Five strategies for improving primary care

Easy access to high-quality primary care is a prerequisite for good public health. Five strategies can be used—alone or in combination—to improve the delivery of primary care.

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Primary care is pivotal to any health system. For most patients, primary care physicians are the health system's "face"—the providers they see most often and the ones with whom they develop long-term relationships.

Most countries have found it hard to deliver good primary care, though. Research we recently conducted in multiple European countries uncovered similar problems in all of them. A growing number of patients, for example, are dissatisfied with their ability to get access to primary care services. The productivity of many primary care physicians is declining, and the quality of care delivered varies widely.

There is a better way. Health systems and payors can use five strategies—alone or in combination—to improve their primary care services: they can increase competition among primary care physicians, tighten their contracting and reimbursement mechanisms, strengthen their performance-management systems, improve their operating models, and increase the integration of primary care with secondary care and social care.

Challenges to primary care delivery

In virtually all health systems, primary care physicians—typically, general practitioners (GPs)—are the clinicians most patients see first when they have a health problem, as well as the clinicians they see most often. Our studies have shown, for example, that 70 percent of all interactions UK patients have with the health system are with GPs. These physicians handle their patients' ordinary health problems themselves, and they coordinate with the rest of the health system when advanced care is needed. In some health systems, GPs also coordinate with social services and other community care agencies to ensure that their patients receive appropriate support at home.

To understand how well primary care is currently being delivered in Western Europe, we analyzed data from six countries: France, Germany, the Netherlands, Spain, Sweden, and the United Kingdom. Some of these countries rely principally on taxes to cover the cost of health care; the other systems are insurance based. Although the countries differ in their approach to primary care in several ways (Exhibit 1), some general conclusions can be drawn. In insurance-based systems, most GPs are independent practitioners who work in comparatively small clinics and are reimbursed (in whole or in part) on a fee-for-service basis. Because market forces tend to be stronger in these countries, they often have more GPs per capita than countries with tax-based funding do. In contrast, the GPs in tax-based systems are usually public employees who work in larger clinics; capitation plays a more significant role in the mixed funding models used to pay these physicians.

However, all of the countries face significant challenges in delivering primary care. These challenges can be grouped into six interrelated categories:

Access: In many countries, patients are dissatisfied with their ability to see GPs in a timely fashion. As a result, some patients present to the emergency room for treatment instead, driving up overall health system costs. Other patients delay seeking help or go without needed care, which often results in more complications and higher costs (this is particularly likely to occur when the patients have chronic conditions, such as diabetes). We have found that poor access to care is a problem in most health systems, but it is

Exhibit 1

Different approaches

Tax-based and insurance-based health systems often take different approaches to primary care.

		General practitioners (GPs), per 1,000 population	Role of GPs	Structure		
				Market rules	Models of care	Financing
Tax based	Sweden	0.6	Varies by region	80% public	51% of clinics have more than 5 doctors	Mix of budget, fee for service, and capitation
	United Kingdom	0.7	Gatekeeper	80% quasi-independent	2 doctors per clinic	Capitation with incentives
	Spain	0.7	Gatekeeper	90% public	4–6 doctors per health care center	Salary and capitation per person
Insurance based	Germany	1.0	No gatekeeper	100% independent	60% of clinics have 1 doctor	Fee for service
	France	0.9	Gatekeeper	70% independent	40% of clinics have 1 doctor	Fee for service
	Netherlands	1.8	Gatekeeper	100% independent	83% of clinics have 1–2 doctors	Capitation fee and payment per procedure

Source: Organisation for Economic Co-operation and Development (OECD), *Health Data 2008*; Vektis; McKinsey analysis

particularly acute in tax-based systems because of their lower number of GPs per capita. In Sweden, for example, many patients report that they cannot get timely access to their GP, especially by telephone.[1] Achieving the right level of access is a significant challenge for all health systems, because costs can rise dramatically if patients find it too easy to access care.[2] Furthermore, easier access to GPs does not necessarily result in a lower number of specialist consultations, as some Swedish payors have discovered. Nevertheless, long wait times for treatment frustrate patients and make an otherwise good health system look as if it is performing poorly in the public's eyes.

Workforce supply: Even countries with insurance-based funding often have a shortage of GPs for a simple reason: many physicians in training do not view primary care as intellectually challenging or economically attractive. Surveys in several countries have shown that fewer than 20 percent of medical students are interested in becoming GPs.[3] Furthermore, the shortage of GPs is likely to get worse in coming years as the baby boom generation moves into retirement. In Germany, for example, the average age of physicians has risen substantially in the past 15 years (Exhibit 2). As the older GPs retire, there is likely to be an insufficient number of replacements available.

Productivity: GP productivity (as measured by the number of patients seen by a physician per week or the number of patients in a given GP's practice) often varies markedly—not only between countries but also between regions in the same country, between different GP offices, and even between individual doctors in the same office. In Spain, for example, GP productivity is twice as high in Baleares as it is in Castilla y León (Exhibit 3). The differences in productivity remain even after the analyses are adjusted for patient demographics and other relevant factors, which suggests that significant opportunities to improve GP productivity exist. Taking advantage of those opportunities is becoming increasingly important, because GP productivity is declining in some

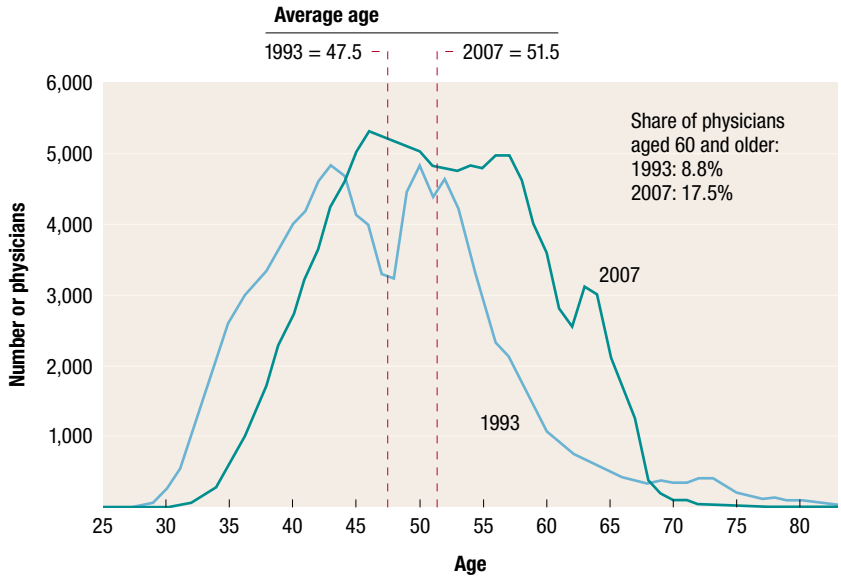
[1] *Väntetider i vården,* vantetider.se.
[2] For insight into how easy access to care has driven up Japan's health care costs, see "Reforming Japan's health system," p. 36.
[3] D. S. Furmedge, "General practice stigma at medical school and beyond—do we need to take action?" *British Journal of General Practice*, 2008, Volume 58, Number 553, p. 581; B. Ali, M. Jones, "Do medical students want to become GPs?" *British Journal of General Practice*, 2003, Volume 53, Number 488, p. 241; E. D. Avgerinos et al., "Greek medical students' career choices indicate strong tendency towards specialization and training abroad," *Health Policy*, 2006, Volume 79, pp. 101–6; and B. Wright, "Career choice of new medical students at three Canadian universities: family medicine versus specialty medicine," *Canadian Medical Association Journal*, 2004, Volume 170, pp. 1920–24.

Exhibit 2

Aging physicians

The number of physicians in Germany aged 60 and older is increasing.

Comparison 1993 vs 2007



Source: German National Association of Statutory Health Insurance Physicians; McKinsey analysis

countries. The productivity of British GPs, for example, has dropped sharply in the past 15 years despite the fact that the government has markedly increased what it pays them.[4] (The United Kingdom is the exception to the general rule that primary care is financially unattractive.) Whether GP productivity is higher in insurance-based systems than in tax-based ones is currently unclear, because insurance-based systems do not typically measure GP productivity.

Quality: A challenge that all countries face is how to ensure that the quality of care delivered by GPs is high; indeed, most health systems—and the payors within those systems—acknowledge that this challenge is one of their core concerns. Unfortunately, very little reliable information is available to enable them to gauge the relative quality of primary care services. There is currently little consensus about what the best quality metrics for primary care should be (for instance, which evidence-based practices should be considered the standard of care). And given that GPs are often widely dispersed throughout their communities, it is often quite difficult for health systems and payors to determine what care has actually been delivered. The United Kingdom has attempted to improve the quality of its primary care services through a new program, the Quality and Outcomes Framework (QOF), which gives GPs additional payments if they meet specified outcome metrics (for instance, the percentage of hypertensive patients whose blood pressure is lowered to the normal range). The program has been successful in focusing attention and improving scores on those metrics, but it has become clear that a GP's performance on those metrics does not always reflect the overall quality of his or her practice.

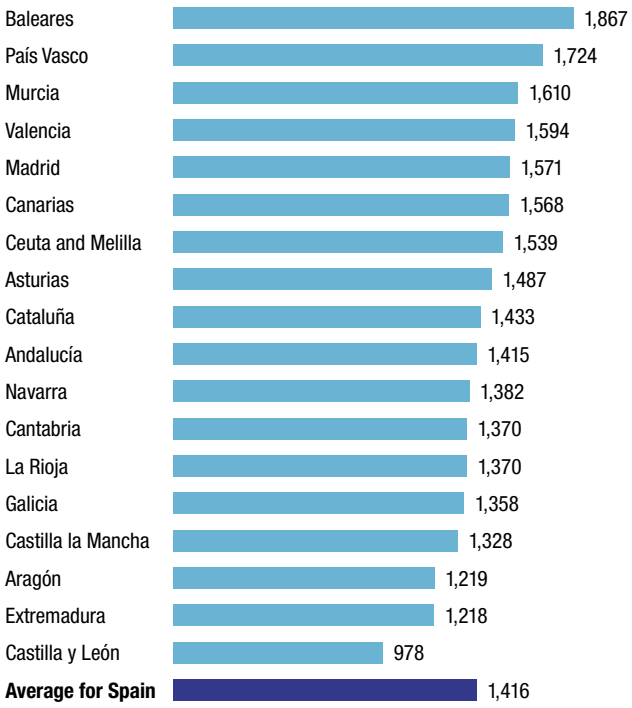
[4] NHS Information Centre, 2006–07 GP workload survey; NHS Information Centre, GP earnings and expenses enquiry 2006–07.

Exhibit 3

Variable productivity in Spain

There are vast differences in productivity among general practitioners in Spain.

Number of health care cards by general practitioner (GP) in the region, 2007



Source: Spanish Ministry of Health; McKinsey analysis

Integration: Another major challenge that all of the countries face is how to better integrate primary care with the rest of the health system. Regardless of whether or not GPs serve as a health system's gatekeepers, they are typically responsible for coordinating with all of the other providers that deliver care to a given patient. However, few health systems have established the communication channels that would enable GPs to do this effectively. This is true even in tax-based systems with comparatively few stakeholders. In Sweden, for example, the regional health authorities are responsible for providing both primary care *and* hospital care; the municipalities are responsible for providing geriatric care. The two groups have put considerable effort into designing care-planning processes to better coordinate the services delivered by primary care, hospital care, and geriatric care providers. Nevertheless, coordination remains suboptimal, which most regional health authorities view as one of the health system's key deficiencies.

Regional variations: It is not only GP productivity that varies widely within countries—so do many other factors that affect the delivery of primary care. For example, many countries have long found it difficult to recruit GPs to rural areas and low-income neighborhoods. However, lifestyle concerns, such as a desire for good weather, also contribute to regional variations in

care availability. The south of France, for example, has markedly more GPs per capita than do the northwestern parts of that country (Exhibit 4). Similar variations in the quality of primary care services have also been documented in many countries. The result of these regional variations is unacceptable differences in service levels for inhabitants of the same country.

Strategies for improving primary care delivery

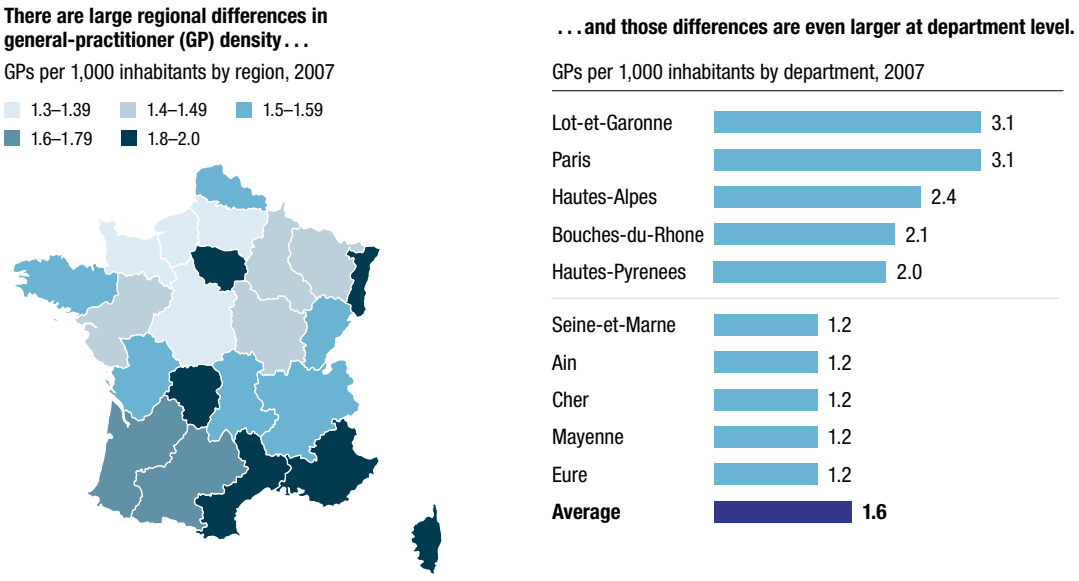
Our experience working in countries around the world reveals that there are five levers health systems and payors can use to improve primary care. In general, it is usually payors who have the greatest control over most of these levers; however, health systems can greatly increase the effectiveness of the levers (particularly increased competition and integration) through supporting policies. It is not necessary that all five levers be pulled; the ones selected should depend on the particular challenges the payor and health system face and the issues they want to prioritize. Here, we describe the five levers; in the next section, we provide examples of how different combinations of approaches have been used to improve primary care.

Increased private provision/competition: In both tax-based and insurance-based systems, competition is a way to increase GP

Exhibit 4

General-practitioner availability in France

Throughout France, the number of general practitioners varies widely by region.



Source: DREES; report of Mr. Ritter to the Ministry of Health on the creation of Regional Health Agencies, January 2008; McKinsey analysis

productivity and the quality of care, because it signals to physicians that they will have to perform better if they want to retain their contracts and patients. Competition can be introduced in several ways. For example, payors can use their tendering process to promote competition among the GPs they currently contract with. They can also encourage new GPs to enter the market in areas with local monopolies. For competition to be effective in improving primary care, however, patients must be able to choose freely among providers. Real patient choice requires that there be easily available information about GP performance, few bureaucratic barriers to switching providers, and a geographic spread of GPs (to ensure that changing physicians does not entail unreasonable additional travel time for patients).

Tightened contracting and reimbursement: Many payors, particularly those in tax-based systems, use block contracts or calculate their reimbursement to GPs based partially or wholly on historical patterns (for instance, the number of patients seen in the previous year). However, these approaches do not reflect current activity levels or quality of care. By tightening their contracting and altering their reimbursement formulas, payors can ensure that the money they are spending rewards higher levels of activity and increases patients' access to care. For example, payors can agree to reimburse for some forms of treatment on a fee-for-service basis. They can also use pay-for-performance or other financial incentives to encourage improved quality.

There is, however, a danger that payors should be aware of if they opt to pull this lever. As they move away from block contracts and historically based funding, payors must make sure that they have established safeguards to prevent providers from overdelivering health services. When reimbursement is based solely on activity levels, some physicians may be tempted to provide more services than are medically necessary. To minimize this risk, payors should put controls in place so that they can compare what services are delivered and what services are necessary. This will require them to define the types of care that should be given to patients with the conditions most commonly treated in primary care (for example, diabetes, hypertension, asthma) and to build the types of IT systems that would enable them to compare care delivered against care needed.

Strengthened performance management: Strong performance management is crucial for driving sustainable improvement in primary care. It includes three key elements: first, payors must define the standards by which they will measure primary care performance and develop a balanced scorecard that will enable them to segment GPs and establish a clear segmentation (or rating) based on their performance. To ensure simplicity and focus, the scorecard should include only a manageable number of appropriate metrics, but the metrics must be diverse to make certain that they encourage the right behaviors—thus, the scorecard should include metrics that assess population-wide preventive measures (for example, vaccination coverage), patient outcomes (such as mortality or admissions rates), and disease-management efforts (for instance, blood-pressure and cholesterol levels). The selected metrics should also be explicitly linked to any performance goals included in contracts or incentive schemes. Second, a management process that includes regular performance dialogues must be put in place; the frequency of monitoring should be

proportionate to each GP's rating. Third, a set of interventions to address underperformance must be established. The performance-management system—and its implications—should be communicated clearly to all GPs.

Improving the operating model: This lever is conceptually simple but often difficult to implement. For example, it often makes a great deal of sense to move physicians away from small (often solo) practices and into larger primary care practices or polyclinics (which include a wider variety of services, including diagnostics and outpatient clinics). Larger practices and polyclinics allow physicians to achieve economies of scale in some areas, such as administration. Furthermore, having a mix of physicians working together can improve quality and provide a more attractive working environment for new physicians (which might then help increase the workforce supply).

If a health system does decide to change its primary care operating model, it should consider a question even more radical than where physicians should work—it should ask whether certain primary care services need to be delivered by physicians at all. In the United States, for example, certain nurses with advanced training (nurse practitioners) are legally able to perform physical examinations, take patient histories, prescribe drugs, and administer many other basic treatments. Nurse practitioners can usually provide these services at a much lower rate than physicians typically can, but with comparable quality.

Increased integration: As we discussed earlier, GPs are typically responsible for coordinating with all the other health professionals and organizations that provide care for a patient. Coordination is hampered, however, by the fact that few health systems have effective methods for ensuring that information is transmitted to the appropriate places. Ensuring that such communication takes place does not require that all providers be part of a single organization. However, it does require that all providers commit to sharing information and coordinating care and that a strong IT system operating on a joint platform is available to facilitate data exchange. Payors can encourage this type of alignment through their contracting (for instance, by requiring the providers to report the same set of metrics).

How these levers have been used

The levers we just described can be used in various combinations to enhance the delivery of primary care services. In Sweden, for example, several regional health authorities have used competition, contracting, and reimbursement. In London, a primary care trust (PCT) has focused on competition and performance management. In Germany, a private payor changed its operating model and its approach to contracting.

Swedish primary care reform—Vårdval

In response to concerns from politicians about poor access to primary care, 3 of the 21 regional health authorities in Sweden have launched primary care reform programs called Vårdval, and several additional authorities are planning to launch similar programs. The reforms have focused primarily on three areas: improving each patient's opportunity to choose among GPs, increasing the number of private providers, and having reimbursement follow each patient's choice of provider. Because there are a number of design choices in each of these areas, the regional health authorities have implemented their reforms in slightly different ways.

Although the reforms are still in their early days, initial results suggest that the regional health authorities are increasing access to care. In the Stockholm area, for example, results from the first six months show that patient visits to GPs rose by 12 percent, and most of the increase occurred in previously underserved areas. Furthermore, the number of GP offices grew by 10 percent; the percentage of patients listed with specific GPs rose to 91 percent, from 87 percent; and patients' satisfaction with access times increased to 82 percent, from 76 percent.[5]

All of the regional health authorities will be continuously evaluating the results of their reforms, and they plan to adjust their efforts as needed to counteract any negative effects they detect (for example, decreased attractiveness of practicing medicine in socioeconomically deprived areas, lower prioritization of patients in certain age groups). In addition, the regional health authorities are reviewing their reimbursement models to ensure that, to as large an extent as is possible, the models reimburse for actual care delivered.

Primary care reform is likely to become more widespread in Sweden, because the government is planning to enact a law requiring all regional health authorities to introduce Vårdval reforms. The law focuses on the free establishment of GP offices and reimbursement that follows patients' free choice of providers.

[5] *"Vårdval Stockholm 2008 – Första Kartläggningen," Hälso- och sjukvårdnämndens förvaltning.*

London PCT

This PCT, which covers one of the most deprived areas of London, had the worst record for primary care access in England. It was also concerned that at least some of the primary care services it was paying for were suboptimal. It therefore decided to employ two levers—competition and performance management—to improve care access and quality.

In England, GPs are private practitioners who contract with the PCTs to provide patient care. Thus, they theoretically compete with each other, but in reality, this does not often occur. To introduce competition, this PCT contracted with a private company to staff a large polyclinic. It also removed several of the worst-performing GPs from its rolls. In addition, the PCT took a number of steps to improve the performance of its weaker GPs; for example, it analyzed the problems their practices were encountering, gave them specific recommendations for change, and then developed a suite of tools they could use to strengthen their operations. In addition, the PCT implemented new procedures that strengthened its ability to assess the GPs' performance. The PCT then announced that it would monitor the GPs' performance and require them to report certain metrics.

The effect of these changes was dramatic. Many of the local GPs realized that they would have to provide better access and better care quality if they wanted to retain their patients, and their productivity rose markedly. Access to primary care also improved significantly; on one national survey, this PCT showed greater improvement than any other PCT did. As a result, the number of patients who sought treatment in the PCT's emergency rooms has dropped and patient satisfaction has risen substantially.

By increasing competition and strengthening performance management, the PCT was able to increase its primary care capacity by a third. Furthermore, it has been able to sustain the improvements through ongoing performance management, including regular assessment of key access metrics.

German private payor

A large health insurer in Germany wanted to get better control over its health care costs and, simultaneously, improve the quality of the care it was paying for. It therefore took advantage of changes to German law that would allow it to contract for services directly with physicians (previously, the country's medical associations had served as intermediaries).

Under the new contract, a GP signs up patients, who agree to use that GP as their primary point of contact for health care. The insurer pays the GP an annual flat amount for each beneficiary he or she signs up and a quarterly flat amount for each patient actually seen; the GP is also given additional amounts for treating chronically ill patients and performing certain preventive services (for example, screenings). The new contract is attractive to GPs because it increases their earning potential significantly (previously, they were at a severe economic disadvantage to specialists), but it also increases their overall responsibility for health care costs. For example, the GPs must consent to meet certain performance targets, such as restrictions on their prescription-writing behavior. They must also agree to work more closely with the insurer and to meet periodically with company representatives to discuss how they can improve the quality and efficiency of the care they deliver. To encourage patients to use their GPs as gatekeepers and accept restrictions on their access to specialists, the insurer waives the quarterly copayment fees for physician visits.

The new contracts were introduced only in May 2008, and thus it is too early to tell what their long-term impact on health care costs will be. However, the insurer has already reported that it is signing up thousands of patients each week and is on track to meet its enrollment targets.

Any payor or health system that wants to use one or more of these levers to improve primary care services must first define the problem it is trying to correct; it must also consider the feasibility of implementation. In addition, the payor or health system must remember that it should not try to do too much at once; focus is crucial when the reforms will affect a large number of diverse providers. It is also crucial that the GPs be engaged in the reforms throughout the process; they must be given a clear understanding of how the changes will benefit them—and the patients they serve. +

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