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Short report

Political, cultural and economic foundations of primary care in Europe

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ABSTRACT

This article explores various contributing factors to explain differences in the strength of the primary care (PC) structure and services delivery across Europe. Data on the strength of primary care in 31 European countries in 2009/10 were used. The results showed that the national political agenda, economy, prevailing values, and type of healthcare system are all important factors that influence the development of strong PC. Wealthier countries are associated with a weaker PC structure and lower PC accessibility, while Eastern European countries seemed to have used their growth in national income to strengthen the accessibility and continuity of PC. Countries governed by left-wing governments are associated with a stronger PC structure, accessibility and coordination of PC. Countries with a social-security based system are associated with a lower accessibility and continuity of PC; the opposite is true for transitional systems. Cultural values seemed to affect all aspects of PC. It can be concluded that strengthening PC means mobilising multiple leverage points, policy options, and political will in line with prevailing values in a country.

Introduction

Measuring and managing the strength of primary care

Primary care (PC) is 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, Boerma, Hutchinson, Van der Zee, & Groenewegen, 2010). The strength of a country's primary care system is determined by the degree of development of a combination of core primary care functions (e.g. accessibility and continuity of PC) in the context of its system (Kringos, Boerma, Hutchinson et al., 2010; Levesque et al., 2012; Starfield, 1992). Suboptimal PC service delivery threatens the achievement of healthcare system goals (Starfield, Shi, & Macinko, 2005).

It is unknown why PC in some countries is more accessible, provides better quality of care, and offers a broader scope of healthcare services compared to others. Strong PC requires continuous efforts to maintain, restore or strengthen its functions to deliver high quality professional care. It is a continuous PC management process that most likely requires resources, political will, public engagement and a facilitating healthcare system context (Groenewegen & Delnoij, 2003). Sidel and Sidel (1977) argued that PC is a reflection of a society's economic, social political, cultural history and the general structure of the healthcare system. Empirical evidence for this statement is however lacking because measuring and monitoring PC development is not common practice, and existing PC instruments are often limited in their measurement domains (e.g. Bower, Campbell, Bojke, & Sibbald, 2003; Tovey & Adams, 2001), geographical scope (e.g. Kringos, Boerma, Spaan, & Pellny, 2008) or use of indicators (e.g. Starfield et al., 2005). However, this situation recently improved with the availability of the comparative data set on the strength of PC of 31 European countries in 2009/10 (see www.phameu.eu) resulting from the EU-funded PHAMEU project. Data are available on the key PC functions measuring the existing PC structures (e.g. PC governance, funding and workforce issues) and key aspects of primary care services delivery of countries (Kringos, Boerma, Bourgueil et al., 2010). The results showed variation in the overall strength of PC across 31 European countries in 2009/10 (see Fig. 1).

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This article aims to explore the relationship between the strength of PC and a country's economic development, political orientation, type of healthcare system, and prevailing values, to identify the conditions favouring the development of strong PC. A number of hypotheses will be tested, as discussed in the following sections.

Economic development

The state of a country's economy not only determines the extent to which resources can be generated for its healthcare system, but also policy options to structure and organise the healthcare system. PC provides a more affordable solution to common health problems as opposed to specialist care (Delnoij, van Merode, Paulus, & Groenewegen, 2000; Kruk, Porignon, Rockers, & Van Lerberghe, 2010). However, high-income countries can afford to base their healthcare system more on hospital care than on PC (World Health Organization, 2008). Despite inefficiencies (Pelone et al., 2012), public satisfaction is often higher in healthcare systems offering directly accessible specialist care (Kroneman, Maarse, & Van der Zee, 2006). In such systems, cost sharing arrangements are commonly introduced to control patients' demands, reducing PC access (Ros, Groenewegen, & Delnoij, 2000).

The following hypothesis will therefore be tested:

Hypothesis 1. *Countries with a higher (growth in) economic development have weaker PC because they can afford to base their healthcare system more on hospital care than on PC, which is often accompanied by a higher public satisfaction.*

Role of politics

Countries with a predominantly left-wing (socialist or social-democratic) government aim to achieve universalism and equity, provide a redistributive social security system and generous benefits, and have a strong interventionist state. The opposite is true for predominantly right-wing (liberal) governed countries (Bambra, 2006; Eikemo, Huisman, Bambra, & Kunst, 2008; Esping-Andersen, 1990; Navarro et al., 2003).

Values commonly lead to political representation in a country. Previous research has shown that the political composition of a country's government is related to healthcare system policy priorities (Boerma, 1989; Groenewegen, 1994; Tenbensel, Eagle, & Ashton, 2012). Left-wing governments are associated with less regional disparities in healthcare supply; and more interference in hospital planning (Bennema-Broos, Groenewegen, & Westert, 2001; Westert & Groenewegen, 1999), likely due to their policy priorities (Tenbensel et al., 2012). PC can be seen as a health equity producing policy. Although the empirical evidence is still inconclusive, there are indications that access for people with low socioeconomic status is better in healthcare systems with strong PC, contributing to equity in health (Starfield, 2006, 2011).

The following hypothesis will therefore be tested:

Hypothesis 2. *Countries that for a longer period have been governed by left-wing parties have stronger PC because strong PC seems to fit with the underlying principles and policy priorities of left-wing parties.*

Structure of healthcare systems

Following the fall of communism in Eastern Europe, the healthcare systems in this region were mostly in transition from their Soviet Union's system to social security-based systems (SHI). SHI and national health service (NHS) systems differ in terms of the role of government, financing, healthcare providers, and users of care. State-regulated healthcare systems (NHS systems) can relatively easily implement government initiated reforms (particularly addressing health outcomes and inequalities), compared to SHI countries with a relatively weak power base of the government, as policy implementation depends on the cooperation of insurers and

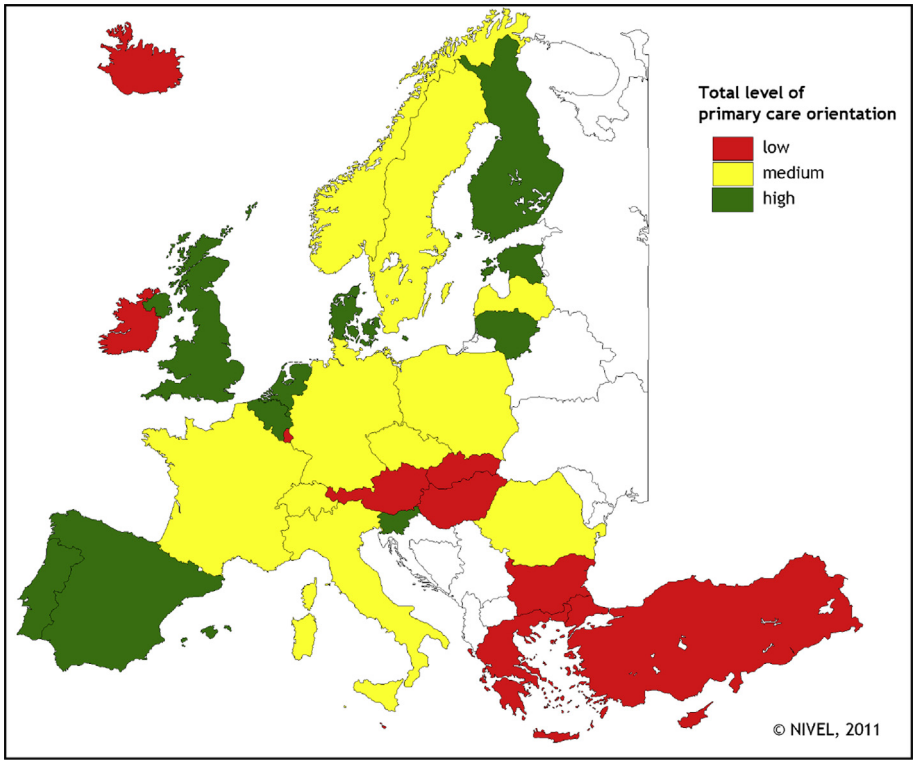

Fig. 1. Variation in primary care strength across Europe.