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WHO Regional Office for Europe meeting on strengthening primary care contribution to the prevention and control of non-communicable diseases

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ABSTRACT

WHO/Europe is developing a new framework instrument to assess how effectively non-communicable diseases are managed in primary care, in collaboration with the Netherlands Institute for Health Services Research.

WHO/Europe presented a draft report on the issue – giving an overview of the available evidence and views expressed in international policy papers, and describing the first steps in developing such an instrument – at a meeting in Amsterdam, the Netherlands on 25–26 January 2012. At the meeting, representatives of 37 Member States in the WHO European Region discussed their experience with tackling non-communicable diseases and ways to further develop the tool.

The instrument aims to assess primary-care performance and gaps in relation to health promotion and the prevention, management and care of cardiovascular diseases and diabetes mellitus. It focuses on evidence-based interventions that can be used in primary-care settings throughout a person's lifetime.

Keywords

CARDIOVASCULAR DISEASES
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Introduction

The meeting was hosted by the Government of Netherlands. Mr Fred Lafeber, Head of Global Affairs Ministry of Health Government of the Netherlands, opened the meeting by emphasizing the good collaboration with WHO and the Government of the Netherlands, and in particular the knowledge institute NIVEL.

He indicated that the Netherlands has a special approach towards prevention. The current Ministry of Health emphasized the responsibility of people for their own choices, rejecting interference in personal autonomy. Also emphasized were training and education in, and providing easy choices for, healthy behaviour. The Minister of Health has eliminated the so called "cessation of smoking program" relating to tobacco from the basic benefit package since the first of January 2012.

The health situation in the Netherlands was generally good. Life expectancy was relatively high, and unhealthy behaviour had been stabilized. However prevalence rates of non-communicable diseases (NCDs) were still too high, especially among women (largely due to smoking). There was an increase in the prevalence of chronic illness.

Background

Where are we with the PHC in the WHO European Region[1]

The current health system pressures, particularly the ageing population and increasing co-morbidities, require accelerated efforts to strengthen the primary health care (PHC) orientation of health systems. From the Declaration of Alma-Ata, whose values and principles are as valid today as they were more than 30 years ago, to the recommendations of the WHR 2008, we see the importance of implementing universal coverage reforms, service delivery reforms, leadership reforms and public policies reforms to protect communities in order to respond effectively to these changes and pressures.

Within the WHO European Region the work is guided by the Tallinn Charter, which inspired countries to act through values to improve health and wealth, affirmed a value-based approach to health system strengthening, and empowered health ministers and ministries to lead change for health improvement. The interim report on the implementation of the Tallinn Charter across the Region was presented to the last RC in Baku in September 2011.

There is a present imperative for efficiency gains within health systems. There are several effective policy instruments to mitigate the impact of the present financial crisis focusing on cost reduction and efficiency gains, such as hospital reconfiguration, an increased focus on primary health care, a shift from inpatient to outpatient care, more rational use of medicines and reduced prices of medical goods. There are good examples in the Region that tell us that these instruments work, for example the Republic of Moldova that has succeeded to expand primary care services to all citizens regardless of their insurance status and also extended the coverage of the health insurance program to the poor by effective pooling of funds from both

[1] Presentation by Dr Hans Kluge Director Division of Health Systems and Public Health, Special Representative of the Regional Director on MXDR-TB in the WHO European Region

the general tax and payroll tax systems into a mandatory health insurance scheme. Another present example is Ireland, where there is an increased political commitment to significantly strengthen primary care and make GP care free to the whole population.

Within the WHO European Region there are a number of successful partnerships in the area of primary health care. Examples are the partnership between the Ministry of Health of the Netherlands and the WHO Regional Office for Europe on PHC, as well as the network of collaborating centres (NIVEL, Gent University in Belgium and the Andrija Stampar School of Public Health in Croatia).

It is necessary to tackle together the perceived barriers to effective PHC: for example the fragmentation of health systems; suboptimal intersectoral collaboration; and insufficient investment in human resources. In order to be successful facilitating factors need to be leveraged: for example sustained political commitment; a greater emphasis on health promotion and prevention; and a more participatory approach.

Health 2020 and the year of NCDs[2]

Many examples from countries tell us that mortality and morbidity from NCDs is intrinsically linked with the social and economic transformations in societies, but it also tell us that dramatic changes over a short period of time are possible. We have to work hard to achieve rapid positive changes.

Health 2020 is a new policy framework and approach within the WHO/European Region that will require strong health systems and strong public health leadership. Health 2020 links evidence and action from the whole of society and whole of government, as well as the health systems strengthening, approaches. We have to show improved intersectorality in our work, and the joint work on PHC and NCDs between the two WHO European Regional Office divisions, Division of Non-communicable Diseases (DNP) and Health Promotion and Division of Health Systems and Public Health (DSP), is an example of such working in action.

Last year was truly the year of NCDs (for example the Oslo meeting, the first global ministerial meeting in Moscow resulted in a declaration that was recognized in the WHA 64 resolution, the Regional Committee in Baku which agreed on a package of actions in the European NCD Action Plan, and the UN High Level Meeting in New York that produced a political declaration. Now we must develop a monitoring framework, targets and indicators, as well as proposals for extending intersectoral partnership.

Global and Regional guidance is there. The 2008 – 2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases provides an overarching model, and a series of products complement it (i.e. the “From Burden to Best Buys” package, Gaining Health; and the European Strategy for the Prevention and Control of Non-communicable Diseases). The European NCD Action Plan takes it further – the 10 priority actions depict concretely what we can do in next 10 years to lower the burden of NCDs. Evidence based approaches in primary care are among them. For example if we can show that we can detect early and appropriately manage cancers, or apply an absolute risk approach to NCD management and respond effectively, we will make a tangible progress.

[2] Presentation by Dr Gauden Galea, Director of the Division of Non-communicable Diseases and Health Promotion

Where are we heading with Health Service Delivery, including PHC, in the WHO European Region[3]

Emerging problems require new solutions. In modern health systems we cannot look at primary care in isolation from specialist and hospital care, and vice-versa. This is why the WHO European Region has worked on conceptualizing what a modern health care delivery system looks like, including the role of hospitals. This work started during a recent meeting in Brussels, Belgium, 21-22 November 2011.

We want to see how we can manage simultaneously the financial crisis while having a long term strategy on transformative changes. How is care at different levels of the health system coordinated and how can the system be best tuned to the needs of people and patients. The deliberations in Brussels made it clear that, while hospitals have very important place in the health system and society, the current clinical and economic model that underpins the hospital is no longer appropriate. The time is right to redefine the role of hospitals in a better balanced health system that gives an increasing importance to care integrated across all care levels.

The Wagner chronic care model, a framework that outlines the key components of a system attuned to provide good care for patients with chronic conditions, reiterates the need for patient centred care. Its key components: delivery system design, clinical information systems, decision support and self-management support, are aimed to produce an informed and activated patient that has productive interactions with a capable and proactive practice team. The instruments to implement the model are known, for example risk stratification tools, routine reminders etc., although we certainly have to make a better use of these.

The DSP Division is currently working on a strategy and “reflection process” to strengthen health system delivery, as well as a roadmap for action between the WHO European Regional Office, Member States and other stakeholders, towards defining modern health service delivery. It is hoped that this will be finalized over the next months. The intention is that DSP will put together a position paper on this subject, including the role of primary care and hospitals, which will be discussed at the Regional Committee in 2013. The Division is also making progress in documenting case studies of good practices, and identifying gaps where further research is needed.

Scope and purpose of the meeting: NCDs and primary care[4]

The most cost-effective interventions at population level, and at the level of high-risk individuals, to prevent and manage NCDs, are known. These are described in what we call “Best Buys Package”. Moreover, there are many examples in the WHO European Region of countries that have implemented “Best Buys” interventions and have succeeded in dramatic reductions of mortality and morbidity from NCDs. An example is Poland that managed to reverse the trend of rising mortality and morbidity, and Ireland that achieved important decrease of coronary mortality. Another example is the UK where a policy change increased the coverage with cervical cancer screening from 60% to 90% after systematic screening was introduced, thereby reducing the incidence of cervical cancer.

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[3] Presentation by Dr Hans Kluge Director Division of Health Systems and Public Health, Special Representative of the Regional Director on MXDR-TB in the WHO European Region

[4] Presentation by Dr Gauden Galea, Director of the Division of Non-communicable Diseases and Health Promotion

The challenge is translating evidence into primary care routine, and ensuring that everyone is getting access to the basic package. *The WHO Package of Essential Non-communicable (PEN) Disease Interventions for primary health care in low resource settings* summarizes what this basic package comprises. We intent to build on this work in the WHO Regional Office for Europe. The new European framework to assess NCD management in primary care, a tool that we will discuss in this meeting, is another step in our joint efforts to equip policy managers and practitioners with guidance and tools to strengthen primary care role in preventing and managing NCDs.

The objectives of this present meeting in Amsterdam are therefore to:

- review evidence of the most effective practices in primary care for the promotion, prevention and management of, and care for patients with cardio-vascular diseases and diabetes mellitus;

- explore examples of good practices in organizational changes that strengthen primary care performance in relation to NCDs;

- gather feedback and reflections on how the proposed assessment framework could be improved in order to increase its relevance to countries' specific contexts; and outline the process for applying the assessment framework in countries in order to maximize its contribution to the implementation of the Global and European NCD Action Plans.

Requirements and tools for strengthening PHC

Characteristics and requirements of strong PHC[5]

The characteristics of strong primary care are:

- Contact (first) with health care
- Context-oriented
- Continuity
- Comprehensiveness
- Co-ordination

There is evidence that strong primary care is associated with better health outcomes, lower costs, better opportunities for cost containment. Primary care provides opportunities for monitoring health, health care utilization, and quality.

There is a need to cope with the challenge of NCDs through the introduction of community-based approaches. It is a requirement that the population to be addressed should be

[5] Presentation by Peter van Groenewegen, Dutch Institute of Primary Care - NIVEL

specifically defined. Incentives for providers, and an integrated rather than disease oriented approach, are also required.

Another requirement is good information systems supporting integrated services for NCDs. Such systems included an integrated or shared electronic medical record, identification of patients with NCD, high risk populations/patients, E-health tools for self-management, and decision support systems.

Package of Essential NCD Interventions (WHO PEN) for primary care in low-resource settings[6]

A number of global challenges –the global burden of diseases, inequity issues, poor governance, low level of finance and budget allocation for health in general and NCDs in particular, inadequate service delivery model with weak primary care and underdeveloped referral networks, insufficient facilities, equipment, medicines, shortage of professionals and their inadequate training, low involvement of patients, families & communities-create pressure to find pragmatic solutions. There are enough guidelines and knowledge about what works, but there are huge implementation gaps and equity gaps. The WHO Package of Essential Non-communicable disease interventions for primary health care in low-resource settings (PEN) is an innovative and action-oriented response to the above challenges. PEN defines what is essential and needs to be made available to everyone.

Populations in low resource settings face particular challenges: low domestic investment in health, double or triple burden of diseases, and weak country and health systems capacity. WHO has taken therefore a difficult task of prioritizing – this is what the “best buys” package is about. Cost effective interventions are available that can be applied in primary care. Other interventions are important, but it is necessary to respond to the greatest burdens.

The WHO PEN Package is a prioritized set of cost-effective interventions that can be delivered to an acceptable quality of care, even in resource-poor settings. WHO PEN is the minimum standard for NCDs to strengthen national capacity to integrate and scale up care of heart disease, stroke, cardiovascular risk, diabetes, cancer, asthma and chronic obstructive pulmonary disease in primary health care in low resource settings. Most importantly, it delineates a minimum set of essential NCD interventions for any country that wishes to initiate a process of universal coverage reforms to ensure that health systems contribute to health equity, social justice, community solidarity and human rights.

National programs are necessary, not just demonstration projects. WHO PEN includes guidance and tools to assess needs and capacity, implement essential NCD interventions, evaluate impact, and strengthen health systems and human resource capacity in PHC with a special focus on primary care (first contact) level. The components have been developed and validated, including protocols for clinical diagnosis and treatment, tools for risk prediction of heart attacks and strokes, guidance on minimum requirements for essential medicines and affordable technologies, standards and indicators to measure progress of implementation and impact.

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[6] Presentation by Dr Shanthi Mendes, WHO Headquarters

Drug treatment should be focussed on people of highest risk. Low risk groups should be covered with population based interventions. Who to treat, and how intensively to treat them, depends of the level of risk.

Primary health care in the Netherlands: the way we organize and pay for bundled primary care on NCDs[7]

In 2006 a new Health Insurance Act introduced regulated competition, risk solidarity, free choice of insurer, a basic health insurance package, and compulsory insurance for all Dutch citizens. The "Triangle" (patient, provider, and insurer) is the basis of the Act.

This means a stronger position for patients and insurers. This is still not the case today: it is still necessary to invest more in the empowerment of patients. There are other problems within the current health system: increasing costs, rising demand and less human financial and human resources, as well as an ageing population. The current policy of the Ministry of Health was focused on increasing specialization and efficiency. Care should be given in the own environment of the people. PHC is a good solution, less expensive, and offering high quality.

A strong PHC facilitates three main public goals

1. Accessibility (division of scare resources, 7 x 24 hours availability, close to clients)

2. Quality of care (patient safety, continuity of care, patient satisfaction)

3. Cost-containment (gatekeeper, cost-efficiency)

However at the moment incentives within both primary care and care for chronic disease do not stimulate the creation of value (a high quality/price ratio). The reasons include:

- Fragmented financing systems (silo's), that prevent co-ordination of care
- Fee for servicepayments
- Capitation fee without an outcome focus
- Hospitals deliver DRG -based diagnosis treatment combinations
- Lack of appropriate amount of care, the so called stepped care approach in the sequence from lighter care to third level hospital care (self-management, primary health care, hospitals)

In the Netherlands new "bundled payments" are now paid to a principle contracting entity or "care group" and include the following elements:

- A single fee to cover a full range of care services for a fixed period, including doctors' fees in primary care, plus hospital costs

[7] Presentation by Karen van Ruiten, Representative, Government of the Netherlands

- The contents of the “bundled payment” are in conformity with the health care system approved by national provider and patient associations. Health care standards describe all treatment elements and activities (the ‘what’, not the ‘who, where and how”)

- All fees for “bundled payment” contracts are freely negotiable

- In 2007: a trial started for “bundled payments” for diabetes

- In 2010 ‘bundled payemts” were introduced on a permanent basis for diabetes, vascular risk management and COPD

- In June 2012 a reprot will be produced on an evapuation of “bundled payments”

The care standards for “bundled payments” have been developed “bottom up”, by care providers, and patients, based on guidelines. The health care standard for diabetes was developed first After that the health care standard for cardiovascular risk management was developed. Prevention forms a part of the health care standards. However insurance companies are afraid that this approach will become very expensive because a large part of the population fits in the standard (high blood pressure, overweight, smoking etc.).

WHO tool to assess interventions in PHC to prevent and manage cardio-vascular diseases and diabetes mellitus[8]

The Netherlands Institute for Health Services Research (NIVEL) was founded in 1965 as the Scientific Bureau of the Dutch College of GPs. NIVEL is an independent not-for-profit foundation with approx. 180 employees; about 100 researchers of various disciplines, and is WHO Collaborating Centre since 1987. In the area of primary health care, NIVEL assisted WHO/Europe in supporting Member States to assess their primary care systems, and develop policy options for their strengthening. This was done using the primary care evaluation tool (PCET) which was a basis for development of the European framework to assess NCD management in primary care (the PHC-NCD tool), the draft of which is to be discussed at this meeting. The PHC-NCD tool shares, therefore, a similar health system approach as PCET. The methodology of the development of the PHC-NCD tool was presented, which included the review of the scientific literature and international policy documents, synthesis of the findings and conclusions on effective NCD interventions in PC. Based on this list of effective NCD interventions in PC, a framework for the PHC-NCD tool was developed with a list of topics that are proposed for discussion by participants.

Discussion and country specific remarks

Romania

There is a new health insurance act, with “bottom up” guidelines; they are however not however appreciated by doctors. Patients receive “conflicted” advice and treatment.

Sweden

[8] Presentation by Wienke Boerma and Sanne Snoeijs, Dutch Institute of Primary Care - NIVEL

Under existing guidelines, health care providers offer health promotion and disease prevention programs. This supports the change towards healthy lifestyle, prevention of NCDs etc. It is important to involve specialists in prevention before surgery, stopping smoking and dealing with other unhealthy lifestyles

Uzbekistan

Focus on

1. General wellbeing
2. Community interventions in lifestyles
3. Stronger interventions through legislation on tobacco and alcohol.
4. Healthy environment, civil society plays a role in these strategies.

Greece

There is a possibility of misuse of statements in point 6.3 (Key points from the Policy documents) of the report. It is essential to refer these statements to the relevant chapters in the report.

Russia

The questionnaire should include why people didn't come to the hospital. Treatment adherence is important to avoid complications of the illness.

Latvia

Prevention is cost-effective on the long-term.

Kazakhstan

Emphasized:

1. Screening
2. Mass campaign diabetes, cervical cancer
3. Not only GPs are involved ,but a multidisciplinary team is essential

The Former Yugoslav Republic of Macedonia

The payment system of GPs should be changed, so that they can offer preventive services.

The Swiss Federation

The importance of promoting healthy lifestyle was emphasized, although the evaluation of outcomes is difficult.

Workshops: How the proposed WHO tool could be improved in order to increase its relevance to various country[9]

The questions for discussion by two parallel workshops were:

What is lacking in this tool? What is not included in the tool so far? Are there issues about equity? Are there other elements?
How to adjust the tool for your country?
What are the suggestions for further operationalization for the items that are proposed in chapters 6 and 7?

The key points made by the two workshop groups were:

- Definitions were needed between primary health care and community care and public health.
- There is a need for peer review of primary care interventions on NCDs
- The NIVEL report lacks an evidence based epidemiological background, and this needs to be devised
- Conflicting treatments for co-morbidities should be avoided through better co-ordination of care.
- There should be an emphasis on prevention, because it is cost-effective on the long-term
- Prevention should be made a part of treatment by primary care and specialists, and not only be provided through public prevention programs.
- A multidisciplinary team in primary care plays a vital role in communication with community care, public health and hospitals etc.
- The payment system of GPs is not adequate to be attractive to work in and to be able to pay attention to preventive tasks

The following comments were made in general discussion:

- Political commitment is essential (despite discontinuity at political level), but the organization of the policy level is different between countries. In particular centralization and decentralization must be taken into account.

- Prevention should be comprehensive in more than one sense. Firstly, as risk factors are more generic than just for CVD and diabetes mellitus, this broader perspective should be taken into account. Secondly, the involvement of primary care should be considered in the context of other levels and sectors (including for example social work; mental health services).

- At the start of the implementation process a stakeholder analysis should be made to make clear which entities are involved and what role they can play.

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[9] Two parallel technical workshops facilitated by Dr Wienke Boerma, NIVEL, and Dr Valentina Baltag, WHO European Regional Office

- Inter-sectoral policy commitment, especially in NCD prevention and management (e.g. with the education, agriculture/food, living environment sectors), is a precondition for success.

- There is a need for more patient centered approaches. Policies and practical implementation of patient involvement and equity enhancing policies needs to be included in the report.

- Coordination and care integration are essential and how this is facilitated in various countries should be reviewed. Other countries can learn from others about how to counter fragmentation across sectors and professional rivalry despite political discontinuity.

- A section should be included on motivating health care providers to integrate preventive activities in their daily work, despite time constraints. Practical solutions need to be reviewed such as delegation of tasks to other primary care providers and facilitation of cooperation (e.g. between GPs, nurses and pharmacists). The possibilities and effects of incentives need to be clarified.

- Attention should be paid to reaching specific high risk groups such as the Roma, migrants, the homeless etc. People in rural areas should also be considered as 'vulnerable' because of the often seen absence of services.

- Methods for increasing health literacy through 'schools' should be explored, for example through the provision of information on disease, monitoring, avoiding complications. In some countries the active involvement of key persons in communities or companies as well as teachers in schools can be very effective for the implementation of prevention programs.

- The current limitation of the Tool to CVD and Type 2 diabetes mellitus DM2 is not appropriate in times where co- and multi-morbidity are growing problems. Therefore a section on co- and multi-morbidity should be included.

- Accessibility of care should also be considered from the provider point of view.

- To increase the applicability of the Tool in countries with varying resources available, it could be advisable to develop a list of steps and interventions starting with those suitable to all countries and then gradually expand to include those which require more resources. To this end coordination with the 'PEN activities' would be good.

Thanks were given to countries for their active participation in the group work, and valuable suggestions that the WHO Secretariat and the NIVEL team would bring forward during the finalization of the tool. It was emphasized that many of the suggestions reiterated the tools strengths, and the high quality of the work of the NIVEL team was acknowledged.

Wienke Boerma and Sanne Snoeijs presented a short review of the main outcomes of the first day, together with the conclusions of the working groups. These outcomes and conclusions would be considered and included, as appropriate; in the final development of the tool.

From evidence to practice

Successful intervention of primary care on respiratory diseases[10]

Chronic respiratory diseases are a major cause of death and disability world wide. Some 4 million people died from these diseases in 2005. A Global Alliance against Chronic Respiratory Diseases has been established, against the background of under diagnosis and under treatment, and little access to essential medicines in many countries. A national action plan endorsed by the Ministry of Health is needed in each country. The Action Plan is a road map for countries, for WHO and for international partners. It covers a six-year period, from 2008 until 2013, and contains sets of actions for Member States, for International Partners, and for the WHO Secretariat.

These sets of actions are grouped under six objectives.

1. To raise the priority accorded to NCDs in development work. This is the so-called whole-of-government or health-in-all policies approach, without which we cannot achieve much in NCD prevention.

2. To focus on actions by Member States to establish and strengthen national policies and plans for the prevention and control of non-communicable diseases. It calls on international partners and the WHO Secretariat to provide technical support to low- and middle-income countries, so that they can build sustainable institutional capacities.

3. To promote interventions to reduce the main shared modifiable risk factors for non-communicable diseases, which I mentioned earlier. These are: tobacco use, unhealthy diets, physical inactivity and the harmful use of alcohol.

4. To require the WHO Secretariat to develop a prioritized research agenda for non-communicable diseases, in close collaboration with international partners and Member States.

5. To call on the WHO Secretariat and international partners to promote partnerships and support a global network to raise awareness, mobilize resources and exchange successful approaches.

6. To call on all parties to monitor non-communicable diseases and their determinants and evaluate progress at national, regional and global levels.

In summary the following were essential to achieve success in primary care:

- Effective interventions, tailored to patient needs

[10] Presentation by Dr Niels Chavannes

- Relevant for large patient groups
- "Close to home situation" ehich is favourable on long-term
- Diagnosis should be valid, aided by secondary care
- Tasks delegated to dedicated professionals
- Simple measures for guidance and follow up

Synthesis on operational changes required to strengthen primary care contributions to NCD prevention, management and care (experiences from three member states)[11]

Policy

Several countries had mentioned the importance of national policy as trigger/driver/facilitator. In some cases, for example Kyrgyzstan, this was specific to NCDs and in others, for example Denmark, to chronic diseases. In many countries there were broader health policy or reform issues.

The importance of a regulatory framework was clear. For example in Denmark roles and responsibilities for chronic diseases had been reorganized. New legislation had been adopted in Kyrgyzstan.

Resource generation

There had been a focus on resource generation. For example in the Republic of Moldova there had been an emphasis on training family doctors, with the creation of the speciality of family medicine around a three year residency program. Also emphasised had been training and capacity building around guidelines (the Republic of Moldova, Denmark) and institutionalized evidence-based practice and quality improvement (Kyrgyzstan).

Finance and incentives

Financing and incentives had been reorganized around primary care, for example to guarantee access (Kyrgyzstan). Also financial incentives for prevention had been developed, with different approaches. For example in the Republic of Moldova payments had been introduced for smear tests.

Delivery

Delivery issues had been important. In Kyrgyzstan improving access for rural populations had been a priority. In the Netherlands there had been a focus on providing care "close to home". Attention has also been given to continuity and coordination of care, focused on developing gatekeeper and first contact care, and long term relationships between carer and patients. Secondary care has increasingly been seen in a supportive role.

[11] Presentation by Dr Jill Farrington, WHO Headquarters

Challenges

Inter-professional rivalry is a key impediment. Who is responsible for the early diagnosis? Who claims the success and gets paid for it?

Sustainability is also an issue. Changes in policy and practice must be given long enough to work e.g. legislative changes relating to tobacco, changes to funding mechanisms.

Fragmentation of services and care remains a real issue.

Successes

Improved cost efficiency and reduced hospital days.

Issues for consideration

Developing a whole system approach is perhaps particularly illustrated by the example of respiratory disease. Such an approach would involve a national plan, supporting smoke free legislation and taxation, having access to essential drugs in primary care, creating partnerships, research, developing the patient role. All these elements need to work together and be mutually reinforcing.

Cross-boundary working

An example here is seen in Denmark, with its emphasis on improving roles, responsibilities and interconnections between GPs, municipalities and hospitals.

Integrated pathways

The Republic of Moldova has shown the importance of improving communication, through shared guidelines owned by both primary and secondary care. The importance of such guidelines was several times mentioned.

Patient empowerment

Examples included patient owned data (Denmark), patient setting treatment goals (Netherlands) and schools for patient education (Kyrgyzstan).

Monitoring

Developments include audit, quality indicators (Kyrgyzstan) and the comparison of data between areas and over time. It is important that such patients and patients' perspectives should be included in such monitoring processes.

Feasibility

Devices here include:

1. The 10 minute presentation

2. Simple guidelines written by GPs for GPs and referral guidelines

3. Pop-up reminders (Denmark)

Country specific discussion

Romania:

From hospital centred to PHC centred care

- Role of GP: referral letter is not needed in the prescription of pharmaceuticals. Now there is a restriction for GP's to prescribe some essential medications. This is reserved for specialists, although this is unnecessary. The GP is sufficiently equipped to fulfil the task of the treatment on NCDs and can assess when referral to a specialist is needed.
- It is important that the GPs have both a fee for service and capitation,
- Clinical pathway: tasks are divided in protocol. This should be developed on a national level. And clinical pathways should be incorporated in pharmaceutical law.
- PHC: Multi-morbidity co-ordinator.
- National program: Diagnosis of 9 NCDs; Screening programs have been introduced via GPs or Universities.

Bulgaria

- There is no connection between the different ministries. There is an integrate NCD program, called CINDI.
- Co-ordinate educational programs for GPs are important , including how to reduce risk factors, initiated on the national level; and including prevention, alcohol, physical activity, diet in local communities>
- Patient groups play an important role; patient education is profoundly important.

Portugal

- In theory the system works through a well-defined network of responsibilities and distribution of tasks.
- The importance of both clinical medicine and public health
- Has developed groups of health centres: 70 groups on a regional level.
- Has promoted health promotion: smoke cessation
- Developed GP's target payments based on the list system
- GP's health units promoting health in the community
- 8 National vertical health programs, including Vertical programs, diseases/risk factors, CVD, cancer mental health, respiratory diseases, tobacco, nutrition. These are national guidelines that are first discussed with doctors and patient groups
- Promoting guidelines for GPs
- Tobacco and salt reduction laws
- Rural areas, shortage of doctors
- How to cope with multi-morbidity?
- Family doctors participate in prevention programs initiated at the national level.

- Local communities involved in preventive actions: patients and providers (GP's)
- Patient education

- Local coalitions for health. How to integrate vertical and horizontal programs?

- The implementation of national programs on the regional level

- There is a lack of a supportive financial basis for prevention in NCDs

- School meals are 'fast food' and not in line with national health programs, there is a lack of co-operation with the Ministry of Education.

- How to motivate the often depressed population? There is a high threshold to adopt a medication in the routine treatment of NCDs

- The importance of communication and collaboration between stakeholders

- The balance between paperwork and clinical work

Workshops: Good practices examples and analysis of organisational changes needed to support their implementation

The aim of the two parallel workshops was to share examples of good practices to address NCDs through primary care interventions and analysing the organizational changes that occurred to support the implementation of good practices.

Working Group 1

The three questions to be asked were:

1. How can we enhance co-ordination of people centered care with a right balance between the responsibility of the patient, community care, primary care and hospital care?
2. How can we enhance co-ordination of personal medical care with public health and social care?
3. How should we address co-morbidity in primary care?

The key issues were:

- A "multi-morbidity co-ordinator" is required : "PHC is the place where you can address co-morbidity instead of specialists, because they are specialists"
- A shift from hospital centred to PHC centred care
- The promotion of c-ordination of care and people centred care. Avoidance of conflicted treatment when co-ordination is adequate.

These issues were considered in turn:

Coordination

- A focus on a prevention research

- Screening programs should be integrated in PHC
- A lack of continuity in health policy

Fragmentation of health/social affairs

- Screening is often only opportunistic
- The lobby of medical doctors influences health policy
- Health targets for the country are important
- An integrated program for all risk factors of NCDs is required
- Implementation of the smoking ban involves both inspection and control

The registration of patient outcomes: this depends upon:

- Electronic data from PHC
- A policy view of public health
- A “bottom-up” approach to development of the public health system Global statistics: surveillance, monitoring data, environmental information.

Working Group 2

Key points were:

- To include a chapter/part on stakeholders analysis (also from the patients perspective not only from the perspective of the Ministry of Health)

- Policies may be established at national, regional and local level. It is important that the Tool accounts for the fact that in various countries the level of centralization and decentralization differ and the tool in its national level part seem to take a perspective of centralized systems only. One option would be to divide this chapter in 1) national policies 2) regional policies 3) local policies

- In policy development is important to ask about existing legislation in areas outside health systems (i.e. education, food and agriculture etc.)

- Add questions regarding political commitment and how they are implemented and monitored, starting from the national to the local level

- Governance: if the tool can look into how to translate national programs in primary care routine

- Topics at the national level should include the intersectoral approach, and the role of media

- Topics for communities should include questions regarding local governance, involvement of local groups in local and national policies

- The current version is focused on what healthcare providers can or should do; alongside what is the responsibility of other sectors. This should be more visible in the tool: The tool is looking at end results (information giving, education of patients) but to be able to eat healthy there should be healthy food

available: The tool therefore needs to look outside health systems. For example, it should look into whether there is a system of monitoring the quality of food products etc. and whether the governments has a health in all policies approach (HIAP)

- The changing role of healthcare providers – from purely medical care to medico-social care - should be captured in respective parts of the tool HCP

- At the same time we should not put on the shoulders of GPs and PC teams more than they can do

- In Financing: incorporate performance linked indicators linked to NCDs outcomes

- Fees for service encourage NCDs related services but not to oppose them with per capita payments

- Financing of medical services is based on curative outputs; to add question how to implement financing that recognizes preventive activities

- To specify the secondary prevention with drugs (i.e. statins), cancer with HPV

- Part 7.2 is very much profession centred, patient centeredness is lacking, i.e. in policy part there is not focus of policies to involve patients

- The tool lacks equity lenses; more particular comments/suggestions about equity

- Ask whether national policies somehow look at equity

- Ask whether there are national guidelines in tackling inequities (i.e. working with vulnerable/difficult to reach groups)

- Ask whether there are guidelines for equity in accessing preventive interventions

- Integrated care and teamwork should be prominent in the Tool; i.e.

- Ask how coordination is happening

- The tool need to be sensitive to issues of how to motivate healthcare providers to integrate prevention, which is time consuming, into a 15 min consultation and heavy routine of general practitioners/family doctors

- For the European NCD Action Plan is important to measure indicators such as what proportion of women have had cervical cancer screening from the target population; what is the HBA2 level of diabetic patience. Need to think how the Tool can help with this

- The tool is limited to CVD and diabetes and it limits a bit the integrated approach, it does not have anything about co-morbidities
- Would be good to make more visible throughout the Tool the framework described at the beginning in the 7.2.1
- It might be good to expand the tool beyond questionnaires and complement the tool with 1) policy briefs and 2) tools on the process of PHC/NCDs reforms implementation
- LMIC versus developed countries dilemma: the tool can look into having a "core list/part" and the countries can have adds-on based on the local context
- The document is more primary care - service oriented – while should be more PHC as in the declaration of Alma-Ata with community role prominent (Note VBA: this is comment from the plenary discussion, not the group work)
- Regarding the classification of prevention that the Tool is using: it opposes primary, secondary and tertiary versus what the tool is proposing; it is not opposite but the two classifications complement each others (Note VBA: this is comment from the plenary discussion, not the group work)

Comments of a more particular nature:

- Restructure the structure of 6.3 - to put resources after access and equity
- Add health determinants and social determinants of health in 7.2.1
- 6.3: accessibility part. access to specialized care and accessibility to medicines is very important and should be reflected better
- Under requirements/conditions: Indicators for quality assurance - add peer review next to the audit
- Use the term "place of prevention" instead of "role of prevention"
- 7.2.1 under governance: ask if there is national policy on how to involve patients organizations
- In Denmark there are guidelines on how to work on prevention: stop smoking, harmful alcohol
- Link with other healthcare workers in 7.2.1 and 7.2.2
- 7.2.3 : schools for diabetes or for hypertensive patients; to add the ways how to achieve high literacy through "schools" – i.e. small groups of patients
- Add question about time constrains under Requirements/conditions

- The 6 paragraph under 6.3 ("prevention does not necessarily reduce cost for healthcare"): this sentence could reverse reforms in some countries; it is important to say that societal benefits are greater even if prevention is costly
- 7.2.1: financing: add expenditures for prevention in PC
- New topic to 7.2.1 and 7.2.3: identifying vulnerable groups such as gypsy, prostitutes, victims of trafficking, at the policy/national, policy/local and PC level
- 7.2.3 on patient satisfaction: look also into providers satisfaction (they can block the reforms)
- Try to measure access not only from patient perception perspective but from services use data as well
- Look into lifestyle of healthcare providers and if it impacts into their patients (i.e. in the patient questionnaire?)

Way forward

Reorientation of health services further towards prevention and care of chronic diseases as described in the NCD action plan[12]

This had been a very rich and rewarding two days based on the excellent work of NIVEL. Very interesting material has come from the country examples this morning. A priority now was to bring the broader population based public health perspective alongside the care delivery function. This will need public health and primary care to keep closely alongside each other in a functionally integrated way. This will look differently in different countries. Too often public health is still within a silo (the SANEPID system), or organizationally and functionally remote, or simply neglected.

In addition the WHO European Regional Office has variously emphasized the importance of primary care acting at the health promotion and disease prevention end of the promotion-prevention-diagnosis and treatment-rehabilitation-care continuum. Here the functional requirements include focusing on population-based promotion and prevention in both the planning/purchasing function and the care delivery function, and providing financial incentives to do so

What was needed now was strengthening of health care systems, based upon a comprehensive overview of what a modern health cares system looked like and how it worked. Care would need to be coordinated much more effectively, based around the role of the empowered patient. DSP would be giving this challenge great emphasis in its future work.

[12] Presentation by Dr Hans Kluge Director Division of Health Systems and Public Health, Special Representative of the Regional Director on MXDR-TB in the WHO European Region

Capacity to implement is an issue, particularly in resource poor countries, and it was important to look at barriers to effective implementation of primary health care. This is a real challenge in all health care systems.

Conclusion[13]

The two days had been extremely useful in clarifying the relationship between the comprehensive management of non-communicable diseases and primary care. Primary care was an essential dimension of management of the modern burden of non-communicable disease. Here the WHO Package of Non-communicable (PEN) Disease Interventions for primary health care in low resource settings gave important pointers to high priority and effective interventions. "The "Best buys" approach had won broad international support and needed to be more fully developed and implemented.

The WHO European Regional Office would now be in a better position to equip policy managers and practitioners with the guidance and tolls they would need to strengthen the primary care role in preventing and managing NCDS. It was essential to be able to advise countries on what worked, and what should be done well and as a matter of priority. Here the NIVEL tool would be an essential contributor to this work in countries, to country self-assessment and improvement, and accordingly to the implementation of the Global and European NCD Action Plans.

[13] By Dr Gauden Galea, Director of the Division of Non-communicable Diseases and Health Promotion

Annex 1: Scope and Purpose

A recent WHO Regional Office for Europe Resolution EUR/RC61/R3 reaffirmed that non-communicable diseases (NCDs) are the greatest cause of preventable mortality and morbidity in the WHO European Region. It puts forward the European NCD Action Plan as guidance for Member States on a series of concrete actions to achieve measurable improvements in NCD control using existing comprehensive, integrated approaches while taking into account existing national legislation and policies, as appropriate.

The resolution urges Member States to strengthen the management of NCDs in primary care, providing universal access to clinical prevention and care using evidence-based approaches and appropriate financing.

In order to assist Member States and organizations in their efforts to implement the priority primary care actions and interventions described in the European NCD Action Plan, the Regional Office has developed a framework to assess NCD management in primary care. The framework aims to assess primary care performance, and gaps, in relation to the promotion, prevention, management and care of cardio-vascular diseases and diabetes mellitus. It focuses on evidence-based interventions that can be used across the lifetime of an individual in primary care settings.

The European NCD Action Plan and its supporting tools are recognized as aiming to give guidance that can be adapted to Member States' varying levels of experience, and their specific political and health systems context. In order to explore the various contexts in which the assessment framework will be applied, and improve its relevance to Member States' individual health systems and socio-economic circumstances, participants will discuss the following key issues:

- current involvement of primary care in management of NCDs, and how it varies in countries with various levels of resources, as well as the changes that should be considered in the assessment framework to reflect these variations;
- the organizational and resource changes required within primary care to deliver a comprehensive service for cardio-metabolic risk (CMR) assessment and management, and how they can be measured effectively;
- how well the proposed assessment framework addresses the health systems aspects of changes required in primary care: what financial, human resources, health information system, drugs and supplies and leadership issues need to be assessed, monitored and improved for better management of NCDs in primary care settings; and
- the recommended process for applying the assessment framework in countries in order to maximize its contribution to the implementation of priority actions as delineated in the European NCD Action Plan.

The meeting represents an important milestone in the implementation of the European NCD Action Plan.

The objectives of the meeting are to:

- review evidence of the most effective practices in primary care for the promotion, prevention and management of, and care for patients with cardio-vascular diseases and diabetes mellitus;
- explore examples of good practices in organizational changes that strengthen primary care performance in relation to NCDs;
- gather feedback and reflections on how the proposed assessment framework could be improved in order to increase its relevance to countries' specific contexts; and
- outline the process for applying the assessment framework in countries in order to maximize its contribution to the implementation of the European NCD Action Plan.

The meeting will be structured around plenary sessions for keynote addresses and debates, sub-plenary sessions for the presentation and discussion of case studies by Member States in the WHO European Region (with an emphasis on lessons learned) and technical workshops.

The main expected short-term outcome of the meeting will be to obtain feedback and advice from participants on improving the assessment framework and especially on how it can contribute better to the implementation of the European NCD Action Plan. In the long term, the meeting is expected to broaden understanding of the organizational changes required to strengthen primary care performance in relation to NCDs, and enhance interest and engagement in strengthening primary care performance for evidence-based management of NCDs among the participants.

Target audience

The target audience includes focal points on NCDs and primary health care from the Ministries of Health of Member States, representatives of the key international agencies and professional associations, representatives of donor and development agencies, invited experts and WHO staff.

Annex 2: Provisional programme

Day 1, Wednesday, 25 January 2012

08:30–09:00	**Registration**
09:00–09:35	**Opening session, objectives** *Fred Lafeber, Head global affairs Dutch Government* *Gauden Galea, Director of the Division of Non-communicable Diseases & Health Promotion* *Peter van Groenewegen, Director of Nivel*
09:35–09:50	**Global and regional developments in NCDs, primary care and integration of care** *Dr Hans Kluge, Director, Division of Health Systems and Public Health, Special Representative of the Regional Director on MXDR-TB in the WHO European Region* *Gauden Galea , Director of the Division of Non-communicable Diseases & Health Promotion*
09:50 – 10:10	**Evidence in what works in primary care to promote, prevent and manage cardio-vascular diseases and diabetes mellitus. Package of Essential NCD Interventions (WHO PEN) for primary care in low-resource settings** *Shanthi Mendis, WHO HQ*
10:10 – 10:30	**Short introduction of primary health care in the Netherlands, 'The way we organize and pay for bundled primary care on NCDs** *Karen van Ruiten, Dutch government representative*
10:30-10:45	**Discussion**
10:45-11:15	***Coffee Break***
11:15-11:45	**Presentation of the WHO tool to assess interventions in primary care to prevent and manage cardio-vascular diseases and diabetes mellitus** *Wienke Boerma and Sanne Snoeijs, NIVEL*

11:45-12:15	**Discussion**
12:15- 13:15	***Lunch Break***
13:15 – 13:30	**Introduction to the afternoon parallel working sessions** *Francois Schellevis, NIVEL*
13:45 – 15:00	**Two parallel technical workshops on gathering feedback and reflections on how the proposed tool, could be improved in order to increase its relevance to various countries context** *facilitated by Wienke Boerma, NIVEL and Valentina Baltag, WHO Europe*
15:00-15:30	***Coffee Break***
17:15-17:30	**WRAP UP OF DAY 1**: *Hans Kluge and Gauden Galea, WHO Europe*
18:30	***Conference dinner for conference participants***

Day 2, Thursday, 26 January 2012 - Theme of the day "From evidence to practice"

9:00- 9:20	**Introduction to the day 2. Next steps in Tool' finalization** *Wienke Boerma and Sanne Snoeijs, NIVEL*
9:20 – 09:40	**From evidence to practice: successful intervention of primary care on respiratory diseases** *Niels Chavannes, Temporary Adviser*
09:40 – 10:20	**Experiences from three member states on strengthening NCD related interventions and activities in primary care, Kirghizstan, Germany and Denmark**
10:20 -10:40	**Discussion**
10:40 – 11:00	***Coffee Break***

11:00 – 12:30	**From evidence to practice: two parallel working groups chaired by Niels Chavannes and Hernan Montenegro** *Sharing examples of good practices to address NCDs through primary care interventions and analysing the organizational changes that occurred to support the implementation of good practices*
12:30- 13:30	***Lunch Break***
13:30-14:15	**Plenary – feed back from group work** **Synthesis of the organizational changes required to strengthen primary care contribution to NCDs prevention, management and care** *Jill Farrington, Temporary Adviser and Wienke Boerma, NIVEL*
14:15-15:30	**Ways forward, wrap up and closure** **A first step towards implementing the reorientation of health services further towards prevention and care of chronic diseases as described in the NCD actionplan** *Hans Kluge and Gauden Galea, WHO Europe*

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