The Grapevine

Spring 2015

Spring is here with wonderful flowers just emerging after a long grey winter! April has crept up on us though and it is now under 1 week to the WONCA Rural 2015 conference in Dubrovnik. EURIPA will have a booth so that will be a good place to meet new colleagues and renew friendships. Come and see us!

We look forward to seeing you in Dubrovnik!

Jane Randall-Smith

Executive Secretary EURIPA

Contents

WONCA Rural 2015: 15th – 18th April 2015, Dubrovnik

Planning is in the final stages for the conference and EURIPA members will be well represented in the programme. The 5 EURIPA workshops are:

Thursday 16th April	Leaders
Teamwork and leadership in rural healthcare	Oleg Kravtchenko
Chronic Morbidity in Rural Areas	Jean Pierre Jacquet
Looking back, 20 years of EURIPA: what has it achieved and what has it to offer the rest of the world	Jose Lopez-Abuin
Friday 17th April	
Rural clerkships for undergraduates in Europe. Including rural expericiences in the (official) curriculum. Barriers and success stories	Jaume Banque - Vidiella
The impact of migration and large scale tourism on small and rural health systems	Jose Lopez-Abuin

The full programme is now available on the web site at a glance:

http://woncarural2015.com/wp-content/uploads/wonca-program-at-a-glance.pdf

The night before the conference begins, Tuesday 14th April, there will be a rural dinner in a village, Ljuta (32 km far away from Dubrovnik). There will be transport by bus, the dinner and return to Dubrovnik with bus, for 35 Euro.

Included in the price is: unlimited welcome drink, appetizer, main course and dessert. More about restaurant can be found at : http://www.konobavinica.com/index.php/en/

Please send an email to: tashamed@gmail.com if you are interested in coming to the dinner.

EURIPA will have a booth at the conference and EURIPA members are welcome to bring information about their national conferences. It will be a good place to meet!

See you in Dubrovnik!

The **winner** of this year's **Carosino prize** has just been announced and we are delighted to include here a short article about her experience in a rural practice by **Catarina Carvalho** from **Portugal**, who visited Dr Helen Herbert's practice in Aberaeron, Wales. You can also read about the experience of the practice by Helen herbert and we hope that together they will inspire other young doctors and also rural practices to particpate in the competition.

My Welsh experience - Hippokrates Exchange in Tanyfron Surgery

In the past 3rd to 14th February 2014, I was given the opportunity to undertake an Hippokrates Exchange in the Welsh rural primary care practice, Tanyfron Surgery, in Aberaeron. Not only I joined my host, Dr. Helen Herbert, in her daily "routine", but also a variety of other professionals working to or with the surgery: doctors, nurses, receptionists, pharmacists and other community agents. During the time I spent with doctors, I noticed some differences to the Portuguese context, related to the appointments length (10 minutes instead of 20), the volume of home visits (about 2 each day instead of 2 each week), the doctor's appearance (own clothes instead of scrubs), the proportion of each nature of contact (mostly non-scheduled consultations instead of mostly scheduled appointments), the communication with the secondary care professionals (written bilateral information with all the helpful data for a concerted care to a "shared" patient) and the little time spent with paperwork (for example, by receiving the diagnostic complementary exam results in electronic format, without the need to type them in the computer as in Portugal). I also perceived a much easier access to mental health care than in Portugal, leading to a much rarer referral to secondary care institutions.

As far as nurses are concerned, they were surprisingly autonomous, especially in the chronic conditions management (respiratory diseases, smoking cessation, arterial hypertension, diabetes), children's and women's health. The primary care nurses often have specialized training in specific areas in both contexts, but in Portugal, they perform all kinds of activities anyway, while in Wales they seem to focus in one or two fields.

The receptionists in Tanyfron Surgery could take a much more active part in the care provided than I was expecting, helping with the referrals, the registration of telephonic consultations requests, the transmission of INR monitoring to the patients under warfarin therapy and the communication with the local pharmacies about the repeat prescriptions.

Health professionals are self-employed or have a private contract. In general, their remuneration is much higher than in Portugal, which doesn't directly correlate with the average cost of living. The fact that health is mostly free for all the Welsh citizens (both consultations and medicines) is also a big difference between the two health systems. The maternity leave is longer in the United Kingdom, and it's easier to proceed working fewer hours per week, after returning, which added to the accessibility to children's care facilities could contribute to the much higher birth rate in that country. Both countries are having some difficulty dealing with the ageing population, as it is a very delicate social challenge. However, I was very impressed with the dedication of the Tanyfron team to this matter, which I realized in their regular Palliative Care meetings and the Dementia group meetings.

The population remarkably appreciates GP's and they are in fact the first contact with the health system in most situations. As in Portugal, health professionals' recruitment to rural areas is a challenge nowadays.

It was a fascinating experience and I felt very inspired. I will definitely recommend the Hippokrates Exchange Programme to my colleagues, and the Welsh context is a very interesting one to learn with. Personally, it was a memorable experience for the incredible people I met and the natural beauty of Aberaeron and its surroundings. I had a very warm reception, for which I thank my dear host Dr. Helen Herbert and the Tanyfron Surgery remarkable staff.

Catarina Carvalho
GP trainee
Aveiro
Portugal

Aberaeron

And, from the host practice:

We used to be a GP training practice but for a variety of reasons no longer do so and we missed the inspiration and pleasure of welcoming young doctors to learn with us and experience life in our rural practice on the West Coast of Wales. I learnt about the Hippocrates exchange scheme when the UK representative came to inform the members of RCGP Wales Council – and I was first to volunteer our practice! Since then we have hosted young doctors from France, Portugal and Uruguay. We are proud that our practice was the first to host a doctor from outside Europe.

It is necessary to agree an educational plan before the visit and we communicated by email and Skype to discuss the timetable. The Hippocrates doctors have observer status only but we enabled them to accompany all members of the primary care and community care teams – from the GPs to receptionists, nurses, health visitors and local pharmacists. They come with us on visits to the patient's home so gaining excellent insight into the living conditions of patients in rural Wales. They also had an opportunity to meet doctors in training on the Aberystwyth Vocational training scheme. We had arranged with the Hospital Consultants for our young doctors to visit the local hospital but unfortunately management would not allow this as our visitors could not provide evidence of CRB checks despite the fact that they were all practicing doctors in their respective counties. We aimed to provide as wide experience as possible in the short time available and all of our staff enjoyed and learnt from the experience.

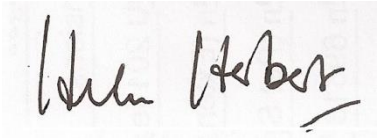
I suppose our only anxiety related to the potential language difficulties but it is incredible how it is possible to communicate a message through gestures, facial expressions, drawings and generally talking around the subject. Catarina from Portugal was fluent in at least four languages but even she was stumped when she was sitting in on nurse consultation and a patient used a swear word – and the nurse was left to try and translate! As many of our consultations are in Welsh, it was sometimes necessary to translate into English first. Needless to say, we have learnt some Portuguese and Spanish too! Our practice manager is Spanish and she was invaluable in writing emails in preparation for the visits and making our guests feel at home once they had arrived. Paola from Uruguay spoke very little English when she arrived but quickly picked up enough to communicate well by the end of her four week stay – besides, her smiles, enthusiasm and infectious laugh were worth a thousand words! Catarina delivered a wonderful powerpoint presentation about her work in the practice and the National Health Service in Portugal – not only to us in the practice but also at the county GP Protected Learning Time and the Health Board GP leads meeting. We learnt much about the differences between the countries health care - from patient expectation to levels of GP pay and national policy.

Above all, our patients really enjoyed being part of the host experience! They were fascinated to learn more about our young new doctors and many a time the consultation was diverted onto holiday experience in Portugal and descriptions of life in Uruguayan general practice. Paola and Catarina commented on how happy and undemanding our patients are! Our patients know of our GP recruitment crisis and I know that many hoped that our visitors would stay - as did I!

We found accommodation for our guests – Catarina and her husband love sailing and were very much at home waking up in Aberaeron to the sound of the waves and the noisy rigging on the yachts in the harbour. We spent several enjoyable evenings together when we cooked traditional meals from our respective countries. Paola stayed with a retired GP who lives on a farm. Both eccentric, they loved each other's company - and took turns in feeding the pig and riding the horses. The local newspaper even ran an article about our Uruguay visitor and one picture showed her observing a consultation with me in the surgery and the other feeding the pig with Dr Dorothea!

Needless to say, as hosts we gained many benefits from opening our doors to our visitors. We compared and contrasted the different ways we practice medicine and the different health systems but more importantly, by sharing the intimacy of the patient consultation and enabling them to visit the patients home with us, we were able to exchange conversations about the most important aspects of holistic patient care, which held such common ground. We learnt so much from each other, not only about medicine but about our different cultures and values – and even more importantly, have made friends for life.

We greeted our guests with the Welsh word "Croeso" (Welcome) and departed with "Diolch" – thank you. I would urge all of you who are able to be hosts to make contact with Hippocrates to offer a placement – your efforts will be repaid many times over by the experience.



Tan-y-fron surgery

The practice team with Paola from Uruguay

Paola with Helen

Staying on the subject of education, we have a summary of the new approach being taken in Germany at the Magdeburg Medical School. Both Jens and Markus will be in Dubrovnik and presenting their work.

Challenging conventional medical teaching:
Innovative selective at the Magdeburg medical school

While Germany generally proves as a country with a high level of health care capacity and a well-established system of in- and outpatient care, current socioeconomic trends, demographic transition and rural exodus of health professionals endanger increasingly Germans' right to universal access to health care. The growing imbalance between urban and rural regions with a high concentration of physicians in cities and a decreasing number of health professionals in rural areas has meanwhile become a priority topic of national health policy. The federal state of Saxonia-Anhalt in the former East Germany depicts the typical challenges of rural health care with an aging population, migration to the cities and decreasing numbers of healthcare providers in rural regions. A series of rather complex, well-coordinated measures are required for safeguarding at least adequate primary health care in rural and remote regions, including significant modifications of priority setting, teaching and environment of medical school faculties.

In order to reduce the existing barriers for students to initiate a medical career in rural areas, the Institute of General Practice and Family Medicine in Magdeburg, the capital of Saxonia-Anhalt, has developed an innovative rural health course for undergraduate training for providing medical students with insights in rural practice and country life. Greater rural exposure earlier in medical training and the encouragement of good rural role models are required to prevent the dissuasion of rural-oriented students from entering rural practice and to allow them to experience both the deeper relationship that rural health practitioners, and the satisfaction of being able to utilise a wide range of skills.

Such an approach challenges the typical roster of medical school teaching and learning that does not model for students appealing to rural practice and gives little relevance to the skills needed by physicians to address community health issues. The prevailing medical school environment does not encourage a career in general practice, and both subtle and overt disincentives prevent medical students from entering primary care specialties and particularly from practicing in underserved areas. Medical schools are located at universities and hence urban-based, provide students with limited opportunities to become familiar with rural health care, and offer a host of negative role modelling experiences. A major barrier for recruiting health workers to rural areas derives from the fact that long-time medical training is almost all in an urban setting what makes it difficult for students to adapt to a rural lifestyle later.

Medical – as well as nursing - students need to have the opportunity to learn about rural communities and rural practice. Moreover, contextual learning in the rural family medicine setting is a necessary cornerstone of medical training for setting up and sustaining a medical office outside urban and even in remote areas. Evidence shows that training programmes in rural-based family practice can provide an excellent contextual learning experience that benefits not only the residents but also rural teachers and the community.

Against this background, the University of Magdeburg decided to pioneer in broadening medical training by offering a rural medicine track for undergraduate students. During the 2014 summer semester, 14 students attended a two-weekend course in a small village in Northern Saxony-Anhalt that allowed them to become more familiar with a rural community and rural health issues. Participants were satisfied with the focus and content of the course since they had a lot of opportunities to get information from a wide set of actors in rural health, including rural practitioners and other health professionals, representatives from the regional outpatient provider association, financial advisors and others. Preliminary assessments proved increased knowledge and awareness of rural working conditions and showed an increase of students' willingness to work in a rural setting after graduation. The two-weekend course will be repeated during the 2015 summer semester.

Jens Holst Markus Herrmann

Reports from EURIPA members

Report of the lecture of **Ferdinando Petrazzuoli** at the
Update Annual Meeting of "Family medicine specialist, Clalit Health Fund,
and The Israeli Association of Family Physicians"
Hilton Hotel Tel Aviv 14 January 2015.

My lecture was the only one in English. The plenary session was quite crowded, nearly 500 participants. At the beginning of my lecture I showed a few photos of my rural practice and my rural tiny village where I live and work. At the end of my presentation I received a few clarifying questions. I felt that many participants were a bit surprised that I am a full time rural GP and at the same time involved in research.

Abstract for Tel Aviv

Real life patients: Multimorbidity, Guidelines and Person Centred Care.

In Primary Care both General Practitioners (GPs) and patients are often blamed for not following clinical guidelines; GPs are also said to be affected (more than secondary care doctors) by some sort of **clinical inertia**. What is the real reason for all that? Guidelines are mainly based on the outcomes of randomized control trials, but how much are real life patients similar to those involved in these trials and how much non-biological factors are taken into account by guidelines? In Primary Care many common diseases are syndromes—that is, common manifestations of diverse processes set in motion by interacting influences on health. The challenges in medical care today are much more complex than in the past because of the marked increase in early diagnoses of diseases and a resulting increase in the simultaneous presence of different diseases. Despite this reality, guideline supporters continue to develop algorithms for management in primary care that are based on an outmoded concept of health problems in populations: single, discrete diseases. Clinical trials do not identify the nature and extent of the health problems experienced by the real life people. Guidelines very often are not developed with consideration of the nature of Primary Care settings: in Primary Care, presenting problems are often not diagnoses but rather symptoms and signs. Nowadays performance measurement is increasingly being extended to interventions

that have only a small clinical benefit and at the same time many important aspects of care are being neglected. Most quality indicators are not based on priorities regarding effectiveness and equity, and they have the effect of encouraging physicians to focus on compliance (both in terms of their own actions and in terms of patients' behaviors) rather than on problem resolution. There are big differences between the secondary care and the primary care settings. The former is said to be disease oriented while the latter is person centred. But what person centred care means? This definition can be easily understood if we think about what GPs do in their everyday life. From the EURACT -WONCA Europe definition of family medicine, *GPs care for individuals in the context of their family, their community, and their culture, always respecting patient autonomy. In negotiating management plans with their patients, they integrate physical, psychological, social, cultural and existential factors, utilizing the knowledge and trust engendered by repeated contacts*. In other words: GPs care for person not patients, they give advice not orders, they deal with problems not diagnoses, and many not only one, they work on long perspective not short ones (single visits).

Barbara Starfield stated that care is much better when it recognizes what patients' problems are rather than what the diagnosis is. A major failure of primary care, is often the great underestimation of the importance of long-term relationships with patients independent of care for specific disease episodes. Physicians and patients working together to reach shared decisions often require a long-standing relationship. Patients are more likely to follow medication regimens if they share their physicians' belief about causes of health outcomes. This is unlikely to be the case when visits are with practitioners not well known to patients (and vice versa).

Person centred approach is more a way of thinking than just a way of acting. It means seeing the patient always as a particular person in a particular context and it includes a total health perspective of a patient, not only the disease elements that can be recognised in the problems and complaints. To sum up Good Primary Care requires the ability of: integrating, prioritizing, contextualizing, and personalizing health care across acute and chronic illness, psychosocial issues and mental health.

Kjartan Olafsson is the new liaison from **UEMO** (Union Européenne des Médecins Omnipracticiens)

I thank you for giving me the opportunity to present UEMO and myself. I am looking forward to following the work of EURIPA, giving your board input from UEMO and bringing back to UEMO your important perspectives on the field of Family Medicine.

The European Union of General Practitioners (UEMO) is an organization of the most representative national, nongovernmental, independent organizations representing general practitioners in the countries of Europe. It covers around 600 000 GPs in about 26 countries.

I was elected VP of UEMO from 2014. In my everyday life I have been working as a GP for nearly 30 years, all of them in the small city of Florø in the North-Western part of Norway. Five thousands of the total twelve thousands inhabitants of our municipality live outside the town centre. The most rural areas being small fjords and valleys as well as islands facing the North Sea. Many GPs in Norway work under the same demography, rural and densely populated areas side by side. After becoming liaison to EURIPA I have asked myself: "Am I practicing rural medicine?" I suppose it depends on the definition. Anyway, the rural perspective has strongly influenced my view on Family Medicine.

It is important that someone gives voice to the rural perspective inside national and international GPs organizations. Why? We need a sustainable Family Medicine. The key to sustainability, what we decide on a policy level must make sense both in rural and other more densely populated areas. GPs are "Near you and everywhere". If we neglect the rural aspect, Family Medicine is no longer for everyone, is certainly not everywhere and is no longer valid in the same way.

As national and international organizations, we are seeking recognition for Family Medicine and the value of GPs work. Sometimes we set the standards higher than what is possible in rural areas and by doing this reduce the sustainability of Family Medicine. Let me give you a Norwegian example. If we demand a mandatory specialty of Family Medicine for all GPs on duty, and demand a backup GP on duty in every district, this would underline the importance of our trade to authorities and our hospital colleagues, but an unfortunate effect could be a very demanding workload for GPs in rural areas. Instead of involuntarily adding weight to this burden, we should actively find ways to ease the load, working for special arrangements, economic compensations and incentives.

Happy doctors, happy patients and happy governments constitutes a holy trinity signifying success. Unfortunately, we are a long way from this situation in our field of Family Medicine. Many colleagues feel hampered by a rising bureaucracy from government quality and cost control initiatives. We have to work proactively with these issues to prevent others from giving us bad solutions. Europe needs general practitioners who can take responsibility under freedom, not frightened practitioners governed by perverted top-down control systems scrutinizing primary care outside of its true context.

The principal objectives of UEMO are:

• to study and promote the highest standard of training, practice and patient care within the field of general practice throughout Europe;
• to defend the role of general practitioners in the healthcare systems;
• to promote the ethical, scientific, professional, social and economic interests of European general practitioners, and to secure their freedom of practice in the interest of their patients;
• to determine the united views of the members and to represent them through the appropriate channels to the relevant European authorities and international organizations;
• to work with other European medical groupings

Presidency and Secretariat

The Presidency and Secretariat function of the UEMO rotates from member organization to member organization on a four-yearly basis. From 2015 Italy has the Presidency with Aldo Lupo as President. The Presidency of UEMO consists of the President, the Secretary-General and the Treasurer from the host country. In addition, four Vice-Presidents are attached to the Presidency.

Meetings

UEMO normally meets in General Assembly twice a year, in spring and autumn.

UEMO policy

UEMO is working to strengthen Family Medicine in Europe and in each member state. One of our main objectives is to make the EU recognize the specialty of Family Medicine or General Practice on the same level as other medical specialties. A few countries in Europe have no specialty of Family

Medicine and we try to assist our colleges in these countries. The mobility of patients and professionals across borders challenge our traditional way of working. We need to harmonize systems and cooperate on many new levels and directions. CME (continuing medical education) is one of many important cross boarder issues. ICT solutions and the exchange of medical information across border are other questions.

For the sake of our patients, Family Medicine needs a higher standing in Europe. Family Medicine is cost effective, and as shown by Barbara Starfield, countries who have well developed systems for Family Medicine benefit from that in better population health and overall use of health care resources. Problems are solved with less unnecessary, painful and expensive examinations than in secondary health care. We often know our patient for many years, so we can use our long and wide perspective to treat people differently. Family medicine invented the concept of personally adapted treatment decades ago, a concept now being hi-jacked by genetic engineers.

The economic challenges in Europe, makes time ripe to strengthen primary health care and Family Medicine. Some countries, like Switzerland, have taken action, others are seeking secondary care solutions, and paradoxically worsening their general practitioners working conditions. This in turn leads to recruitment problems and a lack of GPs.

We meet common people with common diseases and use our common sense. It is sad that those who govern us not always do the same. Winston Churchill once said that the single biggest problem with common sense is that it is not that common. Therefore, we have to continue our fight for acknowledgement of *our* medical perspective as the most important one in building sustainable universal access health care systems throughout Europe.

Kjartan with the ambulance boat for house calls in islands outside Florø and Kjartan

The paper below by **José Augusto R. Simões** is a summary of a presentation given in the EURIPA Invitational Rural Health Forum in Riga in 2014:

Primary Health Care reform in Portugal: effectiveness at the rural area

Portugal is located in the Iberian Peninsula in south-western Europe.

It is an independent nation since 1143, a republic since 1910, a democracy since 1974 and joined the European Union in 1986. It has community health centres since 1971, a National Health Service since 1979 and began a reform of primary health care in 2005.

The Portuguese health system offers universal coverage, a full range of health services, financed mainly through taxes and relying mainly on public care.

In the early seventies (1970s), Portugal was one of the first European countries to adopt an integrated approach to primary health care by creating a network of health centres that comprises most of the country.

Health centres in Portugal are a cultural, technical and institutional heritage that must not only be preserved but also modernized and developed as they continue to be the most efficient and affordable mean to protect and promote the health of the population.

All residents in Portugal have access to health care provided by the National Health Service.
All citizens have the right to health protection and to free, universal care, regardless of economic or social status.

Public provision is particularly present in primary care, the first point of contact within the public system, and hospital care.
Pharmaceuticals, complementary diagnostics and medical consultations are the most significant part of the private provision of health care.

Improvements in recent decades:

• Life expectancy at birth has improved dramatically over the past twenty-five (25) years; the gap in life expectancy compared to the average for the European Union (EU-15 = group of countries at the entry of Portugal) decreased from three (3) years in 1980 to one and a half (1½) years in 2007.

• Potential years of life lost (premature death) were forty percent (40%) more than the EU-15 median in 1980 but only twenty percent (20%) more in 2003.

• Perinatal and infant mortality rates (deaths in the first seven (7) days and in the first year of life, respectively) were the highest of the EU-15 countries in 1980 but were better than the EU-15 average in 2007.

• Mortality rates for some key causes of death under the age of sixty-five (65) years have decreased since 2000; in particular, mortality due to circulatory diseases such as ischemic heart disease and strokes has fallen substantially, as has the rate of death due to motor vehicle accidents.

• Mortality rates on the thirty (30) days following a stroke or heart attack have dropped by roughly a quarter since 2000.

• The five (5)-year survival rates for cancers detected at early stages have improved over the past ten (10) years.

But:
• A number of morbidity indicators, such as self assessed health status and disability-free life expectancy, have not shown similar improvement and results continue to be low in relation to other EU-15 countries.

• There are still sizeable inequalities in health status between men and women and among geographical regions. Women live longer than men, but women appear to live in a poorer state of health with a shorter disability-free life expectancy and lower self-assessed health status than men. Life expectancy is shorter in the less populated and less urban regions of Portugal.

• The Portuguese appear less satisfied with the availability and quality of health care than citizens of other EU-15 countries.

• Total expenditure on health has increased substantially over the past decade. However, the increase in private expenditure, including out-of-pocket payments and cost sharing, has been disproportionate, placing an additional burden on disadvantaged households and potentially limiting access to care.

There are opportunities to respond to these challenges and improve health system performance.
However, any responses to the challenges must be fiscally sustainable.

A critical element in improving health system performance with limited resources is the ability to make political choices to allocate resources in areas where they can be most effective in improving health and equity in health.

The National Health Service is a highly centralized and bureaucratic structure; there are no incentives for good performance or quality.
The job dissatisfaction is a challenge and a threat to the development of primary health care.
Doctors and nurses are government employees with fixed salaries independent of performance.

The starting point for the current reform is therefore the low level of satisfaction of all involved, citizens, practitioners and policy makers, motivated by low accessibility, inefficiency, bureaucratic hurdles and lack of incentives to improve productivity and quality.

The government aimed to organize the health system in order to improve distributive justice, efficiency, effectiveness and the ability to solve citizens' problems.
Every effort is made to keep the principles of solidarity and justice, so that everyone can benefit from scientific and technological advances used to foster health and well-being.

To achieve this vision, provide better health care, it became necessary to change the setting of primary health care, making it more accessible, more efficient and better suited to the needs, not only of citizens, but also of professionals.

The following policy measures were adopted
Restructuring of the health centers through:
(1) The creation of Family Health Units;
(2) Grouping Health Centers.

Family Health Units (USF)
The initial phase and with greater public visibility, was the creation of USF, small multidisciplinary teams, voluntary, self-organized and composed of three to eight family physicians, an equal number of family nurses and clinical secretaries, covering a population between four (4,000) and fourteen (14,000) thousand.

These teams contractualize a basic portfolio of services, have technical, functional and organizational autonomy and very importantly, a mixed payment system (capitation, salary, goals), financial and professional incentives that reward merit (activity-based) and is sensitive to productivity and accessibility and above all quality.

Groupings Health Centers (ACEs)
The reconfiguration of the health centers and the creation of ACeS has the primary objective of providing current health centers with an organizational framework and support structures that enable them to increase the quality of services, maximizing resources and preserving its identity.

These groupings, a maximum of seventy-four at the national level, must obey, to a population criteria that corresponds to a number of residents between fifty (50) and two hundred (200) thousand and complemented by a set of variables such as geographical accessibility, population density and the accessibility of people to hospital care.

Functional units
The USF are functional units of ACeS, are all computerized, have a set of performance indicators for their evaluation, contractualize goals.
For payment purposes of institutional incentives seven areas are evaluated and monitored: availability, accessibility, productivity, technical-scientific quality, effectiveness, efficiency and satisfaction.

The indicators associated with the payment of financial incentives to doctors beyond the home care surveillance, integrate family planning surveillance, monitoring of pregnancy and the child in first (1st) and second (2nd) year of life, diabetes and hypertension monitoring.

There are, however, known limitations and needs of health centres, including the chronic shortage of human resources: the lack of Family Physicians is only the best know.
There is still a need for more nurses, nutritionists, psychologists, social workers, dentists, and other professionals, particularly in rural areas.

Strengthen incentives and training of family physicians, attracting younger candidates.

References:

- Pisco, Luís. Primary Healthcare Reform in Portugal on two fronts: autonomous family healthcare units and management of groupings of Health Centers. Ciência Saúde Coletiva. 2011; 16: 2841–52.

My Practice - Leena Uusitalo, Finland

The health center of Lake Ostrobothnia or Järvi-Pohjanmaa is the health center of three municipalities Alajärvi, Soini and Vimpeli. My practice is very versatile. I am working mostly as a family doctor in Vimpeli.

Visiting six old people's homes monthly belongs to the program. Two homes for people with mental health problems are visited every two or three months. Mentally ill people`s rehabilitation home is visited every now and then. Nurses at homes ask of their patients` care daily. Home visits are there, too.

I am the school doctor of the pupils of two primary schools and of the secondary school and the college in Vimpeli.

I account to the care of abusers of psychoactive substances and mentally ill people`s care. The rehabilitation of children and adults, health care of long-term unemployed persons and contact doctor of infection diseases belong to responsibilities.

Every now and then I work in the child health centre or in the maternity clinic.

The responsibility of education of doctors belongs to the work.

Like you see, my work extends from the time before the birth to the death and after that. I have been working in Vimpeli since 1980. The work is really very interesting.

The distance between Vimpeli and Alajärvi is 23 km and between Vimpeli and Soini 44 km. The distance between the health center of Vimpeli and the home visit houses in Vimpeli may be 20 km and in Soini 70 km.

The climate change can be seen on Vimpeli, too. The really cold time, -25 degrees of Celsius, lasted only about a week. The coldness means that we must warm the machines of the cars for a few hours and scrape the ice from windscreens. We need to wear many warm clothes. Now it is warm, about +2 degrees at night and + 7 degrees in the daytime. I live by The River Savonjoki, and the ice on that I was skiing for one month ago is now partly covered of water.

Leena Uusitalo
Associate chief physician
The Health Center of Järvi-Pohjanmaa
Vimpeli

Update on EURIPA activities

EURIPA's Executive Committee continues to meet regularly and the International Advisory Board has also met recently. There will be a joint meeting Dubrovnik; please let me know (jane@mongtomery-powys.co.uk) if you would like to join us. The up to date membership of both groups is available on the web site at www.euripa.org

Hot Topics continue. Thank you to everybody who completed the questionnaire on Chronic Morbidity – the responses are currently being analysed and will be presented at a workshop in Dubrovnik. The follow up Hot Topic focussing on **Occupational Health** is currently taking place. The link to this supplementary questionnaire and the results of the original survey can both be found on the web site, www.euripa.org

Our Journal
If you are involved in research or training initiatives in rural health we would welcome a contribution to the **International Electronic Journal of Rural and Remote Health Research Education Practice and Policy.**

The Journal contains a European section and we would like to encourage EURIPA members to contribute to the Journal. Original research is always welcomed but there is also the opportunity to send in letters, project reports or personal perspectives.

There is support available to help you get published – new authors are actively encouraged!

Please contact Professor Christos Lionis, our editor, if you would like to make a contribution (lionis@galinos.med.uoc.gr)

Other news

Gramado Statement
The Gramado Statement, the conference statement from the 12th Wonca World Rural Health Conference, held last year in Gramado Brazil has been endorsed by the Wonca Executive. It can now be found on the Wonca website:

http://www.globalfamilydoctor.com/AboutWonca/PositionStatements.aspx

South Africa
Rural Proofing Guidelines have been developed for South Africa by the Rural Health Advocacy Project of the Centre for Rural Health at the University of the Witwatersrand. They were launched in February 2015.

The guidelines can be found at: http://www.rhap.org.za/rural-proofing-health-guidelines/

UK
The Institute of Rural Health (IRH) based at Newtown in Wales has closed at the end of March 2015. IRH was one of the early centres to focus on rural health in Europe and the first in the UK. Dr John Wynn-Jones, now Chair Wonca Working Party on Rural Practice, was the founder and over a period of 18 years it raised the profile of rural health in the UK publishing significant research, running education programmes for students, young doctors and working doctors and crucially engaging with policy makers locally and nationally to raise the profile of rural health.

Publications

Below are some recent publications from across Europe in the international Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy (http://www.rrh.org.au/euro/defaultnew.aspof) that may be of interest to other rural practitioners:

Utilisation of a direct access echocardiography service by general practitioners in a remote and rural area - distance and rurality are not barriers to referral'

In remote Scotland, rurality and distance may no longer impede diagnostic accuracy for GP-managed patients with heart failure.

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=2736

Are there differences between rural and urban populations in long-term outcome after systemic cerebral thrombolysis in a hospital located in an agricultural region?'

Are rural patients with acute ischemic stroke still at greater risk of morbidity? This study is from Poland.

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=2867

Forthcoming Events

Below are a selection of events for 2015 that may be of interest to EURIPA members. Please send in your events for future editions of Grapevine so that we can make this section more comprehensive. Please send to the editor at jane@montgomery-powys.co.uk

WONCA Rural Working Party Conference
Breaking down barriers, bringing people together
15th – 18th April 2015 Dubrovnik, Croatia
Abstract submission will open in September 2014
More information: http://woncarural2015.com/

80th EGPRN conference
Research into new Methods and Techniques in Primary Care
7 – 10 May 2015 Timisora, Romania
More information: http://meeting.egprn.org/home

COPOC 1st International Congress on Controversies in Primary and Outpatient Care
20 – 22 May 2015, Tel Aviv, Israel
More information can be found at: http://www.comtecmed.com/copoc/2015/

Forthcoming Events cont'd

13th National Rural Health Conference
People, places, possibilities……
24 – 27 May 2015, Darwin, Australia
is available at http://www.ruralhealth.org.au/13nrhc/program

EQUIP summer School
25 – 28 June 2015, Zagreb , Croatia
More information: http://www.equip.ch/

International Congress on Rural Health, as a social economic and cultural engine
Lodi (Italy), September 8-11th
Abstract submission is now open up to **30th June 2015.** For more information go to:
http://www.overgroup.eu/ruralhealth2015/

WONCA Europe 2015
Future of Family Medicine…… being young, staying young
October 22nd – 25th 2015 in Istanbul, Turkey
For more information go to: http://www.woncaeurope2015.org/

WONCA Europe Congress, Copenhagen, 2016
Theme: "Family Doctors with heads and hearts"
Date: 15-18 June, 2016
Web: http://woncaeurope2016.com/

Future Contributions to Grapevine

The next issue of the Grapevine will be Summer 2015 and notification of the deadline for contributions will be circulated on the mailing list and announced at the web site.

If you are interested in contributing to the next edition of Grapevine please get in touch with the Editor at Jane@montgomery-powys.co.uk . Please think about what you do in your practice and if you would like to contribute to the new clinical case section, or send us a piece about your practice, tell us about research you are doing or have published, an event that is being held in your country ..... please do get in touch.

Grapevine is YOUR Newsletter and we always welcome new contributors.

Disclaimer:
The views contained in the featured papers above are those of the authors and not necessarily those of EURIPA.