

The Emergence of Primary Care in Latin America: Reflections from the Field

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A U.S. family physician educator working in El Salvador, recently returned from the WONCA Fourth Regional Congress of the *Ibero American Confederation of Family Medicine*, reflects on the state of primary care in Latin America. Progress in primary health care and family medicine is occurring in several countries in the region as many countries are coming to accept that primary care is a systematic solution to their structural problems. The author discusses reasons for this progress in the context of political, economic, medical, and cultural dynamics. He notes several key points of comparing this development with the health care system in the United States and suggests that there is much to learn from those systems that are making their way on the path toward primary care. (J Am Board Fam Med 2013; 26:183–186.)

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I recently returned from 10 days in Cuba to my adopted country of El Salvador. In both countries, I have played the part of visitor. Sometimes I have had the chance to fit into the role of professor or academic scholar—as a Senior Fulbright Scholar funded by the U.S. Department of State, that is what I came south to do. Most often, however, I am in the role of learner. In Havana I was in that role as one of a small contingent of North American attendees at the *WONCA Fourth Regional Congress of the Confederación Iberoamericana de la Medicina Familiar* (CIMF, or *Ibero American Confed-*

eration of Family Medicine). In El Salvador I am often in that role as the sole faculty member from the United States at the University of El Salvador, where I have been teaching in their School of Medicine's Master's in Public Health program.

Both countries, one in the Caribbean and the other in Central America, are low- to middle-income countries that are significantly struggling under markedly different economic systems.^{1,2} Cuba is fundamentally a state-run economy; El Salvador is entrenched in the globalized market economy as a member of the Central American Free Trade Agreement. Both face significant external and internal political pressures that frame the daily lives of their citizens.^{3–7} Yet as both a family medicine and public health physician, what has been most striking about my stays in each of these countries is the attention paid to primary health care as a systematic solution to their structural problems.

Cuba has a long history of promoting community-based responses to the health concerns of its people, which started soon after approximately half of its physicians left the country in the years immediately after 1959.⁸ Two notable occurrences strengthened Cuba's focus on primary health care. In 1984 the government decided to make family medicine (*medicina general integral*, or comprehensive general medicine) the foundation of its medical system, using physicians, nurses, and social workers

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in a model that essentially linked public health and tertiary health care.⁹ Then in 2004 it moved to concentrate undergraduate medical education (in all its medical schools regionally distributed across the country) on training physicians for careers in community-based family medicine.¹⁰ Although there is some discussion about timing and extent—all things Cuban seem rife for debate given the political tensions that still exist^{11,12}—it is generally recognized by the Pan American Health Organization and other observers that the Cuban population has witnessed significant improvements in its health indices because of this primary care orientation.^{13,14}

El Salvador is a more recent convert to primary health care within medicine. It has for many years used community health workers as a foundation for health development; the movement first came into existence during the 1980s.¹⁵ Much more recently, however, as part of an ambitious 8-point plan to reform the public health system (Table 1), the government has made the establishment of decentralized, team-based health clinics the centerpiece of its ambitious health care reform.¹⁶ In these clinics (Community Oriented Family Health Teams or ECOS-Familiar), generalist physicians, nurses, community health workers, and a multipurpose staff member work collaboratively in economically marginalized parts of the country. Despite significant financial and political issues that have limited the implementation of the overall health reform—the country spends only 3.9% of its gross domestic product on health expenditures²—human and capital resources in primary care have expanded by approximately 25% since 2009.¹⁷

Table 1. Eight Key Points in El Salvador's Health Care Reform¹⁶

1. Establish a comprehensive integrated network of health services, focusing on community based health teams.
2. Develop a national system for handling medical emergencies.
3. Improve availability and quality of medicines and immunizations.
4. Coordinate health services through an cross-disciplinary health commission.
5. Establish a national health forum.
6. Create a national public health institute.
7. Design and implement one national epidemiological tracking system.
8. Reorient human resources toward accomplishing these reforms.

What was most striking about the CIMF meeting was that such moves toward implementing primary health care models have not been limited to Cuba and El Salvador. Brazil, Peru, Paraguay, and Venezuela have developed or are developing models that rely on general and family physicians for the future, and other countries are following their lead.^{18–21} Although some countries involved have looked at the Cuban system for philosophical guidance as well as functional leadership—the Venezuelan plan still relies heavily on Cuban physicians to staff both its *Barrio Adentro* (service) and General Community Medicine (educational) programs—others, notably Brazil's Family Health Program, got their start under vastly different circumstances.^{21,22}

Why do medical care systems based on primary health hold such promise in Cuba, El Salvador, and the rest of Latin America? First, the cultures in these countries (as in almost all other countries around the world) are traditionally more collectively oriented than that of the United States.²³ High value traditionally has been placed on family and community, a characteristic that can help support local primary care practices. Second, significant political power will go to those who can implement reasonably functioning health care systems, given that many of these countries are newly democratic. Several have had universal health care plans, albeit marginally functional ones, on the books for decades, and transitioning to models based on primary care makes rational sense to the public health leaders that set policy in these countries.²⁴ Third, many countries in Latin America are coming to recognize the impossibility of continuing down the subspecialist road if they want to extend access to care, especially considering that large proportions of people in most of these countries live in poverty; in El Salvador, for example, the poverty rate nears 40%.² It is increasingly understood that primary health care services are an economically efficient means of providing high-quality services, even when there are strong local and global stakeholders (including subspecialty societies, the pharmaceutical industry, and tertiary medical centers) that still impede the development of more rational health care systems.^{24–27} Fourth, these countries have traditionally seen the United States as a power that has intervened in their internal affairs for well more than 100 years.²⁸ The psychological and economic advantages of creating uniquely national systems of primary health care cannot be underestimated.²⁹

In Latin America one frequently hears echoed critical perspectives about the condition of U.S. health care system. Professional colleagues here in El Salvador commonly note that the United States has done a very poor job of creating a functioning primary health care system within its own borders.³⁰ As a singular entity it is poorly positioned to offer substantive advice on the implementation of primary health care systems based on its own record of not providing the same to its own people.³¹ It is complicit in the migration of valuable human resources to feed its growing need for health care personnel.³² As well, its focus on technocentric, individualistic, biomedically focused solutions to global health problems has severe limitations in places that share neither the resources, cultures, or political realities that are dominant in the United States.³³

South-south collaboration in medicine and public health has been talked about for some time, and in Latin America it seems that such international cooperation is gaining strength with the emergence of primary care. The CIMF meeting brought this cooperative spirit clearly into view: it was a meeting full of thoughtful exchanges and collaborative conversations about this development. Time will tell whether Latin American countries are able to pull themselves out from under the dominance of a subspecialty medical model borrowed, if not overtly copied, from their large neighbor to the north. Time will tell whether they can create systems founded on family medicine principles that are successful despite other medical, political, and economic influences that stand in the way of a sensible systematic change toward primary care. But if they are successful, maybe then it will be time for those in the United States to look south for guidance, so that it too can develop a primary health care system based on patient-, family-, and community-centered values. Then, perhaps, it will be time for us all to assume the role of learner and seek guidance from others as we make our way on the path toward primary health care.

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