

**Mission and Challenges for Family Medicine
and Primary Health Care in the 21st Century;**

**Equity, Integrality and Quality
in Health Systems**

**III Ibero-American Summit on Family
Medicine**

Fortaleza – Brazil

April 29th and 30th, 2008

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and Primary Health Care in the 21st Century;
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The Brazilian Health Ministry, the Iberoamerican Confederation of Family Medicine (CIMF/WONCA), the Pan American Health Organization (PAHO/WHO) and the Brazilian Society of Family and Community Medicine (SBMFC) are holding the **III Family Medicine Iberoamerican Summit** on the **29th and the 30th of April, 2008** in Fortaleza, Ceará, Brazil. The theme proposed for the summit is **Mission and Challenges Faced by Family Medicine and Primary Care in the 21st Century: Equity, Integrality and Quality in Health Systems**.

In 1978 the Alma-Ata Declaration impelled the WHO Member States to adopt the Primary Health Care Strategy in order to reach **Health for All**. We are holding this event in the year the Alma-Ata Declaration celebrates its 30th Anniversary so as to contribute to the strengthening of health policies in the field of Primary Care and Family Medicine in the Iberoamerican Region.

Target-public: Health and Education Ministers from the Iberoamerican region and Representatives of their Technical Teams; State and Municipal Health Departments; WONCA and CIMF Representatives and Representatives of their Member States; Medical-School Education Managers, Program Coordinators of Family Medicine Residence; Representatives of Scientific and Academic Societies interested in Family Medicine and Primary Health Care; other Sanitary authorities from the countries of the region.

WELCOME!

José Gomes Temporão

Brazilian Health Minister

Luis Fernando Rolim Sampaio

Dr. Diego Victoria

Director – Department of Primary Care MS Director - OPAS/OMS - Brasil

Maria Inez Padula Anderson

Dr. Adolfo Rubinstein

President III IBA Summit on Family Medicine

President -CIMF

THEORETICAL-CONCEPTUAL MILESTONE

The historical International Conference on Primary Health Care held by the World Health Organization (WHO) in Alma Ata took place thirty years ago.

In spite of all efforts to make health care available to all, the world is still a long way from reaching the target, *“An acceptable level of health for all the people of the world by the year 2000”*, which was, on that occasion, enthusiastically proclaimed by the delegations of 134 countries as well as tens of representatives of international organizations interested in the area of health care.

After so many years, *“the health care status of a large portion of mankind is still lamentable for it still lacks proper attention to integral, equitable or even basic health care”*. (Buenos Aires Declaration: from Alma-Ata to “The Millennium Declaration”, 2007)

Yet, 30 years later, it is pleasant to observe that talking about Primary Care (PC) no longer brings up questions concerning its relevance to the organization of the health systems. This fact alone can already be considered a great advancement.

The correctness of the strategy devised in Alma Mata has been proved right by the world sanitary intelligence. Nowadays, health care policy-makers have come to a consensus that Primary Care plays a key role in the pursuit of *“Health for All”*.

Whether it be in the range of service or managerial activities, or even in the academic field, it is widely known that, without a health system based on Primary Care, it is not possible to build equitable, efficient and effective health policies. On the contrary, it is widely acknowledged that, without qualified primary care professionals, health systems become progressively fragmented and iatrogenic in addition to the accumulation of unnecessarily high costs.

Moreover, it is necessary to acknowledge that there is a large gap between intentions, decisions and effective actions.

There are many obstacles to the implementation of PC and the sources of these obstacles include the logic of the market, which derives from the medical-industrial complex and its influence upon the configuration of health systems. There are also some operational and conceptual difficulties which can be found in some regions and in academic organizations. These difficulties can also hinder some governmental efforts to enhance Primary Care. Some of these efforts are able to carry out some effectively transformational actions whereas others seem more likely to contribute to the perpetuation of unsatisfactory existing conditions instead of helping to change the status quo.

Notwithstanding, Primary Care has proved to be more and more effective and decisive. Comparative studies have been dissipating lingering clouds of doubt concerning its effectiveness and relevance. Countries that have managed to set up health systems based upon a qualified and inclusive Primary Care have been achieving indisputable results concerning service coverage and costs. They have also been achieving better health indices.

Within this context, it is appropriate to reflect upon the relevance of Family and Community Medicine as the most adequate medical specialty to be used in this field of medical practice.

Primary Care without the effective participation of Family Medicine should no longer be considered complete and vice-versa.

This understanding was progressively built within the scope of Alma-Ata. A noteworthy indicator of this trend is the fact that, ever since Alma-Ata, there has been great progress toward the awareness of the need for proper qualification for primary care professionals as well as the simultaneous amplification of the concept of health and sickness and the impact of these broader views upon the medical knowledge and practice.

In the 70's, the boundaries of the anatomo-clinical model started to become more visible. It used to be the pillar of the biomedical paradigm which projected sickness – (considered as an entity) – as the main object and focus of the medical practice.

Based upon this paradigm which is still in effect, the value and the importance of the medical professional rely upon the precision of his or her perspective and intervention over physiological dysfunctions and diseases. According to this paradigm, the more focal and incisive the medical professional is concerning the disease, the greater his or her value. Medical practice within the realms of a hospital ward is still highly seen as more “complex”, since in that kind of environment health professionals deal with “complex diseases” and make use of industrialized instruments of “high complexity”.

Education, knowledge and medical practice, status and professional valorization are still greatly attached to this biotechnicist concept.

Based upon this same paradigm, professionals who decide on developing actions in and for the Primary Care area, would, supposedly, not have to develop specific qualifications in order to use technologies which are appropriate in this field of practice. This concept leads to a simplistic and disqualified view of the real complexity of this level of medical care.

This equivocated understanding can partly account for the eventual lack of incentives and specific policies which can still be observed in many regions.

In these last decades, however, science has demonstrated that the process health-sickness is a complex phenomenon affected by variables of different biological, psychological, cultural and social dimensions. Moreover, the morbidity and mortality profile of the population, life expectancy, society and culture bring about a reality that is very different from the one which had been configured in virtue of the emergency as well as the implementation of the anatomo-clinical medicine.

If, at that time, infectious diseases used pose the greatest challenge to the medical practice, this picture has changed. Nowadays, the chronic-degenerative diseases influenced by habits and lifestyles learned in the family and society are the major challenges faced by medical professionals. These diseases derive from the violence, general living conditions in small and big urban centers as well as the values imposed by a consumerist society and the globalization process. Health hazards and risk factors have significantly increased ever since Alma-Ata.

Actions intended to provide health care and health education cannot be relegated to a place of minor importance. It is not acceptable to wait for the degenerative processes caused by diseases to continue their “natural evolution” and just then become the object of “treatment” by the medical practice.

It is imperative to develop actions to promote health. It is essential to develop mechanisms of resilience and to struggle for measures that can make for healthy environments and social practices. It is also of prime importance to identify how and why people get sick in the earliest stages of the process and do whatever is possible so that they can get back on the track to good health. These concepts should become the cornerstones of health systems.

All things considered, the importance of Primary Care is much more clearly understood nowadays. It is at this level of attention and care that everything begins. At this level, actions of education, promotion, prevention, recovery and rehabilitation should be carried out in an integrated and articulate way to tackle the most prevalent health problems. The focus should not be on the parts of the body or organic systems; rather, it should be on the people, the families, the community and the processes of getting sick and preserving health which take place therein.

The issues to be addressed and tackled by Primary Care practitioners and health-policy makers are highly complex. Primary Care professionals must be properly and specifically qualified in order to be able to handle the health needs and demands at this level of care, maintain a proper perspective and preserve their autonomy.

Ever since Alma-Ata, we have already gone a long way toward the achievement of these goals.

A lot of good lessons about the understanding and implementation of Primary Care as well as the qualifications of professionals in this area, mainly family and community doctors, can be learned from the experiences of countries of different levels of economic development, including Ibero American countries such as Cuba, Brazil, Mexico, Costa Rica, Spain and Portugal.

Nonetheless, it is important to acknowledge that there is a huge gap between intention and action, especially in what refers to the so-called developing countries.

Some of the major challenges faced in the Ibero-American region are the following:

- (a) Conform and organize fairer and more equitable national health systems based upon Primary Care principles and the work of family doctors.
- (b) Promote health policies which may, at least, minimally guarantee that the whole population can have access to Family and Community Medicine as well as Primary Care (as a right of every citizen and a governmental duty).

In order to accomplish it, it is imperative that some policies be enhanced or implemented in order to strengthen:

1. the valorization and acknowledgement of the Family Medicine and Primary Care by health systems and the development of proper labor and market conditions;
2. the qualification and enablement of family and community doctors;
3. the qualification and enablement of educators, tutors and professors who are able to train Family and Community Medicine practitioners.;

4. the academic institutionalization of Family and Community Medicine;
5. the production and sharing of knowledge within the field of Primary Health Care and Family Medicine;

All of these issues have been an object of study addressed within the sphere of the Ibero American Confederation of Family Medicine (CIMF) and they have also been addressed and discussed at the (SUMMITS) as well as the other activities of CIMF and its national regionals.

The I Summit held in Spain (2002) and the II Summit, held in Chile (2005), as well as the I Mini-Summit, held in Venezuela (2003), came up with concrete recommendations and actions to be implemented in order to cope with the challenges faced by Family Medicine and Primary Health Care at the Iberoamerican level (site www.cimfweb.org)

Based upon these recommendations as well as on the reports of member countries of the Ibero-American Confederation of Family Medicine referring to the current status of the development of health systems, Family Medicine and Primary Care in Ibero-America, the following objectives have been proposed for the III Summit:

GENERAL OBJETIVES

- » Assess the current situation of the Iberoamerican countries concerning the recommendations delivered in the previous summits;
- » Contribute to the development, qualification and consolidation of Family Medicine (FM) and Primary Care (PC) in the Ibero-American countries;
- » Promote collaboration, interchange and partnerships among Ibero-American countries for the development of educational, enablement, assistance and research actions in the field of FM and PC;

SPECIFIC OBJETIVES

- » Positioning and acknowledging family and community medicine as a key specialty for health systems so that it can become a governmental policy;
- » Make it very clear for public health managers that it is of vital importance for the population to invest in the education, qualification and enablement of FM practitioners;
- » Make public health managers aware of the need to invest in the infrastructure and labor conditions for PC professionals in order to achieve greater and better results focused on the efficiency and effectiveness of health systems;
- » Learning about the Brazilian experience in the implementation of the Family Health Strategy, identifying its results, challenges, and applicability to other Iberoamerican settings;
- » Learning about other experiences and successful results in the implementation of PC and FM in Ibero-American countries and identifying its applicability to other Iberoamerican settings;

» Setting agreements, recommendations, strategies and goals that may boost the qualification and enablement of FM professionals and educators, contributing to the interchange of actions intended to qualify the family medicine specialist;

» Setting agreements, recommendations, strategies and targets which can boost and enhance conversion mechanisms of other specialists as well as the processes for the certification and re-certification of FM professionals.

» Promoting policies of academic insertion for FM and PC;

» Fomenting policies for the development of research and scientific production in the FM field based on the work of family health teams and family doctors;

» Including FM in the management of health systems, mainly in the PC sphere.

» Advancing interchange policies for FM residents

SCIENTIFIC PROGRAM

MORNING – APRIL 29TH

7:00 a.m. – 8:00 a.m. – Registration – Congress Materials Pickup

8:00 a.m. – 9:00 a.m.

Opening Table

9:00 a.m. – 9:30 a.m.

What are the Summits? What are we here for?

- What is the WONCA / What is the CIMF – Dr. Chris van Weel - President of WONCA;
- Summary presentation of the other Summits: Oscar Fernandez – President of the South-Cone Regional – WONCA/CIMF;
- What we expect of this III Summit – Maria Inez Padula Anderson – President of the III Summit.

9:30 a.m. – 10:00 a.m.

Conference: Family Health Strategy for the Brazilian SUS (Unified Public Health System) – Results and Challenges – Dr. José Gomes Temporão – Brazilian Health Minister

10:00 a.m. – 10:20 a.m.

COFFE-BREAK

10:20 a.m. – 11:00 a.m.

Conference: The Impact of Primary Health Care and Family Medicine on Health Systems
Dr. Adolfo Rubinstein – President of the CIMF.

11:00 a.m. – 12:30

Round Table 1: The current status of Primary Health Care and Family Medicine: Reports of Experiences in Ibero-America

AFTERNOON – APRIL 29th:

02:30 p.m. – 03:00 p.m.

Conference: Family Medicine Competences and Roles: why this medical specialty must form the basis of health systems.

Dr. Richard Roberts – Elected President of the WONCA

03:00 p.m. – 04:30 p.m.

Round Table 2: The current status of Primary Health Care and Family Medicine: Reports on Experiences in Ibero-America

04:30 p.m. – 05:00 p.m.

COFFEE-BREAK

05:00 p.m. – 06:30 p.m.

Round Table: Family Health Strategy: Reports on Brazilian Experiences

MORNING – APRIL 30th

8:30 a.m. – 10:00 a.m.

Round Table: The Role of Family Medicine in the Renewal of Primary Care

Dr. Luis Fernando Rolim (Director of the Department of Primary Health Care of the Brazilian Ministry of Health)

Dr. Diego Victoria – Representative of the PAHO/WHO for Brazil;

Dr. Chris van Weel – President of the World Organization of Family Doctors - Wonca

10:00 a.m. – 10:30 a.m.

COFFEE-BREAK

10:30 a.m. – 12:00

WORK GROUPS:

DEVELOPING STRATEGIES TO IMPLEMENT AND QUALIFY THE FAMILY MEDICINE AND THE PRIMARY CARE

Group 1: Insertion of and giving value (valorization of) to Family Medicine the Health Policies;

Group 2: Formation and qualification of the Family Physician;

Group 3: Academic insertion of Family Medicine

Group 4: Research in Family Medicine and Primary Care

12:00 – 02:00 p.m.

Lunch

AFTERNOON – APRIL 30th

02:00 p.m. – 03:30 p.m.

WORK GROUPS (resumption):

DEVELOPING STRATEGIES TO IMPLEMENT AND QUALIFY THE PRIMARY CARE AND THE FAMILY MEDICINE

Group 1: Insertion of and giving value (valorization of) to Family Medicine the Health Policies;

Group 2: Formation and qualification of the Family Physician;

Group 3: Academic insertion of Family Medicine

Group 4: Research in Family Medicine and Primary Care

03:30 p.m. – 04:00 p.m.

Coffee-Break

04:00 p.m. – 05:30 p.m.

Round Table: Qualifying the PC and the FM: Professional Qualification and Development of the Family Physician

§ “Conversion”/Specialization;

§ Medical Residency;

§ Importance of the academic insertion of Family Medicine (Departments, Disciplines; Graduation; Post-Graduation – Master’s, Doctorate’s);

§ Distance Education /Permanent education (SGETS/DEGES/Brazil)

05:30 p.m. – 06:15 p.m.

Leonardo Boff: Earth Health/Men Health

06:30 p.m.

Closing Session – Reading of the “Fortaleza Letter”