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EDITORIAL

Family medicine in the crossroad. Risks and challenges

La medicina familiar en la encrucijada. Riesgos y desafíos

The Spanish healthcare system tops the international rankings. According to the Bloomberg Healthcare Efficiency Index, we rank third in the world. Our success is attributed to primary care[1]. However, paradoxically, family medicine is going through an identity crisis that is neither new nor attenuating over time. A recent editorial in this journal[1] draws attention to this problem, noting that although the deterioration already existed before the economic crisis, it has reached its peak in recent months. According to a comparative analysis of primary care in Europe[2], Spain stands out for its access, continuity and coordination of care. But our professionals and future professionals express their discomfort and disillusionment. Young doctors persistently shun family medicine in the MIR election. There is no more recirculation from MFC in the MIR because the number of MIR places offered is very close to that of new graduates, who begin to compete for the mere possibility of specializing. But today, many jobs for family doctors (and for primary care pediatricians too) remain unfilled, especially in remote or rural locations, far from the hospital. Many young family doctors choose to work in hospital emergencies.

The reform of primary care, begun in 1984, took more than 15 years to be completed and by the time it did, in the early 2000s, there were already signs of crisis. Between 2011 and 2017, public spending on primary care fell by 4% while spending on hospitals increased by 7% [3], and the ratio of doctors per 1000 inhabitants has barely increased by 1% in AP but by 6% in hospitals between 2010 and 2016. Nothing better than accounting to know the priorities of a system.

Family doctors are the oldest in age in the public network. In October 2018, 28.5% of them were over 60 years old. Moreover, Moreover, primary care physicians are older than in hospitals (62.4% of doctors working in primary care are over 50 years old, 44% in specialized care). The lack of doctors to fill job positions has shifted the focus of political and media attention towards primary care, which is a great opportunity for primary care leaders to make their voice heard. This year 2019 several professional societies, regional governments and the Ministry of Health have diagnosed the crisis and proposed solutions that in some cases confuse the mission of primary care with the welfare of its workers, and labor demands with social needs. In order to leave the routine and culture of complaint, it is needed innovative impetus [4]. Primary care would have to be renewed from the bottom up, starting from the medical office. Three dead weights have been mentioned, the de-professionalization associated with the functionalization, the inferiority complex in front of the hospital and the low leadership in the teams [4].

But primary care has important advantages, starting with user satisfaction. According to the health barometer 2018 [5], among the general population, primary care is more valued than other levels of care and the family doctor more than other professionals.

There is overwhelming scientific evidence that the systems based on a strong primary care are superior. In addition, primary care plays a key role in improving hospital efficiency (leading coordination and post-acute care, and avoiding unnecessary hospital admissions due to potentially ambulatory conditions) [6], and in leadership of healthcare integration [7]. Primary care provides value for (a) accessibility, (b) continuity of care and longitudinality, and (c) resolutiveness and comprehensiveness. That almost half of the population wait for a consultation with their family doctor for more than five days (data from the health barometer 2018) is a real problem of access. Temporary contracts of short duration are a serious problem for longitudinality, and a great source of inefficiency. Restrictions on the family doctor's request for diagnostic tests and procedures reduce their resolutiveness.

Just because each part of a whole works well does not necessarily mean that the whole does too. It can happen that

[1] https://www.bloomberg.com/news/articles/2019-02-24/spain-tops-italy-as-world-s-healthiest-nation-while-u-s-slips

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many small successes are added in a big failure [8], because sometimes, ''your order is my chaos'' and ''your innovation is my aggravation'', because local innovations can slow down the integration of the whole. More than an island, primary care must be an essential part of the care chain.

A strong primary care that fulfills its mission is the best antidote to the demagogic siren chants towards a MUFACE-style change for the entire population. That ''model'' is characterized by ignoring the primary care and the central role of the family doctor as health coaching of his/her patients. Unlike the British model where money follows the patient and the family doctor buys specialized services, this hypothetical MUFACE model would allow users to directly access any specialist consultation in a health mall with a huge potential risk of over-diagnosis and over-treatment.

Primary care challenges include to assume leadership within primary care and towards the rest of the health system and to society. This necessarily implies generational renewal and a shock plan to increase professional prestige, with determined policies and clear signs of positive discrimination. Primary care must be put back on the agenda. Lost professionalism should be recovered, with an active role in new organizational experiences. Spain is a rich organizational laboratory, although it lacks some visibility and evaluation. Evaluation research is a pending challenge in which primary care has an important role to play. The key question is how to make individually attractive what is socially necessary. Other challenges are to gain resolutive capacity (by means of both diagnostic technology and incentives), to reorganize the work of doctors and nurses, to hire and retain stable and motivated human resources, to improve incentives to good practice, to link retributions to health outcomes, to regain visibility with benchmarking and excellence awards, to improve the academic and research prestige by creating chairs in universities and prioritizing research projects on primary care in public calls.

There is also room for improvement within the clinic and in the health centers, if leadership and management autonomy are restored, in the organization of work focused on the patient, redefining the health center's team and the role of nursing; focusing attention on the continuum of care, from cradle to grave, and on managing complex cases with well-defined strategies. In short, programmes must be reviewed and prioritized in the light of the value they bring.

Conflicts of Interest

I declare that I have no conflicts of interest related to this text

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