Universal health coverage in Latin America 3

Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries

Luiz Odorico Monteiro de Andrade, Alberto Pellegrini Filho, Orielle Solar, Félix Rígoli, Lígia Malagon de Salazar, Pastor Castell-Florit Serrate, Kelen Gomes Ribeiro, Theadora Swift Koller, Fernanda Natasha Bravo Cruz, Rifat Atun

Many intrinsically related determinants of health and disease exist, including social and economic status, education, employment, housing, and physical and environmental exposures. These factors interact to cumulatively affect health and disease burden of individuals and populations, and to establish health inequities and disparities across and within countries. Biomedical models of health care decrease adverse consequences of disease, but are not enough to effectively improve individual and population health and advance health equity. Social determinants of health are especially important in Latin American countries, which are characterised by adverse colonial legacies, tremendous social injustice, huge socioeconomic disparities, and wide health inequities. Poverty and inequality worsened substantially in the 1980s, 1990s, and early 2000s in these countries. Many Latin American countries have introduced public policies that integrate health, social, and economic actions, and have sought to develop health systems that incorporate multisectoral interventions when introducing universal health coverage to improve health and its upstream determinants. We present case studies from four Latin American countries to show the design and implementation of health programmes underpinned by intersectoral action and social participation that have reached national scale to effectively address social determinants of health, improve health outcomes, and reduce health inequities. Investment in managerial and political capacity, strong political and managerial commitment, and state programmes, not just time-limited government actions, have been crucial in underpinning the success of these policies.

Lancet 2015; 385: 1343–51

Published Online
October 16, 2014
http://dx.doi.org/10.1016/S0140-6736(14)61494-X

This is the third in a Series of four papers about universal health coverage in Latin America

Oswaldo Cruz Foundation and School of Medicine (Prof L O Monteiro de Andrade PhD), **Federal University of Ceará** (K Gomes Ribeiro MSc), **Fortaleza, Brazil; Center for Studies, Policies, and Information on Social Determinants of Health (CEPI-DSS), Sergio Arouca National School of Public Health, Oswaldo Cruz Foundation, Rio de Janeiro, Brazil** (Prof A Pellegrini Filho PhD); **Latin American Faculty of Social Sciences (FLACSO), Chile** (Prof O Solar PhD); **Health Systems Division, Pan American Health Organization, Brasília,**

Introduction

Health and disease are established by many factors including environmental exposures, housing, education, and social and economic status.[1] Thus, improvement of population health and health equity needs intersectoral action and social participation, which have been introduced by many Latin American countries.[2]

Health is an important dimension and a sensitive tracer of sustainable development. Health represents the collective effect of social, economic, and physical life conditions. A healthy population enables increased labour productivity and economic returns to households from labour market participation, which creates opportunity for more inclusive and sustainable growth.[3]

The Declaration of Alma-Ata,[4] the Commission on Social Determinants of Health,[1] and the Rio Political Declaration on Social Determinants of Health[5] have underlined the crucial importance of policies and actions on social determinants of health in the promotion of health equity. In 2012, the United Nations General Assembly Resolution "The future we want" affirmed that "Universal Health Coverage is a key instrument to enhancing health, social cohesion and sustainable human and economic development".[6] Universal health coverage contributes to the social, economic, and environmental dimensions of sustainable development, and its pursuit should not be restricted to health care, and should include promotion of population health.[6]

Equity is inherent as a goal of universal health coverage because it implies universal access for all people to needed health services, of sufficient quality across the continuum of care without the risk of financial hardship as a result of using those services. Similarly, following

Key messages

- The broad context of health, including social determinants, democratic progress, and sustainable development, are intrinsically related. Because change in one domain affects others, integrated health, social, and economic actions are needed in the design of public policies and health systems to achieve equitable health and welfare.
- Latin American countries have substantial experience in intersectoral action of varying scope, intensity, and management approaches to improve population health outcomes. As well as time-limited government actions, investment in managerial and political capacity, strong political and managerial commitment, and state programmes have been crucial in underpinning success.
- Latin American countries have effectively used social participation with institutionalised deliberative mechanisms of participation (Brazil) and intersectoral action (Cuba), to enhance equity. However, achievements in population health and social outcomes expressed as country averages hide the unacceptably wide and persistent social and health inequities.
- The health challenges from chronic non-communicable diseases, violence, road traffic accidents, and illicit drug use can only be met in Latin America by simultaneous investments in health systems and actions to address social determinants of health. Hence, broad conception, design, and implementation of universal health coverage need to incorporate actions aimed at addressing social determinants of health if equitable health is to be achieved for present and future generations.

Brazil (F Rígoli MD)**; Foundation for the Development of Public Health (FUNDESALUD), Cali, Colombia** (Prof L Malagon de Salazar PhD)**; National School of Public Health, Havana, Cuba** (Prof P Castell-Florit Serrate PhD)**; Gender, Equity, and Human Rights Team, World Health Organization, Geneva, Switzerland** (T Swift Koller MSc)**; Centre for Advanced Multidisciplinary Studies, University of Brasília, Brasília, Brazil** (F N Bravo Cruz MSc)**; and Harvard School of Public Health, Harvard University, Boston, MA, USA** (Prof Rifat Atun FRCP)

Correspondence to: Prof Rifat Atun, Harvard School of Public Health, Harvard University, Boston, MA 02115, USA
ratun@hsph.harvard.edu

Panel 1: Domains of intersectoral actions

Domain one: scope and target

The first domain is concerned with the design of the intersectoral policy, its scope, the programme, and its target coverage—eg, whether the whole population benefits from the programme as a fundamental right or whether an entitlement is restricted to specific population groups. This distinction of general versus targeted groups is especially important in the analysis of equity in Latin America because poverty reduction does not necessarily lead to a reduction in social and health inequities in population groups. Hence, in the context of Latin America, universal health coverage and its progressive realisation needs to emphasise equity and universality; intersectoral action should strengthen health systems to expand access and address social determinants of health to improve the opportunities for the disadvantaged populations to benefit from health-system investments.[9]

Domain two: organisation of intersectoral actions

The second domain relates to methods of organisation, management, and financing of intersectoral actions, which define their success and sustainability. The analysis considers how decisions are made, the intensity of intersectoral action, how monitoring and assessment are done, and the capacity and knowledge built among stakeholders. Effective organisation of intersectoral action needs involvement at the local level. Decentralisation of decision making, which brings managerial processes closer to the local and community level (in which all sectors have sufficient power and freedom for action to jointly address problems and find solutions) improves programme success.[10] The intensity of intersectorality extends from information sharing to cooperation and coordination, and to integration of policies and strategies.

In our analysis of the organisation of intersectoral action, we focus on the role of the local level and primary health-care services, which are very important for reducing inequities in access and for progressive realisation of universal health coverage. Additionally, we explore the intensity of intersectorality, managerial mechanisms, and the approaches used to address the challenges encountered and to institutionalise actions.

Domain three: results

The third domain relates to the coverage and outcomes achieved by the intersectoral policies or programmes, in particular to the success of intersectoral action in the reduction of health and social inequities. The analysis in this domain seeks to show how intersectoral action contributes to the reduction of health inequities, and affects equitable access to services, including the health and financial consequences resulting from service use.[11]

sustainable development, the universal health coverage notion has been enlarged to cover the continuum of care, including health promotion that addresses social determinants of health.[7]

Structural inequities, which define social hierarchy in countries, also establish different health needs, resources, and capabilities to navigate health systems.[8] Health sector interventions alone are not enough to improve population health and social wellbeing. Policies and actions from economic, education, transport, housing, agriculture, and other sectors are needed to improve social determinants of health. Therefore, the health sector needs to act as a leader to catalyse intersectoral actions aimed at addressing disparities in social determinants of health, improving health, and reducing health inequities.

Social injustice, health and economic inequities, and disparities in social determinants of health have long been a distinguishing feature of Latin America (panel 1) motivating actions that have sought to address them. Therefore, the lessons from Latin American countries are especially relevant for the global agenda on universal health coverage and sustainable development. Here, with case studies in four Latin American countries, we assess the experiences in the design and implementation at national scale social programmes underpinned by intersectoral action and social participation aimed at addressing social determinants of health, improving health, and reducing health inequities. Atun and others[9] provide a detailed analysis of health systems and universal health coverage and Cotlear and others[12] address the historical antecedents of health reforms.

See Online for appendix

Social and health inequities in Latin America

Latin American countries are characterised by their colonial legacies and high and persistent socioeconomic inequalities with among the highest Gini indices (a measure of income inequality in a country) in the world. Poverty and inequality worsened substantially in the 1980s and inequality increased until the late 1990s, when the average Gini index for Latin America reached more than 58.[13] Between 1990 and 2004, income equality continued to deteriorate in many Latin America countries but improved in others (figure 1). In 2004, Latin America had the highest average income Gini index of 52·5, which was 8 points higher than Asia, 18 points higher than Eastern Europe and Central Asia, and 20 points higher than high-income countries.[14] However, from 2005, with economic growth and social policies aimed at addressing poverty and socioeconomic disparities, income equality, as shown by Gini indices, started to improve (appendix).

Between 1980 and 2010, Latin American countries achieved improvements in human development indices relative to the levels of improvement attained worldwide (figure 1). However, especially between 2000 and 2010,

improvements in the Gender Inequality Index have been scarce, especially when compared with countries such as Norway and Sweden where inequities between women and men in relation to reproductive health, empowerment, and the labour market are the lowest in the world (figure 2).

Even in countries such as Brazil, which has achieved huge reductions in poverty and introduced universal health coverage,[9] inequalities in access to health services and health outcomes driven by social determinants of health remain a major challenge. Wide differences exist between socioeconomic groups (measured by educational attainment) in access to antenatal services, infant mortality, under-5 mortality, diabetes mortality rate, and mortality rate from homicide (appendix).

Beginning in the 1990s, many Latin American countries introduced redistributive policies and social sector reforms to address the wide inequities and poor achievement in relation to human development. By the 2000s, these policies had started to exert a positive effect in addressing inequities. For example, between 2000 and 2010, income inequity, as measured by Gini index, narrowed in 12 of the 17 Latin American countries for which comparable trend data are available (figure 3).[15,16] Similarly, labour income inequity and salary differentials among workers have decreased, partly because of government policies implemented in most Latin American countries to increase minimum wages, expand formal employment, and broaden opportunities for basic education and skilling. Additionally, conditional cash-transfer programmes have helped to improve income levels of poor families, stimulated school attendance for children, and increased demand for health promotion and prevention services.[9,17] However, despite these improvements, in 2011, about four in ten workers did not have health insurance coverage or a pension, unlike workers in the formal sector who have insurance coverage.[18]

Starting in 1990 and especially in 2000–10, health levels in Latin American countries improved more quickly than did improvements in income compared with other countries in the world, as shown by the relative improvements of income and health indices (figures 1 and 4).

However, although economic development and public policies that encourage equity have partly reduced social injustices,[3] important social and health inequities persist in Latin American countries facing the growing challenges of non-communicable diseases, urbanisation, road traffic accidents, violent deaths, and increasing illicit drug use—problems rooted in social determinants of health. Rapid urbanisation means the urban population in Latin America is projected to grow from 394 million in 2000, to 609 million in 2030,[19] potentially creating large unmet health needs in conurbations.

Since the early 1970s, researchers in Latin America have explored health and social inequities as a central topic of their empirical and theoretical inquiry to show the complex associations between society and health, and created an important body of knowledge to inform policies. These researchers established strong networks to debate social determinants of health and to promote actions to address them. They also created the social medicine movement,[2] which spearheaded the fight for democracy during the military dictatorships, promoted health rights, and helped shape health system and social reforms in several Latin American countries.[9]

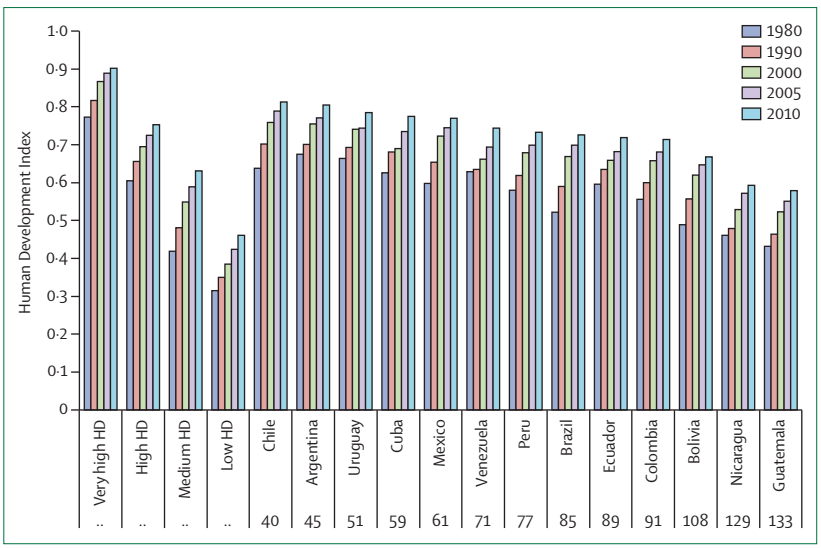

Figure 1: **Human Development Index of Latin American countries compared with countries with very high, high, medium and low development indices (1980–2010)**
Human Development Index is a composite index measuring average achievement in three basic dimensions of human development: a long and healthy life, knowledge, and a decent standard of living. Data from United Nations Development Programme.

For the **source of data for figure 1** see https://data.undp.org/dataset/Table-2-Human-Development-Index-trends/efc4-gjvq

Intersectoral action and social participation to address social determinants of health and achieve universal health care

Intersectorality is a political, administrative, and technical process[20] that involves negotiation and distribution of power, resources, and capabilities (technical and institutional) between different sectors. Intersectoral action not only demands a societal vision or a political intention of the government, but also management capability, along with new institutional arrangements and training for managers in health and other sectors to develop appropriate technical capacity.

Intersectoral action, once regarded as an exceptional response to uncommon events such as epidemic outbreaks, is increasingly used to address emerging challenges related to chronic non-communicable diseases, violence, road traffic accidents, and illicit drug use. Increased evidence and realisation of the importance of social actions in addressing social determinants of health have prompted a transition from coordination of information to coordinated action to address emerging challenges. Increasingly, Latin American countries have faced the intersectoral action dilemma—a transition from an approach in which each sector works by itself, to

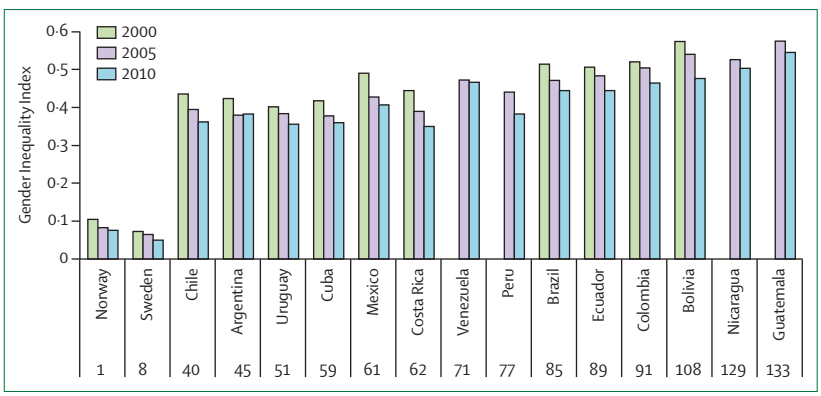

Figure 2: **Gender Inequality Index**
Gender Inequality Index is a composite measure showing inequality in achievements between women and men in three dimensions: reproductive health, empowerment, and the labour market. Data from United Nations Development Programme.

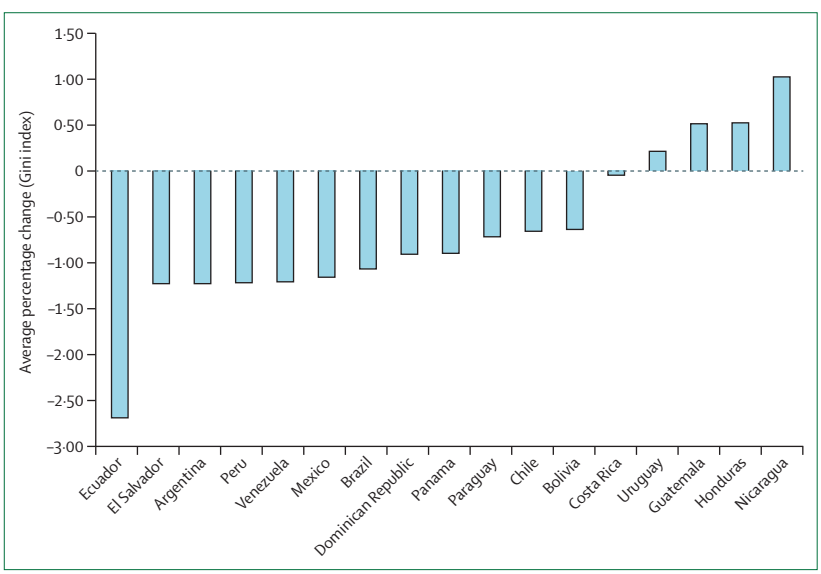

Figure 3: **Decreasing income inequity in Latin America in selected countries, 2000–10**
Calculated with data from the World Bank (1990–2004), and the United Nations Development Programme (2005–10).

For the **source of data for figure 2** see https://data.undp.org/dataset/Table-4-Gender-Inequality-Index/pq34-nwq7

For the **source of data for figure 3** see https://data.undp.org/dataset/Income-Ginicoefficient/36ku-rvrj

a progressive spiral of intersectoral action, with coordination of information among different sectors and implementing activities at intersectoral programming with integrated problem identification policy design and implementation.[21] The intensity of intersectorality ranges from information to cooperation in which the action focus is on intervention of diseases, to cooperation and coordination in which the focus is on prevention and health promotion, and to integration of policies and strategies to achieve health in all policies in which the focus is on interventions aimed at addressing social determinants of health.[20] The extent to which a particular type of intersectoral approach contributes to reductions in social and health inequities remains a central question.

Intersectoral coordination and cabinet meetings on social determinants[15] are now a regular feature of government activities in several countries such as Brazil and Chile, which have created ministries focusing on specific problems (eg, for social development, urban development, sex equality, and poverty reduction). New presidential initiatives exist too, such as those in Mexico, to address societal emergencies such as drugs and violence through intersectoral action. These new governance structures have challenged the traditional unisectoral organisation of the state, and need new approaches for the distribution of power and responsibilities, in particular the participation of local authorities and civil society organisations in partnerships, social mobilisation, and decision making. The new governance arrangements demand more flexible responses from central governments. As intersectoral action and social participation become embedded in new governance arrangements, the loss of autonomy and power of each actor is outweighed by the gains in effectiveness in tackling complex situations.

In our analysis of intersectoral actions in the case studies, we consider three domains: scope and target, organisation of intersectoral action, and results, especially in the extension of coverage and reduction of health inequities (panel 1).

Social participation

The Commission on Social Determinants of Health[22] identified participatory approaches as a crucial component of a health system to tackle health inequities underpinned by "...organisational arrangements and practices that involve population groups and civil society organisations, particularly those organisations working with socially disadvantaged and marginalised groups, in decisions and actions that identify, address and allocate resources to health needs".

In the context of universal health coverage reforms, social participation (especially of marginalised populations) is an important mechanism to gather evidence for the social determinants of health and the causes of inequities that establish access to services and effective coverage—eg, through community monitoring approaches. Social participation also provides the means to act on the social determinants of health and factors that affect access to health services through community mobilisation and appropriate strengthening of health systems.

Social participation has an intrinsic value, as a citizen's right to participate in decisions affecting them, and an important instrumental value, because the participation of communities and civil society groups in the development, implementation, and assessment of public policy is a necessary part of transparent and accountable governance in democracies. Social participation is essential for mobilisation of political support for policies aimed at addressing disparities in social determinants, combating health inequities, and for sustaining the changes introduced by redistribution of power and resources,[23] as shown in Brazil where social participation is an integral part of health system governance

(appendix). The success of such policies relies on broad social mobilisation and wide recognition of the seriousness of health inequities and the urgent need to combat them.[24,25]

Social participation strengthens democracy because institutions and decision makers take into account citizens' views on changing or maintaining the structure and values of a society in relation to a political system and its policies.[26] For example, in Cuba and Venezuela, which have socialist regimes, social participation in the development of public policy is encouraged. In other Latin American countries, including many that fought hard to rid military dictatorships, political regimes based on a representative model of democracy are in force, creating a conducive environment to direct participation,[26,27] as discussed in detail by Atun and colleagues[9] and Cotlear and colleagues.[12]

Factors that impede social participation are a combination of short-term pragmatisms; the dominance of a bureaucratic and technocratic notion of public policies, an underestimation of community knowledge and capabilities, and resistance to the sharing of power.[28] To transcend these obstacles to social participation, there is a need for close relationships between governments and populations in the policy-making process, institutionalisation of mechanisms for participation, training of public actors and communities, strengthening of community organisations, design of coherent communication strategies, dissemination of information, and increased research efforts to understand and promote participatory processes. In conclusion, participation needs to be put into practice because a prerequisite to strengthening participation is the experience of participation itself.

Most Latin American countries have established institutional mechanisms (similar to public ombudsmen, usually called *defensorías del pueblo* in Spanish or *ouvidorias* in Portuguese) to hear and address citizens' demands for publicly provided health services. Additionally, Latin American countries have experience of social participation for public sector issues or specifically for health based on communitarian associative structures, such as municipal health councils, at the municipal level. These participative structures extend beyond sex, race and ethnic groups to include social movements and civil society organisations. Other experiences include patient associations that typically operate at the national level as political actors in regular dialogue with governments.

Intersectoral programmes to address social determinants of health in Latin American countries

We explore intersectoral programmes implemented in Brazil, Chile, Colombia, and Cuba across the three domains of analysis. These programmes, although diverse in terms of target populations, activities, and coverage, share the common objective of reduction of health inequities through intersectoral actions on social determinants of health. In addition to the contributions to health-system goals of improved level and distribution of health, financial protection and user satisfaction, these programmes also contribute to sustainable development goals advanced simultaneously by other sectors.

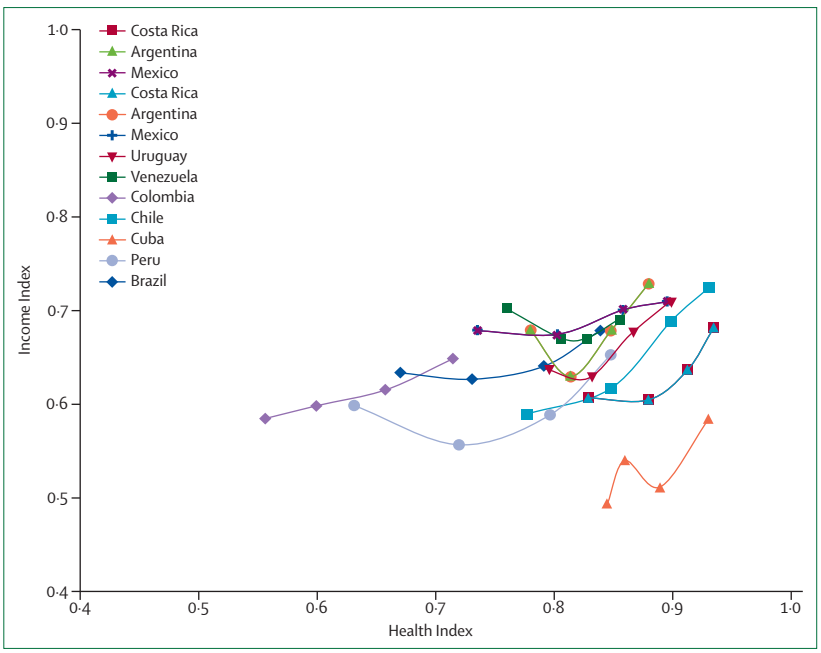

Figure 4: **Income and health indices in selected Latin American Countries, 1980–2010**
Health Index is measured as life expectancy at birth expressed as an index with a minimum value of 20 years and recorded maximum value during 1980–2010. Income Index is measured as gross national income per person (based on 2005 international purchasing power parity in US$, using a natural logarithm) expressed as an index with a minimum value of $100 and recorded maximum value during 1980–2011. Data from the United Nations Development Programme.

For the **source of data for figure 4** see http://hdr.undp.org

Brazil: *Bolsa Família*

The conditional cash transfer programme *Bolsa Família* (family grant) was established in 2003 to ensure access to social rights for health care to provider social rights for health care, thereby expanding access to health and education for families in poverty and extreme poverty, and to reduce poverty and income inequities. The programme unified several existing programmes (School Grant, Food Grant, Food Card, and Gas Grant) and in 2011 became part of the broader government strategy *Plan Brasil Sem Miséria* (Plan Brazil without Misery) to raise population income and welfare.

The Plan Brazil without Misery targets Brazilian households with per person incomes of less than R$70 (about US$30). The programme has three axes: productive inclusion (actions that create employment and income generation opportunities for poor citizens in rural and urban areas, including access to means of production, technical assistance to improve production capacity, and access to markets for food); second, access to public services (in education, health, welfare and food security);

and third, income transfers, which includes provision of Continued Provision Benefit, and the Bolsa Família programme (appendix).

The Bolsa Família programme in Brazil is widely regarded as a success. It has lifted millions of people out of poverty, supported people with the greatest unmet need to access health services and has contributed to progressive realisation of universal health coverage.[29,30] As well as extending the net of social and financial protection, Bolsa Família has contributed to improvements in health indicators for the beneficiary population. Between 2002 and 2011, the percentage of pregnant women (in the target population) attending seven or more antenatal consultations increased from 49·1% to 61·8%.[31] Intersectoral action through Bolsa Família has also contributed to improvements in health and action on social determinants. Integration of health and education policies in Bolsa Família expanded access for the poorest groups in Brazil and in 2003–13, contributed to substantial increases in immunisation and reduced child malnutrition, and in 2004–09 to reductions in under-5 mortality.[9,32,33]

Chile: *Chile Crece Contigo*

Chile Crece Contigo (Chile Grows with You) is a system of protection for early childhood development, with a mission to monitor, protect, and uphold the rights of all children and their families by providing programmes and services, which enable special support for the poorest households that account for most vulnerable families[34] (appendix). The system, which started in 2006 during the government of President Michele Bachelet's (the first woman President of Chile) is continuing. The evidence so far suggests positive effects in reducing child poverty and increasing access to educational opportunities and health.[35]

Chile Crece Contigo contributes to progressive realisation of universal health coverage by providing a universal platform to support early child development for all preschool children younger than 5 years and for all pregnant women, and includes proportional measures to the greater needs of the more vulnerable populations. This combination of universal and targeted support to households with children, with links to other social programmes for the more disadvantaged populations, is designed to reinforce actions aimed at attainment of universal health coverage indicators, enhanced health outcome, and improved social determinants of health (eg, in relation to education, employment) related to sustainable development goals.

Colombia: *De Cero a Siempre*

De Cero a Siempre (From birth to Forever) is the National Strategy for Comprehensive Care in Early Childhood in Colombia. Launched by the Presidency of Colombia in early 2011, the strategy aims to unify the efforts of the public and private sectors, civil society organisations, and international cooperation to improve the experience and outcomes of early childhood in Colombia (appendix).[36]

The strategy[36] builds on an earlier programme, *Hogares Comunitarios de Bienestar Social*, a community nursery programme that provided nutrition and child care for children from poor households. Among beneficiaries, the programme led to improvements in children's nutritional status and employment of women.[37] It offers important insights on intersectoral action in working towards universal health coverage. Of particular relevance is the role of the education sector, which has the coordination lead for the strategy, and yet the strategy is a platform to enhance coverage and quality of health care. Likewise, the strategy focuses on strengthening primary health care, including through participatory and social mobilisation approaches, with the local authorities playing an important part in supporting progress towards universal health coverage and wider sustainable development objectives.

The aim of the strategy, which combines both universal and targeted interventions, is to ensure rights to

	Institutional development	Methods or technologies	Training of human resources
Intersectorality for action on social determinants of health to promote sustainable development	Creation or strengthening instances for intersectoral coordination	Development of methodologies for intersectoral planning and coordination	Training managers and professionals of several sectors
Social participation	Creation or strengthening local committees with the participation of government and civil society	Development of methods to disseminate information to members of committees to support their decision making	Workshops and short-term courses for community leaders and members of committees
Strengthening the role of health sector for universal health coverage and action on social determinants of health	Creation or strengthening of instances in Ministry of Health for health promotion and action on social determinants of health	Development of methodologies of health planning and programming with social determinants of health approach	Workshops and short-term courses for managers and health professionals to develop capabilities to apply the social determinants of health approach to health programmes
Monitoring trends on health inequities for policy making	Creation or strengthening the monitoring inequities and assessment of interventions to support policy making	Creation or strengthening of information systems for monitoring health inequities; development and dissemination of methods for assessment of interventions on social determinants of health	Workshops and short-term courses to monitor health inequities and assess interventions

Table: **Capacity building for universal health coverage and action on social determinants of health**

comprehensive care for 2·9 million vulnerable children in the poorest populations while prioritising populations in extreme poverty, through national coordination of education, culture, planning, health, and social protection sectors at national and local levels. The strategy also aims to achieve 100% coverage of the population aged up to and including 5 years, roughly 4 million children.[35]

Cuba: Dengue Prevention Programme and Eradication of *Aedes aegypti*

Cuba's Dengue Prevention Programme and Eradication of *Aedes aegypti* is a comprehensive set of intersectoral interventions aimed at elimination and control of *Aedes aegypti* mosquito (and other vectors) through environmental sanitation, hygiene, and collective household actions[38] (appendix).

Underpinned by legislation, the programme includes the local government, the Ministry of Public Health, community associations, family doctors, water resources management, the anti-mosquito brigade, and several civil society organisations. The programme has led to a reduction of dengue infections and improved environmental management for vector control.[39–42]

The Dengue Prevention Programme's grounding at the primary health-care level, with implementation leadership provided by provincial and municipal governments and participatory approaches to create local level needs assessment and action plans, offers important lessons for intersectoral action for universal health coverage, and sustainable development. Additionally, as with the other case studies, the experience of Cuba highlights the importance of investment in health promotion and disease prevention as integral components of universal health coverage.

Intersectoral action and social participation to address social determinants of health and advance towards universal health coverage: lessons learned from Latin America

The experiences from the four Latin American countries highlight the challenges faced when addressing health inequities and social determinants of health. These challenges are not only rooted in inherent societal inequities, but also in the institutional organisation of government sectors that encourage unisectoral action and hinder multisectorality.

The country cases and the policies we look at provide an insight into the ways in which integrated intersectoral actions are developed and implemented. The four country case studies show how approaches to universal health coverage and social determinants of health, underpinned by intersectorality and social participation, can be used in a range of situations. For example, communicable disease control (Cuba), improving experience and outcomes of early childhood development (Chile and Colombia), and conditional cash transfers aimed at ensuring rights to health and education and poverty alleviation (Brazil). However, the country cases also show that although meaningful cooperation and coordination between different sectors exists, in practice, real integration of policies and programming with joint design, programming, implementation, and assessment is challenging.

In the four countries studied, integrated intersectoral policies and actions aimed at addressing social determinants of health and reforms for progressive realisation of universal health coverage have been hindered by institutional and managerial constraints, such as rigid budgets department specific performance targets, and limited capacity to implement complex projects and change. To overcome these constraints, capabilities should be developed in four areas: intersectorality, social participation, enhanced role of health sector, and monitoring of health inequities (table). These capabilities need to be underpinned by institutional development, establishment of managerial methods, and mechanisms and training of human resources.

The paucity of systematically collected robust data and well designed assessments in relation to the programmes studied in the case studies also suggest the need to strengthen health information systems to provide disaggregated data by socioeconomic groups for monitoring health inequities and to study the effect of interventions on target populations.

Panel 2: **Achieving intersectoral action to address social determinants of health and universal health coverage**

- Combine demand-side (eg, cash transfers or financial support) and supply-side interventions (services)
- Engage local level leadership for intersectoral action and develop sustainable learning and capacity building to address social determinants of health
- Enhance investment in cost-effective promotion and prevention measures through primary health care that address social determinants of health towards progressive realisation of universal health coverage
- Support community participation, in particular of more disadvantaged populations and through formal mechanisms, in efforts towards universal health coverage and sustainable development
- Use disaggregated data and community-level monitoring to gather information about health and social inequities, in combination with systematic monitoring, assessment, and provision of relevant information to users and policy makers to inform policy, planning, resource allocation, and practice
- Combine targeted measures for the more disadvantaged populations with universal approaches to improve coverage, so that reforms aimed at advancing universal health coverage and sustainable development are equity-oriented in nature, but also ensure all population groups benefit from progress
- Integrate planning, budgeting, implementation, and monitoring activities between sectors in support of universal health coverage and sustainable development, with the health sector playing both the part of a leader and a partner in the initiatives of other sectors
- Create conducive legal and policy environments across sectors for action on key social determinants of health, universal health coverage, and sustainable development

The experiences from the four Latin American countries provide lessons and insights to other countries on the importance of intersectorality and social participation to simultaneously address social determinants of health when developing policies for universal health coverage and sustainable development (panel 2).

The next decade should provide the opportunity to show how a new generation of social policies, emphasising social determinants and universal health coverage, can create a better mix of priorities and investments in Latin American countries. The expanded definition of social rights (including the right to health) in the past two decades means that social policies without a path to universal health coverage will not be acceptable. However, persistent social inequities, changing epidemiological profile, and citizens' demands for rights will need to be addressed, if universal health coverage is to be achieved and sustained in Latin American countries. As Latin American societies prosper, live longer, and become more equal, citizens' demand for improved access to quality health care will increase. A question that remains is how these positive democratic and economic trends will be harnessed for sustainable and equitable development.

There is a window of opportunity for Latin American countries to actively share globally their unique experiences in intersectoral action and social participation to address social determinants of health and achieve universal health coverage, but also to learn from countries that have succeeded in addressing social determinants to grow with more social justice and do less harm for future populations. Latin American countries can learn better ways to coordinate actions between social, biological, and environmental determinants of health, and build health systems with greater emphasis on primary health care to show how governments can orient their actions to improve health, welfare and prosperity for all, and not just a select few.

Declaration of interests

TSK and FR are responsible for the views expressed in this article and they do not necessarily represent the views, decisions, or policies of the institution with which they are affiliated. We declare no competing interests.

References

1 WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. World Health Organization. 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf (accessed Dec 21, 2013).

2 Horton R. Offline: Four principles of social medicine. *Lancet* 2013; **382:** 192.

3 Bloom DE, Canning D. Policy forum: public health. The health and wealth of nations. *Science* 2000; **287:** 1207–09.

4 WHO. Declaration of Alma-Ata. International Conference on Primary Health Care. Kazakhstan, USSR: World Health Organisation, 1978.

5 WHO. Rio Political Declaration on Social Determinants of Health. World Conference on Social Determinants of Health. Rio De Janeiro, Brazil, 19-21 October 2011. Geneva: World Health Organization, 2011.

6 United Nations. UN resolution. A/Res/66/288. The future we want. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/66/288&Lang=E (accessed Dec 20, 2013).

7 Tanahashi T. Health service coverage and its evaluation. *Bull World Health Organ* 1978; **56:** 295–303.

8 Frenz P, Vega J. Universal health coverage with equity: what we know, don't know and need to know. First Global Symbosium on Health Systems Research; Montreux, Switzerland; Nov 16–19, 2010.

9 Atun R, Monteiro de Andrade, Braga J, et al. Health-system reform and universal health coverage in Latin America. *Lancet* 2014; published online Oct 16. http://dx.doi.org/10.1016/S0140-6736(14)61646-9.

10 Castell-Florit P. The intersectoral social practice. Havana: Ciencias Médicas, 2007 (in Spanish).

11 WHO. Blas E, Kurup AS, eds. Equity, social determinants and public health programmes. 2010. Geneva: World Health Organization, 2010.

12 Cotlear D, Gómez-Dantés O, Knaul FM, et al. Overcoming social segregation in health care in Latin America. *Lancet* 2014; published online Oct 16. http://dx.doi.org/10.1016/S0140-6736(14)61647-0.

13 Gasparini L, Cruces G, Tornarolli L. Recent trends in income inequality in Latin America. September, 2009. http://www.ecineq.org/milano/WP/ECINEQ2009-132.pdf (accessed Oct 1, 2014).

14 Gasparini L, Lustig N. The rise and fall of income inequality in Latin America. ECINEQ working paper series 2011–13. http://www.ecineq.org/milano/wp/ecineq2011-213.pdf (accessed Dec 21, 2013).

15 Lustig N, Lopez-Calva LF, Ortiz-Juarez E. Declining inequality in Latin America in the 2000s: the case of Argentina, Brazil and Mexico. The World Bank, Latin America and the Caribbean Region. Poverty, Equity and Gender Unit. October, 2012. http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2012/10/23/000158349_20121023093211/Rendered/PDF/wps6248.pdf (accessed Dec 21, 2013).

16 Pellegrinni A. Decrease in income inequality in Latin America in the 2000s. Nov 22, 2012. http://dssbr.org/site/?p=11973&preview=true (accessed Dec 21, 2013; in Portuguese).

17 Cecchini S. Veras-Soares F. Conditional cash transfers and health in Latin America. *Lancet* 2014; published online Oct 16. http://dx.doi.org/10.1016/S0140-6736(14)61279-4.

18 Bértola L, Gerchunoff P. Institutions and economic development in Latin America. United Nations Economic Commission for Latin America and the Caribbean (CEPAL). 2011. http://www.eclac.cl/publicaciones/xml/0/44960/Institucionalidad_y_desarrollo_final.pdf (accessed Dec 22, 2013; in Spanish).

19 United Nations. Latin America, urbanization, poverty and human development. http://www.unic.org.ar/prensa/archivos/urbanizaciondatoslatam.pdf (accessed Dec 22, 2013; in Spanish).

20 Solar O, Valentine N, Rice M, Albrecht D. Intersectorality in health. 7th global conference on health promotion. Promoting health and development: closing the implementation gap; Nairobi, Kenya; Oct 26–30, 2009. http://www.who.int/healthpromotion/conferences/7gchp/Track4_Inner.pdf (accessed Dec 21, 2013).

21 Andrade LOM. Health and the intersectoral collaboration dilemma. Doctoral thesis. Aug 30, 2004. http://www.bibliotecadigital.unicamp.br/document/?code=vtls000376076 (accessed Sept 10, 2014; in Portuguese).

22 WHO Commission on Social Determinants of Health (CSDH). Challenging inequities through health systems. Final report of the Knowledge Network on Health Systems to the WHO Commission on Social Determinants of Health. Geneva: World Health Organization, 2007.

23 WHO. Closing the gap: policy into practice on social determinants of health: discussion paper of the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil, 2011. Geneva: World Health Organization, 2011.

24 Pellegrini A, Rovere M. Social participation in the definition and implementation of public policies. Rio de Janeiro: Portal DSS Brazil; 2011. http://cmdss2011.org/site/2011/08/participacao-social-na-definicao-eimplantacao-de-politicas-publicas/ (accessed April 5, 2013).

25 Sorj B. By building civil society in Latin America. In: Sorj B, ed. Usos, abusos e desafios da sociedade civil na América Latina. São Paulo: Paz e Terra, 2010: 7–15 (in Portuguese).

26 Ramos G. Social participation in the health field. Revista Cubana Salud Pública 2004. http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-34662004000300005&lng=es (accessed Dec 21, 2013; in Spanish).

27 Salles R, Casilla D. Social participation in health: a challenge participatory in Venezuela. *Cuestiones Políticas* 2012; **28:** 141–56 (in Spanish).

28 Kliksberg B. Strategies and methodologies to promote social participation in the definition and implementation of policies public to combat inequities in health. http://cmdss2011.org/site/wp-content/uploads/2011/07/Participaci%C3%B3n-Social_Bernardo-Kliksberg.pdf (accessed April 12, 2013; in Portuguese).

29 Guanais FC. The combined effects of the expansion of primary health care and conditional cash transfers on infant mortality in Brazil, 1998–2010. *Am J Public Health* 2013; **103:** 2000–06.

30 Shei A. Brazil's conditional cash transfer program associated with declines in infant mortality rates. *Health Aff (Millwood)* 2013; **32:** 1274–81.

31 Brazil Ministry of Health. Department of Health surveillance: information system on live births. Indicators of basic data 2012. Rede Interagencial de Informação para a Saúde. http://tabnet2.datasus.gov.br/cgi/deftohtm.exe?idb2012/f06.def (accessed Dec 19, 2013; in Portuguese).

32 Brazil Ministry of Health. Surveillance secretariat of information on live births and mortality information system health-system. Indicators of basic data 2012. Rede Interagencial de Informação para a Saúde. http://tabnet2.datasus.gov.br/cgi/idb2012/c16b.htm (accessed Dec 21, 2013; in Portuguese).

33 Rasella D, Aquino R, Santos CA, Paes-Sousa R, Barreto ML. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. *Lancet* 2013; **382:** 57–64.

34 Government of Chile. Chile Grows with Executive Secretariat, Department of Health Promotion and Citizenship MINSAL, Division of Healthy Public Policy and Health Promotion. 2010 Guidelines for the promotion of child development in local management. Children at the center of their community. http://www.crececontigo.gob.cl/wp-content/uploads/2010/04/Promocion-del-Desarrollo-Infantil.pdf (accessed Dec 21, 2013).

35 EKOS consultants. Evaluation of the use and identification of critical nodes and improvements to the system registry, referral and monitoring subsystem child protection Chile Grows with You. Final report. 2013. http://www.crececontigo.gob.cl/biblioteca/estudios/ (accessed Dec 21, 2013; in Spanish).

36 Government of Colombia. Zero to always. National Strategy for integral attention to early childhood. http://www.deceroasiempre.gov.co/QuienesSomos/Paginas/QuienesSomos.aspx (accessed Dec 22, 2013; in Spanish).

37 Attanasio OP. Vera-Hernández M. Nutrition and child care choices. Evaluating a community nursery programme in rural Colombia. November, 2004. http://www.rand.org/content/dam/rand/www/external/labor/seminars/adp/pdfs/2008_attanasio.pdf (accessed July 7, 2014).

38 Díaz C, Torres Y, Cruz AM, et al. An inter-sector participatory strategy in Cuba using an ecosystem approach to prevent dengue transmission at the local level. *Cad Saude Publica* 2009; **25** (suppl 1): S59–70 (in Spanish).

39 Noriega V, Ramos I, Couterejuzón L, Martín L, Mirabal M, Díaz G. Organizational status of vector control groups in Havana. *Revista Cubana de Salud Pública* 2009; **35: 1**–16 (in Spanish).

40 Guzmán MG, Halstead SB, Artsob H, et al. Final characterization of and lessons from the epidemic of dengue 3 in Cuba, 2001–2002. *Rev Panam Salud Publica* 2006; **19:** 20–35 (in Spanish).

41 Castell-Florit P. Sustainability of intersectoriality in Cuba. Havana: Ciencias Médicas, 2009 (in Spanish).

42 Sanchez L, Perez D, Pérez T, et al. Intersectoral coordination in Aedes aegypti control. A pilot project in Havana City, Cuba. *Trop Med Int Health* 2005; **10:** 82–91.