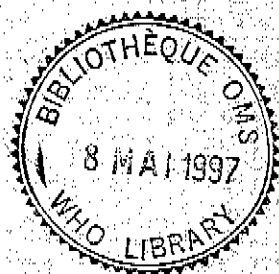




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FAMILY PRACTICE DEVELOPMENT STRATEGIES

Report on the second WHO Meeting of
the Expert Network

Warsaw, Poland
23-25 October 1995

TARGET 28

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

Regulations governing health care delivery are changing; accountability for the cost of services and their effectiveness is increasing while expectations of and demands from users are growing. These and other factors are influencing the manner in which primary health care is delivered today. Qualified family practice, as the basis for first contact with the health care system is the preferred model in many countries of the European Region. However, the challenge of how to adequately train for family practice is still to be met. While the first WHO Meeting of the Expert network on Family Practice Development (Ljubljana, 26-28 January 1995) defined retraining of PHC-based health care professionals as a fundamental strategy for the development of family practice in CCEE, the aim of this second meeting was to review the current situation and experience of different European countries in implementing this strategy as well as existing recommendations to further develop family practice in general, and retrain in particular. The Network seeks to bring to the attention of European governments, universities, general practitioner associations and relevant bodies of the European Union, the issues of current and future concern in the field. Integration of the newly qualified family physician into health care systems today will demand the careful attention of the Network during 1996-1997.

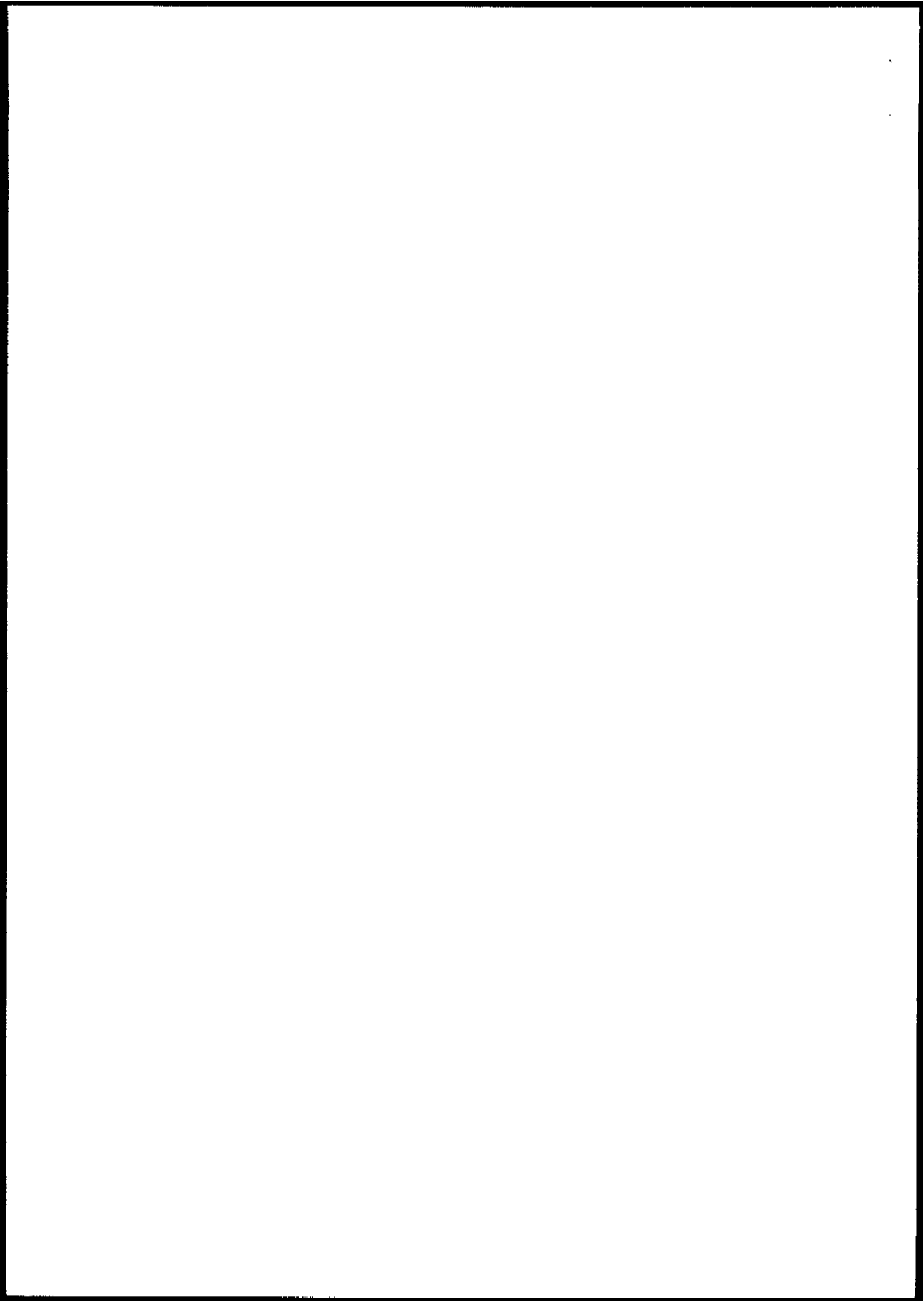
Keywords

PRIMARY HEALTH CARE
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1. INTRODUCTION

As rules and mechanisms governing health care delivery are changing, accountability for the cost of services and their effectiveness is increasing while expectations and demands from its users are growing. These and other factors are consistently influencing the manner in which primary health care is delivered.

Qualified general medical practice (family practice) as the basis of first contact to the health care system is the model preferred today in many countries of the European Region. How to adequately train family doctors is unclear. This challenge coincides with the urgent need to retrain established medical practitioners to deliver a broad range of health care functions.

The Second WHO Meeting of the Expert Network on Family Practice Development Strategies was convened by the WHO Regional Office for Europe (WHO/EURO) in collaboration with the Ministry of Health of Poland to look at strategies for developing family practice. A group of 29 experts (from 13 countries; see Annex 2 - List of Participants) having strong background in education as well as having been involved in the process of primary health care (PHC) development in their respective countries, met in Warsaw, from 23-25 October 1995.

The Director of the Department of Science, Education and International Relations, Ministry of Health of Poland, Professor Aleksander Waslutynski, opened the meeting and an official welcome was extended to the network members and observers by Dr Wieslaw Jaszczynski, Deputy Minister of Health of Poland.

Dr Josep Goicoechea, the WHO Regional Adviser for Primary Health Care at the time, presented the Scope and Purpose of the meeting, highlighting the key role of the Charter for General Practice/Family Medicine in Europe and the need for its further development.

Dr Jacek Putz from Poland was appointed as Vice-Chairman for the Meeting while several participants were selected to chair the individual sessions.

1.1 Objectives of the meeting

While the First WHO Meeting of the Expert Network on Family Practice Development (Ljubljana, 26-28 January 1995) defined retraining of primary health care (PHC) physicians as a fundamental strategy for the development of family medicine in Central and Eastern European Countries (CCEE), the aim of this second meeting was to review the current situation and experiences of different European countries in implementing this strategy and to refine recommendations for future development.

Thus, the goals of this meeting were to:

- present useful experiences in selected European countries on retraining of non-qualified general practitioners as qualified family practitioners;
- define educational objectives for retraining in the Network countries;

- map out the skills required of family doctors in using clinical outcome indicators in their current practice, including the educational means to develop these skills; and
 - become better acquainted with developments in the field in the host country, Poland
- (see Annex 1, Programme).

2. RETRAINING OF PHYSICIANS INTO FAMILY DOCTORS

2.1 Core educational objectives in vocational training for general practice

Professor P. Kekki introduced his presentation by underscoring the importance of establishing proper teaching requirements based on the nature of the General Practitioner's work (i.e. skills, competencies, attitudes). Goals of vocational training in family medicine could be divided into four categories:

- I. Medical professional knowledge and skills;
- II. Social skills;
- III. Research and self-development; and
- IV. Administration.

It was important to strike the correct balance between the hospital and the general practice settings in vocational training. Well designed theoretical training, national examination and teacher training programmes were other important features.

2.2 Experiences in retraining for family practice from selected European countries

Bulgaria:

There are four general practice teaching centres. As a precondition for retraining, three years of primary health care based work must be completed. The retraining programme is supported by the PHARE Project, financed by the European Union. There are two month courses for groups of 30 participants each. To date, about 500 physicians have been trained. There are plans to train a further 1200 doctors by end-1996. The total requirement for family practitioners in Bulgaria is approximately 6000, informed Dr Krassimir Koushev.

Croatia:

Dr Mladernka Vrcic-Keglevic explained that currently about 40% of general practitioners have completed vocational training. The training programme was started in 1960. Unfortunately, not all trained doctors have the possibility to work as family physicians.

Czech Republic:

The retraining programme in the Czech Republic, explained Dr Vaclav Benes, was launched in 1991. A large number of physicians have completed the training and are now specialists in family medicine. The programme is assessed as positive by both the physicians and the relevant authorities.

Estonia:

Professor H.I. Maaroo described the system of retraining for family physicians in Estonia which had started in 1991. A two year curriculum consisting of several one week sessions, are held each month. Following the two year training programme, physicians who pass the national level examination, are then recognized as qualified family physicians. 106 physicians received diplomas as family physicians at Spring 1996 while there are a further 270 physicians in training.

Hungary:

There is a requalification programme for physicians working in PHC. About 3,000 courses have been held, informed Dr Miklos Fodor. There is also a special shorter residency programme for hospital based doctors wishing to transfer to general practice. Optimistic plans have been laid for retraining of all physicians by the year 1998, although this deadline may be postponed to the year 2000, according to proposals put forward by the Hungarian College of Family Medicine.

Kyrgyzstan:

Dr Aynuva Ibrahimova explained that training in paediatrics and adult medical care is separated already at the level of basic medical education. Today, a law exists which establishes general practice for future graduates while plans for retraining of existing PHC physicians to family physicians is under discussion.

Latvia:

300 general practitioners have been trained in family practice to date. There are two ways to achieve a specialist degree in family medicine, informed Dr Andris Lasmanis. The first is a programme for young graduates while the second approach targets general practitioners working in the PHC setting for at least three years. Courses of 2-12 months duration are offered to this latter group.

Lithuania:

New basic and postgraduate curricula have been established. Retraining programmes for district pediatricians and therapists are underway. Dr Julius Kalibatas described retraining courses to last 49 weeks. There are plans to retrain as many primary health care based medical professionals as possible in family practice.

Poland:

Professor A. Sliwowski described two types of training for family physicians in Poland. The first is a three year residency training programme for young graduates while a second programme comprises 6 months of intensive courses and can be classified more as a retraining programme for physicians who have been working in PHC for over 4 years and are specialists in internal medicine, paediatrics or general medicine. This latter training programme is run in 12 Regional Training Units (RTUs) which are linked to university medical schools. Professor Sliwowski demonstrated the advantages and disadvantages of both curricula and offered that the retraining programme for PHC physicians better suited the current reality in Poland.

Portugal:

Dr Isabel Dos Santos spoke about the political and professional background for decision-making in retraining all physicians working in PHC. The development of the retraining programme in Portugal, which started in 1982 will be completed in 1996. Dr Dos Santos showed the achievements as well as the obstacles met during this process.

Romania:

Dr Adrian Restian informed that prior to 1990, training took place in hospital settings. There is no Chair in Family Medicine in Romania. A new curriculum was established after 1990, which included an additional year to be spent in the practice. Update courses for practising general physicians are also offered.

Turkey:

Dr Zerrin Baser informed that a three year specialization programme for family physicians was launched by the Ministry of Health of Turkey in 1985, applicants requiring status of a general practitioner on application to the programme. Training is hospital-based which is problematic in terms of the setting being increasingly less representative of the health problems seen at the community practice level. In 1993, the Ministry of Health initiated a curriculum study aimed to change hospital orientation towards community and primary health care.

At September 1995, there were 198 family physicians while the requirement for Turkey is 16,900* (1 physician per 3,500 population, annual doctor visit rate: 2.4). Family physicians today work in health centres, maternal and child health care centres as well as in private practices. Thirteen medical schools out of 38 have Family Practice Departments.

Slovenia:

No Department of Family Practice exists in Slovenia. Dr Igor Praznik explained, however, that several courses and workshops are offered to general practitioners.

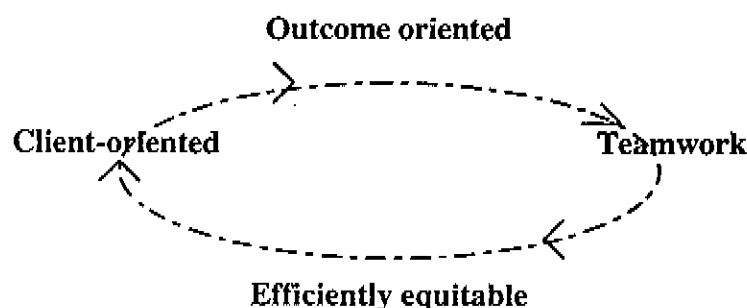
Ukraine:

Dr Eugenia Zaremba informed of near future plans for retraining through established programmes, testing, etc.

3. EDUCATION AND TRAINING NEEDS FOR USING CLINICAL OUTCOME INDICATORS IN FAMILY PRACTICE

What general practitioners need to know to use outcome indicators in their practice

Dr Joan Gené Badia presented the new paradigm for PHC in Europe. This scheme explained the relationships between the *present status, forces creating change, facilitating factors and a new paradigm.*



Dr Gené explained that this paradigm demands the use of health outcome indicators in family practice. Some outcomes were listed which could be suitable for PHC:

- I. Mortality and morbidity data (low birth weight, neonatal mortality, number of potential life expectancy years lost);
- II. Clinical outcome (proportion of diabetics with chronic complications; proportion of hypertensive patients with controlled blood pressure; hospital admission rate);
- III. Prescriptions (drug daily dosage, proportion of drugs prescribed); and
- IV. Patient satisfaction.

Dr Gené stressed that there is a need to account for final health outcomes (e.g. number of deaths) instead of earlier indicators (e.g. level of cholesterol, number of strokes). In conclusion, it was agreed that only very few valid outcomes could be identified and managed. In particular, assessment procedures must balance accessible information with data validity.

During general discussion on this presentation, Professor Restian suggested that quality of life could be a very important health care outcome to bear in mind when developing curricula. Dr Dos Santos felt that there were some limitations to the outcome-oriented approach due to the fact that this approach could be introduced in vocational teaching on the level of knowledge (competencies) but not on the level of performance.

4. GROUP WORK

Following plenary presentations and general discussion, the following pertinent questions were raised for discussion in three working groups:

- Is retraining an *appropriate* and *feasible* strategy for family practice development?

Participants were strongly of the opinion that:

- (a) Retraining primary health care specialists (e.g. pediatricians, internists, gynecologists, etc.) towards family practice is an *appropriate* strategy for the transitional period of PHC reconstruction in CCEE. This strategy would assist in creating a new professional group which would be better prepared to provide a timely response to the health needs of patients.
- (b) Since obstacles still exist (e.g. reluctance of the medical hierarchy, shortage of funds, lack of experience), retraining is a *feasible* solution from the organizational, economic and political perspectives, however, its *feasibility* strongly depends upon well designed and achievable educational objectives. A decision for retraining must be followed up by comprehensive action by all parties involved (e.g. doctors, policy-makers, funders, etc.).
- (c) Retraining is a tool to improve health care, however, if retrained doctors are sent back to work under the old working conditions, it will be a waste of funds, time and energy.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

1. Retraining for family practice has proved a valuable and feasible means of preparing physicians with different carrier backgrounds to perform the tasks and to deliver the health care functions expected of fully qualified general practitioners / family physicians.
2. Re-training programmes should be planned for a specific transitional period, but not taken as a substitute for vocational training in family practice.
3. The content of retraining programmes should be specific to the knowledge, skills and attitudes expected from family doctors - hence the need to emphasize primary health care concepts and values.
4. Retraining programmes should be flexible enough to meet the specific needs of each country and of specific groups of doctors within each country.
5. The end-product of retraining should be the same as formal vocational training for family practice. Doctors who have completed retraining should master the same skills and be awarded the same academic, technical and social recognition.
6. Although retraining is only a small component within health care reforms in CCEE/NIS, it should be considered as an urgent need in those countries.
7. For retraining to have a noticeable positive effect, other health care reform components should be undertaken, e.g. changes in legislation, financing and service organisation related to family practice.

5.2 Recommendations

Recommendations	Gvmt. (1)	Univ. (2)	GPs & Assoc (3)	Eu (4)	WHO
Retraining programmes should be enhanced to allow voluntary retraining of as many physicians as possible	X	X	X		
Retraining should be a component of university training programmes and should be provided mainly in family practice settings to allow doctors in training to maintain continuing contact with these settings.	X	X	X		
Teachers for retraining schemes should be properly trained to perform this task and have family practice background/experience. Their recruitment and training should be based on explicit criteria such as motivation, acceptability as a teacher by peers, etc.	X	X	X		
Legislation, financing and other support mechanisms to the retraining process should be ensured (this includes training the trainers, providing locum-tenens for doctors in retraining, free retraining courses amongst other incentives).	X				
Developing a philosophy and strategy on retraining for family practice is an essential step in this process, as it is to support and assist other parties involved in planning, implementing and assessing the process.			X		
Working conditions for retrained doctors should improve, to allow them to deliver their new functions and practice their new skills.	X				
Retraining programmes, as vocational training, should be a tool to raise self-esteem amongst family doctors.	X	X	X		
A framework for international cooperation, twinning programmes, further exchange of experiences and other forms of interaction should be provided.				X	X
These recommendations should be distributed amongst WHO Member States and other partners and their dissemination promoted.	X		X		X
People from other institutions than the Ministry of Health should be involved in the development of family practice.					X
Ongoing support should continue and further efforts invested to assist the development of family practice				X	

(1) Gvmt: government bodies or agencies at national, regional and local level, as appropriate (e.g. Ministry of Health, Ministry of Education, Ministry of Finance, health care administration, etc.).

(2) Univ.: Medical schools and other academic institutions and bodies, as appropriate.

(3) GPs & Assoc: general practitioners / family doctors and their associations within countries, but also physicians in general and their associations within countries, as appropriate.

(4) Eu: Relevant bodies of the EU and European associations and bodies of general practitioners / family doctors, as appropriate.

Concurrent with the above, participants formulated some recommendations to promote the development of family practice which are not directly related with retraining. They are as follows:

Recommendations	Gvmt (1)	Univ. (2)	GPs & Assoc (3)	Eu (4)	WHO
Family practice should be in the list of top priorities of all country agendas.					
Medical schools should establish a <i>numerus clausus</i> as an essential condition	X	X	X		
A Chair / Department of Family Practice should be established in all medical schools	X	X			
Recruitment of young doctors into family practice should be increased	X		X		
Training in family practice at undergraduate and post-graduate (vocational training and CME) levels should be introduced	X	X			
Scientific associations (colleges) of family doctors working in autonomy of other medical organisations should be established and open to all generalists			X		
The highest professional level for family practice should be maintained, including vocational training, retraining and continuing medical education programmes.		X	X		
Family practice among the population should be promoted and the community involved in re-establishing the role and status of family doctors, through all health programmes and projects (e.g. health promotion, disease prevention, etc.)	X				X
The Expert Network on Family Practice Development Strategies should receive continuing support.					X
Network experts should be able to establish stronger links with their respective Ministries of Health in performing their Network activities	X				X

(1) Gvmt: government bodies or agencies at national, regional and local level, as appropriate (e.g. Ministry of Health, Ministry of Education, Ministry of Finance, health care administration, etc.).

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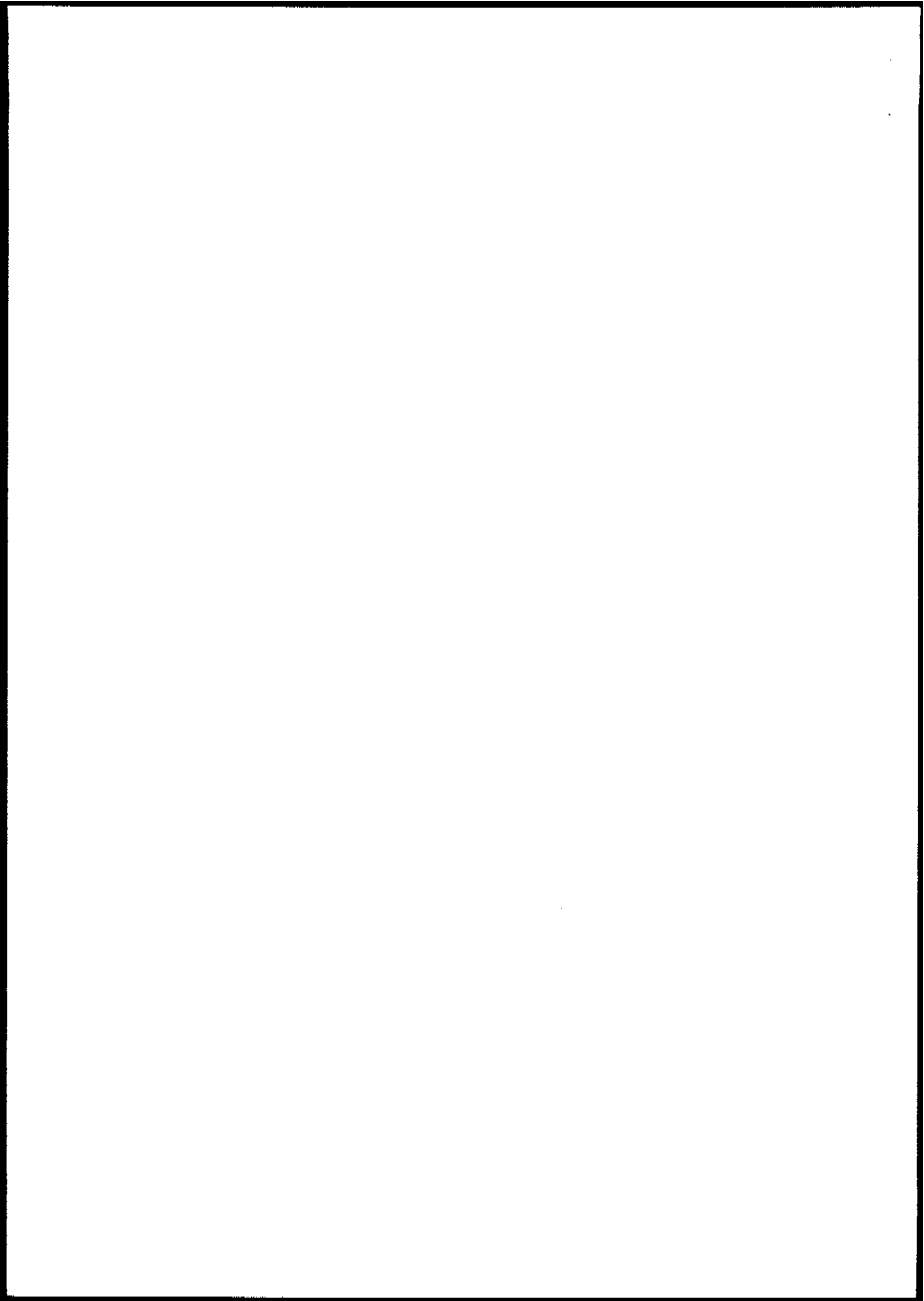
(4) Eu: Relevant bodies of the EU and European associations and bodies of general practitioners / family doctors, as appropriate.

6. EXPERT NETWORK PLANS FOR 1996/1997

Most of the participants agreed that the Expert Network on Family Practice Development Strategies should be formalized to secure its development. Furthermore, each Network member should link to other bodies such as the National Society of General Practitioners, the Ministry of Health or other organizations in their respective countries to enhance dissemination of Network information and achievements. Participants decided it would be preferable that the Network comprise independent experts rather than official representatives. This policy would secure more flexibility and would facilitate the decision-making process. Continuity of membership could bridge research in the field between countries in the European Region.

It was decided that the next meeting of the Expert Network should be devoted to the problem of integrating newly trained family physicians into existing primary health care systems in countries of the Region. Another important topic could be the development of a quality assurance system for primary health care.

Dr Zerrin Baser invited the next Expert Network meeting to be held in Turkey, while Professor Kekki and Dr Fodor offered logistic support to future undertakings of the Network.





ANNEX 1

Second Meeting of the Expert Network on
Family Practice Development Strategies

Warsaw, 23-25 October 1995

ICP/GPDV94/MT02/4

5 October 1995

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Programme

Monday, 23 October 1995

- | | |
|---------------|--|
| 08.45 - 09.15 | <u>Registration</u> |
| 09.15 - 10.30 | <u>Opening addresses and welcome</u> <ul style="list-style-type: none">• Hosting country's authorities• Dr J. Goichochea: The Network within the WHO/General Practice Project, and Scope and purpose of the meeting Introduction of participants
Nomination of meeting officers
Approval of programme |
| 10.30 - 11.00 | <i>Break</i> |
| 11.00 - 13.00 | "Educational objectives in vocational training for general practice" -
Presentation by Professor P. Kekki

"What general practitioners need to know in order to use outcome indicators in their practice" - Presentation by Dr J. Gené

"The Polish experience in general practice education" -
Presentation by Professor A. Sliwowski

General Discussion |
| 13.00 - 14.30 | <i>Lunch</i> |
| 14.30 - 16.00 | "The Portuguese experience in re-training general practitioners" -
Presentation by Dr I. Santos

"The Estonian experience in re-training general practitioners" -
Presentation by Professor H.-I. Maaros

Discussion |

Monday, 23 October (continued)

16.00 - 16.30

Break

16.30 - 18.00

Work in small groups

Re-training has been identified as a strategy for family practice development:

1. Is it appropriate?
2. Is it feasible?
3. Is there any experience in your country? Explain.
4. What would you recommend regarding re-training.

Tuesday, 24 October

09.00 - 10.30

Plenary

Presentation of groups' work:

- Summary of items 1, 2 & 4
- Country presentations by groups (item 3)

10.30 - 11.00

Break

11.00 - 13.00

General discussion

13.00 - 14.30

Lunch

14.30 - 18.00

Visit to local facilities

Wednesday, 25 October

09.00 - 10.30

Group work:

Refine recommendations for the development and implementation of re-training of general practitioners

10.30 - 11.00

Break

11.00 - 13.00

Plenary:

Elaborate agreed Expert Network recommendations

13.00 - 14.30

Lunch

Wednesday, 25 October (continued)

14.30 - 16.00

Network planning

- Scope and purpose of the Network
- Membership
- Working methods
- Review of work done
- Future plans

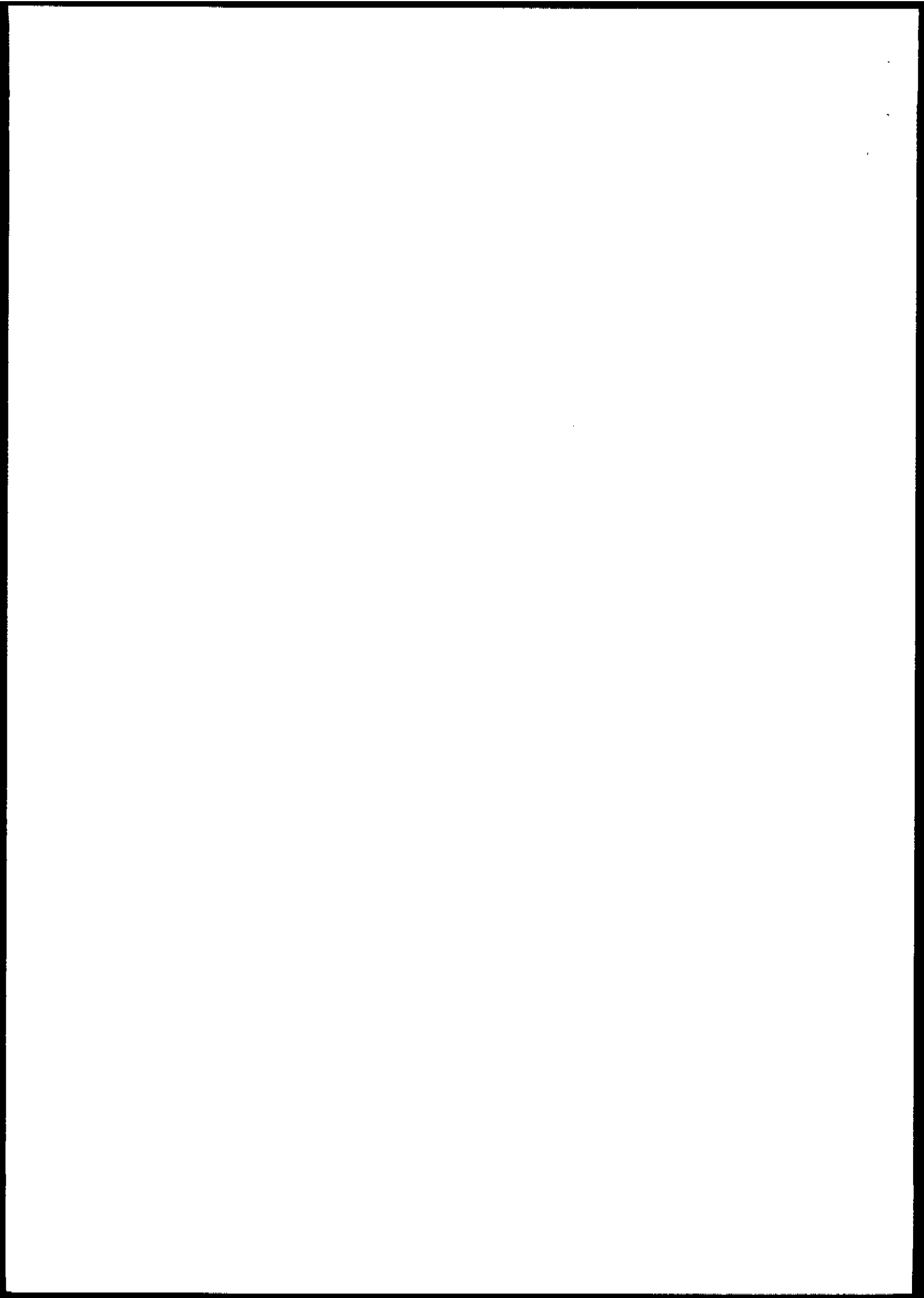
16.00 - 16.30

Break

16.30 - 18.00

Wrapping up:

- What we have learned
- Plan of work for 1996-1997
- Closure of meeting





ANNEX 2

Second Meeting of the Expert Network on Family
Practice Development Strategies

Warsaw, Poland, 23-25 October 1995

ICP/GPDV94/02/MT02/5 Rev.1

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ANNEX 3
FIELD TRIP

Visit to a local primary health care facility in the Warsaw Wola District
24 October 1995

A visit was undertaken by the participants to the Benovo District Health Ambulatory Clinic. This is a primary care setting where generalists and primary care physicians, nurses, dentists, physiotherapists and other health personnel serve a population of 30,000 people comprising mainly young families.

The premises is simple but well kept and functional. Within this public building some private services are offered (e.g. dentistry, a solarium and sauna) as part of the physiotherapy installations.

The Warsaw-Wola district comprises nearly 250 000 population and is serviced by one District Primary Health Care Unit (i.e. health centre) with 1308 employees geographically distributed throughout 23 outposts (health stations or ambulatory clinics). Health personnel comprise 90 general practitioners (2 of which are fully trained family physicians and 4 others currently in training), 80 other primary care specialists, 27 stomatologists, 64 community nurses, 59 school nurses, 34 midwives and 200 other nurses. General practitioners work on average 7 hours a day for 5 days weekly in two sessions daily of 5 and 2 hours. They see an average of 18 patients and visit 2 further patients at home. The average monthly salary, before tax, was at that time Zloty 880+13.3% for doctors, 567+11.8% for nurses, 598+17.5% for administrative personnel and 358+11.5% for other attendants (exchange rate: 1\$=2.4 Zl). As a reference, the average monthly salary before tax for public employees is 680 Zl and the minimum wage is 350Zl. Income tax accounts for about 20% of the salary.

The district health service we visited has the following structure:

A General Director assisted by a Board of Trustees in a staff position. The General Director is assisted, in a lower hierarchical position by a Chief Nurse, Deputy Director for Medical Affairs, Deputy Director for Economic Affairs, a principal bookkeeper, Personnel Manager and Counsellor (lawyer). There is narrow collaboration with the Head of the Warsaw-Wola 2000 Healthy Cities Office Information Division.

The District Health Ambulatory Clinic receives funding from the Voivodship doctor (a managerial line dependant on the Ministry of Health) as well as from contracts with private health providers (e.g. dentists) and other services (sauna, solarium, shops) located in the clinic and/or outposts. It should be mentioned that patients need to pay from their own pocket (or be privately insured) for whatever private health services they use, as there is no coverage by the public system.

In October 1995 there were 262 fully trained family doctors in Poland. One hundred new family physicians were expected to be qualified by November 1995.