RESEARCH PAPER

The World Health Report 2008 – Primary Healthcare: How Wide Is the Gap between Its Agenda and Implementation in 12 High-Income Health Systems?

Le Rapport sur la santé dans le monde 2008 – Les soins de santé primaires : quel est l'écart entre le programme et la mise en œuvre dans 12 systèmes de santé de pays à revenu élevé?

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The World Health Report 2008 – Primary Healthcare

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Abstract

Background: The World Health Organization's 2008 report asserted that the focus on primary healthcare (PHC) within health systems should increase, with four sets of reforms required. The WHO's PHC advocacy is well founded, yet its report is a policy document that fails to address adoption and implementation questions within WHO member countries. This paper examines the prospects for the WHO PHC agenda in 12 high-income health systems from Asia, Australasia, Europe and North America, comparing performances against the WHO agenda.
Methods: A health policy specialist on each of the 12 systems sketched policy activities in each of the four areas of concern to the WHO: (a) whether there is universal coverage, (b) service delivery reforms to build a PHC-oriented system, (c) reforms integrating public health initiatives into PHC settings and (d) leadership promoting dialogue among stakeholders.
Findings: All 12 systems demonstrate considerable gaps between the actual status of PHC and the WHO vision when assessed in terms of the four WHO reform dimensions, although many initiatives to enhance PHC have been implemented. Institutional arrangements pose significant barriers to PHC reform as envisioned by the WHO.
Conclusions: PHC reform requires more attention from policy makers. Meanwhile, the WHO PHC report is perhaps too idealistic and fails to address the fundamentals for successful policy adoption and implementation within member countries.

Résumé

Contexte : Le rapport 2008 de l'Organisation mondiale de la Santé affirme qu'il faut mettre plus d'accent sur les soins de santé primaires (SSP) dans les systèmes de santé, au moyen de quatre séries de réformes. Cette position de l'OMS est bien fondée, cependant le rapport est un document de politiques qui n'aborde pas les questions d'adoption et de mise en œuvre

dans les pays membres de l'OMS. Cet article étudie le potentiel du programme de l'OMS sur les SSP dans 12 systèmes de santé à revenu élevé en Asie, en Australasie, en Europe et en Amérique du Nord, en y comparant le rendement en fonction du programme de l'OMS.
Méthode : Pour chacun des 12 systèmes de santé, un spécialiste des politiques de santé a brossé le tableau des activités politiques liées aux champs d'intérêt de l'OMS : (a) présence ou non d'une couverture universelle, (b) réformes des prestations de services pour créer un système axé sur les SSP, (c) réformes qui intègrent les mesures de santé publique au sein des établissements de SSP et (d) leadership qui favorise le dialogue au sein des intervenants.
Résultats : Après évaluation en fonction des quatre volets de réforme proposés par l'OMS, chacun des 12 systèmes présente des écarts considérables entre le statut réel des SSP et la vision de l'OMS, bien que plusieurs initiatives d'accroissement des SSP y aient été mises en place. Les arrangements institutionnels constituent des obstacles considérables pour la réforme des SSP telle qu'envisagée par l'OMS.
Conclusions : La réforme des SSP nécessite plus d'attention de la part des responsables de politiques. Par ailleurs, le rapport de l'OMS sur les SSP est peut-être trop idéaliste et ne permet pas d'aborder les aspects fondamentaux qui visent une pleine adoption et la mise en œuvre des politiques dans les pays membres.

The 2008 World Health Report focused on the place of primary healthcare (PHC) in health systems (WHO 2008). Central to the report was the assertion that, in the 30 years since the 1978 WHO *Alma-Ata Declaration on Primary Health Care*, little has changed. WHO member countries have failed to implement policies that have at their core a commitment to PHC values and principles. Policies have tended to reinforce development of "selective" PHC focused on medical practitioners and services and treatment of specific conditions, which fall within a general definition of what might be called "primary care" (Marmor and White 2009; Starfield et al. 2005), as opposed to the WHO vision of "comprehensive" PHC, which links health to issues of social justice, equity, participation and broader social development (Rifkin and Walt 1986). Consequently, issues of access to healthcare services and equity of health outcomes continue to confront policy makers, while an imbalance within health systems has been promoted by a disproportionate investment in hospital-based services and technology (WHO 2008). Such investments and related medical specialization have contributed to fragmentation of care delivery. In response, the 2008 report argued that focusing on a set of PHC values, underpinned by placing "people at the centre of healthcare," is required to reorient systems towards the WHO goal of "health for all."

PHC Values and Policy Reforms

The WHO suggests that the translation of PHC values into practical policy requires four sets of PHC reforms:

1. Countries need to aim for universal coverage reforms to improve health equity, end exclusion and promote social justice.
2. Service delivery reforms should reorganize services around primary care. In this sense, the WHO argues that PHC should be the "hub from which patients are guided through the health system." PHC should be delivered by multiprofessional teams that provide comprehensive care, coordinate hospital and other specialized patient services, build partnerships with patients and promote disease prevention.
3. The WHO has advocated for public policy reforms that integrate public health initiatives into primary care delivery, but it also urges member states to work to promote health in the policies of other sectors that influence community behaviours and outcomes, and to aim for "intersectoral collaboration."
4. Leadership reforms need to steer away from either "command and control" or "laissez-faire disengagement" towards a participatory style that promotes "policy dialogue with multiple stakeholders – because this is what people expect, and because this is what works best" in the complex context of contemporary health systems.

The WHO's advocacy was well founded, as evidence shows that PHC makes a considerable contribution to health systems and outcomes (Starfield et al. 2005). The WHO recognized that implementing PHC reforms would have differing implications for different health systems. It noted that high-income systems, the focus of this paper, have scope for reallocating resources from tertiary to primary care, developing public policies with consideration for health and reducing exclusion. Yet, the WHO report is a policy document. As such, it is a set of ideas and recommendations designed to guide developments in member countries. It paid limited attention to the realities of health systems and their politics and, very importantly, questions of the adoption of the WHO agenda and then its implementation. The subject of many studies, implementation is what happens after a policy has been adopted; it is a practical process of getting ideas into place (Hill and Hupe 2002). The capacity for implementation is influenced by an array of factors including the nature of pre-existing institutional arrangements. Elsewhere referred to as "path dependency" (Tuohy 1999; Wilsford 1994), the embedded nature of institutions (the regulatory, financing and organizational arrangements as well as the traditions that govern how healthcare is delivered in a country) means that pursuing new directions is often a challenge. Issues such as the scope of change required to achieve a policy goal will influence potential for change, as will support from those who are affected (healthcare providers and the like) and whether the required mix of resources is available (Hogwood and Gunn 1984).

In light of these considerations, this paper looks at the adoption and then capacity for implementing the WHO PHC agenda in 12 high-income health systems. These represent different parts of the globe and are something of a convenience sample drawn from a research network: five systems are from Asia (Hong Kong, Japan, Singapore, South Korea, Taiwan), two from Australasia (Australia, New Zealand), three from Europe (Germany, Netherlands, United Kingdom) and two from North America (Canada, United States). In keeping with the

aim of this paper, the respective contributing authors each briefly described PHC policy and developments in the health system that they know best. In particular, they were asked to use the framework described above from the WHO 2008 report for four sets of PHC reforms to guide their contribution. The results are presented in Table 2 and in the country vignettes that follow. The paper then goes on to describe the present status of PHC in each of the health systems, the extent to which they might be able to embrace the WHO prescription and, in particular, whether the WHO four-point framework for PHC reform is attainable. In doing so, the authors focus on the gap between the WHO aspirations which, for analytical purposes, are used as a policy baseline that, in the WHO's view, countries should target, and the present situation. The discussion section reflects on the extent of this gap and considers barriers to moving the WHO agenda forward.

Background

Table 1 presents data on the 12 health jurisdictions, which are all market-based economies. The 12 systems have differing methods of funding healthcare. Australia, Canada, Hong Kong, New Zealand and the United Kingdom are tax funded, although Australia's Medicare scheme functions as a form of social insurance. Insurance underpins the funding of care in several of the systems, with different methods for each. Germany, Korea, Japan and Taiwan feature social insurance with a common fee payment schedule. Multiple organizations supply social insurance in Germany and Japan, while Korea and Taiwan have a single national insurer. The Netherlands has mandatory private insurance, while the United States has a mix of public and employer-based private insurance that covers different groups, with a considerable portion of the population uninsured. Mandatory medical savings accounts contribute to Singapore's funding. These differences are reflected in the funding of primary care. In several of the systems, primary care physicians are paid a fee for service, often from a mix of insurance (social or private), government funding and patient co-payments. The United Kingdom is unique in having a full capitation funding model that does not require patient co-payments. Hong Kong and Singapore have public safety-net clinics with very low patient fees for those unable to pay the full cost of unsubsidized private provision. Seven of the systems feature primary care gatekeeping; in the remainder, patients self-refer to specialists. Only New Zealand, the Netherlands and the United Kingdom require that patients formally enrol with a primary care physician, meaning capacity in the others for collecting data on and coordinating services for a population of patients is limited.

PHC in Five Asian Systems

Hong Kong

PHC in Hong Kong is dominated by private general practitioners (GPs), who also dispense their own prescription medicines. There are no government subsidies for private practitioners, so patients are charged full cost. That said, Hong Kong citizens do, in theory, have universal healthcare access because public hospitals waive standard charges when patients are unable to pay, and several government outpatient clinics provide PHC, although these typically have

TABLE 1. Key indicators comparing 12 health systems

	Asia					Australasia		Europe			North America	
	HK	**Japan**	**Singapore**	**South Korea**	**Taiwan**	**Australia**	**NZ**	**Germany**	**Netherlands**	**UK**	**Canada**	**USA**
Population (million)	7	127	4.7	48.5	23	21.2	4.2	82.3	16.7	61	33.4	307
% popn > 65 yrs	13.1	22.2	8.9	10.8	10.7	13.5	12.8	20.3	14.9	16.2	15.2	12.8
GDP/capita (US$ PPP)	42,700	32,600	50,300	28,000	29,800	38,800	27,300	34,100	39,200	35,200	38,400	46,400
Live births per woman	1.02	1.21	1.09	1.21	1.14	1.78	2.1	1.41	1.66	1.66	1.58	2.05
Infant mortality rate per 1,000 live births	2.9	2.6	2.3	4.1	4.9	4.2	4.8	3.8	4.1	5	5	6.7
Life expectancy	81.8	82.6	82	79.4	78	81.4	80.2	79.8	80.2	79.1	80.7	78.1
GDP health expenditure	5.5	8.1	4	6.8	6.2	8.7	9.2	10.4	9.8	8.4	10.1	16
Total health spending per capita (US$ PPP)	n/a	2,581	1,536	1,491	950	3,137	2,510	3,588	3,837	2,992	3,895	7,290
Public spending %	52	81.3	33	52.7	65.4	67.7	78	76.9	62.5*	81.7	69.8	45.4
Practising physicians per 1,000 popn	1.4	2.1	1.4	1.74	1.5	2.8	2.3	3.5	3.9	2.5	2.18	2.3
Ambulatory care physician consultations per capita	12**	13.6	5**	11.8	13.4***	6.3	4.7	7.5	5.7	5	5.8	3.8
PHC gatekeeping	yes	no	yes	no	no	yes	yes	no	yes	yes	yes	no
Formal enrolment policy	no	no	no	no	no	no	yes	no	yes	yes	no	no
PHC doctor payment system	FFS**** private / govt-funded clinics	mix FFS / social insurance	FFS private / govt-funded clinics	mix FFS / social insurance	mix FFS / social insurance	mix FFS / social insurance	FFS / capitation	mix FFS / social insurance	mix FFS / private insurance	capitation	FFS	FFS

Sources: CIA 2009; OECD 2009; WHO 2009

* 2002

** Authors' estimates derived from Census and Statistics Department 2009; Singapore Department of Statistics 2009

*** Chen et al. 2006

**** Fee for service

lower-quality service and long waiting times. These clinics provide around 20% of PHC consultations, with the remainder by private GPs (Wong et al. 2010).

Private GPs have traditionally worked in solo practice. Over the past decade, some groups that provide services for corporate insurers have emerged. Otherwise, there is little by way of PHC coordination. The government has periodically recommended that PHC be emphasized within the health system (Working Party on Primary Health Care 1990), but has lacked the will and capacity to implement change (Gould 2005). A 2008 consultation document again suggests a stronger role for PHC (Food and Health Bureau 2008), but concrete action has yet to result. The government runs various health promotion services, but these are separate initiatives. The lack of PHC and health system coordination was highlighted during the 2003 SARS outbreak (Loh 2004). There have been subsequent efforts for collaboration across the health and other sectors, including, in 2004, creation of a Centre for Health Protection and, since 2006, moves to build an electronic patient record system accessible by private and public providers. Finally, Hong Kong's health system has historically lacked leadership capacity; instead, decisions tend to be forged through exhaustive consultative committee processes dominated by elites, often resulting in a decision to defer commitment to any changes (Gauld and Gould 2002).

Japan

Japan has universal coverage through hybrid financing of social insurance premiums and taxes. PHC medical services are covered but not preventive public health and health promotion programs, which are contracted to separate providers and paid for directly by the government. The fees and rules for billing are set by the national fee schedule, based on fee for service. The patient co-payment rate is 30% but is reduced to 20% for children six or under, and 10% if patients are 70 or over with an income less than the average worker (Ikegami 2005).

The bulk of PHC is delivered by solo-practice doctors who usually have a specialist qualification. Very few medical schools have departments of general practice or family care. There are ENT and ophthalmology clinics, but two-thirds focus on internal medicine. There is no gatekeeping but, to encourage patients to visit PHC doctors first, patients incur an extra charge if they come without referral. Although doctors in clinics constitute only one-third of the total, they have tended to be more politically powerful than hospital specialists and are united in the Japan Medical Association, which negotiates the fee schedule with the government in a model that excludes broader stakeholder and public involvement. As a result, the fee schedule structure for clinic physicians has tended to favour services in PHC compared with hospital care, and their income is generally higher than that of hospital specialists. The government has expressed a desire to encourage more PHC, but policy activity remains focused on acute hospital services (Tatara and Okamoto 2009).

Singapore

Private GPs dominate PHC in Singapore, providing around 80% of consultations and acting as gatekeepers. They receive no government subsidies and dispense their own medicines,

with patients paying the full cost. Government-funded PHC is provided at polyclinics, where patient fees are subsidized and services extend to screening and health promotion. Co-payments remain central to healthcare funding in Singapore in keeping with its philosophy of "shared responsibility" between government and the public, and there is evidence that Singapore's funding model exacerbates inequity (Asher and Nandy 2006; WHO 2000).

Singapore features initiatives aimed at coordinating services for specific population groups. An example is HealthConnect, which aims to reorganize services around the needs of patients with chronic diseases and provide tools for them to better manage personal health. Such initiatives are underpinned by population health concepts. Another example is the Primary Care Partnership Scheme, which permits elderly patients to pay polyclinic rates for private GP consultations. A program driven by a major government hospital is designed to "empower" private GPs by providing them with access to hospital electronic patient records (Gauld 2012). Alongside this, Singapore has a strong health promotion focus in national health policy. In recent years, the government has attempted to redesign components of the health system, in particular, funding arrangements, and services to cope with increasing chronic disease and elderly patients. However, the leadership model remains firmly centralized, with limitations around public and stakeholder input (Barr 2005).

South Korea

Korea's National Health Insurance program provides universal healthcare coverage for the entire population. Healthcare delivery, including PHC, is mainly organized as a private sector–dominated system. Patient co-payments are a fixed percentage of costs, although the poor and elderly are exempted. Co-payments do not pose serious financial barriers to PHC access, and there is a maximum amount of cumulative co-payment in a given time period beyond which patients do not pay.

The role of PHC is limited. There is no incentive for providers to offer preventive or health promotion services, which are funded separately from physician services, and there is a lack of coordination between PHC and the health system. PHC is not clearly defined, and most physicians in Korea (including those in PHC) are board-certified specialists and work either as hospital employees or in their own clinics. Physician and hospital outpatient clinics operate separately from one another and compete for patients, and patients need not register with a PHC provider. Patients can directly visit specialists without restrictions. Referral is uncommon, as providers are reimbursed via social insurance through fee for service, and giving referrals means loss of income.

In addition to inefficient healthcare delivery, population aging calls for strengthening of PHC, but there has been little progress on this front. Hospitals are afraid that stronger PHC will threaten their large outpatient clinics, while office-based specialists oppose a PHC-centred health system because it may reduce their business. The current conservative (and pro-business) government does not have the political will for reform, with healthcare providers working predominantly in the private sector opposed to any change. Patients, for their part, are accus-

tomed to the freedom of choice of healthcare providers and are not willing to accept a system of PHC-led gatekeeping and referral (Chun et al. 2009; Kwon 2005; Kwon and Reich 2005).

Taiwan

The introduction of the National Health Insurance (NHI) in 1995 increased the proportion of the population with insurance coverage from 57% to 98%, ensuring almost universal coverage (Davis and Huang 2008). Taiwan has a highly competitive, market-driven healthcare system, with PHC providers paid on a fee-for-service basis on a fixed-fee schedule. NHI offers virtually unlimited choice, with no formal referral requirement, and people are free to choose any NHI-contracted hospital or community provider to receive care. Most GP clinics are solo practices. Taiwan has one of the highest outpatient visit-per-capita rates in the world, and as a result of short consultation times, patients receive limited advice on how to improve their health (Chang et al. 2005).

In response to rising expenditures, the NHI adopted a co-payment system, although it waives co-payments for certain groups such as veterans, chronic disease sufferers and those with low income. For the remainder, co-payments are small and provide little disincentive to overuse medicine. The lack of an integrated health promotion and prevention dimension to healthcare is a major deficiency of the NHI, and PHC remains neither coordinated nor integrated with other services. PHC physicians continue to decry their lack of influence in the centralized decision-making structures for setting NHI policy and payment schedules; the public similarly has minimal involvement in healthcare decision-making (Wen et al. 2008).

PHC in Two Australasian Health Systems

Australia

Australians of all ages are covered by the universal Medicare insurance scheme, which heavily subsidizes all healthcare costs. PHC services (including non-admitted hospital services) represent about 44% of total health expenditure (Deeble et al. 2008). Most PHC services are provided by private GPs. With Medicare subsidies, about 80% of GP consultations are free from co-payments (Medicare Australia Statistics 2009). GPs fulfill a gatekeeper role in the healthcare system, providing patient referrals for specialist services.

Numerous policy reforms have been implemented in general practice, commencing in 1991 with strategies to reward high-quality care and accredit GPs. The national Divisions of General Practice were established in 1992/1993 to promote GPs – traditionally in solo practice – working together. The divisions' role has since evolved and broadened into fundholding and allied health provision. A range of policy reforms over the next 15 years introduced incentives to promote immunization, employment of practice nurses and allied health workers, health assessments for older people and indigenous people, and multidisciplinary care planning for people with chronic diseases. This said, these developments and associated funding initiatives to promote GPs working alongside other professions have generated a complex system that does not function in an integrated manner.

A newly elected government in 2007 commenced a consultation process with a range of stakeholders. The current focus is the establishment of larger GP clinics across Australia that will provide a full range of PHC services, and the implementation of the First National Primary Healthcare Strategy and the National Preventative Health Strategy. However, there remains no joint decision-making structure nor a common vision for PHC (Healy et al. 2006).

New Zealand

PHC in New Zealand is predominantly provided by private GPs who receive government subsidies along with patient co-payments. In theory, all New Zealanders have universal healthcare access. However, while public hospitals are free of charge, a quarter of the population report not seeing a PHC provider when unwell because of co-payment barriers (Schoen et al. 2009a,b).

New Zealand GPs have always performed a gatekeeping role and, historically, worked in sole or small group practices. Through the 1990s, GPs organized into Independent Practitioner Associations – networks coordinating GP activities and funding contracts – that made inroads into population health planning (Malcolm and Mays 1999).

From 2003, the government aimed to bolster PHC. Most GPs are now members of Primary Health Organizations (PHOs) (Gauld and Mays 2006). Underpinned by Alma-Ata principles, PHOs are community governed, have an enrolled population and a multidisciplinary provider mix. Each receives government funding for improving service access for deprived populations, for chronic disease patients and for health promotion. PHOs are also expected to link with other health-promoting sectors. Planning for population health is thus making its way into PHC settings, while participatory leadership is the expected model, with requirements for stakeholder consultation in decision-making. However, challenges mostly related to funding complexities remain, including incapacity of many PHOs to provide comprehensive PHC, limited cross-sectoral activity and a historic lack of integration between primary and hospital care. Finally, despite its attempts, the government poorly managed the PHO reform process, failing to lay out a clear vision for the future (Gauld 2008). Since 2008, a new government is promoting creation of larger family medicine centres that offer minor surgical services.

PHC in Three European Health Systems

Germany

The Alma-Ata principles have never received much attention in German health policy. However, in line with them, and despite a long history of social insurance funding, universal insurance coverage was achieved for the first time only in 2009. Although health insurance is now mandatory, different levels of coverage exist. Higher-income groups can opt out of social insurance and purchase private insurance, with more than 10% of the population doing so (Bundesministerium fur Gesundheit 2009). Such patients have better access to medical care (e.g., shorter waiting times).

PHC in Germany is mainly provided by private GPs. The majority work in solo practices, with about 25% in shared practices (Busse and Riesberg 2004). Patients have free choice and

direct access to GPs and specialists, and many directly contact specialists without referral. In Germany, there is neither strong collaboration within multiprofessional teams, nor are patients obliged to visit their PHC doctor first before receiving specialist care.

Since the early 1990s, various measures have been taken to strengthen PHC. Payment reforms designed to promote enrolment with GPs and gatekeeping schemes were piloted and, from 2004, all social insurers were required to offer such. The same year also saw introduction of a co-payment for the first physician contact per quarter of the year, with an additional payment if the patient contacts further physicians without referral. Reforms have also aimed at promoting integrated care and preventive medicine initiatives, with limited success. The statutory health insurance has a long tradition of involving multiple stakeholders (with predominance of physician associations and social insurers) (Rothgang et al. 2005), but the focus has not necessarily been on improving PHC. The reforms since the 1990s have increased patients' choice (among insurers and service providers), but patients have never received a strong voice in the healthcare system.

The Netherlands

Since the reforms of 2006, all Dutch citizens are obliged to buy private health insurance, ensuring universal coverage (Westert et al. 2009). The insurers offer a basic care package that is updated annually by the government. Those under 18 are insured for free, with low-income groups receiving financial compensation by tax reduction (van de Ven and Schut 2006).

The PHC system in the Netherlands provides comprehensive medical care for all citizens. Care delivered by GPs is free to patients. Most GPs own their own practices and are reimbursed through capitation for registered patients and fee for service. GPs offer a range of services, including preventive services and management of chronic diseases. Every citizen is obliged to register with a PHC practice, with referrals needed for visits to hospitals and specialists. This approach has resulted in 92% of all new health problems being managed within PHC (Grol et al. 2010). Collaboration among practices has been increasing, with larger teams and organizational networks encouraged by additional payment for chronic care management, quality improvement initiatives and innovation. Care coordination is supported by national guidelines and care pathways for chronic diseases, introduction of practice nurses and physician assistants, and "care groups" that coordinate care through cooperating regional general practices. These collaborative groups do not include local health authorities, and recent studies show that coordination problems remain (Schafer et al. 2010).

A challenge for the Dutch government is to support collaborative and coordinated approaches to PHC delivery, for which the Dutch Association of Family Physicians has consistently advocated. Owing to concerns about the costs of funding new PHC initiatives, these two parties have been unable to reach agreement, meaning that leadership remains fragmented.

United Kingdom

The National Health Service (NHS) is funded through taxation and provides universal cov-

erage with largely uniform, comprehensive benefits. There are no co-payments for medical or hospital services and low co-payments for pharmaceuticals (children, pensioners, those on low income and with selected chronic conditions are exempt), with these being abolished in Wales, Scotland and Northern Ireland. Despite universal coverage, an absence of financial barriers and considerable investment in quality improvement, some important disparities persist in access to healthcare and quality (Millett et al. 2009).

Approximately 90% of contacts within the NHS take place in PHC, which is largely delivered by multidisciplinary teams in general practices. GPs are independent contractors who serve as gatekeepers. Pay for performance, introduced in 2004, rewards improvements in secondary prevention, but there is further scope to align PHC services with key public health priorities, including alcohol misuse and health inequalities (Strategic Review of Health Inequalities in England 2009).

There has been considerable emphasis on increasing patient involvement and professional leadership in local health service development over the past decade. In 2002, this led to the creation of 303 smaller primary care organizations (PCOs) in England. PCOs were tasked with improving population health by commissioning or directly providing services based on local need and working closely with health professionals, communities and local government. Efforts to build capacity were undermined in 2006 when the number of PCOs was reduced to 152 because of concerns that smaller organizations were ineffective at commissioning acute sector services. Practice-based commissioning was introduced in England in 2005 to engage PHC professionals in commissioning local services, but their response to this initiative has been variable. There have also been efforts to increase PHC accessibility with the development of walk-in polyclinics, telephone help lines and Internet-based information. The importance of local PHC leadership was reiterated in the 2008 white paper, "High Quality Care for All" (Department of Health 2008), but engagement with this document remains limited. In 2010, a new government announced plans for GPs to be responsible for all commissioning, with potential for an increased focus on PHC-based patient management. However, many questions remain about whether these reforms will succeed (Kirkpatrick and McCabe 2011).

PHC in Two North American Health Systems

Canada

Canada encompasses 13 separately run provincial and territorial healthcare systems subject to the 1984 *Canada Health Act* (Health Canada 2004). The provinces and territories have considerable scope to direct funding to various areas, meaning wide variation in the structure and organization of PHC. Canada's efforts to ensure universal coverage are restricted by the focus on hospital-based care and physician services within the health system. While family physicians have traditionally played a gatekeeper role, multidisciplinary team approaches to PHC require different funding mechanisms to pay for non-physician services outside of acute care settings, and these are highly variable. Similarly, while medications must be covered by provincial/territorial healthcare systems when provided within in-patient hospital settings, the same

drugs are not required to be covered when prescribed in ambulatory settings.

Service delivery reforms vary both across and within provinces and territories, reflecting multiple models and approaches (Hutchison 2008). While physician payment models (e.g., capitation, fee-for-service and blended models) and financial incentives (e.g., pay for performance) have driven many reforms, other approaches, including accountability agreements and multidisciplinary integrated delivery models, have been established in a number of provinces/territories (Hutchison 2008). While the capacity to evaluate the impact of the varying approaches has been questioned (Starfield 2008), the lack of established infrastructure to support electronic health records and information systems has been noted as a fundamental flaw (Watson 2009).

Surveys suggest that Canada's PHC system performs poorly (Schoen et al. 2006, 2009a). The various difficulties with PHC organization in Canada are widely recognized and have led to a series of recent reviews, reforms and large-scale funding initiatives (e.g., Primary Health Care Transition Fund) (Health Council of Canada 2010). National bodies and the federal government continue to lack direct influence over provincially/territorially run healthcare systems, while medical associations exert significant influence, both positively and negatively, on the advancement of reforms.

United States

PHC in the United States is delivered through a variety of clinical settings, including physicians' offices, hospital outpatient departments, hospital emergency departments and freestanding clinics and neighbourhood health centres in urban areas. Between 1990 and 2006, the proportion of patients' office visits to specialists rose from 36% to 43%, while visits to general and family practice physicians decreased from 30% to 23% (National Center for Health Statistics 2009). There is limited gatekeeping within the US system.

Access to PHC is a major policy concern, with more than 16% of the population lacking health insurance and PHC physicians in short supply (National Center for Health Statistics 2009). It is expected that federal reforms enacted in 2010 will cut the uninsured rate by two-thirds and improve access for lower-income families (US Congress 2010).

Growing interest in two service delivery initiatives is likely to accelerate under the new reforms. The patient-centred medical home (PCMH) model combines continuous, comprehensive and coordinated PHC with increased use of information systems and tools (electronic medical records, e-prescribing), population-based management of chronic illness, quality improvement methods and payment reform methods that reward high performance (Rittenhouse et al. 2009). A complementary reform, the accountable care organization (ACO), may take different organizational forms, but in all cases providers are accountable for a defined population (Rittenhouse et al. 2009). Both PCMHs and ACOs are in early stages of adoption across the United States and face considerable implementation challenges.

Over the past two decades, the use of certain preventive services, such as vaccination, increased greatly (National Center for Health Statistics 2009). Newly enacted reforms emphasize preventive care and are expected to increase the spread of immunization and other preven-

tive practices (e.g., screening for chronic illnesses, such as diabetes and hypertension) across the country. Although PHC will benefit greatly from these payment and service delivery reforms, there is no comprehensive plan nor coordinated leadership around PHC developments.

Discussion: 12 Health Systems and the WHO Framework

Considered together, how close are the 12 health systems reviewed in this paper to satisfying the WHO's prescription for PHC? The following sections discuss performances across the four WHO reform dimensions outlined earlier in this paper and highlighted in Table 2.

TABLE 2. Progress in 12 health systems on four WHO PHC reform dimensions

		Universal Coverage Reforms	Service Delivery Reforms	Public Policy Reforms	Leadership Reforms
Asia	Hong Kong	Little progress in reforming historical institutional arrangements. No government or social insurance funding.	Recognition that these are required; plans outlined, but limited action yet.	Various initiatives but not coordinated or linked with PHC.	No changes to traditional decision-making methods.
	Japan	Varied access to service and prevention services, with patient co-payments.	Little progress in changing the current system of service delivery.	Government interested in promoting PHC, but emphasis remains on hospital care.	No changes to traditional decision-making methods.
	Singapore	Attempts to increase access, but cost barriers and inequities remain.	Some changes to improve services for chronic disease and other patients.	Some initiatives implemented, but limited population coverage.	No changes to traditional decision-making methods.
	South Korea	Universal access to PHC with few barriers and little restriction other than co-payments.	Little progress in changing the current system of service delivery.	No initiatives implemented, but some discussions on reform began recently.	No changes to traditional decision-making methods.
	Taiwan	Universal access to PHC with few barriers and restrictions. Small co-payments.	Efforts but limited progress towards changing the service delivery system.	Since NHI, some initiatives but not coordinated or linked with PHC.	Some change in name but not substance.
Australasia	Australia	Universal PHC access is guaranteed through the Medicare scheme, with some co-payments.	Various funding reforms to improve collaboration among PHC providers and promote better chronic disease management. PHC remains separate from hospitals.	Expectations that PHC works collaboratively with other sectors, but restricted by funding complexity.	Divisions of General Practice promote PHC alongside government, but no common goals.
	New Zealand	Policy to reduce PHC charges, but these remain a barrier to genuine universal access.	PHOs created from 2003. PHC remains separate from hospitals; lack of patient coordinating capacity.	PHC gets funding for public health initiatives. Expected to coordinate with other sectors, but limited by funding.	Elected district health boards are expected to consult with stakeholders in planning.

TABLE 2. Continued

Europe	Germany	Universal coverage introduced in 2009; 10€ co-payment introduced in 2004 set an incentive to visit the GP first, but constrains access for lower-income groups.	Besides pilot projects or rather weak incentives (to strengthen integrated care), no major service delivery reform has taken place. PHC remains separate from hospitals; lack of patient coordinating capacity.	Sickness funds can spend a very limited amount on public policy measures.	Doctors' associations and sickness funds are still the main stakeholders in the system.
	Netherlands	Every citizen has private health insurance; PHC is free of charge.	Collaborative groups offer 24-hour PHC services; these groups offer care for chronic patients, such as diabetes and COPD, but remain separate from hospitals.	Health insurers increasingly take initiatives to set up prevention programs, involving schools and PHC disciplines.	Doctors' association and government are main stakeholders, but do not as yet have common goals for PHC.
	UK	Universal access is provided by government funding. Co-payments for pharmaceuticals being abolished in Scotland, Wales and Northern Ireland.	PCOs created in 2002 but restructured in 2006. Major pay-for-performance incentive for GPs introduced in 2004. Moves to better integrate primary, community and secondary care services.	Focus of financial incentives has been secondary prevention. Better alignment of PHC with major public health priorities needed. PCO engagement with local governments on public health agenda variable.	PCOs developed to improve professional and patient engagement. Practice-based commissioning.
North America	Canada	Universal coverage is governed by the *Canada Health Act*. This limits coverage of non–hospital-based care to physician services, representing a major hurdle for progress.	Key service delivery reforms reflect efforts to establish electronic health records and multidisciplinary teams. However, these are highly variable across the provincial health systems.	A number of national primary care policy initiatives have been established over the last decade. However, with provincial jurisdictional responsibility for healthcare systems, primary care reforms lack coordination.	Regionalized governance of health services is dominant in most provincial systems, although there are recent examples of shifts to more centralized governance in Alberta and Prince Edward Island.
	United States	Insurance and payment reforms expected to cut the uninsured rate by two-thirds, with improved access to PHC for lower-income families.	PCMHs and ACOs expected to increase under reforms and strengthen PHC delivery, but PHC mostly separate from hospitals.	Reforms emphasize preventive services in PHC, especially immunizations and screening for chronic illnesses.	Payment and service delivery reforms will aid PHC, but there is no coordinated leadership around PHC.

Universal coverage reforms

Universal coverage has been achieved to varying degrees across the systems. The United States remains the farthest from this goal and, although the 2010 insurance reforms will address some of the shortfall, implementation challenges persist. Canada, the Netherlands and the United Kingdom stand out for providing universal coverage with no patient fees. However, coverage is restricted largely to PHC medical practitioners, with restricted involvement of other PHC professionals. Australia, Germany and New Zealand have similarly limited scope (although, as discussed below, there have been initiatives to broaden this) with the additional

barrier of patient fees. The five Asian systems have each pursued different methods for universal coverage, although this is not necessarily an aim for all. Hong Kong and Singapore both provide a public safety net PHC system, but unsubsidized private providers continue to dominate. Social insurance, in theory, provides universal coverage in Japan, Korea and Taiwan but services are largely individual medical consultations, and patient charges are common.

Service delivery reforms

None of the 12 systems has undergone service delivery reforms of the type envisioned by the WHO. In only half do PHC providers perform a gatekeeping role, with the potential to be the hub for coordinating patient care. All 12 systems are notable for the fact that PHC remains separated from hospitals, with limited, if any, capacity for patient care coordination. However, in each, there have been varied attempts to develop service integration programs, create multidisciplinary PHC teams (in particular, Australia, Netherlands, New Zealand and the United Kingdom) and build better organizational foundations for PHC. Examples such as New Zealand's Primary Health Organizations and the United States' accountable care organization concept need wider support and implementation if the WHO goals are to be met. In some cases, such as Hong Kong and Taiwan, policy makers acknowledge a need for change, but progress towards service delivery reforms remains limited. Institutional arrangements appear to play a role in constraining capacity for change, given the embedded nature of the private delivery systems. That said, there have been examples, as in Singapore, aimed at improving chronic disease management.

Public policy reforms

Progress on public policy reforms is variable across the 12 systems, and none could be said to have delivered on the WHO goals or be aiming to do so. The Netherlands, New Zealand and the United Kingdom are possible exceptions, with their attempts to link PHC with other health-influencing policy sectors and to move public health programs into PHC service delivery settings. Funding and lack of other incentives, however, have limited the capacity for this, and these issues are common to the other systems. Canada has seen a number of policy initiatives emerging, but these lack coordination. Lack of coordination is likely also to be an obstacle for reforms in the United States, with its similarly complex federal political system. The five Asian systems appear to have weak prospects for public policy reforms. The emphasis within these systems remains predominantly on hospital care, and initiatives to promote public health have often been separate from PHC services or limited in their population coverage.

Leadership reforms

The WHO leadership prescription has also yet to emerge within each of the 12 health systems. In some systems there have been attempts to promote participatory decision-making with multiple stakeholders, particularly in New Zealand and the United Kingdom. However, common goals for PHC among stakeholders are lacking, as with all the other systems. Of course,

the federal political systems in Australia, Canada, Germany and the United States provide an additional barrier to building national consensus and direction. In the five Asian systems there have been no recent discernable changes to decision-making structures, with doctors' associations and the government the dominant stakeholders. These two actors sometimes collaborate, but often with quite separate agendas and not necessarily focused on PHC improvements.

Conclusion

This paper has reviewed 12 high-income health systems – representing different regions of the globe – in the endeavour to gauge the gap between present PHC policy and practice and the aspirations of the WHO as spelled out in its 2008 report. As noted early in the paper, the WHO report is a transnational policy document that provides a set of aims and a framework for policy makers and service providers to focus on when developing national health policy and seeking to improve health system performance. In contrast, this paper has focused on the extent to which health systems have been implementing a strong PHC agenda. The issue of implementation is, of course, a crucial and frequently neglected link in the policy cycle. As such, the analysis presented here is important for understanding whether prescriptions such as the WHO's are attainable and where efforts are required to overcome barriers to improving PHC. In this regard, three sets of issues demanding attention are evident.

1. *The substantial gap between the present status of PHC in the 12 systems and the WHO goals cannot be denied.* While PHC is an important policy theme in each of the 12 systems, it is not receiving the desired attention. One reason for this is the inadequate emphasis placed on PHC by policy makers, which is an age-old problem (WHO 1978). Another is the institutional arrangements underpinning health systems, and path dependency on these, which work against promoting PHC and broader system reforms and are often cited as a reason the status quo reigns (Blank and Burau 2010; Tuohy 1999; Wilsford 1994). The latter explanation is particularly relevant in the Asian systems, as well as in Australia, Canada, Germany and the United States. As noted in the discussion section above, in each of these systems, strongly embedded institutional arrangements – including investments in the status quo by the powerful medical profession in the Asian systems, by the insurance industry in the United States or simply the complexity of negotiating change in federal political systems – mean that it is difficult to achieve more than small incremental shifts in policy, even where there may be a desire to pursue new directions. As such, historically determined PHC arrangements and organizational forms remain firmly entrenched. This finding points to a need for policy makers to pursue health system redesign, with strengthening PHC as a focal point while working within existing institutional arrangements. Promisingly, as this paper shows, there have been signs of this progress across the 12 systems.
2. *PHC remains largely independent in each of the 12 health systems, both as a sector unto itself and in terms of the organization of practitioners and services within.* Arrangements such as

those advocated by the WHO – with PHC being the hub of a health system – are rare, even unusual. The systems reviewed in this paper that have moved in this direction still face considerable barriers to integrating the range of PHC services, including preventive programs, and developing partnerships with patients. The picture is similarly challenging when it comes to integrating with other health-influencing sectors, with the 12 systems examined in this paper a long way from this goal, although some have made a start with genuine aspirations for intersectoral collaboration. As argued in the WHO 2008 report, this approach should eventually translate into improved PHC and, ultimately, improved patient management, experiences and health outcomes. Yet whether action on all four of the WHO's policy levers is required for robust PHC remains an important question. In some cases, such as where there are strongly embedded institutional arrangements among different PHC providers – as in, for example, the United States – there may be a need for service delivery and leadership reforms above the other two WHO reform areas. That some of the 12 systems are acting on some WHO components but not others may also help explain the implementation gap: these systems are not dismissive of WHO goals for PHC; they instead have their own domestic agenda for PHC reform determined by political preferences, perceived public priorities and path dependency.

3. *The WHO prescription is perhaps too idealistic.* It is, after all, a policy document produced by an international agency that has limited capacity to do more than simply promote directions. McCoy (2006) has questioned whether governments act on WHO advice, suggesting greater monitoring of progress is necessary. However, this view overlooks some fundamental components of successful implementation (Exworthy et al. 2002; Hill and Hupe 2002). There is demand, firstly, for broad agreement on overall policy objectives. This paper implies that, when it comes to PHC, the activities of policy makers in only a few of the 12 systems were aligned with WHO goals. Secondly, the WHO document assumes that policy makers are able to enact and implement change. As noted, institutional arrangements in several of the 12 systems often work against such action. Thirdly, the WHO report presupposes that support exists from constituent agencies and actors for policy directions. As the situation presently stands, it could not be said of any of the 12 systems that the "leadership" model in place provides the basis for forging a consensus around PHC reform. The implication is that while there are differences between the 12 systems in terms of extent of and capacity for implementing the WHO agenda, there is also a disjuncture between what policy makers are agreeing to at a global level and what is achievable locally. Domestic policy makers may therefore need to advocate more strongly within their own health systems for WHO directions, or be more realistic in what they agree to in the drafting of international agreements.

Following from these observations, while the WHO report provides an important vision for PHC, the prospects for delivering on it, at least in the 12 systems that are the focus of this paper, appear limited.

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