GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Iechyd Rhyngwladol International Health

# International Horizon Scanning and Learning Report

## Embedding Prevention in Primary and Community Care

Report 47, December 2023

Canolfan Gydweithredol Sefydliad Iechyd y Byd ar Fuddsoddi ar gyfer Iechyd a Llesiant

World Health Organization Collaborating Centre on Investment for Health and Well-being

## Overview

The International Horizon Scanning and Learning reports were initiated as part of the COVID-19 public health response, to support dynamic response and recovery measures and planning in Wales. They varied in focus and scope, depending on the evolving COVID-19 situation and public health/policy needs at that time. The reports focussed on COVID-19 international evidence, data, experience, policy and public health measures, transition and recovery approaches. Learning and intelligence was collated and synthesized to understand and explore solutions for addressing the ongoing and emerging health, well-being, social, economic and environmental impacts (potential harms and benefits) of the pandemic.

The scope of the reports was expanded in spring 2022 to cover priority public health topics, including in the areas of health improvement and promotion, health protection, and health care public health. The report topics and findings are aligned with and help inform decision-making and on-going work in Welsh Government, the NHS and Public Health Wales. They are also disseminated to wider network of (public) health professionals and partners nationally and internationally.

This is part of a wider Public Health Wales' systematic approach to intelligence gathering and evidence translation into policy and practice, supporting coherent, inclusive and evidence-informed action, which progresses implementation of the Well-being of Future Generations (Wales) Act and A Healthier Wales strategic plan towards a healthier, more equal, resilient, prosperous and globally responsible Wales.

**Disclaimer:** The reports provide a high-level summary of learning from real life experiences from selected countries, and from a variety of scientific and grey literature, including sources of information to allow further exploration. The reports are not comprehensive and are not aimed at providing detailed, robust or in-depth evidence review, analysis or quality assurance. They are meant to offer a brief snapshot or current evidence, policy and practice, sharing relevant country examples and key (reputable) international bodies' guidance and principles.

## In focus:

**Embedding Prevention in Primary and Community Care**

## Contents

# At a glance: summary of international learning

***"There has never been a clearer need to invest in and plan for better integration of primary and community healthcare, alongside an expanded, better resourced, and appropriately trained multidisciplinary public health workforce"***
*(Lopes et al., 2022)*[1]

## Primary and Community Care

- In this report, we **define Primary and Community Care (PCC)** as healthcare services that people often **receive first**, providing access to a range of services to help **meet their health and well-being needs, and empower them** to take charge of their own health
- PCC can **strengthen the resilience of health systems** to prepare for, respond to and recover from shocks and crises
- It is considered an **inclusive, equitable and cost-effective way** to achieve **Universal Health Coverage (UHC)**
- This report focuses on international examples of primary and community care models that have **embedded prevention and public health through integration, systems change, reorientation of funding and workforce, and upstream approaches**

## Drivers for Change

- **Pressures on health systems and global trends and developments** are driving changes to PCC approaches, including:
  - rising **patient need**, particularly among people with multiple and complex conditions;
  - **demand** for care to be delivered closer to the people's home;
  - an **ageing** population;
  - increasing **inequalities** and deprivation;
  - **unscheduled** healthcare use;
  - introduction of **integrated care** systems;
  - the way healthcare is accessed and provided, with **new technologies** advancing communication, expectations and potential for intervention;
  - **ways of working beyond healthcare** with transformation in the nature of work;
  - **workforce challenges** and imbalance in geographical distribution of providers;
  - people's desire and need for support for **self-care, prevention and personalisation**

## Embedding Prevention in Primary Care

- The World Health Organization (WHO) is driving global commitment to **strengthening and investment in PCC** – promoting **multisectoral action, empowering local communities**, mainstreaming **health in all policies**, enhancing **capacity and infrastructure**, and **prioritising essential public health functions across the life course**
- **Essential public health functions** that contribute to **collaboration and integration with PCC** are health promotion, disease prevention, health protection, surveillance and monitoring, and emergency management
- **Integration and co-ordination** of care supports the whole person to **improve continuity**, **reduce fragmentation** and **deliver good outcomes;** and requires **breaking down traditional barriers** between providers, services, sectors and programmes

[1] Invest in primary healthcare and public health for the pandemic and beyond | The BMJ

- The **framing 'prevention is everyone's business' may lead to confusion** over roles, responsibilities and obligations, as it may be seen as nobody's core business
- A **whole-system approach and reinvestment strategies** are essential to prevent creating a transition gap in service provision
- The **role of the health sector (e.g., the NHS) in addressing people's non-medical needs and reducing inequalities** needs to be more clearly defined

## Solution-Based Actions and Learning

- **Core components of a successful integration** strategies include:
  - **defined populations**
  - **aligned financial incentives**
  - **shared accountability** for performance using data and reporting
  - **guidelines** to promote best practice and reduce variation
  - **physician-management partnerships**
  - **effective leadership** and **collaborative culture**, facilitating team working
  - **patient and carer engagement** enabling shared decision-making and self-care
- **Enabling aspects driving integration of public health and PCC** include:
  - **leadership** and champions supporting change management
  - **shared vision and goals**
  - **dual/joint training** and competencies
  - **data sharing** and systems that support integration
  - **funding mechanisms and incentives** that support collaboration, not competition
- **Effective, synchronised digital systems and linked technologies are vital** for effective communication, continuity and quality of care, empowering patients and self-management, developing integrated pathways, tailoring health plans, highlighting risk factors, identifying variations, evaluating impacts, and informing investment decisions
- **Comprehensive assessment and analysis of population health needs and assets** is essential to target resources and services where needed most – based on standardised **outcome and experience indicators and grassroots engagement**
- **Cross-sector partnerships** with local authorities, communities, voluntary sector, and commercial partners **enables upstream prevention delivery**, such as through **social prescribing**
- **Multi-professional practices** enable better care co-ordination and are proactively engaged in preventive care and management of chronic diseases
- Promoting PCC as an **attractive career** for health professionals include improvements to **medical education, working conditions** and remuneration, PCC **models** and integration of service, **workforce planning**
- **Maintaining well-functioning and resourced PCC practices** - establishing community care facilities, extending home-based programmes, expanding the role of PCC workers and increasing telemedicine are key to minimise delays and forgone care for all people
- Moving **primary care into the community** is an international priority as it can **improve efficiency, whilst reducing or stabilising healthcare costs**

## International Approaches to Primary and Community Care

- **Scotland** is investing in **infrastructure** to improve and grow primary care and **support multi-professional teams**
- **Republic of Ireland** is investing in **cross-sector working** with community and voluntary organisations to bring care into the community and closer to people's homes
- The health system in **Canterbury, New Zealand** has undertaken a significant programme of transformation, developing new delivery models, which involved better integration of care, increased investment in community-based services, and strengthened primary care
- **Cuba's** PCC system is centred around community-based clinics, which bring the directors of pharmacies, elderly homes, maternity homes and others into their team
- The **Japanese** government implemented a community-based integrated care system in 2012, building regional frameworks for comprehensive provision of seamless, supportive care and health services for elderly people with chronic diseases and disabilities
- **Australia's** 31 Primary Health Networks aim to increase the efficiency and effectiveness of health services, and improve coordination and integration of care
- PCC reform in **Flanders** is connecting medical care with welfare and social care, strengthening person-centred, integrated and global oriented care by a bottom-up approach, and strengthening population-oriented approaches

## Country Insights

**Brazil**

- Brazil's Family Health Strategy is one of the largest community-based PCC programmes in the world
- It emphasises healthcare in community health facilities and at home to a defined local population using Family Health Teams
- Community Health Workers assess the needs of the community, develop trusting relationships with the households, and work with the local PCC team to ensure that any health and social care issues get resolved quickly

**Slovenia**

- Slovenia's PCC approach delivers person-centred, integrated healthcare through the collaborative efforts of multi-professional teams
- Health Promotion Centers encourage healthy lifestyles and address modifiable risk factors such as unhealthy diet
- During the COVID-19 pandemic, Slovenia was one of a few countries that relied on multi-professional team practices to maintain continuity of care for people

**A brief overview of the PCC in Wales is provided for reference in Appendix A**

# Embedding Prevention in Primary and Community Care: Overview

This report focuses on international examples of primary and community care models that have **embedded prevention and public health through integration, systems change, reorientation of funding and workforce, and upstream approaches**.

## Key Concepts[2]

- **Primary and community care, place-based care and prevention** are defined differently in different contexts. Table 1 provides definitions for this report.
- **Primary and Community Care (PCC)** is a whole-of-society approach to effectively organise and strengthen national health systems to **bring services for health and well-being closer to communities.** It has **three components:**
  - ✓ **integrated** health services to meet people's health **needs throughout their lives**
  - ✓ addressing **broader determinants** of health through multisectoral policy and action
  - ✓ **empowering** individuals, families and communities to take charge of their own health
- PCC enables health systems to **support a person's health needs** (Figure 1)
  - ✓ It is considered an **inclusive, equitable and cost-effective way to achieve Universal Health Coverage (UHC)**
  - ✓ It has been shown to **strengthen the resilience of health systems** to prepare for, respond to and recover from shocks and crises, such as the COVID-19 pandemic

***Table 1.*** **Primary and Community Care, Prevention, and Place-Based Care Defined**

| Term | Definition |
|---|---|
| **Primary and community care[3,4]** | – Healthcare services that people often receive first<br>– A coordinating care function, providing access services in the local community to help meet individual health and well-being needs<br>– Referrals are made to specialist care when required |
| **Place-based care[5]** | – Providers work together to improve health and care for populations they serve<br>– Organisations collaborate to manage common resources |
| **Prevention[6]** | Measures to reduce the occurrence of risk factors, prevent the occurrence of disease, to arrest its progress and reduce its consequences<br>– Primary prevention: lowering the prevalence of risk factors common to a range of diseases (e.g., tobacco and alcohol use, obesity) to prevent the initial occurrence of a disorder (e.g., behaviour change advice); it may also include actions that inhibit environmental, economic and social conditions known to increase risks<br>– Secondary prevention: early detection of existing disease with a view to arresting or delaying the progression of the disease and its effects (e.g., screening and other early detection programs such as routine health checks)<br>– Tertiary prevention: disease management strategies and/or rehabilitation intended to avoid or reduce the risk of deterioration or complications from established disease (e.g., patient education and physical therapy) |

[2] https://www.who.int/health-topics/primary-health-care#tab=tab_1
[3] primary-care - HEIW (nhs.wales)
[4] primarycareone.nhs.wales/files/strategic-programme-handbook/the-strategic-programme-for-primary-care-handbook-2019-2020-pdf/
[5] Place-based systems of care (kingsfund.org.uk)
[6] 9789240038349-eng.pdf (who.int)

***Figure 1. Why is primary care important? Source: Wales Audit Office report[7]***

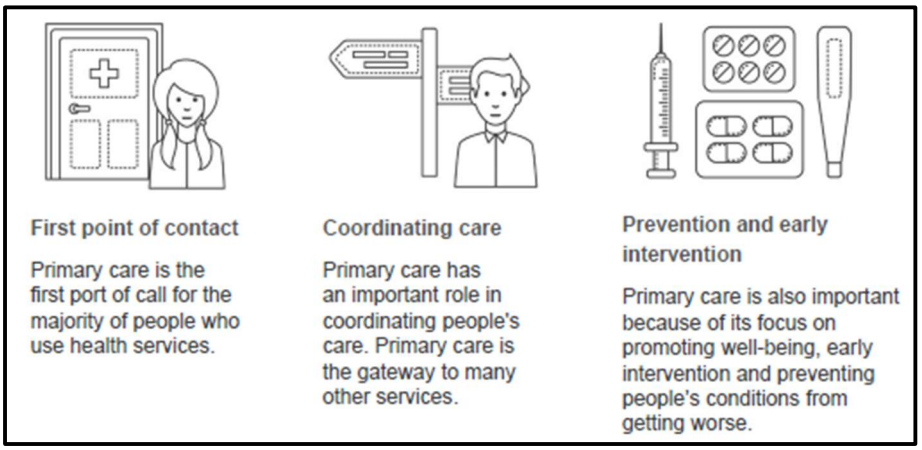



***Figure 2. Percentage of older people (65+ years) who could have been treated in primary care for their last visit to a hospital emergency department, 2017. Source: OECD[8]***

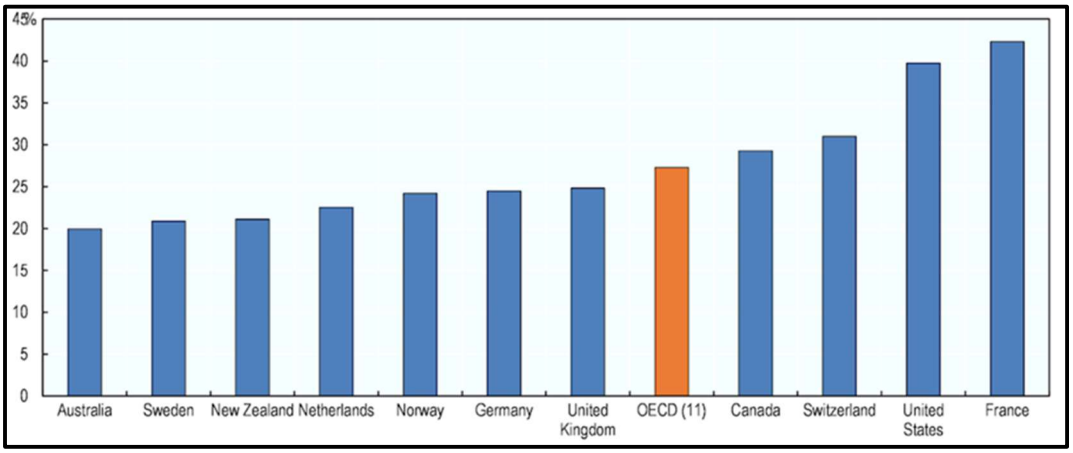
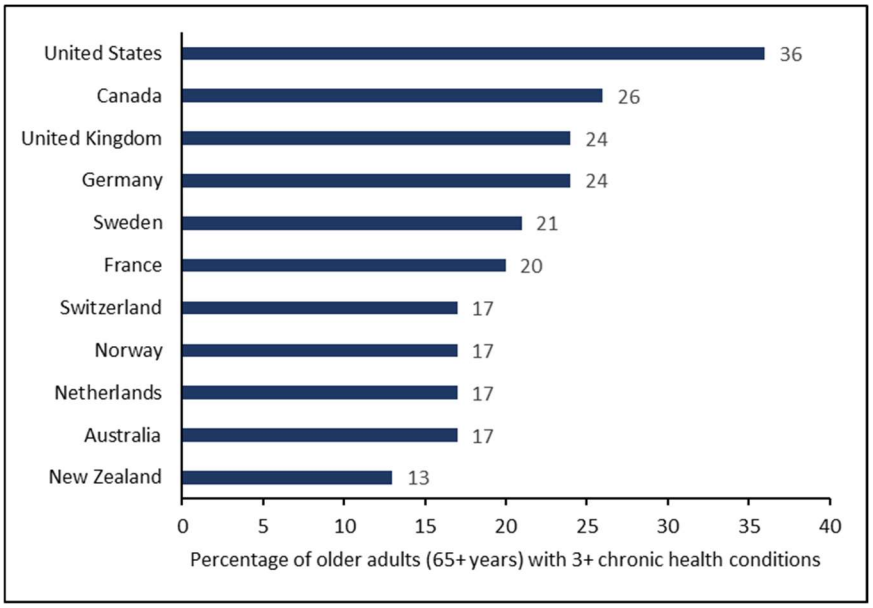



***Figure 3. Percentage of older adults (65+ years) with 3 or more chronic health conditions, 2017. Source: Commonwealth Fund[9]***

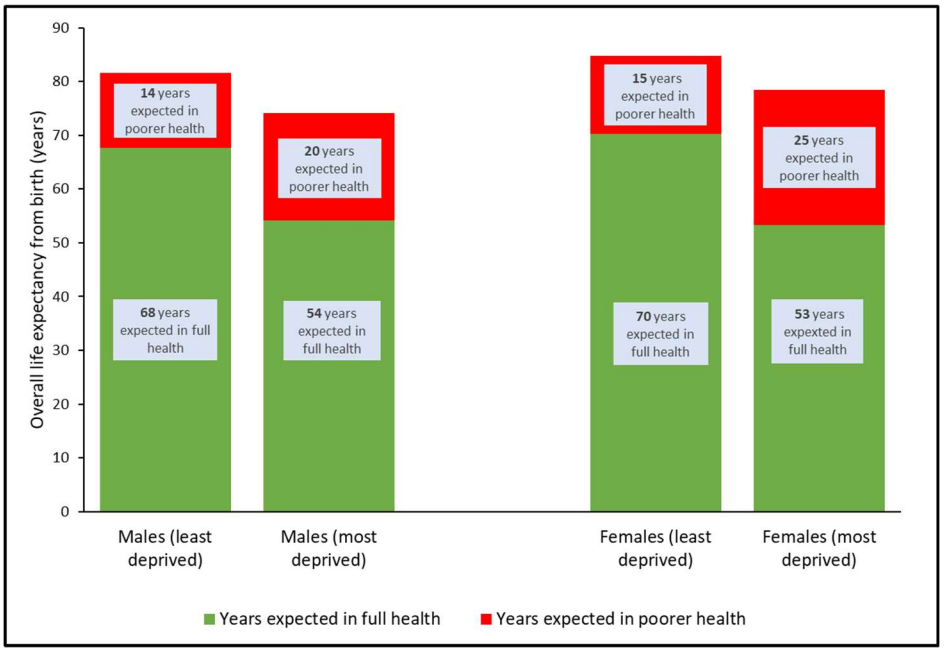



[7] Primary Care Services – Abertawe Bro Morgannwg University Health Board (audit.wales)
[8] Realising the Potential of Primary Health Care | en | OECD
[9] 2017 Commonwealth Fund International Health Policy Survey of Older Adults

## Drivers for Change

- **Pressures** on health systems act as drivers for changing approaches to primary care[10,11]:
  - ✓ rising patient need, particularly among people with **multiple and complex conditions (multi-morbidity)**
  - ✓ demand for care to be delivered **closer to people's homes**
  - ✓ **increasing inequalities and deprivation**
  - ✓ **increasing unscheduled healthcare use** (Figure 2)
  - ✓ an **ageing** global population, which is associated with more complex and chronic health conditions, such as diabetes (Figure 3)
- Gains in life expectancy, particularly healthy life expectancy, are often **not felt equitably**, creating more years in poorer health for some[12] (Figure 4)

***Figure 4. Life expectancy at birth in Wales in years by gender, deprivation, and healthy life expectancy, 2018-2020. Source: Public Health Wales Observatory[12]***




- **Rapid and widespread changes** across health and care services include[11]:
  - ✓ introduction of **integrated care systems** emphasising collaboration over competition
  - ✓ **new technologies** advancing communication and intervention
  - ✓ changing **employment expectations** (e.g., flexible working)
- **Workforce challenges** are expected to continue as demand rises including widespread global imbalances in the geographical distribution of health professionals[11,13]
- More people want **support for self-care and personalised medicine**[11]
- **Health resources** have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems, a gap highlighted by several health emergencies in recent years[14]

[10] 1213.pdf
[11] NHS England » Evolving to meet a changing world
[12] Public Health Wales Observatory
[13] Policy_brief_A4 (who.int)
[14] New global commitment to primary health care for all at Astana conference (unicef.org)

## Embedding Prevention in Primary and Community Care

- **Essential public health functions** that contribute to health systems strengthening and particularly to **collaboration and integration with PCC** are[15]:
  - ✓ health promotion
  - ✓ disease prevention
  - ✓ health protection
  - ✓ emergency management
  - ✓ surveillance and monitoring
- A **ground-breaking step-change** is enabled by the World Health Organization (WHO) Declaration of Astana 2018[16,17], part of a growing global movement for **greater investment in PCC to achieve UHC,** 40 years since the Alma-Ata Declaration[18], committing to[16]:
  - ✓ **promoting multisectoral action and UHC**, engaging relevant stakeholders and **empowering local communities** to strengthen PCC by mainstreaming a **health in all policies** approach; and
  - ✓ enhancing **capacity and infrastructure for PCC**, **prioritising essential public health functions across the life course**
- While PCC focuses primarily on individuals, public health addresses the needs of the whole population and considers a person's holistic (wider) needs, so **integration is crucial** for comprehensive PCC approach that **builds resilience** across the entire health system,[19,20]
- **Co-ordinated and integrated PCC** better supports the individual and requires breaking down traditional barriers[21]
- **Integrated care** can be[20]
  - ✓ between health services, social services and other care providers (horizontal)
  - ✓ across primary, community, hospital and tertiary care services (vertical)
  - ✓ within one sector (e.g., mental health services through multi-professional teams)
  - ✓ between preventive and curative services
  - ✓ between providers and patients to support shared decision-making and self-care
  - ✓ between public health, population-based and patient-centred approaches to care
- **Approaches to integration** range from mutual awareness, through cooperation to collaboration and full integration involving a single, fully merged organisation with a shared plan and budget[15]
- There is a growing focus on integration and co-ordinated care to **improve continuity**, **reduce fragmentation** and **deliver good outcomes**[22]
- A **whole-system approach and reinvestment strategies** are essential to prevent creating a transition gap in service provision[22]
- Integration can happen at the **micro- (individual clinics), meso- (local area) and macro-level (national)**
- The **framing 'prevention is everyone's business' may lead to confusion** over roles, responsibilities and obligations, as it may be seen as nobody's core business
- The **role of the health sector (e.g., the NHS) in addressing people's non-medical needs and reducing inequalities** needs to be more clearly defined[23]

[15] Integrating public health and primary health services: building strong foundations for population health (who.int)
[16] WHO-HIS-SDS-2018.61-eng.pdf
[17] New global commitment to primary health care for all at Astana conference (unicef.org)
[18] Declaration of Alma-Ata (who.int)
[19] Eurohealth-29-1-14-18-eng.pdf (who.int)
[20] The Evidence Base for Integrated Care (kingsfund.org.uk)
[21] NHS England » Evolving to meet a changing world
[22] 1213.pdf
[23] fph-the-role-of-the-nhs-in-prevention-discussion-paper-final.pdf

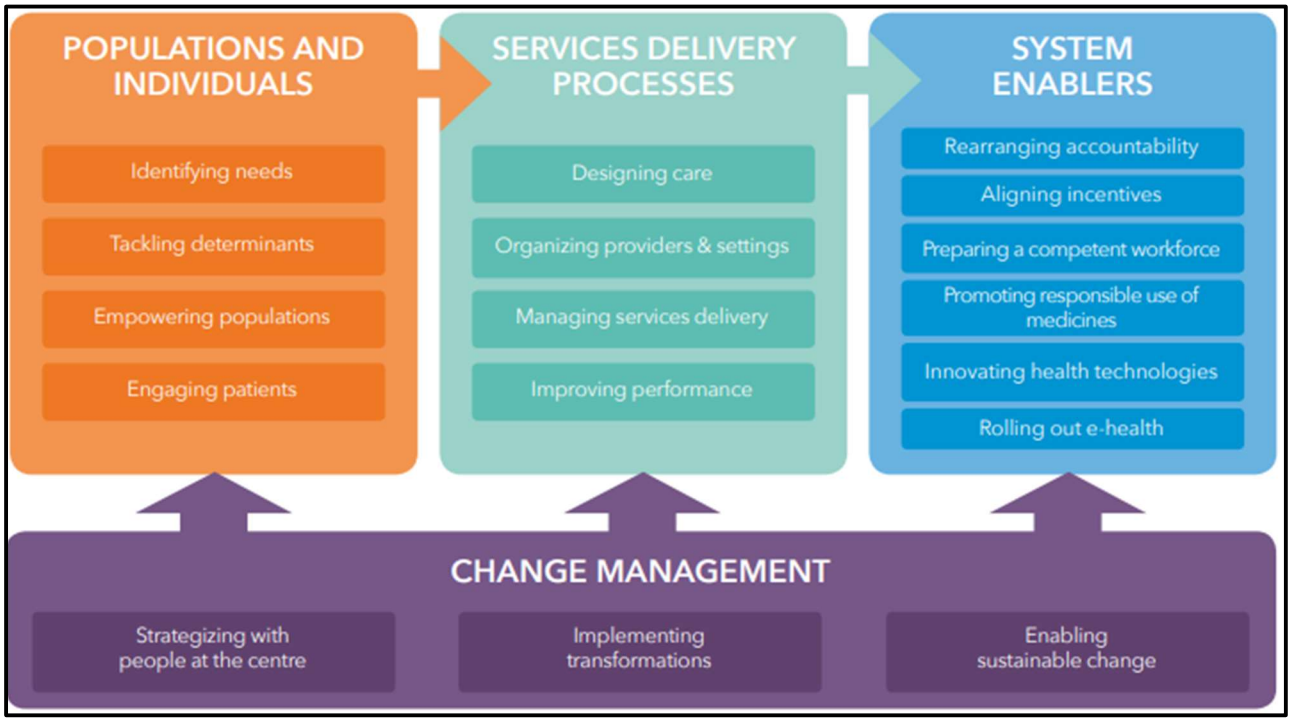
## Solution-Based Action and Learning

- **Core components of a successful integration** strategies include[24]:
  - ✓ **defined populations** to enable PCC teams to develop relationships with groups and communities and target individuals who would benefit from a co-ordinated approach
  - ✓ **aligned financial incentives** to support providers to work collaboratively, to promote joint responsibility for managing financial resources, and to encourage management of ill-health in PCC settings
  - ✓ **shared accountability for performance using data** to improve quality and account to stakeholders through **reporting**
  - ✓ **guidelines** to promote best practice, support care co-ordination, and reduce variations of or gaps in care
  - ✓ **physician-management partnerships** linking skills of healthcare professionals with organisational skills of executives
  - ✓ **effective leadership** and **collaborative culture**, facilitating team working
  - ✓ **patient and carer engagement** enabling patients to make decisions about their own care and enabling self-care
- Several **enabling aspects drive integration of public health and PCC**[25]:
  - ✓ leadership and champions supporting change management
  - ✓ dual training and competencies and supporting joint training
  - ✓ data sharing and systems that support integration
  - ✓ shared vision and goals
  - ✓ funding mechanisms that support collaboration, not competition
- An **effective, synchronised digital system and linked technologies are vital,** requiring agreement between agencies as to expected outcomes and willingness to **pool investment long-term**[26]
- Evidence shows **substantial benefits of integrated digital and data systems,** pooling individual level data to help tailor health and care plans by highlighting risk factors and enabling development of population-based programmes:[25]
  - ✓ People having access to their own records can help **self-management** and can facilitate **better discussion and shared decision-making** with professionals
  - ✓ Using individual data to build **population level analysis** supports the development of **integrated pathways** and can guide investment decisions
  - ✓ This also supports **evaluation of the impacts** of new interventions and **identifying variations** in quality and safety
- **Comprehensive assessment and analysis of population health needs and assets** is essential to make informed decisions at all levels (practice, community and regional) about **resource allocation and service provision**, directed to where they are most needed[27]:
  - ✓ The Patient-Reported Indicator Surveys initiative (PaRIS) has standardised and implemented **new indicators** that measure outcomes and experiences of healthcare to help focus quality improvement efforts, prioritise spending and give people a say[28]
  - ✓ **Grassroots engagement** brings knowledge and experience to understanding populations and developing the best solutions

[24] The Evidence Base for Integrated Care (kingsfund.org.uk)
[25] Integrating public health and primary health services: building strong foundations for population health (who.int)
[26] https://www.scie.org.uk/integrated-care/research-practice/enablers/information-sharing
[27] Deep End Wales Project (rcgp.org.uk)
[28] Patient-Reported Indicator Surveys (PaRIS) - OECD

- **Cross-sector partnerships** with local authorities, communities, voluntary sector organisations, and commercial partners **enables upstream prevention delivery**[29]
- **Addressing perceptions** that PCC is not an **attractive career** option for health professionals, which is often reinforced by substantial pay differences and perceived lower status of General Practitioners (GPs) compared to specialists, through **improvements to**[30]:
  - ✓ medical education: longitudinal educational programmes, diverse teaching formats
  - ✓ working conditions: increasing remuneration and incentives linked to work quality
  - ✓ PCC models: multi-professional working, clinical leadership, integration of services
  - ✓ workforce planning: more stable PCC workforce may reduce work pressures
- **Multi-professional practices** enable better care co-ordination and are proactively engaged in preventive care and management of chronic diseases[31,32] (Figure 5)
  - ✓ Their teams can include a doctor, social worker, physiotherapist and/or staff from local authorities, housing and voluntary organisations[33]
  - ✓ In addition to providing episodic care and responding to acute health issues, they possess the skills and scope of practice to deliver comprehensive, preventive and person-centred care through long-term relationships with the community[34]
  - ✓ Multi-professional teams can allow providers to assess population health needs and choose specialists and experts that better serve those needs[35]
  - ✓ They need support from the system in which they operate, including conducive physical and/or virtual environment, clarity on their overall purpose and performance metrics which reflect their integrated care responsibilities[32]

***Figure 5. European Framework for Action on Integrated Health Services Delivery Overview***
***Source: WHO Regional Office for Europe[36]*** *(Figure not available in Welsh)*




[29] fph-the-role-of-the-nhs-in-prevention-discussion-paper-final.pdf
[30] Policy_brief_A4 (who.int)
[31] 2020_healthatglance_rep_en_0.pdf (europa.eu)
[32] Multidisciplinary Teams: Integrating care in places and neighbourhoods | SCIE
[33] Multidisciplinary teams working for integrated care | SCIE
[34] Eurohealth-29-1-14-18-eng.pdf (who.int)
[35] Integrating public health and primary health services: building strong foundations for population health (who.int)
[36] The European Framework for Action on Integrated Health Services Delivery: an overview (who.int)

## Case Study: Social Prescribing[37]

- 20% of patients in England consult their GP primarily for a social problem; the Low Commission reported that 15% of GP visits were for social welfare advice
- Social prescribing is a unique primary care model that aims at making available new life opportunities for those who need them most, including opportunities to form new relationships, be creative and be independent while improving both physical, mental, emotional, social, and practical needs
  - ✓ It is about treating the person, not the illness
  - ✓ This may be offering facilities, courses, classes, or exercise-related activities to improve physical and or mental health using readily available social activities, whether that be through the third sector, community or private

**Wales[38,39]**

- In Wales, there has been an increase in referrals and use of social prescribing over the previous 3 years, from around 10,000 in 2018/19 to just over 25,000 in 2020/2021
- Research found that people used primary care services less (25% reduction in appointments)
- There is potential for social prescribing to support those on waiting lists and supporting behaviour change to enable optimal outcome of treatment once it is received (e.g., by offering activities such as art classes to reduce loneliness or the National Exercise Referral Scheme to tackle physical requirements upstream)
- Continued use of this model could bring down GP waiting times as well as waiting list lengths

**Scotland[40]**

Scotland Launched the "Community Link Workers Program" in 2016

- Community link workers (CLWs), based within primary care, act as social prescribers, linking people to community-based activities
- Each programme is unique in its set-up, with most involving the third sector
- The Edinburgh network has 24 CLWs across 45 primary care clinics who are employed by 11 voluntary sector organisations, which allows for CLWs to be fully embedded within the community and have a far reach to tackle mental health concerns

**United States[38]**

- Boston Bikes partnered with Boston Medical in Massachusetts to launch 'Prescribe a Bike'
- It promotes preventative health by offering $5 annual vouchers to people who live on public assistance or make less than four times the national poverty level
- This makes it accessible for any party to exercise and is affordable as a method to improve physical health

## Case Study: Estonia's Digital Infrastructure for Primary Care

- Estonia is widely known as a highly digitalised, innovative country, which has benefited the PCC system[41]
  - ✓ More than 99% of the data generated by hospitals and doctors is digitised and citizens can access their medical records via a super-secure online portal and choose who can view the records[42]
  - ✓ Digital identity cards can also be used to vote, log into bank accounts and give digital signatures; 99% of Estonians have ID-cards and 64% of them are actively using them[43]
- It has successfully implemented health system reforms, including a PCC centred on family medicine[40]
- Electronic data management had been in place since the 1990s to submit medical bills to the Estonian Health Insurance Fund (EHIF) electronically; this lacked functionality to support care management
- In 2008, Estonia set the challenge of improving the quality and efficiency of healthcare provided via public insurance by creating a nationwide system integrating data from providers[44]
  - ✓ Electronic health records provide comprehensive profiles of each patient, reducing bureaucracy and giving access to time-critical information in emergencies
  - ✓ PCC providers receive detailed information about their population health status[45]
- In 2010, Estonia began using e-prescriptions, making it possible for EHIF to assess whether family doctors prescribed medications in accordance with clinical guidelines[40]

[37] https://www.gov.wales/sites/default/files/pdf-versions/2023/8/5/1692363121/cabinet-paper-national-framework-for-social-prescribing.pdf
[38] https://phw.nhs.wales/services-and-teams/primary-care-division/social-prescribing/social-prescribing/social-prescribing-interfacespdf/
[39] Social Prescribing - Public Health Wales (nhs.wales)
[40] https://socialprescribingacademy.org.uk/media/4lbdy5ip/social-prescribing-around-the-world.pdf
[41] Microsoft Word - Working paper 3_Estonia.docx (lshtm.ac.uk)
[42] Inside Estonia's pioneering digital health service | Sifted
[43] e-identity-faq-aug2022-1.pdf (e-estonia.com)
[44] Story - e-Estonia
[45] Integrating public health and primary health services: building strong foundations for population health (who.int)

- In 2013, EHIF started remunerating new innovative e-consultations, in which family doctors consulted with specialists through the health information system without sending people to specialist care providers[40]
- Since 2020, PCC physicians and nurses have used the Clinical Decision Support System, which aims to speed up decision-making and improve patient safety by highlighting person-specific recommendations and reminders to support the work of physicians and nurses[40]
- e-Health has resulted in administrative cost savings; provision of digital signatures has led to 2% in GDP savings every year[46]
- Estonia's digital infrastructure prepared them for the COVID-19 pandemic[47]
- Trustworthiness is built into the system's design; every time someone accesses information, it is logged[46]
- Education about how the system was built and how people control their personal information was key to getting buy-in[46]
- Future improvements include fully integrating the national database with social services and increasing capacity to find the most vulnerable populations[48]

## International Approaches to Primary Care

- **Moving PCC into the community** is an international priority - many countries acknowledge the need to **improve efficiency, whilst reducing or stabilising healthcare costs**[49]
- Enabling integration through **investing in infrastructure and cross-sector working:**
  - ✓ The **Scottish Government** has provided £7 million to improve and grow primary care through increasing space in NHS-owned or leased premises and obtaining new sites to support multi-professional teams[50]
  - ✓ The **Republic of Ireland** Department of Health announced €3.5 million in annual funding for community and voluntary organisations to bring care into the community and closer to people's homes[51]

### New Zealand[52,53]

- The health system in Canterbury, New Zealand has undertaken a significant programme of transformation since the mid-2000s - now supporting more people in their homes and communities and moderating demand for hospital care, particularly among older people
- Change was achieved through developing new delivery models, which involved better integration of care across organisational and service boundaries, increased investment in community-based services, and strengthened primary care
- Three enablers for change existed:
  - ✓ creation of the vision;
  - ✓ sustained investment in providing staff and contractors with skills needed to innovate and supporting innovation;
  - ✓ new models of integrated working and forms of contracting where organisations formally agree to work together to balance the best interests of the local population and what is best for the sustainability of the health system and share risks and gains
- Technology, local investment and innovation were keys to success
- Solutions developed with clinical users was key to successful design and uptake
- Models implemented in Canterbury include:
  - ✓ Health Pathways: primary care management and referral pathways developed in partnership between GPs and hospital doctors

[46] e-identity-faq-aug2022-1.pdf (e-estonia.com)
[47] Inside Estonia's pioneering digital health service | Sifted
[48] Integrating public health and primary health services: building strong foundations for population health (who.int)
[49] 1213.pdf
[50] Expanding primary care - gov.scot (www.gov.scot)
[51] gov.ie - Minister Naughton announces additional annual funding of €3.5 million for drugs and inclusion health services (www.gov.ie)
[52] The quest for integrated health and social care: A case study in Canterbury, New Zealand (kingsfund.org.uk)
[53] Canterbury_Summary_Developing_accountable_care_systems_web.pdf (kingsfund.org.uk)

    - ✓ the acute demand management system: people with acute health needs receive urgent care in their homes or communities from GPs supported by rapid-response community nursing, community observation beds, hospital-based specialist advice and rapid diagnostic tests
    - ✓ the electronic shared care record view: a secure online summary care record, combining an individual's GP records, hospital records, community pharmacy records and laboratory and imaging results; records can be viewed by clinicians across hospital, community and primary care services
- Previously, Canterbury regularly experienced gridlocks in hospital emergency departments and long waiting times
- Post-integration, Canterbury had low rates for acute medical admissions compared to other health boards
- Reduced strain on the hospital and greater efficiency within it prompted fewer cancelled emissions and waiting times for elective surgeries decreased
- Fewer people entered care homes as more were supported in the community
- Improving the interface between primary and secondary care has led to better-quality referrals and reduced spending on pathology and imaging tests

**Cuba**[54,55,56,57]

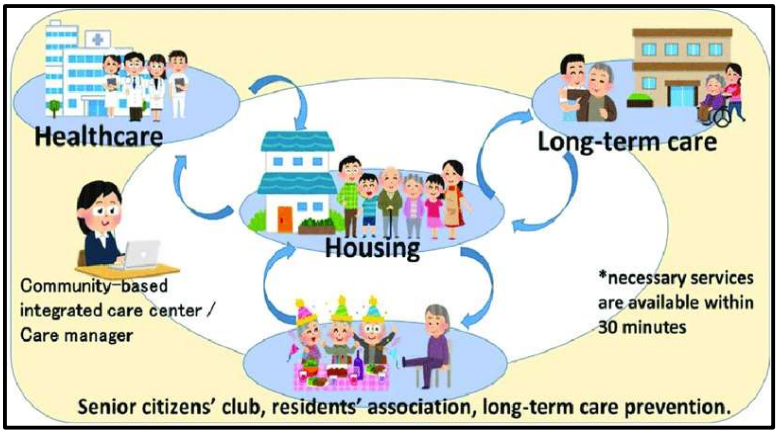
- Cuba's primary care system is centred around community-based clinics, so doctors and nurses know their patients not only as patients, but also as neighbours
    - ✓ 498 community-based polyclinics serve a catchment area of between 30,000 and 60,000 people
    - ✓ They act as the organisational hub for 20-40 neighbourhood-based family doctor-and-nurse offices, and as accredited research and teaching centres for medical, nursing and allied health sciences students
    - ✓ Polyclinics and family doctor-and-nurse offices play a leading role in capacity building and quality control among health-related institutions in their communities
    - ✓ They bring the directors of pharmacies, elderly homes, maternity homes and others into their team and offer training to the Federation of Cuban women's health promoters, professionalising their work in the community
- Since 2002, 241 polyclinics have undergone renovation to add services previously only available in hospitals
- Intersectionality is reflected in national regulations that encourage participation by all social sectors in health promotion, disease prevention, treatment, and rehabilitation
    - ✓ This involves co-ordinated intervention of representative institutions from various social sectors in actions aimed at addressing issues associated with health, well-being and quality of life
    - ✓ This strategy has increased the response capacity of Cuba's health system to face challenges in the national and international socioeconomic context and has helped improve the country's main health indicators

[54] Cuba: Where Primary Care Is All About Community | Commonwealth Fund
[55] PMC2647439.pdf (who.int)
[56] Primary care in Cuba: A public health approach: Health Care for Women International: Vol 16, No 4 (tandfonline.com)
[57] mr-sept-2019.indd (scielosp.org)

**Japan**[58,59]

- Primary care services in Japan are provided in both the community and hospital setting
- Demographic shifts, such as an aging society and low fertility rate, as well as economic challenges, including escalating healthcare expenditure and slowing of economic growth, have resulted in calls to reform the health system
- The government implemented a community-based integrated care system in 2012, building regional frameworks for comprehensive provision of seamless, supportive care and health services for elderly people with chronic diseases and disabilities (Figure 6)
  - ✓ It was modelled after the system implemented in the rural town of Mitsugi, where the growth of healthcare costs and proportion of bedridden elderly individuals decreased
- The system integrates community healthcare resources through coordination of hospital outpatient and inpatient sections as well as welfare facilities, home-visit care services and mutual support activities among neighbourhoods
  - ✓ Home-based care is prioritised because traditional facility-based care is costly and there was a dire shortage of welfare facilities for long-term care
  - ✓ Families, peer residents and volunteers are encouraged to provide care for elderly relative with mild disabilities; people with severe diseases or disabilities are encouraged to receive care at home from visiting medical and welfare professionals
- The system provides medical and long-term care as well as social services in a seamless manner in accordance with people's needs
- In establishing the system nationwide, several things will be considered:
  - ✓ it should be tailored to each community and care must be taken in cities where hospitals may be hard to co-ordinate;
  - ✓ residents should participate in decisions as recipients of care;
  - ✓ proper allocation of resources to each municipality is key for economic sustainability

***Figure 6. Japan's community-based integrated care system model. Source: Hatano et al., 2019[59]***




**Australia**[60,61,62]

- Australia's 31 Primary Health Networks (PHNs) aim to increase the efficiency and effectiveness of health services, and improve coordination and integration of care
- To achieve its goals, PHNs:
  - ✓ assess the health needs of their region using a people-centred approach;
  - ✓ commission health services to meet prioritised health needs of people in their region;
  - ✓ work closely with providers to build workforce capacity and ensure high-quality care;
  - ✓ connect health services to encourage better use of resources and avoid duplication
- PHNs tailor health services to the needs of the community and take their own approach to connecting services, so each region has a different model, but they are all guided by the

[58] Building primary care in Japan: Literature review - PMC (nih.gov)
[59] The Vanguard of Community-based Integrated Care in Japan: The Effect of a Rural Town on National Policy - PMC (nih.gov)
[60] Enhancing prevention in primary health care - Phase 1 (preventioncentre.org.au)
[61] What Primary Health Networks are | Australian Government Department of Health and Aged Care
[62] How we support Primary Health Networks | Australian Government Department of Health and Aged Care

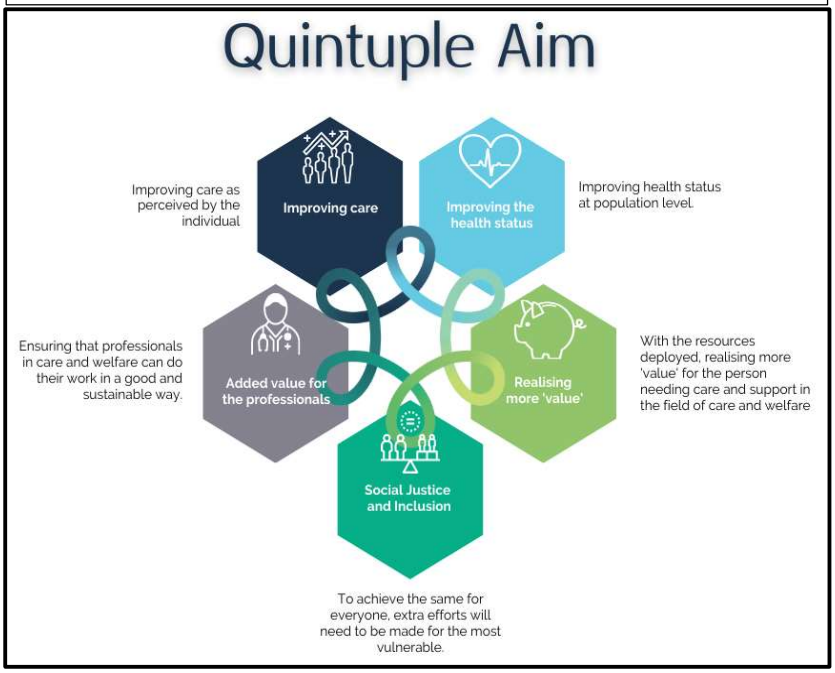
national priorities. These include mental health, Aboriginal and Torres Strait Islander health; population health; health workforce; digital health; aged care; and alcohol and other drugs

- Various stakeholders are involved in decision-making to ensure decisions, investments and innovations are influenced by community representatives, align with local care needs and better integrate local healthcare systems
  - ✓ Skills-based boards made up of experts health and corporate expertise;
  - ✓ GP-led clinical councils made up of doctors, nurses, allied and community health staff, Indigenous health workers, specialists and hospital management staff;
  - ✓ Community advisory committees made up of consumers and carers who have experience with and insights into the health system
- PHNs work to ensure health services connect with each other to share information which:
  - ✓ gives health professionals a clearer picture of people's health and treatment needs;
  - ✓ supports access the healthcare where and when needed

**Flanders**[63]

- Primary care reform in Flanders has three goals:
  - ✓ connecting medical care with welfare and social care;
  - ✓ strengthening people and care actors towards people-centred, integrated and global oriented care by a bottom-up approach;
  - ✓ strengthening population-oriented approaches
- The transition programme focused on three areas:
  - ✓ content: changing the way care is provided
  - ✓ structure: new structures to support changing care
  - ✓ instruments: facilitating desired changes
- 60 primary care zones seek to strengthen collaboration and coordination within the system
- Primary care zones are governed by Primary Care Boards, which have equal representation of four clusters: 1) local authorities; 2) health; 3) well-being; and 4) representatives of people with a need of care and support
  - ✓ In 2022, work began to re-evaluate the role of local authorities, onboard other organisations and expand with additional welfare organisations
  - ✓ Primary Care Boards provide support to primary care professionals and organisations for multi- and inter-professional collaboration and contributions to prevention
- The Flemish Institute for Primary Care (VIVEL), funded by the Flemish Government, fosters organisation of the four clusters (Figure 7)

***Figure 7. VIVEL's quintuple aim***
***Source: Vivel[63]***




[63] 9789289054164-eng.pdf (who.int)

# Country Insights

The following countries are featured as they provide examples of **evidence-based and innovative approaches to embedding prevention and public health** in PCC

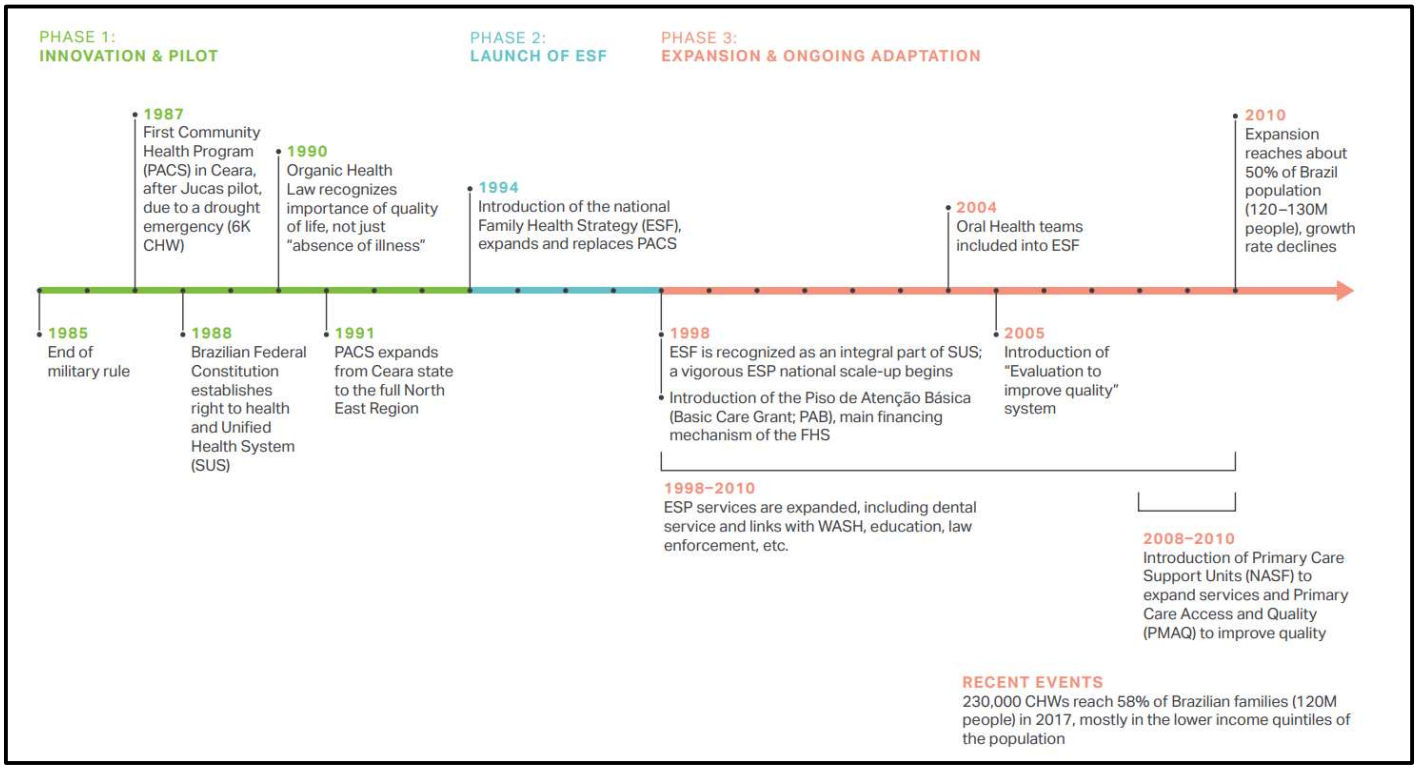
- Brazil's Family Health Strategy is one of **the largest community-based PCC programmes** in the world where **Community Health Workers are at the forefront**
- Slovenia's PCC approach delivers **person-centred, integrated** healthcare through the collaborative efforts of **multi-professional teams**, such as Health Promotion Centers

# Brazil

## Background[64,65,66,67,68,69,70]

- Brazil's health system (Figure 8), Sistema Único de Saúde (SUS), has four key principles:
  1) universality
  2) integrity
  3) decentralisation
  4) community participation
- It is funded by tax revenue and contributions from federal, state and municipal governments; administration and delivery of care are handled by municipalities or states
- 75% (2020) of the population is formally covered by the public health sector, with equal benefits and equal financial protection

***Figure 8. Brazilian health system timeline from 1985 - 2010***
***Source: Exemplars in Global Health[71]***




[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447689/
[65] https://doi.org/10.1093/acrefore/9780199366439.013.413
[66] https://www.who.int/bulletin/volumes/88/9/10-020910/en/
[67] https://pubmed.ncbi.nlm.nih.gov/21561655/
[68] https://www.publichealth.columbia.edu/research/others/comparative-health-policy-library/brazil-summary#:~:text=Urban%2C%2012.6%25%20Rural-,HISTORY,priority%20in%20the%20health%20system.
[69] Assessment and recommendations for the health system in Brazil | OECD Reviews of Health Systems: Brazil 2021 | OECD iLibrary (oecd-ilibrary.org)
[70] Brazil | International Health Care System Profiles | Commonwealth Fund
[71] Brazil Overview | Exemplars in Global Health

## Primary Care[72,73,74,75,76]

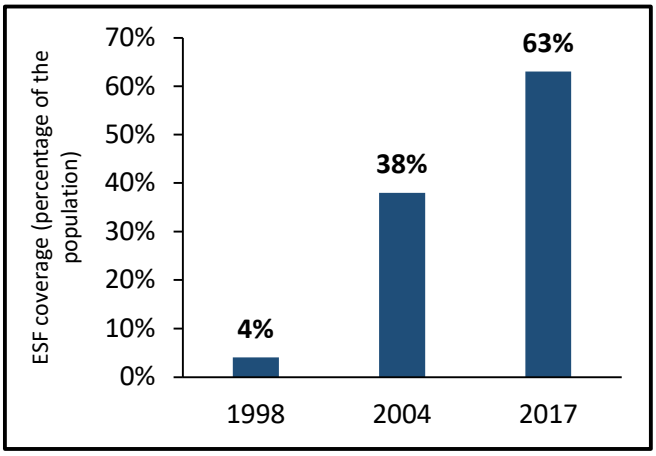
- Following decentralisation of healthcare provision under SUS, 84% of primary care is provided by municipal governments
- Over the past decade, Brazil has implemented reforms to develop the system and improve care quality and the range of services provided by Family Health Teams (FHTs)
- The current phase of reforms, started in 1998 and sought to strengthen care management through regionalisation of the SUS, using FHTs to address challenges in coordination across levels of care
  - ✓ FHTs implemented Basic Health Units in municipalities, the main entry point for PCC; teams serve up to 5,000 people in each region regardless of socio-economic status

## The Family Health Strategy[77,78,79,80,81]

- The Family Health Strategy, *Estratégia de Saúde da Família* (ESF), is the mechanism of PCC delivery through the public system and the main platform for achieving UHC
- ESF promotes the expansion and problem-solving capacity of primary care in an integrated and planned manner
- It is one of the largest community-based PCC programmes in the world, scaling up PCC by successfully increasing population coverage and improving key health outcomes
- It emphasises healthcare in community health facilities and at home to a defined local population using FHTs
- It has reached disadvantaged groups and reduced health inequalities
  - ✓ It was associated with a reduction in mortality from ambulatory-care-sensitive conditions which was twice as high in black/mixed race individuals compared to white individuals[82]
  - ✓ Amongst older adults, the middle and poorest wealth groups had lower risk of all-cause and avoidable mortality than the richest wealth group[83]
  - ✓ Enrolment in ESF was associated with greater reductions in the risk of all-cause mortality for individuals with lower education[84]
- The financing scheme of ESF uses a framework of incentives with two components:
  - ✓ a fixed amount from the federal government (based on the number of inhabitants to finance primary care expenses)
  - ✓ a variable amount conditioned on number of FHTs
- Money from the federal government to municipalities is conditioned on their performance managing PCC, which is monitored through information systems and regulation mechanisms
- ESF provides evidence that scaling up PCC to achieve UHC in a large country with marked inequalities is feasible (Figure 9)

[72] Primary Health Care in Brazil | en | OECD
[73] Brazil's Primary Care Strategy (worldbank.org)
[74] Brazil's Family Health Strategy — Delivering Community-Based Primary Care in a Universal Health System | NEJM
[75] Transition to universal primary health care coverage in Brazil: Analysis of uptake and expansion patterns of Brazil's Family Health Strategy (1998-2012) | PLOS ONE
[76] How did Brazil implement? | Exemplars in Global Health
[77] Executive summary | OECD Reviews of Health Systems: Brazil 2021 | OECD iLibrary (oecd-ilibrary.org)
[78] Family Health Strategy — Ministry of Health (www.gov.br)
[79] Brazil: The Family Health Strategy - Health For All - NCBI Bookshelf (nih.gov)
[80] The impact of the Brazilian family health on selected primary care sensitive conditions: A systematic review | PLOS ONE
[81] The Family Health Strategy coverage in Brazil: what reveal the 2013 and 2019 National Health Surveys - PubMed (nih.gov)
[82] Association between expansion of primary healthcare and racial inequalities in mortality amenable to primary care in Brazil: A national longitudinal analysis - PubMed (nih.gov)
[83] Family Health Strategy, Primary Health Care, and Social Inequalities in Mortality Among Older Adults in Bagé, Southern Brazil - PubMed (nih.gov)
[84] Primary healthcare expansion and mortality in Brazil's urban poor: A cohort analysis of 1.2 million adults | PLOS Medicine

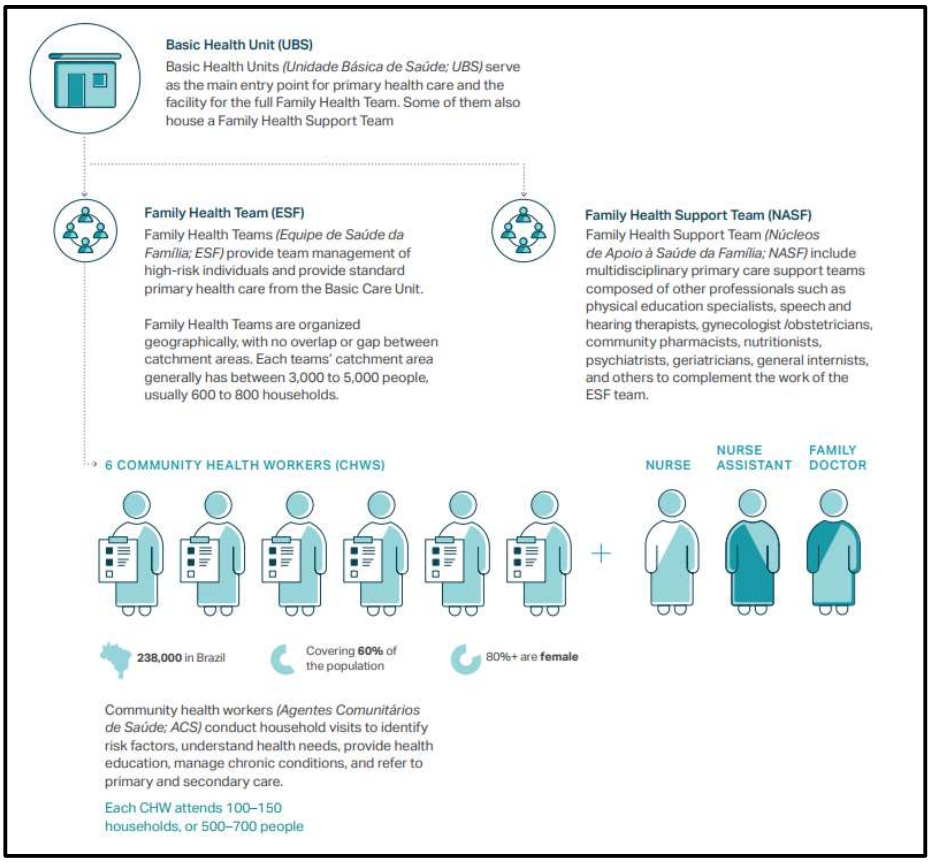
***Figure 9. Percentage of the population covered by ESF, 1998-2017***
***Source: Brazil Ministry of Health data presented by Bornstein et al. (2020, p2)[85]***




## Community Health Workers[86,87,88,89,90]

- ESF places Community Health Workers (CHWs) at the forefront of PCC (Figure 10), enabling services to reach populations on the edges of major cities and in *favelas*
- CHWs operate as members of the FHTs managed by municipalities

***Figure 10. Primary Care Programme overview***
***Source: Exemplars in Global Health[88]***




[85] https://www.exemplars.health/topics/community-health-workers/brazil
[86] Community Health and Wellbeing Worker programme – NAPC
[87] The Community Health Agent Program of Brazil (chwcentral.org)
[88] From Brazil to Westminster: learning from a community health worker model - Imperial Medicine Blog
[89] How did Brazil implement? | Exemplars in Global Health
[90] Health conditions and health-policy innovations in Brazil: the way forward - PubMed (nih.gov)

- Individuals are recruited from neighbourhoods and trained on health and social care issues
  - ✓ They visit all households they are responsible for at least once a month
  - ✓ They assess the needs of the community, develop trusting relationships with the households, and work with the local PCC team to ensure that any health and social care issues get resolved quickly
- Main duties of a CHWs include:
  - ✓ reinforcing public health messaging
  - ✓ resolving vaccine hesitancy
  - ✓ improving screening uptake
  - ✓ supporting the management of individuals with multimorbidity
  - ✓ identifying at-risk children, truancy, social isolation and loneliness
  - ✓ supporting individuals with low-level mental health problems
- Health protection activities include contact tracing, identifying, and giving advice on vectors and their breeding grounds
- Health promotion is provided directly into households on weight loss, healthy diet, physical activity, breastfeeding, falls risks, foot hygiene for diabetics and smoking cessation
- This approach resulted in a 34% decline in cardiovascular disease mortality and 18% decline in mortality for stroke within areas that have fully implemented the model
- Infant mortality rates declined from 114 deaths per 1,000 live births (1975) to 19 deaths per 1,000 live births (2007); life expectancy increased from 52 years (1970) to 73 years (2008)
- The country also has a strong HIV/AIDS programme; has eliminated polio; and has almost eliminated measles, diphtheria and Chagas disease

# Slovenia

## Background

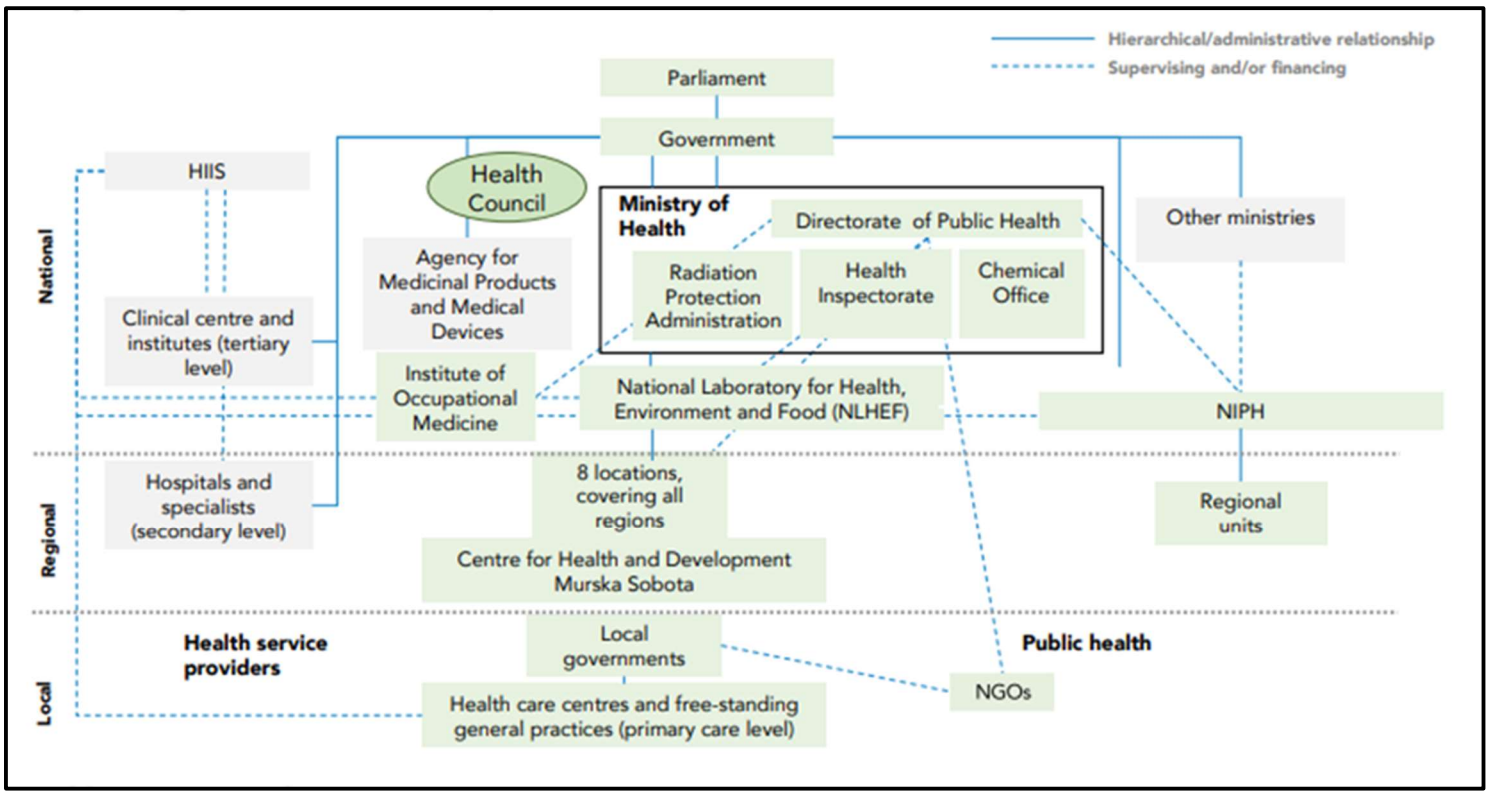
- The healthcare system in Slovenia is based on the Health Care and Insurance (HCI) Act of 1992, which developed the Bismarck-type social insurance system that provides universal health insurance[91] (Figure 11)
- Slovenia has experienced a more rapid growth in life expectancy than any other EU country, and since 2013, it has surpassed the EU average[92,93]
- Slovenia ranks 24th in global health and health systems rankings (the UK ranks 34th)[94]

## Primary Care

- The PCC system adheres to an Integrated Community-Centric Model, providing comprehensive services encompassing prevention, diagnosis, treatment, rehabilitation, palliative care and health promotion initiatives tailored to specific populations
  - ✓ The integrated care model stands out for its emphasis on coordination, networking, and communication within healthcare services, achieving integration both in terms of services and clinically[90]
  - ✓ It promotes external connections between healthcare providers and patients or their informal caregivers, particularly targeting specific illnesses

[91] 9789289055284-eng.pdf (who.int)
[92] Slovenia: Country Health Profile 2017 | READ online (oecd-ilibrary.org)
[93] The evolution of community-based primary health care, Slovenia - PMC (nih.gov)
[94] Health index of countries worldwide in 2023 | Statista

***Figure 11. Slovenian healthcare system***
***Source: WHO Regional Office for Europe[95]***




- The Slovenian Government established the PCC system in alignment with WHO's principles, emphasising the concept of UHC
  - ✓ This approach aims to ensure that healthcare is accessible and affordable for all, regardless of location, and places a strong focus on delivering person-centred care through the provision of targeted patient management and personalised healthcare providers[94]
- PCC services are organised by individual municipalities for their respective regions[94]
  - ✓ Services set out to provide one family medicine practice or one paediatric practice per 1500 inhabitants
  - ✓ In cases where a municipality is too small to independently provide these services, they collaborate with neighbouring municipalities
  - ✓ There are 57 community health centres (CHCs) alongside affiliated satellites or health posts operating across 459 locations
- To further enhance the healthcare infrastructure, a family medicine residency programme prioritising the health needs of the population throughout their life course was introduced in 2000[96]
- To promote public health, Health Promotion Centers (HPCs) were introduced within CHCs in 2002[94]
  - ✓ HPCs encourage healthy lifestyles and address modifiable risk factors such as unhealthy diet[97]

[95] 9789289055284-eng.pdf (who.int)
[96] Changes in primary health care centres over the transition period in Slovenia | European Journal of Public Health | Oxford Academic (oup.com)
[97] Primary health care reforms in Slovenia: leveraging existing structures to expand care | European Journal of Public Health | Oxford Academic (oup.com)

- ✓ There are 28 HPCs managed by CHCs, with operational support provided by the National Institute of Public Health[98]

– PCC delivers person-centred, integrated healthcare through collaborative efforts of multi-professional teams, which include professionals specialising in family medicine, primary care paediatrics and gynaecology, emergency medical aid, general and youth dentistry[99]
  - ✓ PCC services offer physiotherapy, occupational therapy, speech therapy, and mental health services
  - ✓ Community nursing services are provided, alongside health promotion initiatives and health education programmes
  - ✓ Selected secondary-level specialist ambulatory practices are available to cater to more specialised healthcare needs

## Implementing the HPC Pilot[100]

– After 10 years, an HPC evaluation showed that vulnerable populations were not attending free-of-charge preventive services
– A pilot project was developed with the National Public Health Institute as a coordinator enabling HPCs in 25 CHCs to reach their communities with support from social services, employment agencies and NGOs
– The aim was to identify people most in need of preventive services, inform them about availability of services, address specific needs and bring programmes to the community
– Data was provided to make mayors aware of their community health needs and encourage them to invest in appropriate solutions
– The pilot invested €30 million from European funding through the European Union as well as money from the Slovenian Government
  - ✓ €1.6 million was invested in the largest HPC and in the most vulnerable populations
  - ✓ The pilot also relied on communities to invest in public health programmes in their own communities (e.g., premises for physical activities or other community programmes to raise awareness on public health programmes)
– A small unit of Ministry of Health oversaw the pilot while the National Public Health Institute provided co-ordination among regional entities (e.g., mayors and communities)
– HPCs were the key institutions on the ground to ensure all stakeholders were involved appropriately and made action plans for the community
– As a result of the pilot:
  - ✓ participation among the most vulnerable groups in preventive services increased
  - ✓ a plan was developed to systemise the approach and further integrate public health and PCC (particularly mental health services); funding was ensured through an increased regular budget through the insurance fund for all PCC centres
  - ✓ the National Public Health Institute, financed through the state budget, became responsible for co-ordination, provision of local health profiles, and monitoring and ensuring trainings

[98] Primary health care reforms in Slovenia: leveraging existing structures to expand care | European Journal of Public Health | Oxford Academic (oup.com)
[99] Health Systems in Transition: Slovenia (Vol. 18 No. 3 2016) (who.int)
[100] Integrating public health and primary health services: building strong foundations for population health (who.int)

## Outcomes

- Multi-professional family medicine teams expanded to incorporate part-time nurse practitioners, who play a vital role in conducting routine check-ups, referrals and health education[101]
  - ✓ This strengthened preventive measures aimed at managing chronic diseases
  - ✓ During the COVID-19 pandemic, Slovenia was one of a few countries that relied on multi-professional team practices to maintain continuity of care for people[102]
- In 2015, Slovenia achieved a rate of 580.9 per 100,000 for avoidable hospitalisations for ambulatory care-sensitive conditions[103]
- Screening programmes have been highly effective; high participation rates in cervical and breast cancer screening initiatives have played a significant role in reducing mortality in individuals under the age of 65[102]
- Unmet need for medical examination is very low; in 2022, 0.1% or less of adults (16+ years) reported unmet need due to expense, travel time or travel distance respectively, compared to 3.6% reporting unmet need due to waiting times[104]

[101] https://www.who.int/health-topics/quality-of-care#tab=tab_1
[102] 2020_healthatglance_rep_en_0.pdf (europa.eu)
[103] 9789289055284-eng.pdf (who.int)
[104] Statistics | Eurostat (europa.eu)

## Appendix A: Primary and Community Care in Wales

- The PCC approach in Wales has been influenced by several national publications and regulatory activities between 2010 and 2018[105]
- In January 2018, *the Parliamentary Review of Health and Social Care in Wales* set a vision for care in Wales that is preventative and person-centred, empowering individuals to make decisions about their care and access seamless, high-quality care closer to home[106]
- Welsh Government's response, *A Healthier Wales: our Plan for Health and Social Care (2018)*, called for new models of seamless health and social care at the local and regional level; it sets out[107]:
  - ✓ a vision of a whole-system approach to health and social care focused on health and well-being and on prevention
  - ✓ the direction for attaining the *Well-Being of Future Generations Act* (2015)

**Primary Care Model for Wales**[104]

- The Primary Care Model for Wales (PCMW) was developed focusing on place-based care, care closer to home and multi-professional working
- The PCMW evolved from earlier pacesetter work, describing how health and care will be delivered locally as part of a whole-system approach (Figure 12)
- Wales's 60 clusters are at the heart of the model, bringing together all local health and care services divided across geographical areas, typically serving between 25,000 and 100,000 people. Benefits include:
  - ✓ better co-ordinated care, promoting the well-being of individuals and communities
  - ✓ multi-professional groups with representation from health, social care and the third sector
  - ✓ collaboration to identify community assets, needs and priorities
- The PCMW sets out 13 transformational outcomes describing key areas that need to be in place (Figure 13), with three levels of maturity[104]

**Strategic Programme for Primary Care**[104]

- The Strategic Programme for Primary Care (SPPC) drives transformation in primary and community care, applying a 'Once for Wales' approach (Figure 14)
- To strengthen progress of clusters towards the PCMW and the SPPC developed the Accelerated Cluster Development (ACD) programme, which focuses on delivering place-based care through Professional Collaboratives and Clusters, aims to increase understanding of local population needs and enable effective and robust planning and service delivery
- Wales has committed to configuring its PCC approach to address the needs of populations who experience or are at risk of experiencing health inequalities[108]
  - ✓ GPs serving communities and groups with the greatest needs are facing greater challenges with fewer resources
  - ✓ The mutually supportive Deep End GP network helps address this issue

[105] Primary Care Model for Wales - Primary Care One (nhs.wales)
[106] Parliamentary Review of Health and Social Care in Wales Final Report (gov.wales)
[107] A Healthier Wales (gov.wales)
[108] Deep End Wales Project (rcgp.org.uk)

***Figure 12. Primary Care Model for Wales***
***Source: Public Health Wales Primary Care Division[109]***

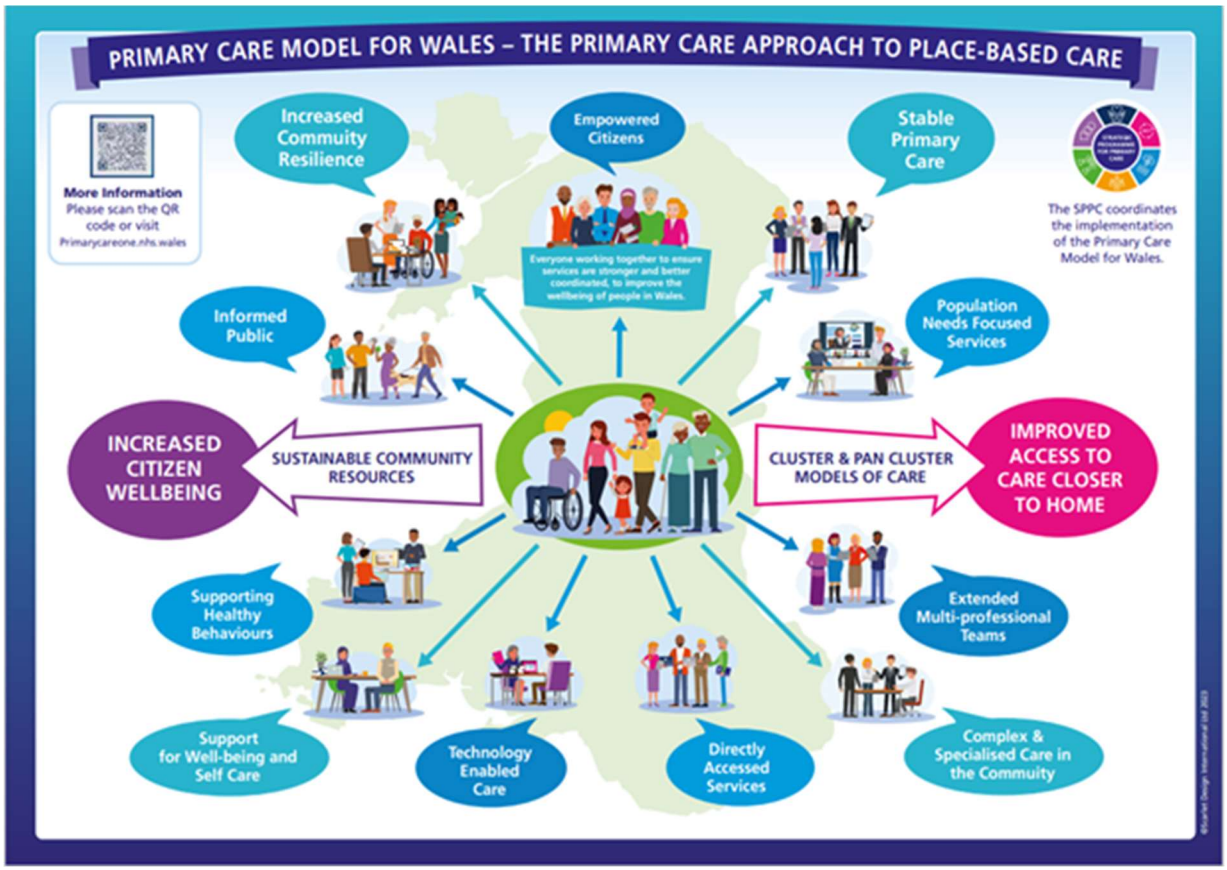
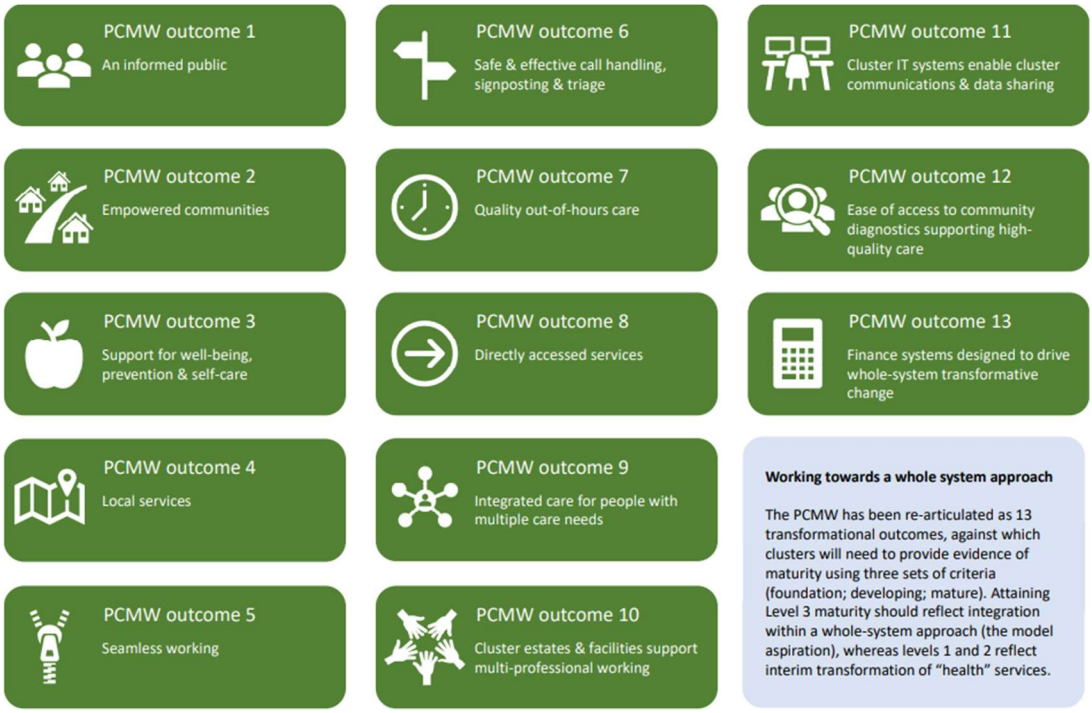



***Figure 13. PCMW transformational outcomes***
***Source: Public Health Wales Primary Care Division[108]***




[109] Primary Care Model for Wales - Primary Care One (nhs.wales)

***Figure 14. Wales's Strategic Programme for Primary Care***
***Source: NHS Wales[110]***


[110] Strategic Programme - Primary Care One (nhs.wales)

## Case Study: The Deep End Cymru Project[111,112]

- Deep End Cymru seeks to introduce measures that mitigate impacts of inequitable health determinants through:
  - ✓ creating a network of GP practices and primary care teams that work in and with the most deprived communities;
  - ✓ supporting the development of these practices (i.e., sharing best practice and educational resources), recruitment and retention;
  - ✓ developing systems leadership and collaboration;
  - ✓ advocating for the communities, as well as for GPs and their practices; and
  - ✓ improving outcomes and staff well-being
- The Deep End movement began in Scotland in 2009 and has extended to multiple programmes in the UK and internationally
- "Deep End" describes the additional needs for populations living in the most deprived areas with the concomitant increase in workload and complexity for GP practices that support these communities
- Deep End programmes identify eligible GP practices and explore common challenges and possible solutions
  - ✓ Most have themes of Workforce, Education, Advocacy and Research (WEAR) to define their priorities
  - ✓ They align with current cluster and place-based approaches to add additional value
- The programmes have generated rich evidence, both qualitative and quantitative and international bulletins are published to share progress
- Deep End Cymru started in late 2022 and invited participation from 100 practices which have the highest proportion of patients living in the most deprived areas based on Welsh Index of Multiple Deprivation
  - ✓ This proportion ranges from 83% of patients in the top practice to 34% in the 100th
  - ✓ This focuses on "blanket deprivation"; Deep End reaches 382,450 patients (about 60% of the target population), so it misses some "pockets of deprivation", which means that many people living in the most deprived areas are registered with non-Deep End practices
  - ✓ However, the impact on the practice workload is therefore proportionately less, and they may have greater capacity to absorb this
  - ✓ Most Deep End practices are in the Valleys, Newport, Swansea and Cardiff
- In November 2022, the project was launched at a face-to-face meeting in Gwent and several key priorities resulted, including:
  - ✓ Patient literacy and advocacy
  - ✓ Workforce challenges
  - ✓ Mental health
  - ✓ Elderly and co-morbidity
  - ✓ Funding and finance
  - ✓ Reducing waiting lists
- Although in its infancy, the first phase has engaged positively with Deep End eligible practices, with 85% eligible practices responding positively; of these, 31% attended at least one of the four events

[111] GENERAL PRACTITIONERS AT THE DEEP END international bulletin no 8 December 2022 (gla.ac.uk)
[112] *Deep End Wales Project (rcgp.org.uk)*

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