Primary Care
In Wales
Rapid review of models and policy
Summary

July 2014
Full report can be found here
Introduction

What would great primary care look like within a holistic integrated health and social care system?

We all want a comprehensive and equitable primary health care system that helps people live long and productive lives and that is rewarding to both citizens and providers. Wales has a history, shared values and characteristics that will influence how learning from elsewhere would fit best. What would be most feasible and acceptable in Wales?

This rapid review of the evidence tries to lay out some of the ideas from elsewhere that may be most useful. The literature search identified 499 papers: 18 papers were selected as key high level policy papers or reviews of policies and nine case studies were selected from these or from the search for service models. These included evidence from the World Health Organisation (WHO), Europe, the UK, USA, New Zealand, Spain, Brazil and Canada.

Key papers are presented in two tables of policy papers and a selection of service model case studies.

Key Messages

We found that in comparison to other countries, we already have a very good primary health care system which provides an effective, efficient and well liked service to individuals and families. However there is unacceptable variation in service provision and quality leading to inequity and unmet need. Citizens complain about difficulties in access, and there are signs of a unsustainable imbalance between workload and capacity. At a time when policies advocate for a shift of care closer to home, there has been a fall in the percentage of health budgets and health workforce in primary care.

What is primary care?

The definition of primary care that we propose is that used by the Primary Care Strategy for Wales in 2001:

First contact, continuous, comprehensive and co-ordinated care provided to individuals and populations undifferentiated by age, gender, disease and organ systems

The service should be:

Comprehensive, person-centred, population oriented, coordinated, accessible, safe and high quality.

The primary care team

We propose that the core Primary Care workforce is the same as that described in 2001: medical, primary and community nursing, midwifery and health visiting, dentistry, optometry, pharmacy, therapy and diagnostic services, NHS direct, health promotion services and the relevant managerial and support staff. This should now include GP Out of Hours Services. Not all of these are members of the core team “wrapped around the patient” and there are new and emerging roles that should now be considered within the core team.
How do we know what’s good?

Primary care is complex and multi-dimensional, with variations in its components in different health care systems. We propose using the model describing all dimensions of a Primary Care developed by Kringos, to evaluate any primary care policy, program or service model:

- **The structure**: governance; economic conditions; and workforce development.
- **The process**: access; continuity of care; coordination of care; comprehensiveness of care.
- **The outcome**: quality of care; efficiency of care; and equity in health.

**Structure (how we run the system)**

- **Resource allocation** should **shift from the current misdirection** into high cost late stage interventions, towards the neglected potential of primary prevention and health promotion which supports the principles of prudent health care.
- There is an emerging and strong consensus in the UK literature that **planning and provision of primary care should be at a small population** meso-level (the Kings Fund proposes an optimum size of 25,000 to 100,000).
- **Public ownership** at this level is a positive influence on service design, delivery and accountability.
- There is an identified need to develop **leadership roles for those in primary care** to drive policy and delivery changes.
- There is consensus that **more centralised governance systems** tend to drive up quality and help to address variation in both quality and outcomes
- There are few models in the primary care literature of **integration with social care**, although policy thinking cites this as a high priority.

**Process (how we provide the service)**

- Primary care should be more **proactive to improve the health and well being of populations**, not just those registered and attending, through greater collaboration with partners: for instance, models based on **Community Oriented Primary Care and co-production principles**
- Primary care teams **should scale up** to be able to deliver more consistently at a population level: models include super-partnerships, federations, community health organisations, family care networks and other formal and informal groupings.
- There is potential to **widen the membership of primary care teams** to include allied health professionals, more generalist roles (e.g. paediatricians), or new roles such as community health workers, or to consider direct employment of community staff such as district nurses.
- There is no single ideal model of employment, and a **greater variety of employment options** could be explored.
- Primary care should shift from the gatekeeper role towards a **coordinator/navigator role**, with wider services wrapped around the primary care teams serving the **defined population**.
- Primary care should develop models that are more seamless across in and out of hours, with **less fragmentation of providers**.
- A multitude of models of service provision have developed in many countries in response to local contexts, and there is **no single model** that emerges, other than that of the **generic small team supporting the patient** that is a feature of most high quality health systems.
Outcomes (health and well being, citizen experience and value for money)

- **Prudent health care**: countries with strong primary care systems tend to have better health outcomes but also higher health spending. However, they also have a slower growth in spend which is likely to become more important in meeting future changing needs.
- There is a consensus that primary care in the UK has too much unexplained and unwarranted variation, and that it should be delivered at a more “industrial scale” which prioritises reducing variation in quality and outcomes.
- Key issues are improving performance measurement, developing more systematic approaches to quality improvement and quality assurance, and transparent reporting.
- **Citizen empowerment** and engagement is cited as a driver for improving quality through accountability.

Conclusion

- This is a **pivotal time for health care systems** globally: the financial crises has galvanised scrutiny of the value we gain from our investment in health care systems and there is an emerging consensus that current models are not financially, or otherwise, sustainable.
- There is also an **emerging consensus that a shift to primary care and population-based approaches are the way forward** to improve health and reduce inequalities in health outcomes. Wales is well placed to build on developments to date around GP clusters and wider community services within integrated Health Boards.
- **Primary care teams should include a wider range of members** with greater integration with secondary care and social care, including navigation and coordination of a greater range of services.
- **Clear outcomes should be the focus** of any new model or policy, using a framework for quality primary care such as that advanced by Kringos et al.
- **Models of provision characterised by Community Oriented Primary Care principles and citizen engagement are likely to be the most transferable** to the Welsh context, as are approaches tailored to tackling the Inverse Care Law and to co-production of health.

Next steps

Wales should lead the way in developing new models, and adapting tried and tested models, through grassroots engagement, if supported by a rapid change process with strong leadership and management. We suggest using a change model that is suited to a large, complex system with a distributed leadership.