“Goal-Oriented Care: from chronic disease management to participatory patient management.”

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Chairman European Forum for Primary Care
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http://www.huraprim.ugent.be

https://www.ugent.be/ge/huisartsgeneeskunde/en

http://iom.edu/Activities/Global/InnovationHealthProfEducation.aspx
Goal-Oriented Care: from chronic disease management to participatory patient management

1. Challenges: demographical and epidemiological transition
2. Adressing multi-morbidity
3. Being a GP in the 21st century
4. 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%?
The ageing society
High blood pressure
Stroke
Diabetes
Linear (High blood pressure)
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)*
Goal-Oriented Care: from chronic disease management to participatory patient management

1. Challenges: demographical and epidemiological transition

2. Addressing multi-morbidity

3. Being a GP in the 21st century

4. Conclusion
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Developed by The MacColl Institute
© ACP-ASIM Journals and Books

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

Community
Resources and Policies
- Self-management Support

Health Systems
Organisation of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Patient
Improved Outcomes
But…
Jennifer 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 Jennifer 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 Jennifer had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Jennifer’s goals. I visit Jennifer 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

#### Time  Medications
<table>
<thead>
<tr>
<th>Time</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM</td>
<td>Ipratropium dose inhaler</td>
</tr>
<tr>
<td></td>
<td>Alendronate 70 mg/wk</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>Calcium 500 mg</td>
</tr>
<tr>
<td></td>
<td>Vit D 200 IU</td>
</tr>
<tr>
<td></td>
<td>Lisinopril 40mg</td>
</tr>
<tr>
<td></td>
<td>Glyburide 10mg</td>
</tr>
<tr>
<td></td>
<td>Aspirin 81mg</td>
</tr>
<tr>
<td></td>
<td>Metformin 850 mg</td>
</tr>
<tr>
<td></td>
<td>Naproxen 250 mg</td>
</tr>
<tr>
<td></td>
<td>Omeprazol 20mg</td>
</tr>
</tbody>
</table>
| 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                                    |

#### Referrals
- Physical therapy
- Ophthalmologic examination
- Pulmonary rehabilitation

#### Patient education
- Foot care
- Osteoarthritis
- COPD medication and delivery system training
- Diabetes

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

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

ABSTRACT

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

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

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

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

<table>
<thead>
<tr>
<th>Definition of Health</th>
<th>Problem-oriented</th>
<th>Goal-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of disease as defined by the health care system</td>
<td>Maximum desirable and achievable quality and/or quantity of life as defined by each individual</td>
<td></td>
</tr>
</tbody>
</table>
### Problem-oriented versus goal-oriented care

<table>
<thead>
<tr>
<th>Purposes of Health Care</th>
<th>Problem-oriented</th>
<th>Goal-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eradication of disease, prevention of death</td>
<td>Assistance in achieving a maximum individual health potential</td>
</tr>
</tbody>
</table>
“Problem-oriented versus goal-oriented care”

<table>
<thead>
<tr>
<th>Measures of success</th>
<th>Problem-oriented</th>
<th>Goal-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death</td>
<td>Achievement of individual goals</td>
<td></td>
</tr>
</tbody>
</table>
"Problem-oriented versus goal-oriented care"

<table>
<thead>
<tr>
<th></th>
<th>Problem-oriented</th>
<th>Goal-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator of success</td>
<td>Physician</td>
<td>Patient</td>
</tr>
</tbody>
</table>
What really matters for patients is

- Functional status
- Social participation
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.
Figure 1.10 How health systems are diverted from PHC core values

Health systems

Current trends
- Hospital-centrism
- Commercialization
- Fragmentation

Health equity
Universal access to people-centred care
Healthy communities

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

[ see www.15by2015.org ]
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?
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.
The Quality and Outcomes Framework

QOF - transforming general practice

Edited by Stephen Gillam and A Niroshan Siriwardena
Foreword by Iona Heath
How QOF is shaping primary care review consultations: a longitudinal qualitative study

Carolyn A Chew-Graham¹,²*, Cheryl Hunter³, Susanne Langer⁴, Alexandra Stenhoff⁵, Jessica Drinkwater⁷, Elspeth A Guthrie⁶ and Peter Salmon⁷

Abstract

Background: Long-term conditions (LTCs) are increasingly important determinants of quality of life and healthcare costs in populations worldwide. The Chronic Care Model and the NHS and Social Care Long Term Conditions Model highlight the use of consultations where patients are invited to attend a consultation with a primary care clinician (practice nurse or GP) to complete a review of the management of the LTC. We report a qualitative study in which we focus on the ways in which QOF (Quality and Outcomes Framework) shapes routine review consultations, and highlight the tensions exposed between patient-centred consulting and QOF-informed LTC management.

Methods: A longitudinal qualitative study. We audio-recorded consultations of primary care practitioners with patients with LTCs. We then interviewed both patients and practitioners using tape-assisted recall. Patient participants were followed for three months during which the research team made weekly contact and invited them to complete weekly logs about their health service use. A second interview at three months was conducted with patients. Analysis of the data sets used an integrative framework approach.

Results: Practitioners view consultations as a means of ‘surveillance’ of patients. Patients present themselves, often passively, to the practitioner for scrutiny, but leave the consultation with unmet biomedical, informational and emotional needs. Patients perceived review consultations as insignificant and irrelevant to the daily management of their LTC and future healthcare needs. Two deviant cases, where the requirements of the ‘review’ were subsumed to meet the patient’s needs, focused on cancer and bereavement.

Conclusions: Routine review consultations in primary care focus on the biomedical agenda set by QOF where the practitioner is the expert, and the patient agenda unheard. Review consultations shape patients’ expectations of future care and socialize patients into becoming passive subjects of ‘surveillance’. Patient needs outside the narrow protocol of the review are made invisible by the process of review except in extreme cases such as anticipating death and bereavement. We suggest how these constraints might be overcome.

Keywords: Primary care, Long-term conditions, Quality and Outcomes Framework (QOF), Consultations, Longitudinal qualitative research
“Not everything that is countable counts, and not everything that counts, is countable”

(I. Newton)
Tackling NCDs: a different approach is needed

The NCD Alliance\textsuperscript{1} 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.\textsuperscript{2} Developed, integrated and implemented in the context of integrated primary health care.\textsuperscript{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.\textsuperscript{10}
Tackling NCDs: a different approach is needed

The NCD Alliance\(^1\) 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.\(^2\)

"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 Paolo, Sao Paolo, 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)\(^3\)"
Quality of care

Efficacy

Effectiveness

Efficiency & equity

EVIDENCE

Medical

Contextual

Policy

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”
Primary Health Care and “contextual” evidence

“disease management”

“patient management”
Goal-Oriented Care: from chronic disease management to participatory patient management

1. Challenges: demographical and epidemiological transition
2. Addressing multi-morbidity
3. Being a GP in the 21st century
4. Conclusion
3. Being a GP in the 21st century

- Nano-level
- Micro-level
- Meso-level
- Macro-level
Nano-level:

The patient is the starting point of the process

- Active
- Informed
- Service delivery
- Multicultural

Accessibility
Equity
3.1. Characteristics of GP/patient encounters
4.1. Characteristics of GP/patient encounters

- Commitment - Connectedness
- C
- C
- C
- C
- C
- C
- C
3.2. Characteristics of GP/patient encounters

- Commitment - Connectedness
- Clinical Competence
- C
- C
- C
- C
- C
- C
3.2. Characteristics of GP/patient encounters

- Commitment - Connectedness
- Clinical Competence
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  - C
  - C
  - C
  - C
  - C
4.1. Characteristics of GP/patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
4.1. Characteristics of GP /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- C
- C
- C
4.1. Characteristics of GP / patient encounters

- Commitment - Connectedness
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- Comprehensiveness
- Complexity
- C
- C
4.1. Characteristics of GP / patient encounters

- Commitment - Connectedness
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- Context
- Comprehensiveness
- Complexity
- Coordination
- C
4.1. 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.

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
GUDDING PATIENTS THROUGH COMPLEXITY: MODERN MEDICAL GENERALISM

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

October 2011
• Diabetes clinic: horizontal approach to chronic conditions

• Objectives:
  – Improving the care for diabetes type 2 patients through a structured multidisciplinary follow-up and health education
  – Improve self-efficacy of patients
  – To tackle social inequalities in relation to chronic diseases
Diabetes clinic: horizontal approach to chronic conditions

- Programme:
  - biomedical and behavioural follow-up by nurse, diabetes educator, dietician and family physician, implementing guidelines in the context of the patient
  - exchange of experiences by the patients (groups)
  - “diabetes-cooking” (3 x / year)
4. Being a GP in the 21st century

- Nano-level
- Micro-level
- Meso-level
- Macro-level
Intersectoral action for health: the community

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”

Access to dental care
COPC-example: dental problems: periodontal disease in childhood

Risk factor for:

- Diabetes
- Coronary Heart Disease
- Preterm birth and low birth weight
- Osteoporosis
Identifying health problem:
Family physicians/nurses: problematic oral condition of toddlers, leading to feeding problems, crying, not sleeping,...

COPC-project: from individual care to community health care
A dentist?
I cannot afford that.

I don’t know where
to find a dentist

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

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

Focus Group sessions –
involving the community

COPC-project : DENTAL FITNESS
COPC-project: DENTAL FITNESS

Working together with…
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-Europe)
- no previous dentist consultation
Childhood caries:

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

**Strategies:**

Community oriented, intersectoral, participation.

Educational platform for students in dentistry
Accessible primary dental care

Centre for Primary Oral Health Care
Botermarkt Ledeberg (CEMOB)

Started 01/09/2006

Towards accessible oral health care!

Ghent University
The promotion of primary health care since 1978 has had a profound political impact: it forced medical educators around the world to address the health needs of all people and it spurred the global recognition of family doctors as the primary medical providers of health care in the community. Yet, on the 30th anniversary of the Alma-Ata Declaration, disillusionment with and failure to appreciate primary care’s contribution to health persist. The missing link in the translation of the principles of Alma-Ata from idealism to practical, at the expense of population health. The challenge of this balancing act is illustrated in the interchanged use of the terms “primary care”, which usually means care directed at individuals in the community, and “primary health care”, which usually means a population-directed approach to health. To simplify this discussion and to reduce confusion, we will use the term “personal care” instead of “primary care” and “community-oriented primary care” (panel) instead of “primary health care”.

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c.vanweel@hag.umcn.nl

The Lancet 2008;372:871-2
Figure 20. The partnership pentagon
4. Being a GP in the 21\textsuperscript{st} century

- Nano-level
- Micro-level
- Meso-level
- Macro-level
Figure 3.5 Primary care as a hub of coordination: networking within the community served and with outside partners. 

Specialized care
- Diabetes clinic
- TB control centre
- Community mental health unit
- Consultant support
- Referral for multi-drug resistance
- Referral for complications

Diagnostic services
- CT Scan
- Cytology lab
- Pap smears
- Environmental health lab
- Cancer screening centre
- Waste disposal inspection
- Mammography

Primary-care team: continuous, comprehensive, person-centred care
- Self-help group
- Liaison community health worker
- Other

Emergency department
- Traffic accident
- Placenta praevia
- Hernia

Hospital
- Maternity
- Surgery

Community
- Training support
- Alcoholism
- Gender violence
- Women’s shelter
- Alcoholics anonymous
- NGOs
Intersectoral action for health: city

- 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
Health council of the City of Ghent

Goals 2020:

• Partnership with all stakeholders
• Evidence-based health policy
• Intersectoral action to address health equity
• Ghent: a healthy city with healthy communities
• To strengthen impact of health promotion
• To improve mental health of citizens
• To give every child a fair start in life
• To improve access to health care
Box 2.6 Social policy in the city of Ghent, Belgium: how local authorities can support intersectoral collaboration between health and welfare organizations

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.
4. Being a GP in the 21st century

- Nano-level
- Micro-level
- Meso-level
- Macro-level
THE STRENGTH OF PRIMARY CARE IN EUROPE

Dionne Sofia Kringos
Figure 2: Overview of the primary care dimensions, features and total numbers of indicators

Framework of the European Primary Care Monitor

Dimensions of the Structure of primary care

- **Governance of PC system**
  - System goals
  - Equity in access policies
  - Collaboration policies
  - (de)Centralization
  - Quality management
  - Patient advocacy
  - Total: 12 indicators

- **Economic conditions of PC system**
  - PC expenditures
  - PC coverage
  - Employment status
  - Remuneration system
  - Income of PC workers
  - Total: 11 indicators

- **PC Workforce development**
  - Profile PC workforce
  - Professional status
  - Supply and planning
  - Academic status
  - Prof. associations
  - Total: 16 indicators

Dimensions of the Process of primary care services delivery

- **Access to PC services**
  - Density PC workforce
  - Geographic availability
  - Access at practice level
  - Affordability of services
  - Patient satisfaction
  - Total: 12 indicators

- **Comprehensiveness of PC services**
  - First contact care
  - Disease management
  - Sole GP contacts
  - Medical procedures
  - Preventive care
  - Health promotion
  - Medical equipment
  - Total: 10 indicators

- **Continuity of PC**
  - Longitudinal continuity
  - Informational continuity
  - Relational continuity
  - Total: 9 indicators

- **Coordination of PC**
  - Gatekeeping system
  - Skill mix
  - Collaboration of care
  - Public health integration
  - Total: 7 indicators

Dimensions of the Outcome of primary care

- **Quality of care**
  - Prescribing behaviour
  - Diagnosis/treatment
  - Chronic disease management
  - Maternal & Child Care
  - Preventive care
  - Total: 17 indicators

- **Efficiency of PC**
  - Home visits
  - Telephone consultations
  - Consultation duration
  - GP consultations
  - Referrals to med. specialist
  - Total: 5 indicators
Figure 1: Variation in primary care strength across Europe

Total level of primary care orientation
- low
- medium
- high
“The analysis showed that strong primary care was associated with better population health; lower rates of unnecessary hospitalizations; and relatively lower social inequality, as measured by an indicator linking education levels to self-rated health.”

(Kringos et al, Health Affairs 2013;32(4):686-694)
The strength of primary care systems
Stronger systems improve population health but require higher levels of spending

Jeannie L Haggerty associate professor¹, Jean-Frédéric Lévesque chief operating officer², William Hogg professor³, Sabrina Wong associate professor⁴

¹Department of Family Medicine, McGill University, Montreal, QC, Canada H3T 1M5; ²Bureau of Health Information, Sydney, NSW, Australia; ³CT Lamond Primary Health Care Research Centre, Bruyere Research Institute, Ottawa, ON, Canada; ⁴School of Nursing, University of British Columbia, Vancouver, BC, Canada
A mountain of evidence shows that low socioeconomic status is one of the highest risk factors in those presenting to primary care. It is therefore possible that health systems that support and value high quality clinician-patient relationships might give patients—most of whom are in a lower social class than their clinicians—an experience of respect, validation, and empowerment that translates into lower health inequality.
THE FIVE STAR DOCTOR

- assess and improve the quality of care
- make optimal use of new technologies
  - promote healthy lifestyles
- reconcile individual and community health requirements
  - work efficiently in teams
- leadership attributes and acts as change agent
Health professionals for a new century: transforming education to strengthen health systems in an interdependent world

Julio Frenk, Lincoln Chen, Zulfiqar A Bhutta, Jordan Cohen, Nigel Crisp, Timothy Evans, Harvey Fineberg, Patricia Garcia, Yang Ke, Patrick Kelley, Barry Kistnasamy, Afaf Meleis, David Naylor, Ariel Pablos-Mendez, Srinath Reddy, Susan Scrimshaw, Jaime Sepulveda, David Serwadda, Huda Zurayk
Figure 11: Vision for a new era of professional education
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informative</td>
<td>Information, skills</td>
</tr>
<tr>
<td>Formative</td>
<td>Socialisation, values</td>
</tr>
<tr>
<td>Transformative</td>
<td>Leadership attributes</td>
</tr>
</tbody>
</table>

*Table 3: Levels of learning*
### Management versus Leadership

<table>
<thead>
<tr>
<th>Management</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and budgetting</td>
<td>Establishing direction</td>
</tr>
<tr>
<td>Organizing and staffing</td>
<td>Aligning people</td>
</tr>
<tr>
<td>Controlling and problem solving</td>
<td>Motivating and inspiring</td>
</tr>
</tbody>
</table>

*Source: J.P. Kotter. A force for change: How leadership differs from management (1990)*
Goal-Oriented Care: from chronic disaese management to participatory patient management

1. Challenges: demographical and epidemiological transition
2. Adressing multi-morbidity
3. Being a GP in the 21st century
4. Conclusion
Why this Forum?

- Dissemination of expertise and knowledge on Primary Care systems
- Support to members for implementation
- To show the key principles of the World Health Report 2008: “Primary Health Care Now More Than Ever”!!
  - universal coverage (focus of the WHR 2010)
  - service delivery
  - public policy
  - leadership
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 Health Care in Europe

Barcelona 2014 September
1/2
Website: www.euprimarycare.org

Tel: +31 30 272 96 11

E-mail: info@euprimarycare.org
Improving health and primary health care around the world through Community Health Centres

Learn more at: www.ifchc2013.org
The core goals of the IFCHC are

• to foster global collaboration in community-oriented primary health care and

• to expand access to Community Health Centres as the optimal way to achieve the World Health Organization’s vision for equitable access to primary health care for all.
Global Partners

- **Canadian Association of Community Health Centres**
  - Twitter: @CACHC_ACCSC

- **Community Health Australia**
  - Twitter: @CHCAustralia

- **European Forum for Primary Care**
  - Twitter: @PrimaryCare4um

- **US National Association of Community Health Centers**
  - Twitter: @NACHC
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
The way forward: health systems based on:

- Relevance
- Equity
- Quality
- Cost-effectiveness
- Sustainability
- People-centredness
- Innovation
Thank you...
jan.demaeseneer@ugent.be