Lessons from primary health care in the United Kingdom

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ABSTRACT

The health system in Indonesia is facing the persistent burden of maternal mortality and infectious diseases (including COVID-19) and an increasing burden of non-communicable diseases. Thus, health system reform and innovations at all levels are needed, including through lessons learned from other countries. There are at least five lessons from primary health care in the United Kingdom: easy access, digital and online services, continuity of care, managing chronic conditions, and referral and counter-referral system. There are lessons that policymakers and stakeholders at the national and local (city/district) level could potentially learn from. Despite the differences between the UK and Indonesia (e.g. country income level, national health systems), these lessons could be adapted or piloted in some settings.

INTRODUCTION

Like in many low-and-middle-income countries (LMICs), the health system in Indonesia is facing the persistent burden of maternal mortality and infectious diseases (including COVID-19) as well as an increasing burden of non-communicable diseases (NCDs) (Kusuma et al. 2019). Thus, health system reform and innovations at all levels (community, primary care, and secondary/tertiary care) are needed, including through lessons learned from other countries. This commentary aims to provide lessons learned from primary health care (PHC) in the United Kingdom (UK). However, I will first present a brief introduction to PHC and the UK health systems.

DISCUSSION

The concept of PHC started at the International Conference on Primary Health Care, which resulted in the Declaration of Alma Ata (USSR) in September 1978 (WHO, 1978). There are at least two things to be highlighted. **First**, Article 1 provided a definition of health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. This understanding that health is not just physical health, but also mental health and social wellbeing is an essential basis for PHC. **Second**, Article VII stated that PHC addresses main health problems in the community through promotive, preventive, curative and rehabilitative services. These are some examples of PHC services, many of which can now be found at government and private clinics in Indonesia.

In 2008, 30 years after Alma Ata, experts provided reviews and revisions to the concept so that PHC can better respond to current global health challenges, especially in LMICs. These reviews, published in The Lancet journal, included interventions to address maternal, newborn, and child survival for integrated PHC strategies (Bhutta *et al.*, 2008), and how PHC can help improve the prevention and management of chronic disease in LMICs (Beaglehole *et al.*, 2008). In October 2018, WHO and UNICEF held the second global conference on PHC, which resulted in the Declaration of Astana (Kazakhstan). This was to reaffirm the global commitments towards universal health coverage and the Sustainable Development Goals through PHC (WHO, 2018). WHO and UNICEF shared a vision that "*PHC is a whole-of-society approach to health that aims at*

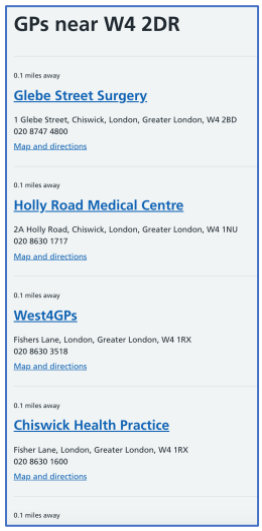
ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (WHO, 2021).

In the UK, the health system is mainly funded through general taxation, with the remainder coming from private medical insurance and out-of-pocket payments. In the provision of services, while PHC and secondary/tertiary care are provided by the National Health Services (e.g., NHS England or NHS Scotland), public health services are provided by public health institutions (e.g., Public Health England or Health Protection Scotland). Primary care is mainly provided by practice-based general practitioners (GP), with practices increasingly including other health care professionals such as nurses. Most secondary care is provided by salaried specialist doctors and others who work in state-owned hospitals. Tertiary services offer more specialized care, and are often linked to medical schools or teaching hospitals (Cylus *et al.*, 2015).

There are at least five lessons from PHC in the UK. **First**, registering or accessing the GP is easy, that is through the NHS website (www.nhs.uk/service-search/find-a-GP). One only needs to enter a town, city or postcode in England and the website will provide a list of clinics to choose from. Filling in a postcode W4 2DR, for instance, will give a list of several GP clinics in London (see Figure 1). Similarly, for rural areas, filling in a postcode WV16 4BX will provide a list of clinics within or nearby Bridgnorth Town, nearly 230 kilometers from London or 44 kilometers from Birmingham.

Figure 1. Easy access to GP

(a) 

(b) 

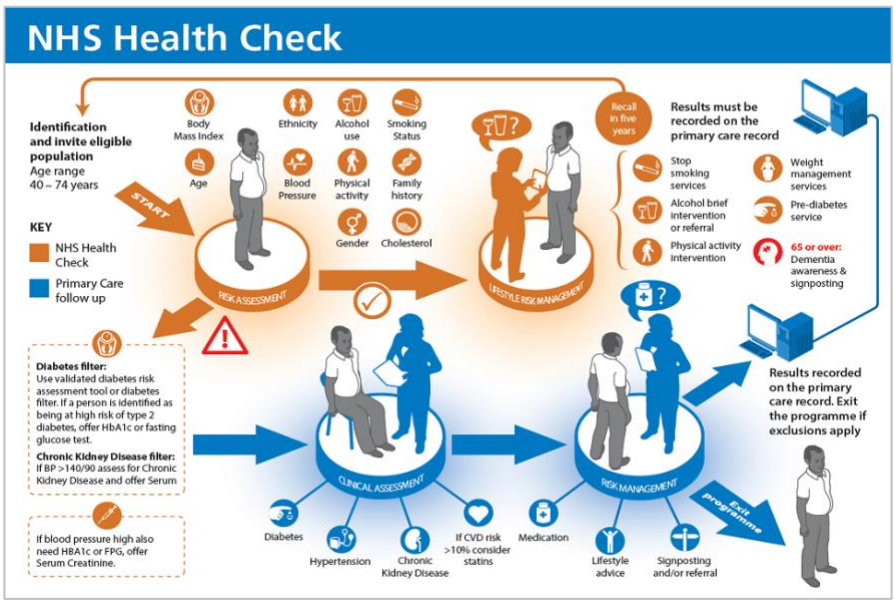
Second, all clinics have digital and online information/services. By clicking one clinic website (e.g., Holly Road Medical Centre in Figure 1 panel b), one will find information on opening times, appointment, services, medical or health team, and contact. While services provided may vary between city and town clinics, all patients need to make an appointment before coming to clinics. This helps reduce patient queue and waiting time at a clinic.

Third, PHC is designed to provide continuity of care for patients. A study in public clinics in Malaysia showed that 85% of sampled patients reported having no own doctor when needing help with health problems (Lim *et al.*, 2021). In the UK, all residents can register with a GP and consult their GP practice without charge. Primary care increasingly means not only a GP but a whole team of doctors, nurses, midwives, health visitors and other health care professionals in a community

setting. GP surgeries provide a range of services, including routine diagnostic services, minor surgery, family planning, ongoing care for patients with chronic conditions, antenatal care, preventive services, health promotion, outpatient pharmaceutical prescriptions, sickness certification and referrals for more specialized care. All this is to support continuity of care for patients (Cylus *et al.*, 2015).

Fourth, PHC provides services and support in managing chronic conditions. A study in Indonesia found that many cities and districts in Indonesia have a very high prevalence of obesity, hypertension, and diabetes among the adult populations (Adisasmito *et al.*, 2020). However, support to help manage these conditions is lacking at the PHC level (Kusuma et al. 2019). In the UK, services at NHS clinics include managing chronic diseases such as diabetes, chronic heart diseases, COPD, and hypertension. There are also support on healthy lifestyles such as smoking cessation, weight loss, and alcohol advice (for example, see: https://www.hollyroadmedicalcentre.nhs.uk/services/). Moreover, the clinics provide NHS Health Check, a national program to assess the risk of developing heart disease, stroke, diabetes, kidney disease among everybody age 40+ years (see Figure 2) (UKGOV, 2021).

Figure 2. NHS Health Check (UKGOV, 2021)



Fifth, a working referral and counter-referral system between PHC and hospitals. A study in Malaysia found that over 80% of doctors at public clinics reported seldom/never or occasionally received counter referrals of their patients from specialists at hospitals (Lim *et al.*, 2021). In the UK, if one wishes to be referred to a specialist at hospitals, s/he should see her/his GP because all medical records are held by that clinic. After a referral, the GP will receive back the information from hospitals (either electronically or by paper or both). All this to ensure an active referral and counter-referral system between all levels of care.

All these lessons are valuable to help improve health systems in Indonesia, especially within the context of achieving *Jaminan Kesehatan Nasional* (JKN), or universal health coverage. The challenges for JKN increase with the rapid growth of the population covered. Among others, service preparedness is among the main challenges. Inadequate medical facilities remain an issue, especially for public hospitals and puskesmas. In 2017, 82% of public hospitals received a passing grade for preparedness; however, only 67% of puskesmas passed. Antenatal care coverage, as one of the service parameters, ranged from 40% in remote provinces such as Maluku

and Papua to 85% or more in urban areas such as Bali and DI Yogyakarta (Agustina *et al.*, 2019). Efforts are needed to strengthen the role of PHC in response to these challenges.
While national adoption of all the lessons from the UK may not be feasible at once, adoptions of select lessons through pilots may be more suitable. City governments may improve registration and access to Puskesmas or private clinics through a website, including helpful information on available services in each clinic. Also, the Ministry of Health may collaborate with some local governments to design and pilot an enhanced PHC at puskesmas or private clinics to better tackle NCDs (e.g. stroke, diabetes) and their risk factors. In Malaysia, the government piloted such reform to improve the performance of the health system in managing NCDs, an integrated care model was designed to enhance existing healthcare services by incorporating public health, primary healthcare and social support as part of a 'network' linked to appropriate secondary and tertiary hospital services (Sivasampu *et al.*, 2020). Also, the Ministry of Health and BPJS (the national health insurance agency) may collaborate with puskesmas and private clinics in creating/recreating an effective national program to improve NCD prevention and control, similar to the NHS Health Check.

CONCLUSION

There are at least five lessons from PHC in the UK that policymakers and stakeholders at the national and local (city/district) level could potentially learn from. Despite the differences between the UK and Indonesia (e.g. country income level, national health systems), these lessons could be adopted or piloted in some settings in Indonesia.

DECLARATIONS

Ethics approval and consent to participate: Not applicable
Conflict of interest: None
Availability of data and material: Not applicable
Funding: None
Authors' contributions: DK conceived, drafted, and revised the manuscript.
Acknowledgments: None

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