

## Chapter 2

# Strengthening primary care systems

*The demand for health care is evolving rapidly in EU countries in a context of population ageing and the growing number of people living with one or more chronic conditions. To meet the challenge of these demographic and epidemiological shifts, EU health systems need to strengthen primary care systems to provide continuous, comprehensive, and co-ordinated care for their populations.*

*This chapter looks at the organisation and provision of primary care across EU countries. It uses a number of indicators to measure access to primary care and its effectiveness and quality, either directly through indicators such as pharmaceutical prescribing quality or indirectly through potentially avoidable hospital admissions. The chapter identifies possible policy options that countries could consider to strengthen their primary care systems, drawing lessons from the recent series of OECD Reviews of Health Care Quality and other relevant OECD work. This chapter shows that some countries, such as Denmark and the Netherlands, generally perform relatively well on several indicators related to access to and quality of primary care. All EU countries, particularly those in Central and Eastern Europe, need to pursue comprehensive reforms to strengthen their primary care system to better address the needs of ageing populations and reduce the unnecessary use of hospital care.*

## Introduction: Addressing the changing demographic and epidemiological context

More than ever, strong primary care systems are needed to provide continuous, comprehensive, and co-ordinated care for the whole population. Strong primary care systems are not only needed to respond efficiently to the health care needs of ageing populations and the growing burden of chronic diseases, but a large body of evidence also shows that they can play an important role in reducing social health inequalities (Starfield et al., 2005; Kringos et al., 2015).

On average across EU countries, the share of the population aged over 65 increased from less than 10% in 1960 to 19% in 2015, and is projected to increase to nearly 30% by 2060. While it is a remarkable sign of progress that life expectancy for people at age 65 continues to steadily increase, for many people, most of the remaining years of life after that age are lived with some health problems and some types of disabilities (see the indicator on life expectancy and healthy life years in Chapter 3). Currently, around 50 million EU citizens are estimated to suffer from two or more chronic conditions, most of them are 65 years and over, and this number is expected to increase in coming years (European Commission, 2015).

Chronic and multi-morbidity patients require good management of their conditions at primary care level and greater person-centred care to be able to continue to live independently and have a good quality of life. Person-centred care is at the core of the strategy that many countries are striving to put in place to address care fragmentation and enable better co-ordinated care. Good co-ordination between and across levels of care is essential for patients with complex needs, who are likely to navigate between various parts of the health system and, in some cases, of the long-term care system. Robust, comprehensive primary care is best placed to provide the type of continuous care needed to manage such multiple and complex care needs.

### Box 2.1. Definition of primary care

The 1978 Alma-Ata declaration defined primary care as the “first level of contact for the population with the health care system, bridging health care as close as possible to where people live and work. It should address the main health problems in the community, providing preventive, curative and rehabilitative services” (WHO, 1978). Primary care services range from educating the population about prevailing health problems, delivering maternal and child health, offering preventive services, and controlling diseases, to delivering appropriate treatment for common diseases and injuries that can be treated outside a hospital. The Alma-Ata declaration recognised that primary care goes beyond services provided by primary care physicians to encompass other health professionals such as nurses, midwives, auxiliaries, and community health workers.

At European level, the PHAMEU (Primary Health Care Activity Monitor for Europe) project defined primary care as “the first level of professional care where people present their health problems and where the majority of the population’s curative and preventive health needs are satisfied” (Kringos et al., 2010). Primary care is expected to provide accessible, comprehensive care close to where patients live on a continuous basis, and to co-ordinate the care processes of patients across the health care system. Although the mix of disciplines that make up the primary care workforce may differ from country to country, general practitioners and family physicians are the most common primary care providers in Europe. General internists, paediatricians, pharmacists, primary care nurses, physiotherapists, and mental health care workers also are primary care providers.

This chapter looks at the organisation and provision of primary care across EU countries. Using the available data, it assesses primary care performance in these countries with regard to access and care quality. Finally, based on country experiences, the chapter recommends policies that could improve access to and quality of primary care.

## Organisation and provision of primary care in Europe

This section presents an overview of the organisation and provision of primary care systems in EU countries. It describes three key organisational features (Table 2.1): i) the gatekeeping function of primary care providers; ii) the predominant modes of primary care provision; and iii) the payment methods for primary care providers.

### **Primary care physicians are the first point of contact in 15 EU health systems**

A gatekeeping system, whereby primary care physicians (PCPs) are the entry point to the health system by controlling access to secondary care, has been a key feature of primary care systems in several countries for a long time and is becoming a key feature in other EU countries. This organisational feature can play an important role in securing the appropriate use of health resources (Kringos et al., 2015). A referral system and registering with a PCP are important strategies for ensuring that patients receive the best possible care for their conditions and for achieving greater care co-ordination. As such, primary care physicians are responsible for co-ordinating prevention, investigation, and treatment of health care needs and for steering demand for secondary care. A systematic review of the literature showed that gatekeeping is associated with lower utilisation of health services and lower expenditures (Garrido et al., 2011).

In 15 EU countries, PCPs are the first point of contact and have the ability to refer patients to secondary care when necessary (Table 2.1). PCPs control access to most types of secondary care in Bulgaria, Croatia, Estonia, Finland, Hungary, Ireland, Italy, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Spain, Sweden and the United Kingdom. Six EU countries have no referral system in place. Patients in Austria, Cyprus, the Czech Republic, Germany, Greece and Luxembourg have direct access to most physicians and secondary care. In the other seven EU countries (Belgium, Denmark, France, Latvia, Malta, Romania and the Slovak Republic), patients have direct access to secondary care without any referral, but financial incentives to obtain a PCP's referral exist in the form of lower cost sharing.

Registering with a PCP who serves as the focal point for co-ordinating care is mandatory in 11 EU countries (Croatia, Estonia, Finland, Italy, Latvia, Lithuania, Portugal, Romania, Slovenia, Spain and the Slovak Republic). By contrast, 13 countries have not established a mandatory patient-registration system (Austria, Bulgaria, Cyprus, the Czech Republic, Greece, Hungary, Ireland, Luxembourg, Malta, the Netherlands, Poland, Sweden and the United Kingdom). The main reason for not establishing such a registration system in most of these countries is concern about the loss of patient freedom. A last group of four countries (Belgium, Denmark, France and Germany) made the choice to introduce financial incentives to register with a primary care doctor to encourage greater co-ordination and continuity of care.

### **In half of EU countries primary care is organised around solo practice**

The way primary care is organised can significantly affect care quality and care co-ordination, both within primary care and between levels of care. Two predominant modes of primary care provision exist across European countries: solo practice and group practice staffed by physicians and

Table 2.1. **Mode of provision, remuneration, and role of primary care in Europe, 2016**

	Do primary care physicians control access to secondary care?	Are patients required or encouraged to register with a primary care physician or practice?	Predominant form of primary care provision	Primary care payments
<b>EU countries</b>				
Austria	No need and no incentive to obtain referral	No incentive and no obligation to register	Solo practice	Fee-for-service
Belgium	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are not required to register but have financial incentives to do so	Solo practice	Capitation/fee-for-service
Bulgaria <sup>1</sup>	Primary care physician referral is required	No incentive and no obligation to register	Solo practice	Capitation/fee-for-service/other
Croatia <sup>1</sup>	Primary care physician referral is required	Patients are required to register	Solo practice	Capitation/fee-for-service/pay for performance
Cyprus <sup>2</sup>	No need and no incentive to obtain referral	No incentive and no obligation to register	Group practice	Fee-for-service
Czech Republic	No need and no incentive to obtain referral	No incentive and no obligation to register	Solo practice	Capitation/fee-for-service/pay for performance
Denmark	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are not required to register but have financial incentives to do so	Solo practice	Capitation/fee-for-service
Estonia	Primary care physician referral is required <sup>3</sup>	Patients are required to register	Solo practice	Capitation/fee-for-service /pay for performance/other
Finland	Primary care physician referral is required	Patients are required to register	Group practice	Global budget
France	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are not required to register but have financial incentives to do so	Group practice	Fee-for-service/pay for performance/other
Germany	No need and no incentive to obtain referral	Patients are not required to register but have financial incentives to do so	Solo practice	Fee-for-service
Greece	No need and no incentive to obtain referral	No incentive and no obligation to register	Group practice	Global budget
Hungary <sup>1</sup>	Primary care physician referral is required	No incentive and no obligation to register	Solo practice	Capitation/pay for performance/global budget
Ireland <sup>2</sup>	Primary care physician referral is required	No incentive and no obligation to register	Group practice	Capitation/fee-for-service
Italy	Primary care physician referral is required	Patients are required to register	Group practice	Capitation
Latvia	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are required to register	Group practice	Fee-for-service/capitation/fixed payments/pay for performance
Lithuania	Primary care physician referral is required	Patients are required to register	Group practice	Capitation/fee-for-service/pay for performance/global budget
Luxembourg	No need and no incentive to obtain referral	No incentive and no obligation to register	Solo practice	Fee-for-service/capitation
Malta <sup>1</sup>	Patients have financial incentives to obtain a referral, but direct access is possible	No incentive and no obligation to register	Solo practice	Fee-for-service
Netherlands	Primary care physician referral is required	No incentive and no obligation to register	Group practice	Capitation/fee-for-service/pay for performance
Poland	Primary care physician referral is required	No incentive and no obligation to register	Group practice	Capitation/fee-for-service
Portugal	Primary care physician referral is required	Patients are required to register	Group practice	Capitation/pay for performance/global budget
Romania <sup>1</sup>	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are required to register	Solo practice	Capitation/fee-for-service
Slovenia	Primary care physician referral is required	Patients are required to register	Group practice	Capitation/fee-for-service
Sweden	Primary care physician referral is required	No incentive and no obligation to register	Group practice	Capitation/fee-for-service
Spain	Primary care physician referral is required	Patients are required to register	Group practice	Capitation/pay for performance/global budget
Slovak Republic <sup>1</sup>	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are required to register	Solo practice	Capitation/fee-for-service/other
United Kingdom	Primary care physician referral is the usual way of accessing secondary care, but patients can also refer themselves for secondary care without consulting a GP	No incentive and no obligation to register	Group practice	Capitation/fee-for-service/pay for performance
<b>Non EU countries</b>				
Iceland	No need and no incentive to obtain referral	No incentive and no obligation to register	Group practice	Global budget/fee-for-service
Norway	Primary care physician referral is required	Patients are required to register	Group practice	Capitation/fee-for-service
Switzerland	Patients have financial incentives to obtain a referral, but direct access is possible	Patients are not required to register but have financial incentives to do so	Solo practice	Capitation/fee-for-service
Turkey	No need and no incentive to obtain referral	Patients are required to register	Group practice	Global budget

1. Information taken from Kringos et al. (2015) and from *Health Systems in Transition Profiles*, [www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits](http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits).

2. Based on the earlier wave of the OECD Health System Characteristics Survey in 2012.

3. Direct access to a dermatologist, ophthalmologist, gynaecologist, and psychiatrist is possible, however.

Source: 2016 OECD Health System Characteristics Survey, [www.oecd.org/els/health-systems/characteristics.htm](http://www.oecd.org/els/health-systems/characteristics.htm).

other health professionals\* (Table 2.1). In 13 EU countries (Austria, Belgium, Bulgaria, Croatia, the Czech Republic, Denmark, Estonia, Germany, Hungary, Luxembourg, Malta, Romania and the Slovak Republic), solo practice is reported as the predominant form of primary care provision. A trend is emerging towards introducing more group practice, however, to improve access to care for patients and respond to the growing preference of many doctors to avoid the constraints and isolation related to solo practice. In the other 15 EU countries (Cyprus, Finland, France, Greece, Ireland, Italy, Latvia, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Sweden, Spain and the United Kingdom), group practice is the predominant model for primary care provision. In countries where group practice dominates, PCPs can work alongside other general practitioners, other specialists, nurses, and other allied health personnel. Most often, nurses are increasingly involved in care delivery. According to the QUALICOPC study (Quality and Costs in Primary Care) (Groenewegen et al., 2015), the median number of other professions apart from physicians working in primary care practice ranges from only one in Austria, Germany, Luxembourg, Italy, Bulgaria, the Czech Republic, Hungary, Romania and the Slovak Republic to eight in Lithuania. A large number of professions also work in group practice in Finland (seven), Cyprus and Spain (six), and Sweden and the United Kingdom (with five other professions).

The trend towards introducing more group practice is generally a step in the right direction. A large body of evidence shows that group practice fosters collaboration with other providers, which encourages better care co-ordination and leads to improvement in care quality (Mousques and Daniel, 2015; Kringos et al., 2015; Ghebrehiwet, 2013). Such models are found to encourage human and infrastructure investments necessary to implement new models of care, encourage collaborative work, and increase the use of new technology. Group practice is generally associated with better patient outcomes, reduced hospitalisation, and enhanced patient and staff satisfaction (Ghebrehiwet, 2013). In France, a recent report concluded that group practices are more efficient than solo practices for several indicators including, for example, monitoring of type 2 diabetes patients, vaccination, screening and prevention, and rates of generic prescribing (Mousques and Daniel, 2015). By contrast, solo practice is more often associated with fewer interactions with other health providers, which might hinder care co-ordination (Kringos et al., 2015).

***Fee-for-service and capitation are still the most common methods of payment in primary care, although use of blended forms of payments is growing***

The majority of EU countries use capitation or fee-for-service (FFS) payments for primary care, although some also pay primary care providers through salary from a global budget (Table 2.1). A single payment method is used only in seven countries (capitation in Italy; FFS in Austria, Cyprus, Germany and Malta; and salary from a global budget in Finland and Greece). The current trend is towards introducing multiple methods of payment for primary care to achieve the multiple objectives of access, quality and efficiency (OECD, 2016a). Seven countries' payment system is a mix of both capitation and FFS (Belgium, Denmark, Ireland, Luxembourg, Poland, Romania and Slovenia). Ten countries (Croatia, the Czech Republic, Estonia, France, Hungary, Latvia, Lithuania, the Netherlands, Spain and the United Kingdom) combine capitation and/or FFS with pay-for-performance (P4P) and four countries (Hungary, Lithuania, Portugal and Spain) with global budgets to control costs.

In primary care, blending payment mechanisms can be a useful tool to counterbalance some of the shortcomings of the different traditional payment methods and to better align incentives to achieve specific health objectives (OECD, 2016a). Traditional forms of payment such as FFS and capitation alone have several weaknesses and are not always aligned with today's health system

\* Group practices are public primary care clinics and private groups that are staffed by at least one physician and other health professionals (e.g. nurses). By contrast, solo practices are private practices where only one physician works by himself (and with no other health professionals).

priorities of changing epidemiology (OECD, 2016a). FFS reimburse primary care only for volume of activities delivered, which may lead to inefficient overprovision of services (through supply-induced demand) and does not reward value or quality care. Whilst capitation is a better payment system to control cost, it may lead to selection of patients requiring less services and lack of attention to clinical need. Hence, taken individually, FFS and capitation in their pure form are not well suited to meet the challenges posed by ageing populations and the rising burden of chronic conditions. As these modes of payment are predominantly used for “siloes” financing of health providers, they also struggle to support new models of care that are required to achieve patient-centred care stretching across several health providers. Many countries have already taken steps to adapt and blend these payment systems, and to develop new innovative mechanisms that incentivise provision of high-quality care and facilitate care co-ordination for people with complex needs across health providers (see the last section of the chapter).

## Evaluation of primary care in Europe

This section examines two core dimensions of primary care performance across Europe: access to and quality of care. By contrast with hospital care, in most countries, less data are usually available to directly assess the quality of primary care. It is possible, however, to assess quality of primary care through indirect measures such as potentially avoidable hospital emergency visits or admissions, or through direct measures such as pharmaceutical prescribing quality. In a growing number of countries new data are also becoming available about patient experience with their primary care providers.

This section shows that some countries such as Denmark and the Netherlands are generally performing relatively well on several indicators of access to and quality of primary care presented in this chapter. For example, these two countries consistently report low rates of unmet medical needs, low rates of avoidable emergency department (ED) visits, and low rates of what is generally considered to be inappropriate pharmaceutical prescribing in primary care. However, in all countries, particularly in many Central and Eastern European countries, there is a need to further improve access to and quality of primary care for the whole population.

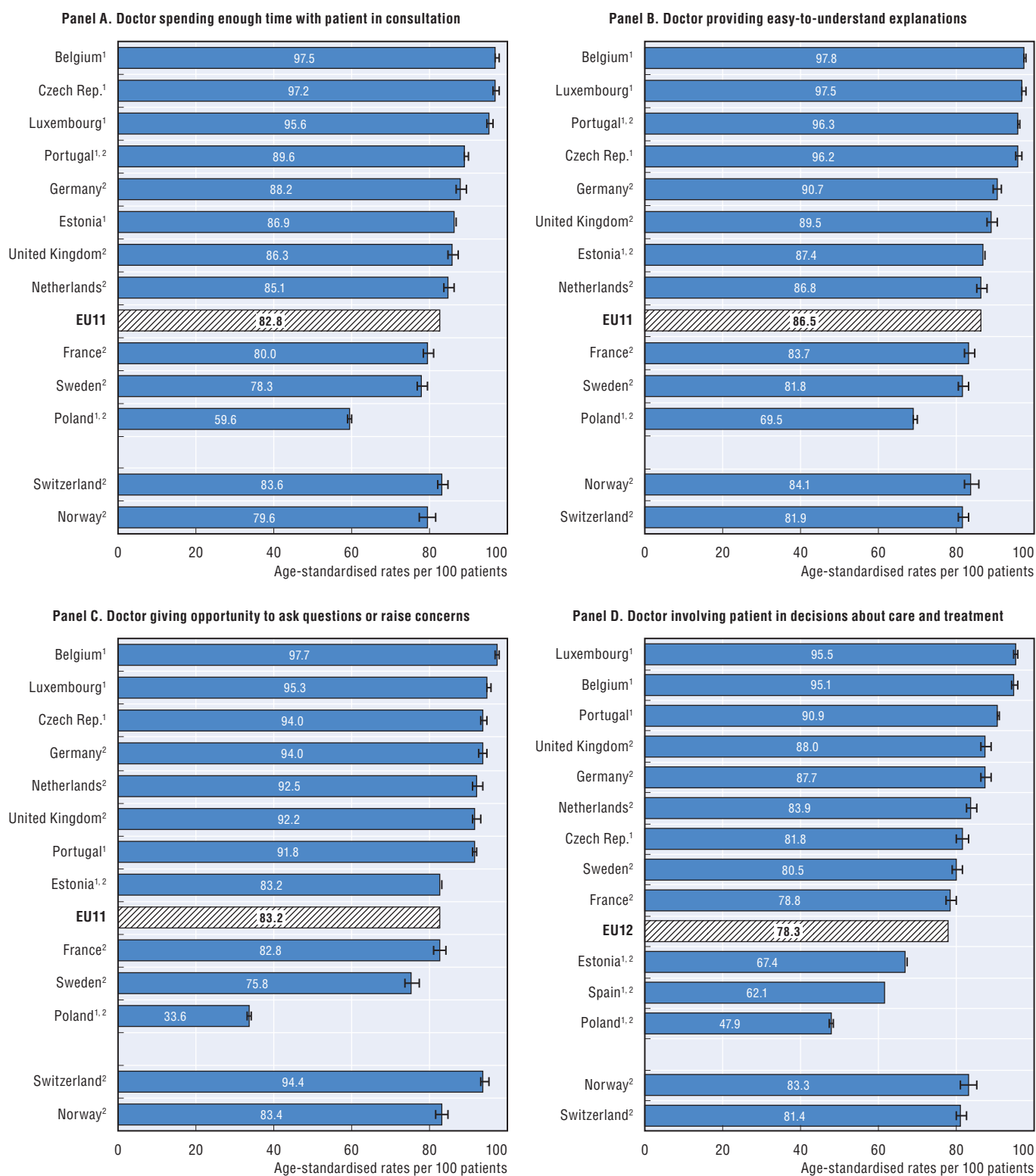
### ***Patients generally report positive experience with primary care***

Patient-reported experience measures (PREMs) with primary care are an important marker of primary care quality from the point of view of those most concerned – patients themselves.

Figure 2.1 shows that most patients report positive experiences in their interactions with their (regular) doctor when it comes to communication and autonomy in the ambulatory health care system. On average across the countries for which such PREM data are available, 82.8% of patients reported that their regular doctor spent enough time with them (Panel A), 86.5% reported that their regular doctor provided easy-to-understand explanations (Panel B), 83.2% reported having been given the opportunity to ask questions or raise concerns (Panel C), and 78.3% reported being involved in care and treatment decisions (Panel D).

For all four aspects of patient experiences, Belgium and Luxembourg score high, with more than 95% of patients reporting positive experience. At the other end of the scale, Poland has the lowest rates for all four aspects of patient experience. For example, less than one in two patients in Poland report having been given the opportunity to ask questions (Panel C) or been involved in their care and treatment during consultation (Panel D). The proportion of patients with positive experience has decreased since 2010 in France, the Netherlands and Switzerland but countries with lower rates such as Sweden and Poland have improved some aspect of patient experiences in recent years (Commonwealth Fund, 2010).

Figure 2.1. Patient experience with ambulatory care, 2013 (or latest year)



Note: 95% confidence intervals represented by H.

1. National source.

2. Patient experience with regular doctor.

Source: Commonwealth Fund International Health Policy Survey 2013 and other national sources.

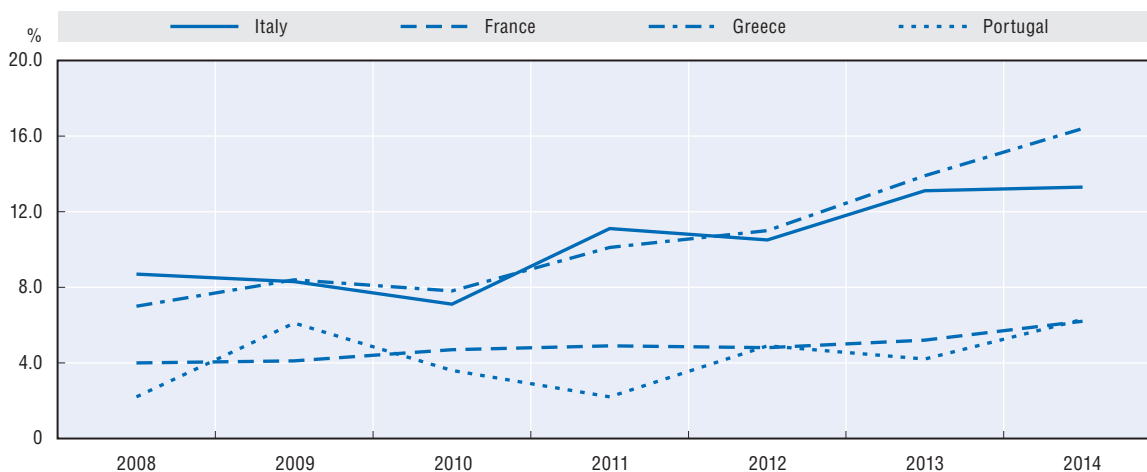
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### **Unmet needs for medical examination and inappropriate visits to emergency departments signal problems in access to primary care**


Whilst ensuring access to care is a priority objective for each health system, available data suggest that universal access to primary care is not always achieved across EU countries. Some of the barriers to primary care services include a lack of available services near people's home, waiting times and financial barriers. Such barriers lead to unmet health care needs and are also a leading source of inappropriate care such as unwarranted ED visits.

Around 3.6% of the population across EU countries in 2014 reported some unmet needs for medical care due to cost, travelling distance, and waiting time, based on data from EU-SILC (see indicator "Unmet health care needs" in Chapter 7). The proportion of people reporting unmet needs was highest in Latvia, Estonia and Greece (with a share above 10%), while less than 1% of the population reported unmet needs in Luxembourg, Spain, the Netherlands, Slovenia and Austria in 2014. Unmet medical care needs were consistently higher in low-income groups compared with high-income groups (see indicator "Unmet health care needs" in Chapter 7). Although unmet needs for a medical examination due to financial reasons remained fairly stable on average between 2008 and 2014, the proportion of people in low-income groups reporting unmet needs for financial reasons increased in several countries after the global financial crisis in 2008 (Figure 2.2). In Italy and France, the proportion of people reporting unmet needs due to financial reasons among the low-income population increased by more than 50% between 2008 and 2014. In Greece, the proportion more than doubled between 2008 and 2014, while it tripled in Portugal over the same period. Increasing unmet care needs, particularly among low-income groups, raise concerns as they may result in poorer health status and increased health inequalities.

**Figure 2.2. Change in unmet medical care needs for financial reasons among the lowest-income group, selected EU countries, 2008-14**



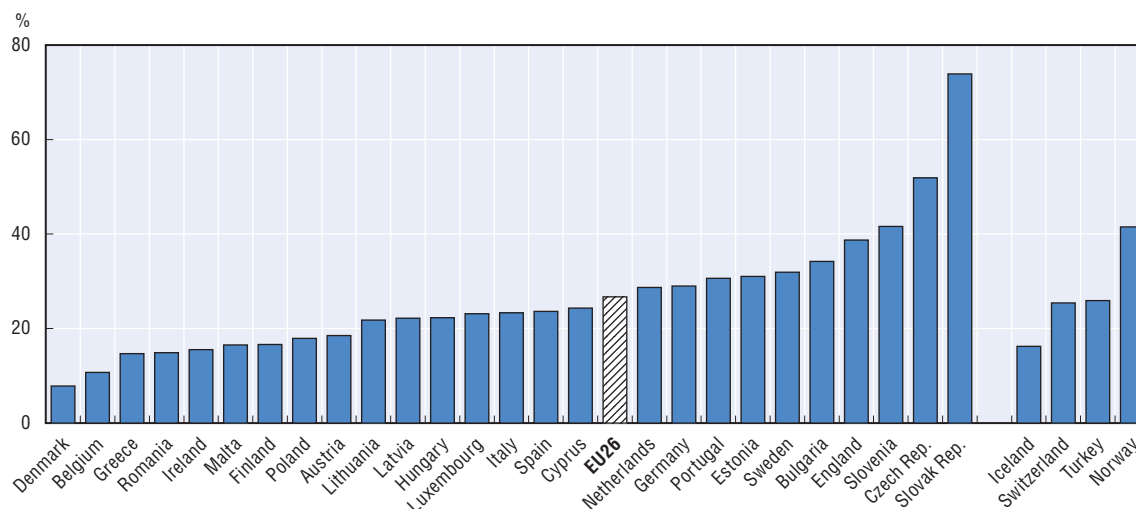
Source: Eurostat Database, based on EU-SILC.

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Unnecessary use of expensive hospital care is another proxy to monitor accessibility of primary care services. A significant proportion of ED visits are found to be unnecessary, for problems that normally should not require emergency care. Figure 2.3 shows that among patients who visited an ED, 27% of patients on average across EU countries did so because primary care was not available (van den Berg et al., 2016). This proportion was lowest in Denmark, Belgium, Greece and Romania, where less than 15% of patients reported going to an ED because of a lack of primary care availability.



Figure 2.3. **Proportion of patients who visited an emergency department because primary care was not available,<sup>1</sup> 2011-13**



Note: Data were collected within the QUALICOPC study (Quality and Costs of Primary Care in Europe) between 2011 and 2013.

1. The reference population is the proportion of people who visited an ED in the previous year.

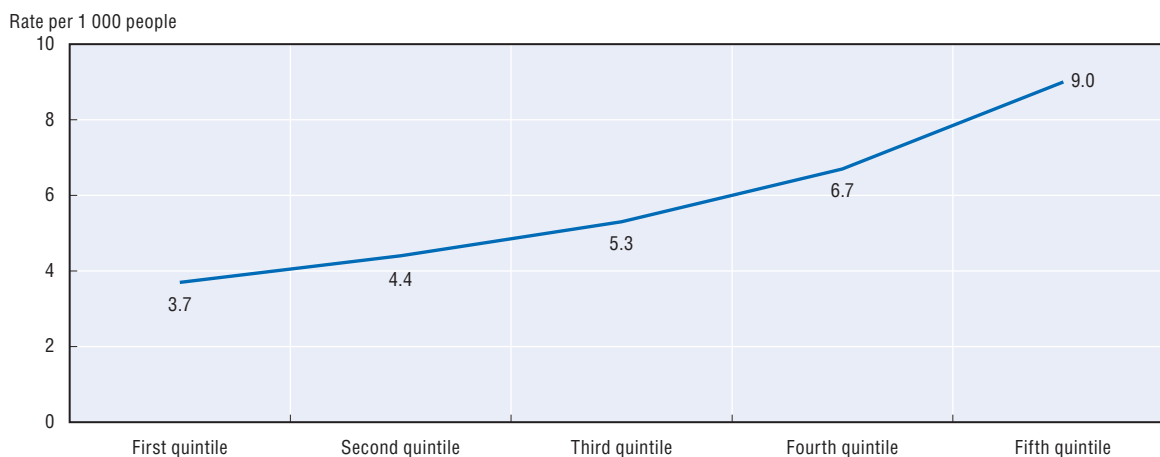
Source: van den Berg et al. (2016).

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At the other end of the scale, the Slovak Republic reported the highest proportion, with 74% of patients going to an ED because primary care was not available, followed by the Czech Republic (52%) and Slovenia (42%).

As for unmet needs for a medical examination, high social inequalities arise in inappropriate visits to EDs. Inappropriate visits to EDs are significantly higher among the most disadvantaged populations. People living in the most deprived areas, low-income groups, low-education groups, or ethnic minorities consistently have a higher risk of unwarranted ED visits (Berchet, 2015). In England, for instance, people living in the most deprived fifth of neighbourhoods (first quintile of income at neighbourhood level) are nearly two and a half times more likely to be admitted to an ED as people living in the most affluent fifth (Figure 2.4) (Centre for Health Economics, 2016). Providing equal access to primary care for the whole population is therefore essential to reduce social inequalities.

Figure 2.4. **Rate of preventable emergency department admissions, by geographic deprivation level (income quintile), England, 2011-13**



Source: Adapted from Centre for Health Economics (2016).

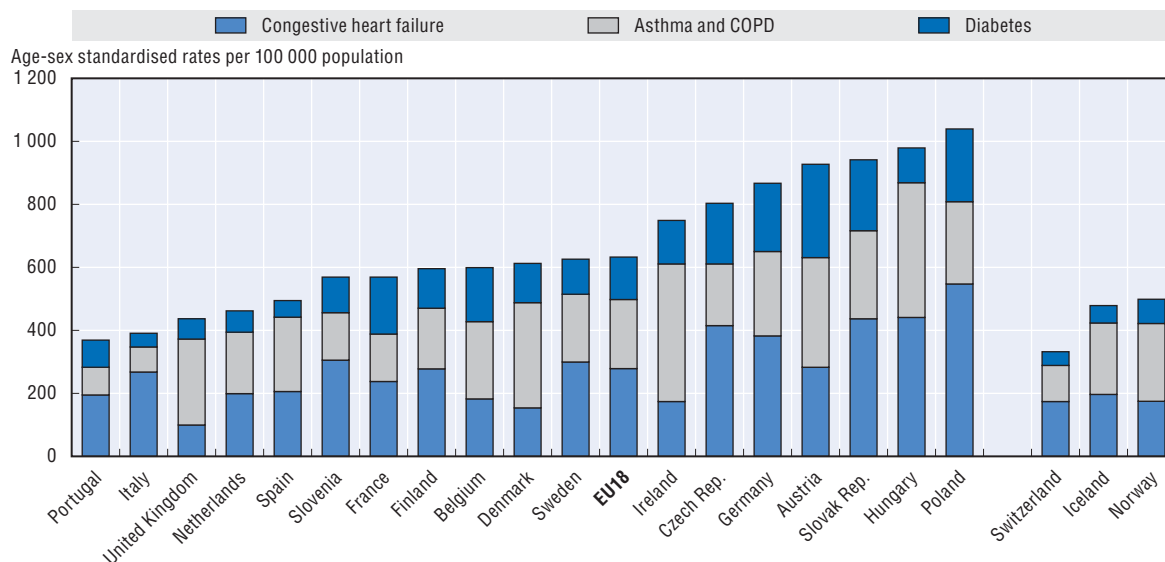
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### **Avoidable hospital admissions for ambulatory care sensitive conditions suggest room for improving access to and quality of primary care**

Ambulatory care sensitive conditions (ACSCs), such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes, are conditions for which accessible and effective primary care can generally reduce the risk of complications and prevent the need for hospitalisation (Purdy et al., 2009, 2012). Potentially avoidable hospitalisations for these conditions are commonly used to measure access to and quality of primary care systems (Purdy et al., 2012; Longman et al., 2015; van Loenen et al., 2014).


All EU countries have a large number of potentially avoidable admissions for diabetes, CHF, COPD and asthma (Figure 2.5). In 2013, these four chronic conditions accounted for 632 avoidable admissions per 100 000 population across EU countries. Portugal, Italy, the United Kingdom and the Netherlands have the lowest rates of avoidable admissions related to these four conditions, while Poland, Hungary and the Slovak Republic have the highest rates, nearly or over 50% higher than the EU average (Figure 2.5).

Figure 2.5. **Avoidable admissions for chronic ambulatory care sensitive conditions, 2013 (or nearest year)**



Note: Rates are not adjusted by health care needs and health risk factors.

Source: OECD Health Statistics 2016.

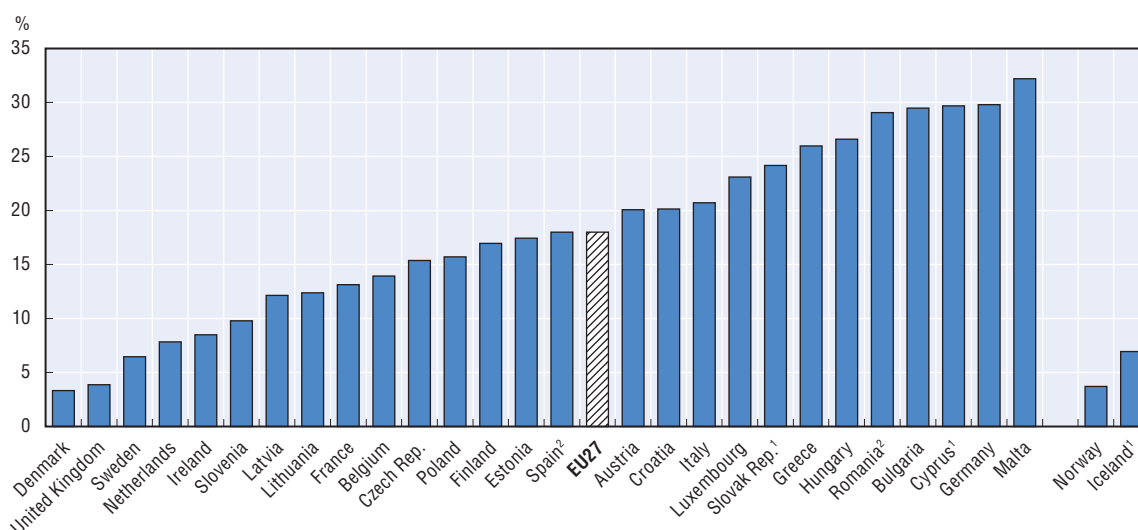
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Most countries have achieved progress in reducing avoidable admission rates in recent years. In Denmark for example, admission rates for these four chronic conditions dropped by 15% between 2006 and 2013, going down from 719 admissions per 100 000 population in 2006 to 613 admissions in 2013. This reflects significant improvements in the management of chronic diseases. Denmark introduced in 2008 some disease management programmes to better manage chronic conditions and keep people out of hospital. Based on the Chronic Care Model in the United States, the overarching objectives were to strengthen co-ordination between primary and secondary care and to empower patients to play a greater role in self-management of their condition (OECD, 2013).

### Prescribing patterns in primary care raise concerns about appropriate use of medications

Prescribing patterns are increasingly used as indicators of primary care quality. For example, antibiotics should be prescribed appropriately and only when indicated, to reduce the risk of antimicrobial resistance. There is also broad agreement that second-line antibiotics, such as quinolones and cephalosporins, should in general only be used when first-line antibiotics have not worked. Their volume as a proportion of the total volume of antibiotics prescribed has been validated as a marker of quality in the primary care setting (Adriaenssens et al., 2011). Figure 2.6 shows large variations in the use of such second-line antibiotics, suggesting that these antibiotics are prescribed unnecessarily in many EU countries. In 2014, 18% of all antibiotics prescribed across EU countries were second-line antibiotics. Denmark, the United Kingdom, Sweden and the Netherlands report the lowest proportions of second-line antibiotics use, whereas Malta, Germany, Cyprus, Bulgaria and Romania report volumes over 50% higher than the EU average.

Figure 2.6. **Second-line antibiotics (quinolones and cephalosporins) as a proportion of all antibiotics prescribed in primary care, 2014**



1. Data refer to all sectors (not only primary care).

2. Reimbursement data, i.e. not including consumption without a prescription and other non-reimbursed courses.

Source: European Centre for Disease Prevention and Control (2016).

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### Policy levers to improve primary care access and quality

Improving the performance of primary care requires working on several fronts. Making sure primary care services are available outside normal working hours, developing new models of shared care, investing in a specialist primary care workforce, linking payment to the provision of high-quality care, and investing in information infrastructure are all promising options for improving access to and quality of primary care.

#### Primary care should be accessible 24 hours a day, 7 days a week

To improve accessibility of primary care and limit inappropriate use of hospital care, EU health systems need to develop primary care services, especially for emergencies outside normal working hours. Yet a recent policy survey shows that most (if not all) EU health systems struggle to ensure comprehensive provision of out-of-hours (OOH) primary care services (Berchet and Nader, 2016). Much of this is due to high workload for primary care clinicians, insufficient remuneration, and lack of personnel and organisational support in remote areas. Poorly functioning primary care systems outside normal working hours are, as mentioned previously, a leading source of inappropriate ED visits.

Among the different models of OOH primary care organisation that exist in EU health systems, general practice co-operatives (GPCs) are found to be one of the most effective to secure safe and accessible primary care services outside normal working hours. Patients report high satisfaction, primary care clinicians' workload is less demanding, and avoidable visits to ED are reduced by diverting these visits to primary care settings (van Uden and Crebolder, 2004; van Uden et al., 2005; van Uden et al., 2006; Giesen et al., 2011).

GPCs are large-scale co-operatives in which primary care providers work on a rotational basis to respond to health care needs outside normal working hours (Berchet and Nader, 2016). This is the case in the Netherlands, for example, where GPCs (known as "huisartsenpost", HAP) are staffed by primary care providers who carry out both telephone and face-to-face consultations. Patients are first required to call the GPC to get medical advice. Depending on the medical condition, the general practitioner (GP), the GP assistant, or the GP triage nurse give self-care advice so that the patient stays at home and can visit primary care during normal working hours. An alternative option is to ask the patient to call back if the health problem gets worse, or to make a home visit. In case of more urgent health conditions, the GP, GP assistant, or GP triage nurse advise the patient to go to the GPC or directly to the hospital ED or to call an ambulance. Patients are discouraged from visiting the GPC for small complaints that do not require immediate attention. In case of minor ailments and without any referral, patients are asked to consult during normal office hours. Some regions in the Netherlands have a model that integrates a GPC and an ED, with one triage point determining which service patients attend, so that patients cannot go directly to the ED (Berchet and Nader, 2016). In 2014, the Netherlands had 122 GPCs.

### ***Developing new care models centred around patients' needs has the potential to promote greater care co-ordination***

Achieving greater patient-centred care entails developing new models of shared-care based on multidisciplinary practice and modernising the role of health professionals to best meet complex health care needs. Both changes have the potential to lead to efficiency and quality gains in primary care.

Several EU health systems have already developed new care models centred on patients to address the needs of those requiring co-ordination of activities between providers in various settings. In Belgium, new integrated care models based on multidisciplinary group practice and a horizontal governance model have been developed by primary care clinicians since 2016 (Auraaen, forthcoming). A case manager is assigned responsibility for the shared-care model. Case managers are most often primary care physicians but can also be nurses, allied health professionals and social workers. They have the responsibility for managing pathways of care within the health system. A similar model exists in Slovenia with the current development of Family Medicine Model Practice (Auraaen, forthcoming). In this new multidisciplinary approach, nurses with an advanced degree are taking new roles to ensure care co-ordination and care continuity, assisting patients in navigating the health system. Norway has established intermediate care facilities to bridge the gap between hospital and community care (OECD, 2014). The overarching objective of intermediate care facilities is to ensure that the right community services are delivered to patients requiring further care after a hospital stay, and that they are well co-ordinated with hospital care. In Finland, a new integrated care model linking primary care, acute care, and social care will be introduced in the whole country in 2019.

New care models seem to have been successful, with evidence suggesting benefits to patients through improved access, care quality and care co-ordination. In Norway, evidence suggests that intermediate care facilities led to better health outcomes for the population and to a reduction in avoidable hospitalisation (Garåsen et al., 2007; Lappégard and Hjortdahl, 2013). Recent evaluation shows that Slovenia's new model of care improved access, including access to broader preventive

medical programmes and reduced care fragmentation. Care co-ordination between primary care, hospitals and long-term institutions significantly improved. The Family Medicine Model Practice is found to be a promising multidisciplinary approach to meet the need of complex, multi-morbidity patients (Nolte et al., 2015).

### **Investing in a specialist primary care workforce is required to provide continuous and comprehensive care**

Improving care quality requires investing in a specialist and distinct primary care workforce that has followed a defined programme of post-graduate training in primary care. The need for a specialist primary care workforce, characterised by a comprehensive and patient-centred orientation (rather than a disease-specialist approach), is particularly important in the context of population ageing and the rising burden of chronic conditions. Provision of continuous and comprehensive care, focusing on prevention and management of long-term conditions, should therefore be at the core of the distinct primary care specialty. Firm evidence suggests the benefits of having a specialist primary care workforce. At the macro level, it promotes the overall health and wellbeing of the population, while at the micro level it contributes to better co-ordination and cost-effectiveness of health care services, particularly with respect to the management of long-term conditions (OECD, forthcoming).

Expanding the role of primary care nurses and community pharmacists is equally important. A body of evidence shows that changing the scope of practice for nurses brings several advantages, specifically for management of long-term conditions. With appropriate training and on-going support from primary care practitioners, nurses have been found to provide as high-quality care as primary care doctors in the provision of care for acute and chronic conditions, and with higher patient satisfaction (Maier et al., forthcoming). An expanded scope of practice for nurses already exists in several European countries. In Sweden and Finland for example, additional training was developed for nurses to be involved in post-discharge protocol, patient education and chronic disease management. Expanding the role of community pharmacists is another avenue to renew the focus on preventive health care. In Finland, for example, community pharmacists are actively involved in the treatment and prevention of major chronic diseases. Expanding the role of nurses or community pharmacists is an important policy lever that European countries could pursue to provide both more preventive health care and better management of long-term conditions.

### **Payment systems should be based on the value and quality of primary care for patients**

Traditional forms of FFS and capitation are still the most common method of payment for primary care across EU health systems, as mentioned previously. Such traditional payment mechanisms should be adapted (for example, by risk-adjusting capitation payments) or blended to best meet the growing health care needs. Alternatively, more innovative modes of payment can be applied to encourage care co-ordination and improve care delivery for patients with chronic diseases. Add-on payments, for example, can be used to incentivise high-quality care and desired activity (for example, particular co-ordinating activities). Replacing traditional payment systems with a single bundled tariff for a range of services, including preventive and care management stretching across different providers, is another innovative approach that can be used to pay for primary care. Such innovations show promise to better align provider incentives with health policy objectives and to reward providers for what they deliver (OECD, 2016a). They could therefore be considered as useful tools to complement or replace traditional payment systems.

Several EU health systems have embarked on such primary care payment reforms (OECD, 2016a). In France, add-on payments were introduced in 2009 to encourage greater care co-ordination and to provide more appropriate services to patients. The new payment scheme, known as *Expérimentations de nouveaux modes de rémunération* (ENMR), entails lump-sum payments per patient for three types of activities: i) co-ordinating activities; ii) provision of new services; and iii) inter-professional

co-operation. Available evidence suggests the ENMR's beneficial impact on both quality and health care costs. The multidisciplinary structures signed up to the ENMR achieved better results than traditional practices for nearly all care indicators (diabetes care processes, prevention and efficient prescription). The organisation of care is also found to be more effective through greater collaboration and greater care co-ordination between health professionals (IRDES, 2014).

An increasing number of countries have introduced P4P schemes to improve quality of primary care. In this case, physicians are rewarded if they meet certain quality targets, typically measured as process indicators (e.g. number of annual HbA1c tests per year for diabetic patients) or intermediate outcomes (e.g. number of diabetic patients below a certain HbA1c value). In Portugal, the introduction of a P4P component in the Family Health Unit model (a multidisciplinary primary care model created in 2006) led to an improvement in care quality and patient and practitioner satisfaction compared to the solo practice model (OECD, 2015). As shown by systemic reviews, evidence on the impact of P4P on health outcomes remains, however, limited or inconclusive (OECD, 2016a).

Another approach recently introduced in several countries is to rely on bundle payments for particular patient groups stretching across health care provision, including primary care. In the Netherlands, for example, bundled payments were introduced in 2007 to improve the delivery of care for patients with chronic conditions (type 2 diabetes, COPD and vascular risk management). For type 2 diabetes more specifically, the bundled payment consists of a single annual payment per patient for all standard diabetic care made to care groups. These care groups are typically composed of groups of GPs and are responsible for care delivery. However, they can decide whether to perform activities themselves or subcontract other providers such as nurses or other health professionals for the provision of certain services included in the bundle. This approach seems promising, with a slight quality improvement observed for several process and outcome indicators (including, for example, body mass index and blood pressure checks, meeting blood pressure and cholesterol targets) (Struijs et al., 2012).

***Investing in a rich information infrastructure underpinning primary care services is essential to improve access to and quality of primary care***

To assess the value that primary care brings to patients, health systems need to better report reliable information on quality of care and outcomes for patients. Collecting patient experience measures is also pivotal to delivering health services that are truly responsive to patients' needs. Not only does collecting PREMs and patient-reported outcome measures (PROMs) empower patients to play a greater role in decisions about their health care, but it also forms the basis for primary care providers to improve their clinical practice.

The United Kingdom has made good progress in developing a rich information infrastructure (known as the Quality and Outcomes Framework) to underpin quality monitoring and improvement in primary care. The volume and detail of information collected within this Framework is impressive, and it is one of the most advanced quality monitoring systems developed across the European Union (OECD, 2016b). The Quality and Outcomes Framework reports rich data at individual provider level, with a large amount of outcome indicators around prevention and management of chronic diseases, elderly care and mental health.

In a similar vein, Portugal collects a large amount of primary care-level data on quality around, for example, chronic conditions, mental health, pharmaceuticals and patient experience (Table 2.2). All health care providers have access to this information, which is a powerful driver of quality improvement. The indicators are used to evaluate performance and achievement, benchmarked against other primary care providers, and measure access, efficiency, and satisfaction (OECD, 2015).

Table 2.2. **Example of indicators collected for primary care in Portugal**

Indicator domain	Indicator
Hypertension	Proportion of patients with hypertension, with at least one record of BMI in the last 12 months
Diabetes	Proportion of patients with diabetes, with nursing consultation to monitor diabetes in the last year Proportion of patients with diabetes, with the last recorded HbA1c lower or equal to 8.0%
Mental health	Proportion of patients aged over 65 years who were not prescribed anxiolytics or sedatives or hypnotics
Pharmaceuticals	Proportion of users aged over 18 years and a diagnosis of depression who were prescribed antidepressant therapy
Patient experience	Proportion of users satisfied or very satisfied Number of complaints per 1 000 medical or nursing consultations

Source: OECD (2015).

## Conclusions

This chapter showed that large variations exist in the organisation of primary care between European countries. While primary care increasingly serves a gatekeeper role across Europe to guide patients through the health system, primary care in many countries is still organised around solo practice and traditional payment mechanisms prevail. However, countries are increasingly taking steps in the right direction to meet the need of complex, multi-morbidity patients, notably by introducing more group practice and blended forms of payments.

International comparisons show that some countries such as Denmark and the Netherlands are among the top performers for several indicators related to access and care quality. These countries consistently report low rates of unmet medical needs, low rates of unnecessary use of hospital care, and low rates of inappropriate prescribing patterns in primary care. All countries, particularly those in Central and Eastern Europe, need to pursue comprehensive reforms to strengthen their primary care system to better address the needs of ageing populations and reduce the unnecessary use of hospital care.

Country experiences show that the following policy options have the potential to improve access and quality of primary care across EU countries:

- Making sure that primary care options are available outside normal working hours is a prerequisite to improve access and to reduce avoidable ED visits (as seen in the Netherlands with the GPCs).
- Delivering high-quality care for patients with complex needs entails developing new models of shared-care, based on multidisciplinary practice and where case managers have the responsibility for managing pathways of care within the health system (as seen in Belgium and Slovenia).
- Investing in a specialist primary care workforce is important to provide continuous and comprehensive care, focusing on prevention and management of long-term conditions. Expanding the roles of nurses and community pharmacists also has the potential to improve care quality (as seen in Sweden and Finland).
- Implementing innovative payment systems that reward the quality and value of care is also important to improve care co-ordination and improve care delivery (as seen in France and the Netherlands). Such innovations show promise to better align provider incentives with health policy objectives, and to achieve greater accountability for patients' outcomes.
- Finally, investing in a rich information infrastructure underpinning primary care services (as seen in the United Kingdom and Portugal) is essential to turn measurement into actions that lead to quality improvement. Health systems need in particular to better report outcomes and quality of care around prevention and management of chronic conditions, elderly care, mental health and patient experience.

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