

“Primary Care at the crossroads: how could primary care start in Austria”

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Chairman European Forum for Primary Care
Former Secretary General The Network: Towards Unity for Health

Intranet Members access

The "PRIMAFAMED Africa Network" is an inter-university network to set up and improve family medicine training in Africa.

PRIMAFAMED Network was started with the Primafamed Project which was a 2 year project financed by EDUFIN-ACP-EU

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Home



Hot news

The Network: TUFH annual conference - 2012
More information is...

5th Primafamed Workshop - Vic Falls, Zimbabwe, 2012
5th PRIMAFAMED WORKSHOP Theme: 'Family Physicians in the developing world: Making it happen!'
Elephant Hills Hotel, Victoria.

The 3rd Wonca Africa Region Conference
3rd Wonca Africa Region Conference WONCA AFRICA CONFERENCE 2012 The College of Primary Care Physicians of Zimbabwe is delighted to have been...

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<http://www.primafamed.ugent.be>

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Visie
Ontstaan
Multidisciplinair team
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Raadplegingen, afspraken en huisbezoeken
Preventieprojecten en gezondheidsbevordering
Inschrijven in het WGC
Voor onze patiënten

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wijkgezondheidscentrum vzw

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9050 Ledeberg
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fax 09/230 51 89
Openingsuren: ma-vr 8.00 - 19.00



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

<http://www.wgcbotermarkt.be>

europa forum for primary care

Netherlands institute for health services research

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News

3 April 2008 | **Quality in Primary Care**
Official journal of the European Forum for Primary Care
The European Forum for Primary Care has adopted the journal **Quality in Primary Care** as its official publication. [more](#)

5 March 2008 | **Southampton, 15 - 17 September 2008**
"The Future of Primary Care in Europe II".
New! [Call for abstracts more](#)

5 January 2008 | **15 by 2015**
Strengthening primary care: addressing the disparity between vertical and horizontal investment.
[Click here for the 15 by 2015 website more](#)

Recent issued documents

EFPC Position Papers

- Disease Management
- The Organisation of Primary Care in Europe 2008

EC Consultations

- Information to Patients
- Open consultation on patient safety

EFPC

Established in 2005, the Forum intends to improve the health of the population of Europe by strengthening Primary Care. In several countries of Europe Primary Care is well developed, in others less so. We all can learn from each other however and create and seize the opportunities there are to make sure that all countries enjoy the benefits of Primary Care.

Newsflashes

- Newsflash 2008 - 7 Workshop Disease Management Positive Paper, Balkan Primary Health Care, new login EFPC site
- Newsflash 2008 - 6a Quality in Primary Care Official journal of the European Forum for Primary Care
- Newsflash 2008 - 6 Launch PHAMEU project, Symposium RIZIV Brussels, European Patient's Rights day 2008

[More Newsflashes](#)

Conferences

- 15/17 September 2008: Southampton, "The Future of Primary Care in Europe II"

<http://www.euprimarycare.org>

THE NETWORK
TOWARDS UNITY FOR HEALTH

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Welcome

The Network: Towards Unity for Health is an international organisation of academic health professions institutions and organizations promoting equity in health through community-oriented education, research and service.

What we do

We promote equity and quality in health through community-oriented education, research and service.

We seek equity, quality, relevance and cost-effectiveness in health care for all communities.

We address health professions education, health services, health policy development and research.

We participate in actions for a change of policies according to our objectives.

Who we are

The Network: TUFH brings together member institutions and individuals from all over the world:

- Multi-professional and interprofessional health providers
- Academic health professionals
- Stakeholders in health systems developments

CALL FOR ABSTRACTS!

November 16-20, 2013
Ayutthaya, Thailand

News

Projects That Work
This year we offer a new opportunity at the conference: Projects That Work
[Read more](#)

Call for Abstracts

We are pleased to announce the Call for Abstracts for The Network: Towards Unity for Health 2013 Conference "Rural & Community-Based Health Care: Opportunities and Challenges for the 21st Century" in Ayutthaya, Thailand.
[Read more](#)

<http://www.the-networktufh.org>

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Community Health Centre:

- General Practitioners; nurses; dieticians; health promoters; dentists; social workers; tabacologist;...
- 6200 patients; 90 nationalities
- Integrated needs-based mixed capitation; no co-payment
- COPC-strategy



Primary Care at the Crossroads: how could primary care start in Austria?

1. The changing society

2. Changes in 'pro-active or pre-care'

3. Changes in 're-active care'

4. Changes in 'chronic care': addressing multi-morbidity

5. Changes in 'community oriented care'

6. The GP/FP as actor in the health system: "Together we change"

7. Conclusion

The changing society

- a. Demographical and epidemiological developments
- b. Scientific and technological developments
- c. Cultural developments
- d. Socio-economical developments
- e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)

By 2100, 85%?

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study



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

Summary

Background Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multimorbidity. We examined the distribution of multimorbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation.

Lancet 2012; 380: 37–43

Published Online

May 10, 2012

DOI:10.1016/S0140-

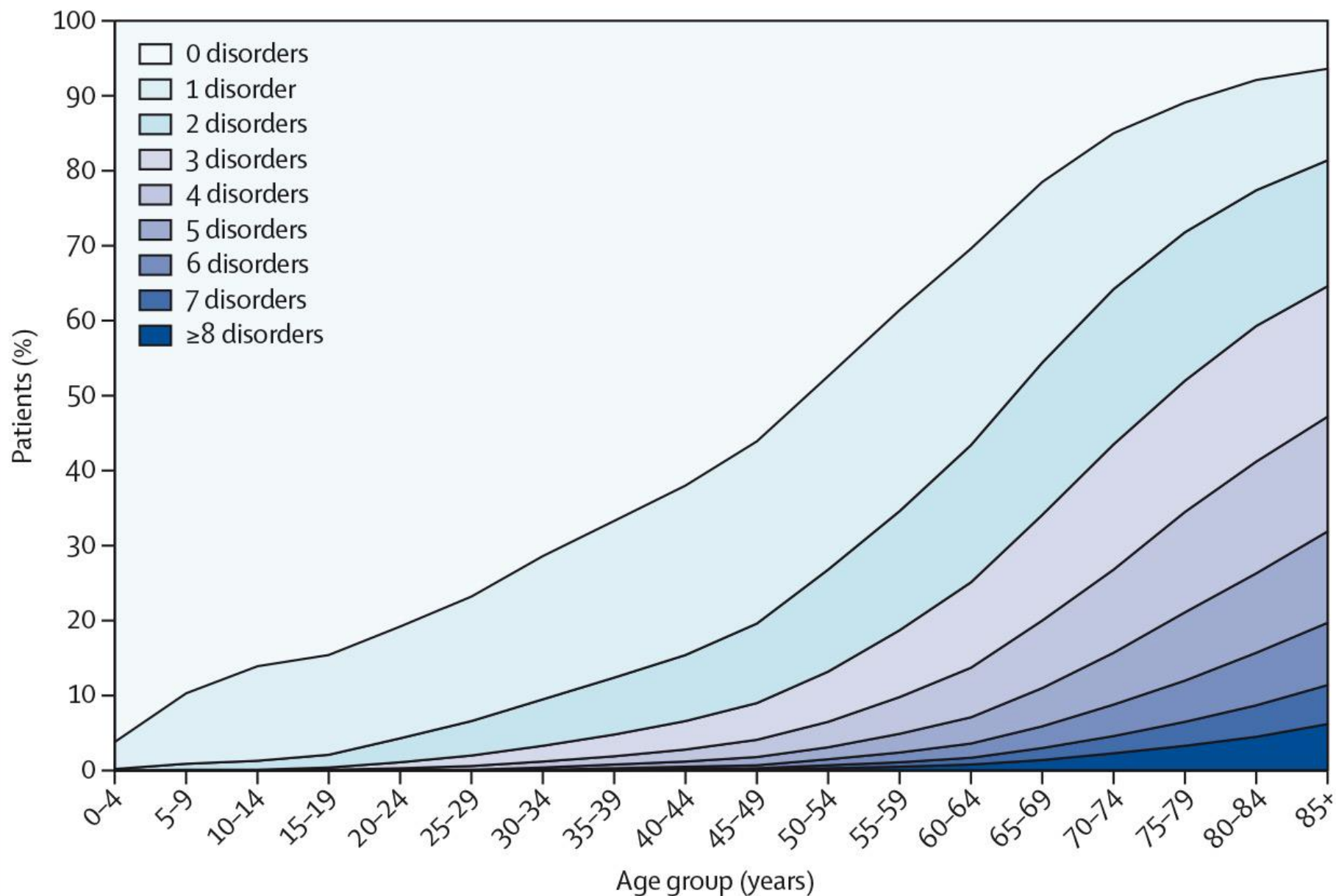


Figure 1: Number of chronic disorders by age-group

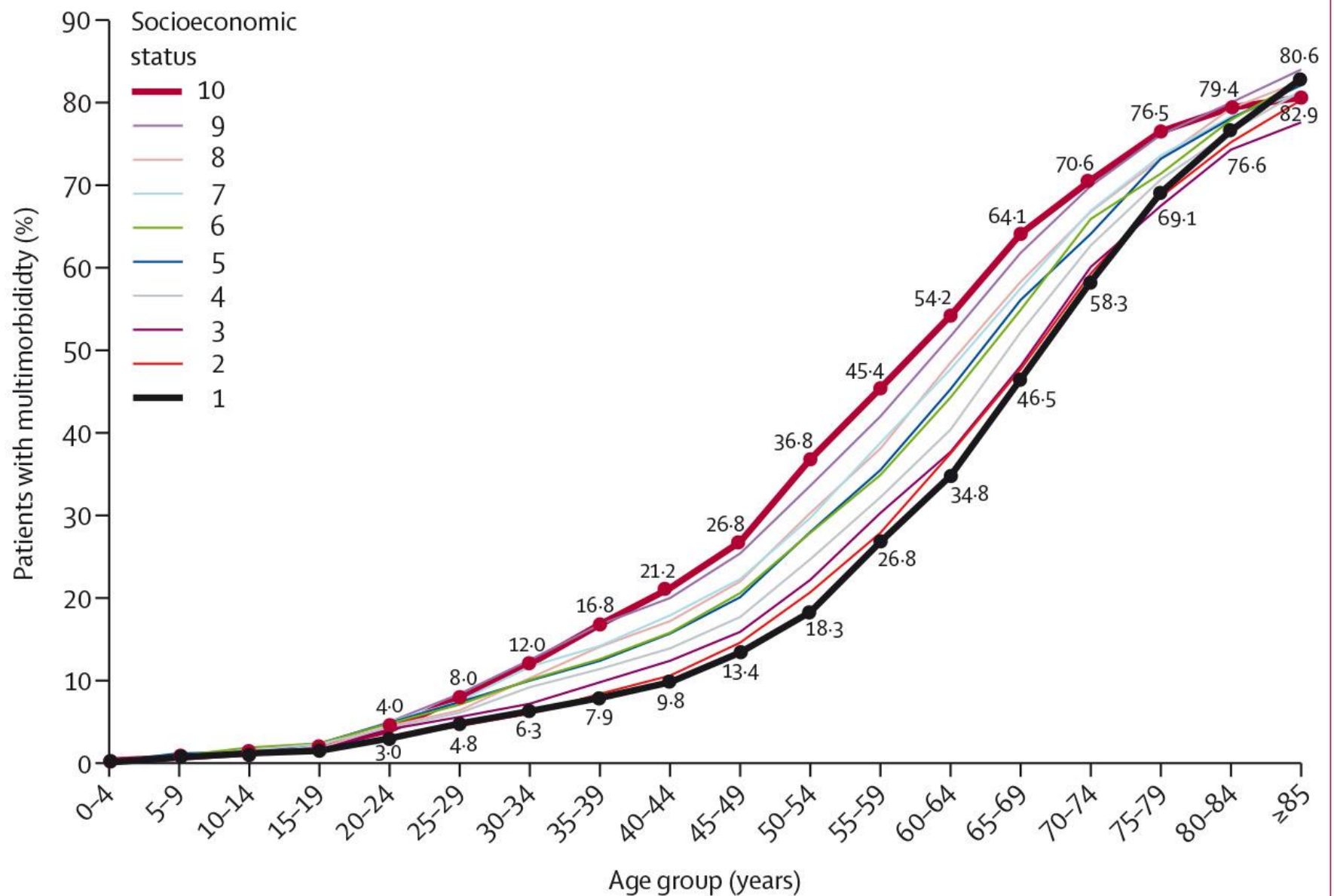


Figure 2: Prevalence of multimorbidity by age and socioeconomic status

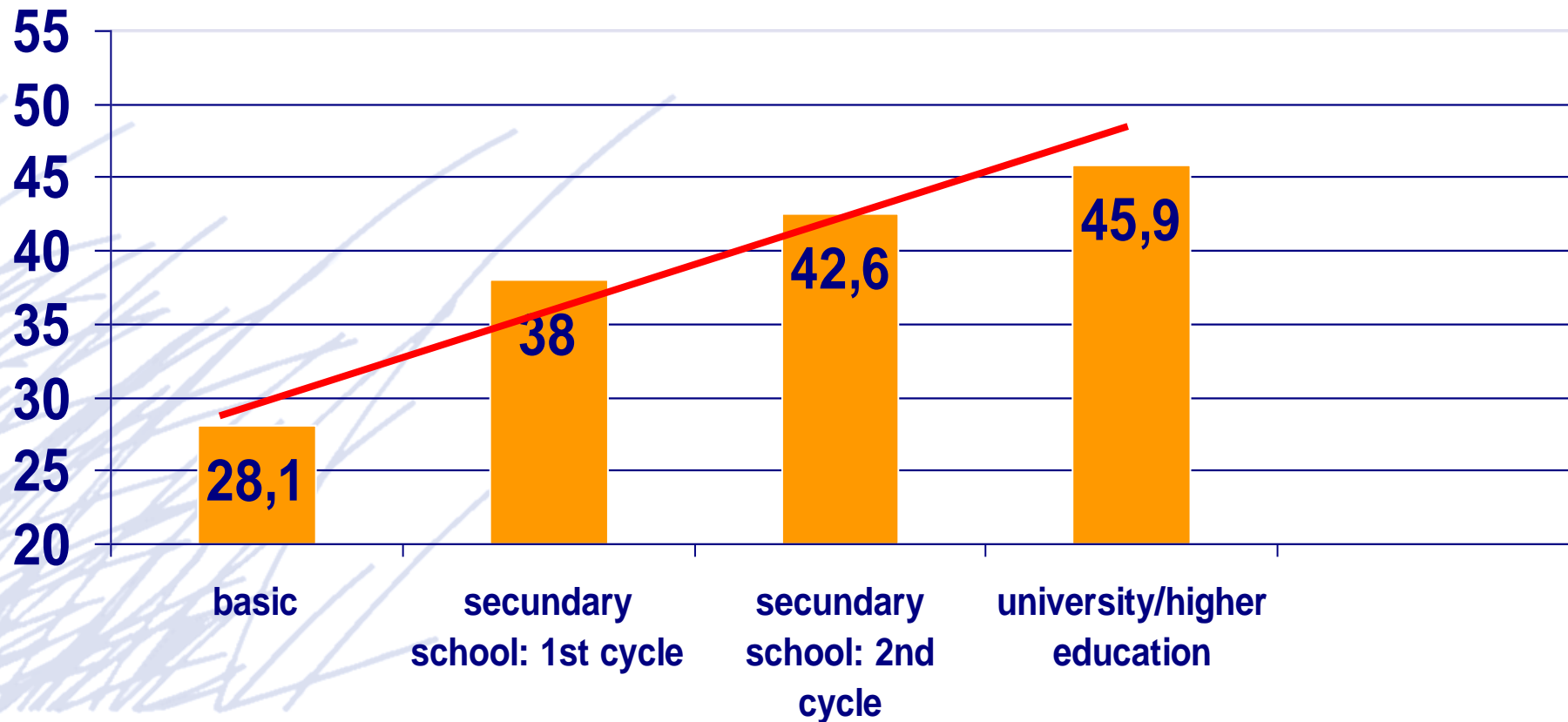
On socioeconomic status scale, 1=most affluent and 10=most deprived.

Healthy life expectancy in Belgium

(Bossuyt, et al. Public Health 2004)

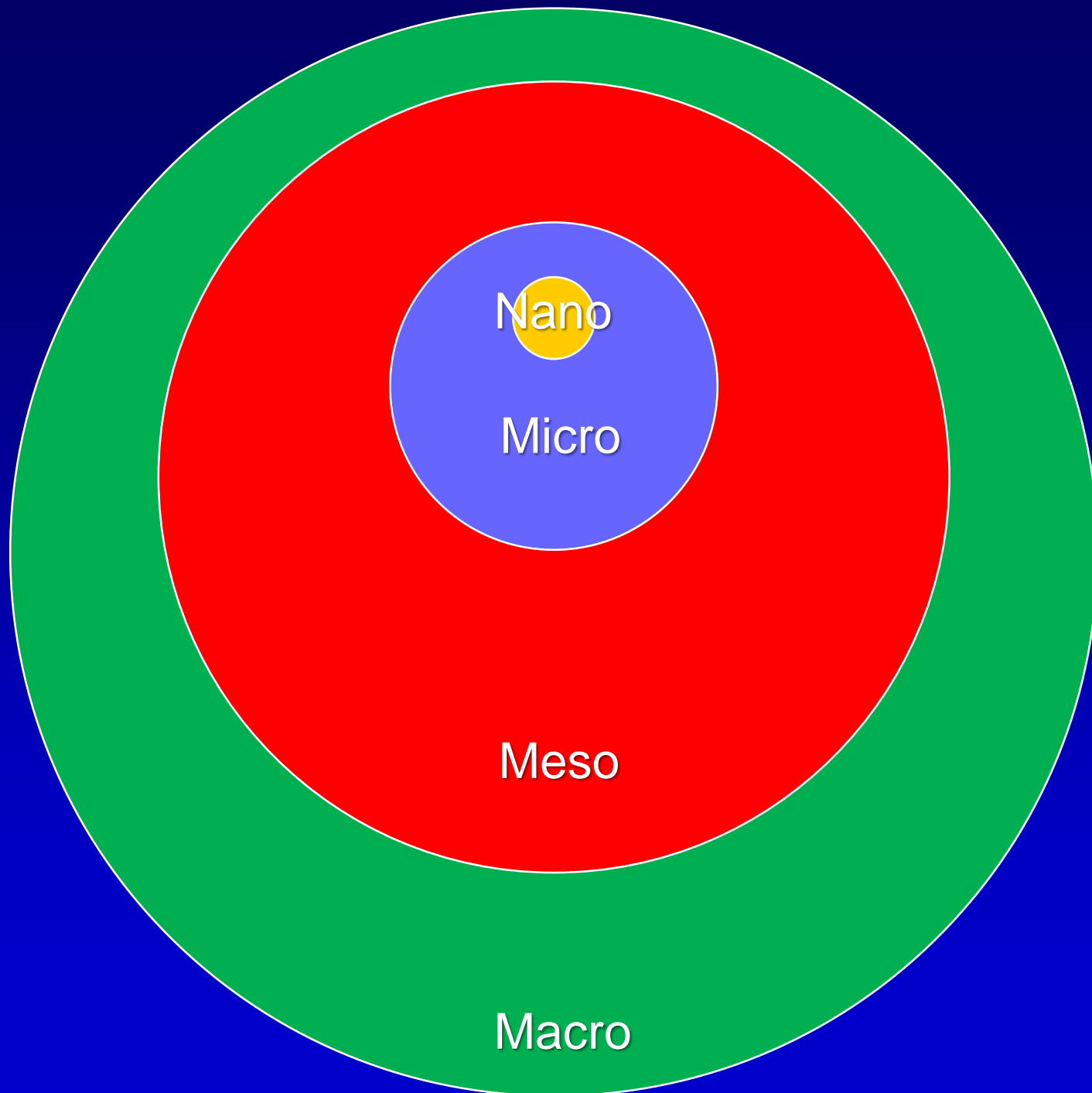
Socio-economic inequalities in health

Healthy life expectancy in Belgium, 25 years, men



General structure

	Nano	Micro	Meso	Macro
Pro-active or pre-care				
RE-active care				
Chronic care				
Community/population oriented care				
GP/FP in Health System				



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Changes in 'pro-active or pre-care'

- Nano: - health literacy
- empowerment
- Micro: - healthy families – relationships
- healthy empowerment
- Meso: - healthy community / city
- social cohesion
- Macro: - healthy environment: air, water
- healthy economy: income inequality

Did you contribute in your practice to one of those topics? Think about an example.

Looking for upstream causes

Accident: scholar severely invalidated



Meeting: police, family physicians, schools, elderly-
organisations, ...

Intersectoral action for health: meso-level

- Platform of stakeholders (including community representatives)
- Implementing a strategy, taking different sectors on board (education, housing, work,...)

Platform of stakeholders:



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



Analysis: unsafe traffic conditions for pedestrians

Formulation of proposals for improvement, involving local population



Establishment safer traffic situation

Assessment: no more severe accidents

City Health Council - Ghent



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Changes in re-active care

- Nano-level: provider-person encounter
- Micro-level: interdisciplinary team-approach
- Meso-level: organizing GP-posts
- Macro-level: switch from fee-for-service to more global payment

Nano-level:

The person/patient is the starting point of the process

- Active
- Informed
- Service delivery
- Multicultural



Accessibility
Equity

Characteristics of FP/ patient encounters

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

Characteristics of GP/patient encounters

- Commitment - Connectedness
- C
- C
- C
- C
- C
- C
- C

Characteristics of GP/patient encounters

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

Characteristics of GP / patient encounters

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

Characteristics of GP / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural 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

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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

GUIDING PATIENTS THROUGH COMPLEXITY: MODERN MEDICAL GENERALISM

**REPORT OF AN INDEPENDENT COMMISSION
FOR
THE ROYAL COLLEGE OF GENERAL PRACTITIONERS
AND
THE HEALTH FOUNDATION**

October 2011

Challenges for Re-Active care

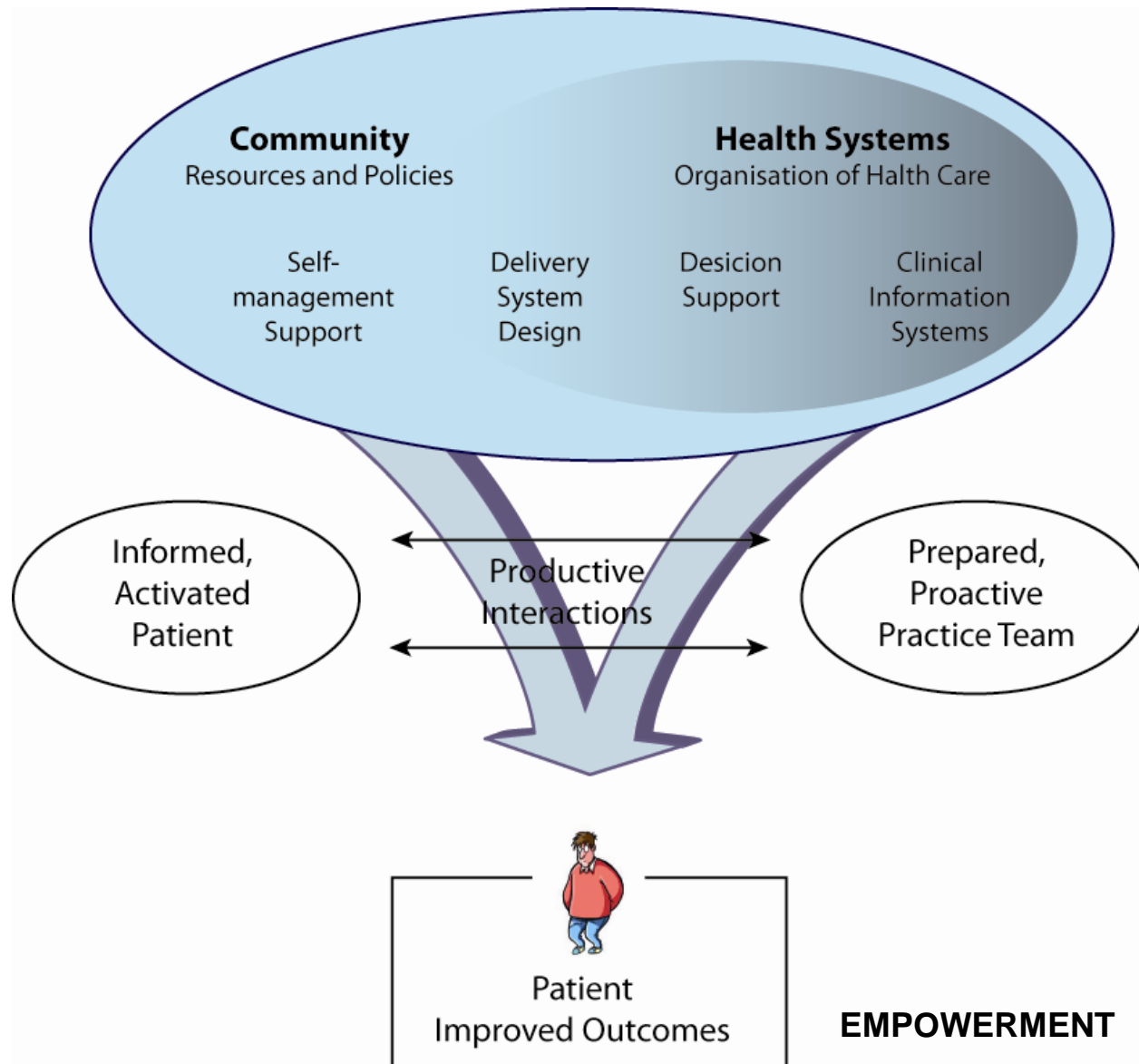
- Optimal *task-shifting* and *competency sharing*: role of nurse practitioners, mid-level care workers
- Integration of new technology
- Arrival of “*personalised*” medicine, or better “*precision medicine*” focussing on genomics, proteomics,...
- “Big data” an alternative for clinical decision making?
- Choices in health care...

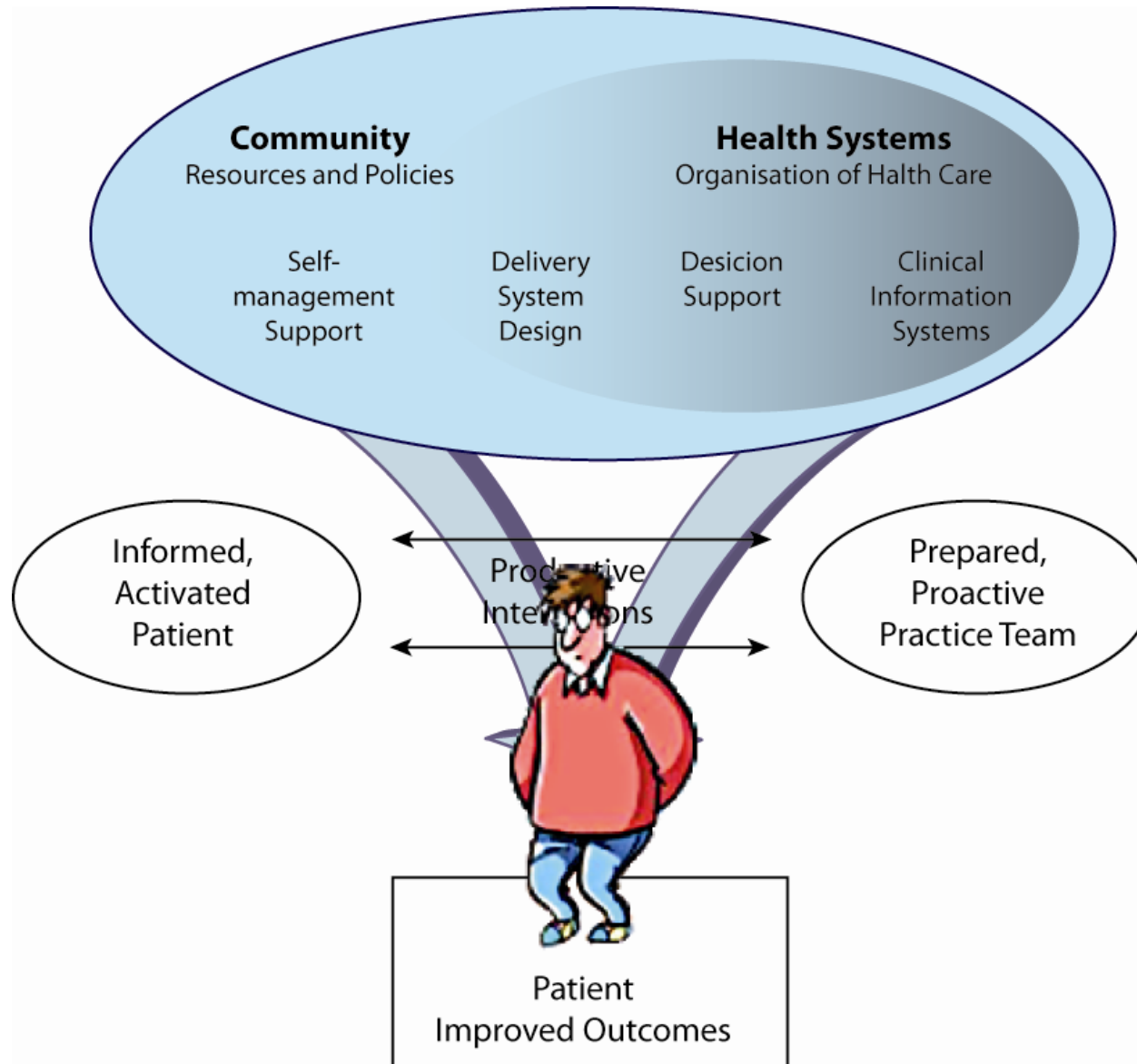
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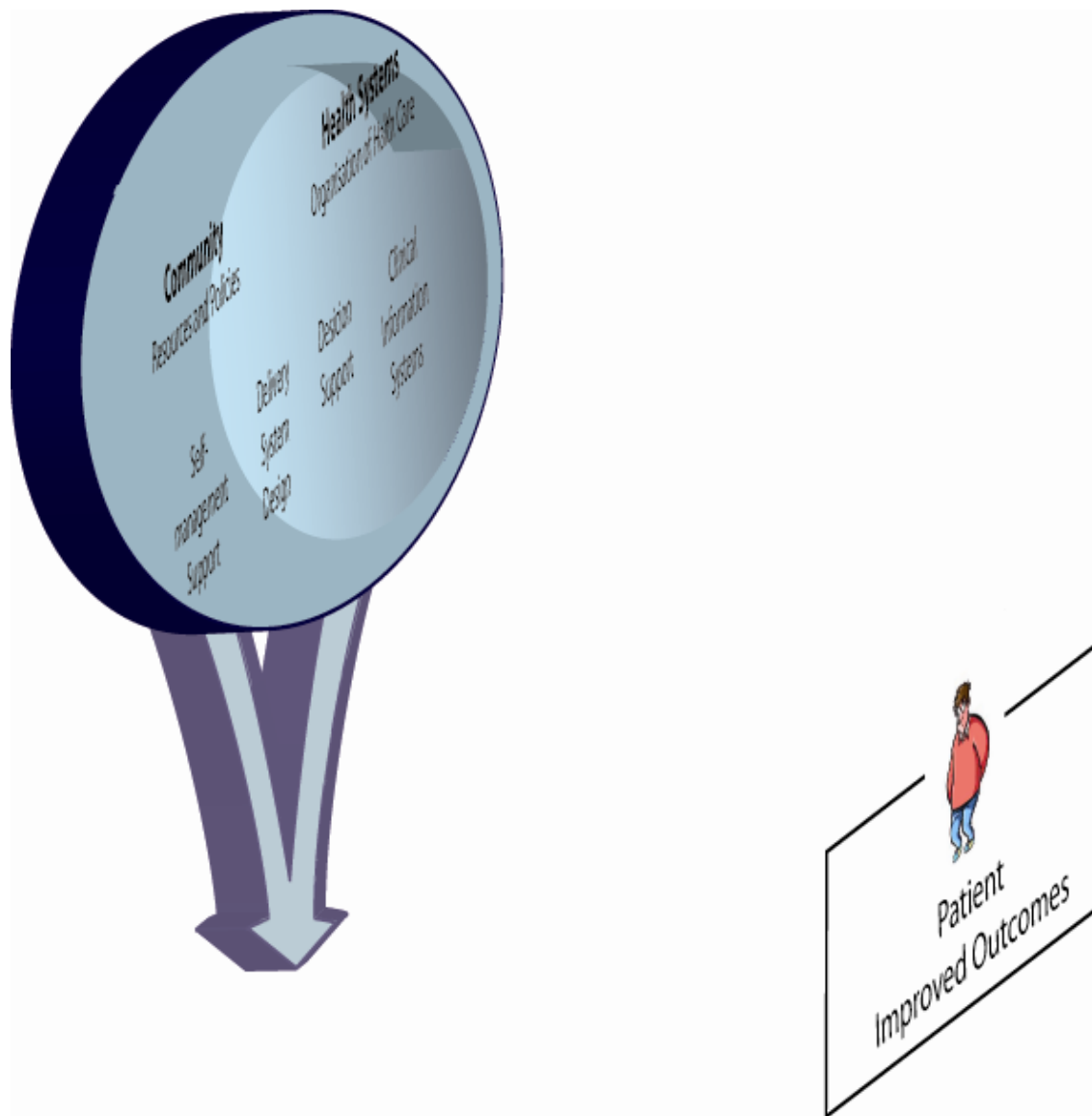


Challenges in patients with multimorbidity





But...



Birgitte 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 osteoarthritis. 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 Birgitte 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 Birgitte had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Birgittes’s goals. I visit Birgitte 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 strengthening
 - Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

Clinical tasks

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

R

- Physical therapy
- Ophthalmology
- Pulmonary

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

Patient education

- Foot care
- Osteoarthritis
- 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.

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

This conceptual model is ideally suited to the understanding and management of acute and curable illnesses. It has also been extremely important for clinical research. How-

“Problem-oriented versus goal-oriented care”

	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”

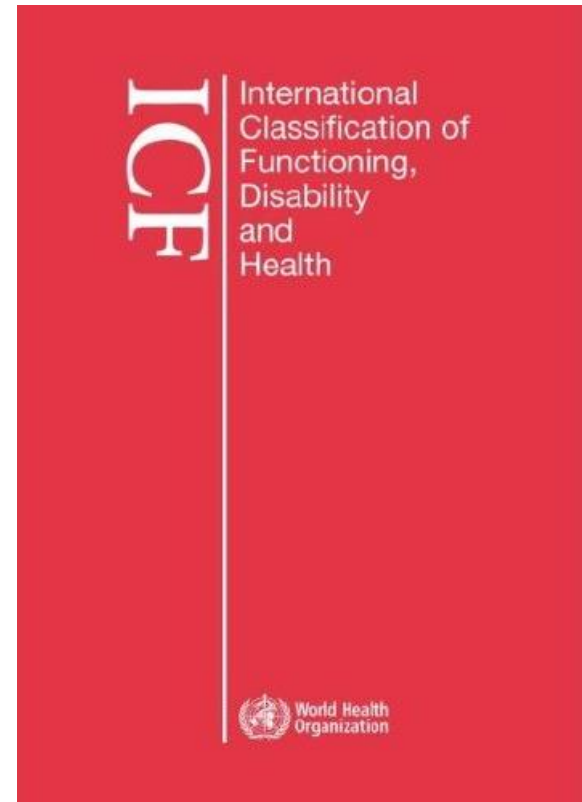
	Problem-oriented	Goal-oriented
Measures of success	Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death	Achievement of individual goals

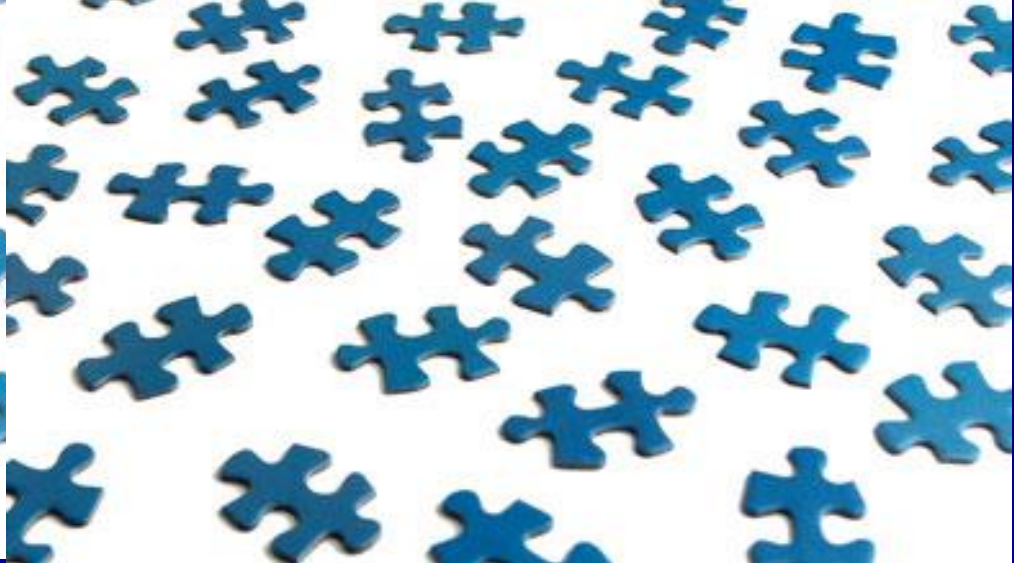
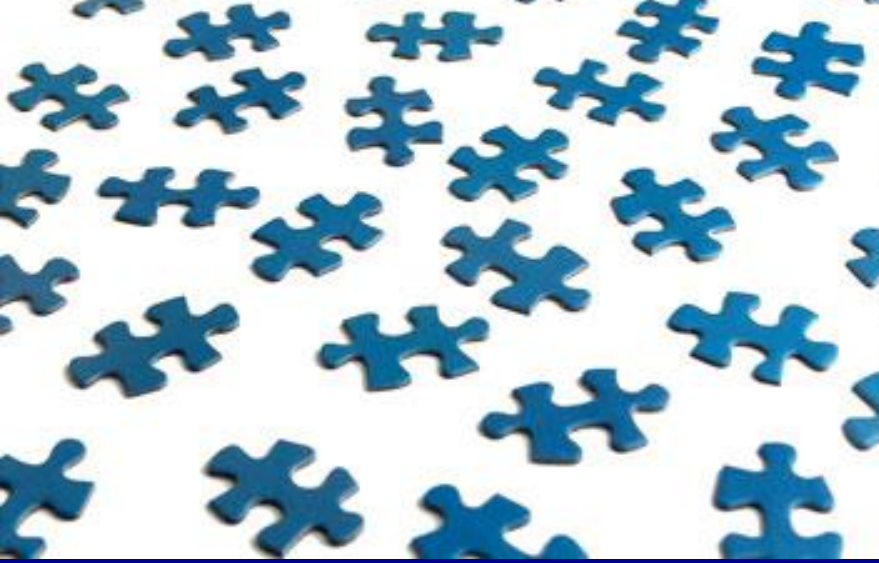
“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Evaluator of success	Physician	Patient

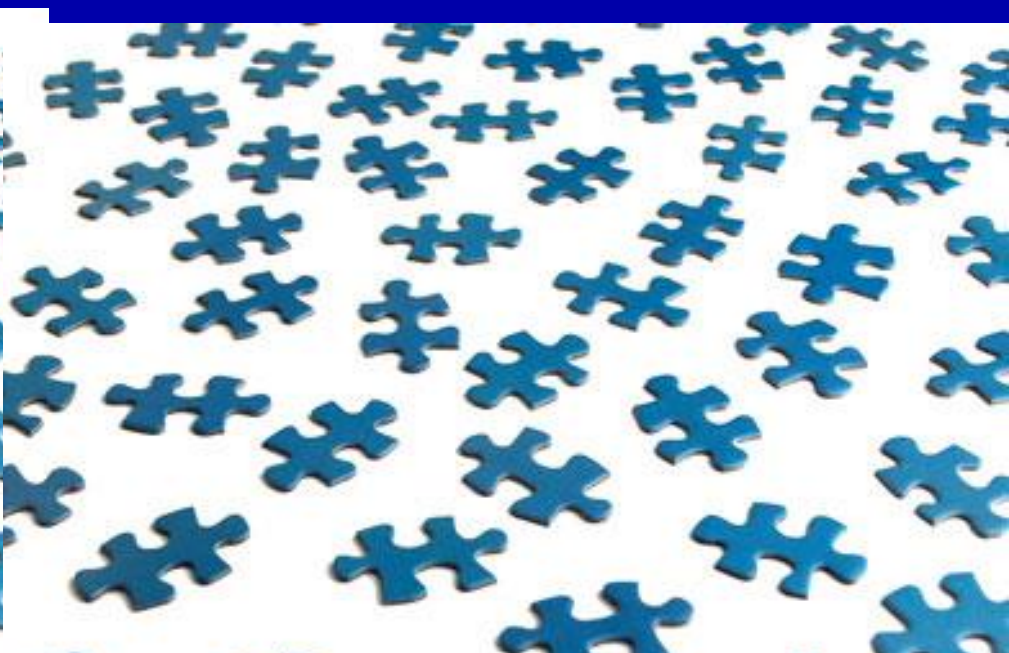
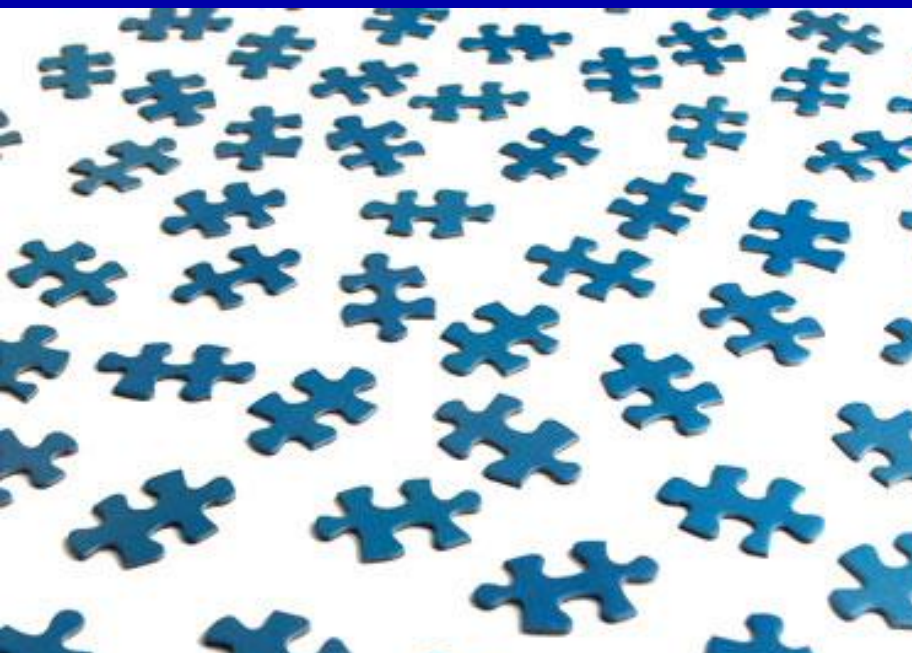
What really matters for patients is

- Functional status
- Social participation





FRAGMENTATION



Monthly
updates online

BMJ

clinical evidence

The international source of the
best available evidence for
effective health care

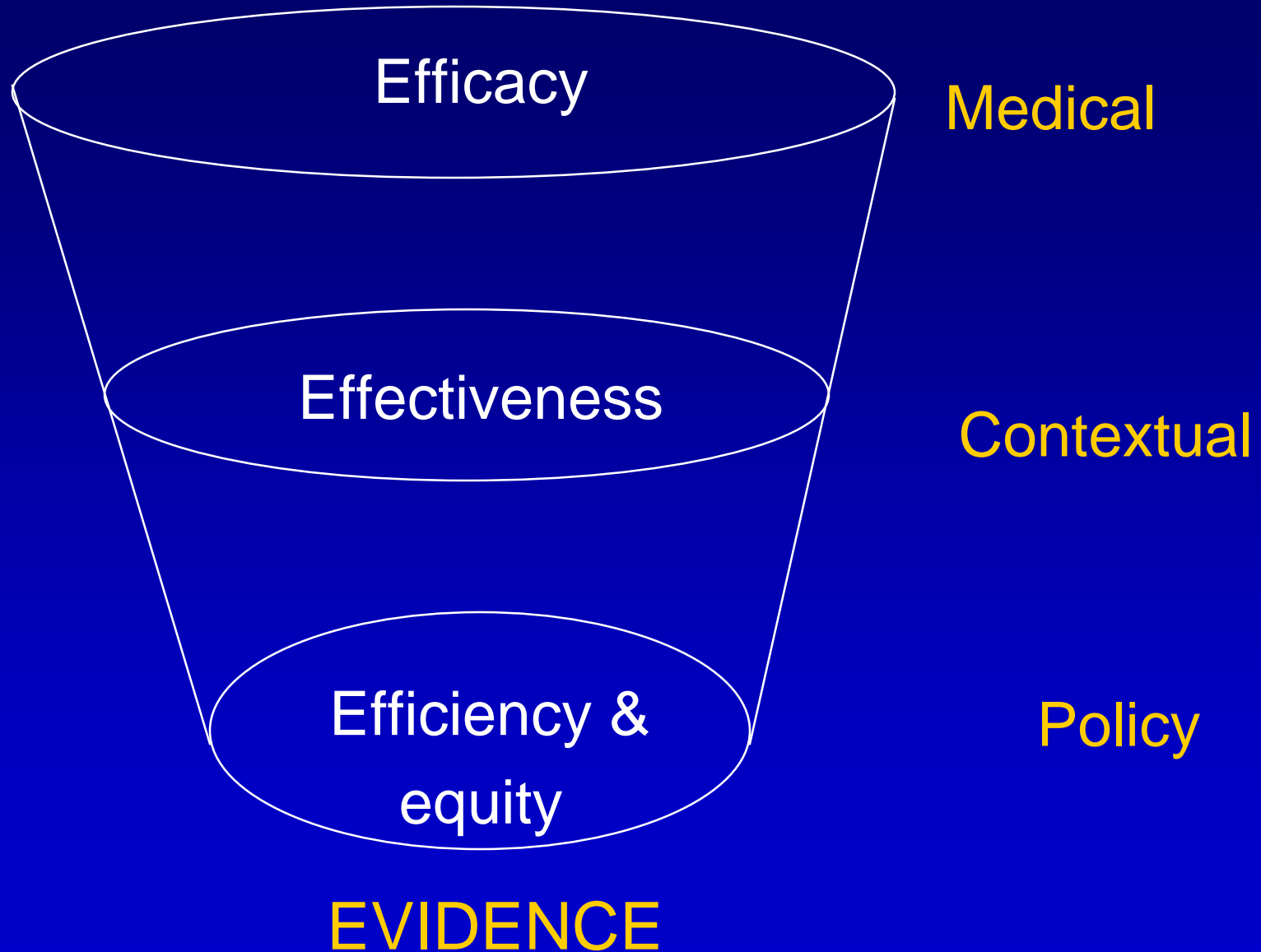
Updated and extended monthly at
www.clinicalevidence.com

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)

Quality of care



“Treat the patient”



“Treat-to-target”

Primary Health Care and “contextual” evidence

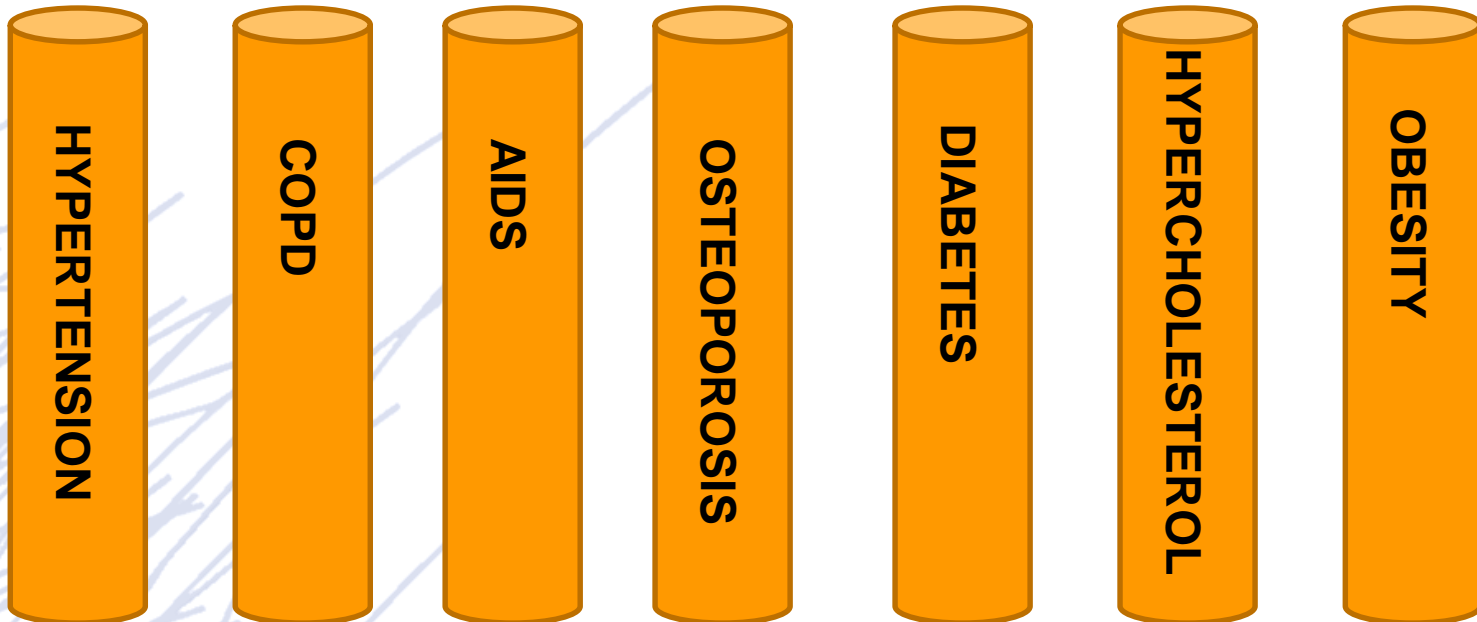
“disease management”



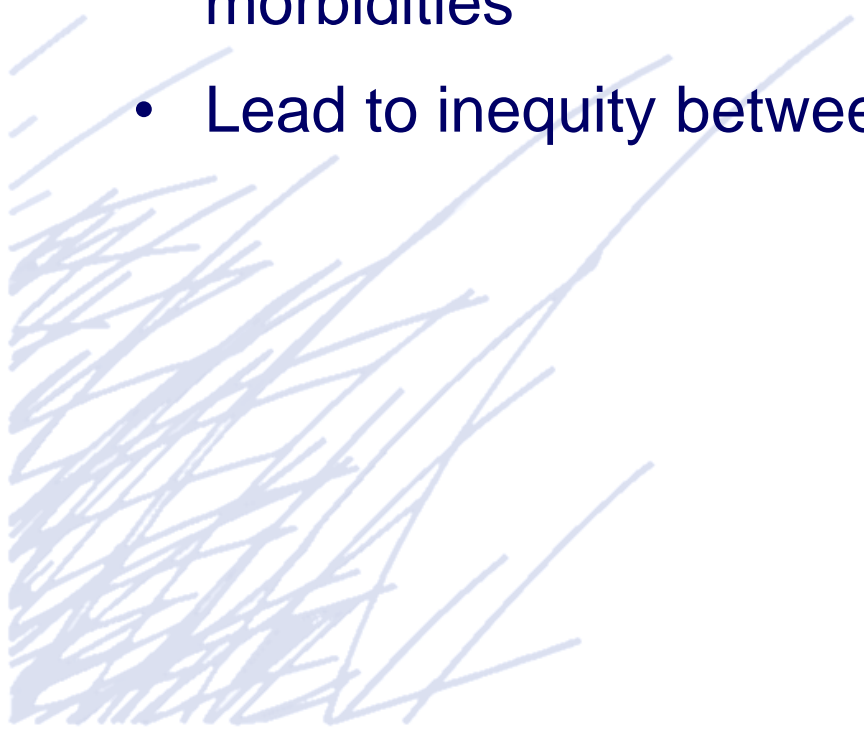
“patient management”

Vertical Disease Oriented Approach

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



The challenge: vertical disease- oriented programs and multimorbidity

- Create duplication
 - Lead to inefficient facility utilization
 - May lead to gaps in patients with multiple co-morbidities
 - Lead to inequity between patients
- 
- Abstract blue scribbles in the bottom left corner of the slide.

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

[see www.15by2015.org]

Tackling NCDs: a different approach is needed



The NCD Alliance¹ aims to put non-communicable diseases (NCDs) on the global agenda to address the NCD crisis. Improving outcomes in morbidity and mortality by 2015 will clearly depend to a large extent on tackling the burden of NCDs, especially in developing countries.²

developed, integrated and implemented in the context of integrated primary health care".⁹ Horizontal primary health care provides the opportunity for integration and addresses the problem of inequity by allowing focus on NCDs while providing access to the care of other health problems, thereby avoiding inequity by disease.¹⁰

Published Online
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6736(11)61135-5



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**Jan De Maeseneer, Richard G Roberts, Marcelo Demarzo, Iona Heath, Nelson Sewankambo, Michael R Kidd, Chris van Weel, David Egilman, Charles Boelen, Sara Willems*

Faculty of Medicine and Health Sciences, Secretariat of The Network: Towards Unity For Health (JDM) and Department of Family Medicine and Primary Health Care (SW), Ghent University, Ghent, Belgium; Department of Family Medicine, University of Wisconsin School of Medicine and Public Health, Madison, WI, USA (RGR); Department of Preventive Medicine, Federal University of Sao Paulo, Sao Paulo, Brazil (MD); Royal College of General Practitioners, London, UK (IH); Makerere University College of Health Sciences, Kampala, Uganda (NS); Faculty of Health Sciences, Flinders University, Adelaide, Australia (MRK); Department of Primary and Community-Care, Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands (CvW); Department of Family Medicine, Brown University, Providence, RI, USA (DE); and Secretariat of Global Consensus for Social Accountability of Medical Schools, Sciez-sur-Léman, France (CB)



Resolution WHA62.12 “Primary Health Care, including health systems strengthening”



The World Health Assembly, urges member states: ... (6) to encourage that vertical programmes, including disease-specific programmes, are developed, integrated and implemented in the context of integrated primary health care.

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- COPC-strategy



COPC-example: dental problems: periodontal disease in childhood

Risk factor for:

- Diabetes
- Coronary Heart Disease
- Preterm birth and low birth weight
- Osteoporosis



COPC-project : from individual care to community health care



Identifying health problem:

Family physicians/nurses: problematic oral condition of toddlers, leading to feeding problems, crying, not sleeping,...





COPC-project : DENTAL FITNESS



A dentist?
I cannot afford that.

Focus Group sessions –
involving the community

I don't know where
to find a dentist

I'm doing Fristi in his
bottle to stop him cry

My child is to afraid of
the dentist and to be
honest, me too





COPC-project : DENTAL FITNESS



Working together with...



VZW

Brugse Poort

De Sleep



Botermarkt



K&G



Vakgroep Huisartsgeneeskunde
en Eerstelijnsgezondheidszorg





COPC-project : DENTAL FITNESS



Results research children 30 months old:

- 18,5 % early symptoms of childhood caries (7,4 % – 29,6 %)
- 100% need for treatment!

Correlation with

- deprivation
- nationality (Eastern-European)
- no previous dentist consultation





COPC-project : DENTAL FITNESS



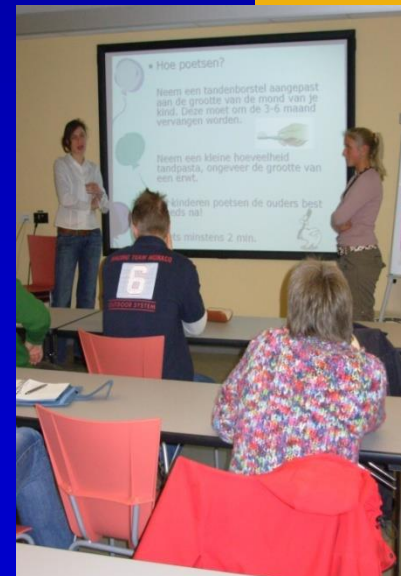
Childhood caries:

- Information and Sensibilisation
 - Involving providers, social workers, parents, schools...

Strategies:

Community oriented,
intersectoral, participation.

Educational platform for
students in dentistry





COPC-project : DENTAL FITNESS



Accessible primary dental care

**Centre for Primary Oral Health Care
Botermarkt Ledeborg (CEMOB)**

Started 01/09/2006



Towards accessible oral
health care !

Ghent University

Integration of personal and community health care

The promotion of primary health care since 1978¹ 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

From the local to the global community:
“Sustainable Development Goals”

New York, UN 25 September 2015

Panel: Proposed Sustainable Development Goals

Goal 1

End poverty in all its forms everywhere

Goal 2

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

Goal 3

Ensure healthy lives and promote wellbeing for all at all ages

Goal 4

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

Goal 5

Achieve gender equality and empower all women and girls

Goal 6

Ensure availability and sustainable management of water and sanitation for all

Goal 7

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

Goal 8

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

Goal 9

Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation

Panel: Proposed Sustainable Development Goals

Goal 10

Reduce inequality within and among countries

Goal 11

Make cities and human settlements inclusive, safe, resilient, and sustainable

Goal 12

Ensure sustainable consumption and production patterns

Goal 13

Take urgent action to combat climate change and its impacts

Goal 14

Conserve and sustainably use the oceans, seas, and marine resources for sustainable development

Goal 15

Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Goal 16

Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels

Goal 17

Strengthen the means of implementation and revitalise the global partnership for sustainable development

The long road to a better life...



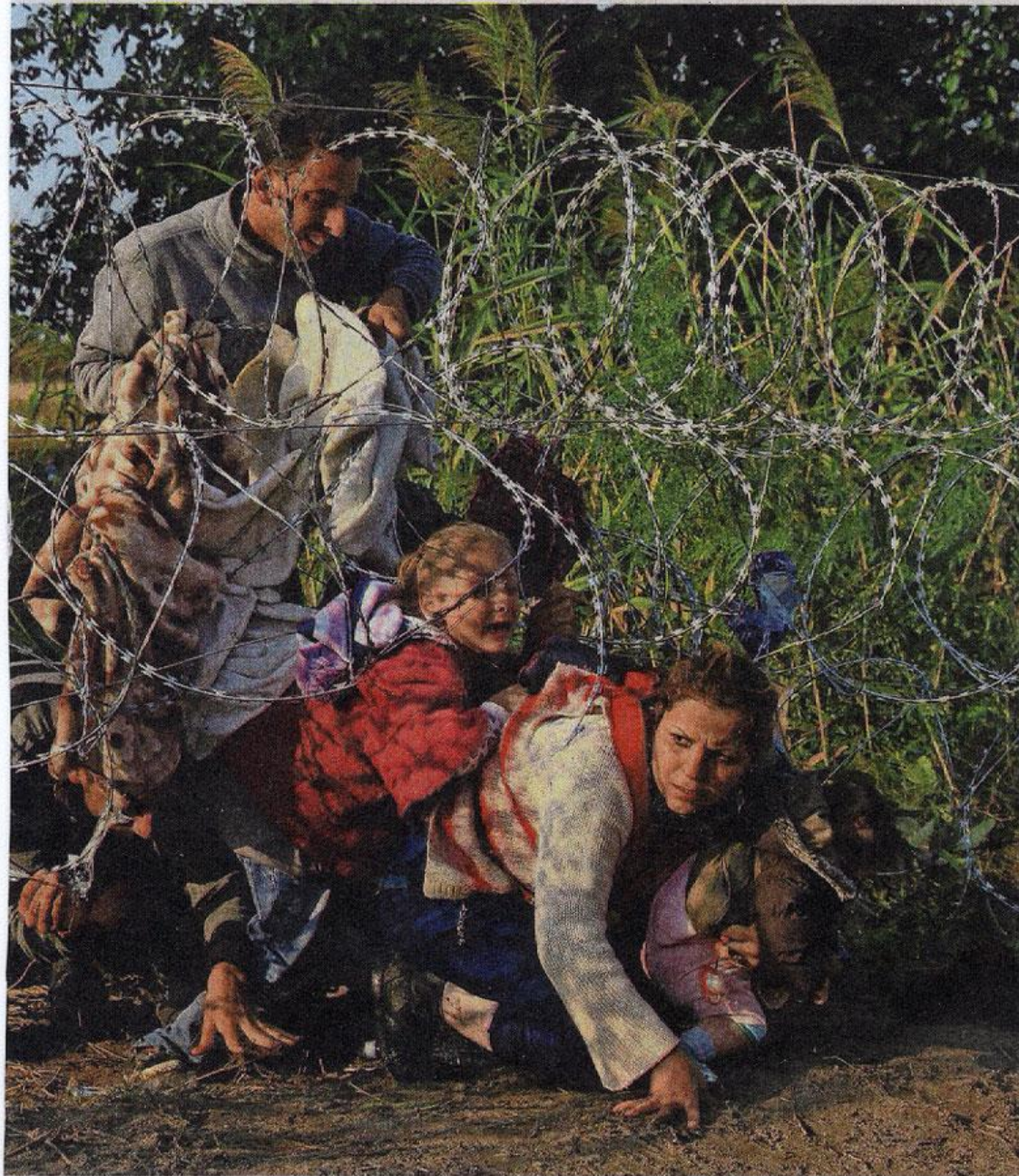
The Long Road to a better life...

► Woensdag redde een Zweeds schip nog 439 mensen voor de Libische kust; 51 anderen waren gestorven. © AP



Boot met honderden vluchtelingen gezonken





► Een gezin vluchtelingen ontwijkt de prikkeldraad aan de Hongaars-Servische grens. 'Op korte termijn is er geen andere optie dan ook in te zetten op een betere buitengrensbewaking.' © REUTERS



► De vrachtwagen met dode lichamen stond langs de snelweg van Boedapest naar Wenen.

© EPA





► Vluchtelingen wachten aan de Dienst Vreemdelingenzaken in Brussel om asiel aan te vragen. Iedere dag staat er zo'n 300 man. © EPA



Wonca Europe 2015 Istanbul Statement:

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



► Kinderen in de lange rij wachtenden voor de Dienst Vreemdelingenzaken. Het klopt niet dat de instroom van vluchtelingen de toekomst van de sociale zekerheid bedreigt.

© PHOTO NEWS



The long road to SDG 16

WELKOM IN MIJN



Gastvrije Gemeente



Vluchtelingenwerk
VLAANDEREN

www.gastvrijegemeente.be

Refugees: Welcome in our community.....

The refugee crisis...

- International relationships: war, unfair trade, social inequities...
- Responsiveness of health and welfare systems worldwide

Primary Care at the crossroads: how could primary care start in Austria?

1. The changing society
2. Changes in 'pro-active or pre-care'
3. Changes in 're-active care'
4. Changes in 'chronic care': addressing multi-morbidity
5. Changes in 'community oriented care'
6. **The GP/FP as actor in the health system:**
"Together we change"
7. Conclusion

Expert Panel on Effective Ways of Investing in Health





Report of the
**EXPERT PANEL ON EFFECTIVE WAYS
OF INVESTING IN HEALTH (EXPH)**

on

**Definition of a Frame of Reference in relation to Primary
Care with a special emphasis on Financing Systems
and Referral Systems**

Opinion on Definition primary care – Definition

Core-definition

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

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.'



TOGETHER WE CHANGE

Eerstelijnsgezondheidszorg: nu meer dan ooit!

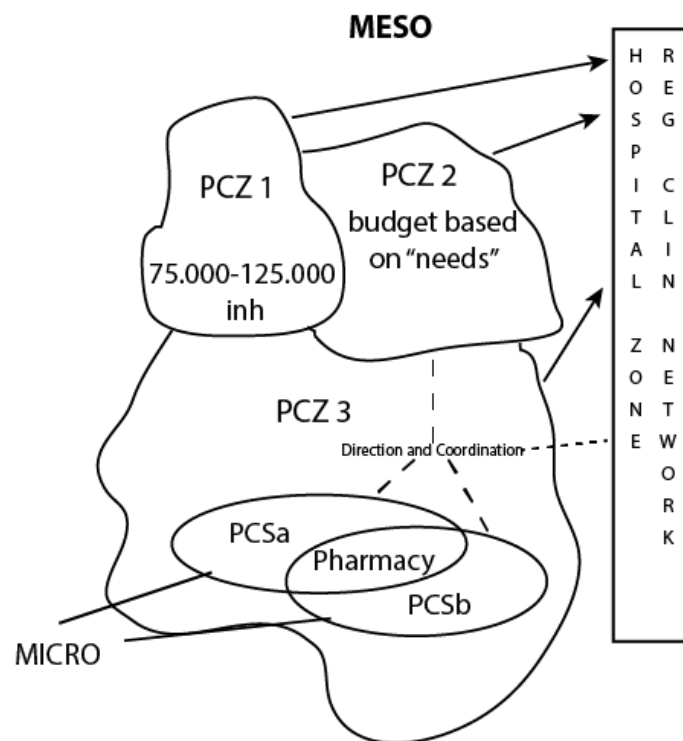
Jan De Maeseneer, Bert Aertgeerts,
Roy Remmen, Dirk Devroey

Meso-level

Primary Care Zones =

- Geographically defined areas
- 75 000 to 125 000 inhabitants
- +/- 110 zones in Belgium
- Supported by 15 to 20 hospital care zones

Figure 1: ORGANISATION PRIMARY CARE



BFR1: Budget Financial Resources PC
 GWC: General Welfare Centre
 PCP: Primary Care Psychologist
 PCZ: Primary Care Zone
 PCS: Primary Care Services
 EPR: electronic Patient Record
 PCCF: Primary Care Coordinating Function
 IMC: Inter Ministerial Conference
 C&F: Child and Family
 HCS: Home Care Services

1 EPR

Micro-level

Every citizen registers with a family practice functioning in the framework of a primary care service

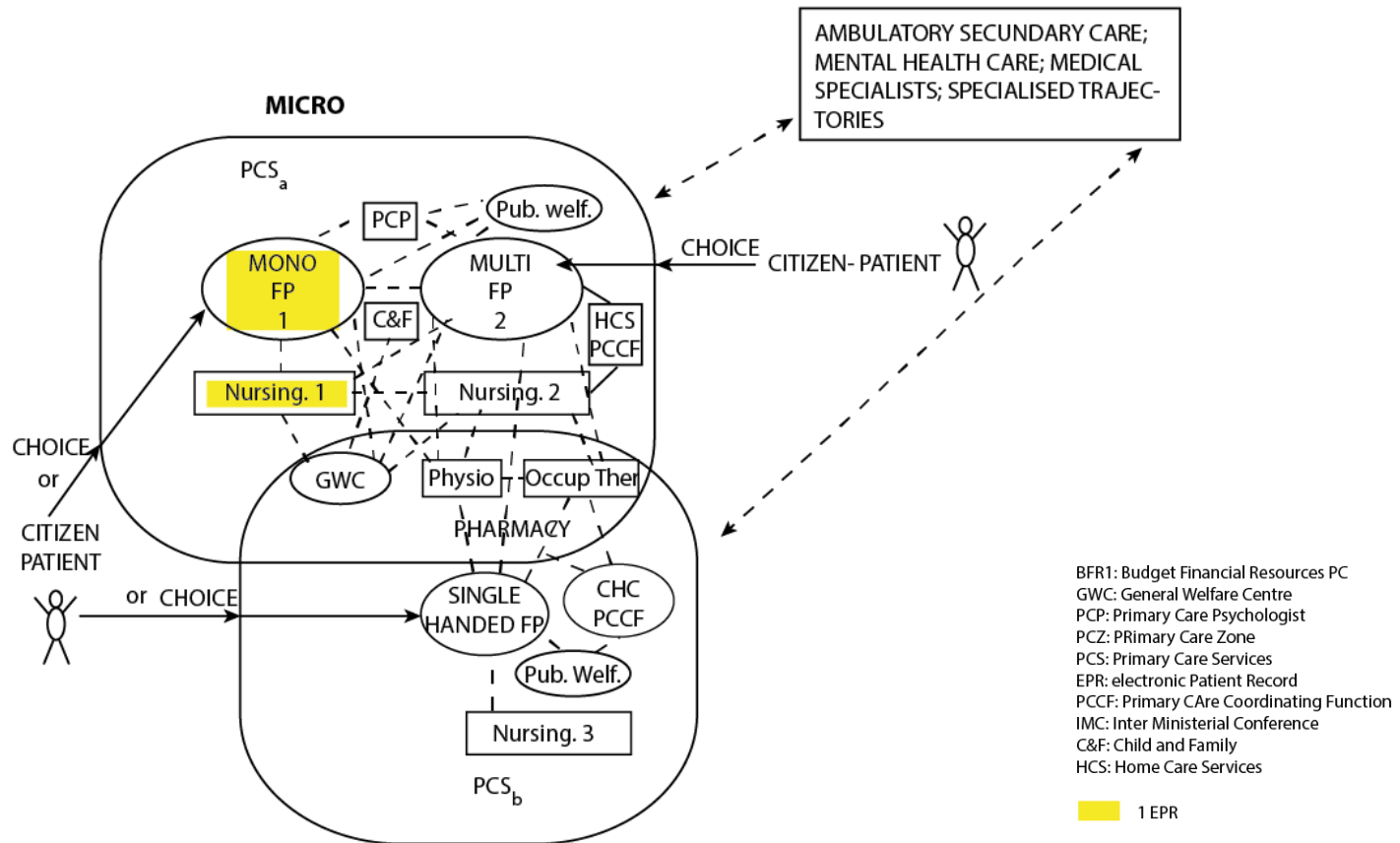
Primary Care Service

- Interprofessional (under one roof, in a network, or both)
- Composed of different primary care practices
- Direct access to primary care services

Primary Care Practice

- Operational unit
- Low threshold generalist care (health and/or welfare)
- Interprofessional approach
- Person- and population-centered

Figure 1: ORGANISATION PRIMARY CARE



Financing at the micro-level

Diversification of the payment system, e.g. for the family physician:

Model A

- Fee-for-service without co-payment utilizing a universal (electronic) third party payment
- Evolution from 80% FFS/ 20% non FFS towards 60% non FFS + 30% FFS + 10% P4Q (Pay-for-Quality)

Model B

- Integrated mixed need based capitation, with 10 % P4Q

Referral

Linear: new
health problems



Spiral:
chronic problems



Policies improving cost efficiency (Belgium)

“The government should strongly encourage patients to consult their general practitioner first as a general rule (except for emergencies) by not reimbursing medical expenses for patients not referred by their GP (gatekeeper).”

OECD economic surveys 2005 – Belgium, pag 68

Abstract blue scribbles in the bottom left corner of the slide.

Botermarkt

wijkgezondheidscentrum vzw



WELCOME to the Community Health Centre Botermarkt

Hundelgemsesteenweg 145
9050 Ledeberg

www.wgcbotermarkt.be
Info@wgcbotermarkt.be

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



GHENT UNIVERSITY TEACHING PLATFORM

Visie

Ontstaan

Multidisciplinair team

Globaal Medisch Dossier

Forfaitair betalingssysteem

Raadplegingen, afspraken
en huisbezoeken

Preventieprojecten en
gezondheidsbevordering

Inschrijven in het WGC

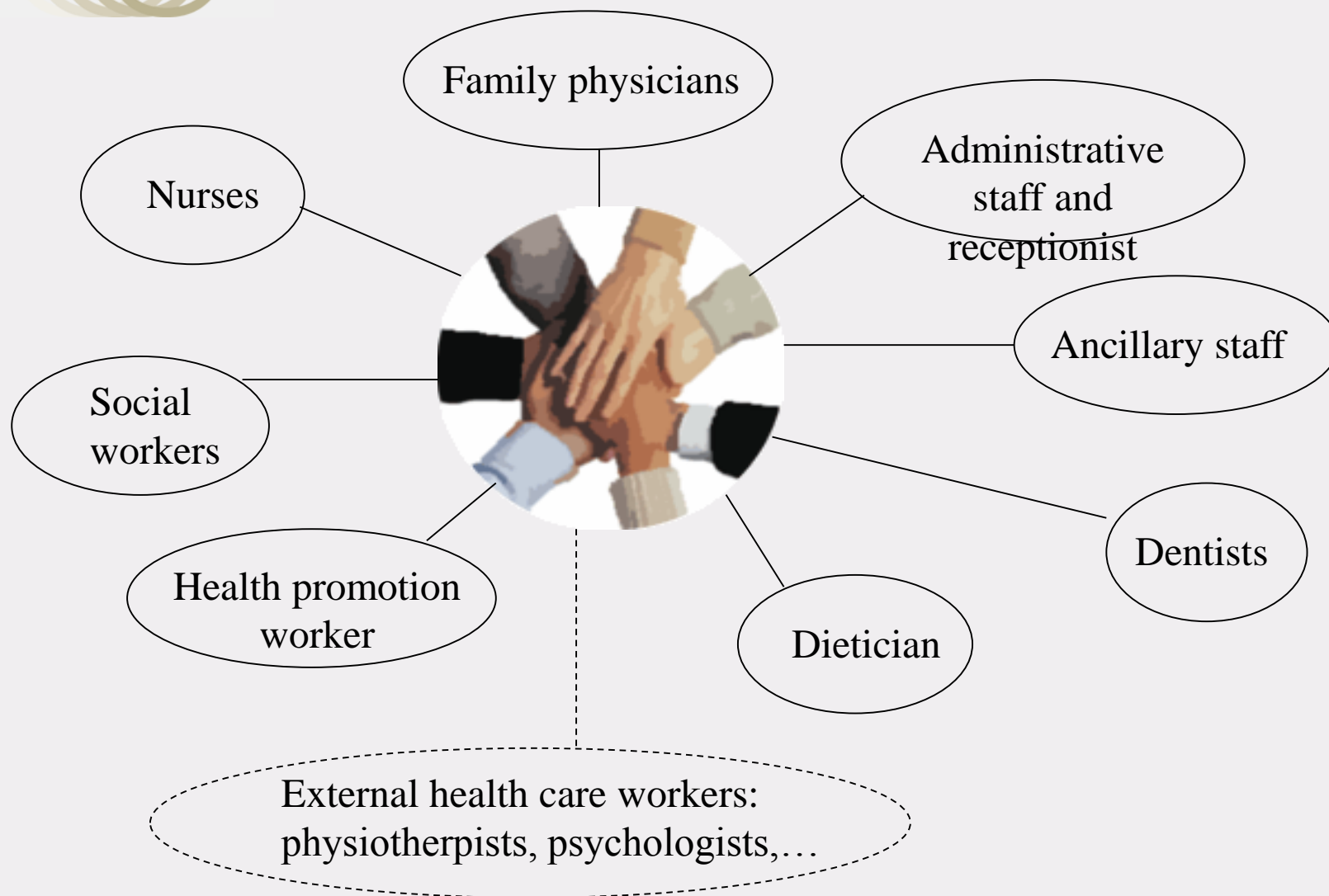
Voor onze patiënten

Community Health Centre:

- General Practitioners; nurses; dieticians; health promoters; dentists; social workers; tabacologist;...
- 6200 patients; 90 nationalities
- Integrated needs-based mixed capitation; no co-payment
- COPC-strategy



INTERDISCIPLINARY TEAM





Community Health Center Botermarkt Ledeberg!

Competency sharing

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



Social Work



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

Integrated care

- Physical, mental, ecological and social well-being
- Taking environment/living conditions into account
 - Citizen/patient in the driver's seat



Medisch overzicht

Roker : 20 [s/dag] (05/03/2013)

Belangrijke actieve GE

Tabaksmisbruik
Menopauzale symptomen/klachten
Niet insuline-afhankelijk diabetes
Symptomen/klachten schouder
Overgewicht
Hypertensie zonder orgaanbeschadiging
Sociaal probleem nao, begeleiding maatschappelijk werk

Familiale antecedenten

Acuut myocardinfarct (Vader)
Niet insuline-afhankelijk diabetes (Moeder)

Medische antecedenten

Zwangerschap, vlotte partus, zoon
Zwangerschap, vlotte partus, dochter
Zwangerschap, vlotte partus, dochter

Chirurgische antecedenten

appendectomie in 1999

Chronische medicatie

Metformine Sandoz tab 100x 850mg
Asaflow tab EC 168x 80mg
Simvastatin Sandoz tab 100x 20mg

Vaccins

☒ Toegediende vaccins
☒ Geplande vaccins

GezondheidsElementen

Alle AB A ☐ ZorqE. ☐ Zorgaanpakken

Beschrijving	A	B	R	Begin	Einde	Zekerheid	Duur	Code	Presteerder	Specialiteit
Acute infectie bovenste l				12/02/2014	16/02/2014	Niet bepaald	Acuut	R74	VANDEDRIK, E	Huisarts
Hypertensie zonder orga	A	E		20/03/2013		Niet bepaald	Chronisch	K86	VANDEDRIK, E	Huisarts
Menopauzale symptomen	A	E		15/01/2014		Niet bepaald	Sub-acuut	X11	VANDEDRIK, E	Huisarts
Niet insuline-afhankelijke	A	E		01/03/2011		Niet bepaald	Chronisch	T90	VANDEDRIK, E	Huisarts
Overgewicht	A	E		05/03/2010		Niet bepaald	Chronisch	T83	VANDEDRIK, E	Huisarts
Preventie	A			05/03/2013		Niet bepaald	Chronisch	A98	VANDEDRIK, E	Huisarts
Sociaal probleem nao, be	A	E		20/06/2013		Niet bepaald	Chronisch	Z29	DEWAELE, Liesbe	Maatschappelijk wer
Symptomen/klachten sch	A	E		01/03/2013		Niet bepaald	Chronisch	L08	VANDEDRIK, E	Huisarts
Tabaksmisbruik	A	E		01/01/1990		Niet bepaald	Chronisch	P17	VANDEDRIK, E	Huisarts
Zwangerschap, vlotte par	E			01/05/1995	16/02/1996	Niet bepaald	Chronisch	W78	VANDEDRIK, E	Huisarts
Zwangerschap, vlotte par	E			01/04/1998	06/01/1999	Niet bepaald	Chronisch	W78	VANDEDRIK, E	Huisarts
Zwangerschap, vlotte par	E			01/07/1993	12/05/1994	Niet bepaald	Chronisch	W78	VANDEDRIK, E	Huisarts

Geneesmiddelen

Beschrijving	Begindatum	Einddatum	A	Presteerder	Specialiteit
<input checked="" type="checkbox"/> Metformine Sandoz tab 100	01/03/2013		<input checked="" type="checkbox"/>	VANDEDRIK, E	Huisarts
<input checked="" type="checkbox"/> Asaflow tab EC 168x 80mg	05/03/2013		<input checked="" type="checkbox"/>	VANDEDRIK, E	Huisarts
<input checked="" type="checkbox"/> Simvastatin Sandoz tab 100	05/03/2013		<input checked="" type="checkbox"/>	VANDEDRIK, E	Huisarts
<input type="checkbox"/> Hygroton tab 30x 50mg	20/03/2013		<input checked="" type="checkbox"/>	VANDEDRIK, E	Huisarts

Planning

Datum	Beschrijving	Statuut	Presteerder	T	Te doe	Specialiteit
11/03/2014	aanvraag aangepast rijbewijs	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	Opvolgcontact bij een diëtist	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	verwijzing - oogarts	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	Test op microalbuminurie	Te doen	VANDEDRIK, E	S	<input checked="" type="checkbox"/>	Huisarts
11/03/2014	Bepaling glucose/HbA1c	Te doen	VANDEDRIK, E	S	<input checked="" type="checkbox"/>	Huisarts
12/03/2014	Onderzoek diabetische voet	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/06/2014	DiabetesSpreekUur, educator	Te doen	VANDE KERCKHO	I	<input checked="" type="checkbox"/>	Verpleegkundige
05/09/2014	vaccin griep	Te doen	VANDEDRIK, E	I	<input checked="" type="checkbox"/>	Huisarts
05/03/2020	vaccin difterie/tetanus	Te doen	VANDEDRIK, E	I	<input checked="" type="checkbox"/>	Huisarts
25/06/2013	DiabetesSprekUur	Uitgevoerd	BLOKLAND, INEK	I	<input type="checkbox"/>	Huisarts

Contacten

Datum	Type	Presteerder	Specialiteit
15/05/2014	Raadpleging	VANDEDRIK, E	Huisarts
11/03/2014	Raadpleging	BLOKLAND, INEK	Huisarts
12/02/2014	Raadpleging	VANDEDRIK, E	Huisarts
15/01/2014	Raadpleging	VANDEDRIK, E	Huisarts
01/11/2013	Raadpleging	DEWAELE, Liesbe	Maatschappelijk wer
16/10/2013	Raadpleging	LANCKSWEERDT,	Dietiste
03/09/2013	Raadpleging	VANDE KERCKHO	Verpleegkundige

Illness prevention & Health promotion

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



Diabetes Fair

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





**Improving health and primary health care
around the world
through Community Health Centres**

Learn more at: www.ifchc2013.org

Austria's 1st Primary Care Center



Search ...

GRUPPENPRAXIS FÜR ALLGEMEINMEDIZIN

Dr. Mayrhofer | Dr. Mückstein | Dr. Lamel

Mariahilfer Straße 95/Stiege 1, Mezzanin
1060 Wien

Tel: +43 1 59 74 337

Fax: +43 1 59 74 337 5

Email: praxis@medizinmariahilf.at

ALLE KASSEN UND PRIVAT

ORDINATIONSZEITEN

MO: 8 - 13 und 14 - 19 Uhr

DI: 7 - 12 und 14 - 19 Uhr

MI: 8 - 13 und 14 - 19 Uhr

DO: 8 - 13 und 14 - 19 Uhr

FR: 8 - 13 und 14 - 19 Uhr

Jeweils vormittags Blutabnahme möglich
Blutabnahmen nur für Patient/innen von

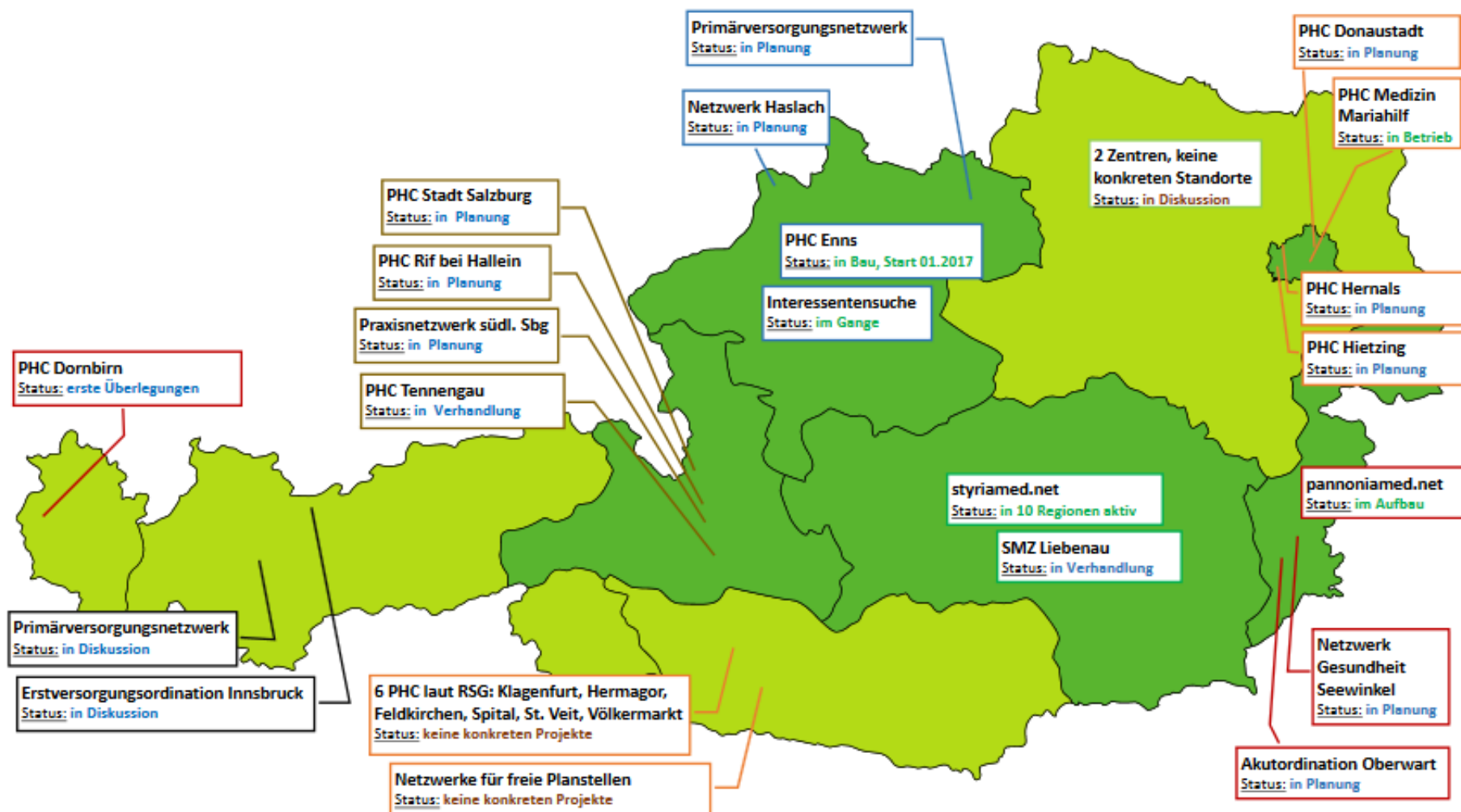
MedizinMariahilf

MEDIZIN MARIAHILF LEISTUNGEN TEAM INFOS AKTUELLES KONTAKT BLOG



TEAM MEDIZIN MARIAHILF

Plans and Initiatives on Primary Care



→ There is some activity but up to Sept. 2016 there is only 1 new primary care model.



Created in 2005

The main objectives

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

The Future of Primary Care in Europe



The Citizen Voice in Primary Care

a social commitment to 'health for all'

Image: João Pedro Rocha

12th EFPC conference
24/26 SEPTEMBER

PORTO 2017

[www.euprimarycare.org/porto/efpc-](http://www.euprimarycare.org/porto/efpc-2017-porto-conference-24-26-september)

[2017-porto-conference-24-26-september](http://www.euprimarycare.org/porto/efpc-2017-porto-conference-24-26-september)

<http://efpc2017.pe.hu>

europa
forum
for primary care



Conference fees



















Students	€ 175
Early bird EFPC members	€ 225
Early bird Non members	€ 400
EFPC members	€ 325
Non members	€ 500
Pre-conference Sunday 24/9	+ € 100

Early bird ends June 16

Primary care at the crossroads: how could primary care start in Austria?

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"Together we change"
7. Conclusion

Conclusion: changes in the role of family physicians: actual performance and the way forward

	Nano	Micro	Meso	Macro
Pro-active or pre-care				
RE-active care				
Chronic care				
Community/population oriented care				
GP/FP in Health System				

Health systems in the 21st century should be built on:

- Relevance
- Equity
- Quality
- Cost-effectiveness
- Sustainability
- Person- and people-centredness
- Innovation

The GP/FP in the CHC-team has a role to play... Now more than ever!

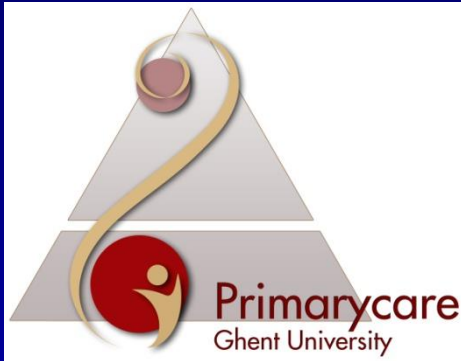
RUNNING FOR...



A SUSTAINABLE FUTURE!

Thank you...

jan.demaeseneer@ugent.be



WHO
Collaborating
Centre on PHC

