



cutting through complexity

The primary care paradox

New designs and models

kpmg.com/healthcare

KPMG INTERNATIONAL



In partnership with

nuffieldtrust
evidence for better health care

The Nuffield Trust

The Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK. Our vision is to help provide the objective research and analysis that boosts the quality of health policy and practice, and ultimately improves the health and health care of people in the UK.

We aim to help provide the evidence base for better health care through:

- conducting cutting edge research and influential analysis
- informing and generating debate
- supporting leaders
- examining international best practice.

www.nuffieldtrust.org.uk

The Euro-Summit

The European Health Summit (Euro-Summit) is a high-level, participative and networking event for UK, European and other international health leaders. The Euro-Summit has been established by the Nuffield Trust as a forum for a select senior group of policy-makers, practitioners and academics from across Europe to examine, in depth, the major challenges facing European health systems. The summit offers an opportunity to discuss how best to respond to these challenges, and allows consideration of how Europe can share international innovations and learn from other parts of the world.

The 2013 Euro-Summit, which was supported by KPMG, focused on the future for primary care. The debates focused on how this can help meet the health and societal challenges facing European nations.

Authors:

Nigel Edwards, KPMG and The King's Fund
Judith Smith, Nuffield Trust
Rebecca Rosen, Nuffield Trust

CONTENTS

| | |
|---|-----------|
| Preface – The primary care paradox | 02 |
| Introduction | 03 |
| The argument for high quality primary care still stands... | 04 |
| Multiple changes in demand and supply | 06 |
| The political and financial context varies | 08 |
| The scale and scope of primary care varies too.... | 12 |
| Primary care needs to change | 14 |
| New models of primary care emerging in Europe | 16 |
| Community based care for specialist conditions | 20 |
| Primary care fit for the future needs to be: | 22 |
| Redesigning primary care | 24 |
| Design principles: access and continuity | 26 |
| Design principles: patients and populations | 27 |
| Design principles: information, outcomes and engagement | 28 |
| Design principles: management and accountability | 29 |
| Future directions | 30 |
| Conclusion | 32 |
| Perspectives from round the world | 33 |

Preface – The primary care paradox

As Saltman and others have observed, primary care has a paradoxical problem. It is, undoubtedly, a crucial part of any strategic solution for sustainable healthcare across the world but its relative weakness (in relation to other parts of the health eco-system) often casts doubt on its capacity and capability to effect large scale change. We recently held an international symposium of expert primary care practitioners to wrestle with this paradox and reflect on what works. Their conclusions were both up-lifting and illuminating.

In many parts of the world, it is clear that aging and the rise of long term, chronic conditions are challenging existing models of primary care that have, to-date, served many countries well. Interestingly, at a time when many developing countries are seeking to establish, build and develop their own primary care platforms, developed health systems are starting to recognize that small scale practices which deliver relatively inflexible and reactive healthcare cannot optimally serve patients, citizens and tax-payers in the twenty-first century. The good news is that innovative practice – across developing and mature health systems – is alive and well in primary care.

While we should be respectful of what has been developed and achieved, our symposium suggests that leading edge practitioners are enhancing care by transforming organization models (providing scale, scope, speed of access and specialism) and delivering both health and social care. Equally, they are orchestrating more personalized, pro-active care and preventative population health, often facilitated by eHealth which enables more home care and self support. We have identified four new design principles – access and continuity, patients and populations, information and outcomes and management and accountability – that may help frame future developments.

While we were not able to discuss all primary care challenges, such as future workforce supply, we hope you enjoy our reflections and insights. I would like to thank our guests and clients for their participation at the conference in Brussels in association with the Nuffield Trust.



Mark Britnell

Chairman, Global Health Practice,
KPMG International, and Partner,
KPMG in the UK

Introduction

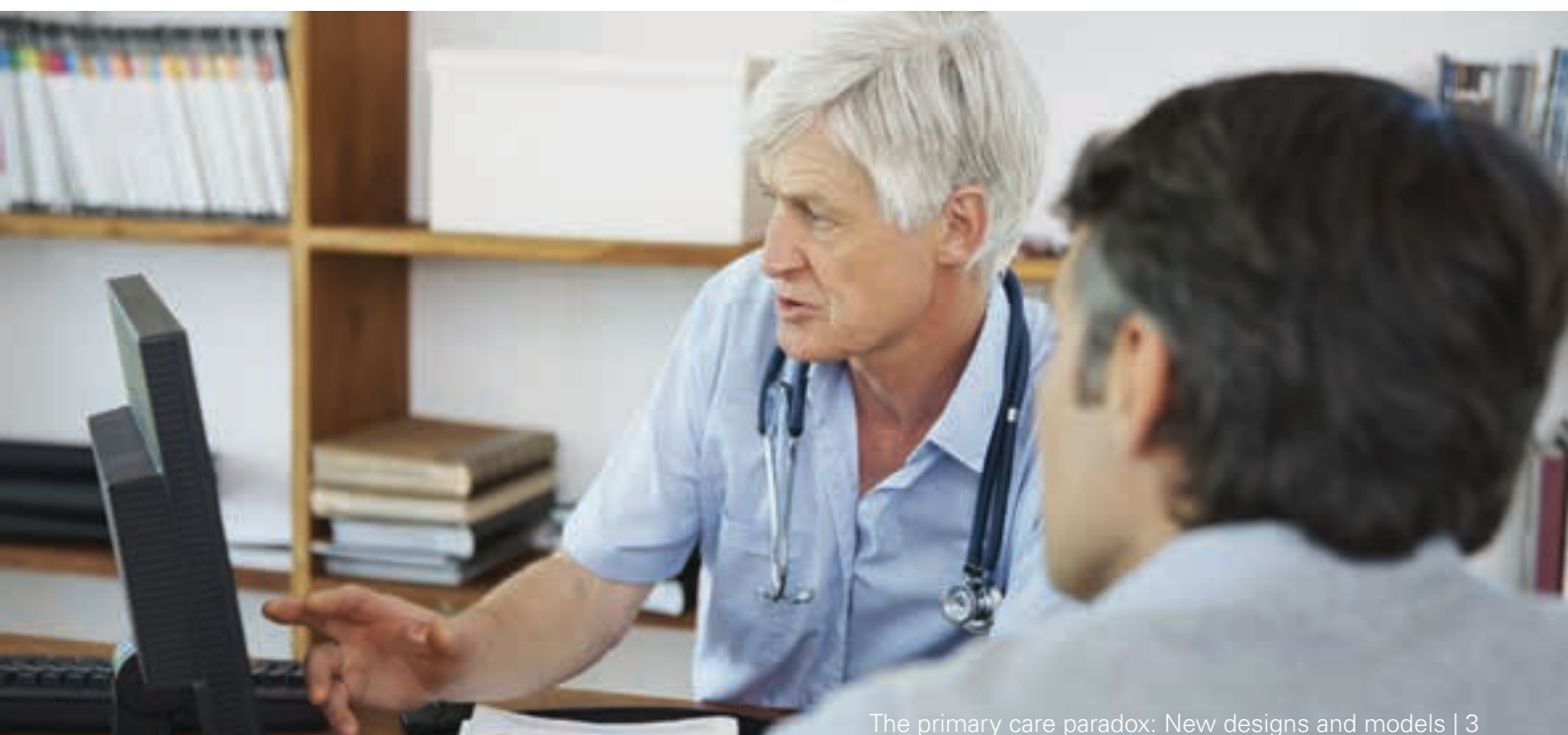
Primary care is a vital building block of many successful health systems. It is however coming under strain as health systems look to this sector to deliver a wider range of preventative, diagnostic and treatment services 24/7, typically as part of plans to reduce reliance on inpatient hospital care and enable better co-ordination of care for groups such as the frail elderly, those living with mental health problems, and vulnerable families. The model traditionally used to deliver primary care in many countries has not changed significantly for many years

Very often primary care:

- is delivered by small independent practices with limited access to a wider multidisciplinary team;
- is based on a model of inflexible and short appointment slots only available from Monday to Friday within normal working hours;
- is unable to offer telephone, email, skype or other modern access to medical and nursing advice;
- has inadequate diagnostic support; and
- is insufficiently connected to specialists, community based services (e.g. pharmacy) and other resources that could help it function more effectively.

Changes in the patterns of disease, expectations, workforce and across the whole of healthcare means that primary care needs to change.

This report presents the results of discussions with primary care experts from across Europe brought together in Brussels by the Nuffield Trust and KPMG.





The argument for high quality primary care still stands...

The evidence

Effective primary care enables improved health outcomes and lower costs (Starfield et al, 2005; Atun, 2004). Recent research has concluded that strong primary care is associated with lower rates of avoidable admissions to hospital and fewer potential years of life lost. The same research points out that primary care requires higher levels of health spending to achieve such benefits, with likely savings accruing in the longer (not short) term (Kringos and others, 2013).

Primary care is playing an increasing role in care co-ordination across sectors (Saltman et al, 2006), although concerns remain about its ability to fulfil this role without parallel investment in integrated patient records and IT, the aligning of financial incentives across health providers, and the development of effective governance arrangements (Rosen et al, 2011).

Primary care has the potential to be the supporter of IT-driven services such as telehealth and telecare and on-line consultations. This requires the parallel development of new models of service delivery, and experience from rural and remote areas in countries such as Australia and Canada, is of particular relevance here. Whilst evidence for telehealth and telecare in countries such as the UK where the interventions have been aimed directly at patients has proved equivocal to date, the technology and knowledge about how to apply it is changing very rapidly. Technology that supports consultation between professionals seems to be helpful in providing specialist support to clinicians.

Components of primary care


Primary care lies between self-care and hospital (or specialist care) and fulfils a range of functions:

- prevention and screening
- assessment of undifferentiated symptoms
- diagnosis
- triage and onward referral
- care coordination for people with long-term conditions
- treatment of episodic illness
- provision of palliative care.

Richard Bohmer points out that the different functions listed above can be divided up between different providers, depending on the history and configuration of a particular health and care system.

This may be necessary if there is not an existing strong family doctor system or parts of it are not delivering as required. The family doctor model has proved a successful way of bringing these components together, but there are growing challenges which are putting strain on that model.

There is increasing interest in many health systems in primary care working on a population health management approach, whereby primary care organizations take responsibility for the health of a register of people, addressing the prevention of ill health as well as presenting illnesses.



Primary care has the potential to be the supporter of IT-driven services such as telehealth and telecare and on-line consultations. This requires the parallel development of new models of service delivery, and experience from rural and remote areas in countries such as Australia and Canada, is of particular relevance here.



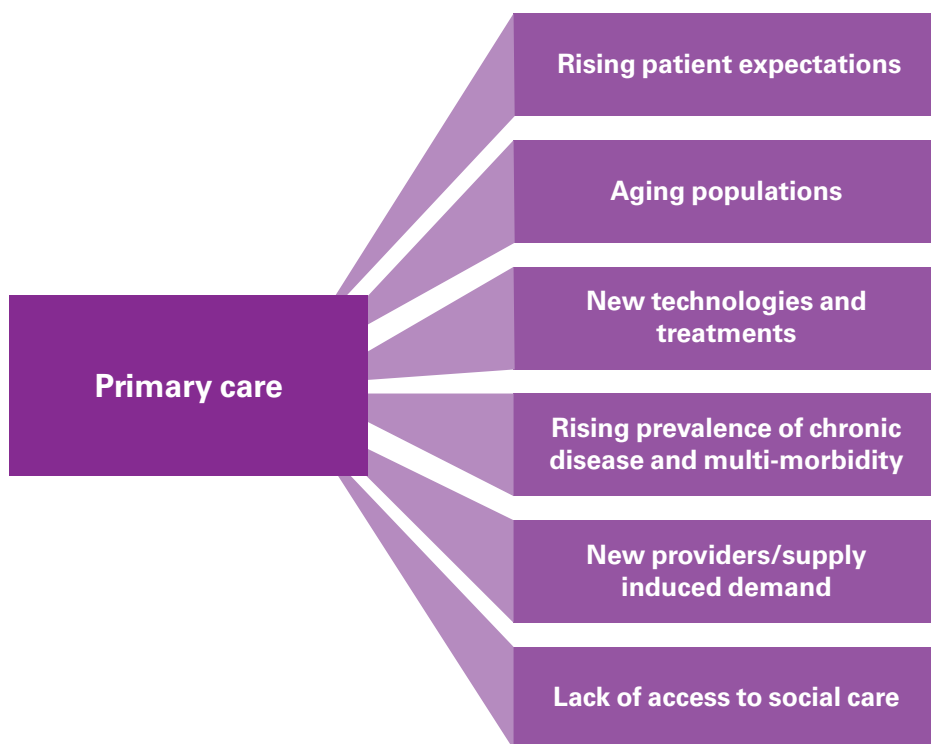
Multiple changes in demand and supply

The rising prevalence of chronic disease due to population aging is focusing attention on unhealthy lifestyle and behaviors. The role of health services in prevention and risk factor modification is under review, as is the need for better coordinated care for people living with complex co-morbidities, and therefore becomes more pressing.

Poor communication between primary care, hospitals and medical specialists often results in fragmentation of care, low-quality patient experience and sub-optimal outcomes. The role of primary care in providing improved coordination of care is under debate in many countries with policy in some countries seeking to develop the 'primary care medical home', where a family medicine practice assumes full responsibility for the health and care of its enrolled patients, even when they are referred for diagnosis or treatment beyond primary care.

Other factors that are creating a need for change in primary care include: the development of technologies that enable new forms of information, access and involvement for patients; innovative drug treatments and therapies that enable more community and home-based care; and changes in patients' expectations about access to care and the range of services that should be available to them.

Developments in information technology are also challenging the whole concept of 'primary care'. For example, electronic health media including the Internet, telehealth and telecare are leading to a significant reappraisal of where a person's first contact with health advice and support takes place and how health providers can utilize such media and technology to support people's care.



Developments in the primary care workforce are also creating new opportunities for people to obtain advice and treatment. For example, extended nursing roles in chronic disease management, minor injury and illness often underpin the delivery of 'walk-in' clinics, minor illness services and primary care for remote, rural communities.

Pharmacists are increasingly providing advice on self-management of self-limiting conditions and some offer support on chronic disease management and public health interventions such as smoking cessation and weight management. Furthermore, healthcare assistants with basic health training but no professional qualifications are, in some instances, taking on roles that were traditionally undertaken by nurses.

Developments in the primary care workforce are also creating new opportunities for people to obtain advice and treatment.



The political and financial context varies

Healthcare in austerity

In many countries, the global financial crisis has driven cuts in public spending, un-predictable revenue for healthcare, and cuts in other essential services which affect health (eg housing). Maldivosky (2008) notes the challenge of implementing austerity policies while achieving national health goals such as equitable access. Research suggest that in some countries, strengthened primary care is regarded as a critical element of a health system reconfigured to provide care in a time of austerity (ref EHO work).

Variation in policy, regulation and payment systems

There are significant differences in the political and economic contexts in which primary care operates. Former central and Eastern European countries illustrate how differences in national policy, payment systems and regulation have shaped the organization of services and, thus, the starting point for primary care transformation. For example, in Hungary fee for service payments and regulatory controls on General Practitioners (GPs) grouping together have largely kept GPs in solo practice with few connections with specialists. In Croatia policy to develop universal access to a broad range of primary care services, linked to investment in polyclinics has co-located GPs and specialists, encouraging some collaboration and shared clinical standards.

In contrast, western European economies pursuing competition and market-driven reforms are exploring policies as a way to introduce new primary care providers and to increase competitiveness and drive innovation.

Health and Care services

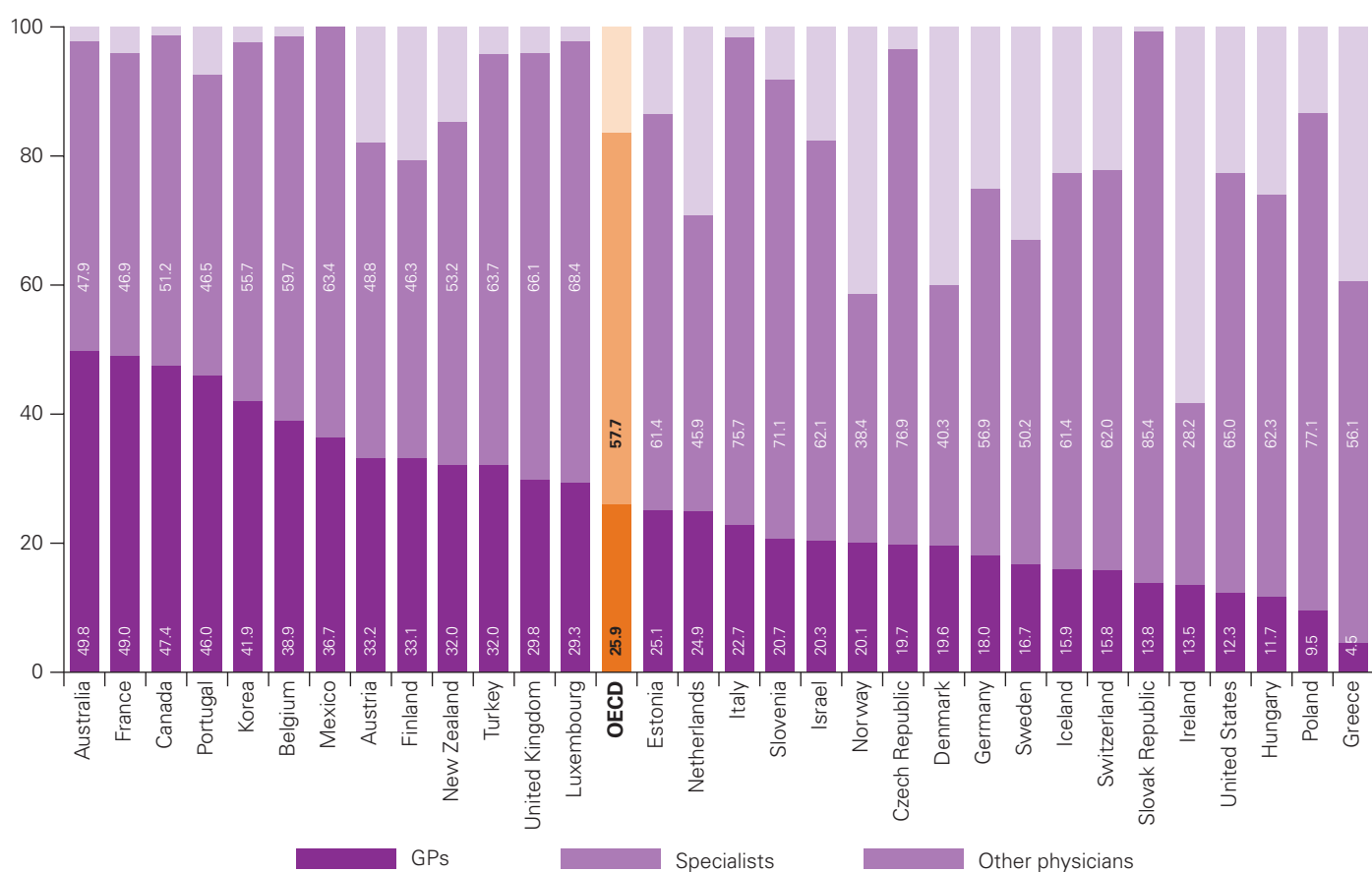
The variability in what constitutes ‘health’ or ‘social’ care across Europe is another key influence on the role and organization of primary care. The Scandinavian model of strong municipal government creates a system in which polyclinics run by municipalities link health and care provision. This contrasts with the UK, where local government care services have tended to operate separately from the NHS.

Policy on access to generalists and specialists

Policies on issues such as direct access for patients to specialists, primary care gate-keeping, and choice of primary care provider sustain diversity in European primary care.

Policy in the Netherlands to reform chronic disease management illustrates how payment systems can drive new ways of working between GPs and specialists in selected services.

Table 1: Relative provision of GPs, specialists and other physicians



Source: OECD Health Data 2011.



Case studies of variability

Case study: Polyclinics in Croatia

Prior to 2008, fee for service payment and the organization of GPs into small private practices resulted in large list sizes, a 49 percent fall in preventive interventions and huge growth in referrals to specialists compared to that achieved under the Yugoslav government.

A 2008 reform program transferred the organization of primary care from national to county government and introduced health care 'concessions' to serve local populations. Concessions are based around polyclinics offering both primary and specialist care.

- Based in primary health care center.
- Doctors are paid 80 percent through capitation and 20 percent linked to delivering selected interventions.
- Standardization of list size for each primary care team to promote equity of access.
- Financial incentive to attract staff to under-provided areas to promote equity of access.
- Initiative to reduce prescriptions of 'sick leave' by primary care physicians, reducing spend on sick leave compensation and increasing national productivity.



Hartola Health Station, Finland

Finnish health and care services are organized around municipalities, which vary in size, with an average population of 5,800. National policy aims to merge smaller municipalities and reduce the total number from over 300 to around 70. The health station in Hartola illustrates the range of services available in 2013 for a population of 3,500, with 5,000 extra summer visitors .

- Municipality-owned health station (linked since 2012 to a cluster of municipalities): comprehensive primary care including preventive care, some specialist and welfare services. Two full time GPs.
- Also offers: home care, dementia unit, diagnostics, social welfare support, community hospital, specialized geriatrics and psychiatry.
- Uses doctors, nurses, allied health professionals, private ambulance staff, administrative personnel, private laboratory company.
- Electronic patient record.
- Introducing the Chronic Care Model into primary care as the 'health value model'.



The scale and scope of primary care varies too....

Primary care organizations

As noted previously, the scale and scope of primary care organizations varies across Europe as does the value base underpinning its role within the wider health and care system (see table 2). Standalone clinics run by single-handed doctors are typical in some countries, and large health centers run by multi-professional teams including social care, being the norm in others.

Mixed views about smaller clinics

The incentives on self-employed sole-practitioners with fee for service payments may drive over-investigation and over-referral. But research also describes benefits for patients in small practices in terms of greater continuity of relationship. And innovative physicians can take a public health perspective, adapting their services to meet population needs, as seen in the Risiori Rural Clinic, Romania.

Bigger primary care organizations

New models of primary care organization are emerging in countries which are seeking better coordination between services for people with long term conditions and stronger links between primary and specialist care. There is a growing trend towards larger scale practices – working through networks; polyclinics; extended physician partnership or integrated systems. The strength of these models lies in their scale which allows:

- an extended range of services with access to specialist advice,
- a focus on population health management,
- development of tailored care for people with multi-morbidity,
- peer review and clinical governance,
- professional human resource, financial and leadership capacity,
- investment in IT and other technologies,
- career development and support for professional and other staff.

Table 2: Typology of primary care organizations and ‘values’

| Organizational type | Structure and process | Value base | Service focus | Location (examples) | Endpoint | Countries (examples) |
|------------------------------|------------------------------|--------------|---------------------------|----------------------------|-------------|--------------------------------|
| Extended general practice | Simple, partnership | Normative | Registered patient list | Health center | Patient | Finland, Portugal, Greece |
| Managed care enterprise | Complex, stakeholder | Calculative | Target groups | Physicians' group | User | Ireland, Italy, England |
| Reformed polyclinic | Coalition, divisional | Commercial | Medical conditions | Multi-specialist clinic | Client | Macedonian and Czech Republics |
| Medical cabinet | Self-employed, independent | Professional | Maintenance | Municipal premises | Attendees | Hungary |
| District health system | Hierarchic, administrative | Executive | Public health improvement | General hospital | Populations | N/A |
| Community development agency | Association, network | Affiliative | Local populations | Health stations | Citizen | N/A |
| Franchised outreach | Quasi-institutional, virtual | Remunerative | Payers | Private, hospital premises | Customer | Poland |

Source: Meads, 2009.



Primary care needs to change

Primary care is often locked into an old model of service of provision which does not serve the needs of modern users. There are a number of key issues:

- There are still too many inappropriate payment mechanisms that incentivize the wrong type of behavior by clinicians.
- Care is not designed with, and for, those who have more than one condition (e.g. longer and personalized consultations).
- There has been a decline in continuity as primary care practices have become larger, employing many (often sessional) doctors.
- Primary care practices typically offer short appointments available only from Monday to Friday within normal business hours.
- Primary care often fails to anticipate issues adequately, concentrating on presenting need, and failing to use its health information to undertake proactive work with people potentially at risk of ill health.
- Primary care practices often struggle to offer 24-hour access to credible clinical advice for episodic problems.
- Primary care rarely makes use of technological innovation at scale, with email and phone consultations still rare in some health systems.
- The much-vaunted strength of primary care as coordinator of comprehensive care over time is often not a reality.
- Primary care often has inadequate access to specialist advice and expertise, resulting in delayed diagnosis and referral.
- Primary care needs to have much better links to other services in the community (e.g. housing, social care and the voluntary sector).

The fundamental paradox of primary care:

... a paradoxical situation: the tension between the relative weakness and un-attractiveness of this level of care versus the intention to assign critical strategic functions to it.'

From: *Primary Care In The Driver's Seat?*
Saltman, Rico and Boerma (eds) 2006

Saltman and others (2006) have argued that the intermediate territory between self-care and specialist/hospital care is changing, with primary care playing an increasing part in coordination and integration of care that is provided by different services. These new roles, together with elements of specialist care that can now be delivered in primary care settings, can be thought of as 'extended primary care'. They are the focus of recent developments in many European countries, often seeking to bridge the divide between generalist first contact care, specialist services and disability or home care.



New models of primary care emerging in Europe

Case studies illustrating the impact of national and local drivers of organizational change in primary care

The following case studies illustrate how national and local factors can stimulate the development of new models of primary care. In the Netherlands, changes in the payment system for diabetes care stimulated individual GPs to group together into local networks. In Sweden, national policy to improve access through greater competition has introduced new private providers and encouraged service innovation. In England, national policy to shift care from hospital to community settings and promote integration has triggered the emergence of larger practices combining primary care with specialist services.

In addition to national policies, local context and professional enthusiasm can be important drivers of change. In the Belgian case study a new philosophy of care based on individual patient goals has emerged in response to the health needs of a deprived local population. In contrast, ParkinsonNet was driven by a new professional vision of the relationships between generalists and specialists combined with innovative use of technology and a focus on patient involvement and choice. The UK case studies illustrate how national policy can create a supportive context for change, but engaging local clinicians in services transformation requires a compelling local story about why change is needed.

Zorg in Ontwikkeling (ZIO) Netherlands

- General practice network of 90 GPs covering 170,000 population.
- Physiotherapists, dieticians, nurses and also members of the network.
- Multidisciplinary primary care organization focused on delivery of coordinated chronic care.
- Disease management programs delivered by all member practices under network contracts to health insurers.
- Integrated payments for a year of care for long term conditions.

- Members receive education, quality systems and IT support, real estate development etc. from the network.
- Piloting population-based budgets.

A requirement that all residents in Dutch nursing homes should have a regular medicines review led to nursing homes ensuring that their residents were only registered with one or two practices rather than the many that was usually the case. This allowed some specialization in this complex type of care to develop with good results on reduced admissions to hospital, reduced falls and so on.

Brahehälsan, Sweden

- Two private primary care clinics established by doctors and dentists who form the Praktikertjänst company.
- This has been enabled by legislation opening up the primary care market in Sweden.
- 12 doctors, 10 nurses, allied health professionals, nurse assistants, clerical staff, social worker.
- Serves 12,600 people and has an electronic patient record.
- A network with specialist outpatients services and the local hospital.

Reforms to increase access and innovation through competition were introduced in Sweden in 2008. The reforms created new entrepreneurial opportunities for primary care and has led some GPs to expand the scope and scale of their practices.

Community Health Centre Botermarkt, Ghent, Belgium

- Not-for-profit multi-disciplinary health center in a deprived area of Ghent, for 6,000 patients from over 70 countries.
- 9 doctors, 4.5 nurses and 8 staff including: health promoters, dieticians, social work and ancillary staff.
- There is an electronic and interdisciplinary record.
- Aims to deliver integrated primary healthcare: prevention, curative care, palliative care, rehabilitative care and health promotion.
- Works within philosophy of Community Oriented Primary Care and co-designs care objectives with patients who have multi-morbidity, and tailors services accordingly.

Based on a philosophy of meeting the goals of the patient rather than focusing on the process and biomedical indicators. What does the patient need to improve their life? This becomes much more relevant for patients with multiple problems as the guidelines developed for single diseases are of limited help and applying them all would mean that the patient's life would be dominated by managing their health.



Whitstable Medical Practice, UK

- NHS general practice and community integrated healthcare for 34,000 patients.
- 19 doctors and 34 nurses and 130 other staff, and plans to integrate social care (Whitstable Integrated Social and Health care pilot – WISH).
- Electronic patient record.
- Provides a wide range of preventative healthcare, screening, exercise programs, smoking cessation programs.
- Redesigned care pathways as basis for developing new primary care services: long-term condition management, urgent care, elective care and diagnostics; and community hospital.

A larger scale model can afford a higher calibre manager than is possible in most smaller practices.

Building on national policy to create integrated services in community settings, the Whitstable Medical Practice built a new health center to combine primary and specialist care.

Professional management also makes a big difference in this model – the large scale allows a higher calibre manager to be employed than is possible in most smaller practices.



Vitality Partnership, Birmingham UK

- Super-partnership formed of practice mergers, serving 50,000 patients across seven sites.
- 27 doctors and 23 nurses and 137 employed staff in total.
- A single IT system and integrated electronic patient record.
- Aims to deliver high quality population-based primary care with in-house provision of specialist services.
- Specialist services include dermatology, rheumatology, orthopaedics and diagnostics.
- Aims to grow to a population of 100,000.
- New career options for doctors and nurses, strong focus on organizational development.

Downward pressure on practice incomes provides an additional incentive to scale up.

A super-partnership results in **new** career options for doctors and nurses and a strong focus on organizational development.



Community based care for specialist conditions

ParkinsonNet

ParkinsonNet is a vision of the future for the management of a complex disease and illustrates the power of the patient as a participant in their own care. The model was built by Professor Bas Bloem. His goal was to create a model that met the needs of the patient while dealing with some of the institutional challenges inherent in the system such as: poor referrals being made to specialists, overtreatment, under treatment, the wrong treatments being used, a lack of specific expertise and poor communication between professionals about patient care. His research led him to believe that the overall gap between evidence and actual clinical practice needed to be closed.

In redesigning his services, he identified five areas that were key to success:

- helping to create an active patient able to manage their care and take key decisions;
- defining what value based care would look like from the perspective of the patient;
- changing the way that doctors and other clinicians work with patients from 'god to guide' by shifting to a partnership approach with patients to identify the regimen that works best for them;
- creating a network of experts; and
- linking all of these together with information technology tools.

Based on these assumptions, Professor Bloem worked with patients to develop a set of comprehensive guidelines including a special version geared towards patients' use. Interestingly, a key part of the guidelines involved patients telling

Supported by electronic tools, patients are able to set their own priorities and build their own networks of care.



their professionals what they needed to stop doing rather than what they should be doing.

Using these guidelines Professor Bloem identified all the professionals working with Parkinson's patients in his region, and trained a selected group of these in the most up to date approach to management of the condition including the provision of physical therapy, symptom control etc.

The next step was to provide these specialists with tools that could facilitate greater communication and the sharing of best practices, new approaches and data about patient outcomes.

With this infrastructure in place, Professor Bloem was able to enroll patients through a web portal, allowing patients to choose an accredited provider, confident in the knowledge that they would be using the same approach as other professionals in the network. Patients are able to set their own priorities and build their own networks of care supported by electronic tools which also allow them to set their own priorities and goals for their care, exchange information with professionals and connect to other patients. The same tools are used to connect the professionals to each other.

Patient outcomes and satisfaction have seen enormous improvements and the initiative has led to reduced hospital visits, a 50 percent reduction in hip fractures and substantial savings for payers valued at US\$27 million across the Netherlands.



Primary care fit for the future needs to be:

Patients and their carers are recognized as core participants in decision-making about care and treatment. When registered with a primary care organization the patient benefits from continuity of care with a professional.

Comprehensive

The organization is accountable for meeting the majority of patients' physical and mental healthcare needs, including: wellness, prevention, acute care and chronic care. Where the right skills or services are not available within the primary care organization, staff play a central role in coordinating virtual care teams involving professionals from other community services and specialists in secondary care and signposting people to relevant local welfare and other social support services.

Person-centered

This is relationship-based, premised on trust and concerned about the whole person. Patients and their carers are recognized as core participants in decision-making about care and treatment. When registered with a primary care organization the patient benefits from continuity of care with a professional. Person-centered care also recognizes the impact of broader life experiences (such as wealth, housing and family circumstances) on an individual's health and care.

Population-oriented

The organization is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include: all individuals registered with the organization, all those who are resident in a specific geographic area and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless).

Adapted from the Primary Care Medical Home model, as described by the US Agency for Healthcare Research and Quality (AHRQ 2013)



Coordinated

Care is coordinated across all elements of the healthcare system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams.

Accessible

Appropriate waiting times for initial consultation and advice, diagnosis and care. Patients have 24/7 access to medical and nursing advice and care and organizations are responsive to patient preferences around access.

Safe and high quality

Care is evidence-based whenever possible, and clinical decisions are informed by peer support and review. Clinical data are shared within the organization to inform quality assurance and improvement. The organization is financially sustainable, such that safety and quality standards will not be compromised by resource pressures.

And sustainable in terms of:

- finance
- workforce
- public trust
- fit with wider health system.



Redesigning primary care

How might we take the learning from these emerging models of more organized primary care, principles for high quality primary care, and our understanding of the challenges ahead to develop new models of primary care?

Policy makers can try to reshape the system, but there are dangers in trying to over-specify, not least the unintended consequences of central direction which may not make sense for local context. Also, doing this precludes getting the advantages of innovation and creativity that can be unleashed where primary care is (re)designed and run locally on the basis of independent businesses and vibrant networks of enthusiastic practitioners from a range of health professions.

The approach we propose is:

1. Identify the design principles that patients or the public would want to see embedded in a new primary care model.
2. Develop enough specificity to allow these to be applied in practice, but leaving a great deal of room for local creativity.
3. Create contractual mechanisms, approaches to measurement, and rules of behavior that foster the evolution of new models while managing some of the risks associated with this.
4. Develop new models and approaches to provision that create some tension in the system and that will promote innovation and change (or at least fill in some of the gaps in those areas where new models may not develop so quickly).

Policy makers can try to reshape the system, but there are dangers in trying to over-specify, not least the unintended consequences of central direction which may not make sense for local context.



New design principles

If we are trying to improve the design of primary care it is useful to ask the question – what can we infer about the design principles of the current primary care and wider system and how might changing these produce a different result? In other words, how does primary care work (or not) for patients, the public and professionals, and how might we redesign services to address this?

Rather than specify a particular primary care model or organization, it makes sense to determine the key attributes required.

The following present a suggested set of design principles for primary care. They will need to be adapted to local contexts and take into account the wide variety of different approaches found across Europe. At their heart, however, there is a key idea that patients have a professional who can work with them over time to manage and improve their health and that there is more standardization in the approach taken.



Design principles: Access and continuity

Early access to expertise

Rather than speaking to an administrator there is a senior clinician, capable of making decisions about the correct course of action available to patients as early in the process as possible.

Patients can benefit from access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology.

Many systems have struggled with this. Recent work by KPMG in the Netherlands has looked at the creation of 24 hour primary care urgent care centers as one response.

The Nairn Healthcare group in Scotland uses its community hospital as the base for 24/7 advice by its nursing team.

Tailored encounters

Patients should have the minimum number of separate consultations necessary, with access to specialist advice in appropriate locations.

Care for frail older people is tailored to individual needs, especially for those in nursing or residential homes

Community Health Centre Botermarkt, Belgium offers patients with co-morbidities a long first consultation at which the patient's individual care goals are explored and agreed.

ParkinsonNet in the Netherlands enables patients to use an interactive tool to locate services in their area. These services are supported by specialists, but delivered in primary care wherever possible.

Accessible diagnostics

Primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.

In Kaiser Permanente (US) sites, they aim to provide primary care, specialist care, pharmacy, some laboratory tests and x-rays under one roof, as the norm.

Continuity and coordination

Continuity of relationship with their health professional should be offered for patients for whom it is important, and access at the right time when it is required.

Care plans, agreed between relevant professionals, to coordinate care during transfers between organizational settings and between health, mental health and social care.

Community Health Centre Botermarkt in Belgium offers a tailored service for people with co-morbidity, with longer consultations, and a range of services deemed to meet the needs of the individual. The health center provides 'standard primary care' services to other patients who do not have multiple long-term conditions.



Patients and populations

Goal oriented care

Wherever possible, patients are supported to identify their own goals and manage their own condition and care.

There needs to be much more emphasis on what the patient values rather than a narrow focus on process measures and biomedical indicators.

The Bromley by Bow Centre in London situates itself as a community organization providing general practice and community health service, supporting them beyond their health needs, teaching new skills and activities, and aiming to give them confidence to achieve their own goals.

Multidisciplinary working

Primary care is delivered by a multidisciplinary team in which full use is made of all the team members, and the form of the clinical encounter is tailored to the needs of the patient. This will include mental health, home and social care services. Increasingly we expect to see more specialists involved – see the principle on ‘Generalism and Specialism’

The Your Health Partnership in the Black Country in the UK has a clinical pharmacist (with prescribing rights) based in its two practices as a core member of the clinical team, supporting medicines management and care of people with complex co-morbidities.

Anticipatory care and population health

Care is proactive and population health-based where possible, especially in relation to long-term conditions.

The ZIO network in the Netherlands delivers evidence-based care for patients with diabetes and with COPD, on a year-of-care basis, working within a contract with health insurers that specifies and incentivize adherence to the evidence-based case management approach.

Generalism and specialism

A theme of these principles is a wish to have the best of both worlds. We need to retain the skilled generalist who can treat the whole patient. But some groups – the very frail elderly, children, and some specialist diseases – may require more specialization within primary care or as part of a wider more specialist network.

A central principle behind ParkinsonNet in the Netherlands is bringing in specialist neurologist expertise when necessary, yet having the majority of care delivered at home, through the Internet or in primary care.

Vitality Super Partnership in the UK has incorporated specialist medical consultants into their structure.



Information, outcomes and engagement

Single electronic record

There is a single electronic patient record that is accessible by relevant organizations and can be read and, perhaps in future added to, by the patient.

Many of the case studies in this report are using an electronic patient record but the real challenge is to link this to homecare providers, hospitals, ambulance services and other parts of the system.

Using middleware to link different systems together is one solution. Creating a single local system that meets the needs of all agencies is difficult.

Quality and outcomes

Primary care organizations make information about the quality and outcomes of care publicly available in real-time.

The Community Health Centre Botermarkt (Belgium) has embraced the use of performance and outcome measures that are focused on the goals of patients for their care and wider life, rather than on more narrow biomedical indicators.

The Vitality Partnership has established an internal performance management framework that enables partners and staff to have real-time information on all statutory and contractual clinical and non-clinical indicators. These are being developed as indicators to share with commissioners.

Use community assets

The ability to link patients to wider social networks, to use health trainers and people not employed in the formal health service will be increasingly important. Many of the problems patients have are related to social isolation and factors not directly related to health services. Being able to direct patients to information about other services and to people who can help them use this is also important.



Management and accountability

Organization and management

Primary care has professional and expert management, leadership and organizational support.

To achieve these design principles, new models of primary care will need to be professionally managed. Primary care networks and organizations require expertise in population health needs assessment, information systems, human resource management, process improvement, strategic planning and general management.

Nairn Healthcare Group in Scotland has used organizational development and business management support for over 20 years, and reports this as a critical factor in the development and expansion of the organization and its services.

Standardize

There is more to do to create standard processes and ways of working in primary care. This is also important so that other providers understand what to expect when care is transferred between providers.

Contract for value

Payers need to move away from contracts that count visits or require large amounts of box ticking and more to using outcomes. The more primary care providers are able to take full responsibility for the care of their populations the more straightforward this becomes.

Rigorous accountability for outcomes, transparent governance are still required. Public confidence in the choices their primary care practitioners make must not be undermined.



Future directions

The design principles aim are consistent with some directions of travel illustrated in our case studies and could help to shape a new approach to primary care.

These design principles can be applied in various ways and need to be adapted to the context of different systems and localities. Those that relate to the nature of a clinician-patient consultation could be applied immediately into primary care in many countries, irrespective of the wider policy and financial context. Those that relate to access to wider services – such as diagnostics and specialists – and to population health may need additional resources and changes in professional education and regulations before they can be applied.

The design principles aim are consistent with some directions of travel illustrated in our case studies and could help to shape a new approach to primary care. Our case studies, and conference findings suggest that primary care systems will need to:

- Be larger.
- Have access to a wider range of professionals as part of the team or working alongside them.
- Offer a better organized out of hours service.
- Provide better continuity to those patients that need it most.

Models that follow this logic will be better placed to go beyond traditional primary care and develop more 'integrated care'. This creates the opportunity for them to take on risk sharing and capitation budgets – as outlined in the journey to accountable care organizations envisaged in the US – the diagram on the right from United Healthcare illustrates this.

Value-based payment continuum



Source: United Health Group, 2012.

The challenge for payers, regulators and governments is how to create a set of incentives that support innovation, experimentation and evolution, that hold providers firmly to account but without unintended adverse consequences, bureaucracy and box ticking. These approaches may allow many different solutions and be permissive on many things but will need to be tight on governance, open book accounts, key outcomes and issues such as conflict of interest. They may have some tight process requirements too. Walking the line between these difficult compromises is the key to success.



Conclusions

Primary care remains a key part of the health system in many countries. The challenge is how to retain the parts that make it special while enabling it to respond to the growing demands of increasingly complex and older patients and populations who have rapidly rising expectations.

The ideas in this paper suggest that it may be possible to combine a number of characteristics which may appear to be hard to reconcile. A way needs to be found to have the best relationship based primary care with continuity for those that value it, as well as rapid and convenient access for those for whom it is important. There is a need to retain the benefits of generalism and longitudinal relationships while offering patients more specialist opinions and clinicians able to deal with complex problems such as the care of the frail elderly. The models in this report are looking for ways to get the best of the biomedical and social models of care: to be excellent in treating both the condition and whole person. We think this is possible but it requires some major changes while at the same time protecting what has made primary care successful and valued.

Greater scale, more standardization, the inclusion of specialist expertise and bringing in social care and other community services are a key starting point. Leadership from within the profession is vital. Bold experimentation building on what works is required to help services evolve to meet a new set of difficult challenges.



Perspectives from round the world

Primary care development in Singapore

Healthcare development and delivery in Singapore, similar to many developing countries in Asia, have historically been centered on episodic care in acute hospitals, which is increasingly unsustainable in the face of aging populations and chronic diseases.

While there had always been an openness in this city-state to learn from the best systems of the world, generous investment in healthcare manpower development (especially for specialist medicine) and an aspiration to become a medical hub for the region, Family Medicine (FM), as a discipline, needed to be adequately recognized and promoted.

In 1988, the idea of structured vocational training for family physicians was mooted by the Ministry of Health. In 1993, the first batch of Master of Medicine in FM graduated, and 5 years later, the Graduate Diploma in FM program was established. There was a concurrent public education campaign pushing for every citizen to have his own family doctor.

However the initiatives fell short of a nation-wide publicly-provided primary care gate-keeping system, with patients making direct walk-ins to specialists for first-contact care.

While acute hospital care is largely public provided, primary care is 80 percent privately provided. However, more than half of all chronic disease patients in primary care are disproportionately cared for by the 20 percent public polyclinics.

In 1993, the first batch of Master of Medicine in FM graduated, and 5 years later, the Graduate Diploma in FM program was established.



Perspectives from round the world

Driven to promote population health and shift care out of costly hospitals into the community, the entire healthcare system is currently undergoing transformation. Providers are being reorganized into Regional Health Systems, and care in the future will be integrated around the individual. The government is strengthening primary care through an elaborate master plan, including new delivery models such as Community Health Centres (shared allied health services supporting private GPs) and Family Medicine Clinics (multi-GP practices to tap economies of scale), and other changes in funding and policy to draw in more private sector GPs.

There is also growing realization of the importance of prevention, healthy lifestyle, and effective empowerment of patients' self-management in their own homes, leveraging on the latest health technology.

Dr Wai Chiong Loke

KPMG in Singapore



Primary Care in the UK

Primary care in the UK will be a critical element to make the shift of care out of hospital a reality. To achieve that there are a number of factors that will come into play.

Unwarranted variation in primary care – this is a significant issue for CCGs and is at the heart of the conflict inherent in the NHS reforms – can GPs be both providers and commissioners? Responsibility for tackling variation is not clear in practice where in some parts of the Country CCG's leads but in others it is NHS England. However this demonstrates the one consistent theme that information on relative quality performance is vital. With information comes insight and this may then drive new behaviors from regulators as the focus increasingly shifts to quality and safety in primary care.

Chains/Networks – This is an area of growth with a number of models emerging in response to the changing role of primary care, the withering of the small practice and the challenge of shifting greater proportions of care pathway delivery into primary/community care.

Provider entities such as GP Care now have 100+ practices federated in their group. 'Super practices' of merged practices are also emerging to face the challenges ahead and finally multi-practice organizations such as the Hurley Group running a number of practices across London.

Payment mechanisms – more work is needed to align incentives to drive changes in behavior. For example, CCGs are exploring how locally enhanced services can incentivize commissioning engagement across practices.

Technological responses – to meet the challenge of shifting care settings primary care will need to fully embrace the technology to make a step change improvement. CCGs are now exploring how to use technology to care for people remotely through to how to use social media to engage with the population.

Leadership and innovation – the primary care model is little different to the 1960's. To meet the new challenges of this century we will need delivery models but also new leaders. This ultimately is the greatest challenge facing primary care in the UK.

Gary Belfield
KPMG in the UK

Responsibility for tackling variation is not clear in practice where in some parts of the Country CCG's leads but in others it is NHS England.



Perspectives from round the world

Primary Care: A South African Perspective

Entrenched in the Constitution, prioritized in the framework for the roll-out of the National Health Insurance and highlighted, as a core lever to strengthen the healthcare system, in the National Development Plan; Primary Healthcare is an integral part of attacking the high burden of disease, achieving social cohesion and addressing the after-effects of past inequalities, in South Africa.

Primary healthcare services are the frontier of the South African healthcare system, which is built on a decentralized model that aims to bring care closer to communities and households. The majority of the population enter the system through mobile clinics or community healthcare centers and receive their treatment, at primary healthcare facilities.

These channels of service delivery have the greatest impact on population-level healthcare outcomes, such as HIV/AIDS incidence and prevalence, tuberculosis detection and cure rates and maternal and child mortality rates. They are also the primary interface of patients with the healthcare system; hence they have a significant impact on patient satisfaction and communities' perceptions of quality of care.

Disabled by a lack of medicines, finances, human resources, essential equipment, physical capacity, infrastructure, adequate management and strategic oversight, the delivery of primary healthcare in South Africa is greatly compromised. Unprecedented political will, vociferous civil engagement and revitalized commitment, from the medical fraternity, are desperately needed to rebuild and fortify this first line of defence.

Anuschka Coovadia

KPMG in South Africa

Primary healthcare services are the frontier of the South African healthcare system, which is built on a decentralized model that aims to bring care closer to communities and households.



Primary Health Care models in India

Primary care is currently an unaddressed area in India. In the private sector, primary care services are offered either by unorganized private practitioners or by private hospital OPDs. Unorganized private clinics present issues related to dubious quality and disintegrated service touch-points whereas private hospital OPDs are fraught with challenges related to inconvenient access, high price points and minimal personal attention. On the public side, the network of 23,000 PHCs, with only 11 percent estimated to be fully functional, is operationally inadequate to meet the needs in the semi-urban and rural areas.

In this context, the country is seeing the emergence of private clinic chains offering care services for general ailments and an overlay mix of specialties (paediatrics, gynaecology, chronic care etc.). These clinics present an integrated health ecosystem for patients combining elements of consultation, pharmacy and diagnostics under one roof. Achieving patient footfalls in these new clinics would necessitate a behavioral change in patients currently accustomed to self-diagnosing or visiting unorganized clinics or hospital OPDs.

On the public side, the Indian Planning Commission has drafted the Universal Health Coverage report emphasizing the need to focus on strengthening primary care delivery. There is also initial evidence of public-private-partnership (PPP) in primary care with select states piloting an outsourced model with NGOs / CSR initiatives.

To summarize, India is likely to see rapid evolution of the primary care landscape over the next decade – with private provider chains as well as PPP models addressing gaps in the current system.

Quote from promoter of a primary care center chain based out of Mumbai: “The traditional concept of a family doctor is now on the decline in India, however it is imperative to have one-point of contact for all medical needs of a family to ensure effective, on-going and timely care and management of illnesses and overall health. Hence, primary care chains help address this need of basic and continuing care for patients under one roof in a systematic and protocol driven manner.”

Amit Mookim
KPMG in India

In the private sector, primary care services are offered either by unorganized private practitioners or by private hospital OPDs.

Member firm contacts for healthcare services

Chairman

Global Health Practice

Mark Britnell

T: +44 20 7694 2014
E: mark.britnell@kpmg.co.uk

Africa

Sven Byl

T: +27 11 647 6713
E: sven.byl@kpmg.co.za

Angola

Fernando Mascarenhas

T: +244 227 280 102
E: femascarenhas@kpmg.com

Argentina

Mariano Sanchez

T: +5411 4316 5774
E: marianosanchez@kpmg.com.ar

Australia

Liz Forsyth

T: +61 2 9335 8233
E: lforsyth@kpmg.com.au

Austria

Johann Essl

T: +43 732 6938 2238
E: jessl@kpmg.at

Brazil

Marcos A. Boscolo

T: +55 11 2183-3128
E: mboscolo@kpmg.com.br

Bulgaria

Iva Todorova

T: +35 95 269 9650
E: itodorova@kpmg.com

Canada

Georgina Black

T: +1 416 777 3032
E: gblack@kpmg.ca

Central/Eastern Europe

Miroslaw Proppe

T: +48 604 496 390
E: mproppe@kpmg.pl

China

Norbert Meyring

T: +86 (21) 2212 2888
E: norbert.meyring@kpmg.co.cn

Czech Republic

Karla Vorackova

T: +420222123500
E: kvorackova@kpmg.cz

France

Benoit Pericard

T: +33 1 55 68 86 66
E: benoitpericard@kpmg.fr

Germany

Volker Penter

T: +49 30 2068 4740
E: vpenter@kpmg.com

Hungary

Andrea Nestor

T: +36 1 887 7479
E: anester@kpmg.hu

India

Amit Mookim

T: +91 22 3090 2141
E: amookim@kpmg.com

Indonesia

Tohana Widjaja

T: +62 21 574 2333
E: tohana.widjaja@kpmg.co.id

Ireland

Alan Hughes

T: +353 17004169
E: alan.hughes@kpmg.ie

Israel

Haggit Philo

T: +972 3 684 8000
E: hphilo@kpmg.com

Italy

Alberto De Negri

T: +39 02 67643606
E: adenegri@kpmg.it

Japan

Keiichi Ohwari

T: +81 3 5218 6451
E: keiichi.ohwari@jp.kpmg.com

Korea

Andy Kim

T: +82 2 2112 7960
E: andykim@kr.kpmg.com

Luxembourg

Patrick Wies

T: +352 22 51 51 6305
E: patrick.wies@kpmg.lu

Malaysia

Yeekeng Lee

T: +60 3 7721 3388
E: leeyk@kpmg.com.my

Mexico

Andrés Aldama Zúñiga

T: +01 55 5246 8589
E: aaldama@kpmg.com.mx

Netherlands

Erik-Jan Vlieger

T: +31 20 6564352
E: vlieger.erik-jan@kpmg.nl

New Zealand

Mike Bazett

T: +64 4 816 4801
E: mikebazett@kpmg.co.nz

Norway

Bente Brandvik

T: +47 406 39579
E: bente.brandvik@kpmg.no

Philippines

Emmanuel P. Bonoan

T: +63 2 885 7000
E: ebonoan@kpmg.com.ph

Portugal

Fernando Faria

T: +351210110108
E: ffaria@kpmg.com

Qatar and Bahrain

Tim Bentley

T: +974 44576444
E: tbentley@kpmg.com

Romania

Maria Elisei

T: +40 37 237 7800
E: melisei@kpmg.com

Russia

Victoria Samsonova

T: +74959374444
E: vsamsonova@kpmg.ru

Singapore

Wah Yeow Tan

T: +65 641 18338
E: wahyeowtan@kpmg.com.sg

Spain

Candido Perez Serrano

T: +34 914 513091
E: candidoperez@kpmg.es

Sweden

Annacari Astner Wimmerstedt

T: +46 8 7236120
E: annacari.astnerwimmerstedt@kpmg.se

Switzerland

Michael Herzog

T: +41 44 249 31 53
E: michaelherzog@kpmg.com

Taiwan

Eric K. J. Tsao

T: +88 628 101 6666
E: erictsao@kpmg.com.tw

Thailand

Alexandra Depoire

T: +6626772133
E: adepoire@kpmg.co.th

UK

Andrew Hine

T: +44 121 2323744
E: andrew.hine@kpmg.co.uk

US

Ed Giniat

T: +1 312 665 2073
E: eginiat@kpmg.com

Vietnam and Cambodia

Cong Ai Nguyen

T: +84 83 821 9266
E: acnguyen@kpmg.com.vn

kpmg.com/socialmedia



kpmg.com/app



The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

© 2013 KPMG International Cooperative ("KPMG International"), a Swiss entity. Member firms of the KPMG network of independent firms are affiliated with KPMG International. KPMG International provides no client services. No member firm has any authority to obligate or bind KPMG International or any other member firm vis-à-vis third parties, nor does KPMG International have any such authority to obligate or bind any member firm. All rights reserved.

The KPMG name, logo and "cutting through complexity" are registered trademarks or trademarks of KPMG International.

Designed by Evalueserve.

Publication name: The primary care paradox: New designs and models

Publication number: 130561