



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 139th SESSION OF THE EXECUTIVE COMMITTEE

*Washington, D.C., USA, 29 September 2006*

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*Provisional Agenda Item 5.1*

CE139/5 (Eng.)  
28 September 2006  
ORIGINAL: SPANISH

### **HEALTH AGENDA FOR THE AMERICAS 2008–2017 Proposal for Regional Discussion**

The Director is pleased to transmit to the Executive Committee the draft Health Agenda for the Americas 2008-2017. This document is a product of the efforts of the seven Member States participating in the Health Agenda Working Group, and is a draft document for discussion purposes only; it is not intended to be quoted.

The Executive Committee is invited to comment on this draft and provide general observations regarding the concepts and areas of action described therein. In the period following this session of the Executive Committee, the draft will be further refined based on your comments, then disseminated throughout the region in a broad consultative process that will last seven months. After this process, the Health Agenda for the Americas will be launched by the ministers of health of the Region in mid- 2007.

### **Statement of Intent**

1. The governments of the Region of the Americas jointly adopt this Health Agenda to guide the collective action of national and international stakeholders who seek to improve the health of the peoples of this Region in the next decade.
2. The governments reiterate their commitment to the vision of a region that is healthier, more equitable in regard to health, and that shows improvement in the determinants of health and access to individual and public health goods and services. This commitment is to a region where all people, families, and communities have the opportunity to develop to their greatest potential.
3. The Health Agenda for the Americas is a response to the health needs of our peoples. It reflects the commitment of each of the countries to work together with a regional perspective and solidarity that supports the development of health in the Region.
4. This Agenda is the highest-level political instrument for health. It defines principal areas of action with a view to reinforcing the commitments made by countries in international fora and to strengthening the response to meet these commitments.
5. The agenda incorporates and complements the global agenda included in the World Health Organization's Eleventh General Program of Work, adopted by the Member States at the 59th World Health Assembly in May 2006. The Agenda is also aligned with the goals of the Millennium Declaration.
6. The agenda will guide the preparation of future national health plans as well as the strategic plans of all organizations interested in cooperating on health with the countries of the Americas, including the Pan American Sanitary Bureau. Assessment of progress in the areas of action outlined in this agenda will be done by evaluating the achievement of goals set in these plans.
7. The governments of the Americas emphasize the importance of ensuring that stakeholders and institutions working in health will benefit from a concise, flexible, dynamic, and high-level Health Agenda that guides their actions, facilitates the mobilization of resources, and influences health policies in the Region.

## Principles and Values

8. The Agenda respects and adheres to the following principles and values:
9. Human rights, universality, access, and inclusion. The constitution of the World Health Organization states that: “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition....” With a view to making this right a reality, the countries should work toward achieving universality, access, and inclusion in health systems that are available for individuals, families, and communities.
10. Pan American solidarity. Solidarity, defined as collaboration to advance shared interests and responsibilities to meet common targets, is fundamental to the development of health in the Region. This is particularly important for overcoming inequities and for maintaining Pan-American health security during crises, emergencies, and disasters.
11. Equity in health. The countries of the Americas seek to eliminate avoidable, unjust, and remediable inequalities in health among populations or groups defined by their social, economic, demographic, ethnic, or geographical status. Gender equity, understood as an appropriate response to the different health needs of men and women, is fundamental to reducing inequity in health.
12. Participation. Social participation in defining and carrying out public policies and assessing their outcomes is critically important to the development and implementation of the Health Agenda.

## Health Trends in the Americas

### (a) *Trends in Context*

13. Given existing evidence on the significance of *social determinants of health* as variables that explain the range of health conditions in a region or country,<sup>1</sup> it is important to review the principal socioeconomic indicators when describing the health situation trends that inform the Health Agenda for the Americas. In the period 2001–5, the per capita gross domestic product of Latin America and the Caribbean grew by 4.2%,<sup>2</sup> and poverty fell from 42.5% to 41% of the population. This means that the number of people living in poverty went from 207 million in 2000 to 213 million in 2005.

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<sup>1</sup> World Health Organization Commission on Social Determinants of Health. *Action on the Social Determinants of Health: Learning from Previous Experiences*. WHO, Geneva, 2005.

<sup>2</sup> Economic Commission on Latin America and the Caribbean (ECLAC). *Statistical Yearbook for Latin America and the Caribbean*. ECLAC, Santiago, 2005.

This region continues to be among the most unequal in the world in terms of the distribution of wealth.<sup>3</sup>

14. Inequalities in health are related to socioeconomic determinants. Wealthier countries generally exhibit longer life expectancies than poorer countries; however, the differences in life expectancy are reduced when income distribution is taken into account. Countries that have a more equitable distribution of income reach life expectancy levels that are comparable to, and sometimes better than, those of wealthier nations with a more unequal distribution of income.<sup>4</sup>

15. Population growth has slowed in all countries of the Americas.<sup>5</sup> With regard to the age distribution of the population, the increase in the proportion of people over 60 years of age<sup>6</sup> requires a response to changes in the epidemiological profile associated with an aging population. Although there are marked differences among countries, in general urban areas have grown significantly, resulting in greater access to basic services and sanitation.<sup>7</sup> However, urbanization has also been associated with widespread adoption of certain consumption patterns and lifestyles, the deterioration of social support networks, sedentary lifestyles, obesity, drug abuse, and an increase in accidents and violence.

16. Better access to education is reflected in the increase in literacy, which went from 88% of the population in 1980 to 93.7% in 2005, as well as in variable increases in school attendance in most countries. Educational coverage is greater for men than for women, especially in rural areas, and the quality of education is clearly differentiated by household income levels. As a consequence, there is less opportunity for these groups to develop healthy behaviors and have access to quality employment and improved living conditions.

17. The Region's environment has deteriorated as a result of air and water pollution and soil contamination, along with natural and man-made disasters. Natural disasters,

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<sup>3</sup> ECLAC. *Social Panorama of Latin America 2005*. LC/G.2288-P/E. ECLAC, Santiago, November 2005.

<sup>4</sup> At the end of 1990, the difference in life expectancy at birth between the richest and poorest populations was declining, with a difference of 9.8 years (75.6 and 65.8, respectively). In 2000, it was calculated that life expectancy at birth in the countries of the Region ranged from 54.1 to 79.2 years, with a difference of more than 25 years between countries with the longest and shortest life expectancies at birth. Between 1950–55 and 1995–2000, the difference in life expectancy between men and women increased from 3.3 to 5.7 years in Latin America, from 2.7 to 5.2 years in the Caribbean, and from 5.7 to 6.6 years in North America.

<sup>5</sup> Population growth ranges from 0.4% in the non-Latin Caribbean to 2.1% in Central America.

<sup>6</sup> UN Population Division, Department of Economic and Social Affairs. *World Population Ageing 1950–2050*. United Nations, New York, 2002.

<sup>7</sup> The proportion of the population living in urban areas ranges from 53.2% in Central America to 89.9% in the Southern Cone. On average, the urban population grew from 68.8% in 1980 to 78.8% in 2005.

mainly those resulting from hurricanes, have been especially severe in the Central American and Caribbean countries. Over the past 10 years, at least 20 major natural disasters have affected more than 17 million inhabitants, causing some 50,000 deaths. With regard to sanitation, 93% of the population is covered by drinking water services, but significant deficits persist in terms of clean water access in rural areas. The situation is less positive regarding excreta and household waste disposal, treatment of wastewater, and food hygiene.

18. Exclusion in health in the Region appears to be closely linked with poverty, marginalization, and discrimination (racial, social, and gender), as well as with other forms of social exclusion and cultural issues such as the language, informal employment, unemployment and underemployment, geographical isolation, and level of education and information available to health systems users. The situation is as follows: 218 million people are without protection against disease risk because they lack social security coverage in health; and 100 million people are without access to health services due to geographic location, economic barriers, or the lack of health service facilities near their homes or workplaces.<sup>8</sup> With regard to immunization, it is estimated that 40% of the municipalities in Latin America and the Caribbean do not reach the immunization goal of routinely vaccinating 95% of children under one year against polio and diphtheria, tetanus, and whooping cough; and that at least 800,000 children in Latin America have not been adequately protected against these diseases before the end of their first year<sup>9</sup>.

**(b) Trends in the Health Situation**

19. The regional health panorama is characterized by the coexistence of threats due to communicable diseases—some of them under relative control, such as tuberculosis and malaria, and others emerging, such as HIV/AIDS<sup>10</sup>—with chronic-degenerative and trauma-related illnesses. The latter have replaced communicable diseases as leading causes of death and disease in all of the countries.<sup>11</sup> Threats have appeared from changes in the characteristics of agents such as influenza viruses, whose variants could induce a severe pandemic.

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<sup>8</sup> International Labor Organization/Pan American Health Organization. *Overview of the Exclusion of Social Protection in Health in Latin America and the Caribbean*. Report presented at the ILO Tripartite Regional Meeting with the Collaboration of PAHO on “Extension of Social Protection in Health to Excluded Groups in Latin America and the Caribbean” (Mexico, 29 November to 1 December, 1999).

<sup>9</sup> Source: Annual reports from the countries to the PAHO Immunization Unit through tables from the Expanded Program on Immunization and joint forms for notification of PAHO/WHO/UNICEF for the Americas (data for 2005).

<sup>10</sup> In countries with greater access to antiretroviral treatments, mortality from HIV/AIDS has begun to decline, but the progression of the epidemic continues. It is advancing at greater strength in the countries of the Caribbean.

<sup>11</sup> Some authors have coined the term “epidemiological polarization” to refer to this profile of morbidity and mortality.

20. Despite the fact that in recent years there have been overall improvements in the traditional principal health indicators,<sup>12</sup> the health situation in the region is characterized by large differences among and within countries. Inequalities in health are marked by significant disparities related to geography, age, gender, ethnicity, education level, and income distribution.<sup>13</sup> Available indicators for the 45 million indigenous peoples are consistently worse than those for the non-indigenous population.<sup>14</sup>

21. Progress in reducing early and avoidable mortality has largely been the result of specific actions by the health sector, chiefly in primary care, such as increased vaccination coverage, family planning, and oral rehydration therapy. Although maternal mortality has declined, the region still had a rate of 71.9 deaths per 100,000 live births in 2005. This rate rises to 94.5 when only Latin America and the Caribbean are considered, with the highest rate of 523 in Haiti and the lowest of 13.4 in Chile.<sup>15</sup> Pregnancies among adolescents, for the most part unwanted, have reached 20% of total pregnancies in many countries, a situation implying evident challenges for the future mothers and their children. Avoidable causes of death, such as cervical cancer, septicemias, malnutrition, and acute respiratory infections, can be reduced through greater primary health care effectiveness and coverage.

22. In many cases, progress that can be achieved through specific actions of the health system appears to be limited. There is increasing recognition that the risk factors that require intervention and that are associated with the principal causes of disease and death are outside the direct control of the health sector. For example, deaths from external causes and from certain morbidities (such as cardiovascular disease, diabetes, chronic obstructive pulmonary diseases, HIV/AIDS) depend to a great extent on living conditions, lifestyles and behavior. To make headway in reducing the burden of preventable disease, it is necessary to review and act on the major determinants and risk factors of principal health problems. Ensuring the effectiveness of interventions requires analysis of evidence based on international experience that can support policy decisions and strategic partnerships – both inter-sectoral and inter-institutional.

23. In terms of the contribution of health to a more equitable distribution of wealth, experience shows that interventions that promote the maximum development of children's potential can improve access to productive employment and produce future

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<sup>12</sup> In Latin America and the Caribbean, infant mortality over 1985–2005 went from 56.6 to 24.8 per 1,000 live births.

<sup>13</sup> Economic Commission on Latin America and the Caribbean. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. ECLAC, Santiago, 2005.

<sup>14</sup> Pan American Health Organization. *Health of the Indigenous Population in the Americas*. 138th Session of the Executive Committee, Document CE138/13. PAHO, Washington, D.C., 12 June 2006.

<sup>15</sup> Pan American Health Organization. *Gender, Health and Development in the Americas - Basic Indicators* 2005. PAHO, Washington, D.C., 2005.

generations with greater social mobility, which continues to be severely limited in most countries of the Region.<sup>16, 17</sup>

**(c) Trends in the Health System Response**

24. Health systems have not been able to overcome segmentation,<sup>18</sup> and severe performance deficiencies in health finance policies. The situation is highly vulnerable, as some countries have extremely low levels of health expenditure and others are excessively dependent on external resources, and out-of-pocket expenditures continue to rise in most countries. All of this principally affects the most impoverished populations. In general, the allocation of resources continues to be disconnected from the service performance and results, and has not prioritized public health actions.

25. The delivery of health services is characterized by the predominance of a curative model centered on hospitals and individual care, relegating primary care and public health services to a secondary role. This model consists of a system of fragmented services<sup>19</sup> that does not effectively address user needs, nor sufficiently incorporate health promotion. When health promotion is incorporated, this model mainly calls on women to offer their services voluntarily. The model often does not base decisions on knowledge analysis and systematic lessons learned, nor does it take into account cultural diversity.

26. The health sector reform processes promoted in the 1990s focused on financial and organizational issues, marginalizing key aspects of public health. These processes undermined the role of the State in key areas, resulting in a steady decline in the ability of the ministries of health to exercise their steering role and the essential public health functions.

27. Around the year 2005, national health expenditures in Latin America and the Caribbean represented approximately 6.8% of the Region's gross domestic product; this

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<sup>16</sup> World Bank Office for Argentina, Chile, Paraguay, and Uruguay. *International Evidence on Policies on Early Infancy that Stimulate Child Development and Facilitate Female Integration into the Workforce*. World Bank Working Document 01/06, May 2006.

<sup>17</sup> P. Bedregal, P. Margozzini, and H. Molina. *Systematic review on the effectiveness and intervention costs of bio-psychosocial childhood development*. PAHO, Washington, D.C., 2002.

<sup>18</sup> Segmentation is the coexistence of subsystems with different mechanisms for financing, affiliation, and provision—"specialized" in accordance with different segments of the population—that are determined by income and economic position. Segmentation occurs, both in terms of provision as well as insurance, in a public subsystem oriented toward the poor—under the social security subsystem, specialized for formal workers and their dependents, and under the private for-profit subsystem, concentrated on the wealthiest segments of the population.

<sup>19</sup> Fragmentation is the coexistence of many nonintegrated units or entities in the health services network. This limits standardizing contents and working in a coordinated and complementary manner.

amounts to an annual per capita expenditure of US\$500.<sup>20</sup> About 48% of this figure was public health expenditure -- expenditure for Ministry of Health services and the services of other units of central and local government institutions, and health service expenditure financed through compulsory premiums to privately administered health funds or social security institutions. The remaining 52% corresponds to private expenditure, which includes direct out-of-pocket expenditures to purchase health goods and services, and health services obtained through private health insurance arrangements or pre-paid medical coverage.<sup>21</sup>

28. The scarce and poor distribution of health personnel, along with the failure to adapt personnel to actual health needs, is exacerbated by the migration of professionals within countries and by their emigration to wealthier nations. Most countries of the Americas are affected by this phenomenon, which should be addressed at the national level as well as in the context of Inter-American and international frameworks, since a sizable number of countries of the region do not have the personnel necessary to provide minimum coverage (25 human resources for health per 10,000 population),<sup>22</sup> while other countries have five times the minimum personnel. The distribution of health workers is extremely uneven, illustrated by the fact that urban areas have 8 to 10 times more doctors than rural areas. Some countries have significant imbalances in the capabilities of available personnel, with very few nurses per physician and an absence of other indispensable professions. Women occupy almost 70% of the health workforce, but they are minority in line management positions and are most affected by unemployment.

29. The panorama of health trends and their determinants in the Region of the Americas reveals the need to develop strategies to reduce inequities among and within countries. These strategies should facilitate continued progress in providing social protection to the population through health systems based on primary health care and on public policies for good health developed with community participation and implemented by well-informed, respected health authorities. With this perspective, this Agenda identifies eight areas of action.

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<sup>20</sup> Dollars adjusted for purchasing power parity (PPP).

<sup>21</sup> PAHO health expenditure database, 2006.

<sup>22</sup> The World Health Organization and the Joint Learning Initiative have proposed using a measure called the "density of human resources in health" comprised of the sum of the indicator available for all the countries: physicians and nurses per 10,000 population. The measurement of density through this method is imperfect, since it does not take into account all other health workers, but it is the only viable measure for global comparisons.



## **Areas of action: A Health Agenda for the Americas**

### ***(a) Strengthening the National Health Authority***

30. In order to improve the health situation, the national health authority should strengthen its institutional capacity to exercise its steering role in health, as well as its inter-sectoral leadership in bringing together and orienting its partners to promote human development. The authority should foster comprehensive social and community participation, as well as the involvement of all stakeholders - including the private sector - in order to meet national health goals. At the same time, the national health authority should have the legal frameworks that support its management and allow auditing of its performance.

31. The exercise of governance, leadership, and accountability are key elements that enable the national health authority to achieve high-level commitment and political will to strengthen health development. Ministries of health should fully carry out essential public health functions<sup>23</sup> and efficiently perform their role in the execution, regulation, and management of health systems. One major task is to clarify the respective responsibilities that correspond to the government, society, and individuals. Evidence-based decision-making strengthens the national health authority.

32. The national health authority should actively participate in addressing topics related to human welfare, including: globalization, migration, social protection, respect for and protection of health-related human rights, public safety and security, the labor market, the composition of public spending, equality of opportunities for men and women, and strategies to reduce poverty. Dialogue, coordination, and collaboration between ministries of health and ministries of finance and planning should center on forecasting, stability, and continuity in the allocation of financial resources to attain national human development goals.

33. While encouraging greater investment in health, governments should also develop an effective, efficient, and transparent accountability system to support the mobilization of resources and ensure their proper management. In the same vein, the national health

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<sup>23</sup> *Health in the Americas, 2002 Edition* (PAHO/WHO, Washington, D.C., 2002) identifies 11 essential public health functions: (1) Monitoring, evaluation, and analysis of health conditions; (2) Public health surveillance, research into and control of public health risks and harms; (3) Health promotion; (4) Citizen participation in health; (5) Development of public health policies and the institutional capacity for planning and management; (6) Strengthening institutional capacity in public health regulation and enforcement; (7) Assessment and promotion of equitable access to necessary health services; (8) Development and training of human resources in public health; (9) Guaranteeing and improving the quality of individual and collective health services; (10) Public health research; and (11) Reducing the impact of emergencies and disasters on health.

authorities must strengthen their capacity to plan, manage, and coordinate the use of national resources and those from international health cooperation.

**(b) *Tackling Health Determinants***

34. The national health authority should advocate for health as a priority on the sustainable human development agenda. One indicator that this mandate has been fulfilled will be recognition of the role of health determinants and the adoption in national development plans of lines of work and resources to address them.

35. The determinants of health must be tackled in order to effectively protect poorer, marginalized, and vulnerable populations. This refers to determinants that are related to (a) social exclusion, such as income, gender, education, ethnicity, disability, and sexual orientation; (b) exposure to risks, such as poor living and working conditions, unhealthy lifestyles, disinformation, difficulty in obtaining sufficient food and water, and pollution of water, food, and soil; (c) unplanned urbanization that exacerbates the inadequate delivery of water and sanitation services, and housing; and (d) the effects of climate change, which affect the poor more intensely through floods, droughts, and vector-borne diseases.

36. The actions necessary to tackle most of these determinants are outside the mandate of ministries of health and require the involvement of other governmental entities. Consequently, the national health authority has to expand the arena in which public health activities are carried out by promoting public policies for good health through inter-institutional consensus-building and intersectoral work.

37. The countries must invest more in health promotion and have policy frameworks that facilitate its development and the achievement of measurable objectives.<sup>24</sup> Countries should operate health care networks using an intercultural and gender approach, in which active social participation is a key factor. This should be supported by strengthening epidemiological surveillance systems through the inclusion of social, behavioral and lifestyle variables that make it possible to evaluate health promotion interventions.

38. Investment in social protection during infancy and in strengthening the family should be a priority in strategies directed toward tackling the health determinants. The countries should make an effort to guarantee effective protection for all boys and girls from prenatal care onward, employing technologies of proven effectiveness such as emotional bonding between parents and children and early stimulation for psychosocial

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<sup>24</sup> Jakarta Declaration on Leading Health Promotion into the 21st Century. The Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century (Jakarta, 21-25 July 1997).  
<http://www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en/>

development and resilience. This should be accomplished through integrated service networks that ensure appropriate use of subsidies by eligible families. Social risk management by the sectors responsible for public policy is essential for achieving these results.

(c) *Harnessing Knowledge, Science, and Technology*

39. The countries should systematically evaluate the status of knowledge and incorporate it into the process of selecting interventions using effectiveness criteria. This function requires the capacity to integrate, synthesize, and use knowledge in decision-making.

40. Research must be strengthened in order to better understand the relationship between health determinants and their consequences, and to identify entities that can be partners or can be influenced through public policy. Traditional medicine and indigenous knowledge that can contribute to the well-being of populations should be taken advantage of. Efforts should be made to develop the capacity for research and the use of knowledge at local levels.

41. Bioethics must be better disseminated and applied in the countries of the Americas to protect the quality of research, respect human dignity, safeguard cultural diversity and the application of knowledge in health, and ensure equitable access to scientific advances: tools, technologies, pharmaceutical products, vaccines, etc.

42. All people should benefit from progress and have access to health information and education. The countries need to strengthen: their capacity for and level of scientific dissemination; public confidence in research; and the quality of knowledge that supports health actions. Ministries of health must strengthen their capacity for information and knowledge management, and their partnerships with those who generate that knowledge.

43. The national health authority, in the exercise of its regulatory role, must guarantee the quality, safety, and efficacy of the drugs, vaccines, technology, and medical supplies used by the population in all health services. There should be national policies that facilitate access to these products and promote their rational use .

44. Health surveillance should be strengthened at the local, national, regional, and global levels. The capacity of local health teams should be strengthened in order to carry out analytical epidemiological processes that generate scientific data for health planning and for the monitoring and evaluation of interventions. Decision-making in health should be evidence-based, taking into account available scientific knowledge that is systematically and transparently summarized. Furthermore, health information should be

standardized to facilitate comparisons among and within countries, and in order to monitor and evaluate achievement of health goals.

***(d) Strengthening Solidarity and Health Security***

45. The countries of the Americas should prepare and take intersectoral measures to address natural disasters, pandemics, and zoonoses that affect individual, regional, and global health security. Necessary attention must be given to migratory movements and to commerce in food along border areas that can accelerate the transmission of diseases.

46. Concrete intersectoral interventions should be promoted to reduce social and interpersonal violence, insecurity on streets and roadways, personal and community insecurity, and conflicts. These issues are related to the broader concept of public safety, which has implications for health security.

47. Health security requires the preparation of strategies in light of contingencies that exceed national borders and demand effective and sustainable processes for subregional, regional, and global integration.

48. In view of circumstances that threaten health security, the countries of the Americas and international organizations should work together with national authorities to respond rapidly, equitably, and cost-effectively on behalf of the public.

***(e) Diminishing Health Inequities among and within Countries***

49. In trying to achieve greater equity, interventions to improve health should prioritize the most poor, marginalized, and vulnerable people. Indigenous peoples and tribal communities should be a priority. Other important groups that warrant special attention are: migrants and displaced persons; ethnic minorities; and persons with physical and mental disabilities. Countries should safeguard these groups' inclusion, their access to culturally acceptable health services, the collection and use of specific data for appropriate decision-making, and full exercise of their rights as citizens. This will enable these groups to overcome adversity, build on their achievements, and face the future. Health interventions should respond to the specific characteristics of each group.

50. Sexual and reproductive health is a priority issue in the region. It is imperative to provide woman with continuous care that starts during the preconceptional stage and continues during pregnancy, childbirth, and puerperium, including care of the newborn. Breastfeeding of children should be promoted in order to help prevent infections, dehydration, respiratory diseases, and malnutrition. Vaccination coverage should be maintained or expanded, together with the gradual introduction of new vaccines and technology when appropriate. In accordance with efforts to achieve equity, the health

authority should prioritize and emphasize specific actions that reduce maternal, neonatal, and child mortality in all groups of society.

51. With respect to adolescents and young adults, integrated care for their health and development should be expanded, including the promotion of juvenile development and the prevention of risky behaviors and associated problems, such as smoking, alcohol, and drugs, unwanted pregnancy, sexually transmitted diseases, HIV/AIDS, and violence.

52. Maintaining the functionality of elderly people should be part of health programs geared specifically to this age group. Combining economic and food subsidies to accompany these health interventions is key to ensuring that older adults adhere to health programs. Educating health workers about elderly care technologies should be a priority and the focus of specific primary health care training programs.

53. The national health authority should promote parity among the sexes in the formulation and implementation of health policies and programs. Monitoring and evaluation activities should make systematic use of data disaggregated by sex.

*(f) Reducing the Risk and Burden of Disease*

54. While efforts continue to control the transmission of infectious diseases, the countries of the Americas should emphasize action against non-communicable diseases, which have become the principal cause of morbidity and mortality.

55. Specific action should be initiated or strengthened in order to control diabetes, brain and cardiovascular disease, types of cancer with the greatest incidence, and risk factors such as hypertension, dyslipidemias, obesity, and the lack of physical activity. Other problems should also be tackled, including injuries from traffic accidents, smoking, alcohol and drugs, environmental pollution, and mental health.

56. The health authority should be very active in promoting healthy lifestyles and environments. Changes in behavior will only be sustained if they are accompanied by environmental, institutional, and policy changes that convince people to choose lifestyles that involve healthy eating habits, physical activity, and not smoking. Collaborative efforts are needed with industry to produce and market healthier foods, and with the education sector to help schools promote good dietary practices and the development of healthy habits.

57. Current actions must be sustained and innovations introduced to combat communicable diseases — including vaccine-preventable diseases, tuberculosis, malaria, dengue, and HIV/AIDS — that continue to affect the populations of the Americas. All blood collected in the region should come from voluntary, altruistic, and unpaid donors,

and all blood should be screened before being used in transfusions. A more intensive effort should be made to control "forgotten" communicable diseases, as well as diseases that can be viably eradicated. Joint efforts should be strengthened with the agriculture and livestock sectors to prevent and control zoonotic and foodborne diseases.

**(g) *Increasing Social Protection and Access to Quality Health Services***

58. Promoting universal access and improving social protection are issues of growing importance in the political and academic dialogue regarding sustainable human development in the Region of the Americas. Attempts are being made to address the uncertainty generated by the labor market and its impact on family incomes, social security coverage, and health care. In this context, public policies should progressively expand the access, financing and solidarity of social protection systems.

59. Although most countries in the region have legislation that establishes the public's right to universal health, the reality is that effective coverage is still determined by the availability of financing, without explicit criteria for prioritization in most cases.

60. This reality highlights the need to develop insurance systems with mixed and collective financing schemes that reduce the financial burden on families, protecting them from the risk of falling into poverty due to catastrophic out-of-pocket expenditures, and guaranteeing the population a basic package of health services. Given the dilemma posed in prioritizing one service over another, each country must carry out a national dialogue with relevant stakeholders that enables informed decisions that consider epidemiological, economic, equity, and financial and social feasibility factors.

61. Countries should ensure the effective extension of social protection by strengthening: (a) Access to services: the services necessary to provide health care should be available and people should have physical and economic access to them; (b) Financial security: health financing should not threaten the economic stability of households or the development of household members; (c) Collective financing: there should be inter-generational subsidies as well as subsidies that cross over between different risk groups and income levels; and (d) Dignified care: care should be of good quality and provided in an environment that respects people's cultural, racial, and socioeconomic circumstances.<sup>25</sup>

62. It will be crucial to emphasize the primary health care strategy, including universal and equitable access to health services in marginalized rural and peri-urban

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<sup>25</sup> International Labor Organization and the Pan American Health Organization. The Initiative for Extension of Social Protection in Health to Excluded Groups in Latin America and the Caribbean. ILO/PAHO, Washington, D.C., 1999.

areas where services are practically nonexistent. It should be guaranteed that these services are culturally acceptable and that they adequately incorporate local traditional practices. Strengthening referral and cross-referral systems and improving health information systems at the national and local levels will facilitate the delivery of services in a comprehensive and timely fashion.

63. Improving effective coverage of the population will require more effective and efficient service delivery. This in turn will require the use of evidence in the definition of practices and better managerial capacity in the services, while monitoring fulfillment of the commitment to reorient health services toward models of care that encourage health promotion and disease prevention with a family and community approach. Quality control is a cross-cutting requirement of all health systems and services.

64. As for service delivery, it is recognized that the private sector--for-profit and not-for-profit--plays an important role, which should be regulated by the national health authority and encouraged to help achieve the national goals in public health.

***(h) Strengthening the Management and Development of People Working for Health***

65. Governments should collaboratively address the following five critical challenges:<sup>26</sup> (a) Define and implement long-term policies and plans to develop the health workforce based on good information; (b) Find solutions to resolve inequities in the distribution of health workers, assigning more personnel to populations most in need; (c) Create national and international conditions to regulate the migration of health workers in order to avoid a lack of resources in poor countries; (d) Improve personnel management capacity and working conditions in order to get health workers more involved in their institution's mission; and (e) Link training institutions with health services for joint planning to address the needs and profiles of professionals in the future.

66. The environmental working conditions and the health of workers themselves are relevant to retaining trained staff and ensuring the quality of services provided to the population. Training of personnel in the public health sector should be emphasized. A better balance should be sought in terms of the professions that make up the health team, specifically between physicians and nurses.

67. In terms of knowledge and learning, the following should be undertaken: develop shared technical frameworks; evaluate performance using systems of measurement that are comparable between countries; finance research; and share appropriate evidence-

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<sup>26</sup> Pan American Health Organization and Health Canada. Toronto Call for Action.  
[www.observatoriorh.org/Toronto/CallAction\\_eng1.pdf](http://www.observatoriorh.org/Toronto/CallAction_eng1.pdf)

based practices. In policy aspects, ethical methods should be promoted for the hiring and protection of migrant workers, major migrant flows should be monitored to safeguard equity and justice, and support fiscal sustainability.

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