Health Policy 113 (2013) 170–179

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Review

Strengthening weak primary care systems: Steps towards stronger primary care in selected Western and Eastern European countries☆

Peter P. Groenewegen[a,*], Paul Dourgnon[b,1], Stefan Greß[c,2], Arnoldas Jurgutis[d,3], Sara Willems[e,4]

[a] NIVEL – Netherlands Institute for Health Services Research and Utrecht University, Dep. of Sociology and Dep. of Human Geography, NIVEL, PO Box 1568, 3500 BN Utrecht, The Netherlands
[b] 10 rue Vauvenargues, 75018 Paris, France
[c] University of Applied Sciences Fulda, Dep. of Nursing and Health Sciences, Marquardstrasse 35, D – 36039 Fulda, Germany
[d] Klaipėda University, Herkaus Manto str. 84, LT – 92294, Klaipeda, Lithuania
[e] Ghent University, Department of Family Medicine and Primary Health Care, 6K3 – De Pintelaan 185, 9000 Gent, Belgium

ARTICLE INFO

Article history:
Received 27 August 2012
Received in revised form 22 April 2013
Accepted 31 May 2013

Keywords:
Primary care
International comparison
Health policy

ABSTRACT

European health care systems are facing diverse challenges. In health policy, strong primary care is seen as key to deal with these challenges. European countries differ in how strong their primary care systems are. Two groups of traditionally weak primary care systems are distinguished. First a number of social health insurance systems in Western Europe. In these systems we identified policies to strengthen primary care by small steps, characterized by weak incentives and a voluntary basis for primary care providers and patients. Secondly, transitional countries in Central and Eastern Europe (CCEE) that transformed their state-run, polyclinic based systems to general practice based systems to a varying extent. In this policy review article we describe the policies to strengthen primary care. For Western Europe, Germany, Belgium and France are described. The CCEE transformed their systems in a completely different context and urgency of problems. For this group, we describe the situation in Estonia and Lithuania, as former states of the Soviet Union that are now members of the EU, and Belarus which is not. We discuss the usefulness of voluntary approaches in the context of acceptability of such policies and in the context of (absence of) European policies.

1. Introduction

Strong primary care is often seen as a solution for the challenges that (European) health care systems face [1,2]. This raises the policy question of how primary care systems can be strengthened and especially those primary care systems that are traditionally weak. This question will be answered in this article by reviewing changes in two broad groups of health care systems with relatively weak primary care that introduced changes towards a stronger position of primary care. The first group consists of Western European social health insurance systems; the second group consists of transitional countries in Central and Eastern

☆ This article is based on a key note lecture at the EFPC conference 'The future of primary care in Europe' in August 2010 and on the Cochrane Lecture at the Scientific Meeting of the Society of Social Medicine in September 2011 by the first author.

* Corresponding author. Tel.: +31 30 2729 665.
E-mail addresses: P.Groenewegen@nivel.nl (P.P. Groenewegen), dourgnon@irdes.fr (P. Dourgnon), stefan.gress@hs-fulda.de (S. Greß), jurgutis@klaipeda.aiva.lt (A. Jurgutis), sara.willems@ugent.be (S. Willems).
[1] Tel.: +33 1 53934336.
[2] Tel.: +49 661 9640 601.
[3] Tel.: +370 46 398561.
[4] Tel.: +32 9 332 39 84.

0168-8510/$ – see front matter © 2013 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.healthpol.2013.05.024

Europe (CCEE) that (partly) moved from a state-run, polyclinic system to a primary care based system.

Primary care is 'generalist care, consisting of general medical, (physio)therapeutical and pharmaceutical care, nursing and supportive care, and non-specialized mental and social care, together with preventive and health educational activities linked to these forms of care' [3]. Primary care provides in most cases the first point of contact with health care. Strong primary care can be characterized by its generalist approach, taking into account the social and family context of patients, by its accessibility, and by providing continuity, comprehensiveness and coordination of care [4–6]. Typical for strong primary care are a list system, i.e. a defined population for which primary care or general practice is responsible, and a position of general practitioners (GPs) as gatekeepers.

Several positive effects of strong primary care have been documented in the literature [6]: better health outcomes [7], good quality care [8], lower costs [9], and better opportunities for cost containment [10]. Moreover, strong primary care systems provide better opportunities for monitoring health, health care utilization and quality, partly because of the defined population denominator in systems with patient lists [3]. However, the evidence from international comparative studies is not unequivocally strong and mixed in some areas, such as health care expenditures [11], weak in other areas, such as equity [6,12] and avoidable hospitalizations [13], and finally negative in areas related to cancer survival [14].

European health care systems face a number of challenges related to changes on the demand side of care. Health care needs are increasing and changing as a consequence of demographic and socio-cultural changes. People live longer, although not necessarily in good health [15]. They want (or need) to stay longer in their own homes. Many elderly have multiple and complex health problems [16,17]. People are better educated and more demanding as patients and there is increasing diversity in cultural background of patients as a result of complex and multiple migration flows. These socio-cultural changes ask for more patient-centred care. There are also still large and increasing inequalities in health and in access to healthcare [18–20].

To meet these challenges, the World Health Report 2008 [1] has called for stronger primary care. Currently, primary care is often provided in single-handed GP practices with few opportunities for teamwork; incentives both on the supply side and the patient side often do not support strong primary care; different primary care providers are separately funded from different sources, hampering cooperation; payment systems favour separate services instead of integrated care; patients often do not have incentives to visit the same primary care providers and information on patients' illness history and health care utilization is scattered and not available at one point. The sustainability of health care systems is threatened by the unbalanced growth of specialist care, with shifts from hospital to primary care difficult to realize without profound changes in primary care. Finally, demographic changes also result in a projected lack of qualified manpower in health care [21,22].

Among European countries with traditionally weak primary care systems a first group of social health insurance or Bismarckian systems in Western Europe, such as in Belgium, France and Germany, stand out. They are characterized by the small scale organization of primary care in predominantly single-handed practices, by a strong emphasis on freedom of choice, and by demand channelling via co-payments (as compared to gate keeping systems [23]). In these countries we see policy changes to strengthen primary care based on weak incentives and a voluntary basis: GP models in Germany, medical file keeping in Belgium, and preferred GPs in France. A second group of European health care systems with relatively weak primary care are the health care systems in CEE after the transition from communism. Those who joined the European Union (EU) felt a strong urge to reform their health care systems, both from internal (lack of efficiency, worsening health outcomes) and external pressures (accession rules of the EU) [24]. Their strategy was to introduce major reforms, including stronger restrictions such as the introduction of gate-keeping. However, those who did not join the EU had a much slower reform process and still have many characteristics of the Semashko health care system.

In this article we aim to describe these two groups of countries and the way in which they have attempted to change their weak primary care systems to strengthen primary care. The question we will answer is: How have countries with a weak primary care system attempted to strengthen their primary care system?

2. Methodological approach

The research reported in this article is a policy review and the approach can be characterized as comparative descriptive. The description of the policy initiatives and changes is based on published literature (both national and international) and documents describing the policy changes and their backgrounds.

2.1. Selection of countries

We were interested in policies to strengthen primary care in European countries. As a starting point we have looked for countries with a weak primary care system [25]. In CEE the legacy of communism with its Semashko health care systems was one of weak primary care systems [25,26]. From these countries we selected three examples that used to be part of Soviet Union and two of which entered the EU – Estonia and Lithuania – and one that did not – Belarus. In Western Europe we have selected three countries with a relatively weak primary care system, as indicated by the absence of gate keeping and several dimensions of strong primary care [27]. The countries selected are Germany, Belgium and France.

2.2. Dimensions of descriptive analysis

Our analysis focuses on the common elements in the primary care related policies in each of the two groups of countries, on the incentives that were used, and the availability of evidence for the success of the policies.