



# Road Map for Primary Health Care Management

## Changing the Balances





# Presentation



1. The current state of the Vehicle
2. Management and the Direction of Travel  
– What Does the Sat. Nav. Say?
3. The Changing Landscape
4. The Changing Balances
5. Conclusions





# 1. The Current State of the Vehicle Stationary?





## Working Definition of (Extended) Primary Care



- Refers to directly accessible, first contact ambulatory care for unselected, health (related) problems;
- Offers diagnostic, curative, rehabilitative and palliative services in response to the bulk of these problems;
- Offers prevention to individuals and groups at risk in the population served;
- Takes into account the personal and social context of the patient;
- Is provided by a variety of disciplines, either within primary care, secondary care or related sectors;
- Assures patients of continuity of care over time and between patients.

Source: Primary Care in the Drivers Seat: Organisational Reform in European Health Systems; WHO on behalf of EOHSP, 2006



# Primary Health Care Workers 2005 - 2007

DEPARTMENT	MEDICAL STAFF AND ASSOCIATE WORKERS							
	PHYSICIANS				WITH COLLEGE EDUCATION		WITH SECONDARY EDUCATION	
	Total	GPs	Residents	Specialists	Total	Nurses	Total	Nurses
GENERAL MEDICINE								
2005	3336	1740	208	1388	287	266	5668	5533
2007	3422	1778	269	1375	272	247	5433	5108
% Change	+2.5	+2.1	+22.7	-0.9	-5.2	-7.1	-4.1	-7.7
CHILD HEALTH SERVICE								
2005	772	64	62	646	120	113	1213	1113
2007	777	57	60	661	120	112	1204	1087
% Change	+0.6	-10.9	-3.2	+2.3	0.0	-0.9	-0.7	-2.3
SCHOOL CHILDREN & YOUTH								
2005	695	138	57	500	53	51	973	885
2007	689	142	71	476	54	53	946	865
% Change	-0.9	+2.8	+19.7	-4.8	+0.9	+3.8	-2.8	-2.3
WOMENS' HEALTH								
2005	539	5	29	505	52	45	887	421
2007	542	1	30	511	35	28	848	426
% Change	+0.6	-20	+3.3	+1.2	-32.7	-37.8	-4.4	+1.2
SPECIALISED HEALTH CARE								
2005	2955	48	178	2729	822	418	3878	3376
2007	3039	77	200	2762	854	443	4123	3702
% Change	+2.8	+37.7	+11.0	+1.2	+3.7	+5.6	+5.9	+8.8

Source: Health Statistical Yearbook of Republic of Serbia 2005 and 2007



# Primary Health Care Activity 2005 - 2007

DEPARTMENT	OFFICE VISITS			HOME VISITS		REGULAR CHECK UPS	FOLLOW UP EXAMINATIONS
	OFFICE VISITS		TO OTHER MEDICAL STAFF	PHYSICIANS	OTHER		
	TOTAL	1 <sup>ST</sup> VISIT					
<b>General Medicine</b>							
2005	21919229	6633687	19884918	374031	3405980	204743	294444
2007	21921521	7136895	18691130	348676	2447303	260393	99144
% Change	+0.01	+7.6	-6.0	-6.8	-28.1	+27.1	-66.3
<b>Child Health Service</b>							
2005	4505708	2615563	3489295	30607	13769	381705	327851
2007	4220492	2530864	2917389	135229	29192	349748	316985
% Change	-6.3	-3.2	-16.4	+341.8	+112.0	-8.4	-3.3
<b>School children &amp; Youth</b>							
2005	4109912	2415117	2602772	9538	15913	-	-
2007	3900306	2376458	2050807	6377	8583	-	-
% Change	-5.1	-1.6	-21.2	-33.1	-46.1	-	-
<b>Womens' Health</b>							
2005	1823938	747891	1530327	5271	1009	294477	65841
2007	1724698	753155	1444105	415	2395	335449	-
% Change	-5.4	+0.7	-5.6	-92.1	+42.1	+12.2	-
<b>Specialised Health Care</b>							
2005	15312379	8829674	17610248	10104	83748	190198	39847
2007	14127492	8054197	16639590	5687	22797	-	-
% Change	-7.7	-8.8	-5.5	-43.8	-72.8	-	-

Source: Health Statistical Yearbook of Republic of Serbia 2005 and 2007





## 2. Management and the Direction of Travel – What Does the ‘Sat. Nav.’ Say?

Understanding vision, mission and objectives





# Management Involves:



- .....being totally clear about the purpose of the organization and what customers require;
- .....focusing efforts towards goals and objectives;
- .....ensuring that vision, mission and values come from the heart – and are not be meaningless slogans and wordplay
- .....knowing what to measure and how to measure it

Peter Scholte





# Understanding the Road Map



- Understanding the road map for management is therefore highly dependent being clear about:
  - Purpose
  - Vision
  - Mission
  - Values
  - Goals
  - Objectives

For primary health care system development





# PHC Service Objectives for Serbia?



- Population health status improvement
- Equity of access for equal need
- Promotion of 'solidarity amongst all strata of population
- Patient-centred services
- Safety and continuous quality improvement
- Sustainability
- Decentralisation and recognition of regional differences
- Improved efficiency and effectiveness
- Human resource empowerment and development
- Increased community and patient satisfaction

*Source: Health Policy of Serbia 2002*





# PHC Service Outcomes for Serbia?



- Continuously improving population health status;
- Reduced avoidable (amenable) mortality, increased morbidity compression etc;
- Improved quality of life for those in deprived circumstances or living with illness and disability;
- Continuous quality improvement, safety, and service innovation and modernisation in health care delivery;
- Evidence-based practice (appropriate antibiotic use, call and recall screening, consistent use of protocols etc.);
- Increasing levels of community and patient satisfaction with service responses.





# 3. The Changing Landscape

## Influencing the Direction





# Influencing the Route



- Changing demographics (increased ageing population)
- Changing epidemiological profile and with emphasis on chronic non-communicable disease management
- Policy shift from health care to health status improvement
- Continuing health inequalities
- Increasing health system costs
- Need for increased efficiency and effectiveness
- Scientific and technological advances
- Societal expectations
- Primary care focus





# The Increasing Burden of Chronic Disease



- In the WHO European region 86% of all deaths and 77% of the disease burden are attributable to chronic or non-communicable diseases (WHO Europe 2008);
- The most common causes of which are heart disease, strokes, cancer, respiratory disease, diabetes and mental health problems;
- Spending on Sickness and disability benefits represents about 2% of GDP in OECD countries and in some up to 4% (OECD *Sickness, Disability and Work*, May 2009);





## Burden of Disease by Deaths from Non communicable Disease in WHO European Region by Cause (2005)

Groups of Causes (Selected non-communicable diseases)	Disease Burden		Deaths	
	DALYs (1000s)	% All Causes	Number (1000s)	% All Causes
Cardiovascular diseases	34,421	23	5,067	52
Neuropsychiatric conditions	29,370	20	264	3
Cancer (malignant neoplasms)	17,025	11	1,855	19
Digestive diseases	7,117	5	391	4
Respiratory diseases	6,835	5	420	4
Sense organ diseases	6,339	4	0	0
Musculoskeletal diseases	5,745	4	26	0
Diabetes Mellitus	2,319	2	153	2
Oral conditions	1,018	1	0	2

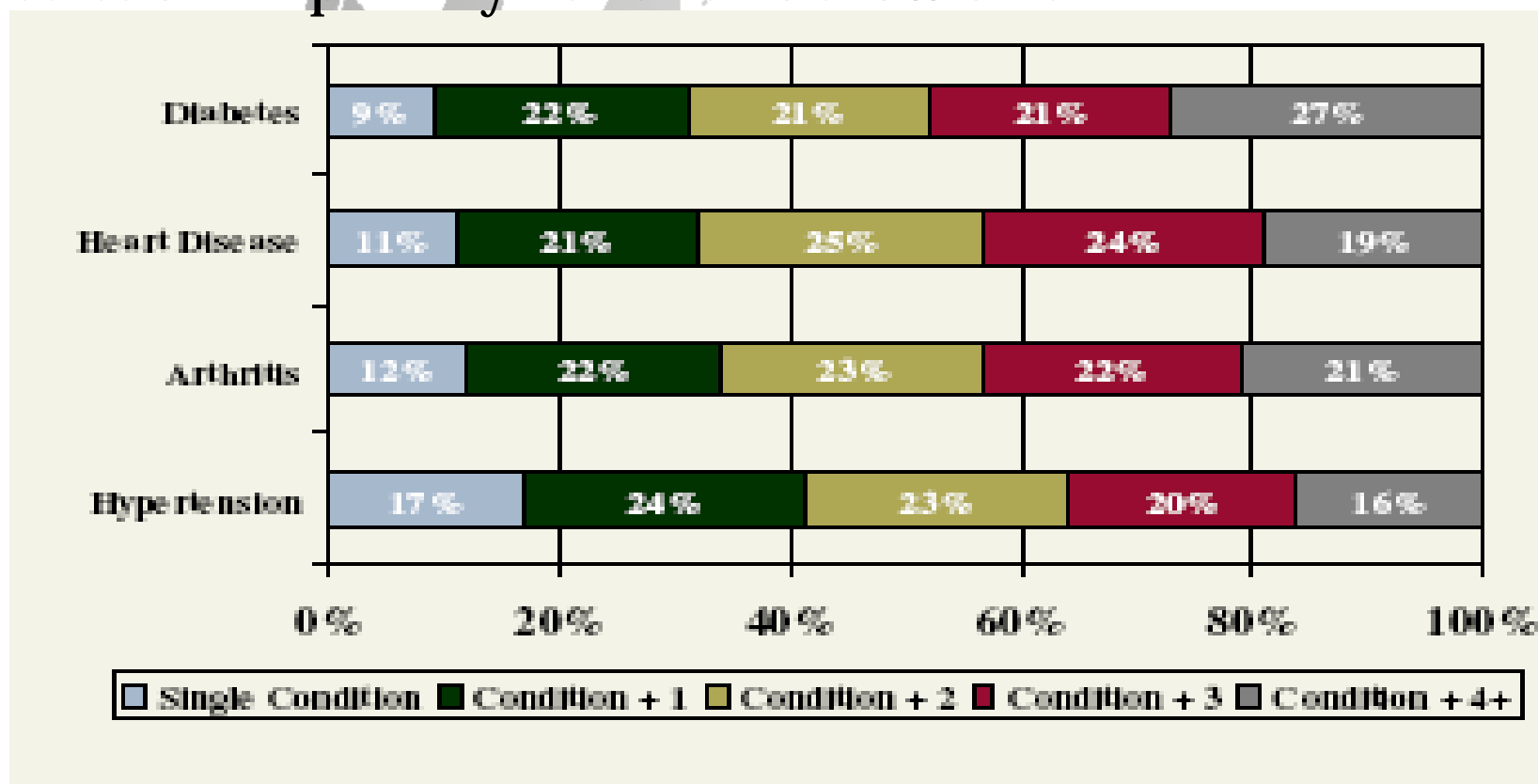




## Increasing Complexity of Medical Practice: In Chronic Disease Co-Morbidity is the Norm



Designers of the John Hopkins ACG system of case mix prediction in primary health care show that:

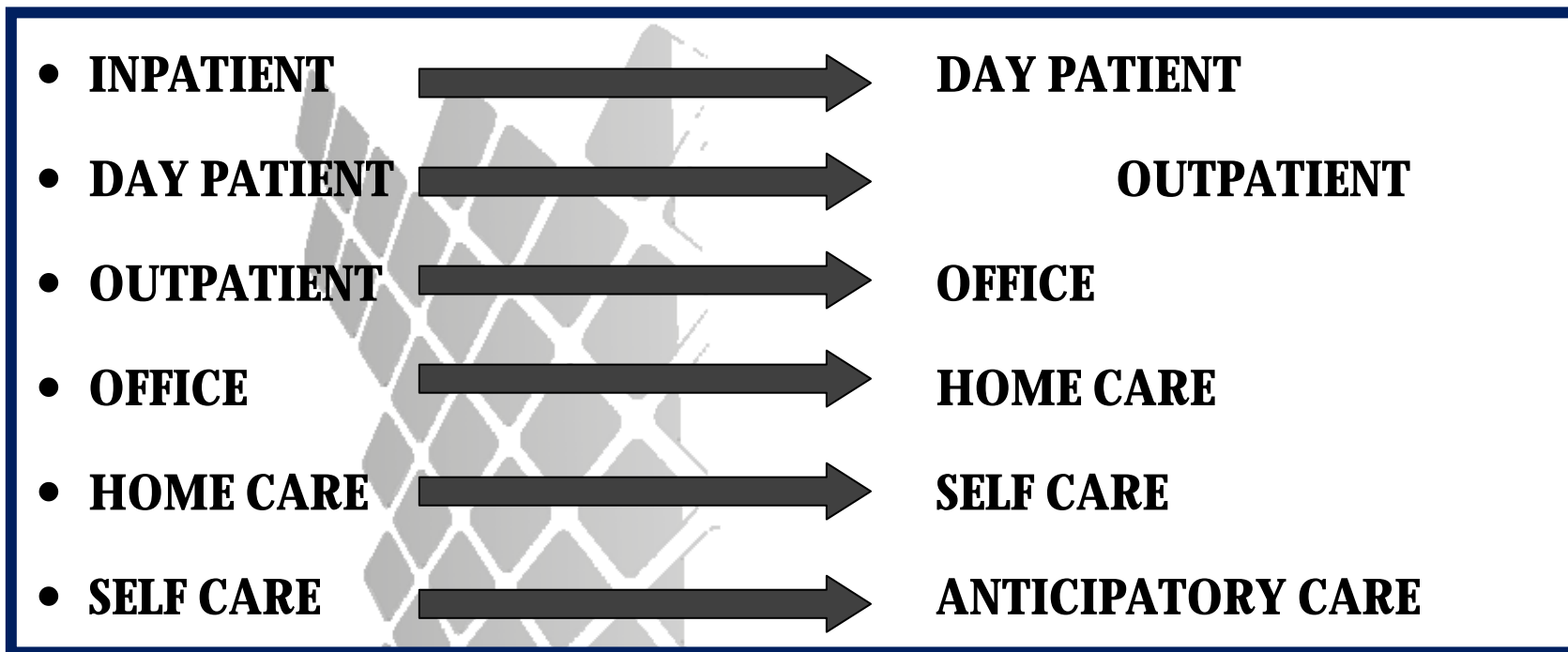


Source: Partnership for Solutions, Johns Hopkins University





# The Basic Dynamic of Health Care Delivery



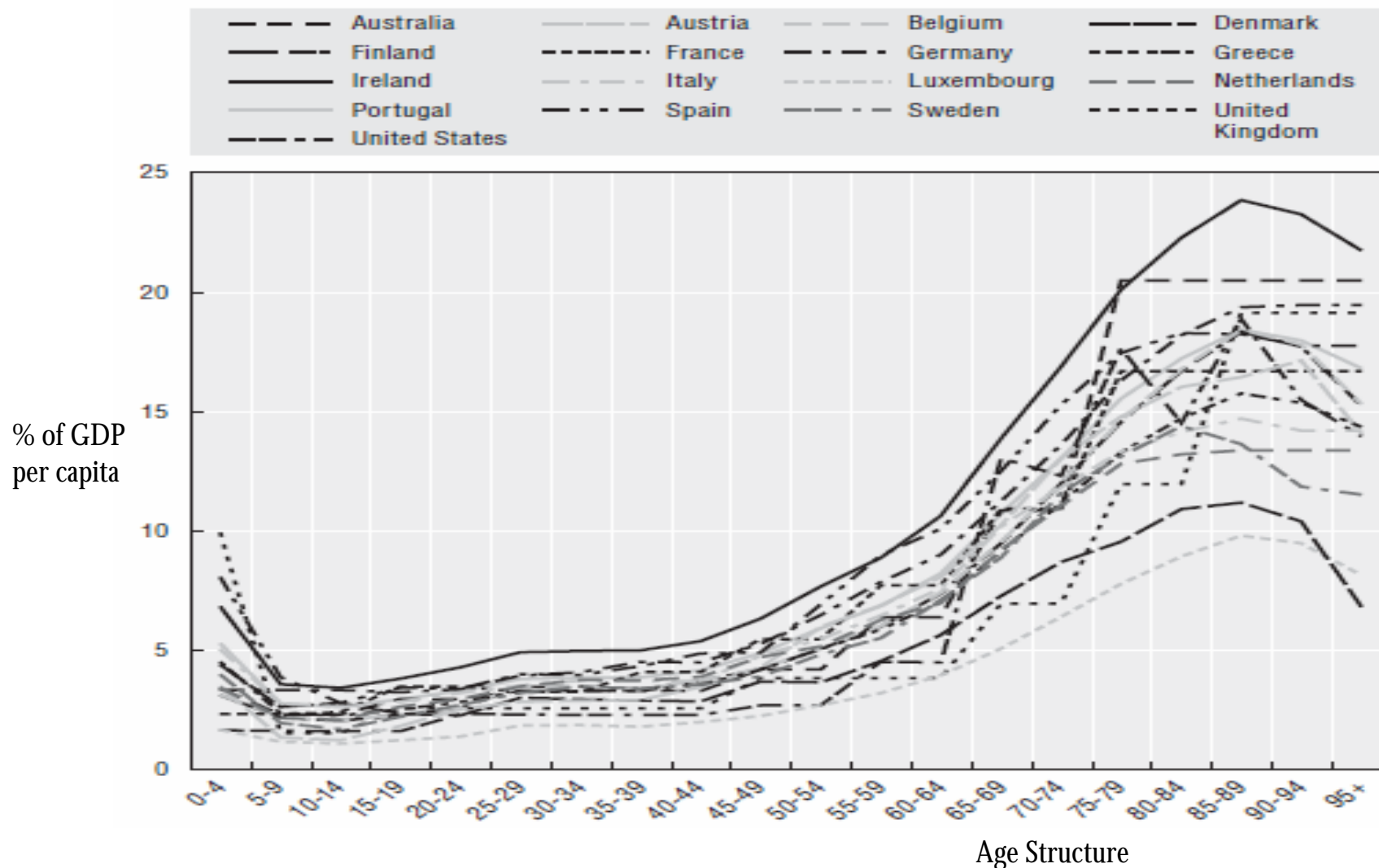
Source: G. Boulton 2007





# Public Health Care Expenditure By Age Group

(Source: OECD Economic Studies No. 43, 2006/2)





## 4. Changing the Balances

1. Between the component parts of the health care system
2. Within primary health care





# The Changing System Balances



- From a health care to a health improvement model
- From a curative to a health promoting and preventive model
- From an institutional to a non-institutional models of care
- From inpatient care to outpatient and ambulatory care
- From institutional to client-group based organisation
- From general patient flows through systems to dedicated organisational pathways





# The Changing Balances within PHC



- Increased emphasis on health promotion, primary prevention, secondary prevention and health maintenance – programmes integrated horizontally into the routine work of PHC services
- Increased emphasis on effective, systemic and systematic chronic disease management
- Closer integration with secondary and tertiary levels, and playing a full role in developed service frameworks and clinical pathways for various patient groups;
- Providing the focus at which many traditional separate parts of the system become integrated.





# What's Wrong with Vertical Programmes?



“ The limited sustainability of a narrow focus on disease control, and the distortions it causes in weak and underfunded health systems have been criticised extensively in recent years. Short term advances have been short-lived and have fragmented health services to a degree that is now of major concern to health authorities.”

“Primary Health Care: Now More Than Ever”, The World Health Report 2008. WHO 2008.





# Policy and Planning



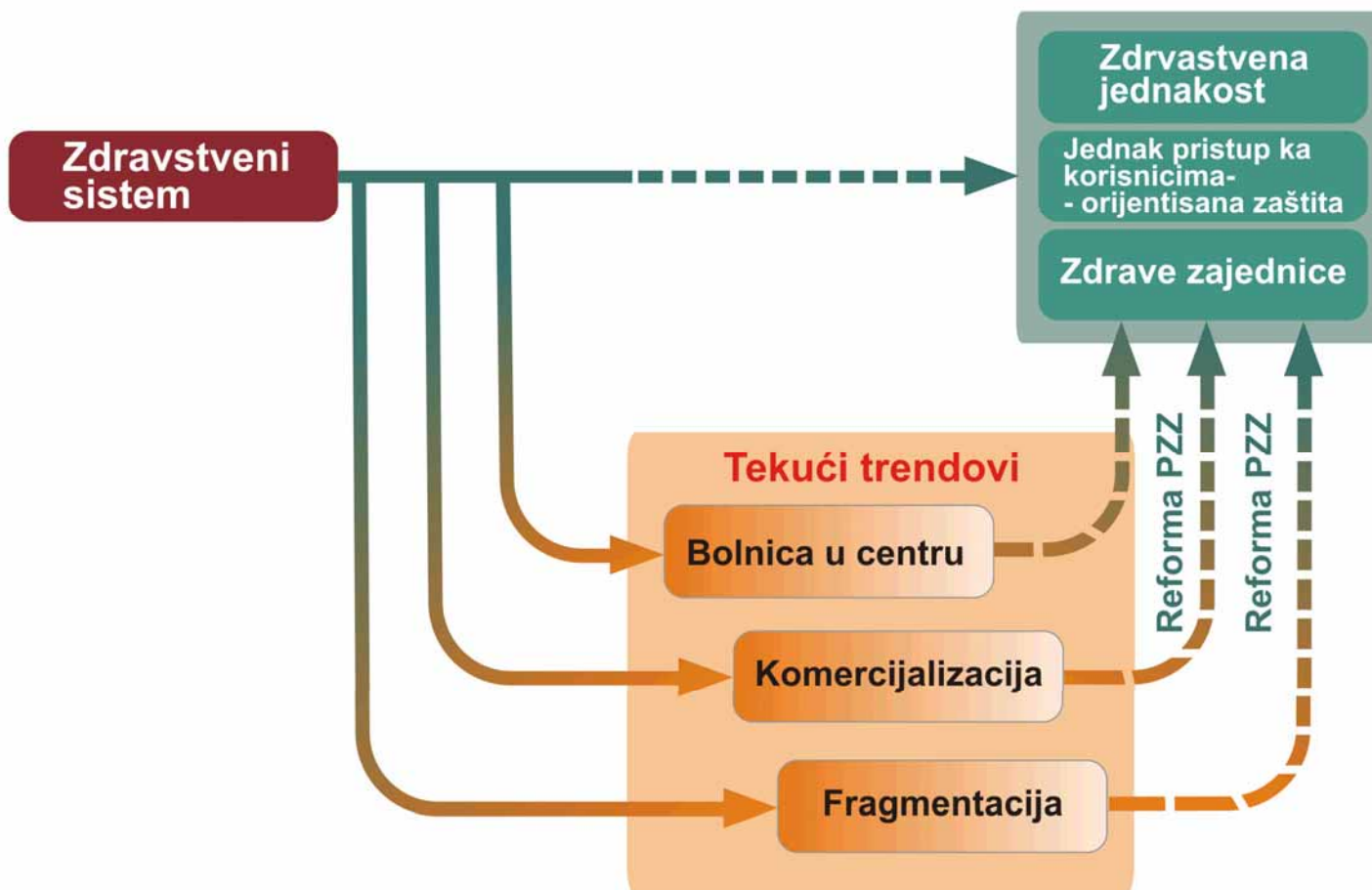
- Some evidence-based outcomes of an effective PHC system include:
  - better health outcomes
  - increased uptake of disease-centred preventive care
  - fewer hospital admissions for preventable complications of chronic conditions
  - lower all cause mortality
  - better access to care
  - less re-hospitalisation
  - less use of emergency services
  - better detection of adverse consequences of medical interventions<sup>1</sup>.

1. *The World Health Report 2008; Primary Health Care: Now More than Ever; WHO 2008*





# What Might Get in the Way?





European  
**Observatory**  
on Health Systems and Policies



## Policy Brief

### Screening in Europe

Screening in Europe

n Europe

by

Walter W Holland  
Susie Stewart  
Cristina Masseria

Screening in Europe



Podrška primeni kapacitacije u primarnoj zdravstvenoj zaštiti u Srbiji  
Projekat finansira Evropska unija





*Table 9: Our recommendations for screening in adults*

<i>Condition</i>	<i>Comment</i>
Breast cancer	National programme should be continued but kept under close review with emphasis on quality control, staff training and good information.
Cervical cancer	National programme should be continued with review of alternative types of tests and of age range of those eligible and frequency of screening. Good information to be a priority.
Colorectal cancer	National screening programme by faecal occult blood testing for adults aged 50–74 years.
Abdominal aortic aneurysm	Ultrasound screening of men aged 65 and over seems a reasonable proposition provided the necessary resources are in place.
Diabetic retinopathy	National programme of screening for all diabetics aged over 12. It is essential to be quite clear about how, when and where screening should happen to ensure effective implementation.
Risk factors for coronary heart disease (CHD)/stroke Blood pressure Cholesterol Smoking cessation	Weight surveillance/case-finding approach in primary care.





*Table 10: Our recommendations for screening in the elderly*

<i>Physical assessment</i>	<i>Mental assessment</i>	<i>Social assessment</i>
Hypertension	Depression	Falls
Early heart failure	Alcohol use	Undernutrition
Hearing loss		Isolation
Vision loss		
Incontinence		
Lack of physical activity		
Foot problems		
Review of medication		





# OECD Quality Indicators for Health Promotion, Prevention, PHC (HTP No. 16)



Health Promotion	Obesity prevalence
	Physical activity
	Smoking rate
	Diabetes prevalence
	Gonorrhoea/Chlamydia rates
	Abortion rates
Preventive Care	Blood typing and antibody screening for prenatal patients
	HIV screen for prenatal patients
	Bacteriuria screen for prenatal patients
	Immunisable conditions
	Low birth weight rate
	Adolescent immunisation
	Anaemia screening for pregnant women
	Cervical gonorrhoea screening for pregnant women
	Hepatitis B screen for pregnant women
	Hepatitis B documentation in record at time of delivery
	Hepatitis B immunisation for high-risk groups
	Influenza vaccination for high-risk groups
	Pneumococcal vaccination for high-risk groups
Diagnosis and Treatment: Primary Care	Congestive Heart Failure readmission rate
	First visit in first trimester
	Smoking cessation counselling for asthmatics
	Blood pressure measurement
	Re-measurement of blood pressure for those with high
	Initial laboratory investigations for hypertension
Hospitalisation for ambulatory care sensitive conditions	





## 5. Conclusion





# Therefore.....



- Changing balances in primary health care requires a new purpose, vision, and mission. A new direction for PHC, a new road map for its management and a new Sat. Nav. to guide the journey;
- Changing the balances involves change to traditional role, functions and boundaries of responsibility (which have traditionally been vertically and administratively drawn);
- This demands a focus on health improvement, which leads naturally to an increased focus on health promotion, primary prevention, secondary prevention and health maintenance;
- Primary health care infrastructure, rooted in the communities, is the ideal vehicle for leading the community health improvement emphasis through horizontally integrated initiatives;
- If primary health care does not take up this challenge why keep the vehicle just to sit in the garage!





## Footnotes:



- The early slide defining ‘management’ mislead you: Scholte’s definition was not definition of ‘management’ it was a definition of ‘leadership’;
- The road map will require the new Association and its members to provide that leadership;
- Can anything else be done to help along the journey: A chair in primary health care medicine in each Medical University with specialist programmes and active post-graduate CME programmes and with equal status with all other specialist departments!

