

BACKGROUND PAPER

Western European best practice in primary healthcare

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Introduction

Political and economic dimensions of health systems shape the governance and organization of service delivery in general and of primary healthcare (PHC) services in Europe in particular. It is clear that the position of PHC and general practice¹ is stronger in some countries than in others. The strength of a country's PHC depends on the balance of health policy power of different actors, mainly governments, insurers and professionals (1).

In this paper, we will review the role of different actors and their interactions in countries of the European Union (EU) where general practice is strong. The reasons why PHC has a key role in the organization of national health services will also be explored.

Different actors for different interests in PHC in the EU

There are several categories of social actors in PHC in Europe. Informal policy power is in the hands of the main collective actors: government authorities, insurers and professionals (1). The main sources of informal policy power are: 1) ownership and financial resources, 2) knowledge and information resources, and 3) social and political support. Differences in PHC in Europe do not lie with the type of actor, but in the way actors relate to each other (2).

Collective actors, endowed with informal policy power, can exert pressure upon the political process (e.g. lobbying for private entrepreneurs) and exercise formal influence (for example, joint decision-making among physicians and insurers). As a result, policy shifts may 1) modify the rules of the interactions (external rules imposed by the government upon other actors), and/or 2) allocate and redistribute resources.

Little is known about the way PHC actors interact with each other (1–3). As a proxy, we can measure the success of the interactions at a country and international level, as reflected in outcomes such as the cost of health systems and the health outcomes produced (4).

Historically, the dominant interest group has included the professional monopolisers, physicians, whose control of medical knowledge both explains and reinforces the dominance of the disease model of illness. Although numerically small, compared for example to nurses, their definitions of health and illness tend to dominate health policy and service provision. Actors with better social reputations (e.g. hospitals versus health centres, or specialists versus general practitioners) and organized interests (e.g. specialists supported by the pharmaceutical and technological industries) enjoy more informal policy power, which might not always lead to efficient coordination solutions.

The dynamic policy process ends with a health service's structure and function, which reflects how rules are established and modified, and how resources are allocated and redistributed. Policy-making being a dynamic process, there is no real end to it, and changes in formal and informal policy power

¹ In Europe, family medicine is synonymous with general practice, and the latter term is used in the remainder of this paper since it is the term used in the countries in this analysis. The same applies to general practitioner versus family physician.

(due to changes in the distribution of resources and social and political support) lead to reforms (1).

Reforms aimed to empower PHC may: 1) increase the power of general practitioners over other levels (pro-coordinating reforms, such as introducing gate-keeping or purchasing rights), 2) broaden the profile (the service portfolio) of general practitioners and other primary care providers, and 3) induce concurrent changes in PHC organizational resources and control systems (necessary for promoting a major role for PHC).

Models of best practice

The position of PHC (and general practice) is stronger in some countries than in others (2–6). The strength of a country's PHC system depends on its actors and their interactions. In some countries, there is a negative circle of low social esteem, poor education, low self-respect, poor earnings, scarce research, and heavy competition from more glamorous specialist and hospital-based medicine (7). Countries that have broken this vicious circle, such as Denmark, the Netherlands and the UK (and to a lesser extent Spain), have strong professional organizations that have elbowed their way into universities and finally achieved postgraduate training courses, which become mandatory for the general practitioner profession (before the EU issued the corresponding legislation).

These four countries are very different. Perhaps the most interesting case is the Netherlands, because of its success compared to Belgium, France and Germany, also wealthy countries with a "Bismarck model" of healthcare system (a social security system, funded from proportional premiums earmarked for healthcare). Generally speaking, governments in countries with Bismarckian systems have played a more hands-off, reactive role, with the two other main actors (professionals and insurers) dominating the policy process (1–3). Governments share in fact their formal policy power with sick funds (public insurers). In these countries, organizational networks follow neo-corporatist schemes, based on joint decision-making by state insurers and professionals (with specialists as the key actors), and (with the exception of the Netherlands) they have a weak general practice.

The status of general practice is better in countries with national health services ("Beveridge systems"), such as Denmark, Spain and the UK. In national health services, funding is through taxation, and services are largely provided in kind by the state, but general practitioners may be contracted and work in private practice, as in Denmark and the UK. In these countries, state authorities have a monopoly on

formal policy power and they are proactive, establishing targeted interventions on external rules, and allocating and distributing resources (1,3). Insurers play almost no role (financing is public, even though private insurance is a profitable business), and professionals are powerful lay actors. The example of Spain is very interesting, being a country with a Beveridge system only introduced in the 1980s which has had reasonable success compared to other Mediterranean countries, such as Greece and Portugal.

General practice forms the solid base of these four European countries' healthcare system. It is aided by protective measures, such as 1) limiting direct access to specialist care and providing general practitioners with the role of gate-keeper (external rules imposed by the state), and 2) allocation of enough financial and material resources (even ownership of health centres in Denmark, the Netherlands and the UK) (1–3).

The current protagonism of chronic illness, comorbidity and disabilities has substantially increased the interdependencies among general practitioners and specialists. Gate-keeping is becoming more important because 1) healthcare, though undoubtedly beneficial, has also potentially harmful effects on patients (healthcare is a risk factor) (8), and 2) having more specialists, or higher specialist-to-population ratios, confers no advantages in meeting population needs, and may have ill effects when specialist care is unnecessary (9,10).

Gate-keeping is perhaps the most important example of mechanisms through which hierarchical coordination power over other levels of care is delegated to general practitioners. The capitation method of payment, associated with patient lists, has proved important for general practitioners, giving them the role of gate-keeper to specialized care in the four countries considered here (although Spanish general practitioners are salaried, with only around 10% of the total amount *per capita*) (2,11).

In Denmark and the Netherlands, the application of the general principle of gate-keeping differs in practice, according to the type of health insurance. For the publicly insured (97% and 60% of the population, respectively, with an income below a certain annual level), this requirement is absolute. Privately insured patients may access specialists directly (2,6).

Gate-keeping gives *de facto* general practitioners a monopoly over patient flow into the secondary level, with the exception of emergency care (11,12). In practice, gate-keeping has improved neither communication nor cooperation between general practitioners and specialists, because administrative rules have dominated the referral process, at least until the

pro-coordination reforms of the 1990s (1). Being mainly a formal process, gate-keeping does not accomplish its full power, and cooperation and redistribution of functions and resources across the interface of levels of care remain in their infancy.

Denmark, the Netherlands, Spain and the UK may be considered examples of best practice for the design and implementation of pro-cooperation reforms in an attempt to further transfer power and tasks to general practitioners (1–6). Comprehensive, strong inter-organizational networks emerge as a result. Having strong general practitioner associations, empowered with informal policy power before the 1990s, has made PHC professionals the natural coalition partner of governmental authorities in pro-coordination reforms, thus facilitating policy change and granting implementation (1,13).

General practitioner associations in Denmark, the Netherlands, Spain and the UK have strong informal policy powers because of: 1) their professional autonomy and status as independent contractors and ownership of premises (not in Spain); 2) their monopoly on first contact (gate-keeping), which has allowed the creation of multidisciplinary groups and expanded task profiles; 3) their knowledge production (research in PHC) and information control (development and implementation of classifications, dictionaries and electronic medical records); 4) their impact on national health outcomes and on health-care system cost control; 5) their contribution towards reversing the impact of social inequity in health; and 6) the population satisfaction levels they have achieved.

In contrast, general practitioner associations are weak and enjoy almost no informal power in other countries with national health systems such as Finland, Greece, Portugal² and Sweden. The same happens in countries with Bismarckian systems, such as Austria, Belgium, France, Germany, Ireland³, Luxembourg and Switzerland, or in transitional countries (ex-communist) such as Bulgaria, Croatia, Hungary and Poland.

In countries with a Bismarckian system, general practitioners have the ownership of provision, are private entrepreneurs, but have no gate-keeping role, and they share the financing scheme with ambulatory specialists, in a context of heavy competition (specialists control more than 50% of the first-contact market) (4). Consequently, it can be said that the balance of relative informal policy power of general practitioners versus specialists does not help

in establishing pro-coordination policies or in broadening the PHC portfolio.

In countries with national health systems and general practitioner salaries, doctors do not enjoy ownership of health centres and have low social esteem. As in countries with a Bismarckian system, general practitioners are frequently skipped by the middle and upper class, who instead go directly to private specialists (14). In transitional countries, even the lower class prefers specialist care (1). Direct access to specialists raises concerns about equity, cost-effectiveness and ill effects when specialist care is unnecessary (4,7,9,11,12).

Discussion

Governments may promote a strong PHC system in different ways, such as expanded pro-coordination experiments (for example, fund-holding in the UK, trans-mural care in the Netherlands) or expanded task profiles (minor surgery in Spain), but its success always lies in receiving the professional support of strong general practitioner associations (1,15).

Gate-keeping as a pro-coordination measure in France and Germany, for example, was blocked at the turn of the 20th century by the powerful professional opposition of specialist associations (and insurer associations with the support of the health industry), faced only with relatively weak general practitioner associations. This approach was successfully introduced in Belgium and France in 2004 on a voluntary basis. The scheme allows patients to select a “preferred” general practitioner, who has the patient’s electronic medical record and who may order referrals to specialists with less cost-sharing for the patient (and better payment for the specialist).

Countries with weak general practice will have problems adopting international best practice, as redistribution of informal and formal policy powers will raise opposition from socio-political actors, and therefore reduce the likelihood or scope of institutional change (15,16). This is the case in France, Germany and Greece, for example (1).

When target decisions by governments of countries with cooperative networks (e.g. Denmark, the Netherlands and the UK) meet the relatively autonomous group practice of general practitioners, a “positive circle” is fulfilled. Public power can play an important role in removing obstacles for networks to achieve efficient system coordination, by means of financial mechanisms, decision-making rules, and the production and dissemination of knowledge. It is important to note here that competition can be an obstacle, because it inhibits cooperation.

² In Portugal, general practitioners have patient lists, a gate-keeping role and salary payment.

³ In Ireland, general practitioners only have patient lists lower-class patients, a gate-keeping role and a capitation method of payment.

PHC actors in European health systems are the same everywhere, but interactions are very different. Patients, providers, teaching institutions, the health industry, financiers or insurers, and the government cooperate to promote health and to avoid morbidity and mortality (in other words, to avoid suffering and to prolong life span). Europe provides many examples of successful health actor interactions, mainly gate-keeping and patient lists.

Experimentation as a way of improvement is common around expanded task profiles for general practitioners and other workers and pro-coordination activities with specialist care. However, many key questions in health services research have no scientific answers as yet, so most decisions are made in a vacuum of knowledge (2,16).

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