WONCA Member Organizations **7th June 2018**

Dear Member Organizations, and WONCA colleagues

As you will see from the June WONCA newsletter, we have a major opportunity in the next 4 months to influence the World Health Organization's strategy for strengthening primary health care over the next 10 years. It is the 40th. Anniversary of the Alma Ata Declaration in October, so many of your country representatives will be attending a major meeting in Astana, Kazakhstan, to agree a new declaration and a programme of work.

Your World Wonca Executive met in Warsaw during May, and confirmed that this is a key focus for our organization in the immediate future. Wonca Executive members are all working hard to try to include family doctors in this vision and document, and to highlight the particular importance of training the workforce to meet the needs of rural, remote, and underserved populations. But getting our voice heard among the many others needs all of us to speak out! So please, as member organisations, please consider taking action at national level. If you can access your country delegates to WHO, or at least send written statements to them, this is a good time to do so. We do not have the Declaration yet, but a version will soon be circulated to countries for their official comment.

People sometimes ask – how do I get my voice heard at this level? Using professional representatives, contacts via your local political representatives, using social and communications media appropriately, ensuring we speak for our patients' needs and not just our own, and building momentum across different organisations, can all help. We attach a briefing document which could form the basis of your statements and outputs. It can be used in part or whole as needed and translated if you want. I do hope you can take this on in your busy lives and support this work. We are a huge global presence, and what we do now may make a difference to the future.

On a more 'internal' note, the Executive also made detailed preparations for Seoul, and for our Council there. We looked at finances, communications strategies, priorities for the next biennium, the outputs of Working Parties and SIGs (including presentations from Chairs of Mental Health and Research WPs), and noted the two recent accreditation pilot visits to China and Canada. We also signed off one new country member and one academic member. Business is good, though the world has many difficulties and our members are at the heart of these in many places. Thanks to all of you for your efforts.

Professor Amanda Howe, WONCA President.

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To the Ministers and Health Secretaries of W.H.O. member states

Esteemed colleagues

It is 40 years since the Alma Ata Declaration first gave global emphasis to the importance of primary care in the creation and maximum maintenance of health for all. Now, as we take shared responsibility to deliver universal health coverage[1], the need to strengthen primary health care is a key strategy. We are writing to you to explain why family doctors play a crucial role in helping achieve accessible, affordable and cost-effective care, which really works both for patients and for population health outcomes.

Many countries are struggling with escalating costs of health care; 10 years on from the 2008 Report,[2] the pattern of unregulated growth in the hospital sector with fragmented and inequitable services continues to be a problem. WHO has taken a clear position in advocating for care that is person centred, and where services are integrated around the needs of individuals and their families and communities[3]. They have also endorsed the need for "*a health workforce geared towards health promotion, disease prevention, and people-centred community-based health services and personalized long-term care*"[4]. Training health professionals is an investment which can profit a country by bringing people into paid employment and improving services, but the design of the system needs to ensure these workers do the right thing at the right time for maximal health gain. The system also needs to use all resources (hospitals, investigations, drugs, staff time) appropriately.

The best systems manage to deliver more effective services at a lower cost in a way that improves both patient experience and population outcomes – and this depends on having a sufficient density of health professionals working on all aspects of prevention, diagnosis and ongoing management. This is where a team with generalist skills that can manage many different aspects of health at the same consultation and setting is shown to be cost – effective.

Family doctors are trained to be *"the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned*".[5] Family medicine is usually a 3 or 4 year postgraduate training, during which the trainees are providing services in community ambulatory care, and in relevant specialties. Some countries which have a historical resource of untrained 'GPs' are offering similar training to upskill these colleagues to be able to offer the modern range of generalist medical competencies needed in a primary care team. Family medicine has existed for many years, but is growing worldwide as countries see the value of a doctor who can diagnose and manage new problems, assess and monitor ongoing ones, and support referrals from community health workers and nursing colleagues without immediate use of hospital attendance (which are expensive both in time, distance, and expenditure). As one patient experiencing the new 'MDGP' service in Nepal put it – "we used to have to find a surgeon, or a physician, or a paediatrician, or a gynaecologist – and they were very far away. Now we have all those rolled into one doctor - and they are right here!" This also highlights the value of family doctors in rural settings, where with extended training for acute emergencies they can again be an effective first point of care and make hospital transfers safer.

Many countries do not have experience of this medical workforce, but you can read about their successful outputs and there is research evidence of their impact. For example, Starfield's research and

[1] http://www.who.int/mediacentre/factsheets/fs395/en/
[2] WHO Report 'Primary Care Now More than Ever' 2008.
[3] WHO Framework for Integrated People Centred Health Services
[4] Dublin Declaration on Human Resources for Health, 2017.
[5] European Academy of Teachers in General Practice (EURACT). The European Definition of General Practice / Family Medicine. 2005;WONCA Europe.
http://www.woncaeurope.org/sites/default/files/documents/Definition%20EURACTshort%20version.pdf

literature reviews showed that better population health outcomes were consistently correlated with a greater density of primary care (family) physicians, and that costs were reduced if they were allowed full population coverage and were the first point of medical care [6]. Countries which have extended the scope of family medicine in the last 10 -20 years include Brazil, Thailand, China, and Ghana, with more than 130 countries now having members in the World Organization of Family Doctors (WONCA, a registered non-state actor with WHO[7]).

In systems such as the U.K., where family doctors have had compulsory postgraduate training since the 1990s, these doctors see all patients requiring medical contact in the community, and any hospital based tests or assessments require their referral. The typical community clinic will include family doctors, nurses, health care assistants (HCA), and administrative staff, with other services such as midwives and child health nurses being available in the same clinic or nearby. Having a medical generalist in the first line of care, with a wide range of clinical and interpersonal skills, means they can integrate aspects of prevention, diagnosis and management; supervise the team to extend their skills and quality of care; and also detect unmet need and address this. Finally, the passion of family doctors to make a difference to the lives and opportunities of their patients strongly aligns with the health equity agenda and the need for social accountability in health professionals. Family doctors see the impacts of the social determinants of health every day in their clinics, and are trained and motivated to be involved in the public and community health interventions with other agencies. Their speciality training is relatively short, they are in service while they become trained, and when they enter the workforce their frontline generalist input reduces hospital use and costs.

We therefore urge governments and decision-makers to ensure that their moves towards stronger primary health care for universal health coverage includes explicit aims to train a suitable medical workforce of family doctors for this purpose; that access to a family physician at first point of care should be a stated goal of workforce planning for UHC and built into the package; and that the impacts of this workforce be evaluated and enhanced over time. WONCA and its member organisations are fully committed to this global agenda, and keen to help as much as we can. So please ask us any questions, and we can share models of curricula, best practice and advice.

Thank you for your hard work and for considering these ideas.

[6] Starfield B, Shi L, Macinko J. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/
[7] See www.globalfamilydoctor.com for further information

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