

Perspectives for Primary Health Care public policy in South America

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THEMATIC ARTICLE

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Abstract *We aim to conduct a comparative analysis of the implementation of PHC in nine South American countries. Three dimensions were highlighted from documentary sources: political commitment, leadership, and governance; care model; and engagement of communities and other stakeholders. The results indicate a formal commitment that places PHC at the center of efforts to achieve universal access. The following can be observed: revitalization processes in public subsystems, based on guaranteeing preventive, promotional, curative and rehabilitation actions; PHC as gatekeeper; emphasis on family and community; assigned population and territory; multidisciplinary teams; and, in some cases, the accent on interculturality expressed in the concept of “buen vivir” (good living). The PHC revitalization processes were affected by political changes. Between progress and setbacks, the segmentation of coverage was not overcome. The current moment seeks to recover more inclusive and broad public policies in the context of the return of the progressive and democratic fields. The dissemination of country experiences can contribute to the development of a comprehensive, integrated, and quality approach to PHC in the Region.*

Key words *Primary Health Care, Delivery of Health Care, Universal Access to Health Care Services*

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Introduction

The comprehensive approach to Primary Health Care (PHC) has become a fundamental component of policy and responses to numerous health issues in South American countries. However, developments in PHC have been heterogeneous¹. PHC revitalization gained prominence with the redemocratization and rise of more progressive governments² from the first decade of the 21st century.

The challenges of building democratic institutions and promoting social inclusion in a context of intense disparities were incorporated into the government agenda, and the fight against poverty was a priority. Several social assistance programs have been implemented, including non-contributory pensions and conditioned income transfers, breaking up the relationship between social protection and the labor market³. In this context, the perspective of universal health systems based on new PHC models has achieved greater visibility, although we still need to overcome the segmented coverage and fragmented care⁴.

In 2022, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) proposed an operational framework that identifies structural and operational strategic conditions for developing health systems based on a comprehensive approach to PHC⁵. It reaffirms the need to strengthen leadership, management, and governance through a renewed emphasis on essential public health functions, the ability of care networks to expand access, and the sustainable expansion of public resources to finance social protection⁵. However, the road to this proposal is not trivial and has faced obstacles, mainly with conservative governments that settled in South America countries in the 2010s⁶. Undoubtedly, analyzing PHC public policies in the Region, their advances, and setbacks, primarily modulated by the context of new democracies, is central to constructing health systems based on the conception of health as a right.

This article aims to conduct a comparative analysis of the implementation of Comprehensive PHC in selected South American nations. From a cross-sectional perspective, we attempted to identify similarities and contrast divergences. We aimed to learn lessons that shed light on the political strategies for the ongoing construction of PHC and that reinforce the guarantee of universal access to health in our unstable democracies.

Methods

We prioritized three dimensions of the PHC Operational Framework for the cross-sectional analysis – political commitment, leadership, and governance; the care model; involvement of communities and other stakeholders – based on the document “Primary Health Care Measurement Framework and indicators: monitoring health systems through a primary health care lens” - PHC monitoring conceptual framework⁵. The dimensions were informed by the study “Primary Health Care in South America” developed by the South American Institute of Health Government (ISAGS) of UNASUR¹ (Chart 1). The dimensions cover structural and operational conditions of governance and organization of health systems based on the comprehensive PHC approach.

To achieve the objective of this current study, we reviewed nine South American countries from a previous study⁷⁻¹⁰: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, and Uruguay. The sources of information and production of the data were bibliographic review, document analysis, searching on the websites of the Ministries of Health and other government bodies, and documents of international organizations. The documentary and bibliographic analysis was complemented with data from the World Health Organization (WHO) and the Economic Commission for Latin America and the Caribbean (ECLAC).

The comparative analysis among the countries and an overview of them enabled us to formulate lessons learned from reform processes. In this way, we could identify future challenges to transform and build resilient health systems based on a comprehensive and integrated PHC approach.

Results

Political commitment, leadership, and governance

Leadership, political commitment, and governance reflect a comprehensive vision and formal commitment (policies, laws, and structures) that places PHC at the center of efforts to achieve universal health access⁵ (Chart 1).

Legislation on the right to health access

In democratization processes, several South American countries enacted new constitutions

Chart 1. Adapted conceptual framework for the analysis of PHC strategic conditions, 2022.

Dimensions	Definition	Categories
Political commitment, leadership, and governance	Political commitment and leadership placing PHC at the center of efforts to achieve universal health. Governance structures, policy models, and regulations to support PHC that build alliances within and between sectors and promote community leadership and mutual responsibility.	Health legislation in place
		Social protection in health and health coverage segments
		National Health Policy oriented to PHC and universal access in place
		Attributions of government spheres in PHC
Care model	Care models that promote high-quality PHC focused on people and essential public health functions, such as the core of integrated health services throughout life.	Approaches and PHC care models
		Service design
		Physical infrastructure
		Care coordination and integration of networks
		PHC labor force
Involvement of communities and other actors	Commitment of communities and other actors from all sectors to define problems and solutions and prioritize actions through political dialogue, valuing intercultural policies and actions.	Use of digital health technologies in PHC
		National, subnational, and local strategies for community participation
		Coordination mechanisms between sectors with community participation and commitment
		Interculturality

Source: Authors based on the WHO/UNICEF⁵ and Giovanella *et al.*¹.

where the right to health access must be guaranteed by the State, however, with diverse Government coverage and responsibilities. The right to universal access is explicit in the National Constitutions of Brazil (1988), Bolivia (2009) and Ecuador (2009). In Colombia, the 1991 Constitution enshrines the right to health access as a public service and responsibility of the State, recognized by the Constitutional Court, and the 2015 Statutory Health Law ratifies the right to health access as essential. In Uruguay, it was defined in national legislation (2007). In Paraguay, the right to health access became more explicit with the 2008 National Health System reform. In Argentina, it is established from international statements/pacts that the country has ratified. In Peru, the Constitution defines the right to health access with mixed powers of the State and market. Chile is preparing a new constitution with expanded social and health rights.

Social protection in health and health coverage segments

South American health systems have taken on different shapes with the reforms of the last two decades. However, it was not possible to overcome the segmented coverage with the pres-

ence of subsystems. In these contexts, adopting a comprehensive PHC approach requires a greater leadership capacity by health authorities to coordinate the different stakeholders and institutions responsible for providing services.

Chart 2 synthesizes the segments of social protection in health in the nine countries.

The existence of a national PHC-oriented health policy

All nine countries highlight PHC in national policies as a priority for reducing inequalities and achieving universal health access despite persistent, fragmented networks and inequalities in access and coverage.

National laws or regulations were updated from the first decade of 2000 or ministerial regulations (Argentina, Brazil, Chile, and Paraguay). Seven countries – Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, and Peru – formulated new PHC care models in the period.

Attributions of government levels in PHC

Countries define political guidelines and organize general lines for the operation of PHC from the national level. In all cases, the Ministries of Health are the main responsible for for-

Chart 2. Segments of social protection in health in selected South American countries, 2022.

Country	Social Security (Social Welfare for Formal Market Workers)	Insurance focused on impoverished population or specific group	Ministry of Health and/ Subnational Government Spheres	Private and Prepaid Insurance
Argentina 2019	National Social Works (35%) Provincial Social Works (16%) Social work of retirees – Comprehensive Medical Assistance Program (PAMI) (11.6%)	Explicit guarantees in state health plans – Birth Plan and National Health Plan	Universal access (mainly for the third of the population without coverage of social works) 35%	Prepaid Medical Companies (13.6%) - Voluntary affiliation in part linked to social works
Bolivia 2021	19 Health Funds	Until 2021: Universal Maternity and Childhood Insurance (SUMI) Elderly Health Insurance (SSPAM)	From 2021 – Unified Health System for 51% of the population not covered by the Funds	–
Brazil 2022	–	–	Unified Health System (SUS) formal universal access (100%)	Prepaid Medical coverage (Health Plans) and Voluntary Private Insurance (payments for companies or individuals) (25%)
Chile 2020	Contributory and non-contributory public insurance: National Health Fund (FONASA) (78%)	–	Ministry of Health attends FONASA's insured	Pension Health Institutions (ISAPRE) - Mandatory Affiliation Private Insurance (14%)
Colombia 2021	Affiliation to Business Plans Management (EAPB) Tax regime (insurance can be public or private) (45.3%) Special regimes (4.3%)	Subsidized regime (49.3%) (financed with fiscal resources and contributions)	–	–
Ecuador 2020	Ecuadorian Social Security Institute (17.6%) Campesino Social Security (6.5%) Armed Forces and Police (3.4%)	Maternal and Child Insurance for up to 5 years	Universal access (70%)	Prepaid medical coverage (8%)
Paraguay 2019	Social Security Institute (19%) Military and Police Health (2%)	–	Ministry of Public Health and Social Welfare Universal Access (73%)	Savings funds, health mutual funds, and private insurance (7.5%)
Peru 2022	Social Health Insurance (EsSalud) (25%)	Comprehensive Health Insurance (SIS) (70%)	Collection in public services for uninsured	Other insurance (4%)
Uruguay 2019	National Health Insurance/Total FONASA 72.6% (IAMC 51.0%; Asse 13.2%; Private Insurance 1.9%; Military Health 3.5%; Police Health 3%)	–	21.7% ASSE in the FONASA	Private IAMC (4.8%) Private insurance (0.9%)

ASSE: State Health Services Manager; IAMC: Collective Medical Care Institutions; FONASA: National Health Fund.

Source: Authors.

mulating the policy, except for Argentina, where the provinces have a significant role.

In most countries, PHC services are decentralized to departments or municipalities (Argentina, Bolivia, Brazil, Chile, Ecuador). In others, establishments such as Paraguay and Uruguay are directly linked to the Ministry of Health at the national level. Insurers play a crucial role in countries with diverse health insurance providers. In Colombia, benefit plans' administrators and local authorities have different powers to define their network organization model. Although local governments have a role in Peru, insurance fund managers hire public or private services to provide predefined actions. In Uruguay, the organization of services differs among public entities (more comprehensive) and private (individual care) that underlie the integrated health system.

Care model

A comprehensive PHC approach requires implementing care models that promote high-quality health services focused on people and within the framework of an integrated provision throughout life⁵ (Chart 1).

PHC approaches and care models

Among the countries, we observe a revitalized PHC based on common components: guarantee of preventive, promotional, curative, and rehabilitation actions; strengthened gatekeeping function; family and community approach based on the assigned population and territory; multidisciplinary teams; and, in some cases, such as Bolivia and Ecuador, emphasis on the interculturality expressed in the concept of “*buen vivir*” (good living). For populations with insurance coverage, PHC services focus on individual medical care through outpatient appointments. Chart 3 summarizes PHC country approaches.

Service design

We noted territorialized PHC services with assigned populations by health teams in almost all countries. In Uruguay, the State Health Services Administration has a register of affiliates under the responsibility of each PHC network, although there is no assignment to its care units. Colombia has had a regulated public sector since 2022 for establishing the PHC Teams Program by the Social State Companies (First-Level Public Centers), which must operate in a defined territory¹¹. Bolivia has territorialization, however, although patients are geographically linked to a

single PHC¹² establishment, they can access other PHC services. In some countries, users must register in the PHC services, such as Chile. The active registration of the citizen is also required to access PHC services in Bolivia, Chile, and Colombia.

The number of inhabitants assigned by equipment varies within and among countries. The means range from 3,000 in Brazil and 4,000 in Ecuador, up to 5,000 in Chile and Paraguay. The number of users for each team is specified in Colombia but the guideline still needs to be released. In Argentina, territorialization is only evidenced in some municipalities and provinces. There is no assignment in Uruguay. In all countries, the number of inhabitants the PHC team assigns varies depending on the territorial characteristics, such as belonging to rural areas or areas of greater social vulnerability⁷⁻¹⁰.

A diverse composition of staff and equipment per type of facility characterizes the provision of PHC services. The general practitioner and the nurse are required in health centers in all countries. Nursing assistants or technicians are found in most countries. Following the reforms, countries incorporated Community Health Worker, Health Promoter and PHC technician, either as paid or voluntary workers in PHC teams⁷.

The actions and services, in general, are offered through a portfolio or predefined package in plans or programs, which seek to establish an essential standard of interventions and procedures accessible to the population, including essential medicines. Most countries establish care/prevention/promotion plans based on life cycles, from pregnancy/childhood to elderly, covering women, adolescents, and adults. External appointments, home activities, vaccination, infectious disease control programs, prenatal care, child growth/development, and chronic non-communicable diseases are commonly expected.

Physical infrastructure

In the nine cases, the main types of PHC units are health centers and health small offices, operating from Monday to Friday, in general, through government public structures. We noted initiatives to increase the resolute capacity and the accessibility of services by incorporating diagnostic methods and 24-hour medical services, especially in urban areas. In most countries, health posts operate with technical professionals, with discontinuous care in rural areas. Some social insurance providers attend their affiliates in their establishments, such as in Uruguay and

Chart 3. Summary of the PHC conceptions/models in selected South American countries, 2022.

Countries	PHC conceptions/models
Argentina	"National Health Quality Plan 2021-2024" and the "Quality Evaluation and Improvement Plan at the First Level of Care" guide a PHC model centered on people, with high-resolution capacity, care continuity, and focus on promotion and prevention in environments that promote the safety of users, families, and the community, with a decentralized organization, health participation of Indigenous peoples, prioritized care lines, evaluation of results, and adequate coverage.
Bolivia	"Intercultural Community Family Health" (SAFCI) – aimed at implementing the Unified Health System through community participation, intersectorality, interculturality, and comprehensiveness. SAFCI professionals respond and report to the Ministry of Health and Sports authority, from which instructions, priorities, and action initiatives emanate.
Brazil	"Family Health Strategy" (ESF). The ESF is community-oriented and incorporates and is guided by a preferential gateway, multidisciplinary teams, community participation, intersectorality, addressing the social determinants of health, use of appropriate technology, and sustainable cost-benefit ratio. These general guidelines are evident in the 2011 National Primary Care Policy (PNAB) and changed in the 2017 update.
Chile	"Comprehensive Health, Family, and Community Care Model" (MAIS-FC) – expanded Alma Ata approach: people-centered, comprehensive, and continuing care operated in Family Health Centers (CESFAM) and Community Health Centers (CECOSF) by strengthening PHC health teams, networking, and intersectoral work, local management, and participation.
Colombia	Three independent, unarticulated PHC models: first-level PHC care model, administered by the Benefit Plan Administrative Entities, based on individual risk management through cost-effective clinical actions; models implemented by local health authorities based on collective or public health actions, offered without discrimination; intercultural models of Indigenous peoples.
Ecuador	"Comprehensive Care Model in Family, Community and Intercultural Health" (MAIS-FCI) – interventions in health promotion and prevention, equitable and continuing access to comprehensive services that consolidate the first care level as the gateway to the health system.
Paraguay	"Comprehensive Health Care Model" – comprehensive perspective through the development of a first care level that incorporates public health interventions with an approach based on human rights, social participation, community empowerment, and intersectoral collaboration, with the integration of horizontal programs with high health impact.
Peru	"Comprehensive Life Course Care Model for the Individual, Family and Community" (MCI) – (former "Comprehensive Health Care Model based on the Family and Community" – MAIS-BFC) – gateway from First-Level Health Establishments with their extramural and intramural actions, comprehensive care, with continuing provision and quality of care to cover health needs, emphasizing health promotion and risk prevention of individuals within their family and community and in a framework of shared responsibility with the individuals involved and the social stakeholders.
Uruguay	PHC as a strategy. Prioritizes the first care level with activities targeting individuals, family, community, and the environment, with adequate resolution and comprehensive care to fundamental health needs and the improvement of quality of life, participation of the human core involved and in direct contact with its natural and social habitat, interdisciplinary teams with infrastructure and technologies for outpatient, home, urgent, and emergency care. The First Care Level (PNA) is organized in the public subsector as Primary Care Networks (RAP), which implement units with autonomy in technical, budgetary, and health workforce management.

Source: Authors.

Peru. In Colombia, the State Social Enterprises in the public sector provide care to social insurance users. In some cases, mobile units for the provision of PHC are strategies to increase access to rural and remote populations.

Care coordination and integrated networks

In the nine cases, except for some localized experiences, the Integrated Health Services Networks (RISS)¹³ were not established. Health services operate in parallel for population groups segregated by lines of care or life cycle. High levels of segmentation of health systems hamper

coordination between levels. In this sense, some initiatives for setting the RISS are restricted to the public segment.

We also observe different territorial configurations and health authorities responsible for the RISS. We identify regional authorities in Argentina, Bolivia, Chile, and Ecuador (District/Departmental/Health Services). Colombia has fragmented arrangements, where each insurance provider covers its affiliates. In Paraguay, they are centralized at the national level. In Brazil, the RISS depend on intermunicipal arrangements in slow construction.

The flow of clinical information remains the responsibility of the patients when their care occurs at different care levels, albeit discontinuously. Even in countries that achieved (although partially) implementing electronic records in PHC (Brazil and Chile, for example), the electronic medical history is not integrated throughout the network. In Uruguay, the National Electronic Clinical History ensures a minimum set of data to which it is accessed at different levels of care and among the National Integrated Health System providers, with syntactic and semantic interoperability¹⁴. Waiting times are not publicly monitored or accessible, except for Uruguay and Chile^{8,15}.

The possible referrals are also defined by the asymmetric provision of services, which makes them more feasible in the central and capital regions and challenging in the remote and rural regions.

PHC workforce

The density of physicians per thousand inhabitants is heterogeneously distributed among countries. Uruguay and Argentina have higher rates than the OECD¹⁶ average. The other countries are below the average. Still, two groups can be distinguished: one closer to an average of 2.5 doctors/1000 inhabitants – Chile, Brazil, Colombia, Ecuador; and Bolivia, Paraguay, and Peru, with greater restriction¹⁷.

The variation of professionals is even more pronounced for nurses and midwives, as well as for nursing assistants and technicians. Chile and Brazil (13.3 and 10.1) have a higher ratio of workers in this professional category. Some countries have higher densities of doctors than nurses, such as Argentina, Colombia, and Uruguay¹⁷. Brazil and Chile have the most significant density of dentists and pharmacists, along with Uruguay (only dentists)¹⁷ (Table 1).

Despite the differences, all South American countries have insufficient health workers in the public sector, especially in PHC, emphasizing the medical professionals. There are no organized statistics on the availability of the PHC workforce, but there is consensus that the offer is qualitatively and quantitatively insufficient.

Most countries define that general practitioners must work in PHC. However, professionals with specialization in PHC general practice are scarce. An exception is Ecuador, which records the specialty in Family Health and PHC as the third largest in the country¹⁸.

One of the main problems for retaining professionals is the regulation of labor relationships. There are diverse labor ties and remuneration levels, with a tendency to substandard working conditions without guarantees of social benefits. Most PHC professionals are civil servants only in Chile and Bolivia. Chile has a national PHC functional career.

Cuba cooperated with Bolivia, Brazil, Ecuador and Uruguay to tackle the insufficient offer of doctors. Bolivia provides PHC services with Cuban professionals and promotes the training of doctors at the Latin American School of Medicine in Cuba. Brazil established the More Doctors program in 2013, based on infrastructure, education and provision of PHC doctors. This program improved the health access rates in the country and had a large contingent of Cuban doctors, 80% of the total in 2018¹⁹. The change to the conservative government in Brazil caused the rupture of the agreements with Cuba in 2018.

Use of digital health technologies in PHC

The use of digital technologies is not strongly developed. The countries report information systems without integration and interoperability with the secondary and tertiary care levels and between providers in the several coverage segments, exacerbating care fragmentation.

The COVID-19 pandemic has explicitly increased the need to use Information and Communication Technologies (ICT) for health care. Several countries have implemented actions in this regard, with the resources of telemedicine, digital medical prescriptions, and remote care to users (Brazil, Chile, and Uruguay), screening and monitoring tools (Chile and Colombia), population information, and support for vaccination strategies (Argentina), and virtual training of professionals²⁰⁻²².

Table 1. Health workforce density indicators in selected South American countries, 2020.

Countries	Doctors per 1,000 inhabitants	Nursing* and midwives per 1,000 inhabitants	Dentists per 1,000 inhabitants	Pharmacists per 1,000 inhabitants
Argentina	3.98	2.60	-	-
Bolivia	1.59	1.56	0.22	0.22
Brazil	2.16	10.12	1.25	0.68
Chile	2.59	13.33	1.25	0.53
Colombia	2.18	1.33	0.97	-
Ecuador	2.04	2.51	0.3	0.04
Paraguay	1.35	1.66	0.16	0.03
Peru	1.30	2.44	0.18	0.05
Uruguay	5.08	1.94	1.49	-

*Includes nursing assistants and technicians.

Source: World Health Statistics - OMS, 2020.

Involvement of communities and other stakeholders

The involvement of the relevant communities and stakeholders of all sectors to identify issues, define solutions, and prioritize actions through dialogue is one of the strategic determinants for PHC and universal access to health⁵ (Chart 1).

National, subnational, and local strategies for community participation

Almost all countries have a formal structure of social participation in their healthcare systems and have planned the structure of Health Councils by levels or territories. In Bolivia and Ecuador, the “buen vivir” (good living) conception that guides health policy is expressed in the intersectoral articulation and the social participation levels regarding the cultural identity of populations. Chart 4 shows formal social participation structures in the countries.

Coordination mechanisms between sectors with community participation and commitment

In general, countries have guidelines and structures that favor intersectorality. The National Council for the Coordination of Social Policies in Argentina is part of the Social Ministries. In Ecuador, the coordination of intersectoral actions is performed by the Coordinating Ministry of Social Development, with the articulation of several ministries, including the Ministry of Health. Chile, Colombia, Peru, and Uruguay also have a more structured and specific coordination

of the interaction between sectors. In Brazil, intersectoral actions are identified in specific policies and in the work of the ESF teams, which is also the case in Bolivia, where intersectorality is implemented in the practices of SAFCI teams, and Paraguay, where the ESF (FHS) teams work to strengthen local Committees and Councils.

Interculturality

South America is culturally diverse, with a strong presence of native peoples. The intercultural approach and the integrated knowledge and practices of the traditional healthcare of indigenous and rural native peoples, especially in Bolivia and Ecuador, are found in health policies. The Constitutions establish multinational states and guide their policies for “good living.” In other countries, interculturality is mainly developed in specific Indigenous health programs (Chart 4).

Lessons learned

In many South American countries, the right to health access is expressed in national Constitutions enacted in democratization processes. However, besides the political commitment fundamental to developing universal health systems, the guarantee of rights depends on a broader social process involving values, norms, and a social dynamic that allows effective implementation⁴. The PHC concept, in general, still needs to overcome the continuity of packages for specific groups. This concept maintains a segmented social protection system, despite the expansion of health insurance coverage in recent years. More-

Chart 4. Strategies for social participation, intersectorality and interculturality in health, in selected South American countries, 2022.

Country	Formal structures of social participation in health	Coordination with other sectors	Formal or informal intercultural action
Argentina	None	National Council for the Coordination of Social Policies National Healthy Municipalities and Communities Program; Determinants of Health and Health Relationships Secretariat/Ministry of Health Community Integration Centers	Anahí Indigenous Health Program
Bolivia	Local Health Authority Local Health Committee Municipal Social Health Councils, Departmental Social Health Councils National Social Health Councils	Social development policy oriented by “good living” SAFCI/Mi Salud teams develop intersectoral actions Health councils integrate other sectors	Interculturality is one of the pillars of the SAFCI policy Intercultural approach in health centers Actions of the Vice Ministry of Promotion, Epidemiological Surveillance and Traditional Medicine
Brazil	Municipal Health Councils State Health Councils National Health Council Periodic Health Conferences	Intersectoral actions in specific policies and advice Territorialized community-oriented PHC Teams must mediate intersectoral actions	Indigenous Health Care Subsystem National Policy on Integrative and Complementary Practices
Chile	Local Health Councils and Local Development Centers	Intersectoral Action for Health under the coordination of MINSAL and local governments	Health Policy and Indigenous Peoples/ MINSAL
Colombia	Territorial Councils for Social Health Insurance Community Health Participation Committees Civic Superintendencies and User Associations	Intersectoral Public Health Commission to coordinate and agree with various sectors to act upon the social determinants of health Thematic intersectoral commissions	Indigenous and Intercultural Health System
Ecuador	National Health Council Citizen Councils Local, provincial, municipal, and parish planning councils	The Coordinating Ministry of Social Development coordinates intersectoral coordination with sports, housing, education, environment, human mobility, and health ministries.	National Directorate of Interculturality/Ministry of Public Health
Paraguay	National Health Council Regional Councils and Local Health Councils National Health Council of Indigenous Peoples	Family health teams must carry out intersectoral actions in their territory with self-management, promoting the formation of Neighborhood Commissions and Health Councils	Directorate of Indigenous Health
Perú	Local Health Administration Committees at municipal, district, and provincial levels	National Multisectoral Health Policy by 2030 – Peru, Healthy Country Program	National Center for Intercultural Health/MINSA
Uruguay	National Health Boards Departmental Health Boards Local Health Boards	Uruguay Grows With You with coordinated action between the ministries under the coordination of the Ministry of Social Development	Intercultural Nursing of the NGO Idas y Vueltas.

Source: Authors.

over, it remains circumscribed to the public component of the health systems.

Another challenge is that the implementation processes at the local level did not consistently achieve the broadest and most structuring objectives of PHC national policies. In Chile, for example, 56% of MAIS-FC objectives have been achieved at the national level, with a worse performance in small municipalities with rural populations and with higher percentage of poverty²³. In Brazil, although access to health has increased and high percentages of users refer to the SUS PHC units as their regular source of care, we have observed a decrease in the number of monthly visits by Community Health Workers, incomplete care to users with chronic diseases, and constraints to guarantee healthcare coordination^{24,25}.

Conill *et al.*⁴ warn us that the universalized PHC coverage in South America, without changing the care model, brings risks of increased consumption of health services without responding to the needs of populations. The territorial design of services is a hallmark in South America, which incorporates the social determination of health and ties with communities^{26,27}. However, the extremely varying amounts of registered people weaken these aspects in arrangements with thousands of users registered by the equipment.

The composition of multidisciplinary teams expresses the reforms favoring a renewed PHC. This configuration differs from European countries, which traditionally focus their PHC models on family physicians or general practitioners. Teams with multi/interdisciplinary work are better adapted to complex health needs, with the potential to integrate different approaches²⁸.

The initiatives to improve and qualify the physical infrastructure and service provision by the PHC are part of the different reforms. The structural conditions of the establishments are a determining factor in defining the extent of health practices²⁹. The availability and sufficiency of supplies in the Health Centers/Posts, such as rapid tests, essential medicines, and the collection of biological material can collaborate in reducing inequalities of access. Policies and financing should consider continuous and sufficient availability of equipment. Implementing advanced nursing practices to increase the extent, coordination, and quality of the PHC³⁰ is also critical.

Mobile equipment, teams, and health posts could expand access in remote and rural areas. However, these areas generally do not have the

appropriate physical structure, financing, and human resources³¹. A successful case, for example, in Brazil, is Riverside Health Teams and PHC Fluvial Units, which develop an essential role in providing care to the Amazonian riverine population³².

Technological densification and complete computerization are challenges not overcome which hinder the expansion of PHC's scope and resolutiveness. Together with the availability of ICT, the incorporation of the equipment within the work process is needed. Effective use can be motivated by continuously training professionals by including the subject in undergraduate courses and disseminating the tool among the teams³³.

In the cases studied, the health centers have gradually assumed the coordinating function for the referral to specialized care. However, the implementation of the RISS still needs to be achieved. A crucial factor is establishing monitoring mechanisms, transparent waiting lists, and the maximum times stipulated by law for some diseases, such as in Uruguay and Chile. The expanded adoption of ICT and mutual accommodation strategies are recognized value strategies for promoting the health care continuum. Financial/non-financial incentives, specific agreed clinical and management protocols, defined case coordinators, and available specialized services are necessary. Another challenge is considering the design of the care flows in the context of the users (transport availability, geographical, and cultural) and their usual care trajectories. In this sense, the guarantee of health transport is a crucial factor for access and continuity of care³⁴.

The unbalanced relationship between different professional categories prevents teams from being interdisciplinary. Efforts have been made in public policies to increase the availability of professionals in the South American countries, with increased programs for the provision of doctors and broad participation of Cuban professionals^{22,35}. However, there is a challenge of retaining health workers trained to offer quality services to populations, above all, remote or disadvantaged areas³⁶. Besides the shortage, the distribution is poor and favors urban areas to the detriment of more impoverished rural, remote, or border areas³⁶.

The unstable labor contracts, with a high rotation of professionals, hinder adherence and prevent the establishment of ties between teams, families, and the community. The multiple and heterogeneous labor regimes and the segmented health systems favor "unfair competition" for hu-

man resources between public and private providing entities^{7,37}.

There is consensus that the professionals' education is inadequate because it is not PHC-oriented. The allocation and specialization of doctors are guided by market needs³⁸. The incipient experiences of some countries can guide broader education programs, such as in Medicine, Nursing and multidisciplinary Community and Family Health residencies in PHC, and nursing technicians in advanced practice. In synergy, the expansion of continuous training programs to convert PHC professionals into generalists is urgent.

Community and social participation in actions and services are essential to ensure that the health sector remains aligned with the population's needs and strengthen democracy and social rights³⁹. The need to ensure social participation is found in the reforms and experiences of institutional e multilevel social participation in the healthcare systems, such as in Bolivia and Brazil. These countries provide interlocution channels protected by legal frameworks.

The intercultural approach in PHC is another key to meeting health needs, tackling structural racism, and reducing inequalities of access. The integration of knowledge and practices of traditional healthcare of native peoples is found in health policies, especially in Bolivia and Ecuador. Successful local experiences of intercultural dialogue that work towards complementarity between ancestral and biomedical medicine could gain visibility and dissemination in the Region.

Regarding the study limitations, we can mention the descriptive nature of the results. These were built mainly on normative documents from the respective national health ministries to the detriment of an in-depth debate on the conditions of the central characteristics assumed

by PHC in the Region. For example, financing policies that objectively express the priority and condition the scope of PHC are key issues for future investigations. However, countries do not have comparable data concerning the allocation of resources, nor do they have a consensus on PHC expenditure. Nevertheless, the study's main contribution is to offer an overview of the PHC in nine Latin American countries, presenting a set of variables to establish a broad comparative framework for constructing universal public health systems.

The COVID-19 pandemic crisis unraveled the weaknesses of our health systems. Infrastructure fragilities, insufficient human resources, and external dependence on supplies and medications were evidenced^{21,40,41}. An integrated vision that addresses the interconnection between social, environmental, and economic health determinants has never been so important. The collaboration between multiple sectors and disciplines is crucial to respond to current and future health challenges. The pandemic escalated the implementation of innovations^{20-22,41,42}, which require evaluation and dissemination.

Despite the PHC challenges in our Region, the cross-sectional analysis of cases identified common strengths. There are many challenges, but several countries defend the right to universal health access. This is a time of reviving the social, economic, environmental, and recomposing policies of progressive and democratic fields. Disseminating international experiences can accelerate the application of a comprehensive and integrated approach to quality PHC that addresses social determinants and the needs of people, families, and communities. In general, the PHC perspectives in the Region contribute to establishing resilient, effective, and equitable health systems.

Collaborations

PF Almeida, L Giovanella, N Houghton, E Báscolo, and A Bousquat were responsible for the conception, data collection and analysis, and the manuscript's drafting. S Schenkman, CM Franco, and PO Duarte participated in data collection and interpretation, and the manuscript's drafting.

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