Primary Health Care in South America

UNASUR ISAGS Instituto Sudamericano de Gobierno en Salud

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Primary Health Care in South America

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Presentation

The South American Institute of Government in Health (Isags/Unasur) has the role to develop studies about health policies and to systematize, organize and disseminate technical and scientific health information in order to support the decision-making process and strengthen health leaderships in South America. In compliance with this mandate, Isags/Unasur elaborated and issued in 2012 its first book, "Health Systems in South America: challenges to the universality, integrality and equity". In 2013, the institute published its second book, "Health Surveillance in South America: epidemiological, sanitary and environmental". Both publications resulted from extensive research and articulation with the 12 member countries of Unasur.

Through Isags Annual Operating Plan 2013, the South American Health Council approved the development of the Mapping of Primary Health Care (PHC) Models in South American Countries. This action is understood as an opportunity to discuss PHC concepts and to investigate how primary health care contributes to the construction of universal health systems in the region.

The project aimed to provide unprecedented overview of PHC organization in the region, with the identification of successful experiences, challenges and trends in its implantation. The study of the several PHC models existent in the 12 countries of South America has revealed important data regarding health care provision, organization and coordination, workforce, funding, management and social participation, and addressed questions such as intersectorality and interculturality, with the presentation of tendencies, challenges and successful experiences.

Mapping started in November 2013, with the selection, by Isags, of five consultants from Unasur member countries. The team that has been formed to carry out this study elaborated a methodological matrix with eight dimensions, in order to simplify and standardize the information collected by the consultants in each one of the 12 countries of South America. The aim was to build a South American panorama that would derive from the same research matrix.

Throughout January and February 2014, researchers have been divided by region and started fieldwork to compile information, thanks to the collaboration of the Ministries of Health of the countries and with the support of the Technical Group on Universal Health Systems of the South American Health Council.

The results from these studies were presented at the workshop "Primary Health Care approaches and strategies to retain health workers in remote, underserved areas of South America", which was held by the Institute from May 13 to 15, 2014, in Rio de Janeiro. The workshop counted on the participation of the 12 Ministries of Health of the South American nations and provided consultants with the opportunity to present the preliminary results of the research to representatives from the South American countries and to debate the content and data collected for the elaboration of the authorial documents.

The authorial documents produced by project consultants have a descriptive character and present the synthesis of the results obtained from the mapping of PHC in each one of the 12 South American countries. The documents have been published on Isags online newsletter throughout the second semester of 2014. They provide extra input to support the current debate on PHC in the region. They are available at the library on the Institute's website, in Spanish, and may also be found in their original languages: Brazil's document in Portuguese, and Guyana and Surinam's report in English.

As well as the first two books released by Isags/Unasur, this one is the result of extensive research, articulation with countries, analysis and consolidation of the experiences in the South American region. The book "**Primary Health Care in South America**" is the third publication organized by the Institute and it aims to identify challenges and trends for PHC in the region through an analytical approach.

The content of this book is divided into six chapters. The first one presents a critical overview of primary health care in Unasur countries, through a transversal analysis that highlights problems shared by the countries and suggests ways of solving them. The following five chapters were elaborated by consultants hired by Isags for the mapping and gather the convergence of trends among countries. For example, one chapter groups PHC experiences of countries with insurance-based health systems, whereas another chapter gathers information from nations with similar approaches towards comprehensive health care. Likewise, the book considered criteria such as geographical proximity (which simplified fieldwork) and the country's shared history.

The material that resulted from mapping served as an input for the elaboration of this book, considering aspects such as conduct, funding, characteristics of PHC organization and service provision, the interviews carried out with authorities from the countries and with focal points inside the Ministries of Health, which have been appointed by representatives of the Technical Group on Universal Health Systems (GT-SUS) of the South American Health Council (SHC), and the results of the workshop "Primary Health

Care approaches and strategies to retain health workers in remote, underserved areas of South America".

We recognize that this study was only possible thanks to the generous collaboration of all interviewees: national authorities, local authorities and those responsible for the primary health care facilities visited in the cities of South America. Thank you very much!

This book is not limited to the production of knowledge, it also aims to encourage the formulation of strategies at local, national and regional levels, with the recognition of PHC as a fundamental axis for the concretization of universal health systems in the South American region. We hope this publication can provide governments with information that enable the identification of strategic policies for regional or local action, facilitating the decision-making process and strengthening Unasur as a whole.

Isags-Unasur Directive Board

Preface

Moving towards the new PHC: Comprehensive health care with the participation of all

Oscar Feo Istúriz

In compliance with the mandates of the Ministers of Health, Isags has carried out a particularly important research to characterize and analyze the role of Primary Health Care (PHC) in the health systems of Unasur member countries, now published in this book. This work enables a political and conceptual reassessment of PHC regarding health as a human and social fundamental right. It has built a rich methodology for analysis based on eight dimensions: 1. Conduct, 2. Funding, 3. Provision and organization, 4. Coordination of care and integration of PHC in the service network, 5. Workforce, 6. Intersectoral activities, 7. Social participation and 8. Interculturality, which allows a precise diagnosis of the PHC status in the South American region. Furthermore, it synthetizes the status of PHC in each one of the Unasur member countries, and becomes a document of analysis and reflection for action. Congratulations to Isags that, once again, accomplishes its role as a center for strategic thinking in the field of health.

Now, allow me to consider some issues regarding Primary Health Care. Many people believe that it originated from Alma-Ata, but it is essential to remember that there were several previous experiences. Two of them are widely known: the *feldsher,* from Russia and countries in Central and Eastern Europe, and China's barefoot doctors, who followed the Cultural Revolution during the late sixties. They were both based on non- medical personnel trained to solve health problems in rural areas. However, I must also mention two experiences that are closer to Latin America and still not widely known in the region. The first one is "simplified medicine" in Venezuela (González, 1968), which, since 1962 has developed a proposal to provide health care to rural regions by training settlers from these communities to become "simplified medical auxiliaries", thereby being able to cover over 3000 rural ambulatory clinics. The second experience

took place in Central America, and it was based on community health care programs with strong influence from liberation theology and the ideas of Paulo Freire about popular education (Zúniga, 2003).

Nevertheless, it is only after the International Conference on "Primary Health Care" held in Alma-Ata, in 1978, that PHC becomes worldly recognized and institutionalized. To a considerable degree, this was thanks to a single document, known as the Declaration of Alma-Ata, which is of great importance to the history of global health and extremely valuable, due to its recognition of the considerable inequalities existent and for claiming a "new international order" that delivers health care to all through the strategy of primary health care. This declaration incorporates original key concepts for that period. Firstly, health as a human right, giving the State the responsibility to ensure it; secondly, universality and integrality as key elements to the organization of health care, with the recognition and the request for intersectoral action; and finally, the organization and participation of the community as a central component for the social construction of health.

However, the polysemy of our language played a trick on PHC, for the word "primary" has radically opposite meanings: primary as essential and fundamental, and primary as primitive and elementary. Naturally, many organizations have chosen the second definition, thus converting PHC that was initially comprehensive into selective PHC, with the provision of limited services, preceding the "basic packages" that were a characteristic of the neoliberal reforms of the nineties. In this reformulation of PHC, the Rockefeller Foundation and Unicef played a fundamental role. They promoted an international conference in Bellagio, only a year after Alma-Ata, which created selective PHC and reduced it to the provision of a few services, among which, oral rehydration salts, immunization and breast-feeding, directed towards the poor sectors of the population (Testa, 1993; Giovanella, 2008).

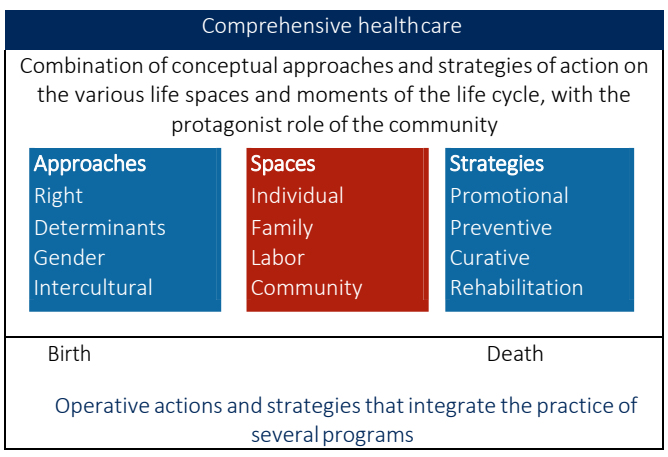
On the other hand, some consider that there has been an important semantic problem at the outset, considering that "Primary Health Care" has been translated from English into Spanish as "*Atención Primaria de Salud*", therefore changing the term "care" for "attention" and using the confusing word "primary" that, according to some, should have been translated as "comprehensive". An article published by Tejada (2003), who was the coordinator of the Alma-Ata conference and the assistant director-general of the WHO, says that the phrase "*cuidado integral de la salud*", or "comprehensive health care" is a better expression of the original meaning of Alma-Ata. This situation creates what some might consider the original sin of PHC, that is, to allow it to be defined as "basic sanitary attention", thereby reducing comprehensive PHC to selective PHC. The transformative political content of the idea of health to all was lost somewhere along the way and PHC started to gain more importance as an operative strategy, deprived of its original meaning.

Hence, we may say that the term PHC has created a great misunderstanding that still exists nowadays. There are countries in which PHC refers exclusively to the first level of care, whereas in other ones, it encompasses special programs for the poorest, or sometimes it may even be an office or an address within the Ministry of Health, thus leaving the central ideas

of PHC aside. As highlighted by Rovere (2012), PHC has been used for everything, for truly transformative programs or for financial organisms to promote service packages.

In 1991, the WHO published an interesting document, "From Alma-Ata to the year 2000: reflections at the midpoint on progress and prospects", which carries the speech of Halfdan Mahler, an important Danish sanitarian who was the director of the WHO at the time and closed the Alma-Ata conference with a memorable speech, in which he posed eight questions that, according to him, would define the success and the future of PHC. Some of these questions were: Are you ready to address yourselves seriously to the existing gap between the health "haves" and the health "have-nots"? Are you ready to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority? Are you ready to commit politically and assign the necessary resources? Are you ready to overcome social, economic and professional resistances? The answers to these questions hold the key to the reason why the objective of health to all by the year 2000 has not been attained (WHO, 1991). It is clear that there has been no political commitment to overcome inequalities or to build a new international order, which are essential in order to achieve the goal of health to all, by using PHC as a strategy. Now, almost forty years after Alma-Ata, the situation remains the same. Several meetings were held and many commissions organized to analyze the causes that have detained this achievement, but we continue to search for the "new international order" that, whit justice and solidarity, will ensure health to all.

Before concluding, a reflection on the perspectives of PHC. In 2003, on the occasion of 25 years after the meeting of Alma-Ata, the Pan American Health Organization PAHO/WHO promoted a process of analysis and evaluation of PHC that enabled the appraisal of the lessons learned throughout these 25 years. The result of this process was the elaboration of a proposal known as PHC renewal, which is complemented with integrated health service networks and PHC-based health systems. However, in order to make this re-launching of PHC come true, it is essential to make substantial changes: to move from the paradigm of the disease to the paradigm of health, to strengthen public and universal health systems and new models of health care and management, with an active participation of communities and social organizations (OPS/OMS, 2007).



It is necessary to change Flexner's model for training health professionals, which focuses on the disease, has a fragmented vision that inevitably leads to subspecialization and is characterized by practices that are increasingly dehumanized and commercial. We need a training model that is more comprehensive, solidary, human, and that incorporates

the concept of social determinants of health and disease and facilitates intersectoral action.

We must re-conceptualize integrality, by understanding it as a combination of conceptual approaches and strategies of action throughout the entire life cycle and within the many social environments, with social participation, which must be conceived as a matter of power and of actual decision-making capacity. Only after the redistribution of power and of the decision-making capacity will we have a transformative PHC.

In conclusion, here is a comment and a proposal for PHC and for the global health agenda. Over the last forty years, the health agenda has varied from PHC in the eighties to reforms and basic packages in the nineties, MDGs in the first years of the new century and now it is apparently imposed as Universal Health Coverage. But it is important to pay attention to the fact that, over the last years, thanks to technical and scientific development, there has been a significant change in the sense and meaning of health and medicines, which changed from an eminently clinical practice to a practice of elevated technological density, a fundamental change that establishes health and medicine as important components of the economy, by turning them into production and capital accumulation factors.

Nowadays, great private chemical, pharmaceutical, technological medical and insurance corporations form a financial industrial medical health complex, which has become an important actor in the arenas that define health policies. From this perspective, one of the fundamental determinants of the health policies is the economic interest and, therefore, we must be careful in order to identify how those interests are attached to the global health agenda. It has been reported that the Universal Coverage proposal seemed to favor the capital and the market, for it implicitly carried the insurance, with the lead role of the private sector (Heredia et al., 2014).

Due to this situation, and in order to completely address the issue of the post-2015 health agenda, we propose two fundamental categories: the Universal Public Health Systems and the Social Determinants of Health, both under the framework of the concept of health as a human and social fundamental right of the population. In this context, PHC can play a major role, by becoming a transformative factor of the health system. With Unasur, we are convinced that integration is the way to advance towards the construction of health and wellbeing for our peoples. Only if we are united will we be able to solve the serious social inequalities that affect us and to move forward towards a more human and solidary development model, with a culture of peace and social justice and the attainment of health to all.

We are attuned to the countries that embrace the "well living" proposal as a model that can attend to the needs of all, in balance with nature, and we advocate the need to redefine PHC: let us dare to leave the past behind and learn from it, but also to overcome it, and let us adopt a proposal for **comprehensive health care with the participation of all.**

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Primary Health Care in South America: reorientation towards comprehensive health care?

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Introduction

In South America, since the Declaration of the Alma-Ata International Conference on Primary Health Care (PHC) in 1978, there has been tension between the different ways of conceiving and addressing the implementation of PHC in the countries over the years. The Alma- Ata Declaration has disseminated a concept of comprehensive primary health care, by interpreting it as part of a health care system integrated with the economic and social development of a society, which involves cooperation with other sectors in order to address the social determinants of health and the promotion of social participation.

Achievement of these principles vary from country to country and approaches to PHC in South America revealed different focuses over the last decades, according to the different political contexts and social protection systems and the prevailing health systems (Conill et al., 2010; Rovere, 2012; Tejerina Silva et al., 2009, Acosta Ramírez et al., 2011).

In contexts of authoritarian regimes and structural macroeconomic adjustments, many South American countries, over the 1980s and 1990s, adopted selective and focused PHC models promoted by multilateral financial agencies that defended the reduction of the role of the public sector and the implementation of minimal health service packages, directed at marginalized groups of the population (Labonté et al., 2009).

The vertical programs directed at groups of the population or to specific health problems were strengthened with the creation of insurances focused on specific groups of the population, which deepened segmentation and social inequalities within the health systems of the countries of the region (Soares, 2001). With the sectoral reforms of market-oriented and insurance-based health systems, in many cases, PHC has turned into a model affected by the separation of individual and collective health risk management, the packaging of health benefits, the focalization of intervention domains, managed care, the reduction of health care expenditures, the segmentation and fragmentation of health care systems, the pubic-private mix of insurance and provision, the competition between insurance and service providers and the limitation of community and social participation and of the outreach of intersectoral action for health.

In the first decade of the 21st century, with changes in the political field and in the development models of some countries, as a result of the re-democratization process and with the assumption of power by governments that were more committed to social justice, there is a process of revitalization of PHC in its comprehensive approach, in accordance with the Alma-Ata concept. The goal is to build health systems guided by a comprehensive PHC as the coordinator of care in an integrated service network that articulates community and intersectoral actions that affect the social determinants in order to promote health, to reduce health inequalities and to ensure the universal right of access to health services.

At the same time, international health agencies such as the Pan American Health Organization (PAHO/WHO, 2005) and the World Health Organization (WHO, 2008) have urged member countries to renew PHC in order to achieve universal health coverage and promote health equity.

Characteristics and the magnitude of these PHC renewal processes in the Region are still somewhat unknown, partly due to its recent history, partly due to the effort that is implied in carrying out research within that many countries. The objective of this chapter is to provide an overview of PHC in the 12 countries of South America, to analyze their approaches, conditioning factors and challenges for the implementation of a comprehensive primary health care in the Region.[1] It aims to identify the concepts that orient the current assistance models in the countries of South America and to explore the hypothesis that, unlike what was supposed by the PAHO/WHO (2005), that PHC would be the guide to the strengthening of health systems, in fact, the modalities of social protection in health and the segmentation of health systems condition the PHC concept implemented and detain the implementation of new comprehensive PHC models.

[1] A summary of the initial version of this chapter has been published in an article of the magazine Saúde em Debate n. 105, 2015

The mapping of PHC in South America

This chapter presents the main results of the mapping of primary health care in the twelve countries of South America, carried out by the South American Institute of Government in Health (Isags), an international organism part of the South American Health Council of the Union of South American Nations (Unasur).

The elaboration of a "Mapping of Primary Health Care Models in the countries of South America" by Isags was proposed by the Council of Ministers of Health of Unasur with the objective to generate knowledge concerning concepts, models, experiences and current challenges of primary health care (PHC) in the Region. The proposal was to provide a concise overview of PHC in South America, organized into common dimensions and similar information, therefore providing countries with mutual knowledge regarding primary health care.

By drawing parallels and contrasting experiences it is possible to identify and understand shared problems and to find possible solutions according to the lessons learned from the experiences developed in each country, which may encourage other national or regional policies. Therefore, the goal is to contribute to the orientation of strategic policies for regional or local intervention on the way to the construction of universal public health systems and of the guarantee to human right to health.

Case studies were carried out in each one of the twelve countries of South America, based on a similar methodology, including multiple strategies for information and data collection: literature review, document analysis, visits to Ministries of Health and PHC services, interviews with key informants and exchange of information with community organizations. The national representatives of Unasur's Working Group on Universal Health Systems provided support to organizing visits to countries, interviews in the Ministries of Health, collection of data and documents and *in situ* observation of PHC experiences and services elected by the Ministries of Health, from November 2013 to April 2014.

The collection of information for PHC mapping was based on a common matrix. The construction of this matrix and the definition of its dimensions are based on the concept of comprehensive primary health care of the Declaration of Alma-Ata, with the intention to operationalize its fundamental principles.

The matrix is organized in the following dimensions: PHC conduct, PHC funding, characteristics of PHC provision and organization, coordination of care and integration of PHC into the service network, PHC workforce, social participation, intersectoral activities and interculturality. For each dimension, there was a definition of components, which are summarized below in Chart 1. Regional and social inequalities in the access to PHC have been considered as a transversal axis of analysis for the elaboration of the case studies.

Starting with this information and with literature review, a case report of PHC Mapping was elaborated by each country. The full version of each study is available at Isags' website (http://www.isags-unasur.org).

Chart 1 – Matrix for the analysis of PHC in South American countries: dimensions and components

Dimensions	Components
PHC Conduct	Concepts of primary health care in health policies
	Functions of governmental spheres and/or social security in the implementation of PHC policies
PHC Funding	Participation of governmental spheres in PHC funding
	Co-payments in PHC
	Mechanism for financial transfers between governmental spheres for PHC
PHC provision and organization	Types of health facilities that provide PHC
	Main actions/services offered by PHC Formation and organization of PHC teams
	Regionalization and population affiliated to PHC units
	Number of people assigned per team
	Guarantee of access and definition of goals for maximum waiting time in primary health care
	Estimated population coverage by PHC services in the new assistance model
Coordination of care and integration of PHC into the service network	Organization of the health system in levels of care
	Definition of the preferential entry point to the health system
	Gatekeeping role of PHC physician/team
	Definition of referral flows from PHC to specialized care
	Waiting lines for access to specialized care
PHC Workforce	Availability of PHC professionals (physicians and nurses)
	Medical specialization for PHC
	Regulation of labor relations in PHC (employment contracts, remuneration, career in PHC)
	Health workers training and duties
	PHC workforce training strategies (undergraduate, postgraduate and continuing professional development)
Intersectoral activities	Interaction with other public policy sectors at the national level to address the social determinants of health
	Duties of PHC team professionals/workers in the development of intersectoral/community actions
	Community action of PHC teams (relationship of PHC teams with other sectors of public policies or organizations in the region; diagnosis by PHC teams of problems within their region and planning of local interventions)
Social participation in PHC	Forms of user representation and participation in PHC
Interculturality in PHC	Concepts of interculturality
	Articulation of PHC services with traditional medicine actors from indigenous peoples and peasants

This chapter summarizes the results of the mapping carried out in the twelve South American countries according to the main dimensions of the matrix, thereby drawing parallels, contrasting differences, highlighting similarities and identifying their conditioning

factors, especially those concerning characteristics of social protection and of the health systems of the countries, which have influence the ways of conceiving and implementing PHC.

It is not a *stricto sensu* comparison, it is understood that the current configuration of health systems and of PHC in each country is conditioned by contexts, actors and historic backgrounds, different policies and economies and that evaluative comparisons between health systems performances with the production of concise indexes and the plus and minus grading system are inappropriate for the analysis (Oliver, 2012). Therefore, the comparison of our approach does not intend to establish a comparison of more or less, better or worse, but to contribute with a more analytical approach that enables the elucidation of the main challenges for the achievement of a comprehensive primary health care within our countries.

In order to contextualize the analysis of PHC, the chapters start with a brief synthesis of the characteristics of health systems in South America, with the identification of the main segments of the population covered and information about the corresponding subsystem to which the PHC analysis refers. Next, there is a description and an analysis of each one of the PHC dimensions and their main components.

The context: characteristics of health systems in South America

In South America, unlike Europe, the universalization of social protection has not yet been completed. From the outside, the main characteristics that are traditionally prominent in Latin American health systems are segmentation of coverage, organizational fragmentation and privatization in health service funding and provision (Giovanella et al., 2012).

The classic European Bismarckian models of social security, based on mandatory social contributions from employees and employers and the Beveridgean model of national health services with universal access, based on citizenship and financed through taxation, have influenced the health policies of the region, but they have not been fully implemented.

In most of the countries of South America, there is still an important segmentation of social protection in health with the presence of several subsystems with different rules for funding, affiliation, access to service provision and service network, which are responsible for the health care of different groups of the population, according to their employment status, social group and ability to pay. It is possible to identify four main segments (Chart 2): i) a social security segment that covers groups of middle income included in the formal labor market (20% to 40% of the population); ii) a public health system with partial coverage of the population with lower income through direct public provision; iii) coverage by selective package through public insurance focused on specific groups, such as mother-child, the elderly or those under a specific level of income, implemented since the 1990s; and iv) private health insurance (prepaid medicine) with coverage of higher income groups; besides out-of-pocket payments, which affects almost all groups, and the persistence of an important

exclusion in health in some countries.

For each segment, there are different providers and services covered, which form health subsystems of different classes with significant inequalities. The other side of segmentation is fragmentation, with the absence of coordination between public, social security and private institutions, and the existence of several uncoordinated entities within each subsystem. Fragmentation leads to discontinued care and inefficiency.

Chart 2 – Segmentation of health systems in South America: coverage of the population by segment, 2010

Countries	Social security (workers in the formal	Public insurance focused on	Public system / Ministry of Health / subnational spheres	Private insurance and Prepaid medicine
Argentina	++++	+	++	+
Bolivia	+	+++	+	-
Brazil	-	-	+++++	++
Chile	+++++	-	-	++
Colombia	+++	++++	-	+
Ecuador	++	+	+++	+
Guyana	+	+	+++	+
Paraguay	+	-	+++	+
Peru	++	+++	+	+
Suriname	++	++	-	+
Uruguay	++++	-	++	+
Venezuela	++	-	++++	+

Source: Adapted from Giovanella et al., 2012.

From the perspective of funding, health coverage in South America is strongly privatized. In seven out of the twelve countries of South America, participation of public expenditure in the total expenditure on health does not reach 60%. Nevertheless, it is possible to note an increase in the public participation in health expenditure in six countries from 2000 to 2010, which indicates a trend towards improvement in public coverage in the region (Table 1).

Table 1 – Health expenditures as % of the GDP in 2010 and public expenditure as % of the total expenditure on health in South America in 2000 and 2010

Country	Total expenditure on health % of GDP	Public expenditure as % of he total expenditure on health	
	2010	2000	2010
Argentina	8.3	53.9	64.4
Bolivia	5.5	60.1	66.2
Brazil	9.0	40.3	47.0
Chile	7.4	52.1	59.5
Colombia	6.5	79.3	74.6
Ecuador	7.9	31.2	40.2

Guyana	4.2	84.7	79.5
Paraguay	9.6	39.9	34.4
Peru	4.9	58.7	56.2
Suriname	5.3	53.4	51.7
Uruguay	8.1	54.6	65.3
Venezuela	5.3	41.5	38.8

Source: WHO, 2012. Adapted from Giovanella et al., 2012.

In contrast, there is significant participation of private organizations in health service provision in many countries. For example, in Argentina, 68% of facilities with inpatient care are private; in Brazil, 65% of hospital beds and 86% of the computed tomography scanners are private (Giovanella, 2013). The high level of private participation in service provision hinders access to users of public systems and integration of the assistance network. Therefore, governments are required to have greater ability to regulate, but this is still underdeveloped.

The processes of neoliberal health reforms that came after the structural adjustment programs of the 1980s and 1990s have accentuated the characteristics of segmentation, fragmentation and privatization of health systems and the selectivity of primary health care in South America. Hence, social inequalities have been deepened, with the constitution of citizens of first, second and third classes that may or may not access different service packages and networks according to their ability to pay. This institutional legacy seriously obstructs reforms carried out by current progressive governments in favor of the guarantee the right to health and to the construction of universal public health systems.

PHC CONDUCT

Concepts of Primary Health Care in Health Policies

The current documents of South American countries about health policies highlight PHC as a strategy to attain comprehensive health care and health equity. References to the Declaration of Alma-Ata appear in the policies or programs of all twelve countries, and the renewal process is seen in ten countries (with the exception of Guyana and Paraguay).

With different approaches, their national policies incorporate the three main components of the Declaration of Alma-Ata that conceives PHC as a strategy: i) PHC as essential care, part of the national health care system, of which it is the main focus, the first level of contact and first element of a continuing health care process; ii) health as an inseparable element from the economic and social development of a society, which implies its incidence on social determinants; and iii) the encouragement of social participation.

In this revitalization process of PHC – called PHC renewal in some countries, influenced by the PAHO –, seven countries currently manage the implementation of new health care models (Chart 3). These new models have some components in common:

focus on the family, reference to comprehensive care and focus on the community, with multi-professional teams and defined regions (Bolivia, Brazil, Chile, Ecuador, Paraguay, Peru and Venezuela). Venezuela, Ecuador and Bolivia share the intercultural focus with respect for and assimilation of the knowledge and health practices of native peoples expressed by the concept of "living well". These countries also share the priority of health promotion, which is understood as the intersectoral action on its social determinants.

Chart 3 – Concept/definition of primary health care in current health policies of South American countries

Countries	Current PHC policy
Argentina (2004)	PHC is the *"Strategy that integrally conceives health-disease-care problems of people and the social group, through the integration of assistance, the prevention of diseases, health promotion and rehabilitation".* [1] Several federal programs are directly linked to the PHC strategy (Community Doctor Program, *Remediar* + Networks Program, *Plan Nacer*).
Bolivia (2008)	The legislation does not employ the term PHC. The Family, Community and Intercultural Health Model (Safci) with principles of community participation, intersectorality, interculturality and integrality, contemplates the elements of PHC. The Safci model is defined as the *"Combination of actions that facilitate the effective, efficient and timely development of processes for health promotion, prevention and treatment of diseases and rehabilitation through horizontality, integrality and interculturality, so that health policies are presented and articulated with people, families and the community or neighborhood".*[2]
Brazil (2006, 2011)	*"Basic care is characterized by a series of health initiatives, both individual and collective, which include health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, damage reduction and health maintenance in order to develop comprehensive care that impacts on the health condition and autonomy of persons and the determinants and conditioning factors for health in communities".* [3] The main PHC model is the Family Health Strategy (ESF), with multi-professional teams and a territorial basis.
Chile (2005, 2013)	The new Family and Community Comprehensive Health Care Model aims to "ensure a *more equal distribution of health resources in order to provide essential care based on 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 at every stage of their development in the spirit of self-reliance and self-determination".* The new Family and Community Model of Comprehensive Health Care is: *"The group of actions that promote and facilitate efficient, effective and timely care, more strongly directed at the patient than to the disease as an isolated fact, to people considered in their physical and mental integrality as social beings that belong to different families and communities, which are in a continuing process of integration and adaptation to their physical, social and cultural environment".* [4]
Colombia (2011)	*"PHC is the strategy of intersectoral coordination that enables comprehensive and integrated care, starting at public health, health promotion, the prevention of diseases, diagnosis, treatment, rehabilitation of the patient in all levels of complexity in order to ensure a greater level of wellbeing for users, with no prejudice to the legal competences of each one of the actors of the General System of Social Security for Health."* [5] Act 1,438 of 2011 has introduced Primary Health Care as a national strategy, but is has yet not been implemented, there is not a unified PHC model and experiences are local.

Ecuador (2008, 2012)	The Constitution of 2008 defines primary health care as a base of the system in Act 360: "*The system shall ensure, through the institutions that are part of it, the promotion of health, prevention and family and community comprehensive care, based on primary health care; It shall articulate the different levels of care; and promote the complementarity with ancestral and alternative medicines*". [6] The Family, Community and Intercultural Comprehensive Health Care Model (MAIS-FCI) supports and incorporates the PHC renewal strategy. It is defined as the series of strategies, norms, procedures, tools and resources that, by complementing each other, organizes the National Health system in order to answer the health needs of persons, families, community and their surroundings, therefore enabling integrality at all levels of care in the health network. [7]

Chart 3 – Concept/definition of primary health care in current health policies of South American countries (cont.)

Countries	Current PHC policy
Guyana (2013, 2010)	The Document Health Vision 2020 reaffirms the commitment to PHC and the importance of addressing the social determinants of health, but it makes no direct reference to the concept of PHC. The health system is based on PHC. Universal access to health free of charge is a constitutional right (1980). The package of publicly guaranteed health services (2010) focuses on promotion and is comprehensive. It includes from primary to specialized and hospital services with provision through an integrated network organized in levels of care, starting at health posts with community health workers and Medex technicians for remote areas. [8]
Paraguay (2008)	The document Public Policies for Quality of Life and Health of 2008 considers PHC as the structure of a universal system. Its strategic axes are the organization of Comprehensive Health Service Networks focused on the implementation of the PHC strategy and intersectoral articulation in order to address social determinants. It aims to increase the access of excluded populations through family health teams and facilities assigned with predefined regions. In the current management, PHC is understood as: *"a strategy that integrally conceives the health-disease-care process for persons and communities, in consideration of the different stages of life. It provides health services and addresses the ultimate causes (social, economic, political and environmental) of the absence of health".* [9]
Peru (2003, 2011)	The new Comprehensive Health Care Model Based on the Family and the Community (MAIS-BFC) the PHC definition of Alma-Ata and the principles, values and strategies of PHC renewal as the *"foundation of the health system. To this end, it is necessary to […] rearrange health services towards promotion and prevention; this adjustment must be achieved through the assignment of proper roles to each level of government, the integration of public health and individual care services, the development of an orientation towards families and communities and the creation of an institutional framework that encourages the improvement of the quality of services; it also requires a special concentration in the role of human resources and the development of strategies to manage this change*".[10]
Suriname (2012)	The government Development Plan "Suriname in Transformation 2012-2016" gives PHC a central role in the achievement of health equity. It does not conceptualize PHC, but it mentions some PHC pillars such as the importance of addressing the social determinants, multi-sectoral collaboration and social participation, as strategies to fight chronic non-communicable diseases. [11] The health systems is segmented and each subsystem implements PHC services in a different way.

Uruguay (2007)	Act 18,211 that created the Integrated National Health System (SNIS) in 2007, establishes that the SNIS shall be organized into networks, by level of care, according to the needs of users and to the complexity of provision. It shall have primary health care as a strategy and prioritize the first level of care. *"The first level of care is formed by the systematized set of sectoral activities focused on the individual, the family, the community or the environment, which tends to answer the basic health needs and to improve quality of life with proper case-solving capacity, developed with the participation and involvement of the human nucleus and with direct contact with its natural and social habitat. Actions towards comprehensive health care shall be held by interdisciplinary teams with proper infrastructure and technology for clinical, home, urgent and emergent care".*[12]
Venezuela (2004, 2014)	The Inside the Neighborhood Mission, created in 2004[13], shows PHC as its fundamental strategy: *"PHC is part of the National Public Health System, of which it is the central function and main focus, and of the overall social and economic global development of the community. It represents the first level of contact of individuals, the family and community with the National Health System, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process [...] It crosses different levels of care and their networks, thereby ensuring timely, continuing and sufficient health response".*[14] *"The State shall use PHC as a strategy to ensure the right to health, to improve the quality of life, the collective wellbeing and the universal and equal access to health conditions, resources and services, so as to answer the social needs of the entire population, according to its different expressions in human groups, territories and social categories and by bringing health care as close as possible to where people live and work".*[15]

Sources: 1) Argentina, MSAL, 2004; 2) Bolivia, MSD, 2008; 3) Brasil, Ministério da Saúde, 2011; 4)Chile, Ministerio de Salud, 2007; 2013; 5) Colombia, Congreso de la República, 2011; 6) República del Ecuador, 2008; 7) Ecuador, MSP, 2012; 8) Paraguay, MSPyBS, 2008; 9) Paraguay, MSPyBS, 2014; 10) Perú, Ministerio de Salud, 2011; 11) Suriname, 2012; 12) República Oriental del Uruguay, 2007; 13) República Bolivariana de Venezuela, 2004; 14) Venezuela, Ministerio de Salud, 2006; 15) Venezuela, MPPS, 2014.

Functions of governmental spheres and/or social security in the formulation, funding and implementation of PHC policies

The modality of social protection in health and the countries' territorial, political and administrative organization condition the distribution of functions among governmental spheres and/or social securities in the formulation and implementation of PHC policies.

In general, the sphere responsible for the formulation of PHC policies is the national level, that is, the Ministry of Health. In Argentina, with its federal organization and with the autonomy of its provinces concerning health, this function is mainly provincial. In Colombia, the General Social Security Health Care System, with its individual approach, has not incorporated a model of care based on PHC in Act 100 of 1993, but it did so with Act 1,438 of 2011. However, the design and implementation of PHC programs has remained as an initiative of local governments and health insurers, with different experiences. The national legislation on PHC approved in 2011 has not yet been regulated by the Ministry of Health and Social Protection and it is currently in a process of change, being adapted to the insurance approach (Chart 4).

PHC funding sources are the same ones of the health system in general. Considering exclusively public funding, in most of the countries, the responsibility for funding falls on the national level. In Brazil, this responsibility is shared with municipalities and, in Argentina, with provinces. In Bolivia and Peru, there is

participation of insurances focused on the poor or on specific groups. In Colombia, PHC initiatives and funding are national, municipal and of Health Promoting Companies (EPS) with contributory or subsidized systems.

As a result of segmentation, contributions to health care social security for workers in the formal market fund first level individual care for this group of the population in 11 countries, except for Brazil (Chart 2).

With different levels of decentralization of the health systems, the responsibility for the provision of first level services differs among countries, with the prevalence of the municipal sphere in Brazil, Chile and Colombia. Provinces or departments have an important role in the provision of first level services in Argentina, Ecuador and Bolivia. The Ministry of Health remains as the main service provider in Uruguay, Paraguay, Guyana and Venezuela and shares its responsibility with many NGOS in Suriname (Chart 4).

Financial transfers for PHC from national level to subnational spheres occur in extremely different ways. The Ministries of Health transfer financial resources through specific programs stimulated by the national government (Argentina, Ecuador, Guyana and Venezuela) or, in the case of more decentralized public systems, as in Brazil, Chile and Colombia, through *per capita* and/or specific transfers for PHC. In more centralized public systems, the financial execution is a responsibility of the central level, as it is in Paraguay, Uruguay and Suriname. In insurance-based health care models, there are not financial transfers from the Ministry of Health to the subnational spheres for PHC. In these cases (and/or in these segments), transfers are made to insurance providers, as in Bolivia, Colombia and Uruguay. This modality is sometimes mistaken for payment methods to final providers, once insurers treat governmental spheres as providers.

In most of the countries, the access to PHC is free of charge and there are no co-payments in first level public services. Co-payments, which were introduced in the 1990s, have been extinguished after the progressive governments in Venezuela, Ecuador and Paraguay. In Bolivia and Peru, there is a charge for public health care services, except for the population covered by public insurances focused on specific groups (Chart 4).

Nonetheless, most of the countries have elevated private health expenditures (Chart 2) and there are also household out-of-pocket expenditures for medicines and some first level services.

PHC PROVISION AND ORGANIZATION

Provision is characterized by a diversified composition of PHC teams within each country, and it is also different according to the type of health facility. In the twelve countries, the main types of health facilities that offer PHC are formed by health centers and health posts, the latter mainly in rural areas, where there are auxiliary nurses, nurse technicians or community health workers. In Chile and Venezuela, low complexity

hospitals and ambulatory care centers are also part of PHC. In Colombia, PHC is provided in First Level Health Care Providing Institutions, which are selected according to the registration of the user in the social security health insurance.

In the health centers of all countries, teams count on a general practitioner and a nurse. Uruguay also has pediatricians, gynecologists and midwives. The auxiliary nurse or nurse technician is also part of the team in most of the countries (Chart 5).

As part of the health care models reforms, many countries have incorporated the Community Health Worker or Health Promoter into basic PHC teams, as a worker that may be paid or work as a volunteer.

Chart 4 - Functions of governmental spheres and/or social security in the formulation, funding and implementation of PHC policies in South American countries

Countries	Political and administrative organization of the country	Main body responsible for the formulation of PHC policies	Main body responsible for PHC funding	Main body responsible for the provision of first level services	Specific financial transfer mechanisms for PHC from the national level to subnational spheres	Co-payments in first level public services
Argentina	Federative Republic 23 provinces + CABA 2,200 municipalities Constitution of 1994	Provincial Ministries of Health and Ministry of Health of the Nation	Ministry of Health and Provinces (Insurance funds: first level individual care)	Provinces and Municipalities	Through specific program	Nonexistent
Bolivia	Plurinational State 9 Departments 337 municipalities Constitution of 2009	Ministry of Health	Departments Ministry of Health Municipalities Insurances focused on specific groups SUMI and SSPAM	Departments	*Per capita* to municipalities for public insurance focused on children, pregnant women and the elderly. Budget packages to all other services	In public services, except for those insured by insurances focused on specific groups
Brazil	Federative Republic DF + 26 states 5,570 municipalities Constitution of 1988	Ministry of Health	Ministry of Health and Municipalities	Municipalities	*Per capita* specifically for PHC: Primary Health Care Package; variable pay for performance Primary Health Care Package and per Family Health Team	Nonexistent
Chile	Unitary State 15 regions 53 provinces and 346 communes Constitution of 1980	Ministry of Health	Ministry of Health (Fonasa) and municipalities	Municipalities and Health Services	*Per capita* specifically for PHC, transferred by Fonasa and additional contributions from the state	Nonexistent for A and B groups of the Fonasa (co-payments for those insured in sectors C and D and by guarantees and provisions with co-payments in the AUGE)
Colombia	Unitary Republic DC+ 32 departments 1,102 municipalities Constitution of 1991	Ministry of Health and municipalities (national policy in process of regulation)	National budget Municipalities SGSS – EPS subsidized and contributory systems (individual)	Municipalities and Departments; EPS subsidized or contributory systems; hire public or private services	General participatory system *Per capita* – capitation payment units	No co-payments for promotion, prevention, maternal and child care, communicable diseases, high-cost pathologies and preliminary urgent care
Ecuador	Plurinational Unitary State 24 provinces 210 cantons 1000 provinces Constitution of 2008	Ministry of Public Health	Ministry of Public Health and Provinces	Provinces	Through global budget and specific program	Nonexistent (extinguished in 2008)

Chart 4 - Functions of governmental spheres and/or social security in the formulation, funding and implementation of PHC policies in South American countries (cont.)

Countries	Political and administrative organization of the country	Main body responsible for the formulation of PHC policies	Main body responsible for PHC funding	Main body responsible for the provision of first level services	Specific financial transfer mechanisms for PHC from the national level to subnational spheres	Co-payments in first level public services
Guyana	Co-operative Republic 10 regions 27 neighborhood councils Constitution of 1980	Ministry of Health	Ministry of Health and external donations	Regional services of the Ministry of Health International NGOS	Through specific program	Nonexistent
Paraguay	Democratic Representative Republic Capital+ 17 departments Constitution of 1992	Ministry of Health and Social Welfare	Ministry of Health and Social Welfare	Ministry of Health and Social Welfare and Municipalities	Nonexistent	Nonexistent (extinguished in 2008)
Peru	Democratic Republic 24 Departments 195 provinces 1,837 municipalities Constitution of 1993	Ministry of Health	Ministry of Health Focused insurance: SIS Social Security: EsSalud	Local governments Health Insurance Funds Administrator (Iafas) hire public or private services	Nonexistent (SIS focused insurance pays fixed amounts to facilities every four months and a variable amount every three months)	Payment in public services for medicines for population not insured by EsSalud or SIS
Suriname	Democratic Republic 10 districts 62 regions Constitution of 1987	Ministry of Health	Ministry of Health	Ministry of Health NGOS: Medical Mission	Nonexistent	Co-payment for medicines. For the population covered by the Medical Mission, there is no co-payment
Uruguay	Unitary State Republic 19 Departments Constitution of 1997	Ministry of Public Health	Ministry of Public Health Administration of Health Services of the State (ASSE)	State Health Services Administration (ASSE) Municipal Offices Social insurances: ambulatory services in the regulated private sector	Nonexistent (transfers from Fonasa to operators: *per capita,* adjusted to risk by age and gender + accomplishment of assistance targets)	Non existent (co-payment regulated in private social insurance operators)
Venezuela	Bolivarian Republic 23 states + DC 335 municipalities 1,123 provinces Constitution of 1999	Ministry of People's Power for Health	Ministry of People's Power for Health	Municipalities and Ministry of People's Power for Health	Budget package and through specific program	Nonexistent (extinguished in 1998)

SUMI – Mother and Child Universal Insurance; SSPAM – Health Insurance for the Elderly; SGSSS – General Social Security Health Care System; SIS – Comprehensive Health Insurance focused on the poor; EsSalud – Social Security Health Insurance.

Sources: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014c.

With different denominations and with the role of linking the community to the health facility and performing exterior and community tasks, in most cases, Health Workers/Promoters are people with no training in health, who live in the areas of PHC services. In Ecuador, Guyana and Suriname, general health assistants with technical education work in PHC teams, especially in rural areas (Chart 5).

The regionalization of PHC services with the affiliation of population to specific units, with teams being responsible for the populations defined, is observed in eight countries. The number of inhabitants assigned to each team varies within the country and between countries, with averages that start at 1250 in Venezuela, 3000 in Brazil and 4000 in Ecuador, up to 5000 in Chile and Paraguay (Chart 5). The number of people assigned to each PHC team varies according to the characteristics of the region, that is, if it is located in rural areas or in more socially vulnerable zones with (Ríos, 2014b; Almeida, 2014; Vega Romero y Acosta Ramírez, 2014a; Tejerina Silva, 2014b; 2014c).

New health care models focused on PHC renewal are being managed and implemented in seven countries (Bolivia, Brazil, Chile, Ecuador, Paraguay, Peru and Venezuela). Their population coverage varies and depends on the pace of the implementation of these changes. In Brazil, 62% of the population is covered by the "Family Health Strategy"; in Paraguay, 36% by "Family Health Units"; in Venezuela, approximately 60% by PHC teams of "Inside the Neighborhood Mission". In Chile, 90% of the population in the public system receive care at 509 Health Centers certified by the "Family and Community Comprehensive Health Care Model", in 2014. In Bolivia and Peru, there is not precise information about the population covered by "Family, Community and Intercultural Health", in the former, and by the "Comprehensive Health Care for Excluded and Dispersed Populations" and the "Family and Community Comprehensive Health Care Model", in the latter (Ríos, 2014b; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Vega Romero y Acosta Ramírez, 2014a; Tejerina Silva, 2014a; 2014b; 2014c).

INTEGRATION OF PHC INTO THE SERVICE NETWORK

The integration of PHC into the service network is a concern of policy makers and primary health care services defined as being of the first level are increasingly established in official norms as the main entry point to the health system in the twelve countries. They advocate that the PHC physician/team should work as gatekeepers to the access to specialized care, even though this function is not always regulated.

The organization of the network, based on the definition of PHC as the main entry point, faces a strong competition with urgency and emergency care and private services as the first and regular point of contact. In Bolivia, it is possible to select health services freely, whereas in Uruguay, the gatekeeping role may be shared with second level hospitals. This situation is probably aggravated by the insufficient articulation between points of care (basic

and specialized) and by problems in the organization of the working process of PHC teams, with low levels of integration between the development of programed actions, practices for promotion and prevention and provision of unscheduled care, that is, integration between actions for individual care and collective population-based actions is insufficient.

Managers also recognize that there are difficulties in the access to specialized care. The formal definition of flows for the referral of users from PHC to specialized services is a reality reported by managers of the public sector of many countries, especially for services within the new models, as in Bolivia, where there are rules established only for referrals from the "Intercultural, Family and Community Health Care Model". Nonetheless, this definition is not enough for the articulation and communication between services and professionals of the network. In general, referral operates with some imperfections and counter-referral is rarely seen.

Difficulties in access to continuing care are revealed by long waiting lines and periods for access to specialized care due to insufficient public delivery and specialized resources (visits and exams) in the networks of almost all countries. Even though there are high percentages of pertinence of referrals from primary health care to other levels of care, as in the case of Chile, there are waiting lists for some specialties that are less available. Nevertheless, the waiting periods are almost never monitored or made public, with the exception of Uruguay, which defines maximum waiting of 24 hours for first level appointments (general practice, pediatrics, and gynecology) and up to 30 days for specialized care. The information systems of Uruguay enable monitoring of periods and their publication by the Ministry of Health.

There are initiatives being developed to improve qualification and communication between PHC professionals and professionals of other levels, like TeleHealth, in Brazil, and a system of online and phone consultations that is being implemented in Ecuador.

The integration of PHC into the network depends on actions at the level of institutional policies that address the fragmentation of health systems with the strengthening of PHC systems as the main entry point and gatekeeper, besides the expansion of specialized care delivery guaranteed by public systems, with the organization of territorialized networks organized based on PHC.

Chart 5 – Provision of first level services and organization of primary health care in South American countries

Countries	Main types of facilities providing PHC	Composition of basic PHC team	Community Health Workers (CHW) (paid or volunteer)	Regionalization and affiliation of the population for PHC services	Number of people assigned to each PHC team
Argentina	7,532 Primary Health Care Centers (CAPS) 600 Integrated Community Centers (CIC)	Physicians, nurses, auxiliary nurses, midwives, community workers, dentists	Community health worker (paid), health promoters	Yes, regionalization by province	3,200 – 4000
Bolivia	1,671 Health Centers (HC) 1,604 Health Posts (HP)	HC: General practitioner, dentist, auxiliary nurse or nurse technician HP: Auxiliary nurse or nurse technician	People's health workers (volunteer)	Yes, but affiliation is incipient	HC: 1000 – 20,000 HP: 500 – 1000
Brazil	34,013 Primary Health Care Unit (UBS)/ Health Centers/USF 10,651 Health Posts Total active UBS: 38,800 (2012)	Family Health Strategy Team: Physician, nurse, 1-2 auxiliary nurse/technician, 5-6 CHW Oral health teams: dentist, auxiliary and/or oral health technician	CHW (paid)	Yes, population assigned to Family Health Strategy Teams (EqSF)	3000 (up to 4,500) per EqSF
Chile	149 Family Health Centers (CESFAM) 362 General Urban Consulting Rooms (CGU) 106 Low-complexity hospitals 1,204 Rural Health Posts	Physician, nurse, midwife, social assistant and administrative assistant	Volunteer community monitors	Yes, population assigned to each team, affiliation depends on the initiative of the population	Up to 5000 per multidisciplinary team
Colombia	996 first level public health service providing institutions	There is not a general rule for the formation of teams Basic teams are usually formed by: physicians, general nurses, promoters, health assistants and technicians	Health promoters, health walkers, primary health workers (volunteer or paid)	In some municipal models. There are not national guidelines about affiliation to PHC centers and regionalization	No general rule, depends on the PHC model of each territorial entity
Ecuador	319 Health Posts 211 Health Centers (A,B,C) 1,387 Health Sub-centers 1,248 Medical Dispensaries	Physicians, nurse and primary health care technician	Primary health care technician (TAPS) (paid)	Yes, in circuits and districts and population affiliated through continuous medical assessment and risk evaluation	4000 in urban areas 1,500 – 2,500 in rural areas
Guyana	201 Health Posts (Coast: 65 / Interior: 136) 229 Health Centers (Costa: 217/ Interior: 12)	Health centers types 1 an 2: physician, nurse, midwife, medex, laboratory assistant, auxiliary pharmacist, dental assistant, rehabilitation assistant and environmental health assistant	Medex technician and CHW (paid)	No affiliation	–

Chart 5 – Provision of first level services and organization of primary health care in South American countries (Cont.)

Countries	Main types of facilities providing PHC	Composition of basic PHC team	Community Health Workers (CHW) (paid or volunteer)	Regionalization and affiliation of the population for PHC services	Number of people assigned to each PHC team
Paraguay	760 Family Health Units	Physician, nurse and obstetrician, auxiliary nurse and 3-5 CHW For each Family Health Team, an oral care team: dentist and dental technician	Community health workers (paid)	Yes, population assigned to family health teams	3500 – 5000 (or 800 families)
Peru	1274 First level of care Health Facilities 153 Comprehensive Health Care Teams for Excluded and Dispersed Populations (AISPED)	Physician, obstetrician, nurse, nurse technician	Community health workers or health promoters (volunteers)	Yes, users of basic teams are affiliated according to their area of residence at the closest first level health facility	500 – 800 families assigned to each basic health team
Suriname	54 Health Posts (Medical Mission) 63 Clinics of the National Health Services Foundation 146 GP private offices	General practitioner, nurse, health assistant	Health Assistant	No affiliation	–
Uruguay	28 ASSE Health Centers 786 Offices, Polyclinics and Rural Health Posts IAMC: outpatient visits, decentralized offices, home care services and polyclinics	Family or general practitioner, nurse, midwife, pediatrician and external gynecologist (basic ASSE team in Montevideo)	–	No affiliation in ASSE	–
Venezuela	6712 People's Offices of Inside the Neighborhood Mission 4117 type I and II ambulatories 608 Urban Ambulatories III	Comprehensive general practitioner, nurse, community primary health care worker (ACAP)	Community Primary Health Care Worker (paid)	Yes, population assigned to teams through continuous medical assessment and risk evaluation in Inside the Neighborhood	1250 people or 250 to 350 families per Inside the Neighborhood team

Sources: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014c.

PHC WORKFORCE

One of the main challenges for PHC provision and organization is the availability of health professionals, especially physicians, and their adaptation to PHC training.

The availability of health professionals is different within each country, with deep inequalities in delivery and distribution within the interior of each country and significant gaps in remote and underserved areas. The density of doctors per thousand population is distributed over a wide rank among countries. The sufficiency in availability seems to have been reached in Uruguay, with 4.5 doctors per thousand population, in Argentina with 3.8 and in Venezuela, with an estimated ratio of 3.8 doctors per thousand people. The lack of human resources in health is intense in Bolivia (0.5 doctors/thousand people), Guyana (0.9), Suriname (1.0) and Peru (1.1). The ratio of professional nurses per thousand population is smaller than the ratio of doctors in seven countries (Chart 6).

There are no organized statistics about the availability of human resources for PHC specifically, but there is consensus among national managers that the offer is insufficient both in quality and in quantity. Most of the countries, advocate that general practitioners should work with PHC, but the availability of general practitioners that work with PHC is unknown and general practitioners specialized in PHC are scarce. This specialization is more frequently called family and community medicine (Chart 6).

In order to address the insufficient availability of PHC physicians and, in some cases, of specialized physicians, eight countries (Bolivia, Brazil, Ecuador, Guyana, Suriname, Peru, Venezuela and Uruguay) have cooperation agreements with Cuba (Chart 6).

One of the main issues for retaining physicians in PHC public services is the regulation of labor relations. There is a diversity of employment contracts and payments methods for PHC workforce in all countries, tending to precarious employment conditions, low salaries and instability, with temporary contracts and no guarantee of social benefits.

Only in Chile and Guyana, the majority of PHC professionals is composed of public workers. In other countries, there are combinations of temporary contracts with grant payment, pay for performance or per service provision, unspecified duration contracts for workers of the private sector and public workers. Although almost all countries have part of their health professionals as public workers with paid functions with unspecified duration contracts, only Chile has a specific career for PHC.

The instability of employment contracts, with high rates of professional turnover, complicates their permanence and hinders the establishment of linkage between teams, families and the community.

Chart 6 - Primary health care workforce in South American countries

Countries	Doctors / 1000 people	Professional nurses / 1000 people	Name of medical specialty for PHC (number of doctors)	Employment contracts in PHC	Professional Career for PHC	Presence of Cuban doctors (number)
Argentina	3.8 (2010)	2.2 (2010)	Family and community medicine	Renewable contracts (after performance evaluation) and temporary contracts; public workers	No	No
Bolivia	0.5 (2014)	0.2 (2014)	Physician specialized in intercultural, community and family medicine (general practitioner or family doctor)	Public workers; annual contracts, no professional stability	No	Yes
Brazil	1.9 (2010)	1.5 (2010)	Family and community medicine (3,253)	Public workers; private sector paid personnel; temporary contracts with no stability; grants	No	Yes (11,300)
Chile	2.0 (2013)	1.5 (2011)	Family medicine (629)	Public workers	Yes	Yes (30% of PHC physicians are foreigners and part of them, Cuban)
Colombia	1.7 (2011)	0.9 (2011)	Family medicine (500) Family and community health	Contracts for the provision of services for a determined period (mostly) and public workers	No	No
Ecuador	1.7 (2012)	0.8 (2012)	Family and community medicine (112)	Public workers; short-term contracts (since 2008) no stability	No	Yes
Guyana	0.9 (2013)	1.5 (2013)	General Practice	Public workers	No	Yes (166 physicians, nurses and technicians for PHC and hospitals)
Paraguay	1.3 (2010)	0.8 (2010)	Family Medicine	Renewable contracts with performance evaluations; public workers; payment plus bonus	No	No
Peru	1.1 (2012)	1.1 (2012)	Family medicine (119)	Public workers; temporary contract for the administration of services; private sector paid personnel	No	Yes (PHC and Specialized Care)
Suriname	1.0 (2010)	1.6 (2014)	General Practice Family medicine (since 2014)	Unspecified duration contracts in regional services (salary and complementation *per capita* per number of registered patients); contracts for undetermined period with salary (Medical Mission)	No	Yes (physicians)
Uruguay	4.5 (2011)	1.4 (2010)	Family and community medicine (118)	ASSE: temporary function; private law contract; Public workers; IAMC: private sector paid personnel; provision of services	No	Yes (ophthalmologists)
Venezuela	3.8 (2010)	–	Comprehensive general practice (undergraduate program in Community comprehensive medicine: 20,000 physicians)	Public workers; grants (intensive training programs in primary health care)	No	Yes

Fuentes: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014.

PHC workforce training strategies

There is a consensus among managers that training of health professionals is inappropriate and not oriented towards PHC. In recent years, almost all countries show different initiatives concerning PHC training at all levels: technical, undergraduate, graduate and continuing professional development (Chart 7). Among the main initiatives for the training of PHC workforce, one could highlight the postgraduate programmes for the specialization of physicians in family and community medicine (Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Uruguay and Venezuela) and the training program in Comprehensive Community Medicine in Venezuela, in cooperation with the Latin American School of Medicine Salvador Allende in Cuba (Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Vega Romero y Acosta Ramírez, 2014a; Tejerina Silva, 2014a; 2014b; 2014c).

In order to address the lack of PHC physicians, since 2008 the Venezuelan government has been developing a national training program in Community Comprehensive Medicine. There were 20,000 students enrolled in the program in 2014, from the first to the sixth year, also with a training program developed in academically certified clinics of project "Inside the Neighborhood", which are run by six Venezuelan universities, with a significant presence of Cuban teachers. There are 6,715 physician teachers specialized in general comprehensive practice, with certified teaching components, from the Cuban Medical Mission (Venezuela, MPPS y OPS, 2013; Rojas, 2014). There are 16 thousand community physicians graduated and, among those, six thousand are now graduate students in medicine. By enrolling in the course, students commit to work in the public system and have guaranteed acceptance into the national public health system (Rojas, 2014). The practice of medicine by graduates has been regulated in 2011 (Venezuela, MPPS y OPS, 2013).

At the technical level, one of the most remarkable facts is the training of alternative PHC workers, as in Guyana and Suriname, which traditionally employ this category of health professionals. Guyana hires Medex technicians, who substitute for doctors in the interior, and Suriname uses health assistants, also recruited from peoples of the interior and who go through a comprehensive training program composed of four years, in order to be certified as mid-level health workers (Goede, 2014a; 2014b). Likewise, Ecuador has a more recent experience with the training of Primary Health Care Technicians (TAPS), who are members of the comprehensive health care team (EAIS) (Tejerina Silva, 2014b).

Chart 7 – Main strategy for the training of workforce for PHC in South American countries

Countries	Human Resources Strategies for PHC
Argentina	Graduate Program in Social and Community Health for professionals and a Course on Social and Community Health for technicians and Health promoters, through partnerships with the Community Doctors Program
Bolivia	Intercultural, Community and Family Health Medical Residency (2007), three years almost exclusively in rural communities with short periods of in rural hospitals.
Brazil	National Reorientation Program for Professional Health Education (Pro-Saúde) destined to undergraduate students. Educational Program for Health Work (PET Saúde) develops tutorship-learning groups in strategic areas of the national public health system, National Program to Support the Training of Medical Specialists in Strategic Areas (Pro-Residência) (2012), an incentive for municipalities to develop Family and Community Medical Residency Programs, with the incorporation of residents in Family Health teams. Multi-professional Residency in Family Health. More Doctors for Brazil Program, increases the number of places in medicine schools in regions that lack physicians, universalization of medical residency, one or two mandatory years in general practice, family and community medicine for all medical specialties.
Chile	Grants for specialization in family medicine offered by the Ministry of Health. Diploma in Family Health (1-2 years).
Colombia	Since 2013, the Ministry of Health has been working on the definition of a program for training in family and community medicine and family medicine, but there is not a national policy for education and training of PHC workforce. There are six programs for training in family medicine.
Ecuador	Program for grants in Family and Community Medicine, through collaboration with the Ministry of Public Health and eight universities to qualify 5000 specialists until 2017. Program "Healthy Ecuador, I come back for you", for the repatriation of professionals, by offering transportation, accommodation expenses and employment contracts for doctors living in other countries that decide to return to Ecuador. Training at the Latin American School of Medicine of Cuba for family and community specialists. Training for Primary Health Care Technicians (TAPS) (2000 graduates).
Guyana	The Division of Health Sciences Education of the Ministry of Health trains: community health workers, Medex, nurse and auxiliary nurse, basic midwife (nurse/midwife), rural midwife, Dentex, dentistry assistant, rehabilitation assistant and audiology practitioner. Training of Guyanese doctors at the Latin American School of Medicine of Cuba.
Paraguay	Undergraduate and Graduate Rural Internship Program, Family Medicine Residency, Postgraduate Program in Family Medicine.
Peru	The National Educational Program in Family and Community Health (PROFAM) develops technical coordination of PHC training programs offered by educational institutions with all health professionals of the first level of care.
Suriname	Four-year training program for *health assistants,* directed by the Medical Mission, with students recruited from the population of the interior. Health assistants, by their turn, work as nurses, midwives, and perform some medical functions, supported by telemedicine and coordinated by physicians at health centers. Training of nurses in PHC by the Central School for Nursing and Allied Professions. Training in General Practice by the Faculty of Medical Sciences of the Anton de Kom University of Suriname and specialization in family medicine since 2014.
Uruguay	Graduate Program in Family and Community Medicine, with residency or regular Graduate program.
Venezuela	Extensive Training program in Comprehensive Community Medicine, training of Community Primary Health Care Workers, Postgraduate Program in Comprehensive General Practice.

Sources: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014c.

The most important challenge is to retain health professionals that are qualified to offer quality health services to populations in remote and underserved areas. Besides the lack of workforce, the distribution of health professionals is deficient and favors urban zones. There are different strategies applied by the countries in order to increase the availability of health professionals in remote zones. Some countries have a mandatory period of service for recently graduated students, with different levels of success (for example in Peru, Paraguay, Guyana, Suriname) and/or economic incentives. Many countries have established cooperation agreements with Cuba, as Brazil has recently done, in order to solve the lack of PHC physicians in underserved and remote zones.

INTERSECTORALITY IN PHC

Interactions with other sectors (intersectorality) in order to address the social determinants and promote health, is another essential component of comprehensive PHC. In many countries, health policies defend health promotion as a strategic axis of PHC, conceived as the action on the social determinants and/or changes in lifestyles, which implies policies with intersectoral approaches. The paradigm of "living well" in Bolivia and Venezuela, or the "well-living" in Ecuador, support the activation of public policies and may be interpreted as an intersectoral action for health, which involving a series of social development policies.

In the twelve countries of South America, it is possible to identify guidelines, norms and/or spaces that favor intersectorality in PHC at local and national levels, with the integration of different ministries, such as the National Council for the Coordination of Social Policies in Argentina; the National Intersectoral Commission for Public Health in Colombia, with the participation of nine ministries and three national departments, which aims to orient interventions on the social determinants of health; or in Ecuador, the Ministry for the Coordination of Social Development, which is in charge of the ministries of Sports, Housing, Education, Environment, Human Mobility and Health, with the new administrative division of the country in zones and districts, in order to implement intersectoral programs(Chart 8).

National PHC managers mention income transfer programs for vulnerable groups for the reduction of poverty and the eradication of hunger as important intersectoral strategies. Some examples are: in Bolivia, health and education bonuses, the subsidy to products of massive consumption and the Zero Malnutrition Multisectoral Program, formed by 11 ministries, departmental governments, municipalities and NGOS; the human development bonus and non- contributory pensions in Ecuador; the family subsidy in Venezuela; Uruguay Grows with You, a national policy with interventions focused on extremely poor zones with health and nutrition targets; the *Bolsa Família* program in Brazil; and the program Chile Grows With You, which involves intersectoral actions with the protagonist role of the Ministry of Health and the Ministry of Social Development for actions in health, housing and education (Chart 8).

Intersectorality must encompass different governmental levels, starting at the national sphere

until municipal or provincial governments, but the articulation of intersectoral actions between national and subnational levels is not commonly clearly established. On the other hand, the assignment of resources seems insufficient for the effective execution of actions.

In eleven countries, PHC teams are responsible for carrying out a diagnosis of the territory in order to identify the social, economic and health conditions and priority problems in order to guide interventions in the community with the support of the family file or family record, but this action is not always systematic (Chart 8). Paraguay has built an interesting tool to integrate local governments and communities, called Participatory Community Assessment, with intersectoral tables that analyzes the situation and determines priority health issues for interventions (Ríos, 2014b).

PHC teams' relationship with other sectors are part of their external activities. There are reports of articulation with other sectors, especially in education, social development, housing, environment, sports and salubrity. Community health workers or health promoters are seen in almost all countries (Chart 5) and have duties regarding the diagnosis of the community, the articulation with other organizations and the support to social development programs in the region.

SOCIAL PARTICIPATION IN PHC

National health policies in South America usually have the participation of the community as one of their pillars, with normative framework, policies, deliberation spaces, organization and citizen participation. This scenario was only possible with the democratic transition that occurred in most of the countries of the region by the end of the 20th century, and which brought about the beginning of a new period in history, with the perspective of generating more autonomous, critical and articulated citizenship and the creation of public spaces for participation, conflict and dialogue (Calderón, 2009). This transition has built a basis for the formation of institutionalized spaces for the participation of the population in public policies, as is seen in the field of health.

In general terms, social participation in health in South America has a formalized and institutionalized space, it is also constitutionally protected in some countries. Institutionalized local health councils, in almost all South American countries (Chart 8), enable citizen participation and articulation between the State, civil society organizations and non-governmental organizations.

Chart 8 – Intersectorality and participation in PHC in South American countries

Countries	Development of intersectoral actions	Diagnosis of the region by health team	Institutionalization of social participation in health
Argentina	Some of the main intersectoral initiatives are the National Council for the Coordination of Social Policies, the Mental Health Interministerial Program and the Program for the Training of Health Facilitators in Community Health. Intersectoral articulation converges in Integrated Community Centers (CIC), which integrate the actions of the Ministries of Health, Social Development, Labor, Planning and the Social Office. The CIC is a model of public management that implies integration and coordination of PHC policies and Social Development at the municipal level. The two main intersectoral actions developed by the PHC team are the Program for Territorial Studies and the program *Cuidarse en Salud.* In their region, they are coordinated with community organizations, social clubs and NGOS.	Yes	Local Councils – non-formal bodies
Bolivia	The main intersectoral policy in Bolivia is the Multisectoral Program Malnutrition Zero, integrated by 11 ministries, departmental governments, municipalities and NGOS. At the local level, the reference is the Comprehensive Nutrition Unit. Primary health care teams relate to other sectors for specific activities on education, urban cleaning, etc.	Yes, in My Health program	Committees and councils at national, departmental, municipal and local levels – formal bodies
Brazil	The main intersectoral policy in the country for social development is the *Bolsa Família* Program, which transfers incomes to poor or extremely poor families under determined conditions that are followed up with the support of family health teams. Intersectoral policies defined by the National Primary Health Care Policy are in the Program Health at School.	Yes	Health Councils (national, state and municipal) and Local Health Councils in some Primary Health Care Units - formal bodies
Chile	The Intersectoral Action for Health (AIS) is developed in Chile at all levels, under the coordination of the Ministry of Health and local governments. PHC teams are articulated through the execution of social protection programs and through the Chile Life Committees, which implement policies for health promotion with the participation of health and community teams.	Yes	Local Health Councils and Local Development Centers in each commune - formal bodies
Colombia	At the national level, a number of Intersectoral Commissions have been constituted, including the National Intersectoral Commission on Public Health, with the aim to orient interventions about the social determinants of health. Intersectoral action at the territorial level and the participation of PHC teams is incipient, with some municipal experiences.	Yes, in a few municipalities	Community Participation Committees, Local Councils for Social Planning, Local Health Councils and governing boards in hospitals – formal bodies
Ecuador	At the national level, the Ministry for the Coordination of Social Development is in charge of linking the ministries of Sports, Housing, Education, Environment, Human Mobility and Health in a new administrative division of the country in zones and districts in order to implement intersectoral programs. At the local level, PHC teams relate to other sectors for specific activities as part of its external activity, especially in school facilities.	Yes	Local Health Committee at PHC facilities, Citizen Sectorial Health Council – formal bodies

Chart 8 – Intersectorality and participation in PHC in South American countries (cont.)

Countries	Development of intersectoral actions	Diagnosis of the region by health	Institutionalization of social participation in health
Guyana	Intersectoral collaboration to address the social determinants of health is a key area in the new health strategy of the Ministry of Health, Health Vision 2020. Intersectoral collaboration is facilitated through the Regional Democratic Council, which is responsible for social services in the region.	Yes	Neighborhood councils and village councils, participation established by the Constitution – formal
Paraguay	In their region, Family Health Units (FHU) coordinate their actions with Departments, Municipalities and community organizations such as NGOS, Neighborhood Commissions and Local Health Councils. These actions aim to support, assist and follow up vulnerable groups of people. The interaction of PHC teams with community organizations and NGOS in the region depends on the self-management of each unit (FHU).	Yes	Local Health Councils and Health Subcouncils –formal bodies
Peru	The national guidelines on Intersectoral Actions for Health are in the charge of the General Department for Health Promotion, which defines joint action plans and workflows among sectors. The Secretariat of Health and Education, the Ministry of Housing and the community sector participate in Integrated PHC Health Networks, with the formation of an intersectoral committee for the definition of a territorial health plan and actions for health promotion. At the local level, PHC teams carry out a study on risks, based on family records and on the characterization of the surroundings, which enable a diagnosis by geographic sector that is presented to communities and orients the election of community promoters who participate in the definition of plans for family and community care and sign communal commitments to involve the population and boost intersectoral actions.	Yes	Communal Surveillance Systems, Local Development Committees – formal bodies
Suriname	At district and community levels, the Public Health Bureaus, the Regional Health Services and the Medical Mission integrate intersectoral activities. The Public Health Bureau collaborates with other sectors, especially for environmental health, with the participation of local organizations.	No	There are no formal bodies for social participation.
Uruguay	Uruguay Grows with You is a national policy with interventions focused on zones of extreme poverty, coordinated by the Office of Planning and Budget of the Presidency of the Republic, together with the Ministry of Public Health and other ministries. It defined targets in the fields of health, nutrition, child development and maternal depression. It focused on families with high vulnerability. In the regions, intersectorality is based on this national policy, combined with actions conditioned by the local reality, with an interaction with formal and non-formal organizations of the community and of the State, with territorial presence, such as the Ministry of Social Development, Municipal Offices and Mayoral Offices.	Yes	Formal spaces: ASSE Directory, National Health Board, Consultative councils. Health departmental bodies. Non-formal spaces: neighborhood or support commissions.
Venezuela	Inside the Neighborhood Mission has been conceived as a space for the integration of all social sectors under the principle of "well-living". Health teams have permanent relationship with the educational sector and integrate initiatives for comprehensive local development, such as New Neighborhood, which addresses the global problems of the zones in which it intervenes, with the participation of all sectors of social development. The health staff must be integrated to the community organization of its area.	Yes	Communal Councils and Local Health Committees– formal bodies

Sources: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014c.

One of the obstacles for the effectiveness of comprehensive PHC is that the participation of the community is often limited to the formulation of a diagnosis of the territory, with little participation in the decision-making process regarding changes in public policies that affect the social determinants ofhealth (Labonté et al., 2009).

In countries that share the concept of PHC renewal, in which participation is one of the driving principles of health systems, there is a consolidated perception that spaces for deliberation and participation of citizens are instruments for the democratization of public management and of the increase in the effectiveness of social policies. Nonetheless, the institutionalization of participation has some boundaries. There is no correspondence between the consolidation of public power spaces for participation and the level of action and political and organizational development of the social subjects and there are problems with representativeness, the quality of participation and with the possibility of having an influence on policy deliberation (Breilh, 2010; Escorel y Moreira, 2012).

INTERCULTURALITY IN PHC

The intercultural approach in health services and the integration of the traditional medicine of native peoples and peasants are increasingly a part of national health policies, although with different implementation methods.

Debates regarding the construction of the field of "intercultural health", its due recognition and the comprehension of the ethnical diversity in societies is recent in the field of medicine (Knipper, 2010). Nonetheless, in some countries of South American region, interculturality experiences have generated discussions and the incorporation of aspects of the medicine of native peoples in the health system. However, in most of the countries, formal PHC documents do not clearly mention the concept of interculturality, except for Bolivia, Chile, Colombia and Peru. Venezuela, Ecuador and Bolivia share the focus on an intercultural approach with respect for and assimilation of the knowledge and health practices of native peoples expressed by the concept of "well-living".

The intercultural approach is greatly developed in Bolivia, where the concept of interculturality is one of the pillars of the national health policy and primary health care teams coordinate actions with traditional physicians of the region with which they are assigned. There are intercultural experiences in Chile, Colombia, Ecuador and Peru. Even with the adoption of different concepts and approaches, these countries use PHC for the implementation of intercultural actions (Chart 9).

Chart 9 – Interculturality in PHC in South American countries

Countries	Interculturality as an axis of the PHC policy
Argentina	There is no reference to the concept of interculturality in official documents. This dimension is structured through actions of programs and plans destined to indigenous peoples.
Bolivia	Interculturality is expressed in the political constitution of the country and it is one of the axis of the national health policy. There are concrete interculturality actions developed in several ambits. One of the highlights is the intercultural childbirth and the recognition of traditional therapists.
Brazil	The National Primary Health Care Policy does not mention the concept of interculturality, whose actions are still incipient in the country. It is present in the Indigenous Health Policy.
Chile	Interculturality is one of the purposes of the Comprehensive Family and Community Health Care Model. This model must ensure the recognition, protection and strengthening of knowledge and practices of the medical systems of native peoples and their inclusion in benefits and in the provision of the Fonasa. There is a number of experiences that articulate PHC and interculturality in the country. The health policy model for indigenous peoples has an intercultural approach.
Colombia	Some indigenous communities of the country have formed their own Health Promotion Entities and Institutions for the Delivery of Indigenous Health Care Services of first level, with the establishment of the Intercultural and Traditional Indigenous Health Care System (Sispi). However, there are difficulties for the recognition of the traditional medicine of indigenous peoples. There are local experiences organized by indigenous peoples within their territories.
Ecuador	The National Office for the Management of Interculturality, linked to the Ministry of Public Health, is responsible for the planning of intersectoral actions. There is a specific policy for the implementation of ancient medicine actions in PHC that is currently being developed. There are some local intercultural experiences organized based on the claims of indigenous peoples.
Guyana	Interculturality in PHC is addressed within indigenous questions. The Amerindian Act approved in 2006 establishes a National Council of Toshoas (chief elected by the village), who must be consulted for national decision-making that can influence the life of indigenous peoples.
Paraguay	Some Family Health Units are located in areas of influence of indigenous communities and they coordinate their work with indigenous promoters in order to promote joint work.
Peru	In Peru, there is an interculturality policy headed by the National Health Institute, linked to the Ministry of Health through the National Intercultural Health Center (CENSI). There are several successful experiences in the country, promoted by different organizations since the 1980s.
Suriname	Interculturality is rarely mentioned in health policies documents. The Medical Mission has experiences with intercultural work with Shamans.
Uruguay	The issue of interculturality is not very common, considering the high urban concentration of the population and the little presence of traditional medicine. Nonetheless, there are some barriers (language and difficulty in the comprehension of materials for health promotion and education).
Venezuela	There is a clear mandate in social policies for the integration of the intercultural approach, which is understood as the respect for different ethnic and cultural identities in their concept and preferences in health care. Interculturality must be a transversal axis that activates all sectors. One highlight is the experience with the comprehensive health care program for the Yanomami people.

Sources: Mapeos Isags de APS en Suramérica: Ríos, 2014a; 2014b; 2014c; Acosta Ramírez y Vega Romero, 2014; Almeida, 2014; Goede, 2014a; 2014b; Vega Romero y Acosta Ramírez, 2014a; 2014b; Tejerina Silva, 2014a; 2014b; 2014c.

In most of the countries of the region, the understanding of the intercultural approach is

restricted to a concept of respect for the singularity and social and cultural integration or to the establishment of its bases within indigenous questions (Chart 9).

FINAL CONSIDERATIONS

In conclusion, South America currently holds several processes for the revitalization of PHC. Its implementation is progressive and, in many cases, the expected results have not yet been achieved. Besides the increase in the access to services at the primary level, including experiences that limit access to a set of selected actions, it is possible to identify innovative movements in the organization and practice of primary health care. In some of these experiences and in more consolidated public systems, it is possible to observe characteristics of comprehensive primary health care.

Among the several innovative experiences that can enable the formulation of policies to address similar problems concerning PHC organization and practices as a strategy for the organization of health systems in the region, it is possible to highlight the following:

- the approach to health as a right in national constitutions;
- the initiatives for the development of the first level, with individual, family and collective approaches, integrated to the health systems, with the formation of networks and coordination with specialized and hospital services;
- the initiatives for the improvement of the quality of care provided in the first level;
- the new intercultural approaches;
- the horizontal integration in the territory with other public services and organizations from sectors other than health, which aim to encourage intersectoral actions to address the social determinants and to promote health;
- the experiences with strong community action and their effect on social inequalities, with PHC being integrated into a comprehensive social development policy, as in the paradigm of well-living or living well, even though it may be also found within contexts in which segmentation has now yet been overcome;
- community actions with the action of community workers or health promoters;
- the increase in social participation through local councils and the institutionalization of other forms of participation in health;
- the incorporation of specialized technical personnel to PHC teams; and
- undergraduate and graduate programs for medical professionals with training strategies in PHC.

Some of the most important challenges for the guarantee of comprehensive universal health care are training and continuing professional development for action in PHC and the guarantee of access to health services in remote and underserved areas, although there are

currently several strategies being implemented in order to overcome these problems.

Intersectoral action has been defended by movements in favor of primary health care and health promotion over the last 30 years, but there are still many obstacles for the articulation between the different sectors in South American countries. The identification of problems that require intersectoral actions, the articulation of different interests in each sector and the indication of common objectives in different areas are still important challenges for the organization of intersectorality in primary health care within the countries.

With the recognition of quality health services as one of the social determinants of health, another challenge for the guarantee of comprehensive health care is the achievement of a balance between the individual approach of personal timely care and the collective health approach based on territory, in addition to strategies of community action and local horizontal cooperation. This balance is essential for the guarantee of comprehensive care with the promotion of autonomy of individuals and the prevention of medicalization. In this sense, one issue that must be deepened with further studies are the best strategies for the articulated implementation of a strong first level with effective quality care – with little intervention and with the promotion of autonomy of individuals – and powerful community action to address the social determinants.

In South America, there are still tensions in different concepts of primary health care among countries and within each country, with different implementation approaches. The segmentation of health services with different coverage and service networks for specific groups of the population and the limited public funding of health systems are important obstacles for an effective comprehensive primary health care.

The segmentation of coverage and funding and the fragmentation of care, which were deeply addressed in previous decades, are now obstacles for the implementation of comprehensive PHC, even in the context of comprehensive social policies. The search for the implementation of comprehensive primary health care is indissoluble and it faces the same obstacles for the construction of public universal systems in our Region.

The PHC approaches implemented are conditioned by the segmentation of health protection and health systems. Thus, there is a relation between the directions of proposals for social protection in health and the PHC approaches and concepts implemented.

On one hand, the market-oriented insurance approach, with coverage segmented into private or public insurances with different service packages according to the person's ability to pay, corresponds to a first level PHC approach, focused on individual care, with no territorialization or collective approach; and in the case of subsidized insurance (focused on low-income populations or on mother-child groups), to a (neo) selective PHC with a minimal service package that crystalizes inequalities.

On the other hand, the perspective of the construction of universal public health systems to ensure the right to health and universal access in response to the individual and collective health needs of citizens, regardless of their ability to pay, based on solidarity, corresponds to a comprehensive PHC approach as the one expressed in the Declaration of Alma-Ata, as a strategy

to re-orient health systems and to ensure comprehensive health care.

PHC that coordinates health care in a comprehensive network, with social participation and intersectoral action to address the social determinants and promote health, is inseparable from the strategies for the economic and social development of nations.

Nevertheless, the new assistance primary health care models being implemented in South America, as will be analyzed and synthetized in further detail throughout the following chapters, incorporate components oriented towards the guarantee of comprehensive care: with approaches for the family and the community, multi-professional teams with defined population and territories, comprehensive health services networks based on PHC, with respect for and assimilation of the knowledge and health practices of native peoples, priority to the promotion of health understood as an intersectoral action on its social determinants and institutionalization through social participation.

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Primary Health Care in Argentina, Paraguay and Uruguay

Gilberto Ríos Ferreira

INTRODUCTION

The analysis of the PHC strategy necessarily implies a panoramic consideration of the evolution of political and social procedures of the countries and their health systems. First, it is important to mention that Argentina, Paraguay and Uruguay were under military dictatorships at the moment of the approval of the Declaration of Alma-Ata, in 1978. The PHC concept, among other aspects, recognizes health as a right, stimulates a wide social participation, an active relationship between the community and assistance services and promotes the State as the main axis of this transformation. All these conditions were not feasible, once freedom was restricted, participation was limited and the State, under a dictatorship, had other priorities.

In regard strictly to health aspects, the common factor was the transition of health systems that, since the 1960s, had been characterized by the increasing burden of the public assistance sector, with the prevalence of the approach to communicable diseases and an organization associated with the traditional hospital-based approach. By the end of the 1960s, the first health centers started to be created in the region, within a context of progressive expansion of mainly public assistance networks.

The health systems in Latin America were being shaped based on a mixture of western social protection models. More than the systems of European countries, which pointed to the universalization of social protection, the Latin American subsystems started to specialize in specific strata of the population, grouped by social class, occupation, inclusion

in the formal labor market, ethnic origin and land occupation (urban/rural). There were neither Bismarckian (social security) or Beveridgean (national health services) models established, which resulted in segmented or even atomized systems (Levcovitz, 2014).

Together with the increasing presence of the organized public assistance sector, which was managed and funded by the corresponding Ministries of Health, these three countries created parastatal sectors for the provision of coverage to formal workers, represented by the Insurance Fund, in Argentina, the Social Security Institute (IPS), in Paraguay and the Collective Health Care Institutions (IAMC), in Uruguay. Their typology corresponds essentially to Bismarckian social insurances, designed for the formal sector, but in some cases they also cover specific sectors of the population that do not contribute to social security, but who are granted access through volunteer affiliation, in a prepaid modality. In this sense, the experience with the greatest sustainability over time is in Uruguay, with the IAMC. Simultaneously, private insurances of a volunteer nature appeared, offering assistance exclusively to the population with ability to pay. Affiliation to one of these private insurances, usually called prepaid, enables the access of users to a private assistance center. Since the 1980s, health sector reform processes have started in almost all Latin American countries, with a tendency to favor the participation of the private sector in the management of funding and in service provision, with the consequent reduction of public services (Arriagada, 2005). Neoliberal policies in Latin America meant an increasing reduction of the role of the State, deregulation, privatization and the limitation of the subsidiary public responsibilities focused on poorer and more vulnerable segments of the population. This market orientation affected the health sector of all three countries and, particularly in PHC, led to the reappearance of the selective approach that is understood as a set of simple provisions, often with low quality, directed at the poor (Cueto, 2004). At the same time, the access to a more complex health care, with quality, has started to be growingly associated with the individuals' ability to pay.

PHC renewal happens in a context of political changes in the region, in which left and center-left governments take office, after the profound impact of the economic crisis of 2001-2002, due to the failure of the neoliberal reforms of the 1990s and their repercussions on the health systems. The need to redefine the health component of the social protection matrix was enforced with regard to accessibility, universal coverage and equity. The new perspective retook the vital role of the State in order to form an effective social protection and its guiding role in public health policies.

The Regional Declaration on the New Orientations for Primary Health Care (also called Declaration of Montevideo) recaptured the ideas of Alma-Ata, thereby incorporating health concepts based on PHC as a strategy to reach social inclusion and more equity. This approach advocates the orientation towards health promotion and comprehensive and

integrated health, the fostering of intersectoral work, the orientation towards quality of care and safety of patients and the strengthening of human resources for PHC (OPS, 2005).

The revitalization of PHC was based on the Declaration of Alma-Ata (OMS, 1978), but it must now comprehend the entire health system, including public and private nonprofit sectors. It supports the values of the right to the highest possible level of health possible, equity, understood as the absence of unfair differences in the health status, and social solidarity. Through PHC, guided by the principles of intersectorality, sustainability, social justice, participation, responsibility and government accountability, the aim is to answer the health needs of the population and to orient services towards quality. Health systems based on PHC include structural and functional elements, such as universal coverage and access, the entry point into the system, comprehensive, integrated and continued care, family and community orientation and emphasizes promotion and prevention (Macinko et al., 2007).

PHC is also considered an essential condition to achieve international targets, as the Millennium Development Goals (OPS, 2003).

It was under this general framework of PHC renewal that these three countries, Argentina, Paraguay and Uruguay, have developed their reform processes, which, in some cases was deep and in others only partial, conditioned by the characteristics of their corresponding health systems.

The health system of the Republic of Argentina is formed by three subsystems segregated and structured to offer health care services to different segments of the population. Their subsectors and coverage are schematically characterized in Chart 1.

In Argentina, the state public system covers the entire country and is present at all regional levels. Its services answer hierarchically to different authorities: the Nation, provinces and municipalities with fragmentation. The public subsystem is funded by tax incomes and it provides care to populations not covered by any of the other systems.

The social security system groups the Insurance Fund and is financed through mandatory contributions shared between employers and workers of the formal sector. The National Insurance Fund is the most traditional institution and it necessarily groups all workers comprehended in a sector of activity, with the addition of the Provincial Insurance Fund (OSP), which provides coverage to public workers in the 23 provincial governments, the Autonomous City of Buenos Aires (CABA) and municipalities (Isags, 2012a), and the fund that covers retired people, the National Institute of Social Services for Retirees and Pensioners (INSSJP-PAMI). The PAMI is funded with resources of contributions from active employees and employers, also with contributions from the retired. The social security subsystem is regulated by the Health Services Superintendence (SSS).

The private subsystem comprehends a series of private health insurances called prepaid, which are presented in different organizational forms, especially as mutual

organizations, co-operatives or foundations. They are insurance for profit companies whose delivery is directed at the population with higher income and which enables access to private sector services. As expressed in Chart 1, prepaid insurances, regulated by Prepaid Medicine Act, represent the subsystem with the lower coverage of the population (Morgenstern, 2013).

Chart 1- Health system and segments of the population in Argentina

Subsectors		
Public state system	Social security	Private system
Ministry of Health of the Nation	Insurance Fund	Prepaid [a]
23 provincial ministries + CABA	National Institute of Social Services for Retirees and Pensioners - PAMI (Comprehensive Medical Care Program)	Co-operatives Mutual organizations Foundations
Coverage		
36%	46%	5%
Population		
Population in need of other types of coverage: workers with dependence relation or autonomous not registered Unemployed and inactive without ability to pay	Formal workers Retirees and pensioners	Volunteer contract
Other segments		
State health programs and plans		Prepaid through Insurance Fund [b]
2%		11%

Sources: Argentina, Indec, 2012; Eurosocial, 2007. *2007

a) Prepaid: By the end of the 1970s, under the general denomination of Prepaid Medicine Companies, there was a wide and diverse group of entities formed, whose delivery presented a dispersion in coverage prices and services.

b) Besides the Insurance Fund, which canalizes its contributions to a prepaid insurance, there are private insurances that provide health services through an Insurance Fund, which results in problems of double affiliation and double coverage in the health sector of Argentina (Morgenstern, 2013).

The health system in Paraguay is characterized by its segmentation in state public, non-state public, private and mixed sectors. There are also subsystems with different modalities of affiliation, funding and provision, but there is a fragmentation within each subsystem, with strong vertical integration among funding, planning and provision functions.

The state public sector is formed by the Ministry of Public Health and Social Welfare (MSPBS), the health services of the Military, the Police and the Army. The MSPBS is the main provider, exclusively funded with tax incomes and, in theory, covers most part of the population. Other state public services, as the Health Services of the Military, the Police and the Army, receive tax funds and mandatory contributions based on the salaries of their

personnel and cover the police and the military. The other part of the public sector is the Decentralized Administration, which comprehends the government, municipalities and the National University of Asunción, with the Clinics Hospital and the Maternal and Child Care Center.

The non-state public sector is formed by the Social Security Institute (IPS) as the social security entity for the formal labor marker sector in the country. The Social Security Institute is funded with social security contributions, from employees and employers that may vary according to the type of employment and level of income. It comprehends formal workers from both public and private sectors, and covers 16% of the Paraguayan population (Isags, 2012b; Maceira, 2007) (Chart 2).

In the private sector, which covers 7% of the population, there is a great variety of schemes that vary from small saving funds, mutual insurances, insurances for particular groups to private insurances *stricto sensu* (Holst, 2003).

Chart 2- Health system and segments of the population in Paraguay

<table>
<tr><td colspan="5">Subsectors</td></tr>
<tr><td colspan="2">Public</td><td colspan="2">Private</td><td>Mixed</td></tr>
<tr><td colspan="5">Funding</td></tr>
<tr><td>Taxes</td><td>Contributions of the social security</td><td colspan="2">Private sector premiums</td><td>Contributions from the State + Private foundation</td></tr>
<tr><td rowspan="3">MSPBS</td><td rowspan="3">IPS</td><td>Nonprofit</td><td>For profit</td><td rowspan="2"></td></tr>
<tr><td>Provinces, NGOS</td><td>Prepaid medicine</td></tr>
<tr><td>Co-operatives, associations</td><td>Private providers</td><td>Paraguayan Red Cross</td></tr>
<tr><td colspan="5">Coverage*</td></tr>
<tr><td>77%</td><td>16%</td><td colspan="2">7%</td><td></td></tr>
</table>

Source: Adapted from Isags, 2012b. *2010

One of the greatest challenges to the health system of Paraguay is the extension of the actual coverage of social protection in health. Only 20% of the population is covered by some sort of insurance (social or private), whereas the biggest part of the population depends on the variable and many times limited delivery of the government. It is estimated that around 35% of the population lacks regular access to basic health services and that there are still important gaps in coverage and inequalities in the access to health care among urban and rural populations (Mancuello Alum y Cabral de Bejarano, 2011; Lavigne, 2012).

The fragmentation of the health service provider sector in Paraguay is associated with the segmentation of coverage, with the nonexistence of coordination between the distinct social security health service providers and the Ministry. Another important aspect of the system is that health facilities offering high-complexity care are providers of the social insurance, concentrated in the capital of the country and in the Central Department,

whereas, in the rest of the country, there are only providers of lower complexity services (Isags, 2012b).

The health system of Uruguay, after a deep reform initiated in 2007, is denominated Integrated National Health System (SNIS) and is characterized by the articulation of the public and private subsystems, with the promotion of the assistance complementation and common social service obligations, with a single funding mechanism through contributions to social security (National Health Fund – Fonasa, of the National Health Insurance), thereby ensuring universal coverage and with a National Resources Fund (FNR), in order to guarantee provision of highly specialized medicine and for catastrophic events.[1] The regulatory organism par excellence is the Ministry of Public Health (MSP), which acts as the health authority.

The National Health Insurance (SNS) is based on the contributions of workers, companies and the State. Workers have contribution fees that vary between 3% and 8% according to their level of income; companies have a fixed contribution of 5% plus a quota complement, which is applied when the sum of the contribution of the worker and the employer does not reach the average health quota. The State contributes with incomes to compensate the coverage benefit granted to several workers, especially those with lower income and with many children, whose contributions do not cover the corresponding health quotas for all beneficiaries. Retirees also have a contribution fee that varies from 3% to 6% (Ríos, 2014c). Contributions are collected by the Social Security Bank (BPS), which manages the Fonasa.

The National Board of Health (Junasa), a decentralized organism of the Ministry of Public Health, manages the National Health Insurance financed by the Fonasa and hires integral public and private providers. The BPS, following the mandate of the Junasa, pays to providers a monthly "health quota" for each beneficiary of the SNS, according to their age and gender and to the assistential targets established by management contracts. The separation between the contribution and the use of services is the greatest possible: all beneficiaries of the SNS are entitled to the Comprehensive Health Care Plan (PIAS), regardless of their ability to pay (Uruguay, MSP, 2009).

The main assistential public service is the State Health Services Administration (ASSE). It is the biggest one in structure, geographic extension and coverage (34% of the population). It is responsible for the coverage of the most underserved sectors of the population, which do not access the Fonasa through the general income funding (taxes) (Muñiz, 2014). It is the main public health service provider, but it also covers beneficiaries that contribute to the Fonasa (social security) and choose the ASSE, which has the advantage of not having co-payments, present in most of the IAMC.

Other institutions are also part of the public systems, such as the Clinics Hospital, the School of Medicine of the University of the Republic, the health services of the Social

[1] The National Resources Fund works as a reinsurance for catastrophic diseases, thereby providing financial coverage to high-complexity medical procedures, with the inclusion of high-cost medicines for users of the Integrated National Health System.

Security Institute, called Social Security Bank, the Medical Services of the State Insurance Bank and the first level of care services in the charge of municipalities (Chart 3). Another component of the public sector are the police and army health services, with a coverage of 7% and general income funding and mandatory contributions from the salaries of their personnel (Isags, 2012c).

Private regulated services are formed by Collective Health Care Institutions (IAMC), which group the historic immigrant mutual organizations, medical co-operatives and corporations. They have a long trajectory in the sector and a strong regulation by the State. The IAMC, regulated by Act 15,181 and its regulatory decrees, are nonprofit institutions that offer comprehensive care and cover 54% of the population (Ríos, 2013a).

The remaining part of the private participation in the system consists of volunteer for profit private insurances that, with less regulation, provide care according to the premiums paid by the insured. It covers no more than 3% of the population.

SNIS users are all Uruguayan citizens that contribute to the Fonasa or users of the low-income population that do not contribute, but who are covered through the ASSE public provider.

Chart 3- Health system and population coverage in Uruguay

Subsectors			
Integrated National Health System		Other public services	Other private services
Funding			
ASSE	**IAMC**	**Army and Police Health Services**	**Private comprehensive insurances**
General income	Social security	General income and mandatory contributions based on salaries	Prepaid
Coverage			
34%	54%	7%	3%

Sources: Muñiz, 2014; Isags; 2012c. *2011

PHC CONDUCT

PHC Concept

In Argentina, Paraguay and Uruguay, the concept and development of primary health care (PHC) followed a similar pattern to other Latin American countries. On one hand, an approach focused on vulnerable populations funded by the public sector and, on the other one, a strong conditioning that forces a generalized segmentation and fragmentation of almost all health systems in the region.

The international discussions about PHC renewal, since the first decade of the 21st century (Macinko et al., 2007) was an incentive to retake policies of the 1960s and 1970s and to once more prioritize the agenda towards PHC in the Region. In September 2005, the

health ministers of Latin American gathered together in Uruguay, in an explicit support to the concept of PHC renewal, through the Declaration of Montevideo (Macinko et al., 2007). Later, in August 2007, the government of Argentina, with the support of the PAHO/WHO, convened the International Conference on PHC (Buenos Aires 30/15: From Alma-Ata to the Declaration of the Millennium) to celebrate the 30th anniversary of Alma-Ata. These initiatives have been favored by the democratic political changes in the region.

Since the crisis of 2001, Argentina started a process of change in the health sector, with claims for health as a right and the recognition of the responsibility of the State, focused on comprehensive care, accessibility and the decentralization of health services. Within this framework, several initiatives have been created, such as *Remediar* and the Community Doctors Program (PMC), among others.

In Paraguay, the implementation of PHC traditionally prioritized vertical programs of maternal and child care, immunization and of communicable disease outbreak surveillance. These activities have been carried out at the first level of care with sparse integration with other providers of the service network and concentrated in the public sector and focused on the poorest sector of the population. A process that tends to guarantee the right to health for all citizens starts to be developed in 2008, with the concept of health as a right, supported by the principles of universality, equity, integrality, interculturality and social participation. A new PHC concept is established and materialized by the initiative of the Ministry of Public Health and Social Welfare (MSPBS) for the creation of the General Department for PHC and the project for the construction of Family Health Units all over the territory, which generated an inflection point in the reorientation of the health system.

Immediately after the launch of the PHC strategy, in 1978, Uruguay also reproduced the models of the region. However, despite the profound debate that took place by the end of the dictatorship (1985), it was only recently, after 2005, that it started a deepest reform process, under the framework of a fundamental change of the matrix of social protection in health. The PHC strategy and its dimensions are constantly seen in the documents that conceptualize the reform, created by the SNIS (República Oriental del Uruguay, 2007).

Legal and normative framework

In Argentina, concerning its legislation, the constituent processes of 1994 based the right to health on the fundamental national rule in Article 75, section 22, which integrates the International Human Rights Law. Now, the right to health has constitutional status due to the ratification of international agreements and treaties (Morgenstern, 2013; Isags, 2012a). In Argentina, access to health in the public system is universal and free of charge to all citizens.

The foundation of the Federal Health Plan specifically develops the PHC strategy as the most effective one. It proposes "the design of a new health model based on the construction of health care networks and with the recognition of its primordial basis on the primary health care strategy". PHC is considered the "most effective model for the

improvement of the health of the population and the attainment of a more equal coverage". The strategy is to "ensure effective primary health care coverage to the population of each region and to enable their participation". The Plan establishes primary health care as an "absolute priority" and it affirms that "funds shall be increasingly assigned to actions for promotion and prevention", with progressive, systematic and organized decentralization (Argentina, Presidencia de la Nación, 2004).

Additionally, the regulation of the several programs of the Ministry of Health of the Nation (Minsal) also establishes missions that are directly linked to the PHC strategy. For example, the Maternal and Child Care Program determines the national criteria for the reduction of child mortality, with an important role of services of the first level of care and program *Remediar*, ensuring access to essential medicines within the framework of a series of regulation criteria applied mainly at the territorial level.

In Paraguay, there are several regulations, with different classifications, which address PHC.[2] The ministerial resolution that created the General Department for Primary Health Care, in 2008, mentions most of the PHC dimensions. Some of its missions are the support to the implementation of a health service network, with the definition of Family Health Units (USF) as the entry point to the National Health System and with case-resolving capacity to address health problems in social territories. Moreover, the USF must be responsible for the promotion, adaptation, dissemination and socialization of the comprehensive health care model, with a family and community approach, at national, regional and local levels.

In Uruguay, the most consistent rules related to PHC are integrated in Act 18,211 of 2007, which created the Integrated National Health System (SNIS) and defined its driving principles. The aforementioned law establishes that the SNIS shall "be organized into networks by levels of care, according to the needs of users and the complexity of provision. It shall have primary health care as a strategy and prioritize the first level of care" (República Oriental del Uruguay, 2007). The Act highlights the value of health promotion with an emphasis on the determinant factors of the surroundings and lifestyles of the population. It establishes the fundamental bases of the Uruguayan health system: intersectorality of health policies in order to improve the quality of life of the population; universal coverage that encompasses accessibility and sustainability of health services; equity, continuity and timeliness in the access to service provision; comprehensive quality of care, according to technical rules and care protocols; respect for the principles of bioethics and human rights of users; and social participation of workers and users, among others (República Oriental del Uruguay, 2007).

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2 First of all, articles 3, 68 and 69 of the Constitution of the Republic (República del Paraguay, 1992); Act No. 1,032/96, which creates the National Health System; Decree 21,376/98: Article 20, number 7, which authorizes the Ministry of Health to "dictate Resolutions that regulate the activity of the several programs and services, regulate its organization and determine its functions", and Ministerial Resolutions such as S.G 101 of September 17, 2008, which creates the General Department for Primary Health Care, as part of the Health Sub-secretariat of the Ministry of Public Health and Social Welfare.

Functions and competences of governmental spheres in PHC

The functions and competences of governmental spheres in each country are directly related to their organization and political and administrative division. In Paraguay and Uruguay, unitary centralized countries, the tendency is the concentration of functions and competences at the national level, differently from Argentina, a federal country with a tendency to decentralization with extensive autonomy and delegation of competences and financial responsibilities to provinces and municipalities.

In Argentina, the Minsal is the body responsible for the stewardship of the health system. The Federal Health Plan 2004-2007 (Argentina, Presidencia de la Nación, 2004) has worked as a conceptual framework of the long-term project that must orient the development of the health system. According to the Federal Plan, the assistance of the Nation, primarily consists of the design of a health care model that is adequate to PHC in local centers. In addition, through the Program *Remediar*, the Ministry of Health of the Nation will be in charge of the provision of medicines to ensure the access of the population with lower income, through the provision of milk, vaccines, contraceptives, etc. The channels established for the distribution of important inputs for PHC imply a direct action to incentive the population to seek Primary Health Care Centers (CAPS) instead of hospitals for health services. Furthermore, the Nation and the provinces accredit and classify the CAPS, build capacity and offer incentives to professionals (Argentina, Presidencia de la Nación, 2004).

The policies of the Minsal are implemented by provinces and municipalities. Firstly, the execution is done at the provincial level, that is, within the 23 provinces and the Autonomous City of Buenos Aires, which have health care competences delegated by the federal level. The majority of provinces develop their own PHC vision and define it in their constitution, acts or decrees at the provincial level. The Federal Health Council (Cofesa) and the Regional Health Councils (Coresa) have been created in order to coordinate the national and regional policies.

The first station in the decentralization process of federal plans is always the province: each one of them has a service network within their territory, which manages provincial hospitals and coordinates them with the municipal levels and the first level of care. In most of the provinces, Primary Health Care Centers (CAPS) are within their jurisdiction, except for some provinces as Buenos Aires and Córdoba, with decentralization at the municipal level. Besides the CAPS, the Integrated Community Centers (CIC) also started to be incorporated in PHC, as structures that are subordinated to provinces, with a more comprehensive and integrative concept, which always considers the health sector. In order to accomplish their missions, provinces have their own resources and receive resources assigned by the central government (Ricchero y Tobar, 2003).

After the provincial level, the other level of execution of PHC policies in Argentina is

the municipality. Through its health secretariats, municipalities plan PHC in their territory, in coordination with the province.

In Paraguay, the governmental national sphere with PHC competence and functions is the Ministry of Public Health and Social Welfare (MSPBS), through a specialized organism, the General Department for Primary Health Care. It counts with a specific budget for its operation and is responsible for the management of Family Health Units (USF) and Family Health Teams (ESF). Among its missions are the implementation of a health service network, with USF as the entry point to the National Health System; the accreditation of new USF, according to the assessment of the needs of each social territory; the establishment of guidelines for regionalization and affiliation of the population to USF. It is also responsible for the development of human resource technical capacity for the implementation of the model of care with family and community approach, from the social determinants of health, for service provision and other important activities for the health of the population.

In Paraguay, departments and intendances co-participate in the first level of care with the integration of the assistential network and the participation in other actions that imply intersectorality. The ministerial structure which establishes the health regions in the country also enables departments, municipalities and districts to influence the implementation of PHC in their territory (Chart 4). In summary, at the subnational level, "the conduct of PHC is done by health authorities, supported by political authorities through regional and local health councils, including intendents, community leaders, health professionals and promoters or community workers" (Dullak et al., 2011:2869).

In the SNIS, in Uruguay, the operating legislation[3] gives the Ministry of Public Health (MSP) competences at the national level, which has encouraged an intensive process of decentralization of its organizational structure and hierarchy of its stewardship role and health authority. The other important governmental structure is the National Board of Health (Junasa), a decentralized body of the MSP that manages the National Health Insurance. It also has tools and competences to orient public and private providers towards PHC strategy, through the management contract that must be signed by providers in order to access the funding of the Fonasa and the provision targets associated with the *per capita* payment to all SNIS providers.

At the national level, besides all SNIS providers (collective health care institutions, medical co-operatives etc.), which must move forward with the missions established by law, there is the State Health Services Administration (ASSE), the only comprehensive public provider of the system, which has the greatest responsibility to conduct the reform process towards a new model of care under the framework of the PHC strategy. As the main state provider of comprehensive health care, the ASSE has a health assistance service network that operates over the entire national territory, with a comprehensive health care concept that

[3] Particularly, Law 9,202 (Public Health Organic Law) and Law 18,211.

includes promotion, prevention, diagnosis, timely treatment and rehabilitation (ASSE, 2014b).

According to the political and administrative organization in Uruguay, below the national level comes the departmental level, formed by 19 Departmental Intendancies, which have been historically incorporated into health care, particularly in the first level of care (Chart 4). Despite their variable development, all intendancies have some participation in health through their own resources, with a network with ASSE services and/or community or self-managed polyclinics (Ríos, 2013a). Differently from other countries analyzed, Uruguay does not delegate assistance competences to the municipal levels.

The increasing coordination of efforts by the public provider sector, which enables the optimization of resources and the avoidance of service duplication, comes as a strategy to move forward towards PHC, with the creation of the Public Health Providers Integrated Network (Rieps).

The Rieps is an interinstitutional structure that includes ASSE and all other public providers, the Medical Services of the Social Security Institute (called Social Security Bank – BPS), the Clinics Hospital (HC), the Police National Board of Health, the Armed Forces National Board of Health, the State Insurance Bank (BSE) and the Municipal Intendancies (República Oriental del Uruguay, 2011). It is important to highlight, that although it is not sufficient, the potential of the Rieps to coordinate is a necessary condition to a good public-private complementation under the framework of the SNIS (Benia, 2011).

In Uruguay, other actors which influence PHC policies are the Collective Health Care Institutions (IAMC) as part of the SNIS. They must accomplish the Comprehensive Health Care Plan (PIAS), a national health strategy that includes activities for health promotion and protection, early diagnosis and treatment of health-disease problems, recuperation, rehabilitation and palliative care, besides the access to medicines and the use of sufficient technologic resources. Among these institutions, 11 are located in Montevideo and the other 28, in the interior of the country. The regulation of the MSP compels the development of priority programs conceived from the perception of the population and according to the epidemiological reality of the country. On the other hand, the obligations assumed before the Junasa, with the signature of the management contract and the responsibility to provide all services defined in the Comprehensive Health Care Plan (PIAS), are necessary conditions for providers to access the funding of the Fonasa.

Chart 4 – PHC functions and competences of the governmental spheres in Argentina, Paraguay and Uruguay

Argentina		Paraguay		Uruguay	
Federal		Unitary		Unitary	
Spheres	Functions	Spheres	Functions	Spheres	Functions
Ministry of Health of the Nation	National programs, provision of medicines, capacity building and incentives for PHC human resources	Ministry of Health and Social Welfare	PHC competences at the national level, promotion of the comprehensive health care model, human resources development, regulatory framework, intersectorality	Ministry of Public Health	Stewardship of the system, priority programs, regulation, funding, human resources development, PHC promotion
Provincial Ministries of Health	Delegated competence for health care Services network: provincial hospital and coordination with municipalities			State Health Services Management (ASSE)	Main management of the first level of care service network, development of PHC strategy
Municipalities	Management of lower complexity hospitals, management of the first level of care, PHC strategy	Municipalities	Co-participation in PHC network, support to the assistential network, intersectoral coordination	Departmental Intendancies	Co-participation in the first level of care network, intersectorality

PHC FUNDING

Within a context of political changes, transformations towards the leading role of the State also reflect on the funding sources and assignments to health in two of the three countries. In Argentina and Uruguay, the increase in the participation of the public expenditure over the last five years is significant, reaching two thirds of the total expenditure on health in 2011 (66,5% and 69,5%, respectively). In Paraguay, the public expenditure does not reach 40% of the total expenditure on health and there has been a minimal decrease. This means that, in Argentina and Uruguay, the private expenditure – that is, contributions to private insurances and out-of-pocket expenditure – tends to be reduced (WHO, 2014).

The composition of the public expenditure on health in the three countries is different, which is coherent with their models of social protection in health. In 2009, in Argentina and Uruguay, contributions to social security would prevail within the public

health expenditure, at around 58% (Giovanella, 2013). In Paraguay, contributions for social security have decreased from 52% to 35%. At the same time, there has been a small increase in private expenditure, mainly due to elevated out-of-pocket expenditure, which have reached 56% of the total expenditure, a percentage that, in Argentina and Uruguay, is no more than 21% (WHO, 2014). This data is particularly relevant because PHC is mainly funded through public funds and, to a lesser extent through direct payment by users.

Governmental spheres responsible for PHC funding

In Argentina, the Minsal funds Program *Remediar* + Networks, created to strengthen the response capacity of Health Networks and to hierarchize the First Level of Care Centers as strategic points of contact with the community and as the entry point to the health system for the population. The Program *Remediar* + Networks develops three strategic axes: strengthening of health networks, boosting participatory projects at the provincial and local levels; ii) provision of essential medicines through the transfer of medicine kits; and iii) human resources capacity building (Argentina, Minsal Santiago, 2014). [4]

This program is executed though the availability of medicine and input kits to 6,600 primary health care centers (about 450 active ingredients). Moreover, there is the distribution of immunosuppressive medicines, inputs for the vaccination program, medication to fight epidemiologically relevant infectious diseases such as tuberculosis, leprosy, Chagas disease and HIV/AIDS (Remediate Program + Networks, 2014).

Argentina also has other important state programs in primary health care, whose funding comes exclusively from the Minsal or is shared with provinces. The Community Doctors Program (PMC) for PHC training, is exclusively funded by the central level. Another example is the Maternal and Child Care Program, which develops its missions through the technical and financial assistance to the health sector of Argentinian provinces; the National Program on immune-preventable diseases, responsible for the definition of the national vaccination program and for the supply to the public sector; and Plan Birth, which is funded through transfers from the national treasury to provinces, depending on the number of people registered and on the health results. 60% of resources are monthly transferred through identification and registration, based on results and the levels of inclusion of the population not covered by an insurance fund. And 40% of resources are transferred every four months depending on the accomplishment of ten health goals that are assessed through previously defined indicators (tracers).

Concerning the decentralization in the funding of the health system in Argentina,

[4] Program *Remediar* + Networks has the following aims: "To ensure accessibility to generic medicines by the population that seek CAPS to treat a high percentage of the pathologies present in consultations; to strengthen the primary health care model and to promote health policies with participatory management; to implement the social control and the participatory management of the program; to develop strategies to promote the use of generic medicines; to strengthen the primary health care model" (Argentina, Presidencia de la Nación, 2014). For further information, go to: http://www.remediar.gov.ar/

there is a sharing formula that defines the federal co-participation. Nonetheless, the assignment of resources from the central level does not consider variables related to the health needs of the population or the performance of the sector in the corresponding provinces. At the same time, there is no legislation that demands provinces to assign a specific determined part of its budget to the health sector, which means that each province has the authority to define the percentage of its budget that is destined to health. In other words, each province decides what amount of its budget shall be assigned to public health, regardless of their own tax collection and the co-participation income received.

In Argentina, it is estimated that the public expenditure in primary health care represents 24% of the public expenditure on health. From the total public expenditure destined to PHC, 61% corresponds to municipal governments, followed by provinces, with 25%, and the national treasury, which contributes with approximately 16% to PHC funding in the country (Argentina, Minsal, 2014).

In Argentina, social insurances do not have a specific policy for PHC. The heterogeneous assortment of Insurance Funds usually has PHC strategies or strategies for first level health care and it is not possible to disaggregate the expenditures at this level. PHC service provision delivery by the Insurance Funds correspond mainly to obligations enforced by the Obligatory Medical Program (PMO), which defines the set of medical-assistential services to which beneficiaries of Insurance Funds are entitled.

In Paraguay, PHC funding is exclusively in the charge of the public sector, through a total budget destined to the MSPBS, funded by tax funds. Out of this total, there is a specific assignment to the Department of Primary Health Care (DGAPS), which is available to all primary level services. Nevertheless, the PHC strategy does not depend only on these resources, the set of PHC services goes beyond the activities of the competent ministerial board and is also funded through other budget items of the MSPBS.

In Paraguay, social security, the IPS, which is responsible for assistance coverage of formal workers, does not have its own line of development linked to PHC, but it participates in PHC through a set of services compatible with the first level, through its ambulatory services and/or outpatientvisits.

Concerning mechanisms for assignment and transfers to governmental spheres, the budget assigned to the Department of Primary Health Care (DGAPS) is executed through the planning of expenditures at the central level, combined with transfers to regional coordinating departments and to the USF. The budget assigned to the DGAPS usually represents 7% of the total budget of the MSPBS. Due to the political and administrative characteristics of Paraguay, most part of resources are executed by the central levels and, to a lesser extent, by the decentralized level.

In Uruguay, the funding of the health system is basically based on public funds, that is, contributions by the social security and contributions generated from taxes.

Comprehensive providers of the SNIS (ASSE and the IAMC) do not have specific funding sources for PHC. Neither the ASSE, the main public provider of the SNIS, has a

specific budget for PHC in its internal budgetary distribution. The Metropolitan Primary Health Care Network (RAP-M) is the institution that is the closest to having a specific budget for PHC. It comprises Montevideo and neighboring departments, groups all infrastructure at the first level of care in the area and has a specific item within the general budget of the ASSE. Currently, in the regionalization process of the ASSE, the concept of the RAP is being reproduced in other regions which, thereby will have for the first time a specific budget assigned to the first level, something that shall be gradually extended to the entire country.

In addition, financial transfer mechanisms between governmental spheres have not been defined yet. The budgetary execution of the ASSE is usually done in a very centralized way, despite the recent efforts to define a specific budget for the first level of care. In the case of departmental intendancies, the budget for health is not a priority and it is still under the item of the social expenditures of intendancies. It is possible to assume that the funds destined to health correspond to funds for PHC, once all intendancies and similar entities, currently provide PHC in the region, considering the type of services delivered.

Co-payments in PHC

In order to ensure accessibility, there is a common pattern in the public services of these three countries, which is the inexistence of co-payments in the first level of care for public health services. This is not a minor fact, but an essential condition for an effective and universal PHC system.

In Argentina, the entire population, without exception, is entitled to receive care and health services free of charge at the three levels of care of the subsystem, in primary health care public centers (CAPS), specialized centers and public hospitals belonging to the three government jurisdictions (national, provincial and municipal) (Ríos, 2014a).

In Paraguay, until 2008, despite the focus on the care to poor populations, the assistance public sector had kept a minimum co-payment policy for the access to care. Since the implementation of the "Public Policies for Quality of Life and Health with Equity" (Isags, 2012b), a conditioning factor for its development was the elimination of co-payments, together with the boost of the PHC strategy. Now the access to services of the assistance public sector is free of charge and universal.

In Uruguay, there are neither co-payments for the public provision of the ASSE, nor at the first level of care or in all other services provided at other levels. Municipal polyclinics also have no co-payments for service provision in the region. Moreover, the private regulated system has been requested to eliminate co-payments for basic specialties care, care to children and pregnant women, diagnostic services associated to the services mentioned and medicines for non-communicable chronicle diseases. In other services provided by the social security, there are co-payments.

PROVISION OF PHC SERVICES

The provision of PHC in the three countries is characterized by activities usually developed at the first level of care: general practice, maternal and child care, family planning, immunization, etc., combined with other types of activities that conceive PHC from a perspective that goes beyond the first level and that intends to guarantee the comprehensive health care to the individual, the family and the community, under the framework of PHC renewal. The ability to guarantee services under this new concept is not homogeneous in the countries, among other reasons, due to its conditioning by economic factors, distribution of resources and by the difficulties in the accessibility to remote territories.

The physical structure of first level providers varies from one country to the other and within each one of them, according to the distribution of resources and the characteristics of the territory. There is a prevailing role of the public sector, with partial participation of private regulated providers, which are hired and paid by social security, and a scarce or nonexistent presence of services financed by private volunteer insurances.

The common organizational typology in public services is the Primary Health Care Center (CAPS) in Argentina, the Family Health Units (USF) in Paraguay and the Health Centers (CS) in Uruguay (Chart 5).

There are some higher complexity services developed in association with this basic structure, which include diagnosis and treatment services open 24 hours, with emergency and/or specialized care and, on the other hand, lower complexity services, which may include polyclinics, medical offices and health posts interrelated to the basic common structure and sustained by minimal health teams and with discontinued care.

Chart 5 – Types of PHC units in Argentina, Paraguay and Uruguay

Countries	Type of PHC unit	Number
Argentina	Primary health Care Centers (CAPS)	7,532
	Integrated Community Centers (CIC)	600
	Total	8,132
Paraguay	Family Health Units (USF) with agreements with other community and/or municipal entities	120
	USF in health posts	512
	USF – new buildings	120
	Mobile USF for remote zones	8
	Total	760
Uruguay	Rural health posts, medical offices and community polyclinics	786
	Health centers: higher complexity units articulated with the previous ones; may include 24 hour and emergency care	28
	Auxiliary centers: primary health care centers with urgency entry point, 24 hour operation, 7 days a week with observation beds	19
	Total	833

Sources: Argentina, Minsal, 2014; Paraguay, MSPBS, 2013; Uruguay, Junasa, 2012.

Types of providers

In all three countries, the provision of PHC services is concentrated in the state public sector. The prevailing role corresponds to the different national ministries of health and, in the case of Argentina, as a federative country, also to the provincial ministries of health and health secretariats of municipalities. In the case of Uruguay, the MSP acts as the directive body and the main responsibilities for PHC provision correspond to the ASSE.

The public sector providers also incorporate the structure of the private sector and social insurances, which is highly variable. The participation of other providers may vary according to the country and to the character of the institutions, which may belong to social security (Insurance Funds in Argentina, IPS in Paraguay and IAMC in Uruguay) or provide medical care to users of the variants of volunteer private insurances.

In Argentina, the Insurance Funds co-participate as responsible for a significant part of coverage. They count on a network that is not homogeneous, but which comprehends the entire country. On the other hand, private insurances with a much smaller coverage have a very centralized structure, with services in the farthermost territories. In Argentina, social and private insurances must accomplish the Obligatory Medical Program (PMO), the minimum coverage provision package (Decree 247/96 and modifiers), which is why they provide services compatible with PHC: ambulatory consultation care, home care, immunization, oral health, mental health, etc. (Morgenstern, 2013). [5]

In the case of Uruguay, private regulated services (IAMC) that integrate the SNIS, through their outpatient visit system, home care services and polyclinics, decentralized medical offices and secondary units, also provide PHC services, in accordance with the obligation imposed by the Comprehensive Health Care Plan (PIAS). Based on state regulation, besides actions that provide care to diseases, there are preventive actions focused on vulnerable populations, children, women and people with chronic non-communicable diseases, which require actions for promotion, education and preventive medicine.

In Paraguay, to a lesser degree, the IPS, in a structure with shorter extension and smaller coverage, also provides its users with services compatible with PHC, through ambulatory care or outpatient visit systems.

Members of PHC teams

The composition of health teams also varies within all three countries, depending on the availability of human resources, its geographic distribution and the social and economic inequalities among regions. However, there is a basic common standard among these countries in regard to the staff of primary health care centers that includes physicians, nurses, auxiliary nurses, midwives, community workers and/or auxiliary nurses, dentists and

[5] The Health Service Superintendence (SSS) is the regulation and control entity and its mission is to supervise, inspect and control the Insurance Funds and the private health insurances (Law 26,682).

psychologists.

In Argentina, the first level health care team working in the CAPS is usually formed by general practitioners, pediatricians, clinicians, gynecologists, obstetricians, dentists, social workers, psychologists, nurses, administrative personnel and health promoters or workers, with variations within each province. Health promoters or workers are not uniformly distributed in the country. The presence of health promoters and workers is more intense in farther regions, and they inclusively perform nursing tasks in remote zones and those difficult to access (for example in Salta and Tucumán, in the northeast of the country). The total human resources performing in CAPS is of 67,797 workers, with an average of 11 professionals per facility. Out of the total of physicians working on the public sector, 28% work in CAPS and two out of 11 physicians in the country act on CAPS (Ríos, 2014a).

In Paraguay, the basic family health team is formed by 1 physician, 1 nurse and 1 obstetrician, 1 nursing assistant and 3 to 5 community health workers (ACS). Moreover, for each family health team, there is an oral health team formed by one dentist and one dentist technician.

In Uruguay, the basic team is composed by family or general practitioners, pediatricians, gynecologists, midwives, nurses, auxiliaries, dentists, dentist assistants, social workers and psychologists. As well as in the other two countries, this integration is not uniform, but it is conditioned by the asymmetries in the distribution of the staff available and the difficulties for the permanence of professionals in remote zones.

Organization of the work of the PHC team

The form of organization of the work of PHC teams is variable. On one hand, it depends on the composition of the health teams and, on the other, of the territory in which they act. In metropolitan and urban zones of all three countries, teams are usually in their full formation with all professionals as planned. The functions of each one of the components is well defined and diagnostic services are adjusted for the accomplishment of PHC provision. But in remote, rural areas or in zones that are difficult to reach, teams are often incomplete, and therefore several activities are concentrated on a single professional category. Diagnostic support services are not always available and community health workers frequently play a protagonist role. These teams lack the multi-professional approach targeted by PHC, which tends to reduce its case-resolving capacity.

Nonetheless, these three countries promote teamwork, with the attainment of different results. Sometimes it is translated into a simple addition of disciplines, while in other situations there is a consolidation of actual shared and co-operative teamwork.

Community health workers and health promoters

With different names, health promoters or community workers have a systemic presence in PHC health teams, especially in Paraguay and Argentina. In the case of Uruguay,

health promoters have a marginal participation and lack clearly regulated competences, which is why auxiliary nurses are the ones playing a similar role. The common functions in the three countries are related to health diagnosis in the territory, home visits, registration of pregnant women, follow-up to the newborn concerning risks at home, promotion and prevention campaigns and participation in immunization campaigns. Within all three countries, the community workers of family health teams in countries are the ones with more functions. In the case of Argentina, due to the lack of resources, they are also assigned with other competences in remote areas, such as their qualification as vaccinators.

Main services provided by PHC units

The provision of PHC in the three countries is characterized by activities usually developed at the first level of care. There is a common pattern characterized by the consultation at the unit and at home, scheduled and unscheduled care, the supply of medicines, immunization, surveillance activities, promotion and prevention. These services are combined with other types of activities that conceive PHC, from a perspective that goes beyond the first level and that intends to guarantee the comprehensive health care to the individual, the family and the community, under the framework of PHC renewal. In turn, other services delivered are presented heterogeneously and asymmetrically, conditioned by the capacity of PHC units, especially concerning human resources, geographic location and the social and political surroundings of the region. Charts 6, 7 and 8 provide a concise list of the services provided by PHC units in all three countries.

Chart 6 - Main services provided by PHC units in Argentina

Services provided	Actions
Health assistant in consultation and/or at home	Scheduled and unscheduled visits happen regularly. Variable home care.
Immunization	National Program for the Control of Immuno-preventable Diseases Free-of-charge vaccination mandatory to the entire population, with particular emphasis on children.
Family care activities	National Program for Sexual Health and Responsible Procreation: comprehensive care to sexual and reproductive health.
Activities for information and health surveillance	Comprehensive plan for surveillance and control of dengue and the yellow fever. National Chagas Disease Program.
Supply of essential medicines	Medicines first level of care facilities in kits that cover 80% of the diagnoses (*Remediar*). Access to ARV treatment free of charge to all HIV + population.
Basic rehabilitation	Non-homogeneous provision. Depends on the capacity of each CAPS.
Specific services and care related to women, childhood and adolescence	Plan for the Reduction of Maternal and Child, Women and Adolescent Mortality
Care and follow-up to chronic degenerative diseases	The early registration of these patients, health promotion, education and prevention are activities inherent to CAPS and similar units.
Mental health care and/or in coordination with specialized care	Most of CAPS and CIC have mental health professionals (mostly psychologists and psychopedagogist) as part of the health team.

Services provided	Actions
services	
Oral and dental care	Health Centers have dentist offices and their corresponding technical teams. There is a National Oral and Dental Health Program that moves forward with a strategy called atraumatic restorative treatment.

Source: Argentina, Minsal, 2014.

Chart 7 - Main services provided by PHC units in Paraguay

Services provided	Actions z
Health care by consultation	Scheduled visits and urgencies.
Home health care	Unscheduled and scheduled visits.
Health prevention and promotion activities	ECNT: Diabetic and hypertensive "clubs".
Immunization	At the consultation room and at home – campaigns.
Supply of essential medicines	List of essential medicines acquired by the MSPBS and delivered periodically to each USF.
Information and surveillance activities for health protection	Participation in educational and prevention campaigns. Example: dengue, etc.
Basic rehabilitation	Depends on the capacity of the USF; non-homogeneous provision.
Specific services and care related to women, childhood, adolescence, adults, the elderly, risk groups	Care to children, women and the elderly are priorities.
Care and follow-up to chronic degenerative diseases	Scheduled visits at the medical office and/or at home, as well as the corresponding follow-up. The USF is also in charge of the supply of medicines and the coordination of consultations with specialists at the 2nd and/or 3rd level of care.
Palliative care to terminal patients	Home care, provision of medicines and coordination of follow-up visits with the 2nd and 3rd level of care. Depends on the capacity of the USF; non-homogeneous provision.
Mental health care and/or in coordination with specialized care services	Provision linked to psychologic care to adolescents, creation of adequate networks and systems for referral and counter-referral with the other levels. Depends on the proper integration of the ESF; non-homogeneous provision.
Oral and dental care	Depends on the structure and technologic density of the USF. Most commonly visits to schools of the community for promotion and prevention; non-homogeneous provision.

Source: DGAPS, 2014.

Chart 8 - Main services provided by PHC units in Uruguay

Services provided	Actions
Health care by consultation	Scheduled visits and urgencies.
Home health care	Unscheduled and scheduled visits;
Health prevention and promotion activities	Promotion and prevention approach ECNT.
Immunization	Accomplishment of the Extended Immunization Program, participation in anti-flu campaigns.
Provision of medicines	Therapeutic forms for mandatory medicines to all SNIS providers.

Health Surveillance	New approach. Communicable and non-communicable.
Basic rehabilitation	Variable delivery according to the logistic capacity of the center.

Chart 8 - Main services provided by PHC units in Uruguay (Cont.)

Services provided	Actions
Specific services and care related to women, childhood, adolescence, adults, the elderly, risk groups and chronic diseases	Health provision goals prioritize the care to children, women and the elderly.
Palliative care	Currently being developed with the application of a national program focused on health care in the region.
Mental health care	National Mental Health Program and mandatory provision of the PIAS.
Oral and dental care	National program and mandatory provision of the PIAS.
Sampling collection and reception for laboratory	In health centers.

Sources: República Oriental del Uruguay, 2008; ASSE, 2014a; Uruguay, MSP, 2007; 2011a; 2013.

PHC ORGANIZATION

An analysis of the concepts that sustain national health policies, based on their corresponding normative frameworks, shows that all three countries are developing a new model of care, with a concept of integrality and continuity of care, fostering intersectorality and social participation. This is a transversal approach to assistance, promotion, prevention, education, rehabilitation and palliative care, with planning characterized by a territorial and community approach.

In the case of Argentina, the organization of PHC reproduces the federative and decentralized political administration of the country. At the federal level, the main responsibility falls on the Minsal, with its functions concerning central programs and plans previously described, and the transfer of resources to provinces and municipalities for health care. At the provincial level, the ministries of health have the lead role, with direct responsibility for health care, given that they manage provincial hospitals and have most of the Health Centers under their jurisdiction.[6] All these services act as nodes of the territorial service network of the province and manage funds that are transferred from the central level. However, they also employ their own resources, which are used both to manage their hospitals and to fund health activities of the municipalities. There is great variability in the performances of each province, depending on their economic capacity and on the attitude of the Ministries of Health in the management of funds from national programs. The goal of the national PHC policy is that provincial and municipal governments are the ones concentrating efforts to develop a strategy with actions on promotion and prevention and

the development of health policies, thereby informing and modeling behaviors. In many provinces, municipalities have their own services, mostly Primary Health Care Centers (CAPS) and, in some cases, municipal hospitals.

The organization of PHC in Paraguay starts at the central level, formed by the DGAPS, which operates within the MSPBS, interacting at the same level with other ministerial boards and with a direct dependence on the vice ministry. After this level there are Regional PHC Coordinating Departments, whose territories correspond to the 18 health regions which, in turn, are responsible for comprehensive health care, including the first level of care. The regions comprehend a population from 20,000 to 50,000 people. Regional PHC Coordinating Departments are the ones responsible for the organization of primary health care in a determined region and for the proper coordination with the service network that corresponds to a specific health region. Beyond this intermediate level of coordination, are the USF, the basic nucleus for the organization of the PHC system.

In contrast with this, in Uruguay, the organization of PHC is within the SNIS, with its wide public (ASSE) and private (IAMC) assistance service network, located over the entire national territory and which comprises all levels of care. There is also a central level in which the MSP plays a prevailing role due to its competences of regulation of the system, definition of priority health programs and the change of the model of traditional care. In turn, the Junasa, which works as the manager of the insurance, has instruments to demand public and private regulated assistance services to provide determined PHC services.

Whereas the ASSE has the most developed organization in the territory, the IAMC concentrate their resources in their ambulatory or outpatient consultation services, besides territorial services, with the development of polyclinics, secondary units and first level of care services or decentralized medical offices.

In the ASSE, the health center is the unit that articulates all other structures of the first level of care: polyclinics, both their own medical offices and those subordinated to other institutions, as municipal structures, and non-governmental organizations facilities, also responsible for the referral to the second level of care. Likewise, the ASSE has the most developed physical structure, with comprehensive service delivery and with the proper staffing of professional, technical and auxiliary human resources. Some Health Centers also have emergency services operating 24 hours a day, 7 days a week. The IAMC, which are the units that concentrate the greatest activities of the first level, have installed ambulatory services and outpatient visits in coordination with a home care system and a network of units in the region, such as secondary units, polyclinics, peripheral units, medical offices, etc.

Affiliation of the population to PHC units

The affiliation of the population implies the allocation of a determined amount of

[6] Except for Córdoba and Buenos Aires, where municipalities are responsible for the health centers.

users to a determined functional PHC unit, which starts to function as their reference and which theoretically would limit their care at other units.

In Argentina and Paraguay, there is affiliation to each CAPS or USF, whereas in Uruguay there is no affiliation. Health centers grouped in the ASSE have an actual affiliation that is quantitatively variable but which does not hinder care in other centers.

Argentina has 7352 primary health care centers, with PHC teams of variable compositions according to the availability of human resources in the region, which covers 3200 to 4000 people (Table 1).

In Paraguay, Family Health Teams (ESF) established at USF assume the health and social responsibility over a social territory defined geographic and demographically, with an average of 800 families per team (3500 to 5000 people approximately). In 2014, there were 756 USF operating, with an estimated coverage of 2,467,500 citizens, which corresponds to 35% of the Paraguayan population. In theory, there is one ESF per USF, but there may be more than a team per unit, according to social and demographic characteristics.

Table 1 – Affiliation of the population in PHC services in Argentina, Paraguay and Uruguay

Countries	Type of unit	Population affiliated
Argentina	CAPS	3,200 – 4000 people
Paraguay	USF	3,500 – 5000 people
Uruguay	CS	No

Sources: Ríos, 2014a; 2014b; 2014c.

Implementation of the PHC strategy in Paraguay

In a fragmented and segmented health system, with sparse integration and public assistance subordinated to the MSPBS, highly centered in the hospital-based model, with no expectations for a background reform of the whole system, according to the ministerial resolution 101 of September 17, 2009, Paraguay set off a development process of the PHC strategy that, despite the political changes within the country, remains as a current priority due to that program.

The Resolution created the Department of Primary Health Care (DGAPS) as a part of the Health Sub-secretariat of the MSBSP and a body that coordinates, in the national, regional and local ambit, priority actions linked to the management and implementation of the PHC strategy in the social territories, under the framework of the "Proposal of Public Policies for Quality of Life and Health with Equity".

Their missionsare:

- to support the implementation of a health service network, with USF as the entry point to the National Health System and with effective case-resolving capacity to solve health problems within socialregions;
- to formulate the regulatory framework required by the comprehensive health care model with family and community approach;
- to qualify new USFs, according to the assessment of needs of each social region;
- to establish guidelines for the regionalization and affiliation of the population to USF;
- to develop technical capacity of human resources for the implementation of the model of care with family and community approach for service provision, from the perspective of the social determinants of health;
- to perform a process of interinstitutional and intersectoral integration so as to facilitate socialization, social participation, the execution and sustainability of the comprehensive health care model with family and community approach and the participatory construction of public policies to address the social determinants of health at the local and national levels, also promoting intersectoral and interinstitutional agreements in the territories with the intervention of the USF;
- to formulate the regulatory framework required by the comprehensive health care model with family and community approach; and
- to manage budget assigned to the dependencies of the Ministry of Health and Social Welfare, for the implementation and sustainability of the comprehensive model of care with family and community approach.

From the organizational point of view, the central level is formed by the DGAPS with a direct subordination to vice minister of the MSPBS. Below the DGAPS are the regional PHC coordinating departments, whose territories correspond to the 18 health regions. Regional PHC Departments are the ones responsible for the organization of PHC in a determined region and for the proper coordination with the service network that corresponds to a specific health region.

Family Health Units (USF), the basic nucleus for the organization of the PHC system, are responsible for providing services to provide care and solve most of the health problems of the population of the social region to which they are assigned (3,500 to 5000 people) and for guaranteeing the continuity of care to people through the linkage with specialized care (ambulatory specialized centers), urgency and hospital care (basic, specialized hospitals, etc.), depending on the complexity. The medical regulation, communication and transportation system enables the effective linkage and articulation of all units of the network (Isags, 2012b).

The 760 USF have been installed in health posts (512), with usufruct agreements with other entities (120), in new facilities built (120) or in mobile units for territories that are difficult to access (8) (Paraguay, MSPBS, 2013).

In eight years, the implementation process, with some intermittences, has been continuous. The DGAPS has an exclusive budget, defines priorities, participates in human resources policies for PHC, and acts according to the initial planning.

Sources: Isags, 2012b; Paraguay, MSPBS, 2013.

COORDINATION OF CARE AND INTEGRATION OF PHC INTO THE SERVICE NETWORK

The new PHC concept considers the integrality of care as an essential aspect and, therefore, in all countries, there is a special concern about the guarantee of the continuity of care. With variations among countries, several strategies are applied, with an established referral and counter-referral mechanism, the construction of integrated networks and institutional communication between levels, including the electronic clinic record.

Organization of the health system in levels of care

In all three countries, health systems are organized in levels of care, with a first level that concentrates the main PHC services and with a common pattern of a great territorial development of the public subsector and, to a lesser extent, of the private subsector, which usually is less developed in the territory.

Considering the segmentation characteristic of the systems, the networks that may be formed correspond to the structure of each subsector vertically integrated and the prevailing typology is territorial networks. There are mechanisms being developed to strengthen public networks, with their integration to other providers such as university hospitals, military and police health services, including private providers, as a mean to optimize the use of resources. This is the case of the strategy applied by the Public Health Providers Integrated Network (Rieps) and its interrelation with the private subsector in Uruguay.

Social security providers, as the Insurance Funds in Argentina, as well as the private providers of the IAMC, due to the obligations of the Obligatory Medical Program (PMO – Argentina) and of the Comprehensive Health Care Plan (PIAS – Uruguay), provide PHC services and have first level services in their network. The absence of volunteer private insurance (prepaid) services outside urban centers is also common among countries.

The first level leads to the second level, in which both public and private services usually have the ability to manage demand. At the third level of high specialization, the ability to provide care is not homogeneous and in many cases, public services depend on the specialized offer concentrated in the private subsector.

The gatekeeping role of the PHC physician

In the process of PHC services implementation, despite some differences, all three countries share the promotion of PHC services as the entry point to the system, with the physician usually as the professional that functions as a gatekeeper for referral to other levels. But in this incipient stage of changes and reforms, none of these three systems is able to ensure this role. In fact, hospitals, with their specialists and equipment for diagnosis, and

mainly emergency services, continue to be the entry point to the system, together with PHC services.

Flows for referrals to specialized care

PHC services in all three countries are gradually developing its capacities to ensure the most effectiveness possible in the region. While this is not achieved, referral is made to specialized care systems that basically correspond to hospitals.

The flow for specialized referral in Argentina is established according to the organization of services within all provinces, integrated by Health Centers and hospitals of different complexities, which are usually regionalized by geographic criteria, thereby forming formal service networks and, in some cases, referral and counter-referral systems, usually declared merely as an administrative process. Currently, despite the advancements in the Service Networks, such as municipal referral and counter-referral offices in hospitals and programmatic area services, there are still problems in the implementation and sustainability of a referral system. In general, the operation of the referral and counter-referral network is not planned. The importance of assistance continuity to improve the quality of care and the effectiveness is still not fully incorporated into the organizational culture of the health providers' personnel (CAPS and hospitals).

In turn, in Paraguay, entry points to PHC in the network structure are the Family Health Units (USF). They are responsible for the delivery of services to provide care and solve most of the health problems of the population that corresponds to the social region to which they are assigned and for guaranteeing the continuity of care to people through the linkage with specialized care (ambulatory specialized centers), urgency and hospital care (basic, specialized hospitals, etc.), according to the necessary complexity.

Provision goals: A strategy to reorient the model of care within the SNIS in Uruguay

In Uruguay, in the Integrated National Health System, the capitation payment of the National Health Insurance, associated with an adjustment by age and gender risk, has incorporated the pay for performance for the attainment of assistance goals.

Through the Comprehensive Health Care Plan (the exhaustive list of mandatory provisions for all SNIS services), the Management Contracts signed by the services with the Junasa to integrate the SNIS, and the health provision goals, whose accomplishment is associated with the payment of the corresponding *capita*, services are being reoriented towards a change in their traditional model of care, with the incorporation of aspects of prevention, health promotion, education and the approach to more vulnerable populations.

In order to accomplish these goals, providers started to gradually reorganize their services, getting closer to the territory and prioritizing disciplines as pediatrics, gynecologist, family medicine, nursing and some technical subjects, such as medical registration.

In turn, the process to reach these goals significantly improved information and registration systems, especially in response to the audit of the MSP.

The goals to reorient the model of care are concentrated in the care to children, women and the elderly.

Goal 1 Boys/girls/women	Indicators for boys and girls	Registration of the newborn
		Home visit for newborn care
		Control 1st year of life
		Control 2nd year of life
		Control 3rd year of life
	Indicators for women	Full control of pregnant women
		Complete record of the Perinatal Information System (SIP)
		Early registration of pregnancy
		Domestic violence survey
Goal 2 Reference doctor	Adolescents	Reference doctor
		Registration n of the adolescent clinic record
	Adult	Reference doctor
		Record - Screening according to age
Goal 3 The elderly	65 to 74 years old	Reference doctor
		Medical Record for the Elderly
	75 years old and more	Reference doctor
		Medical Record of the Elderly

There was a rule incorporated to these goals by decree, for the regulation of waiting lists for basic and specialized care. For basic specialties, the rule is to provide consultations within 24 hours and, in specialized care, up to 30 days. Information systems enable the monitoring of waiting lines and this information is managed by the MSP. Since 2013, the MSP publishes the waiting times of each facility, in order to provide users with more elements for decision-making when it is time to choose or change provider, which users are entitled to do once a year (in February).

In summary, through health goals and the regulation of waiting lines, the MSP and the Junasa reorient the organizational and care model of the system, with the incorporation of aspects of promotion and prevention, decentralizing care to regions, prioritizing more vulnerable populations (children, women and the elderly) and with the regulation of waiting lines, which ensures accessibility and continuity of care.

Formally, there are referrals to specialized care, which happen frequently, but this possibility is limited by regional asymmetries in delivery, which makes referral more feasible

in the central region and/or in the capital and less feasible in remote and rural regions. The referral process has a pre-established flow, but the attitude of the physician in the USF also plays an important role, with regard both to his/her technical position and personal relations with specialized service professionals. Counter-referral is the field with more difficulties. The organizational culture still has the image of hospitals with a high position in the hierarchy of health care and, therefore, the dialogue with the first level is not considered a priority.

In Uruguay, from the perspective of progressive care, the system considers the first level of care as the entry point, with differences described between public and private, passing by the second level, until reaching the third level of specialized care.

The construction of flows in the network has not been uniform and has moved back and forth. ASSE, as the public provider, has a first level of care with great territorial development, whereas the IAMC are characterized by a more centralized organization and delivery, with less territorial presence. The hospital is the main focus of the second level of care and this is a common patter in both subsectors. The third level, with specialized care, is not homogeneous in public and private subsectors, which determines the need for complementation, in order to answer the demand for services.[7] Referrals to specialized care are made through the referral and counter-referral system, with variable characteristics depending whether it is the public or the private sector, Montevideo or the Interior.

The greatest challenges remain in counter-referral to the first level, with the absence of a systematic communication that can ensure the continuity of care. This is seen both in the public and in the private subsector. Capitation payment to providers includes a variable amount associated to the accomplishment of specific assistance goals that favor the continuity of care, among them the control of the health of children, the registration and control of pregnancies, the control of newborn risks at home.

Waiting lines

There are waiting lists for specialized care in all three countries, with a persistence of inequalities with regard to the territorial distribution of services and social and economic factors. Waiting times are longer in zones that are more distant from urban centers, in rural areas and in geographic zones that are difficult to access. In urban and metropolitan zones, which concentrate the majority of providers, there are still waiting lines and the prevailing causes are social and economic aspects.

In the case of Uruguay, the control of waiting lines for basic and specialized care has been established by decree. Information systems of the MSP enable the monitoring of waiting times in each social security provider institution. This information has been shared by the MSP with the population since 2013. With this, users are provided with more criteria

and references for decision-making and for the use of his/her right to change providers every February, as a mechanism to force the reduction of waiting times and to enable more timely access.

PHC WORKFORCE

Regulation of labor relations

Considering that forms of regulation mainly address the public subsystems of all three countries, they are the same as the ones applicable to the public service in general, with public calls for budgeted public worker positions. They may also be hired with temporary contracts, renewable after performance appraisal. The private sector applies its own criteria.

Most of the PHC health personnel is composed of public workers and the intention is that this human resource works with exclusive or high commitment. This may be possible for some PHC professional categories, but it is less attainable for physicians and nurses, which are the most difficult professionals to retain.

The salary is the most current and widespread method of remuneration in the PHC public service subsystem.[8] It is combined with incentives related to high commitment, exclusivity and according to the geographic area of activity.

There is not a defined professional career for PHC.

In Argentina, there are several types of contract. Contracts are usually renewable after performance appraisal, but there are also budgeted positions and temporary contracts to address contingencies. The salary is the most current and widespread method of remuneration in the PHC public service subsystem. The Community Doctors Program (PMC), which has the mission to guarantee the presence of professionals in zones that are far from urban centers or difficult to access, remuneration is done through grants that can be combined with local economic bonuses to encourage their permanence.

In Paraguay, the ESF staff receives salaries and is hired by the national government through the MSPBS, with two different possibilities. On one side, renewable contracts after performance appraisal and on the other one, budgeted positions. Applications for the USF are free, but considering the peculiar characteristic of PHC units locations, usually far from urban centers, it is preferable that applicants live in the community where the USF is located or that they are interested in or available to live in the area.

For all categories of ESF members, payment is made through salaries, combined with other bonuses and benefits according to the characteristics of the territory. The strategy used retaining professionals in remote zones is the use of different types of economic incentives besides salaries.

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[7] For highly specialized medicine provision, there is the National Resources Fund, which is in charge of their funding and of hiring Institutes of Highly Specialized Medicine (Imaes) and which all SNIS users may access.

[8] In Uruguay, there is a history of *per capita* payment for family doctors, but after the reform of the SNIS, the system has been standardized with the payment of salaries, as well as the other categories.

In Uruguay, in the public sector, all human resources linked to the first level, with different types of contract, are subordinated to the ASSE, except for those hired through complementation agreements with municipal and community polyclinics, with contractual subordination to the corresponding organization. Types of contract may vary from the public to the private sector. In the ASSE, the most characteristic payment method in public health organizations is the salary. Since the 1990s, Uruguay has created a system for employment contracts in which salaries are combined with an amount paid through professional fees, and which has been specially created for retaining determined categories of professionals in critical areas of the assistance public sector.

In the private subsector, there are several types of contract that go from permanent full positions to public calls for doctors on duty, polyclinic visits, positions to cover leaves of absence and, recently, high commitment positions, in order to concentrate work at a single location, with the prioritization of disciplines such as general practice, pediatrics, etc., besides the promotion of professional development for the retainment of capacity.

Strategies to retain human resources in remote zones include economic incentives, decentralization of training and incorporation of graduate programs in the interior. A new act for medical residencies is under discussion at the moment and it establishes that all residents must complete clinical rotations in the interior at a determined stage of the program. Hierarchically, the main measures taken are economic incentives (high commitment positions), decentralization of education and modality of residencies with clinical rotations in the interior.

Availability of PHC professionals

The availability of health professionals is extremely diverse within all three countries. There is a significant disparity among countries in the availability of physicians, with a more favorable situation in Argentina and Uruguay and a rather deficient condition in Paraguay (Table 2). A common characteristic is the deficit of nurses, which may vary depending on the country.

Table 2 – Ratio of physicians and nurses per 1000 inhabitants in Argentina, Paraguay and Uruguay, 2010

Professional category	Argentina	Paraguay	Uruguay
Physicians x 1000 people	3.80	1.30	4.59*
Nurses x 1000 people	2.24	0.86	1.49

Sources: Ríos, 2014a; 2014b; 2014c. *2011

The availability of health professionals for PHC also varies, and estimates are not precise concerning the offer and the need for PHC human resources.

In Argentina, starting with physicians working in the public sector, which are an absolute number of about 22000, 28% of them concentrate their activities in PHC

provision (Eurosocial, 2007). In turn, the Community Doctors Program (PMC) has been a catalyzer for the formation of medical resources and other disciplines for primary health care.

In Paraguay, the formation of health teams in the 752 operating USF is not uniform. 85% (638) of the operating USF have physicians and the greatest human resources deficit for the completion of the ESF is of community health workers (ACS) (each team should have 5 ACS). Two factors influence this situation: on one hand, funding and contract difficulties and, on the other, selection criteria, which prioritizes nursing students that, after graduation, leave the position as ACS to work as nurses, for higher salaries (DGAPS, 2014).

Table 3 illustrates the current availability of several human resources categories and the gap according to the projection made in 2008 by the DGAPS for USF. The availability of professionals is low in all disciplines, even though the deficit of nurses may be temporarily covered by nursing technicians, who graduated from the National Health Institute linked to the MSPBS and created in 1994 as an institute for higher human resource training and research in the health area (Isags, 2012b).

Table 3 - Human resources for PHC and current and projected gaps in USF in Paraguay, 2014

Human resources	Current (754 USF)	Gap (646 USF)
Physician	638	762
Nurse/ obstetrician	742	658
Dentist	33	247
Auxiliary nurse	727	673
Community health workers	414	5,186
Indigenous health promoters	40	380
Total	2,594	7,906

Source: Barán Wasilchuk, 2014.

Uruguay has a good availability of human resources in comparison with other countries in Latin America. The ratio of physicians per 1000 inhabitants in 2008 was 3.87, which ranked the country in second place, below Cuba (6.34) and above Argentina (3.21). This number reached values close to 4.59 (Uruguay, MSP, 2011b). Nevertheless, there are shortages in professional categories such as nurses, in which the nurse/physician ratio (1/4) is the opposite of the ratios recommended by international standards. Moreover, the distribution of human resources is not homogeneous, with a high concentration in Montevideo and the metropolitan zone to the detriment of the rest of the country. 75% of physicians are concentrated in the metropolitan zone (capital and neighboring areas) and only 25% are located in the interior. Gaps and inequalities increase when these resources are divided into the public and the private subsectors.

Table 4 – Total active human resources and per 1000 inhabitants in Uruguay, 2011

Active human resources	n.	Density per 1000 people
Physicians	15,469	4.59
Nurses	4,018	1.49
Midwives	650	0.19
Auxiliary nurses	18,100	5.37
Total	39,237	11.64

Source: Uruguay, MSP, 2011b.

In 2008, the MSP carried out a census on human resources for health and one of the results included a table that groups positions that could compose the PHC team, especially at the first level of care (Table 5). According to this estimate, approximately one third of physicians could be part of PHC teams, in spite of the low number of physicians specialized in family and community health.

Table 5 - Human resources with PHC characteristics, Uruguay, 2008

PHC professionals	n.
Physicians (general practice)	4,193
Pediatrician	972
Obstetrics/gynecology	504
Family and community medicine	118
Dentist	2,476
Nurse	2,903
Midwife obstetrician	404
Social worker with degree	529
Psychologist	3,266
Nutritionist	1,095
Nursing assistant	15,473

Sources: Uruguay, MSP, 2011b.

a) Physicians with no specialty.

In these three countries, family and/or community medicine is the medical specialty defined for PHC. In addition, all three countries have other specialties that also share PHC functions, such as general practice, rural medicine and others that, before the implementation of the strategy, were seen at the first level.

Main training strategies for human resources

There are PHC human resources training strategies in undergraduate and graduate education and continuing professional development with several types of continuing education programs aimed at the redefinition of medical disciplines for the PHC strategy, especially of general practitioners, pediatricians, gynecologists and nursing personnel.

In Argentina, the main strategy is the Community Doctors Program (PMC), which aims to strengthen the PHC strategy as a State policy in local health systems. It is an extensive professional training program in issues of social and community health, directed at professional and non-professional members of health teams of the first level of care with the purpose to strengthen the working processes of health teams of the first level of care in the region.

Based on agreements with national universities, the PMC develops graduate programs in social and community health for professionals and a course on social and community health for technicians and health promoters (non-professional personnel).

Community Doctors Program (PMC) in Argentina

The Community Doctors Program (PMC) is promoted by the Minsal and it is subordinate to the Secretariat of Health Determinants and Health Relations. It started 10 years ago and it was exclusively aimed at the capacity building of physicians. It was gradually being extended to other disciplines: psychologists, obstetricians, nurses, dentists, nutritionists, health workers, etc. Its general aim is to strengthen the PHC strategy as a State policy at the first level of care. Its specific goals are:

- to strengthen the formation of health teams at the first level of care with the incorporation and funding of human resources for providers of the first level - Health Centers, Integrated Community Centers (CIC), Health Posts, to improve the delivery of services, with extended working hours and better quality;
- to train professional and non-professional members of health teams at the first level of care in social and community health;
- to implement capacity building guidelines of the PMC under the "on duty" modality, that is, within providers and in the field;
- to reinforce activities for health prevention and promotion with community participation and networking among community teams of the first level;
- to retake the interculturality approach in health in order to improve the access to health care for indigenous peoples;
- to incorporate the gender perspective into all lines of action of the PMC; and
- to recognize the specificity of the first level of care and to train adequate human resources.

The PMC is developed through agreements with national universities. It offers a Graduate Program in Social and Community Health for professionals and a Course on Social and Community Health for technicians and health promoters (non-professional personnel).

In general, the personnel selected are already employed by providers of the first level with contracts with the provinces. Applicants are selected on merit and after an interview. Openings are coordinated with the territory where the human resources will be placed and it is important that the applicant lives in the same area. In general, no openings are left unfilled. The contract is signed as a combination of office hours and fieldwork hours and participants receive grants for this.

National Impact of the Community Doctors Program in Argentina, 2014

Human resources	n.
Professionals	
Physicians	2,583
Psychologists	787
Social workers	562
Obstetricians	536
Professional nurses	910
Dentists	828
Other professions	397
Sub total	6,603
Nonprofessionals	
Assistant promoter workers	3,333
Indigenous health workers	752
Sub total	4,085
Total PMC HR	10,068

Source: Orsi, 2014.

In Argentina, most of the professional categories that compose the PHC teams require higher education, whereas non-technical personnel has varied requirements that also depend on the regulations of provinces. A factor that favors continuing education and the updating of health teams is the development of information and communication technologies, which weaken the distance factor. People may manage their time and education spaces with autonomy and flexibility and it is possible to achieve exchange knowledge, trajectories and experiences. The main medical specialty for PHC is family and community medicine, but it is important to note that training for first level health teams includes other disciplines such as general practice, pediatrics, gynecology, etc.

In Paraguay, after the beginning of the process for the implementation of the PHC strategy, there was a limited number of specialists in general/comprehensive or family and community medicine, and in order to answer these needs, there were general practitioners hired to provide services in USFs. In parallel, some alternatives have been generated both at the public and at the private level for specialization in these areas, through a public tender based on the competences of each professionals, which is regulated by the National Commission of Medical Residencies, an entity that is in charge of the distribution of medical specialties through all centers qualified to train residents in the country (Chart 10). The main medical specialty for PHC is family medicine.

Chart 10 – Strategies for PHC training in Paraguay

	Type of strategy			
	Rural undergraduate and postgraduate internship	Family medicine residency	Family medicine postgraduate	Courses and diplomas
Duration	3 – 6 months	3 years	2 years	1 – 3 years
Institutions in charge	Agreements MSPBS National University of Asunción (UNA), private universities, rural USF and hospitals	National Commission of Medical Residencies (Conarem), UNA, private universities	UNA – Social Security Institute (IPS), private	National Health Institute (INS)
Characteristics	Students and/or physicians, undergraduate and technical degrees, title homologation	50 annual openings in 7 educational units (4 in the interior of the country)	Face-to-face and/or online	Face-to-face and/or online

Source: Barán Wasilchuk, 2014.

The strategies incorporated in the DGAPS for continuing education are executed through introductory courses for family health teams' personnel, follow-up capacity building workshops, capacity building based on work guidelines and care protocols in PHC for the ESF and health programs. There have also been experiences with distance learning from the National Health Institute, developed by the Pan American Health Organization and the Canadian cooperation Center of Information and Resources for Development.

Uruguay began new undergraduate education strategy in medicine at the School of Medicine of the Udelar. The Plan 2008 for studies of the medicine career focuses on the

concept of PHC renewal. It prioritizes teaching in the community ambit, the early incorporation of students and teachers in the field and their permanence during their entire career, with participation in the health programs of the entire system. The medical career lasts 7 years and the changes planned include the access to an intermediate title of Technician in Health Promotion and Prevention of Diseases after four years (Benia, 2011).

The new plan aims at the training of physicians with the ability to act on the new model of care, according to the PHC strategy, bringing health systems closer to people, families and social groups and to where they live, work or study, in order to produce promotion, comprehensive health care both to the individual and to the collectivity, and the prevention of risks and diseases. It is important to highlight that other disciplines, as nursing, dentistry and psychology also develop actions for specialized education in PHC.

In medicine, the main specialization strategy for PHC are graduate programs in family and community medicine. They may be carried out as residencies or under the conventional graduate regime, with academic regulation by the School of Medicine of Udelar. This graduate program was created in 2003 and, after the reform of the health system, it became more relevant, increasing openings from 20 in 2003 to 60 in 2012 (Ríos, 2013b). Openings are defined through an agreement between the teaching unit in charge and the Board of the School, in accordance with the budget available for their funding. The funding of residencies traditionally came from two public sources: the Clinics Hospital of the School of Medicine and the MSP. With the health reform and the separation of the ASSE from the MSP, the ASSE started to function as the main funding entity, followed by the School of Medicine and with the incorporation of some providers from the regulated private sector. Practice fields are developed in public and private facilities all over the country. The expansion of funding sources enables an increase in the offer of annual residency positions in strategic areas, such as family and community medicine.

In Uruguay, the Permanent Interinstitutional Working Group (GTIP), another continuing education strategy in the health area, is articulated by an interinstitutional organism with the participation of the the MSP, the Graduate School of Medicine – Udelar, the medical associations (Medical Syndicate of Uruguay, Medical Federation of the Interior) and the National Academy of Medicine. It is based on a system for the accreditation of institutions as providers of continuing medical professional development activities and the accreditation of these activities. The attributes of general practitioners are the ones with more credits among the accreditation criteria, which provides the professional with tools to work under the model of care.

Intersectorality And Social Participation In PHC

All three countries, under the frameworks of the PHC renewal concept, develop several instruments that favor intersectoral and comprehensive actions, with the optimization of capacities in the public sector and the reduction of fragmentation and superposition of interventions. These actions are observed in two plans: on one hand, initiatives from the ministerial central levels (national ministries in the case of Paraguay and Uruguay and national and provincial ministries in the case of Argentina); on the other, instruments for territorial implementation that, in general, come from a combination of local autonomous initiatives with formal spaces created by authorities to these effects.

Intersectoral actions from the national level

In Argentina, firstly, it is important to highlight the creation of the Secretariat of Health Determinants and Health Relations of the Minsal, in 2009, as the organism in charge of the approach to health from the perspective of the social determinants. From the Minsal, and together with the provincial ministries, in the last decade, there have been structured programs developed to improve access to essential health services. Among several initiatives implemented by the secretariat, it is important to remark the Healthy Municipalities and Communities National Program, which promotes a comprehensive approach of health determinants and conditioning factors. Its mission is to strengthen the execution of health promotion activities at the local level, putting it as the highest priority of the political program. To these effects, they support the participation of government authorities and the active participation of the community, foster dialogue, share knowledge and experiences and encourage collaboration between municipalities and provinces, with the construction and strengthening of multisectoral alliances in order to improve social and health conditions in spaces where people live. It advocates the formulation of a healthy public policy, the maintenance of healthy environments and the promotion of healthy lifestyles.

The Healthy Municipalities and Communities Program works from the identification of problems, with the health component as a part of them. It supports intersectorality and addresses healthy nutrition, road safety, residue management, vector control, food safety, quality of water, immunization, health promoting schools, promotion of physical activities, etc.

The Minsal participates in and develops several intersectoral activities, a special note to the following ones:

- National Council for the Coordination of Social Policies (CNCPS);
- Inter-ministerial Program of Mental Health (Ministry of Justice and Health of the Nation);
- Education Program for community health facilitators as an initiative from the Ministry of Social Development and the Minsal, which has already trained 40,000

territorial promoters in the country; and

- Sexual Education Program of the Ministry of Education, with intersectoral articulation with the Minsal (Argentina, Minsal, 2014).

In turn, through the MSPBS, Paraguay defines its intersectoral policy strategy under the framework of proposals derived from the philosophy and promotional strategy of public policies for the quality of life with equity, encouraged by the central government (Paraguay, MSPBS, 2012). The Council of Ministers and the Social Cabinet Technical Unit-Office are the bodies that articulate the public policy. One of the traditional activities is the development of the concept of healthy schools and municipalities, which enables a close relation and coordination with the educational sector and with all the other actors of the territory. The local health diagnosis carried out by the SF teams also determine the coordination with other actors of the territory: housing, education, drinkable water supply, organized community, etc. (DGAPS, 2014).

The very concept of PHC in Uruguay implies intersectorality as a key vector to guarantee integral care. Therefore, there was a revitalization of traditional coordination spaces, such as the spaces for coordination with the educational sector, the social/sports clubs in the region and municipal services. New spaces have been created under the framework of the change in the social protection matrix, with the creation of the Ministry of Social Development (Mides), in 2005, and the Social Cabinet, which gathers several ministries of the Executive Branch under the coordination of the Mides. The Ministries of Public Health, Education, Economy, Housing, Tourism and the Presidential Office are also part of it.

The MSP promotes policies that imply coordination with other institutions of the State for execution. The most remarkable example is project Uruguay Grows with You. As an experience that started with interventions focused on extreme poverty zones, it has been extended to the entire country, directly subordinate to the Presidency of the Republic. Goals have been established in health, nutrition, changes in development, childhood practices and maternal depression. It focused on families with high vulnerability. The first evaluation revealed some achievements, such as 60% of the pregnant women with at least 5 control visits, the reduction in chronic malnutrition, the reduction of anemia from 33% to 10% of the reference population of children (Lustemberg, 2014).

Intersectoral action and social participation in the territory

Social or community participation is a sign of the identity of the PHC strategy in its concept of renewal. All three countries have created legal instruments to enable and facilitate such participation. Likewise, in the territory, with or without formal instruments, participation bodies have been created with the issue of health as a transcendent stimulation factor. Also, the development of this trace of identity has not been homogeneous and its

potentialities are often not developed the desired way. A factor that is common to all three countries is the demand for capacity building in social participation, with the intention to clearly define roles and competences.

Argentina applies the Strategy for the Strengthening of Territorial Management in Health for the design and implementation of plans at the local level, in order to reduce segmentation and fragmentation of the health system, with the formulation and implementation of a municipal strengthening strategy, agreed with national, provincial and municipal jurisdictions.

Intersectoral articulation in the territory is converged in Integrated Community Centers (CIC) that, since their concept and initial planning integrate actions of the Ministries of Health, Social Development, Labor, Planning and the Social Cabinet. The CIC consist of a model of public management that implies integration and coordination of PHC and social development policies in a common physical ambit at the municipal level. At the intersectorality nucleus formed by public organisms, coordination is organized within the territory with community organizations, social clubs, NGOS, etc. The methods of coordination are varied and go from coordination for specific actions to agreements for medium and long-term action plans.

In Paraguay, in the territory, USFs are coordinated with departments, municipalities, community organizations such as neighborhood commissions, local health councils and NGOS, with the intention to support the community, provide health care, follow up vulnerable groups and promote healthy habits.

Local health councils and subcouncils enable citizen participation in health and articulation between institutions of the State, civil society organizations and private institutions[9]. Considering that these are mixed character organizations, it is possible to have the participation of private institutions of different nature, together with official organisms, with a comprehensive integration of the civil society (Paraguay, MSPBS, 2010).

Their actions include the response to emergent situations, the definition of needs and the elaboration of proposals and/or alternatives of solutions that, even though may not be binding, are taken into consideration in decision-making for the design of the local plans (DGAPS, 2014).

Uruguay practices intersectorality in the territory with national policies combined with actions conditioned by local realities, interacting with formal and non-formal organizations of the community and with other institutions of the State with territorial presence, among them, the Ministry of Social Development, departmental intendancies and mayor's offices, to name a few. The educational system structure, both at the primary and at the secondary level, is a traditional ground for the development of intersectoral actions in the territory, with the health sector as an extra component. In this sense, oral health, road

9 Their actions are mainly defined by Act 1,032/96, which created the National Health System and Act 3,007/06, which broadens and modifies it.

accidents, healthy nutrition, physical exercises, etc., are regular issues for intersectoral interventions. In this kind of interventions, there is a conjoint coordination and participation of the actors directly involved (such as teachers, professors, municipal workers responsible for the traffic, etc.), with fruit and vegetables producers in order to provide supplies for the promotion of healthy nutrition and for other activities.

Multiple variants of social participation are seen at the territorial level. The most traditional ones are promoting or neighborhood commissions that, autonomously and without further formalities, organize themselves to address local problems.

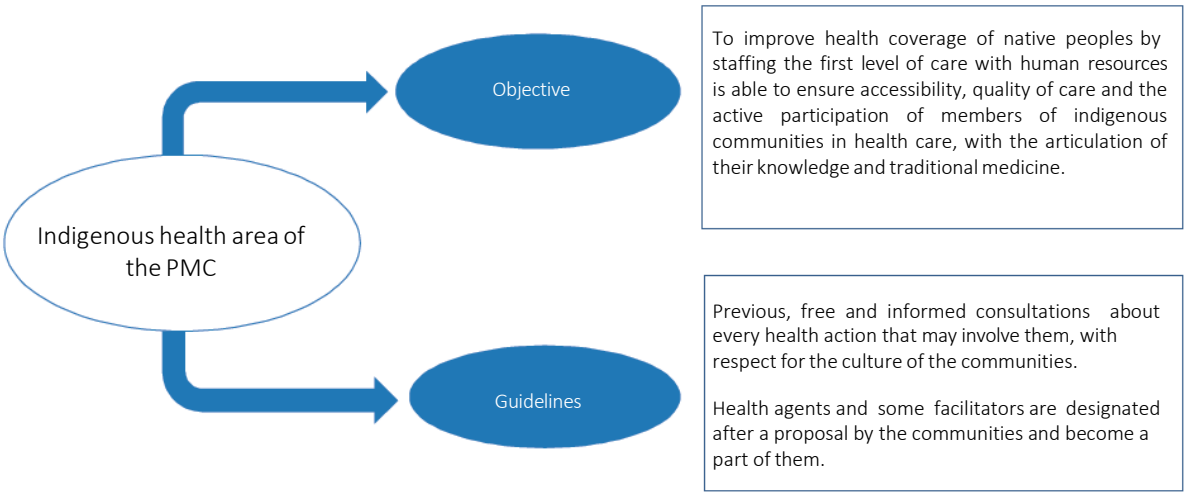
Several spaces for social participation have been created with the formation of the SNIS, and the most transcendent examples are the integration of the ASSE and the participation of Junasa, in both cases with representatives of health users and workers. There are also spaces formed at the departmental level - Departmental Boards of Health (Judesas) - with the participation of health users and workers and representatives of all assistance public and private services in the territory. The Judesas analyze the health needs and solutions of each place. Another formal instrument for participation has been the formation of consultative councils in each one of the comprehensive providers that integrate the SNIS, in which the participation of users and workers has the role of monitoring and controlling the performance of services. An indicator of the implementation of this spectrum of options has been the generation of several organized movements of users, which canalize their participation in these spaces.

INTERCULTURALITY IN PHC

Argentina and Paraguay, due to the characteristics of their population, are more developed in regard to the approach to interculturality, with the use of two different aspects. On one hand, with specific actions directed at native peoples and, on the other, with the articulation with traditional medicine.

In the case of Argentina, the Community Doctors Program counts with an Indigenous Health Area (e.g. the Anahí Program). Since 2005, an action line has been designed and implemented with the purpose to improve health and quality of life of native peoples with social and health interventions with interdisciplinary community teams. The Indigenous Health Area of the PMC promotes actions that ensure access to health for indigenous peoples without discrimination, with respect and quality and is gradually incorporating an intercultural approach to health (Image 1). These actions are established by the Indigenous Peoples Planning Framework, which has been constructed in consultation with the Indigenous Participation Council.

Image 1 – Interculturality health strategy of the Community Doctors Program



Source: Orsi, 2014.

In Paraguay, there is combined work with the Department of Indigenous Health for the implementation of a guidebook for care to indigenous communities. Moreover, some USFs are located in indigenous communities' areas of influence and coordinated with indigenous promoters for combined work and to promote articulation and cooperation with traditional medicine workers of native and peasant peoples.

At the same time, in Uruguay, due to the high urban concentration of the population, the sparse presence of traditional medicine and a rural population of about 6%, the existence of one single language and a percentage 96% literacy, the scenario is different, with less cultural diversity and interculturality being scarcely mentioned in policies. Nonetheless, in the development of the PHC strategy, there are always other types of cultural barriers that emerge, especially concerning language use. In spite of Spanish being the only language spoken, it has some singularities in some regions. Habits and culture are different and very often the content of traditional materials for promotion and education are not developed in a way that reflects this reality.

FINAL CONSIDERATIONS

With collected information it is possible to develop a series of analyses about the status of development of the PHC strategy. First of all, it shows that there is a movement with some variations in the implementation of PHC renewal, which happens at the same time of the political changes that occurred in all three countries analyzed. After overcoming the neoliberal phase of the 1980s and 1990s, with the emergence of left-wing political parties, not

only in these three countries, but also all over South America, there is an emergence of the protagonist role of the State and the boost of a new social protection matrix, which conditions and favors the development of PHC renewal.

In the first place, it is important to highlight that, in all countries, PHC is mainly promoted at the expense of assistance public services, under the framework of a State that gradually recovers its role, which encourages and increases social expenditure and promotes intersectorality of policies, focused on the fight against poverty. In the second place, another common factor has been the competences and functions granted to national and/or provincial ministries of health, in order to recover their powers as health authorities and their stewardship of the system. In the third place, it is possible to envision a heterogeneous legal matrix that goes from constitutional rules, laws, decrees, to ministerial resolutions, creating a mosaic in which the transcendent content of PHC is being settled.

It is also observed as a common characteristic the fact that none of the countries has a specific budget available for the funding of PHC as a whole and, as this strategy is a result of the combination of several structures of the State, it is also difficult to quantify it. The features of the implementation process of the PHC strategy is noticeable at the first level due to the presence of public services from the national sphere, as well as from the territorial ambit: regional, departmental, municipal, community, etc. Finally, another common factor are the various formal and informal social participation bodies that characterize this development process.

In some dimensions that are relevant to PHC, there are problems and challenges that are common to all three countries, especially in respect to regional and social inequalities concerning the organization of PHC and the availability of health workforce. The resources are asymmetrically distributed, with high concentration in metropolitan and/or urban zones to the detriment of suburban, rural zones, and in areas with critical contexts or which are difficult to access.

Despite the differences within the countries concerning the availability of physicians and/or nurses and other professional categories, in which Argentina and Uruguay have a more favorable situation in comparison with Paraguay and with South America as well, all three countries analyzed also share the same problems, such as the quantitative deficit, the difficulty to retain professionals in remote zones and the need to cover determined functions with other professional categories.

A specific but also common problem that makes the integrality of care more difficult is the counter-referral from the second level and/or specialized care to the first level. Referral has improved, but the paradigm of the hospital-based model is still embedded in this relation, with the concept of the superiority of hospitals as a cultural factor of organizations.

Another common problem is the gap between the current staffing of properly trained human resources for PHC and the needs of the system. The university education programs for

health professionals and technicians have been conceived for a model of care that is trying to be modified with the implementation of the PHC strategy.

One of the main challenges is the future organization of PHC according to a more balanced distribution of physical and human resources within countries. It is essential to develop strategies that, on one hand, encourage the choice of working at the first level and, on the other, facilitate the retention of professionals in remote areas or in zones that are difficult to access.

Another challenge, in a policy that converges with the educational sector, is the implementation of changes in syllabi of under graduate programs and the increase of graduate openings in order to ensure properly trained human resources to work in PHC. All countries have developed several actions in this sense and, although it is not recommended that they reproduce each other's singularities, governments should use successful experiences as references.

Due to the difficulties detected, it is also a challenge to find mechanisms that enable a stronger regulation of the participation of the private sector in the territory, with the encouragement of service complementation and its integration to territorial networks.

Another challenge and a constant claim of all three countries is to rethink traditional indicators and to create new ones to assess the impact of this new promotion of the PHC renewal strategy. The production of empirical evidences in regard to the effects of PHC policies and strategies is essential in order to deepen the PHC strategy and to give sustainability to policies when faced with the competent authorities.

Case studies of PHC mappings in all three countries have identified several strategies to keep moving forward, to try to solve problems and to overcome challenges. UNASUR may be the institution that promotes the collective dissemination of this accumulated experiences, thereby facilitating the diffusion of successful experiences and technical exchanges about educational systems for PHC in the region, with the development and dissemination of the profile of the community worker and/or health promoter, strategies for the retention of professionals in remote zones and the promotion of the construction of indicators that are sensitive to the implementation of the PHC strategy.

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Primary Health Care in Bolivia, Ecuador and Venezuela: a transition towards comprehensive primary health care?

Herland Tejerina Silva

INTRODUCTION

Primary health care systems in Bolivia, Ecuador and Venezuela are currently undergoing a transition from a shared reality, in several aspects, to visions that are also similar. In these three countries, the historical background shows the development of health systems, with some singularities in each case, around an assistance hospital-based model centered in big cities to the detriment of promotional, preventive and rehabilitating primary health care to geographic and economically marginalized populations. In the three cases, the systems have evolved throughout the central decades of the 20th century until their segmentation into public services, the Bismarckian social security, nonprofit private institutions (charity to the poor) and for profit private services.

In different ways, all three countries have implemented initiatives inspired by the Primary Health Care strategy defended at the Conference of Alma-Ata, in the 1980s. However, in the following decade, they have all experienced reform processes that followed the programs for macroeconomic structural adjustments and that, aligned with the Washington consensus, with different intensities, but without changing its focus on hospitals and urban centers, marked its management and service structure, also with some common characteristics (Tejerina Silva et al., 2009). Decentralization, the institution of co-payments in public services, the creation of specific focused insurance modalities and the reduction of public funding are some of the characteristics of health policies in that period.

In the decentralization process[1], in the form of devolution, Bolivia transferred the property and management (with the exception of human resources funding) of all public health facilities to its municipalities, leaving the central level only with normative and regulation functions to all levels, including hospitals (Tejerina Silva et al., 2011). Ecuador and Venezuela have implemented decentralization policies with lower intensity. In Ecuador, decentralization has been implemented through the deconcentration of administrative responsibilities from the Ministry of Health to provincial units and the technical conduct, execution and operative follow-up to districts. In turn, Venezuela decentralized the public health management to 17 of its 23 states, initially through devolution, but with regional singularities that show a miscellaneous of delegation, deconcentration and devolution properly said (Alvarado et al., 2008). In their recent history, Bolivia and Ecuador have kept their levels of decentralization, whereas Venezuela has started a recentralization process.

Still as a part of the reform processes, these three countries have introduced user co-payment for health services at their facilities (in Venezuela, they used to be free of charge to patients since the 1970s, whereas in Ecuador and Bolivia there have always been payments for some services), with charges per provision.

Bolivia and Ecuador have implemented several modalities of selective public insurance for some specific health provisions, basically those related to maternal and child health and communicable diseases. These strategies exempted some segments of the population from out-of-pocket payment at public facilities (children, the elderly and pregnant women) for the treatment of some health conditions (essentially perinatal care). Ecuador also tried to allocate public subsidies in health care, through an insurance system with very low contributions for peasants and traditional anglers. In turn, Venezuela has significantly incremented the participation of non-governmental nonprofit organizations as foundations, in the provision of services, with clear prioritization of maternal, child and reproductive health services.

At the same time, health policies of all three countries have concentrated their efforts almost exclusively in the technical and material strengthening of related services (prenatal control, childbirth care, neonatal care, vaccines, contraceptives, treatment of diarrhea and pneumonia in smaller children and epidemiological control of communicable diseases) through vertical programs. The models of care were clearly aligned with the Selective Primary Health Care strategy supported by Bellagio in 1979 and promoted by international

[1] In regard to forms of decentralization: De-concentration transfers a part of the authority and administrative responsibility to subnational levels within ministries or agencies of the central government; delegation transfers managerial responsibilities to functions specifically defined to different organizations of the central government, which are indirectly controlled by it; Devolution implies the creation of subnational autonomous and independent government units that manage services, substantially outside the central control (Rondinelli, 1999).

cooperation agencies as the UNICEF, USAID and the World Bank.

With different intensity, these three countries have also suffered a reduction in public funding for health as part of cutback policies of the State, which resulted in the weakening of its planning and central control structures.

The governments of Hugo Chávez (Venezuela, 1998), Evo Morales (Bolivia, 2006) and Rafael Correa (Ecuador, 2007), which identify themselves with an ideological tendency to socialism, share similar visions about the course of their health policies. After taking office, all three presidents announced the break with former sectorial policies qualified as neoliberal and the implantation of new health models inspired in the strategy defined in Alma-Ata and the evolution of this approach, named by the PAHO/WHO as Primary Health Care Renewal.

In this context, these three countries also share common development goals:

- Free of charge universal access to public health services;
- Models of care based on primary health care;
- Emphasis on the promotion of health, understood as the intersectoral action on its social determinants;
- Intercultural approach with emphasis on the respect for and assimilation of native peoples' knowledge and practices in health.

All three countries have similar ambitions for the development of their health systems, which are expressed in their national legislation. Venezuela, in 1999, and Bolivia and Ecuador in 2008, approved national political constitutions that establish health as a social universal right and put the State as the responsible for its guarantee.

The subsequent legislation and policy documents, in all three cases, establish models of health care based on primary health care, understood as the action on the social determinants of health, the prevention of diseases and the intersectoral and intercultural approach. Primary health care is explicitly mentioned as Renewed Primary Health Care in Ecuador (Ecuador, Ministerio de Salud Pública, 2012) and called Comprehensive Health Care in Venezuela (Venezuela, Ministerio del Poder Popular para la Salud, 2014b). With the use of the Alma-Ata model as an explicit reference, in Bolivia it is called Intercultural, Family and Community Health, a model conceived as a qualitative evolution of PHC, with emphasis on the promotion of health (Bolivia, Ministerio de Salud y Deportes, 2008). The gratuity of public services is also a legal mandate in all three countries.

Their respective governments have explicitly expressed their intention to dismantle the models of social policy established in their countries in the 1990s, inspired by the prescriptions of the document known as the Washington Consensus which, in the health sector, were interpreted as sectorial health reforms.

Other common elements that are not yet completely overcome in all three countries are segmentation and fragmentation[2] of the health systems.

Segmentation, expressed by the strict separation of populations according to the affiliation (or not) to different insurance systems and in their access to health services of different quality, adequacy and funding, has been partially (except by funding) overcome in Ecuador and Venezuela with the implementation of gratuity in public services and the universal access to social security facilities. In Bolivia, access, provision and funding of health services is still deeply segmented, with the perpetuation of inequities.

Paradoxically, the multiplication of initiatives implemented by governments in their urge to transform their primary health care systems in accordance with their new visions, without the elimination of structures inherited from past models, has deepened fragmentation in these three countries.

Another common element is the presence of the Cuban cooperation and its influence on the organization of primary health care systems. Cuban medical brigades have created the Inside the Neighborhood system in Venezuela, on which the country intends to base its new health structure. Bolivia has strengthened part of its public facilities with Cuban professionals, but it also bases its program, My Health, on Cuban-trained physicians, with community care brigades in parallel to the regular services. In Ecuador, the Cuban influence is rather at the conceptual level of health organization, but it is also evident in programs for the training of new professionals.

The access and the segmentation of health systems

The health systems of all three countries mainly divide their population into two big groups: people covered by social security and people without coverage. In the case of Bolivia, there is a third group: people covered by selective public insurances – the Universal Mother and Child Insurance and the Health Insurance for the Elderly.

In Bolivia, in 2010, 53% of the population (5.5 million people) was theoretically covered by some type of state health insurance (from the Ministry of Health or the social security) (Dupuy, 2011a). Nonetheless, a household survey in 2009 demonstrated that only 34% of the population was insured (Dupuy, 2011c). Even so, from 66% to 47% of the Bolivians were not covered by any health insurance and were not able to access services unless they pay for them.

In 2010, 28% of the Ecuadorian population (4,036,302 people), 5% more than in

[2] We understand that segmentation is the characteristic of a system that has different modalities of access, provision and funding of services to different groups of the population, according to their employment status, social group ability to pay. Segmentation leads to inequality. We conceptualize a system as fragmented when its different components work with low level of coordination and with structures, processes and management modalities that are independent and disconnected. Fragmentation leads to inefficiency.

2004, was covered by a public health insurance (Lucio et al., 2011). Nevertheless, since 2011, with the implementation of the universal access to the Comprehensive Public Health Network, which includes public and social security sectors, all people have access to the facilities of the networks, regardless of their insurance status. The case of Venezuela is similar, with 39% of the population affiliated to an insurance institution, but with access for all, who may receive identical services at public networks and social security facilities. In both cases, social security institutions manage their own facilities and pay for their affiliates whenever they use the public services of the Ministry of Health, which does not mean any changes for users, but makes the system more complex and expensive.

A way of assessing the access to primary health care services is the outpatient visit index per people or per year. In Bolivia, this indicator is of 1.27 visits per person in 2012, especially due to children under five (who receive services free of charge with subsidies from the public insurance). In Ecuador, this index was 1.5 in the same year, only considering facilities of the Ministry of Health and 1.8 considering the entire public network (including private nonprofit facilities that, through agreements, also receive public subventions). In Venezuela, this index, in 2012, reached a number close to 3.8 (with estimate information for the regular public network), and 2.9 of it corresponds to the Inside the Neighborhood network.

Another approach to the accessibility of services is the availability of material and human resources. In Bolivia, in 2012, there were 3.08 first level facilities for each 10,000 inhabitants, whereas in Ecuador this indicator is 2.1 and in Venezuela, 5.05. The availability of physicians per 10,000 inhabitants, in the same year, was 7.2 in Bolivia (10.3 for the insured population), 17.1 in Ecuador and 19.4 in the services of the regular network in Venezuela. The data for professionals of the Inside the Neighborhood network is difficult to determine because, besides 15,356 Cuban doctors that had been incorporated until 2011, there is a number that has not been precisely reported (over 5000) of graduate or undergraduate Venezuelan Comprehensive Community Doctors, who also work in these services, especially in the first level. In reality, there were probably about 27 doctors for each 10,000 Venezuelans. The apparent inconsistency in the indicators of Bolivia can be explained by the fact that more than a half of first level facilities in the country do not count on physicians.

In Bolivia, in 2009, 43% of the population with a perceived need for health services did not access institutional care. Populations in the rural area, native indigenous, undereducated people, non-salaried workers, those informally employed and extremely poor people were the ones most excluded from health services, according to a study by the Ministry of Health (Dupuy, 2012). There is no information about similar studies in Ecuador and Venezuela; nonetheless, according to an official survey in the latter, 54% of

the population had used health missions (above all, Inside the Neighborhood) at some point until the second trimester of 2011, most of them people without coverage by the social security and with lower economic incomes (Venezuela, Instituto Nacional de Estadística, 2011).

It is clear that Bolivia has greater problems in the access of its population to health services, most likely because social security facilities only provide care to those insured and due to the economic barrier of the out-of-pocket co-payment at public facilities. These two elements have been eliminated in Ecuador and Venezuela, where exclusion in access may happen due to geographic accessibility, acceptability (probably important to the Inside the Neighborhood services in Venezuela) and due to possible local internal deficiencies in the provision system.

Another important factor may be the working hours at primary health care facilities. In Bolivia, most of the urban centers is only open six hours a day and its staff does not provide clinical home care. In Ecuador and Venezuela, the minimum working hours are eight hours a day and there is a rate of 10% and 47% of care outside facilities (for Inside the Neighborhood network I), respectively.

PHC CONDUCT

Primary Health Care Concepts

Bolivia, Ecuador and Venezuela have assumed Primary Health Care as their main strategy for the provision of public services. Ecuador explicitly abides by the principles of the Declaration of Montevideo for Renewed Primary Health Care (Pan American Health Organization, 2007). In turn, Bolivia has coined its own strategy for health care, called Intercultural, Family and Community Health, which is explicitly inspired by the Declaration of Alma-Ata, but also with clear elements from Montevideo. In Venezuela, however, there is a discussion about the precise concept of primary health care that should be included in its constitutive documents, but there is a clear consensus about its base on the principles of Alma-Ata and Montevideo. Chart 1 summarizes the legal and political definitions of primary health care in these three countries.

The strong emphasis on family and community components of the model of care, based on the concept of social determination of health is very clear in these countries. The intercultural component is also very important in Bolivia and in Ecuador. It is likely that these concepts have common ideological roots (whose analysis is beyond the scope of the present document).

Chart 1 – Legal and political definitions of Primary Health Care in Bolivia, Ecuador and Venezuela

Country	Legal and political definition
Bolivia	Legal definition No clear mention of PHC in the legislation
	Political – model of care Intercultural, Community and Family Health Care Model: combination of actions that facilitate the effective, efficient and timely development of processes for health promotion, prevention, treatment of diseases and rehabilitation through horizontality, integrality and interculturality, so that health policies are presented and articulated with people, families and the community or neighborhood. It establishes 4 principles: community participation, intersectorality, interculturality, integrality.
Ecuador	Legal definition The Political Constitution approved in 2008 explicitly mentions the term PHC, in Art. 360: "The system shall guarantee [...] health promotion, prevention and family and community comprehensive care, based on primary health care..."
	Political – model of care Family, Community and Intercultural Comprehensive Health Care Model (MAIS-FCI): the set of strategies, rules, procedures, tools and resources that, by complementing each other, organize the National Health System in order to answer the health needs of people, families, communities and their surroundings, thereby enabling integrality in the levels of care of the health network.
Venezuela	Legal definition No clear mention to PHC in the legislation
	Political – model of care The Inside the Neighborhood Mission defines primary health care as its fundamental strategy: "PHC is the central function and main focus of the health system, and of the overall social and economic global development of the community. It represents the first level of contact of individuals, the family and community with the National Health System, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process... it is not simplified medicine and it does not consist of minimal medical care and neither can it be limited to simplified actions that aim to make health costs cheaper or to transfer responsibility, social costs and funding to communities"

Sources: Estado Plurinacional de Bolivia, 2008; Ecuador, Ministerio de Salud Pública, 2012; Bolivia, Ministerio de Salud y Deportes, 2008; República Bolivariana de Venezuela, 2000; República del Ecuador, 2008; República del Ecuador, 2012.

"Living well" or "Well-living"

The concept of "Living Well" or "Well-living" has emerged as a school of thought that claims for ethical principles and traditional practices, especially in the Andean region. It started with the kichwas (Sumaj Kawsay) in Peru and Bolivia, by the end of the 1990s, as a proposal to organize their life plan and the management of their territory through their own cosmovision. Nonetheless, it is a principle that integrates the vision of several American indigenous cultures, such as the Guaraní (Iyambae), the Aymara (Suma Qamaña), the Ashuar (ShiirWaras) and others.

In the contexts of the re-emergence of multiple ideological schools that claim for the native culture in opposition to the European cultures imposed since the colonies, the Living Well is presented as an intercultural though in development, with several concepts and interpretations. However, a common element is character of protest against the "living better" paradigm of the western post-modern culture that, since the native cultures, is conceived as a synonym of the search for individual satisfaction based on consumption and competition. The Well-living aims to give bak dignity and self-esteem to peoples marginalized by the European cultural dominance.

The central elements of this paradigm are (Andean Coordinator of Indigenous Organizations, 2010):

- The creation of a solidarity network to overcome inequalities.
- To live with balance and harmony with everything that surrounds us and with all that exists, understanding that, in life, everything is interconnected, interdependent and interrelated.
- It is not possible to live well if the others do not, it is about living well as a part of the community. The community is the structure and unity of life, and it is formed by all means of existence and not only a social structure formed exclusively by humans.
- Spirituality and knowledge are interlaced. There is an inseparable relation between economic, social, natural and spiritual forces. Spiritual and affective values are more important the economic and material ones.
- Decision must be reached through consensus and not through the submission of minorities to majorities.
- It understands health as the balance and disease as the lack of it, in its biological, social and spiritual dimensions. Therefore, the search for causes is more important than knowing the symptoms or their relief.
- Human beings are only a part of the cosmos, which is intimately linked to and dependent on Mother Earth.

Bolivia and Ecuador have incorporated paradigmatic texts in their political constitutions. In Bolivia, the Constitution declares, in Art. 8, that "[…] the following principles are assumed and promoted as ethical and moral principles of the plural society: … suma qamaña (living well), ñandereko (harmonic life), tekokavi (good life), ivimaraei (earth without harm) y qhapajñan (noble life)". Living well is established as a principle in the same hierarchy as equality, liberty and social equity. The "Bolivian economic model is plural and oriented to improve quality of life and the well-living" (Art. 306) (Estado Plurinacional de Bolivia, 2008).

In Ecuador, the Constitution dedicates one section to the "Regime of Living Well", in which the development regime is defined as "the organized, sustainable and dynamic set of economic, political, social, cultural and environmental systems that guarantee the attainment of the well-living, of the Sumak Kawsay" (Art. 275) and the Ecuadorian development plan is called the National Plan for Good Living (República del Ecuador, 2008).

Sources: Coordinadora Andina de Organizaciones Indígenas, 2010; Estado Plurinacional de Bolivia, 2008; República del Ecuador, 2008.

Functions and competences of governmental spheres

Bolivia is a deeply decentralized country, with autonomy of each one of the four management levels (national, departmental, municipal and indigenous/native) (Estado Plurinacional de Bolivia, 2010). Concerning primary health care, the central State level (the Ministry of Health) has the following competences: to elaborate the legislation for the organization of service networks and the normative in regard to the intercultural, family and community health policy; to promote and support the participatory management and social control; to establish national programs for epidemiological control and, in respect to traditional medicines, to preserve the propriety and the intellectual collective rights of indigenous peoples and to ensure the recovery of the traditional medicine.

Although the rule almost exclusively grants the Ministry of Health with normative and regulatory competences, currently, it also directly implements priority programs for service provision:

- My Health Program: strategy of brigades that provide promotional, preventive and curative services, free of charge to the population, in specific priority zones;
- The Medical Residency in Intercultural, Family and Community Health (RM-Safci): medical training postgraduate program based on the activation of residents in underserved zones of the country, through their integration with communities, in order to identify and address the local social determinants of health:;
- The Bono Juana Azurduy: program for financial transfers to the populations, conditioned to the accomplishment of goals in the access to services;
- Oral health mobile teams;
- The Multi-sectorial Program Zero Malnutrition;
- The Moto Méndez Program: Strategy with multidisciplinary mobile teams for identification and care for people with disabilities.

Departmental governments have the following competences concerning primary health care: the structural formation of networks, co-funding, accreditation, epidemiological programs, management of health teams, organization of departmental bodies for social participation and control of pharmaceutic products. This level is represented by the Departmental Health Services (Sedes), which is subordinate to the autonomous government of each one of the nine departments, which hire and manage the regular staff at facilities (except for priority programs with national and municipal management). In two departments, there is also the management of universal autonomous health insurances, which offer services free of charge, as a complement to

national insurances.

Municipal autonomous governments have the competence, to manage the primary health care infrastructure and equipment and to implement the health promotion component. Several municipalities have autonomous management (including human resources) of first and second level facilities. There are two municipalities that develop insurance schemes that are complementary to the national ones. The forth level of government, the Autonomous Peasant, Native and Indigenous Governments, does not have specific competences in Primary Health Care.

In Ecuador, the health system has low decentralization and high deconcentration. The conduct of the system, at the national level, is done by the Ministry of Public Health, with the advisory of the National Health Council, formed by the 17 entities that are part of the National Health System. According to the Organic Health Act, the Ministry has the following functions in regard to, but not exclusively, primary health care: to design and implement programs for care to communicable and non-communicable diseases, disabilities and public health problems declared priorities, to manage immunizations, the care to catastrophic diseases, sexual and reproductive health, violence in all forms, the consumption of tobacco, alcoholic beverage and other substances that affect health, the access to and the availability of medicines, the operation of public and private facilities, to promote and boost the practice of traditional, ancient and alternative medicine, the research and development of science and technology in health (República del Ecuador, 2012).

Provincial and cantonal levels of health (represented by councils) have the roles to formulate and control the application of their respective Comprehensive Health Plans. They are not operative concerning service provision.

Since 2013, the executive organization of the Ecuadorian health system is based on the Model of Political and Administrative Deconcentration of the country (national, 9 zones and 140 districts), given by the National Secretariat of Planning and Development, with competences and resources from the Comprehensive Family and Community Health Care Model (República del Ecuador, 2010). Competences by levels, with clear reference to primary health care are:

Central Level (besides those highlighted in the organic act): strategic planning and conduct of the Comprehensive Health Care Model, thereby ensuring the PHC approach; design and update of the package of guaranteed and prioritized service provision; training and education of health teams, including training in Family Medicine and PHC; organization of the public and complementary networks and district networks and the supervision, monitoring and evaluation of the zonal level; elaboration of health care rules, including service protocols and standards.

Zonal Level: the control of the quality of care (evaluation and audit of medical,

financial and field activities); consolidation, analysis, validation and information feedback; technical assistance, training and follow-up of district technical teams; organization and distribution of human talent; assurance of social participation and organization of the social network; accreditation and articulation of public and complementary networks; assurance of referral and counter-referral; planning, funding and execution of projects for health infrastructure and equipment. The zonal government (provincial) participates in funding with its own resources, besides transfers received from the central level.

District Level: conduct, execution and follow-up of the Comprehensive Health Care Model in the district; articulation of the public and complementary network; conduct, conformation, organization, training and technical assistance to health teams; organization, regulation and management of public services under its responsibility; management of the articulation of first level health facilities, as well as the definition of their construction and equipment. The district level manages economic, human and physical resources.

In Ecuador, the planning, construction and maintenance of the physical structure and equipment for health and education are exclusive competences of the municipal decentralized autonomous government (República del Ecuador, 2010). However, each level of the government is responsible for maintenance and equipment of the facilities under their management. The cantonal (municipal) government may fund actions for the operation of specific health services, according to the needs identified and to its own resources.

In 1990, Venezuela started a process of decentralization of health services through the Organic Act for Decentralization and Delimitation of the Transfer of the Public Power, through which the competences of provision and funding of health systems have been transferred, in various degrees, from the central level to 17 out of the 23 state governments, through agreements (Bonvecchio et al., 2011). This process of decentralization of health services was long and difficult and it contributed to the configuration of a great complex system, with low coordination, until the reform of 1998 nullified many of the decentralized competences with the establishment of new central structures for financial intermediation and management of service provision. Finally, in 2008, a presidential decree opened the doors to the recentralization of health systems in states that wished to do so. Until March 2014, two of the 17 decentralized health states had started this process.

Conduct of the primary health care system is strongly centralized in Venezuela. Management of both the regular network and the Inside the Neighborhood Mission is done through a gradual structure directly connected to the Ministry of People's Power to Health. According to Article 178 of the Constitution (República

Bolivariana de Venezuela, 2000), the government and management of salubrity and of primary health care are a competence of the municipality. However, the participation of this level in management is relatively marginal, since the management and provision of primary health care services is under the control of the national government.

The National Development Plan identifies six strategic regions for comprehensive development that include several states based on a territorial criterion. According to this, the organization of the public health systems, approved in 2012 and now under implementation, is supported by the division of the territory in 600 Community Comprehensive Health Areas (ASIC), which include communal networks.

According to the model of Inside the Neighborhood Mission (Muntaner et al., 2006), primary health care services are organized into regions based on communal networks. Each communal health network is located in a determined social territory, where they perform actions for promotion, prevention, treatment and rehabilitation – with popular participation and intersectoral initiatives. They provide health services free of charge and the training of undergraduate and graduate human resources in Health Sciences. The communal network is formed by assistance, teaching and research units, such as community medical offices, rural and urban ambulatories that compose the regular network, dentist and optical clinics, Comprehensive Rehabilitation Rooms, Comprehensive Diagnostic Medical Centers, academic units, health committees, Comprehensive Community Brigades and other operative units for specific care (for example, to people with disabilities).

The Comprehensive Community Health Area (ASIC) in Venezuela

It is defined as an integrated system of assistance, teaching and research units that provide quality health service, with proper diagnosis and therapeutic means, qualified professionals, where it is possible to solve 90% of the health problems of the population and to train the required health staff, always with the active and protagonist participation of the organized community. The ASIC are the basic units of the public health system and of the primary health care networks. Inside the ASIC, there is the articulation of health with community social networks and other social missions. They apply a comprehensive and intersectoral model for continuing community and family health care that is universal and free of charge.

There are no rigid criteria for the delimitation and formation of the ASIC. It is possible to delimit as many ASIC as necessary to cover the health care need in a specific municipality.

ASICs assemble the social territories of several Communal Councils, which, in turn, have their Health Committees. There is a Health Committee chosen by citizen assembly for each primary health care facility. These committees promote the full improvement of the quality of life of the population, aiming to ensure access to food, education, employment, social integration, culture and the development of values based on solidarity and social co-responsibility.

Source: Venezuela, Health Ministry, 2007.

PHC FUNDING

One of the biggest differences among the three countries is the availability of financial resources, both in the total expenditure on health and in its public component, as shown below in Table 1.

Table 1 - Health expenditure in Bolivia, Ecuador and Venezuela, 2011

Indicator	Bolivia	Ecuador	Venezuela
National public health expenditure (% of GDP)	3.5	7.3	1.8
Health expenditure (billion current US$)	0.7	1.5	16.0
Health expenditure *per capita* (current US$)	70	332	555
Public expenditure on health (% of the total health expenditure)	44.0	41.0	37.0
Public expenditure on health (billion current US$)	0.3	0.6	6.0

Source: Banco Mundial, 2014. a) 2010

Funding sources

All three countries have, as their first national revenue, the income of the hydrocarbon activity, with central management of taxes. The public health sector is usually funded with resources from the national government, with variable participation of other levels of the State.

In Bolivia, these funding sources are mainly general taxes and the Direct Tax to Hydrocarbons. Three out of the four levels of the government of the country (national, departmental and municipal) participate in funding of health services, mainly with funds assigned from the national treasury, but also with their own resources. The public expenditure is mainly concentrated in the payment of salaries and wages with 36% of the total resources. The main source for municipalities are transfers from the General State Treasury to public health insurances: Mother and Child Insurance, with a fixed assignment of 10% of the tax co-participation received with population basis (24% of the public expenditure), and the Insurance for the Elderly, through a premium of 56 dollars for each person (11%). There are also health insurances at the subnational level (for example: universal complementary insurances for nationals in the departments of Tarija and Beni and the school insurance in El Alto), which are majorly funded with resources that are not specific for health and that come from the hydrocarbon taxation. 42% of the public expenditure on health is allotted to facilities offering exclusively primary health care services. Social security is funded through a percentage of 10% of the gross salary of each employee (Tejerina Silva, 2014a). There are no resources specifically assigned to primary health care. In 2011, 65% of the expenditure was allotted to infrastructure, equipment and maintenance, whereas 18% was directed to expenses with personnel (Dupuy, 2011b), in a reversion of the secular tendency that personnel services used to concentrate the greatest part of the budget. This means that,

although the public expenditure has increased in more than 100% between 2005 and 2011, this increase was mostly directed to infrastructure, equipment and maintenance, which changed the proportional distribution. Resources from the General Health Insurance come from the individual mandatory contribution of affiliates, the mandatory contribution from employers (up to 10% of their salary) and the direct contribution from the State (Bolivia, Ministerio de Salud y Deportes, 2011).

In Ecuador, funding of health comes from general taxes and mainly from the national oil income. The participation from provincial and municipal resources is marginal and directed at their own initiatives. The budget for public services, which is a nominal part of the Ministry of Health, is annually shared between provincial health departments (zonal coordination bodies in the new administrative division) based on budget packages that are negotiated annually. The public health budget is assigned automatically to provincial departments (now called zones), area leaderships and municipalities (now districts), according to budgets based on health plans and with criteria of equity, population index and epidemiological risk, with exception of the resources required for the exercise of coordination by the Ministry of Health (Tejerina Silva, 2014c).

In Venezuela, funds for health care come mostly from the oil income, besides other sources as taxes on alcohol and tobacco, the public debt and the dividends of public companies. Funding of social security is tripartite: patronal contributions, contributions from workers and direct contributions from the central government. The initial contribution from companies to fund the Mandatory Social Insurance varies from 11% to 13% of the monthly fixed salary; however, due to a chronic deficit, the government gives subventions to part of its service provision and hires services from the private sector. In parallel, all other public organisms (with the exception of the Ministry of Health) give their workers and dependents the choice of contract with private insurance policies that must be paid for with their own budgets. These private insurances represent at least 15% of the resources of public health expenditure. The Inside the Neighborhood Mission is also funded with public resources, but in an independent way. There is a special account that is funded with direct resources from the oil income, managed by Petróleos de Venezuela S.A. (PDVSA) and, complementarily, by the National Fund for Development. The Ministry of Health makes transfers to states and affiliate entities based on budget requirements and estimation of needs. Moreover, state governments also employ their own resources (from the "*Situado Constitucional*", 20% of the total estimated ordinary income) (Tejerina Silva, 2014b).

Final provider payment methods

Ecuador and Venezuela based their payments to final service providers on budget packages that are assigned according to the ascending plan of the management pyramid, with historical basis and according to priorities defined at the local level and other ones identified in national policies. Each health facility and each managing institution receives a budget assigned by their immediate superior level, based on an approved plan. Resources are transferred from the national level, following the descendent hierarchy of management levels.

In Bolivia, public national insurances are funded with specific resources transferred to municipalities based on their population. The payment of services covered by this insurance to facilities is done per service provision, through a scale that is regularly updated. The Insurance for the Elderly (SSPAM) pays provider facilities through each municipality, which receives a premium from the Ministry of Health that is equivalent to 56 dollars (in 2013) of capitation per each person over 60 years old, who lives and is affiliated to the insurance in the municipality. On May 2, 2014, the Act for the Provision of Comprehensive Health Services was put into force, with the increase of the municipal funding from 10% to 15.5% of the resources from the Municipal Tributary Co-participation and the unification of insurances for mother and child and the elderly, in a public insurance that should pay facilities for each service provision (as in the former Universal Mother and Child Insurance – SUMI). Nonetheless, this mechanism is still under organization. Resources allotted to the payment of personnel and to recurrent operation expenses are assigned to the Departmental Health Services, based on historical budgets and operative programs approved annually.

Co-payments

In Bolivia, the entire public health service provision, with the exception of groups of the population covered by focused public insurance, are offered in exchange for out-of-pocket payment by users. The contributions from public resources to the provision of this type of care is limited to the payment of salaries and the maintenance of infrastructure and equipment. Each health facility determines a tariff regime for their provision, based on departmental guidelines. Costs for patients are of less than one US dollar, for outpatient visits at health posts, and up to hundreds of dollars for high-complexity procedures or tests. This sale of services represents about 5% of the total income of public facilities. Medicines and inputs have no public subvention and are sold for a price that attempts to recover expenses and to plan future investments. Considering that not all medicines required are available in the public system, an important part of out-of-pocket expenditure is allotted to the acquisition of medicines in private facilities.

Since the end of the 2000s, Ecuador and Venezuela have eliminated co-payments whereas Bolivia has failed twice to implement a similar policy (Tejerina Silva et al., 2009). In Ecuador and Venezuela, all services, medicines and inputs are free of charge (since 2008 in Ecuador and since 1998 in Venezuela) for patients in public facilities and for those covered by social security. When a service is necessary and cannot be timely offered by the public system, the service is hired from a private entity under a standardized tariff, which generates a regular flow of public funds to private providers. In Venezuela, if the national system cannot solve a specific problem, the agreement with Cuba allows them to refer the patient to the latter country with all costs covered by the State.

PHC ORGANIZATION

In these three countries, there is a gradual structure of health services that starts at the national level. Bolivia is a decentralized country, with nine autonomous departments. The Ministry of Health directly manages national programs, such as Zero Malnutrition and My Health. Each department has a Health Service that organizes services in networks, in charge of a coordination team, which may include one municipality or more. Within each network, there is a heterogeneous structure, but usually, the intention is that at least one second level hospital functions as a reference to primary health care facilities (comprehensive and ambulatory services in cities and posts, ambulatory centers and inpatient centers in the rural area). Members of the same team may be technically and administratively subordinate to the three levels, once municipalities, even though might not structure formal networks, also hire personnel and manage their own facilities.

A second type of organization is represented by the Municipal Health Network. This structure includes all facilities (public, social security and private) and all other people and institutions with some type of responsibility in health, including action on the social determinants, regardless of their relation with the public system, thereby assuming intersectorality as a strategy of action and is at the head of the Local Health Board and of the Municipal Health Council as the utmost authority. The processes of coordination between the several organizations are difficult and not always successful, and fragmentation persists, in practical terms that is why the Municipal Health Network is not operative in the provision of PHC services.

In Ecuador, the system is organized in zones that group several departments and that are divided into Well-living Districts (management unit for all social services), which are the base of the organization in micro networks and cover a District and its corresponding Circuits (Ecuador, Secretaría Nacional de Planificación y Desarrollo,

2013). These micro networks articulate and integrate the following services: Comprehensive Health Care Teams (EAIS), Mobile Health Service Center (former health post), for dispersed populations of up to 3500 people, and a variable number of health centers providing services of different complexities (A, B or C), according to the population. In some places, in order to ensure conditions of effective access, capacity and/or high complexity provision, macro networks are formed, and receive this denomination due to their functional ambit, since the relationship between health facilities overcomes the territorial limits of Zonal Networks (currently Zones 9, 8 and 6). Initially, networks include social security facilities, even though, in reality, they manage and maintain their own structures. In Ecuador, fragmentation follows the segments of the system: the public subsystem and social security.

Given that the structure of this type of network in Ecuador is very little formalized, it is difficult to quantify its level of operation. Considering the existence of community social structures that work as indicators, the authorities concerned consider that there are municipal networks with structured operations in approximately half of the rural municipalities and only incipiently in some small cities, with pending implementation in the rest of the country.

In both countries, Ecuador and Bolivia, the ambit of territorial coverage of each facility and therefore, of each network, is delimited, selective and comprises the populated territory of the country (with a relatively marginal exception of Intercultural, Community and Family Health and My Health in Bolivia, whose ambit of action may overlap the ambit of regular facilities).

In Venezuela, the situation is more complex, for there are two types of parallel networks that overlap each other. The networks of the regular structure function under a scheme that is similar to the one in the other two countries: gradual complexity facilities grouped into districts. The other service network is the Inside the Neighborhood Mission. This initiative was created on May 22nd 2003, as a social project for community development, in order to answer very concrete needs of poor neighborhoods of the periphery of Caracas, providing them with access to health services, housing, environment, nutrition, recreation education and employment (Briggs y Mantini-Briggs, 2007) and promoting social and community organization, with the participation of 200 Cuban physicians and 30 Venezuelan physicians, with an initial investment of around one billion bolivars (approximately 625 million dollars). Given that the other sectors involved did not begin their activities at the same time, the plan was turned into a health assistance program.

Within the Inside the Neighborhood Mission, the first level of care is formed by Community Medical Offices of Inside the Neighborhood network I, which are also

called health modules (or octagonal due to their type of construction). These facilities are considered as providers of low complexity services, but with high case-resolving capacity (ideally in 85% of cases) thanks to professional capacity, the permanent provision of medicines to this level and its connection with higher complexity networks. Within Inside the Neighborhood network II, Comprehensive Diagnostic Centers provide care for basic specialties such as pediatrics, gynecology-obstetrics, outpatient surgery, internal medicine, basic laboratory, X-ray and emergencies, as well as health care to normal childbirths 24 hours a day (including intensive therapy rooms in two facilities visited). Full Rehabilitation Rooms are specialized facilities that offer services for physiotherapy, kinesiology, speech and language therapy, podiatry, psychology and psycho-pedagogy (some of them also offer alternative therapies such as acupuncture and homeopathy). They are in the charge of physicians specialized in physical therapy and rehabilitation. Even though this network should initially work as a referral level, it is considered as part of primary health care and it often serves as the first point of contact with the patient. Community optical stores, in coordination with facilities of the Milagro Operation Mission (network of facilities specialized in ophthalmological surgery) provide optometry services and lenses. Initially, facilities of the regular network and of Inside the Neighborhood may refer cases to each other, according to their need, but, even though there are efforts being made in this direction, this practice is still relatively marginal.

Historically, this initiative planned the operation of community medical offices for populations that were deprived of an actual preexistent provision of care. Nonetheless, this subsystem now overcomes the regular structure in its two basic network levels – the primary level, with community medical offices, comprehensive diagnostic centers and rehabilitation rooms, and the secondary level, with Community Clinics and High Technology Medical centers. Access to services has visibly improved, but the need for coordination has probably also increased and there are frequent problems. Including within the structure of Inside the Neighborhood, management is fragmented between Cuban and Venezuelan professionals, which, at the local ambit, answer to distinct structures, both technically and administratively.

PROVISION OF PHC SERVICES

Types of PHC units

In all three countries, the public subsector, represented by the ministries of health, is by far the greatest primary health care service provider, as shown in Table 2.

Table 2 - Primary health care facilities subsectors in Bolivia, Ecuador and Venezuela, 2012.

Subsector	Bolivia	Ecuador	Venezuela
Ministry of Health	2,846	1,970	18,360 (including Inside the Neighborhood)
Social security	145	1,120	
Private nonprofit[a]	123	139	-
Private for profit	74	51	1,279
Total	3,188	3,280	19,639

Sources: 1) Bolivia, Ministerio de Salud y Deportes, 2014; 2) Ecuador, Instituto Nacional de Estadísticas y Censos, 2012; 3) Venezuela, Ministerio del Poder Popular para la Salud, 2013.

a) First level private facilities, for profit or nonprofit, reported to the information systems are different in each country. In Ecuador, some NGOS receive subventions from the State; Ecuador and Venezuela hire private services from for profit private institutions when necessary and, in Bolivia, they exclusively receive out-of-pocket payment.

Health services in all three countries share some common characteristics: the most important one is that they are organized in levels of care. The diversity of characteristics of each type of primary health care facility is shown in Table 3.

The first level is the first point of contact and it is usually represented by low complexity facilities that offer services of health promotion, primary prevention of diseases and the healing of pathologies that do not require medical specialties or complex technology. These facilities may be headed by a general practitioner (specialized in PHC or not) or a health technician who may have different specialties. The teams of a typical first level facility are formed by a general practitioner and a nurse, with a variable structure of administrative and support staff. In Ecuador, the comprehensive health care team also counts necessarily with a primary health care technician (TAPS) with specific training.

Based on this, there are different sublevels of complexity among first level facilities.

In Bolivia, more than half (1,624 out of 3,229) of first level facilities are health posts with an auxiliary nurse, with one to three years of training, as their only human resource. The rest of the facilities are ambulatory health centers, health centers with hospital beds (rural), comprehensive health centers and polyclinics or "polyoffices" (of the social security). These facilities also count on dentistry services (Bolivia, Ministerio de Salud y Deportes, 2014).

In Ecuador, the Basic Health Team (EBAS) is formed by a family and community doctor, or a trained general practitioner, a nurse, a dentist, an auxiliary nurse, an obstetrician and a community promoter. Non-medicinal facilities (less than 2%) are headed by a primary health care technician (Ecuador, Ministerio de Salud Pública, 2012).

In Venezuela, almost all facilities have at least one general practitioner. In its regular network, the Rural Ambulatory Type I is headed by a rural physician during the mandatory service period (after the conclusion of his/her undergraduate program), a nurse, a community worker or, in fewer cases, they are provided with auxiliary staff (primary health

care community worker – ACAP), under the supervision of a physician or a nurse.

The service structure of Inside the Neighborhood does not conceptually recognize an organization by levels, but by complementary networks (Guedez, 2009). The Primary Network, which may be assumed as the first point of contact of the population with the system, but in a gradual manner, is formed by Community Medical Offices, Comprehensive Diagnostic Medical Centers and Full Rehabilitation Rooms.

Every facility performs activities of information, communication and education in health. A particular characteristic in Bolivia is that every first level team provides care to natural childbirths at the facility and at home, besides the articulation with practitioners of traditional medicine in the community. Historically, maternal and child care has been prioritized during the 1990s and 2000s all over the region, but in Bolivia both infrastructure and equipment, as well as, to a great extent, the institutional culture of all public facilities, has been almost exclusively concentrated on childbirth and neonatal care (Tejerina Silva et al., 2012). This legacy of selective primary health care is still reinforced in Bolivia by the persistence of the public insurance focused on maternal and child care.

In Bolivia, there are also Comprehensive Nutrition Units of the Zero Malnutrition Program, initially one for each service network, generally placed in comprehensive health centers or in inpatient care centers, with which they coordinate their activities, despite the preservation of an independent management.

Chart 2 summarizes the characteristics of PHC facilities according to the population covered, the health team and the services provided in all three countries.

Chart 2- PHC facilities according to the population covered, the health team and the services offered in Bolivia, Ecuador and Venezuela

Bolivia	Ecuador	Venezuela - Inside the Neighborhood	Venezuela -regular
Health post 500 to 1000 people; Auxiliary nurse or technician; Emphasis on preventive and promotional services, eminent normal childbirth.	Health post Less than 2000 people; Health promotion, prevention of diseases and first aid; Auxiliary or technician nurse;	Community medical office 1250 people or 250 families; Comprehensive general practitioner, nurse and community personnel.	Rural ambulatory type I Less than 1000 people; Recently graduated rural physician, nurse, Primary health care community worker.
Safci brigade Traditionally excluded populations; Emphasis on health promotion, services and medicines free of charge; general practitioner or Safci specialist, variable nursing team.	Mobile comprehensive care team Remote areas; Family or general practice, general dentistry, nursing.	Comprehensive diagnostic center [a] Imaging and laboratory; hospitalization, intensive therapy and ambulatory surgery.	Rural ambulatory type II Less than 10,000 people; General practitioners, nurse and community personnel.
Ambulatory health center 10,000 to 20,000people; General practice, dentistry, nursing, articulated with traditional medicine.	Health center A 2000 to 10,000 people; Family or general practice, dentistry, nursing.	Full rehabilitation room Care to temporary or permanent disability with occupational therapy, language and speech therapy, clinical psychology, orthopedics, podiatry, pain therapy, orthoprosthesis and alternative therapies.	Urban ambulatory type II More than 1000 people; General or family practitioners.
Comprehensive health center In the rural area, from 10,000 to 30,000; in the urban area, from 20,000 to 50,000 people; Medical visit, dentistry and normal childbirth care, non-surgical inpatient care, imaging.	Health center B 10,000 to 50,000people; Family and/or general practice, dentistry, psychology, obstetrician, nursing, nutrition, social work, clinical laboratory, basic imaging, audiometry, institutional pharmacy.		Urban ambulatory type II More than 10,000 people; General or family practitioners; obstetrician and pediatrician, laboratory, radiology and emergency.
Health center with beds Rural area; 1000 to 10,000 people; Same services of the Comprehensive Health Center.	Health center C 25000 to 50,000people; All services of Health Center B plus short stay maternity unit.		
Polyclinic or “polyoffice” (social security) General practice visits, several medical and dentistry specialties and imaging.	General medical office (social security) Family or general practice, obstetrician, general dentistry and psychology.		
Comprehensive nutrition units One for each service network; Nutritionists, nurses and community personnel.			

a) Is part of PHC, even with the provision of second level services.

Initially, each first level facility has a target population assigned to it, based on the population of the geographic zone under their responsibility. Considering that the population is free to choose service providers within their geographic region, this is not really relevant concerning the activity performed within facilities (healing care, vaccines, prenatal control, and childbirth care), but it is important for community activities (home visits, vaccination campaigns, files such as family records, etc.). Table 3 shows the number of PHC facilities in each country per each 10 thousand inhabitants.

Table 3 – Ratio of PHC facilities (selected types) per each 10,000 inhabitants in Bolivia, Ecuador and Venezuela, 2012

Bolivia		Ecuador		Venezuela	
Health center	1.54	Health subcenter	0.90	Popular medical office	2.22
Health post	1.47	Outpatient care clinic	0.81	Rural ambulatory type I	1.13
		Health post	0.21	Rural ambulatory type II	0.32
		Health center	0.14	Urban ambulatory type I	0.23
				Comprehensive diagnostic centers	0.20
				Full rehabilitation room	0.20
All PHC facilities	3.08	All PHC facilities	2.10	All PHC facilities	5.05

Sources: Elaborated by the author based on data from: Venezuela, Ministerio del Poder Popular para la Salud, 2009a; Venezuela, Ministerio del Poder Popular para la Salud, 2009b; Ecuador, Secretaría Nacional de Planificación y Desarrollo, 2014a; Ecuador, Secretaría Nacional de Planificación y Desarrollo, 2014b; Bolivia, Sistema Nacional de Información en Salud, 2014. For Venezuela, there was also an electronic file provided by the person responsible for the system during the visit.

Table 4 provides a contrast between the current availability and use of primary health care teams and the delivery intended by rules and policies of each country, presented in Chart 2.

Table 4 – First primary health care visits per year and population per facility in Bolivia, Ecuador and Venezuela, 2012

Indicator	Bolivia	Ecuador	Venezuela
First visits per person per year	1.3	1.5[a]	3.8[b]
Population per facility	3,414	4,723	1,525

Sources: Elaborated by the author based on data from: Venezuela, Ministerio del Poder Popular para la Salud, 2009a; Venezuela, Ministerio del Poder Popular para la Salud, 2009b; Ecuador, Secretaría Nacional de Planificación y Desarrollo, 2014a; Ecuador, Secretaría Nacional de Planificación y Desarrollo, 2014b; Bolivia, Sistema Nacional de Información en Salud, 2014. For Venezuela, there was also an electronic file provided by the person responsible for the system during the visit.

a) Only includes public facilities. With the inclusion of private facilities of the complementary network, the ratio is 1.8 visits per person/year

b) 2.9 of the visits correspond to the Inside the Neighborhood network.

In Venezuela and Ecuador, every health team takes responsibility for all the families within the jurisdiction of their facility through a mechanism for affiliation or continuous

medical assessment and risk evaluation. In Bolivia, this process is still incipient and is carried out through the completion and control of family files in the community, which has not yet been completed.

Curative home care is part of the regular functions of primary health care teams in Ecuador and Venezuela, but not in Bolivia, where usually only Safci brigades (and the My Health Program) perform this role. The auxiliary nurse of rural facilities dedicates half of his/her time to visit communities, majorly for vaccination, to control the growth of younger children and to complete Family Files, with home care as a secondary and eventual activity. Whenever teams, especially in the rural area, make home visits in order to promote health through vaccination campaigns, they usually find cases of pathologies that, depending on the will and resources of the team, may be treated at the first level with simple prescriptions or usually with some guidance. However, in Bolivia, the interaction with community authorities to address problems concerning the health determinants seems to be greater than in other countries.

Main services provided in PHC

Sanitary policies of all three countries explicitly orient primary health care services towards integrality, understood as the ability of teams at first level to solve most of the health problems of the population with actions for promotion, prevention, treatment and rehabilitation offered at the same facility and by the same team. Initially, all primary health care facilities of the three countries are conceived to ensure comprehensive service packages.

Nonetheless, the level and the method for the attainment of this command depend on human, physical and technological capacities available in each case. In Bolivia, health posts (almost half of the PHC public facilities) are exclusively headed by an auxiliary nurse, whose level of training (one to three years of education in technical schools) greatly limits his/her possibilities of diagnosis and treatment of medium complexity pathologies. In Venezuela and Ecuador, the provision of care by assistants is marginal and limited to remote populations.

The case-resolving capacity is greater in teams directed by a physician specialized in primary health care (comprehensive general practitioner in Venezuela, family and community doctor in Ecuador or physician specialized in Safci in Bolivia) than in those under the responsibility of a professional without this specialization. Therefore, the integrality of each system also depends on these professionals' level of comprehensiveness. All Venezuelan services of the Inside the Neighborhood count on a specialist in general and comprehensive practice and training of new human resources (to cover the regular network and substitute Cuban professionals) is accelerated. In Ecuador, coverage is smaller, but there are also plans and programs to rapidly specialize first level teams, whereas in

Bolivia the policy does not explicitly contemplate this aspect (the priority is still to staff non-medicinal posts with general practitioners) and its saves the few specialists in Safci for community actions and specific programs.

On the other hand, services in Venezuela and Ecuador (especially in the Inside the Neighborhood network, in the former) are strongly oriented towards treatment activities and health follow-up; on the contrary, Bolivia has prioritized community-based promotional services.

In Bolivia and Ecuador, the same polyvalent team of the first level of care (with specific limitations for centers without doctors) is conceived to provide care to all low and medium complexity problems (except for malnutrition in Bolivia, which has specialized services) and also refer to general hospitals patients in need for more complex resources. The regular network in Venezuela still works with a similar logic, but the Inside the Neighborhood model organizes its services into complementary networks in which ambulatory specialized services are also provided in facilities specialized in outpatient care for specific cases: full rehabilitation rooms for locomotor, learning problems, etc., and Comprehensive Diagnostic Centers for exams and laboratory procedures, imaging, endoscopy and some medical specialties.

In Bolivia, health posts headed by auxiliary nurses divide their activities within the facility between outpatient care, in which the provision of treatment is limited to basic medicines (over-the-counter) and minor healing; preventive activities, the control of growth and development of children under five years old and vaccination. Similar structures exist in Ecuador and Venezuela, but rather marginally in quantity. The Comprehensive Nutrition Units of the Zero Malnutrition Program, which are initially one for each service network, are usually physically located in facilities with which they coordinated activities, with independent management. Historically, many health facilities have improved during the 1990 and 2000s in order to become maternal and child care centers (the name remains the same in most cases), which is why its infrastructure, equipment and, to a great extent, institutional culture are concentrated in childbirth and neonatal care (Tejerina Silva et al., 2011).

Even though they may have varied formal definitions, the array of primary health care services in all three countries include, in all cases, promotion, prevention, care to prevalent pathologies and nursing and emergent care. Then, according to the level of complexity, it usually includes general practice, dentistry, radiology and imaging care (radiology and echography) and laboratory (hematology, blood chemistry, direct microscopic diagnosis and, in some cases, rapid HIV test).

In Bolivia, all levels must provide care to natural childbirth and to the newborn with cultural adequacy. Higher complexity primary health care facilities – comprehensive centers in Bolivia, type C centers and type II ambulatories and comprehensive diagnostic centers in Venezuela – provide maternity and short-term inpatient care. Ecuador and Venezuela

provide care to childbirths at specialized facilities in the urban area.Ecuador organizes its services in comprehensive health care packages according to life cycles: comprehensive care to women, children, adolescents, adults, the elderly, to the human environment and epidemiological promotion and control.

The "My Health" program and Cuban cooperation in Bolivia

Cuban cooperation in health has moved a contingent (1,848 in 2008) of health professionals, including specialists in comprehensive general practice and epidemiologists, to selected zones of Bolivia in order to offer medical care free of charge with variable levels of coordination with the structures of the regular health system. In parallel, there was the implementation of the Milagro Operation program, which established 18 centers specialized in ophthalmology. Fifty hospitals have been strengthened with cooperation equipment and personnel. Around 5000 Bolivian young people have been given study grants to study medicine at the Latin American School of Medicine (ELAM) in Cuba.

The "My Health" program started in 2013, mostly with professionals returning from Cuba (150 physicians) to work in 13 prioritized municipalities.

The program has the double aim to provide access to marginalized populations and to implement the family and community health care model integrally as an experience. It has two essential components:

Mobile Safci brigades that, with a team of physicians (most of them recently graduated from the ELAM, but also 11 Safci specialists) and nurses, visit poor neighborhoods in order to offer medical home care free of charge and to collect data about the social determinants of health with the tool called family file. They may have an operation center at the nearest facility or in places lent by the community or the municipality.

The strengthening of first level of care facilities with the improvement of their structure, provision of equipment and radiology laboratory technicians.

Unlike care in the regular system, the program provides medicines and performs complementary exams free of charge to patients, including those not covered by public insurances.

The program could contribute to the deepening of the fragmentation of the service system, since its personnel has different technical and administrative subordination, network management teams and facilities do not officially know or control their activity and they also have parallel supply and information systems.

In Bolivia, the My Health Program represents a possibility of an initiative for a cooperation strategy with Cuba, assumed by the government in order to implement a desired health policy (gratuity of services in a model based on family and community care) within a context in which the transformation of the structures established is not in accordance the desired policy, and thereby is not considered a realistic option. The beginning of the Inside the Neighborhood Mission, in Venezuela, was a similar example.

Maternal, child and family planning health care services have been highly prioritized and strengthened in all three countries by the reforms in the 1990s (with decreasing intensity in Bolivia, Ecuador and Venezuela). The new policies that emphasize comprehensive care, the promotion of health and the primary prevention of diseases intend to integrate these components in their services, without losing the capacities already developed in maternal and child care. In Venezuela and, to a lesser extent, in Ecuador, official documents and declarations assume this integration as an achievement.

In Bolivia, considering the presence of the public insurance focused on maternal and child care, health care to this group of the population continues to be the priority axis of services. In this country, perinatal care and especially childbirth care is considered an essential task of all primary health care teams, including lower complexity ones. In Ecuador

and Venezuela, including the functions of the first level, childbirth care is prioritized in medium complexity facilities and also in specialized hospitals (maternity ward).

The control and treatment of communicable endemic local diseases is a priority of services in all three countries. There are specialized epidemiology programs in all cases, with a remarkable vertical approach in Bolivia and Venezuela and, to a lesser extent, in Ecuador. The access to essential medicines, or at least part of it, is covered by the public service provision systems in these three countries. In Venezuela, both the public traditional provision and the provision of Inside the Neighborhood have lists of medicines that must be provided free of charge to all patients that require them. In the regular system, especially in hospitals and less in the primary network, there may be eventual shortages, according to declarations by the authorities, due to shortages in providers of the national level, most likely due to similar reasons of other massive consumption products (speculation and concealment). This is not usually seen in Inside the Neighborhood. Social security institutions in Venezuela also provide essential medicines, and when a product is not available at the facility, its cost of acquisition in a commercial drugstore may be refunded to the patient.

Similarly, primary health care facilities in Ecuador make available and provide the medicines defined for the first level to all patients free of charge. Shortages are not usual.

In Bolivia, medicines are only covered by the public system for beneficiaries of public insurance (almost entirely for children under five and pregnant women and a limited list to adults over 60, which may vary according to their place of residence). The remaining patients have institutional pharmacies that sell medicines with prices lower than in commercial stores.

COORDINATION OF CARE AND INTEGRATION OF PHC INTO THE SERVICE NETWORK

In all three countries, each health facility is subordinate to a well-defined management body and has specific territory and population under its responsibility. In all cases, the first level facility closest to their residence is the preferential entry point to the system. However, patients are actually free to choose the health provider that will function as their first contact and no public facility (including hospitals) can refuse the provision of care to those who seek assistance (with the possible exception of those who cannot afford the cost of the registration in Bolivia) or who seek an emergency room.

Bolivia and Venezuela usually continue to provide care through visits in a first-come first-served basis. In Ecuador, a visit arrangement system by phone has been implemented. Except for Bolivian hospitals that offer specialized outpatient visits and that can actually be considered as first level, there are no long waiting lines for primary health care. On May 2, 2014, the Act for the Provision of Comprehensive Health Services was put into force in Bolivia (Estado Plurinacional de Bolivia, 2013). This act establishes out-of-pocket payment

for non-emergency care or urgencies that are received at second and third level public hospitals without the referral from a primary health care facility. The application of this rule is still under organization.

Operating policies herald a comprehensive approach to primary health care, but all three countries continue to have programs to provide care to health problems or to vulnerable groups considered a priority. In Bolivia, the strategy called the continuation of care (during the life cycle) is still steeped by the prioritization to maternal and child health. Malnutrition has a strong sectoral and intersectoral program; multidisciplinary brigades have started an active screening of people with disabilities; the kidney health program tries to prevent and treat cases of insufficiency and vector-borne diseases and the HIV are still under the burden of vertical programs. In Ecuador, there are focused programs which are being integrated to primary health care services, such as the Adult Preventive Health for non-communicable chronic and infectious diseases, the Intersectoral Strategy for Family Planning and Prevention of Pregnancy in Adolescents, the Plan for the Accelerated Reduction of Maternal and Neonatal Mortality and the National Plan for the Eradication of Gender Violence.

These three countries have well-structured rules for referral and counter-referral that include the preferential entry point, gradual provisions (which exclude each other) to each level and the procedures for the transportation of patients between facilities. Nonetheless, systems and their networks are still under implementation, with different levels of development and, in all cases, functioning a high level of informality and with difficulties of transit between primary health care services and hospitals, especially with respect to counter-referral.

Access for patients referred to high complexity levels is not considered a major issue in Ecuador. In Venezuela, the greatest challenge seems to be the lack of coherence between the model of care and the medical culture of hospitals of the regular networks and the new model promoted by Inside the Neighborhood. The access to the hospital level is a concern in Bolivia, mainly because all costs of high complexity procedures are prohibitive to most of the population not covered by public insurances.

Coordination between the different elements of the primary health care system is headed by management teams in each country. The Network Coordination in Bolivia, the District Board in Ecuador and the Community Comprehensive Health Area must ensure that facilities, brigades and other components of the system provide access, continuity and quality of services. In Ecuador and Venezuela, these management teams are almost exclusively assigned with the coordination, supervision and technical monitoring of services (including health promotion and community participation). In Bolivia, besides these functions, management teams of each network are in charge of the financial management of economic resources generated by each facility with the sale of services and,

mainly, of management of disbursements in view of municipal governments and the use of payment for services covered by public insurances. These tasks consume an important part of their time and work.

PHC WORKFORCE

Characteristics of PHC teams

In the public systems of Ecuador and Venezuela, according to their rules, the leader of primary health care teams must be a physician specifically specialized in the PHC function: family and community doctor, in the former, and a comprehensive general practitioner in the latter. Nurses or support staff complete the basic team, which may also be staffed with professionals such as physical therapists, psychologists, nutritionists, etc., besides some physicians with specialties such as gynecology and pediatrics, depending on the specificities of the facility. In Ecuador and Venezuela, this team must also include technicians specialized in community actions: primary health care technician (TAPS), in the first country and community primary health care worker (ACAP), in the second one. In Bolivia, there is a person in the staff specialized in community actions. Since the 1980s, a number of community health workers have been trained (in the public sector and in NGOs) to work as community volunteers that cooperate with the teams of each facility. Personnel is coordinated with most of the rural services, but they have no formal relationship with the health system and have no legal responsibilities.

In the social insurance system in Bolivia, the physician specialized in Family Medicine is the primary service provider, but he/she is allocated in urban "polyoffices" without an actual primary health care team. In this country, the rules establish that first level public facilities are under the responsibility of a general practitioner. Even though there is a medical specialty designed for primary health care (physicians specialized in Intercultural, Community and Family Health), they are not considered the leaders of the team at first level facilities, but their scope of operation is the community, where they lead mobile brigades mainly in charge of promotion and preventive care.

The reality of these three countries also shows differences in regard to what is established by their rules. Health technicians, not physicians, are the ones who provide care at the most remote facilities (especially in Bolivia) and recently graduated general practitioners are in charge of other rural facilities. Ecuador and Venezuela have implemented programs to address these deficits. The differences in the availability of human resources for primary health care among all three countries are very clear (Table 5).

Table 5 – Availability of human resources in the health sector in Bolivia, Ecuador [a] and Venezuela, 2012

Indicator	Bolivia[1]	Ecuador[2]	Venezuela[3]
Ratio of physicians per thousand people	0.5	1.7	3.8[b]
Ratio of professional nurses per thousand people	0.2	0.8	n/a
Ratio of dentists per thousand people	0.1	n/a	n/a

Sources: 1) Bolivia, Ministerio de Salud y Deportes, 2014; 2) Ecuador, Instituto Nacional de Estadísticas y Censos, 2012; 3) Venezuela, Ministerio del Poder Popular para la Salud, 2013.

a) 2011

b) Includes Cuban professionals of the Inside the Neighborhood Mission

Bolivia suffers from a serious deficit of professionals, whereas Ecuador has reached average rates and Venezuela largely surpasses the other two. Although there is no data available for the three countries, authorities in Ecuador and Venezuela consider the chronic deficit of professional nurses as one of the problems of their systems. The availability of dentists does not seem to be an issue of concern in these three countries, probably due to the yet low incorporation of oral health in the public systems.

Primary health care staff are partially hired as public workers in all three countries, that is, with unspecified duration contracts, fixed salaries and all social provisions granted by law. However, eventual employment contracts are also common in Bolivia and Ecuador. Since 2008, after the declaration of health emergency, Ecuador has carried out massive contracting of new personnel through short-term contracts. In 2014, the process for the regularization of labor relations with these human resources was still in progress. By its turn, Bolivia tries to overcome this deficit of professionals, especially of physicians and nurses, by hiring new staff as consultants. An undetermined (but considered important by authorities) amount of human resources has been working for at least eight years with annual contracts (in the Ministry of Health and departmental and municipal governments) with diverse methods of remuneration, which are usually lower than the ones received by the regular staff, without employment stability or social provisions.

Human resources training for PHC

Until the end of the 1990s, none of the countries had made serious efforts to provide primary health care with enough trained staff to cover the total population. With reforms that prioritized this strategy in the first decade of the 2000s, they also started to implement programs to strengthen human resources for PHC.

In Bolivia, the Medical Residency in Intercultural, Family and Community Health is a medical graduate education program based on the most underserved zones of the country, which aims to impact on the local social determinants of health. Besides the three years of academic education, these physicians provide promotional, preventive and curative services to the population, in coordination with the health facilities of the public network.

At the end of their education, these professionals must be integrated to the

intercultural, family and community health brigades and to the My Health program, but there is not a clear plan for them to substitute the general practitioners who are currently in charge of first level facilities. Considering the approximate number of 80 graduates per year, and with the addition of a similar number of those who return from undergraduate programs in Cuba, it is expected that primary health care services will be under the responsibility of professional with a different profile within the next ten years.

In Ecuador, the Ministry of Health has started a grant program in Family and Community Medicine that aims to train 5000 specialists until 2017 (Ecuador, Secretaría Nacional de Planificación y Desarrollo, 2013). With this program, general practitioners (generally those working at first level facilities) access a three-year training program that is developed at their own working place, together with Family and Community Medicine specialists of the network, who act as assistant instructors. After three years of study, the specialist is automatically hired for another three years in the system (ideally in the same network where he/she graduated) as a compensation for his/her grant. This contingent, together with the approximately 2500 physicians that currently graduate from the Latin American School of Medicine in Cuba, should cover the need for professionals committed with the new primary health care model. Despite what is established by the policy, the intensive training of Primary Health Care Technicians, who should participate in the entire PHC according to the rule, has not yet begun[1].

The Venezuelan government, through the Inside the Neighborhood Mission, implemented in 2004, a three-year graduate program in Comprehensive General Medicine, with an academic program that is identic to the Cuban homologue. The program includes clinical and surgical training for the resolution of the prevailing pathologies with emphasis on the approach to health as a right, the promotion of health and community actions. Students spend three years of education in facilities of the primary and secondary network within a Community Comprehensive Health Area, and it is expected that they are incorporated to it as in-house personnel providing supervised care. It is expected that the more than 5000 experts in Comprehensive General Medicine who graduated and are almost automatically hired by their respective area, are put in charge of the facilities of the Inside the Neighborhood network and progressively substitute professionals from the cooperation program with Cuba. There is a training program in Community Comprehensive Nursing planned to start in 2015.

It is important to note that even before the intensification of cooperation with Cuba in health, these countries have been sending young high school graduates to the Latin America School of the Americas in Cuba to conclude their undergraduate program in medicine. The new professionals return to their countries immediately after graduation and

[1]Interviews with the National Director of the First Level of Health Care and the National Director of Human Talent Management for Health of the Ministry of Public Health in Quito, in January 2014.

are integrated to primary health care services.

Since 2003, in Venezuela, members of the community receive clinical capacity building with special emphasis on the promotional and preventive approach of the new comprehensive community health care model in rural facilities, both within the regular network and in Inside the Neighborhood I, as community primary health care workers. 2,380 workers have been certified by 2013[2], and now integrate the teams of the ambulatory rural centers type I (in many cases as the only human resource)

The postgraduate program in Comprehensive General Medicine in Venezuela

Inside the Neighborhood was conceived as a response to the chronic lack of facilities, and mainly of medical personnel specialized in primary health care all over the country, with the exception of big cities' central area. The staff of the Cuban Medical Mission rapidly supplied this deficit since 2003, with an increment of 110% in the provision of services and, in parallel, there was a program for the training of Venezuelan physicians in order to ensure the sustainability if the system.

Traditionally, the university system trained one hundred specialists with an academic diploma in family medicine every year. In parallel, since the end of the 1970s, the Ministry of Health trains physicians called "assistance specialists", through a program residency that used to grant diplomas with no academic degree.

In 2000, the Malaria and Tropical Diseases Institute Arnaldo Gabardón was re-inaugurated as the Institute of High Studies in Health (IAES) and it was accredited by the council of universities to award postgraduate diplomas in areas of tropical medicine and public health.

In 2004, the recently created Inside the Neighborhood Mission and the Ministry of Health, through IAES, started a three-year postgraduate program in Comprehensive General Medicine, with full grants given by the State, and an academic program identic to the Cuban homologue, all instructors and coordinators being Cuban operating academics.

The academic program includes clinical and surgical training in order to solve at least 85% of the prevailing pathologies, besides a strong emphasis on the approach to health as a right and its promotion, understood as the action on the social determinants of health and community actions. Physicians are submitted to a three-year training program in facilities of the primary and secondary network of a Comprehensive Community Health Area and provide supervised care while they receive academic contents and are evaluated by assistance teams, which are also trained as teachers and responsible for their education.

During the first management periods, 984 Venezuelan physicians have been admitted. During the following 6 years, the program incorporated those who graduated from the Latin American School of Medicine in Cuba and, during the last two management periods, the first generations of Comprehensive Community Physicians trained in the country, in a total of almost 5000 graduate or undergraduate specialists until 2013. This contingent is in charge of the facilities of Inside the Neighborhood I and, progressively, shall substitute for Cuban professionals. By the time of their graduation, these specialists are almost automatically hired by the administration of their respective area.

Venezuela has also started an undergraduate training program in Community Comprehensive Medicine (Venezuela, Ministerio del Poder Popular para la Salud, 2014a), with 20,000 students in 2014 and over 16,000 graduates (Rojas, 2014). The program is developed with students operating in PHC services at academically certified clinics of Inside

[2]Interview with the Director of the Institute of High Studies in Health Dr Arnaldo Gabardón – IAES, in Maracay, in March 2014.

the Neighborhood under the responsibility of six Venezuelan universities, with an important presence of Cuban teachers (Venezuela, MPPS y OPS, 2013). The intention is that, during the six years of training, students feel linked to a first level facility of their place of origin. It is expected that this contingent of approximately 6,000 graduates per year, together with specialists in Comprehensive General Medicine, will be able to be employed at all posts of the primary health care network within the next five years[3].

Primary health care teams function as instructors for under and postgraduate education national programs in both Venezuela and Ecuador. Bolivia does not have this type of organization.

INTERSECTORALITY IN PHC

The paradigm that sustains social development policies in all three countries is the "Living Well" in Bolivia and Venezuela or the "Well-living" in Ecuador, which may be interpreted with a wide and holistic definition of health. From this point of view, the whole activation of the public policy may be interpreted as an intersectoral action for health. Specific actions as the ones taken for the reduction of poverty, as income transfers to vulnerable groups – the human development bonuses and noncontributory pensions in Ecuador, the Family Subsidy in Venezuela, the health and education bonus in Bolivia and the subvention to massive consumption products; the program for the eradication of illiteracy in Bolivia, social housing, water missions, etc., in Venezuela – are initiatives that will very likely have positive impact on the social determinants of health.

On the other hand, policies in the three countries defend health promotion as the main axis of their strategy, conceived as the impact on the social determinants at the local level. The family file or record is the tool through which each health system must identify negative determinants to orient responses in the community and local governments. The implementation of this instrument for the collection of the living conditions of each family is relatively recent and still partial in the three cases (decreasingly in Venezuela, Bolivia and Ecuador). There are no records of concrete results of this initiative.

An example of a national intersectoral program is Zero Malnutrition in Bolivia. Since 2007, the National Council for Food and Nutrition coordinates public institutions in education, health, rural development, plural economy, water and environment. For this initiative, 11 ministries, all departmental and municipal governments and also numerous NGOs participate in actions for alphabetization, complementary school nutrition, drinkable water, sanitation, micro irrigation, food production and distribution, breastfeeding, complementary nutrition, in addition to micronutrient supplementation, nutritional rehabilitation and food fortification. The sectorial health

[3]Interview with the Director of the Institute of High Studies in Health Dr Arnaldo Gabardón – IAES, in Maracay, in March 2014.

department of this initiative is the Comprehensive Nutrition Unit, a first level specialized facility generally close to the facility at the top of each service network (the highest complexity facility).

In Ecuador, there is a Ministry for the Coordination of Social Development, which is responsible for linking the ministries of Sports, Housing, Education, Environment, Human Mobility and Health. Its planning basis has implemented a new administrative division of the country in zones and districts to implement intersectoral programs as the Living Well Schools, Basic Sanitation and Safe Water and many other for comprehensive social development as, for example, the prevention and fight against the consumption of tobacco, alcohol and drugs, the avoidance of the consumption of contaminated food and the control of the exposure to agrochemicals and other toxic substances.

In Venezuela, there are "territorial corridors" created to organize, with the participation of state governments and municipalities, services provided by a diversity of social missions: alphabetization and education; registration and identification of childbirths; care to homeless children and adults; commercialization of subsidized food; capacity building for work; ophthalmological care; access to housing; access to and dissemination of cultural expression; access to science and technology; land tenure and production, besides others for comprehensive care to mining communities and indigenous peoples. Nevertheless, the results of this coordination are not documented.

At the local level, primary health care teams of all three countries relate with other sectors for specific activities, such as school health actions, community health fairs, cleaning campaigns and sanitation of public concentration spaces (markets, streets, etc.). In Venezuela, health teams must encompass the comprehensive local development initiatives, such as the ones in New Neighborhood. PHC teams also interact regularly, but at a variable intensity, with local authorities and those responsible for the community, in order to develop comprehensive developmentactions.

SOCIAL PARTICIPATION IN PHC

Each one of the national management models includes the participation of the community as one of its pillars. In the three cases, regulations and policies establish structures and deliberation spaces for the organization of this participation.

In Bolivia, with the recognition of the Local Health Authority as the legitimate representative of the community or neighborhood within the health system, there have been committees and councils created at the local, municipal, departmental and national levels. These instances are built for planning, follow-up and control, and they operate together with the health team of the corresponding health instance, which must integrate

this social representation in the decision-making process (Bolivia, Ministerio de Salud y Deportes, 2007). At the same time, there are deliberation spaces in which the social and institutional structures must meet in order to reach a consensus: at the local level, the type of meeting depends on the customs and habits, at which point municipal boards, departmental and national assemblies are implemented. The operative plans and programs of each level must necessarily be approved by these bodies.

In Ecuador, social organization is conceived as a counterpart of the control of the exercise of the right to health and the operation of service networks. Each operating first level health unit must have a Local Health Committee, but their development is still variable and incipient. Ecuador usually invites representatives of the community to participate in planning and in the accountability of the period. The Sectorial Citizen Health Council (still in organization) must work as the consultative body in the formulation and implementation of public policies. Cantonal Councils for the Protection of Rights follow up and evaluate municipal public policies of all sectors. The Peasants' Social Insurance actively promotes community organization, with the formal goal to collect contributions from families. However, this organization has enabled users and health care teams to acquire a culture of combined and negotiated decision-making (Ecuador, Ministerio de Salud Pública, 2014).

In Venezuela, social participation in management of the entire public structure is defined by law (the 7 Acts of the Communal Power) and it aims to have states and municipalities organize neighborhood groups and decentralize and transfer the administration of social services to communities that demonstrate capability. "Health Defenders" are people elected by the community to be trained and to provide support to primary health care teams in their integration with the community. The vast majority of facilities of the Inside the Neighborhood network I and some ambulatory centers of the regular network count on this type of community personnel. Communal Councils include Health Committee, which control and propose health actions. In 2006, there were 8,951 committees. The list is being updated and the Health Strategic Plan that is being elaborated contemplates the institutionalization of citizen assemblies as a base for planning in all areas and of comprehensive health centers in order to have participation with a political decision nature, beyond its instrumental characteristics (República Bolivariana de Venezuela, 2009).

INTERCULTURALITY IN PHC

The intercultural approach to health services and the integration of Traditional Ancient Medicine are part of the health policies in all three countries. The integration of traditional physicians to the health system is more advanced in Bolivia, where the Ministry has recognized a first group of 200 traditional physicians and where some health facilities

are staffed with traditional midwives and physicians as part of their regular staff with fixed duration contracts. Ecuador has started some processes to recognize ancient therapists and currently develops a specific policy to this end, whereas in Venezuela, this process is still marginal, and actions are limited to the comprehensive health program for the Yanomamis.

Intercultural obstetrician care

Andean cultures, especially in Bolivia and Ecuador, have a long standing tradition of obstetric care by traditional practitioners, usually called midwives.

This care refers both to care of the physical health of the mother and child and to aspects of their emotionaland spiritual health.

Several initiatives have tried to integrate this wisdom and practices with perinatal care of the regular health services, especially with the aim to improve institutional care coverage.

Bolivia and Ecuador have integrated intercultural obstetric care in their national health policies.

Implementation practices are numerous, but there are some common characteristics:

Traditional midwives are integrated to health teams or at least they coordinate their activities with them. He/she participates in perinatal control (in combined or independent sessions) with his/her own diagnoses and advisory, which must be compatible with national rules.

For example, he/she does palpation to know the position of the baby and, eventually, he/she may try to correct an abnormal position. In the first stage of labor, the midwife does not perform vaginal acts, but he/she only palpates "the vein", which turns hard at the beginning of labor, and offers the parturient highly energetic food and natural teas.

When the time comes for pushing, he/she massages the abdomen and puts a blanket under the back and applies movements. During the expansive period, he/she helps the women in a vertical squatting position for delivery. Finally, during the puerperium, he/she helps to prevent or cure complications, which include hemorrhage and infections, but also includes several others, according to the traditional nosology of each culture.

Whenever the health system aims to incorporate this practice in institutional care, it is necessary to have the adequate environment and equipment.

The experiences have been very positive in general, which has led the ministries to try to generalize this practice as an alternative offered to all women, mostly in indigenous areas. Nonetheless, the result of this expansion is still very diverse and the most successful experiences are still limited to specific projects and initiatives (for example Patacamaya, in Bolivia and Jambi Huasi in Ecuador), and, in most cases, limiting regular facilities to the implementation of teams and training for vertical childbirth care.

The experience of Jambi Huasi (Health Unit)

In 1984, there was an indigenous movement in Ecuador that claimed for land, identity and health in view of the poor access of indigenous populations to basic social services due to economic, social and especially cultural barriers.

The Jambi Huasi cultural movement initially expected to organize health services free of charge, from indigenous people to indigenous people. Since 1994, with an agreement with international cooperation organizations (United Nations Fund for Population and several North American and European NGOS), it evolved to an intercultural health service with emphasis on sexual and reproductive health care and health promotion. It had strategies such as education, research and self- management.

The Jambi Huasi foundation currently manages a comprehensive intercultural health care center (clinic) in the city of Otavalo. The facility integrates health care services in Western and Andean ancient medicine.

The goals of the Jambi Huasi are:

- To provide health care, considering the social and cultural status and the cosmovision of the population of the province of Imbabura (majorly kichwa, but also African American and with other nationalities);
- To institutionalize integration between indigenous and western medicine;
- To develop projects and programs in health and indigenous education;
- To revalue indigenous medicine and the role of its Jambigkunas (health workers);
- To keep records of the experiences for research and dissemination.

The principles that guide this initiative are: solidarity, reciprocity, integrality, respect and complementarity.

The Ministry of Public Health supports the facility with a physician (in mandatory rural service), a dentist, a nurse and an obstetrician. The foundation also has as permanent personnel a Yachak ("wise doctor"), a Jakuk (Andean traditional physiotherapist), a Kuyfichay (guinea pig healer) and a Pakarichik mama (midwife).

All staff must be able to communicate both in Spanish and in Kichwa and work based on the principles of respect and complementarity between the Western and Andean medicine cultures. This implies a continuous effort from the facility to raise awareness and train the staff assigned by the ministry, which rotates annually.

The model of comprehensive health care in Ecuador gives special emphasis to the intercultural approach to health, which makes the Jambi Huasi a very important experience. Sources: Conejo, 1998;2013.

FINAL CONSIDERATIONS

Bolivia, Ecuador and Venezuela have started, in the recent past, deep process of political, social and economic transformations that, with some exceptions, achieved significant improvements in the quality of life of the majority of their populations. The health sector, and specifically the primary health care sector, are no strange to this process. The base for the reforms are the new political constitutions of each one of the States. The guarantee of the right to health, the priority of health promotion and prevention services and their gratuity for users are principles that are common to the three countries. The management and health service provision models are also similar and the emphasis on community and family health with an intercultural approach, based on the idea of the "Well-living or Living Well", is also a key element of the three health policies.

Nonetheless, the operation of the constitutional mandates and political principles is under implementation, with different levels of progress, in all three countries. The undesirable fragmentation and segmentation of systems which, to a great extent, result in social exclusion inherited from previous models, are still present, most likely in Bolivia than in Ecuador and Venezuela.

More specifically, the fact that almost half the Bolivians do not have financial

protection for their need of health services – in a country that has doubled its gross domestic product in ten years – and that a number of people is still excluded from care due to economic barriers, is ethically unacceptable and socially and economically inefficient. The gratuity of services for users has been an important attainment towards social inclusion in health and the reversal of the segmentation of systems in Ecuador and Venezuela.

Transformations such as the reform of management and health care service structures, the change of selective features, the institutional culture of managers and providers and the adaptation of human resources, are tasks that are still pending in all three countries, in different magnitudes. In the three cases, segmentation in funding, management and infrastructure and especially the fragmentation of the system, could have been deepened by having new initiatives overlap the operating structures.

Bolivia, Ecuador and Venezuela have made a strong and explicit bet on comprehensive primary health care as the base of their health policies and the organization of their health systems.

The materialization of this idea, based on the corresponding political constitutions of their States, through the construction of new structures for systems, is still very recent if considered in a historical perspective, which makes it unfair and inefficient to evaluate its results and, even less, its impact. However, the urgency of solving health problems that cause pain and death and, above all, the voices of the population in need, require celerity and efficiency from the corresponding governments.

Actions such as human resources training for primary health care, the restructuration of networks and economic investments in first contact services are some progresses made towards the intended direction and may be more or less tangible depending on the country. Achievemt of the intercultural approach to services, the articulation of primary health care with levels of referral, intersectoral action to address the social determinants of health, the concrete implementation of family and community components of their corresponding models and the effective implementation of community participation in the management of systems are less obvious components and, therefore, are considered challenges.

The history of each country and each health system is unique and irreproducible. However, the amount of common elements demonstrated by the present study clearly indicates that the exchange of experiences among all three countries would be of great use to decision makers and managers of each system. The singularity of the social and health ideology of the models and of the transformations made by each country, show that traditional technical cooperation agencies in health may not be fully equipped to accomplish their due role of assistance. In both cases, the space and the opportunity are presented for organizations such as Unasur to contribute to the fulfilment of these needs.

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Primary Health Care in a universal system: the case of Brazil

Patty Fidelis de Almeida

INTRODUCTION

For the first time in the history of Brazil, the Federal Constitution of 1988 included health as a right guaranteed to all citizens by the State through economic and social policies aimed at the reduction of the risk of diseases and the access to actions and health services that are capable of promoting the welfare of its population.

The *Sistema Único de Saúde* (Unified Health System, SUS) is a national health system of universal access, funded by taxes and based on the following principles:

- comprehensive health care as a universal right and a responsibility of the State, which means universal access to actions and health services by all citizens, regardless of their income, social class, ethnicity, occupation and contribution;
- decentralization to states and municipalities, with shared responsibility among governmental spheres; and
- citizen participation.

Despite the existence of a national health service in the country, the universalization of access was not accompanied by the necessary additional contributions in public funding and, in parallel, there was an increase in the coverage by private health plans and insurances. In 2012, 25% of the population (48.5 million people) had volunteer private health insurances (Datasus, 2014b), with coverage that overlaps the right to access the SUS. The implementation of the SUS and the first initiatives for the strengthening of Primary Health Care (PHC) started in the nineties, a basis for the reform of the health system. Another highlight is the unfavorable international scenario, with the publication, in 1993, of the report Investing in Health, by the World Bank, whose recommendation was that health was only a public responsibility in some specific situations, with a clear inducement to the universalization of packages for selective programs focused on the poor (Senna, 2002).

In this context, policies for broadening PHC in the country have started to be implemented, induced by the federal government, with the goal to promote changes in the assistance hospital-based model, consolidated in the period of the dictatorship (1964-1985). In 1994, the Brazilian Ministry of Health created the "Family Health Program" (PSF) as a selective program directed at high-risk groups of the population. The teams, formed by a

supposed "general" practitioner, a nurse, an auxiliary nurse and community health workers, should be responsible for the health care of up to 4500 people in a specific area assigned to them. Some years have passed without any expansion of the PSF: until 1998, the country had not much more than 3000 teams that covered 7% of the population, most frequently in small municipalities.

In 1998, a financial *per capita* incentive transferred directly by the federal government to municipalities stimulated the expansion of the Family Health Program and, as the actions gained visibility in the national territory, the basic PHC package would grow and show its potentialities to create new types of health care and to address health inequalities. A classic study about the country, carried out by Macinko et al. (2006; 2007), with the analysis of the impact of the PSF on the child mortality rate between 1990 and 2002, through a longitudinal ecological approach, revealed an important contribution to the reduction of mortality among children under 1 year old, and estimated that an additional increase of 10% in the coverage of the PSF could lead to a 4.5% decrease in the mortality rate.

20 years after the creation of the Family Health Program, in January 2014, there are 35,812 teams implemented, distributed throughout 5,352 municipalities. The teams cover 57% of the Brazilian population, which represents almost 111 million people (DAB, 2014a). The PSF is now called Family Health Strategy (ESF), in order to mark its unequivocal difference from selective programs and to highlight the potential of a strong PHC for the construction of new health care models that are more ethical and provide better results in health.

It is important to clarify that PHC in Brazilian municipalities, as highlighted by the National Primary Health Care Policy (Brasil, Ministério da Saúde, 2011a), has not been uniformly and homogeneously developed and did not necessarily follow the ESF model. In the country, different forms of organization of PHC coexist and it is even possible to find different strategies within the same municipality.

The organization and provision of PHC is so diverse, from Health Centers with basic specialty teams (called traditional model) to Family Health teams or community health workers and nursing professionals, that it becomes difficult to build a mapping that can reflect these specificities (Almeida, 2014). Local experiences, from North to South, in regions with historically distinct development standards, as well as the access to the health care network, demonstrate the potentialities and also the challenges for the construction of a strong PHC that can contribute to the effectiveness of the right to social protection in health and the reduction of important social inequalities in Brazil.

The current National Primary Health Care Policy (2011) reinforces the theoretical and conceptual base of PHC and the importance of the restructuring of the Unified Health System, whereas the organizational model of Health Care Networks reaffirms the idea that integrality can only be attained when care units of differentiated technological complexity mutually support each other and communicate based on robust

base: Primary Health Care (Brasil, Ministério da Saúde, 2011a).

PHC CONDUCT

PHC Concept

By the end of the 1990s, the Family Health Strategy started to be considered by the Brazilian government as the main strategy for the transformation of the Primary Health Care model. In the same decade, the country adopted the term Basic Care, in order to differentiate it from the proposals and concepts that reduced the potential of PHC to a selective array of services. Currently, the National Primary Health Care Policy (2011) adopts the terms "basic care" and PHC as equivalents.

The National Primary Health Care Policy presents the principles and guidelines that define the concept of PHC and that should orient the organization of services, actions and practices:

> *"Basic care is characterized by a set of health actions in the individual and collective ambit that include the promotion and protection of health, the prevention of diseases, diagnosis, treatment, rehabilitation, the reduction of injuries and the maintenance of health with the objective to develop comprehensive care that impact on the health status and on the autonomy of people and on the determinants and conditioning factors of the health of the collectivity"* (Brasil, Ministério da Saúde, 2011a:19).

The legal framework defines that PHC actions and services must be implemented by municipalities, under the principle of political and administrative decentralization, based on fundamentals: territory assignment and interconnected network; universal access to quality and effective services by accessibility attributes; preferred entry point to the health care network; linkage (longitudinal) and continuity; coordination of care; and social participation that encompasses the need for an increased autonomy of users for the conduct of its process of care to address health conditioning factors, based on the exercise of social control (Brasil, Ministério da Saúde, 2011a).

The official concept of PHC incorporates the characteristics defined by Starfield (2002), broadly disseminated in the country since 2000, and which orient the development of a set of methodologies for its assessment. None of the chapters of the National Primary Health Care Policy define PHC merely as the first level of care of the health service system. Even though the definition of Health Care Networks remarks that basic care is structured as the first and preferential point of care, it also considers that its multidisciplinary teams must integrate and coordinate care based on the health needs of the population through horizontal actions, including intersectoral practices and vertical integration with other levels of care.

Nonetheless, it is possible to observe that, in the implementation of PHC, some of

these attributes have been more strongly developed, such as the expansion of access and coverage, the conformation of a preferential entry point and the decentralization of actions and management. According to data from a survey carried out in 2008, 57% of the population declared that the Health Center was their regular consultation health service (IBGE, 2010). On the other hand, the elements that compose the great field of integrality, such as the coordination of care, the integration of the network and its "longitudinality", are the less developed PHC attributes.

Functions and competences of governmental spheres

Throughout the 1990s, according to the constitutional principle of decentralization and with a series of rules that aimed to regulate the organization and operation of the SUS, the Brazilian municipalities gradually assumed responsibility for the delivery of comprehensive care to their populations and the full management of PHC. Since 2004, all 5,570 municipalities and the Federal District are responsible for the management of the municipal health system in the organization and execution of PHC actions. In order to ensure comprehensive health care, there is a proposal for the organization of health regions that incorporate several municipalities.

The National Primary Health Care Policy (2011) defines common and specific responsibilities for the three government spheres of the SUS (federal, state and municipal) in regard to the provision and management of PHC. A group of general principles is highlighted as common functions, such as the contribution to the reorientation of the model of care based on the support to the expansion and qualification of the Family Health Strategy; the tripartite funding; the stimulation of social control and participation, among others (Brasil, Ministério da Saúde, 2011a).

It is the responsibility of the Ministry of Health to permanently review and articulate the guidelines of the national policy, to ensure funding to compose PHC budget, to support and carry out processes for the qualification and evaluation/institutionalization of monitoring and to induce curricular changes in the courses of the health area, among others.

It is part of the role of the State Health Secretariats, in general, to support municipalities in the evaluation and monitoring, in the guarantee of quality in PHC and in the consistency of data from the information systems, as well as sending them to the federal manager and supporting permanent health education and the formation of health regions.

Municipalities must implement, that is, are responsible for the organization, execution and management of PHC services and actions based on the needs of the population of the territory, through the assignment of municipal resources; evaluation and monitoring; permanent health education; selection, hiring and payment of professionals; the physical infrastructure of facilities; provision of data to national information systems; organization of flows and guarantee of referrals in health service networks and the

accomplishment of the work load by PHC teams' staffs (Brasil, Ministério da Saúde, 2011a). As an example, one of the roles of municipalities is the political decision of implementing the Family Health Strategy.

It is a consensus that the decentralization process, which started in 1990, based on a set of operational rules edited by the federal manager, represented an important progress for the construction of the Unified Health System. Even so, it is important to highlight that the decentralization of PHC to the current 5,570 municipalities has generated several challenges and difficulties to guarantee the provision of comprehensive care, the definition of quality standards (infrastructure, coverage of services offered and human resources, among others), the responsibility for funding and, above all, the construction of regionalized health systems. According to Spedo et al. (2009), the health decentralization model in Brazil, influenced by different concepts, contradictions and conflicts, has favored the conformation of atomized and disarticulated municipal health systems, with different levels of case-solving capacity and capability of local governments to perform this role. The situation has been aggravated by insufficient cooperation and technical support, especially at the state level, in a direct relation between the municipality and the federal manager (Solla y Chioro, 2008).

PHC FUNDING

Governmental spheres responsible for PHC funding

In Brazil, since the creation of the Unified Health System, the public funding of health is a responsibility of the three government spheres – Union, states and municipalities – through taxation. Nonetheless, the complementary act that regulates the Constitutional Amendments 29/2000 was only approved in 2011, with dispositions about the minimum values that must be annually applied by each federative entity in public health actions and services (Brasil, Presidência da República, 2012a). According to Complementary Act 141/2012 it is the role of the Union to apply the amount corresponding to the expenditure of the previous year, incremented in, at least, the percentage corresponding to the variation of the Gross Domestic Product. The rule works differently for states and municipalities. States must apply in health at least 12% of their tax income, while municipalities and the Federal District, 15% of their own resources.

In the country, the biggest part of the public expenditure in health is funded by the federal government, which also concentrates the biggest part of national tax income: 56%. From this total, 25% is available to states and 18.5% to municipalities. Although the public health expenditure might be related to the availability of resources, only 47% of the aforementioned expenditure is funded by the federal government, 25% by states and 28% by municipalities (Giovanella, 2013). There is an increase in the participation of municipalities in the funding of health as a result of the decentralization process and after the approval of Constitutional Amendment 29/2000.

The percentage of federal financial resources executed by the Ministry of Health that is destined to fund health care actions and services in 2012 represented 67% of the total expenditure of the federal manager[1], about R$300 per person/year. PHC represented 23.5% of the expenditure (or R$105 per person/year) of the Ministry of Health and medium and high complexity care, 44%. Data from the Ministry of Health indicate an increase of 105% in the federal budget for PHC from 2010 to 2014, from R$9.7 billion to R$20 billion in the period (from 4 to 8.3 billion US dollars) (Datasus, 2014c).

Mechanism for the transfer of resources between governmental spheres

Brazil has a tripartite funding of PHC, which involves resources from municipalities, states and the Union. In 1996, *per capita* based transfers – the Basic Care Floor – have been implemented for PHC funding and the Basic Care Variable Floor, to induce the implementation of strategic actions as the Family Health Program. Federal funding for PHC is formed by shares, as observed on Chart 1 (Brasil, Ministério da Saúde, 2011a).

Chart 1 – Shares of the federal transfer to PHC, Brazil, 2014

Share	Composition	Amount*
Per capita funding (Fixed Basic Care Floor)	Fixed amount received monthly, calculated based on the municipal population	BRL 23 to BRL 28 per person/year (2013)
Funds for specific projects	Regional singularities, requalification of the physical structure of units, resources for implementation	BRL 773000 for the construction of Basic Health Units [1] (2013) BRL 10,695 per team/month – ESF modality 1[a] (2012) BRL 20,000 per Family Health Team implemented (2012)
Funds for strategies/priority programs	Family Health Teams, Oral Health, Family Health Support Center (NASF), riverine populations, Health Academy, etc.	BRL 7,130 per team/month – ESF modality 2[b] (2012) BRL 20,000 monthly – NASF (2013) BRL 1,014 per community health worker/month (2014) BRL 50,000 for Fluvial ESF with oral health professionals month
Funds conditioned by the improvement in quality	National Program for the Improvement in Access and Quality of Primary Health Care (PMAQ-AB)	BRL 1,700 to BRL 8,500 per PHC team month [d] (2013) BRL 500 to BRL 2,500 per Oral Health Team month[e] (2013)

Source: Brasil, 2011a.

*1 USD = 2.4 BRL (25/09/2014)

a) Funds for the construction of Basic Health Unit Type IV through presentation of project, destined to host at least 4 Basic Care Teams (2013).

b) Municipalities of up to 30,000 people and/or teams that provide care to *quilombo* populations or settlements

c) All teams that do not meet the criteria of modality 1, which are the majority of teams in the country, that is, teams with physician, nurse, technical nurse assistant and 4 to 6 CHW.

d) Monthly funding incentive to Fluvial Basic Health Units.

[1] The "health care" component does not include funds destined to investments in infrastructure, basic sanitation actions, and expenses with active public employees, retirees and pensioners and funds from parliamentary amendments.

e) Amounts depend on the rank achieved by teams in the quality assessment.

As mentioned before, the three levels of government are responsible for the funding of PHC and for other health actions and services in the ambit of the SUS. Federal transfers from the Basic Care Share to municipalities are done in an account of the Municipal Health Fund specifically created to this end, under the criteria of fund-to-fund transfer, in order to enable the follow-up and social control by the Municipal Health Council.

It is estimated that federal transfers to PHC correspond to less than 50% of the public funding for PHC. A study by Vieira and Cervo (2013) illustrates the participation of federated entities in health funding. According to the authors, in the several basic care organization models, the participation concerning expenditures with human resources is prevailing and reaches 60% of the expenditure with PHC actions and services. In 2010, the contributions of the Ministry of Health to Family Health teams modality II (4 Community Health Workers, physician, nurse and technical nurse assistant), which are prevalent in the country, have reached BRL 13,756 per team, which represents 34% of the total cost of a team. This calculation considers the basic care variable floor (around BRL 4,500 per month per each 3000 people) and the amount of the basic care fixed floor (BRL 18 per person/year) (Vieira y Cervo, 2013). Other studies also indicate that the federal resources to ensure specialized care are considered insufficient by local managers, which compromises comprehensive care and the coordination of care by PHC teams (Giovanella et al., 2009b; Almeida et al., 2010; Santos, 2013).

Inexistence of co-payments in PHC

In Brazil, there are no co-payments in the SUS, despite the fact that the public network does not provide all medicines prescribed.

PROVISION OF PHC SERVICES

Types of health facilities that provide PHC

The majority of PHC facilities (96%) are public municipal units, generically called Basic Health Units (UBS). According to the National Record of Health Facilities, in 2014 there were 34,013 Health Centers or Basic Health Units and 10,651 Health Posts, which are lower complexity units destined to the provision of scheduled or unscheduled assistance to a determined population by mid-level professionals, with the intermittent presence or absence of a medical professional (CNES, 2014).

According to a census developed by the National Program for the Improvement in Access and Quality of Primary Health Care (PMAQ-AB), in 2012, the SUS had 38,800 active UBS (PMAQ-AB, 2012). The numbers differ when compared to the National Health Facilities Database, whose information depend on updates by providers and managers, which does not always happen.

According to the guidelines of the National Primary Health Care Policy, it is

recommended that Basic Health Units have a medical office, a nursing office, and a dentistry office; rooms for the reception of unscheduled visits, for administration and management, for collective activities, for vaccination, for procedures and areas for disposal and storage of medicines, among others (Brasil, Ministério da Saúde, 2011a). However, as the structures can vary significantly among the different regions of the country, there are different types of UBS that, according to data from the PMAQ-AB (2012), have from one (70%) to four or more (1%) basic care teams. Report results also indicate, for example, that only 37% of the teams interviewed affirm having a specific room to welcome users (PMAQ-AB, 2012).

Among the federal initiatives for the expansion and qualification of PHC are the Program for the Requalification of UBS, which, by recognizing the inadequacy of infrastructure, assigns financial incentives for the repair, expansion and construction of new units after the presentation of projects. The goal is for units to able to have adequate structures to perform basic care actions (Brasil, Ministério da Saúde, 2011c; 2011d). In 2014, 26,000 Basic Health Units were under construction or repair in the country.

Professionals offering PHC

PHC teams are formed, depending on the modality to which they belong, by physicians, nurses, dentists, oral health assistants or technicians, technical nurse assistants and, in the case of Family Health Teams, also by Community Health Workers (CHW). In the country, there are approximately 258,000 CHW, which are professionals without previous training in health, hired by municipalities and who live in the areas where the Family Health Teams are established (DAB, 2014a). Besides the registration of all people assigned to the Family Health Units, the CHW is the link between the needs of the population of the territory and the health service. The CHW is responsible for the follow-up of priority and vulnerable groups in the community and of the conditions of the *Bolsa Família* Program and for the development of actions for health promotion and protection through popular mobilization and intersectoral action.

In "traditional" Health Centers, the team may be formed by medical specialties of basic clinics (pediatric, gynecology and general practice), nursing professionals and other mid and high-level professionals, which makes it difficult to define a homogeneous model.

Other professionals may also be part of the teams, according to the local reality (Chart 2). Since 2008, PHC teams have Family Health Support Centers (NASF), formed by multidisciplinary teams whose objective is to extend the outreach, approach and case-resolving capacity of basic care through matrix support. The matrix support is carried out by a group of professionals with several specialties. It aims to ensure that PHC teams have specialized care support, aiming to increase the efficacy of PHC action, through inter-consultation, continued education, debates about clinical cases, etc. Matrix support aims to offer assistance backup, with consultations and other specialized care, as well as technical-pedagogical support to basic care teams (Cunha y Campos, 2011).

The National Primary Health Care Policy also defines PHC teams for the care of populations with specific needs. One of them is the "Street Clinic Team", with exclusive responsibility for the comprehensive care of the homeless (Brasil, Ministério da Saúde, 2011a).

Other PHC modalities consider the specificities of the Amazon region, in which managers can choose between two modalities for the organization of PHC teams. Riverine Family Health Teams, whose access to communities is made through the river; and Fluvial Family Health Teams, which perform all functions at Fluvial Basic Health Units.

Chart 2 – Modalities and professional training of PHC teams, Brazil, 2014

Modality	Composition
Family Health Team	1 physician, 1 nurse, 1-2 auxiliary/technician nurse, 4-6 community health workers
Basic Care Team	Pediatrician, gynecologist, general practitioner, nurse, auxiliary/technician nurse, etc.
Oral Health Teams I	Dental surgeon and oral health assistant
Oral Health Teams II	Dental surgeon, oral health assistant and oral health technician
Family Health Support Center	May include the following professional profiles: social assistant, physical education professional, pharmacist, physiotherapist, language and speech therapist, gynecologist/obstetrician, homoeopathist, acupuncturist, nutritionist, pediatricians, psychologist, psychiatrist, occupational therapist, geriatrician, internal physician, occupational physician, veterinarian, art-educator, sanitarian[a]
Street Clinic Teams	Nurse, psychologist, social assistant, occupational therapist, physician; social worker, technician or auxiliary nurse, oral health technician[b]
Riverine Family Health Teams	Physician, nurse, auxiliary/technician nurse, community health workers, microscopist, laboratory technicians and/or biochemist.

a) Professionals selected according to the NASF modality.
b) Multi-professional teams that can be organized in three modalities and incorporate from 4 to 7 of the professionals presented.

Comprehensive primary health care: The case of the Igaraçu Fluvial Basic Health Unit in the municipality of Borba, Amazonas

The municipality of Borba is located in the region of River Madeira, in the Southeast of the State of Amazonas, and can only be accessed by air or by the river. The population estimated in 2013 is of 28,000 people, formed by 240 riverine communities and approximately 60 indigenous villages and settlements.

A restructuration process of PHC in the municipality started in 2005, with the expansion of coverage and changes in the working process. The amount of Family Health Teams raised from 2 to 9 and 6 of them are in the urban area, 2 in riverine communities and one at the Igaraçu Fluvial Basic Health Unit, the first riverboat in Brazil built specifically to operate as a fluvial health center.

The Fluvial Basic Health Units are part of the Brazilian National Primary Health Care Policy, whose objective is to answer to the specificities of health care to riverine populations. The funding of these units is made by the federal government through contributions to municipalities. Nonetheless, the monthly federal contribution of BRL 50,000 is considered, by municipal managers, insufficient for the maintaining of the unity, whose monthly costs are estimated tobe of BRL 130,000.

The physical structure of the craft is the same of a terrestrial unity, with offices, immunization rooms, pharmacy, laboratory, etc., besides lodging for health professionals and the crew. The Igaraçu Fluvial Basic Health Unit travels 20 days every month in the area defined for its action, which includes fluvial trips to communities and direct care to riverine populations. The population registered in 2014 is of 3,157 people distributed in 44 rural communities, seen by the Family Health Team with Oral Health in Igaraçu, formed by: 1 nurse, 1 physician, 2 nurse technicians, 2 oral health assistants, 1 community health worker per community, 1 manager, 1 dentist and 1 biochemistry professional. In the communities, health care is organized by the Community Health Worker that

does the follow-up of the families.

After 20 days, the team returns to Borba and the professional may rest for 10 days. The other 10 days before the next trip are used to plan actions, routes, analysis of epidemiologic data, team meetings and also to see some people seeking professionals at the unit when it is on land.

The first trip of Igaraçu was in April 2013. Since 2007, the municipality had been developing actions concerning the health care of rural communities, which used to be a great challenge. The visits were improvised in schools and social centers, without any privacy, and in ships rented by the municipality, which were adapted to provide health care. On land, care was provided at community centers or schools in the community.

Procedures such as the collection of material for the pap test were carried out in houses of the community. Prenatal coverage was low.

The Igaraçu family health team made an effort to provide quality and effective care, without losing the continuity of actions. The fluvial unit enables an increase in linkage, vaccine coverage, in the number of procedures and a better control of malaria.

Source: Secretaria Municipal de Saúde de Borba (AM), 2014.

Main services provided in PHC

According to the National Primary Health Care Policy (PNAB) (2011), considering the context of the restructuring of the health system, in accordance with the format of health care networks, there are priority functions of PHC that shall contribute to the proper operation of Health Care Networks. These functions are:

- To function as the base: to be present in all municipalities in the most decentralized and distributed way possible;
- To be effective: to be able to generate diagnoses of health and the status of the population living in the territory under its responsibility, considering risks, needs and demands in health;
- To coordinate care: to act as a communication center between the different points and levels of care, maintaining the follow-up and organization of the flow of users, with the aim to produce a shared management of comprehensive car through the use of micro management tools such as clinical protocols, care lines, management of the waiting list, among others. Besides, to articulate with other structures such as logistics and support systems, intersectoral relations and social participation of the community.
- To organize networks: PHC should organize the health needs of the population under its responsibility concerning the access to other points of care, in order to contribute to the planning of the services provided to be based in the actual health need of the population.

In 2011, the National List of Health Actions and Services was established by Presidential Decree 7,508, with the definition of responsibilities and of the set of actions and services that should be provided by the SUS. The federated entities can adopt specific and complementary actions, if they respect the responsibilities regarding their funding (Brasil, Ministério da Saúde, 2011b).

The Administrative Act 841/2012 of the Ministry of Health, in accordance with the

attributes defined by the National Primary Health Care Policy, extensively defines that PHC actions and services include:

> *"[...] health promotion; risk prevention; health surveillance; treatment, follow-up, reduction of damages and rehabilitation. [...]; reception and care of the unscheduled demand, including urgency and emergency care at basic health units; continued/programmed care in basic healtxh units and at home (when necessary); indication, prescription and execution of therapeutic procedures and diagnoses in the ambit of PHC; activities of individual and collective care (ex.: family, community); health surveillance activities: care to all citizens under its responsibility, regardless of life cycles, gender and health problems presented; home care; oral health care; integrative and complementary practices; nutritional and food surveillance and nutritional care; coordination of care, including the access to actions and services outside the ambit of Primary Health Care"* (Brasil, Ministério da Saúde, 2012b).

Although the definition of procedures, services and actions might be considered a progress for the establishment of competences and responsibilities in the ambit of PHC, the recent reorganization of basic care through the Family Health Strategy was still unable to overcome the tension between the prioritization of programmatic actions and the guarantee of timely care to the spontaneous demand and to minor urgencies. Some difficulties remain in the organization of the working processes of teams to achieve a proper balance between the resolution of individual demands and individual and collective programmatic actions, to ensure comprehensive care. Besides, there is a great diversity of actions offered by teams, depending on their infrastructure, professional availability and capacity and set of services defined by different municipalities.

PHC ORGANIZATION

Assistance model proposed for PHC

The concept of PHC expressed in the National Primary Health Care Policy (PNAB) is in accordance with the principles and the extensive concept of health established by the Constitution of 1988. The PNAB (2011) reaffirms the consolidation of the Family Health Strategy as the main device for the reorganization of Basic Care in Brazil, although it may coexist with other models of care. Some fundamental principles orient the organization of the assistance model proposed for PHC in Brazil. The multiprofesional team that acts in the territory assigned and the interconnected network, as close as possible to the community life, are key elements to the definition of practices and intersectoral actions capable of impacting on the social determinants of the health/disease process. PHC must ensure universal access to quality and effective services characterized by the attributes of preferential entry point to the care network, linkage (longitudinality), co-responsibility and continuity of care. Another

principle is the coordination of care through horizontal integration strategies (programmatic actions and unscheduled visits, actions on health surveillance and assistance, multi-professional and interdisciplinary teamwork) and vertical integration between the different levels of care that form the Health Care Networks. The principle of social participation aggregates the need for an increase in the autonomy of users for the conduct of their care process and for the confrontation of their health conditioning factors (Brasil, Ministério da Saúde, 2011a).

Population affiliated to PHC units and the work of the teams

The Family Health Strategy has specificities in regard to its operation and in the organization of the working process of its teams. Every population assigned to a Family Health team must be registered and followed up in monthly home visits by a Community Health Worker, who is responsible for up to 750 people (150-200 families). The recommendation is an average of 3000 users registered by team, but this number may vary according to the specificities and vulnerabilities of the territory and population dispersion.

Each professional must be linked to one Family Health Team only, with a workload of 40 hours a week. An exception is allowed in the case of the physician, who could be linked to up to two teams, as long as its workload does not exceed 40 hours. From this weekly workload, up to 8 hours may be dedicated to the provision of services in the municipal urgency network or to permanent education (Brasil, Ministério da Saúde, 2011a).

Guarantee of access

There is no explicit definition of minimum and maximum times for care in the national policy, despite a clear instruction about reception and mechanisms that must ensure accessibility and guarantee that the "[...] health unit must receive and listen to all patients that seek its services, in a universal way and without any excluding distinction" (Brasil, Ministério da Saúde, 2011a:20). Some municipalities have defined waiting times for PHC and some others propose radical changes in the organization of the workflow of teams in order to guarantee the end of waiting lines for PHC, as will be described in the case of the municipality of Curitiba.

Comprehensive primary health care: The case of "advanced access" in the municipality of Curitiba, Paraná

Since 1979, the municipality of Curitiba has adopted strategies for the hierarchization of health services based on Primary Health Care principles. In 1985, the municipality adopted Integrated Health Actions, by receiving federal funds for the expansion of its network of health centers and dental clinics. Since 1991, experiences which focus on the health of the family are being developed, with the training of multi-professional teams and the incorporation of oral health. In 1992, the Regional Health Units have been created, thereby starting the decentralization process. The electronic clinical history, implemented since 1999, is an important strategy for the integration of the network in order to guarantee the continuity of care.

Although a robust health service network has been formed in the city, since 2013, with the new municipal

management, there has been a restructuration of the working processes and organization of the network based on the principle that PHC must, in fact, assume its role of organizing health care networks and coordinates care. This entire process is being discussed by the management teams of several UBS.

Part of the changes promoted in the organization of PHC services comes from a diagnosis that determined that, although there might be a well-structured Health Center Network, about 30% of users in Curitiba and its metropolitan region would seek the 8 Prompt Care Units of the city as the first contact service for cases that could be seen and followed up in PHC. The competition between Prompt Care Units and UBS as the entry point are the result of problems in the organization of PHC units, structured by programmatic actions destined to priority groups and pathologies, which makes part of the population start to seek urgency services as their first contact.

The initiatives include repairs in Basic Units, the extension of the set of services offered by PHC with the acquisition of equipment for electrocardiography, electrocautery, material for skin biopsy, among others, including strategies of variable remuneration.

The most important changes, which affect the most the organization models of the team's working process is in the field of access. One of the proposals, which is already being implemented, is the extension of working hours at units. Nevertheless, the most audacious proposal of the current management refers to the implementation of the "advanced access", with experiences that bring new possibilities for the organization of the access to PHC units based on the flexibilization of schedules in order to ensure the timely use of services.

There is not one single way for the implementation of advanced access strategies. This process, promoted by the PHC Department of Curitiba, is under discussion and each basic Health Unit organizes itself according to its needs and criteria.

The main point is to organize the schedule of the physician and of the nurse in order to provide care to users on the same day they seek it.

The diagnosis that encouraged these changes showed that PHC actions developed in the logic of vertical programs would occupy the schedule of professionals with pre-scheduled visits to priority groups traditionally followed up, as children or those with chronic illnesses, which resulted with the rest of the population seeking other entry points, such as urgency care, for problems that could be seen by PHC. The Municipal Health Secretariat of Curitiba has developed a booklet for professionals, which shows the objectives, motivations and tools for changes in the organization of schedules. It is important to highlight that the user that "cannot be seen at the Health Center when he/she needs to, may feel discouraged or loose trust in the team, which leads to the weakening of the linkage and to second thoughts about the choice of service in a future situation of health necessity" (Wollmann et al., 2014:6).

The discussion and the development of new forms of organization for the working process have been highly heterogeneous within units, with some resistance from professionals and some teams already working with the logic of advanced access, whereas others are still in the restructuration process and some others have not yet implemented any changes.

Sources: Secretaria Municipal de Saúde de Curitiba (PR), 2014; Wollmann et al., 2014.

Population coverage of the Family Health Strategy

About 62% of the Brazilian population is covered by Family Health teams (Table 1). Another part of the population has access to basic care teams formed by basic medical specialties (pediatrics, general practice and gynecology) and, in general, nursing professionals. It is estimated that the overall PHC coverage in the country is of more than 70% of the population.

Table 1 – Implementation of community health workers, family and oral health teams and population coverage, Brazil, November 2014

Population	Community Health Workers		Family Health Team		Oral health Teams	
					Modality I[a]	Modality II[b]
	n.	% estimated coverage	n.	% estimated coverage	n.	n
193,976,530	265,272	66.3	39,064	62.2	21,982	2,261

Source: DAB, 2014a.

a) Oral Health Teams linked to Family Health teams formed by a dentist and an oral health assistant.

b) Oral Health Teams linked to Family Health teams formed by a general dentist, an oral health assistant and an oral health technician.

In the country, the increase in coverage by Family Health teams is evident, especially since 2000. From 1998 to 2006, population coverage of the Family Health Strategy, which was of 7%, reached 46% of the population. This expansion was extremely significant in areas that were historically deprived of health services and with unfavorable social indicators, as is the case of the Northeast Region, which presents the highest rate of coverage by Family Health teams among the regions of Brazil (DAB, 2014a). Coverage that is equal or superior to 70% may be found in municipalities with lower income and low or medium HDI.

From 2006 to 2013, there has been a gradual growth of the population covered by Family Health teams, distributed in 5,460 municipalities (Table 2). The significant increase in 2014 was possible due to the More Doctors for Brazil Program of the federal government, which hired 14000 doctors for basic care in the country, 11000 of them from Cuba.

Table 2 – Evolution of the percentage of population registered in the Family Health Strategy by region, Brazil, 2006-2014

Region	2006	2007	2008	2009	2010	2011	2012	2013	2014
North	41.9	42.5	47.3	50.6	51.8	50.9	51.4	52.8	59.7
Northeast	67.2	67.4	70.6	70.7	72.2	72.5	72.6	75.7	79.6
Southeast	34.0	34.6	36.9	38.1	39.6	41.9	44.2	44.3	51.1
South	37.0	44.9	47.9	49.4	50.4	51.7	53.7	56.5	63.3
Center-West	44.7	45.9	48.2	49.8	53.0	53.2	54.8	55.7	60.3
Brazil	46.2	46.6	49.5	50.7	52.2	53.4	54.8	56.4	62.2

Source: DAB, 2014a.

Another important fact was the clear increase in the coverage of oral health, which, until then was predominantly provided by the private sector, whose demand for payment represented a barrier to the access to this sort of care to most of the Brazilian population. In November 2014, there were 24,243 Oral Health Teams implemented in 5013 municipalities (DAB, 2014a).

COORDINATION OF CARE AND INTEGRATION OF PHC INTO THE SERVICE NETWORK

Organization of the levels of care

Traditionally, the organization of the Brazilian health system is held in three levels of care: basic health care, specialized care (polyclinics, specialized services, ambulatories at hospitals, among others) and secondary and tertiary hospital care, connected through mechanisms for referral and counter-referral intermediated by Regulation Centrals. Recently, with the publication of Decree 7,508/2011 the "health regions" started to be considered strategic spaces for intergovernmental articulation, based on integrated regional planning and on the execution of health actions and services to the population of a determined territory (Brasil, Ministério da Saúde, 2011b).

In the area of the 436 health regions instituted by the states, in articulation with the corresponding municipalities throughout the country, there must be effective, timely and quality access to actions of health promotion, protection and rehabilitation. In health regions, services must be organized in Health Care Networks, which shall articulate with basic care, health surveillance, psychosocial care, urgency and emergency, ambulatories, specialized and hospital care. In order to ensure integrality, there may be other territorial arrangements, with the inclusion of another health region.

In the SUS, PHC services, urgency and emergency, psychosocial care and "open access special" services are considered the entry points to health actions and services in regionalized and hierarchical networks. Based on pacts of Inter-management Commissions, new entry points could be defined, according to the specificities of the region. PHC is assigned with the functions of reception, linkage of users and co-responsibility for care to meet their health needs, starting at the principle that the health unit must receive, listen to and see every person that seeks it, in a universal way and with no barriers in the access and also with the responsibility of referral to specialized and hospital levels.

From the moment of the implementation of Family Health Teams, the population is automatically affiliated and hereupon starts to have a team of reference, that is, there is no freedom to choose services and professionals. The other services of the network may be accessed through referrals by the entry points and, in these cases, there is also no choice of professional and/or service.

Although there might be some incorporation of the official speech that defines PHC teams as those of first contact, studies show that other services, especially "urgency" services, compete for the function of entry point. In a study carried out in three municipalities of the state of Bahia, 35% of users declared to seek urgency/emergency care services in case of disease, including when PHC Units are working (Almeida y Santos, 2014). Results of the National Program for the Improvement in Access and Quality of Primary Health Care (PMAQ-AB), in 2012, demonstrated that 93% of PHC teams save places for care on the same

day, but 35% of the users interviewed that sought urgency care affirmed not to have gone to Basic Health Units because they believed that the team would not provide this sort of assistance (32%) or that it would be closed (35%). Also according to the results of the PMAQ-AB, for access to basic care visits, 31% of users reported that they had arrived at the unit early in the morning and had to wait in line for it to open (PMAQ-AB, 2012; Fausto et al., 2014).

Gatekeeping role of PHC physicians

The SUS does not have the gatekeeping role regulated for the physician working in PHC (Giovanella, 2013). Nevertheless, PHC services are considered as the preferential entry point and specialized and hospital care services usually can only be accessed through referrals from primary health care.

Gradually, family health teams assume the role of entry points of the system and the physician assumes the role of gatekeeper to other levels. Results of the PMAQ-AB (2012) indicate that 63% of users referred to other health services had their visit scheduled by the Basic Health Unit (PMAQ-AB, 2012; Fausto et al., 2014).

Referral flows from PHC to specialized care

Health actions and services must be planned and executed based on the diagnosis of the affiliated population. According to their needs, people may be seen at different points of care based on orientations from entry points to the SUS, in a process called referral, once services with more technological density are not first contact services. Once the user is seen at other services and health facilities, he/she must be counter-referred to the PHC team for the follow-up.

In general, the process of regulating access to specialized care is made through Regulation Centers, which may be municipal, regional or may belong to states. According to data from the National Health Facilities Database (CNES), in 2014, there were 846 Assistance Regulation Centers, which were responsible for the distribution of the available specialized visits and tests, and for the regulation of hospital beds, and 214 Urgency Regulation Centers (CNES, 2014).

In the country, there is a variety of information systems that perform this role, some of developed by municipalities themselves. The most used one is the National Regulation System, an online system developed by the Ministry of Health and which is present in 1,600 municipalities, with 204 Ambulatory Regulation Centers and 19 Hospital Regulation Centers (Brasil, Ministério da Saúde, 2014c). In the PMAQ-AB (2012), 99% of participating teams reported to have an office for the appointment of specialized visits and 95,5% counted on offices for the regulation of exams, which demonstrates the institutionality of the mechanism for the organization of assistance flows in the SUS (PMAQ-AB, 2012).

There is a determination to organize flows, which will depend on the availability and configuration of actions and services in health regions. Still, the results of the National Program for the Improvement in Access and Quality of Primary Health Care (2012) show that only 58% of the Family Health teams had documents with the list of specialized services for referrals and flows (PMAQ-AB, 2012). Even though it might not be possible to affirm that there are no flows established in the country, the high proportion of teams that do not have documents with guidelines for referrals suggests a low level of institutionalization of rules, the presence of informal flows and an insufficient integration of PHC into the network.

Specialized ambulatory care and hospital care are provided at public specialized centers, polyclinics, state and municipal hospitals and in private services hired by the SUS (65% of hospital beds in Brazil are private).

Waiting lines for the access to specialized care

In the country, there are waiting lines for specialized care and this is considered by many as the bottleneck of the SUS. The identified causes come from different places: low case-resolving capacity of PHC, which is being confronted through several initiatives for its qualification; the insufficient provision of specialized care which is still bought/hired from the private sector; low pay by the federal manager (SUS tables) for specialized procedures; problems with the integration into the network; pressure for specialized care provision; absence and low availability of specialists in some areas, among others.

The monitoring of waiting lines is not an institutionalized practice and it depends on the organization of each municipal health system. The municipalities that have adopted computerized regulation systems can access and analyze waiting lists and times, which are still not publicly available. Referral rates and their quality can also be monitored by municipalities, depending on the grade of organization and digitalization of their assistance regulation complexes.

PHC WORKFORCE

Regulation of labor relations

In Brazil, health professions are self-regulated, that is, professional registration and licensing for practice are defined by professional councils, which are public non-state entities regulated by law, with the role of supervising ethical and legal aspects for the professional practice, such as the Federal Council of Medicine, Nursing and Psychology.

The Federal Council of Medicine participates in the planning and definition of graduate and residency courses, whose regulation is a responsibility of the Ministry of Education (Merchán-Hamann et al., 2013). Only by mid-2000s the Ministry of Health started to have some influence upon the definition of vacancies for medicine specialties, even though the constitutional texts defines that the SUS must organize the training of human resources for health.

Basic care professionals are hired by municipalities and there are different contracts established. From the 16,811 higher education professionals that participated in the PMAQ-AB in 2012, 42% reported to be public workers, 26% hired under the private sector labor legislation (CLT rules) and 29.5% reported to have temporary contracts, the majority of them characterized by the absence of the guarantee of their labor rights. In municipalities with 50,000 to 100,000 people, temporary contracts reach 47% (Seidl et al., 2014).

The greatest difficulty for hiring and retaining professionals in PHC is in regard to physicians. The concentration of physicians in big urban centers and the lack of availability hinder the implementation and the sustainability of PHC services, especially in regions in the North, Northeast, in the interior of the country, in peripheries and in violent areas of big cities.

Several municipalities establish associations with non-governmental organizations, especially to hire professionals for PHC teams. In Brazil, PHC is traditionally a direct responsibility of the State. Nonetheless, since 1990, with the advancement of the implementation of the Family Health Strategy, there have been contract forms made possible through associations between the public power and philanthropic nonprofit entities.

Carneiro Júnior et al. (2011) state that, since the beginning, the implementation of the Family Health Strategy has been marked by the flexibilization of labor relations for the conformation of teams, with alternative forms of human resources contracts, which were initially justified by the singularity of the work of the community health worker, who should belong to the same territory of the implementation of the team. According to the authors, the precariousness of labor relations, characterized by losses in labor and social security rights through temporary contracts and grants, among others, enabled the collaboration between municipalities and several types of entities, such as non-governmental organizations, cooperatives, neighborhood associations, support foundations, religious associations, social organizations and state foundations, among others. This collaboration was initially restricted to contracting professionals and, more recently, occurs in management and direct provision of services, as observed especially in big cities such as Rio de Janeiro and São Paulo (Carneiro Júnior et al., 2011).

In general, the main payment method to PHC workers and health workers is the salary. Some local initiatives establish additional pay for performance, but this is not a common practice. Some municipalities also offer benefits that are complementary to salaries, for professionals working in more vulnerable and remote areas.

Availability of PHC professionals

In 2010, the country presented a ratio of 1.86 physicians per 1000 inhabitants, with a significantly uneven distribution among its regions: 0.9 in the North, 1.1 in the Northeast, 2.5 in the Southeast, 2.1 in the South and 1.8 in the Center-West Region (Datasus, 2014a).

Data from the survey "Medical demography in Brazil", carried out by the Federal Council of Medicine, based on the active registration of professionals in the respective

Regional Councils of Medicine, reveal that out of the 388,015 physicians with active registrations in 2012, 207,879 (53.5%) were specialists and 180,136 (46.5%) were professionals with no Medical Residency (Scheffer, 2013). The study highlights that the majority of physicians with no residency is composed by young people 29 years old or younger. In this age group, 81% of professionals do not hold a specialist title, although a great part of them are currently in a Medical Residency Program. Specialties such as General Practice, General Surgery and Family Medicine count on younger physicians. The number of physicians with Residencies in Family and Community Medicine represents 1% (2,632) of physicians with residency among the 53 specialties recognized by the Federal Council of Medicine, a percentage that is lower than the number of those with residency in plastic surgery (2%), for example. Another result of the census is that places with a concentration of doctors also have a concentration of specialists and of medical residency positions (Scheffer, 2013).

Table 3 – Indicators of health workforce in Brazil and regions, 2000, 2005 and 2010

Indicators	2000	2005	2010
Ratio of physicians per thousand people in the country[1]	1.39	1.68	1.86
North	0.42	0.82	0.90
Northeast	0.81	0.99	1.09
Southeast	1.97	2.28	2.51
South	1.43	1.73	2.06
Center-West	1.24	1.68	1.76
Number and ratio of physicians specialized in family and community medicine per thousand people[2]	3,253 and 0.0168 (2010)		
Ratio of nurses per thousand people in the country[1]	0.44	0.55	1.51
North	0.32	0.48	1.19
Northeast	0.38	0.47	1.05
Southeast	0.53	0.60	1.91
South	0.37	0.57	1.41
Center-West	0.40	0.59	1.45
Ratio of dentists per thousand people in the country[1]	0.86	1.13	1.27
North	0.35	0.48	0.64
Northeast	0.40	0.53	0.65
Southeast	1.25	1.59	1.72
South	0.85	1.19	1.42
Center-West	0.92	1.29	1.46
Ratio of community health workers per thousand people[3]	0.82	1.17	1.28

Sources: 1) Datasus, 2014b; 2) Scheffer, 2013; 3) Calculation by the author, based on the DAB, 2014a.

According to data from the Federal Council of Nursing, in 2010, there were 1,449,583 nursing professionals registered in the country, 287,119 (20%) of them being nurses, 625,863 (43%) technicians and 533,422 (37%) auxiliary nurses (Cofen, 2011). The majority of professionals (52%) is concentrated in the Southeast Region, but there are less difficulties to hire nursing and dentistry professionals, in comparison with physicians, especially due to the fierce competition with the private sector.

Only since 2011, the Ministries of Health and Education collectively adopted a set of measures to attract physicians to remote areas with difficulties in retaining professionals and

to change education. In October 22, 2013, Act 12,871, which creates the More Doctors for Brazil Program, was promulgated (Brasil, Presidência da República, 2013a).

The More Doctors for Brazil Program was a measure of the Brazilian government in response to the problem of retaining physicians in remote and underserved areas. One of the actions of the Program was a call for foreign physicians, enabled through an international cooperation agreement and a review of the diploma revalidation process. Among the 14,400 physicians that participated in the Program in 2014, 11,400, approximately 80%, are Cuban doctors hired through a cooperation between the Pan American Health Organization and the Brazilian government. The others ones are 1,600 Brazilian physicians and 1,400 foreigners with individual adhesion. Professionals are present in more than 3500 municipalities, mostly in regions of higher social vulnerability, such as the semi-arid of the Northeast Region, the suburb of big cities, municipalities with low or extremely low HDI-M, regions with native *quilombo* populations and the Amazon region (Brasil, Presidência da República, 2014d).

Initially, the project will last for three years and the Ministry of Health will be responsible for the payment of physicians through a "training grant" of BRL 10,000 per month (USD 4,300). Municipalities are responsible for their lodging, food and labor conditions. Positions open by municipalities are offered to Brazilian professionals as a priority. If there are still open positions, foreigners are then allowed to apply. The workload is 40 hours a week in Basic Health Units and a participation in a specialization course in family health. Foreign participants are not allowed to practice outside the Program.

In order to improve service delivery, the More Doctors Program intends to create 11.4 thousand vacancies in medicine schools in the country until 2018, and 3203 of those have been already authorized in 2014. The expansion of positions in medicine courses in a specific location supposes the existence of three medical residency programs. Another plan is to open 12000 new medical residency positions until 2017, with the intention to have specialization positions available to every graduated student. Vacancies will be open in priority areas for the SUS, such as Family and Community Medicine, Pediatrics, Psychiatry, Obstetrics, Gynecology, among others. The expansion of graduate courses in areas with the highest need for professionals will be followed by the expansion of residency positions in the same location, since the offer of residency positions is associated with the permanence of the

Medical specialization for PHC

General and Community Practice has been recognized by the Ministry of Education, through the National Commission of Medical Residency, in 1981 However, there have been specific education programs in the area since 1976, in some municipalities. In 2002, a proposal presented by the Brazilian Society of Family and Community Medicine established the current denomination, Family and Community Medicine, through a joint resolution

between the Federal Council of Medicine, the Brazilian Medical Association and the National Commission of Medical Residency, despite the corporative resistance of some specialties.

In the country, the Federal Council of Medicine acts on planning and definition of higher education courses and medical residencies. The National Commission of Medical Residency, created in 1977 and linked to the Ministry of Education, is responsible for regulation, supervision and evaluation of medical residencies in the country, whose principle should be to meet the needs of the SUS. However, as highlighted by Carvalho and Souza (2013), the Commission has a certain submission to the rules of the market, making it the main instigator of professional choices for medical residency. The authors highlight that the absence of state regulation brings consequences, such as the high percentage of open positions for the Residency in Community and Family Medicine, which reaches approximately 70%, especially due to its lack of market attractiveness, since residency training is not required for the practice in PHC services and, at the same time, represents a field of work that is mostly directed to the public service and which is not highly regarded by doctors from the social and economic perspective.

Main training strategies for human resources in PHC

One of the initiatives taken to transform health education in the country is the National Reorientation Program for Professional Health Education, PRO-Health. The PRO-Health is directed at university students, teachers and health professionals. Projects are developed by higher-education institutions together with the public health services. The central axis of the program is the integration education-service, with a consequent insertion of undergraduate students in the field of health into the practice of the SUS Network since the beginning of their education, with an emphasis on PHC.

Another initiative to promote changes in professional education is the Educational Program for Health Work, which aims to foster tutorial learning groups in strategic areas for the SUS, as a tool for the qualification of health workers, as well as the initiation in the work and education of undergraduate health students. The perspective is to qualify care and to consider the need for services as a source for knowledge production and research at universities. Both programs have, as their premises, the consolidation of the integration education-service-community and education through work.

In permanent education in the field of PHC, another highlight is the creation, in 2007, of the Brazilian National Telehealth Network Program, whose objective is to strengthen and improve the quality of PHC, with the integration of education and service through tools and communication and information technology in four fields: teleconsultation, formative second opinion, telediagnosis and tele-education.

Since 2012, there has been an incentive for municipalities to develop residency programs in Family and Community Medicine within its respective Health Care Networks, for the

insertion of the resident in Family Health teams, with the follow-up of a tutor and the recommendation of equalizing the grants to the average salary of family health physicians in the municipality.

Another initiative is the Program for Basic Health Professional Valorization (Provab), which provides the action of physicians, nurses and dentists for 12 months, through grants. Under the supervision of a higher-education institution, it includes the participation of the professional in a PHC specialization course. Every week, the professional performs practical activities for 32 hours in Basic Health Units and the remaining 8 hours are dedicated to the specialization course.

INTERSECTORALITY IN PHC

Health promotion is defined as one of the functions of PHC in Brazil, according to the National Primary Health Care Policy (2011) and it is part of the extensive and comprehensive concept of health and of the function of all professionals in PHC teams. It includes actions in the individual and collective ambit, which are able to impact the "health status and autonomy of people and on determinants and conditioning factors of the health of the collectivities" (Brasil, Ministério da Saúde, 2011a:19). In general, the sectors of education and development are the ones most articulated with PHC teams, both due to the Health School Program or to the follow-up of the conditions of the *Bolsa Família* Program. The Community Health Worker is the professional who is most directly involved in intersectoral actions.

In the scope of PHC, two intersectoral programs are remarkable by their institutionality: the School Health Program and the Health Academy. The School Health Program works for collective action of the Ministries of Education and Health for the promotion of comprehensive care to children, teenagers and young students in basic public education, kindergartens and preschool education. Some of the actions that must be developed by basic care and education teams are: clinical and psychosocial evaluation; promotion of healthy nutrition; corporal practices and physical activities at schools; sexual and reproductive education and prevention of the use of alcohol, tobacco and other drugs, among others (Brasil, Ministério da Saúde, 2011a).

Intersectorality is a principle for the development of actions of the Health Academy Program. Academies are part of PHC and must be coordinated by it, as another point in health care, which must be articulated with other health services in the network. Academies are linked to a Family Health Support Group or to a Basic Health Unit. The main objective is to "contribute to health promotion and production of care and of healthy life habits to the population, from the implementation of poles of excellence with qualified infrastructure and personnel" (Brasil, Ministério da Saúde, 2013b).

Another initiative in intersectoral articulation is the interface between social assistance and health, in the ambit of the *Bolsa Familia* Program (PBF). The PBF, under the

management of the Ministry of Social Development and Fight against Hunger, is a device for direct income transfer to families in situation of poverty or extreme poverty, with a goal to promote the access to basic social rights and to break the intergenerational poverty cycle. The Program is carried out through financial support to families, which is linked to the accomplishment of commitments in health, education and social assistance, called conditions. Community Health Workers identify vulnerable families to be enrolled in the PBF, follow-up, encourage the accomplishment of the health conditions and keep record of them. The *Bolsa Familia* has three main axes: transfer of income to promote the immediate relief of poverty; the accomplishment of the conditions, in order to ensure the access to basic social rights in the field of education, health and social assistance; and actions and complementary program aimed at the development of families to help beneficiaries overcome their vulnerability.

Rasella et al. (2013), in a research based n secondary data of 2,853 municipalities, have observed that the *Bolsa Familia* Program reduced in 19% the general under-five mortality rate in municipalities covered by the program, and this reduction was even more significant when it considered the mortality rate specifically due to causes such as malnutrition (65%) and diarrhea (53%). The authors have also verified that the association between the PBF and the Family Health Strategy produces synergistic effects in the reduction of under-five mortality rates. The study concluded that the increase in income, enabled through financial transfers, supports the access to food and other health-related goods. These factors support the reduction of poverty for families, improve life conditions, eliminate difficulties in the access to health and, as a consequence, contribute to the reduction in deaths among children.

Research by Giovanella (2009a) in four urban centers revealed that development of intersectoral actions in territory by Family Health teams could be boosted by intersectoral articulation at the municipal executive level. Results showed that about half of professionals of Family Health teams carry out surveys on the community problems and participate in activities together with other sectors, to solve community problems. Results are coherent to studies that show low rating of "community orientation" by users, even though they are better than those in traditional basic health units (Giovanella et al., 2009a).

SOCIAL PARTICIPATION IN PHC

In Brazil, social participation is institutionalized as one of the guidelines of the Unified Health System and the rules for social control have been defined by Act 8,142 of 1990, which establishes the implementation and operation of Health Councils in order to receive fund-to-fund financial transfers (Brasil, Presidência da República, 1990).

The National Health Council exists since 1937, but until 1990 it functioned as a consultative body and its counsellors were designated by the government (Coelho, 2012). In

the configuration of the SUS, the councils represent collegiate bodies of permanent and deliberative character, formed by representatives of governments, service provides, health professionals and users (50% of members), which act on the formulation of strategies and on the control of the execution of the policy of their corresponding instance, federal, municipal or state, through monthly meetings.

Health Conferences are another social participation body of the SUS. Held every 4 years, they must necessarily count on the participation of organized social movements, entities linked to the health area, managers and service providers. The main objectives are to evaluate the health status and the access to health services and to propose guidelines for the formulation of policies. Deliberations at Conferences must orient governments in the elaboration of health plans and in the definition of priority actions at the three levels: state, municipal and national.

For the implementation and accreditation of Family Health teams by the Ministry of Health, the project elaborated by the municipal management must be approved by the Municipal Health Council formed by representatives of the civil society, providers, health professionals and managers, before it can be forwarded to the state health secretariats. Fund-to-fund resource transfers for PHC from the Ministry of Health to municipalities is made in an account specifically opened for this purpose, in order to facilitate the follow-up by Municipal Health Councils, which receive the notification about the reception of the credit. The proof of the application of "fund-to-fund" resources is presented to the federal manager through management reports and must be approved by the corresponding Health Council.

At the local ambit, there may be Local Health Councils, which are responsible for the evaluation of the health policy in the area of coverage of basic units. The National Primary Health Care Policy (2011) recommends that Basic Health Units should have councils/management boards that enable social participation at the local level (Brasil, Ministério da Saúde, 2011a). The results of the PMAQ-AB (2012) indicate that 59% of PHC teams work with Local Councils and that 73% of them have communication channels with users (PMAQ-AB, 2012).

Health councils and conferences are prioritized by official texts and by the majority of social actors as the main forms of social participation and division of power between managers, workers and users in the SUS (Coelho, 2012). There are structural and political problems recognized, above all, in the municipal sphere, such as: low representativeness and renovation of members, dominance by more organized groups, resistance of governmental bodies to work with new social actors, the concept by managers and professionals that the user is not able to contribute, and the disadvantaged position of users in councils concerning the availability of time, transportation, etc., in comparison with other groups (Coelho, 2012).

Nevertheless, there is a common interpretation that, although the legal definition of social participation through councils and health conferences does not ensure by itself full and effective participation, it represents an achievement in the construction of citizenship (Vianna

et al., 2009) and that institutionalized spaces for participation may contribute to the formation of collective identities.

INTERCULTURALITY IN PHC

In Brazil, the incorporation of interculturality to PHC official documents and policies is recent. The preoccupation with an intercultural approach is more traditional in indigenous health policies.

The Basic Care department defines that: "interculturality is understood as the mode of coexistence in which individuals, groups and institutions, with different cultural characteristics and positions, live together and are openly, inclusively, horizontally and respectfully integrated, and mutually reinforce each other in a shared context" (Brasil, Ministério da Saúde, 2014a).

In the National Primary Health Care Policy, there is no reference to the concept of interculturality, whose actions are incipient in the country. Still, it claims that PHC must consider the subject with its singularity and social and cultural insertion, in order to achieve comprehensive care.

The publication of the National Policy on Integrative and Complementary Practices, in 2006, institutionalizes homeopathy, medicinal and phytotherapy plants, traditional Chinese medicine/acupuncture, anthroposophic medicine, among others, in the Unified Health System. It considers that the use of medicinal plants and derived products as therapeutic resources is conditioned to the comprehension and valorization of multiculturality and interculturality by managers and health professionals for more equity (Brasil, Ministério da Saúde, 2006).

There are references to interculturality in the SUS in the National Policy for Health Care to Indigenous Peoples (2002), which defines the right of populations to a differentiated care in the Unified Health System, in respect for their cultural singularities (Brasil, Fundação Nacional de Saúde, 2002). The creation of the Subsystem for Indigenous Health Care recognizes the historical inequalities and inequities experienced by indigenous peoples in Brazil (Langdon y Diehl, 2007).

The Special Secretariat for Indigenous Health is the area of the Ministry of Health responsible for the coordination of the National Policy for Health Care to Indigenous Peoples and the entire management process of the subsystem for Indigenous Health Care. The Special Secretariat was created in 2010, based on the need for a reformulation in the management of indigenous health in the country, a demand vindicated by indigenous peoples during National Conferences on Indigenous Health (Brasil, Ministério da Saúde, 2014b). States, municipalities and non-governmental organizations may act complementarily in the execution of indigenous health actions (Brasil, Fundação Nacional de Saúde, 2002); nonetheless, contracts with non-governmental organizations are predominant in the health care of indigenous peoples in Brazil.

FINAL CONSIDERATIONS

The Brazilian experience with Primary Health Care shows a diverse scenario of practices, despite the remarkable legal and normative framework implemented by the federal manager. In general, the perception is that the concept, organization and evaluation of PHC, since 2002, make strong reference to the works of Bárbara Starfield (2002), whose essential and derived attributes have become the image-objective in the search for a robust and comprehensive PHC. The Brazilian concept aggregates the importance of the territory, a key concept for the definition of actions capable of impacting on the social determinants of health and overcoming the logic of the working process predominantly oriented by programmatic actions offered to determined vulnerable groups or to specific health problems, such as the follow-up of the development of children, prenatal, hypertension, among others (Starfield, 2002).

The characteristics of the decentralized atomized process, that is, in a direct relation between the Ministry of Health and the more than 5.5 thousand municipalities with a considerable level of autonomy and low participation of states, have contributed to the diversity of experiences, in many cases successful and closer to the local and regional needs. On the other hand, these same characteristics have also contributed to the multiplicity of types of employment contracts, the heterogeneity in infrastructure and labor conditions. Above all, the excessive decentralization was an obstacle to the formation of networks that were able to ensure integration and integrality of care, which is an important challenge for the SUS. Some authors state that the Unified Health System presents coordination and integration levels within the operation of its assistance network that are insufficient so as to call it a system (Cunha y Campos, 2011).

The diffusion and institutionality that PHC reached over the last two decades in Brazil is unquestionable. Beyond the official discourse that institutes PHC as the preferential entry point, accessible, comprehensive, longitudinal, focused on the community, coordinator of care, which ordinates networks, among other functions mentioned in the national policy, some points seem to be key to the effective materialization of the discourse and to ensure universal access to quality health care.

Evaluative researches and literature on the issue show that there are diverse problems that prevent PHC from fully performing its role as the entry point of the system and users from receiving care as soon as they need to. According to Campos et al. (2010), the dimension of the provision of care implies the arrangement, organization and preparation of teams to receive, at different times, great variety of demand, with the ability to make risk evaluation and to ensure maximum case-resolving capacity. Problems with the use of basic units as the first contact service, inclusively in municipalities that count on a PHC that is historically consolidated, as Curitiba, suggest that the approach to this issue is beyond the

necessary standardization of procedures, for it demands changes in the organization of the working process of teams based on the health needs of the territory.

The organization of the network based on the definition of the preferential entry point through PHC faces a strong competition with urgent and emergent hospital care services as first contact services. This is a situation that is probably aggravated by the insufficient articulation between points of care (basic and specialized) and by problems in the organization of the working process of Family Health teams, with a low level of integration between scheduled actions and care to spontaneous demand. In this sense, it is possible to say that the coordination of care depends on institutional policies that can address the fragmentation of health services, strengthen regional articulation bodies, expand delivery and improve the regulation of the access to specialized care based on PHC (Almeida y Santos, 2014).

Another nodal point is funding, not only of PHC, but of the public health systems, whose public expenditure still does not represent 50% of the total expenditure on health in the country. Although there has been an increase in federal resources for PHC since 2000, the tripartite composition of public investments is still insufficient to ensure the strength intended. At the same time, some studies have demonstrated that, in average, 60% of the expenditure of Family Health teams are destined to human resources: once more, municipalities are overloaded with difficulties in the attraction of professionals and even compromise their budgets in order to hire physicians (Vieira y Cervo, 2013). Constitutional Amendment 29, with its recent regulation, after more than a decade being processed by the National Congress, was a progress in the guarantee of stable but rather insufficient sources and, to a certain extent, also reflects the correlations of power involved in the achievement of a universal health system.

The rules that define the outreach of actions that must be developed in PHC are quite comprehensive. Nonetheless, the implementation of a set of procedures depends on several conditions within Brazilian municipalities, in regard to infrastructure, the availability of professionals, continuing education, social inequalities and the concept of the role of PHC in the health system.

It is important to mention that these conditions do not minimize the primitive effects of the evident expansion in the access and qualification of PHC, which has been observed since 2000 and include the significant reduction in geographic and economic barriers due to the capillarity in the distribution of Basic Health Units, which enables the access to most of the users within a walking distance. The incorporation of Oral Health to the Family Health Strategy also represented the public provision of services in a field that, until then, was monopolized by the private initiative.

As if the mission of mapping PHC in the country is not sufficiently complex, we must deal with distinct models of organization. Approximately 62% of the population is formally covered by Family Health teams. Another part of the population uses basic health units and centers called "traditional", whose organization may vary. It is estimated that the

coverage of population through the basic care of the SUS in the country reaches over 70% (DAB, 2014b). Therefore, we find ourselves in a heterogeneous panorama. This coexistence is more common in bigger urban centers that already counted on a network of PHC facilities before the Family Health program. Although the National Primary Health Care Policy may define guidelines to all types of organization for PHC, very often there are greater difficulties in territorial and family action and for the insertion of professionals in these traditional units, since there are very diverse types of contract, workload and services provided, generally following the logic of vertical programs.

We also live with an important part of the population covered by private health insurances, with direct access to specialists and under a model of ambulatory care that operates according to a market logic that is completely different from the public system. Besides being strongly regarded by the means of communication and by the population due to the ease of access and despite the good health results of the public systems, private insurances are strong competitors for the employment of human resources, especially physicians, and they contribute to the low valuation of professionals working in the SUS.

The mapping hereby presented focused on PHC characteristics as part of the public system which, however, coexists with an important private system. Some of the elements presented indicate the level of segmentation of the health system and of PHC. The public funding of the SUS was not able to reach the necessary amounts to enable the universality proposed by the Constitution. Segmentation is observed with an important percentage of the population covered by the private health system, especially groups of higher income or which receive this benefit through labor insertion and which have access to health services and procedures conditioned by their ability to pay. Another highlight is that public coverage is non-excludable and therefore the entire Brazilian population may benefit from the SUS, even if it is through collective or high-complexity/cost activities such as hemodialysis or the treatment of AIDS. In PHC, there is a level of segmentation among the population covered by the traditional model and the Family Health teams that, in general, present better results when evaluated in regard to their essential attributes. The differences between municipalities with regard to their network, infrastructure and availability of professionals also condition provision and the distinguished access to health care, generally in PHC.

One important element for the implementation of the SUS is the incorporation of other actors and institutional spaces for a shared management of the system, in addition to formally constituted spaces. Nevertheless, beyond official dispositions it seems urgent to search for devices that favor the organization and participation of local communities in the effective co-management of PHC services, with the strengthening and expansion of Local Health Councils. With the mapping of this wide and diverse field of basic care in the country, in spite of successful local initiatives, there is a perception that, in the federal management, policies and actions to induce and strengthen social participation are still incipient, even with

the institutionality of the National Health Council and the Sanitary Movement, which has aggregated several sectors of the Brazilian society in the formulation of a unified health system, based on the universal right guaranteed by the State since the end of the 1970s.

In this very field, and another aspect of the same problem, Family Health teams generally present an insufficient intersectoral and community action, as well as the corresponding municipal executive powers, with low capacity for intersectoral articulation.

We also highlight that the mapping of PHC dimensions makes it possible to emphasize on some critical points faced by the federal manager. The recognition and confrontation of the precariousness of the infrastructure for PHC services is an important initiative by the Ministry of Health that gives significant contributions to the expansion, repair and construction of new units through the presentation of projects from municipalities in the ambit of the Program for the Requalification of UBS.

Investments in Information and Communication Technologies, with the creation of a computerized clinical history, regulation systems based on PHC and telehealth tools, available to 18.5% of teams that adhered to the PMAQ-AB in 2012, are concrete possibilities for closer relations between professionals of different specialties, for improvements in coordination and continuity of care and the increase in the case-resolving capacity of PHC. Without underestimating the importance of such initiatives, something that has come to our attention is that simple technologies, as the use of the telephone to book a visit to the Health Center, are still an improbable reality in the country, as demonstrated by the PMAQ-AB (2012). On the other hand, investments in the matrix support through multidisciplinary teams of Family Health Care Units since 2008 have broadened the knowledge and qualified practices in PHC. It is possible that the greatest progress of the current federal management of PHC has been attained in the area of health work, even though these initiatives have not reached consensus. The main initiative is the More Doctors for Brazil Program, which enabled the entrance of foreign physicians, mainly Cuban (more than 11000) or Brazilian, graduated overseas, to act on PHC services in remote and underserved areas. Studies carried out to evaluate the satisfaction of users seen by professionals of the Program show that 95% were satisfied or very satisfied with the action of the doctor and 86% consider that the quality of health care is better/much better after the arrival of the doctors of the program (Brasil, Presidência da República, 2014d).

The expansion of Family Health teams and Family Health Support Units was followed by initiatives funded by the federal manager, which combine undergraduate health education with the practice at facilities, especially in PHC, with the participation of students, university teachers and health workers that function as tutors.

Nonetheless, there is still the self-regulation of professions by their respective councils and the definition of medical specialties by the Federal Council of Medicine. Although the medical residencies may be funded by public resources, it was only recently that the Ministry of Health started to intervene effectively in the definition of the offer of positions by each

specialty. Despite the due considerations in regard to the differences between health systems, Starfield (2002) defines that one of the parameters that can indicate the strength and orientation of the system towards PHC is the number of PHC physicians in comparison with other specialists. In a reality in which we have more professionals with residency in Plastic Surgery than in Family and Community Medicine, we could question the possibilities for the construction of a model of health based on a strong PHC. There are no State policies to address the precariousness of labor contracts, with the creation of carriers for the SUS. The absence of a professional career in the SUS affects PHC more dramatically, once the continuity of the professional-user relation is defined as an ethical and organizational guideline.

The institutionalization of the evaluation in PHC is a priority issue for the Ministry of Health, which gained impetus with the expansion of the Family Health Strategy. Important associations between the federal manager and learning institutions have been established over the last years for the development of evaluative studies and monitoring of PHC. In 2012, the first sequence of evaluation of the Program for the Improvement of the Access and Quality of Basic Care (PMAQ-AB) started to be developed and counted with the adherence of about 17,000 PHC teams. The PMAQ-AB conditions the reception of resources to the attainment of quality standards. In 2013, the second sequence of external evaluations was carried out, with the expansion of the number of adherents to more than 30,000 teams in 5,211 municipalities.

An important progress in the PHC national policy since 2006 is the recognition of populations with differentiated health needs, with the creation of specific financial contributions. These are the cases, for example, of the recognition of the singularities of the riverine populations of the Legal Amazon area, with the provision of Fluvial Basic Health Units, whose structure is fully funded by the Ministry of Health under a different funding model. The experience with the first Fluvial Basic Health Unit in the municipality of Borba, reported in this chapter, may be noted as a successful and exemplary experience of the diversity of a comprehensive PHC in the sense of being capable to maintain its essential attributes while it is organized in a singular way in order to meet the needs of a specific territory.

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Primary health care in insurance-based health systems: the case of Chile, Colombia and Peru

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INTRODUCTION

This chapter presents a comparative analysis of the mapping of Primary Health Care (PHC) in Colombia, Peru and Chile. This work started in November 2013, with the collection of information in each of these countries and was concluded in the first semester of 2014. The study used qualitative techniques for document analysis, technical visits for field observation and interviews with several actors of the Health System at national and local levels. The information was later analyzed in a critical reflexive process based on predefined categories and some emerging ones, which are presented subsequently in a narrative synthesis.

Concerning general characteristics, it is important to remark that Chile, Colombia and Peru have segmented health systems, based on reforms that have introduced the social and private insurance to wage earner employees and independent sectors, and public assistance to the poor with no ability to pay. The systems follow the rules of separation and specialization of the roles of management, funding, insurance and provision of services, with the inclusion of multiple public and private actors. They maintain exception subsystems to special groups of the population, among them some workers of the public sector and public enforcement officers. In these three countries, health is formally proclaimed as a social right, but there are different means for its application. Likewise, Primary Health Care (PHC) is considered a strategy of the public component of the health system.

The Chilean health system is dual, with a public and a private component, for insurance and the delivery of services. The public insurance is formed by the National Health Fund (Fonasa), which hires health service provision for its affiliates from a public network of providers that integrate the National Health Services Network, although higher-income affiliates may have the option to choose private providers by paying an additional bonus. Private insurance is constituted by Health Insurance Institutions (Isapre) that hire the health care of their affiliates from private providers. The system delivers health care to the population through plans for the protection of individual and collective health risks. The

Fonasa offers a universal plan to its affiliates with predefined individual provisions whereas the Isapre offer volunteer plans at varied prices, according to their ability to pay. The system includes public health actions incorporated to distinct programs and activities for the reinforcement and protection of collective risks for the overall population. Affiliates of both components of the system have guaranteed access to health service providers protected through a rule of Explicit Health Guarantees (GES), which regulate the quality, the timeliness of care and the financial protection of households from a set of priority health problems. Currently, 80 pathologies are included in the GES system (Chile, Ministerio de Salud, 2014a; Chile, Superintendencia de Salud, 2014; Chile, Ministerio de Salud, 2012a). According to Fonasa, in 2010, the affiliation covered 93% of the population, 74% with Fonasa, 17% with Isapre and 2% in the army.

Colombia's health system is a public/private mix formed by a General Social Security Health Care System (SGSSS) composed of two regimes, a contributory one, for the population with ability to pay, and another one, subsidized, for the poor. It includes a public/private intermediation through Health Promoting Companies (EPS) for the management of the insurance to health risks and the administration of public funds. The EPS hire health service provision from private providers, for the contributory regime, and from public and private providers, for the subsidized regime. The insurance system protects the population through two types of provision: 1) a Compulsory Health Insurance with predefined rates that cover individual health risks of affiliates of both regimes; and 2) a Public Health Insurance that covers collective risks of the population as a whole. Affiliates with higher incomes may improve the Compulsory Health Insurance with a Complementary Insurance at variable prices. Likewise, these same sectors of the population have the option to purchase private prepaid medicine insurance plans at variable prices. Teachers at schools and some public universities, employees of the Colombian Oil Company (Ecopetrol) and law enforcement officers have health regimes outside the SGSSS (Ramírez Moreno, 2010). According to the National Survey on Quality of Life, in 2013, 91% of the Colombian population was affiliated to the General Social Security Health Care System (SGSSS). 49% of the SGSSS affiliates were covered by the contributory regime and 5% of affiliates were covered by the subsidized regime (Colombia, DANE, 2014). The 9% of the population not affiliated to the SGSSS included affiliates to exception regimes, poor beneficiaries of the subsidized services and people without any protection.

Peru's health system is also a segmented public/private mix. It includes a social health insurance of contributory character, an assistance public insurance subsystem focused on the poor, a private subsystem and another one for the army and the police. The Health Insurance Funds Administrator (Iafas) is in charge of risk management and funding of the system, which includes several health subsystems: the Social Security Health Insurance (EsSalud), which corresponds to the Social Security of formal and independent workers with ability to pay, who can count on a specific network of health service facilities; 2) the

Comprehensive Health Insurance (SIS) in the public assistance subsystem, which is subsidized to the poor and semi-contributory to informal workers with low ability to pay, and hires public facilities that provide health services from the Ministry of Health and from operating networks; 3) Private Iafas, for private and contributory insurance; and 4) the Health Services of the army and the police, which have their own specific institutions providing health services (Wilson et al., 2009; Giovanella et al., 2012; Perú, SIS, 2014). The population of Peru benefits from two general types of provision: the individual and predefined ones, with a minimal priority list, for affiliates of the social security system; and the public health insurance for the overall population. According to the National Household Survey 2012 of the National Institute of Statistics and Informatics of Peru, 61.9% of the population is affiliated to a health insurance, despite the differences according to the area of residence, which favors the rural sector (72%) in comparison with the urban area (59%). Moreover, there are wide differences by region (that rank between 88% and 41%). 31% and 24% of the population reported to be affiliated to the SIS and to the EsSalud, respectively, in 2012 (Perú, Ministerio de Salud/Sunasa, 2013).

PHC CONDUCT

PHC emergence and history

Despite historical differences, Chile, Colombia and Peru have recently started to put into practice the Primary Health Care recommendations that came from the Declaration of Alma-Ata in 1978 (OPS/OMS, 1978). Even though it had an unequal development, this first stage was later affected by the market-oriented reforms in health systems.

Chile, under the military administration of Pinochet, has constituted the current dual health insurance public/private system since 1979. This system replaced the previous National Health Service, created in 1952, which was a result of the development of the social medicine encouraged by Salvador Allende (Waitzkin, 2011). Since 1981, aiming to reduce the expenditures of the central State and to promote the privatization of health services, the military government decentralized the management of primary health care medical offices, centers and posts, which became partially municipalized and with their management in charge of municipal health departments and private health corporations (Scarpaci, 1989; Chile, Ministerio de Salud, 2012a; Bass del Campo, 2012), even though some of the services remained under the control of the Health Service, in the charge of the Ministry of Health.

Colombia, which had an unequal development of a combination of "primitive", selective, first-level, primary health care schemes with Local Health and Health Promotion Systems during the former National Health System, dismantled what had been achieved up to the beginning of the 1990s with the constitution of the SGSSS, in 1993 (Vega Romero et al.,

2012). With an approach that used to privilege market relations, this reform chose private devices that substituted the role of the State and PHC in the conduct and orientation of health services, with management through Health Promoting Companies (EPS), in order to ensure access to care and management of health risk.

In Peru, many PHC experiences have been developed under the framework of this first long path that dates from the end of the 1970s until the 1990s. It is widely known that these experiences have been characterized, in general, by the development of selective PHC forms, located in specific areas of the territory, such as the Rural Medicine program in Puno (directed by Dr Manuel Núñez Buitrón), the Primary Health Care and Basic Sanitation Project in Cajamarca (Altobellu et al., 2001), Project 2000, Basic Health and Nutrition Project, Project New Initiative and Basic Health to All Program (Calderón, 2004).

After these initial experiences, which, in general, did not fully incorporate the guidelines of the Declaration of Alma-Ata of 1978 and as a consequence of the difficulties and failures of the market-oriented sectorial reforms, new PHC initiatives started to emerge, although they were limited by the logic of insurance systems. In order to move forward, it was necessary to have initiatives of national and local progressive governments (Laurell, 2008), the involvement of civil society organizations and the promulgation of research reports that endorsed the importance of PHC to strengthen health systems, to address the social determinants of health and to attain equity (PAHO, 2007; Labonté et al., 2008; OMS, 2008; Acosta Ramírez et al., 2011).

Under these circumstances, the government of these three countries found themselves obliged to continue to recognize the importance and the presence of PHC and then started to take some measures, although in different moments, to convert it in a public strategy of health systems and society or, at least, to strengthen what already existed, to justify the changes of health care models and to promote public health programs.

Chile was the first one to move in that direction. With the governments of the political coalition *Concertación*, several measures have been taken, such as the introduction of the funding mechanism through per capita payment of services, since 1994, which replaced the previous payment by service delivered; the search for the transformation of primary health care traditional offices and centers into family and community health centers with the population in charge, since 1997; the strengthening of the Fonasa as a public fund for health and not only for its affiliates, since 2000; the creation of public health boards and service networks to improve health management; the introduction of the rules of the Explicit Health Guarantees; the formulation and implementation of a Comprehensive Health Care Model, based on a family and community PHC approach; and finally, the inclusion of the intercultural approach in health care with Exempt Resolution No. 261 of 2006 of the Ministry of Health and the National Policy on Health and Indigenous Peoples (Scarpaci, 1989; Chile, Ministerio de Salud, 2006; Infante y Paraje, 2010; Montero et al., 2010).

In Colombia, there have been initiatives for the reinsertion of PHC based on the

perception of the inability of the General Social Security Health Care System (SGSSS) to manage individual and collective health risks, the lack of a comprehensive health care model and the crisis in public health. Although the implementation of Act 100 of 1993 (Colombia, Congreso de la República, 1993), concluded the PHC experiences carried out during the National Health System, it later originated three general approaches: the first one, with predominantly biomedical and assistance individually-oriented actions, "neoselective"[1] and with managed basic care, controlled by the EPS; the second, with collective public health actions, based on health promotion and prevention of diseases, under the influence of municipal, district and departmental health authorities; and the third, an intercultural approach based on native peoples, with different expressions according to the cultural traditions of ethnic communities that put them into practice, but in close relation with the role of these communities in the conduct of EPS and Institutions Providers of Indigenous Health Services (Vega Romero et al.,2012).

With the insurance reform process and the decentralization of health, Peru has initiated, since 2003, through Resolution 729 of the Ministry of Health, a first version of PHC based on basic health teams and distinct family health strategies, which were called Comprehensive Health Care Model (MAIS). This was considered a fundamental reform of public health and of the prevailing assistance model. However, due to the limited sectorial outreach of its implementation, its poor development, the persistent assistance policies, the fragmentation of care and the lack of a clear family, community and environmental approach, since 2011, there have been adjustments to the strategy through the Comprehensive Health Care Model Based on the Family and the Community (MAIS-BFC). This model represented the beginning of the third period of PHC development in Peru (Medicus Mundi et al., 2012; Perú, Ministerio de Salud, 2010; 2011). It was assumed by the network of health facilities of the Ministry of Health, by regional governments and, explicitly, by the EsSalud, whereas this approach is not clearly established in the policy documents and plans of the Comprehensive Health Insurance. Although apparently with less strength than in the other two countries, the MAIS-BFC promoted an intercultural approach to health care.

Definition and current PHC approach

All three countries promote the PHC renewal approach (PAHO, 2007) that, even though it follows the guidelines of the Declaration of Alma-Ata of 1978, is adapted to the sectorial insurance-based reform model. The PHC model claims to be family and community-oriented; to include characteristics of entry point, integrality, coordination, longitudinality and

[1] This document denominates as neoselective the prioritization, under cost-effectiveness criterion, of individual provision of promotion and prevention included in the POS and controlled by insurance companies, referred to 4 or 7 interventions prioritized by Selective-PHC (GOBI and GOBIFFF) at the beginning of the 1980s to reduce child mortality rates in poor and vulnerable populations.

continuity of care; to emphasize on the prevention of diseases, health promotion and effectiveness; and to consider community participation and intersectoral action for health. Some governments make an effort to build an institutionality that is adequate to the model of care, to strengthen and qualify procedures, to organize work, to improve the staffing of human resources, infrastructure and equipment of the first level of care, and to develop integrated health service networks based on PHC.

Therefore, in Chile, for example, PHC aims to:

> *"make health services closer to the population in order to reduce the existing gap between 'privileged' and 'underserved' ones, ensuring a more equal distribution of health resources in order to provide essential care based on 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 at every stage of their development in the spirit of self-reliance and self-determination"* (Chile, Ministerio de Salud 2007:7).

Peru aims at the:

> *"transformation of health systems, with PHC as its foundation. To this end, it is necessary to [...] rearrange health services towards promotion and prevention; this adjustment must be achieved through the assignment of proper roles to each level of government, the integration of public health and individual care services, the development of an orientation towards families and communities and the creation of an institutional framework that encourages the improvement of the quality of services; it also requires a special concentration in the role of human resources and the development of strategies to manage this change and in to be in line with international cooperation focused on PHC"* (Perú, Ministerio de Salud, 2011:23).

In Colombia, PHC is defined as:

> *"the strategy of intersectoral coordination that enables comprehensive and integrated care, starting at public health, health promotion, the prevention of diseases, diagnosis, treatment, rehabilitation of the patient in all levels of complexity in order to ensure a greater level of wellbeing for users, with no prejudice to the legal competences of each one of the actors of the General System of Social Security for Health"* (Colombia, Congreso de la República, 2011).

Act 1,438 of 2011 establishes that PHC shall be "formed by three integrated and interdependent components: health services, intersectoral/transectoral action for health and social, community and citizen participation".

Functions and competences of governmental spheres

Shortly after the approval of legislative rules by the Congresses of all three countries, the Ministries of Health were assigned with the duty to formulate and give technical orientation to the implementation of PHC, which had different developments in each country. Considering

the prevailing public/private and decentralized insurance model, other levels of territorial government and market players in charge of the payment of care and of the management of health risks assumed duties that have been assigned to them by national government authorities.

In Chile, the responsibility to formulate and implement PHC-related policies is mainly of the Ministry of Health and, within the Ministry, of the Sub-secretariat of Assistance Networks/ PHC Division, which gives guidance to municipalities and health facilities through 29 Health Services. Each Health Service has a network manager, PHC and complexity levels. The Sub-secretariat implements the health priorities defined by the Sub-secretariat of Public Health and the actions to achieve its goals; defines policies that link PHC to the health care network; ensure the development of a comprehensive, family and community approach of the health care model; ensures the integration, efficiency and quality of the networks and defines policies that enable the development of the workforce required by the model of care. The Fonasa defines the funding priorities of health plans and programs and contributes to the follow-up and assessment of PHC.

PHC management contains two levels: a central one and a municipal one. The central level is in charge of 28 communes that include facilities, general rural and urban offices, rural health posts, medical stations and also programs for the reinforcement of primary health care and low complexity hospitals of the primary level, which are managed by the Health Services (Chile, Ministerio de Salud, 2007; 2013a; 2013b). Municipalities are in charge of other 321 municipal health communes. These communes are responsible for most of urban and rural health facilities through 267 Municipal Health Departments and 53 Municipal Health Corporations of private character, 29 of which operate in the metropolitan region. Moreover, there are 8 non-governmental organizations (NGOs) (autonomous institutions) that develop experimental PHC forms with State funding, the oldest one being 30 years old. In summary, municipalities may have four different operating types of PHC management: Development Corporations, Health Departments, Health Services and Experimental NGO methods (Chile, Ministerio de Salud, 2010a; Püschel et al., 2013). In turn, native peoples participate in the construction of the model of intercultural and comprehensive approach, but with self-management by the community of the funds assigned to it.

In Colombia, the Ministry of Health and Social Protection, via the Vice minister of Public Health and Service Provision and the Department of Service Provision and Primary Health Care, is responsible for general regulation of PHC implementation. To this end, there are pilot tests being developed in some regions of the country. Local health authorities (department, district and municipalities) define and implement PHC models based on collective actions of the public health plan. Health Promoting Companies (EPS), with contributory and subsidized regimes, define and implement private primary health care models based on individual actions, as a strategy for competition among them. Finally, Indigenous EPS and indigenous authorities define and implement, together with the government, the

intercultural health care models based on PHC. The role of the government in regard to promoting integration of the individual interventions of the Compulsory Health Insurance, run by the EPS, with public health institutions that are headed by local health authorities is not clear. Nonetheless, this integration has partially occurred due to the self-initiative of some local health authorities and indigenous communities.

In Peru, the entity responsible for the definition of technical PHC rules is the Ministry of Health, through the General Office for People's Health. Contrastingly, the Regional Health Departments, linked to the Ministry of Health, are responsible for the execution of technical-normative orientations and the supervision of the implementation of the strategy. The scope of execution of the MAIS-BFC over the national territory are health-related institutions within the local governments and health facilities of public, private and mixed character. The model defines dimensions and components for the formulation, implementation and management of the MAIS-BFC. There are two dimensions, political and operative. The former is responsible for national, regional and local government institutions and is in charge of the formulation and implementation of policies, programs and plans for the adoption of the MAIS-BFC and for addressing the social determinants of health through intersectoral interventions. The latter is responsible for health facilities, for the general population and for the implementation of the new MAIS-BFC. There are four components defined for the implementation of the MAIS-BFC: management, organization of delivery, health service provision and funding. The Regional Health Departments apply the technical-normative regulations and supervise their implementation; local authorities, health facilities and communities develop the model; the Health Insurance Funds Administrator (Iafas) manages resources to cover risks. The National Intercultural Health Center is responsible for the coordination of the National Sanitary Strategy of Indigenous Peoples' Health, but there is no information of their active participation in conduct and management.

PHC FUNDING

PHC expenditures in all three countries are funded with resources from different sources: taxes, parafiscal, out-of-pocket family expenditure and donations. Given the insurance character of the organization of the health systems and their intention to ensure the universal health coverage of primary health care services, salary contributions and contributions from incomes of independent workers provide resources for the costs of the access of affiliates with ability to pay to individual provisions, whereas national tax resources and those from subnational entities pay for individual provisions of people without ability to pay as well as for public health activities, such as the construction of physical infrastructure, staffing and the maintenance of health equipment. In general, there is no reliable information about the total PHC expenditure as a percentage of the Gross Domestic Product in each one of these countries, or data about the ratio of public expenditure in PHC. Only in Chile, it is known

that, in 2012, central level PHC expenditures as a percentage of the total public health expenditure, without the expenditure of municipalities, was 15%; and that, concerning other levels of complexity, PHC expenditures oscillated around 25% of the total public expenditure on health (Chile, Dirección de Presupuesto, 2013; Bass del Campo, 2014).

Responsible governmental spheres and their participation

The main funding source of municipal PHC in Chile is per capita payment (article 49 of Act 19,378 of 1995). The Ministry of Health/Fonasa transfers by decree, every year, a per capita base amount to each commune, according to the number of beneficiaries enrolled at primary health care facilities and medical offices. This basal per capita amount is complemented by a variable (communal) per capita payment that is adjusted according to conditions of poverty, rurality, presence of older adults, access to health care and difficulties in the delivery of provision. There are 48 communes that have fixed costs due to the number of beneficiaries (less than 3,500), geographic dispersion, rurality, difficulties in access and performance (Decree No. 82 of 2013 of the Ministry of Health).

The state per capita payment covers the set of provisions in the Family Health Plan. The amount is transferred to each municipal or central (Health Services) manager entity, or directly to PHC facilities and non-governmental organizations that have agreements with health services. The per capita amount covers 275 communes with a population of about 11,950,000 people, which corresponds to 73% of the total Chilean population (17 million people, approximately). Around 86% of the PHC budget is assigned to municipalities and the other 14% to Health Services of the ministry. Of the resources destined to Municipal Primary Health Care, 69% is transferred via per capita payment, 23% is assigned to programs for reinforcement and extraordinary initiatives for training and improvement and the other 8.3% is assigned to fund expenditures with employee benefits (Chile, Ministerio de Salud, 2013a).

Besides the per capita transfer, another mechanism for resource transfer is the prospective payment by service provision. It refers to the additional contributions by the State to municipalities, authorized by article 56 of Act 19,378 for plans and programs approved by the Ministry of Health for actions beside the ones already included in the Family Health Plan. These include diagnostic imaging, goals, targets and procedures for the PHC assessment, among others. These resources are assigned through agreements that are signed between the Health Services and the municipal entities that manage primary health care.

Moreover, there are resources assigned to public health programs, such as vaccination and nutrition programs, among others (Chile, Ministerio de Salud, 2007; 2014a). On the other hand, the Health Services of the Ministry of Health may assign funds through history-based Primary Health Care budgeting to facilities that depend on them and that carry out primary level actions. The Ministry of Health and the National Fund for Regional Development transfer tax resources for investments in constructions and for the maintenance of civil

constructions and equipment. Municipalities that manage PHC may use their own funds according to the needs of their population.

In Colombia, articles 42, 43 and 46 of Act 1,438 of 2011 establish the funding methods for public health actions within the Collective Interventions Plan and individual low complexity provision in the framework of the PHC strategy. Article 42 defines that the resources should come from the following sources: the public health component of the General Participation System defined by Act 715 of 2011; the Capitation Payment Unit, destined to the promotion and prevention of the subsidized and contributory regimes that manage the Health Promoting Companies; the sub-account of promotion and prevention of the Solidarity and Guarantee Fund; the resources for promotion and prevention that come from the Compulsory Traffic Accident Insurance; the promotion and prevention resources that manage and are destined to the Professional Risk Insurances; resources from the National General Budget for public health; a quarter-point of parafiscal contributions of the Family Compensation Fund; other resources destined to territorial entities.

In practice, funding resources established by Act 1,438 have been used discretionally by each actor of the General Social Security Health Care System (SGSSS) in the corresponding activity of their competence, with sparse or no actual concurrence with the several funding sources for activities of basic health teams, in order to facilitate the comprehensive health care they were supposed to provide. In general, the funding sources for primary health care under the responsibility of Health Promoting Companies (EPS) are part of the resources that the Solidarity and Guarantee Fund pay to each EPS per each affiliate, for provisions of the Compulsory Health Insurance. These total resources are called Capitation Payment Units (UPC) [2] and their amount is calculated according to the age, gender, place of residence (remote zones, normal zones, big cities) of each affiliate. The main funding source of PHC models based on activities of the Collective Interventions Plan are the funds of the General Participation System, the National General Budget and local contributions from municipalities, districts and departments, which are transferred as an income to the health secretariats of these territorial instances. When there are agreements between the territorial entities and the EPS of the subsidized regime, or service provision contracts between the public service provider institutions and the EPS, there may also be taxes and UPC resources, which are generally transferred to territorial entities or to private providers hired by them.

In the case of Peru, assignments for Primary Health Care (PHC) comprehend national ordinary resources for personnel with unspecified duration contracts in basic teams of public character Health Facilities (ES). In turn, the Comprehensive Health Insurance, as the Health Insurance Funds Administrator (Iafas), cover the provision of health services to its affiliates through agreements with regional governments to which the public ES belong and/or

[2] The Capitation Payment Unit is a source of insurance premium equivalent to the value of health risk coverage included in the Compulsory Health Insurance, which enables the participation of public and private actors, who receive these payments per each individual affiliate, adjusted according to their age, gender and territorial location of people.

through contracts with private health service providers. The ES also receive regional and local resources from regional health departments and from municipal health departments. The assignment of national resources to PHC prioritize public strategic ES in the first level of care. Furthermore, ES receive funds called "directly collected", which depend on the contract for the provision of services to affiliates of the Social Security Health Insurance (EsSalud), which, in turn, collects funds from the contributions of formal employees and their employers.

Co-payments

Although all three countries claim that the access to PHC is free of charge, especially to determined groups of pathologies and to the population with lower income, in many cases there are still out-of-pocket payment by households and payment for primary health care services and medicines. In Chile, even though there are no formal co-payments in the public health care to lower income groups A and B, those insured by the Fonasa of C and D sectors pay a maximum of 10 and 20%, respectively, for the guarantees and provisions that have co-payments in the Universal Access with Explicit Guarantees (AUGE). If the family has a health problem in the AUGE and co-payments or payment deductible from two salaries are accumulated in a period of 12 months, or from three salaries if the family has two or more health problems in the AUGE, the Fonasa will take over 100% of the co-payment during the corresponding accumulation period (Chile, Fonasa, 2014). In private services, 50% correspond to Fonasa affiliates, who partially pay out-of-pocket for the gaps in the public health care (payment shared between Fonasa and the patient). Out-of-pocket health payment as a percentage of the total expenditure on health was of 38% in 2008, approximately 2.8% of Chile's Gross Domestic Product that year (Cid Pedraza y Prieto Toledo, 2012).

In Colombia, there are co-payments for different procedures, except for promotion and prevention, maternal and child care, communicable diseases, high-cost pathologies and initial urgent care. Out-of-pocket expenditure[3] as a percentage of the total expenditure on health was around 18% (Colombia, Ministerio de Salud y Protección Social, 2014a) and 20% (Ramírez Moreno, 2013) in 2011, especially for ambulatory services, such as general medical visits and medicines.

Peru's SIS provides free care to the population affiliated to the subsidized regime, but there are payments for health care to the population not insured by the EsSalud or the SIS in public health services, as was shown by the national health accounts study (Perú, Ministerio de Salud, 2008). In 2005, households would fund 34% of the total expenditure on health and 97% of this were out-of-pocket expenditures for payment of private services, medicines and payment fees at public facilities (CetráNGOslo et al., 2013). In

[3] Includes expenditure with co-payments, moderation or recuperation quota, expenditure for general or specialized visit, hospitalization, lab tests and diagnostic aid, medicines, prosthesis and other health care related direct payments.

2006, the private health expenditure increased to 42% of the total health expenditure and 77.5% of it were direct household expenditures (Alcalde et al., 2014).

Payment methods to the final PHC provider

The payment methods to the final PHC provider vary from one country to the other. In Chile, the prevailing methods are per capita payment and the prospective payment by provision. Colombia uses the prospective fixed global payment, per capita payment and payment per event. According to article 52 of Act 1,438, low complexity services may be hired by capitation[4], except for activities of promotion and prevention, which are generally paid per event; other services must be hired, including indicators and the assessment of health results. The Ministry of Health and Social Protection has no competence for the regulation of fees, payment methods or the assignment of the UPC to the different provisions included in the Compulsory Health Insurance, beyond what is established by articles 52 and 53 of Act 1,438 of 2011[5]. In Peru, the SIS pays the first level Health Facilities through capitation with the transfer of four-monthly fixed amounts (generally of 20%) and a variable trimestral amount conditioned to the accomplishment of predefined indicators of structure, process and result. Regional and municipal health departments hire Health Facilities through performance-based budgets, according to performance indicators.

PROVISION OF PHC SERVICES

In all three countries, primary health care services are provided through units of the first level of complexity, which are public and private, although there is no precise information of their total number, in some cases. Public primary health care facilities are generally municipal institutions with administrative autonomy. Some units are private for profit companies, independent from or vertically integrated to insurance companies, whereas the other providers are nonprofit non-governmental organizations or entities that belong to some communities, as is the case of native peoples. These units provide individual and/or collective health care to their beneficiaries as described below.

Types of health facilities and professionals that provide PHC

In Chile, primary health care facilities are formed by general medical offices,

[4] That is, through per capita payment to providers from EPS and other payers.

[5] Article No. 53 of Act 1,438 of 2011 states that: "Payment mechanisms, service contracts, agreements or internal policies that limit the access to health services are forbidden, as well as those that restrain their continuity, timeliness, quality or that result in the fragmentation of the health care to users".

comprehensive health centers (family and community), low complexity hospitals, rural health posts and rural doctor stations, which are organized according to the level of integrality of care and the size of the population affiliated. General Medical Offices are ambulatory services that may be rural or urban, and that perform prevention, promotion, treatment and rehabilitation activities. Family Health Centers (Cesfam) are certified health offices or centers that offer primary assistance services – including secondary services for more case-resolving capacity – of treatment, rehabilitation, prevention and promotion, besides transversal dental and kinesiology programs. They organize their work into sectors with 20,000 to 40,000 people, with multidisciplinary general teams in charge of families, found their decisions in evidence-based medicine and carry out intersectoral and community participation activities. Community Family Health Centers (Cecosf) are community decentered strategies of Offices or of the Cesfam, through which part of the provisions of the Family Health Plan is provided to a maximum population of 5000 people, focused on actions for promotion and prevention. Low Complexity Hospitals are institutions being transformed into community hospitals, among which is the Community and Family Hospital, which offers ambulatory care services, inpatient, urgency, home and community care, among others. Rural Health Posts are facilities that operate in rural communities and which are staffed with at least one permanent paramedic. It is complemented with periodic visits by a medical and paramedical team, which may vary according to its size and the population affiliated in the region. The team may be staffed with one physician, one nurse, one midwife, one nutritionist and one social assistant. Rural Medical Stations are decentered working strategies of the Medical Offices, the Cesfam or Rural Health Posts for rural dispersed zones. They deliver health services, programs or activities in locations provided by the community. They have no permanent staff, but only the periodical support of health teams of the facilities to which they are linked.

In 2013, Chile had 362 General Urban Offices, 205 General Rural Offices, 140 Cesfam, 194 Cecosf, 1,166 Rural Health Posts, 153 Primary Health Care Urgent Services and 106 Low Complexity Hospitals. Out of the total 2,069 primary health care facilities, 1,876 were municipal, 172 Health Services and 21 were delegated. Out of the 360 General Urban Offices, 333 were municipal, 26 Health Services and one delegated. Out of 205 General Rural Offices, 202 were municipal and three delegated. Out of the 1,204 Rural Health Posts, 1,166 were municipal, 37 Health Services and one delegated. Out of the 194 Cescof, 175 were municipal, 11 Health Services and eight delegated. Finally, out of the 106 Low Complexity Hospitals, 98 were Health Services and eight delegated (Chile, Ministerio de Salud, 2014c).

According to the Service Provision and Primary Health Care Department of the Ministry of Health and Social Protection of Colombia, the current regulation does not define a "Primary Health Care Providing Unit". Nevertheless, since in Colombia the provision of PHC services is usually delivered at institutions that provide the first level of complexity, there may be an inference of a classification of the national distribution of these institutions according to their public or private juridical nature and according to their territorial character, which may

be national, departmental, district, municipal or indigenous. According to the aforementioned, in June 2014, at the national level, there were 996 operating institutions providing first level of complexity health services with public juridical nature and five private ones (Colombia, Ministerio de Salud y Protección Social, 2014c). Out of the public ones, 69 were of national territorial level, 147 departmental, 27 district, 695 municipal and 58 indigenous, with 2,879 and 38,926 services in total. Out of the private ones, there were one district, one municipal and three indigenous, with seven facilities and 29 services in total. Nonetheless, the existing institutions were not effective enough and did not have the sufficient infrastructure and organization to meet the requirements of a modern PHC approach. On the other hand, the high level of segmentation and fragmentation of the health systems made the adequate provision of services even more difficult (Colombia, Ministerio de Hacienda y Crédito Público, 2011; Colombia, Ministerio de Salud y Protección Social, 2012a; 2014c).

In Peru's Comprehensive Health Care Model Based on the Family and the Community (MAIS-BFC), the provision of services is conceived as comprehensive, continuous, with quality of care, oriented to meet the health needs (development, maintenance, derived from injury and disability) of the population, with emphasis on the promotion of health and the prevention of individual risks in the contexts of their family and community under a framework marked by the co-responsibility with the key social actors involved. In the first trimester of 2014, a total of 1,274 first level of care health facilities (16% of all first level facilities) informed to the Ministry of Health that they were implementing the MAIS-BFC and that they had Family and Community Basic Health Care Teams (Perú, Ministerio de Salud, 2013). In 2013, there were 153 Comprehensive Health Care Teams for Excluded and Dispersed Populations (AISPED Teams) distributed over 17 regions of the country, with an estimated coverage of 768,520 beneficiaries (Perú, Ministerio de Salud, 2013).

Members of PHC teams

External and internal health teams are another characteristic of the organization of primary health care in all three countries. The former tends to carry out community activities in dispersed population zones and the latter, rather individual and family activities. Teams are usually multidisciplinary and are usually formed under two modalities: basic and complementary teams. Indigenous communities also form health teams that establish intercultural relations.

In Chile, health care is guaranteed through multidisciplinary teams in the biomedical, psychological and social areas that include paramedic technicians and administrative staff. With these professionals and technicians, the health teams are organized to answer biological, psychological and social needs of individuals, families and the community. There are two types of multidisciplinary health teams: 1) basic teams, formed by physician, nurse, midwife, social assistant and administrative assistant; and 2) basic teams with complements, which adds

psychologists, kinesiologists, physical education professional, occupational therapist, nutritionist, dentist and dentist assistant. In some health centers there are transversal teams (described ahead) that represent a transition to type 2 teams, depending on the availability of local resources. In Mapuche communities there is an intercultural model with two types of health teams: one that is specific for the development of Mapuche health care, which includes activities with "wise men and women" of the community (elder adults selected due to their knowledge of the Mapuche history and culture), *machis* (traditional mapuche physicians), "bonesetters", midwives (piñiñalchefe) and herbalists (or *lawenches,* who prepare extracts from local medicinal plants); and a western team formed according to the previous rules mentioned above, in the case of Health Centers or Rural Health Posts (Neira Rozas, 2011).

Transversal teams have staff for clinical support in vaccination, healing, sampling and procedures, sterilization, as well as for the development of the National Program on Complementary Nutrition, the National Program on Complementary Nutrition for the Elderly, Rooms for Acute Respiratory Infections and Adult Respiratory Diseases, oral and administrative services. The municipalities are responsible for staffing PHC teams (PHC Bylaw Act 9,378), after a proposal sent to the Health Service, which is in charge of reviewing it. Its constitution, which may vary from one municipality to the other, is projected according to the Planning and staffing for the network in the corresponding year (see title I of Act 19,378).

In Colombia, primary health care is usually provided through traditional medical practice centers, but Act 1438 of 2011 states that the PHC strategy that drives the State shall be organized through basic health teams for the execution of collective, promotion and prevention actions defined by the Public Health Plans. According to Act 1,438, these teams must be formed in accordance with the needs and requirements of the population, with workforce that comes from the public health and from other sectors that develop actions to address the social determinants of health. Article 15 establishes that the territorial entities are in charge of the definition of the requirements to qualify the formation of the aforementioned teams after regulation by the Ministry of Health and Social Protection. Nonetheless, until now, the regulation has not been developed, which makes basic teams to be formed at the discretion of territorial health entities. Besides basic health teams, some territorial entities have implemented support or complementary teams, according to their available resources. The staff that forms basic health teams is usually formed by health promoters, assistants and health technicians, but some of them also have general physicians and nurses that work part-time, according to the availability of resources. In some cases, support teams may include dentists, nutritionists, psychologists, among others, depending on the resources of the corresponding territorial entity. In Health Promoting Companies, primary health care units usually have general physicians, nurses and dentists, along with specialists in basic medical areas, but they are not organized with the logic of a basic health team. Some of them include health staff with subspecialties, but this professional profile is not part of the low

complexity level, is complementary to assistance work (Vega Romero y Acosta Ramírez, 2014a). In the indigenous communities of Sierra Nevada de Santa Marta, basic health teams are formed by health assistants, bacteriologists, dentists, physicians, nurses and bilingual translators, who must always be present, since not all indigenous people speak Spanish. In native communities of the Department of Cauca there are two types of teams: community-based and support teams. Community-based teams are formed by *The Walas,* midwives, community health promoters, "pulse healers", eye healers, agro-environmental activity coordinators, *sobanderos* (people who treat simple fractures with balms and massage) and oral hygienists, who are coordinated by a nurse. Support teams deliver mostly assistance and western care and are also composed of general health professionals, technicians, assistants and technologists, and staff with other sorts of knowledge, such as alternative medicine and ancient wisdom (Vega Romero y Acosta Ramírez, 2014a).

In Peru, the strategy is developed with Family and Community Basic Health Teams (EB-SFC) assigned to first level of care health facilities (category I-2 and forth); moreover, I-4 health facilities should have physicians specialized in family medicine. The EB-SFC should, at least, be formed by human medicine professionals, with higher degrees in obstetrics, nursing, nurse technicians and professionals added depending on the local health scenario (Perú, Ministerio de Salud, 2013). According to the technical rule of the Ministry of Health (Perú, Ministerio de Salud, 2011), these teams cover families living up to 4 hours from the health facility to which the EB-SFC are assigned. For families located at a greater distance, there are mobile teams called Comprehensive Health Care Teams for Excluded and Dispersed Populations (Perú, Ministerio de Salud/DGSP, 2013). These teams are formed by a multidisciplinary group similar to the groups for zones with a concentration of population (physicians, nurses, obstetricians, nurse technicians), besides anthropologists and dentists.

Main services provided in PHC

In all three countries, PHC includes two sets of services, insurable and collective ones. Insurable services are a set of provisions that cover individual risks, medical-assistance services, medicines and technology, which are organized under the scheme of social insurances delegated to public or private insurers, which hire provision from public or private providers. Collective services are public health plans or programs that cover collective risks (public goods with high externality), which are under the responsibility of the government, with decentralized and usually public management.

In Chile, activities for prevention, promotion, treatment and rehabilitation are mainly included in two types of plans: the Family Health Plan and reinforcement programs. There are also other public health activities offered and the program *Chile Grows with You.* The delivery of provision, activities and programs is prioritized through the Explicit Health Guarantees regime (GES). Since 2012, the Family Health Plan is formed by 96 services provided, plus the

Explicit Health Guarantees, which include 80 pathologies (Chile, Ministerio de Salud, 2014a). This provision includes consultation for acute and chronic diseases at all ages and comprehensive care for prevention, promotion, treatment and rehabilitation (the latter especially for adults and the elderly), which may be individual, for the family or the community. Integral provision is organized by age groups through their life cycle: 14 of them refer to children, 15 to teenage health, 11 to women's health, and 11 to adult's health. 13 to the health of the elderly, 11 to oral health, 9 for general activities and 12 for activities with GES (see Annex No.1 of Chile, Ministry of Health, 2013b).

Reinforcement programs have been created in 1990 and include an incentive fund for the improvement of management at the primary level of health care, oral support to women and men with low income, acute respiratory infections program for children, respiratory disease program for adults, program for the diagnosis, ambulatory support of respiratory problems and urgent primary health care program, among others (Beteta, 2005). In public health, PHC includes activities of programs for the reinforcement of the Extended Immunization Plan, the National Program on Complementary Nutrition, the National Program on Complementary Nutrition for the Elderly, PHC promotion actions and activities, the Winter Campaign Program to address acute respiratory diseases, social protection activities in the Program for Support to the Newborn and basic PHC occupational health activities for uncovered workers. Furthermore, PHC is the basis of the program Chile Grows with You[6].

Primary health care activities in Colombia are also collective and individual, even though, unlike in Chile, its provision is not guaranteed in an integrated way due to the segmentation of the assignment of funds between insurance regimes (contributory and subsidized) and between the Public Health Insurance and the Compulsory Health Insurance (POS). Through basic health care teams (article 16 of Act 1,438 of 2011) and the Public Health Insurance (Colombia, Ministerio de Salud y Protección Social, 2013) the emphasis is, respectively, on the management of individual, family and community risks and on the inducement of the demand for services, as well as on promotion and prevention actions related to environmental health, healthy lives and non-communicable conditions, the health of informal workers, mental health and social life, food and nutritional safety, sexual and reproductive health, emergency and disasters, with an approach according to life cycle, gender, ethnic, disability and other vulnerability conditions. POS is a package of services, medicines, procedures and technologies for the protection of individual risks and medical assistance of all

[6] This is a complementary program for the social protection of the early childhood, which offers comprehensive care to girls and boys from pregnancy to kindergarten (four to five years old). This program includes, among other primary health care activities, the strengthening of prenatal care, comprehensive care to families in a psychosocial vulnerability situation, education of the pregnant mother and her partner or significant other and the program for the support to the newborn, strengthening of the control of the health of boys and girls for their full development, educational interventions for the support to children, strengthening of interventions with children in situation of vulnerability, delay and deficit in its full development, among others (Gobierno de Chile, 2013).

pathologies, except from esthetics, experimental and those not approved by the government. It includes activities for the recovery of health, prevention of diseases and transitory economic provision in situations of disability due to disease, accident or maternity. Primary health care provisions included in the POS are individual assistance activities and low complexity promotion and prevention[7].

Provisions are delivered through the network of the first level of complexity, which, according to the organization of PHC by EPS, territorial entities or indigenous communities, may assume different organizational forms, but usually with a combination of traditional basic care centers and health teams. Some models essentially deliver individual provisions of the POS; some other deliver provisions of public health promotion and prevention; others include traditional indigenous medicine (intercultural). The national government, territorial health authorities and Health Promoting Companies (EPS) do not integrate the provisions of the Compulsory Health Insurance (POS) with actions of the Public Health Insurance at the delivery point. This only occurs when the EPS of the subsidized regime hire POS low complexity activities from public institutions that provide services and are responsible for the implementation of public health actions. EPS of both regimes only perform individual POS activities, and not those of the Public Health Insurance. The reason is that these activities are under the competence of territorial health authorities, which hire public providers of the first level of care assigned to the municipal or district health secretariats. This segmentation and fragmentation of the insurance model hinders the integration of primary health care actions for individual and collective risks by territory and with the same service provider.

With the same insurance and public health logic seen in Chile and Colombia, Peru promotes the provision of comprehensive services for the health care of needs and risks (individual, family and community) through external and internal activities. Health care packages include both preventive-promotional and recuperation activities. Promotion is centered in several areas, such as basic sanitation and the consumption of safe water, physical activity, healthy nutrition, environments free of smoke and tobacco, values and good treatment to health staff, transit culture and vial safety, mental health with actions to address the violence against women, abilities for life, healthy family surroundings and child care. Prevention includes programs by life cycle and prioritized health problems such as teenage health, health of the elderly, eye health, vector-borne diseases, control of tuberculosis, maternal and neonatal mortality, chronic malnutrition, etc. Promotional services are provided

[7] According to Resolution No. 412 of 2000 of the Ministry of Health and Social Protection, these activities are: brochures for special attention to diseases as tuberculosis, leprosy, leishmaniasis, malaria and other of public health interest. 2) inducement of demand – information and education activities of affiliates in accomplishment of activities, procedures and interventions for specific protection and early detection of diseases; and 3) specific protection of individual risks and early detection of diseases that include: vaccination interventions according to the Extended Immunization Program, preventive oral health care, birth care, newborn care and family planning, early detection of alterations in growth and development, alterations in pregnancy, alterations of older adults (over 45 years old), cervical and breast cancer, and alterations of the visual acuity.

universally and free of charge to the entire population. The individual prevention and recovery services depend on the needs of the population and on the service portfolio, according to the level of complexity of health facilities to which basic teams are assigned. For affiliates of the Iafas of the Comprehensive Health Insurance, these services are defined in the Essential Health Insurance Plan, which includes explicit mandatory guarantees with almost 1,200 conditions covered. Moreover, there is a Complementary Plan with almost 4000 diagnoses and Plan Hope for cancer, funded by the Intangible Solidary Health Fund and the Comprehensive Health Insurance (Perú, SIS, 2012).

External interventions are carried out by health teams based on intervention packages to the individual (by life cycle), to the family and to the community. These imply successive home visits to: identify risks and elaborate a diagnosis of the needs of individuals, families and the community through household records, canalization and schedule of visits for the development of individual comprehensive care plans; 2) negotiate with the family the development of a Family Comprehensive Care Plan and follow up the scheduled visits, departments and other health interventions; and 3) follow up specific programs, interventions and departments in agreement with the family. Internal actions are developed by Health Facilities and include the elaboration of a comprehensive clinic record by life stage and care by professionals that receive referrals to health care according to the needs identified by homes visits.

PHC ORGANIZATION

Assistance model proposed for PHC

All three countries characterize their proposed PHC models as comprehensive care models, since they aim to reduce both the effects of diseases through treatments and rehabilitation and its incidence through prevention and also improve the well-being and quality of life of the population through the promotion of health and action on the social determinants of health. The models do not intend to limit their actions to individuals or to the health sector, but to extend them to families and communities and to convene other State sectors and the society. Likewise, they advocate that sectorial actions of low level of complexity should be linked to those of secondary and tertiary level. Despite the prevalence of traditional primary health care facilities with individual professional practice, the new ones, family and community-oriented, aim to work with basic health teams and to promote community participation, interculturality and intersectoral action for health. Nonetheless, as a public strategy, PHC continues to have an assistance emphasis and an approach focused on the poor.

Chile develops a family and community comprehensive health care model defined as:

"the set of actions that promote and facilitate efficient, effective and timely care, directed – rather

than at the patient or the disease isolated – at people, considered in their physical and mental integrity and as social beings belonging to different types of family, which are in a permanent process of integration and adaptation to their physical, social and cultural environment" (Chile, Ministerio de Salud, 2005:9).

The model of care, which includes gender and intercultural focus, is based on PHC, biopsychosocial, centered in the user and includes attributes such as integrated care, continuity, management of health personnel, intersectorality, emphasis on promotion and prevention, open care, participation in health, use of proper technology and quality. In order to reach the transformations that will lead to a system and a model of health care with such characteristics, they encourage physical and organizational transformations within health centers, in training of human resources and in the service delivery method to the population (Chile, Ministerio de Salud, 2007). The implementation of this new model of care and management is going through a process of transformation from old general medical offices and conventional health centers to Family and Community Health Centers; strengthening of basic health teams, evidence-based clinical management, network and intersectoral work planning and national programming of activities; and local management and community participation (Chile, Ministerio de Salud, 2012a; 2012b).

With the formulation of Act 1,438 of 2011 (Articles 13 and 53), Colombia promotes a model of care that is formally focused on the person, the family and the community; apparently interested in cultural, racial, and gender singularities of the population; and theoretically founded on promotion and prevention and on the work of basic health teams by territories. This model includes three basic components: provision of services, intersectoral action and social, community and citizen participation. The first component aims to expand health care coverage and to strengthen the case-resolving capacity and integrated and comprehensive care based on interdisciplinary health teams, the qualification of the low complexity level and the organization of integrated health care networks. The second component is directed at the action on the social determinants of health through public policies, plans and programs for intersectoral/transectoral action through the coordination of all levels of government, institutions and society. The third component aims to have social, community and citizen processes expressed in decision, management, control and follow-up of policies, plans and programs, as well as in the health care system and its institutions.

The Comprehensive Health Care Model Based on the Family and the Community (MAIS-BFC), is defined as a comprehensive, continuous and quality provision health care service oriented to meet the health needs (development, maintenance derived from injury and disability) of the population, with emphasis on the promotion of health and the prevention of individual risks in the contexts of their family and community under a framework marked by the co-responsibility with the involved key social actors (Perú, Ministerio de Salud, 2011).

Organization of the work of the PHC team

In regard to the sector-based work division and to the affiliation of population to health centers or teams, the situation is heterogeneous among these three countries and within each country. Whereas in Chile and Peru the goal is to work through sectors and with population assigned to health teams, in Colombia there are no clear national guidelines with respect to it, even though some territorial entities have been developing this according to their possibilities.

The affiliation of people to health teams in Chile is done through PHC centers based on the free choice at the national level. Nonetheless, the person cannot be registered in more than one center at the same time. In rural areas, the population is assigned to the health center of their corresponding territory of residence. Multidisciplinary teams may have up to five thousand people registered per team and Family Health Centers may have from 20 to 40 thousand people registered. The sector defines itself as a "territorial space where a group of the population (people/family) lives, which constitutes the "affiliated population" of general practice teams, around which there is a work developed in the field of health" (Chile, Ministerio de Salud, 2013b:37). The division into sectors is organized according to geographic barriers and the natural limits of each population settlement, among them, surface, number of people, available equipment and infrastructure and organization of resources (Chile, Ministerio de Salud, 2013b). Each health center is assigned to a specific territory and population, and is subdivided into geographic sectors. Each subsector has a multidisciplinary team that must watch for the health care of the population affiliated (Chile, Ministerio de Salud, 2013b). Nevertheless, in some cases, there seems to be no rule defined for the regionalization of activities of PHC units and teams (Vega Romero y Acosta Ramírez, 2014a). This division into sectors aims to achieve a series of goals, such as the diagnosis of the health status of families and communities, the identification and potentiation of capacities and resources of the community and actions for prevention, protection and rehabilitation of health with a family approach.

Teams are closely related to the population affiliated. For example, they know where and how they live and work, the morbidity and mortality profiles and health care coverage. They plan their annual activities in order to accomplish the PHC functions concerning coordination and continuity of care, integrality (promotion, prevention, healing and rehabilitation), biopsychosocial and risk approach (Chile, Ministerio de Salud, 2013b). Nonetheless, this rule is not always accomplished. In Lautaro, for example, multidisciplinary general practice teams are not always able to work as a team due to the inherited vertical tradition, the high personnel turnover and the resistance to change from one model to the other (Vega Romero y Acosta Ramírez, 2014b).

In Colombia, the division into sectors and the affiliation of the population may occur in some PHC models organized by territorial authorities based on health centers or teams (Vega

Romero y Acosta Ramírez, 2014a). For example, in the city of Barranquilla, each health promoter is assigned with 400 households in a given territory and each Timely Health Care Point, which may be centered in ambulatory services for promotion and prevention or curative of low and medium complexity, have an area of influence with a population that varies according to the density of the area, which oscillates from 10000 to 15000 people. The affiliation of people entitled to health care at the Timely Health Care Point is defined according to their place of residence. In Medellín, each basic health care team is responsible for 780 families. In Palmira, health "builders", which are assistant and technical health teams, are assigned to areas called micro zones (at most within 1000 meters radius from their place of residence) with an average population of 1600 people in the urban zone and 800 people in the rural zone. In Bogotá, the sectorization of the work of public health teams is done into micro territories and territories. Thus, each basic health team operates in a micro territory and is assigned with 800 families; 12 basic health teams and a support team operate in each territory and are responsible for 9600 families. Besides families, teams are supposed to provide care to schools, kindergartens, community homes, public spaces, environmental areas and vulnerable street population, among others. In contrast, indigenous communities of Santa Marta's Sierra Nevada have external and permanent teams. External teams travel to each one of the indigenous population and, upon their arrival to a place, they must always make a previous cultural exercise with the *Mamo* (indigenous superior authority), in order to enable the provision of western health services. It is rare to find a Health Promoting Company (EPS) that divides primary health care services into sections and organizes health teams with a population assigned by territorial area, since, within the same territory, the population may be affiliated to different EPS, including members of the same family. Therefore, the level of segmentation, fragmentation and dispersion of the population makes this kind of organization inefficient. However, after Act 1,438 of 2011, in 2014, some EPS of a Family Compensation Fund started to organize teams formed by a health promoter per each 1000 families, a coordinator of health services per each 15 promoters and a coordinator of social services per each 15 promoters. In some cases, and more recently, they have started to add professionals and assistant health personnel to multidisciplinary teams and ambulatories in order to perform georeferenced and focused activities with families of these priority groups. There is no evaluation of teamwork or an inventory of the total number of health teams or affiliated families.

Each basic health team in Peru must be responsible for 500 to 800 families, which corresponds to an average of 100-125 families per professional in the team. Users of basic health teams are registered by area of residence at the nearest first level health facility with the criterion that families should be placed, at most, within a 4-hour distance from the health facility to which Family and Community Basic Health Teams (EB-SFC) are assigned (Perú, Ministerio de Salud, 2011). For families located at greater distances, there are de f i n e d mobile teams called Comprehensive Health care Teams for Excluded and

Dispersed Populations (AISPED Teams). In the first trimester of 2014, a total 1,274 first level Health Care Facilities (16% of all first level health facilities), have informed the Ministry of Health to have about 144,409 family records registered in priority areas with social and economic vulnerabilities in several regions of Peru (Perú, Ministerio de Salud, 2013). Concerning AISPED teams, there were 153 listed in the National Health Facilities Database in May 2013, distributed over 17 regions of the country, with an estimated coverage of 768,520 beneficiaries (Perú, Ministerio de Salud/DGSP, 2013). Although there is no an evaluation of team work, in experiences visited at the Health Center of Tambo and the José Olaya de Lima Health Post, cohesion is favored by employment stability and the commitment of workers that have been trained about PHC attributes in the program fostered by the Ministry of Health (Acosta Ramírez y Vega Romero, 2014). Chart 1 summarizes the characteristics of PHC provision in all three countries.

Chart 1 – Organization and provision of PHC in Chile, Colombia and Peru, 2014

Dimensions	Chile	Colombia	Peru
Characteristics or name of the model of care	PHC adopts a single comprehensive care model, for the family and the community, with gender and intercultural approach	PHC does not have a single model. There are three approaches: 1) individual actions, biomedical, assistance "neoselective" and managed care (EPS) 2) collective public health actions: focused on health promotion and prevention of diseases (local health authorities) 3) intercultural: for native peoples, combined with traditional medicine	PHC is applied through the Comprehensive Health Care Model based on the Family and the Community (MAIS-BFC)

Chart 1 – Organization and provision of PHC in Chile, Colombia and Peru, 2014 (cont.)

Dimensions	Chile	Colombia	Peru
Main type of PHC unit	Provision and programs delivered through low complexity facilities network (includes low complexity hospitals, family health centers, general practice offices and rural posts)	Provision delivered at the first level of complexity According to the organization of PHC by EPS, territorial entities or indigenous communities, it may assume different organizational forms, but usually with a combination of traditional basic care centers and health teams	PHC is developed through first level of care health facilities
PHC teams	There are two types of teams: 1) basic teams (physician, nurse, midwife social assistant, and administrative assistant) and 2) basic teams with a complement (psychologist, kinesiologist, physical education professional, occupational therapist, nutritionist, dentist and dentistry assistant)	There are two types of teams: 1) basic teams (created by Act 1,438) and 2) support or complementary teams (created by some territorial entities, according to their resources) Their formation depend on the PHC model	Basic health teams must be formed by professionals in human medicine, an obstetrician, a nurse and a technician nurse
Population affiliated to teams	Teams may have up to five thousand people registered	There is not a unified parameter	Basic teams must cover from 500 to 800 families

Duties of community health workers

Another characteristic of the primary health care models of these three countries is the incorporation of community health workers. This action, which is not a recent innovation in primary health care systems, seems to be especially retaken for the execution of tasks of external and community health teams that develop activities of the promotion and prevention program.

Even though there are no community workers in health teams in Chile, part of the employees working in PHC belong to the population affiliated to the health center and aim to work with volunteer community instructors, in order to incorporate the perspective of the community into teamwork (Vega Romero y Acosta Ramírez, 2014b).

In the case of the cities Barranquilla and Medellin, in Colombia, community health workers (*caminantes*) and primary health care workers are part of primary health care teams that perform ambulatory public health external activities. As highlighted in the previous section, including in some EPS of the Family Compensation Fund, there are now health promoters being paid with resources from the Funds. Other territorial entities, as Bogotá and Santander, have substituted community health workers for public health or nurse assistants and technicians (Ruiz-Rodríguez et al., 2011). Some community workers are paid and some are volunteers, as is the case of Barranquilla. Community workers are usually trained to develop activities such as the characterization of individual, family and community risks, first contact, education in health, inducement of the demand for services, guidance to pregnant women and the elderly, community support for complementary social actions and programs, promotion of community participation, intersectoral action and activities for follow-up and control. There are indigenous and community health promoters in native communities of Sierra Nevada de Santa Marta and Cauca that were elected by their own authorities. They combine western medicine activities with indigenous traditional medicine. They meet the needs of their communities, families, people and territories with their ancient knowledge and they do not have employment or technical subordination to authorities and western professionals. They are trained in indigenous spiritual and material tasks by their ancient authorities and in western medicine skills (Vega Romero y Acosta Ramírez, 2014a).

In Peru, public health actions involve Community Health Workers who act as volunteers and connect the community and Health Facility to address health problems identified together with basic health teams. Since 1989, NGO *Medicus Mundi* has developed actions for cooperation and support with the Ministry of Health and some Regional Health Guidelines via several projects that emphasize intercultural model, projects leading Community Health Workers and traditional therapists into maternal perinatal health.

Guarantees for the access to primary health care

PHC services are generally free of charge, but they do not count on specific information systems that enable the assessment of the access and timeliness of health care. Nonetheless, after the national surveys on households and quality of life, it is possible to highlight the persistent barriers in the access, which may be geographic, economic and administrative, especially for populations in social and economic disadvantage, in dispersed rural zones and in marginalized areas of big cities (Perú, INEI, 2012; Colombia, DANE, 2014).

Chile's official indicators may not account for the level of refusals in medical visits (which may reach 30%), timeliness of basic tests and availability and delivery of medicines (Bass del Campo, 2014). In Colombia, the waiting time for the access to primary health care consultations is variable, according to the type of EPS and the model of care of the

corresponding territorial entity, but it is known that in the best EPS the waiting period is of two days of for general medicine and dentistry (Vega Romero y Acosta Ramírez, 2014a). In Peru, it is also important to note the financial, geographic and timeliness barriers to health care, such as lack of money, long waiting periods and distance (Acosta Ramírez y Vega Romero, 2014).

Coordination of care and integration of PHC into the service network

The health care systems of these three countries are organized by levels of complexity, as in Chile and Colombia, or by levels of care, as in Peru, being the first level the entry point to secondary and tertiary levels. PHC is usually the basis of the organization of health care networks by levels of complexity of health care.

In Chile, PHC is considered the axis of the health care systems and the platform for sectorial, intersectoral and community interaction through specialized care, prevention of disease and promotion of health. Likewise, it is considered the entry point to the system and the holder of devices that filter the demand for the assistance network, based on its effective character for most of the health needs and its role of favoring referral and counter-referral processes to other levels of medium and high specialized complexity, hospital and urgent care (Chile, Ministerio de Salud, 2012b; Chile, Ministerio de Salud, 2014b). The concept of network is not restricted to the health sector, but it includes what is called the "intersector" and the community (Chile, Ministerio de Salud, 2013b). The role of connection of the network is developed by health centers, not only in respect to the sector, but also in respect to the "intersector" and the community.

Organization of health care networks: Chile's experience

The continuity of the assistance process within primary, specialized, hospital, surgical and urgent care, according to their need, is mediated by primary health care centers through referral and counter-referral mechanisms. In order to enter primary level network facilities to access other levels of complexity, the patient must be referred from the corresponding PHC facility, except in cases of hospital urgency.
Specialized, hospital, surgical and urgent services are provided by SNSS and private institutions.
In order to promote the integration and coordination of the assistance network, there are several strategies and tools in Chile. Some of the most important strategies are:

- Committees for the integration of the Assistance Network;
- Integrated management for the coordination of the ambulatory elective network in the public network;
- The use of information and communication technology (ICT);
- The use of mechanisms for the monitoring of the length and width of waiting lists for specialties and tracer services.

Some of the tools are:

- The clinical management with the approach of evidence-based medicine;
- The use of integrated information registration of the families affiliated;
- Referral and counter-referral systems; and
- The introduction of innovation in the delivery of services, as home inpatient care and surgical/day care.

Source: Chile, Ministerio de Salud/Subsecretaria de Redes Asistenciales/División de Atención Primaria, 2014.

Article 62 of Act 1,438 of 2011 of Colombia directs the formation of Integrated Health Service Networks under the guidance of PHC. These networks must be organized and formed under the responsibility of territorial and national authorities, "in coordination with Health Promoting Companies through Territorial Councils on Social Security in Health", and may include "public private and mixed providers that deliver services according to the Benefit Plan of which they are in charge" (Colombia, Congreso de la República, 2011). Article 63 remarks that among the determining criteria for the formation and accreditation of integrated health service networks, there must be a "model of primary health care focused on people, families and the community, which considers the cultural, racial and gender singularities" (Colombia, Congreso de la República, 2011) and that, according to article 64, must have "consensus about the implementation of the Primary Health Care strategy" (Colombia, Congreso de la República, 2011). Until now, the Ministry of Health and Social Protection has not regulated the creation of Integrated Health Service Networks, but a determination of the Council of State has defined that it should be developed within three months (Arboleda, 2014). Health care networks must be integrated since their offer and by territory, in the public health service providers sector or around EPS, for affiliates of the contributory regime. Nonetheless, since the first level of complexity, territorial entities and EPS develop actions for referral and canalization (to induce the demand) to other levels of complexity of the assistance network to other social services. In some territorial entities, such as the District Health Secretariat of Bogotá, primary health care coordinates sectorial, intersectoral/transectoral and community responses according to their health needs (Colombia, SDS, 2014). They have developed specific tools for referral and counter-referral.

PHC in Peru is the entry point to the health care system. Medical professionals refer patients to health facilities of other levels of care according to their particular conditions, with the employment of standardized formats. Public health facilities are grouped in integrated service networks with subdivisions according to the different regions. Thus, there are units that develop health programs and services to regional hospitals and health networks formed by several regions together with local hospitals and micro networks, which correspond to health centers. Since 2011, there is a national policy being developed to reach agreements that aim at the exchange of health care between regional governments, the Comprehensive Health Insurance and assistance networks of the Social Security Health Insurance (EsSalud). Their goal is to overcome administrative barriers to access, with the provision of closer health services, regardless of the affiliation category. Therefore, those insured by the Comprehensive Health insurance may be received care at the EsSalud facilities of medium and high complexity, whereas those insured by the EsSalud may receive care at first level health care facilities of the regional governments.

There are still waiting lists for specialties and services with insufficient offer in Chile. Although there are high rates of pertinence of referrals (93%) from primary health care to

other levels of care, there are still bottlenecks in the access to medical visits for specialties such as ophthalmology, traumatology, otorhinolaryngology, cardiology, gastroenterology and neurology, diagnostic and surgical procedures (Chile, Ministerio de Salud, 2007). In Colombia, there are still barriers to access to health services (Flórez y Camacho, 2012). In 2011, the timeliness in the schedule of visits in entities that administrate benefit plans was of 8.0 days, whereas in service providing institutions it was 8.9 days. In some specialized services that face shortages, the waiting time may last several months. One instrument that has been aiding the mitigation of the problem of lines is the writ of injunction, which is when the court interferes in waiting times, in order to make them shorter. In Peru, in the last three months of 2013, the delay in health care was mostly in facilities of the Ministry of Health and in private clinics, but there is no information about the waiting time (Perú, Ministerio de Salud/Sunasa, 2013).

PHC WORKFORCE

Regulation of labor relations

The Regulation of labor relations in these three countries occurs in the context of a development model of economic overture and liberation that has promoted not only market-oriented health systems, but also a flexibilization of the labor market with an increment of informal employment[8]. Nonetheless, this trend seems to have been weakened by some specific labor rules for protection and incentive to work, as a result from demands of workers and of the negative consequences of the labor flexibilization for economic growth and the quality of the development of primary health care, as an example of the incompatibility between the permanence of the relation between the professional and the patient and the high level of turnover. Nonetheless, these are heterogeneous trends in all three countries. For example, in Chile it is possible to identify a professional career for PHC, even though there are local heterogeneous implementations. In Peru, there are national regulations for the labor relations with a professional career for the public sector and incentives for the health personnel working in PHC and dispersed zones, whereas in Colombia, there is no specific career for PHC and there is a prevalence of the policy for the flexibilization of the labor market, which determines predominantly instable labor relations.

In Chile, there is a Municipal Primary Health Care Bylaw (Chile, Ministerio de División de Atención Primaria, 2014b), which regulates the professional career concerning the entrance and promotion via public examination, training, performance evaluation,

[8] This is a type of employment without sufficient social protection, precarious salaries, temporary contracts and worse working conditions in comparison with formal workers.

responsibilities, duties and interrelation with health services and the special regime for high hierarchy directors. Nevertheless, this regulation does not cover aspects such as the integration of multidisciplinary health teams, the competences of those that are part of them, among other aspects, and it is still possible to have local non-standardized implementations that maintain the multiplicity of professional careers, unequal payment and training programs discretionally defined in each commune.

Primary health care personnel in Chile is mostly hired (56%) for unspecified duration schemes, benefitting from a professional career; it differs in regard to the stability of the activity for a great number of professionals hired with fixed duration contracts. Remuneration includes fixed and variable components (achievement of goals, conditions of access and provision of difficult services, competences, among others). The payment is done through salaries, except in special programs (agreements), in which the payment is done per activity (goals).

The strategies of the government of Chile to attract and ensure the permanence of primary health care professionals in underserved and remote zones are multiple and are based on economic and education incentives. Thus, for example, in order to retain staff for general practice teams, there is a bonus for difficult performance (which is an additional 5%, 10% or 15% of the monthly salary) that, however, is not yet considered to work properly, since it is not attractive to physicians. There are also grants for professional education (according to the years of permanence), but the competition due to the existence of demand gaps for specialists is hard. There are also training programs in basic specialties such as obstetricians, pediatrics, internal medicine and psychiatry for early graduates from the university that combine clinical practice in PHC with hospital practice (Montero et al., 2010). Nonetheless, these programs are not applied to the training of specialists in family medicine, an area that requires special incentives due to the lack of professionals: there are only 629 in the country, with only 41.5% of them working in the public sector (Chile, Ministerio de Salud, 2014c).

Through Act 50 of 1990 and Act 789 of 2002, Colombia has been developing a policy for labor flexibilization. This act mediates employment and work relations between insurances, territorial entities, service providers and most part of the workforce. It generates instability, low salaries, and lack of economic and educational incentives, especially in rural and urban zones that are difficult to access. This policy has facilitated that insurance entities and service providers offer informal employment and hire workforce for short terms. Likewise, it limits the sustainable development of capacities to qualify medicine practitioners, other health professionals and technicians to implement the principles and attributes of PHC.

The fact that in Colombia there is no specific professional career for PHC and that it has a strong flexibilization policy has a structural effect on the operation of this strategy. These characteristics hinder broadening of education and continuing training of the workforce, makes the efforts for training of personnel lose their effect, makes it impossible to achieve learning curves and affects the continuity of relations between institutions, health

teams and communities, families and individuals (PUJ/ UIS, 2011). Even though in the past few years the national government and some territorial governments have been developing policies for the formalization of work and programs for training in PHC, these efforts are still incipient, have low coverage and are not comprehensive, as will be seen ahead.

Hiring of health personnel in Peru also includes unspecified duration and temporary modalities (Perú, Ministerio de Salud/DGGDRH, 2014). The first one includes workers of the Ministry of Health, of Implementing Entities and of the Regional Government, which corresponds to half of the human resources for health. The second one comprehends workers linked to Health Facilities through Contracts for the Administration of Services (Perú, Ministerio de Salud/ DGGDRH, 2014). The first one receives full social benefits; the second one supplements patronal benefits with their own incomes from the contracts with Health Insurance Funds Administrator (Iafas), which receive resources that are called directly collected funds (Perú, Ministerio de Salud/ DGGDRH, 2014).

Peru implements strategies to foster the permanence and retention of human talent in priority zones at the national level. Thus, since October 2013, there has been a program established for economic compensations and incentives for professionals working in isolated, border and emergency zones or who work with primary health care providing specialized or critical services. The same occurs with specialists in family medicine who work at health facilities of the public sector. The requirements to receive the bonus include work in the first level of care and training in the Model of Comprehensive Health Care based on the Family and the Community (Perú, Ministerio de Salud/DGGDRH, 2014).

Availability of PHC professionals

The quantitative and qualitative availability of PHC professionals is deficient in all three countries. Although there have been efforts to achieve a greater availability of professionals, there are still great inequalities in its distribution and hiring among countries and also among sectors within the same country.

According to statistics of the Ministry of Health, in Chile, the highest rate of staffing of human resources for health is in nursing and the lowest one, in kinesiology. The amount of physicians is lower than the amount of nursing personnel and, since 2010 there was a tendency towards reduction, reaching 2.55 physicians per 1000 population in 2013 (Chile, Ministerio de Salud/Subsecretaría de Redes Asistenciales/ División de Atención Primaria, 2014). Out of the 3000 physicians working in PHC, more than 90% are general physicians and only 629 are physicians specialized in family medicine. Among them, 41.5% work in Municipal Primary Health Care, 17% in Health Services and 42% work exclusively in the private sector" (Chile, Ministerio de Salud, 2014d). Despite the normative ratio of PHC physicians being of 3 physicians per 10,000 population, the actual ratio is 2.5 x 10,000 people. Even though the allocation of this resource has increased in 30% from 2009 to 2013,

according to Act 19,378, there is still a shortage of approximately 1500 PHC physicians (Chile, Ministerio de Salud/Subsecretaría de Redes Asistenciales/División de Atención Primaria, 2014), The problem is aggravated due to the fact that public sector physicians are easily attracted by the private sector: more than 60% are in the private sector, providing care to 15% of the population (Bass del Campo, 2012). In addition, Chilean physicians do not seem to be interested in working in PHC. Apparently, around 30% of professionals are foreigners (from Cuba or who studied in Cuba, Ecuador, etc.) and once their titles are revalidated in the country, they also move towork in other sectors.

Incentives to retain personnel in urban centers are not sufficient. Thus, for example, at the Family Health Center (Cesfam) Laurita Vicuña, in Santiago, the annual turnover of physicians is of approximately 40%. In another Commune in Santiago, Quinta Normal, physicians are the health professionals with the highest level of turnover, which is generally attributed to problems with prestige, recruitment methods and income (Vega Romero y Acosta Ramírez, 2014b). In Lautaro, a small city in Araucanía, physicians usually remain there only for one year, among other reasons, due to lower incomes in comparison with the private sector and to the fact that the incentives meet for their permanence do not match their ambitions to become specialists in other areas (Ulloa, 2014). The deficit of personnel in Chile has implications in the quality and integrality of health care. For example, at the Cesfam of Lautaro, it seems that, despite the accomplishment of the standards for the ratio Human Resources / Population defined by the Ministry of Health, the reality indicates that the demand for care is greater than the offer, which leads to the prioritization of the assistance activities to the detriment of promotion and prevention and home medical care.

Colombia and Peru have similar examples. Thus, even though Colombia might have an increasing availability of health professionals, it is still insufficient for the needs of PHC personnel. In 2011, there were approximately 25.4 physicians and nurses per each 10,000 population. The ratio of general practitioners per 1000 people was 1.46 in 2005 and 1.68 in 2011, nurses had 0.68 in 2005 and 0.92 in 2011 and dentists had a ratio of 0.79 in 2005 and 1.86 in 2011. It is known that, in the country, there are only 500 family doctors, but there is no clear data about the amount of community health workers (Observatorio de Talento Humano en Salud, 2014; Colombia, Ministerio de Salud y Protección Social, 2014b). Despite the increase in the workforce of general health professionals, it is known that this tendency is being neutralized by the increasing demand for care as a consequence of the expansion of insurance coverage, the unification of benefit plans and the demographical epidemiological transition of the population. It is estimated that there is a deficit of over 2000 physicians and that it can be even greater in some regions, especially in municipalities with less than 20,000 people (Facultad de Salud Pública, 2000; Ruiz et al., 2008).

The deficient availability of health professionals in Peru also shows great regional disparities (Perú, Ministerio de Salud/DGGDRH, 2013). Thus, in 2013, the country counted on 1.2 physicians and nurses per each 1000 inhabitants, with regions that had twice the

amount (Callao) and some others that had less than half of it. Considering the level of complexity of the health facility, in 2013, medicine professionals were concentrated in first and third level institutions, with 42% e 36% respectively, and the remaining 22% were working at second level facilities (Perú, Ministerio de Salud/DGGDRH, 2013). The indicator of the total availability of medical, nursing and obstetrician professionals in 2013 was 27.4 per 10,000 population. In turn, the number of family doctors hired by the Ministry of Health of Peru was 119, and these professionals were working at hospitals in 18 departments, a number considered rather insufficient for the needs of the country (Perú, Ministerio de Salud/ DGGDRH, 2013).

Chart 2 summarizes workforce in these three countries.

Chart 2 – PHC workforce in Chile, Colombia and Peru, 2014

Chile	Colombia	Peru
The ratio of physicians was 2.5 per 1000 people in 2013, with a higher ratio of nurses.	The ratio per 1000 people was 1.7, and the ratio of nurses0.9, in 2011.	The ratio of physicians per 1000 people was 1.2, and the ratio of nurses 1.1 in 2013.
There is a deficit and tendency towards increasing gaps of physicians in PHC. 10% out of almost 30,000 physicians work in PHC. Among those, only 629 are family doctors and about 50% of them work in the private sector. About 30% of PHC physicians are foreigners.	It is estimated that there is a deficit of over 2000 physicians, which may be higher greater in some regions, especially in municipalities with less than 20,000 people. Health professionals tend to be concentrated in municipalities with more than 500,000 people.	Great geographic disparities (some regions have half the national average rate and some other have twice the amount). 42% of medicine professionals in the first level of care. Most part of it concentrated in zones of quintile V, which are the ones with more economic resources.

There is no clear data about the amount of community health workers that integrate basic health teams in these three countries, once activities are usually volunteer or with instable contracts. In Colombia, there is an explicit policy for the linkage through payment of community workers, especially in rural zones and in marginalized urban communities (Colombia, Ministerio de Salud y Protección Social, 2014a). This is not the case of Chile and Peru, where there seems to be more incentives for the connection between family and community health volunteers.

For example, Act 1,438 of 2011 of Colombia establishes that basic health teams must include health promoters and public health assistants. Territorial entities, in occasional association with the EPS of the subsidized health regime, employ varied numbers of health promoters in basic teams, according to the resources available, as occurs in Barranquilla, Bogotá, Medellin and Palmira. Likewise, PHC programs developed by native peoples include indigenous health workers who are used in order to guarantee the intercultural character of their own health systems, as will be seen ahead. Nevertheless, this is not usually the case in PHC programs developed by the EPS of the contributory regime, once its PHC approach is

more focused on professional health personnel (Vega Romero y Acosta Ramírez, 2014a).

Caminantes de la Salud: Community health workers in Barranquilla, Colombia

In the city of Barranquilla, Community Primary Health Care is developed through the program "Health at home" and through complementary actions.
"Health at home" is directed by two types of actors: on one side, community health workers called "*Caminantes de la Salud*", recruited from the community of the neighborhood where they live, trained as health technicians or auxiliary nurses and paid by the operator of the program to develop specific activities for promotion and prevention. On the other one, members from households of the territory that, with small incentives, offer to work as volunteers in certain activities for the support to health at their own homes, which is called "Healthy Homes". The *caminantes* and volunteers of the subprogram Healthy Homes perform activities for the characterization of individual and collective risks, first contact, incident education in health, inducement of the demand of services (without considering the affiliation regime) for health programs such as guidance to childhood, pregnant women and the elderly, community support in actions and complementary programs and activities for follow-up and control. For the support to activities, they use techniques and devices for zone mapping, communication, biometry, weighting, meters, tensiometer, glucometer, flip charts, educational brochures and bags to carry their working equipment.

Training strategies for human resources in PHC

In Chile and Peru there are national policies for education and training of workforce for primary health care, with some differences in their implementation, whereas in Colombia the highlights are programs ran by some territorial entities.

The national training policy in Chile is adopted by municipalities with direct investments from their own resources, and each commune defines the emphasis of their training. For example, in the Commune Quinta Normal there are 40 hours year/person dedicated to training. This is done in clinical adjusted groups, social networks, nutritional labeling, preventive medicine, mental health, intercultural health, alcohol and drug consumption, among others. Resources from the Ministry of Health enable complementary training in several ways: diplomas (300 hours in family medicine and technical competences), courses, national and international internship, online self-managed learning (under management commitments), etc.

Professional education in Chile is defined by universities, but they do not meet the requirements of PHC. Human resources training continues to have a biomedical approach, on one side due to the fact that professionals are trained at high complexity hospitals and not at family health centers and, on the other one, because there is an underutilization of the few grants offered by the Ministry of Health for specialization in family health. For instance, from 2002 to 2007, only 12% of the positions for training in family medicine have been filled, against 70% in other specialties (Montero et al., 2010). On the other hand, there is not enough continuing education resources for workforce involved in PHC.

In Colombia, there are also efforts for education and training of workforce in PHC. In the case of Bogotá's District Health Secretariat, this is a requirement of the work of health teams and of the employment of new personnel in these teams (PUJ/UIS, 2011). At the level of the Ministry of Health and Social Protection, the actual efforts for training at the national level are still insufficient considering the challenge of implementing the PHC strategy. With the support of the Pan American Health Organization (PAHO), an online program (e-learning) was elaborated for the socialization of PHC fundaments (Colombia, Ministerio de Salud y Protección Social/OPS, 2012). Concerning postgraduate education, although there are six operating programs in family medicine, only after 2013 the Ministry started to work on the definition of a unified program in family and community health and family medicine (Colombia, Ministerio de Salud y Protección Social/OPS, 2012b). There is usually a prevalence of the biomedical approach in education and practice of human resources, with fragile and discontinued re-training programs.

In Peru, human resources training in PHC is done through the National Educational Program in Family and Community Health (Profam). The project is developed through a certification program, with technical and financial support from the PAHO, the Italian Cooperation, *Medicus Mundi* and Health Without Limits. One of the achievements reported is a coverage, in 2012, of 346 participants in the program, who came from the basic health teams of nine out of the 26 regions of the country and were selected among the personnel appointed by the Ministry of Health and Regional Governments (Perú, Ministerio de Salud/DGGDRH, 2013). The goal for the next five years is to have 5000 health professionals trained every year, in order to cover the total human resources working in the first level of care (Perú, Ministerio de Salud/DGGDRH, 2014). The Department of Human Resources Development Management (DGGDRH) of the Ministry of Health is currently developing technical guidelines for PHC training programs, which should be offered to higher education institutions regulated by the Ministry of Education (Perú, Ministerio de Salud/DGGDRH, 2014). Program includes a certification program[9] in comprehensive care for PHC (for all health personnel in the first level of care, including technicians and assistants) and specialization programs in (i) Family Health (directed at all types of professionals), (ii) Family Medicine and (iii) Comprehensive Medicine and Health Management (aimed at medicine professionals) (Perú, Ministerio de Salud/DGGDRH, 2011).

INTERSECTORALITY IN PHC

These three countries have normative guidelines and/or national institutional spaces that promote intersectoral action for health, even though they might have a vertical concept. At the local level, some institutions and PHC teams carry out a situation analysis of health problems

[9] The certification program offers continuing re-training of professionals with short-term courses.

in the territory and try to develop actions together with other sectors. Nonetheless, the connections between national and subnational levels in terms of intersectoral action are not clear, and the assignment of funds to this end seems to be insufficient.

Intersectoral Action for Health (AIS) is developed in Chile from the national to the local level, under the coordination of the Ministry of Health and local governments. PHC is articulated with the AIS through the execution of social protection programs and Life Chile Committees, which implement policies for health promotion with the participation of health teams and the community. At the national level, there are mixed health and education commissions operating in the area of social protection, with complementary specific ambits of coordination in health promotion in the Community Development Guidelines of municipalities. Intersectoral activities for prevention are also developed with the participation of the National Corporation for the Control of Stupefacient, Education and Community Development Guidelines, among others. There is also the development of the AIS at the sectorial level. In the Family Health Center in San Joaquín, in Santiago, the social assistant promotes intersectoral tasks about social benefits. At schools, there are midwives, social assistants, psychologists, nutritionists, occupational therapists, physicians and nurses. There are also environmental and judicial programs and the Woman's House, among others.

Colombia has created AIS Commissions, such as the Intersectoral Commission for Early Childhood Comprehensive Care, the Intersectoral Committee on Sanitary and Phytosanitary Measures, the Intersectoral Commission of the National Agency for Overcoming Extreme Poverty: UNIDOS Network, the Intersectoral Commission of the Strategy 'From Zero to Always', the Intersectoral Commission on Food Safety and Nutrition, the Technical Intersectoral Commission for Prevention and Control of Air Pollution and the Intersectoral Commission for Rural Social Interest Housing, among others. Recently, the Ministry of Health and Social Protection, through Decree No. 859 of May 6, 2014, created the Intersectoral Commission on Public Health, formed by nine ministries and three national departments, with the aim to coordinate and follow up the Ten-Year Public Health Plan. Among other duties, the aforementioned Commission must orient the intervention on health determinants through public policies, the promotion of coordination, cooperation and agreement among sectors and the coordination of the abovementioned intersectoral commissions, among others. These achievements, which occur mostly at the national level, are implemented despite the individual, biomedical approach of the health care model, focused on the disease. At subnational levels, there are distinguishable efforts and strategies for intersectoral actions commanded by some territorial entities, based on the political will of mayors, as is the case of the municipalities of Palmira, Medellin and Bogotá.

Intersectoral action in the Municipality of Palmira, Colombia

In the municipality of Palmira, basic PHC teams are articulated with the Social Integration Secretariat for intersectoral actions through the Special Plan for Social Inclusion, which counts with 40 community managers.
They develop joint interventions in vulnerable territories in areas such as citizen culture, recreation, training for work and generation of income, improvement in infrastructure and urban equipment. There are also technical intersectoral boards, as the public health one and the one on childhood and adolescence.
A critical factor for the effective development of intersectorality is the political and decision support of the municipal mayoralty, which is reflected in the destination of their own resources to PHC strategies and to the development of intersectoral actions for the Vulnerable Population through the Special Plan for Social Inclusion, which enables the harmonization of common objectives.

In Peru, national guidelines on AIS are supervised by the General Department for the Health Promotion, which uses a causal model methodology that involves all social actors, with the definition of roles, agreements and commitments for an articulated and coordinated work (Perú, Ministerio de Salud, 2014). Thus, there is the definition of action plans and joint working plans among several sectors and institutions, such as: the Ministry of Education, the Ministry of Transports and Communication, the Ministry of Housing, the Provincial and District municipalities and some NGOS and organizations of the community. In order to strengthen these bonds, in December 2013, there was a regulation promulgated (Legislative Decree No. 1,166), with the definition of Integrated PHC Networks and the participation of the Health and Education Secretariat, the Ministry of Housing and the community sector. They formed an intersectoral committee to participate in the definition of the territorial health plan. At the local level, the starting point is the assessment of risks through family records and the characterization of the surroundings, which enable a diagnosis by geographic sectors that may be presented to the community and the election of community promoters who will participate in the definition of Family and Community Care Plans and sign communal commitments to involve the population and stimulate intersectoral actions (Perú, Ministerio de Salud, 2014).

SOCIAL PARTICIPATION IN PHC

All three countries promote social participation in health, but it continues to be deficient, especially in disadvantaged and discriminated sectors and social conditions. At the local level, their adoption, interpretation and development is not homogeneous.

Orientations of the government of Chile aim to foster community participation and the formation of new participation spaces in territories in view of the exercise of a full citizenship to improve health, quality of life and to reduce health inequalities. It is stipulated that this participation must be carried out based on an approach to the social determinants of health

and rights in order to contribute to the redistribution of power relations and resources among groups of the population (Chile, Ministerio de Salud, 2013b). Participation is channeled through Local Health Councils (CLS) and Local Development Centers (CDL). CLS are not autonomous and do not make binding decisions. CDL are built by communes and the health centers are part of them. Even though both CLS and CDL formally aim to promote a comprehensive participation of citizenship and of several sectors and public and private actors, participation is limited by the lack of resources and by their exploitation. There are also other strategies for participation in health, as the Consultative Councils of Users, participatory diagnoses, Workshops for Information, Claims and Suggestions and mechanisms to evaluate the satisfaction of users.

Many examples given by Chilean employees of health centers that were interviewed show characteristics of community and social participation in health in Chile. At the Family Health Center Laurita Vicuña, in the Commune of Puente Alto, social participation in health is done through CDL, with the participation of community organizations and through the Mixed Commission on education, health and kindergartens (Vejar y Flórez, 2014). At the Family Health Center San Joaquin, in the Commune with the same name, in the metropolitan region of Santiago, there is a coordinated work with the community and with political and social leaderships at Local Development Centers (CDL) (Campodónico, 2014). CDL are able to make decisions, but they must work together with authorities in order to materialize them. General practice teams coordinate meetings with social leaderships within their territory (Neighborhood Boards or Local Health Councils). One or two leaders of the Local Health Council are part of the CDL, which, in turn, are coordinated by a higher level, at the Communal Intercouncil, which belongs to the commune as a whole. By contrast, the latter is coordinated with other Intercouncils of other communes of the corresponding health service (Buenas Prácticas APS, 2014). Differently from what happens in the communes of Puente Alto and San Joaquin, in the Commune of Quinta Normal, social participation in decisions of the health plan, municipal corporation, health facilities and health teams is almost inexistent. The importance given to social participation in each commune depends on the criterion of each municipal government.

The Political Constitution of Colombia of 1991 highlights that the State must contribute to the promotion of democratic mechanisms for participation, agreement and supervision of the public management. These concepts have been retaken by Act 1,438 of 2011, with the definition that one of the key components of PHC should be social, community and citizen participation. Nonetheless, the Ministry of Health and Social Protection recognizes that social, community and citizen participation at the national level is deficient and it usually serves the interests of powerful actors of the health system (EPS, hospitals and health authorities), besides being bureaucratized (Vega Romero et al., 2012). At the local level, it is also claimed that participation has served the health institutions rather than the communities, with rigid guidelines for workers in charge of their promotion, which makes it difficult for citizens to

participate in decisions, to be empowered and to be politically qualified to interact with state institutions and organisms of the health government in a more independent way (Restrepo Vélez y Mosquera Méndez, 2009). Besides the limitations of the health sector for participation, there are typical restrictions of democracy and of the violence that is still prevalent in Colombia, the lack of guarantees for the processes of organization and social mobilization and the lack of spaces that are sufficient and efficient in order to enable citizens and communities to have binding participation in the decision-making process, in the execution of actions and in the control and follow-up of management.

Social participation in Peru is considered a fundamental component of PHC and is implemented with the involvement of Community Health Workers in public health actions. These workers work voluntarily and are given the role of linking the community with the Health Facility in order to address the health problems identified together with basic health teams (Perú, Ministerio de Salud, 2014). Moreover, it fosters organizations as the Communal Surveillance Systems and the Local Development Committees, patient and health users committees and/or associations, as well as base social organization such as community refectories, neighborhood boards, the glass of milk, etc., and centers of nutrition surveillance for mother and child linked to municipalities. One example of joint actions between these organizations are the working groups to foster health and self-care culture through workshops with demonstration sessions for the practice of better uses for typical food in the area (Perú, Ministerio de Salud, 2014).

The Communal Book in Peru

Peru promotes mechanisms for community participation such as community diagnoses with the "Communal Book", for the recognition and improvement of living conditions in the community.
The Communal Book is elaborated by authorities, leaders, community organizations and families with the support of the health personnel of the health facility.
Municipalities grant official documents that certify neighborhood boards and this enables them to develop small projects to address some social determinants, such as waste collection, cleaning of irrigation channels, etc.
One example is the Regional Health Department of Ayacucho, which implemented training strategies for volunteer health workers and for the support to the development of communal surveillance centers, which integrate members of the community for the development of joint actions about problems identified by the population.

Source: Perú, Ministerio de Salud, 2014.

INTERCULTURALITY IN PHC

Despite the differences in their concept and approach, in Chile, Colombia and Peru there are several experiences with intercultural health policies that use PHC for their implementation.

One of the goals of the development of the Comprehensive Family and Community Health Care Model based on PHC in Chile is to "contribute to the improvement of the health status of native peoples through the progressive development of a model of health with intercultural approach that involves their active participation in the construction, execution, control and evaluation of the process" (Chile, Ministerio de Salud, 2006:23). The incorporation of this approach started in the Region of Araucanía, around 1996 and it was later reinforced with the sectoral reform in 2005 and the constitution of Program Origins, of the Ministry of Health.

Exempt Resolution No. 261 of 2006, issued by the Ministry of Health, promotes interculturality in health services, based on several articles of Act 19,253. This rule has enabled the formulation of a Health and Indigenous Peoples policy that promotes a model of health care with an intercultural and participatory approach (Chile, Ministerio de Salud, 2006). Among other aspects, the model must ensure the recognition, protection and the strengthening of knowledge and practice of the medical systems of native peoples and the inclusion of them in the benefits and provisions guaranteed by the Fonasa at all levels of care. The Ministry of Healthestablishes that:

> *"The Act of the health authority and internal regulations of the Ministry of Health as well as those of the Health Services, clearly mention the sectorial responsibility to include a different perspective of making health within their work, with the incorporation of the respect for the culture existent in territories and the active participation of the communities and organizations of native peoples in actions developed by the health sector, which involve them."* (Chile, Ministerio de Salud, 2013b:23-24).

It also defines that:

> *"the Comprehensive Health Care Model (...) must incorporate strategies of cultural pertinence that answer to the singularities of the different native peoples and foreign population living in the country into policies for health care, prevention, rehabilitation and promotion, which should be designed, executed and evaluated in a participatory way"* (Chile, Ministerio de Salud, 2013b:23- 24).

One experience with the application of the intercultural model in Chile is in the health service of Araucanía.

Intercultural, Comprehensive and Community Health Center Boroa Filulawen, Chile

Boroa is a mapuche territory in the rural zone of Ciudad Nueva Imperial. In December 2003, an Intercultural, Comprehensive and Community Health Center was created and started to operate in 2004, after an agreementbetween President Michel Bachelet and the coordinator of mapuche communities in the territory.

An agreement between the Health Service Araucanía Sur and the Intercultural Health Committee Boroa-Filulawen, signed in 2005, delegates the management of the center to the community committee. This includes administrative spaces, western health provision and mapuche health care.

The center delivers western services of primary health care of the Family Health Plan through a health team formed by a midwife, a physician, a nurse, a dentist, a social worker and a nursing technician. Another mapuche medicine team, which operates in a different physical space that is adequate to the cultural requirements of the tradition of the mapuche medicine, is formed by *machis* (healers) and a *lawenche* (herbalist), who make referrals to the bonesetter and to the *piñiñalchefe* (midwife).

Both spaces are physically and functionally connected through referrals and counter-referrals between the two teams whenever necessary. Resources are transferred from the Health Service Araucanía Sur to the Community Health Committee through *per capita* payment for services of the Family Health Plan to approximately 1,300 people registered and affiliated to the Fonasa.

The provision of health services at the mapuche component is done with respect for the payment traditions between people and mapuche health agents, but the State also funds actions on individual and collective health that are typical of the mapuche culture. According to the agreement, the community committee must give account to the Health Services for western and traditional services provided at the Health Center.

The mapuche medicine is put at the same level of western medicine (complementarity) and the health personnel performing western medicine, hired by the community, must respect the mapuche medicine. These professionals are submitted to an intercultural inducement previous to the beginning of activities in the Center.

Source: Neira Rozas, 2011.

In Colombia, although there are difficulties for the full recognition of traditional medicine approaches, some indigenous communities of the country have formed their own Health Promoting Companies and Health Service Providing Institutions of the first level of complexity and, therefore, were able to advance until they achieved the creation and legitimation of the Indigenous System of Traditional and Intercultural Health, which has now been recognized as a fundamental right of indigenous peoples by the statutory health Act of the country. In the PHC models of these communities, there is a wide use of indigenous health workers and community health promoters, who have gone through a strategic election to perform the double mission of showing and promoting the cosmovisions and practices of the traditional indigenous medicine and to work as interlocutors between the indigenous and western medicine workers. The intercultural health model in Colombia has been built by native peoples in their territories as a result of their struggles, by overcoming the belief that the State and experts could act on their behalf. One example is the programmatic experience of organizations of indigenous communities of the department of Cauca, in the South of the country.

Interculturality and PHC in the Indigenous Health Program in Cauca, Colombia

In the South region of the country, the indigenous communities of Cauca, settled in 29 municipalities of the department, with a population of approximately 248,532 people, have built a struggle platform that includes several comprehensive and intercultural programs, among them the Indigenous Health Program (PSI). This program has guidelines that aim to defend their fundamental rights, especially their food autonomy, traditional medicine and interculturality, to adapt health policies of the State and the western medicine to their cultural needs and singularities, to end discrimination in western health services, to promote education and research in intercultural health and to strengthen the organization of communities.

The PSI includes the creation of a Traditional and Intercultural Indigenous Health System (Sispi) that aims to strengthen their own medical systems and to clarify their relation with the western health system in terms of the right to health, interculturality, gratuity and integrality of care.

The Sispi is based on the indigenous cosmovisions, which believes in harmony and balance between men, nature and the territory. This relation is reflected in their cultural rules and practices, which work together to produce individual and collective well-being in all ambits of life.

The model of health care of the PSI is based on PHC, which works with two types of teams: community-based and support teams. The first ones are formed by indigenous workforce and include *The Wala* (traditional doctor of the Nasa people), midwife, community health promoters, pulse healers, eye healers, agro-environmental activity coordinators, sobanderos (people who treat simple fractures with balms and massage) and oral hygienists. The second ones are formed by western workforce, among them, professionals such as the general practitioner, dentist and bacteriologist, besides auxiliary nurses, laboratory and nursing (vaccinator) personnel and professionals with other kinds of knowledge, such as alternative medicine and ancient wisdom.

The model, which can vary according to the ethniticity, is characterized for being "comprehensive and intercultural, based on life cycles (family, human being, community and territory), on the family and the community", and for strengthening their traditional medicine.

Its aim is to "take care of the health of the indigenous populations, guaranteeing comprehensive care based on the indigenous medicine with the cosmovisions and cultural practices for the well living of each People, with the articulation of actions from other medical models accepted by the community and the application of comprehensive and intercultural primary health care strategy".

Sources: CRIC, 2010; Realpe, 2014.

In Peru, there is an intercultural policy ran by the National Health Institute through the National center for Intercultural Health, which coordinates the National Health Strategy for Indigenous Peoples. This includes the development of the Observatory on Interculturality, studies in traditional medicines (cultural syndromes) and alternative and complementary medicine and projects as the National Database of Medicinal Plants and the promotion of the safe and informed use of alternative and complementary medicine. One example is the "Health of the Indigenous Peoples Initiatuve", developed by the PAHO from the 1990s to the beginning of the 2000's, oriented by the principles of respect and revitalization of indigenous cultures, reciprocity in relations, the right of indigenous peoples to self-determination, the right to systematic participation and the holistic approach to health (Brocker et al., 2001).

In cooperation with the Ministry of Health of Peru and some Regional Health Departments, since 1989 *Medicus Mundi* has been developing several intercultural projects and programs for community participation that include community health workers, traditional therapists and base organizations of peoples in excluded and extreme poverty zones, especially in areas of indigenous peoples (Calandria et al., 2009). A highlight of this initiative is an internationally awarded project for the operation of the Comprehensive Health Care Model in the Province of Churcampa-Huancavelica (León et al., 2013; Sánchez et al., 2013). On the other hand, the strategy for sexual and reproductive health has been fostering the development

of maternity waiting homes. A distinguished experience is the intercultural model developed by the Regional Health Department of Ayacucho, which promotes that Health Facilities provide users with elements for the option of vertical birth, medicinal herbs and waiting homes for the families of the patients (Alanya et al., 2014).

REGIONAL AND SOCIAL INEQUALITIES IN THE ACCESS TO PHC

All three countries share important challenges to equity, due to the persistence of regional and social unfair inequalities in the access to PHC and in the assignment and distribution of the resources available.

One of the problems that come from the Chilean insurance model refers to inequalities in funding, whose origin seems to be in the asymmetries of the per capita payment for the basic array of services between Health Insurance Institutions (Isapre) and the National Health Fund (Fonasa) and in the lack of resources, which obligates regions and municipalities to assign complementary funds to the provision of services. For example, whereas in 2008 the Isapre would spend US$ 1,363 ($750,000 Chilean pesos) per beneficiary to cover 16% of the population, the Fonasa would spend US$ 582 ($ 320,000 Chilean Pesos) per beneficiary to cover 70% of the population. The problem is aggravated due to the absence of solidarity between insurance schemes (Salud un Derecho, 2011). The funds assigned to PHC have increased to about 26% of the public expenditure in health services and the goal is to cover at least 80% of the burden of disease and to overcome inequalities due to conditions of rurality, poverty, older population and access to services. Nonetheless, the amount of resources to fund the basic array of services and the Explicit Health Guarantees, as well as the adjustment mechanisms to overcome the inequalities of the basal per capita and of public health reinforcement programs (which are not adjusted in accordance with the mentioned indexes) do not seem to be enough (Torche, 2009; Montero et al., 2008; Montero et al., 2010; Chile, Senado, 2012). There are also significant inequalities concerning the general distribution of physicians (Chile, Ministerio de Salud, 2010b) and, particularly, of certified family doctors by region (Chile, Ministerio de Salud, 2014b). It is also knowledgeable that local health teams, especially those in rural zones and underserved territories, do not count with the necessary resources of diagnostic and therapeutic equipment and workforce to provide comprehensive and sufficiently effective services.

In the majority of municipalities in Colombia (72%), there are only public providers of health services, which are the only option for health care. Such health service providers are concentrated in the biggest and economically affluent cities of the country and only 430 (39%) of the national total of 1,102 municipalities are able to manage resources and the provision of health services of low complexity “required by the poor population in the case of what is not covered by subsidies to the demand" (Decree No. 4,973 of 2009), since the other cities are not certified to do so. The existing institutions are not sufficiently efficient and adequate in their

infrastructure and organization characteristics in order to meet the requirements of a modern approach to PHC and there are great difficulties in regard to its institutionality and the management of municipal resources to lead processes and activities for the contract of insurances under the subsidized regime and collective actions of the public health insurance (Colombia, Ministerio de Hacienda y Crédito Público, 2011:62; Colombia, Ministerio de Salud y Protección Social, 2012a). Additionally, the Ministry of Health and Social Protection recognizes the existence of a high level of fragmentation in health service provision due to the competition for price among insurances and health service providers, besides the difficulties in the continuity of care and the increase in the costs of care to patients, which leads to the low effectiveness of services, difficulties in quality and prevalence of a biomedical approach focused on the individual and on the disease (Colombia, Ministerio de Salud y Protección Social, 2014a).

In Peru, an analysis of the distribution of physicians by population poverty quintiles showed that in 2012, the highest number of these professionals was concentrated in zones of quintile V, which correspond to those with greater economic resources (Perú, Ministerio de Salud, 2006). It also demonstrated that, in 2005, there was a significant correlation between the availability of human resources and health indicators, such as the ratio of maternal mortality. The study found an inverse relation that shows that in departments with less human resources, maternal mortality rates are higher and there is a higher level of poverty (Perú, Ministerio de Salud, 2006). In order to address this situation, parallel to the mentioned economic incentives, there was the implementation of the strategy Rural and Marginalized Urban Health Services, which aimed to hire professionals with funds from the Ministry of Health and regional governments. In 2013, 8,980 medical professionals were hired under this modality and distributed among vulnerable areas, prioritized by criteria such as high level of uncovered basic needs, maternal mortality, childhood malnutrition and gaps in human resources (Perú, Ministerio de Salud/DGGDRH, 2013).

FINAL CONSIDERATIONS

In the three countries included in this study, Chile, Colombia and Peru, PHC is a strategy of the public component of their health systems. These systems shared the fact that they have been developed under the framework of sectorial reforms, with market-oriented insurance models, therefore following the rules of separation and specialization of the roles of direction, funding, insurance and provision of services, with the inclusion of multiple public and private actors. PHC depends on the public subcomponent of these systems, which is generally designed for the protection of the population with no ability to pay and the working population with lower incomes. Even though they might have different models for the management of insurance funds, the administrators are in charge of the management of risks, funds, access of affiliates and hiring of service provision.

Despite the fact that national and territorial systems are formally in charge of directing the design and implementation of PHC based on PHC Renewal, the result of these characteristics of their health systems is that the power of public or private institutions in charge of insurance funds is decisive at the moment of the definition of the approach, organization of resources and the determination of the model for the operation of PHC.

The PHC model claims to be family and community-oriented; to include entry point characteristics, integrality, coordination, longitudinality and continuity of care; to emphasize on the prevention of diseases, health promotion and effectiveness of care; and to consider community participation, intersectoral action for health and interculturality.

An important characteristic shared by all three countries is the decentralization of PHC, which gives territorial entities the competence for the application of technical rules and the implementation of models with emphasis on public health, as occurs in Colombia, and managers of insurance funds with the hiring of individual provisions for affiliates. In general, the application of the family care model tends to be articulated with individual provision and community care model with public health actions.

PHC expenditures in all three countries is funded with resources from different sources: parafiscal, taxes, out-of-pocket family expenditure and donations. Given the insurance-based character of the organization of the health systems and the intention of including the poor in primary health care services, salary contributions and funds from the income of independent workers affiliated to the social insurance provide resources for the access of affiliates with ability to pay to individual provisions, whereas national taxes and resources from subnational entities provide funds to individual provisions as well as to people without ability to pay and for public health activities such as the construction of physical infrastructure, staffing and maintenance of health equipment.

Transfer of resources between insurance fund managers and the State is determined by the type of provision to be funded. Transfers for the funding of individual provisions of affiliates are usually done through per capita payments calculated according to adjustments by age, gender, place of residence, poverty, etc., of the affiliate. Transfers from the central State to municipalities or from municipalities to service providers for the funding of collective actions are done through global fixed payments with history-based budgets. The concurrence of these funds is usually limited by the separation between individual and collective provision and the segmentation of health systems, which makes it difficult to integrate individual and collective primary health care actions in a single provider in Colombia.

Although all three countries claim that the access to PHC is free of charge, especially to determined groups of pathologies and to the population with lower income, in general, there is still out-of-pocket payment or household co-payments and payment for the access to individual provision and medicines not delivered by the primary health care public system. Out-of-pocket expenditure as a percentage of the total health expenditure oscillates between 20 and 40%. Forms of payment to the direct primary health care service provider may vary, the

most frequent ones being the per capita payment and the prospective or fixed payment for assistance activities, whereas the payment per event seems to be more used for promotion and prevention activities. There is also a tendency to use incentive performance-linked incentives for providers and for health results.

In these three countries, individual, family and community PHC services are delivered to the population through public or private first level of complexity health units, with different sizes and levels of integrality, according to the number and density of the population served and their urban or rural location. Most of these units are municipal public institutions with administrative autonomy. Some provider institutions are private for profit companies, independent from or vertically integrated to insurance companies, whereas the other providers are nonprofit non-governmental organizations or organizations that belong to some communities, as is the case of native peoples. A general characteristic of these units is that they combine internal or external basic health teams with traditional forms of organization of work for the provision of health services.

External health teams tend to perform activities in communities and in dispersed population zones and internal health teams tend to perform rather individual and family activities in zones with a higher concentration of population. Teams are usually multidisciplinary and tend to be formed under two modalities: basic and complementary teams. Teams are usually formed by general physicians and nurses, midwives or obstetricians, health promoters and/or auxiliary nurses. Complementary teams include other professions such as dentistry and psychology, among others. Indigenous communities also form two types of health teams, but with intercultural relations between them.

In all three countries, PHC includes two sets of services, insurable and collective ones. Insurable services are a set of provisions that cover individual and family risks, medical-assistance services, medicines and technology, which are organized under the scheme of social insurances, with the management of insurance funds and of risks delegated to public or private entities that hire the provision of services from public or private providers. Collective services are public health plans or programs that cover collective risks (public goods with high externality), which are under the government's responsibility, with decentralized management and public provision, in general.

There is also the provision of intercultural services guaranteed to native peoples, after the achievement of agreements with governments. These include both insurable and public health provisions and recognize practices of the traditional indigenous medicine. Provision may be internal or external. The difficulties presented are concerning the integration of individual, family and collective actions, especially in Colombia and Peru, due to segmentation, fragmentation and the intermediation of the insurance system.

Even though traditional primary health care facilities are prevalent in individual and assistance professional practice, family and community-oriented facilities under the new model of care, aim to work at health centers with basic and complementary health teams. These

centers are undergoing a process of organization and physical adaptation to the requirements of the multidisciplinary, family and community work, and they promote community participation, interculturality and intersectoral action for health. Nonetheless, as a public strategy, PHC continues to have an emphasis on social assistance and an approach focused on the poor.

In regard to the sectorization of work and the affiliation of population to health centers and teams, the situation is heterogeneous among the countries and within each country. Whereas in Chile and Peru the aim is to work through sectors and with population assigned to health teams, in Colombia there are no clear national guidelines in respect to it, even though some territorial entities have been developing this according to their possibilities. In places with the affiliation of the population to teams, the principle of the freedom of choice is not always respected and this is stronger among rural populations. There is also no common rule followed by countries concerning the size of the sector and the number of people to be affiliated according to the health care unit and team. The diversity of situations presented seem to be influenced not only by technical and cultural choices, but also by economic restrictions. Sectorization and the affiliation of population aim to organize the work of primary health care units and teams at the territorial and micro-territorial level.

PHC is usually the basis of the organization of health care networks by levels of complexity or health care. All three countries have tools that were specifically developed to facilitate referrals from PHC to other services and they started to use ICT to this end. Nonetheless, there are still waiting lines to access specialized and hospital services, which are sometimes deficient.

The regulation of labor relations in PHC in these three countries occurs in the context of development models of economic overture and liberation that have boosted not only market-oriented health systems, but also the flexibilization of the labor market with an increment of informal employment as a consequence. Nonetheless, this tendency seems to have been weakened by some specific labor rules for protection and incentive to work, such as the creation of professional careers, which resulted from demands from workers and from the negative consequences of the flexibilization of employment in the quality of primary health care performance, as the example of the incompatibility between the permanence of the relation between the professional and the patient and the instability of work. Nonetheless, these are heterogeneous trends in all three countries.

There are still difficulties to attract and retain health professionals in marginalized zones and in areas that are difficult to access, despite the effort of some countries to generate incentives to this end. One of the main problems for the linkage, attraction and permanence of these professionals in primary health care is their deficit, which is aggravated by the competition of the private with the public sector and the persistent tendency to specialization, due to the lack of proper employment, work conditions, professional and training incentives and low salaries in general practice. The speed of the production of professional workforce for

PHC in these countries is not sufficient to answer the demand for this resource, given that PHC is intensively used and, besides, that there has been a growth in the demographic and epidemiologic coverage of the health systems, which generates an increase in demand that goes beyond the supply of human resources. This situation has been generating serious inequalities and migration problems between countries, but these questions have not been thoroughly studied yet.

One of the characteristics of the primary health care models of these three countries is the incorporation of community health workers. This action, which is not a recent innovation in primary health care systems, is being taken up especially for the execution of tasks of external and community health teams that develop activities for promotion and prevention in public health programs. Likewise, native peoples use indigenous health workers that perform a role of intercultural articulation between the traditional indigenous medicines and the contemporary model, from the perspective of indigenous health systems. There is no clear national data about the amount of community health workers/promoters that participate in the activities of primary health care teams in these three countries, since the activities are usually volunteer or hired through instable contracts. What has been observed, especially in Colombia, is the development of an explicit policy about the use and paid association of community health workers to the primary health care public strategy, especially in rural zones and urban marginalized communities. This is not the case of Chile and Peru, where there seems to be more incentives to the connection of family and community health volunteers.

These three countries have normative guidelines and/or national and local institutional spaces that promote intersectoral action to address the social determinants of health, despite their vertical approach. The method that adopts intersectoral action at the national level is the creation of intersectoral commissions with governmental institutions. At the local level, some PHC units and teams carry out a situation analysis of health problems and aim to develop actions to solve problems together with other local power sectors. Connections between national and subnational levels concerning intersectoral action are unclear, as is the identification and prioritization of needs and the assignment of resources to meet them.

Despite the differences in their concepts and approaches, in Chile, Colombia and Peru there are several experiences being developed with intercultural health policies that use PHC for their implementation. Native populations are the main actors of the concept of interculturality, self-management of resources and of considering their traditional health and medicine as the core of interculturality. Nonetheless, the state rationality expressed through contracts and agreements that reflect the logic of market-oriented insurance systems tend to limit the freedom of indigenous communities to develop their own health systems, service provision, human resources training and research based on their own knowledge and experiences.

The three countries share important challenges with regard to equity, due to the

persistence of regional and social unfair inequalities in funding, distribution of human resources and health services and in the access to PHC. Although they might claim that primary health care is free of charge, there are still economic, geographic, administrative and cultural barriers. These barriers mainly affect populations in social and economic disadvantage, those living in dispersed rural zones and in marginalized areas of big cities. Many of these inequalities, which are a result of basal social inequalities, are reproduced by the type of health insurance model that, without being universal, segments the population between the poor and rich. These inequalities are also expressed in the integrality of provision and services offered, in the access, in the quality of care and in the health status of the populations. Even though it is known that PHC may contribute to reduction of health inequalities, there must also be economic, social, political and cultural transformations that go beyond health systems, but that also include them, so that PHC is at its optimum to collaborate for social justice in health.

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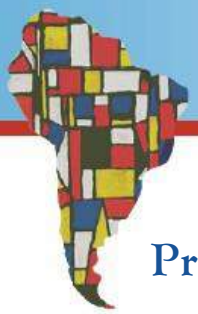


Primary Health Care in Guyana and Suriname: diversity and challenges to overcome health inequalities within populations of the interior and the coastal area

Hedwig Goede

INTRODUCTION

This chapter presents a comparative analysis of the experiences with the implementation of Primary Health Care (PHC) in Guyana and Suriname. It is based on the mapping of PHC in each one of these countries, which has been developed as part of the technical work of the South American Institute of Government in Health (Isags) for building knowledge and reviewing the experiences with PHC models among South American countries (Goede, 2014a; 2014b).

The mapping was carried out from February to June 2014 and was based on the analytical framework for PHC developed by Isags. The framework was structured as a matrix with several dimensions of Primary Health Care that included PHC conduct, funding, service provision, organization, coordination and integration, workforce, intersectoral actions, interculturality, social participation in PHC as well as planning, information systems and quality monitoring.

The activities developed for the mapping included a review of secondary source documents, interviews and discussions with key actors of the policy and management levels of PHC and field visits for observation.

Context of the countries

Guyana and Suriname are bordering countries at the North Coast of South America. They are the only countries that are both part of the South American region and the Caribbean and they both are State members of the Union of South American Nations (Unasur) and the Caribbean Community (Caricom).

Guyana is the only English speaking country in South America and Suriname the only Dutch speaking country in South America.

With the same geographical features and a shared colonial history, the two countries have a lot in common, including some characteristics of the population. Both countries have small populations with cultural and ethnic blends (with more diversity in Suriname) and they both have large overseas emigration flows. In the case of Guyana, citizens with higher education persistently migrate to the USA, Canada, the United Kingdom and to neighboring Caribbean countries. After independence, approximately one third of Suriname's population migrated to the Netherlands in the mid-seventies.

However, despite the similarities, these countries have also remarkable differences due to divergences in colonial times as well as the different political, social and economic development in post-colonial periods. Guyana and Suriname have both been colonies by the British and Dutch Kingdoms, respectively, until their independence, which is relatively recent: Guyana gained independence from the United Kingdom in 1966 and Suriname from the Dutch in 1975, almost ten years later.

Guyana was cofounder of the Caribbean Community (Caricom) in 1973, after a developmental process that lasted approximately ten years and represented a joint effort with other previous colonies of the United Kingdom. Suriname remained considerably isolated within the American region due to the language barrier, its late independence and strong ties with the Netherlands. Its membership in Caricom only took place after 1995 and efforts for integration with South America and the Caribbean region are also recent. Chart 1 summarizes selected demographic and economic information on these countries[1].

1 Only estimates from the same international sources were used for comparison.

Chart 1 – Demographic and Economic Characteristics of Guyana and Suriname

Characteristics	Guyana	Suriname
Population	748,900 (2012 census)	541,638 (2012 census)
Settlements and population density	Total Coastal: 89.1% Urban coastal: 26.4% Rural coastal: 62.7% Interior: 10.9% Total Urban: 26.4 % Total Rural: 73.6%, Total population density: 3.5/Km² Smallest density: 0.4/ Km² (Interior regions 7 and 9)	Total coastal: 86.8% Urban coastal: 66.3% Rural coastal: 20.5% Interior: 13.2 % Total Urban: 66.3% Total Rural: 33.7% Total population density: 3.3/Km² Smallest density: 0.2/ Km² (Interior district of Sipaliwini)
Ethnicity as % of total Population	Indo-Guyanese: 43% Afro-Guyanese: 30% Mixed: 16.7% Amerindians (Indigenous): 9.2% Portuguese and Chinese: 1%	Hindustani/Indian descendants: 27.4% Maroon/descendants of slavery escaped African slaves: 21.7% Creole/mixed African descendants: 15.7% Javanese/Indonesian descendants: 3.7% Mixed: 13.4% The remaining 8% consists of other groups such as Indigenous/Carib, Arawak, Trio, Wayana and other native inhabitants, Chinese and Dutch descendants, Lebanese descendants
Economy	Agriculture (sugar, rice), mining (gold, diamonds and bauxite) Classification: lower middle income GDP: US$3,584/capita Stable economic growth since 2006. Annual average of 4% Recovered from the classification as a heavily indebted country	Main economy: mining (gold, oil, bauxite) Classification: upper middle income (from lower middle to upper middle income in 2010) GDP: US$9,376/capita
Language	Official language: English Nine other languages from Indigenous populations	Official language: Dutch Other languages spoken: Sranan-ToNGOs (lingua franca), Sarnami Hindi, Javanese, + 10-12 languages from indigenous and Maroon populations

Sources: Bureau of Statistics Guyana, 2014; General Bureau of Statistics Suriname [Algemeen Bureau voor de Statistiek], 2011; WB, 2014

Guyana was classified as a heavily indebted poor country during the period of the economic crisis of the region, in the 1980's. Since 1997, it has moved up in the World Bank classification as a lower middle-income country.

Guyana's health status indicators show an important gap in comparison with those of Suriname (Table 1) and this might be a reflection of the differences in critical determinants of health. Although Guyana has benefited from investments in health since 2000 and that, since then, it has shown a robust economic growth (IMF, 2014), the country has a lower GDP per capita (Chart 1) and more human and financial resource constraints for health.

Table 1 – Health indicators, Guyana and Suriname

Indicators	Guyana	Suriname
Infant mortality rate per 1000 live births (estimated) in 2010	30	26
Under five mortality rate per 1000 live births (estimated) in 2012	35	21
Maternal mortality rate per 100,000 live births (estimated) in 2013	250	130

Sources: PAHO, 2014; World Health Organization, Unicef, United Nations Population Fund, The World Bank, 2014.

Health system

Guyana and Suriname share many challenges in the protection of the health of their populations due to similar social, environmental and geographic contexts that represent a threat to health. In contrast with these shared challenges are the remarkable differences between their health systems.

Suriname's health system is a public-private mix system. It is a complex and highly segmented system with different financial modalities and different service providers for diverse segments of the population according to income, employment status and place of residency (Suriname, Ministry of Health, 2011; Isags, 2012b). More than twenty percent of the population does not have coverage by any health scheme and makes out-of-pocket payments (Suriname, Ministry of Health, 2006). For higher costs (hospitalization), individuals in this category who fall ill may obtain a temporary health card from the ministry of Social Affairs to avoid catastrophic health expenditure. Those below or near the poverty level are covered by the Ministry of Social Affairs with a health card that gives access to PHC services of the state-owned Regional Health Services Foundation and through referral to other health care services in the public system in the country (Bitrán et al., 2002).

In the early 1980s, shortly after Alma Ata, Suriname reorganized its health system and built structures and capacity for comprehensive PHC. Amendments to the constitution were prepared to include health as a right, once the previous constitution did not have this definition. However, in the period of economic crisis and structural adjustment in the 1990's, the attention to the construction of a comprehensive PHC diminished and the focus was mainly on maintaining essential services with a selective PHC approach (Goede et al., 2014).

A health sector reform program, financed by the Inter-American Development Bank (IADB), was implemented at the beginning of the first decade of the 20th century, with a growing private sector offering specialized care and high-technology diagnostic services. The latest developments in the reform of the health system are the efforts made to introduce the compulsory national basic health insurance (approved by law in September 9, 2014) as part of an overall social system reform (Government of Suriname, 2014). The reform intends to reduce out-of-pocket payment, give choice of provider to the poor (who now do not have this option) and probably reduce the level of segmentation by merging some of the population segments in the same scheme. However, some segments of the population will remain in separate schemes, such as the large public service workforce, their families and those covered by private insurances paid by their employers.

For the upcoming national insurance scheme, the government has chosen a market-oriented approach. Private insurance companies will cover the insured population. For those without ability to pay, the government will pay the affiliation premium to private insurers. The government is also considering covering the health insurance premium for the population under 16 and the elderly (65+ age group). However, the financial implications, the formation of the basic package and service delivery modalities were still being debated when this study was completed, in mid-2014.

There are procedures for referral from one level of care to another, but services in Suriname are not organized as a delivery network. The authority over the different levels of care is not unified and there are no legal relationships between the different levels of care.

Guyana's health system is primarily a public system that provides health services free of charge to all. Despite the growing private health care sector, at the national level, the system does not show a high level of segmentation. The public system does not make a difference between segments of the population, and all who seek care will receive the available services without charge. The public system is organized as a service delivery network, showing characteristics of a hierarchized district health system, in which the different health facilities in a particular region are formally related to each other and this is regulated by law.

There were three main phases identified in the restructuration of the health system in Guyana. First, in the 1970s, the country introduced, in a structured manner, two categories of health care workers – health technicians called Medex and community health workers (CHW) – to ensure service provision to the remote and hard-to-reach populations in the interior and rural villages. These populations did not have access to health care services besides the ones provided by indigenous healers. The work took place as a part of a cooperation network among several countries and was a stepping-stone to PHC (University of Hawaii, 1983).

The second critical change was brought by the Local Government Act (1998), which was directed at decentralization and stipulated the responsibilities of the local government and its structures for health services. With this act, health service provision became a responsibility of the Local Government (Government of Guyana, 1998). The third development process of the health systems came with the implementation of a health sector reform program with funds from the IADB, since 2000. The Regional Health Authority Act and the Ministry of Health Act (2005) were approved during this period, as rules that strengthen the stewardship role of the governmental entities of the health systems. (Government of Guyana, 2005a; 2005b). Recently, Guyana has started a new process of reorganization of the health services with the establishment of diagnostic centers in several parts of the country, with the support of Cuba and with the return of large numbers of Cuban trained Guyanese physicians.

PHC CONDUCT

Both countries have the right to health assured by the constitution. In this sense, Guyana refers to the right to free medical care whereas Suriname states that everyone has the right to health. Both countries make the link to the determinants of health, but in different ways.

While Guyana's constitution indirectly assumes the responsibility of the government for health care, in the following article it mentions the duties of citizens to participate in the improvement of the environment and in the protection of the health of the nation (Government of Guyana, 1980). In turn, Suriname, in the article about health and the duties of the State, establishes the promotion of health care through the improvement of living and work conditions and the provision of education for the protection of health (Government of Suriname, 1987).

Concept of PHC

The concept of PHC is indirectly found in official documents of both countries, as shown in Chart 2.

Chart 2 – Concept of PHC in Guyana and Suriname

PHC Concept	Guyana	Suriname
Health in the constitution and legal documents	Article 24 of the Constitution states: "Every citizen has the right to free medical and social care in case of old age or disability". The link to the determinants of health and to social participation is made in article 25 of the constitution. Art. 25 states: "Every citizen has the duty to participate in activities designed to improve the environment and to protect the health of the nation" (Government of Guyana, 1980). The Act of 2005 of the Ministry of Health refers to a shared responsibility between the State and individuals concerning health.	Article 36 of the Constitution states that everyone has the right to health and that the state promotes health care by systematically improving the living and work conditions and providing education for the protection of health (Government of Suriname, 1987).
Legal or official definition of PHC	PHC is not explicitly defined in laws. PHC as a strategy is mentioned in national health policies and plans in a consistent way since the late 1970s, with its particular description. Nevertheless, the principles of PHC are fully reflected in the system.	PHC is not explicitly defined in laws. PHC as a comprehensive strategy is mentioned in national health plans and official documents, following the definition of Alma Ata, until late 1980s and referred to as basic care after this initial period.
Recent conceptualization of PHC	Recently, the health policy document (Guyana, Ministry of Health, 20143) refers to PHC as a basic principle of the systems and emphasizes on the approach of the social determinants.	In 2014, a strategic plan developed for the renewal of PHC presents this strategy in a comprehensive approach and not merely as a level of care.

Sources: Guyana, Ministry of Health, 2013; Suriname, Ministry of Health, 2014; Government of Guyana, 1980; Government of Suriname, 1987.

Functions and competences of governmental spheres

Guyana is decentralized and has local governance structures under the jurisdiction of the Ministry of Local Government and Regional Development. The roles and functions are legally defined by the Municipal and District Councils Act of 1988 and the Local Government Act of 1998. All ten regions that form the political and administrative division of the country have a Regional Democratic Council (RDC), which is the highest governance structure at the regional

level and which is responsible for all social services in the region.

Each RDC has a Health Department and a Regional Health Committee (RHC) (Government of Guyana, 1998; 1988). The local structures play a key role in PHC. The Regional Health Committee is the platform that brings together actors from the health sector and regional leaders in health planning.

Suriname shows significant differences in comparison with Guyana. The country has no local government for health and, therefore, subnational levels of the government have no specific authorities and duties in PHC. Suriname uses semi- autonomous institutions in the delivery of health care. The government has some control over these institutions through Boards appointed by the government and by the public funding from the Ministry of Health. However, unlike subnational public entities, these institutions cannot be held accountable in view of the local populations. Therefore, the populations still have limited influence on primary health care institutions in Suriname. Nevertheless, the country is in the process of the development of the local government at the district level.

PHC FUNDING

The Government of Guyana takes responsibility for the provision of health services free of charge to the entire population. Resources are shared between the Ministry of Health at the national level and the Regional Democratic Councils at the subnational level.

PHC is mainly public funded and is supplemented with donation funds. PHC expenditures in 2009 as a percentage of the Total Health Expenditure (THE) of the government is estimated in 8%, whereas the expenditure on hospitals is of 38% (Usaid, 2011).

The Ministry of Health estimates that in 2009, 40% of the sources of health funding in Guyana came from the government, 48% from external funding (donation funds) mainly directed at priority diseases and vertical programs and 12% were out-of-pocket household expenditure on private services (Shamdeo, 2011; Isags, 2012a).

As a heavily indebted poor country and with the implementation of the poverty reduction strategy paper, Guyana successfully mobilized extensive external funds for the health sector. Nonetheless, in the past few years, external resources for health have been reduced and, in 2012, they were leveled to the average of lower middle-income countries, according to statistics of the WHO (WHO, 2014a; 2014b). However, there was a significant increase in overall national health expenditures from US$ 58 per capita total expenditure in 2005 to 235 US$ in 2012 (WHO, 2014a).

With the absence of local governance in Suriname, all public resources come from the national government. The Ministry of Finance collects taxes and allocates funds for health to four different ministries that are related to the delivery of services to different segments of the population: Ministry of Health (hires semi-autonomous institutions as health providers to the general population), Ministry of Social Affairs and Housing (provides funds to the population in situation of poverty), Ministry of Defense (in charge of the members of the army and their families)

and the Ministry of Justice and Police (in charge of members of the public security and justice). The Ministry of Finance also manages the contributions of the State Health Fund Foundation. The contributions are a combination of public employee share in the premium and of the contribution of the government as their employer.

The Ministry of Health, in turn, allocates funds to a number of non-governmental and semi-autonomous state foundations involved in PHC.

In relative terms, Guyana's government spends more on health (66% of THE) if compared to public expenditures in Suriname (57% of THE), but in absolute terms, Suriname's public expenditure per capita is higher (Table 2).

Co-payments for public services do not exist in Guyana, whereas in Suriname, co-payments are a nominal amount in drug prescriptions. This is a very small fixed payment independent from the real costs of prescribed drugs.

Table 2 – Health expenditure in Guyana and Suriname, 2012

Indicator	Guyana	Suriname
Total health expenditure as % of the GDP	7	6
Public health expenditure as % of the total health expenditure	66	57
Total external expenditure on health as % of total health expenditure	11	4
Total expenditure on health per capita (US$)	235	521
Public health expenditure per capita (US$)	155	297

Source: WHO, 2014a.

PHC ORGANIZATION

In Guyana, PHC is organized as a nation-wide regional network of health services integrated with higher levels of care. There is one integrated regional health service delivery network for each region as a component of the Regional Democratic Council. The ten regional networks are supervised by the department of Regional Health Services of the Ministry of Health. The facilities, staff and services are well defined within the public system. There is a small number of private autonomous PHC facilities. PHC services in the private sector are also provided by the six private hospitals located in urban areas.

In Suriname, the organization of PHC is geographically divided into two subnational networks: one for the coastal area and one for the interior, the Amazon rainforest. By contrast with the organization in Guyana, where the supervision of all PHC services belongs to one department, the Regional Health Services Department. In Suriname, the Regional Health Service Foundation is responsible for PHC in the coast and, in the interior, the institution responsible is the Medische Zending Primary Health Care (Primary Health Care Medical Mission).

Suriname's Regional Health Service (RHS) is an autonomous institution, founded by the government as an executive body of the Ministry of Health (MoH). Legally, it is a foundation and the directive board is appointed by the minister of health. The RHS originated from the MoH Medical Service Department and its development is, to a great extent, inspired by the Alma Ata PHC strategy (Stichting Regionale Gezondheidsdienst, 2014a). The Regional Health Service provides care to the population throughout the northern coast of the country, which represents 10% of its land mass and is where about 87% of the total Surinamese population live, distributed in urban and rural coastal areas. Private general practitioners provide a more limited package of first line care, whereas the services of the Regional Health Service are more comprehensive and include population-based services (Suriname, Ministry of Health, 2014).

The Medische Zending (MZ) is a PHC foundation in Suriname, established by religious organizations. Its work area is the interior of the country, which covers 90% percent of the country's land mass and is part of the Amazon rainforest. The area is sparsely populated (13% of the country's total population), with various Indigenous and Maroon populations who live mainly in traditional villages along the large rivers.

The government was not involved in health care services in the interior. Shortly after independence, the government and the MZ signed a formal agreement on health care in this area of the country. This agreement stipulated that the MZ would provide services free of charge to populations of the interior and that the Ministry of Health would provide the funds required for this end (Stichting Medische Zending PHC Suriname, 2014a).

Similarly, both PHC organizations in Suriname divide their service area geographically in service regions that form service networks with institutions of different capacities and thereby coordinate the work from health posts with limited services to clinics and health centers. The health center is better equipped and staffed. Unlike Guyana, in Suriname, the PHC regional networks do not include higher levels of care as an integral part of the network.

In Suriname, the private offices of general practitioners are an additional important resource of first contact with the health system for those covered by the State Health Insurance, by private health insurances and for out-of-pocket payers. Private offices are only found in the coastal belt and largely in the most populated urban areas, such as Paramaribo, the district of Wanica and Nickerie. Table 3 indicates the distribution of PHC facilities by geographic area in both countries.

Table 3- Distribution of public and private PHC facilities in Guyana and Suriname by Geographic Area

	Guyana		Suriname	
Area	Public	Private	Public	Private
Coast	173	27	63	157
Interior	148	0	54	0
Subtotal public	321	27	117	157
Total	348		274	

Source: Guyana, Ministry of Health, 2014; for Suriname, data from 2010 provided by the Department of Planning of the Ministry of Health.

In Suriname, health care service delivery is more segmented and complex, in comparison with Guyana. The 54 PHC facilities in the interior that belong to the Medische Zending are not actual public facilities, but nonprofit private facilities, which provide PHC services with public funds. They have been included in Table 3 under public facilities because the MZ provides PHC services free of charge to the population in interior villages through an agreement with the Ministry of Health and with funds from the government. By contrast, in the coastal area, although most of the family practitioners' offices are organized as private services, to a great extent, they are also funded by the government. This is because the State Health Fund, a governmental foundation, hires services from private physicians for public workers enrolled in the fund and their families. A considerable proportion of the funds comes from the Ministry of Finance and the remaining part is a contribution from public workers.

The private PHC facilities of Guyana consist of a few entities in which individuals pay fees out of pocket. It also includes a number of health facilities from the sugar company Guysuco, a state-owned corporation that covers the PHC of its employees and their families.

According to information from interviews with staff of the health institutions[2], in both countries, the public PHC facilities have a specific geographically defined population that is covered and is registered at the health facilities.

Although the interior population in both countries has relatively numerous PHC facilities, in comparison with the small proportion of the total population that they represents, these institutions only guarantee local access to limited health services.

For access to a broader range of diagnostic and treatment services, individuals of the Interior need to cover long distances and frequently travel over rivers, by road and sometimes by air. Recently, the Ministry of Health of Guyana has expanded the outreach with mobile teams of physicians for remote areas. This intends to reduce the need for patients to travel to diagnostic centers or hospitals. The Medische Zending in Suriname has experiences with coverage for oral health and is now in the process of introducing other specialist coverage to reach remote populations.

In Guyana, the health care system counts on health posts staffed with community health workers, which are not restricted to the interior and are frequently also found in rural villages in the coastal area. In Suriname, this model is not used.

In Guyana, supervision and monitoring of PHC services are responsibilities of two units within the MoH. The Regional Health Services Department of the MoH of Guyana has a supervising and coordinating role. The tasks include the supervision of referral systems, assistance in the provision of specialist health care services and the guarantee of adequate staffing of health centers and hospitals in the regions. On the other hand, the PHC program of the MoH of Guyana

[2] Interviews carried out during the technical field visit to health workers of the Regional Health Services Department in Georgetown, Guyana, in March 2014, and to health workers of the Regional Health Services Foundation, Suriname, from February to March 2014.

defines guidelines to priority services and monitors the quality and results of PHC services. The tasks include the development of policies and programs in the area of maternal and child care, nutrition, oral and rehabilitation services. It also includes monitoring service provision, assessing nutritional needs and status, monitoring environmental conditions and the impact on the health status of the population.

In Suriname, the PHC renewal strategic plan aims to fill the gap in PHC national leadership and to establish a unit at the level of the MoH for the supervision of the implementing agencies (Regional Health Services Foundation and Medische Zending) and to harmonize PHC between these two agencies (Suriname, Ministry of Health, 2014). The Regional Health Services Foundation and the MZ have developed their own strategic plan and are implementing strategies to strengthen a more comprehensive PHC approach (Regional Health Service Foundation Suriname, 2013; Medische Zending PHC Suriname Foundation, 2010).

PHC SERVICE PROVISION

In both countries, PHC services are viewed as a comprehensive set that includes the range of preventative, health promotion, curative and rehabilitation services. The services offered prioritize mother and child care services and the treatment of common illnesses, but they also aim to address a broad range of complaints presented by users, including chronic conditions. In addition, in both countries, there are population-based services provided that include health education to groups and screening campaigns for the early detection of illnesses in high-risk populations. In Guyana, PHC facilities also play a role in environmental health and environmental health assistants are part of the PHC team. In Suriname, environmental health assistants are not integrated into PHC teams. Environmental health is primarily addressed by the Bureau of Public Health of the Ministry of Health, which is the national public health authority, but there is coordination with PHC organizations, especially in the interior of the country.

Guyana has a well-defined Package of Publicly Guaranteed Health Services, which describes in detail the services provided at all levels of care (Guyana, Ministry of Health, 2010). The Package is a broad range of personal and collective services. It is used as a guiding instrument to move forward with the improvement of the access to health. It is considered the standard of services that the government wants to provide to the population. Currently, not all services defined are delivered in all facilities. The most important barrier is the inability to achieve the necessary staff for the delivery of these services. For example, an environmental health assistant is defined by the Package as a member of the PHC team in order to provide the community with environmental health services. Nonetheless, due to the lack of staff, this professional might be needed to cover the area of many health centers and, therefore, service delivery will be limited[3].

The Package of Publicly Guaranteed Health Services defines not only the services, but also the needs of personnel, essential equipment and supplies for each level of care. The range of

[3] Information from interviews carried out with health workers of Region 10 in Linden, Guyana, during a technical field visit in March

services is comprehensive: it includes care for acute and chronic conditions of levels 1 and 2 and is extended to community level preventive services, rehabilitation and oral health services, as well as specific programs for population groups such as adolescents, under-five, women and the elderly (Guyana, Ministry of Health, 2010).

In Suriname, the package of services is not formally defined. The services provided by the Regional Health Services (RHS) and by the Medische Zending are quite similar, but not completely the same. Whereas the entire population can benefit from a restricted set of preventative PHC services, regardless of their insurance or coverage scheme, at the PHC facilities of the RHS and MZ, this is not so for the entire range of PHC services provided. In the interior, the entire population is covered free of charge by the MZ based on their place of residence (15% of the total population in the country). In the coastal area, the RHS cover only those below or near the poverty line with all services free of charge. These are the ones with a health card from the ministry of Social Affairs (24% of the population). Those enrolled in the State Health Foundation (21%) or private health insurances receive their general health services at private or public facilities from physicians with whom they have registered (Suriname, Ministry of Health, 2011). However, the RHS offer maternal and child health services at their facilities to all, including those who are not cardholders or not registered in their patient database. There is a small contribution for registration in under-five and perinatal clinics within PHC facilities of the RHS.

At the PHC level, both countries refer patients who are in need for secondary and tertiary care to hospitals. In Guyana, referral to all levels in the public system is free of charge. In Suriname, this happens only for residents of the traditional villages in the interior. In the coastal area of Suriname, those who have a medical card in the social security system and those covered by the State Health Foundation or by a private health insurance scheme do not have to pay for referrals. Those not covered (approximately 20% of the population) by any of these schemes must pay some fees. However, for a number of health conditions of public health importance, individuals in Suriname may present themselves at specialist care centers without a referral letter and free of charge. These include services for leprosy, sexually transmissible infections (including HIV testing) and programs on tuberculosis and malaria of the Bureau of Public Health. In addition, antiretroviral therapy and specific lab tests for HIV (CD4 cell count) are publicly funded and provided free to all patients living with HIV whether or not covered by an insurance plan.

Inequity in the access to services in both countries is, to a great extent, related to residency in some geographic areas that present social and economic disparities, as the interior population, which is in the most disadvantaged position.

Chart 3 summarizes PHC service provision in Guyana and Suriname by geographic area: coast and interior. In general, reproductive and child health services, programs prioritized by the ministries of health, show the least differences between coastal and interior regions in terms of availability of the services at PHC facilities. However, the availability of technologies such as ultrasound shows a prominent difference between coastal and interior regions in the area of reproductive health. Furthermore, for interior and rural coastal populations, many other factors limit the access to and utilization of these services. Distance and lack of transportation are the

predominant barriers. On the other side, active outreach to remote communities in recent years has reduced the previously wide gap in vaccination coverage between interior and coastal regions in Guyana (Woolford, 2012).

In the area of health education and health promotion services, the interior population may have an advantage on the urban population, since these services and community-based activities are an important component of service provision and are less prominent in urban areas. In Guyana, the data of the Demographic Health Survey (DHS) 2009 suggest that seeking health care for common childhood illnesses (acute respiratory illnesses, fever and diarrhea) is higher among the interior population than it is in the coastal population. In the interior, for example, treatment for diarrhea among children under five years old is sought in 80% of the cases. The findings of the survey suggest that in coastal areas the search for health care treatment is 25% lower (Guyana, Ministry of Health, 2009). Although the DHS numbers on recent childhood illnesses were too small for definite conclusions, it might be a suggestion that the interior population is better informed about how to manage common childhood illnesses and/or that the numerous health posts with CHWs in the communities have a high acceptance level among the populations.

The largest disparity between coastal and interior populations lies in the availability of diagnosis and treatment of illnesses that require urgent attention (acute emergencies) or are more complex (chronic conditions) and require high skilled professionals or advanced health technologies. In the interior, the access to health care by physicians is often made through periodic visits and doctors are not constantly available as in coastal regions. Moreover, lab and imaging diagnostic technologies are absent or limited in the interior and in some rural coastal communities. In both countries, health officials in charge of health services for the interior report that delay of timely diagnosis, including early detection of high-risk pregnancies, results in high costs of emergency transport from the interior to urban hospitals and in poor health outcomes due to the lack of early interventions[4].

Chart 3 - PHC service provision in Guyana and Suriname by geographic area

Services	Guyana		Suriname	
	Coastal population	Interior population	Coastal population	Interior population
Acute and chronic medical care at PHC facilities	Medical care by physician or Medex at most facilities, laboratory tests at selected sites, local provision of medicines, referral to regional or tertiary hospital with the option of ambulance transport from regional hospital	Syndromic diagnosis and treatment of common illnesses by CHW at health posts, medical exam by Medex at selected health centers or by medical visit and treatment of chronic conditions, simple laboratory tests, emergency evacuation by ambulance or airplane	Medical care by physician at all sites, laboratory tests at selected sites or referral to private laboratories, diagnosis, provision of medicines on site or prescriptions at public or private pharmacies, ambulance services for emergencies in rural districts and selected health centers in urban areas	Limited medical care by health assistants, syndromic diagnosis and treatment of common illnesses, medical care by physician at selected centers or by medical visit, simple laboratory tests, "flying lab" at selected sites, emergency evacuation by ambulance or airplane

[4] Information from interviews with the Medex manager of the Regional Health Services Department during a technical field visit in Georgetown, Guyana, and to workers of the Medische Zending in Paramaribo, Suriname, from February to May 2014.

Chart 3 - PHC service provision in Guyana and Suriname by geographic area (cont.)

Services	Guyana		Suriname	
	Coastal population	Interior population	Coastal population	Interior population
Reproductive and sexual health care	Family planning and contraceptives, prevention of mother-to-child HV transmission, pre and postnatal care, deliveries at health centers and selected health posts, periodic missions for cervical cancer screening, evacuation by ambulance/airplane to hospital for emergency obstetric care		Family planning and contraceptives, prevention of mother-to-child HIV transmission, pre and postnatal care, deliveries at all facilities in the interior and at selected centers in the coastal area, periodic missions for cervical cancer screening, evacuation by ambulance/ airplane to capital for emergency obstetric care	
Under-five and EPI	Growth and development monitoring, vaccination on site and, by extension, to remote communities, education for breastfeeding and nutrition		Growth and development monitoring, vaccination on site, education for breastfeeding and nutrition	
Oral health care	Youth dental care units at selected facilities	Oral health education and periodic dental care missions	Youth dental care units at selected RHS sites	Periodic dental care missions at PHC facilities
Ophthalmologic care	Referral to secondary level and to specialized hospitals	Missions for the screening of eye diseases and referrals	Referral to the secondary level of care	Periodic missions of ophthalmologists and referrals, if necessary
Health promotion and education (HP/HE)	Patient education and more extensive community-based HE/HP activities in the interior through CHW and Medex		Patient education and community-based HE/HP activities with the involvement of community-based organizations	
Environmental health	Community-based activities through environmental health assistants in PHC teams		Limited, there is not an environmental health staff in PHC teams (vertical approach through the Bureau of Public Health)	
Essential medicines	Provision of a limited set of medicines at health facilities	Provision on site: limited set of medicines at health posts	Provision at local pharmacies, at RHS or at private pharmacies	Provision of a limited set of medicines, or sent from Paramaribo to chronic patients
Palliative care and home care	CHW home visits, rehabilitation assistants, for postnatal care, the elderly, terminal patients and those with disabilities		Limited, mostly home visits for postnatal care, the elderly and terminal patients	
School health	Periodic visits to schools		Periodic visits to primary schools for the early detection of conditions	
HIV care	Rapid test at selected sites, screening/staging, treatment at most PHC facilities	Rapid tests, staging requires travel to the next level of care, follow-up treatment at most sites	Rapid test at selected sites, screening/staging, treatment at most PHC facilities	Rapid tests at all sites, staging requires travel to the capital, follow-up treatment at most sites
Referrals to specialized care	Referrals according to the levels of care to specialists, hospitals, imaging centers, advanced laboratories, rehabilitation, rarely to a dietician or psychologist	Referrals to specialists, hospitals, imaging centers, advanced laboratories, rehabilitation (requires extensive travel to the capital)	Referrals to specialists, hospitals, imaging centers, advanced laboratories, psychologist, physiotherapy, dietician, optometrist	Referrals to specialists, hospitals, imaging centers, advanced laboratories (requires extensive travel to capital), rarely to paramedical specialists

Sources: Guyana, Ministry of Health, 2010; Stichting Regionale Gezondheidsdienst, 2014b; Stichiting Medische Zending PHC Suriname, 2014b; Interviews of the author with managers of the Medische Zending and Regional Health Services in Paramaribo, Suriname in May 2014.

a) Blood samples collected on site by laboratory assistants and transported to Paramaribo for analysis.

b) Dental care to adults only by private dentists with out-of-pocket payment or private insurance

COORDINATION OF CARE AND INTEGRATION OF PHC INTO THE SERVICE NETWORK

Guyana's service delivery system is organized into five levels of care. Levels one to four form a service network in the administrative regions. There are ten networks corresponding to the ten administrative regions of the country. Level 5 health care has facilities of national level (the Georgetown Public Hospital and the Psychiatric Hospital) and serves as a nation-wide reference, offering tertiary and secondary care. Comprehensive PHC services are offered at care levels 1 and 2, with the highest number of facilities. The roles of these levels are, firstly, to offer the majority of health care services from the health care service package and secondly, to facilitate referrals to higher levels of care whenever necessary.

The system prescribes that referrals should go from one level to the next level and that counter-referral should take place accompanied by the necessary information on diagnosis and treatment. However, in rural coastal areas, for example, a lower level often bypasses the next level and refers directly to the regional hospital in emergency cases[5].

In addition, patients frequently decide to bypass lower levels facilities to seek care at the regional hospitals or at the national hospital that, according to their perception, could provide a higher quality of care. Bypassing occurs mostly in the populated urban areas, where additional costs of travel are minimal and it occurs less in the rural areas where travel costs to reach a higher level of care are substantial. This bypassing results in inefficiency, since clinics at hospitals are overcrowded, whereas community PHC facilities are sometimes underutilized (Shamdeo, 2011).

On a daily basis, every patient seeking care at any facility in the public system in Guyana will be admitted and receive the necessary care.

Since most of indigenous villages are small, isolated and in geographically challenging environments, the Ministry of Amerindian Affairs plays a vital facilitating role in the referral of individuals from the remote villages to Georgetown. Through the department of Health and Welfare, this ministry coordinates with the Ministry of Health, provides housing in Georgetown (Amerindian hostel) for patients and organizes return transportation to villages after patients received in and outpatient health care from a specialist at the Georgetown Public Hospital (Guyana, Ministry of Amerindian Affairs, 2014).

Suriname does not have geographically defined service networks that formally integrate higher levels of care with PHC. The connection between first level and higher levels of care is made through the referral of individual patients and it does not include a routine structured communication or coordination mechanism. Both PHC delivery organizations (the Regional Health Services - RHS and the Medische Zending) have geographic networks within their

[5] Information from interviews carried out with health workers of Region 10 in Linden, Guyana, during a technical field visit in March 2014.

boundaries of PHC services. For the Coastal area, RHS is geographically organized into eight districts, which are subnational administrative regions. These include a number of facilities, from basic polyclinics to health centers, with some auxiliary polyclinics for isolated communities. Each district has a nurse and a medical coordinator responsible for coordination among the facilities and the staff within the district and for the maintenance of communication with the central office of the RHS (Regional Health Service Foundation Suriname, 2013).

For the interior population, the MZ has a similar internal coordination, organized into four large geographic regions, with health posts, basic polyclinics and a health center. The regions have physicians as managers and experienced health assistants as heads of the polyclinics (Medische Zending PHC Suriname Foundation, 2010).

The PHC level serves as the entry point to the health care system in Suriname and also works as a filter. Physicians at PHC facilities are the gatekeepers and facilitate the referrals to secondary and tertiary levels of care. Entrance into these higher levels requires a referral letter from a general physician.

All individuals covered in the system of the RHS, Medische Zending, State Health Fund and private health insurances have access to medicines from the national list of essential medicines (or the list of the private insurance company) through a prescription from the general physician. For laboratory services, imaging diagnostics (with limitations and/or co-payment for computed tomography scans and magnetic resonance imaging) and hospital care, it is necessary to have the referral of a physician from the health facility where he/she was registered.

Similarly to Guyana, the bypassing of PHC facilities occurs frequently and, in the case of Suriname, where district hospitals are limited, the bypassing is primarily to the emergency room of the Academic Hospital in the capital, which has reported an increasing overload of cases that should be addressed at the PHC level (Bearingpoint Caribbean, 2012).

There are many complaints on the referral and counter-referral systems from both sides. Medical specialists complain that the PHC level does not always provide sufficient historical information on the health condition of referred patients and PHC physicians complain about the consistent lack of counter-referral, as identified by the analysis carried out during the PHC planning meeting in 2012, with the participation of the main actors (Suriname, Ministry of Health, 2012).

The high level of segmentation of the health system in Suriname results in a complex environment for service delivery and in disparities in the access to care, which represents a huge challenge to the coordination of PHC. Each subsystem has its own amendments to the essential medicines list, its own referral forms and organization of the services and there are disparities in patient choices for admission to hospitals (public or private).

In both countries, the population of the interior has not much choice other than PHC facilities, due to the high costs of transportation and time involved.

Waiting periods for appointments of specialized health care are not extensive in Suriname and Guyana. However, the overcrowding of hospital outpatient care is a major concern to both

countries and each country has taken initiatives to improve the acceptability of PHC services as well as to improve the access to specialist care where there are gaps.

Over the past few years, Guyana has taken at least three main initiatives to improve the access to specialist care and to reduce the load of referrals to the Georgetown Public Hospital, which serves as the tertiary referral hospital but, at the same time, offers secondary care to the population of region 4, since this region does not have a regional hospital. The following measures have been taken by Guyana:

Expanding the outreach to remote populations in the interior: the Regional Health Services department organizes mobile teams for the provision of services. Although the visits to remote areas with skilled staff had already been incorporated into the system, visiting teams have started to offer specialist care, often in coordination with the Georgetown Public Hospital. The first objective is to improve the access to specialized care by bringing the specialist to a group of patients, instead of having patients traveling one by one to reach secondary and tertiary care. The second objective is to reduce the number of emergency evacuation of patients, which often involves high-cost air transportation. Emergency evacuation is often the result of the lack of timely diagnosis and beginning of the necessary treatment[6].

Opening of diagnostic and treatment centers in the coastal area: through the strengthening of the collaboration between Cuba and Guyana in 2006, four diagnostic and treatment centers have been inaugurated. These centers are located in densely populated rural and semi-urban areas along the coast. They have modern diagnostic equipment (imaging, laboratory and electrocardiogram), and an operating room, with which they achieve the capacity to respond to emergencies and to perform simple surgeries. The centers have counted with physicians and technicians from Cuba since the beginning, and, after some time, they have been replaced by Cuban trained Guyanese physicians and technicians. Since these centers are well equipped and staffed, they serve as referral to nearby PHC centers and they reduce the referral load to the Georgetown Public Hospital. They are considered as level 4 facilities, providing services comparable to a Regional Hospital.

Strengthening of the public-private collaboration: Guyana, as a lower middle-income country, has limitations in the provision of high technology tertiary care through the public system. Specific tertiary health care services beyond the capacity of the Georgetown Public Hospital can be obtained from the private sector through public-private collaboration programs, as the example of renal dialysis.

Suriname has also adopted similar initiatives to improve access to health care:

Expanding opening hours of selected PHC health centers: the RHS started to extend hours until nighttime in two of the larger health centers, located in urban and semi-urban neighborhoods. Physicians, pharmacy and laboratory services, as well as ambulance services for emergency transportations are available to the entire population from early morning to 11 pm,

6 Information from the interview with the Director of the Regional Health Services in Georgetown, which took place during the field visit for the Project, in March 2014.

seven days a week. These centers are also equipped to provide care for minor accidents and are able to offer transportation to the hospital whenever necessary. The objectives are to respond better to patients' needs and to reduce unnecessary visits to the emergency room of the academic hospital.

Organization of missions to the interior with medical specialists: the Medische Zending, in collaboration with specialists from hospitals and different health institutions, organizes periodic missions to address the barrier of individual transportation of patients from remote communities to the capital. Recently, these missions have included eye, dermatology and pediatric care. The advantage is having a specialist traveling to see a number of patients who need medical care, with no need for them to travel[7].

Telemedicine: the Medische Zending is also developing a pilot project for the use of telemedicine in an area of the interior, in order to improve the access to specialist care. Health assistants in the field share information of patients with physicians at the coordinating center and with specialists at the referral hospital in the capital city. This reduces unnecessary trips of patients to visit a specialist in Paramaribo and improves diagnosis and subsequent treatment at the local level (Stichting Medische Zending PHC Suriname, 2014c).

PHC WORKFORCE

In the geographic areas of Guyana and Suriname's coast and interior, there are differences in the availability of PHC professionals. There is a concentration of professionals in urban coastal areas and different categories of health care workers practicing in different areas of both countries.

Historically, in Guyana, PHC has been developed through particular human resources strategies, with the expansion of the outreach to extremely remote populations along riversides and in the interior. The national human resources standards in Guyana establish that the PHC team at the health center level should include: a physician and a Medex or health visitor[8], a Dentex or dental assistant, a pharmacy assistant, an environmental health assistant (part-time/visiting), a nursing assistant, nurse/midwife or rural midwife, a lab assistant or multipurpose technician and an administrative assistant (Guyana, Ministry of Health, 2010).

In more remote villages, the team is usually incomplete and, therefore, the Medex with her/his broad range of multipurpose skills is the most appropriate health care worker to be placed in remote areas. The development of the category of Medex, together with the introduction of community health workers (CHW), has been a key human resources strategy in the expansion of the access to Primary Health Care services for remote populations.

The Medex is a midlevel health care worker, considered to be the backbone of the health system in remote areas. The Medex program started in 1977 and the Medex Act was approved in 1978, with the regulation of the practices of this innovative professional category of health care

[7] Information from the interview with the director of the Medische Zending in Paramaribo, during the field visit for the project, in the first semester of 2014.

[8] The health visitor is a nurse trained in public health.

workers (Government of Guyana, 1978). The original 18-month training program recruited trainees from the nursing pool. The Ministry of Health introduced a new Medex pathway at the 30-year celebration of the program (Guyana, Ministry of Health and PAHO/WHO, 2007). In this second stage, trainees are recruited among secondary school graduates to follow a 42-month training program.

The advantage of this new pathway is that trainees may be recruited from a wider group and the nursing group will not be depleted as before. An additional advantage is that it facilitates the direct recruitment of trainees from the interior. This was more difficult in the original program, since most of the individuals with a nursing diploma came from the coastal belt and not from remote areas (Ramsaran, 2007).

Medex - CHW Primary Health Care in Guyana

Guyana has been the cradle of the Medex program, together with Micronesia, Thailand, Lesotho and Pakistan. These countries have carried out field trials of the Medex program in the late 1970s and early '80s and followed by other countries, which resulted in the implementation of Medex in 22 developing countries all over the world.

The program has offered Guyana a significant human resource for PHC and exceptional approaches to PHC for more than 35 years. The Medex and the CHW form, together, a unified system for remote populations with a strong community development focus beyond medical care.

Medex are trained in: health center management, community health needs and actions on social determinants, training and supervision of CHW, medicine supply and in basic general medical skills.

Medex are PHC workers with tasks of service provision, health management and of training and supervising CHW.

CHW are trained for a period of six months, with a strong focus on prevention and health promotion and first aid.

As they belong to the community, as well as to the formal health system, CHW form a bridge between the service and the community. Since the beginning of the program, their skills have been adapted and expanded to emerging needs. Some CHW were able to move up in the career ladder from nurse assistant or rural midwives to registered nurses and Medex.

The Medex have high prestige in the interior. Among all categories of health care workers, they have the longest average years of service in the public system in the country. In isolated indigenous villages, they serve as the interface between the village and the national system and the external 'world'.

The development of the Medex program was coordinated and guided by the Health Manpower Development Staff, John A. Burns School of Medicine of the University of Hawaii.

Sources: University of Hawaii, 1983; Goede, 2006; Guyana, Ministry of Health and PAHO/WHO, 2007a.

Almost simultaneously to the introduction of Medex as mid-level health care workers, Guyana introduced the community health worker (CHW) program. Initially, the CHW was a volunteer selected by his/her own remote population, shortly trained by the Ministry of Health and working from his/her own home with remuneration in kind by the community. The program evolved with time and CHW are currently fully integrated into the formal health system as lower level health care workers. CHW are now trained in a six-month program, are all working from a health post, are recognized as a position in the Public Service system and are integrated into the

public salary scale. After some time, the training program has been adapted to the needs and realities of the isolated populations and now its emphasis is on including midwifery skills in the CHW training.

Most of the health posts are staffed with a single community health worker. CHW are supervised by a Medex, nurse/midwife or by a physician who periodically visits the health posts. Guyana applies the strategy of employing shortly trained PHC workers in several areas of health care.

In all health worker positions, there are different levels of competences and categories of shortly trained PHC workers are introduced into the system as a measure to address the extreme shortage of professional health care workers in the public system. Hence, CHW and Medex are central in the provision of PHC services in Guyana.

In Suriname, the conventional PHC team is formed by a doctor/nurse or nurse assistant, sometimes with a nurse/midwife, a pharmacy assistant and a lab assistant at centers that have laboratories. On the other hand, "Health Assistants" are midlevel health care workers that are the backbone of service delivery to the population of the many, but sparsely populated villages in the interior, where teams are not complete. Health Assistants are mainly recruited from the population of the interior and are trained in a comprehensive four-year program, commissioned by the Medische Zending and recognized by the Ministry of Health (Medische Zending PHC Suriname, 2003).

All levels of facilities, from health posts to health centers in the interior, are staffed with one or more health assistants. Medical doctors are only found at a few health centers. The remaining health centers and polyclinics are periodically visited and supervised by medical doctors at a fixed schedule.

Midlevel health care workers for the villages in the Amazon rainforest in Suriname

Midlevel health care workers, who are considered the pillars of PHC in the villages of the interior of Suriname, are called "health assistants". They are frequently recruited from the population of the interior, although, in recent times, they also come from the coastal belt and often from the indigenous or maroon populations, with family ties in the interior.

They are trained in a four-year program that prepares students to perform a wide range of functions that are normally performed by nurses, midwives and physicians.

Physicians supervise their work either directly at the clinic or indirectly from a nearby health center or from the coordination center in Paramaribo.

The coordination center in the capital has daily radio contact for the daily schedule of visits with all health facilities staffed with health assistants. With the introduction of modern telecommunication technology in the interior, radio communication is gradually being replaced and, more recently, cell phones have started to be used.

Contracts, recognition and incentives

In Guyana, workers of the public system are paid a fixed salary as public workers, according to the salary scale scheme of the Public Service Ministry for all civil servants. The retirement age for civil workers is 55 years old.

PHC workers are generally hired by region, through the Regional Democratic Council (RDC). However, the majority of regional health officers who supervise PHC services are hired by the Ministry of Health. Therefore, human resources at the regional level are a shared responsibility of the Ministry of Health and the RDC and are all part of the Public Service Ministry system.

There is no national incentive system for retention or for the performance of health care workers. Housing is provided as an incentive to those working in rural areas. On the other hand, the regions provide incentives to residents of their area for enrolling in nursing training programs by providing a monthly remuneration, which covers admission costs and accommodation for those who are enrolled in schools outside their area of residence. Sponsorship for students is also provided by the Georgetown Public Hospital and the private Mercy Hospital, who have their own nursing training programs. There are several annual prizes for the recognition of outstanding professionals.

Emigration of health professionals is an additional difficulty in Guyana. A study of the PAHO identifies, as key underlying factors to the emigration of health workers, specifically nurses, the lack of consideration with their welfare by authorities, the lack of involvement in the decision-making process and of professional recognition, limited career options in the nursing profession and low salaries (PAHO, 2011).

In Suriname, there is no uniform system for hiring professionals. Contracting and payment differs according to the subsystem. The RHS contract staff and staff is paid a fixed monthly salary. Physicians are paid a flat rate and may increment their payment according to the number of patients from health insurances registered with them. Therefore, salaries of RHS physicians are not the same for all and some facilities are more attractive for physicians than others, due to the higher number of health-insured individuals registered at the health facilities.

The Medische Zending hires staff and pays a fixed monthly salary. Recently, a performance assessment system has been introduced with incentives linked to performance (Human Resources Unit, Medische Zending PHC Suriname Foudation, 2011).

Availability of professionals for PHC

Guyana has an absolute shortage in all categories of health care workers. Additional challenges are the maldistribution of health human resources, which results in a disparity between urban and rural areas and in the relatively high proportion of shortly trained workers for health services at different levels of care, especially in the nursing profession (Guyana, Ministry of Health y PAHO, 2007).

The Ministry of Health has staff standards for all levels of care. The only category of health care worker in the public service without a noteworthy shortage is the CHW. There are few vacant positions for CHW in some regions.

Most of the CHW and Medex are employed in PHC. Table 4 shows that CHW are mainly employed in rural and interior communities.

Table 4 – Community Health workers (CHW) and Medex in direct service provision (levels 1-3) by region in Guyana, 2013

Geographic area	CHW	Medex [a]	Population
R 1	54	7	26,941
R 2	35	6	46,810
R 3	34	9	107,416
R 4	19	14	313,429
R 5	12	6	49,723
R 6	15	5	109,431
R 7	31	6	20,280
R 8	27	3	10,190
R 9	54	3	24,212
R 10	33	11	39,452

Table 4 – Community Health workers (CHW) and Medex in direct service provision (levels 1-3) by region in Guyana, 2013 (cont.)

Geographic area	CHW	Medex [a]	Population
Total urban coast	8	17	191,810
Total rural coast	140	34	535,193
Total remote areas	166	19	81,623
Total	314	70	747,884

Source: Adapted from Guyana, Ministry of Health, Department of Regional Health Services, 2013.
a) Ten additional Medex are registers in region 4, in different institutions: the central office of the MoH, the Georgetown Public Hospital, the Palms residence home for the elderly, the prison, the malaria program and in Port Health sites. The national Psychiatric Hospital located in region 6 has a Medex.

Table 5 shows the availability of human resources for PHC by geographic region in Suriname. It is possible to observe a geographic asymmetry in the availability of professionals between the coast and the interior. The density of general practitioners in the coast is 0.54 per 1000 inhabitants and 0.13 per 1000 inhabitants in interior communities.

Table 5 – Availability of human resource for PHC by geographic region in Suriname

	Total/national population 541,638		Coastal population 470,142		Interior population 71,49	
	n.	ratio/1000 people	n.	ratio/1000 people	n.	ratio/1000 people
Registered nurses	895	1.65[a]	-	-	2	0.03
Health assistants	110	0.20	0	0	110	1.54
Polyclinic assistants	24	4.00	0	0	24	0.34
Midwives	53	0.10	53	0.11	0	0
General practitioners	255	0.47	254	0.54	9	0.13

Source: Author calculation of ratios, based on national data from the Department of Planning of the Ministry of Health from 2010.
a) 74% of registered nurses work at hospitals, according to what was reported by the Department of Planning, MoH Suriname.
b) This includes those in administrative and management positions.

The Department of Planning of the Ministry of Health in Suriname reports a remarkable disparity in the coastal area, between the urban coast (greater Paramaribo) and rural coastal areas. The estimated density of general practitioners in greater Paramaribo is 1.1 per 1000 inhabitants and 0.3 per 1000 inhabitants in rural coastal communities. Although general physicians in the capital Paramaribo are also in administrative positions, in public health programs, and not only in direct service provision at the PHC level, the difference to rural areas remains huge.

Guyana is a country with high emigration of individuals with higher education. Therefore, emigration is an important factor in the loss of skilled workers, which impacts on the lack of health workforce, especially concerning the attrition of nursing professionals. In order to address the shortage of these professionals, the intake of nurses in pre-service education programs has been

more than doubled. However, the training capacity is limited and therefore the output of trained nurses is not as high as expected.

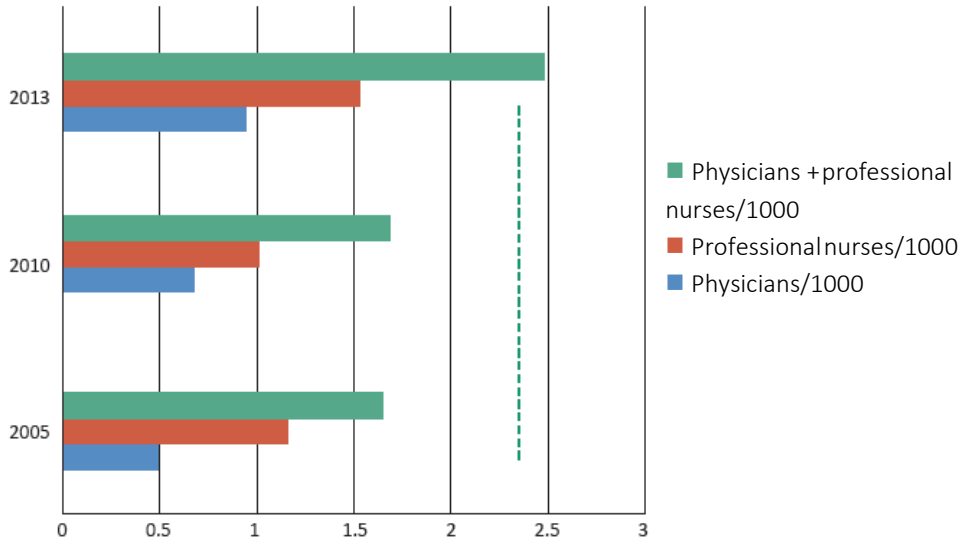
In 2006, the presidents of Guyana and Cuba signed an agreement for the strengthening of health care in Guyana. Subsequently, a large group of 500 Guyanese students were accepted in the Latin American School of Medicine in Cuba. This is a significant number, considering the total population of less than one million people in Guyana. The agreement also included the establishment of four diagnostic and treatment centers in coastal rural areas with Cuban physicians and technical staff, who would be gradually replaced, as the Guyanese students graduated and returned to the country. The centers serve as referral to PHC services. Guyanese physicians trained in Cuba are contracted to work five years in the public sector, especially in underserved areas. Professionals of other disciplines, also trained in Cuba, should serve for 2 to 3 years[9].

Due to the high number of Guyanese students enrolled in the Latin American School of Medicine in Cuba, the shortage of physicians has been steadily reduced over the past few years. According to the WHO, the absolute minimum threshold of heath professional is of 2.3 per each 1000 inhabitants, so that it is possible to provide the delivery of essential services. This rule arises from the global analysis of the Joint Learning Initiative on Human Resources (2004). Only recently, Guyana achieved this minimum requirement for service provision (Picture 1), due to the return of Guyanese physicians trained in Cuba. However, it is important to note that, in earlier periods, Guyana has intervened in the shortage of health care workers with the assignment of tasks to shortly trained health care assistants.

The availability of midwives in Guyana has changed. Although the complete update of the distribution across the levels is not yet available, in 2008, 33% of the 491 midwives (registered nurse/midwives and rural single trained midwives) were working in PHC (Gordon, 2009). The vast majority works in hospitals and a small proportion is teaching or working in the administration.

[9] Information from interviews with health workers carried out during field visits to Georgetown, Guyana, in March 2014

Picture 1 – Ratio of physicians and nurses per 1000 inhabitants in Guyana



Source: Adapted from Guyana, Ministry of Finance, 2013.

Picture 2 shows the total national density of physicians and nurses in both countries, in which it is possible to notice the abovementioned improvements in Guyana, even though Suriname remains with the highest indicators.

Picture 2 – Density of physicians and nurses in Guyana (2008) and Suriname (2011)

Source: PAHO, 2014.

SOCIAL PARTICIPATION IN PHC

Social participation of health actors and communities is a legal obligation enshrined

in the constitution of Guyana. Local government authorities must regularly hold local meetings to involve communities in the assessment of needs and in the decision-making process for the development of health and service delivery. Neighborhood Councils and Village Councils provide official structures for the social participation of citizens (Government of Guyana, 1998). For example, the Regional Health Authority of region 6 has established Health Management Committees. These committees facilitate the interaction between health professionals and representatives of the communities and health facilities. Community events are organized at health centers and a system of complaints for patients and for the community is in development (Usaid, 2011).

Guyana has only a few patient associations, but a larger number of NGOs work actively in the area of HIV with the support of external funding for activities on prevention and care. More intense community participation in health is observed specifically in disease-related activities, with focus on HIV (Usaid, 2011).

The exception is the Community Based Rehabilitation (CBR) NGO. This organization is active in several communities and has been able to involve community actors in the area of disabilities, as well as to empower people with disabilities and their families. A review of the CBR program in 22 countries showed that Guyana is among the outstanding countries, for generating positive results at the individual, family and community levels (Sharma, 2007).

Although it may focus on a specific health problem, CBR is well integrated in PHC through connections with and support from the rehabilitation assistants of the PHC teams of health centers in rural and interior sites[10]. Besides belonging to the framework of the Regional Democratic Council, PHC also operates within the context of the Amerindian Affairs.

In Suriname, a previous study (until mid-2013) showed that the importance of social participation in PHC documents is continuously acknowledged in national plans and papers. However, after the initial period following Alma Ata (until mid-eighties), national documents hardly mentioned these components and, in some instances, social participation was even narrowed down to the participation in the implementation of specific programs. This contrasts with the national health plan 1982-1984, in which social participation was described as an integral part of the PHC strategy in all phases, from planning to implementation (Goede et al., 2014).

Although social participation (as well as intersectoral collaboration) is a recurrent subject in most of national plans and policies in Suriname, the gap between policies and practice lies in the lack of formal structures and systems for social participation. Even though several initiatives to establish local health councils for participation and collaboration in health have been taken, these were informal, and were not established as a formal structure within the local health system (Suriname, Ministry of Health, 2012). Therefore, they were not sustainable over time.

Despite the absence of formal structures for social participation at the local level, there are several significant experiences of participation and collaboration between PHC services, on one

10 Information from interviews with rehabilitation staff during the field visit to Linden, Guyana, in March 2014.

side, and workers from non-health sectors, community structures and community members on the other[11]. Unfortunately, these experiences are not documented.

INTERCULTURALITY IN PHC

Interculturality in health, in Guyana, is mostly linked to indigenous populations. The Ministry of Amerindian Affairs has several mechanisms and structures to protect indigenous cultures and to involve the population of the villages in the interior in development areas.

The Amerindian Act was approved in 2006 and established a National Council of Toshoas. The 200 Amerindian villages have a Toshoa, who is the chosen chief of the village. The Amerindian Act establishes the consultation to all indigenous villages in national decision-making processes that might influence the situation and the life of indigenous peoples. It also regulates the functions and responsibilities of Toshoas and counselors who are part of the governance structure of the villages. The focus is primarily on land rights, but it also includes the protection of the indigenous culture and heritage, the promotion of the use of indigenous languages and the development of strategies to reduce poverty and improve the access to education and health services (Government of Guyana, 2006).

In Suriname, interculturality is rarely referred to in policy documents. When there is any reference, it is to address the importance of taking cultural appropriate measures or the need for cultural sensitivity in PHC. This often includes the involvement of local organizations and, therefore, it goes hand in hand with social participation and collaboration between the local PHC system and local populations. The work developed by the Medische Zending in collaboration with Shamans in the South of the country is a promising example of interculturality.

Interculturality: collaboration with Shamans in Suriname

Kwamalasamutu and Pelele Tepu are Trio indigenous villages in the south of Surinam, where the Medische Zending (MZ) has PHC polyclinics. A collaborative work was built between PHC workers of the MZ and Shamans (indigenous traditional healers) in these villages.

With the support of the Amazon Conservation Team (ACT), a NGOS from the USA, a clinic, which is adjacent to another MZ clinic, was built for Shamans to practice traditional indigenous medicine.

The aim of the MZ was to acknowledge traditional wisdom and healing and to enhance collaboration between modern/western and traditional medicine, anticipating that this collaboration would positively affect the healing process of the population. With this purpose, several training workshops have been organized to raise awareness about traditional health practices among PHC workers and awareness among Shamans about the PHC services.

A major obstacle faced was the rejection of indigenous healing by health assistants of the MZ. Although these health care workers were also from indigenous peoples, their concepts about indigenous culture and medicine were negatively influenced by foreigner Christian leaders, especially through the local Christian school, in which they had studied in their youth. However, through participations in workshops, it was posible to achieve respect and acceptance.

As a result, referrals are routinely made to each system and a there is a high level of coordination, which generated mutual respect and the change of practices among both group of health workers.

[11] Information from field observation and interviews with workers from the regional services and from the Medische Zending during the technical visit to the cities of Paramaribo, Marowijne, Brokopondo, Sipaliwini in Suriname in 2013- 2014.

The outcome was the increased trust in health care within the communities and the preservation of the cultural identity. After the positive result, an additional facility will be added, now with healers in a Maroon village.

Sources: Mignone et al., 2007; Herndon et al., 2009; interview with the director of the Medische Zending during the technical visit in the first semester of 2014.

INTERSECTORALITY IN PHC

Intersectoral collaboration to address social determinants in Guyana is a key area in the new strategy of the Ministry of Health: Health Vision 2020 (Guyana, Ministry of Health, 2013). The decentralized structure in Guyana has the ability to link different sectors at regional and sub-regional levels. Intersectoral collaboration is facilitated through the Regional Democratic Council, which manages development and social services in the region (Government of Guyana, 1998).

In Suriname, policy documents refer to the importance of intersectoral collaboration as part of PHC (Suriname, Ministry of Health, 2014). However, Suriname does not have decentralized formal structures to coordinate intersectoral collaboration. At the local level, intersectoral collaboration is often linked to social participation. The Bureau of Public Health and the PHC organizations (Regional Health Services and the Medische Zending) are the health institutions involved in the leadership of intersectoral collaboration at district and community level. The Bureau of Public Health collaborates with other sectors based on their mandates in the area of prevention and health protection, especially concerning environmental health.

Intersectoral collaboration at the national level is increasingly taking place, since the efforts made to include health in all policies. One example is the success achieved with the broad national collaboration for the WHO Framework Convention for Tobacco Control, which created a supportive environment for intersectoral action on health in the country. Suriname was the first Caribbean country to achieve a high level of legislation on tobacco control. The national assembly unanimously approved the new law on tobacco control in 2013, after a period of intense public and political debates (United Nations Suriname, 2013).

FINAL CONSIDERATIONS

Primary Health Care in Guyana and Suriname has been developed within different contexts of overall organization of the health systems and with diverse national and local governance frameworks.

Different historical, political, social and economic development of the nations, their recent independence (Guyana in 1966 and Suriname in 1975) differences in British (Beveridge) and Dutch (Bismarck) health care models, are determining factors to explain differently shaped health systems in the two countries.

Suriname segments the population in terms of health services rights and arrangements. The country applies a social protection scheme for the poor, whereas Guyana does not segment the population, since it considers it a duty of the state to provide health services free of charge to all. The decentralization of the government in Guyana, with local governance structures responsible for health services, results in a stronger connection of PHC with general health service delivery networks. These networks are organized in line with the regional networks and the Regional Democratic Councils. As a result, hospitals and PHC facilities are part of the same service delivery network, since this is based on the administrative region.

Suriname does not have a local governance, although the preparation of this is in progress. Therefore, there is no overarching structure covering and coordinating the different levels of care. The social and economic context of the two countries is an additional difference that has an impact on PHC. Only recently, Guyana is recovering itself from its condition as Heavily Indebted Poor Country and, since poverty is a strong determinant of health, this reflects on the gap in the health status of the population, in comparison with Suriname.

Despite the significantly different contexts in which PHC operates, both countries show a number of similarities. These parallels are found primarily in overcoming the challenges of reaching the scattered indigenous populations in the interior of the country. Both countries have introduced non-conventional midlevel categories of health care workers who deliver services to the remote populations and who support these isolated health care workers from a central coordination office through a radio system, even though they have started to use more modern communication technologies (mobile phones). Both Guyana and Suriname try to address the geographic inequality in the access to specialist care with the displacement of this sort of professionals as a strategy to increase the outreach to remote villages.

On the other hand, both countries are in a process of significant transformation in their health systems, although from very different perspectives.

Guyana, with rapid increase in the availability of Cuban trained Guyanese physicians and with the establishment of modern diagnostic centers, is going through a major change that can drastically strengthen the quality of care. However, the country may need to consider the applicability and advantages that the CHW-Medex team has for PHC in remote areas, in order to determine the place of these categories of workers when the availability of physicians increases. The review of the Medex training program shows strong emphasis on the development of skills that characterize comprehensive PHC: integration of health education, health promotion and social participation and collaboration to address health determinants. Considering the underdevelopment of the interior, with many social and environmental risk factors, this integrated and comprehensive approach remains highly relevant. The Medex is also specifically trained to supervise CHW and together they form an appropriate team for remote populations.

Suriname's current transformation is linked to the introduction of a compulsory health insurance scheme for all residents, which will be introduced through private sector market mechanisms with private insurance companies. This will bring major changes for PHC and for the more than 21% of the population that is currently covered by the social security system of the

Ministry of Social Affairs. The Regional Health Services provides services to the coastal population and the Medische Zending provides services to the interior population, both focused on the integration of individual and population-based services with a community approach. They both have expressed, in separate plans, their commitment to the strengthening of the integration of health promotion and prevention, social participation and multisectoral collaboration in their health services.

The combination of personal and community-based services that these organizations provide in Suriname is part of the PHC approach, but on the contrary, private insurance companies focus exclusively on the coverage of personal services. Therefore, Suriname will need to consider the sustainability of community-based services, which are especially relevant for those with unfavorable health determinants, such as the urban and rural poor populations and the interior population living in a challenging underdeveloped environment. On the other hand, since an insurance scheme itself does not guarantee the access to quality health services, it is necessary to pay special attention to the current unequal geographic distribution of health resources within the country, in order to ensure universal access to health services.

In recent policy documents, both countries have expressed their commitment to important characteristics of comprehensive PHC, namely the strengthening of intersectoral collaboration to address the social determinants ofhealth.

Overall, the most striking parallels between Guyana and Suriname lie in the efforts made by both countries to overcome the challenges of health inequalities between interior and coastal populations.

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List of abbreviations and acronyms

ACAP	Agente Comunitario de Atención Primaria (Primary Health Care Community Worker)
AIS	Acción Intersectorial por la Salud (Intersectoral Action for Health)
Aisped	Atención Integral en Salud a Poblaciones Excluidas y Dispersas (Comprehensive Health Care for Excluded and Dispersed Populations)
ARV	Antiretroviral
ASIC	Área de Salud Integral Comunitaria (Community Comprehensive Health Area)
ASSE	Administración de Servicios de Salud del Estado (State Health Services Administration)
AUGE	Acceso Universal a Garantías Explícitas (Universal Access with Explicit Guarantees)
BPS	Banco de Previsión Social (Social Security Bank)
BSE	Banco de Seguros del Estado (State Insurance Bank)
CABA	Ciudad Autónoma de Buenos Aires (Autonomous City of Buenos Aires)
CAPS	Centros de Atención Primaria de Salud (Primary Health Care Center)
Caricom	Caribbean Community
CDL	Centros de Desarrollo Local (Local Development Center)
CDR	Consejo Democrático Regional (Democratic Regional Center)
Cecosf	Centro Comunitario de Salud Familiar (Community Family Health Center)
Censi	Centro Nacional de Salud Intercultural (Intercultural National

	Health Center)
Cesfam	Centro de Salud Familiar (Family Health Center)
CHW	Community Health Worker
CIC	Centro Integrador Comunitario (Integrated Community Center)
CLS	Consejo Local de Salud (Local Health Council)
CNCPS	Consejo Nacional de Coordinación de Políticas Sociales (National Council for Social Policy Coordination)
CNES	Cadastro Nacional de Estabelecimentos de Saúde (National Health Facilities Database)
Cofesa	Consejo Federal de Salud (Federal Health Council)
Coresa	Consejo Regional de Salud (Regional Health Council)
CRS	Comité Regional de Salud (Regional Health Committee)
CS	Centro de Salud (Health Center)
DC	Distrito Capital (Capital District)
DGAPS	Dirección General de Atención Primaria de la Salud (Department of Primary Health Care)
DGGDRH	Dirección General de Gestión y Desarrollo de Recursos Humanos (Department of Human Resources Development Management)
EAIS	Equipo de Atención Integral de Salud (Comprehensive Health Care Team)
EBAS	Equipo Básico de Salud (Basic Health Care Team)
EB-SFC	Equipo Básico de Salud Familiar y Comunitaria (Family and Community Basic Health Care Team)
Ecopetrol	Empresa Colombiana de Petróleo (Colombia's State-run Oil Company)
EDS	Encuesta Demográfica de Salud (DHS – Demographic and Health Survey)
ELAM	Escuela Latinoamericana de Medicina (Latin American School of Medicine)
EPS	Empresa Promotora de Salud (Health Promoting Company)
EqSF	Equipo de la Estrategia Salud de la Familia (Family Health Strategy Teams)
ESF	Estratégia Saúde da Família (Family Health Strategy)
EsSalud	Seguro Social de Salud (Social Security Health Insurance)

FNR	Fondo Nacional de Recursos (National resources Fund)
Fonasa	Fondo Nacional de Salud (National Health Fund)
GES	Garantías Explícitas en Salud (Explicit Health Guarantees)
GTIP	Grupo de Trabajo Interinstitucional Permanente (Permanent Interinstitutional Working Group)
HC	Hospital de Clínicas (Clinics Hospital)
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
IAES	Instituto de Altos Estudios en Salud (Institute of Public Health Advanced Studies)
IAFA	S Institución Administradora de Fondos del Aseguramiento en Salud (Health Insurance Funds Administrator)
IAMC	Institución de Asistencia Médica Colectiva (Collective Health Care Institution)
ICT	Information and Communications Technology
IDB	Inter-American Development Bank
Indec	Instituto Nacional de Estadística y Censos (National Institute of Statistics and Censuses)
INSSJP-PAMI	Instituto Nacional de Servicios Sociales para Jubilados y Pensionados – Programa de Atención Médica Integral/ Por una Argentina con Mayores Integrados (National Institute of Social Services for Retirees and Pensioners – Comprehensive Medical Care Program)
IPS	Instituto de Previsión Social (Social Security Institute)
Isags	Instituto Suramericano de Gobierno en Salud (South American Institute of Government in Health)
Isapre	Institución de Salud Previsional (Health Insurance Institution)
Junasa	Junta Nacional de Salud (National Board of Health)
MAIS	Modelo de Atención Integral de Salud (Comprehensive Health Care Model)
MAIS-BFC	Modelo de Atención Integral de Salud Basado en la Familia y la Comunidad (Comprehensive Health Care Model based on the Family and the Community)
MAIS-FCI	Modelo de Atención Integral en Salud Familiar Comunitaria e Intercultural (Family, Community and Intercultural Comprehensive Health Care Model)

Mides	Ministerio de Desarrollo Social (Ministry of Social Development)
Minsal	Ministerio de Salud (Ministry of Health)
MPPS	Ministerio del Poder Popular para la Salud (Ministry of People's Power for Health)
MS	Ministerio de Salud (Ministry of Health)
MSD	Ministerio de Salud y Deportes (Ministry of Health and Sports)
MSP	Ministerio de Salud Pública (Ministry of Public Health)
MSPBS	Ministerio de Salud Pública y Bienestar Social (Ministry of Public Health and Social Welfare)
MZ	Medische Zending (Medical Mission)
NASF	Núcleo de Apoio à Saúde da Família (Family Health Support Center)
OMS	Organización Mundial de la Salud (World Health Organization)
OS	Obra Social (Insurance Fund)
OPS	Organización Panamericana de la Salud (Pan American Health Organization)
OSP	Obra Social Provincial (Provincial Insurance Funds)
PAHO	Pan American Health Organization
PAI	Programa Ampliado de Inmunización (EPI - Expanded Programme on Immunization)
PAIS	Plan de Asistencia Integral a la Salud (Comprehensive Health Care Program)
PBF	Programa Bolsa Família (Family Grant Program)
PDVSA	Petróleos de Venezuela S.A. (Venezuela's State Oil Company)
PET Saúde	Programa de Educação pelo Trabalho para a Saúde (Educational Program for Health Work)
PHC	Primary Health Care
PIAS	Plan Integral de Atención en Salud (Comprehensive Health Care Plan)
PIB	Producto Interno Bruto (GDP – Gross Domestic Product)
PMAQ-AB	Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (National Program for the Improvement in Access and Quality of Primary Health Care)
PMC	Programa Médicos Comunitarios (Community Doctor Program)

PMO	Programa Médico Obligatorio (Obligatory Medical Program)
PNAB	Política Nacional de Atenção Básica (National Primary Health Care Policy)
POS	Plan Obligatorio de Salud (Mandatory Health Care Plan)
Profam	Programa Nacional de Formación en Salud Familiar y Comunitaria (National Educational Program in Family and Community Health)
Pro-Residência	Programa Nacional de Apoio à Formação de Médicos Especialistas em Áreas Estratégicas (National Program to Support the Training of Medical Specialists in Strategic Areas)
Pro-Saúde	Programa Nacional de Reorientação da Formação Profissional em Saúde (National Reorientation Program for Professional Health Education)
Provab	Programa de Valorização do Profissional da Atenção Básica (Program for Basic Health Professional Valorization)
PS	Puesto de Salud (Health Post)
PSF	Programa Saúde da Família (Family Health Program)
PSI	Programa de Salud Indígena (Indigenous Health Program)
RAP-M	Red de Atención Primaria Metropolitana (Metropolitan Primary Health Care Network)
RBC	Rehabilitación Basada en la Comunidad (CBR – Community-based Rehabilitation)
Rieps	Red Integrada de Efectores Públicos de Salud (Public Health Providers Integrated Network)
RM-SAFCI	Residencia Médica de Salud Familiar Comunitaria Intercultural (Medical Residency Program in Family and Community Intercultural Health)
Safci	Salud Familiar Comunitaria Intercultural (Family, Community and Intercultural Health)
SGSSS	Sistema General de Seguridad Social en Salud (General Social Security Health Care System)
SIS	Seguro Integral de Salud (Comprehensive Health Insurance)
Sispi	Sistema Indígena de Salud Propio e Intercultural (Intercultural and Traditional Indigenous Health Care System)
SNIS	Sistema Nacional Integrado de Salud (Integrated National Health System)
SNS	Seguro Nacional de Salud (National Health Insurance)

SRS	Servicio Regional de Salud (RHS – Regional Health Service)
SSPAM	Seguro de Salud para el Adulto Mayor (Health Insurance for the Elderly)
SSS	Superintendencia de Servicios de Salud (Health Services Superintendency)
SUMI	Seguro Universal Materno Infantil (Mother and Child Universal Insurance)
SUS	Sistema Único de Saúde (Unified Health System)
TAPS	Técnico en Atención Primaria de Salud (Pimary Health Care Technician)
THE	Total Expenditure on Health
UBS	Unidade Básica de Saúde (Primary Health Care Unit)
UNA	Universidad Nacional de Asunción (National University of Asuncion)
Unasur	Unión de Naciones Suramericanas (Union of South American Nations)
Unicef	United Nations Children's Fund
UPC	Unidad de Pago per Cápita (Capitation Payment Unit)
Usaid	United States Agency for International Development
USF	Unidade de Salud Familiar (Family Health Unit)
WHO	World Health Organization

Throughout the nineties, health underwent a deep commercialization process that had a negative impact on accessibility to health systems and on social justice in South America. In addition, it also aggravated their assistance-based and medical-centered character, reducing primary health care (PHC) strategies to their minimum expression.

At the beginning of the 21st century, South American countries started to carry out reform processes in their health systems that were contrary to the ones promoted by neoliberalism ten years earlier.

These reforms aim to combine universality and social justice, with the guarantee that no one will be excluded from the health system, that the quality of care is homogeneous and that funding mechanisms are guided by the principle "from each, according to his ability, to each, according to his needs". People's participation and the management of professional health services are the central axes of the operation of the health systems in construction in South America.

These reforms may generate a gravitational change of the model of care towards a strategy based on primary health care, so that it can transform policies for health promotion and prevention of diseases into the focus of health systems.

We are convinced that the primary health care strategy is key to the attainment of a system that efficiently uses its resources, with fair distribution and, above all, which contributes for the improvement of our populations, this being the most important feature of a system.

PHC experiences within the twelve member countries of Unasur are the core of this book. It also presents a transversal analysis of the model comprehended as the basis for a universal and equal health system with quality. Undoubtedly, it is highly recommended.

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UNASUR ISAGS Instituto Suramericano de Gobierno en Salud

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