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Meeting with Prof. Jan De Maeseneer, MD, PhD
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Chairman of the European expert panel on effective ways of investing in health

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First of all, Mr Professor, allow me to congratulate you on your appointment as Chairman of the Expert Panel. Thank you also for this interview. We notice that the views you express are not necessarily the views of the Expert Panel but reflect your own vision.

With the publication of the disruptive innovation report, and its 12 conclusions and policy recommendations, I had to do some searching before I found a recommendation on the "Training and motivation of health professionals". What do you think when I say that the personnel are the most important capital of the health care system?

> I agree. But today, the situation has changed. The changing position of the patient is the most important disruptive innovation. Patients are playing a more active role in their care process and laws and organisations are changing to accommodate this. In accordance with this changing position of the patient, the health workforce has to change as well. Interprofessional approaches will need to be looked at to support a goal-oriented approach, where patients will spend more time at home in their care process. Considering an increasing number of multi-morbidity patients, we have to evolve from a vertical disease-oriented approach in the past towards a patient's goal-oriented system. Move away from education which puts emphasis on specialisation, emphasising generalist skills. In the future, there will be a greater need for Family Physicians who will have to be trained to acquire new skills and work with new technologies.

2016 has been the year of integrated care, can I ask you what is on the agenda for 2017?

> The new Panel just received new mandates and already started to work on them. We hope to publish our first opinions in 2017.

Do you think that the model of primary care and community care provides sufficient guarantee for workforce planning and quality care standards?

> I am sure of it, but if you consider the situation from a macroeconomic point of view, we need to change the focus of our approach from hospital care to primary and community care and shift resources accordingly. Hospitals will play an episodic role (diagnostic work-up, surgery, ...). The stay in hospitals will be reduced to a few days and otherwise care will be delivered in primary and community care facilities. Most chronic diseases, e.g. diabetes (type 2), can be addressed in primary care facilities.

And what about the relationship between hospital and primary care? And what should we pay attention to when speaking of the further development of primary care?

> Studies from the OECD and the WHO have shown that strong primary care is contributing to quality care. But today's trend of reducing the number of hospital beds (2 % over 15 years) is not going fast enough, to give primary care the necessary financial boost.

According to sources of the EU, broadly speaking, 2017-2018 will be years with the focus on payment models for expensive innovative drugs, access to health care in the EU and methods of assessment of primary care. It seems to me that this is a very ambitious programme?

Yes, this is ambitious, but, in the last 3 years, the Expert Panel has been able to produce more than 10 opinions. All opinions are available on the website http://ec.europa.eu/health/expert_panel/.

Together with HFE, we want to focus on workforce organisation with the aim of the efficient use of medical technology and the efficient screening of diseases. And what should be our first aim here?

Our aim should be accountable for a population through the development of primary care networks which go further than family physicians working in single-handed practices. Proper attention will have to be given to establishing a link with the hospitals through informatics (e-monitoring, electronic counselling). This will also require new integrated ways of financing. Working together with the hospitals can have a positive influence on primary care. If we are to increase the trust of patients in primary care, those networks of providers have to be organised as teams in which, apart from the physician(s), all kinds of professionals, nursing staff, social workers, are cooperating. Inter-professional education is the way forward. Moreover, attention has to be given to dealing with obstacles to recruitment for primary care, such as the less favourable “image” nurses working in primary care have in comparison with nurses working in hospitals.

Telemedicine, telehealth, here I am of the opinion that nursing plays a key role and provides a variety of services with the same quality as physicians. Can nurse practitioners alleviate the projected primary care physician shortage?
Is it possible for nurses to take over some tasks of the general practitioner? For example, as regards flu vaccination, this could perfectly be done by nurses through primary care.

Let me give an example of the situation as it is in Belgium. Since 1994, medical graduates are given the opportunity to specialise as family physicians, such as other medical graduates can choose to specialise in a particular field of medicine. The training in primary care is of high quality. In Flanders, from 94 in 2006, today, there are 320 medical graduates training for Family Medicine. What are the advantages? It offers a solution to the shortage problem by taking away the threshold for becoming a Family Physician. Graduates are given the opportunity to work in the community and contribute responsibly to changing the healthcare process.
Working in a primary care network has a favourable effect on the professionalism and responsibility of providers, especially nurses.
In hospitals, the challenge is mainly of a technological nature. The more machines you handle, the higher your status will be. In the community, your status will increase with the difference you will be able to make for the people, especially those most in need.

As far as nurses are concerned, my personal view is that there is a need for more masters level trained (advanced) nurse practitioners. Certain roles can indeed be shifted between those nurses and Family Physicians. Moreover, those nurses would bring in a more holistic view in the team and make it possible to provide more comprehensive care.
Another advantage of working in primary and community care is that the primary or community carer can better organise the combination of their work and private life.

Ageing and the increase of chronic diseases. The number of people with complex care needs require delivery systems that bring together a range of professionals and skills (healthcare – long-term care – social care). Will this remain the task of hospitals or can primary care provide a partial solution to this?

Older patients may suffer from a combination of complex diseases. In hospitals, they would go from one specialist to the other. The approach in primary care is different with more attention given to the comprehensive approach to the patient. This global approach will be better for the well-being of the patient.

What is your view on the development of new technology in health care? Could a potential project be a study on workforce organisation through efficient use of medtech?

Quality has many components and one of them is technology. Patients need to be involved in the development of new technology. By focusing the development of new technology on patients' goals, new technologies will be more relevant for them and resources could be better allocated. On the other hand, there is a need for more evidence that technology makes a difference in care. I advise to focus innovation on integrated personal health records (where all primary care personnel work in the interprofessional records and there is a link with secondary and tertiary care).