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A CHARTER FOR GENERAL PRACTICE/FAMILY MEDICINE IN EUROPE

WORKING DRAFT

Discussion Document



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PRIMARY HEALTH CARE

By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.

ABSTRACT

This document is a discussion document containing an introduction to and a working draft of a proposed Charter for General Practice/Family Medicine in Europe.

Keywords

FAMILY PRACTICE
PRIMARY HEALTH CARE
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ABOUT THE CHARTER

Appropriate health care is one of the foundations of health development. In its endeavour to reorient health services towards better health the WHO Regional Office for Europe (WHO/EURO) is convinced that their potential contribution to health for all cannot take place without the active contribution of general practice, through the delivery of a wide range of integrated health care functions including health promotion, disease prevention, curative, rehabilitative and supportive care. Amid the changes underway in the health sector in a large number of Member States in the Region, general practice provides an acceptable and affordable model able to deliver good quality primary health care as proved in countries where it has a long standing development.

The Working Group on the Formulation of a Charter for General Practice in Europe, met in Utrecht, the Netherlands, on 9-11 June 1994 under the auspices of WHO/EURO and hosted by the Netherlands Institute of Primary Health Care (NIVEL). It was composed by representatives from five WHO Collaborating Centres for Primary Health Care, the International Society of General Practitioners (SIMG), and the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA). The purpose was to formulate an agreed first version of the Charter for General Practice in Europe.

The Working Group met at the end of a long preparatory process during which WHO/EURO convened a number of international meetings to analyze The Role of the General Practitioner in the CINDI Programme, Heidelberg, 11-13 April 1991; The Contribution of Family Doctors/General Practitioners to Health for All, Perugia, Italy, 22-25 May 1991; Needs Assessment in Local Areas and its Consequences for Health Care Provision, Jerusalem, 27-30 October 1991; The Development of General Practice in the Countries of Central and Eastern Europe, Benesov, Czechoslovakia, 22-25 April 1992; The Role of General Practice Settings in the Prevention and Management of the Harm done by Alcohol Use, Vienna, 19-22 October 1992; Reforms in Family Medicine or General Practice in Countries of Central and Eastern Europe, Sinaia, Romania, 25-28 October 1993, and the First Meeting of an Expert Network on Family Practice Development Strategies, Ljubljana, 26-28 January 1995. A Consultation on the Formulation of a Charter for General Practice in Europe, held in Utrecht on 20-21 March 1992, explored the practical issues involved in supporting and enhancing the development of general practice in connection with the provision of primary health care. WHO/EURO has also given support to the European Study on General Practice Task Profiles which is yielding a wealth of information relevant to this subject.

At this stage the Charter for General Practice in Europe has to be seen as a comprehensive process to develop awareness on the needs of general practice to grow towards the achievement of its goals formulated in terms of population health. Several elements are to be considered as parts of this process. First the Charter presented here, an advanced and elaborated working draft being proposed to the national and international associations and bodies of general practitioners, family doctors and primary care physicians, to policy and decision-makers, university departments and research institutions of general practice and primary health care, as a tool for reflection and debate. The debate promoted by presenting this Discussion Document should provide an opportunity to identify sources in the literature which help qualifying on scientific grounds the statements advanced here. Then the background publications referred at the end of this draft. They have been prepared to facilitate a more in-depth review of certain aspects dealt with in the Charter.

WHO/EURO expects to gather the feedback of this debate in Member States to develop the final version of the Charter for General Practice / Family Medicine in Europe. This should include what can be learnt through this informal consultative process, identifying the essentials which are applicable everywhere and leaving room for specific improvements where they are feasible.

Copenhagen, August 1995

DEBT TO PAST GENERALISTS

This Charter would not be possible without the devotion and work of many unknown medical 'generalists' existing in all countries, that have developed the technical, ethical and cultural basis of health care in Europe; which is the essential European heritage and cornerstone of the future developments.

Their work and experience, formulated recently as a growing technical, scientific and educational potential, was to be recognized and assisted to fill the gap between human rights, needs and technical application of science in the field of health.

The invaluable has to be valued and open to new opportunities of future developments.

PURPOSE OF THIS CHARTER

The purpose of this Charter is to explain and promote the central role of general practice* in the health care systems of Europe in contributing to improve the health of individuals and groups. Many European countries are facing the need for change in the ways in which health care is organized and delivered. In some countries fundamental restructuring is needed. In others, existing systems are failing to ensure all the benefits offered by a fully developed general practice service. Still in other countries family doctors want to improve their already successful and central position. Health care systems throughout Europe are being critically examined in the light of financial constraints and rising costs of health care. Available evidence shows that general practice is able to offer:

- accessible and acceptable services for patients
- equitable distribution of health care resources
- integrated and coordinated delivery of comprehensive curative, palliative and preventive services and health promotion
- rational use of secondary care technology and drugs
- increasing cost-effectiveness

This results in an effective and efficient primary care service of high quality, which should positively affect the workload and quality of specialized and hospital care.

The Charter has been developed with an appreciation of the varied nature of the systems currently operated and the problems faced by different European countries. It is designed to apply equally to those who are at an early stage in the implementation of education and training programmes to provide a first generation of family doctors, and those with established systems of general practice which could be strengthened.

The principles of general practice can be elaborated and organized in a variety of ways, depending on the country's circumstances, resources and tradition. The Charter provides information on the basis of which the most appropriate model can be implemented.

It focuses on all parties involved in health care: decision makers at different levels, financiers, planners and managers, academic institutions, various organizations of family doctors and patients and their representatives. The successful development of general practice requires not simply the willingness but the wholehearted commitment of all these persons and bodies. Such commitment must be long-term, and combined with a willingness to respond flexibly and positively to problems as they arise. Legislation and regulations have to be developed, e.g. financing, insurance schemes and payment systems have to be tailored to the principles of general practice, programmes for vocational training and continuing medical education have to be developed or adapted, family doctors have to be trained or re-trained. From the viewpoint of the population served, an effective primary care service will meet the health needs of the community, and result in a high degree of satisfaction among individual patients.

* In this Charter the term general practice refers to qualified general practice or family medicine. To avoid repeating expressions like general practice/family medicine in the text, the term general practice is used except in a few instances. Likewise, the term family doctor(s) applies to qualified general practitioner(s) and family doctor(s).

CHARACTERISTICS OF GENERAL PRACTICE

General practice can thrive in different health care systems. Despite differences in the ways those are planned, organized and managed, general practice can be characterized by the following features:

1. General

Care provided by family doctors is not limited to certain categories of the population; it is for everyone, irrespective of age, gender, social class, race or religion. It is also general in the sense that no category of complaint or health related problem is excluded.

2. Accessible

There is easy access to general practice services with a minimum of delay. This access should be ensured as well on geographical and cultural terms and not be affected by financial factors.

3. Integrated

General practice includes curative and rehabilitative care, but also health promotion and disease prevention.

4. Continuous

General practice is not limited to one particular episode of an illness, but covers the individuals' health care longitudinally over substantial periods of their life.

5. The team

To achieve all these aims the family doctor needs to be part of a well functioning multidisciplinary team.

6. Holistic

Health problems of individuals, families and the community should be considered from the physical, psychological, and social perspectives.

7. Personal

General practice is primarily person-centered, rather than disease-centered. It is based on the personal relationship between the patient and the doctor.

8. Family oriented

In general practice problems are studied in the context of the family and the individual's social network.

9. Community oriented

The patient's problems should be seen in the context of his/her life in the local community. The family doctor should be aware of the health needs of this community and should collaborate with other professionals and agencies from other sectors and with self help groups to initiate positive change to local health problems.

10. Coordinated

Although the vast majority of the health problems presented by individuals at their first contact can be dealt with by the family doctor, in other cases he or she should decide on the

appropriate referral of the patient. The results of such a referral should be communicated by the family doctor to the patient. The family doctor should inform about available services and how best to use them, and be the coordinator of all the advice and support that the patient receives.

11. Confidential

People should expect to be seen with total confidentiality by their family doctor, and that this protects the confidentiality of all the information concerning them.

12. Advocacy

Family doctors should be the patient's advocate on health matters at all times and in relationship to all other health care providers.

A balanced development of the above characteristics provides a framework for general practice to contribute to health through reducing and controlling chronic disease and disability, addressing the specific health needs of children and young people, women, elderly people and patients' groups, promoting healthier lifestyles and the improvement of the environment at local level, delivering appropriate care and supporting health development through health information and research, a variety of partnerships and high ethic standards.

CONDITIONS FOR THE DEVELOPMENT OF GENERAL PRACTICE

The conditions necessary for providing high quality primary care based on a model of general practice can be specified in a number of levels. Some are related to the structure of the health care system, others to the organization at local level. Some may be easier to realize and at an earlier stage than others. Below three different aspects are considered: structural conditions, organizational improvements and professional development.

I. STRUCTURAL CONDITIONS

1. Discrete population

In order to work in a personal, comprehensive and continuous way, family doctors need a system which facilitates a continuing relationship with a well defined group of people. A personal or family list system, for instance, strongly facilitates this relationship, and furthers continuity of care over time. A choice of doctor is a basic right of the population as is changing from one doctor to another.

2. Serving the general population

Family doctors should see children, elderly people, men and women without distinction. They must be trained to deal with the health problems of all these groups. It is unhelpful to general practice when different doctors deliver primary care to certain categories of the population only, e.g. children, women, elderly people, groups of workers.

3. Working environment

General practice is based in the community, close to the patients, with easy access. With the increasing concentration of health care providers and increases in scale, extra precaution should be taken to avoid reduction in accessibility and the threat to the personal character of

the provision of care. Administrators and doctors should find a balance between the need for efficiency and the requirements of family practice.

4. Referral system

The final consequence of the coordinating role of the family doctor is that direct access to other medical specialists should be avoided whenever possible. This will promote a cost-effective use of specialized and hospital based services. The family doctor has been trained to make a selection from the health problems presented to him or her. Only a small number of problems will have to be referred to secondary care at some stage. The appropriate referral system implies reciprocity between family doctor and other medical specialists: the family doctor must provide an appropriate referral and information must also be fed back from the specialist to him or her and the patient must also be referred back likewise.

5. Remuneration

The payment system should be well balanced to stimulate the provision of the full range of activities within the domain of general practice and to provide the structures required for its realization. The payment system can be a valuable instrument to promote high quality primary care by offering different incentives. The system may help ensuring the delivery of health promotive, curative and preventive services as well as other aspects of practice like general availability, keeping an information system, teaching tasks when appropriate, and maintaining the premises and equipment. If market elements are introduced, standards of quality should be safeguarded. The most appropriate remuneration system will be decided locally, depending on opportunities and priorities.

II. ORGANIZATIONAL IMPROVEMENT

6. Keeping patient records

Keeping systematically detailed, problem oriented and complete records of all encounters is important to maintain continuity over time, to identify episodes of illness, to create a patient history, and to coordinate care where several providers of care are involved. Systematic preventive procedures are impossible without a sound record system that enables the identification of patient groups at risk. Finally, records can be helpful in audit of care, peer review etc.

Patients records may contain highly confidential information. Patients have the right to access their own records. Information may only be exceptionally withheld from patients when it reasonable appears that it would cause them serious harms without any expectation of obvious positive effects.

7. Team work

Coordination in health care requires having a knowledge of the training of other health professionals and understanding on what and how they can contribute to the work of other health care providers. Furthermore, the cooperation between all health care providers involved in their diagnosis, treatment and care is a right of the patients. Team work is by no means a solely privilege of providers who work in shared premises. Those who work from separate offices and premises also have the opportunity to meet regularly and develop common aims and shared objectives and evaluate the achievements of these objectives

together. Team work facilitates pooling the skills and expertise of a number of health care professionals.

8. Practice organization

Family doctors need adequate housing, equipment and ancillary staff. These should respect the privacy of the patients, provide opportunities for diagnosis and treatment and facilitate accessibility. Family doctors may work alone, in groups or in health centres, but whatever the structure, the practice organization should be flexible, which among other things means providing direct help for emergency cases and an appointment system for patients with less urgent problems. Supporting services, such as X-ray and laboratory facilities, should be directly accessible to the family doctor. With respect to the 24 hours cover, family doctors should be involved in the planning and management of out-of-hours services for the population and contribute to find solutions that are feasible and acceptable to all parties involved.

III. PROFESSIONAL DEVELOPMENT

9. Education

Education for general practice has three elements: undergraduate, postgraduate vocational training and continuing medical education.

- a. A first requirement is an adequate **basic medical training**. General practice should already be an integrated part of undergraduate programmes. Medical students should be exposed to general practice to open a career choice for them.
- b. **Vocational training** must be a requirement to become a family doctor. The majority of the vocational training should be primary care oriented and based in general practice. Practices affiliated to academic departments should have a prominent role in teaching. The trainee should be offered sufficient opportunity to acquire broader skills, for instance communicating with patients, counseling and practice management. Drawing up a core content of general practice may be helpful in developing a vocational training programme.
- c. For updating skills, maintaining and improving the quality of care **Continuing Medical Education (CME)** is a prerequisite. CME programmes must be general practice oriented. Distance learning techniques may be used to reach doctors in remote areas.

10. Quality assurance

General practice should be open to evaluation. Quality assessment and improvement is essential, irrespective of the employment status of family doctors. CME can be an important instrument in quality assurance. Systems of medical auditing organized by doctors themselves and carried out in peer groups are effective. Agreed professional guidelines, as they are currently being developed in some countries, are important tools for professional development. However, since they are adapted to individual national situations they may require modification.

11. Academic departments of general practice

Recognition as an academic discipline is essential to the acceptance of general practice as a full partner in the provision of health care. Efforts must be made to establish fully funded academic departments and professors of general practice where they do not as yet exist. These

departments, with sufficient resources of all kinds, must be headed by practicing family doctors or persons with a solid background in general practice and appropriate academic credibility, and supported by their peers. They should be continually involved in clinical general practice.

12. Research

An academic discipline cannot be created in a vacuum. It needs a scientific basis to create its own body of knowledge. Departments of general practice should not only concentrate on training and education but also on research. Vocational training programmes should make future family doctors research-minded. There should be opportunities for trainees to carry out research in the vocational training programme. General practice research should be carried out in practices affiliated to academic departments. Motivation for research will increase if research topics are relevant to the daily work of the family doctor.

13. Professional organization

From the earlier mentioned conditions it can be concluded that the profession of general practice needs an effective organization to identify professional needs and promote professional development at national and international level and to support local initiatives. The two functions, 'political' and 'academic', are usually separately organized, although a single organization combining both functions is possible. It is vital that family doctors are represented at the highest levels in all the relevant medical decision making bodies.

STRATEGIES FOR THE DEVELOPMENT OF GENERAL PRACTICE

THE STARTING POINT

There are huge differences between the countries in the European Region with regard to the fulfillment of the conditions mentioned in the previous chapters of this Charter. Some countries can rely on a history of decades of improving the position of general practice, while others have just started. Especially for these last mentioned countries it is useful to have some indication how and where to start to implement the recommendations of this Charter. Some of the conditions are easier to implement than others.

OPPORTUNITIES FROM WITHIN THE PROFESSION

Achieving some of the professional conditions may be considered as a suitable starting point of implementation. Irrespective of the specific structure of a health care system the creation of an association for the improvement of the position of family doctors and of a College for the promotion of the content and the quality of their professional activities is an important first step in the development of general practice. The College can act as a pressure group influencing the universities and both organizations can be focal points for those devoted to the improvement of their profession. The link between the creation of professional organizations and post graduate education is quite clear; proposals on the content of a undergraduate and postgraduate curriculum can be initiated by these organizations. The vicious circle of low professional esteem, low support from the population, low social rewards and strong competition with other medical specialists can be stopped if motivated general practitioners organize themselves in order to improve the quality of their work and the conditions of their work situation.

THE ROLE OF DECISION-MAKERS

Without support from outside the profession it may be difficult to implement the development of general practice. For the fulfillment of various conditions an active support of policy- and decision makers, politicians and the general public is needed. Policy- and decision-makers should be sensitive to valid claims of cost-effectiveness, politicians and the general public by equitable, accessible and comprehensive care.

Implementation of general practice requires appropriate legislation and regulations. For instance, access to secondary care has to be regulated in order to avoid competition between family doctors and other medical specialists, which may present a threat to the proposed system. The current attitude of the population in various countries, which associates quality of care with highly specialized services will need re-education.

It seems to be more feasible not to start with a large scale operation. The training of family doctors takes time. Furthermore the possibilities of initiating a pilot project prior to full implementation of a programme will provide the opportunity to correct mistakes without long-term consequences.

PROPOSAL FOR A RESOLUTION

Aware of the changing demographic and epidemiological patterns characterizing the population of the European Region, and the ensuing progressive increase of the proportion of elderly people, persons affected by chronic, multiple physical and behavioural health problems, and several forms of disability;

Taking into account the effects of profound social and political changes in the countries of the European Region on their populations' health and health care needs;

Aware that increasing specialization and technology may easily lead to fragmentation of health care, which represents a threat to integration and coordination;

Recognizing that lack of coordination of health services may result in ineffective and inefficient use of resources and patient dissatisfaction because care is not always provided by the most appropriate health care provider;

Considering that the provision of appropriate care requires an adequate recognition and selection of health problems at the point where these problems are first presented;

Concerned that at that stage problems are often undifferentiated and consist of physical, emotional and social elements, and that unnecessary somatisation and medicalisation should be avoided;

Recognizing that the ability to select these health problems is based on knowledge of relevant physical, psychological and social components and their interactions;

Acknowledging that this skill also implies a thorough understanding of the individuals' family and of the local community and its prevailing health values and needs;

Aware that the first encounter with health-related problems requires adequate referrals and collaboration between various providers of health and social services as well as knowledge of other relevant services available in the community;

Considering that it is vital that members of a community are involved in their own health care;

Aware that the Health for all policy for Europe recommend that health care systems should be founded on primary health care;

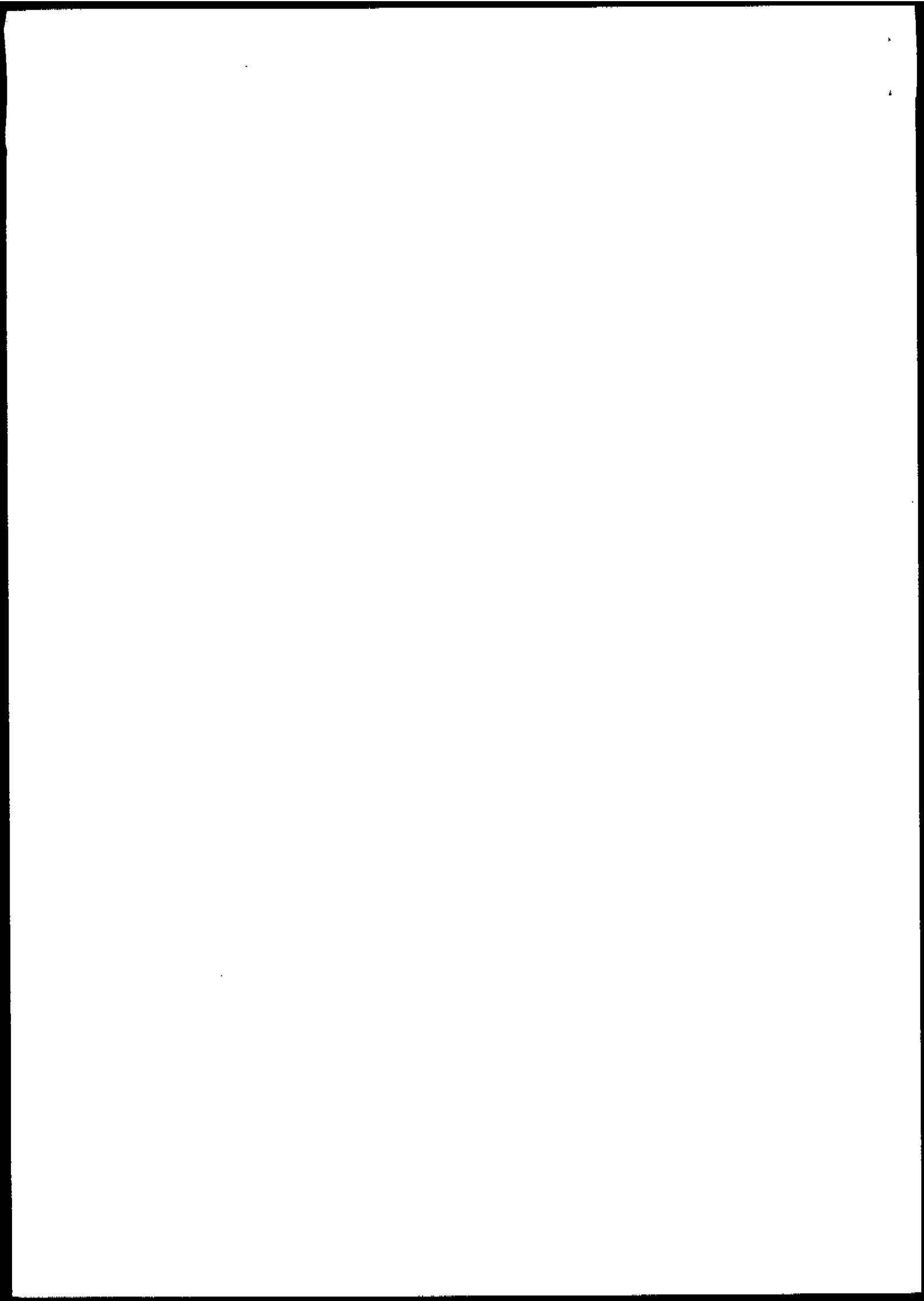
Considering specially Target 28 statement that the provision of a wide range of health promotive, curative, rehabilitative and supportive services should be reached *inter alia* by ensuring adequate numbers of appropriately qualified family health physicians and nurses for the primary health care services;

Member States are URGED

(1) to acknowledge the proven potential of general practice/family medicine to provide comprehensive care, at the interface of informal and formal care and in the context of primary health care;

(2) to review, within the context of the organization and reform of their health care systems, the specific contribution of general practice/family medicine to health improvement of the population;

(3) to promote and support the required conditions for the development of general practice/family medicine along the lines presented in this Charter.



Background publications

The role of general practice in primary health care
Wienke Boerma and Douglas Fleming (Under preparation)

The opinions of the decision-makers concerning general practice and general practitioners in nine European countries, by Pertti Kekki. University of Helsinki, 1994

Potential contributions of general practitioners to health for all: a discussion paper.
WHO/EURO (Under preparation)

All comments and suggestions for improvement of this Charter are welcome.
Please address them to:

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