

clarity. There is further confusion between the delivery of primary care through public health and through primary care services. Van Weel has suggested that *it is time to integrate personal health care and public health, and organise primary care on the principle of care for individuals in the context of an identified population over time* and that *The future of primary care, and health care in general, will depend on how effectively primary practices achieve this community-oriented primary care approach and contribute to equity and social cohesion.*[1]

This presentation will use case studies to explore this challenge from a public health perspective and the implications for future training and practice in public health.

Reference:

1. van Weel C, de Maeseneer J, Roberts R. Integration of personal and community health care. *Lancet* 2008; Sept 13:372 (9642):871-2.

SY15-02

The Interplay of Public Health and Primary Care at the Local Level: Changhua Experience

Yen-Po Yeh

Director-general, Changhua County Public Health Bureau, Taiwan

Health care utilization in Taiwan is characterized by the lack of restriction on consumers' seeking behavior. Frequent upgrades in seeking outpatient services result in the deficiency in the clear hierarchy of the medical system. Both the hospitals and the clinics provide the first-line health care for their patients, either by specialists or generalists, the so-called generalist-specialist mixing. During the past two decades, the expansion of the hospitals had put great pressure on primary care and forced the later to change. Bureau of National Health Insurance launched the Family Physician Integrated Care Program (FPICP) in 2003. The novel approach was to organize the community healthcare group as the basic unit for collaboration. However, FPICP revealed its weakness in linking other preventive services or disease management programs.

There were 478 primary care clinics (PCCs) and 27 health centers in Changhua county in 2008. Around 30% of chronic patients and 70% of the other non-chronic were cared in primary care settings. The adoption of disease management programs and preventive services was low in PCCs. The Changhua Regional Integrated Primary Care Program (CRIPCP), sponsored by Department of Health and collaborated with Taiwan Joint Commission on Hospital Accreditation, focused on the integration of related preventive services and disease management programs and also tried to scale up the range of PCCs' participation.

CRIPCP followed the "three phases, six elements" implementation process, including: the infrastructure building phase (from 2004 to 2005), the model learning

phase (from 2005 to 2006) and the care integration phase. The six elements were based on Chronic Care Model (Wagner EH., 1996), with the primary health care team (PHCT) as the core of the delivery system design. The focus areas of CRIPCP included major disease management programs (i.e. diabetes, hypertension and chronic kidney disease) and selected preventive services (i.e. adult preventive care, cancer screening and developmental screening for children). RE-AIM model (Glasgow RE, 1999) was used for program evaluation. In the early phase, there was a significant two-fold increase of the manpower of certified diabetes educators and a two-fold increase of the ratios of diabetic cases enrolled in disease management from 27% to 53%. 20% of PCCs participated the cancer screening programs. Two thirds of the primary pediatricians involved the developmental screening program for children and developed an innovation of outreach screening program for preschool children. Totally, 29% of all the PCCs in Changhua were involved in at least one of the above focused primary care programs in 2006. The percentage grew up to 40% in 2009.

From the experience of CRIPCP, we found community and policy support is indispensable for integration. However, to position clearly the physician's role in public health programs is the key for success. The inherent weakness of PCCs made the service provider's change more difficult and physicians' awareness of the need to change is the key. PHCT could support the physician's change. The linkage between the screening programs and disease management programs should be emphasized. The information system should progress from "single-user friendly" to "team-user-friendly".

SY15-03

Arts as Assets for Primary Health Care in Asia

Masamine Jimba

Department of Community and Global Health, Graduate School of Medicine, The University of Tokyo

According to WHO, the ultimate goal of primary health care is better health for all. To achieve this goal, WHO has identified four reforms in 2008 World Health Report: 1) universal coverage reforms; 2) service delivery reforms; 3) public policy reforms; and 4) leadership reforms. In the same report, people centered approach and their participation were also emphasized to carry out these reforms.

For people to become centered and to make active participation, empowerment is crucial. For this, assets-based approach is known to be effective. High-level medical workers, however, tend to take needs-based approach, by which they identify medical problems of individual and in a community; then, they try to help them to solve the problems. In contrast, assets-based approach seeks the potential of individual and community; then, they are expected to contribute themselves to solve their own problems. In primary health care, we need to strengthen this assets-based