ANALYZING AND OVERCOMING ACCESS BARRIERS TO STRENGTHEN PRIMARY HEALTH CARE
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FOREWORD

The past three years have been a great learning experience for those of us who are part of the public health community in the Region of the Americas. We have faced the greatest global health crisis of our generation and now we are facing the serious social, economic, and health consequences of this crisis. Our health systems, with their strengths and especially with their long-standing weaknesses, had to respond to a prolonged, large-scale emergency. This meant that the access barriers that the Region’s populations already faced were exacerbated by new difficulties and new barriers resulting either directly or indirectly from the pandemic.

In this context, the Pan American Health Organization (PAHO) has redefined its role, based on five strategic pillars: first, a commitment to help Member States end the pandemic in the Americas using the best available tools, such as surveillance and vaccines; second, promoting the application of the lessons learned from the pandemic and tackling the Region’s vulnerabilities with determination; third, ensuring rapid and equitable access to health innovations for all countries in the Region; fourth, focusing on building resilient national health systems, based on renewed and strengthened primary care; and finally, strengthening PAHO’s own capacity to support Member States in dealing with these challenges.

The set of resolutions adopted over the past two years, such as the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains and the Policy on Integrated Care for Improved Health Outcomes, complement each other. They update and reaffirm efforts made to achieve universal health, and above all, they emphasize the importance of ensuring access to health services. Removing access barriers is undoubtedly a prerequisite.

The Region has a roadmap for advancing toward universal access, but it requires greater involvement of multiple actors with decisionmaking capacity and influence in a wide range of sectors. The path toward the elimination of barriers is one that is shared with processes to reform and comprehensively transform health systems, explicitly affirming the right to health, overcoming fragmentation and segmentation, and addressing inequities and social determinants of health.

This report presents the results of collaboration between PAHO and its Member States to identify and analyze the access barriers facing users and to develop a set of policy options aimed at reducing and eliminating these barriers. We hope that, like the country studies, this report will be useful for decisionmakers and the public health community, and that it will raise awareness and speed progress toward reducing and eliminating barriers in order to guarantee effective access and the right to health.

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Pan American Health Organization
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This report gathers experiences of countries in the Region of the Americas in the analysis and formulation of policies to address access barriers in the context of health systems transformation and strengthening. Staff from PAHO country offices provided guidance in the analysis of information and technical inputs during the preparation of the report. Coordination of the study in Colombia was overseen by Mónica Padilla, Advisor on Health Systems and Services for PAHO Colombia, with the support of David Bardey and Anghella Rosero, researchers at the University of the Andes in Colombia, who are co-authors of the corresponding chapter. Daniel Albrecht, PAHO Advisor on Health Systems and Services, and Padmini Singh, national consultant on Maternal Mortality Reduction, coordinated the study in Guyana. Rachel Cohen, PAHO international consultant, provided technical support for the development of tools and for the collection, analysis, and presentation of information. The Honduras study was coordinated by Carlos Ayala, Advisor on Health Systems and Services for the PAHO country office in Honduras, with the collaboration of PAHO staff in Honduras: Evelyne Degraff, Advisor on Family, Health Promotion, and Life Course; Odalys García, National Advisor on Immunizations; and Ricardo Rodríguez Buño, Advisor on Noncommunicable Diseases and Mental Health. In Peru, the study was coordinated by Hernán Rodríguez González, PAHO Advisor on Health Systems and Services in Peru. Additional thanks to the team from the National University of San Marcos (Peru) for their contributions to the qualitative component of this analysis: Lucy Herminia López Reyes, Pedro Jesús Mendoza Arana, Gustavo Franco Paredes, and Ruth Iguíñiz-Romero. The contributions of Miguel Dávila Dávila, PAHO national consultant, during the study are also appreciated.

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ACRONYMS

CI  confidence interval
CPU  capitation payment unit
ECV  National Quality of Life Survey (Colombia)
ENADE  National Household Survey (Peru)
ENDESA  National Demographic and Health Survey (Honduras)
EPHF  Essential public health functions
EPS  Health-promoting companies (Colombia)
FISSAL  Intangible Solidarity Health Fund (Peru)
FLC  first level of care
GDP  Gross domestic product
GPHC  Georgetown Public Hospital Corporation (Guyana)
HRH  Human resources for health
IAFAS  Health insurance fund administration institutions (Peru)
IHSDN  Integrated Health Service Delivery Networks
IPRESS  Health services provider institutions (Peru)
IPS  Health services provider institutions (Colombia)
LES  Statutory Health Law (Colombia)
MINSA  Ministry of Health (Peru)
MNS  National Health Model (Honduras)
MSPS  Ministry of Health and Social Protection (Colombia)
PAHO  Pan American Health Organization
PEAS  Essential Health Insurance Plan (Peru)
PHC  Primary health care
POS  Mandatory Health Plan (Colombia)
SDG  Sustainable Development Goal
SESAL  Secretariat of Health (Honduras)
SGSSS  General System of Social Security in Health (Colombia)
SIS  Comprehensive Health Insurance (Peru)
SOGCS  Mandatory Health Quality Assurance System (Colombia)
WHO  World Health Organization
INTRODUCTION

This publication comes at a critical time, as the countries of the Region of the Americas and the world are recovering from the impact of the COVID-19 pandemic. The prolonged nature of this crisis has highlighted the centrality of the population’s health and well-being, underscoring the urgent need to improve coordination between policies to build more resilient systems that respond in a timely manner to the health needs of the population. The pandemic has reversed the progress made over the past 20 years toward achieving universal access to health and universal health coverage, exposing and exacerbating structural weaknesses in health systems and health inequalities (1, 2).

In this framework, the countries of the Americas have already envisioned an era of post-COVID-19 development that integrates primary health care (PHC) into societies and health systems. To this end, countries will need to prioritize the strengthening of health systems aimed at achieving universal access to health and universal health coverage, while incorporating pandemic preparedness and response as a key component of this work. In such a context, access barriers should be understood and addressed through coherent and integrated health policies if the noble goals of the 2030 Agenda for Sustainable Development are to be achieved (1, 3).

Within the framework of the Strategy for Universal Access to Health and Universal Health Coverage of the Pan American Health Organization (PAHO), access to health services is presented as a central dimension that examines health systems’ responsiveness to people’s needs. This dimension makes it possible to interpret the extent to which the health system adapts to needs, expectations, and cultural, social, and economic conditions, as well as the relationship between health systems’ performance and the population’s health needs (4).

The scope of analysis of access, as well as access barriers to health, goes beyond the delivery of individual services; it has the potential to recognize the strengths and weaknesses of health systems’ capacities, in particular the stewardship of health authorities to ensure interventions that address risk factors, environmental health, and the social determinants of health. Consequently, the analysis of access barriers occupies an extremely important place in the framework of processes to evaluate and strengthen the essential public health functions (EPHF) (5).

Identifying the baseline for access to health services and the barriers faced by the population has been a first milestone on the path to the subsequent development of fundamental technical and political consensus to advance toward universal health.¹ In this regard, the Compact 30-30-30: PHC for Universal Health (6) was established, which calls for a commitment to eliminating access barriers by at least 30% by 2030. To complete the critical triad for accelerating the achievement of universal health and the Sustainable Development Goals (SDGs), it is further proposed to increase public health financing to at least 6% of gross domestic product (GDP) and to invest at least 30% of this public financing in the first level of care (FLC) (6).

¹ PAHO uses the term universal health to refer to both universal access to health and universal health coverage.
Given the impact of the COVID-19 pandemic, efforts have been made to transform health systems and reaffirm the right to health, as well as the principles of equity and solidarity within the context of PHC, through new mandates approved by the PAHO Governing Bodies in 2021 and 2022. Both *the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains* and the *Policy on Integrated Care for Improved Health Outcomes* are strategically focused on access and the need to define and address access barriers as an essential step in guiding the design of transformative policies for health systems (7, 8).

With this situation in mind, PAHO is helping countries better understand the barriers faced by the most vulnerable groups—such as the indigenous adolescent population of Peru’s Condorcanqui region, children and women in Honduras, and populations in the interior regions of Guyana—and analyze barriers in the context and trajectory of different health system reforms, as in the case of Colombia and Peru. In terms of lessons learned, this report presents the results of the collaboration between PAHO and its Member States to define and analyze the access barriers faced by health services users, in order to propose a set of policies to reduce and progressively eliminate these barriers.

The first chapter of the report describes the Region’s health systems and the challenges to universal access in the context of the COVID-19 pandemic. The second chapter presents a methodological and analytical framework for studying access barriers and defining policy options. Using the knowledge accumulated in recent years, PAHO has explored the available methodologies and has developed an analysis tool that synthesizes the most recent contributions of various authors and the experiences of the World Health Organization (WHO). It explores different tools that have not been used as frequently for research in the health field, such as mixed-method studies, which triangulate information and monitor changes in how barriers are perceived and experienced in different countries and territories over time. Chapters 3 to 6 present the results of this collaboration with Member States. Finally, by way of conclusion, general recommendations are presented that will enable progress in the still unfinished path toward universal health.
Despite the commitments assumed with respect to universal health and the progress made toward the development of health systems in the different countries, even prior to the start of the pandemic, structural challenges and inequities related to access to health services persisted.

The low level of systems performance, preventable premature deaths related to persistent unmet health needs, and the high prevalence of access barriers accounted for the problems faced by health and social protection systems.

About one-third of the population of the Americas recognized unmet health needs and barriers to access to health services. It is estimated that this unmet need for health care is responsible for 150 000 preventable deaths per year in the Region.

The context of inequality in which people in situations of greatest vulnerability face barriers, and the intersectionality of these barriers, posed a challenge in terms of equity in health systems and health care even before the pandemic.

With the onset of the COVID-19 pandemic, these challenges increased. The pandemic exacerbated access barriers on both the supply and demand sides. It also affected the availability of health personnel and magnified problems related to the acceptability of and demand for services.

Faced with a new impetus in the design and implementation of strategies aimed at transforming and strengthening health systems, there is an emerging opportunity to prioritize policy initiatives that respond directly to challenges related to access to health services.
1.1. Context prior to the COVID-19 pandemic

Health systems in the region have evolved based on relationships, competencies, and interdependencies among their components (organizations, institutions, resources, individuals). These interactions also extend to the context in which these systems exist and develop (9). Undoubtedly, the COVID-19 pandemic represented a pivotal moment in these trajectories, influencing several social, environmental, and economic determinants of health, and modifying relevant aspects of the context of health systems that influenced the supply and demand of services, medicines, and technologies (2).

Prior to the pandemic, transformation processes could generally be characterized in two ways, according to changes in governance. Some processes focused on expanding health insurance and increasing the financial coverage of the population, while others focused on changing the organizational model of health services, adopting a PHC model with a comprehensive perspective, developing the FLC, and incorporating public health interventions based on a human rights approach that is participatory and intersectoral (10). Transformations based on the logic of demand have long been proposed in the Region. They have been the preferred paths toward overcoming segmentation into subsystems with different modalities of financing, affiliation, and provision. This has promoted the unification of funds for the financing of social security and public health services; the free selection of providers or insurers; and, in some cases, the expansion of services to unsalaried people and those in situations of greater vulnerability through the establishment of health benefit packages (11).

Different indicators can account for the progress that health systems in the Americas made prior to the start of the pandemic, in aspects related to both universal coverage and universal access. The universal health care service coverage index, which is composed of 14 tracer indicators and used to measure progress in SDG indicator 3.8.1, showed an increase in the weighted average value for the Region, from 65 in 2000 to 77 in 2019. Another SDG monitoring indicator showed a reduction in the incidence of catastrophic health expenditure (more than 10% of household expenditure) in the Region of the Americas, from 8.1% in 2005 to 7.1% in 2017, and a reduction in impoverishment resulting from health expenditure, from 0.5% in 2000 to 0.1% in 2017 (12).

The availability of critical health system resources increased during the first 20 years of the 21st century, although not quickly enough to ensure timely supply and access to quality and comprehensive health services. Public expenditure on health as a percentage of GDP increased slightly, by 1.1 percentage points. Out-of-pocket expenditure on health as a percentage of total health expenditure fell from 40.3% to 32.2%, and the availability of human resources for health (HRH), as measured by the density of medical staff, nurses, and midwives per 10 000 population, increased by 2.4% and 2.3%, respectively, between 1990 and 2019 (13).

Although health systems in the Region of the Americas experienced improvements, the pace of development was affected by structural challenges that have not yet been fully overcome. At the start of the pandemic, the Region remained far from the recommended level of public expenditure on health needed to reduce inequities and increase financial protection (6% of GDP) (4); it was far from allocating 30% of these financial resources to the FLC (6); it had an incidence
rate of catastrophic health expenditure that, according to estimates, still affects 7.1% of the population (13); there were persistent inequities in the availability, distribution, and quality of the health workforce (between and within countries, between levels of care, and between the public and private sectors) (14); and it was not able to universally ensure timely and effective access to individual and population-based health services and interventions.

Social and economic conditions prior to the start of the pandemic were marked by social inequality and the persistence of other structural problems, such as high levels of inequality, labor informality, lack of social protection, poverty, and vulnerability. These coalesced with challenges of the new century: the expansion of marginalized urban settlements that lack access to basic services, large migratory flows, conflicts, and consequences of the climate crisis (15). In general, the health and social protection systems that face the challenges described above began the pandemic in conditions of weakness, fragmentation, and high segmentation, with reduced funding, and with weakened steering entities.

1.2. Unmet needs and prevalent access barriers

The low performance level of health systems prior to the pandemic reflects these conditions. In 2019, more than 2.5 million potentially preventable premature deaths occurred in 33 countries in the Region of the Americas, representing about 1 in 3 deaths (16). Regarding the resulting access conditions, the analysis for the Region (based on data from 15 countries with available household surveys) estimated that about 29.3% of the population (95% confidence interval [CI] 27.4, 31.3) had unmet needs for health care, with the population of low- and lower-middle-income countries being the most affected (Figure 1) (17). Extrapolating the study result to the entire Region, we can approximate about 295 million people with unmet needs for health care.
Figure 1. Percentage of the population with unmet needs for health care, by World Bank income group, 2011–2021

Note: Percentage of the population that had a health need (illness or accident) and did not seek health care. This includes 15 countries in the Region of the Americas that have household surveys and is based on the latest survey available in each country. The estimated percentages are the averages of each country, weighted by the population size.

Source: Based on household surveys about living conditions and health following the methodology presented in Báscolo E, Houghton N, Del Riego A. Leveraging household survey data to measure barriers to health services access in the Americas. Rev Panam Salud Publica. 2020;44:e100. Available from: https://doi.org/10.26633/RPSP.2020.100.

The unmet needs of the Region’s population are greater in countries with a lower score on the Human Development Index. The relationship between these indicators is relatively strong ($r = 0.235$) (Figure 2), demonstrating persistent inequality between countries and the need to deepen the analysis of the factors underlying access problems.
Figure 2. Relationship between the Human Development Index and unmet needs for health care, 2021

Note: BOL: Bolivia (Plurinational State of); CAN: Canada; CHL: Chile; COL: Colombia; DOM: Dominican Republic; ECU: Ecuador; GTM: Guatemala; HND: Honduras; MEX: Mexico; NIC: Nicaragua; PER: Peru; PRY: Paraguay; SLV: El Salvador; URY: Uruguay; USA: United States of America.


This high level of unmet needs mainly arises from various barriers that prevent people from seeking and using the health services they need, due to economic and sociocultural factors, as well as organizational aspects of health systems, among others. Although the variables included in the Region’s different household surveys and demographic and health surveys may not be equivalent or comparable given differences in design across surveys, they allow an initial approximation of the dimensions of the prevalent access barriers. Analysis of the surveys demonstrates that contact barriers (absence of care-seeking when people believe that an accident or illness is mild or that care is not necessary) are the most prevalent reason for not seeking health services (43.4% [95% CI 40.9, 46.0]), while barriers related to effective coverage and lack of quality or relevance of care emerge as the second group (39.7% [95% CI 36.8, 42.6]). Leaving these reasons aside, it is possible
to identify a set of relevant barriers directly related to the different capacities of the health system. In this regard, 13.1% of the people surveyed attributed the absence of care-seeking to barriers related to service availability, i.e., infrastructure, human resources, medicines, and supplies; 10.8%, to financial accessibility; 8.3%, to organizational accessibility; 3.7%, to geographical accessibility; and 6.3%, to acceptability (Figure 3).

**Figure 3.** Barriers to access to health services, by dimension and income level, 2011–2019

These unmet needs for health care can increase the risk of avoidable morbidity and mortality. Studies that rely on household surveys to estimate unmet needs, as well as studies that use data from the Global Burden of Disease Study to estimate avoidable mortality, indicate that countries with higher unmet needs have higher rates of avoidable mortality, with a relatively strong association ($r = 0.259$) (Figure 4). This corresponds with recent estimates indicating that about one-third (29.3%) of the deaths that could have been avoided with adequate and timely care in Latin America and the Caribbean are due to nonutilization of services, according to 2016 data. This represents almost 150 000 preventable deaths per year (18).
These factors are also related to other systemic social inequities, such as ethnic and gender inequities, which magnify access barriers and disproportionately affect the most disadvantaged populations. A recent study presents some clear evidence regarding the barriers women face in seeking care for themselves or their children, and the association between these barriers and the use of different essential health services. The main barrier faced by women surveyed in eight countries was difficulty obtaining money for the visit or treatment (56.7%), followed by distance to the health facility (36.6%), not wanting to go alone (29.7%), and finally, difficulty obtaining permission to go (13.5%) (Table 1).
Table 1. Barriers women face when seeking health care, by income quintile, geographical area, and marital status, 2001–2019

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Income quintile</th>
<th>Geographical area</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q1 (poorest)</td>
<td>Q5 (richest)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>In civil union, without participation in household decisions</td>
</tr>
<tr>
<td>Distance</td>
<td>36.6%</td>
<td>59.3%</td>
<td>20.6%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Not wanting to go alone</td>
<td>29.7%</td>
<td>40.5%</td>
<td>23.8%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Not having money</td>
<td>56.7%</td>
<td>74.2%</td>
<td>37.2%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Not obtaining permission</td>
<td>13.5%</td>
<td>18.4%</td>
<td>10.7%</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

*Note:* Q1: quintile 1; Q5: quintile 5.


The study reveals that women with lower educational levels, from rural areas, and from the poorest quintile face a significantly higher percentage of barriers. The study’s regression analysis shows that reporting of access barriers is associated with lower utilization of essential services by women (19). The intersectionality of access barriers and the inequality with which various sectors of the population experience them is clearly reflected in the country studies presented in this report.
1.3. The effects of the COVID-19 pandemic

PAHO and the Economic Commission for Latin America and the Caribbean (ECLAC) have prepared reports on the progression of the pandemic and its implications for health, society, and the economy. They have also defined potential scenarios for short-term control and trends and long-term lines of action to strengthen the State’s capacity to respond to the population’s health needs and their determinants in the context of a transformative recovery of health systems (8). While there are positive signs of economic recovery and continuity of services, the prolonged nature of the crisis makes it clear that the combination of remaining structural challenges, weaknesses in the systems, and a context of inequality resulted in the devastating consequences of the pandemic, both in terms of health and the social and economic development of the population (2). As of 31 August 2022, the Region of the Americas had accumulated over 175 million confirmed COVID-19 cases and nearly 3.23 million deaths (44% of the world’s deaths, when the population of the Americas represents only 13% of the global population), with a disproportionate effect on groups in situations of greatest vulnerability (20). Faced with the saturation of health services, in December 2022, 88% of a selection of 25 countries in the Region reported some type of interruption in the provision of essential health services unrelated to the coronavirus (Figure 5), a situation that mainly affected FLC and community care services (21).

Figure 5. Percentage of services interrupted, by country, 2021

Notes: ARG: Argentina; BHS: Bahamas; BLZ: Belize; BMU: Bermuda; BOL: Bolivia (Plurinational State of); BRA: Brazil; CHL: Chile; COL: Colombia; CRI: Costa Rica; CUB: Cuba; DMA: Dominica; DOM: Dominican Republic; ECU: Ecuador; GTM: Guatemala; HND: Honduras; HTI: Haiti; MSR: Montserrat; PAN: Panama; PER: Peru; PRY: Paraguay; SLV: El Salvador; SUR: Suriname; TTO: Trinidad and Tobago; URY: Uruguay; VCT: Saint Vincent and the Grenadines. Number of tracer services = 66.

At the same time, vaccine distribution has been slow and uneven, mainly due to limited availability and logistical complications. As of 2 September 2022, 69.4% of the population of the Region’s countries had completed the vaccination schedule (20), which still leaves a part of the population at greater risk of death, morbidity, and loss of well-being.

This health scenario is further aggravated by the social, economic, and environmental determinants of health resulting from the impact of COVID-19 on the Region’s economy and social and political structures: the configuration of a prolonged social crisis with high unemployment and informality rates and low activity rates among women and youth; the impact on the education system and teaching-learning processes, which has sometimes been referred to as “the risk of a lost generation”; and rising consumer prices (especially for food, which exacerbates food insecurity) (22). As a corollary, in 2021, the poverty and extreme poverty rates in Latin America and the Caribbean were estimated at 32.1% and 13.8%, respectively. This represents a setback of 14 years of political and economic efforts to reduce poverty and 27 years in the fight against extreme poverty (15).

In short, the pandemic has exacerbated access barriers on both the supply and demand sides, affected the availability of health personnel, and magnified problems related to the acceptability of and demand for services. In some cases, this means delays and setbacks on the road to reducing access barriers by 30%, a commitment assumed in the Compact 30-30-30: PHC for Universal Health (6).

As a result of the challenging scenario, the countries of the Region have a new impetus to design and implement strategies to transform and strengthen health systems. This includes new initiatives underway in different countries, with different focuses, such as strengthening the governance of financing toward pooled and solidarity funds; strengthening the governance of service delivery within the framework of Integrated Health Service Delivery Networks (IHSDN) with a comprehensive PHC approach; strengthening regulatory capacities linked to stewardship in the face of growing private sector participation in the financing and delivery of health services; and strengthening the territorial, gender, and ethnic-racial equity approaches.

For these new efforts to produce better health and well-being outcomes, and greater protection of the right to health, it is important to prioritize policy initiatives that directly address the challenges to accessing comprehensive, adequate, timely, and quality health services. As proposed in this report, a critical first step on the path to universal health and resilient health systems lies in reducing and eliminating access barriers and understanding and addressing the full range of factors that act as access barriers. In this framework, PAHO recognizes the importance of guaranteeing access to essential health services in the context of a prolonged pandemic, together with the application of coordinated and integrated social protection and public health measures that serve as a basis for transforming health systems following the principles of PHC.
Based on previous frameworks and methodologies, a concurrent triangulation design was implemented. Quantitative and qualitative information was obtained in parallel from secondary sources, workshops, and interviews, then analyzed in an integrated manner using a common analytical framework.

The analytical framework is based on the Tanahashi model of effective coverage (23) and on the most recent PAHO and WHO experiences in the analysis of access barriers.

The methodology was organized in four phases: 1) definition of governance, collaborative planning, and adaptation of the study; 2) parallel collection of quantitative and qualitative information; 3) triangulated analysis; and 4) policy dialogue.

Application of this methodology demonstrated that it was feasible to use mixed approaches to understand the magnitude and complexity of the different access problems faced by diverse population groups at both the national and subnational levels, as well as the context and underlying factors related to the implementation of policy initiatives.

Through the participation and involvement of health authorities, use of the study’s findings was promoted, and collaborative proposals were made for policy options to reduce and eliminate access barriers.

Future studies could explore the incorporation of mixed approaches to assess barriers to access in national and local monitoring and evaluation systems.
2.1. Relevant background for the implementation of this methodology

A critical first step in effectively removing access barriers is to identify which aspects of the health system and population should be prioritized in policy-making and implementation processes. In this framework, the analysis of access barriers becomes very important to understanding the factors that act as obstacles and facilitators for timely access to health interventions (24).

In recent years, initiatives have emerged that aim to deepen the analysis of access barriers. One that stands out is the use of the WHO guide for the analysis of barriers to access to health services during adolescence (25). This tool was preceded by country studies conducted by the WHO Regional Office for Europe (26), and its application was subsequently extended to other WHO regional offices (27). In the Region of the Americas, the creation of the PAHO Monitoring Framework for Universal Health in the Americas stands out (28). The framework is an instrument based on mixed methods that has been applied in different countries of the Region to analyze progress in health policies and the incorporation of dimensions and indicators to measure barriers. Also noteworthy are quantitative approaches, such as the mapping and analysis of data on access barriers from household surveys (24) and the analysis of FLC experiences from the patients’ perspective carried out by the Inter-American Development Bank through telephone surveys in six countries (29). The emergence of mixed-methods studies should also be highlighted. Recently, an approach based on the combination of qualitative and quantitative methods has been successfully used to define barriers and facilitating factors for access to maternal and child immunization programs (30).

The results of these studies suggest the need to integrate qualitative elements into the analysis and to promote mixed-methods studies to characterize the diversity, intersectionality, and complexity of access barriers. In relation to health systems and services, these approaches allow a better characterization of complex and multidimensional phenomena and processes and facilitate the detection of inconsistent patterns that may arise from the separate application of qualitative or quantitative methods (31). In fact, they make it possible to enhance the strengths and counteract the weaknesses when quantitative and qualitative approaches are applied independently (32) and to improve the reliability of studies’ conclusions by integrating the results (33). It is for these reasons that the case studies presented in this report adopted a mixed methodology to analyze barriers to access to health services in the framework of sectoral reform processes in the countries of the Region.

2.2. Framework for the analysis of barriers to access to health services

While acknowledging that there are multiple frameworks for analyzing the accessibility of health services (24), the case studies presented in this report were primarily based on the Tanahashi effective coverage model (23), which was previously used to analyze equity in access in the Region of the Americas and globally (23–25). The framework is composed of five dimensions: availability, accessibility, acceptability, contact, and effective coverage. In turn, the accessibility dimension is divided into geographical, financial, and organizational accessibility (Figure 6). Availability is defined as the adequacy and availability of resources (such as facilities, human resources, medicines, and
health technologies) to provide comprehensive health services. Geographical accessibility refers to the availability of quality health services within reasonable reach to those who need them. Financial accessibility means the ability to pay for services. Organizational accessibility is the organization and adequate delivery of health services that allow users to receive these services when they need them. Acceptability is considered as a dimension closely related to trust and influenced by the interrelationship between the characteristics, beliefs, and practices of health care providers and users. The contact dimension considers people’s willingness to contact health services, which is profoundly influenced by the population’s education about health-related issues. Finally, effective coverage is defined as the ability to use health services in a timely manner when needed and with a level of quality that is adequate to obtain the desired effect and potential improvement in health.

**Figure 6. Tanahashi’s model of effective coverage**

Note: The Tanahashi model illustrates how different dimensions are necessary to achieve universal access to health and universal health coverage.


### 2.3. Methodology for the analysis of barriers to access to health services

A concurrent triangulation design was selected in which quantitative and qualitative information obtained from a systematic literature review, household survey data, and narrative data from workshops or interviews were collected in parallel, and their analysis was performed in an integrated manner (34). Finally, the results supported policy dialogue that promoted the participatory formulation of recommendations to reduce and eliminate access barriers. The proposed methodology was organized into a four-phase protocol, described below (Figure 7).
**PHASE 1. Definition of the governance, collaborative planning, and adaptation of the study:**
This initial phase consisted of the formation of an inter-institutional team responsible for conducting the study. Depending on the case, the team was composed of experts and technical staff from national or subnational health authorities, WHO regional offices and PAHO/WHO country offices, and national academic entities. During this stage, activities were carried out to raise awareness about the issue of access barriers, disseminate the analysis methodology, create common knowledge bases on priority access problems for the country or locality, and adapt the methodology to the national or local context. The methodology was then jointly adapted to respond to local needs, which required the definition of the subject of the study, as well as decisions regarding which population groups and health conditions would be included and which key actors should be involved.

**PHASE 2. Parallel collection of quantitative and qualitative information:** During this stage, quantitative and qualitative data were collected through a literature review, cross-sectional analysis of household survey data, and in-depth interviews.

The literature review was carried out following the recommendations of the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement (35) to synthesize quantitative and qualitative information from open access studies published during relevant time periods for each case. To this end, search terms were established and subsequently used in three open access repositories: PubMed for access to the MEDLINE database, Scientific Electronic Library Online (SciELO), and Latin American and Caribbean Health Sciences Literature (LILACS). To find additional records from the references of the retained articles, the snowball technique was applied. Gray literature about the subject corresponding to technical reports and reports by national organizations, international organizations, and foundations was also included. Once the duplicates were eliminated, the abstracts and titles were evaluated to decide about their inclusion according to the established selection criteria (Table 2).
Two review authors then extracted the full text of the selected articles and analyzed them to assess their definitive inclusion. Inconsistencies and disagreements regarding inclusion were resolved through consensus.

**Table 2. Examples of terms used in the literature search on access barriers**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Search terms</th>
<th>Inclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Country</td>
<td>Publications in Spanish and English.</td>
</tr>
<tr>
<td></td>
<td>health system(s), health service(s)</td>
<td>Published between 2009 and 2020.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Search terms</th>
<th>Inclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>barriers, facilitators, acceptability, financial barriers, availability, contact, effective coverage</td>
<td>Terms selected in the title, abstract, or keywords. Studies that are quantitative, qualitative, and mixed, and empirical, primary, and secondary, with full text that is freely accessible. Articles that explore access barriers for the general population and for populations in situations of vulnerability.</td>
</tr>
<tr>
<td></td>
<td>equity, inequity, quality, reform</td>
<td>accuracy, demand, supply, satisfaction, seeking</td>
</tr>
<tr>
<td></td>
<td>access</td>
<td>primary health care, first level of care</td>
</tr>
</tbody>
</table>

Simultaneously, a cross-sectional analysis of data obtained from the household surveys available for each country was performed, as described above (17). The main variables included populations with a health care need that did not seek care due to availability, financial, geographical, organizational, acceptability, contact, and effective coverage barriers; women who identified financial, organizational, and gender relations and roles as access barriers; and rates of utilization of essential services.

In addition, information was gathered through semi-structured interviews or participatory workshops to validate the information gathered from secondary data analyses and determine context-specific solutions. For the interviews and workshops, a guide was developed that incorporated open questions about access barriers and possible actions to overcome them.

**PHASE 3.** Triangulated analysis: Synthesis of quantitative and qualitative data was performed using thematic analyses to group access barriers according to the five dimensions of access, followed by narrative description that highlighted complementary and contradictory points from the qualitative and quantitative data that could support findings and reveal knowledge gaps. The relevant information was extracted from the data sources analyzed using different procedures.

In the case of the literature review, a data matrix was created using Microsoft Excel®. A second group of reviewers then analyzed and validated the extracted information to ensure the correct application of the classification criteria and ensure the quality of the data.
For the analysis of the quantitative data from household surveys and demographic and health surveys, the reasons given for not seeking health services were reclassified according to the dimensions of the analysis framework, and individual-scale expansion factors were applied to calculate national totals. Where the unweighted number of observations in a specific subgroup was less than 25, results were omitted. The analysis included the cross-tabulation of different sociodemographic variables (area of residence, ethnicity, wealth quintiles, sex, insurance or non-insurance, and type of health insurance) with all the access barrier indicators. For the individual women’s questionnaire, where demographic and health survey data were used, the results of the indicated access barriers and the utilization of essential health services were compared through descriptive statistics. Multivariate models were then created to assess the association between the independent and dependent variables. The odds ratio (OR) coefficients were calculated using logistic regression and specifically, the stepwise regression method.

For quantitative data analysis, the statistical software Stata® version 15.1 was used. To support the interpretation and dissemination of the country report results, graphs were developed using Tableau Desktop® version 2021.3.3.

Regarding the qualitative data extracted from interviews with key informants or participatory workshops, a computer-assisted thematic qualitative analysis of the transcripts was performed using NVivo® version 12 in the cases of Guyana and Honduras, and ATLAS.ti® version 9 for Colombia and Peru. The dimensions of the barriers were coded using a descriptive approach, based on the analysis framework. This required associating fragments of discourse to the dimensions of the access barriers. To identify the type of barriers (with a subcode within each
dimension), an inductive process of in vivo coding was selected, through which the barrier type subcode was created from participants' literal reports (36). The same approach was chosen for the analysis of the factors underlying the barriers, enablers, and policy options. Once the initial codes were obtained, the information was organized through unification and codebook creation processes.

During the final stage, the thematic constructions were synthesized into analytical themes that articulate the general dimensions of access through a descriptive-type deductive approach. Finally, the results were analyzed thematically and the contradictions and complementarities between the different study components were highlighted, following the recommendations on the use of mixed methods (37). Consistency across multiple data sources ensured the internal validity of the findings and increased the richness of the analysis. The interpretation of the relevance of the findings was reached through consensus across the entire analysis team, in collaboration with the health authorities.

**PHASE 4. Policy dialogue:** This last phase involved the implementation of policy dialogues to share findings and formulate strategies to overcome access barriers. Participants included representatives of different areas of the ministries of health (those engaged in the planning, monitoring, and evaluation of policies); decisionmaking bodies (national directors, deputy ministers, medical directors); civil society; and academic institutions. The results of these dialogues were considered when organizing the final report, so as to include both the characterization and analysis of the group of barriers and a series of policy recommendations aimed at reducing and eliminating barriers to access to health services.
CHAPTER 3
COLOMBIA: Mandatory Health Plan

• Over the past three decades, Colombia has made great efforts to improve universal health coverage. As a result, in August 2022, 98.54% of the population was covered by the health system; in 2019, out-of-pocket spending on health was 14.9%; and, since 2015, the country has an implicit, comprehensive health benefits plan.

• Despite extensive efforts, the Colombian population faces different obstacles to accessing health services. An analysis of the main access barriers present in the Colombian health system was conducted to better understand the situation.

• Multiple access barriers were identified in the study. The main barriers are long wait times to receive health care and the excess processes needed for the approval of services, largely associated with limited financing, cost-containment incentives, and problems arising from the negotiation of service fees.

• Colombia also has different realities in terms of the supply of services and the conditions for health care access in its territory, which highlights the need to establish differentiated models. The unequal distribution of human resources and providers in the national territory is a major issue.

• Lack of knowledge about how the health system works, coupled with problems related to the acceptability of services, can limit access to health care, despite efforts to implement the Indigenous Intercultural Health System (SISPI).

• Despite the country’s great strides in reducing financial barriers, part of the population continues to face significant budgetary constraints that prevent them from accessing health services.

• Although Colombia has a Mandatory Health Quality Assurance System (SOGCS), health services are not always in the best conditions and there are no clear quality standards at the sector’s different levels and processes.
• The situation of access barriers highlights the need to strengthen the health authority’s stewardship and governance at different levels of the system, its regulatory and oversight capacities, and integration, coordination, and interoperability among information systems.
• HRH and infrastructure are key to improving the health service delivery conditions. Therefore, policies are needed to improve their conditions and facilitate their availability.
• Quality should be improved in a cross-cutting manner across the Colombian health system, supported by financial and nonfinancial incentives for all actors.
• To improve the conditions of access to health services and the well-being of the Colombian population, it is essential to adopt a long-term vision that seeks to strengthen PHC and the EPHF.

3.1. Introduction

Since the creation of the General System of Social Security in Health (SGSSS), Colombia has made great efforts to improve universal access to health and increase universal health coverage for its population. Figure 8 summarizes the different initiatives and reforms adopted by Colombia to improve its health system. Law No. 100 of 1993 (38) gave rise to the current Colombian health system, which is composed of three schemes: contributory, which formal workers and their families should join; subsidized, which is open to people without the ability to pay, informal workers, and the unemployed; and the special exception, which corresponds to workers in special systems, such as the military forces and public sector teachers. Initially, an explicit and differentiated Mandatory Health Plan (POS) was established for each scheme. However, from 2009 to 2012, the health plans of the two main schemes, the contributory and the subsidized, were unified. In 2015, the Statutory Health Law (LES) (39) transformed the POS into an implicit and comprehensive Health Benefits Plan (PBS), with certain explicit exclusions. As a result of these efforts, the country has achieved a high rate of affiliation to the SGSSS. Reflecting this, in August 2022, 98.54% of the population was covered (40). Likewise, Colombia has low out-of-pocket expenditures by the population. In 2019, these expenditures represented 14.9% of current expenditures on health, compared to an average of 32.44% for Latin America and the Caribbean (13). This has also been accompanied by significant public expenditure on health, representing 5.54% of GDP in 2019, a figure that exceeds the average public expenditure of several countries in the subregion (13).

The LES, enacted in 2015, represents a great advance toward the goal of guaranteeing the right to health. This law not only represents a significant step toward a comprehensive PBS, but also toward meeting the State’s obligation to guarantee the right to health (39). The LES recognizes that the right to health comprises 14 elements and principles, including availability, acceptability, accessibility, quality and professional suitability, universality, equity, continuity and timeliness of care, efficiency, sustainability, solidarity, and interculturality and protection for indigenous peoples, which is developed in the Indigenous Intercultural Health System (SISPI). Likewise, the LES assigns to the State the responsibility of adopting policies that ensure equal
Analyzing and Overcoming Access Barriers to Strengthen Primary Health Care

The LES seeks to generate guarantees and mechanisms to protect the fundamental right to health, which include community participation, the organization of the health system into service networks, and the express prohibition of denial of health services. The LES also seeks to protect the autonomy of health professionals, and their ability to work in a dignified and respectful manner. It also mandates the establishment of guidelines for the optimal management of health data and intersectoral coordination to achieve solid pharmacological and public health policies, all based on innovation, science, and technology.

The country has introduced multiple initiatives and strategies to strengthen public health and PHC. With the creation of the current health system, competencies were assigned to the territories (municipalities, districts, and departments) to undertake actions related to health promotion and disease prevention, and to ensure and finance the provision of treatment and rehabilitation services up to the third level of community health care, either directly or through contracts with public, community, or private entities (41). In 2001, it was determined that the territorial entities would be responsible for carrying out public health actions in the area of health promotion and disease prevention aimed at the population of their jurisdiction. This includes people in the POS of the subsidized scheme, whose values would be deducted from the respective capitation payment unit (CPU). However, these initiatives have faced multiple difficulties, considering the assistance-curative vision that has persisted in the SGSSS and the different territorial entities (42). In 2011, the national government adopted the PHC strategy and ordered the development of ten-year public health plans, the most recent of which was prepared in 2022, with implementation until 2031. In 2016, with the aim of supporting the regulation of the LES, the Comprehensive Health Care Policy (PAIS) (43) was implemented. It is grounded in PHC, with a family and community approach, and based on care, comprehensive risk management, and the differential community and territorial approach, whose development was based on the Comprehensive Health Care Model (MIAS) (39). Implementation of the latter revealed important intra- and inter-territorial deficiencies. In 2019, it was replaced by the Comprehensive Territorial Care Model (MAITE), which seeks to improve the PHC-related coordination of the SGSSS actors in a territorial area, including benefit plan administration entities (EAPB) and health services provider institutions (IPS).²

Legislative and judicial entities have created tools for people who consider that their right to health has been violated, so that they can seek special protection. The regulation that pursues the due guarantee of the right to health is constantly updated, although it has a high degree of complexity. Even prior to the 2015 LES, Colombian legislation established administrative mechanisms such as technical-scientific committees to try to ensure access to

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² This designation includes the health-promoting companies (EPS) in the contributory and subsidized schemes, including the conventional and indigenous; entities in the emergency scheme; family compensation funds in their health activities; administrators of voluntary health plans (supplementary plans and prepaid medicine); occupational risk managers (ARL) in their health activities; health-focused mutual partnerships; solidarity health companies; insurers in their health activities; and universities that carry out health activities. See Abadia CE, Oviedo DG. Bureaucratic itineraries in Colombia. A theoretical and methodological tool to assess managed care health care systems. Social Sci Med. 2009;68(6):1153–1160. Available from: https://doi.org/10.1016/j.socscimed.2008.12.049.
health services that were not covered by the POS. The judicial system has also provided tools such as a writ for protection (acción de tutela), a relatively mediated mechanism to guarantee the protection of individual rights, in particular, the right to health. With respect to this last tool, the LES showed that a lengthy evidence collection process is not required to demonstrate the connection between the case studied and the patient’s right to life and health. This expedites related rulings and, in turn, access to needed treatments (44).

Despite considerable progress and efforts, there are significant shortcomings in guaranteeing effective access to health services for the Colombian population. In the country there are still barriers that impede the population’s timely access to health care. This is reflected in the increase in complaints and claims, as well as writs for protection to request access to health services (45–49). Accordingly, PAHO conducted this study in collaboration with the University of the Andes in 2022, with the objective of contributing to policy formulation processes for strengthening the health system. The study used mixed methodologies and triangulated the information collected from the literature review on barriers to access to health services, the analysis of health information obtained from two surveys (the National Quality of Life Survey [ECV] from 2003 to 2021 and national studies to evaluate the services of health-promoting companies [EPS] from 2019 to 2021), and information collected through interviews with key actors from the SGSSS. This publication presents the study’s main findings and recommendations.

**Figure 8.** Evolution of the health regulations of the General Social Security System in Health of Colombia, 1992–2020

Note: CPU: capitation payment unit; MAITE: Comprehensive Territorial Care Model; MIAS: Comprehensive Health Care Model; MIPRES: My Prescription; PAIS: Comprehensive Health Care Policy; PBS: Health Benefits Plan; PHC: primary health care; POS: Mandatory Health Plan; POS-C: Mandatory Health Plan - contributory; POS-S: Mandatory Health Plan – subsidized; RC: contributory scheme; RS: subsidized scheme; SGSSS: General System of Social Security in Health.
3.2. Main access barriers

According to the results report for the evaluation of the SGSSS 2009–2019, published by the Ministry of Health and Social Protection (MSPS) in 2020 (50), Colombia managed to considerably expand the population affiliated with the SGSSS, from 91% of the total population in 2009 to 95% in 2019. However, the percentage of people needing health care (not including hospitalizations and emergencies) in the SGSSS decreased from 11% to 6% in the same period. In turn, the ECV data show that the percentage of the population that did not seek care when they needed it increased from 25.4% in 2010–2012 to 33.1% in 2019–2021, due to a combination of complex factors that affected the responsiveness of the SGSSS.

Problems related to health services organization and delivery constitute one of the main barriers to access to health services in Colombia. One of the main reasons for the Colombian population's dissatisfaction with the SGSSS relates to long waits and excessive processes for the assignment of medical appointments, in particular, specialized medical appointments (Figures 9 and 10). Similarly, in the literature about access barriers and interviews with key actors in the Colombian health system, there is agreement that the large number of processes, added to the lack of communication between insurers and providers, ends up generating delays not only in the management of procedures, but also in the assignment of medical appointments (45, 51–53). Likewise, the ECV data show that the percentage of the population that does not seek care when they need it, due to long wait times and excessive paperwork, increased from 3.8% in 2003 to 5.0% in 2021 (Figure 11). This situation also seems to have worsened in the context of the COVID-19 pandemic. The reports from the 2019–2021 national EPS service evaluation studies show that the average number of waiting days between a request for a family medicine appointment to the appointment date increased from 24.9 days in 2019 to 31.3 days in 2020 and 44.4 days in 2021 (54–56).

Long wait times and excessive paperwork occur for different reasons. On the one hand, limited financial resources translate into cost-containment incentives for EPS, leading to dangerous constraints on service provision. Historically, the value of the CPU—the premium paid to the EPS by each member to finance the health services and technologies that are part of the PBS—has not been sufficient relative to the values required to offer the benefit plan's full coverage, particularly for the subsidized scheme. For this reason, the EPS may be encouraged to increase the processes to access health services and to restrict their network of services,
to the detriment of their members’ well-being (57). On the other hand, inadequate negotiated fees for health services between the EPS and the IPS result in financial difficulties for the IPS, which is detrimental to the supply of health services. These factors, added to restrictions in the supply of human resources, can prolong wait times for allocating appointments in health services. As reported in the interviews, “the current fee manuals do not necessarily cover operating costs and expenses, [...] and are also outdated.” In Colombia, two fee manuals are used for this type of negotiation: the fee manual of the Compulsory Traffic Accident Insurance (SOAT) (58), which governs the public IPS, known as State social enterprises (ESE); and the ISS Fee Manual (59), which was created to regulate the rates of the Social Security public EPS and is currently liquidated. The 2001 version is the one that is most widely used to negotiate contracts for the provision of services, but it is not updated (59). Very few IPS have private rates that are different from the ones in these manuals. This usually occurs when the procedures are not included in these manuals. For all health services, the IPS require service provision to be authorized by the EPS to which the user is affiliated, except for emergency services. The IPS can provide emergency services without prior authorization, but there are certain rules for this type of situation and for referral and counter-referral processes. Therefore, some IPS prefer to prioritize their attention toward services for private plans and private services if the negotiated rates and service authorization conditions do not favor their profitability.
Access barriers were classified according to the dimensions of access, into availability (availability and adequacy of resources), geographical accessibility (availability of services within a reasonable reach), financial accessibility (ability to pay for services), organizational accessibility or accommodation (organization and adequate provision of services), acceptability (willingness to seek services when social or cultural factors do not discourage the population), contact (willingness to contact health services), and effective coverage (ability to use health services at a commensurate level of quality). The size of the boxes represents the frequency with which the access barriers were mentioned in the literature.

Note: HRH: human resources for health; PBS: Health Benefits Plan.
Figure 10. Barriers to access to health services in Colombia identified by key actors from the General Social Security System in Health during interviews, 2022

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of opportunities in health care, without real prioritization of those with the most urgent needs</td>
<td>high</td>
</tr>
<tr>
<td>Medical records do not favor follow-up of users throughout the entire care process, leading to reprocessing and delays in diagnosis and treatment</td>
<td>high</td>
</tr>
<tr>
<td>Some services impose excessive processes for accessing excessive processes to access services, with differentials between EAPB and providers</td>
<td>high</td>
</tr>
<tr>
<td>Significant lack of knowledge about the functioning of the health system</td>
<td>high</td>
</tr>
<tr>
<td>Geographic conditions limit access to health services in remote areas, increasing the concentration of services in and around urban areas</td>
<td>high</td>
</tr>
<tr>
<td>Some people lack the financial resources to cover co-payments</td>
<td>high</td>
</tr>
<tr>
<td>Important differences in the availability of infrastructure and human talent throughout the region. Outlying areas are most affected</td>
<td>high</td>
</tr>
<tr>
<td>Shortage of medicines related to difficulties in contracting</td>
<td>high</td>
</tr>
<tr>
<td>Human resources are insufficient in some areas, mainly in medical specialties</td>
<td>high</td>
</tr>
<tr>
<td>Precarious conditions for health personnel and corruption affect the quality and effective delivery of services</td>
<td>high</td>
</tr>
</tbody>
</table>

Access barriers were classified according to the access dimensions, into availability (availability and adequacy of resources), geographical accessibility (availability of services within a reasonable reach), financial accessibility (ability to pay for services), organizational accessibility or accommodation (organization and adequate provision of services), acceptability (willingness to seek services when social or cultural factors do not discourage the population), contact (willingness to contact health services), and effective coverage (ability to use health services at a commensurate level of quality). The size of the boxes represents the frequency with which the access barriers were mentioned in the interviews.
CoSaobia has different realities in its territory in terms of access conditions related to proximity to health centers, supply of services, and health authorities’ capacities in subnational areas. At the national level, there is a significant deficit of HRH, mainly of nursing professionals. In 2019, Colombia had 14.80 nurses per 10 000 inhabitants, while the average for Latin American and Caribbean countries was 19.25 (60). Likewise, the Colombian Association of Faculties of Medicine (ASCOFAME) reported that there is a significant deficit of personnel in medical specialties and subspecialties: in 2020, of the 110 000 medical professionals in the country, 27 000 were specialists and only 1200 were intensivists (61). At the same time, the availability of health services throughout the Colombian territory is highly variable, not only because of the possible differences between rural and urban areas, but also because of the different levels of development. For example, the ratio of providers in 2019 was 1.3 per 1000 inhabitants in departments with a robust level of development, while the availability was 0.5 providers per 1000 inhabitants in departments with an early level of development. The same is observed for the availability of medical personnel, with a ratio of 37.2 doctors per 10 000 inhabitants in departments classified as robust, compared to 12.6 doctors per 10 000 inhabitants in departments with an early development environment (50). The above data were reinforced by interviews with experts, who highlighted the regional differences in the infrastructure available for care services, particularly in rural areas: “There is not enough infrastructure in terms of quantity, distribution, or quality throughout the national territory.” Another commented: “Human resources are concentrated mainly in urban areas and even in these areas, the supply of specialized services may be limited.” Interventions are needed to increase the availability of services, without reducing their quality and instead, improving it.
The problem of unequal distribution of providers throughout the national territory has not been solved with the inclusion of large private actors in the health system. According to one interviewee: “Laws and regulations have to be instrumentalized and, if they are not instrumentalized through infrastructure, processes, and human talent, they do not work.” This, in turn, forces a significant part of the population to travel long distances to access health services (49, 52, 53, 62, 63). According to data from the national ECV survey on quality of life, the indigenous population is particularly affected by this situation: 6.9% of indigenous people did not seek health care for this reason, compared to 1.2% of those who do not identify as indigenous. This reinforces the great inequalities that the Colombian population faces in accessing health services. Even in urban areas, SGSSS users cannot always access the IPS closest to their place of residence; rather, this depends on the relationship between these institutions and the EPS, which directs users to health care locations in the network of contracted providers.

Since 2011, responding to the mandate of the Declaration of Montevideo (64, 65) and with a focus on ensuring the comprehensiveness and continuity of user care at different levels of care and scenarios, it was established that the SGSSS would operate through IHSDN (66), whose coordination is overseen by the territorial entities in coordination with the EPS. However, since 2016, with the adoption of the Comprehensive Health Care Policy (43), the EPS have the essential function of organizing the comprehensive networks of health services providers (RIPSS) (67). This means that the coordination of care continues to depend on the negotiations between the EPS and the IPS. Although there are providers closer to their residence, users still have to travel long distances to receive health care—sometimes to other municipalities if the EPS do not have contracts with the IPS in the territory of residence. Even within urban areas, SGSSS users cannot always access the IPS closest to their place of residence, according to a key informant:

“An example is the E.S.E. [name omitted], which has a large infrastructure: people who live nearby cannot seek care there because they are from the contributory scheme and the E.S.E. provides care for the subsidized scheme, [...] so those people have to travel somewhere else in the city to receive care”.

Likewise, although the EPS should authorize the RIPSS and register this information in the Special Registry of Health Services Providers (REPS), information about the authorized RIPSS is not available to all users, violating their right to free choice of an IPS. This underscores the need to review the SGSSS legal framework to correct possible perverse incentives that undermine the continuity and comprehensiveness of health services delivery.

There are also weaknesses in the planning processes and the exercise of the competencies of those who support or perform the function of local health authorities (68). While Colombia has made an effort to decentralize its health system, the effectiveness and efficiency of local authorities are often constrained by the heterogeneity of existing governance structures and public health capacities, including in areas such as access to internet services (69). Another problem related to centralization is an increase in red tape, hindering quick decisionmaking and
the adoption of response measures at specific times and places (70). These difficulties are also accompanied by the great political and socioeconomic heterogeneity of the communities served by these institutions, which require differential approaches adapted to their needs.

Finally, the inadequacy of the CPUs exacerbates the inequities in service provision in the national territory. CPUs in Colombia vary according to disease risk by age group, sex, frequency of health service use, and geographical area (71). Likewise, CPUs are differentiated according to their scheme, including whether the service provider is indigenous. Although a premium is added to the value of CPUs in remote areas of the country, the concentration of more complex services in the main cities fundamentally conditions the resources received, leaving regions such as the Pacific and the Amazon behind in terms of installed capacity (72). At the same time, these regions are characterized by a smaller population and higher rates of labor informality relative to the national average (73). This means that they receive more resources from the subsidized scheme than from the contributory scheme, even though several of their municipalities have a CPU higher than the national average.

Lack of knowledge about how the health system works, coupled with problems of acceptability of services, can limit access to health care. According to the information presented by the 2019–2021 national EPS service evaluation studies (54, 56), the percentage of people who reported using the information on the rights and duties of SGSSS affiliates increased from 16.4% in 2019 to 56.9% in 2021. However, there is still a large percentage of the population that does not know about this information, as expressed in interviews: “Knowing how to move in the health system is what can determine access to all services.” This is evidenced in the literature review, which indicates that users without sufficient knowledge about how the health system functions are less likely to claim their rights in a timely and effective manner and achieve effective access (51, 52, 62). Lack of knowledge could also be related to the resolution of health problems in other ways. The ECV shows that, among the reasons for not seeking health care, self-medication persists (declining from 16.3% in 2003 to 15.7% in 2019–2021) and the use of home remedies is increasing (from 10.4% in 2003 to 13.3% in 2019–2021) (Figure 12).

In addition, acceptability problems related to cultural and language barriers persist, despite efforts to implement the SISPI. The existence of different dialects in the national territory and the challenges of serving the population with cultural and linguistic diversity were reported by the experts interviewed: “For example, in La Guajira, in the Maicao hospital, the vast majority of doctors do not speak Wayuu and approximately 80% of patients are Wayuu. Some of them don’t speak Spanish.” In many cases, information on the health system has not been adapted to the different dialects that exist in the national territory. This exacerbates access-related inequalities due to cultural and religious differences.
Despite the country’s great strides in reducing financial barriers, part of the population continues to face significant budgetary constraints that prevent them from accessing health services. The ECV shows a significant reduction in reported financial access barriers as a reason for not seeking care, from 12.2% in 2003 to 2.1% from 2019–2021 (Figure 11). This denotes a substantial improvement in this regard, accompanied by a significant expansion of affiliation to the SGSSS (98.54% in 2022). However, there is a percentage of the population that still lacks coverage. This includes the migrant population, uninsured poor people who do not meet the minimum requirements for joining the subsidized scheme, and special populations that are not affiliated with any health insurance scheme (74). This situation gives rise to significant inequalities: according to ECV data, financial barriers continue to be more prevalent among the uninsured population (13.8%, compared to 2.1% in the subsidized population and 0.1% in the contributory regime). Both the literature on access barriers and the experts interviewed agree that, although the most vulnerable population may be able to fully access subsidized health services, in some cases they need medicines that are not available or have to pay for transportation to health services. There is a proportion of the population that cannot cover such expenses (51, 52). There may even be expenses related to requesting authorization or assigning appointments for service provision that some individuals, “particularly those living in remote rural areas, cannot cover,” says a key informant. Likewise, the population with partial subsidies or those who have to make co-payments due to their type of affiliation do not always have the necessary resources to be able to access health services. (51, 53, 62, 75–77).

While the population may be able to access health services, the conditions for the provision of these services are not always optimal. Colombia’s Mandatory Health Quality Assurance System (SOGCS) provides tools and methodologies for the entire health sector in order to

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**Figure 12.** Percentage of Colombian population that did not seek health care when needed, by reason, 2003–2021

![Percentage of Colombian population that did not seek health care when needed](source)

generate, maintain, and improve the quality of the country’s health services (78). This is based on the criteria of accessibility, timeliness, security, relevance, and continuity. The SOGCS is made up of four components, namely: the Single Qualification System (SUH), the Audit Program for Quality Improvement (PAMEC), the Single Accreditation System (SUA), and the Information System for Quality. However, health services are not always in optimal conditions and there are no clear quality standards for the sector’s different levels and processes. This is associated with the lack of minimum fees paid to service providers, in accordance with the qualification requirements. Because fees are not properly regulated, providers enter into price competition to cover their cost structure, rather than competing for other quality attributes. This price competition has been linked to declines in technical quality, a situation that is not always perceived by users even though it affects them (79). Another weakness of the SUA is that it does not always consider the differentiated needs and possibilities of rural areas. An example of this is found in the department of Guainía, where there are health posts that fail to meet the authorization criteria related to infrastructure, preventing them from functioning (69). This is because licensing standards are applied homogeneously to all hospitals and health facilities in the country. If there is a quality standard that cannot be achieved or financed in the short term, the health center must be closed, further limiting the access of the population in rural areas. The need to address rural areas’ conditions and needs in a differential manner was included in the National Rural Health Plan (80), which also includes the intercultural adaptation of health facilities.

At the same time, it is necessary to work on the other components of the SOGCS to detect and address other potential situations, such as professionals’ lack of specialized knowledge, the lack of tools, and the presence of errors in giving diagnoses and providing appropriate treatment. This, in addition to cases of mistreatment by health workers that have been identified, can lead people to avoid seeking health care (46, 62, 75). In some cases, these situations are associated with the poor working conditions of certain health workers, who may have multiple jobs or service contracts, unpaid wages, and a lack of supplies and tools for providing services. Although barriers related to quality and effective coverage are generally the least frequent in the literature and interviews with key actors, this does not necessarily mean they do not exist.

There is a need to strengthen control and supervision mechanisms, as well as effective sanctions, in the health sector. Different experts from the Colombian health system pointed out this situation:

“It is necessary to work on issues related to weighting, so that CPUs can be better distributed based on diagnoses and health outcomes. It is necessary to align all actors around the issues of health outcomes, including a culture of co-responsibility with users”.

“The system’s big problem is the bad practices of the agents involved—everyone, including the users.” Also, in some cases “there are public hospitals in remote territories with corruption problems. In this case, inequality arises due to corruption.”
3.3. Policy recommendations

The following are the policy recommendations prioritized by the health system actors who participated in expert interviews. These were complemented by technical documents and specialized bibliography of a regional scope that provide recommendations for improving universal and equitable access to health services. Such actions could be developed in the short- and medium-term.

Strengthen the stewardship and governance of the Ministry of Health and Social Protection at different levels of management

The changes required to close the gaps in access conditions require the leadership of the MSPS and territorial entities, as well as the strengthening of governance mechanisms, paying special attention to the capacities to lead a comprehensive approach to PHC. The LES has represented a great opportunity for the Colombian health system regarding its purpose of overcoming barriers to access to health services. However, to achieve the objectives established in this law, it is necessary to continue promoting a more comprehensive perspective of PHC, accompanied by sustained budgetary prioritization. Therefore, the complete regulation of this law provides an opportunity to establish the necessary mechanisms to guarantee the right to health and strengthen the EPHF (5) and to renew the commitment to the Compact 30-30-30: PHC for Universal Health (6). A renewed EPHF initiative in the Region of the Americas could guide this process, constituting a tool to evaluate and strengthen the institutional capacities needed for integrated actions that promote the strengthening of the SGSSS, paying due attention to public health priorities and in line with the approaches of comprehensive PHC (5, 7).

Strengthen governance and management capacity at the subnational levels, quality assurance instruments and effective access, financial flows, and results. Although the MSPS is the governing body of the Colombian health system, it is a decentralized system and multiple health-related responsibilities fall to territorial entities. Historically, the territories furthest from the large metropolitan areas have had to assume their administration and operation in contexts of generalized violence and various political interests, as a result of which local administrative performance is quite asymmetrical throughout the national territory (81). To strengthen governance processes at subnational levels, it is necessary to understand the health-related inequalities and differential needs of the different territories, but with the same cross-cutting purpose: to strengthen the comprehensive PHC approach and reduce barriers to access to health services. This will require redoubling efforts to close the gaps in the conditions of effective access, in particular by improving the supply and availability of resources, strengthening the response capacity of the FLC public network in the most disadvantaged areas, and coordinating the actors responsible for ensuring the right to health. It is also important to strengthen public health capacities at the regional level with the necessary resources, especially through the provision of human resources with minimum characteristics that favor their performance.

Strengthening the National Superintendence of Health and its inspection, surveillance, and control capacities in a decentralized and regional manner will also make it possible to address access barriers in their different geographical contexts and according to institutional
characteristics. This entity plays an important role in protecting the rights of SGSSS users and ensuring that the actions of the actors are in line with the purposes of the MSPS in health. For this reason, it should have sufficient tools not only to control and supervise the system’s actors, but also apply the necessary sanctions to reorient actions toward optimizing the provision of services. Although Law 1949 of 2019 (82) strengthened the sanctioning capacity of the National Superintendence of Health, it seems that these new tools have not been sufficient since there are still barriers to access to health care (83). This makes it necessary to reassess the role of the entity and its ability to control various actors in the health system. In terms of sanctions, it is necessary to avoid making only the “entities—providers or insurers—financially” responsible for the health care system. In the words of a key informant: “Direct sanctions are required for individuals, with the support of other control entities, the Prosecutor’s Office, the Comptroller’s Office, the Attorney General’s Office, working for the same purpose.”

Promoting the transformation of the national health technology regulatory system will bring autonomy and sustainability to evaluation activities, and could result in the reduction of barriers related to the availability of medicines and technologies. “Innovation contributes to the health system, generating savings if it is well used by the patients who require it,” said a key informant. Given the growing restrictions on the supply of medicines throughout the national territory, it is necessary to understand the reaction of the international supply of medicines and health technologies to Colombian legislation and make the necessary adjustments to avoid both shortages and significant delays in access to medicines and state-of-the-art health technologies. It is also necessary to identify the processes that require transformation or strengthening within Invima, which is responsible for health surveillance policies and the control of medicines and health technologies, to increase their supply in the country.

**Strengthen information systems in order to have better decisionmaking tools**

There are challenges related to the integration, coordination, and interoperability between information systems, as well as lack of clarity regarding stewardship of production and the use of information in the sector. Colombia has large health-sector databases; however, fragmentation persists and there is little coordination between information systems (84). In many cases, it is necessary to improve the quality of the information and enrich it with data from other sectors for better decisions about quality and public policy in general. Finally, it is necessary to strengthen health monitoring and evaluation systems, to detect system inefficiencies in a timely manner and, if necessary, redirect actions to improve health outcomes.

Cross-cutting strengthening of information systems throughout the health system should be a priority. In line with strengthening the governance of the Colombian health system, there is an urgent need for a health information system with interoperable and interconnected management mechanisms and processes. The transparent and appropriate use of information should be led by the MSPS. This should be based on technical foundations in terms of both information and communications technology and proper processing, with the purpose of improving efficiency and avoiding duplication in the collection of information by the sector’s different public entities. Clear guidelines are also required regarding the quality and manner in
which all actors should provide information, particularly information related to minority groups. This implies intersectoral work with different government entities aimed at providing updates to the data system regarding the allocation of subsidies, participation in the labor market, and any other information deemed necessary to create health strategies, programs, and policies that lead to improved health conditions for the Colombian population. These strategies should aim to implement the 2015 LES, considering the policy for the management of health information and ensuring the essential elements of the fundamental right to health, namely: 1) availability of competent services, technologies, institutions, programs, and human resources; 2) acceptability, respecting sociocultural particularities, the health-related worldview, and confidentiality; 3) equal accessibility of services and technologies, including access to information; and 4) quality and suitability of health facilities, services, and technologies, in compliance with the necessary requirements.

Monitoring and evaluation systems need to be strengthened throughout the health system. This need refers not only to health outcomes, but also to the health system’s capacity to respond to the population’s needs, both in terms of infrastructure and human talent. It is also necessary to strengthen accountability mechanisms at all levels and facilitate reporting channels, which should be centralized or interconnected to facilitate the traceability of any deficiencies that arise, as well as the necessary solutions and interventions. It is therefore necessary for the qualification system to recognize the differentiated needs of rural areas and offer alternatives adjusted to local realities.

Formulate and implement strategies to strengthen human resources and infrastructure

It is necessary to improve the availability of HRH, as well as their working conditions, as they constitute a fundamental pillar in all health systems. The hiring of health personnel without full labor guarantees (in some cases leading to breaches of labor obligations, such as non-payment of wages, labor contracts with third-party intermediation, low salary levels, lack of protection measures, and absence of State support) (85) can generate problems with staff turnover and migration to other countries, as well as problems with the quality of service delivery. For this reason, it is necessary to formulate policies that favor the recruitment of health workers in optimal and safe conditions and, in turn, create incentives for them to use their skills most effectively for the population’s well-being. This should be applied both in urban and rural areas.

Strengthened government intervention is needed to improve the availability of human resources and infrastructure throughout the country, particularly in remote areas. The country has a deficit of human resources in areas such as nursing and certain medical specialties and subspecialties, and the situation is worse in remote zones. For this reason, strategies coordinated with the education sector are needed to improve the supply of these professionals, focusing on areas that currently have fewer human resources. It is also necessary to combat the concentration of infrastructure in urban areas and improve infrastructure in the most remote areas, with special attention to first-level services. For this, it is necessary to promote the incorporation of technologies and innovations in the intra- and extramural provision of services, especially at the first and second levels of care, which includes home services and evidence-based telemedicine and telehealth tools (86).
Strengthen quality-related incentives, both financial and nonfinancial, across the health system

It is necessary to harmonize incentives throughout the health system and have all actors commit to the same health-related goals in order to provide timely and quality services to SGSSS members. Strategies need to be developed that link payments made in the system to health outcomes and quality criteria. In the case of fund administrators, CPU payments could be based on service quality and health outcomes. In the case of IPS, it would be necessary to update and standardize the fees for health services to include quality criteria that encourage better results in the provision of services. Performance-based hiring should also be expanded, with objective measures of expected results. Similarly, the hiring of human talent in health should consider quality-oriented mechanisms: both to protect and respect their dignity, and to incentivize the quality of the care they provide. It has been shown that the type of contract for health professionals (fixed salary versus variable salary) can have an impact on the quality of care they provide to patients (87). However, all these strategies need to be carefully studied and analyzed, as poor implementation can lead to financial risks and supply-side constraints. It is necessary to analyze the sufficiency of the CPUs for these areas, considering not only demographic variables, but also population density, the labor market, and the efforts needed to improve their capacity. This is particularly relevant at the FLC, since this affects the performance of these regions more than in the large cities.

It is therefore necessary to analyze possible non-financial incentives in parallel, as well as standardized quality criteria for all actors. The application of the different strategies should respond to the characteristics of the system's actors. The many options that should be studied include public sector procurement that favors entities with better results. Regarding human talent in health, educational strategies are needed to strengthen institutional capacity in remote areas, particularly in specializations.

Strengthen the long-term vision of health system strategies, including those that seek to foster financial sustainability

Health system strengthening strategies should have a long-term approach. Great political commitment is required to establish sustainable strategies to strengthen the SGSSS over the long term that are not limited to government periods. The different strategies should prioritize financial sustainability to ensure the availability of resources that allow effective access to health services. Given the relationship between the type of affiliation to the health system and the allocation in the labor market of people between the formal sector (compulsory affiliation to the contributory scheme) and the informal sector (affiliation to the subsidized scheme), as well as the solidarity component of the SGSSS, it is necessary to work in collaboration with the labor sector on strategies that strengthen labor formality and contributions to the health system.
Over the past two decades, Guyana has achieved significant progress in access to essential health services, improvements in infectious disease control, and positive results in improving maternal and child health indicators. It has also worked to strengthen the health system’s response to chronic noncommunicable diseases.

However, persistent barriers to access to the health system, combined with the pressures created by the COVID-19 pandemic, could reverse these gains, and hinder the effectiveness and long-term continuity of ongoing health initiatives.

Using primary and secondary data from various sources, including interviews with key informants from the Ministry of Health at the central and regional levels, this chapter provides evidence on how supply and demand barriers limit access to health services for the Guyanese population.

Demand-side factors such as low health literacy (lack of access to health information) and social and cultural beliefs (including gender norms and roles) hinder users’ ability to seek health services. Meanwhile, supply-side factors such as geographical barriers, poor transportation, limited availability of human resources, and lack (or inadequacy) of health facilities increase these access problems, particularly in the country’s interior regions.

International evidence suggests that a stronger PHC approach as the foundation of health system organization could be the path for Guyana to overcome the barriers identified.
• To improve access to health services, equity, and universal health coverage, the appropriate focus areas for the country may be to improve the stewardship and governance capacities of the Ministry of Health, financial sustainability, expansion and strengthening of the FLC, increased provision and retention of adequately qualified human resources, and special attention to the interior regions in the coming years.

• Steps to understand and overcome barriers throughout this process include the development of community-based interventions, effective advocacy and participation, and community ownership.

4.1. Introduction

Over the past 30 years, Guyana has focused on health sector reform, policy formulation, and the adoption of health service agreements to improve access to essential health services. Figure 13 summarizes the different initiatives and reforms Guyana adopted to improve its health system, which have contributed to considerable progress in infectious disease control and maternal and child health over the past decade. In addition, in recent years, the country has recognized the challenges posed by chronic diseases and is working to strengthen the health system response in this area.

Figure 13. Universal health policy initiatives in Guyana

[Diagram showing timelines and initiatives]

Note: SDG: Sustainable Development Goal.
Guyana’s Ministry of Health recently made a commitment to adopt reforms to strengthen PHC. A new package of essential health services was finalized and budgeted, and a new public health law is being drafted. Reforms are currently underway to increase the training of new HRH and their retention in the health sector, along with initiatives to strengthen the planning and leadership capacities of all regional health officers. The country has also renewed its commitment to implement IHSDN to achieve universal health coverage by 2030.

The COVID-19 pandemic has interrupted and, in some cases, reversed years of progress in providing universal access to essential health services in the Region of the Americas. Ensuring the effective implementation and long-term continuity of the above-mentioned initiatives is essential to improving access to health services in Guyana.

In applying and adapting the barrier analysis methodology in Guyana, we sought to define barriers to access to health services and explore possible areas of intervention. The extent to which these access barriers were affected by the emergence of the COVID-19 pandemic was also analyzed. The study included a systematic literature review and an analysis of the health surveys available in the country. Ten regional health officers (RHOs), eight senior health visitors (SHVs), and the primary decisionmakers from the Ministry of Health, including four directors, were interviewed.

### 4.2. Main barriers to access to maternal and child health services

**Demand-side barriers**

Social and cultural beliefs, including gender norms and roles. These factors pose the most significant challenge to improving women’s access to maternal and child health services in Guyana. Most of the barriers found in the literature were related to acceptability (36.4% of 22 barriers) (Figure 14), with articles suggesting that cultural and religious beliefs regarding sex and marriage have an important influence on the uptake of vaccines and sexual and reproductive health services \(^{(88, 89)}\). This finding was further discussed with Guyana’s health authorities, who recognized that such factors often influence care-seeking patterns, especially in the interior regions, where most of the indigenous or Amerindian population resides. The sources consulted also mentioned that these communities tend to use traditional and herbal medicines to remedy diseases related to maternal and child health.
Gender inequality and power dynamics in households. The officials interviewed explained that family expectations often prevent women from making individual decisions regarding their sexual and reproductive health. In many cases, women are expected to consult their husband or partner about this issue. This is supported by the quantitative data reviewed. The 2009 Demographic and Health Survey (GDHS) showed that nearly 17% of Guyanese women did not want to go alone to a health facility (a barrier to access to health care) (Figure 15), and about 4% of women indicated that they needed permission to go. A logistic regression further showed that these women were 46% more likely to forgo an institutional delivery, compared to women who did not require permission from a family member or spouse (19).
Chapter 4. Guyana: The impact of COVID-19 on access to maternal and child health

Figure 15. Women in Guyana who reported difficulties in accessing health care when sick, by residence, income, marital status, and participation in household decisionmaking, 2009


Low health literacy makes it difficult to seek care. The bibliographic evidence reviewed for this study shows that some indigenous population groups lack knowledge about basic reproductive physiology and maturation, as well as about the transmission and prevention of human immunodeficiency virus (HIV) and human papillomavirus (HPV) (90). Health officials confirmed that low literacy related to sexual and reproductive health, communicable diseases, and immunization services remains a problem. They further indicated that women are not always well informed about the maternal and child health services available in Guyana, resulting in an unmet demand for prenatal and postpartum care. Some health officials believed that delayed care-seeking for antenatal services was a strategy used by some women to compensate for financial barriers. However, others thought that delayed care was due more to a lack of recognition of the importance of pregnancy-specific services. These are important factors that may explain why levels of institutional delivery in the interior regions are lower than in other regions of the country.

Supply-side barriers

Geographical barriers. The existence of geographical barriers that disproportionately affect women and children living in Guyana’s rural interior was a factor recognized in much of the evidence analyzed (Figure 16). The quantitative data reviewed show that 13.7% of women indicated that distance to a health facility is a barrier to accessing health care. In addition, women in rural areas reported financial (21.1%) and geographical (8.1%) barriers more frequently than those in urban areas (15.4% and 16.0%, respectively).
The regression analysis also showed that women are 51% more likely to forgo institutional delivery services when distance is a barrier to reaching their health facility (19). Interviewees mentioned that the indigenous population is unevenly distributed in rugged and less developed terrain. For example, one official mentioned that the nearest health center could be more than 60 kilometers away in inland communities and that some families cannot afford indirect transportation costs.

Health facilities may also be inaccessible due to transportation limitations. In the interior regions, since health posts lack equipment (ultrasound, for example), referrals to regional and district hospitals are often required. However, this is constrained by the lack of reliable regular transport and long travel times, resulting in missed hospital visits. In addition, boats, all-terrain vehicles, and prolonged walking can cause extreme stress and increase the risk of preterm birth and mortality. This explains, in part, why women living inland tend to delay seeking prenatal care.

Lack of health personnel, technologies, and infrastructure. The second most common category among the barriers identified in the literature reviewed was the limited availability of key supplies (23% of 22 barriers). Interviewees indicated that limited medical personnel and supplies are a major barrier to care (Figure 16). This is particularly pressing in inland regions where health posts are staffed by community health workers who are often not equipped to manage pregnancy risks.

Electrical power supply. A regional health officer mentioned that health facilities often lack a regular supply of electricity, which affects the proper storage of supplies (e.g., vaccines). Most children living in the interior regions travel outside their communities to receive routine vaccinations. However, as mentioned in the previous section, travel in the interior is logistically challenging and can contribute to inequalities in immunization coverage.

Financial barriers. While services are free at the point of care, a portion of the Guyanese population cannot afford the direct and indirect costs of care. Quantitative data show that women in all wealth quintiles cite the need for money to help pay for health services as a challenge to accessing needed care. According to the 2009 Demographic and Health Survey, about 19.4% of Guyanese women reported lack of money needed to pay for services as a barrier to accessing health care. This disproportionately affects the poorest women and women in rural areas.

The relationship between the wealth index and financial barriers is consistent with the specialized literature and qualitative data, which indicate that poverty rates are higher in rural interior regions (89). In addition, financial barriers are linked to geographical barriers; thus, poorer women point to distance as a barrier seven times more frequently than richer women. Essentially, women in the interior regions are not only poorer, but also more likely to encounter logistical problems when trying to access services.
Chapter 4. Guyana: The impact of COVID-19 on access to maternal and child health

Figure 16. Distribution of the barriers mentioned by health officials in Guyana, by access dimension, 2021

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Geographical accessibility</th>
<th>Acceptability</th>
<th>Financial accessibility</th>
<th>Organizational accessibility</th>
<th>Effective coverage</th>
<th>Contact</th>
<th>Availability</th>
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<td>Health center is too far</td>
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<td>Lack of transportation for referrals between establishments</td>
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<td>Traditional or folk medicines are preferred</td>
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<td>Language barrier among the immigrant population</td>
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<td>Perception that the public health system is worse than the private system</td>
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<td>Lack of trust in health personnel</td>
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<td>Lack of awareness about available health services</td>
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<td>Long wait times</td>
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<td>Lack of health personnel in facilities</td>
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<td>Disrespectful providers</td>
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<td>Inadequate hours of operation</td>
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<tr>
<td>Administrative requirements result in the exclusion of temporary and semi-permanent residents</td>
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Note: The data are based on the results of the application of qualitative methods. Health officials were asked to talk about barriers that hindered people from accessing maternal and child health services prior to the pandemic. From their perspective, most of the aspects that represent access barriers involve geographical accessibility (23 mentions or 43%) and acceptability (16 mentions or 30%). Regarding geographical accessibility, the most frequently identified barriers were the long distance to health facilities and the lack of transportation to reach them. In addition, health officials frequently reported that preferences for traditional or folk medicines and language barriers with the immigrant population were major acceptability issues. Other barriers noted include not having enough money to pay for services (5 mentions or 9%) and lack of health personnel in facilities (5 mentions or 9%), classified as financial accessibility and availability barriers, respectively.

4.3. Effect of the COVID-19 pandemic on barriers to access to maternal and child health services

When discussing barriers to access to maternal and child health services in Guyana during COVID-19, health officials and decisionmakers reported that the pandemic had not created many new barriers, but had exacerbated pre-existing ones. Overall, the main findings in this section were as follows:

Fear and distrust of COVID-19 diagnosis and vaccination. The demand for and acceptability of health services were negatively affected by the pandemic, as mentioned by most interviewees. Fear of COVID-19 diagnostic tests or vaccines in hospitals affected demand in inland regions, where some indigenous communities refused the entry of community health workers to carry out childhood vaccination activities due to anti-vaccine beliefs. Misinformation also filtered through to the general population. Some women reportedly refused to seek care for fear that, despite choosing not to get vaccinated and not providing consent, they would be forcibly vaccinated against COVID-19.
Financial barriers. According to health officials, a major impact of COVID-19 has been unemployment and lack of money. In response, some families have sought employment in mining camps in the interior regions, where access to health services is limited. In addition, certain health services have become more expensive as providers reoriented their activities toward the COVID-19 response, limiting patients’ access to services offered by their usual provider.

Although maternal and child health services were never interrupted, they were affected nevertheless. The response to COVID-19 resulted, for example, in the reorientation of senior health visitors to support care in Georgetown. This in turn reduced the availability of services in local areas. Health officials also reported that many health facilities reduced their operating hours due to requests for maternal and child health workers to participate in COVID-19 immunization activities throughout the country.

4.4. Policy recommendations

Health officials and decisionmakers provided recommendations to overcome barriers to access to maternal and child health services and other essential health services in Guyana. Based on the information provided, this section provides a list of policy recommendations that could be implemented in the short- and medium-term. These are complemented by international evidence, existing technical guidance, and peer-reviewed literature.

Strengthen the primary health care approach

The priority that the health officials and decisionmakers interviewed mentioned most frequently was strengthening the PHC approach in the health system. The reviewed evidence suggests that the actions that can be taken to achieve this goal include:

Strengthen the regulatory framework, stewardship and governance capacities, and institutional structures of the Ministry of Health. While this process is currently under way through the drafting of a new public health law, the process to update health legislation could be further expanded. For example, a review of existing legislation related to regional health authorities and the reorganization of the Ministry of Health structure seem necessary to strengthen public health and health system planning at the national, regional, and district levels.

The adoption of a new national health strategy and a national cooperation strategy provides an opportunity to adopt specific approaches that address the determinants of barriers to access to essential health services, especially in rural and inland communities. Evidence shows that open dialogue with diverse stakeholders is linked to a successful health system strengthening process.

The current preparation of a new public health law, with an EPHF-based approach, is an opportunity to strengthen the stewardship of the Ministry of Health. The new law can promote the formulation and implementation of policies using a comprehensive and coordinated approach among the health system’s different actors. Measures aimed at developing these capacities should include better regulation of critical health system resources, especially PHC human resources. The renewed approach to EPHF published in 2021 by PAHO (5) offers guidance in this regard.
Sustainable public expenditure on PHC. The most recent study of national health accounts in Guyana showed that 31% of health resources went to the FLC (91). However, budget constraints are frequently cited as a supply-side barrier in Guyana. Despite the increase in public expenditure on health in recent years (from 2.3% of GDP in 2010 to 3.7% in 2018), it still has not reached the 6% reference recommended by WHO to reduce health inequities.

A strong stance on investment sustainability and equity is needed, especially given projections that Guyana will remain one of the fastest growing economies in the world, growing by almost 20% of its GDP in 2022 and projected to rise to 37% in 2023 (92). In this context, discussions about new revenues related to oil production and commercialization could be used to make a firm commitment to the sustainable financing of the health system.

Expansion of the FLC as a cornerstone of the IHSDN. The FLC is often the closest point to access the health system at the community level, and evidence shows that the FLC has played a key role in the COVID-19 response. Strengthening of the FLC seems to be a promising approach to ensuring a resilient health system in Guyana. The recent adoption of the Package of Essential Health Services (PEHS) for PHC reaffirms this commitment. The new benefits plan, in addition to ensuring the delivery of comprehensive health services from a life-cycle approach, includes essential components to prevent, detect, and track outbreaks. The package also ensures continuity of care by guaranteeing the referral of complex cases.

It is also promising that, by adopting the PEHS (currently in the start-up phase), Guyana is committing to expansion and strengthening of the capacities of health posts, health centers, and district hospitals in all ten regions of the country. Increased availability, improved response capacity, and an emphasis on inland regions will help reduce barriers to access to the health system. Planning out systems for referrals to services and establishments is also important. These interventions will address many of the concerns expressed by the health officials interviewed for this analysis. Finally, in the context of the COVID-19 pandemic, these interventions can reduce the demand for services at the Georgetown Public Hospital Corporation (GPHC) and for facilities created to specifically address the COVID-19 pandemic.

Prevention and health promotion to improve access to health services. Acceptability is a central element of the access barriers defined in this study. Community participation and awareness seem to be key to addressing these barriers and would serve to develop prevention programs that address acceptability barriers and restore community perceptions of the performance of the FLC. The health officials interviewed reported that these initiatives have been useful for reducing false information and negative perceptions of health services, with even greater effectiveness than messages in the national media. In this regard, community-led awareness programs can serve to promote vaccine acceptability and explain the efficacy and benefits of herd immunity. In addition, improved communication about the availability of maternal and child health services can deconstruct the cultural barriers, fear, and stigma that women encounter when accessing health services.

Community-led health profiles. International experience shows that community-led epidemiological profiles better reflect the health needs of a population. The outcome of this process will provide valuable information for RHOs to determine health priorities in their
regions. In this regard, community leaders should be consulted in the early stages of health policy formulation and implementation. Likewise, all participatory mechanisms used to engage these leaders could be institutionalized as permanent forums.

Human resources for health and working conditions

An important suggestion from interviewees was to increase the availability and distribution of qualified personnel to improve access to maternal and child health and other essential health services in Guyana. GPHC physicians emphasized this by explaining how refocusing staff to respond to COVID-19 resulted in a significant reduction in staff in many hospital wards. It is also worth noting the lack of personnel and specialized services throughout the country.

While the issue of HRH is not new to Guyana, it remains a serious challenge, according to the health officials interviewed. Although the ratio of medical personnel per 10,000 inhabitants has doubled in the last 10 years (with the training of around 500 Guyanese medical professionals in Cuba), the availability of nursing professionals is very limited. This problem is compounded by low retention rates of nurses after graduation. In 2020, the ratio of health professionals (11.4 medical professionals, 31.4 nurses, and 4.4 midwives per 10,000 population) was the minimum recommended by the WHO to reach the SDG benchmark of 44.5 professionals per 10,000 inhabitants.
Problems reported by interviewees include high turnover of staff posted to the interior of the country, migration to foreign countries (brain drain), vacancies that often remain unfilled, attrition of human resources, and the lack of an HRH planning unit in the Ministry of Health. Without a robust HRH staffing, Guyana will not be able to ensure that all regions are equipped with specialized services and personnel—in surgery, gynecology, and pediatrics, among other fields—most of which are currently concentrated in Georgetown.

The steps that the Ministry of Health is currently taking to assess the number, location, and skills of human resources in the health sector, together with the creation of an HRH unit within the Ministry, are the country’s first fundamental steps toward organizing and implementing a national HRH strategy to solve problems related to HRH training, redistribution, retention, and shortages. Such a strategy should also promote greater coordination with the education sector, especially between government and training institutions. To present the future opportunity that the adoption of such a policy provides, it is useful to show not only the health benefits it will produce, but also the benefits to the country’s economy. Indeed, a reform of the HRH approach will improve the employment of skilled personnel in the general labor market, in turn contributing to the sustainability of Guyana’s economic growth.

In the short term, as detailed by the interviewees, there is a need to respond to the shortage of nursing professionals and specialists on a regional scale. Another strategy that could be applied in the short term is training to fill the knowledge gaps that affect the quality of care.

An important factor impacting HRH retention is working conditions, especially for those in vulnerable environments (e.g., COVID-19 care and surveillance tasks; postings in inland regions). In addition to financial incentives, training activities related to interculturality and interpersonal communication could be included, where feasible, to support the elimination of acceptability barriers.

Finally, in this area, Guyana can explore ways to promote the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (93) in collaboration with the main destination countries for Guyanese skilled migration. In addition to HRH development and training, bilateral and regional partnerships can be established with destination countries to promote “circular migration” of health professionals, technical assistance for HRH training and retention, access to specialized training, and technology and skills transfer.

Health technologies, communications, and transport

The interviewed officials identified geographical barriers as one of the population’s main difficulties in accessing health services in their regions. They also noted that more equitable distribution of technology is needed in all regional facilities. For example, senior health visitors serving inland communities reported that facilities often lack landline telephones, making it difficult to contact patients who miss appointments. At the time of the interview, most health workers in the interior regions were assuming the costs of calling patients using their personal mobile phones.
Officials also noted that increasing the availability of ultrasound equipment would reduce the number of women who need to travel from the interior to the country’s only national referral hospital (the GPHC). This can also reduce wait times at the GPHC. In addition, in coastal areas such as Region 6, there is a need to increase the infrastructure and stability of services that require electricity to store vaccines and other medical supplies.

Finally, health officials across the country report that they could be more responsive if information systems were improved, especially during emergency situations such as those experienced during the COVID-19 pandemic. While discussions about communication and transport infrastructure have not entered the public health debate, there is clear evidence that such infrastructure would have a significant impact on access to health care, particularly in remote areas, in addition to contributing to sustainable development.

It is promising that infrastructure investments are a priority for the Ministry of Health, as they generate positive health externalities by reducing geographical barriers and improving referral and counter-referral between health facilities at different levels, in order to ensure continuity of care.
Over the past three decades, Honduras has implemented various policy initiatives aimed at overcoming barriers to access to health services and their determinants. However, ensuring the effective implementation and long-term continuity of these initiatives, as well as the management and coordination of the system, is essential to improving the supply of and access to health services, especially given the country’s socioeconomic context and the pressure created by the COVID-19 pandemic.

The shortage of medicines and other supplies, and the lack of personnel in health facilities, are recognized as some of the main obstacles to using health services faced by the Honduran population.

Social and cultural beliefs and aspects, including gender norms and roles, coupled with bad experiences during care, affect access to health services in Honduras.

Lack of ability to pay is a significant barrier to access to health services in the country, and one that has become more acute in recent years.

The greatest health system challenges affecting access conditions are the high level of segmentation and fragmentation, which hinders the development of institutional and political capacities related to the stewardship function of the Secretariat of Health (SESAL), and the low public budget allocated to health, which conditions the possibilities of expanding the service supply.
• Policy dialogue has provided recommendations related to strengthening SESAL’s stewardship by leading collective action and harmonizing the health sector’s regulatory framework. It is therefore essential to strengthen the regulatory framework, SESAL’s stewardship capacity, and institutional structures, to coordinate actions aimed at strengthening the PHC approach.
• Other recommendations relate to capacity building in health services, prioritizing the FLC and the model of care centered in individuals, families, and the community; the necessary formulation and implementation of a strategy to strengthen HRH; and the need for more and better financing, as well as appropriate budget planning.

5.1. Introduction

Over the past three decades, Honduras has launched various policy initiatives aimed at overcoming barriers to access to health services and their determinants (Figure 17). The greatest achievements may be the improvements made in access conditions, resulting from the transformations in the health system as it transitions toward a PHC model with a comprehensive perspective. Notable aspects recognized by the sectoral actors are SESAL’s capacity-building initiatives, the creation of community health units within the Access Program framework, and the construction of infrastructure within the Strategy for Poverty Reduction framework (94). It is also worth mentioning the initiatives to reorganize hospitals, the creation of health regions, the organization of networks of health services delivery units, and finally, the approval and implementation of the National Health Model (MNS) in 2013.

Figure 17. Health sector policy milestones and initiatives in Honduras, 1991–2019

Improved access conditions have also been linked to the adoption of new regulatory frameworks. Those that stand out are the expansion of the Guaranteed Set of Health Benefits and Services (95), the inclusion of medicines in the national list of essential medicines, and the legislation that regulates the provision of specialized health services. The incorporation of technologies, community empowerment, and intersectoral collaboration are other characteristics that are linked to initiatives aimed at improving access in Honduras. These have had the virtue of being framed in medium- and long-term strategies aimed at reducing poverty and achieving the goals—first, the Millennium Declaration (96) and later, the 2030 Agenda for Sustainable Development (3).

Ensuring the effective implementation and long-term continuity of these initiatives, as well as the management and coordination of the system, is essential to improving the supply of and access to health services, especially given the country’s socioeconomic context and the pressure created by the COVID-19 pandemic. Honduras faces high rates of poverty, labor informality, and low participation of women in the labor market; violence and instability; and political conflicts that constitute structural barriers and determine the access conditions in the country (97). The impact of the COVID-19 pandemic in Honduras has been significant. In addition to the more than 300,000 infections and 10,000 deaths associated with the novel coronavirus (98), the pandemic has led to the disruption of at least 65% of essential health services (99). This exacerbates the access barriers that hinder the Honduran population’s effective enjoyment of the right to health.

To substantiate how the Honduran health system can address the barriers to access to essential health services that persist among the population, an analysis was conducted focused on determining the main obstacles and areas of intervention. The study was based on a systematic literature review and analysis of data from the National Demographic and Health Survey (ENDESA) (100). The information was presented in a joint validation and analysis workshop with various actors from the Honduran health system, such as managers of SESAL health networks and services, the Honduran Social Security Institute (IHSS), the country’s localities and municipalities, and civil society organizations. This publication builds on the results of this study and aims to support decisionmakers in the ongoing processes of health system strengthening and transformation.

5.2. Main access barriers

The shortage of medicines and other supplies, together with the lack of health personnel in facilities, are recognized as the main obstacles faced by the Honduran population in using health services (Figure 18). The most recent ENDESA data show that the lack of medicines in health facilities discouraged 4.3% of the people surveyed from seeking care in 2019. This is higher for populations that are lower income, live in rural areas, and have a lower educational level (Figures 19 and 20). The lack of health personnel, which includes doctors, nurses, and specialists, is another primary limitation of the response capacity of the country’s health facilities (Figure 18). This leads to long wait lists, delays, problems with the continuity of care, and user dissatisfaction. This is in addition to the poor conditions for professional practice (for example, work overload and constant staff turnover) and lack of training (101). The high turnover of health personnel and their assignment to understaffed facilities significantly limits their adequate and
timely training. The inadequate infrastructure of health facilities emerges as another important barrier, exemplified by overcrowded facilities, with insufficient rooms and beds, without thermal conditioning, and with inappropriate construction designs, such as the absence of wheelchair ramps and signage. Distance to health facilities, lack of transportation, and geographic dispersion are also important determinants of access (Figure 18), mainly in remote geographic areas, with vulnerable populations, and in high-risk areas affected by violence (102, 103).

Social and cultural beliefs and aspects, including gender norms and roles, coupled with bad experiences during care, affect access to health services in Honduras. Fear of treatment or related side effects due to false beliefs, lack of understanding of treatments, and false contraindications is a relevant barrier in Honduras. Other barriers relate to a partner’s or family members’ opposition to an individual seeking and obtaining health services, including the use of medicines or vaccines (Figure 18). In this regard, 10.6% of the women surveyed in the 2019 ENDESA considered having to obtain permission to seek care as an access problem (Figure 21). This significantly reduces the ability to obtain childbirth and family planning services (19). Likewise, 31.8% of the women surveyed indicated that not wanting to go alone to the health facility is a problem in seeking services (Figure 21). This reduces the possibility of their children receiving care when suffering from acute respiratory infections and of accessing delivery care services (19). Finally, bad attitudes, mistreatment, or disinterest on the part of health personnel are a barrier that is frequently considered in the literature (Figure 18). It is recognized that stigma and discrimination by health personnel is one of the reasons why the population has bad care experiences. In 2019, 4.0% of the people surveyed in the ENDESA indicated the poor quality of care as one of the reasons for not seeking health care. This barrier was identified more frequently in rural contexts and among the poorest population (Figure 20). In addition, 69.6% of the Honduran population does not seek medical care or advice because they perceive that they do not need it (Figure 19). This is associated with a lack of promotion and prevention campaigns, such as information about diagnoses, disease complications, aggravating behaviors, rights, and where to seek care (103, 104).
Figure 18. Barriers to access to health services in Honduras found in the specialized literature, by access dimension, 2010–2020

<table>
<thead>
<tr>
<th>Availability</th>
<th>Organizational accessibility</th>
<th>Financial accessibility</th>
<th>Acceptability</th>
<th>Geographical accessibility</th>
<th>Contact</th>
<th>Effective coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of medicines and supplies in the health facility (vaccines, oral and injectable contraceptives), preventing the service from meeting the demands of the population</td>
<td>Lack of health personnel (for maternal immunization, recruitment)</td>
<td>Provider's refusal to provide treatment (cataract surgery)</td>
<td>Reduced consultation time impedes improved patient education</td>
<td>High out-of-pocket spending in private and social security clinics to access services and medicines (recovery fee for health services and medicines)</td>
<td>Financial vulnerability due to the household's limited economic conditions or situation of labor informality</td>
<td></td>
</tr>
<tr>
<td>Lack of training or practice (in MNI vaccines)</td>
<td>Poor conditions for medical practice and training (work overload, sexual harassment, constant staff turnover)</td>
<td>Inability to take time off from work to go to the health center</td>
<td>Disorganized admissions process</td>
<td>Lack of childcare alternatives when going to the health center</td>
<td>Lack of health insurance coverage</td>
<td></td>
</tr>
<tr>
<td>Good attitude, respect, or interest on the part of health personnel</td>
<td>Fear of treatment or its results (fear of side effects, fears based on negative experiences, false beliefs, and false contraindications)</td>
<td>Long distance to access the health facility or great geographic dispersion of services (family planning, ophthalmology, pharmacy)</td>
<td>Long waits (caused by lack of personnel, administrative organization)</td>
<td>Limited hours of health centers</td>
<td>High transportation and overnight stay costs</td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge about the treatment</td>
<td>Difficulty reading and writing in the Spanish language reduces the chances of seeking health services</td>
<td>Experiencing stigma or discrimination on the part of health personnel</td>
<td>Perceiving not receiving informational materials or notices about vaccination campaigns and vaccine-preventable diseases</td>
<td>Lack of awareness of public and private clinics</td>
<td>Impoverishment resulting from high out-of-pocket or catastrophic health expenditure (mainly due to expenditure on medicines, transfers, and payment to other public or private units)</td>
<td></td>
</tr>
<tr>
<td>Opposition from the partner or family members to accessing services or use medications or vaccines</td>
<td>Disabling about the efficacy of the vaccine or medication</td>
<td>Difficulties for health providers and community agents to access high-risk areas and vulnerable populations</td>
<td>Perception of not needing the indicated treatment or medication or lack of user commitment</td>
<td>Lack of awareness of public and private clinics</td>
<td>Discrepancies in vaccination recommendations among providers and lack of coordination between services and the national immunization program</td>
<td></td>
</tr>
<tr>
<td>Lack of information about the diagnosis, disease complications, aggravating behaviors, and rights (noncommunicable diseases, HIV, HPV)</td>
<td>Perception of not need intervention in the diagnosis, disease complications, aggravating behaviors, and rights (noncommunicable diseases, HIV, HPV)</td>
<td>Weak information systems make it difficult to comply with the EPI</td>
<td>Self-medication as an alternative to seeking health services</td>
<td>Interruption of treatment or contraceptive use (due to the side effects experienced)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial vulnerability due to the household's limited economic conditions or situation of labor informality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: EPI: Expanded Program on Immunization; HIV: human immunodeficiency virus; HPV: human papillomavirus; MNI: maternal, neonatal, and infant.
Lack of ability to pay is a significant access barrier to health services in Honduras, one that has become more acute in recent years. In 2019, 18.4% of people surveyed in the ENDESA pointed to the lack of money to pay for services as a reason for not seeking medical care or advice (Figure 19). In addition, the lower-income population reported financial barriers more frequently: 29.6% of the population in the lowest income quintile, compared to 5.3% of the population in the highest income quintile (Figure 20). The need to obtain money to pay for health services was also identified as a barrier by 53.4% of the women surveyed in the ENDESA (Figure 21). This reduced the likelihood of obtaining prenatal care services by 20% and the likelihood of having a Pap smear by 34% (19). The high cost of medicines, the existence of recovery fees, the lack of insurance coverage, and indirect costs related to transportation and overnight stays are other identified financial accessibility barriers (Figure 18). For those who manage to use services, high out-of-pocket spending on health can lead to catastrophic expenditure or impoverishment. According to an aggregate sample of households in Honduras, Nicaragua, and Guatemala, in 2008, 24% of households that reported that they had incurred health expenses had to sell an asset or apply for a loan, and 19% of households had to resort to savings (105).

Figure 19. Percentage of Honduran population that did not seek care when needed, by type of barrier, 2005–2006, 2011–2012, and 2019

Figure 20. Barriers to access to health services in Honduras, by income quintile, type of insurance, education level, geographic area, and sex, 2005–2006, 2011–2012, and 2019

Note: IHSS: Honduran Social Security Institute; Q1: quintile 1; Q5: quintile 5.

**Figure 21.** Percentage of women aged 15 to 49 in Honduras who face some type of access barrier, by geographic area, income level, type of insurance, and marital status, 2011–2012 and 2019

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Year</th>
<th>Get money to pay for health services</th>
<th>Distance to health facility</th>
<th>Not wanting to go to the health facility alone</th>
<th>Getting permission to seek care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic area</td>
<td>2011–2012</td>
<td>48.5%</td>
<td>24.4%</td>
<td>31.1%</td>
<td>11.7%</td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>47.9%</td>
<td>24.1%</td>
<td>27.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Income level</td>
<td>2011–2012</td>
<td>34.3%</td>
<td>21.1%</td>
<td>29.9%</td>
<td>48.5%</td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>35.0%</td>
<td>20.1%</td>
<td>25.3%</td>
<td>42.2%</td>
</tr>
<tr>
<td>Insurance</td>
<td>2011–2012</td>
<td>34.3%</td>
<td>21.1%</td>
<td>23.7%</td>
<td>11.7%</td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>30.6%</td>
<td>17.1%</td>
<td>17.5%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Marital status</td>
<td>2011–2012</td>
<td>50.6%</td>
<td>33.7%</td>
<td>28.0%</td>
<td>9.4%</td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>56.9%</td>
<td>47.6%</td>
<td>39.5%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Total</td>
<td>2011–2012</td>
<td>51.9%</td>
<td>37.9%</td>
<td>35.6%</td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>53.4%</td>
<td>36.7%</td>
<td>31.6%</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

Note: IHSS: Honduran Social Security Institute; FF. AA.: Armed Forces.

5.3. Challenges in the health system

The high level of segmentation and fragmentation of the Honduran health system hampers institutional and political capacities related to SESAL’s stewardship. The existence of different health subsystems that offer services of differentiated quality for different population groups gives rise to inequities in terms of health and access conditions (106). System segmentation and fragmentation also hinders the management and regulation of critical health system resources, including financial, technological, human, and infrastructure resources. This creates the need to establish institutional arrangements that allow the online delivery of health services based on equity and quality, while ensuring that all institutions in the sector, including the Honduran Social Security Institute (IHSS) and the private sector, are harmonized with the health authority’s strategic priorities. Regarding decentralized health service management initiatives through public-public, public-social, and public-private agreements, there have been some positive results, but also pending challenges. While these processes allowed the expansion of the service supply to hard-to-reach locations, there was also an increase in the cost of service delivery and the exclusion of some services that were left out of management agreements, particularly at the FLC. The first-level networks also seem to experience difficulties with integration and coordination related to double governance generated in networks and centers with different management modalities (public, private, and mixed) (107).

It is important to consider aspects related to the technical and political feasibility of recently promoted initiatives. In particular, the Framework Law for the Social Protection System (108) was approved in 2015 with the aim of progressively implementing a solidarity-based, equitable, inclusive, universal social protection system focused on the population in situations of greatest vulnerability. Although the draft Framework Law is based on recognition of the limited coverage of the social security system and the limitations and deficiencies of the benefits, various actors in the health system recognize that it approved a modification of the institutional management model that would weaken the role of SESAL and the public subsector. It is also recognized that the Framework Law has been adopted without considering the legal feasibility of its implementation and possible conflict with the objectives of the MNS.

The low public budget for health limits the options for expanding the supply of services. This limits the ability to address access barriers associated with a lack of community health units that are able to respond to challenges at the FLC, including the supplies, medicines, and human resources needed to meet the population’s needs. Despite progressive efforts to expand public expenditure on health from 2.0% of GDP in 2017 to 2.9% in 2020, projections based on the 2021 general budget anticipate a contraction of expenditure relative to GDP of 2.7% (109). These values are quite far from the 6% target established for the Region of the Americas in the Strategy for Universal Access to Health and Universal Health Coverage (4). The distribution of expenditure by function also suggests that there is a relationship between the lack of financing for prevention and public health services and the persistence of contact barriers such as lack of information or knowledge about the health conditions and diseases experienced by the population. According to the latest national accounts report available in the country, spending on prevention and public health represented only 3.63% of total health expenditure in 2011 (110).
5.4. Policy recommendations

The following policy recommendations on access barriers were prioritized by health system actors who participated in the workshop to validate the results of the analysis. These were complemented by technical documents and specialized bibliography of a regional scope that provide recommendations for improving universal and equitable access to health services. Such actions could be implemented in the short and medium term.

Strengthen the stewardship of the Secretariat of Health to transform and strengthen the health system with a primary health care approach

To coordinate actions to strengthen the PHC approach, it is essential to strengthen the regulatory framework, SESAL’s steering capacity, and institutional structures. There is also a need to improve the harmonization of the health sector through a new law to strengthen the Secretary’s stewardship. The imminent discussion on the National Health System Law (111), one of four laws in the social security transformation process (draft version announced in 2020) provides an opportunity to overcome the gaps and contradictions that followed approval of the Framework Law. For this, SESAL’s active role as a promoter of related in-depth discussions and of the participation of the multiple and diverse health sector voices are crucial. As highlighted in the Strategy for Universal Access to Health and Universal Health Coverage:

Some of the most successful examples of transformation of health systems toward universal access to health and universal health coverage have been based on open dialogue that involves the participation of society as a whole (4).

The new National Health System Law should aim to strengthen the regulatory framework and the functions of SESAL. In line with the previous recommendations, it should generate a framework to strengthen the public system and develop the PHC model in a way that improves access conditions in the country.

Parallel to discussion of the new law, SESAL must commit to promoting the strengthening of the EPHFs in order to strengthen the institutional capacities needed to exercise stewardship in public health. The new conceptual framework for EPHFs, contained in PAHO’s 2020 report (5), provides clear guidance for this. Technical cooperation from PAHO could facilitate implementation of a cooperation initiative in this regard (5, 112). It is necessary to promote strategies for the formulation and implementation of comprehensive policies based on coordination among all system actors. This requires an intersectoral approach and the participation of the population—that is, a whole-of-government and whole-of-society approach—to improve public health capacities and health system resilience in a post-pandemic framework. This is in line with the recommendations made by PAHO Member States in May 2021 in the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains (7). This increase in capacities should also include improved regulation of the health system’s critical resources, mainly human resources in PHC.
The participation of users in the planning, design, and evaluation of health policies is a recommendation that goes beyond specific discussion of the National Health System Law. To overcome acceptability barriers, greater public ownership of health policy initiatives is needed. This participation could have an impact on a proactive attitude toward health care, healthy lifestyles, and care for the environment. In this regard, the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains (7) calls for a paradigm shift in health systems to foster inclusive social participation and coordination among sectors and stakeholders. In addition, the PAHO Directing Council, in approving the Strategy for Universal Access to Health and Universal Health Coverage, urged Member States to:

Implement plans, programs, and projects to facilitate the empowerment of individuals and communities, through training, active participation, and access to information for community members, in order for them to know their rights and responsibilities, and for them to take an active role in policy-making, in actions to identify and address health inequities and the social determinants of health, and in health promotion and protection (4).

Strengthen the capacity of health services, prioritizing the FLC and a people-, family-, community-centered model of care

Strengthening the response capacity of health services, with due prioritization of the FLC through strategies that guarantee the adequate availability of the supplies and services necessary to meet the population’s health needs, is a fundamental step to addressing access barriers in Honduras. The operating hours of facilities (health posts and centers) should be extended with a second shift of staff to reduce the long wait times experienced by the population. To improve the availability of medicines, pilot initiatives could be promoted to dispense medicines in other cities or send them to homes. These measures should be framed within the work of SESAL, aimed at developing and strengthening a people-centered model of care, with community actions and multidisciplinary teams, and within the framework of IHSDN. This will ensure comprehensive care and the effective transit of system users through the different levels of care.

To accomplish this, it is necessary to revitalize the MNS, as well as its objectives and principles, reaffirming a cross-cutting approach based on PHC. The MNS was built on the Country Vision 2010–2038 (113) and the national development strategies to achieve that vision. Its principles of universality, equity, continuity, integrality, social effectiveness and efficiency, quality, co-responsibility, solidarity, and interculturality are closely aligned with the Strategy for Universal Access to Health and Universal Health Coverage (4, 114). As stated in the previous section, both the Framework Law and the decentralization and outsourcing process have posed a challenge to the effective implementation of the MNS. In this context, to reactivate a roadmap toward strengthening SESAL’s capacities, it is necessary to have clear signals regarding the role of the public sector and of the MNS.
These efforts should be part of work to reconfigure the IHSDN. This requires the improvement of referral and counter-referral guidelines and better definition of responsibilities in mixed contracts, to help overcome gaps and lack of coordination, as well as barriers to continuity of care (65, 115). The second level of care should be strengthened, starting with the capacities of regional hospitals, which should aspire to have specialized care units. In future stages of evaluation and review of the decentralization process, regional hospitals’ capacities and needs should be considered, along with the necessary regulation and investment to ensure access to health technologies for those residing in medium-sized cities and rural areas. Incorporation of technologies and innovation at the first and second levels of care should also be promoted, especially the implementation of evidence-based telemedicine and telehealth tools with local teams that understand the country’s realities (86).

**Formulate and implement a strategy for strengthening human resources for health**

In Honduras, the strategic challenge of strengthening HRH policy is recognized as a priority. In particular, it is necessary to address the redeployment and reorganization of health personnel and to adopt training strategies and incentives for professional mobility. In this regard, PAHO’s *Strategy on Human Resources for Universal Access to Health and Universal Health Coverage* (14) proposes the need to incorporate appropriate staff retention and rotation mechanisms, with economic incentives and professional development, to ensure adequate conditions for personnel in the areas to which they are assigned. It establishes three strategic lines and a set of interventions that should be adapted to the Honduran context: 1) strengthen and consolidate governance and leadership in HRH; 2) develop conditions and capacities to expand access to health and health coverage, with equity and quality—such as incentives (economic and non-economic) for staff retention in rural areas, FLC team profiles that are adequate to address the social determinants of health, and psychosocial support for health workers to meet the challenges posed by situations of violence experienced in some areas (116); and 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 (14). Aspects that would benefit from improved coordination with the education sector are the strengthening of soft skills and the
inclusion of intercultural health content and tools for the cultural adaptation of future health personnel. Both are closely related to the barriers caused by the poor treatment perceived by health service users. The promotion of interprofessional education among the country’s training entities can also contribute to improving the quality of training in the human aspect (101). Finally, it is also necessary to increase the capacity to train specialists and improve their distribution to avoid concentrations of talent in large cities.

Increase and improve funding based on consistent budget planning

Beyond the country’s challenge of increasing public expenditure on health to reach the reference value of 6% of GDP proposed by PAHO’s *Strategy for Universal Access to Health and Universal Health Coverage* (4), two intermediate actions are recognized: first, implementation of budget planning according to the population’s needs; and second (as a short- and medium-term proposal), continued development of planning capacities, promoting analytical economic evaluation studies (e.g., of the cost of medicines and reference values for the exchange of services between providers) and establishing goals and indicators that are explicitly reflected in the health budget.

From a budgetary point of view, it is also essential to prioritize strategies aimed directly or indirectly at overcoming access barriers. First, strategies should aim at shifting system financing toward the progressive reduction of out-of-pocket spending, which currently exceeds 50% of national health expenditure. These actions will make it possible to overcome some of the financial barriers that fall on families in situations of greater vulnerability. Second, increased investment in the FLC, prevention services, and other public health services (which currently represent a negligible part of health expenditure) offers a great opportunity to overcome some of the identified access barriers.
In recent decades, Peru has launched various health system reform initiatives aimed at addressing barriers to access to health services and their determinants.

The main barriers identified are acceptability problems, including distrust in health personnel and services, which disproportionately affect indigenous peoples and the poorest populations. There is still low demand for care, possibly associated with lack of knowledge about available services, sociocultural factors, and the poor response capacity and quality of health services.

There is evidence of inadequate availability and distribution of HRH, supplies, and medicines, mainly in the FLC and in rural and hard-to-reach areas. Services' organizational barriers have an impact on the continuity and quality of care.

Although the country has made great strides in reducing financial barriers, these persist in the population in situations of greatest vulnerability.

The health system challenges that most greatly affect access conditions include those related to the national health authority's stewardship and governance capacity to confront the segmentation and fragmentation in the system. Challenges remain related to the coordination, organization, and resourcing of the FLC and the sustainability, equity, and efficiency of health expenditure.

Policy dialogue led to five major recommendations: 1) strengthen stewardship and governance capacities, with a renewed EPHF perspective to overcome the fragmentation and segmentation of the health system; 2) promote policy and social
dialogue for the formulation of government policies and improve understanding of the population’s needs; 3) promote the training and improve the distribution of health personnel by strengthening the health authority’s cooperation with the education sector; 4) prioritize the FLC by allocating resources to health centers and posts and reorganizing health service networks; and 5) close the gap for the 5% of the population that is uninsured.

6.1. Introduction

In recent decades, Peru has launched various health system reform initiatives aimed at overcoming barriers to access to health services and their determinants (Figure 22). Many of these actions emerged from the constitutional reform of 1993 (117), which establishes the Peruvian population’s right to the protection of their health and free access to health benefits through public, private, or mixed entities. In the following years, major innovations were implemented through the promotion of integrated health development zones (ZONADIS) as a way of applying the local health systems approach and operationalizing the PHC strategy.

Figure 22. Health sector policy milestones and initiatives in Peru, 1993–2019

![Timeline of health sector policy milestones and initiatives in Peru, 1993–2019](image)

Note: ED: Emergency Decree; GHL: General Health Law; IHSDN: Integrated Health Service Delivery Networks; LD: Legislative Decree; PEAS: Essential Health Insurance Plan; SD: Supreme Decree; SIS: Comprehensive Health Insurance; UHI: universal health insurance.

The General Health Law (Law No. 26842) of 1997 (118) was a step forward in defining individual health as a responsibility shared by the individual, society, and the State. The Law emphasized the State’s responsibility to protect in particular the health of mothers, children, adolescents, and the elderly, giving rise to the introduction of the concept of public insurance through two health coverage programs that provide insurance focused on two priority populations. First, the Free School Insurance was introduced in 1997 (to cover a population of 6 million people) and the Maternal and Child Insurance was introduced in 1998 (to cover approximately 1.9 million people). As the 1990s drew to a close, there was also a boost in investment through the Cooperation Fund for Social Development (FONCODES), mainly through the creation of health posts instead of health centers.
In 2002, the Comprehensive Health Insurance (SIS) scheme, created by Law No. 27657 (119), was established as the public entity responsible for administering funds for the financing of health benefits, prioritizing populations in situations of vulnerability. The SIS consolidated the merger of the two targeted insurance policies (which were temporarily merged into the Public Insurance Unit in 2001), expanding the coverage target to 13.3 million citizens (120) and offering three different benefit plans. Within this framework, the Intangible Solidarity Health Fund (FISSAL) was also created to complement the financing of high-cost care. Although regulatory progress has been made with the introduction of the SIS, it should be noted that investment in health remained unchanged in absolute terms during the 2002–2008 period, and its share of GDP decreased from 5.19% to 4.44% (121).

With the adoption of the Decentralization Law (Law No. 27972) (122), a decentralization process began between 2003 and 2004, through which the autonomy of regional and municipal governments was extended and public health functions were decentralized. At the level of health facilities, networks and micro-networks were created, extramural care options were developed, and mobile services for dispersed populations emerged (123). This was accompanied by the presentation of the technical document Integral Health: Commitment by All—the Comprehensive Health Care Model (124), on the development of PHC in the country.

New SIS plans, target populations, and list of priority interventions. In 2006, Supreme Decree 006–2006-SA (125) introduced three new plans in the SIS aimed at specific populations: adults living in poverty and adults in the semi-contributory scheme. The process was completed with: approval of the CRECER national strategy (126) in 2007, which prioritizes 880 rural districts in situations of poverty and extreme poverty for direct affiliation to the SIS; creation of the predecessor of the Essential Health Insurance Plan (PEAS) (127); and the Prioritized List of Health Interventions, established by Supreme Decree No. 004–2007-SA (128).

The political debate on the future of the Peruvian health system in 2005 opened the possibility of a national agreement among political parties for health, laying the foundations for the Framework Law on Universal Health Insurance (Law No. 29344). This law ensures “the full and progressive right of every person to social security in health” (129) and establishes a series of principles and characteristics of universal health insurance. The law and subsequent implementing decrees reorganize the system and define the functions of the different actors: the National Superintendence of Health Insurance (SUNASA), the health insurance fund administration institutions (IAFAS), and the health services provider institutions (IPRESS). A relevant milestone is the creation of the PEAS, approved by Supreme Decree 016–2009-SA (130), which is mandatory for all IAFAS (public and private). During this process, access to FISSAL was also reorganized to include high-cost diseases (131).

2013 was also a key year for increasing investment in health, returning to levels from 2003. The operational tasks of the Ministry of Health (MINSA) were decentralized and the Superintendence was transformed and strengthened (from SUNASA to SUSALUD) along with the IAFAS, as a result of a new national agreement. This is reflected in a series of legislative decrees authorized by Law No. 30073 (132). This was accompanied by an improvement in health financing, especially at the FLC; expansion of the Rural and Marginal Urban Health Service (SERUMS); and some
transformation of the SIS, from a program aimed at focused expenditure to a public insurance program that has shifted from poverty to vulnerability as the key criterion (I32).

In recent years, priority has been given to measures to close the gap in the population that lacks health coverage. Emergency Decree No. 017–2019 of 2019 (I33) makes the rules for access to the SIS more flexible thanks to the creation of a sub-scheme for the uninsured population under a subsidized scheme that makes this group eligible regardless of the socioeconomic classification applied. This is accompanied by measures aimed at strengthening the FLC through the formation and operationalization of IHSDN (I34) and at strengthening the stewardship capacity of the MINSA (I35).

In the framework of efforts to address the COVID-19 pandemic, a new version of the PEAS was approved, as were two emergency decrees that will be crucial for including people who do not have health insurance through the SIS: Decrees No. 046–2021 and No. 078–2021 (I36, I37). The SIS for All plan allowed the SIS to finance the PEAS (1400 diagnoses) and the SIS Supplementary Plan (12 000 diagnoses) for members entering the sub-scheme provided by Decree No 017–2019. It also allowed any person of Peruvian nationality who did not have health insurance to enroll. This resulted in almost 5 million new SIS members between 2020 and 2021, who were able to access the affiliation process virtually (I38). Finally, after the work of a multisectoral commission formed for this purpose in 2019, Supreme Decree No. 023–2021-MIMP (I39) approved the update of the PEAS, which incorporated insurable conditions, interventions, and mandatory bankable benefits for all IAFAS, IPRESS Management Units (UGIPRESS), and IPRESS.

### 6.2. Main access barriers

Problems of acceptability, including distrust of health personnel and services, disproportionately affect indigenous peoples and the poorest population. Information from the National Household Survey (ENAHO) (I40) shows that about two-thirds of the Peruvian population do not seek health care when faced with a health problem. In 2021, 18% of the population indicated they did not seek care due to lack of trust in health personnel, a figure higher than the 14.9% expressed from 2003–2005 (Figure 23). Distrust of health personnel is a problem that discourages care-seeking, mainly among populations who are indigenous, lower-income, or affiliated with the SIS (Figure 24). In 2021, 31.7% of the indigenous population reported that they did not go to health facilities for this reason, well above the percent reported by the non-indigenous population (14.5%) and the national average (18.0%). Likewise, the perception of this barrier was higher: among the population in the lowest income quintile (31.6%), compared to the population in the highest income quintile (12.4%); and among SIS affiliates (21.0%) than private subsector users (3.0%).

Research carried out over the last 12 years on the access barriers faced by the Peruvian population has also confirmed the persistence of these problems. In fact, most barriers identified in the literature correspond to problems related to the acceptability of health services (22.1% of 326 barriers identified in the specialized literature) (Figure 25). These include users’ fear and distrust of health personnel and of seeking diagnostic and treatment services. It also
highlights the population’s experiences of poor treatment and discrimination, which result in less willingness to seek services. In discussing the barriers that persist in the health system, key informants recognized that experiences of mistreatment, often associated with capacity problems in health facilities, are one of the most important current access-related problems. An informant explained this situation as follows: “Today, access-related problems are mistreatment, the limited capacity of establishments to resolve problems, and long waiting lines” (informant no. 15). Another defined the relationship with quality-related problems as follows:

I would say in terms of quality and the treatment of patients and users [...]harm is done by human resources; there is mistreatment in different dimensions, sometimes in unexpected ways. It is not their desire to mistreat, but they do this when they have to provide care for 20 people instead of 15; it takes away from their time. Since I do not have time to ask what else you may have, I simply ask what hurts you so that I can decide what I can do for that patient. It is not a patient, it is not a person, it is a medical history number patient (informant no. 19).

Related to the lack of trust in services is the lack of integration of the customs and practices of indigenous medicine in the services offered and how they are organized. Most articles on this topic point to the absence of alternative and traditional medicine in health facilities, as well as the preference for medicinal plants by a large part of indigenous communities, as the most common barriers to seeking health services. Likewise, the results of the literature review showed that health professionals rarely know the language of indigenous communities, which limits access (141, 142). A civil society representative stated that both existing language barriers and the indigenous worldview of health “are not contemplated in Western medicine and are not sufficiently studied or respected” (informant no. 19). Barriers based on gender roles and relationships constitute a final point of concern among acceptability barriers. Some studies point to a lack of service seeking due to “having to ask permission” from their partner, family member, or community leader (Figure 25).
Figure 23. Percentage of the Peruvian population that did not seek care for a health problem, by reason given, 2003–2021

Note: UHI: universal health insurance.

Data corresponding to the National Household Survey (ENAHO) of Peru for 2003 to 2021.

Figure 24. Barriers to access to health services in Peru, by ethnicity, income quintile, sex, and type of insurance, from 2003–2005 to 2021

Note: FF. AA.: Armed Forces; Q1: quintile 1; Q5: quintile 5; SIS: Comprehensive Health Insurance.

Data corresponding to the National Household Survey (ENAHO) of Peru for 2003 to 2021.

Low demand for care may be associated with a lack of knowledge about available services, sociocultural factors, and the poor response capacity and quality of health services. ENAHO data for the 2003–2021 period show that, faced with a health problem, most people (39.2% in 2021) choose not to seek care because they do not consider it necessary or serious. Likewise, a large proportion of the population (18.0%) opt for self-medication when they consider that the symptoms are not important (Figure 23). Although the differences are not very marked, this behavior is more frequent in men (Figure 24). This could be related to the fact that women tend to have greater awareness of health care and family care (due to attendance at prenatal check-ups and family planning services) or that men and women have different perceptions, influenced by sociocultural factors.

In general, the literature on the behaviors adopted when faced with a health problem in Peru relates to lack of knowledge about the services available and, consequently, about how to use them; lack of knowledge about the benefits of health care and health-related rights; and misinformation about the mechanisms for scheduling or using services (Figure 25). When discussing these issues, the key informants recognized that the Peruvian population makes little use of health services and accesses emergency services when they perceive worsening of symptoms, since they consider that “it is not serious” or “it is not necessary” to go earlier. Similarly, people choose not to seek care or self-medication in pharmacies because they consider that the health post lacks the necessary services or technologies or wait times are too long, or they do not trust the effectiveness of services. An informant’s comment exemplifies this situation: “People prejudge their illness, their diagnosis, and poor conditions—especially the lack of technology at the nearest health post—leading them to forgo care” (informant no. 03).

Interestingly, disruption of health service delivery, fear and mistrust, and limited mobility (143) exacerbated this phenomenon during the COVID-19 pandemic. ENAHO data covering the pandemic period (2020–2021) show an increase, compared to 2019, in the percentage of the population that chose not to seek care for a health problem because they did not consider it serious or necessary, did not trust medical personnel, or opted for self-medication (Figure 23). In addition, reports from the National Institute of Statistics and Informatics (INEI) show that, in 2020, the population with chronic diseases reported these barriers more frequently than those with acute conditions (71.2% versus 57.4%).

This underscores the importance of improved understanding of the population’s behavior when facing a health problem. Delays in timely care-seeking can lead to higher rates of emergency department utilization and avoidable hospitalizations, and worse health outcomes (144).
The results are from a systematic literature review about barriers to access to health services in Peru from the point of view of users and health personnel. Access barriers were classified, according to access dimensions, into availability (availability and adequacy of resources), geographical accessibility (availability of services within a reasonable reach), financial accessibility (ability to pay for services), organizational accessibility or accommodation (organization and adequate provision of services), acceptability (willingness to use health services at a commensurate level of quality), and effective coverage (ability to use health services at a commensurate level of quality). The size of the boxes represents the frequency with which the access barriers were mentioned in the literature. N = 326.

There is inadequate availability and distribution of HRH, supplies, and medicines, mainly at the FLC and in rural and hard-to-reach areas. ENAHO did not determine whether the availability of system supplies and resources affects seeking and obtaining health services in Peru. However, 20.2% of the barriers found in the articles reviewed in this analysis highlight the lack of human resources and supplies for health services as important factors that limit access. According to
the results of a recent PAHO study of service capacities during the COVID-19 pandemic (145), 94% of community representatives reported that one of the main access barriers prior to the pandemic was the lack of personnel, medicines, and equipment in health facilities.

Improving the availability of HRH has been a priority for Peru, especially in rural areas. However, inadequate availability and geographic distribution of health personnel—including the lack of specialists and general practitioners and nurses—remains one of the most frequently mentioned barriers in the literature. The absence of incentives and better working conditions are also recognized as factors that accentuate problems with human resource availability. A 2018 report by the MINSA General Directorate of Health Personnel (146) found a national average density of 34.5 health professionals per 10 000 population, a value lower than the 44.5 per 10 000 recommended by WHO as a minimum amount to achieve universal health and the SDGs (147). Likewise, the 2011 MINSA report shows that the gap between the supply and demand for specialized medical professionals in the SIS represented approximately 45%; and the gap was wider in the basic specialties (internal or family medicine, pediatrics, general surgery, and gynecology and obstetrics). The gaps found in EsSalud are concentrated in the regions and in the same basic specialties (148). Key informants acknowledged the weaknesses in the provision of specialized personnel at the FLC, and also agreed that this problem has been exacerbated during the COVID-19 pandemic. An informant’s comment exemplifies this problem: “The size of the gap—in terms of specialists and personnel at the FLC—is truly gigantic; and calculations need to be made for investment in a progressive plan that can truly and seriously solve this issue” (informant no. 04).

The lack of medicines, diagnostic material, and other supplies in health facilities also emerged as a frequent barrier in the literature review, due to insufficient budgets and the supply of medicines for treatment in facilities. A secondary analysis of the National Survey on User Satisfaction in Health (ENSUSALUD) 2014–2016, which evaluates user satisfaction (149), ranks the lack of medicines as the third most frequent problem (with 25.8% and an upward trend), following delays in care and mistreatment. Factors that explain the persistence of this barrier include lack of financing, supply problems, insufficient local production capacity, inadequate pharmaceutical legislation, the influence of trade agreements, lack of private sector social responsibility, and market deregulation (150). Recently, and as a result of audits in more than 250 facilities, a report by the Comptroller General of the Republic (151) put this phenomenon into numbers: most facilities (63%) do not use centralized purchasing mechanisms and, of the medicines requested using this mechanism, 24% are in understocked3 and 18% are in shortage conditions.

The lack of personnel and supplies is accentuated in rural and hard-to-reach areas of the country. Despite improvements in the infrastructure at the first level of the SIS, the literature recognizes that the dispersion and scarce availability of facilities in these areas of the country

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3 According to the definitions of the Ministry of Health General Directorate of Medicines, Supplies, and Drugs, “understock occurs when two months’ demand cannot be covered with the available supply; and shortage occurs when there is no stock of a medicine to meet the demand.” See: Contraloría General de la República de Perú. Resultados del operativo “Por una salud de calidad”: informe ejecutivo. Lima: Contraloría General de la República de Perú; 2018. Available from: https://doc.contraloria.gob.pe/documentos/operativos/OPERATIVO_POR_UNA_SALUD_DE_CALIDAD.pdf.
make travel times and distances very long. This is accentuated by the lack of adequate means of transport, the poor conditions of roads or highways, and the difficulties health personnel face in reaching remote areas due to distances or long travel times. According to informant no. 19:

We are a very complex country in terms of geography, with altitude that also poses difficulties, as well as great dispersion of the rural population and the Amazonian population. In general, in the jungle area, the different characteristics of the three major geographical regions of Peru affect access to services and how geographical barriers are experienced, especially due to the great dispersion of the rural population and the Amazonian population in general in the jungle zone.

Organizational barriers in health services affect the continuity and quality of care. Organizational barriers in health services—such as services or pharmacies with inadequate operating hours, non-compliance with hours, inappropriate management of wait lists, lack of coordination that prevents scheduling of appointments, and delivery of quality care in an acceptable time—represent 21.2% of the barriers found in the specialized literature (Figure 25). Other quality-of-care issues include a lack of guidelines for comprehensive treatment and interdisciplinary coordination, and the absence of referral mechanisms. Based on data from ENSUSALUD, it has been shown that long wait times in Peru generate user dissatisfaction and a lower level of acceptability (152). Regarding this issue, ENAHO data for 2021 (140) show
that, faced with a health problem, 4.3% of the population chose not to seek care because they considered wait times to be too long. This figure is higher than the one reported in the 2003–2005 period (2.0%), but lower than for 2019 (7.8%) (Figure 23). In 2021, the population affiliated with the SIS (4.6%) reported this problem more frequently than the population affiliated with the private sector (0.5%) (Figure 24). In discussing the challenges in responding to the increased demand for health services resulting from the expansion of insurance, the informants recognize that greater efforts are required to extend the hours of operation at the FLC and double the shifts at the second level. An informant exemplified this situation as follows: “Today’s access barriers are mistreatment, the limited capacity of establishments to resolve problems, and long waiting lines” (informant no. 15).

Although Peru has made great strides in reducing financial barriers, they persist in the population in situations of greatest vulnerability. Key actors recognize that improving financial accessibility to health services was one of the priorities of the reform process in Peru. ENAHO (140) reports a significant reduction in unmet needs for health care for financial reasons, from 17.1% in the 2003–2005 period to 3.0% in 2021. This is accompanied by a reduction in the absolute inequality gap between people in the lowest and highest quintiles, from 26.2 percentage points from 2003–2005 to 1.7 percentage points in 2020. Despite these improvements, key informants recognize outstanding challenges associated with the persistence of high out-of-pocket spending, which may have increased during the pandemic among people in situations of greatest vulnerability: “Economic barriers have been reactivated and out-of-pocket spending has increased again, which was something that was being combated” (informant no. 17). On the other hand, in Peru, 14.5% of the adult population still lacks health insurance. This population group faces more financial barriers than other groups (5.3% in 2021) (Figure 24). Lack of health insurance is also the main persistent financial barrier identified in the literature. Most of these articles refer to the inequalities associated with lack of insurance. An econometric study using data from ENAHO 2010–2014 (153) showed a direct association between lack of insurance and higher out-of-pocket spending on health. A study on health coverage and health-related perceptions conducted in Lima (154) concluded that uninsured people are more likely not to receive medical attention or to go to pharmacies, which may be associated with self-medication.

6.3. Challenges in the health system

Stewardship and governance capacity of the national health authority in addressing the challenges posed by the segmentation and fragmentation of the system. While Peru has adopted several measures to strengthen its stewardship—including the reorganization of the government into different vice ministries, the delegation of functions to specialized agencies, and the strengthening of the National Superintendence of Health (SUSALUD)—it is perceived that the national health authority’s current structure and lack of capacities to ensure greater coordination and complementarity continues to be a factor that reinforces the inequity of the health system. The existence of different subsystems of insurers and providers limits the possibility of ensuring equitable conditions of access to and quality of health services, especially in a context where there are gaps in institutional capacities at the central level that have been
further weakened by the transfer of public health functions to the regions (155). As a result, the health system’s critical resources (human, technological, and financial) are fragmented into different subsystems. This generates inequities in access conditions and limits the ability to strengthen the supply of services through networks with sufficient capacity to respond to the population’s needs with the necessary levels of quality. At the same time, through the decentralization process, the central level has lost some of the benefits of its stewardship and decisionmaking roles, because certain EPHFs were prematurely delegated to regional and local authorities before competencies in these areas were fully developed.

One of the strategies adopted in recent years to solve the problems of fragmentation, especially in the context of the pandemic, was to promote exchanges of benefits between subsystems to improve access to services and promote efficiency in delivery. In this regard, key informants highlighted the difficulties faced by the national health authority in coordinating this work. Some informants pointed out, for example, EsSalud’s limitations in offering FLC services in remote locations despite providing insurance to 27% of the population. They highlighted the lack of complementarity with the SIS, which would allow access to a wider first-level network and additional services throughout the territory.

The complementarity of capacities and mobility of beneficiaries with different types of health insurance has been limited by insufficient exchange of benefits, both between public institutions and between public and private entities, as well as within the framework of public-private partnership initiatives. For example, the evaluation of the pilot benefit exchange agreement in the Cajamarca region (156) suggests some lessons learned, but also shows that the benefits exchanged were insignificant compared to the total and that only a small number of centers participated in the exchanges. Although legislative progress has favored the exchange of benefits, through Legislative Decrees No. 1302 and No. 1466 (157, 158), the flow of resources between the SIS and EsSalud over time has been negligible. According to a World Bank report (159), the lack of incentives for the exchange of benefits between the SIS and EsSalud in the FLC is due to the “hidden subsidy” generated when EsSalud users seek services in the SIS, pay a co-payment that does not cover the total cost of the benefit, and (unlike what happens in other countries) the State does not charge EsSalud for the care for its insured. This hidden subsidy, which also discourages complementarity and a benefit exchange, is estimated to be equivalent to up to 7% of the public health budget. The COVID-19 emergency exacerbated these problems. Despite being driven by Legislative Decree 1466, enacted during the pandemic, the benefit exchange faced administrative obstacles and differences in the cost of benefits (160).

Response capacity at the FLC, including the availability of supplies and HRH and the coordination of services. Peru has made significant efforts to address problems related to the capacity of the FLC and the coordination and continuity of care delivery across levels of care. The Framework Law on Universal Health Insurance (129) was accompanied by the establishment of a minimum threshold of health benefits that the PEAS must cover. Since 2018, there has also been a legal instrument for the organization of integrated service networks. In addition, the successful SERUMS program has ensured the presence of a doctor in remote health centers. However, despite efforts, challenges remain related to coordination, organization, and resourcing at
the FLC. Expansion of the supply and capacity of health facilities has been slow in the face of the rapid expansion of health insurance. Initiatives to transform the organization of health services with a more holistic PHC perspective have not been a sustained political or budgetary priority during the last decade. At the same time, what one interviewee calls “unfunded mandates” persist. This refers to administrative or legal resolutions that hold the government responsible for certain actions, such as public health plans and programs, that are not accompanied by a specific budget allocation that facilitates their implementation. This results in benefits or programs that are low-quality or have little sustainability and scalability. As a result, barriers persist related to the lack of human resources trained in family and community medicine (and their unequal distribution in the territory), the scarcity of material resources and budget, and problems with the coordination of the network and services (161).

Sustainability, equity, and efficiency of health expenditure. Considering the levels of health expenditure in Peru, the implementation of strategies and policies that seek substantive improvements in access would require the commitment of additional funds, especially from public sources. Public expenditure on health as a percentage of GDP in Peru is below the average for Latin America and the Caribbean (3.3% in 2019) (13) and a large proportion comes from out-of-pocket spending. In this framework, it is necessary to consider an increase in public expenditure that tends toward the reference value of 6% of GDP proposed by PAHO’s Strategy for Universal Access to Health and Universal Health Coverage (4), while prioritizing investment in the FLC. The effect of the financing shortage is evident when considering the availability of resources in Peru. While physical access to services has improved through investment in infrastructure, significant gaps remain in the FLC. For example, in 2017 the investment gap in the FLC was estimated at USD478 million (162). There is also a deficit in the FLC that has not been considered in the National Infrastructure Plan for Competitiveness (163), which focuses on hospital infrastructure and public-private partnership contracts. To overcome these obstacles, administrative costs and system inefficiencies could be reduced while efforts are made to increase the flow of resources.

6.4. Policy recommendations

The following policy recommendations were prioritized by key informants during interviews. These were complemented by technical documents and specialized bibliography of a regional scope that provide recommendations for improving universal and equitable access to health services. Such actions could be developed in the short and medium term.

Strengthen the stewardship and governance capacities with a renewed perspective of the EPHFs, to overcome the fragmentation and segmentation in the health system. Segmentation and fragmentation between subsystems, regions of the country, and national authority agencies leads to inefficiencies in service provision and inequalities in access. In this framework, strong leadership by the health authority and appropriate governance structures are required to contribute to the sustainability and success of any measures aimed at reducing access barriers. At the same time, the difficulties Peru has faced due to the COVID-19 pandemic call for transforming the system to achieve greater resilience, accelerate recovery, maintain health
Analyzing and Overcoming Access Barriers to Strengthen Primary Health Care

gains, and return to the path toward universal health, paying due attention to public health competencies and the population's needs (7).

To this end, it is essential to strengthen the institutional capacities related to the stewardship and governance at the central level through a new emphasis on EPHFs. The renewed focus on EPHFs outlined in PAHO's 2020 report (5) provides guidance for this process. PAHO's current technical cooperation could facilitate the launch of a related cooperation initiative. Evaluation and strengthening of EPHFs should lead to a set of actions aimed at strengthening the stewardship and governance capacities needed to reduce the access barriers identified in this report. These include actions to strengthen the health authority’s stewardship and governance capacities related to the coordination of the system's actors, such as innovative coordination and complementarity plans among FLC providers; measures aimed at the construction and development of integrated health networks, giving priority to the FLC and the family- and community-based model; and, notably, improvements in the quality and acceptability of health services supported by independent monitoring and evaluation of the efficacy of their effects among the country's subsystems and regions. Equal priority should be given to mainstreaming the PHC approach in the health system, to strengthening prevention and health promotion strategies (particularly those that have an impact on service acceptability and quality), and to an integrated approach to human resources planning in the country's different regions.

Potential approaches to solving the problems of fragmentation and segmentation (debated by policy and academic actors) include government programs (164), declarations (165), constitutional reform projects (166) and, as mentioned by key informants, the transition to a unified or integrated health system. Considering the characteristics of the Peruvian process, this would involve the progressive integration of the different existing insurance subsystems, starting with coordination between the SIS and EsSalud, and possibly continuing with a progressive expansion of the complementarity of services between providers as medium-term strategies. In the short term, EsSalud needs a higher public profile. Its delivery capacity should be used to help solve the population's health problems and overcome the difficulties caused by the existence of differentiated provider networks. The current wage differentials between public entities constitute, in turn, a major bottleneck for this type of integration, and should be addressed when updating the human resources strategy.

Promote policy and social dialogue for the formulation of government policies and improve the understanding of the population's needs. In a context with new challenges for the sustainability of public policies, the participation of community organizations and civil society in policy dialogue could open a path toward a new stage of health system reform. In this sense, key informants considered the agreement by the political parties in 2002 as an important facilitator of the health system reform process, in particular the approval of the Framework Law on Universal Health Insurance (129) and the creation of the PEAS. It is important for social actors to take an active role in the formulation of policies and actions aimed at detecting and reducing health inequities (4). Policy and social dialogue with these characteristics should consider the advances in the intersectoral coordination achieved by MINSA with the National Multisectoral Health Policy to 2030 (167). It is also important to build a vision for the Peruvian population's
health that is aligned with the vision for the country formulated by the National Center for Strategic Planning (CEPLAN) for the year 2050 (168). Specific actions are required to strengthen social participation and incorporate these actors into regular policy-making processes. To this end, the capacities of the National Health Council could be strengthened, allowing MINSA to move from its advisory role to binding agreements. At the same time, innovations are required to better understand the community's needs, focused on improving the model of care and the joint response to the access barriers that persist in Peru. Within this framework, it is essential to strengthen the role of SUSALUD as an entity responsible for the empowerment of users and an advocate when facing decisionmakers in order to meet the population's needs.

Promote training and improve the distribution of health personnel by strengthening the health authority's coordination with the education sector. Peru has taken several important steps to address HRH-related obstacles, such as the creation of the National Registry of Health Personnel (INFORHUS) in 2013; the Diploma in Comprehensive Care with a Family and Community Health Approach (PROFAM), aimed at strengthening the PHC approach, in 2009; and the introduction of financial incentives to improve productivity and the geographic distribution. The challenge for the future is to continue and to strengthen these strategies. To address the lack of both specialized and non-specialized health personnel and their efficient and sustainable geographic distribution, strategic planning for HRH should continue, starting with the updating and application of the National Human Resources for Health Policy Guidelines 2018–2030 (169) and the PLANDES Bicentennial (170). Both instruments are harmonized with PAHO's Strategy of Human Resources for Universal Access to Health and Universal Health Coverage (14). During this planning, priority should be given to joint work with academic institutions to update undergraduate training in accordance with the vision of health during this new stage of the reform. Emphasis should be on the PHC approach and the incorporation of soft skills, especially intercultural skills that guide the professional toward treatment focused on the population's needs. It is suggested to promote a career path at the FLC that allows young professionals to count on a people-focused job focused on disease prevention and health promotion, with prospects for professional development and remuneration similar to those of their colleagues who choose hospital work. This initiative can be aimed at recognizing and incentivizing young professionals who participate in the SERUMS. Responding to the shortage of specialists is also a pending point on the agenda between the health sector and universities that offer specialized training (medical residency).
Prioritize investment in the FLC (supply and response capacity) by reorganizing health service networks. Despite improvements in recent years, insufficient availability and quality of infrastructure has substantially limited access to health services and the quality of care they provide. As shown in previous sections, a high proportion of the population chooses not to seek care or chooses to self-medicate, indicating gaps in the provider network capacity, lack of trust in covered services, and poor quality and insufficient acceptability of services. Expanding and strengthening response capacity at the FLC is therefore an essential condition in the short and medium term for reducing the access barriers that persist in Peru. Priority should be given to the population in situations of greatest vulnerability. As mentioned above, access barriers are a major concern for the poorest population and for populations in rural and hard-to-reach areas of the country.

Measures to increase the supply and quality of services should be accompanied by measures to reduce fragmentation. Part of these needs could be covered through the complementarity of services and coordination between providers (in particular, between the SIS and EsSalud). Other relevant aspects to ensure the process to develop and strengthen the FLC include strategic resources and the incorporation of information and communication technologies in the care process and in the organization of services. There are still gaps in the availability of supplies and HRH that should be resolved through improvements in the supply chains, greater resources to ensure the presence of basic health teams, and improvements in the coordination and supply of services (operating hours and wait times, continuity and quality of care). Actions such as the implementation of double shifts in health posts or centers should be accompanied by a similar expansion of the supply at the second level to avoid the creation of new bottlenecks.

The implementation of evidence-based telemedicine and telehealth initiatives can provide a new opportunity to reduce wait times and simplify the processes for booking appointments and referrals and counter-referrals (86). The incorporation of technologies and innovation at the first and second levels of care can gradually open the way for new models of technology-based relationships between users, providers, the health authority, and the general population. This would lead to a health system that guarantees a quality omni-channel experience, with uniform messages through various digital and physical media that promote a homogeneous vision of the health system (171, 172). In particular, universalization of electronic health records could play an important role in expanded complementarity and toward the integration of subsystems. The interviewees considered the Metropolitan System of Solidarity (SISOL), a municipal health care model created in 2004, to be a good primary care network initiative in an urban context. A 2013 study already highlighted its good performance in terms of productive consultations and satisfaction levels (attributed to the presence of specialists at the FLC); an innovative public-private structure (rather than outsourcing); and an incentive system based on shared risk management (173).
Close the gap for the 5% of the population that still lacks health insurance. Achieving universal health coverage has been a clear goal in Peru, with impressive results. In particular, regulatory efforts such as the Framework Law on Universal Health Insurance of 2009 (129) and the decrees to expand the SIS in 2019 and 2021 (133, 136, 137, 139) have resulted in the expansion of insurance to 95.16% of the Peruvian population in 2021 (174, 175). The population that has access to the benefits guaranteed in the PEAS has seen reduced out-of-pocket health expenditures (176). Additionally, the progressive strengthening of FISSAL, together with Plan Esperanza, have contributed to financing for the diagnosis and treatment of high-cost diseases and oncological diseases, with the potential to achieve a reduction in catastrophic health expenditure. These changes have led to important achievements in reducing unmet health needs for financial reasons. However, despite these improvements, out-of-pocket household health expenditure still constitutes about one-third of total financing (177) and the population that is not yet insured continues to face financial barriers, highlighting the need for a long-term strategy to ensure 100% coverage.

In the context of the COVID-19 pandemic and the post-pandemic phase, it is necessary to redouble efforts to sustain the gains that have been made and to focus on populations in situations of vulnerability that continue to experience these challenges. The application of strategies aimed at expanding the criteria for SIS affiliation should continue, providing coverage for population groups that do not meet EsSalud coverage requirements. However, this should take place within the framework of a more comprehensive health strengthening process that addresses gaps in the capacity of health services to meet demand and improve acceptability. Finally, it is suggested to promote FISSAL as a consolidated reinsurance fund in order to overcome the perception that it is simply a complementary fund.
CONCLUSIONS
AND OPPORTUNITIES

The country studies included in this report present an overall characterization of the challenges involved in achieving access to health services, the persistence of barriers and, in some cases, the exacerbation of these barriers as a result of the COVID-19 pandemic. The high prevalence of access barriers reflects an important and persistent problem in the Region of the Americas. These barriers affect almost one-third of the population, in particular low- and middle-income countries and populations in situations of greatest vulnerability who are in the first income quintile, have less education, and reside in rural or remote areas. The presence of these barriers is also associated with potentially avoidable premature mortality, highlighting the importance of identifying and addressing access barriers. Faced with this structural and complex problem, the analysis of access barriers requires the incorporation of a perspective from both policies and health systems. While the results presented in this report are determined by each country’s context and the trajectory of its health systems, the analyses reveal some important patterns that can be addressed at the regional level through the exchange of knowledge and experiences with technical cooperation, resource mobilization, and policy advocacy.

First, there is evidence of a transition in the characteristics of access barriers. This is linked to the focus of policies for health systems transformation, leading to the reduction of some barriers and the prevalence or emergence of others (10). As previous studies have found, countries that underwent reforms aimed at expanding insurance coverage achieved significant reductions in unmet needs related to financial barriers and, in some cases, improvements in financial protection. In those cases, an increase in the prevalence of barriers related to the health system’s organizational and cultural aspects was also observed. Long wait times, appointment booking systems, how users are treated by health personnel, and the intercultural skills of health workers became an increasingly frequent reason for not seeking health services in those countries. The case studies of Colombia and Peru show examples of this situation. It is important to highlight
that, in these countries, the capacity to overcome access barriers is not homogeneous across the entire population. Populations in situations of greatest vulnerability still face financial barriers associated primarily with out-of-pocket expenses and indirect expenses related to transportation or overnight stays. At the same time, there are increasing reports of further barriers related to acceptability, quality, and continuity of care. In other cases, by strengthening the FLC, especially in the context of health systems transformation processes aimed at changing the model of care, some countries were able to address other barriers, such as those related to the geographical accessibility and availability of services. In the case of Honduras, although the challenges are still significant, implementation of the MNS may have contributed to the reduction in barriers related to the distance to facilities, availability of medicines, and perceived quality of care.

Another important pattern is the persistence or increase of nonfinancial barriers that sometimes receive less attention in agendas focused on strengthening and transforming health systems. These include barriers associated with the intercultural adaptation of services; gender roles and norms; intrafamilial power dynamics; ethnicity and trust in services; and health literacy. The findings also suggest that the interaction between these barriers may be more important than each factor’s individual role, highlighting the complex and multifactorial nature of access to services. For example, aspects related to gender norms and roles and women’s empowerment in household decisionmaking determine how women perceive access barriers. Women who simultaneously identify financial, geographical, and gender-related barriers have seen a decline in their ability to use essential health services. A similar situation is observed in the indigenous populations and those in rural or remote areas, where barriers intersect and exacerbate access problems. The case of Guyana exemplifies the combination of demand-side factors, including a lack of access to health information and social and cultural beliefs, which interact with supply-side factors, such as long distances, deficient transportation, limited availability of human resources, and insufficient health facilities. All of these interact and hinder timely health care-seeking in rural and remote areas of the country. This highlights the urgent need for an in-depth understanding of how barriers manifest themselves in different territories and differentially affect the different population groups in situations of greatest vulnerability, in particular the indigenous and native populations of the Region, Afro-descendant people, children and adolescents, women, and LGBTQI+ people. It also indicates the need for differentiated policy interventions adapted to the context of each country and local area. In other cases, problems related to the availability of HRH were compounded by insufficient supplies and infrastructure.

The recommendations emerging from the country studies highlight shared areas of intervention with respect to access barriers. First, it is necessary to adopt a comprehensive approach to PHC, mainly oriented to the adoption of care models that strengthen health promotion, as well as the community and multisectoral component, in order to improve factors related to the demand for and acceptability of services. Second, there is a need to strengthen regulatory frameworks and governance structures at all levels of management, in some cases with special attention to institutions with management and response functions in territorial (or subnational) jurisdictions. In most cases, recommendations to strengthen management and response were related to capacities to promote intersectoral action, increase social participation in health, and strengthen strategic planning in health. Third, interculturality should be mainstreamed, primarily
in terms of the intercultural adaptation of health services and the recognition of specific needs in certain population groups. Fourth, it is necessary to improve the quality of care, in particular the organizational aspects of service provision, the fulfillment of functions and standards for coordinating provision, and the guarantee of rights. And finally, all the case studies highlight the need to improve health financing to implement policy proposals.

Beyond guidance for the health sector, evidence-based analysis of barriers can also make a fundamental contribution to the design of intersectoral policies, including transport, telecommunications, and social, labor, and education policies. For example, the development of telecommunications and new road infrastructure was included among the recommendations for Honduras and Guyana as a key element in improving the accessibility of services. In both cases, it was emphasized that the development of telemedicine and telehealth tools can be stimulated by expanding communication infrastructure, while the removal of geographical accessibility barriers, such as reduced distances and transport times, can be greatly affected by improving road infrastructure. The points mentioned above are relevant at the regional level since the recommendations are aligned with the strategy adopted by PAHO Member States to achieve resilient health systems and protect health achievements. Member States reiterated the need to adopt the recommendations of the High-Level Commission included in the publications *Universal Health in the 21st Century: 40 Years of Alma-Ata* (178) and *Compact 30-30-30: PHC for Universal Health* (6).
Finally, the country studies also demonstrated the relevance of evidence and knowledge about the different barriers to access to health services faced by populations in situations of greatest vulnerability. Even in data-limited settings, the use of a common mixed methodology in studies allowed the set of access barriers to be defined holistically, including their magnitude and interrelatedness, their determinants, and the policies and contextual factors in each country. This methodology allowed a holistic approach to access barriers, aimed at determining whether health systems and services respond to the needs of different population groups. In this sense, the equity dimension is a fundamental pillar of the methodology. Together with solidarity and the right to health, equity should constitute one of the structural pillars of both the systems and the tools used to evaluate progress toward universal health. Finally, the methodology not only sought to characterize access barriers, but also included as an objective public participation in proposed policy options to reduce and eliminate barriers in the context of system transformation processes. Future studies could explore the incorporation of mixed approaches to evaluate access barriers in national and local monitoring and evaluation systems. In addition, the methodology could be extended to amplify the voices of communities and the perspectives of users (for example, using focus groups, in-depth interviews, and other methods).
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This report presents the results of the collaboration between
the Pan American Health Organization and its Member States
to analyze barriers to access to primary health care and to
formulate policy options aimed at reducing and progressively
eliminating these barriers. The first chapter presents a
characterization of health systems in the Region of the Americas
and challenges to universal access in the context of the COVID-19
pandemic. The second chapter presents a methodological
and analytical framework for studying access barriers and the
delineation of policy options. Chapters 3 to 6 present case studies
focused on the barriers faced by groups in situations of greater
vulnerability in the context and trajectory of different health
system reforms. By way of conclusion, general recommendations
are presented to promote the still unfinished agenda toward
universal access to health and universal health coverage.