Family Practice
The International Experience

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Content:
1. Family Medicine-led Primary Care: The evidence
2. International Experience
3. Current & Future Trends
4. Options for the Iranian Context
The Evidence
Comprehensive Coverage
Total Population
A Whole System Approach
Equity
Social Protection
Solidarity
(Social Contract)
Choice
Engagement
Universal Coverage through PHC
Free at time of Delivery
“My doctor”
“My Clinic”

- Extended Opening Hours
  -- 24/7 (+ On-call)

- Appointment
- Gatekeeping (referral)

- Fully trained Professionals
- CPD
- Unit Cost
- Efficiency & Safety
- Range of service (Basic to Essential)

- Personal, continuity
  - Holistic
  - Acceptability
  - Effectiveness
  - Satisfaction

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The Experience

- Australia
- Brazil
- Malaysia
- KSA
- UK
Australia
Over four out of five Australians will see a GP or other primary care health professional at least once a year
The primary health care system works well for patients when there is a GP there, and when they can get to a GP.

Improving PHC for all Australian 2011
GP-led Primary Health Care

- Australians are able to more easily access the care they need, where they need it.
- Fewer people need to use hospital emergency departments or go into hospital as they would receive their care in the community.
- Local communities have health services that respond better to their needs.
Malaysia
Public/Private Mix: Malaysia

<table>
<thead>
<tr>
<th>Year</th>
<th>Public Sector</th>
<th>Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>4091</td>
<td>4122</td>
</tr>
<tr>
<td>1998</td>
<td>4377</td>
<td>4589</td>
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<td>2000</td>
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<td>2001</td>
<td>5494</td>
<td>7026</td>
</tr>
<tr>
<td>2002</td>
<td>7593</td>
<td>8,494</td>
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<tr>
<td>2003</td>
<td>10,442</td>
<td>10,606</td>
</tr>
<tr>
<td>2004</td>
<td>10,602</td>
<td>9,658</td>
</tr>
<tr>
<td>2005</td>
<td>11,926</td>
<td>11,045</td>
</tr>
<tr>
<td>2006</td>
<td>13,393</td>
<td></td>
</tr>
</tbody>
</table>
Growth of OOP Spending: Malaysia

- OOP (RM million):
  - 1997: 3,152
  - 1998: 3,269
  - 1999: 3,541
  - 2000: 4,109
  - 2001: 4,045
  - 2002: 6,146
  - 2003: 7,958
  - 2004: 7,959
  - 2005: 9,022
  - 2006: 9,805

- Per Capita OOP Spending (RM):
  - 1997: 145.45
  - 1998: 147.30
  - 1999: 155.92
  - 2000: 177.33
  - 2001: 169.62
  - 2002: 250.44
  - 2003: 317.71
  - 2004: 311.12
  - 2005: 345.28
  - 2006: 368.05
• **Public Health & PHC**
  State Funding and Delivery
  * Regulations, Cross-cutting Issues, HRD, etc

• **Secondary + Tertiary Care**

**Funding**

- **H Insurance: Employers**
  - Employers’ Contributions (family-based)
  - Gov Contribution
- **H.I.: Self Empl:**
  - Gov HI Sold \ (x% Cost)
  - Identify % core Subsidy
- **H.I.: General-Funded**
  - Unemployed
  - Disadvantaged
  - Elderly/Retired
  - Refugees
  - Disabled etc

**Commissioning/ Contracting**

- Collection
- **H Insurance (Funding) Agency/ Authority**
  - Commissioning1
  - Acute Services
  - Commissioning2
  - Mental Health
  - Commissioning Community Ser
    - Other than PH & PHC
  - Contingency 3 Fund

**Provision**

- Public Hospitals
- University Hospitals
- Private Hospitals
- NGOs
- Overseas Providers

Source: Rawaf, 2009
KLINIK DESA KAMPUNG RINC HING TENGAH
WAKTU PUNCAK
PENGANG 0830AM - 1245PM
Brazil
1988: Constitution - *Universal & equal access*
1994: Family Health programme *started*
1996: Municipality: *free health care to each individual funded by states & federal Gov*

Today: FHP 80% Pop Family Medicine Trained
Today: $23b H Budget $2b cost of FHP
Brazil have learned many lessons in the past 16 years from the implementation of the Family Health programme.

They have learned that it is possible to build a new model for primary health based on FM with the principles of fairness and solidarity as long as there is the political will to do this.
Brazil’s National Health System
Sistema Único de Saúde (SUS)

- Undergraduate Education
- Postgraduate Training
- Modern & accessible infrastructure
Developing Family Medicine

Modern & Equitable Community-Based Infrastructure

Strong Postgraduate Training

Solid Undergraduate Learning

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Professor S Rawaf
First Draft

Fully Integrated & Comprehensive Healthcare Project

[Towards A Whole-System Reform]

Reviewers' Comments

Part 1

EXTERNAL
Professor Dr. Salman Rawaf
Professor Dr. Richard Roberts
Professor Dr. Alain Montegut
Professor Dr. Michael Kidd

INTERNAL
Professor Dr. Adnan Albar
Dr. Tawfik Khoja
Dr. Ali Al-Shehri
Dr. Sameeh Al-Almai

Riyadh, September 2009
U.K.
A National Health Service...

“...to secure equal access to comprehensive healthcare for every individual across the country regardless of their ability to pay”

N Bevan, 1946
The Prime Consideration of the NHS Founders:

- To remove the financial constraints to healthcare

- There were no explicit statements of the finance methods to be used

London, 1946
1948 Strong Founding Principles:

1. Funded through Taxation
2. Free at the point of Delivery
3. Comprehensive
4. Equitable
5. Public Involvement (1997)
Health Line

Healthy Living

PC

Hosp Care

Cost: 10% + 11%

Contacts: 80% - 90%

50% Acute, 15% MH

10-20%

100% Registration

100%
Possible Course of Actions for Iran
Iran: Achievements so far

- Significant Improvements in all health status indicators
- Access, especially in Rural Areas
- Integration of Medical Education and Health services
- Political Commitments to Primary Care (through Family Medicine)
Iran: The Challenges

- Rich Country .... High Public Expectations
- System Fragmentation
- Strong, Influential, Unregulated Private Sector
- High OOP .... Huge burden on families
- Multiple sources of social protection (disease)
- Disease model
- Continuously increasing public expectations
- Limited public involvement
- HRH and Standards
Out-of-pocket payments as a function of gross domestic product (GDP) per capita, 2007

[Graph showing the relationship between out-of-pocket payments as a percentage of total health expenditure and GDP per capita (US$) on a log-scale.]
The effect of out-of-pocket spending on financial catastrophe and impoverishment

Percentage of households

Financial catastrophe
Impoverishment

Out-of-pocket payments as a percentage of total health expenditure

Source: WHR10 Ch3
Exposure to Catastrophic Health Expenditure & Impoverishment in WHO EMR 2004-2015

Source: WHO/EMRO/HEC estimate
Build on Strengths to meet needs & Expectations
Iran: Some of the Solutions

- Build on Strengths to meet needs & Expectations
- Health System Finance
Build on Strengths to meet needs & Expectations
Health System Finance
Introduce full Family Medicine Training Programme
New Entrance:
Introduce A structured Training Program
Family Medicine 3-5 Years .. Iranian Board

Current PHC Doctors
One Year on-the-Job Training Program
Postgraduate Diploma in Family Medicine
On the job in-service Training Programme in Primary Care
Iran: Some of the Solutions

- Build on Strengths to meet needs & Expectations
- Health System Finance
- Introduce Family Medicine Training Programme
- Engage People in their own health & the running of health services
Build on Strengths to meet needs & Expectations
Health System Finance
Introduce Family Medicine Training Programme
Engage People in their own health & the running of health services
Health and Healthcare Regulations
Iran: Some of the Solutions

- Build on Strengths to meet needs & Expectations
- Health System Finance
- Introduce Full Family Medicine Training Programme
- Engage People in their own health & the running of health services
- A whole System Approach
- Health and Healthcare Regulations
- Strengthen Public Health at all levels
Two observations
It is the most important factor to convince people about the value of FM

- Training
- Competencies
- Attitude
- PCM
- Personal-relationship
- Public involvement
## Change in antibiotic prescribing 1995-1998: GPRD

<table>
<thead>
<tr>
<th>Age</th>
<th>Males (%)</th>
<th>Females (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>-22</td>
<td>-23</td>
</tr>
<tr>
<td>5-15</td>
<td>-26</td>
<td>-23</td>
</tr>
<tr>
<td>16-24</td>
<td>-15</td>
<td>-16</td>
</tr>
<tr>
<td>25-34</td>
<td>-18</td>
<td>-15</td>
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<td>35-44</td>
<td>-16</td>
<td>-15</td>
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<tr>
<td>45-54</td>
<td>-13</td>
<td>-12</td>
</tr>
<tr>
<td>55-64</td>
<td>-9</td>
<td>-10</td>
</tr>
<tr>
<td>65-74</td>
<td>-9</td>
<td>-6</td>
</tr>
<tr>
<td>75-84</td>
<td>-9</td>
<td>0</td>
</tr>
<tr>
<td>85+</td>
<td>-10</td>
<td>-1</td>
</tr>
</tbody>
</table>
Referral Patterns

% of Visits Referred

Percent of Visits Referred (age, sex, standardized)

Australia

New Zealand

United States
Mean Number Annual Primary Care Visits per Person in Australia, New Zealand, and the United States

![Graph showing mean number of annual primary care visits by age and gender for Australia, New Zealand, and the United States. The graph compares the total visits, male and female visits for different age groups (0-17, 18-64, 65+).]
# National Prevalence (England)

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>National Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease (CHD)</td>
<td>3.6%</td>
</tr>
<tr>
<td>Left Ventricular Dysfunction (LVD)</td>
<td>0.4%</td>
</tr>
<tr>
<td>Stroke</td>
<td>1.5%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11.3%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.3%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>1.4%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>2.2%</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.5%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.5%</td>
</tr>
<tr>
<td>Asthma</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

The tables present prevalence for 11 disease areas for 52,833,584 registered patients in 8,486 practices. Prevalence is defined as

\[
100 \times \left( \frac{\text{number of patients on disease register on 14 February 2005}}{\text{number of registered patients as at 1 January 2005}} \right)
\]
Percentage of patients with diabetes with HbA1C \( \leq 7.4\% \) in last 15 months

Regression of Percentage Achieved for DM06 Against List Size

- R-Squared = 0.0013
- Correlation Coefficient = 0.0362

DM06

99% CI

Fitted values
GMS quality indicators (process) - median practice achievement
GMS quality indicators (outcome) - median practice achievement

- HbA1c < 7.4
- HbA1c < 10
- Cholesterol < 5
- BP < 145/85

Comparison between 2003 and 2005.
Incentives
Incentive vs No incentive in Family Medicine

Campbell et al. Effects of Pay for Performance on the Quality of Primary Care in England, NEJM 2009
OP vs Family Medicine
This is a giant step

- Leadership
- Champions
- Share the evidence
- Mental set up frame
- Real investment
- Time

? How to break the resistance barriers
and Finally
A general practitioner for everyone in the world

Effective primary care that is accessible to all is vital, yet global targets continue to be missed.

We are fast approaching the 30th anniversary of the World Health Organization’s Alma Ata declaration, which set the aspirational target of “Health for all by the year 2000” (BMJ 2008;336:536-8). The reasoning, laid out in the declaration’s article 10, was that “an acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts.” Tragically, since 1978, spending on war and armaments has continued unabated, while the Alma Ata target recording the current life expectancies for women as 46 years in sub-Saharan Africa and 78 years in the UK and the rate of deaths of children aged under 5 years as 179 in 1000 in sub-Saharan Africa and six in 1000 in the UK. His report also emphasised the importance of primary care: “The most pressing needs in developing countries are for balanced and integrated health systems with a particular emphasis on public health and primary care, not hospitals and tertiary care, although these have their place.” Yet he made no mention of the role and importance of primary care medicine. This perplexing absence based profession within which the physician’s interpersonal skills and capacity to interact therapeutically with the patient are of central importance to the clinical outcome.

Poor people are no less aware of the skills of doctors than more affluent people, and many of the desperate parents of those many children dying before the age of 5 in sub-Saharan Africa will incur crippling debt or sell vital livestock to see a private doctor if one is available through the public healthcare system. The poorest people in the poorest countries of the world are exposed to the most disease and
The poorest people in the poorest countries of the world are exposed to the most disease and therefore need commensurate access to properly trained doctors.
Thank you