Moving toward universal access to health and universal health coverage: a review of comprehensive primary health care in Suriname

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ABSTRACT

Objective. *To provide an overview of comprehensive primary health care (CPHC) development and implementation in Suriname in peer-reviewed literature.*

Methods. *Building on work funded by the Teasdale-Corti Global Health Research Partnership Program/People's Health Movement, the authors searched MEDLINE, the Cochrane Library, and POPLINE for articles focused on CPHC within the Surinamese context. Two authors independently reviewed abstracts and then jointly reviewed the selected abstracts. The final selection was completed using a data extraction form.*

Results. *The initial search resulted in 1 556 abstracts. The initial review identified 58 articles. Only three of the 58 articles met the inclusion criteria for the final review. The three selected articles provided partial overviews of CPHC in Suriname and examples of its implementation, with a focus on the service delivery network in the interior of the country, which was designed to improve rural access to basic health care services by training community members as service providers. They also included examples of how preparations for health reform in Suriname in the late 1990s and early 2000s, influenced by global neoliberal reforms, led to expectations that disparities in health status, design of health system components, and service provision related to differences in power and historical context (e.g., the influence of medical professionals, political parties/ethnic groups, and wealthier populations concentrated in urban areas) would be addressed.*

Conclusions. *Given the focus on primary health care in the Americas and the notable developments that have occurred in Surinamese health policy and health care, particularly in health care reform, the paucity of published research on CPHC in Suriname was an unexpected finding that may be partly due to prioritizing research on disease control rather than health policy and systems research. The limited amount of scientific literature on this topic 1) prevents clear understanding of CPHC development and implementation in Suriname and 2) underscores the need to strengthen the national health research system to better inform policies for moving the country toward universal health access and coverage to improve the health of all of its citizens.*

Key words Equity in health; primary health care; health services research; universal coverage; health policy, planning and management; Suriname.

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Ongoing debates among global health experts about the development agenda for 2015 and beyond have led to significant advocacy for universal health coverage (UHC). While there are many different iterations of UHC in the literature, its overall goal as defined by the Pan American Health Organization/World

Health Organization (PAHO/WHO) is that health systems are capable to serve the needs of entire populations, including the availability of infrastructure, human resources, health technologies, and medicines, stressing the values of equity, solidarity, and access (1). Universal access to health is defined as the absence of geographical, economic, sociocultural, organizational or gender barriers and is achieved through the progressive elimination of the barriers that impede all people from using the integral health services, equitably established at the national level (1). Noting the lack of one common UHC framework, Stuckler et al. elaborated five UHC themes: 1) access to care, 2) coverage, 3) point of entry to the health system, 4) a rights-based approach, and 5) social and economic risk protection (2). The PAHO/WHO definition of UHC described above is linked to the 1978 Alma-Ata Declaration, which advocated health promotion, appropriate use of resources, intersectoral action, and moreover universal access to health, where all people have equitable use of appropriate, timely, good-quality health services, and the role of the state, as well as safe, effective, and affordable good-quality medicines (1). As countries try to implement UHC, considerable challenges have emerged, due in part to the "law of inverse care" (3),[4] with regard to socioeconomic inequities (4), and to the deleterious effect of vertical programs on health systems. These challenges underscore the need to reexamine the principles espoused in the Alma-Ata Declaration, which advocates primary health care (PHC) that is people- and community-centered (designed with the participation of actors and based on their needs and acceptance of services and technology), intersectoral at the upstream policy level, and universally accessible at a cost that is affordable for both the health system and individuals (5) and thus contributes to improving health for all.

There are two types of PHC: comprehensive and selective. Comprehensive PHC (CPHC) focuses on addressing socioeconomic variables affecting human health (social determinants, health inequities) and thus comprises health care promotion, community development, advocacy, intersectoral activities, and population health approaches, as well as disease prevention, treatment and care, and rehabilitation, whereas selective PHC (SPHC) focuses on a set of activities targeting specific issues, mainly to cure ill health and prevent diseases. While the framework and characteristics of CPHC continue to evolve, the overall emphasis is on health as a function of social and economic development, reflecting the principles advocated in the Alma-Ata Declaration and other international agreements and initiatives (e.g., the 1986 Ottawa Charter for Health Promotion, the United Nations (UN) Millennium Development Goals for 2015, and the 2011 Rio Political Declaration on Social Determinants of Health). SPHC, on the other hand, focuses on cost-effective medical interventions for the most prevalent and severe health conditions. The SPHC approach led to "vertical" health programs that 1) amassed considerable financial resources to treat conditions prioritized by funders; 2) contributed to skewed human resource allocation; and 3) strained health systems, which undermined countries' abilities to address the broad spectrum of health needs. Consequently, the focus of the global health sector has shifted toward strengthening universal access to national health systems—a country-specific approach that requires examination and evaluation of PHC.

In Suriname (known officially as the Republic of Suriname), the social security system is currently undergoing various reforms, including the introduction of a national health insurance system to consolidate the various payment mechanisms and expand coverage.[5] The Ministry of Health (MoH) has also launched initiatives to overhaul national PHC strategy and systems (6).

Located on the northeast coast of South America, Suriname borders Guyana, Brazil, and French Guiana and includes a diverse population (including Hindustani, Creole, Maroon, Javanese, and indigenous groups, among others) estimated at 549 631 (7). About three-quarters of the population live in 1) the urban coastal capital of Paramaribo, 2) the peri-urban coastal area near the capital, or 3) the border area shared with Guyana. The rest of the population lives in rural areas along the coast and in the vast interior.

Individuals' right to health is evident in Suriname's constitutional framework. The role of the state is to protect public health, and the MoH is the lead ministry. This role includes supervising health services to ensure sufficient quality, availability, and accessibility of care. The primary tasks of the MoH include 1) management of human and material resources, including pharmaceuticals and other medical supplies; 2) supervision of health institutions; 3) oversight of medical practice; and 4) monitoring compliance with legislation related to the environment and human health. Additional tasks include 1) health education and promotion, and 2) the provision of health care to populations and individuals that would not have access to it otherwise (8). These tasks are assigned and delegated to specialized MoH departments and subdepartments, government institutions, and foundations.

The MoH Bureau of Public Health (*Bureau voor Openbare Gezondheidszorg*, BOG) is a government institution that 1) delivers and coordinates population-based programs for prevention and treatment of specific diseases (e.g., malaria), and 2) promotes the well-being of communities (e.g., family health). The Regional Health Service (*Regionale Gezondheids Dienst*, RGD) is a government foundation established in 1991 that provides preventative (e.g., prenatal) and health care (medical services for children under 5 years old) at publically funded clinics based on regulations developed during Dutch colonization through Suriname's independence in 1975 (9). RGD polyclinics (clinics that offer a wide range of outpatient services, including diagnostics) serve much of Suriname's coastal population, including the poor and "near-poor," who are identified by the Ministry of Social Affairs (MSA).

In the coastal areas, general practitioners (GPs) operate private polyclinics. Payment for services provided by these clinics comes from either private insurance (individual or employer) or the individual (i.e., "out of pocket"). Only a few private GPs provide preventative services such as vaccinations and reproductive health services. Because of their overlapping functions, RGD physicians can function as private GPs with approval from the MoH.

[4] The idea that availability of good medical care varies inversely with need, especially when services are exposed to market forces.

[5] KPMG. Progress on the social security system. Public information session on national insurance reforms. 12 June 2013. Paramaribo: KPMG; 2013.

In the interior of the country, a nongovernmental organization (NGO) known as the Medical Mission (*Medische Zending*, MZ) provides PHC services. Officially established as a foundation in 2001, the MZ has a history of service provision (10). For example, it has been contracted by the MoH to provide services in numerous villages. MZ clinics are primarily staffed with health assistants who are usually recruited from the interior and are trained in a four-year program. The health assistants are supervised by a small group of physicians and registered nurses at the MZ coordinating center in the capital city of Paramaribo. Physicians provide support to the health assistants and medical care to patients through scheduled field trips, although a few health centers have physicians based onsite. For specialist care, registered individuals are referred to facilities in Paramaribo.

A recent reform process of Suriname's social insurance model to address overlap in the MSA public health insurance payment system (parallel mechanisms administered by different payers) began in mid-2013. The MSA provides poor and near-poor populations with insurance cards[6] that allow them to register and receive care at their local RGD clinic (free of charge, other than small copayments) for six months to one year. Qualification is based on 1) a standard calculation using a basic food basket, and 2) information gathered during MSA visits to households. In addition to the MSA system, the Ministry of Finance (MoF) administers insurance for civil servants and approved family members through the State Health Insurance Fund (*Staatsziekenfonds*, SZF). Registered inhabitants of MZ service areas in the interior can access MZ services free of charge. A number of private insurance packages are also available through employers and insurance companies.

Historically, there was considerable international influence on the development of Suriname's health sector. In 1882, almost a century before the country's independence from the Netherlands (1975), a medical training institution was established to produce health workers for essential medical care. Until the establishment of a national nursing school in 1982, Surinamese nursing practice was aligned with a Dutch model that emphasized hospital practice (11). In 1972, shortly before national independence, the Pan American Health Organization (PAHO, the regional office of WHO) established the first UN presence in the country (12). PAHO's presence likely precipitated the influence of the 1978 Alma-Ata Declaration (1978), and thus CPHC, as PAHO/WHO provided notable recommendations during that period (11). One important influence of the Alma-Ata Declaration on the country's health system was the aggregation of all government clinics, leading to the establishment of RGD.

Prior to Surinamese independence, the Netherlands established a fund to support the new republic's political transition, including the development of health infrastructure (13). The Inter-American Development Bank (IDB) supported the emphasis on infrastructure in the terms of its six-year loan to Suriname in 1998. Due diligence review for the loan (which was partially financed by the Government of Japan) began in the late 1990s and early 2000s and included a strong focus on the development of a national health insurance system, reflecting the global trend toward health care reform that emphasized the establishment of social insurance systems in middle- and low-income countries (14).

The study reported here was conducted from 2012 to 2013 to provide an overview of the implementation of CPHC in Suriname, distilled from peer-reviewed literature.

MATERIALS AND METHODS

This study applied and expanded on a conceptual framework developed in research initiated in 2007 and funded by the Teasdale-Corti Global Health Research Partnership Program (15). The original study was multifaceted and based on several different inputs and experiences, including research on CPHC implementation in various economic, political, and social contexts. Seven CPHC characteristics were identified based on the main characteristics of CPHC found in the original study (Table 1).

TABLE 1. Seven characteristics of comprehensive primary health care (CPHC)[a]

Characteristic
Equitable access to basic health care
Integration of rehabilitative, curative, preventive, and health promotion components
Community involvement/citizen participation
Collaboration with/involvement of other sectors
Action on non-medical social determinants of health to reduce risk exposure
Incorporation of a rights-based approach
Explicit value of health equity

[a] (15).

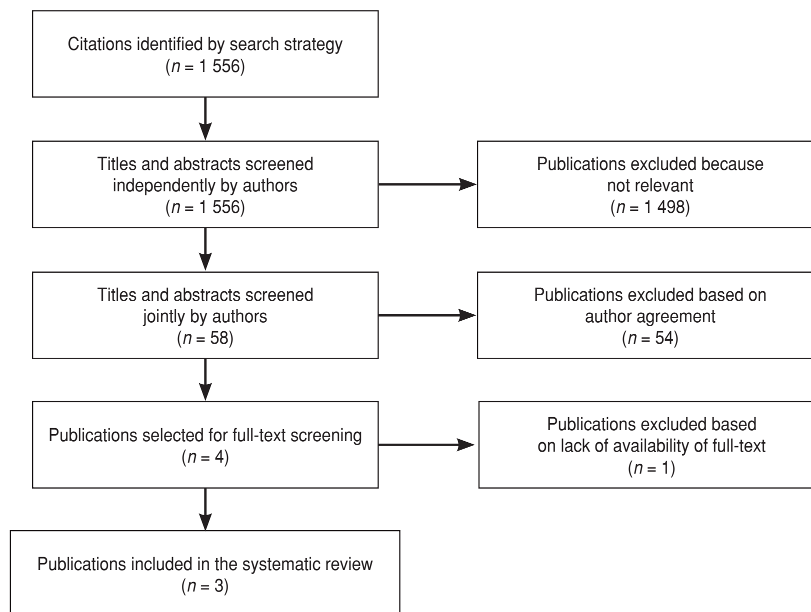
Broad inclusion criteria were established for the 2012–2013 literature review reported here, including two main requirements: an explicit focus on Suriname, and reference to at least one of the identified characteristics of CPHC. The exclusion criteria were 1) research that was not specific to Suriname, and 2) lack of empirical analysis. The broad range of inclusion criteria, defined by the research team, was used to establish a sufficiently comprehensive pool of articles for review. The selection process consisted of discussions with stakeholders on the historical context of PHC and PHC service delivery, followed by preliminary and in-depth author reviews of the initial sample of publication titles and abstracts generated by database searches. In the preliminary reviews, two authors screened the publication titles and abstracts independently based on the inclusion criteria. In the second, joint in-depth review, the authors rescreened the content selected in the first round, using the same criteria, for quality control.

The initial sample was generated by applying MeSH search terms in Cochrane Library, MEDLINE, and POPLINE databases. The MeSH search terms were "primary health care," "health system," "health sector," "health services," "health status disparities and determinants," and "health services administration." The databases were searched without date or language restrictions. The pool of peer-reviewed publications generated by the search terms was imported into RefWorks reference management software (RefWorks-COS, ProQuest LLC, Ann Arbor, Michigan, USA) (January 2009 release).

To illustrate their selection process, the authors created a flow chart based on PRISMA criteria (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Figure 1).

[6] The *onvermogen kaart* ("inability-to-pay card," for the poor, which states that the individual and his/her dependents are unable to pay the costs of health care) and the *minvermogen kaart* ("reduced-ability-to-pay card," for the near-poor, which states that the individual and his/her dependents are only able to pay a limited amount for health care). To obtain the latter card, the recipient must make a small payment.

FIGURE 1. Flow chart for review of research on comprehensive primary health care (CPHC) in Suriname, 2012–2013



In their joint in-depth review, the authors used a data extraction form based on the CPHC tool/framework used in the original study (15). The form contained fields for descriptive information about the publication (author, year, study site(s), study focus, etc.); basic study information (objective, population, design, definition of PHC, etc.); information about CPHC within the local context (e.g., definition of its characteristics), its actual or expected outcomes, and/or lessons learned from its implementation; lessons learned about CPHC in general; and other notes.

RESULTS

Study sample

The database searches yielded 1 556 publications related to Suriname, most of which focused on the Guiana Shield (one of South America's three cratons, with one of the highest levels of biodiversity in the world). The preliminary screening of the titles and abstracts of the 1 556 articles by the two authors resulted in the selection of 58 publications for further review. In the joint review, four of the 58 articles were selected for the in-depth review with the data extraction tool. Of the four articles, only three were ultimately included in the final study because one was not available as full text. The unavailable article was part of the 1990 UN series on world population policies (16), which was not available online at the time of the study. The step-by-step selection process is shown in Figure 1.

The three articles included in the final study sample were a part of a comparative analysis across four "territories"[7] (the Bahamas, Martinique, Suriname, and Trinidad and Tobago) on 1) distribution of health sector responsibilities, 2) health care financing, and 3) human resources, respectively (11, 17, 18). The review of health sector responsibilities (11) sought to define models of devolution[8] within the health sector of the four "territories" (primarily based on legal status). While no models of devolution were found in Suriname, models for this type of health decentralization were found in the other three "territories."

Devolution involves the transfer of administrative authority (but not political authority) to local offices of central government ministries/units. Mills et al. (11) related two variations on this model to the functions of the ministries of health—particularly environmental health, community health services, and individual medical care. The first—the delegation model—refers to the transfer of managerial responsibility to public agencies outside the central government that are only controlled indirectly by it. The article related this model to Suriname's hospitals, which are relatively self-managing, and the RGD, which has been granted authority by the MoH for integrated primary care in the coastal region. The second—the privatization model—refers to the transfer of government functions to NGOs or private for-profit or nonprofit enterprises. The article related this model to Suriname's contract with the MZ for services in the interior and the ability of individuals with private insurance to select private providers.

The review of health care financing compared Suriname to Martinique and a number of European countries because of its social insurance system, which appears to have capitation schemes for certain populations (17). Other linkages were made between the Surinamese system and global trends to reduce state involvement in the direct provision of health services, resulting in the autonomy of Suriname's hospitals and the establishment of the RGD and MZ. The article characterized Suriname's health financing as a "reimbursement" model—a model that is often plagued by unjust diffusion of entitlements to free health care, according to the literature. Noting this as a significant challenge, the authors of the article suggested that the health reforms that took place in Suriname from the late 1990s to the early 2000s move toward a single-purchaser contract payment mechanism, an arrangement that would aim to increase the purchasing power of the public sector.

The study by Walt et al. (18) focuses on the historical development of human resources, particularly doctors and nurses. Significant emigration occurred at the time of independence, decreasing the supply of human resources for health. This led to governmental policies to encourage health professionals educated elsewhere to return to Suriname, but they were not entirely successful. The health reforms of the 1980s were influenced by global priorities to reduce government involvement in direct service delivery. This increased the autonomy of hospitals, which in turn increased the number of private medical practitioners and nurses, a trend that continued well beyond the 1980s (18).

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[7] Although Suriname was officially the Republic of Suriname starting in 1975, the authors of the articles described it as a "territory."

[8] Subnational levels of government substantially independent of the national level with a clear range of functions.

CPHC in Suriname: characteristics

The three selected articles provided brief summaries of CPHC characteristics, but without a focus on implementation. This limited the ability of the authors of the review reported here to answer the underlying questions about the tangible outcomes of implementing CPHC in Suriname. The model for health service delivery in Suriname's interior was associated with the CPHC characteristics defined in Table 1 mainly because of its aim to improve access to health (which includes essential preconditions for health and integrated services along the continuum of care). Community involvement is imperative in this model, in which trained community members are service providers (18) and special committees exist to increase community participation in service provision. The model for Suriname's health service delivery in the interior was lauded for its contribution to CPHC despite the fact that the elements relevant to the approach were not adopted throughout the country (13).

Many other countries have documented the implementation of CPHC in rural areas while private health providers remained in areas with higher population densities (4, 19). While the achievement of CPHC requires national commitments, these pockets of CPHC implementation are not sufficient. These scenarios are often related to the interests and power of medical professionals with a preference for serving high-density, urban populations, as well as limited incentives, planning, training, and supervision (18). Some of the authors of the three articles included in the study speculated that this aspect would be addressed in the health reforms of the 1990s and 2000s.

The authors of the selected articles also speculated that the health reforms of the 1990s–2000s would improve access to health and a broader focus on the national health system, and away from previous health reforms that focused on infrastructure. Their main proposal included a move away from the reimbursement model to a model that merged existing schemes into a national scheme and established a contract payment mechanism, a move that would reduce disparities in power and thus access to services (17). These proposals would reduce financial barriers to health, increasing the affordability of care while ensuring that everyone had access to a basket of appropriate services that would likely include preventive and primary services. These proposed reforms would bring about changes in the division of political tasks, especially with regard to allocation of the MSA insurance cards that provided access to services (11).

Given the shift in global health consensus toward the contract payment model at the time (late 1990s /early 2000s), the authors of the articles selected for this review expected future reforms to move toward a contract payment mechanism that would aim to increase the purchasing power of the public sector, enabling a focus on more efficient resource allocation (11, 20). The resulting reduction in the influence of providers would most likely result in an increased focus on unmet needs of the population.

DISCUSSION

It is evident that there is limited information in peer-reviewed literature regarding CPHC in Suriname. While the articles selected for this review provide some perspective on CPHC, and offered some recommendations for future research, they provided very limited information on the outcomes or impact of CPHC implementation. There are several possible explanations for the limited number of peer-reviewed papers on CPHC. First, understanding of the concept of CPHC may vary across different contexts, resulting in the use of different terms in scientific articles. Second, there are significant challenges involved in developing national health research systems that are equipped to address system-wide issues such as CPHC (e.g., resource allocation, capacity, etc.). Third, there is a limited global arena for research on health policy and health systems. Although a large number of publications on CPHC was not expected, neither was the paucity of articles on CPHC overall, or the absence of Suriname-based authors and institutions in the literature, as notable health developments have occurred in the country in the past few decades, many of which would seem relevant to research on CPHC.

Global health reforms occurred during the late 1990s and early 2000s. Research was a prerequisite for that process—the start of a sector-wide initiative. As such, the Government of Suriname, with the financial support of the IDB and the Government of Japan, convened numerous sectoral studies (21). Yet, only three studies met the inclusion criteria for this study, and those three articles did not provide analysis of CPHC impact or outcomes because much of the global discussion on the reforms were still in the initial stages at the time of their publication. No articles were found in the review that covered the process or outcomes of the health reforms.

Further, the PAHO regional focus on revitalizing PHC to improve service delivery highlighted the need to move from vertical health programs and look outside the health sector to address underlying conditions affecting health. The literature from neighboring countries, particularly Brazil, Guyana, and French Guiana, seems to reflect the focus on CPHC components and health system development, particularly the need to address the social determinants of health, and the need to strengthen health system building blocks. Because of the many similarities between these countries and Suriname (e.g., colonial history, geographic location, health outcomes, and migration patterns), this literature may facilitate understanding of CPHC implementation within the Surinamese context. Health-related developments in Suriname that might clarify future impact and outcomes of CPHC in the country include the change in population dynamics noted by national censuses (e.g., urbanization and migration); the availability of Master of Public Health (MPH) programs, both at the national university and online, through an agreement with a U.S.-based institution; and the evolving significance of Suriname within the realm of global health, including the country's hosting of the Union of South American Nations (UNASUR) summit, and the election of Henry Leonard Mac-Donald, Suriname's Permanent Representative to the UN, as chair of the Social, Humanitarian, and Cultural Affairs Committee of the 67th session of the UN General Assembly in 2013.

Expanding the focus to neighboring countries, both regional and global literature reviews on CPHC are available in the literature. One literature review on CPHC in South America (22) used a framework similar to that used in the review reported here. Unfortunately,

neither Suriname nor its neighboring countries Guyana and French Guiana were included in the study. Although the review reported here found fewer articles than the South American (regional) review, there were some similarities in the two sets of results. For example, in both reviews, the majority of included studies used a descriptive and theoretical approach to answer questions regarding context and processes related to universal access, PHC policies and the effect on implementation. In addition, the contribution of historical developments and structural processes to CPHC implementation was a common theme. This included 1) the initiation of CPHC as primary care, due to biomedical advances; 2) the support of international initiatives from organizations such as PAHO advocating for renewed championing of CPHC within the PHC realm; and 3) privatization, as international banks advocated for structural adjustment programs related to neoliberal health reforms, reducing public involvement in service delivery. On the other hand, the regional review identified articles that described the contribution of health care reforms to CPHC and provided evidence of CPHC effectiveness—two crucial aspects not addressed by the articles included in the review reported here. Ascertaining more specific similarities and differences between the results of the two reviews would require further research.

Continuing the progress toward universal coverage and access to health in Suriname will require country-specific research mechanisms as a core aspect of health reforms. Health systems research will need to be strengthened by ensuring adequate human and financial resources, better coordination of research processes, and prioritization within national policy-making to allow for adequate discussion and use of the results. The first WHO Ministerial Summit on Health Research held in the Americas in 2004 brought these issues to light and established a network of decision-makers to follow up on the meeting resolutions, as well as a platform for specific initiatives to strengthen health systems research. The need for health systems research has increased with the current focus on achieving UHC in middle- and low-income countries. The importance of this type of research was reiterated in the WHO World Health Report for 2013, which calls for developing and broadening the global and national health systems evidence base for UHC (23). While the Alma-Ata principles are at the core of this focus, information on linkages to CPHC and its implementation remains scarce. There is a fundamental need to incorporate research on CPHC implementation in the evidence base for interventions designed to promote and achieve UHC.

Limitations

Despite all the efforts that were made to locate published articles on CPHC implementation in Suriname, the limited sources that were identified, given the ongoing health developments in the country, seem to suggest that Surinamese initiatives in this area are not being published in the peer-reviewed sphere. In light of the limited information from the peer-reviewed literature, a follow-up review from the grey literature with key informant interviews has been conducted and is forthcoming.[9] Further work is needed to identify grey literature written within the country context.

Conclusions

This review revealed limited information in the peer-reviewed literature regarding CPHC in Suriname. The lack of published data creates challenges in understanding the outcomes of CPHC implementation within the country. At a time when universal health access and UHC is being championed globally, and given the fact that there is no standard model for its implementation, a thorough understanding of the Surinamese experience and context is needed. This will require strong research systems, including human and financial resources, as well as policy-making that renders the use of health system data as an essential aspect of country approaches to improving quality of life, sustainable development, and equity for all.

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Conflicts of interest. None.

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RESUMEN

Avanzando hacia el acceso universal a la salud y la cobertura universal de salud: un análisis de la atención primaria de salud integral en Suriname

Objetivo. Proporcionar una visión de conjunto de la implantación de la atención primaria de salud integral en Suriname en la bibliografía arbitrada.
Métodos. Aprovechando el trabajo financiado por el Programa de Alianza de Investigación en Salud Mundial Teasdale-Corti/Movimiento de Salud de los Pueblos, los autores efectuaron búsquedas en MEDLINE, la Biblioteca Cochrane y POPLINE de artículos que se centraran en la atención primaria de salud integral en el contexto surinamés. Dos autores analizaron los resúmenes independientemente y a continuación examinaron conjuntamente los resúmenes seleccionados. La selección final se completó mediante el empleo de un formulario de extracción de datos.
Resultados. La búsqueda inicial obtuvo como resultado 1 556 resúmenes. El análisis inicial seleccionó 58 artículos. Solo tres de estos 58 artículos satisficieron los criterios de inclusión en el análisis final. Los tres artículos seleccionados proporcionaban un panorama parcial de la atención primaria de salud integral en Suriname y ejemplos de su implantación, se centraban especialmente en la red de prestación de servicios del interior del país, diseñada para mejorar el acceso a los servicios de atención básica de salud en el entorno rural mediante la capacitación de los miembros de la comunidad como proveedores de servicios. También incluían ejemplos de cómo los preparativos para la reforma sanitaria de Suriname a fines de los años noventa y principios de siglo XXI, influidos por las reformas neoliberales a escala mundial, generaron expectativas de que se abordarían las disparidades en el estado sanitario, el diseño de los componentes del sistema sanitario, y la prestación de servicios de atención de salud relacionadas con diferencias de poder y contexto histórico (por ejemplo, la influencia de los profesionales de la medicina, partidos políticos y grupos étnicos, y las poblaciones más ricas concentradas en las zonas urbanas).
Conclusiones. Dada la importancia concedida a la atención primaria de salud en la Región de las Américas y el notable desarrollo experimentado por la política de salud y la atención de salud de Suriname, particularmente en la reforma del sector sanitario, la escasa investigación publicada sobre la atención primaria de salud integral en Suriname fue un hallazgo inesperado, que en parte puede ser debido a que se ha priorizado más la investigación sobre el control de enfermedades que la investigación sobre políticas y sistemas de salud. La limitada cantidad de bibliografía científica sobre este tema 1) impide una comprensión clara del desarrollo y la implantación de la atención primaria de salud integral en Suriname y 2) destaca la necesidad de fortalecer el sistema nacional de investigación en salud con objeto de fundamentar mejor las políticas que hagan avanzar al país hacia el acceso y la cobertura universales de salud para una mejora de la salud de todos sus ciudadanos.

Palabras clave Equidad en salud; atención primaria de salud; investigación sobre servicios de salud; cobertura universal; políticas, planificación y administración en salud; Suriname.