Opinion and analysis

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Expansion of family medicine in Latin America: Challenges and lines of action*

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ABSTRACT *This article summarizes the current challenges facing family medicine in Latin America and proposes possible lines of action to consolidate its development. In the last 40 years, the health systems of the Region of the Americas have undertaken reforms whose results have been negative in terms of health equity and primary health care. Far from reducing inequites, these strategies were narrowly focused and selective. In this context, technical proposals to increase training positions in family medicine and to insert family medicine in medical careers have lacked consistency and a clear policy focus. Their lack of effectiveness can be considered a symptom of incomplete reforms. In this regard, the Ibero-American Confederation of Family Medicine made recommendations on the political commitment of governments to ensure the necessary structure and funding to consolidate family medicine as a mechanism to implement and organize primary health care, training programs, working conditions for family physicians, and professional certification, among other issues. These technical recommendations, without consistent and timely policy initiatves, will be no more successful than previous attempts.*

Keywords Latin America; primary health care; family practice; human resources; health policy; health planning.

Programs for specialization in family medicine (FM) in Latin America were first developed in Mexico and Brazil in the 1970s. After these early experiences, there was a boom in such programs when the Declaration of Alma-Ata proclaimed the fundamental and strategic importance of primary health care (PHC). However, the health system reforms launched over

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the last 40 years by the countries of the Region of the Americas have yielded limited, contradictory, and even negative results in terms of health equity and health indicators. A narrowly focused and selective conception of PHC, without care networks integrated with the hospital level, has produced major inequalities in access to health services and in guarantees of the right to health (1).

The Region currently suffers a shortage of health professionals, with 1 to 2 physicians per 1,000 inhabitants, and 3.5 health centers per 100,000 inhabitants, and wide variability in their quality, size, and type. The predominantly curative, hospital-oriented care model allocates limited resources to prevention. With the exception of Brazil, Uruguay, and Costa Rica, the financing systems are not integrated. Only Cuba has a unified health system, financed entirely with public resources. In the remaining countries, health system financing models tend to be fragmented, with a mixture of public and private insurance and coverage; however, a considerable percentage of the population is uninsured (2).

This paper summarizes current challenges to FM in Latin America and proposes possible lines of action to consolidate the development of this specialty.

THE RENEWED PUSH FOR FAMILY MEDICINE

In 2003 the Pan American Health Organization (PAHO) made a series of recommendations to strengthen PHC in the Region of the Americas and encouraged Member States to revive the values of Alma-Ata: social justice and the right to better health for all, with participation and solidarity (3). Recommendations on FM training included focusing human resources policies on helping to develop PHC.

With this renewed push for FM, several countries expanded their specialization programs in the field, with uneven results. In Mexico, where it is estimated that the public sector will need more than 20,000 family physicians by 2030, the Mexican Institute of Social Security (MSSI) stepped up its shift towards a PHC-based system. MSSI raised the annual number of FM positions offered from 316 in 2001 to 1,136 in 2012 (4), and was highly successful in filling them. In contrast, despite a rise in the number of FM positions offered in Argentina, 60% went unfilled each year (5). A similar situation can be seen in Brazil (6). One factor that probably influences this difference is that in Mexico, the MSSI hires the majority of family physicians who finish their residency training.

Another noteworthy example is the case of the Municipal Health Secretariat of Rio de Janeiro (SMS-RJ), which from 2008 to 2016 used PHC as a strategy to transform its system, moving away from the previously prevailing selective approach. In 2008, family health teams covered only 3.5% of the city's population, the lowest of any Brazilian capital. In barely five years, with its PHC reform program the SMS-RJ covered more than 40% of the population, with 732 new multidisciplinary teams comprising physicians, nurses, nurses' aides, community health workers, and dental professionals, covering more than 2.5 million people (7). To keep up this rapid pace of growth, SMS-RJ began to attract family physicians from every region of Brazil by raising salaries and performance incentives; moreover, in 2011 they launched the largest FM residency program in Latin America (8). This program began by offering 60 residency positions, which rose to 150 in 2015; in recent years it has filled 90–100% of the available positions. This success was partly due to implementing a number of mechanisms to attract young graduates, including: an incentive added to the training grant paid by the federal government, which tripled the final amount; sending residents to the health centers with the best training facilities; and training supervising physicians in competency-based education, with a supervisor for every two residents (6, 8). In late 2015, SMS-RJ had hired 63% of the program's graduates.

Despite these exceptions, the public sector in Latin American countries tends to operate as the sole or principal employer of family physicians, even though these systems lack a real capacity to absorb all of their graduates. In some countries, graduates lack job security, with such high unemployment rates that they may find themselves compelled to emigrate (9). The presence of underqualified professionals is another major weakness of the Region's health systems. The relative proportion of FM specialists is still very low, compared to physicians without a specialization. In Mexico, the proportion of general practitioners is 24%; only 8% are family physicians (4). There is a major gap between the importance given to PHC in health systems planning, and the actual implementation of the strategy.

FAMILY MEDICINE IN UNDERGRADUATE PROGRAMS

One of the greatest achievements of Latin American FM has been its incorporation into undergraduate curricula, assisted in part by the support of international organizations. A 2005 PAHO meeting led to the Toronto Call to Action, which promoted intersectoral efforts to develop human resources for health in the countries of the Americas. One of the indicators designed to monitor progress made in the area suggested that by 2015, 80% of health science schools would have reoriented their educational programs towards PHC.

However, surveys of medical students in recent years show that they are not considering careers as FM specialists. In different studies, the main reasons cited for choosing a specialty were: economic potential, free time, personal affinity, and the influence of professors (10). Furthermore, the perception that other specialties are more prestigious also contributes to students' lower appreciation for FM (11). A similar situation occurs in countries with a longer FM tradition, such as the United Kingdom and Canada, but in these countries there has not been a decline in positions filled; indeed, there has even been an increase in the number of graduates choosing FM (12, 13). This highlights the existence of more complex processes underlying the selection of a specialty, requiring interventions that include a sociological examination of the next generation's employment needs and preferences (14). For example, preselection mechanisms designed to recognize applicants with high possibilities of focusing their careers on FM and other underserved health care areas have been shown to improve the numbers selecting a specialty, and eventually a career, in those areas (15).

In this regard, according to Feuerwerker, positions remain unfilled not only because of attitudes towards certain specialties, but also because certain institutions fail to promote them (16). Furthermore, Belmartino et al. point out that the messages that students and graduates receive in training and in

TABLE 1. Approximate monthly salary of a family doctor (entry level in the public system), in US dollars

Country	$US
Brazil	3,300
Chile	3,000
Ecuador	2,641
Colombia	2,200
Uruguay	1,800
Peru	1,600
Mexico	1,350
Argentina	850
Venezuela	104[a]

Source: The authors
[a] Based on Venezuela's official conversion rate (source: DICOM)

practice—both from the provider system and the training centers—lead them to follow market demand when they seek a specialty (17). The experiences of Rio de Janeiro and MSSI, where the models of care are based on FM, may be related to their high proportion of positions filled. A comparative analysis shows that the SMS-RJ wages are among most competitive in Latin America (Table 1).

CONCLUSIONS AND RECOMMENDATIONS

The development of Latin American FM has shown great progress thus far, reflecting the policy decisions of countries in the Region. Isolated technical efforts did not achieve the expected results because they lacked a clear policy direction supported by governance capacity, and leadership that considered health to be a human right and PHC the appropriate strategy to guarantee that right. The partial successes in training more FM specialists can be interpreted as a symptom of incomplete reform, with FM holding center stage in public policy statements, but still marginalized within health systems.

In this regard, the conclusions of the 2010 Workshop on Human Resource Planning and Primary Health Care, held in San Salvador, recognize that it is a challenge for governments to implement state policies aimed at expanding social protection and health coverage. Facing this challenge requires innovative strategies to design and build feasible, sustainable plans. One of the principal recommendations of the San Salvador Agreement—arising from the Workshop and signed by representatives of different areas of government of the countries of the Region—is to build governments' leadership capacity, as well as mechanisms enabling intersectoral dialogue, exchange, and learning, with a shared responsibility approach.

Along these same lines, the Ibero-American Confederation of Family Medicine (CIMF) has recommended reconceptualizing universal coverage: going beyond the technical aspects of health financing and incorporating the principles of equity, equality, and solidarity into the right to health—as well as governments' responsibility for making this possible (18). As a mechanism for implementing PHC, FM should maintain a personal, family, and community approach, strongly focused on preventing disease and promoting health (19). FM should account for 40% of all positions, which is the case in countries with national health systems (18). Therefore, it is necessary to train a higher number of supervisors for residents, establish a pay scale for FM residents, and pay supervisors of residents, all in addition to facilitating the incorporation of family physicians into undergraduate and graduate teaching programs. These recommendations include guaranteeing that resources will be allocated to develop the full capabilities of the multidisciplinary teams that are crucial to FM, to achieve its maximum potential (19).

In the Fortaleza Charter, CIMF recommended promoting performance incentives, continuous professional development, and the certification and periodic recertification of family physicians. Given the high proportion of physicians without specialization in the Region, it is reasonable to expect that within 10 years a FM specialty will be compulsory for physicians who want to work in PHC, and that professionals already working in the field be required to become certified, if they are not already. A timeframe of at least five years should be allowed for this, so that specialized training can be provided by the respective professional associations in strategic coordination with health ministries and universities (20).

Finally, it should be emphasized once again that technical recommendations without coherent and timely policy action will fail to achieve the goal desired by all of us who believe in FM: putting PHC at the center of development policies to build healthier, longer-lived societies, with a better quality of life.

Conflicts of interest. The authors are family physicians who participate actively in their national professional associations and in CIMF.

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Expansión de la medicina familiar en América Latina: desafíos y líneas de acción

RESUMEN

Este documento tiene por objetivos resumir los desafíos actuales de la medicina familiar en América Latina y proponer posibles líneas de acción para consolidar su desarrollo. En los últimos40 años, los sistemas de salud de la Región de las Américas han encarado reformas cuyos resultados fueron negativos en términos de equidad, y la atención primaria de la salud, lejos de ser aquella estrategia destinada a reducirla, se restringió a una política focal y selectiva. En este contexto, las propuestas técnicas de expansión de las plazas de formación en medicina familiar y su inserción en las carreras de Medicina, han carecido de coherencia y de una dirección política clara, por lo que su falta de eficacia puede leerse como un síntoma de estas reformas incompletas. Al respecto, la Confederación Iberoamericana de Medicina Familiar realizó recomendaciones sobre el compromiso político de los gobiernos para asegurar la estructura y el financiamiento necesarios, consolidar el modelo de medicina familiar como mecanismo de instrumentación de la atención primaria de la salud, la jerarquización de los programas de formación, las condiciones laborales de los médicos de familia y la certificación profesional, entre otras. Estas recomendaciones técnicas, sin acción política coherente y oportuna, no serán más exitosas que los intentos previos.

Palabras clave

América Latina; atención primaria de salud; medicina familiar y comunitaria; recursos humanos; política de salud; planificación en salud.

Expansão da medicinafamiliar na América Latina: desafios e linhas de ação

RESUMO

Este documento tem como objetivo resumir os desafios atuais da medicina familiar na América Latina e propor possíveis linhas de ação para consolidar seu desenvolvimento. Nos últimos 40 anos, os sistemas de saúde da Regiãodas Américas encararam reformas cujos resultados foram negativos em termos de igualdade, e a atenção primária à saúde, longe de sê-la aquela estratégia destinada a reducir-la, restringiu-se a uma política focal e seletiva. Neste contexto, as propostas técnicas de expansão das praças de formação em medicina familiar e sua inserção nas carreiras de Medicina, não dispuseram de coerência e de uma direção política clara, razão pela qual sua falta de eficácia se pode ler como um sintoma destas reformas incompletas. Neste sentido, a Confederação Ibero-americana de Medicina Familiar realizou recomendações sobre o compromisso político dos governos a fim de assegurar a estrutura e o financiamento necessários, consolidar o modelo de medicina familiar como mecanismo de instrumentação da atenção primária à saúde, a hierarquização dos programas de formação, as condições laborais dos médicos de família e a certificação profissional, entre outras. Estas recomendações técnicas, sem ação política coerente e oportuna, não serão mais exitosos que as tentativas prévias.

Palavras-chave América Latina; atenção primária à saúde; medicina de família e comunidade; recursos humanos; política de saúde; planejamento em saúde.