Quality in Primary Care 2011;19:63–5

Guest editorial

The future of primary healthcare in Europe III, Pisa 2010

Diederik Aarendonk MA
Coordinator of the European Forum for Primary Care

Jan De Maeseneer MD PhD
Chair of the European Forum for Primary Care

The third biennial conference of the European Forum for Primary Care (EFPC) in Pisa, August 2010, aimed at enabling participants to identify, define and appreciate topics – ranging from policy to organisation, management and clinical care – which are likely to determine the future of primary care (PC) in Europe.

As one of the participants in the discussions that led to the 2009 World Health Assembly resolution on PC (WHA 62.12), the EFPC wants to take this resolution as the guideline for further development of policy advice to all the countries in the European region that signed the resolution.

Crucial for the success of the primary healthcare response is to ensure that PC professionals continue to work in and with communities. To make health care more effective, disease-specific vertical programmes should be implemented in the context of integrated primary health care (see: www.15by2015.org). Good practice in the integration of responsive PC and providing a wide range of services can be found everywhere in Europe. At the Pisa conference a number of these good practices from various countries including Canada, The Netherlands, the UK, Spain and of course the hosting country Italy were presented through video presentations. A debate session was held around the specific theme of health inequalities in PC. All these examples were underpinned by high-level keynote speeches from front-runners in the area of community oriented primary health care.

The EFPC is always looking to support contributions which address, in particular, issues of equitable access, cost-effectiveness, service delivery, clinical quality and the maintenance of continuity of care. Both urban and rural settings are relevant, with their differing but equally important modern pressures.

The recent rapid increase in the number of member countries, in both the European Union (EU) and the WHO European Region, demands a clear understanding of the overall impact on health and public service systems of both the emergent new clinical approaches and service delivery models in contemporary primary health care. Internationally these range from small general medical practices to multiprofessional, community oriented PC centres. All national health systems currently share similar pressures for change and development. Collaboration in understanding both these pressures and the responses they require is essential if the modern Europe is to take forward its economic and social development, and enhance the overall health status of its divergent but increasingly interdependent communities.

In this context six common pressures for change and development were identified from a review of individual states' current policies and from relevant international research. These may be regarded as the formative influences on the future organisation of primary health care in Europe. Together they represent the agenda for shared learning:

- chronic disease management
- interdisciplinary collaboration and leadership
- patient expectations and involvement
- monitoring of PC performance
- health indicators including patient-related health outcomes
- research, funding and developments in PC.

Chronic diseases are increasing rapidly in most of the European countries. The majority of the European healthcare systems have responded to this 'epidemic' through the development of disease management programmes. This approach is enhanced by the availability of an increasing number of guidelines. Many management programmes utilise quite a 'mechanistic' approach: a definition of a patient group with a chronic condition, definition of targets (very often process related, and when outcome oriented focusing on intermediate outcome indicators), distribution of guidelines and the creation of (financial and/or organisational) incentives. This strategy has led to an increasing number of vertical disease-oriented programmes, not

always comprehensively integrated within the primary and secondary healthcare systems and requiring an increasing amount of resources.

On the other hand, the investment in PC reforms to improve the overall performance of healthcare systems has been substantial. There is, however, a lack of up-to-date comparable information to evaluate the development of PC systems. The EU funded Primary Healthcare Activity Monitor for Europe (PHAMEU) project aims to fill this gap by developing a PC monitor for implementation in 31 European countries. This project collects information on the features of PC systems that reflect their stage of development. The focus is on PC governance; economic conditions; workforce development; accessibility for patients to PC services; continuity of patient care; coordinative capacity of PC to streamline care processes; scope of services delivered in PC; quality of care and efficiency of care. According to Prof. Peter Groenewegen, the second speaker at the conference and director of the Netherlands Institute for Health Services Research (NIVEL), the leading institute in the PHAMEU project, EU countries provide a laboratory for comparative research knowing that there are important differences in national contexts and strategies. Little research is carried out in Eastern European countries. Inputs are needed to determine which key topics comparative European research should cover in these countries in order to improve European decision making. Health services research could look at how services may integrate the paradigm shift from 'problem-oriented' to 'goal-oriented' care, looking at patient function and social participation, rather than just biomedical indicators, as important indicators of outcome.

Primary care should not only apply results produced by specialists, but also produce its own knowledge. Nowadays clinical guidelines are often not based on research in PC, and none are based on research with complex multimorbidity, as our first keynote speaker Dr Giovanni Tognoni observed. Research in PC should become an instrument of 'patient-based care', tailored for the need of the specific part of the population. Inclusion criteria in intervention research should be as wide as possible in order to match real people's needs, particularly with regard to women and elderly people with comorbidity. Dr Tognoni also emphasised the need to be patient oriented when it comes to the involvement of patients in research, which would mean abandoning the typical terminology of 'enrolling' patients in research.

Health quality indicators are increasingly being locally, regionally and nationally developed for performance assessment, service regulation and quality improvement. Indicators are being seen as a lever for improvement, underpinned by sanctions or incentives, e.g. pay for performance. Indicators have previously been developed for organisational structures and healthcare processes but more recently measures of patient outcome or experience, so-called patient related outcome measures (PROMs) and Patient Related Experience Measures (PREMs), have been included in the picture. The evidence on how, whether and to what extent health indicators can lead to improvements in quality of care is equivocal.

A multidisciplinary approach that includes all the health determinants should become the base of multicentre European research projects in the near future, in order to fill the gap between disease-oriented knowledge and the problems seen daily in PC practices. Most healthcare systems in Europe struggle with inadequate coordination of care, whether it is for emergencies or for people with chronic conditions, often leading to a lack of responsiveness to health needs. Strengthening PC by extending roles and skills within health systems is increasingly regarded as a solution, although it requires investment to improve local capabilities and performance. Some systems also need to respond to skill shortages, others to resistance to change among PC professionals.

The dissemination of experiences about interdisciplinary collaboration and leadership features is probably key for the development of modern PC capabilities throughout Europe and the ultimate delivery of effective and high-quality services. The next step will be to convince governments, doctors, insurance organisations and patients of the urgent need for change according to research findings. However, according to the fourth speaker, Dr Ri De Ridder from the Belgium National Institute for Health and Disability Insurance (NIHDI), system change depends on external pressure, internal 'strategic' interventions and incremental but strategic 'little steps' – 'And system change takes time!'.

The third speaker at the conference, Prof. Arnoldas Jurgutis, reported from the Northern Dimension Partnership on Public Health and Social Wellbeing (NDPHS) Workshop 'Tomorrow's role of family doctors and nurses' about unequal distribution (rural vs urban) of primary healthcare (PHC) practices, the increasing workload of PC professionals and the need for extended PHC teams and more emphasis on patient-centred, holistic care.

Moreover, recent discoveries in the medical field have achieved important results for the history of our society. On the one hand, these discoveries allow us to live longer and better, but on the other hand, medicalisation permeates every aspect of life, leading many people to believe that medicine can solve every problem. Death is also felt to be an avoidable event that happens because 'not everything was done that was possible'. This approach demands that medicine be present everywhere, and economic interests transform health care into an industry. The risk of an industrial pattern is a conflict of interest that is present not only in the pharmaceutical industry, but also in

doctors, groups of doctors, groups of patients and in organisations like the diagnostic factories. 'Disease-mongering' is one of the results of the conflict of interest that is giving healthy people new reasons to feel ill. The theme highlights the need for exploration of unwanted side-effects of medicine in general and the role of PC in particular.

Finally, according to Prof. Barbara Starfield, our last distinguished keynote speaker, we might, by achieving interprofessional community oriented PC: a) avoid an excess supply of specialists, b) achieve equity in health, c) address comorbidity and multimorbidity, d) respond to patients' problems, e) coordinate care, f) avoid adverse effects, g) adapt payment mechanisms, h) develop information systems that serve care as well as clinical information functions and i) establish the PC–public health link: the role of PC in disease prevention.

With these expectations we are looking forward to the next EFPC conference in Graz, Austria on 16 September 2011 and to our next biennial conference on 3 and 4 September 2012 in Gothenburg, Sweden.

ADDRESS FOR CORRESPONDENCE

Diederik Aarendonk, European Forum for Primary Care, Otterstraat 118–124, 3513 CR Utrecht, PO Box 1568, 3500 BN Utrecht, The Netherlands. Email: d.aarendonk@euprimarycare.org