Training health professionals for Primary Health Care in the 21st Century

Prof. Jan De Maeseneer, M.D., Ph D.
Chair Educational Committee Medicine – Ghent University (Belgium)
Head of Department of Family Medicine and PHC – Ghent University
Director International Centre for Family Medicine and PHC-Ghent University, WHO CC on PHC
Family Physician (part-time), Community Health Centre Botermarkt – Ghent
Chairman European Forum for Primary Care
Secretary General The Network “Towards Unity for Health”

Almaty, 06.11.13
Training health professionals for PHC

1. Response to the changing society
2. Characteristics of PHC-encounters
3. Community-oriented interprofessional training
4. Social accountability of health professional education worldwide
5. Conclusion
The changing society

a. Demographical and epidemiological developments

b. Scientific and technological developments

c. Cultural developments

d. Socio-economical developments

e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)
By 2100, 85%?
Health professionals for a new century: transforming education to strengthen health systems in an interdependent world

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

*Table 3: Levels of learning*
The future: WHO-six star provider (Boelen C et al)

THE SIX STAR PROVIDER

- assess and improve the quality of care
- make optimal use of new technologies
  - promote healthy lifestyles
- reconcile individual and community health requirements
  - work efficiently in teams
- leadership attributes and acts as change agent
Training health professionals for PHC

1. Response to the changing society
2. Characteristics of PHC-encounters
3. Community-oriented interprofessional training
4. Social accountability of health professional education worldwide
5. Conclusion
The patient is the starting point of the process

- Active
- Informed
- Service delivery
- Multicultural

Accessibility
Equity
Characteristics of PHC / patient encounters

- C
- C
- C
- C
- C
- C
- C
- C
- C
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- C
- C
- C
- C
- C
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
  - C
  - C
  - C
  - C
  - C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- C
- C
- C
- C
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
  - C
  - C
  - C
  - C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- C
- C
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- C
Characteristics of PHC / patient encounters

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

Compassion ↔ Computer
Quality in primary health care: a multidimensional approach to complexity

Good care is much more than meeting disease specific targets. Iona Heath and colleagues argue that assessments of quality must take into account all the complexities of primary health care.

In his 1913 novel Chance, Joseph Conrad wrote about the changing fashion for certain words: “You know the power of words. We pass through periods dominated by this or that word—it may be development, or it may be competition, or education, or purity or efficiency or even sanctity. It is the word of the time.” Today’s word is quality.

In order to assess the quality of primary health care, we have to define what quality means in this context. But who should care may improve disease specific outcomes but can also have unintended consequences in fragmentation of care and higher costs for reduced value.

Quality of care is particularly challenging in the fragmented and pluralistic systems often seen in low and middle income countries and in some high income countries, most notably the United States. Most of the elements deemed responsible for the failure of primary care programmes in these countries are more related to structure than process. Such elements include limited, erratic, or unsustainable funding; inadequate training and equipment; and primitive rather than primary health care, which occurs when primary care is conceptualised as providing basic services only for poor people rather than as the foundation of care for all people.

Most patients presenting in primary care have multiple, interacting, and compounding problems—physical, psychological, and

---

Iona Heath, general practitioner, Caversham Group Practice, London NW5 2UP
Adolfo Rubinstein, professor of family medicine and public health, Division of Family and Community Medicine, Hospital Italiano, Faculty of Medicine, University of Buenos Aires; president, Institute of Clinical Effectiveness and Health Policy, Buenos Aires, Argentina
Kurt C Stange, professor of family medicine, epidemiology and biostatistics, sociology, and oncology, Case Western Reserve University, Cleveland, OH 44106, USA
Mieke L van Driel, professor of general practice, Faculty of Health Sciences and Medicine, Bond University, Gold Coast, Qld 4229, Australia; Department of General Practice and Primary Health Care, Ghent University, Ghent, Belgium
GUIDING PATIENTS THROUGH COMPLEXITY:
MODERN MEDICAL GENERALISM

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

October 2011
Training health professionals for PHC

1. Response to the changing society
2. Characteristics of PHC-encounters
3. Community-oriented interprofessional training
4. Social accountability of health professional education worldwide
5. Conclusion
Ghent University
Faculty of Medicine and Health Sciences
located on the University Hospital campus
## Third Year

<table>
<thead>
<tr>
<th></th>
<th>1st semester</th>
<th>2nd semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Methodology</td>
<td>Health and society II</td>
<td>Problems of Digestive Tract, Endocrine Systems and Nutrition</td>
</tr>
<tr>
<td></td>
<td>Infection and immunology</td>
<td>Problems of Ear, Nose, Throat, Neck, Skin and eyes</td>
</tr>
<tr>
<td></td>
<td>Mechanisms of disease</td>
<td>Family Medicine and Primary Health Care</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and Therapeutic Methods</td>
<td>Evaluation 1</td>
</tr>
<tr>
<td></td>
<td>Christmas Holidays</td>
<td>Intersemmestrial Holidays</td>
</tr>
<tr>
<td></td>
<td>Evaluation 1</td>
<td>Problems of Ear, Nose, Throat, Neck, Skin and eyes</td>
</tr>
<tr>
<td>Pr</td>
<td>Medical Decision Making and</td>
<td>Communication skills III</td>
</tr>
<tr>
<td>Pr</td>
<td>Projects: analysis and</td>
<td>evidence based medicine I</td>
</tr>
<tr>
<td>Pr</td>
<td>Exploration: Contextual Medicine and</td>
<td>reporting of Research Data</td>
</tr>
<tr>
<td>Ex</td>
<td>Clinical and</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Sk</td>
<td>Communicative skills III</td>
<td>Studium generale</td>
</tr>
<tr>
<td>Pa</td>
<td>Explorative and Contextual Medicine and</td>
<td></td>
</tr>
</tbody>
</table>

### Winter (W.

| W. | 2 | 3 | 3.5 | 2 | 2.5 | 5.5 | 5.5 | 2 |

### Summer Holidays and Resit
Undergraduate Medical Education – Ghent University
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.
Community Oriented Primary Care

Ghent 2002-2013

- Medical students
- Social paedagogic students
- Sociology students
- Health Promotion students
Cumulatie kansarmoede-criteria
Scores hoger dan anderhalve keer het stadsgemiddelde

Poverty index

WGC Brugse Poort
WGC De Sleep
WGC Botermarkt
University Hospital
Nieuw Gent

P (Spreidingswaarde) > 1.5
- 1 criterium
- 2 criteria
- 3 criteria
- 4 criteria
- 5 criteria
Geen enkel criterium + Niet in aanmerking (Totaal bevolking < 100)

Informatieverwerking C-Luma bvba
Community Health Centre:

- Family Physicians; nurses; dieticians; health promoters; dentists; social workers; …

- 5800 patients; >60 nationalities

- Integrated needs-based Capitation; no co-payment

- COPC-strategy
FIGURE 1.2: The COPC Process

Define and Characterize the Community

Identify Community's Health Problems

Involve Community

Develop Intervention

Monitor Impact of Intervention
Visit to a family living in poverty
Exploration in the neighbourhood
Process of data-collecting
Criminality figures
Confronting experiences
Making a community diagnosis
Presentation to local stakeholders
PROBLEMEN
Praat erover

Goed in je vel, goed in je buurt
COPC is an interprofessional TEAM-experience!
Integration of personal and community health care

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

*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
“Towards Unity for Health”

PARTNERSHIP PENTAGON

Policy makers

Health managers

Communities

Health professions

Academic institutions

HEALTH SYSTEM BASED ON PEOPLE'S NEEDS

www.the-networktufh.org
The mean percentage of third-year students and master of social work (MSW) and master of social welfare studies students (2003-2007) agreeing or disagreeing with statements on a questionnaire evaluating the effects of the community-oriented primary care (COPC) exercise at Ghent University. The figure shows which percentage of the students agreed or disagreed with the statement "working with students of another discipline was an enriching experience".

Percent of respondents

- Agree
- Disagree

Medical students

MSW and Master of Social Welfare Studies students
I got a feeling of powerlessness.

It was very interesting and fascinating to discuss the problems in the community from different points of view.

You realize that everybody had his/her own background and that his/her disease fits in a bigger global picture.

Two days are too short to make a good community diagnosis.

To get in touch with different disciplines in health care.

The interviews with the caregivers give you an idea of how hard working in a deprived area can be.

I got a feeling of powerlessness.
An Interdisciplinary Community Diagnosis Experience in an Undergraduate Medical Curriculum: Development at Ghent University

Bruno Art, MD, Leen De Roo, MA, Sara Willems, MA, PhD, and Jan De Maeseneer, MD, PhD

Abstract

Since 2002, the medical curriculum at Ghent University has incorporated a community diagnosis exercise, teaming medical students with master of social work and social welfare studies students. The course focuses on the interaction between the individual and the community in matters of health and health care.

During one week, small groups of students visit patients and their caregivers in six underserved urban neighborhoods, and they combine these experiences with public health data, to develop a community diagnosis. Local family physicians and social workers monitor sessions. The course requires students to design an intervention tackling one community health issue. At the end of the course, the students present their diagnoses and interventions to community workers and policy makers who provide feedback on the results.

In the authors’ experience, medical and social work students all value the joint learning experience. The occasional culture clash is an added value. The one-week course is very intensive for students, mentors, and cooperating organizations. Although students criticize time restraints, they feel that they reach the outlined objectives, and they rate the overall experience as very positive.

The authors find that this interdisciplinary, community-oriented exercise allows students to appreciate health problems as they occur in society, giving them insight into the interaction of the local community with health and health care agencies. Combining public health data with experiences originating from a patient encounter mimics real-life primary care situations. This campus–community collaboration contributes to the social accountability of the university.

Working for Health Equity: The Role of Health Professionals
Year 5 (MA2)

Interprofessional development of a care plan for patients with:

- Multiple Sclerosis
- COPD
- Reumatroid Arthritis

A 3-days group experience
Interprofessional module: developing a care-pathway for patients with chronic conditions (2012)
Learning from patient experiences
Students from nursing, medicine, management, health promotion
Experts feed-back on the proposed care pathway
Feed-back by the students: qualitative assessment

It is important to learn how other disciplines work and how we can cooperate.

Development of care plans focusing on prevention and goal-oriented care is important.

Organisation and logistics: room for improvement.
INTERPROFESSIONAL EDUCATION
for COLLABORATION
Learning How to Improve Health from
Interprofessional Models Across the
Continuum of Education to Practice
WORKSHOP SUMMARY

Global Forum
on Innovation
in Health Professional
Education

Institute of Medicine
Washington
Student Participation

as a strategy to learn transformational leadership
Transformational leadership occurs when leaders articulate the purpose and the mission interactively with the group and are intellectually stimulating the group, championing innovation, inspiring group members to become change agents. Transformational leadership is characterized by connecting the member’s sense of identity and self to the project and the collective identity of the organization: being a role model for the group-members that inspires them and keeps them interested. Transformational leadership challenges group members to take greater ownership and strategic understanding of the context, the strengths and the weaknesses that have to be addressed in the change process. Transformational leadership creates a climate of trust, a process of empowerment and guarantees safety so that group members can look beyond their own self-interest(2) in order to make change happen.

Prof. Jan De Maeseneer.
Prof. Dawn Forman.
SWME: Student Workgroup on Medical Education

- Participation of the students in the committees that built the different “units” and “lines” in the curriculum
- Participation of the students in the Educational Commission, Faculty Council
- Participation of the students in different governance structures of the university.
- Organisation of monthly meetings, a student Research Symposium, a yearly seminar, that produces a report (30p) with a fundamental analysis of the curriculum and the proposals for the improvement
- High degree of “ownership” of the curriculum by the students
What did SWME students learn in student participation?

"It is our responsibility to improve accessibility of care" (4.23)
"It is our responsibility to improve quality of care" (4.52)

• "dealing with decision making in an ethical way" (4.25)
• "defending the viewpoints of the group I represent" (4.34)
• "formulating compromises when there are different opinions in a group" (4.15)
• "tackling problems in an effective way" (4.38)
• "anticipating future developments" (4.18)
• "developing a vision for the future" (4.30)
• "formulating proposals for improvement" (4.33).
LEADING CHANGE

JOHN P. KOTTER

HARVARD BUSINESS REVIEW PRESS
## Management versus leadership

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

*Source: J.P. Kotter. A force for change: How leadership differs from management (1990)*
Training health professionals for PHC

1. Response to the changing society
2. Characteristics of PHC-encounters
3. Community-oriented interprofessional training
4. Social accountability of health professional education worldwide
5. Conclusion
THEnet’s Evaluation Framework for Socially Accountable Health Professional Education
Social Accountability

- Recruitment and retention
- Students from rural, remote and poor areas
- Students from ethno-cultural minorities
- Curriculum responsive to the needs of the population
Social Accountability: workforce in Family Medicine

Global Medical Record: patient list

New curriculum Ghent University: COPC

Impulseo-funding PHC

Better payment for residents in Family Medicine
Human Resources for Primary Health Care in Africa (HURAPRIM)

AN international FP7 collaborative research project.

Aims at developing and assessing policies and key interventions to address the personnel crisis in (PRIMARY) health, in Africa.
Health workers per 10 000 in HURAPRIM countries

- South Africa
- Botswana
- N. Sudan
- Uganda
- Mali

- Doctors
- Nurses
- Midwives
## Distribution of MUST* Alumni

<table>
<thead>
<tr>
<th>Currently in Uganda</th>
<th>687 (88%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work for:</td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>270 (35%)</td>
</tr>
<tr>
<td>NGO or Private</td>
<td>510 (65%)</td>
</tr>
<tr>
<td>HIV related NGO</td>
<td>383 (51%)</td>
</tr>
<tr>
<td>Effort dedicated to HIV</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>119 (15.8%)</td>
</tr>
<tr>
<td>Less than 50%</td>
<td>317 (42.2%)</td>
</tr>
<tr>
<td>Over 50%</td>
<td>314 (42.0%)</td>
</tr>
<tr>
<td>Donor program not HIV</td>
<td>169 (22.5%)</td>
</tr>
</tbody>
</table>

*Faculty of Medicine n=790
Primary Health Care Family Medicine Education Network

Family medicine in Sub-Saharan Africa

www.primafamed.ugent.be
Primafamed started in South-Africa: a central curriculum with decentralised community based training in FM and PHC

- Undergraduate Curriculum
  - Postgraduate Family Medicine Training
    - Training Complex:
      - PHC-centers + clinics
      - District Hospital
    - Training Complex: Rural and remote areas
  - E-learning
  - Exposure
17 Family Medicine Training Complexes in South-Africa
Training sites

- Improving the infrastructure of training complexes
- New training complexes appointed
- Rural and remote areas, townships
Primafamed Partners

Ghana – University of Ghana
Sudan – Ahfad University for women
Sudan – University of Gezira
Nigeria – University of Lagos
Kenya – Moi University
Uganda – Makerere University
Uganda – Mbarara University
Tanzania – Aga Khan University
DR Congo – University of Goma
Rwanda – National University of Rwanda
The Family Medicine Unit is currently attached to the Department of Medicine.

Primafamed is assisting to set up a department and also develop an undergraduate curriculum.

The unit is working towards becoming a full department within 5 years (2007-2011).
Training session University of Ghana
A set of 3rd undergraduate students having a tutorial just before their clinical exposure in family in medicine in the department’s conference room (Makerere University College of Health Sciences)
The South African-Family Medicine-Twinning Project (July 2009 – JUNE 2013)

STRENGTHENING DEVELOPMENTAL CAPACITY FOR FAMILY MEDICINE TRAINING IN AFRICA
The University of Botswana (UB) is supported by the Stellenbosch University (SU) in SA. UB launched its own MMed program in Family Medicine in January 2011 and enrolled 8 first year registrars. 4 of the registrars are being trained in the Maun Training Complex four in the Mahalaype Training Complex. UB also entered into an agreement with SU to license the Clinical Family Medicine module and materials for their students. There is also good progress of the Botswana MMed students on the SU program with the likelihood of having the first graduates in 2011-2012.
MALAWI: College of Medicine (COM) of University of Malawi is supported by Department of family Medicine and Centre for Rural Health at WITS (SA).

A 6 week family medicine rotation for undergraduate medical students at COM took of in March 2011. Students (22 in 2011) were divided over 4 mission hospitals that served as training site. Post-graduate training is in planning phase.
An African wide plan is needed to scale up the capacity of family medicine training:

By 2020 Africa should have \textbf{30,000 more trained family physicians}!

How to make this happen?
“The data suggest an estimated 10,000-11,000 graduates per year from medical schools in sub-Saharan Africa”

What happens if 50 % of these graduates are from now onwards trained in a 2-years program in Family Medicine?
Reverse the deadly carrousel of brain-drain
Political action at the international level:

*Every Western country should reimburse the country that trained the physicians and nurses they receive in their health system, with the full cost of training in the receiving country*
Training health professionals for PHC

1. Response to the changing society
2. Characteristics of PHC-encounters
3. Community-oriented interprofessional training
4. Social accountability of health professional education worldwide
5. Conclusion
Conclusion: “Training health professionals for PHC in the 21st century”

- “Six star provider”
- Team with appropriate skill mix
- Community Orientation
- Interprofessional training
- Quality Assurance: international accreditation
- No brain-drain but support for Africa
- Social accountability of Training Institutions of Health Professionals
Thank you

Jan.DeMaeseneer@ugent.be