



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 adopted this opinion at the 6th plenary of 10 July 2014 after public consultation

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

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

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

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

Expert Panel members

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

Contact:

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

SANCO-EXPERT-PANEL@ec.europa.eu

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

The members of the Working Group are:

Expert Panel members

Professor Werner Brouwer
Professor Jan De Maeseneer (Chair / Rapporteur)
Professor Lasse Lehtonen
Dr Dorjan Marušič
Dr Sarah Thomson

External experts

Dr Dionne Kringos
Dr Judith Smith

The declarations of the Working Group members are available at:

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

ABSTRACT

In this opinion the Expert Panel on effective ways of investing in Health (EXPH), considers primary care to be the provision of universally accessible, integrated, person-centred, 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 care givers, in the context of family and community and play a central role in the overall coordination and continuity of people's care.

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.

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

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

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

European Union (EU) health systems show a trend towards blended provider payment systems in primary care, combining risk-adjusted capitation with some fee-for-service reimbursement. The Expert Panel describes factors that may contribute to the effectiveness of pay-for-performance (P4P) programs and implementation features that may weaken the effectiveness of financial incentives.

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

Keywords : Primary (health) care, definition, financing, referral systems, EXPH, Expert Panel on effective ways of investing in Health, scientific opinion

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1. BACKGROUND

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

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

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

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

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

2. TERMS OF REFERENCE

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

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

3. OPINION

3.1. Primary care and health system performance

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

3.1.1. Primary care scoping

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

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

The scientific evidence base that strong primary care contributes to improved health system performance has significantly increased over time (e.g. Delnoij et al 2000; Macinko et al 2003; Shi et al 2005; De Maeseneer et al 2007). The most recent study (Kringos et al 2013a), performed across 31 European countries, looked at the 'strength' of primary care. Countries are commonly considered to have a strong primary care system when the key functions of primary care are well developed, and they are supported by essential conditions. We speak of a strong primary care system when primary care is accessible, coordinates care on a continuous basis, provides a broad range of health care services (comprehensiveness), and operates with supportive governance structures, appropriate financial resources and investments in the development of the primary care workforce. The study showed that at the present time, strong primary care is associated with better population health, lower rates of unnecessary hospitalizations and relatively lower socioeconomic inequality in self-perceived health. The same study (Kringos et al 2013b) showed that the countries with relatively strong primary care in Europe are Denmark, Estonia, Finland, Lithuania, the Netherlands, Portugal, Slovenia, Spain, and the United Kingdom (UK). The study also showed that countries with a relatively strong primary care structure have higher total health care expenditures than countries with a relatively weak primary care system.

However, countries with more comprehensive primary care had a slower growth in health care spending, compared with countries that provided less comprehensive services.

European countries either have many primary care policies and regulations in place, combined with good financial coverage and resources, and adequate primary care workforce conditions, or have consistently only few of these primary care structures. There is no correlation between access, continuity, coordination, and comprehensiveness of primary care within countries: countries have invested without much coherence in the process features of primary care. Therefore, a country may provide easily accessible primary care, but at the same time may offer little continuity of care, or provide a small scope of health care services in primary care.

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

3.1.2. Health system goals

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

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

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

- **Improved health** (for instance, better health status and reduced health inequalities)
- Enhanced **responsiveness** to the expectations of the population, encompassing respect for the individual (including dignity, confidentiality and autonomy), and client orientation (including prompt attention, access to services, quality of basic amenities and choice of provider)
- Guaranteed **financial fairness** (including households paying a fair share of the national health bill; and protection from financial risks resulting from health care)

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

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

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

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/

Table 1 Health system goals

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

Source: adapted from WHO 2000 and Kutzin 2009

The level of attainment of these goals relative to resources reflects the performance of the system as a whole. However, as there are variations in health conditions and health systems among countries, the country context needs to be taken into account when comparing the performance of health systems. In addition, due to changing economic, cultural and societal circumstances, over the years some additional health system objectives have been described: e.g. relevance (that is, the health system should be able to deal with problems that matter to people, starting from an eco-bio-psycho-social concept of health and well-being).³ The Expert Panel proposes the use of these essential characteristics of a high-performing health system as criteria for performance assessment.

3.1.3. Challenges for health systems in a changing world

Fundamental developments challenge health systems: demographic and epidemiological developments, scientific and technological developments, cultural developments and socio-economic developments (De Maeseneer et al 2007).

Demographic and epidemiological developments

Eurostat forecasts that life expectancy will continue to increase in the EU in the coming decades, to reach 84.6 years for males and 89.1 for females in 2060. The percentage of older people in the population will continue to increase in all EU-member states in the period up to 2020 by 3 to 6% (Social and Cultural Planning Office 2000). Moreover, the proportion of over-75s in the over-65 age group will also increase. This increase in life expectancy should be welcomed as a positive societal achievement. The health forecast shows that the world will experience dramatic shifts in the distribution of deaths from younger to older ages and from communicable diseases to chronic conditions during the next 25 years. The epidemiological consequences of this demographic transition will be an increase in diseases such as diabetes, COPD and depression, among others, and a growing number of people with multi-morbidity. For example, in Scotland half of the people aged 75 and over have two or more chronic conditions, and 40 % of them have four or more chronic conditions, a lot of them with an impaired functional status (Barnett

³ This concept is an extension of the bio-psycho-social model developed by George Engel. Engel enlarged the biomedical model with psychological and social aspects, integrating them in both diagnosis and therapy. He stressed the interaction of the different dimensions. In 1997, Rosenblatt added the ecological perspective as a fourth dimension. In this approach environmental factors are also integrated in a comprehensive approach towards patients and communities. This approach requires health systems to be dynamic and innovative.

et al. 2012). Moreover half of adults living in the European Union are now overweight or obese. Obviously, all these developments will have an effect on the health workforce. The retention problems in primary care could be alleviated by different solutions, such as training more primary care professionals and changing the health worker skill-mix in primary care.

Scientific and technological developments

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

Evidence-based medicine is an important tool for improving health care practice and organisation. However, it is clear that in addition to health evidence we will need more research about contextual evidence (looking at effectiveness in the relevant practice-context) and policy evidence (looking at efficiency from an equity perspective) (De Maeseneer et al 2003).

Cultural developments

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

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

Increasing mobility and migration on the one hand and the concentration of the world population in big cities on the other hand (by 2030, 70% of the world population will live in an urban context, which throws into question the future of health care supply in rural areas) mean the health system will be faced with new challenges and opportunities as global problems become apparent at the local level ('glocalisation').

Specifically within the EU, there has been growing mobility of health professionals between EU countries in recent years, aided by the mutual recognition of professional qualifications. Moreover, a recent EU Directive (Directive 2011/24/EU on patients' rights

in cross-border health care) clarifies the rules on mobility of patients, particularly their access to health services in another EU country, including reimbursement. The Directive also promotes cooperation on health care between EU countries. In some ways all these developments should be taken into account when improving health systems. Their complexity will require a multi-dimensional response.

Socio-economic developments and financial constraints

Over the long term, expenditures on health have been increasing, 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 Oliveira 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 the value 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 resource allocation, questions regarding fiscal constraints (i.e. how to raise the money required for the health care sector) are prominent. 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.

3.2.Primary care: definition

3.2.1. History

In this opinion, we focus our attention on 'primary care'⁴ as originally defined by WHO at Alma-Ata, and subsequently developed and updated by the Institute of Medicine and others. These definitions encompass health promotion and disease prevention, first contact advice, diagnosis, care for common ailments, referral for specialist advice and treatment, coordination of individual care (including for long-term conditions) and end of life care.

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

The defining moment in the contemporary history of primary health care is generally considered to have been the WHO Alma-Ata Declaration of 1978, which stated that

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

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

Primary health care: 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly; ---(and) ---- includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs' (Section VII. 2 and 3).

The Alma-Ata definition was striking in its focus on primary care as an approach to health development, and its holistic approach reflecting the concern of WHO in relation to improving the health of populations and minimising disparities in health status within countries. These points were emphasised strongly by Barbara Starfield as critical goals for any health system, as part of her wider analysis of the role and importance of primary care (Starfield 1998).

Vuori (1986) suggested four ways of examining primary care: as a set of activities; as a level of care; as a strategy for organising health care; and as a philosophy that permeates health care. The idea of primary care as a level of a health system, and also a strategy or philosophy for organising approaches to care, was taken up by Tarimo (1997) in a paper revisiting Alma-Ata. Tarimo distinguished between **primary health care as**

⁴ Reflecting widespread usage, in this document 'primary care' and 'primary health care' are used interchangeably.

an approach to health development (that is largely concerned with population health and community development, 'primary' effectively meaning fundamental and essential) and **primary health care as level of care**, namely the point of first contact between a person and the health system. In many ways, this conceptualises the ideal of Alma-Ata on the one hand, and the pragmatic approach taken by many countries in organising their health services into primary, secondary and tertiary sectors, on the other.

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

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

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

- The point of first **contact** for all new needs
- Person-focused rather than disease-focused **continuous** care over time
- **Comprehensive** care provided for all needs that are common in the population
- **Coordination** of care for common needs and also those that are sufficiently uncommon to require special services.

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

In 1996 the Institute of Medicine updated its earlier 1978 definition of primary care, recognising three additional perspectives of particular relevance to the patient and the family; the community; and the integrated delivery system. They define primary care as (Donaldson 1996:31):

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

The inclusion of integration of care is an important and highly relevant aspect of the proposed IOM definition, as is the concept of working with people in their family and community context. What is missing, however, is an emphasis on care co-ordination, something that is an ever-increasing concern for primary care as people are living with a greater number of long-term conditions. The role for primary care in coordinating care for those with complex multi-morbidities, and doing this in partnership with professionals in specialist or secondary care services, social care, mental health services and so forth, is considerable, and something that characterises the challenge facing primary care in 2014. Coordination of care across complex pathways is therefore the name of the game in the 21st century or, as the French say, a 'compagnon de route', accompanying people on their journey of care.

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

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

'Effective primary health care is more than a simple summation of individual technological interventions. Its power resides in linking different sectors and disciplines, integrating different elements of disease management, stressing early prevention, and the maintenance of health' (Gillam 2008: 538).

Primary care has, from the very beginning always adopted a 'community-perspective'. This was most clear in the development of the concept of Community Oriented Primary Care (COPC), defined as: an approach to health care delivery that undertakes responsibility for the health of a defined population. COPC is practiced by combining epidemiological study and social interventions with clinical care of individual patients, so that the primary care practice itself becomes a community medicine program. Both the individual patient and the community or the population are the foci of diagnoses, treatment and on-going surveillance' (Rhyne 1998:10-11).

BOX A: Development of Community Health Centres in Flanders: the Community Health Centre Botermarkt

The Community Health Centre Botermarkt is a not-for-profit organisation set up in 1978 in Ledeborg, a deprived area in the city of Ghent. The primary care team is composed of family physicians, nurses and other staff, including a receptionist, health promoters, dieticians, social workers, ancillary staff, smoking-cessation experts and dentists. The 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 centre aims to deliver integrated primary care. Service delivery focuses on accessibility (no financial, geographical or cultural barriers) 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.

Patients are registered on a patient list. All inhabitants living in a defined geographical area are eligible to be on the list. A patient 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 (consultations and home visits), integrated home care by an interdisciplinary team, nursing services, Community Oriented Health Promotion, nutrition services, social work and dental care.

The centre is financed through contracts with the insurance companies that include a monthly capitation payment for every patient on the list. Since 2013, there has been 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. Contacts are agreed with secondary care providers, physiotherapists, psychologists, palliative services and social services, in the framework of an integrated primary care system. In 1986 the health centre created a local care platform: primary care providers, local schools, local police, citizen organisations and organisations of ethnic-cultural minorities, meet every three months to develop a 'community diagnosis' enhance inter-professional and inter-sectoral cooperation, and tackle the upstream causes of ill health.

Community Health Centres in Belgium take care of 3% of the population.

Contact: www.wgcbotermarkt.be and the International Federation of Community Health Centres: www.ifchc2013.org



3.2.2. Core definition⁵

The Expert Panel considers that primary care is the provision of universally accessible, integrated person-centred, 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.

The professionals active in primary care teams include, among others, dentists, dietitians, general practitioners/family physicians, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.



⁵ See the glossary for an explanation of different terms.

BOX B: Local health units in Portugal

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 excess bureaucracy, difficulties in using communication channels or guidelines for the referral processes and 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 challenge 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 older people 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 materialise.

3.2.3. Developments in primary care

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

Primary care continues to adapt

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

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

These changes are likely to continue to occur in the future and it is important to anticipate and explore the implications. This leads to challenging questions about the future role, content and providers of primary care, including about the use of electronic and mobile health, new forms of diagnostic tests that can be used at home or in primary care settings, and moves towards a greater degree of self-management by patients of long-term conditions. The lines between primary and secondary sectors may become more blurred (e.g. with specialists forming a part of integrated care networks) when considering increasing integration of care. However, responsibility for the coordination of care for patients living in the community will be with the primary care team.

To give a few examples:

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

Primary care is not a static concept. The content, organisation and role of primary care has changed over time, in response to changes in, amongst others, general and medical technology, demographic and epidemiological trends and the organisation of the health care system itself. Advances in medical technology allow primary care to offer an

increasing range of services to citizens and patients, and for this to happen through media such as online text, voice and video messaging, phone, email and telehealth and telecare. Primary care now encompasses a very comprehensive set of interventions and this is likely to grow even further in the future.

The role of patients is changing

The role of patients has also changed. They are increasingly perceived to be more informed, articulate and involved in their treatment decisions. Contemporary concepts like shared decision making emphasize this. While there has been some research into the changing relationship between patient and health professionals, this developing fundamental relationship remain an important area for research. Increasingly, other professionals have a growing role in the way people are accessing primary care. For instance, nurses, community pharmacists, physiotherapists, dieticians and occupational therapists are increasingly involved in meeting people's health care needs and expectations.

Primary care coordinates people's care

Health care needs are becoming more complex; ageing populations are leading to more chronic illnesses and multi-morbidity. This means that coordination of care is increasingly important, including in primary care itself.

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

In the framework of an interprofessional team, this coordination may be defined in different ways:

- GPs may delegate tasks to other health workers such as nurses (e.g. measuring blood pressure, performing pap smear tests or providing lifestyle advice) and in some countries diagnostic and therapeutic tasks may (partly) be taken over by nurses with additional training
- GPs may refer individuals to other (secondary) types of care. This is highlighted further in section 3.3
- GPs or other members of the multidisciplinary team may act as coordinators of care providing guidance in cases where patients suffer from multiple illnesses which require the attention of more than one professional (possibly from more than one sector of the health care system)

- In some health care systems (e.g. previously in the UK) GPs in the role of fundholders may also purchase non-urgent, elective and community health care services for patients.

Continuity of care is often mentioned as a core aspect of primary care. This continuity also pertains to the task of coordination and to keeping records of various treatments in order to maintain a 'holistic' view of an individual's care.

Primary care seeks to balance continuity and access

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

Care is increasingly provided across one or more pathways which span traditional sectors, services and institutions. Given that so many people now live with one or more long-term conditions, specialists are much more likely to be involved in a person's care, acting as advisers to (or even as members of) the integrated care team. Specialists are therefore often providing secondary care in the community. Hence the role of primary care as lynchpin of the wider team is becoming more significant – for instance along the lines of the primary care 'medical home' model as implemented in the United States (Arend et al., 2012).

Primary care is collaborative

Primary care providers are increasingly organized in teams or networks, and often located in primary care centres or community hospitals. This facilitates work processes (e.g. weekend shifts), but also interprofessional cooperation within primary care. Different primary care professionals (such as nurses, pharmacists, physiotherapists, GPs etc) can be brought together in primary care networks or centres to facilitate cooperation, coordination and accessibility of health care facilities. These care centres may be simply geographical clusterings of services or organisations offering various forms of primary care. The notion that primary care is collaborative challenges health systems in terms of training professionals (to recognize and appreciate the interdependence of health professions, to learn to work in teams and to develop leadership through transformative learning (Frenk et al, 2010)) and regulation, including the role of professional bodies in promoting and adjusting professional self-regulation towards meeting people's needs. This development also involves issues such as ICT support, sharing health information between providers and case management. The role of individuals in determining goals, accessing and perhaps even adding to their own records challenges the role of the 'traditional primary caregiver'.

The primary care workforce is changing

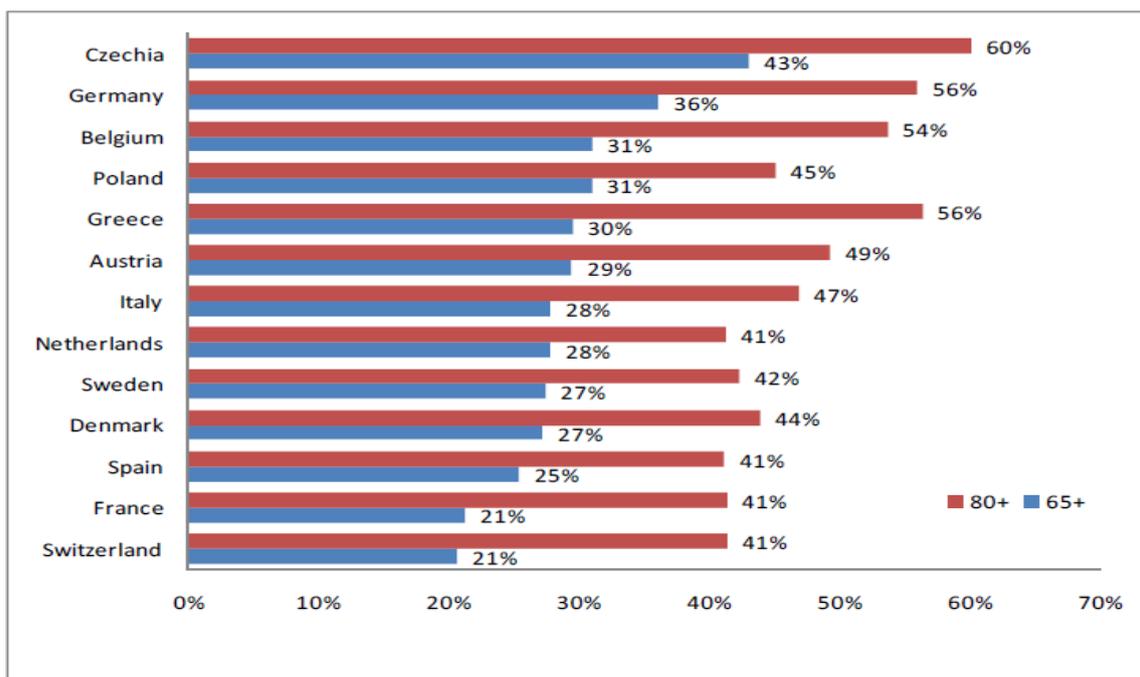
The workforce continues to change, to meet both the needs of a new generation of health professionals, and the different patterns of care required by people living longer and with a range of chronic conditions. For example, the shift in gender balance in the health workforce, the associated increase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

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

Informal caregivers

A large part of the care provided to patients in Europe is informal. Figure 1 shows that a large share of older people in Europe receives informal care, especially those aged over 80. However, while older people may be especially dependent on informal care, there are also many younger people in need of care, such as patients suffering from rheumatoid arthritis or physical or mental disabilities.

Figure 1 Share of older people receiving informal help or support, selected European countries, 2006



Source: Riedel and Kraus (2011)

These figures translate into substantial proportions of the population providing informal care. In the Netherlands, for instance, 10% of the population act as informal carers, often for long periods of time and intensively, often on a daily basis for several hours per day (De Boer 2005). These carers undertake tasks ranging from emotional support, support with household activities to support with activities of daily living such as washing, dressing and using the toilet (Brouwer et al 2004).

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

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

BOX C: New models of primary care organisation in England

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

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

3.3.1. What is the purpose of referral?

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

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

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

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

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

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

Access to secondary care is sometimes contingent on referral. In such instances, primary care plays a 'gatekeeping'⁶ role, controlling the patient's entry into the health system preventing unnecessary use of secondary care, and taking responsibility not only for providing care but also for coordinating specialised care through referral. Gatekeeping can therefore be seen as an organisational mechanism to promote coordinated care (Saltman et al 2006). However, it is sometimes used as a means of controlling costs, particularly where there are long waiting lists for secondary care, in which case primary care may slow the rate of referral to help regulate waiting times.

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

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

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

3.3.2. What makes an effective referral system?

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

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

⁶ 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.

Research suggests that gatekeeping by GPs can help reduce overall health system costs (Martin et al 1989, Franks et al 1992, Delnoij et al 2000, Schwenkglens et al 2006). For example, a recent systematic review of the literature found gatekeeping to be associated with lower use of health services (shorter and fewer hospital visits, fewer emergency department visits and lower use of ambulatory care) and lower spending. The review noted, however, that there was substantial variation across studies in the direction and magnitude of changes in use and costs; some studies found no difference or higher levels of use (Garrido et al 2010). The review also highlighted the limited quality of many of the studies; only a few examined the effects of reduced use on patient outcomes, with inconclusive results.

These findings may have motivated some countries to introduce financial incentives to encourage patients to obtain referrals for specialist consultations (see Box 1) – a growing trend in EU health systems in recent years (Reibling and Wendt 2012).

Box 1: The French system of 'preferred doctors'

Since 2004 (Health Insurance Reform Act), all those benefiting in France from health insurance coverage must choose their 'preferred doctor (*médecin traitant*). As a result it costs more to consult a specialist directly, without being referred by their *médecin traitant*. This form of soft gate-keeping has been generally well-accepted, perhaps because a number of specialties were excluded from the referral system – for example, psychiatrists for patients up to 25 years old, ophthalmologists, gynaecologists, stomatologists and paediatricians. Also, adherence to the preferred doctor scheme mainly reflected existing patterns of access. Indeed, in 2006, 92% of the patients that had chosen a preferred doctor, already had this doctor as the usual family physician. Moreover, in 2007, after the implementation of the scheme, the share of patients consulting outside the gate-keeping system was 20% on average for all categories of specialists, whereas it was only 30% prior to the implementation of the reform. This shows that prior to the reform, French patients were already following a kind of gate-keeping model, despite enjoying large freedom of choice. Finally, freedom of choice of doctors has not actually been restricted at all, since patients are still able to choose which doctors they want to visit (having been referred or not) and they can very easily switch preferred doctors (by filling out a form with the doctor of their choice).

Source: Durand-Zaleski 2010

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

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

gatekeeping role as more of an advisory function, helping patients 'navigate' the health system. 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.

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

Source: Reibling and Wendt 2012 adapted from Coulter 2010

A Cochrane Collaboration systematic review of interventions to improve outpatient referrals from primary care to secondary care found that passive dissemination of referral guidelines was unlikely to lead to better referral quality (Akbari et al 2011).⁷ Although the number of rigorous evaluations of different interventions is low, the study suggests that the use of 'in-house' second opinions and other intermediate primary care-based alternatives to outpatient referral seems promising, and that while financial interventions can change referral rates, their effect on referral quality is uncertain. The authors found that referral guidelines are more likely to be effective if:

- Local secondary care providers are involved in dissemination activities
- Structured referral sheets are used
- Secondary care management is responsive to changes in primary care behaviour as a result of the guidelines
- The guidelines reflect local circumstances and address local barriers

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

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

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

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

3.3.3. Conclusion

The Expert Panel considers that referral systems, including gatekeeping, can have strong advantages – spelled out above. The following factors may contribute to their effectiveness:

- 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 person-centred approach exploring the needs, expectations and goals of the patient, using appropriate communication skills; this includes a form of personal relationship between the GP/primary care team and the patient through a patient list
- primary care providers have timely access to the results of medical imaging and other diagnostic tests
- secondary care responds promptly and in a coordinated way once patients are referred from primary care, with fast-track facilities where a serious diagnosis is suspected (life-threatening conditions in children, cancer etc)
- patient management based on maximal subsidiarity providing follow-up as much as is effective at the primary care level to avoid long waiting times for referred patients

- a change in hospital organisation guaranteeing support to primary care, centred on the needs and goals of the patient (e.g. in case of multi-morbidity) and avoiding fragmentation of care (Curry 2010).
- electronic referral systems to facilitate referral of a patient and to ensure feedback and timely sharing of relevant information
- interactions between referral processes and payment systems are taken into account and incentives (both financial and non-financial) are aligned
- the establishment of leadership by stakeholders acting as change agents (professionals, institutions for health professional education, payers, citizen representatives) in order to change mindsets and practice in the health sector

3.3.4. Areas for future research

Further research is required to:

- identify the most effective interventions to improve referral appropriateness, including: evidence-based education activities, structured referral management sheets, electronic referral, enhancement of primary care and in-house second opinions, the usefulness of decision-support systems underpinning referral decisions, the impact of financing mechanisms at the level of primary care and secondary care on referral-patterns, the effect of tools focusing on patient-empowerment in relation to the referral process
- explore effects of gatekeeping on quality of care and health outcomes

Box D: Upgrading primary health care in Slovenia

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 health of the population. The strategic goal is to establish a flexible health system that will effectively fulfil citizens' needs by offering them quality and safe health care services.

At the time of the 1992 health reform, primary care 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.

The current 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 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 of 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 'reference 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 services. 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 reference 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 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.

BOX E: Finland: the Health Care Act of 2010

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 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; and home care services.

The 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 Act strongly emphasises 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.

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.

3.4. Financing primary care

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

3.4.1. Ensuring an adequate level of financing for primary care

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

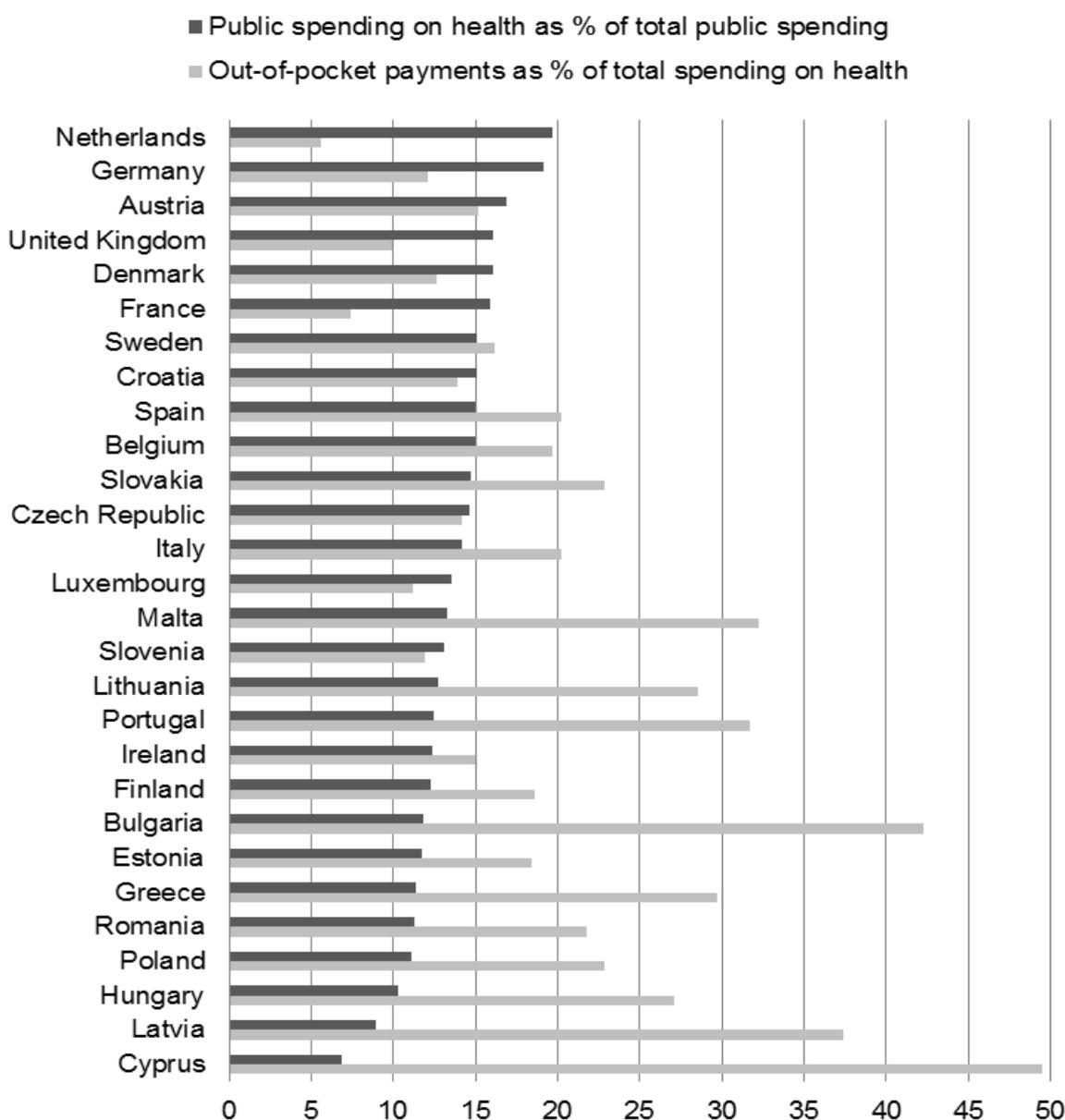
Spending on the health system

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

Since GDP and the size of government are not immediately amenable to health policy levers, a more relevant indicator for health financing policy is the share of public spending allocated to the health sector. The priority or commitment given to the health sector in public budgetary processes⁸ affects levels of public spending on health, which in turn affects levels of out-of-pocket spending on health. Countries with similar degrees of fiscal space may allocate very different shares of public spending to health. Figure 2 shows how EU countries vary in this respect. It also shows how countries that allocate less to the health sector tend to have higher levels of out-of-pocket spending on health. We discuss the implications of this in the next sub-section.

⁸ 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.

Figure 2 Public spending on health as a share (%) of public spending and out-of-pocket spending on health as a share (%) of total spending on health, EU28, 2012



Source: WHO Global Health Expenditure Database 2014

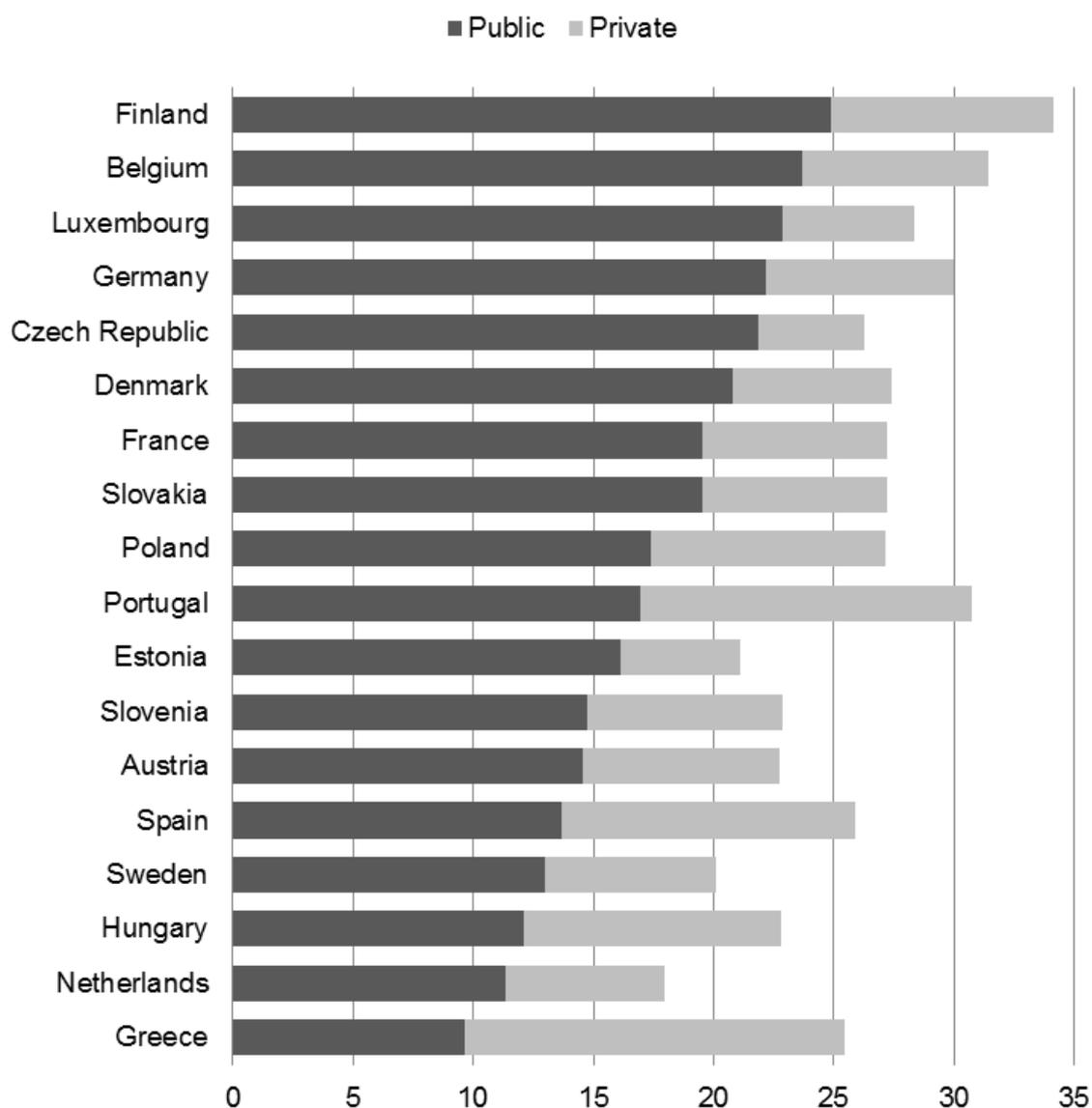
Spending on primary care

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

It is difficult to compare spending on primary care across countries due to the absence of a uniform definition and substantial national differences in primary care structure and organisation. Figure 3 shows how public and private spending on 'ambulatory care' varies

as a share of total spending on health. These comparative data should be interpreted with caution, however, since in many countries ambulatory care includes both primary care and secondary care provided by office-based specialist physicians. Also, some of the countries in which total spending on ambulatory care is relatively high rely quite heavily on private financing (for example, Portugal, Spain, Hungary and Greece).

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



Source: OECD Health Data 2014

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

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

However, while there are strong quality and efficiency arguments in favour of providing care in settings that are closer to a patient's home, in practice many countries have struggled to move care out of hospitals, especially where the necessary community-based infrastructure is lacking (Royal College of Nursing 2013). Investing in primary care and other community-based services is therefore likely to be a pre-requisite for moving care out of hospitals and, ultimately, for improving efficiency in service delivery. Other pre-requisites include changes in the health worker skill mix and adapting the training of professionals around the new roles and tasks, so that nurses and others can play an enhanced role, to increase community orientation (Frenk et al 2010) and to change the mindset in favour of working collaboratively. These should help to ensure primary care workers have the skills to address a wide range of health problems.

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

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

3.4.2. Ensuring equitable access to primary care

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

Equity in financing and financial protection

Cross-national analysis of the composition and level of spending on health shows two things. First, financing mechanisms vary in terms of the financial burden they impose on richer and poorer households.⁹ Direct taxes (eg on income) and social insurance contributions are found to be generally much more 'progressive' than indirect taxes (eg VAT) and out-of-pocket payments (OOPs), and OOPs are usually highly 'regressive' (Wagstaff and van Doorslaer 1999). Whether a progressive distribution is considered to be fairer than a proportionate distribution will vary across countries, but all countries can promote equity in financing by reducing their reliance on OOPs.

⁹ 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.

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

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

Is there a role for user charges?

Most EU countries provide universal access to a reasonably comprehensive basket of primary care services. In contrast to population and service coverage, however, policies on user charges vary substantially across countries. Around half of all EU countries do not charge patients for publicly financed primary care office consultations,¹⁰ but almost all charge for outpatient prescription drugs.¹¹ As a result, individual spending on prescription drugs accounts for a relatively large share of catastrophic OOP spending in many countries, particularly among poorer people (Kronenberg 2014; Vörk 2009).

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

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

In addition, applying user charges to relatively cost-effective utilisation, such as obtaining outpatient prescription drugs in primary care, has been shown to shift utilisation to settings where charges are not in place, which is often more expensive,

¹⁰ 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.

¹¹ 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.

such as inpatient and emergency care (Tamblyn et al 2001). Overall, there is little evidence to suggest that user charges lead to more appropriate use or long-term cost control or successfully contain public spending on health care.

User charges could potentially contribute to enhancing efficiency in the use of health services if they are applied selectively based on value. A value-based approach would remove financial barriers to cost-effective health care, clearly signal value to patients and providers and ensure that patient and provider incentives were aligned (Chernew et al 2007). Such an approach is not a panacea, however, and is most likely to be useful when user charges are already widely used, there is clear evidence of value and it is politically unfeasible to target providers (Thomson et al 2013).

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

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

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

Allocating financial resources to purchasers

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

Evidence of unequal access to and access barriers in primary care

Table 3 shows how countries vary in terms of the affordability of care provided by specialists and GPs. In every EU country people find GP care to be considerably more affordable than specialist care. This is confirmed by other research showing that in OECD

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countries, the better-off are more likely than poorer people to visit specialists and dentists and undergo breast and cervical cancer screening than poorer people, whereas GP visits are more equally distributed across income groups (OECD Health Working Paper 2012). The authors of the OECD research also highlight the important effect of health financing policy on equity in the use of health services, but note that some of inequalities in health service use cannot be explained by financial barriers.

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)

3.4.3. Paying providers to promote efficiency and quality in primary care delivery, including financial incentives to improve care coordination

Provider payment objectives and limits to 'pure' payment methods

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

Box 2 Check list for designing effective provider payment systems

- Enable and encourage providers to deliver accepted procedures of care to patients in a high quality, efficient and person-centred way
- Support and encourage providers to take other actions that lead to improved efficiency, quality and patient outcomes and reduced costs
- Not encourage or reward overtreatment; use of unnecessarily expensive services; unnecessary hospitalisation or rehospitalisation; provision of services with poor patient outcomes; inefficient service delivery; choices about preference-sensitive services that are not compatible with patient desires
- Nor reward undertreatment of patients; the exclusion of patients with serious conditions or multiple risk factors; provider errors; adverse events
- Make providers responsible for quality and costs within their control, but not for quality and costs outside their control
- Support and encourage coordination of care among multiple providers, and discourage providers from shifting costs to other providers without explicit agreements to do so
- Encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce costs of care
- Not reward short-term cost reductions at the expense of longer-term cost reductions and not increase indirect costs in order to reduce direct costs
- Not encourage providers to reduce costs for one purchaser by increasing costs for other purchasers, unless the changes bring payments more in line with costs for both/all payers
- Minimise the administrative costs for providers in complying with payment system rules
- Multiple payers should align standards and methods of payment to avoid unnecessary differences in incentives for providers

Source: Miller 2007 as cited in Langenbrunner et al 2009

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

Because pure payment methods contain conflicting incentives for productivity and cost control and rarely encourage quality, many countries have adapted them so that they are more likely to achieve desired outcomes. Adaptations may involve adjusting capitation payment to account for patient risk, blending payment methods (Robinson 2001) and bundling or unbundling payments (Table 4), all with the aim of correcting undesirable

incentives. For example, countries increasingly use fee-for-service with capitation in primary care, to encourage the provision of preventive services or home visits.

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

Table 4 The spectrum of bundled vs unbundled provider payment methods

Bundled				Unbundled		
Global budget or salary	Capitation	Per period	Per patient pathway	Per case, diagnosis or 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

Source: Charlesworth et al 2012

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		

Source: Kroneman et al 2013

Notes: Text in italic: the type of remuneration is new for the country; underlined text: the type of remuneration has changed since 2000; * fairly new and does not form a significant share of total revenue; ** in the Netherlands 7-12% of GPs are in salaried employment with independent GPs; in the UK the share of salaried GPs rose from 10% in 2004 to 19% in 2008

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 service 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 and 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).

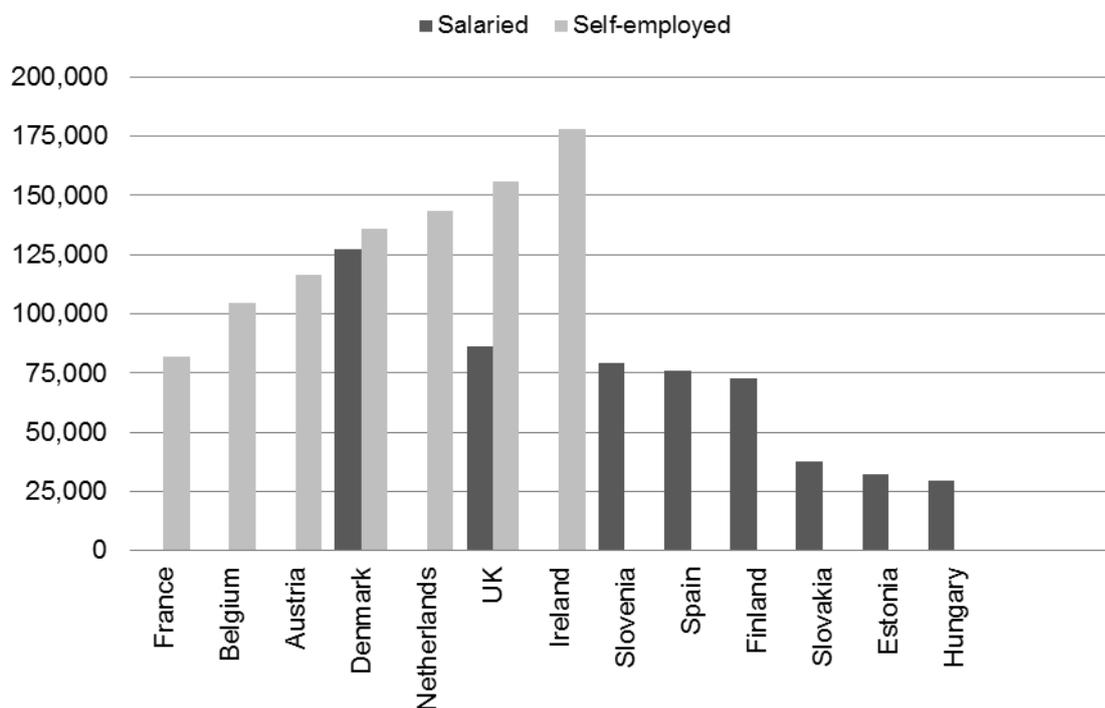
A single fee is paid by health insurers to a contracting entity (the 'care group') which should cover all primary care needs required by patients with these chronic diseases. The care group sub-contracts general practitioners, medical specialists, nurses and other disciplines. Approximately 78% of GPs 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 is conducive to the organisation and coordination of care. It also seems to result in improved adherence 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 seen in care groups, 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.

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



Source: OECD Health Data 2014

Note: only shows the EU OECD countries for which data are available; PPP = purchasing power parity

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).

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

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

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

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

- Factors that contribute to effectiveness:
- Programmes are most effective when they are aligned with and reinforce overarching strategies, objectives and clinical guidelines that are accepted by stakeholders.
 - Programmes are more successful when the incentive is integrated into and complements the underlying payment system.
 - Programmes are more effective when they focus on specific performance problems that require broad-based approaches for improvement.
 - The structure of service delivery is important for whether or not providers can and do respond to the incentives, and programmes tend to favour larger, more urban providers.
- What to avoid:
- Complex and non-transparent programme structure.
 - Selective participation in programme domains.
 - Specific incentives to improve the organisation of service delivery, since these are not usually evidence-based and often impose an additional administrative burden on providers. Direct support for investment in (for example) IT may be more effective.

Source: Cashin et al 2014 in press

Factors to consider when using financial incentives to encourage coordinated care

Improving the performance of one part of the health system is more likely to be effective if the process is informed by a whole-system view. Changing the way in which primary

care providers are paid may not be sufficient to stimulate performance improvement, particularly where care coordination is concerned. It is therefore important for financial incentives to be aligned across the whole system, including hospitals and purchasing organisations.

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

There is no ideal method of paying providers. The effectiveness of any payment system will be influenced by context and all payment systems need to be carefully monitored and evaluated (Langenbrunner et al 2009). In order for financial incentives to improve quality of care, they should be part of a comprehensive approach.

3.4.4. Areas for future research

- It is difficult to estimate and compare spending on primary care across countries due to the absence of a uniform definition of the services and providers involved in primary care. While some countries have found ways to define their primary care services and costs, there is a need for comparative research to improve our understanding of differences between EU countries.
- The literature consistently finds blended payment methods to be better than pure payment methods. However, we do not know enough about optimal combinations of payment systems. More structured research in this area is needed.
- Optimal changes in payment methods are likely to depend on the starting point: the financing and organisation of a health system, its problems, its goals. Reforms should fully reflect and account for context.
- It is difficult to compare provider remuneration across countries. Better methods are needed here too.
- Many payment systems aim to improve the performance of a particular type of care (hospital care, GP care). However, interactions between different sectors of the health system need to be better understood and accounted for in provider payment reform, particularly if the aim is to improve care coordination.
- Service delivery systems need to be flexible enough to meet the varying needs of different people at different times – one size does not fit all patients or even all the needs of a single patient. Again, provider payment reforms need to account for this.
- Financial incentives are not the only available tool and need to be accompanied by other tools to ensure service delivery is in line with health system goals.

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- Provider payment requires constant monitoring and evaluation, but evaluative methods are often limited and do not capture important dimensions (including context).
- Used effectively, P4P programmes can be an important governance tool and catalyst for health system performance improvement. However, questions remain about the size and effects of unintended consequences; aspects of programme design and implementation that may be associated with their effectiveness; and the cost-effectiveness of programmes.
- As the patient is at the centre of the health system and primary care has a coordinating role, we need more research on referrals and efficient information flows to and from secondary care.
- What sort of purchasers are most likely to ensure coordinated care?
- What type of provider payment is most likely to encourage team-based care delivery?
An appropriate skill mix?
- Can we develop primary care quality indicators at the EU level?

BOX G: Remuneration of GPs in Spain

Primary health care (PHC) 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 organised in health teams. The health team includes GPs, paediatricians and 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 most regions. Regional health services are responsible for the planning and management of health care, and for the selection, contract and remuneration of health professionals.

From 1960 the standard model of payment for GPs in the Spanish health system was based on capitation (80% of income) and salary (20%). In 1985-1990 this was changed to 20% capitation, 70-78% 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 was the distribution of incentives between the individual part and the team. A third was the decision about the weight of this kind of remuneration in relation to other forms. It also necessitated a process of cultural change.

Today, the regional health services negotiate and set objectives for PHC teams annually (e.g. programmes or activities related to 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.). Managers use a set of indicators, inform doctors about their progress and base payment on results. Professionals usually participate in the teams assessing performance.



3.5. Conclusions and recommendations

1. **Primary care definition:** The Expert Panel considers primary care to be the provision of universally accessible, integrated, person-centred, 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.

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.

2. **The rationale for strengthening primary care:** Primary care is responsive to the challenges facing health systems: the demographic 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 globalising world.

The Expert Panel finds the evidence good 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.

3. **Referral systems and gatekeeping:** The Expert Panel emphasises 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.

The Expert Panel considers referral systems, including gatekeeping, to have strong advantages. The following factors may contribute to their effectiveness:

- a strong and responsive high-quality primary care system, organised in (interprofessional) group practices and health centres, with a practice-based patient list and opportunities for second opinions at the primary care level
- a person-centred approach exploring the needs, expectations and goals of the patient, using appropriate communication skills and involving a continuous

personal relationship between the primary care team and the patient (through, for example, a patient list)

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

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

Ensuring that the whole population is able to access a comprehensive range of primary care services without facing financial hardship is critical to promoting financial protection, equitable access and efficiency in service delivery. The Expert Panel notes that user charges policy and design varies substantially across countries. Given the lack of evidence to show that user charges lead to more appropriate use or long-term cost control, and noting the significant role of providers in initiating use and prescribing drugs, the Expert Panel stresses that where user charges are applied, policy makers should aim to ensure these charges do not create or exacerbate financial barriers to accessing effective services and, in particular, to protect people with low incomes and those who regularly use health care. In general, countries should engage in better monitoring of the effects of user charges on financial protection, equity, quality, efficiency and outcomes.

The Expert Panel has identified a trend towards blended provider payment systems in primary care, often combining risk-adjusted capitation with some fee-for-service reimbursement. More recently, countries have introduced performance-related programmes that aim to enhance quality of care. These programmes can help to establish or sustain performance improvements, but are most effective when they are aligned with and reinforce overarching strategies, objectives and clinical guidelines that are accepted by stakeholders; when financial incentives are integrated into and complement the underlying payment system; and when they

focus on specific performance problems that require broad-based approaches for improvement. The Panel notes that financial incentives alone are unlikely to move provider behaviour in appropriate directions, and should be accompanied by other tools, including monitoring and feedback.

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

A. General research questions

- the roles and composition of interprofessional teams
- the implementation and impact on quality and outcomes of e-Health and M-Health developments
- new forms of diagnostic tests (HTA), including their use by primary care providers
- exploring appropriate ways to strengthen person-centredness, integrating the goals of the individual and to enhance comprehensiveness, integrating health care and social care
- the role and place of informal care in the provision of (primary) care in the EU, especially in relation to the ageing population, as well as on ways to support informal carers and to monitor their health and wellbeing
- training health care professionals with the appropriate skill-mix to deliver services in the community
- comparing primary and community care services in the EU to better understand and share best practice across Member States

B. Research questions in relation to referral and financing

- It is difficult to estimate and compare spending on primary care among EU countries due to the absence of a uniform definition of the services and providers involved in primary care. While some countries have found ways to define their primary care services and costs, there is a need for comparative research to improve our understanding of differences among EU countries.
- How are primary care systems responding to the epidemiological shift to multi-morbidity?
- How can primary care contribute to more equity in health?
- Identification of which interventions are changing primary care outpatient referral rates and/or referral appropriateness.
- Research to explore further the possible effects of gatekeeper systems and waiting lists on health outcomes
- How can provider payment systems enhance the flexibility of service delivery systems?
- How to monitor the impact of changes in provider payment?
- How can P4P programmes contribute to quality, efficiency and equity in health?

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

- stimulate countries to strengthen primary care and make it universally accessible for a broad range of problems

- adopt a system that integrates optimal channeling of patients and patient-related health information throughout the health system
- strengthen the community orientation of primary care with special emphasis on intersectoral action for health promotion and prevention, looking at the upstream causes of ill health and the social determinants of health
- 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
- 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
- stimulate the development of integrated partnerships between patients, providers and informal caregivers in order to better address health challenges

4. PUBLIC CONSULTATION

A public consultation on this opinion took place via the website of the Expert Panel on Effective Ways of Investing in Health (EXPH) from 20 March to 19 May 2014. Information about the public consultation was widely communicated to national authorities, international organisations and other stakeholders.

Fifty-nine organisations and one individual participated in the public consultation providing input to the opinion. In total 286 contributions were received. Out of the 59 organisations participating in the consultation, there were 19 public authorities, 21 health professionals' associations, 15 NGOs and 4 commercial companies.

Each submission was carefully considered by the Working Group and the EXPH and the scientific opinion has been revised to take account of relevant comments wherever appropriate. The list of references has been updated with relevant publications submitted during the consultation.

All contributions received and the reaction of the EXPH will be accessible from the end of July at: http://ec.europa.eu/health/expert_panel/consultations/primarycare_en.htm.

5. MINORITY OPINION

None

6. LIST OF ABBREVIATIONS

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

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8. GLOSSARY

Accessibility (of health services)

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

Accountability

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

Community

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

Community medicine

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

Comprehensiveness (of care)

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

Continuity (of care)

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

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

Coordination

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

Health needs

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

Informal caregivers

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

Person-centeredness

People-centered care

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

Subsidiarity

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

Universality

Universal (health) coverage

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

Ensuring that all people can use the promotive, preventive, curative, and rehabilitative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. (WHO World Health Report 2010)