

FRIDAY 14th OCTOBER, 2011:

Location : City Council Conference Room

09.00 - 09.45: 1st Keynote Speaker: Prof. Adam Windak, PhD – Poland.

Theme: “The main directions of family medicine in Poland, including future prospective”

Poland is a Central European country with over 38 million of inhabitants. 13,5% of population is over 65. Life expectancy on birth is 79,96 for females and 71,26 for male. Total healthcare expenditures are equal to 6,4% of GDP.

97,7% of inhabitants are obligatory insured by National Health Fund – the exclusive public health insurance company. In the year 2009, 13,25% of its budget was reserved for the primary care services. The health insurance fully covers primary care services, which are provided free of charge, without any patient co-payment. Primary care is reimbursed mainly on per capita basis and only small part of them are paid as a fee-for-service, mainly in case of preventive programmes. These last activities are often financed separately by local governments from their own resources. Primary care physicians can work both as a salaried personnel or as independent contractors. Over 60% of all PC physicians and over 80% of vocationally trained family physicians run their practices as independent contractors. PHC physicians are allowed to have their own lists of patients. The average patient list size is 1539. However in rural areas this figure can be far bigger, while in big cities smaller. In the theory PHC physicians act as gate keepers. However referrals are not needed to psychiatrists, oncologists, dermatologists or ophthalmologists. PC practices should be open from 8 a.m. to 6 p.m. during all working days.

Family medicine was recognized as a speciality in 1994 and since that time over 10 thousands of physicians completed vocational training in this field. By law only physicians vocationally trained in family/general medicine are allowed to work as primary care doctors within the public system. All other physicians, already working in PC settings, are allowed to continue their work up to 2017 and till that date they should complete specialization in family medicine.

All insured patients have an unlimited access to his/her own PC physician. Patients have rights to choose a family doctor or alternatively an internist or a paediatrician. At the end of 2010, 8129 family physicians worked as PHC doctors (33%). In the same time there were 9899 internists (41%) and 6252 paediatricians (26%) working within the public system. Family medicine is considered as a deficit speciality, what results in special governmental financial incentives to increase number of trainees in this field. This policy increased number physicians choosing family medicine as their future professional career. However still more training places are available for future internists than for family doctors. Family medicine is also taught to medical students at all universities with minimum number of 100 teaching hours. Vocational training lasts 4 years and more than a half of this time is spent in family practice.

The main professional organization of PHC doctors is the College of Family Physicians in Poland established in 1992. The College undertakes initiatives aimed at practice and system organization improvements, quality assurance, education and research. Since 1996 the College is a full member of WONCA. Other important organization active in PHC is Federation of Unions of Employers in Health Care, which defends financial and material interests of family doctors, mainly those acting as independent contractors. There are two major medical journals for family physicians. The educational one “Lekarz Rodzinny” (Family Physician) is published 11 times per year with 15000

copies per issue, while the scientific one “Problemy Medycyny Rodzinnej” (Topics in Family Medicine) is published quarterly.

Currently the main problems for family medicine in Poland are due to low number of new trainees, which may result in future workforce shortage, unclear vision of future PHC development and inadequate financing and increasing bureaucracy imposed mainly by National Health Fund. The main challenge is further academic development of the discipline, resulting in more attractive career options for medical graduates as well as stable vision of the role of family medicine within the whole health care system

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FRIDAY 14th OCTOBER, 2011:

Location : City Council Conference Room

09.45 - 10.30: 2nd Keynote Speaker: Prof. Samuel Coenen, MD, PhD – Antwerp, Belgium.

Theme: “Infectious Diseases in Primary Care; managing the interface between the person and the community”.

Infectious diseases still are among the commonest new diagnoses in primary care. The most common infectious diseases in primary care are respiratory infections. The most frequent reasons for encounter is acute cough. Managing respiratory infections, primary care physicians have to make antibiotic prescribing decisions in a context of diagnostic uncertainty, patient preferences and the global problem of antimicrobial resistance.

A causal link between antimicrobial resistance and antibiotic prescribing in primary care can be illustrated both at the ecological and the individual patient level. The most recent ESAC (European Surveillance of Antimicrobial Consumption; www.esac.ua.ac.be) data confirm persistent variation in outpatient antibiotic use in Europe. Mixed-effects models allow statistical assessment of the trend over time over the last decade of both total use and seasonal variation.

Data from GRACE (Genomics to combat Resistance against Antibiotics in Community-acquired LRTI in Europe; www.grace-lrti.org) observational studies show that variation in clinical presentation does not explain the considerable variation in antibiotic prescribing between 14 primary care networks in Europe for adults presenting with acute cough. Less than half of those who were prescribed antibiotics received a first choice antibiotic (i.e. tetracycline or amoxicillin). No (relevant) differences in recovery were found between those treated with any antibiotic, a particular antibiotic class or no antibiotic. Patients with discoloured sputum were prescribed antibiotics more often, but sputum colour, alone or together with feeling generally unwell, was not associated with recovery or benefit from antibiotic treatment either. Patient expectations regarding antibiotic prescribing might have changed, but still determine the antibiotic prescribing decision as do the prescribers' perceptions of patient expectations.

While establishing the aetiology, diagnosis and prognosis in adult patients with acute cough remains a challenge in primary care, preliminary results from a first randomised double-blind placebo-controlled trial in GRACE, including more patients than all trial in the current Cochrane Review, seem to corroborate the results from the observational GRACE studies. Another randomised controlled trial within GRACE assessed the effect on antibiotic prescribing of either an online training on the use of a C-reactive protein point-of-care test supplemented with the provision of such a device or an online communication skills training supplemented with the provision of an interactive patient booklet endorsed by the European Antibiotic Awareness Day (GRACE INTRO). Preliminary trial results suggest positive effects of both interventions and great opportunity for large-scale support of primary care physicians to manage the interface between the person and the community when dealing with respiratory infections in primary care, particularly the antibiotic prescribing decision.

**Prof. Samuel Coenen MD, PhD,
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SATURDAY 15th OCTOBER, 2011:

Location : City Council Conference Room

08.30 – 09.15: 3rd Keynote Speaker: Prof. Waleria Hryniewicz, MD, PhD – Poland

Theme: “The Risks related to Streptococcus Pneumoniae Infection, including preventive options, early diagnosis and treatment”.

The risks related to Streptococcus pneumoniae infection, including preventive options, early diagnosis and treatment

Waleria Hryniewicz, Department of Epidemiology and Clinical Microbiology, National Medicines Institute, Warsaw, Poland

Streptococcus pneumoniae (Pneumococcus) a Gram positive diplococcus is divided into 93 capsular serotypes all able to produce disease in humans but only some of them are responsible for the majority of infections. Pneumococcus is a leading cause of human infections, often very severe, acquired mostly in the community and causing a variety of both invasive and noninvasive disease. The former usually present as bacteremia, meningitis and bacteremic pneumonia; and the latter as upper and lower respiratory tract infections. S. pneumoniae is not only associated with very high morbidity but also in certain conditions with extremely high mortality. This is due to the variety of virulence factors and acquisition of multiple antibiotic resistance genes. According to WHO over 1mln children die every year of pneumococcal infections. The risk of developing pneumococcal infection is higher in patients at extremes of age (< 2 years old and > 65). Others at risk include patients with chronic pulmonary, cardiac and kidney diseases, diabetics, immunocompromised such as HIV/AIDS, asplenic, patients with sickle cell anemia, alcoholics and patients abusing nicotine. Viral infections often precede acquisition of pneumococcal infection by facilitating their spread from nasopharynx and thus development of a secondary disease. In infants and younger children very high nasopharyngeal colonisation has been observed which is particularly frequent in children attending day care centers. Administration of antibiotics to those children promotes emergence and spread of resistant strains. Diagnosis of S. pneumoniae infection is mostly based on clinical picture and epidemiological data. However, several attempts have been made to develop reliable and rapid microbiological diagnostics for POC. Some progress has been made with the introduction of rapid urine test to diagnose pneumococcal pneumonia, especially applicable in the adults. Several commercial and in house molecular methods have become available to diagnose of invasive disease. During last decade a dynamic spread of resistant strains has been observed. Nonsusceptibility to penicillin exceeds in certain regions 50% and very often is associated with resistance to macrolides/lincosamides, tetracyclines and cotrimoxazole. In some countries growing resistance to parenteral IIIrd generation cephalosporines among invasive organisms became a real therapeutic challenge. In the light of the above immunoprophylaxis plays a significant role. There are 2 vaccines available, first containing 23 capsular polysaccharides, mostly used in elderly, second comprising protein-conjugated capsular antigens for children below 5 years of age. Two formulations are at the market :10-valent (Synflorix) and 13-valent (Prevenar13).

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