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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

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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
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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).

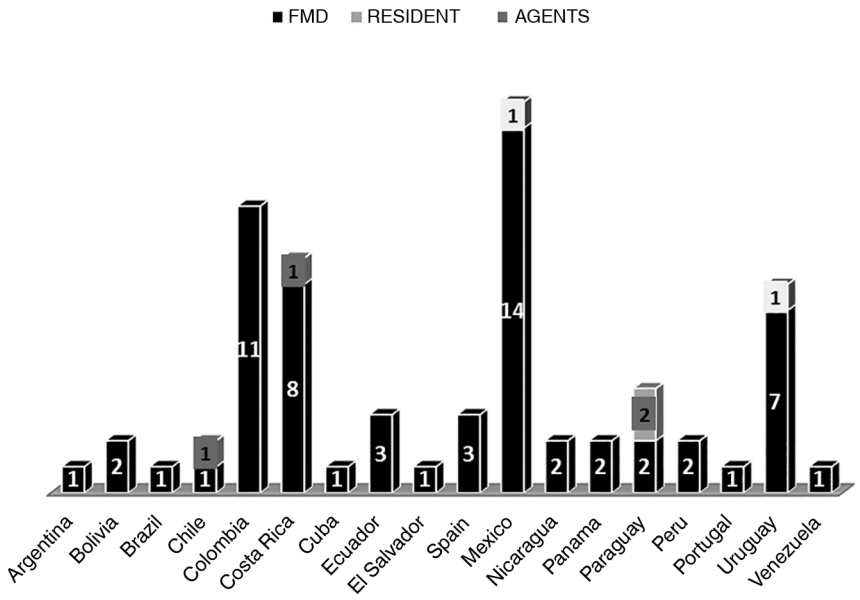


Chart 1. Countries participating in the survey.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

This is the result of the questions made:

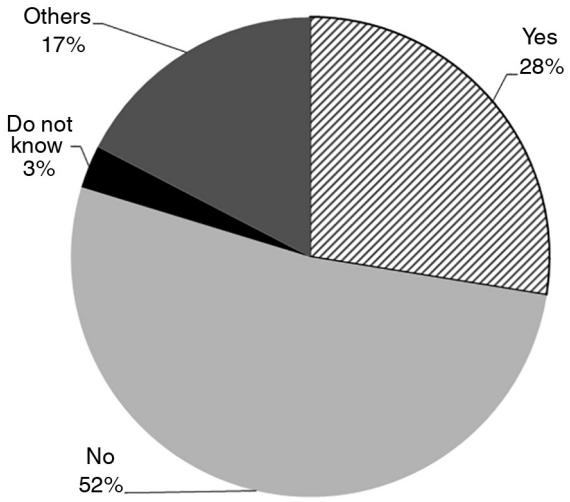
In the question "Do you think that in your country there is EQUITY when rendering primary health care services?

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.

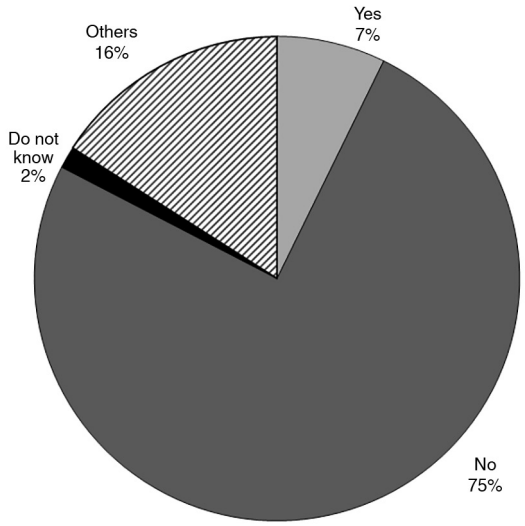


Chart 3. Existence of equity and quantity of FCD per country.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

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.

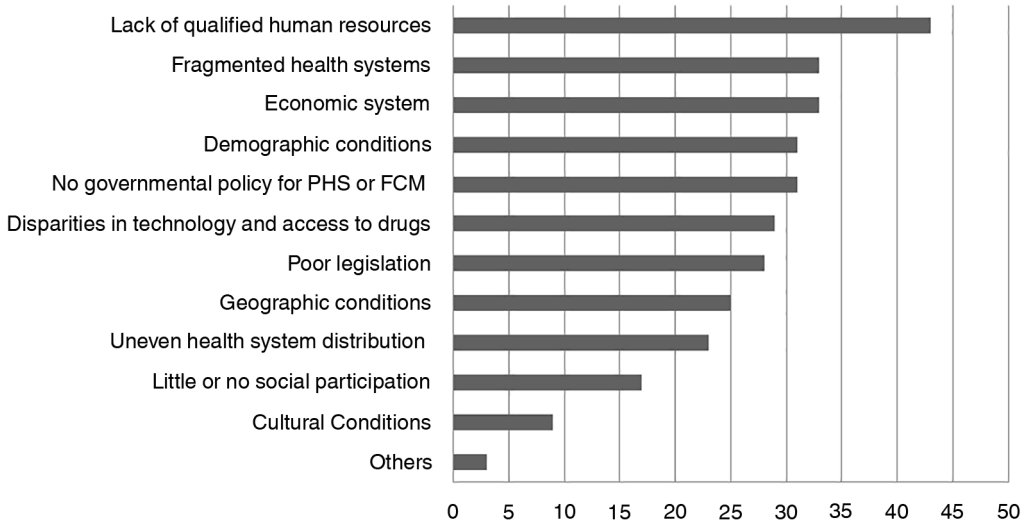
27% believe that the lack of access to technology and drugs leads to inequity.

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).

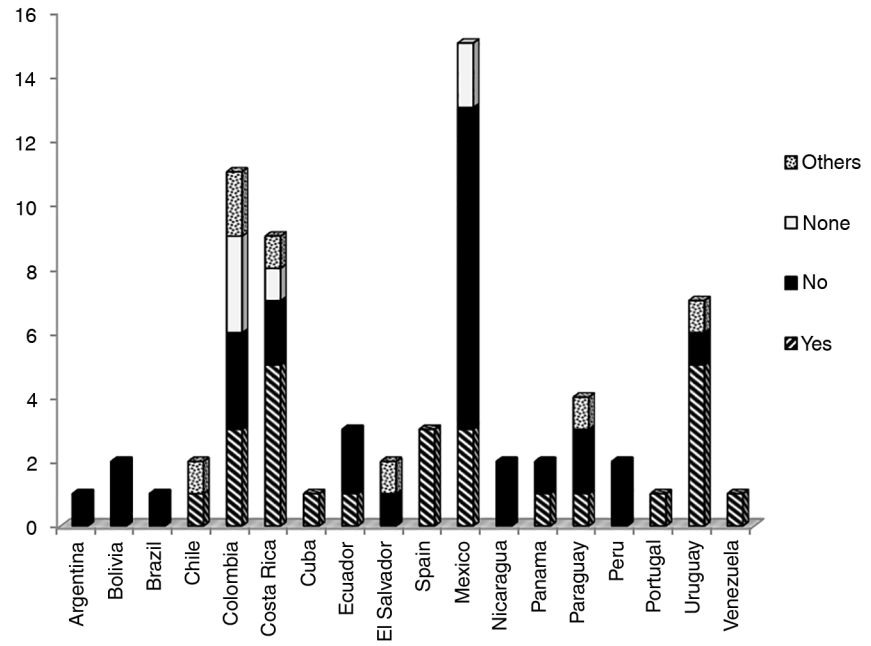


Chart 5. Agreements with the government strategies to reach equity.
Source: Survey Equity Working Sub-Group - VI Iberoamerican CIMF Summit.

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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