

REGIONAL POLICY DIALOGUE 2025

# Towards High Performing Health Systems

➔ September 10-11  
Medellín, Colombia



Final Report



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# Executive Summary

In September 2025, the Inter-American Development Bank convened the Regional Policy Dialogue “**Towards High-Performing Health Systems**” in Medellín, Colombia, bringing together more than 110 participants from 22 countries, including ministers, vice ministers, senior health officials, technical experts, and strategic partners. The Dialogue focused on how countries can deliver better health outcomes, greater equity, stronger public trust, and more efficient care. Several key messages emerged from the Dialogue, highlighting what countries need to do to transition from expanded coverage into high-performing health systems in the region.

## Key Messages

**Access alone has not translated into the results people need.** Latin America and the Caribbean countries have made major progress in expanding health services: most women receive prenatal care and skilled birth attendance, most children are vaccinated, and a large share of the population lives close to a primary care center. Yet too many patients still receive care that is fragmented, delayed, poorly coordinated, or clinically ineffective. **Seven out of ten amenable deaths in the region are associated with poor-quality care rather than lack of access.** This quality gap also creates economic costs, weakens public confidence, and limits the promise of universal health coverage.

**Countries need to redesign how health systems work, not simply do more of the same.** Isolated projects, additional inputs, and provider training are not enough. Health systems often have infrastructure, clinical guidelines, trained staff, and service data, but still lack the integrated processes, leadership, incentives, and accountability mechanisms required to deliver reliable care. The central challenge is to redesign workflows, care pathways, service networks, team roles, and management systems so that they consistently produce better outcomes.

**High-performing health systems require a system-wide approach to quality anchored in primary care.** A high-performing system improves population health, protects families from financial hardship, uses resources efficiently, earns public trust, adapts to changing needs, and closes equity gaps. To achieve this, countries need continuous, coordinated, people-centered services, with primary care serving as the foundation. They also need to move from fragmented quality initiatives toward **institutionalized quality as a core function of the health system.**

**The roadmap for transformation combines five mutually reinforcing elements.** Countries need a **shared vision** with clear, measurable quality aims that align policymakers, providers, patients, communities, and partners. They

must **redesign service delivery, organization, and management** so that care models support the outcomes they seek. They need to **implement, learn, adapt, and scale** through data, feedback loops, and continuous improvement. They must **institutionalize governance and accountability** so quality survives beyond individual champions and political cycles. And they need to **sustain progress through policy, financing, and capacity** so improvements become part of routine system functioning.

**Regional experiences show that transformation is possible when redesign responds to local needs and receives sustained support.** Costa Rica redesigned adolescent health services through an intersectoral model that expanded access to adolescent-friendly care and contributed to reductions in adolescent fertility. São Paulo combined physical infrastructure upgrades with digital integration to strengthen primary care access, continuity, and responsiveness. The HEARTS initiative showed how standardized, team-based approaches to hypertension and diabetes can improve chronic disease management at scale. These cases show that redesign works best when countries adapt solutions to local needs, embed them in primary care, and support them with strong governance.

**Health systems need to shift from a culture of judgment to a culture of learning and improvement.** Measurement should help teams learn and improve, not only evaluate or sanction them. Failure should generate information for redesign, not blame. Health workers need systems that allow them to take pride in their work, not only incentives or pressure. Patients and communities should help design better services, not merely receive them. **Learning must become a core operating function of the health system, not a luxury.**

**Governance turns quality from a temporary initiative into a sustained system function.** Countries need governance structures to support improve performance that operate across national, regional, and facility levels, with clear roles, accountability lines, reporting mechanisms, and room for local adaptation. Quality must be embedded in laws, regulations, budgets, accreditation processes, and institutional routines, rather than depending on individual champions or political cycles. Strong governance also requires visible political commitment, distributed leadership, and mechanisms that combine accountability with learning, so systems can remove barriers, adapt strategies, and sustain improvement over time.

**The next step is to turn shared understanding into concrete action.** Countries do not need a single recipe, and no model will fit every context. But they can move forward by aligning around shared goals, redesigning care around people's needs, embedding continuous learning, strengthening governance, and investing in the capacities required for lasting change. Universal health coverage will only fulfill its promise when it delivers not only access, but **effective, equitable, trustworthy, and high-quality care for all.**

# Introduction



# Introduction

The Health, Nutrition, and Population (HNP) Division of the Inter-American Development Bank (IDB) convened its annual Regional Policy Dialogue (RPD), “Towards High-Performing Health Systems,” on September 10–11, 2025, in Medellín, Colombia. The Dialogue engaged regional policy and decision makers in sharing best practices and addressing challenges in developing high-performing health systems that effectively meet population needs and deliver measurable health outcomes.

While Latin America and the Caribbean (LAC) have achieved significant advances in expanding coverage of essential health

services, persistent gaps in service quality continue to undermine health outcomes and erode public trust. Research estimates that approximately seven out of ten amenable deaths in the region—deaths preventable with timely and effective care—are attributable to low-quality health services (Kruk et al., 2018). Beyond health impacts, poor-quality care carries substantial economic costs; projections suggest that by 2030, LAC could lose up to 1% of potential GDP due to inadequate quality of care (Blake et al., 2018). Addressing these challenges requires a systemic perspective that extends beyond simply providing resources and inputs, emphasizing health system design, governance, and operationalization.



The Dialogue convened over  
**110 participants**  
 from **22 countries**

Participants included **five Ministers, nine Vice Ministers, and 41 senior directors responsible for health service delivery and care networks.**

Strategic partners included PAHO, the Institute for Healthcare Improvement (IHI), SURA, University College London, and Mexico's National Institute of Public Health (INSP).



**Objectives:** The general objective was to discuss best practices and challenges in building high-performing care systems that address population needs and produce measurable health improvements.

**Specific objectives included:** (1) examining gaps in quality of care and challenges to address them; (2) establishing shared understanding of high-performing health systems and their key elements, highlighting the integration of health system performance, primary health care, and quality of care strategies; (3) exploring structured approaches to building high-performing health systems responsive to different contexts; and (4) promoting learning and collaboration among countries.

**Structure:** The two-day Dialogue was structured as a progressive journey through four interconnected sessions.

DAY 1  
September 10

- » **Session One** examined persistent quality gaps across the region, establishing a common understanding of current challenges through data on amenable mortality, economic costs, and discussed the challenges of current approaches to address quality of care.
- » **Session Two** explored what high-performing health systems look like in practice, developing a shared vocabulary and conceptual framework for quality, with particular emphasis on primary care as the foundation for effective service delivery.

DAY 2  
September 11

- » **Session Three** presented a roadmap to build high-performing health systems consisting of five key elements (Vision, Redesign, Learning, Governance, and Sustainability).
- » **Session Four** created a space for participants to identify priority areas for learning, sharing, and co-creating as a region on health system performance.

[See Annex 1: Agenda](#)

Through this sequenced structure—from facing the challenges to defining high performing systems, from developing a roadmap to committing to action—the Regional Policy Dialogue created both understanding and momentum, equipping participants with frameworks, peer connections, and concrete commitments to translate dialogue into measurable progress toward quality care for all.



## Opening Remarks

The opening session featured remarks from **Ferdinando Regalia**, Manager of the Social Sector at the Inter-American Development Bank (IDB); **Ana María Ibáñez**, Vice President for Sectors and Knowledge at the IDB (virtual); and **Jaime Urrego**, Vice Minister of Public Health of Colombia. Speakers underscored that while Latin America and the Caribbean

have made remarkable progress in recent decades — achieving broader coverage, stronger infrastructure, and a larger health workforce than ever before — expanding access alone is not enough. The challenge now is to ensure that healthcare systems deliver quality, continuity, and effectiveness, so that every person receives timely and dignified care, regardless of where they live or their circumstances.

“Seven out of ten avoidable deaths in our region are attributable to poor quality of care—not lack of access. This is not a statistic. These are tragedies for families and lost confidence in health systems.”



**Ana María Ibáñez**,

Vice President for Sectors and Knowledge, IDB



“Health systems must be built with a long-term vision, capable of learning and adapting to new contexts and challenges. Quality care at the primary level is an indispensable foundation.”

**Ferdinando Regalia**,

Manager of the Social Sector, IDB

“We must advance towards high-performance systems with territorial approaches, participatory governance, and sustainability. Health personnel are the backbone of the system.”



**Jaime Urrego**,

Vice Minister of Public Health, Colombia

## Dialogue Overview

“Strategy without tactics is the slowest route to victory. Tactics without strategy are merely noise before defeat.”

Sun Tzu

**Emma Iriarte**, Principal Health Specialist at the IDB, opened with this Sun Tzu quote, establishing the framework for combining strategic vision with tactical implementation. She highlighted the importance of approaching health system transformation from a country perspective—recognizing its inherent complexity and ensuring that all critical dimensions are addressed to ultimately build the kind of system countries aspire to have: one that delivers improved health outcomes, efficiency, quality, equity, and financial protection. She reminded

participants that there are no ready-made formulas, as each country’s context, culture, and conditions are unique. Presenting an overview of the sessions ahead, she outlined the path toward achieving five key results—better health status, quality, efficiency, equity, and financial protection—anchored in guiding principles and actionable strategies.

Iriarte stressed that health system performance is *not a project, not a pilot, and not a disease-focused effort*, but a long-term journey toward building coherent, people-centered systems. The goal is to establish foundational elements and encourage meaningful discussions that lead to consensus and concrete commitments, even if all the answers are not yet clear. With strong national will and the IDB’s sustained commitment, countries can begin charting a multi-year path toward health systems capable of delivering both intermediate and long-term results.



**Emma Iriarte**, Principal Health Specialist, IDB

# Session One: Current Outlook for Quality in Primary Health Care Systems in LAC



# Session One: Current Outlook for Quality in Primary Health Care Systems in LAC

## The Orchestra Metaphor: When Parts Don't Make a Whole

The room fell silent as the musicians took their positions. Each held an instrument representing a vital piece of the health system—governance, leadership, human resources, service delivery, monitoring and evaluation and the population. But when they began to play, something was wrong...

The sounds clashed. Each musician played their part perfectly in isolation, yet together they created discord. This powerful metaphor opened our dialogue: *a system only emerges when all parts work in harmony, guided by a shared vision (rhythm) and purpose.*



## Setting the Stage: Gaps in Performance and Quality in LAC

**Javier Guzmán**, Health, Nutrition, and Population (HNP) Division Chief at the IDB, framed the journey toward high-performing health systems as akin to climbing a steep mountain—a demanding endeavor requiring not merely reaching base camp, but summiting the peak. The region has made remarkable progress ascending the initial slopes:

**91% of women** receive prenatal care and skilled birth attendance

**90% of children** are vaccinated

**82% of the population** lives within 30 minutes of a primary care center

Equity gaps between socioeconomic quintiles have narrowed considerably. Yet these coverage achievements mark only the beginning of the ascent. Guzmán emphasized that beneath impressive statistics lies a sobering reality: access does not guarantee quality outcomes. Seven out of ten amenable deaths in the region—376,000 annually—are attributable to poor quality of care, not lack of

access. Healthcare providers know the correct clinical approach roughly two-thirds of the time yet only apply that knowledge correctly 47% of the time, revealing a fundamental knowing-doing gap that reflects systems failure rather than individual incompetence.

“Coverage is not enough. A woman may have access to skilled birth attendance yet still die from postpartum hemorrhage if the quality of care is inadequate.”

**Javier Guzmán**, Division Chief, IDB

**The Quality Crisis in Primary Care:** The dysfunction manifests in stark numbers: 45% seek emergency care for conditions manageable in primary care; 28% wait two months or more for specialists; 61% believe primary care fails to coordinate their care; and one in five hospitalizations could have been prevented with adequate primary care. Public trust reflects this reality: only 20% consider the system functional, and just 59% trust they would receive quality care if seriously ill.

**Economic Consequences:** If current gaps in quality persist, the region could lose up to 1% of GDP by 2030 due to preventable mortality and reduced human capital. Currently, 7.7% of households face catastrophic health expenditures exceeding 10% of their budget. Yet efficiency improvements could increase life expectancy by 3.5 years and expand service coverage by 6 percentage points.

**The Fundamental Gap:** Guzmán articulated what the region has versus what it needs: We have inputs and clinical guidelines but need integrated processes and results management. We have clinically trained personnel but need leaders who combine clinical expertise with management skills. We have service production data but need quality data and mechanisms for institutional learning. We

have services designed for episodic care but need systems for patient continuity. We have fragmented quality initiatives but need systemic approaches. This gap between current capabilities and required competencies defined the challenge confronting participants and set the stage for exploring pathways toward high-performing health systems capable of delivering not just services, but meaningful, effective, and equitable care.

## Defining High Performance

Guzmán outlined six defining characteristics of high-performing health systems that would guide the dialogue’s exploration and are closely related to the objectives of health systems:

- **Quality** – a health system that consistently maintains and improves population health
- **Public trust** – populations must have confidence in their health system’s ability to meet their needs
- **Adaptability and resilience** – systems must evolve continuously in response to changing population needs; health reform is not a one-time effort but a sustained process
- **Equity** – systems should close persistent gaps in care and quality across geographies and population groups.
- **Efficiency and sustainability** – systems should optimize resources to maximize health outcomes, and remain financially viable over time
- **Financial protection** – high-performing systems must prevent individuals from falling into catastrophic health expenditures that can drive families into poverty

In closing, Guzmán emphasized that improving health outcomes requires a system-level

approach. Training healthcare providers or empowering patients in isolation is insufficient. True transformation demands a networked, integrated, and systemic perspective—one that strengthens coordination across all levels of care and ensures that every component contributes harmoniously to the shared goal of better health and wellbeing for all.

“There is no single recipe, no ready-made solution that fits all countries. But we are committed to walking this path together. We have clear elements on how to be strategic and proactive, which we are eager to share—and we want to reaffirm our full commitment to supporting the region on this journey.”

**Javier Guzmán**, Division Chief, IDB



**Javier Guzman**, Division Chief,  
Health, Nutrition and Population, IDB

## Current Approaches to Quality in Health Systems are not Enough

**Dr. Pedro Saturno Hernández** from Mexico’s National Institute of Public Health challenged fundamental assumptions about quality management. After four decades of improvement initiatives, why do gaps persist—or worsen? He presented sobering data: Mexico leads LAC with 435 preventable deaths per 100,000 population; even Costa Rica’s performance, which is the best in the region, has 141 per 100,000 preventable deaths which exceeds OECD averages. When countries evaluated essential public health functions in the 2000s, quality assurance consistently ranked as the least attended function by governments—the Cinderella of health priorities.

### Three Conceptual Errors Undermining Quality Approaches

- 1. Fragmentation and limited scale.** Decades of isolated projects—single diseases, individual facilities, specific protocols—yield localized improvements but never population-level impact. He cited successful collaboratives in Spain and Chile that generated enthusiasm and measurable results yet never scaled beyond pilots or became institutionalized. *“We always asked: when will this become essential, routine, and supported by the entire Ministry—not reduced to isolated experiences?”*
- 2. Unidimensionality.** Quality has been conflated with single dimensions—first accessibility, then safety, recently efficiency—rather than understood as inherently multidimensional. The intense focus on patient safety, while valuable,

has narrowed the quality agenda. As he provocatively stated underlying the importance of preventive care for the population: *“The safest care is the care never given—there you will not harm the patient. Safety matters profoundly for those accessing services, but what about effectiveness, equity, timeliness, and responsiveness for entire populations?”*

- 3. Inputs ≠ Quality.** There is persistent tendency to equate inputs, which are often referred as structural quality, — more beds, doctors, equipment, and training— with better clinical quality and outcomes, assuming more inputs and professional knowledge automatically translates into appropriate practice. Yet providers apply correct protocols only 47% of the time despite knowing the right approach. As Dr. Saturno emphasized: *“Structure is necessary but never sufficient. You can have highly trained professionals, but if they don’t apply what they know, it’s not enough.”*

### Three Essential Innovations to Address Quality Gaps

1. Go from quality of individual clinical care to system-wide quality across all services—not just treating illness, but prevention, health promotion, and population health
2. Address all dimensions simultaneously across all organizational levels with appropriate indicators for each
3. Elevate quality from a clinical attribute to an essential public health function with profound implications for equity, universal coverage, social determinants, environmental sustainability, and health security

### The Need for a Systemic Approach for Quality of Care

After decades of pilots, protocols, and quality circles, the region has accumulated valuable experience but insufficient transformation. As Dr. Saturno stated:

*“We cannot keep waiting for institutionalization to happen someday. We must begin with institutionalization—making quality a visible, prioritized, complete system supported transparently by Ministries of Health.”*

**Pedro Saturno**, INSP, Mexico



The question is no longer whether we know what high-performing systems require. The question is whether health authorities will make quality the organizing principle it must become—and sustain that commitment across political cycles and competing priorities. As 71% of preventable deaths remind us daily, anything less is unquestionable, unacceptable, and unjust.

# Session 2: What is a High-Performing Health System?



# Session 2: What is a High-Performing Health System?

## Building High-Performing Health Systems in LAC

“Every single instrumentalist was trying as hard as he or she could to be the best saxophonist or the best drummer. What you get is sub-optimization—everybody trying hard to do their single best, and often to be better than the person next to them. That doesn’t work. Greatness comes from learning together.”

Donald Berwick,  
Institute for Healthcare Improvement

**Dr. Donald Berwick’s**, from the Institute for Healthcare Improvement (IHI), keynote reminded us of a fundamental truth often obscured by institutional complexity: healthcare improvement is not about trying harder but about learning together. Drawing from decades of global experience and the foundational work that began with the Institute of Medicine’s seminal reports, he presented a compelling framework for transformation anchored in six dimensions of quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity and as he expressed, “Quality, simply put, means meeting people’s needs with minimal waste, and these dimensions define what excellence looks like.”

Yet perhaps his most provocative insight came in challenging ten durable but wrong beliefs that permeate our systems when considering systemic changes.

- 1. Trying harder does not create improvement, learning and redesigning systems do.** “Every system is perfectly designed to achieve the results it achieves,” he emphasized, urging participants to stop blaming individuals and start redesigning systems.
- 2. Extrinsic motivation is not the key to performance; people want to find pride and joy in their work.** People are not primarily motivated by rewards or punishments; they are intrinsically motivated to do good work, and systems must nurture that.
- 3. Great parts do not make a great whole; great systems achieve great results.** Excellence is not achieved by assembling heroic individuals but by enabling teams and systems to function well together.
- 4. Measurement for judgements hurts; measurement for learning helps.** Quality measurement does not drive improvement unless purpose and will to learn are present.
- 5. Pressuring the current system would not improve performance, radical redesign will.** Pushing harder on the existing system yields little; redesign can break through to new performance.
- 6. Quality does not cost more; it is the route to financial success.** Quality is not an additional expense, but a necessity to reduce waste and make a more effective use of existing resources.
- 7. Failures are not to be avoided; but treasured.** Failures, far from being shameful, can be the key to improvement when approached through disciplined cycles of Plan-Do-Study-Act.

**8. Competition does not beat cooperation.**

Cooperation and shared learning are the most valuable assets for improvement.

**9. Patients' demands are not insatiable; they bring invaluable knowledge.**

Patients are essential partners in designing better health systems.

**10. Learning is not a luxury, but the route to improvement.**

Learning cannot be optional: without dedicating time and space for learning, performance will not improve.

Dr. Berwick brought these principles to life through regional success stories that demonstrate what's possible when we combine clinical science with improvement methods and unwavering leadership support. Peru, achieved cure rates of 66% for multidrug-resistant tuberculosis, when in addition to having 41 clinic-based improvement teams, the Ministry of Health decided to form an improvement team ("Team 42") to remove systemic barriers to tuberculosis treatment—transforming global perceptions of what's achievable in resource-limited settings. In

Ecuador, systematic approaches to diabetes care increased control rates from 20% to 55%. Brazil's Intensive Care Unit collaborative reduced complications across more than 100 units through shared learning and standardized best practices.

These examples share a common DNA: team-based approaches, systematic application of improvement science, radical redesign rather than incremental pressure, and firm political commitment. They also embody a shift from extrinsic motivation to creating conditions where healthcare workers find pride and joy in their work—a principle Dr. Berwick positioned as fundamental to sustainable change.

He proposed a 10-year cooperative project for Latin America that resonated deeply with participants: developing learning health systems that achieve unprecedented improvements together through "Learning-Sharing-Transparency-Ambition." The vision is clear—move from isolated projects to systemic transformation, from competition to cooperation, from measurement for judgment to measurement for learning.



**Donald M. Berwick, MD, MPP, FRCP** is President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI)

## Group Activity: Challenges to Build High-Performing Systems in LAC

After the keynote presentation there was a group activity in which participants discussed the challenges they saw to build high-quality

health systems in the region. To guide the discussion each table received a circular board with five core-elements of a high-performing systems and cards explaining what they entailed. Groups then discussed the challenges they had in each country, and they then consolidated the common challenges of countries in the same group.

### Elements of high-performing systems

### Challenges identified

#### People-centered care



People and communities are at the center of the health system, ensuring that care is respectful, responsive to their needs, culturally appropriate, and promotes their active participation in their own care.

- Services are not consistently adapted to cultural and community contexts.
- Community participation and patient engagement remain limited.
- People-centered models are unevenly implemented and hard to scale.
- Geographic barriers restrict access, especially in rural areas.

#### Service delivery



Care is organized to be reliable, continuous, accessible, and effective, adapted to the real needs of people and communities.

- Fragmented and poorly integrated care.
- Outdated processes and information systems.
- Limited capacity for comprehensive, chronic-care services.
- Care models still oriented toward episodic rather than continuous care.

#### Measuring, Accountability and Learning



The system has clear metrics for the health outcomes it seeks to achieve and uses them systematically to improve, learn, make decisions, and be accountable.

- Weak M&E systems and poor-quality data.
- Indicators misaligned with priorities.
- Limited accountability and learning culture.
- Fragmented, non-interoperable data systems.

#### Human Resources for Health



Medical and non-medical health teams that are competent, coordinated, and motivated, with clear roles and adequate working conditions.

- Misaligned roles, weak training, and poor incentives.
- High turnover and migration.
- Persistent shortages in key professions.
- Low levels of training, continuous education and supervision.

#### Governance and Leadership



Governance with a clear vision, rules, and responsibilities to align stakeholders and ensure equitable services; leadership mobilizes teams, drives continuous improvement, uses data, and promotes community participation.

- Outdated policies and fragmented systems.
- Weak leadership, planning, and coordination.
- Limited political commitment and misaligned incentives.



## High-Level Panel on Challenges to Build High-Performing Systems in LAC

After the activity a panel of health ministers from the region discussed the strategic challenges from their perspective. The panel include the participation from **Hon. Michael Darville**, Minister of Health and Wellness from Bahamas; **Bertrand Sinal**, Ministry of Public Health and Population from Haiti; and **Rodolfo Montero**, Minister of Health and Sports from Mendoza, Argentina. It was moderated by **Kavita Singh**, Lead Health Specialist at the IDB.

Minister Montero emphasized that policymakers must focus on proper system design and configuration rather than viewing themselves as “orchestra conductors” who direct everything. He stressed the need to institutionalize policies so health systems function effectively regardless of which temporary officials are in office.

*“We have instruments that generate incentives for the actors in the system - incentives for patients, for professionals, for financiers, for providers. We need to design and configure systems that generate the right incentives to lead us to our objectives.”*

**Rodolfo Montero**, Minister of Health and Sports, Province of Mendoza, Argentina

Minister Sinal stressed that achieving a high-performing health system requires strong national leadership with development partners in a supporting role. He emphasized aligning partners with national priorities, addressing health worker retention, and ensuring equitable access despite security challenges from armed gangs affecting 3 of Haiti’s 10 departments.

*“As Minister of Health, I take the lead in directing the health sector, while our partners accompany and support these efforts. This reflects in practice the approach we promote in health: national leadership with coordinated support from partners.”*

**Bertrand Sinal**, Ministry of Public Health and Population, Haiti

Minister Darville highlighted the critical importance of establishing strong universal primary health care with no cash at point of service before advancing to catastrophic coverage. He identified digitization for archipelagic nations and regional cooperation to address health worker “brain drain” as essential elements for system strengthening.

*“Universal health care coverage without quality is useless. You do not go to catastrophic care until you get primary health care right.”*

**Hon. Michael Darville**, Ministry of Health and Wellness, Bahamas



# Session 3: The Roadmap to Build High-Performing Health Systems



# Session 3: The Roadmap to Build High-Performing Health Systems

## Introduction to the Roadmap

Building a high-performing health system is not a destination but a journey that requires integrating five fundamental elements: Vision, Redesign, Learning, Governance, and Sustainability. As emphasized by **Karla Schwarzbauer** from IDB during this presentation, ignoring any of these components puts at risk the coherence, continuous improvement, and sustainability of the system. Only by integrating all five do we achieve quality care for all—efficient, resilient, and trustworthy.

The roadmap toward high-performing health systems represents a framework where each element is interdependent and mutually reinforcing. Health systems produce exactly what they are designed to deliver; therefore, achieving quality, equitable, and reliable care for the populations they serve requires intentional design, continuous adaptation, and sustained commitment across all dimensions.

## The Five Elements of the Roadmap



**1. Building a Shared Vision** – Aligns all actors around common priorities with measurable goals, creating shared responsibility across the system. Without this foundation, investments become disconnected, and reforms work at cross-purposes.



**2. Optimizing and Redesigning Service Delivery** – Recognizes that current performance reflects current design. Achieving different outcomes requires evidence-based redesign

of service networks, workflows, and operational processes—not merely incremental adjustments.



**3. Implementing, Iterating, Learning, and Scaling** – Builds capacity for continuous adaptation through iterative improvement cycles, leadership cultures that foster learning rather than blame, and measurement systems that guide improvement rather than merely recording performance.



**4. Institutionalizing Governance and Accountability** – Embeds quality into every role and aligns policies, incentives, and resources with continuous improvement. Strong governance ensures that quality initiatives outlast individual champions and political cycles.



**5. Sustaining through Policies, Financing, and Capacities** – Ensures lasting improvements by deliberately building institutional infrastructure, sustainable financial mechanisms, strategic partnerships, and organizational capacities that maintain performance over time.





## Integration as the Key to Success

These five elements do not operate independently but form an integrated approach. A shared vision without the capacity to redesign services remains aspirational. Redesign without learning becomes rigid and unable to adapt. Learning without governance structures cannot scale. And none of these endure without deliberate attention to sustainability.



### Roadmap 1: Build a Shared Vision and Define the Joint Quality Aims

## Building a Shared Vision

“Before we do anything at all, we need to know where it is that we actually want to go,” emphasized **Sebastian Bauhoff**, Principal Health Economist at the IDB, introducing

Captain Jack Sparrow’s compass as the perfect metaphor. Unlike an ordinary compass pointing north, Jack’s compass points to “*the thing that he wants most in the world.*” This is exactly what we must work on with our vision—a compass that gives direction, but only if we can identify it, articulate it, and agree on it.

Without alignment, as Bauhoff warned, “*the needle in this compass will just keep spinning around and not give us the direction and guidance that we need to actually proceed.*”

The vision defines a shared desire among stakeholders—where we want our health system to be, the ideal state, our common aspirations and priorities.

**1. Assess the Current Situation:** More than identifying gaps—understand “*the structures, policies, and context*” that shape performance. “*This is really a systems analysis and understanding what is important systemically that stands in the way of making progress.*”

**2. Engage Diverse Stakeholders:** *“The vision can’t just be written by technical experts alone.”* Involve Ministry leadership, providers, patients, and private sector. *“Getting the right people involved throughout this process is not just about ownership, but it’s also about effectiveness and sustainability.”*

**3. Co-Create the Vision Statement:** Aspirational, people-centered, realistic.

**4. Establish SMART Health Goals:** Establish Specific, measurable, achievable, relevant, and time bound (SMART) goals to guide health system performance.

**5. Identify Critical Domains & Systems Change:** Patient engagement, organizational capacity, care models. *“Keep a systems perspective, because all these issues are very complex, and they don’t just exist by themselves. They interact with each other.”*

**6. Establish & Track Key Indicators:** Balance outcome indicators with system indicators. *“Should be meaningful and actionable, and support accountability and learning as we go along.”*



**Sebastian Bauhoff**, Principal Health Economist, IDB

## Shared Vision Activity: Newspapers Headlines from 2030

To make the abstract concrete, participants created newspapers from 2030 announcing a collective vision that was inspiring, but feasible of what health systems could achieve. For the activity groups had to deliberate what does the frontpage of a newspaper in 2030 would say about the achievements of their health systems, along with measurable results.

Participants created different headlines that illustrated what they envision and aspire for their health systems in the future.



According to one participant the exercise revealed that “when we write the headline we want to see, we begin to understand what needs to change today.”

“This is step one on the roadmap. And it is critical, of course, because the first step is, in a sense, the beginning of the journey, the foundation of everything that follows.”

**Sebastian Bauhoff**,  
Principal Health Economist, IDB



## From Vision to Action

Building on the previous insights about current challenges and the roadmap framework, **Ana Mylena Aguilar**, Lead Health Specialist at the IDB, framed a pivotal transition: the journey from vision to action demands more than commitment—it requires rethinking how we design and deliver care. She reminded participants of the ten durable, but wrong beliefs Dr. Berwick had challenged, emphasizing that trying harder within broken systems yields only frustration; learning and redesigning systems yields transformation.



Ana Mylena Aguilar, Lead Health Specialist, IDB

## Graphic summary of session 1



See Annex 1: Graphic Summary Images



## Roadmap 2: Optimize/ Redesign Service Delivery, Organization and Management to Achieve Quality Aims

How to translate shared quality aims into concrete changes in service delivery, organization, and management? The challenge is stark—even when countries agree on ambitious goals like reducing preventable maternal deaths or improving diabetes control, achieving those aims requires more than protocols and training. It demands system redesign that addresses access, potentiates quality and safety as strategic organizing principles, and reduces waste as a catalyst for organizational transformation.

## Why Redesign and Which Tools Can be Used?

**Paulo Borem** of the Institute for Healthcare Improvement (IHI) argued in his presentation that improving health-system performance in Latin America now requires a shift from simply expanding access to **making quality THE central strategy** of service delivery and system management. Building a shared vision of quality, co-created with stakeholders, patients, and families, is the starting point—yet turning that vision into action demands redesigning the system rather than pressuring the current one. The vision he articulated to serve as a guiding principle was the Triple Aim framework, simultaneously improving population health, enhancing patient experience, and reducing per capita costs. Drawing on Deming, IHI's experience, and improvement science, Borem emphasized that every system is perfectly designed to get the results it currently produces; therefore, meaningful change requires redesign, not isolated training or exhortations.

A key theme was **the primacy of system design over individual effort**. *“95% of system results stem from how the system is*

*designed, not from individual performance.”* This challenges the common reflex to blame providers for poor outcomes and redirects attention to the structures, incentives, and processes that shape their work. Leaders must therefore focus on reducing unwarranted variation, simplifying processes, and eliminating waste. Clinical variation, such as inconsistent application of protocols or large differences in C-section rates, creates a self-reinforcing cycle of errors, inefficiency, and poor outcomes. Breaking this cycle requires standardizing care and processes. Waste reduction, eliminating unnecessary steps, delays, duplications, and inefficiencies, emerges not as a cost-cutting exercise but as a strategic lever that simultaneously improves patient outcomes, increases staff satisfaction, reduces costs, and builds system resilience.

Drawing from Brazil's experience, Borem illustrated how **addressing priorities for reducing variation should ideally start with both clinical and operational areas**. Clinical priorities can drive system-wide change when approached systematically. The focus areas he highlighted—reducing healthcare-associated infections, improving surgical outcomes, optimizing emergency department flow, strengthening maternal and child health, and operational priorities for improving hospital efficiency include bed turnover rate and hospital length of stay—these are not isolated technical challenges, but have been shown to increase hospital capacity without the need to start building new hospitals. They are all entry points for cultural transformation that can ripple across the entire health system.

**Improvement science can be an accelerator for results**, health systems cannot wait years to reduce maternal mortality, surgical delays, or hospital-acquired infections. Proven tools such as value-stream mapping, huddles, leadership walk arounds, and the Model for Improvement help teams see hidden problems, experiment rapidly, and sustain gains.

Finally, Borem highlighted the role of **leadership and communication**. Leaders must cultivate psychological safety, avoid demanding success that forces people to hide failures, empower teams to find solutions, and **model the courage needed for system redesign**. By reducing variation, removing waste, optimizing communication, and centering quality as strategy, countries can improve population health, enhance patient experience, and reduce costs simultaneously, fulfilling the Triple Aim.

*“If you always demand success, people will feel forced to hide failure.”*

**Paulo Borem,**  
Institute for Healthcare Improvement



## Service redesign in practice: case studies from the region

The panel that followed brought these principles to life through three examples of service delivery redesign tailored to specific population needs and contexts.

### Costa Rica: An intersectoral model to address adolescent fertility

**Patricia Jara**, Lead Specialist at the IDB, presented Costa Rica's comprehensive strategy to reduce adolescent pregnancy—a challenge with profound health, social, and economic implications. The intervention was not a single program but a multi-dimensional redesign of how primary care engages adolescents. Key elements included extending consultation times, creating adolescent-friendly service hours to ensure privacy and confidentiality, providing sexual and reproductive health education with didactic materials, implementing risk screening instruments, ensuring availability of modern and reversible contraceptive methods (including subdermal implants, IUDs, injectables, and condoms), and developing complementary education strategies including peer-to-peer education.

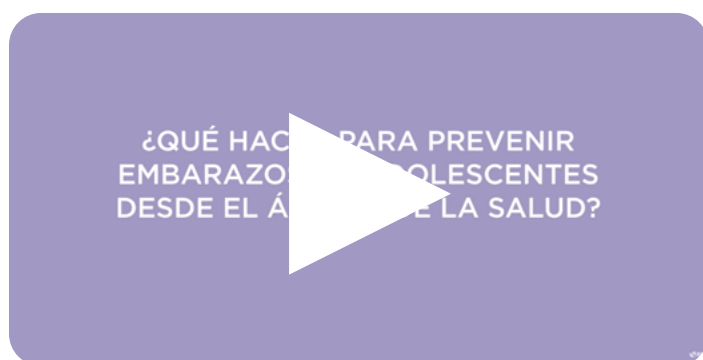
Critically the model was intersectoral from the design and it created a portfolio of services to be provided to adolescents by different institutions (health, education, child welfare) depending on their risk assessment and needs. To make intersectoral work effective, the model also included coordination mechanisms at the local, regional, and central level, and an information system to track cases and services to be provided by the different institutions.

Results were significant: adolescent fertility decreased by 22% compared to baseline, accompanied by measurable improvements in access to information, contraceptive use, and adolescents' perceptions of sexual and reproductive health services. The model achieved sustainability through institutionalization—contraceptive methods were added to the official medication list of the Social Security Fund, information systems were integrated into the unified health platform, normative changes were formalized, and decentralized governance structures with continuous quality improvement teams ensured ongoing monitoring and adaptation.

The model demonstrated that 68,000 adolescents received sensitive clinical consultations through an approach implemented with support from 11 health areas and 124 primary care teams in the poorest districts in the country, adapting national policies to local territorial realities.



[Learn more about Costa Rica's model of adolescent fertility](#)



## São Paulo's Integral Digital/Physical Model of Primary Care

**Marcelo Takano** from São Paulo's Ministry of Health presented a different challenge how to redesign primary care to delivery timely and equitable access to services for the city of São Paulo, an 11 million people city facing

deep social and health inequities. To do this the city launched a major effort to modernize both the physical infrastructure and the digital foundations of its primary health system.

With support from the IDB, the city expanded and upgraded its care network: 13 new urgent care centers, 10 new primary care units, and 88 renovated facilities were added in recent years. This investment also enabled the largest primary-care quality accreditation cycle in Brazil's public sector, certifying 368 primary care units, based on international standards to embed a culture of quality and patient safety throughout the system.

In parallel, São Paulo designed an ambitious “physical-digital” model to connect patients, providers, and services more effectively. Rather than replacing existing software, the city created a unified data repository that integrates 84 different information systems and has already processed more than 1.5 billion health events. This platform supports a growing telehealth network with nearly 20,000 professionals, over 2 million teleconsultations, and a citizen-facing app with 3.4 millions of active users.

The approach aims to strengthen—not substitute—face-to-face care. Digital channels offer timely guidance for minor urgent needs, help patients participate more actively in their own care, and promote digital inclusion, including for people with disabilities. For health workers, new tools such as a clinical viewer and AI-supported summaries make it easier to access patient information, track clinical indicators, and respond rapidly to emerging issues.

Together, these physical reforms, digital innovations, and strong quality-management practices have made São Paulo's health system more integrated, patient-centered, and responsive—reflected in independent surveys naming SUS the city's best public service. The model shows how large urban systems can improve performance by expanding networks with clear quality standards, using digital tools

to strengthen (not replace) human connection, balancing scheduled and urgent care, and protecting adequate consultation time. As Takano emphasized, true digital transformation must build trust, co-responsibility, and universal access.



[Learn more about São Paulo digital health transformation](#)

## HEARTS Approach to Redesign Primary Care for Persons with NCDs

**Esteban Londoño** from the Pan American Health Organization (PAHO) presented the HEARTS initiative—a powerful example of how standardized approaches to chronic disease management can be adapted and scaled across diverse contexts. Critically, he framed HEARTS not as a vertical disease program, but as a primary care quality improvement initiative that strengthens health systems while addressing the leading cause of preventable death in the region.

The scale and momentum of HEARTS is remarkable: 28 countries are actively implementing the program, 33 countries have committed to implementation, over 10,000 primary care centers are participating, and 6 million patients are enrolled—though Londoño emphasized that this is just the beginning. The

urgency is undeniable: of all noncommunicable disease deaths, one-third are due to cardiovascular disease (CVD). Every day, 6,000 people die from CVD in the region, and 70% of these deaths are attributable to poor quality of health system performance.

Londoño was direct in his diagnosis: *“The problem lies in how the system functions and how primary care services are organized.”* HEARTS addresses this through a structured and simplified clinical pathway that guides evidence-based management of hypertension and diabetes, but the real challenge—and opportunity—is developing implementation strategies that work within each country’s unique context.

Two countries exemplify what is possible with strong political will and governance. El Salvador and the Dominican Republic have achieved effective implementation and measurable reductions in cardiovascular disease burden through governance frameworks that engage leadership at the presidential and ministerial levels. This underscores a recurring theme throughout the dialogue: sustainable change requires political commitment that transcends individual champions and becomes embedded in institutional structures.



[Learn more about HEARTS in the Americas.](#)



## Key Takeaways: Principles for Redesign

Several cross-cutting insights emerged from the presentations and discussions:

**First, re-design must be patient-centered and equity-focused.** Both Costa Rica and São Paulo succeeded because they started by understanding the specific barriers faced by their target populations—adolescents navigating sensitive health decisions, or urban residents struggling to access timely, quality care. Solutions were tailored accordingly, not imposed uniformly.

**Second, integration is essential.** Whether integrating health and education sectors (Costa Rica) or integrating physical and digital care delivery (São Paulo), fragmentation is the enemy of quality. High-performing systems connect across traditional silos—clinical specialties, levels of care, sectors, and technologies.

**Third, governance and institutionalization sustain gains.** Examples succeeded in embedding changes within formal structures—updated medication lists, accredited facilities, integrated information systems, and decentralized quality improvement teams. This ensures reforms survive leadership transitions and political cycles.

**Fourth, technology amplifies good design but cannot compensate for bad design.** Automated sepsis protocols in Brazil, digital chronic disease management in São Paulo all enhanced impact—but only because they supported well-conceived clinical and organizational strategies.

**Fifth, learning and adaptation must be continuous.** All presenters emphasized the importance of monitoring, feedback loops, and willingness to adjust based on evidence.

Finally, **waste reduction is a strategic priority, not merely a cost concern.**

Paulo Borem's framing was powerful: eliminating unnecessary processes, delays, and inefficiencies doesn't just save money—it improves patient outcomes, increases staff satisfaction, and builds organizational resilience to respond to future challenges.

As participants broke into working groups to apply these lessons to their own contexts, a shared understanding crystallized: **the roadmap's second milestone—optimize and redesign service delivery—is not about marginal improvements within existing structures. It is about courageously reimagining how care is organized, managed, and experienced**, guided by clear quality aims and anchored in the lived realities of the populations served.

## Group Activity. Patient's Diary: Redesigning care from a patient's perspective

After the presentations, participants worked in groups in an activity designed to redesign service delivery, organization and management starting from a patient's perspective. Country teams received a case study about Rosa, a patient with hypertension navigating the health system, along with strategy cards for service delivery organization and management, and a board where they include the strategies they chose for the redesign.

The four-step methodology guided participants to: (1) read Rosa's case and identify the patient's feelings and frustrations, (2) design strategies across three dimensions—WHAT to do (service delivery), HOW to do it (management), and WHERE to provide the services (service organization) based on cards provided (3) identify necessary conditions for



implementation, and (4) imagine how the patient would feel with the redesign in place.

Plenary discussions revealed priorities including personalized health plans, extended hours with telemedicine, interoperable electronic health records, quality-based payment models, medication availability, multidisciplinary teams, and clinical practice guidelines with defined roles. Teams emphasized critical enabling conditions: integrated and comprehensive care, person-centered approaches, data analytics competencies, humanization of care, and community education.



The final closing emphasized that Rosa represents millions of Latin Americans who will benefit from the collaborative redesign work—transforming abstract quality principles into concrete service delivery improvements grounded in patient experience and system thinking.



### Roadmap 3: Implement, Iterate, Learn, and Scale

The third element of the roadmap confronts perhaps the most vexing challenge in health system transformation: how do we move from sporadic successes to sustained, system-wide improvement? History is littered with pilot projects that demonstrated promise but never scaled; innovations celebrated in conferences but abandoned within months, and quality initiatives that flourished under champions but withered when leadership changed.

This session began with a fundamental reframe *implementation is not about executing a fixed plan—it is about learning our way forward*. This requires embracing iteration, building institutional capacity for reflection and adaptation, and creating structures that enable knowledge to flow across organizational boundaries.

### Group Activity: Marshmallow Challenge



This session started with the marshmallow challenge—a team-building exercise that served as a powerful metaphor for the relevance of learning in health systems. Country teams received spaghetti sticks, tape, string, scissors, and one marshmallow, with 18 minutes to build the tallest freestanding structure with the marshmallow on top.

The exercise revealed critical lessons about systems change. Winning teams emphasized the importance of a solid foundation

(paralleling strong primary care), effective use of limited resources, trusting team solutions, and deliberate planning. Teams that struggled often spent excessive time debating approaches without testing prototypes—mirroring health systems that plan endlessly without implementing and learning.

Facilitators drew explicit connections to health system improvement: the urgency of results leaves little time for learning, yet learning is essential; deliberation and consensus are difficult when everyone has ideas; collective work requires collaboration; systems need constant adaptation; clear guidelines enable innovation; and sustainability requires maintaining gains over time, not just achieving initial targets.

The challenge demonstrated improving health system performance, like tower-building, requires balancing planning with rapid iteration, leveraging diverse team strengths, learning from failures, and recognizing that working with limited resources demands creativity and prioritization—not waiting for perfect conditions before acting.



## What is a Learning Health System?

**Meike Schleiff** from University College London presented based on theory and evidence what distinguishes health systems that continuously improve from those that stagnate. She emphasized that *“learning health systems are not defined by having better data or smarter people, they are defined by embedding systematic learning into the everyday work of care delivery.”*



Meike Schleiff, UCL

Schleiff presented a framework organized around three dimensions of health system learning.

**First, learning operates at multiple levels:** individual and team learning based on evidence, experience, and intuition; organizational learning that captures institutional knowledge; and system-level (cross-organizational) learning that integrates lessons into policies and reforms.

**Second, learning happens through different loops:** single loops involve daily adjustments to practices and processes to solve immediate problems; double loops question whether we’re doing things correctly and foster openness to innovation; and triple loops fundamentally

examine how we learn and drive cultural and capability shifts across the entire system.

**Third, learning requires specific enabling conditions:** robust information and data analysis; deliberation spaces where stakeholders can share knowledge; and system capacity—the infrastructure and human resources necessary to absorb and act on learning.

These dimensions underscore a critical insight: *“building learning capacity is as important as building clinical capacity.”* Training providers in hypertension management is necessary but insufficient; systems must also develop their capability to monitor whether protocols are being followed, understand why adherence may be suboptimal, test solutions, and refine approaches based on evidence.

Three core capabilities distinguish learning health systems: **They create psychological safety**—environments where teams can test changes, report problems, and share failures without fear of punishment. As Dr. Berwick emphasized the previous day, *“fear is the enemy of learning.”* When staff are afraid to acknowledge what isn’t working, systems cannot adapt. **They establish infrastructure for iterative improvement**—structured processes like Plan-Do-Study-Act (PDSA) cycles that enable rapid testing of changes on a small scale before widespread adoption. **They facilitate horizontal learning**—creating mechanisms for peer exchange and collaborative problem-solving across sites facing similar challenges.

## Learning & iteration in practice: 2 case studies from the region

### Patient-Centered Learning: SURA’s Approach to Diabetes Care

**Carlos Andrés Agudelo** from SURA presented how deep analysis of patient data and continuous feedback loops enabled radical redesign of diabetes care. SURA’s journey began with a puzzle: despite investing in diabetes management programs and ensuring medication availability, hospitalization rates for diabetes-related complications remained stubbornly high. Initial analysis blamed medication non-adherence, but deeper investigation revealed the problem was far more complex.



By systematically analyzing patient journeys—not just clinical indicators but the **social, behavioral, and logistical barriers** patients faced—SURA discovered that many patients couldn’t attend appointments because they lacked family members to accompany them, couldn’t afford transportation, or faced work schedule conflicts. Others struggled with medication regimens not because drugs were unavailable, but because of alcohol use, cognitive difficulties, or lack of understanding about why treatment mattered.

This led to fundamental service redesign: bringing care to patients' homes when clinic visits were impossible, creating differentiated care pathways based on individual patient needs, and embedding behavioral support within clinical care. Critically, SURA invested in capturing and analyzing conversations between patients and care teams—turning qualitative insights into actionable intelligence for continuous improvement.

Agudelo emphasized a lesson that echoed throughout the dialogue: *"We cannot understand why patients don't follow*

*treatment plans by looking only at what happens inside clinics. We must examine the full context of their lives."* This requires humility—acknowledging that providers' assumptions are often wrong—and investment in listening infrastructure that many health systems lack. The results were compelling: improved glycemic control, reduced hospitalization, and higher patient satisfaction. But perhaps more valuable was the cultural shift: SURA built an organization that is not afraid to face and handle errors, tests assumptions rigorously, and learn and adapt continuously based on evidence.

### Field Visit: Care for Persons with Diabetes in IPS SURA San Diego

As a pre-conference event to the dialogue, around 40 participants had the chance to visit the IPS SURA San Diego that specializes in outpatient care for persons with Diabetes. There all participants had the chance to learn about the model of care, and then they were divided in groups to learn more about their approach for results-based management, digital tools for health management, and their training ecosystem for health workforce development.

SURA has developed an integrated care model for people living with diabetes, combining advanced risk management, interdisciplinary teams, digital transformation, and an articulated service network. Drawing on data from around 177,000 persons with confirmed diabetes, the model uses predictive analytics and machine learning to identify, segment, and stratify risk, enabling timely and personalized interventions. Patients are cared for by multidisciplinary care teams—expert general practitioners, specialists, nurses, and support professionals such as psychologists, nutritionists, rehabilitation therapists, and podiatrists—

who follow differentiated care pathways depending on whether the patient is controlled, uncontrolled, or decompensated, with a strong emphasis on continuity and coordination of care. The model also acknowledges different patient profiles—*informed, believer, unconcerned, and dependent*—and tailors communication and adherence strategies to encourage self-care and continuity of treatment.

A central pillar is the digital transformation that acts as a key enabler: structured electronic medical records, decision-support tools, population-health control dashboards, self-scheduling, WhatsApp-based education, and alert systems all facilitate cohort management, risk anticipation, and ongoing patient support. In parallel, human capital formation is supported by a continuous learning ecosystem that strengthens clinical, technological, and interpersonal competencies. SURA promotes micro-learning, mentorship, external training, and multiple educational formats to build capabilities and reduce gaps that undermine service quality.

Results show improvements in metabolic control, fewer complications, and greater satisfaction among both patients and care teams. Nonetheless, challenges remain, including achieving a fully integrated service network, managing non-adherent patients, and standardizing clinical criteria.

Overall, the visit to the IPS SURA San Diego, helped illustrate a modern, person-centered vision of healthcare, where the combination of data, skilled human talent,

and digital tools enables safer, timelier, and more effective care for people with complex chronic conditions. More importantly, the visit offered tangible evidence of how the theoretical principles of the roadmap—shared vision, strategic redesign, continuous learning, institutionalized governance, and sustainability—materialize in daily clinical practice, providing a valuable case study for the challenges faced by health systems in the region.



## Coaching for Quality: Shoulder to Shoulder's Work in Honduras

**Karla Perla** from Shoulder to Shoulder, who coordinates a decentralized provider for primary health care in Honduras, presented an innovative approach to building improvement capacity in resource-constrained primary care settings in rural Honduras. The model centers on developing coaching skills in middle-managers to guide quality improvement rather than traditional training—recognizing that knowledge transfer alone doesn't change practice, but ongoing mentorship and hands-on support can.

Karla Perla emphasized that although many decisions are made at central levels, the success of a health system ultimately depends on frontline workers—people with emotions, limitations, and vocation—who are responsible for putting changes into practice, often under difficult conditions.

At the beginning of the Coaching Program, local teams faced fear, uncertainty, and resistance to change. However, coaching became a valuable tool to help them get organized, innovate with limited resources, and work collaboratively, demonstrating genuine partnership. This approach led to tangible improvements—cervical cancer screening results turnaround times dropped from over 60 days to under 30, coverage increased, patient satisfaction improved, and teams developed stronger internal coordination. These improvements have been sustained despite challenges like staff turnover, limited resources, high patient demand, and bureaucratic processes.

Among the lessons learned, Karla Perla highlighted the importance of effective communication with patients, empathy, ongoing supervision, and collaborative learning. She emphasizes that improvement

cycles are learning opportunities and do not happen on their own. The coaching process strengthened leadership, management, and team commitment, reminding participants that a health system is not merely a physical structure—it is made up of people.



[Learn more about Coaching Middle-Managers in Honduras](#)

## Key Takeaways: Principles for Iterating, Learning and Scaling

Several cross-cutting insights crystallized across the presentations: **Learning must be embedded, not episodic.** High-performing systems create regular forums—team huddles, case reviews, quality improvement meetings—where learning happens as a routine part of work. **Failure is data to learn, not shame.** When teams fear punishment for acknowledging problems, they hide issues until they become crises. When failure is reframed as an opportunity to learn, problems surface early when they're easier to solve.

### **Horizontal learning accelerates spread.**

The most powerful knowledge transfer happens through practitioners learning from practitioners—not through experts lecturing from afar. **Context matters profoundly.** Scaling requires adapting, not replicating—taking core principles and redesigning them to fit local realities. Infrastructure enables learning. **Data systems that provide timely feedback,** protected time for reflection, coaching support, and platforms for peer exchange—these are essential enablers of improvement. Finally, **patience and persistence** are required. Systems that commit to long-term capability building ultimately outperform those chasing quick wins through sporadic initiatives.



## Roadmap 4: Institutionalize governance and accountability to drive high-system performance and quality

### A Tale of Two Cities: The Power of Leadership

**Rashad Massoud**, Head of Global Health at IQVIA, opened with a provocative thought experiment that immediately captured the room's attention. He presented participants with a stark choice: imagine two cities, with similar resources, infrastructure, and workforce—but vastly different in outcomes. In one city, health systems function smoothly, patients receive timely care, and staff work collaboratively toward shared goals. In the other, dysfunction reigns—delays, fragmentation, frustration, and preventable deaths.

*“My question to you is: which city do you want to live in?”* Massoud asked. The answer was obvious, yet his follow-up cut to the heart of the dialogue's purpose: “What makes the difference? Governance with clarity on the vision and what constitutes success. Leadership which sets direction and empowers and supports at every level. Accountability for implementation to the best of everyone's ability.”



**Rashad Massoud**, Head of Global Health at IQVIA

[Video Tale of Two Cities](#)

This was not theoretical rhetoric. Massoud's “tale of two cities” drew from his own experience observing health systems that succeeded or failed based not on resources alone, but on the quality of governance and leadership structures. The contrast was visceral—a reminder that high-performing health systems are not built by accident but by design, sustained by deliberate governance choices and leadership commitment at every level.

### Ten Principles for Institutionalizing Quality

Ten evidence-based principles for institutionalizing governance and accountability for quality distilled from decades of global experience supporting health system transformation:

- 1. Move from vertical programs to system-level quality performance.** Fragmented disease-specific initiatives, while valuable, cannot substitute for integrated, system-wide approaches to quality.
- 2. Develop a national quality policy and strategy** that sets a small number of ambitious national health outcome targets, addresses equity as integral to every improvement, capacitates all levels of professionals, engages patients and communities, and creates national, regional, and local structures to drive implementation.
- 3. Build learning and adaptation as an integral component of implementation**, not an afterthought. Systems that learn continuously outperform those that implement rigidly.
- 4. Foster workplace psychological safety** and cultivate openness for testing changes and reporting results—including failures—without fear of punishment.
- 5. Ensure health information system readiness for real-time data**, annotation, aggregation, and multilevel monitoring. Data must serve learning and improvement, not just accountability.

**6. Provide leadership support and troubleshooting at every level.** Leaders must be visible, accessible, and actively engaged in removing barriers.

**7. Celebrate and reward achievements.** Recognition matters profoundly—both for individuals and teams—and sustains momentum.

**8. Ensure financial and leadership support** that signals quality is a genuine priority, not merely aspirational language.

**9. Take advantage of technological advances** to support implementation, but never allow technology to substitute for human connection and judgment.

**10. Separate quality assurance activities from improvement.** Inspection and support require different mindsets, structures, and skill sets; conflating them undermines both.

Massoud emphasized that these principles are not sequential steps but interconnected elements that must function in harmony—much like the musicians in the opening performance whose instruments, when coordinated, produced beautiful music rather than cacophony.

## Leadership in Action: Voices from Three Countries - High-Level Panel on Governance for High-Performing Systems

After Rashad's presentation, a panel of health ministers from the region discussed key elements for governance to guide and nurture health system performance. This ministerial panel brought Massoud's principles to life through the lived experiences of three countries at different stages of health system maturation—revealing both the universal challenges and context-specific strategies that define successful governance for quality.

**Hon. Kevin Bernard**, Minister of Health and Wellness from Belize, spoke with disarming candor about the realities of sustaining quality improvement in a small nation facing limited resources and chronic workforce turnover. His central message resonated across the room: *“Quality cannot be the priority of one administration and forgotten by the next. It must become institutionalized in our laws, our budgets, and our culture.”*

Belize has worked deliberately to embed quality standards into accreditation processes and establish continuous quality improvement teams at facility levels. Yet Bernard acknowledged ongoing struggles—particularly workforce retention in a small nation where trained professionals are often recruited abroad, and the persistent need for external support during the vulnerable institutionalization phase when systems are being built but not yet self-sustaining.

**Bernardo Martorell**, Undersecretary of Healthcare Networks in Chile, presented a more mature governance architecture where quality is woven into the fabric of healthcare network management. Chile has established formal quality units at national, regional, and facility levels, with clear accountability lines and regular reporting mechanisms that create transparency without paralysis.

Martorell's key insight addressed a tension every health system faces: *“We set national standards and targets, but regions and facilities must have the flexibility to adapt strategies to their contexts. Accountability without empowerment breeds resentment; empowerment without accountability breeds chaos.”* Chile's experience demonstrates that governance structures can evolve from informal to formal, from voluntary to mandated—but this maturation requires patience, sustained investment, and unwavering political backing across administrations.



**Victor Atallah**, Minister of Public Health from the Dominican Republic, offered perhaps the most striking example of high-level political commitment transforming governance possibilities. He described how the Dominican Republic has elevated quality to a presidential priority, with direct oversight from the highest levels of government—enabling rapid resource mobilization, streamlined decision-making, and whole-of-government coordination that would be impossible without such backing.

Atallah’s observation cut to the heart of why governance frameworks succeed or fail: *“Governance structures alone are insufficient—they must be inhabited by leaders who genuinely believe in the vision and are willing to fight for it.”* The Dominican Republic’s cardiovascular disease reduction efforts through HEARTS implementation exemplify this approach, with governance frameworks extending seamlessly from the presidency through ministries to primary care facilities—proving that political will, when genuine and sustained, can overcome bureaucratic inertia and resource constraints.

## Common Threads: What Works Across Contexts

Despite vastly different contexts—a small island nation, a regionally decentralized middle-income country, and a nation with strong centralized presidential leadership—several powerful themes emerged:

**Governance must be multi-level and networked.** All three countries have established structures spanning national, regional, and facility levels, with clear roles, responsibilities, and communication channels. Quality cannot be managed from the center alone; it demands distributed leadership and accountability that reaches the frontlines.

**Political commitment at the highest levels matters profoundly.** Whether presidential engagement in the Dominican Republic, ministerial advocacy in Belize, or undersecretary leadership in Chile, transformation requires champions with authority and visibility who can mobilize

resources, remove bureaucratic obstacles, and sustain focus despite competing priorities.

**Institutionalization requires embedding in law, regulation, and budget.** Voluntary efforts and pilot projects eventually fade when champions depart; lasting change demands institutionalization through official policies, dedicated funding streams, mandated reporting, and meaningful consequences for non-compliance.

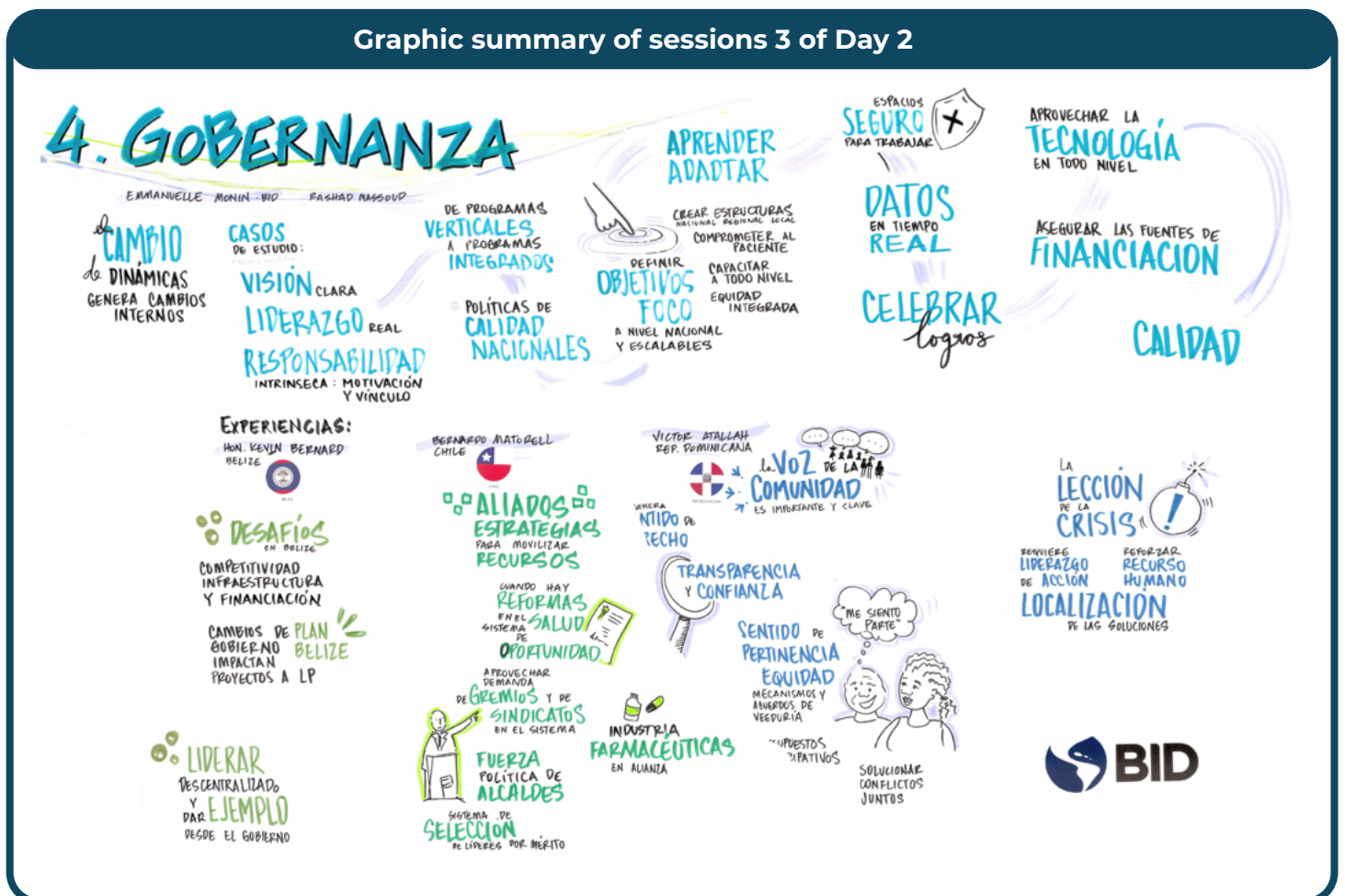
**Learning must be built into governance structures.** Chile’s regular reviews, Belize’s quality improvement teams, and the Dominican Republic’s HEARTS monitoring systems all create structured opportunities for reflection, adaptation, and course correction—embodying Massoud’s principle that learning and accountability must coexist, not compete.

**Patience and persistence are essential.** All three ministers acknowledged that building

governance infrastructure takes years, not months, and requires sustained commitment through leadership transitions, budget crises, and competing health emergencies that inevitably threaten to derail long-term quality agendas.

This fourth roadmap element—institutionalize governance and accountability—completes the strategic framework presented over the two-day dialogue. Vision without governance remains aspirational. Redesigned services without governance revert to old patterns. Learning without governance stays localized and fragile. But when all four elements align—shared vision, optimized service delivery, embedded learning, and robust governance—health systems gain the capacity not just to improve once, but to improve continuously, adapting to new challenges while never losing sight of their fundamental mission: delivering quality, equitable care to every person, every time.

Graphic summary of sessions 3 of Day 2



# Session 4: Building the way forward together



# Session 4: Building the way forward together

## From Dialogue to Action: Charting a Collective Path

As the two-day Regional Policy Dialogue drew to a close, **Emma Iriarte** opened the final session with a reflection that captured both the journey traveled and the road ahead: *“We have climbed far together over these two days—from understanding the gaps in quality that cost lives and erode trust, to envisioning what high-performing health systems look like, to mapping the roadmap that can get us there. But a roadmap is only valuable if we commit to walking it.”*

Before turning to collaborative work, Iriarte summarized the dialogue in four key messages.

### 1. Internalize the Elements of a High-Performing Health System

Iriarte emphasized a fundamental shift in perspective: *“This is not about isolated topics—it is about the system with all its components.”* High-performing health systems emerge when governance, financing, workforce, service delivery, information systems, and quality improvement function together coherently. *“From now on, you must hold this conjunction of elements in your mind as a system, not as separate themes,”* she urged. *“This is not minor: many meetings discuss a topic; here we addressed the complete system.”*

### 2. Quality Will Not Improve on its Own

Quality requires intentionality—deliberate, sustained effort. *“That intentionality must be practiced without being prescriptive,”* Iriarte noted, acknowledging the tension between standardization and local adaptation. *“It must be planned. Otherwise, things happen by inertia, by chance, or by reaction.”* Leaving quality to emerge organically is a strategy for failure; building quality requires strategy, commitment, and discipline.

### 3. The Challenge Is Not Only Technical

Above all, transformation demands leadership, collaboration, and commitment. These qualities must emanate from the highest levels of government—ministers, presidents, undersecretaries—but simultaneously require listening to those at the frontlines: the population, health workers, citizens, and our users. As Iriarte emphasized, *“Without their voices, without their engagement, we design systems that do not serve them.”* Technical expertise enables change, but leadership and collaboration sustain it.

### 4. We Can Do This with What We Have

Perhaps the most empowering message: *“We can do this with the systems we have, with the resources we have, with the health teams we have.”* Participants need not wait for perfect conditions, unlimited budgets, or ideal circumstances. As Dr. Berwick had emphasized earlier, *“It is not only about doing differently, but thinking differently and designing differently.”* Iriarte added a provocative observation: *“I would almost dare to say that money is not even the first thing we need.”* *What matters most is the willingness to question assumptions, redesign processes, and commit to learning.*

Iriarte concluded this framing by reaffirming the Inter-American Development Bank’s commitment: ***“We will work together with countries—not just through formal negotiations or technical training, but by maintaining this strategic dialogue. This cannot remain merely an event of discussion and memories.”*** The IDB pledged to provide sustained support, facilitate ongoing collaboration, and ensure that the momentum generated in Medellín translates into measurable improvements in health systems across the region.

## Group Activity: Learn, Share, Co-Create Together

The session then shifted from presentations to participation, to learn how participants wanted to continue engaging and working together. The task was simple participants will need to collectively deliberate on ideas based on the Dialogue of what they would like to Learn, Share, and Co-create.

Through structured dialogue and collective prioritization, participants identified the most critical areas requiring regional collaboration, for learning, sharing and co-creating together. Overall, around 85 different ideas were captured from the activity, below is a high-level summary organized by topic, along with the percentage of ideas that were generated by topic.

### Reflections from Participants

*“For too long, we have treated quality as an aspiration rather than a requirement,”* reflected a minister from Central America. *“This dialogue has given us permission—and a roadmap—to make quality non-negotiable.”*

A program director emphasized the value of honest cross-country learning: *“Reading about São Paulo’s digital transformation is interesting; hearing directly from the team about their failures and course corrections is invaluable. We need more of this candid exchange.”*

A vice minister highlighted the necessity of political courage: *“Technical solutions are necessary but insufficient. Quality transformation requires the willingness to challenge entrenched interests, reallocate budgets, and stay committed through electoral cycles. That courage is easier to sustain when we’re not alone.”*

On the next page we see the results of the Group Activity.



## Themes on what participants will like to learn, share and co-create

### Learn



QUIERO APRENDER DE:  
I WOULD LIKE TO LEARN ABOUT:  
GOSTARIA DE APRENDER SOBRE:  
J'AIMERAIS APPRENDRE SUR:

#### Quality-48%

##### Management

Quality-management systems

##### Measurement

Integrate quality indicators into information systems

##### Experiences

Implementation experiences in different countries and contexts

#### Service delivery-18%

##### Primary Health Care

Replacing vertical programs with strategies for continuity of care

##### Networks

Integration across levels of care

#### Human Resources-10%

Continuous training in PHC  
Role reconfiguration  
Human resources management

#### Governance-7%

Develop leadership skills at the technical and strategic levels

#### Learning-5%

Organizational learning strategies and a culture of quality

#### Financing and efficiency-10%

Financing linked to quality  
Initiatives to optimize resources

### Share



ME GUSTARÍA COMPARTIR SOBRE:  
I WOULD LIKE TO SHARE ABOUT:  
GOSTARIA DE COMPARTILHAR SOBRE:  
J'AIMERAIS PARTAGER SUR:

#### Service delivery-37%

##### Primary health care

Integrated PHC Model

##### NCDs

Scaling up HEARTS

##### Digital Health

Examples from Brazil and Chile

#### Quality-16%

##### System

Quality-improvement methodology at the system level

##### Measurement

Development and use of monitoring systems

#### Human resources -12%

High-performance training and incentives  
Continuous training in PHC

#### Governance-5%

Leadership and governance in remote settings

#### People-centered care-5%

Perspectives of Indigenous Peoples

#### Financing and efficiency-12%

Development and use of monitoring systems

### Co-create



PROPONGO CO-CREAR EN:  
I PROPOSE TO CO-CREATE ON:  
PROPONHO COCRIAR EM:  
JE PROPOSE DE CO-CREER SUR:

#### Service delivery-44%

##### Digital Health

Digital transformation of clinical and non-clinical processes  
Digital health experiences

##### Primary health care

Exchange of experiences

##### NCDs

Chronic care

##### Community models

Community-based work models

#### Quality-30%

##### General

High-performance community of practice  
Exchange of good practices among countries  
Technical expert group

##### Measurement

Information systems for quality

#### Human Resources-7%

Innovative practices in training processes

#### Financing and efficiency-6%

Health financing system  
Regional bioequivalence center

#### Learning-6%

Repository of successful best practices

#### People-centered care-5%

Involving the population in decision-making

Notes: Percentages based out of 86 ideas (75 individual and 11 collective) that emerged from the activity. Ideas were organized by common themes to present a summary.

# Closing Reflections: The Journey Continues



**Javier Guzmán**, HNP’s Division Chief, delivered closing remarks that brought the dialogue full circle, returning to the data that opened the event: “We began by confronting an uncomfortable truth—that seven out of ten preventable deaths in our region result not from lack of access but from poor quality of care. We end with a roadmap, concrete commitments, and a community determined to change that reality.”

He emphasized that the IDB’s commitment extends beyond convening dialogues: “We will walk alongside you—providing evidence, technical cooperation, and resources adapted to your contexts. But the leadership must come from you. High-performing health systems

cannot be imposed from outside; they must be built from within, with vision, persistence, and the courage to learn from both successes and failures.”

Guzmán concluded with a challenge that will measure the dialogue’s impact: “When we reconvene next year, I want to hear not just about what you learned here, but about what you changed back home. The measure of this dialogue’s success is not the quality of our discussions in Medellín but the quality of care experienced by patients in Tegucigalpa, Port-au-Prince, Lima, and every community across our region.”

## Full Circle: The Orchestra Reunited

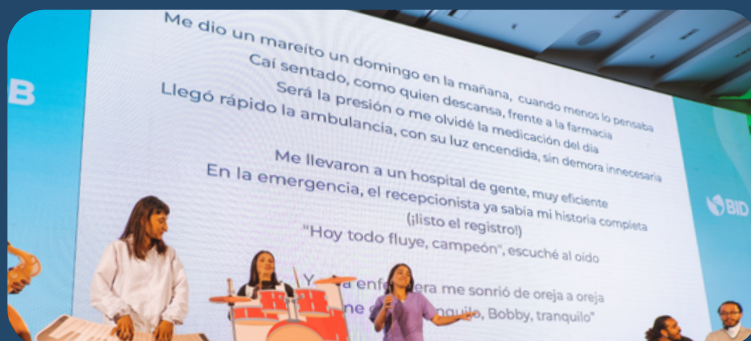
As the dialogue drew to its close, the musicians returned to the stage. But this time, something had fundamentally shifted. Armed with two days of learning about shared vision, integrated redesign, continuous learning, strong governance, and sustainability, they received a new instruction: play the same tune together.

The familiar opening notes of Juan Luis Guerra’s “El Niágara en Bicicleta” filled the room—but with transformed lyrics that captured everything participants had explored. Where the original song celebrated the impossibility of riding Niagara Falls on a bicycle, the new version proclaimed: *“Porque es hermoso recorrer este camino en bicicleta”*.

The catchy rhythm proved irresistible. Musicians engaged the audience, who rose

to their feet, clapping and singing along to lyrics that transformed an impossible dream into an achievable reality. What seemed unattainable in isolation—delivering quality care for all—becomes possible when vision aligns, parts integrate, systems learn, governance strengthens, and commitment sustains.

The metaphor had come full circle: from discord to harmony, from fragmentation to integration, from impossible to achievable. The room resonated with a single melody—a shared vision of high-performing health systems that no longer seemed like riding waterfalls on bicycles, but rather like an orchestra finally playing the music it was always meant to create together.



## Annexes

The following links provide you with additional information:

- [Agenda](#)
- [Presentations](#)

### Photos

- [Event Photos](#)
- [Sura Photos](#)
- [Graphic Summary](#)

### Video

- [RPD 2025 Video Summary](#)
- [¿Qué hacer para prevenir embarazos en adolescentes? Iniciativa Salud Mesoamérica en Costa Rica | Presentation Patricia Jara](#)
- [Two Cities | Presentation Rashad Massoud](#)

### Interviews

- [1. Donald Berwick](#)
- [2. Ferdinando Regalia](#)
- [3. Javier Guzmán](#)
- [4. Karla Perla](#)
- [5. Kevin Bernard](#)
- [6. Paulo Borem](#)
- [7. Rashad Massoud](#)
- [8. Victor Atallah](#)



