Primary Care Evaluation Tool

Why evaluate primary care?

Although the strengthening of primary care services is a priority of health reforms in many countries throughout the WHO European Region, the backgrounds to and reasons for the reforms vary. In western Europe, emphasis on primary care is expected to provide an answer to rising costs and changing demand resulting from demographic and epidemiological trends. Central and eastern European countries, as well as those formerly belonging to the USSR, are struggling fundamentally to improve the performance and cost effectiveness of their entire health systems. Primary care, which used to be poorly developed or nonexistent in these countries, is now being developed to improve the cost–effectiveness of the overall system and to bring adequate and responsive health services closer to the population. In many of these countries, health care reforms have been and continue to be part of profound and comprehensive changes in essential societal functions and values (1).

Evaluations and measurements of performance increasingly play a role in health care reforms. Stakeholders need this information to guide their decisions in steering the health system towards better outcomes (2). In the past, reforms were not always based on evidence, and progress was often driven by political arguments or the interests of specific professional groups, rather than by the results of sound evaluations. This situation is changing. Stakeholders in health care, including governments, are increasingly held accountable for their activities, and this requires evidence, for instance, on the progress of reforms.

In addition, demographic and epidemiological changes bring about the need for health systems to adapt to new health demands of the population. This requires evaluation of the responsiveness of health services from the patients' perspective. Such evaluations generate information about access and convenience of services, how patients are treated by health staff, how patients perceive information and communication about their conditions that can impact on their own behaviour and well-being and how finally their care is managed – at the primary care level or beyond.

Further, evaluations and performance assessments should be explained within the country context. Only then can performance information provide direct input to policy-making and regulation. However, the role of governments

goes beyond the direct use of information. The stewardship role also implies that the necessary flow of information is generated and made available to other stakeholders in the health care system, as well as that the necessary analytical capacity is available (2).

A final major requirement of evaluations and performance assessments is to start from a proper framework from which measures are developed. Deriving indicators from an accepted framework advance the relevance of the (proxy) indicators and the good coverage of areas identified in the framework. The following sections describe the framework used to develop the Primary Care Evaluation Tool (PCET).

Evaluating primary care and the health systems framework

A health system can be defined 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 action is 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 (3).

Health systems aim to achieve three fundamental objectives (1,3) as shown below.

- 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).

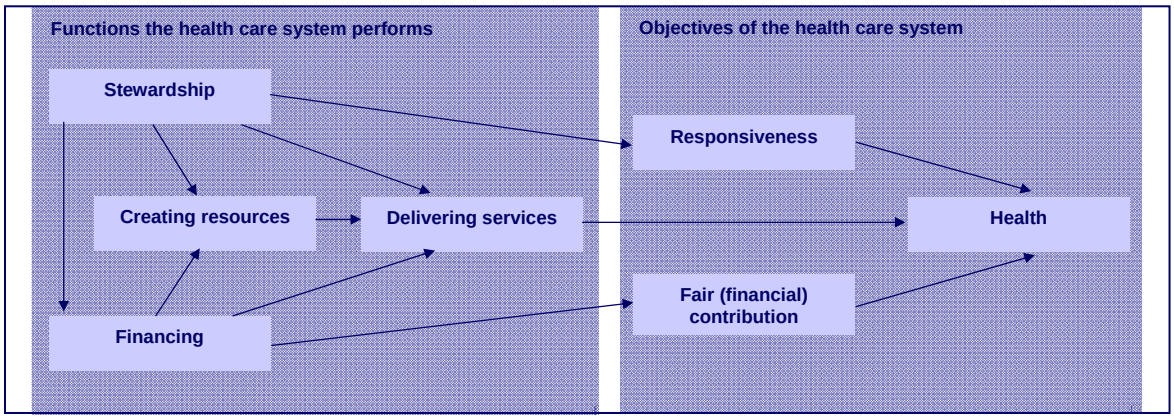
The level of attainment of these goals ultimately reflects the performance of the system as a whole. However, as there are variations in both health conditions and health systems across countries, the country context needs to be taken into account when comparing the performance of health systems. Thus, the measurement of performance should cover both goal attainment and available resources and processes.

The WHO health system performance framework (see Fig. 1) indicates that performance is determined by the way in which the following four key functions are organized (2):

- stewardship
- resource generation
- financing
- service provision.

Indeed other approaches to performance measurement can be found in the international literature (2–5), however, these all use similar insights or related concepts. The four functions can be applied to the whole health system of a country – or, for example, to the primary care level only – with specific sub characteristics for the service provision function in primary care.

Fig. 1. WHO health system functions and objectives



What is the meaning of the four system functions?

Stewardship

Stewardship is an overriding function (but broader than regulation), in that it oversees all basic health system functions. It has direct and indirect effects on the outcomes of a health system (4). Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. It covers three main aspects: (a) setting, implementing and monitoring the rules for the health system; (b) assuring a level playing field for purchasers, providers and patients; and (c) defining strategic directions for the health system as a whole. Stewardship can be subdivided into six sub functions: overall system design, performance assessment, priority setting, regulation, intersectoral advocacy and consumer protection (3). In short, stewardship deals with: governance, information dissemination, coordination, and regulation of the health system at various levels.

Resource generation

Any level of a health system needs a balanced variety of resources to function properly, but these have to be further developed (and expanded) in order to sustain health services over time and across levels and geographical areas. The resources needed encompass physical assets (equipment, facilities), consumable supplies, human resources and knowledge/ information. It is crucial that the quantity and quality of human resources is adequately matched to the demand for services across the various levels of health care and equitably distributed across the country. Naturally, to ensure quality of care, the skills and knowledge of health providers need to be up to date and compatible with developments in technology and evidence-based medicine. Policy development concerning human (physical) resource planning, and a regulatory framework for assuring high quality service provision and consumer

protection falls under the stewardship function – however, the actual state of affairs relating to workforce volume and distribution and professional development (training, continuous medical education, research, knowledge production) is usually measured under the resource generation function.

Financing

In general, financing deals with the mobilization, accumulation and allocation of funds to cover the health needs of the people, individually and collectively, in the health system (5). The financing function in health systems is defined by Murray and Frenk (3) as “the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities”. Three subfunctions can be distinguished: revenue collection, fund pooling, and purchasing. Revenue collection means the mobilization of funds from primary sources (households, firms) and secondary sources (governments, donor agencies). There are a number of mechanisms through which funds can be mobilized, varying by health systems context, e.g. out-of-pocket payments, voluntary insurance rated by income, voluntary insurance rated by risk, compulsory insurance, general taxes, earmarked taxes, donations from nongovernmental organizations and transfers from donor agencies. In order to share and reduce health risks, funds can be pooled through various forms of health insurance. The allocation of funds to cover the costs (staff, durables and running costs) of specific health service interventions by health providers (institutional or individual) is purchasing (5). The way these subfunctions are organized and executed has an impact on the access to health services.

Service delivery

Service provision involves the mix of inputs needed for the production process within a specific organizational setting leading to the delivery of health interventions (5). It relates to preventive, curative and rehabilitative services delivered to individual patients and to services aimed at larger populations (e.g. health education, promotion) through public and private institutions. Providing services is something that the health system does (and there are four key characteristics that define good provision; see below) – it is not what the health system is.

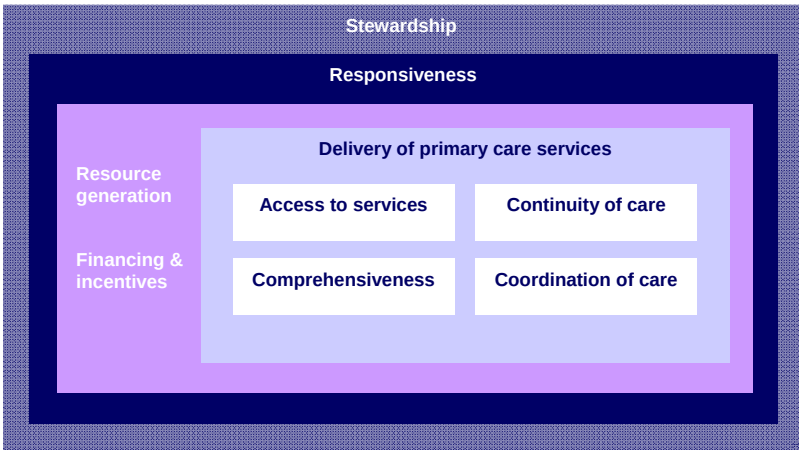
Primary Care Evaluation Framework

The characteristics of primary care vary from country to country, and there are different definitions of what constitutes primary care (see also Annex 1). However, a comprehensive or well-developed primary care system has the following characteristics (6):

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

The Primary Care Evaluation Framework (see Fig. 2) from which the Primary Care Evaluation Tool (PCET) is developed, encompasses the four functions of a health care system (as mentioned above), combined with the four key characteristics of primary care services that are part of service delivery, as derived from the above definition.

Fig. 2. Primary Care Evaluation Framework



What is the meaning of the four key characteristics of a good primary care system?

Access to services

In general, access to health services can be defined as the ease with which health care is obtained (6). Alternatively, it can be defined as "the patients' ability to receive care where and when it is needed" (7). There are various barriers of a physical, psychological, socio-cultural or financial nature that can restrict accessibility. Included in the PCET scheme are, for instance, geographical limitations (distance to and distribution of general practices = geographical access), and factors related to the organization of primary care practice (office opening hours, distant consultations, timeliness = organizational access), as well as the costs incurred by patients (cost sharing, co-payments = financial access).

Continuity of services

An important feature of primary care is that health care interventions should be geared to patients' health care needs over a longer period and cover successive episodes of care/treatment. A general definition of continuity is the

“follow-up from one visit to the next” (8). WHO provides a more comprehensive definition, which takes into account the (possible) involvement of various health care providers. It is described as “the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional continuity), or are an uninterrupted series of contacts over the long term (longitudinal continuity)” (7).

Several levels of continuity can be distinguished (9): first, informational continuity that relates to an organized body of medical and social history about each patient, accessible to any health care professional caring for the patient. Second, there is longitudinal continuity, which points to a specific locus where a patient customarily receives health care from an organized team of providers in an accessible and familiar environment. Third, interpersonal continuity, which is defined as an ongoing personal relationship between the patient and the care provider, is characterized by personal trust and respect (9). Furthermore, Reid et al. (10) add another level, namely, management continuity: the provision of timely and complementary services within a shared management plan. The PCET scheme includes informational, longitudinal and interpersonal continuity of care.

Coordination of delivery

Particularly because primary care is the entry point to health care and often serves a gate-keeping function to other levels of care, the coordination of services at primary care level is an important determining element in the responsiveness of health services provision and the health system as a whole. The potential for problems in coordination are particularly evident at the interface between primary and secondary care, or between curative care and other (public health) services in the field of health promotion (11). A general definition of coordination is “a technique of social interaction where various processes are considered simultaneously and their evolution arranged for the optimum benefit of the whole” (5). More specifically, it can be defined as “a service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and necessary and effective interventions, no more and no less. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination refers to the interlinkages among staff members and agencies over a longer episode of treatment (7). In the PCET scheme, the various dimensions of coordination encompass collaboration within the same primary care practice, within the same level between primary care providers (e.g. general practitioners (GPs), community nurses, physiotherapists, etc.) and between primary care and other levels of care through referral systems.

Comprehensiveness

Comprehensiveness can be defined as the extent to which a full range of services is either directly provided by a primary care physician or other provider or specifically arranged elsewhere (8). In the primary care setting, comprehensiveness refers to the fact that services comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention (11). The comprehensiveness of services is not only manifested in the specific range of services provided but also, and related to that, refers to

the practice conditions, facilities and equipment, as well as the professional skills level of the primary health service provider. In addition, the community orientation of primary care workers plays a role. All these dimensions have been taken into consideration for the PCET scheme.

The Primary Care Evaluation Scheme

Taking the Primary Care Evaluation Framework (4) as its basis, the Primary Care Evaluation Scheme focuses on specific issues, policies and health care priorities relevant to countries. The Scheme consists of measurable topics and items related to essential features and national priorities for change in primary care and the facilitating conditions. The Primary Care Evaluation Scheme, which in its turn forms the basis of the Primary Care Evaluation Tool (PCET), is structured as follows:

- stewardship
- financing and incentives
- resource generation
- delivery of primary care, subdivided into: accessibility, continuity care, coordination of care comprehensiveness of services.

Table 2 shows that, for every primary care (PC) system function, a number of key dimensions have been identified. Each dimension has, in its turn, been translated into one or more information items or proxy indicators for the dimension.

Table 2. Overview of selected functions, dimensions and information items

FUNCTION	SUBFUNCTION	DIMENSION	SELECTED ITEMS/PROXIES
STEWARDSHIP		Policy development	PC policy priorities
		Professional development	(Re)Accreditation system for PC
			Quality assurance mechanisms for PC
		Conditions for the care process	Laws and regulations
			Human resources planning
		Conditions for responsiveness	Involvement of professionals and patients in policy process
			Patient rights; complaint procedures
RESOURCE GENERATION		Workforce volume	Numbers and density
		Professional development	Role and organization of professionals
			Education in PC
			Scientific development and quality of care
		Professional morale	Job satisfaction
		Facilities and equipment	Medical equipment
			Other equipment
FINANCING and INCENTIVES		Health care/PC financing	PC funding
		Health care expenditures	Expenditures on PC
		Incentives for professionals	Entrepreneurship
			Mode of remuneration

		Financial access for patients	Cost sharing/co-payment for PC
DELIVERY OF CARE			
	ACCESS TO SERVICES	Geographical access	Distance to PC practice
			Distribution of PC physicians
		Organizational access	List size
			PC provider workload
			PC outside office hours
			Home visits in PC
			Electronic access
			Planning of non-acute consultations
		Responsiveness	Timeliness of care
			Service aspects
			Clinics for specific patient groups
	CONTINUITY	Informational continuity	Computerization of the practice
			Medical records
		Longitudinal continuity	Patient lists
			Patient habits with first contact visits/referrals
			Endurance of patient–provider relationship
		Interpersonal continuity	Patient-provider relationship
	COORDINATION	Cohesion within PC	PC practice management
			Collaboration among general practitioners/family doctors
			Collaboration of PC physician with other primary care workers
		Coordination with other care levels	Referral system/gate-keeping
			Shared care arrangements
	COMPREHENSIVENESS	Practice conditions	Premises, equipment
		Service delivery	Medical procedures
			Preventive, rehabilitative, educational activities
			Disease management
		Community orientation	Practice policy
			Monitoring and evaluation
			Community links
		Professional skills	Technical skills

In order to evaluate the complexity of any PC system, information is gathered on different (administrative) levels, and from the supply and demand sides, i.e. from health care providers and patients. Therefore, the Primary Care Evaluation Tool consists of three separate questionnaires:

- on the situation of primary care policies and structures at national level,
- for PC physicians/GPs, and
- for patients.

Together, the three questionnaires cover all identified primary care functions, their dimensions and information items, as derived from the scheme. The questionnaires for GPs and patients are pre-structured, with pre-coded answers. The questionnaire for the national level contains pre-structured and open ended questions on the health system, as well as a list on statistical data to be provided.

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