Primary Care and Public Health in the UK and Canada: Quality of Service delivery and Lessons for Ukraine

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Agenda

- Common characteristics of Canadian and UK primary health care
- Defining Primary Care
- Key determinants of successful implementation
- Primary Care in Canada and the UK
- Primary Care and Public Health
- Key Issues and Challenges
- Strategies for Change

Why Primary Health Care?

- Primary health care became a core policy for the World Health Organization with the Alma-Ata Declaration in 1978 and the 'Health-for-All by the Year 2000' Program.
- All health systems, to be effective and efficient, must rest on strong foundations: first among these are properly designed and adequately funded and recognized components for Public Health and Primary Health Care.
- Identified key principles
  - Social equity
  - Nation-wide coverage
  - Self-reliance
  - Inter-sectoral coordination
  - People's involvement in the planning and implementation of health programs

Distinguish from – primary care, primary medical care, family doctor/general practice

Defining Primary Health Care

- Health or medical care that begins at time of first contact between a physician or other health practitioner and a person seeking advice or treatment for an illness or an injury.
- Essential health care made accessible at a cost that a country can afford, with methods that are practical, scientifically sound and socially acceptable.
- Everyone should have access to it and be involved in it, as should other sectors of society.
- It should include community participation and education on prevalent health problems, health promotion and disease prevention, provision of adequate food and nutrition, safe water, basic sanitation, maternal and child health care, family planning, prevention and control of endemic diseases, immunization against vaccine-preventable diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.

What is Primary Health Care?

- PHC is essential health care that is socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors.
- It includes the following:
  - health promotion
  - illness prevention
  - care of the sick
  - advocacy
  - community development

Who delivers primary health care?

- Professionals:
  - Generalist physicians
  - Nurses
  - Pharmacists
  - Allied health professionals
- Non-professionals:
  - Lay health workers
  - Peer support
  - Families
  - Patients - self care

Key Determinants for Successful Primary Healthcare Implementation

- **Capacity**: the key role of individuals and institutions in designing and implementing reforms;
- **Continuity**: the stability required for reforms to be implemented, and the institutional memory that prevents mistakes from being repeated
- **Catalysts**: the ability to make use of windows of opportunity
- **Contexts**: policies relevant and appropriate to circumstances.

Key Determinants Continued

- Multi-disciplinary teams – physicians, nurses, allied health professionals, lay health workers
- Continuity of patient care (experienced continuity):
  - Excellent information transfer following the patient *(continuity of information; continuity and coherence of medical record)*
  - Effective communication between professionals and services and with patients *(cross-boundary and team continuity)*
  - To be flexible and adjust to the needs of the individual over time *(flexible continuity)*
  - Care from as few professionals as possible, consistent with other needs *(longitudinal continuity)*
  - To provide one or more named professionals with whom the patient can develop a therapeutic and interpersonal relationship *(relational or interpersonal continuity)*
- Defined practice list – a registered population

Commonalities between UK and Canada primary care

- Ease of accessibility - local services, accessible and appropriate
- Gatekeeping role – manages care and refers for other care
- Traditional medical models of PC moving towards more primary health care
- Long established training programmes in primary care (UK since 1950s) – specialist generalists
- Professional standards for training – academic and professional qualifications
- Accountability and performance monitoring – professional regulation and validation, agreed core activities, CPD, clinical audit etc
- Universal standards of care
- Shift from medical professional to broader inter-professional models
- Adequately rewards practitioners
- Funding mechanism focused on primary care

Current System in Canada

- Thirteen provincial and territorial health care systems that operate within a national legislative framework
- Canada Health Act (1984) defines standards required to received federal funding: universality, portability, public admin, accessibility, comprehensiveness.
- Most health care publically financed, but privately delivered.
- Fee for service remuneration, clinical autonomy, control over location and organisation of practice.
- Physicians at heart of decision-making.
- Medically necessary services are free at point of care.
- Specialist referral by GP is the norm.

Source: Hutchinson et al (2011); Freund et al (2015)

Early 2000's policymakers realized:

- Limited potential for big reforms, incremental change needed.
- No single funding for payment method will transform primary health care.
- Primary health care renewal needs major investment in system transformation and infrastructure.
- In 2000, $800 million Primary Health Care Transition Fund to accelerate reform.
- In 2003, First Minister's Health Accord $16 billion federal investment in reform.

Source: Hutchinson et al (2011); Marchildon et al (2016)

Key Developments - Canada

- Support for interprofessional primary health teams.
- Group practices and networks.
- Patient Enrollment with a primary care provider.
- Financial incentives and blended-payment schemes.
- Primary health care governance mechanisms.
- Expansion of primary heath care provider pool.
- Electronic medical records.
- Quality improvement training and support.

Source: Hutchinson et al (2011); Birtwhistle et al (2015)

Statistics - Canada

- Family physicians 51% of physicians.
- 23% of family physicians in solo practice, 74% in group practice.
- 48.3% of physicians derive 90%+ of income from fee for service payments.
- 91% of Canadians report regular source of care, usually a family physician.
- 13% have difficulty in accessing routine or ongoing care
- In 2004, 70% rated quality of care from family physicians as excellent or very good, this increased to 76% by 2010.

Source: Hutchinson et al (2011); CAHSPR (2013

Primary Care Practice Settings

- Community health centres – integration of health professionals under one roof.
- Family health networks – groups of family physicians working to coordinate patient care.
- Family health teams – locally driven teams to provide continuity of care in localities.
- Walk-in clinics – convenient for patients, open after work hours.

Source: University of Ottawa (2016)

Community-Based Primary Health Care

- First and most frequent point of contact with the health system.
- Gateway that connects patients with the care they need.
- Covers a range of services across the continuum of care (public health, health promotion, disease prevention, chronic disease management, treatment, rehabilitation support, home care, end-of-life care).
- Integrated interprofessional and interdisciplinary care model, collaboration of many providers.

Source: CIHR (2015)

Outcomes - Canada

- Improved access to primary care services.
- Better coordination and integration of care.
- Improved quality of care with a focus on prevention and management of chronic and complex illness.
- Emphasis on patient self-care.
- Electronic medical records.
- Population-based approach to planning and delivery.
- Public participation in decision making.
- Greater heath equity, accountability, efficiency, sustainability.

Key Issues and Challenges - Canada

- System complexity risk of system incoherence, high admin and transaction costs, change process hindered by multiple reforms.
- Physicians hesitant to embrace any model seen as threatening professional autonomy.
- Transition to team-work challenging given that physicians used to being undisputed team leaders.
- Investment is substantial.
- Limited performance measurement and disease management support.
- Persisting inequities in access to care.

Source: Hutchinson et al (2011); Levesque et al (2015)

Primary Care in the UK

- Long tradition of local, community-based, generalist healthcare practitioners in UK – now mainly group practices/teams
- Free, universal and comprehensive
- Well embedded concept of the practice with a patient population (the patient list) 2,500- 20,000+
- General practitioner manages care and acts as gatekeeper to secondary care
- National contract with some local variation
- Capitated funding with some performance and special service funding – although this is changing
- Role of community nurses well established and strong community health services system
- More recent acknowledgement of role of community pharmacists

General practice

- Universal system of groups of General practitioners supported by nurses – about 11,000 practices in UK
- Normally two or more doctors – with some practices of 15+ and multi-practices
- Historical trend towards larger practices – supported by government and professional policies
- First point of contact
- Registered list of patients
  - Average list size between 1600 and 2100 patients
- Refer to all other care
- Approximately 340 million contacts per year
- Provide all care management for their patients

Other primary health services

- Community health services (part of NHS)
  - Wide range of professional health services - nurses, care assistants
  - Community specialist doctors
- Work alongside general practice but new more integrated models emerging

And range of other community health services - mainly paid for privately

- Dental health services
- Opthalmic services
- Pharmacists
- Podiatrists

Closer working between general practice and pharmacists becoming more common

Current developments in the UK

- Move to larger practice organisations
- Developing networks of practices and local groups of practices:
  - As loose networks of co-operation
  - Federations
  - New organisational models
- However, the practice currently remains the key unit of organisation
- Changing payment methods – shift away from single contract structure
- Move away from pay for performance based on specific clinical and process activities (Quality and Outcomes Frramework)
- Still capitation based but mixture of core for GP activities and additional services paid against agreed activities

Key Issues and Challenges - UK

- How to move away from a structure dominated by the general practitioner but retain essential positive features of localised general practice
- Prioritising community based care and support for people with long term conditions and multi-morbidity
- Many physicians hesitant to embrace any model seen as threatening professional autonomy – gradual shift away from a partnership model
- Building more networks of practices and multi-practice organisations with stronger population focus
- Gradual increase in investment following decline – aim for 12% of NHS budget + pharmaceutical costs.

Primary Health Care-Oriented Countries

- Have more equitable resource distributions
- Have health insurance or services that are provided by the government
- Have little or no private health insurance
- Have no or low co-payments for health services
- Are rated as better by their populations
- Have primary care that includes a wider range of services and is family oriented
- Have better health at lower costs

Sources:

Starfield and Shi, Health Policy 2002; 60:201-18.

van Doorslaer et al, Health Econ 2004; 13:629-47.

Schoen et al, Health Aff 2005; W5: 509-25.

Primary Health Care and Outcomes

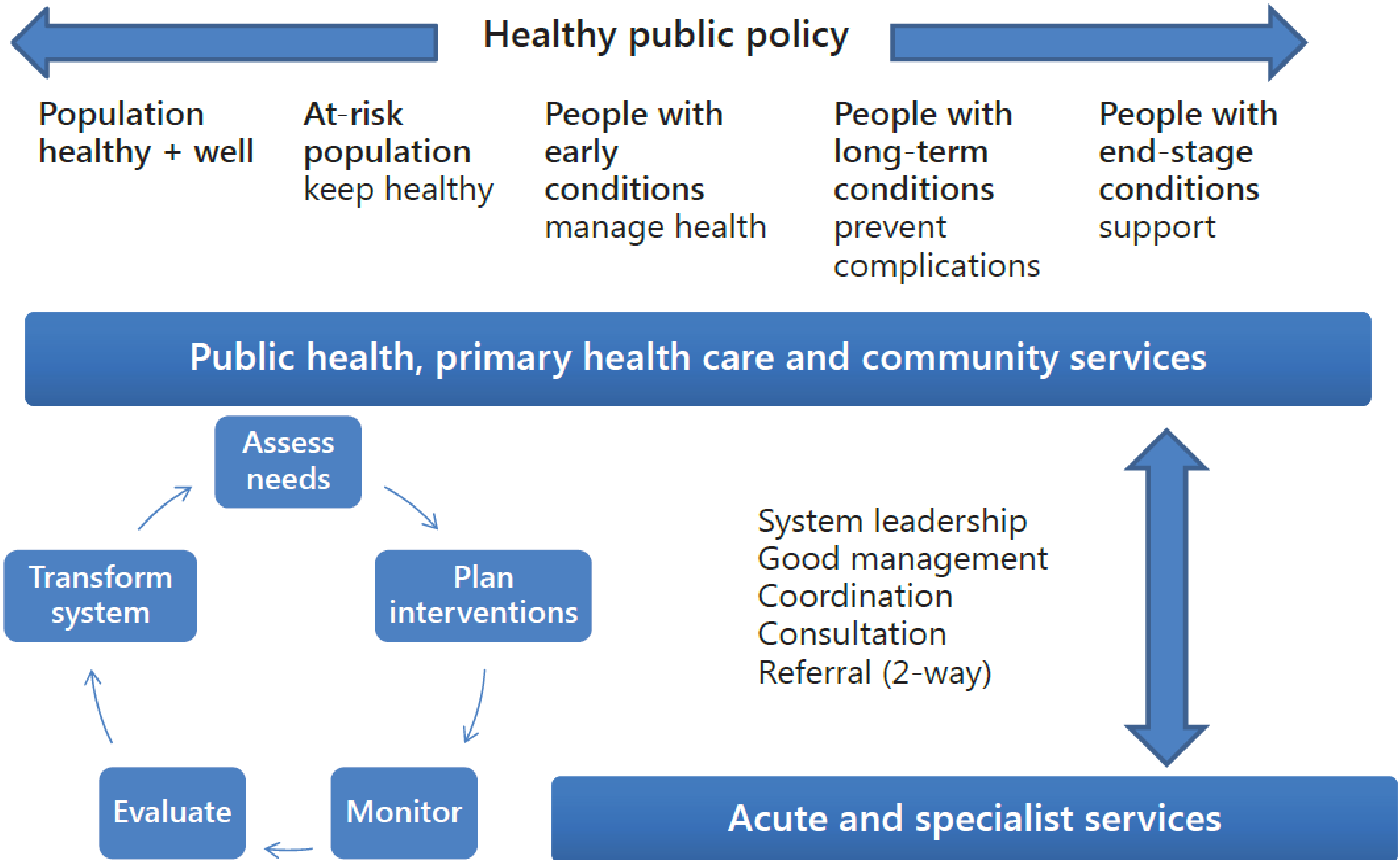
Many other studies done WITHIN countries, both industrialized and developing, show that areas with better primary care have better health outcomes, including total mortality rates, heart disease mortality rates, and infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer, and melanoma.

The opposite is the case for higher specialist supply, which is associated with worse outcomes.

Sources:

Starfield et al, Milbank Q 2005;83:457-502.

Macinko et al, J Ambul Care Manage 2009;32:150-71.



Strategic alignment of policy and services
across the continuum of health needs (schematic)
Healthy public policy
Population healthy + well
At-risk population keep healthy
People with early conditions manage health
People with long-term conditions prevent complications
People with end-stage conditions support
Public health, primary health care and community services
Assess needs
Plan interventions
Monitor
Evaluate
Transform system
System leadership
Good management
Coordination
Consultation
Referral (2-way)
Acute and specialist services

Primary Care and Public Health

- Public health care includes basic medical and curative care at the first level, as well as secondary and tertiary care.
- Five principles: Accessibility, Public Participation, Health Promotion, Appropriate Technology, Intersectoral Cooperation
- Primary Care is the first line clinical service that provides an entry point to the health care system.
- A recent review of prevention and health improvement activities in general practice in the UK found that screening and secondary prevention were dominant. This reflects:
  - a current focus on prevention is on creating diseases from risk factors
  - transferring the major responsibility for prevention from public health to clinical services, although the major concern for equity is population benefit
  - building markets for the pharmaceutical and other new health industries (new professionals, new professional roles, consulting activities)

Changing Primary Care Practice

- It's difficult! However, the use of various implementation strategies (either individually or in combination) most often achieves small-to-moderate (but important) improvements in the performance of health care providers.
- For example median absolute improvements in performance for implementing clinical practice guidelines were:
  - 21% (range 10 to 25%) for patient-mediated interventions
  - 4% (range –1 to 34%) for reminders
  - 8% (range 4 to 17%) for dissemination of educational materials
  - 7% (range 1 to 16%) for audit and feedback
  - 6% (range –4 to 17%) for multifaceted interventions involving educational outreach visits

Some Strategies for Change:

- The effects of some interventions, such as audit and feedback, are more likely to be larger when baseline compliance to recommended practice is low and when the intervention is provided more intensively.
- Other factors could increase the effects of interventions. For example, for educational meetings, which are likely the most widely used implementation strategy in low-income and middle-income countries, more interactive meetings and higher attendance rates may increase their effectiveness.
- The effects of interventions may also depend on the targeted behaviour. For example, the effects of educational outreach visits were relatively consistent for prescribing, but varied widely for other behaviours.
- Tailoring interventions to address specific barriers to change in a particular setting is probably important but further work on identifying, selecting, and addressing barriers to change is needed.

Source: Lewin et al Lancet (372) 2008.

Limits - Population versus Clinical Bases for Health Policy Decisions

Individual risk factors for tuberculosis in Russia:
1) low household wealth, 2) incarceration in prison or detention, 3) drug misuse, 4) financial insecurity, 5) unemployed, 6) overcrowded living, 7) living with a tubercular person, 8) heavy drinking

Population risk factors for tuberculosis in Russia:
1) unemployment, 2) consumption of raw milk

Conclusion: Health policy decisions should be targeted with consideration of risk factors that are common in populations. The differences between societal and social influences is the difference between population and individual approaches to risk factors.

Source: Coker et al, BMJ 2006; 332:85-7.

Strategy for Change

- Achieving primary care
- Avoiding an excess supply of specialists
- Achieving equity in health
- Addressing co- and multi-morbidity
- Responding to patients' problems: using International Classification for Primary Care for documenting and follow-up
- Coordinating care
- Avoiding adverse effects
- Adapting payment mechanisms
- Developing information systems that serve care functions as well as clinical information
- Primary care-public health link: role of primary care in disease prevention

Five Key Enablers for Change

All are interconnected and fundamental to achieving change:

- Leadership
- Policies and Legislation
- Capacity Building
- Innovation and Spread
- Measurement and Reporting

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