La Medicina Familiar en un contexto de desigualdad social y de salud

Family Medicine in the Context of Social and Health Inequality
Medicina de Família no Contexto da Desigualdade Social e de Saúde

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Conferencia magistral presentada por el autor en el 19th World Conference Cancún, México May 2010

First of all, I would like to thank the organizers of the 19th WONCA World Conference for their kind invitation to talk to you today about two great problems of current society: social inequality and health inequality. Both problems, two sides of the same coin, affect the entire world to different degrees, but much more seriously in the less developed countries.

Family Medicine in Mexico

The development of Family Medicine in Mexico is based on experience accumulated over many years. Indeed, this medical specialty is backed by more than 50 years of health care programs for our population. The Mexican Social Security Institute (Instituto Mexicano del Seguro Social) started the first health care program in 1953, in the city of Nuevo Laredo, Tamaulipas.

Something similar can be said about the training programs for Family Doctors. Almost 40 years ago, in 1971, the same Institute began the process of training. Nowadays, nearly 40,000 Family Doctors have been trained; there are several research programs in Family Medicine and specialized medical journals in the field; we have an institute for the certification of the specialists; there are academic and professional societies in Family Medicine, and the National Academy of Medicine has seats for the most egregious graduates in the specialty, as it has for other medical specialists.

Between 1974 -when many of us witnessed then the WONCA meeting at Mexico City-, and 2010 -when this meeting is now being held here at Cancún- Family Medicine has ripen academically and in coverage, it has become stronger as a specialty and its progress is undeniable.

Family Medicine and Public Health

The family physician is very important in any scheme of social security. In the case of countries like ours, he or she should be the pillar of the public and private health structure. Family doctors are fundamental because Family Medicine should be the Preventive Medicine *par excellence*. Family Medicine is a specialty that provides medical attention to individuals from an integral perspective since it places them as part of a family, as part of a community, and, as we all know, every community shares interests and values but also diseases.

Family is the core of society. Hence, Family Medicine is significant for any public health system. Health care with this approach allows a healthier, more balanced family development which must be translated into better levels of social welfare, particularly among the less developed countries and the more vulnerable social groups.

The preventive and holistic approaches of Family Medicine allows us to integrate biological, psychological and social aspects into a longitudinal scheme that favors the prevention of illness and the monitoring of individuals' health-sickness processes. By establishing the adequate illness treatment and by coordinating medical, familial and social resources available for their optimal application, Family Medicine seems to be the most adequate health care strategy.

The preventive action of Family Medicine, based on a risk approach, contributes to the identification of the probabilities that certain individual or environmental characteristics may condition a disease. This approach provides the opportunity to plan the most appropriate strategies for disease management, from an integrating perspective of curative care and rehabilitation, as well as preventive care for groups exposed to specific causal factors.

Similarly, the medical study and monitoring of the family, not only of the individual, allow us to understand the fundamental biopsychosocial environment inhabited by any given individual, and places the family as the social group within which the health-sickness process develops with respect to a set of structural, functional and cultural factors that can either favor or limit individual and community health.

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Aten Fam 2010; 17(4):93-96.

Family Medicine's preventive approach seems especially adequate in view of the aging of the population and the unusual increase in chronic degenerative diseases as the main causes of mortality. Similarly, familial health-care education may help to prevent diseases, particularly among the social groups with the lowest income levels, which are the most vulnerable of all.

Therefore, in the current national and global context of high levels of poverty and social inequality, of changes in the pattern of diseases and the financial vulnerability of the public system of social security, it seems indispensable to strengthen and to expand the preventive and comprehensive approach of Family Medicine within the system of social security and within public health care policies and programs.

An Unequal World

Undoubtedly, a doubt, the process of globalization, partly the outcome of the scientific and technological revolutions, has rendered considerable achievements for different aspects of the development of society, although the economic aspect is the most visible and preponderant. However, the benefits of these advances and achievements have not been equal for all countries and social groups.

The levels of education and access to information, the degree of economic development, the level of industrial production achieved and international trade, the advance of democracy throughout the world, the concern for human rights and a rise in life expectancy are some of the extraordinary achievements that human beings have accomplished.

Nonetheless, parallel to these achievements in almost all fields, we find great inequalities, deficiencies and social injustices. Old problems endure and have become more pressing, and new tensions have been generated: for instance, the global dimension of the economy has favored a huge concentration of wealth and has increased social inequalities, poverty and social exclusion. The technological modernization of production has generated unemployment and has propelled underemployment as well as informal employment. The population growth rate in developing countries continues to be high. The damage to the environment has reached such high levels that they not only threaten the sustainability of development but life on the planet as well. Finally, in the field of health care, paradoxically millions of people, mainly children, die as a result of common well-known illnesses, for which we have very effective means for their prevention and cure.

Today, with a world population of more than 6.9 billion people, 82% of the total population lives in developing countries, around 800 million are illiterate and in 2007 there were more than 70 million children without any access to education. It is estimated that by the year 2050 the population of the developed countries will grow 42 millions, whereas the population in poor countries will grow 2.2 billion, that is, it will be 54 times greater. [1]

Poverty is one of the greatest enemies of human dignity. It frequently comes along with ignorance, unemployment and disease. For this reason, and because of the ethical implications that it entails, one must express the strongest rejection to the conditions of poverty that we have reached. It is true that the number of people who live in extreme poverty decreased by 500 million during the period between 1990 and 2005. Nevertheless, if we do not take into account China's accomplishments in this matter, it turns out that during the period previously mentioned the number of people who live in extreme poverty has increased 36 million. Indeed, there are still 1.4 billion people who live in this condition. The optimistic forecast predicts that in five years we will still have 1 billion people in extreme poverty.[2]

In the current information and communication society, to extreme poverty we must add social inequality, which does not seem to diminish. The gap between those who have everything, even in excess, and those who do not even have the basics, has become wider.

The average GDP *per capita* in the developed countries is of US$33,831, whereas in the poor countries it amounts to US$2,531, that is to say, almost thirteen times less. The difference in GDP *per capita* between the countries which today occupy both extremes of the charts is overwhelming: Luxemburg has a GDP *per capita* of US$78,000, which is 120 times greater than the GDP *per capita* in Malawi, Burundi or Sierra Leona, which is less than US$700.[3] There is no doubt that something in our society is not working properly. The mode of life and the economic system are not the convenient ones. It is urgent that we change.

The Right to Health

Since health is fundamental for the life of individuals and societies, health care provision is a fundamental obligation of every modern State. Health is a personal and a social right. It is a prerequisite necessary for individuals and societies to achieve their complete development. Health is one of the greatest equalizers of society. It is nothing less than an authentic expression of social justice. There is neither wellbeing nor progress without health.

As the Economic and Social Council has stated, health is intrinsic to a commitment to human security and an indispensable element for social stability. Health constitutes an ethical imperative for the governments of all countries, regardless of political orientation or levels of culture or development. Where health does not exist, what prevails –along with disease and its sequels– is a lack of opportunities, life without dignity and scarce productivity.

Consequently, the World Health Organization (WHO) and other international organizations have sustained that health's worst enemy is poverty. It should therefore come as no surprise that health is given priority in so many international meetings, where it is asserted that it is indispensable to provide fair access to health care services and programs and where it is admitted that inequality in health care provision is a risk and an attempt against the stability of societies. It should be admitted that few are the public investments that can be as productive and beneficial as those related to health care.

Health and Inequality in Mexico

Social inequality is a problematic present in Mexico since its origins as an independent nation. It is related not only to historical and cultural factors and the rate of economic growth but also to the way in which the fruit of this growth is distributed.

The unfair distribution of wealth creates unequal access to health care and educational services. Similarly, poverty favors malnutrition and a high degree of propensity to disease which, in turn, generates lower individual performance, absenteeism and school dropout that, inevitably, have a repercussion in training, in the future possibilities of employment and in opportunities to engage in better paid activities, which enable the overcoming of these conditions of poverty.

The inequality that the country suffers is clearly reflected by the place that Mexico occupies among the nations of the world. A few figures suffice to illustrate this fact. According to the *Competitiveness Report* elaborated by the World Economic Forum, our country occupies the 11th place on the domestic market size index among 133 countries. In spite of that, we rank 38 on life expectancy and 65 on primary education. On tuberculosis incidence Mexico ranks 39 and on malaria incidence and infant mortality we rank 75 and 89 respectively.[4]

The Gini coefficient is a range designed by economists to duly measure the degree of inequality of income distribution in a collectivity. In the Gini coefficient world ranking, Mexico is placed 113 out of 142 countries.[5]

In health care, our country has accomplished important achievements in the past 60 years. In 25 years, life expectancy rose from 50 years in 1950 to an estimated 75.3 years in 2009. The progress of women regarding this indicator stands out since their life expectancy is now 27 years greater than it was. General mortality was cut by a third, from a rate of 16.2 deaths per one thousand people in 1950 to a rate of slightly less than five deaths per one thousand people last year. The progress achieved in infant mortality has been even greater, since this rate diminished by 85%,[6] which represents an outstanding achievement for the Mexican health care system.

Despite these advances, it can be said that, regarding health care, today Mexico faces ancestral as well as new challenges. Today's challenges call for profound and comprehensive changes.

Among the current challenges, in the epidemiological aspect what stands out are the recent changes in the pattern of diseases, among them the increase of diabetes and degenerative diseases as causes of mortality, along with the high level of infant mortality that prevails in our country. In 2009, diabetes was already the main cause of mortality, with more than 70,000 deaths, which explains one out seven deaths in Mexico.[7]

Over the past 16 years, Mexico was only able to increase the life expectancy of its population from 70 to 74 years. In contrast, countries such as Sweden, South Korea and Chile, were able to increase the average life expectancy of their populations by 11, seven and six years respectively. Some more developed countries like Japan, Canada and Spain also added four years to this indicator, but we must take into account the fact that they did so starting from the ages of 77 and 79, when it is more difficult to increase this indicator, whereas Mexico started with a mean of 70 years.[8]

What has been accomplished in the past decade and a half concerning infant mortality falls short of the expectations, especially if we compare it with international standards. Mexico's rate of infant mortality, despite its reduction, is higher than that witnessed in highly developed countries: it is six times greater than that in Japan, five times higher than that in Germany, France and Spain, and four times greater than that in Canada. Moreover, Mexico's rate is even higher than the one registered in countries with a level of development similar or even lower than ours: it is three times higher than Cuba's rate and twice the rates in Chile and Costa Rica.[9]

Another set of challenges comes from the available national health care infrastructure and from the poor performance that it yields regarding results. Thus, for instance, nowadays, in the public sector alone we have 167,000 physicians, 223,000 nurses, 20,510 medical care attention units, including 1,213 hospitals with almost 80,000 beds. Last year 300 million medical consultations were given, 5.5 million patients were hospitalized and 3.5 million surgeries were performed.[10]

In spite of the above, the organization, administration and funding of the health care sector are inadequate. Some of the problems that we encounter have to do with a lack of health care coverage and with the quality of the services, which are characterized by their heterogeneity. Likewise, we have to address the fragmentation of the institutions that provide health care services because as a result many people have no coverage whatsoever while others are covered by two or three public institutions.

Another problem of our health care system is related to the absence of a homogenous model of attention. This means that while some institutions are organized according to health care levels, with systems of reference and counter-reference and based on Family Medicine as the ground of the organization, other institutions do not operate with any of these elements.

In order to reduce inequality in our country we must not only recover the rhythm of economic growth but also achieve a better distribution of wealth. In particular, we need to establish a great national agreement covenant to ensure that the benefits of economic growth are distributed in a more equal manner and, at the same time, we need to develop a network of social security and protection to cover all Mexicans.[11]

Some Measures To Reduce Health Care Inequalities

As stated in the document *Global Forum Update on Research for Health*,[12] unequal health access is determined by economical, geographical, institutional, political, social, cultural and technological barriers. Therefore, research and public policies are needed in order to identify and gain a better knowledge of

those barriers so that we can set forth action strategies to overcome them and achieve conditions of more equality in health access.

Those who study the factors that determine the health levels of the population have identified that non-biological factors are the most significant, and these factors are precisely the economical, environmental, political and even social conditions. Those factors are the health levels' "cause of causes". For that reason, public actions and efforts should be oriented to promote and guarantee social rights and reduce the noxious impact that those factors have on the health levels of the population.

In our case, I am one of those who sustain that we have reached a point in which it is imperative to organize a National Health Service according to the following basis: it should offer universal coverage; it should be unique, public and decentralized; it should have a health care model based on micro-regionalization; it should have well established medical care levels and its design should be based on Family Medicine; it should privilege prevention and ensure the quality of the service.[13]

One issue that we have to consider when we talk about improving health care systems in order to achieve greater equity is pharmaceutical production. As some specialists sustain,[14] the pharmaceutical production for the treatment of the endemic diseases of the developing countries has always been scant: only 1% of all the pharmaceutical products destined for human consumption registered during the period between 1975 to 1997 were destined to tropical infections. Additionally, new medicines and vaccines are generally inaccessible to the people who live in poverty. More investment in the public sector is required in order to stimulate the production of pharmaceutical drugs for the poorest sectors of society.

Final Considerations

In developing countries, during the last few years, the combination of epidemiological manifestations related to poverty with emerging problems of contagious and non-contagious diseases, along with the huge population that lives in poverty and in extreme poverty, contributes to limit the possibility of offering high quality health care services to broad segments of the population, particularly to those with less resources. To remedy these health inequalities between and within developing countries, it is necessary to develop strategies to improve the social determinants of health.

The quest for equity in health recognizes the need to balance the unequal opportunities to be in good health, not only by reducing poverty but also by dealing with the determinants of health, which include the global and national factors, the social, environmental and economic conditions and more immediate factors such as employment, food, education, quality of life, housing and social relations.

I must say that on matters of health, Mexico has progressed significantly. Health conditions today are not comparable to those that existed four or five decades ago. However, there is still much to be done and we should advance faster.

It is clear that the health system in our country requires a reform if it is to respond to the new challenges and bridge the inequality gap. The aging of the population, the changes in the pattern of diseases and the instability of the labor market added to extreme poverty, and social inequality, forecast significant increases and modifications in the demand for social security, which should be considered in the design of the new programs.

The reform should take adequate measures regarding human resources, research and technological development. It should also count on appropriate funding, planning and evaluation systems, and with transparency and accountability mechanisms that will satisfy everyone.

The reform cannot neglect actions to stimulate the fostering of those values that helped to establish the doctor-patient relationship as a therapeutic tool and hindered the intervention of intermediaries in the relation. In this context, it is essential to strengthen and broaden the approach and the practice of Family Medicine as a natural field for health care and prevention of disease.

The question that we need to answer then is this: Is Family Medicine in our country prepared to live up to the new challenges? In this regard, I have no doubt in emphatically answering in the affirmative. Family Medicine can rely on more than 50 years of experience in the operative field, and 40 years in the academic and professional training field. We have much experience and we only need to make the corresponding decisions. This is the right time to do it for the sake of health and for the next generations.

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