

# Impressions from the 17<sup>th</sup> WONCA World Conference for Family Doctors, Orlando, USA, 13-17 October 2004 – Part 1

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The **17<sup>th</sup> World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA)** Conference was held in Orlando, Florida, USA from 13 -17 October 2004. This association of 100 member organizations in 72 countries represents the constituent organizational members. WONCA's mission is to:

- improve the quality of life of the peoples of the world,
- foster and maintain high standards of care in general practice/family medicine,
- promote personal, comprehensive, and continuing care for the individual in the context of the family and community, and
- encourage and support the development of academic organizations of GP/ FP.

At the Council meeting preceding the conference, WONCA proudly admitted its 100<sup>th</sup> member, as well as a whole new Ibero-Americana (South America) region. WONCA has grown tremendously over the past triennium under the leadership of Dr Michael Boland from Ireland and is now truly representative of most of the world. The new WONCA President for 2004-2007 Prof Bruce Sparks from South Africa was inaugurated during the conference. The WONCA website is a very useful resource for all family practitioners and can be found at <http://www.globalfamilydoctor.com>.

The WONCA meeting was held in parallel with the annual American Academy of Family Physicians (AAFP) congress at a very large conference centre in International Drive in Orlando. International Drive displays all the typically American attractions such as Disney World, Universal Studios, etc. October is autumn in Orlando and was very hot and humid with rain now and then. The WONCA meeting was

attended by 1813 physicians from 96 countries. The WONCA meeting was one of the smallest in recent years (smaller than the successful 2001 WONCA congress held in South Africa) due to the political situation around US policies. The AAFP Scientific Assembly, which has mainly a continuing medical education focus, was attended by 5180 physicians including speakers. The AAFP congress included a large exhibition, said to be more than 4600 exhibitors on-site.

A total of 1278 abstracts from 78 countries were submitted for the 17th World Conference of Family Doctors. 1246 of those abstracts were accepted for presentation at Wonca 2004. Eight abstracts were submitted and presented in Spanish. There were also parallel translations into Spanish at the Council meeting to accommodate the large new Ibero-Americana region. The Wonca program book contained 1224 abstracts from the meeting. The breakdown of abstract categories was: Posters: 483, Oral Presentations: 574, Workshops: 106 & Symposia: 61.

The WONCA conference was structured in the usual plenaries and parallel sessions. Unfortunately there were only two parallel sessions during each day, as the size of the conference centre allowed more than 30 parallel sessions to run at any point in time. The result of this was that most of the parallel sessions were poorly attended due to the large number of sessions on offer. Nevertheless I was pleasantly surprised with the clinical focus of much of the research presented at the conference. I was also struck by the fact that the research we do in South Africa compares very well in quality with that done internationally.

## **Wonca 2004 Plenary presentations**

There were a number of trendsetting plenaries at the conference. The three

that made a lasting impression on me were:

- Women as Leaders in Tomorrow's Health Care by May Cohen, from Toronto, Ontario, Canada.
- Worldwide Issues in Primary Care Barbara Starfield, Baltimore, Maryland, USA
- Family Doctors in the 21<sup>st</sup> century – embracing the global health imperative by Dr Timothy Evans, Assistant Director-General of WHO-Evidence and Information for Policy in Geneva.

**Dr May Cohen** (Canada) gave the first WONCA plenary address titled **"Women Physicians as Leaders in Tomorrow's Health Care"**. She reminded the audience that the increasing number of women in family medicine is not reflected in the leadership of the discipline. This discrepancy is not simply a lack of equivalent numbers (equality) but represents an absence of consideration of the broader context of gender in society. In many countries the vast majority of family physicians are female representing what has been called the "feminization of medicine". These women are often practicing with limited resources and are poorly remunerated, reflecting the position of women in these societies. In more affluent, often western societies, women's career trajectories differ from men reflecting differing choices, but still are a function of societal expectations based on gender. Examination of the role of women physicians in family medicine span issues of 1) women in training, 2) women in practice, 3) women in academia, 4) women in organizational medicine, 5) women doctors taking care of themselves and their families, and 6) women physicians and the doctor-patient relationship. Pervasive concerns encompass sexual stereotypes resulting in "ongoing unintended slights",

harassment and discrimination, family responsibilities, institutionalized attitudes, policies and practices, relationships within the health care team, differential compensation, limited opportunities for training, mentorship, promotion and leadership and the risk of tokenism, research both by and about women, the personal health of women physicians and consequent burnout, depression, and substance abuse, and the special concerns of rural practitioners and lesbian physicians. The increasing number of women in family medicine offers the discipline the opportunity to expand understanding of the role of culture and society in medical care.

Women physicians often have a practice style that differs from men utilizing longer visits, more overt patient-physician negotiation, and an emphasis on prevention. Women's leadership style is also more likely one of "communicate and inspire" rather than "command & control". Women are under-represented as policy and decision makers in FM organizations. The challenge will be to incorporate women's knowledge, culture, and experience in leadership Dr. Cohen called on the FM organizations to prioritize issues of sexual harassment, domestic violence, reproductive rights, stereotyping and the balance of professional and personal lives. She proposes that increasing number of women will challenge institutional norms and our understanding of leadership. Consideration of gender equity must be one of many considerations necessary for WONCA to realize its mission.

**Prof Barbara Starfield**, professor in the Bloomberg School of Public Health at Johns Hopkins University and internationally well-known public health expert, gave a fascinating talk on "**Worldwide issues in primary care**". She has done extensive research on health related policies that improves health outcomes, and uses a vast range of statistics to prove her point. She has also published extensively in the field. During her talk she:

- Demonstrated how a strong primary care infrastructure is associated with greater effectiveness of services
- Described how a strong primary care infrastructure is associated with greater equity in distribution of services overall
- Explained the importance of a health care system to have an appropriate

balance of family doctors and other specialists

- Reviewed how children are especially disadvantaged by a health system that is over balanced with other specialists, and
- Compared international health services and their relationship to health care provided in the US with some useful lessons

Dr Starfield showed that a primary care focused health system improve health outcomes for instance in England each additional doctor per 1000 people is associated with a 5% decrease in mortality, and this effect is greater if this doctor is a family physician (FP). One more FP per 10 000 people decreases the infant mortality rate with 7% and delivers services with 33% lower costs. She continued to show the positive effect of FPs on a variety of diseases.

Most of the evidence is from industrialised countries, but there is evidence that developing countries that devote more funding to public health has better child survival rates. Primary care has been shown to have better outcomes than specialist care as it is more effective, efficient, equitable, and produce better generic outcomes. She said that specialists are trained to look for zebras in stead of horses therefore they do more tests and investigations which trigger a cascade of events and increases adverse effects. The latter is the 3<sup>rd</sup> most common cause of death in the USA. Specialists can also not deal with co-morbidity due to the narrow focus of their fields.

Prof Starfield proposed that information systems should be oriented towards person-focused areas as well as population-oriented.

**Dr Timothy Evans** is a Canadian who currently serves as Assistant Director-General of WHO-Evidence and Information for Policy in Geneva. His talk was on "**Family Doctors in the 21<sup>st</sup> century – embracing the global health imperative**". In his talk he:

- Described the nature of global health challenges in general
- Provided an overview of the global human resources for health challenges
- Reviewed the role of the professions, from beyond training to learning and problem solving, and
- Suggested specific proposals for family medicine and global health.

He outlined the fundamental changes in the health profile of the world with increasing ageing, increase in infectious diseases such as HIV/AIDS as well as increase in chronic non-infectious diseases and injuries. The prospects of meeting the millennium goals are grim for instance there will have to be a 4% per year global decline of child mortality to reach these goals. Secondly another large challenge is health inequities over the world where the greatest need for care is in the areas where there is the least care available. Dr Evans said that 85% of the health burden can be met with cost-effective treatment but that the problem is that health systems are not getting the treatment to the people. He listed the following as contributing to the problem:

- Too many players trying to do good without any co-ordination
- Predominant disease (vertical) focus
- The trend to go for the big initiative rather than the smaller
- System-wide constraints and errors

Dr Evans said that the challenge is to build ACROSS systems in stead of building systems around diseases only. He proposed a systems view on the health workforce which should address the following issues:

- The majority of the budget should go into the workforce
- The workforce must be seen as an asset and not only as a recurrent cost
- Rigid professional boundaries should be broken down
- Difficult working conditions should be addressed
- Leadership for solving problems must be encouraged
- The growing global market for health professionals must be addressed.

Interestingly he said that the vast majority of energy in global health systems has gone into training the workforce that is using educational strategies, and that other issues which impact on the workforce have not been given the same attention. There is a whole set of factors which determine the supply of health care workers such as demand, policies and resources, employers, working conditions etcetera. He said that there is a need to mobilise 1 million health workers for Africa by the year 2010 and described his vision of creating a global workforce.