# Chapter 3
# Main Challenges to Reduce Health Inequities in Latin America


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## Introduction

Before beginning the analysis on the evolution, progress, and impact of strategies to address health inequities in Latin American countries, it is necessary to review policies and strategies. The aim of this chapter is to draw attention to the structural challenges faced as a result of the glacial pace of change in most low- and middle-income countries (LMICs) since such challenges are among the reasons actual changes always fall short of expectations. To this end, the arguments put forth by scholars on the subject, especially leaders of the Latin American region, are outlined. Neoliberal policies promoted by international agencies, such as the International Monetary Fund (IMF) and World Bank, social policies such as the eradication of extreme poverty, employment policies, and food security, and territorial initiatives as expressed in global health and urban health programs are critical issues when it comes to understanding and strengthening processes of change.

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This paper does not present an in-depth analysis of these policies because, first, they do not constitute the central theme of this publication and, second, there already exists a wealth of reports and publications on these topics.

Equity is not an objective itself; it needs to be inserted in a wider context of a search

- Do Latin American countries have the knowledge, political will, structures, and capacity to deal with health inequities?
- Why do pilot projects achieve greater progress than government programs?
- Do we create bubble situations decontextualized from reality to please international community, or to justify the money invested?

for social justice where the dimension of power becomes a central variable. This approach is inescapable because health equity has to do with "social, economic and political determinants outside the health sector, which profoundly affect the health status of the population" (Diderichsen et al. 2002:4). A deeper understanding of the factors influencing the processes is needed. Equity should not only be a goal but a sociopolitic process of sustainable change: it would not be possible to achieve sustainable development without it. To drive a development process, the broad support of successful policies is required, and this will be difficult to achieve if the benefits of development are not widely shared (IPES 1999:8–9).

The study of the relevance and feasibility of previous recommendations should be done in the context of each country, local territory, and region. It is recognized that local action generates change; however, change is influenced relationally by the global economy, relationships among countries, and power relations. In this sense, the impact of local action can sometimes be limited, until changes are made in the asymmetric distribution of power and resources that perpetuate inequities in health and until concrete actions are taken aimed at reducing vulnerability and negative effects on health conditions of the most vulnerable and exposed individuals, groups, and communities.

A critical review of the nature and fundamentals of the theoretical bases of each strategy and its advances and factors that influence its performance will produce inputs to help identify the mechanisms contributing to a successful implementation based on the identity of each country/region.

Globalization has been defined in various ways, although most of the definitions address similar principles and characteristics. According to Melucci (1996:295), it is neoliberal economic globalization or universalization. Beck (1998), cited by Pazos Beceiro (2002), describes it as a "process (formerly a dialectic process) that creates links and social and transnational spaces, and revalues local cultures." Giddens (2000:25). Caldbick et al. (2014) argue that globalization is not only a process, but "complex processes that operate in contradictory and unethical manner." It is important to point out that some of these processes are related to the market economy, transnational corporations, consumerism, and free trade, among others (Franco-Giraldo 2006).

Globalization is also understood as an explanatory category of major transformations, at the global level in recent decades; as per Laurell (2014:854), "globalization means that the organization of societies on the principle of the market and under the dominion of the transnational capital is currently leading." For Stiglitz (2002:308) "globalization seems to replace the old dictatorships of national elites, by new dictatorships of international finance." Under globalization, capital promotes projects of global reordering based on the precepts of neoclassical economics and neoliberal ideology; it has among its characteristics the primacy and unrestricted mobility of financial capital and the transnationalization of economies, where a small group of companies define world production and trade (López Arellano et al. 2008:325).

> For most of the remaining countries, many of them in Africa, Latin America, and Eastern Europe, globalization has not lived up to its promises owing to a combination of poor domestic conditions, an unequal distribution of foreign investments, and the imposition of new conditions further limiting the access of their exports to the OECD markets. In these developing countries, the last twenty years have brought about a slow, unstable, and unequal pattern of growth and stagnation in health indicators (Cornia 2001:834).

> Liberalization refers specifically to the marketization of healthcare and involves shifting from state modes of governance to the market mode for the distribution of healthcare provision. There is evidence that suggests that liberalization in healthcare creates inequities in terms of access to health and health outcomes in many developing countries, with the poor unable to afford basic healthcare or medicines. (Barrientos and Lloyd Sherlock 2000, 2003; Hutton 2004; Mackintosh and Koivusalo 2005 are part of the meeting cited for Kay and Williams 2009:6)

The multidimensional integration of the progressively accelerating globalization process demands critical thought on its effects in the health field. In this sense, globalization has been considered a determinant of enormous complexity having a major impact for health, aside from other factors such as urbanization, poverty, education, gender, ethnicity, and access to services (Hospedales and Jané-Llopis 2011).

In the case of the globalization of health promotion (HP) strategies, a process of extension and planetary management has been noticed in different dimensions. Implicitly it allows for relating glocalities (the orb, specific territories, socioeconomic realities, and different policies, but oriented by central guidelines that reproduce themselves through traditional institutional practices of adoption and adaptation, under centralized logics of implementation and execution) and glocalizations (temporalities and practices).

> Never before was greater intelligence required as well as an imaginative and creative ability of governors and academics to renew conceptions, effective actions of HP strategy that create new spaces for public health in the world of globalization. Certainly, the concern about the ineffectiveness of HP actions has been great. Insistently real and effective experiences are sought to strengthen evidence based on HP (Franco-Giraldo 2012:194).
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> Globalization provides new opportunities of collaboration to improve health and decrease transnational risks that threaten it. These opportunities include advances on information, technologies and communications; and availability of the best mechanisms for global governance and the exchange of experiences (WHO 2005:2).

The aforementioned document recommends that all sectors and fields act in accordance with "strategies of health promotion in a globalized world" through the following measures:

> Advocating for health based on the human rights and solidarity; invest in policies; measurement and sustainable infrastructure to address the determinants of health factors; create capacity for the development of policies, leadership, knowledge exchange and to conduct research; establish regulatory standards and laws that ensure a high grade of protection facing possible damage and the equality of opportunities for health and well-being of all persons; conduct partnering and alliances with public, private, non-governmental and international organizations and civil society to promote sustainable outcomes. (WHO, 2005:3).

Franco-Giraldo (2012:200) identified critical aspects associated with the "lack of effectiveness of HP in the context of globalization." For Salazar (2012:26) the current international order does not guarantee the effectiveness of social actions aimed at reducing health inequities; "the evidence on the effectiveness of these initiatives does not account for their complex nature given their multidimensional, intersectoral, and intergovernmental actions. Meanwhile, Woodward et al. (2002:37) assert that "at the national level, policies should be designed to explicitly increase the well-being of the population, rather than assuming that it is achieved automatically through policies aimed at economic growth."

It is not easy to find studies that establish the required clarity with respect to the economic benefits of globalization versus concrete benefits for health development (links between national economies and health systems) in LMICs. Globalization also threatens the identity and cultural values of populations. It has driven transformations that have increased differences and intensified permanent disparities among various social groups, which represents opportunities to improve health in the context of globalization, according to various authors:

> Social groups had very uneven resources to deal with the opportunities and the risks created by these transformations, so it is not surprising that sectors with greater economic resources, the best social networking and the best educational capital would take ownership of a significant portion of the benefits created by globalization. (Reygadas 2008:111)

Franco-Giraldo (2016:130) proposes to delineate the scope of a "Latin American global health perspective" based on some analytical axes and practices, such as "governance, accountability (transparency, accountability, etc.), social justice, human rights, reduction of inequalities, processes of reform of the health sector, universal coverage and quality of services (perspective of health rights)."

## Potential Impact of Globalization on Strategies Aimed at Reducing Health Inequities

Globalization with respect to health has different connotations and implications, leading to the idea of health "without borders" as promoted by all sectors of development; additionally, it is associated with migrant phenomena (involuntary), which have generated many concerns and fostered new coresponsibilities in terms of containing, for example, at the planetary level, the emergence of contagious diseases, the resurgence of infectious diseases, and the intensification of chronic diseases. Some authors have presented globalization in value terms, perhaps without

considering the underlying national processes (Feachem 2001; Dollar 2002). Thus, questions such as what kind of globalization is good and what kind is bad for human health, the growing concerns about the impact of globalization on health equity, the diseases associated with globalization, and the effects on health equity in a world marching toward globalization must be addressed. Chen and Berlinguer (2002) have identified at least three interactive links:

> First is the clear transmissibility of health determinants and risks. Enhanced international linkages in trade, migration, and information flows have accelerated the cross-border transmission of disease and the international transfer of behavioral and environmental health risks. (...) A second criterion is shared risks and consequences worldwide and over time.Intensified pressures on common-pool global resources of air and water have generated shared environmental threats. Environmental damage due to global warming, ozone depletion, chemical pollution, and the unsafe disposal of toxic wastes are examples. While local and regional contexts may shape the health dimension of environmental insults, many new threats are genuinely global in scale. (...) A final dimension is health change associated with the technological and institutional transformations of globalization. The technological advances underpinning globalization are profoundly altering the landscape of global health. Some examples are the market-driven priorities of private pharmaceutical companies, the penetration of private markets into health services, the neglect of research and development against "orphan diseases" afflicting the poor, and iatrogenesis due to inappropriate application of new and often expensive health technologies. (Chen and Berlinger, 2001: 38–39).

Llambías Wolff (2003) raised the need to progress toward a paradigmatic change, which requires a specific capacity to do so; but what kind of capacity does he refer to: the capacity related to institutional strengthening, which constitutes an enormous challenge, or the capacity to undertake processes of implementation? The execution of policies demands a different type of rationality, mainly if the intention is to raise awareness on the significant importance of health in the context of socioeconomic development. The challenge is not an exclusive responsibility of the health sector; it is a matter of coresponsibilities that requires thinking about equity as a guiding paradigm.

> The challenges are rather in the ability to promote paradigmatic changes to successfully implement policies around a reconceptualization of health, as an integral part of social economic development, and transform it into an ethical and valuable indicator of modernity (Llambías Wolff 2003:237).

Contrary to the widespread idea about international economic integration and the creation of greater inequality between rich and poor countries, as well as within the countries, Dollar (2002) mentioned in his article "Is globalization good for health?" that the existence of an "abundant number of studies that have linked the incomes of the poor to their health situation authorizes us to think that globalization has positive indirect effects on nutrition," "infant mortality and other health aspects related to income." However, Dollar (2002) stressed some harmful effects on health of globalization, based on the idea of "side effects of traveling and migrations, although also the trade of food and other products can spread diseases." According to Dollar (2002), the migratory phenomena of some countries led to the spread of various diseases. Likewise, trade of tobacco products demanded the implementation of health policies to deal with these problems. This controversial article did not go unnoticed by another author, Villa-Caballero (2004), who made the following point:

> While some defenders of the global scheme argue for and underline the existence of benefits in the area of health for poor countries (Dollar 2001, part of the appointment of Villa-Caballero (2004)), the evidence shows that there is no decrease in new cases of AIDS, tuberculosis, and malaria, and that also now these diseases are exported, such as the epidemic of AIDS that is currently observed in countries of Europe and Asia as a result of migration from Africa. Another effect of globalization on health is the spread of harmful patterns of behavior. In addition to the known negative influence from tobacco and alcohol, backed by multinational companies with offices around the world, there is another element of emerging risk to health: nutrition. Adequate nutrition has a determining role in the health of populations. As is known, in a large number of developing countries, the availability and administration of food is compromised, and these countries currently face a new challenge in connection with international commercial exchange without borders. (2004:105).

Following Walt (1998, cited by Chen and Berlinguer 2002) regarding the existence of legitimate concerns about global inequities in health, Chen and Berlinguer (2002) argue that the evidence is inconclusive, so it can be inferred that larger and more timely studies are needed that identify specific structural factors conducive to global inequities in health while at the same time rethinking the strategies to provide appropriate solutions. However, Chen and Berlinguer (2002) put forth hypotheses on some mechanisms of deterioration of equity in health:

> Private markets, unconstrained and inadequately regulated, are perhaps the most powerful globalizing force driving inequities in health Particularly disturbing is the commercialization and commodification of health, for example, the sale of body parts, such as kidneys (sometimes even from live donors) (Berlinguer 1999). Penetration of private markets into health services eat at a time when the state is under attack as inefficient and misused through private "rent-seeking" behavior of politicians and civil servants. (...) The main equity concern in relation to biomedical sciences is the tendency to ignore the diseases suffered by the majority of human beings and to concentrate instead on commercially profitable products (Chen and Berlinger, 2001:40–41).

The direct and indirect effects of globalization on Latin American countries are considerable; one of the most important relates to economic and political constraints, which at the same time produced additional constraints on important dimensions of human development. However, various authors mention some advantages of globalization. On the other hand, Stiglitz (2002) made the following statement:

> Foreign aid, another aspect of the globalized world, although it suffers from many shortcomings, nevertheless has benefited millions of people, often in ways that have not been news: the guerrillas in the Philippines, when they left the weapons, they had jobs, thanks to projects financed by the World Bank; irrigation projects over-duplicated the incomes of farmers, and therefore had access to water; educational projects expanded rural literacy; in a handful of countries projects against AIDS have led to an expansion of the disease. Those who vilify globalization often forget its advantages, but its supporters have been even more biased; for them, globalization in "developing countries must accept it if the objective is to grow and fight effectively against poverty. However, for many in the developing world, globalization has not fulfilled its promises of economic benefit." (2002:29)

Brieger (2002) unraveled the meaning and produced a balance between the implementation of different globalization measures, its discursive (ideological) success and the myth created around neoliberal policies in Latin America, as well as the expectations formulated by the propagandist theorists, based on the idea of overcoming the backwardness into which populism and statism had plunged them,

which did not match the results achieved. This reality has demanded an international rethinking regarding control measures, intensifying strategies such as prevention and HP, coupled with the commitment of the different social actors involved with the actions of prevention and disease reduction:

> The balance parameter for the neo-liberal theories is the quantity and quality of the reforms applied. In this sense, they consider that the decade of the '90s has been a resounding success whose results have already been transferred to the general welfare. (2002:344)

Accordingly, the complexity of health demands the establishment of structurally interrelated aspects (economic, social, and political) through new global policies that encourage the possibility of using greater economic resources and compliance with regulations executed by different development sectors. This has led to tensions that had hitherto not existed between local and national, regional and intercontinental governments and organizations. Gamage (2015) formulated questions related to policies, programs, and mechanisms within a framework of globalization and how all these favor communities with greater vulnerability and risk of being socially excluded.

> One question arising out of the borrowing and lending of globalizing policies as well as the transfer of capital, technologies, goods, personnel, ideologies, and expert knowledge is: whose interests do they serve? In development contexts, we also have to ask whether the policies and programs being launched under the name of globalization are well targeted. And to what extent do they benefit the marginalized sectors and disadvantasged communities of society? Do they contribute to further inequalities? What policies in health, education, welfare, housing, and income generation have been developed in specific countries with a focus on the adversely affected sectors and communities? What mechanisms exist in existing policies and programs that address social equity and social justice, issues pertaining to the affected segments of society? (2015:9)

Chen et al. (1999, cited by Chen and Berlinguer 2002), writing about the central question of the relation between globalization and health, posed the following additional questions: What is the relation between globalization and health? How can specific diseases be directly related to globalization? Why are some diseases included and not others? The response must necessarily link specific diseases to the core of globalization processes. In summary, the opportunities and threats posed by globalization and global economic policies demand strong and democratic states, such as policies, structures, and legislation that promote social justice, health equity, and well-being for citizens.

Because multidimensional factors are involved in the effective implementation of strategies aimed at reducing social and health inequities, it is important to reflect and act in accordance with this complexity. One question that demands is a response concerns the role of the health sector in the expected transformation processes. Again, at this point, the scope and operative meaning of the primary healthcare (PHC), HP, and health in all policies (HiAP) strategies in this construction should be questioned. The next section will address these issues.

## Neoliberal Economic Policies: Impact on Health

The link between health and socioeconomic status has been documented; there is also evidence linking geographic areas, gender, and ethnic group to health conditions. Globalization is a widespread exchange of goods and services without physical boundaries, but only countries with adequate capacity have reaped benefits in terms of dealing with health-related challenges. These are the countries that have the resources and infrastructure needed to compete. Globalization strengthens policies that produce, maintain, and increase social and health inequities and leads to problematic situations in national health systems that should respond promptly and efficiently to emerging crises without the needed resources; therefore, globalization could reinforce and accentuate inequality.

The implementation of neoliberal reforms in Latin America brought with it the dismantling of the welfare state and its social benefits (Daulaire 2003). The putting into place neoliberal accumulation mode, according to Galafassi (2014:83), "produces a separation again, perhaps no longer between the worker and his original means of production, but between the worker and his improved living conditions thanks to the conquest of common social goods." The neoliberal structural adjustment model is one of the identified forms of capitalism, to remain, to reinvent itself, and to intensify its coercive actions, of containment and impoverishment of millions of people, over time. Busso (2010) analyzed poverty and social vulnerability in Argentina through a recount of the origin, permanence, and expansionist character of the capitalist system. In this sense, he found in Argentina a replicable model similar to that in most countries of the American continent:

> Two situations can be evidenced in the history of what Argentina and South America are today, which show evidence throughout half a millennium: the impressive social transformation in the countries of the region. On the one hand, the pre-Columbian communities possessed an economic, social, environmental, and demographic dynamic that was totally altered by the arrival of the Spaniards, carriers and enablers of the capitalist system in Latin America. On the other hand, and at the current point of arrival, at the end of the twentieth century the expansion of capitalist production relations to (almost) all territories and communities that conform it is complete.…Five moments or phases can be mentioned: the process of consolidation of the nation-state of a capitalist type (1810–1880), the agro-export model (1880–1930), the model of industrialization by import substitution (1930–1975), and the neoliberal model of external opening (1976–2009). (2010:10)

The hegemonic neoliberal political project discarded the possibilities of social transformation from politics through this type of action. In the developing economies of Latin America, the implementation of neoliberal policies resulted in the economic contraction of labor demand, which brought greater possibilities to women and adults, characterized by low wages. As a result, the employment of young people and young adults was reduced. The actions of neoliberal economic policy sharpened social inequality, characterized by impoverishment.

Latin America presents a singularity: its countries share common features and also have unique features, unlike Asia and Africa, for example. In the contemporary world, with regard to the world system, Latin America is in a peripheral situation, as a metropolis under center-periphery logic. De Sousa Santos (2010) has described the consequences of neoliberal policies (chaotic and agreed adjustments):

> After the crisis of the model of structural adjustment and neoliberal policies, political change is happening in many Latin American countries. A claim to the state arises in a regulatory role vis-à-vis transnational corporations and traditional material powers to recover old diminished social rights as well as new social and collective rights (water, food security, quality of life), including rights of nature, which reflect new conceptions of rights and aspirations for good living, from diverse cultural traditions. (2010:13)

Latin American countries have presented systematic fiscal deficits, which have been faced through the fiscal policy—as an appendix of the economic policy. In this way, the state budget, the public expenditures, and regulatory taxes have been subject to changes in order to preserve economic stability, but negatively influencing population well-being.

> Although the redistributive power of fiscal policy in Latin America is considerably greater when evaluating the effect of public social expenditure on education and health, compared to the effect of public cash transfers and direct taxes alone, the final impact of fiscal policy on reducing inequality is still limited in the region, especially when compared to that of the OECD (Organization for Economic Cooperation and Development) countries.…The results of this study suggest that one of the greatest challenges faced by the region is to improve the redistributive power of fiscal policy, both through taxes and expenditures, in order to promote greater equality in the distribution of available income and greater reduction of poverty levels. (ECLAC 2015:115)

The serious problem of Latin American countries lies in the difficulty of overcoming this situation. Thus, the countries must incur economic debts, which involve greater and prolonged external indebtedness, due to the corresponding increases in the interests. This policy requires a fiscal adjustment, which should encourage investments that sustain growth:

> Latin America's public debt has increased gradually and heterogeneously, going from 33.2% of GDP in 2014 to an average of 34.7% of GDP in 2015. Although this level remains low in many countries, the accumulation has been due to the financing needs in front of a deceleration scenario, at a relatively low cost. Today, the vulnerability of the region to external shocks is very different. In 1990, external public debt amounted to 90% of total debt, and by 2015 this ratio had fallen to 48%. Likewise, the expansion of public indebtedness has been greater than the growth rate in several Latin American countries, implying greater management challenges for the coming years. By subregions, the public debt has presented a dissimilar characteristic. In Central American countries, debt levels grew up to 2013 at a faster rate than in South America. The weight of public debt remains higher in the Central America subregion, where it reached an average increase of 8 percentage points of GDP between 2008 and 2015. In South American countries, this increase was of 4.4 percentage points of GDP. (ECLAC 2016:10–11)

The Fiscal Panorama of Latin America and the Caribbean (2015) document, published annually by ECLAC, compares the behavior of different regions of the world and observes that Latin American governments spend on health services, as a percentage of GDP, less than their peers in North America, Europe, Central Asia, or the Organization for Economic Cooperation and Development (OECD) countries, but more than in Africa, the Middle East, and South Asia.

> However, if per capita expenditure in health (both public and private) is assessed, the differences between regions are very large. On the one hand, the countries of North America, the OECD, and Europe and the Central Asia region spend per capita US $8,200, US$4,400, and US$2,300, respectively, in purchasing power parity. On the other hand, in sub-Saharan

> Africa and South Asia regions, the per capita expenditure barely reaches US$155 and US$124 (PPA), respectively. The countries of Latin America and the Caribbean are in an intermediate position, since they have average health expenditures (including public and private sectors) of around US$872 per capita (ECLAC 2015:84).

The disappointing current economic situation in Latin American countries, a widespread concern throughout the world, affects the performance of the development sectors, slows its progress as it reduces the scope for public investment in key areas such as health, education and housing:

> Governments of the region have been forced to make large, non-discretionary expenses on wages, salaries and interest payments on the debt, reducing the scope for public investment in key areas such as infrastructure, health and human capital improvement. In 2015, the index worsened by 1,9 percentage points, indicating a deterioration of flexibility, despite the improvement in fiscal balances (ECLAC 2016:32–33).

The 2016 Latin America and the Caribbean document "Will the Current Cold Front Be Prolonged?" lists the factors that influence the current situation, the low potential growth, and the economic prospects of the South American countries. The previous document and the article "Latin America and the Caribbean: Managing Transitions" (2016) examine the current situation in several countries on this side of the world, where moderate economic growth is observed, some very slowly and others below their historical average, together with the fiscal policies and the capacity to adapt to the current transition situation:

> The current adjustment to persistently low commodity prices, despite its recent slow recovery, and idiosyncratic domestic developments continue to define growth performance and the economic perspective for South America. The economies of this region as a whole are expected to contract for the second consecutive year in 2016, before growth recovers to 1.1 per cent in 2017. However, policy perspective and priorities vary considerably within the region. (IMF 2016:13)
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> To maintain economic development in the region, policies will be required to facilitate the transition to lower commodity prices, while reducing poverty and inequality and addressing the bottlenecks that have long held back investment and productivity in the region, without derailing the significant gains made in macroeconomic stability that have been so beneficial to the region (Werner 2016; IMF 2016).

In the projection for South America, a growth in real GDP in its percentage variation (0.8), after the contraction of 2016 (−2.0), is observed. The projection is positive in Latin American countries like Argentina, Colombia, Mexico, Peru, and Chile, versus negative projections in Venezuela and uncertain forecasts in Brazil.

## The Concept

Various authors have provided definitions of *territory*. According to Rodríguez-Páez et al. (2012) territory is understood as

> Geographic space constitutive of the state, where natural and social subsystems coexist, where multiple social groups are organized with diverse cultures and habits that modify the physical and social environment, which participate in the construction of a cultural structure

> that varies according to the institutional participation and the degree of economic development. (2012:82)
>
> Geographic space socially organized, corresponding to a social space, real and objective, crossed by the cultural values and the meanings of the subjectivity. It has no definite limits, since it is characterized by its symbolic dimensions, and is not identified with administrative territorial criteria. (Santos 1988 in Junges 2003:4, cited by Fuenzalida Díaz et al. 2013:93)

A territory, understood as a unit of analysis and action, requires the construction of social networks characterized by cohesion, which can benefit the renewal of local responses. In that sense, the strengthening of the territory is the way to generate social cohesion. The territory can be understood in two ways: vertical and horizontal. The first refers to the ability to capture information, knowledge, and resources; the second refers to solidarity, recognition, and cooperation between the different actors. The interaction between these two forms is due to the possibility of redefining social problems and the responses to them through horizontal networks, which use vertical networks to capture resources that help strengthen responses. The interaction of these two forms promotes and benefits political and technical-political decision making, stimulating responsibility, identity, solidarity, and social integration. Territory's potential was recognized by the World Health Organization (WHO) (2016), which states that a healthy cities strategy engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning, and innovative projects.

## The Requirements

The close association between territory, population, and health requires the allocation of resources, initiatives, and a territorial approach to health actions. According to Fuenzalida Díaz et al. (2013:101), "The adoption of territory as a unit of analysis becomes essential to understand the behavior of any phenomenon related to inequity environments and their health outcomes." A systematic vision is necessary to establish the types of development related to health–disease processes to improve the capacity for intervention. The development of a territorial plan for action in health implies, from health authorities (there may be other actors wishing to achieve the same goal), the design of a prospective scenario within a given territory identifying the variables that influence or could influence the situation currently or in the future. Variables such as political, economic, social or cultural, technological, ecological, and demographic must be taken into consideration (Torres Andrade 2009).

Gradually, public health professionals and epidemiologists have begun to understand territory as a fundamental component of analysis that is not static, but dynamic, so its complexity is not strictly physical. The anticipatory capacity to visualize the intersectorality and the territorial dimension requires the planning of collective health in a territory. Systematically thinking about a problematic situation, defined by different actors (municipal authorities, community representatives, and civil society

organizations), demands the observation of the whole and of the parts and how they interact in a specific context, under what logic and influence, internal and external.

The foregoing definitions reflect an increasing interest in reinforcing the permanent work between sectors related to health and population welfare, within the framework of political and social processes. These political processes of change must be systematic, reflexive, anticipatory, and, to some extent, reactive owing to the emergence of contextual situations as well as factors that have an impact on a population's vulnerability. It is in the territory as a unit of analysis where the social determinants of health find their maximum expression.

It should be noted, for example, that researchers from several countries have reported that areas of residence are associated with health, beyond individual risk factors (Diez-Roux et al. 2000; Jones and Duncan 1995; Kaplan 1996; Kawachi and Berkman 2003; Macintyre et al. 1993; Pickett and Pearl 2001, cited in Bernard et al. 2007). This involves the idea of the influence that the social determinants of health have on the territorial context, where each individual's actions and collective actions have a direct or indirect impact on the health status of the population (Fuenzalida Díaz et al. 2013:93).

A territory requires development strategies for its advancement and competitiveness, within the framework of world capitalism:

> Territorial development is considered to retain the broadest meaning of development since it alludes to the natural territory, the equipped or "intervened" territory (which contains transport systems, equipment) and organized territory (characterized by activities of greater complexity, human settlement systems, transport networks, etc.). (Boisier 1999:8)

Sustainable territorial development emerged as a complementary concept or subconcept, after the emergence of the concept of sustainable development (in the mid-1980s), designed as an essential anchorage to a place or territory in which to govern it, with everything it needs. This concept is essentially associated with sustainable management implemented and developed by municipal administrations.

Rural territorial development has been defined by Schejtman and Berdegué (2003:13) as a process of productive and institutional transformation in a given rural area, whose aim is to reduce rural poverty.…Institutional development aims at stimulating and facilitating the interaction and coordination of local actors among themselves and between them and relevant external agents and increasing the opportunities for the poor to participate in the process and its benefits. It has the advantage of connecting issues of rural poverty with contemporary elements of public action, such as local economic development, levels of competitiveness, decentralization, and the environment.

According to Dallabrida (2008), the idea of human development is closely linked to the dynamics of territorial development:

> Referred to the set of actions related to the development process, carried out by actors, agents, organizations and institutions of a society historically and territorially identified. Its use supports the hypothesis that development has a direct relationship with the dynamics (social, economic, environmental, cultural and political) of the different territories. Depending on the type of action, passive or active territorial actors in the defense of their interests, before the process of globalization, territories assume development options that

> promote or hinder, at different intensities, becoming submissive territories/losers or winners of an innovative type. This global-local dialectic process, reaction-action, whose intentions are designed by total size, but occurring in the territory, territorial inequalities or differentiations. (2008:6).

Sustainable development, according to Novo (2006), retains in its conception the following guidelines: a systematic approach, ecological viability, equity, global vision, endogeneity, and development processes. It may be added that the social and institutional viability (identification of strengths and opportunities) of a set of interrelated areas of development (scientific and technological, economic, capacities, political, societal, community, cultural, population, institutional, and human, among others) is inseparable from the notion of well-being. All of the aforementioned categories are structured on the basis of the purpose of integral development, which requires a systematic approach (relational, circular, procedural) by institutions, managers, and actors, who guide, mobilize, and act, according to the proposed social change actions, from the social capital built on the basis of past actions.

Educational institutions, workplaces, cities, and universities are sites serving as the main locus where actions in HP have taken place and where intersectoral action has begun. In line with this logic is the approach of Grueso-Hinestroza et al. (2013), who point out in their study on organizational health the actions required to generate the integral well-being of workers. The actions of organizational health refer to the set of activities that the organization can take, with a preventive approach, to generate greater well-being for its workers (Grueso-Hinestroza et al. 2013:67). Among the different definitions and recommendations set out in The Declaration of Alma Ata (1978), the need was pointed out—within the framework of HP—for greater development and growth of occupational health, for example. In the field of organizational health, promotion actions have a significant impact on cultural values and the adoption of organizational practices, as noted by Grueso-Hinestroza et al. (2013).

Some authors warn that the promotion of health in organizational environments is a challenge that must be faced since it is still adopted in a limited way in formal work environments with specific, sometimes fragmented, actions (Grueso-Hinestroza et al. 2013:65). The development of actions to promote health in organizational contexts is a hot topic, so it is necessary to carry out an investigation to identify the implications that this has in terms of the organization itself and in terms of the well-being of workers. Grueso-Hinestroza et al. (2013:65–66).

Authors from different locations and disciplines refer to intersectoral and transdisciplinary action in various studies and systematic reviews, where they reinforce the need for active actions to address social issues associated with the health conditions that various social groups experience in specific territories. Vargas Porras et al. (2010), Franco-Giraldo (2012), García Cachau et al. (2013), Duarte-Cuervo (2015), Díaz-Mosquera et al. (2015), and Santiago Declaration (2016) are among the researchers investigating this topic; however, this identification is insufficient (it is not enough to know what is necessary); it is also necessary to create conditions that facilitate the implementation of processes supported by political, legislative, technical, cultural, and regulatory changes aimed at ensuring the viability and sustainability of these interventions as well as generating concrete actions for structural transformation.

## Intersectoral Management

The study "Inequity(ies) in health care in greater Buenos Aires. A view from local management" by Chiara et al. (2009) analyzed the processes of decentralization, relative autonomy, and relationships between subnational governments (provinces and municipalities), important governmental actors (characterized by unequal levels of power) versus the central government, and its supralocal authority (regional, national, and international). Of course, each municipality has defined its local socio-territorial configuration based on the characteristics of its population, its welfare levels, the availability of resources, and the local political fabric, among other factors (Chiara et al. 2009). This study reviews the different impacts, particularly those of political dynamics, on health care in the effective exercise of the right to health:

The development of the "relative autonomy" potential of the local level in the formulation of health policy has been informed by these historically shaped tensions and by the crises that marked the functioning of state institutions and structurally modified the conditions of reproduction of the life of the population in recent decades. (Chiara et al. 2009:107)

In Colombia, the 2012 "Plan Decenal de Salud Pública" document mentions the different interactions between actors and specific actions that each subnational government should lead, based on the purpose of reducing inequities in health, based on the social determinants of health:

> It brings together the actions that must lead the territory, appealing to the different sectors, institutions, and community, to develop them through projects aimed at the construction or generation of conditions, capacities, and means necessary for individuals, families, and society as a whole to intervene and modify the social determinants of health in that territory and, thus, the conditions conducive to quality of life, consolidating a healthy culture based on values, beliefs, attitudes, and relationships that allow individual and collective autonomy that enables identifying and making positive choices in health in all aspects of their lives, with respect to the cultural differences of our peoples. This line includes the following actions: formulation of public policies, social mobilization, generation of healthy environments, generation of social and individual capacities, citizen participation, and health education. (2012:41)

To address local problems, it is necessary that the different actors and sectors participate in the processes of diagnosis, programming, implementation, and evaluation of actions. Therefore, networking is a tool to solve community problems since it promotes participation and interdisciplinary and intersectoral articulation (Dabas et al. 2006, cited by; García Cachau et al. 2013:171).

The identification of common factors affecting each country and the type of work carried out up to now by and between the different sectors and actors involved serve as a basis for establishing comparisons between countries in order to analyze the procedures established by the experiences (successful or not) that through adaptations can be replicated in similar territories. The expected results correspond in many nations of the region to country goals with limited time horizons, which do not present the continuity or foresight needed to focus all the short-, medium-, and long-term efforts on progress from the gradual reduction toward the end of the problems of social inequity and health.

The solutions proposed are not structural and correspond to temporary actions. This challenge to address the reduction of health inequities requires the revision and incorporation of renewed governance ideas, new foresight capabilities, and exercises in planning systems that overcome short-term thinking and strengthen the construction and vision of the future in the medium and long terms.

A strategic plan for territorial development that is comprehensive and sustainable (municipal and regional) requires the ability to think strategically and involve different perspectives (spatial, territorial, regional, and local), as well as the development of a diagnosis, identification of vocations in the territory, strategic objectives, and a local development strategy, which must present a comprehensive vision that incorporates demographic central aspects related to the basic needs of the population (infrastructure and communications services, housing, health, education, and culture). This strategic plan requires citizen organizations involved in planning processes (local bodies, consensus building, participatory budgeting) to expand decision alternatives. At the municipal level, a strategic plan for territorial development requires the autonomy of local governments. Initiatives at the local level facilitate the active participation of the population in the planning of complementary community actions and in the development of programs and projects that affect the reduction of health inequities.

## Governance and Balance of Power Relationships Among Key Actors

Globalization has different effects and scopes, which require the review of some forms or initiatives to overcome them. In this sense, Daulaire (2003) points to "a new era in international relations. While the world has outgrown traditional mechanisms for addressing global issues, it has not yet developed new forms of effective governance. This temporary void poses threats and enormous opportunities." Regarding the direct and indirect effects on human health, which involves some aspects of economic globalization, Kay and Williams (2009) point out the following:

> Works on global health governance regularly footnote the centrality of economic globalization, including how such factors as increased volumes of international trade, investment and finance are having direct and indirect effects on human health, not least in the more rapid transmission of infectious diseases resulting from trade flows and spatial compression. (2009)

Daulaire (2003) underlined the concern about the apparent lack of adequate governance in the context of globalization. This situation is giving rise to a series of threats to public health, especially in regions marked by economic instability:

> Some critics fear that globalization has shot beyond its traditional bounds and is now a runaway chain reaction that cannot be managed. Such concerns are fueled by the apparent lack of appropriate governance. Existing transnational governance structures were created when the world was dominated by the spirit of national sovereignty. (2003)

Buss (2014) referred to the results of a report on global governance for health prepared by *The Lancet*/Oslo University Commission, published by the English journal (Lancet 2014:683, cited by Buss 2014). This document lists the failed aspects of the

global governance system that affect the health protection of the poorest, most vulnerable, and most marginalized population. This report attributes to the five dysfunctions of the global governance system the adverse effects of global political determinants of health: (a) democratic deficit, (b) weak accountability mechanisms, (c) institutional immobility, (d) inadequate political space for health, and (e) nonexistent or even embryonic institutions. In this regard, the commission proposes three main initiatives:

> (1) Creation of a multistakeholder health governance platform—including global civil society, the UN, entrepreneurs, and NGOs—to function as a forum for policy discussion and agenda formulation and evaluation and its impact on health and equity in health, as well as proposing adequate solutions and overcoming barriers to its implementation; (2) creation of an independent scientific monitoring panel on the influence of global governance processes on health equity, through mandatory impact analysis on levels of health equity in international organizations; (3) use of human rights mechanisms for health, such as special inspectors, as well as stronger sanctions against a broad spectrum of violations committed by nonstate actors through the international legal system. (Buss 2014:683)

Different experiences have happened in Latin America regarding collaborative work between different actors and institutions, as well as efforts to include health issues in working agendas. In Brazil, according to Puerto (2009:78), "one of the social responses to social and environmental conflicts was the creation in 2001 of the Brazilian Network of Environmental Justice, which includes social movements, affected populations, environmentalists and academic groups."

> In Latin America, it was not until the 1990s that the relationship between the environment, health, human rights and justice became part of the political agenda of some countries with the adoption of the concept of environmental justice. Generally, in Latin America, situations of environmental injustice, in addition to other factors such as high social inequality and ethnic discrimination, emerge more intensely depending on their insertion in the international economy from the intensive and simultaneous exploitation of natural resources and hand of work, that is, for its role in the export of rural and mining products. (Puerto 2009:80).

Several authors have stated that this process of processes imposed a new developmental model that justified initiatives associated with the reduction of social inequities and health strategies. According to Feo Istúriz (2013:888), it "imposed a model of thinking" that is known as neoliberal and constitutes the economic paradigm of our time.…This model of development hinders the redistribution of wealth, concentrates capital, produces poverty and unemployment, and has a profound impact on life, the environment, and health." Many countries on several continents have suffered systematically from the precarious and unequal conditions (prior and new) imposed by globalization. Contributing to the perpetuation of the unfair accumulation of social inequalities and inequities and of health (challenge of the public health), as Cornia (2001) says,

> Globalization could impact inequalities through factors associated with economic growth and development, such as the loss of diverse natural habitats, the risk of pollution, and the vulnerability of single-crop economies to infestation or disease. Within many countries, including the UK, the USA, the Netherlands, and India, there is a wealth of evidence documenting the continued existence of health inequalities (Acheson 1998; DH 2005; Dorling 2006; Groffen et al. 2008; Lantz et al. 2001; ONS 2004; Subramanian et al. 2006 are cited of Naidoo and Wills 2010:83).

Over the last three decades, three health-related areas have attracted increasing interest: the social determinants of health, HiAP, and governance. Thus, the importance of the collective effort to integrate the social determinants of health and HiAP concepts has been gradually understood, which helps to explain the role of governance in health as a decision-making system based on the complex aspect of relations of power. Like many health concepts with multiple meanings, governance is an evolving practice. For McQueen et al. (2012), governance, with respect to SDH and HiAP, constitutes

> the most relevant concept of the three, which is imposed on the other two. However, many of the published explanations of the concept of governance were passive or structural rather than active, that is, they generally described which government agencies or bodies were making governance decisions, rather than explaining how agencies were making those decisions. (2012:4)

The foregoing statement, underlined by McQueen et al. (2012), is critical because of the guidance it offers regarding the nature of the contents of the available documents on the actions taken with respect to governance. The contents of the reports differ in their intentionality; most describe the agents and institutions responsible for the different decisions, while few analyze the internal processes that guided decision making. According to McQueen (2012), governance is the main element acting on social elements, and the achievement of HiAP is essentially based on two dimensions:

> (1) the structures that unite the actors and (2) the actions that emerge from their commitment and their mutual deliberations (e.g., the agreement by which policies are articulated in a concrete way, the decision to adopt some policies, the use of concrete policy instruments to implement their implementation). (2012:12)

Government agencies, through their governance, are responsible for managing tools such as regulation, law, and legislation. These instances must act in a process of permanent interaction between participants that are inside and outside the formal structures of government. McQueen (2012:14) points out that cross-sector governance structures (intersectoral relations, joint budgeting, and citizen participation, among others), understood as an analytical category, facilitate collaboration among different ministries, departments, and sectors. These structures facilitate actions that aim to align other governance policies with health objectives through evidentiary support, goal setting, coordination, advocacy, monitoring and evaluation, policy guidance, financial support provisions, legal mandate, implementation, management, and intersectoral governance structures. According to McQueen (2012:14): "An intersectoral governance structure is effective to the extent that it contributes to the integration of health into other policies." This is linked to the purpose of the final outcome of intersectoral actions: changes in other policies (structural issues) that make it impossible to achieve better results.

Governance is the system of decision making in which the guidelines are marked, legislative authority is exercised, and events are controlled and managed. Governments that recognize the complexity of social and economic factors will govern through collaboration with the market and civil society actors for the implementation and development of policies. Governance can include action that goes far beyond government, through the delegation of policy formulation and implementation

of policies or parts of them to interested parties or organizations. In essence, governance is based on power relations. (2012:14)

McQueen (2012:6) states that "In more advanced economies, governance by definition has an important role in all sectors of society. The government, whether central, regional, or local, takes responsibility for various aspects of society, from the mundane (sewerage, transportation, housing, energy, commerce) to the human (education, art, sports). The question is whether LMICs are aware of the policies, plans, structures, funding, and mandates that are necessary for a successful implementation of the strategies to which they have committed themselves. What is required to increase territorial governance?"

## Social Structures and Health Systems

The strategies outlined earlier (PHC, HP, and HiAP) have evolved according to new conceptions of health and ways of creating and maintaining it; however, this development has not taken into account the constraints on LMICs' ability to implement them. On the contrary, what has been done is to add new responsibilities and complexity, which, although necessary, demand changes in the political and social systems, policies, and regulatory frameworks that support them. This statement is not new, and the WHO referred to HP as a philosophy that conceives of health as a human right, which responds to political and social determinants to obtain improvements in health equity for which it must develop "inclusive policies that are dynamic, transparent, and supported by legislative and financial commitments."

Health promotion practice responds to diverse complexities, structures, and scenarios, as well as to specific problems and priorities, so the emphasis of its practice reflects the intention to solve a specific problem. Understood in this way, the problems could be utilized as entry points or conjunctures conducive to scaling up and widening the scope of interventions addressing not only a specific problem but also more structural actions aimed at reducing social and health inequities. In this way, HP could also act as a mediator and materializer of intersectoral action, framed in social and political processes. Unfortunately, this role is not reflected in the reports; on the contrary, it has been pointed out that those aspects that transcend the provision of health services, under the radar of the health sector, are not reported in most cases, according to studies carried out by De Salazar (2012) and Díaz Mosquera et al. (2015). The reasons for this situation are considered central in this publication, so the exploration and understanding of the challenges, potentialities, and limitations will be the object of investigation in the following sections.

> It is clear that the imbalances generated by the globalization process and increased health risks exceed by far the established capacities of various national health systems, even though many of them have undertaken substantial reforms in recent years. It is this limitation that makes it urgent to build a new international institutionality that succeeds in successfully confronting the risk aspects of globalization in health matters. It is clear that the

> paradigms that guided the isolated action of national health systems are rapidly being overcome, as is the case with traditional approaches to safety, which tended to reduce it to dimension. (León 2006:152)

Previous decisions are not the initiative of an actor or sector but rather the result of political agreements rooted in models of development and social management. This is why there has not been substantial progress in the transition from instrumental to structural actions. The question that arises is whether the health sector can be the standard bearer to take this step. Experience has shown us that it is very unlikely. Does the scope of actions to address the determinants of social and health inequities need to be rethought in the light of what the sector is able to do? Or should the health sector necessarily act within the political and strategic framework of territorial development plans?

> Essentially what the critics are arguing is that health promotion programmes and interventions need to be assessed in relation to the social and structural influences that determine health. They therefore need to adopt an approach to evaluation that implicitly acknowledges the need for outcome data but explicitly concentrates on process or illuminative data that helps us understand the nature of that relationship. This approach to evaluative research that recognises 'people variables' and natural settings within the community has been applied to some interesting and testing case studies (Allison and Rootman 1996; Costongs and Springett 1997 are cited of Macdonald and Davies 1998:9)

These types of questions must be solved in the light of our reality, linking endogenous actions of the health sector with exogenous actions, in order to avoid tensions that arise when there are no complementarity and integration, frustrations and contradictions; on the contrary:

> An interesting example was the "Rescue" or "Health Systems Development in Central America, with an Emphasis on Efforts Developed by Civil Society" (2001)—developed after the signing of the peace agreements in Guatemala, a little against the course of the health sector reform at the time. The objective was to study the development of health systems from the perspective of civil society, based on the principles of primary health care (PHC), Health for All. Research with universities in Nicaragua and El Salvador, involving civil society organizations and decision makers in these countries and Guatemala, immediately after the armed conflict, became an important collective learning process. (Barten 2012:348)

Barten (2012) points out the close relationship between health systems and health inequities and in turn identifies the need to reorient and strengthen the formative foundations of health professionals in the face of the complexity of social determinants of health:

> Health systems deepen inequities, and therefore vertical coordination or intrasectorality demands the same attention as horizontal coordination or intersectorality. I agree with

> Mario Rovere that the current situation calls for a deep reorientation in the education of health professionals, in addressing social determinants, the social determination of health inequity. (2012:349–350)

Health systems have multiple objectives, including to improve health and exercise by the most efficient use of available resources. Barten (2012) underlines the difficulty of research in health systems in Central America, which provides multiple lessons in integrating different actors.

Two cases are reported in South America, one is the Colombian case. Rodríguez Villamil et al. (2013:36) point out the existence of several studies that confirm the unfavorable state of the Colombian health system, which makes difficult the implementation of the HP strategy:

> The current Colombian health system, as evidenced by various studies and especially the daily experience of citizens, is an adverse context for the development and practice of HP and for the guarantee of the right to health. (2013:36)

The second case took place in Chile. the Universal Access Plan with Explicit Guarantees (AUGE) was implemented in 2005 as a new reform of the Chilean health system, motivated by the need to "address social inequities in access and use of the Chilean health system to respond to the epidemiological changes that have occurred in recent years, which are among the first in Latin America…." (Espinoza and Cabieses 2014:46). The objective of this plan lies in "…ensuring equity in the population's access to health, regardless of people's ability to pay…" (Biblioteca Nacional de Chile 2002, in Espinoza and Cabieses 2014).

In general, it is necessary to reflect on the feasibility of a country or system to apply principles that allow for the application of the previously mentioned strategies in the face of sociopolitical changes and new health demands, as a result of the epidemiological transition and phenomena such as globalization, industrialization, and urbanization and their effects on health and equity. According to López Pardo (2007:2), equity principles should be applied at two levels: in the decision-making process and in the evaluation of outcomes as a result of the decisions taken. The author recommended undertaking a comprehensive analysis of both levels, given that equitable procedures do not necessarily guarantee equitable outcomes and vice versa López Pardo (2007:2). Therefore, continual reflection on the dynamic changes to operational definitions of these strategies is required, and national and international meetings promoted by countries and cooperation agencies represent an excellent opportunity for this. To engage in such reflections, these meetings should encourage the effective participation of all countries, not only those able to finance their participation but those facing complex challenges. It is necessary to expand the scope of these knowledge exchange scenarios from being merely informative to being prepositional and political scenarios in response to old and new challenges, according to differences between countries and regions. Hence, these meetings should transcend the moment of the conference to enter into politics and develop strategic plans that constitute work agendas financed by the countries and supported by the regional financing and cooperation agencies.

**Key Issues of Practice and Questions to Consider**

1. Research, monitoring and evaluation (M&E), knowledge sharing, and permanent advocacy are necessary to understand, interpret, and transform complex realities imposed by the multidimensional nature of strategies and a poor capacity to intervene. Often the definitions of terms such as *participation*, *empowerment*, and *capacity building* are applied loosely, so the requirements and resources to implement, evaluate, and appraise their success or failure are not clearly defined.
2. Strengthening of social and community participation in the process of formulating public health policies (OPS 2016:4). The question that arises here is the type and scope of participation, conditions under which participation takes place, and for what?
3. Imbalance between theory and practice: theoretical developments are not compatible with implementation achievements and expected results.
4. The relevance, feasibility, sustainability, and adequacy of structures for the appropriate implementation of strategies are not fully analyzed.
5. The political will to modify structures of power (institutions, groups, and social organizations, among others) is very limited. How can they be strengthened?
6. New strategies could serve as an entry point to strengthen previous ones; moreover, new strategies represent a valuable opportunity to integrate all strategies as well as to make more efficient use of available resources and scale up.
7. Knowledge development should be treated as a process, which is produced not only from the sciences but the permanent observation of the studied realities.
8. The responses to the following questions would help in the analysis of strategies to reduce health inequities and improve population health conditions.
9. Are unsatisfactory results mostly due to a lack of knowledge, capacity to produce the expected changes, to a lack of political will, or all of the above? What are the priorities?
10. Do the international and domestic agendas include actions to overcome previous challenges?
11. The means to improve people's health and exercise greater control over it: Several questions arise from this intentionality: Who is responsible for providing these means in a sustainable manner and without expiration effects? What kinds of state policies guarantee the adequacy, timeliness, and quality of the means to exercise control over health? Have the results of alliances between countries and cooperation agencies influenced regional and global policies and agendas? Do political wills generate social and economic conditions to balance power relationships between territorial actors? Could HiAP be an entry point to respond to previous gaps? How? Could it allow for the integration of PHC and HP strategies, addressing political and social dimensions neglected in the past? Do actors in the territory use a cross-cutting approach to the formulation and analysis of health policies?

Thus, the agendas of the cooperation agencies could be informed by such considerations [or issues], reflecting not only their interests, but also those of the countries. This would place the countries in a position to negotiate the nature and scope of cooperation. It is also necessary to have forums for informing, reflecting, and proposing regional agendas whose interpretation and actions respond to the complex social, geographical, and political realities of the regions/countries. This requires the permanent and participative construction of mechanisms for critical thinking—to raise awareness about the complexity of the determinants of health inequities—as social facts, external to individuals, which correspond to complex long-term structural processes. In summary, it is imperative to rethink whether the strategies being implemented to reduce health inequities are in fact the ones those we are carrying out, considering our political systems, as well as the scope of our practice and institutional capacity to generate expected changes.

Do the current strategies aimed at reducing health inequities include actions to intervene in the direct or indirect social determinants of health, which are responsible for health inequities?

Do the intersectoral actions start by recognizing the links and interactions between economic, educational, employment, opportunities, and health, or are they based on circumstantial encounters between sectors?

## Appendix

Tables 3.1, 3.2 and 3.3

**Table 3.1** Main globalized processes and strategies

| Dimension | Processes and strategies |
|---|---|
| Economic | Origin of large economic and political blocs in the world |
| | Privatization of economy and minimization of the role of governments and nation-states |
| | Deregulation and expansion of transnational market economy |
| | Free movement of capital |
| | Fall of protectionist trade barriers |
| | Foreign investment conditioned by low potential of national industrial development |
| | Transnationalization of mega companies (transnational corporations) |
| | Labor flexibility |

(continued)

**Table 3.1** (continued)

| Dimension | Processes and strategies |
|---|---|
| Politic | Origin of large economic and political blocs around the world |
| | Loss of state sovereignty |
| | Pauperization and marginalization of states |
| Social | Dismantling and crisis of welfare state |
| | Privatization of public services |
| | Globalization of positive and democratic localisms, rights, freedoms, and solidarity |
| | Weakening of trade unionism |

**Table 3.2** Effects of globalization on health in Latin America

| Description | Source |
|---|---|
| With globalization, transnational activities involving actors with different interests and degrees of power, such as states, transnational corporations, and civil society, have increased. When there are conflicts of interest or major inequities in power, these transnational activities can be inequitable and have negative health effects, whether intentionally or unintentionally. In these cases, the fight against inequity in health is both a global and a political challenge. Fulfilling this challenge requires actions that go beyond the health sector or the nation-state and require an improvement of global governance in all sectors | Ottersen et al. (2014:5–6) |
| New health threats emerge that overlap with traditional diseases, driven, at least in part, by the forces of globalization, which are generating epidemiological diversity and complexity. Three examples, discussed in what follows, are emerging: infectious diseases, environmental hazards, and social and behavioral disorders | Chen and Berlinguer (2002) |
| The impact of globalization on health and safety at work in Latin American countries shows many critical elements | Luna (2009) |
| Similar studies: | |
| Hiba (1999) *Impacto de la globalización en la salud de los trabajadores* | |
| Betancourt (2003) *Globalización y salud de los trabajadores* | |
| Feo (2003) *Reflexiones sobre la globalización y su impacto sobre la salud de los trabajadores y el ambiente* | |
| Rodríguez (2003) *Desigualdades en salud y seguridad en el trabajo que son inequidades: causas y consecuencias* | |
| Neffa (2004) *El impacto de la desocupación y la precarización del empleo sobre las condiciones y medio ambiente de trabajo (CYMAT)* | |
| Smoking and obesity are the best examples of emerging risks linked to globalization, which is imposing a double burden on health systems around the world, further complicating health inequities | Frenk y Gómez-Dantés (2007:158) |
| Globalization has not reduced poverty; on the contrary, the gaps between rich and poor have widened. One-fifth of the world's population lives on less than a dollar a day, a situation that threatens the achievement of the millennium development goals (MDGs) to eradicate extreme poverty and hunger by 2015 | |

(continued)

**Table 3.2** (continued)

| Description | Source |
|---|---|
| Globalization, from an economic point of view, resulted in the consolidation of supranational institutions that imposed as a consequence a restriction of power in the states since these surpassed the national authority to make decisions that affect the citizenship of each country. But even though there is a restriction on the economic and political maneuverability of national entities, it should be noted that the very strength of the state since the end of World War II has allowed globalization to strengthen | |
| Neoliberal globalization and the geostrategic recomposition of the world impose a predatory and harmful order on the life and health of peoples and drives processes that put at risk the viability of the planet (global climate change, wars for renewable and nonrenewable resources). Crises related to renewable energy and, more recently, food supply and the global financial system have emerged | López Arellano et al. (2008:327–28) |
| The effects of trade liberalization are manifested in economic inequality and insecurity, the conditionalities of international financial institutions and privatization policies on access to social services, deregulation in occupational health and the environment (15, 18), and the massive financial fraud committed against the lives of billions of people (31) | |
| In the area of health, the budget allocated to this area has suffered major cuts in developing countries, leading to the reemergence or permanence of diseases of poverty, such as certain infectious diseases like tuberculosis, malaria, and AIDS, as well as others like malnutrition | Villa-Caballero (2004:104) |
| If left unattended, the forces of globalization could significantly aggravate health inequities....It is unlikely that liberalized or poorly regulated private markets, which only obey commercial interests, will favor equity. Because only small groups have access to the benefits of globalization, many could be left behind, which will increase health inequities. Some trends in the 1990s underline these concerns about equity in health: the world's worst health indicators are those of countries plagued by conflict; the decline in mortality has been reversed in regions affected by the AIDS pandemic, especially in sub-Saharan Africa, and life expectancy has declined sharply in Russia during its political and economic transition | Chen and Berlinguer (2002) |
| States have less power and lose the ability to guarantee social rights, including the right to health. However, they must guarantee rights to health services and do their utmost for disease prevention and HP (conception of common goods) | Franco-Giraldo (2006: 11) |
| Countries that are not prepared to compete in trade and technology have lagged behind in multilateral treaties and have suffered the consequences, thereby widening the gap between North and South, that is, the gap between rich and poor countries. This is why the process of globalization has been characterized as a means to overwhelm or overpower and as a sign of economic neo-Darwinism | Villa-Caballero (2004:103–4) |

(continued)

**Table 3.2** (continued)

| Description | Source |
|---|---|
| Globalization generates poverty, exclusion, and poor health conditions. The poor are also living in worse environmental, social, and health conditions and have the worst access to public policies of any order. Health is a condition and, at the same time, a result of these political processes: health as law and health as a situation. In both cases, we turn to the political determinants of health | Franco-Giraldo (2006:14) |
| Globalization has emerged as an aggravating or detonating factor of a governance crisis. In general, it is limited by the fragility of institutions, the consequence of an exclusive economic model such as that of Latin America, where inequality and social marginalization are at the forefront of social and cultural trends. There is no doubt about the need to seek alternatives that favor social inclusion and the reduction of inequalities, in a world under the sway of economic globalism and its wake of inequities | Franco-Giraldo (2006:6) |
| The massive globalization of capital and its ferocious impact on workers' strikes, the progressive weakening of states, and the general relation of labor value are gradually hampering social cohesion at all latitudes. Even in the United States obvious signs of these realities are emerging, including their impact on the salaries of workers, as reported by Lester Thurow, director of the Sloan School of Business Management at the Massachusetts Institute of Technology, who claimed that 80% of the labor force in that country saw its wages decline in the 1990s while GDP has risen by a third. Thurow comments: "Probably no country has ever had such large movements in the distribution of wages without having gone through a revolution or without having lost a war...." | Pazos Beceiro (2002:28) |
| The main strategies of globalization—indiscriminate privatization, exportable agriculture, rapid economic growth, deregulation, and the gradual diminution of state power in the economic affairs of nations—have had a negative impact on all the determinants of health conditions: budgets, development programs, nutrition, health status, and many others. These effects are reflected in the most important health indicators, in addition to the anguished general situation of poverty in which those are framed. Some pain was undoubtedly necessary, but in my view, the development suffered by developing countries in the process of globalization and development guided by the IMF and international economic organizations was far greater than necessary. The reaction against globalization derives its strength not only from the damages caused to developing countries by policies guided by ideology but also from the inequalities of the global trading system | Pazos Beceiro (2002:33)<br>Stiglitz (2002:17) |

(continued)

**Table 3.2** (continued)

| Description | Source |
|---|---|
| Critics of globalization accuse Western countries of hypocrisy, who force the poor to eliminate trade barriers but retain their own, preventing underdeveloped countries from exporting agricultural products and depriving them of desperately needed income via exports....Even when the West was not being hypocritical, it set the globalization agenda and made sure to monopolize a disproportionate share of profits at the expense of the underdeveloped world. It was not only that the industrialized countries refused to open their markets to the goods of developing countries—for example, they maintained their quotas against a multitude of goods, from textiles to sugar—although they insisted that they open their own to the goods of affluent nations; it was not only that the industrialized countries continued to subsidize agriculture and hinder the competition of poor countries, insisting that they suppress the subsidies for their industrial goods. Globalization had negative effects not only on trade liberalization but on all its aspects, even despite apparently good intentions. When Western-recommended agricultural or infrastructure projects, designed with advice from Western advisers and funded by the World Bank, fail, poor people in the underdeveloped world must repay loans equally, unless some form of debt forgiveness is applied. If the benefits of globalization have too often turned out to fall short of what their defenders promised, the price paid has been higher because the environment was destroyed, corrupt political processes were allowed to become entrenched, and the rapid pace of change left countries insufficient time for cultural adaptation | Stiglitz (2002:31–33) |
| The consequences for the health policies of economic globalization affected the following thematic areas. (1) Globalization under current conditions favors policies of pharmaceutical multinationals (the top ten companies control 35% of the world market). These companies restrict, guide, and regulate the market according to demand, not the needs of the social majorities. They guide research from unique economic profitability criteria and, through patents, control the production of raw materials and their use in the production of generic drugs. (2) Globalization, through the application of adjustment policies, decapitalizes government social programs, favoring insufficient resource use of all kinds in healthcare networks of character and public ownership. Therefore, they abound in the prestige and inability to solve health problems of the same, in addition. Do it in their own professional dissatisfaction and lack of motivation. (3) The application of neoliberal macroeconomic policies leads to social marginalization and an increase in poverty among already impoverished sectors of the population. This is the main risk factor for human health. (4) Advances in diagnostic and treatment technologies can be observed around the world. However, such advances are cost-prohibitive for the poor, increasing the lack of equity in universal access to health benefits | |

Some studies identified regarding their direct and indirect health effects in the short, medium, and long terms

**Table 3.3** Opportunities for health improvements in globalization

| Description | Source |
|---|---|
| In a positive light, globalization can be seen as an extraordinary opportunity to reduce inequalities and inequities between and within countries, so that among human populations around the world, the exercising of human rights, solidarity, equality of opportunity, and protection of our planet allow for an alternative perspective from which to view globalization as a movement that seeks global social justice | |
| Not only was health introduced as a citizen's right and state obligation in Brazil's 1988 national constitution, which marked the end of the military regime in the country, but also the effective organization of a national and public health system was guaranteed. This system was launched in the early 1990s | Elías et al. (2006:148) |
| Information technology, one of the driving forces behind globalization, has enabled the acceleration of the "transmission of knowledge" in real time. Thus, now, through the Internet, we have immediate access to new technology in health and therapies to combat diseases that afflict humanity | |
| For globalization to have a positive impact on health, it is necessary to radically change the current approach to economic issues, both nationally and internationally. At the national level, policies must be designed with the explicit aim of increasing the population's well-being, rather than assuming that it will be achieved automatically through policies geared to economic growth, complemented by other elements such as safety nets and safeguarding health and education expenditures | Woodward et al. (2002:37) |
| Foreign aid, another aspect of the globalized world, despite its many drawbacks, has nevertheless benefited millions of people, often in ways that have not been reported: when the guerrillas in the Philippines turned in their guns, they were given jobs thanks to projects financed by the World Bank; irrigation projects more than doubled the incomes of farmers who thereby gained access to water; educational projects expanded literacy to rural areas; in a handful of countries, AIDS projects have contained the spread of this lethal disease. Those who vilify globalization often forget its advantages, but its supporters have been even more biased; for them globalization (when it is typically associated with the acceptance of triumphant American-style capitalism) represents "progress." Developing countries must accept it if they want to grow and fight poverty effectively. However, for many people in the underdeveloped world, globalization has not delivered on its promises of economic benefits | Stiglitz (2002:29) |
| A successful example of well-exploited globalization opportunities is the effort to immunize children in the world's poorest countries. This efforts has been funded by the Global Alliance for Vaccines and Immunization (GAVI), an alliance established between the World Bank, WHO, the United Nations Children's Fund, developed donor countries, private foundations (such as the Bill and Melinda Gates Foundation), and other partners. GAVI established a vaccine fund that supports basic immunization (DTP + polio) as well as for hepatitis B and HiB in 70 countries with GDP per capita below US$1000. More than six million children have been immunized with basic vaccinations | |
| There is no single recipe for transforming the equation of globalization/poverty and exclusion/worsening of health conditions into an equation of globalization/equity and inclusion/health. Certainly, global solutions must be formulated under the aegis of specific national and local initiatives to effect the concrete expression of globalization, poverty, and the health–disease situation at these levels | |

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