Primary Health Care as a strategy to achieve equitable care

Prof. Dr. J. De Maeseneer, MD, PhD
Family Physician (part-time), Community Health Centre ,
Ledeberg-Ghent (Belgium)
Chairman European Forum for Primary Care
Director Primafamed Centre – Ghent University, Belgium
WHO Collaborating Centre on PHC

Sara Willems, MA, PhD, Ghent University
Bojnice, 22/10/2010

UNIVERSITEIT GENT

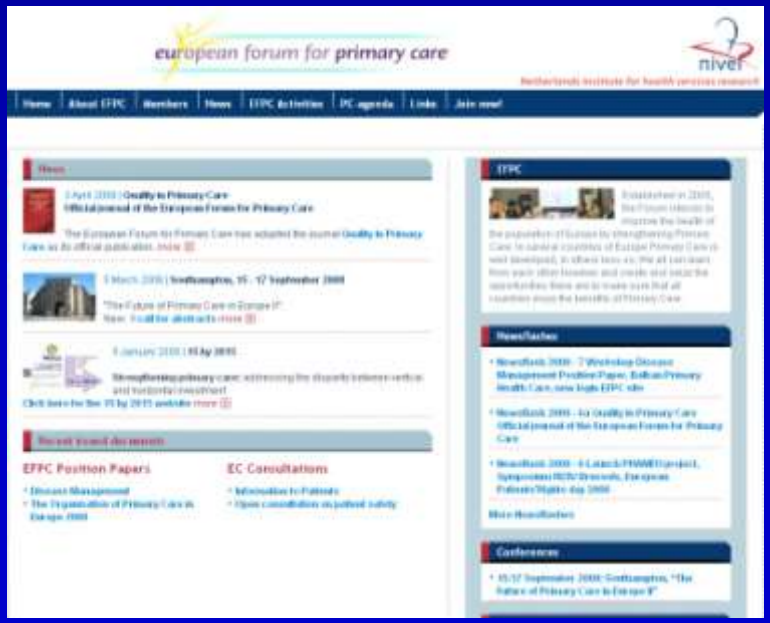
THE NETWORK
TOWARDS UNITY FOR HEALTH

european forum for primary care

Primafamed
International Centre for Primary Health Care and Family Medicine

http://www.primafamed.ugent.be

http://www.wgcbotermarkt.be



http://www.euprimarycare.org

http://www.the-networktufh.org

Primary Health Care as a strategy to achieve equitable care

1. Can primary care make a difference to health inequalities?
2. Primary health care and health inequalities at different levels
3. The role of Family Medicine
4. Conclusion

World Health Organization

Commission on Social Determinants of Health

Closing the gap in a generation

Health equity through action on the social determinants of health

Primary health care as a strategy for achieving equitable care:

a literature review commissioned by the Health Systems Knowledge Network

Prof. J. De Maeseneer, M.D.[1], Ph.D; S. Willems, M.A., Ph.D. [1]; A. De Sutter, M.D., Ph.D. [1]; I. Van de Geuchte, M.L. [1]; M.Billings, M.Sc[2].

[1] Department of Family Medicine and Primary Health Care, Ghent University. Belgium.

[2] Global Health through Education, Training and Service, Attleboro, USA.

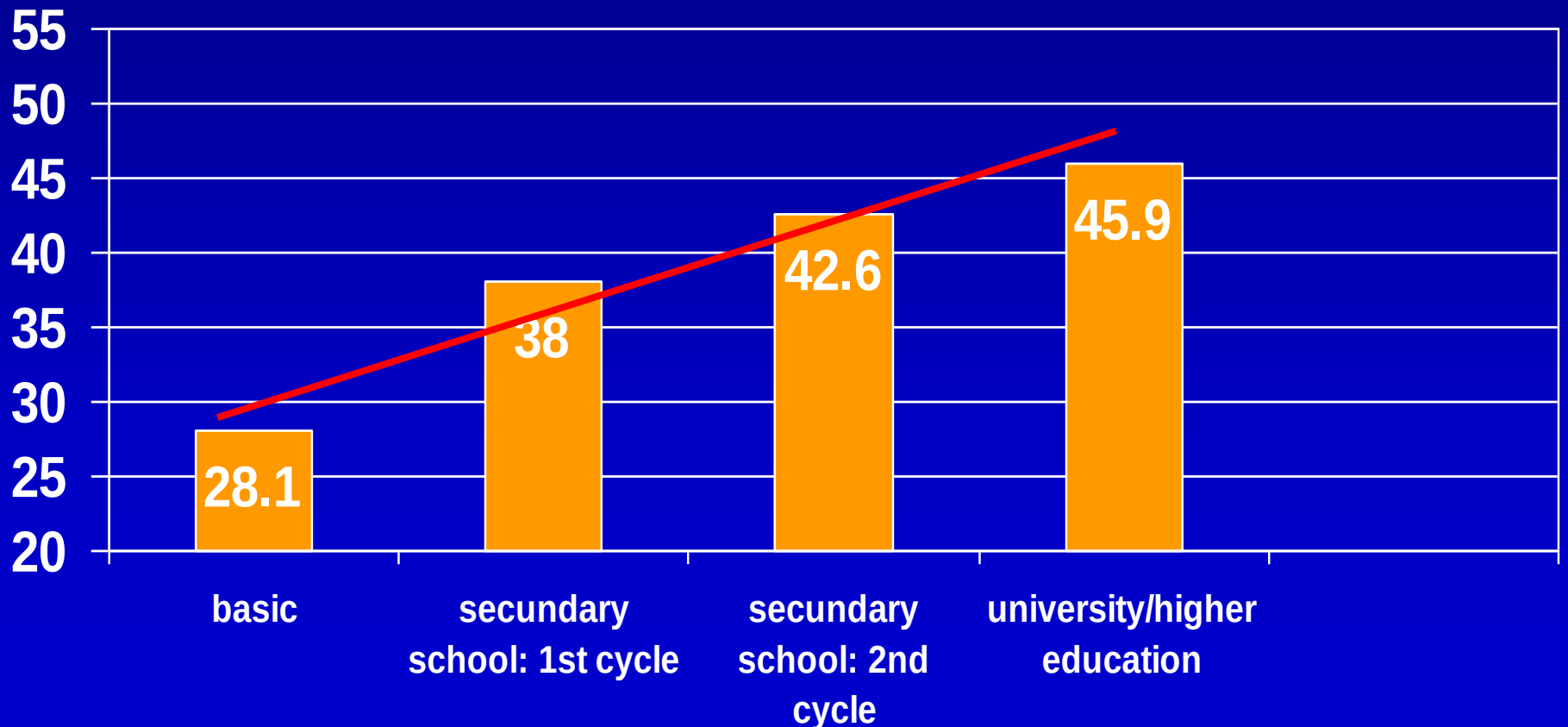
http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf

Healthy life expectancy in Belgium

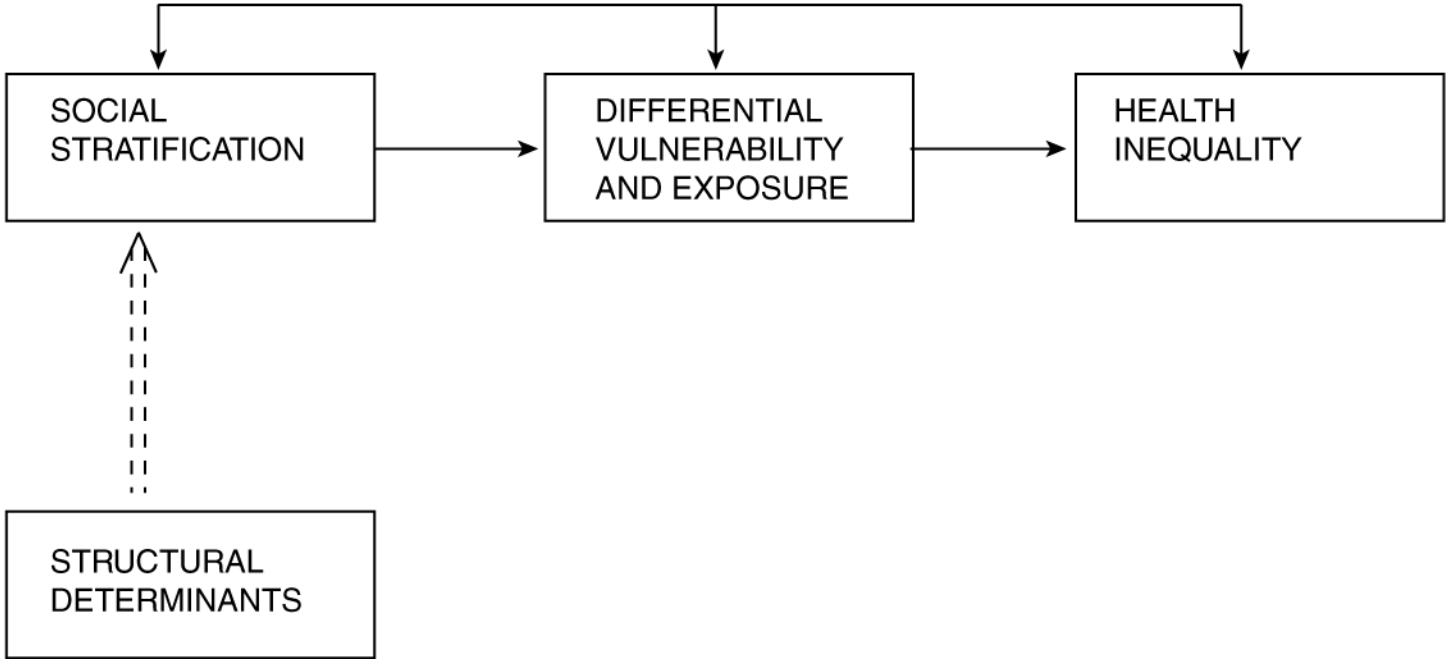
(Bossuyt, et al. Public Health 2004)

Socio-economic inequalities in health

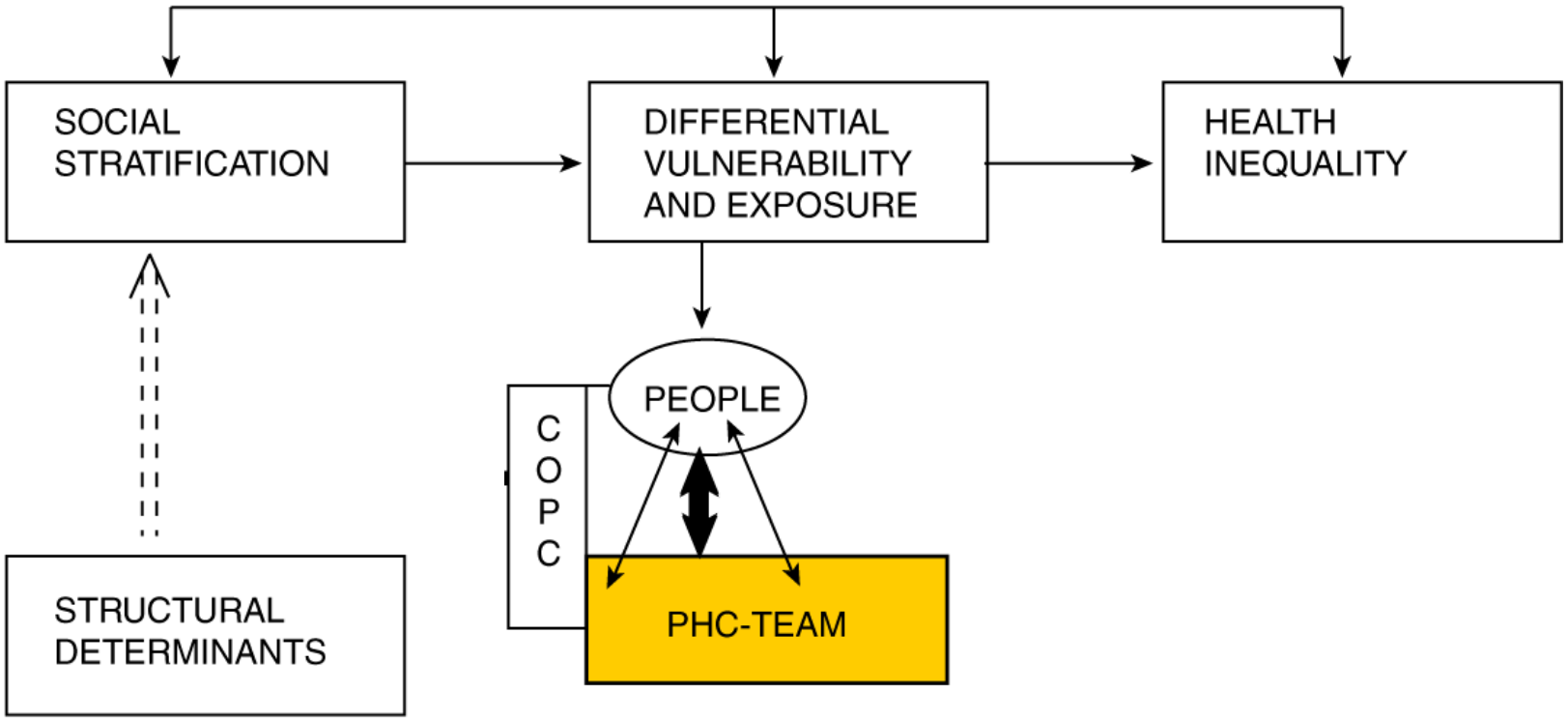
Healthy life expectancy in Belgium, 25 years, men

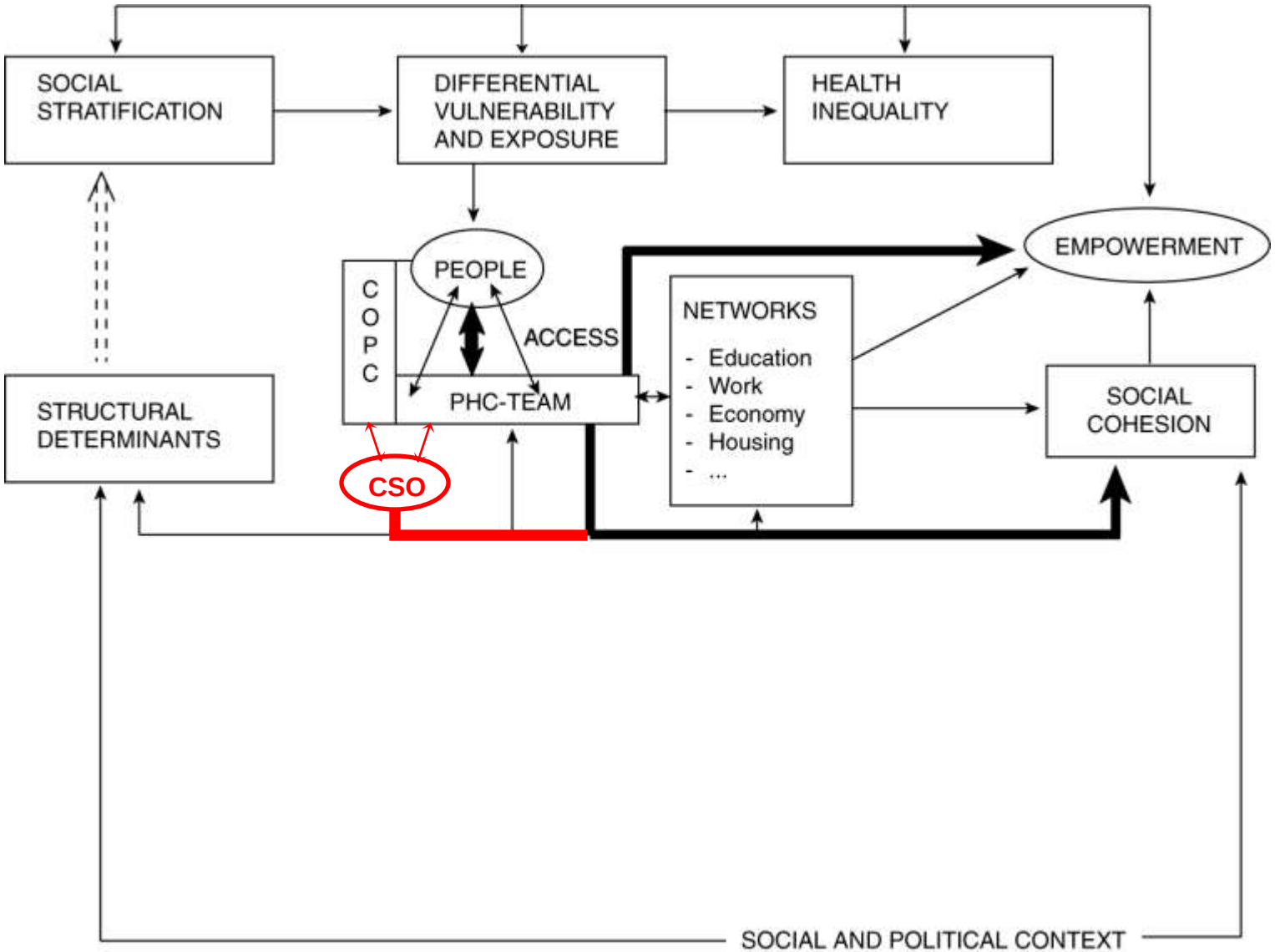


Primary health care as a strategy for promoting health equity and intersectoral action

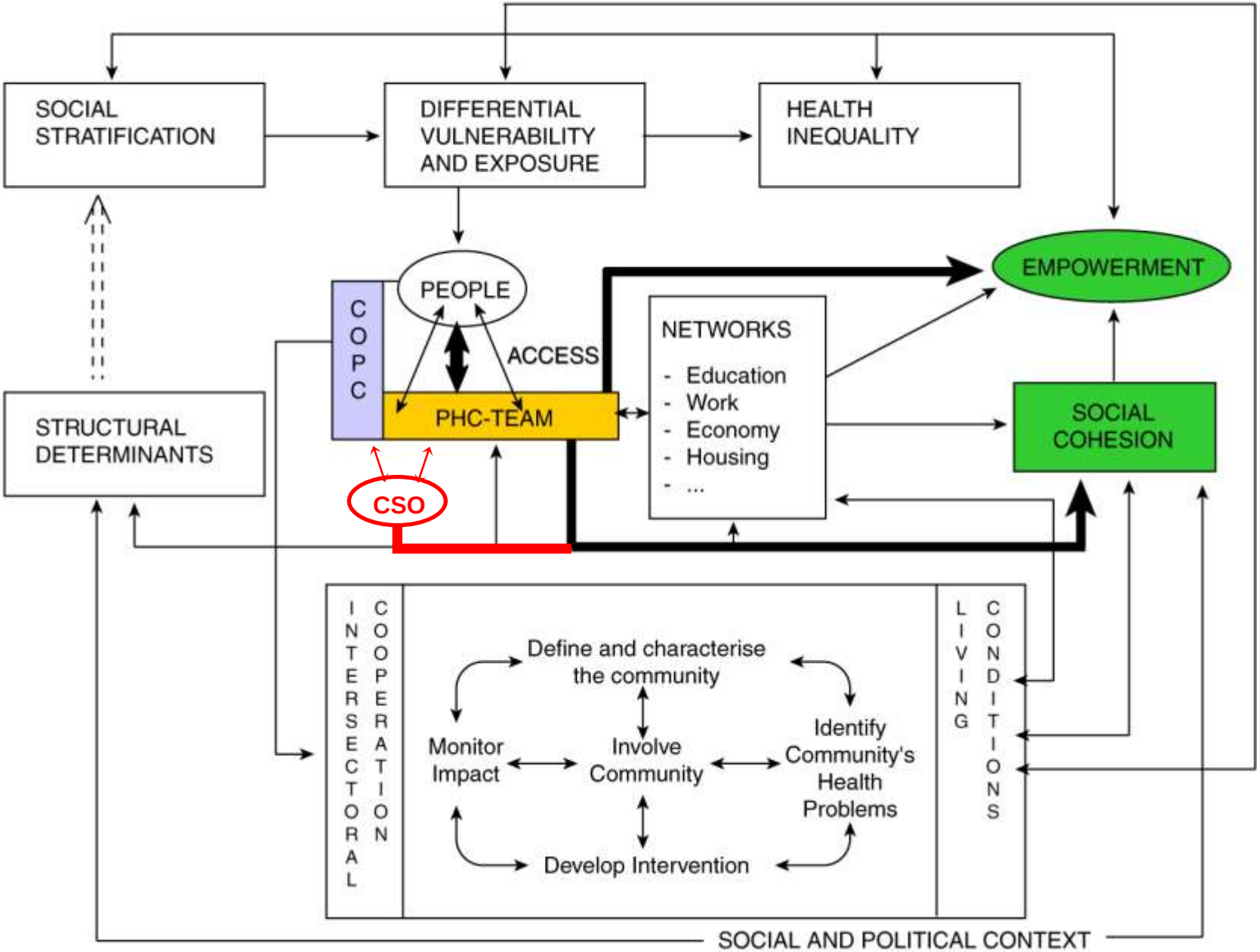


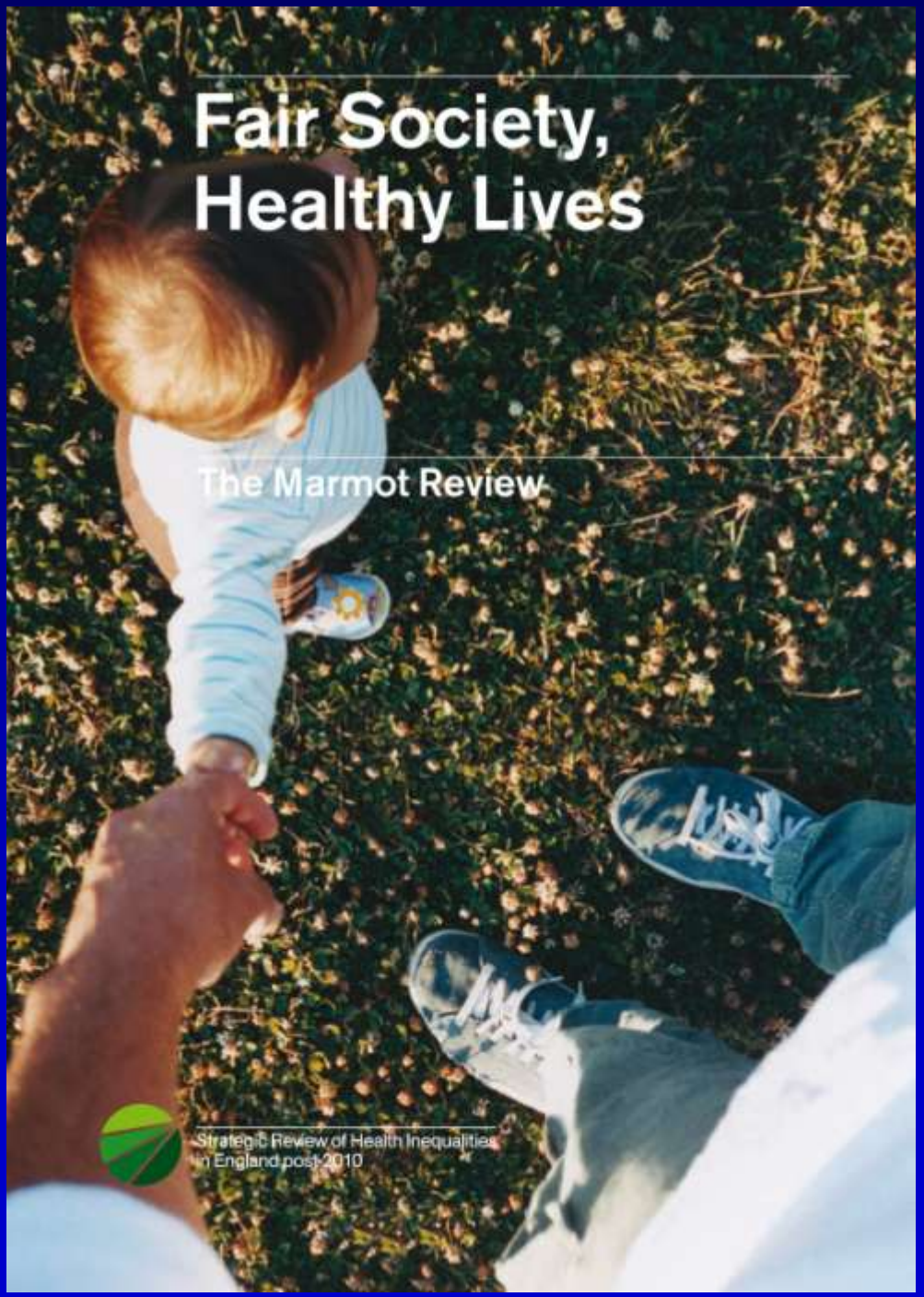
Primary health care as a strategy for promoting health equity and intersectoral action




SOCIAL STRATIFICATION
DIFFERENTIAL VULNERABILITY AND EXPOSURE
HEALTH INEQUALITY
EMPOWERMENT
PEOPLE
COPC
ACCESS
NETWORKS
- Education
- Work
- Economy
- Housing
- ...
STRUCTURAL DETERMINANTS
PHC-TEAM
SOCIAL COHESION
CSO
SOCIAL AND POLITICAL CONTEXT

Primary health care as a strategy for promoting health equity and intersectoral action




Fair Society,
Healthy Lives
The Marmot Review
Strategic Review of Health Inequalities
in England post-2010

Key recommendations of the Marmot Review

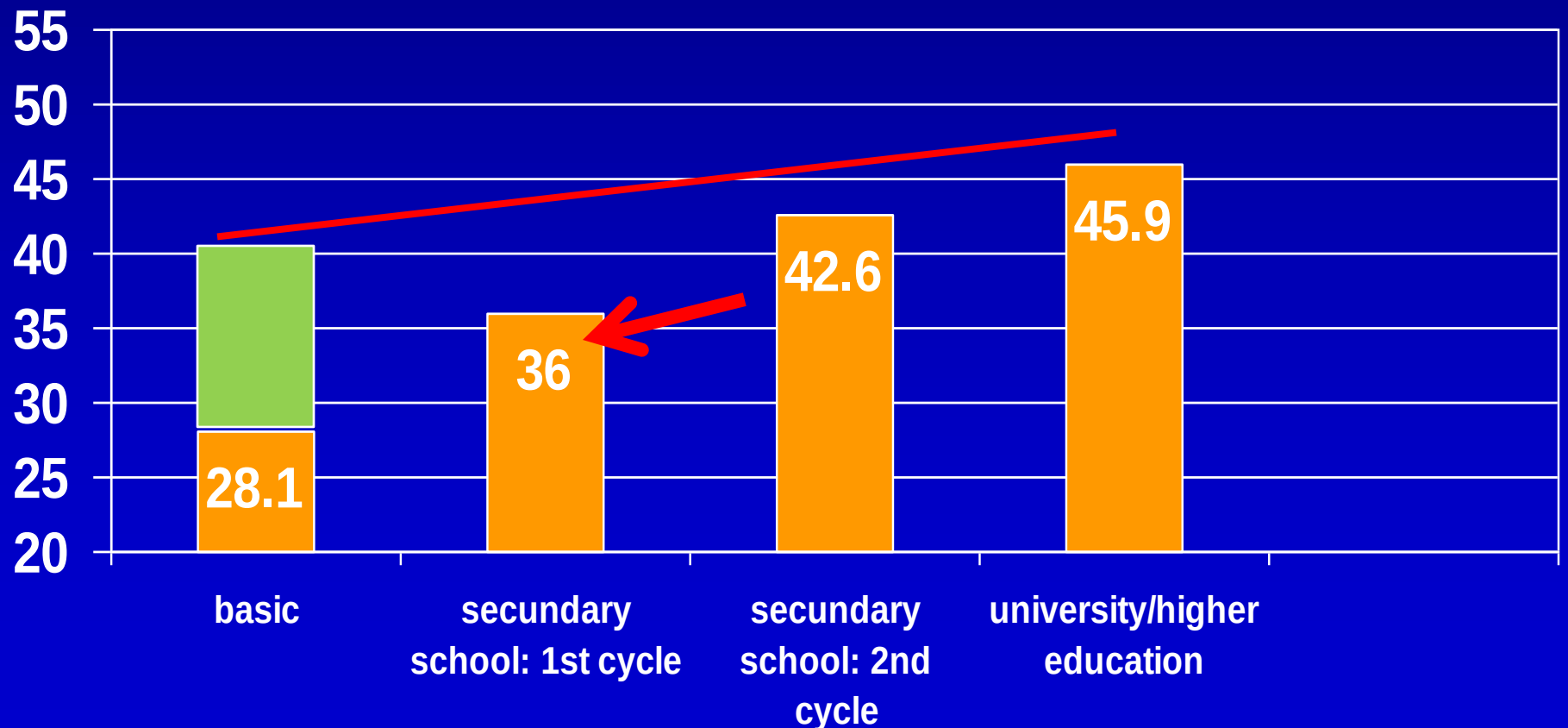
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

Healthy life expectancy in Belgium

(Bossuyt, et al. Public Health 2004)

Socio-economic inequalities in health

Healthy life expectancy in Belgium, 25 years, men



Key recommendations of the Marmot Review

- Reducing health inequalities will require action on six policy objectives:
  - Give every child the best start in life
  - Enable all children young people and adults to maximise their capabilities and have control over their lives
  - Create fair employment and good work for all
  - Ensure healthy standard of living for all
  - Create and develop healthy and sustainable places and communities
  - Strengthen the role and impact of ill health prevention

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How do people living in poverty experience access to health care?

vzw De Keeting, Mechelen

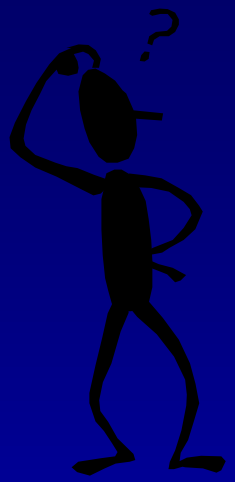
vzw De Willers, Willebroek

Willems S. “Social inequalities in health: a neverending story?” 2005

Exploring the accessibility of the health care system in Belgium

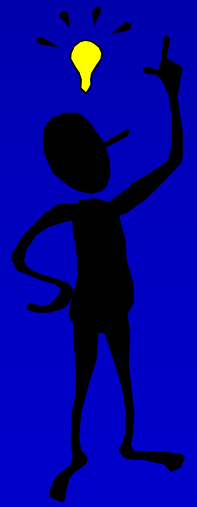
- Literature review
  e.g. the yearly poverty reports

- Quantitative research
  e.g. National Health Surveys,
  provider reports, ...



- The target group is not represented in databases
- Understanding contextual nature & the underlying mechanisms

Consulting the target group,
using a qualitative research design



Aim of the qualitative study

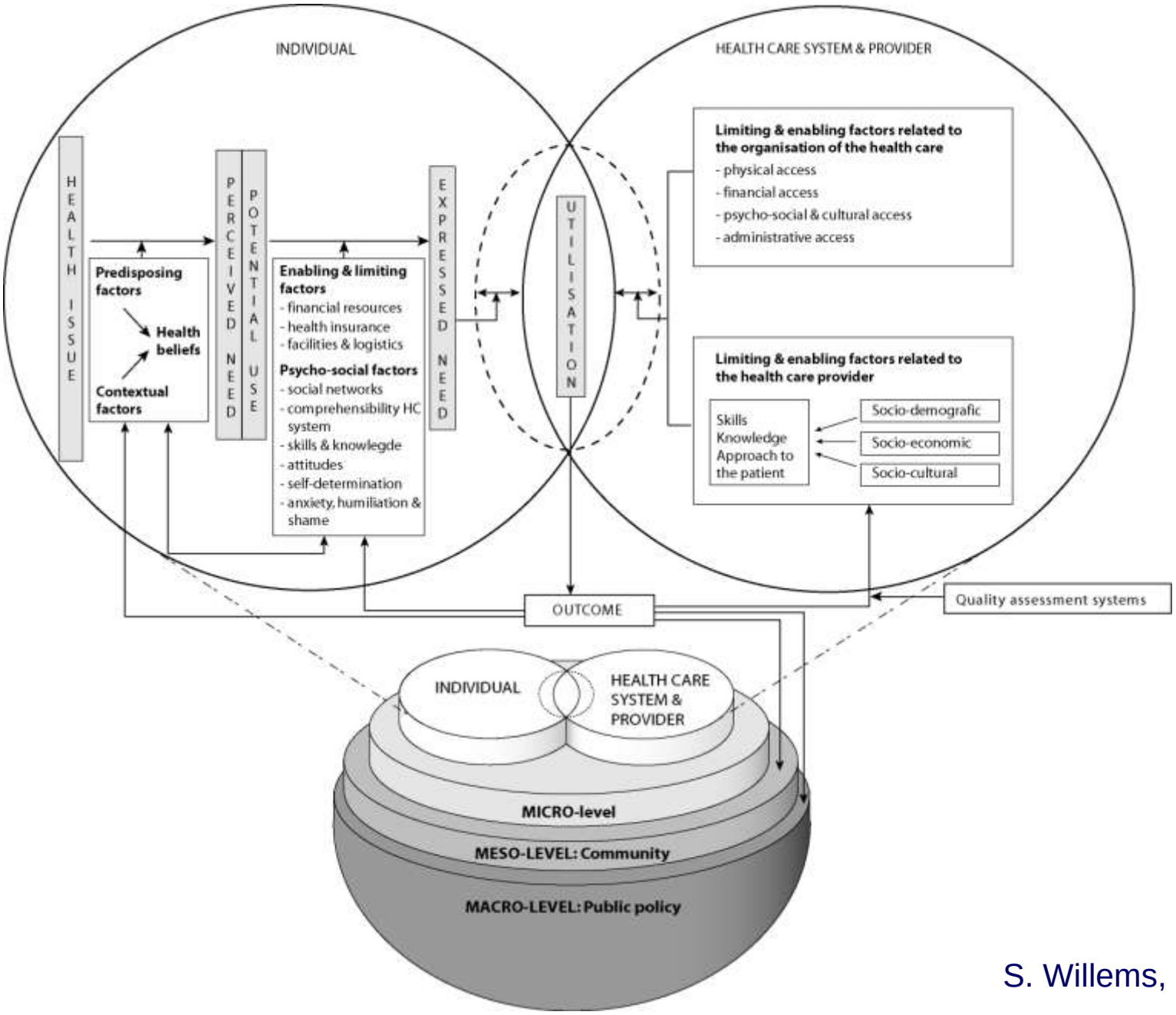
- to **explore** the breadth and the scope of the barriers and facilitators to health care as disadvantaged people in Belgium experience them
- to develop a **conceptual framework** that integrates the barriers

Method

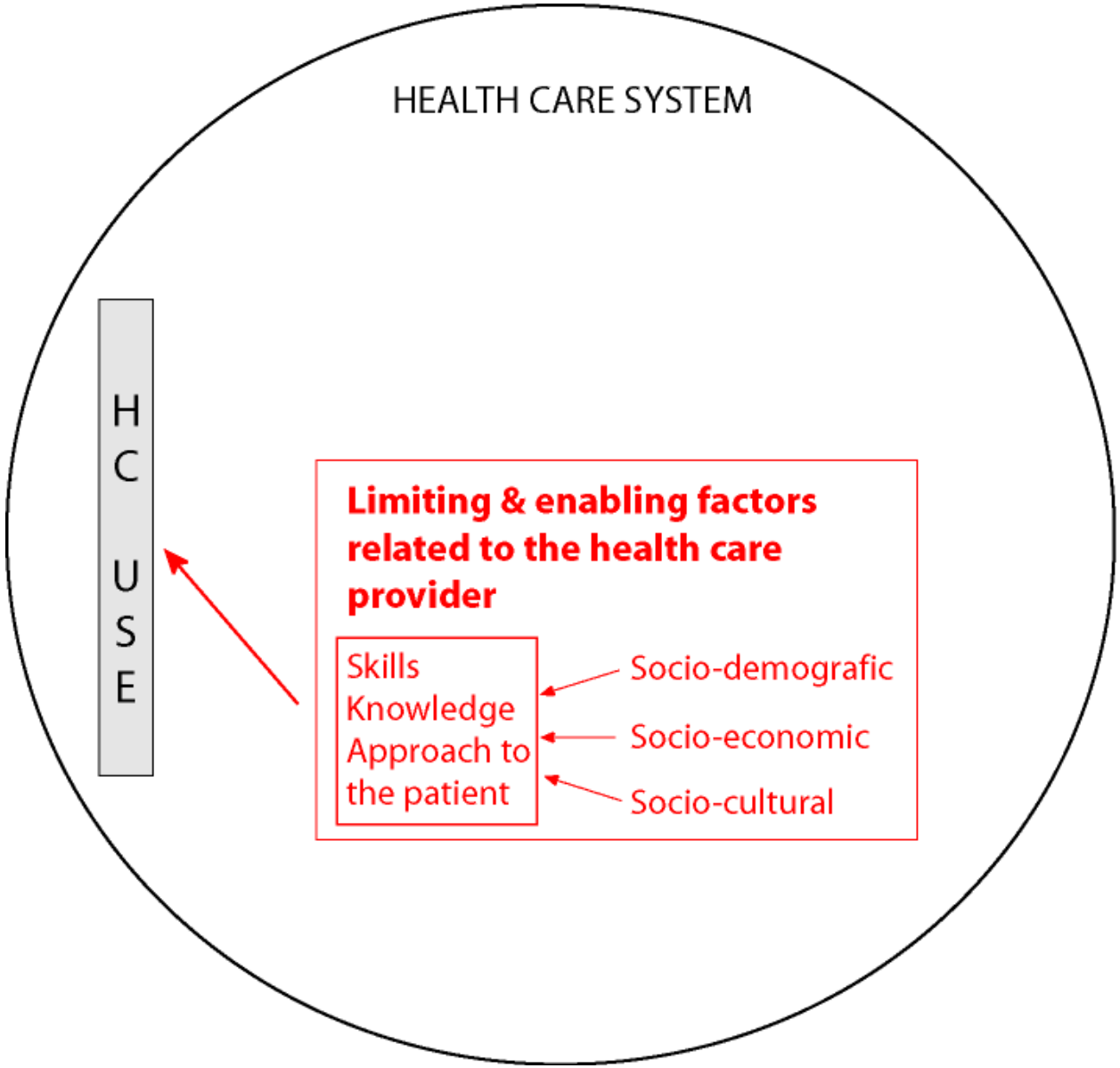
- Focusgroup interviews
- Sample selection: the Service for the Fight against Poverty, Insecurity and Social exclusion
- Purposive sampling
- 7 local organisations organised in a working-group

Method

- Participants selected by the organisation
- Variability among participants was reached
- Number of discussions:
  until saturation / 21 (90’ - 120’ / 5 - 12 part.)
- Moderated by a social worker & a researcher
- Interview guide (pretested)
  Starting point: the experiences of participants



S. Willems, 2005



S. Willems, 2005

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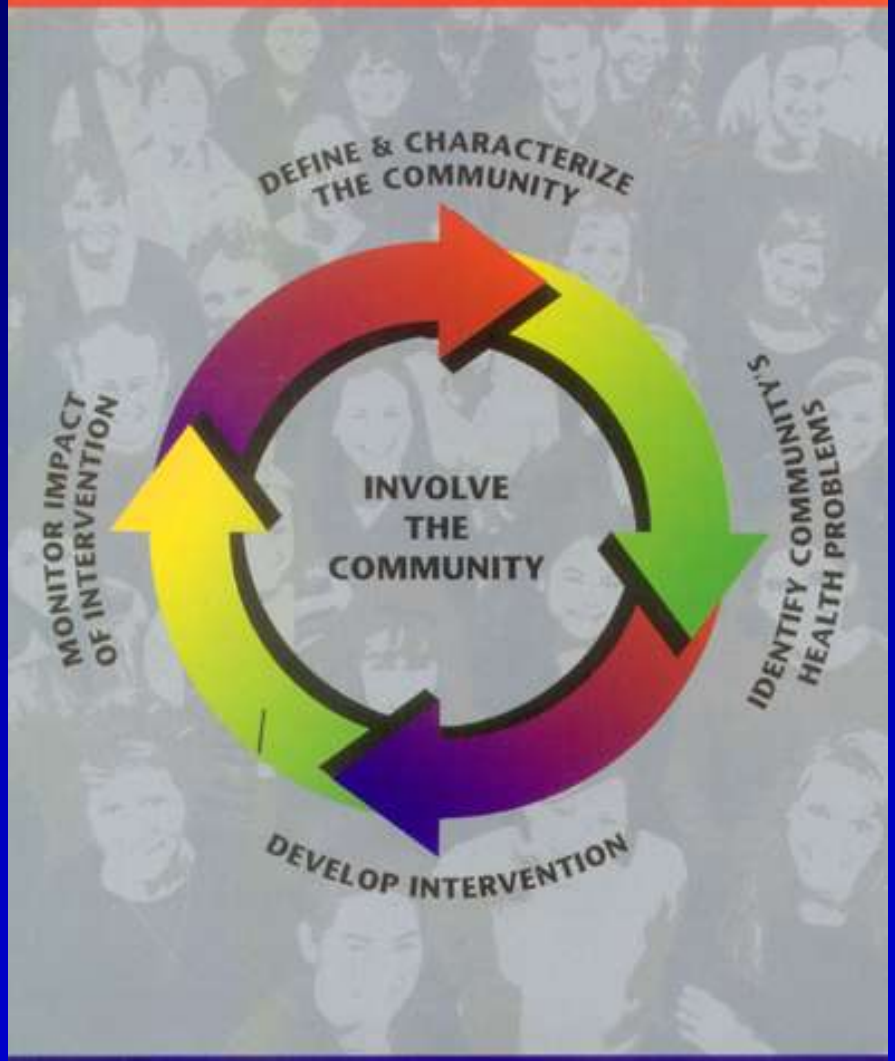
Community-Oriented Primary Care: Health Care for the 21st Century



Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D., Gary Kukulka, Ph.D., Hugh Fulmer, M.D.

WGC Botermarkt | Wegbeschrijving | Links | Login

Botermarkt
wijkgezondheidscentrum

- Visie
- Ontstaan
- Multidisciplinair team
- Globaal Medisch Dossier
- Forfaitair betalingssysteem
- Raadplegingen, afspraken en huisbezoeken
- Preventieprojecten en gezondheidsbevordering
- Inschrijven in het WGC

Voor onze patiënten

Community Health Centre:

- Family Physicians; nurses; dieticians; health promotors; dentists; social workers; …
- 5700 patients; 55 nationalities
- Capitation; no co-payment
- COPC-strategy

Hundelgemsesteenweg 145, 9050 Ledeberg | tel. 09/232 32 33 | fax 09/230 51 89 | info@wgcbotermarkt.be | ma-vr 8.00 - 19.00

COPC-project: children's physical condition

- Consultation: problematic physical condition

•WGC Botermarkt

COPC-project: children's physical condition

- Survey: children were two times longer in front of television and videogames, and had less physical activity compared to the flemish youngsters

COPC-project: children's physical condition

- Community diagnosis: lack of playgrounds

COPC-project: children's physical condition

COPC-project: children's physical condition

COPC-project: children's physical condition

- **Evaluation:**
  - ↓ street criminality
  - ↑ social cohesion
  - ↑ physical activity

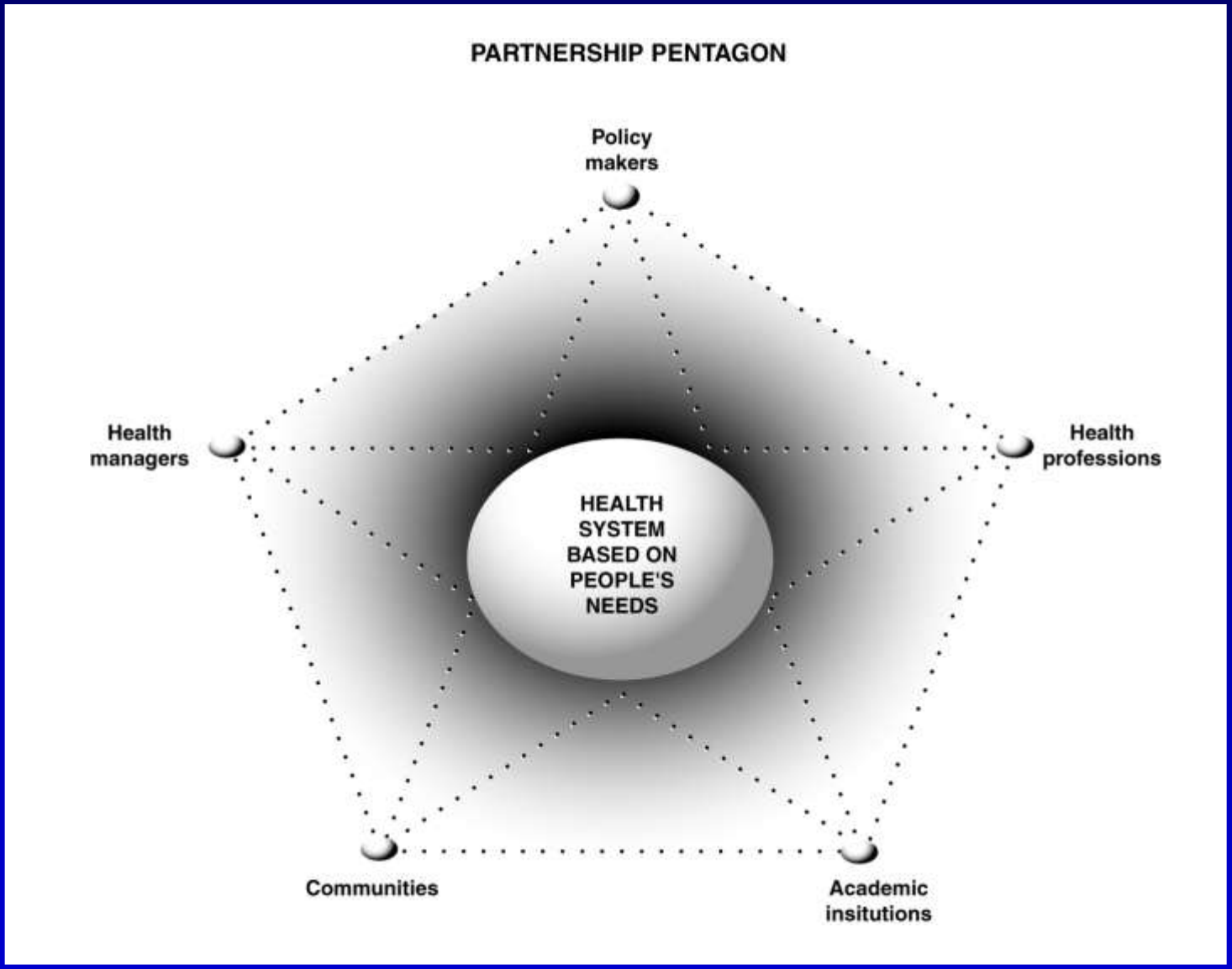
Integration of personal and community health care

The promotion of primary health care since 1978[1] 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,[2] 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".

*Chris van Weel, Jan De Maeseneer, Richard Roberts
Department of General Practice, Radboud University Nijmegen Medical Centre, 6500 HB Nijmegen, Netherlands (CvW); Department of Family Medicine and Primary Health Care, Ghent University, Ghent, Belgium (JDM); The Network—Towards Unity For Health, Maastricht, Netherlands (JDM); and University of Wisconsin School of Medicine and Public Health, Madison, WI, USA (RR)
c.vanweel@hag.umcn.nl

The Lancet 2008;372:871-2

“Towards Unity for Health”



THE NETWORK
TOWARDS UNITY FOR HEALTH

Announcement | Annual Conference

Integrating Public and Personal Health Care in a World on the Move

International Conference
September 17 - 22, 2011
Graz, Austria

Organised by The Network: Towards Unity for Health, Medical University Graz (MUG) and Styrian Academy of Family Practice (STAFAM)

Post-Conference Excursions to Slovenia and Hungary
September 22 - 24, 2011

Announcement | Annual Conference

Integrating Public and Personal Health Care in a World on the Move

September 17 - 22, 2011 | Graz, Austria
The Network: Towards Unity for Health,
Medical University Graz (MUG) and
Styrian Academy of Family Practice (STAFAM)

The Network: Towards Unity for Health (The Network: TUFH)

The Network: TUFH is a global association of universities, health policy makers, health practitioners and community groups committed to improve the health of the people and their community by innovating health systems and the education of human resources for health. It is a non-governmental organisation in official relationships with the World Health Organization.

Conference formats

Network: TUFH conferences intend to cater for the learning needs of all participants. Therefore, the conference format is dominated by medium-size thematic sessions where a few posters or a brief introduction aim to ignite a debate among all attending. On the first day of the meeting any participant may propose a session on any topic - and if there are enough participants interested to attend, that session will occur. Because these conferences usually see participants from over 40 countries, they provide a most stimulating opportunity for exchange of ideas and experiences.

More information | registration

Please consult our conference website
(available by the beginning of February, 2011)
www.the-networktufh.org/conference

or contact The Network: TUFH
secretariat-network@ugent.be

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The World Health Report **2008**

Primary Health Care

Now More Than Ever

World Health Organization

Box 2.6 Social policy in the city of Ghent, Belgium: how local authorities can support intersectoral collaboration between health and welfare organizations[76]

In 2004, a regional government decree in Flanders, Belgium, institutionalized the direct participation of local stakeholders and citizens in intersectoral collaboration on social rights. This now applies at the level of cities and villages in the region. In one of these cities, Ghent, some 450 local actors of the health and welfare sector have been clustered in 11 thematic forums: legal help; support and security of minors; services for young people and adolescents; child care; ethnic cultural minorities; people with a handicap; the elderly; housing; work and employment; people living on a "critical income"; and health.

The local authorities facilitate and support the collaboration of the various organizations and sectors, for example, through the collection and monitoring of data, information and communication, access to services, and efforts to make services more pro-active. They are also responsible for networking between all the sectors with a view to improving coordination. They pick up the signals, bottlenecks, proposals and plans, and are responsible for channelling them, if appropriate, to the province, region, federal state or the European Union for translation into relevant political decisions and legislation.

A steering committee reports directly to the city council and integrates the work of the 11 forums. The support of the administration and a permanent working party is critical for the sustainability and quality of the work in the different groups. Participation of all stakeholders is particularly prominent in the health forum: it includes local hospitals, family physicians, primary-care services, pharmacists, mental health facilities, self-help groups, home care, health promotion agencies, academia sector, psychiatric home care, and community health centres.

Intersectoral action for health: federal (1)

- **Interministerial conference for social integration**
  - → Insurability
  - → Maximum bill
- **Population Health Survey**

Intersectoral action for health: regional (2)

- **Local social policy framework:**
  - → Access to social rights
  - → “Social house”

- **Flemish Health Council: comprehensive health care system**

Flemish Health Council (2006)

Health and welfare: comprehensive approach

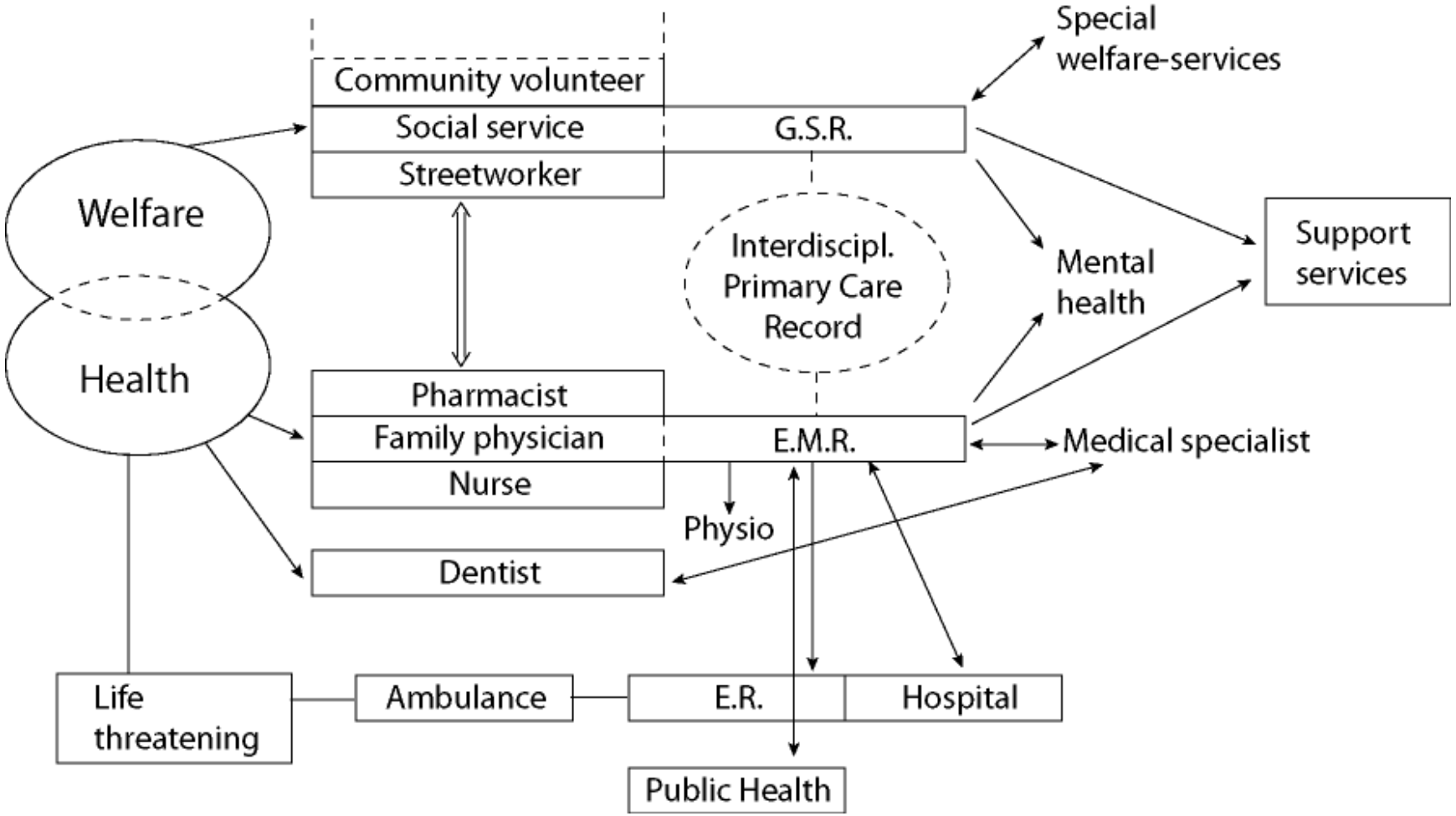
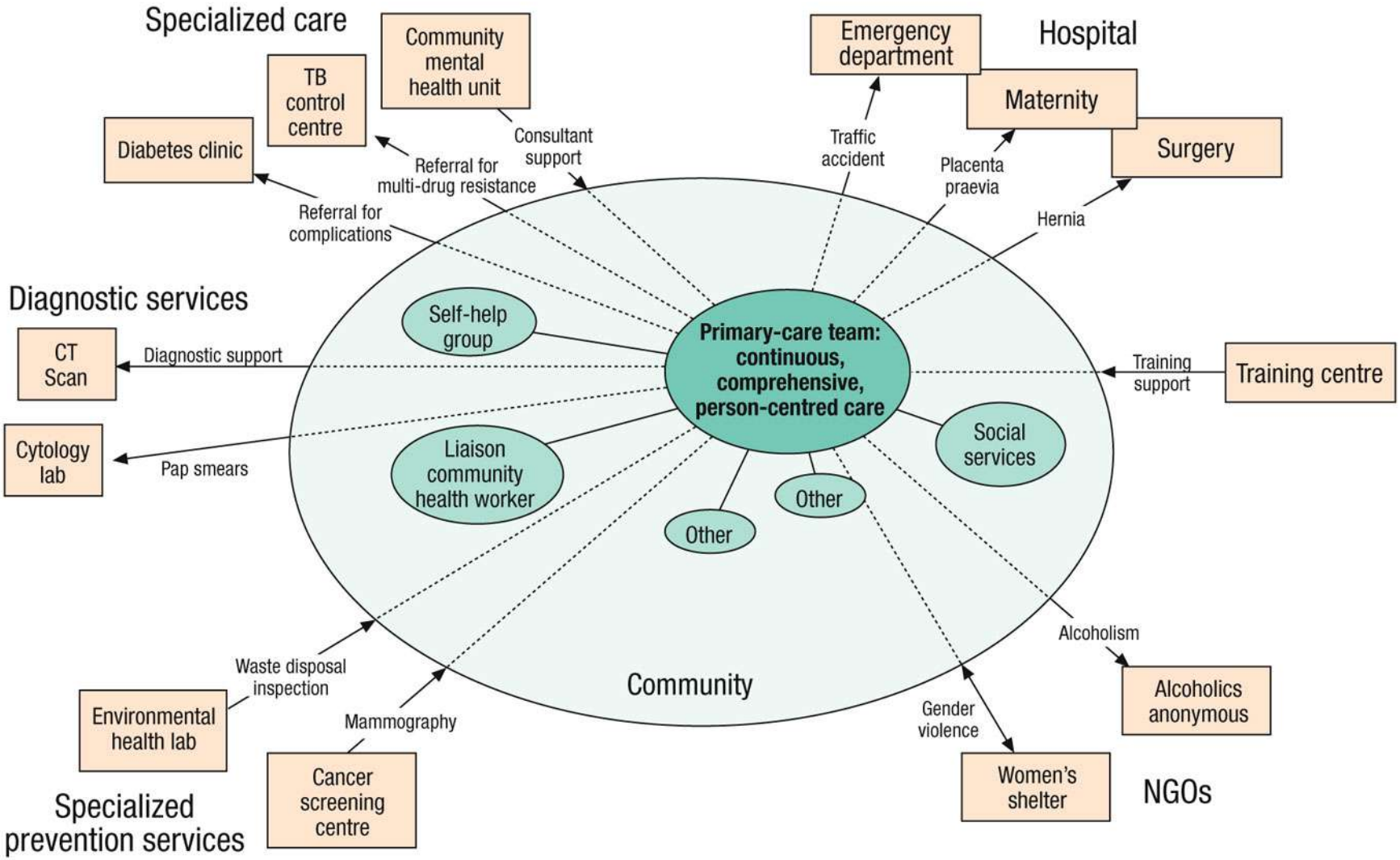


Figure 3.5 Primary care as a hub of coordination: networking within the community served and with outside partners[173,174]



Intersectoral action for health: local (3)

- **City of Ghent (225.000 inh.)**

  → Implementation Local Social Policy:

  11 clusters:

  - Work
  - Interculturality
  - Youth
  - Elderly
  - …
  - Health

- **Top-priorities:**

  → Living conditions (housing)

  → Access to health promotion and care

  Creation of a City Health Council

Intersectoral action for health: the community (4)

Ledeberg (8.700 inh.)

- Platform of stakeholders
- Implementing COPC-strategy, taking different sectors on board
- Accessible, comprehensive, quality local health care facility: a multidisciplinary Primary Health Care Centre

Platform of stakeholders:

- 40 to 50 people
- 3 monthly
- Exchange of information
- “Community diagnosis”

Intra-family violence

Health Equity Through Intersectoral Action:

An Analysis of 18 Country Case Studies

Public Health Agency of Canada
Agence de la santé publique du Canada

World Health Organization

Intersectoral action for health

- Territorial approach
- Universality
- Comprehensiveness

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Physician wellness: a missing quality indicator

Jean E Wallace, Jane B Lemaire, William A Ghali

Lancet 2009; 374: 1714–21

See Editorial page 1653

Department of Sociology, Faculty of Social Sciences (Prof J E Wallace PhD), **Department of Medicine, Faculty of Medicine** (Prof J B Lemaire MD, Prof W A Ghali MD), **and Department of Community Health Sciences, Faculty of Medicine** (Prof W A Ghali), **University of Calgary, Calgary, AB, Canada**

Correspondence to: Prof Jean E Wallace, Department of Sociology, University of Calgary, 2500 University Drive NW, Calgary, AB, Canada, T2N 1N4
jwallace@ucalgary.ca

When physicians are unwell, the performance of health-care systems can be suboptimum. Physician wellness might not only benefit the individual physician, it could also be vital to the delivery of high-quality health care. We review the work stresses faced by physicians, the barriers to attending to wellness, and the consequences of unwell physicians to the individual and to health-care systems. We show that health systems should routinely measure physician wellness, and discuss the challenges associated with implementation.

Introduction

> "Healthy citizens are the greatest asset any country can have."
>
> *Sir Winston Churchill*

Physicians are important citizens of health-care systems, and evidence indicates that many physicians are unwell. Physicians who are affected by the stresses of their work may go on to experience substance abuse, relationship troubles, depression, or even death.[1–4] Results of emerging research show that physicians' stress, fatigue, burnout, depression, or general psychological distress negatively affects health-care systems and patient care.[5–12] Thus when review the potential consequences of self-neglect by physicians, both individually and at the level of health-care systems. We also address why health systems should routinely measure physician wellness as an indicator of health-system quality in view of the growing recognition that suboptimum physician wellness adversely affects system performance. We discuss some of the measurement and operational challenges associated with implementation of this missing quality indicator, and raise several issues that will need to be addressed to achieve the desired outcomes of improved physician wellness and system quality.

The Scottish Parliament
Pàrlamaid na h-Alba

31 October 2008

MORE GPS REQUIRED IN DEPRIVED AREAS

There needs to be a shift in GPs from affluent areas to more deprived areas where they are most needed, according to the Scottish Parliament's Health and Sport Committee.

Publishing its response to the Scottish Government's publication *Equally Well*, the committee calls on the Scottish Government to take a robust stance in its negotiations with the British Medical Association over the terms of the next GP contract. According to the committee's Health Inequalities Inquiry, the current funding allocation formula for GP practices needs to be revised if deep-rooted health inequalities are to be addressed.

Grahame calls for more GPs in deprived areas

KATRINE BUSSEY

THE Scottish Government was yesterday urged to act in a bid to ensure there are more doctors in the country's poorest communities.

Members of Holyrood's health and sport committee said GPs working in deprived areas suffered a financial disadvantage under the current funding system.

And they warned that unless changes were made "progress in tackling the consequences and root causes of health inequalities will be much slower and more fragmentary than it ought to be".

The committee called on the government to take a "strong line" on the issue when negotiating the terms of the next GP contract.

Convener Christine Grahame said: "We know that health problems for the most-deprived people in Scotland are around three times those encountered by those living in affluent areas. Yet there is a flat distribution of GPs across Scotland. That cannot be right."

Ms Grahame spoke as the committee published its response to a government report on reducing health inequalities.

When that was unveiled in June, Public Health Minister Shona Robison said a redesign of services aimed at improving the situation would be backed with fresh funding of £15m – although £1.78bn is to be spend in total on tackling the problem over the next three years.

Members of the health committee carried out a short inquiry into health inequalities as they considered the government's action plan.

The committee argued the current minimum income guarantee for GP practices militated against funding additional doctors in deprived areas.

MSPs noted that the Scottish Government wants to revise the contract with a view to this guarantee eventually being taken away.

And they called on ministers to "take a robust stance in its negotiations on this matter".

Ms Grahame said: "We need to make sure that GP practices in our most-deprived areas have the resources to enable GPs and nurses to address the often complex health problems faced by the people.

"The way that the funding formula currently works means that GPs working in deprived areas are financially disadvantaged compared to their colleagues working in more affluent areas. That is unfair both to the people working in the GP practices and the patients they serve.

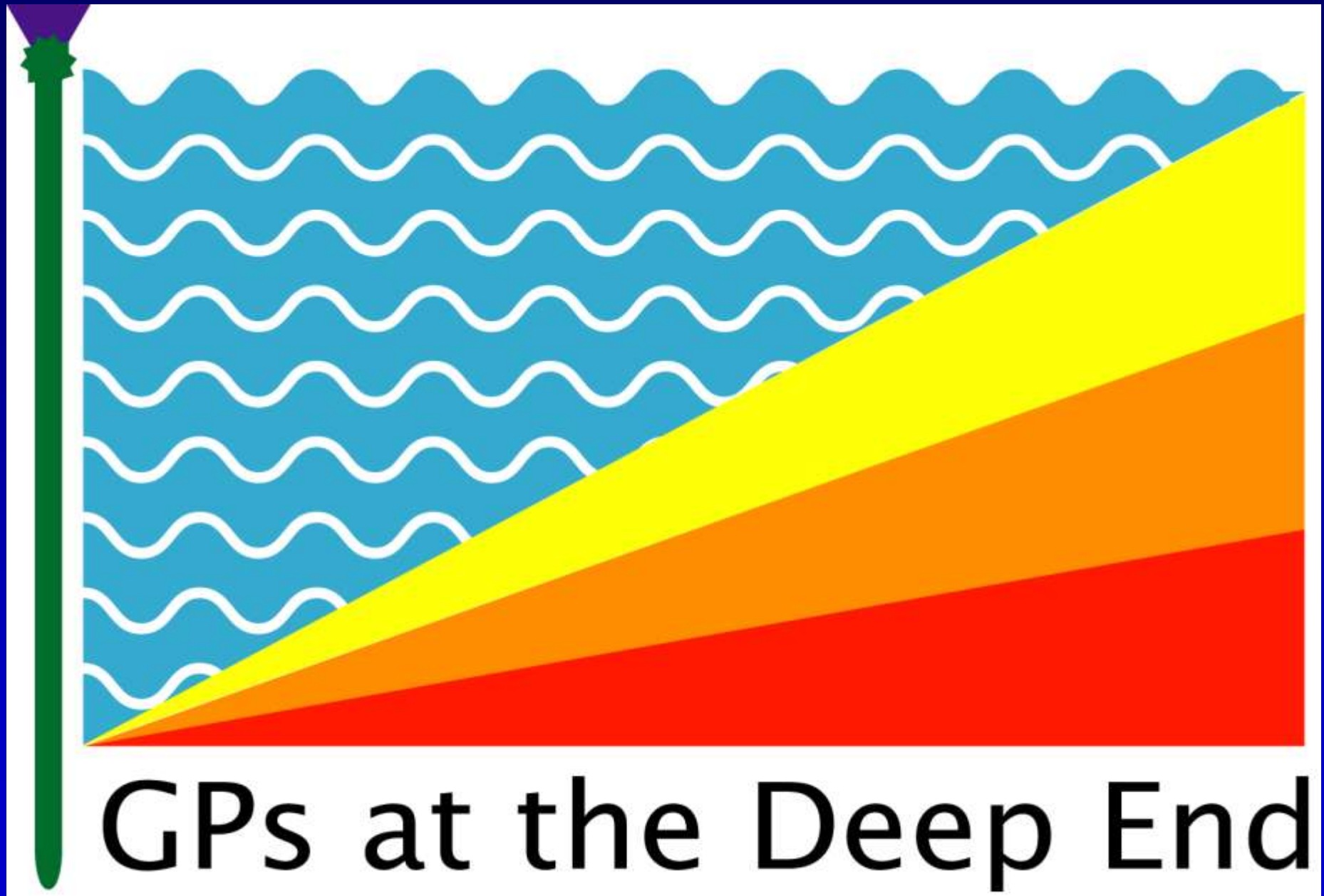
"Clearly, it's also a disincentive to GPs working in deprived areas."

A Scottish Government spokesman said changes to the current GP contract will reduce the extent to which the Minimum Price Income Guarantee mechanism prevents surgeries in the most disadvantaged communities from receiving a larger share of resources.

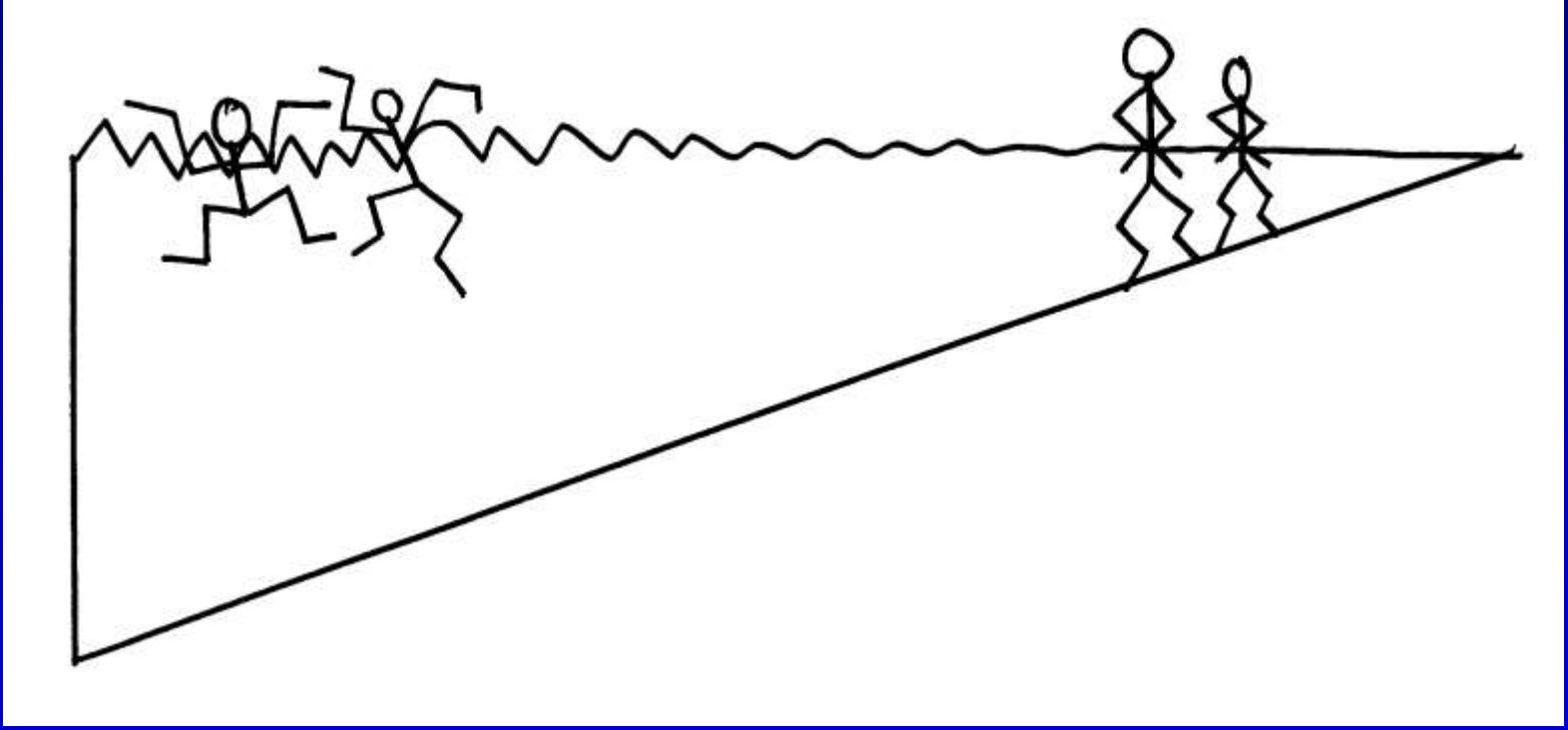
"It has also been agreed that the current prevalence adjustment contained in the quality and outcomes framework will be amended so that payments to GP practices will better reflect the relative incidence of long-term conditions in local communities," he added.

WHO LOOKS AFTER THE MOST DEPRIVED

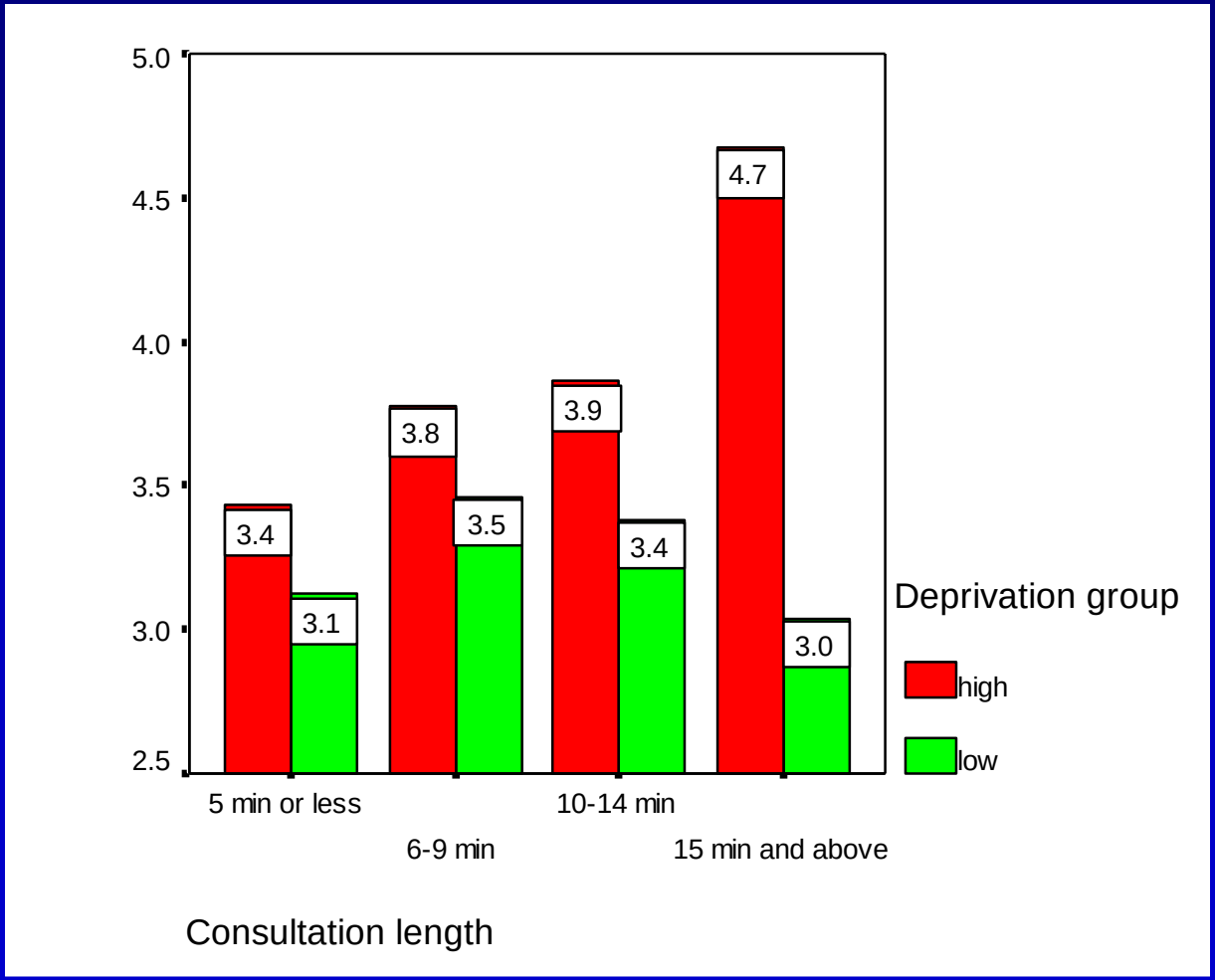
10% OF THE SCOTTISH POPULATION ?


GPs at the Deep End

GENERAL PRACTITIONERS AT THE DEEP END

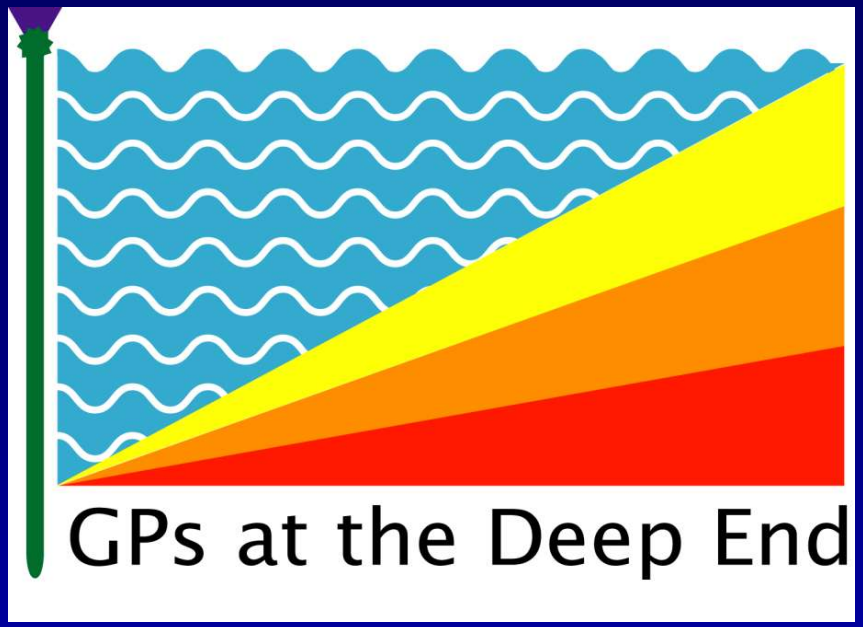


GP stress by clinical encounter length in areas of high and low deprivation



DEEP END MEETINGS

1. The first meeting
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters in deprived areas
7. Education and training (4th June)
8. Social prescribing (July/August)
9. Learning journey (17/18/20 August)
10. Alcohol (tbc)
11. Vulnerable families (2 – tbc)
12. Care of the elderly (26th August)



Primary care at its best shows :

Access
Contact
Co-ordination
Continuity
Flexibility
Long term relationships
Trust

but this only improves population health when combined with

Coverage, co-ordination and leadership

CHALLENGES OF FRAGMENTATION

REQUIRING CO-ORDINATION AND LEADERSHIP

Within practices

Between practices

Across boundaries

Within communities

Afternoon-session:
‘Roma-people’: Cinema Hall: 13.00-16.00

Primary Health Care as a strategy to achieve equitable care?

1. Can primary care make a difference to health inequalities?
2. Primary care and health inequalities at different levels
   - 2.1. Patients living in poverty
   - 2.2. Action at the community level: COPC
   - 2.3. Intersectoral action for health
   - 2.4. Provider well-being: a quality indicator
   - 2.5. Translational research and equity
3. The role of Family Medicine
4. Conclusion

D-09-02569R1

S0140-6736(09)61082-5

The role of academic health science systems in the transformation of medicine

Victor J Dzau, D Clay Ackerly, Pamela Sutton-Wallace, Michael H Merson, R Sanders Williams, K Ranga Krishnan, Robert C Taber, Robert M Califf

The challenges facing the health in communities around the world are unprecedented, and the data are all too familiar. For 5 billion people living in developing countries, environmental factors and inadequacies in hygiene, economic development, and health-care access are the main causes of shortened life expectancies. Improvements in health status, including reductions in infant mortality and declining incidence of infectious diseases, are being met by the new epidemics of obesity, diabetes mellitus, and cardiovascular disease.[1]

The system needs to overcome two distinct translational blocks or gaps in the discovery-care continuum.[11,12] The first is the gap between a scientific discovery and its clinical translation (ie, from bench to bedside); the second is the gap between expert acceptance of the application and its broad adoption in practice by local and global communities (ie, from bedside to population). AHSCs traditionally give their discoveries to industry at the first gap and to practising physicians at the second gap, thereby creating barriers and inefficiencies. We believe

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See Online/Comment
DOI:10.1016/S0140-6736(09)61594-4

Duke Medicine, Durham, NC, USA (Prof V J Dzau MD, D C Ackerly MD, P Sutton-Wallace MPH, Prof M H Merson MD,

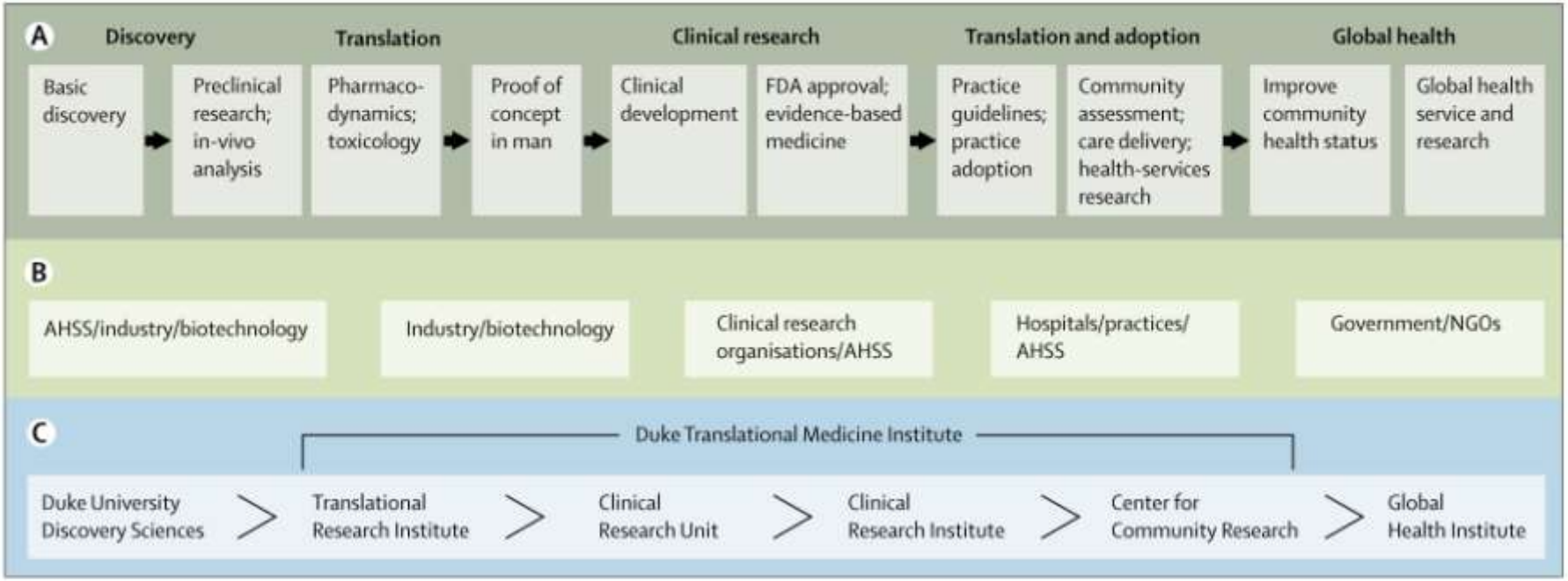
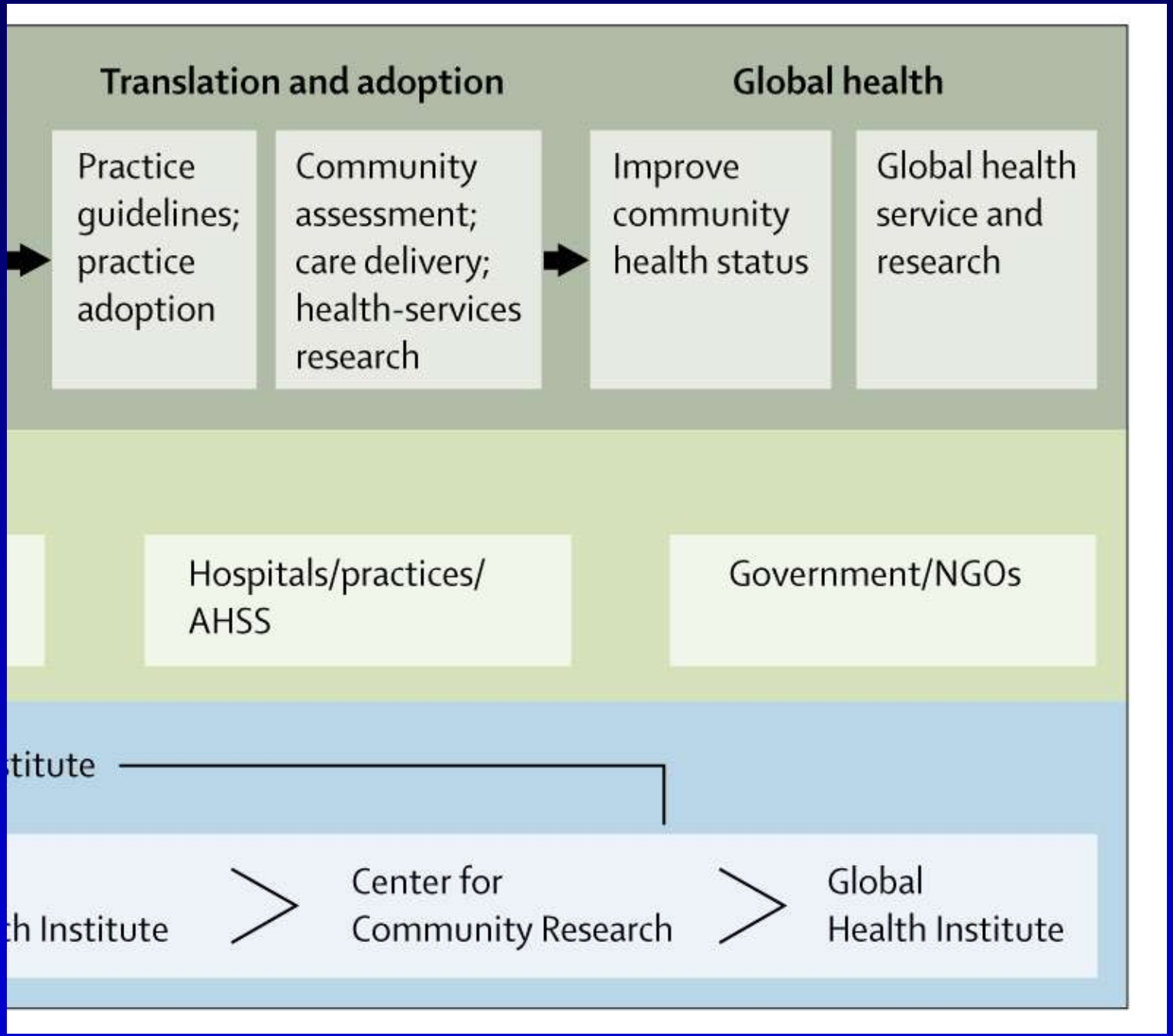


Figure 1: **Academic health science systems as integrators**

(A) The discovery-care continuum, including discovery science, preclinical and clinical research, adoption in practice, and global uptake; (B) current fragmented organisational structure of the clinical research enterprise; (C) Duke Medicine model: a continuous, intercommunicated discovery-care model. FDA=US Food and Drug Administration. AHSS=Academic health science systems. NGOs=non-governmental organisations.


Translation and adoption
Global health
Practice guidelines; practice adoption
Community assessment; care delivery; health-services research
Improve community health status
Global health service and research
Hospitals/practices/ AHSS
Government/NGOs
titute
h Institute
Center for Community Research
Global Health Institute

Primary Health Care as a strategy to achieve equitable care?

1. Can primary care research make a difference to health inequalities?
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4. Conclusion

3.1. The patient is the starting point of the process

- Active
- Informed
- Service delivery
- Globalisation /Glocalisation
- Multicultural

Accessibility

Equity

The World Health Report **2008**

Primary Health Care

Now More Than Ever

World Health Organization

Director General's message

Four sets of reforms that reflect a convergence between he values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts. They include:

- Universal coverage reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion
- Service delivery reforms that re-organize health services around people's needs and expectations
- Public policy reforms that secure healthier communities
- Leadership reforms

Dr. Margaret Chan
Director General
World Health Organization

Figure 1 The PHC reforms necessary to refocus health systems towards health for all

3.2. Characteristics of FP/ patient encounters

- C
- C
- C
- C
- C
- C
- C

3.2. Characteristics of FP/ patient encounters

- Commitment
- C
- C
- C
- C
- C
- C

3.2. Characteristics of FP/patient encounters

- Commitment
- Clinical Competence
- C
- C
- C
- C
- C

3.2. Characteristics of FP/patient encounters

- Commitment
- Clinical Competence
- Context
- C
- C
- C
- C

3.2. Characteristics of FP / patient encounters

- Commitment
- Clinical Competence
- Context
- Comprehensiveness
- C
- C
- C

3.2. Characteristics of FP / patient encounters

- Commitment
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- Context
- Comprehensiveness
- Complexity
- C
- C

3.2. Characteristics of FP / patient encounters

- Commitment
- Clinical Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- C

3.2. Characteristics of FP / patient encounters

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

Compassion ↔ Computer

Quality in primary health care: a multidimensional approach to complexity

Good care is much more than meeting disease specific targets. **Iona Heath and colleagues** argue that assessments of quality must take into account all the complexities of primary health care

In his 1913 novel *Chance*, Joseph Conrad wrote about the changing fashion for certain words: "You know the power of words. We pass through periods dominated by this or that word—it may be development, or it may be competition, or education, or purity or efficiency or even sanctity. It is the word of the time." Today's word is quality.

In order to assess the quality of primary health care, we have to define what quality means in this context. But who should

care may improve disease specific outcomes but can also have unintended consequences in fragmentation of care and higher costs for reduced value.[3]

Quality of care is particularly challenging in the fragmented and pluralistic systems often seen in low and middle income countries and in some high income countries, most notably the United States. Most of the elements deemed responsible for the failure of primary care programmes in these countries are more related to structure than process. Such elements include limited, erratic, or unsustainable funding; inadequate training and equipment; and primitive rather than primary health care, which occurs when primary care is conceptualised as providing basic services only for poor people rather than as the foundation of care for all people.

Most patients presenting in primary care have multiple, interacting, and compounding problems—physical, psychological, and

Iona Heath general practitioner, Caversham Group Practice, London NW5 2UP

Adolfo Rubinstein professor of family medicine and public health, Division of Family and Community Medicine, Hospital Italiano, Faculty of Medicine, University of Buenos Aires; president, Institute of Clinical Effectiveness and Health Policy, Buenos Aires, Argentina

Kurt C Stange professor of family medicine, epidemiology and biostatistics, sociology, and oncology, Case Western Reserve University, Cleveland, OH 44106, USA

Mieke L van Driel professor of general practice, Faculty of Health Sciences and Medicine, Bond University, Gold Coast, Qld 4229, Australia; Department of General Practice and Primary Health Care, Ghent University, Ghent, Belgium

3.3. From ‘Chronic Disease Management’ (CDM) towards ‘Participatory Patient Management’ (PPM)

1. The epidemiological context: multimorbidity
2. Patient-centredness and the paradigm-shift from problem-oriented to goal-oriented care
3. The chronic care model: an answer to the challenges?
4. The threats
5. The way forward

Multimorbidity becomes the rule, not the exception

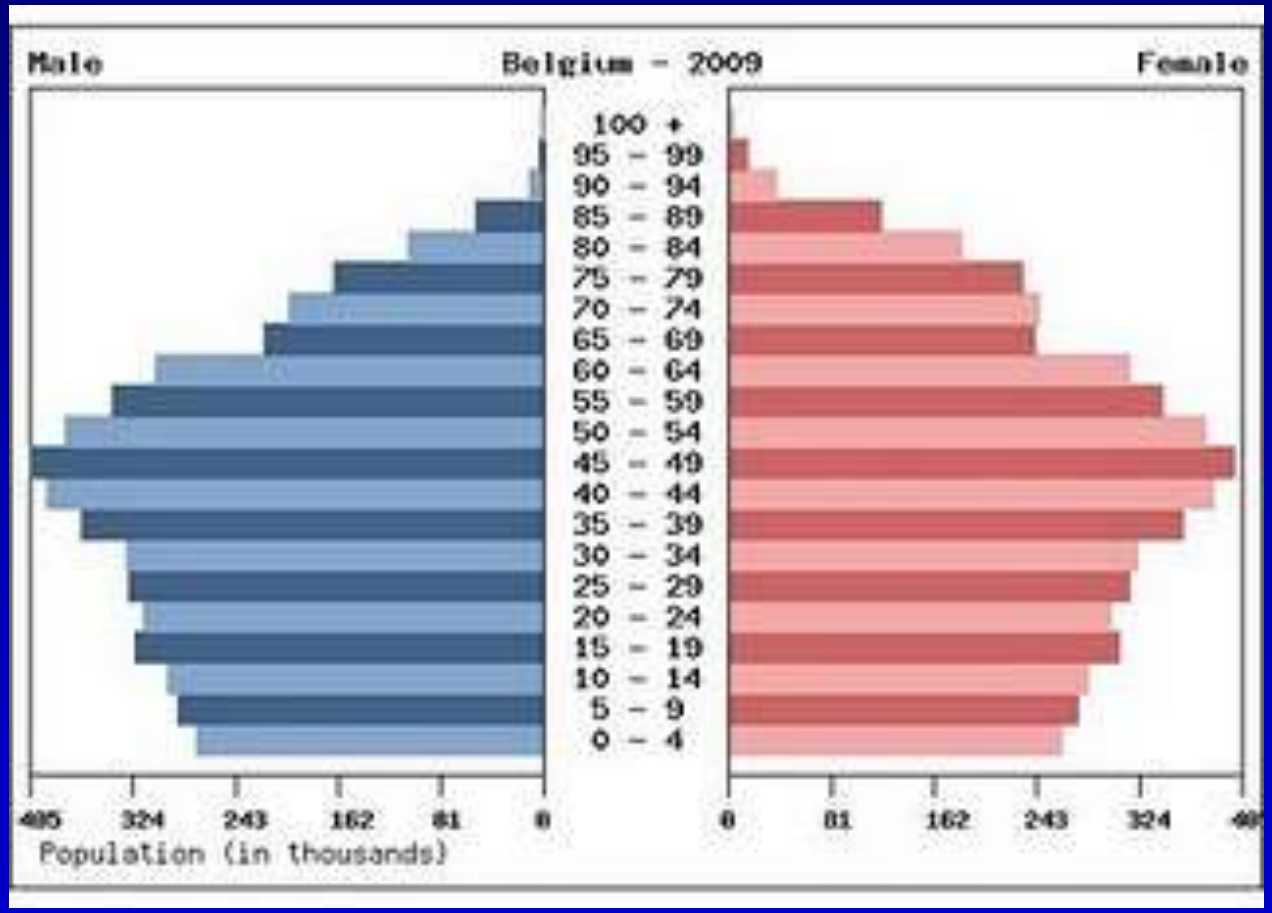
- More than half of the patients with COPD have either cardiovascular problems, or diabetes
- Patients with COPD have a 3- to 6-fold risk to have all these problems

  (Eur Respir J 2008;32:962-69)

- 50 % of 65+ have at least 3 chronic conditions
- 20 % of 65+ have at least 5 chronic conditions

  (Anderson 2003)

The ageing society



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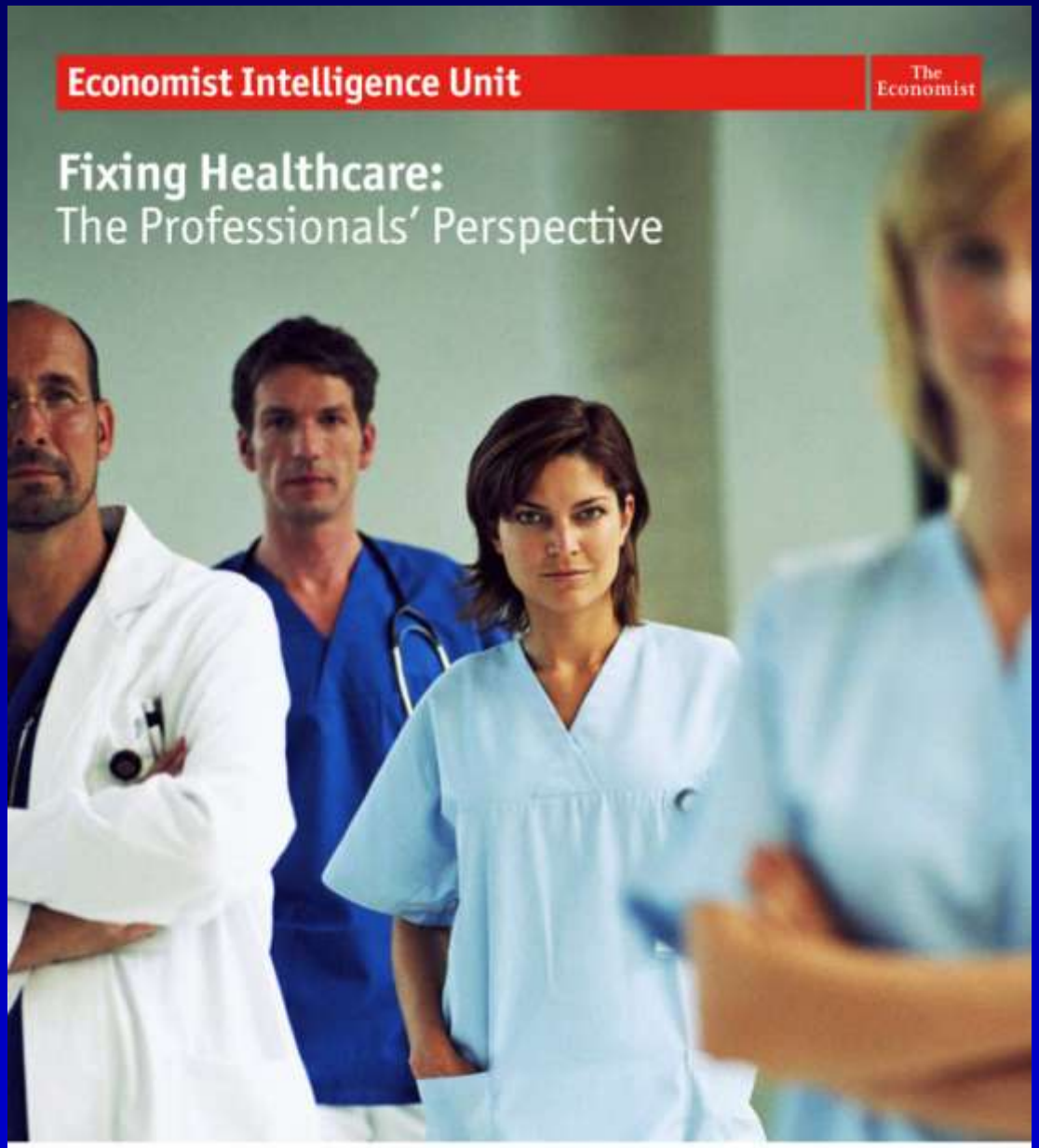
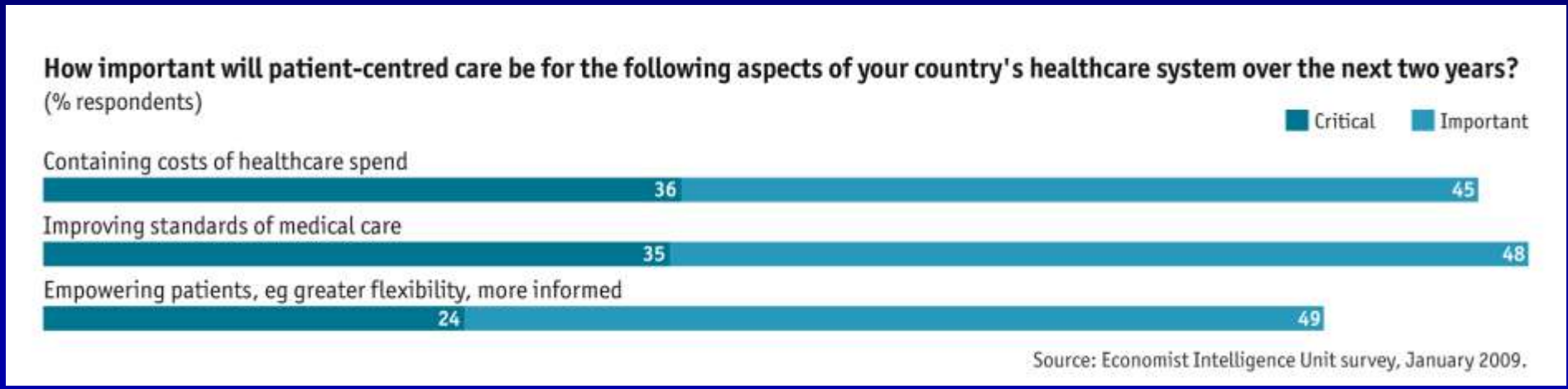


Commissioned by Philips

The first report in a series of four from the Economist Intelligence Unit

PHILIPS


How important will patient-centred care be for the following aspects of your country's healthcare system over the next two years?
(% respondents)
Critical
Important
Containing costs of healthcare spend
36
45
Improving standards of medical care
35
48
Empowering patients, eg greater flexibility, more informed
24
49
Source: Economist Intelligence Unit survey, January 2009.

Margaret is 75 years old. Fifteen years ago she lost her husband. She is a patient in the practice for 15 years now. During these last 15 years she has been through a laborious medical history: operation for coxarthrosis with a hip prothesis, hypertension, diabetes type 2, COPD and osteoartritis. Moreover there is osteoporosis. She lives independently at her home, with some help from her youngest daughter Elisabeth. I visit her regularly and each time she starts saying: "Doctor, you must help me". Then follows a succession of complaints and unwell feeling: sometimes it has to do with the heart, another time with the lungs, then the hip, ...

Each time I suggest – according to the guidelines - all sorts of examinations that did not improve her condition. Her requests become more and more explicit, my feelings of powerlessness, insufficiency and spite, increase. Moreover, I have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which worsens her glycemic control.

The adaptation of the medication for the blood pressure (at one time too high, at another time too low), cannot meet with her approval, as does my interest in her HbA1C and lung function test-results.

After so many contacts Margaret says: "Doctor, I want to tell you what really matters for me. On Tuesday and Thursday, I want to visit my friends in the neighbourhood and play cards with them. On Saturday, I want to go to the Supermarket with my daughter. And for the rest, I want to be left in peace, I don't want to change continually the therapy anymore, ... especially not having to do this and to do that".

In the conversation that followed it became clear to me how Margaret had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Margaret's goals. I visit Margaret again with pleasure ever since: I know what she wants, and how much I can (merely) contribute to her life.

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 strenghtening
- Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

R

- F
- Ophta
- Pul

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

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

Patient education

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

Boyd et al. JAMA, 2005

Special Article

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.

(Fam Med 1991; 23:46-51)

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

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Definition of Health	Absence of disease as defined by the health care system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Purposes of Health Care	Eradication of disease, prevention of death	Assistance in achieving a maximum individual health potential

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Measures of success	Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death	Achievement of individual goals

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Evaluator of success	Physician	Patient

What really matters for patients is

- Functional status
- Social participation

3.3. From ‘Chronic Disease Management’ (CDM) towards ‘Participatory Patient Management’ (PPM)

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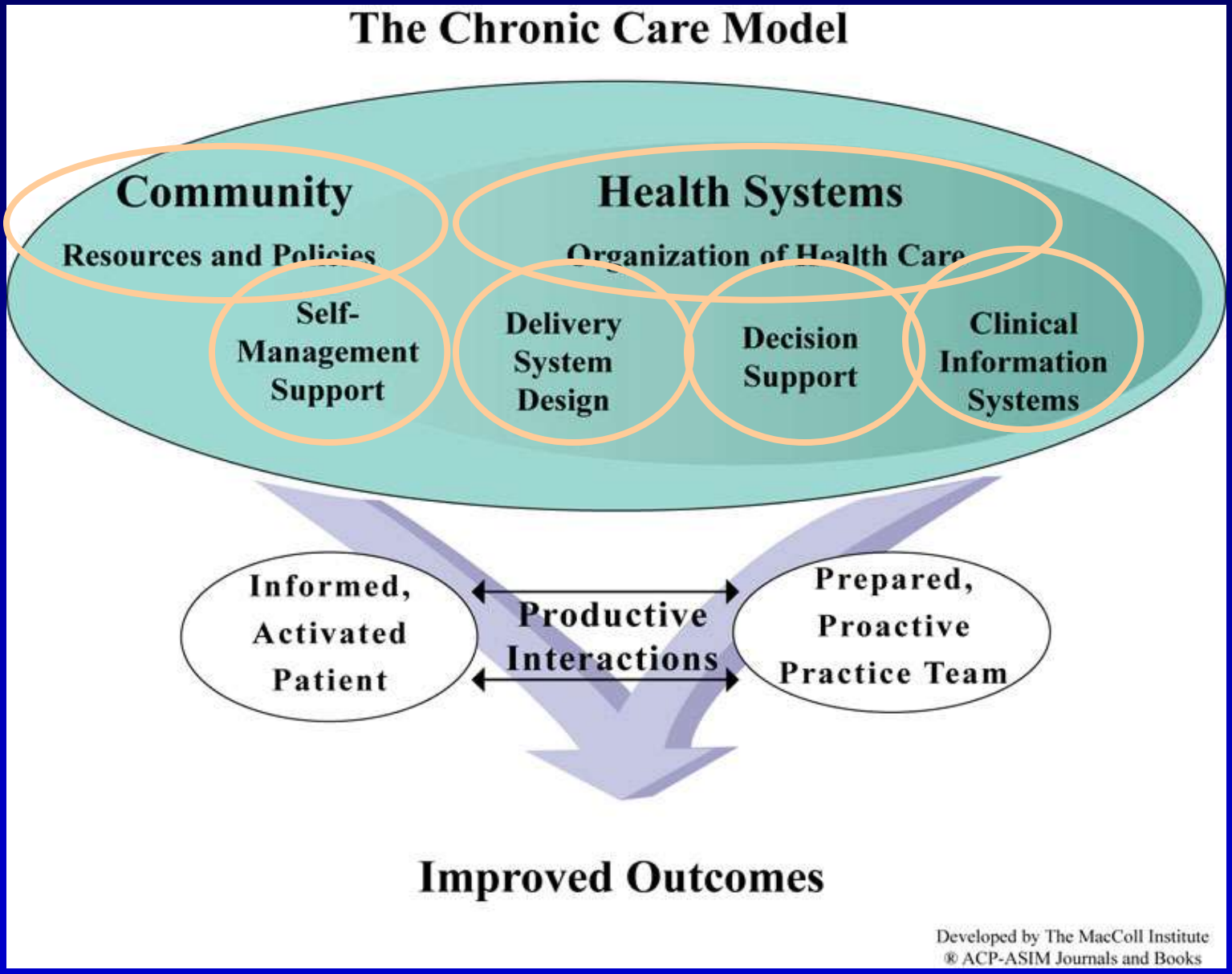
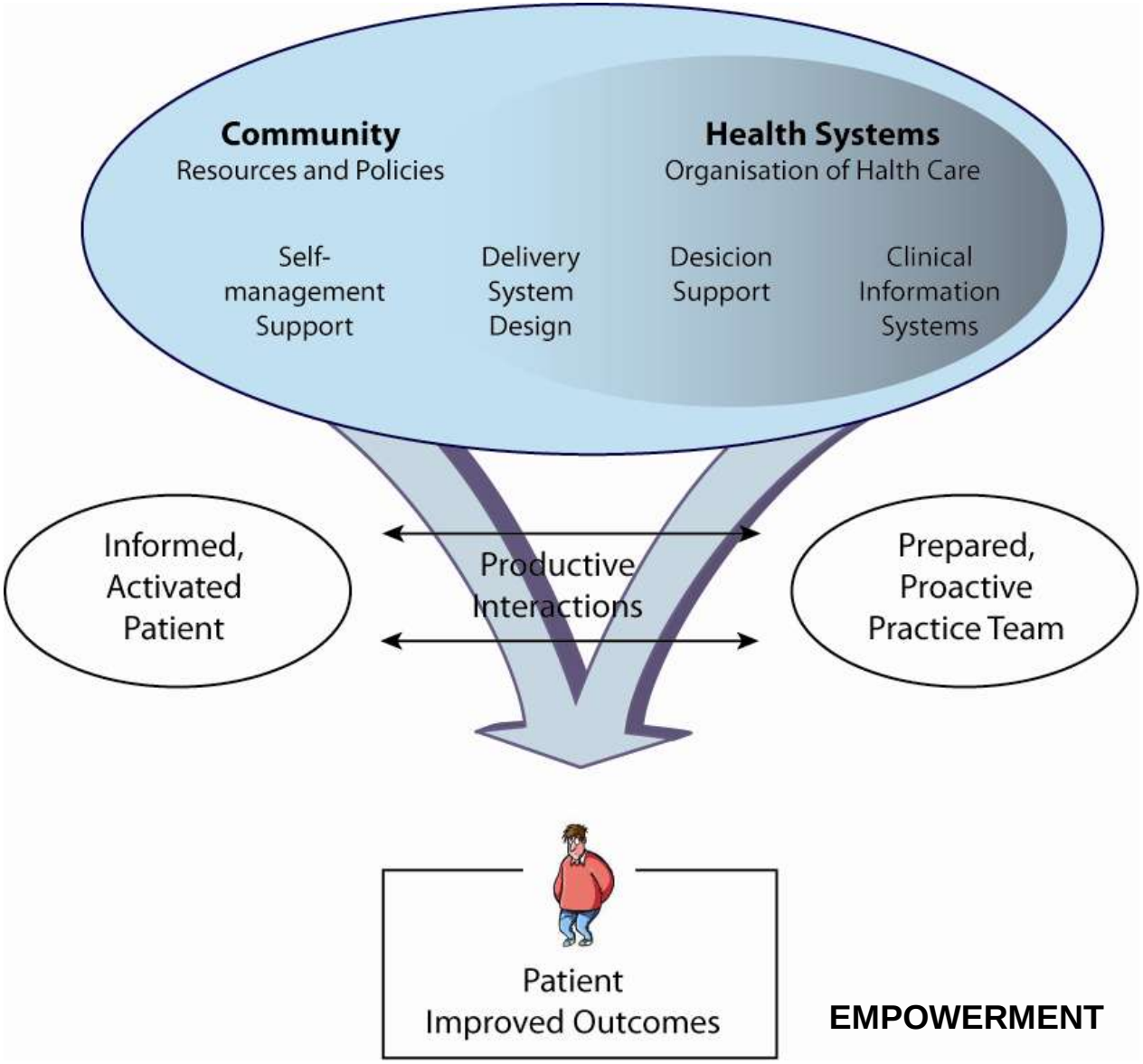
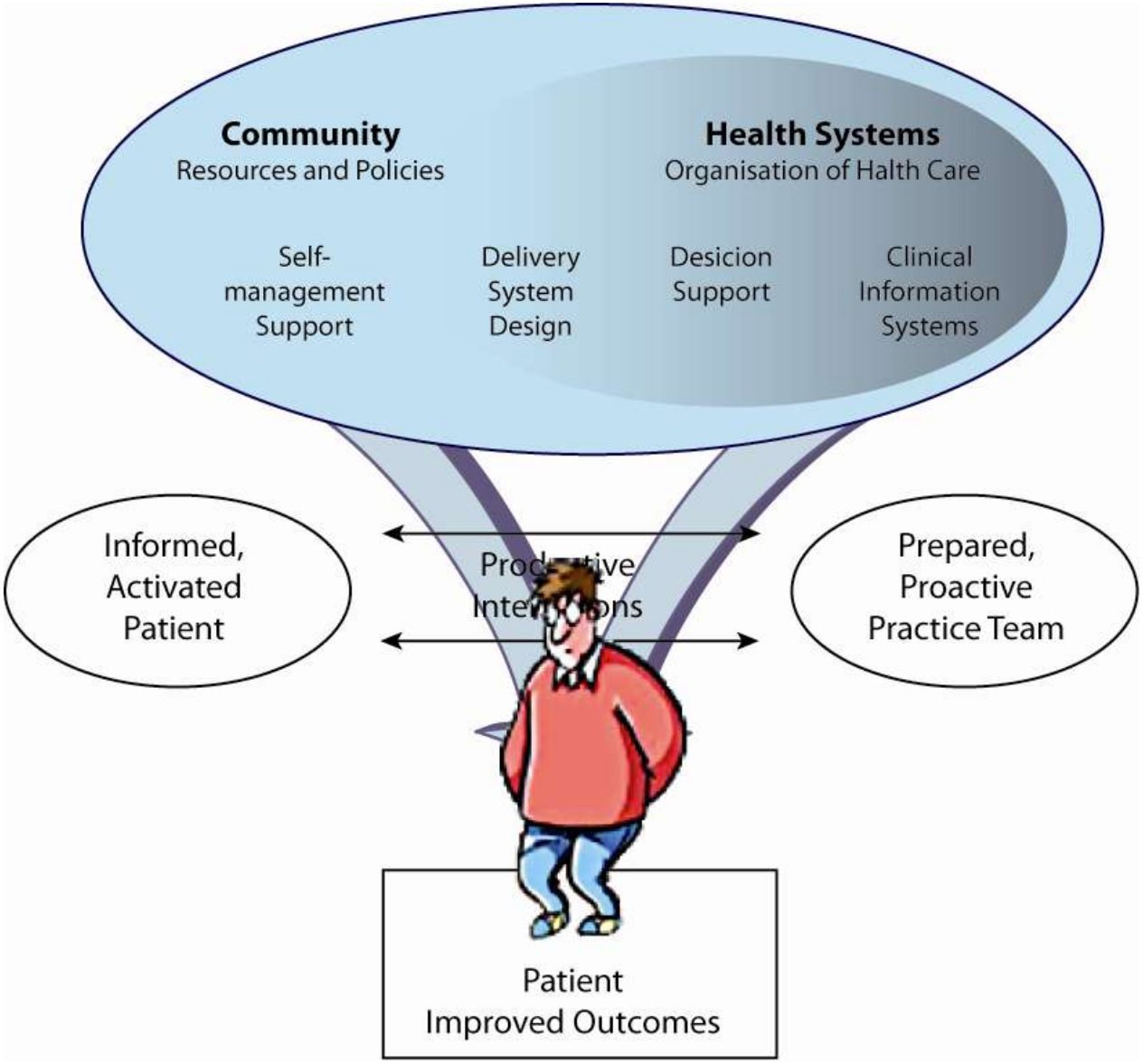


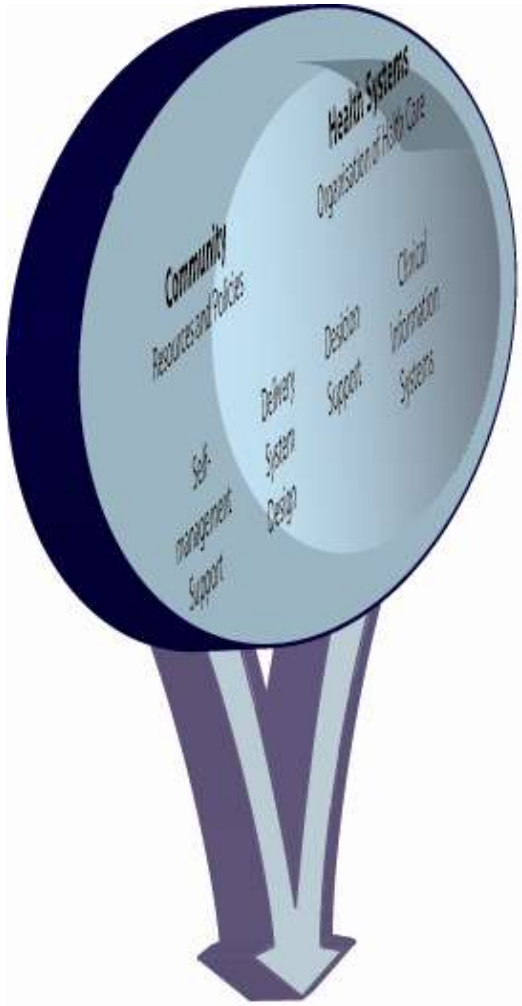
Wagner EH. Effective Clinical Practice 1998;1:2-4



EMPOWERMENT


Community
Resources and Policies
Health Systems
Organisation of Halth Care
Self-management Support
Delivery System Design
Desicion Support
Clinical Information Systems
Informed, Activated Patient
Prepared, Proactive Practice Team
Patient Improved Outcomes

But…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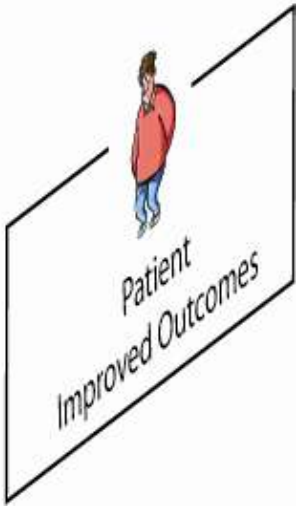
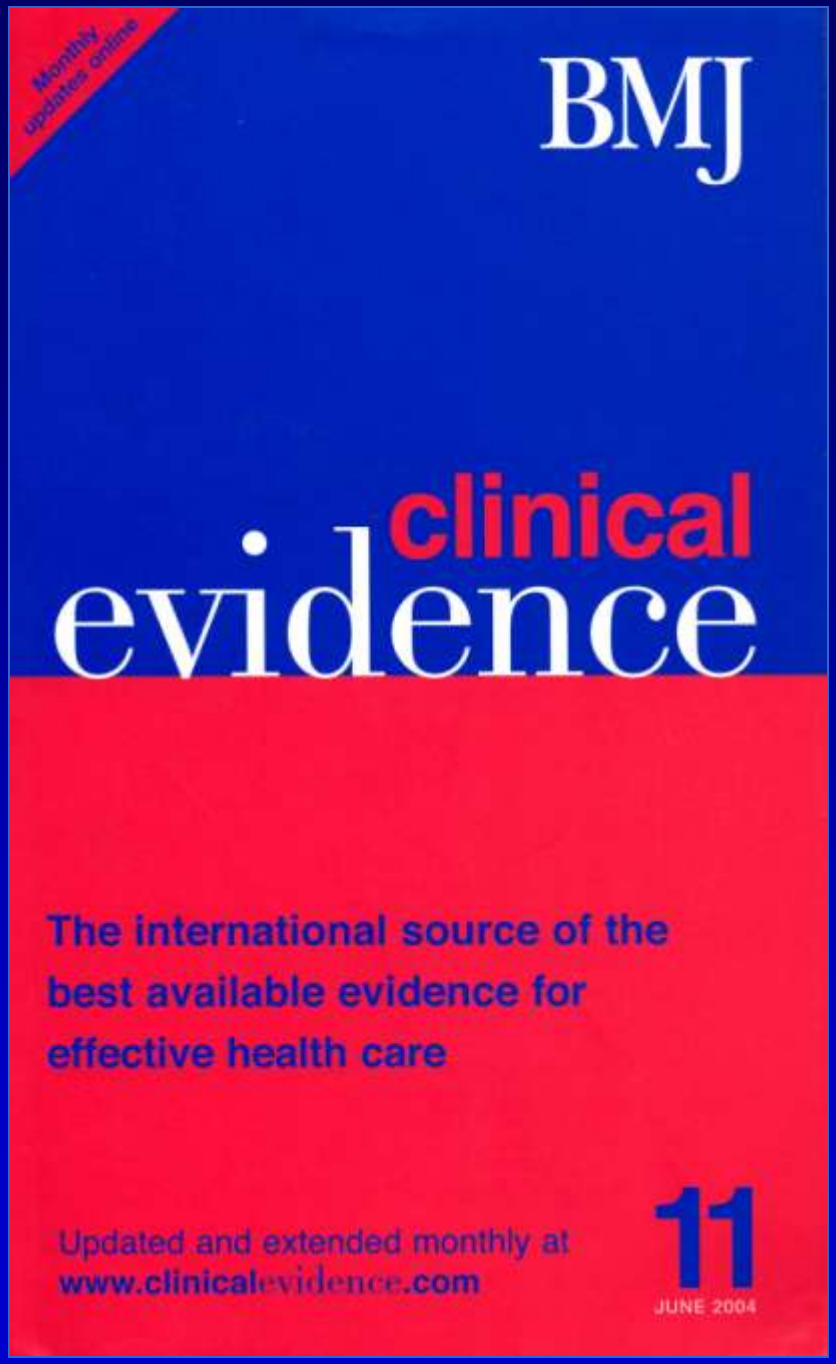

Patient
Improved Outcomes


Monthly updates online
BMJ
clinical
evidence
The international source of the best available evidence for effective health care
Updated and extended monthly at www.clinicalevidence.com
11
JUNE 2004

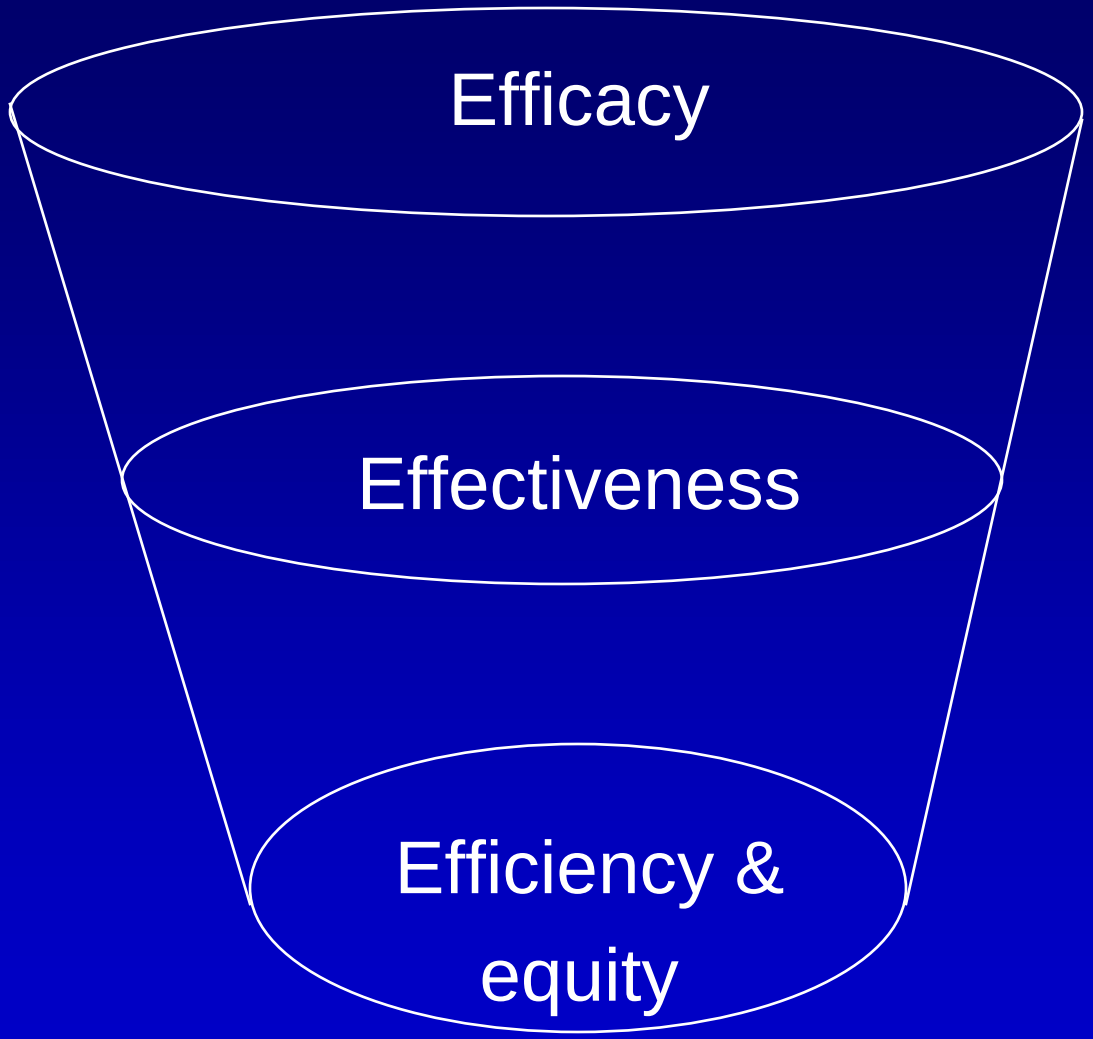
Problems with guidelines in multimorbidity

- “Evidence” is produced in patients with 1 disease
- Guidelines may lead to contradictions (e.g. in therapy)

“Treat the patient”

“Treat-to-target”

Quality of care



Medical

Contextual

Policy

EVIDENCE

De Maeseneer J, et al. The Lancet 2003;362:1314-19

Primary Health Care and “contextual” evidence

“disease management”

“patient management”

Evolution from
‘Chronic Disease Management’
towards
‘Participatory Patient Management’

Puts the patient centrally in the process.

Changes the perspective from ‘problem-oriented care’.

towards ‘goal-oriented’ care.

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The need for a shift in chronic care: from "Chronic Disease Management" to "Participatory Patient Management".

- In many countries, specific access to services is conditioned by the diagnosis of the patient. This may lead to a new kind of "inequity", the "inequity by disease".

- It is worthwhile studying what is the actual presentation of this phenomenon, and what could be done to handle it appropriately. How will market forces and commercialisation play a role in this development?

“Inequity by disease” becomes an increasing problem both in developed and developing countries

[zie www.15by2015.org]

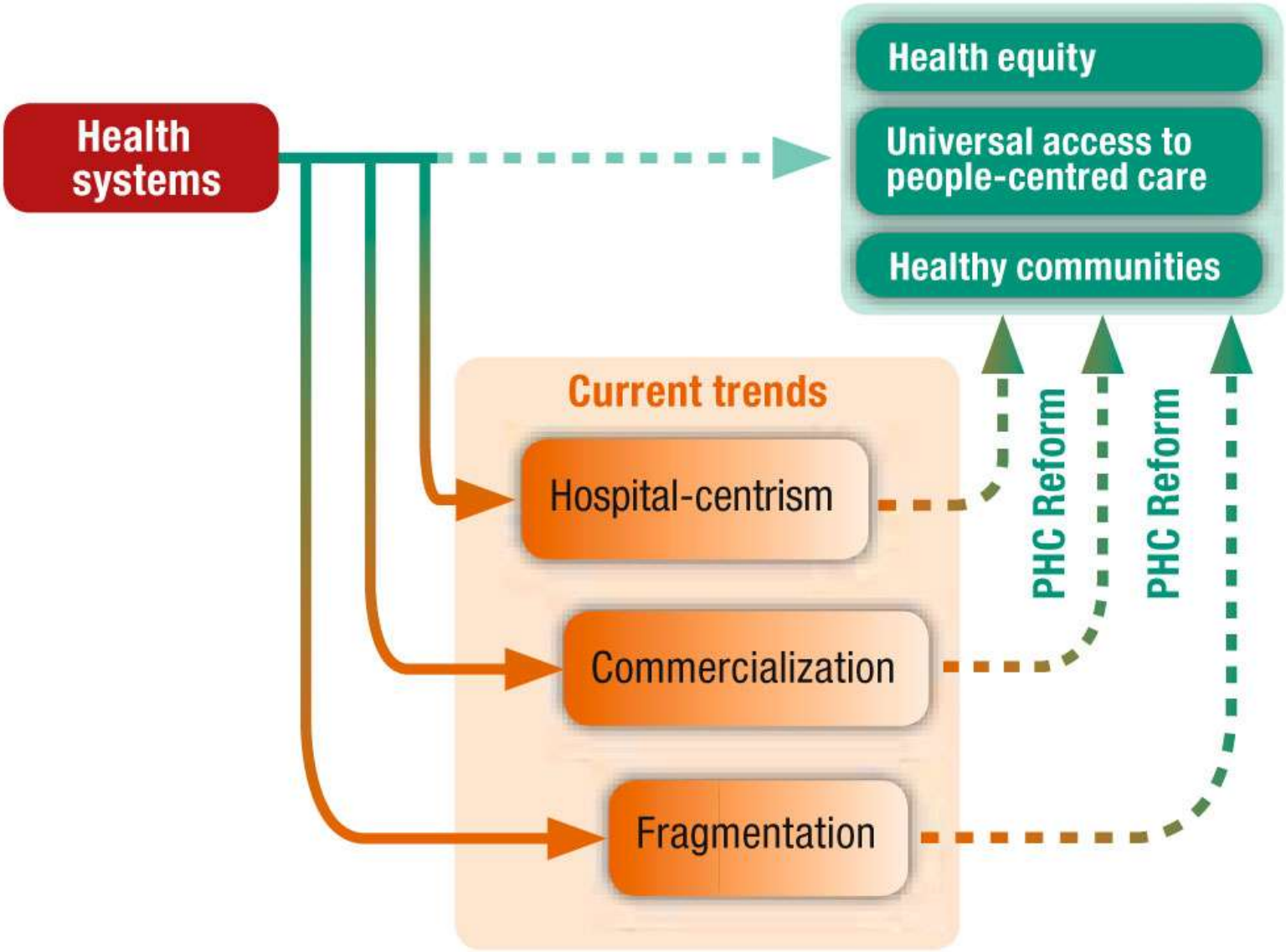
The World Health Report **2008**

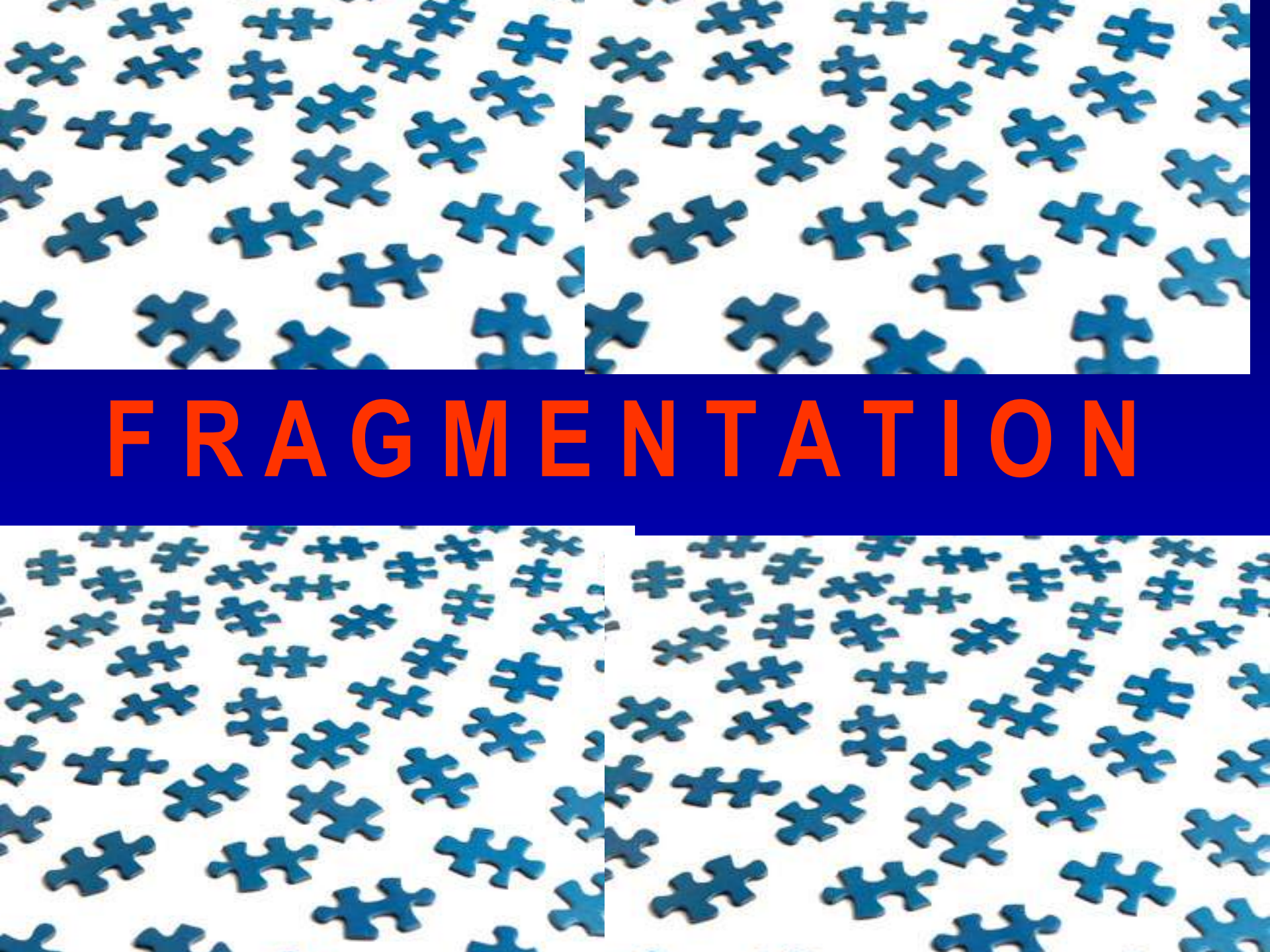
Primary Health Care

Now More Than Ever

World Health Organization

Figure 1.10 How health systems are diverted from PHC core values




FRAGMENTATION

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The way forward

- Implementation research in the framework of translational research
- The paradigm-shift : from “problem-oriented” to “goal-oriented” care
- Patient participation and empowerment
- Taking into account context and diversity

Primary Health Care as a strategy to achieve equitable care

1. Can primary care make a difference to health inequalities?
2. Primary health care and health inequalities at different levels
3. The role of Family Medicine
4. Conclusion

Primary Health Care as a strategy to achieve equitable care: conclusion

1. Primary health care contributes to equity and social cohesion
2. Family Medicine is the medical clinical discipline in the PHC-team
3. Primary health care responds to the challenges of people with chronic conditions
4. Primary Health Care is cost-effective

Thank You!

jan.demaeseneer@ugent.be

www.euprimarycare.org

european forum for primary care

THE NETWORK
TOWARDS UNITY FOR HEALTH

Announcement | Annual Conference

Integrating Public and Personal Health Care in a World on the Move

International Conference
September 17 - 22, 2011
Graz, Austria

Organised by The Network: Towards Unity for Health, Medical University Graz (MUG) and Styrian Academy of Family Practice (STAFAM)

Post-Conference Excursions to Slovenia and Hungary
September 22 - 24, 2011