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# CONTINUITY OF CARE IN CHANGING HEALTH CARE SYSTEMS



WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE  
COPENHAGEN

## **TARGET 28**

### **PRIMARY HEALTH CARE**

*By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.*

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# CONTINUITY OF CARE IN CHANGING HEALTH CARE SYSTEMS

Report on a WHO Working Group

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11 – 14 December 1991

## ABSTRACT

The importance of primary health care (PHC) and one of its principal components – continuity of care – receives considerable lip service. Nevertheless, a poor understanding of these terms, and organizational barriers and rapid changes in health care systems, particularly in the countries of central and eastern Europe, combine to keep a well functioning PHC team a rarity. A variety of European experts, mostly from these countries, comprised the WHO Working Group on Continuity of Care in Changing Health Care systems. The Working Group examined trends in continuity of care and teamwork in PHC and in health care in general, and identified the most useful means to promote teamwork in changing health care systems. The Group made recommendations to governments, the providers and managers of health services, training institutions and WHO, urging:

- the importance of PHC and continuity of care;
- the provision of sufficient well trained personnel for PH teams (particularly general practitioners);
- better management and evaluation of PHC services; and
- incentives and improved training for the managers, leaders and members of PHC teams.

These improvements would create a health care environment that would encourage the development of teamwork and continuity of care in PHC.

### *Keywords*

CONTINUITY OF PATIENT CARE  
DELIVERY OF HEALTH CARE – trends  
PRIMARY HEALTH CARE  
CCEE  
EUROPE

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## Introduction

The Working Group on Continuity of Care in Changing Health Care Systems, organized by the World Health Organization Regional Office for Europe in collaboration with Local Health Unit No. 19 of the Venice Region, met in Cittadella (Padua), Italy from 11 to 14 December 1991. Its main purpose was to focus on teamwork among the various providers of primary health care (PHC). Professor Bruno Paccagnella was elected Chairperson of the Group and Professor Luca Kovacic, Vice-Chairperson. Professor Pertti Kekki was the Rapporteur. Annex 1 comprises a list of background documents and Annex 2 lists the participants in the Working Group.

Continuity of care is not only one of the main characteristics of PHC but also a sensitive indicator of the functioning of a health care system. Continuity is particularly important in care given at home. Care provision must be properly organized to ensure continuity. The main method to accomplish this task is teamwork among the providers of health care and health-related services at various levels.

In principle, the conditions for teamwork are favourable in health services, where the focus is on health centres and group work. Nevertheless, practice (or the structure and functioning of services) often diverges significantly from theory. This is also the case in the health care systems of the countries of central and eastern Europe, which have polyclinics, health outposts and district health services with different administration systems. Further, the changes taking place in these countries include trends towards mixed health care systems, decentralization, a degree of privatization and a greater role for (and hence competition between) individual health care providers. These trends may endanger teamwork, which may be regarded as less important than issues such as new remuneration systems and better technology or drug availability.

The effectiveness of the continuity of care and cooperation need to be assessed. Thus the participants first reviewed the present situation and trends in continuity of care, teamwork in PHC and cooperation among health care providers in their countries, with a special focus on home care. The Working Group then used the review to identify the most successful mechanisms for teamwork in the present

climate of change. The emphasis was on the roles of the different members of the PHC team in the decision-making process. The Working Group discussed the interaction and leadership needed in various team activities, and considered the starting point for any kind of teamwork: the task of assessing the needs of individuals, population groups or the whole community. In this task, the Group focused on new approaches to teamwork for priority groups or special conditions.

## Research on Teamwork in PHC

Collaboration is fundamental to teamwork, and comprises: sharing in planning, making decisions, solving problems, setting goals and evaluating achievements, coordination in making and carrying out plans for patient care, and cooperation between team members. Collaboration requires people to be both assertive (meeting their own needs) and cooperative (meeting others' needs). Assertiveness without cooperation results in competition. Cooperation without assertiveness results in appeasement. Either of these can ruin teamwork.

The results of research on teamwork show many problems in practical application. In most cases, the findings indicate a clear lack of even the idea of teamwork in PHC, although the definition of teamwork is widely known among staff. It seems obvious, however, that the problem lies in the perception of the definition. The frequent use of such expressions as health team, teamwork and collaboration in relation to PHC gives the idea that teamwork is widely accepted, understood and practised by PHC workers. In reality, very few workers seem to understand what it means. Although the literature on teamwork indicates that a well functioning team is effective and efficient, such teams are rare.

The most important obstacles to successful teamwork include the following:

- the perception of teamwork as a risk to professional identity;
- a lack of knowledge and understanding of the work of others;
- poor communication and transfer of information;
- competition between professional groups and their organizations;

- shortages in basic professional training; and
- the lack of managerial support for teamwork.

The Working Group considered all of these extremely important; they should be taken into account when teamwork is promoted in PHC. In particular, the training of the leaders and members of teams is important.

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1982

1983

## Continuity of Care

Continuity of care as an essential element of primary health care was briefly summarized. The Working Group identified three levels for continuity of care: the individual care provider, the PHC team and a network of services. At the first level, continuity means a continuing relationship between a provider and a user of services. At the second level, it is a continuing relationship between a service user and an identifiable primary health care team (whose various members fulfil common objectives). At the third level, continuity of care is secured in a wider network of services through a well functioning referral and feedback system. Such a system demands better communication between services.

## Discussion

For more thorough consideration of the key issues, the Working Group was divided into three smaller groups. The topics discussed were: continuity of care, the efficiency of teamwork and the management of the team. The reports of the groups and the following discussion formed the starting points for the making of recommendations.

### Continuity of care – general considerations

Members of the first subgroup agreed that general practitioners are the key to achieving continuity of care in PHC because they coordinate most of the activities related to patient care. Several other types of

personnel can contribute, however, as members of or resource people for the PHC team, depending on the health care system. The community or public health nurse or social worker can be particularly important here. In some cases, a voluntary community care organization (or a voluntary health worker) may also be important.

In some central and eastern European countries, the structure of the PHC services hinders continuity of care. The general practitioner may be the only care provider and thus unable to meet the requirements for continuity. The primary need at the local level is an acceptable mixture of other care providers to work with the physician. A natural obstacle, of course, is the extreme shortage of all health resources. This problem should be dealt with first.

Problems of continuity are also present in services dealing with social issues such as juvenile delinquency and drug addiction.

In addition, methods of gaining access to health services were seen as a potential threat to continuity. These were related to both the patient's freedom to choose care providers and the method of financing services in various sectors.

### *Pros and cons*

Why should continuity of care be considered desirable. The subgroup listed six benefits and only one disadvantage. The first benefit is the potential for integrating the physical, psychological, social and economic dimensions of care. Continuity of care also improves the relationship between the users and providers of services, and helps the users to play a more active role in maintaining their health, thus reducing the over-use of health care. Further, it reduces the costs of care by preventing the duplication of services and overtreatment. Finally, continuity of care increases the satisfaction both of users with services and of health professionals with their jobs.

The disadvantage of continuity is that it can hide poor quality care, particularly in a system that does not allow a free choice of care provider.

The subgroup concluded that continuity of care requires specific encouragement and incentives. It should not be imposed, however. People must have the right to choose their own care providers, and the

health care system should aim to create conditions that encourage patients to choose to continue with the same providers.

### *Structural considerations*

The financing and organization of health services can create only the opportunity for continuity of care. The subgroup saw patient information systems and the use of a single patient record as crucial, however. Another important structural element was the creation of a system giving incentives to health workers to seek training in the essentials of PHC.

Payment systems were mentioned in the discussion. A system based on capitation payment was thought to encourage continuity more than one based on fees for services. It was concluded that the aim of a well functioning PHC system is to create a climate that encourages continuity of care.

### **Management and efficiency of PHC teams**

The other two subgroups addressed issues in the management and efficiency of PHC teams. These topics are both closely related and extremely important to the users of services.

#### *Management*

The managers of a health care unit or organization should understand the requirements for and characteristics of effective teamwork. They should also understand their own role and responsibilities in supporting teamwork and the results of failing to give this support. These responsibilities include the setting of goals and informing subordinates about them. Managers also form PHC teams, and specify their members and the reasons for their inclusion.

It is very important for successful teamwork that managers also appoint the leaders of the teams. Experience with effective PHC teams clearly indicates the need for a leader, who must be qualified for the task. The variety of backgrounds of the members of the PHC team makes the leader's job demanding. This is an important reason why the leader needs strong support from management.

Further, the managers of PHC services need training in teamwork. The members of the management team must value the objectives of the organization more than the interests of their professions. In addition, the management of PHC at the local and district levels needs to be strengthened and lines of authority need clarification.

### *Leading a PHC team*

Several important issues in leading a PHC team were raised. The principal functions of the leader are coordinating the work of the team (or its members) and guiding, motivating and supporting the team members. The leader should also ensure open communication within the team, and assign and clarify the roles of the members.

In ensuring the efficiency of the team's work, the leader's most important task is guiding the team to identify its objectives. These must harmonize with the goals and mission of the organization to which the team belongs. The objectives of the team should address the health problems and needs of its clients, be measurable and feasible, and be intended to improve the situation. Further, the team leader should share the tasks of planning, implementing and evaluating the team's work with its members, and carry out training to improve the team's ability to achieve its objectives.

Members must identify with the team. This is thought to be facilitated by working towards shared objectives and regular evaluation of their achievement. Motivation through achievement was stressed.

The leader of the PHC team needs training in the management of small multiprofessional and multidisciplinary groups. Training should focus on management, not administration; that is, it should help the leader to organize, coordinate, motivate and guide the team to achieve its objectives. No standard training scheme was proposed; rather, meeting the needs of each team leader was emphasized.

The discussion of this topic emphasized the importance of the team leader in making decisions about the team's work. Although no autocratic decision-making system should be promoted, the leader is responsible for the team's work and thus also for discussions about its activities. Further, the composition of the PHC team should be

adjusted to local circumstances and innovations from members should be supported.

### *Effectiveness*

The effectiveness of the work of PHC teams was an important topic. Teams should assess their effectiveness, collecting information on their activities and comparing the results with their objectives. Case analyses, for example, could be used for this task. Teams need training to be able to evaluate their work.

Effectiveness must be measured to allow the measurement of efficiency. Both process outcomes and final outcomes can be used. It is important to recognize how a team works to achieve its objectives. The difference between the general goals of health care and the specific objectives of the PHC team should be understood. The more closely such objectives are related to specific problems, the easier the evaluation of achievement becomes.

## Recommendations

### **To governments**

1. Governments should identify situations in which the balance of various PHC providers is unfavourable for the attainment of continuity of care and take corrective action, including the training of new health care personnel.
2. Government should recognize the importance of well trained general practitioners as the key to their PHC systems.
3. Governments should create conditions that facilitate continuity of care. They should create incentives that encourage health care providers, particularly general practitioners, to value continuity of care. To encourage training and other aids, incentives could be linked to payment systems.
4. Governments should establish and support programmes on PHC in undergraduate medical education and in training for other health

care personnel. This includes establishing and supplying resources to new departments of general practice or PHC.

5. Ministries of health should strengthen the management of PHC at the district and local levels. The administrative responsibilities and lines of authority in PHC services should be clarified to avoid confusion, ineffectiveness and inefficiency.

6. In countries where health services are to be reorganized, governments should closely study the positive and negative aspects of the system, and particularly the ways in which the preventive and curative PHC services should be developed. The study should include an assessment of the costs of reorganization and when the effects (the changes resulting from the reorganized services and training of personnel, and the new attitudes and behaviour of the population) can be expected to appear.

7. Governments should increase their support to research to improve the understanding and development of PHC.

#### **To health workers' professional organizations and the managers of health services**

8. Health workers' professional organizations in the WHO European Region should stress continuity of care as a principal element of PHC and should organize services in a way that encourages continuity of care. Referral and feedback systems for PHC and other service sectors should be established.

9. Where resources allow, providers of PHC should be organized in teams. The concept of a multidisciplinary team as the basic unit of the PHC system should be promoted.

10. Every effort should be made to strengthen the management of PHC services at the district and local levels. This includes allocating funds for the training of existing management teams. This training should focus on problems in PHC and the development of skills in teamwork.

11. Multidisciplinary PHC teams should have leaders appointed by the local – or district – level management (depending on the system).

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The leaders should be accountable to the management. In turn, the managers should firmly support the leaders and their teams, and facilitate the training both of leaders in their task and of teams in more effective teamwork.

12. All health care objectives should be assessed, particularly for feasibility and measurability. The objectives of care providers should be not only measurable and feasible but also based on identified health problems and needs. PHC teams should regularly evaluate their progress towards their objectives, to measure the effectiveness of their work.

13. Health workers' professional organizations should seek to establish partnerships with university departments of PHC for training, research and development activities.

### **To training institutions**

14. Institutions providing undergraduate medical, nursing and social service education should change their curricula to increase the attention paid to PHC.

15. Every university that has not established a department of general practice or PHC should give this task high priority in its medium-term plans. Universities with such departments should provide them with adequate resources.

16. Strong university departments of general practice or PHC should try to collaborate with health service organizations in training, research and development activities.

17. Universities and training institutes should give courses and educational activities to improve the skills of the managers of PHC services at the local and district levels. This training should be multiprofessional and a part of continuing education activities. It should focus on developing the skills of PHC teams.

### **To WHO**

18. WHO should emphasize the importance of continuity of care in PHC and promote the dissemination of information on teamwork as the foundation of PHC.

19. At meetings and other events, WHO should emphasize the importance of training for the managers of PHC services, advise training institutes capable of taking part in such training, and stress the need for integrated multidisciplinary educational activities for PHC personnel.

20. WHO should give information on experts in and analysts of PHC services to other international organizations involved in the development of the health services in the countries of central and eastern Europe (such as the European Community and the World Bank).

21. WHO should urge the governments of these countries to study their present health systems carefully before launching major reorganization processes. WHO should also set up expert teams or task groups as resources in the development of new PHC systems in central and eastern European countries.

22. WHO should stress the importance of well trained general practitioners as the key to PHC services in the countries in central and eastern Europe. At every opportunity, WHO should point out the importance to effective health services of increasing the status of these physicians.

23. WHO should ask governments in Member States to note the problems created by an improper mix of health care providers in PHC, and recommend ways to change the situation.

*Annex I***BACKGROUND DOCUMENTS<sup>a</sup>**

- EUR/ICP/PHC 399/g01      General practice in five European countries. A review and discussion by D. Wilkin and C. Whitehouse
- EUR/ICP/PHC 336      The role of general practitioners in the provision of comprehensive primary health care. Report on a WHO study by Z. Jaksic
- EUR/ICP/PHC 348      The contribution of family doctors/general practitioners to health for all. Report on a WHO Working Group, Perugia, Italy, 22-25 May 1991
- EUR/ICP/NCD 218      The role of general practitioner in the CINDI programme
- EUR/ICP/PHC 3145(4)      Primary health care development in southern Europe. Report on the Fourth WHO Forum, Nea Madytos, Salonica, 21-24 April 1991
- Developing Teamwork in Primary Health Care, a practical workbook by P. Pritchard and J. Pritchard
- EUR/ICP/PHC 331      The role of primary health care in changing lifestyles. Report on a WHO Working Group, Rovigo, Italy, 13-16 June 1989
- EUR/ICP/HMD 159      Teamwork in primary health care by P. Kekki
- BUL/PHC 301      The development of primary health care in Bulgaria by C. Whitehouse and D. Wilkin
- SSR/PHC 311      The development of primary health care in the USSR by C. Whitehouse and D. Wilkin
- POL/PHC 310      The development of primary health care in Poland by C. Whitehouse

<sup>a</sup> Copies can be obtained from the Primary Health Care unit, WHO Regional Office for Europe, 8 Scherfigsvej, DK 2100 Copenhagen Ø, Denmark.

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