directing council | *regional committee*

PAN AMERICAN HEALTH ORGANIZATION
XXXIX Meeting

WORLD HEALTH ORGANIZATION
XLVIII Meeting

Washington, D.C.
September 1996

Provisional Agenda Item 5.2

CD39/12 (Eng.)
16 July 1996
ORIGINAL: SPANISH

RENEWAL OF THE CALL FOR HEALTH FOR ALL

The Executive Board of the World Health Organization, in Decision EB93/7 of its Ninety-third Session, requested the Director-General to report on progress toward attainment of the goal of health for all (HFA) at its Ninety-sixth Session in May 1995. This request was formulated in connection with the fulfillment of resolutions aimed at addressing the global changes that are affecting the Organization.

The Pan American Health Organization (PAHO), for its part, has also reflected on renewal of the goal of health for all and the primary health care strategy in light of the global changes that are currently affecting, and will probably continue to affect, the health of the people and the health services systems. In essence, it reaffirms faith in a world in which health is the legacy of all, and it offers for consideration a comprehensive vision of health and of ways in which the Hemisphere can respond to the challenges. These proposals have been enhanced by consultations at the national and hemispheric level, as well as by contributions from individuals associated with various institutions whose work has an impact on health. This proposal was taken up during the 26th Meeting of the Subcommittee on Planning and Programming and the 118th Meeting of the Executive Committee and includes the suggestions that emerged from these discussions. The members of the Executive Committee discussed the document *Renewal of the Call for Health for All* (see Annex) and reaffirmed its importance as an essential input for the development of health policies at the national and regional level, as well as for the formulation of the strategic and programmatic orientations of PAHO for the next quadrennium. Mention was also made of the importance of setting concrete goals and operationalizing the renewal in specific programs, both in the processes geared toward maintaining the progress made in health and in those aimed at improving health levels in the future.

During this meeting the participants were informed about the results of the Regional Conference on Future Trends and Renewal of Health for All that was held in Montevideo, Uruguay, from 9 to 12 June, sponsored by the Ministry of Public Health of that country and PAHO. Briefly, the recommendations issued at this event were aimed at maintaining the social goal of HFA, emphasizing universal access by the population to the health services and redefining the priority operational goals in a participatory manner. Primary health care (PHC) in its broadest sense was maintained as the basic strategy, grounded in social participation. The members of the Executive Committee were in agreement on the need to emphasize social participation as the mobilizing element of the proposal, a factor that will translate into healthy communities and a healthy environment for all.

New levels of convergence and renewed commitment will facilitate application of the PHC strategy, with a view to generating political will, resources, and individual and collective responsibility for health, greater decision-making power for the community, and an appropriate reorientation of the health services toward the established objectives. At the subregional and hemispheric level, it is hoped that HFA and the PHC strategy will become the guiding vision and framework for health development processes in the coming years—elements that will be supported by the application of suitable approaches that facilitate the design of alternative cost-effective and equitable responses to the Hemisphere's future health challenges.

Renewal of the Call for Health for All represents an input that will contribute to the preparation of a global health charter that will be submitted to the World Health Assembly in 1998. PAHO/WHO will collaborate with the countries to ensure that this global and regional policy framework becomes a key element for guiding the countries' health policies, plans, and projects and that the various initiatives under way in the health sector are consistent with the renewal of HFA.

The Executive Committee reviewed and discussed the topic, made suggestions which have been incorporated in the attached document, and adopted Resolution CE118.R10, as follows:

THE 118th MEETING OF THE EXECUTIVE COMMITTEE,

Having reviewed the document on renewal of the goal of health for all (Document CE118/10) and taking note of the activities linked to this initiative that are being promoted in the Region of the Americas,

RESOLVES:

To recommend to the XXXIX Meeting of the Directing Council the adoption of a resolution in the following terms:

THE XXXIX MEETING OF THE DIRECTING COUNCIL,

Having reviewed Document CD39/12 on renewal of the goal of health for all (HFA); and

Recognizing the critical role of community participation in renewing health for all,

RESOLVES:

1. To take note of Document CD39/12 and of the national and regional efforts geared toward renewal of the goal of HFA and its strategies.

2. To urge the Member Governments to evaluate progress in meeting the goal of HFA and applying the primary health care strategy, with a view to identifying the areas that require priority action and the elements that hinder or facilitate this progress.

3. To recommend that the Member Governments:

(a) Renew their commitment to the goal of HFA and its health strategies, within the context of the social, economic, political, environmental, and technological trends that are affecting the health of their populations, environment, and health services;

(b) Give priority to the adoption of policies to resolve their health problems in a sustained manner, with a view to steadily improving the quality of life of their populations.

4. To request the Director:

(a) To provide the technical cooperation appropriate to support the countries regarding the renewal of the goal of HFA;

(b) To promote the mobilization of national and international resources to support renewal of the goal of HFA that target the design and application of appropriate strategies.

Annex

RENEWAL OF THE CALL FOR HEALTH FOR ALL

CONTENTS

Page

Executive Summary . . . 3

1. Introduction . . . 4

2. The Experience of Health for All in the Americas . . . 4

3. New Realities and Challenges for the Twenty-first Century . . . 6
   - 3.1 The Economic, Political, and Social Dynamic . . . 6
   - 3.2 Epidemiological and Demographic Trends . . . 7
   - 3.3 The Health Sector and Inequity of Access . . . 8

4. The Call to Renew the Vision and the Commitment . . . 9

5. The Vision of Health for All as a Hemispheric Response . . . 10

6. Orientations, General Objectives, and Strategies . . . 12
   - 6.1 Policy Orientations for Health for All . . . 12
   - 6.2 General Objectives . . . 15
   - 6.3 Strategies . . . 15

7. The Role of PAHO . . . 17

References . . . 18

Annex

EXECUTIVE SUMMARY

The third monitoring of the global strategy of health for all (1994) demonstrated that, notwithstanding the countries' efforts to promote health and the achievement of this goal, there are some objectives that were not met and new challenges that must be faced. The identification of those areas in which the countries need to concentrate their efforts to reduce or eliminate the gaps in health between and within countries, with special emphasis on the gap between different population groups, is an essential and primary element in the renewal of the goal of health for all.

The potential impact of certain macroenvironmental trends on the health of the populations of the Hemisphere, coupled with the waning of enthusiasm in the health sector with regard to the original proposals of Alma-Ata, calls for a reaffirmation of the commitment by all to improve the health of the peoples of the Americas and to take the debate on health to new levels of discussion, mobilization, and community and social decision-making in the countries. Health should be an essential and explicit part of sustainable human development processes, where the values of equity, solidarity, and sustainability are guiding elements for action in health.

The policy orientations presented in this document are geared toward making HFA a reality. These orientations can be summarized as: social participation in decision-making; the application of a social model of health practices; intensified connections between the health of the population, the environment, and sustainable human development; the promotion of alliances and coalitions; intersectoral analysis and action; global cooperation for local development; mobilization of national capacity; the strengthening and local development of services; and leadership.

The general objectives of this proposal are broad and geared toward the search for equitable, collective, and sustained access to health and health services, through actions in health promotion and recovery, disease prevention, and the attainment of higher levels of health. In defining its specific goals, each country will consider the objectives that are most suited to its epidemiological situation. The primary health care (PHC) strategy is still valid, and an effort will be made to strengthen particular aspects in accordance with national realities.

PAHO will continue to discharge its constitutional responsibilities and strengthen its leadership in health in the Hemisphere. As indicated in the annex to this document, several activities are proposed at the regional, national, and Secretariat level for the period 1996-1998, aimed at evaluating the achievement of the goals of HFA and the future actions necessary, within the framework of a renewed health policy for the Region.

1. Introduction

The Pan American Health Organization, faced with a multiplicity of trends that are affecting the health of its peoples and the challenges posed by the consequences of these trends and taking into consideration the results of the last review and evaluation of health for all (HFA) *(1)*, considers it urgent to mount an effective response to this situation. The macroenvironmental context has been changing rapidly, and social actors have taken new positions, some of them with significant influence on the outcome in terms of the health of the people and the environment. This is the right time to be thinking about the strategies and actions that are needed in order to ensure that health will be at the top of the development agenda in the Americas.

This document presents for consideration by the Executive Committee a proposed discussion which initiated a formal process of consultation during the 26th Meeting of the Subcommittee on Planning and Programming, held 25-27 March 1996. This proposal, which incorporates the suggestions of the members of the Subcommittee, is aimed at establishing a Pan American health policy position as a feasible strategic response by the Hemisphere and a reaffirmation of the Region's commitment to the health of its entire population.

2. The Experience of Health for All in the Americas

The countries of the Region assumed their commitment to the goal of HFA at the World Health Assembly in 1977 and subscribed to this goal the following year at the historic meeting in Alma-Ata. On that occasion they agreed that the most important goal of society is for all the citizens of the world to attain by the year 2000 a level of health that will enable them to live a socially and economically productive life *(2)*. The strategy of primary health care (PHC) was seen as the vehicle for attaining HFA, and each country proceeded to translate these commitments into the terms of its particular socioeconomic and health situation, while at the same time recognizing certain minimum targets that all countries must achieve. In the Americas, the establishment of HFA/2000 and implementation of the PHC strategy were embodied in the regional strategy of HFA/2000 in 1980 and in the Plan of Action in 1981 *(3)*. These documents facilitated the setting of targets, operational priorities, and baselines against which to measure progress toward health for all in the future.

The third monitoring of the global strategy of health for all *(1)* evaluates topics related to health trends, the implementation of PHC, the development of PHC-based health systems, resources available for health, healthy lifestyles, and population and economic development. This evaluation exercise brought to light the areas in which the countries need to focus their efforts in order to reduce or eliminate existing health-related disparities both within their borders and with respect to other countries, with special emphasis on gaps between different population groups.

This review of progress in the principal strategies aimed at achieving the goal of HFA revealed that the development of national policies and strategies has not included the participation of other sectors and actors, and that the definition and organization of priorities has often been based on interests that ran counter to the attainment of HFA and the implementation of PHC. Moreover, the organization of national systems has not been based on primary health care, and management of the services has frequently been plagued by bottlenecks in the collection, analysis, and utilization of information for the definition of priorities, plans, and policies. Participation, while it has increased and has served to open up opportunities, has sometimes been utilitarian or has petered out once specific projects were completed. While the importance of equity has been preserved in the rhetoric, it has not been translated into improvements in the distribution of resources, and the hospital has continued to be at the center of the health services system.

One of the main problems standing in the way of implementation of the PHC has been the shortage of resources following the crisis of the 1980s, which forced the countries to adopt economic adjustment and fiscal austerity programs, leading in turn to steady and rapid deterioration of the health infrastructure and reduced operating capacity in the public health services. This chain of events, coupled with the relative lack of competitiveness in the health sector, impaired the services' ability to respond at a time when the decentralization processes were still too embryonic to support changes at the local level. Other obstacles were insufficient political commitment at decision-making levels, shortage of inputs and supplies, inadequate supervision, neglect of the sociocultural aspects of health, little information being provided to communities, weak technological development, limited support from the medical profession, and opposition from certain sectors. The mobilization of resources for HFA has also been affected by the slowness of internal negotiations and definition of national priorities, insufficient knowledge about opportunities for cooperation and the resource mobilization process, and limited national experience in project design and management. At the same time, the broad terms in which the goal and the strategy are expressed have given rise to interpretations that have failed to give adequate consideration to questions related to sustainability and financial feasibility.

It was also a time when democratic governments were being strengthened, and this process opened up opportunities for the participation of citizens in the national endeavor. The nongovernmental sector assumed a growing role in implementation of the PHC strategy, sometimes with significantly more resources than were being handled by the national governments. In the mid-1980s the countries of the Region were promoting the processes of decentralization and local health system development. During that same time, the health promotion strategy was placing more emphasis on social action and development with equity and envisaging the formulation and execution of policies to promote the health of individuals and the environment, strengthen alliances and networks for social support, and increase the people's control over their own development *(4)*.

The improvements in general morbidity and mortality and the increases in life expectancy were not attributable exclusively to the implementation of PHC and HFA but chiefly to the political will of many governments to move forward in this area. These approaches were nevertheless essential to the achievement of some improvements in health status, in the coverage, organization, and management of health services, in the improvement of surveillance systems, and in the dissemination of a more comprehensive view of health. Poliomyelitis has been eliminated and the incidence of other diseases preventable by vaccination has been reduced; life-spans have increased; and in many cases conventional indicators have improved despite cutbacks in national budgets. Still, the conception of PHC, both in its comprehensive and its specifically targeted sense, has not been internalized or incorporated into the operations of the health services systems.

3. New Realities and Challenges for the Twenty-first Century

At the world level, the globalization of information and access to and the transfer and use of technology have served to reinforce interdependence and accelerate social, economic, cultural, and technological changes. At the regional and national level the key factors in shaping the health needs of the people will be the demographic and epidemiological trends, including the rapid urbanization of the Americas over the last 30 years. At the national level, government action or inaction plays a role which cannot be ignored in the areas of development policy that are especially relevant for health, such as the economy, education, population, housing and urbanization, food and agriculture, and industrialization. The role of women as an essential variable in the health status of families and communities has been recognized, and gender-based approaches can be expected to exercise increasing influence on the formulation of policies, projects, and health plans. The consequences of the economic adjustment policies and the new macroeconomic models can be expected to have an increasingly important impact, especially on the differences between social groups in terms of access to services and the outcomes for health. Other important factors include the cost of services and the quality of care.

3.1 *The Economic, Political, and Social Dynamic*

In recent years complex economic, political, and social, processes have increased the popularity of liberal democracies and fostered the opening of economic markets and the intensification of regional integration processes. The declarations of the world summits and pronouncements by the governments of the Region have emphasized the importance of health in human development and expressed concern about equity and social justice in multicultural contexts. The social aspect has taken on renewed importance in the furtherance of economic reforms, and a balance is being sought between the fruits of economic development on the one hand and social well-being on the other. Poverty has made it difficult to meet the Alma-Ata standard of a socially and economically productive life, while increased concentration of income in most of the

countries is cutting off increasingly larger segments of society from the benefits of development, thus aggravating inequities within and between countries, threatening political stability, and causing living conditions to deteriorate even further. However, the constitutional reforms that are currently being instituted have strengthened the processes of decentralization, and as a result states, provinces, municipalities, and communities now have better opportunities to participate in social life through the expression of citizenship as a strictly local and political process.

Between 1991 and 1993 the economies of the countries of the Region grew by 14% and the per capita GDP increased by 6.1%, although in 1995 the countries still had a total cumulative debt of approximately US$ 576 billion *(5)*. It is expected that during the period 1993-2000 the average annual growth of the economies is likely to be somewhat higher than the rate achieved during the recent period of recovery in 1990-1992 but only slightly higher than the high rate seen in the 1970s. It is estimated that 200 million people are living in poverty in Latin America and the Caribbean (46% of the total population), and that at least 100 million (23%) of these do not have access to basic health services. The annual per capita public expenditure on health (in constant 1988 prices) declined in Latin America from $18.8 in 1980 to $14.6 in 1990, or from 84% to 72% of total expenditures on health *(6)*.

School attendance has declined relative to family income, and the stratification of the educational system has aggravated the existing heterogeneity and undermined the system's function as an instrument of social cohesion and equity. Informal employment has increased, as well as urban unemployment in some of the countries, and the figures are higher for adults and heads of household.

3.2 *Epidemiological and Demographic Trends (1,6)*

The total population of the Latin American and Caribbean countries stands at around 481 million. By the year 2000, 23 of the 45 countries and territories of the Region will have populations of more than 1 million, with 12 of them accounting for 90% of the total, and almost 80% of the total will be living in urban areas. Even at its current growth rate, the population will double in size in the next 37 years. Rural poverty persists: between 10% and 20% of the poorest segment of the population lives in rural areas. Rural dwellers represent more than half the population in six of the countries and 80% of the total indigenous population.

There has been a shift in the age distribution of the population, with increases in both the working-age component and the over-65 group. In many cases the differences in reducible mortality between social groups, age groups, places of residence, the sexes, and ethnic groups remain unchanged or have actually become greater. In 1990 these differences represented, on average, 45.5% (in a range of 5% to 71%) of the deaths in Latin America and the Caribbean area, while in Canada and the United States of America

the figure was only between 1.6% and 7.1%. This means that every year some 1.5 million deaths in the population under age 65 could be avoided.

Domestic and urban violence, traffic accidents, and work-related accidents are pressing concerns, while infectious diseases continue to be a major cause of morbidity and mortality. At the same time, the relative importance of chronic and degenerative diseases as causes of death has increased, and problems associated with overnutrition and undernutrition, mental health disorders, and disabilities continue to afflict the countries in varying degrees and call out urgently for responses at the policy-making level.

3.3 *The Health Sector and Inequity of Access*

The reforms of the State have resulted in transformations in the health sector, including reduced State involvement in the design and delivery of services and greater private sector participation. These reforms attempt to improve the quality and efficiency of the service delivery system in terms of financial sustainability so that it will be possible to mount comprehensive and complementary responses to health problems through more effective and efficient interaction between public services, social security programs, and the private sector. In many cases the coverage of social security programs has failed to increase and has even declined. Moreover, the countries' expenditures on health are distributed unequally between the different income groups.

Serious financial constraints, inefficient utilization of resources, weak institutional leadership, and, in some cases, the outdated skills of health workers are problems that remain unremedied and are actually deepening in the face of current challenges and the situation that looms in the future. At the same time, medical technology is expanding unevenly, with an increase in installed capacity at the third level of care, while at the primary level there continue to be problems such as the availability of basic supplies. While it is true that greater diversity in the modes of service delivery has added to the number of options available and brought new players into the health market, the health care infrastructure has failed to keep up with this growth, and there is evidence in fact that it has deteriorated, although in several countries the coverage and complexity of the health systems has been improving steadily. Indeed, there is reason to doubt that, even if central government resources were efficiently allocated and utilized, it would be possible to finance a package of universal health service coverage that would guarantee equity of access.

The main challenge currently facing the health sector is to overcome the inequity expressed in differences in access and coverage and in health conditions—differences that are a reflection, in turn, of the social and economic inequities that currently prevail in the Region. These inequities are manifested in different ways according to the characteristics that distinguish the various groups, such as social class, gender, ethnicity, income, place of residence, and years of schooling.

4. *The Call to Renew the Vision and the Commitment*

The call to renew the vision and the commitment to HFA has grown out of the findings from the recent regional evaluation of the strategies of HFA, the analysis of the potential effects of some macroenvironmental trends on the health of the populations of the Hemisphere, and the gradual loss of enthusiasm in the sector for the goal and its strategies. Renewal means reaffirming the commitment of all to improving the health of the peoples of the Americas and taking the health debate to new levels of discussion, mobilization, and decision-making at the community and societal level in the countries. Health should be an essential and explicit component of a sustainable human development process in which development is centered on the human being, and equity and environmental and social sustainability are the criteria that guide intersectoral development policies and the processes of individual and social transformation. Thus, health must be regarded as an essential component in the growth of individuals and societies, in policy-making discussions and decisions, and in the financing of government plans and programs—in which the ethical dimension of health and the right of all citizens to have access to a health system should be overriding.

Renewal is an ongoing process that needs to be constantly adapted, developed, and adjusted to conditions and opportunities as they are presented in the surrounding environment. Within the flexibility of HFA, at each level of application (regional, national, or local), the proposal should define a list of expected outcomes, a series of quantifiable and measurable goals and indicators, and an evaluation system designed to monitor their fulfillment. Implementation will rely on adequate human, material, and internal and external financial resources, processes, and systems. National resources should be subject to ongoing and systematic analysis so that priorities can be redefined, strategies readjusted, and alternatives selected for the solution of problems, when necessary, in order to ensure that the response will be integrated into the social production of health.

In order for HFA to have some political viability, it will be necessary to devise a plan for sustaining it. Such a plan should include alternative scenarios that recognize and make it possible to identify opportunities and threats in regard to the operations and actions that the countries need to carry out in pursuing HFA. In other words, reducing the health gap calls for action—and not only by the health sector—that will influence the determinants of health (the social and physical environment, genetic heritage, individual and collective behaviors, and the health services systems). It should also be possible to monitor and evaluate the impact of these determinants with scientific rigor in order to devise corrective interventions to improve the living conditions of different population groups.

Generally speaking, the present political and social situation does offer opportunities for the renewal of HFA. With regard to the macroenvironment, advantage

should be taken of the following trends in the near term: democratization, the exercise of citizenship, and social peace; the commitment made by authorities and embodied in the related reforms of the executive process to include health on the political agenda, to develop a legal framework for social participation, to decentralize, and to incorporate the right to health within the national constitutional frameworks; the institution of State policies to combat poverty; the peoples' greater awareness of their responsibilities in attaining better levels of health and environmental conditions; the increased scientific and political recognition of the social determinants of health; and the international banking policies that favor investments in social areas, including health.

In terms of elements more directly related to the health sector, the following trends, among others, should be taken into account: the rapidly accumulating international experience in disease control and technological progress; the opening up of opportunities to work on an interinstitutional, intersectoral, and interagency basis with the participation of new actors in industry, trade, government, and organized civil society; the expansion of sectoral and technological managerial capacity; the growing support of the medical profession; the stronger university ties with HFA; and the improved ability to set priorities for the sector.

At the same time, however, there are circumstances that pose a threat for renewal of the goal, such as the possible effects of current economic models that may work counter to the attainment of equity and solidarity; the absence of comprehensive long-term vision in government and health sector decision-making; outdated ideas about health and disease; and lack of a plan for development of the skills needed in order to meet the new demands. In addition, the existing economic, ethnic, and social heterogeneity in some of the countries poses a special challenge that will require decentralized and regionalized policies that are sensitive to the sociocultural factors involved. Moreover, the absence of an adequate service delivery model and effective control over the rising cost of medical care, the transfer of this cost to the population, and the transfer of State costs to the private sector could lead the market to produce further inequities in access to health services, with the consequent impact on the health of users.

5. The Vision of Health for All as a Hemispheric Response

The vision of HFA represents a desired future state that we will approach by renewing commitment to the goal and by implementing suitable strategies and concrete actions. This vision, forged from national consultations and technical discussions held during 1995, may be summarized as *a shared understanding of health in which the Hemisphere's energies respond ethically to the challenges that arise for the achievement of sustainable human development with dignity and equity in the future of the Americas.*

This vision is based on a value system guided by equity, solidarity, and sustainability. To achieve equity means diminishing or eliminating differences that are

unnecessary and avoidable and which, moreover, are regarded as unjust *(7)*. Equity is defined as equal opportunity for individual development and, in the specific case of health, equal opportunity of access to health and to health services. Equity also means guaranteeing equal access by all citizens to health information, medical care, and such health services as society and the State are able to maintain economically in a context of solidarity.

Solidarity refers to the relationships at the individual, family, community, and societal level that are aimed at strengthening support networks for the common good. Solidarity in health includes the ways in which a society shares and becomes responsible for the maintenance of public health and the medical care system. In the present context, the goal of HFA is enhanced by a spirit of solidarity that calls for community participation and intersectoral articulation, involving all the actors from the various sectors concerned with health.

Sustainability is concerned with how strategies can meet the needs of the present population without compromising the ability of future generations to meet theirs. Ensuring the sustainability of the changes resulting from the application of a renewed health strategy will require not only carrying out regular surveillance but also having the flexibility to adapt and change in response to elements that work against it.

The vision will become a comprehensive social response by means of the commitment and direct involvement of the population in its conception and achievement and by making it operational through concrete action. Its conception and operation should take into account biological, psychological, sociocultural, and environmental concerns, and it should include both the recuperative and the preventive and promotional aspects of health. In terms of the direction it takes, it should coherently encompass individuals, families, communities, and the environment.

This response will be adequate and applicable to the extent that it succeeds in constructing a vision and a framework of essential values within which each country's specific priority problems are identified based on its level of development. The political viability of the renewal of HFA will depend on the degree of the governments' political commitment to achieving the highest levels of health and well-being for their peoples, the room for health personnel to advocate policies at all levels of activity, and the people's ability to ensure compliance with a health agenda that will ensure their well-being today and in the future.

6. Orientations, General Objectives, and Strategies

6.1 *Policy Orientations for Health for All*

Social participation in decision-making. Effective social participation and the development of skills aimed at increasing the options available to individuals and the control they exercise over those options is the essence of the goal of HFA. The participation of organized individuals in development activities constitutes an active process of social mobilization whereby the population generates or increases its control of the ecosystem and resources, and the people benefit through increased power, confidence, knowledge, vitality, and the ability to achieve authentic endogenous growth. Such participation implies a definitive change in the power structure that alters the relationship between civil society and the State, especially when equity is an objective and participation in the definition of sustainable development options is emphasized.

The decentralization processes that are unfolding in democratic contexts in the countries of the Region represent a good opportunity to develop and strengthen the social participation of peoples in their own development. At the local level it is more viable to have greater transparency on the part of social actors and in their proposals, as well as a greater degree of social control and association between the NGOs and other social institutions that are more closely identified with the people, particularly the marginalized populations. Furthermore, the implementation of policies of social equity and intersectoral articulation will be successful once a system is in place that favors alliances at all decision-making levels, from the central government all the way down to the local units.

It will be necessary for the countries to consider the policy orientations outlined below in their national processes directed toward the attainment of HFA.

Social model of health practice. It is necessary to develop to its proper dimension a health practice that is aimed at individuals, diseases, and cure—an initiative that has been promoted but has not yet been attained under the PHC strategy. Accordingly, the notion of a care model or a health services delivery model should be a component of the social health practice model that is constructed in each population-space in response to its own ideals, needs, or problems. The public health and medical care services should be defined within this broader framework when it comes to setting priorities and policies and deciding on interventions. At this point it will be essential to incorporate knowledge and methods drawn from the social sciences in order to more effectively analyze and incorporate the culture, aspirations, and expectations of rural and urban populations, indigenous communities, women, urban youth, and other priority groups.

Intensified connections between the health of the population, the environment, and sustainable human development. The relationship between these three elements is fraught

with questions that are essential for human well-being and survival, and Chapter VI of Agenda 21 refers to PHC as an instrument for sustainable human development at the local level. Hence, the concern among national governments, states, municipios, and local communities about protecting the environment and human health must translate into action that impacts on the factors that lead to greater gains in health (e.g., the availability of drinking water and sanitation services, food and nutrition, a safe environment, proper management of community and industrial waste) and the most important trends that affect health (e.g., demographic and ecological changes, the protection and conservation of natural resources, urbanization, social stratification). These efforts should be directed toward intensifying the struggle against extreme poverty, especially in the most fragile habitats.

Promotion of alliances and coalitions. The essential components of the ties and close collaboration between the actors and sectors that are concerned with, or have influence on, the attainment of HFA are society in general through community organizations, the political decision-making levels, governmental and nongovernmental organizations, and the private sector, including the technological and pharmaceutical industries and insurance companies, among others. Steps should be taken to strengthen the capacity of groups, institutions, and public and private organizations at the international, national, local, and community level to participate actively in health advocacy, promotion, and protection. It is therefore essential to develop mechanisms to monitor the changes in national, regional, and global policies that can affect the sector or the health of the population in the medium and long term.

Intersectoral analysis and actions. The renewal of HFA implies the harmonization of social policies, including health policies related to the promotion of socioeconomic development—specifically, macroeconomic policies—and among these, especially policies that have to do with fiscal adjustment and reduction of the fiscal deficit. The intersectoral approach facilitates the structuring of social policies that take into account the multicausal nature of problems and make it possible to incorporate the views of the population about their health conditions and their preferences in regard to the design, management, and evaluation of health plans, programs, or projects *(8)*. Steps should be taken to strengthen national capacity to analyze the health situation of the different population groups and to monitor the impact of actions on their health and well-being as an essential component of the decision-making process.

Global cooperation for local development. This orientation fits within the framework of globalization of economies and information exchange, as well as recognition of the importance of local socioeconomic development aimed at optimizing social policies for the attainment of community well-being. Mechanisms for general cooperation between countries and/or regions, while recognizing the differences between them, should promote the expression of and response to local needs in health development. It is fundamental, moreover, to establish responsibility at the appropriate

levels for the impact of economic, industrial, and technological developments on the health of communities at the local level. Past experience also indicates that many local health problems (e.g., communicable diseases) can be tackled more effectively through regional or subregional programs.

Mobilization of national capacity. It is necessary to identify, enlist, and make accessible the various moral, political, scientific, cultural, economic, and organizational capabilities and resources for health development that exist in each of the different societies. If health is not ranked among the central objectives of national development and translated into investments aimed at improving health, it will be very difficult for the health services systems alone, even if well endowed with resources, to attain the goal of HFA. The growing demand for self-determination, self-reliance, and self-management in some of the Region's most socioculturally organized communities is a good indication that it is possible for the countries to strengthen the will and the commitment of their own populations to political action in health.

Strengthening and local development of services. There should be capacity in the communities and at the decentralized levels of health (states, municipios, cantons, departments) to maintain or achieve a high quality of service in which the use of existing resources is maximized. New programs should consider their effects on the organization and dynamics of society, on the ability of primary health care workers to provide services, and on the capacity of the health care structure to adequately supervise and support community health workers. The strengthening of health services at the local level, moreover, implies recycling processes or the teaching of new skills to personnel.

Leadership. Leadership ensures the future success of institutions and the sector by bringing together and expressing a set of values, a mission, and a vision of where they are headed. Leadership has more to do with distributing power than with being in control—in other words, with self-discipline. It also has to do with developing the ability to systematically think and discuss policy in order to convince others, with knowing how to listen to differing opinions, and with developing the ability to think prospectively through the processes of analysis, planning, and management at all levels, including the promotion of new models of strategic thinking and participatory management.

These priorities and strategies should ensure that the necessary financing is obtained through the effective mobilization of resources and mechanisms for the planning of international cooperation, as well as interagency coordination. Greater and more effective interagency coordination will be required on the part of governments, United Nations agencies, and bilateral and multilateral cooperative initiatives, including NGOs, in pursuing the shared objectives that have been jointly defined. It is essential for the State to be present in the coordination and regulation of the nongovernmental sector so that this process will be in alignment with national goals and policies. Finally, the proposal for the renewal of HFA should be financially and economically feasible, and

it should take into account the entire health sector at all its levels, the private subsectors, and the social security system, as well as the management levels in the national and local governments.

6.2 *General Objectives*

The objectives listed below are general in nature; they will vary in importance depending on national realities and their priority in national political agendas. The definition of concrete goals corresponding to the priorities defined by each country will benefit from an epidemiological reassessment—in other words, a rethinking in terms of the possibilities for controlling or eliminating diseases, damages, and conditions, considering the capacity of the country's infrastructure to meet the goals, the upgrading of human resources' skills to meet the objectives, the degree of decentralization that has taken place, and the organizational support that is available. The objectives are:

- To ensure cost-effective access by the entire population to high-quality health education and health information, essential drugs, nutrition, water supply and sanitation, as well as cost-effective and quality health services;

- To reduce the negative impact of socioeconomic, political, and ecological conditions on the health of the most vulnerable groups;

- To seek to develop populations that are physically, psychologically, and socially healthy and violence-free, in a process characterized by dignity and respect for cultural diversity, which takes gender-based aspects into account in the planning of interventions;

- To eradicate, eliminate, reduce, and control the main diseases, injury, and conditions that adversely affect health, especially emerging or re-emerging diseases;

- To promote and facilitate access by all to healthy environments and living conditions through the promotion of healthy lifestyles, and the reorganization of health and environmental services and regulatory mechanisms;

- To ensure the availability of the knowledge and technology needed for their application in recovering and achieving gains in health.

6.3 *Strategies*

The XXIV Pan American Sanitary Conference approved the strategic and programmatic orientations for PAHO for the period 1995-1998, which refer to the following areas: health promotion and protection, disease prevention and control,

promotion and protection of the environment, health in human development, and development of health systems and services. This latter area constitutes a point of departure for processes aimed at reshaping the strategies for action, or identifying new ones, aimed at renewing the goal of HFA in the Americas. Furthermore, the principles that undergird the renewal of the call for HFA will contribute to the formulation of the forthcoming Strategic and Programmatic Orientations for the next quadrennium.

The essence of the PHC strategy is the recognition that the factors which determine health and disease are by nature complex, multicausal, and tied to the development process. HFA makes it a social right, inscribed in the statutes of citizenship of a modern and democratic society, that health and development policies should focus on the creation of healthy living conditions in all environments and on the struggle to eliminate inequity. HFA and PHC are proposals aimed at establishing priority programs for the entire population, and they include a series of interventions and implementation strategies that are designed to have maximum impact on the health and well-being of the population in the context of the resources available. Several international conferences and commitments have recognized the importance of health, a fact that has translated into resolutions consistent with the process of renewal currently under way; for example, there is agreement that reproductive health, including sexual health, should be universally guaranteed through the application of the PHC strategy, which emphasizes the attainment of well-being throughout the life cycle of women and men. The PHC strategy, which has gained momentum with the advent of health promotion, should be geared to the requirements of the current and expected health situation at the national and local level. The strategies that are defined should address priority health problems and be aimed at recovering, repairing, and achieving health gains based on the technical, economic and financial, social, and cultural feasibility of the policies, plans, and projects.

The principles and components of the strategies should be expressed in concrete and instrumental terms, while at the same time maintaining flexibility so that they can be adapted to different national and local situations. In the final analysis, the success of the strategies aimed at achieving HFA will be measured in terms of the qualitative and quantitative transformations that take place at the level of individuals, the population, the environment, and the services. It is not clear whether the sectoral reforms that are being implemented in the Region are leading to the attainment of health for all, since there is already an explicit political commitment to respond to the needs of the population, and thus some of the principles of HFA (for example, efficiency, equity, the basic package, participation) are shared. This is an area that requires careful analysis in order to facilitate the formulation of specific strategies that will ensure attainment of the values that underlie HFA. Ways should be sought to ensure that the health sector will make an effective contribution in terms of information, the analysis of policies, and the proposal of substantial alternatives to the decisions that have been made regarding reforms in the organization and financing of services which will impact on the population's access.

The current context of reform is characterized by changes that have not yet been evaluated but which could have a profoundly negative affect on the population's access to quality services. It is therefore suggested that increasing importance be given to creating or strengthening the technical capacity to plan strategically for medium- and long-term health policies, programs, and projects that will be aimed at improving equity of access and the population's quality of life, while at the same time ensuring that national expenditures are efficient and effective.

It is essential to reopen consideration of the health sector's contribution to economic and social development and to the productivity and competitiveness of the work force. On the other hand, the strong correlation between occupational training and school performance, on the one hand, and living conditions and the health situation of the population, on the other, suggests that investments in health will be a complementary factor that will help to ensure the social profitability of investments in education and training programs for the work force. In addition, it is important to raise the question of articulating the health sector and its actors into the agenda of discussions at the national and regional level and to recognize the intersectoral nature of health policies that respond to the problems in question.

7. The Role of PAHO

The new vision of development to which the countries of the world are committed requires effective action on the part of PAHO in regard to health in the Americas that takes into account the specific characteristics of each country in terms of the technical cooperation required. This response will be reflected not only in the implementation of policy orientations in the medium term but also in the ongoing search for, and review of, mechanisms, priorities, and modes of long-term international technical cooperation in order to contribute efficiently to attainment of the highest objectives of sustainable human development in the Americas.

The Pan American Health Organization has constitutional responsibilities which refer basically to its role in international technical coordination and cooperation in the area of health. Accordingly, PAHO will continue to take action to improve its position in regard to health in the Americas, while at the same time clearly defining its role in the future of regional health. It will attempt, in addition, to strengthen its leadership in health in the Americas, playing a catalytic role in intersectoral collaboration, investment in health in the face of new regional and global contexts, and support for the ministries of health in the articulation of political and technical arguments in favor of health. PAHO will identify and strengthen the most effective ways of supporting the attainment of HFA; it will renew its role in the provision of advisory services and in encouraging the countries to adopt doctrines and political action in health with functions that include surveillance, monitoring, and evaluation of the regional health situation.

Annex

REFERENCES

1. PAHO. *Monitoring and Evaluation of the Strategies of Health for All by the Year 2000.* CSP24/21, September 1994.

2. WHO/UNICEF. *Primary Health Care.* Joint Report of the Director General of the World Health Organization and the Executive Director of the United Nations Children's Fund. Geneva/New York, 1978.

3. PAHO. *Regional Plan of Action for the Implementation of Health for All.* Washington, D.C., 1982, and *Regional Strategy for Health for All in the Year 2000.* Washington, D.C., 1980.

4. Ministry of Health and Welfare of Canada/WHO/CPHA. *Ottawa Charter for Health Promotion.* International Conference on Health Promotion, 17-21 November 1986. PAHO/Ministry of Health, Colombia. *Promoción de la salud y equidad.* Declaración de la Conferencia Internacional de Promoción de la Salud. Santa Fé de Bogotá, November 1992.

5. World Bank. *World Development Report.* Washington, D.C., 1995.

6. PAHO. *Health Conditions in the Americas.* Washington, D.C., September 1994.

7. Whitehead, Margaret. *Conceptos y principios de la equidad en salud.* WHO, Office for Europe, Health Policy and Planning Program. Ministerio de Sanidad y Consumo, Spain, 1990.

8. PAHO. Meeting on Intersectoral Action for Health, Geneva, 29 April-1 May 1985, and in consultations prior to the Technical Discussions on Intersectoral Action, held during the Thirty-ninth World Health Assembly in Geneva in May 1986. INPLAN/7 Documents. Washington, D.C., 30 April 1982.

Timetable of Activities, 1995-1998: Health for All in the Americas

Dates	Member States	Governing Bodies	Secretariat
1995			
February			Present and discuss preliminary document for activating HFA renewal process to Director's Cabinet.
1-3 March			Establish Advisory Group to Director for this activity, its principal objective being to advise on general directions and approaches relating to attainment of HFA in the Americas.
13-14 March			Report to PWRs.
February-March			Working group to prepare terms of reference for meeting on overall consultation process for renewal of HFA strategy, agenda for national and regional consultations, and draft basic document for national and regional discussions; terms of reference and basic document to take into account evaluation of HFA in the Region, the SPO, and the overall planning process with a view to linking up the principal elements.
3-4 April	Meeting of the Advisory Group to the Director on Renewal of Health for All in the Americas (RHFA), Washington, D.C.		
24-25 April		Report to Subcommittee on Planning and Programming.	Prepare and distribute final report of Advisory Group; Director's Cabinet to review plan of action and basic document; distribute them to countries and PWRs.
28 April-1 May		Director to present plan of work and draft basic document to Global Program Committee (GPC).	Confirm establishment of interprogram group for preparation of supporting document for national consultations on renewal of HFA.
1-12 May		World Health Assembly	Establish Regional Group for HFA.
5 May		WHO Executive Board (EB).	Activities during this period to include consultations with other United Nations agencies, international organizations, and NGOs; visit countries and present the subject in subregional meetings.

Dates	Member States	Governing Bodies	Secretariat
19 June-1 July		Report to Executive Committee.	Prepare supporting document for national and regional consultations and for technical discussions of PAHO, to include comments and suggestions from health leaders in the Region.
August-October			Begin to prepare for meeting on Future Trends and Renewal of HFA to be held in Uruguay, 9-12 June 1996.
19-30 September		Report to Directing Council.	
21-22 September	Technical Discussions in the countries with the participation of nationals in several of them.		Technical Discussions at Headquarters and in the countries on HFA in the Americas.
October			Introduce changes in document; prepare publication on Technical Discussions; prepare for Meeting on Future Trends and Renewal of HFA.
November-December	Continue national consultations and enhancement of renewed HFA.		
December		Report to Subcommittee on Planning and Programming.	Prepare document on impact of resolutions of summits on HFA.
1996			
January			Update programming for 1996 based on results of activities in 1995; propose other activities for considering the new context in the Region and recommendations emanating from previous events.
26-27 March		Present regional document to Subcommittee on Planning and Programming; discussion.	Step up consultations with international organizations, universities, and other institutions affected by the RHFA process.
April			Introduce changes in document based on recommendations of SPP.
May		Report on progress toward HFA in the Americas at World Health Assembly.	Continue support of national consultations.

Dates	Member States	Governing Bodies	Secretariat
9-12 June	Meeting on Future Trends and Renewal of HFA, Montevideo, Uruguay, in conjunction with meeting of the International Health Futures Network and presentation of the Health Futures Manual for RHFA.		
June		Present revised document to Executive Committee.	
September		Present document to Directing Council.	
October-December	Organize regional and national activities to update or formulate new goals as part of the implementation of the regional policy of HFA.		PAHO support in the organization of regional and national activities to update or formulate new goals, as part of the implementation of the regional policy of HFA.
	Implement a regional plan for the attainment of HFA.		
1997			
January-December	Interface RHFA activities with evaluation of SPO 1995-1998 and the preparation of the SPO 1999-2002.	Meetings of the Governing Bodies.	Support implementation of the regional plan; interface RHFA activities with evaluation of SPO 1995-1998 and the preparation of the SPO 1999-2002.
1998			
		World Health Assembly presentation and approval of New Global Policy and Charter on Health.	Apply the Global Policy and Charter on Health to the regional context.