Policy Dialogue

PDP1 - Strengthening the National Network of Primary Health Care Providers to Improve the Health Status of population, children and adults (including vulnerable population)

A4 – Developing a model of integrated services at community level

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Outline

- Objectives
- Methodology
- Country cases:
  - Hungary
  - Netherlands
  - Norway
  - Romania
  - Slovenia
- Recommendations

Objectives

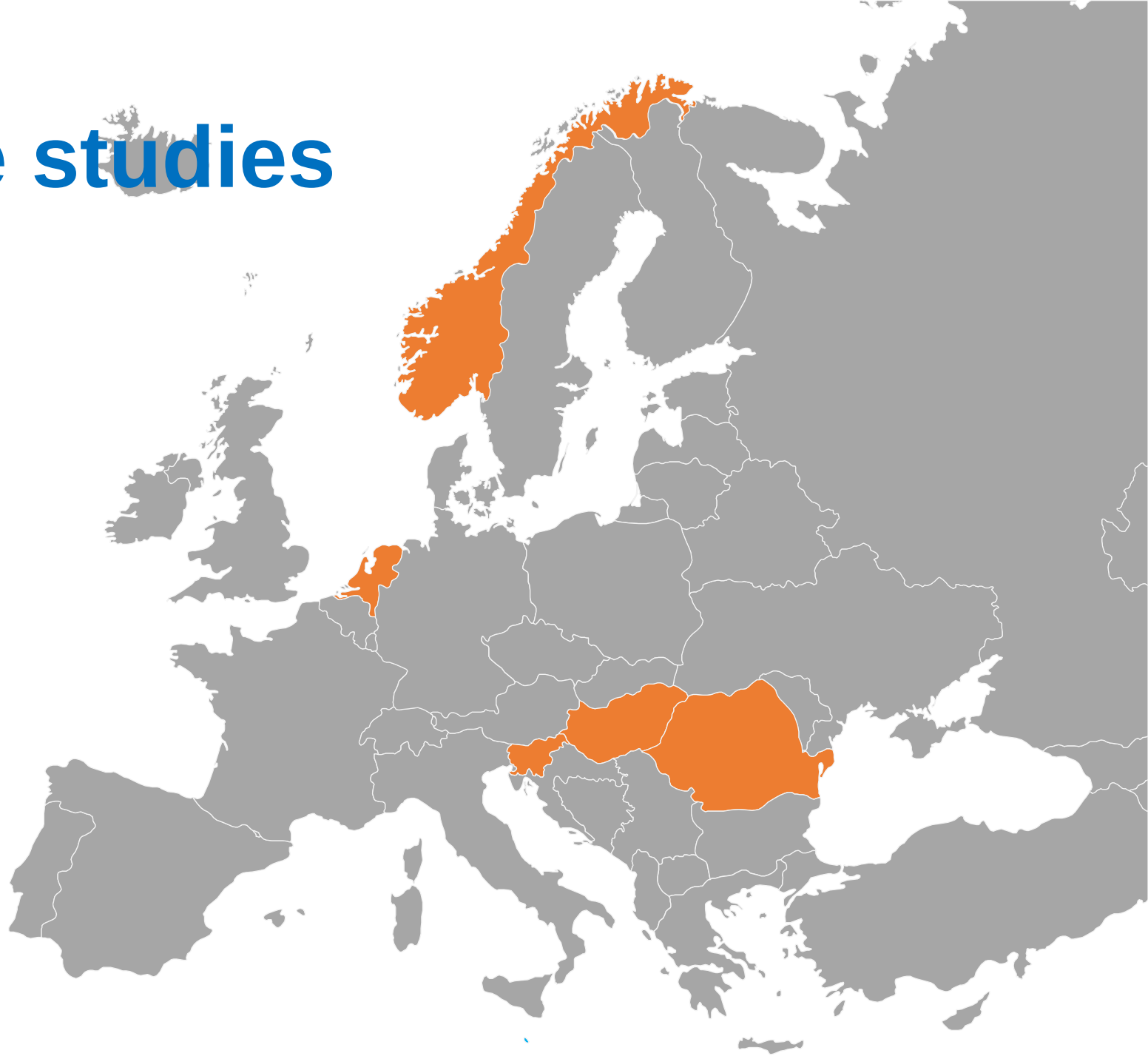
- Review country experiences in organising primary care and community health services.
- Explore the role and responsibilities of community nurses in each context.
- Seek for inspirational configuration and innovations.

Methodology

- Desk review and interviews with national experts on primary care and community health.
- Selection of countries combining three factors:
  - the level of maturity of primary care and community health services;
  - similar health system configuration;
  - geographical proximity.
- Structured country case reports covering health system description, organization of services, and focusing on community health centres and community health nurses.

5 country case studies

- Hungary
- Netherlands
- Norway
- Romania
- Slovenia



Hungary

An opportunity towards universal health coverage

Health system

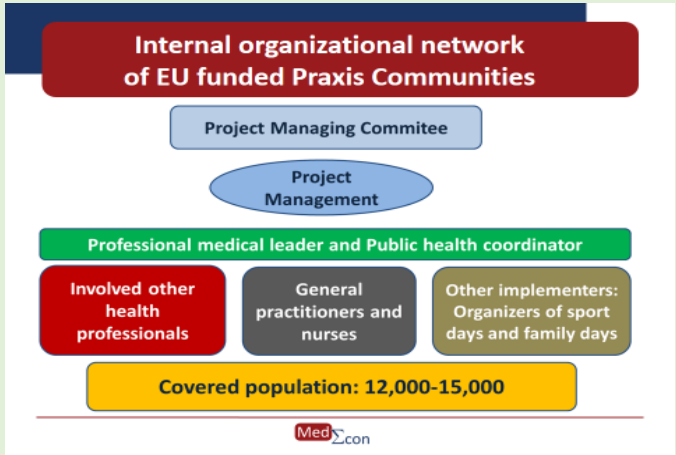
- Centrally-governed
- Compulsory **Health Insurance as single purchaser**
- Financed by social security contributions
- Compared with other countries, there is a **lack of** health professionals, especially **nurses**
- A National Electronic health service system (EESZT) ensures all healthcare service providers connect including pharmacies and all GP offices.
- **Lack of integration between health and social**. Regulations of primary health care and primary social care are separated. Social care is funded by state budget.
- Some local governments employ district nurses.

Hungary

An opportunity towards universal health coverage

Primary health care

- GPs are self-employed or in company with contracts with local governments and the Fund.
- **District nurses** are considered part of the basic package of services.
- Regulation of primary health care and primary social care is **separated**



Innovation in service delivery

- Move from single practice towards **group practices and praxis communities** including nurses, public health coordinators and health visitors.
- Reorganization has depended on international and European Union funds.
- Modern practices run **health status surveys** to plan community prevention programmes, lifestyle clubs, and care for chronic patients.
- Results show that the referral rates to secondary care are lower in the new model.

Hungary

An opportunity towards universal health coverage

Role and responsibilities of public health coordinator

- ►Coordinates multidisciplinary teams work (dietician, physiotherapist, mental health specialist, medical and district nurses, health mentors).
- ►Proposes effective implementation of preventive services.
- ►Manages health status surveys deployment.
- ►Conducts Praxis Community meetings
- ►Monitors and reports progress
- ►Defines local guidelines for implementing new services
- ►Liaises with local organizations

Hungary

An opportunity towards universal health coverage

What can we learn from Hungary?

- Experimentation with **new models of care** provide insights to the way forward.
- Overdependence on international aid can hamper scale-up of good practices.
- The role of community nurses expand from a primary health care towards **preventive services**.
- Integration with social services is difficult if the funding streams are separated.
- Information technology and physical infrastructures are crucial to develop collaboration between health agents.
- The role of **public health coordinators** is a catalyser of community health activities.

Netherlands

A community care model focusing on elder care

Health system

- Based on mandatory **social health insurance** for all citizens
- Reformed in 2006 with a **single** compulsory insurance scheme for essential curative care with competition among multiple private health insurers.
- The **Ministry of Health, Welfare and Sport** is responsible for defining the basic health insurance package, service tariffs, setting public health targets, and deciding the capacity in long-term care institutions.
- Local governments are responsible for **long-term care**, including home care services
- Since 2002 there has been a focus on shifting care from secondary care to primary care, mainly for chronic diseases
- Health services are funded by a mix of **obligatory social and private insurance**, with additional co-payments for long-term care.
- Many social services are financed from **municipal funds**.

Netherlands

A community care model focusing on elder care

Organization of services

- Healthcare is organised around a **strong primary care** system.
- Primary care professionals work in **multidisciplinary teams**: family doctors and GPs, community nurses, specialised nurses, practice nurses, home care nurses, physiotherapists, midwives, occupational therapists, speech therapists, dentists, community pharmacists, primary care psychologists, social workers, and dieticians.
- **Task shifting** from medical to nursing professionals is a common practice (e.g. diabetes management) and has contributed to shift care to primary care.
- There are different **nursing profiles** based on their training: general nurses, nurse specialists, enrolled nurses.
- The Dutch Association of Nurses and Carers has developed a **Quality Register** for Nurses.
- Home nursing, personal care and long-term mental healthcare is now covered by the **Health Insurance Act**. Support care, day care and mental health for adolescents is part of the **Social Support Act** provided by local governments.

Netherlands

A community care model focusing on elder care

Nurses in the community

- Community nurses are **employed** by primary care practices to provide a link between patients, informal carers, healthcare providers and official bodies.
- Home nursing care is provided by **district nurses** who assess the needs of their clients and coordinate care with other providers.
- Since the 90s, nurses and allied health workers develop their own **clinical guidelines**.
- **Educational materials and tools** have been developed to complement these guidelines.

Netherlands

A community care model focusing on elder care

Innovative model

- Buurtzorg (“Neighbourhood Care”) is a healthcare provider organised as a network of **small autonomous teams**, with a maximum of 12 skilled community nurses, who deliver high quality home care at low costs supported by an innovative IT system.
- The main innovation of the Buurtzorg model consists of shifting **decision-making to the frontline** and avoiding all forms of central management.

Netherlands

A community care model focusing on elder care

What can we learn from the Netherlands?

- **Shift care** from secondary to primary care and from doctors to nurses.
- Adapt services offering to **population health needs**.
- Create an **ecosystem for innovating** in health service delivery.
- A flattened management structure, supportive IT and empowered community nurses are the key of **Buurtzorg's success**.
- Increasing community nurses' **autonomy and expanding their scope of service** to their competencies leads to positive results in the quadruple aim of better care, efficiency, and enhanced patient and professional experience.

Slovenia

A century-long tradition of community nursing

Health system

- **Social health insurance** system since 1992
- One of the **strongest primary health care** systems in Europe (Kringos et al, 2015)
- PHC is funded through service contracts with the Health Insurance Institute of Slovenia (**HIF**)
- Ministry of Health owns and manages all public hospitals and national institutes while **local governments** own and run community health centres (CHC).
- Governance tiers helps to adapt services to local needs, but it is a source of **fragmentation** and can hamper coordination across levels of care.
- All CHCs have a contract with the HIF that is funded with **payroll taxes**.
- Service contracts include **performance incentives** to improve PHC.

Slovenia

A century-long tradition of community nursing

Organisation of services

- 57 CHCs provide services to 459 locations.
- Most are **owned** by local governments and the rest are **concessions** to private doctors.
- **Multidisciplinary teams** include general practitioners (GPs), specialists in family medicine, paediatricians, gynaecologists, dentists, community nurses (patronage nurses), nurse practitioners (NPs), midwives, pharmacists, physiotherapists, kinesiologists, psychologists.
- **Health promotion centres** were established in some CHCs to support and enable positive lifestyle changes, with Norwegian funding.
- The Strategy of development of nursing and health care in the Republic of Slovenia for the period from 2011 to 2020 defines the **key activities** for the field of health care within community health nursing.

Slovenia

A century-long tradition of community nursing

Patronage nurses

- The first regulation of community nursing was enacted in **1919**.
- Slovenes have the **right to community nursing** services as a constituent component of primary health services
- Community nurses are an important pillar of primary care services in Slovenia providing services to **2 500** inhabitants.
- They operate as an **organizational unit** of basic nursing and provide health promotion and preventive care services to individuals, families and groups wherever they live and work, including at home, in social care institutions and in the community.
- They can work as **employees or concessionaires** (under capitation and fee-for-service).
- It exists a **strong nursing association** with a section on community nurses that advocates for nursing matters.

Slovenia

A century-long tradition of community nursing

What can we learn from Slovenia?

- People-centred, integrated primary care can generate rapid improvements in health outcomes, inequities and financial protection, to progress towards **UHC**.
- The role of the **national coordination of community nurses** at the National Institute of Public Health has accelerated their consolidation through a registry of activity and development of guidelines.
- At local level, the **autonomy of community health departments** in CHCs has helped to increase outreach.
- An **integral approach** to community nursing has been achieved by visiting families from new-borns to elders.

8 drivers for a successful implementation

1. Community care centres hinged on PHC
2. Central regulation in order to avoid fragmentation and guarantee equal and standard opportunities for all
3. Training of professional to achieve change management and cultural change
4. Changing perspective of care delivery, empowering patients
5. Shared guidelines and healthcare pathways in order to guarantee continuity of care between professionals and between different healthcare settings
6. Information System to feed circulation of data (EHR) and monitoring processes
7. Family doctors network acting as gatekeeper
8. Keep population informed in order to facilitate access to services, collect their feedback, rise awareness, set tailored solutions and increase compliance.

5 concluding recommendations

1. Focus on **population health needs** to define the scope of practice of community health centres and professionals.
2. The key element for a successful community care is its **integration with existing primary care structures**. It increases accessibility, responsiveness and reduces referrals to secondary care and hospitals.
3. Specific primary health care **governance at central level** facilitates planning and implementation of community health.
4. **Professional training and information campaigns** are key strategies to achieve change management and tackle cultural change, improving patient empowerment and compliance to therapies.
5. **IT systems** enable collaboration and networking among stakeholders, support implementation and monitoring, and set the scene for health service innovations.

Thank you

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