

**International Workshop:
Strategies to Sustain Comprehensive Primary Health Care**

Cuenca, Ecuador September 14-17, 2009

Workshop Report

Rapporteur: Walter Flores

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Sixteen researchers from both Canada and Latin America participated in the workshop. The annexes include the workshop agenda and a brief bio of each participant. What follows is a summary of the discussion and agreements achieved during the meeting.

Discussion on concepts

One of the issues that emerged during country presentations is the lack of consensus on basic definitions. Although the recent article by Labonte and colleagues¹ proposes a characterization of Comprehensive Primary Health Care (CPHC), several of the participants thought that country experiences being presented reflected primary care and first level of care but not CPHC experiences. Country presenters explained that they were presenting the actual situation, which is characterized by a lack of CPHC. After this initial discussion, it emerged that we should clarify when we are talking of CPHC as a goal to be achieved, and when we are characterizing the country experiences, which in most parts have been selective PHC and not CPHC.

A second moment of discussion emerged when trying to clarify what is the relationship and differences between the concept of CPHC and other concepts such as “healthy communities/cities” and “health systems strengthening”. Some of the central questions related to concepts that emerged are: How CPHC relates to health systems? Is CPHC part of health systems? Is CPHC bigger than health systems? And who should lead CPHC? Is it the health system/sector? Or should it be a ministry of social development or such?

- Some of the answers to the above questions that were provided during the discussion were:
Relation of CPHC with healthy communities: They are related if they are connected through the health system or primary care services.
- The concept of PHC belongs to the health sector and one of the purposes is to move the health system towards more intersectorial work, therefore, under PHC the health sector leads. Once there is work in other sectors, those sectors should lead. Other sectors may use different names or concepts (e.g. sustainable development in the environment sector) to refer to their intersectorial work.

¹ Labonte et al (2009) Implementation, Effectiveness and Political Context of Comprehensive Primary Health Care: Preliminary Findings of a Global Literature Review. *Australian Journal of Primary Health* — Vol. 14, No. 3, pp 58-67.

Scope of action in CPHC

There was a discussion about what should be the scope of action for an intervention to be accepted as PHC and even CPHC. For instance: Do policy efforts and reforms in a city or geographical region constitute CPHC? Do they have to be efforts led from the central level? Do they have to be universal interventions to be catalogued as CPHC?

CPHC under the public sector: Does it mean covering for every single illness and disease including the use of every single new drug and technology?

What are the minimal requirements to name an experience as PHC or CPHC? What should it include?

Intersectorial work

The issues of intersectorial work generated considerable discussion among participants. It was clear that intersectoriality is very important, not only in developing countries but also in Canada. It is also important for working on health determinants.

Some participants suggested that there should be a clear definition on what constitutes intersectorial work since it may mean a very different thing to different people. A participant gave the example that some people think of intersectorial work as if the health care sector should do everything whereas for others, intersectorial work means having strategic coordination with other sectors and public policies.

Other participant put forward the question of what is the role of public institutions within intersectorial work: Must public institutions be responsible for implementing activities and achieving outputs/outcomes? Or is implementation not as relevant as long as the funding for intersectorial work comes from public institutions?

Other questions of relevance that emerged during the discussion were:

- What should be the involvement of other sectors?
- Must the health sector lead to be considered PHC?
- Who should participate? What should be the level of integration?
- What are the ethical concerns of intersectorial work? What are the cross-cultural concerns?

The presentation of the Brazilian experience also generated important questions about the role of municipalities in CPHC. Should it be a provider? Should it be an ally?

Factors affecting universality and sustainability

The experience presented by Rosario (Argentina) showed a successful policy reform that expanded PHC and improved equity of access, particularly for poor population groups. However, it also showed the opposition of the middle class to finance (through taxation) a public system that is not being used by them (since they have social or private insurance). From the above, the questions emerged were:

How can “wealthy” be drawn to support public systems? How to draw in middle classes to use public system? Under what conditions do middle and upper classes accept to pay for a health care system that they are not using?

In the above questions, the structure of fiscal (taxation) systems is central, including the relevance of progressive taxation systems, hence a relevant question is: What taxation and fiscal measures are necessary to sustain CPHC policies?

In the discussion of PHC sustainability and the importance of fiscal structures/policies, we have to be aware that there is competition to obtain fiscal resources, not only within the health sector but also for all the other sectors (education, employment, justice etc) therefore, we should not fall in the trap of competing among social sectors or pushing for “health imperialism”. Rather, this is the opportunity to bring CPHC into the discussion of wider social policies, including human and sustainable development.

There was also discussion on the challenges of sustaining CPHC in segmented health care systems (as it is the case in most Latin American countries). It was argued that one option is pushing for a unified health care system that would reduce the negative consequences of segmentation.

There was also a relevant discussion about the arguments to move public opinion and political decision towards CPHC sustainability. An important argument is the non-health care benefits of a more equitable health system and of intersectorial work that can be obtained through CPHC. These benefits are good for the governability of society, which was referred to as the strengthening of democracy, equity and social justice.

Human resources

The discussion of issues around human resources was generated by the presentation on the Cuban experience. From the presentation, it was clear that a powerful element in the successful experience of Cuba with CPHC is the ethics and value system that are part of the training of all human resources. Hence, some relevant questions proposed by participants were:

What are the explicit values of medical and nursing school curricula? What is the content of such curricula that may be considered as pertinent to CPHC?

The Cuban experience also generated questions from participants on replicability in other contexts. There are conditions embedded in the Cuban political system that enables policy changes and the sustainability of interventions. It is also clear that Cuba faces very different political pressure groups than the rest of the countries face.

Other questions emerging from the Cuban experience (particularly in relation to the high ratio of medical doctors per population) include whether efficiency is being maintained, and the risk of “over-medicalization” of PHC. In here, the relevant questions put forward by participants were:

- What is the role of physicians in relation to broader community/other professions?
- What is the right “mix” of profession?
- What are the optimal ratios (i.e. # of physicians per population) to obtain the best benefit for equity and others goals?

The experience of Brazil with community health agents and other countries with community health workers (CHW) in general, generated an important discussion among participants. The discussion was about the implications of having voluntary/salaried CHW that are accountable to their communities as opposed to having CHW employed (and salaried) by ministry of health/municipality or NGOs. The central questions in this topic are:

- How does the use of community health workers (voluntary or paid) affect CPHC?
- Are voluntary workers essentially disempowered?
- What are the power relations between CHW and other professionals that are part of PHC teams?

Information Systems

The issue of information systems also generated a good deal of discussion. Several of the key components of information systems were addressed:

How comprehensive should an information system be for CPHC? Health information systems should not be reduced to morbidity and mortality only. It should open-up to information from wider socio-political contexts. However, there are additional questions:

- Do we need to create comprehensive information systems managed by PHC staff?
- Should we coordinate and connect with other information efforts that are already being implemented (such as Public/health intelligence and information systems for sustainable development)?

Another relevant question debated in the group was: *What are the technology and information platforms that are needed for CPHC?* In El Salvador, the lack of integrated information systems is causing major problems to advance in the process of implementing CPHC. In the case of Canada, some participants commented that there may be very good integrated data; however, it exists alienated from people that take decisions or people that are relevant for that information (this could be health care authorities and workers at the local level, amongst others).

In HIS (health information system) it is important to recognize who will steer the information. Should we expect that the health system is responsible for all intersectorial information? Or should we have a clear framework in which it is recognized how the different information systems, under different sectors, coordinate and communicate with the health sector system?

Some other key questions emerged during the discussion were:

- Does having a ‘comprehensive’ system of health information (including social determinants of health) lead to change in practices or policies within health sector, across other sectors, and under what socio-political or other contextual conditions?
- What systems exist for measuring the impact of community development/social activism as part of CPHC? What would be the measures of empowerment? How does such information affect ‘higher level’ policies?
- What is the role of qualitative data in HIS?

Governance of CPHC

All participants agreed on the relevance of governance, however, it is worrying that very little research has been done on that topic. This could be an opportunity for research on governance of PHC.

There was also a discussion on the importance of clarifying what “approach” to governance we were talking about since there are several different approaches. When the World Bank talks of good governance, is different (conceptually and ideologically) from what the UNDP (United Nations Development Program) refers to, and the work of other groups that talk of “democratic governance”.

It is important to describe and analyze all the different political processes and pressure groups (corporation and others) that play a role in decision-making. This was evident during the presentations of Quebec and Guatemala. The central questions that emerged during the discussion were:

- How does a more democratic, transparent, accountable system of governance of CPHC improve outcomes related to comprehensiveness?
- What is the role of social participation in ensuring such governance?
- What models/styles of democracy in decision-making are supportive/enabler of CPHC?
- What incentivization exists (economic, normative, values-based) for ‘good’ governance?
- Does an emphasis on governance remove responsibility of government?
- What role can human rights play as an enabler of democratic governance?

DAY THREE: BRAINSTORMING AND DISCUSSION ON COLLABORATIVE RESEARCH PROPOSALS

Day three was devoted to discussing how to bring the issues and questions identified in day 1 and 2 into collaborative research proposals. Two proposals were identified and a very general outline for each of them was drafted:

Proposal 1: Comparative studies of Community Primary Health Care Centres

Building on the T-Corti program, a research proposal could be developed around a set of questions of equal importance to Canadian CPHC and Latin American CPHC. A comparative case study approach, perhaps selecting 2 or 3 CPHC centres in both Canada and in LA (but not more) could be used.

Potential Canadian sites: Somerset West CHC, Saskatoon Community Health Clinic, CLSC in Quebec, Nova Scotia (North End Health Centre)

To determine: Key questions, sites in LA: One or two of largest centres in Rosario (~40 staff) (with Jeannie Haggerty), Bogotá (building on past case study), Bolivia (Cochabamba possible, Ernesto Báscolo/Maija Kagis to follow up), Polyclinic (Cuba) (Robert Huish and Jerry Spiegel, with research partners from Cuba), Cuenca (Arturo Quizhpe) (health centre going from more medicalized to more comprehensive PHC).

Key research activities:

- A brief literature review based on other search terms associated with, but different from, CPHC terms (e.g. sustainable development and health; social protection and health) but would need to be carefully constructed.
- A critical review of other initiatives (e.g. World Bank in Latin America) that appear to be close in theme to our concerns.
- Incorporate into research design meetings with associations of health centres to re-frame questions, share experiences, form a response/advisory committee to individual case study centres
- Incorporate a history/contextualization of each of the case studies.
- Social scientist/key informant interviews; documentary analysis
- Need for an internet platform

Team: Ron Labonté, Ernesto Báscolo, Arturo Quizhpe/José Ortiz, Walter Flores, Maija Kajis, Robert Huish, Corinne Packer.

Proposal 2: Prospective case study of CPHC reforms in El Salvador, Ecuador, Argentina and Guatemala.

This will require some discussion of the key questions (which could be similar to those for the CPHC centre case-studies; and include as one focus the expansion and role of community health workers/health promoters and a ‘de-medicalization’ of the health system); and considerable thought on methodology, although a participant/observer ethnography with additional secondary data and interviews/focus groups might suffice.

- Basic approach:
Documentation of policy intention for reform (political context, stated policies, key informants); ongoing monitoring of meetings (observer), policy changes, data on impacts, 2 or 3 researchers for triangulation (ethnographer, political scientists).
- Requires an advisory group (involving all case countries and Canadian researchers?).
- Researchers would be locally based but with advisory group comprised of researchers all case countries, and Canadian researchers (1 or 2 only).
- 3 year study plan.
- Also Participatory Action Research-PAR (to include some policy people).
- Two approaches/designs: ethnography and PAR, thus a triangulation of methodologies.
- Possibility of adding epidemiologist at later date if new secondary data become available, to work across all three cases
- Plan B if the key actors disappear due to political forces: Feasibility of study; may require abandonment if no longer possible. If participant/observer ethnography, documentation can continue but PAR may be compromised

Team and countries: Ecuador: Arturo Quizhpe, Jaime Breihl; Guatemala: Walter Flores; El Salvador: Eduardo Espinoza, someone in University (not government); LA/international advisory group: Ron Labonté, Corinne Packer, Jeannie Haggerty?

ANNEXES

Agenda for Meeting on Strategies to Sustain Comprehensive Primary Health Care

14-16 September 2009

Monday, 14 September	
8:30- 9:30	<p>Introduction and comments.</p> <p><i>Arturo Quizhpe Peralta</i></p> <p>Introduction to CPHC/governance issues and materials to be discussed</p> <p><i>Ronald Labonté</i></p>
	SESSION ON NORTH AMERICA
9:30-11:30	<p>(C)PHC in North America (Canada and US)</p> <p><i>Presented by Ron Labonté</i></p> <p>Community Health Centres (CHCs) in the other provinces</p> <p><i>Presented by Maija Kagis</i></p> <p>Community Health Centres (CHCs) in the province of Quebec</p> <p><i>Presented by Terry Kaufman</i></p> <p><i>Commentator: Robert Huish</i></p>
	SESSION ON SOUTH AMERICA
11:30-12:30	<p>(C)PHC in Ecuador</p> <p><i>Presented by Arturo Quizhpe Peralta</i></p> <p>(C)PHC in Argentina</p> <p><i>Presented by Ernesto Báscolo</i></p> <p><i>Commentator: Maria Hamlin Zuniga</i></p>
12:30-1:30	Lunch

1:30-2:45	<p>(C)PHC in South America in general and Colombia in particular</p> <p><i>Presented by Román Vega Romero</i></p> <p>(C)PHC in Brazil</p> <p><i>Ligia Giovanella</i></p> <p>(C)PHC in Cuba</p> <p><i>Robert Huish</i></p> <p><i>Commentator: Ernesto Báscolo</i></p>
	SESSION ON CENTRAL AMERICA
2:45-4:45	<p>(C)PHC in Central America in general and Nicaragua in particular</p> <p><i>Presented by Maria Hamlin Zuniga</i></p> <p>(C)PHC in Guatemala</p> <p><i>Presented by Walter Flores</i></p> <p>(C)PHC in El Salvador</p> <p><i>Presented by Eduardo Espinoza</i></p> <p><i>Commentator: Francoise Barten</i></p>
4:45-5:00	<p>Overview of the day and briefing for next day.</p> <p>Determination of key issues and questions to carry forward into next day.</p> <p><i>Discussion co- chaired by Ronald Labonté and Arturo Quizhpe Peralta</i></p>

Tuesday, 15 September

8:45-12:30	<p>Spill over from Monday</p> <p>Guest speaker: <i>Jerry Spiegel</i></p> <p>Open discussion on key issues and questions for maximum learning and benefits.</p> <p><i>Discussion chaired by Ronald Labonté and Francoise Barten</i></p>
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	Short coffee break during this session.
12:30-1:30	Lunch
1:30-5:00	<p>Identifying the findings to bring forward into the consensus statement of the meeting.</p> <p>Preparation of a draft consensus statement to share with symposium participants for feedback.</p> <p><i>Discussion co-chaired by Walter Flores and Maija Kagis</i></p> <p>Short coffee break during this session.</p>

Wednesday, 16 September	
8:45-12:30	<p>Identifying the important gaps in knowledge for future research and possibilities for funding this research.</p> <p><i>Discussion co-chaired by Ronald Labonté and Román Vega Romero</i></p> <p>Coffee break during session.</p>
12:30-1:30	Lunch
1:30-2:30	<p>Continuation of morning discussion on gaps in research and potential collaboration</p> <p><i>Discussion co-chaired by Ronald Labonté and Román Vega Romero</i></p>
2:30-4:45	<p>Discussion of outline of report to funder</p> <p>Identification of anything else we want to bring up at Symposium</p> <p><i>Discussion chaired by Walter Flores and Arturo Quizhpe Peralta</i></p>
4:45-5:00	<p>Closing of meeting and Special thanks to the Global Health Research Initiative (GHRI) and the Canadian Institute of Health Research (CIHR) for their contributions.</p> <p><i>Arturo Quizhpe Peralta and Ronald Labonté</i></p>

List of participants

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Representative of the People's Health Movement, Canada.

Maija Kagis has worked as a consultant in health policy, particularly primary health care and health systems, for many years. She worked in the first health centres in Canada, and has worked throughout Latin America. She is currently the coordinator of the Canadian People's Health Movement, and continues to research and write on health systems issues.

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Terry Kaufman is a consultant and speaker on health, social and community services in various Canadian provinces and member of the board of directors of the Canadian Alliance of Community Health Centres Association (CACHCA). Terry was Executive Director of CLSC Notre-Dame-de-Grâce, a community health centre providing primary health care services in western Montreal. In recent years, He has been working on the dossier of privatisation and equity of access.

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Is Assistant Professor in International Development Studies at Dalhousie University. He holds a Ph.D. in Geography from Simon Fraser University, a Trudeau Foundation Scholarship and a SSHRC post-doctoral scholarship at the Université de Montréal. His research interest deals with strengthening human resources for health in the global South, and specifically on how medical education impacts migration and retention. He has focused extensively on Cuba's Latin American School of Medicine and its impact in training thousands of physicians for poor and vulnerable communities. He has published his recent findings in Social Science & Medicine, WHO Bulletin, Global Health Watch 2, Public Health, as well as in various other journals.

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Graduation in Medicine (Federal University of Santa Catarina, 1979), Master in Public Health (1989) and PhD in Public Health (National School of Public Health/ Oswaldo Cruz Foundation, 1998). Currently is senior researcher of the Health Management and Planning Department/ National School of Public Health/ Fiocruz, Rio de Janeiro, Brasil, and coordinator of project Southern Cone Countries Multi-Center Study in Primary Health Care: Health Care Models, Health System Integration and Intersectorality in Urban Contexts in Argentina, Brazil, Paraguay and Uruguay. Experience in the field of Public Health/ Health Policy working mainly in the areas of health systems comparisons; evaluation; health reform; primary health care and family care.

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<p>Graduated from the Faculty of Medicine of Nijmegen's University, master in epidemiology (CIES, Nicaragua). Investigator in Systems and Policies of Health of Radboud Universidad Nijmegen. Prof. Honorary of JOIN León, Nicaragua. She takes part in the management committee of the project ALCUEHealth</p>	
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<p>Jerry is Director, Global Health, Liu Institute for Global Issues; and Associate Professor, School of Population and Public Health at the University of British Columbia (UBC). He is a Michael Smith Foundation for Health Research Scholar and Canadian Institutes for Health Research (CIHR) Institute for Population and Public Health New Investigator. He was also founding President of the Canadian Coalition for Global Health Research. Jerry currently directs research programs on globalization, social organization and health and the ecosystem approach to human health and vulnerable populations. His focus is on Latin America and he currently heads projects in Cuba and Ecuador on effective intersectoral and transdisciplinary methods for managing environmental health risks, with specific investigations into the integration of primary care provision with the management of health determinants and ways to strengthen the capacity of universities to work effectively with communities and other stakeholders. He is presently director of a 6 year UPCD Tier 1 project, "Sustainably Managing Environmental Health Risks in Ecuador" that includes the University of Cuenca.</p>	
ROMAN VEGA – ROMERO	roman.vega@javeriana.edu.co
<p>Román Vega Romero is currently Associate Professor, Faculty of Economics and Management, at the Pontificia Universidad Javeriana in Bogota, Colombia. His focus is on health policy, health and social security and health systems governance. He recently conducted an extensive literature review of comprehensive primary health care experiences in South America and is publishing the findings from the review. Román has also worked as a researcher and public health advisor for the City of Bogota.</p>	
MARÍA HAMLIN ZÚÑIGA	maria@mundonica.com
<p>Public Health Activist US citizen who has lived for nearly 40 years in Central America, in both Nicaragua and Guatemala. Profession: Public Health Educator with Masters in Public Health from the University of Minnesota, USA. Founder and President of the Board of the Center for Information and Advisory Services in Health, Nicaraguan NGO. Founder and Coordinator of the Regional Committee for the Promotion of Community Health, a network of Primary Health Care Programs that has been functioning for 33 years in Central America, Mexico and the Caribbean. Founder, and former Global Coordinator of the International Peoples Health Council - IPHC. – a politics of health network . Member of the Steering Council of the Global People’s Health Movement and of the Coordinating Commission of the Latin American People’s Health Movement.</p>	
EDUARDO A. ESPINOZA	eduardo@espinoza.ca
<p>Eduardo Espinoza is former Dean of the School of Medicine, Secretary for National and International Relations of the University of El Salvador with extensive research and teaching experience in public health. He has long been active in the People’s Health Movement (Movimiento de Salud de los Pueblos). On 1 June 2009 he was appointed Vice-Minister of Health in El Salvador.</p>	
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Walter has been working as a university lecturer, project manager and as a consultant in the area of Health Systems Development, Equity, Governance, Health and Human Rights. His work has been carried out in more than 20 countries in Latin America, Africa, Asia and Europe. His current interests are in the area of citizen participation in public policy-making, development of conceptual frameworks and data collection tools to research health systems governance and the assessment of the right to health in developing countries. He is the principal researcher of the project: "Strengthening Governance through improvements in Equity and Accountability in Health Systems of Latin American Countries", funded by IDRC-Canada. Walter is the director of the Center for the Study of Equity and Governance in Health Systems, a private research organization based in Guatemala. Walter is also a past President of the Executive Board of the International Society for Equity in Health.

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