Generalitat de Catalunya
Consell Assessor de Salut

STRATEGIC RECOMMENDATIONS ABOUT PRIMARY AND COMMUNITY HEALTH CARE MODEL

Health Advisory Council

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The assignment of the Health Advisory Council

The Council shall make it possible to rethink and redirect the model we want in the future in line with the social, demographic and technological needs and changes of the forthcoming twenty years. The Council shall enable calm reflection away from the day-to-day running of the Ministry and, therefore, be an instrument that can help us as a country to ensure the future of health is well thought out and planned.

Alba Vergés, Minister

The commitment of the Health Advisory Council

The Health Advisory Council has to act as a thinking hub focused on the model needed for the coming years (...) helping to address the challenges of the system and laying the groundwork to build the model that will provide an appropriate response for everyone.

Manel Balcells, Chair of the Health Advisory Council

Contents

1. Situation and rationale

The future of health systems depends on their ability to meet the health needs, demands and expectations of the public. Consequently, for many years health system managers have been involved in rethinking, planning and implementing ongoing reforms against the backdrop of an ageing society with growing social inequalities and in which there are increasing numbers of people with chronic conditions (1) or at risk of developing them. At the same time, the costs of services, treatments and innovative technologies are ramping up budgets that draw on limited resources raising concerns about the sustainability and viability of health systems. To address all these challenges, efforts have focused on an inter-sector public policy approach to mainstream health in all policies (2). This emphasises promoting environments to encourage healthier behaviours and prevention, while redirecting the care model towards more comprehensive and integrated, fair, efficient and community-based care (1).

Primary and community care (PCC) leads the care process and looks after people's health throughout their life. It is defined as essential and efficient care which is easily accessible to the entire community and includes health promotion and autonomy, disease prevention, maintenance of health and autonomy, health education and rehabilitation (3,4). Experts argue that to achieve universal health coverage, reforms should focus on enhancing primary health care (PC) to ensure fairness, reduce inequalities (5-7) and curb costs (4). Furthermore, quality PCC has been shown to enhance the performance of health systems by cutting overall expenditure while improving health and accessibility (4,8-10).

PC models in Europe, albeit complex and varied, show a certain degree of consistency. These models share the overall vision and future challenges such as the commitment to universal access to services and being the point of entry to the healthcare system (10).

There is widespread consensus in our neighbouring countries that a well-developed PCC model is the foundation for a quality, safe, effective and efficient health system which is responsive to people's needs (11). In general, they have beneficial effects on the health system as a whole, especially in terms of enhanced coordination and continuity of care as well as better opportunities for expenditure control (10). Specifically,

there is evidence that strong PC is related to a better level of health of the population, lower rates of avoidable hospitalisations and lower socio-economic inequalities in health (10,12,13).

The United Kingdom is one of the countries with the most robust health system in terms of its PC orientation (10,14). A recent report, which examines new organisational models of PCC to meet the future needs of the British National Health System (14), shows that there is no single PCC model of care that works the same for everyone. It also points out that the way in which the new models are implemented is as important as the models themselves. This review of PCC models, commissioned by Health Education England (HEE), a public body funded by the Department of Health and Social Care, identified innovative models with the potential to address the challenges of the National Health Service. The results were grouped into three categories: 1) Models that introduce new roles, or change existing roles, in general practice; 2) Models of collaboration among professionals and among the primary health care, secondary care and social care sectors; and 3) New organisational forms for general practice (14).

In Catalonia, three major reforms of the PCC model have been undertaken over the last thirty-five years. All of them inspired by the principles of the 1978 Declaration of Alma Ata, which more recently have been reaffirmed in the 2018 Declaration of Astana (2):

1. The reform of primary health care (RPC) which began in the 1980s was a turning point in the development of the public health system and in the goal of making PC the first step in access to the system. The RPC sought to achieve a comprehensive reform of the public health system in Catalonia by establishing the “delimitation of a territorial framework aimed at the operational sectorisation of the care network, integration and coordination between the different levels of healthcare staff and between the different levels of care, and taking on health promotion, psychosocial care and rehabilitation activities” (15). It took more than twenty years for the deployment of the reform to reach all of Catalonia.
2. In 2007, work began on the Primary Health Care and Community Health Innovation Plan (PIAPISC in its Catalan initialism), which was approved in 2010 by government decision (16). The PIAPISC emphasises improving integrated care for the individual,

giving priority to PCC as well as care for dependent persons and those with chronic health problems.

3. Recently, work began in 2017 on the development of the National Primary Health Care and Community Health Strategy (ENAPISC in its Catalan initialism) as the instrument to define the Ministry of Health's Primary and Community Care (PCC) model. The strategy involves hundreds of professionals and seeks to ensure cross-cutting and global continuity of care by placing the person at the centre of the health system. The model is consistent with the world consensus on the values and principles of PC, the Declarations of Alma Ata in 1978 and Astana in 2018 (2), and with the recent reports prepared by leading institutions such as Health Education England (14) and the King's Fund (17).

Drawing on knowledge of the current situation, the Health Advisory Council (HAC) addresses the challenge of rethinking the care model in Catalonia, which is what is really at stake.

The shift in paradigms and values means that a changing society, one which constantly requires interaction, is asking for a different response from the one that has been provided so far. Thorough knowledge of the position on the ground and a vision of the future are needed in order to overcome conjunctural situations and seek structural solutions while keeping in mind the immediate environment.

The Health Advisory Council (HAC) believes it is essential to focus on the primary and community health care model, an area that should lead the transformation of the health system. The proposal, that must provide for a social and health care model and cater for people's real needs, will also lay the foundations for the implementation of regulatory, financial, organisational and care instruments.

2. Purpose of the document

To make proposals formulated as strategic recommendations that guide the Primary and Community Care (PCC) model and address the care model from a proximity perspective.

3. Methodology

Face-to-face and virtual work and discussion meetings between Health Advisory Council (HAC) members. Collaborative work tools were used and previous reports and relevant literature were reviewed.

4. The discussion process

The HAC was established as a forum for calm reflection. It was designed as a thinking hub focused on laying the foundations for structuring the future of the care model. Prior to the discussion, it was decided to expand the conversation beyond the current regulatory framework.

Relevant priority issues were identified during the discussions over five sessions that have provided the basis for the preparation of this document. These issues were considered from global and cross-cutting system perspective and with the application of efficient and fair resource allocation. This involves applying good practices to all actions and reinvesting the proceeds of these good practices in the system itself. Furthermore, health care, education, research and innovation should be aligned with the needs of individuals and communities by tailoring the roles, competencies and functions of healthcare professionals.

The fact that a significant part of these ideas reiterate the proposals of other policy documents underscores the need for action. It is time to learn from mistakes and address the failures of previous attempts at reform and to try out new care and organisation models.

5. Strategic recommendations

Strategic recommendations regarding the Primary and Community Care (PCC) model focusing on complementarities or opportunities for improvement.

Recommendations in relation to the primary and community health care model. Health Advisory Council

1. *Reform primary and community health care so that it becomes the cornerstone of the healthcare and community model of the Health System in Catalonia while ensuring its viability.*
2. *Identify the National Strategy for Primary and Community Health Care as the essential, relevant and ambitious instrument for achieving the objectives of primary and community health care.*
3. *Strengthen community health care by specifying and budgeting for the interventions to be undertaken in this area.*
4. *Foster trust relationships between the public, the professionals and the institutions.*
5. *Set up forums for permanent dialogue between all the stakeholders.*
6. *Gather and include the public's values and expectations about primary and community health care and make them co-responsible for their health.*
7. *Gather and include healthcare professionals' values and expectations about primary and community health care.*
8. *Redefine professional roles and train them to meet people's needs in flexible organisations.*
9. *Move towards organisations that are more flexible with organisational capacity and autonomy to adapt to changing needs and realities.*
10. *Address the social determinants of health and inequalities in health and in care, especially for individuals within a vulnerable context.*
11. *Integrate the components and tools needed to meet people's needs to ensure the primary and community health care model is accessible, cross-cutting and longitudinal.*
12. *Introduce the necessary reforms in specialised care as part of the transformation of primary and community health care.*
13. *Enhance the integration of public health with primary and community health care.*

14. *Integrate social care needs into the person-centred primary and community health care model.*

15. *Specify the primary and community health care services portfolio to improve resolutive capacity.*

16. *Ensure that funding for primary and community health care is consistent with the responsibilities assigned to it, with particular attention to territorial equity and economic inequalities.*

17. *Evaluate primary and community health care, make the process visible and disseminate outcomes tailored to the different audiences (population, patients, professionals and organisations).*

18. *Acknowledge and enhance the relevance of primary and community health care in teaching.*

19. *Ensure that research is one of the key to changing primary and community health care.*

20. *Further promote innovation in primary and community health care as a strategy and as an instrument for improvement.*

21. *Consistently and efficiently promote information and communication technology as an indispensable tool in the reform, implementation and evaluation of the model.*

5.1. Reform primary and community health care so that it becomes the cornerstone of the healthcare and community model of the Health System in Catalonia while ensuring its viability.

PCC is crucial to a quality and fair health system that ensures equitable and efficient universal access to health for everyone.

The debate about PCC calls for political courage because it involves questioning and reviewing the healthcare system, overcoming difficulties and forging strategic partnerships in coordination and cooperation with all the other stakeholders.

The different levels of intervention have to be aligned: 1) the political level, with the commitment to promote reform; 2) the institutional level, with the involvement of officials from central and local government bodies; and 3) the care level, with the engagement of individuals and professionals.

The debate about community strategy needs to be shared given that these are cross-cutting policies which call for the involvement of both local authorities and the social sphere.

5.2. Identify the National Strategy for Primary and Community Health Care as the essential, relevant and ambitious instrument for achieving the objectives of primary and community health care.

The reform calls for instruments driving a people-centred PCC model from a holistic perspective, providing proximity care that properly addresses people's health needs in their usual surroundings and is oriented towards combating health inequalities. A legal framework is also needed to develop projects and transform the theoretical framework into actionable plans for which accountability must be ensured. The organisational structures of PCC must be flexible and a culture of adaptability has to be fostered.

In this regard, the strategy needs to be rounded out by fitting in specialised care and a real integration of public health, along with including key factors such as social care. It is essential to specify the scope of the reform with detailed budget forecasts and its expected impact in health and financial terms.

It is also critical to examine why previous PCC reform plans have not succeeded in tackling the changes as well as to acknowledge or give continuity to previous measures with good health outcomes, and analyse the critical features of the interventions which may derail them. Any intervention calls for a previous trial that demonstrates feasibility and allows identification of implementation difficulties, logistic and funding requirements, outcomes achieved and changes to be introduced.

5.3. Strengthen community health care by specifying and budgeting for the interventions to be undertaken in this area

Community health (CH) is coordinated through joint work in primary health care and public health services together with local authorities, the community and the sectors involved in addressing priority problems or needs while continuing to perform their regular activities (18).

Evidence and efficiency-based CH interventions should be part of the healthcare system's package of services and their funding, implementation and evaluation have to be secured.

In order for teams to deliver CH, current operations need to be rethought in order to find the moment to carry it out. A PC system facing high pressure on healthcare as at present makes it impossible to articulate CH and only highly motivated people or teams end up implementing it.

5.4. Foster trust relationships between the public, the professionals and the institutions.

The implicit bonds of mutual trust between people, as the centre of the system's actions (the public), those immediately responsible for interventions by and with the public (professionals) and the guarantors of care (decision-makers) must be nurtured, facilitated and promoted.

Holistic and integrated care is only possible in an environment of collaboration and trust involving all stakeholders and in all areas with an impact on people's health. In order to engage the public and professionals, the strategies for transforming PCC must be presented in an understandable and transparent way so that it can reach everyone.

Formulas have to be drawn up to include multidisciplinary care aimed at meeting the needs of the public and of PCC professionals.

5.5. Set up forums for permanent dialogue between all the stakeholders

Institutions, public and private organisations, professionals and the public involved in people's wellbeing and healthcare need to make a commitment to the transformation of PCC.

From an instrumental standpoint, ongoing dialogue between all stakeholders is needed. This dialogue has to ensure the alignment of strategies and transform them into agreed, coordinated and flexible interventions which meet health needs in a equitable, effective, efficient and resolute way. In this sense, the potential of Information and communications technology (ICT) has to be leveraged in establishing and maintaining this forum for discussion in order to generate knowledge and drive changes in the model.

5.6. Gather and include the public's values and expectations about primary and community health care and make them co-responsible for their health.

Challenge the theoretical framework by building the public into the decision-making process so that the individual has tools which enhance their capacity to decide on their life project. The empowerment and inclusion of the public's voice entails using it to corroborate the programmes and interventions designed and those that have been implemented. This has to be done from a perspective that systematically and rigorously includes ethical standards which meet the demands of the public and do so with absolute respect for their preferences and values.

It is essential to be proactive in including the voice of vulnerable and often under-represented people in order to achieve representation of diversity.

At the same time, measures must be taken to increase the public's self-responsibility throughout their lifecycle through informative and educational outreach activities aimed at self-care and health literacy. The public has to feel that PCC has the resources needed, including the care time of professionals, to provide safe and quality care in which shared decisions are a key factor in the empowerment of people.

For these principles to be implemented, new venues for real public participation must be set up in order to improve the transparency and quality of the health system and above all of PCC.

5.7. Gather and include healthcare professionals' values and expectations about primary and community health care

Healthcare professionals are the people whose knowledge, expertise and commitment enable the health system to deliver services. Health outcomes, the result of their care practise, depend on their training, motivation and engagement.

The empowerment of professionals entails ensuring their independence and bringing their voices into decision-making. Respect for the rights and wellbeing of professionals is essential for their involvement in maintaining and improving a quality, equitable and sustainable healthcare system.

5.8. Redefine professional roles and train them to meet people's needs in flexible organisations

Transforming PCC takes leadership capacity. Professionals, especially in medicine and nursing, must be empowered to develop their potential to lead PCC and improve their capacity to intervene to meet the needs of individuals, families and communities. It is also crucial to enhance the role of administrative and management profiles in the teams, drive social work coordination roles and make teams more multidisciplinary (especially in addressing chronicity and frailty). To do this, new spaces for real participation by professionals have to be developed along with a shift towards more flexible organisations with the organisational capacity and independence to adapt to changing needs and realities.

The challenges posed by the shift in the social paradigm and scientific and technological progress mean that professional roles must be foreseen and tailored to people's present and future health needs. The evolution of the care model involves specifying roles, competence upgrading and providing the system with the right professionals and jobs by overcoming the rigidity of administrative structures.

Training for practising professionals should focus on continuing education that enhances the humanistic aspects of the healthcare professions and stimulates critical thinking. At the same time, relations with the educational system, especially with universities, have to be strengthen in order to deliver training models tailored to social realities, the needs of the system and the values and expectations of the public.

Clinical leadership has to be implemented through PC itself in the units/services making up the PCC network in coordination with the hospital and socio-health levels, and not be led solely from the hospital level. The tools required for care, indication and prescription must be provided to help the development of their competencies on behalf of the people they attend to.

5.9. Move towards organisations that are more flexible with organisational capacity and autonomy to adapt to changing needs and realities

Organisations involved in healthcare need to be flexible in order to respond promptly and appropriately to the needs of individuals, families and communities. A flexible response is one that allows resources to be used effectively, efficiently and

equitable at the right time and in the right place.

In this context, the culture of adaptability, leadership and innovation must be especially encouraged in order to meet the challenges of a complex environment.

5.10. Address the social determinants of health and inequalities in health and in care, especially for individuals within a vulnerable context.

PCC has to be able to take into account the social determinants of health and health inequalities in order to protect individuals and groups with the greatest needs.

Addressing health inequalities through PCC is especially relevant to the following areas: access, comprehensiveness and quality of care, PC teams, inter-sectoral work and community orientation. Specific plans should be drawn up to address all these perspectives, covering both prevention of and care for the disease while always

bearing in mind that this must be a commitment made by the system and the team and not only by the professionals .

The most vulnerable people must be taken into account and appropriate care should be provided for individuals with diverse and/or complex health and social care needs. The complexity of the response is down to a number of factors: disadvantaged social class, ageing, frailty, chronicity and dependency.

Vulnerability calls for shared responsibility and is nurtured by collaborative work. It is essential that professionals from different fields share knowledge about the personal circumstances and information of the people they care for.

As noted above, the approach to tackling inequalities must be inter-sectoral and inter-institutional and involves intervention in other areas such as justice, housing, education and employment, among others.

5.11. Integrate the components and tools needed to meet people's needs to ensure the primary and community health care model is accessible, cross-cutting and longitudinal

PCC should be available to everyone and the first point of contact with the health services. It also has to deliver longitudinality, which means a long-term relationship between key professionals and people. However, it additionally has to be cross-cutting and integral in order to identify all people's health problems and address them, and provide, if necessary, coordination between services, such as social care, the education system, etc., and obviously the community approach which includes prevention. With these attributes in mind, aspects such as home care or care for chronic diseases would have to hinge on PCC.

It is important to highlight that people need to identify their key professionals (primarily medical, nursing and social work practitioners) and know that they have their support in all circumstances. Awareness of the life history allows professionals to make empathetic, flexible and decisive decisions which will affect the emotional satisfaction of all those involved. PCC has to ensure continuity in care and the conditions in which it is delivered in a model in which each person has key professionals and where cooperation and coordination between the professionals in the teams (with different

experiences) enables the best outcomes while retaining personalised contact and longitudinality.

5.12. Introduce the necessary reforms in specialised care as part of the transformation of primary and community health care

PCC reform cannot be achieved without reforming specialised care. The fit between PCC and specialised care levels is essential to ensure integrated and comprehensive health care for people. Mutual support between both areas of action is crucial and the traditional view of levels as compartmentalized must be abandoned.

PCC key professionals have to address the care of people jointly with their key professionals from other specialised care units, complementing each other and avoiding duplication of care (minimising iatrogenesis in the patient) and administrative procedures and thus improving the allocation of resources/value for money.

Specialised care, especially hospital care, has to prioritise the assignment of regular key professionals for people who need more continuous or intensive care due to their health constraints. This will additionally make it easier to work together with PCC key teams and share knowledge of people's life history while also improving care and satisfaction for the public and professionals.

5.13. Enhance the integration of public health with primary and community health care.

Public health, as a collective expression of the health of individuals and groups in a defined community (18), means that professionals in this field have to work together with PCC in order to fulfil their responsibilities to the community. The response to community needs calls for collaborative work by PCC and public health based on joint responsibility with local authorities and an inter-sectoral and multidisciplinary approach.

Strategies addressed to the community have to specify the public health actions that require the involvement of PCC, including providing for assessment of the impact and allocating the resources needed.

5.14. Integrate social care needs into the person-centred primary and community health care model

Successful PCC intervention calls for an integral and integrated response to health needs but also to social needs by putting people at the centre of the system. The involvement of the ministries responsible for social and health services in all dimensions of the model is essential for effective integration.

The joint work of practitioners from social and health PC and the other ministries involved needs to include and share decisions on care with the people concerned and their families, respecting their preferences and values and keeping them in their usual environment, preferably their home.

5.15. Specify the primary and community health care services portfolio to improve resolutive capacity.

The PCC service portfolio needs to be assembled with evidence-based, safe and cost-effective interventions. The portfolio must include evaluation of benefits and their impact in terms of both health and financial outcomes to ensure it is sustainable. The care and financial evaluation of the new services added to the portfolio must be systematic and include the care and financial impacts on other levels of care.

Mechanisms must be put in place to ensure that innovation is built into the service portfolio and that the system's stakeholders are involved in drawing up and upgrading the services making up the service portfolio.

The PCC service portfolio has to include the benefits from the various fields of action, especially health promotion, prevention from primary to quaternary (19) and health care for people with health problems. Promotion and prevention must be implemented in both the consulting room and the community settings.

5.16. Ensure that funding for primary and community health care is consistent with the responsibilities assigned to it, with particular attention to territorial equity and economic inequalities.

PCC is underfunded at present and this leads to even greater healthcare pressure and difficulties in achieving many of its objectives such as community guidance, research and innovation. Its funding needs to be increased until it reaches 25% of total health expenditure as advocated by the WHO.

The funding allocation system should be geared towards health outcomes and support changes in the model while avoiding undermining it.

The allocation of resources to PCC, to the teams, has to be consistent and proportionate to the responsibilities assigned to them for the health and wellbeing of individuals and families in their environment and of the community. This allocation must take into account the socio-economic context of the target populations (territorial and socio-economic fairness) and must ensure PCC has the capacity to resolve all issues affecting people's health.

PCC reform should have a specific budget that demonstrates the commitment to transforming this level of care.

5.17. Evaluate primary and community health care, make the process visible and disseminate outcomes tailored to the different audiences (population, patients, professionals and organisations).

Evaluation and monitoring of PCC strategy and its impact are essential. Health outcomes and the reduction in the variability attributable to PCC actions will lay the foundations on which its ability to resolve issues through accountability will be measured. Evaluation needs to take into account the attributes of PCC and the approach to the social determinants of health and health inequalities, and make progress in assessing the effectiveness of educational interventions with respect to both their implementation and outcomes.

An evaluation framework should be drawn that lays down criteria and sets out parameters to determine the expected impact, how it will be measured and compared and what the socialisation mechanisms will be.

The information has to be published and accessible, understandable and easy to find. It is important that the public, professionals and institutions have the results to encourage the culture of evaluation.

5.18. Acknowledge and enhance the relevance of primary and community health care in teaching.

PCC is constantly evolving and calls for trained professionals who are eager to continuously gain new knowledge and also able and willing to pass on everything they have learned.

The educational role of healthcare professionals and their ability to teach at all levels (undergraduate, graduate and continuing education) from a multidisciplinary perspective must be acknowledged, appreciated and encouraged.

It is crucial to bring the speciality of family and community care to the fore in teaching, enhancing it and raising its profile throughout all stages of the training of healthcare professionals in order to encourage the acquisition of knowledge and skills specific to this field.

5.19. Ensure that research is one of the key to changing primary and community health care.

Research is needed in the specific knowledge area of PCC to improve care for people and service organisation and it requires a budget appropriation.

Research needs to be made accessible and attractive to PCC professionals. Encouraging their commitment to research and steering it towards their own areas will ensure that it takes on the required relevance, quality and impact. Professionals must have time and incentives for engaging in research and acknowledgement of its results.

5.20. Further promote innovation in primary and community health care as a strategy and as an instrument for improvement.

Innovation is now a must for PCC as a tool for bringing in competition to support its transformation. Innovation improves outcomes by making it easier to eliminate non-value-adding processes.

PPC has to foster innovative thinking and culture as a lever for change in the system. The knowledge and skills of PCC and its professionals must be developed for the performance of daily practise with an innovative capacity and attitude.

5.21. Consistently and efficiently promote information and communication technology as an indispensable tool in the reform, implementation and evaluation of the model.

ICT plays a key role in PCC as it enables the model to be deployed by enhancing the quality of care, especially in terms of accessibility, efficiency, safety, knowledge and communication.

Investment in the use of ICT is needed as an indispensable tool in the reform, implementation and evaluation of the model. The public, professionals and managers should be encouraged to use ICT in order to develop new management and service delivery methods to achieve better health outcomes.

ICT should support interaction between system stakeholders and ought to be further implemented and evaluated. It also needs to underpin integration and speed up coordination between intervention areas and the levels involved in ensuring people's wellbeing.

6. Priority actions

1. Establish the regulatory framework needed to transform the Primary and Community care (PCC) model into actionable plans for which there will be accountability.

2. Test and evaluate new models of PCC governance by driving coordination between levels, the required increasing multidisciplinary and organisational flexibility that will give real decision-making capacity to the professionals involved.

3. Make changes in the regulatory framework to provide legal coverage to professionals for the development of their skills in taking on the new roles that are required of them and provide them with the tools they need.

4. Facilitate and encourage individual and group leadership, which allows the development of the various skills of professionals and recognition of their added value.

5. Put the person at the centre of decisions and establish measures and tools that enable shared decision-making with the public and professionals.

6. Articulate, test and evaluate innovative public participation models to consolidate participatory practices in the discussion about the orientation and approach to the healthcare and social challenges affecting people's health and evaluate the outcomes.

7. Establish community strategies to work towards the empowerment and shared responsibility of the public in rational use of the resources available in PCC.

8. Specify joint public health and PCC actions, furnish them with the resources needed and evaluate their impact.

9. Define the Community Healthcare services portfolio in order to specify PCC measures.

10. Test and evaluate new spaces and formulas for integrated care and funding of health and social care.

11. Coordinate PCC with municipal policies, especially with local social PC to ensure that there is no duplication of care and that person-centred care is improved. To this end, it is essential to share information, circuits and professionals with local authorities.

12. Progressively increase funding for PCC to the 25% of health spending recommended by the World Health Organisation.

13. Encourage and acknowledge the good practices of each of the professionals and of the teams as a whole based on meaningful effectiveness, efficiency and suitability standards.

14. Drive a new system for access and development of specialities that affords prominence to family and community care.

15. Acknowledge and foster the role of PCC in teaching at all levels (undergraduate, postgraduate and continuing education).

16. Drive accredited research in PCC by providing time for professionals to research and build networks.

17. Enable PCC to identify opportunities and have agencies and instruments to hand for implementing innovation in this field.

18. Test complementary technological models and tools for accessibility, such as virtual access to essential advice for the most common symptoms, virtual selection of the degree of need for emergency care and virtual monitoring of banal symptoms.

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