Universal Health in the 21st Century: 40 Years of Alma-Ata

Report of the High-Level Commission

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

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Washington, D.C.
2019

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TABLE OF CONTENTS

Members of the High-Level Commission
"Universal Health in the 21st century: 40 Years of Alma-Ata"

Michelle Bachelet Jeria
(Former President of the Commission)

United Nations High Commissioner for Human Rights; former President of Chile two times; former Minister of Health and of Defense; first Director of UN Women; former President of the Advisory Council for Social Protection of the International Labor Organization (ILO) and the World Health Organization WHO).

Néstor Méndez
(President of the Commission)

Assistant Secretary General of the Organization of American States (OAS); former Ambassador of Belize in the United States of America; former Permanent Representative of Belize to the OAS; former Nonresident High Commissioner of Belize in Canada.

Carina Vance Mafla

Former Minister of Public Health of Ecuador; Executive Director of the South American Institute of Government in Health (ISAGS-UNASUR).

Laís Abramo

Director of the Social Development Division of the Economic Commission for Latin America and the Caribbean; former Director of the ILO office in Brazil; ILO regional specialist in gender and labor.

Daniel Olesker

Former Minister of Public Health and Social Development of Uruguay; Full Professor, Department of Economics, School of Economic Sciences, University of the Republic of Uruguay; economic advisor and director of research at Instituto Cuesta Duarte PIT-CNT; technical advisor to the Uruguayan Federation of Mutual Assistance Housing Cooperatives.

Mario Mujica Vidart

Former representative of the Workers Sector, National Health Board of Montevideo; member of the National Health Users' Movement (MUSPP); board member of the Uruguayan Health Federation; leader of the Federation of Drink Industry Workers and Employees.

Chelauna Providence

Program director, Guyana Responsible Parenthood Association (GRPA) (Georgetown, Guyana); project officer and consultant, Caribbean Development Centre; coordinator for social change, Society Against Sexual Orientation Discrimination (SASOD).

Hernando Viveros Cabezas

President, Afro Colombian Global Initiative (Washington, DC, United States); permanent representative for North America, Latin American and Caribbean Network for Democracy; member of the OAS Society Civil Forum.

Vivian Camacho Hinojosa

Health coordinator, Pueblos Bolivia; former representative for the Andean Region, Coordinación Latinoamericana Movimiento Mundial por la Salud de los Pueblos; former National Director of Ancestral Traditional Medicine, Ministry of Health of Bolivia; Quechua midwife; advocate for respectful childbirth and ancestral midwifery.

Toni Reis	Executive Director and founder of Grupo Dignidade LGBTI (Brazil); board member, GayLatino Regional Network; Director of the LGBTI+ National Alliance (Brazil); member of the HIV/AIDS commission, city of Curitiba (Brazil).
Mirna Kay Cunningham Kain	President, Directing Council of the Fund for the Development of the Indigenous Populations of Latin America and the Caribbean (FILAC) (La Paz, Bolivia); former advisor to the President of the United Nations General Assembly for the World Conference of Indigenous Populations (United Nations).
María Soledad Cisternas	Special envoy of the United Nations Secretary General on Disability and Accessibility; member of the Advisory Committee of the National Institute of Human Rights; former Chair of the United Nations Committee on the Rights of Persons with Disabilities.
María Isabel Rodríguez	Public Health Hero of the Americas; Member of the Royal Academy of Medicine of Spain; former Minister of Health of El Salvador; former Rector of the University of El Salvador; Presidential Advisor on Health and Education, Republic of El Salvador.
Denzil Douglas	Former Prime Minister of Saint Kitts and Nevis; President of the Labor Party of Saint Kitts and Nevis; former Advisor to Her Majesty's Privy Council (United Kingdom); Member of Parliament; physician and surgeon.
Loyce Pace	President and Executive Director of the Global Health Council; member of the advisory council of the WHO Global Action Plan; former regional program director, American Cancer Society; executive consultant to the LIVESTRONG Foundation.
Mauricio Bustamante García	Director, School of Medicine, USIL-Peru; former Vice-minister of Health of Colombia; Secretary of Health of Bogotá and of the Andean Health Agency; director of regional and multi-country projects.
Andrea A. Cortinois	Assistant professor, School of Public Health, University of Toronto (Dalla Lana School of Public Health); Co-director, research group on global migration and health.
Mabel Grimberg	Director, Institute of Anthropological Sciences, School of Arts, University of Buenos Aires; Principal investigator, National Scientific and Technical Research Council.

Foreword

In 1978, representatives of the health and development sectors met in Alma-Ata and issued an unprecedented declaration. Recognizing the accumulated experiences and the duty to respond to inequality, they called on the international community to make a commitment to urgent action: Health, they said, must become a condition for the well-being of all people, and no one should be excluded. As a result, it became a settled issue that health should be promoted as a guaranteed human right.

Forty years later, the call to action has been sounded again and is equally relevant today. While commemorating the 70th anniversary of the Universal Declaration of Human Rights, the World Health Organization recalled the magnitude of the tasks still facing us. Despite notable advances over the years, less than half the world's population receives all the health services it needs; nearly 100 million people are pushed into extreme poverty because they have to pay out of their own pockets for health services; and it is estimated that a child dies every five seconds, most often from preventable causes.

Universal health as a guaranteed right: continuing on an active path 40 years after Alma-Ata

Under the leadership of the Pan American Health Organization (PAHO), the Region of the Americas decided to hold deliberations and contribute to the lessons learned to guide further action, channeling this effort through a High-Level Commission "Universal Health in the 21st Century: 40 Years of Alma-Ata." I had the honor to participate in the process and to chair the working sessions of this group of valuable, varied, committed people. Ambassador

Néstor Méndez's professionalism and rigor was essential to reaching our destination and submitting this report to the Director of PAHO, Dr. Carissa F. Etienne.

The report's recommendations are the result of years of field work, research, and national and local public policy-making, accurately reflecting the diversity of our Region, where ancestral wealth and innovation intersect with the most pressing challenges of our time, including epidemiological, environmental, social, economic, and political challenges.

We believe that this report fulfills two purposes. First, it highlights contributions that our hemisphere can make to other regions of the world, which can enrich their national health policies with experiences that are often equivalent in terms of obstacles and opportunities. Second, and more importantly, the report emphasizes that it is up to us to ensure that all people enjoy the necessary conditions to fully exercise their right to health. In all regions of the world and at all times, this is an effort that must continue.

This report offers a path for action on primary health care, understood as a comprehensive strategy to act on social determinants and create specific spaces for communities to take part in 21st century models of care.

There can be no doubt: States play an essential role, whether as provider or regulator, as guarantors of the common good. They are responsible for long-term policy-making, financing, territorial coverage, inclusion, and protection. And they have primary responsibility in the defense of human rights, including the right to health.

Technological progress, pharmaceutical developments, and increased health budgets are of no use if they are not at the service of human beings in all their diversity and wealth; in other words, if they do not guarantee people's rights.

Forty years after Alma-Ata, the premises remain the same, but our capabilities have increased, as has the conviction that we can do better. We must continue on this long path, working actively to make health an irrefutable, unquestioned, and unrenounceable human right.

Michelle Bachelet Jeria
United Nations High
Commissioner for Human
Rights

Preface

In the 20th century, one of the most revolutionary public health reports ever to be published was prepared in Canada and named after the country's Minister of Health at the time, Marc Lalonde. The Lalonde Report affirmed that health and disease are not related only to biological factors and infectious agents; rather, most diseases have a socioeconomic basis or origin.

According to the report, 90% of health issues are related to lifestyles, environmental factors, and human biology, and only 10% to health systems. It also warned of an inverse relationship with health resources, 90% of which were allocated to health care and very little to other relevant factors.

A new perspective on health care began to evolve, summarized in the World Health Organization (WHO) definition:

«Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity»

The first International Conference on Primary Health Care was held in 1978 in Alma-Ata, framed by this process of reformulating the concepts of health and health care. The Declaration of Alma-Ata, adopted by the Conference, reaffirmed the right to

health as a fundamental human right of all people. Its definitions have led to an understanding of primary health care (PHC) as a political strategy by which governments and civil society can transform health systems and the processes of social determination of the population's health.

Today, we accept the challenge and the call by PAHO Director Dr. Carissa F. Etienne, who convened the High-Level Commission "Universal Health in the 21st Century: 40 years of Alma-Ata," to reflect on this legacy, which is expressed in our collective vision.

In these 40 years, we have amassed knowledge and experience in health, but the agenda remains unfinished: There are

goals yet to be met and millions of people who lack access to the right to health. We reaffirm that PHC is a sustainable path to achieving universal health, understood as a right of all people, with quality, equity, and social justice, through State policies that guarantee these rights, respect diversity, and have sufficient and equitable economic resources, strengthening communities as a transformational factor, so that no one is left outside the health system.

PHC is a concept that forms part of a proposal for the social, political, and technical construction of the right to health for all, especially for those in conditions of vulnerability and social exclusion.

This vision and these premises guided the discussions and recommendations made by the Commission in this report.

One of the most important legacies of the Declaration of Alma-Ata —and of ancestral health care traditions— is the idea that

the transformation of health systems should stem from a new model of care focused on the health needs of the population, guaranteeing equity and social justice.

In our discussions, we noted the growing inequality in the world and the very high concentration of wealth, as well as a development model that is harmful to the environment and public health, making the quest for universal access to health and universal health coverage still more necessary.

Another element very present in our discussions was the role that social determination processes play in health development. Hence the importance of discussing the health system and universal access and coverage in dialectic interaction with comprehensive social protection systems, including education, housing, and social security, among other components.

Social inequality is a historical and structural feature of societies in our Region, strongly associated with productive structures and sociocultural conditions, and manifested in institutions, customs, and practices throughout history. It is important to emphasize that inequalities in our societies refer not only to inequalities in income, access to productive and financial resources, and property, but to countless disparities that we have discussed and systematized, namely: socioeconomic; gender-based; ethno-racial; territorial and environmental impact; life-course-related; disability-related; those related to sexual orientation and gender identity; and disparities related to migratory processes. These inequalities are intertwined, exacerbated, and interconnected throughout the life course, thus creating a matrix of social inequality that must be addressed if we are to advance toward improvement. In some countries of the Region, we see the persistence or reemergence of poverty-related infectious diseases, social exclusion,

and changes to the physical and economic environment that reveal the limitations of health systems and other social policies.

At the same time, as the result of progress with coverage and social protection in most of the countries of the Region, health processes have become focused on noncommunicable diseases (NCDs), which perhaps are better referred to as "socially transmitted diseases." This is occurring in the context of the emergence of new socio-economic, demographic, and environmental factors, such as the consolidation of an economic model based on globalization and private sector expansion, increasing commercialization of living conditions, greater urban growth, and irregular and forced migration of populations.

A very important issue in our discussions was the use of comprehensive public health policies as a strategy to address the common risk factors for NCDs (tobacco and alcohol use, sedentary lifestyles, and unhealthy diets). In this context, we focused on three other key areas of health-disease processes: the emergence of mental disorders due to psychoactive substance use, road traffic injuries, and interpersonal violence, which are among the leading causes of disability.

Public health policies are not limited to prevention. It is also essential to initiate health promotion plans aimed at developing activities and lifestyles that foster health through collective and individual action.

It is clear that the Region of the Americas continues to face significant challenges as it strives to guarantee the right to health for all. In the 21st century, with our accumulated knowledge and experience, technological advances, and available resources, social exclusion and health inequities are unacceptable; but at the same time, they can be overcome. In the Inter-American system, we cannot continue predicating and promoting de-

mocracy, human rights, security, and comprehensive development without also focusing on an issue as essential as the health of our peoples. In this report, the Commission presents proposals for action, some of which have already been heard in the Region and around the world, but which are imperative for the achievement of universal health.

We are convinced that through the political will of States and concrete actions to produce the necessary changes in health including fostering real, inclusive, accessible social participation and effective accountability mechanisms, we will achieve health for all and sustainable human development.

The Commission is grateful for the leadership and contributions of Dr. Michelle Bachelet Jeria, who guided its work from the time it was formed until September 2018, when she became United Nations High Commissioner for Human Rights. In this new position, I am sure she will

continue working actively with us toward making the right to health and other related human rights a reality for our peoples in the 21st century.

Ambassador Néstor Méndez
Assistant Secretary General, Organization of American States

President of the High-Level Commission: "Universal Health in the 21st Century: 40 Years of Alma-Ata"

Introduction

To mark the 40th anniversary of the Declaration of Alma-Ata, the Pan American Health Organization (PAHO) convened the Regional Forum "Universal Health in the 21st Century: 40 Years of Alma-Ata" on December 11-12, 2017, in Quito, Ecuador.

As part of this regional movement, PAHO Director Dr. Carissa F. Etienne convened a High-Level Commission: Universal Health in the 21st Century: 40 Years of Alma-Ata, chaired by Dr. Michelle Bachelet and Ambassador Néstor Mendez, and made up of an interdisciplinary group of regional experts, including representatives from communities and academia, as well as political actors, such as former health ministers, trade union leaders, and representatives of different social movements.

The objective of the Commission was to develop recommendations for the PAHO Director on how to give effect to the right to health as a fundamental human right, based on an analysis of the progress and challenges faced by health systems in the Region of the Americas.

This document reflects the Commission's position regarding primary health care (PHC), the search for solutions to ensure the right to health, and the approach taken in discussions, analysis, and recommendations on how to guarantee this right. It is based on reports prepared by the five thematic groups addressing: a) health care model, b) institutional model, c) financing model, d) health and social protection, and e) human resources for health

(see annexes to the present report). The thematic groups were led by members of the Commission, bringing together a great number of academic experts and social movements from different countries in the Region. In this report, the Commission presents 10 recommendations for achieving health for all in the Region of the Americas in the 21st century.

The Commission also participated actively in the processes that produced the new declaration on primary health care (Declaration of Astana), adopted by the Global Conference on Primary Health Care held in Astana (Kazakhstan) in October 2018. This global and regional discussion forum was very timely, not only enabling the Commission to advocate for the values and principles of Alma-Ata, which remain valid today, but also enriching this report by emphasizing key aspects that the Commission believes cannot be overlooked in order to achieve universal health.
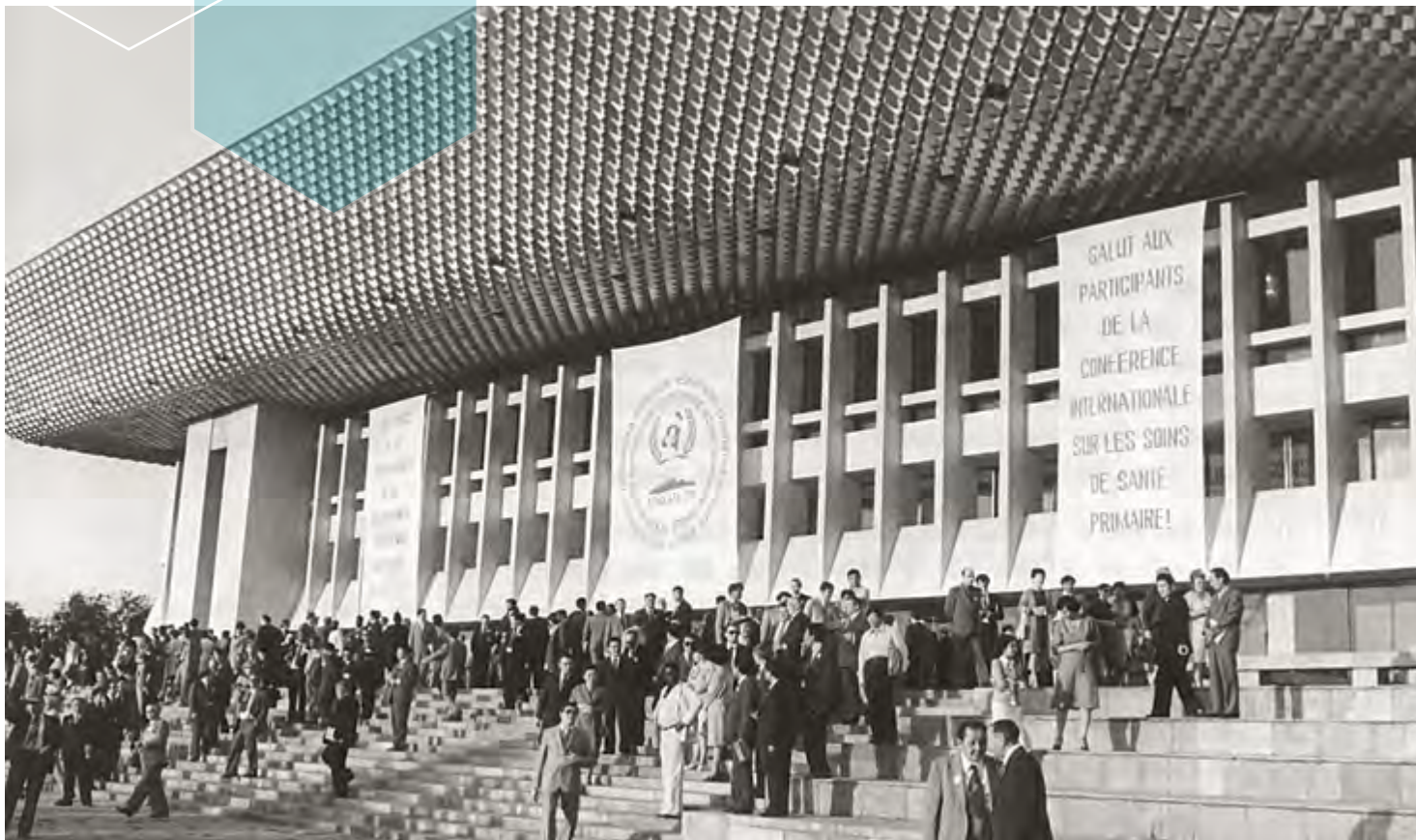
VISION AND PREMISES OF THE COMMISSION

The International Conference on Primary Health Care, held in Alma-Ata in 1978, remains at the heart of discussions on public health, health policy, and human development. The Declaration provided a visionary framework for advocacy and action, asserting the right to health as a fundamental human right of all people. It meant that PHC could be interpreted as a political strategy of States and civil society to transform health systems and intervene in the processes of social determination of the population's health.

One of the most important legacies of this declaration is the idea that the transformation of health systems should be based on a new model of care focused on a coordinated approach to health needs, with an integrated response from the State that incorporates intersectoral interventions and that impacts on the processes of social determination of health.

In these 40 years, we have generated and accumulated knowledge and experience in health. At the same time, we face an unfinished agenda, targets to be met, and millions of people without access to the right to health.

In this new context, we reaffirm PHC as a necessary and sustainable path towards the achievement of universal health, which is a right of all people, with quality, equity, and social justice; with State policies that guarantee this right and respect diversity; and with economic resources that are sufficient and equitable; while strengthening communities as a means to transform realities so that no one (citizens and non-citizens) remains outside the health system. For this reason, the slogan "health for all" constitutes an ongoing and fundamental imperative.

This proposal is based on the human rights framework, which recognizes human diversity as its

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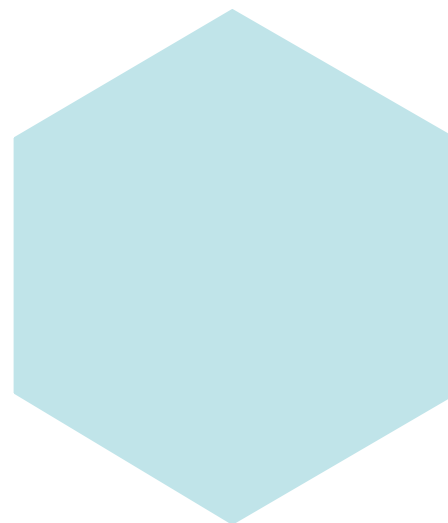
foundation, and a key aspect for improving health care. Awareness and characterization of human diversity make it possible to formulate and interpret the State's responses to people's differentiated needs, as a key aspect of guaranteeing equity and dignity.

This document embraces the concept of the social inequality matrix as a way of understanding how the confluence of multiple and simultaneous forms of discrimination and exclusion lead to mutually reinforcing inequities in health and other areas of social development. This concept challenges us to consider people's realities and experiences in a holistic manner, rather than compartmentalizing them, in order to create policies that more effectively address this complexity. This perspective also emphasizes how social relations and asymmetries of power affect the exercise of people's rights, including the right to health.

According to the "social determinants of health" approach, health inequities are the result of the circumstances in which people are born, grow up, live, work, and age, circumstances that in turn are shaped by asymmetries in the distribution of money, power, and resources. But while recognizing the progress represented by the social determinants approach and the importance of incorporating this approach into the Sustainable Development Goals (SDGs) as a strategic instrument for global development, we also believe that the approach must be deepened by including critical scrutiny of the consequences of unsustainable economic development models. We find the "social determinants" approach insufficient in that it can be compartmentalized and even decontextualized without asking why, for whom, and for what purpose such determinants arose.

The present document reflects a "social determination" approach that requires us to act on our societies' social processes and power dynamics, interpreting them within the historical framework that replicates and perpet-uates them, thereby intensifying inequities.

The social inequality matrix complements the social determination approach by recognizing inequality as a historic and structural characteristic of the societies in our Region, and by identifying elements that shape the circumstances of people's lives. These include socioeconomic conditions, gender, race, ethnicity, place of residence, stage of the life course, and others, such as disability, migratory status, and sexual orientation and gender identity.

Health, determined by social processes and power dynamics, is intrinsically related to other dimensions of well-being, such as access to housing, basic services, education, decent work, social protection, and political participation, among other things. The structural forces of inequality intersect and strengthen one another, and they manifest themselves in the violation of rights.

BACKGROUND AND CHALLENGES

The Declaration of Alma-Ata was framed with the goal of health for all. Since then, in the Region of the Americas, it has served as a reference point to guide the transformation of health systems, but it also represents a milestone that allows us to examine pending challenges and update its message in new contexts.

The Declaration has inspired a number of regional strategies and initiatives that have generated a wealth of experience, in implementation and advocacy, characterizing the evolution of PHC in the Region. The local health systems proposals of the 1980s, the Declaration of Montevideo in 2005 and the Pan American Health Organization (PAHO) publications on the Renewal of PHC in the Americas and the Integrated Health Services Networks (IHSNs) are just a few examples of initiatives in line with Alma-Ata. With the renewal process in the early 2000s, PHC came to be seen as a potential strategy for the transformation of health systems and as an intervention on the processes of social determination of health.

However, despite significant progress in recent decades such as innovations in insurance and greater public spending on health, conditions of health inequality and inequity are persistent and deepening in many countries of the Americas.

The pending challenges are considerable. Eradication of poverty and extreme poverty and reduction of inequality in all its dimensions continue to be central challenges for the countries of the Americas. Although the Region made important advances in this respect between the beginning of the last decade and the middle of the present decade, this progress has been eroding since 2015, particularly with respect to extreme poverty. Also, high levels of inequality are an obstacle to development, impeding poverty eradication,

the expansion of citizenship, the exercise of the right to health and other rights, and democratic governance.

Inequalities involve not only income, but also disparities in access to and use of resources, opportunities, capacities development, and recognition. The social inequality matrix in the Region is shaped by the production matrix and by a culture of privilege, a historic feature of societies in the hemisphere. In addition to socio-economic stratification, inequality in the Americas is characterized by other structural dimensions, including gender, ethnicity and race, territory, life course, disability, migratory status, and sexual orientation and gender identity. The structural dimensions of the social inequality matrix intersect, reinforce each other, and solidify throughout the life course, generating multiple factors of inequality or discrimination that interact simultaneously and accumulate over time and generations.

Social protection systems and health systems in the countries of the Region have been unable to eliminate health inequities. One of the main shortcomings of health systems in serving the needs of the population is seen in the persistence of various access barriers. These constraints are due to the paucity of efforts to transform health systems on the basis of a new model of care. Persistent problems include an approach that is predominantly hospital-based, health services that lack sufficient human resources, insufficient training in PHC, limited social participation, lack of public resources, and inadequate infrastructure.

Moreover, reform agendas exclusively focused on the health sector, medical services, and the expansion of insurance coverage have displaced public health and the processes of social determination of health as factors that shape the State's response to the population's health needs.

The persistence and reemergence of certain infectious diseases associated with poverty, social exclusion, and changes

in environmental and economic conditions highlight the limitations of health systems and other social policies. Inequitable health conditions are reflected today in a chronically high burden of communicable diseases in some countries for certain social groups and in the poorest regions, with a still high number of preventable maternal and infant deaths, including those due to nutritional deficiencies, which is totally unacceptable and, in some cases, continuing to grow.

Finally, the unmet goals of the Declaration of Alma-Ata reflect political processes that have not managed to represent the interests and rights of the population in conditions of vulnerability; nor have they sustained the important transformations in institutional rules that are necessary to eliminate the many barriers to access health. The role of the private sector is growing in health services delivery, health insurance, and the creation and production of medicines and health technologies, but also in national and

global political power processes that wield major influence on the "rules of the game" and that determine which interests and values benefit from the institutional model of economic relationships, from the structure of the State, and from the health system.

Our pending challenges need to be examined within a new context, with new problems demanding innovative responses to the political, social, and economic factors that determine

the health and health equity conditions of the population in the 21st century. Today, the social determinants of health include new and interrelated socioeconomic, demographic, and environmental factors. The emergence and consolidation of an economic model based on globalization and an expansion of the private sector, with increasing commercialization of living conditions and greater demographic urbanization, has consequences that include environmental deterioration, environmentally unsustainable conditions, and climate change, along with the reproduction of economic and social exclusion and the forced migration and displacement of populations.

Some of these conditions have led to an increase in noncommunicable diseases, greater prevalence of mental health disorders, and new barriers to access health for people with different types of disabilities, as well as a rise in road traffic injuries and an upsurge in violence in different areas, such as gender violence, violence associated with unlawful activities, and armed conflict.

These new conditions pose challenges that call into question the status quo in terms of the type of State response needed to guarantee the right to health as a fundamental human right. It is necessary to strengthen health systems and integrate them into social protection systems capable of influencing the social determination of health.

Several regional and global mandates express the commitment of States to social rights as fundamental points of reference for interpreting challenges and opportunities. The 2030 Agenda for Sustainable Development, adopted in September 2015 by the United Nations General Assembly, is a global capstone in this regard. The scope of the 17 Sustainable Development Goals (SDGs) stated in the Agenda requires integrated and collaborative approaches to address the causes of health inequities

in the Region, acknowledging health as a human right in all its dimensions. The SDGs are an important tool for addressing social determinants with the support of Heads of State since they serve as a policy instrument of strategic political and global relevance, involving all State sectors, with strong international positioning and the commitment of the entire United Nations system. Nevertheless, it is necessary to recognize the possible contradictions of including objectives and recommendations that reflect a development model based on indefinite and hence unsustainable economic growth. In this context, it is essential, while valuing the global scope of this political agenda, to stress the need for a human development model that features social inclusion and natural and environmental sustainability.

With the same approach, in October 2014, PAHO Member States adopted the Strategy for Universal Access to Health and Universal Health Coverage. This Strategy is a response to ongoing challenges in health, especially inequities in the conditions of access to comprehensive health services, and it goes beyond an understanding of universal coverage as merely coverage of the population. Rather, it includes equitable access to health and to quality, comprehensive health services as key objectives of the transformation processes.

How to guarantee the effective exercise of the right to health as a fundamental human right

The fundamental premise of this proposal is that the right to health is a fundamental right and that the State is fundamentally responsible for making its exercise a reality.

Pronounced health inequities and their determinants are a result of the State's limited ability to strengthen social protection systems and health systems that guarantee the right to health. This is occurring in a context where the private sector plays a more influential role, not only economically, with an increasing

concentration of wealth, but also politically, with marked asymmetries of power, both at the global and national levels. In this context, a basic premise informing the Commission's work is the need to strengthen State responsibility and commitment to the right to health as a fundamental human right.

This premise has the following three linchpins: 1) care models with intersectoral interventions; 2) political and institutional processes; and 3) key resources.

The first linchpin refers to care models with intersectoral interventions. Care models must be centered on people and communities in their territories, which implies recognizing diversity as an essential human characteristic and incorporating intersectoral interventions that affect the social determinants of health.

The exercise of the right to health requires equitable conditions for effective access to interventions by the health sector and other institutional sectors. The different access barriers to these interventions, heavily influenced by the social inequality matrix in the Region, indicate the pending challenges we face. Eliminating these barriers requires a people- and community-based care model with an intercultural approach that addresses the processes of social determination of health.

From this perspective, a people- and community-centered model of care is an expression of the State's response to people's needs and to the diversity of people's living conditions. It is also the result of the political and institutional processes advanced in the course of transforming health systems.

The second linchpin involves political and institutional processes that provide content and support for the transformation of health systems, and for social protection systems. The State's responsibility for guaranteeing the right to health depends on political processes that provide viability and legitimacy to the necessary institutional changes. These national processes must be coordinated with regional and global entities.

In this framework, accountability is a valuable mechanism to involve actors at different levels. Political processes should strengthen participatory democracy through comprehensive public policies and institutional processes that involve relevant

actors in the health sector and in the social protection system. Democratic processes give the States legitimacy, and the deeper and more participatory the democracy is, the more congruence can be expected between the actions of the State and the public interest.

Political processes also involve power relations between different actors (State and non-State, national and supranational) that can influence the institutional framework that promotes and supports the processes of social determination of health.

In order to provide leadership for the complex institutional processes needed to transform social policies, it is crucial and in the public interest to strengthen the technical and political capacities of governmental agencies, as well as other actors committed to these values. And it is essential to work for the empowerment and participation of actors in conditions of vulnerability, in order to defend and protect their rights. For this reason, it is necessary to forge broad partnerships with a

variety of stakeholders that have varying viewpoints and strengths but that are guided by the same core values.

Institutional processes focused on the right to health involve structural changes in the State and in the social norms that underlie the social inequality matrix. These changes require innovation in the structures and functions of the State in different institutional sectors. This can be accomplished through a stronger social protection system and a stronger health system, with funding sources provided by progressive tax systems, and with solidarity-based, equitable pooling mechanisms.

With regard to the third linchpin, the ability of the State to respond to health needs requires key resources that strengthen health systems and social protection systems. These key resources are human, technological, and financial in nature, and they are all indispensable for institutional transformation. In order to develop people- and community-based care models, health workers must be competent, available, and committed.

Technological resources are needed to address the population's health needs, and public resources are essential to finance the development of a care model in conditions of equity.

These key resources have two important characteristics: First, they are necessary to meet the health needs of the population; and second, the availability and allocation of these resources depends on the necessary political and institutional processes.

RECOMMENDATIONS

SYNTHESIS

1 Ensure an institutional model that enables the State to meet its ineluctable responsibility to guarantee the population's right to health within the framework of human rights.

2 Develop people- and community-centered PHC-based models of care that take into account human diversity, interculturalism, and ethnicity.

3 Create social participation mechanisms that are genuine, deep, inclusive, and accessible, with a perspective of intercultural and functional diversity to guarantee full exercise of the right to health.

4 Establish mechanisms to regulate and oversee the private sector in order to align it with the objective of ensuring the right to health.

5 Eliminate the barriers to universal access to health.

6   *Address the processes of social determination through intersectoral health interventions that promote substantive changes in the environmental, social, economic, housing, and basic infrastructure conditions of a population in a given territory.*

7   *Reposition public health as an axis of the State's response for the transformation of health systems.*

8   *Recognize human resources as protagonists of the construction and consolidation of PHC-based models of care.*

9   *Promote rational use and innovation in technological resources to serve the population's health needs.*

10   *Develop a financing model that ensures sufficiency, quality, equity, efficiency, and sustainability.*

RECOMMENDATION 1

Actions

- Develop the necessary legal and regulatory frameworks to guarantee the full exercise of the right to health for all.

- Establish institutional structures and processes that enable health authorities to fulfill their responsibilities. This includes stewardship and regulation of health systems, and capacity for intersectoral coordination to address the processes of social determination of health.

- Ensure that health-related competencies at the different levels of State de-concentration and decentralization are clear and complementary, for an intercultural approach that is appropriate to the needs of a diverse population, while seeking to reduce inequities.

- Implement mechanisms for accountability, including the production of timely, accessible, quality information to guarantee the exercise of the right to health.

- Link national and supranational processes to build synergy and have greater impact on the key institutional arrangements in the health system.

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Recommendation 1: Ensure an institutional model that enables the State to meet its ineluctable responsibility to guarantee the population's right to health within the framework of human rights.

This involves developing legal and regulatory frameworks that define institutional models, organizational structures, assignment of responsibility, and allocation of necessary resources. This is especially relevant to public institutions responsible for guaranteeing the right to health. Effective accountability mechanisms should also be included.

To accomplish this, national processes should be coordinated with supranational processes to create synergy and more effectively influence the institutional arrangements that facilitate effective access to the right to health. In this context, it is necessary to strengthen the United Nations entities associated with the reports that the States Parties submit to the United Nations Human Rights Council and the United Nations human rights committees that function with the support of the Office of the High Commissioner on Human Rights. This approach will link the concept of health with a broader notion of sustainable development for the well-being of all people, regardless of their age or where they live.

Unless governments have the political will and explicitly take responsibility for the changes required to guarantee the population's right to health, especially for people in situations of social exclusion, the right to health will remain a formal declaration with no effective response.

It is governments that are responsible for establishing institutional mechanisms that respect and protect the full exercise of the right to health. These mechanisms are political, regulatory, administrative, and judicial, and they need to have a complementary and coordinated approach. The right to health is guaranteed by strengthening the political and technical capacities of all State institutions, agencies, and entities in order to address the economic, social, and cultural di-

mensions that shape health/disease processes and that are expressed in them.

There is a legitimate right to judicialize health in order to ensure access to health, but this should be a last resort, since the political and institutional complexity associated with this approach can reproduce inequities of access to health services. The judicial system has increasingly been used in recent decades to ensure access to goods and services for which demand has not been met; however, it is important to realize that in many cases these processes increasingly reflect pressure from other private-sector stakeholders, using judicial action as a mechanism to introduce new health technologies without adequately considering criteria such as equity, efficacy, safety, cost-effectiveness, and ethical consideration associated with such interventions. When this occurs, the judicial decision impacts other functions of the State, especially within institutions that govern the health system, limiting their influence and impeding their capacity to act. This can fragment the State's ability to address the political, institutional, and economic challenges and ultimately limit the exercise of the right to health.

These situations can put pressure on the workings of the health sector, especially when prioritizing resource allocation, and on strategies to enhance conditions of access and coverage of health services for the population groups in greatest need.

To avoid these problems, different sectors and branches of the State should operate in an integrated manner. Accountability mechanisms are a way to strengthen the commitment of health authorities to the full exercise of the right to health, considering each national context.

Linchpin 1: The model of care with intersectoral interventions

The first linchpin of the Commission's recommendations involves creating a people- and community-centered model of care as the best strategy for ensuring that the population's diverse needs, conditions, and characteristics will be addressed. This linchpin emphasizes the organizational model of health services provision as the element that guides the State's response to its population's health needs.

RECOMMENDATION 2

Actions

- Develop a comprehensive and integrated health model that "cares more and cures what is necessary," promoting the health of ecosystems and Mother Earth on the path to Good Living, based on PHC and with a community, intercultural, territorial, and intersectoral approach.

- Promote integrated health services networks (IHSNs) with a responsive first level of care, supported by specialized services (including hospitals), in order to guarantee effective access to timely, quality, and continuous health services to all.

- Allocate the necessary financial resources to guarantee proper access to health services, spending at least 30% on the first level of care.

Recommendation 2: Develop people- and community-centered PHC-based models of care that take into account human diversity, interculturalism, and ethnicity.

PHC is a strategy for transforming health systems through a comprehensive people- and community-centered model of care. This approach depends on a responsive first level of care integrated within comprehensive health service networks (IHSNs), including complementary and intercultural medicine.

The integrated PHC model of care is in itself comprehensive, rights-based, territorially focused, family-oriented, community-based, pluri-ethnic and intercultural, solution-oriented, and intersectoral. In the digital context of the 21st century, PHC provides the opportunity to drive effective mechanisms for democratic and truly community-based social participation by utilizing technological advances in communication. Doing this requires eliminating barriers to real-time digital communication between health teams and communities (from health teams, to the community, and back to the health teams) in order to construct the PHC approach on the foundation of a defined territory and a specific community. This PHC concept requires a platform that can drive health in all policies, and that can act on the social determination of health in the 21st century.

The creation of IHSNs requires the development and strengthening of functions such as governance, as well as the organization, management, and allocation of adequate resources. In this context, the comprehensive health model should have at its disposal the necessary resources to guarantee real and effective access for all people to quality, timely, and continuous health services.

As a strategy to overcome the system's fragmentation and segmentation, this model should have as extensive a reach as possible within the health system. A strengthened first level of care should foster social participation, functioning as a node connecting with other organizations (both public and private) and with institutions at different care levels, including specialized levels (i.e., hospitals). In this framework, no less than 30% of the health system's expenditure should be allocated to the first level of care in order to ensure its prioritization and promote its strengthening.

This model calls for health teams that employ a transdisciplinary approach which facilitates coordination between the

different levels. It centers on promoting healthy living in everyday life; the ecosystem; and a care system focused on health promotion, disease prevention, people's recovery from illnesses and disease, rehabilitation, and palliative care, with nodes that provide support from specialists when required.

This proposal employs a health network concept that incorporates not only the formal institutional sector, but also community actors and intersectoral areas. This approach to the organization and management of health services includes planning at the local level, with mechanisms to guarantee social participation, as well as comprehensive monitoring and evaluation of the health care provided to groups in conditions of vulnerability. Communities that are informed and educated on health promotion and primary disease prevention are fundamental in this regard. In addition to participating fully in decisions on their own health care, these communities must be full participants in the system's decision-making, helping to shape the design of policies and services. This proposal is further consolidated by a management model that is based on the establishment of trained health teams assigned to a given territory and provided with care guidelines to address the health problems of the defined population.

Reorienting a biomedical care model toward a PHC-based model involves adopting strategies that put people and communities at the center, and that incorporate ancestral traditional medicine, complementary medicine, and interculturalism. The health care model must take account of ethnic and cultural diversity, immigration status, gender, life course, sexual orientation and gender identity, and disabilities.

We recommend a comprehensive health model that offers more care and only the necessary treatment, promoting the health of ecosystems and of Mother Earth to achieve "Good Living" *(Buen Vivir)*. Rather than a system focused on curative care—indeed, one that neglects care and dehumanizes health care—we propose more care for patients, for caregivers, and for ecosystems affected by industrial ruin and pollution.

The Region of the Americas has great cultural diversity and deep ancestral roots. In order to overcome cultural barriers, its health systems should adopt measures that incorporate this cultural diversity. This should be done by fostering dialogue and points of connection between the diverse cultures of different social groups, such as indigenous populations and people of African descent, ensuring that their historical and cultural roots are taken into account, as well as their

world views regarding approaches to health and disease. This means respecting ancestral traditions and taking a comprehensive approach to human beings that goes beyond bio/psycho/social aspects and incorporates the spiritual dimension.

This model protects the planet's diverse ecosystems and makes it possible to advance toward non-polluting energy generation and responsible production and consumption, while ensuring access to the resources needed to sustainably ensure life with dignity. In this context, we propose to preserve ancestral knowledge and traditions as a part of a territory which is at the service of caring for Mother Earth, plants and animals, human beings, and the natural environment itself. Our reference to Mother Earth points to Good Living as a paradigmatic change of the horizon within which life unfolds, as a search for harmony in which respect for the life of the creatures sharing our Earth is a necessary condition for guaranteeing the right to health in a framework that sustains the natural world.

Successful experiences with intercultural policies in indigenous populations in our hemisphere must be promoted and learned from. We must delve deeper into the complementarity and diversity of knowledge provided by conventional medicine, ancestral traditional medicine, and complementary medicine, and thus advance toward a broad approach to health that includes Mother Earth (who sustains our human community), while integrating the various healing practices in widespread use in our Region. Some major institutional advances have promoted such complementarity, with providers of ancestral healing services such as midwives, traditional healers, herbal healers, and spiritual guides, among others, playing an integral role as health workers who serve the population and collaborate with conventional health services.

Linchpin 2: *Political and institutional processes*

Political processes that strengthen the State's response require not only the legitimacy and support provided by social participation, but also the regulation of private interests whose position threatens the values associated with the right to health, solidarity, and equity. Institutional processes aimed at the health system transformation involve changing the rules of the game to redefine the responsibilities and structures of the State in terms of how it guarantees the exercise of the right to health.

RECOMMENDATION 3

Actions

- Design and implement legal frameworks that define participation and representativeness, with community-based mechanisms. These frameworks should sustain effective participation and consider the diversity of communities and social organizations, while involving health workers in these processes.

- Develop mechanisms to link recommendations arising from social participation forums with health-related decision-making processes.

- Finance participation processes with State funds, focusing on the public interest.

- Develop mechanisms for training and communicating with members of civil society organizations to strengthen their participation.

*Recommendation 3: **Create social participation mechanisms that are genuine, deep, inclusive, and accessible, with a perspective of intercultural and functional diversity to guarantee full exercise of the right to health.***

Although the health sector has provided opportunities for participation with successful results in different initiatives (priority programs such as immunization and HIV), and has led social mobilization (health councils and the health movement promoted by Brazil's Unified Health System), there is a growing trend toward a culture that is based on the individual and is less committed to the values of equity and solidarity.

An examination of social participation processes raises fundamental questions relating to the overarching objectives of such participation, definition of the agenda, and the channels and stakeholders involved in such processes. With respect to the objectives, social participation in the health sector represents an opportunity to deepen participatory democracy and empower the population to influence the processes that affect health in all areas.

Health systems in countries seeking to universalize access are undergoing institutional transformations that involve ongoing tension over the distribution of resources and power. As part of democracy-building, this involves not only ensuring basic health conditions for the poorest people, but also making the right to health a core element of human rights.

As part of the agenda for social participation, this perspective incorporates interventions that address living and working conditions and strengthen public policy-making. In this context, we propose that participatory processes exert a real influence on identifying health problems and their causes, formulating policies, and implementing and evaluating them.

Social participation should not be limited to validating decisions already made in the halls of power. Such participation should be influential, and authorities must be held accountable on the key issues that drive social transformation and health system transformation.

Promoting channels of participation in the human rights framework requires going beyond participatory forums that systematize the opinions, expectations, and needs of the citizenry.

In order for the results of participatory processes to influence public policy decisions on health, they must be binding.

Channels for participation should be protected by legal frameworks that define elective mechanisms and representativeness criteria. They should also consider the diversity and needs of the social groups that make up the community.

Moreover, social participation processes can serve as mechanisms for oversight of the State employees and entities that play a key role in achieving quality and equity in access to health services.

Institutional models should establish mechanisms that include public education and communication with civil society (organized and unorganized), in order to strengthen public participation. These mechanisms should facilitate the public's ability to identify and interpret problems and formulate health policy solutions. They should also help to link the population's demands, especially those of various organized and unorganized social groups, with responses that support the sustainability of health system strengthening and transformation processes.

The promotion of social participation should also be a mechanism to foster cohesion and social justice. Accordingly, participatory channels should be identified that effectively serve to democratize health services while advancing institutional transformation processes that generate relevant institutional change.

Finally, it is essential to identify and empower stakeholders who should be included in social participation in order to ensure institutional transformations and protect the rights of the social groups living in the conditions of greatest vulnerability.

The participation of society, and especially social movements, is a necessary condition for the democratic construction of the right to health in the framework of human rights. Social participation is part of the process of building partnerships. It alters existing power relationships and makes it possible to ensure the political sustainability of transformative processes in state policies and institutions that guarantee the right to health.

When identifying the stakeholders involved in the process of social participation, it is necessary to consider the diversity of each country's communities and social organizations, not relying merely on criteria of representation. Full participation by civil society requires guaranteeing access to participation without leaving anyone out. It is important to make whatever reasonable adjustments are needed so that participation mechanisms work in the context of the people's diverse conditions and capacities, allowing social participation to take place in accordance with the population's needs, interests, and cultural conceptions.

We must ensure that social groups in conditions of vulnerability are able to participate in ways that benefit their own conditions of accessibility. This includes access to the physical environment, transportation, information, communications, technology, processes, procedures, and goods and services, both in urban and rural areas. Health workers and health teams must play a leading role in social participation processes. Without active actors who are committed to creating services and interventions that address the social determination of health, it is impossible to sustain highly politically complex transformative processes.

RECOMMENDATION 4

Actions

- Strengthen the stewardship capacities of the national health authorities to regulate the private sector, based on the public interest and in line with the objectives and strategies of national health policies.

- Develop mechanisms for evaluation and oversight of the private sector. Equitable access to quality health services is a key aspect.

- Strengthen State structures to facilitate the private sector's contribution to processes aimed at the well-being and health of people and communities, while managing conflicts of interest.

Recommendation 4: Establish mechanisms to regulate and oversee the private sector in order to align it with the objective of ensuring the right to health.

During the past four decades, both the influence and complexity of the private sector have grown significantly in a number of critical areas of the health system: development and provision of technology, delivery of health services, management of financial resources, and growing political influence on the institutional framework at the national and global levels. Outside the health sector, it should be emphasized that globalization and commercialization of living conditions and consumption mean that private markets for the mass consumption of goods and services have also become determinants of the population's health status.

Private sector strategies and expansion in health systems have brought different innovations, playing an ever more influential role in their operation. Given that the growing participation of the private sector can be attributed to the profit motive, it is important to recognize the challenges that this poses in terms of working toward more equitable conditions of universal access. The private sector is also increasingly present through non-governmental organizations and in the form of donors and funders, with heavy influence on the agenda of international organizations and on the global health agenda. This influence must be put to the service of strengthening the stewardship of health authorities and supporting national health policies.

In this context, there is a need for a broad agenda to strengthen and modernize State institutions and facilitate the private sector's contribution to innovation to advance toward universal health. It is essential to establish regulatory and oversight provisions that meet the standards set and take the population's well-being as their goal, using mechanisms that provide transparency and accountability over governmental entities responsible for regulating the private sector. Equitable access to quality health services should be a key aspect of evaluation and oversight of these mechanisms.

RECOMMENDATION 5

Actions

- Analyze the living conditions of the population (including migrants), considering the geographical, social, and cultural issues of the population in each territory, and the diversities and inequities within them.

- Implement initiatives to eliminate the various access barriers to health services and to all interventions that impact the health of the population.

Recommendation 5: Eliminate the barriers to universal access to health.

The analysis and formulation of initiatives to eliminate access barriers to health services and all interventions that impact the population's health are indispensable components of the processes of formulating and implementing the necessary transformations.

This recommendation encompasses all the above proposals, since it is necessary to recognize organizational and institutional factors related to barriers arising from the limited capacity of the model of care to respond to the population's needs.

In adapting the model of care and the organization of health services to the needs and characteristics of the population, both the epidemiological conditions of the population and the diversity of its social and economic conditions should be considered.

Even when coverage for health services exists, effective access can be limited by barriers that act simultaneously. These include economic, linguistic, and cultural barriers, lack of physical or communicational accessibility to facilities as a result of disability, and attitudinal barriers (prejudice, discrimination, or stereotyping by health workers) that can limit access for indigenous, Afro-descendant, LGBTI, and disabled people, as well as migrants and persons living in conditions of social exclusion.

This approach also involves territorial analysis of the population's living conditions (both citizens and migrants), considering geographical, social, and cultural factors, as well as diversities and inequities. These factors include health needs, working conditions, cultural and traditional constructs, and everyday activities, among others.

This approach also analyzes the various responses of the State, its social initiatives and social policies, and the development and deployment of strategies to expand services with a PHC approach. The objective is to identify geographical access barriers related to the availability of resources, and to explain existing gaps between resource allocation (financial, human, technological, and infrastructure-related) and population needs.

In order to address cultural barriers, a people- and community-centered care model with an intercultural focus and participation in decision-making on health services is essential. Out-of-pocket payment for services should be eliminated to reduce the economic barriers facing the population.

There are other types of institutional barriers, such as people's lack of access to information about their rights and about the way services are offered and operated.

Social protection can be an important tool to overcome access barriers to health services. The inclusion of complementary health provisions and interventions (i.e., conditional transfer programs) can stimulate the demand for health services, often in remote rural areas or marginalized urban areas where services are nonexistent or of poor quality.

These programs can facilitate access to health services, provided that sufficient resources are present and used in a framework of transparency and accountability. Field workers in social protection programs are especially well positioned to interact with populations in conditions of vulnerability. They can also help health services overcome typical access barriers to specific groups, using public policies to reduce unjustifiable disparities and discrimination are helping to close access gaps faced by indigenous and Afro-descendant populations.

RECOMMENDATION 6

Actions

- Develop and strengthen universal, integrated social protection systems throughout the life course to reduce inequities in health, including specific actions to address inequalities in the Region.

- Implement intersectoral actions that recognize cultures and traditions, addressing inequalities and including policies on education, housing, habitat, employment, and regulation of wages and working conditions.

- Develop affirmative policies for social inclusion in the areas of education, decent work, participation, culture, and communication.

*Recommendation 6: **Address the processes of social determination through intersectoral health interventions that promote substantive changes in the environmental, social, economic, housing, and basic infrastructure conditions of a population in a given territory.***

In order to address the processes of social determination of health, it is necessary to identify, analyze, and address the environmental, social, economic, housing, and basic infrastructure conditions of a territory's population through different types of intersectoral interventions.

The health sector leadership needed to carry out such intersectoral interventions is not self-evident, and the mechanisms for coordination between different social sectors are not natural, conflict-free processes. Health authorities should strengthen their technical and policy-making capacities to build sustainable intersectoral partnerships that operate in different institutional sectors and spheres. Different actors and corporations with their own interests and ideas participate in shaping the regulatory mechanisms that have the greatest impact, and they do so with great asymmetry in terms of power. For this reason, it is the responsibility of the State to guarantee the population's right to health, with the involvement of communities and stakeholders committed to these values.

Intersectoral interventions to impact the social determinants of health can be implemented in different areas. Countries should build and strengthen systems of universal and comprehensive social protection covering the entire life course. And there is growing consensus that social protection is a powerful tool for eradicating poverty, reducing vulnerability and inequality, and fostering inclusive growth. All this has a positive impact on the population's health.

Social protection is a direct buffer against the high costs associated with using health services and can prevent or mitigate the impact of other indirect costs (such as loss of income due to illness or disability, non-medical expenses such as transportation, food, care, etc.). This helps prevent households from falling into poverty, or into greater poverty.

More specifically, social protection and PHC are complementary, mutually reinforcing strategies. For example, where social protection mechanisms focus on reducing risks in the

child population (whether by targeting them directly or by targeting families with children) by ensuring good nutrition and access to quality health and educational services, they can promote the healthy cognitive, emotional, and social development of this population group. This can have positive health effects and can reduce inequities over the long term.

In short, social protection mechanisms act on a variety of fronts to strengthen PHC and ensure a level of health that allows all people to lead socially and economically productive lives. These mechanisms can also be a platform for intersectoral policies that advance people's well-being through a multidimensional, comprehensive, rights-based approach.

Furthermore, growing urbanization, new lifestyles, and the levels and forms of consumption associated with commercialization and economic globalization are increasingly impacting the population's health problems. These conditions require leadership from health authorities, who must be able to promote governance mechanisms and foster political and technical sustainability. This leadership should be exercised in coordination with other State sectors, including other agencies responsible for formulating and implementing public policies that impact health, such as those responsible for education, safety, social development, economics, trade, environment, and agriculture, among others.

Finally, a model of care based on PHC that responds to the population's health needs will depend on interdisciplinary and intersectoral teams with complementary skills, who are responsible for the health of the population in a defined territory. It is crucial for health workers to have the critical capacities needed to address the processes of social determination affecting a population and its territory, and to coordinate policies, interventions, services, and resources from different sectors and social policies.

RECOMMENDATION 7

Actions

- Position the essential public health functions (EPHFs) as a key strategy of the agenda to strengthen and transform national health systems.

- Within health systems, strengthen the planning of public health activities with an integrated approach in the framework of EPHFs.

- Develop comprehensive plans and policies that promote collaboration with communities and with agencies both within and beyond the health sector, in order to reduce the current institutional fragmentation.

Recommendation 7: Reposition public health as an axis of the State's response for the transformation of health systems.

In order to guarantee the right to health, it is necessary to revitalize and strengthen the EPHFs. The process of transforming health systems in the Americas has focused excessively on health insurance coverage, with little attention to the need to improve public health.

A pending challenge is to transform the traditional idea that the health system is limited to providing health services. This idea fails to recognize the interaction that takes place, or should take place, between the health system and other public health activities. It reflects the current structure of most health systems in the Americas, which separate the institutional structures that provide collective health services from those that deliver individual health care. This contributes greatly to the fragmentation of health systems and to the deterioration and neglect of public health.

At present, public health actions and functions are generally managed by different government agencies operating under fragmented institutional structures. The various public health interventions and programs are often isolated from individual health care services. At the same time, many public health policies are vertically structured, focus exclusively on specific diseases, and are poorly coordinated with other social areas, which limits their impact on the population's health. These problems reflect the difficulties that prevent health authorities from acting in a way that is consistent with an integrated approach to their functions.

EPHFs and health systems functions clearly overlap. This favors an integrated and intersectoral response to the increasing complexity of current and emerging public health problems. This approach should be included in the planning of public health activities within health systems, and the EPHFs should be included in processes to strengthen health systems. It is fundamental to develop comprehensive plans and policies that encourage collaboration with the community and with the various agencies in and beyond the health sector so as to reduce institutional fragmentation. Such an approach also requires health authorities to take responsibility for ensuring that health services fulfill their public health responsibilities, and for providing direction to health services providers and purchasers so that these actors are more fully involved in public health. It is also necessary to ensure access to health services that stress health promotion and disease prevention.

Linchpin 3: Key resources

The third linchpin involves the key resources needed to strengthen health systems and develop a people- and community-based care model. It includes recommendations on human resource policies, strategies, and regulations, as well as on technologies and financial resources.

RECOMMENDATION 8

Actions

- Develop and implement human resources policies aimed at ensuring the availability and competencies of health personnel to meet the health needs of the population and facilitate their involvement in the processes of health system transformation based on a PHC model.

- Strengthen the mechanisms to link the education sector with the health system in order to develop policies for training human resources for health, with a PHC-based approach. Universities and training centers should be included in the development of these policies.

- Strengthen the stewardship of the health authorities to regulate the competencies and profile of professionals on health teams.

- Integrate human resources issues in policies addressing research on health systems and services.

Recommendation 8: Recognize human resources as protagonists of the construction and consolidation of PHC-based models of care.

A workforce of adequate quantity and quality is a key component in developing PHC-based health systems. It is essential to form comprehensive health teams whose members are sensitive and committed and who can become actors in the transformations required to meet the population's health needs.

Despite a history of major efforts with initiatives involving academic and professional institutions and workers, structural problems persist. The Region's health systems are characterized by insufficient human resources whose skills are not aligned with PHC-based care models. They are not well distributed territorially, and there is a lack of strong regulatory mechanisms to foster job markets that offer decent labor contracts and that incentivize commitment and professional performance.

To address these challenges, national health authorities need to strengthen their capacity for leadership, planning, regulation, and negotiation.

First of all, human resources planning plays a crucial role in creating and strengthening mechanisms to coordinate the education sector and the health system. These mechanisms should help develop human resources training policies that are coherent with policies designed to transform health systems.

The processes involved in transforming health systems are complex and time-consuming, and they require health workers with new profiles, new skills, and new practices, leaving behind deep-rooted concepts. For this reason, human resources training is a strategic pillar for the process of transforming health systems. Universities and other teaching facilities are key institutions and actors in these educational policies. Their participation is essential, both to ensure technical and academic coherence and to support the legitimacy and sustainability of these transformational processes. Finally, it is important to develop incentives and undergraduate/graduate education, and to provide continuous training in health services. PHC and interdisciplinarity should be pillars of undergraduate and graduate education in health.

Second, to guarantee political and technical coherence and synergy, it is essential to strengthen health authorities'

capacity to regulate professional skills and profiles. Such regulations should ensure that professional ethics are coherent with social commitment and with the right to health, solidarity, and equity.

Third, mechanisms that regulate the job market (wage levels and working conditions) can address the institutional fragmentation that keeps the public sector, social security, and the private sector isolated from each other. These mechanisms can generate incentives and commitments that promote the development of PHC-based models. At present, market logic has great influence on the content and types of training available, on the dynamics of the job market, and on professional obligations, skills, and profiles.

Finally, it is important to include human resources issues in policies that address research of health systems and services. Human resources should be considered a fundamental aspect of the challenges discussed above and should be included in the evaluation of initiatives designed to transform health policies. To achieve this objective, it is essential to involve health teams in knowledge production and management in order to foster adequate appropriation of evidence for continuous improvement of work processes.

RECOMMENDATION 9

Actions

- Ensure the public interest in policies on the use of health technologies, prioritizing those that have evidence of effectiveness but are often ignored by industry because they are not profitable.

- Promote the adoption and use of new health technologies based on evidence and unmediated by commercial interests as a fundamental premise to guarantee the right to health.

- Understand that innovation should be interpreted in relation to its value added for the health of the population and the effective exercise of the right to health.

- Promote digital health as an instrument to achieve the Sustainable Development Goals (SDGs) and the Strategy for Universal Health. Mobile technologies, smart devices, and artificial intelligence should be used to close the existing gaps in access to health services.

*Recommendation 9: **Promote rational use and innovation in technological resources to serve the population's health needs.***

The adoption and use of new evidence-based health technologies independent of commercial interests is a fundamental premise for guaranteeing the right to health.

Innovation should be interpreted in relation to the value added for the population's health and for the effective exercise of the right to health. In this context, new technologies do not always constitute innovation, nor should they be considered without regard to their utilization and impact. Innovations should be oriented to rebuilding and legitimizing a more holistic approach to health that leads to a humanized and collective conception of the population's health and disease processes. They should also reclaim ethics as a core value in the decisions involved in patient care and healing.

Technological innovations take many forms and are not limited to medical technologies. Although they are necessary and essential for improving diagnosis, avoiding unnecessary referrals, and meeting people's health needs, there are also risks and harm associated with today's burgeoning medicalization and an extremely technology consumption-oriented popular culture, which can generate inequities.

In order to take full advantage of the potential of new technologies with a perspective that guarantees the right to health, it is essential to strengthen the stewardship role of health authorities. Ensuring an adequate supply of medicines and other health technologies requires the ability to interpret information on how market prices are set and to exert greater influence over negotiation processes. Recent innovations in information and communications, such as 'big data,' should be used to strengthen public health intelligence capacity, with a close eye to the challenges of confidentiality, privacy, and manipulation of public opinion.

Digital health should be used to help achieve the SDGs and the objectives of the Strategy for Universal Health. Mobile technolo-

gies, intelligent devices, and artificial intelligence can eliminate gaps in access to health services if the technologies are available to all; otherwise, they can widen the gaps. These technologies are tools that should be valued for the potential contribution to better understanding the needs, demands, and behavior of social groups in conditions of vulnerability. Living conditions, disabilities, consumption habits, and domestic and international migratory flows provide inputs that must be interpreted in order to grasp the diverse needs of the population and the determinants that shape people's lives.

Finally, the development of these capabilities also provides an opportunity to promote social, organizational, and institutional innovations that can increase the effectiveness, quality, and equity of access to health services. These efforts call for intersectoral interventions and coordination with sectors such as communications and telecommunications.

RECOMMENDATION 10

Actions

- Develop a financing model that promotes equity, efficiency, and sufficient resources within a framework of increased taxation of wealth and capital (financial, productive, real estate), as well as increased taxation of intensive exploitation of natural resources.

- Achieve and maintain a public expenditure in health of at least 6% of GDP as a minimum benchmark to reduce inequities and increase financial protection within the framework of universal access to health and universal health coverage.

- Combat tax evasion and avoidance to obtain the additional resources necessary to guarantee universal health.

Recommendation 10: Develop a financing model that ensures sufficiency, quality, equity, efficiency, and sustainability.

Insufficient, inequitable, and inefficient funding is a persistent problem in the Region's health systems and constitutes a structural barrier to progress toward universal health.

It is necessary to develop a financing model that promotes equity, efficiency, and sufficient resources in a framework of increased taxes on wealth and capital (financial capital, productive capital, and real estate) and that taxes intensive exploitation of natural resources. A financing model with these attributes is a key aspect that should be included in processes aimed at transforming health systems.

The design of a financing model must be adapted to the economic, social, institutional, and political contexts in each country, and also to the needs and social and demographic conditions of the population (aging, poverty, epidemiological profile).

Public spending in health equivalent to 6% of gross domestic product (GDP) is a minimum benchmark for reducing inequities and increasing financial protection in the framework of universal access to health and universal health coverage, although a country's individual realities must be considered.

Equitable financing is achieved through systems that have universal public pooling mechanisms. These systems are financed with mandatory contributions or taxes, calculated according to people's ability to pay. They consist of institutions that function as the health system's single payer and their scale must be sufficiently large. This model should tend to eliminate out-of-pocket payment, which is considered one of the barriers that impedes access to health services.

Efficient financing is promoted by refocusing spending so as to territorially prioritize care for the populations most affected by barriers that impede access to health services, allocating budget lines and making the necessary adjustments based on people's needs. This model should prioritize the first level of care, with attention to salary levels of human resources and to incentives that promote people- and community-based health services networks.

Complementary mechanisms for the procurement and evaluation of technologies and medicines that enhance the

public system's ability to negotiate prices can produce innovations that are more cost-effective and responsive to the population's needs. As part of a public strategy aimed at efficiency, it is important to have transparent information and accountability mechanisms that combat corruption. This enhances the legitimacy of the processes of institutional transformation designed to guarantee the right to health as a fundamental human right.

Globalization and competition between countries for foreign investment have significantly increased tax exemptions and encouraged tax evasion. Tax avoidance and tax evasion must be combatted as part of the effort to obtain additional resources to finance health systems.

Finally, obtaining sufficient resources and establishing an equitable and efficient model is a challenge at the level of political economy, one that requires the participation of strategic actors, especially those in conditions of vulnerability.

CONCLUSIONS

Forty years after the emblematic Declaration of Alma-Ata, despite advances in health in the Region of the Americas, we must acknowledge that we did not achieve the goal of health for all by the year 2000.

Notwithstanding improvements in the population's health and in health coverage, progress has been limited in terms of equity in health. Today's regional and global context confronts us with new epidemiological, environmental, social, economic, and political challenges.

Based on an analysis of this new scenario, the present document offers recommendations for the Director of PAHO. The intention is to help focus the Organization's work on providing leadership in regional processes aimed at ensuring the right to health as a fundamental human right, while supporting the countries in this effort.

These proposals are the result of collective work by the members of the Commission, with collaboration from a large number of experts and stakeholders committed to the right to health.

This report presents the conception of PHC as a necessary and sustainable path to achieve universal health as a right of all, with quality, equity, and social justice. The premise is that the State has an essential responsibility to ensure the enjoyment of the right to health is a reality, and three analytical linchpins have been constructed to give meaning and coherence to our set of recommendations.

The first linchpin is people- and community-based models of care that include intersectoral interventions. This refers to the capacity of State policies to address the population's needs and diversity. The recommendations describe care models that are sensitive to the population's diverse needs, capacities, cultural identities, ethics, sexual orientation and gender identity, ages, and social and economic conditions.

This strategic approach and the PHC perspective define the specific and differentiated health needs of populations and communities as the starting point for the processes involved in transforming health systems. There is no single recipe, nor any single replicable technical approach: Each country must create and employ care models that meet the context-specific needs of its population.

The second linchpin includes the political and institutional processes behind the factors that drive change in health systems and that strengthen social protection systems. The recommendations in this area address the processes and actors that should be involved in the necessary changes. These processes need to overcome the constraints associated with the time frames and complexity of political economy—constraints that explain some of the impediments to significant progress.

Political instability in governments leading these change processes is a constraint that must be addressed through advocacy, in order for policies designed to guarantee the

right to health to become consolidated as government policies. Another constraint is that, despite new regulatory standards in many health system reforms, it remains necessary to develop governmental capacities to enforce compliance, especially in the private sector.

Similarly, the scope of national policies is limited in a global context where private actors and organizations wield growing influence in many dimensions. For that reason, policies for change need to be strengthened and harmonized with supranational processes and entities, including multilateral organizations, regional and subregional integration entities, and South-South cooperation mechanisms. In this context, PAHO/WHO should continue to lead a regional agenda that guarantees technical consistency and contributes to addressing present and future political challenges.

The third linchpin addresses key resources—human and economic resources, and health technologies—and the institutional arrangements that shape the availability of resources considered necessary to facilitate these transformation processes. Without sufficient human, technological, and financial resources, policies to transform health systems and social protection systems cannot be implemented. Allocation of these resources is the concrete manifestation of the State's political will and capacity to guarantee the enjoyment of the right to health as a fundamental right.

Finally, it is of crucial importance to create and strengthen national and supranational accountability and transparency mechanisms that enable effective social participation and that facilitate the quest for solutions and innovations to make the right to health a reality.

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ANNEXES

ANNEX 1:

Toward a Comprehensive Health Care Model

This document has been coordinated and prepared by the members of the Commission Vivian Camacho, Mauricio Bustamante, Mirna Kay Cunningham Kain, and Hernando Viveros Cabezas. For its elaboration, consultations were organized with experts and social actors who made different contributions to the document.[1]

"My love is not the love of only one;
It's the soul of everything to be healed."

Lyrics from the song by Silvio Rodriguez
Por quien merece amor[2]
[To whomever deserves love]

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1 A full list of contributors is available in a web version of this document.
2 Silvio Rodríguez (1982). Por quien merece amor. Álbum Unicornio. Cuba. EGREM.

Introduction

The High-Level Commission tasked Thematic Group 1 with addressing the health care model, centering it around several structuring components discussed during an in-person meeting. The responsible commissioners later invited a wide-ranging group of experts and social stakeholders to prepare a document that would stimulate discussion. Broadly and inclusively distributed for consultation, this document summarizes the proposed rounds of discussion aimed at advancing toward the formulation of recommendations.

The Commission's report was prepared after several work sessions in which the health care model was discussed. This document contains three main points to consider:

1. A comprehensive health care model that "provides more care and cures what needs to be cured," promoting the health of ecosystems and Mother Earth to foster "Good Living."

2. A comprehensive health care model centered on the right to health and integrated health service delivery networks (IHSDNs) based on primary health care (PHC).

3. A comprehensive health care model that has the necessary resources to guarantee all people real access to comprehensive, quality health care and health services in a timely manner and with continuity.

This document was conceived as a proposal, and its proposals are open to broad and ongoing debate.

Toward a Comprehensive Health Care Model

To achieve "Good Living,"[3] prevent premature death, and develop the full potential of all people, in harmony with nature, it is necessary to embrace a new, comprehensive health care model. When considering how to coordinate activities to protect health, we must do so from an anticipatory preventive perspective that begins by improving health and well-being while also considering disease. It must be assumed that health is the product of intercare[4] that people provide to each other every day, while creating the conditions for a dignified life.

When considering a health system and defining its model (that is, the ideal way to organize it), the starting point is to recognize that health is the product of living in society. Health is largely determined by how we inhabit a space, how we live, how we eat, how we move about, how we work, how we interact, the quality of our relationships, how we love, and our shared customs and beliefs. It is important to rethink health with all its implications from the standpoint of different paradigms, seeking its integration and coordination in the construction of a model that enables us to live in a healthier manner while taking care of our common home.

The original models of care focused on the response to disease. They then shifted from hospital-centered models to forward-looking models that sought to anticipate harm. More recently, health care models clearly centered on individuals, families, and communities have begun organizing not only the different aspects of health service delivery, but all functions of the system, including financing, leadership, governance, and intersectoral action. In essence, the stated objective of these models of care has been to make it possible to exercise the right to health, buttressing the State's role as guarantor of that right.

The legacy of Alma-Ata is the effort to move beyond designs based on curative models of care toward a comprehensive health care model. The proposal here is to contribute to that legacy with models of care aimed at ensuring that the entire health system is organized so that the right to health can be exercised.

It should be underscored that this implies the real empowerment of individuals and communities, not merely as passive objects of intervention but as active participants. Furthermore, caring for each other is not someone else's job, but a shared daily exercise. Communities live in a territory that is organized for living a healthy life and protecting nature, one in which all people, in concert with the State, have a role in achieving good living.

The term "care" evokes something profoundly human, something that occurs within relationships and throughout the life

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3   "Buen Vivir" in Spanish.
4   Intercare: Each work team has its own knowledge and care strategies. The intercare approach places value on what already exists in the day-to-day work of each team and attempts to mitigate the incursion of external interventions. Unlike the self-care approach, it values the relational and collective perspective of the group work of the teams (1, 2).

course. This concept refers not only to self-care,[5] because people do not care for themselves entirely on their own. It is important to consider "intercare" in support networks that are not yet considered part of health systems, but without which no health system can function. The comprehensive health care model stresses prevention and promotion and includes clinical services for the treatment of disease, working hand-in-hand with public health to address the social determination of health.

Structuring components

1. Put people, communities, and nature at the center of health systems and services

This structuring component promotes a way of understanding and delivering health care that consciously adopts the perspective of individuals, caregivers, families, and communities in relation to their environment as participants and co-managers of health systems.

Putting nature at the center also implies a commitment by all levels of the system to achieving the Sustainable Development Goals (SDGs), protecting the planet's different ecosystems, advancing toward the use of non-polluting energy sources, responsible production and consumption, and guaranteeing access to the resources needed for dignified and sustainable living.

When people and communities are put at the center of health systems and services:

- Efforts are made to ensure that health systems respect differences and social contexts and are organized less around disease and more around the comprehensive needs that arise where communities live. This will achieve better health outcomes and greater equity. People's health depends on the health of the planet; protecting nature also protects human health.

- A social empowerment process is needed to replace the current vertical and asymmetrical power relationship. This process must also facilitate the flow of information between health systems and services and communities, transferring power to the latter to create a respectful horizontal relationship.

- Both formal and informal caregivers are valued, and in a position to provide adequate and appropriate care in a positive work setting.

- Social production mechanisms guarantee ongoing community engagement and comprehensive monitoring and evaluation of health care for populations living in conditions of exclusion and vulnerability, including Afro-descendant and indigenous populations, which together represent more than 400 million people in the Americas (4). The objective of these mechanisms is to provide access to equitable opportunities in the different sectors and break the cycles of exclusion, structural inequity, poverty, gender inequity, and racial discrimination.

2. Develop a node for the comprehensive care system that coordinates the work of the various elements that make a healthy life possible

It is necessary to move beyond the concept of "levels of care" and delve deeper into the concept of "networks" from the standpoint of promotion, prevention, and territory. The proposal here is for today's first level of care to become the coordinating node of integrated networks that, through transdisciplinary teams, facilitate coordination between: *a)* an intercare system centered on improving healthy living, with a strong local component; *b)* the local ecosystem and social protection system, which are addressed in the intersectoral approach; *c)* components of public health and national health priorities; and *d)* the care system, centered on the recovery of people with ailments or diseases who visit nodes with specialist focal points serving as support.

It also is necessary to move beyond the concept of "gateway," because health does not reside outside the community and it is unnecessary to "enter" any part of the system to participate in it. Another reason why the gateway concept should be discarded is that a coordinating node is much more than a point of access; rather, it is a highly effective and efficient entity that coordinates intersectoral, community, and therapeutic responses for a healthier population.

The coordinating node is comprised of a trained health team that implements all aspects of the primary health care strategy (coordination, continuity/longitudinality, access, and comprehensive care) with excellence and provides its community with lifelong care, developing high response capacity under the comprehensive health care model. By focusing on coordinating nodes and their teams, the health system is brought closer to people and the balance shifts toward the territory where healthy life is generated.

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5   Self-care: when a person is capable of taking care of himself or herself, following certain instructions (3).

This emphasis on the coordinating node is not exclusive, nor does it rule out specialization, because a good system must have reliable quality facilities (nodes) that are specialized. The difference lies in understanding that the core function of these specialized facilities is to provide support in complex or infrequent situations that require evaluation and management in specialized settings. This support is essential, but it is neither at the center of the system nor at the top of the pyramid.

3. Fomenting work in integrated health service delivery networks

This structuring component puts particular emphasis on the need to remedy the segmentation and fragmentation found in health systems and services. The objective is to move toward the delivery of health services organized in integrated networks (IHSNs)[6] that guarantee quality and equity for individuals and communities, ensuring that no one is left behind, and moving toward the implementation of a comprehensive health care model.

This IHSN proposal is based on a PHC approach to establishing a health system that considers human diversity and that is territorial, family- and community-centered, multiethnic, intercultural, problem-solving, intersectoral (health in all policies), participatory, equitable, and democratic, with a health worker-community-health worker flow. To build effective networks, the countries agreed to address 14 attributes (5). This design assumes that those who improve the outcomes for the population are all the providers working together. It likewise conceives the network as being much broader than the formal institutional network, recognizing that there are community and intersectoral actors with whom the network should connect. This implies institutional arrangements between different actors and institutions to meet common goals and targets for health and a dignified life.

4. Policies on access to drugs and health technologies

For positive health outcomes in the population, it is necessary to have adequate access to health technologies (this includes drugs and health interventions) and take advantage of their potential, with due quality assurance. Introducing technologies and drugs on the basis of scientific evidence requires stronger leadership and governance unmediated by conflicts of interest. Advocacy is also needed to promote the accessibility, availability, and rational use of medicines.

It is especially necessary to explore the potential of the new diagnostic, therapeutic, organizational, and information and communication technologies to improve the access of excluded populations and health team response capacity in promotion, prevention, and prognosis. It is important to keep these new technologies from becoming a source of new inequities.

These technologies offer a real opportunity to increase the effectiveness, quality, and equity of the comprehensive health care model's PHC-based coordinating node.

5. Strategies for improving intersectoral interventions to promote the comprehensive health care model

A good PHC strategy considers the structural components of the social determination of health. It evaluates intersectoral interventions that should stem from comprehensive integrated public policies geared to good living.

The Declaration of Alma-Ata (7) calls for basic sanitation and access to drinking water as an essential part of the primary health care strategy; an intersectoral approach and social participation are also essential. Today, new elements must be included, given the complex issues we are facing in the new century, among them the health impact of climate change, human and natural ecosystems, disasters, food security, the viability of development, and migration.

The intersectoral approach is employed in all spaces, beginning with the local space and taking a territorial approach. Health teams must have a good understanding of local ecosystems for there to be negotiation and dialogue in the joint intersectoral work with institutions and civil society.

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6   An IHSDN is understood a "a network of organizations that provides, or makes arrangements to provide equitable, comprehensive […] health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served" (6).

6. Traditional ancestral medicine, complementary integrative medicine, and the intercultural approach

The Region of the Americas is notable for its rich multiethnic and multicultural diversity, its large number of ancestral languages, and the unique world views of its indigenous and Afro-descendant populations. This implies recognizing other incontestable realities within countries. Some of the major challenges are to close the equity and equality gaps, confront structural racism and its contemporary forms of racial discrimination and exclusion, and promote the enforcement of civil and political rights to guarantee full citizenship. Health should be understood as a basic right that all States must guarantee to ensure that all people have access to health services as part of the comprehensive health care model.

Given the Region's vast cultural diversity and deep-rooted ancestral traditions, it is essential to make an epistemological break and move beyond monoculturalism to reach points of intercultural dialogue and complementary knowledge between conventional medicine and traditional ancestral medicine. We have already witnessed a number of successful experiences with intercultural health policies and institutional advances in the Region involving traditional ancestral and integrative medicine as part of health systems. These experiences show that it is not only possible but urgent that they be replicated to eliminate the social exclusion in access and health care for historically marginalized peoples. We can delve deeper into the complementarity of knowledge and move beyond the biopsychosocial sphere to incorporate the spiritual dimension, tapping into the beliefs and understanding of the diverse human groups that are part of the system.

We must ensure the visibility of intercultural policy experiences related to the health of the indigenous populations of the Region and learn from them. We can learn to delve deeper into the complementarity of knowledge between conventional medicine, traditional ancestral medicine, and complementary integrative medicine to develop a comprehensive approach to health that involves the health of Mother Earth, who sustains the human community. Coordination among these different concepts of medicine, widely employed in the Region's populations, facilitates their incorporation into health systems as a necessary resource for PHC-based IHSDNs on the path toward universal health.

7. The responsibility of the State in guaranteeing universal health through a comprehensive health care model

To guarantee the universal right to health with equity and quality, the State must exercise stewardship, which is also necessary for directing and managing the social production of health, involving national and local governmental, nongovernmental, private, and civil society institutions. This implies that health must be a consideration in all policies and the intersectoral approach in actions, given the social determination of health. It is also important to confront and eliminate access barriers and structural, economic, social, cultural, political, and health inequities and encourage the active social engagement of empowered social stakeholders.

The State's responsibility is expressed both at the national and local levels, in macro-, meso-, and micro-management settings, and through strengthened leadership and governance mechanisms at each level of national policy management and administration. These mechanisms must be aligned with existing legal and administrative frameworks and the characteristics of the centralization, decentralization, or deconcentration of power and resources that give varying degrees of autonomy to the comprehensive health care model but by no means limit or reduce the public responsibility of the national and subnational State and respective health authorities, guaranteeing the universal right to health where no one is left behind.

It is necessary to strengthen specific mechanisms that govern the comprehensive health care model for individuals, families, and communities who are empowered to take charge of their health and participate actively in the related processes of social determination. Health institutions and other entities are accountable to them as part of the social oversight of health.

The democratic sustainability of the comprehensive health care model requires the empowerment of social stakeholders, as well as the State's commitment to provide adequate financing (at least 6% of public health expenditure as a proportion of GDP). It also requires the allocation of at least 30% of health expenditure to the development of the comprehensive health care model's coordinating node. Moreover, out-of-pocket individual and family health expenditure should be limited to less than 20% of the total national health expenditure, and it is necessary to guarantee an adequate supply (number), distribution, and quality of human resources essential for the operation of the comprehensive health care model.

Currently, human resources education is based on a mechanistic biomedical model and aligned with the interests of the medical-industrial complex. The regional strategy and plan of action for human resources sets a demanding agenda for changing the civil service hiring and career development systems and the placement and stability of well-trained health professionals and workers in disadvantaged areas. These new human resources need to become the heart of the coordinating node of integrated networks with a comprehensive approach to health care. Family health and advanced nursing practice are essential to the viability of this new model.

For the proposed model to be sustainable, an incentives policy for health workers is required. Worker well-being, respectful and decent hiring systems, the intercare system, and continuous worker encouragement and motivation are of particular concern.

As an expression of the State's responsibility and commitment, and as part of leadership and governance of the comprehensive health care model, accountability is required from three areas: a) institutions; b) their representatives; and c) organized civil society. This is a democratic expression of social empowerment and improved social oversight and social legitimacy. It also reflects the ethical commitment to the defense of the right to health, at all levels of institutions and civil society.

The responsibility of the State, the stewardship role of the national and subnational authorities, and the governance of integrated health service delivery networks, both for individual and collective health, are also expressed in the efforts to reduce the segmentation and fragmentation of health systems and services and increase the degree of linkage, coordination, and integration in health networks.

Conclusions

This paper offers a proposal for a comprehensive health care model based on a PHC strategy that promotes the health of ecosystems and Mother Earth for good living, while strengthening the voice and engagement of communities, civil society, and organized peoples. It is also a call to join forces, resources, and actions to guarantee universal health as a human right, reaffirming the values of the Declaration of Alma-Ata.

"In the meantime: play music for her, fill the house with flowers, have the birds sing, take her to the ocean to see the sunsets, give her everything that can make her happy."

"No medicine cures what happiness cannot."

"Love in the Time of Cholera"
Gabriel García Márquez [7]

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ANNEX 2:

Institutional Model

This document was coordinated and prepared by commissioners Carina Vance Mafla and Maria Soledad Cisternas. The coordinators consulted a group of experts who made different contributions to the document: Félix Rígoli, specialist in health systems and services, South American Institute of Government in Health (ISAGS); Eduardo Hage, specialist in health surveillance; Ángela Acosta, specialist in medicine and health technologies; Isabel Urrutia, surgeon specialized in cardiology, Central University of Venezuela; Ligia Giovanella, researcher at the Oswaldo Cruz Foundation (FIOCRUZ); Mauricio Torres, professor at the Department of Public Health of the National University of Colombia; and Osvaldo Salgado, Director of the Southern Metropolitan Health Service of the Government of Chile.

Introduction

The attainment of the right to health for all requires social and political construction, based on building awareness of the right to health as a fundamental human right and on a political understanding of the necessary process of change. The State plays an essential role in constructing the right to health for all and its responsibility cannot be delegated. To ensure that the right to health is effectively ensured, institutional models that act consistently on multiple linchpins or axes must be implemented. Furthermore, certain living and working conditions are necessary to make the attainment of this right possible.

Health is understood as both a public good and a human right, and since the factors that affect it are strongly influenced by commercial, economic, and political interests. It is therefore crucial that governments exercise stewardship, planning, regulation, coordination, funding, control, and management of health systems in the best interests of the public and from within the health sector. And it is essential that their approach be based on the "social determination of health," in coordination with other sectors. Social, popular, and community involvement is an essential mechanism for the development of public policies that respond to the needs and aspirations of society as a whole. States must also ensure social participation, considering the diversity of the population, the power dynamics expressed within it, and the resulting inequities.

On the 40th anniversary of the Declaration of Alma-Ata, this is a timely moment to consider the progress made toward universal health and the challenges that still stand in its way, and, particularly, to analyze the role of the State and its various institutional models in supporting the aspirations of Alma-Ata.

This report does not provide an exhaustive description of these elements, but rather analyzes those regarded as essential, considering the current situation and the main issues faced by the health sector on the 40th anniversary of the Declaration of Alma-Ata. The authors hope to contribute elements of analysis to strengthen those institutional models which enable the effective achievement of the right to health for the entire population.

Main issues

Achieving universal health in a comprehensive and sustainable manner will require profound transformations in today's societies. These changes are only possible through participation based on an analysis of the power structures that engender inequity. Faced with the expansion of an individualistic, hegemonic culture, it is necessary to recover and strengthen the original world views of our own Region that are based on harmony among body, spirit, community, and nature in an integrated manner (such as the concept of "good living" or buen vivir), which can serve to guide social organization. Only by empowering the population can be we achieve alternatives to the prevailing hegemonic model. For example, worrying about the foreseeable effects of climate change without proposing a different model of development is like swimming against the current in increasingly rough seas.

These transformations require everyone to participate, but it is essential to assign roles and recognize their legitimacy. The main obstacle to achieving the right to health remains the same as 40 years ago: the profound asymmetry of power and the interests of those who hold it. The proposal here is to manage power in the public interest, based on the aspirations of the people and the principles of equity and social justice. In this context, the State plays a key role in representing the interests of the population. Democratic processes underlie its legitimacy and the more entrenched and participatory a democracy is, the more alignment can be expected between the actions of the State and the public interest, including the right to health.

It should be noted that, throughout this document, "governance" does not mean the level of responsibility of different actors—an idea that has become increasingly popular worldwide. Rather, the intention is to highlight the tensions and issues that the State faces, both structurally and in relation to other actors, as a key driver of change, based on the popular will and the public interest. This paper seeks to shed light on factors that cannot be ignored in pursuit of the goal of universal health.

First, we must briefly address the concept of "social determination" versus "social determinants." It is not possible to summarize the extensive discussion of this concept, which originated in the Americas. However, in the approach described in this document, it is essential to act on the social processes and power dynamics that exist within our societies. These must be understood in the historical context in which they continue to be replicated and perpetuated, accentuating inequalities and affecting access to health. This also suggests that the "social

determinants" approach is insufficient, as it can occur in a compartmentalized and even decontextualized manner, without asking "why" these determinants arise, whom they affect, and to what effect. The "social determinants" approach represents progress and its inclusion in the Sustainable Development Goals (SDGs) as a globally recognized strategic instrument is important. Nevertheless, there is a need to go deeper, with a critical eye to unsustainable development models.

Analysis of the present historical context has revealed four key issues that States must face and which have an impact on the State's ability to ensure achievement of the right to health. These issues highlight the need for technically capable, robust, agile, transparent, and inclusive institutional models to allow States to effectively ensure the right to health of their populations.

First, at a moment in history in which the social determinants approach is recognized as essential to improving the health status of the population, effective intersectoral governance is key. Second, it is essential to have a governance model that modulates the relationship and tensions between the public and private spheres in such a way that the ultimate goal of collective welfare prevails in all societies. The third issue is that of central versus local governance, especially given the variety of institutional arrangements in our Region, ranging from highly centralized to highly decentralized. Finally, global governance is becoming increasingly important, and poses new challenges to achieving health for all.

These issues will be considered in an analysis of the linchpins of the institutional models described in further detail below.

1. Intersectoral governance

When considering the processes of social determination of health, it is clear that health is one of several sectors that influence the exercise of the right to health. However, the health sector is responsible for guiding efforts to achieve the greatest possible impact on these processes. Its leadership is neither self-evident nor unanimously accepted by the other sectors. The power to influence policymaking in sectors that, in turn, have an impact on the social determination of health is in constant dispute, and the marked asymmetries in the ability of each sector to influence within the State must be taken into account. The health sector has traditionally been somewhat weak (for example, in relation to trade, finance, industry, and agriculture).

The State plays an essential role in governance. Its structure and interventions must ensure coordination between the different sectors, based on effective intersectoral actions. To achieve the highest achievable degree of well-being in terms of health, it is crucial to address how the health sector can have a greater impact on the allocation of budgetary resources, without limiting this merely to the delivery of health services. To be efficient, States need to ensure comprehensive coordination of their various sectors and policies, and this should be linked to criteria of inclusion.

In this regard, and based on the social determinants of health approach, health governance can be linked to SDG 3 of the 2030 Agenda and some of its targets and indicators. Health governance is also linked to other 2030 Agenda goals in which other sectors play a leading role. The question is, which institutional architecture of the State best addresses this need? This will be considered later, when discussing the roles of the health authority.

2. Public-private governance

The road to universal health must include strengthening the public system to ensure that it meets quality standards, with a positive impact on outcomes. In addition, due to the divergent logics of the public and private sectors, it is imperative to develop efficient mechanisms for regulation, management, and for addressing conflicts of interest. Within the health system, the private sector must abide by the rules of the democratic rule of law and by regulations to ensure the population's access to health and the sustainability of the system itself. This requires a strong government that exercises its role as health authority and in steering the health system.

For instance, an important part of the delivery of health services is funded by contributions managed by private organizations and by private providers. It is essential to find mechanisms to protect the population as a whole so that this reality does not become a barrier to access. Likewise, there must be mechanisms in place to restrict the structuring of systems based on demand-side subsidies, which have a negative impact on system sustainability and encourage irrational, inefficient use of systems, worsening inequities.

3. Central-local governance

The objective of implementing decentralized models has been to provide or devolve decision-making power to local governments, stimulate greater social participation, and fund systems

with local taxes. These objectives have been partially achieved, but new issues have also arisen. Heterogeneity in implementing policies and strategies, in quality, in system response capacity, and even in the possibilities of control gives rise to greater opportunities and advantages for certain groups, and to barriers or negative impacts for others.

Sectoral governance must seek the principle of universality, providing equitable access to all, complying with standards of quality and availability, which, in turn, should address the particular needs of different groups. Another issue associated with decentralization processes is that they have not been followed by a greater allocation of resources to the local level, compared to the volume of resources that major cities have historically received.

4. Global governance

In the current global context, both States and multinational corporations strongly defend their commercial and economic interests. However, common positions have been identified and agreed upon, to defend the health interests of the population. Forums such as the World Health Assembly and coordinated strategies to address industry interference with the design and implementation of public policies show that joining forces in the support of causes that promote universal health provides greater counterweight than carrying out isolated, disjointed actions. Efforts to promote the public interest usually face highly coordinated backlash from industry and commercial interests. Tobacco, breast milk substitutes, and other industries and sectors illustrate this reality.

In this context, the 2030 SDGs provide an opportunity within the framework of a highly consensus-driven international agenda that not only directly tackles health objectives but focuses on social determinants of health that should be addressed in an intersectoral manner, in which State responsibility is not limited to the health sector. This is an opportunity to strengthen intersectoral action and establish and institutionalize intersectoral relations in which the health sector acts as a catalyst for policies that affect health indicators. It is also an opportunity to configure a new institutional architecture for the State and a new institutional model to guarantee the right to health.

LINCHPINS

Having identified the key issues discussed above, we will now highlight what we consider to be the linchpins of system governance and stewardship, with emphasis on the factors that

are most common in the current scenario. It is essential that these be analyzed both within the specific contexts of each country and from a regional perspective. An approach to health governance is needed that includes analysis of the formal and informal "rules" which influence both actors operating in the health system and the system's core resources (human resources, technology, funding). These "rules" can be based on the linchpins of the system's architecture.

The following seven linchpins or axes are proposed:

1. Health system stewardship and regulation.

2. Timely and transparent information.

3. Coordination between levels of government.

4. Social participation.

5. Health as a universal right with accommodation for diversity.

6. Prioritization of intersectoral management.

7. Integration processes for the benefit of the population.

1. Capacity for governance, stewardship, and regulation of health systems, based on their structure and operation

In recent decades, there have been major advances in terms of increasing the regulatory capacity of the State, but this process has been uneven across the Region and there have been periodic setbacks. Structural changes have been made by several States that have achieved greater complexity in their regulatory agencies and strengthened their functions. This has occurred in a context of regulating a market that has greater economic weight and influence in many areas of health service delivery and financing (e.g., supplies, medicinal products, and technology). These are indicators of a strengthened stewardship function, with greater capacity to govern the system.

However, the reforms promoted by demand-side subsidies helped further segment, fragment, and weaken health systems, limiting the capacity of ministries of health to ensure the right to health of the population. Some consequences of this process warrant special emphasis. Ministerial powers have been restructured, weakening stewardship capacity. This shift has separated ministries of health from the management and funding of health services.

How can ministries implement policies that are robust, sustainable (i.e., capable of surviving changes in the economic or political environment), based on scientific evidence and impact assessment, on the best interests of the public and on the

health needs of the population, when faced with internal and external influences that have other interests in mind? The Region has experience in developing representative case studies and these can be used to analyze the factors that underpin sustainability. Some examples that could be analyzed in depth are the Programa de Saúde da Família component of the Brazilian Unified Health System, the Misión Barrio Adentro in Venezuela, the National Health System of Cuba, and the experiences of El Salvador, Nicaragua, and Uruguay, among other countries that have changed and adapted their systems across different governments without abandoning their core features.

States need structures, technical skills, tools, and political capacity to form broad coalitions and produce social and political legitimacy in order to achieve the necessary changes. Although constitutional and legal frameworks grant the health authority responsibility for stewardship and governance of health systems, this is not a "natural right." This capacity is instead built through a set of conditions. Structures must take into account the essential functions of public health, including the capacity for intersectoral articulation at all levels, from the highest authorities to the most local ones. Likewise, social legitimacy is not achieved merely through "tacit approval," but also by facilitating the real, enriching participation of diverse communities.

Developing the technical competence necessary to exercise stewardship and governance should not be limited to people with strong academic training. Technical competence must provide for high-quality teams at all levels, pooling together knowledge from several disciplines, supported by leadership and by a collective, permanent discussion of whichever policies are to be implemented. A relatively small group with great capacity for discussion, clear processes, and continuous improvement can be more effective than a large group of people lacking clear structure.

It is vitally important to recognize the value of personnel. This includes fulfilling obligations towards them, implementing training and awareness-building processes, and continuous assessment at all levels. A broad, deep level of social participation should also be sought to ensure that personnel training responds to the needs and aspirations of society.

Structural conditions are related to Policy (with a capital "P")

The health systems of countries that seek to universalize access to health are generally more conducive to equality than their societies as a whole, where power relations are more pal-

pable. But in both cases there is a permanent tension between the distribution of resources and power. Spaces are needed in which the interests of society can be included. This will allow pushback against the most economically powerful sectors, which may oppose policies or regulations that are in the public interest.

Major efforts have been made to establish organizational structures that strengthen the role of health authorities in addressing the health problems of the population. A comprehensive guide to the essential public health functions has made a key contribution to strengthening the role of the State. In parallel, the full, effective participation of the various sectors of the population, especially the most vulnerable ones, is essential. Strengthening social participation processes is crucial to enhancing institutional capacities and ensuring their sustainability. This can be accomplished through improved participation channels and empowerment of the aforementioned sectors of the population. It is critical to ensure that any advances transcend current political scenarios.

Improving participation channels is not limited to rallying the various actors of civil society around a particular decision or the evaluation of a particular health outcome. Promoting participation also involves exercising governance and promoting social cohesion and social justice. Participation involves power relations, and, for communities to exercise real influence, they must be empowered to fight hegemony. Community and citizen participation should be promoted to ensure that the best attainable health status will be achieved under the principle of equity. This means prioritizing distributive justice in health care and facilitating all mechanisms that make such an approach possible.

Making health a universal right is part of a democracy-building process; it is not limited to providing minimum health conditions to the poorest sectors of the population. Furthermore, it is essential that health systems be made a constituent part of citizenship itself. It is very important to stress that health, as an economic, social, and cultural right, has equity as a substrate. Thus, applying the principle of progressive realization of these rights does not mean applying heterogeneous standards to the population (e.g., simplified services for the poor), nor does it mean halting improvements which have already by achieved by arguing a lack of public resources.

No good way has yet been found to integrate social participation into the decision-making processes. The novel role of social networks, which can be a mechanism for disseminat-

ing knowledge and promoting participation, must also now be considered. These networks can be a tool for misinformation or manipulation by powerful structures, usually at the service of the highest bidder. Social media can improve the system's ability to operate, but it can also make progress invisible and even hinder and destroy it. Effective, direct communication with society is vital. Political will can easily yield; therefore, civil society must also participate in protecting the interests of the population.

Capacity for intersectoral governance that acts on the processes of social determination of health

There is growing awareness that it is not effective to treat health problems without addressing their determinants. Ministries of health have had to leave their comfort zone of hospitals and health care delivery. In doing so, they have advocated for health in broader policy fields that require systemic action traditionally under the purview of other ministries. These include healthy eating, urban violence, road safety, sedentary lifestyle, smoking, chronic noncommunicable diseases, disease prevention, access to basic services such as drinking water, decent housing, and education, among others.

Addressing the social determination of health and influencing the structures that generate inequality requires that policies be implemented in various sectors. To coordinate these policies and measure their impact, the mandate of ministries of health cannot be limited to the provision or regulation of health services. There is often resistance to the role of health as a primary objective in all policies, either for political reasons or because it is perceived as running counter to prevailing interests. For example, financial authorities are often wary of "health expenditures" because they threaten financial equilibrium (in many countries, ministries of health receive direct funding from the nation's treasury).

In any government, there will be tension between development models and their implications for health. The tobacco industry, processed food industry, automobile industry, and pesticide industry all have ties to the ministries of industry, commerce, and agriculture, among others. These ties mean that such sectors can be led considering economic arguments alone, without considering their impact on health. Discussions which propose an enhanced mission for the ministry of health and "health in all policies" are not always easy. On the other hand, it is increasingly common for some ministries or departments to become natural allies in this bid for priority treatment with-

in the government. Social development, education, women's rights, and human rights are often added to these efforts, and are often on the same side in discussions about health-related public policies. These new actors are allies in inclusive health policies, but they also require the sector to leave its medicalized environments and find new modes of action that are more inclusive of human and environmental diversity, in the context of "good living."

It is important to develop State structures that facilitate intersectoral coordination and mitigate tensions, taking the above aspects into account. It is essential to establish a flow of information with the government entities in charge of areas such as education, industry, and manufacturing, among others, that highlights the relationship between their scope of action and the field of health. Other initiatives have also yielded positive results, such as the creation of vice-presidencies or coordinating agencies to oversee the actions of sectoral ministries such as health, education, sports, agriculture, and economic and social inclusion. This ensures consistency between policies and actions and coordination between the different levels of government, from the highest authorities through professionals to community workers.

The 2030 Agenda has enormous importance as an instrument for addressing social determinants, despite its shortcomings. It has the support and endorsement of the heads of State –something that involves all State sectors, not only the health sector. It is a novel element with tremendous value and potential in this scenario. International commitment to compliance with the SDGs is widespread (although follow-up is needed on specific actions, as well as ongoing analysis of their impact), and the entire United Nations system is involved. It bears stressing that the SDGs are a time-sensitive instrument, which constitutes an essential additional incentive to achieving the goals and their targets– both those directly related to health and others which also require strengthening of State stewardship and governance capacities.

Financing

An essential element to ensure that institutional arrangements are effective is sufficient, sustainable funding that responds to any needs that may arise in the health sector (e.g., disasters, emerging epidemics, etc.). One strategy that many health ministries in the Region have already implemented is to establish dedicated units to carry out economic analyses of the impacts of health policies. In addition, they also evaluate the cost-bene-

fit of strategies both within and without the health sector (considering that these also influence the process of social determination of health). Finally, they identify strategies to improve the efficiency of the system. Generating and managing such information is essential in order to influence decisions and the budget allocated to the health sector.

To expand the right to health for all, the State must obtain resources—essentially, through tax collection. There is strong evidence that this increase in investment in health results in medium-term economic growth (1). However, in the short term, movements aimed at expanding access to health with public funds are met by resistance in economically powerful sectors opposed to losing part of their profits to the full realization of the right to health. In addition, the population may be wary of the State's ability to use these resources efficiently and transparently. Therefore, it is essential to continue the processes of continuous service quality improvement, eliminating access barriers and implementing mechanisms for the transparent use of resources.

The importance of a redistributive, non-regressive tax collection structure cannot be overstated. This structure should be based on fiscal justice and should create the necessary fiscal space for health and social investments. There must be fiscal space to allow allocation of enough resources to achieve universal access to health. This requires collection of data and statistics, followed by measurement of indicators that identify the needs of the population and quantify them for national-level budget proposals. Likewise, this entails fighting corruption and tax evasion, as well as preventing the diversion of resources to tax havens. The Economic Commission for Latin America and the Caribbean (ECLAC) estimates that the countries of Latin America and the Caribbean lose US$ 340 billion to tax evasion each year (approximately 20% more than total annual health expenditures). This is one particular field of battle between the interests of the majority of the population, which could benefit from a reliable health system, and those of the remaining 1% (2), which includes the greatest tax evaders, who can afford to pay for health care anywhere in the world.

Another portion of funding, especially in low-income countries, comes from multidimensional and multidirectional international cooperation, particularly for health care in traditionally marginalized sectors. While these support sources may be relevant to countries' efforts, it is essential that these processes take place within a framework of respect for the priorities established by each State at various levels. Also, such support should not undermine efforts to strengthen States' leadership and governance through their health authorities. It is common for countries to receive sporadic funding entirely divorced from the macro processes they may be implementing. There are also many examples of the creation of parallel structures to receive and manage funds from international cooperation. These weaken the state structure and act outside the institutional framework, which should be designed to strengthen state stewardship.

Regarding the contribution of private companies to the health sector, it is necessary to ensure compliance with the United Nations Guiding Principles on Business and Human Rights (2011). In addition, possible conflicts of interest should be considered. For example, a possible contribution from a private provider of health services or from the pharmaceutical industry could be associated with an interest that benefits the industry, but that is not in the public interest. WHO has issued a rule on relations with third parties to prevent private companies from interfering with the design and implementation of effective health-related public policies.

The mechanisms employed by the industry to defend its interests above those of the population can be subtle, and it is easy to overlook the fact that they are a violation of human rights. One example is the processed-food and sugar-sweetened beverage industry investing in the promotion of physical activity by children. These industries hinder the implementation of policies such as front-of-package labeling, although there is evidence that it is not effective to simply promote physical activity without changing patterns of processed food consumption. Such actions may not be interpreted as a violation of human rights, but the fact of the matter is that the right of the population to the highest attainable standard of health and well-being is under attack. There are myriad well-documented cases of industry interference, starting with the tobacco industry. Considering all of this, it is vital that industry involvement be regulated.

2. Timely and transparent information that captures targeted elements of the system

An indicator of stewardship capacity is the availability of relevant, timely, high-quality information, obtained in accordance with the strategic framework of the proposed changes. To achieve substantive equity, it is essential that asymmetries be highlighted through the use of tools that tend to equalize unfair and avoidable differences. The intelligence capacity of ministries of health is of key importance. This includes their

capacity to analyze health problems, the process of social determination of health, the limitations that health systems may have, and the recognition of policy options to strengthen intervention. Valuable contributions from the field of collective health, which insist on the need to address "social determination" rather than a mere sum of social determinants, are particularly noteworthy. These contributions highlight the need to transform production and consumption systems, as well as the development model itself, and have generated evidence of their negative impacts on health. These notions are also connected with the field of critical epidemiology, a concept developed in this Region, resulting in a conceptual framework to address the processes that have the greatest impact on health.

National or regional averages are less and less useful. However, caution is warranted because, when asymmetries are first detected and measured, problems that were hidden suddenly become apparent; this may reflect a true deterioration of conditions or may simply give the appearance that the situation has worsened because previously undetected issues have been revealed. Such information should be translated into a more equitable distribution of resources and greater specificity in the implementation of policies and strategies that take local factors into account. It could also be used to argue for changes in primary care-based models of health care delivery.

At the same time, there is a need for systemic heuristics that eschew single-cause and cause-effect relationships. From the standpoint of political communication, proposing single solutions is very tempting and may even be necessary. However, transformations must be systemic, even if some "flagship" programs are used to make changes visible. It is also important that systemic changes follow processes of reflection and participation that confer legitimacy in the eyes of society at large, so that they are not affected by changes of government. Policies must be designed as State policies and not simply government policies if they are to be long-lasting.

Societal participation is not enough to implement processes; the bureaucratic apparatus of the State must be involved. Achieving balance between changes and permanent processes is an art that requires leadership, tightly knit teams, and internal communication within the aforementioned apparatus. Internal leadership ("institutional change teams"), intersectoral coordination, and the involvement of distinct communities are also necessary.

Information about and analysis of the actors that impact health and health systems

Information systems must generate inputs for political analysis. A map of sociotechnical systems and feedback loops that incorporates drivers and inhibitors of change is particularly valuable. This is an important tool because actors such as the pharmaceutical and insurance industries, as well as high-tech specialty groups, can be mapped to identify their connections with the political machine. Many of these tend to create oligopolies or patent mechanisms which, through collusion with regulatory authorities (so-called "regulatory capture"), have negative impacts on people's lives and health.

Due to these connections, transparency and surveillance aimed at preventing undue practices is not merely a moral or ethical issue, it is also a highly effective way of preventing economically powerful sectors from interfering with public policies, which almost always translates into political influence. Those seeking to advance the cause of universal health never have unanimous support, even when they enjoy strong support from the executive branch. Hence, the importance of identifying allies for each issue and at each step.

Traditional management is not very helpful in this respect. A common talking point from those who oppose universal health is that "health already has enough funding; it's just mismanaged." There is always room for improvement in management, especially within complex and changing professional systems. However, it is an illusion to think that, in Latin America and the Caribbean —where (in relative terms) public spending on health is half that of any country with a universal health system in any other region— this objective can be achieved by blind extraction of maximum productivity through purely quantitative goals (e.g., fewer inpatient days or more patients seen per hour). Goodhart's law, which notes that a quantitative target tends to lose its value as an indicator or measure of the phenomenon of interest when the target is used to reward performance, is worth remembering here.

Public provision of health services is generally more efficient and less burdensome than its private counterpart, although significant efforts are made by the media to discredit this evidence. All global health indicators have found that national health systems achieve better results at a lower cost than systems governed by market mechanisms (3). Spain is a good example, recognized worldwide for its robust public services. However, health care systems themselves all have private and public components, which operate under different and not necessarily homogeneous

logics. When setting public policies, can private providers be asked to abandon or restrain the profit motive? Is this reasonable to ask? Legal tools are available for this purpose. In fact, several health systems worldwide have accepted the challenge of including private providers while placing constraints on the logic of profits, including the theory of "permanently failing organizations," Systems such as France's or Canada's include private providers that are always close to market disequilibrium. Understanding this balance better means ensuring that the cost structures of private providers are transparent. This is a particularly valuable input when the public system acquires private services, since the setting and implementation of fees based on reasonable costs is essential in this context.

Different strategies for managing the contradictions between the logic of commodification and the logic of the right to health must be considered. How to manage these contradictions that are expressed in different spheres is a question that assumes that the private sector not only exists but modulates a large portion of the logics in dispute. Simultaneously, the private sector has many ways of evading the logic of public interest (including, but not limited to, corruption). The most frequent arguments in its favor refer to a purported greater efficiency, although they have been shown to be erroneous based on the evidence from evaluations.

3. Clear organization and coordination between levels of government, taking into account the different degrees of system deconcentration or decentralization

The systems of each country feature different models and levels of decentralization (transfer of competencies such as planning, coordination, control, and management; provision of health services to local governments with different degrees of autonomy in relation to the central government) or deconcentration (presence of central-government representatives within each territory, with different competencies and roles assigned to each level, but all reporting to the authority of the central government). It bears stressing that decentralization poses a challenge to the achievement of comprehensive and integrated care networks. Within this framework, regionalization must be analyzed to leverage economies of scale and ensure the comprehensiveness of the system.

In any event, it is imperative to ensure that the right to health is realized. This entails seeking a balance between universal access and the need to adapt benefits to local characteristics or particular social groups. Thus, health systems and policies

cannot be homogeneous, as the prevailing logic is to structure systems designed for those who hold the more power (e.g., white men living in major urban centers). There is a need for a system in which concepts and actions are at once integrated and diverse. The many examples of this include intercultural health (traditionally focusing on indigenous populations), health for women, girls, children, elderly people, people with disabilities, migrants, and people living in rural areas, island territories, or far from major urban centers, and people affected by natural disasters and humanitarian emergencies. To quote Boaventura de Sousa Santos: "We have the right to be equal when our difference makes us inferior, and the right to be different when equality jeopardizes our identity."

Centralized, decentralized, and deconcentrated models must all include characteristics that supplement the principles set forth in the Declaration of Alma-Ata. These include greater possibilities for social participation, adaptation of public policies to local realities, and greater representation of people from the areas where policies will be implemented. Some characteristics stray from the principles of Alma-Ata, such as inequity. Positive and negative characteristics do not simply come about naturally; they are the result of the specific arrangements that are implemented and that can be specifically regulated.

Coordination among the different spheres and levels of the State contributes to the development of coherent policies and strategies that promote the health and well-being of the population, considering different regional, national, and local realities, and with equity. Likewise, there is a need to coordinate the different types of providers (public, social security, military social security, police, private sector, etc.). Fragmentation and segmentation run counter to the principles of the Declaration of Alma-Ata on primary health care, they divide families and communities, and they turn systems into labyrinthic barriers to access. Also, some models of decentralization depend largely on health services provided by private entities. This can contribute to further segmentation of the population and differentiated access to services, something that should be avoided. It is feasible and necessary to ensure that systems are not based on privilege and that they promote equity in access, regardless of their degree of decentralization or deconcentration.

4. Social participation: empowerment to achieve change

It is important to define social participation, an essential factor for achieving transformations in the processes of social determination of health and in influencing the operation, design,

evaluation, and control of health systems. A mechanism whereby people and communities merely rubber-stamp the proposals of those in power cannot be considered true social participation. Social participation processes must be ensured in the identification of problems and in the design, implementation, and evaluation of policies. In addition, participation processes must consider the diversity of people and their freedom of association, without losing sight of the fact that they can reflect the asymmetric power dynamics of today's societies. This means providing the necessary support so that all communities can express their opinions, their will, and their preferences. No person can be deemed "unfit to participate."

Traditionally, it is the State health sector that works toward social participation in health. At the local level, health workers are not always those best trained for this purpose. If social participation is to be promoted, this aspect has to be addressed. In this line, experts in social sciences could play an important role as part of health teams. Having an empowered community and ensuring that workers and providers are also part of these processes, all within participatory spaces, can lead to a virtuous cycle.

It is worth noting that there is an (apparently growing) trend to create social or civil-society organizations funded by large multinationals that do not defend the public interests, but rather the private interests of their funders. How can we ensure that social participation defends the public interest? By way of example, a recent study (4) analyzed 104 patient advocacy organizations and found that 83% of those who disclosed the identity of their funding sources were supported by the pharmaceutical or biotechnology industry, while 12% did not declare their sources of funding at all. More than 40% of them had current or former pharmaceutical or biotechnology industry executives on their boards. Only 10% had a defined policy on conflicts of interest with the industry. Evidently, this also demonstrates low institutional support (including financing) for social organizations that defend the right to health. The industry is only too eager to fill this gap, and patients and family members must helplessly accept this result.

Some community or civil society organizations are enormously resource-poor and thus unable to carry out their management and operations and are supported only by their members' and partners' commitment to the public interest. This is often the case, for instance, of grassroots organizations for people with disabilities or older adults, both in urban and rural environments. Some organizations for people with mental disabilities (as well as other segments) have constantly complained of their inability to access more expensive new drugs that might be more effective and feel that they must rely on drugs supplied by the public system, which they consider less effective. This is a huge challenge because achieving universal access to medicines while ensuring their rational use means curbing the enormous pressure of the pharmaceutical industry to incorporate "new" drugs that are not necessarily more effective or safe but are always more expensive.

This reality underlines the need to implement health technology assessment processes that identify the most cost-effective medicines, based on the principle of the right to health, while protecting citizens and the State itself from the pharmaceutical industry. Pharmaceutical laboratories often try to market products that are not truly innovative or more efficacious, but simply represent higher profits because their prices are higher.

It is also necessary for states to conduct transparent assessment processes for new technologies and for them to inform and educate the population about the utility of these technologies. This should be based on the public interest to protect the health of the population and achieve system sustainability. The industry strategies described here are not only intended to deceive consumers, but also to create the perception of a limitation to access, even when equally (or more) effective therapeutic alternatives are available at a lower price. Clearly, identifying this problem is not enough; proactive actions must be undertaken to achieve a better understanding of it.

Institutional models must be capable of detecting the demands of the population and reacting in a relevant and timely manner. Returning to the example of advocacy organizations for people with mental (psychosocial) disabilities, their demands include the need to permanently push back against various regulations that allow involuntary institutionalization of these persons, violate their personal integrity through invasive and irreversible psychosurgical procedures, and even sterilize them without free and informed consent. Older adults perennially protest different aspects of health care, including the denial or insufficiency of palliative care. This includes, for example, restrictive laws preventing the use of opioids even in clear-cut cases of painful conditions or terminal illness.

Civil society organizations are faced with the challenge of securing funding that allows them to operate better, independently, and attending to the actual needs of their members. These organizations call for State economic support for public participation in the grassroots movement to be enshrined in law

and regulated. Just as political parties receive financial support from the State for their activities, so should social organizations.

Creating venues for dialogue is not enough. Proactive initiatives are needed to establish spaces for training and educating the population on issues related to health, the public interest, the social determination of health, active citizenship, and the conditions that threaten the full realization of the right to health. Meeting the population's demands cannot be limited to demanding more doctors, medicines, health centers, ambulances, and hospitals, though these are important. The health field is extremely complex and is becoming ever more complicated and the strong commercial and private interests that operate within it complicate it further. To address this reality, training processes must be established which incorporate methods such as popular education, whereby a process of mutual learning takes place based on recognition of the value of the diversity of human experiences. These processes must also establish links between the integrating aspects of the right to health and the strategies and policies that allow these aspects to be available with high quality and in an equitable, timely manner across all territories (including funding, governance, personnel training, care model, etc.). Furthermore, these venues for learning and active participation must involve health workers and providers, who are an integral part of their communities and can generate valuable joint construction processes.

Merely complying with existing, formal participation systems is not enough. We must constantly seek to create settings for participation in a fluid, dynamic manner, with special consideration for those who are not usually found in these settings. The most excluded people are not often represented, and they are the ones whose right to health is most violated. It is important to consider the dynamics of power that exist in our societies. These lead to inequities related to gender, ethnicity and race, culture, age, immigration status, sexual orientation, gender identity, socioeconomic status, and disability, among others. Participation processes may replicate this dynamic. Therefore, it is essential to look for effective mechanisms that allow the inclusive and equitable participation of all.

5. Ensuring the right to health, with particular attention to the institutional conditions that generate universal access, and providing for reasonable accommodations that consider human diversity

Care models that overvalue specialized services is something that the Declaration of Alma-Ata sought to overcome,

but it remains a reality. It is important to adapt care models that have not been designed for cities with increasingly dense populations. Primary care-based models in the different territories must be adapted to the characteristics of the population served, including location, mobility, activities, cultural practices, and social structures.

There are large gaps in access caused by insufficient numbers of health personnel to meet the needs of the population. This demonstrates the need for institutional models for adequate planning of human talent and capacities. Comprehensive policies that affect health personnel must be consistent with the overarching health care model and with the health needs of the population. To ensure this, they must be coordinated with the higher education system. Existing gaps must be determined according to the model of economic, social, and cultural rights, and to the prevailing model of care and the national health system. PHC-based models should be prioritized in the training of health professionals. This should begin with the university syllabus (focused on the community, based on primary health care, and considering the main health issues in the population) and continue in community practice settings. Implementation of a career track for health care providers may be a way to generate incentives for the most needed specialties, and to enhance the availability of trained and motivated professionals in remote rural areas. Equity in wage policies for health personnel must also be guaranteed.

Ensuring that working conditions for health professionals are not precarious is an essential condition for realization of the right to health. This entails implementation of fair, safe, and healthy employment arrangements for workers in the health sector—precisely those forms of work which do not prevail in the world today. Likewise, the role of health workers themselves is irreplaceable. There is an imperative need to strengthen human talent policies that recognize this fact and the particular nature of working in health care, and that address, for example, the burden involved in working in highly demanding areas, such as mental health or palliative care. We must also emphasize the importance of developing permanent, continued training policies so that health personnel are sensitive to and aware of the needs of the population from the perspectives of inclusion, interculturality, the life course, disabilities, etc. This also entails a greater capacity to create clinical protocols and guidelines that target specific conditions and population groups with particular needs.

Another barrier to access is caused by gaps in material resources, such as health facilities and equipment, where and at the time they are needed, according to technical criteria. This can be a complex issue to address due to political and economic factors, especially since the health system has suffered decades of neglect in many countries. Therefore, institutional models and authorities capable of finding solutions are required.

Access to medicines is another necessary condition for the achievement of universal health. Addressing this extremely complex need requires a national medicines policy that covers several aspects. These include defining a basic formulary of essential medicines, availability (taking not only price into account), price fixing, negotiation capacity (which may include regional joint negotiation mechanisms), promotion of rational drug use, and the use of traditional medicines. Likewise, capacity for health technology assessment is an essential condition. Otherwise, even policies to regulate access to medicines and other health technologies can be subverted into a strategy of the health industry to allocate resources toward expensive treatments with dubious benefit—resources that should instead be invested in primary care for the greater benefit of the people, as proposed in the Declaration of Alma-Ata.

With respect to facilitating access to medicines, various coalitions have participated in such processes for at least the last 20 years. In theory, these coalitions advocate for improving the health conditions of a country or region. Their activities include initiatives to support the promotion, prevention, control, and treatment of diseases based on the creation of support networks between different agents of the health and manufacturing sectors, such as industry, academia, civil society, charitable organizations, and, in some cases, governments. On the other hand, relations between industry and the State are considered coalitions in which a certain degree of codependence and cooperation develops to ensure results that will benefit both parties, since companies need the State to ensure their profits and the State can use these profits to fund its activities and implement various policies (5). These coalitions can achieve a favorable balance to support the supply of specific drugs, but they do not always represent the best intervention in health from a therapeutic and financial point of view.

Finally, another barrier that should receive priority attention is the lack of citizen access to information on the delivery of services, organization of the system, and the prevailing service model, among other aspects. The use of technologies that facilitate people's access and communication (mobile apps, telephone appointments, SMS, etc.) may be effective. Information is a potently empowering resource and must therefore be democratized.

Reasonable accommodation

Accessibility is an essential factor for the realization of the right to health. In this context, accessibility is understood as the set of conditions that must be met by physical spaces, transportation, information, communications, technologies, services, products, processes, and procedures so that everyone can use them in the safest and most comfortable way possible. They should also be affordable. Accessibility is an obligation based on human rights. It is the result of universal design, which entails that all people can use a certain environment without the need for adaptations or special design adjustments. For example, accessible spaces or transportation modalities can be used by people with disabilities, older adults, pregnant women, and infants in strollers, among others.

Reasonable accommodations are necessary and appropriate modifications and adaptations that do not impose a disproportionate or undue burden when they are required in a particular instance. Their purpose is to ensure that people with disabilities can fully realize or exercise all of their human rights and fundamental freedoms on equal terms with everyone else. Denial of reasonable accommodations constitutes a form of discrimination within the framework of human rights. As a result, accessibility is a permanent requirement in hospitals and other health facilities in terms of physical space, equipment, and personnel training. In contrast, reasonable accommodations are applied in individual cases according to their specific needs.

Another important consideration is that some people need extra support to express their wishes. This is vitally important when obtaining informed consent for surgery and other procedures. It implies that all personnel must offer information to the user in simple, direct language, and devote as much time to this step as is needed. The different forms of support needed for the person to express his or her wishes must also be identified.

Implementation of full accessibility requires legislation, budget, social participation, training, and oversight. The provision of reasonable accommodations and support in particular cases also requires a keen awareness of the environment of the per-

son who needs them and, obviously, of the health services. If these conditions are not met, millions of people will not be able to exercise their right to health—understood not only as access to care services, but also to the various aspects of the content of this right.

Judicialization of health

The judicialization of health, defined as the use of legal mechanisms to secure rights or induce the State to take compulsory action to meet certain health needs, has historically been used to realize and advance rights. As such, it is a legitimate mechanism that must be available to the public. International treaties on collective rights set forth that citizens should be able to resort to legal remedies to protect their rights; in this line, the authors reaffirm the fundamental value of this mechanism.

However, it is important to note that these mechanisms are sometimes used to favor third parties such as the pharmaceutical, tobacco, processed food, and other industries. Some countries in the Region have faced legal proceedings whose consequence is to force States to acquire medicines and other high-cost technologies that have not necessarily shown evidence of their efficacy and, in some cases, even of their safety. A recent study (6) conducted in the state of São Paulo, Brazil, found that 77% of drugs whose purchase was mandated by the courts did not comply with the established protocols of the Brazilian Ministry of Health. In addition, a statistically significant concentration of doctors and lawyers was found among the beneficiaries of these legal actions. This strongly suggests that the outcomes of such legal action benefit patients with better access to the legal system and medical advice.

Funding for these drugs and technologies comes from the health sector and can affect budgets earmarked for population-wide or collective health. This trend must be identified and analyzed in greater detail, so that strategies can be developed to address it. Health authorities define which medicines and health technologies can be used and acquired with public funds in a given country, and the outcome of some legal proceedings undermines their stewardship role.

Since the judicial branch is part of this problem, it is necessary for specific training and awareness strategies to be aimed at different parts of the health sector. These issues are highly complex and require a high level of technical knowledge on the subject. Ministries of health must have the capacity to mount strong legal defenses based on the right to health, and that take into account both technical health aspects and legal aspects.

The right to health is progressively implemented, like other economic, social, and cultural rights. Its realization through the judicial system must be compatible with more general interests (e.g., legal remedies against discrimination in health care).

6. Prioritization of sectoral management with oversight and control capacity

Institutional mechanisms to ensure transparency in the use of resources are essential. Examples include the use of public procurement processes for the purchase of goods or services with the possibility of citizen oversight and social control. In the event that the national model provides for the purchase of services from the private sector (which, as noted above, may run counter to the objective of achieving universal health), it is essential that such procurement be done at set prices that take into account cost structures consistent with the local reality and the rational use of State resources. To this end, information on the cost structures of public and private services must be made available. Often, this information is difficult to access because it reveals unjustifiable inefficiencies in the use of public resources.

The issue of transparency warrants more systematic analyses to ascertain the reach of strategies designed to contain corruption, a phenomenon that affects not only the health sector. If there is no clear meaning of what corruption is and how it operates structurally, tackling it decisively will be impossible. In other words, corruption cannot be regarded only (or even mainly) as an individual matter. It is an organic issue, with firmly established structures and processes that must be clearly recognized in order to be destroyed.

Within the context of countries with historically underfunded health sectors, there is a permanent need for renewal of infrastructure or equipment. It is imperative to ensure transparent procurement processes that comply with quality standards, but at the same time are subject to rigorous cost-benefit analysis, especially in virtue of the multi-million-dollar amounts allocated to these purchases. Furthermore, oversight and control should not be limited to the moment when the need is identified or even to the procurement process itself. Adequate maintenance must be ensured in order to prevent early deterioration, short service life, and the subsequent cost of replacements. The same applies to the procurement of medicines and medical devices, among other goods.

Transparency in personnel hiring is also important. Meritocratic systems that promote greater representation of social diversity in the health professions strengthen the capacity of services to reach out to the population, ensuring cultural and linguistic relevance and enhancing quality of care.

Other elements that must be considered, depending on the structure of the system, are medical auditing processes (to ascertain the relevance of purchased services and the appropriate and timely use thereof), citizen oversight of management, as well as the planning, management, and evaluation of results at all levels of management, with measurable indicators.

Focusing efforts on responding to the health needs of the population requires nominal information systems. Examples include electronic health records and epidemiological and health surveillance systems, which must interface with different surveillance systems, different levels of care, and different public and private providers. It is essential to establish follow-up processes to verify the degree of agreement between resources used, interventions carried out, and health outcomes achieved. Adequate funding must be permanently available for this purpose. In addition, qualified human resources should be available to carry out oversight and control tasks. Otherwise, the stewardship function will be fruitless.

7. Regional integration as a mechanism to strengthen health policies in the Americas

In the current global context, many major actors (states, multinational corporations, and even individuals) have achieved levels of economic power unprecedented in human history, allowing them to forcefully assert their interests. An effective response in such cases is to reach common, shared positions among states, since, in a democracy, the State is the legitimate representative of the population in defending the best interests of its health from a shared perspective. The strategy of sharing positions at venues such as the World Health Assembly has proven effective to place on the agenda issues such as universal access to medicines and the incorporation of control mechanisms against potential conflicts of interest in the relationship between third parties and WHO. Other examples include cooperative strategies to push back against industry interference in the design and implementation of public tobacco control policies, labeling of processed foods, and regulation of advertising of breast milk substitutes. Regional health goals such as universal access to health and universal health coverage are being continually weakened by subordination to eco-

nomic and financial constraints. This requires forging regional alliances and creating forums for negotiations that favor health in the Region.

Joint, coordinated stances at the global level continue to drive common-interest approaches, such as health as a right, PHC-based health care delivery models, control of third-party participation, ensuring transparency when conflicts of interest are present and sovereignty in the process of strengthening surveillance (e.g., in implementation of the International Health Regulations), using horizontal international cooperation and the exchange of technical experiences as tools.

Integration processes that offer mutual support in the pursuit of common health goals are fundamental for equitable development among countries, optimization of the use of resources, and acceleration toward the achievement of targets. Regional integration processes have created venues for the identification and exchange of best practices, policies, strategies, regulations, protocols, and technical instruments. This can be achieved through bilateral cooperation or through multilateral strategies to speed implementation of effective policies or prevent re-implementation of processes that did not have the expected impact.

There are many noteworthy experiences in the Region, such as the work done by the health authorities of the Caribbean Community (CARICOM) and its public health agency, CARPHA; the Andean Health Agency; and UNASUR, which includes universal health systems among its objectives. A concrete example of the valuable contribution of UNASUR to regional health is its drug pricing database, launched in 2016, which revealed massive asymmetries in drug procurement conditions between countries. It also stands out for its focus on social issues (something excluded from integration mechanisms established for trade purposes) and for the establishment of its Institute of Government in Health, which focuses on strengthening State capacity for stewardship and governance. The Southern Common Market (MERCOSUR), meanwhile, has jointly negotiated drug prices and made important advances in improving the negotiating capacity of its Member States.

Processes such as forced displacement and the many impacts of climate change are becoming more acute. It is therefore increasingly important to strengthen diplomacy, international relations, and integration for health. These mechanisms are clearly weakening in the current scenario, making it essential to make their contributions more visible, since, at least in the field of health, their contributions have been invaluable.

CONCLUSION

This document has sought to highlight the issues that challenge institutional models today and going forward, as well as the linchpins in the process of strengthening the stewardship and governance capacity of the State as an effective guarantor of the right to health.

Forty years after the Declaration of Alma-Ata, advances and challenges in health in the Region highlight the need for robust institutional models to exercise stewardship and governance over health systems. These models must also be able to address the social determination of health through intersectoral relations and inclusive, comprehensive, and effective participation mechanisms.
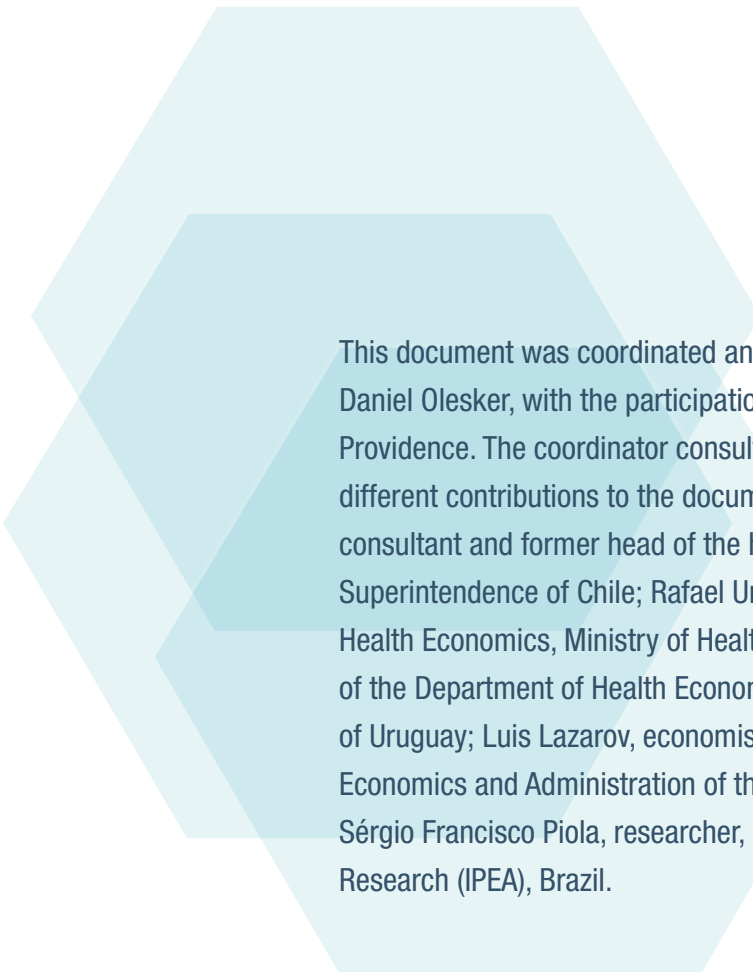
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ANNEX 3:

Financing Model

This document was coordinated and prepared by commissioner Daniel Olesker, with the participation of commissioner Chelauna Providence. The coordinator consulted a group of experts who made different contributions to the document: David Debrott, independent consultant and former head of the health studies department, Health Superintendence of Chile; Rafael Urriola, economist, Department of Health Economics, Ministry of Health of Chile; Ida Oreggioni, head of the Department of Health Economics, Ministry of Public Health of Uruguay; Luis Lazarov, economist, graduate of the Faculty of Economics and Administration of the University of Uruguay; and Sérgio Francisco Piola, researcher, Institute of Applied Economic Research (IPEA), Brazil.

Introduction

The subject area of health financing models comprises the following key elements:

1. Financing models.

2. Appropriate public financing.

3. Fiscal space to ensure universal health.

4. Political viability of fiscal space.

5. Financing alternatives and sustainability of health expenditure.

6. The need to invest in health and the costs of not doing so.

7. Conflicts of interest in health financing.

These key elements reflect particular concern regarding resource pooling processes and ensuring sufficient public financing to develop a comprehensive health model based on primary health care and guided by the Universal Health strategy. Fiscal space must be created to increase resources for this purpose.

This fiscal space should be created through changes in fiscal policy that do more to raise revenues progressively, from sectors with greater economic capacity. It is also necessary to establish medium- and long-term mechanisms that guarantee the sustainability of financing, given the need to effectively contend with future health and demographic challenges.

Good health is a factor in economic growth and development, and this means there is an opportunity cost associated with failure to invest in health. Health systems should also be given adequate regulatory capability to address conflicts of interest and their consequences, which is crucial in order to avoid waste of resources.

The following sections address each of the seven key topics in more detail.

FINANCING MODELS

The financing of health systems gives expression to the concepts of universality, social justice, and equity in access to health.

Therefore, beyond the necessary technical discussions to define a direction of a model, the choices to be made basically concern political economy. How to finance the system and how to allocate resources are two key decisions that relate to the political economy of health.

Some models prioritize the social and solidary nature of health financing, in the sense of accessibility, and therefore dissociate access to care from people's ability to pay. These financing models are based on public resources (1). Other systems rely on private financing, making use of mechanisms such as prepayment, copayments, or direct payment of the total cost of care at the time of utilization, or requiring prepayment of private insurance premiums.

In models based on social-public financing, the central objective is to achieve universality, with egalitarian access and with no financial burden on households. State intervention is strategic and defines the health regulation model desired.

In models based on private financing, universality is seen as a function of the market's capacity to offer more efficient services. State intervention is subsidiary, intended to correct market failures and provide access to excluded sectors.

It is obvious that for health to be accessible and universal, there is no alternative other than a model based on public financing.

1. Structure for financing health systems

Two main theoretical models exist: the Bismarck and Beveridge models. In terms of financing sources, the Bismarck model is based on social security contributions, whose level is pegged to the income of contributors. The Beveridge model is basically financed through general taxes that are not specifically for health, but tax contributions are proportional to income (2, 3).

In both cases, the exercise of the right to health is independent of the individual's economic contribution. Furthermore, the quantity and quality of health care is the same for everyone, and its financing is predominantly public.

A full exploration of the differences between these two models and their background is beyond the scope of this paper. Instead, the models may be seen as two systemic alternatives to the private financing of health, a system notorious for its exclusionary tendencies. But it is important to point out that the political economy of health systems and the decision to adopt one or the other of these two models, or a mixed model, also depends on the situation of each country, and in particular, on its distribution of wealth and the level of formality or informality of its labor market.

It should also be noted that the debate about the consequences of applying these models refers to the models in their "pure" forms. However, the reality is more complex and multifaceted, and therefore these conclusions should be kept in perspective (3, 4).

Once these adjustments have been made, it can be seen that in the most advanced cases of application of these models, health financing funds are pooled[1] so that they cover the probable or expected costs of care for the population, ensuring that the financial risk of health care is socialized.

Some studies differentiate cases involving national health insurance from the Bismarckian social security-based models of health. The former models feature varied sources of financing (contributions or general taxes), pooling of resources, and a single-payer structure, together with a diverse health care model in which both public and private entities participate in the provision of services, subject to public regulation (5, 6).

As outlined above, the pooled resources constitute a public, universal fund, connected with a national health service, under the Beveridge model; or a health social security fund under the Bismarck model; but in both cases, the core element is the establishment of a single fund.

It should be noted that Bismarckian models did not initially feature a single fund, but rather funds attached to the economic branches or sectors that employed the workers who were beneficiaries of these funds. This was the pattern for decades. However, as these models have developed further, proposals have been made in the most advanced cases for changes aimed at achieving equity in financing. These proposals involve a requirement to create a single fund, through a mechanism based on redistribution of income and risk-adjusted payments, usually capitated, to the health or sickness funds (7). This current vision will be discussed further below.

2. Characteristics of health funds

Some key characteristics of these funds are:

- Contributions or taxes are set in proportion to the individual's ability to pay, and those who lack the capability to make contributions are afforded similar coverage and access.

- Enrollment in the fund is compulsory.

- The administrative organ of the fund serves as the single payer for comprehensive coverage of mandatory services through the health system.

- The mechanism of payments to health providers for care is based on the expected cost of the health risk.

- The large scale of these funds leads to gains in efficiency and makes it possible to avoid the effects of external shocks.

Clearly, financing models should be coordinated with models of expenditure. Otherwise, there is a risk of establishing an exhaustive catalog of models, options, structures, instruments, and objectives, both qualitative and quantitative, that may or may not be compatible with desirable levels of expenditure.

Financing has its own objectives of universality and social justice, but at the same time, it has to serve as a means of achieving the objectives of health spending in terms of health and social efficiency. Among these, it is particularly important that health coverage offer certain benefits and a consistent quality of services.

Another important issue in the debate on financing is the need to minimize, and eventually eliminate, out-of-pocket expenditures, so that they neither create barriers of access to the health system nor impose catastrophic or impoverishing expenditures when people face health problems (8, 9).

APPROPRIATE PUBLIC FINANCING

1. Sufficient financing

A second linchpin is appropriate and sufficient financing. These qualifiers are related to each other, since the condition of "sufficient" raises the question of "sufficient, for what purpose?" This leads to the concept of "appropriate."

In the short run, fragmented, curative models of health care probably require fewer resources to implement than comprehensive, prevention-based models. But in the long run, they are clearly not sustainable financially. They do not ensure health, but merely provide "benefits."

By contrast, with respect to what is "appropriate," the process that was initiated in response to the Declaration of Alma-Ata

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1   The Bismarckian models do not always feature a centralized and complete pooling of resources that allocates resources to sickness funds or insurance funds. This has been the tendency since the 1990s in countries such as Germany, Belgium, the Netherlands, and Switzerland, to name a few of the clearest cases (Van de Ven et al., 2003).

defined a comprehensive model based on the strategy of primary health care (PHC), with emphasis on addressing the social determinants of health.

2. Financing for universal health

At its annual Directing Council in 2014, the Pan American Health Organization (PAHO) set the goal that public expenditure on health should be equivalent to 6% of gross domestic product (GDP). The document proposed that, considering the particular circumstances of countries, public health expenditure equal to 6% of GDP is a useful benchmark for reducing inequities and increasing financial protection within the framework of universal access to health and universal health coverage (9).

The PAHO resolution reaffirms the proposal for public health expenditure equivalent to 6% of GDP. It also emphasizes that allocation of these resources should give priority to the first level of care in order to expand the supply of quality services and rapidly address unmet health needs (9). Some countries and authors even maintain that the percentage allocated to PHC should not be lower than 30% of total expenditure (10).

An increase in public health expenditure is a necessary though not sufficient condition to achieve universal access and universal health coverage (9). The literature shows that those countries that present better indicators with regard to access to health services and financial protection surpass this threshold (8, 11). This is an indispensable central element of a strategy for strengthening health systems with emphasis on primary care.

Studies presented to this group by the PAHO health economics and financing team show that few countries of the Region have achieved this level of health spending. In some cases, they are a significant distance away from the goal (12). This reality points to the importance of the next core element, fiscal space.

FISCAL SPACE TO ENSURE UNIVERSAL HEALTH

The various studies carried out by PAHO teams define fiscal space for health as the decision by governments to allocate additional resources to health. Such allocation should not alter the general fiscal sustainability of the government, nor reduce expenditure in other areas of fiscal and macroeconomic priority (13-15).

Accordingly, fiscal space rests on the following pillars:

- Justification of the need for an increase (why and for what purpose more resources are needed).

- The political will of governments to grant the increase, giving priority to general social spending and to health spending in particular.

- Generation of sustainable additional resources.

- Utilization of these additional resources in a manner that reflects health priorities.

- The overall sustainability of expenditures.

1. Sources of additional resources

It is clear that there are different ways to raise additional resources, depending on the nature of a country's health system and the public system that finances it.[2]

An "inertial" source of additional resources for increased expenditure are resources obtained through economic growth. Obviously, with respect to an inclusive political economy, economic growth in itself guarantees nothing—neither distribution of wealth nor access to social goods. The link between growth and development (including comprehensive and inclusive health systems) depends on the nature of the growth model (16). In the neoliberal models, which are externally oriented, reproduce inequality, and feature a deeply deregulated "health marketplace," growth of GDP may not result in additional resources for health. Indeed, such growth may even trigger price increases in the sector, resulting in higher health expenditures without any impact on health.

An initial debate concerns the adoption of a formula that specifies an increase in general social spending and health spending in particular as a proportion of the increase in general revenues, creating an initial source of fiscal space for health. Greater fiscal space depends not only on an increase in overall revenues, but also on a decision to direct a greater share of those revenues to health expenditure.

A second key source of additional resources consists of mandatory, wage-based contributions by both users and employers (who, as will be seen below, benefit when their workers are in good health). At the same time, in some countries of the Region

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2   PAHO's analytic framework recognizes the following sources of fiscal space: a) economic growth, b) reprioritization of health in total public expenditure, c) taxes, d) reduction of informality, e) specific taxes, f) reduction of tax expenditures, g) external financing, and h) increased efficiency (PAHO, 2018).

such as Chile, only personal contributions are required, and not employer contributions. But the size of these contributions depends on the degree of formality of the economy and on average wage levels, and thus their viability is often influenced first and foremost by a comprehensive policy of labor market formalization (14).

The third source of resources is, without question, a comprehensive overhaul of taxation schemes throughout the Region. This involves an increase in general taxes, especially in countries where tax rates are low, and especially with regard to taxes levied on wealth and capital (financial capital, productive capital, and real estate) or on intensive exploitation of natural resources (14).

A fourth source of financing consists of specific taxation of products that are harmful to health. The underlying rationale for using such taxes to help finance health expenditure is to improve the health of the population. Examples include tobacco and alcoholic beverages, among others. It should be emphasized that the benefits of such taxes do not depend entirely on their collection (tax revenues should come mainly from the direct taxes mentioned previously). Rather, the taxation of risky products is in itself a public policy aimed at discouraging their consumption and thus reducing damage to health (14, 17).

A fifth source of resources comes from making countries' tax-collection processes more efficient. This implies taking action to curb tax evasion and tax avoidance. It also entails policies to reduce the high rates of labor market informality that characterize the countries of the Region (14).

The efficiency of health expenditures can also be a source of fiscal space, a point that will be discussed below.

The advance of globalization and competition between countries for foreign investment has significantly increased tax concessions (or "tax expenditures") granted by countries of the Region. The results should be evaluated and further discussed in light of the revenue losses they generate. The reduction of these tax expenditures becomes a sixth source of additional resources (18).

Finally, the size of health expenditure as a share of total public expenditure needs to be addressed. Enlarging this share may serve as a source of new resources for health, although strictly speaking these are not new resources in terms of overall public expenditure. Increasing the fiscal priority to health in national budgets is an option that should be seriously considered in a Region where public health expenditure represents, on average, scarcely 12% of total public expenditure (12).

2. Efficiency of health expenditure

It is clear that increased expenditures should be accompanied by improved efficiency. Some authors describe efficiency gains as a source of fiscal space, because resources previously spent ineffectively are freed up for better uses (14). Accordingly, together with indicators of health expenditure and its distribution by level of care, factors related to production or territory should be included in an analysis that incorporates efficiency indicators. In this case, redistribution of expenditure and the key elements of efficiency analyses are included. And it is evident that this fiscal and macroeconomic priority should not depend on business cycles but should constitute a permanent source of resources for health. This requires political will on the part of governments, along with organized social participation.

a. Redistribution of expenditure

Another way to create additional resources is to redirect health expenditures within the system, with both immediate and medium-term effects.

Based on the Declaration of Alma-Ata, and in line with the orientation of PAHO, the additional resources should be used to help transform the highly inefficient model of care that is prevalent in the Region, centered on hospitals, curative care, and specialized medicine. To enhance efficiency, additional resources should be used to strengthen the first level of care, in accordance with a PHC strategy, increasing the resolution capacity of primary care within integrated health networks (10, 19).

Use of health technologies, in terms of their access, evaluation, and optimized supply, is another aspect of the efficient use of resources. It is essential to carry out technology assessments, focusing on both quantity and quality, within the framework of a model that gives priority to the primary health care strategy.

Another factor affecting the distribution of expenditures is the unequal wage structure that predominates in our health systems. Inequality should be reduced by making improvements at the base of the pyramid, especially for nonmedical health personnel. Beyond addressing the political and ethical aspects of wage inequality, such improvements have an impact on efficiency. Generally speaking, unequal wages disadvantage primary care professionals and favor specialists, a pattern incompatible with the model and strategy set forth in the Declaration of Alma-Ata.

It should be kept in mind that the production of health services is labor-intensive. Expenditures are concentrated in this seg-

ment of the health sector, with an impact that goes beyond wage levels.

Also relevant are the models for contracting human resources, which vary widely between countries. Processes of solarization coexist with the deregulation of specialist personnel and with the role of medical companies that sell services. It is time to consider the need to standardize these systems.

A final aspect of distribution has to do with territory. Inequalities in per capita resources between different regions are significant and should be reduced. A related problem is the provision of resources to less-developed territories, for both personnel and infrastructure. There is a critical need for policies that promote decentralized or deconcentrated investments, as well as decentralized or deconcentrated provision of human resources.

b. Efficiency in health

Efficiency is a concept applied to the economy and its sectors. In health, it has specific meanings, based on some of the following definitions:

Technical efficiency: In general, technical efficiency implies obtaining the best possible results from a given level of resources, or rather, minimizing the utilization of resources for a given level of health services delivery (20).

Allocative efficiency: Allocative efficiency generally implies doing the right thing, at the right place and time, allocating resources in a manner that reflects social priorities in health. Allocative efficiency includes technical efficiency and implies taking the correct actions and executing them well (19).

Dynamic efficiency: This refers to the flexibility of the health system in terms of its ability to innovate and to introduce new technologies (e.g., new drugs or procedures), new programs, and new forms of organization, in order to better meet the needs of the population and of health system users, with the same level of resources or less, and with sustainability (19).

As discussed above, technological innovation should be evaluated not only in light of financing capacity, but also in relation to the health system model and access to the system. When it comes to high-cost technologies, government support is key.

Applying these concepts to health, we can say that an efficient allocation is one that distributes resources among health providers and services, that seeks to optimize the function and production of each care network, and that achieves the greatest possible reduction of morbidity and mortality, equitably and with financial protection. An equitable allocation of resources is one

that helps bridge the gaps in access to health care and that links distribution to the sociodemographic characteristics of the population, considering the social determinants of health.

The allocation of resources should help narrow the gap between per-person health expenditure based on critical health factors and the demand for services. Furthermore, it should support health actions aimed at promotion, prevention, and control of diseases at the territorial level.

3. Expenditure on primary health care

The first level of care is the catalyst for the system of health services delivery. It is the central element to be developed as part of any strategy to strengthen health systems, including the universal health strategy. The aim should be to strengthen the first level of care to improve its capacity for articulation of service networks as well as its resolution capacity.

In turn, the first level of care should promote the primary health care strategy, which relates to promotion, prevention, treatment, and recuperation. The focus should be on people and communities, on work with interdisciplinary teams, and on addressing the social determinants of health.

Measuring expenditure on primary care is a complex task. Financial (usually budgetary) information systems are not structured by level of care, and they register expenditures without necessarily linking them to these levels. Even when national health accounts are expertly prepared, essential information is lacking. There is a need to define and establish the scope of the first level of care and of PHC.

A review underway at PAHO finds that average spending on the first level of care as a share of total public health expenditure is between 20% and 25%. Toward the high end of the scale, El Salvador and Bolivia spend 44.2% and 38%, respectively, on the first level of care, but with low per capita health spending. By contrast, the most developed countries of the Region spend smaller percentages on the first level of care (12.5% in the United States and 19% in Canada) but have much higher per capita expenditure (easily 15 times greater). Cuba's expenditure on PHC (42% of total health spending) is the highest per capita in Latin America and the Caribbean, equivalent to almost 2,500 international dollars (13).

All these percentages appear low, however, considering that the first level of care should be able to respond to 70% of the burden of disease, as is often stated (21), and that it probably handles more than 80% of patient consultations (22). It is

important to set goals in this regard in order to motivate the countries to place greater emphasis on PHC spending.

4. Health and social policies

Although this issue is addressed in another strategic line of action, the efficiency of health systems depends to a great extent on the larger set of social policies that a country adopts. Here, therefore, we will consider the integration and articulation of health policies with social policies from a multisectoral perspective, considering the social determinants of health.

Health systems are enmeshed in the broader system of social protection, with respect to both universal coverage and the support of populations with greater social vulnerability. In this context, the formalization of the workforce is a central public policy because of its implications for health insurance (23).

POLITICAL VIABILITY OF FISCAL SPACE

It is obvious that the debate on fiscal space for health includes a political economy component that cannot be ignored (14). In particular, there is a need for social and political coalitions that can lead the effort to promote creation of this fiscal space within the framework of a socially inclusive model. Steps should be taken to launch initiatives involving actors who should take part in the broad social dialogue that lends political viability to fiscal space for health.

Proposals for the reform of taxation should outline the purpose of the new spending that these economic changes would support. In other words, it should be clearly explained what the new expenditures on health will consist of and how they will benefit citizens. For example, health reform in Uruguay, where the first step was to include children and adolescents in the health system, enjoyed wide acceptance because there was transparency about how the new resources would be used (24).

At the same time, increased health spending should give rise to new institutional frameworks that support the development of systems of universal coverage and universal access, and that guarantee citizens and health providers a stable social consensus around health.

Furthermore, the capture of new resources for health should stem from changes in fiscal, tax-related, and social security policies with a view to raising more revenues from sectors with greater contributory capacities. These changes should aim at a progressive financing structure, so that the tax burden is proportionately greater on high-income and upper-middle-in-

come sectors than on low-income sectors (25). Contributions pegged to income, such as social security contributions or income taxes, are more favorable to equity than indirect taxes tied to consumption.

This brings us back to the political economy of health. Changes to the structure of taxation that give priority to raising revenues from high-income sectors, and from patrimonial capital and inherited wealth, are a central pillar of a socially inclusive model and the transformation of health systems in the Region.

FINANCING ALTERNATIVES AND SUSTAINABILITY OF HEALTH EXPENDITURE

In a context of efficiency and equity, sustainability can be achieved through continuous application of the concepts outlined above. The system should have the capacity to incorporate the necessary innovations and withstand external pressures, such as those due to economic crises.

1. Pressures that threaten sustainability

Some pressures come from the demand side. These are linked to rapid epidemiological change, with a growing predominance of chronic diseases, and to the health needs of aging populations. They also reflect the steadily increasing expectations of citizens.

On the supply side, pressures arise from the complexity of the system itself, from the drive to incorporate increasingly complex technologies used in treatments, and from the fragmentation that characterizes segmented health systems.

Furthermore, countries are experiencing a slow economic recovery after a massive crisis and severe indebtedness that has led to structural adjustment and fiscal austerity policies, with variations among countries.

2. Measures to promote sustainability

Different policies can contribute to the sustainability of expenditure when applied in tandem with appropriate and sufficient financing. One with potentially the greatest impact, according to studies, is a change in payment systems that motivates health care providers to collaborate and to participate in people- and community-centered activities. Another approach is to carry out intersectoral actions to achieve synergies to address the social determinants of health. These are valuable policies that can be implemented or strengthened to support sustainability.

It is important to keep in mind that fragmented and isolated financing initiatives will not solve the problem of sustainability of health systems. A holistic view of these systems is necessary, along with an institutionalized belief that the health system plays a necessary and vital role in a country's economic and social development. From this perspective, sustainability can be addressed through four strategic lines of action:

1. Improve the sources of resources for health.

2. Promote efficiency with solidarity through the pooling of resources.

3. Efficiently allocate and manage these resources to achieve health objectives.

4. Strengthen general planning and budgetary planning in the public sector.

With regard to financing sources, as discussed above, the low fiscal priority given to health is a problem that must be addressed to make national health strategies sustainable. Pooling of resources should be promoted and institutionalized with a view to extending it to the maximum possible. Health systems benefit from economies of scale achieved through resource pooling, as well as from the associated improvements in efficiency and sustainability.

With regard to resource allocation and the competent and efficient management of expenditures, it is important to deepen the implementation of integrated health services networks based on strengthened primary care, with a financing system that promotes such networks. Steps should be taken to bolster information systems, strengthen the basic functions of the organization, and promote the use of protocols in order to reduce variation in clinical practice that increases costs, among other consequences. Within this context of work in integrated networks, there is a need to reform the budgetary structure, which should reflect the new patterns of service delivery.

Finally, sustainability should be underpinned by regulatory mechanisms (which are analyzed in depth in other sections of this paper), as well as by strong information systems. This includes regulation of medicines through policies for joint or centralized procurement, use of explicit lists of medicines subject to universal coverage, promotion of the use of generic medicines, development of protocols to support rational use, and direct regulation of prices to ensure sustainable access.

THE NEED TO INVEST IN HEALTH AND THE COSTS OF NOT DOING SO

The need for more resources for health is not only a matter of access and coverage. It is also important to evaluate the likely consequences of failing to invest in health. This is one of the key points in the debate on economy and health.

1. General investments in health

Various studies carried out by PAHO show the costs associated with failing to invest in health systems and in comprehensive social protection mechanisms. These studies focus on specific pathologies and social determinants. For example, the effects of tobacco, sedentary lifestyles, and obesity, and the absence of prevention policies aimed at these risk factors, drive up health expenditures and jeopardize the sustainability of the health system as a whole.

Health investment also has an impact on labor productivity, and by extension on economic growth. Various authors agree that better health together with better education results in higher-quality work. This implies greater productivity and, thus, greater economic growth. Other studies point to the positive effects of better health on the individual's capacity for learning, flexibility, and ability to adapt to change. All this gives rise to a virtuous circle: as more resources are generated, they make possible a higher level of expenditure (26-30).

In only a few decades, health has gone from being a residual factor in analyses of economic growth to occupying a central space. Economic theory has recognized health as one of the principal explanatory factors in productivity, growth, and poverty reduction.

The report of the WHO Commission on Macroeconomics and Health, known as the Sachs Commission (31), was decisive in establishing the relationship between health and growth, calling for investment in health as a means to promote economic development of the poorest countries. The justifications set forth by the international agencies that supported formulation of the Millennium Development Goals in the year 2000, and more recently the Sustainable Development Goals, are grounded in this same logic.

The Global Health 2035 report, produced in 2013 by the Lancet Commission on Investing in Health, again highlighted this connection. In 2016, a WHO/UN report on investment in human resources for health, jointly led by the director of WHO and

the presidents of France and South Africa, also based its analysis on the relationship between health and growth (32, 33).

History offers us various examples of countries —the United Kingdom and Canada, among others— that accelerated their development in large part thanks to the good health of their populations (31). Moreover, a number of studies suggest that countries with high rates of disease experience little or no economic growth.

In the Region of the Americas we find a correlation between greater public expenditure on health and better outcomes (12). The relationship between life expectancy at birth and public health expenditure as a percentage of GDP in the countries of the Americas shows that increased public health expenditure is strongly associated with higher life expectancy and with lower mortality from diabetes mellitus, heart disease, and cancer. The same holds true of the infant mortality rate. This relationship has been confirmed in other regions and countries of the world (34, 35).

2. Investment in PHC

In countries that have achieved better levels of health, health systems are focused on primary care, with a more equitable allocation of resources for PHC. In these countries, the government provides health services or health insurance, with limited participation by private health insurance, and there are no copayments (or very low copayments) for health services (36, 37).

In England, each additional primary care physician per 10,000 population (an increase of approximately 15% to 20%) is associated with a nearly 6% reduction in mortality, after controlling for limiting long-term illness and for demographic and socioeconomic characteristics. Another study that monitored adults age 25 and older for five years, carried out in the United States, showed that both spending on health care and the mortality rate are lower when an individual's personal physician is a primary care physician, rather than a specialist. Those in the subgroup with a primary care physician had 33% lower costs of care and were 19% less likely to die (38).

Many other studies conducted in industrialized and developing countries show that areas with more robust primary care present better health outcomes with respect to the overall mortality rate as well as heart disease, infant mortality, and early detection of cancers such as colorectal, breast, cervical, and uterine cancers and melanoma. In areas where highly specialized care predominates, a contrasting picture is seen, as this tendency is associated with worse results (37).

CONFLICTS OF INTEREST IN HEALTH FINANCING

Transparency and regulation against conflicts of interest in health financing is crucial. Conflicts of interest can arise because of the market structure in models where the private sector plays an important role. These models are conducive to collusion, which in turn has an impact on prices, on the quantity and quality of benefits, and, less visibly but just as harmfully, on selection processes. This may result in a lack of necessary services, with negative effects on equity, or, conversely, in an excess of services or their unnecessary use, because of the effect of moral hazard on supply and demand.

Some of these problems also occur in public models, for example, as a reflection of underfinancing, which encourages the exclusion of groups that present greater costs to the health care system. Corruption also appears in deregulated models at several levels of the health system, for example, in procurement of medicines (9). This represents an important loss of resources for the system and for society that should be avoided.

Private industry, such as pharmaceutical interests and makers of other health technologies, should be regulated so that necessary medicines and technologies can be incorporated into health benefits appropriately and acquired at the lowest possible cost, not at prices influenced by monopoly or collusion.

It is essential to strengthen capacities for regulation, leadership, and steering of the health system and its institutions. Also vital are intersectoral relations with the agencies concerned with these types of problems in the economy as a whole.

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ANNEX 4:

Health and Social Protection: Elements for Discussion[1]

Introduction

Equality is an ethical imperative. However, in a region characterized by profound structural gaps in various areas, including health, it also has direct implications for increasing productivity and accelerating economic growth.

Reducing inequality is a necessary condition for development of the Region. The social disparities that affect populations in the Americas are a key obstacle to the population's effective enjoyment of their economic, social, and cultural rights. Inequality also has a negative impact on productivity, fiscal policy, environmental sustainability, and the spread of the society of knowledge (1). In addition to being unjust, inequality is inefficient and constitutes a barrier for growth, development, and sustainability. Therefore, equality should also be seen as an impetus for efficiency (meaning the full utilization of capacities and resources) and for the sustainability of the economic system.

Guaranteeing the right to health is the cornerstone for the eradication of poverty, the reduction of inequality, and for sustainable economic growth and development. Infringement of this basic right, as expressed in unequal access and the resulting health outcomes, reduces capacity and hence opportunities, thus compromising innovation and increased productivity. Healthy, well-nourished people have greater physical and mental capacity for work and lower rates of absenteeism. Their state of health also indirectly affects productivity by aiding cognitive development, learning capacity, and educational performance, as well as their ability to learn and acquire new skills (1).

In the Americas, heads of State and government leaders have recognized that health is a fundamental right of the entire population, an essential condition for the integral and sustainable development of peoples, and a necessity for economic growth with equity. At the last Summit of the Americas, held in Panama in 2015, the countries of the Americas proposed to move forward on various fronts. These included universal access to health and universal, quality, comprehensive, and timely health coverage without discrimination and access to safe, affordable, effective, quality essential medications as essential elements in achieving equity and social inclusion.[2]

Universal access to health and universal health coverage means access by all people and communities, without any form of discrimination, to appropriate, timely, and quality integral health services. The World Health Organization (WHO) has recognized that enjoyment of the highest attainable level of health is one of the fundamental rights of all human beings, regardless of race, religion, political ideology, or social or economic status.

At the Inter-American level, recognition of the right to health and universal health coverage is also established in a number of binding legal instruments, including the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, better known as the Protocol of San Salvador, adopted in 1999. This instrument enshrines the right to health and mentions the fulfillment of this right. Within the context of development of a health system it states that, however basic, such a health system should guarantee access to primary health care (PHC) and the progressive and continued development offering coverage to the country's entire population. The Social Charter of the Americas, subscribed within the framework of the Organization of American States (OAS), affirms the fundamental international principle that "the enjoyment of the highest attainable standard of health is a fundamental right of all persons without discrimination" for race, religion, political ideology, or social or economic status, and recognizes that "health is an essential condition for social inclusion and cohesion, integral development, and economic growth with equity". In this context, the Member States have reaffirmed their responsibility and commitment to improve the availability, access, and quality of health care services geared to advancing towards fulfilling the enjoyment of the right to health.

The concept of health has gone through a long history of redefinitions, from the notion of the absence of disease to "a state of complete physical, mental, and social well-being," established in the Constitution of the World Health Organization (2). Today, health is seen as a multidimensional phenomenon that involves individuals interacting with their sociocultural and environmental context. This approach has made it possible to open up

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2   See follow-up and implementation of the health-related mandates emanating from the Summit of the Americas at http://www.summit-americas.org/sisca/health_sp.html [Internet].

a debate on the relationship between health, the policies and programs that seek to promote it, and other areas of well-being. From this broad view of health, poverty and inequality are powerful obstacles to the full enjoyment of health. Poverty, especially in childhood, can trigger scenarios that are harmful to health, while also aggravating inequalities in this area and others as well. Therefore, as various social protection tools are enlisted to ensure a basic level of socioeconomic well-being and guarantee access to social services, including health, they can be more powerful for reducing inequalities in health.

In addition to their central role in reducing health inequalities, social protection tools can strengthen PHC as a strategy for guaranteeing the right to health. As stated in the Declaration of Alma-Ata, the role of PHC goes beyond being the first level at which the national health system has contact with individuals, families, and the community. Within the health systems framework, PHC is geared towards providing the services of health promotion, disease prevention, treatment, and rehabilitation. Thus, it encompasses a series of actions that can be strengthened through such social protection mechanisms. These include actions for providing information and education on health problems and their prevention; promotion of food supply and proper, healthy nutrition; maternal and child health care, including family planning; and immunization against the main infectious diseases, among other activities.

This document offers four perspectives from which to consider the connection between health and social protection:

1. The social inequity matrix and its relationship to the social determinants of health.

2. The cost of not addressing inequalities in health.

3. Social protection as a means for reducing inequalities in health and strengthening primary health care.

4. How this discussion fits within the context of the 2030 Agenda for Sustainable Development.

The social inequity matrix and its relationship to the social determinants of health

Inequality is a historical and structural characteristic of societies in the Americas. It involves economic inequality or inequality of means (income, property, and financial and productive assets), as well as inequality of rights, capacity, autonomy, and reciprocal recognition. Despite recent progress, high levels of inequality continue to pose a challenge for the Region, undermine sustainable development, and serve as a powerful barrier against the full exercise of rights, including the right to health.

The legal basis for the right to health is found in a number of obligations that States are required to fulfill under ratified international instruments. Still, there is a gap between formal entitlement to the rights and the effective implementation of public policies. In Latin America, inequality in access to basic human rights is among the most important causes of health inequalities. This affects the lives of people, replicating and often deepening their situation of vulnerability.

This concern is not new. In fact, inequalities in health were among the main drivers leading to the Declaration of Alma-Ata: "The existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially, and economically unacceptable and is therefore of common concern to all countries."[3] The persistence of these inequalities between and within countries calls for new approaches and, above all, revitalized efforts to combat them.

The social inequality matrix is the result of the productive structure and culture of privilege passed down through the history of our societies (3, 4). The labor market links a heterogeneous productive structure (with its inherent inequality in terms of productivity, access, and quality of employment) to stark inequality in household income. This productive structure is marked by a concentration of employment in poor-quality, low-income informal jobs and little or no access to social protection mechanisms. This situation has resulted in stratified access to social security, a high degree of social vulnerability, and levels of well-being that are often unacceptable. Thus, the first and most basic axis of inequality is the socioeconomic stratum. The central elements of this axis are the structure of ownership and the distribution of productive and financial resources and assets. One of its clearest and most evident manifestations is income inequality, which is both the cause and effect of other disparities in such areas as health, access to basic services, and education (3).

In addition to the socioeconomic stratum, inequalities in the Americas are also structured by other factors: gender, ethnicity and race, area of residence, life stage, disability, migration status, and sexual orientation and gender identity (Table 1). Each

3 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Available at: https://www.paho.org/hq/index.php?op.tion=com_content&view=article&id=13774:declaration-of-alma-ata&Itemid=2080&lang=en

Table 1. The social inequality matrix

Theoretical approaches	Social inequality matrix	
	Formative axes	Rights affected

• Structural heterogeneity (productive matrix)
 	
• Culture of privilege
 	
• Concept of equality:
  - Equality of means (income and productive resources)
  - Equal rights
  - Equal capacities
  - Autonomy and reciprocal recognition
	• Socioeconomic level
	• Gender
	• Race and ethnicity
	• Life stage
	• Area of residence
	• Disability
	• Migration status
	• Sexual orientation and gender identity
		• Income
		• Labor and employment
		• Social protection and care
		• Education
		• Health and nutrition
		• Basic services (water, sanitation, electric power, housing, information and communication technology)
		• Citizen safety and a violence-free life
		• Participation and decision-making

Source: Own preparation.

of these factors has an impact on the configuration of social inequalities, measured by its constitutive and determinative weight in the production and reproduction of social relationships and the subjective experience of individuals, or in other words, its impact on the magnitude and reproduction of inequalities in the various spheres of development and the exercise of rights (3).[4]

The axes of the social inequality matrix intersect, are amplified, and interlinked throughout the life course. This leads to a multiplicity of inequality factors or discrimination that interact and accumulate over time and generations. The confluence of discrimination and multiple inequalities makes for the "hard core" of poverty, vulnerability, and social exclusion, and ensures that they persist and replicate. Furthermore, there are direct correlations between ongoing exposure to discrimination and exclusion, and a long list of mental disorders and physical conditions. These correlations have been observed in both cross-sectional and longitudinal studies and they even persisted after adjustment of the control variables (5). Discrimination and exclusion are damaging to health for several reasons. For example, they can trigger a stress response that leads to behaviors that are harmful to health.

One of the main contributions of the concept of the social inequality matrix is that it helps us understand how the multiple

and simultaneous confluence of forms of discrimination and exclusion leads to inequalities in health and other areas of social development, and how these inequalities are self-reinforcing. The approach challenges us to consider the people affected and their realities from a holistic rather than a compartmentalized perspective and to create policies that respond more effectively to this complex situation.

Certain sociocultural patterns that are strongly rooted in our societies can be identified. These patterns work together forming the foundations of the inequality matrix. These are: a violent patriarchal culture, racism, Euro-centrism, hetero-normativity, and stereotypes based on age, disability, place of residence or origin, and a culture of privilege. This latter concept alludes to a pattern inherited from the colonial times that normalizes social hierarchies and marked asymmetries in access to the fruits of progress, political discussion, and productive assets. This culture is implicitly accepted by the groups that benefit from it, and by those who are excluded (1).

There are three basic characteristics of the culture of privilege: a) normalizing inequality as difference; b) establishing and perpetuating group hierarchies by biased groups that are the same and that take all the benefits; and c) this hierarchy disseminates through the social structures and institutions (1). A key aspect

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4   As a formative historical process, social inequality is the result of power relationships in which dominant sectors appropriate/expropriate the property of or dispossess subordinate sectors. While these processes are individual events, they are materialized simultaneously in varying experiences of exclusion and social marginalization, and they are interpreted, acted upon, or resisted individually or collectively in different ways. Taken together, they form a process of simultaneous inequalities in the creation of subjective life opportunities and trajectories. Within this framework, social inequality should be seen as a process of both social and subjective construction that involves a complex web of social exchange based on relationships of power and social regulation which lead to stigmatization and social discrimination against subordinate groups within a framework of multiple forms of violence.

in perpetuating the culture of privilege is the concentration of power in decision-making. In our societies, a person's socio-economic level is directly associated with his or her level of influence on decision-making. This concept is also reflected at the global level, where the imbalance of economic power between countries, organizations, and corporations is increasing as a result of their impact on policies and health interventions.

Furthermore, the "social determinants of health" approach considers that inequalities in health are the result of the circumstances in which people are born, grow up, live, work, and grow old, which in turn are configured by asymmetries in the distribution of money, power, and resources (6). In this line of reasoning, the social inequality matrix complements and deepens the analysis of the social determinants of health by proposing other elements that affect the circumstances in which people develop—beyond money, power, and resources. These elements are gender, ethnicity and race, place of residence, life stage, and other aspects such as disability, migration status, social orientation, and gender identity, which also, in turn, underlie the asymmetric distribution of money, power, and resources.

Another point of congruence is that both approaches recognize that health is intrinsically related to other dimensions of well-being, such as access to housing and basic services, education, decent work, social protection, and policy engagement. Just as the axes that configure inequality intersect and are mutually reinforcing, there are also connections between the rights being violated that need to be examined. Low levels of schooling, poor health, unemployment and the lack of decent work opportunities, social vulnerability, inadequate housing, poverty, and political invisibility are situations that also intersect and reinforce one another (4). Therefore, guaranteeing the right to health is

not only an ethical imperative but also a condition that will lead to the enjoyment of other rights, and vice versa.

While there is no doubt that health indicators have improved both in terms of access and outcomes, the Region still faces major challenges for the population as a whole, and some groups continue to experience acute disadvantages. The inequality scenario that characterizes the Region is seen especially in indigenous and Afro-descendant children and youth, for whom serious health inequalities represent a grievous infringement of their rights and have consequences for the later stages of their lives (4). Infant mortality (in the first year of life) and childhood mortality (up to 5 years of age) are indicators that clearly express the inequalities that affect indigenous and Afro-descendant children in Latin America starting from birth (Figures 1 and 2). In the United States, the infant mortality rate in the Afro-American population is twice as high as for white non-Hispanic infants (7) and this gap persists even when the mother has higher levels of education and income (8). In Canada, infant mortality rates for the First Nations and Inuit people are 1.7 to more than 5 times higher than in the country's non-indigenous population. These inequalities are especially pronounced in the post-neonatal period (9).

The inequalities in health that affect indigenous and Afro-descendant populations need to be addressed by health and social protection systems from an intercultural perspective. Furthermore, participatory mechanisms should be revitalized and the spaces to influence on decision-making need to be created, especially at the local level. To address these inequalities, new approaches for the intervention and participation of communities in decision-making processes and the guiding of health and social protection systems.

Figure 1. Mortality in infants under 1 year of age in indigenous and nonindigenous populations in 11 countries of Latin America, circa 2010 (number of deaths per 1,000 live births)

Indigenous population   Nonindigenous population
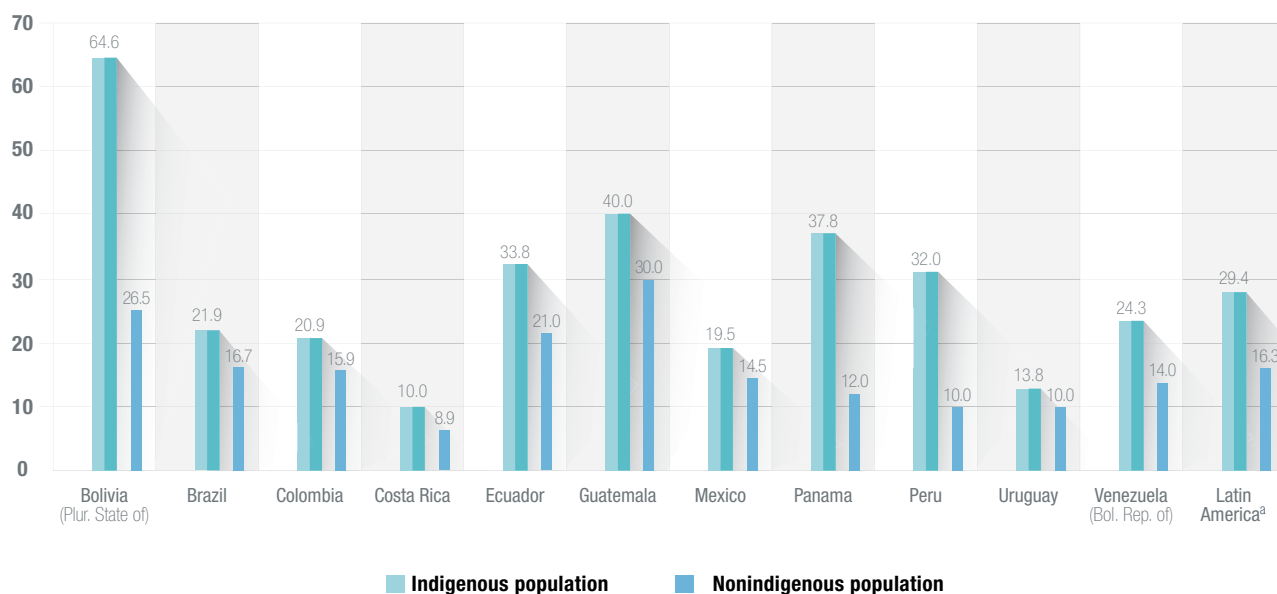
Source: ECLAC (11).
[a] Simple average of the figures for each country.

Figure 2. Maternal mortality by ethnic and racial status, Brazil, Colombia, and Ecuador, circa 2011 (number of deaths per 100,000 live births)[a]

Afro-descendant   National total
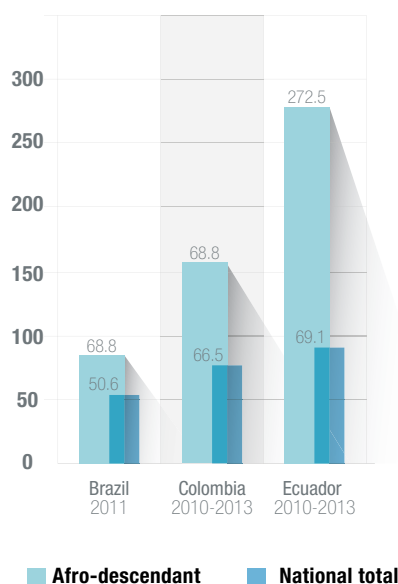
Source: CEPAL (10).
[a] The total corresponds to the white population, not the national total.

There are also sizable gaps in the indicators for access to basic water and sanitation services, which are key to health (Figures 3 and 4), as well as affiliation with a health system (Figure 5) or pension program. In all these cases, the multiple dimensions of the social inequality matrix in the Americas discussed earlier are evident.

Figure 3. Households with access to potable water, by area of residence, 15 countries of Latin America, circa 2014 (percentages)
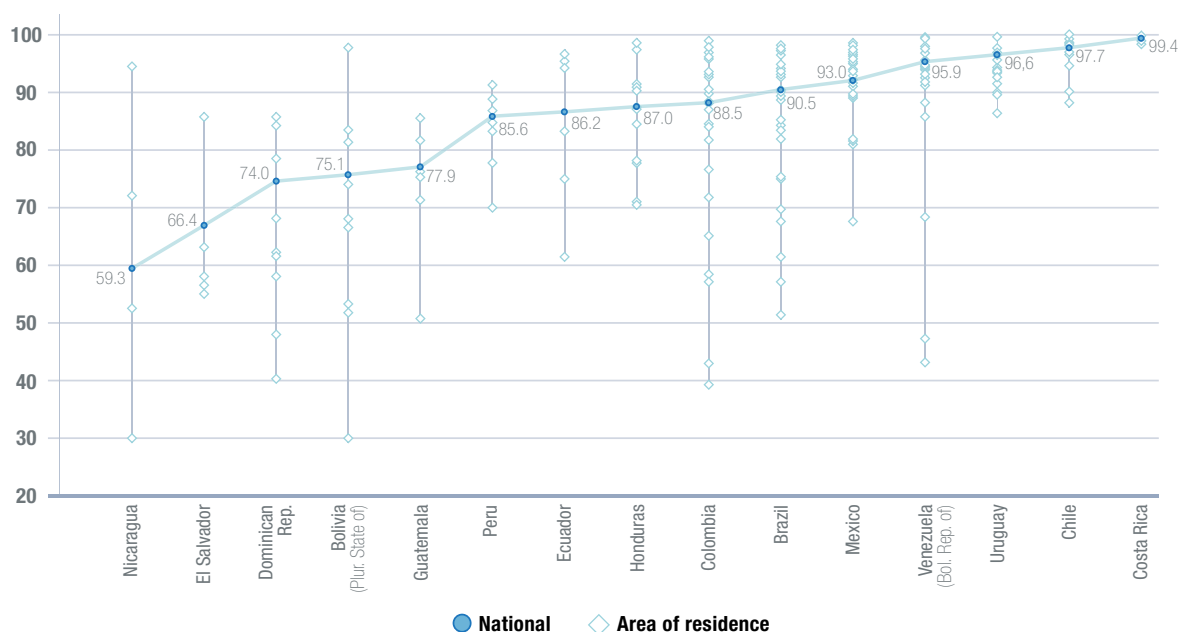
Source: ECLAC (3).

Figure 4. Households with access to sanitation, by area of residence, 14 countries of Latin America, circa 2014 (percentages)
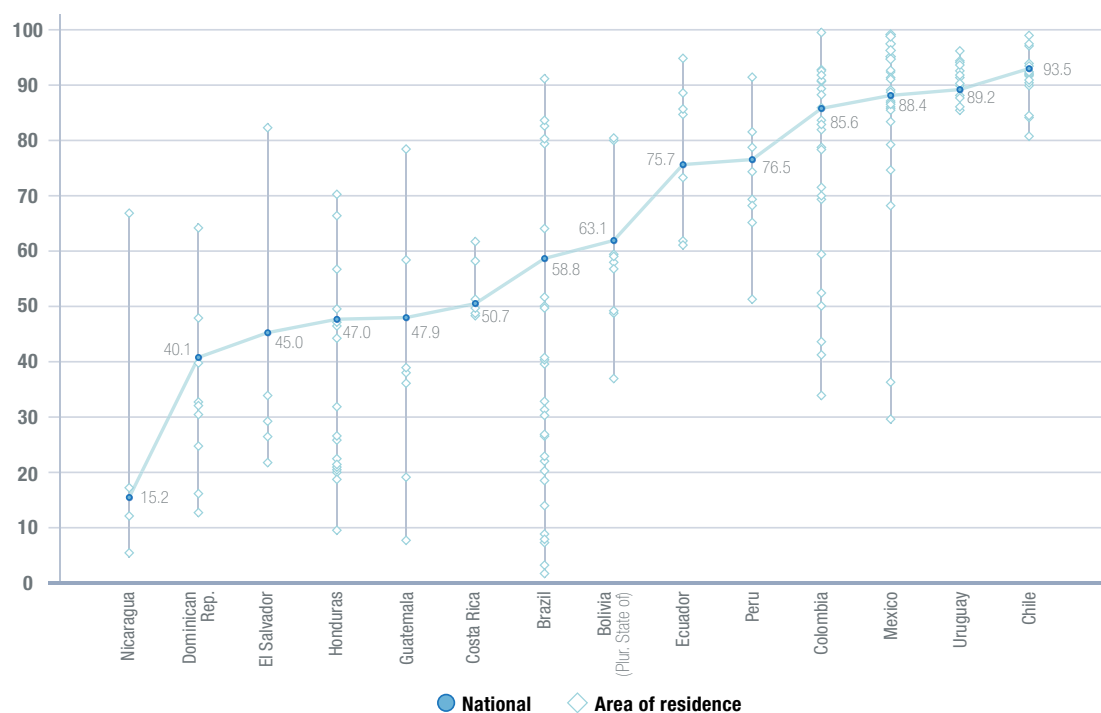
Source: ECLAC (3).

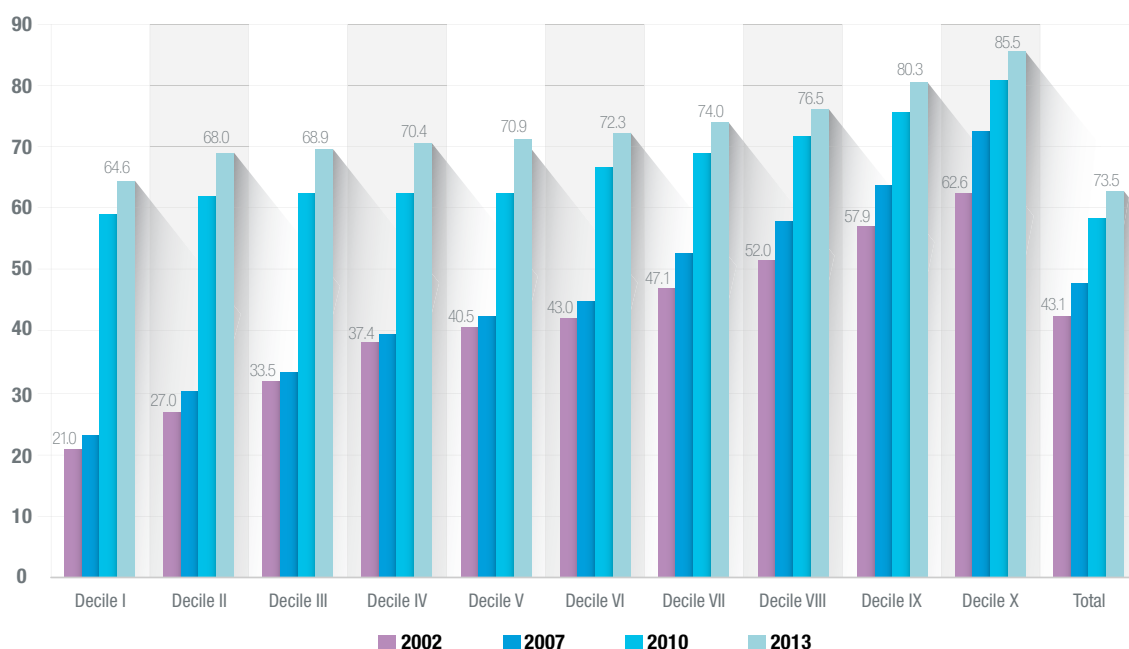**Figure 5.** Pension system affiliation among employed persons aged 15 years or over, by income decile, national totals, 13 countries of Latin America, 2002-2013[a] (percentages)

Source: ECLAC (11).
[a] Weighted average of figures for each country.

These health inequalities are avoidable. A population's health is the result of political, economic, and social decisions. The fight against inequalities in health should be part of the legal framework that defines and regulates the national health systems and services. An important pathway toward reducing inequalities in health is to promote the creation and strengthening of universal social protection systems that are integrated to provide service throughout the life course.

The cost of not addressing inequalities in health

In addition to being unjust, inequalities in health handicap the future of individuals, families, and societies and result in significant interrelated costs at each of these levels. As mentioned above, health inequalities in society undermine the capacities and opportunities of individuals, thus limiting innovation and productivity.

Another aspect to consider is the short- and long-term costs of failing to invest in health and reduce inequalities. For example, the social and economic costs of malnutrition (undernutrition, overweight, and obesity), which increasingly affect economically vulnerable populations, have been documented. These costs have repercussions on the health system, the educational sys-

tem, and the economic system as a whole due to the loss of potential productivity (12). For example, it is estimated that the combined impact of the double burden of malnutrition results in a net annual loss of 4.3% and 2.3% of the gross domestic product (GDP) in Ecuador and Mexico, respectively. In contrast, in Chile, where undernutrition has been eradicated, this cost represented only 0.2% of the GDP (12). In the United States, it was estimated that eliminating health inequalities that affect ethic and racial minorities in 2003-2006 would have reduced direct medical care expenditures by about US$ 230 billion (in 2008 inflation-adjusted dollars), not including the indirect costs associated with illness and premature death (13).

Adolescent motherhood is an example that illustrates the high personal and family cost of health inequalities and the resulting chain of inequalities throughout the life span and across generations, which also cross-cut the other axes of inequality. Despite a dramatic reduction in fertility in Latin America and the Caribbean, the rate still remains high among adolescents. It is a worrying situation because the consequences of motherhood during adolescence are profound and usually negative, especially when it occurs in early adolescence. The adverse impacts of early motherhood also extend to the children born

to adolescent mothers and their families. At the level of society, early motherhood has been identified as a key factor in the intergenerational transmission of poverty in the Region (3).

Adolescent motherhood affects the population unequally, with concentration in rural areas, indigenous groups, Afro-descendants, and girls living in poverty. In addition, it perpetuates social inequalities because it affects the educational level

achieved by these mothers and, therefore, their present and future options to find work and have access to social protection. For example, women in the Region aged 20 to 24 years who were adolescent mothers had an average of 3.2 fewer years of schooling than women of the same age who were not adolescent mothers (Figure 6), and they also had less access to health insurance (Figure 7).

Figure 6. Median years of schooling, women 20 to 24 years of age, 6 countries of Latin America and the Caribbean, circa 2011 (years)
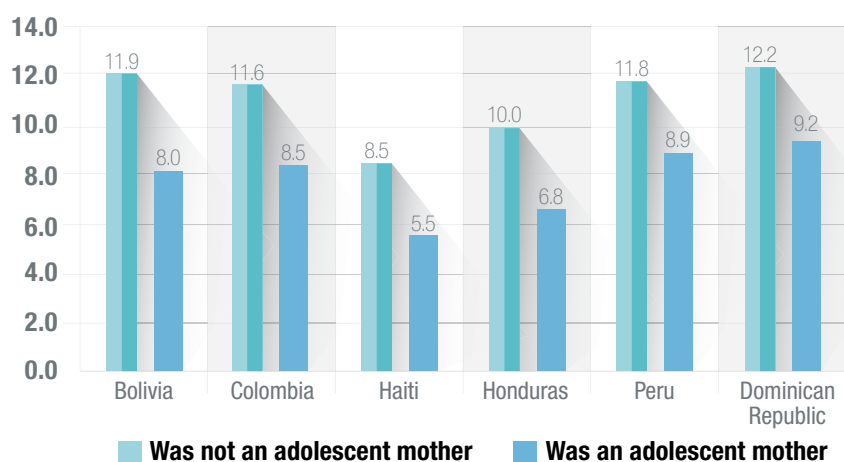
Source: ECLAC (3).

Figure 7. Women 20 to 24 years of age who have health insurance, 4 countries of Latin America and the Caribbean, circa 2011 (percentages)
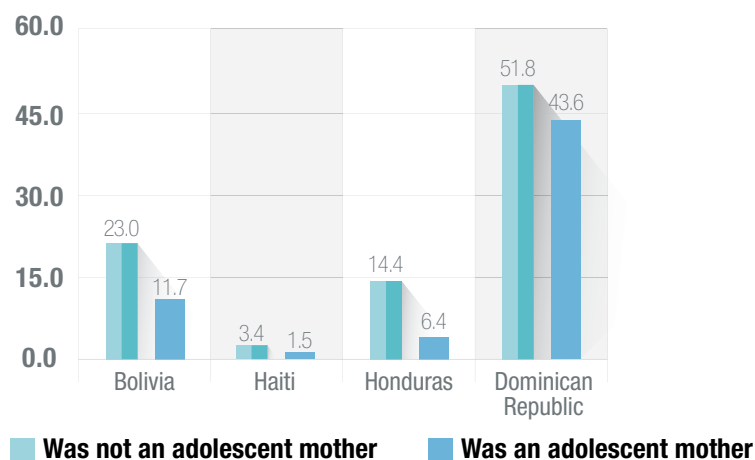
Source: ECLAC (3).

Connections between social protection and health: social protection as a means of reducing inequalities in health and strengthening primary health care

There is growing consensus that social protection is a very effective tool for eradicating poverty, reducing vulnerability and inequality, and fostering inclusive growth, with positive impacts on the health of the population. Social protection policies and programs (including the provision of care services) are especially critical for dealing with the challenges posed by the demographic changes taking place in the Region. As the proportion of older people continues to increase, the need to ensure the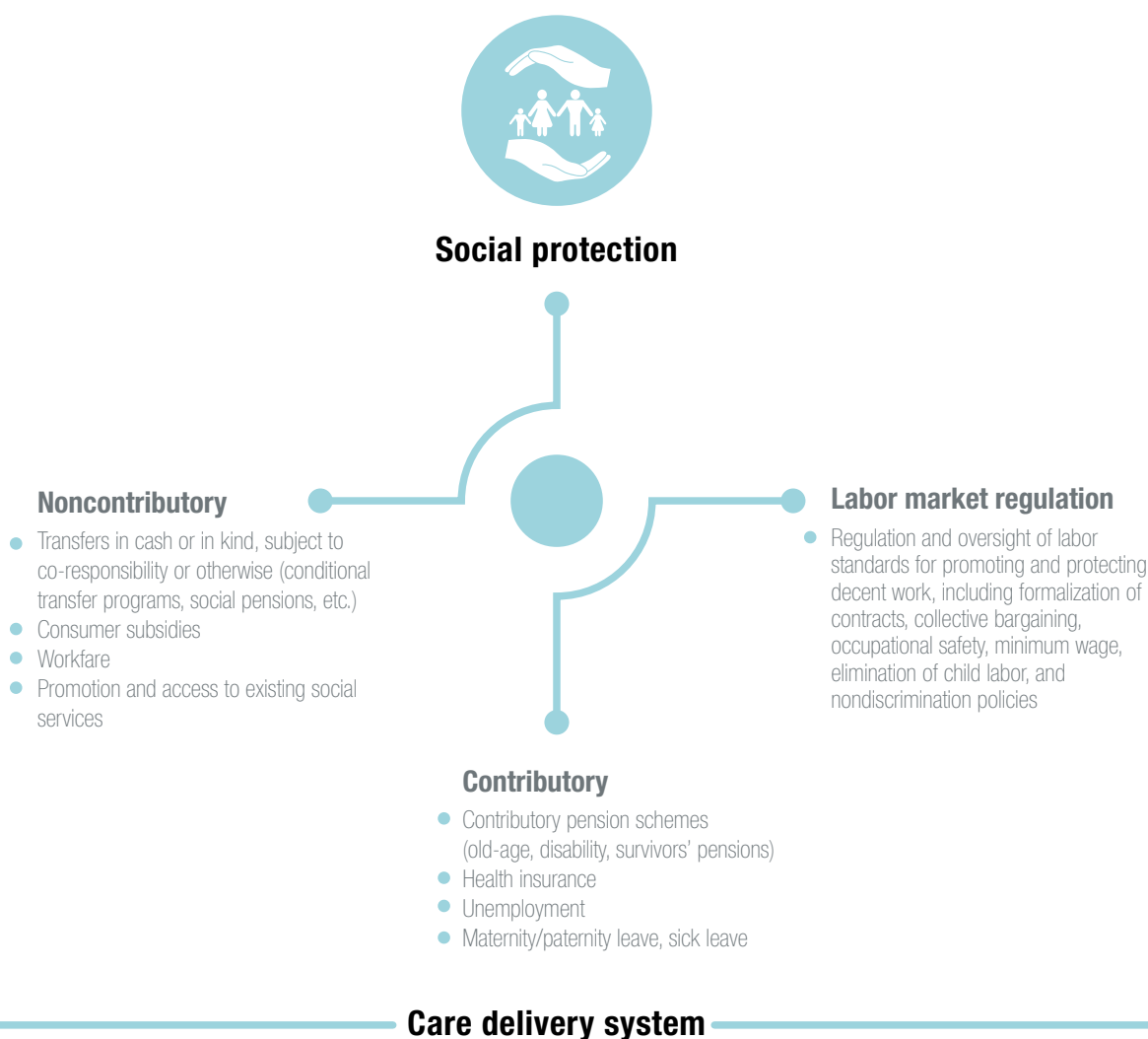ir well-being and income security becomes increasingly urgent. At the same time, it is essential to strengthen the social protection of families with children, since they are overrepresented in the population living in poverty, extreme poverty, and vulnerability to poverty, conditions that have enduring effects on the healthy development of children and adolescents.

Social protection focuses on three main concepts: guaranteed basic well-being, insurance against risks in the surrounding environment or inherent to the life course, and mitigation or repair of social damage caused by social problems or risks. Accordingly, social protection is aimed at responding not only to the risks faced by the entire population (for example, disability or old age), but also to structural problems such as poverty and inequality (14). Thus, it is proposed that social protection be understood from a broad and integrated perspective that encompasses both contributory and noncontributory policies and programs, including measures for regulating the labor market as well as systems for providing care (15).

Figure 8. Components of social protection

Social protection

Noncontributory
- Transfers in cash or in kind, subject to co-responsibility or otherwise (conditional transfer programs, social pensions, etc.)
- Consumer subsidies
- Workfare
- Promotion and access to existing social services

Labor market regulation
- Regulation and oversight of labor standards for promoting and protecting decent work, including formalization of contracts, collective bargaining, occupational safety, minimum wage, elimination of child labor, and nondiscrimination policies

Contributory
- Contributory pension schemes (old-age, disability, survivors' pensions)
- Health insurance
- Unemployment
- Maternity/paternity leave, sick leave

Care delivery system

Source: Cecchini (15), p. 134.).

In the Inter-American context, social protection has been officially defined as "an integral approach consisting of a diverse set of universal and targeted policies and programs that seek to support people against the various risks that they face during the course of their lives, its specific design to depend on the conditions, needs and decisions of each Member State" (Declaration of Asunción, Second Meeting of Ministers and High Authorities of Social Development). In the Social Charter of the Americas, the countries of the Region recognized that they have "a responsibility to develop and implement comprehensive social protection policies and programs, based on the principles of universality, solidarity, equality, nondiscrimination, and equity that give priority to persons living in conditions of poverty and vulnerability, taking into account their national circumstances" (Chapter III, Article 14). The Social Charter's corresponding Plan of Action implements its principles by establishing targets and strategic lines of action. One of the priority strategic lines is social protection, with the objective to "create or strengthen comprehensive social protection systems based on respect for human rights and on the principles of universality, sustainability, equality, inclusion, shared responsibility, solidarity and equity that include the generation of opportunities needed for families and individuals in vulnerable circumstances to enhance their well-being and quality of life." Another strategic line in the Plan of Action is health, where the objective is to "progress toward universal access to health care and universal coverage of comprehensive and quality health care, with equity, accompanied by social protection models in health care for populations in situations of vulnerability."[5]

In this broad sense, various social protection mechanisms can help directly by offsetting the high costs associated with seeking health services, and they can also prevent or reduce the impact of indirect costs such as lost income due to illness or disability, as well as nonmedical expenditures associated with using health services such as transportation, meals, caregiving, etc. Support of this kind can help households from falling into poverty or prevent their poverty from getting worse. At the same time, field workers in social protection programs have the opportunity to interact with people living in vulnerable situations. Social protection can also be used to support health service users to overcome a common access barrier for specific groups by using public policies to reduce discrimination and unjustified differential treatment. All these measures will contribute toward closing access gaps for Afro-descendant and indigenous populations and other groups living in rural areas.

More specifically, social protection and PHC are complementary mutually reinforcing strategies for advancing toward the full enjoyment of rights, including the right to health (Table 2). For example, to the extent that social protection mechanisms focus on reducing the risks that threaten the child population (whether through strategies aimed exclusively at children or at families with children), guaranteeing adequate nutrition and access to health services and quality education can contribute to the healthy cognitive, affective, and social development of this population. These initiatives can not only have positive effects on health but also reduce current inequalities in health and other areas over the long term.

Conditional transfer programs seek to expand access and reach out to family participants in local health services, as well as to promote adequate nutrition and provide guidance and advice on health matters through counseling and informal talks. Finally, there are a number of social protection tools that can help to promote the universalization of health and the reduction of inequalities (16). Some of these points will be explored next.[6]

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5   See Plan of Action of the Social Charter of the Americas at http://www.oas.org/en/sedi/dsi/equity/social-charter.asp.

6   It should also be kept in mind that health is one of the key components of the Basic Social Protection Floor (17) and especially ILO Recommendation 202 on social protection floors.

Table 2. Examples of social protection mechanisms that can strengthen primary health care

Social protection component	Social protection interventions and their connection to elements of primary health care
Noncontributory pillar	*Conditional cash transfers:* • Expand access to health services, especially those connected with maternal and child health and populations living in poverty or extreme poverty • Share information on health promotion and disease prevention with participating families • Foster intersectoral coordination *In-kind transfers (e.g., feeding programs, nutritional supplementation):* *Meet the nutritional needs of children, especially those living in poverty and extreme poverty. Integrated care programs for children in early infancy:* • Articulate measures in the areas of health, nutrition, education, and care for children in their early infancy aimed at fostering their full development • Foster intersectoral coordination *Programs for promotion and access to housing:* • Expand access to housing with basic services and reduce exposure to health risks in the environment
Contributory pillar	*Health insurance:* • Expand coverage and access to health services • Provide financial protection for households *Leave (maternity/paternity):* • Facilitate latching and breastfeeding

Source: Own preparation.

Social protection tools for supporting health and nutrition across the life course: childhood, adolescence, and youth

The first stages of the life course are critical for preventing health inequalities and interrupting the intergenerational transmission of poverty and inequality. It is during these stages that the foundations are set for future cognitive, affective, and social development. To begin with, this is the risk period when conditions that undermine health and nutrition, early stimulation, learning and socialization, and growth and development in the family and community environment can have a long-term impact on biological, psychological, and social development (18). At the same time, the infringement of rights during these stages can have profound and irreversible effects for the current and future well-being of children and youth. In the Region, concern over this situation has led to the adoption of various social protection tools for addressing and preventing infringement of the right to health during these stages of the life course.

From the perspective of prevention, nutrition is key. Adequate and healthy nutrition starting early in life and the adoption of proper eating habits can play an important role in avoiding health problems over the long term. There are various social protection strategies in the area of nutrition mainly designed to target pregnant and breastfeeding women, preschoolers, and children in primary and secondary school. These include supplementary feeding, meals provided in schools, the encouragement of breastfeeding, food banks, and supplementation and fortification with micronutrients. Some examples are the Social

Milk Program in Mexico, the National School Feeding Program in Brazil, the Qali Warma National School Feeding Program in Peru, and the Women, Infants, and Children Program in the United States.

Other initiatives that have recently gained ground in the Region include policies to promote integral care and integral protection systems for early infancy.[7] The concept of integral protection encompasses a set of actions, policies, plans, and programs that can be implemented by a State, organizations within a State, and other actors, especially civil society. The objective of these programs is to ensure that the human rights of all children are fulfilled effectively and without discrimination, while at the same time attention is given to special situations (19).

These policies are integrative because the associated programs address different aspects of child development, bringing together interventions in health, nutrition, early education, and other aspects of care. Beyond that, interventions by the State that seek to promote and protect the rights of children are also articulated with the provision of services, goods, transfers, and protective regulations (for example, parental leave). Without this integrative approach, isolated programs can generate competition between sectors instead of creating a shared vision for development during these stages (18). Articulation and coordination of these measures needs to occur at different levels. It should occur between institutions, between different levels of administration, and across all stages of child development. Integrated care programs in early infancy can serve as a platform for intersectoral integration and coordination.

Other policies on sexual and reproductive health aimed at adolescents and youth include policies on sex education (e.g., the National Integrated Sex Education Program in Argentina and the Sex Education Program with Emphasis on Gender and Sexual Rights in Cuba). They also include policies on pregnancy prevention and the transmission of sexually transmitted infections,[8] as well as regulations on the interruption of pregnancy and emergency contraception (20). At the regional level, the Montevideo Consensus emanating from the Regional Conference on Population and Development emphasizes comprehensive, timely, good-quality sexual health and reproductive health programs for adolescents and young people, including

youth-friendly sexual health and reproductive health services with a gender, human rights, intergenerational, and intercultural perspective.

While sexual health and reproductive health are very important for the adolescent and youth population, other health issues, such as mental health, violence, tobacco use, alcohol and illegal substance abuse, and, increasingly, nutritional issues and noncommunicable diseases, have important long-term consequences (21). In these areas, there is a concerning paucity of policies and programs that target these health issues of great importance for the adolescent and youth population in the Region. This, in turn, reflects the lack of opportunity for youth to participate in the design, implementation, and follow-up of health policies and programs, resulting in vertical care systems that predetermine what are considered the priority "problems" for this population, pigeonholing the youth generation, oversimplifying their challenges, and failing to get them to use the services.

Conditional transfer programs

Since the mid-1990s, most of the countries of the Region have implemented conditional transfer programs (CTPs). These noncontributory social protection tools have had a positive impact on a number of health and nutrition indicators. They are for families living in poverty and extreme poverty. Currently, the Region has 30 CTPs in 20 countries, reflecting the central role of these programs in public policies aimed at combating poverty in Latin America and the Caribbean. Although they are widely used, the programs are quite heterogeneous in terms of the characteristics of their components, coverage, amounts transferred, function, and application of the conditions, among others.[9]

The objective of CTPs is to increase the resources available to low-income households for purposes of consumption, with the goal of meeting basic needs. At the same time, they are intended to foster human development with a view to interrupting the intergenerational transmission of poverty. Both cash and in-kind resources are provided through these programs. They facilitate access to a broad range of social services, in exchange for which families living in poverty and extreme poverty agree to assume certain commitments in the areas of education, health, and nutrition.

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7   Examples of policies of the kind that are already being implemented include Brasil Carinhoso (Brazil Nurtures) in Brazil, Crece Contigo (Grow With You) in Chile, Crece Contigo in Urugay, De Cero a Siempre (From Zero to Always) in Colombia, and Educa a Tu Hijo (Educate Your Child) in Cuba. Other countries that have made substantial progress in programs for infants are Ecuador, Panama, Peru, and the Dominican Republic.

8   Policies for distributing contraceptive devices and condoms are being implemented by the National Sexual Health and Responsible Procreation Program in Argentina and the National Integrated Health Program for Adolescents and Youth in Chile, which aims to offer health services of equal quality to all youth in the country, responding to their particular needs with regard to gender and cultural affiliation.

9   See a description of the objectives and types of CTPs in Cecchini and Martínez (15) and information on recent trends in coverage and investment in Cecchini (22).

Because of the conditions that relate to health and complementary health interventions, CTPs stimulate the demand for health services, often in remote rural areas or on the urban fringe, where they are not available or the quality is poor. As a result, these programs have had a positive effect by facilitating access to health services for traditionally excluded population groups (Table 3). In addition, when there are sufficient services, health and nutrition outcomes have improved in both numbers and quality (23). The CTPs promote equity by focusing on and addressing the greatest differential needs of people living in poverty. They can also contribute to universal health coverage as services adapt to the needs of those who have been socially excluded and by introducing an equitable approach in universal programs (23).

Table 3. Required health commitments in conditional cash transfer programs, Latin America, 2013[a]

Country	Program	Medical checkups (children)	Medical checkups (pregnant women)	Medical checkups (older adults and the disabled)	Vaccinations (children)	Vaccinations (pregnant women)	Health counseling
Argentina	Universal allocation per child for social protection	0-18 years	X		0-18 years	X	X
Bolivia (Plur. State of)	Juana Azurduy mother-child voucher	0-2 years	X		0-2 years	X	
Brazil	Family Grant (*Bolsa Família*)	0-6 years	X		0-6 years		
Chile	Ethical Family Income (*Ingreso Ético Familiar*)	0-18 years					
Colombia	More Families in Action (*Más Familias en Acción*)	0-6 years					X
Costa Rica	Let's Move Forward! (*Avancemos!*)	12-25 years[b]					
Dominican Republic	Solidarity (*Solidaridad*)	0-5 years					X
Ecuador	Human Development Grant (*Bono de Desarrollo Humano*)	0-5 years	X				
El Salvador	Communities in Solidarity (*Comunidades Solidarias*)	0-5 years			0-5 years		
Guatemala	My Safety Grant (*Mi Bono Seguro*)	0-5 years	X				
Honduras	10,000 Grant (*Bono 10.000*)	0-5 years	X				
Mexico	Opportunities (*Oportunidades*)	0-19 years	X	X			X
Panama	*Opportunity Network (Red de Oportunidades)*	0-5 years	X				
Paraguay	Tepokorâ Program	0-18 years	X	X	0-18 years		
Peru	Together! (*Juntos!*)	0-5 years	X				
Uruguay	Family Allocations/Equity Plan (Asignaciones Familiares/Plan de Equidad)	0-18 years		X			
Latin America	Number of programs conditioned on health commitments	16	10	3	5	2	4

Source: Cecchini (23).

[a] *X in a cell means that the category is part of the CTP conditional commitment; an empty cell indicates that the category is not one of the conditions of the program.*

[b] *The Costa Rica Social Security Fund (CCSS) covers a complete medical evaluation for students enrolled in a secondary public school during the school year in question.*

As for health-related outcomes from these programs, there is evidence that health service access has increased for children and adolescents of participating families. Improved outcomes in health and nutritional status have also been observed (24). Despite these gains, however, some studies of CTP participation point to uneven health indicator outcomes according to area of residence, sex, age, and duration of participation in the program (23). At the macro level, a favorable effect of these programs has been an increased demand for services, which has helped to reduce access barriers and increase the availability of services. A wide array of governmental social promotion policies and programs have been put within reach of populations heretofore living in social exclusion.

As with integral health care programs for infants in early childhood, CTPs have the potential to coordinate actions across sectors, with a multidimensional perspective on well-being. However, reductions in the population coverage of these programs in some countries pose a challenge that needs to be addressed.

Universalization of health care

The debate on the universalization of health care has advanced in the Region, at least in basic terms. However, there continue be fundamental issues (for example, in the distinction between universal coverage and universal access) as well as practical and operational challenges for achieving it (25). Over the last decade and a half, health systems in Latin America have undergone various reforms, supported by increases in health expenditure (which rose from 2.4% of GDP at the end of the 1990s to 3.6% in 2014) that have made it possible to expand coverage and improve equity in access (26).[10]

However, the characteristics of health systems (in terms of investment, out-of-pocket expenditure, integration of the public health and social security systems, coverage of the services, and health outcome indicators) differ widely between the countries (Table 4). These differences are associated with the historic evolution of the welfare state, which in turn is influenced by each country's particular economic, social, demographic, and political variables (27). These differences need to be considered in the development of policy recommendations, which will inevitably have varying degrees of relevance depending on the prevailing health system model in each of the countries.

In the Region, Brazil with its Unified Health System, and Cuba with its National Health System, guarantee free universal access to health financed by general taxes. Costa Rica, for its part, has achieved universalization through social security, which since the 1980s has included informal workers and families living in poverty (27). From the perspective of equality, it is worrisome that the Region continues to see sharp fragmentation and overlapping benefits and coverage, as evidenced in the significant differences that exist in the quality of services provided to different groups of the population. Generally speaking, the health systems in Latin America are organized around the services provided by the public sector for people living in poverty, social security services for informal workers, and private services for those who can pay for them (28). These systems remain segregated, offering different types and quality of services to different population groups, which prevents them from being really universal and equitable (29).

Even in countries where the law guarantees universal coverage, there are economic, geographic, cultural, linguistic, attitudinal, and other barriers that limit effective access to health services, despite access being a legal right. Given the multiple inequalities that characterize the Latin American and Caribbean societies, it is helpful to think in terms of policies that seek to achieve universal coverage sensitive to the differences. This means policies with a rights-based approach that can also use specific, selective, or positive action mechanisms to break down the barriers that are preventing access to health services in order to address "individuals living in conditions of poverty or vulnerability, women, Afro-descendants, indigenous peoples, persons living in deprived areas, persons with disabilities, and migrants, as well as children, young people, and older adults" (3, p. 81).

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10 In the United States, approximately 13% of adults between 18 and 64 years of age were without health insurance, and this figure was as high as 27% in the Hispanic population (NCHS, 2016). Even among those who have insurance, the system for financing medical care in the United States is regressive, which exacerbates inequalities and discourages use of services by the poorest population (30).

Table 4. Health system indicators in 11 countries of Latin America

Country	Public health expenditure (% of GDP)		Public health expenditure per capita (2010 USD)		Out-of-pocket health expenditure (% of total household expenditure)	Integration of public health systems and social security	Population health coverage by sub-systems				Maternal mortality ratio (deaths per 100,000 live births)	
	1998	2014	1998	2014			Public (%)	Social Security (%)	Private (%)	Other (%)	2000	2015
Argentina	3.8	5.0	349	535	5.0	Segmented	Universal	51.0	7.9	3.2	60	52
Brazil	3.7	5.2	327	622	5.0	Integrated	Universal (Unified Health System)	0.0	19.6	0.0	66	44
Chile	2.4	3.9	226	569	4.3	Integrated	Universal (Explicit Health Guaranteed)	73.5	16.3	6.7	31	22
Colombia	2.0[a]	2.1	95[a,d]	146d	1.9	Integration under implementation	Universal (Basic Health Care Plan)	91.1	…	3.9	97	64
Costa Rica	4.7	6.5	263	560	2.1	Integrated	Universal	0.0	0.0	0.0	38	25
Cuba	5.1	10.4	159	650	…	Integrated	0.0	100.0	0.0	0.0	43	39
Honduras	1.8	3.4	30	70	11.2	Segmented	60.0	18.0	2.9	…	133	129
Mexico	2.0	2.7	156	251	4.7	Segmented	4.7 (Seguro Popular)	42.9	4.5	4.5	77	38
Peru	1.5[a]	2.4	48[a]	128	7.0	Segmented	37.0	24.0	5.5	…	140	68
Uruguay	2.9	5.9	259	736	2.8	Integrated	45.3	45.0	1.8	7.6	31	15
Venezuela	2.0	3.9	159	343	3.1	Segmented	Universal (Barrio Adentro)	17.5	11.7	…	90	95
Latin America	2.4[b]	3.6[b]	131[b]	292[b]	4.7[c]	…	…	…	…	…	91[b]	60[b]

Source: Acosta (27).

The gaps in access and quality of the services pose a challenge for effective social protection to reduce inequality and leave no one behind. It is necessary to strengthen the countries' commitments to coverage and universal access to health, which is a crucial step for constructing social protection systems from a rights-based perspective. Also, progress is needed in improving the quality of health services and promoting an integral and holistic approach to health, with a view towards creating pos-itive and synergistic links with other dimensions of well-being. Indeed, there is abundant evidence that coherent policies in education, labor, and social protection, among other contributing areas, can be useful in improving the health status of the population. And this can have an important impact on children, women, and older adults. In other words, the initiatives articulated with social policies can reinforce the campaign against inequalities in numerous areas.

In summary, social protection instruments can act on various fronts to strengthen PHC and provide all people a level of health that allows them to lead a socially and economically productive life, as established in the Declaration of Alma-Ata. In its principles, this visionary declaration presents PHC as a space for the construction of health as a right centered on the people and their communities. Through the expansion of coverage and universal access, the promotion of health and nutrition and the prevention of disease, coherence in policies, and, most fundamentally, the continued fight against poverty, inequality, and exclusion (which are at the root of health problems), social protection plays an indispensable role in progress toward guaranteeing the right to health in the Region.

Health, social protection, and the 2030 Agenda for Sustainable Development

The 2030 Agenda for Sustainable Development reflects a consensus on the need to move toward more egalitarian, cohesive, and solidarity-based societies. It is also people-centered, promoting a sustainable development model and calling for "no one to be left behind" on the road to development, with emphasis on those for whom the gaps are greatest (3). Therefore, inequality, considered from a comprehensive and multidimensional perspective, is at the heart of the 2030 Agenda, not only in Goal 10 (which specifically addressed the need to reduce inequality within and between countries), but in the other Sustainable Development Goals (SDGs) that emphasize access and the inclusion of all people in the development process.

With regard to identifying disadvantaged groups, Target 17.18 proposes, by 2020, "[…] to increase significantly the availability of high-quality, timely, and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts." To meet this target, it will be necessary to improve available sources of information in order to have regularly updated, high-quality, and disaggregated statistics to move beyond national averages and identify and address the health needs of those who in fact are being left behind. Analyzing health inequalities from the social inequality perspective helps, precisely, to identify the populations that are farthest behind so that they can receive priority attention.

The SDGs are universal, integrated, and indivisible, bringing together the three dimensions of sustainable development: economic, social, and environmental. In the 2030 Agenda the social dimension includes not only the diverse list of subjects and aspects that the subject includes, but also its deeply intertwined relationship with the economic and environmental dimensions. Thus, the social dimension is not only reflected in the 10 SDGs that specifically mention social targets;[11] the "extended" social pillar also relates to a number of the targets under the other seven SDGs, where any strides forward or reversals have a direct impact on progress in the social area in terms of the fulfillment of rights, beyond their economic, environmental, or institutional content (18).

With regard to SDG 3, the 2030 Agenda for Sustainable Development makes clear that human health and well-being are interrelated with economic growth and environmental sustainability. Progress toward Goal 3 will not only promote enjoyment of the right to health for all, but also support progress toward the attainment of other SDGs, and vice versa. Given this interrelationship, efforts should be made to consider the cross-cutting role of health in public policies (as in the emphasis on Health in All Policies) in order to seek synergies and avoid harmful health impacts and thus to improve the health of populations and achieve greater equity in health (31).

The 2030 Agenda for Sustainable Development also underscores the importance of social protection in combating poverty, as in Target 1.3, "Implement nationally appropriate social protection systems and measures for all, including floors, and, by 2030, achieve substantial coverage of the poor and the vulnerable," and for the reduction of inequalities, as in Target 10.4, "Adopt policies, especially fiscal, wage, and social protection policies, and progressively achieve greater equality." As indicated in the most recent progress report of the United Nations Secretary-General, social protection systems are essential for preventing and reducing poverty and inequality at all stages of the life course, especially through support and benefits especially for children, mothers with small children, people with disabilities, older adults, and those living in poverty or without access to work (18). Social protection is also fundamental for achieving other SDGs, including Goals 2 through 5 and Goal 8.

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11 Goal 1 focuses on ending poverty; Goal 2, on hunger and malnutrition; Goal 3, on health and well-being; Goal 4, on quality education; Goal 5, on gender equality; Goal 6, on water and sanitation; Goal 8, on decent work and economic growth; Goal 10, on the reduction of inequality; Goal 11, on making cities sustainable and inclusive; and Goal 16, on peace, justice, and inclusive institutions.

Conclusions and recommendations

Maintaining a broad and integrated view of health and social protection, bearing in mind the matrix of social inequality, is key to leaving no one behind on the road to development in the Americas. As has been pointed out in the sections above, social protection and PHC are complementary and mutually reinforcing strategies for progressing toward the full enjoyment of the rights by all citizens, including the right to health. There are various social protection tools that contribute to promoting the universalization of health and the reduction of health inequalities. Reducing these gaps should be a priority for all countries in the hemisphere. Rather than a luxury that only high-income countries in the Region can afford, correcting inequality is a necessary precondition for assisting those countries that lag behind in order to attain the productivity levels enjoyed by the former (1). One way to move forward in this direction is to promote the creation and strengthening of universal, integrated social protection systems throughout the life course to support the health of the population and reduce inequalities in health.

Progress needs to be made in universal access to quality health services. Even in countries where the law guarantees universal coverage, there are economic, geographic, cultural, linguistic, attitudinal, and other barriers, not always evident, that effectively limit access to health services. Therefore, health policies should explicitly identify the fight against inequality and consider specific measures for addressing the multiple inequalities that characterize American societies. To achieve this end, it is useful to have policies with a universal view that are also sensitive to the differences.

It is also important to recognize that significant progress has been made in access to health and health outcomes in recent decades within a favorable economic context. Emphasis has been placed on policies designed to reduce poverty and inequality and on proactive policies in the labor market. These health-related advances are commendable, but the danger is that they may lead to complacency when in fact they are easily reversible. In the current, more complex and uncertain context, a key message is to not lose any ground in policies that promote equality and the fulfillment of rights, because any backsliding could undermine achievements in key health indicators and the reduction of health disparities, in detriment to the progress of our societies.

One element that can offset and potentially prevent relapses is the empowerment and participation of civil society. In addition to being a right, participation can ensure that health systems, and PHC in particular, will continue to respond to the needs of the populations they serve, and in a more adequate and relevant manner.

Health care and positive health outcomes cannot be an exclusive dimension of the culture of privilege. The hard contrast in the quality of care between the public and the private systems feeds into a perception of privilege and discrimination. Currently, the right to health continues to live on as a hierarchy of first- and second-class citizens (1). Access to health care can reduce gaps as long as the services are of good quality. The segmented health systems that continue to exist in our Region solidify and perpetuate inequalities in health. Concrete measures are needed to equalize the quality of services (for example, through the use of technology) in order to achieve equality and the full enjoyment of the right to health.

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ANNEX 5:

Human Resources as Protagonists of Health Systems Based on Primary Health Care

This document was coordinated and prepared by commissioner María Isabel Rodríguez. The following experts were coordinated by Dr. Rodríguez: Mario R. Rovere, Director of the Master of Public Health program, National University of Rosario (Argentina); Laura Nervi, professor/researcher in systems, services, and health policies, School of Population Health, University of New Mexico (United States); Pedro Brito, professor, Andalusian School of Public Health (Spain); and Francisco Campos, specialist in scientific and technological development policies, Oswaldo Cruz Foundation (FIOCRUZ) (Brazil). The secretary of the expert group was Guillermo J. Argueta, administrative technical assistant, Health and Education advisory group, Republic of El Salvador.

Introduction

Human resources for health (HRH) is an extremely important and highly complex technical and policy area. It involves developing human resources and integrating them in the workplace. It is closely linked to health, labor, and educational policies, and to scientific and technological development.

Latin America and the rest of the world have long recognized the importance of human resources (HR) in achieving health targets, despite bumps along the way in terms of government and multilateral action. In the decades prior to the Declaration of Alma-Ata (1978) some authorities in the Region of the Americas acknowledged the crucial importance of training professionals; for example, in the 1961 Punta del Este Charter. During the 1970s, the relationship between medical training and social structures came to the fore, with a recognition of the role of the job market and the conditions that determine medical practice. The 10-Year Health Plan for the Americas (1972) recommended that each country integrate comprehensive HR planning into its health plans (1). The main goal was to expand coverage to disadvantaged populations, especially in rural areas. The 10-Year Health Plan proposed specific recommendations for the geographic distribution of personnel. Other significant experiences in HR development within the framework of subregional integration include the Health Training Program for Central America and Panama (PASCAP), operating from 1982 to 1997, and the Latin American Centers for Health Education Technology (CLATES Brazil and CLATES Mexico) in the 1970s and 1980s.

The World Health Organization (WHO) has taken widely documented actions based on the Declaration of Alma-Ata. Marking its tenth anniversary, document no. 9 of the Health for All series presented a package of decisive actions in which WHO and the Pan American Health Organization (PAHO) played a role, and which led in 1979 to the definition of strategies aimed at aligning the work of training institutions with commitment to the objectives of Alma-Ata. In 1980, WHO called on countries to step up their efforts to achieve a critical mass of health leaders (2). And in 1984, the World Health Assembly and the PAHO Directing Council adopted a set of resolutions to promote the analysis of universities' role in this area and promote their integration into a common multidisciplinary effort.

Latin American universities responded differently to this call, in an era marked by major political change, economic and social crises, and underfinanced academic institutions in a state of upheaval. Several projects strove to fulfill academia's mission of contributing to a more just and democratic society, and its need to assume leadership in the defense of human life and citizens' fundamental rights, including health (3).

The results of these efforts were uneven. However, over time, the idea prevailed that they did not have a major impact on any of these areas: criteria for organizing health services, redefinition of the rules of the job market for health professionals, the orientation of training, and the production of knowledge relevant to improving population health. Ultimately, the HRH field is subject to the same political and economic processes as health systems.

1. Human resource policies in health systems based on primary care

Health systems and determinants of HRH development

It is important to bear in mind the international situation when the primary health care (PHC) strategy was launched with the goal of achieving Health for All by the year 2000 (4). The International Conference on Primary Health Care was held in Almaty (formerly Alma-Ata), Kazakhstan (then in the USSR), in the midst of the Cold War and a clearly bipolar world (5). The leaders of the Conference recognized the unacceptable nature of major socioeconomic inequalities among and within countries, as well as the poor state of health of millions of people, particularly in developing countries. Alma-Ata proclaimed that PHC should be accompanied by the establishment of a more just "New International Economic Order."

However, events since then have moved in the opposite direction from these aspirations. The Americas, and the rest of the world, have witnessed the consolidation of a neoliberal economic model that has widened inequities between and within countries. Furthermore, recent years are seeing the resurgence of authoritarian governments, and setbacks that affect citizens' rights and democratic principles (however imperfect). There is now less space for diplomacy, and debate on the possibility of a more just international order has been shut down. At best, the

idea is being promoted that countries should be responsible for their own wealth and poverty, even though their margins of autonomy and sovereignty are increasingly narrower (6).

Among advocates of neoliberal policies, there has been a widespread effort to prove that universal and equitable health systems are economically inviable and unsustainable. The most common prescriptions aim, implicitly or explicitly, to privatize health care, promote a fragmented insurance market, and increase out-of-pocket expenditure.

History shows us that the achievement of universal access requires health systems based on a solid majority of public financing (7). It is important to recognize that tax reform remains a pending issue in our countries—because in almost all of them, the existing tax systems are regressive and insufficient, failing to exact a fair contribution to overall tax revenue from each social stratum (8). If there is no room in tax policy to increase public resources, how can health systems be financed and maintained?

In many countries, universal health coverage (UHC) is viewed as an aggregate of population coverage segments having different qualities and costs, differentiated by socioeconomic strata. In this current formulation, UHC leaves the door open for the public sector to subsidize the for-profit private sector through contracting private service delivery or intermediate services. In theory, the entire for-profit private provider system could operate at the expense of public-sector financing or through deductible premiums, copayments, and coinsurance paid directly by citizens.

It is also important to remember the PHC concept began to be coopted and denatured almost immediately after the goal of "Health for All by the year 2000" (World Health Assembly, 1977) was launched, followed by the Primary Health Care Strategy (Alma-Ata, 1978. A group of international actors with economic interests came up with so-called selective or simplified PHC, comprising a set of low-cost ("cost-effective") actions targeting poor populations (9). This was the first neoliberal health proposal that combined basic benefits and targeting the poorest populations. Many countries adopted this limited, cost-cutting view, widely promoted by international financial institutions and some bilateral agencies through a bare-bones social policy for the poor that focused on providing a basic package of services.

Some countries (and regions/municipalities within countries) tried to implement the comprehensive Alma-Ata PHC proposal, but in most cases it was abandoned or barely implemented. The reality was that the majority of countries implemented a combination of both visions; however, their health systems provided deficient coverage, and very limited access to insufficient services in areas far from the large cities. The health systems in countries of Latin America and the Caribbean (LAC) have long been characterized by problems of social segmentation and institutional fragmentation. These realities have severely limited—and continue to limit—the access, comprehensiveness, continuity, and quality of services.

The boom in neoliberal reforms (based on the proposal of the World Development Report 1993: Investing in Health[1] published by the World Bank, and its implementation in Latin America following the proposal of "structured pluralism") strengthened the mercantile rationale underpinning health systems (i.e., health care is not a right; rather, it is a good that has a price on the markets where citizens should acquire it). These reforms also focused almost exclusively on curing disease, relegating health promotion, prevention, and public health actions to the back burner, both in terms of political priorities and financing.

The successive waves of neoliberal reforms since the early 1990s have maintained the same basic ideas, while taking new and different forms. At present, most of the countries in Latin America have followed a structured pluralism approach to reforming their systems (10), opting for a financial model of segmented insurance to achieve the goal of UHC. There have been (and continue to be) exceptions, but they are increasingly uncommon (11-13). One condition for profit-based models of care to gain strength is the weakness of PHC-based health systems. If the business of health is at the center of health systems, this is incompatible with the values of the Declaration of Alma-Ata.

Historical experience around the world shows that only health systems featuring strong, comprehensive PHC can ensure UHC, universal access to services, and an effective quality health system. Only health systems with solid, majority public financing can guarantee the right to health (14). It is a serious omission to discuss UHC and not mention the right to health as a central element in public policies that support UHC, as is

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1   World Bank. World Development Report 1993: Investing in Health. Washington, D.C., 1993.

denying the crucial contribution that health workers make to health systems, of which they are the essential component.

In this general context, both HR development and recognition of the leading role that health workers play in health systems were largely overlooked. In neoliberal reforms, the workforce is a variable subject to policies aimed at dismantling the civil service and its institutional capabilities (i.e., downsizing), de-regulating labor (more flexible work, lack of job security), de-centralization, privatization of social security and pension systems, and privatization of the educational system, especially with regard to health professions and to higher education and technical training.

Human resources as the cornerstone of health systems and of public health care

An indispensable component of strong PHC is a health work-force comprising comprehensive health teams, with sufficient quantity and quality to guarantee universal quality access to health. The workforce should be competent, sensitive, and able to serve the needs of the community. Forty years after Alma-Ata, this workforce strength does not exist in the majority of Latin American countries. The shortage of PHC health personnel is the principal problem of HRH in the Region of the Americas.

What kind of systems are these? Existing health systems are characterized by authoritarian management, with little or no worker representation. Labor relations have deteriorated at both the individual and collective levels. Health workers experience increasingly precarious employment conditions. The process of dehumanizing health workers has intensified, as can be seen in the focus on performance analysis.

This vision hinders an understanding of the role of health workers in facilitating or obstructing change (or in maintaining the status quo), and as architects of health systems. But above all, it denies them ownership of their work and enjoyment of their rights, both in terms of policy as well as in labor relations (15). It is curious that attempts to incorporate social participation into health systems almost always bypass health workers.

Weaknesses of policies on health and health workers

The macro-level problem of the shortage of PHC health personnel in health systems is, essentially, a political problem stemming from the weakness, insufficiency, and/or absence of HR policies aimed at meeting the health needs of the population (16).

Long-standing problems of absolute and relative scarcity of health workers at the basic levels of care and in the poorest areas farthest from capitals and large cities have yet to be resolved. In many cases, they not only persist, but have worsened (17).

The policies implemented in some countries have not had the expected success—or they have simply failed. In many countries there have never been policies to step up the presence of health teams in the poorer, more remote areas (18).

Given this situation, it is important to try to answer the following questions. What policy windows do governments have for developing HR policies? What strategies can be developed within government? (For example, how should national governments lead the creation of policies and financing for health systems?) How can treasury departments stop deciding what categories of the health budget are eliminated or are cut in the event of a fiscal crisis, and how can they respect the priorities marked by health leaders to control the budget? Who regulates the actions of agents and stakeholders in the health field, and how? And with regard to national and international private actors and interests, how can countries increase their decision-making power regarding cooperation resources? How can private actors be regulated, and how can health workers be included in the development of health policies? Who are the social actors able to help increase policy opportunities?

Ensuring financing for primary health care workers

One of the main problems underlying all of these issues is insufficient funding to provide health services and service networks with the staffing levels required for PHC to have high response capacity. Traditionally, PHC approaches have not been a budget priority, leading to budgets that have nearly always been—and continue to be—insufficient. When economic crises or natural disasters strike, or austerity policies are implemented, or funds are scarce, budget cuts tend to target PHC.

To achieve universal health, it is important for every health system to make PHC a strategic priority. Actions would then be designed to ensure that the required resources are available for teams at the different levels of care, to serve all populations, everywhere. This is not only a matter of ensuring resources for physicians, but for all health teams and for comprehensive health actions, including the public health actions that are inherent to any health system.

When resources are scarce, health authorities too often have to make a choice between gateway services to the system and hospitals, which are more complex; this is especially true in the absence of integrated health services networks (IHSNs). Because of political and media pressure, authorities generally support the hospitals with the greatest clout and the professional associations with the greatest mobilization capacity.

There are serious problems in nearly every country in the Region: doctors holding multiple jobs, a growing lack of job security, and health workers employed in the informal sector, among key issues that affect the health planning process (19).

Planning and management of public health care personnel

In the absence of health policy priorities to strengthen PHC, it is very difficult to plan for staffing needs. Data systems generally are unprepared to help define these needs. Health personnel data systems must be strengthened and should consider not only basic care units, but also IHSNs, which comprise the essential levels and settings for strengthening the PHC strategy.

Unequal distribution of health workers in the large cities—to the detriment of areas that are more remote, less developed economically, and suffering greater poverty—is one of the most serious problems that must be resolved. It is not only a consequence of deficient personnel policies or lack of resources. Training processes that are concentrated in hospitals and, especially, in the most complex health facilities, create conditions for a professional practice that tends towards specialization, technological dependency, and creates expectations regarding liberal professional practice.

In addition to staffing strength, other complex areas must be considered. The most critical is retention of health workers in the more remote and poorer areas of a country. To address this problem, some ministries of health have implemented monetary incentive schemes to retain personnel, following the recommendations of development banks. There is no evidence confirming that such interventions have led to large-scale sustained successes.

Comprehensive public health care teams

When health policy strongly and continuously favors PHC-based systems, this strategy leads to comprehensive, continuous care that responds to community needs and is sensitive to the local culture. Like all health interventions, it should be effective and efficient, focused on teamwork, and cover promotion, prevention, recovery, and rehabilitation. And it should be carried out in a democratic relationship with the population that it serves.

To achieve this, it is necessary to have a set of essential, specific, and complementary skills. Together, these should ensure quality care meeting the above criteria. PHC requires a competent, integrated health team.

The Region has a great deal of experience regarding this issue. Nearly every country has tried to build and maintain health teams to ensure implementation of different approaches to a PHC strategy. Likewise, there is a string of successes and failures in this area.

The general consensus is that, for a harmonious division of knowledge and responsibility, teams should have skills in:

- Instrumental and technical mastery and management of health technologies, as well as the information and communication skills pertaining to each discipline.

- Public health, including skills for analyzing the health situation and social determinants of health, health surveillance, and service management.

- Comprehensive population care, which involves the mastery of skills regarding promotion, prevention, treatment, and rehabilitation.

- Capacity to work in IHSNs, ensuring the comprehensiveness and continuity of care.

- Participatory management and relations with the community, civil society, and local government.

Many of these skills are not acquired in professional or technical studies. Educational models and programs at most health science schools do not provide students with the skills they need for work within the context of a PHC strategy. A clearly defined policy is necessary to promote special postgraduate programs and continuing education to keep health professionals abreast of new developments, and for them to learn new skills.

Service fragmentation and weaknesses of integrated health services networks

Institutional and organizational fragmentation is the other major structural problem of health systems in LAC countries. Health organizations belonging to the different institutions that form a health system may coexist, but with little or no coordination,

complementarization, or collaboration. Examples of this include services provided by health ministries; social security (public or private); private services with different levels of capital concentration; and services associated with faith-based, community, or philanthropic groups, or with the armed forces. This lack of coordination is exacerbated by services with different levels of management capabilities and installed capacities, and alternative medical models and services cobbled together with official models and services.

Fragmentation is one of the factors affecting the lack of continuity and comprehensiveness of care, which in turn contributes to the poor quality of care and the extraordinary waste of resources. After three decades of attempts to strengthen PHC, the Region has been forced to consider the IHSN model to overcome this fragmentation. IHSNs undertake to organize the health system at every level, while forging collaboration and coordination relationships among the different organizations providing care in a given population or territory (20).

PAHO/WHO has developed theories and methodologies that were made available to countries; however, broad experience with IHSNs is still unavailable, and there is a lack of comparable, evaluated projects. Some countries have had limited local or regional experiences, but these are still very far from having a sustained epidemiological impact. Interest in IHSNs has focused almost exclusively on ministries of health, while the social security sector and, especially, the private sector (both nonprofit and for-profit) have not been integrated, since this poses challenges related not only to health systems' fragmentation, but also to their segmentation.

These difficulties mean that most local-level health personnel in PHC settings continue to work in isolation, separated from the levels of higher complexity, without referral and cross-referral systems, and without effective communication between the teams themselves and between teams and hospitals.

Gender and the workforce

Historically, the health workforce has been marked by a majority presence of women. The notable increase over the last several decades in the proportion of women physicians has helped increase the visibility of this phenomenon in the medical profession. The consequences of these changes are far from being solely demographic, and they highlight how in many countries, HR policies and management—including incentives

for taking a post in underprivileged areas—have been based on working condition and contracts basically designed for men. There is a need for substantially more analyses of gender and the health workforce in order to define fairer policies in all technical and professional categories (21).

Migration of health workers

It is also important to address the issue of health worker migration. If countries are incapable of retaining their technical personnel and other health professionals, they will be unable to maintain a stable, well-trained workforce. When wealthy countries absorb health workers from poorer ones, a growing number of these workers ultimately do not join the health workforce of the receiving country, but rather find employment in other, less skilled positions. Adequate study and evaluation of current experiences regarding the mass movement of professionals are essential, as well as bilateral agreements (within the framework of South-South cooperation or not) on personnel movement to strengthen PHC in receiving countries that are trying to solve their staff shortages.

2. Human resources training and primary health care: The challenge of universal health

Forty years after the Declaration of Alma-Ata, the shortage of PHC health workers remains the principal human resources problem in the Region. This deficit not only results from the lack of resources for hiring staff to work in PHC settings. The problem goes beyond the health system and involves the educational system—especially higher and technical education, which is mainly responsible for training health workers.

It is a commonplace in public health circles to refer to the "divorce" between staff training and the performance requirements for the same staff in health services. This problem is older than Alma-Ata and it still has no effective, structural, and sustainable solution.

Beyond, despite, due to, or perhaps in the absence of health policies, hospitals in LAC countries (which is where health professionals are trained) have increasingly adopted a model of specialization, with ever greater dependence on technology and medical devices. These disease-focused settings tend to develop a recovery-oriented model of care revolving around the figure of the specialized physician, and also a training model leaning towards specialization and overspecialization.

Alma-Ata defined PHC as a force for transforming this dominant model in health care and staff training. Forty years later, we know that structural change did not take place, but we also know that some progress was made.

University education

In its strategic dimension, PHC represents a reform agenda for the health sector aimed at developing and guaranteeing the conditions needed to realize the right to health for all. In most cases, it has acquired greatest visibility in the substantial expansion of first-level care (in terms of quality and quantity), and in provision of health services in the same settings where people live, study, work, and play.

Through PHC, hundreds of thousands of community workers, nurses, midwives, general practitioners, family physicians, and physicians with basic specialties worldwide have expanded the frontiers of health services. These professionals have interacted with communities whose identities and cultures had remained hitherto nearly invisible and have learned from them.

PHC poses enormous challenges to professional health training. The necessary skills are so many and so complex that it has become necessary to create a new figure, on which rests the expectations of reaching underserved communities. That figure is the health team: a multidisciplinary health team using a combination of knowledge and training levels that can cover everything from promoting health and preventing disease to discovering or adapting context-appropriate technologies or learning the local native languages.

However, university education systems have remained rigid and powerless in the face of these challenges. There are not many inter-professional experiences in undergraduate education, nor has the role of community health workers been standardized and professionalized adequately. In some situations, the professional skill sets needed to work in the first level of health care are taught in postgraduate programs that include a certain amount of un-learning of what students learned as undergraduates.

In most countries, the health and education sectors have different mentalities. The health sector still finds itself forced to provide very short-term responses, whereas the education sector is subject to a much slower dynamic and faces the difficult task of surmounting the educational models of the past. This is even more problematic in countries where the dynamics of governing coalitions often mean that the author-ities in one sector are from a different party than those in the other, hindering intersectoral dialogue and possible synergies between health and education policies.

There were serious attempts at change, and some success stories, in the more than five decades of educational reforms prior to the Alma-Ata Conference. These attempts all questioned training models based on scientificism, and they offered community-oriented learning experiences to varying degrees. Outstanding among them were initiatives introducing community medicine in the United States, Canada, and some Latin American countries. Highlights include the Mexican and Canadian reforms of medical education in the late 1970s, the widespread introduction of social and preventive medicine in Latin American medical schools, and the integration of training into care settings, which eventually led to the integration of teaching and research in community services. Also noteworthy were the attempt to promote multidisciplinary training, involving the Latin American associations of medicine, nursing, dentistry, public health, and social medicine; and events such as the Medical Education Conference hosted in 1994 in Punta del Este by the Pan American Federation of Associations of Medical Schools (FEPAFEM) and the Latin American Association of Medical Schools (ALAFEM).

In the early 1990s, a project with an international scope was created, called "University and Health for All." It was a remarkable experience in its conceptual development, but with limited impact on ordinary activities in ministries of health and medical schools. Intersectoral health and education commissions were proposed, but it was difficult to enlist support from ministries of health, which were subject to different technical and political agendas.

Even where political commitment is present on both sides, the ethos of these areas has held back major progress. The spirit of Alma-Ata and its message have been reduced to a topic on the syllabus, or part of a master class on social or preventive medicine. Only in very few cases has it been mainstreamed across the curriculum.

The multilateral level has seen a reaffirmation of the importance of achieving common policies for health and education. An example is the 2005 Toronto Call to Action, and the Strategy on Human Resources approved at the 29th Pan American Sanitary Conference in September 2017, which reaffirmed that course and renewed the commitment of governments in the Region. This can be seen in the Strategy's line of action

3: "Partner with the education sector to respond to the needs of health systems in transformation toward universal access to health and universal health coverage" (22).

The role that PAHO/WHO has played in technical cooperation to develop medical education and the health professions is widely acknowledged (23). For example, the project on University and Population Health, developed between the Union of Universities of Latin America and the Caribbean (UDUAL) and PAHO/WHO between 1987 and 1993, tried to establish a university support program for health development. This initiative was preceded by a long reflection which recognized that a mono-professional approach would not be able to achieve the basic principles of a comprehensive health approach, and that health services and universities were travelling on parallel paths that rarely coincided. Another example was the journal *Educación Médica y Salud* (Medical Education and Health), published between 1966 and 1995, which became a key vehicle for scientific communication. In the mid-1990s, an initiative of the Kellogg Foundation and PAHO/WHO led to a series of projects based on close cooperation among universities, health services, and communities (known as UNI projects) that carried out innovative work in several countries. In conjunction with this initiative, in 1997 the PAHO/WHO Textbook Program published the influential *Educación médica* (Medical Education)[2] which sparked the next wave in curriculum reform that embraced problem-based learning and a community approach. In the 2000s, the series *La Renovación de la Atención Primaria de la Salud en las Américas* (The Renewal of Primary Health Care in the Americas) promoted new reforms and put a reinvigorated PHC at the heart of study programs for health careers.

Continuing health education

Continuing health education (CHE) constitutes a similar concern and presents notable shortcomings, given its absence at the university level and the limited interest of health ministries. At present, CHE is limited, discontinuous, and often mono-disciplinary or oriented towards special programs that try to incorporate first-level services into the scope of their objectives. This is no simple task, since it has to address a great deal of territorial dispersion, isolation, travel costs, the risk of losing participants' attention, and low access to basic communication services (electricity, land lines or mobile phones, and internet services). These factors tend to be used as arguments for delaying or postponing CHE mechanisms for health teams, despite being nearly as vital to their work as supplies or equipment.

PAHO/WHO technical cooperation in CHE has been intense, producing publications, educational materials, and direct cooperation to define, implement, and evaluate CHE policies and programs (24-32).

Technological innovations in communications are making it possible to combine continuing education with distance learning and telemedicine, while reducing the limitations and costs of maintaining an interactive education process that not only reaches first-level teams but also involves more complex levels in local conditions, thereby enriching the responses of an IHSN.

Dramatic changes in morbidity constitute another challenge for health teams' continuing education and training, which to date have remained relatively rigid despite substantial changes. There are many examples of these transformations, including changes in communicable diseases as a consequence of the explosive combination of globalization, climate change (especially in the vector diseases), and growing resistance to antimicrobial drugs; a notable increase in chronic diseases (communicable and noncommunicable) in all the stages of life; and increased longevity. There are many other changes, as well, including those affecting adolescent health, which have led to intersectoral actions aimed at reducing accidents, self- or hetero-aggression, and early pregnancies; the consequences of addictive substance abuse; large-scale migration, which compels health services in different countries to share knowledge and experience; and natural and man-made disasters, which demand a higher level of first-aid training from health teams (33).

New demands on training institutions and continuing education for health teams

Since health services are a prime learning setting, there is a recognized need for them to play a key role in the coordination of teaching, research, and community services. This requires diversifying beyond the university hospital, transforming the entire service network into a training ground.

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2   Venturelli J. Educación médica: Nuevos enfoques, metas y métodos. Series PALTEX Salud y Sociedad 2000, Washington, D.C., 1997.

Health services may feel that coordinating learning experiences is a "donation" to universities, and universities do not readily take on responsibility for CHE, since they see this as a task that "naturally" corresponds solely to the health services as the "employers" of health workers. Establishing mutually beneficial agreements that integrate universities into CHE has obvious strategic potential.

Today's training programs enjoy fresh opportunities, thanks to important advances in learning methods, using information and communication technology that not only expand possibilities for formal education, but actually transform it. Different media, pragmatic tool combinations, and techniques are forcing us to rethink how we create and circulate knowledge, as well as methods of evaluation and documentation. This is leading to an expansion of technical and professional training and CHE into new settings, and creating new instruments or revamping traditional ones, such as supervised training sessions, consultations, telemedicine, and properly documented in-person or online referrals.

Immediate challenges

New clinical and service management skills are required to meet the demand for expanded first-level care as a condition for universal access and coverage. These include enhanced intercultural and environmental skills, better values training (especially with regard to gender, ethnic, and generational equity), and a higher capacity for working in multidisciplinary teams that include community health workers.

It is very important to move forward in the consolidation and redefinition of health teams as key players in achieving greater access, coverage, and social protection, substantially expanding their training in family and community health, public health and population health, and service management, and to promote inter-professional teams within IHSNs to ensure access to more complex levels of care when necessary.

The institutional, technical, and political foundations for this desirable result will involve an intersectoral strategic partnership between education and health—a partnership able to expand, sustain, and consolidate comprehensive health teams that are well-trained, motivated, and committed to the right to health at all times, everywhere (34).

3. A PHC approach to research on health systems and services

Health research

Since the early 2000s, there has been a focus on the vital importance of health research (across the board) in order to strengthen health systems and services. Three WHO milestones in this area are the World Report on Knowledge for Better Health (2004),[3] the 2005 Ministerial Summit on Health Research in Mexico City, and the 2008 Bamako Summit.

All available studies and diagnoses recognize that, in LAC: a) the production of knowledge offering responses to the Region's health needs is insufficient; b) knowledge organization and knowledge are inadequate; c) most research findings are discarded; and d) research lacks the necessary rigor (35).

In 2009, the PAHO Member States approved a regional health research policy for the Americas. Since then, the majority of them have developed national health research policies. By December 2017, 16 countries reported having established such a policy, and 18 Caribbean Community (CARICOM) countries endorsed a common policy (36).

Major differences remain between countries in their ability to produce, use, organize, and monitor health research. Research organization and management are sometimes nonexistent. Unfortunately, in LAC health research remains a weak public health function, and there is a consensus that this must change (37).

With regard to health research, it must never be assumed that a common situation prevails throughout the Region of the Americas, given the enormous disparities in health research between the United States/Canada and LAC. The health research field reflects, like almost no other, the huge gap between North and South. This does not mean that the North does not have its own shortcomings, inequities, and challenges, but the North determines scientific and technological developments, mainly in equipment and drugs; and it also determines the models of care that have taken root in much of LAC, especially in the service and insurance models targeting the middle classes (38).

Research capacity in LAC remains low, but there have been some improvements. The first is that in the last 15 years, spending on research and development grew from 0.57% to

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3   World Health Organization. World Report on Knowledge for Better Health: Strengthening Health Systems. Geneva: World Health Organization, 2004. http://www.who.int/iris/handle/10665/43058

0.8% of GDP (although this is still below the expenditure of OECD countries, which ranges from 2.5% to 2.8% of GDP). Moreover, in the same period, the number of scientific publications in the health field tripled (39).

An increasing proportion of the biomedical research carried out in LAC universities, research centers, and health services consists of clinical trials and population studies financed by the pharmaceutical industry or philanthropic groups from the United States. This issue has not been sufficiently addressed or examined, and it has consequences for the ethical—and many other—aspects of research (40-41).

Contributions of research in the area of human resources for health

A significant part of research on health systems and services has to do with the labor component; i.e., with health workers. Until the late 1980s, health sector analysis was mostly limited to services and training. The health workforce was considered part of the service area, and perceptions regarding their working conditions were associated with available skills, training, and inputs. Progress was made thanks to a broader understanding of HR that incorporated into health services not only the training dimension, but also the labor dimension (job markets, work processes, labor relations).

HRH research shows that the health workforce is characterized by a wide variety of hiring and employment practices (many different hiring arrangements, workdays with variable hours, and statutes that change from the national to the provincial and municipal levels). Officials often do not know the size or positions of their staff and there are no reliable statistics on wages and salaries. Several countries began studying working conditions and hiring systems as a part of designing, implementing, and evaluating their policies. These studies showed that in the 1990s, the health sector was one of the hardest hit by the introduction of flexibility into the labor market. They also showed that in the first decade of the 2000s, the situation tended to be reversed in some countries, and that at present, new employment models are once again having an impact on the sector. Many of the programs for expanding coverage in LAC were based on precarious employment and hiring models. These studies also showed that health workers (together with educators) continue to have the highest number of labor conflicts and work stoppages in many LAC countries. The sector also has a significant level of overemployment (due to long workdays) and multiple jobholding (two, three, or even more

positions held at once) in medicine, and to a lesser extent in nursing. There are also major differences among geographic areas within the same country, as well as between different countries (42).

Based on this evidence and with a view to promoting the definition of staff development policies, PAHO/WHO spearheaded the creation of a Human Resources for Health Observatory, aimed at dynamically monitoring these issues. This led to advances in the consideration of HR management as a critical resource for achieving health policy goals.

Another area of research in this field is the sociology of health professions. The health professions are considered models for studying the transformation of occupations throughout a complex process involving knowledge, power, and standards within specialized institutions, which differentiates them from other economic activities. LAC is characterized by weak institutions and strong professional associations, including those for health workers (43).

Despite nearly three decades of research on the health workforce and its importance as a critical factor in sectoral, technological, and organizational changes in health systems, this does not seem to have contributed to the development of policies improving the objective situation of the workers in the sector.

Lack of research on health systems and services with a public health care approach

As early as the 1980s, Halfdan Mahler had already identified the unfortunate worldwide shortage of researchers specialized in health systems. He pointed out that this type of research had not gained respectability among biomedical scientists (44). Indeed, research on health systems and services (and especially on health systems with a PHC approach) is the least developed kind of health research in the Americas, having less funding in both absolute and relative terms, and is conceptually weakest in terms of its epistemology, theory, and methods. It is widely recognized that, in LAC, decisions concerning the orientation of health policies are not generally based on knowledge production or scientific evidence. This is partly because health policy decisions are subject to restrictions and pressures from outside of the field (usually financial, but also ideological when models of care are concerned). To a lesser extent, this can also be explained by the lack of a solid corpus of research that addresses health service needs and potential in each context.

The scientific evidence produced in the North and in the South concerning major programs for primary and secondary prevention (prevention of cervical cancer, prevention and treatment of diabetes at the PHC level, screening for colorectal cancer, and prevention of lung cancer, among many others) is either not followed or is impossible to introduce in countries that have adopted, at least partly, a PHC-based health systems approach.

Using this evidence would save lives and money in the medium and long term, but lack of political commitment is the most commonly reported obstacle. Operations research in health services carried out by the health workers themselves is practically nonexistent. Where it does exist, the challenges to implementing its results are huge, because the settings where this knowledge is produced are resistant to change. However, there have been and are initiatives to step up research in this field, although there have also been obstacles to disseminating its results in the very settings where they could be most advantageous.

In LAC, information systems hold a wealth of data that could be used to promote this type of research, despite the imperfections and many shortcomings of these systems, depending on national situations and the historical moment. The data available in health services, at all levels, could contribute to high-quality observational studies, while the process of research itself could identify inconsistencies, gaps, and opportunities to improve information systems.

Lack of trained research personnel and allocated financial resources, an absence of effective research policies in this field, and barriers to the dissemination of results are the problems most commonly reported both by researchers at universities and the leaders of health systems.

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