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REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC
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EDITORIAL

VI Iberoamerican Summit on Family and Community Medicine

VI Cúpula Ibero-Americana de Medicina de Familia e Comunidade

VI Cumbre Iberoamericana de Medicina Familiar y Comunitaria

In recent years, with the increase of the prevalence of chronic non-communicable diseases, gender inequalities, social and health inequities, violence, climate change, lifestyles of human society and the reiteration of health as a fundamental human right, health systems have been taken to value and strengthen the primary care level.

All over the world, Family and Community Medicine (FCM) has been a pillar for a qualified Primary Care (PC), developing a comprehensive care for people, providing better health services to all populations and in all social settings. It is a medical specialty and an academic discipline that studies the health-disease process of the person, their family and community from a systemic perspective and a bio-psycho-socio and cultural approach. Its practice is characterized by knowledge, skills and attitudes that differentiate it from other specialties. However, it is a specialty that still needs to be valued in the Latin American context.

Political discourse and international recommendations speak of the importance of the PC and the FCM in the provision of healthcare services, based on the premise of better utilization of resources, equity and social justice. However the different degrees of commitment and efforts made to strengthen education and training in PC and FCM in Latin America health systems have been insufficient. It could be said that in many cases the efforts are very little or almost nulls, if not contradictory, even reverse the signed agreements.

As a way to discuss, reflect and support the development of appropriate policies for health systems to a qualified PC, with Family and Community doctors, the Iberoamerican Confederation of Family and Community Medicine (Wonca Iberoamericana CIMF) promotes the realization of Ibero-American Summits of Family Medicine. The summits, as well as a political event, are also a technical and an academic event. Through the exchange of experiences and participatory activities, with strategic representatives from the areas of health, education and research, solutions are sought for organizational problems, assistance, training and research in Iberoamerican health systems, especially those related to Primary Care and Family and Community Medicine.

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Health Ministers of the Iberoamerican region, representatives of the World Health Organization (WHO) and PAHO/WHO, representatives of CIMF and the World Organization of Family Doctors (WONCA), Managers of Health and Education, Academic Societies representatives interested in Family Medicine and Primary Care, and representatives of organized society are invited to attend these events.

Since 2002, there have been six summits: in 2002, Summit of Seville, Spain; in 2005, Summit of Santiago, Chile; in 2008, Summit of Fortaleza, Brazil; 2011 Summit of Asuncion, Paraguay; 2014 Summit of Quito, Ecuador, and in 2016, the Summit of San José, Costa Rica, the subject of specific interest in this supplement of the Brazilian Journal of Family and Community Medicine (RBMFC).

The VI Ibero-American Summit of Family and Community Medicine was held during 12 and 13 April 2016, in the city of San José, Costa Rica, under the theme: **"Universality, Equity and Quality in Health Systems: Family and Community Medicine as Axis"**.

This great event was organized by the Ministry of Health of Costa Rica, the Costa Rican Department of Social Security, CIMF, WONCA, the Association of Family and Community Medicine of Costa Rica (MEDFAMCOM), PAHO/WHO, with the collaboration of the Universidad Iberoamericana (UNIBE).

We had the honourable participation of Dr. Fernando Llorca Castro, Minister of Health of Costa Rica; Dra. María del Rocío Sáenz Madrigal, Executive President of the Costa Rican Social Security Fund; Dra. Lilia Reneau-Vernon, OPS Costa Rica, the authorities from the WONCA Executive Committee: President Dr. Michel Kidd, Executive Secretary Dr. Garth Manning and President Elect Dr. Amanda Howe, as well as the Executive Committee and Board of CIMF and representatives of the Ministers of health from Brazil, Colombia, Honduras, Mexico, Panama and Puerto Rico; as well health managers, teachers, residents and students. In all, 170 people from 24 countries were gathered reflecting and discussing the Family and Community Medicine (FCM).

In this VI Summit, participants were given the task of developing 5 working axis through 5 groups, divided into 8 sub-working groups:

- Axis 1: Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis
- Axis 2: Training in Family and Community Medicine, Certification and Recertification
- Axis 3: Reference and Counter Reference System: care coordination mechanisms and role of Family and Community Medicine in the structure of Network Health Services
- Axis 4: Research in Family and Community Medicine
- Axis 5: Quaternary Prevention: Medical Ethics, Evaluation and Efficiency in Health Systems

During the Sixth Summit, the situational diagnoses of the countries of the region related to the referred themes have been presented. After a participatory discussion in working groups, 7 central definitions and 22 recommendations were generated to form the letter of San Jose. The Letter as well as 8 articles on the topics of this summit, are published in this supplement of the Brazilian Journal of Family and Community Medicine (RBMFC).

This time, unlike the previous one, when the conclusions of the summit were published only in Spanish, we decided to publish in 3 languages: Spanish, Portuguese and English. The aim is to provide relevant information to the decision makers and medical community about the strengths and opportunities presented by the Latin American countries on key issues for the development of more efficient and fairer health systems, based on the PC and FCM.

We know we have the challenge of improving the processes of scientific production, as scientific associations we are. We believe that the articles that integrate this number of the RBMFC are part of the construction of this story. A story that has been developed based on cooperation and collaborative spirit among family and community physicians from all the countries of our Confederation, committed to FCM. Furthermore, the articles are relevant because they provide important and new information.

Finally, we thank everyone involved in the publication of this work, from the scientific part, and including those who contributed to the publishing production, as is the case of Marli Machado, from RBMFC; our external reviewers, Professor Arnulfo E. Irigoyen-Coria, Editor of the Journal of Family Care and Professor of the Faculty of Medicine of the National Autonomous University of Mexico (UNAM); Master Jose Enrique Alfonso Manzanet, Head of Department of Medical Journal Editors, Editorial Medical Sciences, National Information Center of Medical Sciences of Cuba and Dr. Danae Ricardo Aldana, Editor from the same institution.

"Publication of position papers and the conclusions of the CIMF Summits, represent a clear editorial and scientist effort to consolidate the Family Medicine - our speciality- at the Latin American level. We must be convinced that without the arduous and complex execution of these tasks -the Family Medicine in Iberoamerica- cannot be consolidated. More than forty years have passed since the academic training of specialists in family medicine began in Mexico; and it can be said that without these scientific-publishing efforts, the desired consolidation of the specialty will be further away each day."

Arnulfo E. Irigoyen Coria

Thomas Meoño Martin
President
VI Iberoamerican Summit of Family Medicine
President MEDFAMCOM

Maria Inez Padula Anderson
President
Wonca Iberoamericana CIMF
Supplement Editor
VI Summit - RBMFC

Miguel Ángel Fernández
Vicepresident Mesoamerica
Wonca Iberoamericana CIMF
Supplement Editor
VI Summit - RBMFC

REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
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ESSAYS

Family and Community Medicine as the core of Health Systems Universality in Latin America: an exploratory analysis of the region

A Medicina de Família e Comunidade como Eixo da Universalidade nos Sistemas de Saúde de Ibero-América: uma análise exploratoria da região

La Medicina Familiar y Comunitaria como Eje de la Universalidad en los Sistemas de Salud de Latinoamérica: un análisis exploratorio de la región

Thomas Meoño Martín. Association of Family and Community Medicine in Costa Rica (MEDFAMCOM); School of Medicine of the Autonomous University of Central America; Costa Rican Department of Social Security; University of Costa Rica; CIMF-WONCA. Costa Rica. drmeono@gmail.com *(Corresponding author)*
Maria Inez Padula Anderson. Iberoamerican Confederation of Family and Community Medicine (CIMF); Family and Community Department - Rio de Janeiro State University (FCM/UERJ). Rio de Janeiro, RJ, Brazil. inezpadula@yahoo.com.br
Marcela Cuadrado Segura. Uruguayan Society of Family and Community Medicine (SUMEFAC); Group CIMF Family and Community Medicine in rural areas; Department of Family and Community Medicine, Faculty of Medicine, University of the Republic of Uruguay. Uruguay. marcelacua@gmail.com
Pablo Araya Via. University of Valparaiso, Chile; Waynakay Movement - Chilean Society of Family Medicine; Thierry Jean and Marie CESFAM. Chile. pabloarayvia@gmail.com

Working Group
Andrea de Angulo (Colombia), Arnaldo Ortiz Fanego (Paraguay), Carlos Martínez Rentería (México), Carmen Cabezas (Ecuador), Catalina Coral, Christine Leyns (Bolivia), Clarivel Presno Labrador (Cuba), Daymé Quintero (Panamá), Edgar León (Ecuador), Jenny Magne Anzoleaga (Bolivia), José Obando Romero (Costa Rica), Karen Muñoz (Colombia), Lilia González (Cuba), Lysdamis Morera (Perú), Macacrena Moral (Chile), Mauricio Vargas (Costa Rica), Milagro Muñoz (Costa Rica), Sergio Minué (España), Xenia Sancho Mora (Costa Rica)

Abstract

The scope of Universality in service delivery in health care systems is one strategy that has proven to have great impact on global health indicators; this paper explores the situation of Latin American countries in the access to health services and the role of the specialist in Family and Community Medicine as an appropriate estrategy to achieve individual, family and community coverage. **Objective:** To contribute to the development of concepts and practices related to Universality in Primary Care and Family and Community Medicine in Latin America. **Methodology:** qualitative and quantitative exploratory study by applying an electronic form self-administered survey type with open and closed questions to members of associations of family and community medicine in Latin America, scientific associations, teachers and health managers identified in each country. **Results:** 63 people from 21countries completed the electronic survey sent, taking a representative sample of Latin American countries; 84% agreed with the concept of universality with focus on Primary Health Care and Family and Community Medicine, 47% agree that the main determinant limiting the scope of the universality in health care is the structure in management and health, followed by finance (36%) and the model of care (30%). Of the total respondents, 67% believe that the main constraint to universal coverage is the structure and health management and 60% felt that national health policies are not focused and prioritized towards universality of the APS and the MFC.

Keywords:
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Resumo

O alcance da Universalidade na prestação de serviços nos sistemas de saúde é uma das estratégias que tem demonstrado ter grande impacto sobre os indicadores globais de saúde. **Objetivo:** contribuir para o desenvolvimento de conceitos e práticas relacionadas à universalidade na Atenção Primária à Saúde (APS) e na Medicina de Família e Comunidade (MFC) na Ibero-América, mediante a exploração da situação dos países latino-americanos em relação ao acesso aos serviços de saúde e o papel do especialista em medicina familiar e comunitária para alcançar uma estratégia adequada para a cobertura individual, familiar e comunitária. **Metodologia:** estudo exploratório quali-quantitativo, realizado por aplicação de um questionário em formato electrónico auto-respondido, com perguntas abertas e fechadas, dirigido aos membros de associações de medicina familiar e comunitária na Ibero-América, associações científicas, professores e gestores de saúde identificados em cada país. **Resultados:** 63 pessoas de 20 países completaram a pesquisa electrónica enviada, havendo uma amostra representativa de os países Ibero-Américanos; 84% concordaram com o conceito de universalidade elaborado a partir do enfoque da Atenção Primária à Saúde e da Medicina de Família e Comunidade; 47% concordam que o principal fator determinante que limita o alcance da universalidade nos cuidados sanitários é a estrutura da gestão em saúde, seguido do financiamento (36%) e do modelo de atenção (30%). Do total de entrevistados, 67% acreditam que a principal restrição para a cobertura universal é a gestão da estrutura da saúde e 60% sentiram que as políticas nacionais de saúde não estão focadas e priorizadas para a universalidade da APS e da MFC.

Palavras-chave:
Universalidade
Cobertura Universal em Saúde
Atenção Primária em Saúde
Determinantes de Saúde
Saúde Global

Resumen

El alcance de la Universalidad en la prestación de servicios en los sistemas de salud, es una de las estrategias que ha demostrado tener gran impacto sobre los indicadores de salud global. **Objetivo:** contribuir con el desarrollo de los conceptos y de las prácticas relacionadas a la Universalidad en Atención Primaria y Medicina Familiar y Comunitaria en Iberoamérica, mediante la exploración de la situación de los países iberoamericanos en cuanto al acceso a los servicios de salud y el papel que cumple el médico especialista en Medicina Familiar y Comunitaria para lograr una adecuada estrategia de cobertura individual, familiar y comunitaria. **Metodología:** estudio exploratorio cuali-cuantitativo mediante la aplicación de un cuestionario electrónico autoadministrado mediante una encuesta con preguntas abiertas y cerradas a los miembros de las asociaciones de medicina familiar y comunitaria de Iberoamérica, asociaciones científicas, profesores y gestores de salud identificados en cada país. **Resultados:** 63 personas de 20 países cumplimentaron la encuesta electrónica enviada, teniendo una muestra representativa de los países iberoamericanos; 84% estuvieron de acuerdo con el concepto de universalidad con enfoque en Atención Primaria en Salud y Medicina Familiar y Comunitaria, 47% acuerdan que el principal determinante que limita el alcance de la universalidad en la atención en salud es la estructura en gestión y salud, seguido del financiamiento (36%) y del modelo de atención (30%). Del total de encuestados, 67% consideran que el principal limitante hacia la cobertura universal es la estructura y gestión en salud y 60% consideraron que las políticas nacionales en salud no están enfocadas y priorizadas hacia la universalidad de la APS y la MFC.

Palabras clave:
Universalidad
Cobertura Universal en Salud
Atención Primaria en Salud
Determinantes de Salud
Salud Global

Introduction

In 1978, the Declaration of Alma-Ata about Primary Health Care called for action for health, social and economic sectors for the "achievement of the highest attainable standard of health", leading to the movement of Health for All that obtained a big boost in 1980 and 1990. In 1997, a new concept is inserted in the health sector, aiming to extend support to increase health practices. At the 1997 Conference of the World Health Organization, a definition on intersectorial action for health originated:

> *"A recognized relationship between part or parts of health with the part or parts of another sector that has been formed to decide on an issue to achieve health outcomes (or intermediate health outcomes) in a form more effective, efficient and sustainable than could be achieved by the health sector alone."*[1]

However, universal health coverage shows an irregular and inadequate pattern in Latin America. According to the Pan American Health Organization, WHO and the United Nations Economic Commission for Latin America and the Caribbean, available data indicate that improving access and coverage, along with the reduction of inequalities in health, constitute a pending task in most Latin American countries.

Health systems in Latin America are highly fragmented. The rights granted, coverage and institutional arrangements vary among different groups of the population. In the countries of this region, health systems are usually organized by a combination of traditional public sector services for low-income groups; social security services for formal employees (in some cases extend to their families), and private services for those with ability to pay. The lack of coordination between the three sub-sectors has been a source of inefficiencies and inequities, once that fragmentation hinders the efficient use of the resources required to achieve universal health coverage.

In some countries it has tried to integrate contributory funded by taxes on wages, with public systems financed by general taxation; in others, there remains a great segmentation. Costa Rica is a traditional reference, considering that the funding sources are integrated to ensure a unique level of coverage. Currently ensures health coverage to more than 93% of the population, and about 50% of the amount contributed by employees in the formal sector covers the financing of health services of the population that does not contribute.[2]

Different situation occurs in Chile, where integration is partial, since individuals decide whether to enroll in integrated public system (National Health Fund, FONASA), financed by contributions and by general taxes; or a private insurer (health insurance institutions, ISAPRES). Because any real choice depends, significantly, to the income of the contributors, the Chilean system is considered a dual system. Chile has an almost universal coverage of social insurance, where the 80% of the population is covered by FONASA, and 17% by ISAPRES.[3]

Universality and Universal Health Coverage

Universality on Health is defined as the coverage that the population has for accessing health services and fulfill their right to it, which must be protected financially by public policies and actions of the state. Must have scale and intensity proportional to the needs, which was defined by Marmot as proportionate universalism “actions must be universal, but with a scale and intensity that is proportional to the disadvantaged, rather than focusing only on the most favored”,[4] thereby articulating the definition of Universality with Equity. Therefore, it is necessary to recognize equitable access to health services as a human right and not a privilege for those working in the formal sector or with greater financial resources.

Refers then to the right of the population to have access to health services with integral approach, integrated and continuous, regardless of socioeconomic or geographical condition of the individual, family or community.

Build universal health systems requires not only health authorities will, but also a societal consensus that puts health and its determinants in the center of national priorities. It means reaching a new social pact to devote major efforts on improving the conditions and quality of life. Fully meeting the health needs and promoting proactive interventions in factors and social determinants such as education, food, social security and environmental care.

However, for the recognition of the universality as a human right can be a common denominator among nations, strategies to achieve this goal they must be defined by each country, since it is a complex process of adapting health systems at the national level. Achieve universal coverage goals requires defining the progressive percentage of the population covered, the services to be provided and the costs to be covered.[5]

The World Health Report 2010 defines the concept of Universal Health Coverage (UHC) as a goal that “all people have access to services and do not suffer financial hardship paying for them.” According to this definition, the objective of the UHC is clear, namely to ensure, for all, access to health care is needed with proper financial protection.[6]

For a community or a country can achieve UHC have to meet several requirements, namely:

1. Existence of a solid health system, efficient and functioning, that meets the priority health needs within a focus on people (including services related to the care of patients with HIV, tuberculosis, malaria, not communicable diseases, maternal and child health) which shall:
    - provide people with information and incentives to stay healthy and prevent diseases,
    - detect diseases an early stage,

- have the resourses suport to treat diseases,
- help patients through rehabilitation services.

2. Affordability: there must be a system of financing health services, so that people do not have to suffer financial hardship to use them.
3. Access to essential medicines and technologies for the diagnosis and treatment of medical problems.
4. Adequate health workforce well trained and motivated to provide services that meet the needs of patients, based on the best scientific evidence available.

The UHC can be achieved through different institutional and financial strategies, but came to be thought of as an offer of insurance plans which cover a limited set of health services offered by public or private providers of health. But, different from that, universal health system (UHS) seek to promote the development of a single public institution to provide and finance all medical and preventive services to citizens.[7]

In the seventies, the Primary Health Care (PHC) was proposed as the model to ensure that all citizens enjoy their right to health, with governments responsible for setting the PHC as part of comprehensive national health systems.[8] This institutional arrangement has been termed as integral, unified or universal health system (UHS)[9,10] presupposes, therefore, the existence of a single public entity responsible for the provision of preventive services and medical care to all citizens, with the same pattern of care regardless of their socioeconomic status. Equity is one of the main objectives of UHS, because all people receive comprehensive care based on their health needs and not on ability to pay.[7]

In the Letter of Quito, produced as a final product of the V Ibero-American Summit of Family and Community Medicine, universal coverage is defined as: "*the guarantee of the right to health for everyone, provided by a comprehensive and integrated basis state system with public financing, allowing access to services equitably, equal, timely, comprehensive and quality, based on the principles of solidarity and social participation; taking the first level of care as the focus of care, with male and female Family and Community doctors in health teams, ensuring the first contact and continuous monitoring, focusing on the person, their family and community context, in accordance with the health needs presented in the course of their lives*".[11]

Universality in Iberoamerica

Latin American health systems face the challenge to regain the equity value, for which measures must address the different levels of government involved.

It is not about decide whether to set priorities, but what is the better way to do it; because in the process of achieving universality they have introduced different ways to define priorities and shape their health benefit plans, experiences from which we can obtain three lessons:

1. Benefits plans offered in the region, have different shapes and sizes and are not restricted to a list of essential services even in societies with severe resource constraints. Comprehensive plans are described in countries such as Chile, Colombia, Costa Rica and Uruguay; restricted plans are described in Mexico, Peru and Argentina.
2. The countries of the region require institutional capacities to define and regularly update benefit plans. They require political and technical leadership backed by legal grounds, in addition to adequate resources to provide quality services available, accessible and acceptable; hence the importance of financial resources and investment in human resources and infrastructure.
3. It is necessary to improve the monitoring of health policy and evaluation at the national level, in order to establish whether, in fact, effectively plans have resulted in improvements in health and health quality in a happier citizenship.

To achieve universal health coverage an agenda focused on research and development of skills for setting priorities is required, with the Latin American experiences as a starting point.[3]

Another challenge is to exert effective steering role of state that results in a generating presence of order and should be, in the context of all available resources and according to the scientific-bioethical and technological trends, who guarantees the right to protection health and reflected in access to quality and timeliness. All this is possible if there is a responsible and sustainable criteria of equity, efficiency, transparency and accountability financing; based on a homogeneous model of care based on social determinants and the increasingly resolute primary care. Also in the actions of disease prevention and health promotion, organized through networks of public and private institutions offering comprehensive services and high quality to the population this one last being the one that would become subject passive to active.

Several countries are in the process of implementing reforms of their health systems based on primary health care. In most of them are presented the following challenges: availability of human talent and trained in sufficient numbers; need to overcome the fragmentation/segmentation of health systems; ensure financial sustainability; improve governance, quality of care and information systems; reduce inequities in health; expand coverage; prepared to face the consequences of an aging population and changing the epidemiological profile and increase the response capacity of the public health system.

The PHC has the potential to reduce social inequities in health approaching universality; for which the following objectives and key areas suggested:[12]

1. Collect and disseminate information for action:
   a. Social variables in clinical history as educational level, have key indicators such as teenage pregnancies, quality criteria related to equity in health care for example: accessibility and loss to follow according to social variables, diagnosis of the social determinants of health, knowledge and characterization of the needs of the population served.
   b. Provide updated information on local resources and initiatives for citizens.
   c. Report on: the relationship between socioeconomic status and health outcomes, social inequalities and inequities in the quality of the relevant care at PHC, the impact of the management of PHC on the health of the population, its determinants and the social determinants of health (SDH).
2. Strengthen social participation: fostering capacities and knowledge on population health:
   a. Inform users of their rights to health and patients' rights.
   b. Collaborate in the development of programs aimed at capacity development in the population that facilitate their participation.
   c. Strengthening and development of the roles of area nurse and pharmacist and empowerment of equity and social determinants of health in professional networks.
3. Education and training of human resources:
   a. Have practical knowledge and expertise in the application of interventions on social determinants of health.
   b. Enhance training in health promotion and disease prevention framed in action on the social determinants of health and dissemination of good practice.
   c. Harness deformations to show the relevance of equity. Generate training materials that show the contribution to clinical and social effectiveness of incorporating the axis of equity to health care, and allocates the resources necessary to act on SDH.
4. Intersectoriality:
   a. Knowledge of health and social resources.
   b. Foster partnership working with other sectors (education, social services, local agents, ...).

c. Include the axis of equity in all intersectoral action plans and projects following.
d. Development of intersectoral participation organs.
e. Encourage professionals to promote intersectoral action

5. Reorienting health care:
   a. Consider the impact of daily practice in health inequalities and targeted interventions to complement universal coverage mechanisms.
   b. Expand recruitment services in the streets and homes of unserved population.
   c. Comprehensive care of the person according to their needs devoting time to consider the root causes of their health problems and devoting time and effort in proportion to the need.
   d. Identify groups that do not access and facilitate their coverage.
   e. Development of structures to strengthen community action in health primary care teams, in collaboration with other sectors (education, social services, local agents, public health, etc.).
   f. Establish procedures to deal with the circumstances and needs of disadvantaged and marginalized groups, and to eliminate existing barriers to accessibility.

Relationship between Universality, Primary Care and Family and Community Medicine

In 2010 the member states of PAHO/WHO reaffirmed their commitment to the vision of the Declaration of Alma-Ata to recognize that the PHC, including the promotion and protection of health, are essential not only for the welfare of individuals but to ensure sustainable and inclusive socio-economic development.

Defining a health system based on PHC, as a comprehensive approach to the organization and operation of health systems, makes the right to attain the highest level of health its main goal, while maximizing equity and solidarity of the system.

Individuals can meet their health needs to get universal health coverage and access to system services without the ability to pay constitutes a limiting factor. Universality becomes a target image towards which guide system transformation. These terms are commonly understood as the existence of units of primary care homogeneously distributed in a territory.

Universality is determined strongly by Primary Care because:

- It is the entrance door to health system.
- Territorialization with situational diagnosis, identifying groups that do not have access.
- The capacity for action of its community dimension: empowerment, participation.
- Partnerships that can establish with other actors - intersectoriality.

It is worth mentioning that the PHC as the core of health systems is presented today with a renewed focus, reasoned and based on the evidence so that it can achieve a universal, comprehensive and integrated care.

Different studies already put in evidence that health systems based on the principles of PHC have the ability to solve at least 80% of health problems of a defined population, at a sustainable cost, especially if it has the support and participation of the community, economic and social sectors.

Various experiences of PHC with the effective participation of Family and Community Physician can be found in many countries, including Mexico, where “Primary Care is Family Medicine, and is the permanent care provided in the first point of contact, oriented to the person and his family; that meets the health needs of each person. It refers only those rare cases. Coordinates care involves continuous care, equity, emphasis on prevention and promotion. Organization and management practices at all levels to achieve quality, efficiency and effectiveness. Adequate and sustainable human, economic and technological resources”.[13]

Objective

Considering the importance of the Universality and the role of Family and Community Medicine, and a qualified PHC to achieve it, this study aimed to: reviewing the concept of Universality in Latin American Health Systems and knowing Doctors of Family and Community perspective on this concept. Moreover, get the information on the situation of Latin American countries in relation to universal health coverage, considering the stage of PHC and FCM in Iberoamerica.

Methodology

An exploratory quali-quantitative study was performed by applying an electronic questionnaire, with open and closed questions, to members of associations of family and community medicine in Iberoamerica, scientific associations, proffesors and health managers identified in each country. In the first phase it was asked to a group of collaborators review an initial proposal of Universality conceptualization, based on the concepts conceived during the previous summits. Furthermore, put questions whose answers might meet the objectives related to obtaining information about the situation of the Iberoamerican region in relation to the proposed concept. In the second phase, a survey was developed as a collection tool, based on analysis and proposals recommended by the collaborative group (see appendix). The third phase took place in the framework of the VI Ibero-American Summit of Family and Community Medicine conducted on 12 and 13 April 2106 in San Jose, Costa Rica; where the Universality Sub-Working Group had the opportunity to review the contributions derived from the survey and propose a series of recommendations to achieve a regional improvement in obtaining better access to health services, according to the criteria evaluated.

Results

63 people from 20 countries completed the electronic questionnaire sent out, having a representative sample of the Iberoamerican countries; from which, 58 were specialists in Family and Community Medicine and the remaining 5, resident doctors in the same specialty. (Figure 1)

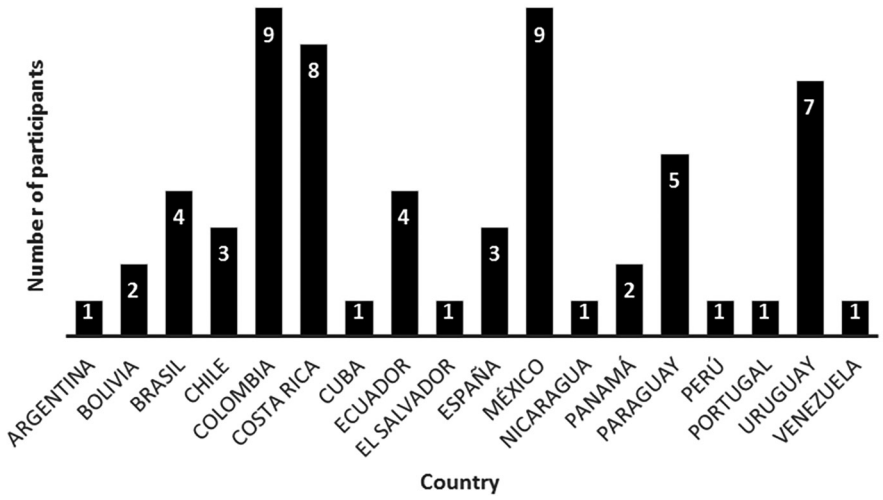

Figure 1. Distribution of participants by countries in the online survey on the assessment of the Universality Health in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

In relation to the agreement with the proposed Universality concept, from the perspective of the family and community doctor, 84% of respondents agreed with the statements, 13% did so with respect to general but provided suggestions, 2% disagreed and 1% did not respond (Figure 2).

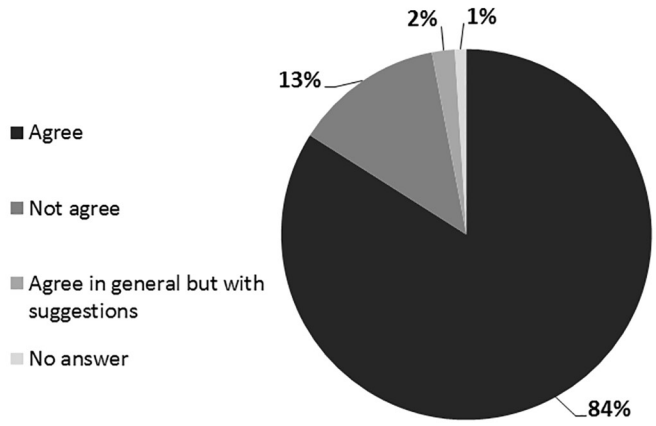

Figure 2. Concordance with the concept of Universality raised in the electronic survey on the assessment of the Universality Health in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

The consultation on the main determinants in Latin America that limit achieve universality of the PHC and the FCM showed that: 75% of respondents agree that the main determinant is the structure and health management; followed by finance (57%), inadequate Health Care System model (48%), insufficient qualified human resources and the lack of steering role (35%); inadequate social participation and inadequate accountability (30%), lack of access to medicines and health technologies (21%) and inefficiency in the performance of essential public health functions (17%). (Figure 3)

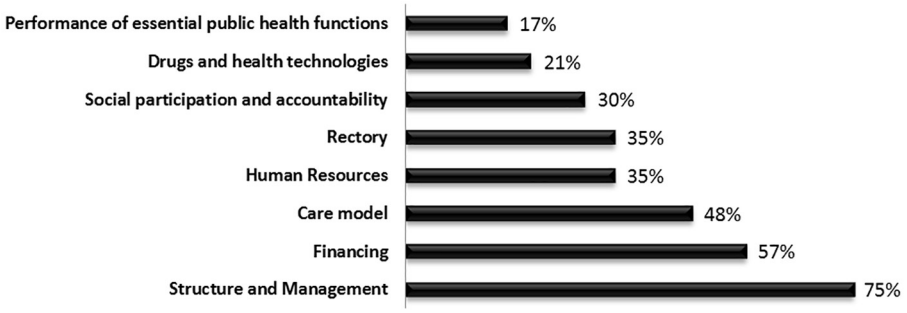

Figure 3. Principal determinants in Latin America that limit achieving the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

The analysis of the answers on the factors limiting considered by country to achieve the universality of the PHC and FCM showed that 67% of respondents agree that the main determinant is the structure and health management; followed by finance (51%), insufficient human resources (46%), the Health Care System model (40%), the rectory (38%), social participation and accountability (35%), access to medicines and health technologies (17%) and the characteristics of the performance of essential public health functions (17%). (Figure 4)

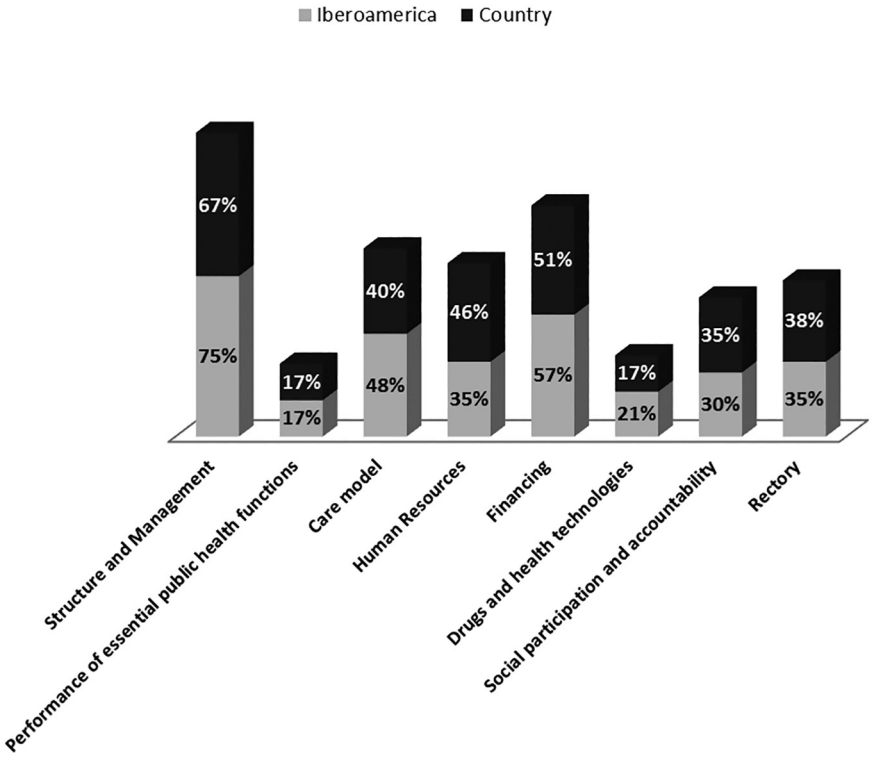

Figure 4. Main factors by country and region level that limit achieve the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

Of all respondents, 60% considered that, in the context of Latin America, national health policies are not focused and prioritized towards universality of the PHC and the FCM in Latin America and 48% think similarly for their countries; 17% indicated that policies do exist in this context at the level of Latin America and 28% at the country level (Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Spain, Mexico, Nicaragua, Portugal and Uruguay). (Figure 5)

Discussion

Although participation of 20 countries of Latin America was held, the data collected in the survey represent the perception of only 63 participants; thus limiting obtain a comprehensive picture of the situation of universal health coverage in the region.

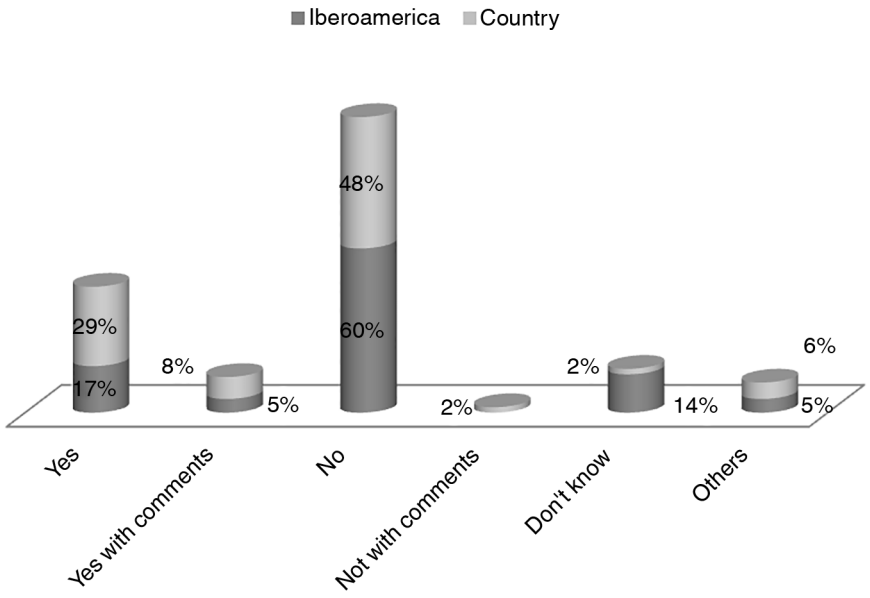

Figure 5. Perception of the existence of national policies that allow achieving the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016.
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

However, it is interesting to verify that the data analysis is consistent with what explored by other authors as Ortiz Salgado et al.[14]; who performed a comparative analysis of two health systems to highlight strategies and gaps for greater universal health coverage, highlighting the need for national policies focused on primary health care with participation of Family and Community Medicine.

There is variability in the perception of the concept of universality in the region, which could be explained both by lack of dissemination of the work and proposals of the previous summits; as well as the lack of a better internalization of the concept, considering the reality of each country, and their understandings about the meaning of comprehensive health care to the population.

Conclusions

To achieve universal health coverage must act strategically in the five key action areas of primary health care: (1) Collect and disseminate information for action; (2): Strengthening social participation: fostering skills and knowledge of the population on health; (3) Training and capacity building of human resources; (4) Acting intersectorally; (5) Reorient health care.

There is a Latin American consensus (over 80% of countries) that the concept of universality involves the right of the population to have access to Primary Health Care (PHC) and Family and Community Medicine with comprehensive approach, integrated and continuous, regardless of socioeconomic or geographical condition of the individual, family or community.

Even though in some countries there are policies geared towards achieving the universal coverage of health services; continuous, balanced and structured work is necessary to ensure that those populations with less access to services reach, staggered and well-defined manner, the route process to define the scope according to their realities.

The active participation of members of the CIMF in the context of developing country policies to achieve improved access to services is necessary and binding; regional strategies must be generated in which those with more experience provide a platform for the countries universalization, find a space of consensus on which to prepare their strategies for presentation to local governments.

Recommendations

From the work done during the two days of the VI Ibero-American Summit of Family and Community Medicine in the city of San José de Costa in April 2016, based on the literature review and analysis of the survey; the following recommendations were derived:

1. Rescue and disseminate the concept of Universality developed and consensus in the Charter of Quito under the V Ibero-American Summit of Family and Community Medicine.
2. Strengthen the primary care level with the presence of Family and Community Doctors based on primary health care strategy, ensuring contact regardless of geographical, social and economic status of the population.
3. Effectively and equitably manage of resources, based on the analysis of the health situation of the population, and also integrating social participation as one of its axis.
4. Family Medicine as the axis of the first level leading the multidisciplinary team, keeping the individual, family and community approach, with emphasis on activities of health promotion, prevention and education.
5. Establish transdisciplinary qualified teams with leadership of the specialists in Family Medicine and Community to ensure effective access of health services to individuals, families and communities in the First Level of Care.
6. Guarantee the resources to enable the first level of care to realize their potential to solve most of the problems/needs of the individual family and community equipment; estimated at least in 80%.
7. Each country should strengthen mechanisms for planning and national dialogue on the requirements in the formation and transformation of specialists in Family and Community Medicine; guaranteeing their employment and equitable distribution depending on the needs of the population.

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Annexes

Survey prepared with contributions from the collaborator group:

Universality concept focusing on the PHC and FCM:

1. What do you think are the main determinants in Latin America that limit achieve universality of Primary Health Care and Family and Community Medicine?

a. Structure and Management
b. Performance of essential public health functions
c. Care model
d. Human Resources
e. Financing
f. Drugs and health technologies
g. Social participation and accountability
h. Rectory

Please justify:

Other:

2. What do you think are the main determinants of your country that limit achieve universality of PHC and the FCM?

a. Structure and Management
b. Performance of essential public health functions
c. Care model
d. Human Resources
e. Financing
f. Drugs and health technologies
g. Social participation and accountability
h. Rectory

Please justify:

Other:

3. Do you consider that national health policies in Latin America are focused and prioritized towards universality of the PHC and the FCM?

a. Yes
b. No
c. Don't know

Please justify:

4. Do you consider that national health policies of your country are focused and prioritized towards universality of the PHC and the FCM?

a. Yes
b. No
c. Don't know

Please justify:

5. What are the main strengths of the health system of your country that ensure achieve universality of the PHC and the FCM in your region?

a. Existence of a management policy that values and invests in PHC and FCM
b. Good performance of essential public health functions
c. Existence of a Care Model suitable to PHC and the FCM
d. Existence of Human Resources policy towards the maintenance and strengthening of PHC and FCM qualified and quantity required
e. Existence of a financing policy that specifically supports the development of the PHC and FCM
f. Availability and access to drugs and health technologies
g. Social participation and accountability

Please justify:

Other:

6. How do you think that family medicine can influence achieving fulfill the principle of universality in your country?

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ESSAYS

Family and Community Medicine as the core of the Health Systems Equity in Latin America: an exploratory analysis of the region

A Medicina de Família e Comunidade como eixo central da Equidade nos Sistemas de Saúde de Ibero-América: uma análise exploratória da região

La Medicina Familiar y Comunitaria como eje central de la Equidad en los Sistemas de Salud de Latinoamérica: un análisis exploratorio de la región

Marcela Cuadrado Segura. Sociedad Uruguaya de Medicina Familiar y Comunitaria (SUMEFAC); Grupo CIMF Medicina Familiar y Comunitaria en medio rural; Departamento de Medicina Familiar y Comunitaria de la Facultad de Medicina de la Universidad de la República del Uruguay. Uruguay. marcelacua@gmail.com *(Corresponding author)*
Maria Inez Padula Anderson. Confederación Iberoamericana de Medicina Familiar y Comunitaria (CIMF); Departamento de Medicina Integral, Familiar y Comunitaria (FCM/UERJ). Rio de Janeiro, RJ, Brazil. inezpadula@yahoo.com.br
Thomas Meoño Martín. Asociación de Especialistas en Medicina Familiar y Comunitaria de Costa Rica (MEDFAMCOM); Escuela de Medicina de la Universidad Autónoma de Centroamérica; Caja Costarricense de Seguro Social; Universidad de Costa Rica. Costa Rica. drmeono@gmail.com

Working Group
Andrea De Angulo (Colombia), Dayme Quintero (Panamá), Dora Patricia Bernal (Colombia), Francisco Ariza Montoya (Colombia), Jesús Reyes Carranza (Colombia), Jorge Brandao (Portugal), Lizette Pérez Pérez (Cuba), María Naxalia Zamora González (Nicaragua), Milagro Muñoz (Costa Rica)

Abstract

The objective of this paper is to perform a review of an equity concept in general and equity in health in particular from the perspective of considering Family and Community Medicine an essential specialization in primary care. This communication resulted from the exchange of the members of the ethics working group at the VI Ibero-American Summit of Family and Community Medicine in San Jose, Costa Rica on April 2016. The methodology consisted of a preliminary survey and the discussion during the summit about the obtained data. All the stages of the work of the task force are presented in this report: an equity new definition, analysis of the equity in health, influential factors, equity through distribution and number of Family and Community doctors in Latin America, governments' strategies oriented to achieve equity providing healthcare to the entire population, and the acceptance or not of this strategies by family and community doctors. The data obtained from the surveys showed a lack of equity in family and community healthcare facilities due to inadequate number and distribution of qualified human resources, lack of legislation and commitment from governments. It is proposed to work from the concept of equity involving different actors to generate changes oriented to enhance equity in healthcare with family and community medicine as an instrument.

Keywords:
Health Equity
Equity in health systems, family and community medicine as core
Strategies for equity

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Resumo

O objetivo deste trabalho é revisar o conceito geral de equidade e de equidade em saúde, em particular, a partir da visão da Medicina de Família e Comunidade como especialidade fundamental do primeiro nível de atenção à saúde. Surge como produto do intercambio do grupo da VI Cúpula Ibero-Americana de Medicina de Família e Comunidade. A metodologia de trabalho se deu através de uma enquete prévia e discussão dos dados durante a mesma cúpula em San Jose, Costa Rica, em abril de 2016. Neste artigo são apresentados os resultados do trabalho grupal em todas suas etapas que consistem em: nova definição de equidade; análise de equidade em saúde; fatores que influenciam a mesma; a equidade na distribuição e quantidade de Médicos de Família e Comunidade na Ibero-América; estratégias governamentais para alcançar a equidade na assistência à saúde da população e a concordância ou não dos Médicos de Família e Comunidade com as mesmas. Da enquete se obtém a informação de falta de equidade nos serviços de saúde onde se encontram inseridos os Médicos de Família e Comunidade, seja pela distribuição inadequada, seja pela quantidade de recursos humanos qualificados para o primeiro nível, pela falta de legislação e de compromisso dos governos. Para alcançar a equidade, surge a necessidade de trabalhar a partir desse conceito envolvendo diferentes atores para gerar uma mudança no sentido de uma maior equidade em saúde, tendo como um recurso fundamental a Medicina da Família e Comunidade para o alcance da mesma.

Palavras-chave:
Equidade em saúde
Equidade e Medicina de Família e Comunidade
Estratégias para alcançar Equidade

Resumen

El objetivo de este trabajo es realizar una revisión del concepto de equidad en general y de equidad en salud en particular, con la visión de la Medicina Familiar y Comunitaria como especialidad fundamental del primer nivel de atención. Surge como producto del intercambio del grupo de la VI Cumbre Iberoamericana de Medicina Familiar y Comunitaria. La metodología de trabajo fue por medio de una encuesta previa y discusión con datos durante la misma cumbre en San José de Costa Rica, en el mes de abril de 2016. En este artículo se presentan los resultados del trabajo grupal en todas sus etapas, que consisten en: nueva definición de equidad, análisis de la equidad en salud, factores que influyen en esta, equidad en la distribución y cantidad de Médicos de Familia y Comunidad en Iberoamérica, las estrategias de los Gobiernos para lograr la equidad en la atención a la salud de la población y la aceptación o no de los Médicos de Familia y Comunidad con las mismas. Surgen de las encuestas la falta de equidad en los servicios de salud donde se encuentran insertos los Médicos de Familia y Comunidad, sea por inadecuada distribución y cantidad de recursos humanos calificados destinados al primer nivel y la falta de legislación y compromiso de gobiernos. Se plantea la necesidad de trabajar desde el concepto de equidad involucrando a diferentes actores para generar un cambio a favor de mayor equidad para la salud, teniendo como recurso fundamental a la Medicina Familiar y Comunitaria para el logro de la misma.

Palabras clave:
Equidad en salud
Equidad y medicina familiar y comunitaria
Estrategias para lograr equidad

Introduction

Ibero-America is formed by South America including the Andean Region and the Southern Cone, besides Central America and the Iberian Peninsula and together make a world region with one of the biggest social inequalities,[1] serious disparities in health conditions and access to health services in spite of the development programs looking for exactly the opposite result.[2] To put it simply, there are issues such as different health conditions between individuals and social groups inside and outside the countries which are a key factor among health systems.

Family and Community Medicine (FCM) identifies the importance of this topic due to its characteristic insertion in primary care, integrated by inter disciplinary teams who work closely to where people live, work or study.

The growing disparities in living and health conditions among social groups and geographic regions around the world have worried various social organizations who have considered the issues as emergencies compromising the future of humanity.[3]

The term ”equality”[4] derives from the Latin *aequitas*, which comes from *aequus*, and means “equal”, it consists of giving each individual what they deserve according to their merits or conditions.

Aristotle said “the nature of equity is the rectification of the law when it is insufficient in its universal characteristic”. It is understood that the law has a general feature thus many times it is imperfect or difficult to apply in special circumstances. It is here when equity has a judging role, not from the legal standpoint but from the justice that the law itself is meant to do.

Aristotle said. “Justice and equity are the same thing”: equity is superior, not to fairness in itself, but to what the law states about it and that because of its universality it is subjected to a mistake” “Equity represents, in front of legal reasoning, the feeling that justice sometimes departs from the law to deal with circumstances that if neglected, would determine a legal injustice” if the paradox is allowed.[5]

Bárbara Starfield[6] defines equity as the lack of systemic differences among populations. She states that “primary health care, allows a higher access and it is much flexible to the changing needs of the health society” The effectiveness and efficiency of good primary health care has been proven when compared to specializations and more recently its key role when improving equity in health. This is achieved because it is centered in people and the community, it satisfies their common needs and integrates health care with other levels of service.

When viewing equity regarding health services and medical care processes, several authors identify specific aspects related to the various ways of making the concept in the health system operational. Whitehead[7] identifies four types of equity: a) equity in the available access to equal necessity; b) equal utilization for equal necessity (as in equal distribution of existing health resources among the individuals that need them; c) equity in health quality; d) equity in the result.

Other authors as Berman[8] and Daniels[9] point that the three key elements to achieve equity within the health system are: progressive financing equal assignment of resources within the system, universal rights/universal access and quality in health care.

From WHO World Health Organization,[10] they have been trying to give a more operative meaning to the term. Equity in health care is defined as a) the way in which the resources are assigned, b) the way in which the resources are received by the population, c) the way in which the services are paid.

From a different standpoint there are papers on individuals’ health improvement and health equity reach in populations of from political perspective.[11] The conclusion has been that there is a need a multidisciplinary approach that deals with socio economic factors that are determine health, social and economic policies that affect the distribution of income as well as the health services that strengthen primary care in health (HPC).[12] All this requires health task forces and within those family and community doctors[13] to decrease the inequalities in the health system and achieve equity for people in the process health sickness.

Method

There has been a concept revision on the topic of Equity to later have a debate with participants from various family medicine associations.

There was an online poll for the non face to face phase to FCM residents, post graduates, health specialists and agents. The poll creating process was prior to the VI FCM Summit aiming to learn about equity in everyday life.

Polls were sent to every Ibero-American country through FCM associations. It consisted of 6 questions with closed, semi close and open options to answer. There was research on the concept of equity, its existence in every day practice, inequity leading factors and government strategies to develop equity. The participants gave their opinion on the strategies.

There was a face to face stage carried out during the VI FCM Summit on April 12th 2016 in San Jose de Costa Rica. Members of the Summit sub group had a participation in order to develop a definition of equity according to the FCM that adjusts to the region and formulate recommendations on the subject.

Results

The definition developed during the Summit in Costa Rica is shown following a methodology order.

Definition: The equity term is closely connected to the health right and its legal practices, it is the choice of behaving following a feeling of duty or conscience rather that what the law states or legal actions imply.

In relation to social justice, equity implies a quality - quantitative distribution of health - integrated services in accordance to the needs, in other words, each person, family or community receives what is necessary to keep their health and wellbeing from social processing management and inter sectorial participation.

From the beginnings of FCM, equity has been practised in health care centered in people, family and community respecting their political, cultural biological and psychological environment as well as their free self determination from the development of welfare, managerial, training and researching functions to provide answers to their health needs.

Survey Results

After the analysis the survey's conclusion was:

Total participants 69, 63 are FCM, 4 residents and 2 agents.

There were 18 represented countries from every region. Southern Cone: Argentina, Uruguay, Chile, Brazil and Paraguay. From the Andean Region: Ecuador, Peru, Bolivia, Venezuela and Colombia; from Central America: Mexico, Costa Rica, Panama, Nicaragua and Cuba participated; from the Iberian Peninsula: Spain and Portugal. (Chart 1).

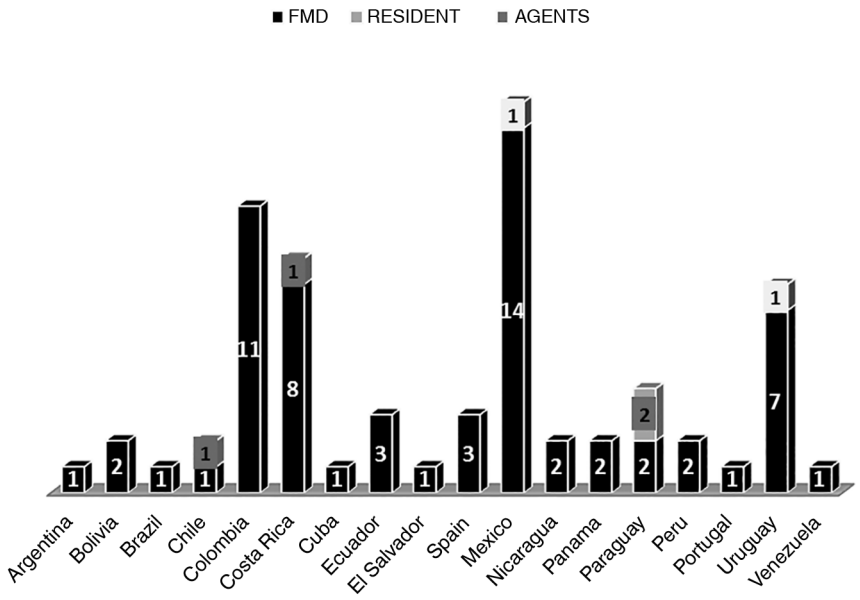


Chart 1. Countries participating in the survey.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

This is the result of the questions made:

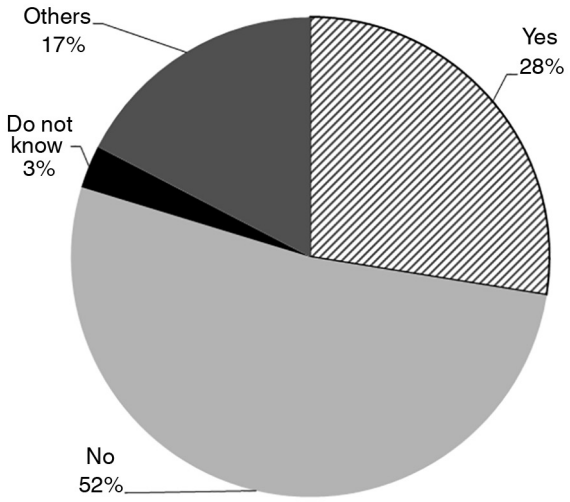
In the question "Do you think that in your country there is EQUITY when rendering primary health care services?

52% of the participants considered that there is a lack of equity and 28% thinks otherwise.

In the country analysis, it can be considered that those who think that there is equity are those with a unique health system, like it is the case of Cuba.

17% of the participants that answered differently state that in their countries they are heading for a road towards equity, others say that there is equity when the patient lives in urban areas. (Chart 2).

In the question "Do you think that in your country there is EQUITY in the quantity and distribution of FCD (family and community doctor)?



Chat 2. Existence of Equity when rendering Primary Health Care.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

75% of the participants believe the answer to this question is “no”.

7% thought otherwise.

16% of the participants that had a different answer think that distribution and quantity vary according to the geographic area. They state that the number of specialists in FCM depends on salaries, possibility of practising their specialization, training vacancies and status.

They say that FCD has obtained a working position in areas where they are welcome but not necessarily needed or can contribute. 55% of the participants thinks that they are concentrated in big cities. Chart 3.

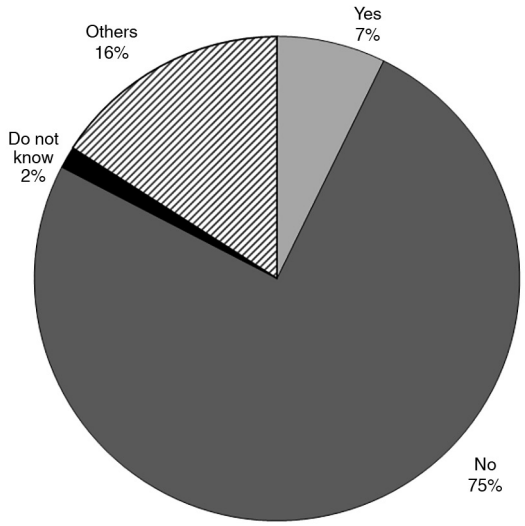


Chart 3. Existence of equity and quantity of FCD per country.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

In the question “Which are the factors that mostly contribute to INEQUITY in terms of Primary Health Care and FCM in their country?”

64 pointed to more than one option, and only 4 answered only one.

About the analysis 44% believe that the lack of qualified human resources is the main cause of inequity.

33% think that health service fragmentation as well as the economic factor are the issues that have the highest impact.

31% pointed to other important factors such as economic conditions and the lack of PHC and FCM government policies, something not applicable in countries with a unique health system such as Venezuela, Cuba and Spain.

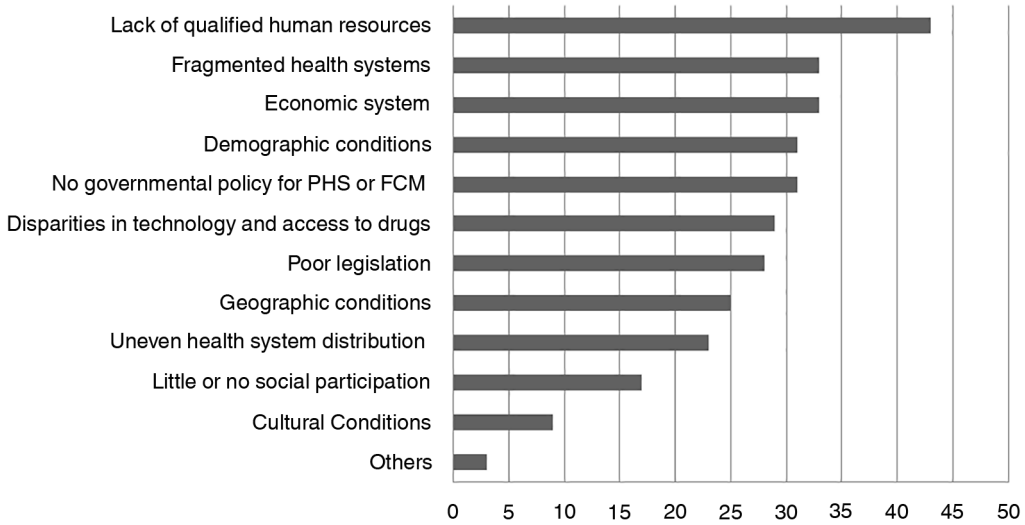
27% believe that the lack of access to technology and drugs leads to inequity.

26% believe that the lack of legislation is an important restriction for developing equity improvement.

25% think that geographic conditions and accessibility limit equity. There are regions in Ibero-America that obstruct health service access.

23% answered that the uneven distribution of health services is another key factor.

17% and 19% think that the lack of social and cultural participation is something to be considered. These two factors are referred to population, health professionals, institutions, agents, politicians and professional organizations (Chart 4).



Chat 4. Factors that contribute to inequity in terms of PHC and FYCM in the country.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

In the question about strategies of the health system in the country to look for equity in terms of PHC and FCM, 26% said that we should find most of the strategies in the search for equity in human resources training and quality, widening the residences vacancies so as to increase the number of specialists and calling to more public bids as a way to getting better qualifies professionals.

20% of the participants considered that demanding the FCM degree to work in the first level is of a great importance too.

Other strategies were: PHC and FCM priorization policies with resource distribution all over the territory and assessment policies all over the country.

A smaller number of participants stated research, monitoring and evaluation are key strategies to equity.

The last question asked whether they agree or disagree with the government strategies to reach equity. 42% of the participants said “no” while 41% said “yes”. A 13% thinks there are no strategies. (Chart 5).

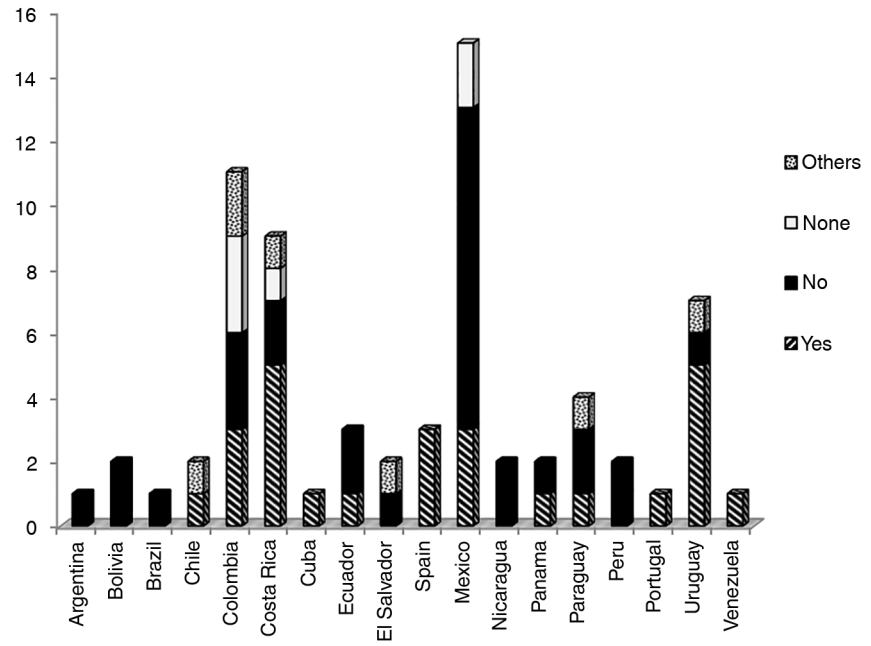


Chart 5. Agreements with the government strategies to reach equity.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

Discussion

To achieve equity in the health system it is required to base it in solid primary health care as it not only depends on medical attention or health systems.

Equity's reach vary according to the several health systems within the same country, whether they are private or public or the areas either urban or rural.

Depending on the countries, public or private services do not make a big difference.

The survey shows no doubt that rural areas are clearly less equitable tan urban ones.

FCM's distribution is inequitable for various reasons; health service distribution, better offers and opportunities in other cities and specialization recognition.

The lack of trained human resources is among equity biggest restrictions, followed by the lack of governmental, legislation or stewardship policies. Health services location has limitations, especially when there is no geographic access.

From the strategies countries have to improve equity, training specialists in FCM is the most important one by means of exams for public service so as to obtain the qualified resources. Adequate distribution, good remuneration and incentive systems are equally relevant.

Government support is of the upmost importance.

In order to narrow inequity gaps, we conclude there should be total support on quality.

40% believes there are no strategies to achieve equity and the same percentage believes otherwise, some cases were reported within the same country. This leads to the reflection that strategies vary according to where they are applied, to geographic location (urban or rural) and resources training within the same country, sometimes equitable and sometimes not.

Regarding the role FCM plays in equity, opinions were based on the idea that FCM is the most equitable of all specializations. This is so because by working in PHS (primary health system) they are inserted in a community where patients live, work, get sick and recover their health. They are closer and know people's needs, providing them

with the right answer without ignoring others' thus permanently generating strategies to achieve equity. Equity is multi- dimensional and since FCM works with a human being vision, they are a key element to develop policies that favor equity principles within a homogeneous public policy.

In order to achieve so, measures should be taken at a political level, participating in policy and standards design in each country. This will only be feasible if the FCD is properly trained, carrying out good clinical, family and community practices, with the correct management inside their work environment, with a dignifying salary equal to other specializations.

The research samples show the following weaknesses: 1) from the quality standpoint, it is not representative, it is a convenience simple; 2) from the quantitative standpoint, it is enough; 69 participants for a universe of 20 countries that make up the region with a representation of 18.

Among the strengths, we were able to make a comparison with the existing literature without finding unstablished factors. We saw a divided universe in this field with highly committed governments to improve equity; nations with various ideas in this field and others far from achieving the goal.

It is necessary to re direct health services towards a context of "public health and equity" so as to focus and reach "better health and its distribution for the population" heading for a model of key factors that consider not only health within the community but also individually.

Placing people in a more active role is essential. When saying "giving more…" it is understood as if there was a group giving and the other receiving. Though there is something of the sort, we should aim for self managed, participative groups, where the most needed is the one who gets the most, without having the above (ones giving the other receiving).

The role of FCM can be more emphatic and determining within equity. FCM can have various chances of impact in this field given its wide range in the professional field and the political nature of the movement at a regional and global level. The chances of promoting equity go from actions and positioning at a clinical level to teaching and investigation; from the research or teaching topics of their choice to their working areas. Its thrive at a community level within local territories is also relevant, fostering the culture of rights and population empowering as well as knowledgeable talks that enlighten both professionals and citizens.

Recommendations

1. Being aware that there is a long way to achieving equity and health care coverage if country governments do not take the necessary actions.
2. Establishing multi - disciplinary and qualified teams led by FCD that facilitate the access to health services to individuals, families and communities within PHC (primary health care).
3. Ensuring resources that enable the team finding solutions to most of the problems/needs families, communities and individuals face (minimum 80%).

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ESSAYS

Health Quality Assessment in Family Medicine and Primary Care in Ibero America

Avaliação da Qualidade em Saúde na Medicina de Familia e na Atenção Primária na Ibero-América

Evaluación de la Calidad en Salud en la Medicina Familiar y en la Atención Primaria en Iberoamérica

Maria Inez Padula Anderson. Rio de Janeiro State University (UERJ), Family and Community Medicine Department; WONCA-Iberoamericana CIMF. Rio de Janeiro, RJ, Brazil. inezpadula@yahoo.com.br *(Corresponding author)*
Macarena Moral. Universidad de Chile; Certified High Management of Health Institutes, Chile. Chile. moralmacarena@hotmail.com
Marcela Cuadrado Segura. Universidad de la República del Uruguay, Community and Family Medicine Department; Sociedad Uruguaya de Medicina Familiar y Comunitaria; CIMF Family and Community Medicine in Rural Areas Group. Uruguay. marcelacua@gmail.com
Thomas Meoño Martín. Universidad Autónoma de Centroamérica de Costa Rica; Costa Rican Family and Community Medicine Association; Caja Costarricense de Seguro Social. Costa Rica. drmeono@gmail.com
Sergio Minué. Escuela Andaluza de Salud Pública de Granada. Spain. sergiominue21@gmail.com
Ricardo Donato. Rio de Janeiro State University (UERJ), Family and Community Medicine Department. Brazil. ricardodonato2@yahoo.com.br
Lilia González. Escuela Nacional de Salud Publica. Cuba. lili@infomed.sld.cu

Working Group
Catalina Coral (Colombia); Christine Leyns (Bolivia), Felipe Moreno-Piedrahita Hernández (Ecuador), Jenny Magne (Bolivia), José de Almeida Castro Junior (Brazil), José Obando Romero (Costa Rica), Lisdamys Morera Gonzales (Peru); Pablo Aravia (Chile), Ajayrakeshvarma Chennareddy (India), Alejandra Paulo (Uruguay), Alexis Correa Taja (Nicaragua), Allison Acevedo (Colombia), Anahi Barrios (Uruguay), Anderson Mondragon (Colombia), Andrea Gamarra (Paraguay), Beatriz Salgado (Chile), Betsy Ballesteros Barragán (Colombia), Carmen Elena Cabezas (Ecuador); Cecilia Llorach (Panama), Daniel Capelli (Uruguay), Débora Teixeira (Brazil), Diana Yuruhan (Paraguay), Dora Bernal (Colombia), Dulce rivera (Mexico), Edgar Leon (Ecuador), Enrique Falceto de Barros (Brazil), Esteban Cordero (Costa Rica), Gabriela Di Croce Argentina Gady Torres (Ecuador), Garcia Vergara Figueroa (Brazil), Henry Solis (Bolivia), Isabel Cristina Puello (Colombia), Jesús Martínez Ángeles (Mexico), Jorge Brandão (Portugal), Juliana da Rosa Wendt (Brazil), Julio Braida (Uruguay), Karen Muñoz (Colombia), Maria Belen Giménez (Paraguay), Marina Almenas (Puerto Rico), Mauricio Alberto Rodríguez Escobar (Colombia), Mery Munive (Costa Rica), Noris Serrudo (Venezuela), Orlando Espinosa Bermúdez (Colombia), Oscar (Mexico), Osvaldo García Torres (Mexico), Patricia Taira Nakandoj (Brazil), Patricia Vargas (Chile), Philipp Oliveira (Brazil), Ricardo Anzures Carro (Mexico), Ricardo Espitia (Colombia), Rodolfo Deusdará (Brazil), Verónica Casado (Spain), Victor Manuel Campos (El Salvador), Xenia Sancho (Costa Rica), Yolanda Flores (Ecuador)

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Abstract

The purpose of this study is to contribute to the development of the concept and the assessment of Quality in Primary Care, under the perspective of Family and Community Medicine (FCM). The study was based on texts reading, discussion in a working-group, and a survey with the application of a semi-structured questionnaire to FCM and other professionals from 19 countries. Information about PC services, as well as the perception of its evaluation processes, including those related to permanent education, motivation and work overload was obtained. The results suggest that the quality assessment of PC in Iberoamerica is still a very incipient process. In addition, with the exception of a few countries, there is not even a universal PC with FCM in the health teams. Considering the principles and practices of the FCM, it seems that there is a limitation of the instruments commonly used to evaluate the quality in PC. It is concluded that to achieve a better quality assessment in order to conduct continuous improvements in the PC services, it is necessary to include indicators related to the concepts and tools of FCM. Considering the competences of the FCM, a quality concept in PC is proposed and dimensions to be included in the evaluation processes are indicated.

Keywords:
Health quality
Family and Community Medicine
Primary Care

Resumo

O objetivo deste estudo é contribuir para o aperfeiçoamento do conceito e dos processos relacionados à avaliação da qualidade na Atenção Primária à Saúde (APS), sob a perspectiva de Médicos de Família e Comunidade (FCM). O estudo foi realizado com base na leitura de textos, discussão em grupo de trabalho e uma pesquisa com a aplicação de um questionário semi-estruturado a MFC e outros profissionais provenientes de 19 países. Foram obtidas informações sobre os serviços de APS e das percepções sobre seus processos de avaliação, incluindo os relacionados à educação permanente, motivação e sobrecarga de trabalho. Os resultados sugerem que avaliar adequadamente e sistematicamente a qualidade da APS na Ibero-América ainda é processo muito incipiente. Além disso, com exceção de alguns países, não existe sequer uma APS universal com MFCs nas equipes de saúde. Por outro lado, se considerarmos os princípios e práticas de MFC parece ser uma limitação dos instrumentos utilizados para avaliar a qualidade em APS, Conclui-se que para alcançar uma avaliação de qualidade que possa ser condutora de uma melhoria contínua dos serviços de APS é necessário incluir indicadores relacionados aos conceitos e ferramentas da MFC. Um conceito de Qualidade na APS é proposto e são indicadas dimensões para ser incluídas nos processos de avaliação, considerando-se as competências da MFC.

Palavras-chave:
Qualidade em Saúde
Medicina de Família e Comunidade
Atenção Primária

Resumen

El propósito de este estudio es contribuir al desarrollo del concepto y de los procesos relacionados a la evaluación de la Calidad en la Atención Primaria de Salud, bajo la perspectiva de Médicos de Familia y Comunidad (MFyC). Fue basado en la lectura de textos, discusión en grupo de trabajo y en una investigación con la aplicación de una encuesta semi estructurada a MFyC y otros profesionales provenientes de 19 países. Fueran obtenidas informaciones acerca de los servicios de AP y de las percepciones de sus procesos evaluativos, incluyendo los relacionados a la educación permanente, a la motivación y la sobrecarga de trabajo. Los resultados sugieren que evaluar de forma sistemática y adecuada la calidad de la AP en Iberoamérica aún es un proceso muy incipiente. Además, excepto por algunos pocos países, ni siquiera existe una APS universal con MFyCs en los equipos de salud. Por otro lado, si consideramos los principios y las practicas de la MFyC, parece haber una limitación de los instrumentos utilizados para evaluar la calidad en AP. Se concluye que para alcanzar una evaluación de calidad que pueda ser propulsora de una mejora continua de los servicios en la AP es necesario incluir indicadores relacionados a los conceptos y herramientas de la MFyC. Un concepto de Calidad en AP es propuesto y se indica las dimensiones a ser incluidas en los procesos evaluativos, considerando las competencias de la MFyC.

Palabras clave:
Calidad en Salud
Medicina Familiar y Comunitaria
Atención Primaria

Introduction

From Alma Ata - the World Health Assembly carried out in 1978 - there have been important advances in the establishment and implementation of Primary Care (PC) models, especially in countries with a more developed economy, but the world is far from achieving the goal set in that conference.[1] In countries with a fragile economy, low implementation of qualified PC is seen as a relevant problem due to a series of conceptual, political, financial and professional obstacles.[2] There is not even a national or international standard regarding concepts and comprehensiveness of the health services that must be taken to get quality in PC. In these countries, different models of PC coexist, and most of the times are focused on specific illnesses control and implemented by means of vertical programs and protocols.[3]

In Latin America, Family Medicine, the specialization by excellence to develop a quality PC, shows different stages of development. With the exception of Cuba and Mexico, it is not necessary to have the specialization to work in PC, contrary to what happens in countries with a more developed economy like England, Canada, Portugal and Spain.[3] But times are changing, and some Latin American countries are experiencing real reforms in their health models, even inside the countries themselves, such is the case of the city of Rio de Janeiro, Brazil.[4]

In this context, when a qualified PC model replaces a non-qualified one, professionals involved in its practice should reflect about it to review its objectives. In this case assessment processes must be re-considered to achieve excellence in the professional practice and to offer new services. To review assessment process in these circumstances should be considered positive, especially when it is suggested in a collaborative way, involving the specialists in PC and their associations. Assessment must be considered in this context a key instrument for the continuous quality improvement in Primary Care.[5]

Furthermore, the concept of quality in health, itself, must evolve. With humanity development and advances in medical biotechnology, it is necessary to make a call to re humanize health care and offer higher quality services from a holistic standpoint, including human resources, commitment and the political it is required to offer good health care. The concept of Quality must be thought from a multi disciplinary perspective,[6] with the right professionals and accessible and equal health services.[7] Quaternary Prevention concept must be included (avoiding, reducing and palliating the damage brought about by medical interventions).[8] Patient's satisfaction and expectations with the services received must be evaluated as an active and relevant part of this process.

It is important to highlight that quality has a historical and cultural connotation, that is to say, specific for a given society. Subjective, psychological and social factors are important among individuals, professionals and the community (believes, values, etc).[9] In other words, PC quality improvement must be a permanent goal and adjust to the new challenges, in the growing complexity of people's health needs as to the epidemiological and demographic transition and the current social and political context.[10]

Bárbara Starfield[11] studied many health systems (mainly from the 90's during the XX century) and evidenced that the main characteristics to define a quality PC is related to seven attributes. Four essential attributes: 1) first contact/ access, 2) longitudinality, 3) comprehensiveness and 4) coordination; and three derivate ones: 1) family orientation, 2) community orientation and 3) cultural competence.

Considering the hypothesis that PC quality evaluation is insufficiently developed in Latin and Ibero America, this research has the purpose of contributing to concept and practices of Quality in health from a Family and Community Medicine perspective.

Metodology

Exploratory research with quali-quantitative approach, developed by a task force for pre, per and post activities of the 6th Family Medicine Summit, that took place in San Jose, Costa Rica, in April 2016. As part of the working process, the first step involved creating a group of representatives from Family and Community Medicine Associations in Ibero America in October 2015. Then, literature data collection directed to PC evolving processes, highlighting the ones used at a country or regional level was carried out. During January and February 2016, with the help of the task force, a semi structured survey was created and used with Family and Community Medicine (FCM) and other interested professionals coming from 19 countries who answered through an online mode. The survey searched for the characteristics on the services surrendered by PC in those countries, as well as perceptions on their assessment processes. The information obtained covered: profession, specialization, knowledge on quality assessment in their countries; the assessment characteristics included: professionals participation, frequency, national adoption or not; used indicators, unit activity planning, type of services rendered to the society as well as feeling overwhelmed or motivated to work. Next the task force met to analyze and debate on the data, taking survey results into consideration for later recommendation on the subject.

Results

PC quality reasearch

Research was conducted with the following search words: quality, primary care and family medicine with the objective of finding information to evidence a country or region perspective, specially in Latin or Ibero America. A systematic literature review carried out in Brazil was identified,[12] with the purpose of identifying national or international instruments for PC evaluation. This article found 3048 studies, published between 1979 and 2013. Validated and highlighted instruments translated to Portuguese, Spanish and English were: (1) WHO Primary Care Evaluation Tool (PCET); (2) ADHD Questionnaire for Primary Care Providers (AQ-PCP); (3) General Practice Assessment Questionnaire (GPAQ), PACOTAPS (Applied to APS); y (4) PCA Tools (Primary Care Assessment Tool), (5) EUROPEP (European Task Force on Patient Evaluation of General Practice Care and (6) PMAQ (National Program for Access Quality improvement and Quality in Primary Care) used in Brazil.

Among these, we must emphasize 3 for having a wider nature including, necessarily PC organization and practice and for committing health teams in the assessment process. Besides, they are being used in an international or in Latin American countries such as Brazil:

a) PCA Tool based on health services quality assessment model suggested by Donabedian[13] - structure measurement, process and results - developed by Starfield's team at John Hopkins University is composed of 77 questions (items) within the 7 PC attributes and allows, by means of Likert type answers, a punctuation from 1 to 4 for each attribute. It is directed to health professionals and the population they served. There is no distinction between general physicians or family doctors or any other specialization, not even if the professional is a nurse. It does not include specific approaching techniques or tools centered in people, family or community.

b) PMAQ-AB (2011), used in Brazil to evaluate and foster family health strategy advance/APS,[12] it has been specially elaborated and implemented for the PC context. It also includes health professionals that integrate teams, users and local and central health managers. It was the result of governmental initiative. The goal is to widen the access and improving the quality of PC, assuring a comparable pattern of national, regional and local quality to allow higher transparency and effectiveness of government actions directed to PC. It is based among others, mainly on:
   - Health Team Self Evaluation. Based on the answers from the participants, even users, fosters the group to review the working process and the way to change it to overcome problems and reach the goals set for that group.
   - Monitoring: attention indicators record and social demographic data.
   - Permanent Training: Fostered by team/community local needs demanding from their actors (workers, agents and users) higher analysis skills, intervention and autonomy for setting transforming practices.
   - Besides Professionals evaluation, it is an external assessment based on:
     - A process of incremental, continuous and progressive improvement of patterns in quality and access indicators covering: management, work process and results achieved.
     - Transparency at every stage, allowing permanent follow up for the actions and results.
     - Voluntary Participation: in PC teams as well as in municipal agents, success depends on motivation and the pro activity of the actors involved.

c) EUROPEP - devoted more specifically to explore PC quality from the user's perspective, it is a patient's evaluation system on the services provided by family physicians. EQUIP[14] developed it during the 90's with

collaboration from different European countries. Its objectives are improving practice, performance and assistance of family physicians in PC. EUROPEP is made of 3 parts:

1. Key Indicators (relation and communication, health care, information and support, continuity and cooperation and new services organization.)
2. Satisfaction indicators specific areas: (consultation, programmed agenda and access, professional characteristics, health centers conditions and rendered services).
3. Users information: (social, economic and health data and attitude after the service).

It does not discriminate doctors' specialization either.

Survey's result

81 professionals from 19 countries answered the survey: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Spain, Mexico, Nicaragua, Panama, Paraguay, Peru, Portugal, Puerto Rico, Uruguay, Venezuela; two came from other regions: India, and US. The professionals that answered the questions were considered key informants once they represent Ibero-American Family Medicine Associations and/or had been indicated by them. Distribution, complying with their working activity, was as follows: Family and Community Physicians: 87.7% (71 participants); FCM Residents: 9.9% (8); Health Agents: 2.5% (2).

Regarding whether there was systematic evaluation at PC level, 41% responded negatively. In the cases of positive answers, there was criticism on the quality of the tool used, as it would not reflect precisely whether there is quality service or not (Figure 1).

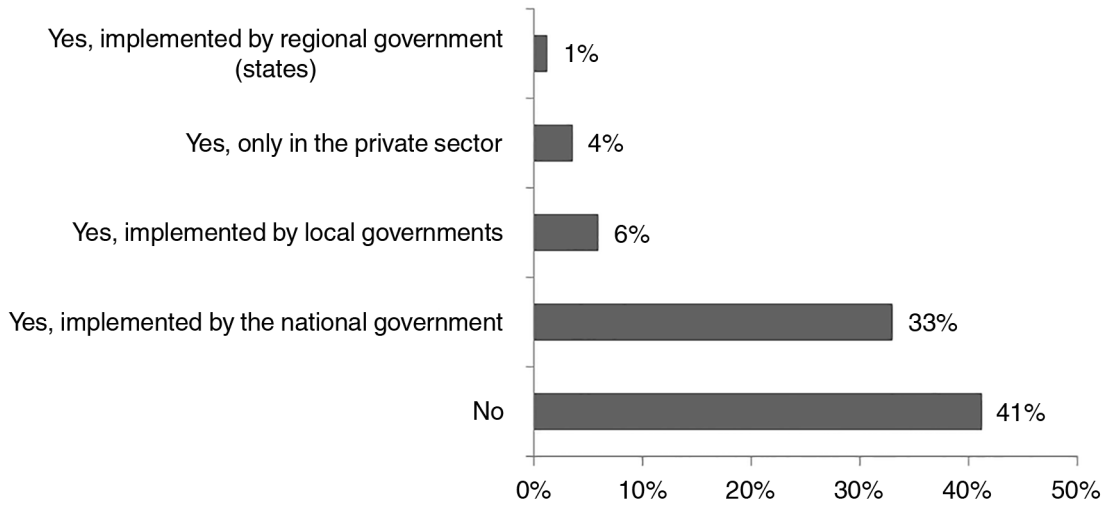

Figure 1. Does your country systematically evaluate quality in PHC?
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Regarding frequency: 41% reported it is performed once a year and 39% said it was every six months.

Regarding perception on motivation and professional work load, 91% said it is not systemically assessed. Whether Family and Community Physicians (FCPs) are motivated (Figure 2), 80% thinks that FCPs in their countries feel overwhelmed with the work load (Figure 3).

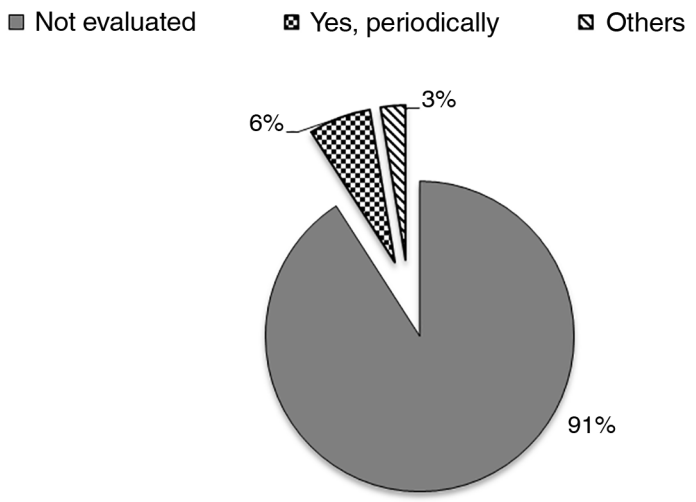

Figure 2. Does your country systematically evaluate if FCP are motivated to work? (77 answers)
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

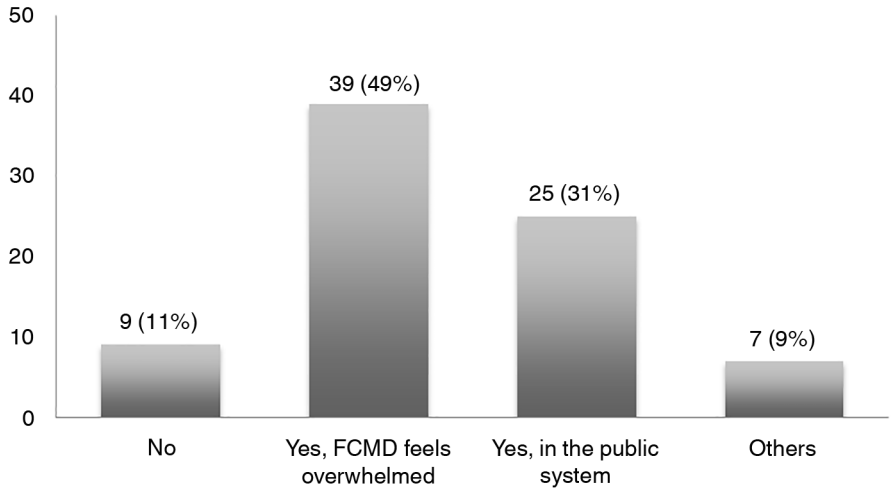

Figura 3. Do FCMDs in your country feel overwhelmed with the work load?
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Health Professionals direct participation in PHC units on quality assessment processes

Around 67% reports they do not participate directly and around 29% stated they assess the services themselves.

Health Action Planning and/or work process organization

35% said there are not frequent meetings with this purpose. For those who meet, they have a monthly frequency for 43% of the cases, weekly for 27% and six monthly for 22%.

Health professionals' continuous training performed according to local population health needs

Around 70% answered positively. Round this topic, some reported that many times FCPs do not feel interest in getting training and others said that FCPs participate in training but the rest of the professionals in the unit, do not.

PC assessment indicators

Regarding PC quality assessment indicators, quantitative ones are the most used (50%) - illnesses prevalence and incidence (29%). Only 23% states that their country use process indicators to assess PC for example: (Body Mass Index decreasing rate - BMI) in obese people and smoking interruption rate, among others).

Among PC essential and derivate attributes according to Barbara Starfield, the most used indicators to assess the participants within the survey were: access ones (34%) and care coordination (19%). Cultural competence, community and family approach, and longitudinal reach less than 15% (Figure 4).

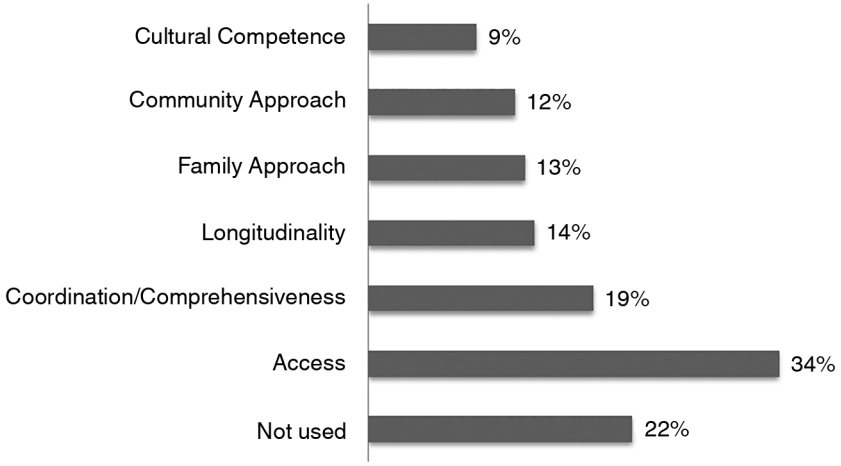

Figure 4. Considering essential and derivate attributes in PC (according to Barbara Starfield) mark indicators frequently used in your country.
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Services rendered in PC

For most participants (78%) there is a PC assistance package, but 43% thinks this is not equal all over the country. On the other hand, there seem to be important restrictions to access some services in health units: Electrocardiogram (ECG) is available in 48% of the cases, X Ray imaging testing in 38%, Eco Scan in 4% and other diagnostic tests in 46%. At the same time, there are barriers to access TSH measurement (thyroid stimulating hormone), Glycated Hemoglobin or Myocardial Scintigraphy.

Regarding services provided at PC, 69% reported childcare is not performed within the services. Home visiting, genre and sexuality approaches and mental health services are performed in 60% of the cases. Social participation and health educational group activities only in a 38% and 25% respectively (Figure 5).

Discussion

This research shows the limitations of an exploratory investigation. Thus, it has a problematized perspective and invites to a deeper reflection on health care practices and PC assessment processes from FCP's standpoint in different Latin American countries. It raises potentially relevant problems in the process, such as the possible limitations on existing assessment tools and even the mere lack of processes on quality assessment.

Based on the previously mentioned PC quality assessment revision article, it can be said that on PC quality research there is no specific consideration on the existence or need of having Family Physicians in the teams as a quality parameter. Probably because most of the research is done in countries where FM is a compulsory specialization, required to work in PC, thus no need to explain it. But that is a potential problem when the research is done in

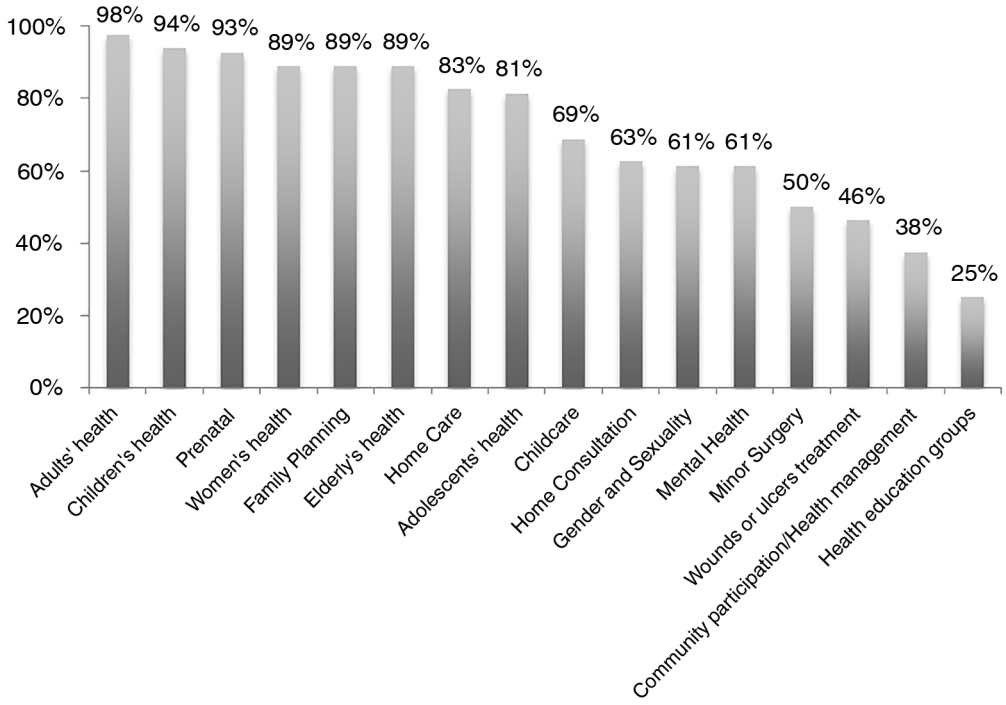

Figure 5. Services rendered in PC units according to participants.
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

countries where the specialization is optional, there might be the chance of mistakenly attributing PC, per se, with or without the FM, the good or bad results.

It is important to say that research does not generally cover specific tools used every day in clinical practice on people, family or community centered approach, like genogram, Eco map, technics of community diagnosis, etc. These dimensions are assessed on the user's or on the health professional's general impression. It is possible that is a limited perception because of local conceptions on what FCM is, thus the use of specific tools during practice is generally placed on common sense.

The fact that there is little systemic investigation on PC organization or performance and no critical vision of institutional mechanisms for its monitoring it is really a worrying problem.

Regarding survey results, it is relevant, for example the fact that there is no research on FCM's professional motivation or work overload, not even on user's satisfaction.

Most people reported that there is no direct participation of health professionals in PC units on quality assessment. It is worrisome that evaluation indicators are mostly quantitative with very little attention to process indicators.

It is surprising the limitation or even the lack of existence itself, of some PC basic services, including childcare, home visiting, mental health approach and topics such as genre and sexuality. Social participation and health education groups activities do not take place as expected or required.

At the same time, there seems to be little interest in evaluating PC essential or derivate attributes such as coordination, longitudinality, cultural competencies and family and community approaches. There are still obstacles to access evaluations; and although there are PC packages available, they are insufficient or heterogeneous even inside the countries themselves.

We can mention as positive results, the existence of health actions planning and the organization of PH working process in most of the answers, as well as the existence of a continuous professional development process for health professionals.

Conclusion

Implementing a universal PC in Latin America with FCPs inside the teams represents a challenge. Evaluating PC quality in Ibero-America is under development and there is still much to be done. In order to achieve it with efficiency, respecting current health quality standards as well as FCPs' ones, it is essential to involve FCPs to create, review and suggest improvements for the existing tools. It is necessary and strategic to include tools and specific aspects of FCM practice. Maybe they are not frequently approached or correctly included when quality parameters are created only by other professionals or specialists.

FCPs should be involved in practical activities related to PC quality evaluation either in an assessment role or as active health professionals. It is crucial to point out the need to specify the existence or lack of existence of FCPs inside the health teams as one of the most relevant factors to consider quality in any PC.

As contribution to this work, from the proposals and considerations obtained, we believe that:

- QUALITY in Family and Community Medicine as a specialization and PC as a strategy must be interdependently assessed.
- It must be a process of continuous improvement based on a quantitative, qualitative, systemic and dynamic assessment.
- It should retro feed and perfect health actions developed and directed to a given population assigned to a PC unit.
- It should cover self regulatory and self evaluating mechanisms, involving professionals from the health teams, people, families and the assisted community.
- It must be related to a role of principles and actions which must be evaluated in a systemic, permanent and dynamic mode having in mind that the target is the development and continuous improvement of:
  - The Essential Attributes (Access/Access gate; Health Coordination, comprehensiveness, longitudinality) and PHC Derived Attributes (Family Orientation, Community Orientation, Cultural Competency);
  - The strategies and tools derived from FCM (Biological, psychological and cultural approach of the health-illness process, Person centered approach, family and community oriented care; independently of their gender, age group of health state;
  - The Clinical practice with high responses to the most frequent health problems presented in a given population.

It must necessarily cover multi dimensional indicators related to 10 groups of essential elements:

1. PC essential and derivate attributes.
2. FCM tools, with the biological, psychological and social paradigm as basis and a systemic perspective, including that used for the People, Family and Community Centered approach - for example, genogram and community diagnostic instruments among others.
3. Health Care considering health problems and needs along people, families and a given community life cycles.
4. Basic health team for a given population group, minimally with a family physician, a nurse and health technicians.

5. Effectiveness and equity in the health services offered, considering the inverse care law and patients safety, based on quaternary prevention principles.
6. The social and health team participation in the diagnosis of health problems as well as on the planning of the services to be offered.
7. Health team members' continuous development of professional and personal competencies, including their work motivation and satisfaction.
8. PC role inside the health system, considering integration, coordination and reference and counter reference among the different health care levels and considering other inter sectorial actors as well.
9. Adjusting the diagnosis and therapeutic process according to health needs, assuring the necessary resources, including structure and functional conditions in the health unit.
10. People, families and communities safety and positive experiences in relation to the professional care humane treatment and provided health services.

Considering the presented and discussed concepts in this task force, we have the following guidelines:

1. Suggesting a model for assessing quality in FCM and PC in Ibero America taking into account the characteristics and concepts proposed in this document; and considering existing and available instruments, specially PMAQ and PCATOOLs. both already translated into Spanish and Portuguese.
2. Organizing and implementing regional research so as to stablish a base line that allows achievement assessment and goes hand in hand with continuous improvement of quality in PC and FCM in Ibero-America.
3. Standing for the implementation of an assessment model suitable for PC and FCM within health systems in Ibero-America and maybe at an international level.

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ESSAYS

Referral and Counter-Referral Patient Management Systems in Latin America: Care Coordination Mechanisms and the role of Family and Community Medicine

Os Sistemas de Referencia e Contra-Referência de pacientes na América Latina: Mecanismos de Coordenação Assistencial e papel da Medicina de Família e Comunidade

Los Sistemas de Referencia y Contrarreferencia de pacientes en América Latina: Mecanismos de Coordinación Asistencial y el rol de la Medicina Familiar y Comunitaria

Miguel Ángel Fernández Ortega. Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM); Subregión Mesoamérica de Confederación Iberoamericana de Medicina Familiar (WONCA Iberoamericana-CIMF). Ciudad de México, México. miguelaf03@live.com *(Corresponding author)*

Jacqueline Beatriz Roo Prato. Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM). Ciudad de México, México. jroop3@gmail.com

Arnulfo Emanuel Irigoyen Coria. Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM); Academia Nacional de Medicina de México. Ciudad de México, México. coriaa@unam.mx

Sofía Blanco Lara. Asociación de Medicina Familiar de Costa Rica. Costa Rica. sifiablanco@yahoo.com

Alan Edward Barrell. Ex Asesor de la Facultad de Medicina, Universidad Autónoma de Guadalajara, México. aebarrell@yahoo.com

Víctor Manuel Juárez Téllez. Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM); Instituto Mexicano del Seguro Social (IMSS); Representante por Waynakay, México. victorjt82@gmail.com

Working Group

Alexis Correa Taja (Nicaragua); Ana Margarita Muñiz Roque (Cuba); Ana Lucía Meyer (República Dominicana); Ariel Cruz Igartua (Puerto Rico); Cecilia Llorach (Panamá); Guillermo Franco Gil (México); Grace Bethel Aparicio (El Salvador); Mariela Rodríguez (Chile); Miguel Ángel Fernández Ortega (México); Sofía Blanco Lara (Costa Rica); María Alicia Macedo Cantero (Paraguay); Neimaru Abreu (Venezuela); Victor Salvador Narcizo Zarate (Perú); Paulo Poli (Brasil); Miguel Ángel Suárez Cuba (Bolivia); María del Rosario Caballé (Argentina); Víctor Manuel Juárez Téllez (México); Jorge López Gálvez (Chile); Daniel Ulate Gómez (Costa Rica); Karla Patricia Jiménez Ríos (Costa Rica); Ma. Alicia Macedo (Paraguay); Pablo Armijos Peña (Ecuador); Ysabel María Díaz Brito (República Dominicana); Flavia Solórzano Morera (Costa Rica); Melba Váques Escalante (Costa Rica); Adriana Villafranca Brenes (Costa Rica); Willy Loria Quiros (Costa Rica); Roberto Cerda (República Dominicana); José Adalberto Mejía (Honduras); Ada Alicia López (Honduras); Aron Hernández Cervantes (Costa Rica); Joao Werner Falk (Brasil); Ricardo Fábrega (Chile)

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Abstract

The results of the Situational Analysis among their various levels of healthcare of 16 countries in Latin America related to their Referral and Counter-Referral Patient Management Systems are presented in this document. The research results were analyzed by WONCA Latin America country member representatives at the VI Ibero-American Family Medicine Summit in San Jose, Costa Rica in April 2016.

Keywords:
Primary/Secondary Integration
Health Systems
Primary Healthcare
Family Medicine

Resumo

São apresentados os resultados do diagnostico situacional de 16 países da América Latina em relação aos seus Sistemas de Referência e Contra-Referencia de pacientes entre os três níveis de atenção médica. Os resultados da pesquisa foram analisados por representantes dos países membros da WONCA Ibero-Americana CIMF no âmbito da VI Cúpula Ibero-Americana de Medicina Familiar em San Jose, Costa Rica em abril 2016.

Palavras-chave:
Integração Primária/Secundária
Sistemas de Saúde
Atenção Primária de saúde
Medicina de Família

Resumen

Se presentan los resultados del diagnóstico situacional de 16 países de América Latina, en cuanto a sus Sistemas de Referencia y Contrarreferencia de pacientes entre los tres niveles de atención médica. Los resultados de la investigación fueron analizados por representantes de los países miembros de WONCA Iberoamérica CIMF, en el marco de la VI Cumbre Iberoamericana de Medicina Familiar en San José de Costa Rica en abril de 2016.

Palabras clave:
Integración
Primaria/Secundaria
Sistemas de Salud
Atención Primaria de salud
Medicina Familiar

Introduction

According to the World Health Organization (WHO), governments around the world have the responsibility to ensure that, their health systems meet the needs of its population effectively and efficiently, basing their models Health in Primary Care (PHC). Based on this premise, the Member States was committed in 2005 to develop their health financing systems so that all people have access to services and not suffer financial hardship to pay for them, this objective is defined as "Universal coverage".[1]

Mrs. Margaret Chan, Director of WHO mentioned "between 20% and 40% of health spending is wasted by inefficient health systems". The lack of planning in the services provision, resources duplication, registration and information inefficient systems, as well as the lack of properly trained and qualified human resources lead to the networks ineffectiveness to provide services. Therefore generating serious problems of access and coverage inequality resulting in the death of many people each year.[1]

WHO suggests that a healthcare system "consists of a set of organizations, people and actions whose purpose is to promote, restore or maintain health".[2-4]

In 2011, during the 64th World Health Assembly of WHO the final agreement regarding the Integrated Services Delivery Model, was worded as follows:

> *"The healthcare organization is evolving into a sort of "Integrated Services Delivery networks". Through adapting the acquired experience in the development of district health systems to a pluralistic healthcare system. The actual integrated services delivery networks are organized as primary care providers who are either close to the customer - public, private or mixed, and backed by hospitals and specialized services. These networks are responsible for the health of a defined population, offering services of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care...".*[1,5]

In this regard, WHO, mentioned in the document "Renewing Primary Health Care in the Americas" 2007:

> *"Primary care services should be supported and complemented by different levels of specialized care, both ambulatory and hospital ambiance, as well as the rest of the network of social protection. For this reason,*

Healthcare Systems should work seamlessly for the development of mechanisms that will allow coordination of care across the entire services spectrum, including the referral and counter-referral patients network development...".[6]

In many countries of the world, their health systems have been organized under the strategy of levels or staggering of medical care. A keystone of these systems are the operational units identified as of the first level (Clinics, Family Medicine or Family Health Units, Basic Health Centers, etc.), which provide specific outpatient care and solves between the 80-85% of most common health problems with only using low complexity technology support.[7-16]

The second level of care, with medium complexity technology resources, involves General hospitals, Specialty Clinics and the so called Polyclinics, and is responsible for solving the 10-15% of health problems referred by the primary care or those consulted spontaneously through the emergency departments.[14-16]

The third level of care is handled through "The National Institutes of Health and Medical Specialty Centers which are designed to meet 5% of the health problems that require highly complex technology resources and the highest levels of medical savvy...".[14-16]

The integration between the various levels of medical care, working as a coordinated network of health services, promotes the continuity and integrity in the service delivery; this translates in most countries as the Referral and Counter-Referral Patient Management System (R&CRPMS).[17]

The Referral and Counter-Referral Patient Management System (R&CRPMS) is defined as the coordination process between the operational units of the three levels of medical care. The basic purpose is to facilitate sending and receiving patients, in order to provide timely, comprehensive medical care and quality which goes beyond the limits of regional and institutional levels for the benefit of the patient.[7,8,11-14]

From a general perspective, R&CRPMS is organized according to the needs of each country in two forms: geographically or institutionally oriented, although there may be a mixture of both. It is also known that there are different levels of organizational structure, ranging from the national or federal level; state and local (county, municipal or city hall). System effectiveness and efficiency, mainly in the execution of processes of counter-referral varies.[7,8,11,12,17-20]

Objective

Through a Situational Diagnosis, determine the Referral and Counter-Referral Patient Management System (R&CRPMS) status in the health systems of the countries of Latin America in order to identify strategies linked to the practice of Family Medicine in the countries of the region that can be strengthen.

Methods and Material

This paper is the result of a transversal, exploratory situational diagnosis study, performed between October of 2015 and March of 2016. An official invitation was issued to the 20 WONCA Ibero-American Presidents of Family Medicine country associations, so they could appoint one or two expert delegates per country for this purpose.

Among its participants, academics, researchers, clinicians and national scientific society boards' members were included. They main task was to answer a 33 items questionnaire related to the Referral and Counter-Referral Patient Management System (R&CRPMS) in their respective countries.

The questionnaire's content was originally reviewed and validated by teachers and professors from different educational institutions of Mexico and Costa Rica, and in a second stage by the group of study participants.

The evaluation tool was sent by email to each of the participants, and their answers identified per country. The final answers joint report was sent for review of its contents and approval to all the participants. Further analysis and discussion of this material was done at the working sessions of the VI Ibero-American Family Medicine Summit in San Jose, Costa Rica in April 2016.

Results

Sixteen out of the 20 invited countries did answer the questionnaire, so this report integrates the answers from: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Dominican Republic and Venezuela. The countries that did not provide answers were Ecuador, Spain, Portugal and Uruguay.

We will describe the results:

Health Models that have Family Medicine Specialists

All of the countries that answered mentioned that they consider the Family Medicine Specialist as part of their Healthcare Model. In some countries with a greater degree of consolidation to this role as in Cuba, Brazil and Mexico, while in others as Panama, Peru, Paraguay, Costa Rica, Dominican Republic and Colombia a considerable progress has been made in light of new reforms to the Health Systems so the Family Medicine Model and Family Healthcare become keystones of their systems.

Levels of care in the Latin American countries

Of the surveyed 16 countries, one hundred percent reported having three levels of care. Each one classified accordingly to a complexity degree, where the first level of care corresponds to a set of activities with less infrastructure and the largest coverage as a generalist service provider. In the case of Colombia the system also describes three levels of care, however, in the healthcare environment, "a fourth level" is mentioned, which actually corresponds to the third level of care in the rest of the countries.

Family Medicine Specialists' role in the medical care levels

The Family Medicine Specialists are mainly assigned to the Primary Care Level in all the evaluated countries. Cuba, Brazil, Panama and Venezuela considered an almost exclusive clinical and administrative participation in primary care. The other 11 countries such as Argentina, Bolivia (National Health Fund), Chile, Colombia, El Salvador, Mexico, Nicaragua, Paraguay, Peru and the Dominican Republic, also reported a predominance of the Family Medicine Specialist into Primary Care in their care assignment. However, they in these countries they can also be located on the Second Level of Healthcare, involved in hospital emergency care, chronic degenerative diseases, palliative care efforts and administrative functions. Only in the cases of Costa Rica and Puerto Rico, it was stated that administrative tasks and medical management was referred as the main work environment for them (Table 1).

Table 1. Location of family physicians based on their roles in the levels of care

1st Level (Medical Care and Administrative Tasks)*	Cuba, Brazil, Panama, Venezuela
1st and 2nd Level (Medical, Administrative Tasks, Emergency Room Duties)*	Argentina, Bolivia, Chile, Colombia, El Salvador, Mexico, Nicaragua, Paraguay, Peru, Dominican Republic.
1st, 2nd y 3rd Level (Administrative and Managerial Tasks)*	Costa Rica and Puerto Rico
Teaching/Educational	All of them (except Nicaragua)
Research*	None

*As main activity.

Referral and Counter-Referral Patient Management System (R&CRPMS) existence

All of the evaluated countries do have a Referral and Counter-Referral Patient Management System (R&CRPMS). Thirteen of them in a national level well defined way. Four names were the most commonly way to address them mainly due to local spelling variations: Sistema de Referencia y Contrarreferencia de pacientes (Bolivia, El Salvador and Puerto Rico), Sistema de Referencia y Contrarreferencia de pacientes (Colombia, Cuba, Mexico, Peru And Dominican Republic), Sistema de Referencia y Contra-referencia de pacientes (Brazil, Chile, Paraguay and Venezuela); in Panama There is a small variation in the wording including "Unique"; so it is known as Sistema Único de Referencia y Contrarreferencia (SURCO). In spite of the modalities, they are all indicative of a system for patient referral in their healthcare environments. Argentina, Colombia and Peru do not have a consolidated national referral system; rather they work at an institutional level. In the same token, neither Costa Rica, Argentina or El Salvador have a precise legal framework, however, their Healthcare Ministries are working in the creation of integrated networks of services that will allow controlled flow of patients through the different levels of care.

The Role of the Family Physician as "gateway" to the health system of each country

Nine of the 16 surveyed countries indicated the mandatory pre-review by a Family Physician or a General Practitioner prior to other specialists access and further hospital services. Access to specialized medical services without involving the Family Doctor or General Practitioner is acceptable in Argentina, Colombia, El Salvador, Nicaragua, Peru, Paraguay and Venezuela (Table 2).

Table 2. The Family Physician as a gateway to the health system

1st Level Mandatory Clinical Review	Bolivia, Brazil, Chile, Costa Rica, Cuba, Mexico, Panama, Puerto Rico and Dominican Republic
They can Access further Specialty levels	Argentina, Colombia, El Salvador, Nicaragua, Peru, Paraguay and Venezuela

Regionalization and patients' office assignment for the Family Medicine Specialists and the General Practitioners

About regionalization and patient population assignment per each Family Doctor or General Practitioner, we found that in 11 of the 16 questioned countries there is a reported associated geographical distribution of the office attached population (Bolivia, Brazil, Chile, Costa Rica, Cuba, El Salvador, Mexico, Paraguay, Puerto Rico, Dominican Republic and Venezuela). The shared indexes included variations ranging from 1,500 patients in Cuba; 2500 in Mexico and the Dominican Republic and more than 10,000 patients in the case of Bolivia in different health institutions. This data is not available in the case of Argentina, Colombia, Nicaragua, Panama and Peru, as it has not been possible to carry out this regionalization process, or it has only been partially accomplished.

R&CRPMS at the inter-institutional level

In three of the 16 researched countries the actual inter referral of patients cannot be done (Bolivia, El Salvador and Dominican Republic). In the remaining 13, it may be performed under different referral mechanisms such as administrative cooperation agreements or subrogated payments for rendered services (Table 3).

Table 3. Overview of the Referral and Counter-Referral Patient Management System (R&CRPMS) in Latin America

Country	Levels of Medical Health Care in LA	Fam Med location in the Health Care Levels	Teaching	R&CRPMS	Legal Frame	FAM as gateway for other Health Care Services	Assigned Patient Population per Office	Inter-Institutional R&CRPMS	Electronic Record Availability
Argentina	3	1st & 2nd	Yes	Not in all the country	No	No		SI	No
Bolivia	3	1st & 2nd	Yes	Yes	Yes	Yes	5000	No	No
Brazil	3	1st	Yes	Yes	Yes	Yes		Yes	Certain Areas Only
Chile	3	1st & 2nd	Yes	Yes	Yes	Yes		Yes	Yes
Colombia	3	1st & 2nd	Yes	Yes	Yes	No		Yes	Certain Areas Only
Costa Rica	3	1st, 2nd & 3rd	Yes	Yes	Yes	Yes		Yes	Certain Areas Only
Cuba	3	1st	Yes	Yes	Yes	Yes	1500	Yes	No
El Salvador	3	1st & 2nd	Yes	Yes	No	No		No	No
Mexico	3	1st & 2nd	Yes	Yes	Yes	Yes	2500	Yes	Yes
Nicaragua	3	1st & 2nd	Yes	Yes	Yes	No		Yes	No
Panama	3	1st	No	Yes	Yes	Yes		Yes	Yes
Paraguay	3	1st & 2nd	Yes	Yes	Yes	No		Yes	No
Peru	3	1st & 2nd	Yes	Yes	Yes	No		Yes	No
Puerto Rico	3	1st, 2nd & 3rd	Yes	Yes	Yes	Yes		Yes	Yes
Dominican Republic	3	1st & 2nd	Yes	Yes	Yes	Yes	2500	No	Certain Areas Only
Venezuela	3	1st	Yes	Yes	Yes	No		Yes	No

In 15 of the 16 countries (except Colombia), the processes are very similar. There is a basic need to send a patient from the primary care level to a given hospital, either for further medical care or for studies with equipment that does not exists at the initial level of care. Most of the countries (except Venezuela and El Salvador) agreed that must they fill a Referral form (either in a printed or an electronic version), stating the patient data, specialty interconsultation request and referral justification. In Paraguay, the applicant physician, through a telephone conference to the referral hospital physician, presents the patient. Mexico's delegates indicated that it is mandatory to comply with all the diagnostic protocols in each specialty (lab tests and Xrays). In their case the referrals must be authorized by the Leader of the Consultation Section that is sending the patient Senior Consultant.

Who is responsable for the patient referral?

In all the 16 countries, the responsible referral professional is the General Practitioner, or a Family Medicine Specialist. Although, it is important to mention that in Bolivia, Chile, Cuba, Mexico, Paraguay, Puerto Rico, Dominican Republic and in some regions of Brazil, there are other professionals responsible for validating and authorizing the request for the patient referral to a second level of care.

Referral and Counter-Referral Patient Management System (R&CRPMS) control mechanisms in the health care units

In only four of the 16 surveyed countries, a set and well-defined group of control measures between the hospital received referral patients and the primary office patients or home unit counter-referrals were observed. From a general overview, the structured control mechanisms from Chile, Cuba, Mexico and Panama are summarized below:

Chile: all referral processes must be entered to the SIDRA platform; which involves patient transcript data electronic recording. This system allows a monitoring process of referral and counter-referral between the 2nd and 3rd level of care, allowing to identify waiting and allocation of hours on behalf of the patients care. In addition, integration meetings between PHC managers, secondary care managerial staff, and Quality referral analysts are done.

Cuba: there are two instances, the first one is through the Assessment Committee for Quality in Hospitals and PHC and the second one is through Integration Meetings in which PHC managers joint the secondary care staff and the referral and counter-referral process is analyzed.

Mexico: In each of the different health institutions, Referral and Counter-referral control areas had been set. The do monitor patient registrations at their arrival to the hospital and departure to their base clinic of Family Medicine as counter-referral. They verify the correct filling of the registration forms and the reception of the prescribed pharmaceutical treatments. In addition, the grading of the quality indicators in the referral and counter-referral processes are of importance to achieve the certification of the medical care units in each of their healthcare levels.

Panama: The referral transfer made by Family Medicine Specialist or an Internal Medicine deputy must be confirmed and accepted in the hospital through the Department of Medical Records and Health Statistics.

Management of electronic medical record in the first level healthcare units

Of the reviewed 16 countries, a group of seven (Argentina, Bolivia, Cuba, El Salvador, Nicaragua, Paraguay and Venezuela) reported not to have this tool in their first level of care. Different degrees of progress in the widespread use of this instrument was reported by the other nine countries. The most consolidated ones seem Chile, Mexico, Panama and Puerto Rico. Brazil, Peru, Colombia, Dominican Republic and Costa Rica have it available in certain regions of their countries.

Electronic management systems for patient referral and counter-referral in Latin America

Electronic institutional managerial systems for patient referral (i.e. medical appointment control) and subsequently counter-referral are currently being developed. According to our survey, none of the countries has set it as a standard practice. Only five countries recognized a partial level of usage: Chile works through its Information System for Assistance Network (SIDRA), Panama efforts are done through their Social Security Fund (CSS) and some health centers in the capital city organized by their Health Ministry. Only the Mexican Social Security Institute (IMSS) uses it in Mexico and Peru's response in this matter is dealt through the Social Health Insurance (EsSalud).

Use of diagnostic protocols or clinical practice guidelines for patient referral

Ten out of the sixteen countries reported having diagnostic protocols or clinical practice guidelines: Bolivia, Chile, Cuba, Colombia, Costa Rica, El Salvador, Mexico, Nicaragua, Panama and the Dominican Republic.

R&CRPMS effectiveness: defined as counter-referred percentage of patients in relation to the referral numbers

Most countries do not have accurate data precise on the detailed percentage of counter-referred patient numbers. Still, it is noticeable that countries who have control mechanisms report the highest general percentages between the referred patients and those who returned to their clinics; as we could analyze in the case of Chile, Cuba and Mexico.

R&CRPMS Monitoring Committees in the medical units

We found that 10 countries have R&CRPMS Monitoring Committees in various health institutions. Cuba, Mexico, Puerto Rico and Peru have them on a national widespread scheme. Other countries such as Bolivia, Brazil, Colombia, Costa Rica, Nicaragua and Panama have them on an irregular pattern.

First Healthcare Level Physicians shared profile among the countries in the region

In countries like Cuba, Chile, Mexico and Paraguay, most of the primary care units of are served by General Practitioners and Family Medicine doctors. In countries such as Brazil and Peru, the makeup of the group depends on the geographical region. In the other countries as is the case of Argentina, Bolivia, El Salvador, Costa Rica, Nicaragua, Panama, Puerto Rico, Dominican Republic and Venezuela; we can find the presence of even other specialties as Pediatricians, Obstetricians-Gynecologists, Internists or Psychiatrists, Ophthalmologists and Dermatologists, etc. In the case of Colombia Family Physicians are not found on the first level of care, they can be located from the second level also collaborating with other medical specialists.

Accreditation processes of the quality of medical units and R&CRPMS

Only five of the researched countries included benchmark measurement and counter-referral in the accreditation processes of their healthcare units (Chile, Colombia, Cuba, Mexico and Peru.

Home care programs by the Family Physician and/or Family Health team

It is gratifying that in spite of the mentioned difficulties, in 15 of the 16 countries different types of home healthcare are developed. In most cases provided by the Family Doctor or even by the General Practitioner, and in other circumstances by different actors of the basic family health team. In this regard, the country with no home care is Nicaragua.

Discussion and Conclusions

This research allowed us to confirm that the figure of the Family Medicine Specialist is present in the 16 countries surveyed and in the 3 levels of healthcare. They perform a variety of functions, primarily aimed at the clinical and administrative areas, less frequently in educational activities and research.

R&CRPMS is available and functional in 16 countries. Its greatest efficiency is the patient referral from first to second and from second to third level of care. However, the greatest difficulties are observed in the counter-referral, which limits the feedback for primary care physicians, and even those in the second level.

It is worrisome that some countries have incongruent health models, which do not follow any political discourse or own government promoted reforms. Even in the type and number of Family Medicine specialized professionals in Primary Care, do not comply with the international agencies recommendations.[1,5,6]

As mentioned at the beginning, the quality evaluating processes of the health care units, include among its indicators R&CRPMS effectiveness and efficiency indexes. However, in recent years global health forums has promoted the Certification Quality Accreditation of health facilities to improve medical practice.[1,2]

Latin American countries have made progress in their gradual implementation incorporating into their systems the quality assessment of medical practice, the monitoring committees formation; the diagnostic and treatment protocols creation; feedback meetings between the different levels of care; etc.

Countries with higher R&CRPMS effectiveness and efficiency indexes, are those who have achieved more consolidation in their accreditation processes of the quality of health services.

Finally, the working group recommends the following strategies for strengthening R&CRPMS in the region:

- Increase and improve the quality of training programs for specialists in Family Medicine.
- Ensure the presence of Family Medicine Specialists working in the primary care level, in the clinical area, management, teaching and research, which will increase the capacity response of the medical units.
- Establishing certification and recertification of the Quality of medical units at all three levels of care, incorporating indicators of effectiveness and efficiency of R&CRPMS.
- Implement single electronic record systems, allowing data portability and sharing in different health institutions and linked to R&CRPMS in the three levels of care.

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ESSAYS

Strengthening the teaching-learning process of Family and Community Medicine in Iberoamerica

Fortalecimento do processo de ensino-aprendizagem da Medicina de Família e Comunitária em Ibero-américa

Fortalecimiento del proceso de enseñanza aprendizaje de la Medicina Familiar y Comunitaria en Iberoamérica

Fernando Coppolillo. Facultad de Medicina Universidad de Buenos Aires. Argentina. fernando.coppolillo@gmail.com *(Corresponding author)*
Humberto Jure. Facultad de Medicina, Universidad Nacional del Nordeste. Argentina. hjure2000@hotmail.com
Maria Beatriz Ciuffolini. Facultad de Medicina Universidad Nacional de Cordoba. Argentina. mcifiuffolini@hotmail.com
Diana Yuruhán. Universidad Católica Nuestra Señora de la Asunción. Paraguay. dyuruhan@hotmail.es

Working Group
Aguilera Luis (España); Aleida Marlen (Honduras); Alvarez Sintes Roberto (Cuba); Araya Zamora Héctor (Costa Rica); Arias Castillo Liliana (Colombia); Astudillo Romero Xavier (Ecuador); Baza Ricardo (Costa Rica); Braida Julio (Uruguay); Buffa Gabriela (Argentina); Cabrera Haydee (Mexico); Casado Vicente Verónica (Spain); Cascante Gómez Alejandra (Costa Rica); Fernández Larrauri Milagritos (Peru); Fernández Gutiérrez Herrera Raúl (Mexico); Fernández Ortega Miguel Ángel (Mexico); Galván Barrantes Alonso (Peru); González Pantaleón Violeta (Dominican Republic); González Reyes Carolina. (Chile); Hoock Jennifer (US); Icaza Carlos (Costa Rica); León Jose Luis (Costa Rica); López Nancy (Chile); Luna Tellez Yossadara (Mexico); Mahecha Rivera Lina Maria (Colombia); Martínez Bianchi Viviana (US); Montalvo Johanna (Ecuador); Mussetti Gustavo. (Uruguay); Niz Clara. (Uruguay); Ramirez Gerardo (Mexico); Rodarte Alina (Mexico); Rojas Tenorio Nancy (Costa Rica); Rodríguez Sotomayor Jorge Jesús (Panama); Roselli Karina (Uruguay); León Salas Jose Luis (Costa Rica); Sánchez Monge Aurora (Costa Rica); Sandoval Gladys (Paraguay); Silvera Cristina (Panama); Suárez Sergio Ariel (Argentina); Upun Hi Teresa (Guatemala); Valle Jorge Alberto (Honduras); Valverde Juliana (Costa Rica); Vargas Mejía Carmen (Costa Rica); Vargas Patricia (Chile); Villaseca Silva Patricia (Chile); Ysmodes Yvonne (Peru)

Abstract

The teaching-learning process in Family and Community Medicine is analyzed from the perspective of the professional cycle stages: the formation of university degree, specialization in graduate school and finally the permanent education service. For each of these stages the dimensions of the content and clinical abilities to be developed, the stage of the teaching-learning process and skills of teachers for each of them are analyzed. This analysis allows to guide the overall strengthening of specialists in family and community medicine with clinical practice of high quality, person-centered, family-oriented and community-based.

Keywords:
Family and Community Medicine
Teaching Learning Process
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Resumo

O processo de ensino-aprendizagem em Medicina de Família e Comunidade é analisado a partir da perspectiva das fases do ciclo profissional: a formação de graduação, especialização em pós-graduação e, finalmente, a educação permanente em serviço. Para cada uma destas etapas se analisam as dimensões do conteúdo e competências clínicas a serem desenvolvidas, os cenários do processo ensino-aprendizagem e as competências dos professores para cada um das mesmas. Esta análise permite orientar o fortalecimento global dos especialistas em medicina de família e comunidade com uma prática clínica de alta qualidade, centrada na pessoa, orientada na família e baseada na comunidade.

Palavras-chave:
Medicina de Família e Comunidade
Processo Ensino Aprendizagem
Ensino Universitário
Especialização
Educação Permanente em Serviço

Resumen

El proceso de enseñanza aprendizaje en Medicina Familiar y Comunitaria es analizado desde la perspectiva de las etapas del ciclo profesional: la formación de grado universitario, la especialización en el posgrado y por ultimo la educación permanente en servicio. Para cada una de estas etapas se analizan las dimensiones de los contenidos y compentencias clínicas que se deben desarrollar, los escenarios del proceso enseñanza aprendizaje y las competencias de los docentes para cada una de las mismas. Este análisis permite orientar al fortalecimiento global de los especialistas en medicina familiar y comunitaria con una practica clínica de alta calidad, centrada en la persona, orientada en la familia y basada en la comunidad.

Palabras clave:
Medicina Familiar y Comunitaria
Proceso Enseñanza Aprendizaje
Docencia universitaria
Especialización
Educación Permanente en Servicio

"To teach is not to transfer knowledge but to create the possibilities for its production and construction. Whoever teaches learns in the act of teaching, and whoever learns teaches in the act of learning"
Paulo Freire

Introduction

The strengthening of the learning-teaching process (LTP) of family and community medicine specialists (FCMS) in the region constitutes a key objective in health systems to assure access to quality care centered on people. Developing family doctor's clinical competencies should be the main goal in human resources policies.

We have decided to structure the document following a family doctor's training process from their medical studies at university to their specialization, and finally their permanent training once they are working as physicians. To give it a systemic perspective, we have included teacher's training in order they can adapt to the content and processes currently required by the systems.

Objectives

The purpose of this work is contributing to the learning-teaching process (LTP) in FCM strengthening within the region to guarantee clinical competencies and quality care in the communities.

The objectives were:

- Analyzing the right training scenarios, the curricular content in each of the training stages and the characteristics of teacher's training in FCM.
- Evaluating the FCM development level at university, teacher's training and specialization certification processes in their countries.

Methods

After consulting experts three dimensions for each of the learning-teaching process stages in FCM were developed Dimensions: 1. The contribution of Family Medicine in the University. 2: Contents for learning-teaching processes 3: Right scenarios for the learning-teaching process. 4: FCM teacher's training. A semi structure survey was designed

and distributed to WONKA-Ibero-Americana CIMF Scientific Societies. A total of 20 FCM teachers completed the survey, three editors surveyed independently the preliminary document and key indicators were identified. During a second stage there was a focus group were the previous job was analyzed and final indicators stablished.

In a second part, the teachers participating in the first stage were asked to qualify the indicators in a Lickert scale from 1 to 10 (in which 1 is no development and 10 is great development). The aspects analyzed were development of family medicine within universities in their countries, teacher's training and specialization certification processes. An average was estimated for each aspect.

Results

Family and Community Medicine (FCM) contribution for the development of Clinical Competences in under graduate level at Medicine Schools

Some decades from now, educational systems around the world foster the innovation of curricular and educational models and the incorporation of FCM to undergraduate levels. It is in this context that the FCM teacher is responsible for the permanent incorporation and the eventual success of such innovations, bringing about changes in several teaching scenarios. Nevertheless, the incorporation of FCM educational proposals, requires a deep reflection, that considers among other aspects, threats coming from educational policies, the economic system, social movements, administration styles and organizational culture from our universities, mostly supported by the biomedical paradigm and centered on hospital care.

FCM incorporation to undergraduate levels allows pupils to acquire the following competencies:

- Comprehensive and continuous approach to healthy patient's problems;
- Focus risk application on the most frequent ailments;
- Learning on immunization management and epidemiological watch;
- Health education;
- Family approach;
- Patient and family communication.

This allows a more anthropological medical training for students, where they can learn and find interest not only in the psychological and social aspects of their patients but also in biological ones.

Undergraduate levels must emphasize PC (Primary Care) so that graduates, independently of their later specialization, can understand the logics of a health system not centered on hospitals.

FCM widens the framework of the clinical approach; going from sickness analysis to people's approach as a whole within their family context (who will share the patient's health management) and their community (whose determinants will ease or obstruct peoples' health management). Family Medicine changes the clinical analysis standpoint considering people inside their context.[1]

Undergraduate Family Medicine Contents

FCM should provide contents related to the History of the specialization involving the needs and the social context where it was developed.

An interdisciplinary group must develop the subject matters with a wide range of theoretical and practical contents:

- Initially the group must know the relevant sociological and anthropological process at a world and national level to have a biological, social and psychological (comprehensive) approach of the human being.[2]

- They will also know the approach for social health determination and risk social management.
- The group will deepen on environmental health for an ecologic view.
- Knowledge and deepening of the core of FCM itself (most prevalent and/or serious health problems) that allow increase the capacity to solving about 90% of the health problems presented at the community's scenario.
- Community participation development in health care, together with the tools that enable a social diagnosis.
- Encouragement of interdisciplinary activity with other health areas. Curricular working places can be created jointly with other similar curricular activities (nursing, social work, psychology, anthropology, pharmaceutics, physical therapy, etc).
- Quaternary Prevention.
- Evidence based decision making.
- People's comprehensive health approach as a savvy and efficient health activity that tackles the fragmented, uncoordinated and inefficient view of patient's health.
- Family health approach, knowing their living context (rather than making background analysis), knowing the risk and health problems they share and suggesting and reaching health care to overcome them.

Contents should be reviewed and updated according to health systems needs within countries in the region where there is a possibility of family medicine level available. FCM contents must be dynamic and adaptable to countries' needs.

Scenarios and methodology for clinical competences development in undergraduate levels

Ideal scenarios are the primary health care centers, implemented or in agreement with Universities, with shared resources for health care and teaching. Regarding methodology, clinical tutorial is the first choice, although exhibition classes, small groups seminars, problem based learning, conceptual maps, observations and clinical simulations are also options. Having undergraduate content as a basis, practice sites should be guided to community development where the student can follow the community during his studies. They will approach people to learn about their story of life. Later, they will analyze their environment with a social approach and afterwards with family medicine tools. The student will be able to make a comprehensive, systemic approach at an individual, family or community level. For this to be possible there must be a strong interaction between the University and the Health Sector.

Inside the classroom, basic concepts can be addressed with a participative, educational methodology. This will make pupils analyze and think by means of real clinical cases. Actual interdisciplinary practice scenarios would be ideal. At this point, integrating curricular spaces should be considered, common for various health sciences degrees by means of problem solving cases teaching method.

Consultation with the Family and Community Physician will provide them with the chance of directly meeting patients, their main health problems and the person/family centered approach.

The development of face to face and distance tutorials are meant to promote critical reflection and complex thinking. The methodologic proposal contemplates individual and group activities for problem solving. This is meant to bring back previous knowledge that learners have from a constructive standpoint in the learning - teaching process.

FCM teachers' training

FCM teachers must have training with an approach by competencies so as to contribute with the learners when they must challenge problems in context. Knowledge integration (cognitive, procedural and attitudinal) allows them to identify, argument and solve them. Family Medicine teachers should elaborate a concept and methodology that enables observation, analysis, comprehension and design of meaningful interventions in the community.

Undergraduate and post graduate levels must share resources for the unification, congruency and agreement in knowledge building and to make teaching processes administration sustainable as well as teaching management efficient. Family Medicine teacher's training must be broad enough so as to deploy abilities in different knowledgeable frameworks, a wider one (specialized training) and a more specific one (undergraduate) although training remains the same.

Teachers' training must be continuous, recertified and compulsory. Thus a possibility must be presented for teachers to choose for an update that ensures quality education. They must have a teaching/education university degree. From this standpoint, the abilities a teacher must develop are: personal commitment to be updated and their ability to adapt to different scenarios and environments. Undergraduate teachers must carry out team works with interdisciplinary approaches where nurses, anthropologists, public health doctors and health agents among others can interact too. Teachers must know how to elaborate a clinical tutorial and how to feedback pupils. They must have training on observation/evaluation guidelines and teaching methods, written question making and curricular coordination. They must have basic teaching training (pedagogy and didactic) among others such as PHS and FCM specific continuous updating and new didactic teaching techniques.

When considering the target public is under graduate, teachers must be ready to use youth and adult teaching techniques and be able to use information technology or communication techniques that these age groups are familiar with. Problem methodology is crucial so that learning is generated according to students' previous knowledge using talking techniques and knowledge building. It would be great if teachers shared FCM clinical activities.

Teachers should know how to analyze the kind of students they have in the classroom and the various learning processes they feel comfortable with.

FCM teachers must have interdisciplinary training on educational projects developed in a specific action context (Community Health Care Space). These are meant for discussion, analysis and sharing of previous experiences that allow significant and relevant knowledge from a comprehensive point of view. Active citizens' participation must be promoted as a right that will impact on social health determination processes.

FCM contents in Post Graduate Education (Residency or Specialization)

The content of FCM specialist training program could be outlined as follows:

a) Patient Care: doctors under the specialization process must be capable of providing compassionate, appropriate and effective health care to patients so as to find solutions to their health problems and promote it as well. They will provide necessary clinical care for patients in the ambulatory or hospital environment regarding technical proceedings exclusive to family doctors according to the community needs within their working area. They must also understand how to take care of healthy individuals. They will prioritize prevention to assistance, offer continuous individual help considering it a priority by means of Problem Oriented Clinical History, with clear and precise information that allows continuation under their responsibility. The must include patients who require continuation of the treatment at home, will offer continuation of health care to hospitalized patients. They will also home visit the elderly, disabled, terminal or socially risky patients. They will coordinate and integrate each patient's care to keep their responsibility over their patients in every environment. They must also be able to deal with patients from different ethnic groups.[3,4]

b) Medical Knowledge: They have to state their knowledge of established or developing concepts on sciences such as biomedical, clinical, epidemiologic, social and behavioral, applying them to patient, family and community care. Analytical and inquisitive thinking is required to approach patients in: population groups such as teenage and children' s health, women's health, adult' and elderly health, mental health, human

behavioral science, community medicine and health system management. They must be aware and apply support and basic sciences related to FCM and will apply community research methodology principles including situation diagnosis applying intervention and participation techniques.

c) Practice based learning: They must show their research and evaluation capacity to take care of patients and their family, deepening and analyzing scientific evidence. They should set learning goals and practice improvement. They must systematically analyze practices using quality improving methods. They will find, evaluate and assimilate scientific evidence related to health problems in patients, their families and communities. They will use information technology thus supporting their own learning process. They will have an active role in patients, family and community, resident doctors and members of the primary health team training.[5]

d) Interpersonal communications skills: Resident doctors must be capable of showing interpersonal communication abilities resulting in the effective information exchange as well as stablishing a team relationship between the family, patient and the health professionals. They will internalize a verbal and non - verbal language communication methodology.[6]

e) Professionalism: Resident doctors must show their commitment to carry out professional responsibilities and fulfill with ethical principles. They must show humanism, compassion, integrity and respect for the others and provide patients, their families and communities with answers overcoming their own personal interest. They will respect patients and families' privacy and autonomy. Must be sensitive and have the response capacity to diverse populations without any conditioning on genre, age, culture, race, religion, disability or sexual orientation. They must have University Teaching and provide students with the experience acquired.

f) Health Services Management: Resident doctors must show conscience and response capacities to the health system biggest context being able to selectively claim the resources to the systems to provide the best service. They will efficiently work in health care within the different environments (hospital, health centers, at patient's homes, etc) They will coordinate patient and family care within the system and practice health care having the in mind the cost effectiveness relation and resources distribution so that quality and equity are not at risk. They will know how to merge with health care managers and providers, to evaluate, coordinate and improve the service knowing how these activities can affect the system's running. They will know how to apply PHC service provisions and will incorporate access and availability concept.

g) Family Approach: The family must be the research goal integrating a series of abilities typical of family management. Families as the research goal for family doctors must be understood as a social institution. They must recognize family types, family and couples evolution cycles as well as couples functionality and dysfunctionality. They must use tools such as Genogram and concept approaches such as General Systems Theory, General Communication Theory. They must acquire abilities for decision making before critical family events and get training at the different levels of prevention, information counseling, guidance and family therapy. They must have abilities to interfere with other disciplines facing couple problems, intra family violence, addictions, poor school performance, migration or any other situations that alters family wellbeing.[7]

Scenarios and methodology for FCM clinical abilities development in Postgraduate (Residency and Specialization)

It should mainly be developed in PHC, inside the community, patients homes and in general, in all those scenarios that allow direct contact with their patients and where they can evaluate their pathology.

The proposal is to work with methodologies that facilitate the meaning and reorganization of knowledge, values, attitudes, skills that enable the comprehensive approach to health problems inside the community scenario. There

is a need for prioritizing innovative methodologies aiming to progressively generate competencies in the different areas contemplated in the program which require interdisciplinary activities that together with self reflection brings positive aspects and the ones to be improved in every problematic situation.

FCP must deploy their services in different scenarios from hospitals or clinics to emergency rooms or doctor's offices but they must also develop abilities from different health care angles such as home - visiting, day hospitals, and interdisciplinary team work for future multiple pathology approach.

Scenarios and methodology for permanent training in favor of Family and Community Medicine Specialists.

Permanent Health Training is an educational and methodological strategy encouraged by PAHO since 1995 for human resources development and institutional capacities that allow a quality improvement of health care. Licensed Practitioner Cristina Davini defines it as: "An institutional - pedagogic intervention strategy oriented to achieving efficiency and effectiveness when providing medical services (quality assistance, and customer satisfaction) towards the improvement of work processes within the health team and towards worker's individual and group promotion. According to this model FCP strengthen interdisciplinary practices.[1,8]

Thus, Permanent Health Training (PHT) suggests inserting health staff training deep inside team works. They meet to analyze and solve problems from everyday life trying to improve attitudes, knowledge and abilities.[9]

This methodology is practiced inside the work environment, analyzes team's institutional mission and the working process one deals with technical aspects, relations and human processes, users and institutional ones as well. It is mainly people centered from the official to the user. It identifies and analyzes, in the right context, the concept of Health Care Network. There should be a different scenario per health area and lead to certification and recertification processes of professional competencies.[10]

Experts qualitative evaluation on FCM training development within the region

There was a wide variability of the development perception of the studied dimensions and there is effort to be made in the region to improve those aspects. (Chart 1) (Graphics 1, 2, and 3)

Chart 1. Average score (0 to 10) of the dimensions subject to evaluation.

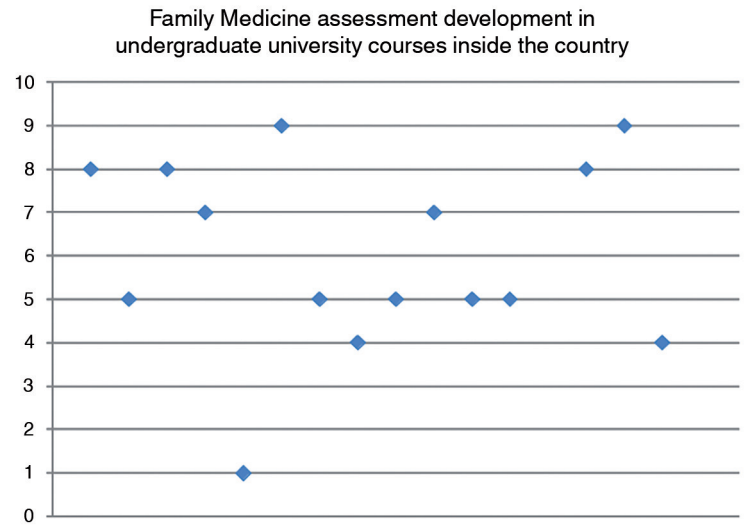
Dimension	Average
Family Medicine Development at University	5.6
Family Medicine Teachers´ training	5
Specialization Certification Development	5.2

Discussion

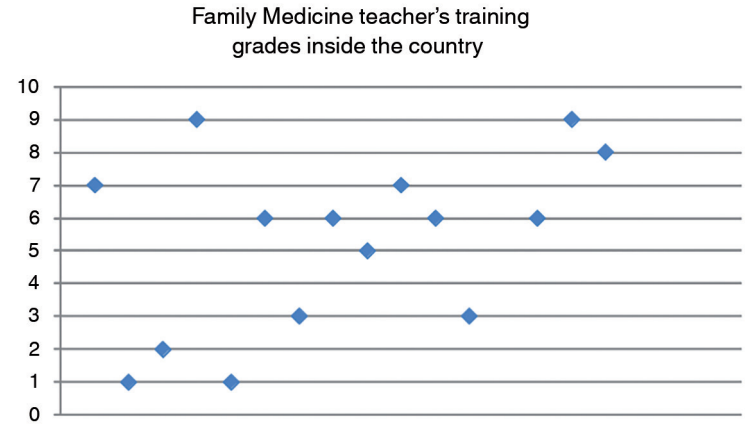
Making a comprehensive approach on Health - Illness Care Process requires in the first place to re think our own practice and understanding this "way of doing things" feeds on a certain concept of health and its care, and to a certain comprehension of the person and his/her family or community environment; and to some knowledge building and health teams practice.[2,3]

In a Learning-Teaching educational process - in order to make the complexity of the Health Illness Care Process understood - comprehension and approach devices must be assured to evidence the relation between society general processes, different lifestyles within groups and special conditions in people's lifestyles.[4]

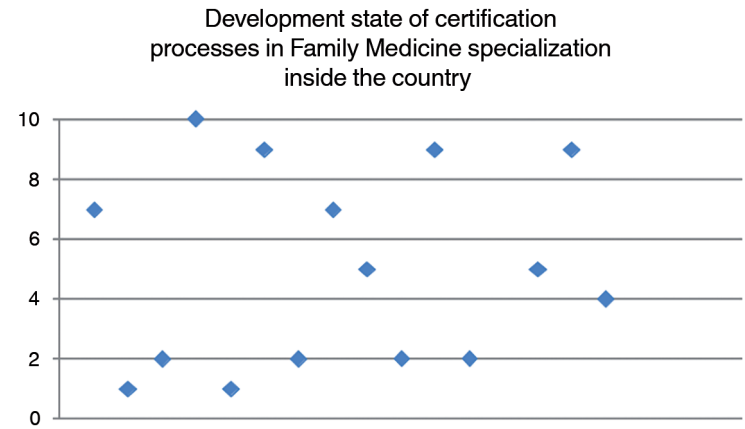
We must begin then from the sickness concept as one that does not result from the external action of an aggressive environmental agent or the internal reaction of a susceptible host, but from a total process of pathological



Graphic 1. Family Medicine assessment development in undergraduate university courses Inside the country - Lickert Scale - 1 is no development and 10 is great development.



Graphic 2. Family Medicine teacher´s training grades inside the country - Lickert Scale - 1 (bad) - 10 (very good) qualification.



Graphic 3. Development state of certification processes in Family Medicine specialization inside the country - Lickert Scale - 1 (bad) - 10 (very good) development state.

effects and understand health as a constant in permanent tension and conflict in search of a better quality of life. This process is conditioned by the potentialities, capabilities and limitations that people, families and communities face when handling available resources.[8,9]

Conclusions

1. Training contents are oriented towards acquiring professional competencies that ease a comprehensive and holistic approach of the illness-disease-health care process. This must be supported by a social view that fosters the capacity of solving health problem with the biggest incidence on our population, during all stages in life.
2. Introducing educational proposals on Family and Community Medicine requires deep thinking that consists, among other aspects, of threats coming from educational policies, the economic system, social movements, administration styles and organizational cultures that prevail in our Universities mostly supported by the biomedical paradigm.
3. The ideal training scenario is the Primary Health Care Center. Regarding methodology, tutorials should be used mainly, although other options are recommended as well: FCP office's follow up, classroom workshops, role play, Gessell Camera, student's videos during consultation, problem solving based learning and case studies.

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ESSAYS

Certification, Recertification and Accreditation in Family and Community Medicine in Iberoamerica

Certificação, Recertificação e Acreditação em Medicina de Família e Comunidade na Ibero-América

Certificación, Recertificación y Acreditación en Medicina Familiar y Comunitaria en Iberoamérica

Haydee Cabrera Reyes. Ibero American Group of Certification, Recertification and Accreditation in Family Medicine; Sociedad Campechana de Especialistas en Medicina Familiar, A. C. Mexico. cabrehay@hotmail.com *(Corresponding author)*
Diana Yuruhán Mohrbach. Ibero American Group of Certification, Recertification and Accreditation in Family Medicine; Paraguayan Society of Family Medicine; Universidad Católica de Nuestra Señora de la Asunción. Paraguay. dyuruhan@hotmail.es *(Corresponding author)*
Patricia Vargas. Ibero American Group of Certification, Recertification and Accreditation of Med School; Universidad de Chile (UCh); Sociedad Científica de Medicina Familiar. Santiago, Chile. elizavargas@u.uchile.cl
Nancy del R. López Vásquez. Iberoa American Group of Certification, Recertification and Accreditation in Family Medicine; Universidad de Chile (UCh); Sociedad Científica de Medicina Familiar y General. Santiago, Chile. nancylopez@med.uchile.cl
Johanna Montalvo Vázquez. Ibero American Group of Certifiation, Recertification and Accreditation of Family Medicine; Equatorian Society of Family Medicine; Unidad de Medicina Familiar Hospital UTPL. Ecuador. johanna.montalvo@hotmail.com

Working Group
Carlos Icaza. (Costa Rica), Diana Yuruhán Mohrbach. (Paraguay), Gerardo Ramírez Sandoval. (México), Gladys Sandoval. (Paraguay), Haydee Cabrera Reyes(México), Johanna Montalvo Vázquez. Montalvo J. (Ecuador), José Luis León. (Costa Rica), Karina Roselli. (Uruguay), Nancy del R. López Vásquez. (Chile), Patricia Vargas. (Chile), Xavier Astudillo Romero. (Ecuador) and Yossadara Luna Téllez. (Mexico)

Abstract

Objective: To determine the status of the Certification, Recertification and Accreditation in the countries of the region of Latin America as a follow up to the first survey in the V Ibero-American Summit Family Medicine in 2014 inQuito, Ecuador. **Methods:** Cross-sectional descriptive. The population consisted of 10 countries: Ecuador, Peru, Chile, Venezuela, Mexico, Brazil, Paraguay, Colombia, Puerto Rico and Costa Rica. To the presidents of associations of family medicine, they were sent by e-mail a structured survey of twelve questions about certification, recertification and accreditation; the response was received by the same route. Descriptive statistics and simple and relative frequencies was made. **Results:** Certification is carried out in 60% of the surveyed countries; this process is voluntary in 40% and performs scientific societies. The recertification is installed and is operational in 30% of the participating countries, this process is voluntary in 80% and running different organisms among which are scientific societies. 50% of countries conduct the accreditation of family medicine programs through universities. **Conclusions:** Certification not yet instituted in some countries in Latin America, continues to be voluntary, and only half of the countries make the accreditation process. Therefore, we must work more in each of the countries in the region to achieve certification, recertification and accreditation to ensure the quality of specialists in Family Medicine.

Keywords:
Certification
Recertification
Accreditation
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Resumo

Objetivo: Conhecer a situação da Certificação, Recertificação e Acreditação nos países da região da Ibero-Americana como seguimento do primeiro levantamento realizado na V Cúpula Ibero-Americana de Medicina de Família em 2014 em Quito, Equador. **Métodos:** desenho transversal descritivo. A população do estudo foi composta por dez países: Equador, Peru, Chile, Venezuela, México, Brasil, Paraguai, Colômbia, Porto Rico e Costa Rica. Se enviou por email um questionário estruturado de doze perguntas sobre Certificação, Recertificação e Acreditação; a resposta foi recebida pela mesma via. Foi realizada uma análise estatística descritiva, com frequências simples e relativas. **Resultados:** As sociedades científicas envolvidas participam nos processos de Certificação, Recertificação e Acreditação nos países em que são implementados. A certificação foi realizada em 60% dos países pesquisados, este processo foi voluntário em 40%. Recertificação é implementada e está ativa em 30% dos países participantes, este processo é voluntário para 80% e são realizadas por diferentes organizações, entre as quais sociedades científicas, atuando isoladamente ou como parte de uma equipe de avaliação. Destes países, 50% procedem à acreditação de programas de medicina de família através de universidades. **Conclusões:** A Certificação ainda não está estabelecida em alguns países da Ibero-América, é voluntária. Uma porcentagem menor de países implementaram o processo de recertificação, o qual é voluntário em sua maioria. Apenas metade dos países realizam o processo de acreditação das Unidades Formadoras.

Palavras-chave:
Certificação
Recertificação
Acreditação
Medicina de Família e Comunidade

Resumen

Objetivo: Conocer el estado de la Certificación, Recertificación y Acreditación en los países de la región de Iberoamérica como seguimiento a la primera encuesta realizada en la V Cumbre Iberoamericana de Medicina Familiar en 2014 en Quito, Ecuador. **Métodos:** Diseño transversal descriptivo. La población estuvo conformada por diez países: Ecuador, Perú, Chile, Venezuela, México, Brasil, Paraguay, Colombia, Puerto Rico y Costa Rica. A los presidentes de las Asociaciones de Medicina Familiar, se les envió por e-mail una encuesta estructurada de doce preguntas acerca de la Certificación, Recertificación y Acreditación; la respuesta se recibió por la misma vía. Se efectuó un análisis estadístico descriptivo, frecuencias simples y relativas. **Resultados:** Las Sociedades Científicas participan en los procesos de Certificación, Recertificación y Acreditación en los países en los cuáles están instalados. La certificación se realizó en 60% de los países encuestados, este proceso fue voluntario en 40%. La Recertificación está instalada y es operativa en 30% de los países participantes, este proceso es voluntario en 80% y lo ejecutan diferentes organismos, entre los cuales están las sociedades científicas, actuando solas o como parte de un equipo evaluador. De estos países, 50% de los países realizan la Acreditación de los programas de medicina familiar a través de las Universidades. **Conclusiones:** La Certificación todavía no se instaura en algunos países de Iberoamérica, es voluntaria. Un menor porcentaje de países tienen implementado el proceso de Recertificación, el cual también es voluntario en su mayoría. Apenas la mitad de los países efectúan el proceso de Acreditación de las Unidades Formadoras.

Palabras clave:
Certificación
Recertificación
Acreditación
Medicina Familiar y Comunitaria

Introduction

The changing processes that economic globalization face, set quality requirements in favor of medicine which include the certification of an optimal and competitive professional practice in favor of the population.[1] One of these aspects is the quality improvement in medical care, where strategies as certification and recertification have been included so as to try to ensure it.[2]

It is essential to define here what is called quality in medicine. The concept varies in different moments and societies, nevertheless the definition suggested by Donabedianes is integrating and globalizing to think in her terms: "Quality is the level at which the most desirable means are used to achieve best improvements possible".[3] *Ruelas* points that "quality is a combination of benefits, risks and costs where what we try to offer is higher benefits with the least possible risks and at a very reasonable price". At the same time, *Aguirre-Gas*, says that "quality in medical services is providing proper care to the user, complying with medical knowledge and current ethical principles, that satisfy health needs and users, providers and institution's expectations".[4-6]

Related to the above, professional certification is a process that guarantees technical standards that adapt to the society and to the kind of quality health care patients require. They control a body of knowledge and/or relevant experiences in the health care environment to provide the corresponding certification,[7] that is to say, it is of the upmost importance providing certification to Family Medicine Specialists in every Ibero American country. It can be understood as a validation process that ensures society that the professional has the knowledge and necessary

competences to provide comprehensive and continuous care to the individual and their families with high quality standards based on principles and practices from their specialization.[8-10] Family doctors must be responsible and active protagonists in defining, implementing and administering certification processes in institutions that certify professionals.[2] Although certification is a quality standard that every family doctor must have, some of the countries in the Ibero American region have not implemented it yet. In others like in the US it is voluntary[10] and in a few like in Mexico, certification is compulsory (2011), expressed in article 83 from General Health Law.[11]

Thus as a consequence of the technological advances that permanently occur in the medical sciences, the same as epidemiologic and demographic transition that take place in every society, family medicine specialists are forced to constantly update and renew their knowledge. Thus it is necessary to prove the validity of their professional competences by means of recertification. This is possible by means of acquisition of new emerging competences, given the growth in knowledge and the complexity of family doctors role within health systems.[7,8,10] In family medicine, recertification tries to keep the medical commitment with high quality standards, to the individual or their families, according to the advances in family medicine and the other population's health demands.[9]

To complement these processes it is necessary to develop a programs certification system for family medicine. Certification must be understood like a process by means of which an organization is capable of measuring the quality of their services and products and the efficiency of those compared to national and international well known standards.[12] In the same direction accreditation is a process to confirm program fulfillment on behalf of High Education Institutions, to confirm professional training requirements in different specializations in medicine in agreement with global state of the art medicine and community and people's needs.[13]

Margarita's Declaration stablishes that each country must be responsible for setting minimum certification requisites for Family Medicine Residencies. The objective is to ensure a basic profile of medical competencies in each of all the countries specialization training units, and to do so the following aspects should be considered: specialization name, professional profile, length, entry and term requisites, leave requisites, CV, teacher's requirements, characteristics of family medicine academic or support hospital.[8] This means that the certification process represents a huge effort in which educational, health and civil organizations can participate to upgrade the quality levels the family doctor provide.[14]

Quito Charter during the V Ibero-American Family Medicine Summit recommends: "Recognizing that professional Certification and Accreditation in Family and Community Medicine allows the strengthening of on time assistance in Family and Community Medicine and stimulation of professional update."

All this said, a group of Family Medicine specialists formed an Ibero-American group made up of 8 countries. In the first instance it builds and gathers information from the survey made by this experts committee. With the information collected a SOWT (strength, opportunities, weaknesses and threats) analysis was carried out and the advance levels of certification and accreditation within Family Medicine in Ecuador, Venezuela, Bolivia, Mexico, Argentina, Paraguay, Brazil and Chile were compared. The results were handed in 2014 during the V Ibero-American Family Medicine Summit in Quito, Ecuador.[15]

The present research constitutes the second moment within the working team with the aim of acknowledging the Certification, Recertification and Accreditation state within the region.

Methods

A transversal descriptive research was carried out in ten countries from the region WONCA-CIMF (World Organization of Family Doctors - Ibero American Confederation of Family Medicine Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Paraguay, Peru, Puerto Rico y Venezuela during November 2015 to March 2016; nations that had Family Medicine Associations or Societies. Presidents or board of directors members of those entities, were sent through e mail a survey with 12 questions on certification, recertification and accreditation in Family and Community Medicine and the answers were received via the same means.

The survey was sent to 20 countries and only the ones previously mentioned answered. Argentina, Bolivia, Uruguay, Cuba, Spain, El Salvador, Panama, Portugal, Honduras and Dominican Republic did not forward their answer.

The analysis of the data used descriptive statistics with relative and simple frequencies related to Statistics Program SPSS v.21

Results

Only half of the countries answered the survey (10/20). 40% had executive roles, 30% as presidents and 30% as members of the Family Medicine Society, a crediting entity and post graduate director.

Figure 1 shows question data: Does your country have a family medicine certification process? 40% (4 countries) still do not have that process. It is important to say that in only two countries the process is compulsory; one of them is Mexico compulsory since 2011 and the other is Venezuela. For the other 4 countries in the region the certification is voluntary (Figure 2).

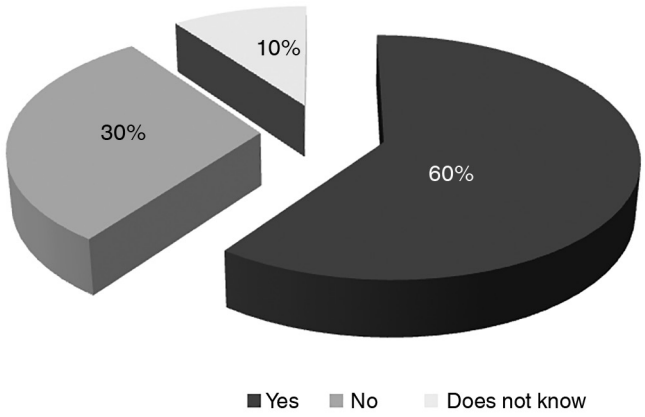

Figure 1. Country Certification Process Realization.
Source: POLL GICRAMF* F 2015-2016.
*Note: Ibero American - Certification Group, Recertification and Family Medicine Accreditation.

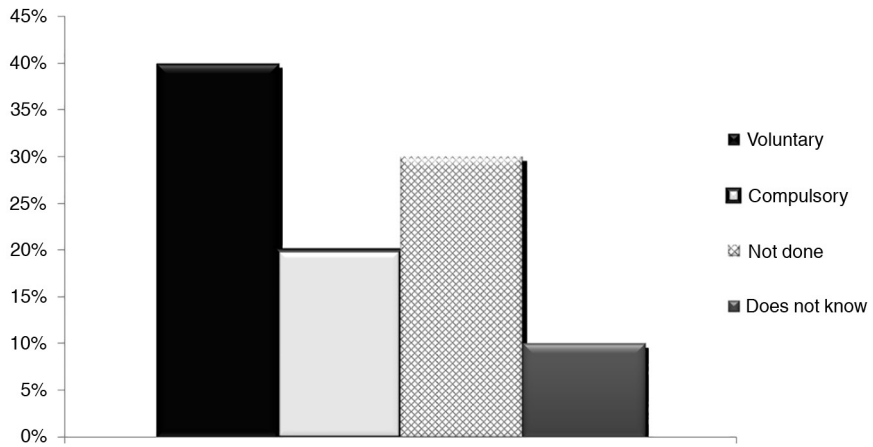

Figure 2. Mandatory Nature of the Certification Process.
Source: Survey GICRAMF* - Informing countries CIMF 2015-2016.

In most countries (6/10), certification bodies of Family Medicine specialists, are executed by the Scientific societies and College of physicians and only in Mexico the certification is issued by The Mexican Certification Counsel. (Table 1)

Chart 1. Family Medicine Certifying bodies per country (CIMF)

Country	Certifying Bodies			
	Scientific Society and Medical School	Universities	Ministry of Health	Certification Counsel
Brazil	x			
Chile	x	x		
Costa Rica	x			
Colombia				
Ecuador				
Mexico				x
Paraguay	x			
Peru				
Puerto Rico				
Venezuela	x	x		

Note: Ecuador has no certification. Source: Survey GICRAMF 2015-2016.

Certification is installed and operative in 30% of the participating countries, this process is voluntary in an 80% and it is executed by different bodies among which scientific societies, certification counsels as well as public and private organizations.

Regarding the accreditation process of family medicine training programs, half the participating countries (5/10) have installed accreditation (Figure 3).

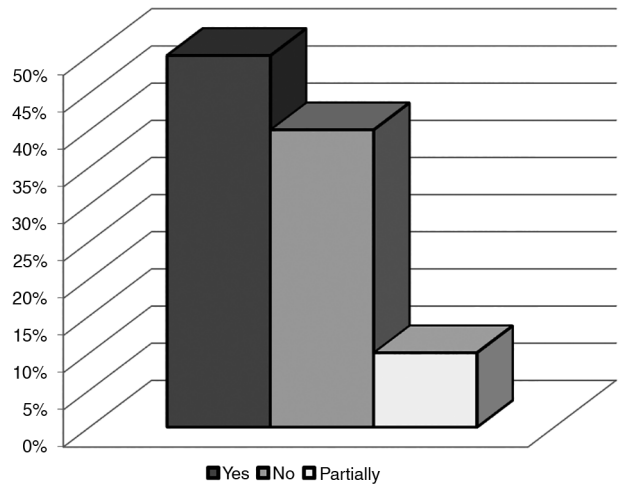

Figure 3. Country Accreditation Process Realization.
Source: Survey GICRAMF 2015-2016.

Universities are the most prestigious accreditation entities (3/10), followed by public and private bodies (4) and scientific associations. Figure 4 shows accreditation process within the countries. At a national level, family medicine training programs, show 50% of the countries have differences, are equal in 40% and there is very little differences between them (2/10).

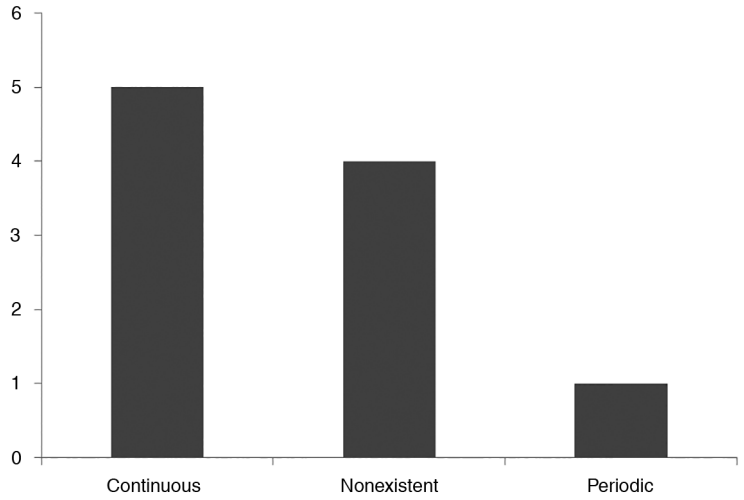

Figure 4. Country Accreditation Process Continuation.
Source: Survey GICRAMF 2015-2016.

Discussion

Survey's Most Important Findings

Not all Ibero-American countries have certification and in others it is still voluntary, a smaller number has the recertification process implemented, which is voluntary as well and only half the countries use the recertification system. Thus, it is necessary to work more on increasing awareness in each country within the region so as to ensure Family Medicine certification, recertification and accreditation are carried out in Latin America to guarantee the quality of specialization and consequently the Family Medicine specialists' too which will directly impact on quality for patients and their families.

One of the findings within this research is that scientific societies participate in most of certification and recertification processes in Family Medicine, compared to training programs accreditation, where universities are the principal entities.

Research Strengths and Weaknesses

Strength

One of the strengths says that there is a bigger commitment in societies regarding certification, recertification and accreditation as well as in Societies which answered the survey on strengthening certification and recertification processes. Another is that it has been possible to identify specialization certifying bodies or organizations within Ibero-America.

The accreditation in Family Medicine training programs is continuous in half the countries in the survey, which may imply that the quality in training programs within Family Medicine might be worrying. Besides, thanks to the enquiry the organizations and institutions that certify training programs came to light, the survey also assesses the aspects of the accreditation programs and verifies that the process is installed within the Ibero-American countries.

The main strength is in the survey sent to Family Medicine Specialists involved in the certification, recertification and accreditation process, thus their opinion has ground.

Limitations

The most important ones were difficulties in communication and data collection for their delivery but also the reception among CIMF Family Medicine Ibero American Confederation.

Another weakness is the lack of validation on the survey by other experts, it was only validated by the Family Medicine doctors within the group and it was not sent jointly to all countries in the region. The survey was clearly directed to topics of interest in the group and the assessment was performed by some members of the group and it was tough to manage the discussion. Finally, there are no elements that help obtain a more qualitative research and assessment on certification, recertification and accreditation in Family Medicine training programs.

Comparison with existing literature

Although certification has been wanted as a standard for long, it is surprising the wide range of opinions when it comes to interpret it in the different nations. For some, certification is the one given at the end of postgraduate courses in the residency which is the approval on tests that allow doctors work as such. In other countries it is a certificate to those doctors who when finish the residency in a formal program do not pass the corresponding tests having then to sit for an special exam that allows them to certify their competence as a specialist before the society. In others it is called certification to general doctors accreditation as specialists in Family Medicine through the approval of certain courses, clinical practices and the like which are later on approved by some academic committee.[14]

The fact that 60% of the countries have the certification process ingrained in their societies, shows that family medicine specialists are conscious of the need of assuring the quality of the medical demand, nevertheless, the different existing models in these processes can be considered punitive, that is why high level pedagogy is required to explain in a very simple way this process and its benefits so it is not considered an exam but a method towards "improving professional competence".[16]

Implications in the research area and/or professional practice

There are serious implications in this research, deriving from the importance Certification, Recertification and Accreditation processes have in the society and Health Sytems within each country. The most meaningful ones. How important are these processes in their countries? Which entity is responsible for regulating them? How can results be used after the analysis in favor of professionals and the community? The biggest challenge we face is creating a process model for the region taking into consideration the results from the present research and future ones.

It is of the upmost important in professional practice that family medicine specialist have this test. It should be divided in two parts: when the training process ends (certification) and during their career (recertification), in this way we would be assuring the fact that the professional has and keeps their competences of a family medicine specialist. Given the diversity of training programs of family medicine in the region, they must be accredited to certify their consistency with the profile of a family doctor. That is why it is necessary to have an updated situational analysis in these three processes as they will be the generation point of future research in the field.

These processes have to answer to the State need, thus there must be task forces among organizations legally established as such, the Academy and Family Medicine Scientific Societies so as to assure a comprehensive evaluation system with a family medicine profile.

Certification and Recertification must be constituted in voluntary processes at first so as to make specialists value the importance of doing so and feeling the hierarchy. Nevertheless, National Health Systems in each country, must assure the professionals competencies by formalizing these processes by means of tests which should not be considered punitive but as an opportunity of validating their competences throughout their careers and a chance to adapt to scientific changes with the passing of time.

Scientific societies must have an active role and serious commitment offering Family Medicine Doctors accessible training opportunities by means of continuous training in their field reaching the members through virtual or face to face means.

Conclusions

Certification is not present in every country as it is voluntary. A small number of countries have the certification process implemented, which is mostly voluntary too. Only half the countries have the accreditation process thus hard work should be done in each country to achieve certification, recertification and accreditation in family medicine within Ibero-America to assure training programs and professionals quality which will definitely have an impact on the patients and their families.

Considering that there are different training programs within the same country, standarizing the certification and accreditation processes is essential. This implies a challenge for Scientific Associations or Societies as well as for CIMF to achieve a basic assessment matrix applicable to the different countries and that reflects their competencies. It will be necessary to work in a continuous and coordinated mode in each country within the region to make certification, recertification and accreditation programs in family medicine continuous in Ibero America with the aim of assuring the quality of family medicine training programs and its specialists.

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ESSAYS

Research in Family and Community Medicine in Ibero-America

Pesquisa em Medicina de Família e Comunidade na Ibero-América

Investigación en Medicina Familiar y Comunitaria en Iberoamérica

Noris Margarita Serrudo de Domínguez. Gobernación del Estado Zulia Secretary of Health; Ibero American Confederation of Family Medicine Wonca-Iberoamericana-CIMF; Family Medicine Center Padilla. Venezuela. norisserrudo@gmail.com *(Correspondig author)*
Jacqueline Ponzo. Universidad de la República, Facultad de Medicina (UDELAR); Red IBIMEFA, Wonca Iberoamericana-CIMF. Uruguay. ponzo4@gmail.com *(Correspondig author)*
José Manuel Ramírez Aranda. Universidad Autónoma de Nuevo León (UANL); Hospital Universitario "José Eleuterio González"; Mexican Network of Family Medicine Researchers AC. Mexico. sersabe2010@gmail.com
Carla Alexandra Argudo Haro. Family Health Center San Joaquín, Family Health Department Universidad de Chile; Facultad Medicina. Ecuador. carliarg@yahoo.com
Miriam Elisa Riveros Ríos. Facultad de Ciencias Medicas, Universidad Nacional de Asunción; Family Medicine Santa Rosa Branch. Paraguay. melisarr76@hotmail.com
Pablo Vargas Villarreal. Caja Costarricense del Seguro Social; Universidad de Costa Rica. Costa Rica. pavavi@gmail.com
Juan Víctor Ariel Franco. Hospital Italiano de Buenos Aires; Centro Cochrane - Instituto Universitario del Hospital Italiano de Buenos Aires; Universidad de Buenos Aires. Argentina. juan.franco@hospitalitaliano.org.ar
Sergio Adrián Terrasa. Service and Research Department at Hospital Italiano de Buenos Aires; Public Health Department at Instituto Universitario Hospital Italiano. Argentina. sergio.terrasa@hiba.org.ar
Juan Carlos Perozo García. Universidad Nacional Experimental Francisco de Miranda (UNEFM); Teaching Integration Department, Biomedical Research Center (UNEFM); Sociedad Venezolana de Medicina Familiar (SOVEMEFA). Venezuela. jucape33@gmail.com
María Cristina da Costa Días. Sociedad Venezolana de Medicina Familiar (SOVEMEFA); Military Ambulatory Medicine. Venezuela. cristydacosta@yahoo.com
Fausto Gady Torres Toala. Makroscopio Servicios de Salud Cia Ltda; Universidad Católica del Ecuador. Ecuador. gtorres@makroscopio.com
Roberto Flete González. Hospital General Engombe. Dominican Republic. robertoflete@gmail.com - fleteroberto@hotmail.com

Working Group
Abril Collado RO (Perú); Avila A (Colombia); Bermúdez GA (Venezuela); Caballero L (Argentina); Cardozo de Angulo RA (Venezuela); Colon González MC (Puerto Rico); Cordero Tapia PA (Bolivia); da Silva AL (Brasil); Domínguez Serrudo NV (Venezuela); Ehlerman Escalante CC (El Salvador); Esteban S (Argentina); Gavilanes Cueva YP (Ecuador); Germosen Almonte YR (República Dominicana); Gloria Cristina Cordoba Currea GC (Colombia); Homero de los Santos Reséndiz H (México); Karen Vanessa Muñoz Chamorro KV (Colombia); Luna-Ruiz MA (México); Martinez-Bianchi V (Argentina); Meaux JA (Puerto Rico); Mejía M (Venezuela); Morón Vásquez A (Venezuela); Munive Angermuller M (Costa Rica); Olinisky Bentancor MM (Uruguay); Patricia Elizabeth Hernández Coronado PE (Bolivia); Paulo A (Uruguay); Paz NA (Honduras); Piñol Moreso JL (España); Ramirez Nizza R (Paraguay); Rava Dellepiane P (Uruguay); Rivera P (Panamá); Rodríguez Escobar MA (Colombia); Rojas Velasco GW (Ecuador); Trindade TG (Brasil); Vietto V (Argentina)

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Abstract

In order to contribute to the development of research in Family Medicine and Primary Care in Ibero-America and the consolidation of the IBIMEFA Network, the Work Group #4 was created for the VI Ibero-American Summit of Family Medicine in San José, Costa Rica, 2016, which was composed by a group of 54 family physicians from 21 countries. Two general coordinators and 10 subgroup coordinators were designated. The work developed by this group throughout an 8-month period has resulted in the identification of both active and priority research lines in Family Medicine and the need to develop strategies for the promotion of scientific production, such as: a) the development of research internships across the different regions, b) the identification of sources of financing; c) the design of a virtual platform with support for consultancy and research forums coordinated by IBIMEFA.

Keywords:
Research
Family medicine
Primary care
IBIMEFA

Resumo

O grupo de trabalho nº 4 da VI Cúpula Ibero-Americana de Medicina Familiar em San Jose, Costa Rica de 2016 se organizou para colaborar com o desenvolvimento da pesquisa em Medicina de Família e Atenção Primaria na Ibero-América, assim como consolidar a Rede IBIMEFA. Foi composto por 54 médicos de 21 países. Dois coordenadores gerais e 10 sub-coordenadores foram nomeados para organizar os cinco subgrupos. O trabalho realizado durante oito meses por este grupo obteve como resultado a identificação de linhas ativas e prioritárias de pesquisa em Medicina de Família e a necessidade de serem estabelecidas estratégias para promover a produção científica tais como: a) implementação de estágios de pesquisa em diferentes regiões; b) identificação de fontes de financiamento; c) desenvolver uma plataforma virtual, dar suporte para consultoria e realizar fóruns de pesquisa coordenados pela IBIMEFA.

Palavras-chave:
Pesquisa
Medicina de família
Atenção primária
IBIMEFA

Resumen

El grupo de trabajo # 4 de la VI Cumbre Iberoamericana de Medicina Familiar en San José, Costa Rica, 2016 se conformó para lograr contribuir al desarrollo de la investigación en Medicina Familiar y Atención Primaria en Iberoamérica, así como para consolidar la Red IBIMEFA. Estuvo integrado por 54 médicos de 21 países. Se nombraron 2 coordinadores generales y 10 coordinadores para dirigir los cinco subgrupos. El trabajo realizado por este grupo durante ocho meses, obtuvo como resultado la identificación de líneas activas y prioritarias de investigación en medicina familiar, la necesidad de realizar estrategias para promover la producción científica, tales como: a) desarrollo de pasantías de investigación en diferentes regiones; b) identificación de fuentes de financiamiento; c) lograr una plataforma virtual, soporte para asesorías y foros de investigación coordinados por IBIMEFA.

Palabras clave:
Investigación
Medicina Familiar
Atención primaria
IBIMEFA

Introduction

In the history of the Ibero-Amrican Family Confederation (IFMC) various relevant moments can be identified to promote research in the region: the first Family Medicine Workshop,[1] organized in Cali (Colombia, 2008) adopted the recommendations of the Ontario meeting,[2] *The World Organization of Family Doctors* (WONCA) to foster the research of family medicine and primary care and set the IBIMEFA network.[3]

During the VI Ibero-American Summit on Family Medicine (2011, Asunción, Paraguay), the effort of the research team issued a diagnosis document briefing the difficulties, opportunities, challenges and some recommendations to advance.[4] The Quito Charter - result of the V Ibero-American Summit, suggests promoting research as a key element to keep the professional level of family phisycians.[5] In 2015 the Second Ibero-American Workshop of Family Medicine and Primary Care Research took place in Montevideo, simultaneously with the first editor's meeting on family and community medicine (FCM) of the region.

The current document was a result of the VI Ibero-American Summit on Family and Community Medicine framework (San José, Costa Rica, 2016) and triggers the continuation of the summarized processes. It was written during the IBIMEFA Network, and contributes to researchers close contact, fosters the involvement of CIMF member associations with research activities and provides valuable elements for research strategic planning in Ibero-America. The objective is contributing to develop research in Family Medicine and Primary Care in Ibero America and consolidate the IBIMEFA Network as a tool for permanent collaborative actions.

METHODS

It is the result of an open work team, settled from the CIMF Executive Board's call to member Associations and to the Young Family Doctors Movement (Waynakay). The group included representative people appointed by the association as well as foreign Family Physicians who were connected to Ibero-America and answered the call (US and Denmark).

Doctors from countries that are not currently CIMF members, such as the case of Honduras y Nicaragua, were integrated so as to promote FCM in their nations and their integration to the Confederation. Once the task force was settled, priority lines for research development were defined and from there, the goals set, and five sub groups created. The working process went on for eight months, (September 2015 - Abril 2016) with the participation of 54 medical doctors from 21 countries.

There were 23 virtual meetings and e mail exchange, that included collaborative creation of documents. Once the first phase was over, there was an integrated result analysis and recommendations and conclusions were drawn. During the VI FCM Ibero American Summit held in San José, a workshop was organized and it deepened into some aspects of the preliminary document. Young doctor's from Waynakay family movement had an outstanding participation during the final phase.

Chart 1 summarizes methods and sources for every work objective.

Chart 1. Document objectives in sub groups

Work Sub groups	Objectives	Methodology	Data Sources
Diagnosis Updating	Identifying advances and research needs for research development in Ibero-America	Revision of medical history secondary data bases	Previous Summits, Congresses and 2º Research Workshop (Montevideo 2015). Interviews to researchers Researchers Data Base
Scholarships under research	Identifying places and mechanisms for scholarships implementation which are under investigation	Data collection by sub groups members Protocol Planning for Systemic Survey	Interviews to FCM organizations' web sites and Universities
Active Research lines	Describing topics under research by FCM in the Region. Data Compilation of identified research lines leaders	Online Survey	Media campaigning by means of local representatives (spreading by *snowball or sampling*) e-mailing and social networking sites (Twitter and Facebook)
Prioritized Research Lines	Identifying research lines that regional FCM group finds a priority	Online Survey	
Financing	Describing Financing Sources supporting regional access and research	Online Survey	

Results

The Situation in Ibero-America

The need for strengthening research through networking sites led to WONKA's meeting in 2003. The meeting in Cali, Colombia (2008), with the creation of IBIMEFA, pointed to the increase in research methodology competences. Incentive generation and Family Medicine and Primary Care master's degree creation was of the outmost importance but there was no advance in the mechanisms to fulfill with them.

During the III Ibero-American Summit (Fortaleza, Brazil),[6] the Cali agreements were ratified as well as the importance of spreading knowledge in the region as another strategy to contribute to academic development.

The IV Ibero-American Summit (Asunción, Paraguay)[7] pointed investigation as an strategic axe to develop more efficient and equal health systems. The need for research mentoring was expressed as well without stating at that time, the mechanisms to put it into action in the various centers where research finds its place. The benefit of having a common research agenda for every Ibero-American country was stated as well together with the importance of communicating the results of the investigations to the decision makers.

The V Ibero-American Summit (Quito, Ecuador),[8] outlined the importance of strengthening the use of communication and information technologies for research. Nevertheless, CIMF IT support is still limited and needs a widening of the strategies or action lines to respond to the idea. In 2014, research lines derived from a poll with the participation of 13 countries were the following: Degenerative chronic diseases (diabetes mellitus, high blood pressure, chronic renal disorder) health centers organization, health service evaluation, family health, community health, social determiners, health education and the elderly).

During the 2nd Ibero-American Family Medicine and Primary Care Workshop held in Montevideo (Uruguay),[9] within the framework of the 4th CIMF Ibero-Americano Congress, data was gathered and a regional research record was created. The record is considered the first step for the necessary data base collection. Thanks to an online form, there was a register of 97 researchers with an average age of 45, (SD 12), 65% women with a 65% of PhD's or master's degrees (80% has completed some kind of formal research methodology). There was a participation of 15 nations, who commented on the interest areas for research as follows: community orientation, chronic degenerative diseases, the effectiveness of educational methods, clinical problems solution competence, health centers organization, preventive view, the elderly care.

Guidelines for the medium and long term were stablished as follows:

a) Development of research scholarships in different regions and countries so as to promote scientific interchange, coordination and production;
b) Identification of financing sources to strengthen and execute the necessary research lines;
c) Creation of a virtual platform, consultancy support and research forum coordinated by IBIMEFA which should ideally be located at the WONCA Ibero-Americana-CIMF website.

Ibero-American active research lines

There were 86 entries to the online form since October 22nd to November 23rd 2015, with representation in 16 countries.

It was discovered that 16% of the active research lines had a methodology approach, that is to say, oriented to the development and improvement of certain activities, (for example; the design of primary care clinical practices guides) while the remaining 84% were headed to practice problems in FCM (ex: primary care approach to domestic or gender violence).

49% reported having financing for the al mentioned research lines.

From the reported research active lines, 15 of them (17%) did not have undergoing research activities; 24 of them (28%) had work under progress and the remaining 47 had already finished them.

Chart number 2 shows active research lines and their countries.

Priority Research Lines

There were 114 participants in the poll, resulting in 107 satisfactory answers and 7 incomplete or incorrectly answered not considered in the poll. Most of the participants reported either a lack of active research lines (64%) or had not heard about IBIMEFA Network (60%).

Chart 2. Family and Community Medicine active research lines in Ibero-America. April 2016.

Research Line Name	Country
Smoking approach	Spain
Physical Activity and Health	Spain
Adjustment and Coordination of PCAT versions in Ibero America	PCAT Ibero American Network
Analysis of Emergency Room´s non urgent consultation	Costa Rica
Family Care	Spain
Women´s care	Spain
Teenage care	Spain
Elderly care	Spain
Bioethics	Spain
Quality of life	Venezuela
Quality life related to health in middle aged women	Cuba
Patient´s quality and safety	Mexico
Cancer	Spain
Minor Surgery and Dermatology	Spain
Post abortion or Death Comprehensive Consultation	Costa Rica
Palliative Care	Spain
Dementia	Spain
Severe Dependence	Chile
Diabetes	Spain
Dyslipidemias	Spain
Sexual Diversity and old age	Uruguay
Eco Scanning	Spain
Efficency of motivational interview when managing obesity	Panama
Non transmisible chronic diseases	Colombia
Cardiovascular Diseases	Spain
Non Transmisible Chronic Diseases	Venezuela
Infectious Diseases	Spain
Infectious Communicable Diseases	Venezuela
Respiratory Diseases	Spain
Rheumatic Diseases	Spain
Approach on Biological and Psychological risk in adults	Venezuela
Approach on Biological and Psychological risk in children and teenagers	Venezuela
Leptospirosis research on Risk Human Groups environment.	Uruguay
Risk factors and cardiovascular diseases follow up in South American Cone.	Uruguay
Diabetes Report Type 2 Diabetic quality of life test Type-2 Policlinic Hugo-Spadafora April-May 2013	Panama
Test on quality of life in Type 2 diabetes - Polyclinic Diabetes clinic Hugo Spadafora April May 2013	Panama
Evaluation on metabolic Control Goals. Family Medicine Patients with diabetes Policentro de Parque Lefevre 2010-2011	Panama
Risk factors	El Salvador
Family	El Salvador
Human Talent Training in Family Medicine within the region	Colombia
Genetics Clinics and Rare Diseases	Spain

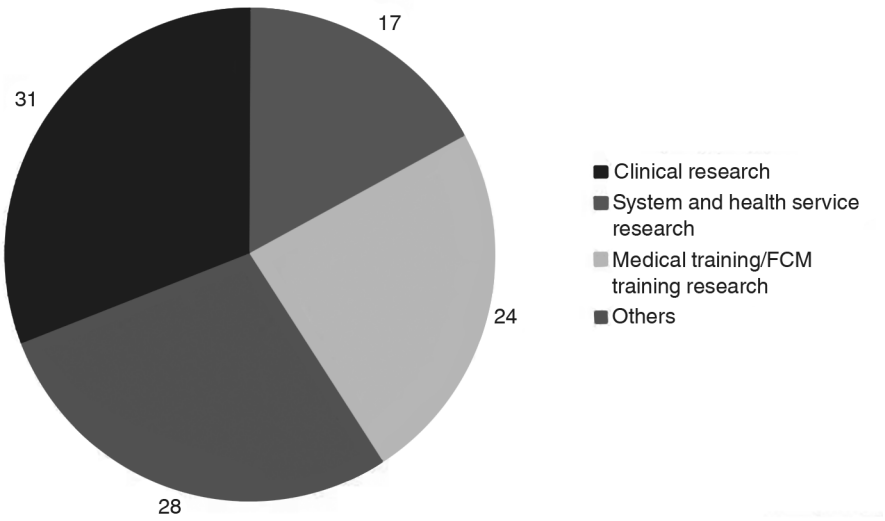
Continued Chart 2.

Research Line Name	Country
GIEMFAPS. Family Medicine and Primary Care Strategic Research Group	Venezuela
Level of fulfillment of therapeutic objectives on Type 2 diabetes mellitus patients of FCM Service from Assistance Teaching Unit (UDA) Saint Bois	Uruguay
High Blood Pressure	Spain
International Collaboration to Promote Scholarly Activity Among Young Family Physicians	Colombia
Drugs Intervention	Spain
Educational Health Intervention	Venezuela
Therapeutic Management	El Salvador
Evidence Based Medicine	Spain
Family Medicine as Health System Quality Management Strategy	Ecuador
Family and Community Medicine	Venezuela
Family and Community Medicine	Venezuela
Family Medicine and Public Health	Venezuela
Herbalist Medicine in Comorbid Patients of Family Medicine in Policlinic Presidente Remón. OCTOBER - DECEMBER 2014	Panamá
Rural Medicine	España
Educational Measures for caretakers´ in old people´s hospital	Paraguay
Multimorbid and its impact on the health system	Brazil
Nephrology	Spain
Neurology	Spain
Nutrition and Diet	Spain
Orientation to PHC Primary Health Care as an strategy to improve quality in the first level	Argentina
Cuaternary Prevention	Peru, Argentina
Primary Care Assessment Tool - PCAT. instrument adjustment and health service evaluation.	Argentina, Bolivia, Brazil, Uruguay
Primary Care Proceedings	El Salvador
Training Programs for Health Teams. On patient education Education Programs for chronic diseased patients and their families.	Venezuela
Health Services Referral and Counter Referral	Argentina
Health Risks/PHC Training	Venezuela
Emotions based Health	Spain
Family Health and Primary Care	Colombia
Mental Health	Spain
Public Health and Community Medicine	Colombia
Sexual and Reproductive Health	Venezuela
Patient´s Safety	Spain
Sifting	El Salvador
Shared Decision Making and Medicine Centered in People	Argentina
Toxicology and Occupational Health	Venezuela
Transdisciplinary and PHC	Marcelo Salinas Rojas salinasmarc99@gmail.com (Independent Researcher)
Knowledge translation	Argentina
Urgencies and Continous Care	Spain

Continued Chart 2.

Research Line Name	Country
Primary Care antibiotics use. HAPPY AUDIT II South America	Argentina, Bolivia, Paraguay, Uruguay y Denmark
Edimburgh Scale use for post partum risk depression in women who gave birth in Florida (Department)	Uruguay
Drugs Usage	Spain
HIV	Spain

The priorities identified are distributed in three similar fractions, with a slight predominance of interest in clinic research (31%), specially in chronic problems that account for 15% of the total. The other fractions are: health systems research (28%), particularly on Health Service Assessment and *Primary Care Assessment Tool* (PCAT) (11%). Finally, 24% points FCM training as a priority within the research (Graphic 1).



Graphic 1. Distribution of prioritized research lines according to big areas.

Comparison of active and prioritized lines

From the comparative analysis of lines identified as priorities and active lines, there was a big coincidence. The ten lines that obtained the most responses in favor of their prioritization were analyzed and checked if there had been active research for each of them. This crossmatch can be seen on Chart 3. Every of the ten prioritized lines has active research in family and community medicine.

La coincidence found can be interpreted as a sign of coherence between the FCM specialists convictions and their actions in relation to this research.

Research Scholarships opportunities

A protocol was written as the basis of the initial survey the purpose of which is deepening and improving IBIMEFA's continuous work. Its aim was describing the scholarship places with data available on the web, polls or institutions identified for researchers' scholarship (Chart 4).

Chart 3. Comparison between active research lines and prioritized ones in Ibero-America, according to the V Ibero-American Family and Community Medicine Summit (April 2016).

Prioritized ResearchLínes*	Response frequence favouring priorization	% of active lines covering the suggested proposal(coincidence)**
1. Report on chronic diseases in the first level of primary care	16	14.95
2. Family Medicine training	15	14.01
3. Health Service Tests	11	10.28
4. Family Medicine Tools Adjustment and Build	6	5.60
5. Health technology tests according to MBE	6	5.60
6. Technological Health	5	4.67
7. Stress and Quality of Life	5	4.67
8. Family Medicine in Rural Areas	5	4.67
9. Family Medicine as health policy	4	3.73
10. Quaternary Prevention	4	3.73

* Includes the 10 most relevant lines according the answers of their preference. ** This was taken on a total of 86 identified active lines.

Chart 4. Institutions offering research scholarships. (n=26)

University	• Universidad El Bosque - Bogota Colombia • Universidad del Valle - Cali Colombia • Universidad Peruana Cayetano Heredia - Lima Peru • Universidad Mayor de San Marcos - Lima Peru • Universidad de Chile - Santiago de Chile - Chile • Universidad de la Sabana - Bogota - Colombia • Universidad Nacional Autónoma de Honduras/Medical School • Universidad Nacional de Asunción - Paraguay • Universidad de la República (Family and Community Medicine Department) - Uruguay • Universidad Nacional Autónoma de Nuevo León, Monterrey-Mexico • Universidad de Colima - Mexico • Universidad de Texas. San Antonio, Texas • Pontificia Universidad Católica del Ecuador
Non Governmental Organizations (NGO)	• University Foundation of Health Sciences - FUCS/Colombia • Missionary Association of Family Doctors/Argentina • University Foundation, Juan N. Corpas. Bogotá/Colombia • Hospital Italiano-Family Medicine Service/Argentina
Governmental Institutions	• Ministry of Social Protection/Colombia • Primary Health Department/Chile • Government Town Halls and Community Boards/Honduras • CONCACYT/Paraguay • Health Sciences Research Institute - IICS/Paraguay • Biomedical and Social Research Institute/Bolivia • National Health Institue/Mexico • Public Health Institute of Mexico/Cuernavaca • Public Health Institute PUCE Quito/Costa Rica

Front the 26 resulting bodies, 13 turned out to be universities, 10 governmental organizations and 4 non governmental. There was no data from 11 cases.

There was no report on exclusive in classroom training, there was a case of exercise training and 18 use both (classroom/exercise) and there was no data on 7 institutions.

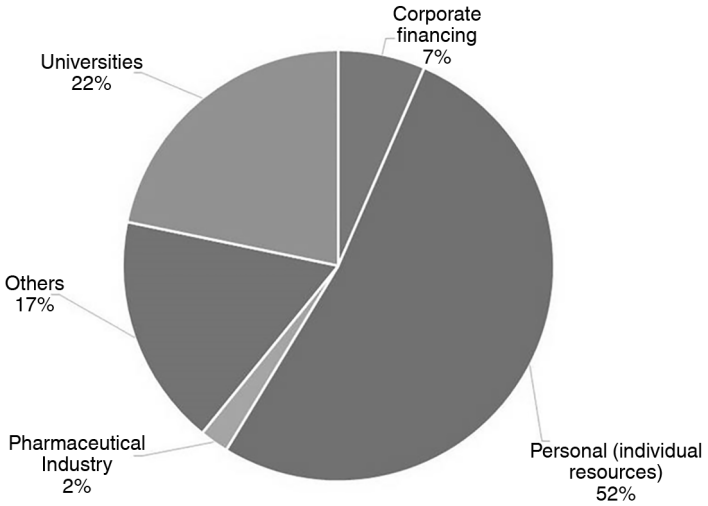
Regarding the required profile to apply for a research scholarship, 16 entities require full time dedication and 7 needed previous training.

The Latin American movement of Young Family Doctors (Waynakay) which gathers specialists with up to 5 years of graduation and residents in their specialization, works on the coordination of scholarships in various institutions through CIMF member organizations and young family doctors organizations from other WONCA regions. This strong grants strategy has been described as a valuable resource for promoting and empowering specific training scholarships.

Family Medicine research financing

Sixty professionals, mostly family physicians, were interviewed by means of a virtual tool with the objective of obtaining financing information, 77% of them reported experience in research, mostly as head researchers. The percentile 75 for seniority reached 15th (Range 1-39).

Most of the surveys were financed with researchers funds (Graphic 2). In the cases that an external financing source was identified, it was mainly from a private source of funds over the public ones. Universities accounted for 22% of the financing sources.



Graphic 2. Family and Community Medicine research financing in a non probabilistic sample of active researchers in Ibero America (n=60).

Most interviewed people did not know the research financing sources and 25% thought that there were legal obstacles to access it. The experience of financing funds management was qualitatively assessed. A minority expressed satisfaction towards the speed and simplicity of the procedures. In most of the cases barriers and difficulties were observed at different levels in this management: access (insufficient prioritization of primary care research), bureaucracy, taxes, management necessary time, delays in institutions pay out.

Conclusions

Previous Summits have defined crucial strategies to strengthen research in different nations and in the region itself. Nevertheless, there is a need for advancing in the implementation of these actions, either as a region or individually as countries.

It is of the upmost importance then to assure communication and cooperation among countries in Ibero-America, by means of a common agenda, joining efforts and the development of a shared platform to disseminate information,

projects, resources, opportunities, methods and investigation techniques in Primary Care. IBIMEFA seems to be the essential resource to implement this strategy.

The presence of researchers working actively on the region's priority lines, has been identified as an important element in this survey. It reports on the coherence of family and community medicine researchers who investigate into priority issues and at the same time giving an initial and accurate qualification to the research being carried out in the area.

Another identified resource was the wide range of opportunities to get grants in different governmental and non governmental centers in the region. Universities are the main reference point in this respect.

Limitations to financing sources are obstacles overcome in an effort to boost FCM research in Ibero America. The intention of researching witnessed clearly by the predominant self financing as resources source in the region, has to go hand in hand with knowledge and competences acquisition in the search of funds. IBIMEFA Network can contribute greatly to power intrinsic resources in family and community medicine and its research associations while generating new spaces and resources for coordination and implementation. Improving investigation abilities will boost funds raising for knowledge production in FCM and primary care.

Research Limitations

The most important weaknesses identified here are the non systematized data collection method, and the non probabilistic sampling, that limit inference results. Nonetheless, the high level of participation of people and countries in this group and the number of responses from representative people within FCM in each country can power data in spite of the identified flaws. Future can be designed to widen the scope of this research to the researchers universe or a representative sample.

Almost 60% of the interviewed professionals on the investigation lines to be prioritize were not active researchers at the moment. Having this in mind, the answers may reflect necessary lines in the region or topics where there is a need for a higher updating of knowledge in clinical practices which might or might not be solved with research. Despite this, the consistency between prioritized and active lines adds consistency to the results.

Recommendations

1. Continue working to develop and strengthen the IBIMEFA network as a resource to integrate researchers within the region; identifying and building opportunities to train researchers and finance projects.
2. Keep the updating on the research situation in Ibero America active and forward looking.
3. Stablishing a regional formal researchers report with data that facilitates experience interchange, training and collaborative study research.
4. Continue identifying research priority lines with a careful call on FCM researchers and referent people in each country, Young FCM professionals and the community to enrich the list of priorities that has resulted from the first phase of this research.
5. Developing a financing management process with international representation with a consulting role for FCM researchers.
6. Promoting a more fluent dialogue from CIMF with universities and financing institutions as a way of contributing to the generation of opportunities in Ibero American Region to foster research in FCM.
7. Increasing resources and actions for communication and spreading within CIMF so as to favor a higher researcher integration and scientific production dissemination.

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ESSAYS

Quaternary Prevention: Medical Ethics, Evaluation and Efficiency in the Health Systems

Prevenção Quaternária: Ética Médica, Avaliação e Eficiência nos Sistemas de Saúde

Prevención Cuaternaria: Ética Médica, Evaluación y Eficiencia en los Sistemas de Salud

Miguel Pizzanelli. CIMF Quaternary Prevention Interest group; Family and Community Medicine Department, Facultad de Medicina de la Udelar. Uruguay. miguelpizzanelli@gmail.com *(Correspondig author)*
Marina Almenas. Family Medicine Academy of Puerto Rico; CIMF/WONCA; American Academy of Familiy Physicians. Puerto Rico. dra.almenas@gmail.com
Robert Quirós. Universidad de Costa Rica; Moravia Health Area, San José, Costa Rica; Costa Rican Family and Community Medicine Association. Costa Rica. rmqdoc@gmail.com
Carlos Pineda. Universidad del Valle; Colombian Family Medicine Society. Colombia. capineda1@gmail.com
Esteban Cordero. Caja Costarricense de Seguro Social (CCSS). Costa Rica. estebch@gmail.com
Niurka Taureaux. Facultad de Ciencias Médicas "General Calixto García". Cuba. niurka.toro@infomed.sld.cu; niurkataureauxcu@gmail.com
María de Lourdes Rojas. Universidad de Quintana Roo; Colegio Mexicano de Medicina Familiar. México. educación.rubi@gmail.com
Karin Kopitowski. Departamento de Medicina y Directora del Departamento de Investigación del Instituto Universitario Hospital Italiano. Argentina. karin.kopitowki@gmail.com
Ricardo La Valle. UBA área Salud Publica; Instituto Universitario del Hospital Italiano. Argentina. lavayear@gmail.com
Mónica Nivelo. Departamento de Atención Primaria y Salud Familiar en la Universidad de Chile; Sociedad Chilena de Medicina Familiar. Chile. monicla61@gmail.com
Verónica Menares. Hospital Clínico FUSAT; Sociedad Chilena de Medicina Familiar. Chile. v.menaresl@gmail.com
Agustina Piñero. Facultad de Ciencias Médicas, Universidad Nacional de Córdoba. Argentina. agusep@hotmail.com
Sonia Ortiz. Academia Médicos de Familia de PR. Puerto Rico. seofmd@aol.com
Rolando Herrera. Sociedad Boliviana de Medicina Familiar. Bolivia. enfoquealasalud@gmail.com
Alexis Correa Taja. Universidad de Ciencias Medicas (UCM). Nicaragua. acorrea5969@hotmail.com

Task Force collaborators during the Costa Rica Summit
Andrés Szwako, Paraguay; Carmen Nadal, Chile; Daniel Odio, Costa Rica; Diana Cáceres, Chile; Fernando Castañeda, Panamá; José Luis Contreras, Chile; Leticia Laura, México; María de Lourdes, México; Nina Monteiro, Portugal; Pedro Gómez, Costa Rica; Virginia Cardozo, Uruguay; Yamileth Quintero, Portugal.

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Abstract

Quaternary Prevention as main focus and practice, promotes changes in developing health care and practicing medicine, prioritizing the person centred care.Their conceptual framework is sustained on ethical and philosophical aspects essential to medicine practice, in epistemological aspects of social and others related to political nature. Its objective is to protect fundamentally the patients, but also the members of the health group from excessive medicalization and unnecessary and hurtful practices. The present article is the result of the synthesis of the work documents, discussion and proposals carried forward by a large group of committed professionals from CIMF, with particular interest in Quaternary Prevention. The materials were produced in collaboration through a complex long distance work process, done during preparatory forums of the VI Ibero-American Summit of Family And Community Medicine. The work documents made during the same summit in San José of Costa Rica, in April 2016 were added to this material. The purpose of this document is to spread the state of development and current commitment to this approach and the outstanding initiative that it has had in Ibero America in the last five years. Due to its relevance, the intention is to stimulate greater dissemination of the concept; the implementation of content related to at in the training and academic levels. At a political level, to promote its consideration on decision making and public health issues so as to broadcast to demographic levels and promote the making of quality content. Finally to offer reflection clues to consider and concrete application tools.

Keywords:
Quaternary Prevention
Physician-Patient Relations
Bioethics
Medicalization
Overdiagnosis

Resumo

A Prevenção Quaternária consiste em desenvolver cuidados de saúde e exercer a medicina priorizando o cuidado centrado na pessoa. Seu arcabouço conceitual se sustenta em aspectos éticos e filosóficos fundamentais ao exercício da prática médica, também em aspectos epistemológicos e de caráter social. O seu objetivo é proteger os pacientes, mas também os membros da equipe de saúde, dos excessos da medicalização e das práticas excessivas ou desnecessárias ou prejudiciais. Este artigo é o resultado da síntese dos documentos de trabalho, discussão e propostas levada a cabo por um numeroso grupo de profissionais comprometidos com a CIMF, com particular interesse na Prevenção Quaternária. Os materiais foram produzidos de forma colaborativa através de um extenso e complexo processo de trabalho a distancia, realizado durante as reuniões preparatórias da VI Cúpula Ibero-Americana de Medicina de Família e Comunidade. A estes materiais se somaram os documentos de trabalho preparados durante a mesma cúpula em San Jose, Costa Rica, em abril de 2016. O objetivo deste artigo é o de difundir o estado de desenvolvimento e de compromisso atual com esta abordagem e o impulso notável que tem havido na Iberoamerica nos últimos cinco anos. Por sua relevância, pretende-se estimular uma maior difusão do conceito, bem como a implementação de conteúdos relacionados a ele na formação e em nível acadêmico; a nível político, promover sua consideração na tomada de decisões de políticas públicas de saúde; difundir a nível da população e promover o desenvolvimento de conteúdo de qualidade; oferecer pistas de reflexão e ferramentas práticas para sua implementação.

Palavras-chave:
Prevenção Quaternária
Relações Médico-Paciente
Bioetica
Medicalização
Sobre diagnóstico

Resumen

La prevención Cuaternaria consiste en desarrollar cuidados de salud y de ejercer la medicina, priorizando los cuidados centrados en la persona. Su marco conceptual se sustenta en aspectos éticos y filosóficos centrales en el ejercicio de la medicina, en aspectos epistemológicos y de carácter social. Su objeto es proteger fundamentalmente a los pacientes, pero también a los integrantes del equipo de salud, de los excesos de la medicalización y de los excesos o prácticas innecesarias o dañinas. El presente artículo es el resultado de la síntesis de los documentos de trabajo, discusión y propuestas llevadas adelante por un amplio grupo de comprometidos profesionales de CIMF, con interés particular sobre la Prevención Cuaternaria. Los materiales se produjeron en forma colaborativa por medio de un largo y complejo proceso de trabajo a distancia, realizado durante los foros preparatorios de la VI Cumbre Iberoamericana de Medicina Familiar y Comunitaria. A estos materiales se sumaron los documentos de trabajo elaborados durante la misma cumbre en San José de Costa Rica, en el mes de abril de 2016. El cometido de este artículo es difundir el estado de desarrollo y de compromiso actual con este enfoque y el destacado impulso que ha tenido en Iberoamérica en los últimos cinco años. Por su relevancia, se pretende estimular una mayor difusión del concepto: la implementación de contenidos relacionados con él en la formación y en el nivel académico. A nivel político promover su consideración en la toma de decisión, en políticas de salud pública. Difundir a nivel poblacional y promover la elaboración de contenidos de calidad. Ofrecer pistas de reflexión y herramientas concretas para su aplicación.

Palabras clave:
Prevención Cuaternaria
Relaciones médico paciente
Bioética
Medicalizacion
Sobre diagnóstico

Introduction

The current article has been the result of a process of a tight summery of documents, discussions and proposals of a large group of professionals. The material leading to the elaboration of this communication was taken from a collaborative environment during a vast and complex process of long distance work that were part of the preparatory forum of the VI Ibero American Family and Community Medicine Summit. To the existing material were added the documents result of the San José de Costa Rica Summit, that took place during April 2016. This should be understood then as a very concise version of the production content the objective of which is to communicate advances. To access the whole document it is necessary to do it through the Member Scientific Associations or making contact with the CIMF Task Force of Quaternary Prevention.

It was in March 2015 during the 4º Family and Community Medicine Congress that Quaternary Prevention was considered for the very first time as one of the theme axis in an Ibero American Congress. It was during this event that the Quaternary Prevention Interest Group was formally created within CIMF.[1] Likewise, Quaternary Prevention appeared for the first time as part of the agenda of an Ibero American Summit.

Definition/Concept principles

Quaternary Prevention can be defined as: *"a group of implemented actions to identify a patient or a population under medicalization risk, protect them from invasive medical interventions and suggest ethically accepted care/ proceedings"*.[2]

Quaternary Prevention, in terms of approach and practice, fosters changes in the way that health care is developed and medicine is practiced, prioritizing that the care be centred in people.

Its concept framework is based on ethical and philosophical key principles. Its mail goal is not only protecting patients, but also the health team, from excessive medicalization or unnecessary hurtful practices.

The concept was born in 1986 when Marc Jamoulle (Figure 1) combined in the same concept scheme, prevention timeline with relational dimension (person - doctor): the concept of a patient's vision facing the doctor's in a health episode.[3]

From the model Leavell and Clark proposed,[4] prevention levels have been stablished. Every level sets out actions to avoid illness onset, interrupting its advance and mitigating side effects once they have shown up. Each measure is in close relation to the stages of the natural history of the illness and they are commonly classified until the emergence of quaternary prevention in the three levels. Thus, quaternary prevention is not lineal regarding the others, it can also be applied in other action fields thriving for necessary, pertinent safe activities based on balanced evidence without risks. This approach can be applied to every level of traditional prevention but it is not exclusive to it. It is oriented to health care in general thus it is not restricted to preventive or healing processes.

Quaternary prevention can be understood as a strategy meant to diminish iatrogenia and avoid unnecessary practices and to ease secondary effects deriving from those necessary practices.

In other words, it would be and new and updated concept of "Primun non nocere" passed on doctors' generations.

Quaternary Prevention is more than an objective activity. It invites to think more broadly about practices from different levels of complexity. The reflection and later modification of practices can be used in different ways: thinking about health organizations differently, the way we face people's communication, the approach to the survey questions, sifts risk benefit balance, the effects on over diagnosis and excessive treatment, the consequences of unnecessary treatment, conflict of interests. Excessive care and the resulting resources exhaustion must be analyzed from an ethical point of view as they can result in people with unnecessary care or populations with difficulties to access the right assistance, something that happens quiet frequently in Ibero-America.[5]

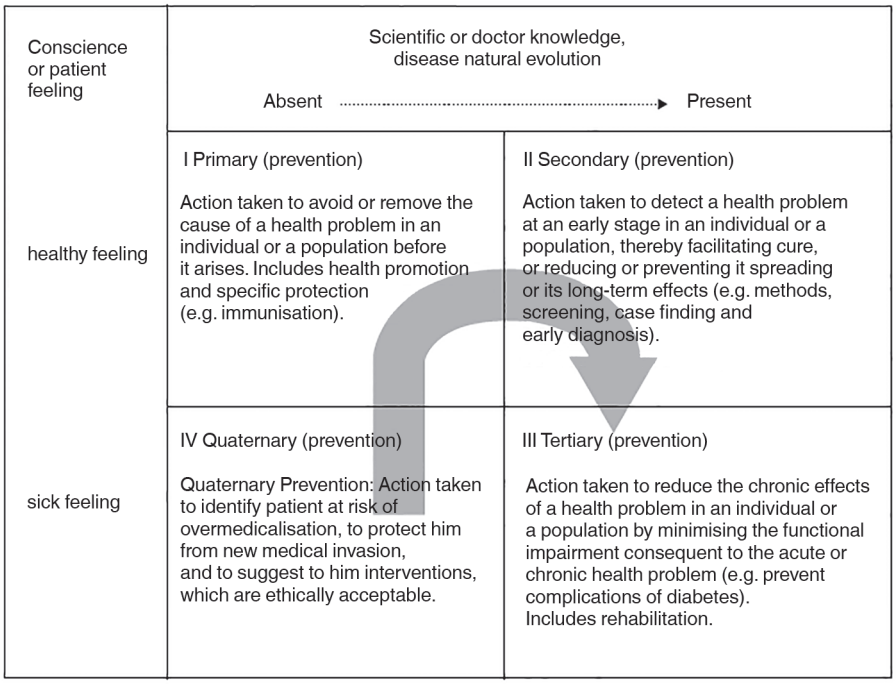

Figure 1. The definitions already published on Prevention I, II and III are complemented by Prevention IV and offer a new vision of family physician activity fields.
Source: Adapted from Jamoulle M, Gomes LF. Quaternary Prevention and limits in medicine. Rev Bras Med Fam Community. 2014;9(31):186-91. Available in: http://dx.doi.org/10.5712/rbmfc9(31)867

Medicalization

Medicalization is understood as the process of changing vital situations into pathological ones and trying to solve by means of medicine situations that are social, professional or interpersonal relationships but not medical.[6,7]

It is also a medical issue solving situations that are not medical or which were not considered as such. Health professionals are at the same time actors and victims in the process.[8,9] Medicalization has as main consequences making healthy people ill, increasing iatrogenic harm, the consumption of sanitary resources and the lack of processes meant to regulate population's expectations, setting medicine's action field, fostering self care and behaving according to existing health evidence.

Description on the current situation of dissemination and application in Ibero America

Although there is an enormous drive to make the concept popular in the region from the CIMF societies, it is necessary to improve dissemination and impact.[10]

Method

In order to gather more reliable data on this reality, doctors active in the team work participated in a survey on some topics related to dissemination and application of Quaternary Prevention in health systems, governments and each country.

Data on the situation of the following 13 countries was gathered: Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Spain, Mexico, Nicaragua, Paraguay, Puerto Rico, Dominican Republic and Uruguay.

From the total, 58% of the participants, stated that their countries have promoted the incorporation of Quaternary Prevention. Only two countries confirmed the adoption of recommendations based on the principles of Quaternary Prevention in Family Physicians ractices.

Results

58% reported knowing about activities on the topic carried out in congresses, scientific events or training societies.

50% reported having areas to think about the issue. Four countries (33%) published information related to the subject, though. Three countries reported knowledge on research projects with a related approach.

Only two of the surveys reported knowledge on Quaternary Prevention on the general population.

Two thirds of the surveyed parts confirmed talking about Quaternary Prevention with patients. Two countries (16%) reported knowledge on behalf of governmental institutions in their countries. Only 4 countries (33%) confirmed government Quaternary Prevention actions in their countries and 63% recognized the real possibility of having this topic discussed at a government level.

Discussion

Although the obtained results cannot be considered totally representative of Latin America, it is still necessary and insufficient the dissemination at a population level within the medical and academic environments as well as between health authorities and decision makers.

The methodology to elaborate preparatory documents and those oriented to elaborate recommendations to the Summit, was carried out in a very participative way and was divided in two parts: a virtual and a face to face one. The first one was through networking sites, long distance work and communication and took place between August 2015 and April 2016. The second part (face to face) took place in the summit resulting in: final conclusions, recommendations, contributions to the final declaration and conclusions and communication products were shown during the plenary.

Different contents and strategic lines were developed in three working axis: recommendations to introduce the concept of family doctor's training (under and post graduate), in the community, in the general population and in public health policies levels.

Action Lines in the Academic Scenario

At an academic level, it is necessary to disseminate, consolidate and apply the concept of Quaternary Prevention among health professionals, especially in the under and post graduate circles at universities.

It is imperative to promote the concept of Quaternary Prevention and present it as a genuine clinical activity in our daily community practice. It should deepen and invite colleges to think on its meaning and how to apply it in real situations.

University binding to have a proposal for Quaternary Prevention in the C.V.

The university must consider, as its own, the problems identified in the environment and contribute to its solution and thus gain prestige in the community who, in turn, will transform their opinion about the institution. At the same time, the university will be assuming the role that corresponds to itself, especially with regard to undergraduate and graduate education and training.[11-15]

Strategies for curricular management on Quaternary Prevention in Ibero-American professional training

Making a document on curricular recommendations with a basic concept of Quaternary Prevention and its implications in health; setting the competencies it implies with their respective cognitive, procedural and attitudinal knowledge.
1. Training: under and post grade.
Inserting Quaternary Prevention Modules in under and post grades.
Promoting participation of Quaternary Prevention in professional training.
Strengthening the use of critical reading tools of articles that help develop critical thinking and bias analysis.
Developing workshops for ethical discussions, effective communication, health care centered in people and shared decisions.
Favoring research development focusing on Quaternary Prevention for Resident Family Doctors.
Inclusion of Quaternary Prevention in professional evaluations or certifications for Specialization Councils.
2. Generating documented heritage on Quaternary Prevention.
Developing a Quaternary Prevention Observatory.
Generating a digital normative file on Quaternary Prevention.
Developing journals and videos on Quaternary Prevention.
Favoring interdisciplinary work on Quaternary Prevention (health teams, other health and technical professionals, specialists).

Quaternary Prevention includes topics such as:

- Medicalization;
- Concept of health and illness;
- Over diagnosis;[16]
- Excessive preventive interventions;[17]
- Cancer Screening;[18]
- Cardiovascular risk;
- Executive Check ups;
- Vaccination effectiveness and safety;
- Illnesses Marketing;
- Excessive use of laboratory tests, diagnostic imaging, incidentalomas;
- Over medicalization: polipharmacy, deprescription (rational use of medicines), side effects and pharmacological cascade;
- Patients' safety;
- Research on factors that affect medicalization, Medicine Based on evidence: Research Ethics, Bioethics on current clinical practice;
- Clinical Method: effective communication, clinical method centered on people, rel clinical method centered on relation, health care centered on people, shared decision making and decision making help.

Curricular Path

The process of how to materialize the previous into a micro curriculum, is a complex task because every university has its own syllabus. The following exercise is a mere theoretical approach to the contents that could be included in certain courses in a specific curricular sequencing.

Proposals to establish policies in accordance with Quaternary Prevention thinking

Any reform of a health system must start from the ethics standpoint and be founded on sustainable development with clearly stablished political principles that assure ecologic care, community participation and different sectors as a group so as to co create solutions for a sustainable change.[19]

A comprehensive strategy on human development and health strategy, with an equity approach and impact on health determinants requires: a health system that pursues poverty and starvation overcoming; that assures health care and promotes well being for everyone all over their life cycles; that contributes to education and development opportunities and genre equity, to water sustainable use and management, to sustainable economic growth with dignifying work, fosters access reliable and sustainable energy, that helps design nature disasters resiliency infrastructure; fosters steady innovation and industrialization, encourages country inequity reduction, contributes to production patterns and sustainable consumption, takes measures to fight climate change and its impact, fosters the rational use of natural resources towards sustainable growth, collaborates to protect land ecosystems and biodiversity, participates promoting peace in inclusive cities, strengthens the means to implement social associations, in this particular case, global health for sustainable growth.

In this context quaternary prevention has a special contribution. If we consider it as a movement,[20] it can bring about changes in the way medicine is and is used, in the way health systems are organized emphasizing the ethical and philosophical goal of protecting patients and health team members from medicalization excess and commodification and profit eagerness of some actors. The following principles are suggested to begin this change:

1. Health is a right not a marketing object.[21]
2. Health cannot be understood only analyzing the health sector and ignoring its context, it is necessary to incorporate the social and political look in favor of the profession and include the social determinants when developing health policies. The predominant current medical model, analyzed from the sociological point of view can be defined as hegemonic, reductionist, fragmented, inhumane and profit oriented and mercantilist.[22]
3. Medicine as a science is mainly social. It should quit the reductionist view from positivism and neo positivism and become an art before becoming a science to recover that capacity to deal with people who feel and suffer, understanding the importance of incorporating science and technology without overlooking their biomedical knowledge.
4. The definition of a health system is political and it is engrained in the definition of the model country it belongs to.
5. The practice of medicine is cut and determined by politics and physicians thus, they can not have a passive role, they must contribute with their particular view of the society and participate in the role model.
6. Primary Health Care (APS) only works when it is integrated to a health system, it can not work isolated from the rest. It has to be integrated to all attention levels transversally distributed in complexity levels.
7. Family Medicine must be considered as a transversal specialization.
8. Complexity in medicine must be defined in relation to the health agent problem solving capacity and not in relation to technology.
9. Knowledge and medicines are social goods. The seventh principle in the World Health Organization Preamble "The benefits of Medical and psychological knowledge and the like, must be extensive to all nations as it is essential to achieve the highest grade of health".[23] The existence of obstacles to access it, patents and excessive pricing are against the task of achieving this goal.

Some concrete measures to take this to a political level:

- Identifying public policies in the countries signing the San José Charter, which do not fulfill with the criteria stated in it.

- Creating working environments in every scientific society, with the aim of revising and periodically updating the implemented national guidelines.
- Promoting thinking and continuously design associated policies to disseminate information related to health interventions.

Proposal on action lines to disseminate and apply the concept or Quaternary Prevention in the society

Medicalization and risk management as health practice, brings about new categories, totally unknown to medicine "the new sick or healthy sick" Healthy people are given importance in the world of the sick, in many occasions with a lot to lose in terms of damages and nothing to gain in terms of health. There are several engines that have driven to this situation in which almost no one is healthy. One of those engines is the excessive worry on behalf of the public in general for keeping health at very high prices. In many cases patients force medication[24] ignoring the causes this can have.

The demand for a cure is usually present together with total abolition of symptoms. Sometimes the patient does not relate what is going on and that the body expresses with a symptom something that has to do with life and not necessarily with an illness. In some sectors health is viewed as a consumable good and not as a right. This situation favors medicalization, the abundance of test, unnecessary and harmful many times and drugs prescription. Society has displaced to the medical field the search for solutions inherent to social and subjective reality, besides their obsession for perfect health has become a pathogenic factor.

There is a phenomenon called (health paradox) that keeps an eye on developed countries and middle and high class layers in developing countries. This paradox consists of: the higher the objective health (health indicators, life expectancy) the more the declared health problems and the more the resources used in health, the bigger amount of people that feel sick. That is to say, society lives overly worried exaggerating about their health. There is such dependence on medicine "call your doctor in case of any question" that people become incapable of taking care of themselves, tolerating suffering or discomfort.

The idea is walking towards an information transmission model in every possible way: leaflets, social networking sites, billboards, radio, television, networking sites ads, blogs, videos. The purpose of the dissemination of material is showing balanced content, with pros and cons and assuring quality material that avoid sift. It is like this then, that each person will have a more balanced opportunity of choosing according to their values and their rights for self determination.

Proposals:

- Spreading the concept of Quaternary Prevention as a fundamental aspect of the current medical practice.
- Promoting the fact that practices should match people's needs, prevention levels and be based on the best possible evidence.
- Stablishing clearly and with scientific evidence how suitable a test can be measuring its cost/effectiveness in every preventive level matching people, family or community needs.
- Creating messages that stimulate relevant dialogues between the public and the family doctor.
- Recommending the idea of non medicalization in normal life stages or existential problems.
- Setting practices in which the proceedings are accurate from the ethical and scientific point of view, people centered and based on shared decisions.
- Helping patients to ask about their options and pro and cons of each of them.
- Fostering among doctors, general population, politicians and decision makers the search for necessary documentation to strengthen the knowledge on Quaternary Prevention on portal or virtual libraries such as: Choosing Wisely, USPSTF, Evalmed.es.

- Promoting the use of documents, billboards, leaflets and educational videos with access through CIMF Quaternary Prevention networks.

Conclusions

Priority proposals are included as conclusions for the summit's final document:

- Disseminating the concept of Quaternary Prevention as the main approach among health professional practices, in under and post graduate levels, on continuous training, on investigation, making a recommendation document with that purpose and making contact with the different organizations that define current Medical education policies.
- Promoting non medicalization during typical life stages by means of strategies jointly developed with health teams and communities.
- Fostering health interventions directed to the population, are based on the best scientific evidence and ethically acceptable for the local context where people are centered.

Quaternary Prevention deals with the activities that mitigate or avoid unnecessary o excessive practices.

SHARED DECISION MAKING

Doctor and patient can work together, to select better options, having in mind the best available scientific evidence, as well as values and preferences of a well informed patient.

FOR MORE INFORMATION: Some websites where you can learn more about Quaternary Intervention

www.choosingwisely.org

www.familydoctor.org

www.uspreventiveservicetaskforce.org

www.nogracias.eu

www.facebook.com/PrevencionCuaternaria

GRUPO DE TRABAJO DE PREVENCION CUATERNARIA-CUMBRE IBEROAMERICANA DE MEDICINA FAMILIAR SAN JOSÉ, COSTA RICA 2016

What is Quaternary Prevention?

Mandatory screening

Some massive programs are fostered and instituted by the health system by means of regulations or law. In other cases they are imposed by habits and customs.

Excessive Screening by frequency

The inadequate frequency of screening tests increases the possibility of a positive test result.

What is Quaternary Prevention?

There are various kinds of prevention being primary, secondary and tertiary the most common but Quaternary Prevention is equally important.

Quaternary Prevention refers to a group of actions taken to avoid or mitigate side effects deriving from excessive and unnecessary practices.

WHAT IS IT FOR?

- It can be understood as a strategy that intends to diminish unnecessary practices and palliate side effects.
- Fights iatrogenic health problems: those processes that would have never happened if recommendations, tests, pharmacological or health available treatments that have serious side effects had not been used.
- It fights life medicalization: the process of making situations that have been regular in pathological cases, and intends to solve, by means of medicine, social, professional or interpersonal situations that are not medical.

- Quaternary Prescription intends to raise a voice and give currency to one of the most valuable methods "Primun non nocere" (avoid damaging first)

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LETTER OF SAN JOSÉ

VI Iberoamerican Summit of Family and Community Medicine
San José, Costa Rica
12th and 13th April 2016

On the 12th and 13th April 2016, in the city of San José, Costa Rica, the VI Ibero-American Summit of Family and Community Medicine was held under the theme:

"Universality, Equity and Quality in Health Systems:
Family and Community Medicine as Axis"

This great event was organized by the Ministry of Health of Costa Rica, the Costa Rican Department of Social Security, the Latin American Confederation of Family Medicine (CIMF), the World Organisation of Family Doctors (WONCA), the Association of Family and Community Medicine of Costa Rica (MEDFAMCOM), the Pan American Health Organization/World Health Organization (PAHO/WHO), and with the collaboration of the Universidad Iberoamericana (UNIBE). The primordial objective was that of reviewing the concepts of universality, of quality, and of equity in health systems, and the role to be played by the Family and Community Physicians.

Family and Community Medicine (FCM) in the world has been a pillar of comprehensive care for people, providing efficient health services to all populations and in all social scenes, based on the principles of Primary Care (PC). For this reason, representatives from 24 countries as members of WONCA, WONCA-Iberoamericana-CIMF, advisers from PAHO/WHO, Government Institutions, Academic Institutions, Local Governments and Civil Society, were given the task of engaging in discussions based on 5 theme axes:

Axis 1: Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis

Axis 2: Formal Medical Education in Family and Community Medicine, Certification and Recertification

Axis 3: Reference and Counter Reference System: care coordination mechanisms and role of Family and Community Medicine in the structure of Network Health Services

Axis 4: Research in Family and Community Medicine

Axis 5: Quaternary Prevention: Medical Ethics, Evaluation and Efficiency in Health Systems

Target

Health Ministers from Ibero-America and their representatives; Health Departments - State/Provincial and Municipal; representatives of WONCA, WONCA Iberoamericana-CIMF and their member countries; deans and authorities from medical schools, residency program coordinators of Family and Community Medicine; representatives of scientific and academic societies of this medical specialty, other members of health teams and health authorities of the countries of the region.

From partaken discussions in the working groups, the following definitions and recommendations were generated.

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Definitions

The following definitions were established in order to build a common conceptual framework from the perspective of Family and Community Medicine:

a) Family and Community Medicine and the Physician Specialist in Family and Community Medicine

The Family and Community Medicine is an essential medical speciality to ensure the sustainability of health systems. It provides care focused on the person, in their family and community context, continuously, regardless of age, sex, socioeconomic or health status, integrating, in the care process, physical, psychological, social, cultural, and existential factors that resulted in the health-disease process.

The Physician Specialist in Family and Community Medicine has a professional and social responsibility to their community. They play their role, through promoting health, preventing disease and providing clinical, rehabilitation and palliative care; doing it according to health needs, respecting cultural diversity and optimizing the resources available in the community. Must take responsibility for developing and maintaining their skills, personal balance and values as a basis for providing safe and effective care. The Family and Community Medicine is a key tool for the development and maintenance of the people's health. (Padula A. & León, 2016)

b) Universality with focus on Primary Care and Family and Community Medicine

We understand Universality as the people's right to have access to PC services as well as to the FCM ones, with a comprehensive, integrated and continuous focus, regardless of socioeconomic or geographical condition of the individual, their family or community. Universal health coverage implies the need to recognize the crucial role of all sectors to ensure the people's health and the importance of its inclusion in the network of health services.

c) Universal Health Coverage

It is the guarantee of everyone's right to access the health system; provided by a comprehensive and integrated state-wide basis with public funding; allowing equalitarian, equitable, timely, comprehensive and qualified care; based on the principles of solidarity and social participation; with the first level of the system as the coordinator of care; with family and community doctors in health teams; ensuring first and continuous contact; centred in the person and his/her family and community context; in accordance to the health needs that arise in the course of their lives.

d) Quality in Primary Care

It is a systematic process of qualitative and quantitative evaluation that aims for the development and continuous improvement of the PC's and the FCM's essential attributes and derivatives. It includes training and specific professional performance for this level of health care, it considers the processes of caring and the outcomes achieved, physical and functional structures of health units, with the objective that at this level of health systems, health care becomes available in a fair and qualified way, in accordance with the needs of health for all people referred to it. It also involves aspects concerning work motivation and satisfaction, the health model and the degree of social participation from the health team in relation to the solution of problems and results achieved, as a strategy of social empowerment in the health field.

e) Equity in Primary Health Care

The term equity is closely linked to the right to health and its legal practices. It is a principle of social justice; equity implies a qualitative and quantitative distribution of comprehensive and integrated health services tailored according to the needs, in other words, that every person, family and community gets what they need in order to restore and maintain health and wellness, from both management in the social process and intersectoral participation. Since the beginning of the FCM, equity has been practiced with focus on individuals, families and communities, respecting their biopsychosocial, political, and cultural environment, as well as their self-determination; from the development of management, teaching and research assistance functions in order to meet health needs.

f) Quaternary Prevention

Quaternary Prevention consists of developing health care and practice medicine, prioritizing person-centred care. Its conceptual framework is based on core ethical and philosophical aspects in the practice of medicine, in epistemological aspects and of social character. Its purpose is primarily to protect patients, as well as the members of the health team, from the excesses of medicalization and excess or unnecessary or harmful practices. It is a strategy that tends to reduce iatrogenesis and mitigate the adverse effects of the interventions required.

Recommendations

Axis 1: Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis

1. At the level of each nation, organize dialogs about the role of the FCM in moving towards universality, equity and quality in health systems.
2. Manage effectively and equitably the resources, based on the analysis of the health situation of the population, and also integrating social participation as one of its axes.
3. Incorporate the model of family medicine as a mechanism for implementation of the PC, in the first level of care, with the addition of FCM specialists leading the transdisciplinary team, keeping the individual, family and community approach, with an emphasis on fomentation, prevention and health education activities.
4. Establish trans disciplinary FMC specialist teams with qualified leadership, in order to ensure effective access to health services (individuals, families and communities), in the first level of care.
5. Ensure the resources that allow the primary care health team to develop their potential to solve at least 85% of the demand for medical care at this level.
6. Strengthen, for each country, the planning and national dialog mechanisms on the requirements for the formation and transformation of FCM specialists; assuring them of universal distribution, employment and economic compensation as a specialist doctor.
7. Propose an evaluation model of the quality of care in PC and FCM for Latin America, considering the already existing models.

Axis 2: Training in Family and Community Medicine, Accreditation, Certification and Recertification

8. Training:
   - 8.1. Guiding the training contents towards acquiring professional skills, in order to facilitate the development of a comprehensive and holistic approach model of health-disease-care process, based on a social determination approach which fosters solving the health problems most prevalent in our populations, in all stages of the life cycle.
   - 8.2. Incorporate FCM educational proposals which consider the threats coming from educational policies, the economic system, social movements, management styles, and organizational cultures that prevail in our universities, most of the time supported by the biomedical paradigm.
   - 8.3. Train FCM specialist on the stage of a Centre for PC, with appropriate teaching methods: mentoring, monitoring office of MFC, workshops in the classroom, role playing and Gessell chamber, videotaping student in medical consultation, Problem-Based learning, Case Method, among others.
9. Accreditation:
   - 9.1. Establish a curriculum based on the core competencies of family and community physicians, as well as that of forming units to ensure the integrity of learning, considering local and national needs. These processes should involve different entities such as scientific societies, medical college, universities, government agencies, health institutions, WONCA-Latin America-CIMF, and other organizations that may be involved.
   - 9.2. Have quality accreditation systems of the training programs, which include peer review process.
   - 9.3. Establish a communication system for the exchange of experiences between the different countries of the Region.
10. Certification

    Promote the development of Family and Community Medicine specialist systems of certification and recertification in the countries of Latin America, fostering the improvement in the provision of health services by competent physicians, scientifically and technically updated, in spite of the environment in which it develops.
11. Recertification

    Establish systems of recertification gradually, according to the contexts of development of the specialty adopted in the different countries, respecting their needs and local reality. Should be temporary (e.g. every 5 years), and, in no case, viewed as final, and contain the basic pillars of the competencies of Family and Community Doctor.

Axis 3: Reference and Counter-Reference System: care coordination mechanisms and role of Family and Community Medicine in the structure of Health Service Network

12. Ensure the participation of family and community doctor from the primary care level Patient Referral and Counter-Reference System (PRCS), performing tasks of classification, prioritization and management of care coordination mechanisms.
13. Ensure a single medical record system, which is linked to PRCS.
14. Standardize clinical and reference protocols in order to increase the response capacity of PRCS.
15. Set PRCS Evaluation Committees including Family Physicians.

Axis 4: Research in Family and Community Medicine

16. Continue working for the development and strengthening of IBIMEFA Network as an integration resource for the researchers from the region, as well as the identification and dissemination of training and funding opportunities.
17. Advance in identifying research priorities based on methodologies such as expert group (DELPHI or RAND methods), to build consensus on the most important lines in the region and strengthening FCM and PC research networks.
18. Increase resources and actions of communication and broadcast within WONCA-Latin America-CIMF to achieve greater integration of researchers and wider dissemination of research projects and scientific production.

Axis 5: Quaternary Prevention: Medical Ethics, Evaluation and Efficiency in Health Systems

19. Spread the concept of Quaternary Prevention as vital approach in medical practice and management of health services.
20. Contribute to the implementation of the concept of Quaternary Prevention in formal education of health professions in undergraduate, graduate, continuing education and research; preparing a paper of recommendations to contribute to the discussion of the concept with different organizations which define education policies.
21. Promote non-medicalization of proper events of the stages of life, through strategies developed with health teams and community.
22. Encourage that health interventions aimed at the population are based on the best scientific evidence, are ethically acceptable to the local context and are centered on people.

Once carried out the analysis of the regional situation and country, the undersigned* are guarantors of providing continuity to the process of participatory discussion in each of our countries; inclusively and in order to achieve the goals proposed in accordance with the deadlines established in the different recommendations proposed.

Dr. Fernando Llorca Castro
Health Minister of Costa Rica

Dr. Maria del Rocío Saénz
CEO Department of Social Security
Costa Rica

Dr. Michael Kidd
WONCA President

Dra. Maria Inez Padula Anderson
Wonca Iberoamericana CIMF - President

Dr. Thomas Meoño Martins
VI Iberoamericana CIMF President
MEDFAMCOM President

Dr. Francisco Ariza Montoya
Health Ministry Delegate
Colombia

Dr. Luis Alberto Mendieta Rivera
CEO Medical National Services
Department of Social Security
Panamá

Dr. Jorge Jesus Rodriguez Sotomayor
Health Ministry Delegate
Panamá

* The Charter of San Jose has been signed by all the aforementioned authorities, in its original version in the Spanish language.