

# HEALTH FOR ALL IN THE AMERICAS

## Technical Discussions

21 to 22 September 1995  
Washington, D.C.

*Final Report*



Office of Analysis and Strategic Planning  
Pan American Health Organization  
World Health Organization



#### **NOTE**

*These technical reports are produced by the Office of Analysis and Strategic Planning, Pan American Health Organization (PAHO/WHO), with the purpose of disseminating information and stimulating discussion about topics of interest in public health policy and planning.*

*The opinions expressed in these documents are the sole responsibility of the author(s) and should not be attributed to the Pan American Health Organization.*

*The material included in this publication can be cited or reproduced without restrictions, provided that the source is mentioned and that the reference number is included. One copy of the reproduced material should be forwarded to the Office of Analysis and Strategic Planning, Pan American Health Organization, 525 23rd Street, N.W., Washington, D.C. 20037, United States of America.*

# **HEALTH FOR ALL IN THE AMERICAS**

## **Technical Discussions**

*21 to 22 September 1995  
Washington, D.C.*

*Final Report*

Office of Analysis and Strategic Planning  
Pan American Health Organization  
World Health Organization

### **Acknowledgments**

*This publication has been possible thanks to the contribution of numerous people. The Background Document to the Technical Discussions included in the Annex I was elaborated by a technical group formed by Mario Boyer, José Roberto Ferreira, Américo Migliónico, Cristina Puentes-Markides and Luis Ruiz. The final edition was in charge of Cristina Puentes-Markides with the administrative assistance of Justin O'Brien and Matilde Cresswell.*

*Juan Manuel Sotelo  
Chief  
Office of Analysis and Strategic Planning*

---

# Table of Contents

• <b>Background</b> .....	1
• <b>Introduction by Dr. David Brandling-Bennett,</b> .....	2
<i>Deputy Director, PAHO/WHO</i>	
• <b>Presentations of the Panelists</b> .....	4
<i>Dr. Abraham Horwitz, Director Emeritus, PAHO/WHO</i>	
<i>Dr. Juan Carlos Veronelli, PAHO/WHO Representative in Uruguay</i>	
<i>Dr. James Sarn, Save the Children Foundation</i>	
• <b>Remarks by Dr. Mirta Roses Periago,</b> .....	18
<i>Assistant Director, PAHO/WHO</i>	
• <b>Reports of the Discussion Groups</b> .....	19
• <b>Final Remarks by Dr. George A. O. Alleyne,</b> .....	31
<i>Director, PAHO/WHO..</i>	
• <b>Annex I</b> .....	37
<i>Health for All in the Americas</i>	
<i>—Background Document for the Discussions</i>	
• <b>Annex II</b> .....	57
<i>List of Discussion Participants by Group</i>	



# Background

The Pan-American Health Organization (PAHO/WHO) reaffirms the need to renewing the goal of Health for All (HFA) and the Primary Health Care (PHC) strategy in light of the global changes that are affecting—and will continue to affect—the health of populations, the health services systems, and the prevailing modes of technical cooperation in the Region of the Americas. In essence, the renewal of HFA reaffirms our faith in building a world where health is the patrimony of all. The achievements in the Americas have been significant but clearly not enough as the recent evaluation of Health for All indicates. The redoubling of efforts is no longer an option but a necessity. What we need, moreover, is innovative thinking and leadership. We need to adapt the strategy to confront the new challenges, incorporating new methodologies and tools that will enable us to achieve the HFA goal.

Faced with the multiplicity and speed of the trends affecting the health of populations and the challenges that they represent in terms of technical cooperation, PAHO convened a regional advisory group in Washington, D.C. on 3-4 April

of this year,<sup>1</sup> in which public health leaders of the Americas participated along with representatives of UNICEF and WHO. The group reviewed the implementation of HFA in the Region. It analyzed the social, economic, and political changes that had occurred, as well as demographic and epidemiological aspects, reassessing health and emphasizing the ethical imperative of Health for All *as soon as possible*, while underscoring the importance of equity, solidarity, and sustainability as essential elements to the process. The group made important contributions that are consolidated in the final report of the meeting, and it proposed the preparation of background documents to support the coming national and regional discussions aimed at revitalizing efforts toward Health for All in the countries. Achieving the goal implies crafting a feasible strategic hemispheric response that involves the mobilization and participation of other sectors and actors in the promotion of HFA, including the private sector, nongovernmental organizations, professional associations, legislatures, and the mass media.

# Introduction

## **Dr. David Brandling-Bennett, Deputy-Director of PAHO/WHO**

Welcome to the technical discussions on *Renewing the Call for Health for All*. I want to thank our panelists—Abraham Horwitz, James Sarn, Juan Carlos Veronelli—for leading off the discussions, and the Office of Analysis and Strategic Planning and the Staff Development Program for organizing these technical discussions. Dr. Mirta Roses Periago, Assistant Director will moderate the panel discussions.

Over the next day and a half we will be discussing a theme which has been fundamental to our work for more than 20 years. Indeed, we trace concepts of primary health care to the 1960s and 1970s, and concepts of equity and the right to health are clearly expressed in the WHO constitution.

Though "Health for All" (HFA) is a timeless goal, it was most clearly expressed in the Conference in Alma-Ata in 1978 and the series of developments and documents that resulted. I will not go into details of the history, as I expect that our panelists, will be referring more extensively to many of the important events before and after Alma-Ata.

The clear articulation of the goal (incorrectly called a strategy) of Health for All by the year 2000 was motivational and inspirational, providing WHO with renewed sense of mission and direction. Specific targets and indicators were elaborated and programs of work developed, which were published in a series of colored documents which should be familiar to you all. In addition, periodic monitoring and evaluation of progress was carried out by the countries, regions, and globally.

This sense of purpose extended into the Americas, as the Region actively adopted the goal and strategies in the late 1970s and early 1980s,

elaborating a regional strategy and a plan of action. Much was accomplished, and one can refer to the excellent documents presented to the Pan-American Sanitary Conferences in 1990 and 1995 for details. Unfortunately, it is not possible to say how many of these accomplishment were due to the goal of HFA or the fundamental strategy of primary health care (PHC). Obviously, the effort to achieve HFA and the eight fundamental elements of PHC were not carried out in isolation from other major social and economic forces, nor from other activities in the health sector.

In the Americas, HFA lost force in the mid-1980's for a variety of reasons: the economic crisis, lack of political will, a high level of centralization of decision-making, lack of support from the medical profession, and a variety of interpretations of what PHC meant, from minimal care only for the poor to all aspects of care for everyone. Other regions promoted the creation of Offices of HFA or PHC, often directly under the Minister of Health or even the Prime Minister or President. This made it possible to foster a uniform approach and to respond more easily to the monitoring and evaluation questionnaires. However, these offices often turned into parallel programs which failed to solve the political difficulties, many of which were similar to those encountered in the Americas.

Some of you may want to spend time exploring in greater depth the reasons why the goal of HFA fell into decline in the Americas. The lessons we learn should be applied today, if our renewed efforts are to succeed.

In the late 1980s and early 1990s, a number of countries began to express dissatisfaction with the work of WHO, for a variety of reasons; some of which included the recognition that we would certainly not achieve HFA by the year 2000 by whatever measure and that, if anything, progress toward the goal was slowing. The WHO Executive Board (EB) articulated these concerns and established a working group on WHO Response to Global Change. We are fortunate to have Dr. James Sarn with us today. Dr. Sarn was a member of that EB group and provided a report on its work to PAHO's Directing Council in 1993. I hope he will elaborate on the relevant aspects of the group's findings during his remarks.



An important thrust of WHO's response to global change has been renewal of the commitment to HFA. But this renewal is not simply a restatement of principles or approaches, which remain valid today. It is a reassessment of what is needed, on the part of WHO globally, the regional offices, and the countries if we are to achieve HFA.

I would like to refer you to the WHO consultation document on Renewing the HFA Strategy, included among the documents you received, particularly to pages 19, 20, and 21. The documents state that the policy proposes a focus on five strategic priorities:

- To reduce poverty and its health consequences;
- To ensure equity of access to, utilization of and outcome of the health system;
- To secure the place of health in the overall development framework, including financing of the health systems;
- To ensure the availability of newly acquired information and the rational application of existing knowledge and technology; and
- To mobilize various actors in international health work.

These indeed sound familiar, and the coincidence with PAHO's Strategic and Programmatic Orientations (SPO) may seem

remarkable. It should not, because we are talking about fundamental approaches which form the foundation of public health practice.

If the Strategic and Programmatic Orientations, indeed the very mission statement of PAHO, coincide with the renewed priorities of HFA, are we justified in feeling comfortable? I would suggest not, because one of our major deficiencies has been to allow HFA to become business as usual. We came to believe that whatever we did would contribute to Health for All, so that the goal became ill-defined and almost useless. Therefore, it is critical that we examine the strategic and programmatic orientations to see how they should be implemented in support the priorities of HFA. In addition, we must ask ourselves whether HFA should be a broad, comprehensive concept that may include multiple approaches, or should be focussed, specific, and targeted. It is probable that we cannot afford to take either extreme, but it will be a challenge to find a workable middle ground?

Another important aspect of renewing the commitment is consultation, which should take place globally, nationally, regionally, and locally. The process was initiated in the Americas in April of this year and is continuing. We should take these technical discussions as our opportunity for consultation amongst ourselves. I hope they will also serve as an opportunity for personal commitment, a commitment not to business as usual, but a serious personal commitment to contribute toward HFA in the Americas.

# Presentations of the Panelists

**Dr. Abraham Horwitz,**  
*Director Emeritus of*  
*PAHO/WHO*

I would like to thank the Director for the opportunity to comment on the subject of the Technical Discussions—Renewing of the Goal of Health for All—which will be held today at this seat of the Organization. According to the Dictionary of the Royal Spanish Academy, "to renew" is to make something like new or to return it to its original state.

I do not believe that the first meaning expresses the purposes of the Technical Discussions as I understand them. What we are talking about is reiterating the postulates, principles, purposes, and objectives of the Declaration of Alma-Ata and, more importantly, making strides toward their realization based on the lessons learned from their application in the Americas. We in PAHO, however, must affirm this declaration with deep conviction—a genuine feeling of pride and self-esteem that we are participants in a process characterized by great moral content and social justice. Not many have the opportunity in this life to serve people they do not know but whose health they wish to protect and promote because it is essential for human development and social well-being. I am referring to the concept of service as a spiritual mandate and a moral obligation.

Our Region has a wealth of experience that predates Health for All and its strategy of action, Primary Health Care, both inspired by the World Health Organization. I would like to remind you of two events that support this statement.

The first was the formulation of the 10-Year Health Plans for the 1960s and 1970s. Both clearly reaffirmed the universal concept of health as an end for each individual and, at the same time, as a means for the society to which he or she belongs, since health is a component of human and economic development. Today we hold that it should be the essential component. These plans pointed to the rebirth of ecology to underscore the permanent, reciprocal relationship

between health and the environment, placing the responsibility for the disease-generating air, water, and soil pollution squarely on the shoulders of human beings. Education should change the behaviors that have so deleterious an effect. One of the plans foresaw the consequences of uncontrolled population growth: poverty, overcrowding, greater risk of communicable diseases, violence, and crime.

These 10-year Plans established measurable objectives for the principal health problems perceived in the Region, where most of the countries were in an incipient or intermediate stage of the demographic and epidemiological transition. On an ethical plane, they determined that every inhabitant should have access and the right to use the health system and benefit from the highest quality care available in the country. The State had the main responsibility for guaranteeing access and controlling or removing geographical, economic, technical, and cultural barriers to this access. Unlike today, intense and extensive private sector participation in health did not exist. This explains why, particularly in the 10-year Plan of the 1970s, the emphasis in the countries is on coverage through increasingly complex health services, which should permit patients to be referred on the basis of their diagnosis and the transfer of technologies according to need.

In my opinion, the 10-Year Health Plans left us very valuable lessons that would have been enriched with new experiences in time, had the exercise continued. Unfortunately however, it did not. The plans underscored the significance of health to progress and well-being. They promoted joint efforts by governments and international organizations, with the leadership of PAHO, to promote disease prevention, health protection, and the timely treatment of patients. Moreover, their emphasis was on systematic planning; a methodology that made it possible to identify the problems with the greatest impact, assign them an order of priority, establish measurable objectives for each of them, apply proven techniques and procedures, assess processes and impact, and reformulate the exercise. More important, perhaps, from a conceptual standpoint, as Governor Muñoz Marín of Puerto Rico pointed

out to me, “planning teaches democracy to reason.” In short, a basic purpose of the 10-Year Health Plans was to create the conditions to bring about Health for All, without expressing it as a slogan and a goal as WHO subsequently did.

The second event that shows that the Americas anticipated the concept of Health for All occurred in Panama. Around 30 years ago, Minister of Health Dr. José Renán Esquivel decided that the motto of his Ministry would be “Equal Health for All.” The concept was clear and precise and was bound up with the moral meaning of health, which accepts no distinction or discrimination among inhabitants. Health should be equal, in the sense that every human being has the right to benefit from the best quality services that the country has to offer.

Esquivel was deeply convinced that health should be a community achievement brought about with the active and informed participation of the inhabitants. To put his doctrine of Equal Health for All into practice, he toured provinces and communities throughout the country with staff from the ministry, calling on leaders and other inhabitants to crusade on behalf of their health and that of their families and neighbors. I had the pleasure of accompanying him on several of these tours and observing with deep satisfaction, the very positive reaction of people and their intention to collaborate. A distinguished pediatrician, Esquivel also had a great deal of experience in agriculture, which enabled him to promote family, community, and school gardens to improve the quality of food intake. This can be considered an expression of intersectoral work.

There was no democracy in those years in Panama and possibly because of this, the Esquivel initiative ended with his ministry. Only in a democracy are ideas tolerated that awaken a country’s conscience about rights and responsibilities, including those related to health. Dictatorships are characterized by insecurity, intolerance, ignorance, and the violent suppression of every idea or purpose that might alter the social order. I am certain, however, that something of the meaning of health for human development and the sense that it should be equal for all remained in the spirit of the people of Panama.

Despite these events, which reveal that the Americas foreshadowed the WHO doctrine of

Health for All, and there must be others, we have the moral obligation to implement the doctrine as the basis of primary health care. Nevertheless, I repeat, we in PAHO must do it with the faith of a crusade that will lead to authentic equity. If we ourselves are not convinced, it will be difficult to convince governments, nongovernmental organizations, and the institutions of civil society interested in the social function of health.

It is useful to recall one of the guiding principles of the Declaration of Alma-Ata, which is that by the year 2000, all the peoples of the world should attain a level of health that enables them to live socially and economically productive lives. Primary health care is the key to reaching that target as part of development, in the spirit of social justice.<sup>2</sup>

It is also appropriate to list the activities included under primary health care as they appear in the original Declaration. They are:

- *Education on the prevailing health problems and methods to identify, prevent, and control them.*
- *Promotion of food supply and proper nutrition.*
- *An adequate supply of safe water and basic sanitation.*
- *Maternal and children’s health care, including family planning.*
- *Immunization against the major infectious diseases.*
- *Prevention and control of locally endemic diseases.*
- *Appropriate treatment of common diseases and injuries.*
- *Provision of essential drugs.*

These were, without a doubt, the most frequent health problems at the time and reflected the demographic and epidemiological transition of most of the countries of Latin America and the Caribbean. The appropriate technology existed for the prevention and control of most of these problems—a technology that is efficient, that can be financed by countries and individuals, and is

culturally acceptable. However, the problem was enormous. More than half the of the world's population did not receive adequate health care. All the more reason to undertake a collective effort to reduce this problem progressively and achieve Health for All. The 134 participating governments and 67 organizations of the United Nations made a commitment to this, as did the specialized agencies and nongovernmental organizations represented at the Conference.

In the 17 years since the Declaration there has been progress in some of these activities in certain countries of our Region. The data in *Health Conditions in the Americas* and other information sources back up this assertion. Among the notable successes has been the eradication of the wild poliovirus in the Americas. An important reduction in infant mortality and an increase in life expectancy at birth have also been registered. It is doubtful, however, that the progress is enough to meet the target of the year 2000. I would like to analyze some of the reasons behind this relative progress, which is proceeding more slowly than necessary and anticipated. The purpose is to capitalize on mistakes, because experience shows that even they can be useful as lessons; to avoid them in the future.

Health for All has been interpreted in ways that clearly depart from the original concept and conspire against fulfillment of the goals of equity and social justice. Some authorities have regarded it as a separate—that is, unintegrated—program under the health system. Viewed in this manner, it diverts resources that could be more productive: that is, that serve more people better. Others have regarded Health for All as geared exclusively toward the poor in rural settlements or areas on the periphery of major cities. Health care would be delivered through simple, and therefore low-cost, techniques, whatever their effectiveness. There have also been those who consider the strategy a parallel system implemented by nonprofessional health workers whatever the nature of the problems. Where the health systems were reorganized, the execution of Health for All remained an independent process.

It appears timely to recall the criterion of primary health care—the strategy for carrying out Health for All—as enunciated at the Conference of Alma-Ata. The Conference defined primary

health care as “essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation. “This, at a cost that the community and the country can afford at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and the main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of an ongoing health care process.”<sup>3</sup>

All the erroneous interpretations of the original concept that I have mentioned, and there are others, place a common emphasis on curative medicine, without the necessary attention to disease prevention and health promotion and protection. These conditions give rise to an unending process that does not reduce the disease burden and whose burgeoning costs obviate any possibility of financing, even in the absence of economic crisis. This is what is occurring in all the countries of the Americas, even the industrialized countries, and it should move the governments and all organizations, both national and international, to emphasize health when formulating their respective policies and to contribute the necessary resources.

- *David Tejada de Rivero<sup>4</sup> tells us that the four basic elements of primary health care are not put into practice (except in legislation and in speeches):*
- *There is no real decentralization (this is disguised by temporary and revocable delegation of authority within the bureaucracy).*
- *There is no effective participation and social control (at most, there is consultation and information for the formal ratification of the decisions made by technicians).*
- *Technologies are not carefully selected and adapted (they are not adapted to the circumstances nor can they be used by the population itself), or else, the selection is done*

*independently of, and in tandem with the indiscriminate adoption of sophisticated and expensive technologies in the traditional health services system that operates parallel to PHC.*

- *Primary health care is reduced and limited to the bureaucratic services of the Ministries of Health and some other institutions of the so-called sector (there is no effective multisectoral action).*

During the evolution of Health for All, targeted primary care was introduced, which concentrates resources on certain health activities. Significant among these are immunization against specific infectious diseases; oral rehydration in cases of acute diarrhea to prevent dehydration, which can cause death in children; and vitamin A supplementation to prevent nutritional blindness. The value of these interventions is indisputable, and they should not only be maintained but their coverage increased. However, this is a limited approach to comprehensive primary health care as enunciated in the Declaration of Alma-Ata, which considers all human beings in their need for health promotion, disease prevention, diagnosis, and timely and effective treatment when they become ill. Moreover, targeted primary care creates an image of health care that is conceptually simple and low-cost; it is implemented using simple techniques applied by auxiliary health workers and requires a smaller budget. In addition to contradicting reality, all this leads political authorities to make decisions that, in the medium and long term, are not going to benefit the population.

The economic crisis of the 1980's clearly led to structural economic reforms, which gave rise, in the final analysis, to a marked reduction in social investments, among them health. In some countries this led to a serious deterioration in institutional care without an intensification of preventive interventions for certain diseases and health promotion. The image of simplicity fostered by this targeted primary care explains why those responsible for decision-making on health policies, programs, and budgets believed that they were proceeding rationally for the benefit of their populations and communities. And they were not, as time has told.

There is evidence that, however well formulated, health policies and programs do not in themselves solve specific problems. Other development sectors have a positive or negative impact on improvements in health. Among these sectors are education, agriculture, the economy, work, trade, tourism, and transportation, to cite a few. Nutrition, linked as it is to agriculture and the economy, is an example of the complementarity that exists among the components of development to produce and sustain good health. To summarize a great deal of research, it can be stated that good nutritional status is essential for the normal growth and development of children, their attention span and cognitive abilities and school performance, the productivity of adults, and longevity. Good health and proper nutrition are reflected in the quality of life and lead to the joy of living. With respect to foreign affairs, Dr. Alleyne points out that "national health is a matter of international interest."<sup>5</sup>

Other examples can be cited justifying a multisectoral approach in order to carry out the functions of health with a better likelihood of success. While this is what we have been preaching, it is not what we have usually practiced. What is serious is that with the same resources, we could have raised the level of health and extended it to more of the population. Moreover, we have not fulfilled what the Background Document of PAHO indicates<sup>6</sup>; that is, if health is not among the key objectives of national development, it is only with great difficulty that the health services on their own be able to bring about Health for All, even if they are very well provided with resources.

A strong current of opinion holds that health is essential and should be accorded high priority in objectives and resource allocation in order to guarantee sustainable human development. In addition, as we have seen, health must be a key element when formulating, analyzing, and implementing economic and social development plans, as well as those related to the modernization of the State. Those who speak for health must insist on the moral obligation that we all have to protect our health and that of our families and to promote the health of all citizens. Without health there can be no sustainable human development nor better conditions to foster economic growth and the changes that lead to fair and equitable development.

We have not even integrated the institutions within the sector—that is, the Ministries of Health, the social security services, private insurance, the nongovernmental organizations that cooperate in health, etc. All of these institutions should contribute toward the formulation and implementation of the national health policy promulgated by the State; all should participate in the design of programs, apply the accepted regulations and procedures, implement them, observe their development, evaluate and report on the results in terms of the established objectives. The government should periodically issue a report on these national efforts. No matter what the coverage of the social security and private insurance systems, they cannot proceed independently—much less discriminate against those they serve—and ignore the country's interests with respect to improving health. A mechanism that can facilitate this process is the National Health Council with the participation of all the agencies indicated and a solid Technical Secretariat that, among its other responsibilities, can identify problems and suggest solutions to the Council for approval.

While the prevailing market economy in all the countries of the Americas has promoted economic growth and bolstered the income of large sectors of the population, it has also, unfortunately, brought with it an increase in poverty and indigence as defined in each country. In this latter category, the disease burden is much higher, as is the mortality rate. It is essential to implement the policy of Health for All and the primary health care strategy, not as an approach aimed at the poor, but as a comprehensive approach to which all citizens have a right.

Few countries guarantee the use of health services on the basis of need. Coverage is limited for geographical, economic, technical, cultural reasons or because of a lack of information. Poor roads and transportation in many parts of certain countries make it impossible for people to reach the health units on time, and they often lack the resources to pay for the care. Also, the techniques employed are far from adequate or people do not accept them due to life-styles or cultural differences. Even worse, people jeopardize their own health because they are not properly informed. The State and civil society should control these factors, which keep Health for All from being realized. Only then will there be genuine equity, solidarity, and social justice.

There has been no continuity in the execution of the Primary Health Care strategy, whatever the approach. As indicated in the Report of the Director's Advisory Group, this continuity is essential for ensuring the sustainability of the changes over time, and it will enjoy greater success if it is grounded in a change in attitude and practices among the population.<sup>7</sup>

We have spoken a great deal about decentralizing the health services in the sense of transferring decision-making power and resources to the local health authorities. These are usually provincial, departmental, or municipal, depending on the political and administrative structure of each country. This process, where it has been attempted, has turned out to be more complex and far more costly than it seemed. In the final analysis, it requires a substantial change in behavior on the part of the officials to whom the new authority and responsibilities are transferred. As Fromm, a distinguished psychoanalyst, said, "man is afraid of freedom." The natural tendency is to continue to consult the central authorities and to share responsibilities, especially in the most complex decisions. This does not facilitate real decentralization, particularly when the goal is to modernize the State by making it smaller, more involved in policy-making than policy execution, and devoted to establishing general norms and procedures.

Experience shows that a bad decision is better than no decision at all. A bad decision can always be corrected to make it effective. Paralysis interferes with progress.

Efficient decentralization fosters intersectoral relations to improve health. At the local level, joint programming of the activities of several sectors is more frequent than at the central level. Relationships involving greater collaboration among decision-makers may be generated. As Aristotle pointed out, a community is viable when everyone recognizes the face of his neighbor.

We should bear in mind that a growing current of opinion proposes that decentralization go beyond the political and administrative structures of each country and focus on human beings. This view regards health as a right recognized by the United Nations—a right that should be translated into the opportunity to benefit from the best services that a country has to offer. At the same time, each of us has the duty to

protect our own health and that of our family and to promote the health of our neighbors and the community in which we live.

The WHO/UNICEF<sup>8</sup> Report on Primary Health Care clearly states that community participation is the process whereby individuals and families assume responsibilities with regard to their own health and well-being and that of the community, and improve the community's ability to contribute toward its own economic development. They arrive at a better understanding of their situation and discover incentives to solve their common problems. This makes it possible for them to act as agents of their own development instead of passive beneficiaries of development assistance. To accomplish this, they must understand that they do not have to accept inadequate conventional solutions but can improvise and innovate to find desirable ones. They must acquire the necessary skills for assessing a situation, weighing the various possibilities and calculating what their own contribution can be. Just as the community must be willing to learn, the health system must explain and advise, as well as provide clear information on the positive and negative consequences of the proposed activities and their relative costs.

There are many who believe that the goal of responsibly incorporating human beings into the complex process of protecting their health and that of their families and promoting the health of all is the most rational mechanism for reducing the disease burden and the growing costs that it entails. Without this community contribution, as we have said, it will be not only difficult but impossible to finance the health systems in all the countries, be they industrialized or developing. I have argued that, in addition to being the good most valued by each human being, health is a productive investment and not an unproductive expenditure because it creates human capital.

The eight essential components of Primary Health Care that we listed are still valid, because they have not been fully met and we cannot claim to have met them. What is important is to intensify efforts to move toward achievement of the general goal. However, I agree with the Strategic Priorities proposed in the PAHO Background Document that we consider bringing the original objectives truly up to date, taking the

experience gained and emerging problems into consideration. The objectives are:

- *to ensure access to education and health information, essential drugs, nutrition, water and sanitation, and utilization of the health services to the entire population.*
- *to reduce the negative impact of socioeconomic and political conditions on the health of the most vulnerable groups.*
- *to seek the development of populations that are physically, psychologically, and socially healthy, free of violence, doing so with dignity while respecting their cultural diversity.*
- *to facilitate access by the population to effective quality health services.*
- *to eradicate, eliminate, reduce, or control the principal diseases and conditions that adversely affect health, with particular attention to the control of emerging or reemerging diseases.*
- *to permit access by all people to safe and healthy environments and living conditions.*
- *to ensure the availability and application of knowledge and technology to improve health.*
- *to mobilize actors and resources at the national, regional, and international level to support the attainment of Health for All.*

This is an ambitious agenda justified by the great moral significance of health. Subsequent to a situation analysis with respect to the functions proposed, each country will establish an order of priority for these objectives, with the commitment at the highest political level to fulfill all of them, which includes financing them.

The Pan-American Health Organization in its own right and as the Regional Office for the Americas of WHO, must continue to exercise genuine leadership among the international organizations that cooperate in health to disseminate the concept of Health for All and give form, content, and extension to primary health care with their collaboration. Organization staff

must carry out their important work with the firm conviction that they are actors engaged in a great enterprise for well-being and progress in the Americas. This spiritual resolve will enable them

not only to devote themselves fully to their noble work, but to hone their creative imagination and innovate so that Health for All will become a reality.



**Dr. Juan Carlos Veronelli,**  
*Representative of PAHO/  
 WHO in Uruguay*

I must thank the Director's office and the Chief of DAP for the opportunity they have given me to participate in this meeting. I vividly recall the emotion that I felt—a mixture of joy and surprise—the first time I was in this hall. Today's emotion is a mixture of fondness and the beginnings of nostalgia, and it is also sweet.

I must confess that I resisted to the utmost what I am now doing—that is, thinking out loud—knowing that you deserve a more well-thought out presentation with much more time spent in the manufacture of the message. I could not resist Dr. Sotelo's request, because I have great respect for him and still greater fondness, so you will be the victims of my weakness.

Many of you know that to acquire fluency in the traditional language of international documents—something we all do—is a skill that understands the relativization of the debatable, the enumeration in which no one will feel left out, the valiant emphasis on what cannot be argued. I cannot and will not use that language with you, which I distrust even though I am sometimes forced to use it. A few years back, when I had to do a job in my native country, I stated that I wanted to devise a measure that would be so difficult to express in words that it would have to be done with action.

I am afraid of language, because I learned from McNeill that when faith evaporates, only ritual and routine remain, and you deserve only my messages of faith, few though they may be.

Juan Manuel communicated his request to me last Tuesday in Brasilia. I began to read the material that DAP has provided on the return flight from Montevideo; The San Francisco Charter of 1945, in which the word "health" was incorporated at the suggestion of the delegate from Brazil; the proceedings in which the recommendation was made to create a health agency; the preamble of the Constitution of WHO, approved in 1948, which establishes health as a basic human right and the objective of WHO as

the attainment by every human being of "the highest attainable standard of health."

I reviewed the 10-year Plan of the Charter of Punta del Este for the decade 1962-1971 and the 10-year Plan for 1972-1981. In both, particularly the latter, the demand for equity and the denunciation of inequality seem clear and explicit.

I reread the Declaration of Alma-Ata and the documents from the meeting in Riga. I remembered the impression that the charismatic Halfdan Mahler made on me and the discussions that we had here, in this house, during the meetings when the Plan of Action was presented. We joked during coffee breaks, imagining the documents in which we would explain in 1995 why things that have been largely achieved today had not been accomplished. The demand for equity, for social justice, is present in all those documents. It was and is valid and legitimate, expressed as a desirable situation for the year 2000 or beyond. With a timetable, it can be called a goal. With no timetable, it is an objective. In order to build a political consensus and disseminate this message among the population, its articulation should be brief and require no further explanation. If adopted on the basis of individual action, as in the World Health Assembly of 1977, it will be difficult to implement and perhaps even presumptuous to attempt. If the focus is the population, as in the preamble of WHO or the Declaration of Alma-Ata, goals can be established with different timetables.

What is the value of this exercise? I believe it is always necessary, and I am certain that it is necessary today. I have always wanted to learn praxeology, the study of human action that Raymond Aron dreamed about. Hence, for years I searched in planning. Among the most useful of principles, I would place the advice of Goethe, who said that one should always keep reality in mind, but should lean on it with only one foot, placing the other on the vision, the objective, the ideal, or the dream. And if it is a shared vision or objective, or dream, then nothing is impossible.

To share that vision or objective, it should be well framed and communicated with zeal. Like that dream of Martin Luther King, which continues to move us, it cannot be limited to rational

discourse or directed solely to the intelligence, if it is to arouse the fervent support of other wills.

An example of this discourse, which speaks to both the intellect and emotion is a single statement, one of many by Dr. Mahler (World Health Assembly, 3 May 1988), who said that in order to improve the health of a society, it is necessary to improve the health of its less fortunate members. This is not simply an epidemiological platitude but a moral obligation, the principle of principles that WHO has promoted since its inception.

I believe, then, that we should renew the objective, either in its current form or in some other form that has the characteristics described. However, I also have a moral obligation to communicate to you, without ritual or routine, those areas in which my faith evaporates.

For years we said that health was both a means and an end. I myself repeated it and taught it, although I stated that, for me personally, it was essentially a means. We also said that it was a means to, and an end of socioeconomic development, an expression that the United Nations has replaced with another, richer term, "human development." I believe that health is a means to and a part of that human development. It would be good to come to an agreement and simplify this concept, so that everyone can understand us. Health is important enough for everyone to make it unnecessary to raise altars to it or to attempt to expand its scope.

In those limits—or *vicinities*—it is related to all other aspects of life, but it does not contain them. Saint-Exupéry said in *Citadel* that when you write, you are loading a ship, but few arrive. They founder at sea. Few phrases have retained their resonance throughout history—perhaps because they have sought to mean much but have captured little. Let us take care not to overload our ships, lest they founder. This way, it will be easy to lead them, no matter who is doing the leading: ourselves, health workers, or people in the community or the family.

Let us now move to the other strategy of Alma-Ata, Primary Health Care. I understand and agree with what they were trying to convey there, but I believe that the ship was overloaded in port.

Whitehead, in his Introduction to Mathematics, quotes Lewis Carroll's *Alice in Wonderland*: "Humpty Dumpty says that he pays words extra so that they will mean what he wants them to." We pay the words "primary health care" so that they will not only signify a Copernican revolution in the organization of the health services system but also encompass basic sanitation, local development, participation, training, the intersectoral approach, and the referral system, among other, also important things. I believe that we have exceeded the limits of an extra payment.

The interpretation of our former Director-General of WHO encompassed even more, especially his rejection of medicalization, technological excess, the pretension to omnipotence of some interpreters of the role of medicine who could not read McKeown. I largely share Mahler's attitude, but I do not believe that using anathema or caricature will alter the situation. Nor do I believe that change can be brought about only through the medical schools or by reviling hospitals as cathedrals of technology while they continue to absorb the lion's share of the health budgets.

Many of the ministers of health with whom we must work to bring about change, have been trained in that environment which we want to change. We must ensure that they understand us without offending them. The system that is to be changed has created within and without, a web of interests, and it still enjoys credibility in many societies. We all know that health is not synonymous with medicine, but some physicians believe that they are the only legitimate dispensers of health.

Finally, I would like to devote a few words to the situation on which our future will be based, in order to support the other foot. Allow me to take liberties with Saint-Exupéry, repeating with him that providing for the future is, first and foremost, thinking about the present.

The Region's present is characterized by the democracies won in the 'lost decade', the globalization that permits protection only of the strongest, the rise of the free market—which also flowered in the China of the Mongols or the Great Britain of the 18th century—with the colonial arrogance that resists to the death. It is as bad a

time as any that man has had to live through. The growth of the possible compels us to define more precisely, the desirable.

In our Hemisphere, one of the most peaceful on earth, population growth is beginning to slow. The demographic transition in the Americas is complete in some countries, and those in which it is nearing completion are many. In some, or in some parts of them, the process has just recently begun. The epidemiological changes that are occurring in tandem simply highlight the importance of behavior in determining or influencing health.

The health situation has improved. A good part of the achievement depends on the greater self-confidence and better education of half of the Hemisphere's population: women. Confidence and education that they won by themselves, despite what appeared to be the natural order of things. A Uruguayan historian, José Pedro Barrán, recounts that foreign travelers were surprised at the spontaneity and independence of Uruguayan women. Men there are as macho as they are everywhere, but Uruguayan women average more years of schooling today than men. It is women who have determined the size of their families and utilized the means available—*many of them very simple*—to reduce mortality among their children. This contribution has led to a marked increase in life expectancy.

We in the Americas are not only free of smallpox but have also eliminated poliomyelitis and are on the verge of achieving the same thing with measles. Cholera reentered the Hemisphere by the door that we left open when we allowed the urban population to grow, to lack the necessary sanitation, and when we made it possible for economic adjustments to allow the deterioration of the maintenance of our sanitary infrastructure. However, this time the case-fatality rate was low, even in countries where the hospitals were on strike for higher wages. We knew how to inform and provision the population, which was the hero on this occasion.

We acquired defenses against some hemorrhagic fevers, but we could not prevent new pandemics. Dependent as they are on behavior, these scourges can be controlled by our population, if we find the right messages and the right audiences.

We committed errors in the move from vertical campaigns to comprehensive programs in the services, and malaria exploited our lack of skill.

We have achieved much, yet there is much left to achieve. We sometimes hit the right note, at other times we face a challenge.

Medical care will continue to be an important determinant in populations in transition and will lose out to health promotion when the transition is complete. Our message can help to change systems prepared for episodic health care to others that ensure greater continuity. It can also preserve the environment, perhaps the greatest problem looming in the uncertain face of the future. However, learning to express ourselves, we can gear our message toward governments and peoples. Machiavelli spoke to the people in order to educate the prince. We can speak to both princes—*that is, to the people*—and governments. Mass communication is open to us. Every day, the population of the Hemisphere will be better prepared to understand us, if we are clear and unpretentious but at the same time fervent. The rest is empty words. Borges said that, from the standpoint of eternity, conservation and creation, words that live in perpetual struggle are synonymous.

I have tried to load this little ship only with a few ideas. I do not know if they are true or false, but they are indeed fervent. The boat is not yet seaworthy; it is only ready to reach you, who are nearby. This I believe it will do, when we are separated by space. I am more fearful about it traveling through time. Perhaps fervor will protect it.

## **Dr. James Sarn,** *Save the Children Foundation*

Distinguished members of the PAHO staff, ladies and gentlemen, it is a distinct pleasure for me to be present with you today and to have an opportunity to be on a panel with such distinguished guests. It is also a pleasure to talk with you about these very interesting issues and to help provide some background and ideas for your discussions over the next few days.

I was very fortunate to be a member of the WHO Executive Board Working Group on the WHO Response to Global Change which looked at trying to make positive recommendations regarding the impact of major global health, economic, environmental and political changes upon the Organization. As a matter of fact, I ended up being the editor of that report which became a major activity and effort of the entire Executive Board.

The report and the effort, I might say, came from a genuine concern by the Executive Board, back in 1991 and 1992, that we were not going to achieve the goals of Health for All that were laid out at Alma-Ata. We looked at the need to have some very strong mid-course corrections. We reviewed some of the individual problems preventing the full achievement of HFA, which included the level of expectations of HFA, the actual capabilities within the countries and the Ministries of Health and the financial and institutional capabilities of the international organizations, particularly WHO.

That overall look was basically provided in the Report of the Executive Board Working Group in the WHO Response to Global Change. I am going to mention several things in my presentation with regard to that report. Although, in general, formal responses to each and every issue raised by the EB have been provided in that report, I believe the organization has not sufficiently faced the core issue of what we need to do in correcting the vision of the international health community to achieve HFA, one of the most noble and important, global collaborative undertakings.

In reviewing the questions presented for your deliberation over the next few days, there

appeared to be several questions within your work scope that seem to be asking similar questions on the work of the EB. These questions regard various aspects of the goals of HFA, Primary Health Care coverage and strategies being implemented (sic achieved) by countries in your region. In addition, you are examining other important related issues. What kind of major changes and events have transpired since 1978? What kind of health services have become more effective and efficient? Which services are lacking? What are the major issues regarding improved equity? The EB attempted to put forward some similar questions, ideas and vision, to deal with these issues, in particular the problem of equity. The targets of your meeting are so important for strengthening PAHO's future work that I must congratulate Dr. Sotelo for his excellent background papers and agenda and for getting us all involved in these critical issues.

Possibly, from my "new" perspective as an NGO staff member, I might begin to look, in some limited way, at some of these issues outlined in your materials with regard to how the United States has responded to implementing HFA on a national level. The basic issue for examination would be to what degree have we been able to fulfill the goals of HFA in the United States between 1978 and the present?

I believe that if we look at the health achievements since 1978, many of us can feel a sense of accomplishment and very good about our work over these years. In particular, globally, we are seeing a major revolution in child survival, decreases in infant and child mortality, increases in longevity, increases in the coverage of basic primary health care services, enormous advances in medical sciences and significant global reaction and mobilization to unexpected outbreaks of such emerging diseases as AIDS and recurring problems such as tuberculosis and sexually-transmitted diseases.

If one looks at the health situation in the United States, I do not think that we can take the same full sense of pride, as many countries in other parts of the world have far outpaced our recent achievements. There are some very cold and hard numbers that indicate that while the United States has made progress since the

beginning of HFA, relative to many other developed countries we have "lost ground." For example, over the last twenty years under-five mortality has decreased from 30/1000 live births to 10; infant mortality has decreased from 25/1000 to 9, and overall life expectancy has increased from 70 to 76.

At the beginning of the conceptualization of primary health care, relative to the rest of the world, these key indicators ranked the U.S. as the tenth best globally, however, now we are no better than 23rd. What was happening in the U.S. while the rest of the world advanced so rapidly? Although the U.S. did dramatically increase its health budget, most of the resources did not go into primary health care, prevention and promotion but instead went into expensive secondary and tertiary curative services and the administrative expenses of multiple insurance and delivery systems. We were, to paraphrase Dr. John Knowles, spending more and relatively feeling worse.

We developed a health system that brought new heights to technology and "quality" to all types of high and low-priority curative care services, but at the same time, underemphasized prevention/promotion and created enormous problems of equity. We also had a relatively underfunded public health system trying to take on too many secondary and tertiary care responsibilities through Medicaid and Medicare, while losing a vision of priority preventive care issues for all Americans.

Although the public health sector, attempted to bring back a priority promotion and preventive health vision, inherent in HFA, through Healthy People 2000, the resources necessary for implementation were limited. Whatever public health resources that were available began to be progressively directed to pay private providers for curative services in Medicaid and Medicare. The private sector has increasingly moved into becoming the major provider of Medicaid and Medicare, and along with the services have come an even greater introduction of costly technology, frequently at the expense of prevention, promotion and HFA.

We can see these issues playing out right now in the (news) papers every day, mostly in partisan political dreams, and I do not want to go

into details of that now, because day to day descriptions in the papers provide sufficient details. But, I do think that the priorities of the debate have been changed by national leaders over the years from a concern and commitment for the humanitarian side of health issues to a greater concern for very complex management issues and financial arrangements and, of course the ultimate bottom line, the enormous political stature and capital associated with manipulating the issues; all of this, as the overall U.S. health status relatively continues to get worse and the need for HFA gets greater.

Somewhere, along the path to HFA, we got lost as a country, and to some extent globally and also within WHO. More alarmingly, to a greater extent, the only "sign" our leaders are reading is that we are not lost at the beginning, brimming with vision and determination, and we are not lost near the end with HFA clearly in sight and only in need of one final push, but that we are lost somewhere in the middle without a clear sense of direction, "will" or determination to find our way to our acknowledged goals.

Now, the way out of this dilemma seems to be one of the key questions that we will be asking of you over the next few days. I would not presume to have a corner on the answer, but I will share some opinions from the point of view and perspective of an NGO.

First, although there were visions, goals and strategies for HFA that emerged from Alma-Ata and subsequent deliberations of WHO with national governments, these concepts were never fully transferred to the local political and professional health and medical care levels. In the United States, at that particular time, I was a state public health physician and later Health Director for the State of Arizona. The message of HFA never permeated to us through the Department of Health and Human Services or any other national organization, although at the same time national leadership participated in international for a drafting and supporting HFA concepts and programs. The issues of HFA were never determinedly communicated nor discussed or identified in federal-state-budgets, and so it never really became a vision or a target for organizational activities, at the state and local levels. Therefore, "buying into" to the vision and strategies really did not occur sufficiently enough,

if at all, at the local levels. Certainly, the people who attended the Alma-Ata conference did their best to develop a forceful, clear, simple vision but the follow-up by participating and supportive governments, specifically in the United States, simply got lost along the way. If we are ever to achieve HFA, health leadership must learn to be better communicators and visionaries to affect the political process and to change the behavior of our own colleagues in the health professions.

Second, we seemed to have gotten lost along the way in management. We found new management technologies to concentrate on, invest in and “play with” and we lost sight of coverage goals for essential HFA primary health care services. We believed that we were going to be able to cure equity and service-delivery problems by introducing ever more complex management information systems, cost-effectiveness and cost-efficiency studies and more consultants. Along the way, we sometimes never even made meaningful contact with the community or the client before we ordered the next program, study or even prescription.

Actually, one of the reasons for the “Global Change” report by the EB was that in our deliberations with program directors at WHO, we rarely came across any official who would state that increasing national implementation of HFA, or expanding the coverage of primary health services, was a major concern of their work. Instead, most were lost in a world of administrative requirements, bureaucratic management techniques and objectives that seldom returned to HFA goals, except at budget development time. There was literally no one that actually focussed every day on how their activities would lead to improving HFA goals and targets and extending services to the most needy of the world. If this is not lived or espoused daily at the “headquarters” of HFA, how can it be a focus at the peripheral or local levels where resource levels are even more acute? To an even further extent, in the United States the vision of HFA has drifted far from the scope of most public health leaders.

Third, we seem to have forgotten how to build on our successes in public health. Our leaders are always looking for a new paradigm or new program, e.g., primary health care begets child survival, which begets integrated case

management . . . or is it the reverse? Successes of interventions become lost in programs and jargon. Successes are nurtured and built upon. In the United States, this has reached epidemic proportions as has the number of “new” agencies implementing programs, highly similar to existing agencies, which suddenly become “competitors” and add to the overall national administrative and organizational costs and structures. Although 90% of those structures could easily fit under the normative umbrella of HFA, primary health care services and existing agencies proliferate.

Another related aspect of public health services in the United States today is a lack of a unifying vision or coordinating principles. There are few compelling central or articulating visions provided by governmental officials. Instead there is in place, a vast array of seemingly, and actually, uncoordinated vertical programs and budgets with few common priorities or impact measurements. Administrative reorganizations seem to be substituted for meaningful vision, strategies and targeted achievement of health promotion, disease prevention or even essential clinical services. Everything seems subject to budgetary trade-offs and processes appear more important than content.

Although there is a lack of “another” vision, there is an absence of “buying” into the wisdom and acknowledged critical importance of HFA, or even in the United States, to the concise plan of Healthy People 2000. Successfully transferring the many successes of basic primary health care activities to needy, uncovered populations, by any name, seems a more important task than ever for WHO, through educating national leadership of the highly cost-beneficial programs at their disposal.

A key question that you will address in your deliberations is how can organizations such as PAHO improve their vision, expand successes and integrate the response to HFA in a global, national and local context to improve service delivery. A possible way to accomplish this formidable task is to build a better sense of partnership in order to strengthen the delivery of services. This has been an effective mode of operation for international NGOs both globally and nationally, and it is well known to PAHO. These partnerships should not only be with governments and the medical care community, but also, and

especially, with communities and clients. The partnerships should not only be viewed as additive but also a way to divest responsibilities, resources and authority to appropriate implementing organizations.

Partnership opens a number of issues for redebate and necessary change. Most important seems to be making partnerships as transparent and equitable as possible. These may require some innovative approaches to current institutional relationships.

For example, there was a very interesting announcement recently regarding the "planned" breakup of AT&T, a company that realized that it could not do everything in a cost-effective manner and could be more effective by divesting responsibility and resources to separate but presumably collaborating entities. This is a very important message to many agencies and governments that over control resources, authority and responsibility.

Another important message for achievement of more effective HFA partnerships maybe the need to place greater responsibility for health behavior and service delivery in the hands of clients and transparent community leadership. "Professional" and governmental direction, through unnecessary controls or licensure requirements, can unwittingly restrict the

provision of critical services. Service delivery expansion can often be realized and standards of quality can frequently be upheld, or even strengthened, through the provision of services by partnerships and training, of key community personnel. In the United States the pendulum of licensure professionalization and "litigation" of many key health services has appeared to become an obstacle to the health and well-being of the community. Brave new steps to reclaim client and community responsibility and control of technology is needed to balance, more equitably, issues of health service availability, accessibility, costs and "safety."

In finding a more rapid road to HFA, it appears important to communicate a greater sense of vision, to simplify management and emphasize service coverage and to build on successes instead of reinventing effective delivery systems. Expanding partnerships, particularly with community leadership and organizations, appear to provide an important, existing bridge to accelerate implementation of HFA goals. The open and frank deliberations that are scheduled over the next few days to strengthen HFA, demonstrate the continued leadership that PAHO has shown to improve the health of the peoples of the Americas.

We all look forward to the outcome of your deliberations.

**Remarks by**  
**Dr. Mirta Roses Periago,**  
*Assistant-Director*  
*of PAHO/WHO and*  
*Moderator of Panel*  
*Discussion*

The presentations of our three guests have been truly excellent and stimulating contributions that reveal the complexity of the work ahead of us. They have elicited questions and comments from the audience.

To sum up very briefly, we would state that there was a consensus on the importance of renewing the call for Health for All as a slogan that evokes a shared vision. There has also been agreement that in the period since Alma-Ata, new paradigms of *development, public health, and technical cooperation* have emerged and consolidated, with the resulting impact on the role of the State, the international agencies, civil society, and institutions. If we declare then, that the principles of equity, social participation, and appropriate technology not only remain valid but urgently need to be applied; for example, we must ask ourselves what will be their most appropriate concrete and operational expression both now and in the future.

For example, we must ask ourselves today, what is:

- *community participation, understood as community organization, now achieved through the political movements of democratization and decentralization. Community participation can now be expressed as the organization of consumers/*

*users to guarantee social control over the quality of services. The criterion of "socially and economically acceptable" established for the definition of "appropriate technology" can also be expressed in an organized fashion.*

- *coverage, previously understood as a network of services (infrastructure), now places greater emphasis on access and incorporates innovative and creative forms that originated in communities during the prolonged crises. Examples of these are collective networks and community insurance, microenterprises, empowerment, etc.*
- *the intersectoral approach, which is no longer joint work and activities between health and education, or health and agriculture, or health and labor, but which requires conceptual alliances for the formulation and implementation of comprehensive policies geared toward the achievement of sustainable human development. It is necessary to conceptualize and operationalize an intersectoral approach that is capable of overcoming the dichotomy between the social and the economic, beginning with the recognition that "health" is both a social sector and an economic productive sector.*

And thus, given the new scenarios of health and development, for each component of primary health care, and for each of our programs, we must ask ourselves as we break up into discussion groups, What is the significance of what we are doing now, 17 years old after Alma-Ata? What difference must we make 17 years afterwards in order to reach our goal by the most direct and fastest route, because the pain and suffering in our Hemisphere demand it?"

Many thanks again to our guest panelists who have generously given of their ideas and their time. I wish you fruitful discussions.



## Reports of the Discussion Groups

### GROUP 1

This group analyzed the discussion guide and accepted it in the terms proposed. It discussed whether HFA should be modified, replaced, or renewed and opted in favor of renewal, given the current conditions.

***In view of the fact that the new proposal may include goals, programs, and strategies that have not had the success anticipated in the past, why do you believe that they can work now?***

The group analyzed the successes and failures, using the lessons learned from the latter to search for ways of adapting to the current situation.

The vision of Alma-Ata remains valid, with its proposals for an intersectoral approach, community participation, social justice, and equity. Alma-Ata helped place health on the countries' political agendas and contributed in some cases to an increase in health service and immunization coverage. It must be noted, unfortunately, that the vision was not accepted widely enough, there was inadequate preparation for its execution, and the mission was interpreted as the goal.

For the renewal to take place, it was considered important to analyze the context in which Health for All originated and that of today. In the 1970s the countries of the Region underwent a number of highly complex transformations associated with the close of a period of macroeconomic growth that had begun in the 1960s and the beginning of the recession in 1978. During that decade, dramatic changes could be observed at every level: the evolution of new social relationships in some countries as a result of agrarian reform and the rise of sweeping social movements, pendular political changes marked by the struggle between democracy and military dictatorship.

Alma-Ata was proposed with a futuristic vision that assigned the State a key role as a

service provider. Under Alma-Ata state social security systems blossomed and grew. Normative planning was promoted as a tool.

In the current context, the general trend is toward globalization, expressed in the emergence of complex networks for the production, distribution, marketing, and consumption of a variety of goods and services. Technology is advancing at an increasingly rapid rate, while the role of the transnational corporation is growing ever stronger.

The State finds itself at a historic moment in which its role versus private sector participation is also evolving. As a result, it is essential to rethink the method of delivering basic services in health and other social sectors in the coming decades, in light of their deficient coverage and quality.

Some strengthening of the formal aspects of participatory democracy and the decentralization processes has occurred, with local governments beginning to play a very important role.

While social processes and, particularly, economic processes are spreading worldwide (although still unevenly and in incipient form in many places), health problems are also becoming global. For example, it is common knowledge that problems linked to violence, environmental pollution, and drug abuse are almost universal now. In the same vein, chronic diseases in the poor countries are on the rise, as are new infectious diseases. These are extremely complex problems, given the growing participation of regional and ethnic groups and of social movements on behalf of women, indigenous populations, and others.

***What is the meaning of the sectoral reforms being carried out in the countries of the Region, within the context of a new vision of Health for All?***

Reform processes are under way in the Region, but they are not uniform. There are a variety of reforms that respond to the interests and the ideological and conceptual positions of the institutions promoting them and to the peculiar characteristics and needs of each country.

Given this situation, a clear vision of Health for All assumes strategic importance. The challenge is to make the vision operational in this new context. The *Vision of Health* should provide direction and serve as the foundation for the proposed reform.

To ensure that these processes respond to the mission of Health for All, their components must be clearly defined. For example, the new role of the State must be defined to transform it from a provider of services to a policymaker and regulator. Intersectoral processes must be defined and refined; the responsibility of the family for its own health must be clarified. The reform will be valid to the extent that efficiency is subordinated to equity. In addition, the quality of care must be a component of equity. Although resources are available for the reform processes, it is necessary to understand that while they can represent an opportunity if we play a role as articulator, they can also be a threat if we cannot influence their use. Health for All offers other paradigms to the reform that do not focus solely on the provision of services.

To ensure that the new vision remains timely, some aspects that should be taken into account were discussed:

- *In rethinking Health for All, prioritizing and targeting must be considered.*
- *We must not forget that although the reform falls within the principles of Alma-Ata, it is not an end but a means. How can Alma-Ata make a proposal for so heterogeneous a Region? The solution is perhaps to define a product.*
- *WHO has had a corporate vision. Changing times have forced it (the Organization) to adopt a more modest and viable mission because it cannot offer all things to all people.*
- *The participation of other sectors that up to a short time ago were kept on the fringes can represent an opportunity or a threat to the extent that the question of how to meet these challenges is left undefined. It will be necessary to propose mechanisms to secure allies.*
- *It is important to focus the intersectoral approach on new and innovative forms, taking into account the traditional links between the*

*various social sectors and new actors who are beginning to participate aggressively, such as the private sector, banks, and financial institutions.*

- *It is necessary to extend the dialogue beyond the health sector and to open up to other sectors—sectors that up to now have not had any relevant participation but are beginning to play a very active role; for example, the NGOs.*

***What do you imagine the integrated health response in your national or local context will be and what characteristic would a renewed vision of HFA have?***

The Organization is faced with the challenge of defining a new approach that offers opportunities, new ways, and processes. It must combine strategic clarity with tactical flexibility.

It is essential to define priorities and selective action. The interventions devised relate to the particular needs in a specific context.

It should be understood that health problems are the responsibility of all and that the barrier of compartmentalization must be broken. It is necessary to strengthen the national vision and to recognize the need for action at the various levels.

Mechanisms should be proposed that facilitate power sharing and generate social responsibility in the community. Health should be for all and constructed by all.

It is important to stimulate internal reflection to arrive at a single consistent position. This should lead us to define the new role in relation to new and longtime actors and the need for securing allies. PAHO should search for and work with other involved parties.

It is necessary to define the role of leadership or partnership with ministries that are growing weaker day by day. Until now, relations with the Ministries of Health have taken a great deal of energy and, if maintained, these ties can turn into obstacles to the achievement of the great objectives of Health for All. In this definition, it is necessary to eliminate the Organization's seeming duality, with its country and regional levels.

It is essential to recognize the complexity of new situations and the need to respond in a more comprehensive fashion—the need for decentralized technical cooperation consistent with the processes under way.

The desired impact should be defined in terms of empowering the Ministries of Health in their new role as regulators and of readjusting technical cooperation to the new realities. The discussion should not be reconfigured to retain power but to take a position on doctrine.

***What factors, internal and external to the sector, would facilitate the formulation of healthy public policies?***

The group believes that this question has already been answered in several parts of the text. However, it would like to add two points: the need to disseminate the doctrine and to define not only policies but healthy practices. The promotion of Health for All should be accompanied by human development.

Finally, the group would like to express its satisfaction at having this opportunity for discussion and to congratulate the technical working group.

**GROUP 2**

The panel members analyzed world events with regard to Health for All, especially in the Americas, identifying its successes and failures, with particular emphasis on what was right about the initiative and what was not. They spoke of the current situation, with its economic and social currents, and the situation in the 1970s, when the goal of Health for All was formulated. In brief, the aspects touched upon by the participants were of such high quality and handled in such depth that it was not difficult for the group to participate in the exercise in discussion and contributions to enhance the work of the Organization in the meeting on Renewing the Goal of Health for All.

The group's account has limitations proper to this type of exercise; too great a wealth of ideas and thought to capture in a single afternoon and express in a few minutes.

***Introduction***

The goal of Health for All is closely linked with fundamental human rights. Health is the most valued of humanity's goods. Health appears in the universal declaration in the Charter of the United Nations, promulgated in 1944, which seeks to open horizons based on humanitarian ideals and brotherhood among all men, establishing the goals of a new economic order, peace, satisfaction of needs, and the abolition of social and economic slavery. These are the values that undergird the goal of Health for All: They are the inalienable rights of every human being.

***Conceptualization of the Goal***

From its inception Health for All was not conceived of as a dream in a utopian world without the sick or the disabled. The goal referred to a desirable and a feasible world, in which individuals, families, and communities enjoyed equitable access to health care; had better means of preventing and controlling diseases in their homes, schools, and workplaces; and were aware of their ability to free the world of preventable diseases and those arising from the behavior of individuals.

The goal of Health for All must be considered not only an objective that we wish to achieve, but a dynamic factor essential for change. Its chief potential lies in its immediate ability to orient and define policies, promote the design of appropriate strategies, formulate actions, and facilitate the creation and mobilization of the resources necessary for carrying them out.

Seventeen years after the goal was promulgated, it is legitimate to ask:

- *Was it a utopian ideal or did it lay the foundations for a greater understanding of what health means in the context of universal economic and social development?*
- *What are its achievements and failures?*
- *Which of its components, among them primary health care, did not achieve the proposed objectives?*

- *Was this due to deficiencies in their concept or to obstacles created by circumstances?*
- *How can it be made viable in the current context, when the political, economic, and social currents are different?*
- *How can it be renewed, now that the health sector is undergoing profound transformations?*

### **Analysis of the Components**

#### *Community Participation:*

Community participation was conceived as a strategy to promote successful development under a general scheme explicitly included in the national development and health policies.

Community participation takes place through a number of strategies, such as health needs assessment; the proposal of solutions and alternative models for the delivery of services; the programming, operation, and delivery of basic health services and environmental health services; the promotion of individual and collective responsibility; the mobilization and utilization of community resources; technical and logistical support; and the supply of equipment and inputs for service operation.

With regard to the inclusion of concepts, goals, programs, and strategies that were not successful in the past, there was an analysis of why community participation did not contribute as much as envisioned in Health for All and in Primary Health Care. The concept and the strategy ran counter to the political context of authoritarian governments that did not allow participation. When it did occur, it did so in situations that were usually limited to narrow programming concepts that diluted the broader concept of community or citizen participation. In other words, community participation was not utilized as conceived: democratizing national life and individual activity.

#### *Decentralization:*

As a strategy of Health for All, decentralization also suffered from misconceptions and improper application. The

1970s did not provide the best context, since decentralization of national life as a broad project was in its initial stages in most of the Hemisphere. Moreover, it ran counter to the extremely centralized and authoritarian regimes. Furthermore, when the processes began, they were often launched in a precipitous and irrational manner. What was intended as a strategic element involving participation and the active presence of citizens in the solution of their own problems, among them health, turned into failure.

Decentralization, as a form of democratization, is closely linked in the current framework to citizen participation. This strategy is likely to be applied better now, however, much of the concept of community participation, linked to local activities and efforts in the health services, was used and abused in the past. Citizen participation is a broader concept that is part of the current concept of development. As a result, decentralization and citizen participation are closely related.

#### *Health Education:*

This is the greatest achievement of the goal and the great achievement in terms of health. Examples in the Hemisphere demonstrate that education plans outnumbered health care plans. In the countries that strongly emphasized health education, understood as the democratization of knowledge in health for the good of individuals and the community, the achievements in health were superior. Health education was successful, and it will be the gateway to health in the 21st century as the basic expression of health promotion.

#### *The Intersectoral Approach:*

The intersectoral approach should go beyond what has been achieved up to now and what was described in the documents of the Organization. The intersectoral approach is an imperative for the work in health. Infant mortality and maternal education can be cited as examples of the intersectoral approach. With equal GNP per capita in two countries, infant mortality was lower in the one where maternal education was higher. When the income per capita is the same in two countries, infant mortality is lower where the maternal educational level is higher. In the past, it was assumed that the health sector was self-sufficient, which reduced the possibility of joint work with other sectors. In today's world,

and to renew the goal, the intersectoral approach should support the work in health. Other sectors should support the health sector by considering it fundamental to their own development. Without health there is no possibility of development.

#### *Primary Health Care:*

Primary Health Care placed too much emphasis on curative medicine. The concept of health promoted did not correspond to the orientation of the activities, which continued to employ a curative approach. Curative medicine continued to be favored over health promotion and disease prevention. Even community participation was directed toward disease. An example of this was the installation of oral hydration centers as a component of PHC instead of teaching how to prevent diarrheal diseases. However, the PHC strategy was perhaps the greatest contribution of the goal of Health for All. PHC was rapidly incorporated into the national health systems, becoming a central function of the services. It clearly influenced the first level of care and the initial contact of individuals, the family, and the community with the national health systems, becoming the first link in a continuum of health care.

PHC is now not only solidly incorporated into the health services but, transcending and encompassing other sectors, it will continue to be a strategic component of the renewed goal. Its emphasis should be on health promotion and disease prevention.

In the past the program aspects of primary health care did not and could not include current problems created by changing situations. The appearance of diseases derived from climatic changes, environmental degradation and the appearance of emerging and reemerging diseases have become new problems that must be included with programming criteria in primary health care.

The outbreaks of cholera, plague, AIDS, and violence demonstrate that primary health care programming and strategies need to be reviewed. It can be said that, in many ways, some regions of the Hemisphere are facing a real health emergency. This reality has had an impact not only on the level of PHC but also on the health services at the national and international level.

#### *The Indicators:*

While still important, the traditional indicators for measuring progress in health, based on the definitions found in the *International Classification of Diseases and Related Health Problems* (and therefore applicable almost exclusively to morbidity and mortality), are not appropriate for analyzing the new problems; stemming from the understanding of health in positive terms, or critical strategies such as health promotion. Efforts should be made to advance in the concept and the methodology of these new aspects in order to promote, whenever possible, the definition of statistics and indicators for the monitoring and evaluation of populations.

#### **Sectoral Reform**

Reforms are transforming the health sector; but whether they can adequately address the problems mentioned above remains to be seen. It is not clear what the final design of the service delivery system will be or whether it will be capable of attending to the future health problems of the population. These questions are cause for concern given the in-depth level of many of the reforms and their long-lasting impact on the quality, accessibility, and efficiency of the system. In terms of the public-private mix, it is not clear what the role of the public sector, particularly its regulatory function, will be. Social and individual responsibility are other areas of concern. For example, does the appearance of financial middlemen in health guarantee increased coverage?

The concept of a "basic package" or "health basket" directed toward specific groups may have points in common with the proposal for selective primary health care or care for certain people, which was rejected in the past. The reform proposals have not determined how they will provide coverage for poor populations within a structure for service delivery that will be in accordance with the payment capacity of the individual or the family.

Considerable urgency surrounds these and other questions in the renewal of the goal. Just as discussion has taken place about the emergence of health problems derived from adverse conditions and emerging diseases, an in-

depth analysis is required of the reform proposals, their ideological concepts, infrastructure, and implementation strategies. Questions arise such as: What contribution has reform or the reform processes made to the renewal of the goal? Are the principles and strategies of reform compatible with the assumptions of the goal of Health for All? What private interests are involved in the reform processes and what will their future impact be on health? What will the role of the Organization be?

Renewal of the goal should provide an opportunity for in-depth analysis of all the components of the reform processes. The Organization should act as a partner to the countries in analyzing and appreciating the benefits of the current reform proposals, which are often offered without much awareness of the history or current situation of the health sectors in the countries.

In order to meet these challenges—renewal of the goal, sector reform, health emergency—the Organization must review its own style of work and how it will face future challenges.

### **Health Promotion**

One of the strategies that has had considerable success in recent decades has been the priority given to primary health care. However, no matter how efficient interventions in recent decades may have been, the fundamental importance of education in achieving sustainability means that health education which brings about changes in habits is needed to ensure improvements in health levels, such as infant mortality. Thus, the principles of sustainability and irreversibility are interdependent with the educational system. Comprehensiveness in development is also reflected in the need for health problems to be attacked at different levels. (For example, epidemics of dengue require not only control of larvae and their breeding sites, but training for medical and nursing personnel to handle patients in shock. The first-level response is not always sufficient.) Thus, the primary health care strategy should be replaced with a health promotion strategy grounded in education and an intersectoral approach. In this vein, health in the 21st century should be sustainable and

irreversible for all, which would require healthy life-style as the only way to achieve health. This brings us to "Health for All and By All in the 21st century."

Although primary health care provided solutions, it was neither sustainable nor irreversible. Its achievements vanished with the stroke of a pen after a change in government. It did not lead populations to a point at which they could internalize the solutions to their problems. Yes, it helped to provide solutions; but it did not show how solutions could be found. In the dissemination of the idea that drives HFA 2000 and of the right to health, the primary health care strategy has developed significantly since Alma-Ata and has achieved important results. But there have also been ups and downs in its interpretations; Dr. Mahler himself had to clarify that hospitals were also part of PHC. These aspects underscore the need to review the strategy of health promotion in the renewed goal of Health for All. For us, it is the most comprehensive strategy, in conjunction with the organizational development of the first level of care; community rehabilitation, community hospitals, maternity homes, ambulatory surgery, the development of health education and mass communication, and the modification of life-styles as a basic element of the new participation in the health of all and with all.

Health promotion expresses health as a more comprehensive, social, and political phenomenon. It does not single out any particular level of health. Instead, it highlights the importance of social and individual responsibility for health and not simply the paternalism of exclusive state responsibility. It emphasizes the considerable effect of education on the solution of medical care problems, but only low technology solutions to health problems, without ensuring sustainability and irreversibility (as PHC has at some times been interpreted). It emphasizes the modification of life-style in the face of new epidemics, such as violence. The most effective solution to the health problems of the 21st century, regarding emerging and reemerging diseases and environmental degradation, will be an educated population.

Finally the group made the following suggestion:

All staff members as individuals and as members of institutional groups must have an accurate understanding of the stages, events, and activities that will be carried out for the Renewal of the Goal, since their daily work will involve them in this effort. Therefore, RMFA should not be the responsibility of any one unit of the Organization, but of all the staff members at all levels.

The group would also like to note the excellent quality of the document prepared by DAP much facilitated the discussions. Specific observations have been shared with a member of DAP so that the possibility of incorporating them into the final text may be considered.

### **GROUP 3**

The group decided to discuss what *renewal* means in general, what the renewal of Health for All specifically implies, and what the consequences of this process will be for us.

In the course of the discussion it was indicated that "renewal" should have two meanings: to renew the commitment and to adapt it to present conditions.

Emphasis was placed on the need to distinguish specifically between the defined objectives that are going to be achieved by the year 2000 and those that will not, in order to avoid falling into sterile discussion. Furthermore, whenever long-term objectives are established, the need will arise to stop and reflect on whether progress toward the goals is being made. By 1982, Dr. Mahler, who was then Director of WHO, had expressed frustration with the way in which the slogan of Health for All and the strategy of Primary Health Care had become debased and corrupted.

It was noted that a contradictory process is developing around the so-called "human factor". On the one hand, greater importance is being assigned to it, as can be seen in the UNDP reports on human development. On the other hand, within the health sector itself less weight is given to human beings than to concepts such as equity and particularly efficiency. Or even

worse; people lose sight of the fact that efficiency, to which they accord a higher value, is simply a subordinate means to obtain objectives, such as equity.

It was suggested that the renewed goal of Health for All is the task we inherit from the breakdown in paradigms. The "Health for All" slogan and the strategy of primary health care strategy reflect an ideology that in some cases became debased and corrupted, but in others was enormously positive and generated important progress and notable commitments to health. In this sense, Health for All is an objective as well as the guiding light of the Organization.

Workers' health was mentioned as a clear example of inequity and injustice; the lack of data and attention cannot conceal that in the past 20 years this area has been bereft of almost any progress. Three hundred people die every day in the Region from occupational accidents. There can be little doubt that there is an epidemic—or at the least, an endemic disease—to which very little attention is being paid. In the same vein, little attention has been focused in general on the problems of disabilities and health determinants, other than purely biological or technological factors.

It was noted that the renewed goal of Health for All should imply the renewal of the effort against such health risk factors as tobacco, which are recognized and controlled in some countries, while in others they are being irresponsibly promoted without government control.

It was also considered that if Health for All is construed more as a motivating idea than as an objective, then the renewal process must redefine the concepts underlying the terms "all" and "health".

Formulation of the goal of Health for All and the PHC strategy developed a new paradigm in which the concept of equity was essential. In this sense, the goal represented an important advance, since equity had often been considered an additional quality, not a central aspect.

The idea of Health for All reflected the ideological optimism of the postwar period, an optimism that was the counterpart of the crisis in liberalism prior to the World War II. Nevertheless,

the enormous impact that Health for All would have had on equity was largely undercut by the budgets of (economic) neoliberalism, so popular since the 1980's. It is not clear whether the goal of Health for All and its strategy can be maintained in the current climate in which neoliberal (economic) considerations continue to override all others. It was also noted that human life is now becoming more debased every day; witness the burden of violence in the daily life of many countries.

There was agreement in the group on the importance of renewing the goal of Health for All, because of the need to chart a course and because today's conditions are different from those of 30 years ago. Furthermore, all the orientations and strategies associated with Health for All need to be renewed and placed within a new context. The process of renewal should have two dimensions. The more important one is political and ideological. It implies rethinking and redefining objectives and general strategies. The other is the area of technical programming, which requires a specific reevaluation of established goals.

With regard to the *goals, programs, and strategies that did not achieve the success anticipated in the past and the reason why they might work in the future*, it was pointed out that one potentially important reason is the current existence of civil liberties in countries and a broad range of rights that would have been inconceivable only a few years ago. This does not mean that we can simply speak of "democracies" in referring to more or less legitimately elected civilian governments. Democracy is an aspiration that all countries share, and that has helped along by progressing toward health goals. In this regard, note was taken of the negative impact of economic adjustment policies on health. The opinion of supporters of such policies, acknowledge that the economic success of adjustment has also spelled tremendous setbacks for the population. In countries considered as "models" by the financial institutions, the level of social inequality and poverty have grown enormously in recent years.

It is likely that the strategies that failed in the past will also fail in the future. However, this should not prevent every effort to carry them out, given that they represent fair orientations and progress for the population. Technological progress can certainly rebound in favor of

progress in health. For example, new communication techniques can contribute toward strengthening democracy, and they need to be used in that direction. Technological innovations, however, can also have negative effects. Indeed, new technologies are often developed with a view to eliminating jobs; thus economic recovery may not generate jobs, and the persistence of high unemployment rates can lead to violence and a deterioration in living conditions across the board. In this sense, prudence must be employed in seeking changes in life-styles because the exposure to harmful working conditions or unhealthy urban environments or life-style is not a choice made by those who suffer their consequences. Young people can take the greatest advantage of messages favorable to healthy life-styles, and accordingly, they should pay special attention to the renewed goal of Health for All.

*Health sector reform* is often presented as an option that the sector chooses in seeking greater equity and justice. However, it almost always results from financial pressures outside the sector. Thus, it is necessary to exert every influence to ensure that reform does not jeopardize equity or the quality of services. On the other hand, rationalization of care can favor both equity and cost reduction, as evidenced by the unnecessary cesarean sections that upper-class women in Brazil receive, for example. The application of the risk approach contributes to equity, which does not mean exactly equal treatment for all.

In terms of *factors internal and external to the health sector that would favor healthy policies*, it was observed that the health sector should understand that its interests may conflict at any given point with those of other sectors. The health sector should thus be a catalyst for long-term interests as opposed to immediate interests in such areas as foreign trade or transportation. The health sector cannot ensure that tobacco or food manufacturers will abandon their profit-seeking goals, but it can indeed promote the prohibition of cigarette advertising and the production and distribution of harmful dietary products. Pointing out that specific policies are not healthy is a responsibility of the health sector. The expression "public policies" was considered inappropriate by virtue of its redundancy. Policy is, *a priori*, a function of the government and the State and is thus public by nature.



On the other hand, the need was considered to disseminate the goal of Health for All among students in the health professions. The vast majority of them have never heard of Alma-Ata or the strategy of PHC. The desirability of promoting knowledge of the ideas concerning the new economy has precedents in the *Small is Beautiful* example of Schumacher, which stems from a view that human beings count and that economic activity must serve them, and not vice versa.

Given the frequent weakness of the Ministries of Health, it is important to seek and promote other ways to promote policies that favor health. Alliances with emerging actors in the social panorama (women, young people, consumers' groups) can be especially important in achieving health. *Municipios* are the best area where alliances can and should be sought and integrated health policies can best be specified. The healthy "*municipios*" movement should be supported fully.

#### **GROUP 4**

##### **Introduction**

The participants of the English-speaking group gathered to discuss the renewal of HFA by the Year 2000. We used the discussion document as a general framework and considered the direction of public health in the Americas since the goal of HFA by the Year 2000 was declared at Alma-Ata. We examined the record of the health situation and health policy in order to draw lessons from failure and achievement. We questioned when and how public health successes can be tied to the Declaration of Alma-Ata, when health policy and the health situation in some countries did not change in its wake. We also considered what each of us individually and as a group might like to see Health for All achieve and what contribution the Pan-American Health Organization itself might make—ideally, but realistically, to that achievement.

It was suggested here yesterday and reiterated in our discussions that increasing health care coverage is what Alma-Ata is all about. But from our group's discussion it was clear that health coverage and health status are not one and the same. Improvements in the environment, work place safety, the quality of life of our urban centers, housing, access to drinking

water and sewerage systems, safety from violence; all of these are essential elements of a healthy society—every bit as much as medical care *per se*. And let us not neglect the paramount role of education—general education and health education—particularly among the mothers of today and tomorrow. Our children's health also depends heavily on our own judgement and the examples we set. And yet, when so many ingredients are essential to health, just focussing our attention becomes a challenge. But there is no alternative: we must learn to nurture both a broad vision and a sharp focus.

At this stage, I'd like to mention some of the obstacles we discussed, which prevented progress in HFA, then the achievements. Thirdly, our concept or vision of what HFA should be; next, what PAHO can and should do as an institution. And finally, why might we anticipate success in what we have failed to achieve over the 17 years since Alma-Ata?

##### **Problems**

- *Insufficient political support. With rare exceptions, there has not been sufficient commitment from the national leadership to HFA.*
- *The goal lacked clarity. It was overly broad. What did it mean? Was the vision ever defined? The message stagnated at the policy level. The sustainability factor was not considered. The mechanisms were not developed that would transmit the goal to the community level. At the same time the nonmedical sectors that are key to HFA were not enlisted.*
- *Authoritarian political landscape. Little opportunity for community development and participation under authoritarian regimes.*
- *Financial constraints. The debt crisis of the 1980s, the so called "lost decade". Who would pay? What measures were cost-effective? These questions were never satisfactorily answered.*
- *The strategy of PHC was treated as 2nd class care for disadvantaged groups. Primary health care encountered active opposition from vested interest groups.*

- *Finally, the technical capacity was not developed—in the countries or in WHO—which would lead to HFA.*

### **Achievements**

We have grouped achievements into five categories:

- *Health status outcomes*
- *Coverage for primary health care*
- *Organization and management of health services*
- *Better data and surveillance systems, and*
- *A more comprehensive concept of health and its achievement, through intersectoral approaches and partnerships.*

Many health problems have persisted or reappeared even as new ones have emerged. Yet, it is clear that there have been significant advances in the Region in terms of health status outcomes. Infant and maternal mortality rates have dropped, families are choosing to have fewer children, polio has been eliminated, and other vaccine-preventable diseases such as measles and neonatal tetanus have significantly decreased. There have been real gains in life expectancy. Moreover, coverage for the essential elements of primary health care has improved.

Yet, serious gaps and inequities in service systems still persist and in many ways have grown larger. As noted, immunizations levels are high and contraceptive usage is increasing. Maternal and child health services are more accessible, drinking water and basic sanitation systems are growing, and supplemental food programs and other nutrition interventions are common. Indicators have improved despite declines in the allocations of national resources in many cases.

In the organization and management of health systems and services we can certainly learn much from the successes in countries like Costa Rica, Cuba, Chile and in the Caribbean which have achieved increased coverage and improved health status, at least in part, through efficient and effective use of human and financial

resources. The technical capacity of providers and the balance struck among professional, auxiliary, and minimally trained health workers have been significant factors of this success.

Technology development has been key. New vaccines have been developed, along with economic means of production and storage, contraceptive methods are easier to use, and information systems are automated. In the case of the information systems, it is possible to have better data on health and quality of life in order to monitor and evaluate health care and health programs and to maintain surveillance systems for important infectious diseases, not to mention other indicators of health and disease such as nutritional status and cancer.

The fifth area in which our group found some measure of success is in the recognition of health as something more than the absence of disease. There is a growing acceptance of the need for intersectoral work as well as a recognition that partnerships are crucial in achieving HFA; partnerships with other sectors, partnerships with NGO's, private/public partnerships, and interinstitutional cooperation among agencies of the international system and the Inter-American system.

What can we learn from these accomplishments to help us as we renew our commitment to the goal of HFA and plot our course for the coming years. Our group identified seven important contributions to these successes, many of which were mentioned by our panelists yesterday and in the previous group reports. Leadership, commitment of government at the appropriate levels, research and technology development, community participation, appropriate use of limited resources, individual responsibility, and a worldwide focus on women have all been important in different ways.

Effective leadership is an important ingredient in success. Leadership at all levels; local, state, national, and international has been innovative, visionary and sustained. Subregional initiatives such as RESSCA, REMSA, CARICOM, and better targeting of interventions for vulnerable population groups have been important.

In the successes we can also see a common thread of research, both in the area of

health services and in health technology. Successes have maximized scientific discovery to prevent and treat disease as well as to solve health care delivery problems while at the same time being able to apply the most appropriate technology in cost-effective ways.

In general, where equity has advanced, so has health along with it.

In analyzing the accomplishments, the group emphasized the crucial role of community involvement at all levels, including at the central as well as the community level, and the advantage of supporting community development as an approach to health as an integral part of economic and social development. At the same time, there was a recognition of the role that individual responsibility plays for his or her own health in terms of life-styles, self-care and personal health awareness.

### **Vision: The Elements of Success**

- *Leadership: determined, competent and strong*
- *Sustainability, efficiency, effectiveness, and equity: Equity in particular needs to be thought through. Total equality of opportunity is not expected, but it means more than just a universal basic package of services, though this would be an important start, particularly for the half of the population of our hemisphere that currently lacks any coverage whatsoever. Yet, what good does equity in access to a hospital, for example, mean to the person without transportation to get there? Other resources and sectors are at stake: agriculture, transportation and education, to name only three.*
- *Time-frame and focus: Distinguish between short-term and long-term goals.*
- *Major focus on health promotion: Informed individuals are more likely to make healthy choices.*
- *How does one design community services? What are appropriate technologies for the community level? The example was mentioned of school-based medicine, not only as a means to extend rudimentary coverage and provide referrals, but to serve as a focal point for health promotion, community mobilization, and family education around health concerns.*
- *Monitoring of outcomes and processes. Needed to target resources and mobilize a rapid response to real and potential hazards.*
- *With decentralization and reform, the role of central government in direct delivery of services will decline, but its regulatory or normative function and the need for vigilant enforcement of health, environmental, and workplace safety standards will require an ever higher technical capacity. As society becomes more pluralistic, so does the health sector. The health ministry of tomorrow will bear little resemblance to what it once was. So, successful health policy most certainly requires nimble coordination among a broad range of actors outside central government.*
- *Healthy environments*
- *PAHO has credibility and sensitivity. As a result of its longtime presence and tradition of activity in the countries, the Organization has developed a standing and sensitivity unique in the field of public health. These assets enable the Organization to make unique contributions to health in the Americas.*

### **PAHO and the Country Mechanisms to Achieve the Renewal of HFA**

- *Strengthen leadership development. Build consensus of leadership to continue developing strategic approaches and political support to address health problems.*

*This consensus can not be achieved if PAHO staff are not prepared and committed to the goal of HFA.*

- *Strengthen Technical Resources. Therefore we need to: Continue the development of technical support capability and build upon existing resources within the countries' own operating structures. Developing effective approaches for training.*

*Developing partnerships for transfer of health-technology.*

- Targeting of goals and technical assistance. *Support cost-effective measures for interventions based on epidemiological priorities.*

*Technical assistance should be tailored to countries' circumstances and conditions.*

*Identify health priorities for improved public health impact.*

- Coordinate efforts from country experiences. *Extract lessons from country experiences and draw upon multi-country comparison to better understand the underlying dynamics of HFA. Exchange of information about what works and target the mobilization of resources.*
- Identify and make use of our comparative advantage. *PAHO has the ability to combine efforts and expertise of different countries to support the development of their own capabilities.*

*PAHO has served as an ongoing liaison among international public health organizations, Ministries of Health, bilateral agencies and other organizations.*

*PAHO has provided leadership in constructing cost-effective measures for intervention, based on epidemiological priorities and*

*provided leadership at the country and regional levels.*

#### **Why it might work now?**

- *We have a better understanding of major impediments to delivering HFA.*
- *Elements of a set of circumstances have come together to provide momentum for change.*
- *National policies are now targeting more investment toward social development. International agencies of cooperation are doing likewise.*
- *Based on observed trends, health is a major growth market for investors, development banks, and other organizations, and PAHO has become a linchpin in the countries reform development strategies as we move into the 21st century.*
- *Better capacity for surveillance of diseases.*
- *Increasing PAHO's competitive position, PAHO can be proactive with major donors and technical agencies, development banks, universities and countries.*
- *PAHO is in unique position to be the liaison among technical agencies.*

## Final Remarks from Dr. George A. O. Alleyne, *Director of PAHO/WHO*

Good morning ladies and gentlemen. I am not going to try to answer any of the questions that were put forward in the discussion and I would have liked to do that, given some of the comments made. For example, I would have liked to have discussed and debated the issue as to whether all policies are public, which is an interesting epistemological question, but it can be discussed at another time.

First, I'd like to thank the panelists. Dr. Veronelli came all the way from Uruguay yesterday, and at very short notice put together a very interesting presentation. I have to confess to Dr. Veronelli that last night I had to go to a dictionary to look up some of the words that he used. That's part of my education. Also, I was very pleased to have read Dr. Horwitz's speech, who really has the vision of four decades of public health in the Region. It is good to have these kinds of reflections. Dr. Sarn, who gives the view of the public sector, is well known from the nongovernmental organizations and is obviously complimented. The panelists' discussions all complemented each other. I am told that the group discussions were interesting, provocative and that interesting materials were produced.

I'd like to make a couple of comments. Why do we have these technical discussions at all? There was a time when there were technical discussions held around the governing bodies, when ministries and their people came and they had these general discussions. I felt that they were of little use because very few of the ministers participated, leaving other people to participate and much of the work went into preparing documentation which didn't really serve for much.

Dr. Macedo felt that a more useful idea would be to have discussions with the staff and I agree that this a good idea. When we say "technical discussions" what do we really mean? Perhaps the word "technical" is off-putting. What we really mean is to have discussions on important topics. It is a discussion within the organization, and differentiation between

"technical" and "nontechnical" leads us into the discussion of what is a technical topic and what is not. The issues you select as topics for discussion by the staff in coming years, will be issues that affect all of the Organization. I wish to see all parts of the Organization participating in the future; that it be not less. The point is that these discussions affect everyone in the Organization and I will hope that when we have these discussions in the other offices in PAHO, in other parts of the Americas, that there will be full participation from all parts of the Organization. These are activities that affect all our work and we cannot make a rigid segmentation and say "this one is technical, this is not technical; this is administrative, this is not administrative," because all of these things affect us all.

In the future, I wish to see all parts of the organization participating in these discussions because it is only through this participation that we get the kind of effervescence of ideas in the reports that you've read; that need all of us to think through, and better, what we are going to do. As I regularly point out there is no point offering participation if everyone does not participate. That is put boldly. If one can offer participation and have limited numbers of persons participate, it defeats the purpose of the offer.

When we offer the opportunity to participate I do expect that participation, and I think that it is important that there be optimal participation of all the staff. For example, the experience when the staff met and looked at the mission of the Organization convinced me that in fact it is a kind of exercise that we must have from time to time in PAHO; that we must give the opportunity for all staff to express their opinions on all important topics, and there can be few more important topics than that of "what does constitute Health for All?"

Some people have asked why we speak of the renewal of HFA. And renewal; does it mean that the goal is no longer valid and does it mean that the goal as set is no longer an "*idea fuerza*?" Does it mean that the strategies that are needed to have this goal in place are no longer valid? We have to remember every time that we look at HFA, as all of you in your groups put it quite well, we cannot think of it as separated from the context in which it was developed. One of the things that is quite clear to all of us I think is, I hope, that all of you haven't set the goal of HFA down.

This (HFA) was essentially a combination or an expression of social objectives plus a combination of a marketing strategy. The idea of setting a time-frame or giving a number is always attractive to marketers. It is one of the things that James Grant did so well. He was specific. He went to a Head of State and said, when the Head of State spoke to him of all the problems he had., James Grant pulled from his pocket, a package of oral rehydration salts and said "Mr. President, this is the answer". Of course that is simplistic, but it served its purpose, and the idea of setting a date was essentially marketing strategy. Talking to Dr. Mahler, he said that obviously nobody expected the HFA for the year 2000, but it defined something that had a clear time-frame and drew attention.

He pointed to the need for change in the immediate present and not the need for change in some distant future. Obviously, we can't go on saying HFA by the year 2000; we have now to move beyond that, and the idea is that if we can resist putting any date, and the ideas would catch attraction to the desired extent, then we would not have to put the time-frame on it anymore.

The concept that we can focus more on is the principle or feeling behind the idea of HFA and less on the time-frame. I think that it is generally accepted the idea that health is a marker, not only for social justice, but for distributive justice underlies the whole concept of HFA. There is a difference between these two things; not all justice is distributive.

In HFA then, we are looking at health as the marker of social justice, and why do we do this? All of us who work for PAHO are convinced, and we are concerned about some basic problems of social injustice. The part that interests me a lot in this presentation, and it is very good, is the idea of the prospects for the future. How we can look at the prospects for the future if we accept that one of the fundamental underlying principles of HFA is social justice. I would like you to have the conditions in the future to allow that to occur, and all of you mentioned the political aspects of it. All of you quite rightly pointed out that between 1978 and now, things have changed. This is an interesting point; that changes which have occurred in the last 17, 18 years must cause us to reflect as to whether to adopt different strategies and different approaches.

All of you pointed out that certainly in this Region, democracy is more evident than it was when Alma-Ata was signed. But something that is very clear, even clearer and more important than the appearance of democracy, is the perception that civil society is a plural phenomenon. There are many actors in civil society and the participation of these actors is as important as the others. The public sector and the nongovernmental organizations are of importance.

One of the things that the growth of democracy has shown is that once you open the door to participation by these other parts of civil society they will grab hold of it. Much of the debate and discussion now is "how are the more traditional parts of civil society going to live with those parts of civil society that are assuming more importance and a louder voice?" That is one of the bases of the next 10, 15 years. How is the State, widely conceived, going to accommodate the growth in importance and voice of these other members of civil society. You only have to look at the last three major international conferences in Cairo, Beijing and Rio de Janeiro, to appreciate the real importance and growing voice of these other parts of civil society.

You only have to read the Washington Post or the New York Times everyday to understand the power of the press and understand the extent to which many of us in health do not quite yet appreciate the power of the press; the value of the press for us as another member of the civil society. I am not saying that the press is the Fourth Estate that has its own entity, its own direction and is not necessarily responsive to what the whole of society preaches. That is a fallacy. One of the great challenges for us in health as a whole is to understand this movement, understand this opening of civil society and understand how the quest for HFA must be viewed in the context of these various actors which were not as evident in 1978 as now they are today.

Many of you mentioned the role of the Ministries of Health. I wish no possibility of misunderstanding on this; the Ministries of Health are our primary interlocutors. This is not going to change unless we change the constitution, and we need to get that straight. There's no point bemoaning weaknesses of the Ministries of

Health. The Ministries of Health can represent a challenge and an opportunity for the Organization, and part of our work is to strengthen those Ministries of Health. At no time have I ever said that the fact that the Ministries of Health are primary interlocutors impedes us from having relations with other sectors. Primary interlocutors are never sole interlocutors. We can mobilize other ministries, we can work with other ministries. I use "ministries" as opposed to "sectors" and in modern parlance, "ministries" and "sectors" have come almost to be co-terminal, and of course they are not.

Inter-sector coordination as a concept really arose, I have been told, because of the concern of economists as to which groups would be productive or not productive. The sectoralization introduced by Ricardo, has stood, defining which parts of society would be productive and not productive. We must appreciate that this segmentation, this reduction as to which part of society has responsibility for A or B is not in our interest. We have to look at the problem *per se* and then see which parts of society are going to fit into the solution of the problem rather than maintaining the fiction that one sector is watertight from another. Unfortunately, we live in the situation where our governments tend to be organized along ministries, and ministries more and more tend to preserve their turf. That is breaking down as we are finding possibilities or articulations at higher levels of government. One of the things, as you know, that we are trying to do in the area of health is to put the discussion about health at the highest levels of government so that we can appreciate the importance of the working together of these various sectors. Let me also speak of the political problems that affect HFA.

We sometimes speak also of the lack of political will. You have heard me say that this is something I do not accept. I have never yet met a politician who wishes not to have a success. Current public choice theory of political action states that politicians will act to ensure their own survival and election, and there is no politician that does not wish to have a success story. Many difficulties lie in the fact that we do not present to politicians the kinds of issues that allow them to take sufficient credit for it. That is fine; when we allow them to put forward the case appropriately. When we speak of HFA, its elements, the social

justice implied for HFA, I have never yet met a politician who has not been enthusiastic about the idea but who says "tell me what we should do about it?". And that is sometimes where we fall down; not being able to present to politicians the kinds of things that allow them to act appropriately. I do believe in the public choice theory in terms of political organization, and whenever we put it to politicians in an appropriate way, you will find that there is not this lack of political will. There may be obstruction and difficulties in terms of funding or internal political machination; that is another issue. But in terms of will, I have never yet met a politician who did not wish to do good or who did not wish to have a success story.

We also speak of the future for HFA in economic terms. Are we going to have HFA in economic terms? And many of you have pointed out that HFA is attractive now. It's probably more attractive now that the countries have passed out of the economic problems that we faced in past decades. I agree, that it is more likely now that countries are going to pay more attention to health issues for very good economic reasons which we have gone over before. But it is now also an advantage which two groups pointed out. Now that the economic climate is favorable (it is important) that we do make the right proposals and do not get into issues of health reform.

We do not make the proposals for health uniquely in the context of financing of the health care system, that is very important for us. We speak of the renewal of the goal of HFA. What does it really mean to have more equity? We cannot make the case that equity will be achieved uniquely through the financing of the care system. Important though the care system is, we cannot only make the case for equity in terms of the financing of the care system. Another thing we shouldn't continue to discuss is the issue of the financial crises; the structural adjustment and stabilization programs. Sometimes I'm unpopular when I say that it's our countries fault that we got into this mess in the first place. We must be more concerned about what we can do as we come out of this unfortunate situation and what we can do to make sure that we are not going to go back to this situation.

There are many things within the competence of the health sector, one of which is

very important: The issue of being able to produce the data, to monitor the human condition, in order to allow these appropriate decisions to be made.

You mentioned technology and I like the idea of the "*prácticas saludables*," not only "*políticas saludables*," and the kinds of technology you are going to apply. There is no doubt that when we speak about what HFA really means, we cannot divorce the concept of health from the absence of health. They are a continuum.

Speaking of the role of an organization like ours in this area, it is the sensitivity, the capacity to define what are these appropriate technologies, and the appropriate technologies are not necessarily as you would call the hard technologies also. The technologies that come from other disciplines are not necessarily purely medical disciplines. Sometimes we think in terms of the technology supplied; the appropriate technology being the hardware. Many of these technologies come from disciplines that are normally outside our comprehension and often they're not only medical; that they're not always hardware technologies but software technologies. Part of our responsibility has to be to find out where these technologies lie. Which other people employ these technologies? How can we adapt and apply these technologies from the problems that occur?

I would debate, although this is not the place to debate, about primary health care; whether you need to change the strategy of Primary Health Care, and a lot will depend on the interpretation of strategy. I agree in a sense with Dr. Capote about the need to revisit primary health care, but I always remember it being said to me that the definitions began with saying that primary health care was essential.

Now we come to discuss what does constitute essential? And what is essential is not ever applied across all of our countries. In some parts, even the smallest countries, it can't be applied from one county to another, to one city, parish, etc. What does constitute essential care? It is a very complex issue. Having said that, there is no other organization better equipped to help our countries to decide as to what should be that essential care, and how that essential care should be made available to those persons who need it. No organization is in a better position than ours to do it. I do agree however, that the focus on

primary health care has been confusing, or its connotation has often been confusing. We think of care only in terms of restoring rather than in terms of preserving. Within the concept, the wide concept of care, we can easily incorporate the fundamental aspects of health promotion, which in fact speaks to the preservation of what we have, not to the restoration of what we have lost. I do not think it is a need, a fundamental need, to throw out the strategy of primary health care. We need in the same way as revisiting HFA, to revisit the extent to which some of the things we applied some 17 years ago need to be changed and modified.

I hope that in the written record of the discussions you give to DAP, you will also provide comments from your colleagues in the countries. But I would insist that this kind of exercise is important for us, and we must make a genuine effort to synthesize these, to put together the really important common threads, do a good content analysis of these to see to what extent these can form much of the bases of our own discourse and our own "*prácticas saludables*" in the future. I look forward to having similar exercises not only here but in the rest of the Organization in the future when we will discuss critical issues for the Organization, issues that would have implications for all.

I am sorry, but I must stop here. There are many points mentioned in the individual discussions that I would have liked to debate, such as whether health coverage was what Alma-Ata was about, for example. I would have also liked to enter into a discussion about the extent to which health care coverage relates to health care status, because a lot has been written about this topic. I would have really liked to discuss about the quantity of political support that one really needs and how to get commitment from leadership. It would be interesting to have the debate on the financing and concerns of reform. It would be interesting to have the debate on the State and the extent to which the changes that are taking place in the State itself are going to have implications for both social justice as well as for its distribution, and other forms of distribution and the extent to which changes in the state are going to facilitate or not facilitate the decentralization process or the other way around; to what extent the decentralization process will weaken the central part of the State.



It would be interesting to debate regarding what is really meant by "ideology". Ideologies are something all of us, all thinking beings have, having reached certain stages of socialization. Ideology has often been given certain connotations, and it would be interesting to debate "what are these new ideologies?" And when one speaks of new paradigms, I would like to know what are these new paradigms? When one uses the word "new," I always like to ask "what are the 'old' paradigms?" Tell me how these new

paradigms are going to differ from the old. And tell me to what extent has the current of thinking reached a stage where you can really describe a new paradigm. But again these are things which I have to deprive myself of, from time to time. So thank you very much indeed for your participation. I hope that the rapporteurs will give all their comments to Dr. Sotelo, and eventually we shall have a really good description of what has taken place. I also hope that you will all feel pleased at having contributed to it. Thank you very much.

## References

- <sup>1</sup> PAHO. *Final Report of the Director's Advisory Group on the Renewal of Health for All in the Americas*. PAHO/DAP: Washington, D.C., Technical Report OPS/DAP/95.5.14, 1995.
- <sup>2</sup> World Health Organization/UNICEF. *Declaration of Alma-Ata. Primary Health Care. Report of the International Conference on Primary Health Care*. Alma-Ata, USSR, 6-12 September 1978. Geneva, 1978.
- <sup>3</sup> Report on the Alma-Ata Conference, page 15.
- <sup>4</sup> Sir George Alleyne. The Prospects and the Tasks for Health in the Americas. "*Boletín de la Oficina Sanitaria Panamericana*". Volume 119, No. 2, page 101, August 1995.
- <sup>5</sup> PAHO/Office of Analysis and Strategic Planning. *Renewal of Health for All*. Background Document for the Discussions. September, 1995, page 23.
- <sup>6</sup> PAHO/DAP. *Health for All in the Americas*. Final Report. Meeting of the PAHO Director's Advisory Group. Washington, D.C. 3-4 April 1995. page 4.
- <sup>7</sup> Joint Report of the Director-General of WHO and the Executive Director of UNICEF. *Primary Health Care*. Geneva, 1978, Item 44, page 58.



---

# *Annex 1*

## *Health for All in the Americas* *Background Document for the Discussions*



---

# Table of Contents

## **Executive Summary**

### **I. Introduction**

### **II. The Experience of Health-for-All in the Americas**

### **III. New Realities and Challenges for the 21st Century**

*3.1 Global Integration and the Regional Economy*

*3.2 Political and Social Context*

*3.3 Population Changes and Disease Profiles*

*3.4 Reform of the Sector and the Health Services System*

### **IV. The Need to Renew the Vision**

*4.1 The Validity of HFA and PHC*

*4.1.1 Implications of HFA in the Americas*

*4.1.2 The Intersectoral Nature of the Responses*

*4.1.3 General Guidelines for the Renewal of HFA*

*4.2 The Value System: Equity, Solidarity, and Sustainability*

*4.3 General Characteristics of the Integrated Response*

### **V. The Hemispheric Response**

*5.1 Priorities and Strategies*

*5.2 Resource Mobilization and Interagency Coordination*

### **VI. Designing National Health Policies to Achieve HFA**

*6.1 The Renewal of HFA as Public Policy: How is it renewed?*



## *Executive Summary*

The Executive Board (EB93/7) of the World Health Organization (WHO) requested the Director-General to submit a report on progress toward achieving the goal of Health for All to the 96th session in May 1995. The report was to include a reassertion of the WHO mission in light of a renewed strategy and goal. Document EB95/15 of 22 November 1994, *Renewing the Health for All Strategy*, includes a proposal for a new world health policy based on the imperative of strengthening WHO leadership and meeting global changes head on. The document highlights the need to renew the vision of Health for All and, therefore, the WHO mission through an approach based on equity, solidarity, and health.

The Pan American Health Organization (PAHO/WHO) has also reflected on the renewal of the goal of HFA and of the primary health care strategy, in light of global changes that will continue to affect the health of populations, health services systems, and the prevailing modes of technical cooperation in the Region of the Americas. In essence, the proposal reaffirms faith in a world where health is the heritage of all. This process of reflection begins with an analysis of the achievements of recent years, the lessons learned, and the objectives that have yet to be fulfilled. The achievements in the Americas have been important, but clearly insufficient, as indicated by the data from the recent evaluation of Health for All: To redouble efforts is no longer an option, but a necessity. Moreover, there is a need for innovative thought, leadership, and strategic adaptation of HFA to new challenges through the incorporation of appropriate methodological and technological advances.

The main objectives of this document are to support the exchange of ideas on health in the Americas nationally, regionally, and within the Organization, and to build a new vision that contributes to the achievement of the highest possible levels of health, and therefore of well-being for all. The document analyzes the HFA experience in the Region and offers some indications of the new realities and challenges that the countries will face in the third millennium. It justifies the need to renew the HFA vision and offers some ideas on what the integrated vision and a hemispheric response to the challenges could be. The series of questions at the end of each chapter constitute suggestions for guiding the discussions. Thus, the document is incomplete, and the suggestions and reflections that arise from the discussions will be incorporated and form part of a regional position on health policy. The definition of the strategy will be a joint task that will emerge from the consultation and collective construction of new ways of addressing health problems. In this regard, the strategy should include a plan for short, medium, and long-term implementation.

## *I. Introduction*

The goal of Health for All was set by the World Health Assembly in 1977. It was directed toward achieving a level of health for the population that would promote economically and socially productive lives. The countries of the Americas endorsed the goal at the historic meeting of Alma-Ata in 1978. Health for All (HFA) was interpreted as a goal, and the strategy of Primary Health Care (PHC) as the vehicle to achieve it. HFA was interpreted by each country in light of its socioeconomic and health conditions, with some common goals that no country should fail to meet. Equity

was one of the most important values built into the vision of HFA.

In view of the variety and speed of the trends affecting the health of populations and of the challenges to technical cooperation engendered by the effects of these trends, PAHO convened a regional advisory meeting attended by public health leaders from the Americas and representatives of UNICEF and WHO on 3-4 April of this year in Washington, D.C.<sup>1</sup> The group reviewed the achievement of HFA in the Region and analyzed social, economic, political, demographic, and epidemiological changes. The group assigned greater value to health, while underscor

ing the ethical need for *Health for All as soon as possible* and for equity, solidarity, and sustainability as essential values in the process.

The group emphasized that the goal of Health for All remains valid, in view of the many challenges to health in the Region, and it noted that the goal intersects other currents of world thought directed at overcoming poverty and neglect. These aspirations emphasize the creation of a more participatory democracy to influence the factors that determine health.

The group emphasized that the goal of Health for All remains valid, in view of the many challenges to health in the Region, and it noted that the goal intersects other currents of world thought directed at overcoming poverty and neglect. These aspirations emphasize the creation of a more participatory democracy to influence the factors that determine health.

The advisory group proposed that background documents be prepared for the national and regional consultations to be held in the coming months, aimed at revitalizing national efforts in search of Health for All. Achievement of HFA will require a feasible strategic hemispheric response involving the mobilization and participation of other sectors and actors in HFA promotion, including the private sector, nongovernmental organizations, professional associations, legislatures, the mass media, and others.

The definition of the philosophy, values, and lines of action for renewing the goal of Health for All in the Americas constitutes a new vision of health for the Organization and the Member States. Accordingly, the essence of the product will be the development of a long-term regional commitment based on the inputs of broad-based, participatory consultations.

It will be necessary, as part of the consultative exercise, to evaluate public health action over the past twenty years and to detect what the determinants of success for the new strategy will be. This assessment must account for such issues as the meaning of human health, the role of attention to health beyond medical care, the creation of health, and the types of investment or approaches that lead to greater gains for health and to a greater capacity to

realize human potential. The benefits of development, which demands democracy, equity, and sustainability will then be at reach. These elements represent lessons learned over the years and, largely, what has been garnered from several events, especially major international summits.

## *II. The Experience of Health for All in the Americas*

---

*This section offers a retrospective examination of the experience of Health for All and primary health care in the region. It defines those elements or factors, internal and/or external to the sector, which helped or hindered the achievement of the goals. Participants in the discussions are asked to examine this document in light of national experiences and to propose necessary changes.*

In the late 1960s and 1970s, many countries in the Region of the Americas had important national and local experiences in what was later to be called the primary health care strategy. HFA was defined in 1978 at Alma-Ata and PHC provided the foundations for new moral leadership, and a broad social, managerial, and technological response. During this period, the Region attempted to fulfill the goals established in the Ten-Year Health Plan of the Americas, most of which were geared toward extending health service coverage.

The main problem in carrying out the strategy of primary care and the achievement of the goal had to do with the lack of resources (as a result of the crisis of the 1980s, Lack of leadership to generate self-sufficiency affected the capacity of the countries to respond in a context where the decentralization processes were not profound enough to sustain changes at the local level. Other obstacles stemmed from a lack of political commitment at decision-making levels and a lack of support from the medical profession. Yet another problem was related to the variety of interpretations assigned to PHC in the countries, ranging from types of low-cost services for the poor, or care at the first level of the system and to a comprehensive strategy which included all levels of care for all people.



Multilateral organizations such as WHO and UNICEF were those most committed to HFA. The multilateral financial and regional agencies, in turn, exerted an influence through their financial policies applied to development. The bilateral development agencies of donor countries played an important role, especially in Central America and the Caribbean. Even many private institutions, such as universities, foundations, professional associations, nongovernmental organizations, and the private sector contributed in different ways to identifying PHC development policies, for the research, design, and development of appropriate technologies, influencing the formulation and implementation of health policies. Experiences in the Americas varied, but their general success depended on the degree of commitment and ability of the public services to provide technical and logistical support for the activities of local community personnel, who tended to receive few supervisory or other supports.

The great merit of the PHC strategy and HFA/ 2000 was that they formed a vision of health that contributed to the establishment of health policies and programs geared toward greater equity and effectiveness. This effort crystallized in the Regional Strategy for HFA/2000 in 1980 and the Plan of Action in 1982. PAHO led this process at the national level in all the countries. This helped to establish goals and operational priorities for the PHC strategy. A baseline was set to measure subsequent progress in the PHC strategy in the Region, even though effective follow-up activities were never carried out.

In this context, the PHC strategy in its most comprehensive meaning, foundered. More selective PHC approaches, such as those promoted by UNICEF and other agencies in the 1980s, accorded priority to low-cost, highly effective interventions that could still be carried out during the economic crisis that afflicted the developing countries.

Economic indicators (product and employment) in Latin America suffered a set back doubling the proportion of the population living in poverty in most countries. As a result of the foreign debt crises in the eighties, the countries, often at the urging of international financial institutions (IFI's), adopted economic adjustment and fiscal austerity programs. Through the

decade, the health infrastructure and the operating capacity of public services suffered a progressive and accelerated deterioration.

The decline of authoritarian governments and the strengthening of more democratic and participatory governance in the Region marked the decade of the eighties. This situation opened the way for the inclusion of civic sectors in several areas of national activity, including health. Their participation was significant because the nongovernmental sector assumed a growing role in the accomplishment of the PHC strategy. In some countries, the size of resources mobilized by nongovernmental organizations was significantly greater than that which the national government was managing.

In the mid-1980s, the countries of the Region promoted decentralization and the development of local health systems as an operational tactic for stepping up the achievement of the PHC strategy. PAHO and the countries made great efforts, but with mixed results that have still not been fully evaluated.

As the economic and fiscal crises in the countries worsened, the Ministries of Finance became more involved in determining the availability and use of public funds for health and other social sectors. This contributed to weaken the political and policy-making capacity of the health sector, jeopardizing the formulation and sustainability of coherent and effective policies.

The cholera epidemic, which began in 1991, marked the decade and spread through much of the Region, with hundreds of thousands of cases and thousands of deaths reported. The notable reduction in morbidity and mortality from diarrheal diseases in all countries was achieved through significant health mobilization on the part of the governments and the population, which undertook collective and individual control measures.

Concerning new approaches to socioeconomic development, the United Nations Development Program (UNDP) emphasized the concept of human development in its 1991 Report, which placed the health dimension within the indicators of development. The 1992 *World*

*Development Report* of the World Bank was devoted to the issue of poverty and the need to implement effective antipoverty policies as part of the economic adjustment and State modernization programs. Both the World Bank and the Inter-American Development Bank (IDB), adjusted their investment portfolios to substantially increase the share of their regional operations in the social sector in general and in health, nutrition, and basic sanitation in particular. In addition, the 1993 *World Development Report*, "Investing in Health," proposes a new approach to orient the design of national health policies, priorities, and strategies in the developing countries. The proposal is embodied in health sector reform projects, as part of the State modernization programs being carried out in some countries. In December 1994, the Heads of State of the Hemisphere, attending the Summit of the Americas in Miami, assigned PAHO the task of monitoring the health sector reform processes in the Region and, along with the IFIs and other bilateral and multilateral agencies, the responsibility of establishing effective coordination mechanisms for regional and national efforts.

#### • Discussion Guide

• HFA/2000 and PHC include three major categories: *Goals for the impact on the health of the population* (life expectancy at birth, infant mortality, maternal mortality, low birth weight, nutritional status of children); *goals for the coverage of essential programs of PHC* (prenatal, childbirth, and puerperium care, growth and development, family planning, basic sanitation (drinking water and excreta disposal), immunizations (DPT, polio, measles, TB, tetanus toxoid); health education and promotion, food supply and adequate nutrition, prevention and control of local endemic diseases, appropriate treatment of common diseases and injuries, supply of essential drugs); and *strategies* (development of national policies and strategies for HFA, organization of the health system based on PHC, intersectoral collaboration, community participation, management processes and mechanisms, human resources, research and technology, resource mobilization, cooperation between countries, and international cooperation). What degree of fulfillment was achieved in each of the three categories in your country?

• What events since 1978, in your opinion, have helped, hindered, or invalidated the development of the different programs and strategies, as originally proposed at Alma-Ata and newly endorsed in the "Strategies and Plan of Action" in the Region of the Americas?

• Goals, programs, and strategies that failed to produce results in the past may be included in the new proposal. Why do you believe that they now could bear fruit?

### *III. New Realities and Challenges for the 21st Century*

---

*The purpose of this section is to point to the most conspicuous changes in the political, economic, social, epidemiological, and demographic situation in the Region of the Americas, which justify the need for renewing the goal of Health for All. It is important that the participants deliberate to identify the most important trends in different areas and the determinants of health. The participants in the discussions are asked to examine this text in light of their own national experiences and to propose the necessary changes.*

#### *3.1 Global Integration and the Regional Economy*

The different forms of liberal democracy and the opening of the economic markets in the world have enjoyed growing popularity. The relevance of telecommunication systems strengthens the interdependence of the countries and their economic integration on a global scale. These phenomena increase insecurity and the lack of knowledge about the future, so that in qualitative terms, entirely unpredictable events and phenomena assume greater importance. Significantly, the exclusion of large segments of the population from decision-making processes continues while varying degrees of political instability have become more apparent.

Following the economic crisis and adjustment of the 1980s, between 1991 and 1993,

the countries of Latin America and the Caribbean saw their economies grow by 14% and the GDP per capita by 6.1%, despite a cumulative debt of approximately US\$ 534 billion. It is expected that for the period between 1994-2000, the growth of the national economies will be barely higher than the average rate of growth for the decade of the seventies. On the other hand, the consequences associated with the Mexican crisis, force us to be cautious regarding any predictions about economic growth in the future.

The reduction in personal income in most of the countries, along with the increase in poorly remunerated employment in the informal, commercial, and service sectors, has placed a growing number of people below the poverty line and left a large number of competing public needs and ever wider gaps between social groups. The relative proportion of poor people are greater in rural areas, although most people affected by poverty live in urban areas. The population living in poverty in Latin America and the Caribbean is estimated at 200 million, which represents 46% of the total population. Of these, at least 100 million people (23% of the total population) do not have access to basic health services.

### 3.2 *Political and Social Context*

Certain features in the current scenario differ from those that characterized the period of the late 1970s. Nowadays, there is a new emphasis on health in human development, major concern about equity and social justice, special consideration for cultural aspects, knowledge of how to foster social changes and their relation to health policy design, emphasis on participation as a local and political process linked to decentralization; growing concern about quality in health care, services, and consequent consumer satisfaction; and an emphasis on the responsibility for health and the right to health. The social policies of past decades are perceived as extensions of economic policies agreed upon by all the countries of the Region and the groups linked to economic liberalization. The market has been the dominant force in current social dynamics, consolidating the globalization of knowledge and of economies. Moreover, the renewed importance of social factors has provided needed support for economic reforms.

The decentralization processes intended to modify and reconfigure the State. The changes included modernizing it, and making it more efficient, capable of leading, forging consensus, and regulating, with a significant component of community participation reflecting the trend toward democratization. In this context, democracy is viewed as a means to achieve social equity and has been strengthened by the constitutional reforms under way. In some countries, democratization facilitated the political participation of the population, guaranteeing social participation at other levels of civil society. This participation in health represents a mosaic of approaches and strategies with varying degrees of success.

The levels of schooling have continued to increase thanks to a sustained growth in enrollments and the maintenance of the official teacher-student ratio. Between 20% and 30% of the children in the countries of Latin America and the Caribbean live in overcrowded conditions, which is one of the factors closely associated with poor school performance<sup>2</sup>. There has been a deterioration in the quality of education, leading to considerable gaps between the level and type of education of employees and the sectors in which they find work.

Health promotion activities are raising general awareness of attitudes, practices, and perceptions of health and disease, particularly among community organizations. These changes will facilitate their role in healthy public policy formulation. Changes in mortality, fertility, and urbanization have created a new type of nuclear family, one with fewer members and different structure; roles, attitudes, and composition. Worthy of note is the more active role of women, in economic and reproductive and social areas, especially family health.

Besides these political and social issues, other areas have gained prominence in Latin America and the Caribbean and merit consideration in the planning of health activities. Among them are rural conflicts, ethnic cultural demands, conflicts over values and expression in the legal system, controversy over legislation on the family, abortion, public AIDS-prevention campaigns, violence, environmental concerns, and the persistence of human rights violations.

### 3.3 Population Changes and Disease Profiles<sup>3</sup>

It is estimated that in 1995, the population of Latin America and the Caribbean will be close to 481 million or 8.4% of the world population. By the year 2000, 23 of the 45 countries and territories of the Region will have populations exceeding one million, 12 of these countries will account for 90% of the population of the Region. It is forecasted that 74.2% of the population in 1995 will live in urban areas. These demographic and epidemiological changes present a great challenge because they indicate that the situation of neglected groups must be improved and solutions found to both persistent problems and the new ones that are the products of recent changes.

As fertility has fallen from six to three children per woman between the periods 1960-1965 and 1990-95 (a reduction of one child per decade in the past 30 years), the crude demographic growth rate has declined. Even so, it is calculated that, if the current growth rate holds, the population will double in the next 37 years. The proportional and absolute increase in the number of adolescents and young adults will require better and more significant comprehensive services.

The crude mortality rate, which in 1950 was 12.4 per 1,000 population, has declined to 7.8. Changes in the age distribution of the population have increased the proportion of working age people and of those over 65 years of age, due to a reduction in mortality at early ages and in fertility rates. The infant mortality rate, which in 1965-1970 was 91 per 1,000 live births, has been estimated at 47 per 1,000 for 1990-1995. Life expectancy at birth for the same period is 68 years in Latin America and the Caribbean and 76.1 years in the United States and Canada. During recent 5-year periods in most of the countries, specific kinds of mortality have declined at slower rates in almost all age groups below 65 years of age. In many cases, the differences in reducible mortality among social groups rates that vary according to the age distribution, place of residence, gender, and ethnic group of the population have not declined or have even increased.<sup>4</sup>

Domestic and urban violence, traffic accidents, and work-related accidents all

constitute demanding concerns in the area of public health, and they represent significant losses in terms of personal and material security. Infectious diseases continue to be serious causes of morbidity and mortality in most countries, with the leading causes listed as acute diarrheal diseases, acute respiratory infections, tuberculosis, vector-borne diseases, AIDS, and other sexually transmitted diseases. It is estimated that at least three million people in the Americas are HIV-positive.

The incidence of tuberculosis and corresponding mortality has shown rising trends in several countries. More than 200 million people reside in malarious regions, with an annual incidence of one million cases a year. Dengue has become endemic, with periodic epidemic outbreaks in almost all the countries in tropical areas. It is estimated that at least 16-18 million people in the Region live in dwellings infested with *Triatoma infestans* or other domestic vectors of Chagas' disease.

An increase in vaccination coverage among children under five years of age, interruptions of the transmission of wild poliomyelitis virus, and a notable reduction in the frequency of measles, diphtheria, and whooping cough have been the most important achievements in recent years. The frequency of neonatal tetanus has diminished; cases occur in a small number of areas in 16 countries of Latin America. In 1992 only four countries in the Region reported cases of human rabies, and there was a substantial reduction in the number of cases of canine rabies in urban centers.

The proportional importance of chronic and degenerative diseases as causes of death has risen, despite the fact that mortality with variations in the incidence and prevalence of these diseases has not increased and, in some cases, has even declined. Obesity and malnutrition affect countries in varying degrees, while infant malnutrition is related to poverty, low educational levels among women, and lack of appropriate services. Increasingly significant components in the Regional health profile are mental health problems. Disabilities are still a poorly identified problem in terms of magnitude and type; the response from the services is very limited, if nonexistent.

### **3.4 Reform of the Health Sector and the System of Services**

The health care infrastructure in the Region has not expanded at the rate required, and some evidence indicates that it has in fact deteriorated, mainly as a result of reductions in public health expenditure. Recently, the situation has grown more acute as a consequence of macroeconomic policies and structural adjustment programs. Nevertheless, several countries have developed health systems whose coverage and complexity have gradually improved due to better historical conditions, experience in establishing local health systems, and community participation. Just the same, significant distortions have been introduced: uneven expansion in medical technology, with an increase in installed capacity in third and fourth level technology, and deficiencies in basic inputs and essential drugs have been identified in some countries.

Social security coverage has not expanded in most countries, and in some cases it has decreased, owing in part to the exclusion of the growing ranks of informal sector employees and farm workers. Competition between insurance companies and private insurance plans has been proposed in some countries as a means of increasing coverage and has contributed to a weakening of the social security institutions.

Even with significant improvements in the efficiency of central government resource allocation and utilization, the public resources will not have the capacity to finance universal coverage of a basic package of health services. In relation to sector financing, it is calculated that total health expenditures in the Region represent 5.7% of the gross domestic product (GDP), or US\$ 122 per person per year (in 1988 dollars). In the lower-income countries, per capita health expenditures represent one-sixth of that corresponding to the higher income countries. Between 1980 and 1990, central government health expenditures increased from 1.1% to 1.5% of GDP, although there were considerable variations from country to country, and sometimes government expenditures actually declined. The data reveals an uneven distribution of health expenditures among the different income groups in the countries.

The countries must face the challenge of implementing policies to transform their health service systems in order to improve quality and efficiency on a sound and sustainable financial basis, while adhering to the basic principle of equity that they adopted upon signing the proposal of Health for All. Although each reform process responds to the individual characteristics of its corresponding situation, it is feasible to identify aspects in common for different countries. The sector reforms are intended to achieve comprehensive responses to health problems through more effective and efficient interaction between public and private services and social security so that services complement each other.

Currently, the most widespread sector reform model involves the establishment of new financing mechanisms and forms of service contracting, the adoption by public institutions of private sector management techniques, the creation of public sector social enterprises with management autonomy, the formation of networks to provide highly complex diagnostic and therapeutic services, the introduction of approaches to incorporate the total quality concept, cost control, and recovery, and competition among services. On the other hand, the reform processes require quantitative and qualitative adjustments in the use of human resources, new forms of hiring and remuneration to encourage quality and continuous care, and more efficient benefits. The organization of services should also incorporate arrangements to help the continuity of care, whether at the institutional level, in the home, or through other social services. Private providers should assume community responsibilities consistent with the principle of social solidarity.

Differentiation between the roles related to financing and to providing health services may require the creation of multiple public and private entities with the responsibility of collecting funds to finance benefits and contracting medical care for their members according to established rules. The purpose of such an arrangement is to increase efficiency and ensure the competitiveness of the entire system, which requires the creation of mechanisms to ensure the equity and social commitment of the health system.

Another objective of health sector reforms is to expand coverage and achieve a greater impact, especially among the most vulnerable population groups with the least access to health services. This will require the development of targeted actions and intervention programs to resolve the most urgent problems. It is essential to carefully coordinate the targeted approaches with across-the-board activities; the resulting programs should be flexible and involve health promotion, with other approaches geared toward restoring health.

The reform processes are frequently characterized by basic packages of services based on the prevailing epidemiological profiles; they provide policy options, make certain resources available, and reflect social preferences. The development of the basic packages of services should be broadly negotiated and built upon a consensus among the different stakeholders. There is a trend in the social security systems toward separate treatment of long-term risks, pension funds, and health services which seeks greater efficiency in the system.

#### • Discussion Guide

- If the health services must become more efficient, would it be appropriate to expect that economic modernization be oriented towards greater equity? How can we best monitor the effect of economic policies on the health and well-being of the population?
- What are the most significant health profiles in the Region or in your country? What interpretation should be given to recent changes? How can we consider the resurgence of “old” diseases and the emergence of new assaults on health in formulating plans, policies, and projects?
- What elements would characterize the health sector reform that is under way in the countries of the Region in the context of a new vision of Health for All?

## *IV. The Need to Renew the Vision*

---

The purpose of this section is to consider the validity of HFA and PHC in the current and likely future context of the Region, taking into account the values that should sustain it, its characteristics, and components, as well as the policy orientations that would support the goal.

### *4.1 The Validity of HFA and PHC*

Health for All is a goal within a process where the health policies' objectives are oriented toward equity and the creation of healthy living conditions in all environments. Health for All affirms a social right of citizenship in modern democratic societies. The core of the PHC strategy acknowledges the complexity and multicausality of health determinants linking them to socioeconomic development. HFA and PHC aim at establishing priority programs for all, with a set of corresponding interventions and implementation strategies intended to achieve the greatest impact on the health of the population with participation and notable improvements in general well-being. To speak of health for all, therefore, implies an ongoing examination of the general and specific factors that determine the health situation and intersectoral health policy-making.

The proposal is socially just because it offers equality in basic elements to all members of society; it is politically viable (it is difficult to imagine that there could be groups opposed to it); technically feasible (the knowledge and technology are available); economically feasible (its costs are within what currently the countries can bear, including some resources deriving from international cooperation). In addition, it retains the pertinence of the basic postulates of PHC: Access and universal health care coverage according to need, self-sufficiency and social participation, intersectoral action for health and appropriate technology including cost effectiveness criteria. The eight operational elements of PHC<sup>5</sup> are also maintained: Promotion of adequate nutrition and safe water supply; basic sanitation; maternal and child care, including

family planning; immunization against the main communicable diseases; prevention and control of endemic local diseases; education about the most prevalent health problems, and ways to control and prevent them; appropriate treatment of diseases and injuries, even when some of them should be reviewed and adapted accordingly.

Assigning greater value to health and HFA in the Americas would require a thorough analysis of the PHC components, taking into consideration those mandates, plans of actions and national, regional and hemispheric commitments that affect the achievement of health for all. The fact that some problems, even in operational application, are still present, does not invalidate the actions already taken. Sometimes, progress needs to be consolidated; in others, the nature of the intervention has to be modified or substantially intensified; while in still others, it would seem urgent to implement the very same actions that have already been agreed upon. Furthermore, an interpretation of health as an expression of objective living conditions does not negate the importance of health activities and services. These are one of the most important instruments for helping to modify the quality of life and the health situation of different population groups.

#### *4.1.1 The Implications of HFA in the Americas*

The Member States agreed in 1978 that the principal social goal is to ensure that by the year 2000, all citizens of the world attain a level of health that makes it possible for them to live socially and economically productive lives. This approach to the goal moves beyond a strict definition of health as the simple absence of disease, and considers it an expression of the objective conditions of existence of different social groups, in a given space and time, a fact reflected in the quality of life of individuals.

In the wake of Alma-Ata, major efforts have been made to restructure health systems and activities to achieve the proposed goals and objectives. The experience of the countries in defining and executing their respective PHC strategies over the last decade should be evaluated to establish the status of different population groups with regard to HFA goals and to redefine the operations and actions needed to ensure the greatest level of efficiency and equity.

The meaning of HFA ought to be analyzed in each country, taking into account between the general and specific determining factors, those variables beyond the control of health authorities that significantly influence the health situation. These variables cannot be ignored; they contribute to uncertainty and undercut HFA objectives. Thus, any plan supporting HFA ought to consider alternative scenarios, which will include trends and possibilities within and beyond the area of health, searching to improve the prospects for success.

HFA focuses on human groups, and not on the individual or disease in isolation. The general and specific determining factors include a particular range of health problems in different groups, and a range of possible responses. Consequently, the goal of Health for All, like every social goal, is complex and centers attention on the subject-population as the essential core of analysis for national health policies and strategies. These policies can be in greater or lesser accord with the general orientation of socioeconomic development objectives and the allocation of resources, which should consider the hemispheric and regional commitments of the governments. Consequently, one of the main implications of the national HFA strategies is recognition of the intersectoral nature of the health policies developed as a response to problems. If health does not qualify among the central objectives of national development, the health service systems will encounter great difficulty in achieving HFA by themselves. Another implication of national HFA strategies relates to the changes that need to be introduced into the health system and the cost of those changes, so that health care coverage is attainable. Two common related problems are the inability of the services to attend to the growing needs of most of the population, and the inefficient use of resources that help generate inequity in the system.

The concept of PHC as an integrated health strategy affects the entire population and the health system at every level. It involves confronting the problem of the health deficit by obtaining, readjusting, reapportioning, and redirecting the resources of society as a whole to meet needs and aspirations in the health area.<sup>6</sup>

Thus, PHC is not to be conceived of as a limited program for fulfilling in some measure the minimum needs of groups living in extreme poverty. It must encompass the entire population.

#### ***4.1.2 The Intersectoral Nature<sup>7</sup> of the Responses***

The PHC proposals derived from Alma-Ata involve coordinating social and health policies with those intended to promote socioeconomic development, such as macroeconomic policies, particularly fiscal adjustment and fiscal deficit reduction policies. Currently, the establishment of effective intersectoral ties is not just an option for improving social policies. It is a necessity for health action. Responses to current and future health problems will require extra efforts from the health services systems; they will require concerted, cooperative, collective action by responsible individuals, communities, government, and the private sector as well.

The intersectoral approach requires the integration of health policies with social policies, including decision-making spheres and resource allocation systems, reciprocal relationships between the health sector, productive sectors, areas of infrastructure, among other sectors, especially the identification of problem areas in which these relationships operate.<sup>8</sup> The intersectoral approach also characterizes an approach to development and social policy that facilitates the formulation of policies and programs so that they respond to the multi-causality of the problems. Intersectoral coordination helps to improve the decision-making processes by ensuring that decisions at any level are based on a broad range of relevant information and that coherent alternatives to problems are considered. In addition, an intersectoral approach allows the incorporation of people's viewpoints and preferences with respect to their health condition within the design, management, and evaluation of plans, programs, or health projects.

#### ***4.1.3 General Guidelines for the Renewal of HFA***

##### *The Scope of HFA Renewal: What is Renewed?*

The proposed renewal of HFA will become more adaptable and applicable to the extent that it succeeds in constructing a *vision and a framework of essential values* (equity, solidarity, technical and social effectiveness, redistributive justice, and comprehensiveness). Within this framework, the specific and priority problems of each country, at different levels of development, can be illuminated and targeted by HFA/PHC. Incorporating *sustainable human development* as the new health paradigm and a more strategic and less prescriptive approach will increase the political viability of HFA.

The proposal should be expressed through the adaptation and development of new forms for coordinating and understanding health in the countries and the organization of the health sector and its services. It is also hoped that HFA renewal will help to transform international technical cooperation in health, including that of PAHO/WHO, and will involve modifications and adjustments in the operations of the Secretariat (in Regional Programs, Representative Offices, the composition and operation of Governing Bodies).

The renewal of HFA should be an ongoing process, is flexible enough to constantly adapt, develop, and adjust to the changing conditions and possibilities of the political, economic, social, cultural and technological environment. Within the flexibility proposed for HFA, every sphere of implementation (regional, national, and local) should have a set of expected outcomes, goals, and indicators defined and an evaluation system established in order to lend support to the goals, processes, systems, and resources for implementation. PAHO's cooperation should aim at facilitating and promoting concrete efforts to implement the proposal.

#### ***4.2 The Value System: Equity, Solidarity, and Sustainability***

What distinguishes HFA renewal from the original Alma-Ata proposal is the greater



emphasis accorded its basic guiding value; equity. Equity means equality of opportunities for individual development and, as with any other philosophical concept, it contains and may reflect divergent values in practice. It refers to different that are unnecessary and avoidable and are, moreover, considered unjust.<sup>10</sup> The greatest equity in access to health seems to exist when need rather than structural and individual factors determine access to the health system.

If equity is identified with the idea of social justice, it stands to reason that social actions must be promoted and geared toward disenfranchised population groups. Justice seems to dictate that all people are assured access to all of the types of health care that benefit them. At a minimum, it demands that everyone have minimum, equal access to health care, regardless of income, sex, age, or place of residence.

Acceptable levels of equity within the objectives and goals of HFA will depend on the values and prevailing ethical principles of society and its different social groups. However, for a better assessment of equity in HFA renewal, certain interpretations need clarification. The first concerns achieving equity efficiently and effectively in the development of the health systems. A recent review of the literature raises the possibility of an inherent contradiction in this assertion, when equity is measured against the principle of optimal distribution, then solutions cannot be both efficient and equitable. Some authors highlight this incompatibility, affirming to have efficiency and quality, we must change our ideas about equity and to have equity, we must change our ideas about efficiency and quality. If this was indeed the case, we would be supporting the development of a system, likely doomed to failure, framed in a set of conflicting values. The second clarification concerns the idea of equity itself, to deal unequally with those who suffer the inequality. However, this assertion poses other possible interpretations of how to apply it.

Renewal of HFA expands the basic approach to equity by adding *solidarity* and *sustainability*. Here, the concept of solidarity is taken in its social dimension, not only at the individual level. Equity and sustainability, that is, what can be maintained over time should be linked. Assuming that equity is sustainable in the field of health, it would be worthwhile to explore

the possible contribution of various types of sustainability, such as social sustainability (development and maintenance of community support for a program), political sustainability (the political will to stay on target), technical sustainability (staff duly trained to meet needs), managerial sustainability (the ability to plan and lead effectively), and financial sustainability (the provision of resources and materials).

### 4.3 *General Characteristics of the Integrated Response*

The strategy for achieving Health for All in the Americas continues to be primary health care; enhanced, however, with essential new elements such as health promotion and essential elements suggested here. Its *comprehensive nature as an organized social response* is one of these elements. In other words, both in its conception and operation, the social response should include biological, psychological, and sociocultural elements, and the curative, recuperative, preventive, and promotional aspects of health. Its targeting should encompass individuals, families, populations, and the environment.

The societies of the Region need to establish a new social contract based on health, namely: the incorporation of the right to health within the constitutional framework of the countries; the highest levels of awareness regarding social responsibilities (individual, family, community, and social) in attaining better levels of health; a greater scientific and political recognition of the close ties between health and living conditions; the emerging incorporation of health in national initiatives to build citizenship; and institutional efforts to include health in the political agenda of the governments at both the national and international levels. In short, as far as society provides adequate opportunities for its members to take on socially and economically satisfying roles, it exerts a crucial and direct influence on health.

Other elements that would characterize this new vision involve the promotion and support of alliances and coalitions, general cooperation for local and national development; improving the national ability to mobilize resources; strengthening the ties between the health of the population, the environment, and sustainable

human development, invigorating the social model of health practices; and strengthening and developing local services, community participation in decision-making, and institutional recovery of the sector through stronger leadership.

### • *Discussion Guide*

---

- The interpretations and definitions of equity vary greatly. What are the most relevant considerations for promoting social justice in our societies?

- What do you imagine an "integrated response" in health would be in your national or local context? What characteristics would have a renewed vision of HFA?

- What would be the feature of a health services system which considers the satisfaction of current and forecasted health problems, and takes into account the new vision of HFA and those trends that will affect its achievement?

## V. *The Hemispheric Response*

---

*The participants should direct their discussions at defining the adequacy of some approaches to facilitate the achievement of HFA in each national context, keeping in mind the meaning of the strategy for the whole region. It is important to reflect on those approaches that have been successful as well as on those that have not led to the expected results and why.*

### 5.1 *Priorities and Strategies*

The countries should determine their own priorities according to those areas or health problems that require attention. Some of these priorities have persisted for some time while others are emerging. The priorities will also vary according to the importance they are assigned in the national political agenda. Both types of priorities will require an important and committed action from the health sector in the countries, and also from the technical and financial cooperating agencies. The agencies will also need to adapt

the new realities in terms of the nature and type of cooperation provided, as well as in terms of the required skills of their staff.

The countries will also decide the best strategies to follow, and they will be directed at maintaining, recovering, repairing and obtaining health gains. Some strategies include the promotion of health and human well-being, comprehensive health care, protection, and the promotion of a healthy environment, and disease control.

### • *Discussion Guide*

---

- What methods, approaches or techniques are being used to better identify strategic health priorities?

- Which could be the most appropriate strategies (in terms of efficiency and equity in results) to satisfy the priorities identified in the short, medium and long-term?

- What national, subregional, regional, or international activities could help in the socialization of HFA?

### 5.2 *Resources Mobilization and Interagency Coordination*

The main problems and obstacles that have influenced the management and mobilization of resources for HFA in the Region relate to many factors: The limited domestic negotiation capability of the ministries of health in defining national priorities; the limited or nonexistent participation of the health sector in national-level intersectoral activities; the lack of knowledge about the availability of cooperation and the processes for mobilizing resources; the inabilities of the ministries of health to design, carry out, supervise, report on, and evaluate projects; high staff turnover, unqualified human resources involved in the planning and management of international cooperation.

Although the technical cooperation activities are especially developed by the agencies of United Nations, the IFI's are steering their support toward structural changes more than toward the development of basic infrastructure, which was their traditional mandate. This trend

can significantly alter established relationships in the future, because the lion's share of the cooperation provided to the sector could be channeled through nonconcessional loans in the context of State reform and macroeconomic stability, which is to say, not necessarily from a health perspective. Bilateral donors are also steering assistance projects with clearly definable effects.

The international community requires the political commitment of governments in the form of national counterpart funding for the sustainability of projects that support technically or financially. Strengthening counterpart agencies is also a large concern. Greater interagency coordination and joint work will be required among governments, United Nations agencies, organizations for bilateral and multilateral cooperation, and nongovernmental organizations in order to achieve the commonly defined objectives. An important governmental presence will be required to coordinate and regulate the nongovernmental sector so that it responds to the national goals and policies.

At the national level, authorities should take on a promotional and coordinating role in order to ensure a greater level of official development assistance and more efficient and effective use thereof. Thus, it will be necessary to identify the national priorities that will show the true demand for resources that achieving HFA will require. These will include international cooperation to complement national efforts. At the international level, the countries of the Americas should closely follow international cooperation policies and funding for health on an ongoing basis to identify opportunities and actively and creatively use them to achieve HFA. Identifying international cooperation agencies should be an ongoing task that requires a knowledge of the issues and geographical interest. It is also important to know the procedures used to obtain cooperation and also their schedules to present proposals, guidelines for their preparation, and the levels, time periods, and types of financing available.

### • Discussion Guide

Assuming the country has received development assistance, what percentage of it

has gone to health? What are the current trends and variations and what might be the justification for these trends? What percentage of official development assistance for health has been devoted to the achievement of HFA, to primary health care, care for the most vulnerable groups; women, children, refugees, and indigenous populations?

What role can international cooperation agencies such as PAHO play in health in order to support this mobilization? What can be expected from nongovernmental groups in these processes? What could be your contribution to the achievement of HFA?

## *VI. Formulation of National Health Policies to Achieve HFA*

*Within the framework of these discussions, it is hoped that the group will discuss the health policy matters that are most urgent in approaching the achievement of Health for All, in light of the renewed strategic perspective that has developed nationally and taking into account hemispheric, regional, and national commitments, and local preferences and needs.*

### **6.1 HFA as Public Policy: How is It Renewed?**

Public policies are the result of political struggles among various sectors of government and civil society, and they express themselves in governmental actions on specific areas. Healthy public policies, on the other hand are also characterized by their intersectoral and comprehensive nature. They also express a consensus on those coordinated actions that are most favorable to health based on the promotion and sustainability of individual and collective social, economic and cultural practices affecting the health and living conditions of the people.

The PAHO Secretariat and the Member States need to demonstrate and develop substantive leadership, as well as capacity to mobilize groups with ideological or economic interests in order to incorporate HFA into public

policies. This includes political groups, professional associations, different state agencies and civic organizations, the private sector, nongovernmental organizations, and special-interest groups (e.g., ecologists, women, youth, consumers, workers) at the regional, national and local level. It is also necessary to link the HFA to treaties, declarations, and mandates that guide social and economic development at the international level (World Trade Organization, international summits or conferences on the environment, population, children, and women) as well as at the regional and subregional level (Ibero-American Summits; the Summit of the Americas, the Central American Common Market, MERCOSUR, Hipólito Unanue Agreement, CARICOM, NAFTA). These activities have affirmed the need to forge closer ties between the health of the population, the environment, and sustainable human development.

Healthy public policies must be linked to macroeconomic policies, particularly those related to fiscal adjustment and reduction of the public deficit. Moreover, health authorities will need to consider the development of coherent policy arguments to improve the outcomes of discussions of health issues and resources with economic authorities, civil society and the parliament. These arguments should support the concept that health expenditures are an investment integrated into other efforts to increase productivity and quality. Health authorities should also be able to successfully argue that what we gain in days free of disability

and in an increase in the productive life expectancy represents an investment in terms of the productivity of the labor force. Moreover, intersectoral coordination efforts of this nature will also affect changes in a health care model centered on medical resources (which increase costs) toward a more consolidated approach to act upon the socioeconomic determinants of health. Although individual medical care does not exclude equity, the former principles are more coherent with efforts toward achieving equity.

To become a mobilizing and catalytic force, HFA should respond to the concrete problems that the countries face. In this process, the identification of stakeholders and potential alliances which could contribute to the solution of problems is vital. The identification and analysis of those problems, the formulation of public policies, strategies and interventions (sectoral or global), ought to strengthen and support the regulatory capacity of the State in general and that of the health sector in particular. An additional aspect of the renewal of HFA is the need to expand the capacity of the sector and those agencies involved in cooperation in health, to anticipate alternative health scenarios in our Region, which will help to improve our analytical, forecasting, and decision-making capacities.

### **• Discussion Guide**

- What can be done to help the formulation of healthy public policies in your country?

## References

- <sup>1</sup> PAHO. *Health for all in the Americas*. Final Report of the Advisory Group to the Director of the Pan American Health Organization. April 3-4, 1995. PAHO/DAP. Washington, D.C., Technical Report PAHO//DAP/95.4.13, 1995.
- <sup>2</sup> CEPAL. *Panorama Social de América Latina*. Santiago: CEPAL, 1994.
- <sup>3</sup> *Complete information on this topic can be found in PAHO. Health Conditions in the Americas* PAHO/WHO: Washington, D.C., 1994 and *Vigilancia y Evaluación de las Estrategias de Salud para Todos*, CSP 24/21, 1994.
- <sup>4</sup> Around 1990, these gaps represented 45.5% (with a range of 5% to 71%) of the deaths in Latin America and the Caribbean, on average, while in the United States and Canada, this figure ranged from 1.6% to 7.1%. This means that each year 1.5 million deaths among persons under 65 years of age could be avoided.
- <sup>5</sup> WHO/UNICEF. *Primary Health Care*. Joint Report of the Director General of the World Health Organization and the Executive Director of UNICEF. Geneva/New York, 1978.
- <sup>6</sup> The interpretation of PHC as a strategy memo that: once the proposed goal takes its basic inspiration from the reduction in the inequalities between countries and between human groups, this strategy should be valid and applicable to all the population and not be confined to neglected or marginalized groups, although the satisfaction of their basic needs is a key objective. OMS/UNICEF. *La Estrategia de Atención Primaria de Salud*, *op.cit.*
- <sup>7</sup> This is a key component of health promotion, as stated in the Charter of Ottawa, as well as in the XXIX World Health Assembly, which approved resolution WHA 29.22 on Intersectoral Cooperation in National Health Strategies.
- <sup>8</sup> PAHO. INPLAN/7 Documents. Washington, D.C., 30 April 1982. *Meeting on Intersectoral Action for Health*, Geneva, 29 April-1 May 1985, and the consultations prior to the Technical Discussions on Intersectoral Actions carried out during the 39th WHA in Geneva in May 1986.
- <sup>9</sup> Whitehead, Margaret. *Conceptos y Principios de la Equidad en Salud*. OMS, Oficina Regional para Europa, Programa de Políticas de Salud y Planificación. Ministerio de Sanidad y Consumo, España, 1990.



---

## *Annex 2*

### *List of Discussion-Participants by Group*





### **GROUP 1**

*Coordinator:* José María Paganini  
*Rapporteur:* Wilma Freire  
*Participants:* Claude Betts, Janette da Silva, Kate Dickson, Jaime Estupiñan, Ernesto Gozzer, Rodrigo Guerrero-Velasco, Renato Gusmao, Antonio Hernández, Cristina Nogueira, Mónica Padilla, Manuel Peña, Hernán Rosenberg, Gabriel Schmunis, Miguel Segovia, Javier Uribe, Juan Manuel Sotelo, César Vieira.

### **GROUP 2**

*Coordinator:* José A. Solís  
*Rapporteur:* Pablo Isaza  
*Participants:* Pedro Arenales, Fernando Beltrán, Mario Boyer, Pedro Brito, Alberto Cardelle, Rosario D' Alessio, Roxane Eikhof, Enrique Fefer, José R. Ferreira, Charles Godue, Richard Marks, Germán Perdomo, Alcida Pérez, Gladys Rabelo, Helena Restrepo, María Helena Ruzany, Elbio Suárez Ojeda, José Luis Tapia, Maritza Tennessee.

### **GROUP 3**

*Coordinator:* Helena Restrepo  
*Rapporteur:* José Luis Tapia  
*Participants:* Fernando Beltrán, Mario Boyer, Pedro Brito, José R. Ferreira, Helena Restrepo, José Luis Tapia, Roxane Eikhof, Gladys Rabelo, Maritza Tennessee, Germán Perdomo, Pedro Arenales, Alberto Cardelle, Enrique Fefer, Rosario D' Alessio, María Helena Ruzany, Elbio Suárez Ojeda, Charles Godue, Richard Marks, Alcida Pérez.

### **GROUP 4**

*Coordinator:* Stephen Corber  
*Rapporteurs:* Charles Becker, Sandra Land y Saskia Estupiñán  
*Participants:* Monica Brana, Veta Brown, Gloria Coe, Martina De Schutter, Ramón Figueroa, Michael Finley, Bradley Hersch, Cecilio Mingo, Horst Otterstetter, Martha Shimkin, John Silvi, Maxine Siri, Thomas Yerg.

