



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH

(EXPH)

Definition of a frame of reference in relation to primary care
with a special emphasis on financing systems
and referral systems

The EXPH approved this opinion for public consultation at the 4th plenary of 27 February 2014

44

45 **About the EXPert Panel on effective ways of investing in Health (EXPH)**

46

47 Sound and timely scientific advice is an essential requirement for the Commission to
48 pursue modern, responsive and sustainable health systems. To this end, the Commission
49 has set up a multidisciplinary and independent Expert Panel which provides advice on
50 effective ways of investing in health (Commission Decision 2012/C 198/06).

51

52 The core element of the Expert Panel’s mission is to provide the Commission with sound
53 and independent advice in the form of opinions in response to questions (mandates)
54 submitted by the Commission on matters related to health care modernisation,
55 responsiveness, and sustainability. The advice does not bind the Commission.

56

57 The areas of competence of the Expert Panel include, and are not limited to, primary
58 care, hospital care, pharmaceuticals, research and development, prevention and
59 promotion, links with the social protection sector, cross-border issues, system financing,
60 information systems and patient registers, health inequalities, etc.

61

62 **Expert Panel members**

63 Pedro Barros, Margaret Barry, Helmut Brand, Werner Brouwer, Jan De Maeseneer
64 (Chair), Bengt Jönsson (Vice-Chair), Fernando Lamata, Lasse Lehtonen, Dorjan Marušič,
65 Martin McKee, Walter Ricciardi, Sarah Thomson

66

67 Contact:

68 European Commission
69 DG Health & Consumers
70 Directorate D: Health Products and Systems
71 Unit D3 – eHealth and Health Technology Assessment
72 Office: B232 B-1049 Brussels

73 SANCO-EXPERT-PANEL@ec.europa.eu

74

75

76

77

78 **ACKNOWLEDGMENTS**

79

80 Members of the Working Group are acknowledged for their valuable contribution to this
81 opinion.

82

83

84 The members of the Working Group are:

85

86 Expert Panel members

87

88 Prof. Werner Brouwer

89 Prof. Jan De Maeseneer Chair / Rapporteur

90 Prof. Lasse Lehtonen

91 Dr. Dorjan Marušič

92 Dr. Sarah Thomson

93

94

95 External experts

96

97 Dr. Dionne Kringos

98 Dr. Judith Smith

99

100

101 The declarations of the Working Group members are available at:

102 http://ec.europa.eu/health/expert_panel/experts/working_groups/index_en.htm

103

104

105 **ABSTRACT**

106 In this opinion the Expert Panel on effective ways of investing in Health (EXPH),
107 considers primary care to be the provision of universally accessible, person-centered,
108 comprehensive health and community services, provided by a team of professionals
109 accountable for addressing a large majority of personal health needs. These services are
110 delivered in a sustained partnership with patients and informal care givers, in the context
111 of family and community and play a central role in the overall coordination and continuity
112 of people's care.

113
114 The Expert Panel notes that strong primary care systems contribute to equity and
115 improved health outcomes but emphasizes that primary care needs to continuously
116 evolve if it is to respond to changing challenges in society.

117
118 A strong primary care system can be the starting point for effective referral systems,
119 insuring integration between different levels of care. Gate-keeping can offer advantages
120 to patients, providers and the health system so long as important organisational and
121 patient management factors are taken into account.

122
123 The Expert Panel emphasizes the importance of ensuring that primary care services are
124 accessed by the population without facing financial hardship and notes that there is little
125 evidence that user charges lead to more appropriate use and cost control. When user
126 charges are present, there should be protecting mechanisms for people with low incomes
127 and people who regularly use health care.

128
129 European Union (EU) health systems show a trend towards blended provider payment
130 systems in primary care, combining risk-adjusted capitation with some fee-for-service
131 reimbursement. For pay-for-performance (P4P), usually an add-on to another payment
132 system, the Expert Panel describes factors that may contribute to the effectiveness of
133 P4P programs and implementation features that may weaken the effectiveness of
134 financial incentives.

135
136 Finally, the Expert Panel formulates general research questions in relation to the
137 development of primary care in Europe, specific research questions in relation to referral
138 and financing and strategic directions at different levels.

139
140
141 **Keywords :** Primary (Health) care, definition, financing, referral systems, EXPH, Expert
142 Panel on effective ways of investing in Health, scientific opinion

143
144 Opinion to be cited as :
145 EXPH (EXpert Panel on effective ways of investing in Health), Preliminary report on
146 Definition of a frame of reference in relation to primary care with a special emphasis on
147 financing systems and referral systems, 27 February 2014

148
149 © European Union, 2014

150
151 ISSN 2315-1404 ISBN 978-92-79-34907-2
152 doi:10.2772/40087 ND-BA-14-001-EN-N

153
154 The opinions of the Expert Panel present the views of the independent scientists who are
155 members of the Expert Panel. They do not necessarily reflect the views of the European
156 Commission. The opinions are published by the European Union in their original language
157 only.

158 http://ec.europa.eu/health/expert_panel/index_en.htm

159			
160			
161	TABLE OF CONTENTS		
162			
163			
164			
165	ACKNOWLEDGMENTS		3
166	ABSTRACT		4
167	1. BACKGROUND		6
168	2. TERMS OF REFERENCE.....		7
169	3. OPINION.....		8
170	3.1. Introduction: Primary care and health system performance.....		8
171	3.1.1. Primary care scoping.....		8
172	3.1.2. Health system goals.....		9
173	3.1.3. Challenges for health systems in a changing world		11
174			
175	3.2. Primary care: definition		14
176	3.2.1. History		14
177	3.2.2. Core-definition		19
178	3.2.3. Developments in primary care		21
179			
180	3.3. The role of referral systems in strengthening health system performance...		27
181	3.3.1. What is the purpose of referral?.....		27
182	3.3.2. What makes an effective referral system?		28
183	3.3.3. Conclusion		31
184	3.3.4. Future research		32
185			
186	3.4. Financing primary care		37
187	3.4.1. Introduction.....		37
188	3.4.2. Ensuring an adequate level of financing for primary care		37
189	3.4.3. Ensuring equitable access to primary care		40
190	3.4.4. Paying providers to promote efficiency and quality in primary care		
191	delivery, including financial incentives to improve care coordination.....		44
192	3.4.5. Areas for future research		49
193	3.4.6. Conclusions and recommendations.....		52
194			
195	4. LIST OF ABBREVIATIONS		56
196	5. REFERENCES.....		57
197	6. GLOSSARY		64

198

199 **1. BACKGROUND**

200 The Health and Consumers Directorate General (DG SANCO) of the European
201 Commission seeks to investigate how European health systems could benefit from a
202 better integration between different levels of health care, both in terms of increased cost-
203 effectiveness, and in terms of improved quality of care and equity.

204 This investigation should likely be organised along the following three lines of research:

205 First, develop a common understanding of the concept of primary health care in the EU,
206 including its goals, functions, and the players involved, and illustrate differences in
207 implementation. Furthermore, identify the differences between community-based care
208 and primary care and the defining factors of both concepts that can be applied across the
209 diversity of European health systems.

210 Second, a deeper reflection is needed on the role of effective referral systems in ensuring
211 integration between all levels of the health system and in helping to ensure that people
212 receive the best possible care closest to home. An up-to-date overview of referral
213 systems in the EU is actually not available.

214 Third, investigate how to identify and analyse existing typologies of funding mechanisms
215 in primary health care: to individual providers (e.g. fee-for-service, capitation, salaried
216 staff, mixed systems), and at higher organisational levels (e.g. lump-sum envelope
217 systems and case-mix adjustments). The aim is to identify how financing mechanisms
218 may contribute to the functioning of primary care especially in relation to the integration
219 of care, both within primary care and in relation to other sectors.

220

221 **2. TERMS OF REFERENCE**

222 The Expert Panel on effective ways of investing in Health (EXPH) is requested to provide
223 its views on how to structure the investigation, its objectives, main lines of research and
224 methodology to be adopted on how better integration of care could contribute to cost
225 effective and high quality health care systems. In particular, the Expert Panel should:

- 226 1. Provide SANCO with a comprehensive and operational definition of primary care -
227 which includes goals, functions, and players involved. It should also define
228 community-based care, explain the differences with primary care, and present the
229 defining factors of both concepts that could be applied across the diversity of
230 European health care systems.
- 231 2. Pronounce itself on the role of effective referral systems in ensuring the
232 integration between all levels of the health system and helping ensure that people
233 receive the best possible care closest to home. The panel should also provide
234 advice as to whether a dedicated study on referral systems is needed.
- 235 3. Identify the main investigation lines which should be pursued in analysing the
236 financing of primary health care and integrated care in order to guide DG SANCO's
237 future activities on financing mechanisms in primary health care.

238

239 **3. OPINION**

240 **3.1.Introduction: Primary care and health system performance**

241 This introductory section briefly sets out the goals of a health system, identifies some of
242 the main challenges facing health systems in Europe, and considers the role of primary
243 care – the first level of a health system – in improving health system performance and
244 addressing these challenges.

245 **3.1.1. Primary care scoping**

246 Ever since the WHO Alma-Ata Declaration (WHO 1978), strengthening primary care
247 has increasingly been considered to be of the greatest importance for improving
248 population health and wellbeing, and building more equitable societies.

249 Primary care is the first level of a health care system where people present their
250 health problems and where the majority of the population’s curative health needs,
251 health promotion and preventive health needs are satisfied (Starfield 1994).
252 Effective primary care not only prevents diseases at early stages, but also
253 stimulates people to take up a healthy life style. Overall health is considered within
254 primary care in a more holistic matter, paying not only attention to medical health
255 needs, but also to other causes of ill health, such as social or employment
256 determinants. This makes primary care more health-centric than disease-centric.
257 Given its key characteristics, primary care has never left the policy agenda. It is
258 one of the major strategies to realise the new European policy for health – Health
259 2020 – and to achieving the United Nation’s Millennium Development Goals, such
260 as reducing maternal and child mortality. In the spirit of the Alma-Ata Declaration
261 the World Health Organisation articulated in its World Health Report 2008 (WHO
262 2008) the need to bring responsive health services closer to the population and to
263 provide people-centred and equitable care.

264 The scientific evidence–base that strong primary health care contributes to
265 improved health care system performance has significantly increased over time
266 (e.g. Delnoij et al 2000; Macinko et al 2003; Shi et al 2005; De Maeseneer et al
267 2007). The most recent study (Kringos et al 2013a), performed across 31 European
268 countries, looked at the "strength" of primary care. Countries are commonly
269 considered to have a 'strong' primary care system when the key functions of
270 primary care are well developed, and they are supported by essential conditions. In
271 other words: we speak of a strong primary care system when primary care is
272 accessible, coordinates care on a continuous basis, provides a broad range of health
273 care services (comprehensiveness), and operates with supportive governance
274 structures, appropriate financial resources and investments in the development of
275 the primary care workforce. The study showed that at the present time, strong
276 primary care is associated with better population health, lower rates of unnecessary
277 hospitalizations and relatively lower socioeconomic inequality in self-perceived
278 health. The same study (Kringos et al 2013b) showed that countries with relatively
279 strong primary care in Europe are Belgium, Denmark, Estonia, Finland, Lithuania,
280 the Netherlands, Portugal, Slovenia, Spain, and the UK. The study also showed that

281 countries with a relatively strong primary care structure have higher total health
282 care expenditures than countries with a relatively weak primary care system.
283 However, countries with more comprehensive primary care had a slower growth in
284 health care spending, compared with countries that provided less comprehensive
285 services. European countries either have many primary care policies and
286 regulations in place, combined with good financial coverage and resources, and
287 adequate primary care workforce conditions, or have consistently only few of these
288 primary care structures. There is no correlation between access, continuity,
289 coordination, and comprehensiveness of primary care within countries: countries
290 have invested without much coherence in the process features of primary care.
291 Therefore, a country may provide easily accessible primary care, but at the same
292 time may offer little continuity of care, or provide a small scope of health care
293 services in primary care.

294 This points to room for further improving the process of delivering primary care
295 systems. When examining why countries differ in the strength of primary care, one
296 finds that the primary care orientation (or focus) of a country is determined by
297 various contextual factors that influence the policy priorities of a country (Kringos
298 et al 2013c).

299

300 **3.1.2. Health system goals**

301 Health care system goals can be defined in different ways and the terminology used to
302 describe these goals can differ, although a common set of performance indicators is often
303 included (EXPH 2014).

304 The WHO health system performance framework (WHO 2000) has been particularly
305 influential. It defined a health system as a structured set of resources, actors and
306 institutions related to the financing, regulation and provision of health actions that
307 provide health care to a given population. Health actions are conceived as any set of
308 activities whose primary intent is to improve or maintain health. The overall objective of
309 a health system is to optimize the health status of an entire population throughout the
310 life cycle, while taking account of both premature mortality and disability (Murray and
311 Frenk 2001). It is important to recognize that the boundaries between health and other
312 sectors, such as social care and education, and therefore between promoting health or
313 well-being, for instance, may be difficult to draw.

314 Health systems aim to achieve three fundamental objectives, as defined by WHO:

315 • **Improved health** (for instance, better health status and reduced health
316 inequalities).

317 • Enhanced **responsiveness** to the expectations of the population, encompassing
318 respect for the individual (including dignity, confidentiality and autonomy); client
319 orientation (including prompt attention, access to services, quality of basic
320 amenities and choice of provider);

321 • Guaranteed **financial fairness** (including households paying a fair share of the
322 national health bill; and protection from financial risks resulting from health care)

323
 324 WHO and the EU have identified common values for health systems in Europe. The policy
 325 goals outlined in the World Health Report 2000, a landmark publication for health
 326 systems, are reflected in the values of the Tallinn Charter¹ – solidarity, equity,
 327 participation – and in Health 2020, WHO’s European health policy framework – universal,
 328 equitable, sustainable and high-quality health systems (WHO 2000, 2008, 2012). They
 329 are closely echoed in the values and principles underpinning EU health systems –
 330 universality, access to good-quality care, equity, solidarity – as set out in the European
 331 Commission’s white paper ‘Together for health’ and several Council conclusions (Council
 332 of the European Union 2006, European Commission 2007, Council of the European Union
 333 2011, Council of the European Union 2013). Measuring and monitoring performance of
 334 health care systems, covering these diverse (and potentially conflicting) health system
 335 goals, remains an important challenge (EXPH 2014).

336
 337 Table 1 summarises policy goals for the health system, distinguishing between those that
 338 are intermediate or ‘instrumental’ and those that are ‘final’. The former are valued not in
 339 their own right, but for their ability to enable the health system to meet its ultimate aims
 340 of improving health, securing financial protection and providing services in a way that is
 341 aligned with user needs and preferences. Internationally, and among a wide range of
 342 multilateral and national organisations, there is remarkable consensus about the range of
 343 health system goals, although concepts such as responsiveness are not always
 344 consistently defined (Smith and Papanicolas 2013).

345
 346 Globally, the World Health Report 2010 has given renewed impetus to the attainment of
 347 universal health coverage, which it defines as ensuring that ‘all people obtain the health
 348 services they need without suffering financial hardship when paying for them’ (WHO
 349 2010).² The report highlights the critical role of financial (risk) protection in preventing
 350 people from being pushed into poverty when they have to pay for health services out of
 351 their own pockets, noting that this requires a strong, efficient, well-run health system,
 352 access to essential medicines and technologies, and sufficient, motivated health workers.
 353 It also identifies aspects of health financing policy of particular importance in moving
 354 towards universal health coverage: raising sufficient money for health; removing
 355 financial barriers to access and the financial risks associated with ill health; and making
 356 better use of available resources. The World Health Report 2013 emphasises the role of
 357 local and comparative research in addressing the challenge of expanding health services
 358 to meet growing needs with limited resources (WHO 2013) – a challenge that is felt in
 359 the EU, albeit to a lesser degree than in other parts of the world, and one that the crisis
 360 has exacerbated.

361
 362 **Table 1 Health system goals**

Instrumental goals	Health system goals: level and distribution across the population (equity)
<ul style="list-style-type: none"> ▪ Equity in access to or the use of health services ▪ Efficiency ▪ Quality ▪ Transparency and accountability 	<ul style="list-style-type: none"> ▪ Health ▪ Financial protection and equity in financing the health system ▪ Responsiveness

363 Source: adapted from WHO 2000 and Kutzin 2009

¹ Signed by international organisations including the World Bank, the European Investment Bank, Unicef and others.

² http://www.who.int/universal_health_coverage/en/

364

365 The level of attainment of these goals relative to resources reflects the performance of
366 the system as a whole.

367 However, as there are variations in health conditions and health systems among
368 countries, the country context needs to be taken into account when comparing the
369 performance of health systems. In addition, due to changing economic, cultural and
370 societal circumstances, over the years some additional health system objectives have
371 been described: e.g. Relevance: i.e. the health system should be able to deal with
372 problems that matter to people, starting from an eco-bio-psycho-social concept of health
373 and well-being. This concept is an extension of the bio-psycho-social model developed by
374 George Engel. Engel enlarged the biomedical model with psychological and social
375 aspects, integrating them in both diagnosis and therapy. He stressed the interaction of
376 the different dimensions. In 1997, Rosenblatt added the ecological perspective as a
377 fourth dimension. In this approach environmental factors are also integrated in a
378 comprehensive approach towards patients and communities. This approach requires
379 health systems to be dynamic and innovative.

380 The Expert Panel proposes the use of these essential characteristics of a high-performing
381 health system as criteria for assessment of performance. Measuring and monitoring
382 performance of health care systems, covering these diverse (and potentially conflicting)
383 health system goals, remains an important challenge (EXPH 2014).

384

385 **3.1.3. Challenges for health systems in a changing world**

386 There are fundamental developments that challenge health care systems: demographical
387 and epidemiological developments, scientific and technological developments, cultural
388 developments and "globalization and glocalisation", socio-economic developments (De
389 Maeseneer et al 2007).

390 a. Demographic and epidemiological developments

391 Eurostat forecasts that life expectancy will continue to increase in the EU in the coming
392 decades, to reach 84.6 years for males and 89.1 for females in 2060. The percentage of
393 older people in the population will continue to increase in all EU-member states in the
394 period up to 2020 by 3 to 6% (Social and Cultural Planning Office 2000). Moreover, the
395 proportion of over-75s in the over-65 age will also increase. This increase in life
396 expectancy should be welcomed as a "success story" and a positive societal achievement.
397 The health forecast shows that the world will experience dramatic shifts in the
398 distribution of deaths from younger to older ages and from communicable diseases to
399 chronic conditions during the next 25 years. The epidemiological consequences of this
400 demographic transition will be an increase in diabetes, COPD, depression, ... and a
401 growing number of people with multi-morbidity: according to the study by Barnett et al.
402 (2012) in Scotland half of the people aged 75+ have 2 or more chronic conditions, 2 out
403 of 5 of the 75+ have 4 or more chronic conditions. Obviously, the ageing of the
404 population will have an effect on the health workforce. The retention problems in primary
405 care could be counterbalanced by different solutions, such as training more primary care
406 professionals and increasing the skill-mix in primary care.

407 b. Scientific and technological developments

408 Increasingly rapid scientific progress brings the prospect of new prevention and care
409 possibilities in fields such as genetics, cardiovascular disease, replacement medicine,
410 neuro-sciences, cancer care and mental health care (Health Council of the Netherlands
411 2004). In the decades ahead, a growing scientific understanding of the role that genes
412 play in the development and progress of many different diseases will have an enormous
413 influence on health care, especially in terms of diagnosis and prognosis. It is a challenge
414 to find appropriate ways of integrating information coming from genomics, proteomics,
415 etc. in the provider-patient interaction in the clinic. Further, advances in information and
416 communication technology (ICT) will enhance communication.

417 The development of Evidence Based Medicine provides an important tool to better
418 underpin health care practice and organisation. However it is clear that apart from
419 "health evidence", we will need more research about "contextual evidence" (looking at
420 "effectiveness" in the relevant practice-context) and "policy evidence" (looking at
421 "efficiency" from an equity perspective) (De Maeseneer et al 2003).

422 c. Cultural developments

423 The role of patients in health care has changed over time. Nowadays, patients are acting
424 more and more as consumers. Better education enables people to play a more active role
425 in the management of their own health conditions (especially chronic conditions) and to
426 be active participants in the governance of health care institutions. The patient/citizen is
427 "beneficiary", "consumer", but also a key "health actor". The transition from the
428 "user/patient/beneficiary" to "client/consumer" perspective has important consequences
429 for the interaction at the point of service delivery.

430
431 In addition, both in Western countries and in developing countries, there is an increasing
432 "medicalisation" of daily life leading to what some consider the "manufacture" of new
433 diseases (Moynihan 2003). This has been described as the "patient paradox", whereby
434 commercial interests promote overtreatment of profitable conditions, including
435 asymptomatic and essentially conditions detected by screening, leaving inadequate
436 resources for patients with complex and expensive conditions, such as multi-morbidity in
437 frail older people (McCartney 2012).

438 The increasing mobility and migration on the one hand and the concentration of the
439 world population in big cities on the other hand (by 2030, 70% of the world population
440 will live in an urban context; this questions the future of health care supply in rural
441 areas) means the health system will be faced with new challenges as the global problems
442 become apparent at the local level ("glocalisation").

443 Specifically within the EU, there has been growing mobility of health professionals
444 between EU countries in recent years, aided by the mutual recognition of professional
445 qualifications. Moreover, a recent EU Directive (Directive 2011/24/EU on patients' rights
446 in cross-border health care) clarifies the rules on mobility of patients, particularly their
447 access to health services in another EU country, including reimbursement. The Directive
448 also promotes cooperation on health care between EU countries.

449 In some ways all these developments, should be taken into account when improving
450 health systems. Their complexity will require a multi-dimensional response

451

452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497

d. Socio-economic developments and financial constraints

Over the long term, expenditures on health have increased in the last decades, both in absolute (e.g. in euros spent per capita) and relative (percentage of GDP spent on health care) terms, although there have been declines in some countries since the onset of the financial crisis. Thus an increasingly large proportion of national wealth is spent on health care. Most projections of future health care expenditures show that this increase is expected to continue, due to the factors described above (De La Maisonneuve and Martins 2013). Within the EU, total spending on health rose from an average 8.2% of GDP in 2001 to 9.6% in 2011, while public spending on health as a share of total public spending increased during the same period from 13.7% to 15.2% (WHO Health For All Database 2014).

Increasing health care expenditures are not necessarily a cause for concern, because health care results in valuable gains to individuals, society and the economy (e.g. health and productivity). Nevertheless, they raise questions related to the optimal size of health care budgets, fiscal constraints and justification of spending. Resources spent on health care cannot be employed elsewhere in society. Increasing health care expenditures therefore have opportunity costs in terms of private and public spending. This underlines the need to explicitly consider the marginal costs and benefits of additional spending on health and the importance of selecting where and how to invest within the health care sector, so as to promote the attainment of societal and health system goals.

Similar care is required in relation to cutting health care expenditures, especially in times of limited economic growth, when demand for publicly financed health care is likely to increase due to rising unemployment, falling household incomes and reduced ability to pay out-of-pocket for health care. Health care spending growth has slowed and even declined in some European countries since the onset of the financial and economic crisis (OECD 2012, Reeves et al 2013). Analysis of health system responses to the crisis in Europe suggests that carefully targeted cuts aimed at reducing excess capacity, unnecessarily high prices and inflated wages may generate some savings without damaging the performance of the health system; in contrast, blanket cuts in staff and services, cuts to already low staff wages, cuts that are sustained over time and measures that increase the financial burden for patients are likely to undermine performance by exacerbating or creating inefficiencies and access barriers (Mladovsky et al 2012; Thomson et al 2014 (in press)).

Besides the political and economic questions of optimal allocation of resources, questions regarding fiscal constraints (i.e. how to raise the money required for the health care sector) are prominent as well. Equity in financing, financial protection and equitable access to needed and cost-effective services must be ensured to the highest degree possible, and closely monitored. In that context it must be noted that important differences exist across Europe in how the health system is organized and financed, resulting in significant differences in performance.

498

499 **3.2.Primary care: definition**

500 **3.2.1. History**

501 In this opinion paper, we focus our attention on 'primary care' as originally defined by the
502 WHO at Alma-Ata, and subsequently developed and updated by the Institute of Medicine
503 and others. These definitions encompass health promotion and disease prevention, first
504 contact advice, diagnosis, care for common ailments, referral for specialist advice and
505 treatment, coordination of individual care including for long-term conditions, and end of
506 life care.

507
508 We have not used the term 'community-based care'. One could suggest that community-
509 based care is all the care that is delivered in the community (which comes close to the
510 concept of 'ambulatory care'), and primary care is part of community-based care, where
511 it entails the activities detailed above. Furthermore, 'community-based care' has different
512 connotations between nations, in some cases referring to mental health services, in
513 others to home care for people with disabilities, and so forth. Primary care is a term that
514 has clear international currency, and for that reason we use it to unify the analysis set
515 out in this paper.

516 The defining moment in the contemporary history of primary health care is generally
517 considered to have been the WHO Alma-Ata Declaration of 1978, where it was stated
518 that

519 *'[Primary health care] ... forms an integral part both of the country's health*
520 *system, of which it is the central function and main focus, and of the*
521 *overall social and economic development of the community .'* (WHO, 1978,
522 section VI);

523 The Alma-Ata declaration went on to define primary health care as follows:

524 Primary health care: 'addresses the main health problems in the community, providing
525 promotive, preventive, curative and rehabilitative services accordingly; ---(and) ----
526 includes at least: education concerning prevailing health problems and the methods of
527 preventing and controlling them; promotion of food supply and proper nutrition; an
528 adequate supply of safe water and basic sanitation; maternal and child health care,
529 including family planning; immunization against the major infectious diseases; prevention
530 and control of locally endemic diseases; appropriate treatment of common diseases and
531 injuries; and provision of essential drugs;' (Section VII. 2 and 3) The Alma-Ata definition
532 was striking in its focus on primary care as an approach to health development, and its
533 holistic approach reflecting the concern of WHO in relation to improving the health of
534 populations and minimising disparities in health status within countries. These points were
535 emphasised strongly by Barbara Starfield as critical goals for any health system, as part of
536 her wider analysis of the role and importance of primary care (Starfield 1998).

537 Vuori (1986) suggested four ways of examining primary care: as a set of activities; as a
538 level of care; as a strategy for organising health care; and as a philosophy that
539 permeates health care. The idea of primary care as a level of a health system, and also a
540 strategy or philosophy for organising approaches to care, was taken up by Tarimo (1997)
541 in a paper revisiting Alma-Ata. Tarimo distinguished between **primary health care as**
542 **an approach to health development** (that is largely concerned with population health
543 and community development, 'primary' effectively meaning fundamental and essential)

544 and **primary health care as level of care**, namely the point of first contact between a
545 person and the health system. In many ways, this conceptualises the ideal of Alma-Ata
546 on the one hand, and the pragmatic approach taken by many countries in organising
547 their health services into primary, secondary and tertiary sectors, on the other.

548 Starfield drew together these two conceptions of primary care (health development, and
549 level of care) by regarding it very much as a level in a health system of central
550 importance to overall health service organisation and delivery, and in turn population
551 health and outcomes:

552 'Primary care is that level of a health care system that provides entry into the
553 system for all new needs and problems, provides person-focused (not disease-
554 oriented) care over time, provides for all but very uncommon or unusual conditions,
555 and coordinates or integrates care provided elsewhere by others.' (Starfield 1998,
556 pp 8-9)

557 Starfield identified what she considered to be the four central features of effective
558 primary care as follows:

- 559 i) The point of first **contact** for all new needs
- 560 ii) Person-focused rather than disease-focused **continuous** care over time
- 561 iii) **Comprehensive** care provided for all needs that are common in the population
- 562 iv) **Coordination** of care for common needs and also those that are sufficiently
563 uncommon to require special services.

564 Starfield used these 'four Cs' as a way of assessing the effectiveness of a country's
565 primary care system, and asserted strongly that there was an association between
566 strength of primary care orientation, degree of cost-effectiveness of health care, and
567 level of health outcomes achieved. More recent comparative analyses of the relationship
568 between strong primary care systems and population health (e.g. Kringos et al, 2013a)
569 have produced more nuanced conclusions. For example, Kringos et al's work showed that
570 whilst strong primary care is associated with better population health, it is also
571 associated with higher levels of health spending, albeit that there seems to be a link
572 between comprehensive primary care provision and slower overall growth in health care
573 spending.

574 The Institute of Medicine has developed a definition of primary care updating its previous
575 definition from 1978, recognising three additional perspectives of particular relevance to
576 health policy concerns in 1996 the patient and the family; the community; and the
577 integrated delivery system. Their proposed new definition (Donaldson 1996) is:

578 'Primary care is the provision of integrated, accessible health care services by
579 clinicians who are accountable for addressing a large majority of personal health
580 care needs, developing a sustained partnership with patients, and practising in the
581 context of family and community'.

582 The inclusion of integration of care is an important and highly relevant aspect of the
583 proposed IOM definition, as is the concept of working with people in their family and
584 community context. What is missing however is an emphasis on care co-ordination,

585 something that is an ever-increasing concern for primary care as people are living with a
586 greater number of long-term conditions. The role for primary care in coordinating care for
587 those with complex multi-morbidity, and doing this in partnership with professionals in
588 specialist or secondary care services, social care, mental health services and so forth, is
589 considerable, and something that characterises the challenge facing primary care in
590 2014. Coordination of care across complex pathways is therefore the name of the game
591 in the 21st century, or, as the French say, being a "compagnon de route", accompanying
592 people on their journey of care.

593 A further criticism of the IOM proposed definition is its lack of concern for the
594 differentiated needs of people presenting to primary care. For some, coordination of care
595 for complex needs will be vital. For others, the main priority will be rapid access to advice
596 and treatment, and most likely through new technologies such as skype, email, or even
597 phone. Indeed, the concept of a single professional taking responsibility for care of a
598 person on a long-term basis appears (of itself) to be somewhat dated and paternalistic in
599 modern Europe.

600 Primary care remains critically important, arguably more so than ever, given the rapid
601 rise in chronic disease and multi-morbidity, together with the technologies that offer a
602 different scope of communication, advice and care. However, its role is now more
603 sophisticated, complex, and intertwined with other levels of the health system and with
604 services provided by other sectors, and by families or lay-people. In 2008, on the
605 thirtieth anniversary of Alma-Ata, Steve Gillam wrote:

606 'Effective primary health care is more than a simple summation of individual
607 technological interventions. Its power resides in linking different sectors and
608 disciplines, integrating different elements of disease management, stressing early
609 prevention, and the maintenance of health'. (Gillam 2008, p538)

610 Primary care has, from the very beginning always integrated a "community-perspective".
611 This was most clear in the development of the concept of "Community Oriented Primary
612 Care (COPC), that could be defined as: an approach to health care delivery that
613 undertakes responsibility for the health of a defined population. COPC is practiced by
614 combining epidemiological study and social interventions with clinical care of individual
615 patients, so that the primary care practice itself becomes a community medicine
616 program. Both the individual patient and the community or the population are the foci of
617 diagnoses, treatment and on-going surveillance" (Rhyne 1998).

618 **BOX A:**

619 **Development of Community Health Centres in Flanders: the Community**
620 **Health Centre Botermarkt**

621

The Community Health Centre Botermarkt is a not-for-profit organisation that started in 1978 in Ledeborg, a deprived area in the city of Ghent. The interdisciplinary primary health care team is composed of family physicians, nurses, other staff, including receptionist, health promoters, dieticians, social workers, ancillary staff, smoking-cessation experts and dentists. The community health centre takes care of 5600 patients, coming from over 70 different countries. All patient information is coordinated in an integrated, interdisciplinary electronic patient health record.

The main purpose of the centre is to deliver integrated primary health, including prevention, curative care, palliative care, rehabilitative care and health promotion. The service delivery focuses on accessibility (no financial, geographical or cultural threshold) and quality, using a comprehensive eco-bio-psycho-socio frame of reference. The focus is on empowerment of patients and contribution to social cohesion. Participation of the population in the community is of utmost importance.

All patients are registered on a patient list. All inhabitants, living in a defined geographical area, are eligible to be on the list. A patient who is on the list does not have access to other primary health care practices (except for out-of-hours care).

The range of services provided are:

- Health promotion and prevention
- Screening
- Curative care
- Palliative and rehabilitative services (both consultations and home visits)
- Integrated home care by an interdisciplinary team
- Nursing services
- Community Oriented Health Promotion
- Nutrition services
- Social work
- Dental care

The health centre is financed through contracts with the insurance companies that pay monthly capitation for every patient on the list. From 1 May 2013, there is an integrated, mixed, needs-based capitation that takes into account social variables, morbidity, age, sex, functional status, income,... of the patient. Moreover, there are allowances for health promotion in the community and for specific community projects.

There are contacts with secondary care providers, with physiotherapists, psychologists, palliative services, social services, in the framework of an integrated primary care system. The health centre created in 1986 a local care "platform": all primary care

Definition Primary Care – Preliminary opinion

providers, but also local schools, local police, organisations of citizens, organisations of ethnic-cultural minorities, meet every 3 months in order to make a "Community Diagnosis" and to enhance inter-professional and inter-sectoral cooperation.

The Community Health Centre engages in a "Community oriented Primary Care" (COPC)-strategy where information from the daily encounter with patients is complemented by epidemiological and other relevant data from the community and discussed with the community in order to make a "Community Diagnosis" and to develop programmes that tackle the upstream causes of ill-health (social determinants, inter-sectoral action towards education, housing, work,...).

Contact: www.wgcbotermarkt.be

The International Federation of Community Health Centres: www.ifchc2013.org

622

623

624

625

626

627

628



629

630

631

632 **3.2.2. Core-definition³**

633 *The Expert Panel considers that primary care is the provision of*
634 *universally accessible, person-centered, comprehensive health and*
635 *community services provided by a team of professionals accountable for*
636 *addressing a large majority of personal health needs. These services are*
637 *delivered in a sustained partnership with patients and informal caregivers,*
638 *in the context of family and community, and play a central role in the*
639 *overall coordination and continuity of people’s care.*

640

641

642

643

644



645

³ For the used terms, see 6. Glossary

646

647 **BOX B:**

648

649 **Local health units in Portugal**

650

The Portuguese National Health Service (NHS) has a country-wide network of primary care centres and a network of hospitals. They have been run independently for most of its history (the NHS was created in 1979).

The interaction between the two levels of health care has faced, over time, several difficulties, with forward referral (from primary care to hospital care) and backward referral (discharge from hospital care to follow-up in primary care) lacking coordination. The regularly identified reasons for the lack of coordination include the excess of bureaucracy, the difficulties in using communication channels or guidelines for the referral processes and, finally, the different cultures and methods of primary care and hospital health professionals.

The need for further coordination has led to the creation, in 1999, of local health units. These units bring under the same management team a hospital (or group of geographically close hospitals) and the primary care centres in the catchment area of the hospital. The first local health unit was created in 1999, in the metropolitan area of Oporto, and currently there are 7 local health units in the country (in the interior regions, ranging from North to South and in the coastal Northwest and Southwest regions), which cover about 10% of the population. The main organisational objective of the local health unit is to ensure the continuity of care and public health activities in the designated geographic area. Coordination of decisions and organisational improvements (such as, a single medical record across primary care and hospital care, better planning of opening hours of facilities, and sharing of health professionals) are the main drivers to create the local health units.

The benefits attributed to the local health units include better quality of care owing to more focus on long term health impact of interventions, better responsiveness to patient needs, better use of installed capacity, better information available at all levels, all allowing for an improved pathway of patients within the health system.

Bringing together the different cultures of hospitals and primary care centres is the major difficulty in making the model work.

The local health unit is funded by the NHS, which applies an adjusted capitation formula. The adjustment formula includes information on standardized mortality rate, gender, proportion of elderly and children in the population and average schooling levels.

Within the NHS, local health units, like any other entity, do not face competition as catchment areas are defined. Local health units may contract out services to the private sector, and patients may have the option of other health care providers whenever they have health insurance coverage additional to the NHS.

The benefits of the model of local health units were not immediate and are dependent on implementation. The expected advantages of the integrated model take time to materialize.

651

652

653

654

655

656 **3.2.3. Developments in primary care**

657

658 The core-definition as formulated in 3.2.2. should not be seen as static. The Expert Panel
659 wants to view this definition as a dynamic phenomenon, taking into account the
660 developments described in 3.1.3.

661

662 **Primary care continues to adapt**

663

664 Primary care is a central part of the health care system of most nations. Changes in the
665 overall health system (be it in terms of financing, health care organisation or health care
666 supply) can influence the demand for, as well as the role and content, of primary care.

667

668 For example, the model of single primary care-based coordinator of continuous care is
669 increasingly regarded as outdated, given that many people are living much longer with
670 multiple health problems and needing the input and advice of a range of specialist
671 medical teams alongside the care and support of their primary care team. Thus primary
672 care is being expected to play a central role within larger care teams or networks, and to
673 be a core element of what is often referred to as 'integrated care'. In such larger teams
674 or networks, there is increasingly a strong reliance on integrated electronic patient
675 records as the main means of providing effective coordination of the different aspects of
676 people's care.

677

678 These changes are likely to continue to occur in the future and it is important to
679 anticipate and explore the implications. This leads to challenging questions about the
680 future role and content of primary care, including about the use of electronic and mobile
681 health, new forms of diagnostic tests that can be used at home or in primary care
682 settings, and moves towards a greater degree of self-management by patients of long-
683 term conditions.

684

685 Primary care is a part of the wider health care system. Changes in the overall system (be
686 it in terms of financing, health care organisation or health care supply) can influence the
687 demand for, as well as the role and content, of primary care. The lines between primary
688 and secondary sectors may become more blurred (e.g. with specialists forming a part of
689 integrated care networks) when considering increasing integration of care.

690

691 Just to give a few examples:

692

- 693 • eHealth or mHealth developments may lead to new forms of contact between
694 patients and primary care centres. It is important to investigate how these
695 developments can lead to better, more accessible and cost-effective care and
696 how this relates to patients' preferences.
- 697 • New forms of diagnostic tests are likely to become available for use in primary
698 care. This may lead to a higher demand for these tests, raising questions of
699 optimal use.

700 Primary care is not a static concept. The content, organisation and role of primary care
701 has changed over time, in response to changes in, amongst others, general and medical

702 technology, demographic and epidemiological trends and the organisation of the health
703 care system itself. Advances in medical technology allow primary care to offer an
704 increasing range of services to citizens and patients, and for this to happen through
705 media such as online text, voice and video messaging, phone, email and telemedicine.
706 Primary care now encompasses a very comprehensive set of interventions and this is
707 likely to grow even further in the future.

708

709 **The role of patients is changing**

710 The role of patients has also changed. They are increasingly perceived to be more
711 informed, articulate and involved in their treatment decisions. Contemporary concepts
712 like shared decision making emphasize this. While there has been some research into the
713 changing relationship between patient and physician (GP), this developing fundamental
714 relationship remains an important area for research. Although primary care is based on
715 the relationship between the patient and the physician, other professionals have a
716 growing role in the way people are accessing primary care. Nurses and community
717 pharmacists are increasingly involved in meeting citizens' health care needs and
718 expectations.

719

720 **Primary care coordinates people's care**

721 With the increase in complexity of medical care needs, also in light of ageing populations,
722 chronic illnesses and multi-morbidity, coordination even within primary care becomes
723 more important.

724 The provision of coordinated care is an increasingly complex activity, as people's needs
725 become more extensive and they are cared for across many settings and professionals.
726 Moreover, apart from the needs as the starting point of the care coordination, there is
727 increasing emphasis on the "goals as defined by the patient in terms of quantity and
728 quality of life" (De Maeseneer 2012). Coordination requires integrated medical records,
729 IT-based remote or social media approaches, and a more empowered role for individuals
730 and their carers. At times, the coordinator of care will be a specialist, who may be based
731 in a hospital or in the community.

732 This coordination may be defined in different ways: (i) GPs may delegate tasks to
733 support staff such as nurses (e.g. measuring blood pressure, performing pap smear tests
734 or providing lifestyle advice). (ii) GPs may refer individuals to other (secondary) types of
735 care. This is highlighted further in the section 3.3. (iii) GPs may act as coordinators of
736 care providing guidance in cases where patients suffer from multiple illnesses which
737 require the attention of more than one professional (possibly from more than one sector
738 of the health care system). (iv) In some health care systems (e.g. previously in the UK)
739 GPs may also purchase non-urgent elective and community health care services for
740 patients in the role of fundholders. Continuity of care is often mentioned as a core aspect
741 of primary care. This continuity also pertains to the task of coordination and to keeping
742 records of various treatments in order to maintain a 'holistic' view of an individual's care.

743

744 **Primary care seeks to balance continuity and access**

745 People have differentiated needs. As a result, the provision of continuity of care is
746 important for some people at a certain point in time of their lives, but not always at all
747 times to everyone. Access may be more important, for example regarding minor ailments
748 or episodic illness. Continuity may be about a professional/doctor, or health centre, but
749 will also increasingly be about records/information, or a much wider care team.

750 Care is increasingly provided across one or more pathways which span traditional
751 sectors, services and institutions. Given that so many people now live with one or more
752 long-term conditions, specialists are much more likely to be involved in a person's care,
753 acting as advisers to (or even as members of) the integrated care team. Specialists are
754 therefore often arguably delivering aspects of primary care, or at least giving secondary
755 care in primary care settings. Hence the role of primary care as lynchpin of the wider
756 team is becoming more significant – for instance along the lines of the Primary Care
757 Medical Home model as implemented in the United States (Arend et al., 2012).

758

759 **Primary care is collaborative**

760 Primary care providers are increasingly organized in teams or networks, and often
761 located in primary care centres or community hospitals. This facilitates work processes
762 (e.g. weekend shifts), but also specialisation within primary care. Different primary care
763 professionals (e.g. nurse, pharmacist, physiotherapist and GP) can be brought together
764 in primary care networks or centres in order to facilitate cooperation, coordination and
765 accessibility of health care facilities. These care centres may be simply geographical
766 clusterings of services or organisations offering various forms of primary care. The notion
767 that primary care is collaborative challenges health systems regarding training of
768 professionals (to recognize and appreciate the interdependence of health professions),
769 legal systems regarding activities of health professionals and the role of professional
770 bodies in promoting and adjusting professional self-regulation towards a primary care
771 that meets citizens' needs. This development also involves issues such as ICT support,
772 sharing medical information between providers and case management. The role of
773 individuals in determining goals, accessing and perhaps even adding to their own records
774 challenges the role of the 'traditional primary caregiver'.

775

776 **The primary care workforce is changing**

777 The workforce continues to change, to meet both the needs of a new generation of health
778 professionals, and the different patterns of care required by people living longer and with
779 a range of chronic conditions. For example, the shift in gender balance in the health
780 workforce, the associated increase in part-time and flexible working, and advanced
781 nursing roles means that most people relate more to a primary care team than a single
782 physician or nurse. Widening the organisational scale of primary care practices is
783 conducive to the provision of collaborative care, the continuity of patient care, and
784 improves the accessibility of care at organisational level.

785 Shifts in roles of professionals (e.g. from GPs to nurse practitioners, or from primary care
786 teams to integrated care networks) may change the nature of primary care and require
787 its providers to have comprehensive generalist training in a community setting. Such
788 shifts may be supported by technological advances, but their impact on costs, outcomes
789 and 'consumer satisfaction' is as yet unclear. What is clear is that primary care remains a
790 dynamic and central part of the health systems of almost all countries.

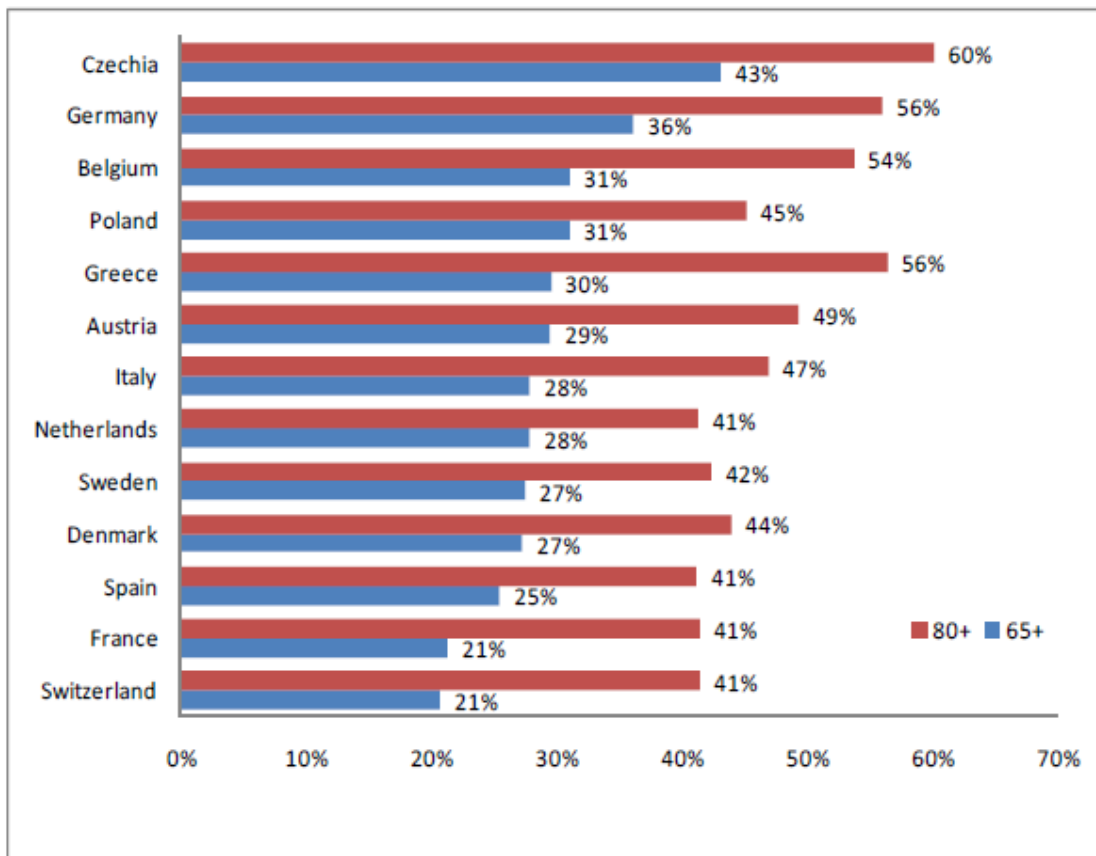
791

792 **Informal caregivers**

793 A large part of total care provided to patients in Europe is informal care. Figure 1, taken
794 from Riedel and Kraus (2011), shows that a large share of the elderly population in
795 Europe receives informal care, especially those over 80. However, while older people may
796 be especially dependent on informal care, there are many younger people in need of
797 care, such as patients suffering from diseases such as rheumatoid arthritis or physical or
798 mental disabilities.

799

Figure 1. Receivers of informal help or support, in % of population group, 2006



Source: IHS HealthEcon calculation 2010 using SHARE 2.3.1.

800

801 These figures translate into substantial proportions of the population providing informal
802 care. In the Netherlands, for instance, 10% of the population act as informal carers,
803 often for long periods of time and intensively (De Boer 2005). These carers provide tasks
804 ranging from emotional support, support with household activities to support with ADL

805 tasks such as washing, clothing and visiting the toilet (Brouwer et al 2004). Especially in
806 the context of chronic or slowly progressive diseases, such as rheumatoid arthritis and
807 dementia, informal care is often required and provided for several years, often on a daily
808 basis for several hours per day.

809 Informal care has been shown to complement but also supplement formal care, for
810 instance through delaying institutionalisation (Van Houtven and Norton 2004). Often,
811 informal care is preferred over formal care by both patients and carers (Brouwer et al
812 2005). Informal caregivers can thus form important partners for primary care
813 professionals by complementing and supplementing formal care, and also through their
814 knowledge of the preferences of patients for instance in treatment choices. In
815 collaboration, the care for patients may be optimised. Given the ageing of populations
816 (which may result in increases of the prevalence of diseases such as Alzheimer) and
817 constraints on health care budgets and available formal care professionals, the demand
818 for and importance of informal care is expected to increase in the coming years. Close
819 links between informal carers and (primary) care professionals may enable the prolonged
820 involvement of informal carers. This is important, because the availability of carers may
821 decline in the coming years, for instance due to increased labour force participation of
822 women and geographical spread of families.

823 Primary care professionals should also be aware of the strain that prolonged informal
824 care can put on carers. Intensive informal care can be associated with substantial
825 burden, decreased health and wellbeing and even increased mortality risks (Bobinac et al
826 2010; Bobinac et al 2011; Schulz and Beach 1999). It is therefore important for primary
827 care professionals to support informal carers if necessary in order to help them to sustain
828 their tasks and prevent overburden or illness (Kraijo et al 2014).

829

830

831

832

833

834

835

836

837

838

839

840

841

842 **BOX C:**

843 **Primary care in England**

844

Primary care in England is under significant strain. GPs and their teams are working hard to try to meet demand from patients while lacking time to reflect on how they provide and organise care (RCGP 2014). New models of care organisation are emerging organically in some areas to meet the challenges facing primary care, including primary networks or federations, expanded community health organisations, large merged family practices known as 'super-partnerships', and regional multi-practice organisations (Smith et al 2013). Local context plays an important role in the emergence of such models, all of which have been developed in an organic and 'bottom-up' manner – they have been at the initiative of local health professionals and communities, not of direct government policy.

Community health organisations have a strong population health orientation with a commitment to meet the specific needs of disadvantaged communities and address health inequalities. These organisations – sometimes made up of multiple practices in a network and in other cases in a single building – combine patient-centredness with a strong population orientation and generally have an ownership model with significant community or public involvement (Smith et al 2013). One example of such an organisation is the Bromley-by-Bow Health Centre in London, a community organisation working in one of the UK's most deprived localities. The centre supports families, young people and adults of all ages to learn new skills, improve their health and wellbeing, find employment, and develop the confidence to achieve their goals and make changes to their lives. The Bromley-by-Bow Centre provides services, facilities, information and advice. Its primary care services are run as a family practice partnership, with the other wider services operating as a charity with distinct but connected governance arrangements. The GP partnership includes: GPs, practice nurses, a health care assistant, phlebotomists and a service user advocate.

A super-partnership is a large-scale single general practice partnership structure that has been created through formal partnership mergers. It seeks to achieve a greater degree of scale for local general practice, offering a wider range of primary and community health services, and using its scale to offer community-based diagnostic services and consultations with specialists. Its scale also enables a wider range of career development opportunities for GPs and their teams. Their organisational and legal form is a single large GP partnership, although they often establish one or more parallel companies that can act as the vehicle for bidding for and managing additional services funded by the NHS or private sources. An example of a such an organisation is the Vitality Partnership in central Birmingham. Vitality offers patients: primary care, a range of outpatient services, x-ray, and intermediate care. The partnership operates with an integrated IT system, real-time patient feedback mechanisms, joint clinics between GPs with a special clinical interest and consultants. The organisation is based across multiple sites and covers 50,000 patients. Its strategic aim is to continue to grow and develop into a 100,000 plus integrated care organisation and ultimately an accountable care organisation (Smith et al 2013).

Contacts:

<http://www.bbhc.org.uk/> Bromley-by-Bow Centre, London

<http://www.vitalitypartnership.nhs.uk/> Vitality Partnership, Birmingham

845

846

847

848 **3.3. The role of referral systems in strengthening health system performance**

849 **3.3.1. What is the purpose of referral?**

850 A referral can be defined as a process in which a health worker lacking sufficient
851 resources to manage a person’s clinical condition seeks the assistance of a better or
852 differently resourced facility at the same or higher level to assist in, or take over the
853 management of, the case (WHO 2006). Referral plays a crucial role in primary care
854 because primary care is the point of entry to the health system for many people.

855 Referral systems aim to improve quality and efficiency in health service delivery by
856 ensuring that people receive appropriate and well-coordinated care. Through referral,
857 patients are guided to the professionals and facilities most suited to treating them.
858 Referral systems can contribute to efficiency by minimising inappropriate care and
859 duplication and by upholding the principle of subsidiarity – that is, that tasks should be
860 carried out at higher levels if they cannot be performed effectively at lower levels (and
861 vice-versa).

862 An effective referral system benefits patients, many of whom may lack sufficient
863 information about their condition and about relevant services to make the right choices,
864 often in difficult circumstances. If accompanied by strong information systems, referral
865 can prevent people from having to repeat their medical history and protect them from
866 the potentially harmful effects of duplication and polypharmacy.

867 An effective referral system also benefits health professionals. In the absence of a
868 referral system, specialists would see too many self-limiting cases, eroding their ability to
869 deal with complex cases; family physicians would not see enough children (for example),
870 eroding their ability to provide effective out-of-hours care to children; and sometimes a
871 second opinion is called for to confirm or reject an initial diagnosis.

872 Referral is often thought of as a linear process in which a patient is transferred from one
873 provider to another. This model is most appropriate for people with new (non-life-
874 threatening) health problems that may be unclear for patient and provider and therefore
875 are best presented at the primary care level. Usually, only around 10% of these
876 problems will require referral to other providers. Thanks to developments in information
877 technology, referral need not imply the physical transfer of patients from one location or
878 level to another. Electronic transfer of information, including diagnostic test results, can
879 enable on the spot decision making.

880 For people with chronic conditions, and especially for those with multiple conditions, a
881 ‘spiral’ model of referral may be more appropriate. Patients are referred within primary
882 care and between different levels of the system on an ongoing basis. This requires a high
883 degree of coordination, explicit definition of the responsibilities of the providers involved
884 and good information for patients.

885 Access to secondary care is sometimes contingent on referral. In such instances, primary
886 care plays a 'gatekeeping'⁴ role, controlling the patient's entry into the health system and
887 taking responsibility not only for providing care but also for coordinating specialised care
888 through referral. Gatekeeping can therefore be seen as an organisational mechanism to
889 promote coordinated care (Saltman et al 2006). However, it is sometimes used as a
890 means of controlling costs, particularly where there are long waiting lists for secondary
891 care, in which case primary care may slow the rate of referral to help regulate waiting
892 times.

893 While all European health systems require referral for admission to hospital, there are
894 four different approaches to referral for specialist consultations:

- 895 • people have direct access to specialist consultations (eg the Czech Republic,
896 Luxembourg);
- 897 • gatekeeping is not enforced, but people are encouraged to obtain a referral for
898 some or all specialist care, usually through financial incentives such as having to
899 pay a (higher) user charge for direct access to a specialist (eg Belgium, Germany,
900 Ireland)
- 901 • GPs act as gatekeepers but people have direct access to specific specialists such
902 as gynaecologists, paediatricians or ear, nose and throat (eg Denmark, Estonia,
903 Poland)
- 904 • people are required to obtain a referral for specialist consultations (eg Croatia, the
905 Netherlands, Spain, Slovenia, the United Kingdom)

906 In recent years, some countries have moved from the first to the second approach
907 (Reibling and Wendt 2012). Choice of provider is possible in any of these approaches.

908

909 **3.3.2. What makes an effective referral system?**

910 Variation across European countries in approaches to referral sometimes reflects
911 historical and cultural differences, but it may also reflect debate and uncertainty about
912 the expected benefits and risks associated with referral – particularly gatekeeping (see
913 Table 2) – and about how best to ensure referral systems are effective in promoting
914 quality, efficiency and responsiveness.

915 Referral rates have been found to vary enormously between providers, independently of
916 health system organisation (Fleming 1993). The earliest study of referral from primary to
917 secondary care in Europe found that higher rates of referrals were associated with
918 gatekeeping, high specialist density and high GP workload, while lower rates were
919 associated with strong GP training programmes (Fleming 1993). Another study has found
920 that (not surprisingly) rural GPs have lower rates of referral than urban GPs (Zielinski et
921 al 2008).

⁴ The gatekeeping principle originates from theories about information-channeling (first developed by the social psychologist Kurt Lewin in 1943) and is now most frequently used in relation to health care.

922 Research suggests that gatekeeping by GPs can help reduce overall health system costs
923 (Martin et al 1989, Franks et al 1992, Delnoij et al 2000 and Schwenkglens et al 2006).
924 For example, a recent systematic review of the literature found gatekeeping to be
925 associated with lower use of health services (shorter and fewer hospital visits, fewer
926 emergency department visits and lower use of ambulatory care) and lower spending. The
927 review noted, however, that there was substantial variation across studies in the
928 direction and magnitude of changes in use and costs; some studies found no difference
929 or higher levels of use (Garrido et al 2010).

930 These findings may have motivated some countries to introduce financial incentives to
931 encourage patients to obtain referrals for specialist consultations (see Box 1) – a growing
932 trend in EU health systems in recent years (Reibling and Wendt 2012). However, the
933 authors of the systematic review highlight the limited quality of many of the studies they
934 reviewed, only a few of which examined the effects of reduced use on patient outcomes,
935 with inconclusive results.

936 **Box 1: French system of "preferred doctors"**

937 Since 2004 (Health Insurance Reform Act), all those benefiting in France from health
938 insurance coverage must choose their "preferred doctor" ("Médecin traitant"). As a result
939 it costs more to consult a specialist directly, without being referred by their "médecin
940 traitant". This form of soft gate-keeping was generally well-accepted, perhaps because a
941 number of specialties were excluded from the referral system for example gynaecology,
942 dermatology, psychiatry, ophthalmology and paediatrics. Furthermore, adherence to the
943 "preferred doctor scheme" mainly reflected existing patterns of access. Indeed, in 2006,
944 92% of the patients that had chosen a preferred doctor, already had this doctor as the
945 usual family physician. Moreover, in 2007, after the implementation of the scheme, the
946 share of patients consulting outside of the gate-keeping system was 20% on average for
947 all categories of specialists, whereas it was only 30% prior to the implementation of the
948 inform. This shows that prior to the reform, French patients were already following a kind
949 of "gate-keeping" model, despite enjoying a large freedom of choice. Finally, freedom of
950 choice of doctors has not actually been restricted at all, since patients are still able to
951 choose which doctors they want to visit (having been referred or not) and they can very
952 easily switch preferred doctors (by filling out a form with the doctor of their choice).
953 (Durand-Zaleski 2010)

954

955 Recent empirical research has highlighted the potentially negative effect of gatekeeping
956 on quality of care and health outcomes (Vedsted and Olesen 2011). An ecological study
957 of 19 European health systems found that gatekeeping was associated with lower rates of
958 cancer survival, perhaps due to delays in diagnosing cancer and/or timely follow-up.
959 Other research has questioned whether GPs in some countries recognise and rapidly refer
960 children with acute medical emergencies.

961 This research challenges the positive claims made for gatekeeping in particular and
962 referral more broadly. It suggests that gatekeeping may not promote quality and
963 efficiency if it is viewed primarily as a cost containment tool and where GPs regard
964 themselves as rationing care (Vedsted and Olesen 2011). If referral systems are to
965 contribute to stronger health system performance, GPs and others will need to view their
966 gatekeeping role as more of an advisory function, helping patients 'navigate' the health

967 system. The aim of gatekeeping should be to guide patients towards the most
 968 appropriate and cost-effective forms of care, and not to limit access to care.

969

970 **Table 2 Potential benefits and risks of gatekeeping**

	Benefits	Risks
Efficiency	Reduces unnecessary use of (specialist) services	Access to necessary specialist services is denied; no reduction in specialist services but more GP visits
Costs	Costs are reduced	No cost reductions; slight increases in costs
Patient satisfaction	High trust in GPs	Patients feel their choice is restricted
Quality	Quality is improved through coordination	Compared with specialist care, GPs provide lower quality care for a given health problem
Equity	Inequalities are reduced; supports decision-making by disadvantaged people; reduces unnecessary specialist use by advantaged groups	Inequalities are maintained due to the better ability of advantaged groups to put pressure on GPs

971 Source: Reibling and Wendt 2012 adapted from Coulter 2010

972 A Cochrane Collaboration systematic review of interventions to improve outpatient
 973 referrals from primary care to secondary care found that passive dissemination of referral
 974 guidelines was unlikely to lead to better referral quality (Akbari et al 2011).⁵ Although
 975 the number of rigorous evaluations of different interventions is low, the study suggests
 976 that the use of "in-house" second opinions and other intermediate primary care-based
 977 alternatives to outpatient referral seems promising, and that while financial interventions
 978 can change referral rates, their effect on referral quality is uncertain. The authors found
 979 that referral guidelines are more likely to be effective if:

- 980 - Local secondary care providers are involved in dissemination activities;
- 981 - Structured referral sheets are used;
- 982 - Secondary care management is responsive to changes in primary care behaviour
 983 as a result of the guidelines;
- 984 - They reflect local circumstances and address local barriers.

985 In addition to the production of referral guidelines based on clearly defined and agreed
 986 patient pathways, other factors that may improve referral quality include:

- 987 • **clinical triage:** ensuring clinical triage is an integral part of any referral
 988 management service to route referrals to the most appropriate health professional
 989 and location (Scottish Executive Health Department Directorate of Delivery 2007)

⁵ 17 studies were included in the review, 12 coming from the United Kingdom

- 990 • **assessment and feedback:** assessing the appropriateness of referrals against
991 guidelines and informing health professionals where referrals do not meet the
992 acceptance criteria
- 993 • **information systems:** the presence and use of good information systems,
994 including the electronic transfer of patient information between providers, so that
995 patients do not have to repeat giving their medical history and to avoid the
996 harmful and wasteful effects of duplication and polypharmacy (NHS Wales
997 Informatics Service)
- 998 • **easily accessible and good quality first contact care:** in many countries,
999 overuse of emergency departments can be explained by access and quality issues
1000 in other parts of the health system; these weaknesses need to be addressed so
1001 that patients can benefit from care provided by the most appropriate provider and
1002 the health system does not waste resources
- 1003 • **provider payment systems that are aligned with health system goals:** how
1004 health professionals respond to financial incentives (Croxson 2001) and the way in
1005 which they are paid and regulated – in both primary and secondary care – can
1006 have significant implications for patient diagnosis and referral

1007

1008 **3.3.3. Conclusion**

1009 The Expert Panel considers that referral systems, including gatekeeping, can have strong
1010 advantages – spelled out above – but, to be fully effective, they must involve the
1011 following factors:

- 1012 - a strong and responsive, high-quality primary care system, organized in
1013 (interprofessional) group practices and health centres, with a practice-based
1014 patient list and opportunities for second opinions at the primary care level.
- 1015 - a patient-centered approach exploring the needs, expectations and goals of
1016 the patient, using appropriate communication skills; this includes a form of
1017 personal relationship between the GP and the patient through a patient list
- 1018 - primary care providers have timely access to the results of medical imaging
1019 and other diagnostic tests
- 1020 - secondary care responds promptly and in a coordinated way once patients are
1021 referred from primary care, with fast-track facilities where a serious diagnosis
1022 is suspected (life-threatening conditions in children, cancer etc)
- 1023 - patient management based on maximal subsidiarity providing follow-up as
1024 much as is effective at the primary care level to avoid long waiting times for
1025 referred patients
- 1026 - referral processes are facilitated and enhanced through electronic procedures
1027 as much as possible

- 1028 - interactions between referral processes and payment systems are taken into
1029 account and incentives (both financial and non-financial) are aligned

1030

1031 **3.3.4. Future research**

- 1032 - High-quality studies to identify the most effective interventions to improve
1033 referral appropriateness, including: secondary care provider-led education
1034 activities, structured referral management sheets, electronic referral,
1035 enhancement of primary care and in-house second opinions, the usefulness of
1036 decision-support systems underpinning referral decisions, the impact of
1037 financing mechanisms at the level of primary care and secondary care on
1038 referral-patterns, the effect of tools focusing on patient-empowerment in
1039 relation to the referral process

- 1040 - Further research to explore and tackle the possible adverse effect of
1041 gatekeeping on quality of care and health outcomes

1042

1043

1044

1045
1046
1047
1048
1049
1050

Box D:

Upgrading primary health care in Slovenia

In Slovenia the reforms to upgrade the health system (2010 – 2020) have a particular focus on prevention and primary health care. The overall aim is to guarantee the positive health of the Slovenian population. The strategic goal is to establish a flexible health care system that will effectively fulfil citizens' needs by offering them quality and safe health care services.

At the time of the healthcare reform in 1992 the primary care level was not a priority. The organisational and financial changes introduced focused on secondary care because of its high expenditure and long waiting times. But it is well-known that 85% of patients' medical problems can be resolved at the primary level. At the same time costs are significantly lower than at the secondary level.

Regarding geographical accessibility the reforms are based on the so-called national pyramid, consisting of three separate levels:

- a widely accessible primary care level acting as a "gatekeeper" for entry to the health care system;
- a secondary level where the patient is referred for specialized treatment;
- and a tertiary level with responsibility for professional advancement and development of Slovenian health care.

At the primary level, public institutions were linked together by ensuring the performance of certain functions in a single location, e.g. establishing Central Emergency Centres, and setting up networks, e.g. Primary Health Care of Gorenjska. This guarantees patients have better access to health care services (e.g. laboratory and radiology services), while treatment is more effective and of a better quality. The changes can result in the potential reduction in non-medical personnel which enables an increase in the availability of medical personnel. The lack of accessible primary health services in some places e.g. rural areas, is being met by promoting the establishment of rural practices in smaller places or by financial incentives to stimulate provision public services.

Another initiative is to reorganise primary care practices. Learning practices have been created. These are practices where a trainee specializing in family medicine will provide care for his own list of patients in his own premises, with the support of a nurse. But the trainee will be under a mentor's supervision. In this way, once the trainee has completed his training, a new primary care team is ready to be set up, with the allocated financial means necessary to guarantee no disruption in service provision.

The working methods of learning practices will be similar to those of 'referential practices' which are practices of physicians working in the public sector who have high levels of expertise. They provide a broad range of services to defined groups of patients, stressing integrated care, use of chronic patient treatment protocols, prevention, quality indicators, and making effective use of laboratory service. These primary care practices, combining physicians and nurses, provide the optimal service provision and enable a broad range of clinical tasks to be carried out at the primary level thereby increasing quality, safety and cost effectiveness in patient treatment.

After the Ministry of Health Project Board adopted a strategic document and action plan, a system of learning and referential practices has been gradually implemented, together with new medical training. By the end of 2011, almost 15% of primary care practices had been reconfigured in this way. The initial success can be primarily attributed to a clear

Definition Primary Care – Preliminary opinion

vision for the development and design of the strategy and the implementation of the action plan. The objectives were publicly presented to all stakeholders; and there was excellent media support. However, there is now an urgent need to carry out an evaluation of the implementation process and progress.

1051
1052
1053
1054

1055

1056 **BOX E:**

1057 **Finland: the new Health Care Act of 2010**

1058

In Finland, since 1972 primary health care has been organized by municipalities which have some 160 local health centres (that may function in several locations). During the past years, however, there have been problems in access to doctors in many places and the waiting times for appointments with a doctor have been quite long. Therefore, legislative changes were implemented in 2010 with the new Health Care Act (1326/2010). The main aims of the act are to promote customer orientation in service, to improve quality and patient safety, to promote health, to narrow regional health differences and to control the growth of health care expenses.

Primary health care is defined in the Act in the following way: Primary health care consists of public health services provided by local authorities, health promotion, and any related provision of health consulting and health checks, oral health care, medical rehabilitation, occupational health care, environmental health care, as well as emergency medical care, outpatient care, home nursing, at-home hospital care and inpatient care, mental health services, and substance abuse services where these are not covered by social services or specialized medical care.

Primary health services in a health centre in Finland include:

- Consultations with a doctor for people who have become ill and for the treatment of chronic illnesses - patients may be referred to specialists or for further examination
- Often a ward for patients requiring nursing care
- Health counselling, including health education, contraception advice, maternity and child welfare and medical examinations
- Screening and vaccinations
- Oral health services
- School and student health care
- Mental health services
- Emergency treatment, emergency cases also handled by hospitals
- Home care services

The Health Care Act contains a common resourcing obligation for primary health care. Each municipality has to assign enough resources to health and welfare promotion and to health care services. In order to produce the required health care services, each municipality or hospital district of a joint municipal authority must employ an adequate number of health care professionals.

Health promotion in the Act has a wide definition. It includes actions aimed at individuals, the population, communities, and living environments with a view to maintaining and improving health, work ability and functional capacity, influencing determinants of health, preventing illnesses, accident injuries, and other health problems, strengthening mental health, and reducing health inequalities between different population groups, as well as systematic targeting of resources in a manner that promotes better public health.

The Health Care Act strongly emphasized equality. The authorities of the municipality and the joint authorities of a hospital district must ensure that health care services are available and universally accessible in the area to the residents that they are responsible for.

Definition Primary Care – Preliminary opinion

The basis for providing health care services are the Uniform Grounds for Medical and Dental Care that the Ministry of Social Affairs and National Institute for Welfare and Health have drafted. The authorities must monitor the situation to see that uniform standards are achieved in their operational field.

1059

1060

1061

1062

1063

1064

1065

1066

1067



1068

1069

1070 **3.4. Financing primary care**

1071 **3.4.1. Introduction**

1072 This section discusses issues in financing primary care, with a focus on how financing
1073 policy can affect the performance of primary care in general and in particular how it
1074 affects coordination within primary care and between primary care and other forms of
1075 health care. It considers three main issues: ensuring an adequate level of financing for
1076 primary care; ensuring equitable access to primary care; and provider payment to
1077 promote efficiency and quality in primary care delivery, including care coordination. While
1078 these issues are discussed separately in the following sub-sections, it is important to note
1079 that they are closely related to each other. A final sub-section highlights areas for further
1080 research.

1081

1082

1083 **3.4.2. Ensuring an adequate level of financing for primary care**

1084

1085 Health systems need to be adequately financed if they are to achieve their goals to the
1086 greatest extent possible given a country's means (WHO 2008). They also need to be able
1087 to make the best use of available resources (efficiency). Adequacy in financing the
1088 primary care sector depends on public resource allocation processes at national level (the
1089 size of the public budget for the health sector including revenues from social insurance
1090 contributions) and on the sectoral level (resources allocated to primary care versus other
1091 sectors).

1092

1093 **Spending on the health system**

1094

1095 At national level, the absolute amount of money available for health is influenced by a
1096 country's income (GDP) and the government's fiscal context (the size of government
1097 measured as a share of GDP). Richer countries spend more on health per person than
1098 poorer countries, although the extent to which national income drives health system
1099 expenditure growth is the subject of debate (Maisonneuve and Oliveira Martins 2013).

1100

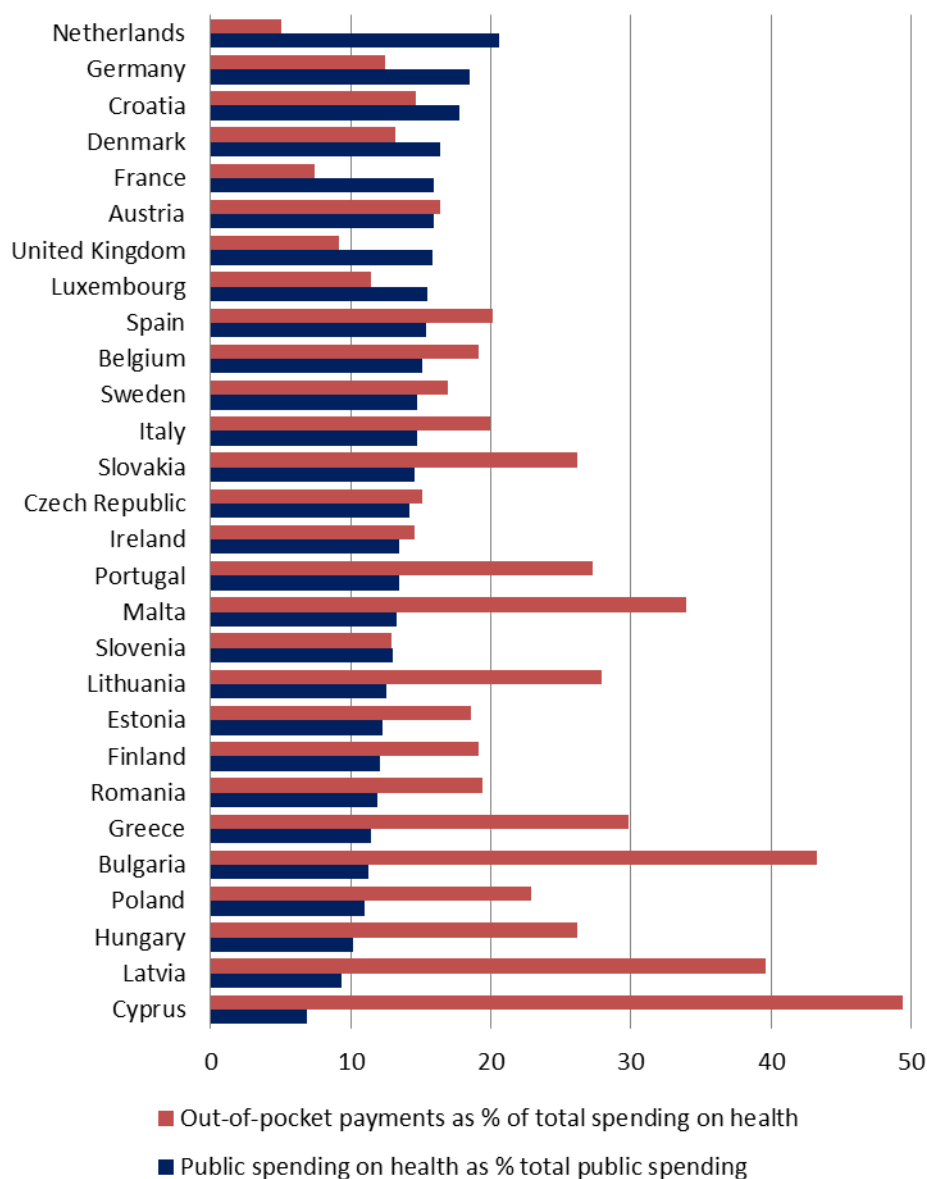
1101 Since GDP and the size of government are not immediately amenable to health policy
1102 levers, a more relevant indicator for health financing policy is the share of total public
1103 spending allocated to the health sector. The 'priority' given to the health sector in public
1104 budgetary processes⁶ affects levels of public spending on health, which in turn affects
1105 levels of out-of-pocket spending on health. Countries with similar degrees of fiscal space
1106 may give very different levels of priority to health. Figure 2 shows how EU countries vary
1107 in the share of public spending allocated to the health sector. It also shows how countries
1108 with lower priority tend to have higher levels of out-of-pocket spending on health. We
1109 discuss the implications of this in the next sub-section.

1110

⁶ This includes decisions about contribution rates for social insurance contributions or mandatory health insurance premiums, which are counted as public spending in national health accounts.

1111

1112 **Figure 2 Public spending on health as a share of total public spending and out-**
 1113 **of-pocket spending on health as a share of total spending on health, European**
 1114 **Union, 2011**



1115

1116 Source: WHO Global Health Expenditure Database 2014

1117

1118

1119 **Spending on primary care**

1120

1121 Once the overall level of public spending on health is established, the relative share
 1122 allocated to primary care versus other sectors comes into play. Recent research shows
 1123 that stronger primary care systems (see 3.1.1. for a definition) are associated with
 1124 higher levels of total spending on health, but that more comprehensive primary care
 1125 systems are associated with a slower rate of spending growth (Kringos et al 2013).

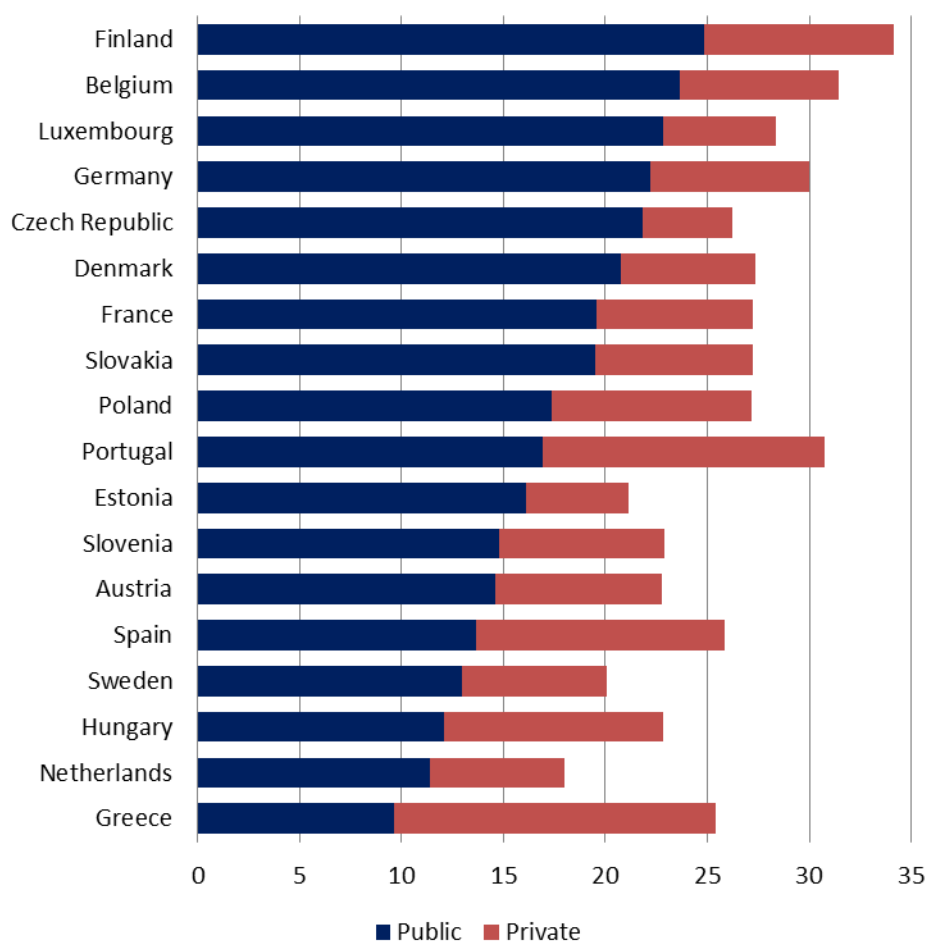
1126

1127 It is difficult to compare spending on primary care across countries due to the absence of
 1128 a uniform definition and substantial national differences in primary care structure and

1129 organisation. Figure 3 shows how public and private spending on ‘ambulatory care’ varies
 1130 as a share of total spending on health. These comparative data should be interpreted
 1131 with caution, however, since in many countries ambulatory care includes both primary
 1132 care and specialist care provided by office-based physicians. Also, some of the countries
 1133 in which total spending on ambulatory care is relatively high rely quite heavily on private
 1134 financing (for example, Portugal, Spain, Hungary and Greece).

1135

1136 **Figure 3 Public and private spending on ambulatory care as a share (%) of total**
 1137 **spending on health, EU OECD countries, 2011**



1138

1139 Source: OECD Health Data 2014

1140 Note: no data available for Ireland, Italy and the United Kingdom

1141

1142

1143 Decisions about allocating resources to different sectors within the health system should
 1144 consider what is appropriate in terms of cost-effective and patient-centred care delivery.
 1145 Where treatment alternatives are available, or a service can be provided in a range of
 1146 settings, it is particularly important to consider cost-effectiveness, so that more can be
 1147 achieved with available resources.

1148

1149 However, while there are strong quality and efficiency arguments in favour of providing
 1150 care in settings that are closer to a patient’s home, in practice many countries have
 1151 struggled to move care out of hospitals, especially where the necessary community-

1152 based infrastructure is lacking (Royal College of Nursing 2013). Investing in primary care
1153 and other community-based services is therefore likely to be a pre-requisite for moving
1154 care out of hospitals and, ultimately, for improving efficiency in service delivery. Other
1155 pre-requisites include changes in the health professionals' skill mix, so that nurses and
1156 others can play an enhanced role, and increased community orientation in training health
1157 professionals (Frenk et al 2010), to ensure primary care workers have the skills to
1158 address a wide range of health problems.

1159
1160 EU countries have adopted different strategies to prioritise financing for primary care,
1161 including giving primary care providers responsibility for purchasing specialist care
1162 (Figueras et al 2005, Saltman et al 2006). Results from a range of primary care
1163 purchasing modalities in the National Health Service in England suggest mixed effects,
1164 with some improvements in broadening the scope of primary care services, but questions
1165 about conflicts of interest and other aspects of accountability.

1166
1167 More recently, in response to fiscal constraints exacerbated by the economic crisis,
1168 strategies used to protect spending on primary care have included targeting budget or
1169 price reductions at hospitals and pharmaceuticals, keeping primary care budgets intact;
1170 protecting or increasing the salaries of primary care staff; and earmarking taxes for
1171 public health programmes delivered in primary care (Thomson et al 2014 in press).

1172

1173 **3.4.3. Ensuring equitable access to primary care**

1174

1175 Ensuring there is enough money in the health system to provide good-quality primary
1176 care is an important first step, but revenues need to be raised, allocated and spent in
1177 such a way as to ensure the whole population is able to access needed and effective
1178 services without encountering financial or other barriers. In operational terms, this
1179 means thinking about equity in financing, financial protection and equity in the use of
1180 services (a proxy for equity of access).

1181

1182 **Equity in financing and financial protection**

1183 Cross-national analysis of the composition and level of spending on health shows two
1184 things. First, financing mechanisms vary in terms of the financial burden they impose on
1185 richer and poorer households.⁷ Direct taxes (eg on income) and social insurance
1186 contributions are found to be generally much more 'progressive' than indirect taxes (eg
1187 VAT) and out-of-pocket payments (OOPs), and OOPs are usually highly 'regressive'
1188 (Wagstaff and van Doorslaer 1999). Whether a progressive distribution is considered to
1189 be fairer than a proportionate distribution will vary across countries, but all countries can
1190 promote equity in financing by reducing their reliance on OOPs.

1191

1192 Second, the level of OOPs is also closely linked to financial protection. Globally, once
1193 OOPs comprise less than 20% of total health spending, the incidence of people facing
1194 financial hardship when accessing services decreases significantly (Xu et al 2007). In EU
1195 countries, where OOP levels are relatively low by international standards (Figure 3), and
1196 social protection systems are relatively strong, policy-makers should consider the

⁷ A progressive distribution of the financing burden implies the rich spend a greater share of their income on health than the poor; a proportionate distribution implies that all households spend the same share; and a regressive distribution implies the poor spend a greater share of their income on health than the rich.

1197 composition of OOPs and user charges policy design in addition to the share of OOPs in
1198 health spending (see below).

1199
1200 Ensuring that the whole population has access to a comprehensive range of primary care
1201 services without facing financial hardship is critical to promoting financial protection and
1202 equitable access. It is also critical to promoting efficiency in service delivery. If primary
1203 care is not easily accessible, people will either delay seeking care, which may mean they
1204 are sicker and more expensive to treat when they do finally make contact with the health
1205 system, or they may be forced to use more expensive forms of care such as emergency
1206 departments. In both cases, the outcome is likely to be inefficient.

1207
1208 **Is there a role for user charges?**

1209 Most EU countries provide universal access to a reasonably comprehensive basket of
1210 primary care services. In contrast to population and service coverage, however, policies
1211 on user charges vary substantially across countries. Around half of all EU countries do
1212 not charge patients for publicly financed primary care office consultations,⁸ but almost all
1213 charge for outpatient prescription drugs.⁹ As a result, individual spending on prescription
1214 drugs accounts for a relatively large share of catastrophic OOP spending in many
1215 countries, particularly among poorer people (Kronenberg 2014; Vörk 2009).

1216
1217 The reasons used to justify user charges include the following: to raise revenue for the
1218 health system, to reduce ‘unnecessary’ demand for health services or to direct people to
1219 more cost-effective services or patterns of use (so-called ‘value-based’ user charges). In
1220 general, however, they are limited in their ability to promote health system goals. As a
1221 means of raising revenue, they are both inequitable and inefficient in comparison to
1222 pooled funding. As a means of moderating demand, they are constrained by the fact that
1223 they do not have a selective effect between necessary and unnecessary treatment.

1224
1225 Consistent evidence indicates that people do not distinguish between health services or
1226 prescription drugs that are essential and those that are not essential; user charges
1227 therefore reduce the use of low- and high-value health services in almost equal measure
1228 (Newhouse et al 1993, Swartz 2010). Consequently, applying user charges across the
1229 board is likely to deter people from using appropriate care, even where charges are low
1230 and protection mechanisms are in place. This undermines financial protection and can
1231 have a negative impact on health (Chernew and Newhouse 2008).

1232
1233 In addition, applying user charges to relatively cost-effective utilisation, such as
1234 obtaining outpatient prescription drugs in primary care, has been shown to shift
1235 utilisation to settings where charges are not in place, which is often more expensive,
1236 such as inpatient and emergency care (Tamblyn et al 2001). Overall, there is little
1237 evidence to suggest that user charges lead to more appropriate use or long-term cost
1238 control or successfully contain public spending on health care.

1239
1240 User charges could potentially contribute to enhancing efficiency in the use of health
1241 services if they are applied selectively based on value. A value-based approach would

⁸ Publicly financed primary care visits are free in Denmark, Estonia, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Malta, the Netherlands, Poland, Romania, Slovakia, Spain and the United Kingdom.

⁹ The exception is the Netherlands, which operates a reference pricing system for outpatient prescription drugs, so patients only pay if they use a drug priced above the reference price.

1242 remove financial barriers to cost-effective health care, clearly signal value to patients and
1243 providers and ensure that patient and provider incentives were aligned (Chernew et al
1244 2007). Such an approach is not a panacea, however, and is most likely to be useful when
1245 user charges are already widely used, there is clear evidence of value and it is politically
1246 unfeasible to target providers (Thomson et al 2013).

1247
1248 A critical question for policy is whether user charges are effective in addressing the
1249 causes of 'unnecessary' demand or inappropriate use, particularly given that most use is
1250 initiated by providers. To avoid unfairly penalising patients for treatment decisions made
1251 by providers, user charges, if they are to be used at all, should be applied sparingly and
1252 accompanied by measures to ensure appropriate prescribing and care delivery. In almost
1253 all instances, targeting providers with appropriate incentives will be more effective than
1254 targeting patients.

1255
1256 Where user charges are applied, evidence underlines the importance of putting in place
1257 adequate protection mechanisms so that the financial burden weighs least heavily on
1258 people with low incomes and people who regularly use health care. To secure some
1259 degree of financial protection, it is also advisable to cap the amount of money patients
1260 are required to pay for a given service or a given period of time. EU countries such as
1261 Austria and Germany are beginning to set caps as a proportion of income, which may
1262 have a more protective effect than flat-rate caps.

1263
1264 Finally, it is important to note that indirect costs incurred by patients when using health
1265 services – for example, paying for transportation or taking time off work to see a doctor
1266 – can be substantial and undermine access and financial protection.

1267

1268 **Allocating financial resources to purchasers**

1269 How public revenues for the health sector are allocated to purchasing agents has an
1270 important bearing on equitable access to health services, including primary care services.
1271 Resource allocation processes from 'national' to 'sub-national' level play a critical role
1272 here. The re-allocation may be to lower-level geographic or non-geographically
1273 determined entities, including regions or health insurers. An important issue here is risk
1274 adjustment of allocated resources to reflect health needs, so that more resources flow to
1275 areas or entities covering people with greater health need. Where competing entities
1276 such as health insurers bear financial risk, robust risk adjustment is a necessary
1277 prerequisite for a well-functioning system of regulated competition (Van de Ven and
1278 Schut 2009). Although the evidence in favour of risk-adjusted resource allocation is
1279 strong, any process that redistributes from one area or entity to another is inevitably
1280 subject to politicisation and can therefore be difficult to achieve in practice.

1281

1282 **Evidence of unequal access and access barriers in primary care**

1283 Table 3 shows how countries vary in terms of the affordability of care provided by
1284 specialists and GPs. In every EU country people find GP care to be considerably more
1285 affordable than specialist care. This is confirmed by other research showing that in OECD
1286 countries, the better-off are more likely than poorer people to visit specialists and
1287 dentists and undergo breast and cervical cancer screening than poorer people, whereas
1288 GP visits are more equally distributed across income groups (OECD Health Working Paper
1289 2012). The authors of the OECD research also highlight the important effect of health
1290 financing policy on equity in the use of health services, but note that some of inequalities
1291 in health service use cannot be explained by financial barriers.

1292
1293
1294

Table 3 Share (%) of individuals surveyed reporting health care to be unaffordable, by type of care, EU28, 2007

Medical or surgical specialists		Family doctors or GPs	
PT	78	EL	43
EL	71	CY	39
CY	66	PT	37
BG	63	IE	33
RO	60	RO	24
FI	59	HU	18
HR	56	FI	17
MT	54	HR	17
IE	53	IT	16
IT	49	SI	16
FR	48	BG	16
HU	45	BE	14
LT	40	SK	14
AT	39	EU27	11
SI	39	DE	10
BE	38	LT	10
EE	37	MT	9
EU27	35	FR	8
PL	31	AT	8
DE	28	PL	8
LV	25	ES	7
SK	24	NL	6
ES	22	EE	6
NL	21	CZ	5
CZ	15	LV	5
LU	14	LU	4
UK	13	SE	4
DK	7	UK	4
SE	7	DK	1

Source: European Commission (2007)

1295
1296

1297

1298 **3.4.4. Paying providers to promote efficiency and quality in primary**
1299 **care delivery, including financial incentives to improve care**
1300 **coordination**

1301

1302 **Provider payment objectives and limits to 'pure' payment methods**

1303 The context in which providers work and the way in which they are paid can have
1304 profound effects on the allocation of resources in the health system and on the quality,
1305 volume and cost of health services (Ellis and Miller 2009; Langenbrunner et al 2009). In
1306 theory, provider payment methods should meet a wide range of goals relating to quality,
1307 responsiveness, health improvement, efficiency and costs, as set out in Box 2. In
1308 practice, no single method is able to achieve all of these goals; each has advantages and
1309 disadvantages (Barnum et al 1995) and, importantly, none on its own is conducive to
1310 enhancing the quality of care. While fee-for-service encourages activity, in contrast to
1311 salary and capitation, it also encourages over-treatment.

1312

1313 **Box 2 Potential goals for effective provider payment systems**

- 1314
- 1315 ■ Enable and encourage providers to deliver accepted procedures of care to patients in a
1316 high quality, efficient, and patient-centred manner
 - 1317 ■ Support and encourage providers to invest, innovate, and take other actions that lead to
1318 improvements in efficiency, quality, and patient outcomes and/or reduced costs
 - 1319 ■ Not encourage or reward overtreatment, use of unnecessarily expensive services,
1320 unnecessary hospitalization or rehospitalization, provision of services with poor patient
1321 outcomes, inefficient service delivery, or choices about preference-sensitive services that
1322 are not compatible with patient desires
 - 1323 ■ Not reward providers for undertreatment of patients or for the exclusion of patients with
1324 serious conditions or multiple risk factors
 - 1325 ■ Not reward provider errors or adverse events
 - 1326 ■ Make providers responsible for quality and costs within their control, but not for quality
1327 and costs outside their control
 - 1328 ■ Support and encourage coordination of care among multiple providers, and discourage
1329 providers from shifting costs to other providers without explicit agreements to do so
 - 1330 ■ Encourage patient choices that improve adherence to recommended care processes,
1331 improve outcomes, and reduce costs of care
 - 1332 ■ Not reward short-term cost reductions at the expense of longer-term cost reductions and
1333 not increase indirect costs in order to reduce direct costs
 - 1334 ■ Not encourage providers to reduce costs for one purchaser by increasing costs for other
1335 purchasers, unless the changes bring payments more in line with costs for both/all payers
 - 1336 ■ Minimize the administrative costs for providers in complying with the payment system
1337 rules
 - 1338 ■ Multiple payers should align standards and methods of payment to avoid unnecessary
differences in incentives for providers.

1339 Source: Miller 2007 as cited in Langenbrunner et al 2009

1340

1341 **Adapting payment methods so that they are better aligned with health system**
1342 **goals**

1343 Because pure payment methods contain conflicting incentives for productivity and cost
1344 control and rarely encourage quality, many countries have adapted them so that they are
1345 more likely to achieve desired outcomes. Adaptations may involve adjusting capitation

Definition Primary Care – Preliminary opinion

1346 payment to account for patient risk, blending payment methods (Robinson 2001) and
 1347 bundling or unbundling payments (Table 4), all with the aim of correcting undesirable
 1348 incentives. For example, countries increasingly use fee-for-service with capitation in
 1349 primary care, to encourage the provision of preventive services or home visits.

1350
 1351 Table 5 provides an overview of changes in GP payment in selected European countries.
 1352 Although there are many differences in provider payment across countries, a clear trend
 1353 has been to move away from reimbursement of the costs incurred by providers in
 1354 delivering services, towards prospectively set payments that reflect outputs rather than
 1355 inputs.

1356

1357 **Table 4 The spectrum of bundled vs unbundled provider payment methods**

Bundled					Unbundled	
Global budget / salary	Capitation	Per period	Per patient pathway	Per case / diagnosis / procedure	Per day	Fee-for-service
Periodic lump sum independent of number of patients	Periodic lump sum per enrolled patient for a range of services	Periodic lump sum per patient diagnosed with a particular condition	Lump sum for all services required for a defined pathway of care	Payment per case based on grouping of patients with similar diagnoses / procedures or resource needs	Payment per day of stay in hospital or other facility	Payment for each system of service and patient contact

1358 Source: Charlesworth et al 2012

1359
 1360

1361 **Table 5 GP payment in selected European countries, 2010**

	Salary	Fee-for-service	Capitation	Performance-based payment	Integrated care payment	Other
Belgium		Yes	Yes		Yes	
Denmark		Yes	Yes		Yes**	
Finland	Yes	Yes	Yes			
France		Yes	Yes	Yes		
Germany		<u>Yes</u>			Yes*	
The Netherlands	**	<u>Yes</u>	<u>Yes</u>		Yes*	Yes
Sweden	Yes					
UK (England)	**		<u>Yes</u>	Yes		

1362 Source: Kroneman et al 2013

1363
 1364 Notes:
 1365 Text in italic: the type of remuneration is new for the country
 1366 Underlined text: the type of remuneration has changed since 2000

1367
 1368 * Fairly new and does not form a significant share of total revenue
 1369 ** In the Netherlands 7-12% of GPs are in salaried employment with independent GPs;
 1370 in the UK the share of salaried GPs rose from 10% in 2004 to 19% in 2008

1371
1372
1373
1374
1375

BOX F:

Bundled payments in the Netherlands

Since 2010 The Netherlands has adopted a system of bundled payments for various chronic diseases to improve integrated services delivery. Depending on the long-term outcomes, this may be the starting point for introducing risk-adjusted, integrated capitation payments for multidisciplinary care groups offering primary care, speciality care to defined groups of patients in the future (De Bakker et al 2012).

The introduction of a system of 'bundled payments' for the care of chronic diseases has contributed to the development of care groups for a particular chronic disease such as for diabetes care, chronic obstructive pulmonary disease care, and vascular risk management. Care groups (often exclusively led by general practitioners) are responsible for the organisation, co-ordination and delivery of care within the care programmes they have contracted with a health insurance fund (RIVM 2012).

A single fee is paid by health insurers to a contracting entity (the 'care group') which should cover all primary care needs required by patients with these chronic diseases.

The care group sub-contracts general practitioners, medical specialists, nurses and other disciplines. Approximately 78% of the general practitioners in the Netherlands are member of a care group (van Til 2010).

Recent evaluations (e.g. De Bakker et al 2012) have shown both positive and negative effects of the bundled payment system. On the one hand, first results seem to indicate that the system of bundled payments is conducive to the organisation and coordination of care. It also seems to result in improved coherence to care protocols and better collaboration among health professionals. However, a negative impact is seen on the administrative burden as a result of outdated information and communication technology systems. Also, price variation has been noticed among care groups which is probably caused by differences in the amount of care provided. In addition the dominance of general practitioners in the care groups is not seen as a positive outcome. However, more time is needed to evaluate the full implementation of the system thoroughly. It is too early to draw conclusions on the impact on the quality of care, costs or health outcomes.

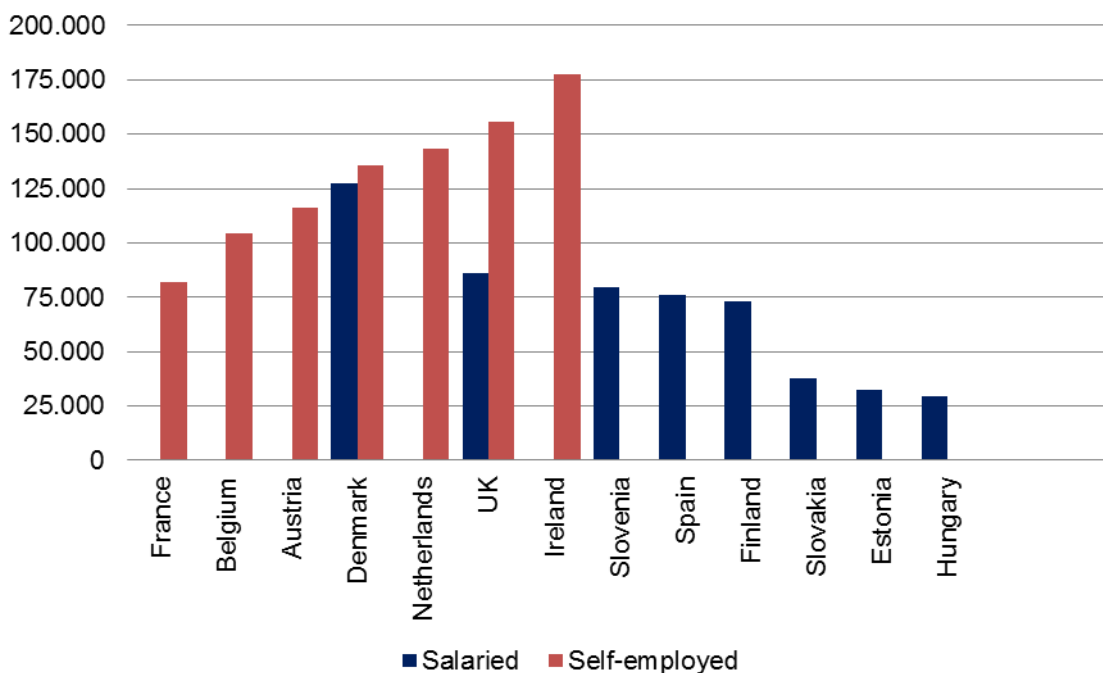
1376
1377
1378
1379
1380
1381
1382

1383
1384
1385
1386
1387
1388
1389
1390
1391
1392
1393
1394
1395
1396

A more recent trend has been to base payment on diagnosis and link it to the provision of care for a specific period of time, to encourage the provision of care that is coordinated among providers and sectors.

Figure 4 shows how GP incomes vary across EU countries and within countries depending on provider payment method. Although these data have been adjusted to make them more comparable, they should be interpreted with some caution. In Austria, Denmark, the Netherlands, the UK and Ireland, the income of self-employed GPs is around three times higher than the average wage, whereas in France and Belgium it is around double.

Figure 4 GP annual remuneration in selected EU countries (US\$ PPP), 2011



1397
1398
1399
1400
1401
1402
1403
1404
1405
1406
1407
1408
1409
1410
1411
1412
1413
1414

Source: OECD Health Data 2014

Note: only shows the EU OECD countries for which data are available

Most of the payment innovations described in this section share one common feature which is that they pay for (expected) outputs, not for outcomes. It has been suggested that paying for outcomes may be a better way to meet health system goals.

Linking provider payment to performance

P4P is not a payment method in itself, but an approach used to refine traditional payment methods. It can be defined as: “The adaptation of provider payment methods to include specific incentives and metrics explicitly to promote the pursuit of quality and other health system performance objectives” (Cashin et al 2014 in press: 6). Between countries there is significant variation in the size of P4P bonus payments. In Europe, their contribution to a professional’s remuneration ranges from 1% to 25%, although large shares are much less common than small shares (Cashin et al 2014 in press).

1415 The evidence on P4P is fragmented and inconclusive, partly because P4P programmes
1416 have often been implemented without adequate monitoring and evaluation, the
1417 evaluative methods available have been limited, and published studies have tended to
1418 focus on narrow aspects of performance rather than placing programmes in context
1419 (Cashin et al 2014 in press). In general, however, the evidence fails to show a
1420 'breakthrough' in quality improvement and there are questions about the size and effects
1421 of unintended consequences, aspects of programme design and implementation that may
1422 be associated with their effectiveness, and the cost-effectiveness of programmes (Cashin
1423 et al 2014 in press, Christianson et al 2007, Eijkenaar 2011, Frolich et al 2007, Damberg
1424 et al 2009, Guthrie et al 2010, Van Herck et al 2010).

1425
1426 Some reviews conclude that the 'spillover' effect of P4P programmes may be their most
1427 important contribution; that is, their ability to reinforce broader performance initiatives
1428 through improved collection and use of data, faster uptake of IT, the development of
1429 quality improvement tools such as guideline-based decision aids, a sharper focus on
1430 priorities, and better overall governance and accountability (Damberg et al 2009, Van
1431 Herck et al 2010).

1432
1433 This finding, combined with evidence of negative, unintended consequences, suggests
1434 that performance measures and incentive payments should play a supporting rather than
1435 a central role (Cashin et al 2014 in press). By strengthening data systems and feedback
1436 loops, and reinforcing a culture of accountability, P4P programmes can help to establish
1437 or sustain a cycle of performance improvement in the health system. In this way, they
1438 may enable a shift towards provider payment systems that define output better (for
1439 example, specifying continuity of care, disease management and clinical guidelines) and
1440 hold providers accountable not just for volume but also for processes and outcomes.

1441
1442 **Box 3 Factors contributing to the effectiveness of P4P programmes and design**
1443 **and implementation features that weaken the incentive**

1444 Factors that contribute to effectiveness:

- 1445 ▪ Programmes are most effective when they are aligned with and reinforce overarching
- 1446 strategies, objectives and clinical guidelines that are accepted by stakeholders.
- 1447 ▪ Programmes are more successful when the incentive is integrated into and complements
- 1448 the underlying payment system.
- 1449 ▪ Programmes are more effective when they focus on specific performance problems that
- 1450 require broad-based approaches for improvement.
- 1451 ▪ The structure of service delivery is important for whether or not providers can and do
- 1452 respond to the incentives, and programmes tend to favour larger, more urban providers.

1453
1454 What to avoid:

- 1455 ▪ Complex and non-transparent programme structure.
- 1456 ▪ Selective participation in programme domains.
- 1457 ▪ Specific incentives to improve the organisation of service delivery.

1458 Source: Cashin et al 2014 in press

1459
1460
1461 **Factors to consider when using financial incentives to encourage coordinated**
1462 **care**

1463 Improving the performance of one part of the health system is more likely to be effective
1464 if the process is informed by a whole-system view. Changing the way in which primary
1465 care providers are paid may not be sufficient to stimulate performance improvement,

1466 particularly where care coordination is concerned. It is therefore important for financial
1467 incentives to be aligned across the whole system, including hospitals and purchasing
1468 organisations.

1469
1470 While P4P looks promising in some contexts, it is still in its infancy and we need more
1471 information on key aspects of policy design. In the context of care coordination and a
1472 greater role for team work, the role of incentives for individuals vs incentives for teams is
1473 a critical issue.

1474
1475 There is no ideal method of paying providers. The effectiveness of any payment system
1476 will be influenced by context and all payment systems need to be carefully monitored and
1477 evaluated (Langenbrunner et al 2009). Financial incentives alone are also unlikely to
1478 move provider behaviour in appropriate directions, and should be accompanied by other
1479 tools, including monitoring and feedback.

1480
1481

1482 **3.4.5. Areas for future research**

- 1483
- 1484 ▪ It is difficult to estimate and compare spending on primary care across countries due
1485 to the absence of a uniform definition of the services and providers involved in
1486 primary care. While some countries have found ways to define their primary care
1487 services and costs, there is a need for comparative research to improve our
1488 understanding of differences between EU countries.
 - 1489 ▪ The literature consistently finds blended payment methods to be better than pure
1490 payment methods. However, we do not know enough about optimal combinations of
1491 payment systems. More structured research in this area is needed.
 - 1492 ▪ Optimal changes in payment methods are likely to depend on the starting point: the
1493 financing and organisation of a health system, its problems, its goals. Reforms should
1494 fully reflect and account for context.
 - 1495 ▪ It is difficult to compare provider remuneration across countries. Better methods are
1496 needed here too.
 - 1497 ▪ Many payment systems aim to improve the performance of a particular type of care
1498 (hospital care, GP care). However, interactions between different sectors of the health
1499 system need to be better understood and accounted for in provider payment reform,
1500 particularly if the aim is to improve care coordination.
 - 1501 ▪ Service delivery systems need to be flexible enough to meet the varying needs of
1502 different people at different times – one size does not fit all patients or even all the
1503 needs of a single patient. Again, provider payment reforms need to account for this.
 - 1504 ▪ Financial incentives are not the only available tool and need to be accompanied by
1505 other tools to ensure service delivery is in line with health system goals.
 - 1506 ▪ Provider payment requires constant monitoring and evaluation, but evaluative
1507 methods are often limited and do not capture important dimensions (including
1508 context).
 - 1509 ▪ Used effectively, P4P programmes can be an important governance tool and catalyst
1510 for health system performance improvement. However, questions remain about the
1511 size and effects of unintended consequences; aspects of programme design and
1512 implementation that may be associated with their effectiveness; and the cost-
1513 effectiveness of programmes.

Definition Primary Care – Preliminary opinion

- 1514 ▪ If primary care is to be at the centre of the health system, we need more research on
- 1515 referrals and efficient information flows to and from secondary care.
- 1516 ▪ What sort of purchasers are most likely to ensure coordinated care?
- 1517 ▪ What type of provider payment is most likely to encourage team-based care delivery?
- 1518 An appropriate skill mix?
- 1519 ▪ Can we develop primary care quality indicators at the EU level?

1520
1521
1522
1523
1524
1525

BOX G:

Remuneration of GPs in Spain

Primary Health Care in Spain is defined as an accessible and comprehensive service. It also plays the role of gate-keeper, and referral to other services. It is organized in health teams. The health-team includes General Practitioners, Paediatricians, Nurses, and, may also include Physiotherapists, Dentists, Midwives, and other professionals. There are well equipped Primary Health Centres in every district, covering populations of about 30.000 inhabitants. Electronic clinical records are kept for every patient. E-prescription is available in the majority of the Regions. The Regional Health Services are responsible for the planning and management of health care, and for the selection, contract and remuneration of health professionals.

Since 1960 the standard model of payment for GPs in Spanish Health System was based on capitation (80% of income) and time-salary (20%). Then in 1985-1990 this was changed to 20% on capitation, 70-78% on salary, and 2-10% pay-for performance. This model has been maintained, with some variations in different regions.

Pay-for-performance was introduced in the former National Institute of Health from 1987, with different results (Lamata et al 1990). One problem was the selection and measurement of objectives and outcomes. Another problem was the distribution of the incentives between the individual part and the team. A third was the decision about the weight of this kind of remuneration in relation with the other parts. It also necessitated a process of cultural change.

Nowadays the Regional Health Services negotiate and set objectives for PHC teams annually (e.g. programmes or activities related with health promotion activities, control and treatment of chronic conditions, prevention of diseases, training activities, coordination with other specialists, activities with schools or with residential homes, use of generics, waiting lists, quality of electronic clinical records, patient satisfaction, etc.). The managers have a set of indicators and they inform the doctors about their evolution. The P4P is paid according to the results. Normally there is participation of professionals in the evaluation teams.

1526
1527
1528
1529
1530
1531
1532
1533
1534
1535

1536

1537

3.4.6. Conclusions and recommendations

1538

1539

1. **Primary care definition:** The Expert Panel considers primary care to be the provision of universally accessible, person-centered, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care.

1540

1541

1542

1543

1544

1545

1546

2. **The rationale for strengthening primary care:** Primary care is responsive to the challenges facing health systems: the demographical and epidemiological transition towards chronic diseases and multi-morbidity; patients being active partners looking critically at quality of services; increasing social inequalities in health; increasing complexity in health care, which requires integration within health care and with other sectors (e.g. social sector, work, education, environment); new needs and approaches in continuity of care; and continuous adaptation to change in a globalizing world.

1547

1548

1549

1550

1551

1552

1553

1554

1555

The Expert Panel finds the evidence strong enough to agree that strong primary care systems contribute to equity and improved health outcomes. Further strengthening primary care by making it the preferred point of contact for the large majority of health needs and by ensuring it provides comprehensive, coordinated and person-focused care will improve its effectiveness in delivering these objectives.

1556

1557

1558

1559

1560

1561

3. **Referral systems and gatekeeping:** The Expert Panel emphasizes the importance of using primary care as the preferred entry point into the health system. Effective referral systems involve more than gatekeeping and the aim of gatekeeping should be to guide patients towards the most appropriate and cost-effective forms of care, and not to limit access to care. New technology enables specialist expertise to be integrated into primary care without physically transferring patients from one location to another. In caring for people with chronic conditions, a "spiral approach" combining horizontal and vertical referrals may be required. Special attention should be paid to care for "urgent" problems.

1562

1563

1564

1565

1566

1567

1568

1569

1570

The Expert Panel considers referral systems, including gatekeeping, to have strong advantages but, to be fully effective, they must involve the following factors:

1571

1572

- a strong and responsive high-quality primary care system, organized in (interprofessional) group practices and health centres, with a practice-based patient list and opportunities for second opinions at the primary care level.
- a patient-centered approach exploring the needs, expectations and goals of the patient, using appropriate communication skills is important in order to start the referral process appropriately. The importance of the continuous personal relationship between the GP and the patient (through e.g. a "patient list") is emphasized for the successful implementation of this requirement.

1573

1574

1575

1576

1577

1578

1579

1580

- 1581 - primary care providers have timely access to the results of medical imaging
1582 and other diagnostic tests
- 1583 - secondary care responds promptly and in a coordinated way once patients are
1584 referred from primary care, with fast-track facilities where a serious diagnosis
1585 is suspected (life-threatening conditions in children, cancer etc)
- 1586 - patient management based on maximal subsidiarity providing follow-up as
1587 much as is effective at the primary care level to avoid long waiting times for
1588 referred patients
- 1589 - referral processes are facilitated and enhanced through electronic procedures
1590 as much as possible
- 1591 - interactions between referral processes and payment systems are taken into
1592 account and incentives (both financial and non-financial) are aligned

1593

1594 **4. Financing primary care:** The Expert Panel recommends that all EU member states
1595 ensure an adequate level of financing for primary care, promote equitable access to
1596 primary care and provide incentives for efficiency and quality in primary care
1597 delivery, including care coordination. Areas requiring policy attention include: the
1598 share of public spending allocated to health in countries where this share is low;
1599 methods for allocating resources within health systems, both across different health
1600 care sectors and across geographical areas; levels of population and service
1601 coverage; the role of user charges; and reform of provider payment.

1602

1603 Ensuring that the whole population has access to a comprehensive range of primary
1604 care services without facing financial hardship is critical to promoting financial
1605 protection, equitable access and efficiency in service delivery. The Expert Panel notes
1606 that user charges policy and design varies substantially across countries. Given the
1607 lack of evidence to show that user charges lead to more appropriate use or long-
1608 term cost control, and noting the significant role of providers in initiating use and
1609 prescribing drugs, the Expert Panel stresses that where user charges are applied,
1610 policy makers should aim to protect people with low incomes and people who
1611 regularly use health care. In general, countries should engage in better monitoring of
1612 the effects of user charges on equity, quality, efficiency and outcomes.

1613

1614 The Expert Panel has identified a trend towards blended provider payment systems
1615 in primary care, often combining risk-adjusted capitation with some fee-for-service
1616 reimbursement. More recently, countries have introduced performance-related
1617 programmes that aim to enhance quality of care. These programmes can help to
1618 establish or sustain performance improvements, but are most effective when they
1619 are aligned with and reinforce overarching strategies, objectives and clinical
1620 guidelines that are accepted by stakeholders; when financial incentives are
1621 integrated into and complement the underlying payment system; and when they
1622 focus on specific performance problems that require broad-based approaches for
1623 improvement. The Panel notes that financial incentives alone are unlikely to move
1624 provider behaviour in appropriate directions, and should be accompanied by other
1625 tools, including monitoring and feedback.

1626

1627 5. **Research questions:** The Expert Panel has identified the following research
1628 questions as priorities underpinning the development of primary care in the EU.
1629

1630 A. General research questions
1631

- 1632 • Research on the implementation and impact on quality and outcomes of e-
1633 Health and M-Health developments
- 1634 • Research on new forms of diagnostic tests (HTA), including their use by
1635 primary care providers.
- 1636 • Research is needed to explore appropriate ways to strengthen person-
1637 centredness, integrating the goals of the individual and to enhance
1638 comprehensiveness, integrating health care and social care.
- 1639 • Research on the role and place of informal care in the provision of (primary)
1640 care in the EU, especially in relation to the ageing population, as well as
1641 research on ways to support informal carers and to monitor their health and
1642 wellbeing.

1643
1644 B. Research questions in relation to referral and financing
1645

- 1646 • It is difficult to estimate and compare spending on primary care among EU
1647 countries due to the absence of a uniform definition of the services and
1648 providers involved in primary care. While some countries have found ways to
1649 define their primary care services and costs, there is a need for comparative
1650 research to improve our understanding of differences among EU countries.
- 1651 • How are primary care systems responding to the epidemiological shift to
1652 multi-morbidity?
- 1653 • How can primary care contribute to more equity in health?
- 1654 • Identification of which interventions are changing primary care outpatient
1655 referral rates and/or referral appropriateness.
- 1656 • Research to explore further the possible adverse effects of gatekeeper
1657 systems and waiting lists on e.g. cancer survival, care for seriously ill
1658 children.
- 1659 • How can provider payment systems enhance the flexibility of service delivery
1660 systems?
- 1661 • How to monitor the impact of changes in provider payment?
- 1662 • How can P4P programmes contribute to quality, efficiency and equity in
1663 health?

1664
1665
1666 6. **Strategic directions:** The most important strategic directions that could be taken at
1667 EU level and by individual countries and regions, are to:

- 1668 • stimulate countries to strengthen primary care and make it universally
1669 accessible for a broad range of problems;
- 1670 • adopt a system that integrates optimal "channeling" of patients and patient-
1671 related health information throughout the health system;
- 1672 • strengthen the community orientation of primary care with special emphasis
1673 on intersectoral action for health promotion and prevention, looking at the
1674 upstream causes of ill-health and the social determinants of health;
- 1675

Definition Primary Care – Preliminary opinion

- 1676
- 1677
- 1678
- 1679
- 1680
- 1681
- 1682
- 1683
- 1684
- 1685
- 1686
- 1687
- 1688
- 1689
- 1690
- 1691
- stimulate the training of the appropriate workforce for primary care, taking into account the need for attractive working conditions, appropriate skill mix in interprofessional teams, and payment incentives that enhance quality of care;
 - stimulate exchange of best practices, e.g. through supporting organisations that bring together stakeholders in primary care at European level in order to create a "European primary care learning community";
 - further explore and tackle the possible adverse effect of gatekeeper systems on cancer survival, care for seriously ill children; estimate the effectiveness of interventions to change primary care outpatient referral rates or improve outpatient referral appropriateness;
 - stimulate and support countries to measure and monitor the performance of their primary care system by means of a comparative set of indicators, to increase their capacity for continuous quality improvement; and
 - stimulate the development of integrated partnerships between patients, providers and informal caregivers in order to better address health challenges

1692

1693 **4. LIST OF ABBREVIATIONS**

1694	ADL	Activities of Daily Living
1695	COPC	Community Oriented Primary Care
1696	COPD	Chronic Obstructive Pulmonary Disease
1697	DG SANCO	Directorate-General Health & Consumers European Commission
1698		
1699	eHealth	Electronic Health
1700	EU	European Union
1701	Eurostat	Statistical office of the European Union
1702	EXPH	Expert Panel on effective ways of investing in Health
1703	GDP	Gross Domestic Product
1704	GP	General Practitioner
1705	HTA	Health Technology Assessment
1706	ICT	Information and Communication Technology
1707	IOM	Institute of Medicine
1708	mHealth	Mobile health
1709	NHS	National Health Service (Portugal / United Kingdom)
1710	OECD	Organisation for Economic Co-operation and Development
1711	OOP	Out-Of-Pocket payments
1712	P4P	Pay for Performance
1713	UNICEF	United Nations Children's Fund
1714	VAT	Value Added Tax
1715	WHO	World Health Organisation

1716

1717 **5. REFERENCES**

1718 Akbari A, Mayhew A, Al-Alawi MA et al. Interventions to improve outpatient referrals from
1719 primary care to secondary care (review). Cochrane database Syst Rev. 2011.
1720 Available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005471/full>

1721 Arah OA, Klazinga NS, Delnoij DM, Ten Asbroek AH, Custers T: Conceptual frameworks
1722 for health systems performance: a quest for effectiveness, quality, and improvement. Int
1723 J Qual Health Care. 2003, 15:377-98.

1724 Arend J, Tsang-Quinn J, Levine C, Thomas D. The Patient-Centred Medical Home:
1725 History, components, and review of the evidence. Mount Sinai Journal of Medicine
1726 2012;79:433-450.

1727 Barnett K, Mercer SW, Norbury M et al. Epidemiology of multi-morbidity and implications
1728 for health care, research, and medical education : a cross-sectional study. Lancet
1729 2012;380:37-43.

1730 Barnum H, J Kutzin and H Saxenian. Incentives and provider payment methods,
1731 International Journal of Health Planning and Management, 1995;10(1):23-45.

1732 Bobinac A, van Exel NJA, Rutten FFH, Brouwer WBF. Caring for and caring about:
1733 disentangling the family effect and the caregiving effect. Journal of Health Economics
1734 2010; 29(4):549-556

1735 Bobinac A, van Exel NJA, Rutten FFH, Brouwer WBF. Health effects in significant others:
1736 Separating family and caregiving effects. Medical Decision Making 2011; 31(2): 292-298

1737 Brouwer WBF, van Exel NJA, van de Berg B, Koopmanschap MA, Dinant H, van den Bos
1738 GAM. The burden of caregiving: Evidence on objective burden, subjective burden and
1739 quality of life impacts in informal caregivers for patients with Rheumatoid Arthritis.
1740 Arthritis Care & Research 2004; 51(4): 570-577

1741 Brouwer WBF, van Exel NJA, van den Berg B, van den Bos GAM, Koopmanschap MA.
1742 Process utility from providing informal care: The benefit of caring. Health Policy 2005;
1743 74(1): 85-99

1744 Busse R, M Blümel and W Quentin. Can innovations in paying physicians and hospitals
1745 square the circle of conflicting incentives? Experience from four European countries
1746 (England, France, Germany and the Netherlands), New York: The Commonwealth Fund
1747 2010

1748 Cashin C, Y Chi, P Smith, M Borowitz and S Thomson (2014 in press), Paying for
1749 performance in health care: implications for health system performance and
1750 accountability, Maidenhead: Open University Press.

1751 Charlesworth A, A Davies and J Dixon (2012), Reforming payment for health care in
1752 Europe to achieve better value, London: The Nuffield Trust.

1753 Chernew M E and Newhouse JP (2008), What does the RAND Health Insurance Experiment tell us
1754 about the impact of patient cost sharing on health outcomes? Am J Manag Care. 2008
1755 Jul;14(7):412-4.

- 1756 Christianson, J., Leatherman, S. and Sutherland, K. (2007) Paying for quality:
1757 understanding and assessing physician pay-for-performance initiatives. Princeton, NJ:
1758 Robert Wood Johnson Foundation
- 1759 Coulter A (2010) Do patients want choice and does it work? *British Medical Journal* 341:
1760 973–975.
- 1761 Croxson B, Propper C, Perkins A. 2001. Do doctors respond to financial incentives? UK
1762 Family Doctors and the GP Fund Holder Scheme. *Journal of Public Economics* 79:375-
1763 398.
- 1764 Damberg, C., Raube, K., Teleki, S. and de la Cruz, E. (2009) Taking stock of pay-for-
1765 performance: a candid assessment from the front lines. *Health Affairs*, 28(2):517-525
- 1766 De Boer A (ed). *View on informal care*. The Hague: Social and Cultural Planning Bureau,
1767 2005
- 1768 De La Maisonnette, C. and J. Oliveira Martins, 2013, "A projection method for public
1769 health and long-term care expenditures", Economics Department Working Papers No.
1770 1048, OECD, Paris.
- 1771 Delnoij D, Van Merode G, Paulus A, Groenewegen P. 2000. Does general practitioner
1772 gatekeeping curb health care expenditure? *Journal of Health Services Research and*
1773 *Policy* 5(1):22-26.
- 1774 De Maeseneer J, van Driel ML, Green LA, van Weel C. The need for research in primary
1775 care. *Lancet* 2003;362:1314-9.
- 1776 De Maeseneer J, Willems S, De Sutter A et al. (2007). Primary health care as a strategy
1777 for achieving equitable care: a literature review commissioned by the health systems
1778 knowledge network., Ghent University.
1779 Available at:
1780 [http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_20](http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf)
1781 [07_en.pdf](http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf)
- 1782 De Maeseneer J, Boeckxstaens P. James MacKenzie Lecture 2011 : multimorbidity, goal-
1783 oriented care, and equity. *Br J Gen Pract.* 2012; (62) (600) : e522-4.
1784 <http://www.ncbi.nlm.nih.gov/pubmed/22782000>
- 1785 Donaldson MS, Gordy KD, Lohr KM et al. 1996. Primary Care: America's Health in a New
1786 Era. Institute of Medicine, Committee on the Future of Primary Care-Division of Health
1787 Care Services, Washington DC.
- 1788 Durand-Zaleski I, Bahrami S, et al. France: health system review. *Health systems in*
1789 *transition* 2010;12 (6):248-249.
- 1790 Eijkenaar, F. (2011) Key issues in the design of pay for performance programs. *European*
1791 *Journal of Health Economics*, 14(1):117-31
- 1792 Ellis R P and M M Miller (2009), Provider payment and incentives in Carrin G, K Buse, K
1793 Heggenhougen and S R Quah (eds), *Health systems policy, finance, and organization*,
1794 Philadelphia: Elsevier.
- 1795 European Commission (2007) *Health and long-term care in the European Union*,
1796 Eurobarometer Survey,
1797 http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf
1798 [accessed 3 March 2014]

Definition Primary Care – Preliminary opinion

- 1799 Eurostat. Expenditure of providers of health care by financing agents in health care - %
1800 <http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do> (10-12-2013)
- 1801 EXPH (Expert Panel on effective ways of investing in health), Definition and Endorsement
1802 of Criteria to Identify Priority Areas When Assessing the Performance of Health Systems,
1803 27 Feb 2014
1804 http://ec.europa.eu/health/expert_panel/opinions/docs/002_criteriaperformancehealthsystems_en.pdf
1805
- 1806 Figueras J, R Robinson and E Jakubowski (2005), Effective Purchasing for Health Gain,
1807 Buckingham: Open University Press.
- 1808 Fleming D N. The European study of referrals from primary to secondary care. PhD-
1809 thesis, Maastricht University. 1993, Thesis Publishers Amsterdam.
- 1810 Franks P, Clancy CM, Nutting PA. 1992. Gatekeeping revisited – protecting patients from
1811 overtreatment. *New England Journal of Medicine* 327:424-429.
- 1812 Frenk J et al. Health professionals for a new century: transforming education to
1813 strengthen health systems in an interdependent world, *The Lancet*, 4 December 2010,
1814 Vol. 376, Issue 9756, Pages 1923-1958
1815 doi: 10.1016/S0140-6736(10)61854-5
- 1816 Frolich, A., Talavera, J., Broadhead, P. and Dudley, R. A. (2007) A behavioral model of
1817 clinician responses to incentives to improve quality. *Health Policy*, 80(1): 179-193
- 1818 Garrido M V, Zentner A, Busse R (2011) The effects of gatekeeping: A systematic review
1819 of the literature. *Scandinavian Journal of Primary Health Care*, 29(1): 28–38.
- 1820 Gillam S (2008), Is the declaration of Alma-Ata still relevant to primary health care? *BMJ*
1821 2008;336:536.
- 1822 Guthrie, B., Auerback, G. and Binman, A. (2010) Competition for Medicaid enrollees based
1823 on performance does not improve quality of care. *Health Affairs*, 29(8): 1507-1516
- 1824 Health Council of the Netherlands 2004. *European Primary Care*. ISBN: 90-5549-549-2.
1825 Available at:
1826 http://www.gezondheidsraad.nl/sites/default/files/European_primary_care_final.pdf
- 1827 Hernandez-Quevedo C, Llano R, Mossialos E. Paying for integrated care: an overview.
1828 *Eurohealth* 2013; 19 (2): 3-6
- 1829 Kidd M (ed) (2013) *The Contribution of Family Medicine to Improving Health Systems: a*
1830 *guidebook from the World Organisation of Family Doctors*. London, Radcliffe Publishing.
1831 ISBN-13: 9781846195549
- 1832 Kraijo H, Brouwer WBF, de Leeuw R, Schrijvers G, van Exel NJA. The perseverance time
1833 of informal carers: introduction and validation of a new measure of burden in caregivers
1834 for dementia patients. *Journal of Alzheimer’s Disease*, in press
- 1835 Kringos DS, Boerma WGW, Van der Zee J, Groenewegen PP. (2013a) Europe’s Strong
1836 Primary Care Systems Are Linked To Better Population Health, But Also To Higher Health
1837 Spending. *Health Affairs* April 2013 vol. 32 no. 4, pp. 686-694.
1838 doi: 10.1377/hlthaff.2012.1242
- 1839 Kringos D.S., Boerma W.G.W., Bourgueil Y., Cartier T., Dedeu T., Hasvold T., Hutchinson
1840 A., Lember M., Oleszczyk M., Rotar Pavlic D., Svab I., Tedeschi P., Wilm S., Wilson S.,
1841 Windak A., Van der Zee J., Groenewegen P.P. (2013b) The strength of primary care in

Definition Primary Care – Preliminary opinion

- 1842 Europe: an international comparative study. *British Journal of General Practice* 2013;
1843 63(616): e742-e750(9).
- 1844 Kringos, D.S, Boerma, W.G., van der Zee, J., Groenewegen, P.P, (2013c) Political,
1845 cultural and economic foundations of primary care in Europe. *Social Science & Medicine*
1846 99 2013: 9-17.
- 1847 Kronenberg C and P Pita Barros (2014), Catastrophic healthcare expenditure – drivers
1848 and protection: the Portuguese case, *Health Policy* 115: 44-51.
- 1849 Kroneman M, Meeuws P, Kringos DS, Groot W, Van der Zee J. International
1850 developments in revenues and incomes of general practitioners from 2000 to 2010. *BMC*
1851 *Health Services Research* 2013; 13:436.
- 1852 Lamata F, Rubio S, Checa I (1990) Incentivos económicos; complemento de
1853 productividad variable en el Insalud de Madrid. *Rol de enfermería* 1990; 141: 15-20.
- 1854 Langenbrunner J C, C Cashin and S O’Dougherty (2009), *Designing and implementing*
1855 *health care provider payment systems*, Washington DC: The World Bank
- 1856 Lewin K. Forces behind food habits and methods of change. *Bulletin of the National*
1857 *Research Council* 108:35-65.
- 1858 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health
1859 outcomes within Organisation for Economic Cooperation and Development (OECD)
1860 countries, 1970–1998. *Health Serv Res.* 2003;38(3):831–65.
- 1861 Martin D, Marinker M, Pereira Gray D. 1989. Effect of a gatekeeper plan on health
1862 services use and charges: a randomized trial. *American Journal of Public Health* 79:1628-
1863 1632
- 1864 McCartney M. *The Patient Paradox*. London: Pinter & Martin, 2012
- 1865 McKee M, Karanikolos M, Belcher P, Stuckler D. Austerity: a failed experiment on the
1866 people of Europe. *Clin Med* 2012;12:346-50.
- 1867 *Medical dictionary for the health professions and nursing*, Farlex 2012.
- 1868 Miller H D (2007), *Creating payment systems to accelerate value-driven health care:*
1869 *issues and options for policy reform*, New York: The Commonwealth Fund.
- 1870 Moynihan R. The making of a disease: female sexual dysfunction. *BMJ* 2003;326:45-7.
- 1871 Murray C, Frenk J. *World Health Report 2000: a step towards evidence-based health*
1872 *policy*. *Lancet*, 2001, 357:1698-1700.
- 1873 NHS Wales Informatics Service. *Electronic Referrals: Electronic Clinical Communications*
1874 *for Wales*.
1875 Available at: <http://www.wales.nhs.uk/nwis/page/52545>
- 1876 Nolte E, McKee M. *Integration and chronic care: review*. In: Nolte E, McKee, editors.
1877 *Caring for people with chronic conditions. A health system perspective*. Maidenhead:
1878 *Open University Press*; 2008. pp. 64-91.
- 1879 OECD Health Working Paper No. 58: *Income-Related Inequalities in Health Service*
1880 *Utilisation in 19 OECD Countries, 2008-2009* (Devaux and de Looper, July 2012).
- 1881 OECD (2012), *Health at a glance 2012*. OECD Publishing

Definition Primary Care – Preliminary opinion

- 1882 OECD (2013). Health at a Glance 2013: OECD indicators, OECD Publishing.
1883 http://dx.doi.org/10.1787/health_glance-2013-en
- 1884 Reeves A, McKee M, Basu S, Stuckler D. The political economy of austerity and health
1885 care: Cross-national analysis of expenditure changes in 27 European nations 1995-2011.
1886 Health-Policy (2013). Article in Press.
- 1887 Reibling N, Wendt C (2012) Gatekeeping and provider choice in OECD healthcare
1888 systems. Current Sociology 60(4): 489-505.
- 1889 Rhyne R, Bogue R, Kukulka G, Fulmer H, editors. Community-oriented primary care:
1890 health care for the 21st century. Washington, DC: American Public Health Association,
1891 1998.
- 1892 Riedel M, Kraus M. Informal Care Provision in Europe: Regulation and profile of providers,
1893 ENEPRI Research Report No. 96., 2011.
- 1894 RIVM (2012). Effects of bundled payment on curative health care costs in the
1895 Netherlands : An analysis for diabetes care and vascular risk management based on
1896 nationwide claim data, 2007-2010. Bilthoven: RIVM.
- 1897 Robinson J (2001), Theory and practice in the design of physician payment incentives,
1898 Milbank Quarterly 79(2): 149-177.
- 1899 Royal College of Nursing (2013), Moving care to the community: an international
1900 perspective, RCN Policy and International Department Policy briefing, London: The Royal
1901 College of Nursing.
- 1902 Saltman RB, Rico A, Boerma W. Primary care in the driver's seat? Organisational reform
1903 in European Primary Care. European Observatory on Health Systems and Policies Series.
1904 2006, Open University Press, England (ISBN 978-0-335-21366-5).
- 1905 Schneider J et al. Carers and Community mental health services. Social Psychiatry &
1906 Psychiatric Epidemiology 2001; 36(12): 604-7.
- 1907 Schulz R, Beach SR. Caregiving as a risk factor for mortality: the caregiver health effects
1908 study. JAMA 1999; 282 (23): 2215-2219
- 1909 Scottish Executive Health Department Directorate of Delivery. 2007. Patient pathway
1910 management: referral facilitation. ISBN: 978-0-7559-5350-9.
1911 Available at: <http://www.Scotland.gov.uk/Resource/Doc/170740/0047851.pdf>
- 1912 Schwenkglenks M, Preiswerk G, Lehner R, Weber F, Szucz TD. 2006. J Epidemiol
1913 Community Health 62:24-30. doi: 10.1136/jech.2005.038240
- 1914 Shi L, Macinko J, Starfield B, Politzer R, Wulu J, Xu J. Primary care, social inequalities,
1915 and allcause, heart disease, and cancer mortality in US counties, 1990. Am J Public
1916 Health. 2005;95(4):674-80.
- 1917 Social and Cultural Planning Office. Social and Cultural Report 2000. The Hague: Social
1918 and Cultural Planning Office; 2000.
- 1919 Starfield B. Is primary care essential? Lancet 1994; 344: 1129-1133.
- 1920 Starfield B. Primary Care: Balancing Health Needs, Services, and Technology. Oxford
1921 University Press, 1998.

Definition Primary Care – Preliminary opinion

- 1922 Tarimo E. 1997. Essential Health Service Packages: Uses, Abuse and Future Directions.
1923 ARA Paper n°15, WHO, Geneva.
- 1924 Thomson S, Foubister T, Figueras J, Kutzin J, Permanand G, Bryndová L. Addressing
1925 financial sustainability in health systems. Policy Summary I. European Observatory on
1926 Health Systems and Policies, 2009.
- 1927 Thomson S, Chernew M and Schang L (2013), Value-Based Cost Sharing In The United
1928 States And Elsewhere Can Increase Patients' Use Of High-Value Goods And Services,
1929 Health Affairs 32(4).
- 1930 Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A (2014 in press),
1931 Health systems, health and economic crisis in Europe, Buckingham: Open University
1932 Press.
- 1933 Valentijn PP et al. Understanding integrated care: a comprehensive conceptual
1934 framework based on the integrative functions of primary care. Int J Integr Care. 2013
1935 Mar 22; 13e010. Print 2013 Jan.
- 1936 Van de Ven, W.P.M.M., Schut F.T. (2009), Managed competition in the Netherlands: still
1937 work-in-progress, Health Economics 18: 253-255.
- 1938 Van Herck, P., De Smedt, D., Annemans, L., Remmen, R., Rosenthal, M. and Sermeus, W.
1939 (2010) Systematic review: effects, design choices, and context of pay-for-performance in
1940 health care. BMC Health Services Research, 10: 247-260.
- 1941 Van Houtven CH, Norton EC. Informal care and health care use of older adults. J Health
1942 Econ 2004; 23 (6): 1159-80
- 1943 Van Til, T. de Wildt, J.E., Struijs. (2010). De organisatie van zorggroepen anno 2010.
1944 Huidige stand van zaken en de ontwikkelingen in de afgelopen jaren (in Dutch).
1945 Bilthoven: RIVM.
- 1946 Vedsted P, Olesen F. Are the serious problems in cancer survival partly rooted in
1947 gatekeeper principles? An ecologic study. Br J Gen Pract. 2011 Aug;61(589):e508-12.
1948 doi: 10.3399/bjgp11X588484
- 1949 Võrk A, J Saluse and J Habicht (2009), Income-related inequality in health care financing
1950 and utilization in Estonia 2000–2007, Copenhagen: WHO Regional Office for Europe.
- 1951 Vrijens F et al. The Belgian Health System Performance Report 2012: Snapshot of results
1952 and recommendations to policy makers. Health Policy 112 (2013) 133-140
- 1953 Vuori H. Health for all, primary health care and general practitioners (1986). Journal of
1954 The Royal College of General Practitioners 36;398-402.
- 1955 Wagstaff A and E van Doorslaer et al (1999), Equity in the finance of health care: some
1956 further international comparisons, J Health Econ 18(3):263-90.
- 1957 Weisbrot M, Baker D, Kraev E, Chen J. The scorecard on globalization 1980-2000: its
1958 consequences for economic and social Well-being. In: Navarro V, Muntaner C. Political
1959 and economic determinants of population Health and Well-being: controversies on
1960 developments. New York, Baywood Publishing Company, 2004, pp.91-114.

Definition Primary Care – Preliminary opinion

- 1961 WHO 1978 Declaration of Alma-Ata. International Conference on Primary Health Care,
1962 Alma-Ata, USSR, 6-12 September 1978.
1963 Available at: http://www.who.int/publications/almaata_declaration_en.pdf
- 1964 WHO (2000), The world health report 2000: Health systems: improving performance.
1965 Geneva, World Health Organisation, 2000
1966 http://www.who.int/whr/2000/en/whr00_en.pdf [accessed 5 December 2013]
- 1967 WHO (2006). Referral systems – a summary of key processes to guide health services
1968 managers
1969 Available at: <http://www.who.int/management/referralnotes.doc?ua=1>
- 1970 WHO (2008), The Tallinn Charter: health systems for health and wealth, Copenhagen:
1971 WHO Regional Office for Europe.
- 1972 WHO (2008), World Health Report 2008: Primary health care: now more than ever!
1973 Geneva, World Health Organisation, 2008.
1974 <http://www.who.int/whr/2008/en/index.html>
- 1975 WHO (2010), The world health report 2010: Health systems financing: the path to
1976 universal coverage. World Health Organisation, 2010
1977 <http://www.who.int/whr/2010/en/index.html> [accessed 5 December 2013]
- 1978 WHO Health systems glossary
1979 http://www.who.int/healthsystems/hss_glossary/en/
- 1980 WONCA Dictionary of General/Family Practice. Bentzen N. (ed), Wonca International
1981 Classification Committee: Copenhagen, 2003.
- 1982 World Bank. Investing in health, World development report 1993. The World Bank,
1983 Oxford University Press, 1993, p. 34.
- 1984 Xu K, Evans D B, Carrin G, Aguilar-Rivera A, Musgrove P and Evans T (2007), Protecting
1985 Households From Catastrophic Health Spending, Health Affairs, 26(4): 972-983.
- 1986 Zielinski A, Håkansson A, Jurgutis A et al. 2008. Differences in referral rates to
1987 specialized health care from 4 primary health care models in Klaipeda, Lithuania. BMC
1988 family practice 2008;9:63.
1989 doi:10.1186/1471-2296-9-63
- 1990
- 1991
- 1992

1993

1994 **6. GLOSSARY**

1995 **Accessibility (of health services)**

1996 Aspects of the structure of health services or health facilities that enhance the ability
1997 of people to reach a health care practitioner, in terms of location, time, and ease of
1998 approach (WHO Health systems glossary)

1999

2000 **Accountability**

2001 The result of the process which ensures that health actors take responsibility of what
2002 they are obliged to do and are made answerable for their actions. (WHO Health
2003 systems glossary)

2004

2005 **Community**

2006 A unit of population, often generally geographically defined, that is the locus of basic
2007 political and social responsibility and in which everyday social interactions involving
2008 all or most of the spectrum of life activities of the people within it takes place. (WHO
2009 Health systems glossary)

2010 **Community medicine**

2011 Specialty of medicine concerned with the health of specific populations or groups;
2012 focuses on health of the community as a whole rather than individuals; includes
2013 epidemiology, screening, and environmental health and is concerned with
2014 promotion of health, prevention of disease and disability, and rehabilitation,
2015 through collective social actions, often provided by state or local health
2016 authorities. (Kidd)

2017

2018 **Comprehensiveness (of care)**

2019 The extent to which the spectrum of care and range of resources made available
2020 responds to the full range of health problems in a given community. Comprehensive
2021 care encompasses health promotion and prevention interventions as well as diagnosis
2022 and treatment or referral and palliation. It includes chronic or long-term home care,
2023 and, in some models, social services. (WHO Health systems glossary / Kidd)

2024

2025

2026

2027 **Continuity (of care)**

2028 A term used to indicate one or more of the following attributes of care:

- 2029 (i) the provision of services that are coordinated across levels of care – primary care
2030 and referral facilities, across settings and providers;
2031 (ii) the provision of care throughout the life cycle;
2032 (iii) care that continues uninterrupted until the resolution of an episode of disease or
2033 risk;
2034 (iv) the degree to which a series of discrete health care events are experienced by
2035 people as coherent and interconnected over time, and are consistent with their health
2036 needs and preferences (WHO Health systems glossary /Kidd)

2037

2038 **Coordination**

2039 Coordinated care is an organisation of health care based on the principle that, by
2040 strengthening administrative arrangements between organisations in joined co-
2041 operation, components in the health care system work together to create a
2042 continuum of health care to a defined population. It includes health promotion,
2043 preventive, curative and rehabilitative interventions and also refers to the extent to
2044 reach activities or co-ordinated across units to maximize the value of service delivery
2045 to patients. (Wonca Dictionary of General/Family Practice; Niels Bentzen – 2003).

2046

2047 **Health needs**

2048 Objectively determined deficiencies in health that require health care, from promotion
2049 to palliation. Perceived health needs: the need for health services as experienced by
2050 the individual and which he/she is prepared to acknowledge; perceived need may or
2051 may not coincide with professionally defined or scientifically confirmed need.
2052 Professionally defined health needs: the need for health services as recognized by
2053 health professionals from the point of view of the benefit obtainable from advice,
2054 preventive measures, management or specific therapy; Professionally defined need
2055 may or may not coincide with perceived or scientifically confirmed need. Scientifically
2056 confirmed health needs: the need confirmed by objective measures of biological,
2057 anthropometric or psychological factors, expert opinion or the passage of time; it is
2058 generally considered to correspond to those conditions that can be classified in
2059 accordance with the International Classification of Diseases. (WHO Health systems
2060 glossary)

2061

2062 **Informal caregivers**

2063 Family members, neighbours, friends or volunteers, involved as non-professionals, in
2064 care delivery. (Wonca Dictionary of General/Family Practice; Niels Bentzen – 2003).

2065

2066

2067 **Person-centeredness**

2068 **People-centered care**

2069 Care that is focused and organized around the health needs and expectations of
2070 people and communities rather than on diseases. People-centered care extends
2071 the concept of patient-centered care to individuals, families, communities, and
2072 society. Whereas patient-centered care is commonly understood as focusing on
2073 the individual seeking care – the patient – people-centered care encompasses
2074 these clinical encounters and also includes attention to the health of people in
2075 their communities and their crucial role in shaping health policy and health
2076 services. (WHO Health systems glossary / Kidd)

2077

2078 **Subsidiarity**

2079 Subsidiarity means that a central, specialised service should have a subsidiary
2080 function, performing only those tasks which cannot be performed effectively at a
2081 less specialized or local level (adapted from Oxford English Dictionary)

2082

2083 **Team**

2084 The Primary Care Team, is leaded usually by a family doctor, and it includes
2085 several primary care professionals, depending on the circumstances (various GPs,
2086 nurses, paediatricians, nursing assistants, physiotherapists, midwives, social
2087 workers, etc.).

2088 The primary care team can work in a health centre, but can also do it with
2089 professionals in different locations through networks of primary care.

2090 In the costs of primary care could be considered included (in order to assess the
2091 expenditure at this level): the requested diagnostic tests (radiological imaging,
2092 laboratory tests) and medication initially prescribed by the primary care physician.
2093 (proposed by F. Lamata)

2094

2095 **Universality**

2096 **Universal (health) coverage**

2097 Universal access to health services with social health protection. (WHO Health
2098 systems glossary)

2099 Ensuring that all people can use the promotive, preventive, curative, and
2100 rehabilitative health services they need, of sufficient quality to be effective, while
2101 also ensuring that the use of these services does not expose the user to financial
2102 hardship. (Kidd)

2103

2104

2105