

# PHC system and improvement of the population health

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There is no conflict of interests in this  
presentation

# Questions and answers

- How did the idea of the PHC arise and how it was implemented?
- Is the PHC effective?
- Our situation at Alma Ata time?
- Future challenges, hazards?

# How did the idea of the PHC arise

- Rapid scientific and technological development following the WW2
- Inequities – among countries and within countries
- Movements for “freedoms”, human rights, humanization of society
- “Health for All by year 2000 ” – WHO General Assemblies 1975 i 1976

# Alma Ata, 1978.

- WHO i UNICEF
- International conference on PHC
- 134 countries
- 67 international organizations
- Many non-governmental organizations (NGO)
- Alma Ata Declaration (12. 9. 1978.)

# Alma Ata Declaration

- 10 main items
- General principles as a ground for PHC
- Operational principles – organization and functioning

# Alma Ata Declaration :

## general principles

- Health – basic human right
- Obligation of governments/states – population health
- Reduction of inequity – social role
- Community participation – decentralization
- Improvement of health and prevention of disease – economic and social progress
- Inter-sector cooperation – (improvement of health)
- Re-distribution of resources – for population health
- International cooperation

# Alma Ata Declaration – operational principles and recommendations

- PHC is the basic health care
- Reflects economic, social, cultural and political features of the country and local community
- Deals with main / basic health problems of local community
- Comprehensive – improvement of health, prevention of diseases, treatment and rehabilitation
- Use of appropriate technologies – specific mode of work

## Alma Ata Declaration – operational principles and recommendations

- Participation of local community – individuals and local authorities
- Inter-sectorial approach – public health, social welfare, education, construction, agriculture, industry..
- Integral part of the HCS – referral, coordination
- Adequately trained HCW– team work

# Declaration destiny?

- Ignoring - USA
- Formal fitting into national health care laws – “lip-service” – our regions?
- Adjustment of HCS to principles of Declaration – Holland , UK
- Declaration as an integral part of the existing system – Cuba, Bolivia...
- Declaration as a stimulus for system reform – Spain, Portugal, Finland

# Declaration destiny?

- Present everywhere (HCW, health politicians, funders, population)
- Selective, not comprehensive?
- Orientation toward community – individual?
- Participation, community involvement?
- Inter-sectorial cooperation?
- Development of specific technologies?
- Social aspects of the PHC – needed?
- “To live in health”, instead “to live for health” – “health for”

# Future?

- Good intentions!!
- Support of the entire community/health system
- Financial support
- Research
- Education of HCW

# Is PHC effective?

- International studies – Barbara Starfield
- National studies
- Different aspects of the PHC
  
- Starfield B. Lancet 1994;344:1129-133.
- Starfield B. New York: Oxford University Press, 1998.

# PHC Index – 11 indicators (primary-care scor)

- 1. Organization – Network (public) dom zdravljas /group practices: 2 – equal distribution; 1 – exist partially; 0 – non-existent**
- 2. Type of doctor: 2 – GP; 1 – PHC specialists; 0 – other specialists**
- 3. Financial affordability : 2 – national or compulsory insurance; 1 – other insurances; 0 – individual /privat/uninsured**

# PHC Index

4. **Percentage of clinical specialists: 2 – less than 50%; 1 – from 50 – 75%; 0 – over 75%**
5. **Salaries – PHC doctor / specialist: 2 – 0.9:1; 1 – 0.8:1; 0 – less than 0.8:1**
6. **Referral system : 2 – exist and mandatory; 1 – exist but avoidable ; 0 – non-existent**
7. **Continuity /longitudinality: 2 – exist, obligatory (GP); 1 – exist but possible to by-pass, 0 – non-existent**

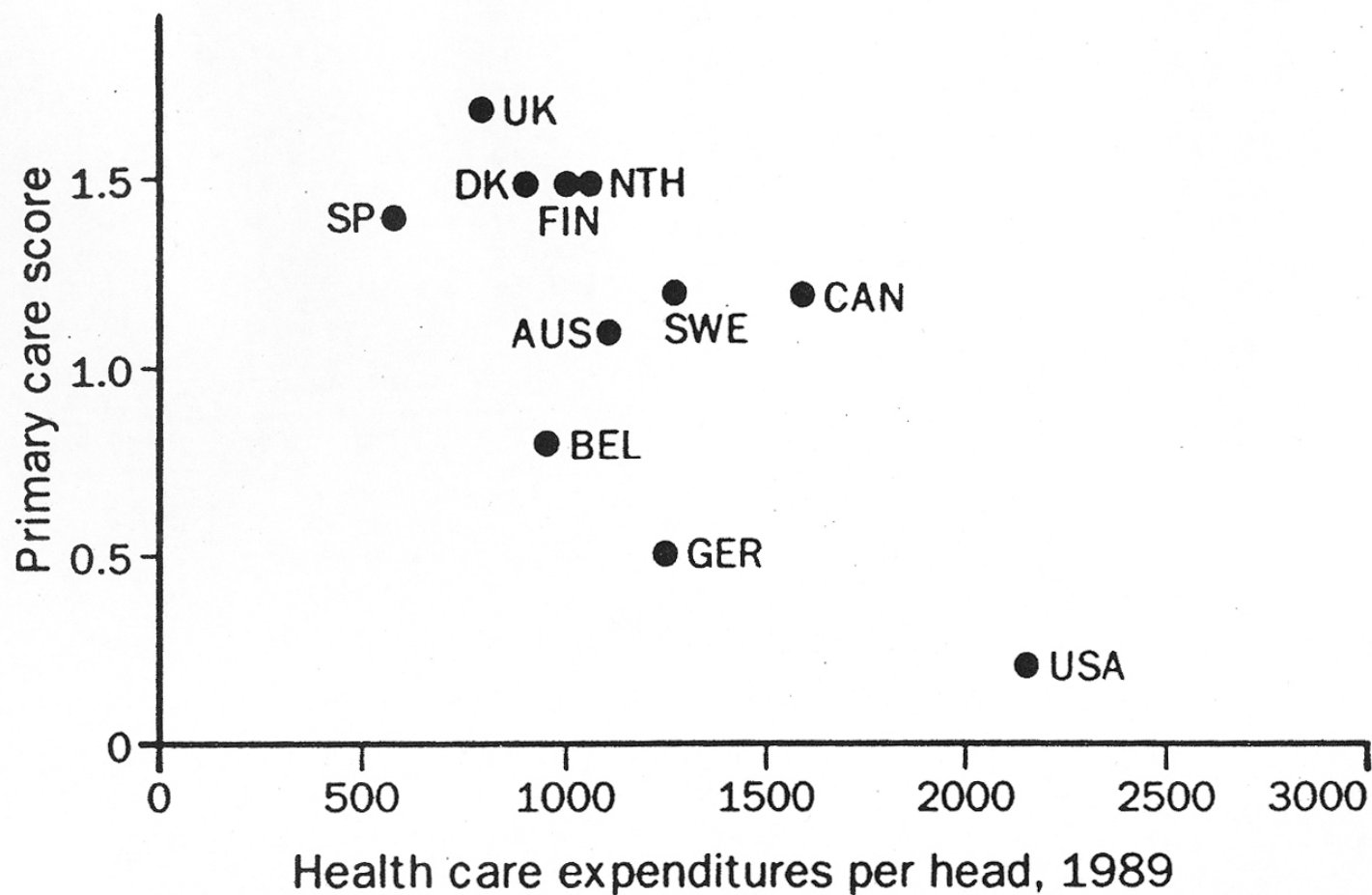
# PHC Index - continuation

8. **Comprehensive (preventive+treatment): 2 – exist (GP); 1 – partially, 0 - non-existent**
9. **Coordination with secondary level care: 2 – well defined rules followed in practice; 1 – exist but possible to by-pass; 0 – non-existent**
10. **Family protection: 2 – whole family with one doctor, 1 – partially; 0 – no family care**
11. **Community orientation: 2 – data about local community used in planning; 1 – only health data used; 0 – no planning based on data**

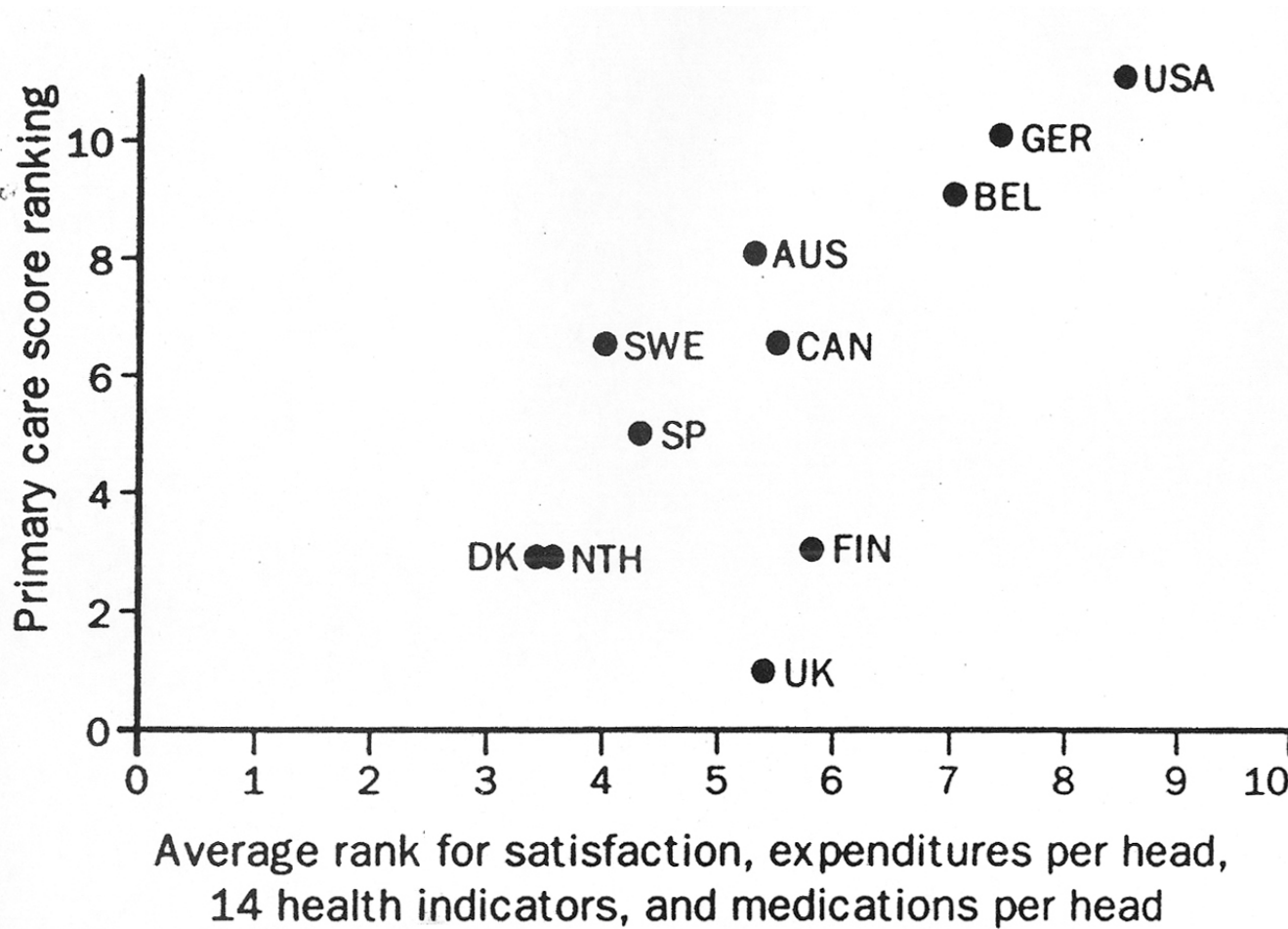
# PHC Indeks – international comparison

- **Great Britain – 1,7**
- **Holland, Denmark, Finland – 1,5**
- **Spain - 1,4**
- **Sweden and Canada – 1,2**
- **Australia – 1,1**
- **Belgium – 0,8**
- **Germany (Western) – 0,5**
- **USA – 0,2**
- **Croatia - 0,8**

# PHC Index / expenses – Starfield, 1994.



# PHC Index / expenditures, satisfaction, 14 health indicators – Starfield, 1994.



# International studies

- Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy* 2002;60:201-218.
- Macinko J. Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organisation for Economic Cooperation and Development (OECD) Countries, 1970-1998. *HSR* 2003;38(3):831-865.

# Number of doctors in PHC/ 10 000 population

Shi 1992, 1994 – USA

- More doctors in PHC better outcomes: low birth weight, infant mortality, specific mortalities : CVD, stroke, lower perception of health

Shi et al, 2003 – USA

- More doctors in PHC - lower total and specific mortalities
- Important number of GPs, number of internists and pediatricians did not have influence
- Increased number of clinical specialists – greater total and specific mortalities

# Number of doctors in PHC/ 10 000 population

Gulliford, 2002, 2004 – UK

- More GPs – lower total and specific mortalities for 15-64 age
- Increase of number of GPs for 15-20% - mortality decrease for 6%
- More GPs – reduced hospital admissions for acute diseases, less juvenile pregnancies

# Continuity / longitudinality

Franks, Fiscella, 1998 - SAD

- Lower mortality – population with permanent GP

Lambrew JM et al. Med Care 1996;34:138-151.

- Greater probability for mammography
- Greater probability PAPA smear

Waren J et al. Can Fam Physician 2001;47:70-76.

- Greater probability of BP measurement
- Greater probability of mammography in last 2 years
- Greater probability of PAPA smear

# Clinical outcomes

Roos 1979 – Canada

- Children referred for tonsillectomy by GP – less postop complications, less respiratory infections and middle ear infections/ self referral

Leggetter et al, 2002 – UK/USA

- Black people in UK – same frequency of amputations due to diabetes as white people
- Black people in USA – two to three times higher frequency of amputations due to diabetes as white people

# Continuity – use of resources

Hjortdahl P, Borchgrevink C. BMJ  
1991;303:1181-4.

- Time spare (complex)
- 10 times less diagnostic procedures
- Less drugs prescriptions (complex)

# PHC and inequities

Shi et al, 1999 – USA – wages inequities

- PHC developed -17% lower postnatal mortality
- PHC not developed – 7% higher postnatal mortality

Shi, Starfield, 2000 – USA – deprived areas

- PHC not developed - 30% higher probability that patients will perceived their health as poor

Shi et al, 2005 – USA

- PHC developed – diminishes the effect of inequity on total mortality, CV and cancer mortality

Reyes et al, 1997 – Mexico

- PHC well developed PZZ– lower children mortality in deprived areas

Perry et al, 1998 – Bolivia

- PHC well developed – decreased children bellow 5 mortaility

# Instead of conclusion

- Attitude of the HC policy toward PHC?

# Situation in our regions

- 1919 – Andrija Štampar, Head of the Hygienic Dept, Ministry of People's Health Belgrare
- Ante Vuletić. United health care in dom zdravlja. Congress of preventive medicine. Bled, 1954.

# Andrija Štampar – 1925. Approach to people's health -10 principles

- Informing population is more important than laws
- The most important is to have people from the community convinced
- People's health – task for all, not only doctors
- Doctor – social therapist, not much achieved by individual work
- Doctor must not be economically dependant on patients
- Must be no difference between rich and poor
- Health organizations where doctors will be looking for patients not vice versa
- Doctor should be people's educator
- People's health – bigger economic than humanitarian significance
- Main place for doctor's actions are residential areas, communities not clinic and labs

# Ante Vuletić

- ....I think that we are the first to try to apply in the practice the principle of united health care in dom zdravljas...
- .....By uniting preventive and treatment efforts, through methods of team work of doctors and other health care and professional workers, social organizations, shifting the weight to the field work, we build a new type of family doctor
- ....Main scientific principles, as a ground for organization of health care in community are the principle of united medicine (functional integration of preventive, treatment and social activities in practice)
- Further principle is de-centralization of health care so it would get closer to the citizens.
- Participation of citizens in the process of solving their health problems is further principle, better said «condicio sine qua non» for successful provision of the health care ..»

# Situation in these regions at time of Alma Ata?

- State – responsible for people's health
- Right to health – human right
- Compulsory health insurance became universal
- Inter-sector approach : education – health promotion, production and trade of food, water supply – law on water protection, industry- labor law and protection at work, transport and construction
- Community participation (self managing interest communities, cooperation in local community, chronic patients clubs....)
- Homes of peoples' health – dom zdravlja – all over the State državi
- Multidisciplinary – general GPs, nurse, field nurse, outpatients clinics (pediatricians, school medicine, gynecology), occupational health, mental health, epidemiologic service, diagnostic services, rehabilitation, drugs supply
- Medical centres – dom zdravljias + hospitals

# Challenges/hazards?

- Responsibility for health is on individual on state, society?
- HC Reforms or development?
- Individual HC insurances – profit /solidarity?
- Market mechanisms and health care (health service)?
- Privatisation of the PHC (GP, pediatrcs...pharmacy... )?
- Distribution of resources (expensive specialized and hospital care, diagnostics ....)?
- HR development – education and retention of professionals?
- Investment in research in and about the PHC (specific technologies: human word, self-help, mutual support, home care and rehab ...?)

# Worth of try ?

- Need for development of the PHC is great – economic situation, inequity!!
- Idea about people's health is deep-rooted
- Rich tradition of the HCS – principles of PHC
- Tradition of community involvement
- Education for the work in PHC – specialization in GM
- Responsibility of decision-makers
- Responsibility of PHC workers