There are almost as many healthcare systems as there are countries - and no system is perfect. The NHS in the UK is seen by many to be an exemplar of health service to a nation, with primary care holding a key place in the system that aims to meet the needs of everyone, is free at the point of contact and is based on clinical need, not ability to pay. To explore the variety of different attempts at implementing primary care services, it is necessary to explore the aims of primary health care.

In 1978, the Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care. It called on governments, health and development workers, and the world community to protect and promote the health of all people, emphasizing, for the first time, the importance of primary health care(1). The declaration was endorsed by many countries attempting to achieve the World Health Organisation's goal of universal health coverage and accessible primary care for all(2).

The Alma-Ata declaration defined Primary Care as, ‘the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constituting the first element of a continuing health care process’.(1) Furthermore, it was expected to address major health problems through promotive, preventive, curative and rehabilitative care.

Before we begin - a brief note
‘General practice’ is not a term widely used in other countries - so here is a list of the other terms and definitions:

- ‘Primary care’ refers to provision of community-based healthcare by a team of people (doctors, nurses etc).
- ‘General practice’ (often called family medicine/practice abroad) refers to the provision of healthcare in community settings by specialised doctors in that discipline (GPs/Family Practitioners).
In October 2018 The Astana Declaration (3) was issued at the Global Conference on Primary Health Care, organised by WHO, UNICEF, and the Government of Kazakhstan, in Astana, Kazakhstan. In it, governments, non-governmental organisations, health practitioners, and researchers recognised that all people are entitled to the highest possible standard of health and wellbeing. The Declaration pledges the development of primary health care systems that are “high quality, safe, comprehensive, integrated, accessible, available, and affordable for everyone and everywhere”.

Barbara Starfield’s wealth of evidence demonstrates those health systems with strong primary care foundations produce better population health outcomes at lower costs(4-6) and the Primary Care systems of Cuba and the USA bookend a spectrum of different approaches to these challenges. It is impossible to give an overview on every global system, but through the examples of Cuba, Israel, South Africa, China and the USA we will examine different examples of primary care approaches and highlight the challenges facing effective implementation of such services.

**NEED TO KNOW**

**TYPES OF PRIMARY HEALTHCARE PROVISION**

There are three main ways in which primary healthcare (and other healthcare) systems work. However, it is important to remember that for millions of people there is very little co-ordinated healthcare.

**Stop and think...**

- What role do you think you should play in the WHOs stated plan of ‘health for all’?
- What might be the benefits of engaging in efforts to strengthen healthcare systems abroad?
- What might be the risks?

The main types of healthcare systems are summarised below.
<table>
<thead>
<tr>
<th>Type</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>State funded and coordinated</td>
<td>• Relatively good value with good healthcare outcomes.</td>
<td>• Increased burden on taxpayer.</td>
</tr>
<tr>
<td></td>
<td>• Free at point of contact.</td>
<td>• Can be abused/overused by some.</td>
</tr>
<tr>
<td></td>
<td>• Reduces health and social inequality.</td>
<td></td>
</tr>
<tr>
<td>Insurance-scheme</td>
<td>• Up-front payment often necessary - may reduce ‘inappropriate’ overuse.</td>
<td>• Intermediate value and health outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Incomplete population coverage.</td>
</tr>
<tr>
<td>Private</td>
<td>• Reduced burden on taxpayer/state.</td>
<td>• Relatively poor value and health outcomes.</td>
</tr>
<tr>
<td></td>
<td>• Profits possible on certain populations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Market may find solutions if left alone.</td>
<td></td>
</tr>
<tr>
<td>Little/no coordinated care</td>
<td>• Local solutions provided by local manpower.</td>
<td>• Often very poor health outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prone to intervention by countries/organisations with motives other than healthcare.</td>
</tr>
</tbody>
</table>

In practice, many countries have a mixture of all the three main systems. The difference between countries is the extent to which each system predominates. For example, the US does have state GPs and hospitals, but investment is low, and facilities are poor quality. Insurance and private schemes are well established but only cover approximately 50% of the population. Health outcomes are very poor in relation to cost (4-6).

In contrast, Scandinavian countries, the UK and Cuba have relatively well-developed state funded primary care facilities with universal coverage and relatively small (but increasing) insurance and private sectors. However, income tax rates in these countries is high (as much as 60%). Health outcomes are very good in relation to cost but Governments appear cash-poor.
MEDICAL PERSONNEL IN PRIMARY CARE

Broadly speaking there are two types of system here:

1. Medical model; GPs or Family practitioners (the more common name abroad) are medically qualified and co-ordinate multi-professional healthcare teams. Tends to be in westernised countries.
2. Insufficient medical personnel exist to perform the roles of GPs. This is the case in the majority of countries. Primary care is delivered by nurses, midwives or non-clinical personnel, such as community health workers, who have often had some form of basic medical training.

In most accounts of healthcare systems, the role of relatives, communities and the third (voluntary) sector appear under-represented.

HEALTH SYSTEM EXAMPLES

CUBA

Cuba is hailed as a true success story for primary care with a unique and highly effective system. Over the last 40 years the country has been strongly committed to achieving universal, high quality primary care coverage and in doing so has succeeded in reducing child mortality deaths from 46 to 7 per 1000 births and achieving one of the world’s highest life expectancies.

The system is based upon a series of around 500 polyclinics, each serving between 30,000 to 60,000 people, which form an organizational hub for neighbourhood-based family doctor-and-nurse offices and serve as accredited research and teaching centres.

The polyclinics have been further developed in recent years to offer a range of additional services from radiography to diabetic foot and acute stroke clinics. Moreover, each is tailored towards the specific needs of the local population. For example, some offer extensive smoking cessation services in high prevalence areas, whilst others a greater number of sexual health or allergy clinics.

In this fashion, primary health care covers over 95% of Cuba's population, with a strong emphasis on prevention. Over 97% of medical trainees spend time in the primary care system post-graduation and the country is rapidly training more family doctors, recognizing their value and contribution to the country's healthcare success(7).
ISRAEL

Israel has managed to retain tight control over health spending. In contrast to many OECD countries it spends just 8% GDP on healthcare (the 8\textsuperscript{th} lowest). It has achieved such impressive figures through the provision of high quality universal primary health care that helps avoid expensive hospitalisation. For example, Israel has the same rate of diabetes (6.5% of adults) as many other countries, but the second lowest rate of hospitalisation for poorly controlled disease.

This avoidance of secondary care services is achieved by co-locating medical teams in community-based health clinics that allow patients access to a broad range of health expertise in a single visit. Moreover, these clinics are held to account through Quality Indicators that track performance across 35 key measures. Unlike other countries that use financial incentives to encourage target attainment (the UK, France, or Australia), Israel helps clinics by showing them where they could improve.

Israel is now expanding its data monitoring systems to cover a wider range of chronic diseases and is attempting to encourage more younger doctors into primary care, to ensure sustainability of its system\(^\text{(8)}\).

SOUTH AFRICA

The South African healthcare system is an exemplar of external forces impacting on development and delivery of primary care services. In the early 1940s, several highly innovative community-oriented primary care clinics were developed, focusing on health of the family and community rather than the individual e.g. through mandatory immunisation, community food gardens, child growth monitoring and other initiatives. This Pholela-model of healthcare, which empowered communities and families to make decisions regarding their own healthcare i.e. patient-centred care, spread across many parts of rural South Africa - a great achievement.

However, plans to construct a National Healthcare System like that in the UK were thwarted by the government’s unwillingness to facilitate taxpayer funding. With the onset of Apartheid, increasing financial and political pressures combined with a racial segmentation in healthcare provision and general deregulation. This led to a disintegration in the well organised community model, from which South Africa has never fully recovered.

Although national progressive policies have attempted to refocus the country towards primary care, significant inequality persists, with dual public and private systems and a plethora of highly variable administrative units. Given the huge pressure on public primary care services, exacerbated by a post-Apartheid exodus of Primary Care Physicians, many individuals opt to use private primary care clinics, which then perpetuates the distinction and maintains the country’s inequalities.

Whilst much rhetoric in South Africa focuses on strengthening and developing primary care, in reality, the economic and workforce pressures loading the system have highlighted how dependent such ideals may be on a supportive external environment\(^\text{(9)}\).
CHINA

The challenges facing primary care in China, as for provision of many other of the country’s services, lie in its huge population. Before the 1970s, under a planned economy, primary care developed rapidly. However, the market-based profit-seeking economy from the 1980s onwards has supported far slower growth in the sector.

Primary care is delivered from Community Health Centres, which have varying levels of government investment and involvement, resulting in highly disparate levels of care. Moreover, given that China’s system involves an insurance-based model, with individual patients expected to make significant co-payment contributions to any treatment, many simply bypass primary care, presenting at more expensive Secondary Care services.

This reflects how overwhelmed Chinese primary care has been by the aging, growing and increasingly multi-morbid population. Until the country trains far more primary care physicians and invests heavily in the sector, China is unlikely to see any improvement. Healthcare costs will continue to escalate, and many patients will go untreated (10).

USA

In theory, the organisation of primary care in the USA is not dissimilar to that in the UK. However, although several family doctors, general practitioners, general internists, general paediatricians, and general obstetric and gynaecologists work in the community, the majority are private practitioners and over a third work single-handedly. Moreover, many work part-time in inpatient settings and few provide home visits. During the 1990s, US managed care organisations tried to encourage primary care physicians to take on a gatekeeper role to secondary care services. However, that proved unpopular for physicians and patients alike, and thus the USA didn’t enjoy the associated cost savings - many Primary Care Physicians are still paid on a fee-for-service basis and patients became dissatisfied when they felt they were paying their generalist to keep them from accessing specialist services.

In stark contrast to the UK, the market forces in the USA are still driving healthcare towards the greater volume and profitability of the hospital sector. Primary Care Physicians earn considerably less than specialists, are associated with a lower status overall, and currently struggle with an unwieldy, unsatisfying electronic patient record system. Thus, it remains an unpopular career choice amongst medical students. With the rescinding of much of the Affordable Care Act ('Obamacare'), which mandated regular state-backed health checks and a well-funded primary care service - the health outcomes of some of the most vulnerable have arguably become more precarious. As we have seen, inequality within countries is a potent cause of disease in itself. There is much rhetoric amongst health system leaders about the need to ‘refocus’ the American system – by far the most expensive in the world, for some of the worst health outcomes – yet on the ground it is hard to see many practical changes, or indeed, what will force such change (11).
SUMMARY

Despite 40 years of global promotion of primary care, universal coverage remains highly variable with success stories and less inspiring tales. However, the positive impacts on both a healthcare system and individual patients of strong primary care foundations are clearly evident. As such, physicians, medical students and policymakers around the world would be well to afford the sector the respect it deserves.

ACTIVE LEARNING

✓ Tell your GP about this week’s theme. Talk to them about their experiences working abroad. What did they think of the systems that they encountered?

✓ Do you know how primary care is delivered where you will spend/spent your elective?

✓ Does this system achieve the aims of Alma-Ata?

✓ What do you think is good about the system? Could the NHS benefit from any of these things to the NHS?

✓ What are the challenges and drawbacks? What would you want to change? Why?

FURTHER LEARNING

RESOURCES

• Find out more about the work of The World Health Organisation (WHO) concerning the development of primary care on an international stage.

• Exchanges and seeing other healthcare systems in action can be a powerful learning experience about other healthcare systems. For more information on exchanges, enquire at your schools about:
  o Erasmus exchanges (2 week fully funded placements in Europe).
  o Hippocrates exchanges (1-2-week self-funded placements in Europe).
  o FM360 exchanges (observational placements based in countries outside of Europe and usually for 4 weeks).

• Find out more about eco-tourism and opportunities to work developing primary care abroad. Blue Ventures are a fine example of this resource - https://blueventures.org

• Find out about the work of Medicine sans Frontieres (MSF) - www.msf.org.uk

• Try reading The Honorary Counsel by Graham Greene for an insight into the life of a Doctor in Brazil or Madame Bovary by Gustav Flaubert about French provincial practice (also a film).
REFERENCES


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC’s Heads of GP Teaching Group.