96 4

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RENEWAL OF THE CALL FOR HEALTH FOR ALL

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

The Pan American Health Organization (PAHO), for its part, has also reflected on renewal of the goal of health for all and the primary health care strategy in light of the global changes that are currently affecting, and will probably continue to affect, the health of the people and the health services systems. PAHO has prepared documents on the renewal of HFA, and these have been widely discussed in the Region as part of a process designed to reach agreement on a Pan American position in regard to this challenge—a process initiated at the Meeting of the Advisory Group to the Director on Health for All in the Americas, held in Washington, D.C., on 3-4 April 1995.

Presented herewith for consideration by the 26th Meeting of the Subcommittee on Planning and Programming (SPP) is a proposal for renewing the Organization's commitment to the goal of HFA which envisions attainment of the highest possible levels of health and well-being. In essence, it reaffirms faith in a world in which health is the legacy of all, and it offers some ideas for a comprehensive vision of health and for ways in which the Hemisphere can respond to the challenges. These proposals have been enhanced by consultations at the national and hemispheric level, as well as by contributions from individuals associated with various institutions whose work has an impact on health.

The members of the SPP are invited to make appropriate recommendations regarding the content of the proposal and its implementation in the Region by the countries and the Secretariat in the years ahead.

CONTENTS

Page

1. Introduction 3

2. The Experience of Health for All in the Americas 3

3. New Realities and Challenges for the Twenty-first Century 5
   3.1 The Political, Economic, and Social Dynamic 5
   3.2 Demographic and Epidemiological Trends 6
   3.3 The Health Sector and Inequity of Access 7

4. The Call to Renew the Vision and the Commitment 7

5. The Vision of Health for All as a Hemispheric Response 9

6. Orientations, General Objectives, and Strategies 10
   6.1 Policy Orientations for Health for All 10
   6.2 General Objectives 12
   6.3 Strategies 13

7. The Role of PAHO 15

References 16

Annex

1. Introduction

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

This document presents for consideration by the 26th Subcommittee on Planning and Programming of the Executive Committee a proposed discussion which is intended to initiate a formal process of consultation aimed at establishing a Pan American health policy position as a feasible strategic response by the Hemisphere and a reaffirmation of the Region's commitment to the health of its entire population.

2. The Experience of Health for All in the Americas

The countries of the Region assumed their commitment to the goal of HFA at the World Health Assembly in 1977 and subscribed to this goal the following year at the historic meeting in Alma-Ata. On that occasion they agreed that the most important goal of society is for all the citizens of the world to attain by the year 2000 a level of health that will enable them to live a socially and economically productive life (2). The strategy of primary health care (PHC) was seen as the vehicle for attaining HFA, and each country proceeded to translate these commitments into the terms of its particular socioeconomic and health situation, while at the same time recognizing certain minimum targets that all countries must achieve. In the Americas, the establishment of HFA/2000 and implementation of the PHC strategy were embodied in the regional strategy of HFA/2000 in 1980 and in the Plan of Action in 1982 (3). These documents facilitated the setting of targets, operational priorities, and baselines against which to measure progress toward health for all in the future.

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

This review of progress in the principal strategies aimed at achieving the goal of HFA revealed that the development of national policies and strategies has not included

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

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

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

The improvements in general morbidity and mortality and the increases in life expectancy are not attributable exclusively to the implementation of PHC. HFA has been responsible for a number of achievements in the state of health; in the coverage,

organization, and management of health services; in the improvement of surveillance systems; and in the dissemination of a more comprehensive view of health. Poliomyelitis has been eliminated and the incidence of other diseases preventable by vaccination has been reduced; life-spans have increased; and in many cases conventional indicators have improved despite cutbacks in national budgets. Still, the conception of PHC, both in its comprehensive and its specifically targeted sense, has not been internalized or incorporated into the operations of the health services systems.

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

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

3.1 *The Political, Economic, and Social Dynamic*

The popularity of liberal democracies has gained momentum, and economic markets have opened up as part of the regional integration processes. The declarations of the world summits and the pronouncements by the governments of the Region have emphasized the importance of health in human development and expressed concern about equity and social justice in multicultural contexts. The social aspect has taken on renewed importance in the furtherance of economic reforms, and a balance is being sought between the fruits of economic development on the one hand and social well-being on the other. Poverty has made it difficult to meet the Alma-Ata standard of a socially and economically productive life, while increased concentration of income in most of the countries is cutting off increasingly larger segments of society from the benefits of development, thus aggravating inequities within and between countries, threatening political stability, and causing living conditions to deteriorate even further. However, the constitutional reforms that are currently being instituted have strengthened the processes of decentralization, and as a result states, provinces, municipalities, and communities now have better opportunities to participate in social life through the expression of citizenship as a strictly local and political process.

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

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

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

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

There has been a shift in the age distribution of the population, with increases in both the working-age component and the over-65 group. In many cases the differences in reducible mortality between social groups, age groups, places of residence, the sexes, and ethnic groups remain unchanged or have actually become greater. In 1990 these differences represented, on average, 45.5% (in a range of 5% to 71%) of the deaths in Latin America and the Caribbean area, while in the United States and Canada the figure was only between 1.6% and 7.1%. This means that every year some 1.5 million deaths in the population under age 65 could be avoided.

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

3.3 *The Health Sector and Inequity of Access*

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

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

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

4. The Call to Renew the Vision and the Commitment

The call to renew the vision and the commitment to HFA has grown out of the findings from the recent regional evaluation of the strategies of HFA and an analysis of the current and possible effects of macroenvironmental trends on the health of the American populations. Renewal means reaffirming the commitment of all to improving the health of the peoples of the Americas. Health should be an essential and explicit component of a sustainable human development process in which development is centered on the human being, and equity and environmental and social sustainability are the criteria that guide intersectoral development policies and the processes of individual and

social transformation. Thus, health must be regarded as an essential component in the growth of individuals and societies, in policy-making discussions and decisions, and in the financing of government plans and programs—in which the ethical dimension of health and the right of all citizens to have access to a health system should be overriding.

Renewal is an ongoing process that needs to be constantly adapted, developed, and adjusted to conditions and opportunities as they are presented in the surrounding environment. Within the flexibility of HFA, at each level of application (regional, national, or local) the proposal should define a list of expected outcomes, a series of quantifiable goals and indicators, and an evaluation system designed to assess the attainment of targets and the use of processes, systems, and resources in its implementation. National resources should be subject to ongoing and systematic analysis so that priorities can be redefined, strategies readjusted, and internal and external human and financial resources adapted, in order to ensure that the response will be integrated into the process of social production of health.

In order for HFA to have some political viability, it will be necessary to devise a plan for sustaining it. Such a plan should include alternative scenarios that recognize and make it possible to identify opportunities and risks in regard to the operations and actions that the countries need to carry out in pursuing HFA. In other words, reducing the health gap calls for actions that will affect the determinants of health, and it also requires the means for evaluating the impact of such changes on living conditions in different population groups.

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

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

At the same time, however, there are circumstances that pose a threat for renewal of the goal, such as the possible effects of current economic models that may work counter to the attainment of equity and solidarity; the absence of comprehensive long-term vision in government and health sector decision-making; outdated ideas about health and disease; and lack of a plan for development of the skills needed in order to meet the new demands. In addition, the existing social, economic, and ethnic heterogeneity in some of the countries poses a special challenge that will require decentralized and regionalized policies that are sensitive to the sociocultural factors involved. In addition, the fact that there is no effective government control over the rising cost of medical care, and the transfer of this cost to the population, along with the transfer of State costs to the private sector, means that the market could tend to produce inequities.

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

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

This vision is based on a value system guided by equity, solidarity, and sustainability. To achieve equity means diminishing or eliminating differences that are unnecessary and avoidable and which, moreover, are regarded as unjust (7). Equity is defined as equal opportunity for individual development and, in the specific case of health, equal opportunity of access to health and to health services. Equity also means guaranteeing equal access by all citizens to health information, medical care, and such health services as society and the State are able to maintain economically in a context of solidarity.

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

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

The vision will become a comprehensive social response once it is made operational through concrete actions. Its conception and operation should take into account biological, psychological, sociocultural, and environmental concerns, and it should include both the recuperative and the preventive and promotional aspects of health. In terms of the direction it takes, it should coherently encompass individuals, families, communities, and the environment. The proposal is an integral part of the social production of health.

This response will be adequate and applicable to the extent that it succeeds in constructing a vision and a framework of essential values within which each country's specific priority problems are identified at the various levels of development. The political viability of the renewal of HFA might be ensured by characterizing it as more strategic than prescriptive and adopting sustainable human development as the new health paradigm.

6. Orientations, General Objectives, and Strategies

6.1 *Policy Orientations for Health for All*

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

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

Global cooperation for local development. This orientation fits within the framework of globalization of economies and information exchange, as well as recognition of the importance of local socioeconomic development aimed at optimizing social policies for the attainment of community well-being. The mechanisms of overall cooperation between countries and/or regions should encourage the expression of, and response to, local needs in health development. Indeed, experience indicates that many health problems can be addressed more effectively through regional and subregional programs. It is fundamental to establish responsibility at the appropriate levels for the impact of economic, industrial, and technological developments on the health of communities at the local level.

Mobilization of national capacity. It is necessary to identify, enlist, and make accessible the various moral, political, scientific, cultural, economic, and organizational

capabilities and resources for health development that exist in each of the different societies. If health is not ranked among the central objectives of national development, it will be very difficult for the health services systems alone, even if they are well endowed with resources, to attain the goal of HFA. The growing demand for self-determination, self-reliance, and self-management in some of the Region's most socioculturally organized communities is a good indication that it is possible for the countries to strengthen the will and the commitment of their own populations to political action in health.

Intensified connections between the health of the population, the environment, and sustainable human development. In its Chapter VI, Agenda 21 refers to PHC as an instrument for sustainable human development at the local level. Concern for protecting the state of the environment and human ecology involves consideration not only of such aspects as water supply and basic sanitation but also of new issues such as the protection and conservation of natural resources and the adequate management of community and industrial waste. It also means being part of the overall effort to fight extreme poverty, especially in extremely fragile habitats.

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

Strengthening and local development of services. There should be capacity in the communities and at the decentralized levels of health to maintain or achieve a high quality of service in which the use of existing resources is maximized. New programs should consider their effects on the organization and dynamics of society, on the ability of primary health care workers to provide services, and on the capacity of the health care structure to adequately supervise and support community health workers.

Participation in decision-making. The implementation of policies of social equity and intersectoral articulation will be successful once a system is in place that is favorable toward alliances at all decision-making levels, from the central government all the way to the local units. It also depends on the degree of decentralization that exists in decision-making and operations management, since at the local level it is more viable to have greater transparency on the part of social actors and in their proposals, as well as a greater degree of social control and level of association between the NGOs and other

social institutions that are more closely identified with the people, particularly the marginalized populations.

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

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

These priorities and strategies should ensure that the necessary financing is obtained through the effective mobilization of resources and mechanisms for the planning of international cooperation, as well as interagency coordination. Greater interagency coordination will be required on the part of governments, United Nations agencies, and bilateral and multilateral cooperative initiatives, including NGOs, in pursuing the shared objectives that have been defined. It is essential for the State to be present in the coordination and regulation of the nongovernmental sector so that this process will be in alignment with national goals and policies. Finally, the proposal for the renewal of HFA should be financially and economically feasible, and it should take into account the entire health sector at all its levels, the private subsectors, and the social security system, as well as the management levels in the national and local governments.

6.2 *General Objectives*

The objectives listed below are general in nature; they will vary in importance from country to country and according to their ranking on the national political agenda. The definition of specific objectives corresponding to the priorities defined by each country will benefit from an epidemiological reassessment—in other words, a rethinking in terms of the possibilities for controlling or eliminating diseases, damages, and

conditions based on the capacity of the country's infrastructure, the degree of decentralization that has taken place, and the organizational support that is available. These objectives are:

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

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

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

- Eradicate, eliminate, reduce, and control the principal diseases, damages, and conditions that adversely affect health, especially emerging or re-emerging diseases;

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

- Ensure the availability and application of the knowledge and technology needed in order to repair and achieve gains in health.

6.3 *Strategies*

The XXIV Pan American Sanitary Conference approved the Strategic and Programmatic Orientations for PAHO for the period 1995-1998, which refer to the following areas: health promotion and protection, disease prevention and control, promotion and protection of the environment, health in human development, and development of health systems and services. The last-mentioned area constitutes a point of departure for processes aimed at reshaping the strategies for action, or identifying new ones, aimed at renewing the goal of HFA in the Americas.

The essence of the PHC strategy is the recognition that the factors which determine health and disease are by nature complex, multicausal, and tied to the development process. HFA makes it a social right, inscribed in the statutes of citizenship of a modern and democratic society, that health and development policies should focus on the creation of healthy living conditions in all environments and on the struggle to eliminate inequity. HFA and PHC are proposals aimed at establishing priority programs for the entire population, and they include a series of interventions and implementation

strategies that are designed to have maximum impact on the health and well-being of the population in the context of the resources available. The primary health care strategy, which has gained dynamism with the advent of health promotion, should be geared to the requirements of the current and expected health situation at the national and local level. The strategies that are defined should address priority health problems and be aimed at recovering, repairing, and achieving gains in health based on the technical, economic and financial, social, and cultural feasibility of the policies, plans, and projects.

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

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

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

7. The Role of PAHO

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

The Pan American Health Organization has constitutional responsibilities which refer basically to its role in international technical coordination and cooperation in the area of health. Accordingly, PAHO will continue to take action to improve its position in regard to health in the Americas, while at the same time clearly defining its role in the future of regional health. It will try, in addition, to strengthen its leadership in the guidance of health in the Americas, including its catalytic role in intersectoral collaboration and investments in health, taking into account the new regional and world contexts. PAHO will identify and strengthen the most effective ways of supporting the attainment of HFA; it will renew its role in the provision of advisory services and in encouraging the countries to decide on their doctrines and political actions in health, taking into account the functions of evaluation and surveillance.

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TIMETABLE OF ACTIVITIES

Health for All in the Americas

Dates	Member Countries	Governing Bodies	Secretariat
1995			
February			Present and discuss preliminary document for activating HFA renewal process to Director's Cabinet
March 1-3			Establish Advisory Group to Director for this activity, its principal objective being to advise on general directions and approaches relating to attainment of HFA in the Americas
March 13-14			Report to PWRs
February-March			Working group to prepare terms of reference for meeting on overall consultation process for renewal of HFA strategy, agenda for national and regional consultations, and draft basic document for national and regional discussions; terms of reference and basic document to take into account evaluation of HFA in the Region, the SPOs, and the overall planning process with a view to linking up the principal elements
April 3-4	Meeting of the Advisory Group to the Director on Health for All in the Americas, Washington, D.C.		
April 24-25		Report to Subcommittee on Planning and Programming	Prepare and distribute final report of Advisory Group; Director's Cabinet to review plan of action and basic document; distribute them to countries and PWRs
April 28-May 1		Director to present plan of work and draft basic document to Global Program Committee (GPC)	Confirm establishment of interprogram group for preparation of supporting document for national consultations on renewal of HFA
May 1-12		World Health Assembly	Establish Regional Group for HFA
May 5		WHO Executive Board (EB)	Activities during this period to include consultations with other United Nations agencies, international organizations, and NGOs; visit countries and present the subject in subregional meetings
June 19-July 1		Report to Executive Committee	Prepare supporting document for national and regional consultations and for technical discussions of PAHO, to include comments and suggestions from health leaders in the Region
August-October			Begin to prepare for meeting on Future Trends and Renewal of HFA to be held in Uruguay, 9-12 June 1996
September 19-30		Report to Directing Council	

Dates	Member Countries	Governing Bodies	Secretariat
September 21-22	Technical Discussions in the countries with the participation of nationals in several of them		Technical Discussions at Headquarters and in the countries on HFA in the Americas
October			Introduce changes in document; prepare publication on Technical Discussions; prepare for Meeting on Future Trends and Renewal of HFA
November-December	Continue national consultations and enhancement of renewed HFA		
December		Report to Subcommittee on Planning and Programming	Prepare document on impact of resolutions of Summits on HFA
1996			
January			Update programming for 1996 based on results of activities in 1995; propose other activities for considering the new context in the Region and recommendations emanating from previous events
March 26-27		Present regional document to Subcommittee on Planning and Programming; discussion	Step up consultations with international organizations, universities, and other institutions affected by the RHFA process
April			Introduce changes in document based on recommendations of SPP
May		Report on progress toward HFA in the Americas at World Health Assembly	Continue support of national consultations
June 9-12	Meeting on Future Trends and Renewal of HFA, Montevideo, Uruguay, in conjunction with meeting of the International Health Futures Network and presentation of the Health Futures Manual for RHFA		
June		Present revised document to Executive Committee	
September		Present document to Directing Council (a major event could be held in Washington at this time to emphasize renewal of the commitment to the goal of health for all the Americas)	
October-December	Organize workshops to review targets for attainment of HFA in national contexts		Support organization of national workshops and formulation of a regional plan for attainment of HFA

Dates	Member Countries	Governing Bodies	Secretariat
	Implement regional plan for attainment of HFA		
1997			
January-December	Interface RHFA activities with evaluation of SPOs 1995-1998.	Meetings of the Governing Bodies	Support implementation of the regional plan; interface RHFA activities with evaluation of SPOs 1995-1998
1998			
	Political conference on global health		