

THE FUTURE OF FAMILY MEDICINE ISTANBUL DECLARATION

12 MAY 2026, ISTANBUL

In Primary Health Care-Oriented Health Systems

We, participants of The Future of Family Medicine - International Joint Meeting in Istanbul, issue this Declaration as a shared call to action to safeguard and strengthen the future of family doctors and the discipline of Family Medicine / General Practice.

In this Declaration, a family doctor refers to an adequately trained and qualified physician who provides first-contact care and acts as a trusted clinical home, delivering person-centred, comprehensive and continuous care, coordinating across services, and working within an interprofessional team. While these functions will be organised according to local context and health system design, the essential standards and capabilities of the role must be protected.

Evidence from diverse settings shows that health systems with strong primary care anchored in family medicine achieve better health outcomes, greater equity and more sustainable use of resources. Future health challenges are intensifying. Demographic change, multimorbidity, mental health needs, social and income inequalities, migration-related inequities, rapid digital transformation, and more frequent crises such as pandemics and natural disasters make it essential to build readiness and resilience into routine primary care.

This Declaration sets expectations for governments, funders, policy makers and health system stakeholders, alongside a shared commitment from family doctors.

1. We reaffirm the essential functions of family doctors: accessible first-contact care that is person-centred, continuous and comprehensive; coordination and navigation of the patient journey; and the integration of public health through community-oriented primary care, with a clear focus on equity and inclusion. We call for continuous strengthening of family doctors' capacity to manage complexity and uncertainty across the life course.

2. We call on governments, funders and policy makers to align financing and system design in order to bring high-value care closer to people's homes. This includes structured referral systems, protected consultation time, removing financial and regulatory barriers that limit evidence-based comprehensive care, and reinvesting efficiency gains into complex, person-centred care.
3. We call for urgent action to sustain the family doctor workforce. This includes manageable workloads, wellbeing support, fair working conditions, expanded primary health care teams, and workforce distribution based on population need to protect continuity, job satisfaction and quality of care.
4. High-quality primary health care requires adequately trained, qualified and supported family doctors. We urge governments and regulators to protect training and accreditation standards, and to reject short-term, numbers-driven solutions that weaken quality and accountability.
5. We call for competency-based education and training with protected supervision and faculty development, including continuing professional development, longitudinal community-based learning, and early and meaningful undergraduate exposure to family medicine.
6. We call for sustained academic capacity in family medicine. This includes protected time for teaching, evaluation, quality improvement, research and leadership, a workable balance between academic and clinical roles, and career pathways for academic family medicine.
7. We call for interprofessional, team-based care with clear roles, clear communication and transfer of responsibility, and explicit accountability. When task sharing is implemented, it should strengthen care without diluting continuity, clinical judgement, patient safety or the quality of the patient experience.
8. We call for practice-based research and learning networks, supported by access to primary care data and responsible data sharing, to generate usable evidence for real-world settings and to include patient and clinician experience alongside outcomes and costs.

9. We call for performance measurement in primary care that reflects outcomes meaningful to patients and clinicians, supports learning and continuous improvement, and does not impose avoidable administrative burden. We also call for transparent and accessible workforce and health system data, shared with the profession and used to understand population needs, plan services and establish feedback loops for better care and accountability.

10. We call for safe, ethical and equitable digital and AI-enabled tools in primary care that are well governed, interoperable, and developed with clinician and patient input. These tools should be accompanied by digital health literacy support for patients and targeted training for professionals, reduce administrative burden, and support clinical autonomy, human connection and continuity rather than fragment care or widen inequalities.

11. We call for emergency-ready primary health care that secures essential services during crises and links primary care with public health, social care and community support systems. Family doctors and their teams must be supported and formally integrated into preparedness plans, surge capacity arrangements, supply chains and communication pathways to enable a coordinated response grounded in knowledge of the local population and its needs.

12. We call for family doctors to be meaningfully involved in policy making and governance, and for professional advocacy that removes barriers to high-quality primary health care. Nothing about primary health care should be designed without family doctors.

13. For our part, we commit to upholding the standards of our discipline, advocating for our patients and communities, and working collaboratively across professions and borders to strengthen primary health care worldwide.

