

Primary Health Care Advisory Group First Meeting Report



20 - 21 June 2017
Almaty, Kazakhstan



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WHO European Centre
for Primary Health Care

Division of Health Systems
and Public Health

20 - 21 June 2017
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Abstract

On 20–21 June 2017, the WHO European Centre for Primary Health Care hosted the first meeting of the Primary Health Care Advisory Group in Almaty, Kazakhstan. The event convened appointed members of the Primary Health Care Advisory Group as well as temporary advisers and guests with the aim of reflecting on two critical considerations: what should primary health care look like in 2030? What do health systems need to do to get there? This reflection was guided by the WHO European Framework for Action on Integrated Health Services Delivery exploring changing demands for acute and chronic care needs in primary health care and then priority avenues as gateways for transforming services in practice: primary health care and hospitals, long-term care and public health services. Primary Health Care Advisory Group members and moderators delivered presentations as champions on the sessions' topics. This report provides an overview of the meeting proceedings and discussions. The themes of these discussions are consolidated in a summary statement providing guidance towards a renewed vision for primary health care in the WHO European Region and will inform themes for the international conference celebrating the 40th anniversary of the Declaration of Alma-Ata in 2018.

Keywords

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Abbreviations

OECD	Organisation for Economic Co-operation and Development
PHC-PACT	Primary Health Care Performance and Capacity Tool
PHAMEU	Primary Health Care Activity Monitor
PHCPI	Primary Health Care Performance Initiative
TB	tuberculosis
WONCA	World Organization of Family Doctors

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About the Primary Health Care Advisory Group

Introduction

The concept of primary health care and its fundamental importance in strengthening health systems was first enunciated in the Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care held in Almaty, Kazakhstan on 6–12 September 1978. It expressed the need for urgent action to protect the health of all people through primary health care via universal health coverage, equity in health, use of appropriate technology, intersectoral collaboration and community participation.

Across WHO European Region Member States at present, there is a renewed commitment to uphold the vision of a primary health care approach. In 2012, the European Member States recognized strengthening people-centred health systems as one of four priority areas in the European health policy Health 2020 (EUR/RC62/R4), with transforming health services delivery among the top agenda items in doing so. A primary health care approach is also at the core of the global framework for integrated, people-centred health services (WHA69.24) and the WHO European Framework for Action on Integrated Health Services Delivery adopted in 2016 (EUR/RC66/R5), working to set priorities for key strategies and areas for taking action in transforming services, respectively. The Sustainable Development Goals also make explicit the role of health services delivery, calling for high-quality essential health services that are safe and acceptable to all people and communities.

This shared need to accelerate health system strengthening, with a focus on transforming health services delivery, has led to the establishment of the WHO European Centre on Primary Health Care in Almaty, Kazakhstan. The aim of the Centre is to provide evidence-informed policy advice to Member States for the continued development of primary health care in accordance with the values of the Declaration of Alma-Ata.



Background to the Primary Health Care Advisory Group

In 2016, following the approval of the European Framework for Action on Integrated Health Services Delivery, the WHO Regional Director for Europe established the Primary Health Care Advisory Group to support the continued advancement of primary health care. Through its annual meetings, the Primary Health Care Advisory Group intends to bring together renowned experts on primary health care and other relevant topics, alongside representatives of special interest groups to share their technical knowledge, experiences and perspectives to inform a future vision for primary health care. Specifically, it seeks to examine how primary health care must continually evolve, working towards integrated health services and people-centred health systems in the WHO European Region.

The core aim of Primary Health Care Advisory Group is to support Member States in strengthening health systems to inform a vision that innovates, transforms and champions primary health care and enables the Region to realize its greatest health potential. A key function of the Primary Health Care Advisory Group, therefore, is to provide advice for shaping a renewed vision of primary health care in the WHO European Region and to help advocate for and facilitate collaboration between all relevant sectors, partners and stakeholders.

Box 1

About the WHO European Centre for Primary Health Care

The WHO European Centre for Primary Health Care acts as a hub of excellence in primary health care and services delivery, setting out to ensure that the WHO Regional Office for Europe is equipped to work closely with Member States in their efforts to transform services delivery. The Centre is one of two specialized centres of the Division of Health Systems and Public Health; the other, situated in Barcelona, Spain, focuses on health system financing. The Centre works in collaboration with other technical programmes of the Regional Office and its country offices. The work of the Centre applies the framework of the European Framework for Action on Integrated Health Services Delivery, informing the specific themes of the Centre's work: populations and individuals, health services delivery processes, health system enablers and change management.

Members of the Primary Health Care Advisory Group play an integral role in keeping primary health care high on the international policy agenda and in promoting the importance of primary health care in current policies, including Health 2020, the European Framework for Action on Integrated Health Services Delivery, the Global Framework on Integrated, People-Centred Health Services and the commitments of the Sustainable Development Goals.

Objectives

The first meeting of the Primary Health Care Advisory Group was held over two days, 20–21 June 2017, at the offices of the WHO European Centre for Primary Health Care in Almaty, Kazakhstan. The meeting adopted a forward-looking perspective, challenging all participants to anticipate health needs and the continued evolution of health systems in order to speculate on the primary health care of the future. Its aim was to provide insight and guidance towards renewing a vision for primary health care that is fit for purpose while maintaining alignment with global and regional commitments.

Two key questions were posed to guide the meeting:

1. What should primary health care look like in 2030
2. What do health systems need to do to get there?

Outline

This report outlines the key discussions, conclusions and recommendations from this first Primary Health Care Advisory Group meeting. The proceedings of the meeting follow the sequencing of presentations and discussions held. The report first examines how the context for primary health care has changed with the significant shifts in population and individual needs across Europe and the implications of this for the demand for acute and chronic care. Priority avenues for integrated health services delivery, as gateways for transforming services in practice, then unpack the level of readiness of primary health care. Finally, recognizing that service delivery is resource-intensive, the meeting assessed the future primary health care workforce and methods for developing performance measurement. The concluding section combines the key messages throughout the event into a summary of cross-cutting themes. These key messages will be submitted to the Regional Director for consideration in putting forward a vision for primary health care in the Region.

Participants

All formally appointed members of the Primary Health Care Advisory Group are expected to participate in its annual meetings. Participation was also extended to experts on the meeting's topics as temporary advisers and invited guests. Annex 1 lists the participants.

“
**Rethinking
primary
health care
calls for a
spirit of
thinking
outside the
box.**
”

Juan Tello, Secretariat, Primary Health Care Advisory Group, Head of Office, WHO European Centre for Primary Health Care

elaborated and agreed upon. The topic champions were invited to prepare a synthesis of pertinent considerations that would facilitate the discussion.

In officially opening the event, the Secretariat challenged members to think outside the box. The space for creativity and collective brainstorming was given priority to push the boundaries of the present. This forward-looking perspective was considered essential to stay ahead of the change. This sentiment was carried throughout the meeting's proceedings.

Launch of the Primary Health Care Advisory Group

The WHO European Centre for Primary Health Care, as Secretariat to the Primary Health Care Advisory Group, officially launched its first meeting. In accordance with the terms of reference of the Primary Health Care Advisory Group, an official member is to oversee the discussions as an elected chair for the duration of the meeting. Anna Stavdal, President, World Organization of Family Doctors (WONCA) Europe, was unanimously appointed as meeting chair. Nick Goodwin, Chief Executive Officer, International Foundation for Integrated Care and member of the Primary Health Care Advisory Group, was appointed as meeting rapporteur.

In preparation for the meeting, Primary Health Care Advisory Group members were invited to champion topics highlighted in the event's programme. Together with the Secretariat, guiding questions for discussions were



Responding to needs

Anticipating the primary health care of the future in the European Region

Moderator: Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

The opening session looked at primary health care according to evolving health needs and the ever-changing context in which services are delivered. The Director of the Division of Health Systems and Public Health of the WHO Regional Office for Europe emphasized that good evidence demonstrates that health systems with strong primary health care tend to be more equitable and to deliver better health outcomes.

Nevertheless, during the past 40 years, models of care have continued to evolve as the context of care has changed. Across the 53 Member States of the WHO European Region, many innovations have sought to strengthen the role of primary health care, but progress is not universal and fragmentation in care remains commonplace.

In her opening address, the WHO Regional Director for Europe acknowledged that Health 2020 set out clear priorities to support countries, including strengthening people-centred health systems, investing in health throughout the life-course and tackling Europe's major disease burdens. To do so, Health 2020 emphasizes investing in the upstream determinants of health, including the social, environmental and behavioural risk factors.

The Regional Director also emphasized that Health 2020 is fully aligned with the objectives of the Sustainable Development Goals, with an aim to reduce premature mortality and improve life expectancy. Progress in both areas has been generally good across the European Region, but the momentum needs to be sustained. Sustainable Development Goal 3 seeks to ensure healthy lives and promote well-being for all at all ages and has several key targets, including universal health coverage, financial protection and access to care but also disease prevention,



1

Throughout this document, primary health care is defined as: the approach elaborated in the 1978 Declaration of Alma-Ata based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system for the delivery of services that are made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. Primary care describes a type of care and setting for health services delivery that supports first-contact, accessible, continued and coordinated care to individuals and communities. Refer to: Glossary of terms: English-Russian version; The WHO European Framework for Action on Integrated Health Services Delivery. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0020/318152/Glossary-of-terms-AIHSD-E-R-versions.pdf).

Box 2

The vision for primary health care of the Declaration of Alma-Ata

Primary health care is the “first contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”, stressing the comprehensive and intersectoral nature of primary health care and emphasizing health promotion, disease prevention, appropriate treatment of “common diseases” and public health measures for controlling infectious diseases.

Declaration of Alma-Ata, 1978

health promotion and rehabilitation. For example, Target 3.8 – achieving universal health coverage – calls for progress to be made in access to quality essential health services that are safe and acceptable to all people and communities.

Primary health care has a crucial role to play in this work. The vision for primary health care established by the Declaration of Alma-Ata in 1978 remains as relevant today as it was before (Box 2). However, the context within which primary health care operates has changed significantly (Fig. 1)¹. This includes a rapidly ageing population, an increased incidence of chronic conditions and multimorbidity, environmental, social and economic pressures and large-scale migration.

These changes have placed new demands on health systems to provide services that are proactive rather than reactive, comprehensive and continuous rather than episodic and disease-specific and founded on lasting patient–provider relationships rather than incidental provider-led care.

Collectively, these challenges make the primary health care agenda both more relevant and more urgent than ever. Further, this evolving context also brings several new opportunities. There is evidence for these changes across the Region, with the management of illness in the community and at home, the uptake of innovative drug treatments and therapies as well as new technologies enabling eHealth, mHealth and other remote applications for personalizing services in ways previously unimaginable.

Many countries across the European Region have shown an impressive ability and vision to ensure that their models of care react and adjust to changing health and

social needs. Action to strengthen primary health care within a system for integrated delivery is needed to enable the comprehensive delivery of quality services across the life-course, designed according to the population's and individual's multidimensional needs, delivered by a coordinated team of providers working across settings and levels of care, effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continually improve performance and to tackle the upstream causes of ill health and to promote well-being through intersectoral action.

Fig. 1. The new context for primary health care presents new challenges and new opportunities

Source: WHO European Centre for Primary Health Care, 2017.

In this new context for primary health care, the Regional Director recounted the known knowns: that is, what can be predicted as emerging health needs across several priority areas over the coming years (Fig. 2). These include, but are not limited to:

- the realities of aging populations, including the increasing old-age dependency ratio and greater prevalence of Alzheimer's and dementia;
- the growing challenge of chronic illness, especially including acute stroke and heart disease;
- the continued rise of issues related to injuries and addiction;
- the significant magnitude of multimorbidity and rise in the number of patients taking multiple drugs, demanding a heightened ability to identify risk factors and promote health and to prevent ill health (especially regarding environmental risk and obesity); and
- the growing burden placed on informal caregivers, who are predominately women and migrants facing undue health risks and who comprise the most rapidly growing vulnerable groups.

Fig. 2. Anticipating emerging health needs in the European Region



Source: WHO European Centre for Primary Health Care, 2017.

Moreover, in parallel to these changes in needs, the European countries can only be expected to continue to evolve in terms of overall context (Fig. 3). This includes for example: the use of innovative technologies, including information and communication technologies, that enable population health management and predictive risk modelling; the growth of remote and wearable health technologies enabling personal health monitoring; and the future use of artificial intelligence and genetic mapping. The continued decentralization of the organization and governance of health systems was also noted, and recent years have signalled the power of citizen activists and the public voicing demands for health transparency and participation. There are also trends towards local ownership in decision-making and an increasing role for public–private partnerships, which are expected to play an increasing role in providing services.

The Regional Director argued that the future requires having foresight to anticipate these changes, to adapt and evolve services delivery systems and to achieve transformation at pace. She emphasized that clear consensus exists on the critical need to challenge our current health systems on their readiness for the future through a “fundamental reinvention of the delivery model” to ensure that health systems and services delivery remain relevant.

The Regional Director concluded that the key to this agenda is upholding primary health care as the cornerstone of services delivery, yet also recognizing that it cannot deliver on services alone. Health transformations need to be sustained by intersectoral action to tackle the upstream determinants of health. Sustaining reforms requires partnerships and new relationships, as patients and populations are increasingly engaged and empowered – but also new forms of relationships between providers themselves as well as with local and regional authorities and national policy-makers. The success of life-course approaches and/or population-based interventions are implied to develop more sophisticated approaches to meeting future health and social demands.

Finally, the Regional Director challenged the Primary Health Care Advisory Group to focus on two key questions in their discussions.

1. What should primary health care look like in 2030?
2. What do health systems need to do to get there?

Fig. 3. The changing context of health services delivery: what does 2030 look like?



Source: WHO European Centre for Primary Health Care, 2017.

A modern agenda for primary health care: reflections from Kazakhstan

Alexey Tsoy, Vice Minister, Ministry of Health, Kazakhstan

In responding to the opening address, the Ministry of Health of Kazakhstan provided some reflections from Kazakhstan on what a modern agenda for primary health care might look like. A key element to progress is the ability to strengthen the availability of a wider range of services within primary health care settings: for example, extending screening (such as for tuberculosis (TB)); supporting self-care; offering electronic and telephone bookings; emphasizing prevention and diagnostics; ensuring patient registration; and providing drugs and other essential services that are free at the point of use. The future development of mandatory health and social care insurance to ensure universal health coverage has been a key part of this movement in Kazakhstan.

Within these investments, primary health care needs to remain accessible, and Kazakhstan has therefore favoured smaller primary health care centres close to the patients to reduce the ratio of general practitioners to patients from 1:2500 to about 1:1500. Evidence of reduced waiting times are seen as a success factor of this. One key innovation in Kazakhstan has been developing 49 mobile clinics supporting more than 300 000 people, plus three medical trains taking care to people living in rural and remote communities.

Another key to the future of primary health care in Kazakhstan is the importance to support effective chronic disease management and to work with patients using a

“rights and responsibilities” approach to promote solidarity, to boost self-help groups and, in doing so, to help to influence healthier lifestyles. Overall, the focus on primary health care, and developing the interface between primary health care and public health, has proven to bring tremendous changes.

A global perspective to primary health care

Edward Kelley, Director, Service Delivery and Safety, WHO

On behalf of WHO headquarters, the Director of Service Delivery and Safety began by reiterating the observation that the vital starting-point towards universal health coverage is the ability of people to access primary health care as the main entry point into the system. Primary health care was also credited with a key role in supporting prosperous and healthy communities. The mantra of “no universal health coverage without strong primary health care” remains a core message.

However, although much progress has indeed been made in the past 40 years since the Declaration of Alma-Ata, returning to the topic of the purpose and future of primary health care is important for several key reasons.

- **The global context of people-centred and integrated health systems.** Primary health care will be the essential route to support the creation of interdisciplinary teams that will be the bread and butter of future care provision. Primary health care in the future will not just be about doctors and nurses but also a wider care team that can have greater influence and partnerships with other sectors to, for example, support effective care transitions between care providers and work effectively with hospitals.
- **Measurement.** The reason that primary health care has perhaps not advanced in many systems as might be expected could be in part due to underinvestment in service measures and metrics to drive improvements in health performance. The ability to measure and track progress is necessary as a means to stimulate innovation and promote quality improvements in primary health care.
- **Knowledge base.** Countries need greater ability to share experiences, good practices and implementation challenges and to benchmark progress. To this end, WHO headquarters has initiated integratedcare4people.org as a means to support such conversations, and more will be required.
- **Overcoming silos.** In providing HIV, TB and child health services as well as other key areas, more needs to be done to overcome fragmentation and do things better for people and communities in a more integrated way. Integrating services at the front line, through primary health care, will be essential and should not be solely confined to key diseases.
- **Global health security.** In providing HIV, TB and child health services as well as other key areas, more needs to be done to overcome fragmentation and do things better for

people and communities in a more integrated way. Integrating services at the front line, through primary health care, will be essential and should not be solely confined to key diseases.

The Director concluded with the personal observation that the primary health care movement would have the opportunity to grow faster if two key issues were addressed: first, political commitment, in which the 40th anniversary of the Declaration of Alma-Ata will play an important role in accelerating this; and second, measurement, which enables greater transparency and accountability for primary health care.

Reflections on putting primary health care reforms into practice

Sophia Schlette, Health Systems Knowledge Management

How do we actually put primary health care in the driving seat? And why does it not happen? This intervention sought to unpack the elephants in the room to be addressed during the first Primary Health Care Advisory Group meeting and understand why, for all the positive evidence that exists to support it, primary health care often suffers from underinvestment in many health systems.

These key reasons were postulated as follows:

- politics and the competition that we do not quite see;
- the driving out of intrinsic motivations among health professionals;
- a lack of effective leadership;
- lack of investment, even disinvestment, in public health and disease prevention, with an inability to integrate such activities into primary health care;
- the lack of training of health professionals to promote primary health care and team-based approaches to care, resulting in current problems of developing multidisciplinary teams; and
- a failure to see and treat the whole person in the context of their family and community.

It was argued that the more successful primary health care-led systems tend to use a capitation-based model of funding, linking care to a specific community in contrast to fee-for-service or other forms of pay for performance. Funding systems need to build in the intrinsic motivations of professionals to do the right thing for their patients and the community rather than crowd out this behaviour and potentially demotivate people.

The example of Cuba was highlighted, where primary health care is underpinned by professional training that emphasizes the delivery of care outside hospitals through trained community health personnel who manage complex care needs in a holistic and humane way. Population health management and accountability for a provider's catchment area are emphasized. In Cuba, the population is stratified into four groups in advance: healthy people, people at risk, people who are acutely ill and people with chronic conditions or more advanced and debilitating stages of illness. This approach mirrors that of Kaiser Permanente in the United States of America but also low- and middle-income countries

that are putting population health management into practice.

It was also argued that more could be done to create spaces for interaction that examine in depth the problems, issues and challenges involved in implementing primary health care so that knowledge sharing is grounded in everyday realities. Specifically, the need to maintain a person-focused perspective was emphasized and to recognize, quoting Don Berwick, that “we are guests in our patients’ lives”.

Discussion

Following the opening presentations, the session moderator led a discussion among the Primary Health Care Advisory Group members and participants by reflecting on the challenges the speakers had presented that appear to have eroded, or set back, the values of the Declaration of Alma-Ata and the subsequent advancement of primary health care. During this round-table discussion, the Primary Health Care Advisory Group was asked to reflect on the underlying core challenges facing health systems in promoting primary health care in the future.

The key emerging themes of this discussion were as follows.

- **Importance of community**

One of the core strengths of the initial primary health care vision was its ability to help build social cohesion and, in doing so, to enable local communities to participate in health in a meaningful way. Through this, theories suppose that upstream investment through disease prevention, health promotion and first-contact care have significant and long-term benefits to people and enable sustainable health systems. However, there appears to be an underlying lack of trust, cohesion and uncertainty as to the value of primary health care. This may be attributable in part to changing contexts in which societal values no longer bring out strong communities and community leaders.

However, the future of primary health care will need this if it is to be effective, especially since the power of primary health care requires an intrinsic understanding of the wider public health context of the people that are being served. The shift towards a more transactional approach in managing patients (such as through choice and funding policies) as opposed to a public health approach means that health systems are at considerable risk of losing momentum towards having effective primary health care.

It was also stressed that it is important to have specific strategies for vulnerable communities such as those in fragile, conflicted states. Primary health care could be a means to build community bridges and promote social cohesion in these contexts in addition to providing essential services.

- **Stress person-centred care**

The mouse in the room is the lack of voice given to the individual. If primary health

care is really going to support a person-centred approach that empowers and engages people, then primary health care must enable individuals and communities to take control and be the prime movers in their own care. However, current health systems sit on the edge of the person-centred approach – often agreeing on its importance in principle but rarely embracing the approach in practice.

- **Address the motivation of personnel**

The motivation for professionals to work in primary health care settings, and the motivation of personnel already in primary health care to embrace new ways of working, were highlighted as causes for concern. Enablers for this are needed.

A key tension in supporting a vision for primary health care that promotes integrated care and team-based working is that the dynamics between health care and social care organizations, and between professional groups, are often very hard to reconcile. Different norms and values, the use of different professional jargon, the implications of job changes and skill mix and the need for behaviour change between professionals to promote joint activity are among the many barriers to joint working often present.

The conservatism of primary health care professionals (general practitioners) was highlighted as a key issue, especially their apparent resistance to modernize and change practices to embrace new ideas such as person-centredness, hours of operation and working with nurses and teams. It was suggested that new employment models for primary health care doctors may be needed.

- **Focus on implementation**

Participants highlighted that one of the key barriers in taking forward a renewed vision for primary health care is the lack of understanding of the key steps needed to help to develop and transform services delivery and ultimately, health systems. Although primary health care has good evidence to support it, practical examples of transformations might help others greatly in understanding the practicalities of this.

In concluding the discussion, the Regional Director urged that perhaps the key barrier to progress has been politics, since primary health care appears to work best in countries that have government support for the goals of universal health coverage, equity and improving population health. If primary health care is to be a route to Health for All, it also cannot be viewed isolated from other parts of the health system but integrated within it. Issues such as social cohesion, education and training, leadership and trust will underpin such efforts. It will nevertheless be important to keep arguments going that primary health care is a core mechanism to achieve universal health coverage.

Acute care needs in primary health care

Primary Health Care Advisory Group champion

Jan de Maeseneer, Chair, European Forum for Primary Care

In this first session focused on responding to needs, the Primary Health Care Advisory Group champion discussed how acute care needs might be supported or managed better through new forms of primary health care. As an initial observation, it was pointed out that primary health care deals with acute problems daily and plays a key role in providing first-contact care and a level of reassurance to people with perceived acute needs that their care will be managed and delivered through cost-effective interventions. To support this, investment in a well-functioning primary health care team should be given priority, with the aim of enabling the right decisions and dealing with 85–95% of new cases.

Primary health care is very well placed to assess acute episodes of chronic conditions in order to implement informed shared decision-making (such as through care planning), and since people present with growing multimorbidity and complexity, a paradigm shift is needed in thinking between disease-oriented care and goal-oriented care.

Other potential services that could be supported in primary health care include accidents and injuries (with the exception of trauma) and can be the base for emergency response, for example by paramedics. Primary health care in rural and remote areas, in particular, needs to have some advanced capacity to support short-term stabilization and safe and rapid transport when access to specialist support is distant.

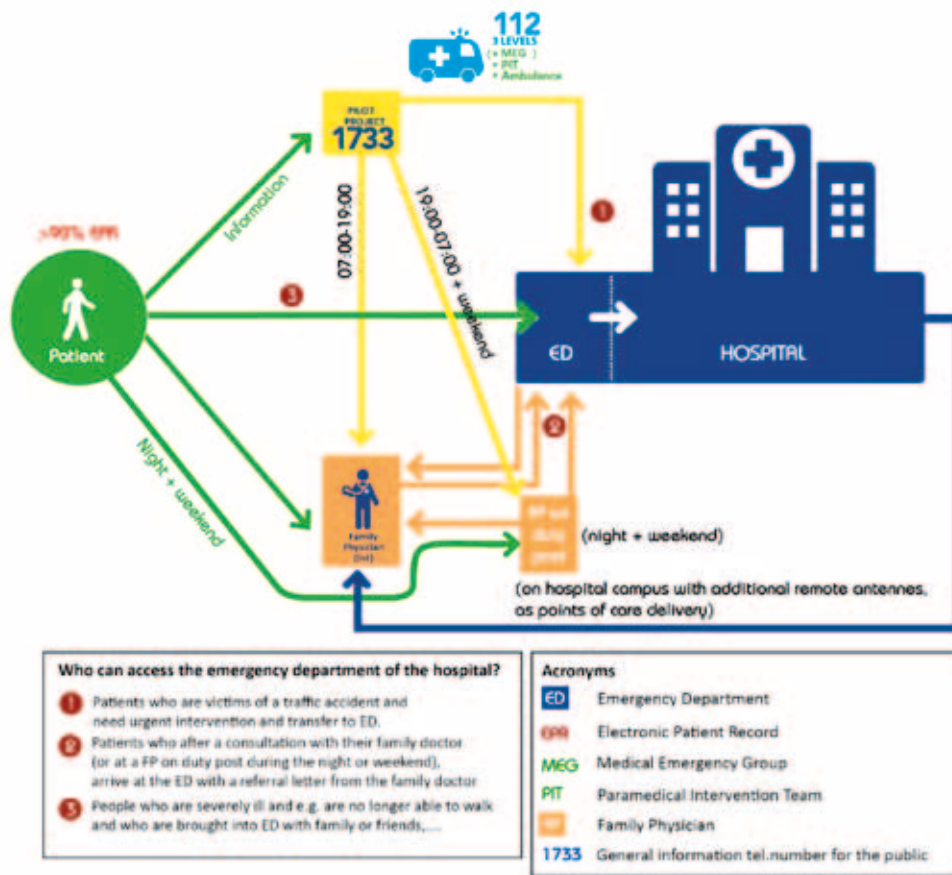
The Primary Health Care Advisory Group champion stressed that centralized gatekeeping and referral from primary health care to specialists is important to prevent overwhelming specialists with non-urgent cases and instead enable those with urgent care needs to be given priority. A registered list of patients is preferable. The move to 24/7 care with effective out-of-hours arrangements would help primary health care to support effective triage. In current systems, these points of weakness fuel unnecessary hospitalization and non-urgent visits. Having an effective approach to managing unplanned care therefore requires effective primary health care capabilities, efficient and safe care transitions and good working relationships with a range of partners (Fig. 4).

Supporting the management of acute episodes of care in primary health care therefore requires continuing improvements to clinical decision-making. This requires understanding patients' reasons for accessing care, knowledge of their care history and circumstances but also an important ability to understand the probability or acuity of their condition. This is especially important in the future context for primary health care, since providers are dealing with more complex needs and therefore require help in decision support as well as (algorithm-based) guidelines.

In terms of the organization of primary health care to manage acute care needs, competent care providers of the future would need to work on developing activated patients and communities who are knowledgeable about their own health and have the capacity to self-manage. Within practices, a team approach to care (especially nurse-

led care) will be essential, requiring task shifting from doctors to nurses to community workers to maximize the competencies and skills of the workforce.

Fig. 4. Model for organizing unplanned urgent care



Source: De Maeseneer J. Model for organisation of out-of-hours care. Internal discussion paper. Ghent: Ghent University, Department of Family Medicine and Primary Health Care; 2016.

Of key importance will be the ability of primary health care to remain the centre of continuity of care at the level of the primary care zone: in other words, to have responsibility for care in a specific jurisdiction and coordinate services effectively for that community with secondary and tertiary care through better defined and aligned accountability arrangements.

In conclusion, the Primary Health Care Advisory Group champion stressed the importance of the gatekeeping role in primary health care as a means to best manage acute care needs. The importance of relational continuity between providers and their patients was stressed, with a strong geographical focus and need for clear pathways for coordinating care effectively across different providers and contexts of care.

The ability to shift services, however, from hospitals to primary health care needs to be carefully thought through (such as through direct substitution) since the costs of such approaches, and the available workforce, might be prohibitive. A better way to manage people with acute care needs would be to regard primary health care as the centre of an integrated delivery system, underpinned by quality generalist care and with a role in effective care coordination and first response.

Discussion

The start of the discussion summarized the important point of the presentation, since the management of acuteness in primary health care was not the like-for-like transfer of hospital-based activities into primary health care settings (with some exceptions, such as minor surgery and diagnostic tests, outpatient and day care) but rather to act as a coordinating point for access to specialist advice and support for acute care needs.

However, it was pointed out that primary health care is often seen as an inferior alternative to specialist or hospital-based care for reasons that include: the perception of lower quality; a cost barrier to consultations; issues of access; and the lack of necessary contact to specialist expertise to reassure patients that they are safe and secure and are being looked after appropriately. The perception that excellence is the hospital, partly because people prefer to see specialists and want to bypass generalist advice, is a pressing issue.

It was perceived that the primary health care model needs to change so that it has a much more proactive role in urgent care situations, for example by reaching in to the emergency room departments and/or being co-located in hospital settings to act as a source of triage or to support out-of-hours care. This might be especially appropriate when hospital care is oversupplied or overused.

However, developing primary health care in hospital settings may potentially train people that going to the hospital is the first route to take for urgent and acute care needs when this could often be better managed in primary health care settings through appropriate gatekeeping. In this regard, it was perceived that gatekeeping may be too biomedical when faced with a broader palate of needs to be considered in strengthening the role of primary health care.

Several characteristics of primary health care for improving the management of acuteness were raised.

- **Acceptability.** The perceived quality and reputation of primary health care needs to be improved to reassure patients that this should be the first point of contact for acute care needs.
- **Availability and access.** The ability to access a network of primary health care services close to where people live and work, with an extended range of services, demonstrably reduces unnecessary activity in acute care settings. The value many people place on accessibility, speed of service and choice needs to be better understood, meaning that primary health care services need to be much more responsive.
- **Affordability.** Reducing any barriers to care through financial disincentives such as out-of-pocket payments for services, but also medicines.
- **Education.** There is a need to invest in health literacy, to ensure that people understand how to use facilities appropriately (this was considered difficult).

- **Team-based care.** Investing in team-based care, especially the advanced role for nurses in supporting the acute needs of people needing chronic care, managing prescriptions and supporting disease prevention holds known yet untapped potential. Evidence suggests that such approaches often increase patient satisfaction and can have a positive impact on costs of care.

It was reported that modern primary health care can often not meet these characteristics and that the continuity of care to patients has been compromised as a consequence. The ability to know and understand patients' needs and their families and have a trusted and ongoing relationship with them means that people are always less likely to go to a hospital compared with primary health care. However, the continuity of care is under threat through team-based, part-time, instant-access approaches to care that undervalue care continuity. People value relational continuity and will evade services that are fragmented or poorly coordinated care that is difficult to navigate.

In conclusion, a key issue for the future of primary health care is (re)building trust with the local population so that people will instinctively visit the primary health care centre in times of need. This requires investing in primary health care since the value you create = your outcome. This needs to encompass 24/7 primary health care provision, embracing all the four C's: accessible contact; service coordination; comprehensiveness; and continuity of care. In so doing, primary health care should be better positioned to effectively manage acuteness and offer a credible alternative to hospital services.

However, the public and political perception of health services appears to remain very pro-hospital. This is likely to be difficult to shift. One strategy might be to build primary health care facilities "in the image of the people" where they can experience and see first-hand the added value that primary health care offers. It was emphasized again that, in managing acuteness, appropriate gatekeeping (not just by general practitioners) is important and that long-standing personal relationships with patients and communities are necessary to build continuity in care.

Chronic care needs in primary health care

Primary Health Care Advisory Group champion

Jill Farrington, Coordinator, Senior Technical Officer, Division of Noncommunicable Diseases and Promoting Health through the Life-Course, WHO Regional Office for Europe

In this session, the Primary Health Care Advisory Group champion examined the role of primary health care in managing chronic care needs. It was described how, within WHO, nine key targets for reducing the prevalence of noncommunicable diseases were established and, in 2017, how the policy narrative shifted to integrate cost-effective noncommunicable disease interventions into the basic package of primary health care to advance the universal health coverage agenda. However, data suggest that the prevalence has continued to rise, especially for key diseases such as diabetes (Fig. 5). Moreover, initiatives for managing people with noncommunicable diseases have not been fully implemented across the Region for a range of reasons,

including time, money and perceived usefulness.

The future primary health care faces a greater complexity of cases, with people expected to have multiple chronic conditions. This presents a challenge to clinical practice, which has traditionally been established to be single-disease specific. Missing the need to manage complexity, alongside associated social care needs and issues related to independence, means that primary health care has to reform to be fit for purpose.

This raises a series of challenges for primary health care, considering the following tendencies:

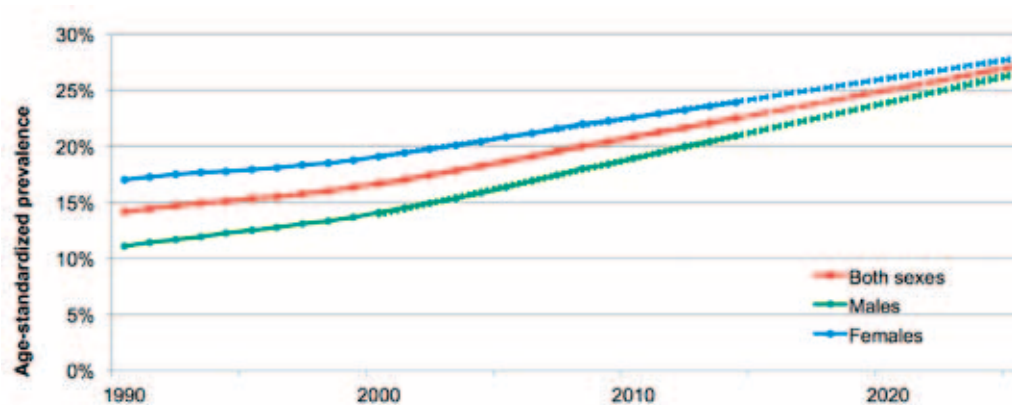
- chronic disease management in clinics that are often disease-specific, increasingly nurse-led;
- disease-specific guidelines, with compliance encouraged through pay-for-performance mechanisms;
- promotion of shared decision-making, patient-centred care and patient self-management when people have several or competing health problems;
- limited consultation time and inconvenience to patients; and
- tensions between fulfilling the patient's agenda and meeting quality targets.

Box 3

Diabetes: quick facts

- In the WHO European Region, 64 million people live with diabetes.
- The prevalence of diabetes in the European Region increased by 2 percentage points from 1980 to 2017 to 7.3%.
- Two fifths of people 20–79 years old with diabetes (23.5 million people) are undiagnosed in the European Region.

Fig. 5. Rising levels of obesity in the WHO European Region

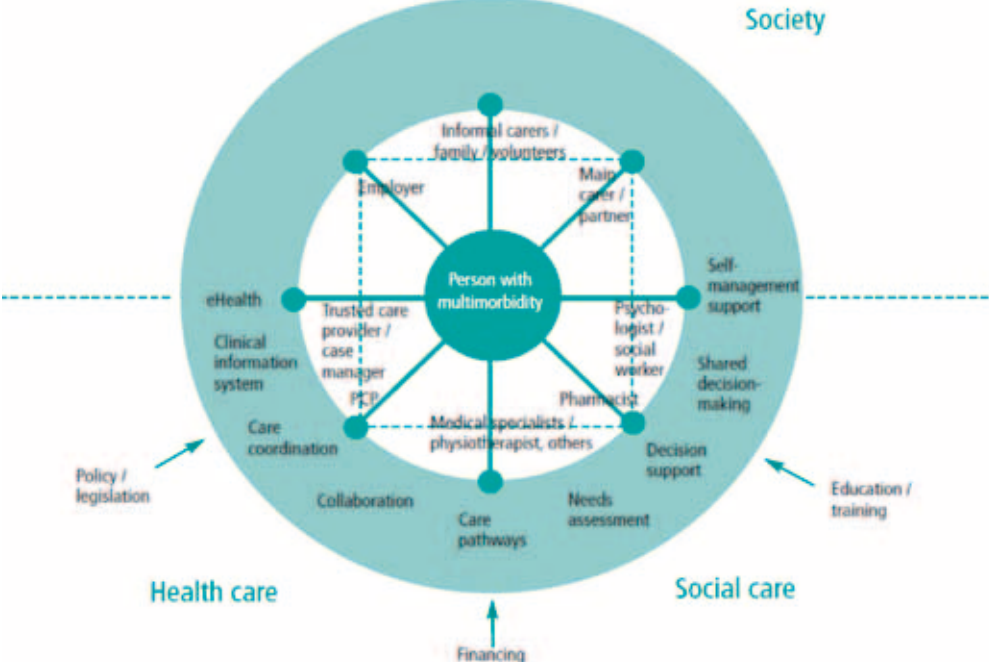


Obesity is defined as BMI ≥ 30 kg/m².

Source: WHO Regional Office for Europe, Health for All database, 2017.

Work has been initiated to challenge the single-disease mindset. For example, in the United Kingdom, the National Institute for Health and Care Excellence has developed national guidance on the clinical assessment and management of multimorbidity. Indeed, an increasing amount of work has articulated the need for a new model of care that develops a more personalized, comprehensive, continuity-of-care approach, especially in socioeconomically deprived areas (Fig. 6).

Fig. 6. Framework visualizing patient-centred integrated care for people with multimorbidity



Source: Rijken M et al. How to improve care for people with multimorbidity in Europe. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0004/337585/PB_23.pdf?ua=1).

However, despite this understanding of new approaches to primary health care that are needed to tackle chronic care and multimorbidity, key barriers were cited to include factors related to clinical practice, professionals, patients and populations and the system (Table 1).

Table 1. Barriers to implementing evidence-informed practice

The innovation (evidence-informed practice)	The adopter (professional)	The beneficiary (patient or population)	The system context
<ul style="list-style-type: none"> • Feasibility • Credibility • Accessibility • Attractiveness 	<ul style="list-style-type: none"> • Awareness • Knowledge • Skills • Attitude • Acceptance and beliefs • Motivation to change • Behavioural routines 	<ul style="list-style-type: none"> • Knowledge • Skills • Attitude • Compliance 	<ul style="list-style-type: none"> • <u>Social issues</u>: opinions, culture, leadership, collaboration • <u>Organizational issues</u>: structures, processes, staff, resources and capacity • <u>Economic and political context</u>: finances, regulations, targets and policies

Adapted from: Robertson R, Jochelson K. Interventions that change clinician behaviour: mapping the literature. London: The King's Fund; 2006 (<https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/Support-for-serviceimprovement-and-audit/Kings-Fund-literature-review.pdf>); Greenhalgh T, Roberts G, Macfarlane F, Bate P, Kyriakidou O. 2004. Diffusion of innovations in service organizations: systematic review and recommendations. *Millbank Q.* 2004;82(4):581–629 (<https://www.ncbi.nlm.nih.gov/pubmed/15595944>); Wallace J, Nwosu B, Clarke M. Barriers to the uptake of evidence from systematic reviews and meta-analyses: a systematic review of decision makers' perceptions. *BMJ.* 2012;2(5) (<http://bmjopen.bmj.com/content/2/5/e001220>); Cabana M, Rand CS, Powe NR, Wu AW, Wilson MH, Abboud PAC et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. *JAMA.* 1999;282(15):1458–65 (<http://jamanetwork.com/journals/jama/article-abstract/192017>).

The example of Kyrgyzstan was presented: long-term trends in the financial burden of health services increased for the population groups with the lowest incomes in its largest cities. Financial and geographical barriers to accessing primary health care, including payment for medication, had led to unaffordable care and the future need to control drug pricing.

Discussion

The discussion about the future of primary health care centred on the growing complexity of need in managing people needing chronic care because of rising multimorbidity, associated mental health issues and long-term challenges such as dementia, frailty, social isolation and social exclusion. There was consensus that a single-disease approach to chronic care management is unlikely to work, necessitating a move to more goal-oriented approaches.

One key approach the Primary Health Care Advisory Group identified was to focus much greater attention on public health interventions to promote health and prevent (or delay) the onset of complex chronic care. Hence, primary health care needs to have prevention at its heart, especially in engaging with communities with the most acute need.

New models of primary health care are also required for primary health care to use its role as a change agent to encourage and promote social inclusion and embrace a role in improving community health. Early identification and screening should be part of

this, but another focus is on health literacy and new strategies to engage and empower people in encouraging healthy behaviour. Emphasis was placed on the new role for the patient in co-producing their own care, with the skills and motivation to manage their health and their social issues in the context of their everyday lives.

The issue of patient compliance was raised, especially the lack of willingness of many people to engage with primary health care. However, the majority view was that patients should not be seen as the problem but that the model of care needs to find new (non-clinical) methods to engage people effectively and enable people to take more responsibility for their care in partnership with the health system.

Population health management focusing on promoting health, preventing ill health and encouraging healthy living and healthy ageing presupposes the integration of long-term care support alongside primary health care: for example, to promote home-based care and end-of-life care effectively. The ability of people to function, enjoy social participation and have a high quality of life should be considered important outcomes of effective engagement. Therefore, bringing public health, social care, schools, community groups, nongovernmental organizations, volunteers and other partners together to work with and alongside primary health care to deal with needs in their local neighbourhoods was a key message to be reinforced.

In conclusion, the Primary Health Care Advisory Group strongly advocated a population-health based approach to managing chronic care, with reorientation from a single-disease focus to managing complexity and supporting people's goals. Hot issues, such as mental health, need to be given priority to avoid the inequality of diseases, in which resources are focused on a few key diseases (such as diabetes). Patients, rather than being the subject of blame, should be regarded as assets since fully engaged patients lead to more effective results. Technological innovations should also be embraced to help manage chronic illness in primary health care.





Avenues for integrated health services delivery

Introduction

Drawing from the discussions on changing health needs, the following three sessions explored priority avenues for integrated health services delivery as gateways for transforming services in practice. These include:

- primary health care and hospitals;
- primary health care and long-term care; and
- primary health care and public health services.

Integration of primary care and hospitals

Primary Health Care Advisory Group champion Nigel Edwards, Chief Executive, the Nuffield Trust

The Primary Health Care Advisory Group champion opened the session by exploring the future relationship required between primary health care and hospitals in a more integrated health system. The emphasis was how the increasing number of people with complex care needs has led to greater expectations and demands for treatment. However, as hospitals have become more specialist-focused, there is a perceived problem in their ability to manage the whole patient, potentially heralding the need for the hospitalist role.

Parallel to this, the skills in primary health care to manage complex patients are limited and have not kept pace with the increasingly specialized and multiple needs of their patients. As a result, there has been a trend for the centralisation of some services into the hospital sector. Nevertheless, the policy intent in general seeks the opposite: to reduce hospital use and promote primary health care-based alternatives.

This dilemma is exacerbated by challenging contexts that, in many European countries, manifest in resource shortages, workforce and skills gaps, regulatory constraints (such as in extending the roles of nurses) and persisting legacy issues.



Hospitals can potentially support and strengthen the role of primary health care in several ways, including:

- enabling access to specialist advice and support to primary health care teams, for example via video, email and case conferencing;
- providing education and training to enable primary health care–based skills in managing people with acute complex illnesses;
- giving rapid access to diagnostics, such as X-ray, ultrasound and test results;
- enabling effective care transitions (such as from hospital to home); and
- changing how specialists organize themselves and where they work.

Ensuring success implies that hospitals need to operate with different business and operating models than usual. This might include developing their own population health or primary health care option (such as in Hospital Clinic Barcelona) or become more integrated with primary health care through forms such as accountable care systems.

Primary health care would need to adapt as well, including:

- investing in new facilities and competencies to support diagnostics or visiting specialists;
- developing wider teams that work with specialists and can better support people with complex care problems, including new roles such as care navigators, case managers and advanced care practitioners;
- standardizing approaches for the management of chronic conditions;
- using information technology infrastructure to promote information sharing; and
- growing the package of services offered, for example in medication management, therapy, counselling, welfare issues and community development.

To achieve this, primary health care would be required to work in much larger scale networks that could retain local access points but with shared or pooled resources to enable subspecialization, such as developing diagnostics, rehabilitation or other shared services.

Supporting integration between hospitals and primary health care would require significant system changes, such as ensuring the alignment of measurement, regulation and payment mechanisms that work to support and enable new approaches to care. Education and training to develop new types of health professionals and to rebalance

the specialist-to-generalist ratio would be important. Overall, it would require political will and a clear narrative on the benefits of change to both hospital and primary health care stakeholders.

Discussion

There was common sentiment that the lack of collaboration between primary health care and the hospital sector is a significant concern. Specifically, Primary Health Care Advisory Group members stressed how patients often felt at the cliff edge when transitioning between hospital and primary health care services because of the lack of coordination. Often, the relationship was one more of conflict rather than collaboration, with negative views held about the value of each other's role. For example, primary health care is often regarded as of poorer quality to specialist expertise within a hospital, and primary health care is most often horribly fragmented compared with the comparatively constant and secure hospital sector.

Issues of interprofessional education, cultural relationships, professional attitudes and competing business models are often at the heart of the problem. Even when primary health care has been given the power of budget-holding, this was not considered to have significantly strengthened their negotiating position with the hospital. Thus, the ability to strengthen primary health care will require changes in how hospitals operate so that they see their role as supporting primary health care in developing its capacity. Currently, however, the relationship between primary health care and hospitals too often perpetuates silos, with primary health care being very much the lesser partner in the relationship.

The Primary Health Care Advisory Group members recognized that the future for primary health care needs strong and effective partnership working with hospitals. Sustainable models of care require reduced hospitalization and better medication management, demanding better balance in investment between primary health care and hospital care, in which goals and aspirations for people's health are shared and having a stronger common purpose in the work are seen as important attributes. Significant potential for hospitals and primary health care to work more effectively together were highlighted to include:

- specialists working as consultants to the primary health care system;
- improved care transitions and coordination between primary health care and hospitals;
- development of intermediate care facilities to act as step-up and/or step-down care facilities to support rehabilitation and re-enablement; and
- more in-reach of primary health care professionals into the hospital to support care management and care coordination.

The more radical solution for the future of primary health care and hospitals is to bring their management and governance together into an integrated service delivery model. A part of this strategy would be an attempt to overcome the often competitive nature of the relationship between primary health care and hospitals in an attempt to refocus

priorities and strategies by, for example, ensuring that primary health care and hospitals are obligated to work together to benefit a specific geographical community. This suggests the need for a new integrated care mindset and to change the business model for both primary health care and hospitals to refocus their energies and strengths, for example, to new models of accountable care.

The Primary Health Care Advisory Group members drew several core conclusions.

- Primary health care requires the support of hospitals, and of specialists, to strengthen their activities.
- The relationship cannot be based on conflict and battle – a new working dynamic must be created.
- Primary health care needs to be provided at a larger scale with more enhanced capabilities. Nevertheless, it is an error to think that primary health care requires continual expansion into new service lines previously held within the hospital. Rather, the way such services are provided needs to be supported in partnerships that focuses on redesigning care.
- Hospitals themselves are changing and are potentially becoming more open to supporting primary health care in the future as a means to improve the sustainability of care provision more broadly. However, such changes are challenging culturally, professionally, financially and politically.
- The challenge of redesigning the relationship between primary health care and hospitals is a larger programme of transformation than we think, especially with regard to the future workforce.
- Many smaller, incremental steps for change might be more effective than a radical process of redesign. The aims and objectives of change need to be very clear in their long-term aspirations.

Integration of primary health care and social care

Moderator

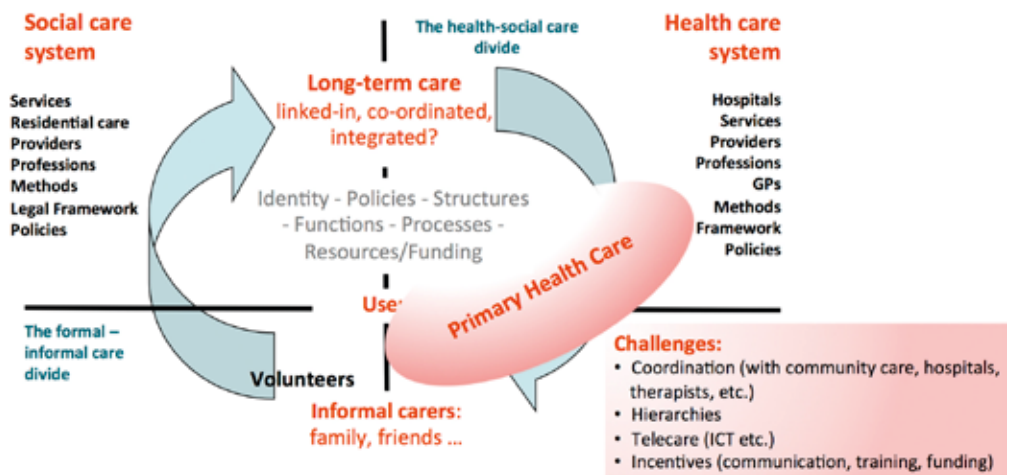
Kai Leichsenring, Executive Director, European Centre for Social Welfare Policy and Research

The session's moderator set out to examine the role of primary health care in the delivery of long-term care services, looking across the health and social care sectors, including the evidence on how services might best be delivered in primary health care settings. The session also aimed to examine what might constitute good practices in a future model of care and the consequences for transforming care systems to enable more integrated delivery of long-term care services between primary health care and other partners in care.

As outlined by previous speakers, people's future health and social needs mean that the future role of primary health care is becoming ever more complex. For example, there is

reason to foresee increasing demand and opportunity for primary health care to support such activities as dementia care, end-of-life care and long-term care for older people. Nevertheless, what is difficult to determine is the scope of the role of primary health care (in long-term care services) and understanding its meaning and future purpose. Fig. 7 shows the potential role of long-term care at the interface with primary health care.

Fig. 7. The role of long-term care at the interface between the delivery of health care and social care



Source: Leichsenring K et al. Vienna: European Centre for Social Welfare Policy and Research; 2013 (http://interlinks.euro.centre.org/sites/default/files/Grafik%20ltc_0.pdf).

The moderator outlined how patients and service users are often immensely puzzled by the health and social care system and frustrated by issues of fragmentation, poor coordination, lack of information and different approaches to issues such as financing. In the future, it will be important for such policies as the European Framework for Action on Integrated Health Services Delivery to adapt to the specificities of long-term care and articulate what this means for cares, informal support, workforce skills and how sectors engage with each other.

Key issues to be addressed in working to strengthen the integration of primary health care and long-term care include:

- mapping support needs across health and social care;
- supporting shared decision-making;
- working in partnership;
- promoting joint working between formal and informal caregivers;
- defining and recognizing new professional roles, such as case managers;
- organizing joint learning and training, such as primary health care and home care teams;
- sharing information between professional groups, such as information and communication technology and data access;
- improving medication safety and reducing medication errors; and
- sharing quality management methods.

Promoting change towards a more integrated health and social care response to long-term care needs is not a simple task. It will require establishing intersectoral networks, developing shared goals, building capacity in local teams, developing and improving a participatory organizational culture, enabling open debate and opportunities for cross-educational activity between stakeholders and examining opportunities for joint funding, including moving from a fee-for-service basis to one in which budgets are brought together (such as through shared savings).

Two examples of good practices were presented that included reablement services in Denmark and the buurtzorg model of home-based care in the Netherlands (Box 4). In each case, the delivery of services was designed around home-based care through small and well-trained (specialist) interdisciplinary teams that include a lead role for community nurses. Characteristics of the models include being based on primary health care, not having hierarchies in teams and substituting coaches and support for managers. In each case, the approach has supported holism, one of

Box 4

Two examples of good practices in integrating primary health care and long-term care

Reablement services in Denmark

Aim. Targeted, time-limited, person-centred, goal-directed interventions addressing loss of functioning. Safe, culturally sensitive, adaptable services in all health and social care contexts.

Approach. Services across all levels of care as an integral part of clinical practice guidelines delivered:

- in clients' homes (community setting);
- by multidisciplinary teams, including the effective use of assistive technology; and
- close collaboration between the health care system, allied health practitioners, care workers and family involved (not always clinician-led).

Results. Outcomes are measurable in different clinical domains and effectively integrated into existing clinical pathways.

Reinventing home care through the buurtzorg model in the Netherlands

Aim. Holistic home care provided by community nurses organized in autonomous teams.

Approach

- Activating all resources in the neighbourhood and close cooperation with primary health care.
- Shift from assessment to care planning and coordination.
- Managing the patient population: for example, if a team of 12 has more than 50 clients, a new team is established in the next neighbourhood.

Results

- Reduced costs with better quality (user and staff satisfaction).
- Lower overhead costs, less hours of care needed, delegation to primary health care.
- Intelligent application of information technology and the Omaha quality management system.
- Employer of the year.
- Growth from one team (2007) to more than 900 (2017).

the core concepts of primary health care. As a final discussion point, the moderator outlined several stages for health and social care integration to move from a situation of full segregation to one of integration (Table 2).

Virtual interventions

The European Patients' Forum stressed how the future role of primary health care would need to adapt significantly to meet the future challenges of long-term care. For example, many people with chronic care issues and multimorbidity are also likely to have long-term care needs. This requires better coordination but also far closer alliances with patients, especially carers, making up a core component of the potential service resources. Informal care is a significant yet undervalued resource in this regard.

Meeting participants argued the need to consider more about the role of primary health care and disease prevention, for example, in such areas as alcohol and tobacco consumption and poverty reduction. The role of primary health care working with the community to build social care interventions should be emphasized. There are also opportunities to capitalize on new technologies, on funding reform and on developing a new cadre of professionals with the skills to work across primary health care and long-term care.

Table 2. Stages of health and social care integration for long-term care

	Segregation	Linkage	Coordination	Integration
Design of care mix	Independent operation of sectors	Loose links around specific conditions or events (such as discharge)	Preventing and addressing health and social needs via complex packages of services spanning the health and social care sectors	Health and social care professionals provide person-tailored, comprehensive and continuous care
Organization of providers	Fragmented care between different levels and sectors, focus on specialist roles, fragmented health information	Links at points of transition between levels of care and sectors, specialist-centric, limited information exchange	Collaboration within and across levels of care and sectors, care coordinators, exchange of information	Fully integrated multidisciplinary teams between health and social sectors, unified points of access, full information sharing
Management of services	Decision-making and resource allocation are top-down and separated	Decision-making and resource allocation independent between sectors	Sectors maintain their independent identity; focus on quality of care and efficient use of resources across and within sectors	Shared goals and pooling of resources across sectors; population-based health and well-being
Continuous performance improvement	Quality of inputs Focus on workforce licensing, accreditation of facilities, operating standards	Quality of outputs Focus on standardization of practice through guidelines, supervision	Quality of processes Focus on quality assurance processes, care continuity, flexibility and feedback mechanisms	Quality of outcomes Focus on intermediate and final user outcomes, governance and user satisfaction
Support for informal care	Uncoordinated support or links with informal carers across the health and social care sectors separately	Awareness of informal carers but limited or no direct involvement in decision-making processes	Informal carers work together with care professionals and are consulted in decision-making processes; carers' needs are assessed and considered in the development of care plans	Full inclusion of informal carers in developing the needs assessment and care plan; appropriate and user-tailored support measures focused on carers' well-being (counseling and respite)

Adapted from: European Framework for Action on Integrated Health Services Delivery. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0004/315787/66wd15e_FFA_IHSD_160535.pdf).

The European Federation of Social Workers stressed the value of a social worker's contribution, especially in supporting long-term care and in providing psychosocial support to clients. The need for future models of care to have significant agility to respond to needs was stressed, since they constantly change in this area. Team-based working, the role of care coordinators and working across flexible boundaries with partners was also emphasized. Multidisciplinary teams need to be supported through education and training and even helped in developing new standards to support cooperation.

A representative from the Swedish Association of Physiotherapists emphasized that,

in managing people with long-term care needs, considerable flexibility in team-based working arrangements between a range of care professionals – a team without walls concept – is required to support people in accessing services and to enable these services to be well coordinated around their needs. This requires a culture of working together.

A representative from Eurocarers argued that there are over 100 million informal carers across the European Union who provide significant value in supporting people

“
**One
profession
isn't
enough;
we have
to do it
together.**
”

with long-term care needs and yet whose contribution is hidden or undervalued. Informal carers and their families bear about 50–90% of long-term care costs, which highlights that future models should better support informal carers with the information, counselling and training they need. Primary health care has a strong role to play in acknowledging the partnership role in long-term care with patients and informal caregivers, especially because they know their patients and their patients' principal carers and providers. Primary health care professionals therefore need to champion carers across the health and social care sectors, help them with their education and rights and support them with the resilience to cope and respond to their mental health needs. WHO fully recognizes the role of informal carers, but culture and mindset need to be changed.

Helena Papa, Executive Director, Swedish Association of Physiotherapists

In summing up, the moderator argued that the complexity of what primary health care

stands for can surely be grown and expanded, but this role needs to be fundamentally disentangled first. New roles for primary health care, whether in long-term care or other sectors, are being continually (re)considered and this produces the need to revisit the core role of primary health care to clarify common understanding. A future with integrated primary health care and long-term care requires an understanding that the doctor (general practitioner) is no longer central and instead sees roles for multiple professionals and delegating responsibility and authority to teams.

Integration of primary health care and public health services

Primary Health Care Advisory Group champion

Salman Rawaf, Director, WHO Collaborating Centre for Public Health Education and Training, Imperial College London

This session set out to examine the role of public health services within primary health care and, specifically, raise the potential importance of primary health care

Box 5
Primary health care and public health services: the example of healthy living centres in England

Healthy living centres in England were promoted through a strategy between 2000 and 2007. The policy represented a new way of working to support community health services through a more holistic approach to health. Most healthy living centres had a large and varied range of services that sought to address health inequalities in local communities from several different directions. The healthy living centres were separate from the rest of the care system, including general practice care and other community-based services such as district nursing. The approach was to provide a new source of services to deal with social, emotional and holistic health needs.

The activities of the various healthy living centres that were established across England included:

- giving health advice and care;
- teaching health skills to the local community;
- supporting self-help;
- providing emotional support;
- providing welfare advice and financial help; and
- tackling social isolation (and exclusion) by providing a range of social activities.

The evaluation of healthy living centres demonstrated that they successfully reached out to the more disadvantaged communities and those with the greatest health needs, although reaching such people had often been a challenge. Despite recognition of their achievements, the healthy living centre model did not see significant uptake.

moving towards a concept more akin to a community-based healthy living centre supporting population health. In this regard, the Primary Health Care Advisory Group champion argued that renewed primary health care does not necessarily mean providing health services themselves but mobilizing resources and assets to influence health outcomes. Implied in this is the concept of primary health care embracing the accountable care system approach in which localities and communities seek to integrate care under a single management structure to benefit local populations.

To support this, it was argued that a new platform for primary health care is required in which improving public health should be their central function. Primary health care working within and alongside the community to support improvements in population health would therefore be essential. The example of the healthy living centre initiative in England between 2000 and 2007 is a working example of such an approach that demonstrated positive outcomes (Box 5). Despite this, the initiative was ultimately short-lived because of lack of political support from the statutory sectors in what might be considered non-core business.

This raises the important point that public health too often remains on the sidelines of primary health care rather than fundamentally central to it as the Declaration of Alma-Ata originally envisaged. A renewed direction of travel for the primary health care movement should therefore aim to build on the successes in enabling universal health coverage and access primary health care but to gravitate now towards the fuller

vision for primary health care that was previously more far reaching. This requires a

commitment to Health for All and a primary health care model that values intersectoral collaboration and has public health – and the pursuit of improved population health in local communities – at the heart of that vision.

A population health-based approach will require new skills for assessing population health needs (including appropriate data) and mechanisms for working with the local community to establish priorities. It also recognizes the need for primary health care to be far more integrated into influencing the environmental and socioeconomic determinants of ill health. This includes, for example, taking a role in issues such as air pollution, climate change, urban design, water security, social stability and many other areas that ultimately influence health and well-being.

Primary health care by itself may not have the capacity to do this, so the fundamental question is what contributory role primary health care can play with other sectors and partners to achieve a whole. The movement towards accountable care organizations and systems in many parts of the world seeks to integrate the purpose and activities of this wider range of sectors and partners, including especially the community, in this way. Indeed, primary health care in many countries has begun to fully embrace its role in promoting public health.

Discussion

Primary Health Care Advisory Group members welcomed a vision that would see multisectoral partnerships working in and with local communities to promote public health and sustainability. However, a challenge was raised concerning existing perceptions of public health, and of population health approaches, since approaches are not seen as tangible with results (if any) being felt over a long time span. The reality, therefore, is that public health is being ignored as a component of primary health care and that the usual business of care in existing and traditional ways will continue. Changing how primary health care operates over time therefore meets considerable barriers related to the inertia inherent in established ways of working.

Another problem related to embracing public health in primary health care is the perception that primary health care might solve all problems. Although primary health care has significant potential as a way of improving population health, the current underinvestment in primary health care capacity (especially the workforce) would suggest that such ambitions remain unrealistic currently. Again, defining the role and expectations of primary health care will be important in the future, although a key role is implied to support community engagement and enable behavioural interventions that empower and engage people in their health. Every contact counts in primary health care, so using every opportunity to support public health activities is necessary. Nevertheless, as in the case of healthy living centres, lifestyle and preventive work is mostly disconnected from primary health care activities.

Primary Health Care Advisory Group members suggested that mapping how primary health care can help and inform the wider approach to population health management could be useful. Reflections considered that such an exercise was undertaken during

the 35th anniversary of the Declaration of Alma-Ata, where the overlaps between public health and primary health care were discussed. In this debate, a core role for primary health care in disease prevention, screening and health promotion was indicated. Moreover, the approach required the combined influence over the individual as well as population health in local communities. Such preventive activities happen every day in primary health care practice around the world, and this capacity would need to be enhanced in the future. The example of community health centres in Belgium was offered to illustrate this approach (Box 6). Promoting primary health care as a core part of a systemic approach to disease prevention and health promotion to defined geographical populations was considered the likely way forward.

Box 6

Primary health care in practice: community health centres in Belgium

Belgium's community health centres illustrate a community-based primary health care model in practice, working concretely to deliver a population-focused package of services. The centres emphasize universal accessibility, integrated person-centredness, comprehensiveness and being accountable for the defined practice population. The centres also emphasize a care team. The team of staff has grown to more than 10 disciplines, including family medicine, nurses, social workers, psychologists and physiotherapists.

Payment is based on a patient list, paid by integrated capitation that covers family medicine, physiotherapy and nurses. The rate is based on an electronic snapshot of the needs of registered patients. The contract is between the national social security system and the community health centres. The interdisciplinary component stimulates a comprehensive package of services but also task shifting and opportunities for better compliance. The payment model stimulates disease prevention and incentivizes quality improvement.

At the centres, nurses play a key role in after-hours care, but also home care services – combining work in the health centre and in the community. The community approach is best illustrated through initiatives that seek areas needing health improvements.

To address several risk factors for chronic conditions and high rates of periodontal disease, centres used focus groups to explore the use and understanding of oral hygiene as well as dental screening of children. In response, a campaign with dental students was launched as well as new practice for primary dental care at the centres. This effort illustrates the population focus of the centres and their proactive effort to improve health outcomes.

Spotlight session: primary health care workforce

Moderator

Ellen Kuhlmann, Senior Researcher

Institute for Economic, Work and Culture, Goethe University Frankfurt

In this first spotlight session, the moderator began by reporting on an ongoing research project exploring what a competent workforce might look like for primary health care in the future². The research encompassed case study investigations in several European countries (including Germany, Latvia, Spain and Sweden). A key conclusion of the study was the lack of reliable data to fully assess the nature of the primary health care

workforce and, moreover, that staffing levels, skill-mix composition, competencies and roles vary significantly across countries.

For example, in Spain, there was a professional culture of primary health care involving large multiprofessional teams and integrated provider organizations. Although primary health care was perceived to be underresourced, a community orientation promoting patient involvement and forms of multiprofessional education were driving workforce competencies. In Sweden, with a similar strong focus on primary health care, the bottom-up establishment of primary health care networks to connect multiple groups through education and training accompanied national and regional governance mechanisms to promote stakeholder engagement.

The conclusion from this research suggests that models of primary health care in Europe need to be expanded. More work needs to be done to actively involve patients, carers and communities, and improved governance and accountability are needed to bring together multiprofessional providers to support primary health care coherently. This research has also underscored the untapped role of professional associations and importance of tightening the link between these actors with the education sector.

Discussion

The Primary Health Care Advisory Group fully endorsed the need for developing workforce competencies, especially since the future of primary health care implies developing new roles and new ways of team-based working. A significant element of these competencies is related to a range of new communication skills: for example, the emotional intelligence to work in teams; the ability to engage as well as advocate and respond to patient needs; the ability to effectively communicate with partners in care; and the ability to embrace a culture of continuous learning and transparency in performance.

Hence, future workforce competencies require skills in enabling interprofessional and interagency working: social competencies that help to build the collaborative capacity required to deliver care effectively in the future model of primary health care. This may require increasing the number of hours of training within the workplace that professional staff receive to support competence growth.

The Primary Health Care Advisory Group was also keen to explore how the development of new workforce roles and competencies would be managed so that role delineation and task substitution activities would produce value in care. It was feared that such approaches often had a rather different motivation to lower costs and create technical efficiency. Attitudes and relationships between professionals are often seen to be in conflict, so addressing these issues would also be an important consideration.

The Primary Health Care Advisory Group agreed that there is a lack of a detailed understanding of the workforce skills and competencies required in the future primary health care within a model of integrated health services delivery. The WONCA tree was suggested as a possible starting-point to build these competencies (Fig. 8) as a

Langins M, Borgermans L. (2015). Strengthening a competent health workforce for the provision of coordinated/integrated health services. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/__data/assets/pdf_file/0010/288253/HWF-Competencies-Paper-160915-final.pdf).

developed set of core competencies for family medicine, a concept obviously closely aligned to the direction in which primary health care is moving. A contribution by the Primary Health Care Advisory Group to reducing that gap in knowledge was recommended.

In conclusion, there is a significant need to develop new workforce competencies across primary health care as its role and function adapts and changes. There may be very many ways to build an effective workforce across different contexts and settings, but one prerequisite would be to ensure that the process is developed with and alongside the local community, primary health care personnel and other stakeholders. This includes importantly the education sector, including medical universities and colleges, as key partners as part of the cycle of competencies consolidation³.

Fig. 8. The WONCA tree: core competencies of family medicine



Source: Allen J et al. European definition of general practice/family medicine. Ljubljana: WONCA Europe, 2011.

Spotlight session: primary health care performance initiatives

Moderator

Juan Tello, Head of Office, WHO European Centre for Primary Health Care Division of Health Systems and Public Health, WHO Regional Office for Europe

This final session of the Primary Health Care Advisory Group meeting included presentations and a panel discussion examining approaches to understand and measure the performance of primary health care. It brought together experiences from several frameworks being developed and adopted on primary health care to examine the common components and synergy across these initiatives.

The WHO European Primary Health Care Capacity and Performance Tool

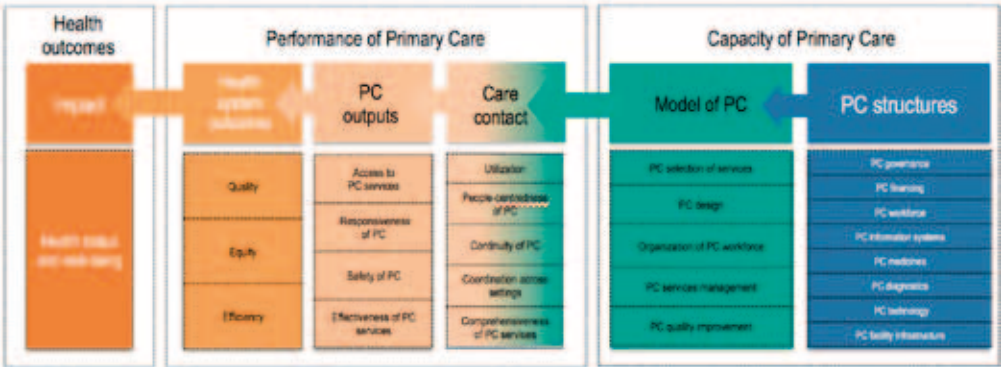
In the WHO European Region, the Primary Health Care Activity Monitor (PHAMEU) was among the first to evaluate the performance of primary health care across Europe and to analyse the determinants and consequences of a strong primary health care system. Funded by the European Commission and Netherlands Institute for Health Services Research, this project ran from 2007 to 2010. A monitoring framework was developed, drawing from existing tools and instruments, and international comparative data for 31 countries were collected and analysed.

At present, the endorsement of the European Framework for Action on Integrated Health Services Delivery has brought a commitment to intensify the measurement of services delivery based on existing data Region-wide. Due diligence to ensure that relevant indicators are reported and updated was set as the primary aim of monitoring implementation.

The Primary Health Care Performance and Capacity Tool (PHC-PACT) (Fig. 9) is the Regional Office’s response to strengthen the measurement of services delivery. The tool aims to understand the relationship between the capacity to provide primary health care across core structural and design components with its subsequent impact on performance and health outcomes, including how performance looks from the perspectives of patients, services and the health system.

This tool has been developed drawing from the PHAMEU exercise and together with the WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems, Academic Medical Center, University of Amsterdam. The PHC-PACT will initially be piloted in countries, and the goal is to collect and analyse data from Member States in 2018 to inform key messages at the 40th anniversary conference of the Declaration of Alma-Ata later that year.

Fig. 9. The framework of the Primary Health Care Performance and Capacity Tool



Note: PC=primary care
Source: WHO European Centre for Primary Health Care, 2017.

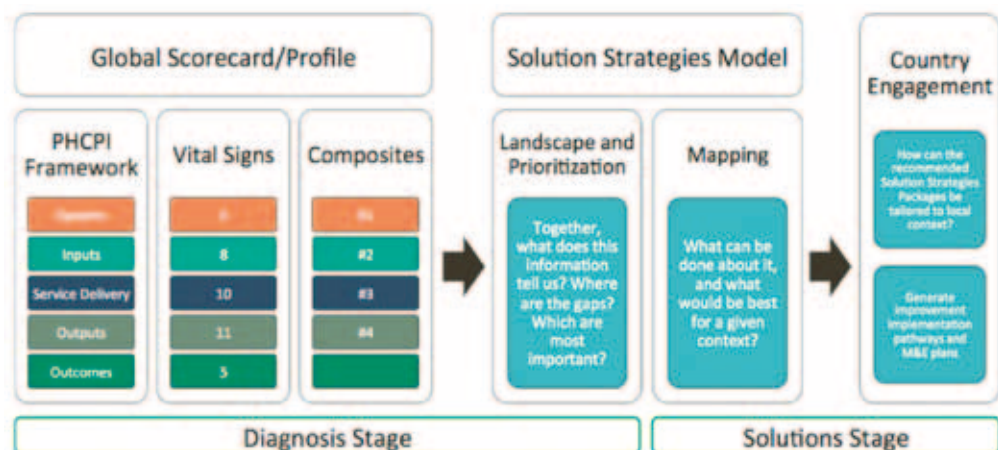
Primary Health Care Performance Initiative

The Bill & Melinda Gates Foundation, World Bank Group and WHO officially launched the Primary Health Care Performance Initiative (PHCPI) in 2015. It is designed as a partnership that brings together policy-makers, health system managers, practitioners, advocates and other development partners to catalyse improvements in PHC in low- and middle-income countries through better measurement and knowledge-sharing. The purpose is to enhance accountability and provide decision-makers with essential information to drive improvements. To make data actionable, the partnership will also provide a platform for countries to share lessons and best practices.

The ultimate goal of PHCPI is to accelerate investments and improvements in primary health care systems in low- and middle-income countries as part of the universal health coverage agenda. The proximate goal is to develop a global scorecard that depicts whether a country's primary health care system is getting stronger or weaker or is stagnant over time. Knowing this will enable countries, donors and other stakeholders to make more informed investment in strengthening primary health care systems (Fig. 10).

In brief, PHCPI aims to establish a conceptual framework that provides for a common definition of primary health care and its core components. It then seeks to ascertain the strengths of different health systems according to these core components, including: the extent to which health systems give priority to primary health care; whether sufficient capacity and capacity is available to support primary health care at all levels; whether services are delivered in an accessible and coordinated way; whether the primary health care system offers support across the life-course; and whether such approaches are delivering better outcomes for people and promoting equity in care.

Fig. 10. The approach of the Primary Health Care Performance Initiative



Source: Primary Health Care Performance Initiative, 2016.

Led by WHO, PHCPI will develop composite measures for each domain of the framework in 2017. These composites are designed to be simple, trendable measures of the performance of primary health care systems to understand whether the system is getting better or worse or is stagnant over time. Composites will be used to launch primary health care scorecards in early 2018.

Primary health care measurement by the OECD

The Organisation for Economic Co-operation and Development (OECD) presented its approach to measuring quality in primary health care. It triangulates evidence from existing data and analytics, country case studies and the sharing of best practices. The OECD framework for health-care quality recognizes three core domains: effectiveness, safety and patient-centeredness.

In terms of measurement, the OECD collates data related to:

- preventive care, such as vaccination and screening coverage;
- care for chronic conditions, such as indicators for diabetes management; and
- patient experiences, such as shared decision-making.

An ongoing area of work is the Patient-Reported Indicators Survey (PaRIS). In collaboration with international partners, uses patient-reported outcome measures (PROMs), patient-reported experience measures (PREMs), and patient-reported incident measures (PRIMs) approaches for people with specific conditions (e.g. cancer, hip and knee, acute myocardial infraction, cardiovascular disease and mental health) and complex needs (such as chronic illness and multimorbidity).





Summary statement

The first meeting of the Primary Health Care Advisory Group clearly finds that the vision of the Declaration of Alma-Ata of 1978 is as relevant today as it was now nearly 40 years ago. This is demonstrated by global, regional and national policies that have been developed in recent years to support the strengthening of health systems across the world, and in particular in the European Region, each continuing to uphold the vision of primary health care and reiterate its principles.

The changes driving the primary health care agenda and making it more relevant and more urgent than ever include in particular: the demographical and epidemiological changes resulting in more people living with chronic illness, demanding continuous but also acute care services; the magnitude of multimorbidities, increasing the number of patients taking multiple medicines requiring coordinated treatment plans; the impact of the determinants of health contributing to widening health gaps, including the growing burden placed on informal caregivers facing undue health risks; and the increasing disruption and fragmentation in society, requiring a strong contribution to more social cohesion. For each, primary health care has an important role to play.

In this context, realizing the potential of primary health care, as a vehicle to promote universal health coverage and universal access to services tackling those needs, demands a renewed vision. This vision for primary health care should set out to reinterpret the original aspirations of the Declaration of Alma-Ata in the context of current health needs and systems. In responding to the guiding questions of this first meeting of the Primary Health Care Advisory Group – what does primary health care look like in 2030, and what do health systems need to do to get there? – Primary Health Care Advisory Group members highlighted the following.



1. The future of primary health care is realizing an approach based on population health

Primary health care is not only about health coverage or access conditioned by out-of-pocket payments. It is also, and fundamentally, about improving population health. Future health needs signal clearly the demographic burden of disease and illness will require a focus on outcome-oriented rather than disease-oriented care. A population health approach adopts this focus, with improvements in the health status of the population as its ultimate goal.

Primary health care as an approach based on population health calls on primary health care to promote health and prevent or delay the onset of complex chronic care by tackling the upstream causes of ill health from the perspective of the population. This approach also calls for a focus on well-being in primary health care, ensuring a response to trends that anticipate rising multimorbidity and the associated mental health issues and the long-term impact of diseases on functioning and social participation.

Putting population-based primary health care into practice challenges primary health care to build bridges with the community and to promote cohesion between services for healthy living and ageing. It requires that primary health care also manages unplanned care and fosters access to and support for people when they have acute care needs. This will require more intensive coordination between public health and primary care services. It also requires primary health care to have an intrinsic understanding of the wider context of the population it aims to serve. This includes understanding and responding to changes in the societal norms, migration and multi-ethnicity.

2. Primary health care plays a pivotal role in strengthening accountability for outcomes

Accountability is central to realizing an approach based on population health. It is becoming increasingly vital to foster accountable systems for health in order to ensure that the full range of health providers, communities and individuals and other health actors work together with the common purpose of improving

outcomes. Primary health care is well positioned to facilitate this accountability in services delivery because of its fundamental alignment with the development-oriented goal of tackling the determinants of health. Primary health care, thus, plays a pivotal role in strengthening accountability for health outcomes.

Realizing this accountability requires overcoming the current institutional and financial boundaries between primary health care and other types of care. There is also need for clear agreement on the preferred model of care for the population to address health needs to different types of services. Primary health care is where new health problems should be presented (except for life-threatening emergencies) and a linear referral system provides continuity across levels of care. In the case of chronic conditions, this model requires adjustment. A 'spiral referral' ensuring patients are taken care of in an interprofessional team and regularly will also be seen in secondary, and when needed, even in tertiary care, is more appropriate.

This accountability starts with a defined list of the population primary health care serves through a practice-based patient-list or a territorially defined population. Building clear lines of accountability between and across actors will be required to support working relationships that anticipate and manage future demands, and ultimately, realize shared accountability for health outcomes. Shared accountability includes also the role of individuals, their families and communities.

3. Primary health care is part of an integrated health services delivery system

In responding to changing health needs, the scope of primary health care has become increasingly fluid and the expectations of what primary health care should deliver on have extended. To respond to changes with a population health based approach, a shift is needed towards primary health care that embraces its role as part of an integrated health services delivery system. That means looking to what roles are being added to primary health care, to disentangle what this means for patients and for the performance of the health system in its entirety.

Integrated primary health care will require primary health care to solidify its capacity to provide locally accessible services and comprehensive services that, for example, provide rapid access to diagnostics and enable both the urgent and chronic care needs of people be met. It also requires that primary health care take on a stronger role as the centre of care coordination and continuity and for strengthening community resilience to tackle upstream determinants of health, maintain and manage health and improve overall well-being.

Doing this will require intensified coordination with hospital care, social care and public health services but also other community services, such as mental health and palliative care, and with other sectors. Integrated health services should encourage that vertical programmes, including disease-specific programmes, are developed, integrated and implemented in the context of primary health

A description of developmental stages of services delivery accompanies the WHO European Framework for Action on Integrated Health Services Delivery. The continuum described allows countries to tailor the strategies and adapt actions based on their status along the stages identified. For the characteristics of health services delivery by developmental stage, refer to: European Framework for Action on Integrated Health Services Delivery. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0004/315787/66wd15e_FFA_IHSD_160535.pdf).

care. Investments required will include new approaches to team-based care and new workforce skills and competencies within primary health care and a more effective model of integration with other sectors. This has significant implications for hospitals and specialists treating common chronic diseases. It presupposes a different and more dynamic engagement with local communities, informal carers and individuals as a means to engage, empower and use their strengths and assets to promote value in services delivery. The interface with the social sector will also become increasingly important as part of an integrated health services delivery system.

4. Incremental yet transformative changes are needed in services delivery

The changes towards improved health outcomes need to start in services delivery as here there is clearly room to manoeuvre in the provision of care to accelerate new models into practice. These changes can start incrementally and are already in practice as new facilities, wider teams, larger networks, for example, are taking place across the WHO European Region.

To maintain this bottom-up innovation, national health authorities need to create enabling conditions and accurate, integrated and comprehensive financial incentives. This includes encouraging a responsible clinical practice and governance that embraces the possibility to implement new models of care in a context of trust and accountability rather than punitive arrangements. The conditions should also be in place to incentivize the early adoption of innovations like new digital forms of reporting and technologies for improving self-care.

The benefits of transformations initiated by services delivery systems underscore recurrent themes of trust, motivation, shared leadership and shared management. Early implementation of changes is an investment in building social cohesion in communities, offering individuals meaningful ways to participate in their health locally but also in minimizing professional tensions and traditional thinking that embeds attitudes and behaviour through a sense of ownership of experience and practice.

There is no single blueprint to this process of transformation. Rather, a continuum of transformations is thought to, allowing countries to recognize their systems along a gradient from conventional to disease-oriented care to coordinated services and ultimately, integrated services⁴. Along this continuum, it is clear it will be important to ensure opportunities for creating an environment that encourages learning loops, education and training to support the future workforce competencies and to invest in the capacity to manage primary health care. Addressing the challenges of low professional prestige and lack of public trust in some countries rely on this investment in competencies.

5. Policy foresight and the system's commitment to primary health care capacity and performance are necessary to realize sustained transformations

Given these fundamental challenges, transformational change is required to bring in new business and operational models. This means ensuring that transformations in services delivery are fully backed and supported by system inputs, arrangements and overall capacity that are congruent with new models of care with view to optimizing performance.

Specifically, sustaining transformations necessitates aligning health system conditions to match: new ways of providing health and social services; regulations that overcome silos of clinical practice; resourcing services with a workforce that has the profile, scope of practice and competencies, including generalist competencies, that correspond to new types of services; and incentives that pay for health outcomes.

A wider social awareness of the long-term vision for health systems will be important to ensure sustainability over time. Importantly, the success of transformations will also hinge on effectively managing changes. Managing change successfully can benefit from drawing on lessons of early practices and innovation.

In conclusion, a vision for the future primary health care articulated by the Primary Health Care Advisory Group centres on the role of primary health care as coordinating hub of an integrated health services delivery network functioning in partnership and being jointly accountable with other providers, other sectors, individuals and the local community to improve population health outcomes.

The future primary health care envisaged fully embraces the spirit of the Declaration of Alma-Ata. The aspirations of primary health care to support intersectoral action, to build resilient communities, to coordinate first contact care and to promote health for all people remain equally relevant today.

Building on the vision of the Declaration of Alma-Ata there is an unfinished agenda to realize primary health care in ways that puts people at the centre and upholds a commitment to population health. Primary health care needs to develop its capacity to respond to this vision.



Annex 1

List of participants

Alphabetical order

Members of the Primary Health Care Advisory Group

Yelzhan Birtanov

Minister and Honorary Permanent Member of the Primary Health Care Advisory Group
Ministry of Health of Kazakhstan

Masoud Dara

Coordinator

WHO Regional Office for Europe

Jan De Maeseneer

Chair

European Forum for Primary Care

Nigel Edwards

Chief Executive

Nuffield Trust

Jill Farrington

Coordinator and Senior Technical Officer

WHO Regional Office for Europe

Ian Forde

Senior Policy Analyst

Organisation for Economic Co-operation and Development

Pascal Garel

Chief Executive

European Hospitals and Healthcare Federation

Nick Goodwin
Chief Executive Officer
International Foundation for Integrated Care

Usman Khan
Director
European Health Management Association

Salman Rawaf
Director
WHO Collaborating Centre for Public Health Education and Training, Imperial
College London

Valentina Sarkisova
Chair
European Forum of National Nursing and Midwifery Associations

Anna Stavdal
President
World Organization of Family Doctors Europe

Hernan Julio Montenegro von Mühlenbrock
Coordinator
World Health Organization

Temporary advisers and guests

Ellen Kuhlmann
Goethe University Frankfurt

Maksut Kulzhanov
Republican Medical Chamber of Kazakhstan
WHO Executive Board

Kai Leichsenring
European Centre for Social Welfare Policy and Research

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Health Systems Knowledge Management

Alexey Tsoy
Ministry of Health, Kazakhstan

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Ministry of Health, Kazakhstan

Michael Van Den Berg
Academic Medical Center
University of Amsterdam

Ethan Wong
Bill & Melinda Gates Foundation

Remote commenters

Marco Greco
European Patients' Forum

Anna Lima
European Federation of Social Workers

Helena Pepa
Swedish Association of Physiotherapists

Stecy Yghemonos
Eurocarers, European Association Working for Carers

World Health Organization

Headquarters

Edward Kelley
Director, Service Delivery and Safety

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João Breda
Head, WHO European Office for Prevention and Control of Noncommunicable Diseases

Renata Brunner
Secretary, Division of Health Systems and Public Health

Zsuzsanna Jakab
Regional Director

Arnoldas Jurgutis
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Connie Petersen
Programme Assistant, WHO European Centre for Primary Health Care

Altynai Satylganova
Consultant, Health Services Delivery Programme

Juan Tello
Head, WHO European Centre for Primary Health Care

Evgeny Zheleznyakov
Technical Officer, WHO European Centre for Primary Health Care

Country Office in Kazakhstan

Tatiana Kolpakova
Head of Office, ad interim

Interpreters

Olzhas Galymzhan

Timur Nurpeissov

Batyrkhan Zhulamanov

Annex 2 Programme

Tuesday, 20 June 2017

11:00 - 12:00 Registration and networking lunch

12:00 - 12:30 Launch of the Primary Health Care Advisory Group

Moderator

Juan Tello, Head of Office, WHO European Centre for Primary Health Care, Division of Health Systems and Public Health, WHO Regional Office for Europe

Election of meeting chair

12:30 - 14:00 Opening addresses

Moderator

Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

A modern agenda for primary health care: reflections from Kazakhstan

Yelzhan Birtanov, Honorary Permanent Member of the Primary Health Care Advisory Group, Minister of Health, Kazakhstan

Anticipating future challenges and taking up innovations in the WHO European Region: is primary health care ready?

Zsuzsanna Jakab, WHO Regional Director for Europe

Interventions

- **Edward Kelley**, Director, Service Delivery and Safety, WHO headquarters
- **Sophia Schlette**, Health Systems Knowledge Management

Discussion and general debate

14:00 - 14:30 Break and group photo

14:30 - 16:00 Responding to needs. 1. Acute care needs in primary health care

Primary Health Care Advisory Group champion

Jan De Maeseneer, Chairman, European Forum for Primary Care

What is the responsive capacity of primary health care for acute care needs?

- What role could primary care play in responding to accidents, injuries and acute episodes of chronic disease?
- How can the threshold of acute care services – from short-term stabilization, pre-hospital care, urgent care to emergent care – be raised to increase the role of primary care in acute care responses? What services can be managed in primary care?

Moderated discussion and general debate

16:00 - 16:30 Break

16:30 - 17:30 Responding to needs. 2. Chronic care needs in primary health care

Primary Health Care Advisory Group champion

Jill Farrington, Coordinator and Senior Technical Officer, Division of NCDs and Promoting Health through the Life-Course, WHO Regional Office for Europe

How well does primary health care actually manage chronic care needs?

- What new or increased chronic care demands will primary care face in the future?
- Given the changing needs, what role can primary care play in managing this demand? What are its current strengths and limitations?

Moderated discussion and general debate

Wednesday, 21 June 2017

9:30 - 10:30 Avenues for integrated health services delivery: primary health care and hospitals

Primary Health Care Advisory Group champion

Nigel Edwards, Chief Executive, the Nuffield Trust

How can primary health care and hospital integration be strengthened?

- What is the role of district and first-referral hospitals in a renewed scope of primary care?
- What is the future of narrow specialists? What working methods can support the primary care workforce in working together with narrow specialists?
- What diagnostic and treatment capacity is required in primary care to manage acute and chronic care needs? What organization does this presuppose for primary care and laboratory services? Primary care and pharmacists?

Moderated discussion and general debate

10:30 - 10:45 Break

10:45 - 11:45 Avenues for integrated health services delivery: primary health care and long-term care

Moderator

Kai Leichsenring, Executive Director, European Centre for Social Welfare Policy and Research

- What is the role of primary care in the delivery of long-term care services across health and social sectors? What is the evidence on the services that can and should be delivered in primary care?
- What are key considerations for delivering long-term care across health and social care sectors? What are good practices in an integrated approach to long-term care?
- How can services delivery as well as health and social systems in general be transformed and adjusted to enable the integrated delivery of long-term care services?

Virtual interventions

- **Marco Greco**, President, European Patients' Forum
- **Helena Pepa**, Executive Director, Swedish Association of Physiotherapists
- **Stecy Yghemonos**, Executive Director, Eurocarers, European Association Working for Carers
- **Anna Lima**, President, European Federation of Social Workers

Moderated discussion and general debate

11:45 - 12:00 Break

12:00 - 13:00 Avenues for integrated health services delivery: primary health care and public health services

Primary Health Care Advisory Group champion

Salman Rawaf, Director, WHO Collaborating Centre for Public Health Education and Training, Department of Primary Care and Public Health, Imperial College

- What is the future role of healthy living centres or similar public health community-based structures? What role can primary care play in delivering these services?
- What is the future of population health management given the advances in technology, data and information management?
- What is the role of primary care in responding to new environmental challenges?

Moderated discussion and general debate

13:00 - 14:00 Lunch

14:00 - 15:00 Spotlight: primary health care workforce

Moderator

Ellen Kuhlmann, Senior Researcher, Institute of Economic, Work and Culture, Goethe University Frankfurt

How can the responsiveness of the primary care workforce be improved?

- What competencies will be required of the primary care workforce in the future?
- How can stakeholder involvement be strengthened for various models of providing primary care?
- What are other effective policy levers to mobilize a people-centred primary care workforce?
- What new research and data are needed?

Moderated discussion and general debate

15:00 - 15:15 Break

15:15 - 16:30 Spotlight: primary health care performance initiatives

Moderator

Juan Tello, Head of Office, WHO European Centre for Primary Health Care, Division of Health Systems and Public Health, WHO Regional Office for Europe

Panel discussion

- **Primary Health Care Performance Initiative (PHCPI)**
Ethan Wong, Program Officer, Integrated Delivery Division, Bill & Melinda Gates Foundation
- **WHO European Primary Care Capacity and Performance Framework and the Primary Health Care Activity Monitor**
Erica Barbazza, Technical Officer, WHO European Centre for Primary Health Care, Division of Health Systems and Public Health, WHO Regional Office for Europe
Michael van den Berg, Senior Researcher, Academic Medical Center, WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems
- **OECD primary health care measurement**
Ian Forde, Senior Policy Analyst, Health Division, Organisation for Economic Co-operation and Development

Moderated discussion

- Where is there synergy in the frameworks described?
- What are the common components and measures across each framework?
- How are the target countries similar and how are they different?
- How do the various initiatives relate to the Sustainable Development Goals?

16:30 - 17:00 Consolidation of recommendations

Moderator

Primary Health Care Advisory Group meeting chair

- **What are the next steps leading up to the 40th anniversary of the Alma-Ata Declaration?**
Juan Tello, Head of Office, WHO European Centre for Primary Health Care, Division of Health Systems and Public Health, WHO Regional Office for Europe
- **Summary of key messages and discussion highlights**
Meeting rapporteur
Nick Goodwin, Chief Executive Officer, International Foundation for Integrated Care
- **Final reflections**
Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

17:00

Closing

The WHO Regional Office for Europe

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