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The Contribution of Family Medicine and Family Medicine Leaders to Primary Health Care Development in Americas - from Alma-Ata to Astana and beyond

A contribuição da Medicina de Família e dos líderes em Medicina de Família para o desenvolvimento da Atenção Primária à Saúde nas Américas - de Alma-Ata à Astana e além

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Abstract *Since 2012, the Besrour Centre for Global Family Medicine at the College of Family Physician of Canada has brought together its partners from the Americas annually, to reflect on the evolution of Family Medicine on the continent since Alma-Ata, and to look forward to future challenges. Family doctors are but one element of a strong health system. Family Medicine provides key ingredients to respond to population health needs especially as countries move through the epidemiological transition to face larger burdens of chronic disease and multimorbidity. In this paper, we provide a high-level overview of the state of Family Medicine on the continent. We then analyze trends in the education of family physicians to face this changing landscape, including the emphasis on the leader role of future family physicians. Postgraduate programs in Family Medicine in the Americas are placing increasing emphasis on teaching collaborative care in view of creating truly interdisciplinary health teams for the benefit of patients.*

Key words *Primary Care, Global health, Curriculum, Capacity building*

Resumo *Desde 2012, o Centro Besrour de Medicina Global de Família, na Faculdade de Medicina de Família do Canadá, reúne seus parceiros das Américas anualmente para refletir sobre a evolução da Medicina de Família no continente desde Alma-Ata e para os desafios futuros. Os médicos de família são apenas um elemento de um forte sistema de saúde. A Medicina de Família fornece ingredientes-chave para responder às necessidades de saúde da população, especialmente à medida em que os países passam pela transição epidemiológica para enfrentar um fardo maior de doenças crônicas e de multimorbidade. Neste artigo, fornecemos uma visão geral de alto nível do estado da Medicina de Família no continente. Em seguida, analisamos as tendências na educação dos médicos de família para enfrentar esse cenário em mudança, incluindo a ênfase no papel de líder dos futuros médicos de família. Os programas de pós-graduação em Medicina de Família nas Américas estão enfatizando cada vez mais o ensino do cuidado colaborativo, a fim de criar equipes de saúde verdadeiramente interdisciplinares para o benefício dos pacientes.*

Palavras-chave *Atenção Primária, Saúde global, Currículo, Capacitação*

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Introduction: the importance of family medicine leadership

The declaration of Alma-Ata in 1978[1] changed the direction of the debate on how health systems should be organized, especially in low and middle-income countries (LMICs), to effectively respond to the needs of communities. Reaffirming that health is "a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal" and concerned with the "existing gross inequality in the health status of the people," the declaration stated that Primary Health Care (PHC) "is the key to attaining this target as part of development in the spirit of social justice". Although the document declared that PHC relies on "health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community", it made no specific mention of any particular medical specialty especially suitable to provide this kind of care.

Barbara Starfield devoted a life's work on research related to PHC and organized the concept in four main attributes: first contact, accessibility, continuity and comprehensiveness of care. In a paper in 1991, she stated that the Family Physician could be the "prototypical primary care physician" due to her/his scope of training and practice, but she appropriately remained focussed on the attributes of practice rather than individual medical specialties[2]. This was meant to be applicable both to the Global North and South.

The 2008 *World Health Report: Primary Health Care--Now More than Ever* described how too often, primary care practitioners remained inadequately trained in LMICs, and cited Family Medicine training specifically as a possible solution:

"Primary care has been defined, described and studied extensively in well-resourced contexts, often with reference to physicians with a specialization in family medicine or general practice. These descriptions provide a far more ambitious agenda than the unacceptably restrictive and off-putting primary-care recipes that have been touted for low-income countries"[3].

But the 2009 World Health Assembly went a step further and "urge[d] member states (...) to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses, midwives, allied health professionals and *family physicians*, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs" [emphasis added][4]. This statement was critical in asserting both the ideal form of training of primary care physicians but also the importance of interdisciplinarity and collaborative care.

The tension between focussing on the combined attributes of teams versus the specific disciplines within them reappeared in the lead up to the recent declaration of Astana, 40 years after Alma-Ata. In the June draft of the Astana declaration, diverse PHC providers were enumerated as concrete examples of key actors to continue to progress towards the dream of Alma-Ata, 40 years later.

"We will ensure adequate public health and primary care workforce (including PHC nurses, *family physicians*, midwives, allied health professionals, and non-professional community health workers) working in teams with competencies to address modern health needs[5]." [emphasis added]

However, the enumeration of PHC providers was removed in the final version of the declaration and replaced by a description of the essential but generic competencies and roles needed to realize the dream of Alma-Ata.

"PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive."

The roles and mandates labelled above are ensured by physicians trained as family doctors during their residency. They are essentially experts at comprehensive health care, which critically includes mental health care. These specialists are the physicians tasked with differentiating physical and psychological complaints, a crucial role for patients who cannot always appreciate how their physical and mental health interact to form their overall state of wellbeing[6,7]. The inclusive practice offered by family doctors allows them to meet unaddressed health needs by

Ciência & Saúde Coletiva, 25(4):1215-1220, 2020

maintaining trustworthy lasting therapeutic relationships[6,7]. This is particularly important with marginal and underprivileged populations as they have special needs to fulfill and may have a history of trauma that decreases their trust in the health care system at baseline[8].

Furthermore, family medicine is based on teamwork and multidisciplinary collaboration which are two of the essential competencies required to fulfill the mission of Alma-Ata. To be able to provide efficient and sustainable primary health care to a larger number of patients, leaders in this field need to be effective interprofessional team players[5]. Family physicians are an integral part of a network of health care providers and are trained to collaborate as team members as well as team leaders[6]. They are coordinating the care of their patients while working daily with other PHC providers.

Thus, expertise in leadership is essential to concretize the Declaration of Astana which suggests that health professionals play a key role in teaching and guiding the population "in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care"[5]. Training in family medicine recognizes the importance of leadership and promotes it through its curriculum. Learners develop management proficiency through mentorship, feedback and assignments while training on-the-job[9]. Family physicians also have the possibility to continue acquiring leadership skills during their career by occupying management positions, by mentoring trainees or by taking part in community engagements[9]. Finally, equipping primary care with physicians with leadership skills can empower them to advocate for high quality health services with respect to their own community particularities[9].

State of family medicine: Developments in Brazil and in Canada

We will focus for the purpose of this series on two countries offering publicly funded health care systems, Canada and Brazil, to illustrate the progress made to fulfill the dream of Alma-Ata and goals of Astana in both North and South America. The flourishing PHC system of Brazil, where considerable improvements were achieved in the last 40 years, will be presented and then compared to the well-established state of family medicine in Canada.

The Alma-Ata declaration took place 10 years before the Constitution of Brazil, which led to the creation of the Sistema Único de Saúde (SUS) in 1989 and to family medicine training establishment in 1994[10-12]. Nowadays, Primary Health Units are well established in Brazil and one full-time family physician provides care for approximately 4,000 patients of all ages[11,12]. Values promoted in the Alma-Ata declaration led to health care reforms, as well as community prompted PHC initiatives influenced by principles of equity, solidarity and collective action with a goal of overcoming social inequalities[10]. The gradual implementation of family medicine played a major role in strengthening the SUS by expanding health care coverage, improving health outcomes and reducing disparities[10,12]. The PHC purpose was also refined to specifically address the needs identified by Brazilians. For example, family physicians called "clinic doctors" by the population are now addressing acute and chronic diseases on a same-day appointment basis, advocating for vulnerable populations and collaborating with interprofessional teams[10,11]. They play an important role in medical education by teaching in clinics involving undergraduate students and residents[12]. However, the integration of Astana recommendations in the Brazil health care system is still in its early stages, and many are still precarious. The major challenge regards the lack of access to primary care in cities, which could be partially explained by the structure of the SUS[10,11]. The Brazilian PHC system is based on vertical programs prioritizing office visits for patients presenting with the most frequent health problems (diabetes, hypertension, mental health and maternal and child health), leaving insufficient capacity for other complaints[10,11]. Other identified features leading to suboptimal primary care services in Brazil include long waiting times to access secondary care (up to two years), emergency services overwhelmed with simple cases that should be seen by PHC providers, underuse of information for health evaluation, and budget deficits from the municipalities who act as the primary financial contributors[10].

The Alma-Ata declaration was adopted six years prior to the passing of the Canadian Health Act in 1984. These two important statements both consolidated the principles of portability, accessibility, universality and comprehensiveness leading to the reinforcement of a health care system in which PHC is recognized as the foundation pillar[13-15]. Family medicine was established in 1966 and there are currently 115 family physicians per 100,000 patients in Canada, in addition to other medical specialists and nurse practitioners

who are also providing PHC. The role of family physicians in Canada is very large and mainly oriented towards universal clinical skills, comprehensive health care and community health[15]. Family practitioners are also the gatekeepers for access to secondary health care through consultations, which require them to have a holistic overview of the health needs of their patients[13,15]. In addition, they also work in many secondary care roles especially in rural Canada while working predominantly in community hospitals and emergency departments. Rural family doctors need to acquire further skills to meet the needs of their community including procedures usually restricted to specialists[16]. Despite the maturation of this country's health care system since the declaration of Alma-Ata, Canada is still facing challenges including long wait lists and accessibility issues related to areas of very low population density and influenced by additional health determinants including age, sex, level of education and immigration status[14,15]. This makes implementing recommendations of the Astana declaration an ongoing challenge.

The visionary mission of comprehensive global primary care is difficult to fulfill, for many reasons specific to each country, as discussed above. Significant work is still necessary in both Brazil and Canada, as well as in all the other countries in the Americas to strengthen PHC towards achieving Universal Health Coverage. However, we strongly believe that the contribution of family medicine to PHC over the last 40 years allowed the countries in America to take a significant step towards this goal.

Effective primary care is increasingly based on teamwork. And we have seen how leadership of teams is a key attribute of family doctors. Let us now examine recent family medicine curricular reforms that are especially promising to prepare us for the future of primary care, a future that, undoubtedly, will be interdisciplinary.

Developing leadership: the response to Astana in family medicine training

We believe that ongoing curricular reforms in Family Medicine residency programs, and indeed health faculties more generally, are an important way to meet the goals of Alma-Ata and Astana. Most important among these are reforms that will continue to ensure that socially accountable curricula focus on comprehensiveness of training and team-based care, to meet the realities of increasing inequity, multi-morbidity, and threats to Universal Health Coverage, particularly for the most vulnerable.

As trainees begin to graduate from newly formed residency programs, or in countries where Family Medicine does not have a solid foothold, new graduates will quickly realize that a focus on clinical skills alone is not sufficient. Of further importance are competencies related to leadership, especially as evidence emerges for the importance of multidisciplinary teams such as in the 'patient-centred medical home'[17]. In fact, in order to highlight the importance of leadership, the CanMEDS competency framework has recently modified the "manager" role to one of "leader"[18].

While leadership has been readily incorporated into the medical education curriculum and professional development of physicians in countries such as Canada, its relevance and development for physicians in low-resource settings has been less well-studied and characterized[19]. Leadership as a set of competencies is associated with the multiple roles and responsibilities that physicians take on when addressing the contextual needs of their primary care systems, e.g. supervising, consulting, allocating resources, managing conflict, etc. The body of literature on primary care physician leadership in low- and middle-income countries is sparse and highly heterogeneous, reflecting the diversity of needs as well as underdeveloped research and training capacities.

The case for investing in curricular reform for primary care physicians is challenged by immediate resource constraints, manifested as relatively low physician densities[20] and over-burdened primary care systems. The role of physicians has been evolving in response to an emphasis on team-based care to reduce dependency on workforce shortages[21]. Nonetheless, several team-based approaches have emerged in low-resource settings in other parts of the world as potential strategies to training non-clinical competencies of primary care physicians, including supportive supervision and collaborative styles of leadership[22-25]. Moreover, investing in leadership equips physicians to be champions for the next generation of physician leaders in addition to advocating for PHC reform at higher spheres of influence. The introduction of the family medicine specialty itself may be seen as a generic intervention to strengthening the leadership capacity of physicians.

Further research is needed to address regional knowledge gaps, define the contextually

Ciência & Saúde Coletiva, 25(4):1215-1220, 2020

relevant leadership needs and competencies, and evaluate the effectiveness of various leadership development practices and approaches. The needs of health systems vary between low- and high-resource settings, as do the roles and leadership competencies required of primary care physicians. While opportunities for countries to collaborate and learn from one another are valuable, the contextual needs may be too diverse to build a universal framework of core leadership competencies. Instead, those involved in developing training and curriculum should focus on relevance and responsiveness to local context and populations served, which is a principle of primary care practice that should be emphasized throughout the planning and implementation process[26].

Leadership is a complex concept that is not only about "taking charge". Effective leaders are above all good team-players, and expert at collaborating with other disciplines for the welfare of patients. Only through collaboration with nurses, social workers, public health professionals, allied health workers, patient navigators, and other community-based workers, will the dream of Alma-Ata be achieved. After all, Primary Health Care is a much broader, and more impactful, concept than the more narrow and clinical concept of Primary Care. Family Medicine has evolved to sit at the intersection of these two concepts. It has evolved to truly sit at the heart of health systems[27].

Conclusion

The ideals of Alma-Ata and goals of Astana will require leadership in the area of comprehensive care and in the promotion of the patient medical home model. Despite this, family medicine models lying at the nucleus of interdisciplinary teams beyond an ideal, to fruition, is still a long way away in many countries in the Americas.

The special role of family medicine-led team-based models is that they embody not only the four principles of family medicine (expert clinician, community-based, resource to a defined patient population, and relationship centred) (6), but can also act as a fulcrum anchoring these principles in the wider health system. For example, in bringing clinical expertise, family medicine-led team-based models can bridge the physical-mental health divide that currently exists in much of the world. Although these models are community-based, they also provide the link between community and facility. As a resource to a defined population, they act as an intermediary between the primary care and public health sectors. And most importantly, being relationship-centred increasingly implies introducing new relationships to our patients in terms of a multi-disciplinary team.

In the end, the World Organization of Family Physicians (WONCA) motto of "a family doctor for every family" and the Alma-Ata dream of "Health for all" are inextricably tied together.

Collaborations

D Ponka, N Arya, V Malboeuf, C Leung, CR Wilson, K Israel, AG Jantsch, MF Cuba-Fuentes, O Michaelides and K Rouleau participated equally in all stages of preparation of the article.

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