Primary care:
its effectiveness and ‘paradox’, and impact on research and academy

Public lecture ANU

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Effectiveness of Primary Care points to cover

• A number of well known facts of primary care
  • Ecology of medical care
  • Multimorbidity

• Effectiveness of Health Care and the Paradox of Primary Care
  • Roles of specialists and generalists

• What does primary care add, to make health care effective

• The need of a new ‘academy’

• Point to declare: on the effectiveness of health care
  • Not on generalists vs specialists, or primary care vs hospital care
Ecology Medical Care and Position Primary Care

- **Primary care morbidity**
  - Unique domain illness, disease
  - Frequency, prognosis, outcome

- **Population perspective**
  - Needs, inter-sectorial
  - Social determinants

- **Patient perspective**
  - Needs, person central, power
  - Person- and context factors

- **System perspective**
  - Navigating resources
  - Health resources utilization

* White et al. NEJM 1961
  Green et al. NEJM 2001

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Primary Care Morbidity, including comorbidity

Percentage of patients

Number of chronic diseases

Role, function family physician

- Medical generalist
  - All health problems
  - All stages
  - All Individuals
  - Need driven
- Community oriented
  - Family or household focus
  - Social determinants
- Personal doctor
  - Patient centred
  - Integrated care
  - Continuity of care

European Definition
Http://www.The European Definition of General Practice/Family Medicine

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Effectiveness of Health Care

Primary care point access associated:
- decrease in mortality\(^1\).
- improved health outcomes (all-cause, cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, self-rated health)\(^2\).
- higher life expectation\(^3\).
- early detection of breast cancer\(^4\).
- early detection of cervical cancer\(^5\).

Poor understanding of why it is effective
Black box, counterintuitive: multimorbidity determining factor


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Primary Care Strength and Premature Mortality in 18 OECD Countries

*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. R²(within)=0.77.

WHO 62nd World Health Assembly

Resolution WHA62.12: Primary health care, including health system strengthening

• People at the centre of health care
• To train and retain adequate numbers of health workers, ... including primary health care nurses, midwives, allied health professionals and family physicians ....
• Vertical (disease-specific) programmes integrated, implemented in primary health care;
• Access to appropriate medicines, health products and technologies, required to support primary health care;
The primary care paradox

“…the observation that primary care physicians provide poorer quality care of specific diseases than do specialists”

Yet primary care is associated with better health, greater equity, lower costs, and better quality of care.

This paradox shows that current disease-specific scientific evidence is inadequate.

Unraveling the paradox depends on understanding the added value of primary care that is hard to see at the level of diseases, but is readily apparent at the level of whole people and populations.

The Paradox of Primary Care:

Compared with Specialty Care, Primary Care is associated with:

1. Apparently poorer quality for individual diseases
2. Similar functional health status at lower costs for individuals
3. Better health, greater equity, lower costs for populations

Population health is more than management of diseases
Raises question of the appropriate measure to value health care
Questions role and contribution hospitals, hospital specialists
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Into the Black Box: what *makes* primary care effective?

- Assumption: it is more important to live a long life functioning well, than living with the best markers of outcome of disease-specific quality of care
  - common chronic diseases, co-morbidity
  - general practice, occupational health, nursing home, care for homeless, family violence, people with learning disabilities
- Looking for clues of *how* primary care operates
  - long-term care of chronic diseases
  - difficult situations (multimorbidity; MUS; requests for euthanasia)
  - Communication skills
Into the black box of primary care
Long-term care of chronic diseases – example COPD.

• Summary of studies
  • Intervention study COPD in general practice
  • 10-year programme early detection, intervention, management COPD (DIMCA)

• Key findings
  • Case finding yielded many undiagnosed cases. But: many more with suspicious signs/symptoms without disease (10 y. follow-up).
  • Patients willing to undergo repeated experimental testing. But: refusal to take experimental medication.
  • Medication of marginal effectiveness. But: early detection and intervention was cost-effective.
Which mechanisms or determinants of effectiveness
Into the black box of primary care
Interpretation in relation to effectiveness of primary care, 1

- Focus on *early* diagnosis and treatment
- *Selective* intervention, wait-and-see approach, masterly inactivity,
- Person-centeredness, orientation on patient-agenda, with emphasis on explaining, and fostering self-efficacy
Into the black box of primary care
Long-term care of chronic diseases - example *depression*

An angle on this: study on depression:
• Aim of study was to establish 10-y recurrence rate depression
• Main findings: low recurrence, enduring impact

• Qualitative analysis of patient perspective:
  • Strong negative connotation of ‘life event’, with recurrent symptoms
  • Preference of ‘learning experience’ to prevent future episodes

• Patient perspective/agenda:
  • Preference of interventions that allow ‘learning’
  • Ambivalence on drugs that take over, or mask symptoms
Into the black box of primary care
Long-term care of chronic diseases – example *Self Management*.

• Summary of study
  • RCT asthma self-management versus usual GP care
  • Dutch College guidelines (ERS/GINA compatible) reference
  • Outcomes: exacerbations, use of medication, hospitalisation

• Key findings
  • GP care and self-management equally good on disease-specific outcomes
  • Self-management lower absence from work.

• Interpretation
  • Importance of social functioning as outcome, and autonomy
  • Importance of work and health
Which mechanisms or determinants of effectiveness
Into the black box of primary care
Interpretation in relation to effectiveness of primary care, 2

- Focus on *early* diagnosis and treatment
- *Selective* intervention, wait-and-see approach, masterly inactivity,
- Person-centeredness, orientation on patient-agenda, with emphasis on explaining, and fostering self-efficacy
- Continuity of care rather than episodic care
- Changing patients’ values and perceptions, rather than changing disease markers
- Functioning and self-development, rather than disease-control as paradigm
Into the black box of primary care
Looking at difficult situations (multimorbidity, MUS, requests for euthanasia).

• Summary of studies
  • Qualitative studies as part of larger projects
  • (i) decision making in patients with multimorbidity; (ii) dealing with patients with MUS; (iii) the concept of ‘unbearable suffering’ in patients requesting euthanasia.

• Key Findings
  • Often differences of perspective between patient and GP
  • Differences in perspective hamper treatment
How do GPs cope
Which mechanisms or determinants of effectiveness
Into the black box of primary care
Looking at difficult situations (multimorbidity, MUS, requests for euthanasia).

• Summary of studies
  • Qualitative studies as part of larger projects
  • (i) Decision making in patients with multimorbidity; (ii) Dealing with patients with MUS; (iii) the concept of ‘unbearable suffering’ in patients requesting euthanasia.

• Key Findings
  • Often differences of perspective between patient and GP
  • Differences in perspective hamper treatment
  • GPs cope by keeping the relation going, postpone decisions, look for opportunities to come back on the decision

• Interpretation
  • Core of the professional relation, and of working over time
  • Relevance clinical guidance secondary to this process
Into the black box of primary care
Communication – example: valuing GPs’ & registrars’ talking to patients.

- Summary of studies
  - Programme for GP registrars’ communication skills development.
  - Work with gold-standard instrument, use NIVEL video library

- Key Findings
  - Low performance of registrars (and GPs) in communication, little change
  - Instrument ignored existing knowledge and other circumstances
  - Adding ‘context’ did lead to higher valuing of performance

- Interpretation
  - Importance of context, individual circumstances
  - Need to teach clinical performance ‘context sensitive’
Into the black box of primary care
Interpretation in relation to effectiveness of primary care, 3

• Focus on *early* diagnosis and treatment
• *Selective* intervention, wait-and-see approach, masterly inactivity,
• Person-centeredness, orientation on patient-agenda, with emphasis on explaining, and fostering self-efficacy
• Continuity of care rather than episodic care
• Changing patients’ values and perceptions, rather than changing disease markers
• Functioning and self-development, rather than disease-control as paradigm
• The personal relation and individual context at the centre
Primary Care

Finding answers to questions of patients for which there are no answers.

This is the point for research, teaching, training to connect in order to renew practice.

Exploration of decision making in multimorbidity
Exploration of patients’ perceived needs and preferences
Responsiveness vs Supply-driven Care

Responsive
- Person-centred
- Context oriented
- Integrative
- Focus ‘understanding’
- Patient empowerment
- A-priory uncertainty
- Interpersonal quality

Supply driven
- Procedure-centred
- Performance oriented
- Analytical
- Focus ‘intervening’
- Disease management
- A-priory grip
- Instrumental quality
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• The need of a new ‘academy’
The new Academy and extend primary care/community capacity

• improving health care

Wonca Kingston Conference: a critical review of the necessity of family medicine research and recommendations to build research capacity’

http://www.anfmimed.org/content/vol2/suppl_2/

• Research and teaching mission related to patient care

• Practice Capacity, Networking
Research into the Community: partnership with practices (PBRN)

- Bring practice to research
- Bring research to practice
- Relation university
- Practice basis academic staff
Primary Care Development
day through unfamiliar grounds

The traditional model: research to lead deficient practice

Research

Practice  Knowledge
Primary Care Development
journey through unfamiliar grounds

The reality: research and practice are resources in their own kind

Research

Empirical wisdom

Practice

Knowledge
Primary Care Development
journey through unfamiliar grounds

The challenge for patient care: to connect different worlds

Research

Empirical wisdom

Practice

Knowledge
Health Care Development
journey through unfamiliar grounds

The challenge for patient care: to connect different worlds

Research

Empirical wisdom

Practice

Knowledge

COMMUNITY

CONTEXT

CONTINUITY
Health Care Development
journey through unfamiliar grounds

The challenge for patient care: to connect different worlds

Empirical wisdom
Research
Practice
Knowledge
COMMUNITY
CONTEXT

Community Diagnosis
Needs and Values
Priorities
Evidence for people and populations
Primary Care as a Specialisation
depth of context, breadth of healthcare

All Health Problems                      All Patients/Groups
                                           All Stages

Directed at:
- Person
- Family
- Living environment
- in reference to social, societal and cultural values

Based on accessibility and time:
- Direct access
- Working in time (continuity)
- Relation in time (trust)
- Responsibility in time
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‘Challance’ of primary care-led health care

Integrate Specialist Expertise in context Primary Care:
• Preserve Coherence Interventions
• Patients in their social context
• Preserve human scale
• **Safeguard Responsiveness**
  • *When possible intervention* => patient
  • *Only when needed patient* => intervention

* White et al NEJM 1961
* Green et al NEJM 2001

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Conclusions

On Effectiveness of health care
• Responsive needs of people and population
• Continuity of care rather than episodic care
• Person-centered, personal relation
• Fostering self-efficacy, patients’ values, functioning
• Early diagnosis, treatment, but selective, masterly inactivity

On innovation, research and development
• Need to link to people, populations, communities
• Continuity asks for commitment
• From individual to team (shared values)

Back to the future
• But when the future is there, we better go that direction