

Family and Community Medicine as the core of Health Systems Universality in Latin America: an exploratory analysis of the region

A Medicina de Família e Comunidade como Eixo da Universalidade nos Sistemas de Saúde de Ibero-América: uma análise exploratoria da região

La Medicina Familiar y Comunitaria como Eje de la Universalidad en los Sistemas de Salud de Latinoamérica: un análisis exploratorio de la región

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Abstract

The scope of Universality in service delivery in health care systems is one strategy that has proven to have great impact on global health indicators; this paper explores the situation of Latin American countries in the access to health services and the role of the specialist in Family and Community Medicine as an appropriate strategy to achieve individual, family and community coverage. **Objective:** To contribute to the development of concepts and practices related to Universality in Primary Care and Family and Community Medicine in Latin America. **Methodology:** qualitative and quantitative exploratory study by applying an electronic form self-administered survey type with open and closed questions to members of associations of family and community medicine in Latin America, scientific associations, teachers and health managers identified in each country. **Results:** 63 people from 21 countries completed the electronic survey sent, taking a representative sample of Latin American countries; 84% agreed with the concept of universality with focus on Primary Health Care and Family and Community Medicine, 47% agree that the main determinant limiting the scope of the universality in health care is the structure in management and health, followed by finance (36%) and the model of care (30%). Of the total respondents, 67% believe that the main constraint to universal coverage is the structure and health management and 60% felt that national health policies are not focused and prioritized towards universality of the APS and the MFC.

Keywords:

Universality
Universal Health Coverage
Primary Health Care
Health Determinants
Global Health

Funding:

none declared.

Ethical approval:

not necessary.

Competing interests:

none declared.

Provenance and peer review:

externally reviewed.

Received: 08/15/2016.

Accepted: 09/15/2016.

Cite as: Meoño TM, Anderson MIP, Cuadrado MS, Araya P. Family and Community Medicine as the core of Health Systems Universality in Latin America: an exploratory analysis of the region. Rev Bras Med Fam Comunidade. 2016;11(Suppl 2):4-16. [http://dx.doi.org/10.5712/rbmfc11\(0\)1382](http://dx.doi.org/10.5712/rbmfc11(0)1382)

Resumo

O alcance da Universalidade na prestação de serviços nos sistemas de saúde é uma das estratégias que tem demonstrado ter grande impacto sobre os indicadores globais de saúde. **Objetivo:** contribuir para o desenvolvimento de conceitos e práticas relacionadas à universalidade na Atenção Primária à Saúde (APS) e na Medicina de Família e Comunidade (MFC) na Ibero-América, mediante a exploração da situação dos países latino-americanos em relação ao acesso aos serviços de saúde e o papel do especialista em medicina familiar e comunitária para alcançar uma estratégia adequada para a cobertura individual, familiar e comunitária. **Metodologia:** estudo exploratório quali-quantitativo, realizado por aplicação de um questionário em formato eletrônico auto-respondido, com perguntas abertas e fechadas, dirigido aos membros de associações de medicina familiar e comunitária na Ibero-América, associações científicas, professores e gestores de saúde identificados em cada país. **Resultados:** 63 pessoas de 20 países completaram a pesquisa eletrônica enviada, havendo uma amostra representativa de os países Ibero-Americanos; 84% concordaram com o conceito de universalidade elaborado a partir do enfoque da Atenção Primária à Saúde e da Medicina de Família e Comunidade; 47% concordam que o principal fator determinante que limita o alcance da universalidade nos cuidados sanitários é a estrutura da gestão em saúde, seguido do financiamento (36%) e do modelo de atenção (30%). Do total de entrevistados, 67% acreditam que a principal restrição para a cobertura universal é a gestão da estrutura da saúde e 60% sentiram que as políticas nacionais de saúde não estão focadas e priorizadas para a universalidade da APS e da MFC.

Palavras-chave:

Universalidade
Cobertura Universal em Saúde
Atenção Primária em Saúde
Determinantes de Saúde
Saúde Global

Resumen

El alcance de la Universalidad en la prestación de servicios en los sistemas de salud, es una de las estrategias que ha demostrado tener gran impacto sobre los indicadores de salud global. **Objetivo:** contribuir con el desarrollo de los conceptos y de las prácticas relacionadas a la Universalidad en Atención Primaria y Medicina Familiar y Comunitaria en Iberoamérica, mediante la exploración de la situación de los países iberoamericanos en cuanto al acceso a los servicios de salud y el papel que cumple el médico especialista en Medicina Familiar y Comunitaria para lograr una adecuada estrategia de cobertura individual, familiar y comunitaria. **Metodología:** estudio exploratorio cuali-cuantitativo mediante la aplicación de un cuestionario electrónico autoadministrado mediante una encuesta con preguntas abiertas y cerradas a los miembros de las asociaciones de medicina familiar y comunitaria de Iberoamérica, asociaciones científicas, profesores y gestores de salud identificados en cada país. **Resultados:** 63 personas de 20 países cumplimentaron la encuesta electrónica enviada, teniendo una muestra representativa de los países iberoamericanos; 84% estuvieron de acuerdo con el concepto de universalidad con enfoque en Atención Primaria en Salud y Medicina Familiar y Comunitaria, 47% acuerdan que el principal determinante que limita el alcance de la universalidad en la atención en salud es la estructura en gestión y salud, seguido del financiamiento (36%) y del modelo de atención (30%). Del total de encuestados, 67% consideran que el principal limitante hacia la cobertura universal es la estructura y gestión en salud y 60% consideraron que las políticas nacionales en salud no están enfocadas y priorizadas hacia la universalidad de la APS y la MFC.

Palabras clave:

Universalidad
Cobertura Universal en Salud
Atención Primaria en Salud
Determinantes de Salud
Salud Global

Introduction

In 1978, the Declaration of Alma-Ata about Primary Health Care called for action for health, social and economic sectors for the “achievement of the highest attainable standard of health”, leading to the movement of Health for All that obtained a big boost in 1980 and 1990. In 1997, a new concept is inserted in the health sector, aiming to extend support to increase health practices. At the 1997 Conference of the World Health Organization, a definition on intersectorial action for health originated:

“A recognized relationship between part or parts of health with the part or parts of another sector that has been formed to decide on an issue to achieve health outcomes (or intermediate health outcomes) in a form more effective, efficient and sustainable than could be achieved by the health sector alone.”¹

However, universal health coverage shows an irregular and inadequate pattern in Latin America. According to the Pan American Health Organization, WHO and the United Nations Economic Commission for Latin America and the Caribbean, available data indicate that improving access and coverage, along with the reduction of inequalities in health, constitute a pending task in most Latin American countries.

Health systems in Latin America are highly fragmented. The rights granted, coverage and institutional arrangements vary among different groups of the population. In the countries of this region, health systems are usually organized by a combination of traditional public sector services for low-income groups; social security services for formal employees (in some cases extend to their families), and private services for those with ability to pay. The lack of coordination between the three sub-sectors has been a source of inefficiencies and inequities, once that fragmentation hinders the efficient use of the resources required to achieve universal health coverage.

In some countries it has tried to integrate contributory funded by taxes on wages, with public systems financed by general taxation; in others, there remains a great segmentation. Costa Rica is a traditional reference, considering that the funding sources are integrated to ensure a unique level of coverage. Currently ensures health coverage to more than 93% of the population, and about 50% of the amount contributed by employees in the formal sector covers the financing of health services of the population that does not contribute.²

Different situation occurs in Chile, where integration is partial, since individuals decide whether to enroll in integrated public system (National Health Fund, FONASA), financed by contributions and by general taxes; or a private insurer (health insurance institutions, ISAPRES). Because any real choice depends, significantly, to the income of the contributors, the Chilean system is considered a dual system. Chile has an almost universal coverage of social insurance, where the 80% of the population is covered by FONASA, and 17% by ISAPRES.³

Universality and Universal Health Coverage

Universality on Health is defined as the coverage that the population has for accessing health services and fulfill their right to it, which must be protected financially by public policies and actions of the state. Must have scale and intensity proportional to the needs, which was defined by Marmot as proportionate universalism “actions must be universal, but with a scale and intensity that is proportional to the disadvantaged, rather than focusing only on the most favored”,⁴ thereby articulating the definition of Universality with Equity. Therefore, it is necessary to recognize equitable access to health services as a human right and not a privilege for those working in the formal sector or with greater financial resources.

Refers then to the right of the population to have access to health services with integral approach, integrated and continuous, regardless of socioeconomic or geographical condition of the individual, family or community.

Build universal health systems requires not only health authorities will, but also a societal consensus that puts health and its determinants in the center of national priorities. It means reaching a new social pact to devote major efforts on improving the conditions and quality of life. Fully meeting the health needs and promoting proactive interventions in factors and social determinants such as education, food, social security and environmental care.

However, for the recognition of the universality as a human right can be a common denominator among nations, strategies to achieve this goal they must be defined by each country, since it is a complex process of adapting health systems at the national level. Achieve universal coverage goals requires defining the progressive percentage of the population covered, the services to be provided and the costs to be covered.⁵

The World Health Report 2010 defines the concept of Universal Health Coverage (UHC) as a goal that “all people have access to services and do not suffer financial hardship paying for them.” According to this definition, the objective of the UHC is clear, namely to ensure, for all, access to health care is needed with proper financial protection.⁶

For a community or a country can achieve UHC have to meet several requirements, namely:

1. Existence of a solid health system, efficient and functioning, that meets the priority health needs within a focus on people (including services related to the care of patients with HIV, tuberculosis, malaria, not communicable diseases, maternal and child health) which shall:
 - provide people with information and incentives to stay healthy and prevent diseases,
 - detect diseases an early stage,

- have the resources support to treat diseases,
 - help patients through rehabilitation services.
2. Affordability: there must be a system of financing health services, so that people do not have to suffer financial hardship to use them.
 3. Access to essential medicines and technologies for the diagnosis and treatment of medical problems.
 4. Adequate health workforce well trained and motivated to provide services that meet the needs of patients, based on the best scientific evidence available.

The UHC can be achieved through different institutional and financial strategies, but came to be thought of as an offer of insurance plans which cover a limited set of health services offered by public or private providers of health. But, different from that, universal health system (UHS) seek to promote the development of a single public institution to provide and finance all medical and preventive services to citizens.⁷

In the seventies, the Primary Health Care (PHC) was proposed as the model to ensure that all citizens enjoy their right to health, with governments responsible for setting the PHC as part of comprehensive national health systems.⁸ This institutional arrangement has been termed as integral, unified or universal health system (UHS)^{9,10} presupposes, therefore, the existence of a single public entity responsible for the provision of preventive services and medical care to all citizens, with the same pattern of care regardless of their socioeconomic status. Equity is one of the main objectives of UHS, because all people receive comprehensive care based on their health needs and not on ability to pay.⁷

In the Letter of Quito, produced as a final product of the V Ibero-American Summit of Family and Community Medicine, universal coverage is defined as: *“the guarantee of the right to health for everyone, provided by a comprehensive and integrated basis state system with public financing, allowing access to services equitably, equal, timely, comprehensive and quality, based on the principles of solidarity and social participation; taking the first level of care as the focus of care, with male and female Family and Community doctors in health teams, ensuring the first contact and continuous monitoring, focusing on the person, their family and community context, in accordance with the health needs presented in the course of their lives”*.¹¹

Universality in Iberoamerica

Latin American health systems face the challenge to regain the equity value, for which measures must address the different levels of government involved.

It is not about decide whether to set priorities, but what is the better way to do it; because in the process of achieving universality they have introduced different ways to define priorities and shape their health benefit plans, experiences from which we can obtain three lessons:

1. Benefits plans offered in the region, have different shapes and sizes and are not restricted to a list of essential services even in societies with severe resource constraints. Comprehensive plans are described in countries such as Chile, Colombia, Costa Rica and Uruguay; restricted plans are described in Mexico, Peru and Argentina.
2. The countries of the region require institutional capacities to define and regularly update benefit plans. They require political and technical leadership backed by legal grounds, in addition to adequate resources to provide quality services available, accessible and acceptable; hence the importance of financial resources and investment in human resources and infrastructure.
3. It is necessary to improve the monitoring of health policy and evaluation at the national level, in order to establish whether, in fact, effectively plans have resulted in improvements in health and health quality in a happier citizenship.

To achieve universal health coverage an agenda focused on research and development of skills for setting priorities is required, with the Latin American experiences as a starting point.³

Another challenge is to exert effective steering role of state that results in a generating presence of order and should be, in the context of all available resources and according to the scientific-bioethical and technological trends, who guarantees the right to protection health and reflected in access to quality and timeliness. All this is possible if there is a responsible and sustainable criteria of equity, efficiency, transparency and accountability financing; based on a homogeneous model of care based on social determinants and the increasingly resolute primary care. Also in the actions of disease prevention and health promotion, organized through networks of public and private institutions offering comprehensive services and high quality to the population this one last being the one that would become subject passive to active.

Several countries are in the process of implementing reforms of their health systems based on primary health care. In most of them are presented the following challenges: availability of human talent and trained in sufficient numbers; need to overcome the fragmentation/segmentation of health systems; ensure financial sustainability; improve governance, quality of care and information systems; reduce inequities in health; expand coverage; prepared to face the consequences of an aging population and changing the epidemiological profile and increase the response capacity of the public health system.

The PHC has the potential to reduce social inequities in health approaching universality; for which the following objectives and key areas suggested:¹²

1. Collect and disseminate information for action:
 - a. Social variables in clinical history as educational level, have key indicators such as teenage pregnancies, quality criteria related to equity in health care for example: accessibility and loss to follow according to social variables, diagnosis of the social determinants of health, knowledge and characterization of the needs of the population served.
 - b. Provide updated information on local resources and initiatives for citizens.
 - c. Report on: the relationship between socioeconomic status and health outcomes, social inequalities and inequities in the quality of the relevant care at PHC, the impact of the management of PHC on the health of the population, its determinants and the social determinants of health (SDH).
2. Strengthen social participation: fostering capacities and knowledge on population health:
 - a. Inform users of their rights to health and patients' rights.
 - b. Collaborate in the development of programs aimed at capacity development in the population that facilitate their participation.
 - c. Strengthening and development of the roles of area nurse and pharmacist and empowerment of equity and social determinants of health in professional networks.
3. Education and training of human resources:
 - a. Have practical knowledge and expertise in the application of interventions on social determinants of health.
 - b. Enhance training in health promotion and disease prevention framed in action on the social determinants of health and dissemination of good practice.
 - c. Harness deformations to show the relevance of equity. Generate training materials that show the contribution to clinical and social effectiveness of incorporating the axis of equity to health care, and allocates the resources necessary to act on SDH.
4. Intersectoriality:
 - a. Knowledge of health and social resources.
 - b. Foster partnership working with other sectors (education, social services, local agents, ...).

- c. Include the axis of equity in all intersectoral action plans and projects following.
 - d. Development of intersectoral participation organs.
 - e. Encourage professionals to promote intersectoral action
5. Reorienting health care:
- a. Consider the impact of daily practice in health inequalities and targeted interventions to complement universal coverage mechanisms.
 - b. Expand recruitment services in the streets and homes of unserved population.
 - c. Comprehensive care of the person according to their needs devoting time to consider the root causes of their health problems and devoting time and effort in proportion to the need.
 - d. Identify groups that do not access and facilitate their coverage.
 - e. Development of structures to strengthen community action in health primary care teams, in collaboration with other sectors (education, social services, local agents, public health, etc.).
 - f. Establish procedures to deal with the circumstances and needs of disadvantaged and marginalized groups, and to eliminate existing barriers to accessibility.

Relationship between Universality, Primary Care and Family and Community Medicine

In 2010 the member states of PAHO/WHO reaffirmed their commitment to the vision of the Declaration of Alma-Ata to recognize that the PHC, including the promotion and protection of health, are essential not only for the welfare of individuals but to ensure sustainable and inclusive socio-economic development.

Defining a health system based on PHC, as a comprehensive approach to the organization and operation of health systems, makes the right to attain the highest level of health its main goal, while maximizing equity and solidarity of the system.

Individuals can meet their health needs to get universal health coverage and access to system services without the ability to pay constitutes a limiting factor. Universality becomes a target image towards which guide system transformation. These terms are commonly understood as the existence of units of primary care homogeneously distributed in a territory.

Universality is determined strongly by Primary Care because:

- It is the entrance door to health system.
- Territorialization with situational diagnosis, identifying groups that do not have access.
- The capacity for action of its community dimension: empowerment, participation.
- Partnerships that can establish with other actors - intersectoriality.

It is worth mentioning that the PHC as the core of health systems is presented today with a renewed focus, reasoned and based on the evidence so that it can achieve a universal, comprehensive and integrated care.

Different studies already put in evidence that health systems based on the principles of PHC have the ability to solve at least 80% of health problems of a defined population, at a sustainable cost, especially if it has the support and participation of the community, economic and social sectors.

Various experiences of PHC with the effective participation of Family and Community Physician can be found in many countries, including Mexico, where "Primary Care is Family Medicine, and is the permanent care provided in the first point of contact, oriented to the person and his family; that meets the health needs of each person. It refers only those rare cases. Coordinates care involves continuous care, equity, emphasis on prevention and promotion. Organization and management practices at all levels to achieve quality, efficiency and effectiveness. Adequate and sustainable human, economic and technological resources".¹³

Objective

Considering the importance of the Universality and the role of Family and Community Medicine, and a qualified PHC to achieve it, this study aimed to: reviewing the concept of Universality in Latin American Health Systems and knowing Doctors of Family and Community perspective on this concept. Moreover, get the information on the situation of Latin American countries in relation to universal health coverage, considering the stage of PHC and FCM in Iberoamerica.

Methodology

An exploratory quali-quantitative study was performed by applying an electronic questionnaire, with open and closed questions, to members of associations of family and community medicine in Iberoamerica, scientific associations, professors and health managers identified in each country. In the first phase it was asked to a group of collaborators review an initial proposal of Universality conceptualization, based on the concepts conceived during the previous summits. Furthermore, put questions whose answers might meet the objectives related to obtaining information about the situation of the Iberoamerican region in relation to the proposed concept. In the second phase, a survey was developed as a collection tool, based on analysis and proposals recommended by the collaborative group (see appendix). The third phase took place in the framework of the VI Ibero-American Summit of Family and Community Medicine conducted on 12 and 13 April 2106 in San Jose, Costa Rica; where the Universality Sub-Working Group had the opportunity to review the contributions derived from the survey and propose a series of recommendations to achieve a regional improvement in obtaining better access to health services, according to the criteria evaluated.

Results

63 people from 20 countries completed the electronic questionnaire sent out, having a representative sample of the Iberoamerican countries; from which, 58 were specialists in Family and Community Medicine and the remaining 5, resident doctors in the same specialty. (Figure 1)

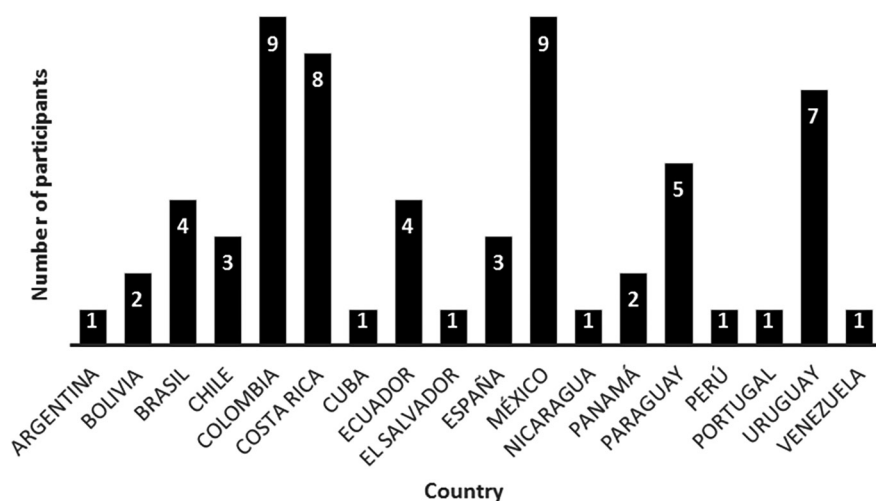


Figure 1. Distribution of participants by countries in the online survey on the assessment of the Universality Health in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

In relation to the agreement with the proposed Universality concept, from the perspective of the family and community doctor, 84% of respondents agreed with the statements, 13% did so with respect to general but provided suggestions, 2% disagreed and 1% did not respond (Figure 2).

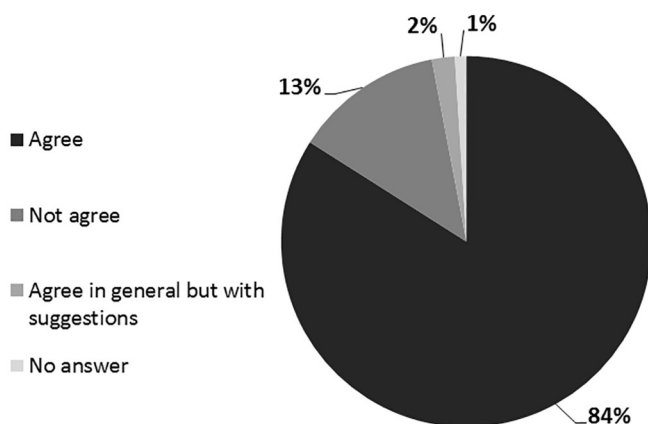


Figure 2. Concordance with the concept of Universality raised in the electronic survey on the assessment of the Universality Health in countries belonging to CIMF-WONCA. 2016
 Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

The consultation on the main determinants in Latin America that limit achieve universality of the PHC and the FCM showed that: 75% of respondents agree that the main determinant is the structure and health management; followed by finance (57%), inadequate Health Care System model (48%), insufficient qualified human resources and the lack of steering role (35%); inadequate social participation and inadequate accountability (30%), lack of access to medicines and health technologies (21%) and inefficiency in the performance of essential public health functions (17%). (Figure 3)

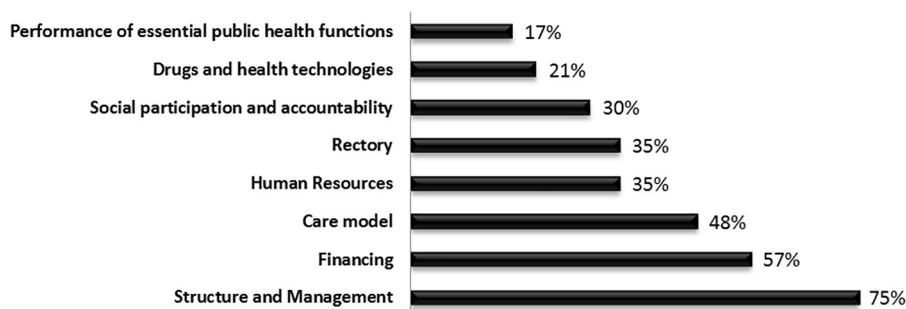


Figure 3. Principal determinants in Latin America that limit achieving the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016
 Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

The analysis of the answers on the factors limiting considered by country to achieve the universality of the PHC and FCM showed that 67% of respondents agree that the main determinant is the structure and health management; followed by finance (51%), insufficient human resources (46%), the Health Care System model (40%), the rectory (38%), social participation and accountability (35%), access to medicines and health technologies (17%) and the characteristics of the performance of essential public health functions (17%). (Figure 4)

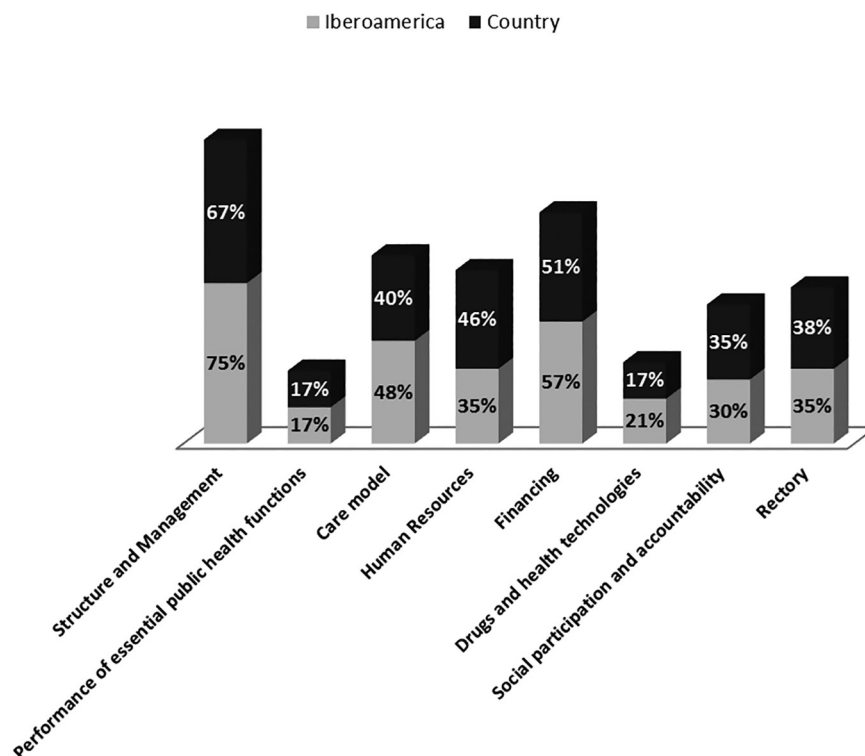


Figure 4. Main factors by country and region level that limit achieve the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016
Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

Of all respondents, 60% considered that, in the context of Latin America, national health policies are not focused and prioritized towards universality of the PHC and the FCM in Latin America and 48% think similarly for their countries; 17% indicated that policies do exist in this context at the level of Latin America and 28% at the country level (Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Spain, Mexico, Nicaragua, Portugal and Uruguay). (Figure 5)

Discussion

Although participation of 20 countries of Latin America was held, the data collected in the survey represent the perception of only 63 participants; thus limiting obtain a comprehensive picture of the situation of universal health coverage in the region.

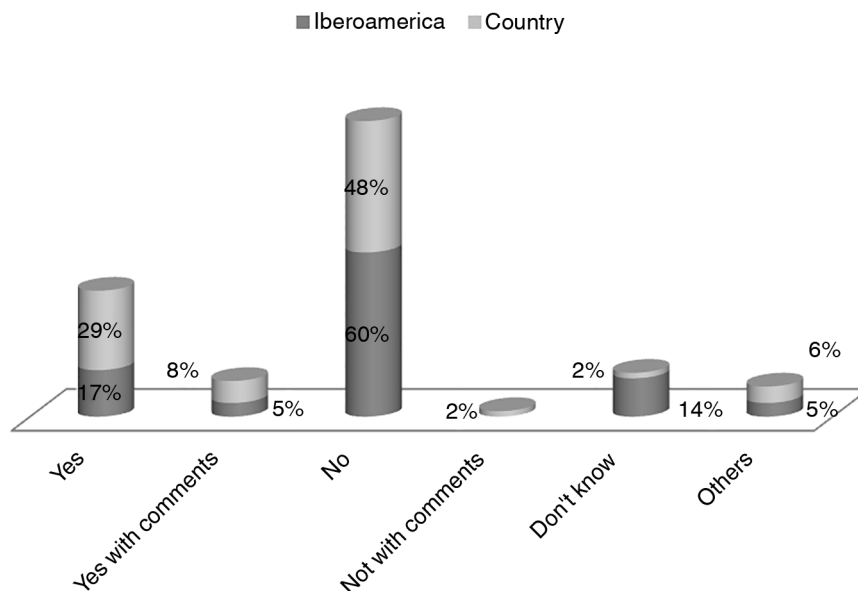


Figure 5. Perception of the existence of national policies that allow achieving the universality of the PHC and the FCM in countries belonging to CIMF-WONCA. 2016.

Source: Electronic self-administered questionnaire. Subgroup 1 Axis Universality, Equity and Quality in Health Systems: The Family and Community Medicine as Axis. 2016

However, it is interesting to verify that the data analysis is consistent with what explored by other authors as Ortiz Salgado et al.¹⁴; who performed a comparative analysis of two health systems to highlight strategies and gaps for greater universal health coverage, highlighting the need for national policies focused on primary health care with participation of Family and Community Medicine.

There is variability in the perception of the concept of universality in the region, which could be explained both by lack of dissemination of the work and proposals of the previous summits; as well as the lack of a better internalization of the concept, considering the reality of each country, and their understandings about the meaning of comprehensive health care to the population.

Conclusions

To achieve universal health coverage must act strategically in the five key action areas of primary health care: (1) Collect and disseminate information for action; (2) Strengthening social participation: fostering skills and knowledge of the population on health; (3) Training and capacity building of human resources; (4) Acting intersectorally; (5) Reorient health care.

There is a Latin American consensus (over 80% of countries) that the concept of universality involves the right of the population to have access to Primary Health Care (PHC) and Family and Community Medicine with comprehensive approach, integrated and continuous, regardless of socioeconomic or geographical condition of the individual, family or community.

Even though in some countries there are policies geared towards achieving the universal coverage of health services; continuous, balanced and structured work is necessary to ensure that those populations with less access to services reach, staggered and well-defined manner, the route process to define the scope according to their realities.

The active participation of members of the CIMF in the context of developing country policies to achieve improved access to services is necessary and binding; regional strategies must be generated in which those with more experience provide a platform for the countries universalization, find a space of consensus on which to prepare their strategies for presentation to local governments.

Recommendations

From the work done during the two days of the VI Ibero-American Summit of Family and Community Medicine in the city of San José de Costa in April 2016, based on the literature review and analysis of the survey; the following recommendations were derived:

1. Rescue and disseminate the concept of Universality developed and consensus in the Charter of Quito under the V Ibero-American Summit of Family and Community Medicine.
2. Strengthen the primary care level with the presence of Family and Community Doctors based on primary health care strategy, ensuring contact regardless of geographical, social and economic status of the population.
3. Effectively and equitably manage of resources, based on the analysis of the health situation of the population, and also integrating social participation as one of its axis.
4. Family Medicine as the axis of the first level leading the multidisciplinary team, keeping the individual, family and community approach, with emphasis on activities of health promotion, prevention and education.
5. Establish transdisciplinary qualified teams with leadership of the specialists in Family Medicine and Community to ensure effective access of health services to individuals, families and communities in the First Level of Care.
6. Guarantee the resources to enable the first level of care to realize their potential to solve most of the problems/needs of the individual family and community equipment; estimated at least in 80%.
7. Each country should strengthen mechanisms for planning and national dialogue on the requirements in the formation and transformation of specialists in Family and Community Medicine; guaranteeing their employment and equitable distribution depending on the needs of the population.

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Annexes

Survey prepared with contributions from the collaborator group:

Universality concept focusing on the PHC and FCM:

1. What do you think are the main determinants in Latin America that limit achieve universality of Primary Health Care and Family and Community Medicine?

- a. Structure and Management
- b. Performance of essential public health functions
- c. Care model
- d. Human Resources
- e. Financing
- f. Drugs and health technologies
- g. Social participation and accountability
- h. Rectory

Please justify:

Other:

2. What do you think are the main determinants of your country that limit achieve universality of PHC and the FCM?

- a. Structure and Management
- b. Performance of essential public health functions
- c. Care model
- d. Human Resources
- e. Financing
- f. Drugs and health technologies
- g. Social participation and accountability
- h. Rectory

Please justify:

Other:

3. Do you consider that national health policies in Latin America are focused and prioritized towards universality of the PHC and the FCM?

- a. Yes
- b. No
- c. Don't know

Please justify:

4. Do you consider that national health policies of your country are focused and prioritized towards universality of the PHC and the FCM?

- a. Yes
- b. No
- c. Don't know

Please justify:

5. What are the main strengths of the health system of your country that ensure achieve universality of the PHC and the FCM in your region?

- a. Existence of a management policy that values and invests in PHC and FCM
- b. Good performance of essential public health functions
- c. Existence of a Care Model suitable to PHC and the FCM
- d. Existence of Human Resources policy towards the maintenance and strengthening of PHC and FCM qualified and quantity required
- e. Existence of a financing policy that specifically supports the development of the PHC and FCM
- f. Availability and access to drugs and health technologies
- g. Social participation and accountability

Please justify:

Other:

6. How do you think that family medicine can influence achieving fulfill the principle of universality in your country?