Statement by Dr. Mirta Roses, Director of PAHO/WHO, at the Close of the Buenos Aires 30/15 International Conference FRIDAY, 17 AUGUST 2007

Greetings to those seated at the table of honor: Dr. Ginés Gonzalez García, Minister of Health of Argentina; Dr. Margaret Chan, Director-General of WHO, and Dr. Halfdan Mahler.
Acknowledgments to the local organizing committee and to the national and international scientific committee, as well as to the Ministry of Health and the Argentine government for this extraordinary conference, its problem-free organization, and the excellent reception we have received.

We have arrived at the final moment of this Buenos Aires 30-15 International Conference. It has been a very intense week for the delegations that are present, with many months of preparation and fruitful participation from across the world. I want to take advantage of the opportunity provided me through this closing statement to share some thoughts with you about:

- The meaning and importance of the Buenos Aires 30/15 International Conference
- The legacy of Alma-Ata
- Systems based on primary health care (PHC)

1- **Meaning and Importance of the Buenos Aires 30/15 International Conference**

At first glance, Buenos Aires 30-15, and the Declaration that it has produced, are very important symbolically because they come 30 years after the International Conference in Alma-Ata, and at the halfway point of the period set for the fulfillment of the Millennium Development Goals (MDGs).

This is not by chance. Dr. Margaret Chan, Director-General of WHO, pointed out in her presentation yesterday: there is a link between the two events.

There is historical continuity between the most important political and doctrinal definition of public health in the world, which established a noble and ambitious goal ("Health for All") and put us on the road to achieve it (Primary Health Care)—we have here with us in the then-Minister and current Minister of Health of Kazakhstan those who can give witness to Alma-Ata—and the most ambitious commitment to combat poverty ever undertaken by the international community.

There is ample evidence of this, and I will take the liberty of summarizing some key points that the participating countries made during the first three days, with their experiences complemented by the presentations of health policy authorities and the declaration of consensus that has been arrived at.

The principal agreements achieved during the first part of the conference point out three challenges: technical, political, and ethical.

The Technical Challenge

It is clear from the serious technical analysis carried out by the participating countries on experiences with health systems that:

- We have a great deal of work to do with regard to health systems; their transformation is indispensable to achieve "Health for All" and the scope of the MDGs; and the countries that have built sustainable, equitable, and PHC-based systems have achieved better results in health and have reached, or are on their way toward reaching, universal access to health services.
- Health workers are the essential component of health systems, but they are inadequately prepared to work in contexts based on PHC. The complex problems seen in terms of health workers should be addressed through long-term, sustainable and comprehensive policies directed not only toward improving traditional imbalances between education and services, but also toward solving problems of migration, multiple employment and unemployment, civil service careers, and improving the skills of the labor sector.
- Financing is a very sensitive indicator of the importance that public policy assigns to health and PHC. There is a lack of financial resources for health, as well as serious problems in health expenditures due to the disproportionate amount of direct out-of-pocket expenditures and the

threat represented by catastrophic expenditure. It is necessary to ensure sufficient, sustainable and equitably distributed financing for health.

The Political Challenge

Along with the technical challenges that must be overcome to build equitable, universal and collective health systems, I think that a great political challenge is evidence. That is, to guarantee all citizens the right to health through access to quality health goods and services according to their needs and without restriction.

Building health systems to achieve health for all is part of the **unfinished agenda.** The spirit of Alma-Ata is still reflected in this task at the dawn of the 21st century.

The Ethical Challenge

Together with this political challenge, an ethical challenge has been put forth: to put an end to unjust inequalities and advance toward equity in health.

In this regard I would like to make some comments about the reality of my Region, and for this I ask for the indulgence of participants from the other regions of the world.

In recent decades, the Region of the Americas has been improving its health indicators. Most of the Region today lives in a new period of economic improvement, thanks to an increase in exports and in foreign exchange earnings that has resulted from the record increase in the prices of exportable goods and significant growth in the world economy. In 2004, the Region had economic growth of 6%—the highest rate in 25 years—and in 2006 the growth rate reached 4.6%. There have already been four consecutive years of economic growth. At the same time, recent ECLAC reports show that, for the first time, this economic growth has been accompanied by a reduction in poverty and unemployment.

I want to emphasize that this is an optimal moment in our Region to invest the surplus in social development that improves the quality of the life of the people. This economic improvement could be fleeting, since it is dependent

on exports of primary goods. Thus, this opportunity to improve social investment, especially in health and education, cannot be lost. To date, there has been neither a modest nor sustained increase in public social expenditure in these sectors.

The other side of the coin of regional development is inequality and inequity. Latin America and the Caribbean continue to be the most unequal region in the world, according to income distribution—that is, not the poorest region, but the most inequitable. Persistent social exclusion and inequity in the distribution of wealth—as well as in access and use of services that is reflected in health outcomes—continue to be the principal obstacles to inclusive human development, to the success of poverty reduction strategies, to ensuring social unity, and to improving the health conditions of populations. In a region rich in natural and human resources, nearly a fourth of the population today lives on less than US$2 a day.

It is on the basis of this scenario that health systems based on PHC should be consolidated as an indispensable strategy to achieve health for all.

2-What Is the Legacy of Alma-Ata?

The social and health policy itinerary from 1978 until 2007 shows us that PHC has had an enormous influence on public policies, on the configuration of health systems, and on the thinking and actions of health workers. These influences include:

- The development of the doctrinal and programming framework for health promotion (Ottawa Charter)
- The recognition of the dialectic relationship between health and economic development and social productivity (Commission on Macroeconomics and Health)
- The immense potential for citizen participation in health-related decision-making (civil society forums-roundtables for social dialogue)
- The central role of the state and its leadership to ensure the development of health with equity (Regional crises of the 1990s and of the 2000 cycle)
- The nature, limitations, and imperfections of markets in health
- The actions of social determinants of health and the need for intersectoral action (Commission on Social Determinants of Health)

- The need for a vision that transcends the ordinary in interpreting the reality of the health situation to correct inequalities and demonstrate inequities in health
- The formulation of the Millennium Development Goals, as has been pointed out by the Director-General of WHO, among many other important authorities.

Those developments derived from Alma-Ata are consolidated and enriched by contributions from political and moral philosophy and the economy of development (as pointed out in the works of Amartya Sen), which have produced a reconfiguration of frameworks for social policy and governmental action. Along the way there has arisen a new vision of sustainable human development and the relationship between economic development, democracy, and social protection that has led to a new view of social and health policies and the contribution of health systems.

The view from this perspective of the fundamental social determinants of health and human development has assigned health a more important place on the global development agenda and has strengthened the role of health in public policies. Health is not only an input for economic growth, but rather, and principally, an essential component of human development.

Following Sen, this new approach regards health as a basic human capacity, as a fundamental requirement for human beings to be able to carry out their life projects and achieve their maximum life potential, and as an essential human right and a dimension of freedom.

Let us remember the great Italian legal and political philosopher, Norberto Bobbio, when he referred to the ideal of social justice: as long as poverty, ignorance, pain, and the abuse by some of others persist on the face of the earth, the ideal of social justice, of solidarity among human beings, will remain in force, and will justify the right and the obligation to rise up against the abuse and misery.

Paraphrasing, we can say that as long as social and health inequities persist and social exclusion in health continues, the ideal, as well as the principles and values of Alma-Ata, will remain in force.

It is on that axiological and ethical legacy, and on the enormous experience of public health workers accumulated over 30 years, that we can and should

build a new vision of the role of PHC in health systems in order to make them capable of achieving health for all. That is to say: health systems based on PHC.

3-What is the task ahead? To build universal, equitable, and collective health systems based on PHC

In 2007, by mandate of the Ministers of Health of the Americas, our Region initiated a collective and participatory process of reflection and analysis with a view to renewing primary health care so that it can guide and support the health systems that are needed to advance toward "Health for All." Following that mandate, a participatory process of regional consultation was carried out that culminated in the signing of the Charter of Montevideo.

Most countries of our Region require profound structural changes in their health systems so that they can contribute effectively to social protection, to guaranteeing the right to health of all citizens, and to social unity. Among those changes, it is essential to improve:

A. Health system segmentation: This refers to the existence of subsystems due to different financing sources and arrangements, reflecting social segmentation by ability to pay or insertion in the labor market. This structural feature consolidates and deepens inequality between social groups and is a factor in social exclusion. This keeps the poor and the informal on the outside.

B. Organizational fragmentation: Coexistence of infrastructure and capacities of various subsystems without coordination and with even less integration. This elevates the costs of duplication and greater transaction costs and also generates different types and levels of quality of services.

C. The previously-mentioned public financing deficit for health, with inadequate distribution of expenditure and low levels of efficiency. In the public-private financing mix, the proportion of private expenditure has prevailed for more than three decades. This high level of direct out-of-pocket expenditure has a greater impact on lower-income families that face the danger every day of falling into poverty because of catastrophic expenditures.

D. Weakness of institutional capacity of the national health authority (that is, the State), weaknesses that particularly affect the functions of:

- Sectoral management, that is, public policy formulation, execution, and evaluation
- Regulation of, for example, public insurance mechanisms and access to health goods
- Supervision and control of interventions and results
- Carrying out essential public health functions.
- Economic-financial management and the generation of resources.

There are countries in our Region and in the world that have managed to build health systems that effectively guarantee universal and equitable access, that are collective and participatory, and that at the same time ensure efficiency, effectiveness, and quality. All of these systems are based on primary health care. With the continuity and quality of their performance, these systems have become a part of their social heritage that people identify with and defend, as if these systems were (within the culture of the countries of South America, and many others) the national soccer team.

As was stated recently at the Meeting Ibero-American of Ministers of Health held in Iquique: How good it would be if all of our countries had health systems with such quality that were defended by citizens as a symbol of national identity, beyond regimes, crises, and external fads or impositions!!!

I believe that it is well worth making the commitment that the health systems of our countries be a source of national pride for all citizens, a public good, because those systems serve all of those citizens.

As indicated in the PAHO/WHO position paper on upgrading PHC in the Americas, a health system based on PHC….

- "…[E]ntails an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the basic principles of PHC…"
- "A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-

enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action."

- "International evidence suggests that health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient, have lower health care costs, and can achieve higher user satisfaction than those whose health systems that have only a weak PHC orientation"
- "The reorientation of health systems towards PHC requires a greater emphasis on health promotion and prevention. This is achieved by assigning appropriate functions to each level of government, integrating public and personal health services, focusing on families and communities, using accurate data in planning and in decision-making, and creating an institutional framework with incentives to improve the quality of services"

This position paper has been the contribution of the Region to the global debate that has been initiated under the leadership of the Director-General of WHO, Dr. Margaret Chan. I am not speaking about ideal health systems. I am speaking about real-life, working, current systems. There are many countries here that have built and in some instances rebuilt those systems and that can show with satisfaction the positive results those systems have produced and will continue to produce.

These are systems capable of protecting the population under any circumstances; resistant and resilient in the face of crises, as demonstrated during the recent history of Argentina and Uruguay; health systems capable of reacting rapidly and developing urgent strategies, based on PHC, in order to provide protection to the population, and that can rebuild themselves on the bases and principles of PHC.

At least three generations have met here, inspired by Alma-Ata and under the wise and firm guidance of the founders, and they are now carrying the torch forwards as in the Olympics. This advance will continue at the next meetings that are being convened in other countries and regions of the world.

From these days of work three points are remain clear for all of us:

We do not want, we do not need, the PHC of the crocodiles that Dr. Mahler criticized with all her moral authority and valor last Monday. We do not need weak, selective, or incomplete PHC that, as we say, is like a poor man's blanket that when stretched to one side leaves the other side uncovered. We want something that covers us all, not a PHC with basic packages only for the poor, or for rural areas, or for marginal areas.

We need and we want PHC that has equity, universality, solidarity, and social participation, that reflects a rich encounter of knowledge, that is intersectoral, that makes it possible for us to successfully address the social determinants of health, and that affirms and ensures the right to health.

We need and we want the PHC of Alma-Ata firmly rooted in the passion and commitment of 1978 and with the projection and capacity to transform current health systems, because we need them urgently, and because they are indispensable to the viability and sustainability of human society in the 21st century, when we will all have to share the same and only planet.

Thank you very much.