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Global Health: Crossing the Equity Chasm

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Abstract: *Despite the commitments assumed and health`s declarations made in the last 80 years; it is a fact recognized by the international organizations that health equity still remains to be achieved in the majority of countries. In addition, there is a lack of agreements in order to define and advance towards systemic policies that can achieve this challenge. During the course of this 21st century, we have witnessed a global COVID-19 pandemic, the return of illness that we believed were already controlled such as Ebola, the progressive threat of environmental problems, the increasing bacterial antimicrobial resistance or the exponential growth of chronic pathologies; all challenges that forces us to make urgent decisions aimed to reorganize the existence of a global health system. As a contribution to a necessary and urgent debate in this sense, this document presents contributions on complexity theories that might be useful for the integration and optimization of the current health model.*

Keywords: Global Health, development, complexity, equity, ethics, quality

INTRODUCTION

Health is one of the basic rights of human beings. Unfortunately, we must recognize that in these days, this right is not equally distributed among the world's population. Achieving universal health with equity and quality for everyone is not only a government's responsibility, but also constitutes a systemic challenge that we should try to reach. It is imperative to discuss what systemic health policies could be the one that guarantees equity and quality in health care for the population, based on local development, with the coordination of all available resources. In our opinion, this debate should be carried out taking into account the needs of the population and the appropriate balance of sectoral contributions, but also within a framework of scientific knowledge and strategies that include a deep philosophical reflection about what health system we have and which one we need.

In order to propose this analysis, we have decided to consider the last 80 years of Public Health for two reasons: On one hand, because in this period, important conceptual and policy documents related

to health have been defined, and on the other hand because we have had the opportunity to experiment ourselves with two generations of politicians, health professionals, doctors, experts, with whom we had closely interacted, hence, we may transmit the spirit of those members of the system were thinking. This text will, therefore, be an analysis not only of a story told but also of a story lived.

In the last 80 years we were able to identified four main documents prepared by international organizations, which are conceptual in relation to health policies and social commitments that countries must assume [1-4].

These documents are: The charter and constitution of the World Health Organization approved in 1946. The universal declaration of human rights defined through the United Nations Organization in 1948. The commitment to achieve the goal of Health for all in the year 2000 defined by the World Health Assembly, WHO 1977 and the political declaration of Rio through the United Nations that defines the commitments of countries to carry out concrete actions in relation to the social health determinants in 2012.

In these four documents we may find a conceptual unity. They all agree on the definition of health as an individual and also a collective-social good that is closely related to sustainable social economic development; defining actions aimed at health as an indivisible set of promotion, prevention, diagnosis and treatment both in its biological, social and environmental components. Likewise, all these documents agreed that health is a basic human right and that it is necessary to achieve universal coverage based on governance and permanent participatory dialogue of all actors of the state and the society.

On the other hand, in the field of moral philosophy, economics and development, we highlight four other documents that are important to establish “Health” as a human right. The first two are the contribution of John Rawls [5] in his book on a theory of justice and the work of Norman Daniels where he explains a theory specifically aimed at health justice [6] . In both proposals, emphasis is placed not only on the need to achieve justice for all; but also, on the importance of the procedures to achieve that goal.

In the field of economics, the contributions of Muhammad Yunus [7] and Amartya Sen [8] identify “local health” as a priority for all Society, as well as to achieve local development that allows defining and executing a specific justice in terms of equity in access. In all these statements, the importance of the type of health system that each county has, is highlighted as a measure of equity and quality that population has. In summary, we can assert that in the last 80 years, a social mandate and a conceptual framework with high value consensus have been defined in terms of identifying health as a social good and as a basic human right that should be available for everyone. It is necessary then, to analyze the path that brought us to the health system we have, and debate the actions that could guarantee the people`s health rights not only in the present but in the future.

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The results obtained so far. "About the successes" achieved.
Among the health successes achieved in the 20th century, we must highlight the eradication of two diseases. Smallpox -WHO 1980-, and poliomyelitis -WHO 1994- as well as the control of measles and other communicable diseases. These achievements were based on a positive combination of knowledge provided by the basic sciences, as well as by public policies to support these activities, and by the adequate organization of the resources of the health systems, the commitment of health personnel and by the active participation of society, schools, families, mothers and fathers. These were concrete examples of the achievements that can be reached through the complementarity efforts of Science, State and Civil Society, when it exists clear and common objectives.

We also observed important advances in knowledge related to health promotion, and development of specific technologies, as well as an improvement in the general health situation measured by global indicators of mortality, morbidity and life expectancy [9].

Even though these mentions are reflections of the conjunction of knowledge from health sciences and global social development; it is necessary to highlight the limitations of using national achievement averages, because even if they mark positive macrotrends, they also can hide serious differences in the opportunities for social development, as well as in the health situation of certain population groups [9]. Hence, global data may mask the lack of social equity that currently exists.

The results. About the problems in equity and quality. “The unfulfilled agenda”.
Regarding failures, there is general consensus that the challenge of health equity has not been solved yet. Back in 1972 it was already stated that a high percentage of the countries' population (37%) did not receive adequate care [10]. From then, documents from international organizations continue to affirm that exists “a problem of exclusion in health and a lack of access to health services of certain social groups” [11] . It is concluded that the goal defined by “health for all” with universal coverage was not reached.

On the other hand, with respect to the quality of health care is provided, various studies and reports demonstrated that there is an big gap between the accumulated knowledge of Medical Sciences and the way in which that knowledge reaches the population [12].

Analysis of results: “The problem is systemic but is reflected in local realities”
The World Health Organization (WHO), and the Pan American Health Organization (PAHO), in the late 1980s, after 10 years of defining the goals of “Health for All” in 1977 and the Primary Care strategy of Health in 1978, initiated actions in the countries of the Region of the Americas, that aimed to accelerate the processes of coverage and comprehensive care. Thus, in 1988, PAHO approved Resolution XV, at the XXXIII Meeting of the Directing Council, which emphasized the urgent need to accelerate the transformation of national health systems through the development and strengthening of Local Health Systems (SILOS) under the principles and values defined in Alma Ata and as an operational tactic of the Primary Care strategy. This resolution defines a Local Health System as an interrelated set of health service institutions and other resources related to health promotion and disease

prevention in areas such as schools, work, and homes of a population living in a specific geographic region (geopolitical unit).

In addition to this PAHO proposal in the Region of the Americas, we highlight another important conceptual contribution of policy and strategy for the development of health districts for health in the WHO publication in 1991 [13] and the regional office of the WHO of the African Continent [14] where a proposal for reform of the health sector is defined, promoting the development of "health districts". The analysis of these experiences leaves us with no doubts. Achieving equity and quality of health is a systemic challenge that is reflected in local realities.

Unfortunately, over the years, these initiatives were abandoned and the lack of coordination led health organizations to move away towards systemic proposals that deepened the lack of equity at local level. In this sense, the WHO [15] in the year 2000 in its report on health systems concluded: "The difference between a health system that functions adequately and one that does not; can be measured in deaths, disabilities, impoverishment, humiliation and hopelessness" facts that the world population has been suffering in recent decades.

In 2007 the director of the WHO [16] Margaret Chan stated: "Something is wrong. For the first time, public health has managed to define and accumulate commitments, resources and knowledge. What is missing is to ensure that the power of this knowledge is combined with the power of health systems to deliver it to the population that needs it, with the appropriate quantity and quality."
In 2013, PAHO Director Carissa Etienne in her inauguration speech as Director of PAHO in Geneva called for a "systemic challenge" stating: [17] "unacceptable inequalities still persist in the levels of health and health care within each country and between countries insisting on the need to achieve health systems aimed at "universal coverage with equity, solidarity and inclusion." She concluded: "this problem cannot be solved superficially with isolated strategies."

In 2020-2021 we have witnessed the reaction of the different governments to face the global risk represented by the COVID-19 pandemic, where the isolation of borders, the bid for basic prevention supplies and the concentration of vaccines in the central countries has shown that the predominance of individual positions and the lack of systemic response to achieve health objectives, has had serious consequences [18].

Proposal for the solution: A scientific strategy based on the general theory of complex social systems

In its Greek origin the word "system" means "putting things together to achieve an objective". We need a debate in terms of putting the "things together" of the State, Civil Society, providers, financiers, the population, academia, universities, science and technology organizations, to achieve a concrete contribution that leads to a better Health for all. We must complete the definition of the goal of "Health for all" with an active policy to achieve "Health with all".

Following Dr. Mario Bunge [19], our working hypothesis is based on considering that "Just as medical sciences are in their praxis the result of the harmonization of various disciplines; the organization of

the health system must also be the result of a scientific strategy of creativity and harmonization of knowledge in the social sphere."

In the search for a theory for the organization of health systems, we explore the concepts of "reason" and "paradigm" developed by philosophy and epistemological debates.The concept of "reason" [21] is defined as "a human virtue of thinking, analyzing and making judgments to define principles, harmonize knowledge and develop processes, creating new forms of analysis and solutions based on new knowledge and the experiences."

On the other hand, we take the concept of "paradigm" developed by Thomas Kuhn [22] as a system of ideas that acts as a frame of reference developed by a work community to define an action project that values and enhances the guiding ideas of thought towards common goals. The paradigm is nourished by reason. Reason requires the construction of a new paradigm.
With these definitions we observe a direct relationship between the concept of reason and the construction of a social paradigm, and the need for a collective thinking in order to define systemic health policies.

The three dimensions of reason
To guide the definition of a systemic paradigm on equity and quality in health, we propose to analyze three dimensions of the reason.

Firstly, the moral ethical reason based on the principles defined about 2,500 years ago [23] by Hippocrates, "the action of medicine must be not only to cure diseases but also to ensure health". When these precepts are transferred to the system of health, we will find there the moral guidelines for the adequate use of knowledge based on the principles of solidarity, justice, equity and quality.

From that time to our days, permanent proposal was made that contributed affirming the need to have a moral ethical reason for health systems. The medical philosopher Edmund Pellegrino [24] summarizes it, admirably in his phrase: "…a post-Hippocratic reconstruction of medical ethics, moving from individual ethics to collective ethics"… stating "if medical sciences decide to advance towards the fair application of their abundant knowledge, towards the development of principles of equity based on philosophical ethics, it will be necessary for health institutions to become aware of their role as moral agents of Society, reflecting this in their management practices, their institutional ethics and their action strategy to fulfill it."

The moral ethical reason is then not only one of the strengths of the health system, but also an internal strength for health organization and external opportunity given by the various development health sectors.

We now find the second dimension of reason, scientific reason. Scientific rigor that arises from the application of experimental logic that enabled the production of knowledge both for health promotion and for the prevention of diseases, diagnoses and treatments. This scientific rigor applied in the basic sciences was also developed in epidemiological research [25] and in clinical studies, health programs,

medical technologies, human resources and medical pedagogy grouped in the so-called health systems and services research [26]. This last area of knowledge was developed by Professor Kerr White at Johns Hopkins University in the 1960s. WHO years later, under the sponsorship of PAHO (together with its director Dr. Carlyle Guerra de Macedo), compiled the body of existing knowledge contained in PAHO 534 scientific publications "An Anthology" [27]. In these documents it is possible to find evidence on the way of organization and management of the health system, focus equity, quality and efficiency of the good provide by them, product that can be measured in terms of coverage, accessibility, humanization, quality, safety and efficiency [28]. Unfortunately, this knowledge was not applied to global policy decisions, while it has been only oriented to isolated programs or subsystems, each with individual expectations of achievement, without coming together in a systemic strategy.
Based in this background, we think that it is necessary to move from promises and declarations to concrete facts that allow us to meet the challenge of equity and quality for all.

To do this, it should be completed the development of the moral reason and scientific reason already mentioned with a third dimension of reason that we call "relational systemic reason". From a theoretical point of view, it is possible to identify the origin of this reason in the 1940s from the so-called linkage theories, which were developed with the participation of the majority of knowledge and sciences concerned with the study of reality as a whole, and giving birth to the "Complexity Sciences". This concept was built with the contributions of John Holland at the Santa Fe Institute in California in the 1960s based on the theory of complex adaptive systems [29]; and then Edgar Morín in 1994 in his contributions on the epistemology of complexity [30] and the theories of networks; the self-organization of Heinz von Foerster, the methods of transdisciplinary contained in the Portuguese declaration [31] and the application of these concepts to management and administration proposed by Peter Senge [32] and Jorge Etkin [33].

From all these authors, it is possible to extract concepts for the definition of "systemic health policies" where "systemic complexity" is a result of the integration of different subsystems and quasi-autonomous associated systems acting based on different logics and degrees of freedom and with commitment to internal and external actions derived from their broad relationship with the context in order to identify shared final objectives

The partial solutions of isolated health policies sometimes might hide the reality or may make us forget the systemic vision. If this mistake is repeated for years, then we drop into a concept what Lyotard calls "the dictatorship of the message" [34].

Recommendations for achieving a systemic model of Health organization that guarantees equity and quality

Once the theoretical bases have been explained, it is necessary to propose a legal framework for the formulation of systemic policies and strategies aimed at achieving universal health with equity, ethics and quality, taking into account the following strategic components:

a. International organizations must integrate efforts so that each of their programs, areas or departments have a common approach that allows them to achieve systemic health objectives.

b. There must be an active participation in each country, to develop an integrated plan at all levels of the State (national, provincial, municipal), with coordinate efforts from public and private sector resources that involve organizations, institutions, health funders, HR training areas, the Academy, Universities, and representatives of the population.

c. It is necessary to move from organizing with a formal systemic logic to a factual logic, generating local health systems in geographic population spaces where the efforts of international and national organizations are integrated. This proposal may help to motivated local persons to run the integrate project; as the philosopher George Santayana says [35]: "If music awakens our emotion and fills us with passion when it reaches our ears with the harmony of the combination of sounds, how much more emotion could we all enjoy with the harmony of a common work in the use of all the knowledge of science towards a better society".

Proposal of 5 steps to adopt a systemic model of healthcare organization

So far, theoretical elements have been provided that aimed to change the way of organizing the health care in order to meet the needs of the population. It is necessary to move towards a practical proposal for countries to organize and implement health equity objectives at national, provincial, municipal and local levels with a systemic approach that requires a new governance strategy that could be achieved in 5 steps:

Step 1.
Defining “Governance” needed. Our proposed definition of governance is “a governing process based on the general theory of complex social systems that promotes harmonious democratic participation by the State and the Civil Society to achieve social development and a stable and active institutional economy. This “Governance” process must be designed to ensure equity, justice, accountability, transparency, responsiveness, rule of law, stability and inclusion, with the empowerment of the population and broad-based participation.
To achieve this health governance at the national level, a working group should be selected, from representatives/participants from the population, the government, the private sector, universities, academic sectors, researchers, and international expert advisors.

Step 2.
Reach an agreement among the country's main political, social and cultural actors focusing on the main national and local problems and health needs of the population. Establish priorities for action, objectives, goals, expected results, and define the indicators in order to measure the achievements and the level of accomplishment of the goals.

Step 3
Achieve a commitment/agreement among Health, Educational, Cultural and Political Institutions of the different national, provincial/state geographical units, and local municipalities to fulfill certain common health objectives established in Stage 2.

Step 4
List all structures, capacities, goods of health and social systems and contrast with the needs in terms of human resources, supplies, technology, standards and general requirements in order to achieve the proposed goals.

Step 5.
Agreement with the different national and local components on an immediate action schedule with expected results in the short and long term, and monitoring of achievements through evaluation of standard indicators, periodically (per week, month, year, month, etc.).

From theory to practice

The above paragraphs are not merely recommendations extracted from theory, but rather the result of more than ninety years author`s lived experience and six decades of management in dozens of countries where we were representatives of international organizations such as PAHO/WHO.
Along those years we have put the ideas into practice, in organizational models that are still active and functioning, demonstrating that the proposal made is possible to put into practice with the contributions from the university, the health and political sectors, and the local population, in order to provide a new integrated model care in specific geographic areas, but that reflects Global Health concept of equity and quality.

For example, in the municipality of Olavarria, Argentina, a home health care model was organized where the community itself, and the university environment (with its teachers and students) regularly visit assigned families, collecting needs, risks and demands, to then be resolved by the local health system, in coordination with all local referents of the health, social and economic programs [36]. These models were replicated in other regions, demonstrating that these achievements can be extrapolated to the entire population of a country.

Resuming the idea of a systemic model of healthcare organization

Over the years, we have seen and verified through health-social indicators that the proposals established in the main international documents have not been translated into concrete global actions and have not managed to change the local reality within the different countries. On the contrary, there has been a fragmentation of the policies carried out by International Organizations in which each program tends to obtain satisfactory results in itself, with objectives and parameters of success based on achievements limited to the subject involved, without being integrated into the compliance with common goals to improve the health of populations.

We aim to promote a new systemic rationality based on scientific foundations, favoring internal and external communication between actors and the population, in order to achieve a global improvement in terms of health.

Participation and self-organization must be seen as a permanent evaluative research project using the unifying power of science to contribute to giving legitimacy and continuity to these processes where the health system, as a whole, initiates a dialogue of action, evaluation, action, between all the

components of the system and all the knowledge that comprise it. It is necessary to evolve from the Cartesian "I think" to a systemic "we think."

The proposal is not an isolated political program, it is a paradigm of systemic theory and science for health that consists of the development of a health system based on social sciences, using evidence that identifies standards and indicators to monitor achievements.
It will not be possible to resolve poverty, marginalization, lack of opportunities in education, work, housing and other determinants of health, without recognizing the responsibility of the entire social economic development in an integrated global system.

In this work we aim to translate what we have written in documents for years into concrete, comprehensive and systemic actions aimed at caring for the health of the population in a universal and equitable manner.

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