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**REGIONAL DECLARATION ON THE NEW ORIENTATIONS FOR PRIMARY
HEALTH CARE (PHC)**

**RENEWING PRIMARY HEALTH CARE IN THE AMERICAS: A STRATEGIC AND
PROGRAMMATIC ORIENTATION FOR THE PAN AMERICAN HEALTH
ORGANIZATION**

The Director is pleased to transmit to the Directing Council the report on the future strategic and programmatic orientations in primary health care (PHC).

FUTURE STRATEGIC AND PROGRAMMATIC ORIENTATIONS IN PRIMARY HEALTH CARE (PHC)

1. The following is a progress report on the fulfillment of the mandates of the 44th Directing Council (September 2003) in Resolution CD44.R6, which calls for Member States to adopt a series of recommendations to strengthen Primary Health Care (PHC). The resolution also calls for PAHO/WHO to:

- (a) Take the principles of PHC into account in the activities of all technical cooperation programs, especially those related to the Millennium Development Goals (MDGs);
- (b) Evaluate the different systems based on PHC and identify and disseminate best practices;
- (c) Assist in the training of health workers for PHC;
- (d) Support locally defined PHC models that are flexible and adaptable;
- (e) Celebrate the twenty-fifth anniversary of Alma-Ata in a year-long process that would end in September 2004; and
- (f) Organize a process for defining future strategic and programmatic orientations on PHC.

2. The 44th Directing Council also carried out three simultaneous round tables on PHC that allowed delegates from countries and other organizations to discuss various topics related to PHC. The report of these round tables called for, among other things, the elaboration of a new regional declaration on PHC.

3. In response to mandate (f) "organizing a process for defining future strategic and programmatic orientations on PHC," on 13 May 2004, PAHO/WHO created a "Working Group on PHC" (WG) whose main function is to advise the Organization on how to build a reinvigorated vision of the PHC strategy that would address the challenges of the new millennium, particularly those posed by the MDGs.

4. The WG is composed of 23 members who have extensive knowledge and experience in PHC at the policy, implementation, and research levels. Of the members of the group, 12 are from PAHO/WHO and 11 are experts from countries of the Region. Close attention was paid to assembling a group that could provide a wide cross-section of

views from the different sectors of government and others that will have a bearing on the effective design and implementation of the PHC strategy.

5. The main objectives of the WG are to examine and reaffirm the conceptual dimensions of PHC as contained in the Alma-Ata Declaration; to develop operational definitions of concepts relevant to PHC; and to provide guidance to countries and PAHO/WHO on how to reorient the Region's health systems and services following the principles of PHC in the context of health sector reform processes. The WG further provided guidance on the drafting of a PAHO/WHO position paper and a Regional Declaration on the renewal of PHC, which reflect the current realities and the way forward.

6. In order to achieve the above objectives, the WG held consultations at the regional and country levels. It is also fostered dialogue with relevant stakeholders, including those from civil society and NGOs, universities, professional associations, and government, to build consensus and to establish strategic alliances for the advancement of PHC throughout the region.

7. The first meeting of the WG was held from 28 to 30 June 2004, in Washington, D.C., followed by a second meeting held from 27 to 29 October 2004, in San José, Costa Rica. By the end of December 2004, the WG produced the first draft of the position paper on the renewal of PHC, which went through PAHO's internal review process until 31 March 2005.

8. During May and June 2005, the second version of the draft (dated 31 March 2005) was sent to every Member State for review and comments. As of August 2005, 21 national consultations to discuss the position paper were held in Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, and Venezuela. The comments received from the countries were incorporated into the third version of the position paper dated July 12th, 2005.

9. Further, the draft of the Regional Declaration on PHC was sent to the Member States for comments during July and early August of 2005.

10. Finally, the Regional Consultation on the Renewal of PHC in the Americas was held 26 to 29 July 2005, in Montevideo, Uruguay. The objectives were to discuss and make recommendations on the drafts of the Position Paper (draft of 12 July 2005) and the Regional Declaration (draft of 22 July 2005). In addition, the Consultation hosted a special session on PHC in Uruguay. The Consultation, which was inaugurated by the President of Uruguay, Dr. Tabaré Vázquez, was attended by more than 85 people representing 31 Member States, NGOs, professional associations, universities, and other

sister U.N. agencies. Member States and territories represented at the meeting were Anguilla, Antigua and The Barbuda, Argentina, Bahamas, Barbados, Bolivia, Brazil, Canada, Chile, Costa Rica, Colombia, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, and Venezuela.

11. The technical recommendations that resulted from the Regional Consultation have been incorporated into the document “Renewing Primary Health Care in the Americas: a strategic and programmatic orientation for the Pan American Health Organization” (Annex A) and the Regional Declaration on PHC (Annex B), both of which are submitted for the consideration of the Directing Council in this Report.

Action by the Directing Council

12. The Directing Council is invited to note this report and based on the document “Renewing Primary Health Care in the Americas: a strategic and programmatic orientation for the Pan American Health Organization, to proclaim the Declaration of the Americas on the Renewal of Primary Health Care annexed to this report.

Annexes

Original: English

Renewing Primary Health Care
in the Americas:
a strategic and programmatic orientation
for
the Pan American Health Organization

DRAFT

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Executive Summary

For more than a quarter of a century Primary Health Care (PHC) has been recognized as one of the key components of an effective health system. Experiences in more-developed and less-developed countries alike have demonstrated that PHC can be adapted and interpreted to suit a wide variety of political, social, and cultural contexts. A comprehensive review of PHC - both in theory and practice - and a critical look at how this concept can be “renewed” to better reflect the current health and development needs of people around the world, is now in order. This document-written to fulfill a mandate established in 2003 by a resolution of the Pan American Health Organization (PAHO)-states the position of PAHO on the proposed renewal of PHC. The goal of this paper is to generate ideas and recommendations to enable such a renewal, and to help strengthen and reinvigorate PHC into a concept that can lead the development of health systems for the coming quarter century and beyond.

There are several reasons for adopting a renewed approach to PHC, including: the rise of new epidemiologic challenges that PHC must evolve to address; the need to correct weaknesses and inconsistencies present in some of the widely divergent approaches to PHC; the development of new tools and knowledge of best practices that PHC can capitalize on to be more effective; and a growing recognition that PHC is a tool to strengthen society’s ability to reduce inequities in health. In addition, a renewed approach to PHC is viewed as an essential condition for meeting the commitments of the Millennium Declaration, addressing the social determinants of health, and achieving of the highest attainable level of health for everyone.

By examining concepts and components of PHC and the evidence of its impact, this document builds upon the legacy of Alma Ata and the primary health care movement, distills lessons learned from PHC and health reform experiences, and proposes a set of key values, principles, and elements essential for building health systems based on PHC. It postulates that such systems will be necessary to tackle the “unfinished health agenda” in the Americas, as well as to consolidate and maintain progress made and rise to the new health and development challenges and commitments of the twenty-first century.

The ultimate goal of the renewal of PHC is to obtain sustainable health gains for all. The proposal presented here is meant to be visionary; the realization of this document’s recommendations, and the realization of PHC’s potential, will be limited only by our commitment and imagination.

Main messages include:

- Throughout the extensive consultation process that formed the basis for this paper, it was found that PHC represents, even today, a source of inspiration and hope, not only for most health personnel, but for the community at large.
- Due to new challenges, knowledge, and contexts, there is a need to renew and reinvigorate PHC in the region that also strengthens the PHC approach so that it can realize its potential to meet today’s health challenges and those of the next quarter-century.
- Renewal of PHC entails recognizing and facilitating the role of PHC as an approach to promote more equitable health and human development.
- PHC renewal will need to pay increased attention to structural and operational needs such as access, financial fairness, adequacy and sustainability of resources, political commitment, and the development of systems that assure high quality care.

- Successful PHC experiences have demonstrated that system-wide approaches are needed, so a renewed approach to PHC must make a stronger case for a reasoned and evidence-based approach to achieving universal, integrated, and comprehensive care.
- The proposed mechanism for PHC renewal is the transformation of health systems so that they take PHC as their basis.
 - A PHC-based health system is an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness, quality orientation, government accountability, social justice, sustainability, participation, and intersectorality.
 - A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action. A PHC-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal management practices at all levels to achieve quality, efficiency, and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system develops intersectorial actions to address other determinants of health and equity.
 - International evidence suggests that health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient, have lower healthcare costs, and can achieve higher user satisfaction than those whose health systems have only a weak PHC orientation.
 - The reorientation of health systems towards PHC requires the adjustment of health services towards prevention and promotion - achieved by assigning appropriate functions to each level of government, integrating public and personal health services, focusing on families and communities, using accurate data in planning and decision-making, and creating an institutional framework with incentives to improve the quality of services.
 - Full realization of PHC requires additional focus on the role of human resources, development of strategies for managing change, and aligning international cooperation with the PHC approach.
- The next step to renewing PHC is to constitute an international coalition of interested parties. The tasks of this coalition will be to frame PHC renewal as a priority, develop the concept of PHC-led health systems so that it represents a feasible and politically appealing policy option, and find ways to capitalize on the current window of opportunity provided by the recent 25th anniversary of Alma Ata and the accompanying international focus on the importance of attaining the Millennium Development Goals, as well as the current international focus on the need for strengthening health systems.

I. Why Renew Primary Health Care?

The World Health Organization has championed primary health care (PHC) even before 1978, when it adopted the approach as central to the achievement of the goal of "Health for All." Since that time, the world--and PHC with it--has changed dramatically. The purpose of renewing PHC is to revitalize countries' capacity to mount a coordinated, effective, and sustainable strategy to tackle existing health problems, prepare for new health challenges, and improve equity. The goal of such an endeavor is to obtain sustainable health gains for all.

There are several reasons for adopting a renewed approach to PHC, including: the rise of new epidemiologic challenges that PHC must evolve to address; the need to correct weaknesses and inconsistencies present in some of the widely divergent approaches to PHC; the development of new tools and knowledge of best practices that PHC can capitalize on to be more effective; a growing recognition that PHC is a tool to strengthen society's ability to reduce inequities in health; and a growing consensus that PHC represents a powerful approach to addressing the causes of poor health and inequality.

A renewed approach to PHC is therefore viewed as an essential condition for meeting the Millennium Development Goals (MDG's), addressing the fundamental causes of health as articulated by the WHO Commission on Social Determinants of Health, and in codifying health as a human right as articulated by some national constitutions, civil society groups, and others. Renewing PHC will require building upon the legacy of Alma Ata and the primary health care movement, taking full advantage of lessons learned and best practices resulting from more than a quarter-century of experience, and renewing and reinterpreting the approach and practice of primary health care to address the challenges of the twenty-first century.

The region of the Americas has made great progress in the past quarter century, but persistently overburdened health systems and widening inequities threaten gains already made and endanger future progress towards better health and human development.

Important progress has been made in terms of health and human development in the region of the Americas. Average values for nearly every health indicator have improved in almost every country in the region: infant mortality has decreased by about one-third, all-cause mortality has declined in absolute terms by nearly 25 percent; life expectancy has increased, on average, by six years; deaths from communicable diseases and diseases of the circulatory system have fallen by 25 percent; and deaths from perinatal conditions have decreased by 35 percent.¹ Considerable challenges remain, however, with some infectious diseases, such as tuberculosis, remaining as significant health problems; HIV/AIDS continues to challenge nearly every country in the region and non-communicable diseases are on the rise.² In addition, the region has experienced widespread social and economic shifts, with significant health impacts. These include aging populations, changes in diet and physical activity, the diffusion of information, urbanization, and the deterioration of social structures and supports which have (either directly or indirectly) contributed to a range of health problems such as obesity, hypertension, and cardiovascular disease; increased injuries and violence; and problems related to alcohol, tobacco, and drugs.^{1,3}

Unfortunately, and of key importance to the effort to renew PHC, these trends exist in the context of an overall worsening of health inequities. For example, 60 percent of maternal mortality takes place in the poorest 30 percent of countries, and the gap in life expectancy between the richest and the poorest has reached nearly 20 years within some countries.¹ The distribution of newly emerging health threats and their risk factors have further exacerbated health inequities both within and between countries.

Widening inequities represent more than just failures of the health system: they point to the inability of societies to cope with the underlying causes of ill health and its unfair distribution. In the 1970's and 1980's, many countries in the Americas experienced war, political upheaval, and totalitarian rule. Since then, transitions to democracy brought new hope, but for many countries the economic and social benefits of these transitions have yet to materialize. During the past decade, economic adjustment practices, globalization pressures, and the impact of some neoliberal economic policies have, along with other factors, contributed to disparities in wealth, status, and power among and within countries in the Americas, and reinforcing negative impacts on health.⁴⁻⁶

A re-examination of the underlying determinants of health and human development has led to a growing realization that health must take center stage on the development agenda. Increased support for health is reflected in the way development has come to be defined: once considered synonymous with economic growth, the predominant understanding is now multidimensional and based on the idea of human development.⁷ This new approach recognizes that health is a basic human capacity, a prerequisite for individuals to achieve self-fulfillment, a building block of democratic societies, and a basic human right.^{8,9}

As the understanding of health has broadened, so has the awareness of the limitations of traditional health services to address all population health needs.¹⁰ For many in the region, "Health is a social, economic and political issue and, above all, a fundamental right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the death of poor and marginalized people".¹¹

Recent research has elucidated the complex relationships among the social, economic, political, environmental determinants of health and its distribution.¹² We now know that any approach to improving health must be articulated within the larger political, social, and economic context and must work with multiple sectors and actors.¹³

Over the past three decades a variety of health reforms have been introduced in most countries in the Americas. Reforms have been initiated for a range of reasons, including rising costs, inefficient and poor-quality services, shrinking public budgets, new technologic developments, and as a response to the changing role of the state.¹⁴ Despite considerable investments, most reforms appear to have had limited, mixed, or even negative results in terms of improving health and equity.^{15,16}

Renewing PHC means more than simply adjusting it to current realities; renewing PHC requires a critical examination of its meaning and purpose. Surveys conducted with health professionals in the Americas confirm the importance of the PHC approach; they also confirm that disagreements and misconceptions about PHC abound, even within the region.¹⁷ Overall, perceptions about the role of PHC in social and health system development fall broadly into four main categories (see Table 1). In Europe and other wealthy industrialized countries, PHC has primarily been viewed as the first level of health services for the entire population.^{18,19} As such, it is most commonly referred to as "Primary Care". In the developing world, PHC has primarily been "selective", concentrating on a few high impact interventions to target the most prevalent causes of child mortality and some infectious diseases.²⁰ A comprehensive, national approach to PHC has been implemented in only a few countries, although others appear to be moving toward more comprehensive approaches and there have been many smaller-scale experiences throughout the region.²¹⁻²³

Various observers have offered explanations as to why PHC differs so radically from country to country. Some argue that, with regards to the Americas in particular, different views on PHC are to be expected, given the historical development of health and healthcare in the region and the legacy of different political and social systems.^{17,24} Others have suggested that the divergence of views is explained by the ambitious and somewhat vague descriptions of PHC as described in the Alma Ata declaration.²⁵ Others argue that while many effective

PHC initiatives were developed in the years after Alma Ata, the main message became distorted as the result of both the changing visions of international health agencies and globalization processes.¹¹ Regardless of the ultimate cause(s), it is clear that the concept of PHC has become increasingly expansive and confused since Alma Ata, and that PHC has not accomplished everything its champions had intended.

Table 1: Approaches to Primary Health Care

Approach	Primary Health Care definition or concept	Emphasis
Selective PHC	Focuses a limited number of high-impact services to address some of the most prevalent health challenges in developing countries. ²⁰ Main services came to be known as GOBI (growth monitoring, oral rehydration techniques, breast-feeding, and immunization) and sometimes included food supplementation, female literacy, and family planning (GOBI-FFF).	Specific set of health service activities geared towards the poor
Primary care	Refers to the entry point into the health system and the place for continuing health care for most people, most of the time. ²⁶ This is the most common conception of primary health care in Europe and other industrialized countries. Within its most narrow definition, the approach is directly related to the availability of practicing physicians with specialization in general practice or family medicine.	Level of care in a health services system
Alma Ata “comprehensive PHC”	The Alma Ata declaration defines PHC as the first level of care that is integrated and comprehensive and that includes elements of community participation, intersectorial coordination, and reliance on a variety of health workers and traditional practitioners. ²⁷ It includes several principles, including: the need to address wider health determinants; universal accessibility and coverage on the basis of need; community and individual involvement and self-reliance; intersectorial action for health; and appropriate technology and cost-effectiveness in relation to available resources. ²⁸	A strategy for organizing healthcare systems and society to promote health.
Health and Human Rights approach	Stresses understanding health as a human right and the necessity of tackling the broader social and political determinants of health. ¹¹ It differs in its emphasis on the social and policy implications of the Alma Ata declaration than on the principles themselves. It advocates that the social and political focus of PHC has lagged behind disease-specific aspects and that development policies should be more “inclusive, dynamic, transparent and supported by legislation and financial commitments”, if they are to achieve equitable health improvements. ²⁹	A philosophy permeating the health and social sectors

Source: categories adapted from ^{30,31}

As PHC became entwined with the goal of “Health for All by the Year 2000”, its meaning and focus also broadened to include a whole range of outcomes that were outside the responsibility of the health system.³² Unfortunately, as the millennium approached it became increasingly clear that Health for All would not be attained. For some, the failure of reaching this goal came to be associated with the perceived failure of PHC itself.

Paradoxically, as the meaning of PHC expanded to include multiple sectors, its implementation became increasingly narrow. Although originally considered an interim strategy, selective PHC became the dominant mode of primary health care for many countries. The approach continued through many sub-population or disease-specific vertical programs. At one level, the push towards selective PHC can be seen as a reaction to the idea that PHC had become too broad and vague, with impacts and successes difficult to quantify, and little in the way of visible dividends for the public or policymakers. The selective approach, in contrast, allowed for targeting limited resources towards specific health targets, although in some cases this approach appears to have been chosen, at least in part, as part of a strategy to attract increased donor financing for health services.³³

Although successful in some areas (such as immunization), the selective PHC approach has been criticized for ignoring the wider context of social and economic development. This is not the same as saying that PHC must address all health determinants, but it does imply that selective approaches are, more often than not, unable to address the fundamental causes of ill health.³⁴ It has also been argued that selective approaches, by targeting narrow populations and narrow health issues, may create gaps between programs that leave some families or

individuals underserved. Moreover, there is concern that the nearly exclusive focus on children and women ignores the growing presence of health threats such as chronic diseases, mental health, injuries, sexually transmitted infections and HIV/AIDS, as well as vulnerable populations such as adolescents and the elderly.³⁵

In addition, questions have been raised over whether interventions focused on a single disease or population group are sustainable, since if interest in that disease or group evaporates, program funding will follow. And finally, there is concern that the selective PHC approach overlooks the fact that many adults (and to a lesser extent, children) are likely to suffer from more than one health problem at the same time—a condition even more frequent among the elderly.³⁶ For all of these reasons, a renewed approach to PHC must make a stronger case for a reasoned and evidence-based approach to achieving universal, integrated, and comprehensive care.

Finally, renewing PHC is expected to contribute to efforts underway to strengthen health systems in the developing world. Attainment and sustainability of global, regional, national, and local health goals (such as the MDGs and the WHO “3-by-5” initiative) will require integrated, horizontal approaches to health system development.^{21,37}

In September 2003, during the 44th Directing Council, PAHO/WHO passed Resolution CD44.R6 calling for Member States to adopt a series of recommendations to strengthen PHC. In addition, the Resolution calls for PAHO/WHO to: take PHC principles into account in the activities of technical cooperation programs, especially those related to the Millennium Declaration and its goals; evaluate different systems based on PHC, identify and disseminate best practices; assist the training of health workers for PHC; support locally defined PHC models; celebrate the 25th anniversary of Alma Ata; and organize a process for defining future strategic and programmatic orientations in PHC. In response to the above mandates, in May 2004 PAHO/WHO created the “Working Group on PHC” (WG) to advise the organization on future strategic and programmatic orientations in PHC. (See appendix A). The WG engaged in a consultative process within the international community through several international conferences, and circulation of the draft position paper to all member countries and experts, in addition 20 countries convened national-level meetings on PHC renewal, and in July 2005, a regional consultation was held in Montevideo Uruguay with 100 individuals representing more than 30 countries in the Region, and including nongovernmental organizations, professional associations, universities, and UN agencies. This document is the principal outcome of these processes.

II. Building Primary Health Care-Based Health Systems

The position of the Pan American Health Organization is that PHC renewal must be an integral part of health systems development and that basing health systems on PHC is the best approach for producing sustained and equitable improvement in the health of the peoples of the Americas.

We define a PHC-based health system as an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness, quality orientation, government accountability, social justice, sustainability, participation, and intersectoriality.

A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action. A PHC-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal management practices at all levels to achieve quality, efficiency, and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system develops intersectorial actions to address other determinants of health and equity.

The essence of the renewed definition of PHC is the same as that in the Alma Ata Declaration.¹ However, this new definition focuses on the health system as a whole; includes public, private, and non-profit sectors; and applies to all countries. It differentiates values, principles and elements; highlights equity and solidarity; and incorporates new principles such as sustainability and a quality orientation. It discards the notion of PHC as a defined set of services, since services should be congruent with local needs. It likewise discards the notion of PHC as defined by specific types of health personnel, since the teams who work in PHC should be defined in accordance with available resources, cultural preferences, and evidence. Instead, it specifies organizational and functional elements that can be measured and evaluated and which form a logical and cohesive approach to firmly grounding health systems in the PHC approach. This approach is meant to provide a flexible means of transforming health systems so that they achieve their goals while being flexible enough to change and adapt over time to meet new challenges. It recognizes that PHC is more than just the provision of health services: its success is dependent on other health system functions and other social processes.

The approach presented here is meant to serve as a foundation for organizing and understanding components of a PHC-based health system; it is not meant to define, exhaustively, all of the necessary elements that constitute or define a health system. Due to the great variation in national economic resources, political circumstances, administrative capacities, and historical development of the health sector, each country will need to design their own strategy for PHC renewal. It is hoped that the values, principles, and elements described below will aid in that process. Figure 1 presents the proposed values, principles, and elements of a PHC-based

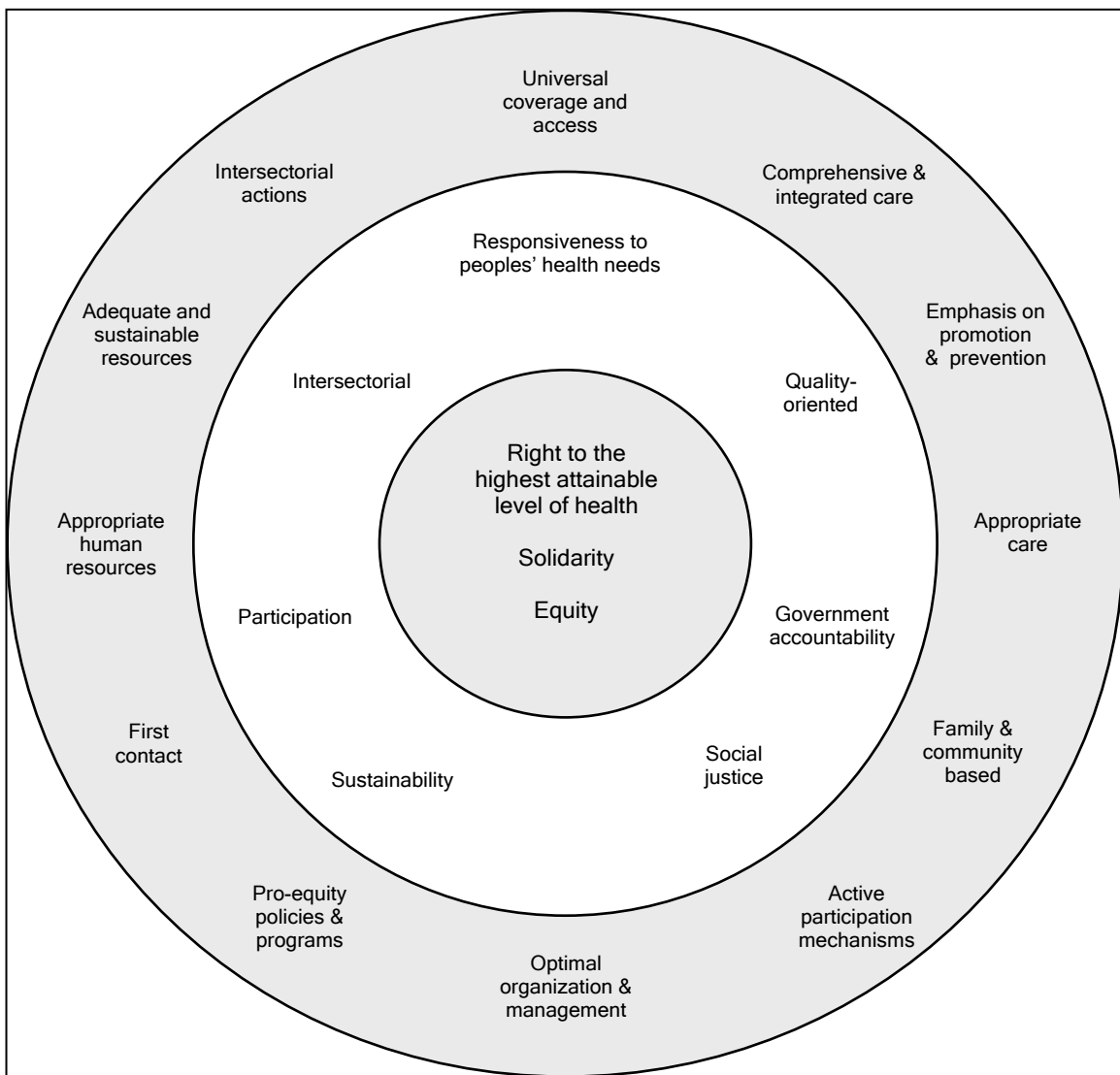
¹ There are other precedents for basing health systems on PHC. For example, the Ljubljana Charter for Health Reform adopted by the European Union in 1996 states that health systems must be: value driven (human dignity, equity, solidarity, professional ethics), targeted on health outcomes, centered on people while encouraging self-reliance, focused on quality, based on sound financing, responsive to citizen's voice and choice, based on evidence; and require strengthened management, human resources, and policy coordination.³⁸

Health System. Appendix B provides a more complete description of the values, principles, and elements described below.

A. Values

Values are essential for setting national priorities and for evaluating whether or not social arrangements are meeting population needs and expectations.¹⁴ They provide a moral anchor for policies and programs enacted in the public interest. The values described here are intended to reflect those in society at large. In any given society, some values may take precedence over others, and may even be defined in slightly different ways based on local culture, history, and preferences. At the same time, a growing body of international law defines parameters necessary to protect the most disadvantaged in society and creates a legal basis upon which they may assert their claims to dignity, freedom, and good health. This implies that the process of basing a health system more strongly on PHC must begin with an analysis of social values and involve citizen and decision-maker participation in how such values are articulated, defined, and prioritized.¹⁴

Figure 1: Core Values, Principles and Elements in a PHC-Based Health System



The right to the highest attainable level of health is expressed in many national constitutions and articulated in international treaties, including the charter of the World Health Organization.³⁹ It implies legally-defined rights of citizens and responsibilities of government and other actors and creates health claims for citizens that provide recourse when obligations are not met. The right to the highest attainable level of health is instrumental in assuring that services are responsive to people's needs, that there is accountability in the health system, and that PHC is quality-oriented, achieving maximum efficiency and effectiveness while minimizing harm. Health and other rights are inextricably bound with equity, and these, in turn, reflect and help reinforce social solidarity.

Equity in health addresses unfair differences in health status, access to healthcare and health-enhancing environments, and treatment within the health and social services system. Equity has intrinsic value since it is a prerequisite for human capacity, freedoms, and rights.⁴⁰ Equity is a cornerstone of social values: the way in which societies treat their most disadvantaged members reflects either an explicit or implicit judgment about the value of human life. Simply appealing to a society's values or moral conscience may not be enough to prevent or reverse inequities in health. This means that people must be able to redress inequities through the exercise of their moral and legal claims to health and other social rights. Placing equity within the core of a PHC-based health system based is intended to guide health policies and programs and to underscore the fact they should be equity-enhancing. The rationale for this is not simply efficiency, cost-effectiveness, or charity: rather, in a just society equity ought to be viewed as a moral imperative and a legal and social obligation.

Solidarity is the extent to which people in a society work together to define and achieve the common good. It is manifested in national and local government, in the formation of voluntary organizations and labor unions, and in other forms of citizen participation in civic life. Social solidarity is one means by which collective action can overcome problems; health and social security systems are common mechanisms through which social solidarity among people of different classes and generations is expressed. PHC-based health systems require social solidarity in order for investments in health to be sustainable, to provide financial protection and risk pooling, and to allow the health sector to work successfully with other sectors and actors whose buy-in is necessary both to improve health and to improve the conditions that help determine it. Participation and accountability at all levels is necessary not only to achieve solidarity, but also to assure that it is maintained over time.

B. Principles

PHC-based health systems are founded on principles that provide the basis for health policies, legislation, evaluative criteria, resource generation and allocation, and operation of the health system. Principles serve as the bridge between broader social values and the structural and functional elements of the health system.

Responsiveness to peoples' health needs means that health systems are centered on people and try to meet their needs in the most comprehensive way possible. A responsive health system must be balanced in its approach to meeting health needs--whether they are defined "objectively" (i.e. as defined by experts or by agreed-upon standards) or "subjectively" (i.e. needs as perceived directly by the individual or population). This implies that PHC must attend to population health needs in a way that is evidence-based and comprehensive, while being respectful and reflective of the preferences and needs of people regardless of their socioeconomic status, culture, race/ethnicity, or gender.

Quality-oriented services respond to and anticipate peoples' needs and imply treating all people with dignity and respect while assuring the best possible treatment for their health problems.⁴¹ This requires providing health professionals at all levels with evidence-based clinical knowledge and with the tools necessary to continuously update their training. A quality orientation necessitates procedures to assess the efficiency and effectiveness of

preventive and curative health interventions and to assign resources accordingly. Appropriate incentives are essential to making this process effective and sustainable.

Government accountability assures that social rights are realized and enforced and that citizens are protected from harm. Accountability requires specific legal and regulatory policies and procedures that allow citizens to demand recourse if appropriate conditions are not met, and applies to all health system functions regardless of the type of provider (e.g. public, private, non-profit). As part of its role, the state establishes conditions to assure that necessary resources are in place to meet the health needs of the population. In most countries government is also the ultimate agent responsible for ensuring equity and healthcare quality. Accountability thus requires monitoring and continually improving health system performance, in a transparent manner that is subject to social control. Different levels of government (e.g. local, state, regional, national) need clear lines of responsibility and corresponding accountability mechanisms.

A just society can be viewed as one that assures the development and capacity of all of its members.⁴² Social justice therefore suggests that government actions, in particular, should be assessed by the extent to which they assure the welfare of all citizens, particularly the most vulnerable.^{43,44} Some approaches to achieving social justice in the health sector include: assuring that all people are treated with respect and dignity; setting health goals that incorporate explicit targets for improved coverage among the poor; using these goals to direct additional resources toward the needs of the disadvantaged; improving education and outreach initiatives to help citizens understand their rights; ensuring active citizen participation in health system planning and oversight; and taking concrete actions to address underlying social determinants of health inequities.¹²

Sustainability of the health system requires strategic planning and long-term commitments. A health system based on PHC should be viewed as the primary means for investing in population health. Such investments must be sufficient to meet population health needs for today while planning to meet the health challenges of tomorrow. In particular, political commitment is essential in order to guarantee financial sustainability. It is envisioned that PHC-led health systems will establish mechanisms (such as legally-defined, specific health rights and government obligations) to assure adequate financing even in periods of political instability or change.

Participation makes people active partners in making decisions about resources, defining priorities, and ensuring accountability. At the individual level people must be able to make free and fully informed decisions regarding their own health and that of their families in a spirit of self-determination and reliance. At the societal level, participation in health is one facet of general civic participation; it assures that the health system reflects social values, and provides a means of social control over public and private actions that impact society.

Intersectorality in health means that the health system must work with different sectors and actors in order to impact the determinants of health, contribute to human development activities, and achieve its equity potential. The extent to which the health sector is responsible for intersectorial actions will depend on the level of development of the country in question and the resources available in PHC and elsewhere.

C. Elements

PHC-based health systems are composed of structural and functional elements. Elements are interconnected, are present at all levels of the health system, and should be based on current evidence of their effectiveness in improving health and/or their importance in assuring other aspects of a PHC-based health system. The core elements of a PHC-based health system additionally require the concurrent action of several of the main functions of the health system.

Universal coverage and access form the foundation of an equitable health system. Universal coverage implies that financing and organizational arrangements are sufficient to cover the entire population, removing ability to pay as a barrier to accessing health services and protecting people from financial risk, while providing additional support to meet equity goals and implement health promoting activities. Accessibility implies the absence of geographic, financial, organizational, socio-cultural, and gender-based barriers to care⁴⁵; thus a PHC-based health system must rationalize the location, operation, and financing of all services at each level of the health system. It also requires that services be acceptable to the population by taking into account local health needs, preferences, culture, and values. Acceptability determines whether people will actually use services, even if they are accessible. It also influences perceptions about the health system, including people's satisfaction with services provided, the level of trust they will have in the providers, and the extent to which they will understand and actually follow medical or other advice they are given.

Comprehensive and integrated care means that the range of services available must be sufficient to provide for population health needs, including the provision of promotion, prevention, early diagnosis, curative, rehabilitative, palliative care, and support for self management. Comprehensiveness is a function of the entire health system and includes prevention, primary, secondary, tertiary, and palliative care. Integrated care is a complement to comprehensiveness in that it requires coordination among all parts of the health system to ensure that health needs are met. For individuals, an integrated approach involves referrals and counter-referrals through all levels of the health system, and at times to other social services. At the systems level, it requires the development of service and provider networks, appropriate information and management systems, incentives, policies and procedures, and training of health providers, staff, and administrators.

Box 1: Renewing PHC: Implications for Health Services

Health care services play a key role in materializing many of the core values, principles and elements of a PHC-based Health System. Primary care services for instance are fundamental for ensuring equitable access to basic health services to the entire population. They allow for an entry point into the health care system which is closest to where people live, work or study. This level of the system provides comprehensive and integrated care that should address the majority of the health care needs and demands of the population. Likewise, it is the level of the system that develops the deepest ties with the community and the rest of the social sectors allowing for effective social participation and intersectorial action.

Primary care also plays an important role in coordinating the continuum of care and flow of information across the entire health care system. But primary care services alone are not sufficient for adequately responding to the more complex health care needs of the population. Primary care services should be supported and complemented by the different levels of specialized care, both ambulatory and inpatient, as well as by the rest of the social protection network. For this reason, health care systems should work in an integrated manner through the development of mechanisms that coordinate care across the entire spectrum of services, including development of networks and referral and counter-referral systems. In addition, integration across the different levels of care requires good information systems that enable adequate planning, monitoring and performance evaluation; appropriate financing mechanisms that eliminate perverse incentives and assure continuity of care; and evidence-based approaches to the diagnosis, treatment, and rehabilitation.

An emphasis on prevention and promotion is paramount in a PHC-based health system, because doing so is cost-effective, ethical, can empower communities and individuals to gain greater control over their own health, and is essential for addressing the “upstream” social determinants of health. An emphasis on prevention and promotion means going beyond a clinical orientation to embrace health education and counseling at the individual clinical level, regulatory and policy-based approaches to improving peoples' living and working environments, and population-based health promotion strategies carried out with other parts of the health system or with other actors.

This includes links with the essential public health functions (EPHF) making PHC an active partner in public health surveillance, research and evaluation, quality assurance, and institutional development activities across the health system.

Appropriate care implies that a health system is not disease or organ-based. Instead, it focuses on the whole person and their health and social needs, tailoring responses to the local community and its context over the life course, while assuring that people come to no harm. It incorporates the concept of effectiveness to help guide the selection and the prioritization of prevention and curative care strategies so that maximum impact can be achieved with limited resources. Appropriate care implies that all care is provided based on the best available evidence, while allocation of efforts is prioritized by considering efficiency (allocative and technical) and equity criteria. Services themselves need to be relevant by taking into account the community and family epidemiologic and social context.

Family and community-based means that a PHC-based health system does not rely exclusively on an individual or clinical perspective. Instead, it employs a public health lens by using community and family information to assess risks and prioritize interventions. The family and the community are viewed as the primary focus for planning and intervention.

A PHC-led health system should be an integral part of national and local socio-economic development strategies, based on shared values, that involve active participation mechanisms to guarantee transparency and accountability at all levels. This includes activities that empower individuals to better manage their own health and that stimulate the ability of communities to become active partners in health sector priority-setting, management, evaluation, and regulation. It means that individual and collective actions, incorporating public, private and civil society actors, should be designed to promote healthy environments and lifestyles.

The structures and functions of a PHC-based health system require optimal organization and management. This includes a sound legal, policy, and institutional framework that identifies and empowers the actions, actors, procedures, and legal and financial systems that allow PHC to perform its specified functions. It is linked to the stewardship function of the health system, and must therefore be transparent, subject to social control, and free from corruption. In terms of operations, PHC-led health systems require good management practices that allow innovation to constantly improve the organization and delivery of care that meets quality standards, provides satisfying workplaces for health workers, and is responsive to citizens. Valuable management practices include, but are not limited to, strategic planning, operations research, and performance evaluation. Health professionals and managers should regularly collect and use data to aid in decision making and planning.

Health systems based on PHC develop pro-equity policies and programs to ameliorate the negative effects of social inequalities on health, to address the underlying factors that cause inequities, and ensure that all people are treated with dignity and respect. Examples include, but are not limited to: incorporating explicit equity criteria in program and policy proposals and evaluations; increasing or improving provision of health services to those in greatest need; restructuring health financing mechanisms to aid the disadvantaged; developing programs to aid the poor in obtaining basic needs; and working across sectors to alter broader social and economic structures that influence the more distal determinants of health inequities.

First contact care means that primary care should serve as the main entry point to the health and social service system for all new health problems and the place where the majority of them are resolved. It is through this function that primary care reinforces the foundation of the PHC-based health system, representing, in most cases, the main interface between the health and social service system and the population. Thus, a PHC-based

health system strengthens primary care in its role as the first level of care, but has additional structural and functional elements that go significantly beyond the first level of the health care system.

Appropriate human resources, include providers, community workers, managers, and support staff with the right knowledge and skills mix, which observe ethical standards and treat all people with dignity and respect. This requires strategic planning and long-term investments in training, employment, retention, and upgrading and enhancing existing health worker skills and knowledge. Multidisciplinary teams are essential and require not only the right mix of professionals, but also delineation of roles and responsibilities, their geographic distribution, and training to maximize the contribution of team work to health outcomes, health worker and user satisfaction.

A PHC-based health system must be based on planning that provides adequate and sustainable resources that are appropriate to health needs. Resources should be determined by health situation analyses based on community-level data and include inputs (e.g. facilities, personnel, equipment, supplies, and pharmaceuticals) as well as operating budgets necessary to provide comprehensive, high quality preventive and curative care. Although the amount of resources required will vary among and within countries, resource levels must be sufficient to achieve universal coverage and accessibility. Because achieving a PHC-based health system requires political will and commitment over time, there must be explicit mechanisms to guarantee the sustainability of PHC efforts that allow decision-makers to invest today in order to meet the needs of tomorrow—even in times of political, economic, or social change.

Health systems based on PHC are wider in scope and impact than the mere provision of health services. A PHC-led system is intimately connected to intersectorial actions and community approaches to promote health and human development. These actions are required in order to address the fundamental determinants of population health by creating synergistic links with other sectors and actors. They require close links between public, private and non-government areas both within and outside health services whose actions have an impact on health or its determinants and include: employment and labor, education, housing, food production and distribution, environment, water and sanitation, social care, and others. The extent to which these actions are implemented by the health sector alone or in partnership with other actors will depend on the characteristics of that country's (and community's) development status as well as the comparative advantage of each actor or sector involved. See box 2.

Box 2: PHC-Based-Health Systems and Human Development

PHC-based health systems create synergistic links with other sectors in order to help drive the process of human development. PHC has a strong (but not exclusive) role, in conjunction with other sectors and actors devoted to promoting sustainable and equitable human development. Making this distinction is important because it allows for the establishment of clear responsibilities among different sectors regarding their contribution to the goal of socioeconomic development; failure to make this distinction could leave health systems to take over the responsibilities of other sectors, with several undesirable consequences. Chief among these are the potential neglect of core functions of the health system; poor implementation of expanded developmental functions due to lack of specialization (e.g. literacy, income generation, housing, etc.); and creation of disputes among responsible actors and agencies (turf wars), resulting in redundancies, wasted energy and resources, and potential damage to the health and overall welfare of the population.

D. What are the Benefits of a PHC-Based Health System?

There is considerable evidence of the benefits of PHC. International studies show that, all else equal, countries with health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient, have lower healthcare costs, and achieve higher user satisfaction than those whose health systems have only a weak PHC orientation.⁴⁶⁻⁵¹

Health systems based on PHC are thought to be able to improve equity because the PHC approach is less costly to individuals and more cost-effective to society when compared to specialty-oriented care.⁵² A strong PHC approach has been shown to assure greater efficiency of services in the form of time saved in consultation, reduced use of laboratory tests, and reduced health care expenditures.^{53,54} PHC can thus free up resources to attend to the health needs of the most disadvantaged.^{50,55,56} Equity-oriented health systems capitalize on these savings by establishing goals for improved coverage in the poor and empowering vulnerable groups to have a more central role in health system design and operation.⁵⁷ They minimize out-of-pocket expenses since these are the most inequitable means of financing health services and instead emphasize universal coverage to remove socioeconomic factors as a barrier to receiving needed care.⁵⁸⁻⁶⁰

Evidence, particularly from European countries, suggests that health systems based on PHC can also enhance efficiency and effectiveness. Studies of hospitalizations for “ambulatory care sensitive conditions”—conditions treated in hospitals which could have been resolved in primary care—and use of emergency rooms for routine care show how PHC systems that assure access and first contact can improve health outcomes and benefit other levels of the health system.⁶¹⁻⁶⁵ Strengthening the PHC base of health systems has been found to reduce overall rates of hospitalization for conditions such as angina, pneumonia, urinary tract infections, chronic pulmonary obstructive disease, cardiac arrest, and ear, nose and throat infections, among others.⁶⁶ Individuals who have a regular source of primary care over time for most of their health care needs have improved satisfaction, better compliance, fewer hospitalizations and less emergency room use than those who do not.⁶⁷⁻⁶⁹

In the region of the Americas, the experiences of Costa Rica show that comprehensive PHC reform (including increasing access, re-organizing health professionals into multidisciplinary teams, and improving comprehensive and integrated care by assigning a specific geographic area to each PHC team) can improve health outcomes. For every five additional years after PHC reform, child mortality was reduced by 13 percent, and adult mortality was reduced by four percent, independent of improvements in other health determinants.⁷⁰ Because the reforms took place first in the most deprived areas (insufficient access to PHC services declined by 15 percent in reformed districts), they contributed to improvements in equity.⁷¹

Evidence has shown that for PHC to benefit population health, services must also be of good technical quality—an area that requires considerable additional attention throughout the region.^{72,73} Finally, more is needed on the evaluation of health systems in general, and PHC in particular.⁷⁴ A commitment to PHC-based health systems will require a more complete evidence base, with appropriate investments made in the evaluation and documentation of experiences (in the Americas and beyond) that allow for development, transfer, and adaptation of best practices.

III. The Way Forward

An approach to renewing PHC will include:

- *Completing PHC implementation where it has failed* (the unfinished health agenda) by: guaranteeing all citizens the right to health and universal access; actively promoting equity in health; and promoting absolute improvements in, as well as better distribution of, health and quality of life indicators;
- *Strengthening PHC to address new challenges* by: improving citizen and community satisfaction with services and providers; improving the quality of care and management; and strengthening the policy environment and institutional structure necessary for the successful fulfillment of all functions of the health system; and
- *Locating PHC in the broader agenda of equity and human development* by: linking PHC renewal with efforts (such as the Millennium Declaration) to strengthen health systems, promoting sustainable improvements in community participation and intersectorial collaboration, and investing in human resource development.

This will necessitate learning from past experience (both positive and negative), developing a strategy for advocacy and articulating the expected roles and responsibilities of countries, international organizations, and civil society groups involved in the renewal process.

A. Learning from Experience

In order to craft a strategy for renewing PHC it is important to learn from past experiences. The country consultative processes and literature reviews were fundamental in assessing the barriers and facilitating factors for successful PHC implementation in the region. Appendix D summarizes these findings in greater detail.

Factors perceived to have been barriers to effective PHC implementation include the difficulties inherent in transforming the health sector from curative, hospital-based approaches to preventive, community-based ones. Constraints included the segmentation and fragmentation of health systems, lack of political commitment; inadequate coordination among communities and local, national, and international agencies (including adjustment policies and emphasis on vertical programs); inadequate use of local data; and poor intersectorial collaboration. The economic climate was also a factor due to changing economic and political ideologies and the volatility of macroeconomic conditions that led to underinvestment in health systems and services.^{11,33,75,76} Investment in human resources was emphasized as an essential area requiring attention, since the quality of health services depends to a great extent on the people who work in them. Health personnel must be trained in both a technical and humanistic perspective; their performance depends not only on their training and abilities, but also on their working environment and on appropriate incentive policies at both the local and global levels.^{73,77} See box 3.

Factors found to have facilitated the effective development of PHC implementation include recognizing that health sector leadership is affected by many factors-some of which are outside the direct control of the health sector itself. Improvements in equity also seem to require sustained political commitment at the national level, including making provisions to ensure that health funding is sufficient to meet population needs.⁷⁸ Successful PHC experiences have demonstrated that simply increasing the number of health centers and providing short-term training of personnel is insufficient to improve health and equity. Instead, system-wide approaches are needed. Reorienting health systems towards PHC has required the adjustment of health services towards prevention and promotion - achieved by assigning appropriate functions to each level of government, integrating public and personal health services, focusing on families and communities, and creating an institutional framework with

incentives to improve the quality of services. Successful PHC services encourage participation, are accountable, have an appropriate level of investment to guarantee adequate services are available, and that these services are accessible, regardless of a person's ability to pay.^{24 11}

Box 3: Human Resource Challenges in the Americas

Current challenges:

- Health professionals are poorly motivated and poorly compensated compared to other professionals
- There are insufficient numbers of qualified health workers to provide universal coverage
- Teamwork is poorly developed or insufficiently fostered
- Qualified professionals prefer to work in hospitals and in cities
- There is a lack of adequate support and supervision
- Pre- & post-graduate training of health personnel is not aligned to the requirements of PHC practice
- International migration of health workers (brain drain)

Human resources implications of designing a health system based on PHC

- Universal coverage will require an important volume of professionals trained in primary care
- Human resources must be planned according to population needs
- Human resources training must be linked to health needs and made sustainable
- Quality policies on personnel performance must be implemented
- Human capacities (both profiles and competencies) must be characterized and each worker profile adjusted to a specific job
- Mechanisms for continuous evaluation are required to enable health workers to adapt to new scenarios and address changing population needs
- Policies must support a multidisciplinary approach to comprehensive care
- The definition of health workers must be expanded to include not only clinicians but also those working in information systems, management, and administration of services

Sources:^{29,79,80}

B. Building Coalitions for Change

Health reforms involve fundamental changes in political processes and power, so advocates of PHC-based health systems will need to pay attention to both the political and technical dimensions of reforms, as well as to the actors involved in these processes. At the Alma Ata conference in 1978, Halfdan Mahler asked participants: "Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of PHC?"^{81,33} Such a question needs to be asked again today, for considerable resources must be put into implementing the vision of health systems based on a renewed approach to PHC.

Supporters of the effort include those who currently work in or on PHC. These include some nongovernmental organizations, health providers who work in primary care settings, professional associations that support PHC (such as those of family medicine and nursing associations), some governments that have supported the development of a comprehensive PHC approach, many public health associations, and some universities and other academic leaders in PHC. Each of them has an interest in seeing PHC gain increased support, and each of them is in a position to actively advocate for change and to implement at the least the technical aspects of the PHC renewal. Unfortunately, most natural PHC supporters are not in a position of great political power and usually have limited financial resources.

Opponents are likely to be those who would see the renewal of PHC as a threat to a status quo that they wish to maintain. Experience has shown that the main opponents to strengthening PHC are likely to be specialist physicians and their associations, hospitals (particularly for-profit ones), the pharmaceutical industry, and some advocacy organizations. These parties are among the most powerful in terms of resources and political capital in most countries, and their interests are often aligned in opposition to serious health reform efforts.

Both supporters and opponents of PHC renewal are outnumbered, however, by the many actors, organizations, and agencies that are likely to be neutral on the issue. These include many multilateral and bilateral agencies, many payers of health services (such as health insurance companies, social security agencies, ministries of health), and most private citizens. Taken together, this neutral group has considerable political and economic clout; however, taken as individuals, their interests often do not coincide. More often they are dispersed and can even be at odds with one another over different issues. Thus, the key for advocates of PHC renewal will be to find an aspect of this renewal effort that will appeal to many of these actors and groups, and mobilize them to ally themselves with PHC supporters.

There are several stages for managing the process of PHC renewal. The first is to work to change the perception of the problem and solutions among all interested parties. PHC renewal must be framed in terms of its overall goals - a more efficient and effective health system, improved health and equity, enhanced human development and its contribution to sustainable economic growth - and explicitly to the achievement of those goals. PAHO's on-going regional consultation process and the country-level consultations have already begun to sensitize interested parties to the importance of renewing PHC.

The next stage is to create new supporters. One method for creating new supporters is to emphasize that the Millennium Declaration and PHC are complementary strategies. PHC is an essential approach to the achievement of the Millennium Development Goals, since it advocates viewing the health system as a social institution that reflects societal values and provides the means to operationalize the right to the highest attainable level of health.³⁷ As PHC strives to re-align health sector priorities, the Millennium Declaration can provide the framework for broad-based development that will both accelerate health improvements and itself be bolstered by good health sector performance.

Focusing on specific actors, funding organizations such as multilateral/bilateral financial and development agencies, institutions, and foundations will need to be convinced that PHC renewal will strengthen the impact and sustainability of their objectives, such as attainment of the 3x5 initiative, realization of the goals of the Global Fund, ensuring more equitable social development, and other international health and development efforts. Advocates of PHC renewal must make the argument that investments in the health sector are crucial in order to create the conditions necessary for broad-based, equitable human development, and that a PHC-based health system provides the foundation for a sustainable and responsive "integrated delivery system" necessary for achieving other objectives such as the WHO 3x5 initiative, the activities of the Global Fund, and others.⁸²

Similarly, PHC advocates will need to convince those of who pay for health services--health insurers, social security agencies, and ministries of health--that a health system based on PHC will, in the end, be worth the investment. The elements of this argument are present, but need to be packaged into an effective communications and advocacy strategy, making sure that evidence on the effectiveness and efficiency of PHC, and the potential it holds for long-term cost savings, is highlighted.

In addition, it will be essential to advocate the adoption of a PHC-based health system to those who will be using it. Citizens across the globe are demanding health services and systems that are effective, of good quality, and accountable; educating them about the benefits of a PHC-based system will empower them to demand specific commitments from their governments. Thus, evidence on the effectiveness of PHC needs to be made available in ways that community members can analyze and discuss, and PHC advocates must solicit citizen opinions about which aspects of PHC they find most important or compelling.

At the same time, PHC advocates must work to strengthen the position of PHC supporters. This will involve development of coalitions and networks, and dissemination of evidence and best practices. Today there is a

unique opportunity to build an international coalition of individuals and organizations dedicated to renewing PHC. This coincides with increased attention given to the issue of equity, the role of the international community in fostering health as a global public good, and increased dissatisfaction with the status quo.⁸³ Advocates for PHC renewal will need access to the evidence base on the benefits of a health system based on PHC. Lessons learned must be disseminated to interested parties, advocates, and change agents at all levels.

Finally, once a critical mass of supporters has been established, and the arguments for PHC renewal have been developed at local level, it may be appropriate to negotiate with those who disagree. The objective should be to identify points of agreement and disagreement, find potential areas where further agreement is possible via compromise, and isolate and narrow the areas that are non-negotiable.

There is a renewed interest in PHC throughout the world. Organizations as distinct as the World Bank, advocacy organizations, the private sector, and WHO have all recognized that strengthening health systems is a prerequisite to improving economic growth, advancing social equity, improving health, and providing treatments to combat HIV/AIDS. Our job is to convince these actors that PHC is the logical and appropriate locus for collaboration, investment, and action. The time for action is now.

C. Strategic Lines of Action

The main objective of the proposed lines of action is to develop or further strengthen PHC-based health systems throughout the Region of the Americas. This will require concerted efforts from health professionals, citizens, government, civil society, multilateral and bilateral agencies, and others.

Given the diversity among countries in the region, the timeline for completing these recommended actions is understood to be flexible and adaptable to different situations and contexts. In general, the estimated time to accomplish these objectives is 10 years. The first two years will prioritize conducting situation analyses and diagnostics, with the remaining years dedicated to specific lines of action specified below.

At the country level (national territory of each country)

Member states, represented by their governments should:

1. Lead and develop the process of PHC renewal with the ultimate goal of improving population health and equity
2. Conduct an assessment of the country's situation and develop an action plan for the implementation of a PHC-based health system within a period of 10 years.
3. Develop a communications plan to disseminate the idea of PHC-based health systems
4. Encourage community participation at all levels of the health system
5. Conduct an analysis of interested parties, and explore policy options and strategies that can lead to the full realization of a PHC-based health system.
6. Ensure that the availability and sustainability of financial, physical, and technological resources for PHC.
7. Guarantee the development of human resources required for successfully implementing PHC, incorporating multidisciplinary teams
8. Create the mechanisms necessary for strengthening intersectorial collaboration and the development of networks and partnerships.
9. Aid in the harmonization and realignment of international cooperation strategies so they are more directed towards the needs of the country.

At the sub-regional level (Andean Region, Central America, Latin Caribbean, Non-Latin Caribbean, North America and Southern Cone)

Subregional groups, under the leadership of PAHO/WHO should:

1. Coordinate and facilitate the process of PHC renewal.
2. Develop a strategy for communication and advocacy to advance the concept of PHC-based health systems.

3. Conduct an analysis of interested parties, and explore policy options and strategies that can lead to the full realization of a PHC-based health system in the subregion.
4. Support PAHO/WHO and other international cooperation agencies in mobilizing resources in support of PHC initiatives at the sub-regional level.

At the regional level (region of the Americas)

PAHO/WHO, OAS, and the regional offices of international cooperation agencies should:

1. Coordinate and facilitate the process of PHC renewal
2. Conduct a stakeholder analysis and explore options and strategies to advance PHC in the region
3. Promote the development of regional networks, alliances and collaborating centers in support of PHC, as well as the exchange of experiences within and among countries.
4. Lead efforts in mobilizing and sustaining resources in support of PHC initiatives at the regional level.
5. Develop a methodology and indicators to monitor and evaluate the progress made by the countries and the region as a whole in the implementation of PHC-based health systems.
6. Evaluate different health systems based on PHC and identify and disseminate information on best practices with a view to improving its application.
7. Continue to assist countries in improving the training of health workers, including policy makers and managers, in the priority areas of PHC.
8. Take the core values, principles and elements of PHC into account in the activities of all technical cooperation programs.
9. Contribute to the harmonization and realignment of international cooperation strategies so they are more directed towards the needs of the region.

At the global level (worldwide)

PAHO, supported by WHO and the headquarters of international cooperation agencies should:

1. Disseminate worldwide the concept of PHC-based health systems as a key strategy for the attainment of the MDGs and for effectively addressing the major determinants of health.
2. Evaluate the global situation in regard to PHC implementation including stakeholder analysis and explore options and strategies for strengthening the approach.
3. Promote the development of global networks, alliances and collaborating centers in support of PHC, as well as the exchange of experiences within and among countries.
4. Establish a working group to study and propose a conceptual framework establishing the links and relationships between PHC and other strategies/approaches such as health promotion, public health and addressing social determinants in health.
5. Determine the appropriate role of PHC in response to epidemics, pandemics, disasters, and major crises.

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The views expressed in this document may not necessarily represent the individual opinions of the individuals mentioned here or their affiliated institutions.

Appendix A: Methods

This document takes as its starting point the results of the first meeting of the PHC working group, which convened in Washington, D.C., in June 2004. In its various draft forms it served as an input to subsequent meetings and discussion. It is a work in progress that continues to benefit from constructive criticism and dialogue.

The Working Group on PHC (WG) was created on May 13, 2004, in accordance with PAHO/WHO Resolution CD44.R6 calling on Member States to adopt a series of recommendations to strengthen PHC. The plenary sessions of the WG were held in Washington (June 28-30, 2004) and in San José de Costa Rica (October 25-29, 2004). The objectives of the WG are to: 1) examine and re-affirm the conceptual dimensions of PHC as contained in the Alma Ata Declaration; 2) develop operational definitions of concepts relevant to PHC; 3) provide guidance to countries and PAHO/WHO on how to reorient the region's health systems and services following the principles of PHC; 4) draft a new regional declaration on PHC that reflects current realities in health services systems and the need for assessment of PHC attainment and progress; and 4) organize and carry out a regional consultation with relevant stakeholders in order to legitimize the above processes.

This process resulted in several documents² that were presented and discussed both through virtual forums and in the plenary sessions of the Costa Rica Meeting. The WG process benefited from field visits to Costa Rica where WG members consulted with local experts on their views and experiences on PHC and efforts to improve equity in PHC, in order to learn from Costa Rica's experiences.

In order to review the evidence base for PHC, we conducted a systematic review of the literature, including peer-reviewed journal articles; international organization and official government publications and working documents; statements and policy recommendations from international meetings and advocacy groups; and reports of field experiences from a variety of international, government, and non-governmental organizations. The results of this review are presented in the annotated bibliography prepared as part of the Working Group³.

In May 2005, the draft position paper was sent to countries with suggestions for the conduct of the national consultation process on PHC and specific guidelines for the analysis of the position paper. Twenty national consultations took place between May and July 2005 (See box 4). At a country level, the position paper was reviewed by representatives of ministries, academia, NGOs, professional associations, health service providers, decision makers, consumers and other social sectors. After the national discussions, the results of each country were sent back to PAHO headquarters, where they were analyzed and suggestions were integrated into the final version of the document.

The drafts of the position paper, regional declaration, and strategic lines of action were discussed in a regional consultation held in Montevideo, Uruguay on July 26-29 2005. The consultation brought together nearly 100 individuals representing more than 30 countries in the Region, nongovernmental organizations, professional associations, universities, and UN agencies.

The current position paper and regional declaration reflect the recommendations made through these consultative processes.

² Revisión y actualización de los principios de APS. Dr Javier Torres Goitia and Group 1; Desarrollo de un nuevo marco conceptual y analítico de APS. Dr Sarah Escorel and Group 2; Integración de los enfoques Horizontal y vertical en la Atención Primaria en Salud. Dr Rodrigo Soto and Group 3; Consulta regional. Términos de referencia. Dr Enrique Tanoni, Dr Juan Manuel Sotelo and Group 4.

³ *Annotated Bibliography on Primary Health Care*. 2005. Prepared by J. Macinko & F. Guanais. Washington, DC: Pan American Health Organization.

Box 4: National Consultations on Renewing PHC

Country	Date
Argentina	May 20 to June 10
Bolivia	June (virtual)
Brazil	June 7
Chile	June 11
Colombia	May 25 to 28
Costa Rica	June 10
Cuba	June 13
Dominican Republic	June 27-30
Ecuador	July 14
El Salvador	June 15th
Guatemala	June 2 and 9
Guyana	May 12
Jamaica	May 5
Mexico	July 1
Nicaragua	June 21 and 23
Panama	July 8
Paraguay	June 2
Peru	July 14 and 15
Suriname	June 30
Venezuela	July 14 and 20

Appendix B: Glossary and working definitions⁴

Acceptability: Degree to which a service is consistent with the cultural needs, values, and standards of a community.⁸⁴

Accessibility: The absence of geographic, financial, organizational, socio-cultural, gender, and/or structural barriers to participation in the health system and/or receiving health and other social services; it is a determinant of whether people can obtain needed services.⁴⁵

Accountability: Accountability is the process of holding actors responsible for their actions.⁸⁵ For governments it includes the obligation to provide for and to disclose periodically, in adequate detail and consistent form, to all directly and indirectly responsible or properly interested parties, the purposes, principles, procedures, relationships, results, incomes, and expenditures so that they can be evaluated by the interested parties.⁸⁴ It includes the necessity of transparency in the degree of achievement of health in the population and adequacy of mechanisms to achieve it.

Active participation mechanisms: Mechanisms (appropriate to the community in question) designed to achieve accountability and representation of community interests at the local and national levels.

Appropriate and effective care: Application of measures, technologies, and resources that are qualitatively and quantitatively sufficient for achieving the desired goal. Requires that an expected health benefit exceed the expected negative consequences by a large enough margin to justify performing the procedure rather than other alternatives. Effectiveness implies that the approaches to improving health have the intended impacts at the population level.

Appropriate human resources: Human resources that have the right competencies (knowledge and skills), skills mix, and geographic distribution to support PHC. This often implies the availability of a variety of health professionals (e.g. medical practitioners, nurses, pharmacists, physiotherapists, social workers, case managers, community-based providers) associated with health promotion, prevention, treatment and on-going care of individuals, families, and communities.⁸⁶

Community Oriented Primary Care: is a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services.⁸⁷

Comprehensive care: The extent to which all essential services needed to provide for all but uncommon population health needs are offered within PHC; those services not available are provided through the referral and coordination component of PHC (see: coordination). This implies the provision of integrated health promotion, disease prevention, curative care, rehabilitation, and physical, psychological and social support that serves to address the majority of the health problems in a given populations.⁸⁸

Coordination: The extent to which PHC facilitates access and integration of other kinds of care and healthcare of increasing complexity when they are not available at the local PHC level. It is the degree to which the care needed by a person is coordinated among practitioners and across organizations and time.⁸⁹ Refers to the connection between and rational ordering of services, including community resources.⁹⁰

Element: a component part or quality, often one that is basic or essential.

Emphasis on promotion and prevention: Care is provided at the earliest possible point of intervention in the chain between risks and health problems and their sequelae. It is implemented both at the individual and the community levels. At the individual level it includes health education and promotion to increase people's capacity for prevention and self-care. At the community level, PHC coordinates with other sectors to implement primary and primordial prevention activities (see prevention and intersectoriality).

Equity in health: The absence of systematic differences in one or more aspects of health (or its determinants) across socially, demographically, or geographically defined groups.⁹¹

⁴ Note that these are working definitions and are subject to clarification resulting from debate, new research findings, or other considered opinions. We encourage suggestions as to how to improve and further operationalize these concepts.

Equity in health services: The absence of differences in access to health services for equal health needs (horizontal equity) and enhanced access or other resources for socially, demographically, or geographically defined population groups with greater health needs (vertical equity).⁹²

Essential public health functions: Include: i) Monitoring, evaluation, and analysis of health status; ii) Public health surveillance, research, and control of risks and threats to public health; iii) Health promotion; iv) Social participation in health; v) Development of policies and institutional capacity for planning and management in public health; vi) Strengthening of institutional capacity for regulation and enforcement in public health; vii) Evaluation and promotion of equitable access to necessary health services; human resources development and training in public health; ix) Quality assurance in personal and population-based health services; x) Research in public health; and xi) Reducing the impact of emergencies and disasters on health.⁹³

Family and community focus: The extent to which PHC considers people within the wider context of their family environment. Health and social services that meet population needs, based on local data and delivered within the social and cultural context of the individual's family or other relevant social context.⁹⁴ Practices must address the health problems of individuals in the context of their family circumstances, their social and cultural networks, and the circumstances in which they live and work.⁹⁵ This implies an active understanding of the circumstances and facts of a person's life, such as one's living conditions, family dynamics and health problems, work situation, and cultural background.⁹⁰

Financial sustainability: The degree to which the available financial resources cover the costs of the health system and its functions in the medium and long term, taking into account projected future expenses, and insulated from political, social, or economic changes.

First-contact: The extent to which primary care serves as a place where health problems are first encountered and dealt with (except for emergency care) and from where decisions are made regarding the need for care of other types.

Health: Defined by the WHO as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".⁹⁶ This definition has been criticized as being unrealistic, since under this definition most people would be considered unhealthy. Health has also been defined as a dynamic state, as a form of (or deviation from) homeostasis, and as a continuum with positive and negative poles. At the population level, health can be viewed as a social, economic, and political issue as well as a human right.¹¹ The Ottawa Charter for health promotion defined the prerequisites to health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.⁹⁷

Health promotion: "The process of enabling individuals to increase control over the determinants of health and thereby improve their health... It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed toward action on the determinants or causes of health".⁹⁸ See: prevention.

Health system: The WHO defines the health system as that which "comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health".⁹⁹ A health system can also be characterized according to its main actors: the government or professional body that structures and regulates the system; the population, including patients, who as individuals and households ultimately pay for the health system (through taxes or other mechanisms) and receive services; financing agents, who collect funds and allocate them to providers or purchase services at national or lower levels; community and local organizations (e.g. voluntary organizations, health committees, private initiatives) who aid in organization, logistic support, direct and indirect financing, and (sometimes) service delivery; and the providers of services, who themselves can be categorized in various ways.¹⁰⁰ Health systems can also be characterized by their main functions: stewardship (or oversight); financing (collecting, pooling and purchasing); creating resources (investment and training); and delivering services (provision).⁹⁹

Human Development: "is a process of enlarging people's choices...by expanding human capabilities and functionings. At all levels of development the three essential capabilities for human development are for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living... But the realm of human development goes further: essential areas of choice, highly valued by people, range from political, economic and social opportunities for being creative and productive to enjoying self-respect, empowerment and a sense of belonging to a community."¹⁰¹ The Human Development Index is one way of capturing the level of human development within a given country. It is composed of national levels of health (life expectancy), knowledge (attainment of primary education), and living standards (gross national income per capita).

Integrated care: Combines events and information about events impacting a person's health and occurring in disparate settings, levels of care, and over time throughout the life span.⁹⁰ It is related to longitudinality, which is an orientation of health services towards people (not diseases) over the course of their lives that is often accomplished through a defined catchment area and with integrated health information systems at both family and community levels. Integrated care thus refers both to care provided over time by a single individual or team of health care professionals ("clinician longitudinality") and the effective and timely communication of health information about events, risks, advice, and patient references across a range of health care professionals ("record longitudinality").⁹⁰

Intersectorial actions: Actions (e.g. data collection and analysis, service or information provision) that bring together actors from all sectors that determine population health. The role of the health system in such actions depends on the cause and magnitude of the problem, the available resources, and other collaboration mechanisms.

Intersectoriality: The extent to which PHC is integrated with efforts to address health determinants that lie outside the health sector, such as water and sanitation, housing, education, environment, and coordination of the development and implementation of a wide range of public policies and programs affecting and involving sectors outside health services. This requires close links between public, private and non-government areas both within and outside traditional health services whose actions have an impact on health status and access to health care such as employment, education, housing, food production, water and sanitation, and social care. Intersectorial approaches draw on all societal resources that influence health.

Millennium Development Goals (MDGs): The Millennium Declaration is a framework for countries to work together and improve their development; it recognizes freedom, equality, solidarity, tolerance, respect for nature, and shared responsibility as essential values for international relations in the 21st century.¹⁰² The Millennium Development Goals were developed in order to guide efforts to reach the agreements set out in the Millennium Declaration. These goals include: eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria, and other diseases; ensuring environmental sustainability; and developing a global partnership for development.

Optimal organization & management: Includes the ability to look ahead and anticipate the future (strategic planning), adapt to change (manage change), and constantly monitor and evaluate the performance of the system (evaluate impact of changes, i.e., performance-based evaluation). Includes the use of criteria to allocate resources (e.g. equity, cost-effectiveness, appropriateness) and choose optimal strategies for achieving health gains with equity. Requires a sound legal, policy and institutional framework that defines the actions, actors, procedures, legal, and financial systems necessary to allow PHC to perform its specified functions, link with other parts of the health system, and work across sectors to address health determinants.

Participation: Individual participation is the degree to which a person participates and shares decision-making regarding his or her own care. A similar concept is "Self-care" or provision of information to members to allow them to provide care for themselves or to better evaluate when they need to seek care for a professional.¹⁰³ Social participation is the right and capacity of the population to participate effectively and responsibly in health care decisions and their implementation. Social participation in health is one facet of general civic participation, a condition for exercising freedom, for democracy, for social control over public action, and for equity.⁹³

Population-based: As opposed to an individual or clinical approach, a population-based approach uses population-level data to make decisions about health planning, management, and priority-setting. It is an approach to improve the effectiveness and equity of interventions and to achieve better health and better distribution of health throughout the population. It does so in the context of the culture, health situation, and health needs of the geographic, demographic, or cultural group to which the population belongs.

Prevention: Prevention traditionally focuses on three levels: *primary prevention* fights against illness before exposures take place; *secondary prevention* fights illness once it has already appeared; and *tertiary prevention* occurs when illness has already run its course.¹⁰⁴ To this typology has been added the notion of "*primordial prevention*", which deals with modifying the underlying conditions that lead to exposure in the first place.¹⁰⁵ Primordial prevention incorporates approaches that create health and modify the conditions "that generate and structure the unequal distribution of health damaging exposures, susceptibilities and health protective resources among the population".¹⁰⁶

Primary care: The level of a health system "that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others."⁵⁶ The term is thought to date to about 1920, when the *Dawson Report* was released in the United Kingdom. That report mentioned

“primary care centres”, which were proposed to be the hub of regionalized services in that country.⁵⁶ Another term, “Community Oriented Primary Care” or COPC originated in the 1940s in South Africa. The COPC approach continues today and is viewed, among others, as an important precursor to the Alma Ata conception of PHC.¹⁰⁷

Primary health care (PHC): In 1978, the Alma Ata Declaration defined PHC as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain... It forms an integral part of the country’s health system...and of the social and economic development of the community. It is the first level of contact on individuals, the family and community...bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”²⁷

Primary health care-based health system: an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness, quality orientation, government accountability, social justice, sustainability, participation, and intersectorality. A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action. A PHC-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal management practices at all levels to achieve quality, efficiency, and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system develops intersectoral actions to address other determinants of health and equity.

Principle: A fundamental truth, law, doctrine, or motivating force, upon which others are based.

Pro-equity policies and programs: Proactive and systematic efforts to reduce unfair health inequalities and/or unfair inequalities in access to health services.

Quality-oriented: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.¹⁰⁸ The main pillars of quality are: effectiveness; efficiency; optimality (balancing health costs against the effects of care); acceptability; legitimacy; and equity;⁴¹ It is composed of both technical quality and user satisfaction with services.

Relevance: represents the degree to which common needs of the entire population and the specific needs of a particular population are met, as well as the degree to which appropriate services are being applied to meet these needs, based on objective evidence. It is a measure by which priorities have been set, accepting that the most important problems must be tackled first.⁹⁹

Resources appropriate to needs: Resources should be sufficient to cover population health needs (prevention, promotion, curative, rehabilitative, intersectoral actions), including resources needed to raise the health status of the most disadvantaged at an equal or faster rate than the general population. At the local level this requires adequate facilities, staff, supplies, and operating budgets.

Responsiveness to population health needs: Care required to achieve population health and equity commensurate with the best level possible at a given level of knowledge and social development.⁸⁶ It is care focused on people rather than on specific organs or symptoms. It the raising of “person-centered” care to the population level and considers the physical, mental, emotional and social dimensions of a person.⁹⁰ It is also defined as care with the following features: whole-person focus; practitioner has knowledge of the person; caring and empathy; trust in health practitioners; appropriately adapted care; and shared medical decision-making.¹⁰⁹

Right to the highest attainable level of health: The Constitution of the World Health Organization and international human rights treaties recognize the right to the “highest attainable standard” of health. Such a right emphasizes the link of health status to issues of dignity, non-discrimination, justice, and participation.³⁹ Rights encompass both freedoms (e.g. freedom to control one’s own reproductive decisions, freedom from torture) and entitlements (e.g. a citizen is entitled to necessary healthcare and healthy living conditions).¹¹⁰ A rights-based approach requires obligations and accountability on the part of responsible agents (e.g. governments) to ensure that citizens may exercise their health claims. These rights also imply ethical conduct and responsibility on the part of health services providers, researchers, and policy-makers. Some international agreements define citizens’ rights as including: the right to freedom from conditions that impinge on achieving the maximum level of health attainable; entitlements such as the right to healthcare and healthy living and working conditions; and expectations in terms of standards of ethical conduct in service provision and in research. Obligations of the state include: obligations to respect (refrain from interfering with the enjoyment of good health), to protect (states must take measures to

prevent third parties from interfering in citizen's health and its attainment), and fulfill (states must adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to meet the full realization of these rights).¹¹¹

Social Justice: is an ethical concept largely based on social contract theories. Most variations on the concept hold that as governments are instituted among populations for the benefit of members of those populations, those governments which fail to see to the welfare of their citizens are failing to uphold their part in the social contract and are, therefore, unjust. The concept usually includes, but is not limited to, upholding human rights and is also used to refer to the overall fairness of a society in its divisions and distributions of rewards and burdens.¹¹²

Solidarity: Solidarity is considered a union of interests, purposes, or sympathies among members of a society to create conditions necessary to improve social conditions. It is exercised through active participation both individually and through organized efforts with others. Solidarity implies working together to achieve goals that could not be achieved individually. This occurs by forging common interests through intense and frequent interaction among group members.¹¹³ It is characterized by the motive of promoting group goals in their own right. For some, an adequate level of social solidarity is essential to human survival.¹¹⁴

Sustainability: The capacity to meet the needs of the present without compromising the ability to meet future needs.⁸⁴

Universal coverage: Financing and organizational arrangements to cover the entire population, removing ability to pay as a barrier to accessing health services and providing financial protection over time.

Value: the social goals or standards held or accepted by an individual, class, or society.

Appendix C: Some PHC Milestones in the Americas, 1900-2005

Year	Global Events	Events in the Americas
1900-1950s	The UN Conference held in San Francisco unanimously agreed to establish an autonomous new international health organization (1945) Development of the Community Oriented Primary Care approach in South Africa and in the USA.	International Sanitary Bureau established (1902) Life expectancy: 55,2 years (1950-1955)
1960s	The Christian Medical Commission was created by medical missionaries working in developing countries. They emphasized the training of village health workers.	Rapid increase in the training of health professionals and investment in health infrastructure throughout the Americas.
1970s	Expansion of the "barefoot doctors" program in China The journal <i>Contact</i> used the term "Primary Health Care" probably for the first time. Basic needs are prioritized: food, housing, water, supplies, medical services, education and employment. Halfdan Mahler is elected the WHO's director general. He effectively supported the community work (1973). First population Conference (1974) 28 th World Health Assembly to prioritize the construction of National Programs in PHC (1975) International Conference of Alma Ata (1978) Eradication of smallpox (1979) Selective Primary Health Care (1979)	The Canadian Lalonde Report develops the idea of "non-medical" determinants of health (1974) Community workers poorly trained Development of regional health goals Small-scale community-oriented primary care projects in Venezuela, Central America, and elsewhere Life expectancy: 66 years (1978)
1980s	Health for All WHO begins program to combat HIV/AIDS Expansion of selective PHC and vertical programs Population Conference (Mexico, 1983)	Development of Regional Action Plan Economic depression Public services deteriorate Democratic governments start running in some countries Donor dependency Local health systems approach (SILOS) Renewed community participation Vaccination coverage for measles: 48% Incidence of measles: 408/1,000,000
1990s	Sustainable development Human development concept World Bank points out the necessity of fighting against poverty and investing in health Health Sector Reform promotes a basic health services package Changing role of the state Children's Summit (New York, 1990) Earth Summit (Rio, 1992) Conference on Population and Reproductive Health (Cairo, 1994)	Cholera epidemic Progressive deterioration of life conditions, social and physical environment Some health reforms strengthen PHC (e.g. Cuba, Costa Rica) Health ministries become stronger PIAS (Environment and Health Investment Plan) End to civil wars in Central America Elimination of Polio in the Americas (1994) Life expectancy: 72.0 (1996)
2000s	Commission on Macroeconomics and Health Expansion of HIV/AIDS pandemic Establishment of the Global Fund for AIDS, Malaria, and Tuberculosis Focus on equity in health Health as a global public health good Millennium Development Goals (MDGs) Commission on the Social Determinants of Health	Vaccination coverage for measles: 93% Incidence of measles: 2 per 1,000,000 Life expectancy: 72,9 years (1995-2000)

Sources: 33,79,115-118

Appendix D: Facilitators and Barriers to Effective PHC Implementation in the Americas

Area	Barriers	Facilitating Factors
Vision/approach to Health	<ul style="list-style-type: none"> • Fragmented vision of health and development concepts • Indifference toward the determinants of health • Lack of a preventive and self-care approach • Excessive focus on curative and specialized care • Insufficient operationalization of PHC concepts • Different interpretations of PHC 	<ul style="list-style-type: none"> • Integrated approach to health and its determinants • Community health promotion • Promotion of individual, family, and community self-responsibility • Need to clarify roles of public health, PHC, health promotion, human development
Segmented and fragmented health systems	<ul style="list-style-type: none"> • Health reforms that have segmented and divided people • Division between public, social security, and private sector • Lack of coordination and referral systems • Deficient regulatory capacity 	<ul style="list-style-type: none"> • Universal coverage as part of social inclusion • Services are based on population needs • Coordination functions at every level • Care is based on evidence and quality
Leadership and management	<ul style="list-style-type: none"> • Lack of political commitment • Excessive centralization of planning and management • Weak leadership and lack of credibility before citizens • Mobilization of interests opposed to PHC • Limited community participation and exclusion of other stakeholders 	<ul style="list-style-type: none"> • Regular assessments of performance • Participatory reform processes • Correct identification of sectorial priorities • Neutral platform to raise consensus • Integration of local and global cooperation • Functional and expeditious referral systems
Human resources	<ul style="list-style-type: none"> • Inadequate employment conditions • Competencies poorly developed • Limited interest in operational research and development • Poor use of management and communication techniques • Culture of curative, biomedical approaches 	<ul style="list-style-type: none"> • Emphasis on quality and continuous improvement • Continuous professional education • Development of multidisciplinary teams • Research promotion • Development of managerial abilities
Financing and macroeconomic conditions	<ul style="list-style-type: none"> • Lack of financial and political sustainability for PHC • Public spending concentrated on specialists, hospitals, and high technology • Inadequate budgets devoted to PHC • Globalization pressures and economic instability 	<ul style="list-style-type: none"> • Policies to ensure adequate financing over time • Systems for efficient and equitable resource utilization • Strengthened and integrated health and management information systems • More sound, pro-poor macroeconomic policies
International cooperation strategies	<ul style="list-style-type: none"> • Disease-specific strategies and priorities • Societal values not considered in reform initiatives • Overly time-bound, limited targets that do not reflect needs • Poor continuity of health policies • Excessively vertical and centralized approaches • Absence of legal framework to implement quality policies • Costs transferred to citizens with limited consultation 	<ul style="list-style-type: none"> • PHC reflects social values and population health needs • PHC as a central element of national health policies • Reforms strengthen the steering role of the state • Political and legal frameworks for health reforms • Progressive decentralization policies • Health reforms strengthen rather than weaken health systems

Sources: ^{1,3,11,33,76,119-122} and country reports generated as part of the PHC renewal consultative process.

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Draft “DECLARATION OF THE AMERICAS ON THE RENEWAL OF PRIMARY HEALTH CARE.”

CONSIDERING THAT:

Although the Region of the Americas has made important advances in health and in implementing Primary Health Care (PHC), persistent health challenges and disparities in health remain among and within the countries of the Region. To address this situation States need measurable goals and integrated strategies for social development.

The countries of the Americas have long recognized the need to combat exclusion in health by expanding social protection as a core element of sectoral reforms in Member States (Resolution CSP26.R19). Countries also have acknowledged the contribution and potential of PHC in improving health outcomes with the need to define new strategic and programmatic orientations for the full realization of its potential (Resolution CD44.R6), and have committed to integrate and incorporate the internationally agreed-upon health-related development goals, including those contained in the United Nations Millennium Declaration, into the goals and objectives of the health policies of each country (Resolution CD45.R3).

The Declaration of Alma-Ata continues to be valid in principle; however, rather than implemented as a separate program or objective, its core ideas should be integrated into the health systems of the Region. This will allow countries to address new challenges such as epidemiological and demographic changes, new sociocultural and economic scenarios, emerging infections and/or pandemics, the impact of globalization on health and the increasing health care costs within the particular characteristics of national health systems.

The experience of the last 27 years demonstrates that health systems that adhere to the principles of PHC achieve better health outcomes and increase the efficiency of the health system for both individual and public health care as well as for public and private providers.

A health system based on PHC orients its structures and functions toward the values of equity and social solidarity and the right of every human being to enjoy the highest attainable standard of health without distinction of race, religion, political belief, or economic or social condition. The principles required to sustain such a system are its capacity to respond equitably and efficiently to the health needs of the citizens, including the ability to monitor progress for continuous improvement and renewal; the responsibility and accountability of Governments; sustainability; participation; an orientation toward the highest standards of quality and safety; and intersectoral action.

WE COMMIT TO:

Advocate for the integration of the principles of PHC into country-level health management, organization, financing, and care in a way that contributes, in concert with other sectors, toward comprehensive and equitable human development, addressing effectively, among other challenges, the internationally agreed-upon health-related development goals including those contained in the United Nations Millennium Declaration, and other new and emerging health-related challenges. To this end, each State should, in accordance with its needs and capabilities, prepare an action plan based on the following elements:

I) Commitment to facilitate social inclusion and equity in health.

States should work toward the goal of universal access to high-quality care that leads to the highest attainable level of health. States should identify and work to eliminate organizational, geographic, ethnic, gender, cultural, or economic barriers to access, and to develop specific programs for vulnerable populations.

II) Recognition of the critical roles of both the individual and the community in the development of PHC-based systems.

Local-level participation in the health system by individuals and collectively by communities needs to be strengthened to provide the individual, family, and community a voice in decision-making, strengthen implementation and individual and community action, and effectively support and sustain profamily health policies over time. Member States should make information on health outcomes, health programs, and health center performance available to communities for use in exercising oversight of the health system.

III) Orientation toward health promotion and comprehensive and integrated care.

Health systems centered on individual care, curative approaches, and treatment of disease need to be reoriented toward health promotion, disease prevention, population-based interventions and comprehensive and integrated care. Health care models should be based on effective primary care systems, have a family and community orientation, incorporate the life cycle approach, be gender and culturally sensitive, and work for the establishment of health care networks and social coordination that ensures adequate continuity of care.

IV) Development of intersectoral work.

Health systems need to facilitate coordinated and integrated contributions from all sectors, including the public and private sectors, involved with the determinants of health in order to attain the best possible level of health.

V) Orientation toward quality of care and patient safety.

Health systems should provide appropriate, effective, and efficient care and should incorporate the dimensions of patient safety and consumer satisfaction. This includes

processes of continuous quality improvement and quality assurance for clinical, preventive, and health-promoting interventions.

VI) Strengthening of human resources in health.

The development of all levels of educational and continuous training programs needs to incorporate PHC practices and modalities. Recruitment and retention practices should include the essential elements of motivation, employee advancement, stable work environments, employee-centered working conditions, and opportunities to contribute to PHC in a meaningful way. Recognition of the complement of professionals and paraprofessionals, formal and informal workers, and the advantages of a team approach are essential.

VII) Establishment of structural conditions that allow PHC renewal.

PHC-based health systems require the implementation of appropriate policies and legal and stable institutional frameworks and a streamlined, efficient health sector organization that ensure effective functioning and management, and that can respond rapidly to disasters, epidemics, or other health care crises, including during times of political, economic, or social change.

VIII) Guarantee of financial sustainability.

States, with the support of international cooperation agencies, must make the necessary efforts to promote sustainable financing for health systems, and a sufficient response to health needs and support for the ongoing process of the integration of PHC into health systems.

IX) Research and development and appropriate technology.

Research on health systems, ongoing monitoring and evaluation, sharing of best practices, and development of technology are critical components in a strategy to renew and strengthen PHC.

X) Network strengthening and partnerships of international cooperation in support of PHC.

PAHO/WHO and other international cooperation agencies can contribute to the exchange of scientific knowledge, development of evidence-based practices, mobilization of resources, and better harmonization of international cooperation in support of PHC.