Renewing Primary Health Care in the Americas

A Position Paper of the Pan American Health Organization/World Health Organization (PAHO/WHO)

Pan American Health Organization
Regional Office of the World Health Organization

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at the opening ceremony of the 1st meeting of the PAHO Working Group on PHC in Washington, D.C., U.S.A. in June 2004.

Primary Health Care in the Americas

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

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Director's Letter

"Nothing great in the world has ever been accomplished without passion." –Hebbel, 1818–63

In 2003, motivated by the 25th Anniversary of Alma Ata Conference and at the behest of its member countries, PAHO decided to re–examine the values and principles that a few decades ago inspired the Alma Ata Declaration, in order to develop its future strategic and programmatic orientations in primary health care. The resulting strategy, presented in this document, provides a vision and renewed sense of purpose for health systems development: that of the Primary Health Care–Based Health System. This position paper reviews the legacy of Alma Ata in the Americas, articulates components of a new strategy for PHC renewal, and lays out steps that need to be taken in order to achieve this ambitious vision.

The vision of a Primary Health Care–based health system is well within the spirit of Alma Ata while acknowledging new developments such as the Ottawa Charter for health promotion, the Millennium Declaration, and the Commission on the Social Determinants of Health.

The process of developing this position paper has helped to invigorate debate about the meaning of health systems and their relationship to other determinants of population health and its equitable distribution in societies. Initial discussions about PHC renewal moved quickly from technical talk about health services to reflection about social values as fundamental determinants of health and health systems. Country consultations and meetings revealed a desire to assure that technical discussions about health policies continue to reflect the real meanings such policies have on the lives of citizens within the Region.

This document presents the work of numerous individuals and organizations, and thus, the extent and ambition of its vision reflects the diversity of its architects. The position paper focuses on the core values, principles, and elements likely to be present in a reinvigorated PHC approach, rather than describing an all–encompassing mold into which all countries are expected to fit. Each country will need to find its own way to craft a sustainable strategy for basing their health system more firmly on the PHC approach.

The road to achieving this vision is not expected to be a simple one, but few things of value come without dedication. Challenges include the need to invest in integrated networks of health and social services that have in many areas been inadequately staffed, equipped or supported. This overhaul needs to take place even within the context of shrinking budgets, which will require more rational and more equitable resource utilization, especially if countries want to reach those with greater needs. The best available evidence supports the contention that a strong PHC orientation is among the most equitable and efficient ways to organize a health system, although we must continue to evaluate innovations in PHC, disseminate best practices, and learn how to maximize and sustain their impact over time.

The position paper "Renewing Primary Health Care in the Americas" is intended to be a reference for all countries moving forward to strengthen their health care systems, bringing health care to people living in urban and rural areas, regardless of their gender, age, ethnicity, social status, or religion. We invite you to read this document conveying the views and feelings of a great diversity of individuals living and working in the Americas, as well as many experts from around the world. We look forward to continuing this ongoing dialogue as we embark together on this ambitious endeavor.

Mirta Roses Periago
Director

The opening ceremony of the Regional Consultation on PHC in Montevideo, Uruguay in July 2005.

Dr. María Julia Muñoz
Minister of Public Health of the Oriental Republic of Uruguay
(1st Left)

Dr. Tabaré Vázquez
President of the Oriental Republic of Uruguay

Mrs. Nora Castro,
President of the Lower House of Congress of the Oriental Republic of Uruguay
(2nd Right)

Mr. Eleuterio Fernández Huidobro
Vice–President of the Upper House of Congress of the Oriental Republic of Uruguay
(2nd left)

Dr. Carissa Etienne
Assistant Director of PAHO/WHO
(1st Righ)

Executive Summary

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

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

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

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

Main messages include:

- Throughout the extensive consultation process that formed the basis for this paper, it was found that PHC represents, even today, a source of inspiration and hope, not only for most health personnel, but for the community at large.
- Due to new challenges, knowledge, and contexts, there is a need to renew and reinvigorate PHC in the Region so that it can realize its potential to meet today's health challenges and those of the next quarter–century.
- Renewal of PHC entails recognizing and facilitating the role of PHC as an approach to promote more equitable health and human development.
- PHC renewal will need to pay increased attention to structural and operational needs such as access, financial fairness, adequacy and sustainability of resources, political commitment, and the development of systems that assure high quality care.
- Successful PHC experiences have demonstrated that system–wide approaches are needed, hence a renewed approach to PHC must make a stronger case for a reasoned and evidence –based approach to achieving universal, integrated, and comprehensive care.
- The proposed mechanism for PHC renewal is the transformation of health systems so that they incorporate PHC as their basis.
  - A PHC–based health system entails an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness to people's health needs, quality orientation, government accountability, social justice, sustainability, participation, and intersectoriality.

- A PHC–based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity–enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action.
- A PHC–based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal organization and management practices at all levels to achieve quality, efficiency, and effectiveness, and develops active mechanisms to maximize individual and collective participation in health. A PHC–based health system develops intersectorial actions to address other determinants of health and equity.
- International evidence suggests that health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient, have lower health care costs, and can achieve higher user satisfaction than those whose health systems have only a weak PHC orientation.
- The reorientation of health systems towards PHC requires 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 decision–making, and creating an institutional framework with incentives to improve the quality of services.
- Full realization of PHC requires additional focus on the role of human resources, development of strategies for managing change, and aligning international cooperation with the PHC approach.

- The next step to renewing PHC is to build an international coalition of interested parties. The tasks of this coalition will be to frame PHC renewal as a priority, develop the concept of PHC –based health systems so that it represents a feasible and politically appealing policy option, and finds ways to capitalize on the current window of opportunity provided by the recent 25th anniversary of Alma Ata, the international consensus on the importance of attaining the Millennium Development Goals (MDGs), and the current international focus on the need for strengthening health systems.


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March 2007

Why Renew Primary Health Care?

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

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

A renewed approach to PHC is viewed as an essential condition for meeting internationally agreed–upon development goals such as those contained in the United Nations Millennium Declaration (the Millennium Development Goals[i] or MDGs), as well as to address the fundamental causes of health as articulated by the WHO Commission on Social Determinants of Health, and to codify health as a human right as articulated by some national constitutions, civil society groups, and others. Renewing PHC will require building upon the legacy of Alma Ata and the primary health care movement, taking full advantage of lessons learned and the best practices resulting from more than a quarter–century of experience, and renewing and reinterpreting the approach and practice of primary health care to address the challenges of the twenty–first century.

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

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

Widening inequities represent more than just failures of the health system: they point to the

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

[i] *Millennium Development Goals (MDGs): The MDGs were developed in order to guide efforts to reach the agreements set out in the Millennium Declaration. These goals include: eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria, and other diseases; ensuring environmental sustainability; and developing a global partnership for development.*

inability of societies to address the underlying causes of ill health and its unfair distribution. In the 1970s and 1980s, many countries in the Americas experienced war, political upheaval, and totalitarian rule. Since then, transitions to democracy brought new hope, but for many countries the economic and social benefits of these transitions have yet to materialize. During the past decade, economic adjustment practices, globalization pressures, and the impact of some economic policies have, along with other factors, contributed to disparities in wealth, status, and power among and within countries in the Americas, which in turn have further exacerbated health inequities.[4–6] Today, the rapid proliferation of new health and information technologies has the potential to help bridge or to further widen these inequalities. Appendix C discusses some of the main developments in primary health care in the world and in the Region of the Americas.

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

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

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

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

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

Various observers have offered explanations as to why PHC differs so radically from country to country. Some argue that, with regards to the Americas in particular, different views on PHC are to be expected, given the historical development of health and health care in the Region and the legacy of different political and social systems.[17, 24] Others have suggested that the

[ii] *Throughout this document, the term "primary care" refers to the first contact and continuing care of health services. Primary care is considered only one aspect of primary health care.*

Table 1: Approaches to Primary Health Care

Approach	Primary Health Care definition or concept	Emphasis
Selective PHC	Focuses a limited number of high–impact services to address some of the most prevalent health challenges in developing countries.[20] Main services came to be known as GOBI (growth monitoring, oral rehydration techniques, breast–feeding, and immunization) and sometimes included food supplementation, female literacy, and family planning (GOBI–FFF).	Specific set of health service activities geared towards the poor
Primary care	Refers to the entry point into the health system and the place for continuing health care for most people, most of the time.[26] This is the most common concept of primary health care in Europe and other industrialized countries. Within its most narrow definition, the approach is directly related to the availability of practicing physicians with specialization in general practice or family medicine.	Level of care in a health services system
Alma Ata "comprehensive PHC"	The Alma Ata Declaration defines PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain…It forms an integral part of the country's health system…and of the social and economic development of the community. It is the first level of contact of individuals, the family and community …bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[27]	A strategy for organizing healthcare sytems and society to promote health
Health and Human Rights approach	Stresses understanding health as a human right and the necessity of tackling the broader social and political determinants of health.[11] It differs in its emphasis on the social and policy implications of the Alma Ata declaration more than on the principles themselves. It advocates that the social and political focus of PHC has lagged behind disease–specific aspects and that development policies should be more "inclusive, dynamic, transparent and supported by legislation and financial commitments", if they are to achieve equitable health improvements.[28]	A philosophy permeating the health and social sectors

Source: categories adapted from [29, 30]

divergence of views is explained by the ambitious and somewhat vague definitions of PHC as described in the Alma Ata declaration.[25] Others argue that while many effective PHC initiatives were developed in the years after Alma Ata, the main message became distorted as the result of both the changing visions of international health agencies and globalization processes.[11] Regardless of the ultimate cause(s), it is clear that the concept of PHC has become increasingly expansive and confused since Alma Ata, and that PHC has not accomplished everything its champions had intended.

As PHC became entwined with the goal of "Health for All by the Year 2000", its meaning and focus also broadened to include a whole range of outcomes that were outside the direct responsibility of the health system.[31] Unfortunately, as the millennium approached it became increasingly clear that Health for All would not be attained. For some, the failure of reaching this goal came to be associated with the perceived failure of PHC itself.

Paradoxically, as the meaning of PHC expanded to include multiple sectors, its implementation became increasingly narrow. Although originally considered an interim strategy, selective PHC became the dominant mode of primary health care for many countries. The approach continued through many sub–population or disease–specific vertical programs. At one level, the push towards selective PHC can be seen as a reaction to the idea that PHC had become too broad and vague, with impacts and successes difficult to quantify, and little in the way of visible dividends for the public or policymakers. The selective approach, in contrast, allowed for targeting limited resources towards specific health targets, although in some cases this approach appears to have been chosen as part of a strategy to attract increased donor financing for health services.[32]

Although successful in some areas (such as immunization), the selective PHC approach has been criticized for ignoring the wider context of social and economic development. This is not the same as saying that PHC must address all health determinants, but it does imply that selective approaches are, more often than not, unable to address the fundamental causes of ill health.[33] It has also been argued that selective approaches, by targeting narrow populations and narrow health issues, may create gaps between programs that leave some families or individuals under–served. Moreover, there is concern that selective PHC's nearly exclusive focus on children and women ignores the growing importance of

health threats such as chronic diseases, mental illness, injuries, sexually transmitted infections and HIV/AIDS, as well as vulnerable populations such as adolescents and the elderly.[34]

Questions have also been raised over whether interventions focused on a single disease or population group are sustainable, since if interest in that disease or group evaporates, program funding may also disappear. And finally, there is concern that the selective PHC approach overlooks the fact that many adults (and to a lesser extent, children) are likely to suffer from more than one health problem at the same time—a condition even more frequent among the elderly.[35] For all of these reasons, a renewed approach to PHC must make a stronger case for a reasoned and evidence–based approach to achieving universal, integrated, and comprehensive care. This is not to say that vertical approaches should be discontinued, or are never needed. Indeed, vertical approaches are often necessary for outbreaks or for "scourges that are so widespread, and affect so high a proportion of the population as to be a dominant factor in hindering the social and economic development of a country".[36]

Renewing PHC is expected to contribute to efforts underway to strengthen health systems in the developing world. Moreover, new vertically–focused global health initiatives such as the Global Fund for Aids, Tuberculosis, and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) represent an important new source of investment, advocacy, and resource mobilization for many developing countries. A renewed approach to PHC will need to consider the extent to which such initiatives can aid in strengthening a more comprehensive and integrated approach to health systems development with the understanding that attainment and sustainability of these initiatives´ goals are likely to require such an approach.[2, 37]

In September 2003, during the 44th Directing Council, PAHO/WHO passed Resolution CD44.R6 calling for Member States to adopt a series of recommendations to strengthen PHC. In addition, the Resolution calls for PAHO/WHO to: take PHC principles into account in the activities of technical cooperation programs, especially those related to the Millennium Declaration and its goals; evaluate different systems based on PHC; identify and disseminate best practices; assist in the training of health workers for PHC; support locally defined PHC models; celebrate the 25th anniversary of Alma Ata; and organize a process for defining future strategic and programmatic orientations in PHC. In response to the above mandates, in May 2004 PAHO/WHO created the "Working Group on PHC" (WG) to advise the Organization on future strategic and programmatic orientations in PHC. (See appendix A). The WG engaged in a consultative process with the international community through several international conferences, and circulated the draft position paper to all Member Countries and experts. In addition, 20 countries convened national–level meetings on PHC renewal, and in July 2005, a Regional Consultation was held in Montevideo, Uruguay. The Regional Consultation brought together nearly 100 individuals representing more than 30 countries in the Region, non–governmental organizations, professional associations, universities, and UN agencies. On September 29, 2005, PAHO's 46th Directing Council approved the Regional Declaration on PHC, known as *Declaration of Montevideo* (See appendix B), and provided further comments to the position paper on PHC. This document is the principal outcome of these processes.

March 2007

Building Primary Health Care–Based Health Systems

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

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

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

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

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

Figure 1 presents the proposed values, principles, and elements of a PHC–based health system. See below for a more complete description.

A. Values[v]

Values are essential for setting national priorities and for evaluating whether or not social arrangements are meeting population needs and expectations.[14] They provide a moral anchor for policies and programs enacted in the public interest. The values described here are intended to reflect those in the society at large. In any given society, some values may take precedence over others, and may even be defined in slightly different ways based on local culture, history, and preferences. At the same time, a growing body of international law defines parameters necessary to protect the most disadvantaged in society, creating a

[iii] *Health system: The WHO defines the health system as that which "comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health".*[38]

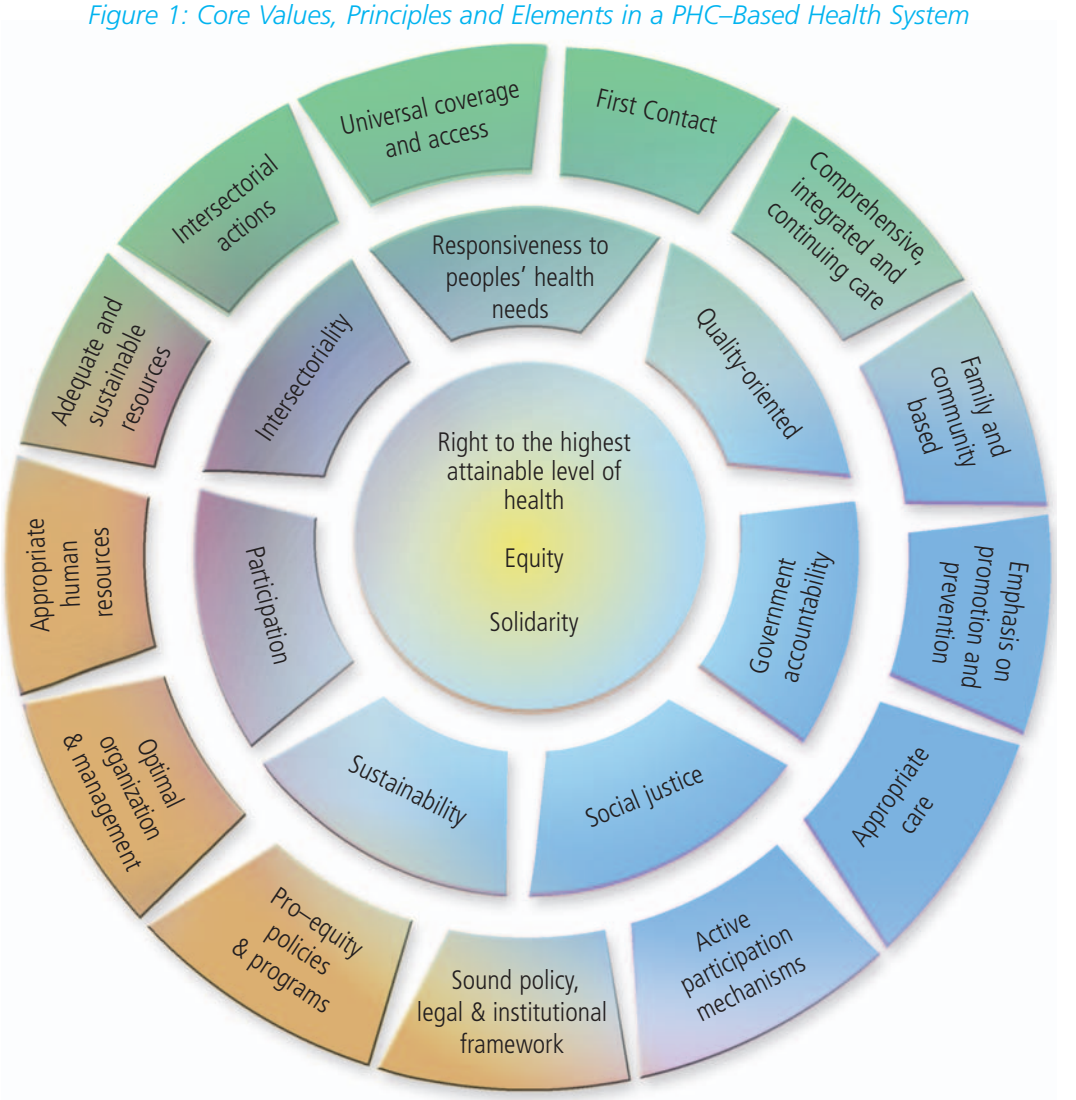
[iv] *There are other precedents for basing health systems on PHC. For example, the Ljubljana Charter for Health Reform adopted by the European Union in 1996 states that health systems must be: value driven (human dignity, equity, solidarity, professional ethics), targeted on health outcomes, centered on people while encouraging self-reliance, focused on quality, based on sound financing, responsive to citizen's voice and choice, based on evidence; and require strengthened management, human resources, and policy coordination.*[39]

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

legal basis upon which they may assert their claims to dignity, freedom, and good health. This implies that the process of basing a health system more strongly on PHC must begin with an analysis of social

health claims for citizens that provide recourse when obligations are not met. The right to the highest attainable level of health is instrumental in assuring that services are responsive to people's needs, that

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



values and involve citizen and decision–maker participation in how such values are articulated, defined, and prioritized. [14]

The **right to the highest attainable level of health** without distinction of race, gender, religion, political belief, or economic or social condition is expressed in many national constitutions and articulated in international treaties, including the charter of the World Health Organization.[40] It implies legally –defined rights of citizens and responsibilities of government and other actors and creates there is accountability in the health system, and that PHC is quality–oriented, achieving maximum efficiency and effectiveness while minimizing harm. Health and other rights are inextricably bound with equity, and these, in turn, reflect and help reinforce social solidarity.

Equity in health addresses unfair differences in health status, access to healthcare and health–enhancing environments, and treatment within the health and social services system. Equity has intrinsic value since it is a prerequisite for human capacity, freedoms, and rights.[41] Equity is a cornerstone of

social values; the way in which societies treat their most disadvantaged members reflects either an explicit or implicit judgment about the value of human life. Simply appealing to a society's values or moral conscience may not be enough to prevent or reverse inequities in health. This means that people must be able to redress inequities through the exercise of their moral and legal claims to health and other social rights. Placing equity within the core of a PHC–based health system is intended to guide health policies and programs and to underscore the fact that they should be equity–enhancing. The rationale for this is not simply efficiency, cost–effectiveness, or charity; rather, in a just society, equity ought to be viewed as a moral imperative and a legal and social obligation.

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

B. Principles[vi]

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

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

Quality–oriented services respond to and anticipate peoples' needs and imply treating all people with dignity and respect, assuring the best possible interventions for their health problems, and avoiding any harm.[42] This requires providing health professionals at all levels with evidence–based clinical knowledge and with the tools necessary to continuously update their training. A quality orientation calls for procedures to assess the efficiency, effectiveness, and safety of preventive and curative health interventions, and assigns resources accordingly. It requires both quality assurance and continuous quality improvement methods. Sound leadership and appropriate incentives are essential to making this process effective and sustainable.

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

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

(e.g. local, state, regional, national) need clear lines of responsibility and corresponding accountability mechanisms. Citizens and civic society also play an important role in assuring accountability.

A just society can be viewed as one that assures the development and capacity of all of its members.[43] **Social justice** therefore suggests that government actions, in particular, should be assessed by the extent to which they assure the welfare of all citizens, particularly the most vulnerable.[44, 45] Some approaches to achieving social justice in the health sector include: assuring that all people are treated with respect and dignity; setting health goals that incorporate explicit targets for improved coverage among the poor; using these goals to direct additional resources toward the needs of the disadvantaged; improving education and outreach initiatives to help citizens understand their rights; ensuring active citizen participation in health system planning and oversight; and taking concrete actions to address underlying social determinants of health inequities.[12]

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

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

Intersectoriality in health means that the health sector must work alongside other sectors and actors in order to assure that public policies and programs are aligned to maximize their potential contribution to health and human development. This requires that the health sector have a seat at the table when decisions about development policies are made. The principle of intersectoriality requires the creation and maintenance of links between the public and private sectors, both within and outside health services, including, but not limited to: employment and labor; education; housing; agriculture, food production and distribution; environment; water and sanitation; social care; and urban planning.

C. Elements[vii]

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

Universal coverage and access form the foundation of an equitable health system. Universal coverage implies that financing and organizational arrangements are sufficient to cover the entire population, removing ability to pay as a barrier to accessing health services and protecting people from financial risk, while providing additional support to meet equity goals and implement health promoting activities. Accessibility implies the absence of geographic, financial, organizational, socio–cultural, and gender–based barriers to care[46]; thus a PHC–based health system must rationalize the location, operation, and financing of all services at each level of the health system. It also requires that services be acceptable to the population by taking into account local health needs, preferences, culture, and values. Therefore, it requires both an intercultural and a gender approach to health services delivery. Acceptability determines whether people will actually use services, even if they are accessible. It also influences perceptions about the health system, including people's satisfaction with services provided, the level of trust they will have in providers, and the extent to which they will understand and actually follow medical or other advice given.

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

Box 1: Renewing PHC: Implications for Health Services

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

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

[vii] *Element: a component part or quality, often one that is basic or essential.*

structural and functional elements that go significantly beyond the first level of the health care system.

Comprehensive, integrated and continuing care means that the range of services available must be sufficient to provide for population health needs, including the provision of promotion, prevention, early diagnosis, curative, rehabilitative, palliative care, and support for self–management. Comprehensiveness is a function of the entire health system and includes prevention, primary, secondary, tertiary, and palliative care. Integrated care is a complement to comprehensiveness in that it requires coordination among all parts of the health system, to ensure that health needs are met and that health care proceeds across time and across different levels and places of care without interruption. For individuals, integrated care involves a life–course approach to referrals and counter-referrals through all levels of the health system, and at times to other social services. At the systems level, it requires the development of service and provider networks, appropriate information and management systems, incentives, policies and procedures, and training of health providers, staff, and administrators.

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

An **emphasis on promotion and prevention** is paramount in a PHC–based health system, because doing so is cost–effective, ethical, can empower communities and individuals to gain greater control over their own health, and is essential for addressing the "upstream" social determinants of health. An emphasis on promotion and prevention means going beyond a clinical orientation to embrace health education and counseling at work, in schools, and in the home. These concerns, including the need to reorient health services toward PHC principles, were articulated in the 1986 Ottawa Charter for Health Promotion. Health promotion also requires regulatory and policy–based approaches to improving peoples' working conditions and safety, reducing health hazards present in the built and natural environment, and carrying out population–based health promotion strategies with other parts of the health system or with other actors. This includes links with the essential public health functions (EPHF)[viii] making PHC an active partner in public health surveillance, research and evaluation, quality assurance, and institutional development activities across the health system.

[viii] *Essential public health functions: Include: i) Monitoring, evaluation, and analysis of health status; ii) Public health surveillance, research, and control of risks and threats to public health; iii) Health promotion; iv) Social participation in health; v) Development of policies and institutional capacity for planning and management in public health; vi) Strengthening of institutional capacity for regulation and enforcement in public health; vii) Evaluation and promotion of equitable access to necessary health services; viii) Human resources development and training in public health; ix) Quality assurance in personal and population–based health services; x) Research in public health; and xi) Reducing the impact of emergencies and disasters on health.*[47]

Appropriate care implies that a health system is person–centered and is not simply disease or organ–based. It focuses on the whole person and their health and social needs, tailoring responses to the local community and its context over the course of life, while assuring that interventions are safe and that people come to no harm. It incorporates the concept of effectiveness to help guide the selection and the prioritization of prevention and curative care strategies so that maximum impact can be achieved with limited resources. Appropriate care implies that all care is provided based on the best available evidence, while allocation of efforts is prioritized by considering efficiency (allocative and technical) and equity criteria. Services need to be relevant, which requires meeting the common needs of the entire population while addressing the specific needs of particular populations such as women, the elderly, the disabled, indigenous, or afro–descendent populations who may not receive appropriate care because of the way the common health care is organized or delivered.

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

The structures and functions of a PHC– based health system require a **sound policy, legal, and institutional framework** that identifies and empowers the actions, actors, procedures, and legal and financial systems that allow PHC to perform its specified functions. It necessitates coordination of health policies and strategic investments in health systems and services research, including the evaluation of new technologies. These activities are part of the stewardship function of the health system, and must therefore be transparent, subject to social control, and free from corruption.

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

In terms of operations, PHC–based health systems require **optimal organization and management** practices that allow innovation to constantly improve the organization and delivery of care that is safe, meets quality standards, provides satisfying workplaces for health workers, and is responsive to citizens. Valuable management practices include, among others, strategic planning, operations research, and performance evaluation. Health professionals and managers should regularly collect and use data to aid in decision making and planning, including the development of plans to adequately respond to future health and social crises and natural disasters.

Appropriate human resources, include providers, community workers, managers, and support staff with the right knowledge and skills mix, who observe ethical standards and treat all people with dignity and respect. This requires strategic planning and

long–term investments in training, employment, retention, and upgrading and enhancing existing health worker skills and knowledge. Multidisciplinary teams are essential and require not only the right mix of professionals, but also delineation of roles and responsibilities, their equitable geographic

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

PHC–based health systems create synergistic links with other sectors in order to help drive the process of human development. PHC has a strong (but not exclusive) role, in conjunction with other sectors and actors, in promoting sustainable and equitable human development. Making this distinction is important for the establishment of clear responsibilities among the different sectors regarding their contribution to the goal of socioeconomic development. Failure to clearly distinguish between different sectors' strengths and comparative advantages could lead to several undesirable consequences. Chief among these are the potential neglect of core functions of the health care system; poor implementation of expanded developmental functions due to lack of specialization; and creation of disputes among responsible actors and agencies resulting in redundancies, and wasted energy and resources.

distribution, and training to maximize the contribution of team work to outcomes, and to health worker and user satisfaction.

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

Health systems based on PHC are wider in scope and impact than the mere provision of health care services. A PHC–based system is intimately connected to **intersectorial actions** and community approaches to promote health and human development. These actions are required to address the fundamental determinants of population health by creating synergistic links between health and other sectors and actors, such as schools, workplaces, economic and urban development programs, agricultural development and marketing, water and sanitation provision, and others. The extent to which these actions are implemented by the health sector alone or in partnership with other actors will depend on the characteristics of that country's (and community's) development status, as well as the comparative advantage of each actor or sector involved. (*See Box 2*)

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

There is considerable evidence of the benefits of PHC. International studies suggest that, all else equal, countries with health systems with a strong PHC orientation are more likely to have better and more equitable health outcomes, be more efficient, have lower healthcare costs, and achieve higher user satisfaction than those health systems with a weak PHC orientation.[48–54]

Health systems based on PHC are thought to be able to improve equity because the PHC approach is less costly to individuals and more cost–effective to society when compared to specialty–oriented care.[55] A strong PHC approach has been shown to assure greater efficiency of services in the form of time saved in consultation, reduced use of laboratory tests, and reduced health care expenditures.[56, 57] PHC can thus free up resources to attend to the health needs of the most disadvantaged.[52, 58, 59] Equity–oriented health systems capitalize on these savings by establishing goals for improved coverage among the poor, and by empowering vulnerable groups to have a more central role in health system design and operation.[60] They minimize out–of–pocket expenses and indirect costs of care and instead emphasize universal coverage

to remove socioeconomic factors as a barrier to receiving needed care.[61–63]

Evidence, particularly from European countries, suggests that health systems based on PHC can also enhance efficiency and effectiveness. Studies of hospitalizations for "ambulatory care sensitive conditions"–conditions treated in hospitals which could have been resolved in primary care–and use of emergency rooms for routine care show how PHC systems that assure access and first contact can improve health outcomes and benefit other levels of the health care system. [64–68] Strengthening primary care services has been found to reduce overall rates of hospitalization for conditions such as angina, pneumonia, urinary tract infections, chronic pulmonary obstructive disease, cardiac arrest, and ear, nose and throat infections, among others.[69] Individuals who have a regular source of primary care over time for most of their health care needs have improved satisfaction, better compliance, fewer hospitalizations and less emergency room use than those who do not.[70–72]

In the Region of the Americas, the experiences of Costa Rica show that comprehensive PHC reform (including increased access, reorganized health professionals into multidisciplinary teams, and improved comprehensive and integrated care) can improve health outcomes. For every five additional years after PHC reform, child mortality was reduced by 13 percent, and adult mortality was reduced by four percent, independent of improvements in other health determinants.[73] Because reforms took place first in the most deprived areas (insufficient access to essential services declined by 15 percent in reformed districts), they contributed to improvements in equity.[74]

Evidence has shown that for PHC to benefit population health, services must also be of good technical quality, an area that requires considerable additional attention throughout the Region.[75, 76] Finally, more is needed on the evaluation of health systems in general, and PHC in particular.[77] A commitment to PHC–based health systems will require a more complete evidence–base, with appropriate investments made in the evaluation and documentation of experiences that allow for development, transfer, and adaptation of best practices.

March 2007

The Way Forward

An approach to renewing PHC will include:

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

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

A. Learning from Experience

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

Factors perceived to have been barriers to effective PHC implementation include the difficulties inherent in transforming the health sector from curative, hospital–based approaches to preventive, community–based ones. Constraints included the segmentation and fragmentation of health systems, lack of political commitment; inadequate coordination among communities and local, national, and international agencies (including adjustment policies and emphasis on vertical programs); inadequate use of local data; and poor intersectorial collaboration. The economic climate was also a factor due to changing economic and political ideologies and the volatility of macroeconomic conditions that led to underinvestment in health systems and services.[11, 32, 78, 79] Investment in human resources was emphasized as an essential area requiring attention, since the quality of health services depends to a great extent on the people who work in them. Health personnel must be trained in both a technical and humanistic perspective; their performance depends not only on their training and abilities, but also on their working environment and on appropriate incentive policies at both the local and global levels.[76, 80] Particular attention has been called to the international shortage and unequal distribution of nurses and the difficulties in retaining nurses due to generally poor employment and working conditions and international policies that may encourage their emigration to the developed world. (*See Box 3*)

Factors found to have facilitated the effective development of PHC implementation include recognizing that health sector leadership is determined by many factors some of which are outside the direct control of the health sector. Improvements in equity also seem to require sustained political commitment at the national level, including making provisions to ensure that health funding is sufficient to meet population needs.[81] Successful PHC experiences have demonstrated that simply increasing the number of health centers and providing short–term training of personnel is insufficient to improve health and equity. Instead, system–wide approaches are needed. Reorienting health systems towards PHC requires a greater emphasis on health promotion and prevention. Successful PHC services encourage participation, are accountable, have an appropriate level of investment to guarantee that adequate services are available, and ensure that these services are accessible, regardless of a person's ability to pay.[24, 11] Out–of–pocket expenses, in particular, have been found to be among the most inequitable means of financing health services: successful PHC approaches in the Region have tended to emphasize universal coverage in order to remove financial barriers to access. [61–63] Finally, the efforts of community health workers and other social activists, even in the face of opposition, were often seen as key to the development of innovative approaches to improving the health of communities throughout the Region.

Box 3: Human Resource Challenges in the Americas

Current challenges:

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

Human resources implications of designing a health system based on PHC

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

Sources: [28, 82, 83]

B. Building Coalitions for Change

Health reforms involve fundamental changes in political processes and power, so advocates of PHC–based health systems will need to pay attention to both the political and technical dimensions of reforms, as well as to the actors involved in these processes. At the Alma Ata conference in 1978, Halfdan Mahler asked participants: "Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of Primary Health Care?"[32] This same question needs to be asked again today, because considerable resources must be put into implementing the vision of health systems based on a renewed approach to PHC.

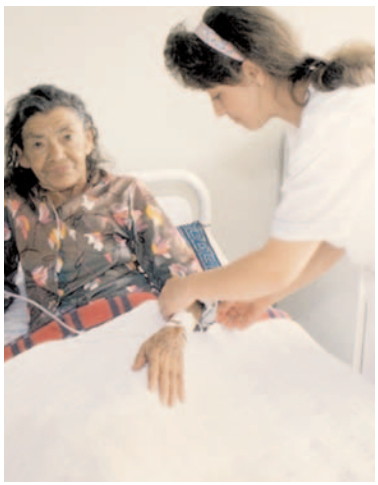
Supporters of the effort include those who currently work in or on PHC. These include some nongovernmental organizations, health providers who work in primary care settings, professional associations that support PHC (such as those of family medicine and nursing associations), some governments that have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

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

Both supporters and opponents of PHC renewal are outnumbered, however, by the many actors, organizations, and agencies that are likely to be neutral on the issue. These include many multilateral and bilateral agencies, payers of health services and most

private citizens. Taken together, this neutral group has considerable political and economic clout; however, taken as individuals, their interests often do not coincide. More often they are dispersed and can even be at odds with one another over different issues. Thus, the key for advocates of PHC renewal will be to find an aspect of the renewal effort that will appeal to many of these actors and groups, and mobilize them to ally themselves with PHC supporters.

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



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

Focusing on specific actors, funding organizations such as multilateral/bilateral financial and development agencies, institutions, and foundations will need to be convinced that PHC renewal will strengthen the impact and sustainability of their objectives, such as attainment of the WHO AIDS Universal Access initiative, realization of the goals of the Global Fund, ensuring more equitable social development, and other international health and development efforts. Advocates of PHC renewal must make the argument that investments in the health sector are crucial in order to create the conditions necessary for broad–based, equitable human development, and that a PHC–based health system provides the foundation for a sustainable and responsive "integrated delivery system" necessary for achieving the objectives of these other international initiatives.[84]

Similarly, PHC advocates will need to convince those who pay for health services–health insurers,

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

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

At the same time, PHC advocates must work to strengthen the position of PHC supporters. This will involve development of coalitions and networks, and dissemination of evidence and best practices. Today there is a unique opportunity to build an international coalition of individuals and organizations dedicated to renewing PHC. This coincides with increased attention given to the issue of equity, the role of the international community in fostering health as a global public good, and increased dissatisfaction with the status quo.[85] Advocates for PHC renewal will need access to the evidence–base on the benefits of a health system based on PHC. Lessons learned must be disseminated to interested parties, advocates, and change agents at all levels.

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

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

C. Strategic Lines of Action

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

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

At the country level (national territory of each country)

Member States, represented by their governments should:

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

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

Subregional entities, working with PAHO/WHO should:

1. Coordinate and facilitate the process of PHC renewal.
2. Develop a strategy for communication and advocacy to advance the concept of PHC–based health systems.
3. Conduct an analysis of interested parties, and explore policy options and strategies that can lead to the full realization of a PHC–based health system in the subregion.
4. Support PAHO/WHO and other international cooperation agencies in mobilizing resources in support of PHC initiatives at the subregional level.

At the regional level (Region of the Americas)

PAHO/WHO, OAS, and the regional entities, including international cooperation agencies should:

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

At the global level (worldwide)

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

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

March 2007

Appendices

Appendix A: Methods

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

The Working Group on PHC (WG) was created on May 13, 2004, in accordance with PAHO/WHO Resolution CD44.R6 calling on Member States to adopt a series of recommendations to strengthen PHC. The plenary sessions of the WG were held in Washington (June 28–30, 2004) and in San José de Costa Rica (October 25–29, 2004). The objectives of the WG were to: 1) examine and reaffirm the conceptual dimensions of PHC as contained in the Alma Ata Declaration; 2) develop operational definitions of concepts relevant to PHC; 3) provide guidance to countries and PAHO/WHO on how to reorient the Region's health systems and services following the principles of PHC; 4) draft a new regional declaration on PHC that reflects current realities in health services systems and the need for assessment of PHC attainment and progress; and 5) organize and carry out a regional consultation with relevant stakeholders in order to legitimize the above processes.

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

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

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

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

The current position paper and Regional Declaration reflect the recommendations made through these consultative processes.

Box 4: National Consultations on Renewing PHC

Country	Date
Argentina	May 20–June 10
Bolivia	June (virtual)
Brazil	June 7
Chile	June 11
Colombia	May 25 –28
Costa Rica	June 10
Cuba	June 13
Dominican Republic	June 27–30
Ecuador	July 14
El Salvador	June15

Country	Date
Guatemala	June 2 and 9
Guyana	May 12
Jamaica	May 5
Mexico	July 1
Nicaragua	June 21 and 23
Panama	July 8
Paraguay	June 2
Peru	July 14 and 15
Suriname	June 30
Venezuela	July 14 and 20

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

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

Appendix B: Regional Declaration on the New Orientations for Primary Health Care (Declaration of Montevideo)

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION
46th DIRECTING COUNCIL
57th SESSION OF THE REGIONAL COMMITTEE
Washington, D.C., USA, 26–30 September 2005

CONSIDERING THAT:

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

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

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

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

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

WE COMMIT TO:

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

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

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

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

Local–level participation in the health system by individuals and collectively by communities needs to be strengthened to provide the individual, family, and community a voice in decision–making, strengthen implementation and individual and community action, and effectively support and sustain profamily health policies over time. Member

States should make information on health outcomes, health programs, and health center performance available to communities for use in exercising oversight of the health system.

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

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

V) Orientation toward quality of care and patient safety.
Health systems should provide appropriate, effective, and efficient care and should incorporate the dimensions of patient safety and consumer satisfaction. This includes processes of continuous quality improvement and quality assurance for clinical, preventive, and health–promoting interventions.

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

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

VIII) Guarantee of financial sustainability.
States must make the necessary efforts to work toward the achievements of sustainable financing for health systems, support the process of primary health care renewal and promote a sufficient response to population's health needs, with the support of international cooperation agencies.

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

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

(Eighth meeting, 29 September 2005)

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

Year	Global Events	Events in the Americas
1900–1950s	• The UN Conference held in San Francisco unanimously agreed to establish an autonomous new international health organization (1945) • Development of the Community Oriented Primary Care approach in South Africa and in the United States	• International Sanitary Bureau established (1902) • Life expectancy: 55.2 years (1950–1955)
1960s	• The Christian Medical Commission was created by medical missionaries working in developing countries. They emphasized training of village health workers	• Rapid increase in the training of health professionals and investment in health infrastructure throughout the Americas. • Life expectancy: 65.06 years (1968, estimated)
1970s	• Expansion of the "barefoot doctors" program in China • Basic needs are prioritized: food, housing, water, supplies, medical services, education and employment • Halfdan Mahler is elected WHO's Director General. He effectively supported community work (1973) • First Population Conference (1974) • 28th World Health Assembly to prioritize the construction of National Programs in PHC (1975) • International Conference of Alma Ata (1978) • Eradication of smallpox (1979) • Selective Primary Health Care (1979)	• The Canadian Lalonde Report develops the idea of "non–medical" determinants of health (1974) • Development of regional health goals • Small–scale community–oriented primary care projects in Venezuela, Central America, and elsewhere • Life expectancy: 66 years (1978)
1980s	• Health for All • WHO begins program to combat HIV/AIDS • Expansion of selective PHC and vertical programs • Population Conference (Mexico, 1983) • Ottawa Charter (1986)	• Development of Regional Action Plan • Economic depression • Public services deteriorate • Democratic governments elected in some countries • Donor dependency • Local health systems approach (SILOS) • Renewed community participation • Vaccination coverage for measles: 48% • Incidence of measles: 408/1,000,000 • Life expectancy: 69.2 years (1980–85)
1990s	• Sustainable development • Human development concept • World Bank points out need of fighting against poverty and investing in health • Health Sector Reform promotes a basic health services package • Changing role of the State • Children's Summit (New York, 1990) • Earth Summit (Rio, 1992) • Conference on Population and Reproductive Health (Cairo,1994)	• Cholera epidemic • Progressive deterioration of life conditions, social and physical environment • Some health reforms strengthen PHC (e.g. Cuba, Costa Rica) • PIAS (Environment and Health Investment Plan) • End to civil wars in Central America • Eradication of Polio in the Americas (1994) • Life expectancy: 72.0 (1996)
2000s	• Commission on Macroeconomics and Health • Expansion of HIV/AIDS pandemic • Establishment of the Global Fund for AIDS, Malaria, and Tuberculosis • Establishment of GAVI • Focus on equity in health • Health as a global public health good • Millennium Development Goals (MDGs) • Commission on the Social Determinants of Health • Bangkok Charter (2005)	• Vaccination coverage for measles: 93% • Incidence of measles: 2 per 1,000,000 • Life expectancy: 72.9 years (1995–2000) • Renewal of PHC in the Americas

Sources: [32, 82, 86–91]

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

Area	Facilitating Factors	Barriers
Vision/approach to health	• Integrated approach to health and its determinants • Community health promotion • Promotion of individual, family, and community self–responsibility	• Fragmented vision of health and development concepts • Indifference toward the determinants of health • Lack of a preventive and self–care approach • Excessive focus on curative and specialized care • Insufficient operationalization of PHC concepts • Different interpretations of PHC
Characteristics of health systems	• Universal coverage as part of social inclusion • Services are based on population needs • Coordination functions at every level • Care is based on evidence and quality	• Health reforms that have segmented people based on ability to pay for health services • Segmentation between public, social security, and private sector • Lack of coordination and referral systems • Deficient regulatory capacity
Leadership and management	• Regular assessments of performance • Participatory reform processes • Correct identification of sectorial priorities • Consensus–building practices • Integration of local and global cooperation • Strengthened and integrated health and management information systems	• Lack of political commitment • Excessive centralization of planning and management • Weak leadership and lack of credibility before citizens • Mobilization of interests opposed to PHC • Limited community participation and exclusion of other stakeholders
Human resources	• Emphasis on quality and continuous improvement • Continuous professional education • Development of multidisciplinary teams • Research promotion • Development of managerial abilities	• Inadequate employment conditions • Competencies poorly developed • Limited interest in operational research and development • Poor use of management and communication techniques • Predominance of curative, biomedical approaches
Financing and macroeconomic conditions	• Policies to ensure adequate financing over time • Systems for efficient and equitable resource allocation and utilization • More sound, pro–poor macroeconomic policies	• Lack of financial sustainability for PHC • Public spending concentrated on medical specialties, hospitals, and high technology • Inadequate budgets devoted to PHC • Globalization pressures and economic instability
International cooperation approach to the health sector	• PHC reflects social values and population health needs • PHC as a central element of national health policies • Reforms strengthen the steering role of the State • Political and legal frameworks for health reforms • Progressive decentralization policies • Health reforms strengthen rather than weaken health systems	• Disease–specific strategies and priorities • Societal values not considered in reform initiatives • Overly time–bound, limited targets that do not reflect population priorities • Poor continuity of health policies • Excessively vertical and centralized approaches • Costs transferred to citizens with limited consultation

Sources: [1, 3, 11, 32, 79, 92–95] and country reports generated as part of the PHC renewal consultative process

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References

1. Pan American Health Organization. Health in the Americas (Vols I and II). Washington, DC: PAHO, 2002.
2. The Earth Institute. A race against time: The challenge of cardiovascular disease in developing economies. New York: Columbia University, 2004.
3. Arraigada I, Hopenhayn M. Producción, tráfico, y consumo de drogas en América Latina. Santiago: ECLAC, 2000.
4. Commission on Social Determinants of Health. Action on the social determinants of health: Learning from previous experiences (March). Geneva: WHO, 2005.
5. Kim J, Millen J, Irwin A, Gershman J, editors. Dying for growth: global inequality and the health of the poor. Monroe, MN: Common Courage, 2000.
6. Stiglitz J. Globalization and its discontents. New York: W.W. Norton & Co., 2003.
7. United Nations Development Program. Human Development Report. New York: Oxford University Press, 2003.
8. Sen A. Development as freedom. New York: Alfred Knopf, 1999.
9. World Health Organization. Health and Human Rights. Available http://www.who.int/hhr/en/, December 14, 2004.
10. Berkman L, Kawachi I, editors. Social epidemiology. New York: Oxford University Press, 2000.
11. People's Health Movement, editor. Health for All Now! Revive Alma Ata!! The Alma Ata Anniversary Pack. Unnikrishnan, Bangalore (India): People's Health Movement, 2003.
12. Commission on Social Determinants of Health. Towards a conceptual framework for analysis and action on the social determinants of health (draft 5 May). Geneva: WHO, 2005.
13. Pan American Health Organization. Atención Primaria de Salud en las Américas: Las Enseñanzas Extraídas a lo Largo de 25 Años y los Retos Futuros. Washington, DC: PAHO, 2003.
14. Roberts M, Hsiao W, Berman P, Reich M. Getting health reform right; A guide to improving performance and equity. Oxford: Oxford University Press, 2004.
15. Homedes N, Ugalde A. Why neoliberal health reforms have failed in Latin America. Health Policy 2005;71:83-96.
16. Kekki P. Primary health care and the Millennium Development Goals: issues for discussion. Geneva: WHO, 2004.
17. Pan American Health Organization. Revisión de las políticas de Atención Primaria de salud en América Latina y el Caribe. Washington, DC: PAHO, 2003.
18. Boerma W, Fleming D. The role of general practice in primary health care. Norwich: The Stationery Office/World Health Organization Regional Office for Europe, 1998.
19. Weiner J. Primary care delivery in the United States and four northwest European countries: comparing the "corporatized" with the "socialized". The Milbank Quarterly 1987;65(3):426–461.
20. Walsh JA, Warren KS. Selective Primary Health Care: an interim strategy for disease control in developing countries. N Engl J Med 1979;301(18):967–974.
21. World Health Organization. Chapter 7: Health Systems: principled integrated care. In: WHO, editor. World Health Report 2003. Geneva: WHO, 2003.
22. World Health Organization. A Global Review of Primary Health Care: Emerging Messages. Geneva: WHO, 2003.
23. World Health Organization. Multi-country Evaluation of IMCI: Main Findings: WHO, 2004.
24. Pan American Health Organization. Special Session on the 25th Anniversary of the Declaration of Alma Ata. 45th Directing Council Provisionary Summary. PAHO publication CD45/SR/4. Washington, DC, 2004.
25. Tejada de Rivero D. Alma-Ata Revisited. Perspectives in Health 2003;8(2):2–7.
26. Institute of Medicine. Defining Primary Care: An Interim Report. Washington, DC: National Academy Press, 1994.
27. World Health Organization. Atención primaria de salud. Informe de la Conferencia Internacional sobre Atención Primaria de Salud. Alma–Ata, URSS, 6–12 de septiembre de 1978. Geneva: WHO, 1978.

28. Peoples' Health Movement. The Medicalization of Health Care and the challenge of Health for all. People's Health Assembly; 2000 December 2000; Dhaka, Bangladesh.
29. Vuori H. Primary health care in Europe—Problems and solutions. Community Medicine 1984;6:221–31.
30. Vuori H. The role of the schools of public health in the development of primary health care. Health Policy 1985;4(3):221–30.
31. World Health Organization. Development of Indicators for Monitoring Progress towards Health For All by the Year 2000. Geneva: WHO, 1981.
32. Cueto M. The origins of primary health care and selective primary health care. Am J Public Health 2004;94(11):1864–74.
33. Ehiri JE, Prowse JM. Child health promotion in developing countries: the case for integration of environmental and social interventions? Health Policy Plan 1999;14(1):1–10.
34. Magnussen L, Ehiri J, Jolly P. Comprehensive versus selective primary health care: lessons for global health policy. Health Affairs 2004;23(3):167–76.
35. Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. Arch Intern Med 2002;162(20):2269–76.
36. Mills A. Mass campaigns versus general health services: what have we learnt in 40 years about vertical versus horizontal approaches? Bulletin of the WHO 2005;83(4):315–6.
37. Freedman L, Wirth M, Waldman R, Chowdhury M, Rosenfield A. Who's got the power? Transforming health systems to improve the lives of women and children. Millennium Project Task Force 4: Child Health and Maternal Health–Interim Report. New York: UN Millennium Project.
38. World Health Organization. World Health Report 2000. Geneva: World Health Organization, 2000.
39. World Health Organization. The Ljubljana Charter on Reforming Health Care. Geneva: WHO, 1996.
40. Fuenzalida–Puelma H, Scholle–Connor S. The Right to Health in the Americas. Washington, DC: Pan American Health Organization, 1989.
41. Sen A. Why health equity? Health Economics 2002;11:659–666.
42. Donabedian A. The seven pillars of quality. Arch Pathol Lab Med 1990;114:1115–8.
43. Sen A. Inequality Reexamined. London: Oxford University Press, 1992.
44. Whitehead M. The concepts and principles of equity and health. International Journal of Health Services 1992;22(3):429–45.
45. Macinko J, Starfield B. Annotated Bibliography on Equity in Health, 1980–2001. Int J Equity Health 2002;1(1):1.
46. Aday LA, Andersen R, Flaming DV. The expanded behavioral model of access. Health care in the US: Equitable for whom? Newbury Park, CA: Sage Publications, 1980.
47. Pan American Health Organization. Public Health in the Americas: New concepts, performance analysis and bases for action. Washington, DC: PAHO, 2002.
48. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff (Millwood) 2004;Suppl Web Exclusives:W4–184–97.
49. Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within OECD countries, 1970–1998. Health Services Research 2003;38(3):819–853.
50. Starfield B. Is primary care essential? Lancet 1994;344(8930):1129–33.
51. Starfield B, Shi L., Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005; 83:457–502.
52. Starfield B, Shi L. Policy relevant determinants of health: An international perspective. Health Policy 2002;60(3):201–16.
53. Van Doorslaer E, Wagstaff A, Van der Burg H, Christiansen T, Citoni G, Di Biase R, et al. The redistributive effect of health care finance in twelve OECD countries. Journal of Health Economics 1999;18:291–313.
54. Macinko J, Guanais F, Marinho F. An Evaluation of the Impact of the Family Health Program on Infant Mortality in Brazil, 1990–2002. Journal of Epidemiology and Community Health 2006;60(1):13–19.

55. Grumbach K. The ramifications of specialty–dominated medicine. Health Aff (Millwood) 2002;21(1):155–7.
56. Forrest CB, Starfield B. Entry into primary care and continuity: the effects of access. Am J Public Health 1998;88(9):1330–6.
57. Raddish M, Horn SD, Sharkey PD. Continuity of care: is it cost effective? Am J Manag Care 1999;5(6):727–34.
58. Shi L. Primary care, specialty care, and life chances. International Journal of Health Services 1994;24(3):431–458.
59. Starfield B. Primary Care: Balancing Health Needs, Services and Technology. New York: Oxford University Press, 1998.
60. Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. Lancet 2004;364(9441):1273–80.
61. Rajmil L, Starfield B, Plasencia A, Segura A. The consequences of universalizing health services: children's use of health services in Catalonia. Int J Health Serv 1998;28(4):777–91.
62. Palmer N, Mueller DH, Gilson L, Mills A, Haines A. Health financing to promote access in low income settings–how much do we know? Lancet 2004;364(9442):1365–70.
63. Gilson L, McIntyre D. Removing user fees for primary care: Necessary, but not enough by itself. Equinet Newsletter 2004;42.
64. Casanova C, Colomer C, Starfield B. Pediatric hospitalization due to ambulatory care–sensitive conditions in Valencia (Spain). Int J Qual Health Care 1996;8(1):51–9.
65. Casanova C, Starfield B. Hospitalizations of children and access to primary care: a cross- national comparison. International Journal of Health Services 1995;25(2):283–94.
66. Caminal J, Starfield B, Sanchez E, Casanova C, Morales M. The role of primary care in preventing ambulatory care sensitive conditions. Eur J Public Health 2004;14(3):246–51.
67. Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Lurie N, et al. Preventable hospitalizations and access to health care. JAMA 1995;274(4):305–11.
68. Billings J, Parikh N, Mijanovich T. Emergency department use in New York City: a substitute for primary care? Issue Brief (Common Fund) 2000;433(1–5).
69. Bermúdez–Tamayo C, Marquez–Calderón S, Rodríguez del Aguila MM, Perea–Milla Lopez E, Ortiz Espinosa J. [Organizational characteristics of primary care and hospitalization for to the main ambulatory care sensitive conditions] (Article in Spanish). Atención Primaria 2004;33(6):305–11.
70. Rosenblatt RA, Wright GE, Baldwin LM, Chan L, Clitherow P, Chen FM, et al. The effect of the doctor–patient relationship on emergency department use among the elderly. Am J Public Health 2000;90(1):97–102.
71. Gill JM, Mainous AG, 3rd, Nsereko M. The effect of continuity of care on emergency department use. Arch Fam Med 2000;9(4):333–8.
72. Weiss LJ, Blustein J. Faithful patients: the effect of long–term physician–patient relationships on the costs and use of health care by older Americans. Am J Public Health 1996;86(12):1742–7.
73. Rosero–Bixby L. Evaluación del impacto de la reforma del sector de la salud en Costa Rica mediante un estudio cuasiexperimental. Revista Panamericana de Salud Pública 2004;15(2):94–1003.
74. Rosero–Bixby L. Spatial access to health care in Costa Rica and its equity: a GIS-based study. Social Science & Medicine 2004;58:1271–1284.
75. Bojalil R, Guiscafre H, Espinosa P, Martínez H, Palafox M, Romero G, et al. The quality of private and public primary health care management of children with diarrhoea and acute respiratory infections in Tlaxcala, Mexico. Health Policy Plan 1998;13(3):323–31.
76. Reyes H, Pérez–Cuevas R, Salmerón J, Tome P, Guiscafre H, Gutiérrez G. Infant mortality due to acute respiratory infections: the influence of primary care processes. Health Policy Plan 1997;12(3):214–23.
77. Global Forum for Health Research. Global Forum Update on Research for Health 2005. Health research to achieve the Millennium Development Goals (available: http://www.globalforumhealth.org). London: Pro–Brook Publishing, 2005.

78. Symposium on National Strategies for Renewing Health–for–All. Final Report. Symposium on National Strategies for Renewing Health–for–All; 1998; Washington, DC. PAHO.
79. Banerji D. Alma–Ata showed the route to effective resource allocations for health. Bull World Health Organ 2004;82(9):707–708.
80. Kupfer L, Hofman K, Jarawan R, McDermott J, Bridbord K. Strategies to discourage brain drain. Bull World Health Organ 2004;82(8):616–9; discussion 619–23.
81. Glassman A, Reich MR, Laserson K, Rojas F. Political analysis of health reform in the Dominican Republic. Health Policy and Planning 1999;14(2):115–126.
82. Pan American Health Organization. Gestión descentralizada de recursos humanos de salud en la reforma sectorial. In: Brito P, Campos F, Novick M, editors. Gestión de Recursos Humanos en las reformas sectoriales en salud: cambios y oportunidades. Washington, DC: PAHO, 1996.
83. World Health Organization. Preparing a health care workforce for the 21st Century. Geneva: WHO, 2005.
84. Birdsall N, Szekely M. Bootstraps, not Band–Aids: Poverty, equity and social policy. Working paper 24. Washington, DC: Center for Global Development, 2003.
85. Smith R, Woodward D, Acharya A, Beaglehole R, Drager N. Communicable disease control: a 'Global Public Good' perspective. Health Policy Plan 2004;19(5):271–8.
86. Casas JA. La experiencia de SPT en la región de las Américas: Implantación de los programas. Renovación de salud para todos. Washington, DC: PAHO, 1996.
87. Rodríguez–García R, Goldman A. La conexión Salud-Desarrollo. Washington, DC: PAHO, 1996.
88. Pan American Health Organization. La transición hacia un nuevo siglo de salud en las Américas: Informe anual de la Directora. Washington, DC: PAHO, 2003.
89. Storia dell'eradicazione della poliomielite. Available: http://www.epicentro.iss.it/problemi/polio/Timeline.pdf December 21, 2004.
90. Organizacion Panamericana de la Salud. Análisis de la situación de salud y sus tendencias en las Américas por subregión, 1980–1998. Boletin Epidemiologico 20 años 1999;20(1).
91. Pan American Health Organization. Health conditions in the Americas 1965–1968. Washington, DC PAHO/WHO, 1970.
92. Comisión Económica para América Latina y el Caribe (CEPAL). Estudio Económico de América Latina y el Caribe. Santiago: CEPAL, 2004.
93. Szekely M. The 1990s in Latin America: Another decade of persistent inequality, but with somewhat lower poverty. Interamerican Development Bank Working Paper 454. Washington, DC: IDB, 2001.
94. Shiffman J, Stanton C, Salazar AP. The emergence of political priority for safe motherhood in Honduras. Health Policy Plan 2004;19(6):380–90.
95. Lewis MJ. A Situational Analysis of Cervical Cancer in Latin America and the Caribbean. Washington, DC: PAHO/WHO, 2004.