



ANALYSIS

Unfulfilled potential of primary care in Europe

The Alma Ata declaration's compelling vision of health for all will not be realised until we take community level prevention seriously, argue **Luke Allen and colleagues**

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To mark the 40th anniversary of the Alma Ata declaration on primary healthcare in October 2018,¹ world leaders gathered in Astana to renew their commitment to health for all. Although primary healthcare is about much more than primary care services, getting this element right is crucial to supporting the overarching principles of equity, population level primary prevention, and action on the social determinants of health. In the context of increasing chronic multimorbidity and ageing populations we consider why European primary care has broadly failed to engage with the prevention oriented approach set out 40 years ago, and what conditions are required to realise its potential.

Contemporary challenges in primary care

Primary care has been defined as “first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system.”² A stronger primary care sector is associated with greater equity, better health outcomes, and, in some settings, lower overall costs.^{3,4} Primary care can manage 90% of all health system interactions, making it central to the realisation of universal health coverage.^{5,6} Over recent decades, improvements in the quality and coverage of primary care have delivered important population health gains around the world.^{3,7-12}

Primary care teams are commonly led by family doctors (also known as general practitioners or family practitioners), who have received postgraduate specialty training to provide comprehensive family and community oriented medical care. In recent decades they have come under pressure from substantial increases in workload, including paperwork and delegation of care from hospitals to the community setting.^{6,13} Task shifting to primary care is often appropriate, but reallocation of responsibility is rarely followed by adequate

reallocation of resources.¹³ Primary care teams have been on the front lines of this century's major demographic and epidemiological challenges, including ageing, socioeconomic inequalities, chronic diseases, rising consultation rates, and multimorbidity.¹³⁻¹⁵ The future sustainability of our health systems depends on primary care successfully meeting increased need with affordable, person centred, high quality care.

By shifting the emphasis of primary care from treatment towards proactive care, prevention, and health promotion at the local population level, it may be possible to deal with health challenges at an earlier stage.

This idea is not new; in fact it is the central thesis of the Alma Ata declaration, which set out to distinguish primary healthcare (box 1) from the status quo of care oriented around sickness. Although moving towards more proactive primary healthcare requires the collective actions of policy makers, communities, and many different health professionals, the primary care sector is uniquely invested with the legitimacy and authority to lead this change.

Box 1: Article VII of the 1978 Alma Ata declaration**Primary healthcare**

- Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical, and health services research and public health experience
- Addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly
- Includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs
- Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors and demands the coordinated efforts of all those sectors
- Requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation, and control of primary healthcare, making fullest use of local, national, and other available resources, and to this end develops through appropriate education the ability of communities to participate
- Should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive healthcare for all and giving priority to those most in need
- Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Primary care systems are currently configured around sequentially consulting unwell individuals, but many of the current challenges in health require upstream action. Population level interventions¹⁶ tackle environmental risk factors as well as social and economic determinants of health. Community level interventions include investment in green spaces, housing, active transport networks, smoke-free zones, traffic calming measures, and local licensing and zoning regulations.

Many practices are taking first steps towards dealing with social determinants through social prescribing. However, this is an individual level approach rather than seeking to influence structural or system determinants that affect whole subpopulations.

Policy makers may be reluctant to invest in pivoting primary care systems towards population prevention for numerous reasons. It is much easier to blame individuals for making poor lifestyle choices than it is to change the environment; prevention and health system reforms require upfront political and capital investment but the benefits are invariably conferred to political successors; it is hard to take credit for things that haven't happened (such as deaths averted); and it is difficult to obtain robust evidence for the effectiveness of population level interventions within the current evidence model. Policy makers also face complex trade-offs between investing in prevention versus other elements of the universal health coverage and primary healthcare agendas, such as improving access to services.

Structural determinants

In many European countries the remit of primary care extends only as far as diagnosing and treating disease in individuals (and only those with the means and motivation to seek care).¹⁷ Although patients may be opportunistically screened for hypertension or offered support with smoking cessation, there

is often no systematic approach to engaging with the broader health determinants at the community level.¹⁸

This is a lost opportunity. In concert with public health teams, primary care teams are well positioned to identify the local drivers of morbidity and mortality, including transport, the food environment, pollution, poverty, early years education, housing, road safety, exercise spaces, and the availability and affordability of alcohol and tobacco. These non-medical factors are responsible for up to 90% of health outcomes.¹⁹ Primary care teams see these local social determinants at work every day²⁰ and have overlapping moral, professional, and (where they are paid by capitation) financial interests in tackling them.

Through collaboration with public health, social care, and other community organisations, primary care professionals are uniquely placed to translate their insights into priorities for community level prevention. Primary care teams have detailed patient datasets and a unique ecobiopsychosocial perspective, and they often develop a high stock of community trust and a rich ethnographic understanding of the local population.²¹ Although the Alma Ata declaration called for population level prevention to become the central organising activity of primary healthcare, teams that operate this way remain rare.

Restricted remit

Early general practitioners such as William Pickles and Frans Huijgen felt responsible for population and individual level practice,²² but the role of contemporary primary care teams is much narrower in many European countries.^{11 23-25} Sutchfield and colleagues argue that an overemphasis on specialisation and the evolving professionalisation of primary care and public health as distinct specialties during the 20th century led to GPs eschewing public health roles.²⁶ Primary care came to focus more on biomedical curative services for individuals and developed its own set of definitions around population health.²⁷ Recent efforts to bring the two isolated specialties back into alignment have been under-resourced and often meet resistance from powerful doctors' organisations.²⁸

Financing has also played a large role. Once ubiquitous fee-for-service systems can lead to the underuse of preventive services,^{29,30} and it is difficult to make people contribute to action on the social determinants as the benefits are a "public good" (that is, one person benefitting does not reduce the benefit for others and no-one can be excluded.)³¹ The international move to capitation has helped provide capital for investment in primary prevention at the community level, but growing multimorbidity often seems to absorb any additional money, as in the UK.^{13 32} Governments tend to govern and finance public health and primary care functions separately, and insurance companies have been reluctant to pay for community prevention delivered through primary care.³³

The degree to which primary care teams engage with even basic individual preventive activity varies widely across Europe, with variation underpinned by differing financing arrangements.^{11 23 34 35} Experience from other continents shows that state regulators often restrict the practice of primary care professionals to individual level functions and disproportionately direct regulatory measures to public sector practices (which may be more likely to consider public health than their private counterparts).^{8 36}

Anecdotally, our primary care colleagues believe that social determinants simply aren't their responsibility, even though they appreciate that these issues affect their work. And can we blame them when modern primary care teams are not trained,

paid, held accountable, or given time for delivering community level prevention?³⁷

Realising the potential of primary care

We have argued that European primary care teams are well positioned to assess and tackle structural determinants of health at the community level, but what does this look like in practice?

The Hedena Health GP practice in Oxford has worked with housing developers, the city council, public health teams, and NHS England to develop a health promoting housing development in a deprived area. The “healthy new town” gives primacy to cyclists, pedestrians, and public transport as well as focusing on social inclusion, safe housing, and the food environment.^{38 39}

In Belgium, the Botermarkt Community Health Centre in Ghent has led several preventive initiatives prompted by assessment of the local population’s health needs. These have included leading a coalition of community stakeholders to redesign a dangerous road section and successfully lobbying the council for a new playground. These activities have helped to reduce road traffic injuries and childhood obesity.^{21 40}

The “deep end” practices serving deprived areas in Glasgow and Clyde work closely with members of the local community to assess and reduce local drivers of disease through initiatives like walking groups, financial advice, community gardens, and supporting the reforestation of disused land. Recognising that tackling social problems can reduce demand by improving health outcomes, Garscadden Burn medical practice closes one afternoon a month to train staff in this area.^{41 42}

Primary care professionals in the Dutch city of Utrecht work with community nurses and social workers to deliver a city-wide programme that supports frail elderly people, identified using routine primary care data.⁴³

System recalibration

Certain conditions are required to facilitate this style of working, starting with financing. The Botermarkt practice successfully lobbied for capitated payment, which they used to employ a community health worker to engage with issues like housing, playgrounds, street lighting, healthy food availability, and active transport.^{21 44} England and Estonia’s quality bonus schemes could be modified to encourage action at the local population level.

Moving away from fee-for-service and towards mixed payment models that include population based weighted capitation is important for sustainability and encouraging population based practice.^{21 45 46} More important is ensuring that the primary care sector is adequately financed. Even in countries like the UK, where primary care is well developed and delivers over 90% of all health system interactions, primary care receives around 10% of government health spending.⁴⁷ Many of our English primary care colleagues believe that this is not enough to provide a bare bones individual level service, let alone expand to include social determinants. Long time horizons are required to realise the gains of investing in primary prevention.

Empanelment is a second prerequisite as primary care teams need to know who they are serving and the characteristics of their patient population.⁴⁸ Staff also need better training on how to identify and deal with social determinants, complemented by easy access to public health specialists. Deeper integration can be achieved through co-location, regular meetings, and shared information systems, work plans, and budgets.³² Qualitative and

quantitative primary care data should be used routinely to develop public health interventions.⁴⁹

Scotland⁵⁰ and Catalonia⁵¹ have tried to improve the coordination of multiple health and social care services around the needs of patients and populations. This integrated working allows primary care teams to engage directly with agencies working on social determinants of health.⁵²

Finally, a cultural shift is required within modern medicine, from specialist hospital treatment to community led prevention and care. The NHS Five Year Forward View⁵³ and Astana declaration⁵⁴ are good examples of policy commitment to prevention oriented care. Medical associations carry enormous weight and will need to catch the vision of what primary care can accomplish for patients when their sphere of concern enlarges to encompass more than consultation rooms. Commissioners and individual practitioners also need to be convinced that this enlarged scope is good for their patients.⁵⁵ Box 2 outlines a few suggested enablers of reform.

Box 2: Enablers of primary care reform

Policy makers

Governance:

- Health in all policies
- Intersectoral collaboration and coordination
- Merging of health and social sectors
- Align professional health curriculums towards skill gaps

Financing:

- Ear marked funding for population level prevention activity
- Strategic purchasing—mixed payment models that include population based weighted capitation
- Allocate resources for transformation in operations

Monitoring and evaluation:

- Performance management—devising financial and non-financial incentives and key performance indicators aligned with overall health system goals
- Accountability—holding primary care teams accountable for delivering activities

Enabling environment:

- Seeking out and disseminating examples of best practice
- Lowering barriers to safe innovation through accountability structures and payment mechanisms that prioritise outcomes over processes.

Managers

- Commissioning and managing local services
- Training
- Building and maintaining relations with community stakeholders
- Convening stakeholders
- Data analysis and performance management
- Routine reporting to providers on the health status of their population
- Improving the financial and human resources allocated to health promotion and disease prevention

Practitioners

Working with public health and community members to:

- Monitor population health status
- Survey risks and threats to public health
- Identify local social determinants of health
- Risk stratify the population
- Develop and deliver appropriate interventions
- Monitor and evaluate interventions with community involvement

Time for action

Primary care teams provide invaluable medical care for individuals, and this will always be required. However, they

are also well positioned to help identify and influence the local social determinants that make their patients ill. Given that primary care workers are not currently trained, paid, or managed to think about community drivers of disease, it is not surprising that this approach is rare. Policy makers in Astana talked the talk, recommitting to orienting health systems around prevention. Introducing empanelment, population weighted capitation, enhanced training, unified budgets, and intersectoral working arrangements would show that they are willing to walk the walk.

Key messages

The 1978 Alma Ata declaration called for a shift in focus from reactively managing sick individuals to prevention and health promotion at community level

Increasing chronic multimorbidity and rising demand make preventive action more pertinent, yet the Alma Ata vision remains unrealised

Most primary care systems constrain rather than facilitate engagement with local public health teams, communities, and initiatives to tackle social determinants

Primary care financing, training, organisational structures, and incentives can and should be better aligned with community level prevention

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