ALMA-ATA 40

Regional Report

Primary Health Care at 40 years of Alma Ata
Situation in the Americas

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

Universal health
Access and coverage for all

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Contents

I. Introduction

For the past 40 years, the Declaration of Alma-Ata has had a strong impact on the formulation and implementation of health policies and the development of health systems in the Region of the Americas. The Declaration's call for a new civilizing order, the reaffirmation of the right to health, equity and social justice, the responsibility of governments to achieve health for all, the need for a new way of organizing health services, make knowledge and health services accessible to people and communities, the call to participate, among many other contributions, have continued to inspire and guide many of the efforts to guarantee the right to health.

This regional report briefly describes the main elements that characterize the implementation of the Primary Health Care (PHC) Strategy in the Americas. Following the guidelines and the thematic order suggested by WHO, the report focuses on the last 10 years; although, in the case of the Region of the Americas, it is necessary to refer to the predating processes. The report begins by describing the regional mandates regarding the transformation of health systems inspired by the Declaration of Alma-Ata and the effect of these mandates in PAHO's strategic planning processes that guide technical cooperation. Next, it addresses the regional results, enabling factors, and obstacles encountered, as well as examples of adaptation at the national level, and highlights examples of countries that demonstrate significant achievements.

The report does not elaborate on the proposals on the future of PHC, since these are being debated within the framework of the Regional Forum "Universal Health in the 21st Century: 40 Years of Alma Ata" and the High-level Commission, created precisely to commemorate the 40th anniversary of Alma-Ata. This report is thus limited to describing the characteristics of the already initiated processes. PAHO will wait for the development of these initiatives before taking a position and defining the specific plans of action for the next decade.

II. The PHC Strategy in the Region of the Americas: Conceptual Evolution from the Renewal of PHC to the Strategy for Universal Access to Health and Universal Health Coverage (Universal Health Strategy)

To describe the PHC situation in the Americas during the last decade we must go a little further back and include the PHC renewal process that began in 2003. In fact, the validity and depth of Alma-Ata's mandates reached a special milestone in the process of PHC renewal. This PHC renewal process was the result of a request from Member States to PAHO's secretariat (CD44R6), which resulted in a broad reflection that had as milestones the Montevideo Declaration in 2005 (CD46/13) and culminated with an important publication in 2007: "The Renewal of PHC in the Americas: Position Paper of PAHO/WHO." This renewal process had two purposes. On one hand, it made possible the recommitment to the main values and principles of Alma-Ata. On the other hand, it enabled the updating and coherence of the PHC movement to support the transformation of health systems in the region.

There were several reasons to develop the renewal process, as highlighted in the 2007 position paper. The most relevant are the following: the weaknesses and inconsistencies that were observed between the different interpretations of what PHC was; the demographic and epidemiological changes that required a revision of the emphasis; the existence of successful practices and lessons learned that guided new interventions to make PHC more effective; and the need to strengthen the role of PHC in the fight against inequity.

The renewal process explicitly sought to realize the potential of PHC to address the challenges of the health systems. This formed the foundation of

the strategy for health system transformation and the inclusion of the social determinants of health to ensure health for all. The process required greater attention to be paid to the systemic elements that go beyond the provision of services considering structural and operational elements in the areas of sustainability of financing, political commitment, solidarity, quality of care, among others.

The renewed focus of PHC was explicitly considered as a support for the development of the Millennium Development Goals, to include the approach to the social determinants of health and to achieve the highest level of health for all people within the framework of their communities. Throughout the process, it was clearly evident that the PHC proposal and the mandates of Alma-Ata remained a source of inspiration for all health actors and for the communities. This vitality was palpable in different contexts in all countries.

A main aspect of the renewal process was to highlight that PHC should not be considered a project or a program, but an inclusive strategic approach that should determine the functioning of the entire health system. In this way, it was configured as a transformation proposal that aspires that all health systems be based on PHC.

Consequently, for the Americas, PHC was defined as a broad approach to the organization and operation of health systems, which makes the right to achieve the highest possible level of health its main objective, while maximizing equity and solidarity."

In this way, the values of Alma-Ata form the central pillars of PAHO's strategies and resolutions on health systems and services and the drivers of the technical cooperation process developed by the organization. These values were supported by key principles and structuring elements of the conceptual frameworks that served to define tools and lines of action for the health systems' transformation processes. The principles that were agreed upon in this process were intersectoriality, participation, sustainability, social justice, orientation to quality, response to the health needs of the population, and governments' responsibility and accountability.

Among the core structural and functional elements highlighted by the PHC renewal process were the following:

a) Access and universal coverage to acceptable services

b) First contact

c) Integral, integrated and continuous care

d) Family and community orientation

e) Emphasis on promotion and prevention

f) Appropriate person-centered care

g) Mechanisms for active participation

h) Solid legal and institutional framework

i) Pro-equity policies

j) Optimal organization and management

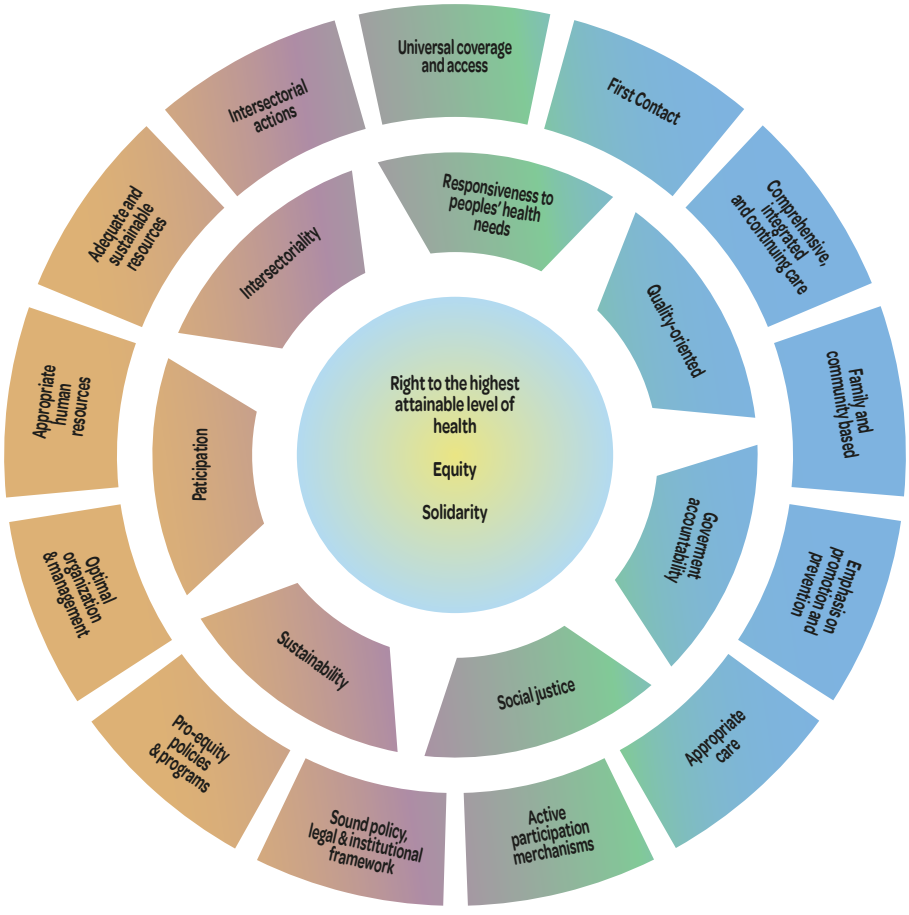
k) Adequate human resources

l) Adequate and sustainable resources

m) Intersectoral actions

A regional agreement was thus consolidated, with 3 core values, 7 guiding principles, and 13 essential elements. These gave conceptual support and guided the work of countries implementing health systems transformation processes based on PHC.

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



The PHC renewal document stressed the importance of reorienting the axis of health systems towards promotion and prevention, giving some guidelines for this, highlighting the need to reassign functions within governments, to integrate and avoid fragmentation of public health and health care services, to maintain the focus on families and communities, and to seek the consistent use of data for planning and decision making. It also advocated for an institutional framework that would guarantee quality improvement, attention to human resources, attention to the alignment of international cooperation, and the use of change management strategies.

It is important to note that during the renewal process, the available evidence was considered regarding the impact that PHC has on improving health systems. The improvements in health outcomes and equity, greater efficiency, lower costs, and increased satisfaction of people were noted. At the same time, it was quite clear that the term "primary health care" had different meanings in different contexts, not only in different regions of the world but also within the Americas Region. This confusion had to be overcome; therefore, the renewal process must follow clear options after examining the different competing visions that exist. In summary, the reflection process allowed the identification of four different PHC concepts that were used by different stakeholders:

1. In some contexts, PHC was understood as the provision of ambulatory or first level of care services for the entire population.

2. In other contexts, PHC was conceived as a set of priority health interventions for low-income sectors, also called *selective PHC*.

3. In other contexts, PHC was conceived as a comprehensive strategic approach to organize health care systems, as well as the society, to promote health.

4. Finally, in other contexts, PHC was conceived as an essential component of human development, focusing on the economic, social and political determinants of health. This concept gave less attention to the aspects related to the provision of health care services.

The PHC renewal position document maintains the essence of the Alma-Ata declaration, but places the emphasis on contributing to the development of health systems. It discards the visions of selective PHC and any service package defined without consideration of the needs arising from a participatory dialogue with the community. It considers important the proposals linked to structural approaches or to the priority of the first level of care, but places as its main axis the comprehensive transforming strategy of each health system based on values, principles, and key elements.

The proposal for the renewal of PHC and, in particular, the call to transform health systems based on PHC, greatly impacted the countries of the Region, as discussed below. However, immediately after, a discussion arose about how to organize the provision of health services. If the renewed PHC was essentially a comprehensive strategy for the whole system, how was the delivery of health services meant to be organized? Where was the first level of care? This opened a new process of reflection and broad debate in the region and the proposal for Integrated Health Services Delivery Networks (IHSDN) emerged. This process began at the end of 2006 and was developed as a resolution presented at PAHO's 49th Directing Council (C49.R22) in 2009. The document that accounts for this process and sets the position of the organization was published in 2010 under the title "Integrated Health Service Delivery Networks: Concepts, Policy Options and Road Map for Implementation in the Americas."

As the resolution makes clear, IHSDNs make possible the realization of the essential elements of the renewed PHC proposal in the field of services, such as access and universal coverage, first contact, appropriate care, optimal organization and management, family and community orientation, intersectoral action, comprehensive and continuity of care, among others. The IHSDN proposal articulates, in the field of service provision, the change of the care model, the priority for the first level of care, the incorporation of public health and intersectoral action, the role of specialized services. These characteristics of IHSDNs guide the work of the different actors in the system. To do this, the proposal considers a comprehensive definition and 14 essential attributes.

The agreed definition of IHSDN allows us to glimpse the scope of this important proposal: "a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served." This definition makes clear that we are not dealing with a classical hierarchy and that not all establishments should be owned by a single entity; rather, it seeks, through various contractual arrangements, alliances, and/or agreements, to operationally integrate the work of all the services available for the same population in a territory, whether public or private. This conceptualization allows and stimulates agreements and complementarities in border areas as well as cooperation between small countries such as in the Caribbean. The definition is also broad enough to accommodate different models that must be designed according to the reality of each country, as well as international or subnational contexts. What is important is that the chosen design meets the necessary attributes to respond to the population it serves. As noted in the publication, the following attributes are crucial:

1. Clear definition of the population/territory covered and extensive knowledge of the health needs and preferences of this population, which determine the supply of health services;

2. An extensive network of health care facilities that offers health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care, and that integrates programs targeting specific diseases, risks and populations, as well as personal and public health services;

3. A multidisciplinary first level of care that covers the entire population, serves as a gateway to the system, and integrates and coordinates health care, while meeting most of the population's health needs;

4. Delivery of specialized services at the most appropriate location, preferably in non-hospital settings;

5. Availability of mechanisms to coordinate health care throughout the health service continuum;

6. Care that is person-, family- and community-centered and that takes into account cultural and gender-related characteristics and diversity;

7. A unified system of governance for the entire network;

8. Broad social participation;

9. Intersectoral action that addresses wider determinants of health and equity in health;

10. Integrated management of clinical, administrative and logistical support systems;

11. Sufficient, competent, and committed human resources for health that are valued by the network;

12. An integrated information system that links all network members with data disaggregated by sex, age, place of residence, ethnic origin, and other pertinent variables;

13. Results-based management;

14. Adequate funding and financial incentives aligned with network goals.

The operative nature of this proposal and its clear alignment with the renewed PHC strategy for the transformation of health systems allowed it to become the main articulating tool of the technical cooperation provided by PAHO in the countries of the region in the region, in the field of health services.

The Strategy for Universal Access to Health and Universal Health Coverage

The most important evolution came later through the **Strategy for Universal Access to Health and Universal Health Coverage**, approved by PAHO in 2014 (CD53/ 5, Rev. 2 and CD53.R14), also known as **Strategy for Universal Health.**

The Strategy for Universal Health is the current framework to guide health systems transformation and takes into account contributions from Alma-Ata to the present day. It builds upon the PHC renewal process, integrates the IHSDN proposal, and provides a comprehensive framework of strategic lines of action to guide health system reforms. It provides recommendations encompassing services, stewardship and governance, financing, and intersectoral action to address the social determinants of health.

This historical continuity with Alma-Ata does not arise from an ex post analytical process; instead, it is made explicit in the resolution that gives life to the strategy, by explicitly stating that the strategy is rooted in the core values and principles of PHC enshrined in the "Alma-Ata spirit." Therefore, the strategy reaffirms the right to health, equity, and solidarity as core values.

Considering the above, the strategy calls on all countries to achieve universal access to health and universal health coverage through strategic and comprehensive actions that are progressive and sustained over time. The resolution clearly recognizes the demand of populations for better health systems within the framework of democratic processes and calls for the establishment of specific action plans that allow for more rapid progress in the coming years.

While noting the need to adapt the process to different contexts, the strategy proposes the following four strategic lines of action that should be considered by any comprehensive initiative for transforming or strengthening health care systems:

a. Expanding equitable access to comprehensive, quality, people- and community-centered health services;

b. Strengthening stewardship and governance;

c. Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service; and

d. Strengthening intersectoral coordination to address social determinants of health.

The strategy is quite clear in setting explicit recommendations in each of these four areas and emphasizes that the initiatives in these 4 lines are interdependent; thus, the initiatives should consider all aspects and not exclusively focus on only some of the aspects.

The strategic line directly linked to health services reinforces the IHSDN framework and expressly states the need to "strengthen or transform the organization and management of health services through the development of health care models that focus on the needs of people and communities, increasing the response capacity of the primary level of care through integrated health services networks (IHSDNs), based on the primary health care strategy." In this way, the continuity and historical consistency of the countries of the Americas from Alma-Ata to the Strategy for Universal Health is summed up in one sentence.

This strategic line, among its recommendations, includes:

- Transform the organization and management of health services through the development of people- and community-centered health care models;
- Increase the response capacity of the first level of care;
- Develop Integrated Health Services Delivery Networks (IHSDNs);
- Identify health inequities among population groups through a detailed analysis of the health situation, surveys and specific investigations, deepening on their determinants;
- Advance in the definition of comprehensive, quality, universal, and progressively expanded health services;
- Ensure that services are available for all people, without differences in quality, regardless of their economic and social status;
- Pay attention to the specific needs of groups in vulnerable situations;

- Increase investment in the first level of care, in order to improve the response capacity, increase access and progressively expand the supply of services to cover unmet health needs in a timely manner;

- Expand employment options, especially in the first level of care, with incentives and attractive working conditions, particularly in underserved areas;

- Structure or consolidate collaborative multi-professional health teams;

- Strengthen the response capacity of health services using information and communication technologies (ICTs)

- Strengthen the professional and technical profiles of human resources for health and/or introduce new profiles, consistent with the transformation or strengthening of the health care model;

- Improve the availability and rational use of medicines (including vaccines), as well as other health technologies;

- Develop the regulatory and assessment capacity to ensure that drugs are safe, effective, and of quality;

- Facilitate the empowerment of people and communities so that they have greater knowledge about their health situation, their rights and obligations;

- Assess and measure unpaid work in health within the home, with a multisectoral approach and deepen the attention of specific health needs.

In the area of Stewardship and Governance, the strategy urges to "strengthen the stewardship capacity of national authorities, ensuring essential public health functions and improving governance to achieve universal access to health and universal health coverage." "Stewardship" is understood as the leadership capacity of the health authorities to shape and support a collective action that allows the creation, strengthening or change of the governance structures of the health system. Governance corresponds to the institutional arrangements that regulate the actors and critical resources that influence the conditions of coverage and access to health services. Recommendations include strengthening the leadership of national health authorities using social participation and intersectoral dialogue through appropriate governance mechanisms. It is expected that national authorities succeed in prioritizing public health interests and ensuring transparency and accountability. In the

same way, it is essential that plans and policies be formulated with defined goals that explicitly state the will of the State to move towards universal health and that are monitored with transparency. The recommendations include the need to review the regulatory and legal framework to lift regulatory restrictions that prevent progress towards the exercise of the right to health and human rights. In this same section, the recommendations include the generation of effective mechanisms to guarantee access to health services; the explicit definition of comprehensive, universal, adequate, timely, quality, progressively expanded health services; as well as the formation, training, and equitable distribution of human resources; the use of health technologies for the benefit of people; and an adequate mobilization and allocation of financial resources. The section on governance also includes a robust call to strengthen national information systems and use it for adequate decision-making to advance towards universal health, and to strengthen health research and knowledge management.

In the area of financing, the strategy expresses the need for "increasing and improving financing with equity and efficiency and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service." The recommendations in the field of financing are explicit and impose a demanding agenda for the coming years. The recommendations include the following:

- Improve and strengthen the efficiency of financing and the organization of the health system, which implies:
    - implementing people and community-centered models of care and the provision of quality services;
    - aligning payment mechanisms with the objectives of the system;
    - rationalizing the introduction and use of medicines and other health technologies with an integrated, multidisciplinary, evidence-based approach;
    - improving the supply mechanisms of medical devices, medicines and other health technologies;
    - optimizing supply management;
    - taking advantage of economies of scale and adopt transparent processes for procurement;
    - fighting against corruption.

- Increase and optimize public financing for health, while seeking:
    - that it be carried out in an efficient, sustainable, and fiscally responsible manner;
    - that allows to expand access and reduce inequities in health, increase financial protection, and implement efficient interventions;
    - that priority be given to the first level of care, to improve its response capacity and its ability to articulate service networks;
    - that public spending for health reaches 6% of GDP.
- Advance towards the elimination of direct payment.
- Move towards pooling mechanisms based on solidarity.

In the area of intersectoral action, the strategy requires to "establish or strengthen intersectoral coordination mechanisms and the capacity of the national health authority to successfully implement public policies and promote legislation, regulations, and actions beyond the health sector that address social determinants of health." In this section, the strategy urges to:

- Assess the health impact of policies, plans, development programs and projects, including those of other sectors;
- Strengthen the leadership of the national health authority in defining the health-related components of public social protection policies and social programs;
- Share good practices and experiences in health related to anti-poverty programs and the increase of equity;
- Strengthen the articulation between the health sector and the community;
- Facilitate the empowerment of people and communities;
- Seek access to information for community members, so they can assume an active role in the formulation of policies, in actions to address the social determinants of health, and in the promotion and protection of health.

III. PAHO's Strategic Plans and the Incorporation of Conceptual Frameworks in Technical Cooperation Processes

In the last 10 years, two PAHO strategic plans have prioritized interventions to implement the resolutions and conceptual frameworks previously outlined.

The 2008-2013 strategic plan explicitly considered how best to support countries to provide integrated and comprehensive people-centered health services based on PHC. This translated into efforts to strengthen national legislative and regulatory policies, as well as the development of national strategies and plans. The indicators and results of the plan included explicit policies on primary care such as measuring "the number of countries that document the strengthening of their health systems based on PHC"; measuring the "number of countries that have integrated an intercultural approach in the development of health policies and systems based on PHC"; documenting the "number of countries that use the renewed PHC strategy in their population-based care programs and priority disease control initiatives"; and measuring the "number of countries that have adopted PAHO's policy recommendations to integrate health services delivery networks, including public and non-public providers." Also, in the field of human resources, references to PHC as a guiding strategy were explicit and the expected results considered to report on the "Member States that receive support through technical cooperation to prepare plans and policies on human resources in order to improve the performance of health systems based on PHC" and the "number of countries with policies to reorient health science education toward PHC."

The strategic plan made it possible to guide numerous improvements, although the evaluation of the global situation in the region was not satisfactory. The challenges that appear in the evaluation of the 2009-2013 plan, as well as in the considerations of the current strategic plan 2014-2019, reveal very important challenges. Indeed, among many other challenges, the report states

that access barriers continued to be a major problem in the region. Nearly half of the countries did not have sufficient mechanisms to guarantee coverage and financial protection, especially for those population groups in conditions of greatest vulnerability, which translated into significant health inequities. The differences between countries and also within them remained considerable. The fragmentation of services remained a significant problem and caused inefficient use of resources, higher costs, dissatisfaction of the population, and access difficulties. The concentration of services in urban areas, deficits in information systems, limited participation of users, lack of transparency and accountability, inappropriate use of medicines and other technologies, and inequitable distribution of human resources were also noted. Additionally, it was reported that there was a very important difficulty with the human resources training sector that was not aligned with the implementation of health systems based on PHC.

The report highlighted in its lessons learned the need to have a coherent framework that could unify the links between PHC, IHSDN, universal coverage, and other approaches such as social determinants of health, governance, etc. This gap was filled in 2014 with the previously mentioned Strategy for Universal Health.

The 2014-2019 strategic plan was developed taking into account the unresolved challenges, and includes the following elements regarding health systems:

- Strengthen health systems based on PHC;
- Guide governance and financing in health towards the progressive achievement of universal health coverage;
- Organize the integrated provision of people-centered health services;
- Promote access to health technologies, as well as their rational use;
- Strengthen information and research systems on health and the integration of evidence in health policies and health care;
- Facilitate the knowledge and technology transfer;
- Develop human resources for health.

Each of these elements of the plan considers objectives, tasks, and indicators that together cover the use of all technical cooperation instruments that have been created around the IHSDN framework in the last 10 years, and the Strategy for Universal Health since 2014.

IV. Description of Observed Results in the 2008-2018 Period

PAHO's planning and evaluation system has made it possible to document the progress made in recent years, as well as to determine the magnitude of the pending challenges.

The evaluation of the strategic plan 2008-2013 highlighted important advances.

During this period countries reported significant improvements in health outcomes throughout the Region: progress was made in reducing infant mortality; childhood deaths due to vaccine-preventable diseases fell by more than 50%; the incidence of malaria also decreased more than 50%; dengue lethality decreased; mother-to-child transmission of HIV decreased; HIV treatment coverage increased; the rate of TB continued to fall; premature deaths due to noncommunicable diseases decreased; eight countries reported a decrease in tobacco consumption; and rubella in the region was eliminated, which was recently ratified, among many other advances.

These improvements in health outcomes were possible through advances in initiatives to strengthen health systems and services. In brief, the population covered by some type of social protection had increased from 46% in 2003 to 60% in 2013; public spending in the region had increased from 3.1% in 2006 to 4.1% in 2012; 19 countries had incorporated the right to health in their legislation and more than 30 had signed international agreements in the same line; 31 countries reported advances in the transformation of their health systems based on PHC; 12 countries had implemented insurance mechanisms that allowed increasing coverage through explicit guarantees and another eight indicated improvements to limit financial risk.

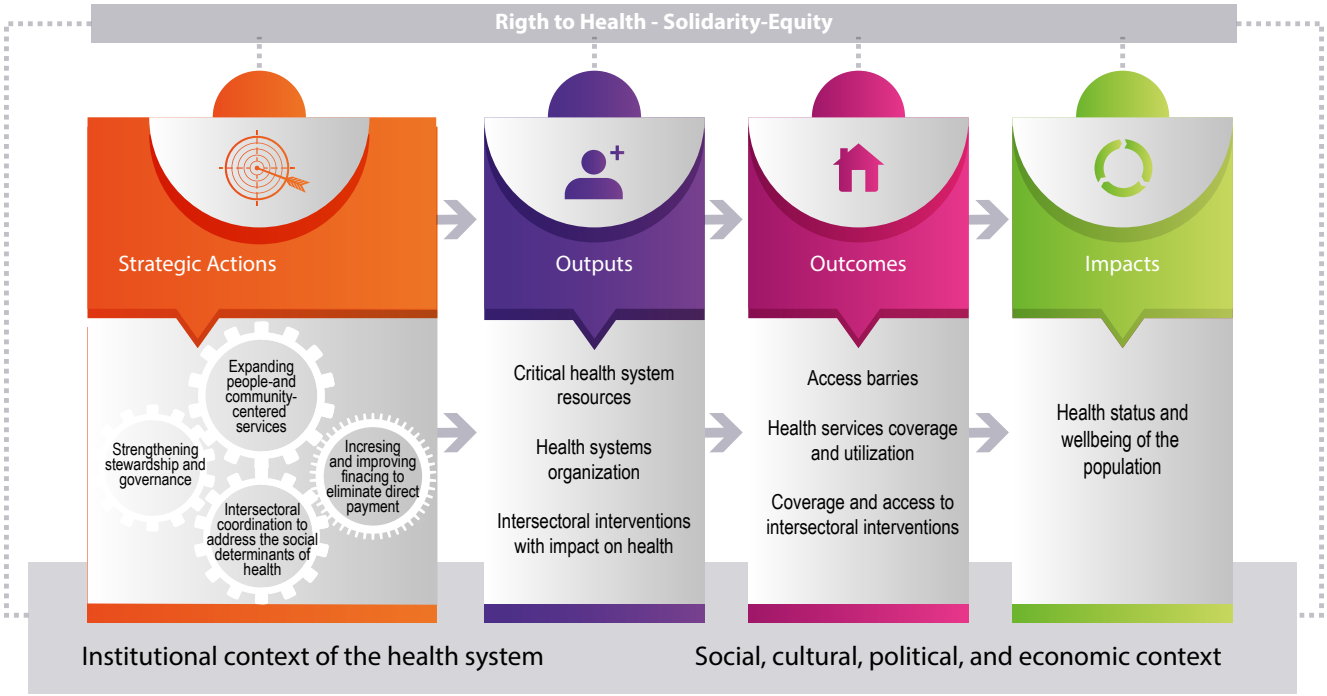
Likewise, 25 countries had reached the goal of density of health professionals per inhabitant established in regional agreements. All countries had developed plans to move forward with medium and long-term proposals; 17 countries had incorporated the IHSDN strategy in the reform and reorganization of their health services; 18 countries had developed initiatives to incorporate

programmatic priorities into an integrated healthcare model, which included strengthening the first level of care, and the family and community health approach. Twenty-nine countries had human resources plans and 9 had implemented careers in the public health sector. Twenty-four countries had strengthened their national processes for the supply of medicines and other health technologies.

The progress achieved in more recent years has been measured through the indicators contemplated in the 2014-2019 strategic plan. These include relevant aspects to measure the progress towards universal health using a special monitoring framework built to comply with the Universal Health Strategy.

The monitoring framework contains four components (strategic actions, immediate results, intermediate results, and impact results) and identifies a set of policies to guide the transformation of health systems towards universal access and universal health coverage. Sixty-four indicators were chosen from a total of 500 indicators considered. The approach proposed to use this framework is based on the measurement of inequities in access and coverage, as well as in the collection of qualitative evidence on the degree of execution of policies and actions.

Figure 2. Monitoring Framework of the Strategy for Universal Health



Access to health is measured with indirect indicators such as utilization of health services, unmet needs, and reported access barriers. Health coverage is measured by the availability and distribution of human and physical resources, the population with the right to care, the availability of medicines and other technologies, among other elements that account for the adopted definition of coverage as the capacity of the health system to respond to the needs of the population.

Following the mandates of the organization, diagnoses are sought that include the equity component by establishing measurements that may not be reflected in the averages. Although many of the results are obtained by country, PAHO does not seek to establish comparisons but rather aims to support each country in identifying gaps and opportunities for improvement according to its own context. Another application is the documentation of experiences to serve as a learning example for decision-makers and policymakers.

The data available for Chile, Colombia, Mexico, Peru, the United States, and Uruguay between 2010 and 2015 show significant improvements in access and coverage. The population coverage by financing schemes was around 98% in Chile and Uruguay, 95% in Colombia, 90% in the United States, 80% in Mexico, and 73% in Peru. However, coverage levels were lower for the poorest families, especially in Colombia and the United States.

Another important element that has been considered to estimate access is the use of preventive health services. This indicator shows significant disparities between countries, but the general trend has been towards the increase in access to health and the reduction of the gap between poorer and richer families. With respect to the access barriers, the percentage of people that reports barriers also varies significantly: 66% in Peru, 36.9% in the United States, 28.8% in Colombia, 20% in Mexico, and 6.8% in Chile. Poor families reported a higher percentage of access barriers, especially in Colombia and Mexico.

Another relevant indicator that has been measured to verify the quality of health services is mortality attributable to low-quality health care. Between 2010 and 2014, this rate decreased in most countries in the Region. However, huge disparities are observed, with rates ranging from 47 per 100,000 to 350 per 100,000 population. The lowest rates were observed in Anguilla, Canada, Cayman Islands, and Honduras. Although this indicator is very useful, it is important to note that registration problems still persist, which calls for caution when interpreting the results.

Out-of-pocket expenses paid by the user to access health services is one of the most important barriers to be avoided. Out-of-pocket spending is still relatively high in the Region, although there are countries that have made progress towards decreasing it. The disparities between the countries are very important and range from 4% of out-of-pocket expenses in Cuba to 64% in Venezuela in 2014.

The availability of human resources accounts for the actual coverage of services available to the population. By 2015, 35 countries and territories achieved the goal of 25 doctors and nurses per 10,000 inhabitants, which marked a very important advance. However, 10 countries (Belize, Bolivia, Brazil, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, and Venezuela) did not reach the target of 25 doctors and nurses per 10,000 inhabitants.

As previously indicated, national averages are not enough by themselves; it is also important to know the distribution of health personnel and the increase in their availability in previously unattended areas. Countries of the Region are implementing initiatives to encourage the placement of personnel in remote areas. Among the programs with notable achievements in this task are the mandatory Social Service of Colombia, the Mais Médicos program in Brazil, the rural and marginal urban health service in Peru, and the legal incentives policy of Costa Rica.

V. The Adaptation of Technical Cooperation Strategies to National Contexts

The approaches to PHC as a strategy were expressed differently in different countries. Although the conceptual agreement built over the years has been strengthened, tensions have persisted between the different ways of conceiving PHC, and the diversity of political, social, and economic contexts have influenced in different ways the development of initiatives. The structural elements that have most affected the diversity and difficulty in developing strategies for strengthening health systems based on PHC are the great degree of segmentation and fragmentation. Indeed, in many countries there are several subsystems that provide health services to different segments of the population through social security or national health services. In addition, private offer varied, both at insurance and provider levels. In this context of great segmentation, it is important to note that, in most countries, unlike what was observed in Europe, the universality of coverage was never completed.

The health sector is structured by different subsectors with different rules and institutional structures that define the responsibilities of the State agencies, financing mechanisms and allocation of resources, different types of affiliation, different characteristics of the services and access to the same, and different population groups for which they are responsible. This has conditioned the way in which the strategy has developed in the different countries.

The vast majority of countries closely adhere to Alma-Ata's postulates. In a recent review, 10 of the 12 South American countries adhered to the PHC renewal strategy. A similar situation is observed in the other subregions, where the policies are explicit in promoting and prioritizing PHC. In 2014, all countries adhered to the Universal Health Strategy, which was approved unanimously by Member States after intense debate. At the same time, it is necessary to state that the ways to implement the initiatives and the specific advances vary.

PAHO's flagship publication *Health in the Americas of 2017* analyzes the transformation processes and characterizes them based on the changes in governance that have been promoted by the health authority. These transformation processes are institutional and political. Institutional because they consist of "transformations in the rules of the game that regulate actors and resources" and political because they are conducted by the health authority and other actors in the framework of the game of values and interests that comprise collective action. Two types of transformation logics are highlighted: those based on changes in health insurance, in order to increase the financial coverage of the population, and transformations based on changes in the model of organization of health services, seeking improvements in the conditions of access to health services.

In the first case, efforts are made to change the regulatory mechanisms of the financing model with emphasis on the insurance of health services. The aim is to increase the population with explicit coverage, defining financial protection and the services included therein. The innovations point to changes in the insurance mode that then become the main driver of the transformation process. The Bahamas, Belize, Colombia, the Turks and Caicos Islands, and the USA are examples of this type of approach.

The second type of reforms is structured on the basis of transformations to increase access to health services. For this purpose, the reform alters the governance of systems and services and the provision of human resources. Bolivia, Brazil, Canada, Costa Rica and El Salvador are examples of this type of approach; whereas Belize, Guyana, Jamaica, and Trinidad and Tobago adopted profound reform processes in the system´s governance model that entailed the regionalization and decentralization of health authorities. In the latter, it is possible to identify as a central element the formulation of a model of care that guides the development of the system following the PHC postulates, from the perspective of population access. These models usually have a clear family and community orientation (in some cases also intercultural), are comprehensive, and have a population and territorial component.

Given that the advances have been different and have followed different pathways, the challenges to face the existing gaps vary for the different countries.

In some countries, the high coverage achieved has not facilitated reducing the access problems for populations in conditions of vulnerability. The greatest weakness of these reforms lies in their limited progress in transforming the model of organization of health services. For this reason, this type of reform requires strategies designed to introduce into the regulatory mechanisms new models of health services delivery, with explicit goals in terms of equity of

access to health services. Likewise, these changes will only be sustainable if changes are made in the mechanisms of regulating human resources, aligned with the new models of care and the goals defined for the scope of PHC.

In other countries, advances in access for populations in situations of vulnerability reach a ceiling, limited by systems that lack solid financing mechanisms. These types of reforms also have pending challenges, related both to the need to move forward with changes against segmentation and to the need to sustain improvements in access to services. This type of reform has tended to be limited to the public sector, with little influence on social security. The need to move forward with coordination or integration mechanisms between the public sector and social security is key to achieving equity and efficiency in the financing model.

The following table lists policies of various countries that illustrate the new approaches taken in recent years.

Table 1. Examples of Policies for Health Systems Transformation Processes

Country	Date	Policy	Objective	Innovations in governance	Achievements and advances
The Bahamas	2016 to present	National Health Insurance Law	Increase coverage: ensure all residents receive health services at no cost at the point of care; the cost will be financed in whole or in part by the government	The National Health Insurance Authority was created to monitor the implementation of national health insurance	Designed in 31 phases, in which phase 1 corresponds to the registration of users
Belize	2001 to present	Health sector reform and establishment of the National Health Insurance (NHI) (2001)	Organizational restructuring and regionalization; streamline and improve coverage and health services quality, in both public and private sectors; achieve an equitable and sustainable financial system	The National Health Insurance is created, and it is attached to Social Security; four health regions are created as entities that coordinate resources, and report to the central level; administrative and budgetary autonomy is established in the only national reference hospital (KHMH)	The National Health Insurance is implemented in a pilot phase in 2001, with subsequent adjustments adopted in 2006; The health sector reform is considered an ongoing process

Country	Date	Policy	Objective	Innovations in governance	Achievements and advances
Colombia	1993	Ley 100 de 1993	Expand coverage	Creation of a regulated competition system with the introduction of private administrators of social security resources	Coverage for 100% of the population
	2012	Convergence of the contributive and subsidized systems with the unification of the covered benefits	Achieve homogeneous coverage of the two subsystems		
	2015		Overcome access barriers	Elimination of the criterion of coverage of included services and transition to a regime of benefits based on exclusions	In process of implementation
Turks and Caicos Islands	2009 to the present	National Health Insurance Plan	Increase insurance coverage (100% as goal); eliminate direct payment and achieve access to a comprehensive benefit plan in the public and private sectors	A National Health Insurance Council was established, in charge of monitoring the plan, defining the benefits, determining the contributions and advising the health minister; it is comprised of representatives of ministries and political parties	Implementation in 2009, but starting in 2016 amendments were approved to extend coverage to the unemployed, children of migrant workers, and to allow voluntary affiliations
United States of America	2010 to the present	Patient Protection and Affordable Health Care	Increase coverage and access to health services for the population without insurance	Private insurance sector: mandatory universal insurance, without rejection of requests, regardless of health status, with the same premium to each plan, with subsidies to premiums and co-payments for those who qualify	Decrease of the population without health insurance from 16.4% in 2010 to 11.4% in 2015 and decline of access barriers
Bolivia	2013 to the present	"My Health" model	Guarantee access to the family group of the population without social coverage	Training of human resources and change of the health care model with the introduction of traditional medicine	Implemented in 306 of the 339 Bolivian municipalities with the inclusion of 2,389 doctors

Country	Date	Policy	Objective	Innovations in governance	Achievements and advances
Brazil	2011	National PHC Policy (35), National Program to Improve Access and Quality (PMAQ)	Guarantee the quality of care	Expansion of health teams with incentives for payment by result	Increase from 71% to 96% of the total of municipalities and from 53% of the family health teams to 94% between 2011 and 2015
Canada	2004 to the present	Development of Integrated Centers for Health and Social Services (CISSS) in Quebec	Transform the care model into 90 CISSS that provide services to specific local populations, with a focus on accessibility and continuity of care with prevention services, as well as curative services for the most vulnerable	Integration of health and social assistance services directed to PHC around "autonomous" family medical clinics; they have encouraged multidisciplinary work through a renewed role for nurses and public health workers, with a focus on the participation of community groups, including citizen committees and community representation	Progress made towards an integrated and integrating network with: expansion of nursing staff functions at the clinical and community levels; integration of other health professionals to support family doctors; monitoring the quality of private medical care for the elderly; low collaboration of citizens in management, but greater participation of users in the planning and better integration of curative and preventive approaches in the practice of family medicine
El Salvador	2009	Building Hope	Guarantee access to health services for the rural population	Organization of health services (community and specialized family health teams)	Increase of 7.21% in institutional births and 13.68% increase in deliveries in regional hospitals between 2009 and 2012

VI. Stories of Advances, Enabling Factors, and Obstacles

In some countries of the Americas, the transformation of health systems based on the principles of Alma-Ata has resulted in advances in health that have gone beyond what was expected for their levels of development and even more so if the great structural inequality of societies are considered. The low infant and maternal mortality in Antigua and Barbuda, Canada, Chile, Costa Rica, Cuba, Saint Kitts and Nevis, and Uruguay—very different countries in social and political terms—seems to have as a common denominator the high coverage of maternal services, integrated into strategies based on PHC and a targeted improvement of access for populations in situations of vulnerability that have been operating for many years. More recently, the improvements observed in Brazil, El Salvador, and Paraguay coincide with a clear priority for strategies based on the principles of PHC and Universal Health. Despite the examples of successful advances, the persistence of segmentation, scarce redistributive capacity of the public sector, and weaknesses of the governing bodies, especially the ministries of health, are key factors to explain the difficulties in the development of PHC strategies in the Region in a consistent and sustainable way over time.

As in other regions, the literature rarely mentions the political processes that have enabled or hindered health reforms based on PHC.

However, the following key elements are observed when progress has been made:

- there has been an important and structured set of strategic actors in different areas of management and decision-making in the political, technical, and academic fields capable of providing leadership and sustainability to the process;

- there has been strong pressure from public opinion to improve the conditions in which health services are accessed, which has stimulated political will;

- and very importantly, there have been organizations interested in the improvements being directed with a strong component of PHC (PHC unions, groups of family doctors, schools of public health, civil society organizations, local and municipal authorities).

These elements must be considered by the stakeholders interested in strengthening the strategies to advance towards Universal Health, even though each change process has its own challenges and a reliable history has not been written to allow us to affirm with absolute certainty what to do in each case.

Regarding the previous elements, a conversation with national experts should add other aspects that could be equally relevant and that should be considered. The first of these is the generation of solid evidence that allows us to affirm what are the expected benefits of the reforms that advance towards universal health.

Although there is solid evidence in international experiences, often, insufficient data is applied to each national reality preventing measuring the situation in specific systems. It is not possible to make transformations without having clear data and reasonable evidence about the effect of the transformations. The evidence must be supported with advocacy and communication work. The data must be communicated to the relevant actors in an appropriate manner at the right time and not spontaneously. The actors interested in promoting reforms have always done great advocacy work. One of the necessary allies in the reform processes has been the public treasury sector. Without relying on the availability of necessary resources, every reform process is doomed to languish. Decision-makers of the public budget are usually very amenable to reforms that reduce the spiral of costs of the health sector, or mitigate the long-term effect of health expenditures, or promote the development of greater productive capacity as a result of a healthy population. Health spending will not decrease, but it can be more efficient (and the beneficial effects in the country may be very convenient for national development) if this increased spending is directed to fund a Strategy for Universal Health. This has been successfully argued by some health ministers.

In as much as there are enabling factors, there are elements that are obstacles in the advance towards universal health. Among the obstacles, the macro trends already described in the 2008 global health report and that are detailed in *Health in the Americas 2017* remain strong. Hospitalo-centrism, fragmentation, and commodification remain very important trends. Although expressed with different intensity, together they conspire against the PHC principles diverting health systems from their focus. Currently in our systems, there are no indicators to measure the strength of these phenomena or some others that the managers point to as a source of concern when steering the

systems. Although less influential, the obstacles caused by the lack of exclusive spaces of professional competence between different professions and also within medical subspecialties are mentioned. Others point to the problems introduced by operational verticalization with a focus on diseases; the risks of research work that is directed according to academic and commercial interests and not always according to the priorities of the population. Mention is made of the problem of narrow and short-term political visions and their influence on the instability of processes. For all these elements, there are many examples and experiences of health workers and managers of change processes, although there are not systematic studies to characterize these phenomena, and it is not always possible to make policy recommendations that confront them explicitly.

In any case, the analysis of the actors involved is essential when promoting processes of transformation. This implies identifying the actors, identifying the relationships established between them, and knowing their technical and political capacities. A distinction must be made between those that are specific to the health sector, those that belong to the financial or commercial arena, and in general to other social environments. It is necessary to recognize their interests, the values that motivate them, and their positions toward the measures that are promoted as part of the transformation processes. It is necessary to identify those who are in positions of support and those who are in a situation of conflict.

It is quite clear that in order to sustain the processes of transformation towards universal health, it is necessary to strengthen the political and technical abilities of the health authority. The ability to weave alliances and cooperation spaces that allow to carry out the process and for the adequate confrontation of conflicts is a fundamental political skill. On the other hand, technical skills are essential to interpret the challenges and offer effective solutions.

As noted in *Health in the Americas 2017*, "although there are social values and sufficient arguments to promote universal health, many of the decisions or measures could be perceived as threats or contrary to the interests" of certain groups and actors in society. Subsequent conflicts will not always be expressed in an open or homogeneous manner. To guarantee the right to health of the population through a PHC strategy, in the framework of universal health, organizational, institutional, and political transformations are required with additional efforts in terms of investment in human resources and greater public financing. The shift towards a care model centered on individuals and communities (recognized by most countries in the Region) must be at the

center of the transformations of health systems in the 21st century. Governance to support PHC, with a care model focused on people and communities, requires changes in the regulation of different relationships or processes:

a. values and conceptions of the actors involved in the health services network,

b. regulation on the interactions between actors involved in the organization, management and care in the provision of health services;

c. regulation of the relationship between services and the population;

d. intersectoral regulations, between services and other social sectors.

VII. The Information Available at PAHO

To monitor the transformation processes in the countries and develop the technical cooperation that supports them, professional teams have been installed and reinforced with international and national consultants. This allows for a situation assessment in both quantitative and qualitative aspects using official information available and building ad hoc information using other sources of the international system or new developments.

In addition to the collection of quantitative information that is linked to the strategic planning processes of the organization and the cooperation plans agreed with each country, each office maintains an active map of stakeholders and a situation analysis room that examines the progress of the different health aspects of the countries, which includes epidemiological aspects and system development. Each international health systems and services advisor stationed in each country, with the PAHO/WHO representative, are able to indicate at any time the status of the health system transformation processes, using quantitative and qualitative up-to-date information. Many of these data are sent regularly to PAHO headquarters, where an annual publication of the most relevant indicators is kept with official data.

This information and strategic knowledge on the progress of the countries is recorded every 5 years the flagship publication *Health in the Americas*, which reports the general trends of a series of classic public health indicators at the regional level, describing trends, advances, and impending challenges. The report includes analyses on the progress of the health situation. Along with this regional scope analysis, a summary of each country is prepared. The most recent version was published in 2017 and is one of the main sources of this report. In addition, the monitoring framework for progress towards universal health has been developed, as discussed in Section IV, which represents an important technical effort involving experts from throughout the Region. In addition to the information that can be obtained through the official channels, PAHO's regional and subregional experts develop situation analyses to guide the technical cooperation and work with the advisors posted in each country through support missions and other mechanisms of accompaniment.

VIII. The Countries' Experiences in the Region

As discussed, in the Region there are several examples of countries that have obtained important advances in their classical health indicators. The report results higher than those expected for their level of development and attribute these successes to health systems based on the PHC strategy. These examples are observed in different contexts and realities that will briefly reviewed.

The case of Belize

Belize initiated a health sector reform program in the latest 90's, aiming to modernize the country's healthcare system. As part of this initiative, many actions were adopted including the operational decentralization of the provision of health services to four health regions and the consolidation of Karl Heusner Memorial Hospital, the main reference hospital, as an autonomous statutory body. In 2001, a National Health Insurance (NHI) scheme was put in place as a financing and purchasing mechanism on behalf of consumers, of primary care level health services, from public and private providers. It is currently financed by government revenues through the Ministry of Health (MoH) and its governance falls under the Social Security Board (SSB), The scope of the scheme was limited to the poorest regions in Belize city, progressively extended to the southern region and some districts in the north of Belize.

After 17 years in place the scheme is still considered a pilot and is pending to be extended to cross-national level. Since it was launched, extensions of coverage have been applied and a good deal of achievements can be identified mostly related to the introduction of doctor-based groups practice for primary clinical care and has allowed for higher staff-to-patient ratios, and the concept of payment linked to performance based on pre-established "key performance indicators" and well defined standards and protocols of treatment, including NCDS. Satisfaction surveys conducted regularly show raising patient satisfaction among the covered population.

Challenges remain and are mostly related to the partial NHI implementation restricted to some geographical areas, which has created inequities and promoted fragmentation at the health facilities level hindering continuity of

care and creating a dual health services provision and purchasing of primary care health services. PAHO evaluation of the level of integration of care in 2016 in Central Region evidenced the need for improvements, highlighting the need for ensuring the availability and equitable distribution of adequate and motivated human resources for health. Another area of improvement in the entire network of health services provision is the need to ensure the availability of quality and adequate health technologies and medicines, by strengthening the regulation of the introduction of health technologies and medicines as well as improvements in their supply chain.

The case of Canada

Despite important efforts and numerous experiences at the territorial level, until the end of the 1990s, reforms based on PHC strengthening did not have a central importance in Canada. The reforms developed since the beginning of this century have managed to strengthen a system based on the PHC postulates. This has led to more than 50 percent of doctors working in the first level of care, most of them working as part of a team. Professional networks were strengthened, people were assigned to a team that provides continuity of care in the provision of services, financial incentives were established, as well as a unified clinical record, and an improvement in the training quality and support for the teams. The experience of Canada shows how governance changes with a strong leadership of the health authority, and the support of professional actors, can allow changes in a system that is based on essentially private providers.

The case of Costa Rica

Costa Rica is another case where a country of intermediate development has achieved very high levels of coverage and access to health for more than three decades. In Costa Rica, there is a clear separation of functions where the Ministry of Health operates as the Rector and the Costa Rican Social Security Fund (CCSS) has the service provider role. This is a special case within the region, where a public entity of social security plays a leading role in the provision of services. In this way, the population is insured in the social security fund and contributes part of their income to finance the system, which also receives contributions from the State and employers. It is assumed that people with no ability to pay are financed by state contributions and there are laws that oblige people with income to contribute. The CCSS is responsible for collecting and distributing resources.

The process of expanding the coverage and access of the population was consolidated in the 1990s with the reform that led to the creation of the EBAIS, integrated basic health teams of the CCSS that currently exceed 1,000 in

number and cover the entire national territory. This process was accompanied by the definition of a new comprehensive model of healthcare based on the PHC principles. The EBAIS has support teams from the health areas and there is a well-defined network of referrals to specialized care made up of the secondary and the tertiary levels of care.

The case of Cuba

In Cuba, the State is the main actor of the health system. Services are regulated, provided, and financed by the State and are based on the understanding of health as an inalienable social right. The Ministry of Health is the governing body that directs and executes the application of policies in matters of public health, as well as in the development of the medical-pharmaceutical industry and medical sciences.

The system is characterized by free services, preventive measures, normative centralization, operational decentralization, accessibility, community participation, and intersectoral action. The entire population has the right to access the system regardless of their income or occupation.

The system is organized to have a complete territorial coverage with outpatient units, it is expected that the first level of care address about 80% of the health needs of the populations with support from secondary and tertiary levels. The service provision is organized with a logic of first level of care based on doctors and family nurses who have an assigned population and develop an analysis of the health situation of their population in a participatory manner. More than 30,000 family doctors work in the system. An office has a population of between 600 and 700 people and every 15 to 20 offices have a support group that has specialists.

The results of health in life expectancy, infant mortality, and maternal mortality are very good, as summarized in table 2.

The case of Chile

Chile also reports favorable health outcomes when compared with countries of similar level of development, in terms of life expectancy, infant, maternal and general mortality, as well as in the regression of infectious diseases.

Prior to the global agreements reached in Alma-Ata, and as in Costa Rica and Cuba, Chile had policies for integrated approaches that allowed health priorities to be addressed with a PHC logic. Together with the service provision actions, the policy focused on elements of basic sanitation, family living conditions, access to drinking water, and in general, the deployment of a preventive approach.

In the Chilean case, the PHC strategy developed very strongly within the context of a segmented health system, with a strong private insurance component, and extensive provision of private services that have greater visibility and resources than public providers.

Starting in the 1990s, and through financial reforms, labor reforms, specific integrated initiatives, and the empowerment of the municipalities, the first level of care increased their participation in the public sector's operating budget from 10% of total expenditure to about 30%. This greater investment resulted in greater response capacity of health services and consolidation of multi-professional health teams. The results was a comprehensive health model with family, community, and intercultural approaches. The 2003-2005 reform introduced health care networks based on PHC and reinforced the development of the health sector. However, achievements in classic indicators have been overshadowed by the new challenges of an aging population and chronic diseases that the system still is not managing successfully.

The case of Jamaica

Jamaica's health system is regionalized with four Regional Health Authorities responsible for service delivery. Health service delivery in the public sector is provided through a network of primary (first level of contact), secondary, and tertiary care facilities.

Jamaica has a long history with Primary Health Care and made a notable contribution to the Alma Ata declaration by presenting its experiences and helping to shape the declaration. In the 1960's and 1970's Jamaica started with the development of a network of health centers island-wide and developing the Health Team for the First Level of Care (FLC). Training programs were established to produce various categories of health workers able to provide services at the FLC. Most outstanding was the training of lay persons as Community Health Aides that started in the late Sixties. At the time of the Alma Ata meeting the Ministry of Health had a network of over 1,200 Community Health Aides in place emphasizing prevention and health promotion.

The central role of services at the First Level of Care (FLC) was reinforced in the operational plan (Medium Term Socio-Economic Policy Framework) 2015-2018 for Vision 2030, the National Development Plan that stated; "The gains in advancing the Development and Protection of Human Capital health of our people must be protected by strengthening primary care including reducing infant and maternal mortality, advancing the health promotion approach, strengthening the system of surveillance and treatment of infectious diseases including HIV/AIDS, and improving the performance of the health service system".

The proliferation of health centers across the country over time, has resulted in a public network of a total of 327 FLC centers with a broad range and scope of services. Health centers are classified by type (type 1-5) according to the services they provide and the population they serve. The FLC centers along with 23 public hospitals are managed by the four Regional Health Authorities together with the 23 public hospitals. The extensive number of centers has increased access to primary health care services for all citizens.

Table 2. Key Indicators of Selected Country Experiences

Country	GDP per capita (PPP), 2017	Maternal mortality, 2015	Under five mortality, 2017	Life expectancy (years), 2017
Belize	7,890	28	18.4	70.8
Costa Rica	16,100	25	9.6	80.2
Chile	23,150	22	8.1	79.9
Cuba	…	39	5.5	80.1
Canada	45,750	7	5.3	82.7
Jamaica	8,690	89	22	76.2
USA	60,200	14	6.9	79.7

Source: PAHO/WHO: Health Situation in the Americas: Core Indicators, 2018.

These examples have been reviewed because they illustrate paths of progress despite very diverse national contexts, and because their reform development have already been implemented for a long time. It is necessary to point out that these are not the only examples that could be reviewed. Uruguay already reached or surpassed Chile, Cuba and Costa Rica in the classic indicators, with reforms that began this century. Antigua and Barbuda has ample experience in adopting the PHC strategy and establishing the first level of care as the first contact with comprehensive and universal services. In Brazil, although there is great heterogeneity, it is possible to see great advances in the last two decades thanks to a strategy of family medicine within the framework of a single health system that has strong social support and that has been very importantly reinforced in recent years through the *Mais Médicos* program. In Saint Lucia, a strong political commitment to PHC was adopted and translated into a policy of access to health facilities in such a way that no one could live more than three miles away from a first-level-of-care health center. Paraguay, Bolivia, and El Salvador have made great strides in covering vulnerable sectors with initiatives to install professionals following the PHC postulates. Guyana

has begun a process of implementation of integrated health services delivery networks. Peru is developing a strong push in telemedicine that is enhancing outpatient care. The region is a vibrant field of innovation and permanent action, where ministerial decision makers try to reverse the fragmentation and commodification trends and lead the systems towards the achievement of universal health.

IX. PAHO's Proposals for the Way Forward

This regional report of the Pan American Health Organization describes the regional situation in terms of mandates deriving from Alma-Ata that have guided the development of health systems and that will prefigure some of the lines for action that will be developed in the coming years. In the organization, and across the public health field in the Region in general, the Alma-Ata spirit continues to inspire the best efforts to achieve universal health. Beyond the diverse interpretations and the different paths that countries have undertaken, there is no reasonable alternative proposal to achieve good health systems for all.

PAHO is undertaking important efforts that will ultimately guide the task during the next decade. From a political and structural point of view, these efforts will be framed by two general initiatives: The Regional Forum "Universal Health in the 21st Century: 40 Years of Alma-Ata" and the High-Level Commission that supports the Forum. Additionally, it is expected that these initiatives will nourish the formulation of the organizational strategic plan for the 2020-2025 period, and that they will allow the achievement of the goals established in the Sustainable Health Agenda for the Americas 2018-2030. The Regional Forum was constituted in Quito, Ecuador, at the end of 2017 and will be extended until 2019. In this forum, reflection and debate about the future of health systems in the Americas are occurring. It is expected that this process will help to forge strategic alliances that would allow the influencing of the health systems transformation considering the voice of individuals and communities. The official document that starts and launches the Forum at the end of 2017 indicated that the following are the expected results:

- Development of a regional, subregional, and country dialogue on the meaning of the Alma-Ata Declaration and its expression in the 21st century: broad debate spaces organized in the form of virtual and face-to-face forums with selected themes.

- Involvement of the general public and the media in the discussion on universal health: what it means and how we can move forward in the 21st century.

- Deployment of participatory information and communication activities aimed at the population.

- Generation of thematic discussion groups on the future of health systems, the development of strategic alliances for the empowerment of people and communities, and the construction of collective movements for advocacy, transparency, and accountability, which will facilitate progress towards universal health

- Celebration of World Health Day 2018, for which Universal Coverage in Health is the chosen theme.

- Celebration of the 40th anniversary of Alma-Ata regionally and globally in 2018.

The Regional Forum will contribute to the global process for the renewal of the commitment to the values and principles of the Alma-Ata declaration organized by the World Health Organization.

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Simultaneously and as a way to channel and promote the debate and to translate it into concrete recommendations, the director of PAHO has established the creation of a High-Level Commission. The commission is made up of regional political leaders, experts, and civil society leaders, who represent a broad group of actors that includes representatives of vulnerable population groups. This commission will also work until 2019, deliberating on the advances after 40 years of Alma-Ata and defining the best pathways to close the existing gaps and face the emerging challenges. The recommendations are expected to support the progress towards universal access to health and universal health coverage as an expression of health for all in the 21st century. The explicit tasks of the established commission, as outlined in the originating document are:

1. To develop a high-level report for the Director of the Pan American Health Organization, with recommendations on the development of health systems, the empowerment of individuals and communities,

multisectoral work, transparency and accountability, taking into account the achievements of the last 40 years and the challenges that persist, as the Region of the Americas moves towards universal access to health and universal health coverage, such as the expression "health for all" in the 21st century.

2. To propose thematic discussion groups to facilitate the development of the high-level report. Likewise, receive and analyze the inputs of thematic discussion groups that are generated by the own initiative of interested actors, of the national and sub-regional dialog and debate spaces aimed at contributing to the high-level report.

3. To define and coordinate the execution of the action plan for the activities of the Regional Forum in 2018 and 2019.

4. To participate in the activities and meetings that PAHO plans to organize throughout 2018 and 2019 in the context of the Regional Forum "Universal Health in the 21st Century: 40 Years of Alma-Ata."

As indicated previously, it is expected that the deliberations of the Forum and the report of the commission will guide the work of the organization for the coming years and that it will be reflected in the provisions of the strategic plan 2020-2025.

At the same time as the political and leadership work is being developed, the technical cooperation initiatives are advancing to support health systems transformations efforts. Among these initiatives proposals exist for increasing the resolutive capacity of the first level of care, a proposal for systemic integration and sustainability of health priorities, the constitution of integrated Health Services Delivery Networks, the reformulation of Essential Public Health Functions, the policy and plan of action for human resources, the initiatives on medicines and health technologies, and the proposals for the area of financing.

Bibliography

Báscolo E, Houghton N, Del Riego A. Construction of a monitoring framework for universal health. Rev Panam Salud Pública. 2018; 42: e81. Available at: https://doi.org/10.26633/RPSP.2018.81

Pan American Health Organization. Health in the Americas+, 2017 Edition. Summary: Regional Outlook and Country Profiles. Washington, D.C.: PAHO; 2017. Available in: http://iris.paho.org/xmlui/handle/123456789/34469

Pan American Health Organization. Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Series Renewing Primary Health Care in the Americas, No. 4, 2010. Washington, D.C. PAHO. Available at: http://new.paho.org/hq/dmdocuments/2011/PHC_IHSD-2011Serie4.pdf

Pan American Health Organization. Regional Forum "Universal Health in the 21st century: 40 years of Alma-Ata" Available at: https://hsinnovacion.paho.org/en/regional-forum-universal-health-21st-century-40-years-alma-ata

Pan American Health Organization. Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas, Washington, D.C., 29 September-3 October 2014 (document CD53/5, Rev. 2). Available at: https://www.paho.org/hq/dmdocuments/2014/CD53-5-e.pdf

Pan American Health Organization. Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas, Washington, D.C., 29 September-3 October 2014 (Resolution CD53.R14). Available at: https://www.paho.org/hq/dmdocuments/2014/CD53-R14-e.pdf

Pan American Health Organization. Strategic Plan of the Pan American Health Organization 2014-2019. Championing Health: Sustainable Development and Equity. Available at: http://iris.paho.org/xmlui/handle/123456789/7654

Pan American Health Organization. The renewal of primary health care in the Americas: position paper of the Pan American Health Organization / World Health Organization (PAHO/WHO). Washington, D.C.: PAHO; 2007. Available at: http://iris.paho.org/xmlui/handle/123456789/31083

World Health Organization. Declaration of Alma-Ata [Internet]. International Conference on Primary Health Care, 6-12 September 1978; Alma-Ata, USSR. Geneva: WHO; 1978. Available at: www.who.int/publications/almaata_declaration_en.pdf

World Health Organization. The World Health Report 2008 - primary Health Care (Now More Than Ever). Available at: http://www.who.int/whr/2008/en/

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