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DRAFT CHARTER FOR GENERAL PRACTICE/ FAMILY MEDICINE IN EUROPE

Report on a WHO meeting

Copenhagen, Denmark
6–7 February 1998

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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

The Meeting, convened to finalize the text of the document, was attended by representatives of professional associations and societies concerned with general practice/family medicine, representatives of the medical and nursing professions as a whole, and experts who had contributed to the preparation of the draft Charter. The Meeting discussed the concepts and intentions of the document, the results of a collaborative study on the work of general practitioners in 31 countries, and the feedback from the consultation process on the draft discussion document, which was circulated in 1995 to a large number of national and international professional associations, colleges and scientific societies and was also discussed in several meetings, workshops and conferences. It was agreed to make it clear that the document addressed issues related to the characteristics and profile of general practitioners as professionals, and was not intended to describe general practice or primary health care as a whole. A number of specific points were discussed and agreed on. It was agreed to change the title of the document to *Framework for professional and administrative development of general practice/family medicine in Europe*. The participants stressed the need to disseminate the document to as wide an audience as possible.

Keywords

HEALTH POLICY
FAMILY PRACTICE
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CONTENTS

	<i>Page</i>
Introduction: scope and purpose of the Meeting.....	1
Concepts and contents of the draft charter	2
Comments and suggestions for revision of the draft charter	2
Ways to strengthen the impact of the charter on the progress of GP/FM	6
Conclusions and recommendations.....	6
Annex 1 Programme	7
Annex 2 Participants.....	8
Annex 3 Framework for professional and administrative development of general practice/family medicine in Europe.....	11

Introduction: scope and purpose of the Meeting

In recent years many countries have embarked on health care reforms, many of which have strengthened primary health care. Most of the reforms affecting primary health care included the reorganization of the established system of general practice/family medicine (GP/FM) or introducing one where it did not exist. Overall, GP/FM was recognized as the key profession in improving care at the primary level, providing continuity and longitudinality of care in coordinating a range of secondary and tertiary care services, and delivering integrated curative, promotive, preventive, rehabilitative and supportive care.

The WHO Regional Office for Europe (WHO/EURO) has been active in the process of health care reform by supporting countries initiating reforms and organizing meetings where experience is shared and policies formulated. The Ljubljana Charter on Reforming Health Care (1996) included a statement for strengthening health care systems through the reorientation of health care towards primary health care (PHC).

Although general practice is an old profession, its profile has been reshaped during recent decades and adapted to emerging needs and new opportunities following social and technical developments. Several professional and scientific groups and organizations have reformulated the status and aims of GP/FM. In particular, there is a need for a clear understanding of the role of GP/FM in many countries of central and eastern Europe (CCEE) and some other countries trying to improve professional support for the development of the PHC concepts.

In March 1992, a Consultation on the Formulation of a Charter for General Practice in Europe was convened in Utrecht, the Netherlands, to explore whether the WHO collaborating centres for PHC in Europe could elaborate a professionally unbiased Charter in order to support and enhance the development of general practice in connection with the provision of PHC. In 1994, a working group consisting of representatives of five collaborating centres at university departments and research institutes and the two main European scientific organizations of general practitioners drew up a draft charter, which was issued in 1995.

The draft charter was widely disseminated in Europe, including to a large number of national and international professional associations, colleges and scientific societies with a request for their comments and suggestions. At least six GP/FM associations translated the draft charter into their national languages and published it. The consultation process produced supportive comments, some suggested amendments, and a few criticisms of particular aspects of the document or of its intent.

A meeting to review and revise the text of the Draft Charter for General Practice/Family Medicine in Europe was convened on 6–7 February 1998 in Copenhagen, Denmark. It was attended by representatives of GP/FM professional associations and societies and the medical and nursing professions as a whole (which have an international European membership), as well as experts who contributed to the preparation of the draft charter and WHO/EURO staff members (list of participants in Annex 2). Dr J. Goicoechea acted as Chairperson and Professor Z. Jakšić as Rapporteur.

Dr Jo E. Asvall, WHO Regional Director for Europe, welcomed the participants. He described the broader development of health policies in the European Region, stressing the importance of the Ljubljana Declaration as a solid basis for further progress in PHC in Europe. Dr Asvall also

described the preparation of the working draft on the health policy for Europe: health for all for the 21st century, which is to be discussed at the Regional Committee this year, as a basis for far-reaching policy decisions. This document and the preparatory discussions stressed the role of GP/FM and of general nurses as family-oriented professional agents. Because the issue is of great importance for individuals and for governments, Dr Asvall invited the participants to discuss the draft charter from a wider perspective, keeping in mind that the objective is to produce a document which will be accepted with a feeling of ownership, not a lengthy statement which will be met with passive acceptance. It should stimulate GP/FM professionals to accept the new role proposed and others to support such a development. Dr Asvall urged participants to consider that this is just the right time to identify new priorities.

The first part of the meeting was taken up with presentations introducing the Charter, including data on the work of GPs in Europe and feedback from the written consultation, which supported a collaborative model of GP/FM in the provision of PHC. The second part of the meeting was devoted to discussion of the draft charter in plenary sessions and to revision of the text chapter by chapter, following the original text of the draft charter. A drafting group then formulated a revised text. Finally, participants discussed ways to strengthen the impact of the Charter on the progress of GP/FM.

Concepts and contents of the draft charter

The principles and contents of the draft charter were summarized by a group of authors who had participated in drafting the charter as representatives of WHO collaborating centres for PHC. They stressed that the intention was to avoid idealistic euphoria and to describe clearly and concisely the current state of GP/FM. A recent collaborative study on the profile of GP/FM in 31 European countries had that styles of work varied among groups of countries and between physicians working in urban and rural areas.¹ GP/FM has a growing role in the strategies to strengthen PHC which are a feature of current health service reforms in all European countries. The intention of the charter was to outline the nature and intentions of GP/FM and to support the professional, political and administrative strengthening of GP/FM.

Reactions to and comments on the working draft of the charter were included in the feedback from a number of meetings and conferences as well as from the written responses received from national and international scientific and professional organizations in Europe. With a few exceptions, the document had been well received. Issues which had proved controversial included the role of GP/FM in the front-line services, its relationship to other professionals, and several characteristics which are particularly important for GP/FM but can also be attributed to all health professionals. Representatives of the European Society of General Practice/Family Medicine (WONCA-ESGP/FM), the European Union of Medical Specialists (UEMS), and the European Union of General Practitioners (UEMO) explained the background and their attitudes towards some of these points.

Comments and suggestions for revision of the draft charter

Participants then gave systematic and detailed consideration to the text of the draft charter and proposed amendments.

¹ Boerma, W.G.W. & Fleming, D.M. *The role of general practice in primary health care*. Published on behalf of the WHO Regional Office for Europe.

In the **introductory part** describing the document and its purpose, participants decided that the descriptive term GP/FM should be used throughout but that the whole text should be carefully edited so as not to mix “general practice” and “general practitioners”. The main message of the document should also be improved by emphasizing the services needed in the PHC context and avoiding unnecessary resistance arising from general statements or from statements which might antagonize different professional groups. The roles of individuals and patients and their needs and expectations have to be visible. It was suggested that it might be better to start with broader issues concerning PHC and proceed to the specifics of GP/FM.

Participants discussed the following section on the *Characteristics of GP/FM* item by item. Some changes in wording and a shortening of the list of characteristics were proposed, with the object of simplifying the description and making it useful, especially for countries where GP/FM is not a familiar professional profile. The characteristics mentioned represent just a list of important topics for further development of GP/FM and are not necessarily present everywhere. Some of them are also applicable to other medical specialties and not necessarily only to GP/FM.

The total number of descriptors was shortened from 12 to 7 for different reasons. The most important was that the characteristics described are inter-related so it is easier to understand them when combined in meaningful combinations. For instance, the characteristic “general” (meaning whole population and unselected health problems) was combined with “accessible” (meaning not limited by administrative, financial and other barriers).

The characteristic “continuous” was combined with “personal”, underlining the longitudinal relationship of people and professionals over a considerable period of time and not just during one episode related to a disease. A “personal” service and relationship, as traditionally used in the description of desirable general practice, was defended and criticized from opposing viewpoints: on the one hand in contemporary health care a personal doctor is not always a reality, whereas on the other all doctors practise personal medicine. The term “continuous” was chosen as common and usual, in comparison with “longitudinal care”, recently used in the literature to describe a distinct characteristic of GP/FM.

After considerable discussion preference was given to the old and often criticized term “comprehensive”, combining the meanings of “integrated” and “holistic”, two descriptors used in the draft text which have different meanings in different countries. The term “comprehensive” should not be used in the document as meaning complete, total or without exception, but to describe the range of services utilized (health promotion, disease prevention, curative, rehabilitative and supportive care) and the concept of dealing with people from the somatic, psychological and social perspectives.

Several participants considered that the term “advocacy” was not well understood and was difficult to translate into different languages. The concept was broadened and better explained under the somewhat vague term “coordinated” (expressing appropriate referral and giving information to the patient) and by extending the term “collaborative” to cover teamwork and preparedness to work with other health and social care providers. The flow of information was important.

Finally, it was felt that the characteristic “confidential” should not be categorically stressed because it should be a general characteristic of all physicians.

The final, revised, list of characteristics now describes (1) the professional characteristics and type of work of GP/FM (general, continuous and comprehensive), (2) intentions in and ways of approaching health problems (coordinated and collaborative), and (3) their orientations (family- and community-oriented).

The meeting left the section on *Conditions for the development of general practice* with the same structure (Structural conditions, Organizational improvement and Professional development) as in the first draft but revised several details. The need to distinguish clearly between GP/FM as practitioners, and professionals and general practice as a service, and PHC as a framework and overall policy was repeated several times. It was also stressed that the very different conditions in European countries must be borne in mind, so that the message as a whole should not be prescriptive but stimulating.

An interesting discussion took place about whether general practitioners should have *discrete populations*, since the rights of people and of professionals were sometimes opposed. Finally, it was decided that the basic right of patients to choose their doctors has the priority, but it is not necessarily an obstacle to registration and construction of personal or family lists, supporting lasting relations through a considerable period of time.

Participants strongly supported the item on *Serving the general population*, even though in some countries this clearly cannot be implemented at present, taking into account the profiles of other professionals. However, they emphasized that GP/FM physicians must be trained to deal with the health problems of all population groups.

The statement in the draft charter on the *Working environment* was reinforced and the meaning explained in the sense that health authorities, administrators and professionals should continuously try to find the balance between workload and quality of care.

Most of the discussion on this section was related to the *Referral system*. Participants felt that trust should be fostered in general practitioners, and patients should have better information in order to make the most appropriate and cost-effective use of secondary and tertiary care. One proposal was to distinguish between referral to hospitals and referral to consultants. However, the most important aim of a good referral system was meant to be avoidance of fragmentation and reinforcement of integration of services. It is important that all partners in the health system clearly understand and accept their proper roles and are specifically trained for them. If specialists wish to work in front-line services they should only be able to do so after appropriate training, given in all cases by those who actually provide such a service and not by people who do not have practical experience but only teach “how it should be done”. The negative statement that “direct access to other medical specialists should be avoided whenever possible” should be changed to a positive statement underlining general practitioners’ role in and necessary training for coordinating the flow of patients in their best interests. The need for “horizontal” referral was also mentioned.

The section dealing with *Remuneration* was discussed as a potent instrument to influence appropriate care and a comprehensive approach as well as in relation to the referral system. A combination of different modalities of payment was suggested as the best solution. The text on remuneration was criticized for not taking teamwork into account and only concentrating on the performance of doctors – nurses being regarded as doctors’ helpers. The importance of that issue was recognized but not elaborated because of its complexity and because the whole document focuses on GP/FM as professionals, not on general practice as a service.

Participants stressed that the section on *Keeping patient records* was an important general statement for all professionals and also for quality of care for patients. They suggested that the wording of this part should be improved to make this position clear. The statement on *Teamwork* was broadened to include all types of service (e.g. prevention and rehabilitation) and also to consider social care professionals. In the section on *Practice organization*, it was suggested that adequate premises, equipment and ancillary staff should not be viewed as doctors' requirements, but as patients' needs for proper services.

In the section on *Professional development*, the meeting accepted the statement that all who work in PHC should be trained in the concepts and specific content of PHC at all levels of training. *Basic medical training* should include GP/FM training programmes. Participants discussed the duration of *vocational training* at length. They regarded the present requirement for two years in some countries as inadequate: it should be at the same level as vocational training in other specialties. However, the situation varies so widely between countries that they finally decided not to mention a specific length of training but to stress what was repeatedly considered as most important: that education and training is provided by those who are actually working in front-line practice. The importance of *continuing medical education* was stressed. The term *quality assurance* was changed to *quality development*, in accordance with the prevalent changes in terminology in the literature.

Participants once again highlighted the *development of GP/FM as an academic discipline* as one of the most important strategies for professional development, as also the provision of opportunities and skills for appropriate and relevant research. They underlined the greater need to study health issues as an important specific subject for *research in GP/FM*. Research was not just data collection, but identification, understanding and evaluation of specific activities and how they are expected to be performed in GP/FM.

Under the section on *Strategies for the development of general practice*, most consideration was devoted to the part on *Opportunities from within the profession*. Participants agreed that negative and prescriptive statements should be avoided. Although there was some disagreement on how much can at present be done from within profession, the recent positive experience from several countries was mentioned. The importance of involving academic communities, and a non-prescriptive approach by administrative decision-makers in combination with international collaboration and support, were regarded as the most successful strategies. Cultural and political differences, however, play an important role. In cases where GP/FM is weak at present, administrative support may be fruitful.

The other point was **the title of the new revised document**. Without a ministerial conference or decision of the Regional Committee, it is not possible to keep the title "Charter for General Practice/Family Medicine in Europe". On the other hand, the document is not the issue of an ordinary WHO working group, but the result of broad consultation with many scientific and professional bodies and organizations throughout Europe. It is also the result of systematic activities during the last seven years dealing with important, controversial and concrete changes in health care organization in many countries. The group expressed concern that the change in the title of the document, already discussed in many organizations, should not be understood as a negative change of policy or attitudes towards GP/FM. There was also concern not to use any administrative or unstimulating overused term such as "report", "guidelines" or "principles". The title must take into consideration the main potential users, namely governments, professional organizations and the public. It also has to express appreciation of the subject, which is not a

minor organizational modification but an attempt to introduce a change in the position and role of an important professional group.² The text of the final document is attached as Annex 3.

Ways to strengthen the impact of the charter on the progress of GP/FM

The last part of the discussion was devoted to possible next practical steps. The timing of future activities and the title of the new revised document were considered the most important issues.

Many arguments were put forward in favour of **speedy publication** of the document. However, health reforms, including the development or reinforcement of GP/FM, are under way in many countries so that the need for prompt information and/or support to professionals and decision-makers is at present necessary. Besides, a book (presented earlier during the meeting) on service profiles and practice conditions of GP/FM in Europe is ready for publication. The book, edited by G.W. Boerma and D.M. Fleming, is the result of joint European research and provides support and explanations for the principles and intentions of the document. If the revised document and the book could be distributed in the next few months it would give suitable time for decision-makers to make progress. The forthcoming annual meeting of WONCA in Dublin could also be the place where the ideas may be successfully spread to a wider audience of professionals.

Conclusions and recommendations

1. The working draft of a charter for general practice/family medicine and the results of the feedback from different WHO meetings and from written consultation with national and international scientific and professional organizations in Europe were considered. Comments were discussed and the text was revised.
2. The need, appropriateness and general support for such a revised and enriched document were emphasized.
3. It was recommended that the final version of the document should be published and distributed as a separate publication under a suitable title, without waiting for discussion by the WHO Regional Committee for Europe. It should be published as part of the forthcoming book on the position of GP/FM in Europe and in other suitable ways so as to reach governments, health administrators, professionals and the media.
4. A suitable period for further discussion and elaboration might be after the adoption of the new HFA policy, on the assumption that there will be possibilities for reciprocal support between the two documents.

² The title subsequently adopted was "Framework for professional and administrative development of general practice/family medicine in Europe".

Annex 1

PROGRAMME

Friday, 6 February 1998

13.30 – 14.00 Registration

14.00 – 14.30 Opening

- Welcome and election of Chairperson and Rapporteur
- Adoption of agenda, programme and scope and purpose
- Briefing on background, purpose and expected outcome
- Miscellaneous

14.30 – 15.30 Presentations on:

- The concept and content of the Charter: *Professor Pertti Kekki*
- What does a GP do in Europe? – The study on the profile of GP/FM:
Dr Wienke Boerma and Dr Douglas M. Fleming
- Strategies to develop and strengthen GP/FM in the context of reform of PHC:
Professor Zelimir Jaksic
- *Dr Mila Garcia-Barbero*: Feedback from the meetings and conferences where the draft Charter was presented and discussed

15.30 – 16.00 Coffee break

- *Dr Anastas E. Philalithis*: Feedback from the written consultation on the draft Charter
- *Dr Frede Olesen*: Is there a benefit for the patient from assigning a gate-keeping function to GP/FM? **The arguments in favour**
- *Mr Leonard P. Harvey*: Is there a benefit for the patient from assigning a gate-keeping function to GP/FM? **The arguments against**
- *Dr Cormac Macnamara*: Is there a benefit for the patient from assigning a gate-keeping function to GP/FM? **The arguments for a collaborative model**

17.30 – 18.00 Discussion

19.00 Dinner

Saturday, 7 February 1998

8.30 – 9.00 Presentation of revised text of draft Charter

9.00 – 10.30 Working groups: discussions on revised text

10.30 – 11.00 Coffee break

11.00 – 11.30 Working Groups: preparation of reports

11.30 – 12.00 Plenary session: Reports of Working Groups on proposed revised text

12.00 – 14.00 Lunch (*Drafting Group to meet*)

14.00 – 15.30 Plenary session: Presentation of amendments to revised text and discussion of amendments

15.30 – 16.00 Coffee break

16.00 – 17.00 Discussion on ways to strengthen the impact of the Charter on the progress of GP/FM in Europe

17.00 – 17.30 Recommendations

Conclusion of Meeting

Annex 2

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Annex 3

FRAMEWORK FOR PROFESSIONAL AND ADMINISTRATIVE DEVELOPMENT OF GENERAL PRACTICE/FAMILY MEDICINE IN EUROPE

In recent years, many countries in Europe have embarked on reforms of their health systems, either as part of broad political changes or as specific policies to improve their health services. Reform of primary health care has been a feature of this movement in several countries, often involving the reorganization of existing systems of general practice or their introduction where none existed. The WHO Regional Office for Europe, convinced of the potential contribution of general practice to health for all, through the delivery of a wide range of integrated health care functions including health promotion, disease prevention, curative, rehabilitative and supportive care, issued in August 1995 a discussion document entitled *A charter for general practice/family medicine in Europe – working draft*.

That document was issued at the end of a long preparatory process during which the Regional Office had convened a number of international meetings on subjects such as the role of the general practitioner in the countrywide integrated noncommunicable disease intervention (CINDI) programme (Heidelberg, 11–13 April 1991); the contribution of family doctors/general practitioners to health for all (Perugia, Italy, 22–25 May 1991); needs assessment in local areas and its consequences for health care provision (Jerusalem, 27–30 October 1991); the development of general practice in the countries of central and eastern Europe (Benesov, Czechoslovakia, 22–25 April 1992); the role of general practice settings in the prevention and management of the harm done by alcohol use (Vienna, 19–22 October 1992) and reforms in family medicine or general practice in countries of central and eastern Europe (Sinaia, Romania, 25–28 October 1993), as well as the first meeting of an expert network on family practice development strategies (Ljubljana, 26–28 January 1995).

A consultation on the formulation of a charter for general practice in Europe, held in Utrecht on 20–21 March 1992, explored the practical issues involved in supporting and enhancing the development of general practice in connection with the provision of primary health care. Finally, the Working Group on the Formulation of a Charter for General Practice in Europe met in Utrecht, the Netherlands, on 9–11 June 1994 with the purpose of formulating a first version of the charter.

The discussion document was sent to a large number of international and national associations and professional organizations of physicians and of general practitioners in Europe, asking them for their comments, views and proposals for improving the document. Several responses were received, in the majority expressing support for the text but on some occasions voicing criticism of the proposed draft. During this period, the document was also discussed in several meetings convened by the Regional Office and by associations and professional organizations of physicians and of general practitioners, as well as by bodies representing nurses. The purpose of this informal consultative process was to identify the essential features that are applicable everywhere and the proposals for specific improvements where they are feasible. The feedback from this long consultation process was discussed during a meeting to revise the draft charter (Copenhagen, 6–7 February 1998). The participants in this meeting were representatives of four WHO collaborating centres for primary health care and of the international associations and organizations of physicians and of general practitioners which had contributed to the debate, as well as a number of experts.

Two issues arose during the consultation period. The first concerned the title of the document. When the original title of *Charter for general practice/family medicine in Europe* was proposed, it was envisaged to hold a conference of Member States of the European Region of WHO to ratify the document, which is the procedure normally followed by WHO for the adoption of a charter. During this period, the plans for a

special conference were superseded by the decision to hold the WHO Conference on European Health Care Reforms (Ljubljana, 17–19 June 1996), where a general debate on health care reform took place. In consequence, the title of the document has been changed to *Framework for professional and administrative development of general practice/family medicine in Europe*, in order to emphasize that the document is addressed to medical professionals and to decision-makers at all levels of the health care system. The second issue related to the need to clarify that the document addresses only matters related to general practice, and does not address matters related to the role and contribution of other medical specialties and health professions in primary health care.

During the same period, the Regional Office had also given support to the European Survey of the Task Profiles of General Practitioners, which yielded a wealth of information on the subject of what general practitioners do in selected European countries and how general practice is organized. The results of this study have been recently published.³

DEBT TO PAST GENERALISTS

It would not have been possible to draw up this framework for professional and administrative development of general practice/family medicine in Europe without the devotion and work of many unknown medical generalists in all countries who have developed the technical, ethical and cultural basis of health care in Europe. This is part of our essential European heritage and a cornerstone of future developments in this area.

Their work and experience, which are now beginning to yield their full technical, scientific and educational potential, are to be seen as helping to bridge the gap between human rights and needs, on the one hand, and the technical application of science in the field of health, on the other.

PURPOSE OF THE DOCUMENT

The need to orient health care systems towards primary health care has been reaffirmed on several occasions. While the organization and functions of primary health care differ from one country to another, because of historical developments and different social, economic and cultural circumstances, the services provided by general practitioners constitute an essential element of primary health care. Irrespective of whether they work in single practices or in partnership with other general practitioners, on their own or as part of a team of health professionals, and as the main provider of first contact care or as one of several specialists to which the population has direct access, their role in providing integrated health promotion, disease prevention, curative, rehabilitative and supportive care is recognized in many countries.

Without ignoring the contribution of other medical specialties and other health professions, it is widely accepted that general practice has the potential to contribute to offering:

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

General practice can thus contribute to an effective and efficient primary health care service of high quality, which should positively affect the workload and quality of specialized and hospital care.

³ Boerma, W. and Fleming, D. *The role of general practice in primary health care*. London, The Stationery Office, 1998

The purpose of this document is to explain and promote the essential role of general practice as a specialty and of general practitioners as specialists in contributing to improve the health of individuals and groups. In this document, given the differences in the way these terms are used and interpreted in different countries, the terms “general practitioner” and “family physician” refer to the medical practitioner who has completed specific postgraduate training, analogous to that of other medical specialties, in the discipline of general practice or family medicine. Correspondingly, the terms “general practice” and “family medicine” and the terms “general practitioner” and “family physician” are used as being equivalent.

The document has been developed with an appreciation of the varied nature of the systems currently operated and the problems faced by different European countries. It is designed to apply equally to those countries that are at an early stage in the implementation of education and training programmes to provide a first generation of family physicians, and those with established systems of general practice that could be strengthened. It recognizes that general practice can be elaborated and organized in a variety of ways, depending on the country's circumstances, resources and traditions. It therefore provides information for a framework for development, on the basis of which the most appropriate model can be selected.

The document is addressed to all parties involved in health care: decision-makers at different levels, those responsible for resource allocation, planners and managers, academic institutions, various organizations of family physicians, health professionals, and patients and their representatives. The successful development of general practice requires not simply the willingness but the wholehearted commitment of all these persons and bodies. Such commitment must be longterm and combined with a willingness to respond flexibly and positively to problems as they arise. Legislation, regulations, recommendations and guidelines should be developed. Financing, insurance schemes and payment systems that support the development of general practice may have to be introduced. Programmes for research, quality development, vocational training and continuing medical education have to be developed or adapted; and family physicians may have to be trained or retrained.

CHARACTERISTICS OF GENERAL PRACTICE

General practice can thrive in different health care systems. Despite differences in the ways these are planned, organized and managed, certain characteristics pertain to general practice in all countries. Although some of these characteristics are also applicable to other medical specialties, they are considered of particular relevance to general practice. They are described below.

1. General

General practice addresses the unselected health problems of the whole population; it does not exclude certain categories of the population because of age, gender, social class, race or religion, or any category of complaint or health-related problem. It must be easily accessible with a minimum of delay; access to it is not limited by geographical, cultural, administrative or financial barriers.

2. Continuous

General practice is primarily person-centred rather than disease-centred. It is based on a long-standing personal relationship between the patient and the doctor, covering individuals' health care longitudinally over substantial periods of their life and not being limited to one particular episode of an illness.

3. Comprehensive

General practice provides integrated health promotion, disease prevention, curative, rehabilitative and supportive care to individuals from the physical, psychological, and social perspectives. It deals with the interface between illness and disease and integrates the humanistic and ethical aspects of the doctor-patient relationship with clinical decision-making.

4. Coordinated

General practice can deal with many of the health problems presented by individuals at their first contact with their family physician, but whenever necessary, the family physician should ensure appropriate and timely referral of the patient to specialist services or to another health professional. On these occasions, family physicians should inform patients about available services and how best to use them and should be the coordinators of the advice and support that the patients receive. They should act as care managers in relation to other health and social care providers, advising their patients on health matters.

5. Collaborative

Family physicians should be prepared to work with other medical, health and social care providers, delegating to them the care of their patients whenever appropriate, with due regard to the competence of other disciplines. They should contribute to and actively participate in a well functioning multidisciplinary team and must be prepared to exercise leadership of the team.

6. Family-oriented

General practice addresses the health problems of individuals in the context of their family circumstances, their social and cultural network and the circumstances in which they live and work.

7. Community-oriented

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

CONDITIONS FOR THE DEVELOPMENT OF GENERAL PRACTICE

The conditions required for general practitioners to provide high-quality services can be specified at a number of levels. Some are related to the structure of the health care system, others to its organization at the local level. Some may be easier to realize and at an earlier stage than others. The aspects that are specific to general practice are considered below, under the following headings: structural conditions, organizational improvement and professional development.

I. STRUCTURAL CONDITIONS

1. Discrete population

The provision of personal, comprehensive and continuous care is encouraged by a continuing relationship between the family physician and the patient, based on mutual trust and agreement between the patient and the doctor. Such a relationship and continuity of care over time are facilitated when family physicians look after a well defined group of people, for example those registered in a personal or family list system. Having a specific family physician does not contradict the basic right of patients to choose their doctor, or the right to change from one doctor to another.

2. Serving the general population

Family physicians must be trained to deal with the health problems of all population groups, including children, men, women and the elderly, without distinction. Providing integrated care to the population is enhanced when services are not fragmented among different specialties and agencies that deliver care to certain categories of patient or of the population.

3. Working environment

General practice is based in the community, close to patients, with easy access by them. When large populations are served and there is an increase in the number of health care providers, extra precautions should be taken to avoid reducing accessibility and threatening the personal character of the provision of care. Administrators, health authorities and doctors should find a balance between the need for efficiency and the requirements of family practice.

4. Referral system

The coordinating role of family physicians is best carried out when their training provides them with the knowledge and skills required to manage the majority of the unselected cases that present to them and to refer appropriate cases to other health care providers, either within primary health care or to secondary specialized and hospital-based services. Cost-effective use of secondary care services is best achieved when only those cases that actually warrant these services are referred to them. Successful implementation of a referral system requires its acceptance by patients, which can be achieved through education and by fostering their trust in the family physician. It also requires good cooperation, exchange of information and reciprocity between family physicians and other medical specialists and health professionals: family physicians must make appropriate referrals, and information must be fed back to them from specialists; patients must also be similarly referred back.

5. Remuneration

The payment system should be well balanced, preferably combining a salary or other form of fixed payment, a capitation fee, and fee-for-service. Its aim should be to stimulate provision of the full range of services within the domain of general practice and to promote high quality primary health care by offering different incentives. The payment system may help to ensure the delivery of health promotive, preventive, curative and palliative services, as well as other aspects of practice such as team-based activities, general availability, operating an information system, carrying out teaching tasks when appropriate, and maintaining the premises and equipment. If market elements are introduced, standards of quality should be safeguarded.

II. ORGANIZATIONAL IMPROVEMENT

6. Keeping patient records

Systematically keeping detailed, problem-oriented and complete records of all encounters is important to maintain continuity over time, to identify episodes of illness, to create a patient history, and to coordinate care where several providers of care are involved. The records should also include other information relevant to patients' care, for example on matters relating to their living and working conditions and their lifestyles. Systematic preventive procedures and assessment of the health needs of the population are impossible without a sound record system that enables patient groups at risk to be identified. Finally, records are an essential requirement for quality development, audit of care, peer review, etc.

As in any type of health care service, patient records may contain highly confidential information, and the confidentiality of the information must be preserved in accordance with existing legislation. Patients also have the right to access their own records, and information may only exceptionally be withheld from them when it reasonably appears that it would cause them serious harm without any expectation of obvious positive effects.

7. Teamwork

Coordination in health care requires general practitioners to have a knowledge of the training of other health professionals and an understanding of what and how they can contribute to the work of other health care providers. Furthermore, cooperation among all health care providers involved in diagnosis, treatment and care, as well as with social care professionals, is a patient's right. Teamwork is by no means restricted to providers who work in shared premises. Those who work from separate offices and premises should have incentives to meet regularly and develop common aims and shared objectives and to evaluate the attainment of these objectives together. Teamwork makes it easier to pool the skills and expertise of a number of health and social care professionals and enhances their respect for each other's role.

8. Practice organization

Family physicians need adequate premises, equipment and ancillary staff. These should respect the privacy of patients, provide opportunities for diagnosis and treatment and facilitate accessibility. Family physicians may work alone, in groups or in health centres, but whatever the structure, the practice

organization should be flexible, which among other things means providing direct help for emergency cases, an appointment system for patients with less urgent problems and home care, whenever appropriate. Supporting services, such as X-ray and laboratory facilities, must be accessible to the family physician. With respect to 24-hour cover, family physicians should be involved in the planning and management of out-of-hours services for the population and contribute to finding solutions that are feasible and acceptable to all parties involved.

III. PROFESSIONAL DEVELOPMENT

9. Education

All health professionals and medical specialists working in primary health care must receive undergraduate, postgraduate and continuing education in the concepts and specific content of primary health care. The appropriate education of general practitioners is thus a crucial element in providing the integrated, comprehensive services that are referred to in this document. Education for general practice can usefully be considered under three headings: undergraduate training, postgraduate vocational training, and continuing medical education.

- (a) A first requirement is an adequate **undergraduate basic medical training**. General practice should already be an integrated part of undergraduate programmes. All medical students should be exposed to general practice, so that they acquire the knowledge that is specific to this discipline and gain the requisite understanding of the need for cooperation among all sectors of the health care system.
- (b) **Postgraduate vocational training** must be a requirement to become a family physician. This vocational training should be equivalent to that of other main clinical specialties and should be primary-health-care-oriented and based, to a considerable extent, in general practice. Practices, possibly affiliated to academic departments, should have a prominent role in teaching. The trainee must be offered sufficient opportunity to acquire broader skills, for instance in communicating with patients, counselling and practice management. Drawing up a core content of general practice is required for developing a proper vocational training programme.
- (c) For updating skills and maintaining and improving the quality of care, **continuing medical education (CME)** and continuing professional development are prerequisites. CME programmes must be general-practice-oriented and based on research, in particular in primary health care. The prime responsibility for CME rests with the medical practitioners themselves, who will need to use different modalities to achieve and maintain their competence. Distance learning techniques may be of great benefit to facilitate access to training by doctors.

10. Quality development

General practice should be open to evaluation. Quality assessment and development is essential, irrespective of the employment status of family physicians. Continuing medical education can be an important instrument in quality assurance. Systems of clinical audit organized by doctors themselves and carried out in peer groups are effective. Agreed professional guidelines, as they are currently being developed in some countries, are important tools for professional development and should be adapted to national and local circumstances.

11. Academic departments of general practice

Given the specific characteristics of general practice as a specialty, its recognition as an academic discipline is essential to the acceptance of general practice as a full partner in the provision of health care. Efforts must be made to establish fully funded academic departments and professors of general practice where they do not yet exist. These departments, with sufficient resources of all kinds, must be headed by practising family physicians or persons with a solid background in general practice and appropriate academic credibility, and supported by their peers. They should be continuously involved in clinical general practice and should have close links with other disciplines.

12. Research

An academic discipline cannot be created in a vacuum. It needs a scientific basis to create its own body of knowledge. Academic departments of general practice should concentrate not only on training and education but also on research. Vocational training programmes should make future family physicians research-minded. There should be opportunities for trainees to carry out research in the vocational training programme. General practice research should be sufficiently funded and closely related to the health problems that family physicians care for and to the clinical activities that they carry out in their daily work.

13. Professional organization

From the conditions described above, the profession of general practice clearly needs an effective organization to identify professional needs and promote professional development at national and international levels and to support local initiatives. The two functions, political and academic, are usually organized separately, although a single organization combining both functions is possible. Family physicians must be represented at the highest levels in all the relevant medical decision-making bodies.

STRATEGIES FOR THE DEVELOPMENT OF GENERAL PRACTICE

THE STARTING POINT

There are huge differences between the countries in WHO's European Region with regard to their ability to meet the conditions outlined in the previous sections of this document. Some countries can rely on a history of decades of improving the position of general practice, while others have just started. Especially for the latter, some indication is useful of how and where to start implementing the recommendations contained in this document. Some of the conditions are easier to implement than others.

One important stage in the process is to gain the broad support and cooperation of the health professions, administrators and health authorities. This will prepare the ground, through information and education, for wide acceptance by the population of the special role of general practice. General practitioners themselves and their organizations should play a significant role in doing this.

OPPORTUNITIES FROM WITHIN THE PROFESSION

Meeting some of the professional conditions may be considered a suitable starting point for developing general practice. Irrespective of the specific structure of a health care system, one important first step is to establish an association for improving the position of family physicians and a College or Institute for promoting the content and the quality of their professional activities. The college can act as a pressure group to exert influence on universities, and both organizations can be focal points for those devoted to improving their profession. There are clear links between setting up a professional organization and engaging in research, quality development and postgraduate education: for instance, proposals on the content of an undergraduate and postgraduate curriculum can be put forward by these organizations.

The process of introducing or strengthening general practice is also facilitated through contacts with countries where it has a long-standing tradition. International collaboration for the development of general practice, while respecting local culture and traditions, contributes to progress by enabling people to learn from the experience of others.

THE ROLE OF DECISION-MAKERS

Without support from outside the profession, it may be difficult to develop general practice. In order to meet various conditions (such as the provision of integrated, well coordinated services), the active support of policy- and decision-makers, politicians and the general public is needed. Policy- and decision-makers should be sensitive to valid claims of cost-effectiveness, politicians and the general public to those of equitable, accessible and comprehensive care.

The implementation of general practice requires appropriate supportive legislation and regulations such as an appropriate payment system. The current attitude of the population in various countries, whereby

quality of care is associated with highly specialized services, will only be changed by the demonstration of quality in general practice.

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

This document is also available on the WHO/Europe website, <http://www.who.dk>. Additional copies can be requested from:

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