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European Society for Quality and Safety
in Family Practice

A network organisation within WONCA Region Europe - ESGP/FM

FACULTY OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF FAMILY MEDICINE AND PRIMARY CARE

TRENDS IN QUALITY AND SAFETY IN FAMILY MEDICINE

Dr. Piet Vanden Bussche, EQuiP President

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GP in a group practice in Belgium

Lecturer at Ghent University,
Dep. of Family Medicine and Primary Health Care

President of the European Association on Quality and Safety in General Practice/Family Medicine (EQuiP)

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TRENDS IN QUALITY AND SAFETY IN FAMILY MEDICINE

1. No quality without equity

2. Focus on safety

3. The more we measure, the better the care?

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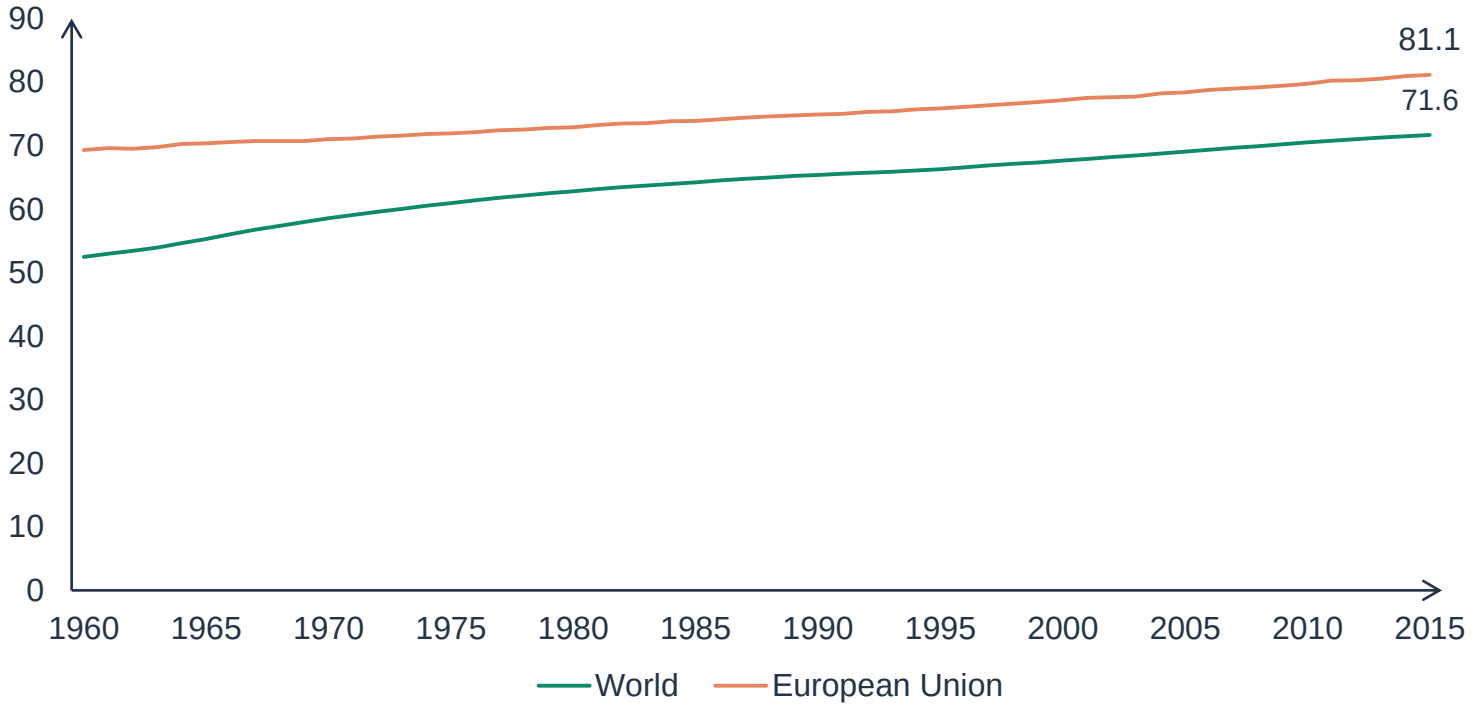
LIFE EXPECTANCY IS RISING …



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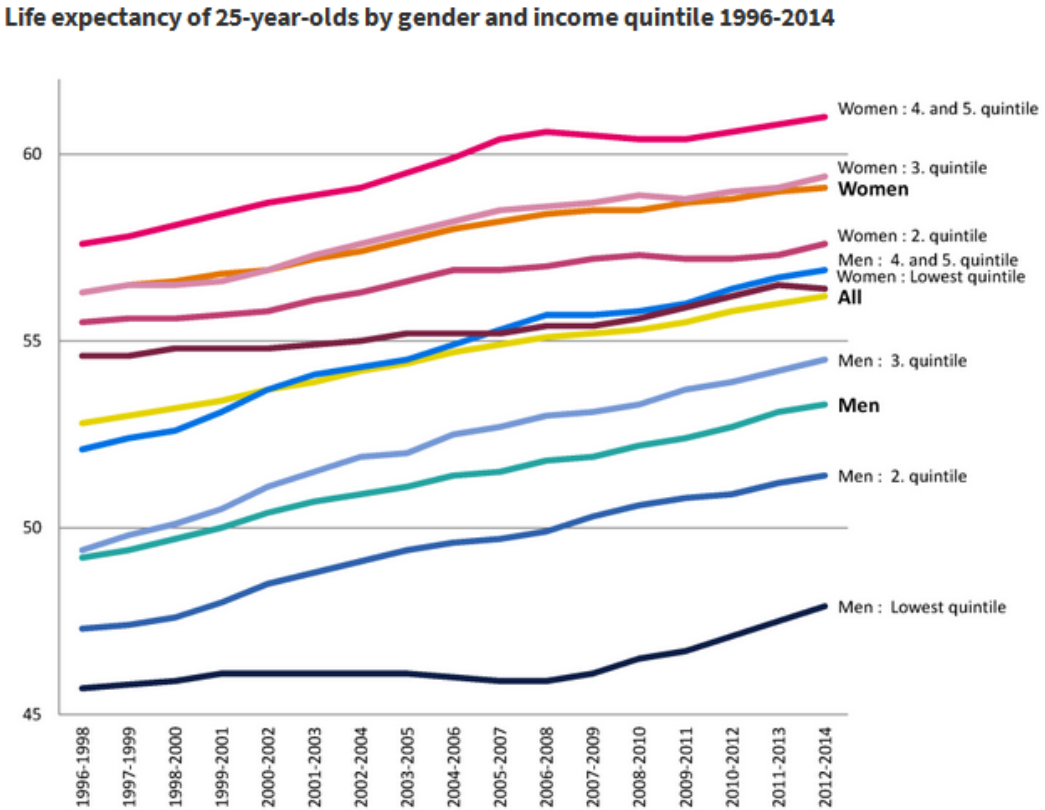
… BUT NOT TO THE SAME EXTENT FOR EVERYONE



Koskinen S, et al. (2016) Elinajanodotteessa suuria eroja tuloryhmien välillä. Tesso 4/2016.

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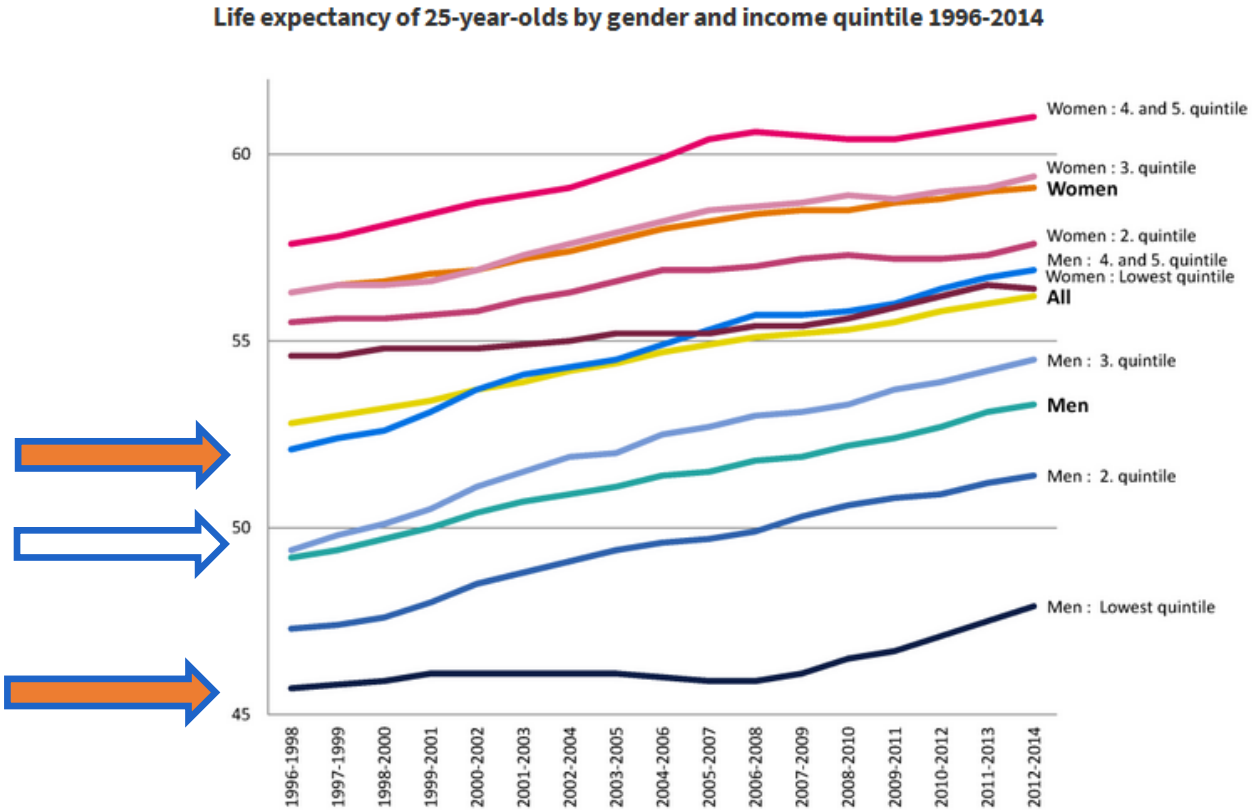

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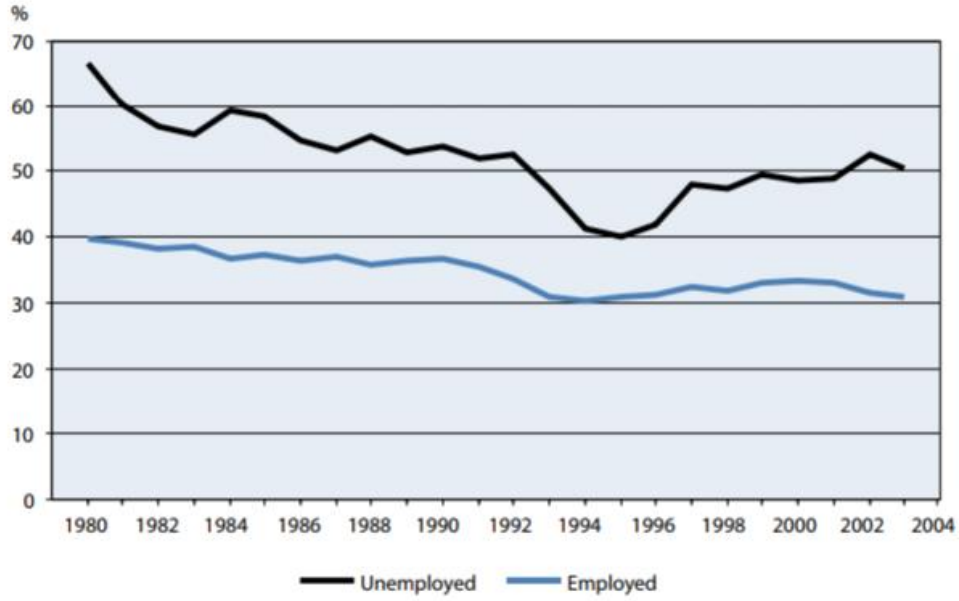
THE UNEMPLOYED: A VULNERABLE GROUP

Figure 4a. Age-adjusted percentage of men aged 25–64 who rated their health as average or poorer in 1979–2004 (three-year moving averages) by labour market status.



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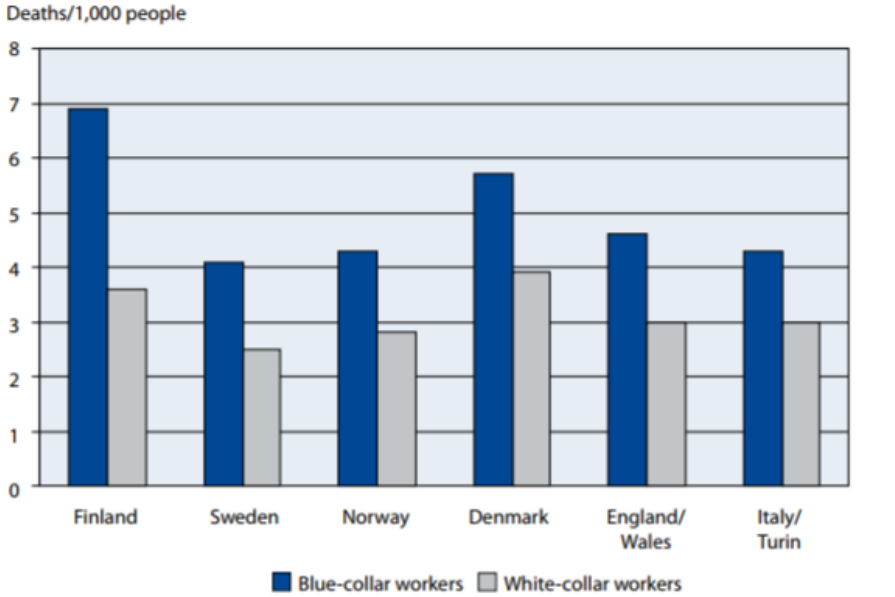
AS ARE THE BLUE-COLOR WORKERS

Figure 5. Age-adjusted mortality of male white-collar and blue-collar workers aged 30-59 in five Western European countries and in Turin around 1991–1995.



Source: Mackenbach et al. 2003

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How can health care tackle inequity in health?

How can health care tackle inequity in health?

Precondition: being equitable!

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Equity in health care?

equal care/same package for everyone?

e.g. hypertension

or: specific care for specific groups?

Stigmatisation? Medicine with two speeds?

What with in-between groups

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Equity in health care =

> “Access to, delivery of, and outcomes of care should not vary according to the patient’s demographic or social characteristics such as gender, ethnic background, social position or sexual preference, but soley to his/her need for care.”

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Equity in health care =

"Access to, delivery of, and outcomes of care should not vary according to the patient's demographic or social characteristics such as gender, ethnic background, social position or sexual preference, but soley to his/her need for care."

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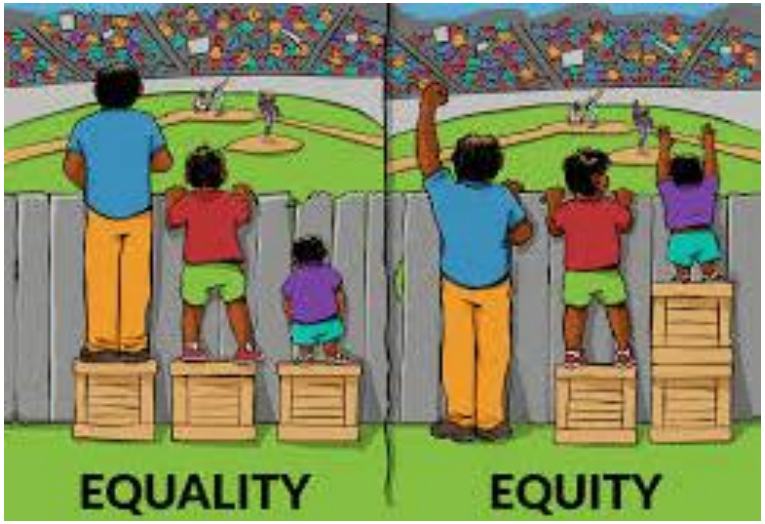
Equal care for everybody = inequity



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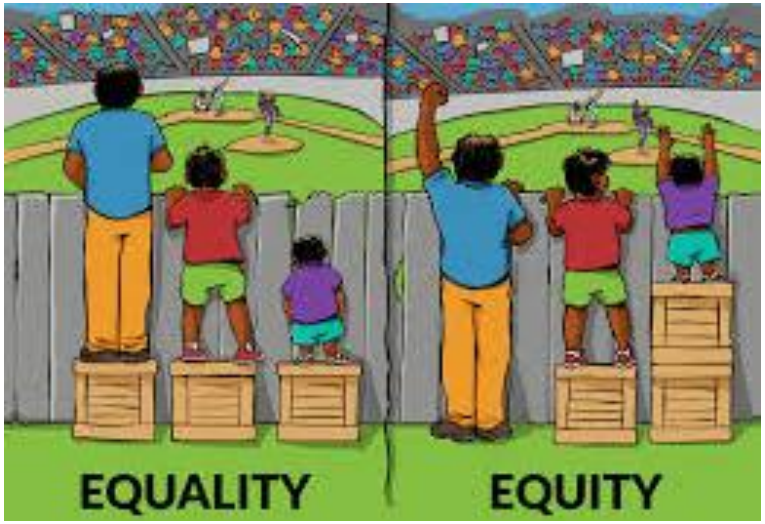
Equal care for everybody = inequity



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Proportionate universalism

EQUITY CHALLENGES IN HC IN FINLAND

- geographical inequities (data available)

- inequities between socioeconomic groups
  (no systematic data available)

- increasing challenge: the ability to provide own language and culturally sensitive health services to ethnic minorities

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GEOGRAPHICAL INEQUITIES

- Large differences between municipalities in service provision and waiting time
  (nb of GP visits, dental care, mental health care, elective surgery in specialized care)

- Differences in resources invested in municipal health care, which persist after needs adjustment
  Note: Large differences in morbidity between municipalities

- Significant age-adjusted variations between five university hospital regions in outpatient care (Häkkinen & Alha 2006)

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SOCIO-ECONOMIC INEQUITIES

- Inequality of distribution of physician visits between socioeconomic groups has decreased somewhat between 1987 and 2000 (Teperi et al. 2006)

- But in 2000 pro-rich inequity in doctor use in Finland still one of the highest in OECD countries (along with the United States and Portugal) (Van Doorslaer, Masseria, Koolman 2006)

- Pro-rich differences in screening, dental care, need-related coronary revascularizations and in some elective specialized care operations (for example hysterectomy, prostatectomy, lumbar disc operation) (Teperi et al. 2006)

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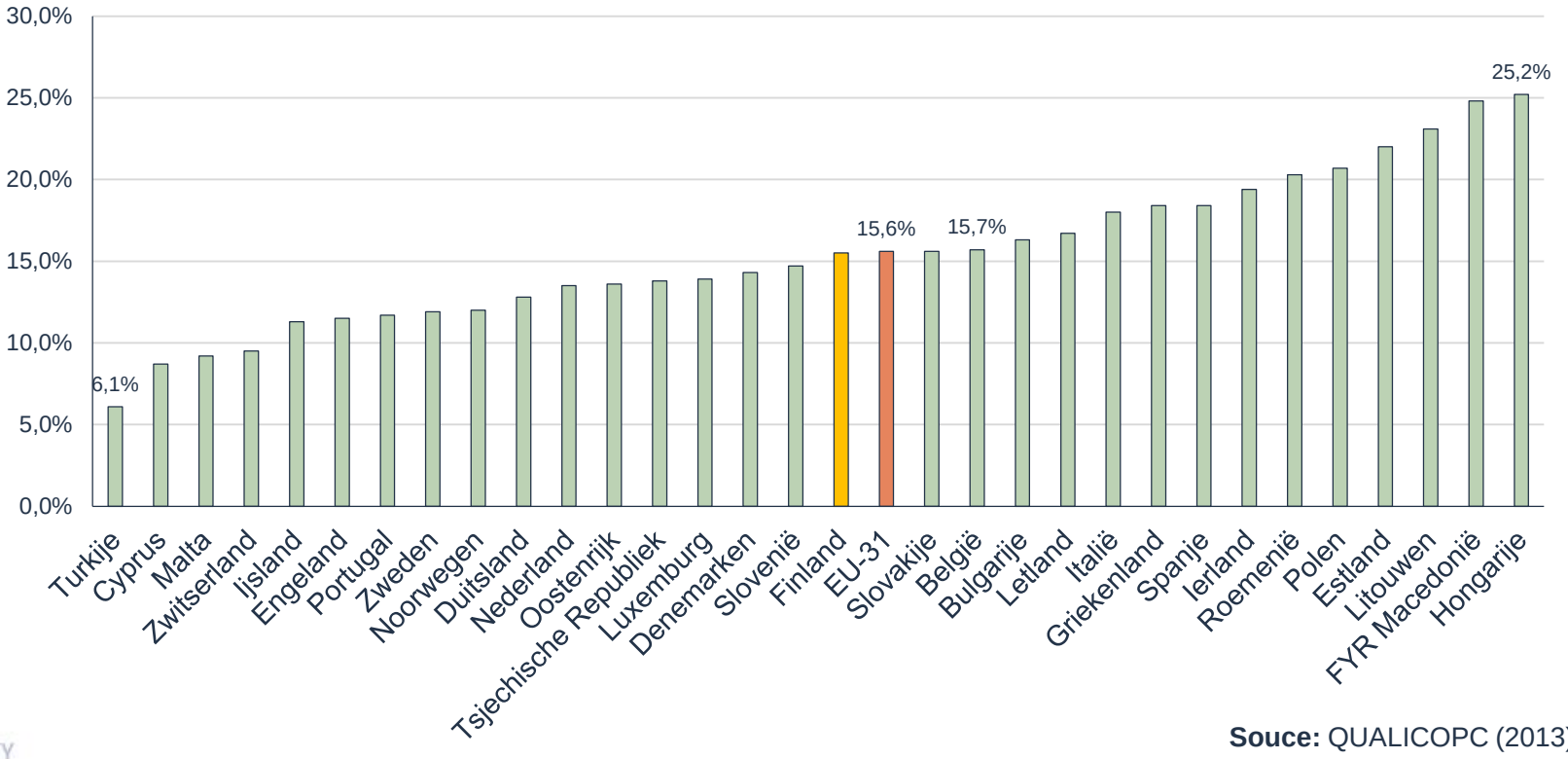
Did you postpone health care in the last 12 months?



Souce: QUALICOPC (2013)

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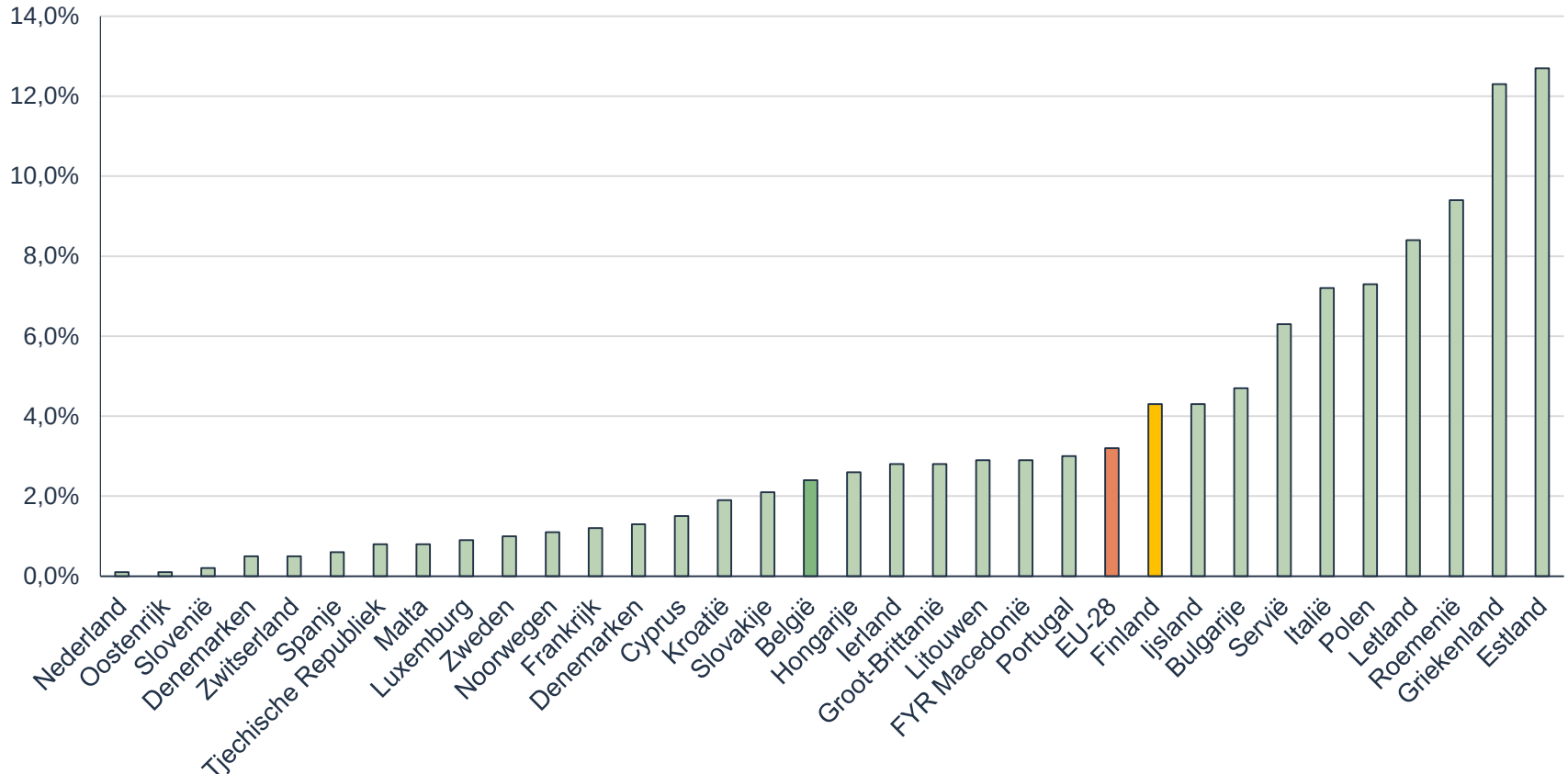
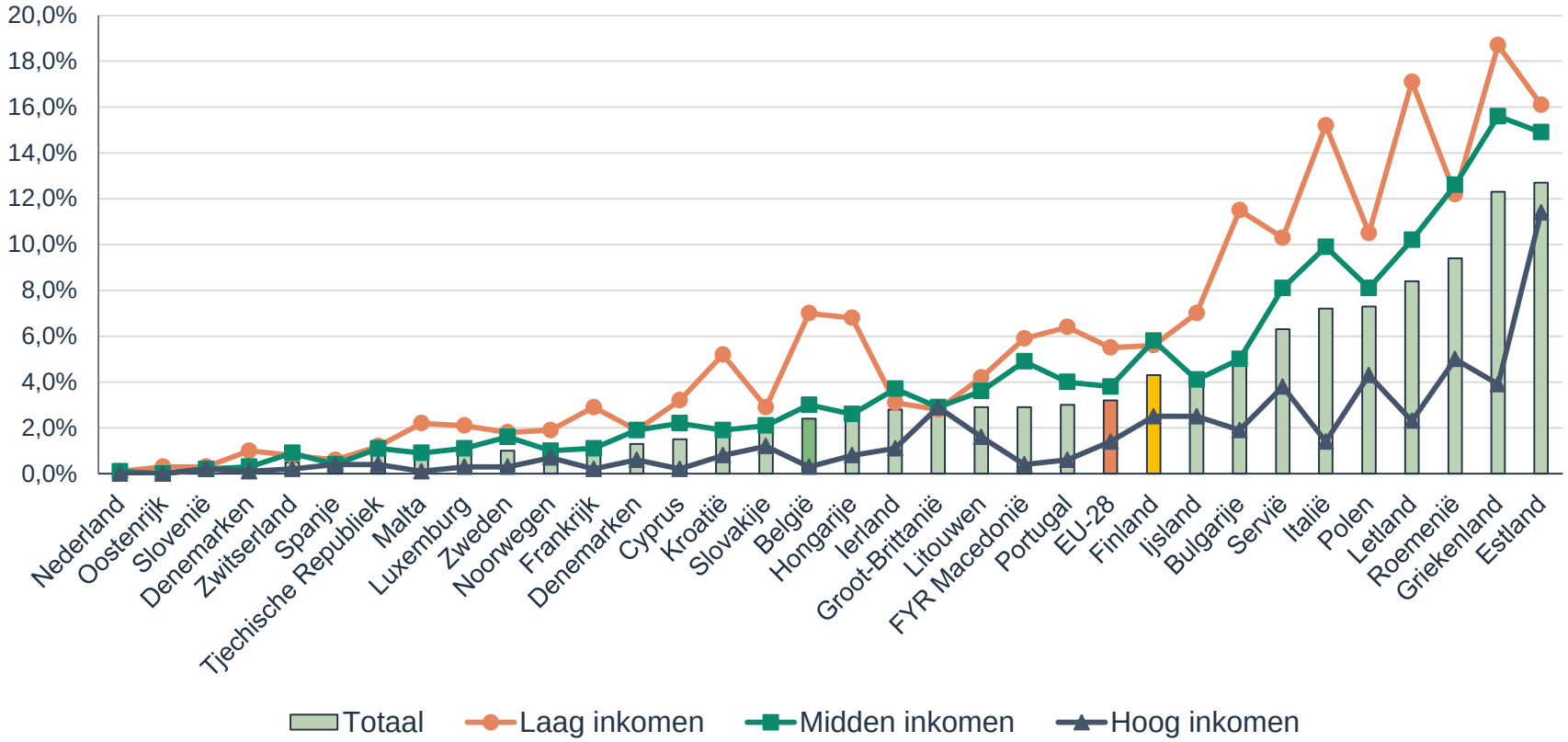
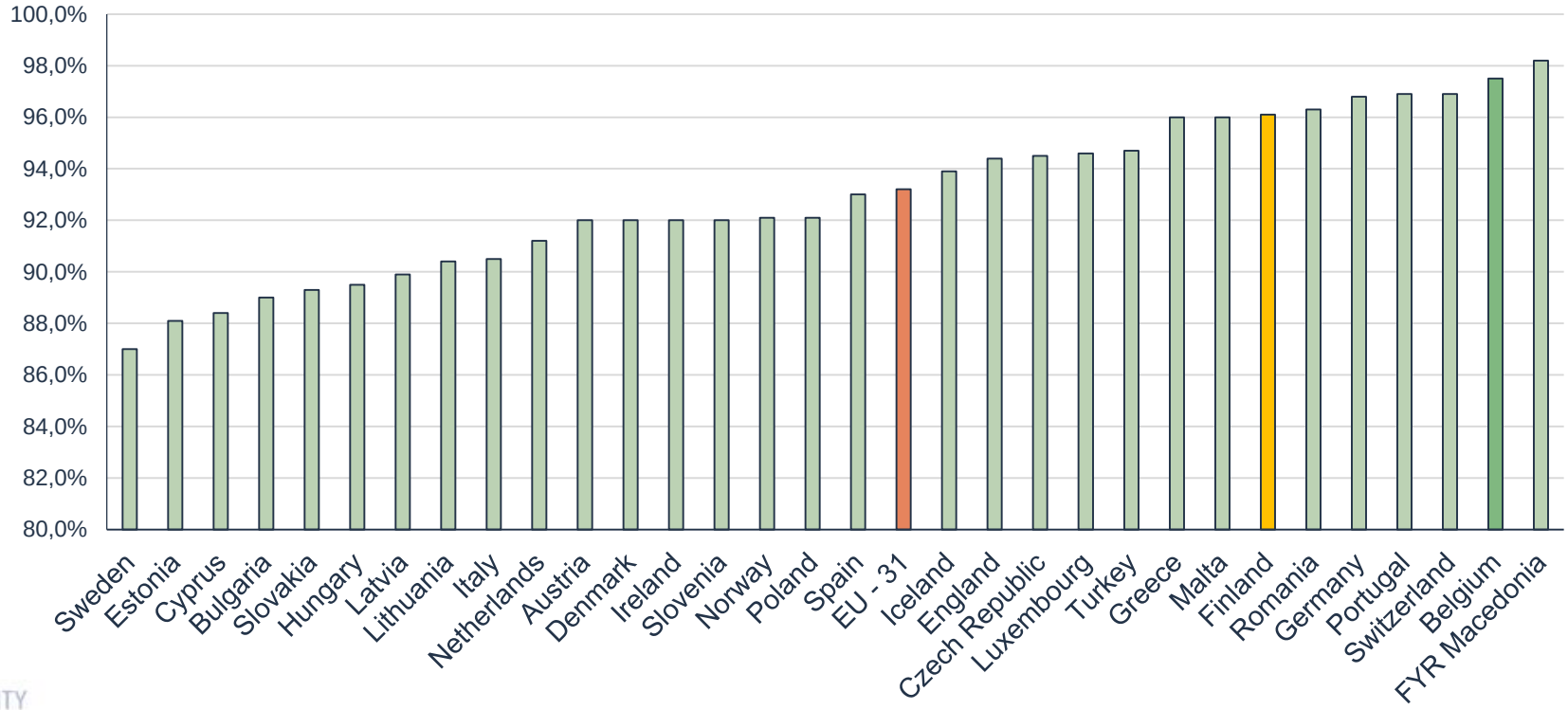
FINLAND EQUALS THE EU MEAN FOR UNMET NEED



… BUT LOWER UNMET NEED IN HIGH INCOME PATIENTS



European patients are usually happy with their GP



Source: QUALICOPC (2013)

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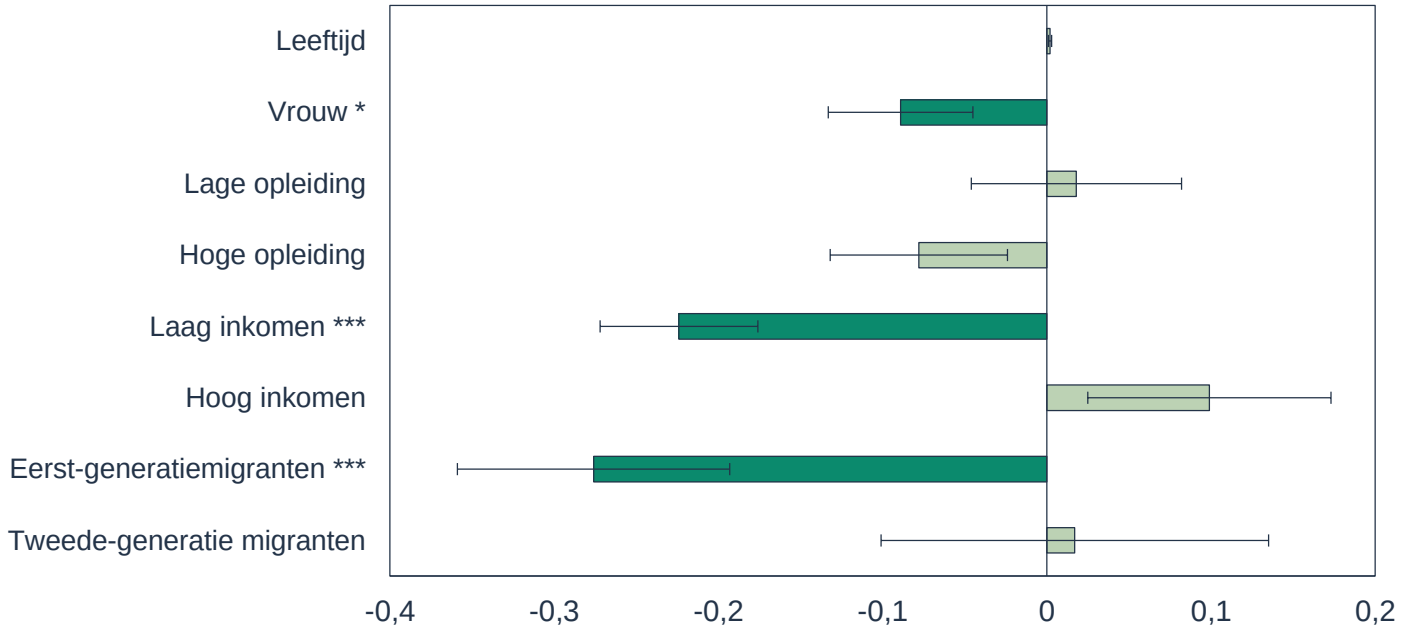
But … some patient groups are less satisfied



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NO QUALITY WITHOUT EQUITY

Position paper EQuiP, Zagreb 18/11/2017

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EQUITY SHOULD BE ONE OF THE CORE PRINCIPLES TO GUIDE PRACTICE ORGANIZATION AND CARE PROCESSES IN PRIMARY CARE.

Primary care providers should **assess patients**' socioeconomic, demographic cultural and other relevant **characteristics**

EQuiP strongly advises primary care professionals and practices to **evaluate the equity of the care** they deliver, and undertake **practice–based quality improvement** initiatives which incorporate the aim of improving equity of health care.

Primary care professionals should take up **the advocacy role** not only for individual patients but also **for patients groups** and populations

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- EQuiP asks that **health authorities support primary care professionals** delivering equitable care and that the level of support is according to the assessed level of need of the population served
- EQuiP recognises **interprofessional collaboration as a key strategy** in the delivery of equitable health care, with most to gain for patients with complex care needs
- EQuiP recognizes **community oriented primary care** as a strategy to tackle the social determinants of health
- EQuiP strongly advises that **all primary care professionals are trained** in the importance of the social determinants of health, community oriented care, dealing with diversity, and interprofessional collaboration.

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FOCUS ON SAFETY

Safety defined/researched in hospital care setting

It is not correct to simply transfer the concept from hospital into Primary Care

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FOCUS ON SAFETY

It is possible to develop safety strategies in family medicine, but the concept is totally different.

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FOCUS ON SAFETY

GP’s task:

Cure

Care

Prevention

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FOCUS ON SAFETY

GP's task:

Cure

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Prevention

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CURE IN FAMILY MEDICINE

- “Working in uncertainty”
  - Low prevelance of serious diseases
  - Vague complaints
  - Psychosomatic perspective
  - Context and culture are very determinating

- We need trained doctors with specific competencies
- The importance of cooperation with specialist care

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SAFE CURE IN FAMILY MEDICINE

- Prevention of diagnostic error (wrong/ late)
  - Diagnostic decision making
  - How to handle lab results and technical investigations
  - Time as a diagnostic tool
- Prevention of therapeutic error (medication,…)
- A balanced workforce

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FOCUS ON SAFETY

GP’s task:

Cure

Care

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CARE IN FAMILY MEDICINE

- A longitudinal proces (from birth to death)

- Organizing continuity

- Multidisciplinary

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SAFE CARE IN FAMILY MEDICINE

- Tertiary prevention is a safety issue !
- PC is often cooperation in a non-hierarchial organisation
- Multimorbidity and polypharmacy
- Patient-participation: goal orientend care
- The importance of the interface between Primary and Secondary care

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FOCUS ON SAFETY

GP's task:

Cure

Care

Prevention

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SAFE PREVENTION IN FAMILY MEDICINE

- Screening and overdiagnosis / overtreatment
- The importance of patientparticipation
- “Worried well” and inequity
- But also prevention of infection (hygiene, vaccination, epidemics, …)

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HEALTH FOUNDATION: FRAMEWORK FOR SAFER HEALTH CARE

“RETHINKING PATIENT SAFETY”

(CHARLES VINCENT)

- Seeing safety through the eyes of the patient – A journey not an incident
- Safety is the management of risk over time (which includes the reduction of harm)
- The management of error rather than the elimination of error
- More attention to adaptation, monitoring and recovery
- Customising strategies and interventions to the context

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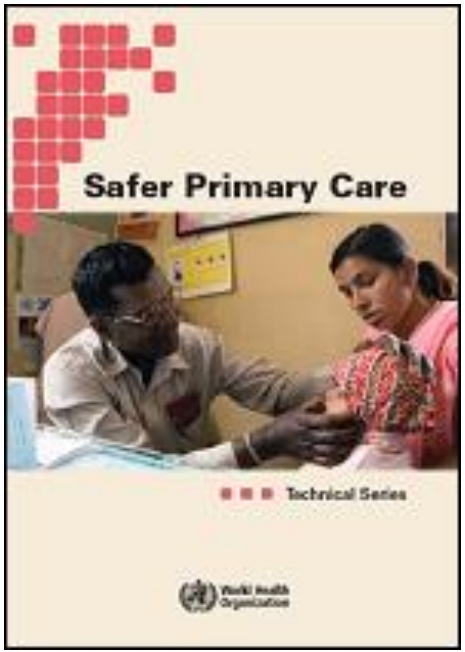
WHO 2016



- Patient engagement
- Education and training
- Human factors
- Administrative errors
- Diagnostic errors
- Medication errors
- Multimorbidity
- Transitions of care
- Electronic tools

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FOCUS ON SAFETY: CONCLUSIONS

- Research is scarce and little is known
- GP/FM seems quite safe but because of the large amount of contacts, safety still is a maior issue
- Processes in FM/GP are difficult to predict and seldom following a strickt protocol
- Errors are normal and inevitable; it is important to limit the number and manage them, instead of trying to eliminate them
- Creating a safety culture is the first priority
- Preventing harm is the priority in prevention but also in chronic care
- High work pressure is a high risk and doctors health is a maior issue in safe care.

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THE MORE WE MEASURE THE BETTER THE CARE?

- Denmark
- Netherlands: “het roer moet om”
- Israel
- GB: QOF
- …..

Data collection and P4Q are under pressure

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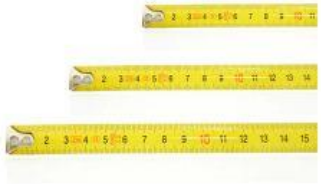
Dr. Don Berwick: Three Eras Of Healthcare

President Emeritus and Senior Fellow Institute for Healthcare Improvement, Fmr Dir. Of CMS

Era I – Noble, Self-Regulating

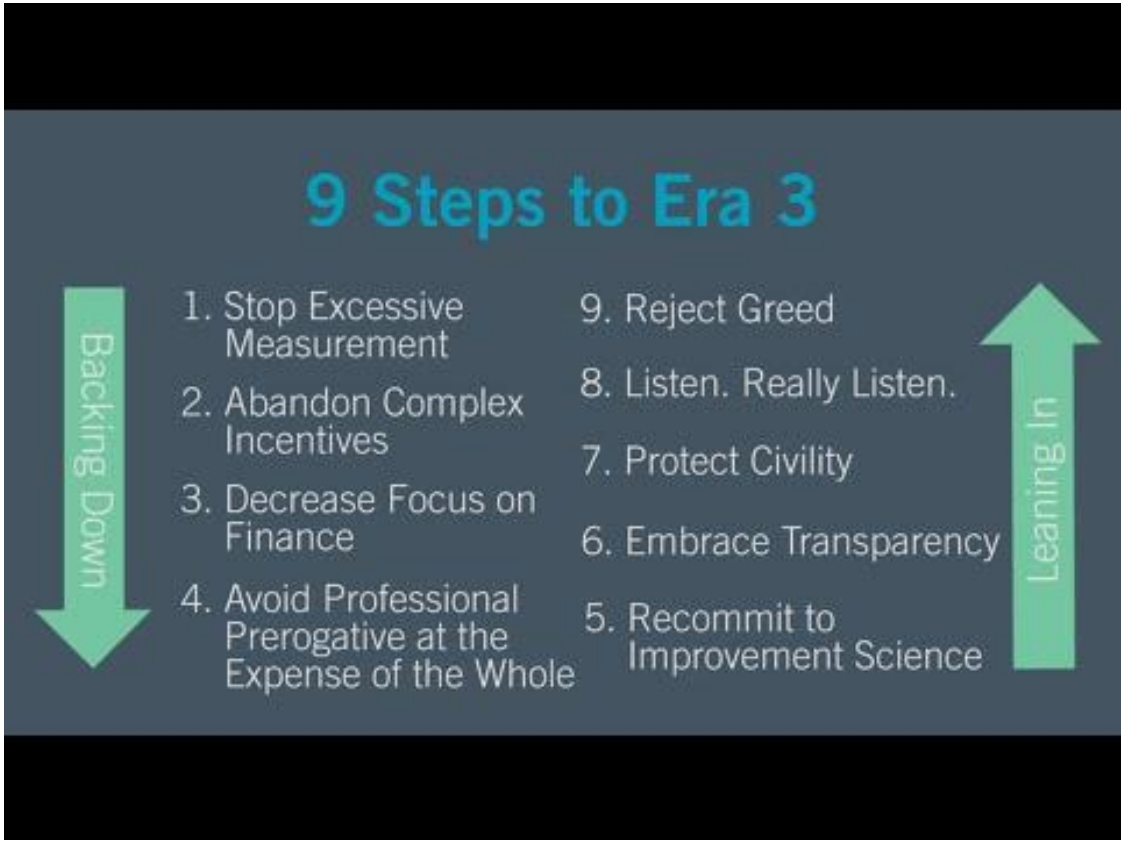


Era II – Present Day Accountability, Measurement, Incentives

Era III – Moral Era, Quality will be at the center

engaged public

DON BERWICK: TOWARDS A MORAL ERA



MORAL VALUES

- Professionalism: practice based continous professional development by structured small group learning
- Autonomy: being able to set your own priorities
- Reflectiveness: Make sure you can generate/find the data you need.
- Leadership: challenging the team
- Transparancy

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TAKE HOME MESSAGE

The general practioner should (again) be able to take responsability and be in the drivers seat for the quality of the care for the population of his practice in a equitable and safe way.

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HTTP://EQUIP.WONCAEUROPE.ORG/

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