

Three Models of Primary Care Organisation in Europe, Canada, Australia and New-Zealand

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The concept of '*primary care*' conveys an ambition of social justice which aims at equal access to basic medical care for all. '*Primary care*' also refers to organisation of outpatient care systems.

In developed countries, three models of primary care organisation have been identified: the hierarchical normative model in which the health system is organized around primary care and regulated by the State (Spain/Catalonia, Finland, Sweden); the hierarchical professional model where the general practitioner is the cornerstone of the health system (Australia, New Zealand, the Netherlands and the United Kingdom) and the non-hierarchical professional model in which the organization of primary care is left to the initiative of healthcare professionals (Germany, Canada).

The evolution of health systems along with the reforms implemented since the 1990's have tended to bring the different primary care systems closer together. This hybridisation of models notably characterises the French organization model: initially based on the non-hierarchical professional model, its health system now borrows organisational characteristics from the other two types of model.

The term *primary care*, frequently employed in international literature but scarcely in France, is a broad concept aspiring towards social justice in its aim to guarantee global accessibility to basic medical care. This principle was retained as the mainstream of primary care as defined during the 1978 Alma-Ata conference organised by the World Health Organisation (WHO) and reaffirmed in its 2008 annual report (World Health Organisation, 2008). Here, primary care is defined as supplying a broad spectrum of healthcare activities from delivering medical care to patients to public health

actions targeting specific populations and, even beyond, to include the sum of policies contributing to health improvement in general. In developed countries, including France, the different health systems each strive to achieve these goals in their own particular manner.

The term '*primary care*' is also often used in a more restrictive, operational sense to designate, in an organizational perspective, part of the healthcare system. In this context '*primary care*' strictly refers to missions ensured by ambulatory care professionals and is more often than not used to denote

'first contact', accessibility, continuity and permanence of care provided in association with other sectors. Here, the general practitioner (GP) plays an essential role although other health professionals, notably nursing staff, can also be involved.

In France, the 2004 law implementing the 'Preferred Doctor' scheme and the coordinated healthcare pathway, the recognition of general medicine as a medical specialisation, the increasing

* Interdisciplinary partnership for Research on the Organisation of Primary Care.

zoning of health policies and the definition of first contact care by the 'Hospital, Patients, Health and Territories' Bill project* are all witness to a reorganization of the ambulatory care sector along the principles of primary care.

In this paper, we aim to identify and analyse the different types of existing primary care organisations in different developed countries so as to shed light on the current reorganisation and potential orientations of the French health system. The following nine countries, each corresponding to a different model of primary care organisation, were selected for study: Germany, Australia, Canada, Spain (Catalonia), Finland, New-Zealand, the Netherlands, the United Kingdom and Sweden.

According to the predominance of certain characteristics (conceptual, legislative, systemic and organisational), the countries studied were grouped into three distinct models of primary care organisation. Obviously, these ideal models are not mutually exclusive.

The hierarchical normative model: a health system organized around primary care and regulated by the State (Spain/Catalonia, Finland and Sweden)

In the hierarchical normative model, legislation organizes the health care system according to previously defined principles and concepts of primary care. In the countries concerned, the law provides a relatively detailed definition of primary care which is then more specifically transformed into classic primary care services with precise levels of funding.

In Catalonia, a 1985 reform bill thus explicitly defined the primary care framework on two main organizational factors: basic health areas delimiting a specific geo-demographical zone and interdisciplinary primary health care providers responsible for the given population. Each basic health area is responsible for between 5,000 to 25,000 inhabitants, exceptionally

40,000 inhabitants in major towns. Each zone comprises at least one community health centre delivering primary health care. These health centres operate 24/24hrs, every day of the year. Similarly, in Finland, the 1972 Primary Care Health Bill defined the requirements and standards to make primary care the cornerstone of the Finnish health system. In 1995, the Swedish government formally recognised the importance of primary care as the basis of the health system. In both Finland and Sweden, the community health centre with its interdisciplinary teams of health professionals (general practitioners, nursing staff and other paramedical professionals) has become the cornerstone of the health system.

The law equally fixes ratios of primary care delivery according to population volumes. This ratio is expressed by the number of professionals (medical and paramedical) by unit of population. In Catalonia, for example, the ratio is based on the number of inhabitants per health care professional: one general practitioner for 1,750 to 2,500 inhabitants aged over 14, one paediatrician for 1,250 to 1,500 inhabitants aged under 14, one nurse per GP, one dentist for 11,000 inhabitants and one social worker for 25,000 inhabitants with possible adjustments according to specific local needs. In health care systems where patients are required to register with a GP, these ratios can also take the form of maximum/minimum numbers lists such as in Finland where the number of patients per GP in a health centre varies from 1,500 to 2,000.

Countries having adopted the hierarchical normative model present similar features. On the one hand they are decentralised: the local authorities (regional in Catalonia, county in Sweden and municipalities in Finland) manage health care delivery. They are equally authorised and responsible for financing health expenditures through tax and social security deductions. National solidarity is guaranteed by the State by means of financial adjustments and thus contributes to 10% of health expenditures in Sweden and 17% in Finland.

On the other hand, their national health systems are in the majority financed by the tax system. The allocation of resources to primary care organisations is carried out

BACKGROUND

This study, financed by the Directorate for Social Security of Ministry of Health, falls within the Irdes research programme and notably, since January 2009, the emergent team entitled Prospere* (Interdisciplinary research partnership on the organisation of primary care). This analysis is backed-up by previous research carried out in partnership with the Regional Union of Self-employed Physicians (URML*) and the Regional Union of Health Insurance Funds (Urcam*) in Brittany and Nord-Pas de Calais. The research was completed by a wide review of foreign literature dealing with the organisation of primary care in each of the countries studied. The aim of this study, effectuated in 2007-2008, was to reveal a typology of organisation models and draw out the key teachings and potential orientations for a policy of primary care in France. It forms part of the preparation for an international seminar to be held in Paris on October the 21st 2009. Its aim, with the intervention of foreign participants, is to examine in greater depth the questions relative to the structuring of ambulatory care within the framework of the future Regional Health Agencies.

* See web site: www.irdes.fr/EspaceRecherche/Projets/Prospere/index.htm

directly by the local authorities according to their available resources, and additional central government funding calculated on a pro-rata basis according to population. These allocations can be adjusted on the basis of certain population characteristics such as age, gender or morbidity.

In these countries, community health centres generally form the basis of primary care organisation. They include GPs and paramedical staff; skill mix is highly developed, notably the role of nursing staff. Specialists essentially practice in hospitals. Health centres are more or less standardised. In Catalonia for example, every primary healthcare centre is composed along the same conventional lines whereas in Finland there may be a greater variety of health professionals depending on the local authority. In certain cases, these health centres may be coordinated with hospitals' internal medicine wards, mainly for elderly populations, and are closer to the local

hospital model such as we know it in France. These centres are managed by the local authorities or, in Catalonia, by the regional health authority.

The hierarchical professional model: the general practitioner as cornerstone to the health system (United Kingdom, Netherlands, Australia and New Zealand)

The hierarchical professional model neither provides a specific definition nor a model of primary care services. All four countries nevertheless have in common the fact that they are organised on the principle of universal solidarity in the face of disease risk. In these countries, the GP plays an essential role both as gatekeeper and cornerstone to the health system as a whole. From the outset, (1941 in the Netherlands, 1948 in the United Kingdom and later in Australia and New Zealand), these health systems, incidentally financed by very different methods, have attributed a central role and mission to the GP. Specialists in the majority practice in hospital structures (except in Australia) as salaried staff.

Primary care is thus largely assimilated to general medicine and is partially organised around professional dynamics. The tasks attributed to each professional, or the roles played by health structures, are not assigned on a standard regulatory basis. Indeed, the services provided to the population are in fact inherent to the said profession or structure as defined by the professional and academic bodies determining activity and training content. The primary care projects established in these countries are nevertheless global and explicit since they are founded on a populational and hierarchical approach. This type of project exists in the United Kingdom, Australia and New Zealand.

Firstly, the *gate-keeping* role is attributed to the GP, who in the majority of cases works in a group practice. Conceived to regulate access to specialist care, delivered in hospital, the role of gatekeeper constituted one of the founding elements in the organisation of primary care.

Three types of approach to primary care

Three types of approach to primary care can be distinguished in the vast body of literature on the subject, essentially from Anglo-Saxon and Scandinavian sources. Their common point is to deliver patients with a professional response during their first contact with the health system.

Primary care defined as a level of care. In this context, primary care is always presented as the base of the pyramid thus differentiating itself from secondary and tertiary care.

The primary level is not segmented either by age, gender, health problem or a patient's financial situation. It must be able to deal with 90% of health problems. Conversely, secondary and tertiary care levels are specialised and therefore segmented. The secondary level refers to specialist medicine in the broad sense of the term (in town or in hospital), and the tertiary level to high technology medicine (university hospitals).

First level primary care is thus the point of entry into the system delivering general, integrated and continuous care accessible to the population as a whole and coordinating and integrating the services necessary for higher levels of care. The gate-keeping role attributed to the general practitioner or the community health centre, is an example of this hierarchical organisation into care levels.

Primary care defined as a combination of functions and activities. This combination can be broached either from the general characteristics imputed to primary care (accessibility and first contact, continuity of care, comprehensiveness and coordination), or from the content and range of the care supplied. From a services point of view, primary care is defined as ambulatory

care directly accessible to patients. With a generalist, community dimension, they are focused on individuals in their family and social context.

Primary care can equally be founded on the range of services delivered comprising three essential characteristics: care for run-of-the-mill health problems by means of a combination of preventive, curative and rehabilitative care; 'integrated' care with the illness considered in a broader socio-economic context: the organisation and rationalisation of 'specialist' resources.

Primary care defined as health professionals providing services.

In this context, the primary care sector is sometimes difficult to analyse because it groups together several types of activity involving different types of health professional with different levels of training that are not always comparable from one country to another: general practitioners, but also nursing staff, physiotherapists, paediatricians, gynaecologists.

Primary care is traditionally assimilated with general medicine since general practitioners have always constituted the first contact with the health system. The term 'extended primary care' used by certain authors, broadly refers to a patient's first contact with a health professional. This intermediary definition, between primary care in the sense of general medicine and the broader view of primary care including the sense of social justice and accessibility for all, aims to integrate ongoing changes. These mainly involve the recognition of a variety of professions and types of intervention in the field of primary care and its corollary, that is to say inter-professional collaboration and coordination of care and care providers with and around the patient.

This role has since evolved to include prevention, coordination and continuity of care using a populational approach in correlation with the grouping together of practitioners in practices combining several health professionals.

In parallel, the reforms increased these team practices' financial responsibility

by additionally entrusting them with resources management. Thus, in the United Kingdom and New Zealand, resources management was decentralised towards regulatory bodies associating health professionals at a superior level such as the *Primary Care Trust* (PCT) in the United Kingdom and the *Independent Practice Associations* (IPA) in

New Zealand. In the Netherlands and Australia (*Divisions of General Practice* (DGP)), the levels of regional health care organisation are primarily aimed at mutualising resources for complementary activities to those practised on a daily basis (continuous training, health promotion program, therapeutic education and information systems).

All these systems are equally characterised by mixed remuneration systems and contract agreements made possible by the registration of the population to a general practitioner. These features go hand in hand with the introduction of payment by results and financial support for the development of team practices associated with the emergence of new nursing roles.

The non-hierarchical professional model: primary care organised on the initiative of health professionals (Germany, Canada)

This model is characterised by the absence of any specific global primary care project, but also by the absence of ambulatory care organised according to population needs and area, notably with regards to the hospital sector.

These systems have in common the coexistence of a collective financing system for health expenditures and a private care offer. They are mainly characterised by the following factors: the existence of a specialised ambulatory care system that may be directly accessible to patients, sometimes on payment of a penalty fee; the predominance of solo practitioners in general medicine; the coexistence of different modes of primary care organization dominated by a majority of self-employed health professionals practicing fee-for-service payment and a minority of health centres oriented towards deprived populations.

In the countries concerned, the primary care offer includes both general and specialist ambulatory care services. If the organisation of ambulatory care answers the primary care prerogatives (accessibility, proximity, permanence and prevention

etc.) it was not initially set up to meet these objectives. In these countries, attempts to structure primary care organisation remains at experimental level and attempts to place it at the core of the health system remain difficult.

Reforms in the 1990's bring primary care models closer together

The majority of developed countries are experiencing similar evolutions despite the contrast in primary care organisation models and funding. In effect, all are being confronted with similar challenges in terms of healthcare provision: on the one hand, an ageing population including health professionals, changing aspirations and an increasing number of female doctors; on the other, greater specialisation and the increasing cost of medical technology, combined with the weight of chronic illness, resulting in heavy public health expenditures. The ongoing reforms committed to answering these challenges are to a greater or lesser degree concerned with the organisation of primary care but all have an impact on this health care sector.

Further regional and financial decentralisation

Decentralisation was one of the key ideas in the health system reforms of the 1990's, notably in countries where health regulation operates at a national, centralised level. The trend was to delegate health system management, or certain responsibilities, to local agents.

In Finland and Sweden, reforms thus granted greater autonomy and greater financial responsibility to the boroughs. In Sweden, responsibility for the long term care of the elderly and the handicapped was transferred from county to borough. Furthermore, central government funding was no longer allocated in terms of the realized expenditure, but evaluated according to the town's wealth and the assessment of its needs. The aim was to make local authorities more aware of their responsibilities by obliging them to assume the costs of their decision-making.

In Finland, the 1993 reform, in addition to increasing the boroughs' financial and decision-making autonomy, reduced the government's financial contribution to health expenditure.

In Spain, after increasing regional responsibility in the 1990's, decentralisation was pushed even further in 1997 and again in 2002: health service jurisdiction was transferred to the regions (or autonomous communities) previously controlled by central government. Within the national legislative framework, each community is able to define its own regulations, but the State nevertheless keeps some degree of control at a general level.

A more coordinated approach to healthcare: grouping together of professionals and disease management

All the countries seek to develop a more coordinated approach to healthcare. Schematically outlined, two paths emerge. The first concerns coordinating health professionals around extended general medicine practices such as the group practices (dominant form in the UK), or health centres and polyclinics in Germany that are once again becoming a trend. The specialists are either completely integrated into the structure or work on a short-term contractual basis. The second path concerns disease management centres focused on chronic diseases and coordinated by the insurers.

Both types of coordination give rise to the development of new roles for nursing staff, or even new health professions. In Finland, for example, if there is a shortage of doctors in a specific domain, nursing staff are authorised to accomplish certain medical acts after appropriate training. This is equally the case in Sweden; after specific training, nursing staff are also permitted to prescribe a limited number of drugs. Prevention programs, chronic care follow-up, as well as the reception and selection of patients are the main areas where nursing staff have extended their skills. This transfer of skills is equally aimed at reducing payroll expenditures.

Mixed remuneration systems and greater cooperation between medical health professions

In the 1990's, Sweden and Finland adopted a new system of remuneration for 'referent doctors' practicing within health centres. The new system is divided up into three components: salary, payment by capitation (according to the number of patients registered with the surgery) and fee-for-service payment. The aim of capitation payment is to favour the accessibility and continuity of care, or in other words maintain a personal and individualised relationship between doctors and patients.

In Canada and Australia, the governments equally favoured restructuring the remuneration system for general practitioners. Several reforms thus recommended the introduction of patient lists and major investments in information technology. In Canada, with the general backing of the health profession, experimental projects were set up in several provinces to try out first contact networks (RSPL*) like the *Family Health Networks* in Ontario and the Groups of General Practitioners (GMF*) in Quebec. These general practitioner groups are conceived to deliver first contact care 24 hours a day to registered patients.

In the United Kingdom, a new contract has been introduced, the *New GP contract*, that rationalises a large number of elements in the traditional contract between GPs and the NHS, and introduces an essential requirement concerning the quality of care. From now on, 30% of the budget allocated by the NHS to the group practice will depend on the quality of care delivered. This quality is controlled by a list comprising one hundred indicators (clinical, organisational and satisfaction) that must be completed for each practice.

Primary care in France: a non-hierarchical professional model ...

The organisation of ambulatory care in France is largely determined by the principles of the self-employed physician charter of 1927: free choice of GP by the

patient, absolute respect of professional secrecy, the right to charge fees for each treated patient, direct payment by the insured party, freedom in therapeutic and drug prescription, and choice of practice area.

The self-employed, which include both general practitioners and specialists, represent the majority of healthcare professionals. Although predominant, self-employed professionals nevertheless coexist with other ambulatory care services and structures. Occasionally very old, these structures are generally organised on a territorial basis, either at municipal level such as home nursing services and a number of community health centres, or at departmental level such as Maternal and Infant Protection (PMI*) units and the departmental fire and emergency services. These structures can be organised at hospital level such as the Hospital at Home service (HAH*), specialist hospital consultations and hospital emergency services, or they can depend on specific institutions such as school doctors, the French National Health Insurance agencies' medical centres, occupational medicine or organisations such as 'SOS Doctors*'.

Ambulatory care is thus largely developed in France and offers a wide variety of services. Organised on a variety of levels, it tends to be non-hierarchical and unequally distributed over the national territory as a whole. In consequence, care coordination largely depends on the patient or the patient's family on the one hand and on the other, the understanding between professionals (trust, initial training in common, and more or less explicit standards of practice). The French primary healthcare system is thus characteristic of a non-hierarchical professional model.

... that tends, given the recent reforms, to come closer to the other two primary care models

The simultaneous progress in epidemiology, technical progress and the increase in the cost of health care have led public authorities to engage in

successive reforms over the last twenty years, all aimed at rationalising healthcare organisation.

Initially focused on the hospital with the creation of the Regional Strategic Health Plan (Sros*), the organisation of healthcare supply at regional level has expanded to the ambulatory care sector through the creation of Regional Unions of Self-Employed Physicians (URML*), Regional Unions of Health Insurance Fund (Urcam*) and recently at a more specific level, the introduction of continuity of care and additional measures to maintain physicians in regions indicating a shortage.

The Preferred Doctor scheme* and healthcare pathway reform introduced in 2004 which strongly incites insured individuals to register with a GP of their choice, has introduced a hierarchical system of accessibility to care. This reform constitutes a major turning point as it potentially places GPs' practice in a populational approach which was the idea behind introducing a gatekeeper. This regional and populational approach traditionally characterises primary care systems, and opens up new perspectives not only in the organisation of first contact care, but also in the practice of disease prevention, therapeutic education, healthcare coordination and the reduction of health social inequalities.

The government's awareness that there will be a shortage of doctors in the next ten years, both GPs and specialists, and their notably unequal distribution over the national territory brings up the question of the organisation of ambulatory care. Two essential characteristics of primary care organisation models have thus been introduced in the Hospital, Patients, Health and Regions Bill project*.

The first is a definition of first contact care. At this level, ambulatory care seems to be moving towards a hierarchical normative model. Contrary to the systems in place in Finland, Sweden and Catalonia where ambulatory doctors are employed by the community health centres, in France they remain self-employed. Their relationship with the French health insurance system

remains under the control of the national collective agreement*. Furthermore, specialists are still very present in the ambulatory sector thus facilitating access to specialist treatment which in the other countries is restricted to the hospital.

Finally, the creation of Regional Health Agencies (ARS*) can be seen more as a deconcentration than a genuine decentralisation. The definition of standards relative to the organisation of first contact care appears to be regionalised since it comes under ARS responsibility defining objectives, providing services to the population and implementing first contact regulation mechanisms by means of collective agreements with health professionals.

The second similarity with primary care models stems from the recognition of the general practitioner's mission in the Hospital, Patients and Territories Bill project, close to the hierarchical professional model observed in the United Kingdom, the Netherlands, Australia and New Zealand.

Meanwhile, the observation of foreign health systems in which primary care is organised by entrusting health professionals with specific missions also reveals the simultaneous development of research and training bodies in relation with these missions. The formulation, dissemination and transmission of validated practices, whether in a theoretical or practical framework, are essential levers in the

realization of a professional project in relation with the missions entrusted to that profession. In this perspective, the logical consequence of recognising the general practitioners' mission in France is the constitution of a research and training apparatus adapted to these missions.

Finally, in all the primary care models studied, first contact care is regulated at an intermediary level between the region and the individual, either via the community or county in the case of complete decentralisation, or via independent health organisations or bodies associating health professional representatives and the local authorities. Structuring first contact care in France and the search for a better coordination between actors at infra-regional level brings up the question of local regulatory bodies, their composition, their roles and their margins for manoeuvre.

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The proposed typology in this research allows us to observe the main characteristics of primary care organisation in developed countries and to identify their similarities and differences. It reveals that primary care organisation systems are converging to form hybrid models. In France, the direction taken seems to be that of laying down fairly general principles to structure the organisation of primary care, the implementation of which will largely fall under the responsibility of future ARSs. If regionalisation

will favour innovative solutions adapted to the history and specificity of each region, it appears necessary to accompany and monitor its development and its effects, notably in terms of equity. ♦

GLOSSAIRE

- **First contact networks** (RSPL): réseaux de soins de premières lignes (RSPL).
- **Groups of General Practitioners** (GMF): Groupes de médecins de famille.
- **Hospital at Home** (HAH): Hospitalisation à domicile (HAD).
- **Regional Strategic Health Plan** (Sros): Schémas régionaux d'organisation du territoire (Sros).
- **Regional Unions of Self-Employed Physicians** (URML): Union régionale des médecins libéraux (URML).
- **Regional Unions of Health Insurance Fund** (Urcam): Union régionale des caisses d'assurance maladie (Urcam).
- **Regional Health Agency** (RHA): Agence régionale de santé (ARS).
- **Collective agreement**: convention
- **(French) national collective agreement (between self-employed physicians and Health Insurance)**: Convention nationale des médecins libéraux.
- **Preferred Doctor Scheme**: Dispositif du médecin traitant.
- **Hospital, Patients, Health and Territories Bill project**: Projet de loi Hôpital, patients, santé et territoires.
- **Maternal and Infant Protection** (PMI): Protection maternelle et infantile.
- **Sos Doctors**: SOS médecins.

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EN ÉCONOMIE DE LA SANTÉ
10, rue Vauvenargues 75018 Paris
• Tél.: 01 53 93 43 02/17 • Fax: 01 53 93 43 07
Site: www.irdes.fr Email: diffusion@irdes.fr
Director of the publication: Chantal Cases
Technical senior editor: Anne Evans
Copy editing: Franck-Séverin Clérembault and Anna Marek
Translator: Véronique Dandeker.
Layout composer: Khadija Ben Larbi
ISSN: 1283-4769 • Diffusion by subscription: €60 per annum - Price of number: €6 - 10 to 15 numbers per annum.