Tamaulipas
Gobierno del Estado

Secretaría de Salud

1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

Autocuidado y su Modelaje en Personal de Salud

Jason. M. Aragon / Dirección de Medicina de Estilo de Vida Saludable

16 de mayo

Tamaulipas
Gobierno del Estado

1er Congreso Internacional

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- *No tengo ningún conflicto de interés que reportar*
- *La información que se va a compartir aquí no establece una relación de medico a paciente.*
- *Todo contenido e imagen tiene derechos de autoría de acuerdo a las referencias mencionadas*

¿ Que significa el “Modelaje” en Profesionales de Salud?

Leman MA, Claramita M, Rahayu GR. Defining a "Healthy Role-Model" for Medical Schools: Learning Components That Count. J Multidiscip Healthc. 2020 Oct 30;13:1325-1335. doi: 10.2147/JMDH.S279574. PMID: 33154649; PMCID: PMC7608004.

BMJ Open

Effects of the expansion of doctors' offices adjacent to private pharmacies in Mexico: secondary data analysis of a national survey

Ricardo Pérez-Cuevas,[1] Svetlana V Doubova,[2] Veronika J Wirtz,[3,4] Edson Servan-Mori,[4] Anahí Dreser,[4] Mauricio Hernández-Ávila[5]

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► Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2013-004669).

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ABSTRACT

Objectives: To compare the sociodemographic characteristics, reasons for attending, perception of quality and associated out-of-pocket (OOP) expenditures of doctors' offices adjacent to private pharmacies (DAPPs) users with users of Social Security (SS), Ministry of Health (MoH), private doctor's offices independent from pharmacies and non-users.

Setting: Secondary data analysis of the 2012 National Survey of Health and Nutrition of Mexico.

Participants: The study population comprised 25 852 individuals identified as having had a health problem 15 days before the survey, and a random sample of 12 799 ambulatory health service users.

Outcome measures: Sociodemographic characteristics, reasons for attending healthcare services, perception of quality and associated OOP expenditures.

Results: The distribution of users was as follows: DAPPs (9.2%), SS (16.1%), MoH (20.9%), private providers (15.4%) and non-users (38.5%); 65% of DAPP users were affiliated with a public institution

Strengths and limitations of this study

- This study is the first that uses nationally representative household data to analyse the characteristics of users of doctors' offices adjacent to private pharmacies (DAPPs), their reasons to attend, perception of quality and associated out-of-pocket expenditures, and runs a comparative analysis with users of other healthcare services.
- This study identified that users of DAPPs: paid out-of-pocket for medical visits and medications, therefore counteracting financial protection policies, and received, on average, higher number of medicines prescribed than users of other healthcare institutions, thus signalling poorer quality of care; for DAPP medical doctors, this situation might reflect a conflict of interest given that they work for the pharmacies.
- The main limitation is that this study is a secondary data analysis; thus with the available information, it was not possible to evaluate in depth the quality of care.

- **Negocio supremamente lucrativo**
- **Alto porcentaje de usuarios**
- **Bajo costo**
- **Aumento en venta de medicamentos**
- **Empleo de miles de medicas y médicos en el país.**

Infodemia

Infodemia, infovigilancia e infodemia

- Internet y redes sociales como nuevo actor informativo en salud
- **Infodemiología,** distribución y frecuencia de la información en salud en internet e **infovigilancia** monitorear estado y tendencias de la información (Eysenbach, 2002)

Ejemplos: análisis de las consultas de los **motores de búsqueda de Internet** para predecir brotes de enfermedades, la vigilancia de las **actualizaciones de la situación de las personas**, la **vigilancia de las publicaciones de interés** para la salud pública en Internet, entre otros.

- 2020 Infodemia: área nueva de investigación, OMS lanza un seminario de infodemia y llama a trabajos para publicación

Editorial > J Med Internet Res. 2009 Mar 27;11(1):e11. doi: 10.2196/jmir.1157.

Infodemiology and infoveillance: framework for an emerging set of public health informatics methods to analyze search, communication and publication behavior on the Internet

Desinformación y salud

- Desinfomación (*disinformation*) y Malinformación (misinformation) en Salud
  - CON intención de manipular, SIN intención de manipular, información errónea.
- Desinformación en salud en internet
  - *Información falsa o que da un mensaje negativo* es frecuentemente **más popular** que la real, conclusión soportada estudios sobre ébola y zika en Facebook y páginas web (Sharma 2017, Xu 2017).
  - Noticias sobre *cannabis como cura milagrosa* para el cáncer tienen 4.26 millones de búsquedas en Google trends, mientras **videos verdaderos solo 0.036 millones** de búsquedas (Dubey et al., 2014).
  - Información falsa se re-tweetea dos veces más que la verdadera (Pulido, 2020)
  - Karlova (2013) propone analizar notas a nivel **macro** (temas y las redes de distribución), o a nivel **micro** (quienes consumen, qué consumen y comparten).

"Salud publica en tiempos de desinformación: desinformación en México (2022): Mtra. Pilar Torres Pereda. ESPM/INSP

El mundo después de Covid19

¿En QUÉ y a QUIEN creemos?

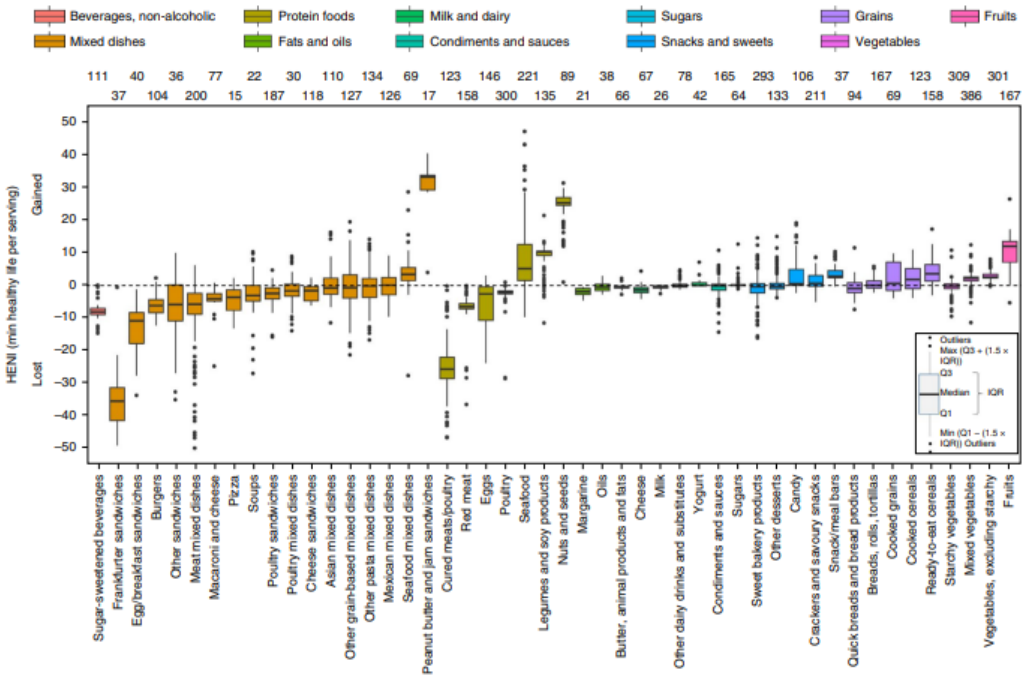
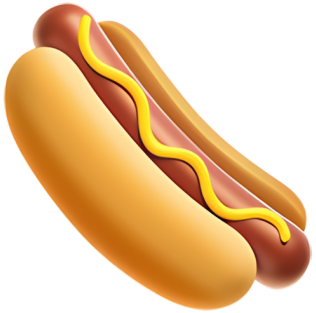


Fig. 4 | HENI score per serving for 5,853 foods in the US diet by food category. Positive scores indicate health benefits. Eleven foods are not shown (additional outliers). Numbers on top denote the number of foods in each category. Q1 = lower quartile of foods within the category; Q3 = upper quartile; IQR = Q3 - Q1.

Katerina S. Stylianou, Victor L. Fulgoni, Olivier Jolliet. **Small targeted dietary changes can yield substantial gains for human and environmental health**. *Nature Food*, 2021; 2 (8): 616
DOI: 10.1038/s43016-021-00343-4



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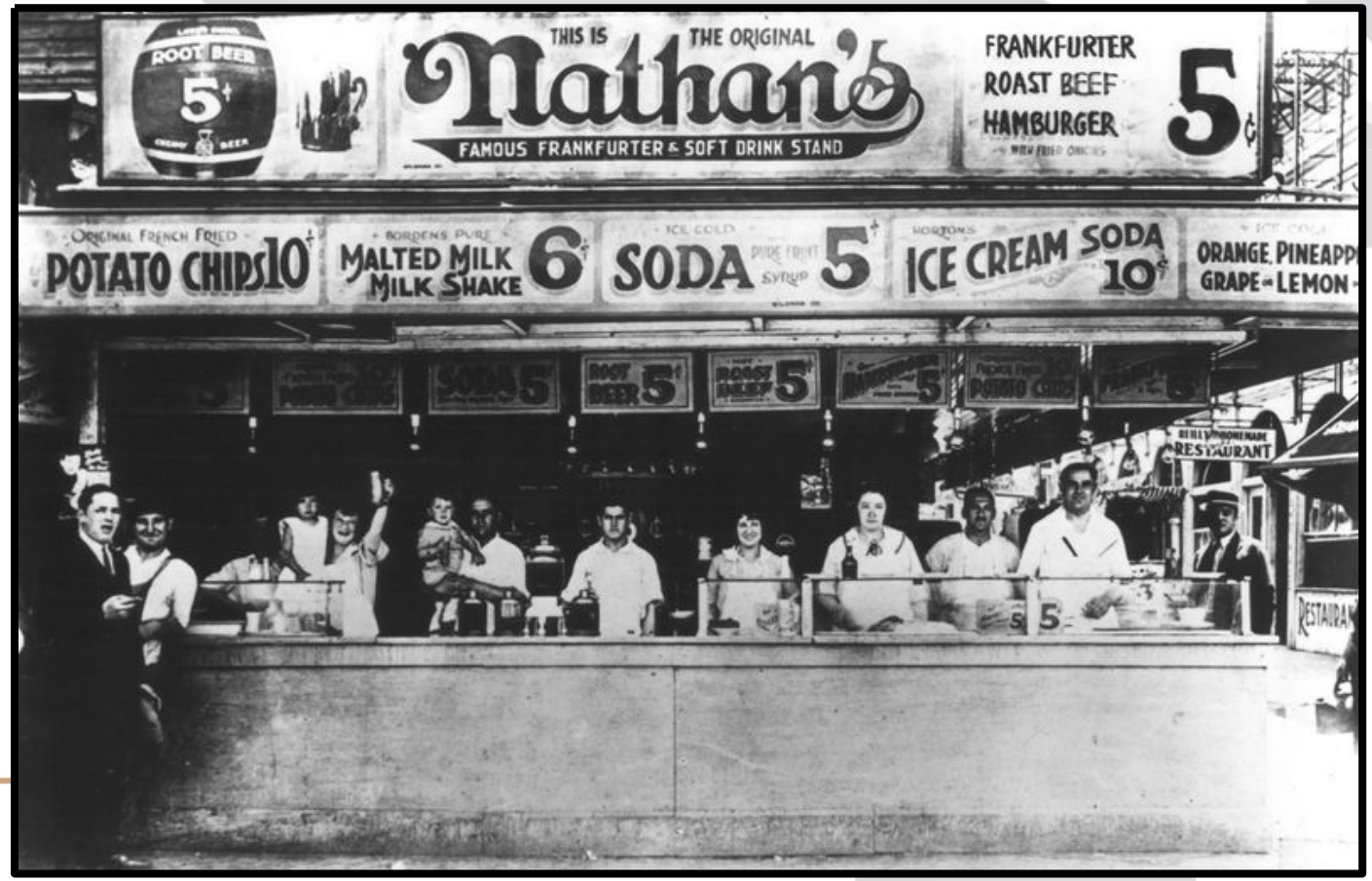
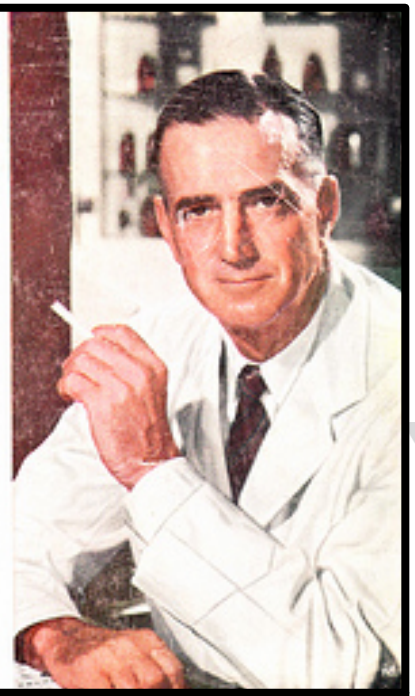


Secretaría de Salud

According to repeated nationwide surveys,

More Doctors Smoke CAMELS than any other cigarette!



Why Physicians Call Our New Brand

"A HEALTH CIGAR"

"I recommend Thompson's MELL-O-WELL cigars to any who are interested in regaining or keeping physical fitness."

"I am convinced that irritants, such as nicotines, glycerides, albuminoids and carbons—dangerous when used to excess by those who are physically below par—are largely removed from Thompson's MELL-O-WELL cigars."

"Many former patients, friends and others who have consulted me, and who, ordinarily, would be obliged to greatly curtail smoking, are now enjoying their usual allotment of cigars in Thompson's MELL-O-WELLS—with no loss of satisfaction or good health."

(Signed) G. Edward Roehrig, M. D.
715 South Bonnie Brae,
Los Angeles, Calif.

NOW...Scientific Evidence on Effects of Smoking!

A MEDICAL SPECIALIST is making regular bi-monthly examinations of a group of people from various walks of life. 45 percent of this group have smoked Chesterfield for an average of over ten years.

After ten months, the medical specialist reports that he observed . . .

no adverse effects on the nose, throat and sinuses of the group from smoking Chesterfield.

First and Only Premium Quality Cigarette in Both Regular and King-Size

MUCH MILDER

CHESTERFIELD IS BEST FOR YOU

YALE JOURNAL OF BIOLOGY AND MEDICINE 84 (2011), pp.269-276.

HISTORICAL PERSPECTIVES IN MEDICAL EDUCATION

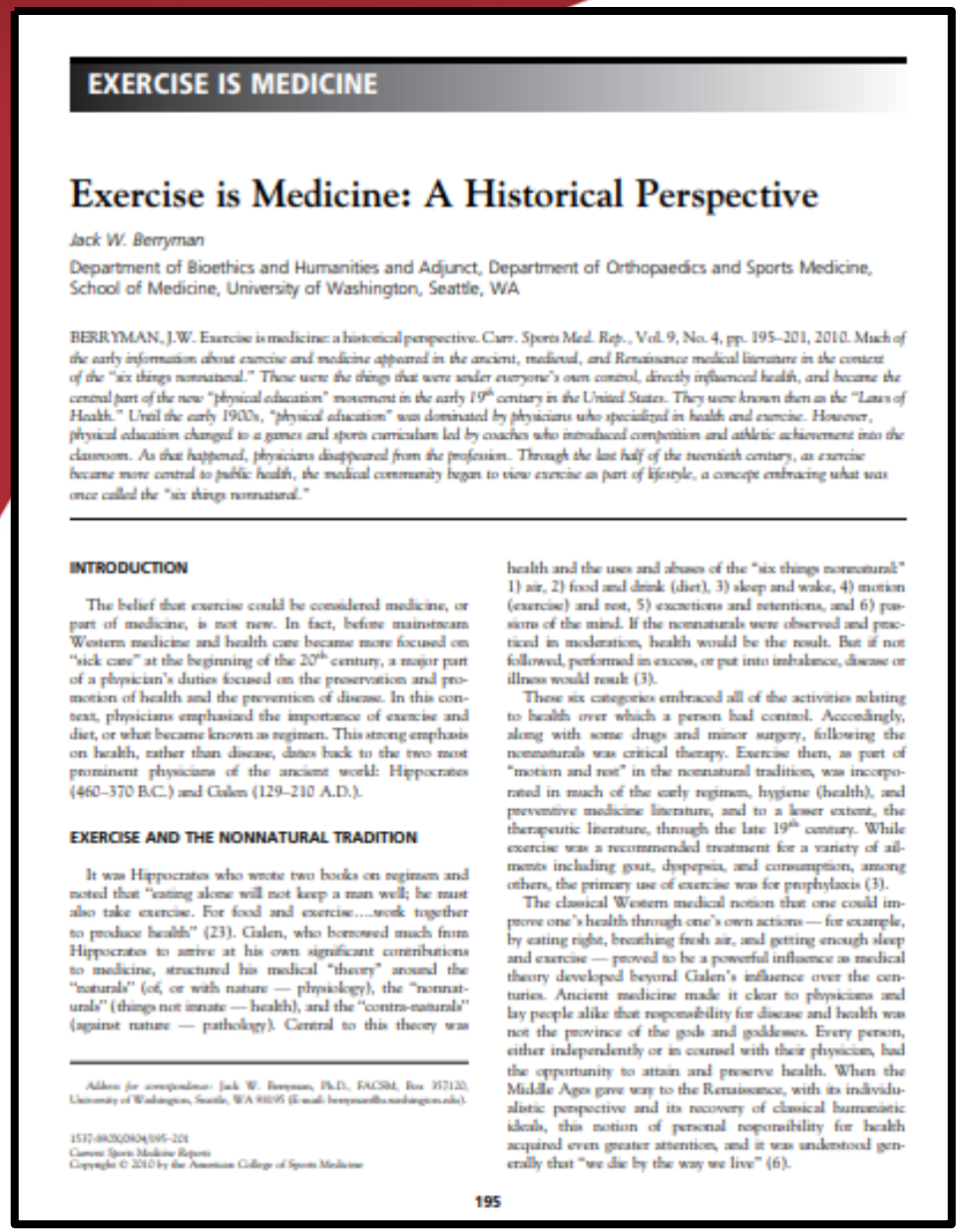
The Flexner Report — 100 Years Later

Thomas P. Duffy, MD

Yale School of Medicine, New Haven, Connecticut

The Flexner Report of 1910 transformed the nature and process of medical education in America with a resulting elimination of proprietary schools and the establishment of the biomedical model as the gold standard of medical training. This transformation occurred in the aftermath of the report, which embraced scientific knowledge and its advancement as the defining ethos of a modern physician. Such an orientation had its origins in the enchantment with German medical education that was spurred by the exposure of American educators and physicians at the turn of the century to the university medical schools of Europe. American medicine profited immeasurably from the scientific advances that this system allowed, but the hyper-rational system of German science created an imbalance in the art

- **Estandarizar**
- **Rigor científico**
- **Cerrar escuelas**
- **Licencias y acreditación**
- **Exclusividad**
- **Legado de educación (basado en evidencia)**



EXERCISE IS MEDICINE

Exercise is Medicine: A Historical Perspective

Jack W. Berryman

Department of Bioethics and Humanities and Adjunct, Department of Orthopaedics and Sports Medicine, School of Medicine, University of Washington, Seattle, WA

BERRYMAN, J.W. Exercise is medicine: a historical perspective. Curr. Sports Med. Rep., Vol. 9, No. 4, pp. 195–201, 2010. *Much of the early information about exercise and medicine appeared in the ancient, medieval, and Renaissance medical literature in the context of the "six things nonnatural." These were the things that were under everyone's own control, directly influenced health, and became the central part of the new "physical education" movement in the early 19th century in the United States. They were known then as the "Laws of Health." Until the early 1900s, "physical education" was dominated by physicians who specialized in health and exercise. However, physical education changed to a games and sports curriculum led by coaches who introduced competition and athletic achievement into the classroom. As that happened, physicians disappeared from the profession. Through the last half of the twentieth century, as exercise became more central to public health, the medical community began to view exercise as part of lifestyle, a concept embracing what was once called the "six things nonnatural."*

INTRODUCTION

The belief that exercise could be considered medicine, or part of medicine, is not new. In fact, before mainstream Western medicine and health care became more focused on "sick care" at the beginning of the 20th century, a major part of a physician's duties focused on the preservation and promotion of health and the prevention of disease. In this context, physicians emphasized the importance of exercise and diet, or what became known as regimen. This strong emphasis on health, rather than disease, dates back to the two most prominent physicians of the ancient world: Hippocrates (460–370 B.C.) and Galen (129–210 A.D.).

EXERCISE AND THE NONNATURAL TRADITION

It was Hippocrates who wrote two books on regimen and noted that "eating alone will not keep a man well; he must also take exercise. For food and exercise....work together to produce health" (23). Galen, who borrowed much from Hippocrates to arrive at his own significant contributions to medicine, structured his medical "theory" around the "naturals" (of, or with nature — physiology), the "nonnaturals" (things not innate — health), and the "contra-naturals" (against nature — pathology). Central to this theory was health and the uses and abuses of the "six things nonnatural" 1) air, 2) food and drink (diet), 3) sleep and wake, 4) motion (exercise) and rest, 5) excretions and retentions, and 6) passions of the mind. If the nonnaturals were observed and practiced in moderation, health would be the result. But if not followed, performed in excess, or put into imbalance, disease or illness would result (3).

These six categories embraced all of the activities relating to health over which a person had control. Accordingly, along with some drugs and minor surgery, following the nonnaturals was critical therapy. Exercise then, as part of "motion and rest" in the nonnatural tradition, was incorporated in much of the early regimen, hygiene (health), and preventive medicine literature, and to a lesser extent, the therapeutic literature, through the late 19th century. While exercise was a recommended treatment for a variety of ailments including gout, dyspepsia, and consumption, among others, the primary use of exercise was for prophylaxis (3).

The classical Western medical notion that one could improve one's health through one's own actions — for example, by eating right, breathing fresh air, and getting enough sleep and exercise — proved to be a powerful influence as medical theory developed beyond Galen's influence over the centuries. Ancient medicine made it clear to physicians and lay people alike that responsibility for disease and health was not the province of the gods and goddesses. Every person, either independently or in counsel with their physician, had the opportunity to attain and preserve health. When the Middle Ages gave way to the Renaissance, with its individualistic perspective and its recovery of classical humanistic ideals, this notion of personal responsibility for health acquired even greater attention, and it was understood generally that "we die by the way we live" (6).

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1537-8020/0904/195–201
Current Sports Medicine Reports

Informe de la Fundación Carnegie sobre Educación Médica de 1910.Su autor, **Abraham Flexner, recomendó cerrar 120 de las 155 facultades de medicina de 155 facultades de medicina por ser «peores que inútiles»** y arremetió la profesión (18). **Una de las consecuencias de estos cambios fue que se formaron menos médicos y los que lo hacían no consideraban la «educación física» como un campo de empleo potencial o en el que su experiencia sería mejor utilizada o apreciada. En consecuencia, el ejercicio empezó a perder la atención que antes le prestaban muchos médicos**

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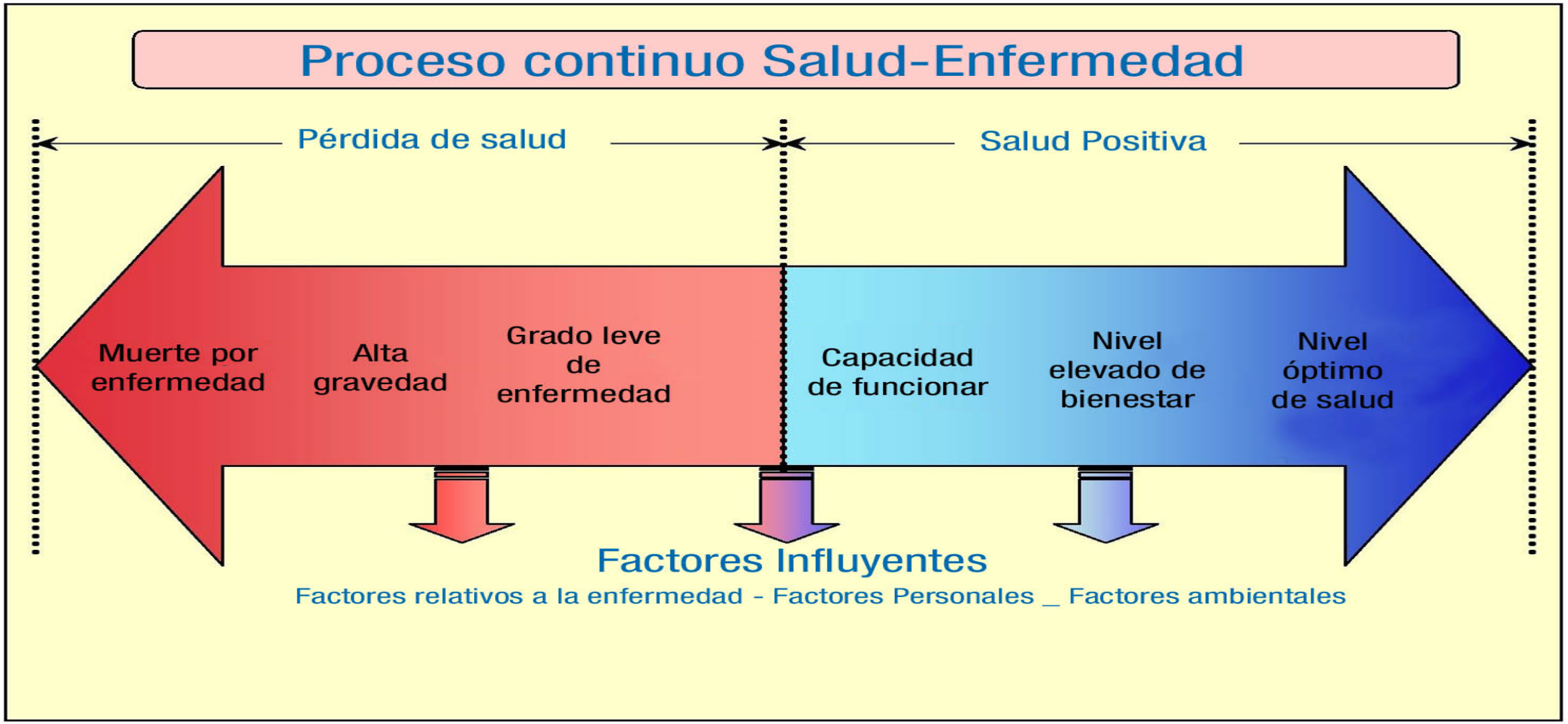
SALUTOGÉNESIS

¿Cómo CREAMOS Salud?



Continuo salud-enfermedad de Catford (1983); Salleras (1985) & Terris, M. (1980)

“la salud es el resultado de la interacción de la biología y la conducta individual, el medio ambiente físico y social, las políticas y las intervenciones gubernamentales y el acceso a cuidados médicos de calidad”

HEALTHY PEOPLE 2010

National Center for Health Statistics. Healthy People 2010 Final Review. Hyattsville, MD. 2012

Opinion

VIEWPOINT

A Prescription for Longevity in the 21st Century
Renewing Purpose, Building and Sustaining Social Engagement, and Embracing a Positive Lifestyle

What guidance should clinicians offer parents of a newborn about how to prepare their child for a life that may last to 100 or more years? What should a physician discuss with adolescents who are beginning college, or young adults starting a new career about how to optimize their healthy life? How does this guidance change when individuals reach midlife and later life? Is there a prescription a physician should provide that would allow individuals at all stages of the life cycle to optimally align life span with health span, compressing morbidity and sustaining high functionality through the arc of life?

VIEWPOINT

A Prescription for Longevity in the 21st Century
Renewing Purpose, Building and Sustaining Social Engagement, and Embracing a Positive Lifestyle

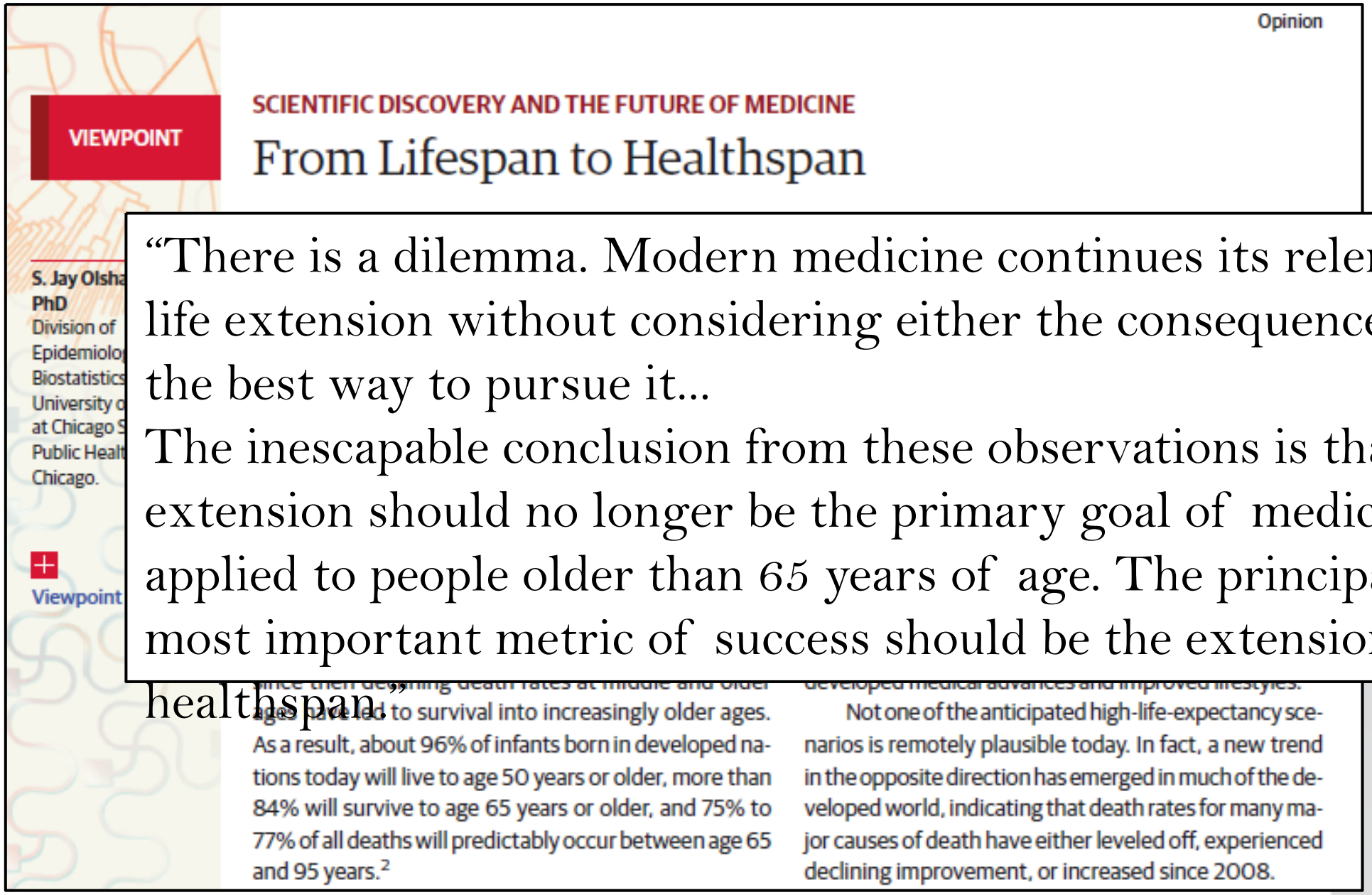
Philip A. Pizzo, MD
Departments of Pediatrics and Microbiology and Immunology, Stanford University, Stanford, California.

What guidance should clinicians offer parents of a newborn about how to prepare their child for a li that may last to 100 or more years? What should physician discuss with adolescents who are beginni college, or young adults starting a new career abo how to optimize their healthy life? How does th guidance change when individuals reach midlife ar later life? Is there a prescription a physician shou provide that would allow individuals at all stages the life cycle to optimally align life span with heal span, compressing morbidity and sustaining hig functionality through the arc of life?

By 2030 all baby boomers, those born between 194 and 1964, will have become 65 years of age and com-

Whether dealing with individuals or communities, as an integral part of their clinical practice.

> Having a purpose, seeking social engagement, and fostering wellness through positive lifestyle choices are important in reducing morbidity and mortality and improving the life journey.



Opinion

VIEWPOINT

SCIENTIFIC DISCOVERY AND THE FUTURE OF MEDICINE

From Lifespan to Healthspan

S. Jay Olsha
PhD
Division of
Epidemiolo
Biostatistics
University o
at Chicago S
Public Healt
Chicago.

Viewpoint

ages paved to survival into increasingly older ages. As a result, about 96% of infants born in developed nations today will live to age 50 years or older, more than 84% will survive to age 65 years or older, and 75% to 77% of all deaths will predictably occur between age 65 and 95 years.[2]

Not one of the anticipated high-life-expectancy scenarios is remotely plausible today. In fact, a new trend in the opposite direction has emerged in much of the developed world, indicating that death rates for many major causes of death have either leveled off, experienced declining improvement, or increased since 2008.

"There is a dilemma. Modern medicine continues its relentless pursuit of life extension without considering either the consequences of success or the best way to pursue it...

The inescapable conclusion from these observations is that life extension should no longer be the primary goal of medicine when applied to people older than 65 years of age. The principal outcome and most important metric of success should be the extension of healthspan."

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JN

Olshansky SJ. From Lifespan to Healthspan. JAMA. 2018 Oct 2;320(13):1323-1324.

Institute of Gerontology at the University of Tokyo

Dr Hiroko Akiyama of the University of Tokyo, sugiere que el estado de salud a los 65 es un fuerte indicador de calidad de vida para el resto de la vida.

“Si eres un japonés que celebra su cumpleaños # 65, puedes esperar tener unos 20 a 25 años de una "segunda vida"

En un modelo de ciclo de vida de 70 años, en el que las personas mueren entre los 60 o 70 años, la salud no es tan importante para las personas en edad laboral; Sin embargo, en el modelo ciclo de vida con expectativa a 100 años, se debe invertir continuamente en la salud desde el punto más temprano posible para mantener la salud después de la jubilación. ¿Pero cómo?

¿Cuánto valoramos nuestra salud?

- NO FUMAR
- Beber y comer menos
- + Movimiento

= 40% Cáncer & 75% DTII ECV.

THE LANCET

1er Congreso Internacional

Perspectives

The art of medicine

Changing minds about changing behaviour

Most of us value our health highly yet act in ways that undermine it. If we ate and drank less, didn't smoke, and were physically more active, 40% of cancers and 75% of diabetes and cardiovascular disease would be avoided. Because these behaviours tend to cluster by deprivation, achieving these changes for everyone could also halve the gaps in life expectancy and years lived in good health between the rich and the poor. In the UK, around 16% of the population smokes, the lowest figure for many decades, although among those who are poorest this rate is doubled. About 25% of those who consume alcohol do so at a rate considered harmful. Excessive eating explains much of why 65% of the population is overweight or obese. But our rates of inactivity top the lot: when measured objectively (rather than by our more generous self-reports) around 95% of us can be deemed "inactive" by failing to meet the guideline of 150 min of moderate intensity physical activity each week. Changing all these behaviours will need many different interventions operating at the same time. Critical will be the use of interventions that are effective at scale and with the potential to reach the entire population.

Informing individuals of the consequences of engaging in harmful behaviours has been core to many strategies for change. Such information can be extremely effective. A sign warning of shark-infested waters stops most of us from swimming. A sign warning of the killing properties of sofas, by contrast, has little impact. While this may increase our awareness of the harms of physical inactivity—and the associated sofa-behaviours of binging on junk food—its impact on actual behaviour is, at best, modest. High hopes abound that personalising risk information—giving people their chance of developing a disease—will prove more effective. Such hopes are ill-founded. But enabling policy makers and the public to understand the reasons why could presage the implementation of interventions that do change behaviour benefiting the health of all.

Personalising someone's risk of developing a potentially preventable disease often involves using one or more of a range of biological markers. This includes blood pressure, body-mass index, blood cholesterol, and gene variants. The expectation is that such information—revealing to an individual that which is usually hidden—will motivate them to reduce their risks by, for example, becoming more physically active, attaining a healthier weight, or stopping smoking. But do they? The bottom line is that—based on the existing evidence from studies involving feedback using a wide range of biological markers—personalised risk information doesn't change behaviour. While such information can change how people think about their risks, critically it doesn't seem to change what they do. The fascinating question is why such information does not change behaviour.

In essence, environments exert a stronger impact on what people do than what's in their minds. Far stronger too than we like to believe—also known as the fundamental attribution error. Dual process models of human behaviour—popularised by Daniel Kahneman's book *Thinking, Fast and Slow*—describe the brain processes that regulate behaviour. Put simply, everything we do is regulated by two sets of interacting processes, conscious and non-conscious. The former is goal-directed, guided by explicit beliefs and values but is slow and limited in capacity. We require it for doing hard sums, learning a musical instrument, and avoiding alcohol in environments that readily cue drinking. It is complemented by a non-conscious set of processes. These are fast, based more on feelings and automatic associations—I see a cigarette lighter, I crave a cigarette; I open my fridge after work, I reach for a beer. These associations regulate our more routine and habitual behaviours, such as taking a shower, travelling to work, and eating chocolate after dinner. Conscious and non-conscious processes mostly work harmoniously to navigate us safely, productively, and enjoyably through our day. But they conflict when two behaviours compete, as is often the case with health-related behaviours: a routine of lying on the sofa each evening with a beer competes with a health goal of 10000 steps a day and no alcohol on week days. Risk information is a weak intervention in this system. It targets the conscious set of processes least involved in regulating our routine or habitual unhealthy behaviours. In short, information-based approaches to changing behaviour are based on partial models of human behaviour, neglecting the

Secretaría de Salud

México es uno de los países con las mayores prevalencias de sobrepeso y obesidad en todos los grupos, y siendo las enfermedades no transmisibles las principales causas de morbilidad y mortalidad, se ha descrito que la combinación **de cuatro factores de un estilo de vida saludable como mantener un peso saludable, realizar actividad física regularmente, adoptar una dieta correcta y no fumar,** está asociada a una reducción de hasta un 80% en el riesgo de desarrollar enfermedades crónicas no transmisibles.

Alfabetización en Salud

- El conocimiento de las personas, su **motivación** y las **competencias** para acceder, entender, apreciar y aplicar la información de salud a fin de hacer juicios y tomar decisiones en la vida cotidiana concerniente a la atención de salud, prevención de enfermedad, así como **promoción de salud** para mantener o mejorar la calidad de vida durante el curso de esta.

R, Marzán DM, Castillo FM, et al. Alfabetización en salud en medicina general integral. Perspectivas en Santiago de Cuba . MediSan. 2013;17(01):126-140.

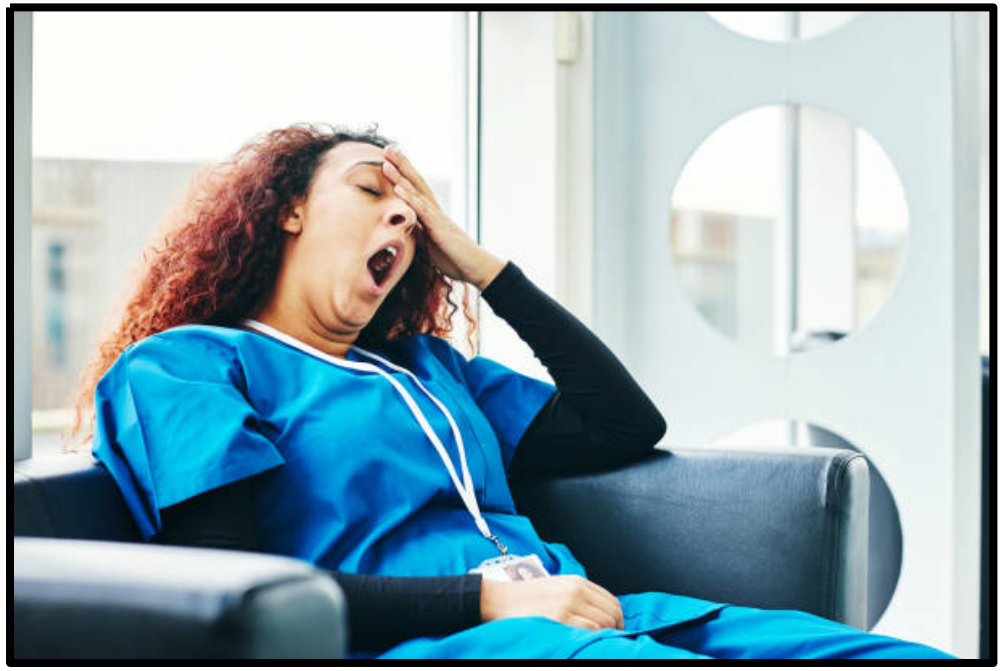
¿CÓMO LOGRAR LA ALFABETIZACIÓN EN SALUD?

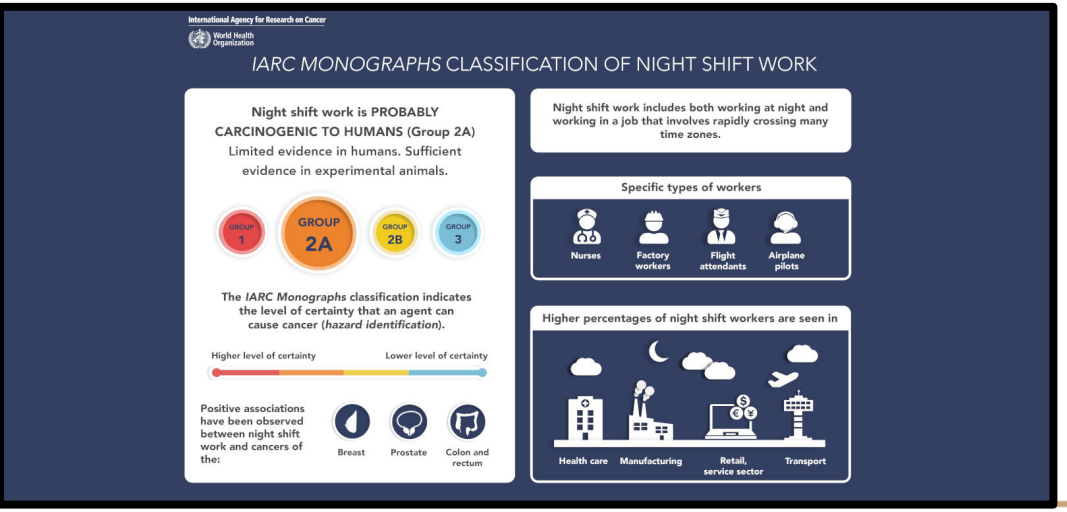
PRIMER NIVEL	SEGUNDO NIVEL	TERCER NIVEL
ATENCIÓN Y CUIDADO DE LA SALUD	PREVENCIÓN DE ENFERMEDADES	PROMOCIÓN DE LA SALUD

Cuadro. Competencias de alfabetización en salud

	Acceder /obtener la información pertinente a la salud	Entender la información pertinente a la salud	Procesar/apreciar la información pertinente a la salud	Aplicar /usar la información pertinente a la salud
Atención/ cuidado de salud	Habilidad para acceder a la información sobre problemas médicos o clínicos	Habilidad para entender la información médica y su significado	Habilidad para interpretar y evaluar la información médica	Habilidad para tomar decisiones informadas en los problemas médicos
Prevención de enfermedades	Habilidad para acceder a la información sobre factores de riesgo para la salud	Habilidad para entender la información sobre factores de riesgo y su significado	Habilidad para interpretar y evaluar la información sobre los factores de riesgo para la salud	Habilidad para tomar decisiones informadas en los factores de riesgo para la salud
Promoción de salud	Habilidad para actualizarse uno mismo en las determinantes de salud en el ambiente social y físico	Habilidad para entender la información sobre las determinantes de salud en el ambiente social y físico y su significado	Habilidad para interpretar y evaluar la información sobre las determinantes de salud en el ambiente social y físico	Habilidad para tomar decisiones informadas en las determinantes de salud en el ambiente social y físico

R, Marzán DM, Castillo FM, et al. Alfabetización en salud en medicina general integral. Perspectivas en Santiago de Cuba . MediSan. 2013;17(01):126-140.





- Después de una jornada de 30 horas sin dormir, los residentes cometen 460% más errores diagnósticos en cuidados intensivos.
- 1 de cada 5 residentes cometerá un error grave relacionado con la falta de sueño que cause daño significativo al paciente.
- 1 de cada 20 matará a un paciente por errores relacionados con el insomnio prolongado.
- Los residentes tras turnos de 30 horas tienen 73% más riesgo de pincharse con agujas o cortarse con bisturí, exponiéndose a enfermedades transmisibles.
- Tienen 168% más probabilidades de sufrir un accidente automovilístico al salir del turno, por fatiga extrema.
- Cirujanos que durmieron menos de 6 horas tienen 170% más probabilidades de cometer errores quirúrgicos graves.
- Tras 22 horas sin dormir, el rendimiento cognitivo es igual al de una persona legalmente ebria

En México, cada año 65 mil personas pierden la vida por causas directamente relacionadas con el tabaquismo . Es la enfermedad que más muertes prevenibles causa en el mundo.

El tabaco es un agente que daña la salud y termina con la vida, erosiona al medio ambiente y destruye las sociedades. Es sin duda alguna, "un enemigo de la sociedad y de la humanidad"

Bernardino Ramazzini (1633–1714). Portrait by Anthony Stones.
Source. Glass B, Stones A, Franco G. *Diseases of Workers by Bernardino Ramazzini. A Tribute in the Year 2000.* Wellington, NZ: Occupational Safety and Health Service, Department of Labour; November 2000. Reproduced with permission.

De Morbis Artificum Diatriba [Diseases of Workers]

Bernardino Ramazzini. From the Latin text of 1713, revised, with translation and notes by Wilmer Cave Wright. (Chicago: University of Chicago Press; 1940.)

I NOW WISH TO TURN TO . . . workers in whom certain morbid affections gradually arise from . . . some particular posture of the limbs or unnatural movements of the body called for while they work. Such are the workers who all day long stand or sit, stoop or are bent double; who run or ride

exhausting compared with walking and running, though it be for a long time. It is generally supposed that this is because of the tonic movement of all the antagonist muscles, both extensors and flexors, which have to be continually in action to enable a man to keep standing erect. . . . It follows that whenever occasion offers, we must advise men employed in the standing trades to interrupt when they can that too prolonged posture by sitting or walking about or exercising the body in some way. . . .

The maladies that afflict the clerks . . . arise from three causes: First, constant sitting, secondly the incessant movement of the hand and always in the same direction, thirdly the strain on the mind from the effort not to

most tonic strain on the muscles and tendons, which in course of time results in failure of power in the right hand. . . .

Those who sit at their work and are therefore called "chair-workers," such as cobblers and tailors . . . become bent, hump-backed, and hold their heads down like people looking for something on the ground; this is the effect of their sedentary life and the bent posture of the body as they sit and apply themselves all day to their tasks in the shops where they sew. . . . Since to do their work they are forced to stoop, the outermost vertebral ligaments are kept pulled apart and contract a callosity, so that it becomes impossible for them to return to the natural position. . . . These workers, then, suffer from

1382 | Voices From the Past American Journal of Public Health | September 2001, Vol 91, No. 9

Salud laboral:
En 1700, el médico Bernardino Ramazzini advirtió: *"¿Qué profesión ejerces? Dímelo, y te diré qué enfermedad padecerás"*.

- México, el país de la OCDE donde más se trabaja (2,128 horas anuales)
- Nunca hemos tenido más herramientas para proteger la salud laboral (como la **NOM-035** o el programa **ELSSA del IMSS**)
- Entornos de trabajo como espacios de producción, no de vida.

Avances y pendientes

A. Lo que existe:

•**NOM-035**: Obliga a empresas a evaluar riesgos psicosociales, pero muchas solo cumplen el papeleo.
•**Programa ELSSA (IMSS)**: Promueve actividad física, alimentación sana y salud mental en centros de trabajo. Ejemplo: talleres de ergonomía para evitar lesiones musculares.
•**Compromiso #46 del gobierno**: Acciones en escuelas y centros de trabajo para reducir obesidad, hipertensión y diabetes.

B. Lo que falta:

•**Cultura preventiva**: Solo el **12%** de las empresas capacitan en salud laboral (STPS).
•**Justicia salarial**: el 30% de los trabajadores no tiene acceso a servicios de salud.

Hacia un nuevo paradigma: Trabajar para vivir, no vivir para trabajar

La **OMS** insiste: *"La salud se crea donde se vive, trabaja y juega"*. Para lograrlo, necesitamos:

1.Empresas que inviertan en prevención: Ejemplo: techos frescos en fábricas para evitar golpes de calor (como sugiere ELSSA).
2.Trabajadores que exijan sus derechos: Usar la NOM-035 para reportar abusos.
3.Políticas con visión ética: Que el **Compromiso #46** no sea solo un número, sino un cambio real en comedores laborales y horarios flexibles.

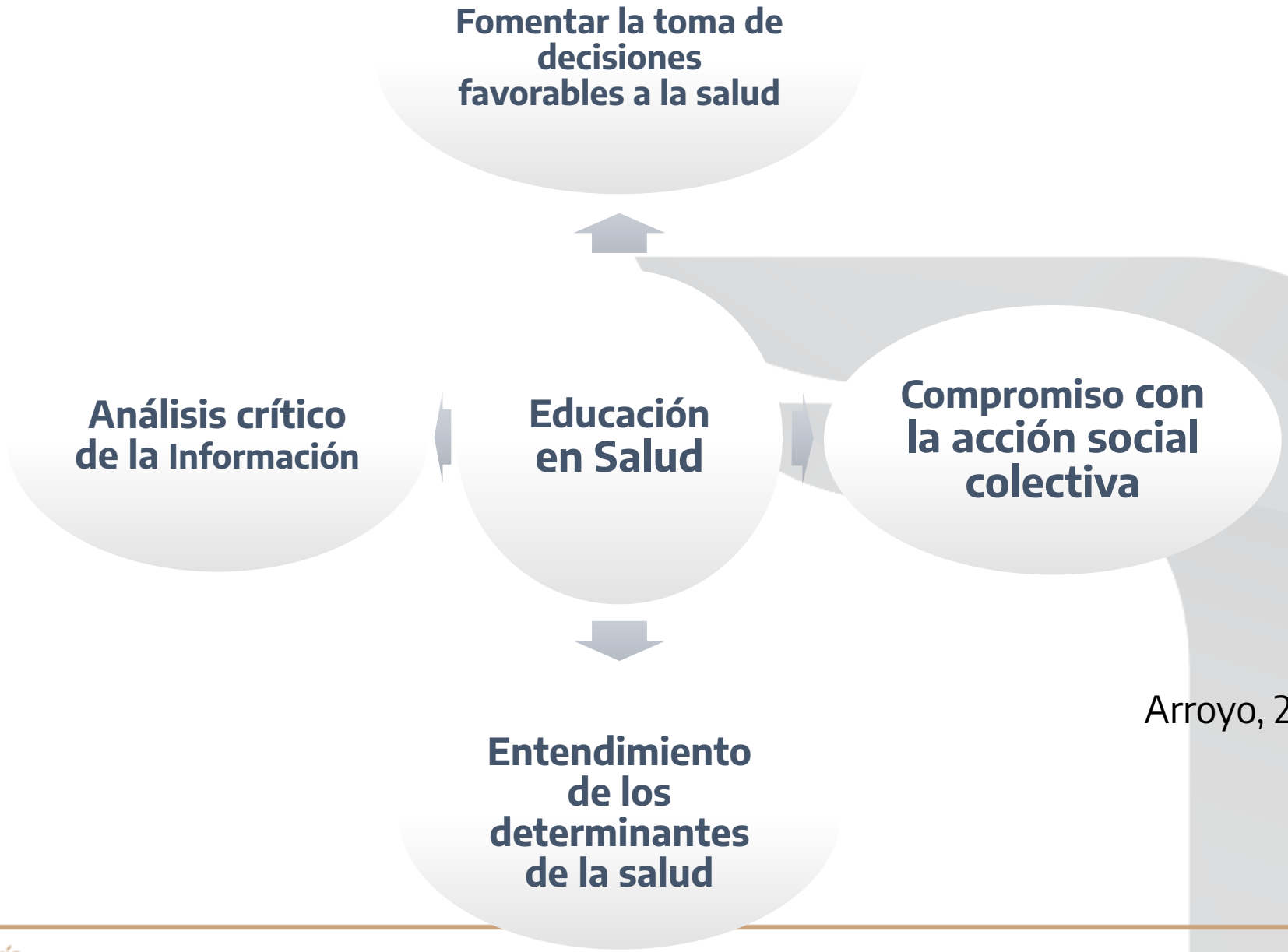
Promoción de la Salud

"La salud es creada y vivida por la gente dentro de los entornos de su vida cotidiana; donde aprenden, donde trabajan, donde juegan y en las relaciones interpersonales."

La Carta de Ottawa (1986)

OPS
Organización Panamericana de la Salud
Organización Mundial de la Salud
Américas

RMUPS
Red Mexicana de Universidades Promotoras de Salud


Fomentar la toma de decisiones favorables a la salud
Análisis crítico de la Información
Educación en Salud
Compromiso con la acción social colectiva
Entendimiento de los determinantes de la salud

Arroyo, 2023


#CHOOSEHEALTH
1
SEGUIR UNA DIETA SALUDABLE
2
MANTENERSE FÍSICAMENTE ACTIVO, A DIARIO Y CADA UNO A SU MANERA
3
VACUNARSE
4
NO CONSUMIR TABACO EN NINGUNA DE SUS FORMAS
5
EVITAR EL CONSUMO DE ALCOHOL O REDUCIRLO
6
GESTIONAR EL ESTRÉS PARA UNA MEJOR SALUD FÍSICA Y MENTAL
12 CONSEJOS PARA GOZAR DE BUENA SALUD
7
MANTENER UNA BUENA HIGIENE
8
NO CONDUCIR A VELOCIDAD EXCESIVA NI BAJO LOS EFECTOS DEL ALCOHOL
9
ABROCHARSE EL CINTURÓN DE SEGURIDAD EN EL AUTOMOVIL Y PONERSE CASCO AL IR EN BICICLETA
10
MANTENER PRACTICAS SEXUALES SEGURAS
11
SOMETERSE A REVISIONES MÉDICAS PERIÓDICAS
12
AMAMANTAR A LOS BEBÉS: ES LO MEJOR PARA ELLOS
Organización Mundial de la Salud

Circulation

Qué es un estilo de vida saludable?

er Congreso Internacional

ORIGINAL RESEARCH ARTICLE

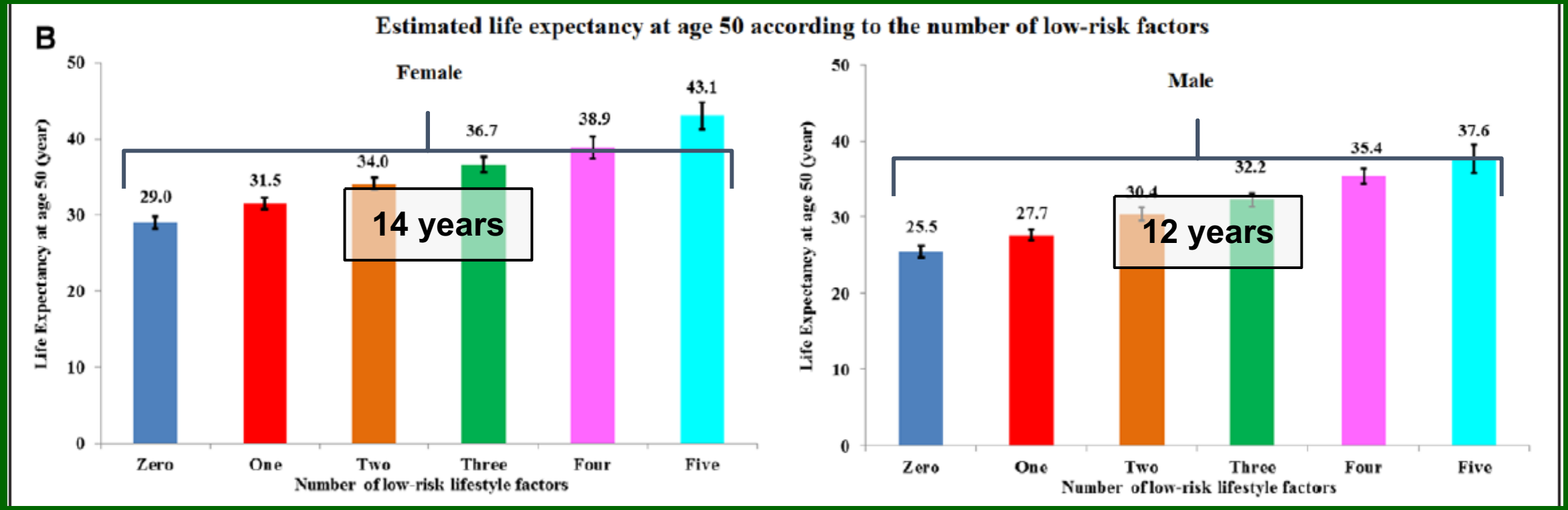
Impact of Healthy Lifestyle Factors on Life Expectancies in the US Population

BACKGROUND: Americans have a shorter life expectancy compared with residents of almost all other high-income countries. We aim to estimate the impact of lifestyle factors on premature mortality and life expectancy in the US population.

METHODS: Using data from the Nurses' Health Study (1980–2014; n=78 865) and the Health Professionals Follow-up Study (1986–2014, n=44 354), we defined 5 low-risk lifestyle factors as never smoking, body mass index of 18.5 to 24.9 kg/m^2, ≥30 min/d of moderate to vigorous physical activity, moderate alcohol intake, and a high diet quality score (upper 40%), and estimated hazard ratios for the association of total lifestyle score (0–5 scale) with mortality. We used data from the NHANES (National Health and Nutrition Examination Surveys; 2013–2014) to estimate the distribution of the lifestyle score and the US Centers for Disease Control and Prevention WONDER database to derive the age-specific death rates of Americans. We applied the life table method to estimate life expectancy by levels of the lifestyle score.

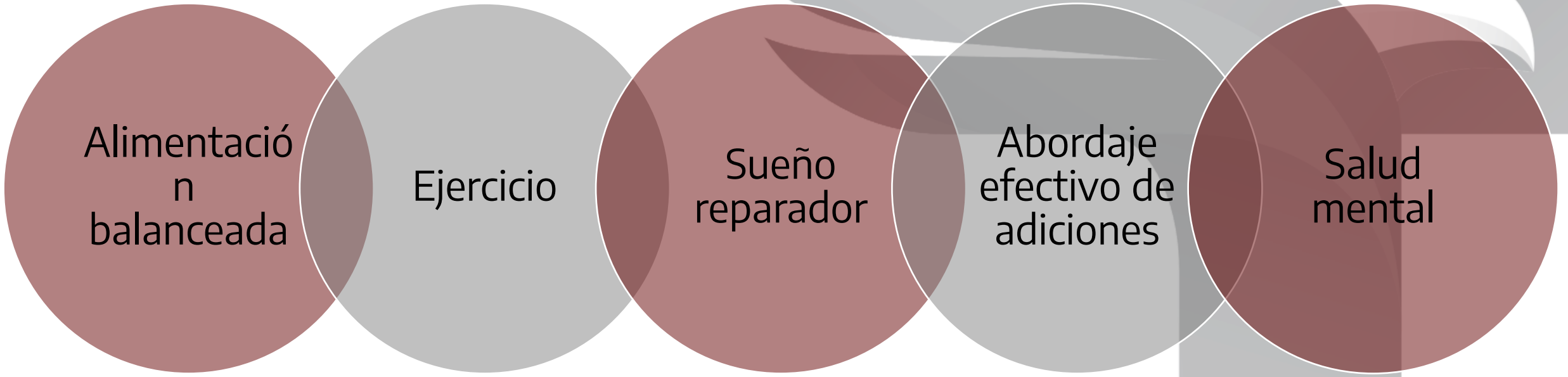
Yanping L
An Pan, P
Dong D. W
Xiaoran L
Klodian D
Oscar H. F
Stephen K
Emanuele
nio, MD
Meir Stam
Walter C.
DrPH
Frank B. H

1. Healthy Diet
2. Healthy physical activity level
3. Healthy body weight
4. NO Smoking
5. NO Drinking


B
Estimated life expectancy at age 50 according to the number of low-risk factors
Female
Life Expectancy at age 50 (year)
50
40
30
20
10
0
29.0
31.5
34.0
36.7
38.9
43.1
14 years
Zero
One
Two
Three
Four
Five
Number of low-risk lifestyle factors
Male
Life Expectancy at age 50 (year)
25.5
27.7
30.4
32.2
35.4
37.6
12 years
Zero
One
Two
Three
Four
Five
Number of low-risk lifestyle factors

República Sana

- Para promover cambios en estilos de vida saludables se recomienda atender los pilares de:



1er Congreso Internacional

"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

ACTIVIDAD FÍSICA

¡Actívate, muévete todos los días (camina, baila y practica deporte)!

NO CONSUMO DE SUSTANCIAS NOCIVAS

Cuídate de las sustancias nocivas y adictivas que dañan tu salud, tu mente y tus relaciones personales

DESCANSO ADECUADO

Descansa. Completa de 7-8 horas de sueño cada noche.

BUENA ALIMENTACIÓN

Come frutas, verduras, legumbres y toma agua natural.

CONTROL DE ESTRÉS

Cuida tu mente y sé positivo.

RELACIONES SALUDABLES

Cuida a tu gente (practica el respeto, la empatía y amistad).

CAMBIO DE COMPORTAMIENTO EN SALUD

COLEGIO MEXICANO DE MEDICINA DE ESTILO DE VIDA

AMERICAN COLLEGE OF Lifestyle Medicine

MEDICINA DE ESTILO DE VIDA

Es una rama de la medicina, basada en la evidencia en la que se utilizan cambios integrales en el estilo de vida (incluida la nutrición, la actividad física, el control del estrés, el apoyo social y las exposiciones ambientales) para prevenir, tratar y revertir la progresión de enfermedades crónicas al abordar sus causas subyacentes.

Lifestyle medicine potential for reversing a world of chronic disease epidemics: from cell to community. Int J Clin Pract. 2014 Nov;68(11):1289-92. doi: 10.1111/ijcp.12509. PMID: 25348380.

ESC European Society of Cardiology

European Heart Journal (2024) **45**, 2584–2586
https://doi.org/10.1093/eurheartj/ehae173

CardioPulse

Global Spotlights

From chronic disease to chronic health: the evolving role of doctors in the 21st century

Luigi Fontana [1,2]*

[1]Charles Perkins Centre, Faculty of Medicine and Health, University of Sydney, John Hopkins Dr, Camperdown, NSW 2050, Australia; and [2]Department of Endocrinology, Royal Prince Alfred Hospital, 50 Missenden Rd, Camperdown, NSW 2050, Australia

The global phenomenon of an aging population, compounded by the pervasive pandemic of abdominal obesity and metabolic diseases stemming from unhealthy lifestyles, presents formidable challenges for governments and institutions worldwide. These trends not only escalate healthcare costs but also strain the sustainability of existing public healthcare systems. However, simply increasing spending is not a viable solution. Despite healthcare expenditure skyrocketing from $2.8 trillion in 2013 to a staggering $4.1 trillion in 2023, the USA has witnessed a unique and disturbing decline in both lifespan and healthspan.[1] In 2019, the life expectancy gap between the USA and other leading industrialized nations was 5.43 years for men and 5.96 years for women. And even within the USA, marked disparities in mortality rates exist, with Asians and Hispanics showing cardiometabolic disease death rates for men 40%–60% lower and for women 30%–40% lower than African Americans.[2] Moreover, nearly 90% of healthcare costs in the USA, as in other developed nations, are directed towards treating chronic diseases retroactively, after they have already manifested.[1] This underscores the urgent need to transition towards preventative healthcare and educational models, rather than predominantly addressing chronic conditions reactively within hospital settings.

From managing illness to promoting chronic health: a cultural revolution in healthcare

It is imperative to lead a cultural revolution reorienting our priorities from managing 'chronic diseases' to promoting 'chronic health'. This entails not only changing individual behaviours but also establishing social and economic health models that prioritize prevention over treatment, with the aim of fostering optimal health throughout life, imposed by the growing tsunami of chronic diseases. Indeed, healthy individuals utilize fewer and less expensive healthcare resources than their unhealthy counterparts.[3] By reducing the prevalence of unhealthy citizens and promoting healthy longevity until the final months of life (20% of centenarians do not develop any major disease before 100 years of age),[4] we can potentially halt or even reverse the trajectory of healthcare expenditure and redirect financial resources towards a greener and sustainable economy. Therefore, embracing a paradigm shift towards prioritizing chronic health is not only beneficial for individuals but also for society as a whole.

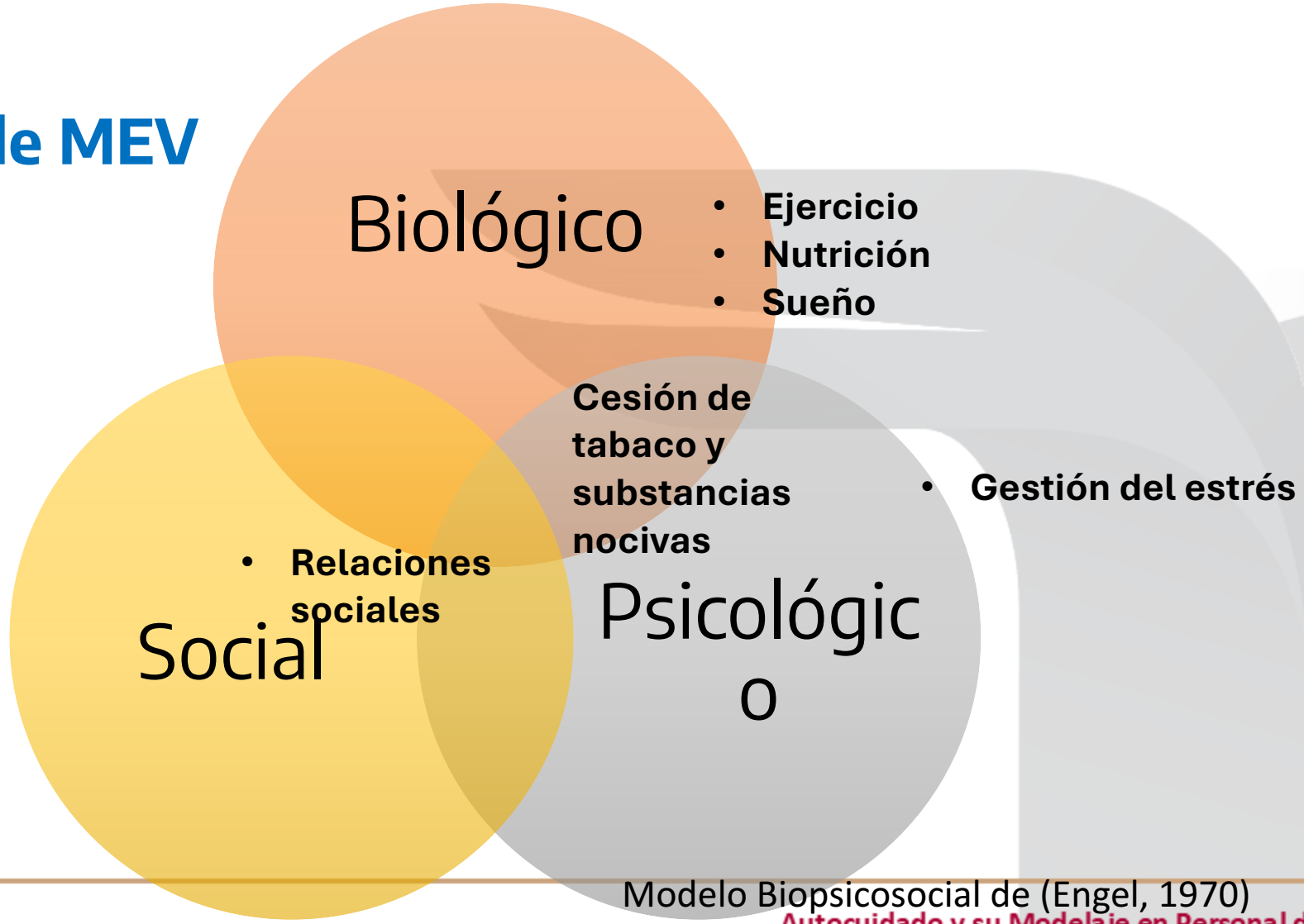
Lifestyle medicine education in schools and community health centres

A wealth of evidence from the field of aging biology indicates that targeting specific metabolic and molecular pathways through selected nutritional, exercise, cognitive, and psychological interventions can inhibit cellular and tissue damage accumulation, extending healthspan and influencing the clinical progression of many common chronic diseases that share a common metabolic substrate.[5,6] Time-dependent persistent exposure to unhealthy lifestyles and other toxic external factors, like excessive calorie intake, poor nutrition, sedentary lifestyle, psychological stress, smoking, alcohol, and pollution, accelerates the accumulation of damage and the deterioration of organs, increasing the risk of developing multiple, chronic medical conditions. Empowering individuals to make informed lifestyle choices, supported by digital and sensor-based platforms (Internet of Bodies) that enhance metabolic health and overall well-being, is essential. This paradigm shift requires early education pathways for health literacy across all levels of the school

"Rama de la medicina cuyo objetivo es mantener una salud óptima y prevenir, tratar y revertir las enfermedades crónicas en todas las etapas de la vida. Las intervenciones utilizadas incluyen estrategias conductuales basadas en evidencia, al tiempo que tienen en cuenta la equidad y la sostenibilidad, para mejorar las habilidades de autocuidado, con el fin de optimizar la nutrición, la higiene del sueño, la gestión del estrés, la conexión social, la salud sexual y la fertilidad, la actividad física y minimizar el consumo de sustancias tóxicas y las exposiciones

Medicina de Estilo de Vida

- 6 “Pilares” de MEV



Modelo Biopsicosocial de (Engel, 1970)

Medicina Tradicional/Convencional	Medicina del Estilo de Vida
Trata factores de riesgo individuales	**Trata las causas relacionadas con el estilo de vida**
El paciente es un receptor pasivo de la atención	**El paciente es un socio activo en su atención**
No se requiere que el paciente haga grandes cambios	**Se requiere que el paciente haga grandes cambios**
El tratamiento suele ser a corto plazo	**El tratamiento siempre es a largo plazo**
La responsabilidad recae en el clínico	**La responsabilidad también recae en el paciente**
El medicamento suele ser el tratamiento final	**Puede ser necesario el medicamento, pero se enfatiza el cambio de estilo de vida**
Enfatiza el diagnóstico y la prescripción	**Enfatiza la motivación y el cumplimiento**
El objetivo es el manejo de la enfermedad	**El objetivo es la prevención primaria/secundaria/terciaria**
Se considera poco el entorno	**Mayor consideración del entorno**
Los efectos secundarios se equilibran con los beneficios	**Los efectos secundarios que afectan el estilo de vida requieren mayor atención**
Involucra otras especialidades médicas	**Involucra también a profesionales de la salud aliados**
El médico generalmente trabaja de forma	**El médico es parte de un equipo**

Estrategia de Atención Oportuna y Disminución del Riesgo Cardiovascular

1er Congreso Internacional
"HACIA UN SISTEMA DE SALUD INTEGRAL Y HUMANISTA EN TAMAULIPAS"

Acciones de Médicos de Primer Nivel

CardioCalc

Tipificación del riesgo en pacientes con enfermedad crónico degenerativa

Plataforma (Px)

Registro y seguimiento de pacientes con enfermedades con riesgo cardiovascular alto, muy alto y crítico

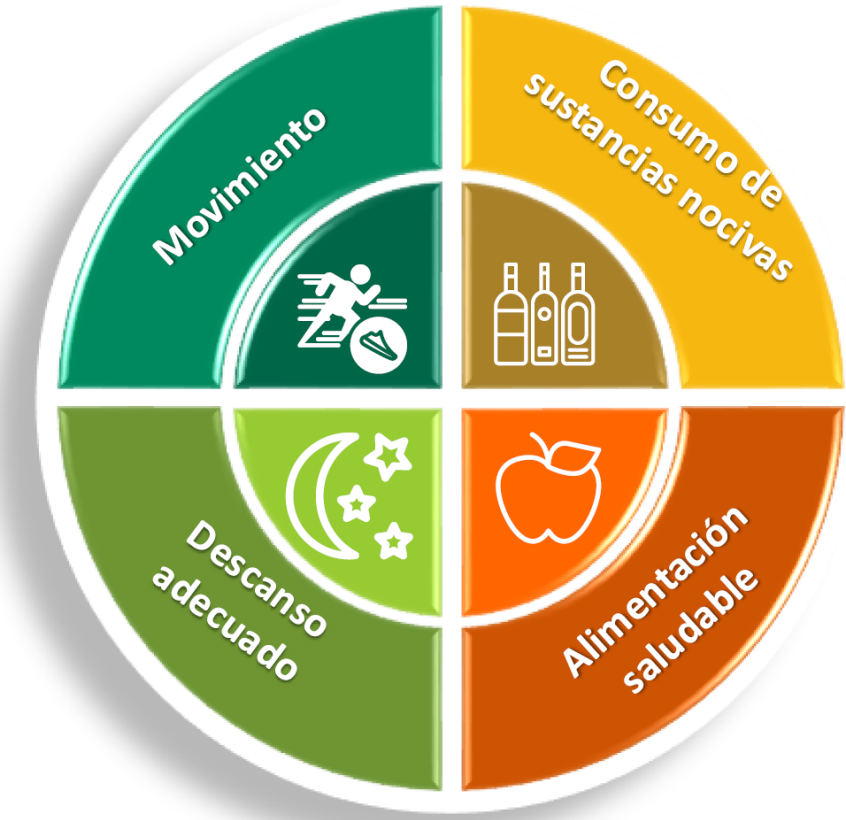
Emergencia Salud Tamaulipas

Capacitacion al paciente para la instalacion de la APP

Manual de Prescripciones

Implementación de la Medicina de Estilo de Vida Saludable para disminuir el riesgo

¡Tienes varias áreas en las que podrías mejorar tus hábitos de estilo de vida para fortalecer tu salud!



Dirección de Medicina de Estilo de Vida Saludable

Diplomado de Medicina de Estilo de Vida Saludable

Perfil de personal capacitado

- Residentes de Especialidades Médicas
- Internos de pregrado
- Pasantes de medicina
- Pasantes de enfermería
- Jefes de enseñanza
- Profesionales de la salud
- Profesionales de la salud extra institucionales
- Personal técnico y administrativo

5293

Capacitados

Fuente: Registros del Programa de Capacitación de Medicina de Estilo de Vida Saludable

IJCP THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

Perspectiva | Acceso Libre

Potencial de la medicina del estilo de vida para revertir un mundo de epidemias de enfermedades crónicas: de la célula a la comunidad

M. Sagner, D. Katz, G. Egger, L. Lianov, K.-H. Schulz, M. Braman, B. Behbod, E. Phillips, W. Dysinger, D. Ornish

Publicado por primera vez:27 de octubre de 2014 | https://doi.org/10.1111/ijcp.12509 | Citas: 26

Las principales causas de mortalidad y costos de atención médica en todo el mundo son las enfermedades crónicas, resultantes del estilo de vida y factores ambientales. La carga económica de las malas elecciones de estilo de vida ya no es sostenible e imposible de ignorar. La mayoría de las enfermedades crónicas son prevenibles. Para tratar las causas de

Lifestyle medicine potential for reversing a world of chronic disease epidemics: from cell to community. Int J Clin Pract. 2014 Nov;68(11):1289-92. doi: 10.1111/ijcp.12509. PMID: 25348380.

Physician Competencies for Prescribing Lifestyle Medicine

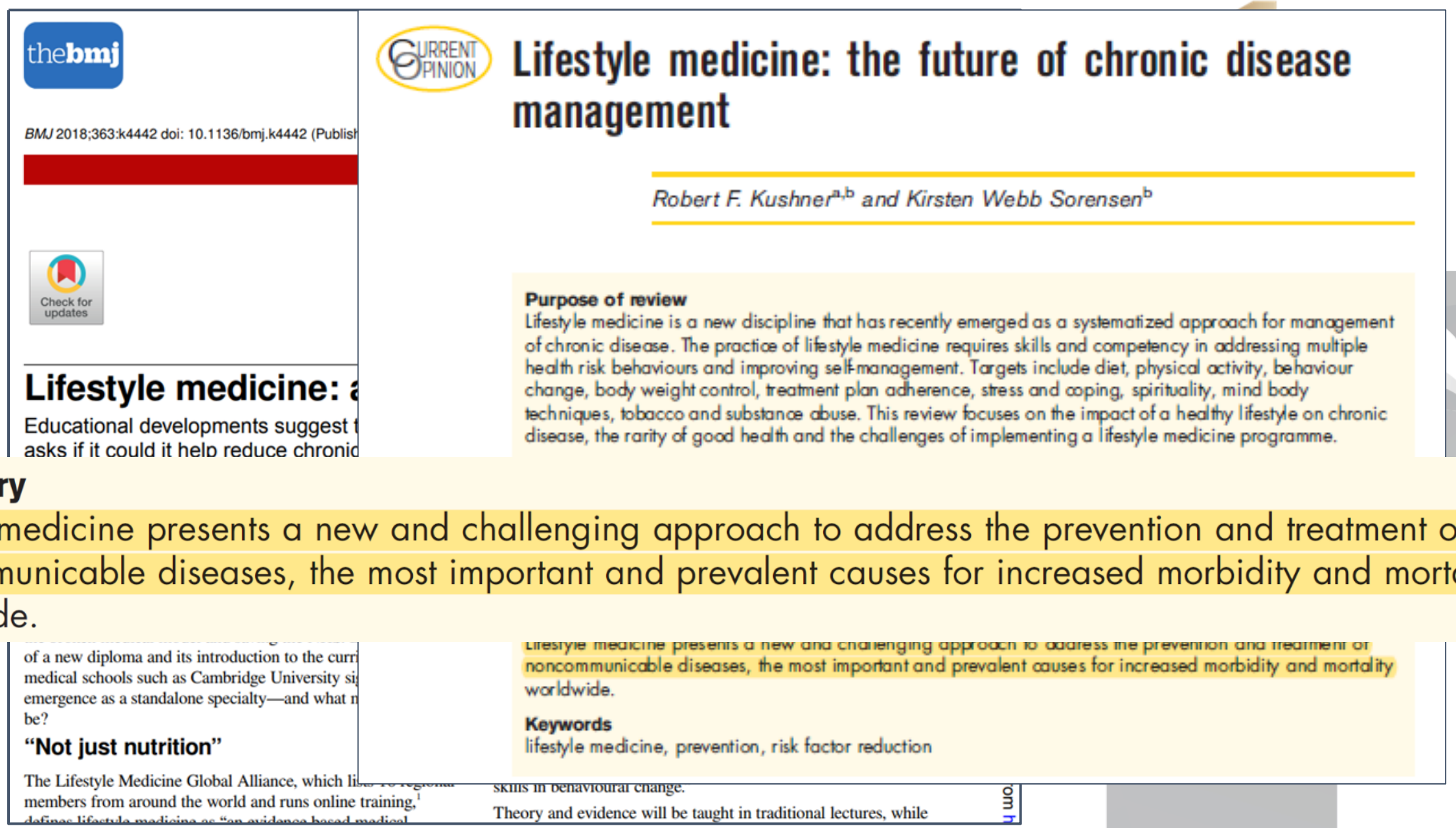
Liana Lianov, MD, MPH

Mark Johnson, MD, MPH

THE LEADING CAUSES OF DEATH FOR ADULTS IN THE United States are related to lifestyle—tobacco use, poor diet, physical inactivity, and excessive alcohol consumption.[1] US residents with these risk factors have plenty of room for improvement—including those who are asymptomatic and those living with chronic disease. Health behaviors could greatly influence future health and well-being, especially among patients with chronic disease. However, only 11% of patients with diabetes follow accepted dietary recommendations for saturated fat intake,[2] and 18% of patients with heart disease continue to smoke, barely better than the general population's smoking rate.[3]

The enormous potential effects of health behavior change on mortality, morbidity, and health care costs provide ample motivation for the concept of lifestyle medicine, ie, evidence-based practice of assisting individuals and families to adopt and sustain behaviors that can improve health and quality of life. Examples of target patient behaviors include, but are not limited to, eliminating tobacco use, improving diet, increasing physical activity, and moderating alcohol consumption. Yet, in practice, patients are advised to lose weight only 36% of the time during regular examinations, a proportion that improves only slightly to 52% if a patient already has obesity-related comorbidities.[7] Furthermore, only 28% of smokers reported that health care professionals had offered them assistance to quit smoking in the past year.[8] Findings such as these reveal 2 important facts: Physicians cannot ascribe the entire responsibility for inadequate lifestyle changes to their patients, and clinicians must accept some responsibility for deficiencies in the quality of health care. Acknowledging the crucial role of environmental and community factors in creating and sustaining inappropriate health behaviors does not eliminate the duty of physicians to assist patients in making health behavior changes.

Physicians also have cited inadequate confidence and lack of knowledge and skill as major barriers to counseling patients about lifestyle interventions.[9] Among the 620 respondents in a survey of family physicians, only 49% felt competent prescribing weight loss programs for obese patients.[10] Even though changing unhealthy behaviors is foundational to medical care, disease prevention, and health promotion, a physician's trusted relationship with the patient must be augmented whenever possible by family support, an interdisciplinary health care team, and community organizations and agencies (Box).



thebmj

BMJ 2018;363:k4442 doi: 10.1136/bmj.k4442 (Publish

Check for updates

Lifestyle medicine: a

Educational developments suggest t
asks if it could it help reduce chronic

of a new diploma and its introduction to the curri
medical schools such as Cambridge University si
emergence as a standalone specialty—and what n
be?

"Not just nutrition"

The Lifestyle Medicine Global Alliance, which lis
members from around the world and runs online training,[1]

skills in behavioural change.

Theory and evidence will be taught in traditional lectures, while

CURRENT OPINION

Lifestyle medicine: the future of chronic disease management

Robert F. Kushner[a,b] *and Kirsten Webb Sorensen*[b]

Purpose of review
Lifestyle medicine is a new discipline that has recently emerged as a systematized approach for management of chronic disease. The practice of lifestyle medicine requires skills and competency in addressing multiple health risk behaviours and improving self-management. Targets include diet, physical activity, behaviour change, body weight control, treatment plan adherence, stress and coping, spirituality, mind body techniques, tobacco and substance abuse. This review focuses on the impact of a healthy lifestyle on chronic disease, the rarity of good health and the challenges of implementing a lifestyle medicine programme.

Summary
Lifestyle medicine presents a new and challenging approach to address the prevention and treatment of noncommunicable diseases, the most important and prevalent causes for increased morbidity and mortality worldwide.

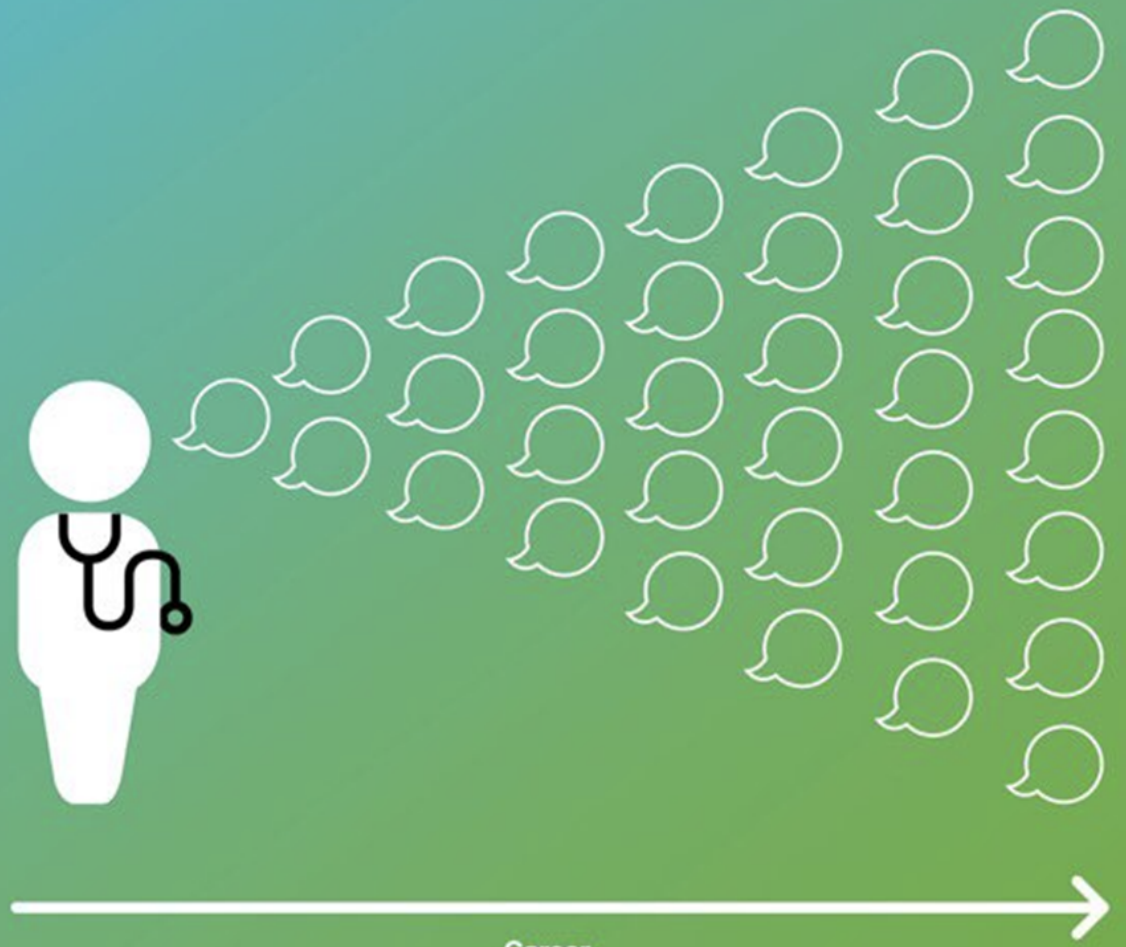
Keywords
lifestyle medicine, prevention, risk factor reduction

Lifestyle medicine presents a new and challenging approach to address the prevention and treatment of noncommunicable diseases, the most important and prevalent causes for increased morbidity and mortality worldwide.

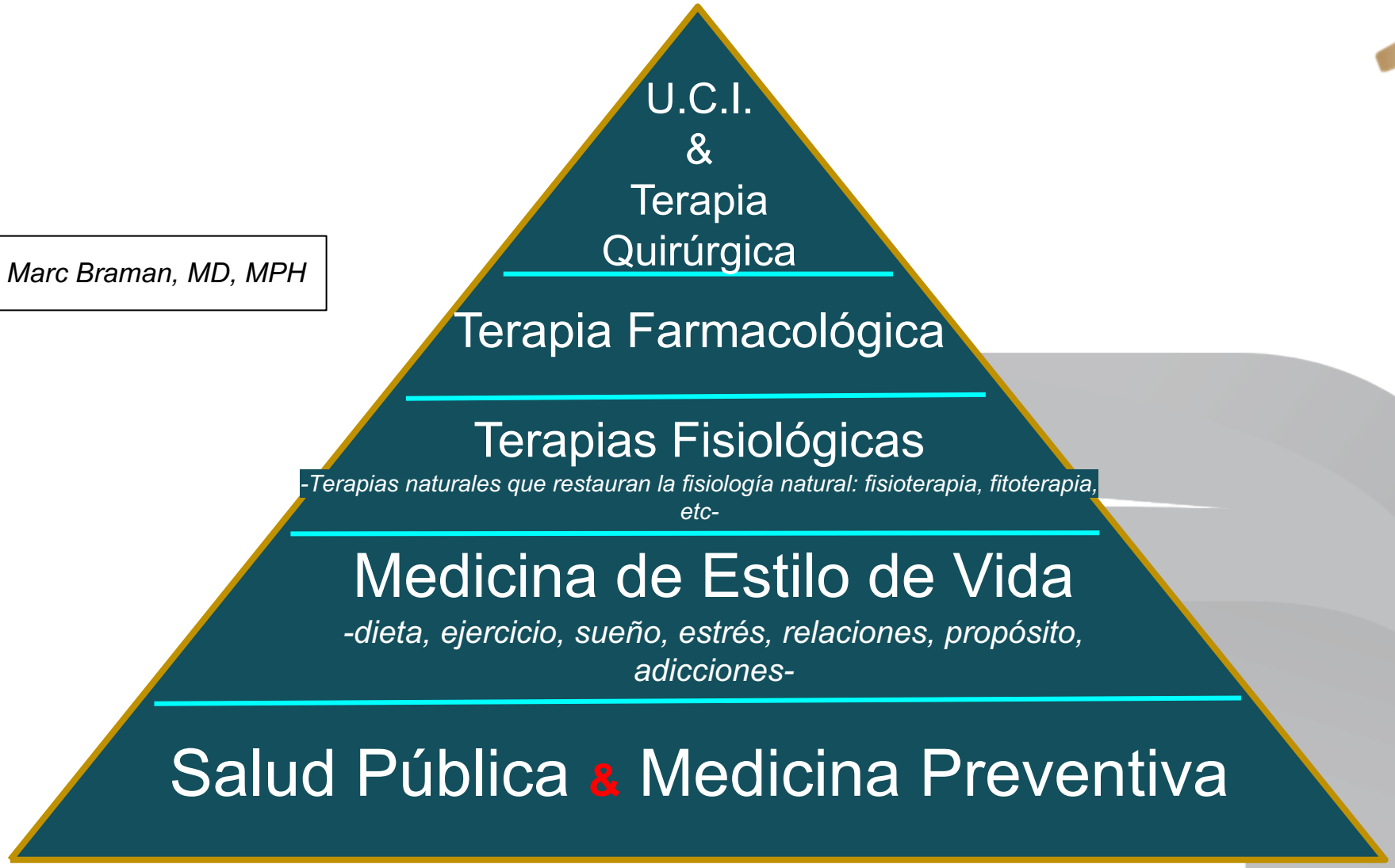
“ A qualified doctor, nurse, midwife or allied health professional may see half a million patients during their professional career: this has enormous potential for advocacy and the promotion of physical activity ”

Ann Gates 2015

Royal College of Surgeons Edinburgh, Round Table meeting “Great Strides” June, 2015.



Adaptado de Marc Braman, MD, MPH



TRIÁNGULO TERAPÉUTICO

Promoción de la salud

Tratamiento y control

Medicina de Estilo de Vida

Prevención de enfermedades

Reversión

“LA CAMINATA ES LA MEJOR MEDICINA PARA LA HUMANIDAD.”

Hipócrates

LET'S Be active
Everyone
Everywhere
Everyday

What Hippocrates called ‘Man’s best medicine’: walking is humanity’s path to a better world
British Journal of Sports Medicine 2018;52:753-754.

Miracle Cure!

BMJ 2019;366:l5605 doi: 10.1136/bmj.l5605 (Published 19 September 2019)

EDITOR'S CHOICE

The miracle cure

Fiona Godlee *editor in chief*

The BMJ

As miracle cures are hard to come by, any claims that a treatment is 100% safe and effective must always be viewed with intense scepticism. There is perhaps one exception. Physical activity has been called a miracle cure by no less a body than the Academy of Medical Sciences (http://bit.ly/2lTqDvc); and, like those who avail themselves of it, the supporting science grows stronger by the day. *The BMJ* recently published a

Are there downsides? There seem to be far fewer than for other widely used preventives and cures. Indeed, physical activity is one of the alternatives to antidepressants and painkillers that Ian Hamilton says we need for people struggling with physical or psychological pain (https://blogs.bmj.com/bmj/2019/09/13/ian-hamilton-prescription-drugs-are-no-cure-for-deprivation). It seems to have few if any side effects, and unlike some

"Las curas milagrosas son difíciles de encontrar, cualquier afirmación de que un tratamiento es seguro y eficaz al 100% debe considerarse siempre con gran escepticismo.

Quizá haya una excepción"…Las personas más activas viven más tiempo y tienen tasas más bajas de enfermedades cardiovasculares, cáncer y depresión.

"TODAS LAS PARTES DEL CUERPO, AL USARSE CON MODERACIÓN Y EJERCITARSE EN LABORES EN LAS QUE ESTÁN ACOSTUMBRADAS, SE VUELVEN SALUDABLES, BIEN DESARROLLADAS Y ENVEJECEN LENTAMENTE; PERO SI NO SE UTILIZAN Y SE DEJAN INACTIVAS, SE VUELVEN PROPENSAS A ENFERMEDADES, CON DEFECTOS, SIN CRECIMIENTO Y ENVEJECEN RÁPIDAMENTE ".

HIPÓCRATES

"Aquellos que piensan que no tienen tiempo para el ejercicio físico, tarde o temprano tendrán que encontrar tiempo para la enfermedad".

Edward Smith-Stanley

COLEGIO MEXICANO
DE MEDICINA DE ESTILO DE VIDA

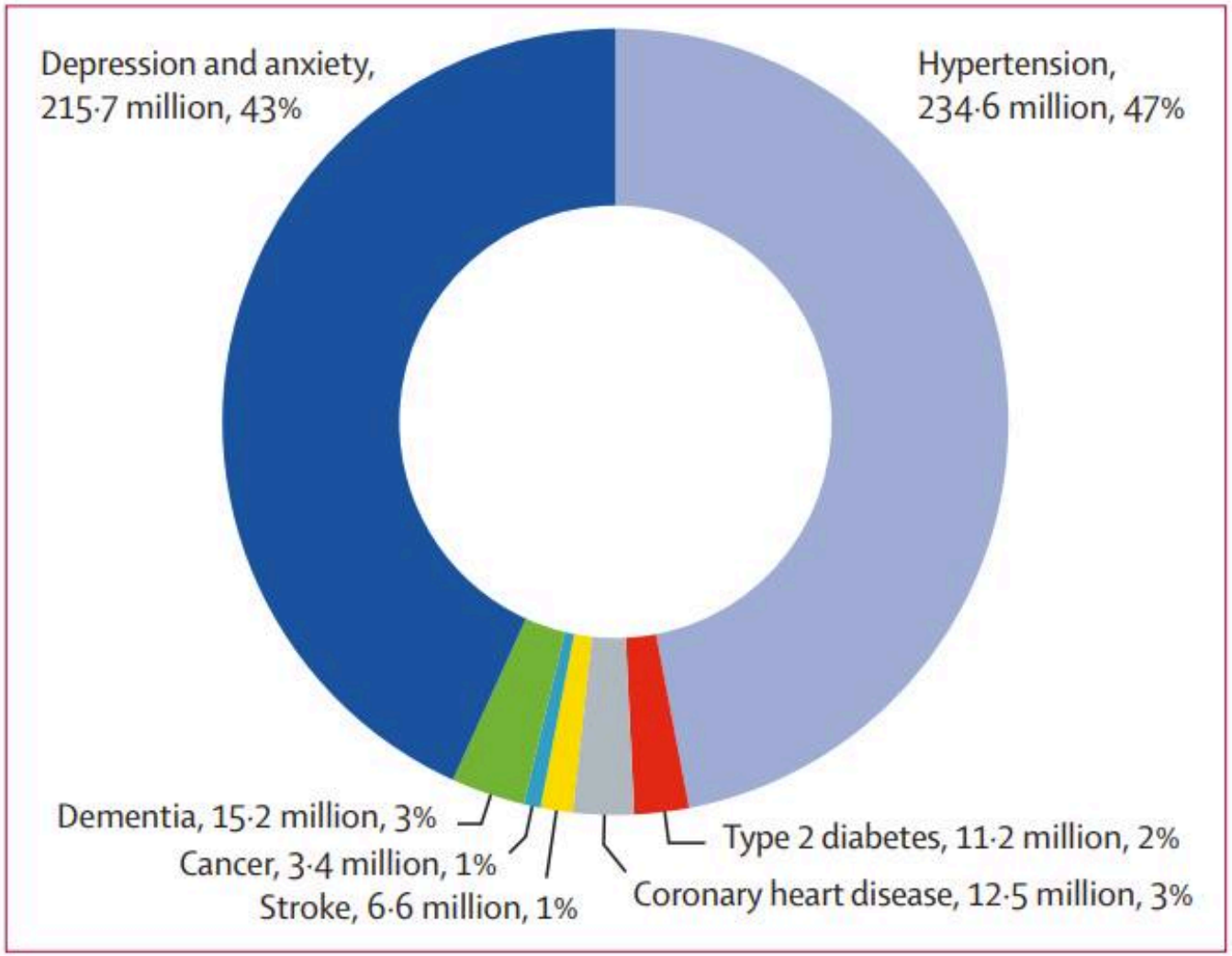


Figure 1: **Total global number and proportion of new cases of non-communicable diseases and mental health conditions attributed to physical inactivity, 2020–30**

Más de 400 millones de diagnósticos de ansiedad, depresión e hipertensión

EN LOS PROXIMOS 7 AÑOS.

Este es el primer estudio que evalúa el costo global para el sistema de salud pública y casos(incidentes) de ENT y trastornos mentales (OMS) debido a la inactividad física, las cuales podrían prevenirse.

https://doi.org/10.1016/S2214-109X(22)00464-8

Signos Vitales de Ejercicio

- "se debe preguntar a cada paciente sobre el ejercicio en cada visita utilizando un signo vital de ejercicio (SVE)... Los médicos tienen la obligación de evaluar el hábito de ejercicio de cada paciente e informarles de los riesgos del sedentarismo..."

Robert Sallis (2015) Exercise is medicine: a call to action for physicians to assess and prescribe exercise, The Physician and Sportsmedicine, 43:1, 22-26, DOI: 10.1080/00913847.2015.1001938

Muscle-strengthening Exercise Epidemiology: a New Frontier in Chronic Disease Prevention

Aunque las pruebas clínicas y epidemiológicas relacionan el ejercicio de fortalecimiento muscular con una salud y un bienestar óptimos, más del 80% de los adultos no cumplen las pautas de ejercicio de fortalecimiento muscular (≥ 2 veces/semana).

¿Conoce la gente este hecho? ¿Y los médicos?

Bennie et al. Sports Medicine - Open (2020) 6:40
https://doi.org/10.1186/s40798-020-00271-w

Durante las últimas décadas, los estudios de salud pública han mostrado evidencia indiscutible de que una buena condición física es el factor más crucial para retrasar la mortalidad por todas las causas y la aparición de enfermedades crónicas, especialmente enfermedades cardiovasculares, metabólicas y cáncer.

Cells **2022**, *11*(5), 872

"No importa si estudias a hombres o mujeres, diferentes grupos étnicos, países diversos, niños o ancianos, los resultados siempre son los mismos: las personas que son activas y tienen buena condición, viven vidas más largas y saludables. Esto ya no es noticia ".

Br J Sports Med 2011;45:473–474.
doi:10.1136/bjsm.2010.083469

COLEGIO MEXICANO
DE MEDICINA DE ESTILO DE VIDA

No es un mensaje nuevo afirmar que la actividad física mejora la salud y reduce el riesgo de padecer enfermedades crónicas.

Sin embargo, es un mensaje que nunca debe olvidarse.

Diabetes, Obesity and Metabolism 15: 987–992, 2013.

República educadora, humanista, y científica

26. Continúa la Nueva Escuela Mexicana.
27. Desaparece la USICAMM. Nuevo sistema de contratación y promoción de maestros.
28. La Escuela es Nuestra se ampliará a nivel medio superior.
29. Las primarias extenderán horarios para incluir deportes y artes.
30. Las escuelas serán espacios de prevención de la salud.
31. Se aumentarán los espacios en educación media superior.
32. 300 mil nuevos espacios para educación superior.
33. México será potencia tecnológica y de innovación.
34. Programa de desarrollo tecnológico para el desarrollo nacional.
35. Todos a ponernos la pila con deporte comunitario y apoyo a deportistas de alto rendimiento.