

COMMENTARY

International Learning on Increasing the Value and Effectiveness of Primary Care (I LIVE PC)

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In February of 2010, the President of the United States signed into law the most comprehensive health reform package since 1965. The Patient Protection and Affordable Care Act (ACA), first and foremost, will assure health insurance coverage to more than 30 million previously uninsured Americans. It also shores up failing state Medicaid systems for a critical period. The ACA and the Congressional testimony that underpinned it, focus heavily on primary care as being essential and important to reducing costs. The ACA's effects, particularly for primary care, will roll out over the next 3 to 4 years, and the Robert Graham Center saw an opportunity to learn from what other countries have done with primary care. Most other developed countries around the world enjoy better health outcomes than we do in the United States, and most typically they have more robust primary care and focus on population health. What may not be widely known is that many of countries of comparison also undertook major health system transformations in the past few years, and many continue to experiment with structural and financing schemes to try to improve their outcomes. Many of these changes and ongoing ex-

periments may offer transferable lessons to the United States, particularly in light of the ACA. Toward that end, in April 2011, with support from the US Agency for Healthcare Research and Quality and The Commonwealth Fund, the Robert Graham Center held a conference that included front-line clinicians, health systems researchers, and policymakers from 6 other countries—Australia, Canada, Denmark, The Netherlands, New Zealand, the United Kingdom—and the United States. This special issue of the *Journal of the American Board of Family Medicine* features summary articles about lessons for the United States from each of the 6 country delegations.

New Models of Care

The United Kingdom developed the fundamental tenets of its National Health System after World War II, but it has been actively experimenting for the last 20 years, including practice improvements. Roland, Guthrie, and Thomé¹ point out that the majority of general practitioners (GPs) continue to own their own practices even as they move toward group practice, add nurse practitioners, and reduce the size of patient panels. Innovation to improve care outcomes are strongly incentivized by contracts (see Payment) but are left largely up to practices. Van Weel, Schers, and Timmermans² reveal that Dutch GP practices also are privately owned and moving more toward group practice and panel size reduction. As a result of 2006 reforms, the most recent innovation is the creation of practice consortia that support chronic care management across member practices and after-hours care.

Nicholson and colleagues³ review Australia's recent health reforms, including placement of "super clinics" in underserved areas. These clinics have a broader array of services and health care team members, designed not only to improve care for the underserved, but also to be a model for what

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other practices could become. Canada organizes its health care at the provincial level and therefore has a natural, ongoing experiment in new models of care.⁴ One of the more consistent changes has been development of multidisciplinary, interprofessional primary health care teams. Danish GPs have comparatively smaller practices with panels averaging fewer than 1600 patients per GP and, like the Dutch, are creating shared after-hours care models.⁵

Accountability and Population Health

Most other developed countries have imbedded population health within primary care, an important, missing relationship in most US practices. The United Kingdom did so at one level by creating Primary Care Trusts (England) and Health Boards (Scotland) as mechanisms of population health accountability and related resource allocation and, as Roland et al¹ point out, they continue to experiment with the level of accountability and resource allocation. Practices in the United Kingdom have dedicated patient registries, although patients can choose practices.¹ The most recent reforms go even further in locating accountability and population health in practices in that the new coalition government abolished Primary Care Trusts and strategic health authorities and created 500 GP consortia, giving general practice physicians more responsibility and accountability for commissioning services. In the Netherlands, practice registries are based largely on geography, and relationships with patients often last a lifetime.² Australia is poised to follow England's geographic accountability model, creating Primary Health Care Organizations, known more parochially as "Medicare locals."³ These geographically based entities will be accountable funding agencies and practice facilitators. Denmark also has practice lists and active feedback on provider quality because of their highly sophisticated patient registries.⁵ Geographic accountability is organized by municipality and includes public health functions that are tied closely to GPs.

As Goodyear-Smith and colleagues⁶ teach us, New Zealand organized care geographically around Independent Practice Associations for many years before creating more formal accountability through District Health Boards in 2001 and new not-for-profit Primary Health Organizations, local structures re-

sponsible for delivering and coordinating primary care to an enrolled population. The 2001 Primary Health Care Strategy aimed for a primary care-led health system, "with a greater emphasis on population health and the role of the community, health promotion, and preventive care; the need to involve a range of professionals; and the advantages of funding based on population needs rather than fees for service."⁶ Funding and accountability flow to Primary Health Organizations, which service a number of GP practices. New Zealand is considering a move to "Integrated Family Health Centers," which will involve larger groups of providers offering 24/7 care for a geographic population. This idea is part of a larger effort to bring more secondary care functions into primary care settings to increase access and efficiency. We could learn from their aspirations and from their experiments.

Practice Support and Change Facilitation

The architects of the ACA recognized the need to facilitate primary care practice transformation and crafted the Primary Care Extension Program modeled after the US Department of Agriculture's Cooperative Extension Program. This function was authorized but not funded, yet it spurred related experimentation and identification of best practice in the United States. A related example from Australia is the Practice Health Atlas, developed by Del Fante et al⁷ in the Western Adelaide Division of General Practice and disseminated to many other GP divisions. This tool could extract patient data from a variety of electronic health records and support the practice by creating a registry, showing how they can maximize quality incentive payments and helping them financially justify new team members for chronic care management. GP networks also provide mental health care and other services that practices might not be able to house or access independently. Presumably, these functions will continue in the geographic model of care organization. An independent physician organization in New Zealand developed an academic detailing function for evidence-based care that provides feedback to practices about the quality of care.⁸ This function, called the Best Practices Advocacy Center (now just BPACNZ), uses information from the US Preventive Services Task Force, the US Agency for Health Care Research and Quality, and

England's National Institute for Clinical Evidence to produce pithy information for practices and patients. Detailers also review practices' prescribing and patient care patterns to then provide specific feedback to the practices. Evidence, quality assessment, and personal relationships facilitate practice change. In England, primary care trusts often also provided peer comparisons, practice counseling about quality improvement, electronic health record implementation support, and supported demonstrations. Not all the participating countries have practice support and fewer have change facilitation, but a number of elements of one or the other and could inform efforts in the United States.

Quality and Safety

The United Kingdom has made concerted efforts at quality reporting and improvement for more than 20 years, with some measureable reduction in disparities and improvement in quality.¹ These measures are now a formal part of the primary care contracts and practices' information technology systems, with development of measures and guidelines by well-respected national institutes. The Dutch developed patient care guidelines more than 20 years ago, but did so in parallel with both a patient education component and an academic research institute to provide evidence for guideline development and testing.² Canada has generally approached quality improvement by successful formation of learning collaboratives based on the Institute for Health Care Improvement's Breakthrough Series model and in partnership with provincial government and medical associations.⁴ In this regard, Canada may be educating the United States about the potential role of a US-based organization in improving primary care, but with enhanced facilitation and buy-in from the payer.

The Danes are further ahead in this regard and offer us many lessons. One level of quality is organized by the Danish Quality Unit of General Practice, which is responsible for development and implementation of an advanced software module in all GPs' electronic record systems that "collects patient care data from the physician's computer, including prescriptions, laboratory tests and information from hospitals."⁵ These data are forwarded to a central database and used for quality improvement and research; in return, GPs have online

access to detailed information about how they fare with regard to clinical guidelines.⁵ The Danes also are able to participate in a program across the Nordic countries called Audit Project Odense, which allows GPs to input data about their practice patterns, receive feedback, develop quality improvement interventions, and evaluate them. This level of quality assessment is an aspiration for the United States.

Information Technology

All the countries featured here (except Canada) have near-universal health information technology adoption in primary care. In the United Kingdom, this grew out of quality measurement and improvement efforts, government subsidies, and pay-for-performance contracts. A nice feature in the United Kingdom is that patients have a record that moves as they move.¹ The level of use of health information technology in primary care is similar in the Netherlands, where practices have electronic information exchange with hospitals.² The Dutch admonish us to "base the health informatics system on primary care informatics,"² and to include the capture of symptom and episode information provided by the International Classification of Primary Care.

Payment Models

None of the conference countries have a gap in primary care subspecialist income akin to the United States. In fact, in several of them, primary care physicians are paid more than subspecialists. Most have or are changing to blended payment models. For example, the Netherlands recently converted to private but universal health insurance scheme that pays physicians under contract with a blended payment model that includes 70% capitation and 30% fee for service.² Separate contracting is done with primary care consortia for disease management and linkage to public health. The most important lesson from the Netherlands is that universal coverage under private insurance can be done and can facilitate primary care.

In the United Kingdom, primary care contracts provide approximately 75% of practice income through capitation, 20% from pay-for-performance, and 5% for providing enhanced services. Although there is variation across Canadian provinces, there is a general move toward

blended payment models that favor capitation over fee for service.⁴ Strumpf et al⁴ say that “successful introduction of new models of physician payment relies on some combination of rostering patients, identifiable electronic medical record data, and support of the provincial medical associations.” One of Canada’s more potent lessons may be that the success of payment changes is tied to a move toward population health management, which requires some external support or facilitation. The Danes would generally agree with this equation. In Denmark, GPs are paid 30% on capitation and 70% fee for service.⁵ In all of the countries, physician-owned practices are the norm.

Conclusions

The 6 countries that participated in this international conference are similar to the United States in that they are still experimenting with their respective health care systems, payment and practice models, practice facilitation, and quality/safety improvement. They differ from the United States in being committed to a primary care strategy that assures access to care for nearly everyone. The ACA takes us a step closer to a primary care strategy and is expected to improve access for many more Americans. These and other countries offer evidence of how this path can improve care, costs, and population health if we will be inspired and learn from the trails they have blazed.

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