

Innovating or Dismantling Primary Care

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Concerns of the direction of primary care based health care reforms

It can be inferred that the forces that drive health care reform are a mixed bag, including the need to deliver evidence-based public health, address health inequalities, and the political imperative for creating a market in healthcare.

Even in countries with traditional comprehensive primary care a development can be observed, in which multidisciplinary consortia or cooperatives provide specific services directed at important health problems and/or groups of patients (for example , in the community) (2). Often, these services compete with existing , more traditional primary care services.

The European Definition: do you remember it ?

- At the core of health care reforms is a paradigm shift from care of acute health problems, in which there are short episodes of care, dominated by a single discipline, to care of chronic health problems where care over time is required and is directed at multiple health problems as well as fluctuations in patients' perspectives. Rather than specialisation-in-depth, this paradigm asks for specialisation-in-breadth [3], providing the ability to integrate domains of expertise and monitor individual needs over time. The competencies that come with this specialty can be summarized as follows: *Medical generalism*, directed at all health problems, in all stages and in all individuals, determined by need, a *community orientation* focusing on social determinants of health and societal (family, household) factors, and working from a *personal professional relation* with patients (person-centred, integrated, continuity of care) [4].

Paradox of primary care

- Organ or health-problem specific specialization and disease-specific programming of health care, research and education follow the paradigm of acute illness, but have been transferred for contemporary health care. In exploring the value of primary care, it is important to analyze how it compares to this disease centered approach . This has been described as the ‘paradox of primary care’ [5]. Within a defined disease perspective, particularly when using disease-specific process of care outcomes, specialists may achieve slightly better than general practitioners-generalists [6].
- When patients’ functional health status (for example, “can I do what I want to do”) rather than disease-outcome (for example, blood pressure reduction) is measured , specialists and generalists achieve similar results – with generalists using fewer resources [7, 8], which represents higher value[5, 9]. In line with this, more primary care is associated with better population health and life expectancy [10, 11] and with a increased population status of controlling major (chronic) diseases [1], at lower cost.

Primary Care between Unification and Diversification

As a consequence, to achieve better population health and functional status for people, primary care should be the key component of a health care system, through which disease specific expertise is provided and coordinated [12, 13]. This raises the question of the very nature of primary care, its professional content and organizational structure, to pursue this function. *That* primary care is essential may well be beyond doubt [1, 5], but it is less well understood *what* of its characteristics [4] determine its effectiveness. This hampers the translation of the principles of which primary care into a coherent primary care structured health care system. The observed development of community based programmes restricted to important health problems and/or groups of patients, should be further analysed against this background.

Primary Care between Unification and Diversification

- ‘items or fee for service’. The attraction of these programmes is in the provision of ‘state of the art’ care of the specific issue, complete with all technical and logistical support. Its direct access, in the community, adds to the primary care flavor: it offers everything for patients, for example; a diabetic specific service will provide all wrap-around services, such as foot care, eye care, blood monitoring and the like. Current principles of health policy with its emphasis on health care as a market, consumer choice and competition between providers, encourages this development and as a consequence, there is a development of diversification of primary care, with more and more single issue programmes or services, in particular ones that can be clearly defined. The success of such programmes is measured in numbers attending and in outcome indicators. However, as has been argued above, these health gains have only limited impact on the health status of individuals and populations.

Cherry picking: disruption and duplication

- And further, against these potential strengths, ‘cherry picking’ patients away from their “normal primary care provider” will result in disruption and duplication. Most people will often present undifferentiated symptoms and problems in the context of multimorbidity. Individual needs require individual responsibility [14] and not only proactively designed interventions. This is where the core values, deeply rooted in the professionalism of general practice and primary care, come into play [4]: *comprehensiveness* and *continuity of care*, focus on the *persons* with the disease, their psycho-social context, and in the *relation over time*. They are related to the most powerful factor health care has to offer, a personal relationship of trust. This makes it possible to carry an integral responsibility for all people, irrespective of their health problem.
- *Conclusions*
- Primary care and general practice are needed – now more than ever. Health care reforms should be directed at strengthening, not dismantling the core of what determine their effectiveness. In as far as specialist expertise or well-organized programmes are relevant – and there will be an increasing demand for this [13, 15] – these should be integrated into comprehensive primary care, to support and empower continuity of care between general practitioner and patient.

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