

President of semFYC, Your Excellency, Distinguished Guests,

[Slide 1] It is with great pleasure that I am standing here before you at the opening of your conference. First, I would like to take this opportunity to bring you the best wishes from the World Organization of Family Doctors, Wonca. Secondly, I would like to thank you, semFYC, for your outstanding contribution to the development of primary care and family medicine – in Spain, but also in the international context, in Europe and in particular in the Ibero-Americana region. As a third point of this introduction, I have the privilege to cordially invite you to the coming World Wonca Conference, that will take place in Cancun, Mexico, May 19 – 23, 2010. This, Wonca's first world conference in Latin America comes as the fruition of your support for this region.

On this occasion, I would like to spend a few words to review with you the future of family medicine and primary care. My basic recommendation is, that to secure the future of health care, primary care and family medicine are indispensable, and to achieve this, it is essential that future practitioners have to be educated and trained **in** the family practice setting, **by** family physicians (FP). Involvement of the University in this – University Departments of Primary Care – are an indispensable aspect of this development.

First: what is and does primary care and what is its international basis? For this, let us explore the model of 'ecology of medical care'.

Throughout my presentation, I will use the words 'primary care', 'family medicine', 'family practice' and 'general practice' as synonymous.

[Slide 2] The 'model of the ecology of medical care' is summarized in this picture. It underlines that most of the people, with most of the health problems they encounter are most of the time in the community. There they get sick, there they have to get better. There, their disease might be prevented and there, their illness interferes with their daily life activities. Most people care for themselves, a medical professional is only consulted in the minority of cases. When medical opinion is sought, it is the family physician (FP) who is involved. From the health problems that come to the FP practice, most are taken care of there – only a small part is referred to the hospital sector. At this moment, in the Netherlands, primary care takes care of more than 96% of the health problems in society.

From this, the role of primary care can be defined:

- Diagnosis, prevention,, treatment and support for the large majority of health problems;
- Navigating health care resources, through the timely referral of patients when needed;
- Responding to community needs, as primary care is closely linked to a defined community;
- Directing the person with the health problem – in terms of addressing their needs and demands and support their self efficacy ('empowerment') .

This is primary care, and this is what primary care does, everywhere in the world. And this is, what has to be developed, through teaching, training and research. So this is where Universities must get involved.

[Slide 3] Let us now look at a study on what FPs do and how they work: a comparison of how FP perform in the treatment of hypertension, in comparison with physicians internal medicine.

The study is from 1982 and from the Netherlands, a time when there was limited knowledge of what FPs actually did.

[Slide 4] The study analyzed the performance of FPs and physicians internal medicine for two types of patients with hypertension – with and without complications. A first finding was that FPs did remarkably well with patients with uncomplicated hypertension: they used limited resources, limited time and came straight to the desired treatment. This was quite different from when FPs were confronted with patients with complicated hypertension. In that case they needed more time, spent more on exploring the patients' condition and needed more resources. This was in contrast with the performance of physicians internal medicine, who appeared to apply a protocol in dealing with complicated hypertension, and less time.

And this is where educators, researchers, policy makers and health care leaders tend to stop, concluding that physicians internal medicine are better in treating hypertension. As a consequence, (future) FPs are sent for their teaching and training to internal medicine – to learn more about, to gain more experience in the treatment of hypertension. Time and again it is forgotten or ignored, what the study also found:

[Slide 5] When physicians internal medicine were confronted with a patient with *uncomplicated* hypertension, they immediately changed their approach, took more tests, spent more time, used more resources. They kept looking, in other words, for the complications that were not there.

[Slide 6] The implications from this study are substantial. It demonstrates how important the patient care setting is, for the skills and performance that is required. What FPs have to master is early diagnosis, and the timely diagnosis of frequent health problems in the community. It illustrates that primary care in different countries has each other probably more to say than hospital care can teach primary care. Just let us ask ourselves the question: would it be more important that FPs learn to spend the most resources on patients with uncomplicated hypertension, or would we prefer – from a healthcare, societal and health economical perspective that they allocate more time and money on the patient with complicated hypertension?

This selection is by and large empirical, based on experience in the field, and this demonstrates why this experience is essential when it comes to the teaching and training of future FPs. And this is why we need primary care in every medical school and university.

[Slide 7] Investment in primary care has a substantial impact on the health of the population. Not only is primary care instrumental for cost-effective care, as Starfield had demonstrated in 1994 – more primary care is related to the most important markers of the health of the nation/population: better life expectancy, improved health outcomes for all cause mortality, cancer and cardiovascular disease, more early diagnosis of important morbidity that benefits from early treatment. The skills to perform this must be developed through knowledge development/research in the primary care setting, and through teaching and training in that setting – and here is the self interest of governments and Societies to push for University involvement with primary care.

[Slide 8] This means that we must strengthen the core values of family medicine and primary health care:

- care provided by a medical generalist, responsible for all health problems, in all stages and all Individuals without pre-selection, based on needs
- community oriented on the living environment of people, the family or household and with a view for social determinants
- the personal doctor, patient- or person centred, with integrated care and continuity of care.

[Slide 9] In academic terms this means that every country in the world needs networks of primary care/family practices, that are linked to universities, research institutes and teaching centres: Practice-based Research Networks (PBRN) where practice and science, patient care and scholarly work are brought together. This brings research and teaching into the community.

[Slide 10] This all comes forward in the WHO resolution, adopted at the World Health Assembly (WHA62.12): **Primary health care, including health system strengthening**

This puts people at the centre of health care, urges to train and retain adequate numbers of health workers, ... including primary health care nurses, midwives, allied health professionals and **family physicians** .... and calls for vertical (disease-specific) programmes integrated, implemented in primary health care; and access to appropriate medicines, health products and technologies, required to support primary health care.

In leaving you with this most important development of 2009 in primary health care, I would like to stress the text in where it states to retain adequate numbers of health workers. Every program of primary care development that starts specialization training of FPs will inevitably land in a primary care environment with established, but not specialty trained, practitioners (often referred to as 'general practitioners'). It is of the utmost importance to seek to include them in the primary care development, value their contributions and stimulate their further professional development. If in anyway possible, it should be avoided that there are different classes of primary care providers.

[Slide11] In conclusion, it is indeed now more than ever: primary care matters. **It saves lives, and not and only money.** It brings better population health and better functioning health care system. Its community orientation and performance in multi-morbidity are key factors as are the core concepts of person centered continuous, responsive, directed at social/family context, built on trust. There is a lot to desired for, and multi-morbidity in patients is priority research: adequate treatment of patients with multi-morbidity is not simply multiplying single diseases' management. To get more insight in the effectiveness of primary care asks for research, teaching and training, for research units and university departments of primary care – now, **more than ever for the health of our populations.**