Primary Care and General Medicine in Europe: A focus on undergraduate education

Slovenská spoločnosť všeobecného praktického lekárstva SLS
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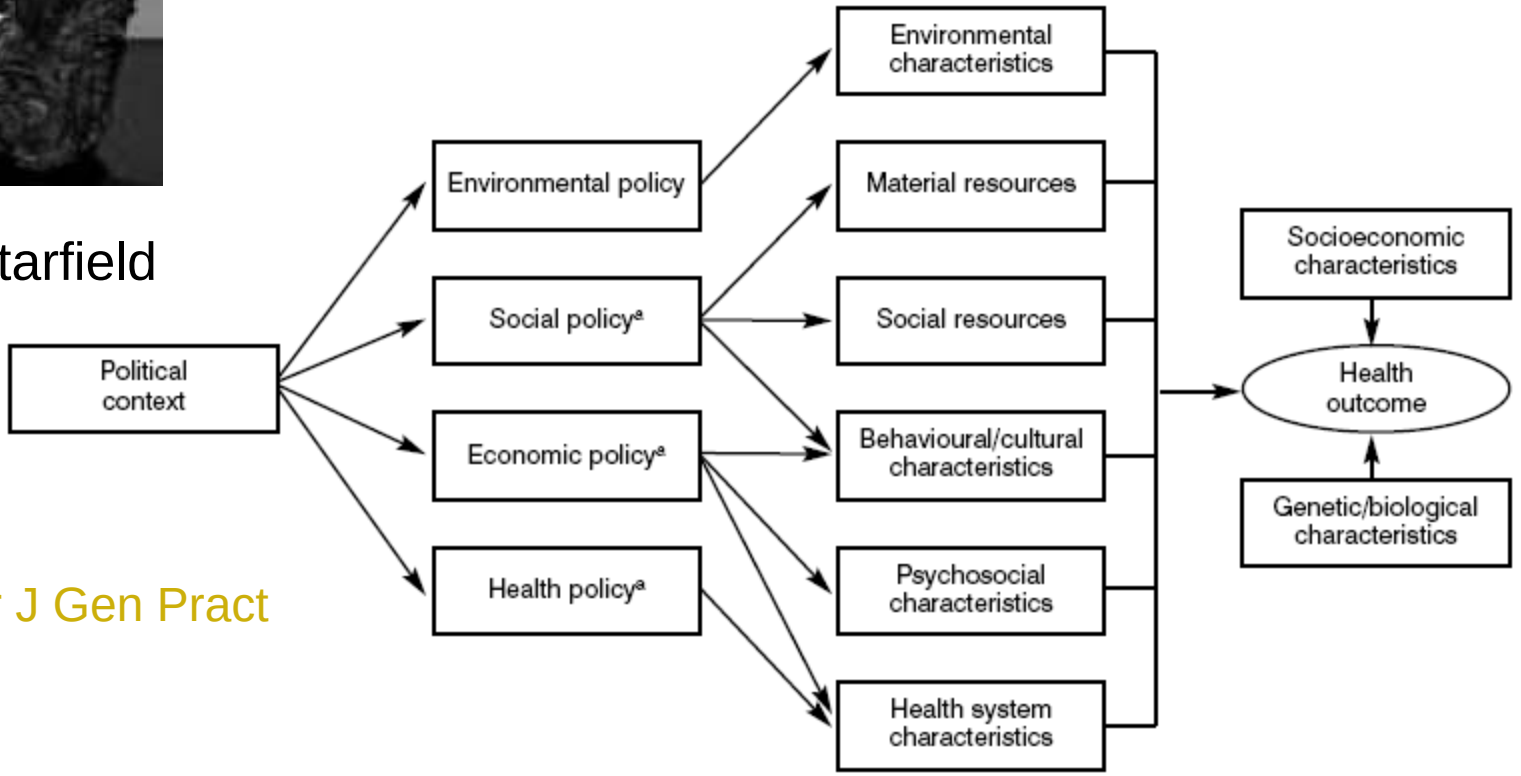
Overview

- PHC/GP : Key issues and reports
- A quick look at Primary care and General Medicine with focus on undergraduate education in:
  -  Great Britain
  -  Netherlands
  -  Sweden
  -  Germany
  -  Turkey
  -  Spain
  -  Portugal
  -  Greece

New challenges for the European primary care-I

Barbara Starfield

- *Broadening the concept of health*



B. Starfield, Br J Gen Pract 2001

Figure 1. A conceptual framework of health determinants: individual model. [a]Reflects a country's approach to the distribution of power ('political jurisdiction).

New challenges for the European primary care-II

Continuity of care: a multidisciplinary review

Jeannie L Haggerty, Robert J Reid, George K Freeman, Barbara H Starfield, Carol E Adair, Rachael McKendry

The concept—and reality—of continuity of care crosses disciplinary and organisational boundaries. The common definitions provided here should help healthcare providers evaluate continuity more rigorously and improve communication

Patients are increasingly seen by an array of providers in a wide variety of organisations and places, raising concerns about fragmentation of care. Policy reports and charters worldwide urge a concerted effort to enhance continuity,[1–3] but efforts to describe the problem or formulate solutions are complicated by the lack of consensus on the definition of continuity. To add to the confusion, other terms such as continuum of care, coordination of care, discharge planning, case management, integration of services, and seamless care are often used synonymously. This synthesis was commissioned by three Canadian health services policy and research bodies. The aim was to develop a common understanding of the concept of continuity as a basis for valid and reliable measurement of practice in different settings.

Seven ages of man?

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Barbara H Starfield *university distinguished professor*

continued over

BMJ 2003;327:1219–21

Assessing the literature

We searched academic and policy literature for documents in which the principal focus was continuity of patient care or continuity. We searched electronic databases (Medline, HealthSTAR, Embase, CINAHL, Current Contents, PsychINFO, AIDSLINE, CancerLit, Cochrane Library, Dissertation abstracts, PapersIst (conferences and paper abstracts), Web of Science, WorldCat) as well as web library catalogues, peer reviewed internet sites, internet search engines, and several in-house databases. The search included documents dated from 1966 to November 2001 written in English, French, or Spanish. The reviewers (RJR, JLH, RMcK) used a data abstraction form to summarise relevant documents from every health discipline, and all reviewers read key documents.

We presented the results of an initial review of 314 documents to participants of a workshop on continuity held in Vancouver in June 2001. We obtained structured feedback to a discussion paper, problem based scenarios, and expert presentations. Participants validated the common themes and proposed features of continuity that did not emerge from the literature but are relevant to clinical practice—for example, dimensions of continuity relationships when care is received from multiple providers.

We identified 2459 unique documents and reviewed 583 (see bmj.com for references). Of these, 226 (39%) were in primary medical care, 109 (19%) in mental health care, 92 (16%) in disease specific care, and 74 (13%) in nursing; another 61 (10%) fell outside these domains, and 21 (4%) focused solely on measures of continuity. The search results and full reports are available on the Canadian Health Services Research Foundation website (www.chsrf.ca/docs/finalrpts/index_e.shtml#comre).

Emphases of different healthcare domains

Primary care

Continuity in primary care literature is mainly viewed as the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease.[4–5] Continuity implies a sense of affiliation between patients and their practitioners (my doctor or my patient), often expressed in terms of an implicit contract of loyalty by the patient and clinical responsibility by the provider.[6] The affiliation is sometimes referred to as longitudinality,[4] relational,[4 7 8] or personal continuity,[9] and it fosters improved communication, trust, and a sustained sense of responsibility.[7 10]

In family medicine, continuity is different from coordination of care, although better coordination follows from continuity. By contrast, a trade-off is required between accessibility of healthcare providers and continuity.[8 11]

A list of reviewed articles is available on bmj.com

- A focus on continuity

"This concept-and reality- of continuity of care crosses disciplinary and organisational boundaries"

Seven ages of man?

New challenges for the European primary care-III

EDITORIAL

Interprofessional education - to break boundaries and build bridges

T Faresjo

Unit for Interprofessional Education, Faculty of Health Sciences, Linkoping University, Sweden

Submitted: 8 June 2006; Published: 7 July 2006

Faresjo T

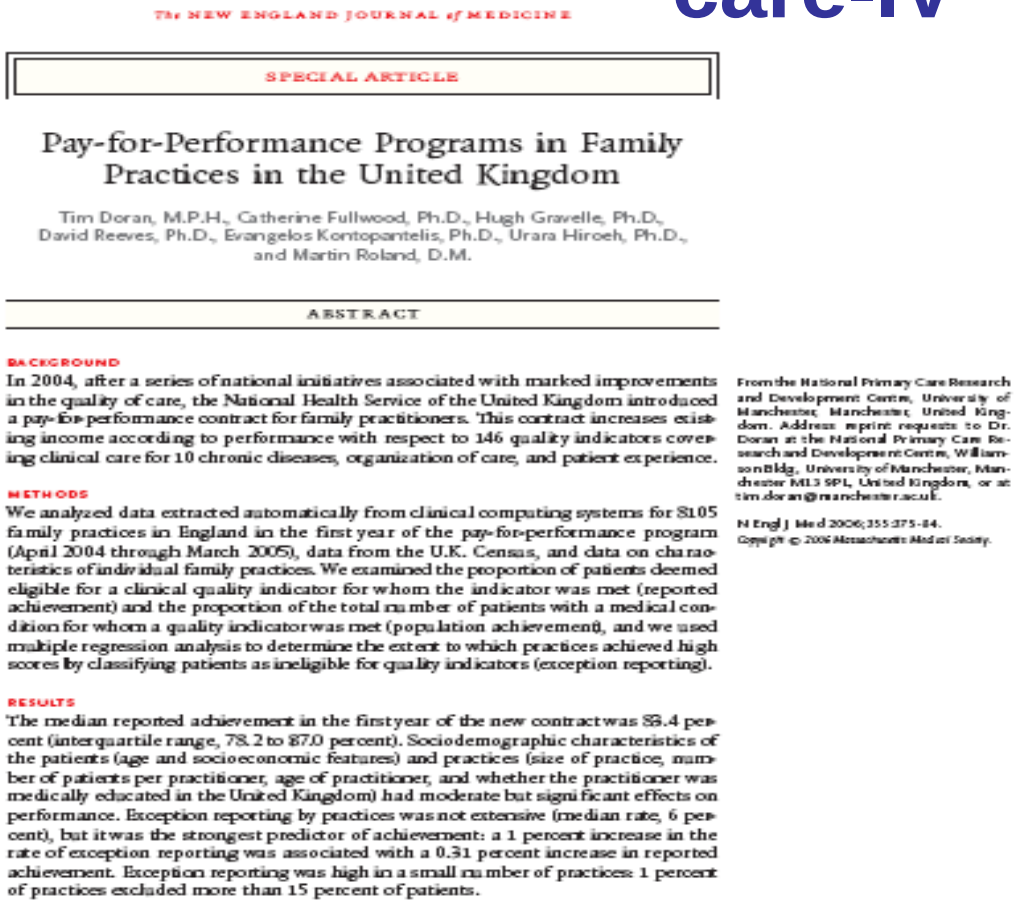
Interprofessional education - to break boundaries and build bridges

***Rural and Remote Health* 6: 602. (Online), 2006**

Available from: http://rrh.deakin.edu.au

- A focus on inter-professional collaboration

New challenges for the European primary care-IV



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Pay-for-Performance Programs in Family Practices in the United Kingdom

Tim Doran, M.P.H., Catherine Fullwood, Ph.D., Hugh Gravelle, Ph.D., David Reeves, Ph.D., Evangelos Kontopantelis, Ph.D., Urara Hiroeh, Ph.D., and Martin Roland, D.M.

ABSTRACT

BACKGROUND

In 2004, after a series of national initiatives associated with marked improvements in the quality of care, the National Health Service of the United Kingdom introduced a pay-for-performance contract for family practitioners. This contract increases existing income according to performance with respect to 146 quality indicators covering clinical care for 10 chronic diseases, organization of care, and patient experience.

METHODS

We analyzed data extracted automatically from clinical computing systems for 8105 family practices in England in the first year of the pay-for-performance program (April 2004 through March 2005), data from the U.K. Census, and data on characteristics of individual family practices. We examined the proportion of patients deemed eligible for a clinical quality indicator for whom the indicator was met (reported achievement) and the proportion of the total number of patients with a medical condition for whom a quality indicator was met (population achievement), and we used multiple regression analysis to determine the extent to which practices achieved high scores by classifying patients as ineligible for quality indicators (exception reporting).

RESULTS

The median reported achievement in the first year of the new contract was 88.4 percent (interquartile range, 78.2 to 87.0 percent). Sociodemographic characteristics of the patients (age and socioeconomic features) and practices (size of practice, number of patients per practitioner, age of practitioner, and whether the practitioner was medically educated in the United Kingdom) had moderate but significant effects on performance. Exception reporting by practices was not extensive (median rate, 6 percent), but it was the strongest predictor of achievement: a 1 percent increase in the rate of exception reporting was associated with a 0.31 percent increase in reported achievement. Exception reporting was high in a small number of practices: 1 percent of practices excluded more than 15 percent of patients.

From the National Primary Care Research and Development Centre, University of Manchester, Manchester, United Kingdom. Address reprint requests to Dr. Doran at the National Primary Care Research and Development Centre, Williamson Bldg., University of Manchester, Manchester M13 9PL, United Kingdom, or at tim.doran@manchester.ac.uk.

N Engl J Med 2006;355:375-84.

- A focus on the issue of organisation and coordination of care

T. Doran, et al, New England Journal of Medicine 2006

New challenges for the European primary care-V

- A focus on patient care improvement

BMJ helping doctors make better decisions

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BMJ 2007;334 (19 May), doi:10.1136/bmj.39217.615637.BE

Editor's Choice

Editor's choice

Improving patient care

Fiona Godlee, *editor*

How to improve patient care-the role of general practice/family medicine

How to improve patient care in a country where General Practice is less developed?

8 June 2007

Christos Lionis, Associate Professor of Social and Family Medicine
School of Medicine, University of Crete, Greece, Zip Code 71003, P.O. Box 2208

Send response to journal: Re: How to improve patient care in a country where General Practice is less developed?

Responding to the Editor's key message that appeared in the BMJ editorial of May 19, and considering this question in countries without capacity for quality of care measurements and clinical governance, such as Greece, I would like to suggest four key aspects that could be easily initiated and implemented by individual GPs, rather than the health care system:

(a) The introduction of a self-assessment process during GP consultation

(b) A medical audit process that will check effectiveness in targeted and selective groups of patients, including those with common problems or at high risk

(c) Efforts to measure the pre-test and posterior diagnostic probability at the general practitioner's office, using simple measurements or diagnostic questions

(d) An evaluation meeting with patients to identity barriers to health care needs and dissatisfaction from doctor's performance

Empirical and experimental research is expected to fully explore the feasibility and effectiveness of the suggested GP-based initiatives on quality improvement.

Primary Health Care

Now More Than Ever

World Health Organization

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

Box 1 Five common shortcomings of health-care delivery

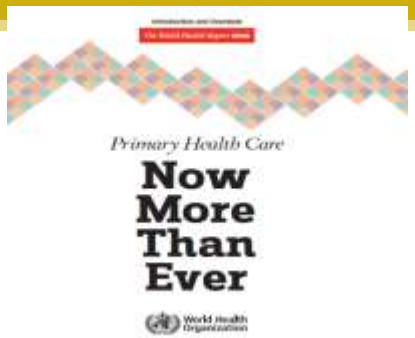
Inverse care. People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least[10]. Public spending on health services most often benefits the rich more than the poor[11] in high- and low-income countries alike[12,13].

Impoverishing care. Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care[14].

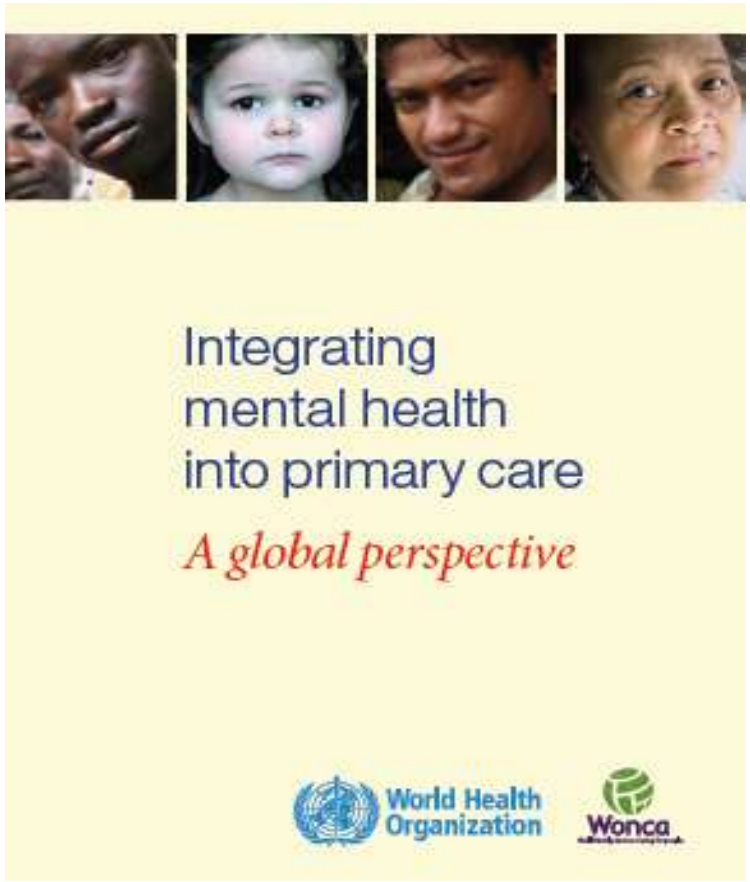
Fragmented and fragmenting care. The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care[15]. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced[16], while development aid often adds to the fragmentation[17].

Unsafe care. Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health[18].

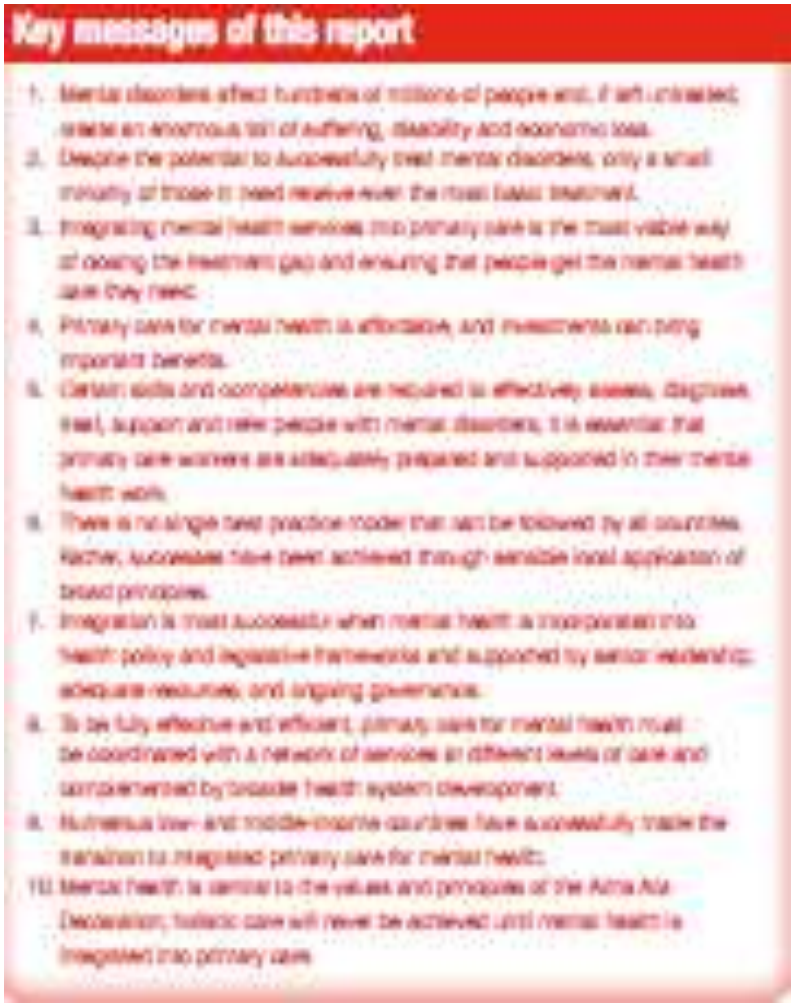
Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden[19,20]. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health[21].



EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it



www.who.int/mental_health/policy



Great Britain

Liberating the NHS

Equity and excellence: Liberating the NHS

Published: 12 July 2010

The NHS White Paper, Equity and excellence: Liberating the NHS, sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how we will:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients - the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

UK Government Follow

Department of Health: Liberating the NHS: Improving outcomes for patients

Jul 19, 2010 13:29 CEST

The consultation document suggests five outcome domains and seeks views on the structure and the core principles that should underpin the development of the framework, as well as the more specific outcome measures that should be used. The proposed domains are:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing the quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Source: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

UNIVERSITY OF CAMBRIDGE

General Practice Education Group (GPEG)

GPEG aims to provide, develop and evaluate high quality teaching for undergraduate medical students

Undergraduate Medical Education in General Practice

Association of University Teachers in General Practice, United Kingdom and Republic of Ireland

General Medical Council

The General Medical Council (GMC) registers and regulates doctors in the UK. The GMC controls entry to the medical register and setting the educational standards for medical schools and year one of the foundation programme.

The GMC is responsible for promoting high standards of medical education. Its Education Committee issues guidance on the education and training of doctors, defines and monitors the standards of undergraduate medical education and promotes good practice in postgraduate training. The 2006 GMC publication Good Medical Practice is intended to be at the centre of all medical education. The GMC publication Tomorrow's doctors, first published in 1993, makes recommendations on the undergraduate curriculum. This document has been updated in September 2009.

Published by
The Royal College of General Practitioners
Exeter
ISBN 85840 99 6

BMA

http://www.bma.org.uk/careers/medical_education/mededatozg.jsp

Netherlands

Primary care manpower 2003

	Number (absolute)	Inhabitants per FTE provider
General practitioners	8,110	2,400
Pharmacists	2,650	6,100
Physical therapists	13,250	1,320
Midwives	1,500	2,280 (WFA)
PC Psychologists	1,285	16,000
Social workers	3,370	7,600

Source: NIVEL – Netherlands Institute for Health Services Research and Utrecht University

[The contribution of general practice medicine to undergraduate medical education]

[Article in Dutch]

Rutten GE, Grundmeijer HG.

Vakgroep Huisartsgeneeskunde, Universiteit van Utrecht.

Abstract

The Blueprint 1994. Objectives of undergraduate medical education, was issued in 1994 and has since been used as a guideline by the eight medical faculties in the Netherlands. This prompted a team of representatives of all eight Institutes for General Practice Medicine of the country to describe the contribution of general practice medicine to undergraduate medical education. The team was guided by two basic principles of general practice medicine, viz. general accessibility for all health problems at all stages and the continuous nature of the care. Out of the 180 general objectives of the Blueprint, 12 were selected of which the teaching should preferably be provided or coordinated by general practice medicine. Out of the approximately 250 problems from the general problem list of the Blueprint, 134 were assigned to general practice medicine: 89 in view of their high incidence in general practice, 15 because of the emergency nature, since GPs are easily accessible, 12 in which a major disease has to be excluded and 18 regarding chronic conditions. In this way, insight is provided into the matters regarding which medical faculties can address departments of general practice medicine about the curriculum to be drawn up. It appears advisable that other specialisms as well should define their potential contributions to undergraduate medical education and the relevant priorities.

EDITORIALS

General practice and medical education: experience in the Netherlands

C VAN WEEL
Professor of general practice,
University of Nijmegen, Netherlands

H F J M CREBOLDER
Professor of general practice,
University of Limburg, Netherlands

British Journal of General Practice, December 1993

Sweden

Swedish Health Care

How is care organized?

Physicians:
Most primary care physicians are employees of the county councils. Some primary care physicians work privately under contract with the county councils.

Hospitals:
Mainly public, operated by the county councils. A few private hospitals that generally have contracts with the county councils. Hospital-based ambulatory care physicians are hospital employees.

Public input:
Generally, the county councils and municipalities both finance and provid responsible for planning and distributing resources. Private providers de of health services, twenty-five percent in primary care. The National Boa supervisory responsibilities for personnel and services.

Sweden's Health Care System

The country of Sweden has a long tradition of delivering high quality, economically viable health care. And for many years Sweden's health care system has regularly ranked at or near the top of most comparative analyses of various international health care systems. The result: Sweden's healthcare professionals offer a wealth of knowledge and insights into most medical fields and healthcare processes.

Source: http://www.swedishhealthcare.se/swedenshealthcaresystem.html

DISCUSSION PAPER

Problem-based medical education in general practice: experience from Linköping, Sweden

MATS FOLDEVI

GÖRAN SOMMANSSON

ERIK TRELL

British Journal of General Practice, October 1994

Rural and Remote Health

FRAME ARHEN

ISSN 1445-6354

The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

7 July 2006

EDITORIAL

Interprofessional education - to break boundaries and build bridges

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Germany

International Journal of Integrated Care – Vol. 9, 20 April 2009 – ISSN 1568-4156 – http://www.ijic.org/

Policy

Special series: Integrated primary health care

Integrated primary care in Germany: the road ahead

Sophia Schlette, Senior Expert Health Policy, Bertelsmann Stiftung, Carl-Bertelsmann-Str. 256, 33311 Gütersloh, Germany

Melanie Lisac, Project Manager, International Network Health Policy and Reform, Bertelsmann Stiftung, Carl-Bertelsmann-Str. 256, 33311 Güters

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Correspondence to: K kerstin.blum@bertelsn

The authors all work Germany-based Berte The network brings to trends and developmer healthpolicymonitor.o international evidence reform.

Abstract

Problem statement: Health care delivery in Germany is highly fragmented, resulting in poor vertical and horizontal integration and a system that is focused on curing acute illness or single diseases instead of managing patients with more complex or chronic conditions, or managing the health of determined populations. While it is now widely accepted that a strong primary care system can help improve coordination and responsiveness in health care, primary care has so far not played this role in the German system. Primary care physicians traditionally do not have a gatekeeper function; patients can freely choose and directly access both primary and secondary care providers, making coordination and cooperation within and across sectors difficult.

Description of policy development: Since 2000, driven by the political leadership and initiative of the Federal Ministry of Health, the German Bundestag has passed several laws enabling new forms of care aimed to improve care coordination and to strengthen primary care as a key function in the German health care system. These include on the contractual side integrated care contracts, and on the delivery side disease management programmes, medical care centres, gatekeeping and 'community medicine nurses'.

Conclusion and discussion: Recent policy reforms improved framework conditions for new forms of care. There is a clear commitment by the government and the introduction of selective contracting and financial incentives for stronger cooperation constitute major drivers for change. First evaluations, especially of disease management programmes, indicate that the new forms of care improve coordination and outcomes. Yet the process of strengthening primary care as a lever for better care coordination has only just begun. Future reforms need to address other structural barriers for change such as fragmented funding streams, inadequate payment systems, the lack of standardized IT systems and trans-sectoral education and training of providers.

Keywords

primary care, care coordination, continuity of care, disease management programmes, gatekeeping, medical care

OPEN ACCESS

Review Article

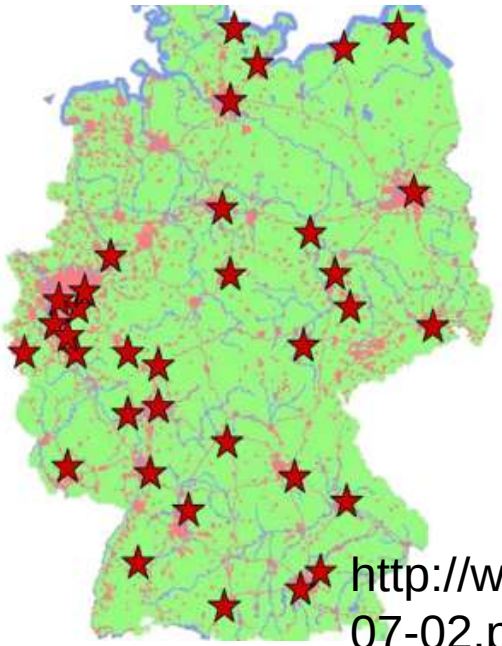
Undergraduate medical education in Germany

Medizinstudium in Deutschland

Abstract

The purpose of this article is to give international readers an overview

Jean-François Chenot[1]



Mandatory clerkships*

- Internal medicine
- General surgery
- Paediatrics
- Obstetrics & gynaecology
- General practice

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2716556/pdf/GMS-07-02.pdf

Turkey

Primary Care
PrimaryCare 2003;3:988–994

Turkey in need of family medicine

Ilhami Unluoglu[a], *Unal Ayranci*[b]

Summary: Turkey's existing health system has been unsuccessful in meeting the health needs of the people living in the country. Neither the patients who spend time seeking treatment in health centres or hospitals, nor the health authorities or health workers, are satisfied with current healthcare services. Although much time has passed since the preparation and referral of health reform proposals to Parliament, they still await confirmation in order to be put in place. The uneven political playing field and fundamental, even controversial attitudes can be cited as the main reasons for the delay. Nevertheless, there are promising developments which suggest that family medicine (FM) could be introduced, such as the upgrading of FM departments in universities and the ever-increasing number of family physicians. In sum, it can be stated that even if it has still not been decided that FM is a viable approach, it is undergoing thorough discussion.

In this paper we discuss the problems of FM in Turkey and present our own views and observations on various aspects of it.

Emergence of the need for FM in Turkey

Up to the year 1984, the health situation of the country was growing increasingly confused; there was no properly functioning national health system, healthcare suffered from a poor organizational structure, health institutions such as health centres and health offices were only partially performing their tasks. Health personnel suffered from lack specialist FM education started in MoH hospitals. At subsequent MoH meetings it was always emphasised that the academic future of FM had to be assured. Of these the most effective was a group meeting entitled "FM education for the improvement of PHC". It was attended by representatives of the Ministry, universities, the Turkish Association of Family Physicians (TFPA) and the Turkish Medical Association (TMA). The meeting urged that all universities support specialist FM education, and that each university should include an FM department [18]. Today, the 11 MoH educational hospitals continue to educate FM assistants.

Source: Unluoglu I, Ayranci U. Turkey in need of family medicine. Primary Care 2003.

Turkey

World Conference Education Science 2009

Family medicine transition period training in Turkey

Süleyman Görpelioğlu[a]*, F. Serdar Gürel[a], Füsun Ersoy[a]

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Received October 23, 2008; revised December 10, 2008; accepted January 02, 2009

Abstract

Vocational training of General practice is a subject of discussion since 1970 in many European countries. In 2003 a health care reform is decided to be implemented in Turkey and by the time of implementation of reform studies, there had been negotiations among the stakeholders wtihin general practice and It was decided that a retraining program is essential for the practicing physicians who are medical faculty graduates or specialists other than family medicine to practice in primary care. A two phased temporary retraining program that is called transition period training (TPT) was planned to meet the urgent need of practicing doctors as family physicians. TPT covers all the physicians who wants to work as a family physician except the family medicine specialists. First phase TPT is an adaptation course, conducted face to face and second phase is a blended learning (b-learning), that is a combination of e-learning and face to face competency based skill training.

Keywords: Type your keywords here, separated by semicolons; family medicine; vocational training; transition period; training methods; e-learning .

Source: Gorpelioglu S, Furel F.S, Ersoy F. Family medicine transition period training in Turkey. 2009.

Marmara Üniversitesi
Tıp Fakültesi Dergisi
Marmara Medical Journal

2003, Cilt 16, Sayı 3, Sayfa(lar) 239-24

[Özet] [Benzer Makaleler] [Yazara E-Posta] [Editöre E-Posta]

ROLE OF FAMILY MEDICINE IN UNDERGRADUATE MEDICAL EDUCATION

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Spain

Primary medical care in Spain

JULIAN TUDOR HART

SUMMARY. The extremely complex and rapidly but unevenly developing system of primary care in Spain is described. The health centre movement in Spain merits close attention, and could be a useful model for our own service.

Rural primary care

The Asistencia Publica Domestica was set up in 1953. Under this system rural areas with populations of 10 000 or less have been served by general practitioners working from public offices or their own homes. Most have worked in essentially the same way as urban general practitioners in the *ambulatorios,* but they have a 24-hour commitment, offer some preventive services, and generally have a more personal relationship with their patients. Posts have in the past been filled through a competitive state examination requiring no postgraduate training, but about 10% of rural general practitioners now enter through the same examination as health centre doctors; where this occurs, about two-thirds of rural general practitioners have postgraduate vocational training in family and community medicine.

Though most of the reforming initiatives in Spain have been in urban health centres, remarkable pioneering work also goes on in some rural areas, notably around Salamanca.

Nature of general practice

The level of private general practice is substantial in some areas. Though in Catalonia and Andalusia it seems as yet almost irrelevant for the mass of the population, it is evidently important in Madrid. An estimated six million people use private general practitioners, though many of these also attend the public services for the more administrative parts of their care. Private practice is growing in many areas because of the generally unsatisfactory quality of public service practice and the rising incomes of most employed people. A bitter struggle seems to be going on between those who still see private practice as the only possible growing point for better care, and those who believe the future must lie with team care from health centres with registered populations. There appears to be a serious and probably inevitable split between general practitioners attempting to develop better care by a combination of private practice and very part-time work in the Seguridad Social (two-hour sessions), and those working full-time in health centre teams. At present both the old and the new public systems of primary care described below co-exist, covering about 80% and 20% of the population, respectively.

Spain

Health Affairs, 29, no. 8 (2010): 1432-1441
doi: 10.1377/hlthaff.2010.0023

Lessons From Around The World

Renewing Primary Care: Lessons Learned From The Spanish Health Care System

Jeffrey Borkan[1,*], Charles B. Eaton[2], David Novillo-Ortiz[3], Pablo Rivero Corte[4] and Alejandro R. Jadad[5]

From 1978 on, Spain rapidly expanded and strengthened its primary health care system, offering a lesson in how to improve health outcomes in a cost-effective manner. The nation moved to a tax-based system of universal access for the entire population and, at the local level, instituted primary care teams coordinating prevention, health promotion, treatment, and community care. Gains included increases in life expectancy and reductions in infant mortality, with outcomes superior to those in the United States. In 2007 Spain spent $2,671 per person, or 8.5 percent of its gross domestic product on health care, versus 16 percent in the United States. Despite concerns familiar to Americans—about future shortages of primary care physicians and relatively low status and pay for these physicians offer lessons for the United States.

Portugal – Primary Health Care (2005)

- 10.5 million residents
- 351 Health Centers (1823 with extensions)
- 7034 Family Physicians and Family Caregivers 7368
- 11.2% of users registered but not assigned MF
- Accessibility little easier
- Freedom of choice by the citizen, his MP, or change of GP reduced
- Physicians and Family Caregivers are officials of the NHS (pay regardless of performance) with a low level of job satisfaction

Slide kindly provided by Dr. Luis Pisco

Portugal

- The "UNIDADES DE SAÚDE FAMILIAR" USF, are small teams multi-professionals formed *voluntarily self-organized*, consisting of **3-8 family physicians**, for the same number of nurses in family and administrative professionals, covering a population between 4,000 and 14,000 people.
- These teams have technical autonomy, organizational and functional, and most importantly, a mixed payment system (capitation, salary and goals), professional and financial incentives that reward merit and are sensitive to productivity, accessibility, but also, and above all, quality.

Slide kindly provided by Dr. Luis Pisco

Greece

International Journal of Integrated Care – Vol. 9, 30 July 2009 – ISSN 1568-4156 – http://www.ijic.org/

Policy

Special series: Integrated primary health care

Integrated primary health care in Greece, a missing issue in the current health policy agenda: a systematic review

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Abstract

Background: Over the past years, Greece has undergone several endeavors aimed at modernizing and improving national health care services with a focus on PHC. However, the extent to which integrated primary health care has been achieved is still questioned.

Purpose: This paper explores the extent to which integrated primary health care (PHC) is an issue in the current agenda of policy makers in Greece, reporting constraints and opportunities and highlighting the need for a policy perspective in developing integrated PHC in this Southern European country.

Methods: A systematic review in PubMed/Medline and SCOPUS, along with a hand search in selected Greek biomedical journals was undertaken to identify key papers, reports, editorials or opinion letters relevant to integrated health care.

Results: Our systematic review identified 198 papers and 161 out of them were derived from electronic search. Fifty-three papers in total served the scope of this review and are shortly reported. A key finding is that the long-standing dominance of medical perspectives in Greek health policy has been paving the way towards vertical integration, pushing aside any discussions about horizontal or comprehensive integration of care.

Conclusion: Establishment of integrated PHC in Greece is still at its infancy, requiring major restructuring of the current national health system, as well as organizational culture changes. Moving towards a new policy-based model would bring this missing issue on the discussion table, facilitating further development.

Department of Social Medicine, Faculty of Medicine
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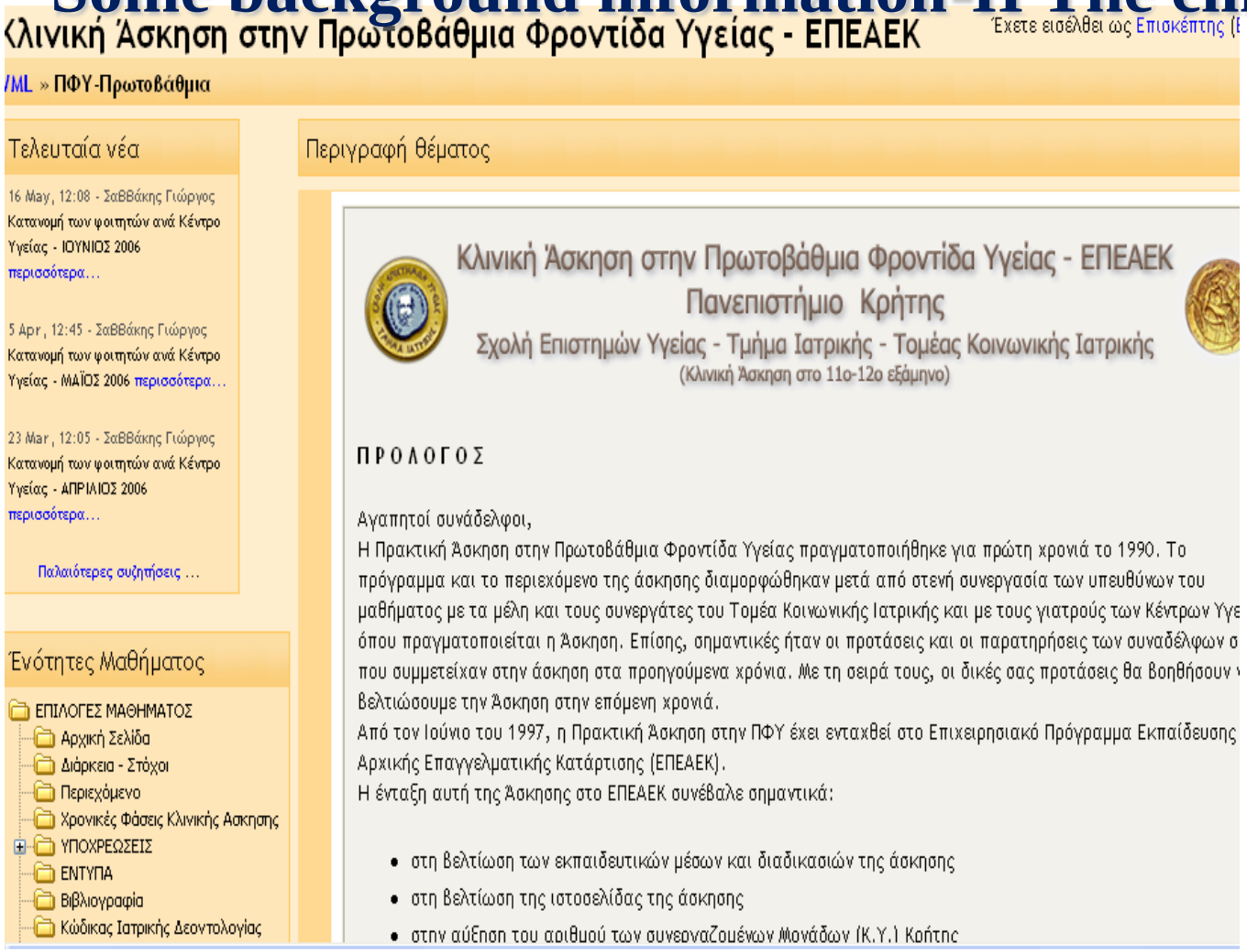
A 4-WEEK COURSE OF MEDICAL STUDENTS IN PRIMARY HEALTH CARE: ACHIEVEMENTS AND DEVELOPMENTS FROM CRETE, GREECE

Ch. Lionis, I. Moschandrea, A. Koutis, E. Symvoulakis, M. Mavrogiannaki, E. Foukaki, N. Hag Efadl, A. Philalithis

Some background information-II The clinical clerkship



- A four-week course in primary care
- Strong clinical orientation
- It combines training in both, general practice and public health
- Rural and Urban setting
- Involvement of physicians and community leaders

The community-oriented clinical clerkship in rural Crete/http://www.med.uoc.gr or http://pfy-epeaek.med.uoc.gr

Some background information-III

The clinical clerkship

Έντυπα

Από εδώ μπορείτε να κατεβάσετε τα απαραίτητα έντυπα για την συμμετοχή σας στην Κλινική Άσκηση.

Έντυπα και οδηγίες για τους Φοιτητές	ΜΟΡΦΗ
Οδηγίες συμμετοχής Φοιτητών στο ΠΠΑ	(.doc)
Σύμβαση Συμμετοχής Φοιτητών στο ΠΠΑ	(.doc)
Καρτέλα Προσωπικών Στοιχείων Φοιτητή	(HTML)
Υπεύθυνη Δήλωση	(.pdf)
Κατάλογος Ιατρικών Πράξεων κ' Δραστηριοτήτων Φοιτητών	(.doc)

A virtual medical lab that reated and supported by G. Savvakis, and N. Papanikolaou

- Students allocated (in rotation) to some of the 13 collaborated rural health care centers and always to the unique urban health care unit of university hospital
- A detailed guide
- An access to the students' website
- Guidelines and educational documents available on line
- Interactive sessions on a virtual medical lab

Background information-IV

The fieldwork assessment

- Assessment of the level of knowledge
- Assessment of clinical skills
- Assessment of their capacity in reporting community health problems

and an evaluation of their opinion towards the course

Students' Opinion

Evaluation items

- A. Evaluation of Introductory Seminar (8 items)
- B. Understanding/comprehension of the principles of General Practice (11 items)
- C. Evaluation of the course at the Health Centers (14 items)
- D. Evaluation of the course at Rural Clinics and House Visits (8 items)
- E. Evaluation of course in the Community/ Preventive Medicine) (3 items)
- F. Evaluation of the Organization and * (carrying out, undertaking…) of the course (8 Items)
- G. Evaluation of General Issues (6 items)
- Decision to follow the Specialty of General Practice

Data

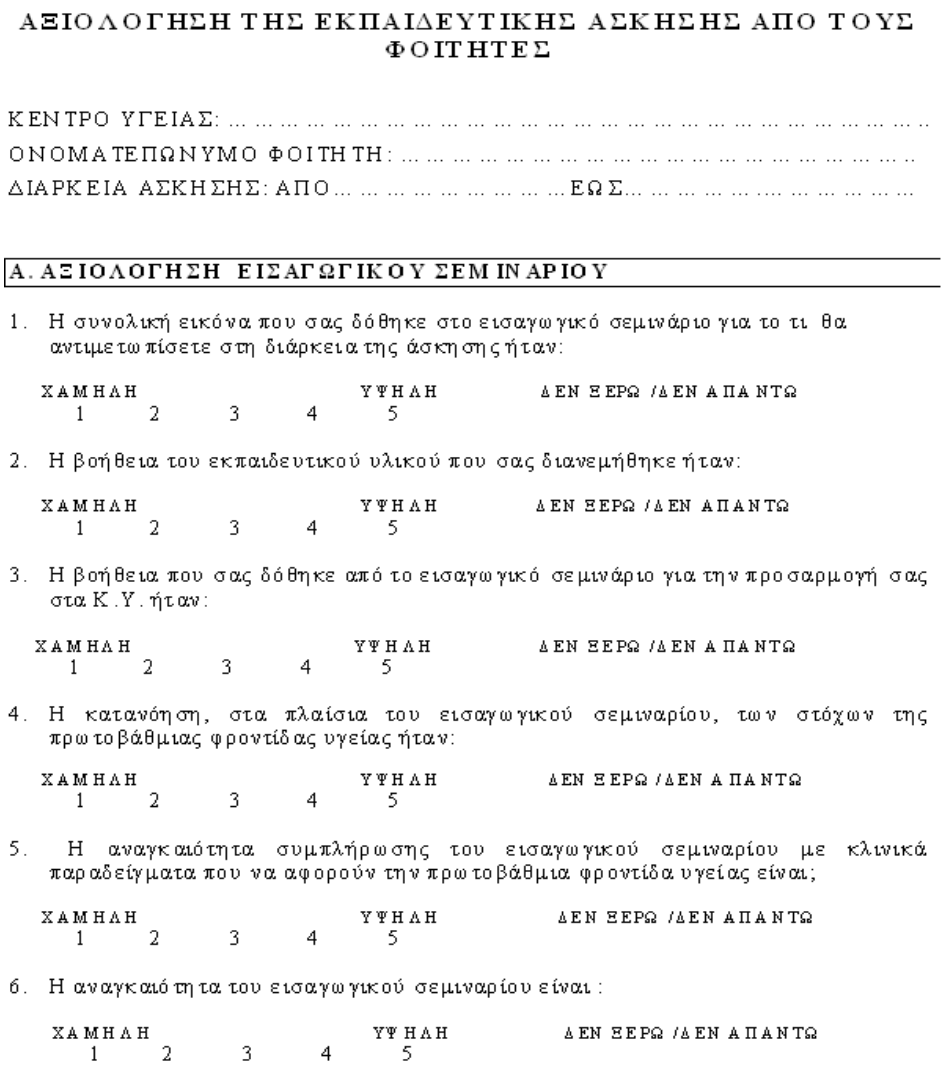
- 59 students out of 99 (59.6%)
- Time period

10/2008 – 10/2009

Scaling grade

- 1 = Low
- 2
- 3
- 4
- 5 = High
- 6 = Don' know
- 9 = No Response

Students' opinion evaluation: **Setting and method**



ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΕΚΠΑΙΔΕΥΤΙΚΗΣ ΑΣΚΗΣΗΣ ΑΠΟ ΤΟΥΣ ΦΟΙΤΗΤΕΣ

ΚΕΝΤΡΟ ΥΓΕΙΑΣ: ……

ΟΝΟΜΑΤΕΠΩΝΥΜΟ ΦΟΙΤΗΤΗ: ……

ΔΙΑΡΚΕΙΑ ΑΣΚΗΣΗΣ: ΑΠΟ…… ΕΩΣ……

Α. ΑΞΙΟΛΟΓΗΣΗ ΕΙΣΑΓΩΓΙΚΟΥ ΣΕΜΙΝΑΡΙΟΥ

1. Η συνολική εικόνα που σας δόθηκε στο εισαγωγικό σεμινάριο για το τι θα αντιμετωπίσετε στη διάρκεια της άσκησης ήταν:

ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

2. Η βοήθεια του εκπαιδευτικού υλικού που σας διανεμήθηκε ήταν:

ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

3. Η βοήθεια που σας δόθηκε από το εισαγωγικό σεμινάριο για την προσαρμογή σας στα Κ.Υ. ήταν:

ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

4. Η κατανόηση, στα πλαίσια του εισαγωγικού σεμιναρίου, των στόχων της πρωτοβάθμιας φροντίδας υγείας ήταν:

ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

5. Η αναγκαιότητα συμπλήρωσης του εισαγωγικού σεμιναρίου με κλινικά παραδείγματα που να αφορούν την πρωτοβάθμια φροντίδα υγείας είναι;

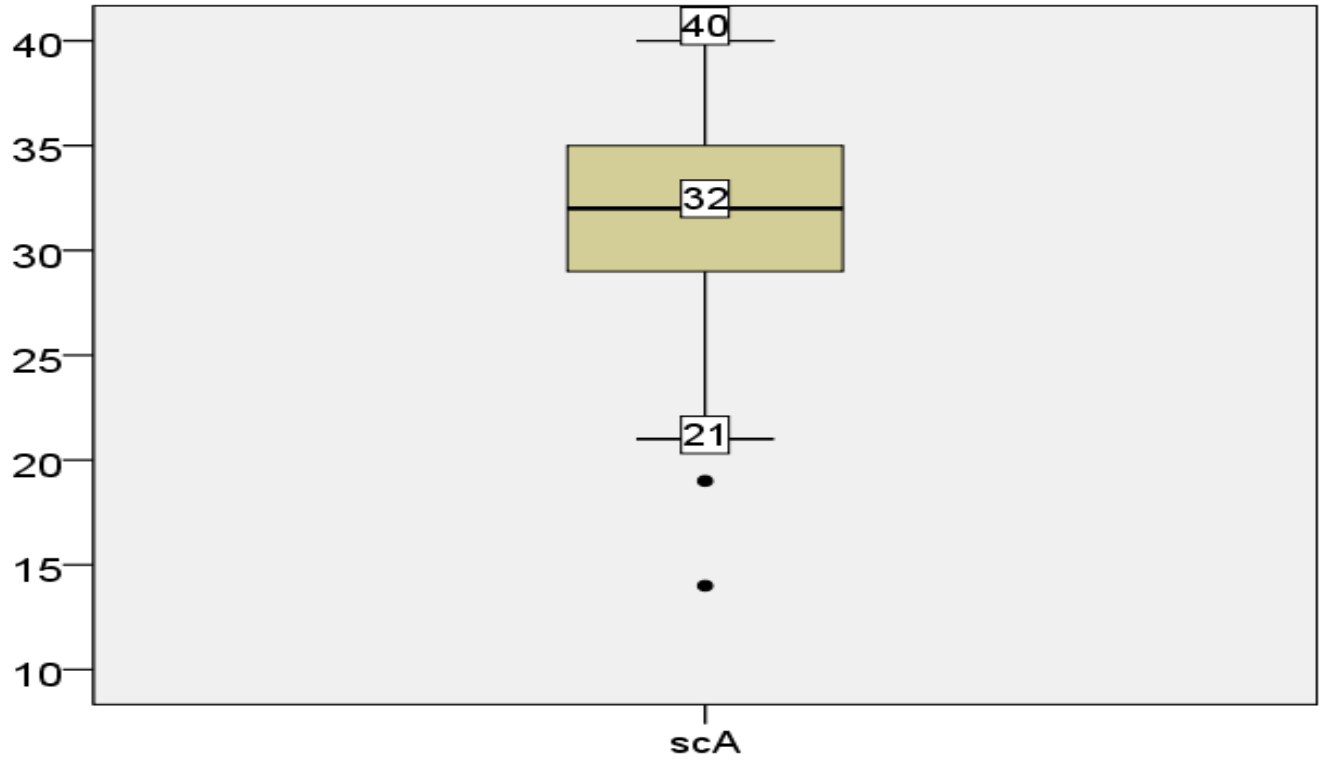
ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

6. Η αναγκαιότητα του εισαγωγικού σεμιναρίου είναι :

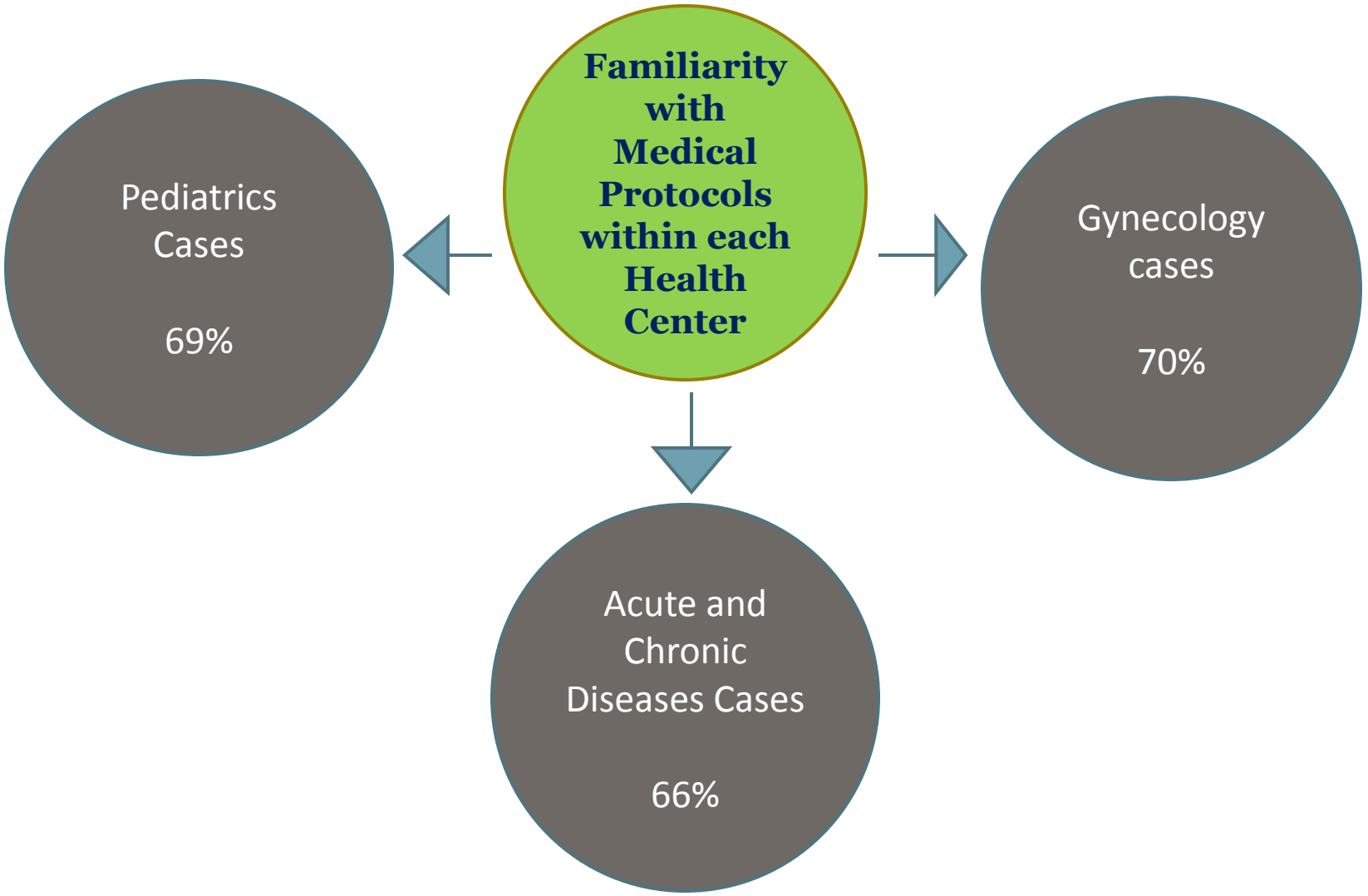
ΧΑΜΗΛΗ 1 2 3 4 5 ΥΨΗΛΗ ΔΕΝ ΞΕΡΩ /ΔΕΝ ΑΠΑΝΤΩ

- A cross-sectional survey
- A pre-tested questionnaire filled in by students at end of the clinical clerkship
- 5-Likkert scale format
- Some few open questions
- 25 items
- Data stored in a SPSS database
- Period of evaluation: 10/2008-10/2009

A. Evaluation of Introductory Seminar 8 Items



C: Items with low score



Students' Knowledge evaluation

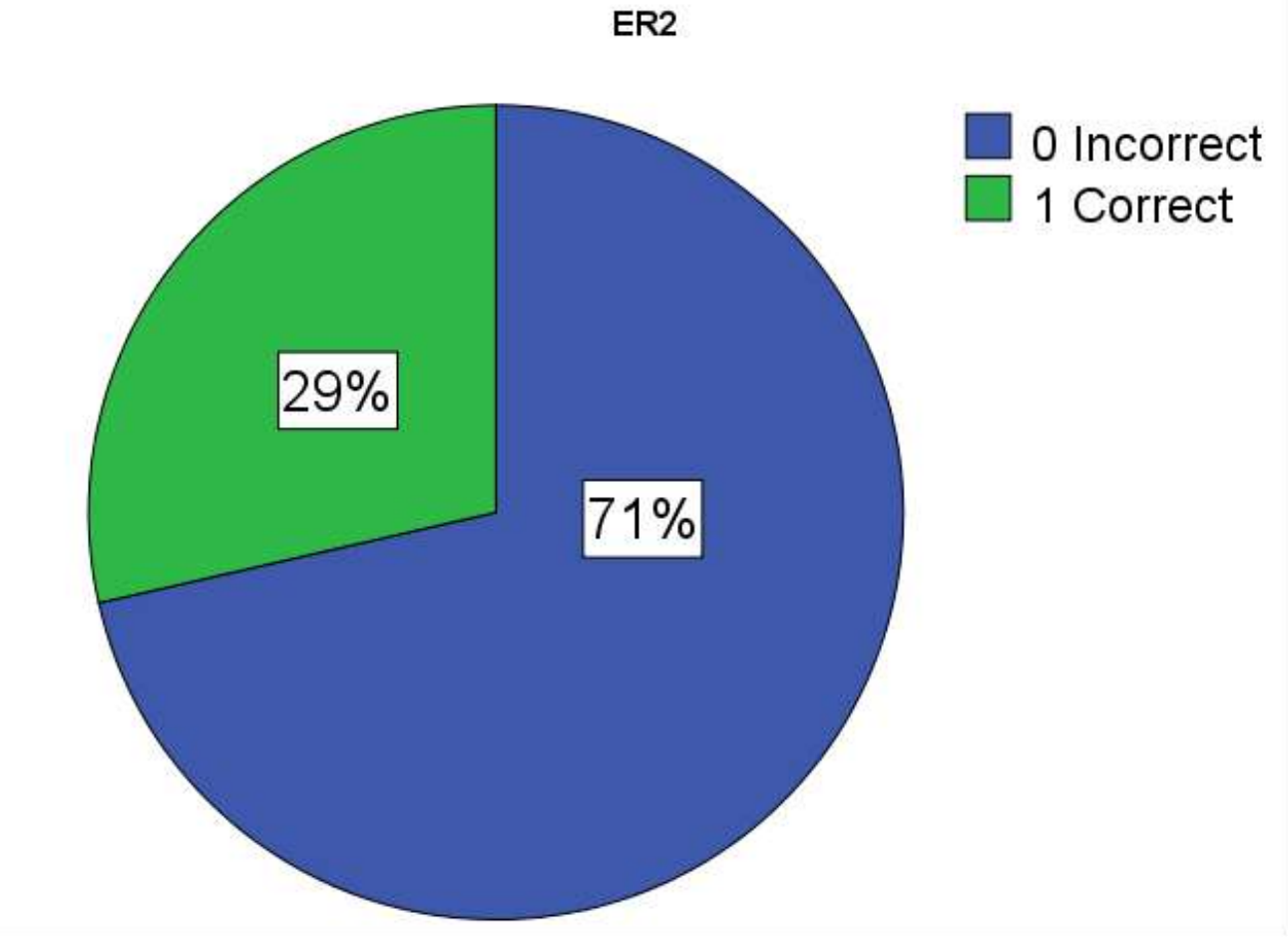
Evaluation items

- Pulmonary diseases therapy
- Metabolic diseases
- Cardiovascular diseases
- Gastrointestinal diseases
- High risk patients management
- Mental disorders
- Preventive and health promotion

Data

- 84 students out of 99 (84.8%)
- Time period
  10/2008 – 10/2009
- Type of answer
  correct / incorrect

FOR PATIENTS WITH TYPE 2 DIABETES WHICH



Points of discussion

- It seems that the one month clinical clerkship together with the available educational material satisfied the great majority of the medical students
- The duration of this training needs to be further discussion.
- The contemporary training at the remote health centres introduces certain concerns
- The acquirement of clinical skills may predict good satisfaction of medical students and it should be enhanced.
- These preliminary results should be confirmed by a thorough analysis of the available data
- The entrance of a new community-based unit is a challenge

After the exams and the social event at the Greek taverna

Building on Capacity-The master on general practice/family medicine and primary care

www.mastergeneralpractice.gr

EURACT

European Academy of Teachers in General Practice / Family Medicine

http://www.euract.org/

4th EURACT Assessment Course for Trainers in Family Medicine
1 – 4 DECEMBER 2010, ADANA, TURKEY

The wind of change: after the European definition--orienting undergraduate medical education towards general practice/family medicine.

Soler JK, Carelli F, Lionis C, Yaman H.

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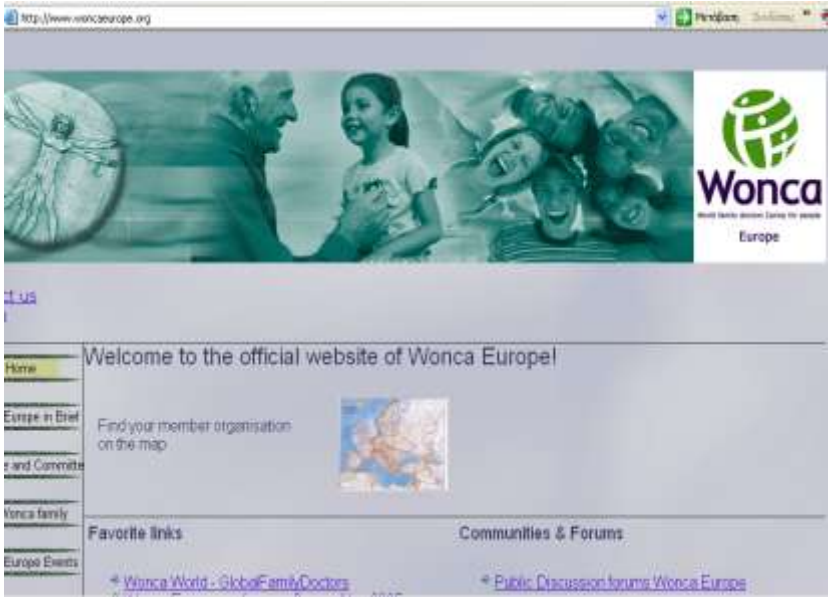
Abstract

Traditionally, medical students are trained in an algorithmic manner, to focus on excluding serious but rare diseases by conceptualizing diagnoses through a process of exclusion based on systematic and technological investigation of an extensive list of potential diagnoses applicable to the patient's presenting symptoms and signs. Students are not often exposed to common diseases, and trivialize all that which cannot be addressed within a strictly medical model. This paper reflects on the recommendations of the EURACT Educational Agenda document, and proposes a return to empiricism in basic medical training by introducing students to primary healthcare, disease, and decision-making processes early in their training. The authors recommend the teaching of communication skills within primary care doctor-patient encounters, the exploration of new ways of teaching the doctor-patient relationship, and that students and young doctors be encouraged to

Strengthening family medicine in Europe

The European Society of General Practice/Family Medicine/WONCA Europe



One of the previous Executive Board

WONCA Europe/ http://www.woncaeurope.org