

International approach

Terms of reference

Thirty-three countries and 34 months. Democracies only; with the possible exception of Cuba, given its sustained global influence over the organisation of primary care. Dr Che Guevara and President Fidel Castro as the founding fathers of Health for All policies: if they shaped international developments during the second half of the twentieth century who are the formative forces for the first half of the present one? Such a fundamental question needs a clear and cogent analysis: robust terms of reference are required.

So, back to our defining agenda. Only countries with major health policy reforms over the past decade, and preferably since 1997 when the New Labour Government came into power in the United Kingdom. Even better if the changes are post-millennium and parallel Prime Minister Tony Blair's mantra of 'Modernisation' for a 'New NHS'. Fortunately the organisational developments of many countries more or less do.

And, for the purposes of comparability, small countries are mostly ruled out. Take ten million as the arbitrary minimum population. But again, on the advice of two directors of the World Health Organization (WHO), there need to be exceptions to the general rule. Some countries are in effect experimental laboratories for modernising and primary care-based health policies – Uganda, Kyrgyzstan and Georgia for instance are, we learnt, sometimes seen informally by global policy makers as three such action research sites. Others ape the complexity of political process and decision making found in larger nation states; and worldwide devolutionary pressures mean, perhaps, that some provinces might even be considered. Ontario (Canada), Oaxaco (Mexico), New South Wales (Australia), Lara (Venezuela) and Northern Ireland, for example, come to mind; but probably not in their own right. Ultimately they are illustrations of the new extended limits of national health policies for local resource management. But, of course, small country success stories should at least be mentioned, where they fit the criteria. Costa Rica and New Zealand definitely, Singapore too, and Greece simply because it seems to be experimenting with the introduction of every health policy reform yet invented; and simultaneously.

So, back to the criteria again. We are looking to make sense of primary care in the twenty-first century. Our perspective is global and our lens alights on developments in countries with novel organisational formations in primary care. These developments have broadly common characteristics. They are partnership based and public health oriented. Their new collaborative approaches to the wider local control of health services and resources require new forms of governance and regulation. Usually these primary care organisations are not only interprofessional in their practice but intersectoral in their management.

Non-governmental public action is a critical component. Communities play a larger part in the executive functions than previously, but in very different ways in very different places: a spectrum stretching from commercial to charitable representation. And, on all fronts, these organisational developments are more open to international influences, through globalisation, than ever before. We live, as the Chinese say, in interesting times and, of course, China itself as the world's largest country, its 'Middle Kingdom', must be included.

Making sense of such times, through defining their direction of travel, is our task in this book. Its preparation has itself involved much travel: 75 flights in one year alone, 280 000 kilometres in all. Along the way more than 200 interviews and 50 visits to local primary care organisations: each one identified by a 'lead' national policy maker as an exemplar of future practice developments. In total, an exhilarating experience and an educational one, leading to numerous follow-up exchanges, both personal and academic, and a plethora of joint articles, shared ideas and curricula, and proposals for further research collaborations.* The theme has been 'transferable learning', with common policy principles the framework for adaptation if not adoption of one site's programmes by its prospective partners elsewhere.¹

As terms of reference, all the above parameters seem to have come together to produce a successful product. A one-year project became a proposed seven-year-long research unit (to 2008). For the author, one fellowship led to another, and NHS grant funding throughout 2002–05 was annually renewed with 'strong' ratings from reviewers. Published articles total more than 20 and this is already the second book, augmenting a series of chapters in other volumes, with some even attracting overseas translations into other languages.^{2–5} There seems to be a thirst for new knowledge through the kinds of multinational exchanges and communications now possible, while just within policy circles of the UK the emphasis on 'joined-up government' has meant briefings and seminars not only at the Strategy Unit of the Ministry of Health but also in the Home Office, the Treasury and, inevitably, the Cabinet Office itself.

As time has passed so such inputs have increasingly, and not infrequently, been requested elsewhere: for example, from the Midland Health Services Executive in Eire; from the major national health insurance corporation in Mexico (IMSS); from the global organisation for the promotion of community-based healthcare education at its 2003 and 2005 annual conferences in Australia and Vietnam (Network-TUFH); from the Inter-Americas Social Security Association in the Dominican Republic; and finally, from the individuals at WHO (Geneva) itself. The level of demand corresponds to the level of dilemma about the future of primary care and its organisation. In terms of growth, the twentieth century belonged essentially to family medicine and its practice. The twenty-first century clearly does not. In the 1990s in England, it was still quite possible for a leading British professional commentator to write, with minimal challenge, that primary care and general practice were synonymous.⁶ The name of the service was also that of the profession, the surgery and

* The research has been reported regularly in a series of 2003–2005 articles for *Medicom's Primary Care Report*, which has been the most-read journal in NHS primary care trusts in England.

the vocational training course. Ten years later it was all change. In just one decade, official documents in the UK relegated the general practitioner (GP) to seventh in the pecking order for direct patient access: behind the triage nurse and community pharmacist, walk-in and healthy living centres, and, of course, the online information and telephone advice services of NHS Direct.⁷ Moreover, this list does not include, because it pre-dates it, the subsequent drive for more self-managed care, backed up by better educational inputs and preventive measures (e.g. on diet, exercise, birth control) from non-NHS agencies.

As the service profile of primary care diversified so its structures and processes have had to change. It is now, by definition, a complex organisation. The simple forms of hierarchic bureaucracy or peer-based partnerships are inadequate, seem to be rapidly passing away and can no longer apply to future developments. At least not as the main organisational vehicles, unlike in the past. Historic strengths should endure, be protected even, but conservatism clearly has its constraints in terms of understanding the future agencies of and for primary care: in terms of their accountabilities, management, operational mechanisms, investment profiles and human resources; and indeed even their ownership. Constructive scenario planning rather than single strategies is needed to take primary care forward, given its new range of different constituents. The international overview provides a rich resource for mapping the alternative routes to 2100. If it is true that primary care must always be locally negotiated, it is also now the case that its future depends as much on international policy and practice influences as it ever did in the past on professional self-determination. If this is the conclusion reached by researchers in such countries as Zambia,⁸ Colombia and Mozambique,⁹ how much more applicable may it be to the larger, more economically developed and therefore more interdependent States of Western Europe and North America?

The cast list

The 24 countries that have been the subject of specific studies can be divided into four groups. Together they supply most of the material for this book. Not enough clearly, but rather more than some previous texts, which have asserted global 'truths' on the basis of evidence derived from as few as four to six countries.^{10,11} Our research framework, in geographic terms, does at least cover all the main continents, although North Africa, the Middle East and the Indian subcontinent are conspicuous by their absence, except as literature references. This omission arises largely from the democratic deficit of recent 'modernising' reforms in many of the States of these regions, plus a shortfall in reliable research. Our framework, too, also covers the six discernible models of mainstream primary care organisation that we define and explain in Chapter 2, and then illustrate in detail in the narrative of the rest of this book. Based on the terms of reference set out above, the research framework facilitated our deliberations as we arrived at the following focus for our fieldwork.

The first cluster of countries identified for study were those which scored on each of the five criteria or dimensions of modernisation we identified at the outset, through our meetings with NHS policy makers and our reviews of their principal academic sources in terms of policy theorists and commentators.^{12,13}

Accordingly, in each national health system there was first a contemporary reform process under way promoting a form of local resource management in primary care. This process also included, second, new collaborations across the public and independent sectors, and third, attempts at more significant community participation. In every setting, the emergent organisations have been subject to, fourth, new forms of regulation as governments seek to exercise effectively their national stewardship roles in public health. And fifth and finally, in all of the following 12 countries we found examples, from our literature searches and documentary reviews, of innovations in the area of interprofessional learning and development. Several of these have now been published.¹⁴

Together these five criteria represent the dimensions of a partnership-based health system founded on modern primary care organisations. Our first cluster of countries for fieldwork enquiry in 2003–04 comprised:

- Canada
- Chile
- Finland
- Greece
- Japan
- New Zealand
- Peru
- Philippines
- Portugal
- South Africa
- Thailand
- Uganda

plus, of course, England and, as our pilot site from a preliminary research visit in 2001, Brazil.

In 2003, we returned to Rio de Janeiro for a short follow-up study. By this time the interest in and the financial support for our programme had grown to the extent that we were able to incorporate into our standard fieldwork approach the countries placed on our reserve list. In each of these, at least one of the main dimensions of modernisation was missing, but equally, on one of the other dimensions, there were indications of developments that might be of particular value in terms of international transferable learning. The ‘Big Bang’ change management style of Bogotá’s decentralisation and the ‘experimental’ values-based orientation of new medical and healthcare curricula designs in New South Wales were two such examples of this potential. The full list comprised:

- Australia
- Bolivia
- China
- Colombia
- Costa Rica
- Czech Republic
- Indonesia
- Mexico

- Singapore
- Venezuela.

The writer and his team undertook fieldwork in all of the above countries in 2004/05. In each, a minimum of two national policy leaders and two local representatives of exemplar organisational developments in primary care were normally the subjects of semi-structured interviews using the same topic guide for transferable learning. In many cases, further interviews were arranged, at the invitation of our various hosts, to provide supplementary information and intelligence. The volume of interviews and visits could reach to a dozen, in a single country.

For our last group of countries a rationale such as that outlined above, with its rational selection process, cannot be claimed. They, in effect, chose themselves. If it was not quite outright opportunism, the motif for research in the following sites does come down to individual interests and associations: sometimes based on the past and personal links of members of the Warwick University IPC research group (as, for instance, in the case of Turkey) and sometimes through invitations from local sites seeking to be included in a new international research project (as, for example, in the case of the Rhondda health services in Wales looking to initiate 'Active User and Carer Involvement' programmes). There were nine countries in the last, very disparate cluster. They are as follows:

- Croatia
- Dominican Republic
- Ireland
- Kenya
- Scotland
- Slovenia
- Spain
- Turkey
- Wales.

Visits to the above were scattered across the 2002–05 time frame for the research programme, with data collected on an *ad hoc* basis around attendance at meetings, workshops and conferences. As sources, this cluster is best thought of as merely providing background intelligence. While some of the opportunistic research on, for example, developments in community-based medical education (in Eldoret, Kenya) has been reported elsewhere,¹⁵ none of the detailed case accounts of Chapters 3 to 8 is derived from this grouping. No more are any universal assertions. Neither the information this research supplied nor the techniques employed in the data acquisition would properly sustain generalisable case studies.

The 33 countries above are our cast list. The United States of America is not included but, as we will see, the American influence is still everywhere and its own developments are often the starting point for both action and analysis, either tacitly or explicitly,^{16,17} in much of recent international health systems comparative research. But for our purposes, in terms of relationship-based primary care and organisational developments which accord with our five key

collaborative criteria of modernisation, the USA does not fit. As a result, the door is open for a wider international exchange, especially between developing and developed countries. It is, I think, an unusual but attractive prospect.

Supporting acts

It is also a proposition now firmly supported by the WHO. Particularly in the early design stages of our programme, WHO staff could not have been more helpful. The phone call from one of its senior members, who was attending a meeting in the Balkans, to check that I was being looked after and could find the data I was seeking on my first visit to his Swiss office still sticks in the memory. Apart from being a singular act of long-distance kindness, it brought home to me the inter-connectedness now of contemporary developments and the feasibility of seeing these truly through a worldwide perspective.

At the Geneva WHO headquarters the global perspective in the post-millennium period is changing subtly. Poverty is replacing primary healthcare *per se* as the principal priority for those addressing the public health improvement agenda. Sustainable development is their touchstone.¹⁸ This is a logical progression on past policies, which represents more than just a change in the top-table leadership of the WHO. The 1978 Alma Ata principles were officially reaffirmed at WHO-sponsored events in 1998, but after more than 20 years there has been a sense not only of fatigue but also of frustration in that so many of the Health for All targets have either been underachieved or sidelined. The focus on mainstream poverty since the WHO Annual Report of 2000 has sought to counter diversionary tactics, especially in dictatorships and some consumerist Western countries, by taking the Alma Ata 'Pillar' principles¹⁹ of cross-boundary collaboration and community participation and extending them beyond the traditional limits of healthcare provision to the full range of public service delivery sectors, in pursuit of enhanced social and economic status for entire populations.

In Europe, this has meant using a range of economic and employment levers to promote an international labour market in healthcare professionals and to stimulate across the continent new waves of social and ambulatory care providers in the independent sector. Long-term European shortfalls in terms of nursing supply and response to special needs and migrant minorities are being addressed,²⁰ and in each country the profile of primary care is becoming more diverse and differentiated as a result.

In the UK in particular, the post-2000 NHS 'journey for major improvement' is being routed through 'a much wider choice of different types of health services' characterised at the frontline by more 'personalised' and 'faster treatment'. For primary care this is said to mean 'new ways of meeting patients' needs', 'new flexibilities', 'a wider range of providers including independent sector organisations' and 'an enhanced range and quality of services'.²¹ For the Ministry itself the first policy task is a new White Paper on 'out-of-hospital care' and the first 'distinctive' role for the Department of Health in 'developing strategy and direction for the health and social care system' is to 'include not-for-profit and private providers – while maintaining (of course) the integrity of the system and its values'.²²

The message could not be clearer. The local contracts and quality initiatives

of the personal medical services and practice-based commissioning programmes were not ends in themselves. Further organisational developments are anticipated. As with education, social care and social housing, these are expected to embrace non-professionals and new participants. Our interviews with NHS senior and middle managers around the UK over the period 2003–05 indicated that, on the ground, they clearly recognised the real underlying direction of travel. The following are typical of their questions, the responses to which we have reported elsewhere.^{23,24}

- How can tomorrow's primary care organisations achieve a parity of interests between their different stakeholders?
- Can new primary care and non-governmental organisations combine to extend primary care and public participation?
- What works and where? (And how do we learn about it?)
- Is it possible to get primary care professionals 'onside' with modern policies?
- Will the new organisational developments release more potential for primary care?
- What will be the impact on public accountability (and personal trust) of more diversity and choice?

All of the above are wrapped up in the simplest and most frequently asked question: 'What should be the defining characteristics of modern primary care organisations?' This is the question that this book addresses. In the UK, it is impossible to do so without first reflecting on the future role of the GP. In the next chapter, employing our international perspective, this is where we start.

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