

Perspective of family medicine in Chile: challenges for professional practice

Perspectiva de la medicina familiar en Chile:
desafíos de la práctica profesional

Perspectiva da medicina da família no Chile:
desafios da prática profissional

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The origins of the Chilean health system date to the organization of charity services, following enactment of the *Mandatory Insurance Law* in 1924, providing for employers and workers to pay monthly quotas into a solidarity fund. This social development milestone laid the groundwork for the subsequent creation of the National Health Service (*Servicio Nacional de Salud*), an initiative spearheaded by physician and then-President Salvador Allende in which the state assumed the leading role and began implementing health policies that took the social determinants of health into account, generating steady improvements in such health indicators as maternal and child mortality. Later years, during the military dictatorship, witnessed a profound change in the administration, with fragmentation of the system through division of the National Health Service into the National System of Health Services, with 27 services distributed according to territories.

Throughout this historical process, the medical profession viewed secondary health services as the level with the best opportunities for professional development, since primary care was seen as a space with scant potential for growth and limited complexity and case-resolution capacity.

In this context, the existence of “zone-based” general practitioners (*médicos generales de zona*) has proven to be an essential strategy to provide access to medical care in rural and vulnerable areas. The policy has existed since 1955 and is maintained to this day under the name “destination and training stage” (*etapa de destinación y formación*), in which physicians apply through an admissions process to guarantee work positions in primary care centers. Based on their performance in primary care, they are awarded points towards scholarships for medical specialization.

In the 1980s, the administration of health care services began to be transferred to the municipalities, leading to worse working conditions under the new employer and consequently a demand by health workers for legislation (passed in 1995) to cover municipalized primary care. The legislation regulated careers, financing, and incentives for health professionals in this context, establishing career categories and incorporating physicians as part of the health team.

In the 2000s, health reform appeared as a policy to support the development of a health system whose pillars were two new laws to allow reorganizing services and provide the population with guarantees for decent care, namely the *Health Authority Law*, with management centered on distribution versus regulation of health care functions, and the *Universal Access with Explicit Guarantees (AUGE) Law*, centered on the search for equity through mandatory guarantees, demandable for a priority set of health problems ¹. Starting in 2003, the Ministry of Health (MINSAL) focused on develop-

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ing primary health care with a shift from the biomedical model to the Comprehensive, Family, and Community Health Model, aimed at solving challenges at the primary care level. This launched the dual transformation of outpatient departments (consultorios) into family health centers and low-complexity hospitals into community hospitals ².

Still, there was a pressing need to improve the case-resolution capacity of care and to expand the available spaces for training and practice in the public sector. The first academic health centers appeared in this context, with primary care playing the leading training role in health careers and launching the training of the first family physicians in the country. However, since there was no explicit policy to support the development of this medical specialty in primary care, not all the specialists who finished this training ended up working in primary care but were scattered across the various levels of care with a variety of positions and adapting their role to existing spaces in each service, making it difficult to measure any impact on persons' health.

In 2014, the MINSAL created an incentive to foment training in family medicine as a specialty, and in turn to enhance professional development in the primary care specialty. This incentive is currently regulated by law, thus guaranteeing its continuity over time.

This initiative has given important impetus to the development of practices in the family medicine specialty within primary care. There are currently local distinctions between family physicians that allow differentiating their work, while supporting the role of other members of the health team in multidisciplinary work ³.

The Piedra del Águila Family Health Center is located in the community of Angol in the province of Malleco, region IX in the south of Chile. This center has 20,000 users enrolled, distributed across 4 sectors, with multidisciplinary lead teams and a territorial management model with a participatory focus.

At this health center, family medicine adopts a practical approach to relevant settings whose integration allows the physician to interact closely with individual users, families and community groups in different spaces, without fragmenting their work. This allows real-time observation of the short and medium-term achievements, based on local planning. We will now describe the most relevant achievements.

First contact or management of the demand for care

Traditionally, it is common to see a long list of treatment offerings, which leads to managing an agenda based on the supply of available hours. However, this management modality usually generates various biases that tend to favor the "inverse care law", that is, care is provided most to those who least need it. Although under-five children and the elderly over 65 years are defined as vulnerable groups, there are other, less visible risk groups in capitated programs, such as persons with some form of dependency, those who never consult health services, and those who have dropped out of care. The proposal is thus to manage the demand for care more inclusively, listening to users' needs and generating differentiated access (which can involve administrative, biomedical, and psychosocial needs). It is crucial for this analysis to include the family physician's view when making decisions on the distribution of this agenda.

Clinical management

Defined as the sum of organizational processes incorporating the distribution and optimization of available resources, guaranteeing timely access to the provision of comprehensive and integrated services with continuity over time, in keeping with users' health problems. The principal measures in this setting relate to the follow-up of users that have experienced hospitalizations for avoidable reasons and those who have appeared spontaneously and multiple times at urgent and emergency care services. These population groups illustrate the fact that health programs (with their biomedical conception) have failed to implement a model of care that favors the generation of care plans to strengthen users or avoid harms. Therefore, when the harm has already occurred and the person's

health has deteriorated, the family physician is essential for rescuing this individual and his or her link to strategies that allow addressing the problem from a different angle, integrating cross-disciplinary work as a relevant link in care plans.

Comprehensive health care

Although comprehensiveness is a preponderant element in health care, the concept has been used in so many different ways that it tends to lose its real meaning, overlooking that in order to achieve comprehensiveness, continuity of care over time is always necessary. The family physician uses diagnostic and therapeutic tools that are multidimensional, such as multiaxial diagnosis, multidimensional approaches, and interlevel linkage to address different health problems, generating connection and integration of the other family members with the proposed strategies, including the protection of their own health. The family physician's professional practice should thus include spaces in the selected risk groups and according to the local reality to ensure that the interventions are sufficiently comprehensive to recover or enhance the resolution of existing problems, considering the frequent tendency to fragment interventions and thus lose their potential impact.

Integration of teamwork

Within the health team, the family physician's leadership is crucial for the therapeutic measures taken with users' families. Chile's health care provisions in primary care do not include family therapy, but other systemic approach tools are available, such as family counseling and comprehensive home visits. In this setting, integration with other team members, especially from the mental health and social fields, allows linking action plans with greater precision that can generate mobilization of the dysfunctional interaction dynamics, generating nodes of local work that jointly enhance the proposed activities with the family physician. However, other members of the health team need to know and draw on feedback from the systemic approach, benefiting families under their care. Again, this requires the permanent figure of the family physician as an advisor accompanying the team in analyzing the cases.

Personalized care plans designed to the family group

Each family is a world of its own that requires appropriate and generative actions in order to produce the adjustments that allow improving interaction among the members. The family physician thus needs to participate in this observation and analysis, generating in the family the sense of belonging and commitment to the prevention of its problems, acting as an educator that anticipates and promotes healthier lifestyles that are perceived as generating wellbeing.

Linkage or bonding with the health care network: finally, fragmentation of the different levels of health has meant that for years users have received overly differentiated treatment according to whether they are at the primary, secondary, or tertiary level. Usually, the secondary and tertiary levels tend not to communicate efficiently on the care individuals require in their recovery, using such inefficient tools as the medical case history or discharge forms that normally contain elements of the history and biomedical indications. The family physician's presence is important here for linkage and continuity of care, incorporating preventive measures as well as addressing the crises involved in the interventions performed in the health system, experienced as a non-normative crisis that affects the family as a whole.

Community setting

In this setting, family physicians develop tools that support them in the relationship with the various community agents and actors, which enhances the success of impact strategies that favor their integration in these spaces, generating empowerment and active participation in local decisions related to the health sector. Community participation features integration with local boards and forums, relations with neighborhood associations and other social actors who are active participants in decision-making, and in promoting initiatives that require the family physician's advocacy. This setting is one of the main challenges for the family medicine specialty, due to the prevailing culture which sees doctors as confined to the clinical domain. However, local experience has shown that the physician's rapport with the community in spaces of permanent dialogue, as well as anticipatory home visits, favor the linkage to the health center, improve user satisfaction, and allow increasing the coverage of persons with adherence to preventive care.

In short, in Chile, family physicians' training is currently one of the targets in the national health strategy, where it is expected that approximately 50% of the physicians allocated to health centers are family physicians. In the mid-term, this should ensure that primary care will rely permanently on this specialty, strengthening the cross-cutting principles of the model of care, with continuity in space and time, comprehensiveness, case resolution, and user satisfaction, with multidisciplinary teamwork, a territorial focus, and citizen participation, thus achieving results that improve the health conditions of users and their families in their territory.

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