COMPACT 30 • 30 • 30
PHC FOR UNIVERSAL HEALTH

Pan American Health Organization
World Health Organization
Americas

PAHO

Universal health
Access and coverage for all

. . . a call to action to the countries of the Region to make PHC the linchpin of health systems for Universal Health

Background

On April 9 and 10, 2019, the launching of the Report of the High Level Commission "Universal Health in the 21st Century: 40 years of Alma-Ata", was held in Mexico City within the framework of the Universal Health Strategy, approved by PAHO in 2014, and the 40th Anniversary of the Declaration of Alma-Ata. The event was attended by representatives of twenty-nine countries, including seventeen health ministers, members of the Commission, international partners and representatives of civil society.

During the closing ceremony, Dr. Carissa Etienne, Director of the Pan American Health Organization, following the recommendations of the High-Level Commission called the countries of the Region to make primary health care (PHC) the linchpin of health systems to accelerate the movement towards universal health and the achievement of the 2030 Sustainable Development Goals (SDGs).

The commitment to Universal Health

Universal health is the foundation of a system based on the values of Primary Health Care: the right to health, equity and solidarity.

The four lines of the Strategy for universal access to health and universal health coverage include the transformation of health systems and the recommendations made by the High-Level Commission:

1. Expanding equitable access to comprehensive and integrated quality health services, centered on people, families and communities. This implies the integration of services and their management, as well as their organization in integrated networks of health services at the territorial level, in which the cornerstone is a first level of care with effective resolution capacity.

2. Strengthening the stewardship and governance of health systems, which means that, through processes of dialogue and social participation, policies, plans, legal and regulatory frameworks are developed, considering the right to health, equity, solidarity in health and the well-being for all people, leaving no-one behind.

3. Increasing and improving financing with equity and efficiency, and advancing towards the elimination of direct payment that constitute a barrier to access at the point of service. As necessary conditions, this implies advancing towards the elimination of direct payment at the point of service, increasing public spending on health to at least 6% of the gross domestic product (GDP), and improving equity and efficiency in the allocation and use of financial resources, with transparency and accountability.

4. Strengthening coordination and intersectoral action to promote public policies that impact access barriers and health determinants. This means advancing at the national, sub-national and territorial levels to articulate the social, sectoral, intersectoral and community stakeholders, as well as the development of economic and social policies that promote and protect well-being, health and human development for the whole of society.

Advances in access to health and health coverage based on these lines are being made slowly in the Region. One of the main challenges is the persistence of the different access barriers to health (table 1). This is explained by the limited efforts to transform health systems towards a new model of care based on PHC, as well as by the lack of public resources invested in health, particularly at the first level of care.

The Compact 30•30•30: PHC for Universal Health

The Compact 30•30•30, PHC for Universal Health is a call to action to intensify and accelerate the efforts of the Region to achieve universal health and the SDGs by 2030. It is a compact to reaffirm that health is a right, and universal means **universal**, that is, that all people have access to and coverage of comprehensive and quality health services, and interventions to address the social determinants of health, without incurring financial hardship.

This requires the commitment to transform health systems of the Region, a concerted effort to eliminate access barriers by at least 30%, and increasing public spending on health to at least 6% of gross domestic product, with 30% of these resources invested in the first level of care. This will catalyze the transformation necessary to achieve universal health and the SDGs by 2030.

Transform health systems by 2030

It is necessary to transform health systems, based on Primary Health Care, with real and inclusive social participation, particularly of groups in conditions of vulnerability. It is necessary that the countries of the Region advance and promote changes in the health systems paradigms, because at present health systems are not addressing the needs of the population, new challenges in health and advances in knowledge and technology. A new model of care focused on people and communities, on health and not disease, is necessary. The new paradigm must incorporate equitable, inclusive, comprehensive, quality services based on PHC. In addition, it must influence health determinants with explicit intersectoral interventions based on the inalienable right to health for all people, and must strengthen public health capacities, with emphasis on the essential public health functions. These transformations in health systems of the Americas cannot wait. Now is the time to transform to achieve universal health by 2030.

The Strategy for Universal Access to Health and Universal Health Coverage calls for progress to improve access to comprehensive and quality health services, progressively expanded and consistent with health needs, system capacities and the national context. It is not enough to improve the coverage and supply of health services. In addition, progress must be made in eliminating the barriers to access that the population faces. Institutional, geographical, economic, organizational, social and cultural barriers constitute the main impediments to equity, health and development in the 21st century (table 1).

Reduce by at least 30% barriers to access health

The Compact 30•30•30 calls on countries to reduce barriers to access health by at least 30%, progressively by 2030, with actions in both the health and other social sectors. This a prerequisite for the Region to achieve Universal Health and the SDGs. Many of these barriers are related to health determinants. Therefore, the elimination of barriers implies the need for sectoral and intersectoral action, and to improve the governance of health systems. This process of defining health, social and inclusive policies to reduce barriers must be carried out with a rights-based approach and increasing the commitment and participation of individuals and communities. To meet the needs of the population, and in particular of people in situations of vulnerability, requires changing the traditional way of making policies and planning in health, and thinking about barriers that prevent people from having effective access to services and to the exercise of the right to health.

Allocate at least 30% of public expenditure on health to the first level of care

Increasing and optimizing public financing in a sustainable way to expand access and reduce inequities means increasing public financing to at least 6% of gross domestic product and allocating new resources efficiently, progressing towards eliminating direct payment and allocating at least 30% of these resources at the first level of care. This will improve resolution capacity of health services networks.

The replacement of direct payment with new public resources will increase the financial protection of the population, avoiding exposure to catastrophic expenses and the risk of impoverishment as a result of health events or conditions.

The Compact 30 30 30 calls for the expansion and strengthening of the first level of care with high resolution capacity, fully integrated into well-organized health services networks, devoting the necessary resources to do so. Health services networks must have the capacity to provide comprehensive quality services, including specialized services.

This effort involves four areas of action: *a)* Improve health equity by providing services and interprofessional teams at the first level of care, as close as possible to all people and ensuring the opportunity, quality and availability of care, resources and supplies in a sustainable way; *b)* Strengthen the capacities of the first level of care to meet the individual and collective health needs of the population and communities, so that the first level of care coordinates and articulates the network of specialized outpatient, hospital and community support services; *c)* Strengthen the capacity of service networks to ensure continuity and quality of comprehensive care; d) Increase public spending on health to reach at least 6% of gross domestic product and invest at least 30% of these resources in the first level of care, prioritizing health spending and improving efficiency in their allocation and use (table 2).

Table 1: Indicators of expenditure and barriers to access to health

Country	Classification according to income *	Population reporting having a health problem who do not seek formal health care services **	Public expenditure on health per capita USD PPP (2016) ***	Out-of-pocket expenditure on health per capita USD PPP (2016) ***	Public expenditure on health % of GDP (2016) **	Public expenditure in NAP% of public expenditure on health (different years) ****	Out-of-pocket health expenditure% total expenditure (2016) ***
Argentina	High	5.6%	1,140	242	5.6%	24.0%	15.8%
Barbados	High	6.0%	607	598	3.2%	33.0%	45.2%
Canada	High	4.0%	3,465	690	7.7%	24.7%	14.6%
Chile	High	6.2%	1,171	696	5.0%	21.0%	34.8%
United States	High	9.7%	8,078	1,094	14.0%	15.2%	11.1%
Uruguay	High	5.0%	1,404	340	6.5%	22.0%	17.4%
Costa Rica	Medium High	3.2%	933	276	5.6%	22.2%	22.1%
Mexico	Medium High	20.1%	507	392	2.9%	28.3%	40.4%
Jamaica	Medium High	15.4%	324	120	3.7%	20.0%	22.4%
Bolivia	Medium Low	66.0%	326	139	4.5%	38.1%	28.0%
El Salvador	Medium Low	41.0%	387	163	4.5%	44.2%	27.2%

Source: Prepared by PAHO.
Note: countries chosen according to available public expenditure data at the first level of care as a percentage of public expenditure on health
* World Bank Country and Lending Groups. Countries classification; ** Household surveys with health module. Last available for each country. The Multiple Indicator Cluster Survey was used in Argentina and Jamaica. In these countries the information corresponds to the percentage of mothers who did not seek formal care for their children under the age of 5 who had diarrhea or symptoms of acute respiratory infection..
*** WHO. Database of health expenditure in the world; **** Tracking Healthcare Financing Resources for Primary Healthcare in LMICs. Wang, H and Berman P, Editors. In press.

Table 2: Maternal mortality, avoidable mortality and chronic diseases

Countries	Country classification by income (World Bank)	Avoidable Mortality	Avoidable Mortality	Avoidable mortality: Percentage change comparing rates between 2001 (as a basis) and 2010	Maternal mortality ratio, estimated (*) (100,000 live births)		Estimated incidence of tuberculosis (100,000 pop)		Prevalence of high blood pressure, standardized by age (%)			Prevalence of elevated blood glucose / diabetes, standardized by age (%)		
		2001	2010	2001 vs 2010	2015		2017		2015			2014		
		Total (men and women)	Total (men and women)	Total (men and women)	(80% UI)		(UB) (&)		Men	Women	Total	Men	Women	Total
Argentina	High	264.45	225.73	-14.6	52	(44-63)	26.0	(23-31)	27.6	17.6	22.6	9.9	9.5	9.7
Barbados	High	187.39	222.65	18.8	27	(19-37)		(0-0)	27.0	21.7	24.4	10.5	13.7	12.2
Canada	High	168.63	139.44	-17.3	7	(5-9)	5.5	(4.7-6.3)	15.6	10.8	13.2	6.2	4.8	5.5
Chile	High	241.72	195.23	-19.2	22	(18-26)	17.0	(15-20)	25.4	16.5	20.9	10.2	10.8	10.5
United States	High	240.29	204.67	-14.8	14	(12-16)	3.1	(2.6-3.5)	15.3	10.5	12.9	8.2	6.4	7.3
Uruguay	High	255.74	220.01	-14.0	15	(11-19)	31.0	(27-36)	24.7	16.8	20.7	9.1	9.8	9.5
Costa Rica	Medium High	243.62	192.26	-21.1	25	(20-29)	9.7	(7.4-12)	21.0	16.3	18.7	8.8	8.9	8.9
Mexico	Medium High	301.42	295.24	-2.1	38	(34-42)	22.0	(17-28)	22.3	17.3	19.7	10.9	11.5	11.2
Jamaica	Medium High	255.7	243.67	-4.7	89	(70-115)	5.1	(3.9-6.5)	24.5	19.2	21.8	9.3	14.4	11.9
Bolivia	Medium Low	n/a	n/a	n/a	206	(140-351)	111.0	(73-158)	19.7	16.1	17.9	7.0	8.9	8
El Salvador	Medium Low	318.13	279.8	-12.0	54	(40-69)	72.0	(55-91)	20.4	17.2	18.7	9.3	10.7	10.1

Source: Pan American Health Organization. Core Indicators 2019: Health Trends in the Americas.
Notes: countries chosen according to available public expenditure data at the first level of care as a percentage of public expenditure on health.
Avoidable Mortality: measures premature death due to health problems that could be avoided. The comparison was made using age-adjusted rates.
(*) Estimates of the United Nations' Inter-Agency Group with 80% of uncertainty interval (UI).
(&) Uncertainty bounds (UB) and ranges were defined as the 2.5th and 97.5th centiles of outcome distributions.

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