

Primary care practitioners

Introduction



Key points

- Primary care practitioners are the cornerstone of any health system. They have a role in prevention, diagnosis, patient engagement and supported self-management, treatment and palliation.
- There is currently an unacceptable level of variation in access to primary care between European countries. Priorities should include an adequate supply of, and ready access to, primary care practitioners who diagnose and treat disease early and refer effectively to appropriate specialists.
- Primary care practitioners can play important roles in smoking-cessation strategies, reducing exposure to tobacco and indoor smoke during maternity and in newborns, improving children's health, reducing adult asthma exacerbations and providing holistic care for patients with COPD.
- Primary care offers a cost-effective and appropriate way to address the global burden of chronic respiratory disease. Its potential is constrained, however, by national health policies that do not recognise its strengths.

The World Health Organization (WHO) states that the only way to cope with today's global disease burden is through better access to, and application of, the principles and approaches of primary healthcare.

This chapter summarises the potential positive impact of primary care practitioners on the burden of respiratory disease in Europe, and describes how they could improve access to care and health outcomes. In particular, we should support the calls of the WHO and the Non-Communicable Disease (NCD) Alliance to take action now to combat chronic lung disease. Primary care needs to be made stronger, with less variation of investment between countries and faster progress towards the goals of the 62nd World Health Assembly (WHA62) resolution.

In a survey of nine countries, the WHO Global Alliance against Chronic Respiratory Diseases (GARD) found that, over a 5-year period, the proportion of patients with respiratory symptoms consulting primary care providers for any reason ranged from 8.4–37%. This reflects the high prevalence and variation of respiratory disease, underlines the need for primary care to be equipped to deal with it, and highlights the fact that some primary care services have the potential to do even more, given the right support.

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Primary care practitioners are the cornerstone of any health system. They have a role in prevention, diagnosis, patient engagement and supported self-management, treatment and palliation. They can work with populations and with individuals. The principles, values and health economics of primary care have been fully described by the WHO (see Further reading).

The current variation in access to primary care, and the increasing divide between the growth in numbers of general practitioners and specialists is unacceptable. According to a report produced by the Office for Economic Cooperation and Development (OECD), there are more specialists than generalists in most European countries, with the exception of Romania and Portugal. Yet the existence of easily accessible, person-centred primary care is associated with a more equal distribution of health in populations that do not necessarily benefit from an overabundance of specialists. In cash-limited health systems, the priority should be an adequate supply of primary care practitioners who diagnose and treat disease early and refer effectively to appropriate specialists. Literature reviews have shown that inappropriate referrals to specialists lead to more tests, an increase in false-positive results and poorer outcomes than appropriate referrals. While in many European countries the primary care model is general practitioner-led, this is not the case in many other countries, where nurses, physiotherapists or other healthcare workers take the lead. The model chosen is less important than the quality of the intervention and the belief system that drives it. The value of the consultation must be to enable patients and their families to be active partners in their care and to recognise the likely existence of multiple comorbidities, particularly in older patients. In some countries, a primary care team provides the necessary skills; in others, individual practitioners have to display a wider range of diagnostic and enabling competences.

Primary care and chronic lung disease

It is internationally recognised that in order to better manage the economic impact of the growing burden of chronic lung disease, preventive, educational and management strategies need to be refined. Primary care is pivotal, but in order to perform its role

Useful websites

- World Health Organization – What we do: data and evidence, health topics, events
www.euro.who.int/en/what-we-do/health-topics/Health-systems/primary-health-care/policy
This website draws together WHO policy on primary care and evaluation reports on the state of primary care in many European countries using the WHO Primary Care Evaluation Tool.
- The Lancet – Health policy and papers for chronic diseases and development, launched in November 2010
www.thelancet.com/series/chronic-diseases-and-development
The *Lancet*'s series of papers was an important contribution to the United Nations high-level meeting on chronic non-communicable diseases. The papers cover a range of diseases, including chronic obstructive respiratory diseases, and present strategies for substantial health gains, monitoring and scaling-up of interventions.
- International Primary Care Research Group – tobacco dependence resources
www.theipcr.org/display/RESTOB/Home
These free resources offer practical tools and evidence to improve healthcare professionals' success in helping their patients to stop smoking.



competently, it needs standards, guidelines and education that are developed specifically for primary care, that acknowledge the limited resources available in many countries, and that answer the questions relevant to primary care using evidence derived from long-term real-life pragmatic studies on populations that reflect primary care practice.

A role for primary care practitioners

Smoking

The International Primary Care Respiratory Group (IPCRG) regards smoking as tobacco dependency, and support to stop smoking as an effective treatment as well as a preventative intervention. This policy should encourage clinicians to take the problem more seriously and to see it as their core work. As primary care clinicians see very large numbers of patients, even the relatively small quit rate achieved from a brief intervention could make a huge impact in absolute numbers. Therefore, the IPCRG advises primary care clinicians to develop a 1-minute smoking cessation strategy that could be used with all patients who smoke. Smoking includes hookah (or waterpipe) smoking, which, although sometimes considered harmless, is in fact a form of tobacco dependency with associated adverse effects. Cannabis smoking also has adverse respiratory effects similar to those of smoking tobacco. A recent UK report found that a 1% increase in smoking rates in patients with asthma or chronic obstructive pulmonary disease (COPD) was associated with an increase in admission rates of a similar magnitude; stop-smoking support is an important treatment.

Maternity and newborn care

Tobacco smoking impairs lung growth and development, predisposing infants to respiratory disorders in early life.

Poorly controlled asthma is associated with poor maternal and fetal outcomes in pregnancy, and there is evidence of the under-treatment of asthma in pregnancy even in high-income countries. Experience in low-income countries suggests there is extremely low or no awareness among local communities of chronic diseases such as asthma and COPD. Primary care teams with a respiratory interest can be powerful advocates for stopping smoking and can be champions for evidence-based and locally appropriate strategies to reduce tobacco dependency and indoor smoke, especially that caused by burning biomass fuel.

Children's health

Asthma and rhinitis (which often coexist) represent the most common NCDs among children. According to the ARIA (Allergic Rhinitis and its Impact on Asthma) study, early treatment of (allergic) rhinitis may positively influence asthma development. Despite advances in many countries in recent decades, children are still not optimally managed, and this compromises their schooling and examination performance. However, effective interventions are available that can be delivered safely in primary care.

Asthma mortality is high in countries where access to 'controller' drugs is low. The NCD Alliance has called for universal access to good-quality, affordable asthma inhalers, and eligible countries should be urged to take advantage of the Asthma Drug Facility of the International Union Against Tuberculosis and Lung Diseases (the Union). The current WHO cost-effectiveness evidence table could usefully be revised to indicate which drugs are 'best buys', rather than just 'good buys'.

Deaths in children and young adults peak in the months when allergen levels are high; healthcare systems should make pollen calendars and other seasonal information available to predict and mitigate some of this risk.


Adults: asthma and cost-effective care

In countries with more advanced primary care, proactive primary care management of asthma (including available anti-inflammatory and bronchodilator treatments) can prevent most exacerbations. If exacerbations occur, most can be handled in primary care without the need for hospitalisation. The OECD therefore suggests that high hospital admission rates may be an indication of poor quality of care or a lack of access to properly funded and supported primary care. There is considerable variation in care between countries and there are substantial opportunities for improvement. Better continuity of care with a family doctor may be associated with a lower risk of admission in all age-groups for 'ambulatory care-sensitive conditions' – conditions without complications that can often be managed in the community rather than in hospital, such as asthma and COPD. Where hospital care is required, integrating and improving coordination with primary care can be effective in reducing (re)admissions.

An example of the benefits of improving primary care is seen in Finland where, despite increasing incidence of asthma, a systematic 10-year programme based on primary care resulted in a decrease in hospital days and disability payments, as well as associated costs.

Chronic obstructive pulmonary disease

Strong primary care is fundamental to the prevention of COPD as it provides support for a reduction in exposure to tobacco smoke, recognises and establishes an



early diagnosis, engages patients in active exacerbation management, and provides ongoing care for patients with established disease through to the end of their life. Spirometry testing should be developed in primary care, along with access to exercise programmes, multidisciplinary collaboration, and effective communication between primary and secondary care for those who need admission to hospital. Importantly, primary care professionals are ideally placed to address the holistic needs (physical, psychological, social and spiritual) of COPD patients as the disease progresses towards end of life.

Improving access to care is more likely to reduce hospitalisation rates for COPD than attempting to change patients' propensity to seek healthcare or eliminating variation in physician practices. Better public funding of primary care is likely to improve access.

Influenza vaccination plays its part in reducing exacerbations of both COPD and asthma. However, there is substantial national variation in its uptake; for example, in 2008, uptake in the Czech Republic was 21.2% in those aged more than 65 years, compared with 77% in the Netherlands, and an average coverage of only 54.2% in 18 European Union countries.

Where infrastructure allows, a registry or database of asthma and COPD patients should be maintained in order to enable long-term review. In addition, given the uncertainty about the best-value interventions for COPD, a dynamic database of international primary care COPD registries would help to answer relevant real-life research questions.

Conclusion

The global burden of chronic respiratory disease will have an increasing impact on the economy and health, affecting the practice of respiratory medicine in Europe. Primary care offers a cost-effective and appropriate way of addressing this burden. However, some of its potential is constrained by national health policies that do not recognise its strengths and therefore do not invest in reimbursement, education, recruitment or procurement strategies which strengthen and sustain its role and contribution.

Further reading



Burden of chronic lung disease

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Primary care practitioners

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Primary care and chronic lung disease

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