XXXth Annual conference of the Slovak Society of General Practice

PHC re-newal and introduction into our joint forthcoming project: why evaluating primary care?

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WHO, Regional Office for Europe

Overview

- Introducing some aspects of the World Health Report 2008: Primary health care – now more than ever

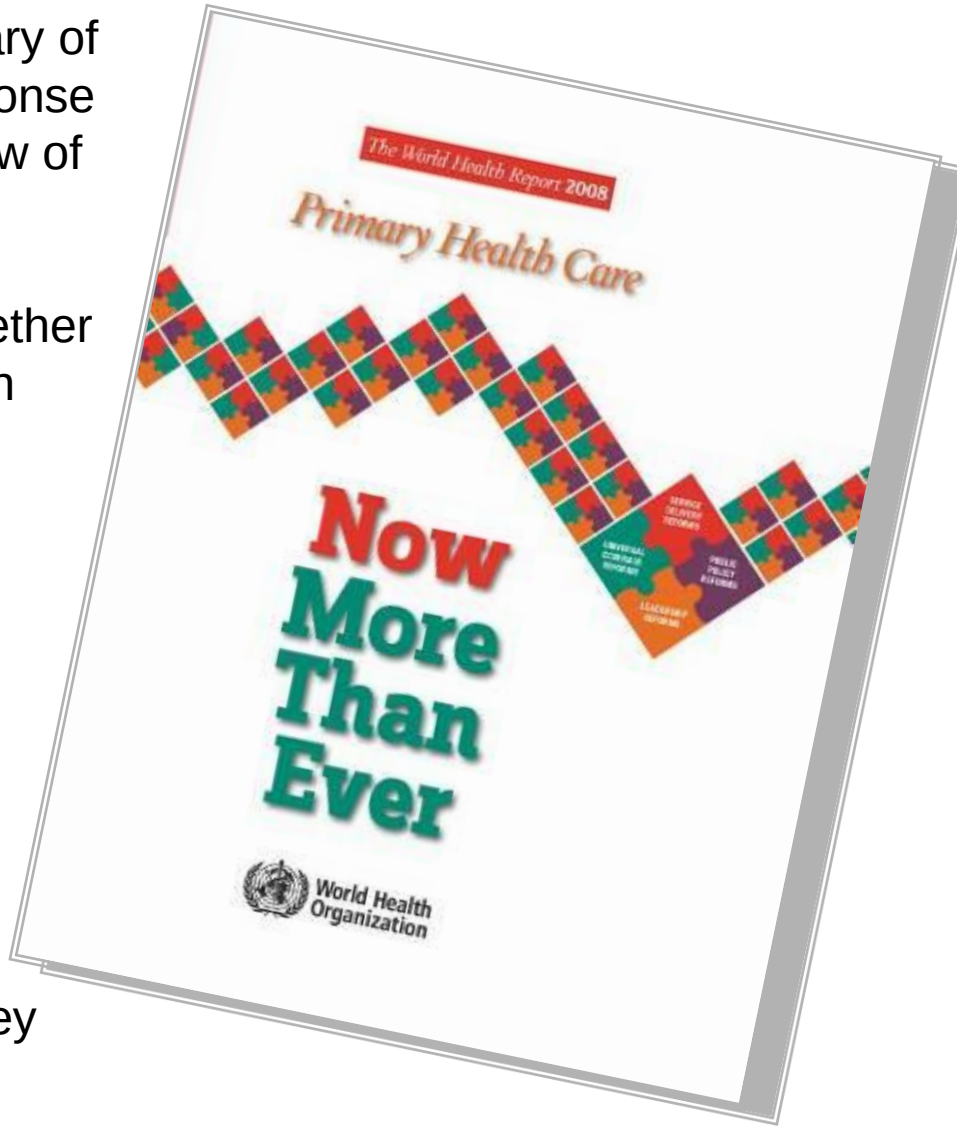
- Link to our forthcoming joint project in Slovakia: the evaluation of the organization and provision of primary care (PCET)
    - project set-up and time-line
    - underlying framework of the PCET

Introducing the WHR 08

- Launched for the 30th anniversary of the declaration of Alma Ata: response to demand for a more holistic view of health

- Feeds into a larger debate, together with the report of the Commission on Social Determinants of Health, the MDG process and the renewed interest in strengthening health systems:
-Tallinn Charter, WHO EURO
- Resolution of WHA 62.12 Primary health care including health systems strengthening

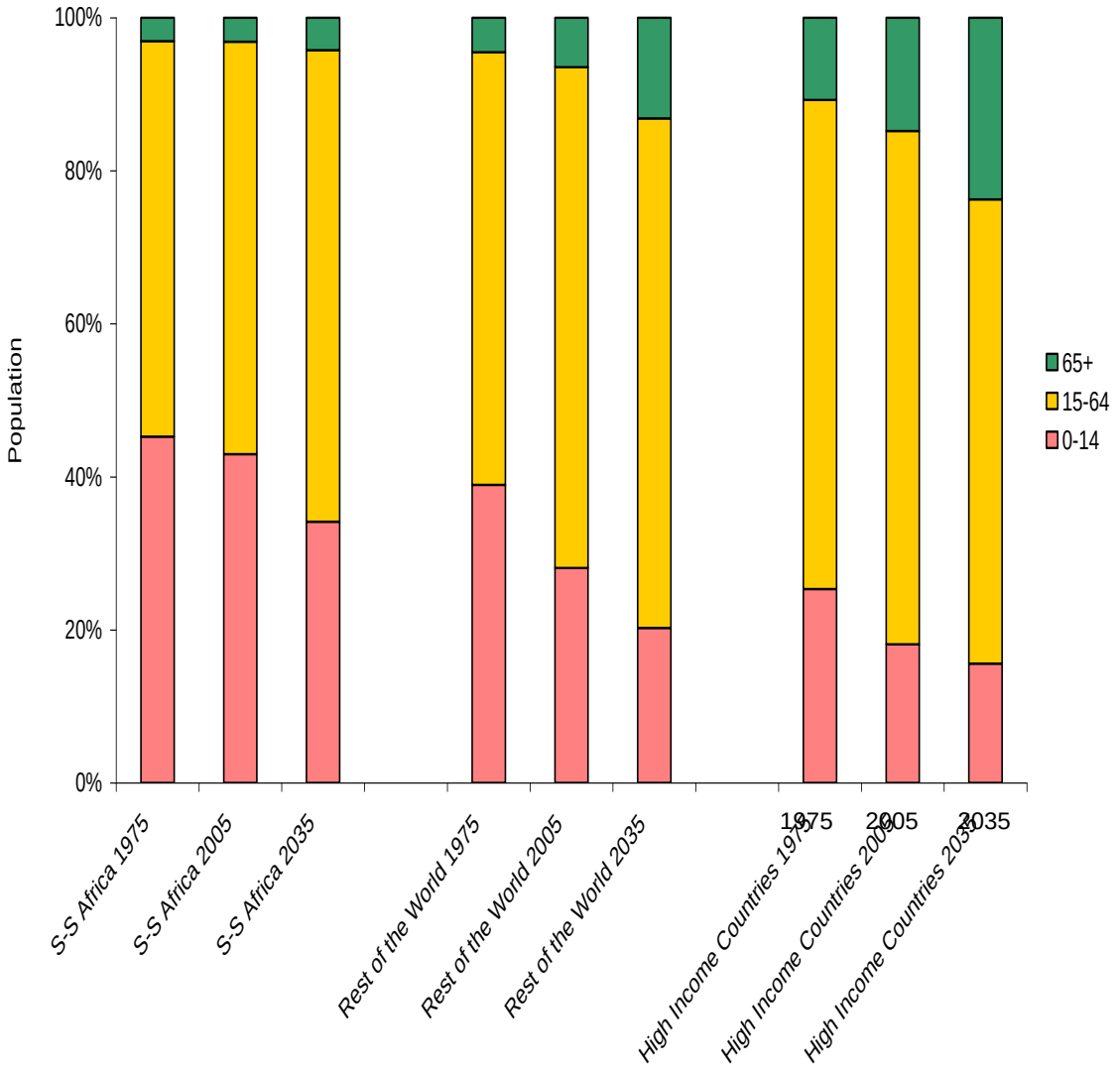
- Putting people first: being responsive to peoples wishes. Key word is people-centred care



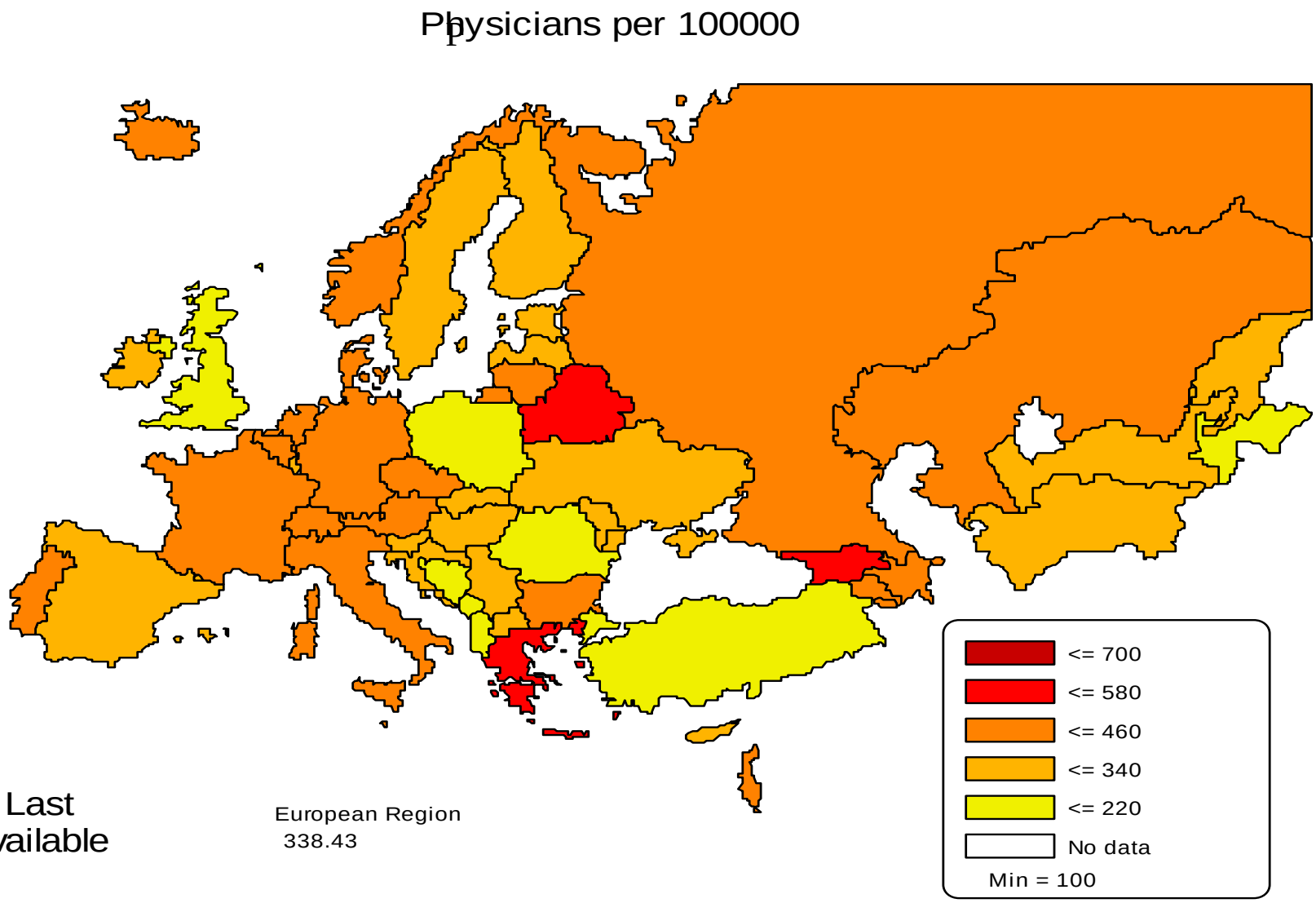
Reason for PHC renewal: aging

- Drives the demographic transition
- Implications for:

- Costs: aging will increase costs for health – people need care over a longer period
- Organization of health care: aging demands for care close to home, comprehensive primary care that can deal with mulimorbidities – away from single disease programs and hospital based care
- Human resources: a smaller workforce has to face a larger workload

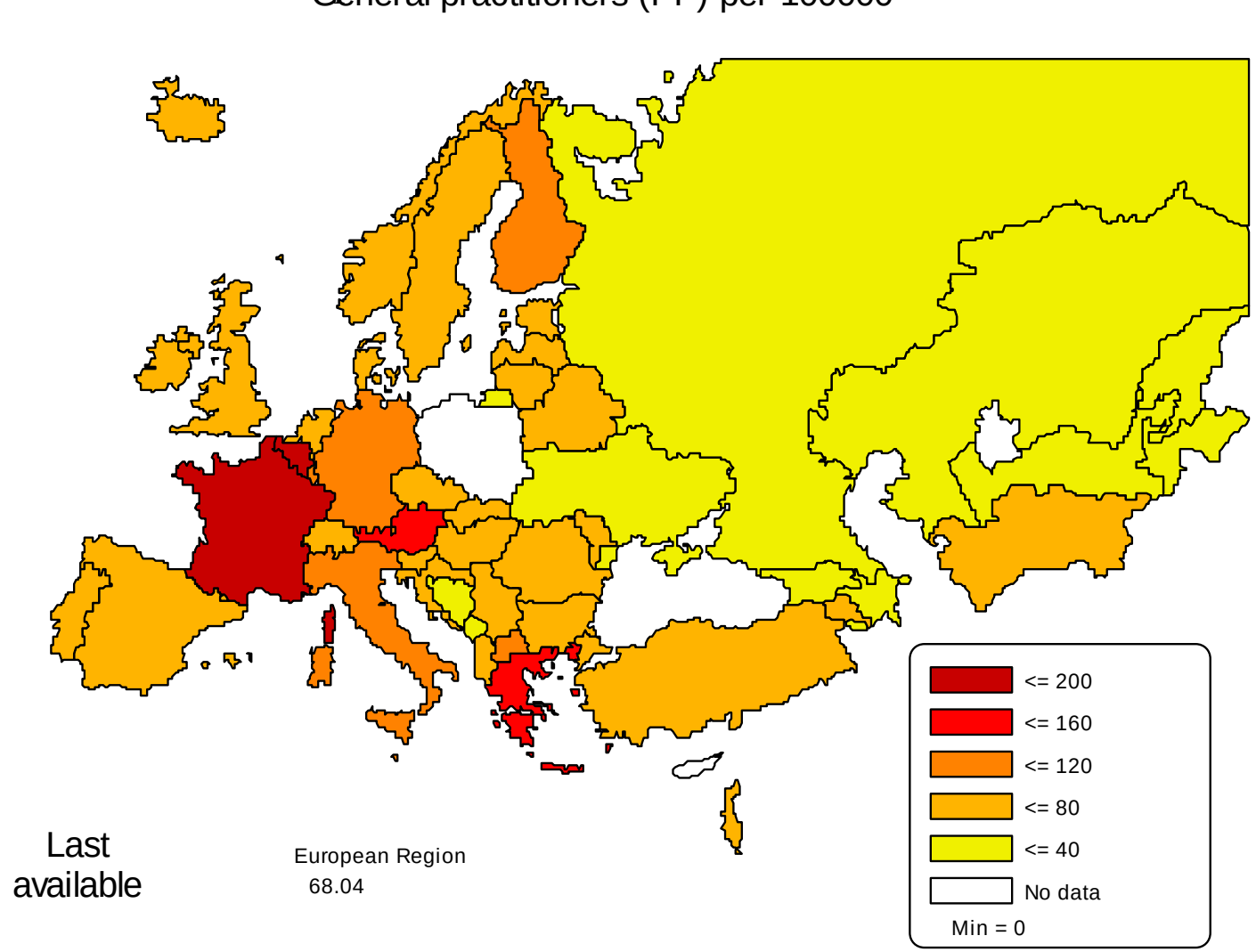


Ex.: Challenges for PHC renewal: human resources



Source: WHO HFA database, 2009

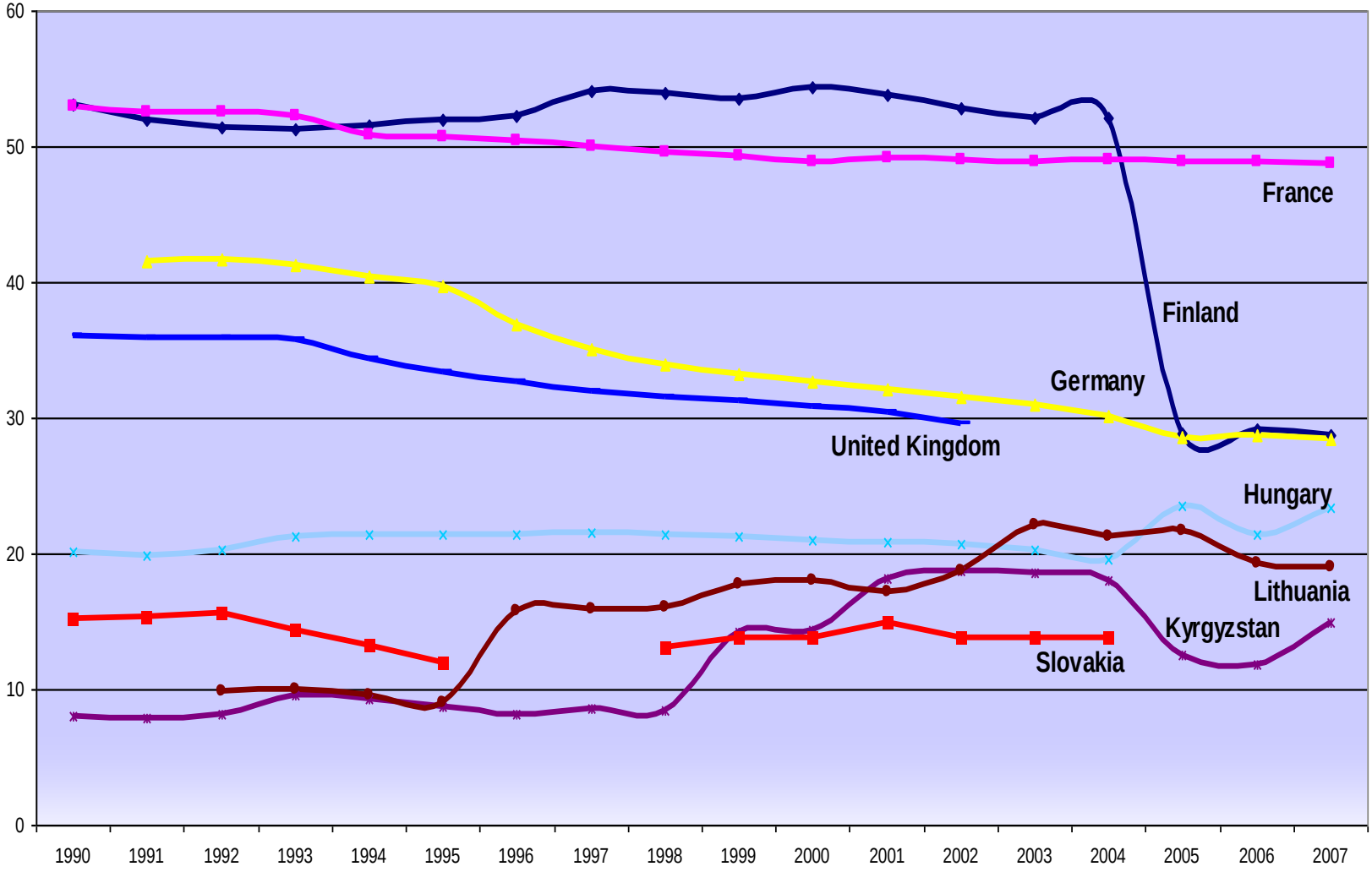
Ex.: Challenges for PHC renewal: human resources for primary care



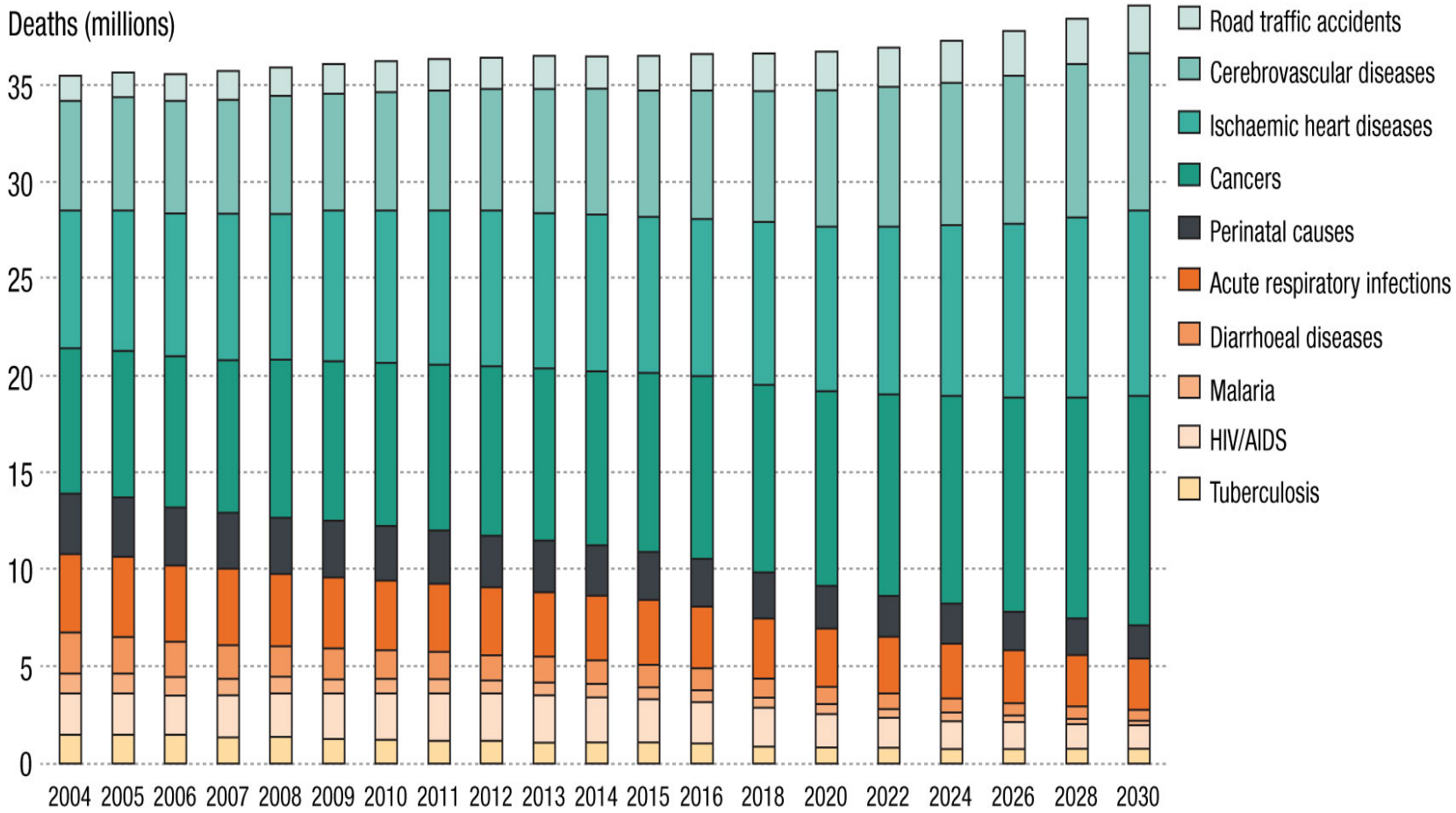
Source: WHO HFA database, 2009

Ex.: Challenges for PHC renewal: human resources for primary care

% of GPs/ all physicians per 100 000 population



Reason for PHC renewal: shift towards chronic and non-com. disease and multi-morbidities

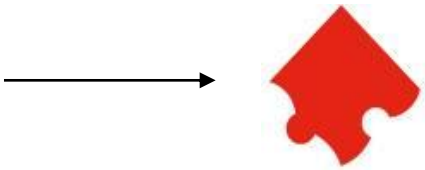


NCDs: leading conditions in Europe

Disease	Disease burden (DALYs)	Deaths
Cardiovascular diseases	23%	52%
Neuropsychiatric disorders	20%	3%
Cancer	11%	19%
Digestive diseases	5%	4%
Respiratory diseases	4%	4%
Diabetes mellitus	1%	1%
Musculoskeletal diseases	4%	0%
Sense organ disorders	4%	0%
Other NCDs	5%	2%
Total	**77%**	**86%**

European Health Report 2005, WHO

Proposed 4 areas for reform



Service delivery reform:

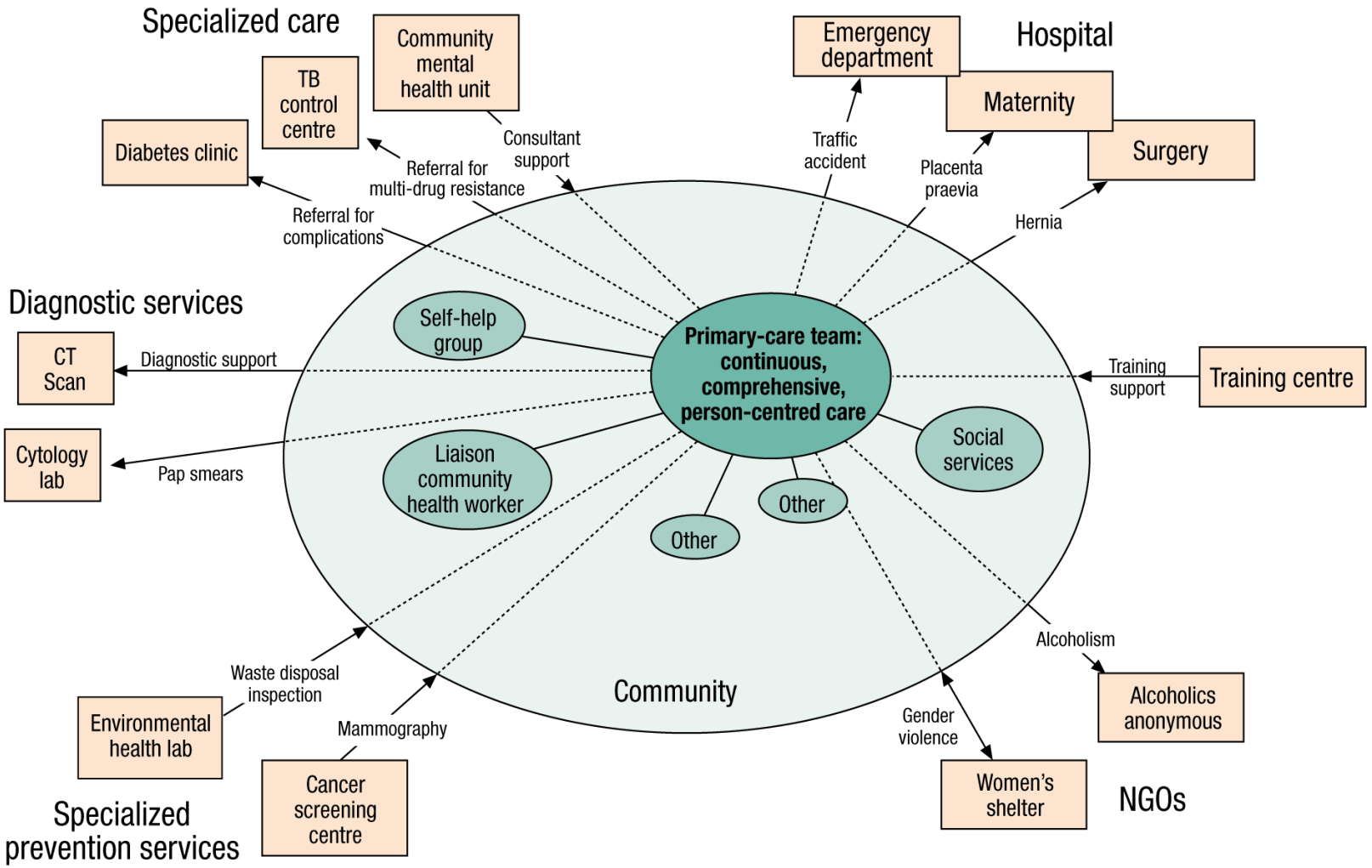
LINK to our common project "the evaluation of the organization and provision of primary care in Slovakia"

→ Results can be used as baseline

What does people-centred primary care mean?

Accessibility	provides accessible care without barriers: distance, financial, organizational (waiting time, time for consultation) etc
Comprehensiveness	provides a wide range of services - includes curative care, rehabilitative care, prevention, promotion; it also relates to practice conditions, facilities and equipment, professional skills, community orientation
Continuity	ensures that health needs/ risks are generated and kept over time (medical records, informational continuity), relates to interpersonal continuity – doctor/ patient relationship
Coordination	ensures that different services are provided in coordination (within PC/ teamwork), helps the patient to navigate through the levels of care

People-centred care: coordination



People-centred care

Conventional ambulatory medial care in clinics of outpatient departments	People-centred primary care
Focus on illness and cure	Focus on health needs
Relationship limited to the moment of consultation	Enduring personal relationship
Episodic curative care	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
Users are consumers of the care they purchase	People are partners in managing their own health

Source: WHR 2008

People-centred care

Putting people first: the “vision”?

Rather than spending all day in traditional overburdened 10-15 minute patient visits, primary care physicians and teams would analyse the health needs of their population and manage them accordingly, either with individual case strategies or in groups according to health risks.

(Thomas Bodenheimer, N ENGL J MED, 359; 20, 2008)

Strategies for people-centred care

Countries in Europe seem to experiment either with:

- Chronic disease management and integrated care models (France, Ireland, Italy, Germany: diabetes type 1+2, COPD, coronary health disease, breast cancer; Denmark: Reha after heart attack with extended team: physiotherapist, dietitian, social worker, psychologist, priest)
- New provider qualifications and transforming practice models (UK; Netherlands: nurse practitioners; case managers)

2nd part of presentation

Overview of our forthcoming project in your country: The evaluation of the organization and provision of primary care

- project set-up and time-line
- underlying framework of the PCET

The partners of the project

Implementation of the projects is a joint effort.

BASIS: BCA between The Ministry of Health and WHO, Regional Office for Europe

- NIVEL, WHO collaborating centre (technical lead) from the Netherlands
- Local partner organization
- The health providers and patients in primary care

The methodology

- Data will be collected in two/ three pilot regions

- 3 different sources of data/ levels:

1. Questionnaire for Primary Care Physicians/ GPs
2. Questionnaire for Patients (15 patients from every second sampled physician)
3. Questionnaire for Policy Experts on the national level and validation meeting

Sample	Planned
PC physicians	Around 250
Patients	Around 1875
Policy experts	Around 5 - 10

The methodology

→ The four functions of the WHO 2000 Health System Framework; plus – 4 features of "good/ people-centred" PC

1. Governance (structure of PC, policy development, legislation, patient rights)
2. Financing (incentives for professionals, financial access for patients)
3. Resource generation (workforce, education, training, equipment)
4. Service delivery:
   a) *Access (geographical, financial, organizational)*
   b) *Continuity (interpersonal, informational)*
   c) *Coordination (within PC and to other levels of care)*
   d) *Comprehensiveness (curative, preventive, rehabilitative)*

Ex. pre-conditions for continuity and integrated care

Self-reported information from family doctors in two provinces in Turkey

Items	**Bolu/ Eskişehir** (N=37+41)
	%
Keeping patients' medical records -routinely -with some reservation	 42 58
Generating a list of patients by diagnosis or health risk -easy -somewhat difficult -very difficult/impossible	 28 36 36
Using referral letters for all or most referred patients	34
Information from medical specialist after treatment -usually -in minority of cases -seldom/never	 3 17 80
Discharge report after hospitalization -within 30 days -seldom or never	 23 77

WHO, 2008

The methodology

- Country specific: both questionnaires will be discussed in a national working group and incorporate country specifics (technical terms, only GPs? etc)
- Specific topics that are under discussion in a country: questions can be added (prevention, NCDs, TB etc)

The phases of the project

1. Phase: Preparation: Identify local counterpart, establish two working groups: one for the national level questionnaire; one which is supporting the implementation, identify pilot regions etc (February – March 2010)

2. Phase: Carry out workshops to adapt questionnaires (country situation, translation), prepare the implementation of the survey (March - May 2010)

3. Phase: Carry out the survey/ field work (including training of field workers), validation meeting national level (June??); data entry (xxx)

4. Phase: Analysis of results and draft reporting (xxx); Validation: discussion of findings and recommended actions (xxx); finalization of report and printing (xxx)

5. Phase: Final conference - dissemination of results to a wider audience and discussions on the way forward (xxx)

Thank you for your attention