

Challenges for Health Care Delivery: perspective 2030

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Family Physician (part-time), Community Health Centre ,
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Chairman European Forum for Primary Care (2005-2017)

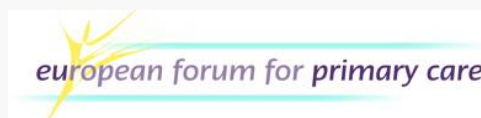
Secretary-General The Network :Towards Unity for Health (2007-2015)

Director International Centre for PHC and FM – Ghent University, Belgium

WHO-Collaborating Centre on PHC

Member Expert Panel on Effective Ways of Investing in Health (2013-today)

Barcelona, 07.02.2020



Challenges for Health Care Delivery: perspective 2030

1. Introduction
2. The changing society: 5 challenges
3. How can health systems respond?
4. Conclusion

Challenges for Health Care Delivery: perspective 2030

- 1. Introduction**
- 2. The changing society: 5 challenges**
- 3. How can health systems respond?**
- 4. Conclusion**

2. The changing society

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

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



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

Summary

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

Lancet 2012; 380: 37–43

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May 10, 2012

DOI:10.1016/S0140-

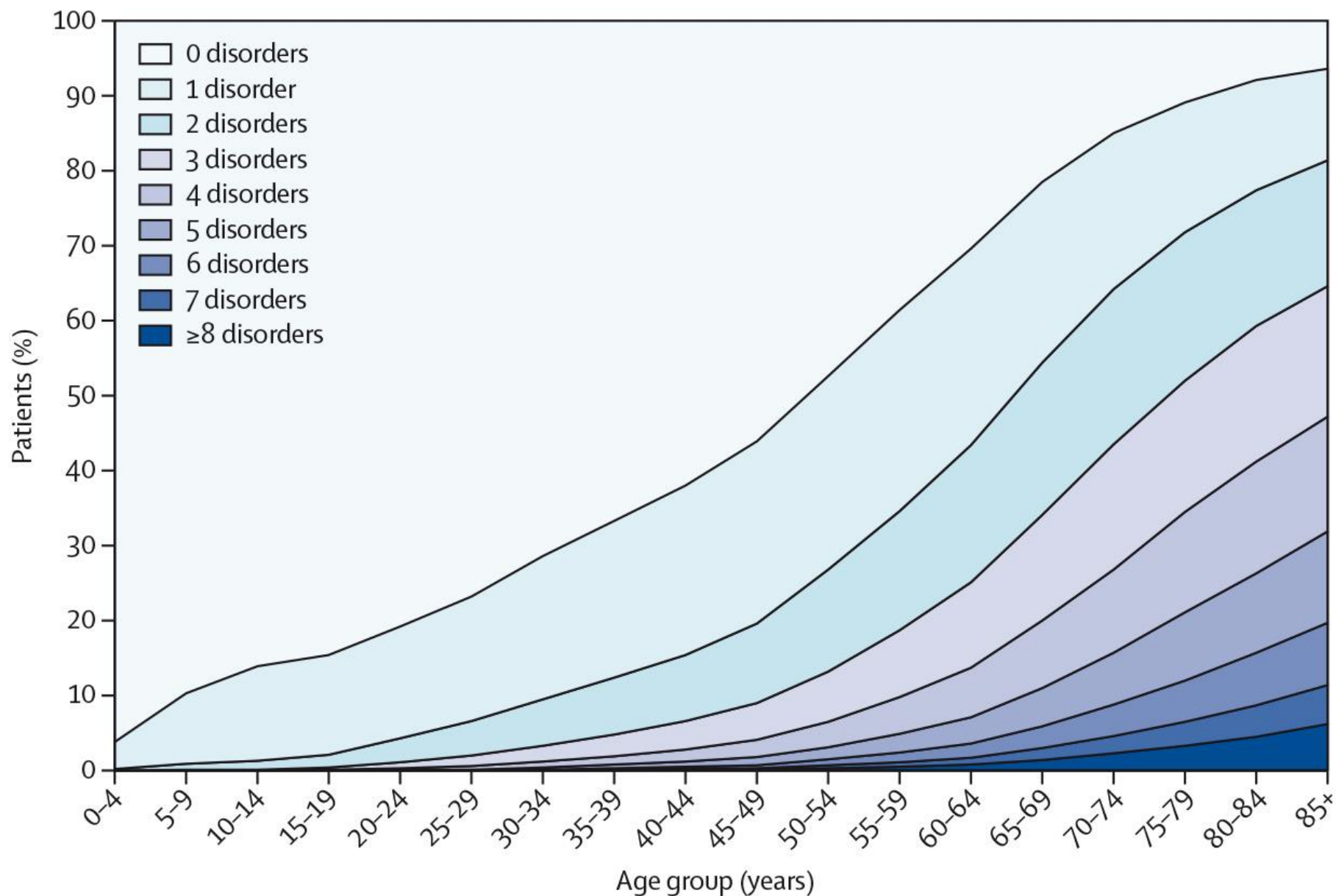


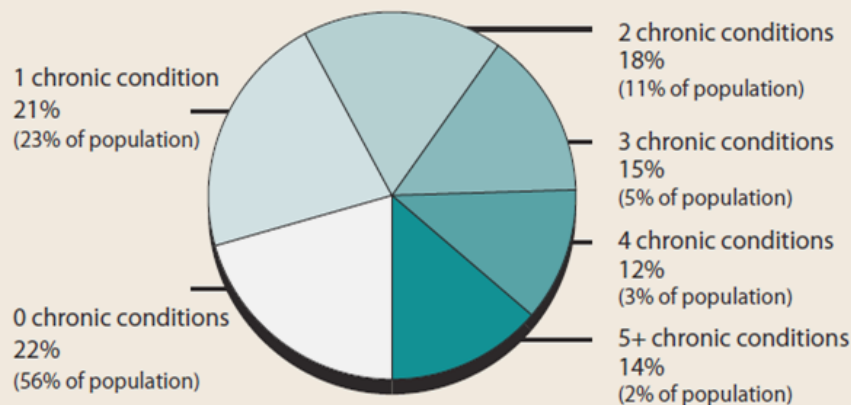
Figure 1: Number of chronic disorders by age-group

MULTIPLE CHRONIC CONDITIONS AND EXPENSES IN HEALTH CARE



More than half of health care spending is on behalf of people with multiple chronic conditions

Percent of total health care spending by number of chronic conditions*
(Percent of population)



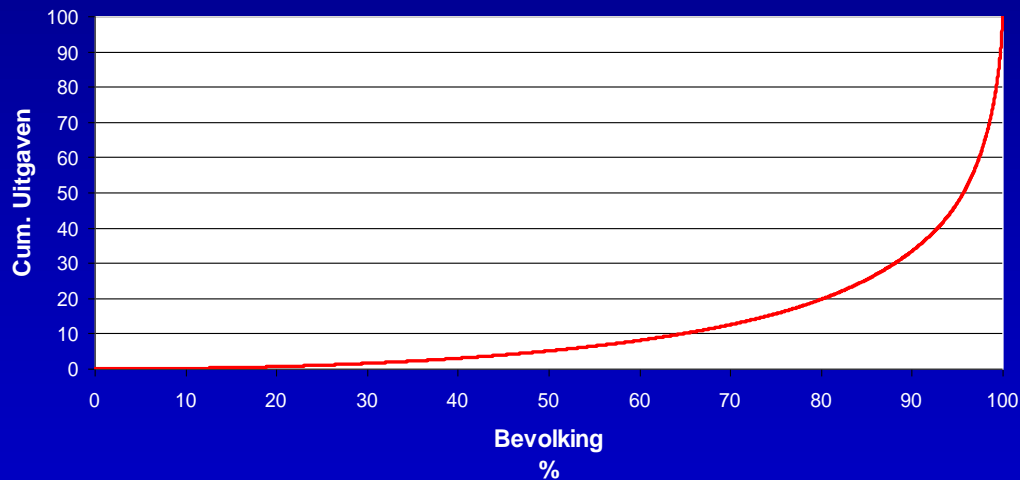
*Equal to more than 100% due to rounding.



Sipkoff M. Health Plans Begins To Address Chronic Care Management. Managed Care, 2003.

Distribution of the expenses for health care in the population

- Only a system based on a broad solidarity is able to guarantee access: Universal Health Coverage.



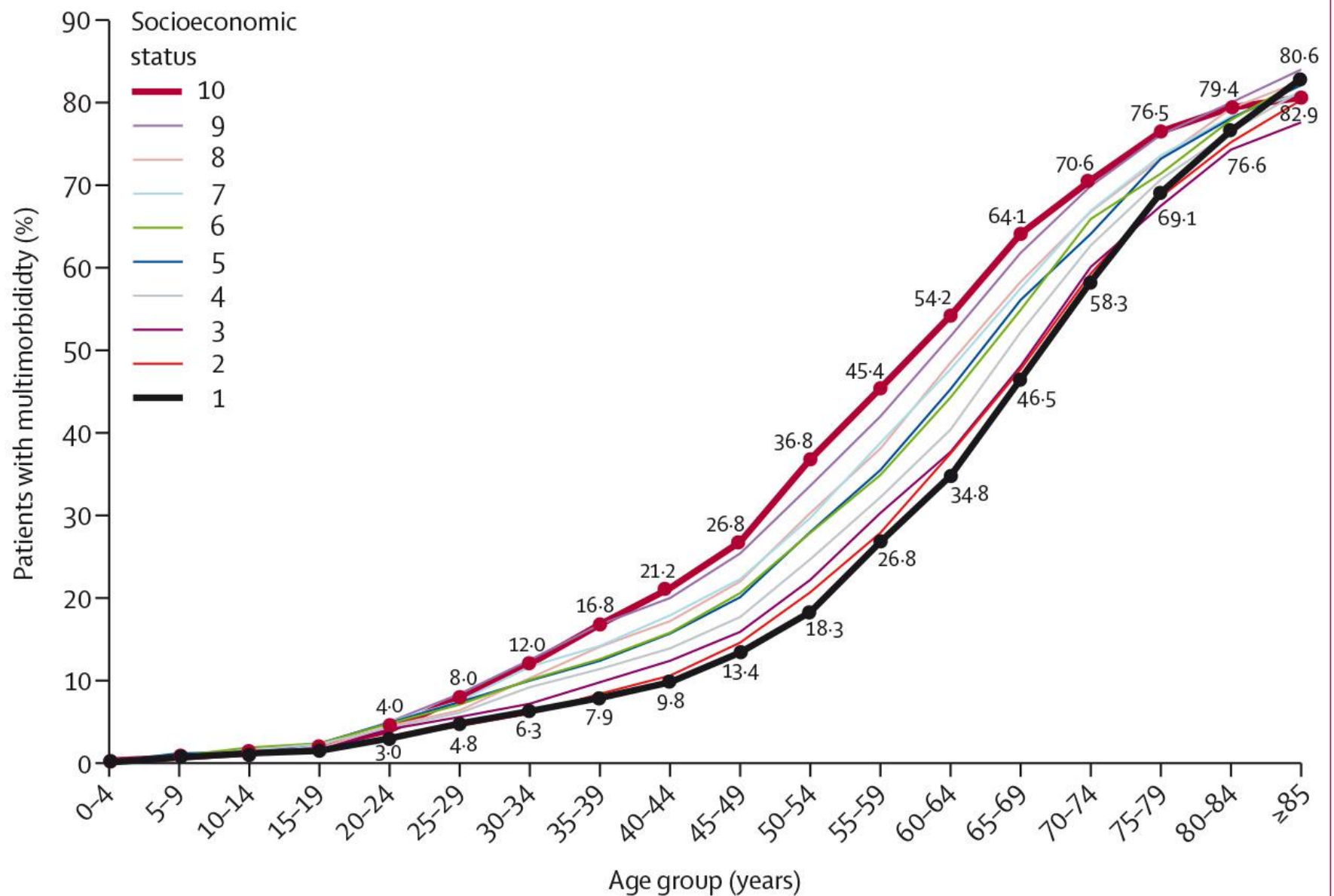


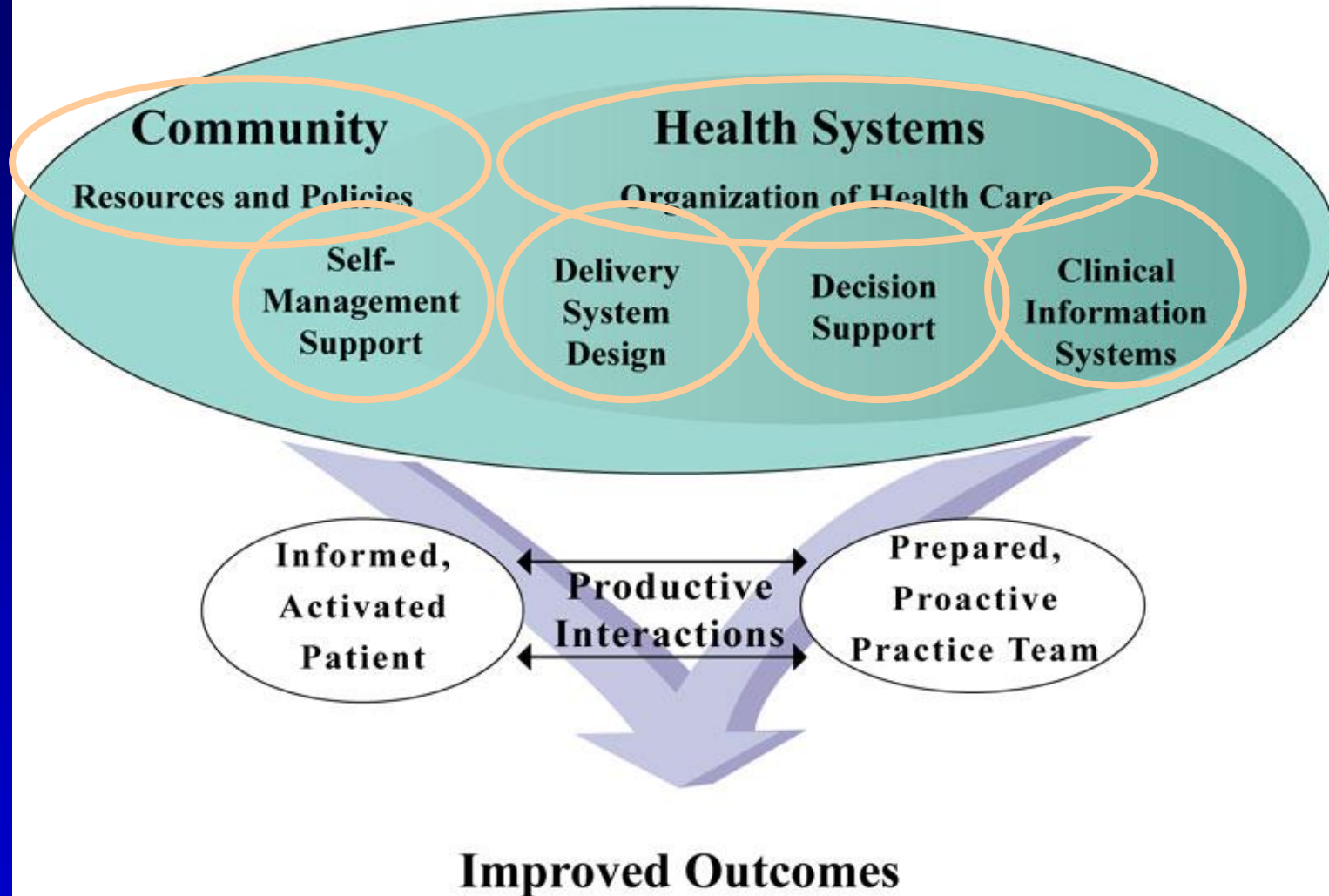
Figure 2: Prevalence of multimorbidity by age and socioeconomic status

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

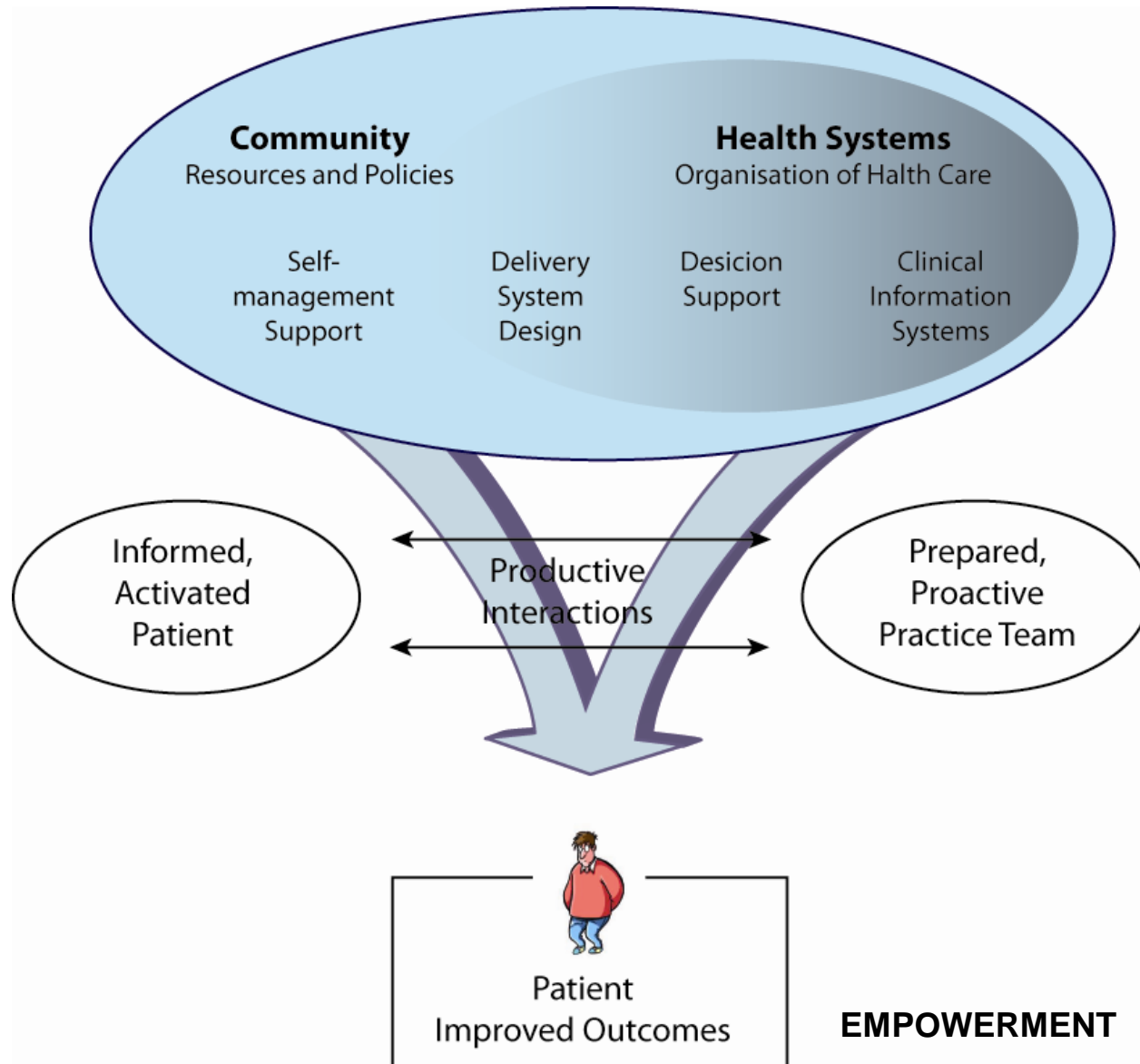


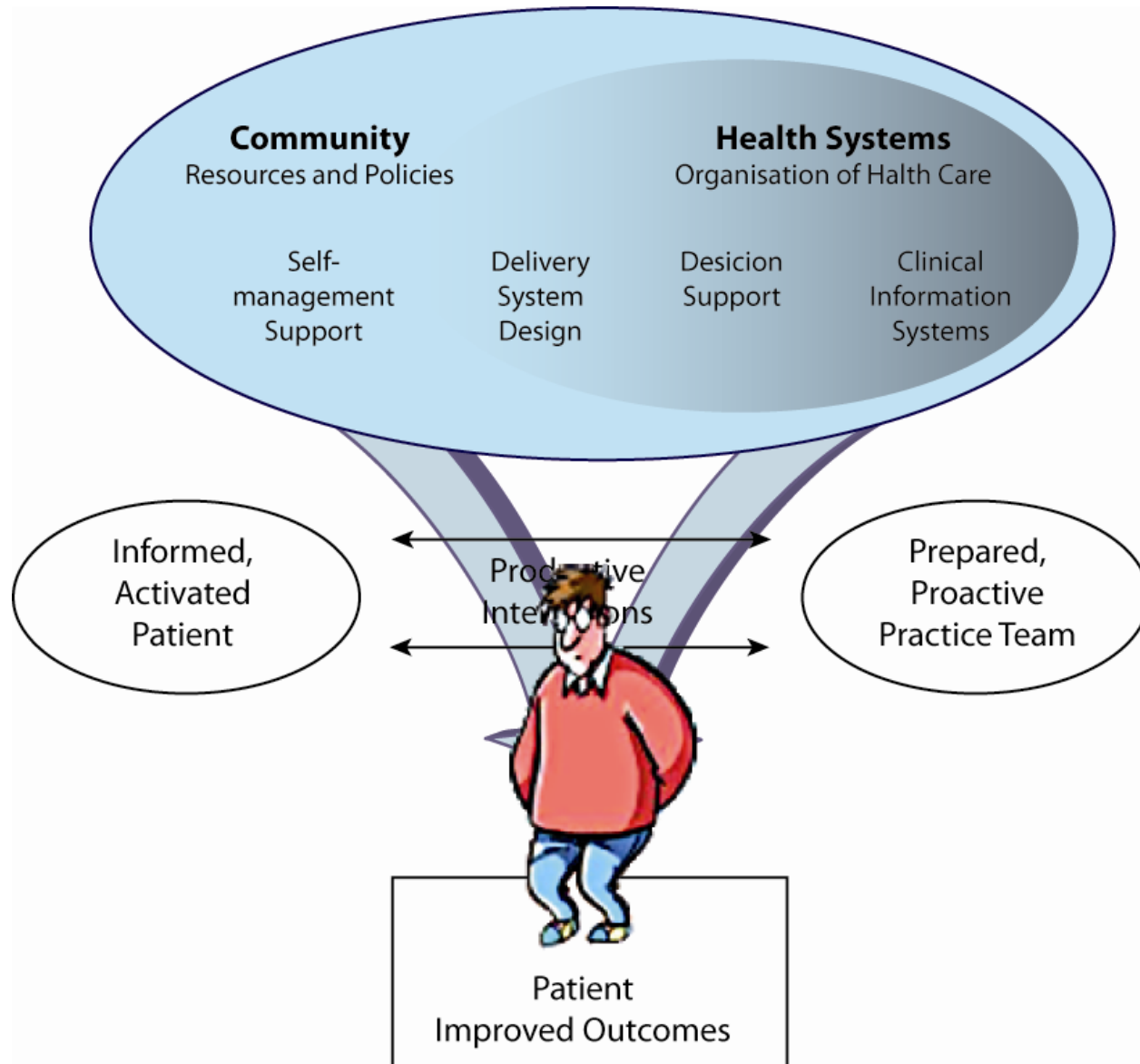
Challenges in patients with multimorbidity

The Chronic Care Model

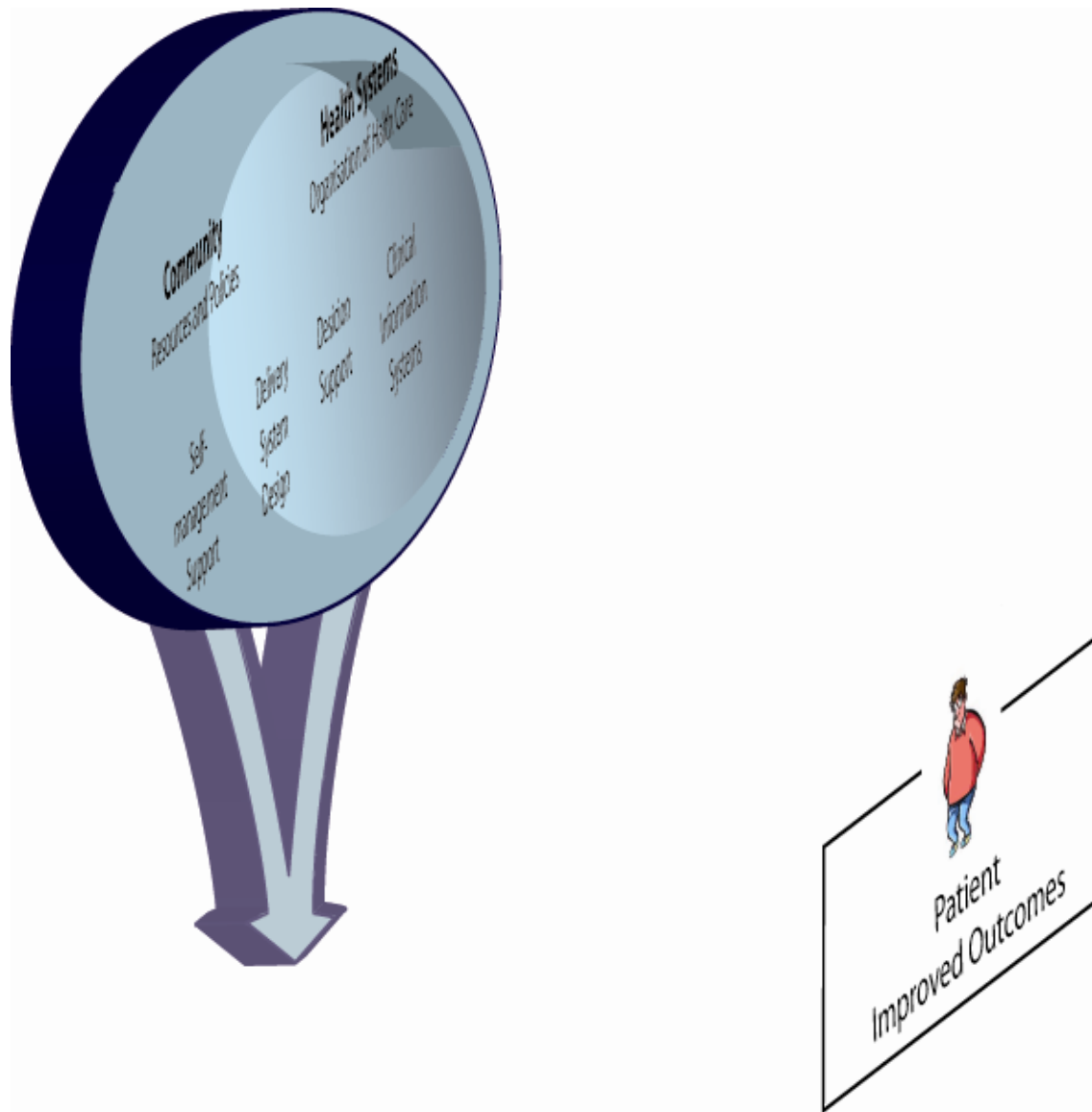


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But...



Pilar 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 Manuela. 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 Pilar 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 Pilar had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Pilar’s goals. I visit Pilar again with pleasure ever since: I know what she wants, and how much I can (merely) contribute to her life.

Sum of the guidelines

Patient tasks

- Joint protection
- Energy conservation
- Self monitoring of blood glucose
 - Exercise
- Non weight-bearing if severe foot disease is present and weight bearing for osteoporosis
- Aerobic exercise for 30 min on most days
 - Muscle strengthening
 - Range of motion
- Avoid environmental exposures that might exacerbate COPD
 - Wear appropriate footwear
 - Limit intake of alcohol
- Maintain normal body weight

Clinical tasks

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

R

- F
- Ophta
- Pul

Time	Medications
7:00 AM	Ipratropium dose inhaler Alendronate 70 mg/wk
8:00 AM	Calcium 500 mg Vit D 200 IU Lisinopril 40mg Glyburide 10mg Aspirin 81mg Metformin 850 mg Naproxen 250 mg Omeprazol 20mg
1:00 PM	Ipratropium dose inhaler Calcium 500 mg Vit D 200 IU
7:00 PM	Ipratropium dose inhaler Metformin 850 mg Calcium 500 mg Vit D 200 IU Lovastatin 40 mg Naproxen 250 mg
11:00 PM	Ipratropium dose inhaler
As needed	Albuterol dose inhaler Paracetamol 1g

Patient education

- Foot care
- Osteoarthritis
- COPD medication and delivery system training
- Diabetes



Boyd et al. JAMA, 2005

Special Article

Goal-Oriented Medical Care

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

ABSTRACT

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

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

(Fam Med 1991; 23:46-51)

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 degree to which the accurately and efficiently and appropriate medicines have been explicated those prob

This conceptual model is identifying and management of acute and chronic problems.

Debate & Analysis

James Mackenzie Lecture 2011:

multimorbidity, goal-oriented care, and equity



work in a situation of multimorbidity?

Let us illustrate this with a patient from our general practice, we call her 'Jennifer' [Box 1].

According to the actual guidelines, Jennifer is faced with a lot of tasks: joint protection, aerobic exercise, muscle strengthening, a range of motion exercising, self-monitoring of blood glucose, avoiding environmental exposure that might exacerbate COPD, wearing appropriate foot wear, limiting intake of alcohol, maintaining body weight. Her medication schedule includes 11 different drugs, with a total of 20 administrations a day. The clinical tasks for the GP include vaccination, blood pressure control at all clinical visits, evaluation of self-monitoring of blood glucose, foot

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Definition of Health	Absence of disease as defined by the health care system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual

“Problem-oriented versus goal-oriented care”

	Problem-oriented	Goal-oriented
Purposes of Health Care	Eradication of disease, prevention of death	Assistance in achieving a maximum individual health potential

“Problem-oriented versus goal-oriented care”

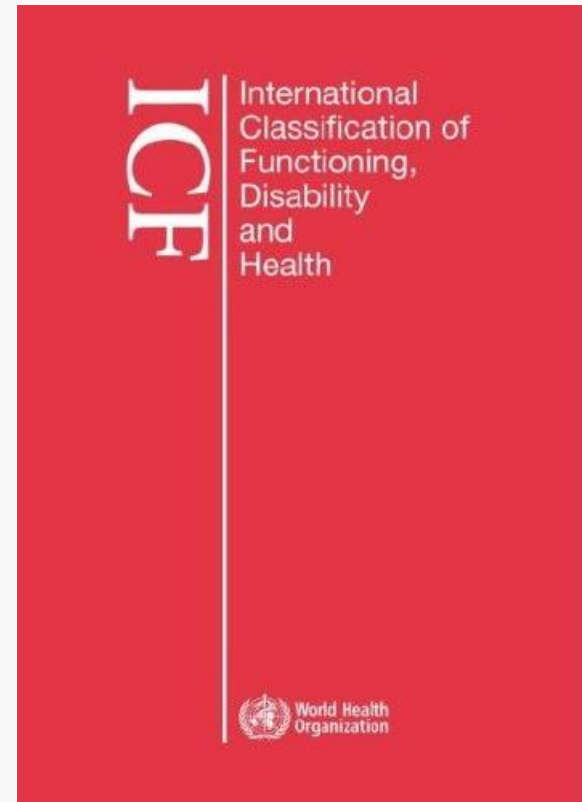
	Problem-oriented	Goal-oriented
Measures of success	Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death	Achievement of individual goals

“Problem-oriented versus goal-oriented care”

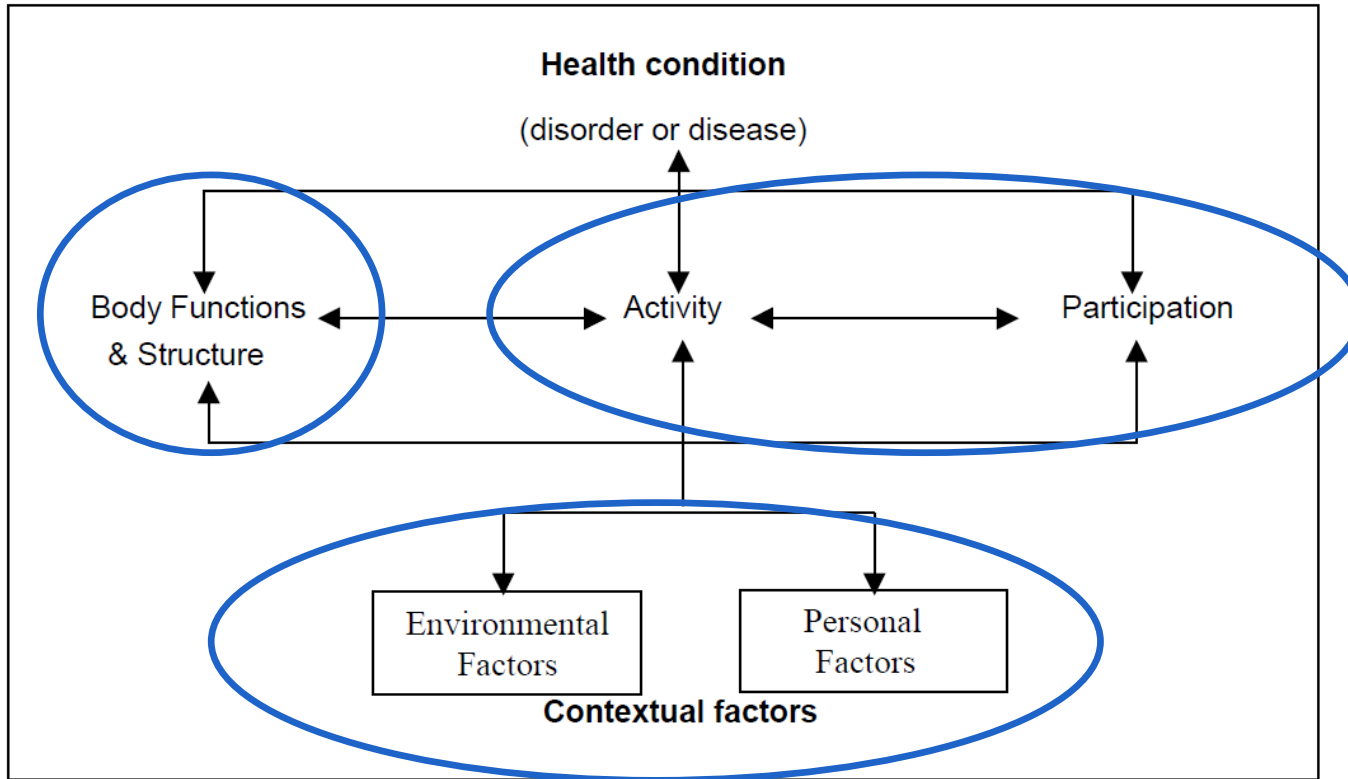
	Problem-oriented	Goal-oriented
Evaluator of success	Physician	Patient

What really matters for patients is

- Functional status
- Social participation



International Classification of Functioning

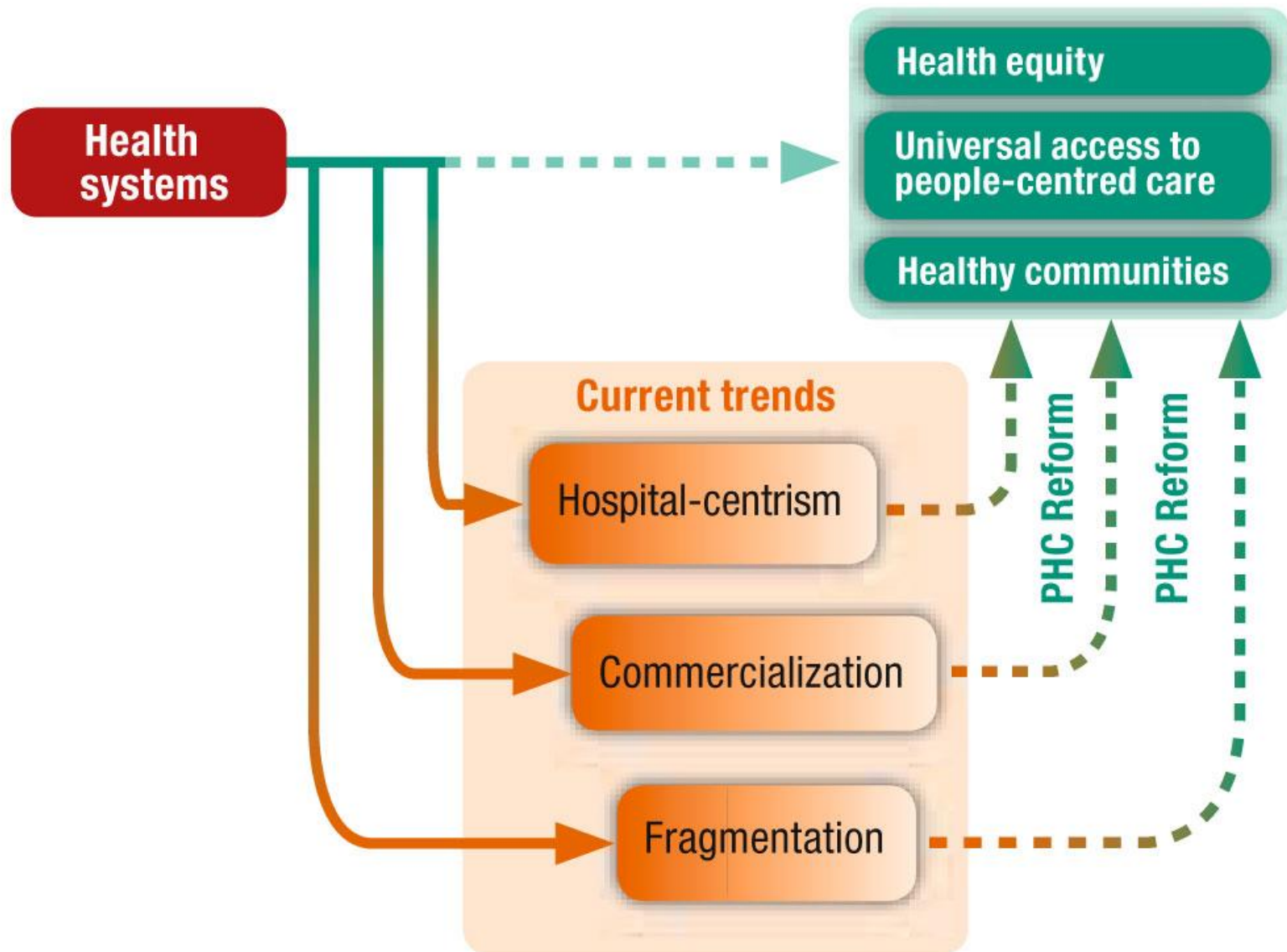


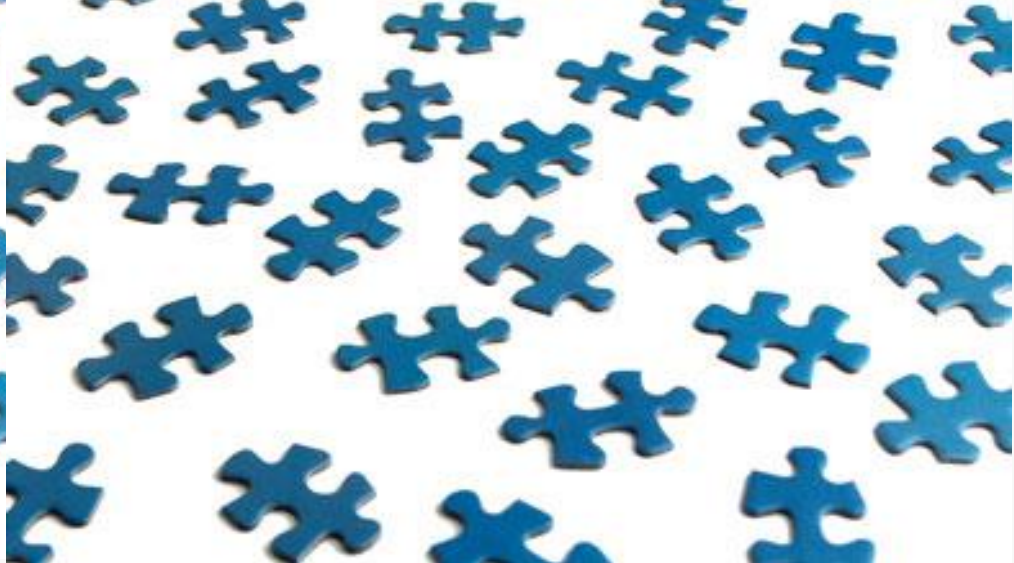
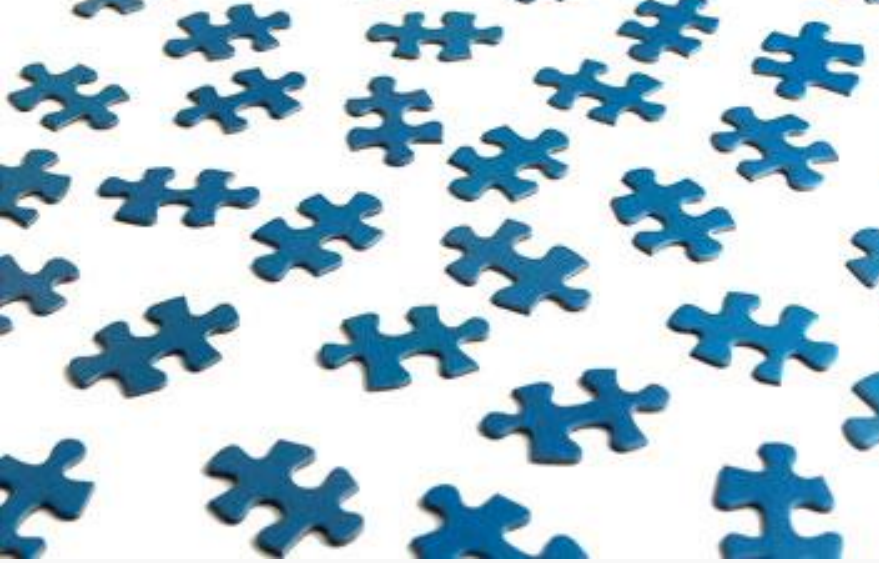
Evolution from 'Chronic Disease Management' towards 'Participatory Patient Management'

Puts the patient centrally in the process.

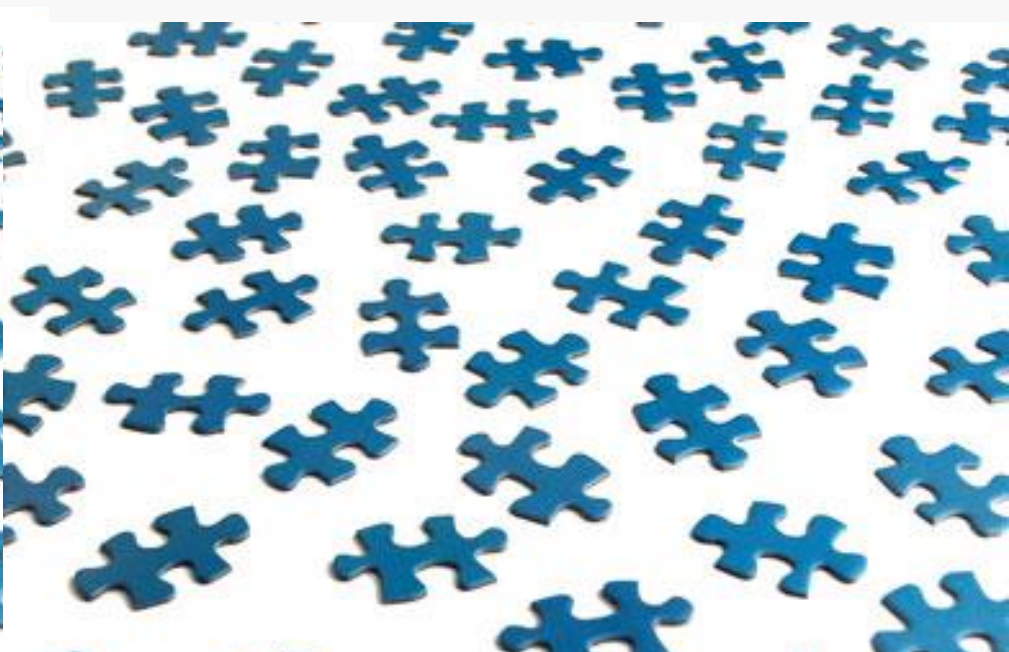
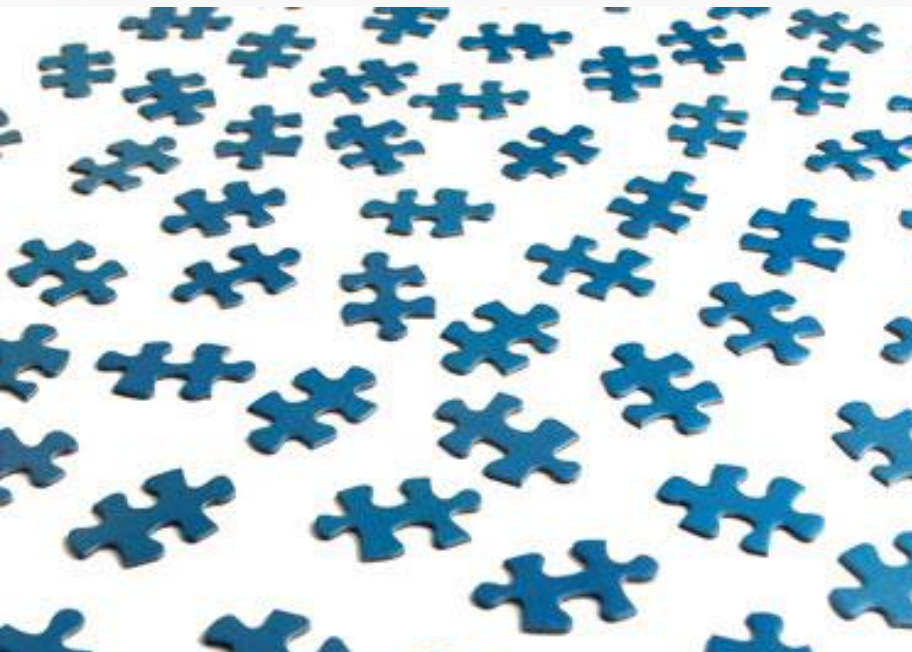
Changes the perspective from 'problem-oriented care'.
towards 'goal-oriented' care.

Figure 1.10 How health systems are diverted from PHC core values



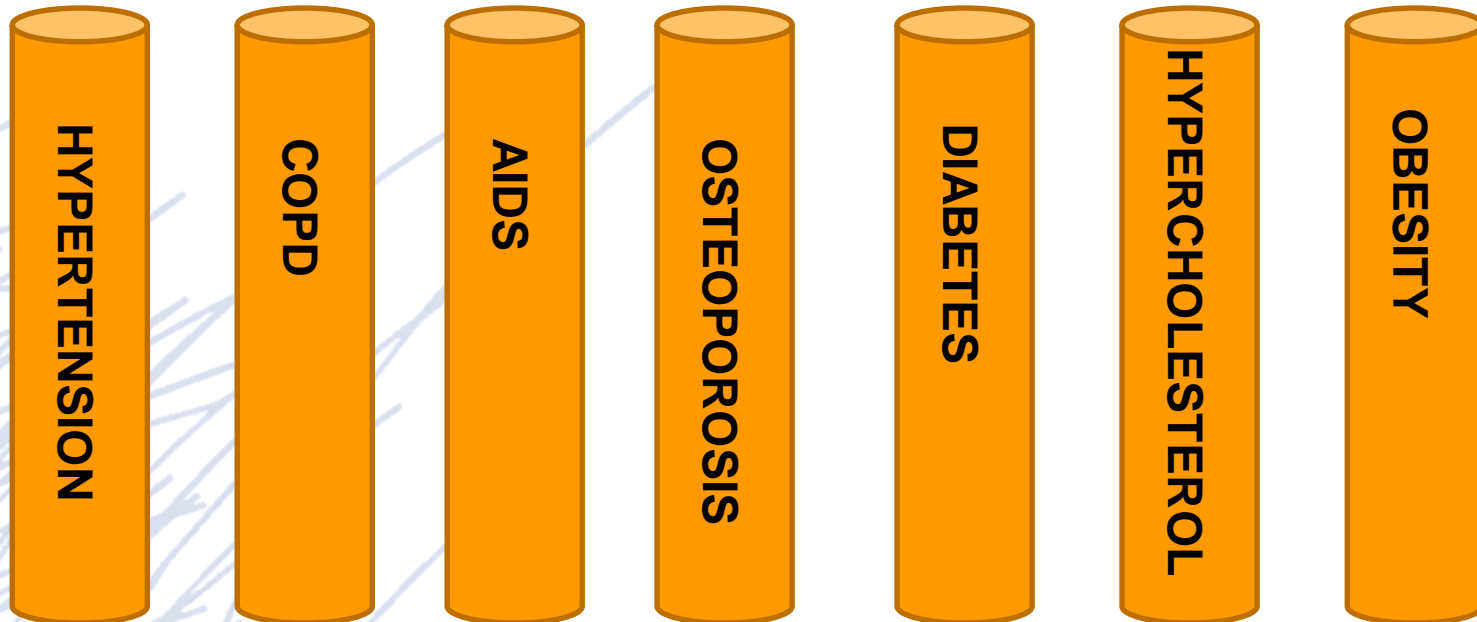


FRAGMENTATION



Vertical Disease Oriented Approach

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



The challenge: vertical disease- oriented programs and multi-morbidity

- Create duplication
- Lead to inefficient facility utilization
- May lead to gaps in patients with multiple co-morbidities
- Lead to inequity between patients

The need for a shift in chronic care: from "Chronic Disease Management" to "Participatory Patient Management".

- 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?

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

[see www.30by2030.org]

Tackling NCDs: a different approach is needed



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

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

Published Online
September 6, 2011
DOI:10.1016/S0140-
6736(11)61135-5



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.

2. The changing society

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

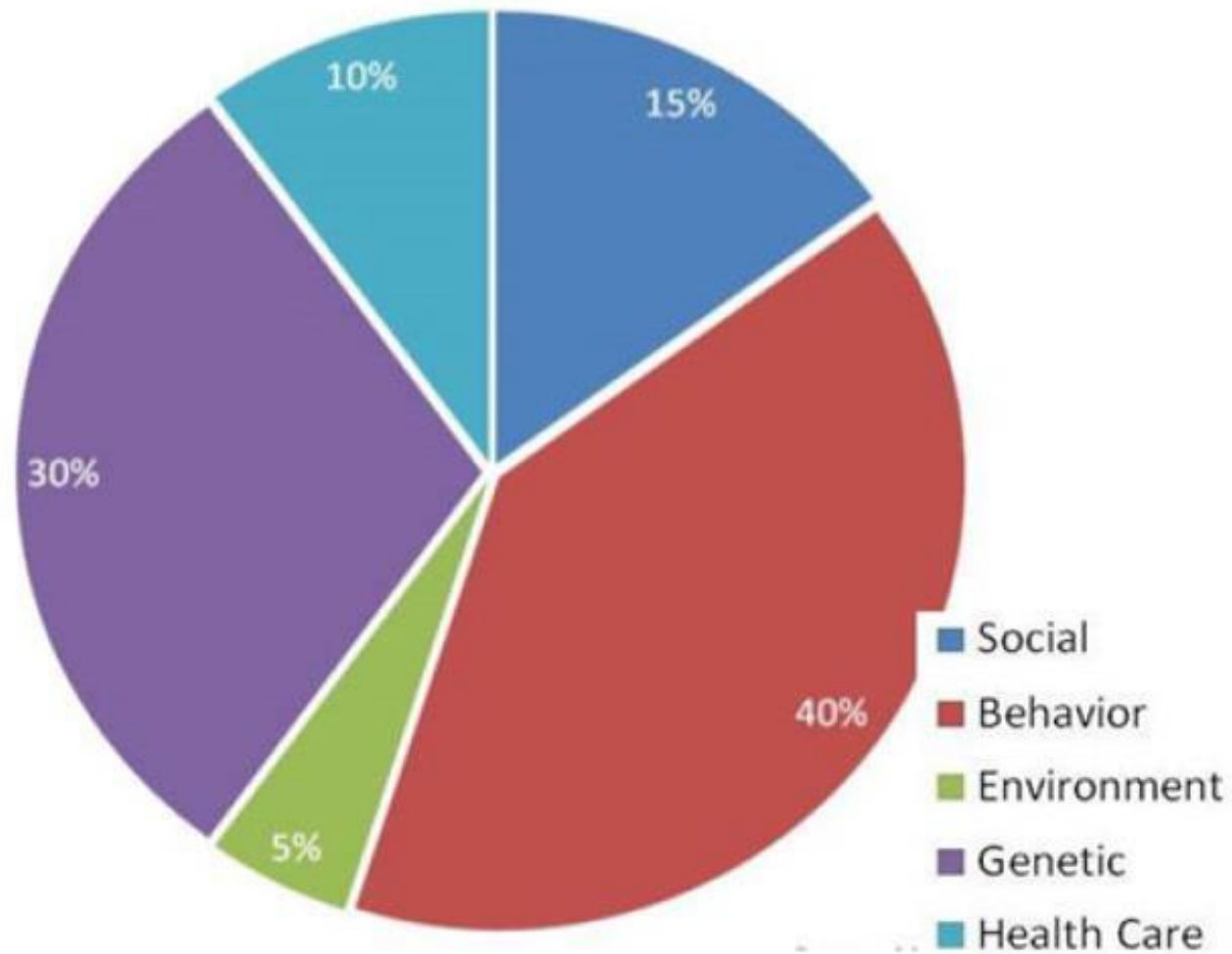


FIGURE 6-1 | Determinants of population health

SOURCE: Figure created with data from McGinnis et al., 2002

REFLECT ON THE INTERACTIONS BETWEEN THESE DETERMINANTS ?



Expert Panel on Effective Ways of Investing in Health



Provides independent non-binding advice on effective ways of investing in health

Established by Commission Decision 2012/C 198/06 following the Council conclusions of June 2011 'Towards modern, responsive and sustainable health systems'; renewed in 2017.



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

on

Disruptive Innovation

Considerations for health and health care in Europe

***What has been – from
your perspective – the
most DISRUPTIVE
INNOVATION in health
care in 2000 - 2020?***

Medisch overzicht

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

Belangrijke actieve GE

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

Familiale antecedenten

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

Medische antecedenten

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

Chirurgische antecedenten

appendectomie in 1999

Chronische medicatie

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

Vaccins

☒ Toegediende vaccins
☒ Geplande vaccins

GezondheidsElementen

Alle

AB

A

☐ ZorqE.☐ Zorgaanpakken

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

Geneesmiddelen

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

Planning

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

Contacten

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

Botermarkt

wijkgezondheidscentrum vzw

Shared Electronic Patient Record

FICTIVO, Denisa (V); Dos. N°01FICTIEF; 01/01/1964 - 50 Jaar 2 Maand(en) 17 Dag(en)

Bestand Bewerken Beeld Vensters Help

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05/09/2014	vaccin griep	Te doen	VANDEDRIK, E	I	<input checked="" type="checkbox"/>	Huisarts
05/03/2020	vaccin difterie/tetanus	Te doen	VANDEDRIK, E	I	<input checked="" type="checkbox"/>	Huisarts
	DiabetesSprekUur	Uitgevoerd	BLOKLAND, INEK	I	<input type="checkbox"/>	Huisarts

Type

Type	Presteerder	Specialiteit
Raadpleging	VANDEDRIK, E	Huisarts
Raadpleging	BLOKLAND, INEK	Huisarts
Raadpleging	VANDEDRIK, E	Huisarts
Raadpleging	VANDEDRIK, E	Huisarts
Raadpleging	DEWAELE, Liesbe	Maatschappelijk we
Raadpleging	LANCKSWEERTD, Dietiste	
Raadpleging	VANDE KERCKHO	Verpleegkundige

The paper concludes that cohesive policies and leadership across all levels of the healthcare system are needed to improve patient safety in primary and ambulatory care. The most pressing policy action is to implement an integrated information infrastructure that enables capturing safety issues as well as allowing information to flow freely between providers, patients and settings. At the practice level, patient involvement in the measurement and

OECD Health Working Paper No. 106

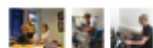
THE ECONOMICS OF PATIENT SAFETY IN PRIMARY AND AMBULATORY CARE

Flying blind

Ane Auraen*, Luke Slawomirski*, Niek Klazinga*



EUROPEAN JOURNAL OF
GENERAL PRACTICE



European Journal of General Practice



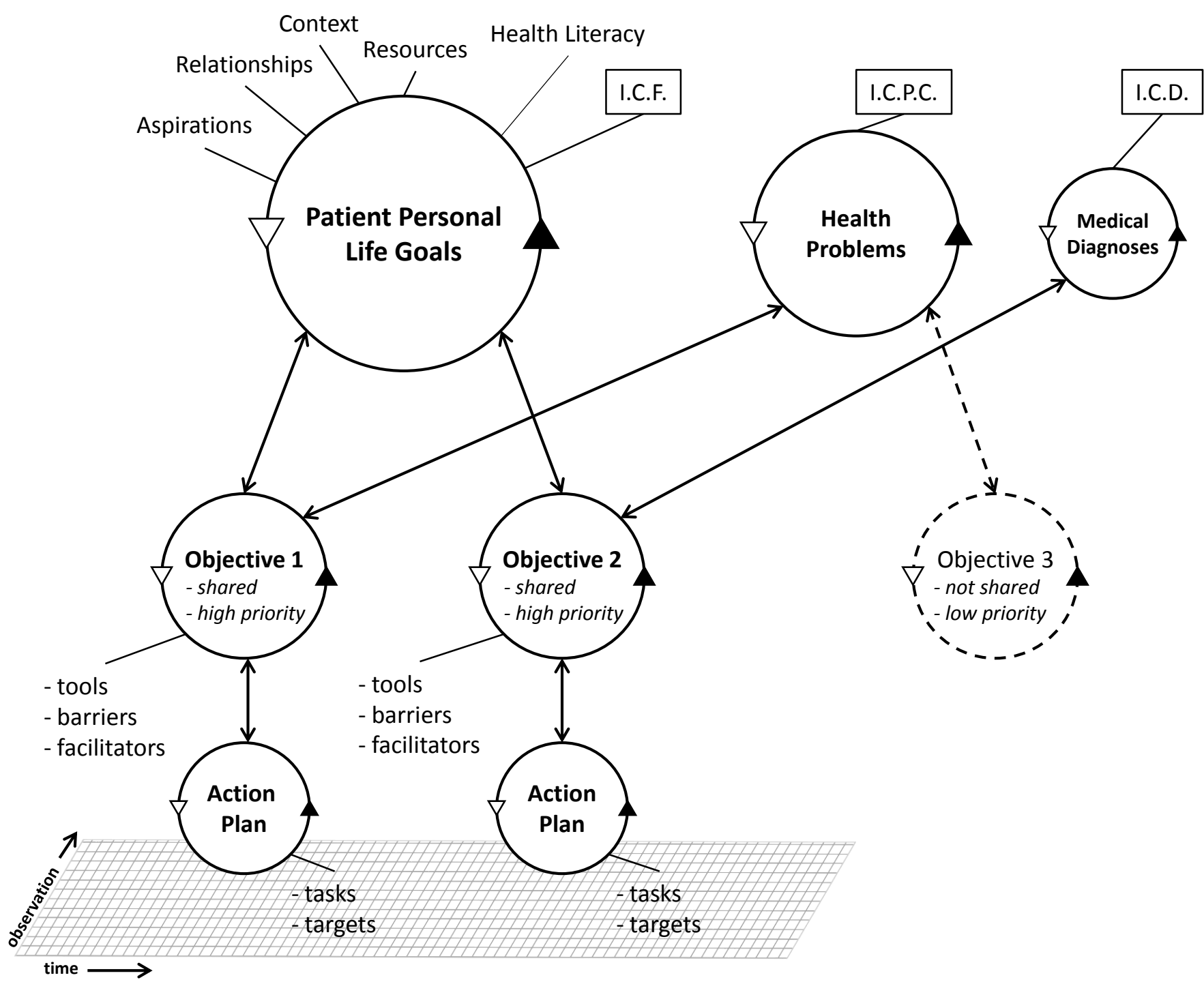
ISSN: 1381-4788 (Print) 1751-1402 (Online) Journal homepage: <http://www.tandfonline.com/loi/igen20>

Towards an overarching model for electronic medical-record systems, including problem-oriented, goal-oriented, and other approaches

Huibert Tange, Zsolt Nagykalai & Jan De Maeseneer

To cite this article: Huibert Tange, Zsolt Nagykalai & Jan De Maeseneer (2017) Towards an overarching model for electronic medical-record systems, including problem-oriented, goal-oriented, and other approaches, European Journal of General Practice, 23:1, 257-260, DOI: [10.1080/13814788.2017.1374367](https://doi.org/10.1080/13814788.2017.1374367)

To link to this article: <https://doi.org/10.1080/13814788.2017.1374367>



2. The changing society

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

Characteristics of provider / patient encounters

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



Compassion ↔ Computer

2. The changing society

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

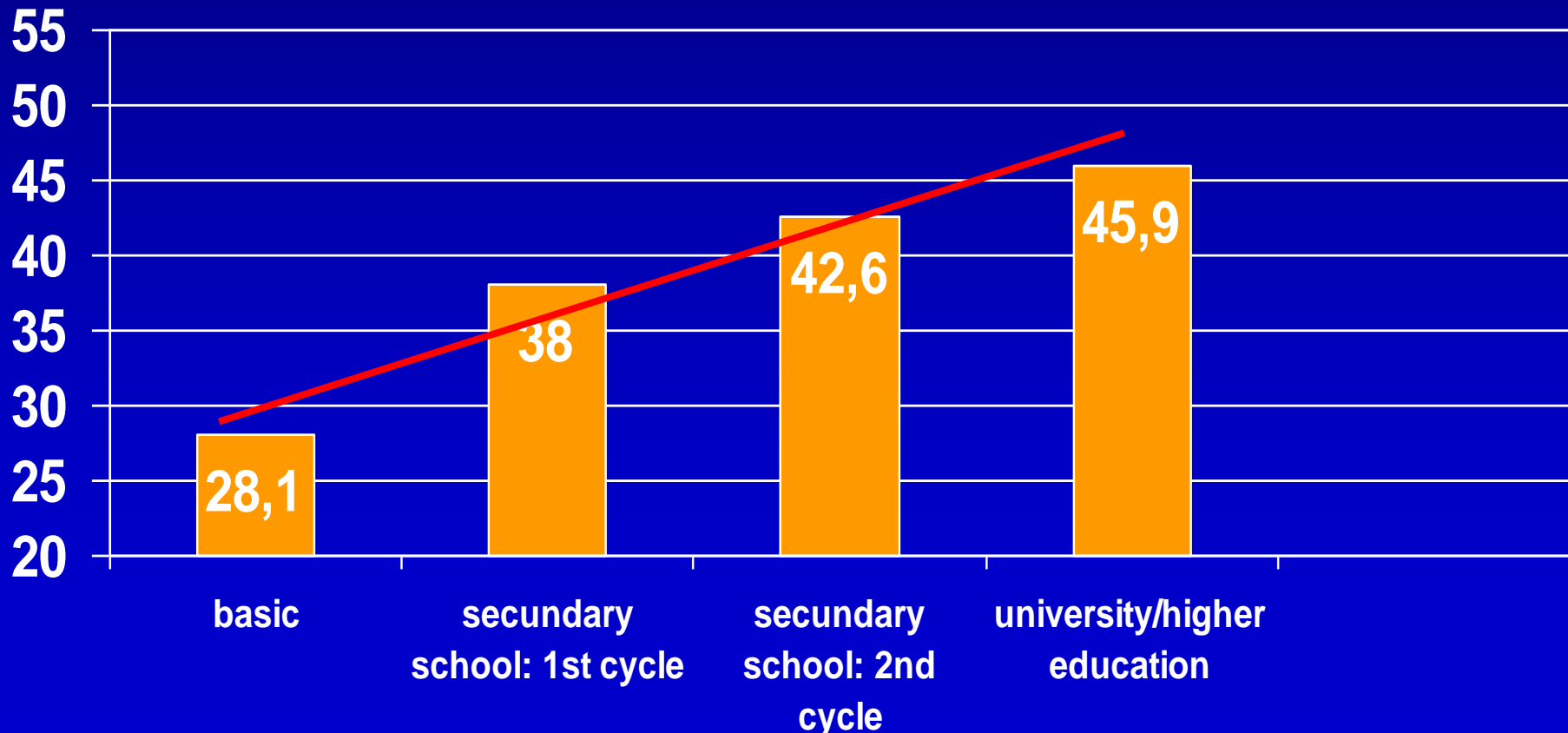
Healthy life expectancy in Belgium

(Bossuyt, et al. Public Health 2004)

Socio-economic inequalities in health

Healthy life expectancy in Belgium, 25 years, men

...1990...2000...2010...2020???





World Health
Organization



Commission on
Social Determinants of Health

Closing the gap in a generation

Health equity through action on
the social determinants of health

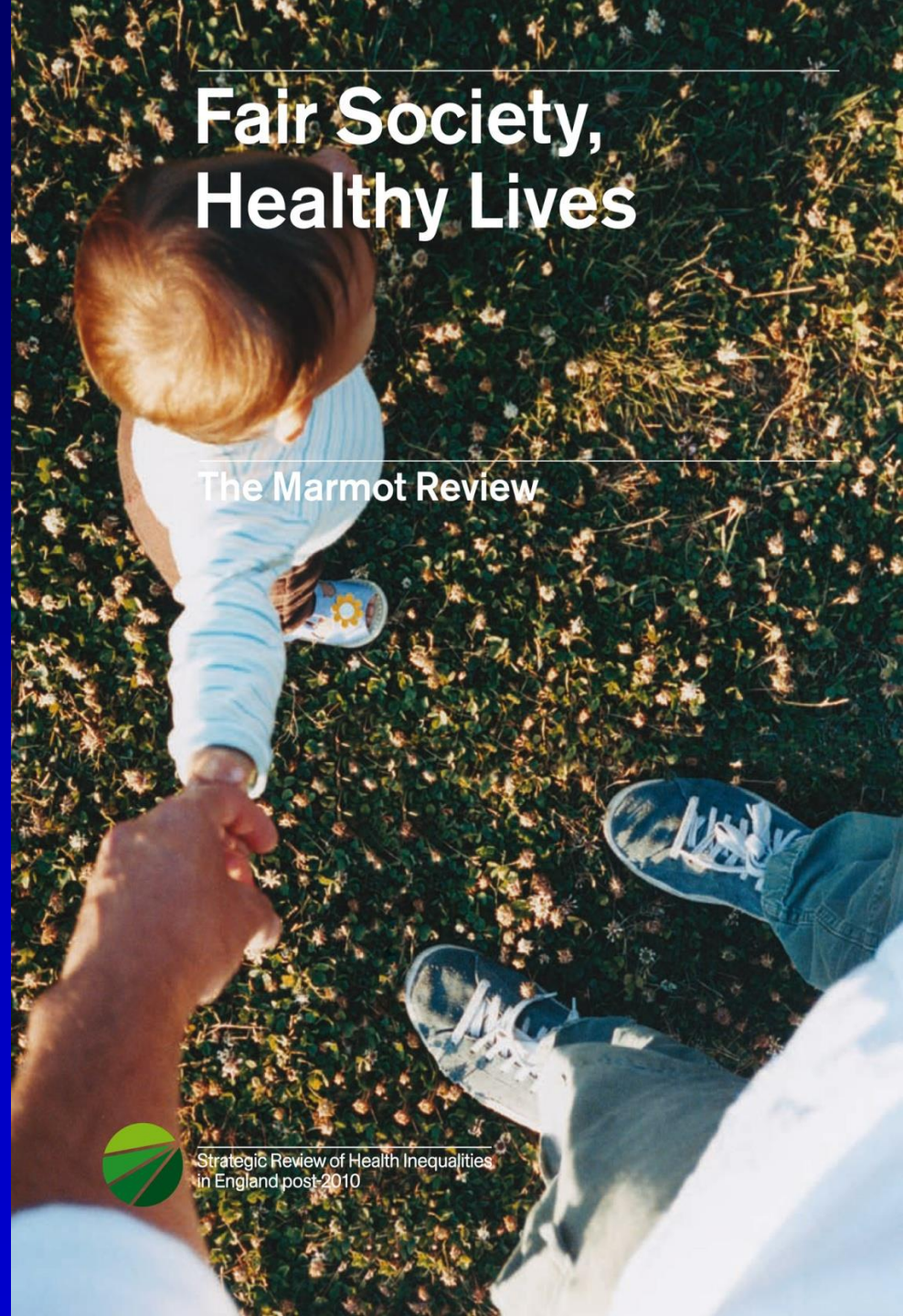


Fair Society, Healthy Lives

The Marmot Review



Strategic Review of Health Inequalities
in England post-2010



Health-care systems have better health outcomes when built on Primary Health Care (PHC) – that is, both the PHC model that emphasizes locally appropriate action across the range of social determinants, where prevention and promotion are in balance with investment in curative interventions, and an emphasis on the primary level of care with adequate referral to higher levels of care.

Primary health care as a strategy for achieving equitable care:

a literature review commissioned by the Health Systems Knowledge Network

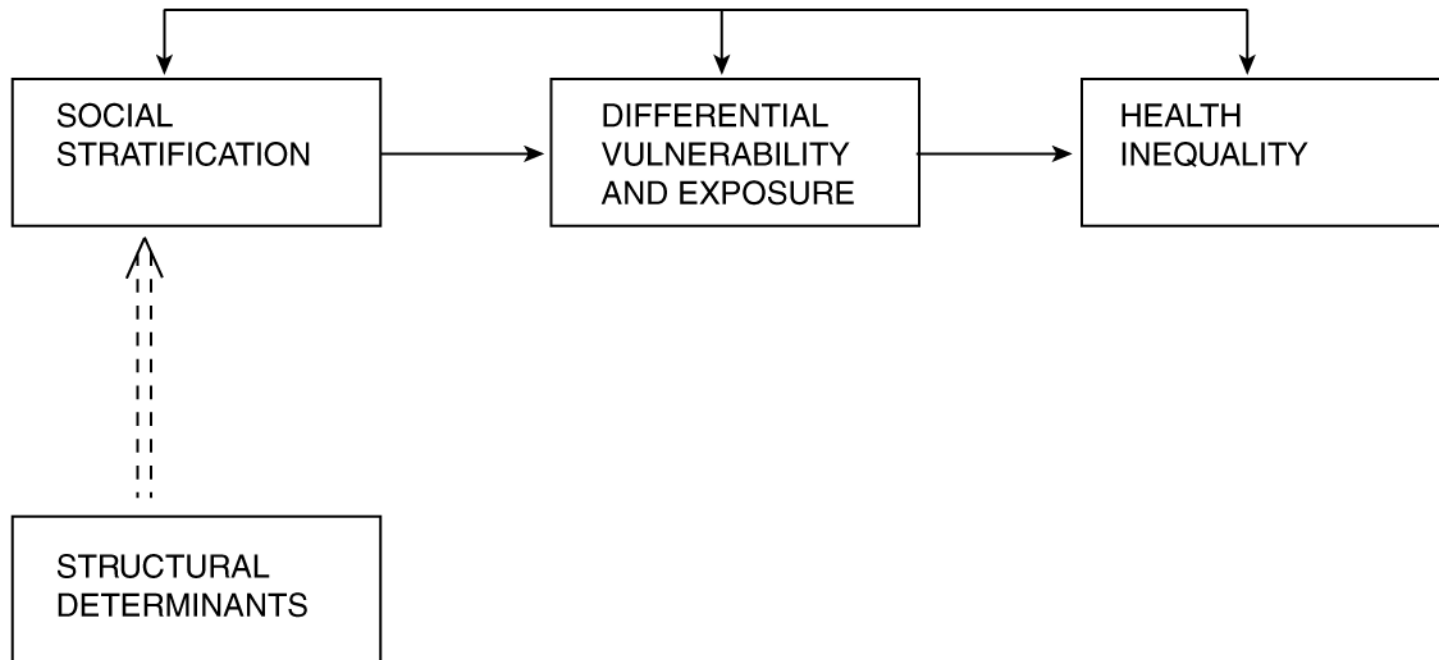
Prof. J. De Maeseneer, M.D.¹, Ph.D; S. Willems, M.A., Ph.D.¹; A. De Sutter, M.D., Ph.D.¹; I. Van de Geuchte, M.L.¹; M. Billings, M.Sc².

¹ Department of Family Medicine and Primary Health Care, Ghent University. Belgium.

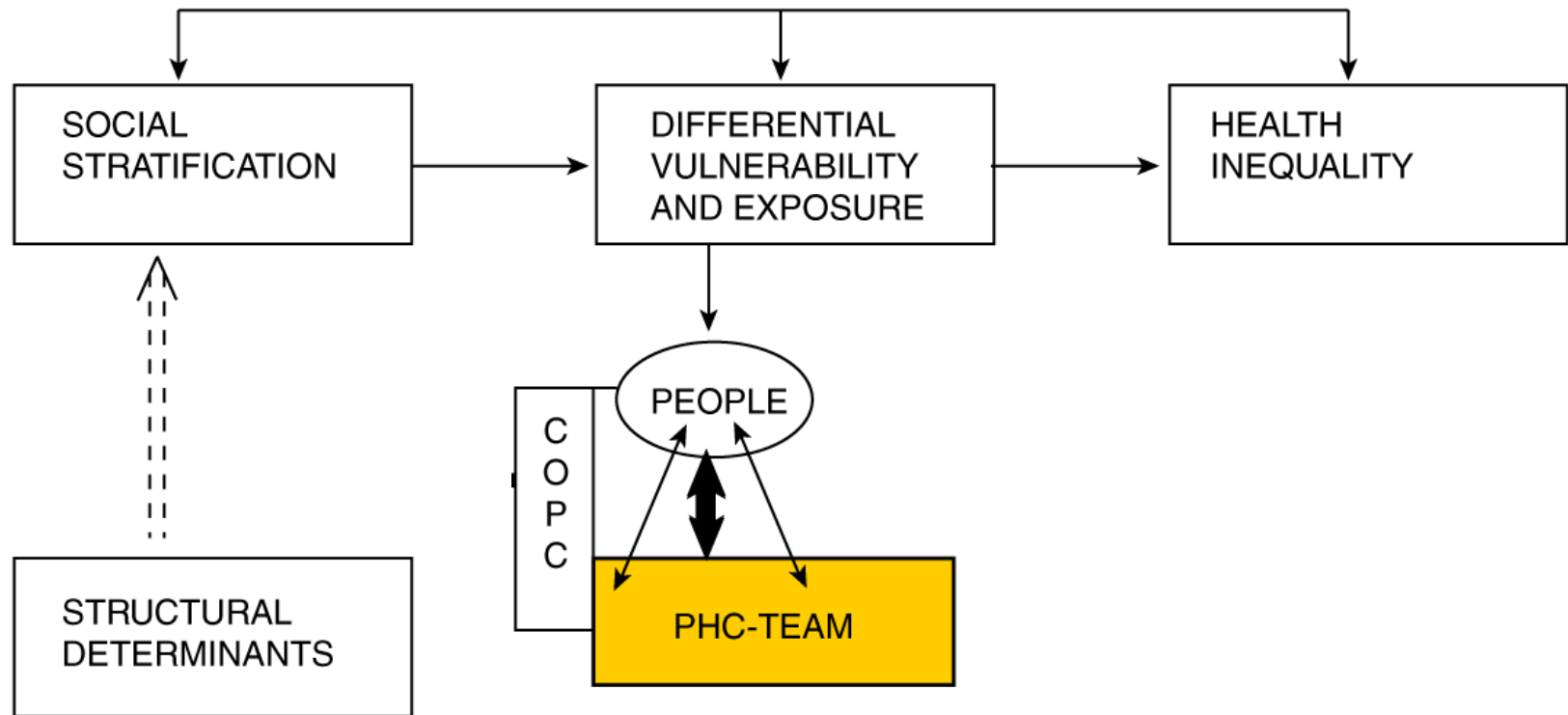
² Global Health through Education, Training and Service, Attleboro, USA.

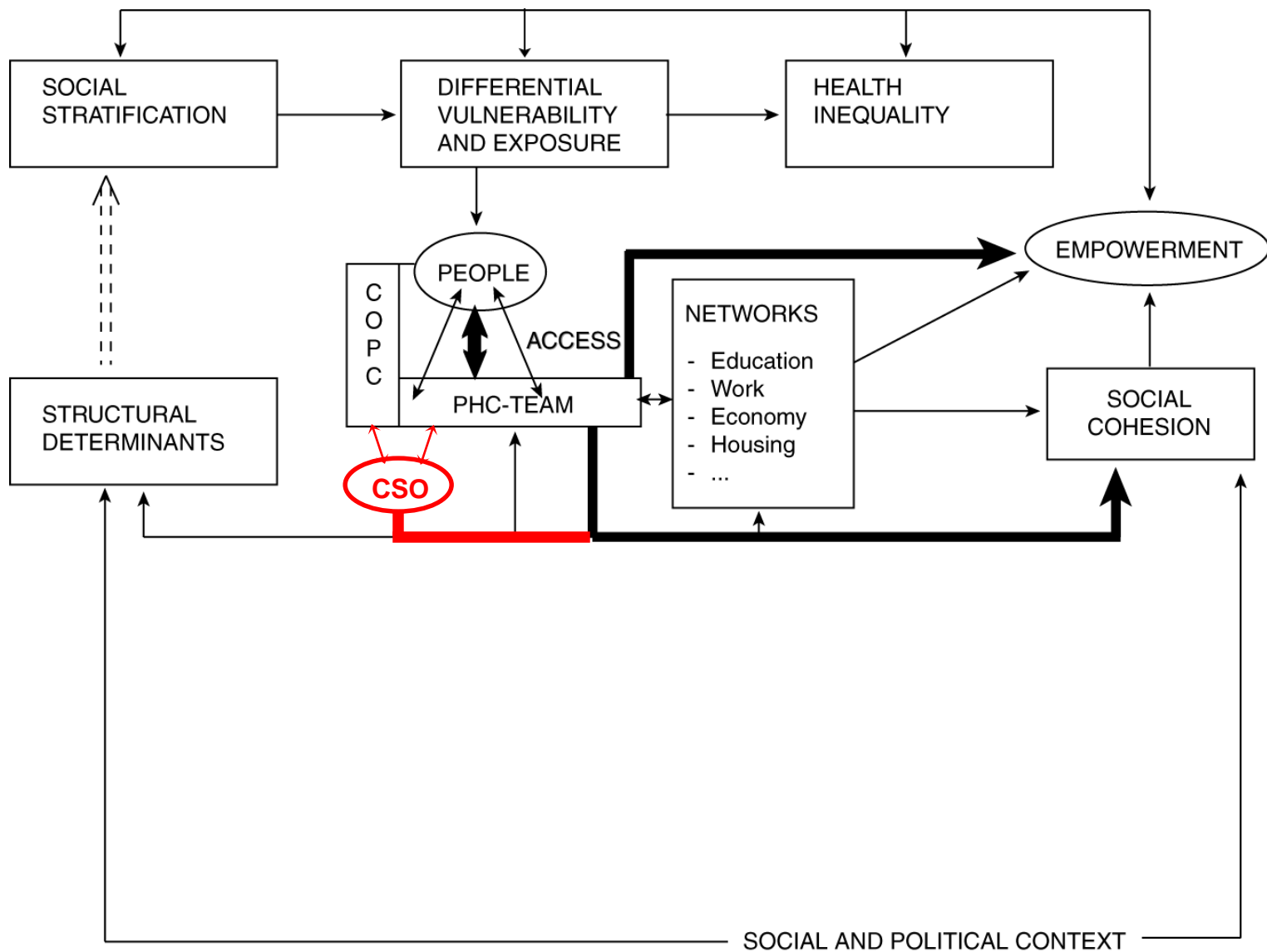
http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf

Primary health care as a strategy for promoting health equity and intersectoral action

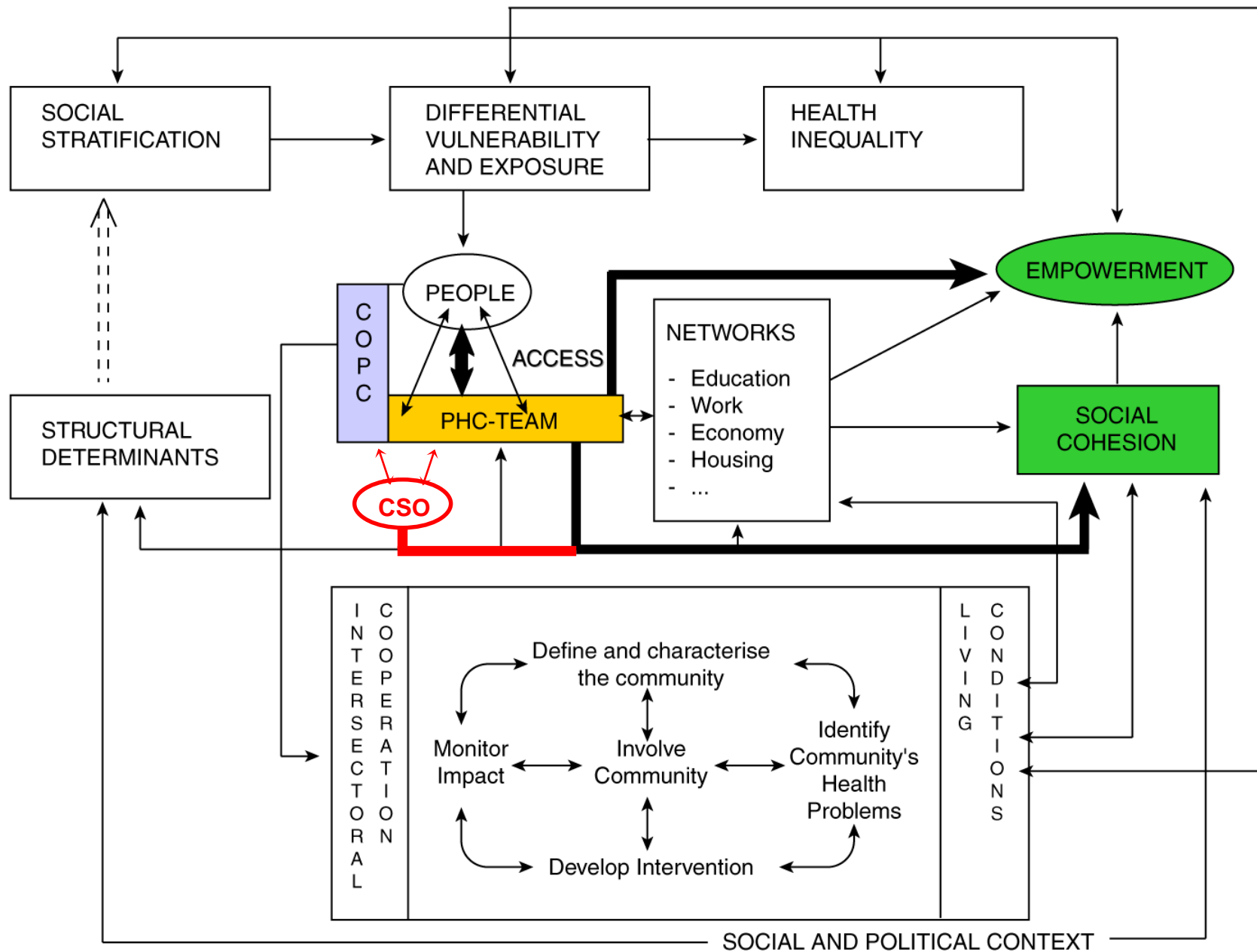


Primary health care as a strategy for promoting health equity and intersectoral action





Primary health care as a strategy for promoting health equity and intersectoral action



Community-Oriented Primary Care: Health Care for the 21st Century



Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D.,
Gary Kukulka, Ph.D., Hugh Fulmer, M.D.

Drs Sidney and Emily Kark:
Pohlela Community – South Africa



Community-Oriented Primary Care:
Health Care for the 21st Century

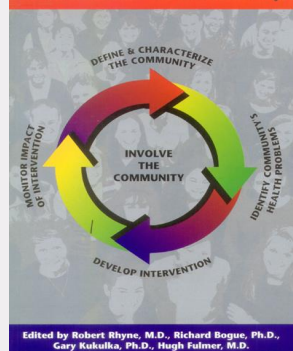
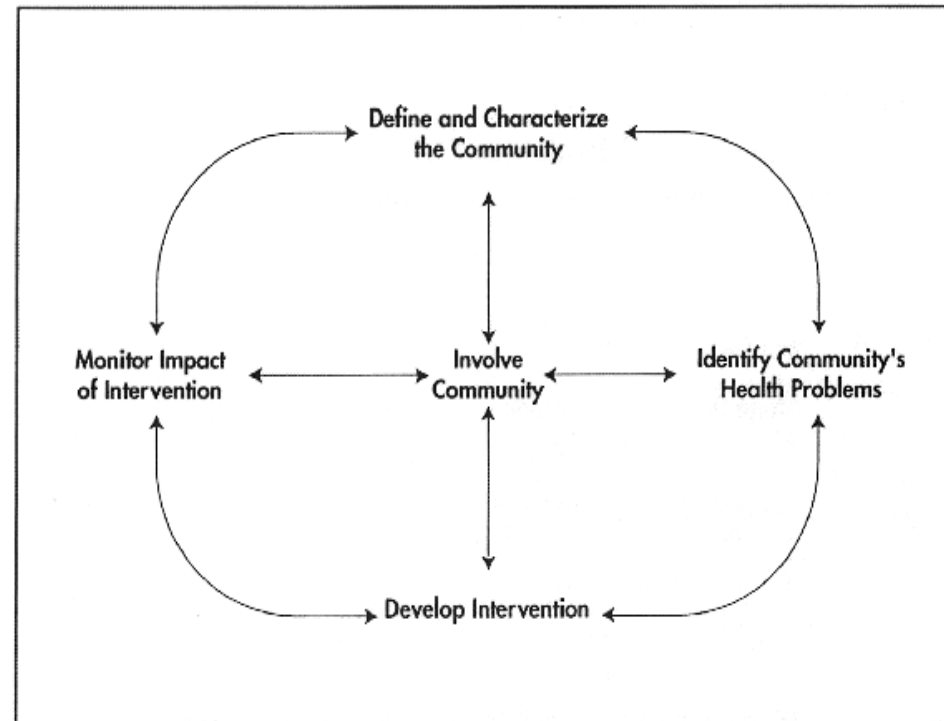


FIGURE 1.2: The COPC Process





COPC-project : from individual care to community health care



Identifying health problem:

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





COPC-project : DENTAL FITNESS



A dentist?
I cannot afford that.

Focus Group sessions –
involving the community

I don't know where
to find a dentist

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

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





COPC-project : DENTAL FITNESS



Working together with...



Brugse Poort



De Sleep



Botermarkt





COPC-project : DENTAL FITNESS



Results research children 30 months old:

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



Correlation with

- deprivation
- nationality (Eastern-Europe)
- no previous dentist consultations





COPC-project : DENTAL FITNESS



Childhood caries:

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

Strategies:

Community oriented,
intersectoral, participation.

Educational platform for
students in dentistry





COPC-project : DENTAL FITNESS



Accessible primary dental care

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

Started 01/09/2006



**Towards accessible oral
health care !**

Ghent University



WHAT IS 'PROPORTIONATE UNIVERSALISM' ?

WHAT IS 'PROPORTIONATE UNIVERSALISM' ?



WHAT IS 'PROPORTIONATE UNIVERSALISM' ?



Dr. Michael Marmot, proportionate universalism "implies a need for action across the whole of society, focussing on those social factors that determine health outcomes"⁴ and "...in addressing health inequity, the strategies that should be given priority are those that are universal but are resourced and delivered with an intensity that is related to the level of social need."⁵

2. The changing society

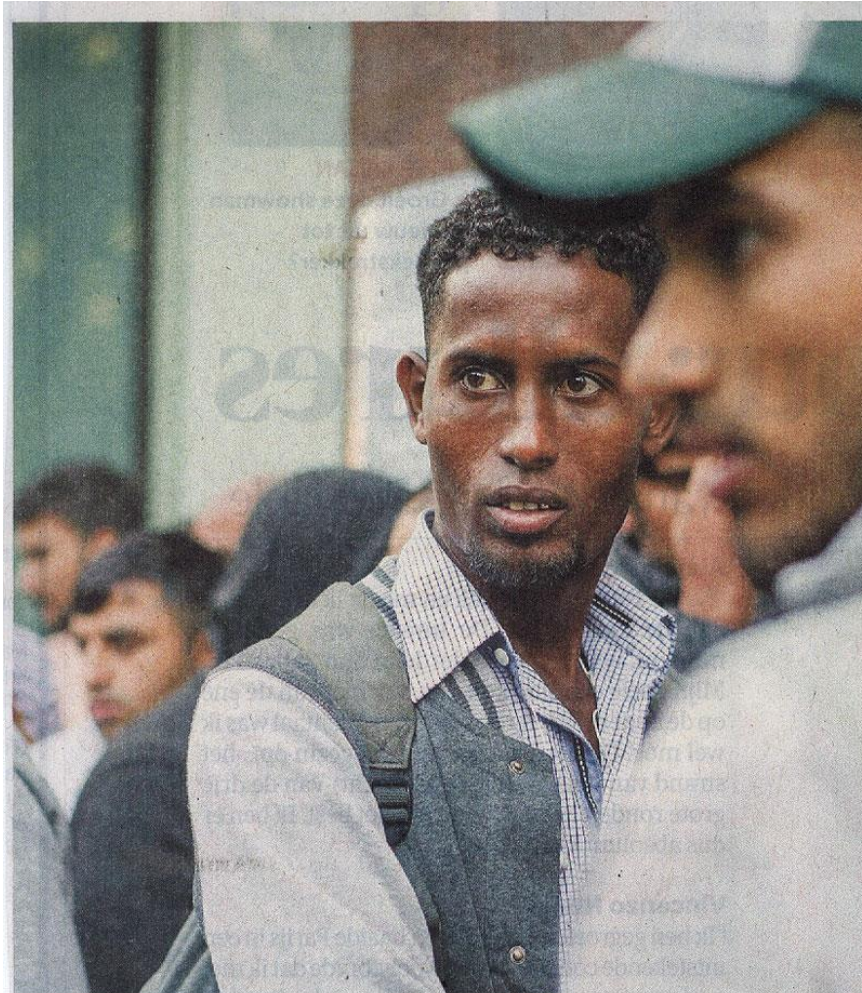
- a. Demographical and epidemiological developments
- b. Scientific and technological developments
- c. Cultural developments
- d. Socio-economical developments
- e. Globalisation and “glocalisation”

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



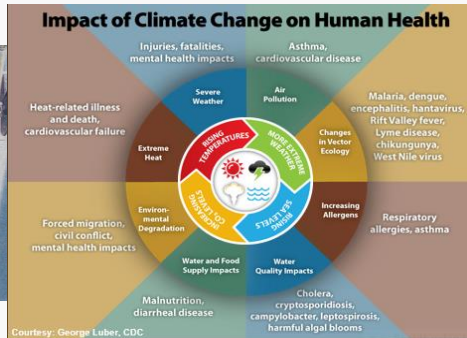
Boot met honderden vluchtelingen gezonken





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

HEALTH IS GLOBAL...



5. Addressing the health effects of migration through capacity building for health care in Africa.

Migration (and refugee-crisis), climate change and capacity building (for healthcare, education, food production ...) in the global South, are strongly inter-related. EU policy could address these issues in an integrated more comprehensive way, looking at push- and pull-factors, socio-economic and ecological drivers. This requires EU to take a leading role in a new dialogue with African countries. This should be operationalised both at research level and at the level of development aid and capacity building. *EXPH: Reflection on priorities for the future of Health Care in EU, APRIL 2019*

2. 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%?

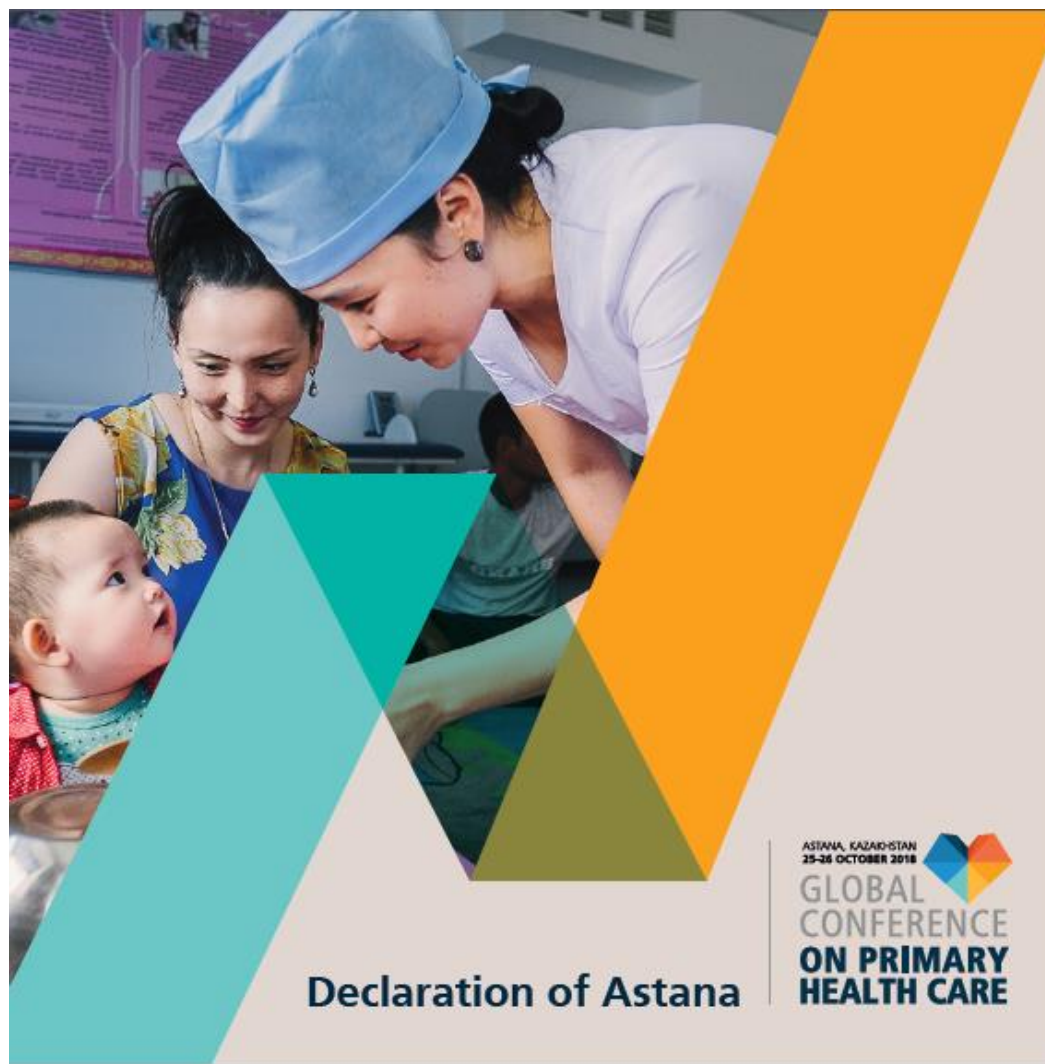
Challenges for Health Care Delivery: perspective 2030

- 1. Introduction**
- 2. The changing society: 5 challenges**
3. How can health systems respond?
- 4. Conclusion**

1978: Declaration on Primary Health Care in Alma Ata



A view of the auditorium



ASTANA 2018

V

Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health². PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks.



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

on

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

Opinion on Definition primary care – Definition

Core-definition

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

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

Gate-keeping and Referral

Linear: new
health problems



Spiral:
chronic
problems



Health systems respond to noncommunicable diseases: time for ambition

Edited by
Melitta Jakab, Jill Farrington
Liesbeth Borgmans, Frederik Mantingh



PRE-FINAL DRAFT FOR CONSULTATION

8

Transforming individual
health services: towards
integrated multidisciplinary
primary health care

Jan De Maeseneer, Liesbeth Borgermans, David Beran, Juan Tello

Agenda for action

Moving towards larger multidisciplinary primary care teams afford an opportunity to scale up core NCD services as part of a comprehensive service offering

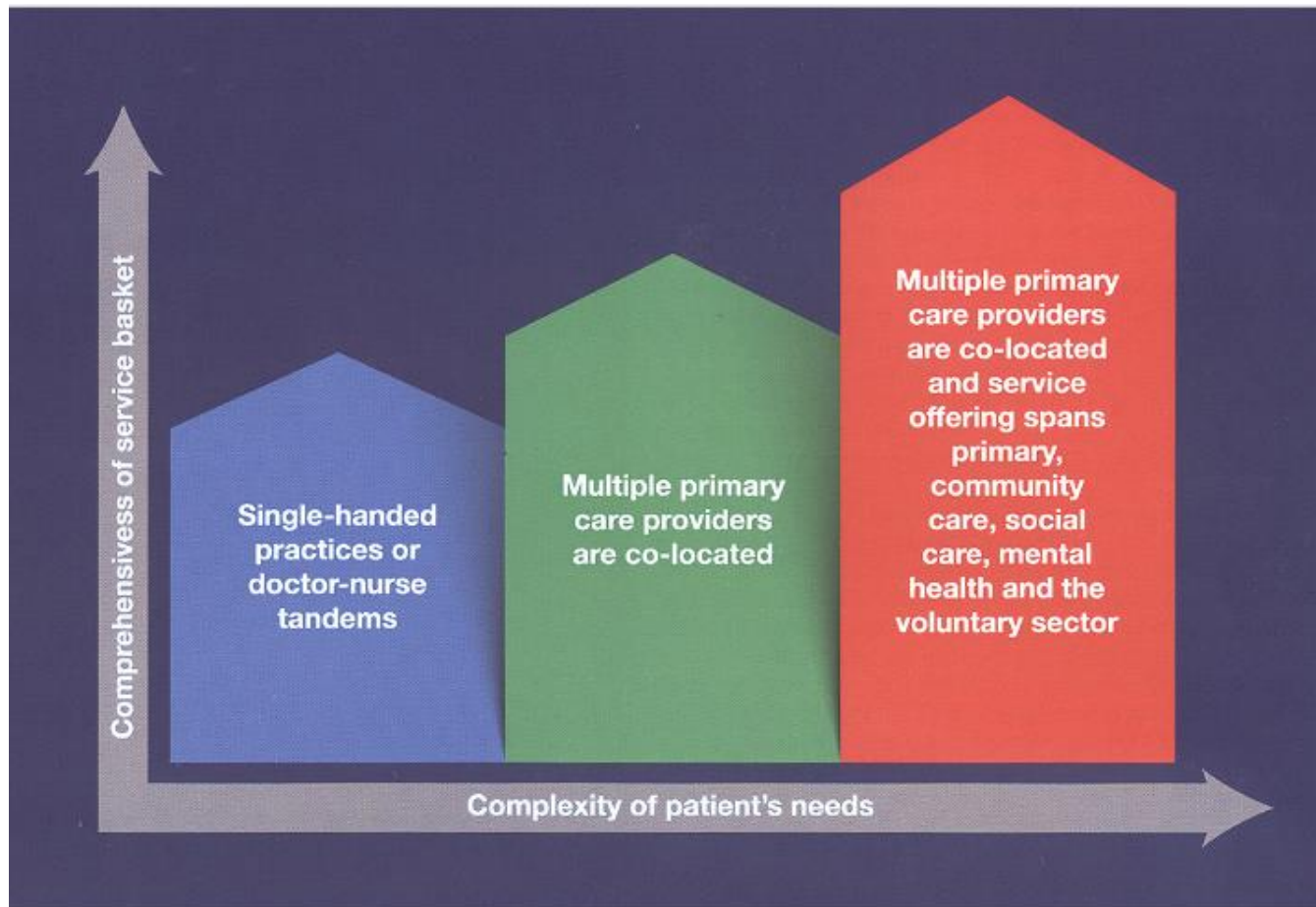
1

2 Community-oriented primary care **responds proactively to people's needs** by using tools to understand and manage population health and its determinants

Coordination and integration are essential for people-centred services and outcome management


3

4 Effective regulatory instruments **offer great potential to expand primary care further**, strengthening its resolute capacity with regard to NCDs and reducing reliance on specialist and hospital services





Community Health Centre
Botermarkt Ledeberg 2006




Botermarkt
wijkgezondheidscentrum vzw

[WGC Botermarkt](#) [Wegbeschrijving](#) [Links](#) [Login](#)

[Visie](#)
[Ontstaan](#)
[Multidisciplinair team](#)
[Globaal Medisch Dossier](#)
[Forfaitair betalingssysteem](#)
[Raadplegingen, afspraken en huisbezoeken](#)
[Preventieprojecten en gezondheidsbevordering](#)
[Inschrijven in het WGC](#)
[Voor onze patiënten](#)

Community Health Centre:

- General practitioners; nurses; dieticians; health promoters; dentists; social workers; psychologists; community health workers...
- 6400 patients; 95 nationalities
- Integrated Needs-based Capitation; no co-payment
- COPC-strategy

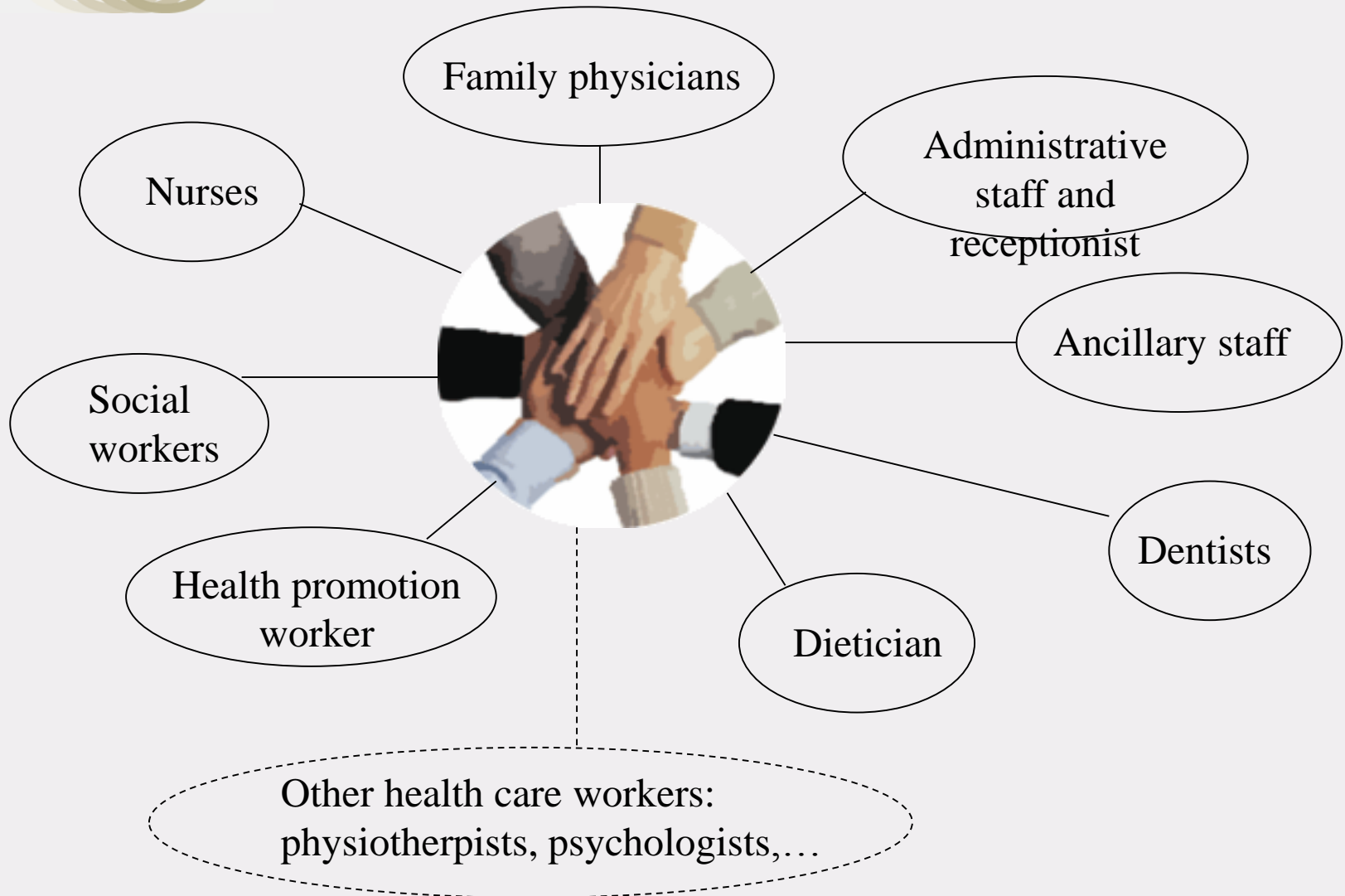


Hundelgemsesteenweg 145, 9050 Ledeberg | tel. 09/232 32 33 | fax 09/230 51 89 | info@wqcbotermarkt.be | ma-vr 8.00 - 19.00

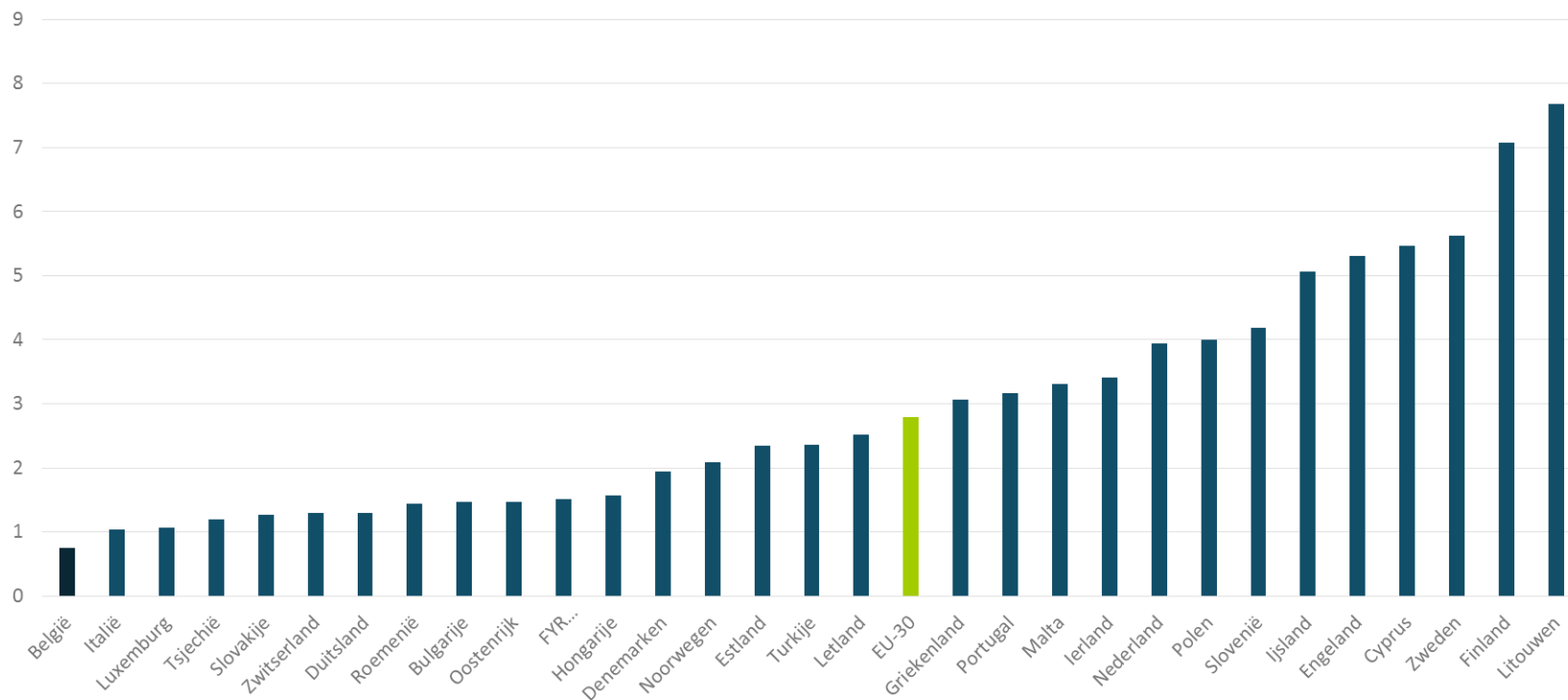


Community Health Center Botermarkt Ledeberg!

INTERDISCIPLINARY TEAM



COOPERATION WITH DIFFERENT DISCIPLINES IN FAMILY PRACTICE (QUALICOPC-STUDY, 2013)



Botermarkt

wijkgezondheidscentrum vzw

WHO
IS THIS
PERSON?



INTERPROFESSIONAL DISCUSSION

Botermarkt

wijkgezondheidscentrum vzw

Patient
(representative
)
participates in
the inter-
professional
discussion



INTERPROFESSIONAL DISCUSSION

Patient
(representative
)
participates in
the inter-
professional
discussion



INTERPROFESSIONAL DISCUSSION



NURSING TEAM: PLANNING MEETING

Task-Shifting and Competency-sharing

Care is provided by the person most equipped for the task and most knowledgeable about the subject.





TASK SHIFTING AND HEALTH SYSTEM DESIGN

Report of the
**Expert Panel on effective ways of
investing in Health (EXPH)**



The traditional (WHO) definition of task shifting

- “the rational re-distribution of tasks among health workforce teams... specific tasks are moved, where appropriate, from highly qualified health workers to health workers who have fewer qualifications in order to make more efficient use of the available HRH [human resources for health]”
- Ignores evidence that some tasks should be shifted upwards to those who perform them better, or to patients and carers, or to machines

An updated approach

Includes:

- *task distribution*
 - overview of who does what, without any implied imperative to change it
- *task sharing and competency sharing*
 - responsibilities are often shared between different professional groups and with the patient and, in some cases their families

Factors driving change

- Changing patterns of disease
 - Multimorbidity, frailty, antimicrobial resistance
- Technology
 - Minimally invasive surgery, intravenous anaesthetics, diagnostic kits, artificial intelligence for image processing, telemedicine
- Professional norms
 - Rejection of traditional hierarchies, growing autonomy of non-physician staff (but still very variable in EU)
- Shortage of health workers
- (Cost containment)
- Decentralisation of organisational structures

Challenges to achieving change

- Limited evidence base
 - What exists is concentrated in a few countries
- Threat to power in established hierarchies
 - Especially where there are financial interests involved
- Obsolete regulation
 - On who can do what, often based on ideas decades old

Why is this important now?

- Sustainability of the health workforce
 - We don't have enough health workers so we need to use those we have as effectively as possible
- Financial sustainability of the health system
 - It is morally wrong to waste scarce resources unnecessarily
- Improved quality of care
 - Those who do the job best should do it
- Resilience of the health system
 - In emergencies, may need different groups to cover for each other

Task shifting from health professionals to patients

- The evidence base for self-management of many long term conditions is relatively weak, reflecting a combination of limitations of many of the studies that have been undertaken and a lack of studies on key issues.
- There is evidence of improved quality of life for patients with stroke and COPD, although self-management of exacerbations of COPD may be associated with higher respiratory mortality.
- Evidence in support of technology is also limited; it has been associated with better control of oral anti-coagulation but other forms of monitoring, such as pulse oximetry, are not supported.

Task shifting to community workers

- Review of 39 systematic reviews
- Most concluded that services provided by volunteers not inferior to those provided by other health workers, and sometimes better.
- However, they performed less well with more complex tasks such as diagnosis and counselling.
- Many reviews concluded that their performance could be strengthened by regular supportive supervision, in-service training and adequate logistical support, as well as a high level of community ownership.

Task shifting from health workers to machines

- autonomous embodied agents (e.g. apps to support people with mental health problems)
- digital image processing (e.g. radiology, sperm counts, haematology/ cytology)
- replacing laboratory personnel by automated production lines (3D printing of implants, automated biochemical analysis, microbial genetic analysis replacing culture)
- autonomous monitoring and alert systems based on wearable technologies supported by artificial intelligence on servers and cloud technology (e.g. blood pressure, ECG, oximetry, blood glucose, ovarian cycle monitoring (e.g. www.ladytechnologies.com))
- robot assisted physiotherapy and rehabilitation
- replacement of administrative staff (e.g. automated hospital coding replacing human coders)
- automatic/robotic medication dispensing systems
- artificial intelligence supported decision making

Task shifting from health workers to machines

- Evidence base surprisingly weak
- Methodology often poor
- Considerable potential, at least in theory
- Some clear benefits in limited areas but...
- Lots of problems with conflicts of interest
- Major concerns about abuse of data

Task shifting between different types of health workers

- In many studies, nurses achieve similar outcomes to doctors when managing routine conditions
- Patient satisfaction often higher with nurses
- However nurses tend to recall more patients and request more investigations
- Results less clear for more complex conditions

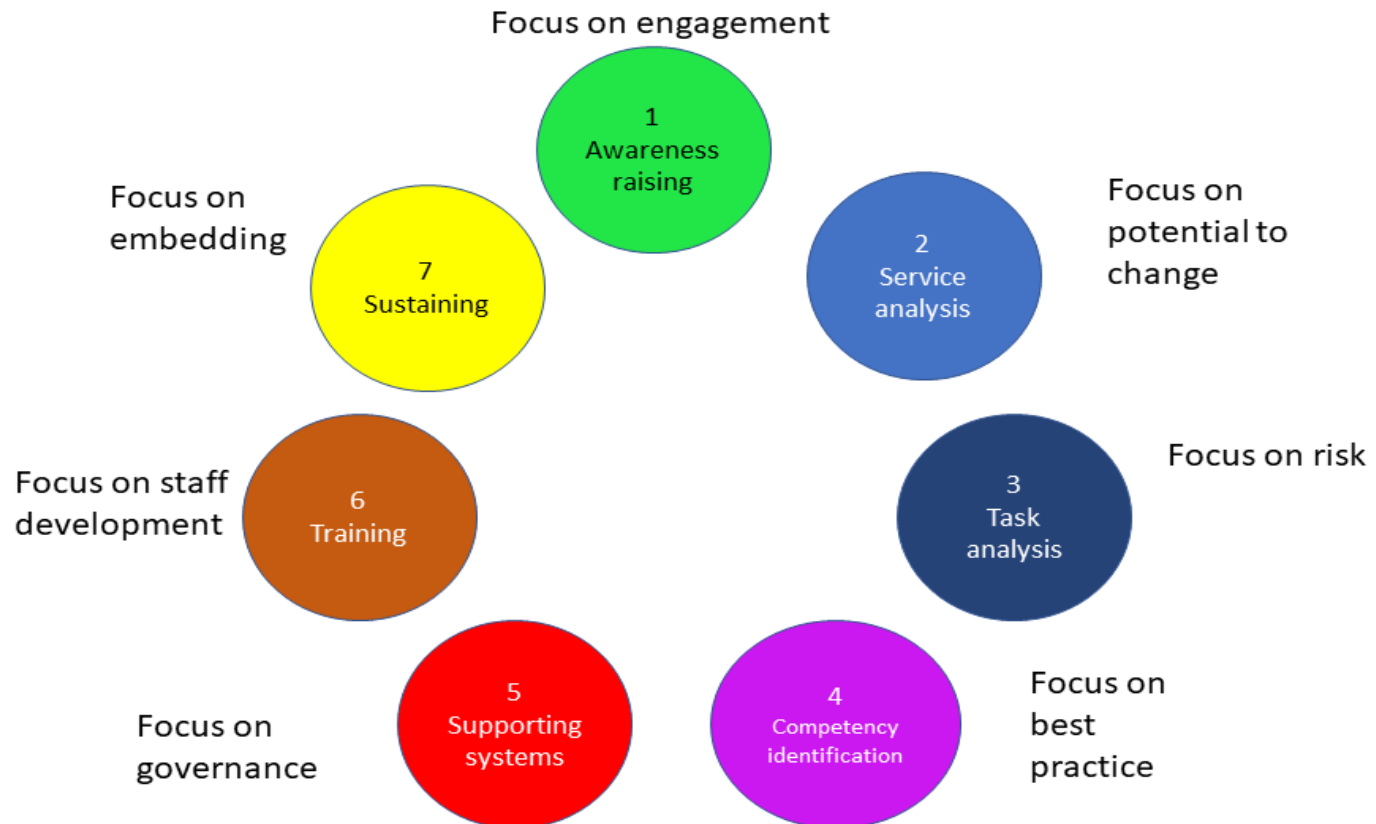
Task shifting between different types of health workers

- Nurses as good as doctors in routine pre-operative assessment
- Pharmacists achieve better results than doctors in medicines reviews and add benefit to multidisciplinary teams
- Prescribing by nurses and pharmacists in routine care often achieves greater adherence
- Evidence on enhanced role of nurses is mixed

Summary of the evidence

- There is little evidence for the rigid demarcation that is between different health professionals, such as doctors and nurses, that exists in many countries
- Groups other than physicians, and especially nurses and pharmacists, can undertake substantially expanded roles compared to what has traditionally been the case.
- However, they must be adequately trained and supported and function in integrated teams with information-sharing.
- There is a need to better understand the optimal combination or “package” of changes and additions that can act synergistically to improve the quality and safety of healthcare as well as patient experience.
- While it is not necessary to evaluate every change, there is a strong argument for doing so where major changes are taking place, as there is scope for unintended consequences.
- This should not, however, be an argument for doing nothing.

Making it happen: The Calderdale Framework

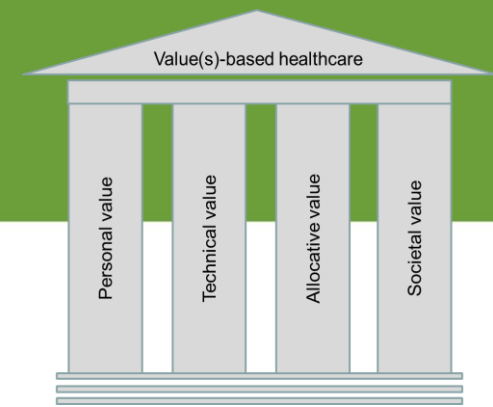




DEFINING VALUE IN "VALUE-BASED HEALTHCARE"

Report of the
**Expert Panel on effective ways of
investing in Health (EXPH)**





ValueS-based healthcare

The EXPH proposes to “*value-based healthcare*” as a **comprehensive concept** built on 4 value-pillars:

1. *achievement of best possible outcomes with available resources*
(**technical value**)
2. *equitable resource distribution across all patient groups*
(**allocative value**)
3. *appropriate care to achieve EACH patient’s personal goals*
(**personal value**)
4. *contribution of healthcare to social participation and connectedness* (**societal value**).

Policy recommendations

- “How [can we use the above definition] to inform healthcare decision making to become more effective, accessible and resilient?”

Recommendation 1

- **Creating greater awareness of health as an essential investment** in an equal and fair European society (“health is wealth”), of its centrality as a European value, and of the commitment, in the Sustainable Development Goals, **to achieve universal health coverage**
- To ensure *societal* value

- In practice: clear narratives how financial sustainability is endangered by
 - over diagnosis and overtreatment
 - inequity by disease & “voiceless” patient groups
 - unwarranted variation in interventions
 - unreasonable (high) prices of treatments
 - waste from inefficiencies, fraud and corruption
- Importance of solidarity for social cohesion and security, contribution to societal welfare

Recommendation 2

- **Develop a long-term strategy for a step-by-step value(s)-based approach towards change of culture**



Create a movement to ...

- Develop a **consistent language** to capture the drive towards sustainability of universal health coverage
- Train “**change agents**” (**leaders**) who assess the risks and opportunities
- Pilot **need-based public R&D** for innovative technologies
- **Orientate digital interventions** in ways that genuinely support high value care

Recommendation 3

- Support methodologies on appropriateness and unwarranted variation

Recommendation 4

- Encourage health professionals to take responsibility and feel accountable for increasing value in health care, which may require freeing resources from low-value care to reinvest in high-value care
 - To achieve allocative and societal value

Recommendation 5

- Support creation of **Learning Communities**
 - bring together expertise, experiences and practices
- Rewarding (co-funding) countries taking systematic approaches to develop and disseminate good practice
- Stimulating exchange on managerial techniques (financial incentives, regulatory mechanisms and managerial instruments) for shifting resources from low to high value care

Recommendation 6

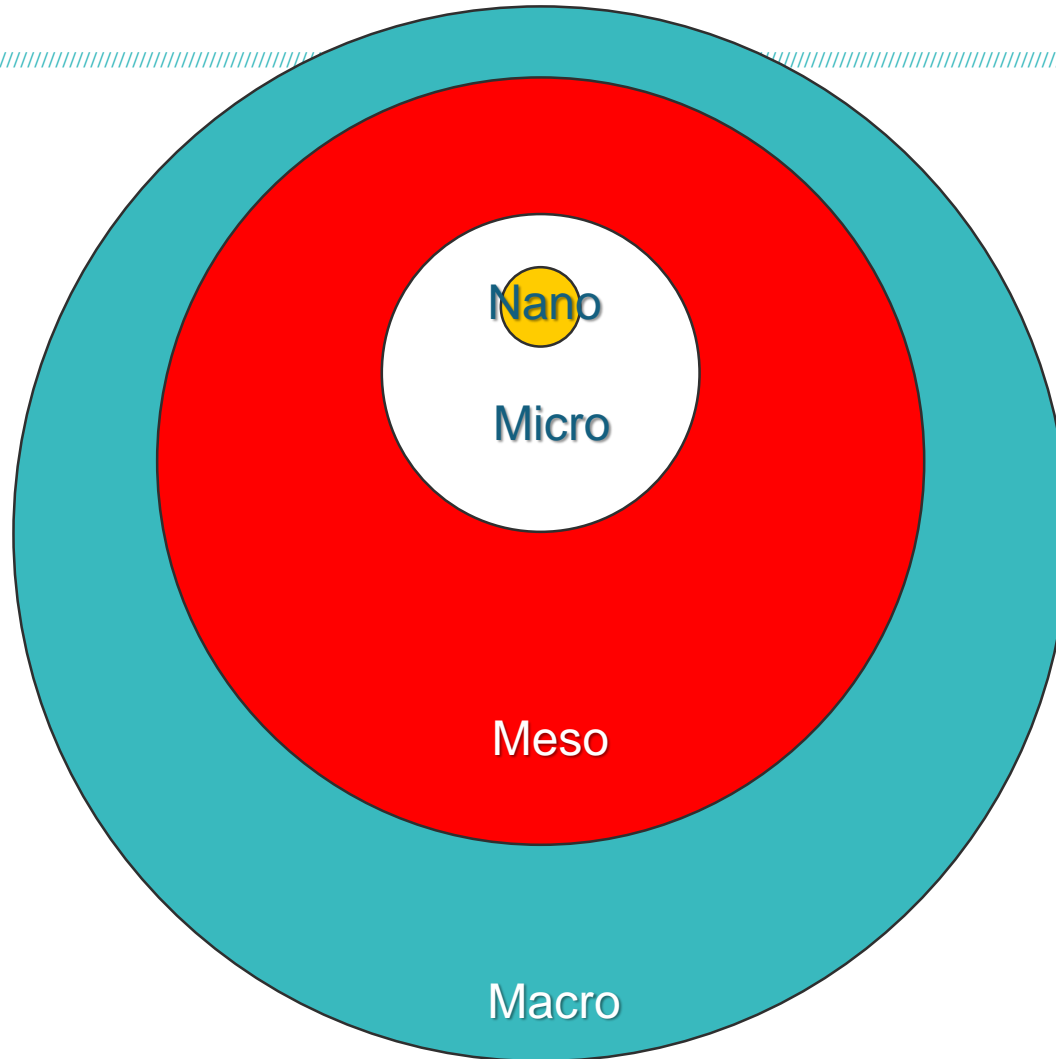
- **Support initiatives for patients' engagement in shared decision-making**, recognising the importance of patients' individual goals, values and preferences, informed by high quality information

Actions include

- Co-creating models of care with the patient community (including families and informal carers) , and adopting a framework for meaningful patient and public involvement in health systems and services design.
- Developing a comprehensive strategy to implement empowering practices and goal-oriented person-centred care.
- Creation and implementation of Patient-defined outcome measures and experience measures (PROMs and PREMs).

Conclusion

A reallocation of resources - the freeing of resources and accordingly the reinvestment - from low to high value care is perceived by the EXPH as the **utmost necessity for sustainable and resilient European healthcare systems.**

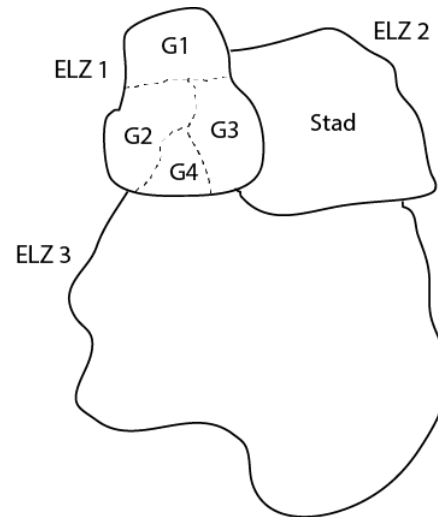




*“Organizing primary care in decentralized entities, for example, **primary care zones (PCZs)**, can contribute to the visibility of primary care. Defining the population that accesses a certain group of services and providers in primary care, can contribute to the accountability of providers in terms of outcomes, access and quality of care.”*

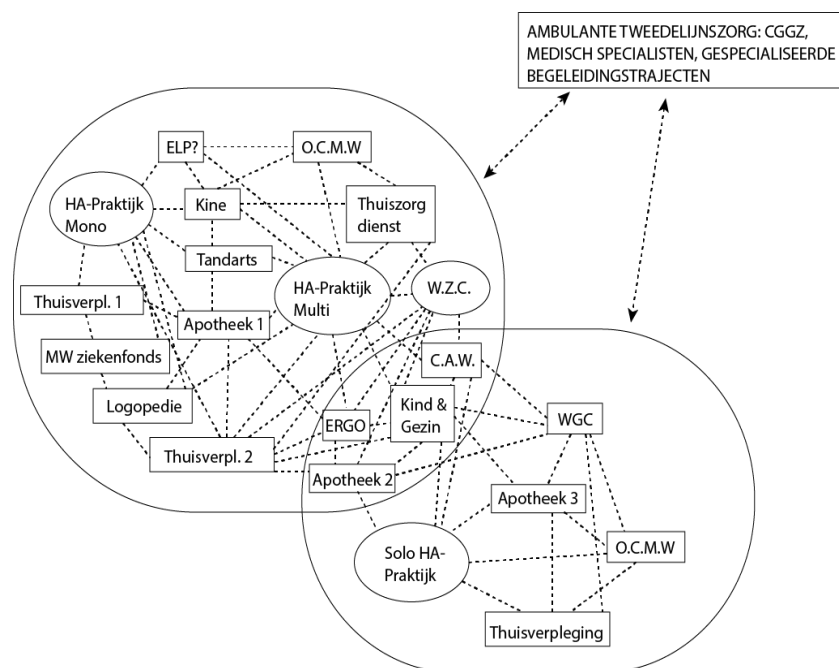
Everybody Counts!
No one should be left behind!

PRIMARY CARE ZONE: MESO-LEVEL: 70.000-125.000 INHABITANTS



Flemish Region of Belgium
(2019)

PRIMARY CARE NETWORKS: > 5.000 INHABITANTS (RURAL) > 10.000 INHABITANTS (URBAN)



PRIMARY CARE ZONE (FLANDERS – BELGIUM): INTEGRATION
PRIMARY CARE, PUBLIC HEALTH, SOCIAL SECTOR, **PATIENT**
REPRESENTATION, LOCAL AUTHORITIES (9 OUT OF 24)



Integration of personal and community health care

The promotion of primary health care since 1978¹ has had a profound political impact: it forced medical educators around the world to address the health needs of all people and it spurred the global recognition of family doctors as the primary medical providers of health care in the community. Yet, on the 30th anniversary of the Alma-Ata Declaration,² disillusionment with and failure to appreciate primary care's contribution to health persist. The missing link in the translation of the principles of Alma-Ata from idealism to practical,

at the expense of population health. The challenge of this balancing act is illustrated in the interchanged use of the terms "primary care", which usually means care directed at individuals in the community, and "primary health care", which usually means a population-directed approach to health. To simplify this discussion and to reduce confusion, we will use the term "personal care" instead of "primary care" and "community-oriented primary care" (panel) instead of "primary health care".

**Chris van Weel, Jan De Maeseneer, Richard Roberts*

Department of General Practice, Radboud University Nijmegen Medical Centre, 6500 HB Nijmegen, Netherlands (CvW);

Department of Family Medicine and Primary Health Care, Ghent University, Ghent, Belgium (JDM); The Network—

Towards Unity For Health, Maastricht, Netherlands (JDM); and University of Wisconsin School of Medicine and Public Health, Madison, WI, USA (RR)

c.vanweel@hag.umcn.nl

The Lancet 2008;372:871-2



TOOLS AND METHODOLOGIES FOR ASSESSING THE PERFORMANCE OF PRIMARY CARE

Report of the
**Expert Panel on effective ways of
investing in Health (EXPH)**

Opinion on Definition primary care – Definition

Core-definition

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

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

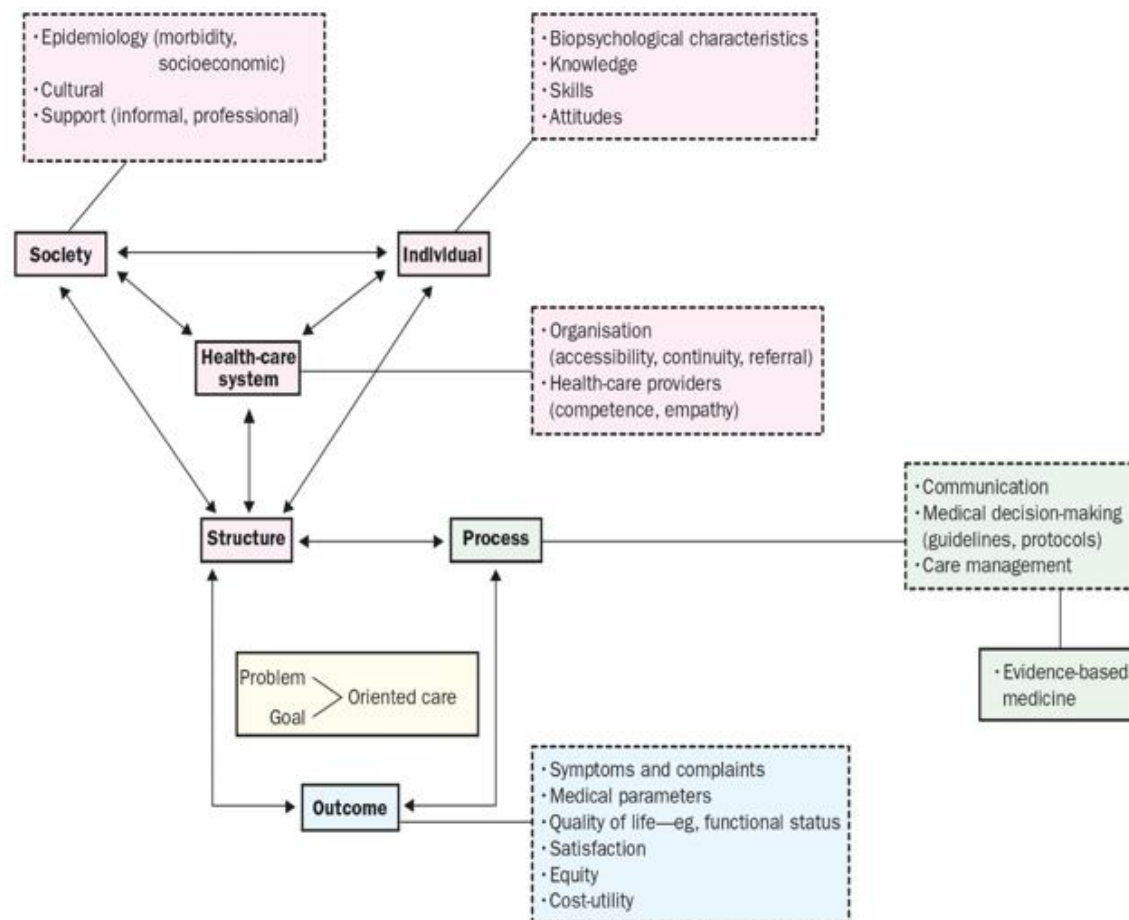


Figure 1: Theoretical framework of structure, process, and outcome (De Maeseneer et al., 2003; courtesy The Lancet)

According to the above framework the core elements of primary care can be classified as follows:

Table 2. Core elements in primary care	
Universality	Structure
Accessibility	Structure
Organisation of professionals and workforce	Structure
Integration	Process
Sustained partnership	Process
Coordination	Process
Continuity of care	Process
Person-centeredness	Outcome



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
1) Universal and accessible	<ul style="list-style-type: none">• % of the population fully covered or insured for PC costs and medicines prescribed in PC• Total expenditure on PC as % of total expenditure on health• Amount patients have to pay for a GP/PC consultation and amount reimbursed• % of patients who rate GP/PC Team care as not very or not at all affordable• Difference between region, province or state with highest and with lowest GP/nurse/social worker/... density• Average number of days waited to see a GP/PC provider when confronted with a health problem

FINANCIAL RESOURCES (PERSONAL VIEWPOINT):

°INCREASE INVESTMENT IN HEALTH CARE: **BY 2050 COUNTRIES SHOULD SPEND 10-15 % OF GDP ON HEALTH**

°REDISTRIBUTE HEALTH CARE RESOURCES TOWARDS PRIMARY HEALTH CARE: **AT LEAST 25- 30 % OF HEALTH CARE BUDGET SHOULD BE INVESTED IN PHC**

Figure 1.2. Health care is progressively shifting out of hospitals but progress in some countries is still low

Panel A. Average annual growth rate of hospital beds, 2000-14 (or nearest year)

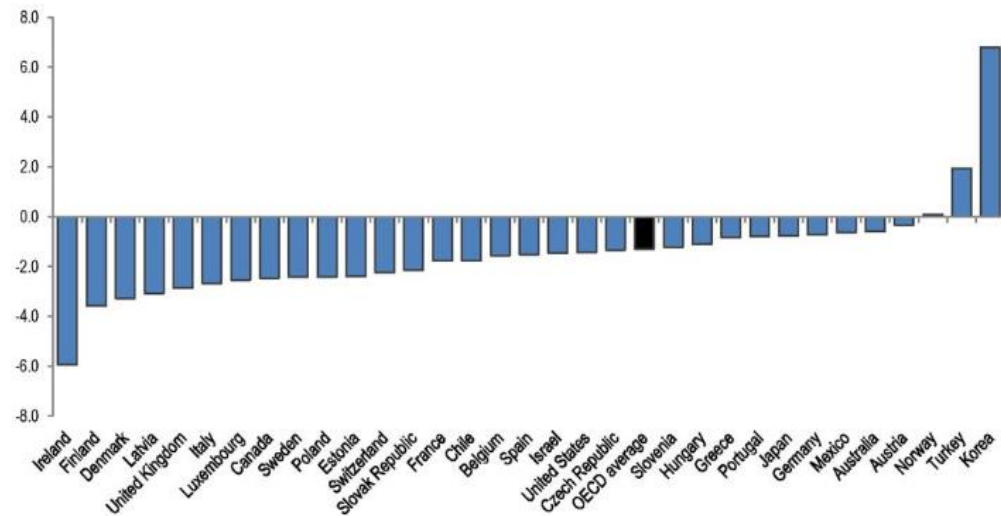




Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
2) Integrated	<ul style="list-style-type: none">• Extent to which GPs/PC Teams carry out preventive activities such as: Testing for sexually transmitted diseases; Screening for HIV/AIDS; Influenza vaccination for high-risk groups; Cervical cancer screening; Breast cancer screening; cardiovascular risk assessment.• Is there a structured cooperation between PHC and social care?• Does the pharmaceutical care integrate the contribution by GP/community pharmacist/nurse e.g. through an integrated pharmaceutical record?• To what extent are disciplines like occupational therapy, physiotherapy, speech therapy,... integrated in PC Teams?



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
3) Person-centred	<ul style="list-style-type: none">• Duration of regular visit (minutes) of different types of providers• % of patients who rate that they i) trusted the GP/nurse/social worker/...; ii) were involved in shared decision making ; iii) were satisfied with PC visit.



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
4) Comprehensive and community oriented	<ul style="list-style-type: none">• Extent to which patients visit a GP for first-contact care for specific health conditions; people with a first convulsion; suicidal inclinations; alcohol addiction problems.• Is FP/GP the only medical discipline in PHC?• Are there activities related to Community Oriented Primary Care?• Is there palliative care at home organised?



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
5) Addressing personal health needs (provide high quality PC)	<ul style="list-style-type: none">• % of infants vaccinated within PC against e.g. diphtheria; tetanus; pertussis; measles; hepatitis B; mumps; rubella; % population aged 60+ vaccinated against flu; HPV vaccinations• The defined daily doses of antibiotics use in ambulatory care per 1000 inhabitants• Percentage of individuals with COPD or asthma who have had a lung function measurement during the last year• Percentage of diabetic population with blood pressure above 140/90 mm Hg observed in the last 12 months• Percentage of patients stating that the treatment contributed to achievement of their life-goals



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
6) Sustained partnership with patients and informal caregivers	<ul style="list-style-type: none">• % of informal caregivers who receive support from primary care• % of patients reporting help by informal care givers• Presence of organisations of informal caregivers in a community



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
7) Coordination of people's care	<ul style="list-style-type: none">• Is there a gate-keeping system (access to specialists through referral)?• Do patients need a referral to access the paramedical and nursing disciplines, to access social care?• Is it common for GPs to have regular (electronic) face-to-face meetings (e.g. at least once per month) with the following professionals? Other GP(s); Practice nurse(s); Nurse practitioner(s); Home care nurse(s); Midwife/birth assistant(s); PC physiotherapist(s); Community pharmacist(s); Social worker(s); Community mental health workers; medical specialists.



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
8) Continuity of people's care	<ul style="list-style-type: none">• Do GP-practices have a patient list system? Or another form of defined population?• % of patients reporting to visit their usual PC provider for their common health problems• % of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.• % of patients who are satisfied with their relation with their GP/PC provider• Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services?



Table 2. Examples of comparative key-indicators along its key domains

Domains	Examples of Indicators
9) Primary care organisation	<ul style="list-style-type: none">• PC payment system, revenues, and operating costs• Percentage of income of GPs through FFS, Capitation, Salary, P4P• Average income of 1FTE GP compared to average income of specialist; of PC nurse compared to hospital nurse,...• Quality control audits• Clear Vision and Mission statements of PC Teams• Existence of continuous quality improvement processes• Is there an organisation at meso-level of the support structures for PC, e.g. in Primary Care Zones,...• Is there an organisation at macro-level of PC e.g. a regional/national Institute for PC?



Table 2. Examples of comparative key-indicators along its key domains

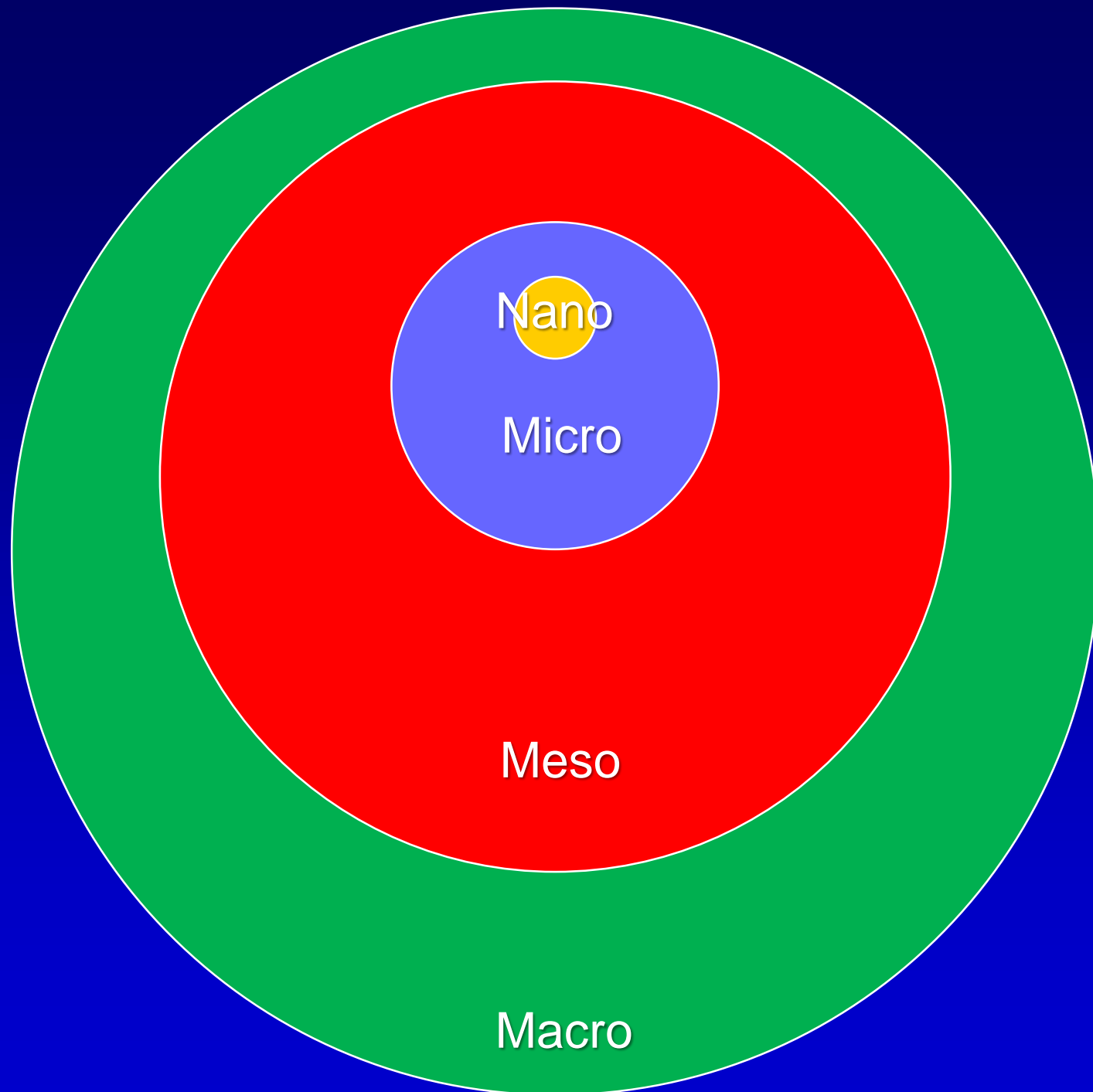
Domains	Examples of Indicators
10) Human resources in primary care	<ul style="list-style-type: none">• Average number of working hours per week of GPs/nurses/pharmacists/social worker/..• Average age of practising providers in PC• Total no. of active GPs as a ratio to total no. of active physicians• Total n°. of nurses active in PHC compared to total number of nurses in PHC, secondary and tertiary care

Re-thinking performance assessment for primary care: Opinion of the expert panel on effective ways of investing in health

Dionne Kringos, Sabina Nuti, Christian Anastasy, Margaret Barry, Liubove Murauskiene, Luigi Siciliani & Jan De Maeseneeron behalf of the members of the Expert Panel on Effective Ways of Investing in Health

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European Forum for Primary Care



Created In 2005 & Secretariat located at the NIVEL institute in the Netherlands.



Why the forum?

- Strengthening PC within EU countries
- Multi professional network
- Citizen/Patient at the centre of care

Activities

- Website & Two weekly Newsflash
- Position Papers in development
- Lunch-Webinars
- Conferences/workshops
 - Ljubljana 27-29 Sept 2020
- Advocacy (EU, National Governments, WHO)
- Multi Country Study Visits

110 institutional & 60 individual members from 3 different levels (Policy, Research & practice)

*Actual Chair : Sally Kendall Professor of Community Nursing and Public Health & former Chair Prof. em. Jan De Maeseneer

EFPC on the Web

- Web based database on European Primary Care:
www.euprimarycare.org
- LinkedIn discussion group:
“Primary Care Forum”
Currently 6500 members from all over the world
- Twitter: **@PrimaryCare4um**
Currently >1925 followers
#EFPC
- Facebook-page: **Primary Care Forum**

www.euprimarycare.org





Photo: Dunja Wedam (Turizem Ljubljana)

EMPOWERING PRIMARY CARE THROUGH DIVERSITY

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Milan Kokalj, Domus medica



15th EFPC Conference

27.-29. September 2020

LJUBLJANA, SLOVENIA

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Conference fees

Students	175 €
Early bird EFPC members	300 €
Early bird non-members	475 €
Registration EFPC members	400 €
Registration non-members	575 €

Abstract submission deadline: 1st May 2020

Challenges for Health Care Delivery: perspective 2030

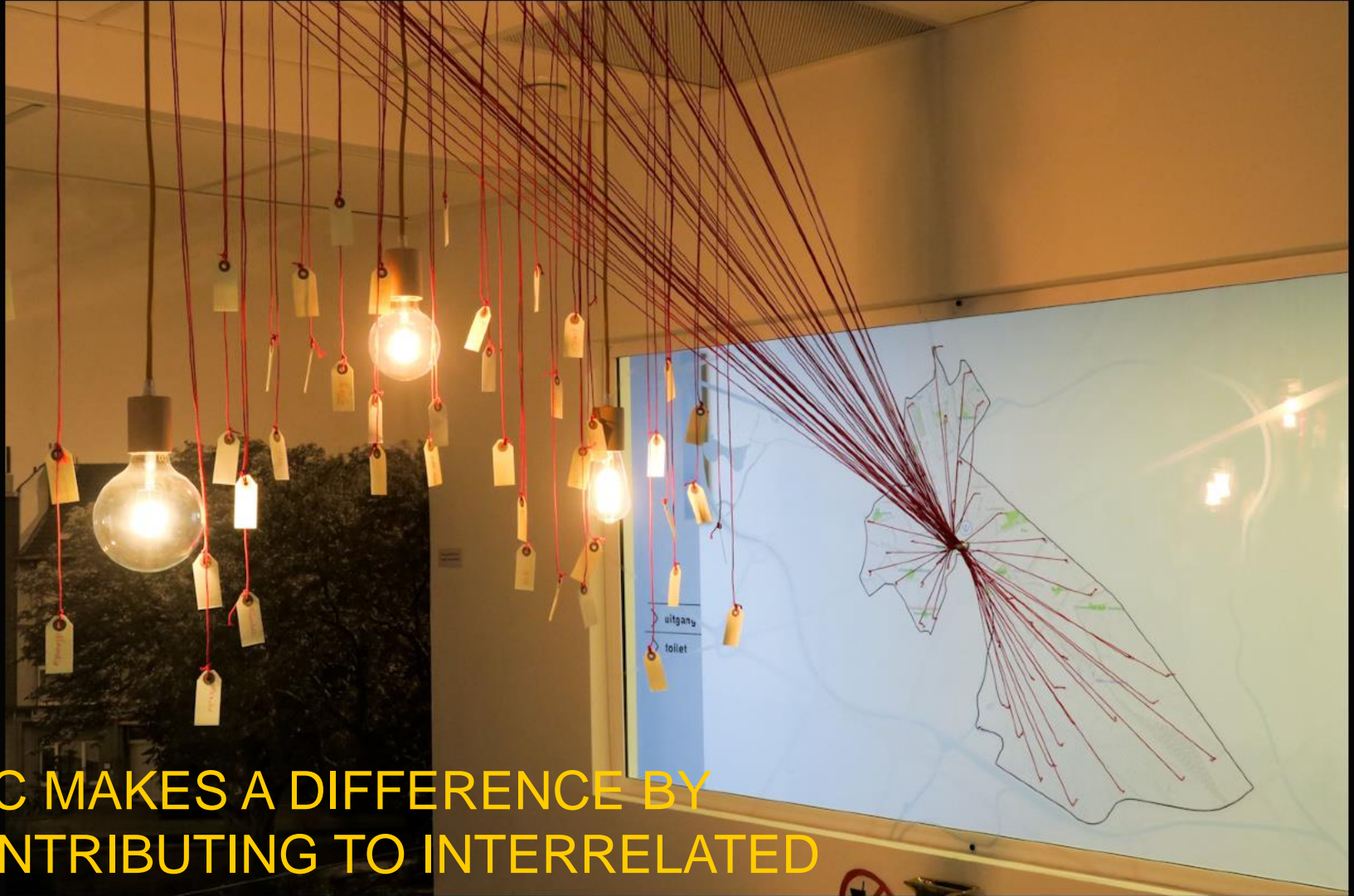
- 1. Introduction**
- 2. The changing society: 5 challenges**
- 3. How can health systems respond?**
- 4. Conclusion**



Jan De Maeseneer
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and Primary Care
At the Crossroads of Societal Change

LANNOO
CAMPUS

PHC MAKES A DIFFERENCE BY
CONTRIBUTING TO INTERRELATED
CONNECTEDNESS AND SOCIAL
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Solidarity
Connectedness
Resilience of Communities
Social Cohesion

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