Family Medicine and Primary Care at the Crossroads of Societal Change

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Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change
http://www.primafamed.ugent.be

http://www.wgcbotemarkt.be

http://www.euprimarycare.org

http://www.thenetworktufh.org
Community Health Centre:

- General Practitioners; nurses; dieticians; health promoters; dentists; social workers; tabacologist;...

- 6200 patients; 95 nationalities

- Integrated needs-based mixed capitation; no co-payment

- COPC-strategy
Family Medicine and Primary Care at the Crossroads of Societal Change

1. The changing society
2. Primary care: the challenges
3. Nano-level
4. Micro-level
5. Meso-level
6. Macro-level
7. Primary Care and Social Cohesion
8. Conclusion
The changing society

a. Demographical and epidemiological developments

b. Scientific and technological developments

c. Cultural developments

d. Socio-economical developments

e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)
By 2100, 85%?
Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

Summary
Background Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multimorbidity. We examined the distribution of multimorbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation.
Figure 1: Number of chronic disorders by age group
Figure 2: Prevalence of multimorbidity by age and socioeconomic status
On socioeconomic status scale, 1 = most affluent and 10 = most deprived.
Healthy life expectancy in Belgium, 25 years, men

Socio-economic inequalities in health

Healthy life expectancy in Belgium, 25 years, men

The changing society

a. Demographical and epidemiological developments

b. Scientific and technological developments

c. Cultural developments

d. Socio-economical developments

e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)
By 2100, 85%?
Woensdag redde een Zweeds schip nog 439 mensen voor de Libische kust; 51 anderen waren gestorven. © AP

Boot met honderden vluchtelingen gezonken
Wonca Europe 2015 Istanbul Statement:

“Urge governments to take action so that all people living permanently or temporarily in Europe will have access to equitable, affordable and high-quality health care services”
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SHIFT FROM HOSPITAL TO COMMUNITY CARE

Figure 1.2. Health care is progressively shifting out of hospitals but progress in some countries is still low

Panel A. Average annual growth rate of hospital beds, 2000-14 (or nearest year)
COOPERATION OF DIFFERENT HEALTH PROFESSIONALS IN THE SAME FAMILY PRACTICE (QUALICOPC, 2013)
FRAGMENTATION
Vertically Disease Oriented Approach

- Mono-disease-programs? Or…
- Integration in comprehensive PHC

HYPERTENSION  COPD  AIDS  OSTEOPOROSIS  DIABETES  HYPERCHOLESTEROL  OBESITY
Panel: Proposed Sustainable Development Goals

Goal 1
End poverty in all its forms everywhere

Goal 2
End hunger, achieve food security and improved nutrition, and promote sustainable agriculture

Goal 3
Ensure healthy lives and promote wellbeing for all at all ages

Goal 4
Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5
Achieve gender equality and empower all women and girls

Goal 6
Ensure availability and sustainable management of water and sanitation for all

Goal 7
Ensure access to affordable, reliable, sustainable, and modern energy for all

Goal 8
Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all

Goal 9
Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation
Primary health care and the Sustainable Development Goals

After the eight Millennium Development Goals (MDGs) that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September 2015. SDG3 explicitly relates to health—to “ensure healthy lives and promote well-being for all at all ages”. This goal is linked to reproductive and maternal health, non-communicable diseases, non-communicable disease risk factors, non-communicable disease management, and environmental health.

When supported and with aligned political and financial commitment, the health sector can make significant contributions to the achievement of many of the SDGs. Given the impressive progress made since the Alma Ata declaration, the absence of reference to primary health care in the current set of global health-related targets is a concern. Yet investment in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report The Lancet series on primary health care, and 37 years since the Alma Ata declaration, the absence of reference to primary health care in the current set of global health-related targets is a concern.

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Luisa M Pettigrew, Jan De Maeseneer, Maria Inez Podula Anderson, Akye Essuman, Michael R Kidd, Andy Haines
Department of Health Services Research and Policy (LMIF), and Department of Social and Environmental Health Research (AH), Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, London WC1 3HB, UK; Department of Family Medicine and Primary Health Care, Ghent University, Ghent, Belgium (JDM); Department of Family and Community Medicine, Rio de Janeiro State University, Rio de Janeiro, Brazil (M-IPA); Family Medicine Unit, Department of Community Health, School of Public Health, University of Ghana, Accra, Ghana (AE); and Faculty of Medicine, Nursing and Health Sciences, Flinders University, Adelaide, Australia (MRK)
luisa.pettigrew@lsthm.ac.uk


Comment

Delivering vaccines and drugs needs a functioning primary care system. Well-integrated and prepared primary health care has a key role in health emergency responsiveness, and it is essential for the achievement of UHC, equitably and cost-effectively.4,5

Moreover, primary health care can contribute to the achievement of many of the 16 other SDGs, for example, its role in addressing the social determinants of health was underscored in the report Closing the Gap in a Generation. Primary care teams worldwide can provide examples from daily practice that illustrate their contribution across the SDGs, including helping to end poverty, improve nutrition, provide health education, and promote lifelong learning, empower individuals and communities to reduce inequalities and promote justice, enable access to safe water and sanitation, encourage productive and sustainable employment, foster innovation, advocate for healthy and sustainable living environments, and promote peaceful communities.


Comment

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Expert Panel on Effective Ways of Investing in Health
Report of the
EXPERT PANEL ON EFFECTIVE WAYS
OF INVESTING IN HEALTH (EXPH)
on
Definition of a Frame of Reference in relation to Primary Care with a special emphasis on Financing Systems and Referral Systems
Opinion on Definition primary care – Definition

Core-definition

'The Expert Panel considers that primary care is the provision of universally accessible, integrated person-centered, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people’s care.

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.’
Opinion on tools and methodologies for assessing the performance of primary care

Expert Panel on effective ways of investing in health

Jan De Maeseneer
Chair of the Expert Panel

Sabina Nuti, Italy
Margareth Barry, Ireland

Brussels, 03 October 2017
Expert Panel on Investing in Health

Provides independent non-binding advice on effective ways of investing in health

<table>
<thead>
<tr>
<th>Domains</th>
<th>Examples of Indicators</th>
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| 8) Continuity of people’s care | • Do GP-practices have a patient list system? Or another form of defined population?  
• % of patients reporting to visit their usual PC provider for their common health problems  
• % of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.  
• % of patients who are satisfied with their relation with their GP/PC provider  
• Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services?                                                                                       |
## General structure

<table>
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<th>Meso</th>
<th>Macro</th>
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Nano-level:

The person/patient is the starting point of the process

• Active
• Informed
• Service delivery
• Multicultural

Accessibility
Equity
Characteristics of PHC / patient encounters

- C
- C
- C
- C
- C
- C
- C
- C
Characteristics of PHC /patient encounters

- Commitment - Connectedness
- C
- C
- C
- C
- C
- C
- C
- C
Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- C
- C
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Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
  - C
  - C
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Characteristics of PHC /patient encounters

• Commitment - Connectedness
• Clinical Competence
• Cultural Competence
• Context
• C
• C
• C
• C
Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity

- C
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- Continuity

Compassion ↔ Computer
The doctor hardly looked at me when we talked

(Schäfer et al., 2011)
International Classification of Primary Care (ICPC)

Allow us to measure what is happening daily in primary care locally, nationally, globally
Primary Health Care should be documented using ICPC in patient records.
International Classification of Functioning
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WELCOME to the Community Health Centre Botermarkt

Hundelgemsesteenweg 145
9050 Ledeberg

www.wgcbotermarkt.be
Info@wgcbotermarkt.be

Tel 0032 9 232 32 33
Fax 0032 9 230 51 89
Family physicians

Nurses

Social workers

Health promotion worker

Administrative staff and receptionist

Ancillary staff

Dietician

Dentists

External health care workers: physiotherapists, psychologists,…
Community Health Center Botermarkt Ledeberg!
Competency sharing

Care is provided by the person most equipped for the task and most knowledgeable about the subject. Disciplines share their competencies!
Social Work

• 2 FTE social workers
• Social work in the health centre includes:
  – first intake, exploring the problem
  – information and counseling
  – advocating, mediating
  – supporting, psychosocial guidance
  – referral to specialised services
  – administrative support, application for allowances, budget planning
  – establishing patient centered networks of care
Integrated care

- Physical, mental, ecological and social well-being
- Taking environment/living conditions into account
- Citizen/patient in the driver’s seat
Challenges in patients with multimorbidity
But…
Sum of the guidelines

Patient tasks

- Joint protection
- Energy conservation
- Self monitoring of blood glucose
- Exercise
  - Non weight-bearing if severe foot disease is present and weight bearing for osteoporosis
  - Aerobic exercise for 30 min on most days
  - Muscle strengthening
  - Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

Clinical tasks

- Administer vaccine
- Pneumonia
- Influenza annually
- Check blood pressure at all clinical visits and sometimes at home
- Evaluate self monitoring of blood glucose
- Foot examination
- Laboratory tests
  - Microalbuminuria annually if not present
  - Creatinine and electrolytes at least 1-2 times a year
  - Cholesterol levels annually
  - Liver function biannually
  - HbA1C biannually to quarterly

Referrals

- Physical therapy
- Ophtalmologic examination
- Pulmonary rehabilitati

Patient education

- Foot care
- Osteoarthritis
- COPD medication and delivery system training
- Diabetes

Time | Medications
---|---
7:00 AM | Ipratropium dose inhaler, Alendronate 70 mg/wk
8:00 AM | Calcium 500 mg, Vit D 200 IU, Lisinopril 40mg, Glyburide 10mg, Aspirin 81mg, Metformin 850 mg, Naproxen 250 mg, Omeprazol 20mg
1:00 PM | Ipratropium dose inhaler, Calcium 500 mg, Vit D 200 IU
7:00 PM | Ipratropium dose inhaler, Metformin 850 mg, Calcium 500 mg, Vit D 200 IU, Lovastatin 40 mg, Naproxen 250 mg
11:00 PM | Ipratropium dose inhaler
As needed | Albuterol dose inhaler, Paracetamol 1g

Boyd et al. JAMA, 2005
Goal-Oriented Medical Care

James W. Mold, MD; Gregory H. Blake, MD; Lorne A. Becker, MD

ABSTRACT

The problem-oriented model upon which much of modern medical care is based has resulted in tremendous advancements in the diagnosis and treatment of many illnesses. Unfortunately, it is less well suited to the management of a number of modern health care problems, including chronic incurable illnesses, health promotion and disease prevention, and normal life events such as pregnancy, well-child care, and death and dying. It is not particularly conducive to an interdisciplinary team approach and tends to shift control of health away from the patient and toward the physician. Since when using this approach the enemies are disease and death, defeat is inevitable.

Proposed here is a goal-oriented approach that is well suited to a greater variety of health care issues, is more compatible with a team approach, and places a greater emphasis on physician-patient collaboration. Each individual is encouraged to achieve the highest possible level of health as defined by that individual. Characterized by a greater emphasis on individual strengths and resources, this approach represents a more positive approach to health care. The enemy, not disease or death but inhumanity, can almost always be averted.

1. There exists an ideal "health" state which each person should strive to achieve and maintain. Any significant deviation from this state represents a problem (disease, disorder, syndrome, etc.).
2. Each problem can be shown to have one or more potentially identifiable causes, the correction or removal of which will result in resolution of the problem and restoration of health.
3. Physicians, by virtue of their scientific understanding of the human organism and its afflictions, are generally the best judges of their patients' fit with or deviation from the healthy state and are in the best position to determine the causes and appropriate treatment of identified problems.
4. Patients are generally expected to concur with their physicians' assessments and comply with their advice.
5. A physician's success is measured primarily by the degree to which the patients' problems have been accurately and efficiently identified and labeled and appropriate medical techniques and technologies have been expertly applied in an effort to eradicate those problems.

This conceptual model is ideally suited to the understanding and management of acute and curable illnesses. It has also been extremely important for clinical research. How
“Problem-oriented versus goal-oriented care”

<table>
<thead>
<tr>
<th></th>
<th>Disease-oriented</th>
<th>Goal-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of Health</strong></td>
<td>Absence of disease as defined by the health care system</td>
<td>Maximum desirable and achievable quality and/or quantity of life as defined by each individual</td>
</tr>
</tbody>
</table>
What really matters for patients is

• Functional status

• Social participation
Shared Electronic Patient Record

Medisch overzicht

Riker: 20 [s/dag] (05/02/2012)

Belangrijke actieve GE

Tabaksbruk
Menopauze symptomen/klachten
Niet-insuline afhankelijk diabetes
Symptomen/klachten schoonder
Overschicht
Hypertensie zonder organbeschadiging
Sociaal problemen na, begeleiding maatschappelijk werk

Familiale antecedenten
Afval myocardinfarct (vader)
Niet-insuline afhankelijk diabetes (moeder)

Medische antecedenten
Zwangerschap, vlotte partus, zoon
Zwangerschap, vlotte partus, dochter
Zwangerschap, vlotte partus, dochter

Chirurgische antecedenten
Appendedome in 1999

Chronische medicatie
Metformine Sandoz tab 160x850 mg
Asaflow tab EC 188x80 mg
Simvastatin Sandoz tab 100x20 mg

Vaccins
- Toegediende vaccins
- Geplande vaccins

Gezondheids Elementen

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Contacten

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<td>Huisarts</td>
</tr>
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<td>11/03/2014</td>
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<td>BLOKLAND, INEK</td>
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<td>01/11/2014</td>
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<td>DRAELEM, Lieve</td>
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<td>03/09/2013</td>
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<td>VANDERLEHM, E</td>
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</tbody>
</table>
Illness prevention & Health promotion

- Individual illness prevention
- Group-based illness prevention
- Health promotion
Diabetes Fair

• Presentation of 7 Self-care Activities, including cooking workshops & fitness classes

Involving informal care-givers!
INTERDISCIPLINARY TEAM

- Family physicians
- Nurses
- Social workers
- Health promotion worker
- Administrative staff and receptionist
- Ancillary staff
- Dentists
- Dietician
- External health care workers: physiotherapists, psychologists, …
Time to Do the Right Thing: End Fee-for-Service for Primary Care

Michael K. Majdill, MD
Department of Family and Preventive Medicine, University of Utah School of Medicine, Salt Lake City, Utah


You can always count on Americans to do the right thing - after they've tried everything else. 

-Winston Churchill

Current fee-for-service (FFS) payment rates for physician visits trace to the origins of Blue Cross Blue Shield insurance in the 1930s. At that time, rates were set that paid generously for hospitalizations and for procedures, such as surgery. Payments for so-called 'cognitive services' were lower per minute of physician time. This disparity has been perpetuated since the 1980s in the calculation of rates set by the Centers for Medicare & Medicaid Services (CMS), based on 'Relative Value Units,' for payment of the Evaluation and Management codes most often billed by primary care physicians. Despite recognition by the Medicare Payment Advisory Commission (MedPAC) and others of the adverse effects of inadequate payment for primary care, only limited progress has been made toward correction of the disparity. This may be due, at least in part, to treatment of total payment for physicians as a zero-beginning in 1945 and expanded in the Health Maintenance Organizations (HMOs) of the 1980s and 1990s. Following collapse of many of the HMOs, payers have experimented with multiple smaller changes in payment models, mostly incremental adjustments to existing FFS, perpetuating structural disadvantages for primary care.

In this issue of the Annals, Basu, et al report on their study in which they calculated potential effects on primary care practice costs and revenue resulting from 3 modifications of FFS payment: increased FFS, traditional FFS plus per-member per-month (PMPM), and traditional FFS plus PMPM plus pay-for-performance (P4P). The authors drew on extensive published literature about how primary care practices can staff and organize to deliver patient-centered medical home (PCMH) services such as enhanced access, care management, and alternative visits, and the impact of these changes on revenue and expense within the practices. The authors created simulated models of these financial effects based on detailed profiles of patient demographics, insurance coverage, and disease burden. They conducted tens of
Belgium: Community Health Centres (3.5% of population)

Integrated capitation system
Since 1982
No cost sharing for the patient

Capitation

spending in PHC in the fee–for–service system in the framework of the NIHDI
total number of citizens in Belgium
Studie: Vergelijking van kost en kwaliteit van twee financieringssystemen voor de eerstelijnszorg in België

KCE reports 85A
Study: comparison payment systems

2008: Federal Knowledge Center for Health Care
Fee-for-service ↔ Capitation

Strengths capitation system
- high degree of accessibility, especially for vulnerable groups
- no risk selection
- patients in the capitated system use:
  - less resources in the secondary care
  - less medications
- the quality of care was at least as good or better
State of the art

- In 2013 the system changed into a system
  - With its own budget
  - Needs-based distribution of resources between the community health centres
The “needs-variables”

- Demographic variables
- Social-economic variables
- Morbidity variables
- Contextual variables
<table>
<thead>
<tr>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/sex (41 combinations)</td>
</tr>
<tr>
<td>Widow</td>
</tr>
<tr>
<td>Low income: &lt; 15 000,00EUR</td>
</tr>
<tr>
<td>Self-employed workers</td>
</tr>
<tr>
<td>Deceased in that year</td>
</tr>
<tr>
<td>Disability</td>
</tr>
<tr>
<td>Urbanization index in the neighbourhood</td>
</tr>
<tr>
<td>Medical supply index in the neighbourhood</td>
</tr>
<tr>
<td>Handicap</td>
</tr>
<tr>
<td>Help from public welfare centres</td>
</tr>
<tr>
<td>Impaired functional status</td>
</tr>
<tr>
<td>Cardiac diseases</td>
</tr>
<tr>
<td>COPC</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Diabetes combined with chronic cardiac condition</td>
</tr>
<tr>
<td>IDD</td>
</tr>
<tr>
<td>NIDD</td>
</tr>
<tr>
<td>Exocrine pancreatic diseases</td>
</tr>
<tr>
<td>Psoriasis</td>
</tr>
<tr>
<td>Rheumatoid arthritis, Crohn’s disease, ulcero-hemorragic recto-colitis</td>
</tr>
<tr>
<td>Psychosis: young adults</td>
</tr>
<tr>
<td>Psychosis: elderly people</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Chronic hepatitis B &amp; C</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Post-transplant immunosuppression</td>
</tr>
<tr>
<td>Alzheimer</td>
</tr>
<tr>
<td>Thyroid diseases</td>
</tr>
<tr>
<td>Thrombosis</td>
</tr>
<tr>
<td>Coagulation disorders</td>
</tr>
<tr>
<td>Protected habitat</td>
</tr>
</tbody>
</table>
Implementation

- Based on an (electronic) “photograph” of the population on the list of the different CHC’s
  → photograph made annually
- Each CHC receives a specific “capitation” for the patients on the list
The integrated needs-based mixed capitation system:

- stimulates prevention, health promotion and self-reliance of the people,
- as there is a global payment for all disciplines, there is an incentive to task-shifting and subsidiarity,
- Prevents risk selection
- Stimulates a global approach to a broad range of problems, avoiding the fragmentation and disease-orientation
Federal Health Minister: “Budget cuts” in Community Health Centres?

- Budget cuts?
- Moratorium: no new CHCs?
- Audit
- ....?
Family Medicine and Primary Care at the Crossroads of Societal Change

1. The changing society
2. Primary care: the challenges
3. Nano-level
4. Micro-level
5. Meso-level
6. Macro-level
7. Primary Care and Social Cohesion
8. Conclusion
PRIMARY CARE ZONE: MESO-LEVEL: 75,000-125,000 INHABITANTS
PRIMARY CARE ZONE: MESO-LEVEL: 75,000-125,000 INHABITANTS

Agentschap Zorg en Gezondheid
COUNCIL PRIMARY CARE ZONE: INTEGRATED IN LOCAL POLICY

PARTICIPATION OF ALL STAKEHOLDERS, INCLUDING CITIZENS
“Organizing primary care in decentralized entities, for example, primary care zones (PCZs), can contribute to the visibility of primary care. Defining the population that accesses a certain group of services and providers in primary care, can contribute to the accountability of providers in terms of outcomes, access and quality of care.”
PRIMARY CARE ZONE: MESO-LEVEL: 75.000-125.000 INHABITANTS
PRIMARY CARE NETWORKS: > 5,000 INHABITANTS (RURAL AREAS)
> 10,000 INHABITANTS (URBAN AREAS)
PRIMARY CARE NETWORKS: > 5,000 INHABITANTS (RURAL AREAS)
> 10,000 INHABITANTS (URBAN AREAS)

New professionals: Advanced nurse practitioners; community health workers;...
PRIMARY CARE NETWORKS: > 5,000 INHABITANTS (RURAL AREAS) 
> 10,000 INHABITANTS (URBAN AREAS)
Role of the Community Pharmacist/Family Physician/Nurse....

“Pharmaceutical care”:

**SURVEILLANCE**

= Optimising therapeutical impact

- Indication appropriate?
- Contra-indications?
- Dose appropriate?
- Appropriate frequency, time-schedule,...?
- Side-effects?
- Adequacy?
- Interactions?
- Adherence?
PRIMARY CARE NETWORK: > 5,000 INHABITANTS (RURAL AREAS)
> 10,000 INHABITANTS (URBAN AREAS)
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FLEMISH INSTITUTE FOR PRIMARY CARE: REGIONAL LEVEL
CHANGE...

From good care for individuals and families by committed and skilled professionals, towards integrated inter-professional accountability for a population:

“Everybody counts!”

“No one should be left behind!”
The promotion of primary health care since 1978 has had a profound political impact: it forced medical educators around the world to address the health needs of all people and it spurred the global recognition of family doctors as the primary medical providers of health care in the community. Yet, on the 30th anniversary of the Alma-Ata Declaration, disillusionment with and failure to appreciate primary care’s contribution to health persist. The missing link in the translation of the principles of Alma-Ata from idealism to practical, at the expense of population health. The challenge of this balancing act is illustrated in the interchanged use of the terms “primary care”, which usually means care directed at individuals in the community, and “primary health care”, which usually means a population-directed approach to health. To simplify this discussion and to reduce confusion, we will use the term “personal care” instead of “primary care” and “community-oriented primary care” (panel) instead of “primary health care”.

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cvanweel@hag.umcn.nl

The Lancet 2008;372:871-2
Improving health and primary health care around the world through Community Health Centres

Learn more at: www.ifchc2013.org
Created in 2005
The main objectives

- To provide information to and share the information between the members
- Advocacy for Primary Care towards policymakers and politicians
- Membership network
- Membership is Multi-Professional (links with a large number of European professional associations)
Family Medicine and Primary Care at the Crossroads of Societal Change

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AGE OF ANGER
A HISTORY OF THE PRESENT
PANKAJ MISHRA
Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change
HOW CAN FAMILY MEDICINE AND PRIMARY CARE MAKE A DIFFERENCE?

- TRUST
- COORDINATION
- CONTINUITY
- FLEXIBILITY
- RESPONSIVENESS
- ADVOCACY
- LEADERSHIP
WE CAN IMAGINE IT, WE CAN MAKE IT HAPPEN

“I hope some day you will join us and the world will live as one”

(John Lennon)
RUNNING FOR...

A SUSTAINABLE FUTURE!
How sustainable is our future?

THE TIME FOR CHANGE IS NOW!
Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change
Thank you...
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