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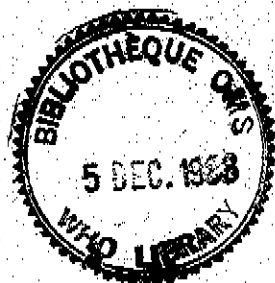


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THE ASSESSMENT OF PRIMARY HEALTH CARE DEVELOPMENT IN THE EUROPEAN REGION

Report on a WHO Working Group

Seville
13-16 April 1988

1988

EUR/HFA target 26

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TARGET 26

A health care system based on primary health care

By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.

Index:

PRIMARY HEALTH CARE %TD%
EVALUATION STUDIES
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INTRODUCTION

A Working Group on the Assessment of Primary Health Care Development in the European Region met in Seville, Spain from 13-16 April 1988. The meeting was hosted by the Andalusian Government and organised jointly by the WHO Regional Office for Europe and the Andalusian School of Public Health, Granada.

The Minister of Health, Senor M Chaves welcomed the participants to Seville on behalf of the Andalusian Government and Dr W Hubrich, WHO's European Regional Officer for Primary Health Care, welcomed the participants on behalf of the Organization.

The Working Group consisted of 15 temporary advisers from 14 European countries, two observers from Spain and two representatives from the WHO Regional Office for Europe. They included medical doctors, administrators and health service researchers. About a third of the temporary advisers were employed by central or local health authorities, a third by schools of public health and a third by academic or other research units. A list of the temporary advisers will be found in Appendix A.

Scope and purpose

The Member States of the WHO European Region are supporting Primary Health Care (PHC) as the key to the attainment of Health for All (HFA) adopted by the Regional Committee for Europe at its thirty-fourth session in September 1984.

In November 1983, a WHO Conference held in Bordeaux made an initial assessment of the development of PHC in Europe. The report highlighted

the fact that there were differences both in the extent and form of PHC development in Europe. Some countries had introduced changes in the health care system in favour of PHC but were nevertheless facing substantial problems despite progress. Other countries had made only limited changes. Subsequently, an increasing number of activities aimed at developing PHC at district level and exploring the possible contributions of districts to HFA 2000 were undertaken.

In 1986 the WHO Regional Office initiated a study of PHC development in nine countries in the European Region to examine the extent to which the main PHC principles (Table 1) had been implemented. The study involved the review of documents relating to PHC at national level and the analysis of data from selected districts to illuminate the relationship between national policies and targets and PHC at district level.

Against this background, the main aims of the Working Group were to:

- consider the report of the study on PHC development in the European Region
- assess progress in this sector, paying particular attention to trends in the various countries since the Bordeaux Conference in 1983
- to make recommendations on ways in which the district health systems approach should develop in the European Region, keeping in mind the possible contribution of districts to HFA
- to show how this would influence the structure of health care systems.

Table 1 Main PHC principles

PHC should:

- be put into a real social and economic context and trends
 - be built on the principle of community participation and continuity of relationship with community members
 - improve self-reliance by creating and developing the social network
 - be based on a multi-sectoral approach and inter-sectoral collaboration in health promotive, preventive, rehabilitative and supportive care
 - be staffed with multi-disciplinary teams through horizontal integration of services and education for PHC
 - serve as the first contact point at the local level in a comprehensive national health system
 - be supported by an effective referral system through vertical integration and coordination of services at various levels
 - systematically identify risk factors and persons at high risk, disadvantaged and underserved in order to overcome inequalities in health and health care
 - encourage the appropriate use of health technology, including quality assurance; and
 - be monitored and evaluated through an organized information system for PHC
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A further aim of the Working Group was to establish links between different projects on PHC at district level in Europe and to set up a network of collaborating centres for PHC and national centres dealing with PHC to monitor trends in Europe.

Programme

The first day of the Workshop consisted of a plenary session.

Dr W Hubrich provided an overview of PHC in the European Region.

Dr H Ramic, the Study Coordinator, presented a report on the findings of the study of the development of PHC and each of the temporary advisers highlighted key aspects of PHC development in their countries on the basis of statements they had prepared before the meeting.

The second and third days were devoted to detailed discussions of a range of issues relating to the development of PHC in three sub-groups. These included the role of PHC in national health policy, trends in the development of PHC, the extent to which one should focus on districts, the issues which should be addressed within districts, the mechanisms for fostering PHC development within districts and the activities which should be focused on at national and international level.

On the final day, the reports of the three sub-groups were presented during a plenary session. Members of the Working Group then considered a draft summary report and approved a set of recommendations.

Organisation of the report

The main section of the report is divided into three sections. The

first outlines the major health trends in the European Region which were identified in the Study Group's Report and which provided a backcloth to the group's discussions about the development of PHC. The second describes the progress which members of the Working Group considered had been made towards specific targets since the Bordeaux Conference, the problems encountered in this process and possible ways of tackling them. The final section summarises the group's views on the contribution which the district health systems approach could make to PHC development in the European Region. The report concludes with a list of recommendations for Member States and WHO.

Primary health care

Despite the jointly agreed definition of PHC in the Alma-Ata Declaration, it was evident from the group's discussions that the term continues to be interpreted in many different ways.

Within the group, PHC was seen

- as a range of promotive, preventive, curative and rehabilitative programmes
- as a level of care - the exact definition depending on the country concerned - backed up by a well organised referral system
- as a strategy for reorienting the health system in order to provide the whole population with effective, essential care and to promote individual and community involvement and inter-sectoral collaboration
- as a philosophy, based on the principles of social equity, self-reliance and community development.

In some countries, however, the term primary health care was still equated with primary medical care and difficulties in understanding the full ramifications of the concept remained as obstacles to the effective implementation of PHC. Research into the actual content of PHC in different contexts would help to tackle this problem.

DISCUSSION

Health trends

The Study Group's report and individual country statements showed that there had been substantial improvements in the population's health in Europe in the last ten years. Infant mortality rates had declined rapidly in most countries and in some had reached a steady low level. Life expectancy was increasing and the proportion of over 65s had risen sharply in most countries.

Within the Region, ischaemic heart disease and cerebrovascular disease are the main killers of the population, accounting for between 30% and 60% of the deaths in the 35-64 age group. In most countries of the Region, however, mortality from cerebrovascular disease was decreasing.

Malignant neoplasms form the second group of major causes of mortality within the Region, being responsible for some 30% of all deaths in men and about 40% in women in the age group 35-64. In most countries, overall mortality from malignant neoplasms in the age group 35-64 is increasing among men and declining among women.

Alongside these positive health trends some negative health trends

were emerging in some countries. For example, in Finland, suicides, smoking and the use of alcohol was increasing among young people.

Inequalities in health between countries and between different population groups within countries also persisted. For example, there was a seven year difference between the extremes of life expectancy in the countries of the Region which participated in the study and infant mortality rates in one country were four times higher than in another. Even within relatively affluent countries, infant mortality rates in the least affluent areas and socio-economic groups could be double those in the most affluent areas and groups.

Members of the Working Group accepted that the development of health care systems based on PHC, together with changes in life-style and changes in the environment were the main keys to further improvements in health and to greater equity in health in the European Region.

Developments in primary health care

Since the Bordeaux Conference in 1983, most countries in Europe had made further progress towards expanding health care delivery systems based on PHC and the goal of HFA 2000. Policy statements endorsing a PHC strategy, supporting legislation, improvements in PHC facilities, increases in the number of health personnel employed in PHC settings and improved access to care were encouraging signs of what had already been achieved. Some felt, however, that more progress had been made in improving primary medical care than in improving PHC.

In all countries, difficulties had been encountered in implementing a PHC strategy at district or local level. Shifting resources to reflect changing health care priorities, reorienting services towards promotive and preventive activities and the needs of entire populations, and involving all the interested parties in developing and evaluating integrated programmes had proved difficult in many countries.

Many of the problems which had been encountered were seen to stem from the absence of strong infrastructures for the development of PHC at district or local level. Further progress was seen to largely depend on renewing political commitment to the development of PHC, strengthening district or local management, particularly the health information support systems and improving the recruitment, training, supervision and continuing education of personnel. Hospital support for PHC was also considered essential.

Policy and legislation

Members of the Working Group recognised that in many European countries in the last ten years there had been a policy shift away from a dominant emphasis on high technology inpatient forms of care and that the development of health care systems based on PHC had become a major policy goal. A variety of policy statements and documents published since the Bordeaux Conference were cited as evidence of this policy shift. Members of the Working Group from Finland, Netherlands, Poland and Yugoslavia were also able to point to policy documents setting out goals and targets in line with the HFA Euro targets.

This policy shift was seen to be driven by the escalating costs of health care and clinical developments. WHO's decision to make primary health care the key to the attainment of HFA 2000 had also reinforced the general trend.

Some members of the Working Group considered, however, that efforts were needed to renew and sustain political commitment to the development of health systems based on PHC in their countries. In some countries, policies for the development of PHC conflicted with other national policies, such as preserving centres of excellence. In other countries, groups who saw an emphasis on PHC as a response to economic constraints rather than as a positive step towards enhancing the quality of care and attaining HFA targets opposed the policy emphasis on PHC.

Despite some resistance, legislative measures had been introduced in some countries to stimulate changes in the health care system and to promote specific elements of PHC. For example, in Finland in 1984 there had been legislation aimed at achieving a balanced distribution of resources in health and social services, the transfer of more responsibilities to health centres and inter-sectoral collaboration. In Ireland there had been legislation in relation to the control of tobacco advertising, restrictions on smoking and road safety and in Portugal a general directorate for PHC had been established.

Community involvement

Members of the Study Group reached the conclusion that community involvement was widely understood in Europe as a network of local mechanisms to represent the community's interest in health and to influence decision

making relating to health issues. Understanding of community involvement, as defined in WHO's Glossary of Terms - that is to say, "the active involvement of people living together in some form of social organisation and cohesion in the planning, operation and control of primary health care using local national and other resources" - remained limited.

In the last five years, various efforts had been made to strengthen officially sanctioned mechanisms for community involvement in health issues in some countries. In Italy, for example, there had been legislation emphasising the need for people to be actively involved in the planning and delivery of PHC, but it had yet to be universally implemented. In the UK, there had been legislation designed to strengthen the role of community health councils - the local bodies which represent the interests of the public in the health service - in the development of PHC. In Yugoslavia, decentralisation had stimulated local initiatives in community involvement but experiences there had been affected by the structure of relationships between the different parties concerned and the issues at stake.

In general, members of the Working Group considered that the level of community involvement in health issues was lower than that required for the effective development of PHC. Some believed that people did not want to be fully involved or lacked the knowledge to become involved in decision-making concerning health. Others maintained that some health personnel did not accept and were hostile to community involvement in health issues.

Members of the Working Groups suggested that greater community involvement could be promoted by decentralisation of decision-making for PHC,

the strengthening of unofficial, as well as official, mechanisms, educating public representatives about health issues, greater public access to appropriate information and the development of more supportive attitudes to community involvement in health issues among health personnel.

Distributing resources

Members of the Working Group saw from the Study Group's report that all countries, except Portugal and Yugoslavia, were devoting a steadily increasing share of the gross national product to the health care sector. Members recognised, however, that since the overall resources available for the expansion of the health care system were no longer growing as rapidly as in previous decades, some of the resources required to develop PHC would have to come in future from other parts of the health sector.

In recent years, only Finland and the UK had devoted a higher proportion of their national health care budget to primary health care. In practically all countries, the hospital sector continued to absorb two-thirds or more of the total health care budget. Belgium had, however, halted the increase in hospital beds and Italy was planning to do so.

Members of the Working Group recognised that it would be an uphill struggle to obtain the resources needed to expand primary care because of:

- the beliefs held by the public, health personnel and politicians about the ability of hospitals to improve health

- the persistence of the image of primary care as poor care for poor people
- the relentless demand from hospitals for resources
- vested economic interests in hospitals
- lack of skilled advocates for PHC
- weak lines of communication between PHC advocates and the political decision-making process
- lack of information on which to challenge the current distribution of resources.

Various suggestions were made for tackling these complex problems. Some suggested that PHC and hospitals should be separately financed. Others saw the need to develop information systems which could provide a basis for a more balanced distribution of resources. Others emphasised the need for studies which demonstrated that PHC was more cost-effective and socially acceptable than hospital care and which challenged beliefs that PHC was poor care for poor people.

While such beliefs persisted, employment conditions in PHC remained poor and the educational system was geared to hospital-based curative medicine rather than the needs of PHC, some countries continued to experience difficulty in recruiting and retaining fully trained PHC personnel. Some countries had too few doctors trained to work in PHC settings and some too few nurses and physiotherapists. Distribution of PHC personnel also remained uneven with rural areas and deprived urban areas frequently experiencing recruitment problems. In other countries under-utilisation of doctors was becoming an issue.

Improvements in employment conditions in the short term and the establishment of academic departments of general practice and institutes of primary health care in the longer term were seen as ways of improving the prestige and attractiveness of PHC in countries where there were recruitment problems.

Reorientating primary medical care

Members of the Working Group recognised that in many European countries health care systems continued to be based on primary medical care rather than primary health care. To transform primary medical care into the ideal of PHC, major changes were called for in the focus, content and organisation of primary medical care.

One encouraging sign of progress in this area in the last five years had been a growing awareness of the need for policies describing the full range of services which PHC should provide. In the UK, for example, the Royal College of General Practitioners had drawn up a list of services which it considered should be available in every practice and in Spain, there had been legislation setting out the aims, functions and composition of PHC.

There had also been recent moves in some countries to extend the range of services provided by the PHC system and to make available more comprehensive services. In Portugal, for example, routine vaccination programmes for infants and teenage girls had been introduced and in both Spain and Portugal attempts were being made to decentralise mental health care from hospitals and specialised clinics to PHC settings. In the German Democratic Republic there were moves to extend ambulatory care and

to reorientate medical education towards PHC.

Other recent moves to reorientate primary medical care included steps to give greater priority to health promotion and prevention. In Belgium, for example, an experimental capitation payment system had been introduced in a few health centres and had been successful in increasing the emphasis on preventive services. In Sweden, the UK and Ireland, there were also signs that health promotion and disease prevention were gradually becoming a higher priority task.

Members of the Working Group considered, however, that much more needed to be done to retrain staff who had been trained to treat illness, to carry out promotive and preventive activities, provide greater continuity of care in primary care settings, to adapt programmes to local needs and to develop more effective links between primary care and hospitals.

Currently, lack of effective links between primary care and hospitals were resulting in unnecessary and inappropriate referrals, duplication of activities and haphazard after care. As a consequence, people were being cared for in hospitals when they might be equally well or better served by well-integrated primary care services.

Factors which Working Group members considered to be associated with this problem included poorly defined referral procedures, differences in status between primary medical care and hospital personnel, the inadequate flow of information to and from hospital and differences between the population served by hospital and PHC personnel.

The development of educational programmes at all levels to motivate

and equip PHC personnel to provide a comprehensive and well-integrated array of services was seen as a way forward. Provision of information about the operation of the referral system - for example, the volume and appropriateness of referrals, waiting times and adequacy of services - was also considered to be valuable.

Developing teamwork

Members of the Working Group recognised the importance of developing teamwork by different types of PHC personnel as a means to achieving HFA 2000. Encouraging trends supporting the development of teamwork included the increasing number of health centres in Greece, Spain and Portugal and the introduction of new regulations and subsidies to support local initiatives and to coordinate the activities of primary care workers, social workers and home helps in Belgium.

In many countries though there were major problems in the way that PHC personnel cooperated, or did not cooperate with each other. Obstacles to teamwork identified by the Working Group included the reluctance of some primary medical care personnel to accept other PHC personnel as equal partners, different organisational loyalties, differences in social and educational backgrounds, financial disincentives to delegate work and lack of teamwork skills.

To achieve the necessary shifts in professional attitudes and methods of working, members of the Working Group suggested that more experiments in multi-professional education were needed at all levels.

Members of the Working Group also recognised the importance of more

active cooperation between PHC personnel and the populations they served. In this context, it was encouraging that in some countries education for health and the promotion of healthy life-styles were featuring increasingly in national strategies, with particular attention being paid to problems such as coronary heart disease prevention, alcohol abuse and smoking.

In other countries, the potential value of self-care was not recognised and efforts were needed to educate both professionals and the public about the roles of health and medical services and lay care.

Coordinating services

There was broad agreement among members of the Working Group that effective PHC development particularly in relation to problems such as smoking, alcohol and traffic accidents, required health personnel to cooperate with personnel from other sectors, such as education, which have an influence on health.

In some countries, recent trends in the health care system, such as the increasing competition on the health care market in Belgium and moves to decentralise and develop community health services for the elderly, the mentally ill and the mentally handicapped in the UK were stimulating new efforts to coordinate local services. In Finland, inter-sectoral collaboration at the national level had been effective in reducing road accidents. In other countries, the health sector's capacity to influence other sectors remained weak and agreement in principle about the importance of inter-sectoral measures rarely found expression in action.

Perceived obstacles to greater collaboration between different sectors on health issues included lack of pertinent information on the policies

of other sectors which influence the development of PHC and lack of information about the resources of other sectors which could be used to improve health. Lack of mechanisms at various levels and lack of resources for collaboration were identified as further constraints to joint working.

Ensuring quality

Members of the Working Group considered that many changes in health care systems in recent years, including increases in resources, manpower and facilities available for PHC pointed towards significant improvements in the quality of services.

Wide variations in referral rates within countries, however, tended to reinforce beliefs that there were substantial variations in the quality of PHC even though these remained difficult to measure precisely.

Financial disincentives, lack of support, training and supervision of PHC personnel and lack of the necessary information to support quality improvements were identified as obstacles to raising standards.

The development of peer review and the dissemination of information about good practices were seen as two ways of ensuring more consistent and higher quality PHC in future.

District health systems

The WHO Global Programme Committee defined a district health system based on primary health care as:

"... a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional."

Some members of the Working Group had difficulty, however, in applying this concept to countries such as the Federal Republic of Germany where there was no clearly defined organisation responsible for all health and social services for a given population and suggested that a more flexible definition which took into account variations between and within countries in Europe was needed.

Members generally welcomed WHO's focus on district health systems as a means of strengthening PHC. It was emphasised, however, that activities at district level should not be seen in isolation from activities at national level. Efforts to improve district health systems based on primary health care required central support and it was important that experience gained at district or local level was fed back to the centre.

Members considered that many of the important issues relating to the development of primary health care could and should be addressed at district or local level. A district focus provided opportunities to reorientate primary medical care, to improve links between hospitals and primary care, to strengthen teamwork, to involve the community and to develop and evaluate comprehensive community-based programmes involving all sectors.

Research, information, education and training, coordination and adequate resources were seen as the keys to strengthening district health systems

based on primary health care, with particular emphasis being placed at this point on the need to collect, analyse and use information about the health problems facing the population, appropriate technology, the satisfaction of users and ways and means of improving and ensuring effective community involvement and inter-sectoral collaboration.

RECOMMENDATIONS

1. Member States should:

- define national prevention targets and monitor progress towards them;
- review the measures needed to develop or strengthen district health systems based on primary care, including the measures needed to adapt current health information systems to strategies for health for all;
- develop education and training activities to support the developing role of general practitioners and other primary health care personnel in prevention and in ensuring that health services are properly managed;
- clarify the services to be provided by primary health care and by hospitals and establish more effective links between them;
- develop mechanisms for involving providers and users in the process of developing primary care at different levels; and
- review the mechanisms for developing a multisectoral approach to prevention.

2. The concept of a district health system based on primary care should be clarified through study of the range of different interpretations in Europe.

3. Case studies should be initiated and supported of the contribution that alternative concepts of district health systems can make to the attainment of health for all.

4. Workshops should be set up for groups of countries facing similar problems in developing primary care, such as countries in central Europe.

5. The creation of professorships and research institutes for primary health care should be supported.

6. Efforts should be increased to distribute reports of WHO studies and information about good practice in developing primary health care in different countries.

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