The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I
The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
“Primary health care brings balance back to health care, and puts families and communities at the hub of the health system.”

“Primary health care also offers the best way of coping with the ills of life in the 21st century: the globalization of unhealthy lifestyles, rapid unplanned urbanization, and the ageing of populations.”
Myths About Specialty and Primary Care

- Specialty care is better than primary care
- Specialty care is complex; primary care is simple
- Specialty care (disease-focused) models are best for primary care (people-focused)
Myth #1: Specialty care is better than primary care
Primary Care Score vs. Health Care Expenditures, 1997

Per Capita Health Care Expenditures

Primary Care Score
Primary Care Strength and Premature Mortality in 18 OECD Countries

*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. \( R^2(\text{within})=0.77 \).

# Indonesia Infant Mortality

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary care*</th>
<th>Hospital*</th>
<th>Infant Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-1997</td>
<td>10.3</td>
<td>4.1</td>
<td>70% improvement in all provinces 1990-1996</td>
</tr>
<tr>
<td>1997-1998</td>
<td>9.6</td>
<td>4.1</td>
<td>14% worsening in 22 of 28 provinces after 1996</td>
</tr>
<tr>
<td>1998-1999</td>
<td>8.5</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>1999-2000</td>
<td>8.2</td>
<td>5.3</td>
<td></td>
</tr>
</tbody>
</table>

*constant Indonesian rupiah per capita, in billions

Chronic or non-communicable disease (NCD) represents about 2 out of 3 deaths worldwide, with 80% of those deaths in low and middle income countries (LMIC).
Non-communicable diseases (NCD)
(cancer, cardiovascular, chronic respiratory, diabetes, mental health)

- 84% health care spending
- 5% people represent 50% health care costs

Family Physician Visits

40.3%  Acute problem
17.7%  Acute problem follow up
16.9%  Chronic problem routine
  6.4%  Chronic problem flare
12.0%  Well exam
  1.4%  Counseling
  1.1%  Pregnancy care
  3.6%  Immunization, administrative

SCIENCE
Screening

Diagnosis

Treatment

Evidence

Guidelines

Performance Measures
How good is the evidence?

**Design:** Review of all original clinical research in 3 major general clinical journal or high-impact specialty journals from 1990-2003 that were cited more than 1000 times.

**Results:** Of 49 highly cited studies, 45 claimed that the intervention was effective.
- 7 (16%) contradicted by subsequent studies
- 7 (16%) found effects stronger than those of subsequent studies
- 20 (44%) were replicated
- 11 (24%) remained largely unchallenged

How good is the evidence?

Case of Hemoglobin A1c

- **ACCORD (N=10,251)** [NEJM 2008;358:2545-59.]

  0.29% greater annual death risk with intensive glucose control

- **ADVANCE (N=11,140)** [NEJM 2008;358:2560-72.]

  Intensive glucose control did not affect death rates or morbidity other than nephropathy.

- **VA Trial (N=1791)** [NEJM 2009;360:129-39.]

  Intensive glucose control did not improve outcomes.
Intensive glucose control in aged?

- ~30 million older Europeans with type 2 DM.
- Expected annual death rate: 1.14%
- Expected annual deaths: 390 000

Intensive glucose control in aged?

- ~30 million older Europeans with type 2 DM.
- Expected annual death rate: 1.14%
- Expected annual deaths: 390 000

- Annual death risk with intensive control: 1.43%
- Annual deaths intensive glucose control: 429 000
- Excess annual deaths with intensive control: 39 000

Mortality Outcomes

Primary care physicians: 1 per 10,000 (20%) more primary care physicians decreases mortality by 40 per 100,000 (5% fewer deaths).

Family Physicians: 1 per 10,000 (33%) more family physicians results decreases mortality by 70 per 100,000 (9% fewer deaths).

Specialists: 1 per 10,000 (8%) more specialists increases mortality by 16 per 100,000 (2% more deaths).

Equity effects of primary care

- Improves self-rated health
- Reduces disparities
- Reduces effects of income inequality

Starfield B et al. Milbank Quar 2005;83:457-502
Personal physician: primary care vs specialist

- 33% lower cost of care
- 19% less likely to die

Frank et al. J Fam Pract 1998;47:105-9
Myth #2: Specialty care is complex; primary care is simple
Complexity

- Average visit: 1.4 – 8 problems
- Diagnoses:
  - “ologist”: top 5 = 90%
  - family doctor: top 25 = 60% total

Primary Care Patients

- 40% new problems never fit any known diagnosis
- 75% of complaints are self-limited
  - 80% < 65 years; 40% > 65 years
- 40% have multiple co-morbid conditions
- 50% over 65 years have at least 3 chronic conditions
- 20% over 65 years have 5 or more chronic conditions
Number of problems in primary care patients (ICPC)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>4.9</td>
<td>5.0</td>
</tr>
<tr>
<td>15-44</td>
<td>4.5</td>
<td>7.3</td>
</tr>
<tr>
<td>45-69</td>
<td>4.6</td>
<td>9.1</td>
</tr>
<tr>
<td>65+</td>
<td>10.4</td>
<td>12.3</td>
</tr>
</tbody>
</table>

Complexity

• **Average visit:** 3 – 8 problems
• **Diagnoses:**
  - other specialists: top 5 = 90% total
  - family doctor: top 25 = 60% total

## Relative Complexity

<table>
<thead>
<tr>
<th></th>
<th>FM</th>
<th>Card</th>
<th>Psych</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. total complexity</td>
<td>44.04</td>
<td>42.78</td>
<td>17.49</td>
</tr>
<tr>
<td>Duration of visit (min)</td>
<td>15.79</td>
<td>20.47</td>
<td>33.63</td>
</tr>
<tr>
<td>Complexity per hour</td>
<td>167.31</td>
<td>125.40</td>
<td>31.21</td>
</tr>
</tbody>
</table>

Total relative complexity and complexity density are greatest in primary care.

Katerndahl DA et al. *Ann Fam Med* 2010;8:341-347
Family Physicians

- Doctors of first & last resort – e.g., cancer
- Continuous & comprehensive care
- Responsible for total health needs
- Time and relationship as diagnostic and therapeutic tools
Myth #3: Specialty care (disease-focused) models are best for primary care (people-focused)
Industrial model of health care

- Engineering principles – lean design, Six Sigma
- Pay-for-performance to promote change
- Goals set at population level
Quality Outcomes Framework

- More organized approach to chronic care
- Modest improvement in process measures
- Improvement in secondary prevention

Quality outcomes framework

- Fragmented care, disrupted relationships
- Improvements not sustained
- No improvement in primary prevention
- Care can become medicalized, mechanistic

Primary Health Care
Tobacco-related disease

Personal
Tar Wars

Professional
Counseling, medication

Public
Tobacco control

Population
Registry, immunization
TRUST
Challenge for Primary Care

Turn tasks to TRUST

- **Time**
- **Reliability**
- **Unity**
- **Skill**
- **Transparency**
Primary health care center IS

- Most care occurs most of the time
- Person is more important than disease
- Responsive to person’s agenda
- Trusted therapeutic relationships essential
Primary care health center is NOT

- Case finding and referral center
- Data collection center
- Polyclinic
Aims & Assets of Primary Care

• Continuity
• Comprehensive
Continuity

- Person
- Practice (team)
- Management (protocols, guidelines)
- Information (EHR)
When it comes to your patients, how well do you . . .

- Know them?
- Make it easy for them to connect with you?
- Stay involved with their care no matter their problem?
- Provide comprehensive services to them?
- Perform the services you provide to them?
- Deserve their trust?
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