

## National respiratory guidelines used by primary care

### Introduction

In May and June 2013 the IPCRG mapped the clinical guidelines used by primary care in its member countries for the chronic lung conditions commonly found in primary care: chronic obstructive pulmonary disease (COPD), asthma, allergic rhinitis, community-acquired pneumonia (CAP), obstructive sleep apnoea (OSA) and tobacco dependence. The mapping collected information on clinical respiratory guidelines at the national level (referred to as national guidelines) that are used by primary care for these conditions and which of these guidelines had involved primary care in their development. The overall aim of the mapping is to provide a resource on the IPCRG web platform that enables country members easily and quickly to share information and learning about national guidelines. The IPCRG anticipates that it will also be useful for health care planners developing national action plans for chronic lung conditions as it brings together for the first time information on guidelines currently in use across a wide range of countries. To ensure this resource remains relevant and useful, it will be updated as new information becomes available and additional countries will be added. This position paper provides a snapshot of the key features of the guidelines included in the mapping in June 2013. Further details of all the national guidelines identified by members can be found at: <https://www.theipcr.org/display/ResMapping/Mapping+of+national+guidelines+used+by+primary+care>. The methodology used for the mapping is described at: <https://www.theipcr.org/display/ResMapping/How+the+mapping+was+developed>.

### The importance of primary care and national guidelines

Primary care's importance in the health system and its health economic value have been fully described in the research

literature.<sup>1,2</sup> The IPCRG has summarised the extensive evidence that primary care has a pivotal role to play in managing the growing global burden of chronic lung disease through prevention, education and disease management.<sup>3</sup> We have also stressed that clinical guidelines, defined by the Institute of Medicine as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances", are an essential tool to enable primary care to fulfil its role effectively.<sup>4</sup> Clinical guidelines seek to improve the quality of healthcare, to reduce inappropriate variations in clinical practice and to support the education of health professionals. They are also used by patients to increase understanding of a condition, to improve self-management and to inform decision-making.

Clinical guidelines developed at a national level are able to take account of contextual factors such as epidemiological, demographic, political and economic factors that international guidelines cannot. Importantly, national guidelines can be designed to reflect the specific configuration of health services in a country including the distribution and resourcing of primary care. They can also address the particular health needs of population groups such as ethnic minorities and take account of cultural issues. In addition, they can include clinical factors that are specific to the country.

### Countries included in the mapping

This mapping included the following 21 countries:

- Australia
- Bangladesh
- Canada

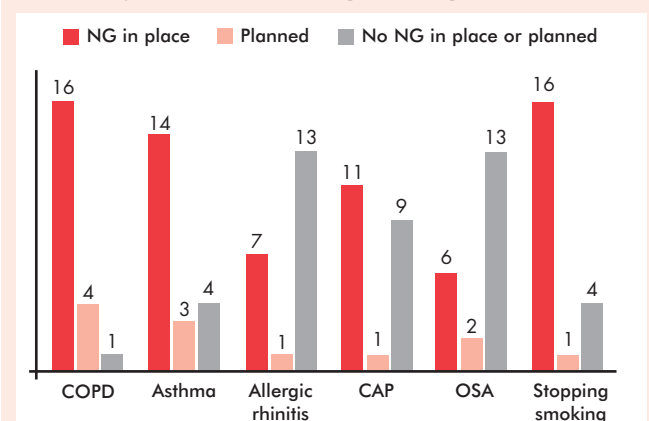
- Chile
- Cyprus
- Greece
- India
- Ireland
- Italy
- Netherlands
- New Zealand
- Norway
- Pakistan
- Poland
- Portugal
- Singapore
- Spain
- Sri Lanka
- Sweden
- UK
- Vietnam

### How many national guidelines did we find?

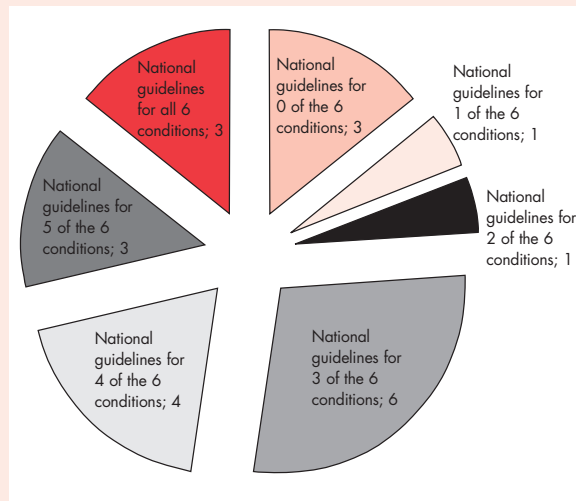
Across these 21 countries we identified a total of 70 national guidelines that were used by primary care for COPD, asthma, allergic rhinitis, CAP, OSA and support for stop smoking. In addition, a further 12 national guidelines were either planned or currently being developed. Figure 1 presents the number of participating countries with national guidelines in place or planned for each condition and the number with no national guidelines in place or planned.

National guidelines were in place for all six of the conditions in three participating countries (14%) and three had no national guidelines for any of these topics (14%). Figure 2 below shows how many national guidelines for the six conditions were in place. The mean number of national guidelines per country was 3.3.

**Figure 1. Number of participating countries with national guidelines (NGs) in place or planned**



**Figure 2. The number of participating countries (n=21) with the number of conditions for which national guidelines are in place**



**Table 1. Guidelines especially developed for use in primary care**

TOPIC	NO. OF GUIDELINES	NO. (%) DEVELOPED FOR PRIMARY CARE
COPD	16	3 (19%)
Asthma	14	3 (21%)
Allergic rhinitis	7	3 (43%)
CAP	11	3 (27%)
OSA	6	2 (33%)
Stopping smoking	16	5 (31%)

useful. As the table 1 shows, the majority of national guidelines identified through the mapping were not specifically designed for use in primary care.

As integrated care models become more predominant, guidelines that include both primary and secondary care are appropriate. However, it is important that primary care's crucial role in case-finding, diagnosis and treatment of chronic respiratory conditions is adequately reflected in guidelines for integrated care. It is also essential that primary care professionals are engaged to develop those sections directed at them to ensure they are relevant and useful.

Therefore, we were encouraged to see that primary care representatives had been involved in the development of between 50% and 86% of the identified guidelines although there was not sufficient information to determine how extensive or meaningful this involvement was. We were also pleased that IPCRG national member organisations were involved in the development of between 17% and 64% of national guidelines. This information is summarized in figure 4.

### The role of evidence

Clinical guidelines are intended to ensure that clinical practice is based on evidence. Therefore, effective guidelines must be based

on robust evidence.<sup>7</sup> IPCRG members have stressed that tools for primary care need to incorporate evidence from primary care which relate to real life populations, their expected multi-morbidities and service using behaviours.<sup>5,6</sup> Participants in the mapping reported that evidence-based methodologies were used to inform the development of between six out of 16 (38%) and four out of six (67%) of the national guidelines used in primary care. The topic for which an evidence-based methodology was most likely to be identified was OSA and the topic for which one was least likely to be identified was stopping smoking. This information is summarized in figure 5. The evidence-based methodologies most frequently cited were AGREE and GRADE.

### Implementing national guidelines

As part of the mapping we asked respondents to tell us about mechanisms and incentives for encouraging primary care practitioners to implement national guidelines. Such incentives were not identified as being in place for most of the guidelines. This is likely to impact negatively on their effectiveness. Incentives for implementation were most likely to be in place for COPD and asthma. Figure 6 provides more information. The incentives most frequently cited were audit and payment. We also asked respondents to tell us about any published research on the

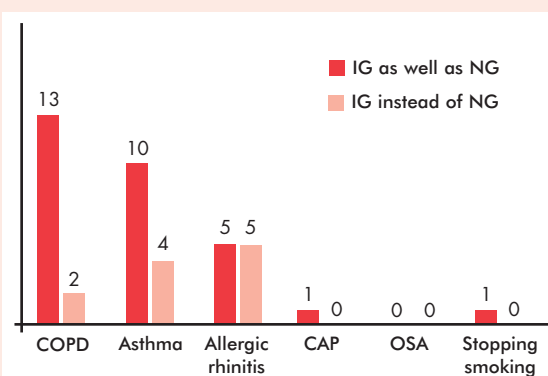
### International guidelines

International guidelines were used in many participating countries. In those countries with national guidelines in place, international guidelines were often used to inform those guidelines or to supplement them. In countries where no national guidelines were in place, international guidelines were sometimes used in primary care practice and in primary care education. The number of participating countries using international guidelines for each topic is given in figure 3. The international guidelines most frequently cited by respondents were GOLD for COPD, GINA for asthma and ARIA for allergic rhinitis.

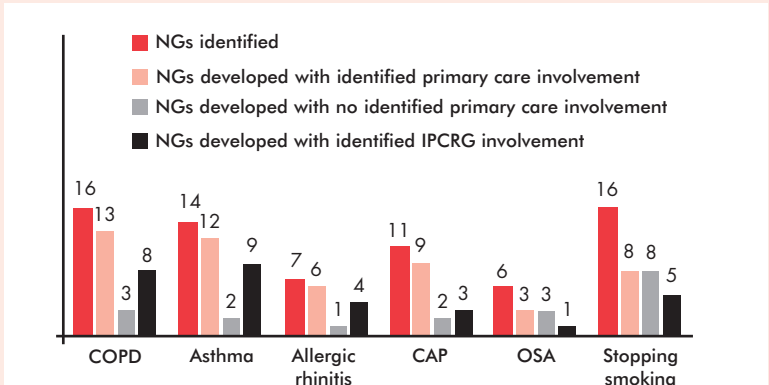
### Primary care involvement in national guidelines

IPCRG members have stressed that effective tools for primary care need to be simple and pragmatic.<sup>5,6</sup> Moreover, it is crucial they are developed with the input of primary care professionals to ensure they are relevant and

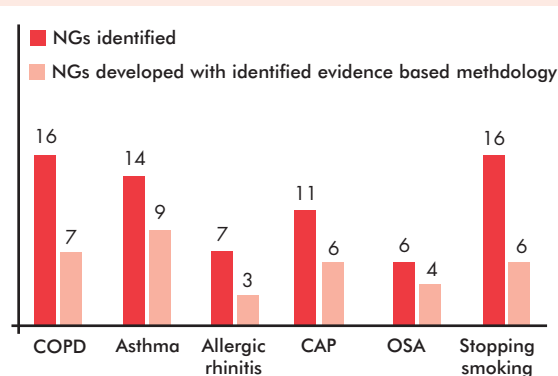
**Figure 3. Number of participating countries using international guidelines (IG) as well as or instead of national guidelines (NG)**



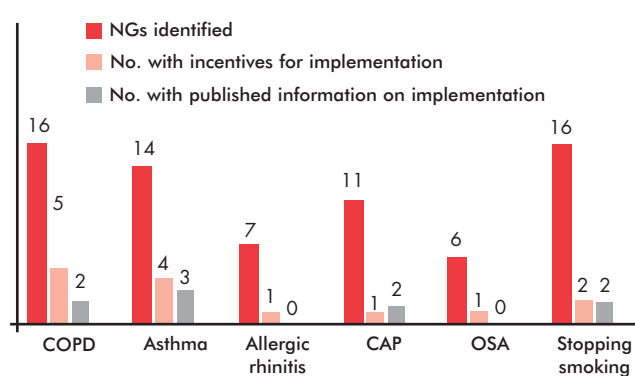
**Figure 4. Number of participating countries with national guidelines (NGs) developed with identified primary care (PC) and IPCRG involvement**



**Figure 5. Number of participating countries with national guidelines (NGs) for each condition developed using identified evidence based methodology**



**Figure 6. Number of participating countries with national guidelines (NGs) for each condition with identified incentives and published information on implementation**



implementation of national guidelines. Such research was identified for a total of only nine national guidelines. This very much supports the IPCRG's Research Needs Statement which concludes "international and national guidelines exist, but there is little evidence on the best strategies for implementing recommendations."<sup>5</sup>

## Conclusion

National guidelines are important tools in supporting primary care to manage chronic lung disease effectively. Across the 21 participating countries the mapping identified a total of 70 national guidelines that were used by primary care to address COPD, asthma, allergic rhinitis, CAP, OSA and tobacco dependence and a further 12 were planned. The mean number of national guidelines per country was 3.3. Primary care representatives were involved in developing most of the guidelines in some way. The mapping was not designed to assess the quality of national guidelines. However, it is notable that for many guidelines, respondents could not identify whether an evidence-based methodology was used. There were no incentives for implementation identified for most guidelines. There was also very little research on the implementation of guidelines. This underlines the continuing relevance of the priorities identified in the IPCRG Research Needs Statement.

## Recommendations

1. Every country should have a national action plan which describes primary care's role in chronic respiratory diseases including COPD, asthma, allergic rhinitis, tobacco dependence and, over time, community-acquired pneumonia and obstructive sleep apnoea.
2. This national action plan should include clinical guidelines relevant for primary care in that country that are based on evidence of real life populations with their expected multi-morbidities and service-using behaviours. Guidelines should encourage the same practice for the same interventions by family physicians or alternative primary care professionals as by hospital-based professionals to ensure coordinated care.
3. Where absent, planners could use the national guidelines identified by the IPCRG as a starting point to develop such clinical guidelines as part of national action plans.
4. Apply the principle of "nothing about me without me" when developing national action plans and clinical guidelines.<sup>8</sup> This means primary care professionals need to be involved in developing guidelines requiring primary care action. It also means patients need to be involved.
5. Every national action plan needs to

include an implementation plan that puts in place mechanisms that encourage clinicians to do the "right" thing (allocating resources where there would be most benefit) and to do it "right" (using appropriate and consistent technical skills). These plans need to be followed up to monitor how effectively clinical guidelines are implemented.

## References

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