
Executive summary

The healthcare systems operating in the various member states of the European Union differ from one another quite significantly. However, all are under pressure from a number of pan-European developments and all are implementing reforms designed to ensure that their healthcare systems are able to cope with these developments. In view of this situation and the general trend towards European integration, it is reasonable to assume that the EU member states' healthcare systems will gradually become more and more alike.

One of the respects in which the healthcare systems operating in EU member states – both old and new – differ most markedly is in terms of the organisation of primary care. As the EU's healthcare systems converge, strategic decisions will have to be made regarding primary care.

Against this background, the Minister of Health, Welfare and Sport asked advice from the Health Council on the current level of knowledge with regard to organisation and significance of primary care. The request for advice contained three questions. In this advisory report, compiled by a Health Council committee, the Council addresses these three questions and formulates a number of recommendations for the future. This summary provides the general answers to the questions of the Minister and five key recommendations. The complete set of recommendations is included in Chapter 6.

Question 1: What are the defining characteristics of primary care and what is the significance of primary care for the general quality of healthcare provision?

The Committee considers primary care (which it regards as synonymous with primary *healthcare*) to be generalist care, consisting of general medical, paramedical and pharmaceutical care, nursing and supportive care, and non-specialised mental and social healthcare, together with preventive and health-educational activities linked to these forms of care. The care is aimed at patients staying at home and is provided as close to the patient's home as possible and, if necessary, at the patient's home. Furthermore, it is accessible to all, irrespective of the nature of their health problems. The system is able to respond to urgent cases, providing immediate access where necessary. The system also realises continuity in responsibility and accountability with regard to long-term care, guidance and preventive initiatives. Primary care is focused primarily on providing care for help-seeking patients, but has a proactive responsibility in relation to both individual and group-oriented preventive activities aimed at promoting health in the local (practice) population. Primary care is provided where necessary by different care providers working together on a coordinated basis within primary care and, if indicated, with secondary care.

Throughout the years, the extent to which people choose to try and cope with health problems without seeking professional assistance has remained remarkably stable. In the great majority of cases, people sort their problems out themselves. This phenomenon is apparent in all countries. Self-care and lay care generally play important roles.

When professional care is sought, an adequately functioning primary care system is capable of successfully diagnosing, addressing and treating most of the health problems presented to it. In many cases, instead of taking over the patients' responsibility for their own health, self-care can be supported by providing health information and advice. The percentage of patients that need to be passed on to specialist carers can be greatly limited. Hence, well functioning primary care is very important for the effectiveness and efficiency of the healthcare system as a whole. Primary care is also capable of showing patients the way through an increasingly complex healthcare system and providing the necessary guidance along the way, in the form of navigation, cooperation, referral where appropriate and follow-up care.

Question 2: What differences exist internationally in terms of the organisation of primary care in relation to other forms of care, and what significance do these differences have for the general quality of healthcare provision?

Across Europe, considerable differences exist in the organisation and positioning within the healthcare system of non-specialist care provided outside a hospital setting. Nevertheless, to a certain extent, all EU countries have primary care with broadly similar characteristics: relatively good access, a generalist profile, continuity of care, and multidisciplinary cooperation.

Significant points on which differences exist are the presence or absence of obligatory patient registration with a general practitioner and the gatekeeper role of primary care. International comparative research has indicated that healthcare systems that have a stronger primary care system are more effective and more efficient than those that do not.

However, the research conducted to date has certain limitations. It is therefore important that international comparative studies are given greater attention as Europe gradually moves towards a situation characterised by care provision that does not recognise internal borders. If the design of international comparative studies of healthcare systems is methodologically optimised, it will in the future be possible to draw more detailed conclusions concerning the mechanism and determinants of effective and efficient healthcare. Such research should also seek to establish how effective various incentives are in promoting quality, coherence, accessibility, efficiency and sustainability of primary care.

This comparative and evaluative research should preferably be organised on a continuous basis, so as to provide a steady flow of new insights and pointers to possible ways of achieving practical improvements. It is up to bodies representing the healthcare professions in Europe, patients' organisations, consumer organisations, insurers, national governments and the European Commission to take up this challenge.

Question 3: (a) Given current insights, what – in terms of the overall quality of healthcare provision – is the most desirable scenario for the development of primary care within the European Union?

(b) Taking EU law into account, which aspects of the preferred development scenario require attention?

In response to part (a) of this question, the following contours can be sketched on the basis of the considerations outlined above:

- As care becomes more complex, navigation and guidance of patients in line with the help they are seeking should increasingly be seen as core competences of generalist care provision.
- There should be further development of evidence-based primary care within Europe, with continuous implementation of new knowledge in the form of professional standards and (multidisciplinary) guidelines for effective, efficient and safe care, as well as education, postgraduate training and international exchange geared to this end.
- While the composition of primary care teams should be geared to local circumstances and needs, clients should have access to the following: general practitioner, practice nurse/nurse practitioner, home nursing and home care, physiotherapist, community pharmacist, midwife and dentist. In addition, it should be possible to call in a community psychiatric nurse, psychologist or social worker. In view of efficiency, opportunities have been identified for further differentiation of tasks in primary medical care. When, for example, within the responsibility of a primary care team, certain patient-related procedures are being carried out by physician assistants and nurse practitioners, general practitioners gain time. In the context of the team, it must always be clear to the patient who of the individual care providers is responsible for the care made available in connection with a given problem. It is necessary to have adequate out-of-hours coverage of medical, nursing and pharmaceutical care and crisis management in primary care, properly coordinated with secondary care. With a view to relieving care providers of administrative duties, consideration should be given to the organisational separation of management activities, possibly on a regional basis.
- Primary care teams should preferably work with well-defined populations or communities. The Committee favours a registered population of ten to fifteen thousand, with scope for variation in line with population density and local problems.

- The general introduction of electronic multidisciplinary patient records is desirable. This would also tie in with the increasing use of ICT by patients for health-related purposes.
 - Primary care teams should regularly produce work plans covering periods of several years, to serve as a functional accountability tool and a basis for need-related resource allocation.
 - The Committee advocates close cooperation between primary care, preventive healthcare, public health and occupational health. Consideration should be given to delivery of certain public health activities in the context of primary care.
 - The development of a more differentiated system of interaction between primary and secondary care, including mental health care, should be encouraged. Those responsible for the funding of care in Europe have an important role to play in this regard.
 - Building on the example of the general practice morbidity registrations in use in many European countries, steps should be taken to improve the provision of information on other disciplines.
 - In view of the benefits that registration of patients with a primary care team (patient list system) has for the continuity of care, for prevention and for scientific evaluation, the possibility of eventually extending this option to all EU countries should be investigated. In European countries without a strongly developed primary care system, there should be scope for comparative experiments with different care set-ups (e.g. with or without the requirement to consult a general practitioner in order to gain access to a specialist).
 - The capacity of Europe's primary care needs to be kept in line with the increasing numbers of older people, people with chronic illnesses and those in need of complex care or home care, as well as with the need for prevention and health promotion among older people. The composition of the primary care workforce can be optimised by utilising the available talent and providing adequate career opportunities.
 - In addition, primary care needs to respond appropriately, in terms of expertise and care supply, to:
 - the increasing ethnic and cultural diversity in European countries;
 - growing individualisation and rising expectations;
 - rapid developments in the field of 'e-health';
 - the increasing potential of home care technology;
 - the rapid growth of new prevention and care possibilities;
 - the need to improve diagnosis and optimise treatment of mental disorders;
 - developments in the field of genetics (giving rise to 'diagnostics' not necessarily related to symptoms or complaints);
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- the increasing demand for accountability with regard to the quality of care;
- outbreaks of known or unknown aetiology and disasters of various kinds.
- Targeted support should be provided for practice-related primary care research and quality improvement, with the emphasis on international cooperation, by prioritisation within the EU framework programmes.

In response to part (b) of the third question, the Committee's presents the view that, as the healthcare systems in the European Union gradually converge, two priorities should be kept in mind: (1) an effective and efficient system of care for the protection, maintenance, and promotion of health in Europe, and (2) the availability of real choice to European citizens/patients in the field of primary care, based on the adequate and open provision of information regarding accessibility, quality and efficiency of care. Given these priorities and in view of the value of guidance/navigation by primary care and of the registration of patients with primary care practices, the committee holds the view that these modalities should be made generally available as options within the European care and insurance system. It is vital to have, in principle, closed circuits of facilities and services, to which the patient is referred in accordance with an integrated care model. The patient would then choose a primary care team in the context of an integrated care circuit, thereby giving up his or her complete freedom to select care providers outside the chosen circuit, in the interests of quality, continuity and efficiency of care. Each care circuit would normally need to include more than one care provider per discipline, so that a degree of choice remained. This would generally not represent any curtailment compared with the amount of choice in many existing systems, which are subject to inherent geographical constraints. If and insofar as it might be concluded that such arrangements are inconsistent with the free movement of services, it would be necessary to develop a special EU policy covering this area in order to enable the relevant modalities in the various member states. Such a policy would need to be designed to enable countries whose systems already feature the modalities concerned to continue on their existing basis. At the same time, the options in question could also be made available to the citizens of other countries, without jeopardising options currently in use. This approach would additionally provide good opportunities for prospective, comparative, evaluation research.

In terms of anticipating primary care development from a policy perspective, a significant step has been made by the Ministers of Health of the EU Member States in connection to the conference 'Shaping the EU Health Community' held in The Hague in September 2004. At the Informal Health Council considering the results of that conference, the Ministers have emphasised the importance of creating more synergy in health care policies, and have expressed the ambition to invest in primary care and community based care.

Key recommendations

In the previous sections, a number of recommendations have been implied to various stakeholders. As key recommendations, the Committee considers the following:

- Primary care must closely follow emancipatory developments in the patient's role. Information provision, effective communication, e-health, and increasing the possibilities for tailor-made homecare are some examples of challenges faced.
- In the interest of prevention, good navigation, continuity of care, and evaluation research, primary care teams and networks should be responsible for well-defined registered populations, with variation in size in line with population density and local problems.
- The Committee advocates close cooperation between primary care, preventive healthcare, public health and occupational health. Consideration should be given to delivery of certain public health activities in the context of primary care.
- Information on primary care must be transparent to all parties involved. Building on the example of the general practice morbidity registrations in use in many European countries, steps should be taken to improve the provision of information on other disciplines.
- As a concrete step in the short run to strengthen primary care on a European level, with the support of the European Commission, a European forum for primary care development should be created and given the remit of:
 - providing for the regular and systematic exchange of experiences and programs for innovation between patients, professionals, managers and policy-makers, and for stimulating the dissemination of best practices in primary care provision and policies;
 - offering consultation and support as appropriate to any country or area that has particular problems in developing a primary care system capable of serving its intended purpose;
 - designing a set of indicators for monitoring the development and quality of primary care throughout the European Union;
 - promoting and coordinating international comparative research.