Family Practice Advance Access published May 11, 2016

Family Practice, 2016, 1–2
doi:10.1093/fampra/cmw032

Editorial

Current primary health care practices and research challenges in Latin America

Since the 1980s, after the return of democracy, most Latin American countries (LAC) experienced both important improvements in the population's living conditions and health status and profound socio-epidemiological and cultural changes (1–3). During this period, the primary health care (PHC) principles have been at the core of many health policy agendas of the Region as a strategy to guarantee the right to health, social participation and multicultural respect and integration, influencing the social determinants of health and improving both equitable access to and quality of health services (2,4).

Given the pace of their increasing legitimacy and strengthening, the PHC principles were called upon to address a wider range of problems including and surpassing the long-standing challenges of still-uncontrolled infectious diseases and maternal–child health. During these years, PHC was increasingly challenged by previously overlooked problems, such as chronic diseases, traffic accidents, social and domestic violence, mental and oral health, and problem drug use and emerging problems such as HIV (human immunodeficiency virus), H1N1 (swine flu) and Zika virus (3).

During these last decades, most countries in the Region attempted reforms in their PHC approaches with different levels of success. Those reforms were implemented willing to shift from a model based in a very limited structure of primary-level services sustained by PHC campaigns and programmes to the establishment of a strong first level of care that serves as the axis for the social-health strategy of the health system (5–9).

There are three tiers of factors that exert a strong influence on these reforms success. The first tier is made up of the political and economic context of each country, which determines the strength of the social protection system, although this system is currently threatened throughout LAC by fiscal restrictions and political tensions (6). The second tier consists of the health system itself, which in most countries is characterized by low levels of public health expenditures; strong limitations with regard to collaborations with other sectors on responses to address the social determinants of health; and segmentation between health subsystems. These challenges result in marked inequalities in the population's health status and in health care coverage, access and quality (9). The third tier corresponds to the system of health services, where PHC faces the challenge of reducing the fragmentation between levels of care and improving health care access, comprehensiveness and quality in order to respond to the population's main socio-epidemiological problems (10).

This issue addresses central challenges that PHC is currently facing in the LA Region at the level of the health system and the system of health services through the results of studies carried out in 13 countries in the Region: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Mexico, Paraguay, Peru, Suriname, Uruguay and Venezuela. The studies included in this issue can be classified into two groups. The first group is made up of studies that analyse the quality and effectiveness of PHC in different health systems, services and programmes (11). The second group is made up of studies that analyse the political, institutional and organizational determinants of the PHC development (9,12).

Among the studies included in the first group is the study by Borja-Aburto *et al.* (13), which analyses the impact of a primary care-based integrated programme by the main social security organization of Mexico and Latin America, the Mexican Social Security Institute, on selected non-communicable chronic diseases. The next two articles analyse the provision of mental health services in public PHC services. The article by Brahm *et al.* (14) estimates the effect of the Play with Our Children programme on maternal sensitivity and mental health in deprived areas of Santiago, Chile. The study by Scazufca *et al.* (15) examines the rate for identification of depression and compares treatment rates for depression with those of diabetes and hypertension among elderly individuals in São Paulo, Brazil. The next two studies, also from Brazil, analyse the relationship between hospitalization for sensitive ambulatory care conditions and the quality of public primary care health services using the PCATool. First, Gonçalves *et al.* (16) analyse this relationship while taking into account the social determinants of health in the population under study. Second, Dos Santos de Sáa *et al.* (17) compare PHC quality in traditional PHC versus in the Family Health Program. While the latter study compares the quality of the care provided through different models of the public health subsystem, Yavich *et al.* (18) compare the PHC-related performance of the public, social security and private subsystems and estimate the extent of subsystem cross-coverage in Rosario, Argentina.

The group that analyses the political, institutional and organizational determinants of the PHC strategy contains four articles. The first article is the already-mentioned article by Yavich *et al.* (18), which belongs to both groups since it analyses whether the differences observed in the performance of the health subsystems are consistent with the predominant institutional and organizational features of each subsystem. The next two articles analyse PHC reforms. First, Báscolo *et al.* (8) describe the Bolivian and Argentinean cases of PHC-based reforms by looking at how the dynamics resulting from the interaction between the institutional process and the characteristics of the stakeholder groups (configuration, capacities to implement and

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manage the new institutional structures and relationships) advocating for institutional change (the collective action) produced the enablers of the collective action's technical and political capacities that are required to achieve the envisioned results. Next, Ramírez *et al.* (19) analyse the PHC renewal processes in all South American countries and describe the PHC approaches being implemented in the Region to provide knowledge on current conceptions, models and challenges. Finally, Hernández-Rincón *et al.* (20) studied the incorporation of both a focus on equity and a social determinant of health approach into the curricula of several Colombian universities to identify opportunities to strengthen the inclusion of this approach.

This selection of studies is intended to expand the dialogue between research and practice in PHC. This assumes that the production of evidence does not constitute a transformative input *per se*, but in the degree to which different actors use this evidence as a trigger to legitimize, inform and promote changes that contribute to the development of comprehensive PHC in LAC and beyond.

Despite important advances in recent decades, progresses were not uniform and Latin America remains the world's most unequal region. This inequality is also reflected in the level of development of research in PHC. In most LAC, the universities and science- and technology-related institutions are unable to provide the training, resources and infrastructure to develop researchers and enable individuals to make research their way of living. Most LA researchers work under severe resource constraints or rely on external funding and donors. In many cases, North–South partnerships and collaborations have been beneficial to the training of researchers and development of studies. Nevertheless, in Latin America, these country-level weaknesses have resulted in a limited body of research and the dependency for resources has contributed to research practices that are often insufficiently guided by the individual countries' needs and rules. Proof of this is that, despite we as Issue Editors having created a quota system for articles per country and per topic in order to promote broad thematic coverage and equitable representation of each country, we were unable to include articles led by researchers from the poorest countries in the Region (such as Bolivia, Guyana, Haiti, Guatemala, Salvador and Nicaragua) and studies about issues such as violence, addictions or traffic accidents that have been shown to be a priority according to the Region's statistics (3,4). It is also important to note the limited use of data collection tools produced based on and taking into account the characteristics of our populations and health systems.

Despite these difficulties, several countries are reforming their science and technology systems and many LA researchers continue to produce significant scientific contributions. The articles on this issue are proof of this.

Declaration

Funding: none.
Ethical approval: none.
Conflict of interest: none.

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