation. In this year in Lombardy, the impact of the new Italian 'fiscal federalism' policies and priorities started to become apparent in the organisation of local primary care. The new 21 health regions now had their own fund-raising powers to supplement NHS taxation with stable DRG (Diagnostic Related Group)-weighted allocations from the central administration, and greatly increased operational management roles. Given the heavy political turnover in Italian national political leadership, this transfer of responsibilities offered the prospect of a more secure basis for primary care development. With their independent status recently confirmed, virtually all general medical practitioners opted, somewhat unexpectedly, not 'to go private' but to accept local NHS professional 'associate' contracts and to work within the emergent sub-regional health strategies.

At Pavia in the Lombardy Region, where there are 15 provincial management units each covering a population of around 500 000, five GPs came together in the first local PCG. Now, in 2008, one in five Italian GPs are in group practices of five or more doctors. Although PCGs have expanded more slowly than the English counterparts that were being created at the same time, they have clearly released Italian primary care from its ties to the specialist internal medicine discipline from which many of its medical practitioners originally emerged. At Pavia, the PCG focus is on the management in the community of specific long-term conditions. For the 6000 population, the number of people with diabetes maintained by GPs has doubled in 2008 to over 85%. Hypertension is the principal preventive target, and cardiovascular hospital admissions have been reduced. The planned developments are for the PCG provision of low-level urgent health care, and shared care with visiting paediatricians and obstetricians.

In clinical terms, progress may seem modest. But in establishing the viability of local primary care as a social organisation with financial probity, the PCG in Pavia is a significant success. There is no whiff of corruption attached to the GPs who do not, unlike many other Italian doctors, ask patients for private contributions to top up public capitation payments. With the provincial commissioning of the PCG has come finance for administration and clinical equipment. And the local level of ordinary general medical services has increased.

The local Roman Catholic Church is of cultural importance in this area – to both believers and non-believers – and the PCG is located now in one of its

buildings. The PCG is on the first floor with the GP individual consultation rooms downstairs. There is one primary care nurse with one visiting public health nurse to support the PCG provided through the provincial management. In terms of staffing and service development, the growth of the PCG is limited, certainly by comparison with the managed care enterprises bearing the same name in England. But the latter are much more agents of central government policy and objects of a rigorous top-down political performance management. This has been witnessed in the UK by successive PCG mergers and the complex restructuring exercises which ultimately led to their replacement by far fewer NHS primary care trusts. In Pavia the sense of civic duty, the concerns for cultural compliance and the laying down of roots in the community suggest that the name of this primary care organisation should survive.

Prague (Czech Republic): reformed polyclinic

Since 1997, all Czech citizens have been required by law to register with a primary care doctor. As a result there are now practice lists and capitation payments. There are not, however, general practices – or at least not to any significant level. By 2005 there were still fewer than 100 fully qualified general medical practitioners in the country, with the large majority of these in Prague. By then their numbers were virtually on a par with the 77 newly established district health institutes to which they were intended to be subordinate. Heavily influenced by the WHO, these institutes were charged with delivering ambitious and comprehensive health gains.

In this increasingly cosmopolitan and commercialised capital city, it soon became evident that reliance on the traditional general practice model within a classic district health system model was simply not viable. Many of the neighbourhood-level institutes were too narrowly focused on hygiene and sanitation issues. The lead-in times for GP expansion were too long for consumers and politicians alike. Above all, in Prague, where the nursing school is only now implementing its first broad-based community nursing curricula, and national requirements for interprofessional modules that have been standard in such countries as Denmark and England since 2001 are still a distant prospect, the majority medical profession would not accept the proposed changes. The outcome is a reformed polyclinic model, both private and public, which incorporates the recent legislative public health and primary care requirements, and some family doctors, but places the medical chambers in a direct commissioning relationship with health insurers for the polyclinics' overall packages of healthcare interventions. For the insurance agencies this offers the potential benefit of being able to specify services designed to prevent hospital admissions, with at least a minimum of support from *in situ* primary health care.

Of course concept and reality are still some way apart. There are continuing concerns over corruption and cartels. A lack of performance management capacity has meant licensing, surveillance and epidemiological monitoring responsibilities have been transferred from the institutes by central government to 23 regional executives. And, as in Serbia, the communes have recovered some of their previous roles in rehabilitation and welfare. But reformed polyclinics are an integral part of the planned approach to local health systems in Prague and seem to represent a pragmatic cultural 'fit' in a country at the very axis of western, eastern and central Europe.

Viseu (Portugal): extended general practice

As abstract concept and concrete capital development, some of the superb health centres in Portugal have few equals in the rest of Europe. The idea that primary care should be a gateway to job opportunities, day care, welfare benefits and training as well as health, and that equally social welfare and education centres should point people to the preventive as well as curative services of the extended general practice seems splendidly modern and enlightened. In theory it should be the means by which the 2003 Law 60 permitting new private and public combinations in health care translates the ambitious proposal for cross-boundary local health systems into practice. But theory and practice are not always the same.

Accordingly, at the admirably appointed Viseu Health Centre north of Coimbra there are 16 general medical practitioners, and the local audits conducted to the standards of the GP-led national Institute for Health Quality help to ensure excellent patient care. But only five of the GPs are full time. Every health programme at Viseu must have the social dimension included, and social assistants now undertake a full five-year pre registration training. But the ratio of social workers is 1:50 000 people, and Viseu has just one. Similarly, while joint GP/nurse management of not just health programmes but also the centre itself is formally required, the national shortage of community nurses is another of the reasons why there are insufficient personnel to register 8000 of the centre's designated 32 000 catchment population. Thirty percent of local people still prefer to access all their health care via the hospital emergency rooms, and their social care through the traditional Catholic charities of the *Misericórdias.*

Then there are the doctors, managers and politicians. With a rapid rate of ministerial turnover, reciprocal trust between these has been in short supply and many GPs are very reluctant to surrender their independent self-employed status. So, too, have been several other frontline healthcare professionals. The Viseu Health Centre has oral hygienists, physiotherapists, administrators, overnight beds and a pharmacy. But the planned sessions from dermatologists, psychologists and dentists have not materialised. Tolerance of mixed public–private status has not been enough when the new weighted capitation payments are seen as too low and the new management level of five regions is perceived as (inefficient) political monitoring. So the Portuguese organisational initiatives remain as much an aspiration as actual, while still supplying a potentially inspirational exemplar in policy formulation terms for much of the rest of Europe.

Winchester (England): managed care enterprise

The aetiology of local resource management through primary care organisations is further advanced in England than elsewhere in Europe. Practice-based commissioning (PBC) under the auspices of just over 150 National Health Service (NHS) primary care trusts (PCTs) is the latest creation in a development process that dates back to 1991 and the first small general practice budgets for purchasing in GP fundholding. The current collaboration in a locality PBC group between 13 previously separate group practices located around Winchester has its roots in combined fundholding contracts for the purchase of minor hospital procedures, and duty cover between GPs in the night time cover co-operatives that also began to emerge in the mid-90s. By late 2008, the aspirations of the managed care enterprise have become much more ambitious as the NHS moves to convert an indicative allocation of up to 40 million Euros into a directly managed budget for the PBC.

This scale of income produces some interesting potential partners for the English version of the managed care enterprise. In middle-class Winchester, the suitors for the PBC have included a globally renowned multinational company offering a full buy-out of premises and major investment in new healthcare and non-healthcare commercial facilities, two venture capital groups, a private healthcare company and, of course, other NHS units including some of the current employees of the local Hampshire PCT. Participants vary widely in their perspectives and responses to the changes taking place. On the one hand, access to major new sources of investment is welcomed. On the other this is seen as a device to cap public expenditure on general medical services and 'creeping privatisation'. Some GPs and nurse practitioners have embraced what are termed 'portfolio' positions, in which clinical work is only a part of a weekly workload that includes management, marketing and training; and the entrepreneurial *motif* is all important. Others remain either sceptical, preferring to stick to their surgery-based duties, or to await a buy-out of their equity stake in present practice partnerships from the highest bidder.

In Winchester the concept shaping the organisational development is 'confederation'. It allows for local difference, professional independence and inter-practice exchange, as well as co-operation, an overall unity of purpose and the inclusion of distinct functions and their incomes under one organisational umbrella. The last include agencies with different formal status, including a commissioning unit, an in-house community health services 'provider arm', and several hybrid services delivered in conjunction with partners that range from private medical specialists to the municipal adult services department. At the PCT, the new skills mix and collaborations are warmly welcomed. At the nearest general hospitals there are serious concerns that acute services are about to be 'stripped out'. At such local PBC health centres as that in the village of Twyford, the individual arriving to self-register at the computerised reception point is still called a 'patient' by the centre's six GPs in their personal clinical roles, but also a 'customer' who merits 'the highest quality of care at the right price' by their 'lead' GP member of the locality group. There is an awareness of the potential competition to provide in 'the multimillion dollar market place of long-term illnesses' from non-GP-led agencies with very different appreciations of what constitutes primary care. Among the senior GPs there is a determination that the PBC's own locally tailored care pathways will determine the direction of future organisational developments, and an acceptance that these will be a public–private mix. At Twyford Health Centre this is already very visible. The services accessed from the site include osteopathy, chiropody, pharmacy, counselling, ultrasound, psychiatry and physiotherapy: as well of course as those provided directly by the GPs and primary care nurses. For the majority of this list co-payments already apply.

In Winchester there is frustration at what is seen as the slow pace of 'incremental' change. Institutional central policy and conservative PCT management is felt to have failed to stay abreast of organisational developments. There is frustration with uniform national performance management requirements, and the NHS is criticised for failing to respond to the local diversification of provision. The move to introduce polyclinics in inner cities[19] has prompted GPs nationwide to join forces with user groups – Twyford, for example, has created its own patient participation forum – and with commercial companies and other

professionals in locality groups to plan primary care-led 'transformations' at the hospital interface. By design or default, PBC in England is leading Europe into previously uncharted policy-making processes for the organisation of primary care.

Summary

Any selection of a relatively small number of case studies is to some extent arbitrary and open to criticism in relation to its omissions. Prominent amongst the latter, for example, would have to be the Swedish health centres, the successful new Bulgarian and Romanian general practices, and their more established Dutch and Norwegian counterparts, and both the Albanian and Scottish health stations staffed by new kinds of healthcare practitioners. While such omissions have to be acknowledged, however, it can nevertheless be postulated that the ten chosen exemplars, having been chosen on the basis of expert advice and contemporary literature reviews, do together represent the trends and profile of European primary care in 2008. The extended general practice is the main model still, but the advance of the managed care enterprise clearly has powerful backers, while the reformed polyclinic represents a pragmatic political compromise for many states, and the medical office a conservative organisational option for the maintenance of primary care. And, depending on the local perspective, the outreach franchise is a very real risk or challenge, as the vicissitudes of the recent Polish experience illustrate.

Perhaps more important than the omission of individual European countries from the selected case studies, is the absence of the two organisational types evident in other parts of the world. The community development agency and district health system, as found in large parts of Latin America and Southern Africa, are emphatically social organisations in ways that the emergent economic business units of European primary care are not. They typically refer to 'citizens' and 'communities', for instance, where 'users' and 'clients' are the language of the managed care enterprise and reformed polyclinic, and lay membership and cross-sectoral collaborations are critical dimensions in the local management of primary care premises and priorities. The differences highlight what some might consider to be a major weakness of current primary care organisation in Europe. At present its policy formulation processes and implementation mechanisms appear insufficiently complex and participative. Often centrally or commercially controlled by particular political elites or partisan professional interests, they may lack the capacity to incorporate the collective views and subjective needs of the local communities and cultures, on which the case for generalist primary care depends.

Too often the result can be simple, unsophisticated and exclusive organisational models. Into this category now fall many of the medical offices and small surgeries that were historically the roots of primary care in Europe, prior to the formulation of health policy itself. In European terms, the outcome reflects the first part of the Lisbon Treaty's injunction to the EU to promote health for its peoples as a basis for prosperity rather more than its second part. This actually gave the promotion of solidarity an equal prominence,[20] but subsequent responsibilities for delivery have resided principally with the European Commission's Directorate that combines health with consumer protection. The impact is apparent, for example, in the location of global 'healthcare business competitiveness' at the top of the criteria for 2007–2013 European health improvement research funds.[21] Efficiency rather than equity now appears to be the formative value in the present organisation of primary care in Europe, and this will be discussed further in Part 2.

ACKNOWLEDGEMENTS

Professor Meads would like to thank those who offered editorial assistance in the preparation for this paper, and in particular Professor Jan De Maeseneer, University of Ghent, Dr Gabriela Parvulescu, Craiova University, Professor Paolo Tedeschi, St Anna School of Pisa, Professor Laszlo Kalabay, Semmelweis University, Professor Tatyana Pasenyuk, Odessa State Medical University and Dr Sara Shaw, University College London. In addition he wishes to acknowledge the contribution of other workshop attendees who considered a first draft of the paper at Semmelweis University on 13 July 2008.

REFERENCES

1 Belcher P. *The Role of the European Union in Healthcare*. Zoetermeer, Netherlands: Council for Health and Social Service, 1999.
2 Atun R. *What are the Advantages and Disadvantages of Restructuring a Health Care System to be more Focused on Primary Care Service?* Copenhagen: World Health Organization Regional Office for Europe, 2004.
3 Meads G, Iwami M and Wild A. Transferable learning from international primary care developments. *International Journal of Health Planning and Management* 2005;20:253–67.
4 European Observatory on Health Care Systems. *Health Care Systems in Transition: country reports*. Copenhagen and London: World Health Organization Regional Offices for Europe, 2002–2007.

5 Saltman R, Rico A and Boerma W (eds). *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006.
6 Calnan M, Hutten J and Tiljak H. The challenge of coordination: the role of primary care professionals in promoting integration across the interface. In: Saltman R, Rico A and Boerma W (eds) *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006, pp. 85–104.
7 McCallum A, Brommels M, Robinson R *et al.* The impact of primary care purchasing in Europe: a comparative case study of primary care reform. In: Saltman R, Rico A and Boerma W (eds) *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006, pp. 105–28.
8 Sheaff Q, Gené-Badia J, Marshall M *et al.* The evolving public–private mix. In: Saltman R, Rico A and Boerma W (eds) *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006, pp. 129–46.
9 Boerma W and Ard-Dubois C. Mapping primary care across Europe. In: Saltman R, Rico A and Boerma W (eds) *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006, pp. 22–49.
10 Baker R, Wensing M and Gibis B. Improving the quality and performance of primary care. In: Saltman R, Rico A and Boerma W (eds) *Primary Care in the Driver's Seat.* Maidenhead: Open University Press, 2006, pp.203–26.
11 World Health Organization. *Primary Health Care. Now More than Ever.* Geneva: World Health Organization, 2008.
12 Macdonald J. *Primary Health Care: medicine in its place.* London: Earthscan, 1992.
13 Meads G, Wild A, Griffiths F *et al.* The management of new primary care organisations: an international perspective. *Health Services Management Research* 2006;19: 166–73.
14 Hanlon N. Sense of place, organisational context and the strategic management of publicly funded hospitals. *Health Policy* 2001;58:151–73.
15 Abelson J. Understanding the role of contextual influences on local health care decision making: case study results from Ontario. *Social Science and Medicine* 2001; 53:777–93.
16 Meads G. Finland: world class primary care. *Quality in Primary Care* 2006;14(2):107–10.
17 Meads G. The community development agency. In: *Primary Care in the 21st Century: an international perspective.* Oxford: Radcliffe Publishing, 2006.
18 Meads G. The outreach franchise. In: *Primary Care in the 21st Century: an international perspective.* Oxford: Radcliffe Publishing, 2006.
19 Darzi A. *High Quality Care for All.* London: Department of Health, 2008.
20 European Commission. *Information Society and Health: linking European policies.* Luxembourg: Publications of the European Community, 2008.
21 European Commission. *Health Portfolio of Projects.* Luxembourg: Office for Official Publications of the European Community, 2007.

FUNDING

The European Forum for Primary Care received funding for the preparation of this position paper from the Dutch Ministry of Welfare, Health and Sports (Department of Public Health).

PEER REVIEW

Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Geoffrey Meads, Institute of Health Sciences Research, Warwick Medical School, UK. Email: G.D.Meads@warwick.ac.uk

Received 4 November 2008
Accepted 3 February 2009