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Family medicine in Mexico: Present and future

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Abstract

Analyzing the challenges and the future scenario of Family Medicine is a priority to address challenges such as the reduction of benefits granted by social security; to adapt their practice to the changing health profile; and to curb demand for specialized services and contain the high costs of care in the second and third level. The program is aimed at three professional roles: medical care, research, and education. It is imperative review these in the light of changing demographic conditions, the type of health needs arising from new social determinants, the public expectations for greater participation in their care, and the evolution of the health system itself with the advancement of technology and a variety of organizational options with frequently limited resources. For primary care, as the core of a health system that covers principles of equity, solidarity, universality, participation, decentralization, and intra- and inter-sectorial coordination, it is necessary to put at the center of the primary care team the family doctor and not an administrator, who plays an important role in supporting the care team, but cannot take the lead. (Gac Med Mex. 2016;152:119-24)

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Introduction

Within the framework of the National Medicine Academy of Mexico (ANMM – *Academia Nacional de Medicina de México)* 150th anniversary, the analysis of medical specialties' challenges and future scenario constitutes a priority objective. The radical transformation underwent by the practice of medicine from the 19th century to the present, as well as changes to come, make deep reflection on the subject indispensable.

In many countries, including Mexico, last decades' advances on diagnosis and treatment of diseases, the discovery of multiple vaccines, achievements on public health, the growing drive of clinical specialization and sub-specialization and technological innovations have had an impact on the sustained growth of life expectancy and improved levels of health. However, inequities in effective access to health services and programs still persist, as well as geographic, cultural and economic barriers and financial difficulties of the health system. At the level of individual care, the doctor-patient relationship has been transformed in such

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way that the person has turned into an external observer of his/her own health status[1].

In view of this panorama, the ANMM has decided to discuss not only which are the challenges medical specialties are going to face, but also which of them should be substantially transformed to answer to the population health needs and close health gaps, by achieving better geographic distribution of health-specialized resources throughout the country, linking training with service-provision institutions and solving the unbalance existing between general medicine, specialties and subspecialties. In this scenario, we will try to analyze which the future of family medicine for the next decades is, whether it should be radically transformed and if its long-term existence still has any sense.

Family medicine is perhaps the only medical specialty that did not arise from the progress in new diagnostic and therapeutic procedures, but from the necessity to address urgent social and health needs of the population, as well as to restore the right to more integrating care to the population. It arises or derives from general medicine to become a discipline with a body of knowledge of its own. It is directed to the care of people and families, rather than to the treatment of conditions or diseases. The family physician practices with a life course comprehensive perspective that looks after physical, mental and emotional health of families at his charge. He is an expert on prevention, the center of the process of care, and helps the individual to move along in a frequently confusing and fragmented health system. His training allows for him to have professional competences on practically all areas of medicine, since he has to effectively diagnose and treat endless acute conditions and is a pivotal resource in the management of chronic problems to prevent or reduce complications and improve the quality of life of the population under his responsibility.

Essential dimensions of the family physician's professional practice are first-contact care, care focused on the individual and his/her family with longitudinal perspective of life course, and comprehensive and holistic care; in sum, the family physician acts as the leader of the healthcare team and coordinator of the medical care required by the person and his/her family[2].

Family medicine historical context

At the beginning of the past century, a large part of medical contacts still occurred as house calls, which produced a more balanced relationship. General medicine was valued as a dignified, socially prestigious profession, credited from the scientific point of view, economically well rewarded, respected by everyone, and acknowledged as a gratifying profession. Medical knowledge volume and complexity were considerably lower, which resulted in less problematic and closer communication with the patient[1]. The "general practitioner" practiced preventive and curative care and often he acted as counselor of the family members; he was, indeed, an authentic family physician.

After the Flexer report[3], and in addition to other structural and social-natured causes, the development of specialties was vertiginous, especially after World War II. In that context, a return to the origins was proposed in the decade of the 60's. By the end of that decade, the family medicine specialty was created in the USA[4], based on the United Kingdom and Canada models, which some years before had already incorporated this specialty in their physician training programs. During the decade of 1970, several countries incorporated family medicine as a specialty as well; such was the case of Brazil, Bolivia, Costa Rica, Argentina, Colombia, Ecuador and Venezuela. In Australia, the Family Medicine program was established in 1973 and in Israel, in 1979. The boost given to the specialty was also a consequence of the Alma-Alta Conference in 1978[8], which combined an approach based on the human right to health with a viable strategy based on primary health care to reduce inequities in matters of health and achieve the ambitious but unmet goal of "Health for everyone in the year 2000". Family medicine was then erected as a revolutionary movement intended to rescue the health system and return to the essential values of medicine practice.

In Mexico, the specialty emerged in 1971 following an initiative of the Mexican Institute of Social Security (IMSS – *Instituto Mexicano del Seguro Social)* and as a consequence, among other reasons, of the restructuring of the family medical system[6]. In 1964, the National Autonomous University of Mexico (UNAM – *Universidad Nacional Autónoma de México)* awarded it academic recognition. In 1980, the Ministry of Health and the Institute of Security and Social Services of State Workers (ISSSTE – *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado)* joined as institutions that prepared specialists. By the year 2013, 21,655 family medicine specialist doctors had graduated from the IMSS and 132 from the ISSSTE; of them, 13,255 had undergone certification tests before the Mexican Council of Certification in Family Medicine,

but by that year, only 2,746 maintained their certification current.

Family medicine practice current situation

In spite of the advances brought by its formalization and institutionalization, family medicine in Mexico, particularly the one practiced in social security institutions, has been severely criticized over the years, among other things due to structural and organizational factors related to the health system rather than to the specialty itself, such as poor quality services, long waits to receive care or specialized consultation at other levels, shortage of medications and laboratory and imaging tests, scarce interrelation between teams of different levels of care and impossibility to freely select the doctor or clinic of choice. As frequently heard in official statements, the "financing" crisis on these institutions and the reforms of the IMSS (1997) and ISSSTE (2009) pensions and benefits systems have aggravated these deficiencies.

When family medicine was institutionalized, the spirit that originated the family physician, who was not only the family doctor, but also a friend who knew the family and helped to solve other problems beyond health problems, was unfortunately not preserved.

The biggest challenge faced by the practice of family medicine in Mexico today is the proposal to reduce the benefits formerly granted by social security in the country. Universal health coverage, foreseen through an incipient reform in health and social security services, proposes an extremely restricted catalogue of services and benefits, when health necessities are expanding and turning more complex to be addressed, limited by its cost-priority vision with a decrease in the quality of services and restricted to curative rather than preventive measures.

The health profile presented today by the Mexican population has a very different face than a few decades ago; the morbidity pattern is not the same, and neither are the causes that lead to death the same; there are fewer children and women who die prematurely or with anticipation, and there are increasingly less fulminating deaths due to infectious diseases or dehydration. Nowadays, people remain ill for longer and with several ailments at the same time; the moment of death has been delaying and people die later, although not necessarily live healthier. This new face of disease, determined by multiple factors and circumstances, also owes its existence to the relevance different medical practices have today and their impact on population health, which in turn impacts on the health system. Adjudicating changes on population health profile to medical practice specializing in some organ or body system, supported by a technology-dependent diagnosis, isolated from the context of people, highly expensive and unfair in terms of opportunity and access, is, in addition to misleading and unfair, highly unlikely.

Since some decades ago, the main approaches to the care of different population groups have emphasized on the importance of gradually increasing the coverage of primary care services and access to a series of interventions with high-impact on public health[7]. Such is the case with vaccination campaigns, oral hydration provision, respiratory infections opportune treatment, de-worming, prenatal control, folic acid provision, children healthy growth and development surveillance and family planning, just to mention some of the most relevant interventions, all of them under responsibility of the family physician and his healthcare team. However, these interventions exclude other actions to address more complex problems and diseases.

More recently, health care policy has been shifting towards a prevention, early diagnosis and risk behaviors modification strategy in order to identify and address problems that formerly were regarded as being beyond the scope of responsibilities or capabilities of the family physician. The most emblematic cases might be diabetes mellitus and arterial hypertension.

Although institutional strategies are focused on prevention, early diagnosis and effective care of a limited group of relevant conditions for each age group, these have been conceptualized only from a restricted vision, since a package of number-restricted actions is established, with a series of prevention, diagnosis and care interventions (all disassociated from risk and its determinants), fragmented in specific age groups (not articulated with life course or gender) and out of the context of the users' needs (relying on health services). In the context of family medicine, these prevention/care packages acquire relevance, since they have to be continuously applied to each individual[8] and achieve sufficient population coverage to obtain the desired impact.

Family physician training current situation

To date, in Mexico, the UNAM maintains, on its Medical Specializations Single Plan, the family medicine residency as a 3-year course, with no previous requirement

of other specialty, and with "clinical and teaching" activities at primary care establishments in order to "propitiate more contact with the area of professional performance". Yet, during the first 2 years, 50% of the time, hospital-level activities are preserved for rotation through basic specialties: internal medicine, pediatrics, obstetrics & gynecology, surgery and emergencies. The contents of the curricular structure are established in three professional functions: medical care, research and education, and the teaching units are proposed as integrating seminars, in order to shape the professional profile in primary care[9]. Other universities have developed programs with similar goals, whose graduate profile includes a role as healthcare team coordinator[10] and the development of competences to "actively participate in health institutions priority programs"[11].

Under this model, it is assumed that, during his training period, the family medicine resident, in permanent contact with the departments of the healthcare units he/she is assigned to, will be taught to provide "comprehensive and continuous primary medical care to the individual and his family"[9]. However, one of the obstacles for the achievement of this purpose is that health services do not ensure the fulfillment of these requirements; in the Mexican health system care model, a predominantly curative and individualist approach prevails, which hardly responds a demand exceeding its capacity of response. There is enough documentation on the unfavorable conditions of care in public healthcare institutions, with prolonged waiting times, shortage of resources and users' low satisfaction[12], as well as lack of comprehensive care in daily practice[13], which makes primary care units to be poorly appropriate as learning centers for the development of the future specialist's identity. In this environment, the opportunity of having teachers available, willing to meet the academic program objectives is little encouraging, as shown by the low clinical aptitude level to handle families by family medicine residents of an important sample of the entire country[14] or the poor success of proposals with innovative academic modalities, such as the curriculum for family physicians training based on competences[15]. The results of semi-face-to-face family medicine specialization programs for practicing general physicians, whose training takes place mostly at their own working environment, with group-based academic activities focused on real-problem solving and a hospital rotation period, have to be assessed[16].

Another aspect that deserves consideration is the expectations of new doctors on the choice of a postgraduate alternative and their experiences during the training period. There are studies conducted in Mexico reporting that only about one third part of family medicine residents has an appropriate perception of the academic working environment[17]; in countries such as Canada, with a health system characterized by its strength on primary care[18], the proportion of aspirants to a medical residence who select family medicine as an option has drastically dropped[19]; early in the last decade, the USA also experienced a decline in the numbers of newly graduated physicians that selected the family medicine specialty (only 10% of aspirants), and the rejection was explained by low prestige, expectations of low income and insufficient learning of this option[20].

The future of family medicine

In order for primary care, as the health system axis, to recover the equity, solidarity, universality, participation, decentralization and intra- and inter-sector coordination principles, among others, reassuming in the family physician practice the spirit that originated this health care approach will become essential. Putting the family physician as the primary care team axis rather than an administrator is required, since even when the latter plays an important role by supporting the healthcare team, he cannot assume the leadership. The doctor has to be placed at the center of the primary care team in order for him to identify and address the community's health needs, understanding primary care as a comprehensive approach, i.e., as a fundamental component of an entire care system that provides services at the place and moment required by the complexity of the person's needs and not to be restrained by a reduced catalogue of services. In addition, the system's rules should be modified so that the community can freely choose his doctor, and vice-versa. The transformation of the epidemiological picture, at the expense of an increase in non-transmittable chronic conditions, and the new medical technologies will demand for the family physician to be better prepared to address the changing healthcare needs of families and to effectively face the challenge posed by teamwork in a system whose main concern is efficiency in the use of the limited available resources.

Family medicine will enter in the health services scenario as a fundamental player to curb the demand for specialized healthcare services and to contain secondary and tertiary care high costs[21], but there are concrete adversities and challenges that the family physician will

have to face, adapting his practice to comprehensively solve and address them. In the first place, it is essential for him to know the population under his responsibility to be able to adequate approach strategies. In second place, he should understand that programs effective coverage is a key element to reach the health levels that currently his population can aspire to. Thirdly, he must participate in and have immediate access to information systems that allow for him to know his performance indicators to be able to opportunely react to coverage failures. Finally, he must act as the leader of the healthcare team and be the natural link between different levels of care.

Far from becoming a healthcare professional with restrained knowledge, the family physician shall be a professional concerned for human rights, a compromised epidemiologist, a statistician interested on quality of information, a professional concerned for research and a complete humanist[22,23]. The promotion of wider and more accurate understanding of the specialty among the population is also important, which will allow for the strengthening of an own identity and for consolidation of the specialty as an attractive option, recognizing family physicians as healthcare leaders, with innovative professional incentives and opportunities for continuing education in a dignified working environment.

Change in policies is fundamental, but the dimension of challenges forces the design of strategies that contemplate the complexity and diversity of each age group health profile. In the specific case of family health, fostering the prevention of risks and damages is essential long before they occur or are detected. It is important understanding that health problems are not unique or specific to each age group and, therefore, the perspective that has to prevail is that of life course. In this sense, the family physician has the perspective of health problems care at each one of life's stages and is the one who can address them with the level of surveillance necessary to ensure that coverage of these interventions is carried out in an opportune, comprehensive and effective form.

A new educational model?

Numerous voices increasingly advocate for the necessity to redirect the family medicine specialty towards a new paradigm. The complexity of the development of a new professional whose field of action is not defined by a list of clinical conditions and whose learning core is in the generation of health care skills that cover the entire spectrum of ages, genders and care necessities in population contexts with very different social determinants is widely recognized[24]. Although the current model includes humanistic disciplines in its study plans, the sum of concepts derived from sociology, economics or social psychology with public health and clinical medicine is not sufficient for comprehensive care when confronted with the reality of daily activity in medical services[25]. Therefore, the educational model cannot be isolated from the health system reality, also imperfect in its own care provision model. Most current family medicine specialty programs are pertinent and well sustained on their principles and contents; however, it should be recognized that its review in the light of the changes in demographic conditions, the type of health necessities resulting from new social determinants, the population's expectation on higher participation on their care and the evolution of the system itself with technology advances and a variety of organizational options, but always with limited resources, is imperative.

Based on this reality, the redesign of the family medicine specialty in Mexico will have to be accompanied by a redirection of the model of medical services towards a true primary care specialty, which rescues for its structure and organization the essential values for the achievement of equity and effectiveness: a model based on health needs, focused on people and with joint responsibility in decision making for their care, with work in multidisciplinary teams with coordinated management between levels, based on evidence and with an emphasis on quality and continuity of care[12].

Conclusions

Family medicine is the medical specialty that arises by the pressure of taking care of imperious social and health needs of the population, this way addressing persons and families, rather than ailments or diseases. It constitutes the center of the process of care and helps the patient to move across a frequently confuse and fragmented health system.

The challenge for the consolidation of the family medicine specialty lies in health and education institutions working together, generating favorable expectations for the graduate resident, as well as appropriate academic development and incentives. Consolidation of the specialty depends on the huge challenges to overcome: promotion of the true identity as a medical specialty, identification of the wide vision on the health of the patient and his/her family, recovery of

the specialty's prestige in academic circles and feasibility to offer the specialty as an attractive option.

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