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PRIMARY HEALTH CARE IN THE AMERICAS: LESSONS LEARNED OVER 25 YEARS AND FUTURE CHALLENGES

In 1978, the International Conference on Primary Health Care held in Alma-Ata defined and granted international recognition to the concept of primary health care (PHC). The Conference identified primary health care as the principal strategy for reaching the goal of Health for All by the Year 2000 (HFA-2000), adopted by the Member States of WHO in Resolution WHA30.43 of 1977 and the subsequent plan of action. The vision of PHC laid out in Alma-Ata, expressed in the principles and recommendations in the Declaration of Alma-Ata and in a set of 22 recommendations, marked the beginning of a new strategy for improving the public health of the peoples of the world and established a new platform for international health policy.

In the Region of the Americas, the countries endorsed the four basic principles of PHC recognized in the Alma-Ata conference: i) universal access and coverage in relation to health needs; ii) commitment, participation, and individual and community self-sufficiency; iii) intersectoral action for health, and iv) cost-effectiveness and appropriate technology, as the available resources permit. Since then, the Member States have established and implemented national primary care strategies based on the development of priority components: expanded coverage of services to improve health and the environment; community organization and participation to improve well-being; development of intersectoral linkages; development of research and appropriate technologies; availability and production of critical products and equipment; education and use of human resources; sectoral financing; and international cooperation.

Twenty-five years after the historic landmark of Alma-Ata, the people of the Americas have made gains in health resulting from priority PHC activities in education and health promotion, food and nutrition, water supply and sanitation, maternal and child care and family planning, immunization, the prevention and control of endemic diseases, the treatment of prevalent diseases and injuries, and access to essential drugs. The collective experience gained in the implementation of primary care has enriched theory and practice in public health. It has also given rise to new challenges and priorities for achieving equity in health, in terms of both public health policies and population-based health interventions, thus reinforcing the redistributive component inherent in the goal of HFA.

The Members of the Executive Committee are invited to study and discuss this document, and to provide their comments and suggestions to assist the Organization in setting policy and carrying out strategies to renew the commitment to primary health care when formulating and implementing national policies for health development and the corresponding initiatives for international technical cooperation.

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Introduction

1. This year marks the 25th anniversary of the Declaration of Alma-Ata of 1978 on primary health care (PHC). For many years, this declaration, together with the definition of the universal goal of Health for All by the year 2000 (HFA-2000), constituted the most important health policy platform for the World Health Organization and the Pan American Health Organization, as well as for many countries in the Region of the Americas and around the world. At the 30th World Health Assembly in 1977, the Member States unanimously decided that the principal social objective to be achieved in their respective countries was a level of health for all citizens that would enable them to lead socially and economically productive lives by the year 2000.

2. Primary health care, as defined in point VI of the Declaration of Alma-Ata, was adopted almost universally as the essential strategy for achieving the goal of HFA-2000 and since then, has been the cornerstone of the reorientation and restructuring of many health systems. According to this original definition, primary health care is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

3. A quarter of a century later, the historical importance of this Conference and the definitions, commitments, and mandates it produced cannot be ignored. It is necessary to emphasize its contribution in terms of the conceptualization of PHC and the political legitimacy it gave to PHC by linking it organically with HFA-2000.

4. Many things have changed around the world and in each of our countries since 1978. Economic, political, and social contexts have shifted, as a consequence not only of national historical processes, but, increasingly, of the configuration of an ever more interdependent world subject to dizzying changes in all dimensions of human life. Epidemiological patterns and the demographic profiles of populations have changed, within the framework of greater exposure to risks and transformations in the social and economic environment. Major changes have also taken place in health systems, the functions of the State, and citizen initiatives to take responsibility for their own health care.

5. PHC and HFA-2000 have been present throughout this complex process, with different degrees of prominence in different cases and different countries, as a political and ethical reference point at the center of decisions that governments and societies have had to make.

6. The underlying values of PHC and HFA-2000 remain valid, and many of the problems and challenges that they gave rise to have yet to be overcome. This is another reason, in addition to the importance of the anniversary, to take stock, reflect, and ponder the future. It is an opportunity to reflect on the impact and relevance of PHC and HFA-2000 in light of the challenges faced by our countries and the world. Some of these are laid out in the Millennium Development Goals, Agenda 21, the resolutions of the Johannesburg Summit, and, almost universally, the political constitutions of the member countries of the Pan American Health Organization.

Background

7. As the 1970s drew to a close, more of half of the world's population was not receiving adequate health care, as noted in point V of the Declaration of Alma-Ata. In the Region of the Americas, this had become a matter of great concern to governments, societies, and the Pan American Health Organization.

8. At the III Special Meeting of Ministers of Health, held in Santiago, Chile in 1972, the ministers reached the conclusion that health services were not delivering benefits to the entire population. They estimated that one-third of the Region's population did not have access to health services. This led to the policy to expand coverage in order to address what was then called "an access crisis." The low level of access was considered the most important of the crises confronting the health systems (cost crisis, effectiveness crisis, and access crisis).

9. The economic context was also critical. The vast majority of countries were having difficulty dealing with the effects of the current oil crisis and had weak and unstable economies emerging from the economic growth and import-substitution model. Populations were becoming primarily urban, with a full demographic transition under way. With certain exceptions, the political context was characterized by military dictatorships in many countries and unstable democracies in others.

10. In terms of health, the 1970s were characterized by national efforts to expand the population's access to health services. The advent of PHC and the commitment to HFA-2000 in the Region of the Americas represented the reinforcement of policies and strategies to expand coverage throughout the Region.

11. It should be pointed out that centralist approaches prevailed in health services organizations at the time. However, the policy to expand coverage, the planning approaches in effect (the so-called CENDES-PAHO model, with its criterion of openness to local programming), and PHC in particular promoted the gradual strengthening of local service units and capacity (which in several countries came to be called the primary care level). These would later serve as the basis for new approaches to social policies.

12. The 1980s were characterized by a very difficult regional panorama, with limited growth in national revenues, low investment rates, persistent balance of payment deficits, high foreign debt, and an intensification of inflationary pressures. In that context, the PHC strategy became the principal orientation for health policy in the countries of the Region. Nevertheless, it should be pointed out that in most countries, the health sector was also characterized by a series of problems, including lack of coordination, both internally and with other sectors, by a shortage of financial resources, and by weak citizen participation in decision-making.

13. During this decade, progress in achieving goals in health was less than anticipated. Notwithstanding the declarations and commitments, in the general context of health systems, the "primary level" was actually given less importance than other levels of the health services. The bulk of public spending continued to go to hospitals.

14. Toward the second half of the 1980s, the countries decided to strengthen the role of PHC as one of three key areas that needed to be developed. In 1988, the 33rd Directing Council of PAHO adopted Resolution XV on to the development and strengthening of local health systems. Within the concepts and strategies for developing local health systems, greater relative weight was given to the primary care level. The emphasis on decentralization, social participation, new models of care, and the development of managerial capacity as conditions for developing local health systems gave impetus to underscoring the role of PHC in the organization of national health systems.

15. Implementation of the PHC strategy in the Region of the Americas was characterized by heterogeneity and discontinuities. At the conceptual level, PHC has been subject from the start to different interpretations that reflect divergent political and health perspectives.

16. Under the original definition, PHC was implicitly a health development strategy, as well as a level of health care services. In the Americas, primary health care was adopted and adapted by each country according to its own realities and its own health and socioeconomic conditions. Within that context, many countries understood PHC as the primary level of care--that is, as the point of contact with the community and the population's gateway to the health system. This concept has tended to predominate in countries that have achieved adequate levels of coverage for basic health services.

17. In another perspective in some countries—within the context of segmented health care, a model increasingly based on technology development and specialization, but with the exclusion of broad social sectors—PHC has been considered a health-care strategy based on the principles of social justice and has been envisioned as the possibility of providing health care to poor and marginalized populations who lack access to services.

18. In another variation in the development of PHC, generalist physicians or nurses are seen as gatekeepers, or those responsible for managing access to the health system. This perspective relies on the capacity of primary care units and personnel to manage a wide variety of health problems that make up most of the demand for health care. The emphasis is on filtering cases that may require specialized care by other organizational levels in the system.

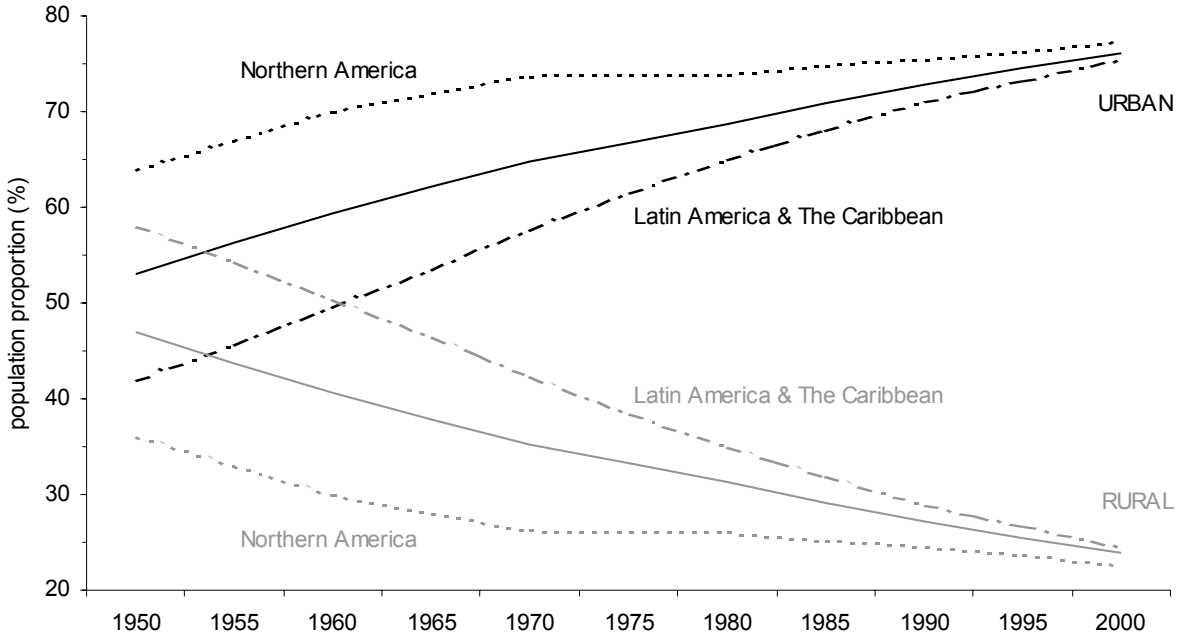
19. In many national health systems characterized by growing complexity, in an effort to respond to populations with different characteristics and organizational arrangements based on segmentation, these various interpretations and applications coexist, generating more than a few disputes and misunderstandings, with a resulting lack of effectiveness and efficiency.

Impact of PHC on Health in the Americas

20. From a historical perspective, in the 25 years since Alma-Ata, the PHC strategy has become the centerpiece of national health policies and sectoral responses to health problems in the countries of the Americas. The countries have stressed that "the conceptual and operational core of primary care is procuring the desired *impact* on population health, with the maximum social efficiency and productivity of resources allocated to the sector." In these terms, the net gain in life expectancy at birth achieved in the Region over this period is a global indicator of the positive impact of the PHC strategy on the health of the population.

21. From 1980 to 2000, regional population increased by 217 million, reaching a total of 833 million. The regional population growth rate is now 1.3% a year. However, for the urban population, 76% of the total population in 2000, the growth rate was 1.7%. The population 65 or more years old is growing at a rate of more than 2% a year, and the population 85 and older, the group with the fastest growth, is increasing at 3% to 5% per year. This evidence reveals three demographic trends of particular importance in the current scenario for assessing the impact of population on the PHC strategy: population growth, urbanization (figure 1), and demographic aging.

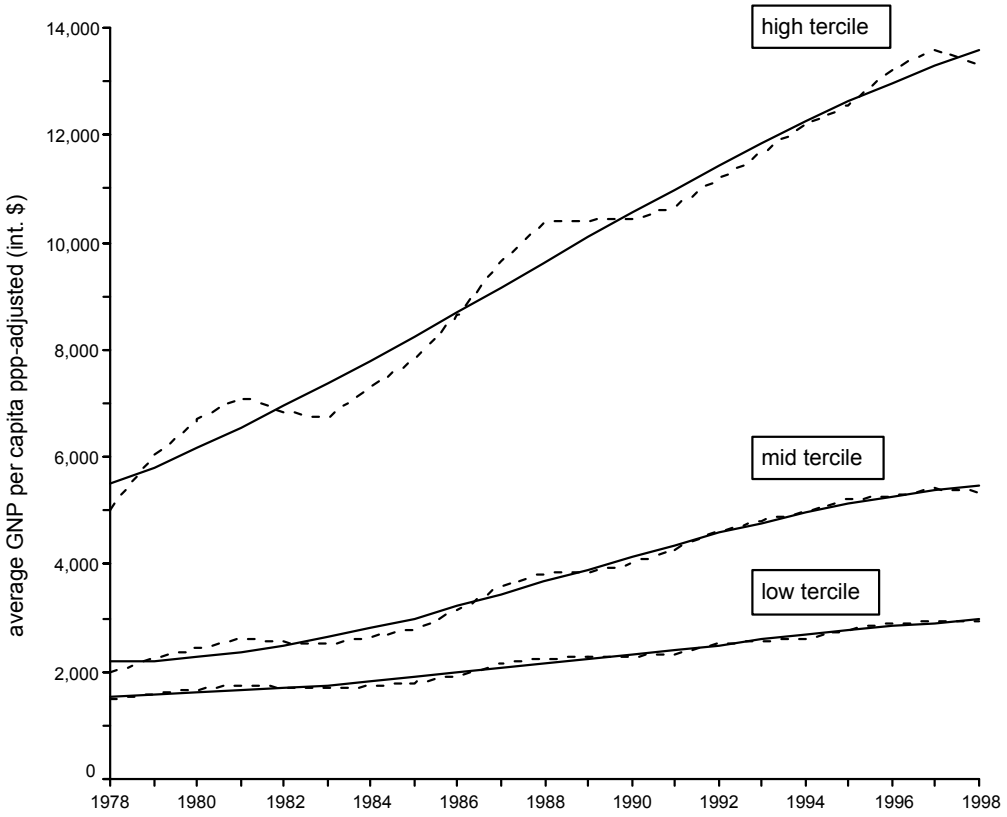
Figure 1. Trends in urban and rural populations in the Americas; 1950-2000.



Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

22. In the last two decades of the 20th century, the countries of the Americas experienced real economic growth, judging by the growth rate of the gross national product (GNP) per capita. Around 1980, the median value of the regional annual GNP per capita, adjusted by purchasing power parity of the currency, was US$ 2,349 (with a range of $1,300 to $15,000). Around 2000, the comparable value was $4,614 (with a range of $1,600 to $25,000); that is, the income level doubled. However, this favorable macroeconomic trend was not distributed equitably, disproportionately favoring the top third of the population in terms of income. As a consequence, the absolute income gap between the richest third of the population and the poorest third tripled, going from $3,551 in 1978 to $10,361 in 1998 (figure 2). The evolution of the socioeconomic context during the period when the PHC strategy was applied in the Americas thus shows the presence and persistence of inequalities that must be considered when evaluating the impact of the PHC strategy.

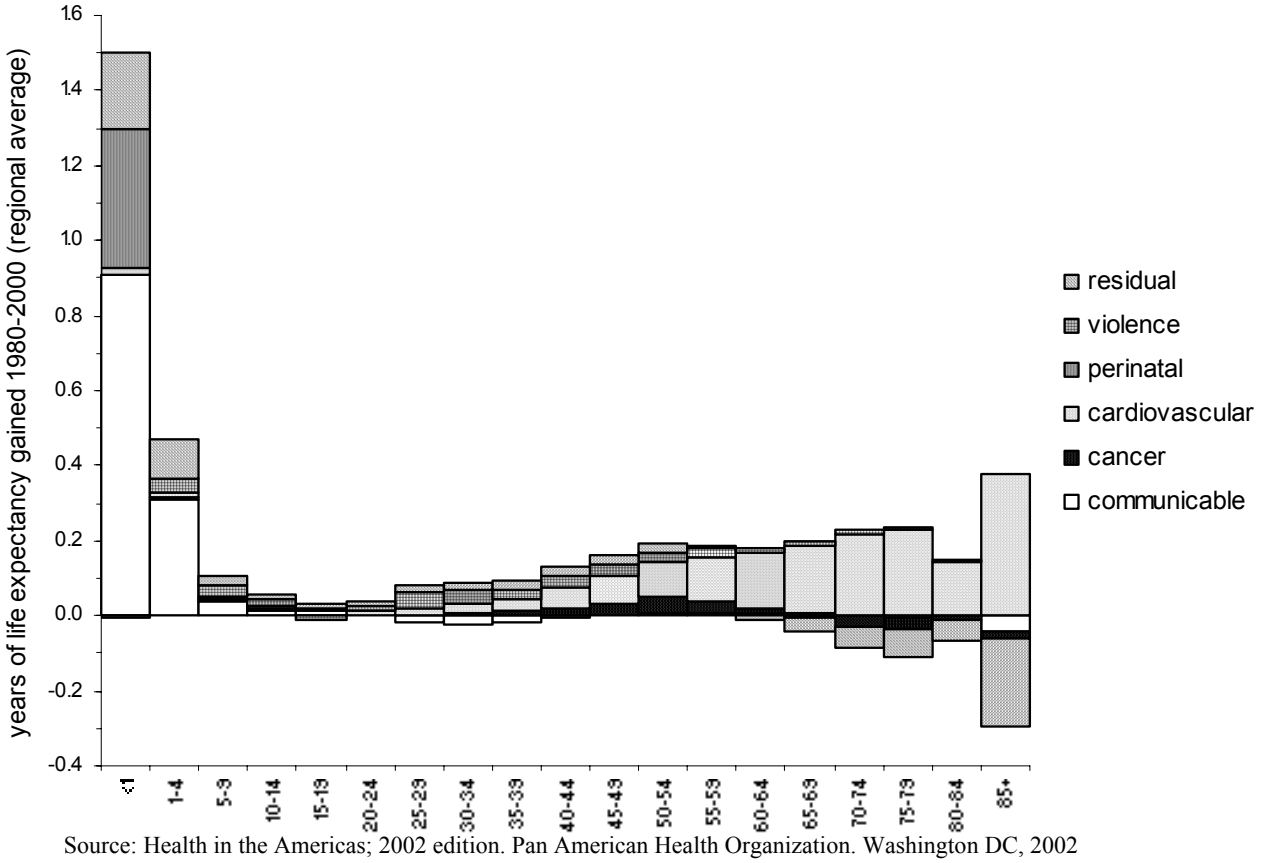
Figure 2. Economic growth trends by income terciles. Region of the Americas; 1978-1998.



Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

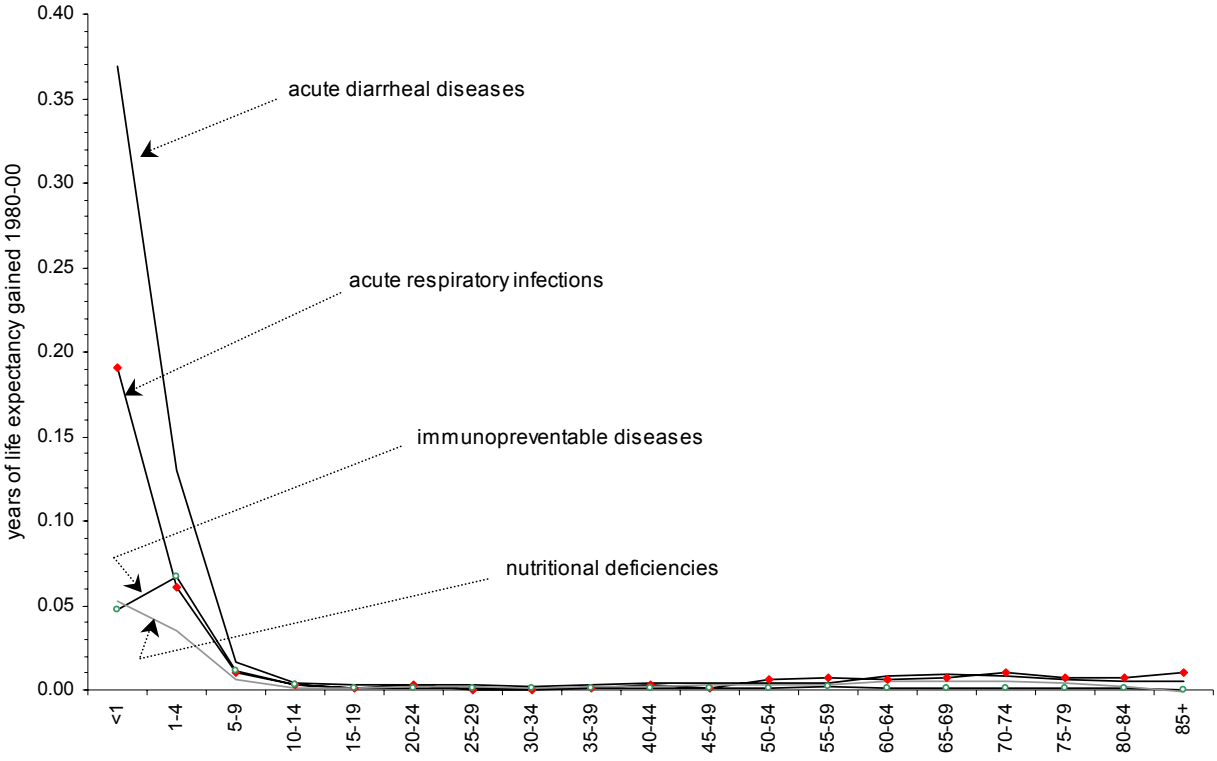
23. In the 25 years since the Alma-Ata conference, the Americas witnessed a 25% reduction in the risk of dying (from 9 to 7 per 1,000 population). As a result, life expectancy at birth for both sexes increased, on average, by 6 years (from 66 to 72 years). Nearly 50% of this increase in life expectancy is attributable to a reduction in the risk of dying from communicable and cardiovascular causes during this period (Figure 3). In fact, at the regional level at least two years of life expectancy were gained just by reducing the risk of dying from communicable diseases (60%) and perinatal disorders (25%) in populations of children under 5 (Figure 4).

Figure 3. Population health impact: distribution of gains in male life expectancy. Region of the Americas; 1980-2000.



Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

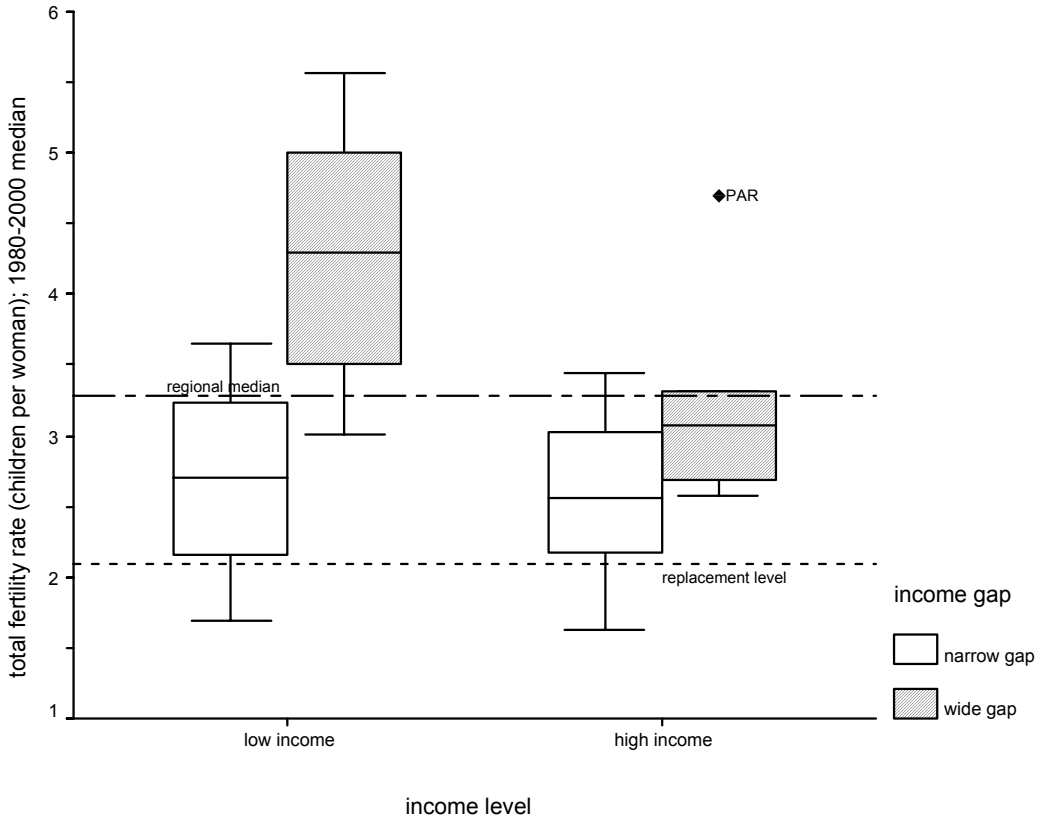
Figure 4. PHC priority diseases control impact on life expectancy at birth; Region of the Americas, 1980-2000.



Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

24. The impact of the PHC strategy has been greater in countries with less inequality in income distribution, regardless of absolute income levels. In contrast, the impact of PHC has been much lower in poor countries with high inequality of income distribution. For example, total fertility rates closer to the replacement level, indicating a more advanced stage of demographic transition, were reached in countries with more equitable income distribution--not necessarily in the richest countries (figure 5). Aspects directly associated with the implementation of the PHC strategy, such as public spending on health (Figure 6), access to safe drinking water (Figure 7), institutional care in childbirth (Figure 8), or literacy (Figure 9) show significant geographical, gender-based, and socioeconomic inequalities when disaggregated by level and, above all, by income. This evidence documents the impact of the goal of HFA and the need to incorporate an equity perspective into PHC, which was the fundamental inspiration of the Declaration of Alma-Ata.

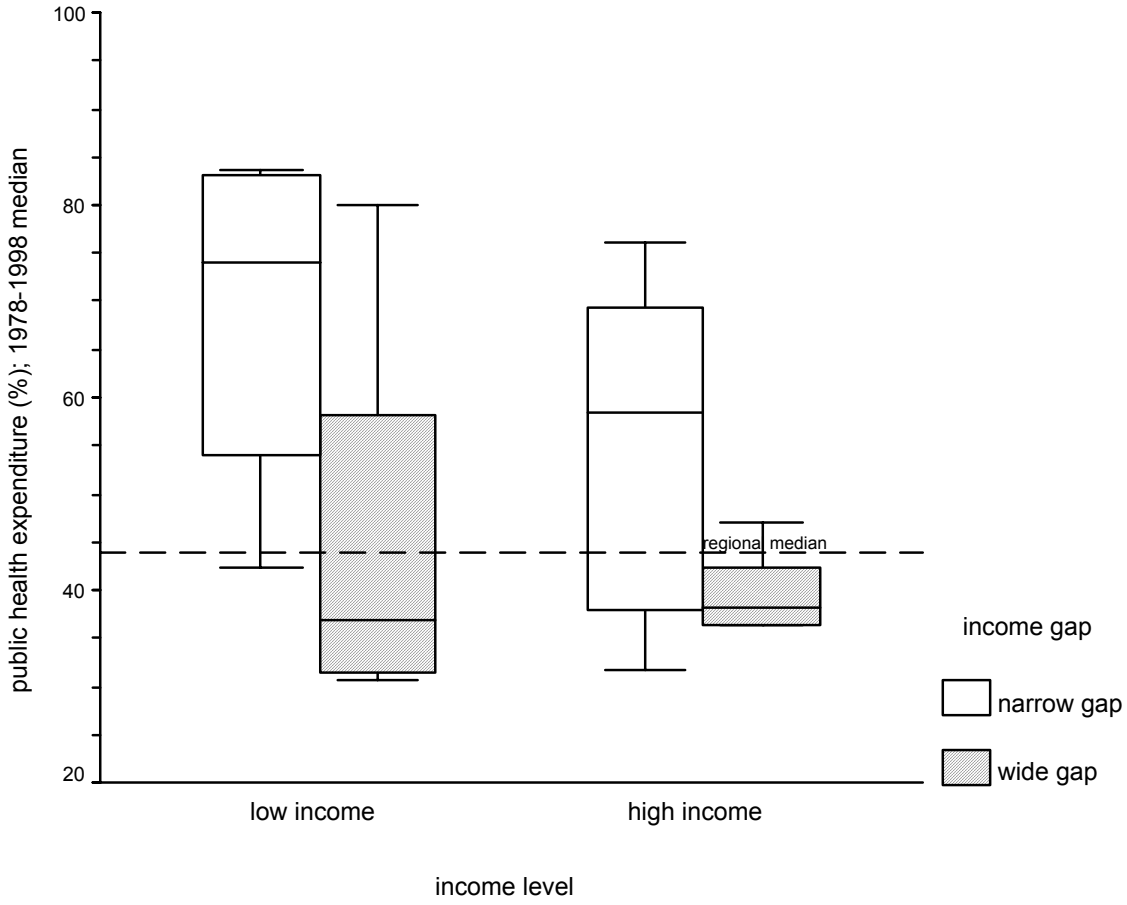
Figure 5. Summary distribution of total fertility by country cluster of income level and income gap. Region of the Americas; 1980-2000



low income & narrow gap:	Cuba, Guyana, Jamaica, Peru
low income & wide gap:	Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama
high income & narrow gap:	Argentina, Bahamas, Canada, Costa Rica, Trinidad & Tobago, United States, Uruguay, Venezuela
high income & wide gap:	Brazil, Chile, Colombia, Mexico, Paraguay

Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

<u>Figure 6</u>. Summary distribution of public health expenditure by country cluster of income level and income gap. Region of the Americas; median value 1978-1998.



low income & narrow gap: Cuba, Guyana, Jamaica, Peru
low income & wide gap: Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama
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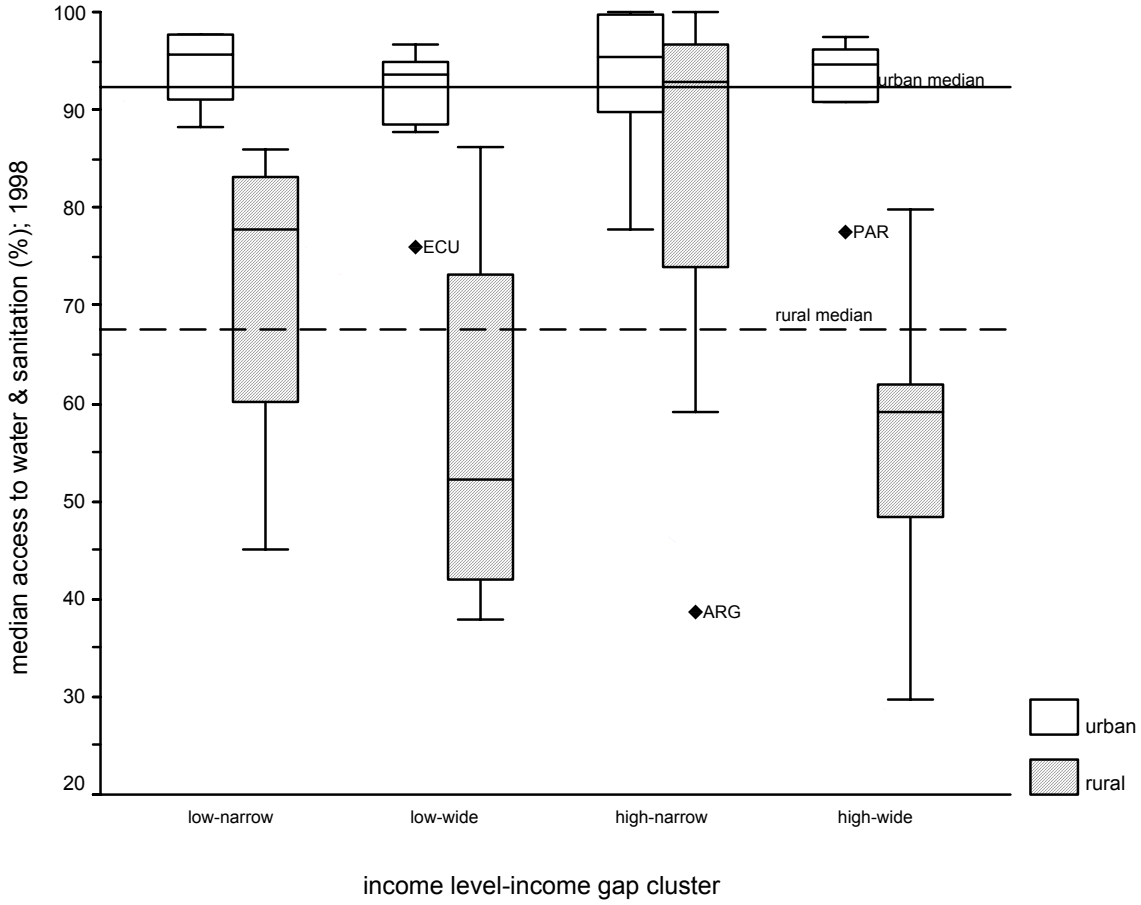
high income & wide gap: Brazil, Chile, Colombia, Mexico, Paraguay

Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

Figure 7. Summary distribution of water & sanitation coverage by country cluster of income level and income gap. Region of the Americas; 1998.



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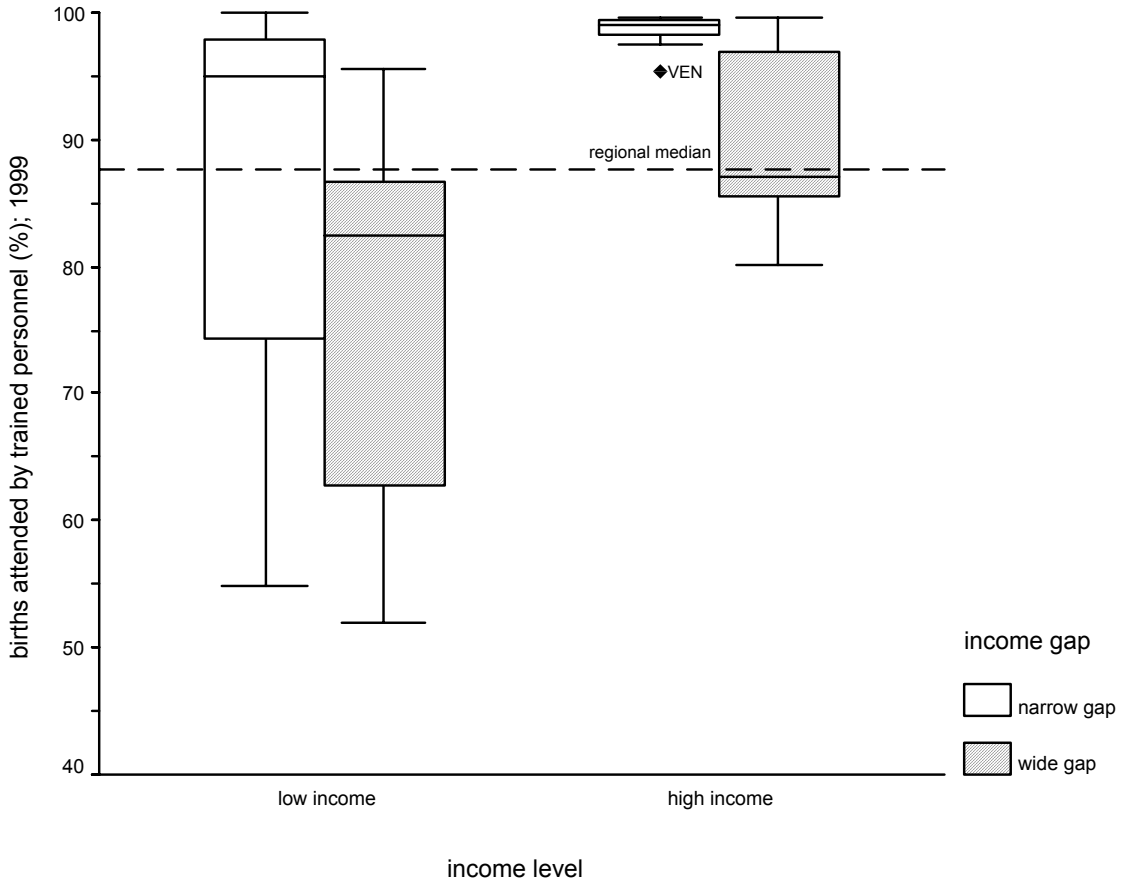
high income & wide gap:	Brazil, Chile, Colombia, Mexico, Paraguay

Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

<u>Figure 8</u>. Summary distribution of institutional delivery coverage by country cluster of income level and income gap. Region of the Americas; 1999



low income & narrow gap:	Cuba, Guyana, Jamaica, Peru
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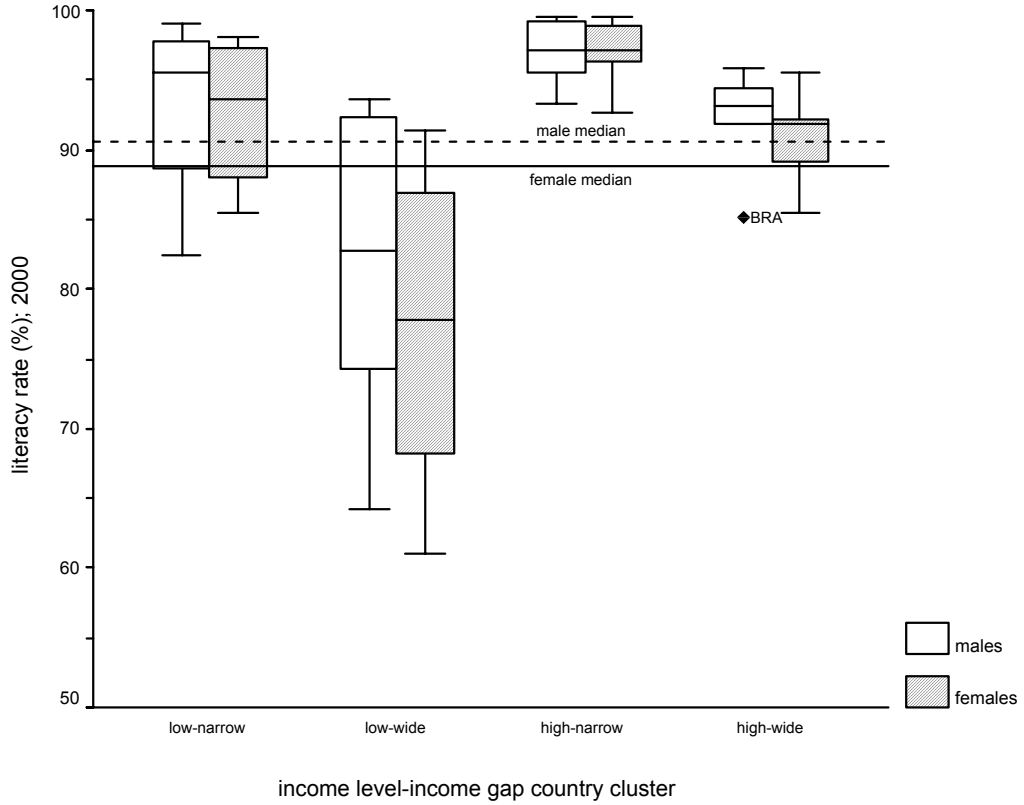
high income & wide gap:	Brazil, Chile, Colombia, Mexico, Paraguay

Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

Figure 9. Summary distribution of literacy rate by sex and country cluster of income level and income gap. Region of the Americas, 2000.



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Source: Health in the Americas; 2002 edition. Pan American Health Organization. Washington DC, 2002

Lessons Learned

25. In the Region of the Americas, PHC was a pioneering experience for the development of health policies. In many ways, PHC marked the beginning of a paradigm shift in public health practice. In fact, PHC has been a central strategy, since several subsequent health initiatives have established goals in the same direction that were already defined in HFA-2000. By changing the health service delivery model, PHC prefigured the sectoral reform processes of the 1990s. Similarly, PHC advanced rationalization processes by establishing a package of essential health

services. PHC innovatively made social and community participation and intersectoral coordination strategic components of change in health. It prioritized health promotion, calling for health action to be forward-thinking and demedicalizing public health. Above all, PHC maintained political concern about health as an element of social integration--that is, emphasizing its universality.

26. At different levels of scope and intensity, the countries of the Region adopted the PHC strategy as a framework for the development of human resources in health. PHC became the frame of reference for adopting and implementing policies to allocate human resources to community health services. It laid the groundwork and promoted the formation of local multiprofessional teams, whose joint efforts revived and enriched the discussions on interdisciplinary cooperation. PHC brought health personnel closer to the community, making new relationships between technical and popular knowledge about health possible and opening the way for community work. In some cases, interdisciplinary work and community participation led to the definition, development, and evaluation of comprehensive health care competencies at the local level, and to the revitalization of clinical and public health capacity, integrating that capacity into the work teams.

27. Including PHC content in the basic programs of study for health professionals and technical personnel was important in the education of nurses and, to a lesser extent, physicians. Recent studies indicate that a substantial proportion of nursing schools in Latin America adopted PHC as a key element in the curriculum and widely incorporated PHC content into teaching. In medical schools, in contrast, PHC was integrated for the most part into specific courses. There has been considerable debate about the impact on the health services of including PHC in the basic training of personnel. Some cases indicate that it had a significant impact, contributing to the creation and organization of PHC services. Other cases, in contrast, show that it did not have the expected effects in terms of the reorientation of health education in general or on the health services.

28. Progress in expanding the coverage of basic health services in several countries is credited to the regional experience in the development of PHC—progress that led to greater community outreach, greater resource mobilization, and greater participation by community actors in such areas as immunization programs, maternal and child care, essential drugs, health education, and basic water supply and sanitation. However, inequity in access to health services still persists, and there is considerable exclusion from mechanisms for social protection in health. Traditionally, populations with less access to health services have been low-income groups, people living in rural areas, and individuals belonging to specific marginalized ethnic groups within society. More recently, the access barriers for people living in the periurban areas surrounding the major cities have been substantial. These inequities are caused by a wide variety of factors, including geographical, cultural, economic, and social barriers as well as the perceived quality of the services.

29. The PHC experience has also led in many countries of the Region to modify health care models to provide contents on disease prevention, health education, and community action, including intersectoral activities. Nevertheless, the emphasis on curative medicine still prevails in health care models. Despite the call for health promotion and disease prevention in the Declaration of Alma-Ata and the appeal for the reorientation of health services in the Ottawa Charter, the prevailing models of health care in the Region are still primarily curative, based on specialized medical and hospital care. In primary care facilities, curative care still predominates over preventive and developmental activities such as health promotion and health counseling. Likewise, initiatives for intersectoral coordination have become part of daily practice at the local level of health in all the countries. In some specific cases, there is also a gap between personal and public health services, between health promotion activities in communities and those carried out in hospital clinics.

30. With the changes in the content, form, and resources for health care resulting from the application of PHC in the Region, concern has also emerged over the problem of the poor quality of health care. Every country in the Region faces major challenges in this respect. These include aspects of technical quality and of quality as perceived by users. Problems with quality show up in low levels of efficacy, efficiency, acceptability, legitimacy, and safety in health services. Their manifestations are multiple and include, inadequate problem-solving capacity at the primary health care level, lack of coordination between levels of care, inefficient use of resources, and user dissatisfaction with services. Regional experience shows us that some of the problems with quality are due to determinants imposed by the model of care.

31. Although the Region has stressed the incorporation of community personnel and the social participation in health care that the PHC strategy implies, there is a recognized need to continue strengthening social participation in health. The Region has made significant progress in developing a corps of non-physician health workers and community agents and in strengthening social participation in health. However, these advances are insufficient in many countries. In many local contexts, community participation is limited to sporadic consultation. Likewise, not every country in the Region has a political and institutional framework that includes community personnel, traditional medicine, and adequate social participation.

32. One constraint faced by the PHC strategy was the implicit understanding that the natural dissemination of innovations would be sufficient to achieve equity in health. Another patent constraint was the need for actions geared not only to reducing social fragmentation but more fundamentally, to building social integration. PHC did not adequately anticipate the dramatic changes in demographic profiles—particularly demographic aging—and the epidemiological evolution that occurred in the Americas in the final decades of the last century. Furthermore, implementation of the strategy was not accompanied by an accurate estimate of the actual costs implied by the change in health that PHC entailed and the goal of HFA-2000.

33. The experience in implementing the PHC strategy in some of the countries in the Region shows us that progress can be made toward equitable access to health services through:

(a) a strong political commitment to combat inequalities in access to health services, as part of a national strategy to reduce socioeconomic inequalities. This commitment is more effective when it becomes permanent State policy and is not limited to the efforts of a particular government administration;

(b) the allocation of sufficient financial resources and incentives of all types consistent with the proposed objectives. Moreover, formulas for allocating resources must be used that are demand-based (that is, on the needs of the population), rather than on the existing supply of services;

(c) mechanisms centered on quantitative and qualitative improvement in health expenditure and the delivery of health services to excluded populations, and

(d) more extensive coverage of insurance plans that provide a basic package of health services, for the general population or specific population groups, contributing to the expansion of social protection in health through social dialogue.

34. Regional experience indicates the health services can be reoriented toward health promotion and disease prevention through:

(a) firm political will to redesign the model of health care. In this case, transformation of the model of care implies not only changing the content of the health services by incorporating health promotion and disease prevention services, but also searching for models of care that promote outpatient care, health services in non-clinical environments (for example, schools, the workplace, the home, etc.), and use of family and community approaches that facilitate adequate knowledge about the physical, social, economic, and cultural realities of the user population;

(b) assignment of intersectoral coordination functions to local, regional, and national governments, as the case may be, and

(c) integration or coordination of personal health services with public health services. Although many public health activities are not within the health care arena, there are many cases in which both types of services can be improved through integration at the local level of care.

35. Global and regional trends over the past 25 years indicate that the quality of health services can be improved through:

(a) the development and implementation of models of care focused on the family and community. This trend is complemented with the search for health service delivery models that are more comprehensive, complete, coordinated, and regular;

(b) improvements in the capacity of local health teams to evaluate and meet the population's needs, expectations, and demands in health within a decentralized framework. At the same time, efforts should be made to improve local capacity to manage change (for example, to adjust the supply of health services to changes in the demographic and epidemiological profiles of the user population);

(c) the establishment of a political and institutional framework that considers and integrates strategies for quality assurance with strategies for continuous quality improvement, and

(d) adequate motivation and development of the technical, clinical, public health, and administrative competencies of health workers. This effort should also include competencies that promote teamwork. To accomplish this, the existing education and training plans should be reviewed and adapted to incorporate the proposed changes.

36. Regional experience shows that social participation in health can be strengthened through:

(a) the establishment of a political and institutional framework to guide and facilitate the involvement of community workers and social participation in national, regional, and local agencies;

(b) the establishment of a gradual process that requires the health authority to transfer decision-making powers to social participation agencies, and

(c) the development of models of care and health care management models that link the different levels, programs, and health care providers in an integrated continuum.

Challenges for the Future

37. Monitoring and evaluation of the goal of Health for All by the Year 2000 have revealed significant progress in health among the peoples of the Americas, attributable to the adoption and application of the principles of the primary care strategy. In addition, the persistence of conditions that militate against full achievement of the goal is also apparent, as is the need to revive HFA as a powerful vision of health that will guide health policy and achieve levels of health that will make socially and economically productive lives possible for all the people of the Hemisphere. Renewal of the HFA vision, in turn, requires reviewing the principles of PHC and reaffirming their adoption as the key strategy for health development.

38. Renewing the commitment to PHC will imply changes and adjustments in terms of the two principal understandings of the concept: as a policy approach, PHC must be seen as promoting and sustaining the development of policies that promote equity in health; as a level of care, PHC should be identified as centerpiece for the development of health services systems in the Region. In the context of the changes that have taken place in the Americas and the renewed perspective of health for all, PHC has great potential as a relevant vehicle for meeting five challenges to the future of Health in the Americas: i) intensifying efforts to guarantee universal access while giving priority to the health of the least privileged groups and to reducing inequalities in health and health care systems; ii) securing a general improvement in the health of the population, with significant reductions in the risks of maternal and child death, an increase in life expectancy, and a better quality of life; iii) health care, with a network of effective, high-quality services for individuals, families, and communities, in which all participate, iv) coordinated development of the various health care providers, and v) strengthening infrastructure and improving institutional capacity for adequate performance of essential public health functions.

39. Especially relevant as a context for renewing the PHC strategy in the Americas are the changes in the Region's demographic and epidemiological profiles. Of particular importance are urbanization and demographic aging; chronic diseases, violence, and disabilities; AIDS and other emerging diseases; vulnerability to disasters and other environmental impacts; cultural, ethnic, gender, and lifestyle diversity, and other macro-determinants of health; political/administrative decentralization; changes in health care- and health services management models; and the diversification of traditional health responses.

40. Within the larger framework of PHC as a development strategy aimed at improving the living conditions of communities, reducing the burden of disease, and fostering equitable access by the population to health care with high-quality, efficient, and effective services and resources, the principles of PHC need to be harmonized with and adjusted to the Millennium Development Goals. Because of its capacity to strengthen health services, PHC can serve as a basic strategy for achieving these international objectives.

41. Similarly, implementation of the PHC strategy must be linked with the performance of the essential public health functions, in terms of operational plans and the standards set by the health authority at the national level—the steering role in health. Of special note are the strategic importance of maintaining information systems and health monitoring; strengthening institutional capacity for health situation analysis, the production of health intelligence for management and the monitoring and evaluation of demographic interventions; and support for training the human resources of local health teams.

42. In this context, the principal lines of action for the renewed PHC strategy must be emphasized as the heart of PAHO corporate policy. At the same time, the commitment of the Member States must be renewed with this support for action, which is fundamental for improving the health of the Hemisphere's inhabitants.

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