

## International exchange

# The organisation of primary care in Europe: Part 2 Agenda – position paper of the European Forum for Primary Care

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### ABSTRACT

The contemporary models and trends of European organisational developments in primary care, identified in part 1 of this article, are the subject of analysis and discussion. Four main issues are identified in relation to the future protection and progress of primary care, and a series of policy interventions specified. These are directed at international agencies and action. Two new case study summaries are supplied as illustrations of the dilemmas now being

encountered by primary care organisations across the extended Europe. With some supplementary material, the article is an edited version of the 2008 European Forum for Primary Care (EFPC) position paper on the organisation of primary care in Europe.

**Keywords:** Europe, organisation, policy, primary care

## Introduction and context

This article is the second to be taken from the 2008 Position Paper on the Organisation of Primary Care in Europe, commissioned by the European Forum for Primary Care (EFPC).<sup>1,2</sup> The first offered a classification of seven types of primary care organisation and identified the contemporary developmental trends in relation to five of these. The article included ten case study exemplars of local organisational developments in different countries based on fieldwork undertaken during the 2003–2008 period. The present article augments these with two further site summaries prepared as part of a parallel research project examining current changes in multiprofessional primary care, supported by the UK Department of Health. This research adopted the same methodology as the previous article published in this journal, and its main findings have also been reported elsewhere.<sup>3</sup>

A synopsis of the different organisational types and their distinctive features is set out again in Table 1, the terms of which are explained in Part 1.<sup>1</sup> The extended general practice was identified in the EFPC position paper as the main European model of primary care (e.g. in Finland and Portugal), alongside the rapid expansion of managed care enterprises (e.g. in Ireland

and Italy), and the revival of polyclinics. The last is especially evident in health systems where, for economic reasons, private sector growth is a pre-eminent force in cross-sectoral policy making (e.g. Poland).

In several countries, however, the unit of primary care remains almost exclusively the individual medical cabinet (e.g. Hungary). Its maintenance can be regarded in some states as essential to the preservation of primary care itself, under the pressure of alternative institutional specialist and commercial healthcare service philosophy and delivery options. Decentralisation in the form of district health systems or community development agencies was found to be largely absent in Europe, although the emergent ‘health homes’ of Central Europe do seem to offer the prospect of new public health and primary care combinations with lay governance (e.g. the Macedonian Republic).

## Aim and approach

Primary care has historically signified much more than a literal first point of health services contact,

albeit one that is outside 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 as much on a sensitive awareness of a patient's context and relationship patterns as they are on data derived from scientifically labelled conditions and specialist clinical procedures. A fundamental question today in Europe is whether or not the contemporary innovations to organisational structures and processes will permit such practice to continue.

The aim in this article is to examine this question, through the prism of the fieldwork typology described in Table 1, with the objectives of providing first, shared and transnational learning, and secondly, a recommended common agenda for European policymakers.

The overriding principle that informs the EFPC approval is that of reciprocity, or an equivalence of status in the exchange, between the different countries and cultures of Eastern, Central and Western Europe. The past two decades have witnessed these subregional areas struggling to move on organisationally from their standard models of the *Semashko* multi-specialist clinics, public institutions and the social market. As yet there is no common agreement on the way forward for the organisation of primary care. There could scarcely, therefore, be a more timely contribution from the European Forum for Primary Care in seeking to promote transferable learning across the whole of its 52 countries or regions. Accordingly, this paper is designed to first facilitate the positive exchange and application of knowledge and experience between the full range of primary care practitioners in different countries, with the local case summaries being of particular interest in this respect. And secondly, it looks to provide the means by which the European Forum may both define its own policy position, and then offer the specific arguments and influential data that may enable such partner institutions as the European Union (EU) Commission, World Health Organization (WHO) European Office, World Organization of Family Doctors (WONCA) and parallel European professional associations to shape theirs.

In addition to the case study material and literature review previously described,<sup>2</sup> the contribution to this paper of the EFPC workshop hosted in the Hungarian capital of Budapest at Semmelweis University on the 23 July 2008 should be recognised. This was attended by 13 nominated experts from nine countries, with a further five states represented in the list of corresponding members. Their names are acknowledged at the end of this article. At this meeting a first draft of this paper was considered. The workshop was informed by a parallel piece of research exploring current policies and priorities for primary care research across

Europe, including specifically for organisational developments. This work in progress is directed by Dr Sara Shaw at University College, London (UK). It suggests that the very limited extent to which research evidence and findings are used by primary care policy makers in general is striking; and justifies in itself the EFPC mission to seek to better integrate the practice of primary care with its policies and research. Drawing on the literature review, case studies and their own expertise and experience, the international EFPC experts agreed on the four issues presented in the next section as of paramount significance for the future organisation of European primary care.

## Issues

Over the past two decades, decentralisation and provider deregulation have been principal political pressures for change in the organisation of primary care across Europe. In the wake of these forces, an increased flexibility and variety in both the forms of local resource management and the status of hybrid service delivery agencies has followed. The examples of each are numerous. Those organisations with newly extended decentralised executive responsibilities for primary care ranged, by 2006, from 431 elected municipal councils in Norway and 89 appointed territorial insurance funds in the Russian Federation to the seven parishes of the Andorran principality and 17 regional *comunidades autonomas* in neighbouring Spain. Similar trends are apparent in terms of the mixed status of primary care service units. Local experimentation again covers a broad spectrum, from state transfers of public dispensaries and registered patient lists to newly designated independent general practitioners (GPs) with private medical offices in Romania, and comparable 'concessionary' arrangements in Slovenian and Macedonian health centres, to a plethora of organisational innovations in public-private partnerships across the UK, Norway and Sweden. These include new types of foundation and charitable trusts, medical and multiprofessional co-operatives and both walk-in and urgent healthcare call centres.

As these examples illustrate, considerable local energy has been released. But the increased diversity that comes with decentralisation and provider de-regulation can also mean fragmentation and a loss of overall coherence in the organisation of primary care. For many European countries there are serious concerns regarding the capacity to implement 'modernising' organisational reforms. While this is most evident in such Eastern and Central European countries as Croatia, Moldova, Serbia and the Republic of Macedonia, it is also seen as a major obstacle by West European policymakers interviewed in Sweden, Ireland, Belgium and

**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 Netherlands. In all these states the missing ingredients are those of vision and strategy and the issue, paradoxically for such an inherently bottom-up mode of service, is the perceived need for European-level leadership to protect and steer the future organisation of authentic primary care. The attachment of the WHO to organisational models that promote public health, but not necessarily primary care, through structures and processes of public participation and vertical control that are not culturally appropriate in European environments, throws this need into even sharper relief.

This need is directly linked to the second issue emerging from our interviews with national policy and professional leaders: that of counterbalancing the financial drivers and economic doctrines for organisational reform in primary care with equivalently powerful social imperatives and pastoral ideas. The pressures for cost containment in relation to hospital and drugs expenditure are now so immense that even such countries as Norway, Sweden and Germany, where historically health expenditure has been a relatively high proportion of gross domestic product (GDP), often no longer view primary care as a separate community service sector with its own ethos and *raison d'être*, but as an adjunct to secondary care services.

Accordingly, the Norwegian organisational reforms of 2002, for example, diminished the influence of its peer-based *utposten* (professional communication networks) by merging research councils and administrative regions, and defining primary care merely as that which is outside the new independent hospital enterprises. Subsequent charging and business development policies for general practices have sought to incentivise those that substitute effectively for acute services. The focus of both Norwegian central policy and research has shifted firmly away from primary health care to hospital-based quality improvement and specialist scientific medicine, as the recent development and growing output of the national Knowledge Centre for Health Services demonstrates. Similarly in Sweden, where county councils assumed responsibility for national expenditure on prescribed drugs in 1998, to go with their existing management of primary care services, over one-third of the 1100 health centres nationwide are now privately run. With an expensive three-tier structure of district county and central county hospitals and six specialist medical regions for just nine million people, Swedish local councillors are looking to share the financial burdens and retain their elected positions by showing they can control the level of demand on their taxpayers. In Germany the move to market behaviour has meant that since 2004, statutory health insurance sickness funds have been obliged to offer subscribers gate-keeping options, with higher levels of user co-payments for both inpatient days and hospital ambulatory care.

These changes have not been accompanied by a requirement that the nominated physician should be a GP, and a growing trade in alternative acute service physicians' businesses has been the consequence.

If the *motif* of managed competition can be detected in the three national examples described above from economically advanced parts of Europe, it is even more apparent when less prosperous Eastern and Central European counterparts are considered. In such countries as Croatia, the Macedonian Republic, Poland and even Bulgaria, where attempts to establish meaningful primary care agencies have been tenaciously pursued, the post-1991 plans for universal coverage through general practice now seem excessively ambitious as the high costs of GP education, resistance from other medical disciplines, and conservative public attitudes have taken their toll. Even where a country has had the status of a virtual WHO pilot site, as in Estonia's case, the evaluation in 2008 indicates only a partially completed initiative.<sup>4</sup> The plight of primary care in these countries highlights the third issue and dilemma in its organisational development in Europe: the growing tendency to separate primary care services from public health interventions.

This division dilutes primary care. It paves the way for it to be located in the marketplace of small businesses so critical to economic growth in developing states, at the expense of its development as a discrete service sector. As such it is attractive to many donor agencies, including the World Bank, and to investors from the US in particular. The private polyclinics of Poland and Slovakia are ready illustrations of this trend, which releases national governments to devote their restricted budgets on more readily attainable public health targets. Moreover these are also easily quantifiable in terms of visible progress, and this in turn brings in further aid and external donations, not least from wealthy American benefactors. At the European institutional level, the separation of the organisation of primary care and public health is a particularly difficult political dilemma. Since the EU's adoption of the Principle of Subsidiarity at Maastricht in 1994, the operational arrangements for national health bodies has been a no-go area, leaving the EU to exercise its influence indirectly through, for example, employment regulations and competitive tendering conditions. But under the terms of Article 152 and the subsequent Lisbon agreement of 2000 it has retained a relatively free rein in respect of public health, especially with a growing awareness of the need for closer European cross-border collaboration to promote patient safety and combat such infectious diseases as severe acute respiratory syndrome (SARS), HIV/AIDS and rabies. The first EU health strategy was well received and that it generated little adverse reaction politically was in part due to the recent arrival in the EU of the Accession countries. For many of their governments, European

support for basic vaccination, screening and health-promotion programmes is regarded as one of the basic benefits of EU membership. Into this category fall not just the likes of Lithuania, Cyprus and the Czech Republic, but also such longer-term EU entrants as Portugal and Greece.

In every instance, the national public health programmes are subject to a form of central administration. The resultant vertical structures can be invidious to the lateral relationships required in broad-based primary care. Yet it is hard for the national governments of those Western EU countries in which the latter has been the norm, such as Denmark, England and the Netherlands, to object. After all they and their non-governmental agencies support very similar vertical initiatives through their parallel membership of the WHO European Region based at Copenhagen and the foreign aid programmes they co-sponsor, especially in Southern and West Africa. And, moreover, they know in the long run cost pressures may even mean that they have to adopt similar structures at home.<sup>5</sup>

This European shift to public health-oriented vertical structures merits more detailed research and coincides with a weakening of community-based horizontal relationships, particularly with social care practitioners. This is the fourth and final issue commonly identified by our interviewees for the contemporary organisational development of primary care in Europe. Primary care, by definition, takes place in local community settings.<sup>6,7</sup> Whether with a doctor, pharmacist, nurse, dentist or optician, it is the first contact for the individual beyond his or her circle of family and friends. As such its core values are personal: respect, self-determination, reciprocity, confidence, and, above all, acceptance. The names of its organisations have traditionally often had strong local cultural connotations. ‘Health homes’ in the Republic of Macedonia, ‘family practices’ in Wales and ‘feldsher’ (nursing posts) in Russia, Armenia and other East European states are part of a society’s folklore.

The personal, cultural and social significance of primary care may now be in peril as its supporting organisational relationships diminish. General medical practice, for example, has always had complementary professional values and roles to those of professional social workers. But the latter are now in decline in Europe as, even in the UK and the Netherlands, statutory social services departments increasingly transfer responsibilities to the independent sector and informal care agencies. Much the same can be stated in relation to such other natural allies of primary care professionals as district nurses, priests, education welfare officers and health visitors. The profile of this decline in the WHO European Region has been sharpened by the presence within and on its borders of countries like the Baltic States, the Russian Federation and Turkey where there is no realistic prospect of professionalised

social care becoming a formal entitlement. With this scenario as the backdrop, primary care is now much more susceptible to incorporation into vertically integrated organisational structures through such specialist acute service-led mechanisms as patient pathways, clinical care protocols, intermediate care packages and a whole range of evidence-based medicine techniques. Lacking the strong horizontal relationships with civil society groupings that characterise primary care in much of South America, European organisations now have the challenge of becoming what are often termed ‘stakeholder’ enterprises. As such they have to face the difficult issues of the multiple relationships these bring, in that the relationships are no longer intrinsically horizontal and reinforcing and may rather be just haphazard and transitory.

From a European perspective, the issues explored here can be converted into basic questions for the future attention of the EFPC and its continental counterparts. These could include the following:

- Why must Europe positively lead the organisational development of local primary care?
- What should be the European social policy for the social organisations of primary care?
- How can Europe’s public health needs be addressed by and with primary care organisations?
- Which organisational relationships in Europe are required to support the effective organisational development of primary care?

## Analysis and discussion

The deficits identified in policy-making processes for primary care organisations appear to be accompanied by a lack of awareness of developments in modern organisational theory and research. Any of these developments now emanate from powerful European business schools, which characteristically have few links to local primary care, even though their new concepts and imagery could be of a significant utility to its proponents. Broad-based health and healthcare research, which incorporates management and policy developments, is, for example, a feature of medical and nursing schools in such university cities as San José in Costa Rica and Londrina in Brazil, where the community development agency model of primary care prevails,<sup>8</sup> but it is a rare occurrence in contemporary Europe. Of course there are exceptions – such as Utrecht, Manchester and the Sant’Anna’s School in Pisa – but the overall picture is one in which the potential of, for instance, developing new *network agencies* to combine primary and self-care, or novel forms of *non-governmental public action* to harness non-statutory resources in hybrid status agencies, is

much less well-defined than is the case in Caracas or Cape Town.

Accordingly, the position of European primary care in 2009 seems to be that of organisational practices and research lagging behind statements of policy intent. Workshop exercises at recent EFPC events at Ljubljana and Budapest have both pointed in this direction.<sup>9,10</sup> At the first Slovenian, Dutch, German and Bulgarian total quality assessment tools each exposed the failure of domestic primary health agencies to meet, for example, self-care, patient empowerment and public participation targets.<sup>10</sup> Similarly at Semmelweis University in July 2008, workshop delegates explored the mismatch between, in particular, the health education and promotion roles of the modern general medical practitioner as set out by WONCA,<sup>11</sup> summarised in Box 1, and their experiences of primary care organisations in their own countries. In both settings the contrast with the speed of autonomy-driven organisational developments in secondary health care was noted. Across the nine countries represented at the Hungarian workshop, this was linked directly to a common theme of generally inadequate organisational infrastructures for domestic primary care, particularly in respect of training, research and management. Delegates viewed this shortfall as potentially opening the door to private specialist practice in the high streets of Europe.

### Box 1 The principal competencies of the modern general practice

Summary of WONCA (2002) recommended core competences:

- primary care management
- person-centred care
- specific problem solving
- comprehensive approach
- community orientation
- holistic modelling

The trend towards more specialist businesses appears to apply to both richer and poorer nations. In France, for instance, the growth in private practice is readily legitimised by its tradition of *la médecine liberale*, which enshrines the patient's rights to choose a physician,<sup>12</sup> while over in the Ukraine new accreditation arrangements appear to be part of a strategy to limit public access to free health services. In these states and many others the services of primary care remain insufficiently differentiated from its disciplines. The classic illustration of this has been in the UK, where until relatively recently 'general practice' has been the name of the profession, the building, the curriculum and the healthcare provision in primary care. In such

contexts the interests of a single interest group tend to dominate decision making and organisations remain in conventional hierarchic mode. These are a long way removed from both modern organic adaptive systems theories and the multiple agendas that shape them.<sup>13,14</sup>

Such agendas now apply to primary care across Europe. Their interaction is vividly expressed in the Bulgarian and Belgian case exemplars of local primary care organisational developments described in Boxes 2 and 3. In both cases an apparently preferred extended general practice model is, in reality, little more than a network of solo medical offices, while the actual policy agenda may well witness a further revival of the reformed (and commercial) polyclinic over the next decade.

Recent commentators have remarked upon the futility now of relying simply on a past superficial consensus in favour of, for example, the 'goodness' of 'health for all' values, when the pressures of mass migration, mixed races, medical tourism, new technologies, ageing populations, and globalisation in all its forms are so overwhelmingly powerful.<sup>16,17</sup> The development of modern pluralistic philosophies for the future organisation of primary care in Europe is clearly a priority in the years ahead.

That the ethical principle of 'equity' will feature prominently in the development of new organisational philosophies can be taken for granted. It is invariably a core principle of primary health care, attached historically to movements in support of either standardised service provision or equal health status, across populations with very different income levels. For the effective organisation of primary care in modern Europe, this principle now needs to be taken further. Equity of resources and process are critical if what has been called 'the dominant discourse of advanced market economies', and especially the US,<sup>15</sup> is to be counter-balanced by considerations of community health and development. In Sweden, primary care development is separately associated with both the creation of social networks and social capital.<sup>16</sup> Swedish policymakers realise that the two do not automatically create each other. Networks can easily foster private not social enterprises, and entrepreneurs, as recent West European research demonstrates;<sup>17</sup> while primary care is only a contribution to social capital if it is explicitly universal and comprehensive. The Flemish 'social houses' and the 'city health centres' in Slovenia are visible expressions of such values in modern primary care organisations. These adopt a territorial approach to integrated health and welfare underpinned by mechanisms for ongoing dialogue with a wide cross-section of people in the local neighbourhoods. They point to how the future organisation of primary care in Europe may witness equity and lead to empowerment, and can indicate the direction for future European policy research priorities.

## Box 2 Bulgaria (Sofia) – extended general practice(?)

Everything about Bulgaria in recent times reads right. Five thousand new GPs since 2001; average doctor–patient ratios of 1:1200 for a population of only seven million, extended three and a half year specialist post-qualifying courses in general medicine backed up by progressively increasing gatekeeper roles and provision for the further advance of group practices by the National Insurance Fund in 2009; and a practice nurse for virtually every GP across Bulgaria's 28 health districts. Taken together, this is an impressive portfolio of change and it is easy to understand why the EFPC experts nominated Bulgaria as a Central European exemplar of the modern extended general practice.

The fieldwork experience, however, is not nearly so clear cut. As in Hungary<sup>1</sup> and Belgium, the bottom line for the maintenance of the primary care organisational unit in Bulgaria remains the individual medical cabinet, and the risk of a shift towards the privatised polyclinic model, that could render obsolete the country's historic commitment to universal medical care, remains very real. Inculcating Bulgarian people with a philosophy of generalist primary health services as a social mission has a long way to go.

The risk of privatisation is evident at the group general practice occupying rooms 211 to 216 in the capital city's 18th municipal ambulatory care centre. Upstairs, with no disabled access, appointments system or separate nursing facilities, alongside 20 other medical specialties with which they share corridor waiting areas, the ten GPs cannot make a viable living just from the provision of frontline primary care. Co-payments and clinical specialisms are the prerequisites of a viable business in primary care. This is a local system where less than 10% of the National Insurance reimbursements go to GPs, and at levels which nullify the policy intention of comprehensive longitudinal care for registered patient lists behind the move to 60% capitation payments. GPs are the Insurance Fund's main litigants. In Bulgaria the 290 municipalities still guarantee annual block grant allocations to the multi-specialist polyclinics that occupy 90% of their locally rented buildings. Accordingly, at the 18th, the pragmatic vision of the leading GPs is for an increase of patient treatment episodes from 70 to 85%, but through the mechanism of joint ownership of future private health centres with selected specialists, subject to majority GP control and with commercial Pharma support if necessary. For the present, each doctor will retain a separate 'cabinet' utilising their collective limited company status simply to share amenities and an accountant, plus two midwives.

The prospects for the extended general practice in Bulgaria are both promising and uncertain. Expenditure on primary medical care now equals that on specialist outpatients; there is a first GP textbook at Pevlen University and the emergent local and national professional GP associations in Sofia look both to the World Bank and to prospective new EU partners for financial backing and policy guidance. These two powerful external influences are not, however, always singing from the same hymn sheet. The 'mushrooming' 100 plus new private hospital units since 2007 find favour with the former, while the development of inter-practice night-time rotas of GP co-operatives covering populations of 25 000 with support from new National Association clinical guidelines, is directly in line with contemporary West European GP counterparts. Current trends can simultaneously point in opposite directions. A thousand doctors have undertaken the specialist GP qualification. Another thousand have left the country. All the public universities now have major departments of general medicine. But the highest-status GP is still only at associate professor level. The National Association is negotiating for new public health targets for coronary heart disease and cancer prevention to be converted into General Medical Fee for Service schedules, but the government has yet to afford it legal rights as a professional body, and one-third of GPs nationally have not taken up membership.

With such divergent patterns the future of primary care organisation in Bulgaria is hard to call. Specialist medical practice levels remain excessive, and with so much of healthcare expenditure still from unofficial sources, the scope for change by pro-primary care policymakers is severely constrained.

## Conclusion

The research for this article had a timeframe reaching to 2009/2010 so that it could recommend criteria for the future organisation of primary care which may inform the EFPC and other European agencies. These recommendations are derived from the research exercise undertaken in the two articles to identify representative case exemplars, trends and common issues.

The investigation has highlighted, in summary, the risks of increasingly fragmented organisational developments in primary care which offer individual business advantages as units of economic activity but lack overall coherence as social policy. This is an assessment that has echoes in related recent European research, in which a growing concern regarding the future continuing care role of the family doctor can be detected.<sup>18,19</sup> It is also an assessment that helps to explain why Europe should now play a positive part in

### Box 3 Ghent (Belgium) – the extended general practice(?)

Despite a national policy commitment to their progress in principle, less than one in four general medical practitioners in Belgium belong to group practices, and the majority of these are themselves still very small. Most of these too are in the northern Flemish regions of what is very much a federal health system, where national policy is largely confined to issues of hospital utilisation and reimbursement through a central health insurance agency (INAMI). This operates for social security purposes to large population units of 100 000. Even in Ghent, with its 280 000 population, there are only 94 GPs and at weekends probably only a pair of these will be on duty. Private solo practice in the medical office prevails, especially in Walloon areas. There is direct access to paediatricians and gynaecologists and only 2% of the country is subject to GP capitation funding arrangements. Home care has historically been the Belgian *leitmotif* and the family doctor has not enjoyed the pre-eminent community professional role that applies, for example, in the Netherlands and UK. Dedicated, university-based GP training did not commence until the 1980s in Belgium. Primary care research remains dependent on a handful of colleges and the Ministry of Education, and GPs' self-employed contracts have developed in tandem with those for home care nurses and local physiotherapists.

Nevertheless, there are signs of growth in Belgian primary health care, with the medical office model being incorporated by progressive local authorities into strategies for comprehensive community health improvement. This is the case, for example, in Nieuw Gent, a poor neighbourhood of 6500 people largely comprising social housing that dates from the early 1960s. Unemployment is over 13%, and 20% of residents are of non-Belgian origin. In 2000, there was one part time GP. In 2006, in premises rented from the local authority and supported as a medical training unit by the University of Ghent there were three. At Nieuw Gent the latter's prospective graduates learn the skills of community diagnosis in week-long placements, and experience for the first time an interprofessional teamwork philosophy in practice as they operate alongside sessional dieticians, nurses and physiotherapists, and, more significantly, up to 30 community development and social workers based at the other facilities co-ordinated from the neighbourhood's community welfare centre. As a result, while the GP registered list remains less than 2000 and treatment still very much individually based, the doctors are now also paid to go out to provide a range of free health prevention and promotion clinics at such designated 'community buildings' as the *Kind et Gezin* (mother and child) centre and *Wijkresto* eating place, and with such community networks as the INLOOP Parenting Support and *Meisjeswerking* (girls' activities) teams.

In Ghent there are now 24 such small general practices, several of which combine their medical offices in collaboration with local facilities that include nine recently designated primary health centres, more than one-tenth of the national total. The regional approach is expressed in the current 'Healthcare, Welfare and Family' title of the responsible Flemish Ministry, which increasingly looks beyond the national administration to EU support and sponsorship for community health programmes and development. Belgium-wide there are now formal links with the *Landelijke Veriging Georganiseerde* (Association of Organised Primary Health Care) and Towards Unity for Health/Community Network sited in Utrecht; while the GPs' own *domus medica* has shifted its attention from trade union rights to issues of clinical quality assurance and evidence-based protocol production. As a reaction to the burgeoning telemedicine and specialist outreach services of private providers and the larger hospitals, especially in southern Belgium, this community-oriented approach is being deliberately designed as a cost-effective alternative for future INAMI funding. Its marketing pitch has many drawbacks including the conservatism of many GPs themselves, whose average nationally is 50 and who often resent the encroachment into professional territory of their liberal academic members. But the approach also has a unique selling point (USP). By preserving the Belgian version of the medical cabinet within a distinctive cultural context of local initiatives for enhanced social capital and domiciliary care, it does give the extended general practice a chance to progress.

providing an appropriate level of strategic leadership to the organisational developments of local primary care.

This EFPC position paper points to the importance of not addressing the future organisational agenda in primary care from a professionally defensive position. General medical practice is as vital to the future health of the new Europe as it has been in the past in what is now Western Europe, but it is not and should not be

the monopoly agency. The range and relationships of the organisations described in the pages above firmly suggest that throughout Europe planned, and sometimes unplanned, competition is here to stay. With this competition comes diversity of service provision, new cross-professional configurations and substitution, the entry of external commercial and charitable agencies and, with varying degrees of effectiveness, management bodies seeking to gain an improved



return on investment for payers and purchasers of health and health care. In another decade it is possible that a future list of European case exemplars would be dominated by the managed care enterprise model.

Such a scenario has its dangers. The shape of the managed care enterprise can be shaped by wealth, in terms of both ownership and service selection. It may fit better with the forces of globalisation than it does with indigenous cultures. It may favour private gain over public well-being. It tends to be more technological than pastoral. Given these dangers, robust criteria are needed to shape both the policy and the practice of primary care agencies as social organisations in Europe. Accordingly, with the EFPC members involved in our research, ten criteria have been identified as the basic components of future organisational developments in primary care. These are listed in Box 4 as a single set of recommendations, with the potential lead (European) institutions for their policy development and delivery. They provide an agenda for the future organisation of primary care and EFPC discussions with its European counterparts.

#### Box 4 Effective primary care organisation in Europe

The essential components of effective primary care organisation in Europe are:

- a comprehensive understanding of the guiding principle of equity (EFPC)
- an openness to relevant management and policy research from beyond health care (European Health Management Association)
- contextual congruence (EU Commission Health Cabinet)
- territorially based roles and responsibilities (EU Research Frameworks)
- networking arrangements that effectively combine site-based personal contact care with indirect and virtual self-care (International Network of Integrated Care)
- sound support infrastructures especially in education, professional development and premises (member states)
- inclusion of mainstream public and mental health responsibilities (Network/Towards Unity for Health, Europe)
- mixed proprietorship across professions and lay representatives (EU Directorate of Health and Consumer Protection)
- integration with community health and development (WHO European Office)
- compliance with core values of universal and longitudinal service access (WONCA and European Nursing Association)

The list in Box 4 represents the considered views of a cross-section of EFPC members, as expert witnesses of the current organisational developments in primary care across the continent. As such they were articulated at the Semmelweis workshop in July 2008. Derived in no small part from 12 contemporary case exemplars 30 years after the world truly discovered primary health care at Alma Ata, it is to be hoped that these ten recommended 'core components' will together help today's European institutions to do the same.

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#### CONFLICTS OF INTEREST

None.

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