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North American Primary Care Research Group

From the North American Primary Care Research Group

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SUPPORTING HEALTH REFORM IN MEXICO: EXPERIENCES AND SUGGESTIONS FROM AN INTERNATIONAL PRIMARY HEALTH CARE CONFERENCE

Primary care is essential for sustainable health care.[1] Mexico is undergoing socioeconomic and health care developments, but a barrier is policy makers' poor understanding of the role and function of primary care. Consequently, the country struggles to meet the health needs of its population. The Mexican College of Family Medicine (MCFM) has the potential to lead health systems change with strong primary care, but lacks capacity. A pre-conference at the 2015 Cancun NAPCRG conference aimed to develop an action plan and build leadership capacity for MCFM (http://www.napcrg.org/Resources/CancunManifesto/SupportingHealthReforminMexico-FullPaper).

International Collaboration

There is substantial international experience in implementing primary care policy to reform health systems.[2-7] This policy implementation requires translating general principles of primary care to local circumstances and priorities; articulating primary care's contribution to population health (ie advocacy); and engaging with multiple stakeholders in a bottom-up process to address population needs.

Mexican Health (Care)

Mexico is experiencing a demographic transition, with an aging population and an increase in chronic diseases (notably diabetes mellitus).[8]

Since 1943 the Mexican Health System has covered various sectors of the population. Additional legislation was introduced in 2014[9,10] and upgraded in 2015, to ensure full health care coverage.

Despite a convergence of services,[11] each health structure that passed legislation has a vertical financing system which increases administrative expenses. In 2011 these administrative costs represented an estimated 10.8% of total expenditure on health.[9]

Coherent primary care is absent. Primary care is provided, depending on the funder, by institution-certified family physicians, general practitioners, or non-certified family physicians or social service interns.[12] Practice visits are short (12 minutes) and curative in focus, with less than 10% being preventive in nature.[13] Accordingly, family medicine accounts for only 4% of over 26,000 training positions.[14] This gives urgency to focus health reforms on primary care, including financing and training.

In summary, the most urgent issues are:

- Lack of structure and coordination between primary care and hospitals
- Insufficient coverage and access for the many poor
- Insufficient understanding of the primary care role
- Lack of teaching, training, or research of health problems in the community
- Poor socioeconomic status of family physicians

Two International Examples of Success

Ontario, Canada provides a lesson on system transformation through physician payment and interprofessional teams.[15-17] Capitation payment blended with fee-for-service and pay-for-performance incentives became the preferred reimbursement, and about one-quarter of physicians were supported with interprofessional teams.

The health transformation increased physician reimbursement and satisfaction. Students' interest in family medicine almost doubled to 40% of graduates. Important lessons learned were to adjust capitation to populations' health needs and to align primary care incentives with the needs of the rest of the health system.

The US experience, often copied in Central American countries, demonstrates that health investment does not lead to a return in health outcomes,[18] without investment in the primary care function. Additionally, markets with fee-for-service payments create mal-distribution of workforce away from areas with high health needs.

As an alternative, decentralized, local "communities of solution" are powerful in achieving more with less resources, as exemplified in the *Hombro a Hombro project* in Honduras.[19] Through an academic/community partnership, "committees" for health identified social determinants of health needing greatest attention and prioritized resources accordingly.

Learning points for Mexico were:
- Blended capitation payment for primary care
- Describing the main health problems in the population
- Family practice specialty training in the community setting
- Insight into numbers and geographic distribution of health care professionals

Working With Stakeholders

Engagement between care providers, patients and their caregivers, managers, and policy makers improves responses to complex needs.[20-23] To secure patient-centered care, primary care providers and researchers need to engage with those who will ultimately benefit.[24-26] Meaningful engagement results in more rapid uptake of evidence into practice, and more satisfaction with care provided.[27-29]

Problems of working with patients in the Mexican situation were:
- Unavailability of consumer organizations
- Patients passive toward health care professionals
- Patients poorly understood the role of primary care

Conclusion

The meeting participants proposed the *Cancun Manifesto*, an action plan for MCFM to lead a long-term strategy for health reform in Mexico.[30] To increase understanding among stakeholders of the values of primary care, and to advocate its development, short-term objectives were identified:
- Describing the *Mexican* Ecology of Medical Care[31]
- Collecting patients' experiences with their family physician
- Defining role and function of primary care [32] in the Mexican context

International support to the MCFM will continue. This pre-conference process can be used with other countries facing health systems change.

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References available in pre-conference report at http://www.napcrg.org/Resources/CancunManifesto/SupportingHealthReforminMexico-FullPaper.

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2016 MATCH SETS RECORD FOR FAMILY MEDICINE CHOICE

The 2016 Match saw the most medical students and graduates matched to family medicine in the history of the specialty (http://www.aafp.org/medical-school-residency/program-directors/nrmp.html). Specifically, 3,105 graduating medical students chose family medicine in the National Resident Matching Program (NRMP), marking the 7th consecutive year that the number of students picking family medicine increased (Supplemental Figure 1, available at http://www.annfammed.org/content/14/3/280/suppl/DC1).

That upward trend is important, but the rate of increase isn't nearly enough to meet demand. Researchers from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care have estimated the shortage of primary care physicians will reach 33,000 by 2035. According to national health care search firm Merritt Hawkins, family physician has been the most highly recruited role in the US health care system for 9 consecutive years.

"The bump up this year is the largest in the last several years for family medicine," said Stan Kozakowski, MD, director of the AAFP Medical Education Division. "While this news is heartening and a step in the right direction, we should not be satisfied with these rather modest results. Far too few students are choosing family medicine to meet the needs of our nation."

US seniors accounted for 1,481, or 48%, of the family medicine positions filled. That was an increase of 59 US grads compared with 2015 and marked the largest single-year bump in 4 years. The number of US seniors matching into family medicine was nearly 400 more than in 2009, the year before the 7-year stretch of improving match rates began.

The 3,105 med students picking family medicine represent an increase of 45 compared to a year ago. The number of slots offered by family medicine residency programs increased to 3,260, up from 3,216 in 2015. The fill rate was 95.2%, up slightly from 95.1 last year.

Most of the 155 unfilled positions were expected to be filled during the NRMP Supplemental Offer and Acceptance Program (SOAP). That process already has taken place, but the numbers from the SOAP weren't reflected in the initial data released by the NRMP.