EDITORIAL

Ten evidence-based policy accelerators for transforming primary health care in the WHO European Region

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POLICY ACCELERATORS FOR PRIMARY HEALTH CARE

It has been said that the adoption of the Astana Declaration is the beginning of a better future for primary health care *(1)*. That future begins with making full use of our health services intelligence.

The 40th anniversary of the Declaration of Alma-Ata has brought with it a dynamic coupling of renewed political will and a critical mass of rich evidence and know-how on services delivery. In the words of Dr Birtanov, Minister of Health of Kazakhstan, earlier this year in the lead-up to the Global Conference on Primary Health Care:

"Each country has a lot of room to improve… [we need] to use success stories from countries to share and to put these on the table. We can benefit from all the history and experience we have gathered during the last 40 years and make primary health care better and more efficient in the future *(2)*."

In this special issue, the evidence and experiences captured have been reviewed, summarized and translated into 10 evidence-based policy accelerators for advancing a primary health care approach in the WHO European Region (Box 1). The accelerators were presented and discussed at two recent events in Kazakhstan: a scientific conference in Almaty, in October 2018, which was a pre-event to the global conference in Astana *(3)*. These accelerators – policy options, must-dos, or leapfrogging opportunities for primary health care – signify high-impact entry-points for implementing bold reforms. While not exhaustive, they are among the "best buys" for allocating time and resources to transforming services delivery through tried and tested research and practice. Furthermore, they are the agenda for a minister of health when further prioritized, based on the needs of a country.

ACCELERATING TOGETHER: POLICY ACCELERATORS DESCRIBED

Services delivery involves multiple actors and its transformation takes the same level of engagement. Internalizing the fact that everyone has a role to play is the cultural change needed for primary health care. This extends from the individual family doctor or general practitioner, nurse, specialist and allied health worker to their organized groups; from patients and their family members to the public, concerned youth and representatives of patients; and from the managers of facilities, regional health authorities and other civil servants to researchers, development partners, policy advisers and ministers of health, and other sectors.

BOX 1. PRIMARY HEALTH CARE POLICY ACCELERATORS

1. Realize a population health management approach for integrated public health and primary health care
2. Adopt a community care model to integrate with social care
3. Empower communities and engage patients to formulate problems, make decisions and take action
4. Network providers to ensure responsive and multiprofiled delivery
5. Invest in the competencies of family doctors and general practitioners and nurses to increase the response capacity of primary health care
6. Establish learning loops in clinical settings for quality improvement
7. Ensure the responsible use of medicines
8. Optimize services with evidence-informed transformations
9. Upgrade facilities for the optimal use of eHealth and health technologies in primary health care
10. Align accountability and incentives with new models of care

The case for each policy accelerator and the known strategies for kick-starting reforms are described in the sections that follow. To depict the policy accelerators, the perspectives of representatives from countries, professional and patient associations and academia, as well as policy experts, have been called on to illustrate in their own words the significance of each accelerator. Representing members of the European Primary Health Care Advisory Group *(4)*, WHO collaborating centres, various technical units and their respective constituents, this multiprofile group presents the level of diverse engagement it will take to accelerate primary health care in practice.

1. REALIZE A POPULATION HEALTH MANAGEMENT APPROACH FOR INTEGRATED PUBLIC HEALTH AND PRIMARY HEALTH CARE

The scale and pace of health changes and widening inequalities signal a need to focus on health-oriented rather than disease-oriented care. A population health management approach adopts this focus. Its realization in practice calls on primary health care to promote health and prevent or delay the onset of complex chronic care by tackling upstream determinants of ill-health from the perspective of the population *(4)*.

This requires intensive collaboration between public health and primary health care. Fortunately, this collaboration is natural, as public health works best when anchored in the health system, giving it a clear locus from where it can reach across the system and other sectors. Primary health care is an obvious ally in this; as the anchorage point for public health services, it optimizes both perspectives and allows them the possibility to continuously learn from each other. This integration is particularly powerful for individual health promotion and prevention services, early detection of health conditions, and condition management, such as for hypertension, metabolic conditions, tuberculosis and mental health issues, among others.

A population-oriented approach allows public health to fulfil its potential to bridge to individual specialties. The threat of siloes to public health services is the loss of intelligence on the population's health as a whole. As our populations move away from a normal distribution, there is a need for bold changes that firmly adopt and uphold a population view.

Primary health care as an anchor for a range of public health services is common to countries in Europe where public health is strong. It takes a workforce that is geared towards a preventive and health-promoting mindset and trained accordingly. In this special issue, in a case study from Belarus, Famenka and colleagues describe the development of the public health and primary health care system and ongoing efforts to strengthen integration. In a case study from Germany, Rolke and colleagues describe a health and equity-oriented approach put in place to deliver services to newly arrived refugees. Lionis and colleagues also put population health outcomes at the centre in their piece describing reforms unfolding in Crete, Greece.

2. ADOPT A COMMUNITY CARE MODEL TO INTEGRATE WITH SOCIAL CARE

Many people with social care needs have a strong demand for primary health care, yet too often face barriers to accessing quality health services tailored to their needs. This is frequently the case for those who live in institutions for older people or for people with mental health disorders. As a result, there is under-treatment and missed opportunities that could prevent acute care episodes or slow down or reverse chronic health and functional decline.

Primary health care plays a critical role in making the link between health and social care. Besides having acute or chronic health conditions, many individuals also have unmet social care needs. Primary health care professionals see patients on a regular basis, and when adequately trained and sufficiently

connected with social care practitioners and institutions, they are well-placed to detect social care needs and offer patients advice about where they can get help. Primary health care is also key to designing individual pathways for patients in need of a continuum between acute and social care, including comprehensive approaches to rehabilitation.

Community-oriented primary health care facilitates these necessary linkages. It works to establish networks that can connect providers through partnerships that are made functional when coupled with shared accountability and backed by the increasing number of examples on how to coordinate health and social care in practice. This is crucial for ageing populations and needs close coordination at the local government level *(5)*.

In Europe, putting this know-how into use is still uneven. In this special issue, in a case study on Finland, Keskimäki and colleagues describe the whole-system reform undertaken to integrate health and social services. Ilinca and colleagues make the case for new professional roles to facilitate cross-sector coordination. And, in a discussion with the WHO inter-regional taskforce on hospitals, a vision for the future role of hospitals in community-oriented primary health care is put forward.

3. EMPOWER COMMUNITIES AND ENGAGE PATIENTS TO FORMULATE PROBLEMS, MAKE DECISIONS AND TAKE ACTION

Access to health services is a basic human right *(6)*. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life with dignity. Equitable access to person-centred, quality health and social care means delivering timely services to every patient who needs them, not only to those who can pay, regardless of gender, age, employment or residence status or level of health literacy. Regrettably, this is not the reality for all.

To achieve this, intersectoral collaboration and action for health is fundamental. It means recognizing that primary health care is everyone's business. This includes having unique roles for all actors, from patients and their families to carers and the public. Political will is key to: ensuring that the rights of all patients are respected, fighting persistent inequalities, creating the conditions for engaging communities, and making health a priority in all policies at the national and European levels.

Working with society has become an important strategy in the European Region. This is especially the case for primary health care. Civil society groups, for example, deliver services that cannot be delivered alone by the state, market or family – from well-run health facilities to outreach services for vulnerable populations and social campaigns *(7)*. Engaging patients directly has proved to be important, as it contributes to self-management and the skills and confidence for patients to take control of their conditions, while encouraging shared decision-making. Carers who provide unpaid support to family members and friends are also a critical resource for extending coverage *(8)*.

Increasingly, politicians are influenced by public opinion, as people are expressing themselves not only at the polls every few years but also rapidly and regularly on social media and other outlets. Nonetheless, the untapped potential for the health community to harness its collective power in shaping health services is apparent. Concrete actions can be taken by the health system to accelerate this. In discussion with Chief Medical Nurse I. Kalinina from Moscow, Russian Federation, the experience of the Moscow Health Department to crowd-source public feedback and set priorities for the city's network of polyclinics is explored. In discussion with M. Langins, the role of professional associations in shaping primary health care reforms is underscored.

4. NETWORK PROVIDERS TO ENSURE RESPONSIVE AND MULTIPROFILED DELIVERY

Multiprofile, or multidisciplinary, primary care teams have the potential to significantly raise the capacity of primary health care to resolve health needs. Such teams bring together and network with a range of practitioners – family doctors or general practitioners, registered nurses, psychologists, health promoters, nutritionists, clinical pharmacists, physical activity counsellors, community health workers, and front desk staff. More than co-locating providers, multiprofile practices work jointly to deliver a comprehensive range of services on a broad health and wellness continuum, including rapid diagnostic testing, while optimizing care transitions with social care and ensuring access to after-hours services *(9)*.

Single-handed practices and doctor-nurse tandems can be a barrier to managing complex and multimorbid patients. Practices with a narrow profile of practitioners are often strained for time and lack the competencies to provide quality patient education or support for patient self-management. As patients increasingly present with more than one primary and secondary risk factor, and often multiple psychological and social needs, different models for practices are needed.

Setting up multiprofile teams requires adequate policy backing. Legal changes to contracting and explicit agreements about quality and equity, as well as educational reforms tackling underdeveloped competencies, are among the key success factors in countries in Europe with experience in setting up multiprofile teams *(9)*. The conditions to support the functioning of multiprofile teams are described in cases from Austria by Rojatz, Nowak and Rainer, and Slovenia by Susič, Švab and Klemenc-Ketis, as both countries work to introduce multiprofile teams in primary care.

5. INVEST IN THE COMPETENCIES OF FAMILY DOCTORS AND GENERAL PRACTITIONERS AND NURSES TO INCREASE THE RESPONSE CAPACITY OF PRIMARY HEALTH CARE

A competent primary health care workforce is the engine behind strong primary care *(10)*. Working at the front line of services, the primary health care workforce is intimately familiar with the health needs of the population and the realities of the health system. The ability of the primary health care workforce to decode these demands and apply newly learned knowledge and skills is the crux of their performance, a measure of their competence and, ultimately, a key determinant of the responsive capacity of primary health care *(11, 12)*.

In spite of political strategies aimed at developing the primary health care workforce, persistent challenges remain, notably: entrenched attitudes in medical schools where training is mono-disciplinary and focused on secondary and tertiary care; a lack of standardized quality education and regulation in primary health care; insufficient policies for retaining family doctors; and the increasing mobility of the health workforce.

Research has increasingly signalled that the development of a competent health workforce is the product of a cycle of investment *(10, 12)*. This cycle extends from the initial teaching of knowledge and skills to their application, repeated reflection and feedback for continued maintenance, learning and further improvement over time *(10)*.

In this process, institutions providing initial training play a critical role. Embedding training institutions in, or connecting them to, universities or other academic institutions has proved to be important for the academic level and scientific quality of training programmes and trainers. Quality training for family doctors and general practitioners and nurses at the undergraduate level as well as early clinical exposure are also important for attracting future primary health care doctors and nurses. In this special issue, Prytherch and colleagues detail actions for strengthening initial training and the development of a primary health care workforce through a case study on Tajikistan. The case for engaging professional associations for a fit-for-purpose workforce is made in discussion with M. Langins. Ultimately, bold changes are needed to curricula in order to re-orient initial training from curative skills for exotic diseases to a preventive mindset and training on issues such as mental health, nutrition and alcohol.

6. ESTABLISH LEARNING LOOPS IN CLINICAL SETTINGS FOR QUALITY IMPROVEMENT

Quality is a basic tenet of services delivery. It ensures public trust, wards off unintended deficiencies in care, contains costs and avoids preventable morbidity and mortality to advance health.

Our understanding of what quality of care is, and how it can be cultivated to optimize inputs, safeguard processes and, in turn, improve outcomes, has developed overtime. However, in practice, quality of care has remained focused largely on ensuring the quality inputs, such as increasing the number of trained health practitioners. The use of quality mechanisms for optimizing processes (e.g. investing in clinical quality review and improvement teams), improving outputs (e.g. systems for patient complaints) and having an impact on outcomes (e.g. patient-reported experience and outcome surveys) is varied across countries, with each at a different stage of advancing systems-thinking in their approach to quality of care.

Intensifying the regular use of quality improvement mechanisms in clinical practice is a key component along this continuum. To this end, the WHO European Centre for Primary Health Care continues to explore the broad range of quality mechanisms and systematize the evidence base for their use *(13)*. Activating a system of clinical governance will take a quality culture supported by necessary conditions, including ensuring that practitioners can allocate time to quality improvement efforts with feedback loops, as well as ensuring that clinicians have additional skills and competencies, such as new ways of communicating between practitioners and with patients. These skills and how they can be cultivated are explored in the context of Kazakhstan in the research of Craig and Kapysheva.

7. ENSURE THE RESPONSIBLE USE OF MEDICINES

The issues around, and consequences of, the inappropriate use of medicines are well-documented *(14)* with one particular concern being the responsible use of antibiotics *(15)*. Access to antibiotics is a cornerstone of modern medicine but many

countries struggle to find a balance between access to and use of antimicrobial medicines to avoid the rapid emergence and spread of antimicrobial resistance.

Most of the consumption of antimicrobial medicines occurs in community and outpatient settings, placing primary health care at the centre of efforts to increase the responsible use of antibiotics. In the European Region, there are patterns of misuse including prescribing antibiotics for conditions that are not caused by a bacterial infection, over-the-counter sales as well as under- and over-dosing *(16)*. Because of antimicrobial resistance, the efficacy of commonly used antimicrobials is currently threatened by several pathogens.

Bringing the right medicines to patients who need them requires efficient medicine policies, regulation of the pharmaceutical sector, awareness of the benefits and consequences of medicines, as well as the engagement of all actors in the responsible use of medicines. Primary health care practitioners and community pharmacists, along with the involvement of individuals and patients, can make a difference by prescribing and dispensing antibiotics only when needed, according to current guidelines. In this special issue, the importance of effective communication and professional competencies to support patients in the management of their treatment and health needs is a key takeaway in the piece by Craig and Kapysheva.

In addition, parental education, combined patient-clinician education, practices that delay antibiotic prescription and electronic decision-support systems are all among the interventions that can improve and reduce antibiotic prescription *(17)*. In primary health care, the coordinated targeting of consumers, nurses, pharmacists and prescribers, through education and awareness raising about the risks associated with the overuse of antibiotics, holds promise for achieving the behavioural changes needed to stop the health threat of antimicrobial resistance. Implementing the WHO ACCESS, WATCH and RESERVE (AWaRe) grouping of antibiotics can also work to ensure that the right antibiotics are prescribed for the right infections.

8. OPTIMIZE SERVICES WITH EVIDENCE-INFORMED TRANSFORMATIONS

The development and use of health information in primary health care is the basis for a strong primary health care system. Experts have speculated that primary health care advances in many systems over the past decades may have been stunted in part due to a global underinvestment in metrics and measures specific to primary health care *(4)*. Services delivery research has also been criticized for being slow to advance from conventional methods, such as controlled experiments, to embrace non-experimental, mixed-methods and process-based approaches *(18)*.

Driving transformations with health information and their use to stimulate innovation and quality improvement has never been more accessible. For example, knowledge about how to maximize the use of health information has advanced, including our understanding that indicators should be based on evidence that draws from various data sources, including professional, contextual and policy evidence. Indicators also need to be adaptable, taking into account the dynamic context of a country, region or community. The choice of indicators should be guided by the ability to routinely collect information, either from administrative sources or from specially designed surveys, and the validity and reliability of the source information. Indicators will also have more meaning if they are regularly reported over time so that trends can be gauged.

In the fast-changing services delivery environment, the timely use of data is needed to preserve its actionability and stimulate learning. It allows users to make decisions promptly, such as for correcting poor performance and improving quality. This cycle of continuous learning and improvement requires institutionalization. This will facilitate the attribution of roles and responsibilities, provide the required tools and resources, recognize good performers, and support low performers in improving their impact. There also needs to be a much greater focus on the way in which evidence is communicated with policy-makers. This includes placing more attention on identifying and communicating the economic benefits of better non-health specific outcomes when the health sector seeks to influence or work with other sectors.

Recent and promising trends in services delivery research include: more readily available primary health care data; the increasing use of new measures, such as patient experience indicators *(19)*; and instruments tailored to Europe that adopt a systems mindset *(20)*. In this special issue, the COORDENA questionnaire presented by Vázquez and colleagues is one example of a tool for generating meaningful data on coordination across levels of care.

9. UPGRADE FACILITIES FOR THE OPTIMAL USE OF EHEALTH AND HEALTH TECHNOLOGIES IN PRIMARY HEALTH CARE

eHealth plays an important role in contributing to the achievement of universal health care. It is well-recognized that electronic information systems and innovative technologies

can contribute to extending the scope and reach of services to previously difficult-to-reach population groups, improving quality through providing readily available information, facilitating coordination across providers, allowing for an increased personalization of services, and achieving new levels of cost–effectiveness in the delivery of services *(21)*. In this special issue, Rolke and colleagues illustrate the dimension of extending access to services through a case study of the use of eHealth in Germany to provide services to newly arrived refugees.

However, leveraging eHealth as a national strategic asset means far more than just the acquisition of technology. In the case of primary health care, where its connectivity is key to its functionality, alignment across settings of care, providers and governance levels of the health system is a must.

Experiences from the early adopters of eHealth and new technologies have signalled elements critical to successful investments in eHealth: from having clear organizational arrangements, structures, roles, standards and legislation, to equipping the workforce with required skills, and managing the culture change needed among those who will utilize eHealth services – any of which can serve to derail initiatives if neglected *(21)*.

10. ALIGN ACCOUNTABILITY AND INCENTIVES WITH NEW MODELS OF CARE

Financial incentives play an important role in shaping organizational structures and interactions within health systems. Many European health systems use historical budgets for funding public health services, capitation for primary care, fee-for-service for outpatient care, and case-based payment for hospital care. While there is logic in adopting each of these payment mechanisms, when viewing them in their totality they: undervalue health promotion, prevention, early detection and condition management; provide no incentives for task expansion in primary health care; reinforce episodic orientation of services; reinforce thinking in terms of fragmented care rather than in an integrated manner with people at the centre; and do not reward coordination and teamwork. These are particularly problematic in the era of multimorbidity.

Having recognized this issue, many countries use additional approaches to mitigate the negative impact of base payment mechanisms, such as pay-for-coordination, pay-for-performance or bundled payments. When well-designed and governed, incentives used as policy levers to strengthen the model of care are likely to serve as improvements to typical interactions in the delivery of services; nonetheless, they still only tinker at the margins. Incremental approaches are insufficient to drastically transform the way in which services are delivered.

Larger scale experiments, such as in Hungary and Germany, have been underway to pay for the totality of services through full capitation payment to a network of providers cutting across levels of care. These experiments have pointed to the critical role of a population health management approach and intermediaries between purchasing agencies and providers to analyse health system interactions, steer patients, and self-monitor providers. The prospect of shared savings can drive system redesign and the reconfiguration of pathways in a bottom-up collaborative manner that prioritizes quality and works towards desired health outcomes. These approaches also harness the agency role of health practitioners and empower managers. By using a mix of financial and non-financial incentives, this can create incentives and instruments for collaboration.

However, progress is too timid in this direction. An ambitious agenda of primary health care transformation requires an equally ambitious agenda in health financing, strategic purchasing and provider-payment mechanisms. In a study by Rojatz and colleagues, the opportunities to integrate health promotion services into primary health care units in Austria is described, with due attention to the supportive financial changes that are needed.

ACCELERATING IN PRACTICE

Over the past four decades, countries of the European Region have worked without exception to advance the principles of primary health care. The evidence and practical know-how in this special issue of Panorama attests to this. Nonetheless, in a period of unprecedented change and with a view to the 2030 global targets, extending coverage to quality services demands that urgent attention be paid to primary health care. The policy accelerators explored here, while not exhaustive, are a necessary shift in gear to focus on implementation. They are a call for today's decision-makers to make progress more quickly, and to prioritize efforts that have proven their effectiveness for transforming primary health care – in the spirit of getting it right, fast.

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