Literature Review

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Abstract

The SARS-Cov-2 pandemic had a severe impact on Latin American health systems, particularly those that were highly fragmented. Despite their challenges, these systems demonstrated remarkable resilience in their ability to respond, even with weak management and a lack of medical specialists and personnel to provide care. Shockingly, 55% of primary care facilities in places like Peru operate without a medical professional. This shortage of health professionals, particularly in rural areas, makes providing coverage care complex. However, despite these challenges, emergency care measures were implemented, including those specifically geared toward addressing COVID-19. Additionally, Information and Communication Technologies implemented contingency plans for other diseases. Primary care, with its vital role in preventing and promoting health while establishing containment mechanisms for health protection, has shown its resilience and adaptability in the face of the pandemic, instilling hope for the future of healthcare in Latin America.

Keywords: Primary care, America Latina,

Objective

This comprehensive review will explore primary care's progress, mechanisms, and enhancement. The approach involves utilizing Preference Reporter Items for systematic review (PRISMA) methodology and analyzing the "Scopus," "Lilacs," and "Google Academic" databases from 2018 to 2021, ultimately identifying 20 relevant studies. Through this research, significant advancements have been uncovered in the use of technology within primary care in various countries, including Spain (3 studies), Brazil (1 study), and Peru (2 studies). The adoption of new technologies in primary care has played a pivotal role during the COVID-19 pandemic, underscoring the relevance and timeliness of our study and instilling optimism about the future of healthcare in Latin America.

Introduction

Since 1978, the WHO has reinforced the importance of primary health care (PHC) to protect the population's health. Public health, it argues, should focus on an upstream approach to disease prevention (Hernández et al., 2017). PHC constitutes mechanisms through which different countries provide quality health to individuals, families, and the community, with inclusion, equity, and reducing costs from the intervention of promotion, prevention, recovery, and safe and effective rehabilitation. Through PHC systems, this intervention created an interface that connected the population with the health system, emphasizing health promotion and primary prevention at the population level. Despite these efforts, health inequalities remained apparent, particularly in Latin America, throughout the 20th century. However, in the 1970s and 1980s, international organizations, recognizing the situation's urgency, prioritized reducing these inequalities. The 1978 Alma Ata Declaration was a significant milestone, with governments committing to providing free healthcare services for the entire population (Aveni, 2019). The 2018 Astana Declaration reaffirmed the Alma Ata Declaration, establishing during economic

growth to increase investment in primary care and achieve universal health coverage (Izarraguirre, 2019). This historical context is crucial to understanding the current state of primary care in Latin America, and it is important for healthcare professionals, policymakers, and researchers to be aware of these global healthcare priorities.

In 2018, the 22nd World Congress of Physicians focused on 'strengthening primary care'. In their renewed commitment to improving primary care to achieve health equity, family doctors emphasized the importance of governments and healthcare systems prioritizing the needs of vulnerable citizens, particularly those in rural areas, to ensure accessible and effective healthcare. This commitment, demonstrated by healthcare professionals on the frontlines of primary care, is a testament to their dedication and should be respected and valued. An example of this is Cuba's utilization of the PHC model in public health, where medical and nursing staff reside and work in the same area as the population they serve. In doing so, they provide comprehensive and high-quality care focused on general medicine and take responsibility for the health of all family members. This model has achieved high efficiency, equity, and satisfaction. According to Gil et al. (2021), the health promotion model emphasizes primary prevention activities that fall under the umbrella of primary healthcare.

In contrast, primary prevention focuses on addressing the health environment, while health promotion occurs within the community. The MINSA (Ministsrio integral se salud asociada) highlights the significance of addressing the social determinants of health with the participation of allies to reduce health inequalities in the community. The PAHO emphasizes the importance of renewing primary health care as an essential component of developing health systems to improve the health of the people of all of Latin America. The goal is universal health with inclusion, equity, and solidarity. The complex nature of health depends on various political, social, economic, and cultural factors, which the WHO seeks to improve 40 years after the Alma Ata declaration of 1978. The creation of integrated health networks' Redes intergrades de Salud (RIS) Strengthens the first-level establishments of care, which serve as the gateway to health

services. The healthcare landscape in the Latin American region is fraught with challenges, with a complex web of public and private health systems further divided into five subsystems. This segmentation has resulted in adverse effects on the population, thereby exacerbating the broken state of healthcare in the region. The Peruvian health system, as a specific case, has undergone various reforms over the years. In 1983, Decree-Law No. 22365 established the National Health System, which aimed to integrate various health services into a coordinated and efficient system. However, this system faced challenges as health service providers acted independently of the MINSA, which only had a regulatory role. Since then, the fragmentation of health services has persisted.

In 1990, the Law of Organization and Functions of the MINSA, given through Decree-Law No. 584, repealed Decree-Law No. 22365 and sought to integrate civil society representatives in forming the National Health Council. Between 1992 and 1995, there was talk of Comprehensive Health Development experiences, and PAHO/WHO promoted RIS as a driving unit. Between 2001 and 2002, Law No. 27783 established networks and micro-networks of health establishments and services. In August 2002, Law 27813 created the National Coordinated and Decentralized Health System. In 2003 the comprehensive health care model (MINSA)was introduced, and the new health policy brought innovation. 2009 Law No. 29344, Universal Health Insurance Framework, was approved, implementing reforms and generating structural tools to promote a RIS strategy. In 2011, the strengthening of the first level of care with regulations began without effect due to a lack of commitment.

On the other hand, the Comprehensive Health Care Model (MAIS) renewed its commitment, starting a commitment focused on the family and community. Legislative Decree No. 1166 established the regulatory framework for comprehensive primary health care networks (RIAPS) operation in 2013. However, in 2017, the RIAPS was rejected due to a lack of regulation. In 2018, the Comprehensive Health Networks (RIS) proposal was approved under Law No. 30885, initiating its implementation for all MINSA and Regional Government establishments.

The emergence of RIS as a strategy to combat fragmentation in the healthcare industry has been widely acknowledged as a significant challenge. Unfortunately, the regulatory framework has not effectively incorporated operational systems, highlighting the state's inefficiency in managing public resources. As a result, governance needs to be improved. However, the governing entity, MINSA, can promote innovation and drive change in the public sector through the regulatory framework encompassing all subsectors. The RIS has demonstrated its effectiveness in various organizational elements and has been successfully implemented in **those areas (See Table 1).**

Elements	**Characteristics**
Identification of Population and families	Identify ,people, areas to create health profiles
Assignment of Health care	Identify family doctors ,and other medical care personal
Door of entrance to the health system	Point of entrance to the health system at home care and emergency room
Risks and disparities	Focus on the individual, family and community
Access coordination services	Interconnections, laboratory clinic ,web of references, electronic records ,chronic problems
Follow ups, care wellness	Multidiscipline, files, follow ups etc.
Government web and characteristics	Health systems governmental and non-governmental

Table 1 Elements of Organization of the RIS ELEMENTS

Characteristics of the RIS

Identifying populations and families identifies the people and geographic areas under their responsibility; this allows the preparation of profiles of the health situation of the individual, family, community, and their homes. Assignment of responsibility for care identifies a family doctor or other physician and their multidisciplinary health team as the usual provider of the portfolio of preventive, promotional, recuperative, rehabilitative, and palliative services. Gateway to the health system It is the first point of contact for users with the health system in the home, pre-hospital, elective hospital, and emergency care, with fewer geographic, financial, and organizational barriers. Stratification of individual and risk families focuses on the person and their health characteristics at the family and community level, addressing risks and obtaining better health results according to the individual and family care plan. Coordination to facilitate access and use they use the outpatient consultation, clinical laboratory, and hospital modules interconnectedly, making the Reference and Counter-Reference network efficient through a single electronic medical record that provides access to appointments inside and outside the RIS. Continuity and complementarity of care They have a multidisciplinary team that monitors health problems through shared care records, thus fulfilling the activities of the service portfolio with an emphasis on chronic issues. Governance in the Network Characteristics It is a unique system of Intersectoral and intergovernmental articulation for actions on social determinants of health with broad citizen participation.

The RIS provides comprehensive, equitable health services to a given population through coordination and articulation, which is accountable for health outcomes, seeking to consolidate the right to health through the integration attributes of PHC, such as opportunity, access, continuity in care, and quality of services. The Organizacion Panamericana de salud (PAHO) (2017) considers that PHCs promote universal health coverage and comprehensive and integrated, continuous care, which is the first contact with health services. According to Carbone

Palomino (2018), in the same way, it is intended to strengthen governance by emphasizing a care model centered on the person, family, and community that optimizes the coverage of social determinants. Barrios underscores the challenge for Universal Health Coverage found within the Sustainable Development Goals (SDG), in which health is "a driver, an indicator and a result." of sustainable development," these public policies play an important role, according to Del Carmen (2019), having to mobilize resources to achieve this objective as a means and end for the development and well-being of the population, since it constitutes the Third State Policy, "Universal Access to Health Services and Social Security," specifying that this should be provided free, continuous, timely and of quality, with priority in areas of concentration of poverty and the populations most vulnerable (p.28. It proposes a universal, integrated, and indivisible vision showing how human health and well-being are intertwined with economic growth and environmental sustainability (PAHO 2017). According to Burgos et al. (2021), primary care is based on the principle of health promotion at the community level, generating changes in the population's lifestyles, thanks to the role of innovation and technology that they apply—the different first-level establishments, where presence is low. However, telehealth consultations, including Curioso et al. (2018) mention that the processes of the health system become a means to strengthen primary care (Martos et al., 2019), as well as the geoprocessing works where the use of ICT renews and enhances this level of care according to (Salinas et al., 2018), to face challenges produced by the pandemic and its variants. According to (Cernadas et al., 2020), ICT is a tool in prevention, diagnosis, treatment, monitoring tasks, and health management, for which the articulated work In this context, The objective of this study is to develop a systematic review applying the PRISMA flow on the advances that are being developed in primary health care within the first level of care in times of the COVID-19 pandemic where regular care has been postponed (Velasquez, 2015). This situation has improved since the use of technology.

Materials and Methods

This review aimed to analyze the progress made in primary health care at the first level of care. To achieve this, the PRISMA statement of Urrutia and Bonfill (2010) was utilized, and a thorough search on Scopus (Elsevier), Lilac, and Google Academic databases from 2018 to 2020 as outlined in Yapes et al. (2021) search process requires the establishment of descriptors based on the research question. (see table 2)

Search Engines	**Key Words**	**Abstract**
Scopus	Primary care, Health Services, Health Care Politics	Primary health care stablishing—first level of care
Lilacs	Primary care, public health, Health Promotion	Primary Health care, Public Health, Health Promotion
Google Academic	Family Care, Primary care, health promotion	Primary Health Care, Family Care, Health Promotion

As a second process for the searches, the keywords and synonyms used in Spanish-speaking countries were keywords such as: (Primary health care) and synonyms such as: (Family medicine, Health promotion, First Level of Care) (Family et al. Level of Care). To be specific, the following equation was established from the combination using Boolean operators “AND,” “OR,” and “NOT,” in such a way that the definitive equation in Spanish has been (“primary care of health” or “advances”), and (“public health” or “health promotion”), (“primary health care” and “strengthening”), (“family medicine” and “first level of care”), and the terms in English correspond to ("Primary health care" or "advances"), and ("public health" or "health promotion"), ("primary health care" and "strengthening (see table 3).

Inclusion and exclusion criteria Inclusion Criteria Exclusion Criteria Peer review Articles with payment Articles from Latin American countries Duplicate Research Full-text articles Original articles Years of publication 2018 -2021 Articles in Spanish and English Peer review

publications Categorization of the publications For the systematization of the material collected from 17,076 publications, the Prisma flow was applied (Yapes et al., 2021), selecting 20 articles, (see illustration 1) Tables 3 and 4

Inclusion. Criteria	**Exclusion criteria**
Revision	Paid Articles
America Latina Articles	Duplicate Articles
Original Articles	
Publication years 2018- 2022	
Spanish and English	
Publications	

Number	**Authors**	**Country**	**Dimensions**
1	Hernandez et al	Colombia	Community Health
2	Aveni, Mariel	Argentina	Health Disparities
3	Iparraguirre,et al.	Spain	Rural Health
4	Rojas, Francisco	Cuba	Equity and quality
5	Gil,et al.	Spain	Determinations of Health
6	Jimenez,et,al	Spain	Social Conditions
7	Macinko et al.	Spain	Human Development
8	OMS	Mexico	Biology Structures
9	Almeida et al	Chile	Health strategies
10	Cosavalente et al	Peru	Universal Care

11	Llanos et al	Peru	Universal access
12	OPS	Spain	Inclusion and ethics
13	Carbone Fernando	Chile	2030 planification
14	Del Carmen, Jose	Peru	Integral Care
15	Burgos	Chile	Perspective care
16	Curioso et al	Peru	Health Globalization
17	Martos et al	Spain	Gestion Virtual
18	Salinas	Brazil	Process information
19	Cernada et al	Spain	Health quality
20	Barrios	Chile	Multicultural Health

The countries that have substantial evidence of the strengthening and progress of primary care are Colombia (1), Argentina (1), Spain (7), Cuba (1), Mexico (1), Chile (3), Peru (5), Brazil (1), of the entire systematic review, carried out, with Spain predominating (7) searches, which support primary health care, demonstrating different health management models, (1,2,3,5,7, 12,13,14,15,17,18,20), virtual management, addressing strategies in primary care, (9,10,15,18), with a focus on health equity, which emphasizes the social determinants that contribute to the quality of life by promoting behavioral changes at the community level,(1,3,4,6,11,16,19) which leads to strengthening the quality of care (4,6,7,8,9,10,11,13,15,17,18,19,20). Searches demonstrate that primary health care is strengthened with inclusion, participation, and health empowerment at the community level, with interculturality, focusing on public health policies such as universal health insurance that constitutes access to primary care, requiring financial resources and more significant investment in the use of ICTs, which favors focused interoperability in population satisfaction. Chile (3)

searches identify challenges and learnings regarding primary care, with a territorial perspective, advancing with comprehensive health networks, strategies for universal health with equitable access, and strengthening the quality of care. Colombia's (1) search emphasizes strengthening community training and addressing health problems through intersectoral action. Argentina's (1) search refers to social inequalities in health, where a disparity equitably affects access to health. Cuba's (1) search addresses health care with the inclusion of a family doctor, constituting high equity, which improves health indicators and strengthens the population's satisfaction. Brazil's (1) search focuses on prevention and promotion, which uses information processes to make timely decisions. Analyzing the information from the 20 countries, almost all of them agree on strengthening primary care from the individual, family, and community level, addressing social determinants, and influencing health promotion and prevention; all these qualities contribute to improving the quality of life of citizens, to this end, health establishments at the first level of care contribute by strengthening integrated health networks, making use of ICTs today, interoperating in such a way that access to health systems is equitable, timely, and inclusive manner. Table 5 indicates that the first level of care summarizes the systematic review from the perspective of the mechanisms, approaches, strategies, and conclusions, evidencing with greater preponderance the use of ICTs to strengthen primary care within the first level of care (6, 11,17,18,19,20), followed by the strengthening of the RIS, which includes universal health coverage as a strategy to approach health systems, through health promotion and prevention(5, 7,10,13,14,15,16). Given the scientific production of the 20 articles, 19 of them present a qualitative approach, and one presents a quantitative approach, concluding that each approach strengthens primary health care; due to the effects of COVID-19, all primary care establishments are making use of technologies by applying telehealth in an incipient way.

(Table 5)

Number	Mechanism	Focus	Strategy	Conclusion
1	PHC	Qualitative	Prevention and health Promotion	Cultural health competency
2	Recompilations and Critics	Qualitative	Analysis in social constructs and inequality	Health disparities are consequence of social construct
3	Astana Introduction	Qualitative	Model: Doctor responsible for the health of all family	Population satisfaction and health improvement
4	APS General	Qualitative	Primary Care	Strength Family Care
5	Prevention, Promotion Primary Care,	Qualitative	Primary Care	Participation of the public
6	Electronic records, 90 health Centers	Qualitative	Zip codes uses to compare socioeconomics	Firs class care level for better cities
7	politic health programs	Qualitative	Central goal to achieve health improve t2030	Universal Health care with equity
8	Health Professionals	Qualitative	Health care and professional	Health as a priority

9	Implementation National Health accesses	Qualitative	Strength primary care	Health Care Access
10	RIS implementation		RIS strategy implementation	MAIS activities
11	TLCS Implementation		Primary care, focus demographics	Video Health
12	Data analysis		Planification and execution	Inequality and social reforms
13	Health Trends		Health politics	Health system development
14	Strength of RIS		Community and government deal	Successful rural health improvement
15	Social and politics implementations policies		Re- design of health systems process	Better quality health system access
16	Focus in helth promotion		Alternative biometrics paradigm	Promotion and prevention as a focus

17	National influence in Health		Propose first class health care	Accessible flexible and affordable
18	Technology revolution		Flexible and affordable health access	Primary care in digital form
19	Technology implementation		Promote digital access	Increase capacity
20	Communication		Health Promotion	Education by social media

In summary, the progress in primary health care has allowed for incorporating scientific evidence into strategies, approaches, mechanisms, and dimensions at the first level of care. Upon analyzing the information, it is evident that out of the 20 authors, 19 used a qualitative approach, which aligns with the first level of care strategies, empowering communities to take control of their health. Additionally, they focus on individual, family, and community levels while promoting health as a vital strategy to address social determinants through the involvement of social actors, telemedicine, and inclusive population outreach. Jiménez et al.'s quantitative (2019)approach analyzed the Z codes to identify the relationship between the socio-economic realities of the population and care received at the first level of care, concluding that primary care health must adopt RIS and the use of ICTs.

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