The urgency of investing in health systems in Latin America and the Caribbean to reduce inequality and achieve the Sustainable Development Goals

October 2024

Foreword

This report by the Economic Commission for Latin America and the Caribbean (ECLAC) and the Pan American Health Organization (PAHO) is being published with six years left to meet the Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development. The combination of the coronavirus disease (COVID-19) pandemic and interrelated and cascading crises has provoked an alarming situation that threatens the attainment of the SDGs globally and in the countries of the region.

The multidimensional effects of the pandemic stalled actions linked to achieving various SDGs, causing a regression in 32% of the SDG targets at regional level. This regression is reflected in key health indicators such as maternal mortality, immunization coverage and others related to malnutrition and mental health. The goals of universal access to health and universal health coverage —which aim to ensure timely, equitable, quality and affordable access to health

Contents

UNITED NATIONS

ECLAC

PAHO Pan American Health Organization World Health Organization Americas Region

services for all according to needs— are still far from being met in the region. Further complicating the situation is the exacerbation of multiple types of pandemic-induced access barriers that prevent people from using health services.

The current outlook is worsened by the structural characteristics of a region marked by high levels of poverty, inequality and labour informality and low productivity and economic growth, in addition to social protection systems with structural and institutional capacity challenges. This comes against the backdrop of a development crisis in Latin America and the Caribbean where three traps persist: a long-term inability to grow, high inequality, and weak institutional capacity and ineffective governance for addressing development challenges. In the health sector, issues such as chronic underfunding, fragmentation and segmentation of the health systems in the countries of the region lead to problems related to sufficiency, access, equity, efficiency and coordination. These elements converge with the social determinants of health, directly impacting people's well-being, widening health gaps and heightening the vulnerability of certain population groups.

Now more than ever, structural transformations of development models and a joint effort by countries are required to correct the course and accelerate progress towards achieving the Goals of the 2030 Agenda. Recognizing health as a basic human right and a fundamental component of comprehensive well-being, this report emphasizes that there can be no sustainable development without health and that exclusionary development models lead to a deterioration in population health. Health is essential for achieving the three dimensions of sustainable development —inclusive social development, economic development and environmental sustainability— and is therefore interdependent with other fundamental rights.

In this context, there is an urgent need to implement health system reforms that ensure timely and quality care for all, move towards universal health access and coverage, strengthen institutional response capacity and resilience in the face of current and future health emergencies, and coordinate with social protection systems under the principle of the right to health, leaving no one behind.

Both ECLAC and PAHO underline the importance of the primary healthcare strategy, considering its three components —integrated services and essential public health functions, multisectoral action and social participation— to be part of the health systems transformation needed for an inclusive and sustainable recovery and to address setbacks in implementing the 2030 Agenda. It is therefore crucial to increase public investment in health to at least 6% of gross domestic product (GDP), allocating 30% of that expenditure to primary healthcare in line with the guidelines of the World Health Organization and PAHO, prioritizing the first level of healthcare and fully guaranteeing its financial sustainability in terms of coverage and sufficiency of services. Only in this way will it be possible to make up for lost ground and return to the path of sustainable development.

José Manuel Salazar-Xirinachs
Executive Secretary
Economic Commission for Latin America
and the Caribbean (ECLAC)

Jarbas Barbosa da Silva Jr.
Director
Pan American Health
Organization (PAHO)

Introduction[1]

Four years after the onset of the coronavirus disease (COVID-19) pandemic —and taking into account the consequent catastrophic effects on key dimensions of inclusive social and economic development, the exacerbation of inequalities and the setbacks in achieving the Sustainable Development Goals (SDGs)— it has become increasingly evident that sustainable development cannot be achieved without ensuring health. Optimal health not only reduces inequality and poverty; it also fosters education, skills development, labour inclusion and social participation, and even productivity and economic growth.

This underscores the interdependence between health and the economic, social and environmental dimensions of sustainable development, as well as the clear link between Goal 3 (ensure healthy lives and promoting well-being for all at all ages) and the other goals of the 2030 Agenda for Sustainable Development. As a result, investing in health contributes to achieving the targets of Goal 3, thus enabling progress towards sustainable development.

The COVID-19 pandemic triggered a profound health, social and economic crisis in Latin America and the Caribbean, reflected in increased levels of unemployment and labour informality, higher rates of poverty, extreme poverty and inequality, and the widening of existing education gaps. In addition, the pandemic caused a displacement effect and prolonged interruption of essential health services, increasing access barriers and excess mortality rates and causing significant setbacks in key dimensions of health such as immunization coverage and food security, with lingering impacts in the region.

The health systems of Latin American and Caribbean countries have significant structural weaknesses, marked by chronic underfunding coupled with high out-of-pocket costs, fragmentation in the provision of services and segmentation of patients according to their ability to pay. There are also challenges linked to institutional capacity and governance that limit their ability to respond to public health challenges. This has resulted in deep inequalities that compromise universal access to health and well-being, as well as financial protections for households.

In turn, the social, economic and environmental determinants of health, which are unevenly distributed and linked to the axes of the social inequality matrix, converge with health systems' structural weaknesses and play a fundamental role in widening pre-existing gaps.

The current situation calls for stronger intersectoral coordination, particularly between health policies and social protection systems, in order to ensure a basic income, well-being and access to social and health services, and in doing so ensure the right to health and create synergies between sectors to overcome poverty and reduce inequalities.

During the COVID-19 pandemic, primary healthcare emerged as a key strategy for advancing towards equal access to health and universal health coverage, and for addressing existing inequalities. This strategy must be comprehensive and accompanied by a first level of care, within integrated networks and in coordination with essential public health functions.

Considering efforts in support of the binding nature of social participation, it is essential to strengthen such participation in policy responses and implementation, grounded in the principle of solidarity and the right to health, leaving no one behind.

Likewise, health system resilience must be reinforced, ensuring the ability to adapt to change and respond efficiently during crises so as to ensure continued access to healthcare. Such resilience is even more important as the region is at a crossroads, marked by crises and transformations such as accelerated population ageing and migratory trends, technological transformation and changes in the world of work, disasters and climate change, and epidemiological and nutritional transitions, among other challenges, which translate into an ever-evolving social risk structure.

The countries of the region must accelerate their efforts to address the backsliding on the SDGs and invest strategically in health system reforms based on the primary healthcare strategy, in order to make progress in fulfilling the 2030 Agenda and ensure universal, comprehensive, sustainable and resilient health systems. The focus of health system transformations must be on ensuring their overall sustainability with regard to coverage, sufficiency and financial sustainability, in a context marked by low growth and macroeconomic uncertainty.

[1] Unless otherwise indicated, this report uses information available up to 13 August 2024.

This report is organized into five sections. Following this introduction is an analysis of the need to strengthen the health systems of countries of the region, using a primary healthcare approach, to address the pandemic's effects on key dimensions of economic development and inclusive social development, as well as its negative impact on progress towards the Goals of the 2030 Agenda. The relationship between the social determinants of health and the impact of the pandemic is analysed in the second section, which highlights the importance of effective coordination between the health sector and the social protection sector to address social determinants and reduce inequalities. This section also highlights the critical role that local authorities, communities and citizen participation played in the pandemic response, identifying lessons learned in that regard, as well as their importance in strengthening primary healthcare. The third section addresses the pandemic's health consequences and the urgency of advancing health system reforms with a comprehensive primary healthcare approach to overcome barriers in accessing healthcare. The fourth section identifies the dimensions of health system sustainability —coverage, sufficiency and financial sustainability—, reviewing current health financing in the region and reflecting on new challenges, with special emphasis on strengthening the resilience of health systems to respond to current and emerging health emergencies. The last section underscores the need to prioritize investment in order to move towards universal, comprehensive, sustainable and resilient health systems that help to overcome inequality and achieve sustainable development.

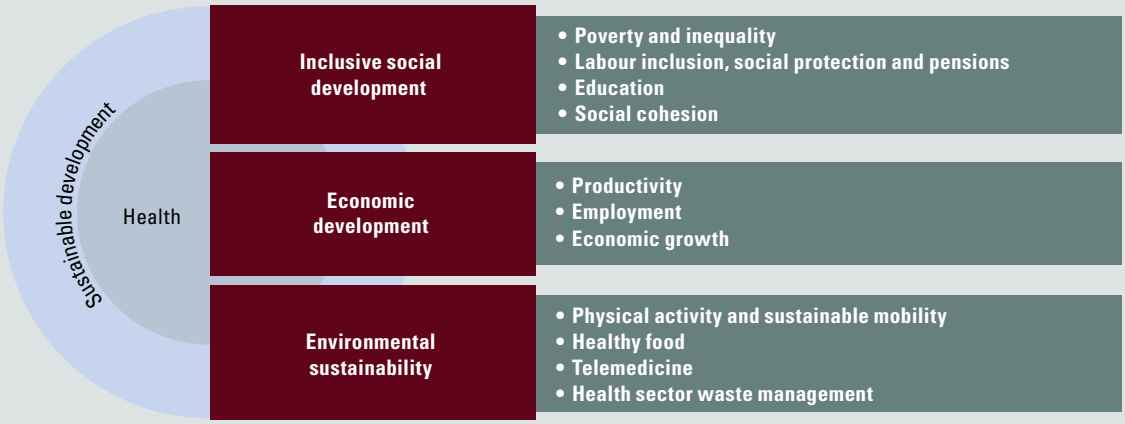
I. Pressing need to strengthen health systems of the countries of the region with a focus on primary healthcare to address post-pandemic setbacks to the 2030 Agenda

A. The centrality of health for sustainable development

Health is a fundamental human right and a core component of comprehensive physical, mental and social well-being (WHO, 1949). Ensuring the right to health for all, leaving no one behind, is an ethical imperative that also helps to reduce poverty and inequalities and, therefore, to foster inclusive and sustainable social development in Latin America and the Caribbean.

The three dimensions of sustainable development —economic, social and environmental— are closely linked to health. Attaining this development model, which is based on the principle of equality and aims to ensure optimal well-being and meet the needs of the present without compromising the ability of future generations to meet their own needs (United Nations, 1987) will require investing in the health of the population. The enjoyment of good physical and mental health is conducive not only to income generation and the reduction of inequality and poverty; its positive effects also include skills development and higher education attainment, greater labour inclusion and increased participation in the various spheres of society, productivity and economic growth, environmentally sustainable food and health practices, food security, and access to healthy food (Marinho, Dahuabe and Arenas de Mesa, 2023) (see diagram 1).

Diagram 1 The relationship between health and the three dimensions of sustainable development



Source: M. L. Marinho, A. Dahuabe and A. Arenas de Mesa, "Salud y desigualdad en América Latina y el Caribe: la centralidad de la salud para el desarrollo social inclusivo y sostenible", *Social Policy series*, No. 244 (LC/TS.2023/115), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2023.

Goal 3, on ensuring healthy lives and well-being for all at all ages, intersects with other SDGs, underscoring the interdependence between the right to health and other fundamental rights (Hone, Macinko and Millett, 2018; Marinho, Dahuabe and Arenas de Mesa, 2023). This relationship demonstrates that sustainable development cannot be attained if health is not guaranteed. Health thus becomes an essential element for achieving the three dimensions of sustainable development,[2] as analysed in further detail in the following section. In other words, investing in Goal 3 is critical for achieving all the Goals that comprise the 2030 Agenda.

Concerning the pandemic's impact on key dimensions of inclusive social development,[3] in 2023, a regression was seen in 27% of the SDG targets of the 2030 Agenda in Latin America and the Caribbean (ECLAC, 2023a) in areas such as health, poverty, inequality, education, labour and nutrition; the region was thus the hardest hit by the triple crisis triggered by the pandemic (ECLAC, 2022c). The latest projections indicate that only 22% of the SDG targets will be met by 2030, while in 46% of the targets, movement would need to be accelerated for them to be met by the deadline and 32% will be missed, underlining the need for countries to intensify their efforts towards achieving the SDGs (ECLAC, 2024a).

The COVID-19 pandemic highlighted the centrality of health in advancing a strategy for sustainable development in its various dimensions. The protracted health crisis, which had a major economic impact and caused a social crisis from which the region has not yet fully recovered, has demonstrated that without health, economic activity and sustainable economic recovery become impossible (ECLAC/PAHO, 2020 and 2021). During the pandemic, various dimensions of economic development and inclusive social development suffered major setbacks, and many still show signs of deterioration compared to the pre-pandemic period.

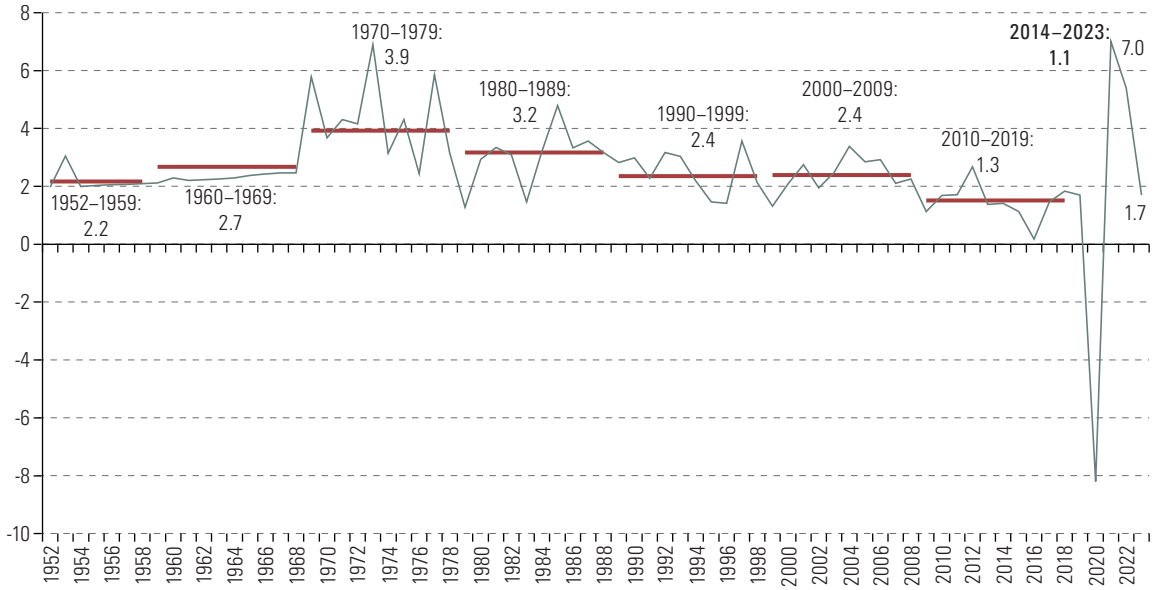
In 2020, owing to the health crisis, Latin America and the Caribbean experienced the largest economic contraction in the last 120 years, with a 7.0% drop in GDP (ECLAC, 2021a). Following a recovery in 2021, stemming from a low base of comparison coupled with the positive effects of external demand, higher prices of the region's commodity exports and an increase in aggregate demand, the region returned to low growth and productivity, with GDP growth of 2.2% in 2023 and projections of 1.8% for 2024 and 2.3% for 2025 (ECLAC, 2024b). This poor economic performance will translate into a slowdown in job creation, along with persistent high levels of labour informality and other inequalities in the labour market, such as gender gaps, which are visible in labour participation and unemployment rates (ECLAC, 2023b and 2024b).

The economic impact of the pandemic in the region, together with the health-related restrictions to contain the spread of the virus, had significant repercussions on the labour market, which was already showing signs of deterioration. This situation has been described as a slow-motion crisis, in which low GDP growth rates are combined with a level of employment that remains the same over time (ECLAC, 2023d). In 2020, the COVID-19 pandemic caused the worst labour crisis in Latin America and the Caribbean since 1950, with a sharp drop in job creation and decline in job quality that had unequal effects across population groups. Between 2014 and 2023, the annual growth rate in the number of employed was estimated at 1.26%, a level even lower than the 3.2% rate registered in the "lost decade" of the 1980s (see figure 1). In 2023, the region's low economic growth rates resulted in weak job creation, with an estimated rise in the number of employed persons below 2.0%, significantly lower than the 7.0 % recorded in 2021 (ECLAC, 2024b). This complex scenario is worsened by high levels of labour informality, the concentration of jobs in low-productivity sectors and persistent historical gender gaps. The projected gender gap in labour participation for 2024 is 22.3 percentage points, with the highest unemployment rates among women (ECLAC, 2024b).

[2] In addition to the direct impact of health on sustainable development and its three dimensions, it is important to highlight the bidirectional nature of this relationship. That is, inclusive social development, economic development and environmental sustainability also condition people's health and well-being and influence the results achieved in these areas.

[3] Inclusive social development, an essential component for achieving sustainable development and closely tied to health and economic development, is defined by ECLAC as "the capacity of States to ensure the full exercise of their citizens' social, economic and cultural rights, providing forums for participation and recognition, targeting gaps in access to key areas of well-being and addressing social inequalities and the axes around which they are structured from the perspective of a universalism sensitive to differences" (ECLAC, 2018b, p. 7).

Figure 1 Latin America and the Caribbean (17 countries):[a] growth in the number of employed persons, averages by year and by decade, 1952–2023
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Economic Survey of Latin America and the Caribbean, 2024* (LC/PUB.2024/14), Santiago, 2024.

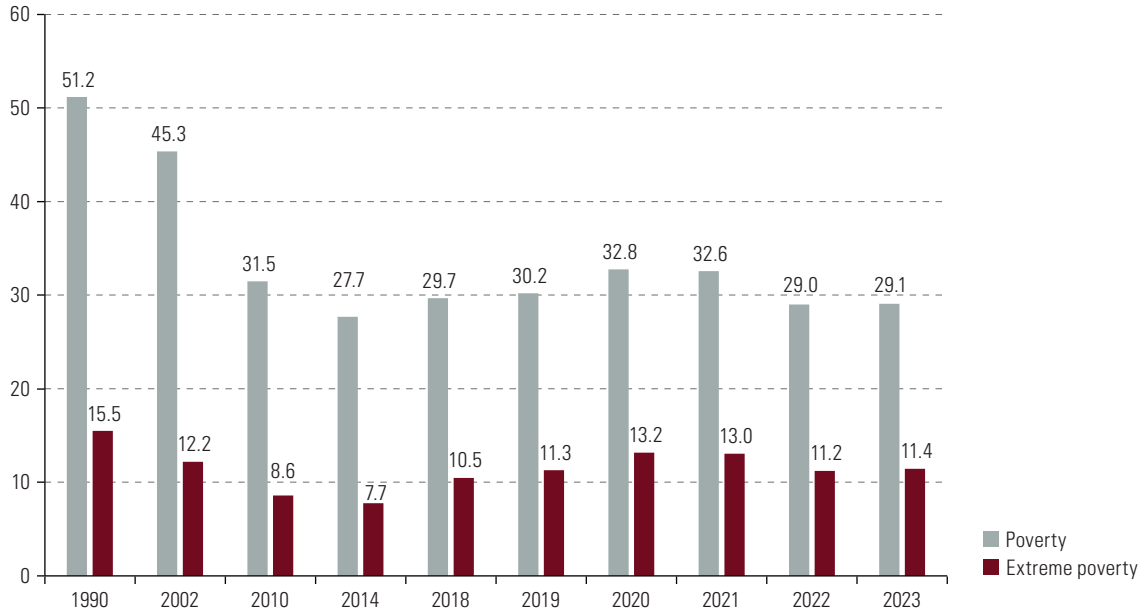
[a] Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

In 2017, Latin America's progress in reducing the Gini index[4] since 2002 came to a halt. Following the onset of the pandemic, the index rose slightly in 2020 as labour participation and labour income fell, particularly in the lowest income strata, because of health restrictions. The Gini index stood at 0.461 in 2021, close to the figure recorded in 2019 (0.464), and emergency monetary transfers were an essential means of compensating for labour market inequalities (ECLAC, 2023d). In 2022, the regional average Gini index was 0.449, almost 3.0% lower than in 2021, representing a fall of 1.1% per year between 2019 and 2022. Thus, the Gini index was at pre-pandemic levels in 9 of the 12 countries in the region with comparable information for that period (ECLAC, 2023d). This occurred in a context of very high inequality —with the top decile receiving 21 times as much income as the lowest-income decile— and a high concentration of wealth. According to 2021 data, the assets of 105 billionaires represented 4% of the wealth of the entire population, surpassing 2019 and 2020 levels (ECLAC, 2023d).

The pandemic's impact on economic growth and the labour market significantly set back progress in reducing poverty and extreme poverty in Latin America and the Caribbean (see figure 2). Between 2019 and 2020, the poverty rate increased by 2.6 percentage points and the extreme poverty rate by 1.9 percentage points, the latter reaching levels equivalent to those recorded 27 years earlier (ECLAC, 2022c). In 2021, these indicators decreased by a mere 0.2 percentage points, with emergency cash transfers playing a central role in sustaining household income. Both indicators improved two years after the onset of the pandemic: in 2022, the percentage of people living in poverty and extreme poverty in the region stood at 29.0% and 11.2%, respectively, down from the 30.2% and 11.3% recorded in 2019. Despite this progress, in 2022, poverty remained above pre-pandemic levels in more than half the countries of the region. In fact, the figures were similar to those of the previous decade, demonstrating insufficient progress towards the goal of eradicating poverty (ECLAC, 2023d). In addition, the incidence of poverty is higher among children and adolescents, as well as among Indigenous and rural populations, highlighting the deep social inequality that characterizes the region. Lastly, there are no expectations of significant progress in this area for 2023 given the region's low economic growth (ECLAC, 2024b).

[4] Calculated using data from 13 countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Mexico, Panama, Paraguay, Peru and Uruguay.

Figure 2 Latin America (18 countries):[a] poverty and extreme poverty rates, 1990–2022 and projections for 2023
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America and the Caribbean, 2023* (LC/PUB.2023/18-P/Rev.1), Santiago, 2023.

[a] Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia and Uruguay.

There were also serious setbacks in education as a result of the pandemic and the associated health crisis. Latin America and the Caribbean experienced the longest "education blackout" in the world, with face-to-face education being interrupted for an average of 70 weeks, well above the world average of 41 weeks (ECLAC, 2022a). Unequal access to connectivity, equipment and digital skills, all of which are closely linked to students' economic status, limited educational continuity. This prolonged suspension of face-to-face classes exacerbated previous educational inequalities in terms of access and quality, the permanent scarring effect of which will negatively affect the educational, labour and development trajectories of a generation of children, adolescents and young people, particularly the most vulnerable (ECLAC, 2022a).

The health crisis caused by the pandemic also highlighted the structural weaknesses of health systems, marked by chronic underfunding coupled with high out-of-pocket expenses, fragmentation in the provision of services and segmentation of individuals according to their ability to pay. These issues reflect a lack of solidarity mechanisms and structural inefficiencies that translate into inequalities that are detrimental to universal access to and the quality and financing of healthcare. During the pandemic, this resulted in high levels of excess deaths (27% of total global COVID-19-related deaths between 2020 and 2022 were in Latin America and the Caribbean), the interruption of essential health services, unmet demand for healthcare, the displacement of essential services and a decline in life expectancy in the region (ECLAC/PAHO, 2021; ECLAC, 2021b; Cid and Marinho, 2022).

The magnitude of the health, economic and social crisis triggered by the COVID-19 pandemic raised awareness of the essential role of health in inclusive and sustainable social development, creating a historic window of opportunity to move towards universal health systems that provide timely and quality care for all through supportive, efficient and sustainable financing mechanisms for quality services. This requires close cooperation between health and other sectors, as well as social participation, and increasing health sector resilience to better face challenges that may arise from new crises and emergencies. This process must also be accompanied by an increase in health spending and a reorganization of health services to make them more efficient, with a focus on a strengthened first level of care in line with the primary healthcare approach.[5]

[5] WHO (2023b) defines primary health care as "a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment".

In a post-pandemic context, maintaining healthcare at the forefront of public policy agendas is imperative, not only because of the duty to ensure the right to health but also because healthcare is a fundamental pillar of inclusive and sustainable social development (Marinho, Dahuabe and Arenas de Mesa, 2023). Financially sustainable healthcare systems that are universal, comprehensive, sustainable and resilient will be crucial for addressing the crises of the future. Strengthening the primary healthcare strategy as part of healthcare reform is pivotal not only for addressing the many enduring impacts of the pandemic but also for overcoming poverty and narrowing equality gaps, in healthcare and other areas.

B. Links between SDG 3 and the 2030 Agenda

The SDGs are closely interlinked, meaning that the outcomes of each are related to overall progress in the implementation of the 2030 Agenda for Sustainable Development. Progress or regression in other SDGs can therefore hasten or hinder the achievement of Goal 3 and vice versa (ICSU, 2017; Pradhan and others, 2017). One example of this interdependence is found in the digital health strategy (see box 1).

Box 1 How digital health contributes to meeting the Sustainable Development Goals

Investing in digital health is a critical strategy for overcoming many existing inequalities and advancing the Sustainable Development Goals. Digital health includes the use of information and communications technologies to improve the quality, efficiency and accessibility of healthcare services. Implementing digital solutions is essential for reaching remote and marginalized communities and ensuring access to high quality medical attention for all, irrespective of location.

Investment in digital health directly contributes to several SDGs. For example, significant advances are being made on Goal 3, on ensuring healthy lives and promoting well-being for all at all ages, driven by telemedicine, digital medical records and mobile health applications, among others. These tools enable continued, personalized care, reducing barriers to access and improving health outcomes in keeping with the principle of leaving no one behind. Digital health also supports gender equality (Goal 5) by ensuring women's access to healthcare services and education, including in communities where they have historically faced significant barriers. It also supports the achievement of Goal 10, on reducing inequalities, by making health services more equitable and accessible for all segments of the population.

Digital health also improves health system efficiency, optimizing resources and cutting costs, which supports economic and environmental sustainability (Goals 12 and 13). In short, not only will investing in digital health transform healthcare systems, it is also a key strategy for achieving sustainable and equitable growth, ensuring that no one is left behind in access to healthcare and services.

Source: Prepared by the authors.

Goal 3 has been found to be linked to Goal 11 (sustainable cities and communities) (Chapman, Howden-Chapman and Capon, 2016), as well as Goal 1 (no poverty), Goal 13 (climate action), Goal 2 (zero hunger) (Hughes and others, 2021; Viana and others, 2022) and Goal 8 (decent work and economic growth) (Nilsson and others, 2018), among others.

The relationship between Goal 3 and the other Goals shows that health is socially determined, and also that it is key for well-being, inclusive social development, economic development and environmental sustainability. In that regard, consideration of the interactions between Goal 3 and the other Goals is essential to enhance the implementation of the 2030 Agenda as a whole (ICSU, 2017; Weitz, Nilsson and Davis, 2014).

Lack of progress on Goal 3 can be attributed in large part to insufficient action on the social determinants of health (which are linked with the other SDGs) and high inequality (Doyle and Stiglitz, 2014). Diagram 2 shows that each of the other SDGs is directly linked with Goal 3. As such, the adverse effect of the pandemic on health was not solely the result of the immediate effects of the health crisis but also stemmed from its negative repercussions for the various SDGs. For example, housing conditions

(Goal 11), an important social determinant of health, proved to be a risk factor for the spread of the disease, with a higher number of cases in communities with overcrowding and substandard housing, such as informal settlements (Ahmad and others, 2020).

Diagram 2 Goal 3 and health-related linkages with the other Sustainable Development Goals

Source: World Health Organization (WHO), "Background paper for the regional technical consultation on: Monitoring the health-related Sustainable Development Goals (SDGs)", New Delhi, 2017.

The situation is similar with Goal 1, given the rise in poverty and extreme poverty, and with Goal 2, as reduced access to food and production issues led to significant health impacts with regard to food security and nutrition (FAO and others, 2021). Undernutrition significantly affects cognitive development and learning outcomes, while overnutrition has adverse psychological, social and school-related effects (Frongillo, Adebiyi and Boncyk, 2024; Kim and others, 2024; Araújo de Souza, Silva Pinto and Lopes de Souza, 2024).

The education crisis triggered by the pandemic (ECLAC, 2022a) also had short- and long-term repercussions on health owing to the importance of education (Goal 4) in shaping health outcomes and fostering opportunities to narrow equality gaps. This is because access to quality education empowers people and creates opportunities that improve the social conditions that determine health outcomes.

Similarly, gains in health outcomes have slowed or been reversed because women are in the most vulnerable conditions and because of gender inequalities related to Goal 5, such as the disproportionate share of unpaid domestic and care work, and limited access to the labour market and to healthcare, which lead to a deterioration or slower progress in health outcomes (Filho and others, 2020).

To advance the implementation of the 2030 Agenda, it is imperative to take into account the lessons learned from the pandemic and ensure that they are sustained; crises present learning opportunities and have the potential to spur major transformations (Jones, 2020). The pandemic can thus be a turning point driving the shift towards a more sustainable development model and coordinated action among other sectors, institutions, government levels and communities with the health sector as a key partner in ensuring public health. The emergency measures taken by governments in response to the crisis expanded the scope of ideas and public policy space, highlighting the importance of the State and of joint work between the public health sector and other sectors for effective and rapid responses (ECLAC, 2021b). The crisis also confirmed the pivotal role of the community in policy design and implementation and the need for policies to be tailored to local and territorial circumstances (Bispo and Brito, 2020). Furthermore, it underscored the importance of quality data for timely decision-making that responds to local needs (Innvaer and others, 2002). It is not enough to have data; what matters most is that information is actionable. Information must therefore be readily available to decision-makers, as evidenced by the vital role played by local governments in the pandemic response.

II. The social determinants of health as key factors in the health impact of the pandemic and heightened inequality: enhancing coordination between social protection and health systems is crucial

A. The relationship between the social determinants of health and the impact of the pandemic

As noted in the previous section, health crises have a documented effect on the economic, social and environmental dimensions of sustainable development, which, in turn, have multiple effects on human health. Many of the socially constructed conditions underpinning those effects are referred to as social determinants of health. The World Health Organization defines them as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms and policies and political systems (WHO/CSDH, 2008). This reinforces the holistic, systemic nature of the concept, which encompasses but is not limited to the inherent economic, political, trade and cultural dimensions of social systems and processes.

The social determinants of health are societal systems and their components, including governments, institutions, regulations and processes and the social resources and hazards for health that they control and distribute, allocate and withhold (Hahn, 2021). Distribution and concentration explain and shape the levels of equality or inequality in health and diseases within a society and are essential for understanding the impact of health crises like the COVID-19 pandemic.

There is ample scientific evidence that health outcomes are generally worse for socially vulnerable groups. Analysis of the target indicators for Goal 3 and related inequalities in the region shows that despite improvements in several indicators, significant gaps remain (PAHO/WHO, 2022b). For example, the maternal mortality rate in the lowest income quintile is more than seven times that of the highest income quintile. The situation is similar for the under-five mortality rate, which in the poorest quintile is some 4.5 times higher than in the wealthiest quintile. The relative difference between the number of people requiring treatment for neglected tropical diseases in the lowest-income and highest-income quintiles widened from 21.4 in 2010 to 80.1 in 2020. The same is true for chronic non-communicable diseases: the risk of dying from these diseases is 46% higher for persons aged 30–69 in the poorest group compared to the wealthiest group. The 2019 data for mortality attributed to unsafe water and sanitation and lack of hygiene is almost six times higher in the lowest income quintile, illustrating the effect of living conditions on human health (PAHO/WHO, 2022b).

These outcomes are worsened by pre-existing inequalities in the social sphere and health, which have a disproportionate effect on vulnerable groups and territories, as evidenced by the higher COVID-19 incidence and mortality among them. This two-way relationship can be understood as follows: the pandemic had an impact on the social, economic and environmental dimensions, which in turn were determinants of the distribution of COVID-19 infection and mortality and its many repercussions.

Several studies in Latin America have found correlations between social vulnerability and the COVID-19 mortality rate (ECLAC, 2022c; McGowan and Bambra, 2022). In Brazil, mortality rates were higher among people living in more socioeconomically deprived areas, despite the higher probability of contracting the disease reported in high-income areas. Similarly, studies in Chile, Colombia and Mexico found a positive association between indicators of vulnerability and social inequality and COVID-19 mortality rates. In Mexico, a municipality-level analysis of COVID-19 deaths between 1 June and 22 August 2020 showed a strong association between income inequality and mortality. In Chile, a study conducted in Santiago showed that COVID-19-attributed mortality rates per 10,000 population were between three and four times higher in the lowest income quintile than in the highest quintile (WHO, 2021a).

The underlying causes of these inequalities are related to differential exposure to adverse conditions that accumulate over the life cycle or engender new forms of social and biological vulnerability that can damage health or make certain groups disproportionately susceptible. Inequalities in exposure are reflected in individuals (embodied) and in the social and health consequences, which also vary by social group and place of residence (WHO, 2010a). Substandard housing and overcrowding are documented risk factors for infection and mainly affect the most disadvantaged social groups. In Medellín, Colombia, COVID-19 mortality rates were higher among residents of informal settlements than among those of other areas of the city (WHO, 2021a). The same is true for employment and working conditions —higher infection rates were reported among essential workers, namely those in the food, transport, cleaning services and informal sectors, for whom it was impossible to stay at home owing to a lack of social protection coverage (Vásquez-Vera and others, 2022). Excess mortality during the pandemic was also higher in countries with higher rates of labour informality (Cid and Marinho, 2022).

The significant influence of social determinants on health outcomes and equality across population groups, territories and countries evidences the need for cross-sectoral coordination. The conceptual framework of social determinants is consistent with the notion of the interlinked and indivisible nature of the SDGs as they apply to health and well-being, and also sounds a clarion call for a holistic approach to the 2030 Agenda for Sustainable Development.

B. The necessary linkages between healthcare and other components of social protection systems

The contours and interactions of the social determinants of health are related to the axes of the social inequality matrix, including income, education, occupation or employment, gender, territory, and ethnic and racial status (ECLAC, 2016). These axes form the social inequality matrix in Latin America, which is determined by its productive apparatus and characterized by a high degree of structural heterogeneity (ECLAC, 2016). The axes of the social inequality matrix, which derive from the region's social and productive structure, thus generate and perpetuate inequality in health, which itself is shaped by the social determinants of health, be they structural or distal, intermediary or proximal.[6]

The influence of these dimensions on health underscores the importance of strengthening linkages between health policies and other components of social protection systems aimed at ensuring adequate incomes for the universal achievement of well-being and access to basic social services such as education, water and sanitation, housing, pensions and health (ECLAC, 2020 and 2021b).

[6] "Structural or distal social determinants" are understood as the institutional and political arrangements and the policies, regulations and values associated with the various public policy areas that shape the social order, distributing power and oppression, whether pertaining to resources, prestige, discrimination or political impact, and are thus also referred to as determinants of health inequalities, as they underpin the latter. "Intermediary or proximal determinants" are understood as the immediate material and social circumstances that mediate between individuals and structural determinants, including their immediate surroundings, work environment, public spaces, habits and lifestyles, psychosocial factors and the provision of health and social services, among other factors (WHO, 2010a).

Complex health issues require action by more than just ministries of health. There is mounting evidence that health programmes and policies that include the social determinants of health, and therefore extend beyond the specific role of the health sector, have a greater impact on health outcomes (Bambra and others, 2020).

In recognizing health as a fundamental human right that social protection systems aim to safeguard, it is crucial to include access to essential healthcare throughout the life cycle as a guarantee of social protection floors, so that persons in need of care should not have to face barriers or incur catastrophic costs (ILO, 2012). Ensuring the right to health also promotes inclusive and sustainable social development and supports economic development and environmental sustainability (Marinho, Dahuabe and Arenas de Mesa, 2023), pointing to a pressing need for closely coordinated cooperation that generates a virtuous circle between both dimensions.

The provision of social protection services in childhood is vital for children's health and future development (ECDKN, 2007; WHO/CSDH, 2008). Social protection system entitlements in support of medical care for children and pregnant women, in particular paid parental leave and cash transfer programmes, as well as timely immunization, early attachment and a sufficient duration of breastfeeding, are central to reducing inequalities and lowering infant mortality and morbidity (UNICEF, 2018; Ramos and others, 2021). At the same time, it is important to promote multisectoral action to address the different dimensions of children's welfare, adopting a child-sensitive approach (Castillo and Marinho, 2022).

Conditional cash transfer programmes have yielded positive results in the areas of child undernutrition, motor and cognitive development, child immunization and vaccination for older persons, access to medical care and reducing child mortality (Attanasio and others, 2005; Fernald, Gertler and Neufeld, 2008; Salinas-Rodríguez and Manrique-Espinoza, 2013; Rasella and others, 2013). The provision of conditional or universal cash transfer programmes for children strengthens comprehensive early childhood care systems and improves outcomes in both health and education, facilitating the development of parenting skills and access to a guaranteed income (Marinho, Dahuabe and Arenas de Mesa, 2023).

Income support and guarantee measures also enhance population health and reduces inequality. The experience of Organisation for Economic Co-operation and Development (OECD) countries illustrate that public pensions can help to lower mortality among older adults by boosting their income (Norström and Palme, 2010). Access to support services and care also enables older persons to be more active, resulting in a healthier older population (WHO, 2015).

Paid medical leave is a key social protection instrument for public health, and is associated with higher recovery rates, lower healthcare costs, high worker productivity and lower absenteeism rates (Scheil-Adlung and Sandner, 2010). Access to these social protection entitlements, initially designed to safeguard against income loss or insecurity resulting from health-related work incapacity, plays a vital role in protecting the population and reducing inequalities. This underscores the urgent need for their universalization.

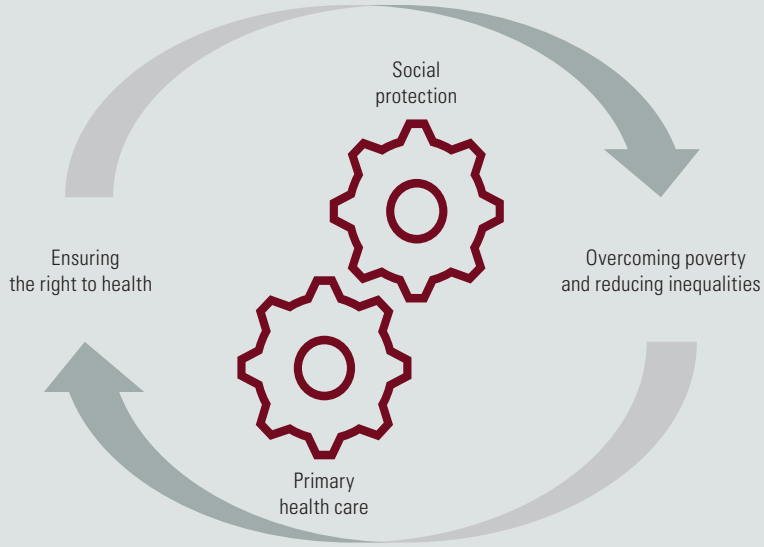
Health inequalities hamper the full development of skills and opportunities, incurring a range of social, economic, employment and environmental costs for society, as evidenced during the COVID-19 pandemic (ECLAC, 2021a, 2022b and 2023d). As such, the panoply of health system and policy initiatives implemented to ensure the right to health have a direct impact on the reduction of social inequality in all its dimensions, poverty and exclusion, which is why it is essential to link them with the social sector, and in particular with social protection systems.

Primary healthcare offers strategic opportunities to strengthen the linkages between health and social protection, by delivering primary care at the local and community levels, strengthening essential public health functions and merging social and health services. Primary healthcare includes actions directly linked with social protection, such as the provision of food and proper nutrition and maternal and child healthcare; financial protection and reduction of out-of-pocket costs; access to sexual and reproductive health, which contributes to gender equality; and risk surveillance with regard to rights violations, for example, gender-based violence, child labour and lack of access to education, among others (WHO, 1978; Hone, Macinko and Millett, 2018; PAHO/WHO, 2019a). This means that primary healthcare also involves implementing measures to eradicate poverty and address inequality and vulnerability in the region, and has an effect on the social determinants of health, furthering inclusive and sustainable social development and the achievement of various SDGs (Hone, Macinko and

Millett, 2018; Marinho, Dahuabe and Arenas de Mesa, 2023). In that regard, strengthening intersectoral cooperation, through application of the integrated model based on the policy cycle proposed by the Pan American Health Organization (PAHO) in its framework for essential public health functions (PAHO/WHO, 2020a), would support a virtuous circle between the health sector and other social protection sectors.

Primary healthcare and social protection thus have the potential to reinforce the feedback loop between ensuring right to health, overcoming poverty and reducing inequalities, through their positive impact on the social determinants of health (Abramo, Cecchini and Ullman, 2020; Marinho, Dahuabe and Arenas de Mesa, 2023) (see diagram 3).

Diagram 3 The synergy between primary healthcare and social protection



Source: M. L. Marinho, A. Dahuabe and A. Arenas de Mesa, "Salud y desigualdad en América Latina y el Caribe: la centralidad de la salud para el desarrollo social inclusivo y sostenible", *Social Policy Series*, No. 244 (LC/TS.2023/115), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2023.

Coordination between primary healthcare and social protection was crucial in the response to the health, economic and social crisis triggered by the COVID-19 pandemic. Social protection measures were essential for covering basic needs and ensuring well-being during the prolonged periods of lockdown and physical distancing implemented to contain the spread of the virus (ECLAC/PAHO, 2021). Between March 2020 and August 2022, 506 emergency measures targeting populations affected by COVID-19 were implemented in the 33 countries of Latin America and the Caribbean. Of these, 411 were non-contributory social protection measures, and included 220 cash transfer and 139 in-kind transfer programmes and 52 measures to ensure access to basic services. The remaining measures were intended to help control the spending of affected households and included tax relief and price-setting for the basic food basket (Robles and Holz, 2024).

Countries' public health efforts to vaccinate against SARS-CoV-2 were also instrumental in the easing of health restrictions and kickstarting the economic and social recovery. However, the inoculation campaigns were not equal: in 2021, just 30% of the region's population had been fully vaccinated, showing significant gaps, both across developed and developing countries and within the region (ECLAC/PAHO, 2021). The role of primary healthcare was critical in the roll-out of national vaccination plans, as were communication and outreach strategies aimed at building trust in the effectiveness and safety of vaccines to boost acceptance and compliance, so that by late 2022, nearly 70% of the population was fully vaccinated (Cid and Marinho, 2022). Primary care also played a vital role in testing, tracing and isolating patients infected with SARS-CoV-2 (ECLAC/PAHO, 2021).

The experience of the pandemic highlighted the need for countries to advance towards a public health agenda that takes a comprehensive and intersectoral approach to health policy, addresses the social determinants of health and has strong linkages with universal, comprehensive, sustainable and resilient social protection systems. Such a shift is key for ensuring basic well-being, access to and the right to health for all, while anticipating potential crises and emergencies (ECLAC/PAHO, 2021).

A predominantly biomedical[7] approach to health issues limits innovation in health responses (Farre and Rapley, 2017). Although there is a need to strengthen health ministries' capacity to collaborate with other sectors and engage in diplomacy on health issues, the political influence of the health sector is often limited compared with other sectors, an important barrier that must be addressed to spur cross-sectoral collaboration (Bryson, Crosby and Stone, 2015). The imperative to advance towards cross-sectoral coordination that transcends social protection systems must be recognized; it should extend to the economic, environmental, security, justice, education, infrastructure, housing, community services, transport, planning, agriculture and food sectors and beyond (Nunes, Lee and O'Riordan, 2016).

The high returns on investment in health equality and the social determinants of health were evident even before the pandemic. Data from the COVID-19 crisis show an even higher potential for such returns (Yerramilli, Chopra and Rasanathan, 2024). In this context, it is important to take into account more than the immediate fiscal pressures. The time to invest in health equality and the broader social determinants of health is now.

C. The role of social participation in democratizing health and designing responses to inequality: a central component of primary healthcare

Civil society organizations are the organized response of vulnerable social groups. These grass-roots organizations have a deep understanding of the diverse needs and challenges of the communities they serve. During the pandemic, that knowledge was critical for identifying and meeting the specific health needs of groups such as workers in the informal economy, migrants, homeless persons, persons with disabilities and other marginalized groups facing extreme difficulties (Maroscia and Ruiz, 2021).

Civil society groups involved in public health issues are a key asset for the democratization of health, which is defined as equitable and universal access to health services and meaningful public participation in decision-making on health policies, programmes and practices (Anigstein, 2008).

Including social stakeholders in the design and implementation of policies aimed at equality and the achievement of the SDGs is essential for long-term policy effectiveness and sustainability. It is also indispensable for instituting comprehensive primary healthcare, grounded in the right to health, leaving no one behind. The need for such an approach was further highlighted during the COVID-19 pandemic, when civil society organizations proved instrumental in meeting needs, customizing interventions and crafting innovative solutions to the crisis (Maroscia and Ruiz, 2021; Batthyány and others, 2021).

Social participation is also a critical factor for ensuring the sustainability of public health policies. Including civil society organizations in decision-making strengthens their commitment to effective policy implementation, builds capacities and empowers them to advocate for policy continuity post implementation.

During the pandemic, civil society organizations mobilized rapidly to address the health crisis and its social and economic impacts. In many countries, they established solidarity networks to supply food, medicine and psychosocial support to the hardest hit communities (Batthyány and others, 2021). Many also adapted their programmes and services to address emerging needs, including by supplying personal protective equipment, encouraging hygiene and physical distancing and providing basic medical care for the sick (Saa and Villa, 2022). In Latin America and the Caribbean, these organizations play a key role in channelling social policy interventions to the communities most in need. Many examples were seen during the pandemic: in some areas, they worked closely with local governments to distribute food and medical supplies to those affected by the economic crisis. Some established programmes to provide financial and employment support to help overcome the economic impact of the pandemic.

[7] The biomedical approach assumes disease or health issues to be "strictly concerned with organic malfunction", in contrast with the biopsychosocial model, which takes into account various psychological and social factors and dimensions of illness (Farre and Rapley, 2017, p. 2).

Civil society organizations were also instrumental in raising awareness on the disease and promoting prevent and control measures. Through outreach and education campaigns, they helped to counteract disinformation and myths about the virus, promoting healthy practices and fostering solidarity and unity during the crisis (Levine and others, 2023).

These organizations were active in supporting public policies aimed at fostering social innovation, equality and inclusion, which have a direct impact on the well-being of people and communities. In many countries, they advocated for the implementation of social protection measures, such as unemployment subsidies, deferral of rent and utilities payments, and free medical care for all, irrespective of migration status (Leisering, 2021).

There were many examples of successful cooperation between civil society organizations and the health sector during the pandemic. In some countries, coordination committees —comprising representatives of these organizations, health authorities and community leaders— were established to develop joint prevention and response strategies. These initiatives proved efficient in reaching marginalized communities and ensuring equitable access to health and social support services (García and others, 2020).

III. The health impacts of the pandemic underscore the urgent need to strengthen the primary healthcare approach to ensure universal access to health

A. Evolution of service coverage and financial protection in healthcare

According to *Tracking universal health coverage: 2023 global monitoring report*, the pandemic worsened existing barriers to accessing health services and created new ones. Access conditions were worsened by the effect on the provision of essential health services, combined with the socioeconomic crisis. This was compounded by waiting lists and forgone care, resulting in a higher incidence of unmet needs due to supply-side and demand-side barriers (WHO/IBRD/World Bank, 2023).

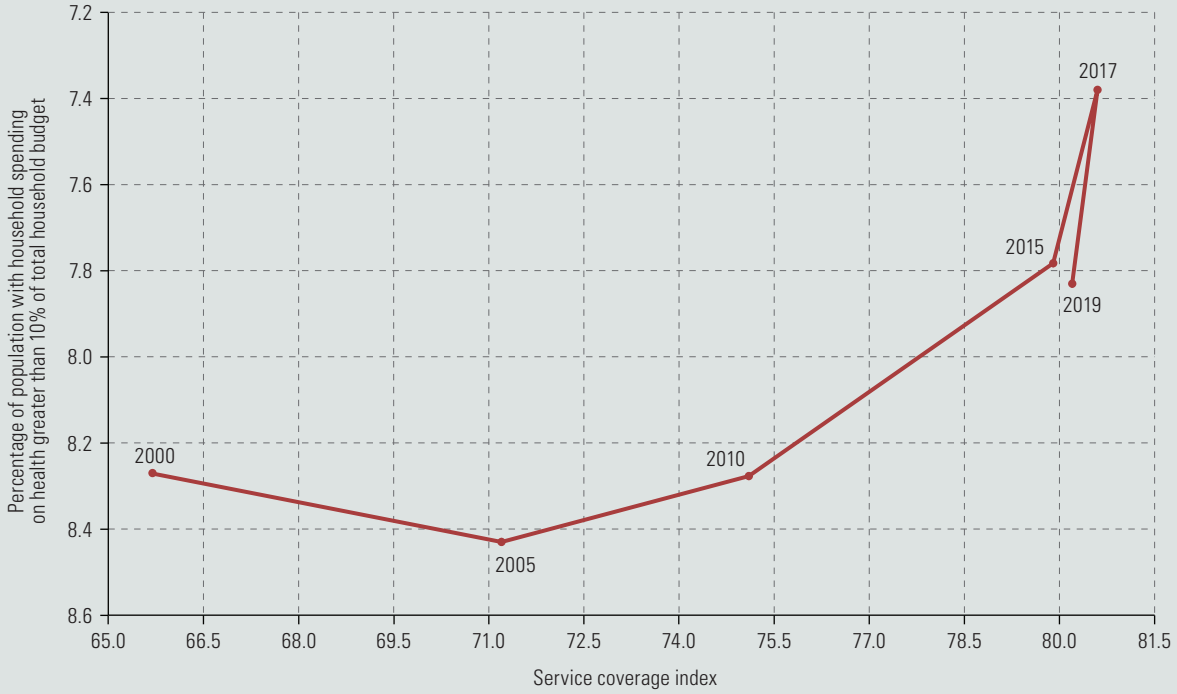
Between 2000 and 2015, there were significant improvements in coverage of essential health services (SDG indicator 3.8.1) in all regions of the world, while some regions recorded setbacks in proportion of population with large household expenditures on health as a share of total household expenditure or income (SDG indicator 3.8.2), which captures financial protection. Improvements in service coverage stalled or slowed after 2015, while the financial protection trend held steady (WHO/IBRD/World Bank, 2023). Some projections to 2030 suggest that, globally, most countries will miss their financial protection targets and that 7% of households will continue to incur catastrophic health spending (measured at the 10% threshold) (Rahman and others, 2022).[8]

Against this international backdrop, the Americas and Europe are among the regions with relatively high service coverage (up from 66% in 2000 to 80% in 2019) and low catastrophic health spending at the 10% threshold (7.7% on average over the same period).[9] However, there are some causes for concern in Latin America and the Caribbean, such as the recent stall in service coverage (at 80%) and the regression in the latest available measure of catastrophic spending at the 10% level, which returned to 7.8% in 2019 —after having improved, down from 7.8% to 7.4% of the population— meaning that around 79 million people were incurring catastrophic costs (WHO/IBRD/World Bank, 2023) (see figure 3). Preliminary data show that, owing to the pandemic, service coverage stagnated again around 2021.

[8] WHO (2010b) defines direct or out-of-pocket payment as charges or fees levied for health services, usually doctors' fees or medicines. Catastrophic spending refers to out-of-pocket spending that exceeds 10% or 25% of household income (WHO/World Bank, 2021).

[9] The universal health coverage service coverage index refers to the global population-weighted score for selected essential services; the higher the score, the better the service coverage. Catastrophic out-of-pocket health spending refers to the global population-weighted incidence rate of catastrophic health spending, defined as the percentage of the population with household out-of-pocket health expenditure exceeding 10% of the household budget (consumption or income); the lower the incidence, the better. Both are calculated for countries in all regions using the methodology described in annexes 1 and 9 of *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (WHO/IBRD/World Bank, 2023).

Figure 3 The Americas: progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2019
(Index and percentages)



Source: Prepared by the authors, on the basis of World Health Organization (WHO)/International Bank for Reconstruction and Development (IBRD)/World Bank, *Tracking Universal Health Coverage: 2023 Global Monitoring Report*, Geneva, 2023.
Note: Data for SDG indicator 3.8.1 are from the WHO database on global universal health coverage, May 2023[online] https://datatopics.worldbank.org/universal-health-coverage/, and for SDG indicator 3.8.2, from the global health observatory database maintained by WHO and the World Bank,[online] https://www.who.int/data/gho/data/themes/topics/financial-protection.

In the wake of the pandemic, the region has suffered greater setbacks than other regions with respect to inequality in coverage between countries, measured by the Gini coefficient of the service coverage index. The steady improvement until 2015 stalled and then reversed, resulting in a setback of roughly a decade (WHO/IBRD/World Bank, 2023).

One of the main lessons from the pandemic is that advances in universal coverage are correlated with the proportion of health budgets channelled through government (fiscal) and social security (contributory) funding, compared with voluntary pre-payment modalities and, in particular, out-of-pocket household spending. Advancing towards universal health coverage will require efficient use and management of public health resources. This highlights the importance of World Health Assembly resolution 58.33 of 25 May 2005 on sustainable health financing, universal coverage and social health insurance, which calls for such an approach, and of resolution CD53.R14 of the Directing Council of the PAHO, by which it adopts the Strategy for Universal Access to Health and Universal Health Coverage and urges member States to "increase efficiency and public financing of health, as appropriate, noting that in most cases, public expenditure of 6% of GDP is a useful benchmark and that these resources should be allocated, as appropriate, on a priority basis to the primary level of care to expand the supply of quality services and quickly address unmet health needs".

A more recent study containing financial protection outcomes for universal coverage to 2030 summarizes the relevant policy recommendations: increase government expenditure on health, invest in mandatory social health insurance programmes, and subsidize premiums for the disadvantaged population, including the poor, uninsured, and unemployed (Rahman and others, 2022).

The foregoing underscores the need to maintain policies that significantly reduce out-of-pocket health spending, not just catastrophic spending that causes financial hardship, and that provide comprehensive responses to financial protection issues, one of the ultimate goals of health systems.

B. Health challenges inherited from the pandemic and the urgent need to build health system resilience

Health system resilience has proven critical in tackling crises that call for flexibility amid change and rapid, efficient responses without disrupting timely access to services and healthcare.

The social and economic repercussions of the COVID-19 pandemic, described above, have triggered a critical situation in Latin America and the Caribbean, threatening public health gains and the achievement of the Sustainable Development Goals of the 2030 Agenda. Public health crises over the past decade have exposed the region's vulnerability to risks that limit the capacity of health systems to effectively respond to the needs of the population (PAHO/WHO, 2016). This has shed light on the importance of resilient public health policies and of strengthening health systems so they are able to deal with and recover from crises such as the pandemic (PAHO/WHO, 2016). The lessons learned from previous outbreaks, including of the Ebola, chikungunya and Zika viruses, have driven the development of multisectoral policies aimed at strengthening health systems based on primary healthcare, making them more resilient and inclusive (PAHO/WHO, 2016). It is crucial to step up efforts to better prepare those systems at both the international and national levels, ensuring the right to health for all in the region, leaving no one behind.

Longstanding weaknesses in health systems, particularly in the areas of prevention and preparedness, have impeded the ability to effectively respond to outbreaks like the recent COVID-19 pandemic (WHO, 2021b). Báscolo and others (2022) state that fragmentation and lack of capacities in health authorities have compromised the delivery of effective and equitable solutions. They also posit that the resulting inequalities can be attributed to factors that include weak leadership and coordination and the politicization of the response, as well as, in some countries, pre-existing structural weaknesses and insufficient attention to stewardship and governance. Against this backdrop, a regional agenda must be implemented to develop truly resilient health systems (ECLAC/PAHO, 2021).

In 2021, the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains was approved (PAHO/WHO, 2021). This Strategy includes lines of action for transforming health systems based on the primary healthcare approach, strengthening leadership, stewardship and governance, strengthening the capacities of health service delivery networks, and increasing and sustaining public financing in health and social protection, as follows:

(a) **Transform health systems:** Accelerate the implementation of a primary healthcare approach that addresses the needs of people, families, and their communities, ensuring continuous access to health promotion and disease prevention services. Encourage the implementation of intersectoral interventions to address the social, environmental and economic determinants of health, fostering inclusive social participation and renewing the commitment to implementing the recommendations of Compact 30.30.30: PHC for Universal Health.

(b) **Strengthen leadership, stewardship, and governance:** Adopt a whole-of-government and whole-of-society approach to enhance key public health capacities, strengthen institutional structures and skills for the coordination of different public health interventions across sectors, and ensure that health authorities have the requisite human, technological and financial capacities and resources. Improve management and coordination, review regulatory and legislative frameworks and establish formal monitoring, evaluation and accountability mechanisms.

(c) **Strengthen capacities of health service delivery networks:** Develop capacities for adaptability, response and reorganization of the health services network, improve management and establish mechanisms for coordination of care along the continuum of health services. Strengthen the response capacity of the first level of care, improve planning and management of human resources and adopt digital solutions to enhance access to health services.

(d) **Increase and sustain public financing in health and social protection:** Increase public investment to overcome structural funding vulnerabilities, improve financial sustainability, and prioritize investments in the first level of care, allocating at least 30% of total public expenditure in health to the first level. Strengthen planning and financial management capacity and improve costing and budgeting.

The experience of the pandemic laid bare the critical need to channel resources towards building resilience in health systems. Such an approach not only safeguards and fosters public health, it also boosts socioeconomic progress. In that regard, governments must adopt focused, strategic measures to address the systemic shortcomings and historical structural weaknesses of the health systems of Latin America and the Caribbean. Action should be directed towards building resilient health systems for the future, by rapidly expanding access and coverage, prioritizing efforts to address health inequalities and environmental risks, and adopting and consolidating the innovations introduced in the health system as part of public pandemic responses.

It is incumbent not only upon decision-makers but also the public health community to promote the implementation of these lines of action. This requires advocating for the development of universal, comprehensive, sustainable and resilient social protection systems that help to combat poverty and reduce the uneven impact of the social determinants of health. It will also call for accelerating and scaling up coordinated action among all sectors and the health sector to spur systemic transformations. Given the persistence of several barriers, a comprehensive and holistic approach to the supply and demand factors that limit access to health services is required.

There is a need for comprehensive public health action that prioritizes health promotion and disease prevention, in line with the principles of comprehensive primary healthcare. Also needed are strengthened health authorities capable of developing comprehensive policies underpinned by more robust legal and regulatory frameworks and the requisite capacities and resources to implement healthcare initiatives. This means having robust institutional frameworks across all dimensions of health systems.

All stakeholders making up the institutional fabric of health systems and other social sectors, including health sector authorities, must work together to address segmentation, fragmentation and the social determinants of health. Long-term planning should guide these processes, rooted in the principle of the right to health as the primary objective in the transformation and strengthening of health systems. Actions should be tailored to national circumstances and local contexts, based on greater knowledge and situational analysis.

The adoption of comprehensive, cross-sectoral approaches that address structural vulnerabilities and promote inclusive and sustainable social development is paramount for building resilient health systems. This includes linkages with social protection systems; coordination between health, science, technology and industry; digital integration, stronger international cooperation and, above all, a primary healthcare and cross-sectoral approach. Some countries of the region, such as Argentina, Chile and Colombia, are implementing proposals to transform health systems using a comprehensive primary healthcare approach, addressing structural deficiencies like fragmented service delivery and lack of funding. These initiatives build on the lessons learned from countries with experience in that approach, such as Brazil and Cuba (Etienne, 2018a; Barreto and others, 2014).

C. Overcoming barriers to access: the critical role of primary healthcare

Eliminating the barriers to accessing healthcare is one of the main commitments of the member States of PAHO in advancing towards universal access and coverage (Etienne, 2018b). An intimate understanding of these barriers must be achieved to effectively address them (Barreto and others, 2014).

Even before the pandemic, the patchwork of access barriers faced by individuals posed challenges for achieving equality in health systems and services (Barreto and others, 2014). A 2022 study with data from 15 countries of the region showed that some 9.3% of the population, or around 295 million people, had unmet healthcare needs (PAHO/WHO, 2023). Moreover, unmet needs were more common in countries with a lower human development index, highlighting the persistent inequality among countries and the need to understand the factors that underpin access problems and health inequalities.

The barriers in access to health identified in the study were attributed to economic, sociocultural and organizational factors in health systems, which affect supply and demand for services (PAHO/WHO, 2023). Among the respondents, 13.1% cited lack of resources, medication and infrastructure as a reason for not seeking care, 10.8% an inability to pay, 8.3% cited organizational issues such as long wait times and excessive paperwork, 6.3% cited acceptability barriers, such as lack of trust in health personnel or lack of culturally appropriate services, and 3.7% mentioned geographical barriers (PAHO/WHO, 2023).

The pandemic also reaffirmed the importance of demand-side barriers related to the social determinants of health. The pandemic brought to light these barriers, which mainly affect vulnerable groups such as informal workers, who account for at least half the region's workers, face job instability and lack social security coverage. For this population group, cessation of employment or remote work were not option; remaining in the home meant losing their jobs and, in many cases, their livelihoods as well. Many informal workers were faced with a dilemma: death by starvation or death by the virus (Coetzee and Kagee, 2020; Zaildo and others, 2023; PAHO/WHO, 2020b).

Unequal and intersecting barriers were posing challenges for equality in health systems and care even before the pandemic. These factors are related to the axes of the social inequality matrix, including socioeconomic status, ethnicity, race, gender and location, among others, which affect access to health, and, when combined, worsen access and disproportionately affect the most vulnerable populations. The demographic and health surveys of eight Latin American countries show that the barriers women face in accessing medical care are mainly related to financial constraints (56.7%), followed by distance to health centres (36,6%), unwillingness to travel alone (29,7%) and the need to obtain permission from the head of household (13,5%) (Houghton and others, 2022) (see table 1).

Table 1 Latin America (8 countries):[a] barriers women face in seeking healthcare, by income quintile, geographical area and marital status, 2001–2019
(Percentages)

	Total	Income quintile		Location		Marital status	
		Lowest-income quintile (quintile I)	Highest-income quintile (quintile V)	Urban	Rural	In a relationship, not a household decision-maker	In a relationship, a household decision-maker
Distance	36.6	59.3	20.6	25.9	51.8	45.0	35.5
Does not wish to travel alone	29.7	40.5	23.8	25.9	35.0	33.9	24.6
Cannot afford to go	56.7	74.2	37.2	50.0	66.3	63.7	54.4
Cannot obtain permission	13.5	18.4	10.7	12.3	15.2	15.5	11.4

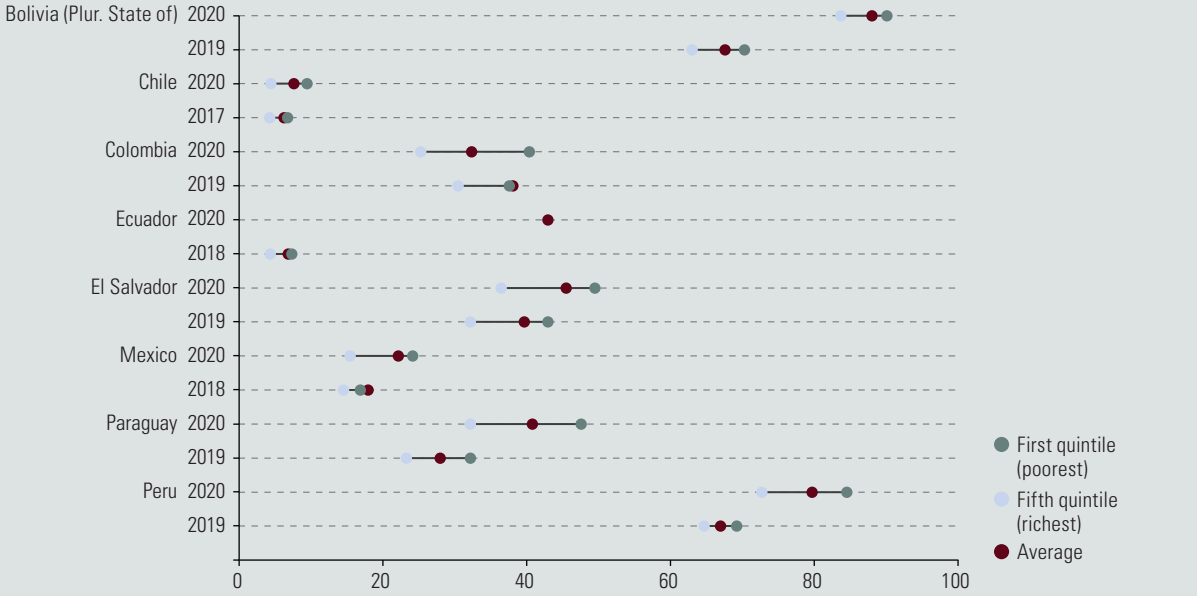
Source: Prepared by the authors, on the basis of N. Houghton and others, "Barriers to access to health services for women and children in Latin America", *Pan American Journal of Public Health*, No. 46, 2022.
Note: Post-stratification weighting based on demographic and health surveys conducted between 2001 and 2019.
[a] The Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Peru and the Plurinational State of Bolivia. Post-stratification weighting from Demographic and Health Surveys conducted between 2001 and 2019.

The pandemic worsened barriers to access in the region, on both the supply and demand sides, hindering service and medical personnel availability and exacerbating issues related to acceptability and demand for medical care. Despite positive signs of economic recovery and continuity of services, in 88% of 25 countries in the region some level of essential health service disruption to December 2022. Staff shortages and a decline in demand for care were the main problems reported (WHO, 2023c).

In addition, according to the latest household surveys (HO/IBRD/World Bank, 2023), the percentage of the population with unmet healthcare needs was higher than before the pandemic in eight countries of the region. On average, the percentage of the population reporting this problem rose from 34.1% prior to the pandemic to 41.5% in 2020 (see figure 4). Moreover, lower-income population groups were more likely to have unmet health needs, as were people living in rural areas and those with lower levels of education, with clear inequalities within the countries surveyed. Likewise, barriers to access varied among the countries.

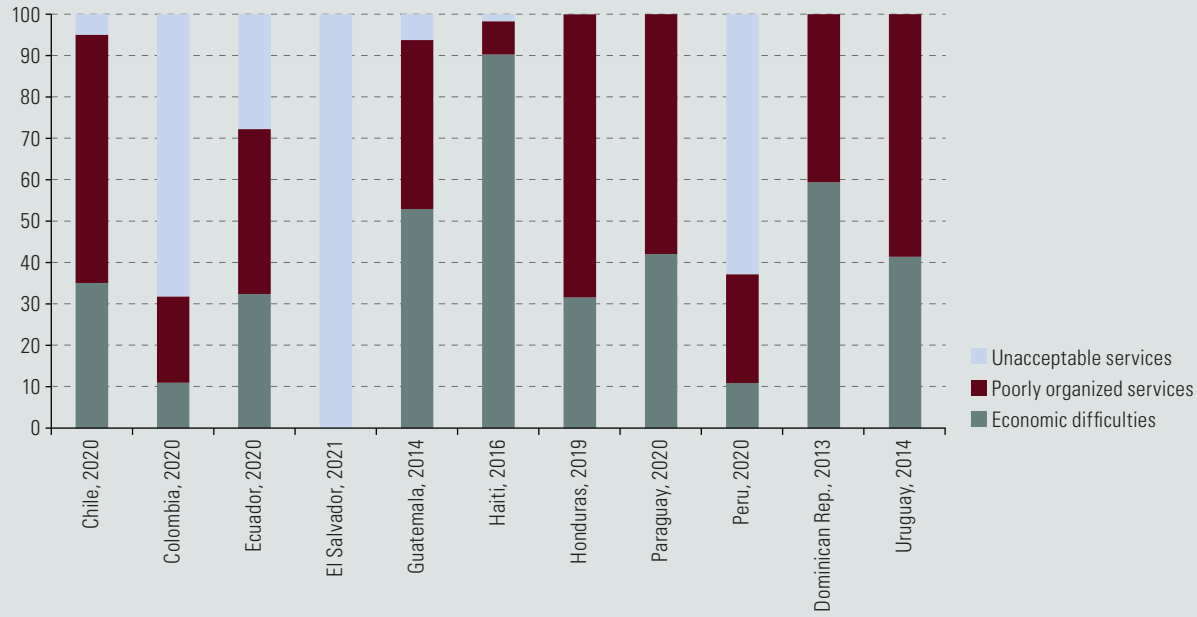
Barriers to access vary across different countries or even within countries. While survey data do not provide a comprehensive view of all barriers, they help to illustrate this problem. For example, in Colombia and Peru, the relative weight of barriers to access reveals that those linked to acceptability (such as lack of trust in health personnel, language and cultural preferences) are reported more frequently than other types of difficulty. However, in countries such as Honduras and Paraguay, financial accessibility continues to be one of the main barriers to access (see figure 5). Barriers related to organization, such as long waiting times and excessive bureaucracy, exist in all countries and are more prevalent in countries such as Chile and Uruguay.

Figure 4 Latin America (8 countries): unmet healthcare needs, by country and income quintile, around 2018 and 2020
(Percentages)



Source: Prepared by the authors, on the basis of World Health Organization (WHO)/International Bank for Reconstruction and Development (IBRD)/World Bank, *Tracking Universal Health Coverage: 2023 Global Monitoring Report*, Geneva, 2023.

Figure 5 Latin America and the Caribbean (11 countries): distribution of unmet healthcare needs, by type of access barrier, latest year with data available
(Percentages)



Source: Prepared by the authors, on the basis of Pan American Health Organization (PAHO), *Analyzing and Overcoming Access Barriers to Strengthen Primary Health Care*, Washington, D.C., 2023 [online] https://iris.paho.org/bitstream/handle/10665.2/58876/9789275127568_eng.pdf?sequence=1&isAllowed=y.

The combined effect of barriers to access may be more significant than the individual impact of each factor, emphasizing the complex and multidimensional nature of access to services. The data presented help to identify common ways to address access challenges. These include adopting a

comprehensive primary healthcare approach, strengthening regulatory frameworks and governance structures, promoting interculturality and improving the quality of care. Available data and the analysis of barriers may also contribute to the design of intersectoral policies, such as the development of telecommunications and road infrastructure to improve the accessibility of health services.

The renewed push to strengthen primary healthcare presents an opportunity for prioritizing policy initiatives that directly address challenges related to access to health services. Reducing and eliminating barriers to access is essential to achieve universal health coverage and build resilient health systems. Understanding and addressing the full range of factors that act as barriers to access is a necessary and critical first step towards comprehensive primary healthcare.

IV. To reduce inequality and move towards inclusive and sustainable social development, ensuring that health systems are sustainable is fundamental

A. Dimensions of health system sustainability

Given that population health is a necessary condition for achieving sustainable development in all its dimensions, investing in health represents a concrete step towards inclusive and sustainable social development. It is therefore essential to establish universal, comprehensive, sustainable and resilient health systems that ensure universal access and coverage, provide timely and quality care to the entire population regardless of their ability to pay, have sustainable solidarity-based financing mechanisms, and can adapt to changes and crises.

Consolidating health systems to include these characteristics requires sustained public investment over time to ensure universal health coverage and access, sufficiency of entitlements and financial sustainability (Arenas de Mesa, 2019). The financial sustainability of health systems is fundamental for both current and future generations to exercise their right to health, thereby contributing to inclusive and sustainable social development. Therefore, countries must consider the present and future tax revenues and expenditures needed for the required health system transformations (Arenas de Mesa, 2016).

To move in this direction and closer to the targets agreed in the 2030 Agenda, three key dimensions must be considered: coverage, sufficiency of entitlements and financial sustainability (ECLAC, 2018a). A balance must be struck between universal coverage, sufficiency and quality of services, and the costs and financial sustainability required, to ensure the sustainability of health systems. This sustainability is threatened if any of these three dimensions is insufficient or inadequate to meet the needs of the population. There is a close link with the four simultaneous, interdependent strategic lines for advancing universal health access and coverage that are proposed by PAHO in the Strategy for Universal Access to Health and Universal Health Coverage: (i) expanding equitable access to quality, people- and community-centred health services; (ii) strengthening stewardship and governance; (iii) increasing financing and reducing barriers to access; and (iv) strengthening multisectoral coordination to address the social determinants of health (PAHO/WHO, 2014). The sustainability of health systems is thus fundamental to ensuring universal health coverage, as referred to in target 3.8 of the 2030 Agenda.

However, universal health coverage, understood as the capacity of the health system to meet needs in terms of financing, infrastructure, human resources and technologies, is intrinsically linked to access to health, defined as the possibility of using comprehensive, quality and timely services without barriers. Human resources for health are a central dimension of health systems strengthening to move in this direction (see box 2). Therefore, without effective access to health, the goal of universal coverage will be unattainable, which in turn will hinder progress towards inclusive and sustainable social development.

Box 2 Human resources for health: critical issues for addressing future threats to public health and building resilient health systems

The COVID-19 pandemic exacerbated existing inequalities in the availability, distribution and quality of the health workforce, with low staff retention in rural and underserved areas, and high rates of mobility and migration. Health personnel suffered social stigma, experienced violence and faced high levels of uncertainty and stress, long shifts, excessive workloads and fear of infection. Approximately 60,000 healthcare workers died from COVID-19 in the Americas (WHO, 2022).

In the region, more than 80% of healthcare workers are women, 56% of whom are nurses. However, women earn 20% less than men, have limited access to leadership positions, and are underrepresented in high-level positions in both health systems and in the political arena.

By 2030, the gap in the health workforce to meet projected needs in Latin America and the Caribbean will be between 600,000 and 2 million people (GBD 2019 Human Resources for Health Collaborators, 2022). A key factor is migration, driven by low pay, limited career opportunities and stressful working conditions. Building resilient health systems must involve implementation of recruitment and retention strategies to stem this exodus.

There is an urgent need to increase investments in the development and well-being of health personnel, providing better working conditions, benefits packages and mental health support, pursuing policies to improve social well-being and close the gender wage gap, and ensuring protection and decent work with a multisectoral approach.

The Policy on the Health Workforce 2030: Strengthening Human Resources for Health to Achieve Resilient Health Systems, adopted by PAHO member States in 2023, provides countries with strategic and technical guidance on these critical issues.

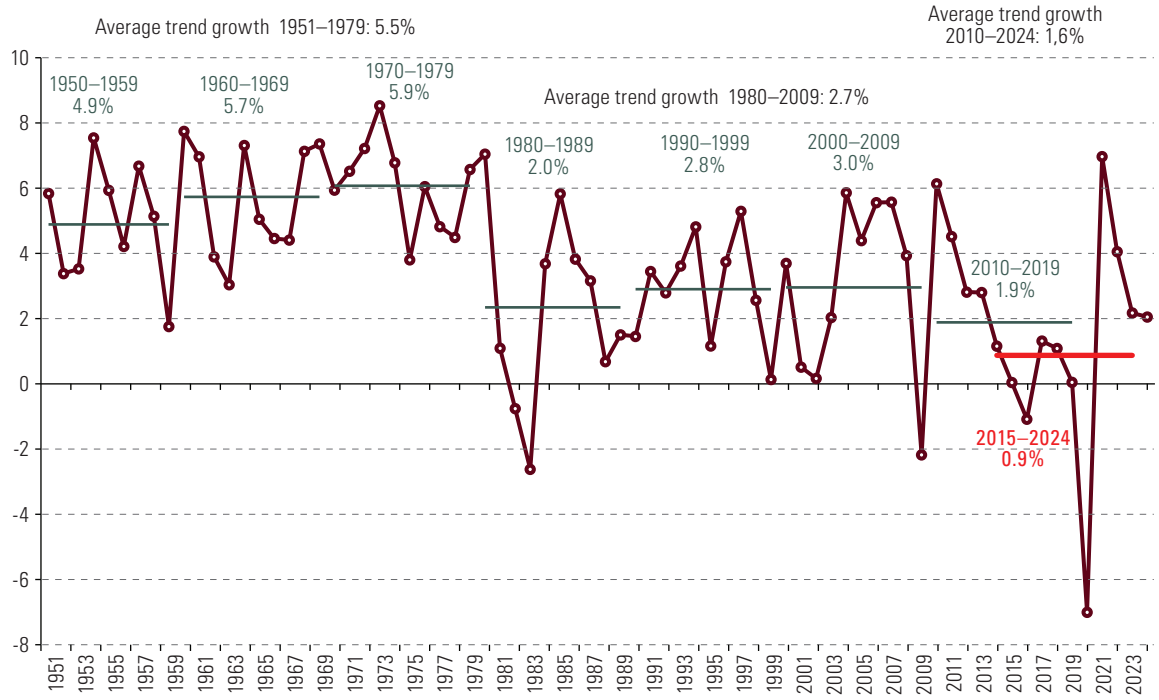
Source: Prepared by the authors, on the basis of World Health Organization (WHO), "Global excess deaths associated with COVID-19 (modelled estimates)", Geneva, 2022 [on line] https://www.who.int/data/sets/global-excess-deaths-associated-with-covid-19-modelled-estimates; GBD 2019 Human Resources for Health Collaborators, "Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019", *The Lancet*, vol. 399, N° 10341, 2022.

B. New challenges for health system financing in a context of uncertainty

The macroeconomic situation in Latin America and the Caribbean conditions countries' available fiscal space when considering the need to increase investments in health. The current scenario is characterized by great uncertainty linked to rapid technological, environmental, geopolitical and demographic changes, as well as high levels of public debt and global inflation (ECLAC, 2022b). Despite a downward trend in public indebtedness, levels remain considerably high. In September 2023, this indicator reached 49.8% of GDP in Latin America, a notable improvement compared with the most critical period of the pandemic, when it was 56.0%. Public debt remains remarkably high and is similar to the levels recorded in the 2000s, a decade marked by economic and financial crises (ECLAC, 2023b). Additional challenges include external debt, the low tax burden characteristic of the region and high levels of tax evasion and avoidance (ECLAC, 2022b and 2023b).

In addition to the above, economic projections for Latin America and the Caribbean point to a period of low growth. According to the latest ECLAC estimates, the region recorded economic growth of 2.2%, on average, in 2023, and growth is estimated at 1.8% for 2024 and 2.3% for 2025 (ECLAC, 2024b). This not only reflects a slowdown in regional growth compared to 2022, but also confirms the downward trend in both the region's economic growth and trend GDP over the past seven decades (see figure 6).

Figure 6 Latin America and the Caribbean: growth in GDP and trend GDP, 1951–2024
(Percentages on the basis of constant dollars at 2018 prices)



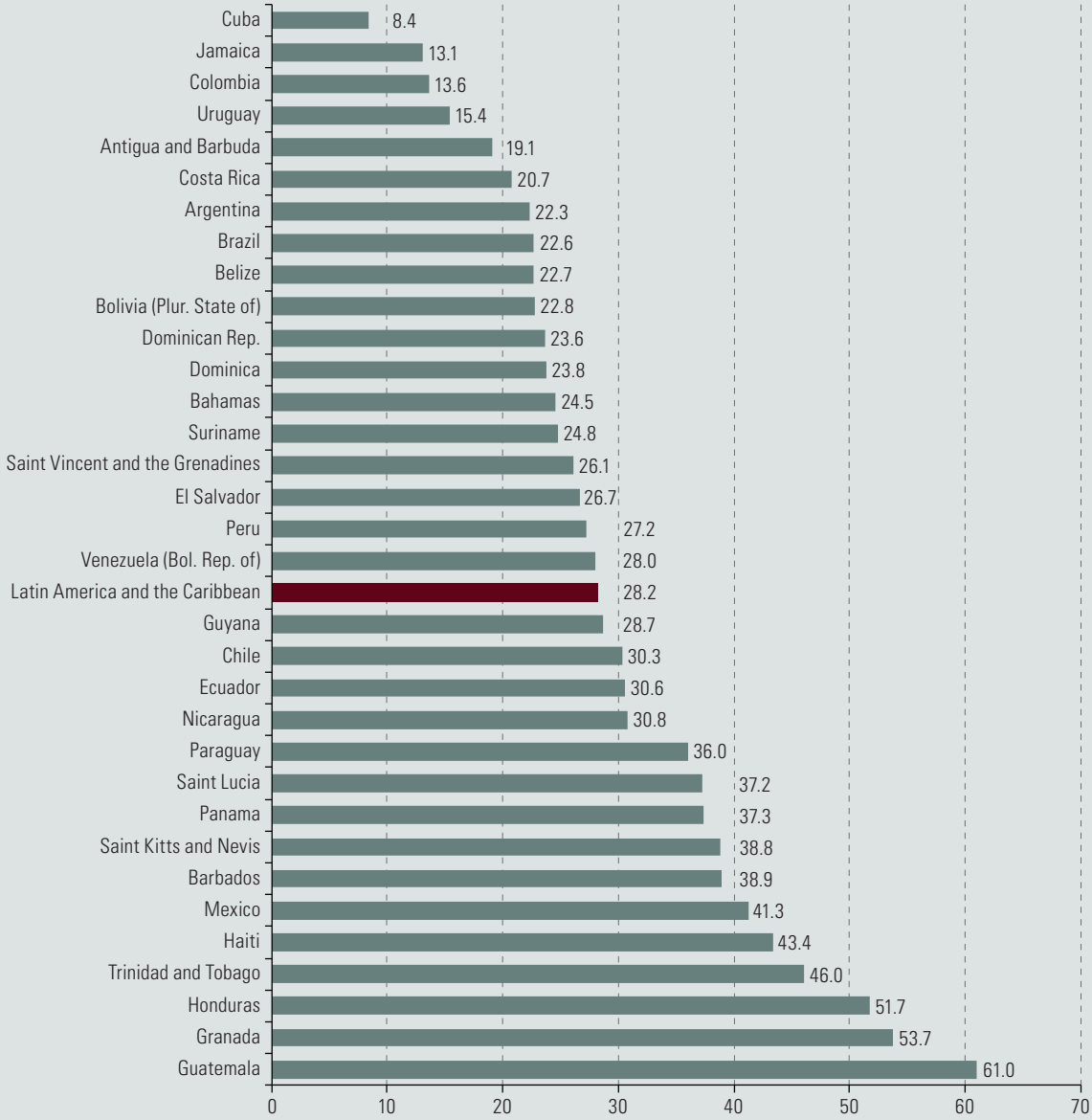
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of *Economic Survey of Latin America and the Caribbean, 2024* (LC/PUB.2024/14), Santiago, 2024, and official figures.

These trends are occurring amid a development crisis in Latin America and the Caribbean, which is manifested in three development traps (Salazar-Xirinachs, 2023). The first is low growth, reflected in figure 6, which requires increased efforts in terms of growth and productive development policies. The second is high inequality, which is exacerbated by weaknesses and deficiencies in economic growth and structural heterogeneity, education and vocational training, gender equality, job creation, tax systems and social policies. The third trap is low institutional capacity and ineffective governance to address the development challenges faced by countries.

This economic and fiscal scenario severely restricts the expenditures and investments needed to consolidate universal, comprehensive, sustainable and resilient health systems. Although public spending on health in Latin America and the Caribbean increased by 25% between 2000 and 2014, the average was 4.5% of GDP in 2021 (WHO, 2023a), remaining below the target of 6.0% of GDP proposed by PAHO/WHO.

In 2021, average public spending on health in the countries of the region represented 61% of total health spending, highlighting the continued prevalence of private spending, which mainly comprises out-of-pocket spending (WHO, 2023a). On average, households in the region had to cover more than 28% of total health spending with out-of-pocket payments in 2021, and in 14 countries, out-of-pocket spending was even higher than the regional average (see figure 7). This figure is worrying, since such expenses reproduce inequalities in access to quality healthcare and may lead to catastrophic expenditure or impoverishment. In countries such as Colombia, Cuba, Jamaica and Uruguay, where public financing of health is predominant, out-of-pocket spending represents less than 20% of total health expenditure; this figure serves as a limit that countries must not exceed to avoid households incurring catastrophic expenditures (Xu and others, 2010).

Figure 7 Latin America and the Caribbean (33 countries): out-of-pocket spending as a share of total health expenditure, 2021
(Percentages)

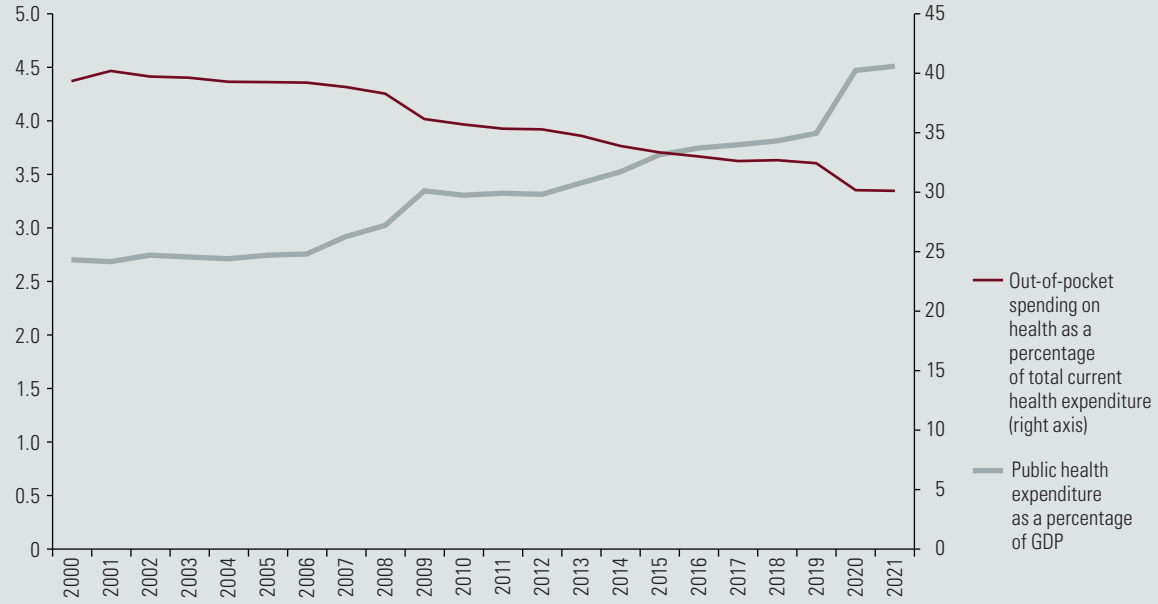


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), Global Health Expenditure Database.

Trends in health spending in Latin America and the Caribbean illustrate the substitutive relationship between public spending and out-of-pocket spending as sources of health financing, which intensified with the onset of the pandemic. In 2021, public spending on health increased to a record 4.5% of GDP, while out-of-pocket spending on health dropped to 30.1% of current health spending (see figure 8). While this trend was already seen prior to the COVID-19 pandemic, the magnitude of the increase in public health spending between 2020 and 2021 was mainly due to the extraordinary expenditures linked to the pandemic,[10] so a slowdown would be expected from 2022 onward.[11] There is consensus that the region will face a major challenge in this area in the coming years, given the weak economic growth outlook and the reprioritization of public spending.

[10] Financed through intersectoral reallocation of resources, the creation of contingency funds and borrowing, among other sources.
[11] The corresponding figures were not yet available for most of the countries of the region at the time this document was prepared.

Figure 8 Latin America and the Caribbean (32 countries):[a] average ratio of public expenditure on health to GDP and out-of-pocket expenditure on health to total current health expenditure, 2000–2021
(Percentages)



Source: Prepared by the authors, on the basis of World Health Organization (WHO), Global Health Expenditure Database.
[a] Includes data from Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago and Uruguay.

Another important aspect of health financing is strengthening the services offered at the first level of care as a fundamental pillar of a primary healthcare approach. A PAHO/WHO study (2024) indicates that the increase in public expenditure on health between 2020 and 2021 in a group of selected countries in Latin America and the Caribbean occurred simultaneously with an increase in spending on the first level of care as a share of total spending, owing partly to the extraordinary expenses incurred in response to the COVID-19 pandemic. However, when extraordinary expenses are eliminated, the results show stagnation or a decrease in the prioritization of spending on the first level of care in most of the countries included in the study.

Monitoring indicators on spending priorities is essential to verify whether health spending is targeting interventions that generate greater value for the resources invested and that improve access with equity and efficiency. Strengthening health systems resilience in the region requires faster implementation of a primary healthcare strategy. While this type of strategy affects all levels of care, it prioritizes investment in primary care services, with emphasis on preventive care and health promotion, which consider the needs of the population and their epidemiological contexts.

The inequalities in access to healthcare, the gaps in the quality of care received and the high out-of-pocket expenses incurred by the population not only underline the urgency of increasing public spending on health and managing resources more efficiently; they also reveal the need to improve the sustainability and predictability of financing in order to strengthen health systems resilience. Countries must move forward with social agreements that are accompanied by solid fiscal covenants that facilitate the necessary investments and provide financial sustainability to the health system.

Increased investment in health should strengthen the primary healthcare approach and the first level of care, recognized as the most inclusive, equitable, cost-effective and efficient strategy to improve population health and social well-being (WHO, 2023b). Investing in the strengthening of health systems based on primary healthcare not only leads to better levels of health in general, but also has positive socioeconomic effects owing to the impact on the social determinants of health at local or territorial level. Within this context, PAHO urges countries to increase public investment in health to at least 6% of GDP.

V. Today, more than ever, investment must prioritize progress towards universal, comprehensive, sustainable and resilient health systems that overcome inequality and achieve sustainable development

The world faces the challenge of achieving all the agreed Goals and targets of the 2030 Agenda within the next six years, after considerable setbacks resulting from the multiple crises triggered by the COVID-19 pandemic and within a highly complex geopolitical scenario. Latin America and the Caribbean is facing this challenge amid a development crisis marked by factors that limit countries' ability to return to the path of sustainable development. It is therefore essential to foster structural transformations in development models and increase efforts to ensure people's right to health, since without health, sustainable development is impossible.

In addition to being a basic human right and a key component of comprehensive well-being, health is a requirement for achieving inclusive social development, economic development and environmental sustainability, so investing in it is also investing in sustainable development. A similar interdependence exists among the different SDGs, such that countries' efforts to meet the Goal 3 targets contribute to and enable the achievement of the other Goals and the 2030 Agenda as a whole.

There is thus an urgent need for the countries of the region to move towards health systems that guarantee timely and quality care for all people and towards universal health coverage and access. Countries should also reinforce their institutional capacity for response and resilience to future crises and improve the linkages between their health systems and social protection systems and other sectors, according to the principle of the right to health, leaving no one behind. Such changes must be undertaken while guaranteeing the financial sustainability of these systems.

Addressing the social determinants of health is imperative to achieve equitable access to health and to reduce social inequality. To this end, there is a need to strengthen comprehensive health systems that guarantee coordination between health policies and the other components of social protection systems, as well as intersectoral action and participation. This in turn will enable simultaneous and synergistic progress in ensuring the right to health and overcoming poverty, as well as reducing the inequalities characteristic of Latin America and the Caribbean.

Strengthening the primary healthcare strategy as part of the structural transformations of the region's health systems is vital and strategic for overcoming the structural weaknesses in health systems and advancing towards greater equality in universal health coverage and access. Comprehensive primary healthcare and an effective first level of healthcare must be consolidated, within integrated networks that liaise with essential public health functions, incorporating multisectoral action and fostering binding social participation, both of which are essential for the democratization of health.

Against today's complex global and regional backdrop, including the threat of increasingly frequent crises and disasters, health systems resilience is crucial for rapid adaptation to changes and efficient response capacity, while avoiding disruptions to essential health services. To this end, the commitment of the countries of the region to the PAHO/WHO Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains (2021) and the PAHO/WHO Policy for Recovering Progress toward the Sustainable Development Goals with Equity through Actions that Address the Social Determinants of Health and Intersectoral Work (2022) is essential, as these instruments present agreements on the need to transform health systems on the basis of primary healthcare, strengthen leadership and governance, improve emergency response capacity, and increase and sustain public financing for health and social protection. Such actions require integrated and multisectoral approaches to address the various structural vulnerabilities and deliver rapid and effective responses, recognizing the crucial role of local authorities, communities and citizen participation.

Lastly, achieving the necessary transformations to consolidate universal, comprehensive, sustainable and resilient health systems requires a significant allocation of public resources. Such investment will secure the financial sustainability of health systems, thereby guaranteeing that both current and future generations can exercise their right to health. Health systems must achieve the necessary balance

between universal coverage of the population, sufficiency and quality of entitlements, costs and financial sustainability in order to ensure their sustainability. This is the only way to achieve inclusive and sustainable social development, overcome inequalities and drive progress towards fulfilment of the 2030 Agenda for Sustainable Development.

Bibliography

Abramo, L., S. Cecchini and H. Ullmann (2020), "Enfrentar las desigualdades en salud en América Latina: el rol de la protección social", *Ciência & Saúde Coletiva* [online] https://www.scielosp.org/article/csc/2020.v25n5/1587-1598/.

Ahmad, K. and others (2020), "Association of poor housing conditions with COVID-19 incidence and mortality across US counties", *PloS One*, vol. 15, No. 11.

Anigstein, M. S. (2008), "Participación comunitaria en salud: reflexiones sobre las posibilidades de democratización del sector", *Revista MAD. Revista del Magíster en Análisis Sistémico Aplicado a la Sociedad*, No. 19.

Araújo de Souza, J., F. C. Silva Pinto and S. Lopes de Souza (2024), "Early-life undernutrition and depression later in life: a systematic review", *Nutrition Reviews*, vol. 82, No. 1, January [online] https://doi.org/10.1093/nutrit/nuad043.

Arenas de Mesa, A. (2019), *Los sistemas de pensiones en la encrucijada: desafíos para la sostenibilidad en América Latina*, ECLAC Books, No. 159 (LC/PUB.2019/19-P), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

__(2016), *Sostenibilidad fiscal y reformas tributarias en América Latina* (LC/G.2688-P), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Attanasio, O. and others (2005), "How effective are conditional cash transfers? Evidence from Colombia", *Briefing Notes*, No. 54, London, Institute for Fiscal Studies.

Bambra, C. and others (2020), "The COVID-19 pandemic and health inequalities", *Journal of Epidemiology and Community Health*, vol. 74, No. 11.

Barreto, M. L. and others (2014), "Monitoring and evaluating progress towards universal health coverage in Brazil", *PLoS Med.*, vol. 11, No. 9 [online] doi: 10.1371/journal.pmed.1001692.

Báscolo, E. and others (2022), "Contributions of the new framework for essential public health functions to addressing the COVID-19 pandemic", *American Journal of Public Health*, vol. 112, S6 [online] doi: 10.2105/AJPH.2022.306750.

Batthyány, K. and others (2021), "Mapeo de iniciativas de las organizaciones de la sociedad civil ante la pandemia generada por el COVID-19", *Colección Eurosocial*, No. 20, Latin American Council of Social Sciences (CLACSO).

Bispo, J. and M. Brito (2020), "Community participation in the fight against COVID-19: Between utilitarism and social justice", *Cadernos de Saúde Pública*, vol. 36, No. 8.

Bryson, J., B. Crosby and M. Stone (2015), "Designing and implementing cross-sector collaborations: Needed and challenging", *Public Administration Review*, vol. 75, No. 5.

Castillo, C. and M. L. Marinho (2022), "The impacts of the pandemic on the health and well-being of children in Latin America and the Caribbean and its effect on child-sensitive social protection systems", *Project Documents* (LC/TS.2022/25), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Chapman, R., P. Howden-Chapman and A. R. Capon (2016), "Understanding the systemic nature of cities to improve health and climate change mitigation", *Environment International*, No. 94.

Cid, C. and M. L. Marinho (2022), "Dos años de pandemia de COVID-19 en América Latina y el Caribe: reflexiones para avanzar hacia sistemas de salud y de protección social universales, integrales, sostenibles y resilientes", *Project Documents* (LC/TS.2022/63), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Coetzee, B. J. S. and A. Kagee (2020), "Structural barriers to adhering to health behaviours in the context of the COVID-19 crisis: Considerations for low-and middle-income countries", *Global Public Health*, vol. 15, No. 8.

Curie, K. and others (2024), "The dynamic influence of nutrition on prolonged cognitive health span across the life course: a perspective review", *Neuroscience Applied* [online] https://doi.org/10.1016/j.nsa.2024.104072.

Doyle, M. and J. Stiglitz (2014) "Eliminar la desigualdad extrema: un Objetivo de Desarrollo Sostenible", *Ética y asuntos internacionales*, Carnegie Council on Ethics and International Affairs.

ECDKN (Early Child Development Knowledge Network) (2007), *Early Child Development: A Powerful Equalizer* [online] https://iris.who.int/bitstream/handle/10665/69729/a91213.pdf?sequence=1.

ECLAC (Economic Commission for Latin America and the Caribbean) (2024a), *The Challenge of Accelerating the 2030 Agenda in Latin America and the Caribbean: Transitions towards Sustainability. Summary* (LC/FDS.7/4), Santiago.

___(2024b), *Economic Survey of Latin America and the Caribbean, 2024* (LC/PUB.2024/14), Santiago.

___(2023a), *Halfway to 2030 in Latin America and the Caribbean: Progress and Recommendations for Acceleration* (LC/FDS.6/3/Rev. 1), Santiago.

___(2023b), *Preliminary Overview of the Economies of Latin America and the Caribbean, 2023* (LC/PUB.2023/22-P), Santiago.

___(2023c), "The 2030 Agenda: Are Latin America and the Caribbean on Track to Achieve the Sustainable Development Goals by 2030" [online] https://www.cepal.org/en/notes/2030-agenda-are-latin-america-and-caribbean-track-achieve-sustainable-development-goals-2030.

___(2023d), *Social Panorama of Latin America and the Caribbean, 2023* (LC/PUB.2023/18-P/Rev.1), Santiago.

___(2022a), *Social Panorama of Latin America and the Caribbean, 2022* (LC/PUB.2022/15-P), Santiago.

___(2022b), *Towards transformation of the development model in Latin America and the Caribbean: production, inclusion and sustainability* (LC/SES.39/3-P), Santiago.

___(2022c), *Social Panorama of Latin America, 2021* (LC/PUB.2021/17-P), Santiago.

___(2021a), *Disasters and inequality in a protracted crisis: Towards universal, comprehensive, resilient and sustainable social protection systems in Latin America and the Caribbean* (LC/CDS.4/3), Santiago.

___(2021b), *Resilient institutions for a transformative post-pandemic recovery in Latin America and the Caribbean: Inputs for discussion* (LC/CRP.18/3), Santiago.

___(2020), *Regional Agenda for Inclusive Social Development* (LC/CDS.3/5), Santiago.

___(2018a), *Social Panorama of Latin America, 2017* (LC/PUB.2018/1-P), Santiago.

___(2018b), *Towards a regional agenda for inclusive social development: bases and initial proposal* (LC/MDS.2/2), Santiago.

___(2016), *The Social Inequality Matrix in Latin America* (LC/G.2690(MDS.1/2)), Santiago.

ECLAC/PAHO (Economic Commission for Latin America and the Caribbean/Pan American Health Organization) (2021), "The prolongation of the health crisis and its impact on health, the economy and social development", *COVID-19 Report*, Santiago.

___(2020), "Health and the economy: A convergence needed to address COVID-19 and retake the path of sustainable development in Latin America and the Caribbean", *COVID-19 Report*, Santiago.

Etienne, C. F. (2018a), "Cuba aims for universal health", *Pan American Journal of Public Health*, No. 42 [online] https://iris.paho.org/bitstream/handle/10665.2/34908/v42e642018-eng.pdf?sequence=2&isAllowed=y.

___(2018b), "Promoting universal health through primary health care", *Pan American Journal of Public Health*, No. 42.

FAO (Food and Agriculture Organization of the United Nations) and others (2021), *Latin America and the Caribbean Regional Overview of Food Security and Nutrition 2021: Statistics and Trends*, Santiago, Food and Agriculture Organization of the United Nations (FAO) [online] https://iris.paho.org/bitstream/handle/10665.2/55213/foodsecurityreport2021_eng.pdf?sequence=5&isAllowed=y.

Farre, A. and T. Rapley (2017), "The new old (and old new) medical model: Four decades navigating the biomedical and psychosocial understandings of health and illness", *Healthcare*, vol. 5, No. 88 [online] https://doi.org/10.3390/healthcare5040088.

Fernald, L. C., P. J. Gertler and L. M. Neufeld (2008), "Role of cash in conditional cash transfer programmes for child health, growth, and development: An analysis of Mexico's Oportunidades", *The Lancet*, vol. 371, No. 9615.

Filho, W. and others (2020), "COVID-19 and the UN Sustainable Development Goals: Threat to solidarity or an opportunity", *Sustainability*, vol. 12, No. 13.

Frongillo, E. A., V. O. Adebiyi and M. Boncyk (2024), "Meta-review of child and adolescent experiences and consequences of food insecurity", *Global Food Security*, vol. 41, June.

García, P. J. and others (2020), "COVID-19 response in Latin America", *The American Journal of Tropical Medicine and Hygiene*, vol. 103, No. 5, November.

Gorostiaga, J. M. (2023), "Pandemia y gobierno de la educación en América Latina: políticas y actores en tiempos de emergencia", *Revista Brasileira de Política e Administração da Educação*.

Gradin, A. and others (2021), "Experiencias de inclusión financiera en los territorios durante la pandemia", *Experiencias en Acción*, No. 1.

Hahn, R. A. (2021), "What is a social determinant of health? Back to basics", *Journal of Public Health Research*, vol. 10, No. 4.

Hone, T., J. Macinko and C. Millett (2018), "Revisiting Alma-Ata: What is the role of primary health care in achieving the Sustainable Development Goals?", *The Lancet*, vol. 392, No. 10156.

Houghton, N. and others (2022), "Barriers to access to health services for women and children in Latin America", *Pan American Journal of Public Health*, No. 46.

Hughes, B. B. and others (2021), *Pursuing the Sustainable Development Goals in a World Reshaped by COVID-19*, Denver, Colorado, Frederick S. Pardee Center for International Futures/United Nations Development Programme.

ICSU (International Science Council) (2017), *A Guide to SDG Interactions: from Science to Implementation*, Paris.

ILO (International Labour Organization) (2012), "R202 – Social Protection Floors Recommendation, 2012 (No. 202)" [online] https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:3065524.

Innvaer, S. and others (2002), "Health policy-makers' perceptions of their use of evidence: A systematic review", *Journal of Health Services Research & Policy*, vol. 7, No. 4.

Jones, D. (2020), "History in crisis: Lessons for COVID-19", *The New England Journal of Medicine*, vol. 382, No. 18.

Kim, C. and others (2024), "The dynamic influence of nutrition on prolonged cognitive healthspan across the life course: a perspective review", *Neuroscience Applied*, vol. 3.

Leisering, L. (2021), "Social protection responses by states and international organizations to the COVID-19 crisis in the global South: Stopgap or new departure?", *Global Social Policy*, vol. 21, No. 3.

Levine, A. C. and others (2023), "The role of civil society organizations (CSOs) in the COVID-19 response across the Global South: A multinational, qualitative study", *PLOS Global Public Health*, vol. 3, No. 9.

Marinho, M. L., A. Dahuabe and A. Arenas de Mesa (2023), "Salud y desigualdad en América Latina y el Caribe: la centralidad de la salud para el desarrollo social inclusivo y sostenible", *Social Policy Series*, No. 244 (LC/TS.2023/115), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Maroscia, C. and P. C. Ruiz (2021), "Las organizaciones de la sociedad civil en época de pandemia. Reflexiones hacia una nueva normalidad: ¿nuevos desafíos o mismas realidades?", *Ciencias Administrativas*, No. 17.

McGowan, V. J. and C. Bambra (2022), "COVID-19 mortality and deprivation: Pandemic, syndemic, and endemic health inequalities", *The Lancet Public Health*, vol. 7, No. 11 [online] https://linkinghub.elsevier.com/retrieve/pii/S2468266722002237.

Nilsson, M. and others (2018), "Mapping interactions between the Sustainable Development Goals: Lessons learned and ways forward", *Sustainability Science*, vol. 13, No. 6.

Norström, T. and J. Palme (2010), "Public pension institutions and old-age mortality in a comparative perspective", *International Journal of Social Welfare*, vol. 19.

Nunes A. R., K. Lee and T. O'Riordan (2016), "The importance of an integrating framework for achieving the Sustainable Development Goals: The example of health and well-being", *BMJ Global Health*, vol. 1, No. 3.

PAHO/WHO (Pan American Health Organization/World Health Organization) (2024), *Análisis del desempeño presupuestario del sector salud en el período 2019-2021. Resultados para Chile, Colombia, Guatemala, Honduras, Panamá, Perú, República Dominicana y Uruguay*, Washington, D.C.

__(2023), *Analizar y superar las barreras de acceso para fortalecer la atención primaria de salud: síntesis de resultados y recomendaciones*, Washington, D.C.

__(2022a), *Building Resilient Health Systems to Advance toward Universal Health in the Americas: Lesson from COVID-19*, Washington, D.C.

__(2022b), "Monitoring and analysis of the indicators of the SDG-3 targets and their social inequalities at the regional, subregional, national, and subnational levels" [online] https://opendata.paho.org/en/sdg3/monitoring-and-analysis/monitoring-of-targets-and-their-inequalities.

__(2022c), *Policy for Recovering Progress toward the Sustainable Development Goals with Equity through Action on the Social Determinants of Health and Intersectoral Work* [online] https://www.paho.org/sites/default/files/csp30-8-e-policy-sustainable-development-goals_0.pdf.

__(2021), "Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains", 59th Directing Council, 73rd Session of the Regional Committee of WHO for the Americas [online] https://iris.paho.org/bitstream/handle/10665.2/58304/CD59-R12-resolution_eng.pdf?sequence=1&isAllowed=y.

__(2020a), *The Essential Public Health Functions in the Americas: A Renewal for the 21st Century. Conceptual Framework and Description*, Washington, D.C.

__(2020b), *Guidelines for Implementing Non Pharmacological Public Health Measures in Populations in Situations of Vulnerability in the Context of COVID-19* [online] https://iris.paho.org/bitstream/handle/10665.2/53078/PAHOIMSFPLCOVID-19200021_eng.pdf?sequence=5&isAllowed=y.

__(2019a), *Compact 30.30.30. PHC for Universal Health*.

__(2019b), *Universal Health in the 21st Century: 40 Years of Alma-Ata. Report of the High-Level Commission*, Washington, D.C.

__(2016), *Resilient Health Systems* (CD55/9), 55th Directing Council, 68th session of the Regional Committee of WHO for the Americas, Washington, D.C.

__(2014), *Strategy for Universal Access to Health and Universal Health Coverage* (CD53/5, Rev.2) [online] https://www.paho.org/en/file/85361/download?token=9a6uHyV1.

Pradhan, P. and others (2017), "A systematic study of Sustainable Development Goals (SDG) interactions", *Earths Future*, vol. 5, No. 11 https://doi.org/10.1002/2017ef000632.

Rahman, M. M. and others (2022), "Global, regional, and national progress in financial risk protection towards universal health coverage, 2000–2030", *Social Science & Medicine*, vol. 312.

Ramos, D. and others (2021), "Conditional cash transfer program and child mortality: A cross-sectional analysis nested within the 100 million Brazilian cohort", *PLoS Medicine*, vol. 18, No. 9.

Rasella, D. and others (2013), "Effect of a conditional cash transfer programme on childhood mortality: A nationwide analysis of Brazilian municipalities", *The Lancet*, vol. 382, No. 9886.

Robles, C. and R. Holz (eds.) (2024), "The future of social protection in the midst of a protracted social crisis in Latin America: Advancing towards universal, comprehensive, sustainable and resilient systems", *Social Policy Series*, No. 246 (LC/TS.2023/163), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Saa, T. H. and T. N. Villa (2022), "Las OSC: dificultades y retos para su desenvolvimiento durante la pandemia por COVID-19 en sectores de población vulnerable en el municipio de León, Guanajuato", *SAVIA Revista de Investigación e Intervención Social*, No. 17.

Salazar-Xirinachs, J. M. (2023), "Rethinking, reimagining and transforming: The "whats" and the "hows" for moving towards a more productive, inclusive and sustainable development model", *CEPAL Review*, No. 141 (LC/PUB.2023/29-P/-*), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC).

Salinas-Rodríguez, A. and B. S. Manrique-Espinoza (2013), "Effect of the conditional cash transfer program Oportunidades on vaccination coverage in older Mexican people", *BMC International Health and Human Rights*, vol. 13, No. 1.

Scheil-Adlung, X. and L. Sandner (2010), "Evidence on paid sick leave: Observations in times of crisis", *Intereconomics: Review of European Economic Policy*, vol. 45, No. 5.

UNICEF (United Nations Children´s Fund) (2018), *Breastfeeding: A Mother's Gift, for Every Child*, New York.

United Nations (1987), *Report of the World Commission on Environment and Development: Our Common Future* [online] https://sustainabledevelopment.un.org/content/documents/5987our-common-future.pdf.

Vásquez-Vera, H. and others (2022), "Inequities in the distribution of COVID-19: An adaptation of WHO's conceptual framework", *Gaceta Sanitaria*, vol. 36, No. 5 [online] https://www.sciencedirect.com/science/article/pii/S0213911121001795?via%3Dihub.

Viana, C. M. and others (2022), "Agricultural land systems importance for supporting food security and Sustainable Development Goals: a systemic review", *Science of the Total Environment,* vol. 806, part 3, Elsevier.

Weitz, N., M. Nilsson and M. Davis (2014), "A nexus approach to the post-2015 agenda: Formulating integrated water, energy, and food SDGs", *SAIS Review of International Affairs*, vol. 34, No. 2 [online] DOI: https://doi.org/10.1353/sais.2014.0022.

WHO (World Health Organization) (2023a), "Global Health Expenditure Database" [online] https://apps.who.int/nha/database/Select/Indicators/en.

__(2023b), "Primary Health Care" [online] https://www.who.int/news-room/fact-sheets/detail/primary-health-care.

__(2023c), *Fourth Round of the Global Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic: November 2022–January 2023. Interim Report*, Geneva, 1 May.

__(2023d), "Coverage of Essential Health Services (SDG 3.8.1)", The Global Health Observatory [online] https://www.who.int/data/gho/data/themes/topics/service-coverage.

__(2021a), *COVID-19 and the Social Determinants of Health and Health Equity: Evidence Brief*, Geneva.

__(2021b), *Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond: WHO position paper* (WHO/UHL/PHC-SP/2021.01), Geneva.

__(2017), "Background paper for the regional technical consultation on: Monitoring the health-related Sustainable Development Goals (SDGs)", New Delhi.

__(2015), *World report on ageing and health*, Luxembourg.

__(2010a), "A conceptual framework for action on the social determinants of health", *Social Determinants of Health Discussion Papers*, No. 2.

__(2010b), *The World Health Report: Health Systems Financing. The Path to Universal Coverage*, Geneva.

__(1978), "Declaration of Alma-Ata", International Conference on Primary Health Care, Alma-Ata, 6-12 September.

__(1949), "Constitución de la Organización Mundial de la Salud", *Diario Oficial*, vol. LVI, No. 32, 9 September.

WHO/CSDH (World Health Organization/Commission on Social Determinants of Health) (2008), *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, Geneva.

WHO (World Health Organization)/World Bank (2021), "Global Monitoring Report on Financial Protection in Health 2021", Geneva.

WHO/IBRD/World Bank (World Health Organization/International Bank for Reconstruction and Development/World Bank) (2023), *Tracking Universal Health Coverage: 2023 Global Monitoring Report*, Geneva.

Xu, K. and others (2010), "Exploring the thresholds of health expenditure for protection against financial risk", *World Health Report (2010) Background Paper*, No. 19, World Health Organization (WHO).

Yerramili, P., M. Chopra and K. Rasanathan (2024), "The cost of inaction on health equity and its social determinants", *BMJ Global Health*, vol. 9.

Zaildo, T. and others (2023), "Barriers to and facilitators of populational adherence to prevention and control measures of COVID-19 and other respiratory infectious diseases: A qualitative evidence synthesis", *European Respiratory Review*, vol. 32, No. 168.

This report was prepared by the Economic Commission for Latin America and the Caribbean (ECLAC) and the Pan American Health Organization (PAHO). The Executive Secretary of ECLAC, José Manuel Salazar-Xirinachs, and the Director of PAHO, Jarbas Barbosa da Silva Jr., oversaw its preparation.

Specialists from both organizations contributed to the preparation of this publication:

ECLAC: Alberto Arenas de Mesa, María Luisa Marinho, Consuelo Farías, Daniela Huneeus, Daniel Titelman and Daysi Sanmartín.

PAHO: James Fitzgerald, Gerry Eijkemans, Ernesto Báscolo, Claudia Pescetto, Juan Pablo Pagano, David Debrott Sánchez, Natalia Houghton, Orielle Solar, Pamela Bernales, Hugo Vásquez, Fabricio Méndez and Santiago Soto.

The United Nations and the countries it represents assume no responsibility for the content of links to external sites in this publication.

Copyright © United Nations, 2024

S.2400869[E]

PAHO Pan American Health Organization World Health Organization Americas Region

ECLAC Economic Commission for Latin America and the Caribbean (ECLAC)
Comisión Económica para América Latina y el Caribe (CEPAL)
www.cepal.org/en