HOW CAN EUROPEAN QUALITY PRIMARY HEALTH CARE SYSTEMS ADDRESS THE CHALLENGES OF THE 21ST CENTURY?

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Introduction

The changing society in the 21st century, will confront health systems with important challenges. First of all there are the demographic and epidemiological developments. The percentage of older people in the population will continue to increase in all EU-member states in the period up to 2020 by 3 to 6 percentage points in most cases (1). At the same time, the percentage young people in the overall population will gradually decline. In 2003, the percentage of the population accounted for by children up to the age of 14 ranges from 14 or 15% in Italy, Spain, Greece, Slovenia and Germany, to 21% in Ireland and on Cyprus (2). In almost all EU-countries, this figure will fall by a further one to 4 percentage points between now and 2020. This demographic change will be accompanied by an epidemiological transition with increasing chronic illnesses, mental disorders, … Moreover, the socio-cultural developments will lead to individualisation and rising expectations of the public towards the health care system. Ethnic and cultural diversity will increase in Europe over the decades ahead. This will have implications for health problems presented to the health system. Within the European countries there are major social-economic inequalities in the likelihood of suffering illness and premature mortality: on average, people of high socio-economic status remain in good health 12 years longer than people of low socio-economic status (3). Scientific and technological developments will raise expectations (e.g. in the field of genomics) and home care technology will create new opportunities for community based ambulatory care. Finally, both political decision-makers and the public are increasingly concerned about the prevention of or the appropriate response to disease outbreaks and disasters. This will require “preparedness” of the health system (4).

Health systems that want to be responsive to these challenges will have to take into account the following principles: relevance, equity (including accessibility), quality and efficiency.

Quality of care

In order to demonstrate their social accountability, health systems have to make clear how they strive for and achieve quality.

Quality of care has 3 components: structure, process and outcome (5). Structure consists of 3 interrelated components: society, the individual and the health care system. For the health care system, organisational aspects (accessibility, continuity, comprehensiveness) and characteristics of health care providers (competence, empathy) affect quality of care. Process refers to all interventions and interactions between patients and providers. Process quality largely depends on adequate communication, medical decision making, and management of care. Guidelines, protocols and algorithms that underpin process are increasingly based on scientific evidence (6). Outcome is defined by how patient and doctor perceive health and disease, and this perception has shifted from problem-orientation to goal orientation (7). As a result - e.g. for a patient with chronic pulmonary disease - the patients’ ability to participate in social life is more important than their change in long-function test.

This consideration results in a range of relevant outcome indicators that can be measured, from signs and symptoms, physical functioning, quality of life, patient satisfaction and social equity.

Improving quality will require, interventions at different levels of structure and process, and will need medical, contextual and policy evidence (6).

How can European quality primary health care systems address the challenges?

There is growing evidence that comprehensive primary health care systems are able to provide relevant, equitable, quality, cost-effective health care (8). Starfield at all find a rationale for the benefits for primary health care in greater access to needed services, better quality of care, a greater focus on prevention, early management of health problems and the role of

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primary care in reducing unnecessary and potentially harmful specialist care. Primary health care should act as the first point of contact for the population, and is able to deal with more than 90% of all the presented problems, acting as a filter and helping patients to navigate in a cost-effective and high-quality way through the health care system. The primary health care team has an interdisciplinary composition, including family physicians, nurses, health promotion-workers, social workers, nutritionists, … and addresses the physical, psychological and social needs of patients, their families and the communities they live in. Through intersectoral cooperation, they may contribute to a "community diagnosis", illustrating the underlying structural problems that contribute to ill health. The role of primary health care in the process of clarifying the importance of social structures and in understanding the social determinants of health, may contribute to the transformation of the social quality of the lives of individuals and communities (9). There is a need for integration between public health and primary health care, because primary health care integrates in a comprehensive way the messages and interventions from the public health approach. Health systems should be organised in an intersectoral network, with crosslinks to environment, economy, work and education at the different institutional levels (national, province, district, …). For primary health care, the full participation of the local community in the designing of services is of utmost importance, which requires a bottom-up approach. Such a primary health care system could contribute to eradication of diseases and, through its effect on social cohesion and empowerment, decrease the vulnerability of populations and strengthen communities in addressing the social determinants of health.

Today the question arises how primary health care and family medicine can be best organised in the health care system? The debate is whether it should be in the private sector, or in the public sector. Certainly in Eastern Europe, there is an increasing tendency to establish private primary health care practices, with family physicians functioning in a fee-for-service system. Certainly, when out-of-the-pocket-payments by the patients at the point of service delivery are high, this model may affect negatively accessibility of the health care system. Advocates of private practice as the organisational model, emphasize the high degree of flexibility and patient orientation of this kind of service. Those who defend primary health care as a public service, stress the importance of a comprehensive interdisciplinary team-based approach, and the need for integration of preventive activities, having a focus not only at the health of the individual, but also at the population health. The evolution in Eastern Europe towards more private practices in family medicine is opposite to the fact in Western Europe, the family physician has switched from a private entrepreneur, towards a comprehensive health care provider, working in team and being socially accountable for a defined population or patient list at the level of e.g. continuity of care, quality of care, cost-effectiveness. For a public primary health are system to be performant, sufficient funding is needed, in order to attract skilled family physicians, nurses, and to assure their retention in the primary health care system. The European Forum for Primary Care (10) may offer the Platform to integrate experiences in designing Primary Health Care Systems in different European countries.

Finally, addressing the challenges of the 21st century will require an empowered citizen and patient, enabled to take adequate decisions in relation to his or her health, underpinned by evidence based information. To integrate health promotion and patient empowerment in primary health care is therefore a very important topic, and I want to congratulate the organisers of the international conference "Quality of primary health care, the perspective of patients" (Ljubljana - 28-29.03.2008) for having chosen this theme.

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KAKŠEN NAJ BO ODGOVOR EVROPSKIH SISTEMOV KAKOVOSTNEGA PRIMARNEGA ZDRAVSTVENEGA VARSTVA NA IZZIVE 21. STOLETJA?

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Uvodnik

Uvod

Družba sprememb 21.stoletja postavlja zdravstveno varstvo pred vrsto pomembnih izzivov. Najprej gre za demografske in epidemiološke spremembe. Delež starejšega prebivalstva bo do leta 2020 v vseh državah članicah EU večinoma narasel za 3 do 6 odstotne točke (1) ob postopnem zmanjševanju deleža mladih. Leta 2003 se je gibal delež otrok, mlajših od 14 let med 14 in 15 % v Italiji, Španiji, Grčiji, Sloveniji in Nemčiji in 21 na Irskem in na Cipru (2). V skoraj vseh državah članicah EU se bo to število zmanjšalo do leta 2020 še za 4 odstotne točke. Te demografske spremembe bodo prinesle s seboj tudi drugačno epidemiološko situacijo s povečanim deležem kroničnih bolezni, duševnih obolenj itd. Poleg tega vodijo družbeno-kulturne spremembe v individualizacijo in večja pričakovanja javnosti v zvezi z zdravstvenim varstvom. V prihodnjih desetletjih se bo povečala etnična in kulturna raznolikost Evrope, kar bo prineslo s seboj tudi vrsto zdravstvenih problemov, s katerimi se bo srečeval sistem zdravstvenega varstva. Zaradi bistveno različnega družbeno-ekonomskega položaja so med posameznimi evropskimi državami velike razlike v stopnji obolevnosti in prezgodnje umrljivosti: tako posamezniki visoko na družbeno-ekonomski lestvici ostanejo zdravi kar 12 let dlje, kot tisti z nižjim družbenoekonomskim statusom (3). Z napredkom znanosti in tehnologije se bodo povečevala pričakovanja uporabnikov (npr. na področju genomike), tehnološki dosežki na področju oskrbe na domu pa bodo prinesli nove možnosti zdravstvene obravnave bolnikov zunaj zdravstvenih ustanov. Odločujoči v politiki in širša javnost se vedno bolj zavedajo, kako pomembno je preprečevanje bolezni oziroma pravilno ukrepanje ob izbruhih bolezni in nesrečah. Zato je nujna stalna pripravljenost sistema zdravstvenega varstva (4).
Vsak zdravstveni sistem, ki se želi ustrezno odzivati na te izzive, mora upoštevati načela relevantnosti, enakosti (v dostopnosti), kakovosti in učinkovitosti.

Kakovost zdravstvenega varstva

Svojo družbeno odgovornost lahko zdravstveni sistemi dokažejo s prikazom prizadevanj za kakovost in načina, kako kakovost dosežejo. Kakovost zdravstvene nege sestavljajo struktura, proces in izid (5). Struktura je sestavljena iz treh, med seboj povezanih, elementov; to so: družba, posameznik in zdravstveni sistem. Na kakovost nege vplivajo organizacijski vidiki (dostopnost, trajnost, celovitost) in značilnosti izvajalcev zdravstvene nege (usposobljenost, empatija). Proces obsega vse postopke in interakcijo med bolniki in izvajalci. Kakovost procesa je v veliki meri odvisna od ustrezne komunikacije, zdravnikovih odločitev in vodenja zdravstvene oskrbe. Smernice, protokoli in algoritmi, na katerih sloni proces, se v vedno večji meri oblikujejo na osnovi znanstvenih dokazov (6). Izid določa način bolnikovega in zdravnikovega zaznavanja zdravja in bolezni, to razumevanje pa je vse manj usmerjeno k problemu in vse bolj k cilju (7). Tako je npr. pri kroničnem pljučnem bolniku njegova zmožnost delovanja v družbenem življenju bolj pomembna kot izvidi testov pljučnih funkcij. Iz tega pristopa izhaja vrsta pomembnih izmerljivih kazalcev izida, od znakov in simptomov, telesne funkcije, kakovosti življenja, zadovoljstva bolnika do družbene enakosti.
Kakovost lahko izboljšamo z ukrepi na različnih ravneh strukture in procesa, podani pa morajo biti tudi medicinski, kontekstualni in politični dokazi. (6)

Kako se lahko evropski sistemi primarnega zdravstvenega varstva odzovejo na izzive?

Vedno več je dokazov, da celoviti sistemi primarnega zdravstvenega varstva lahko ponudijo ustrezno, pravično, kakovostno in stroškovno učinkovito zdravstveno nego (8). Starfield in sod. ugotavljajo, da morajo biti prednosti primarnega zdravstvenega varstva: lažja dostopnost do potrebnih storitev, boljša kakovost storitev, večji poudarek na preprečevanju bolezni, zgodnje zdravljenje in vloga primarnega zdravstvenega varstva v zmanjševanju števila nepotrebnih in potencialno škodljivih specialističnih storitev. Storitve primarnega zdravstvenega varstva predstavljajo prvi stik prebivalstva z zdravstveno os-

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krbo. Predstavljajo rešitev za kar 90 % zdravstvenih problemov, imajo zato vlogo filtra in bolnike na kakovosten in stroškovno učinkovit način usmerjajo skozi zdravstveni sistem. Zdravstveni tim sestavljajo strokovnjaki različnih področij: družinski zdravniki, medicinske sestre, strokovnjaki za krepitev zdravja, socialni delavci, strokovnjaki za prehrano. Vsi ti skupaj rešujejo telesne, duševne in socialne probleme bolnika, njegove družine in skupnosti, v kateri živi. Medsektorsko sodelovanje pomembno prispeva k t. i. »skupnostni diagnozi» in opredeli strukturne vzroke obolevnosti. Vloga, ki jo ima primarno zdravstveno varstvo pri opozarjanju na pomen družbenih struktur in razumevanja družbenih determinant zdravja lahko prispeva k preobrazbi socialne kakovosti življenja posameznika in skupnosti (9). Nujno je povezovati javno zdravje in primarno zdravstveno varstvo in s tem integrirati vse javnozdravstvene ukrepe in napotke v primarno zdravstveno varstvo. Zdravstveni sistemi morajo biti organizirani v medsektorski mreži in povezani z okoljskim gospodarstvom, delom in izobraževanjem na različnih ravneh (pokrajine, okraji itd). Pri načrtovanju storitev primarnega zdravstvenega varstva je bistvenega pomena polno sodelovanje lokalne skupnosti, in sicer po načelu od spodaj navzgor. Takšen sistem primarnega zdravstvenega varstva lahko prispeva k izkoreninjanju bolezni, s tem, da prispeva k povezanosti in krepitvi moči v družbi, pa zmanjšuje ogroženost prebivalstva in pomaga skupnostim pri reševanju družbenih vprašanj zdravja.

Danes se sprašujemo, kako najbolje organizirati primarno zdravstveno varstvo in družinsko medicino v zdravstvenem sistemu: v okviru zasebnega ali v okviru javnega sektorja? Vzhodnoevropske države težijo k ustanavljanju zasebne zdravstvene službe s plačljivimi storitvami družinskih zdravnikov. Jasno je, da bi visoke cene, ki jih bi morali za storitve plačevati bolniki sami, negativno vplivale na dostopnost zdravstvenega varstva. Zagovorniki zasebne prakse kot organizacijskega modela v zdravstvu poudarjajo visoko stopnjo fleksibilnosti takšnih storitev in njihovo usmerjenost k bolniku. Tisti, ki zagovarjajo javno primarno zdravstveno varstvo, pa se sklicujejo na pomen celostnega interdisciplinarnega timskega pristopa in povezovanja preventivnih dejavnosti, ki niso usmerjene le k zdravju posameznika, temveč k zdravju vsega prebivalstva. Razvoj v smeri zasebnega zdravstvenega varstva, ki smo mu priča v vzhodni Evropi, je v nasprotju s položajem v zahodnoevropskih državah. Družinski zdravnik se je iz podjetnika-zasebnika preobrazil v izvajalca celostnega zdravstvenega varstva, v člana tima, ki je družbeno odgovoren za določeno populacijo oz. skupino bolnikov, ob upoštevanju stalnosti, kakovosti in stroškovne učinkovitosti zdravstvenih storitev. Za uspešno delovanje javnega primarnega zdravstvenega varstva so potreba zadostna denarna sredstva, s katerimi je moč pritegniti k delu sposobne družinske zdravnike in medicinske sestre in jih zadržati v sistemu primarnega zdravstvenega varstva. Evropski forum za primarno zdravstveno varstvo (European Forum for Primary Care) (10) lahko ponudi platformo za povezovanje izkušenj pri oblikovanju sistemov primarnega zdravstvenega varstva v različnih evropskih državah.

Ob zaključku bi poudaril, da bo naloge, ki jih prinaša 21. stoletje, mogoče reševati le s krepitvijo vloge prebivalstva, ki bo znalo na osnovi informacij, temelječih na znanstvenih dokazih, sprejemati prave odločitve v zvezi s svojim zdravjem. Povezovanje krepitve zdravja in krepitev vloge prebivalstva v primarnem zdravstvenem varstvu je zato zelo pomembna naloga in rad bi čestital organizatorjem mednarodne konference »Kakovost primarnega zdravstvenega varstva, perspektiva bolnika«, (Ljubljana, 28. – 29. marec 2008), da so za srečanje izbrali prav to temo.

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