Editorial

Towards an Epistemology to Refound Health Systems in the 21st Century: Contributions to the Decolonization of Theories, Policies, and Practices

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The epistemological bases of health systems in Caribbean Latin American region tend to move between the reproduction of a constant coloniality of power and health knowledge [1], making cycles of regional processes to move in accumulations of *reforms of the reforms of reforms,* from the importation of theories and policies or, in the best of cases, in adaptation of said theses and lenses according to the global north or actors of the contemporary world system. Each reform and its episteme have produced sedimentations, institutional condensations in States, societies and health systems throughout the 20th century.

We denominate them "Frankenstein systems": bureaucratic Weberian, bio-medicalized, curative-care and commercialized health care devices, which are perceived as *external* to societies and which accumulated languages, mandates, logics, theses, at the same time that they crystallized dehumanization, racism, inequalities, violence.

Reproduction of *political-health dependence* processes is not only an external phenomenon, but also manifests itself in internal forms and structures in academia, in public health management, or in cultural hegemony in societies.

The agenda, geopolitics, and the actions of liberal global health, of the regional Pan-American doctrine and its national and local impacts have implications in this intrinsic nature of *dependence* on the field of theories and policies about health systems, which has generated homogenization of possible paths and limited understanding of the specificity of health systems located in globally peripheral capitalism [2].

In that sense, thinking health systems for the 21st century requires looking towards and from Latin America, and transcends the thought, theories, and policies of its Eurocentric bases and Pan-American doctrine, because in that categorical framework what is hidden and hides is what justifies the reasons for dependence, for inferiorization, for long theses of *imitation* based on considering transformation horizons through epistemic lenses of the global North.

To understand the specificity of problems in health systems and the State, we start from the need to *deconstruct* – that is, dismantle, take apart, step by step, logically-conceptually, the dominant Eurocentric Pan-American categorical framework and seek to promote and build other categorical systems "from" which health systems can be rethought, with rigor and in depth, based on an epistemology of the global south.

How to get out of this dynamic of reproduction of coloniality, theoretical dependence, public policy and government in the 21st century?

Firstly, returning to problematize the why and what of health systems in the 21st century from the sociopolitical, ecological, epidemiological and intercultural specificity of the South.

This implies two problematization movements: first, a revision of the State's specificity as a fundamental determinant of health systems. It is asking ourselves about the theorization and institutional condensation of the State as an expression of the accumulation of power relations in peripheral capitalism in the South; the State, as expression of social and power relations in society [3]. Thus, in recent decades, the *tsunami* process of institutional and organizational reforms to the State had different rates of reconfiguration: from the adjustment and structural change of the Washington Consensus, to its modernization; from labor flexibility to competing human capital; from decentralization with chronic defunding of the public, to the separation of functions with stewardship and regulation; a State that guarantees

individual rights, but which was modeled to the interests of producing private goods from the government itself in the public sphere [4].

It is evident that these transitional cycles of the State – within market colonialism to the peripheral capitalism of ECLAC developmentalism or to the current neoliberal extractive *financialized* acceleration – expanded reforms of health systems with institutional arrangements: from sanitary colonialism with concern in trade-diseases, to charity-beneficence of public healthcare; from Bismarkian meritocracy or aspirations to import universal *beverige* models, to the new neoliberal social protection, with social risk management and structured pluralism. None of those reforms solved the issue of socio-health inequalities by social class, ethnic-racial and gender, nor did it respond to the determinations of collective health in the region. On the contrary, a second issue is the folds of accumulation of inequities and inequalities that among colonial legacies, exclusive societies and the acceleration of globally peripheral capitalism generated what is conceptualized as processes of "de-citizenship", due to commercialization and dispossession of large groups of Latin American and Caribbean societies, who separated themselves in the materiality of their lives from the public sphere, from the fabric of the common and collective issues of living well in society, in community.

Health systems have accumulated institutional and organizational changes promoted by international organizations, like the World Bank, the Inter-American Development Bank or Pan American Health Organization/World Health Organization (PAHO/WHO), economic-financial actors and the (neo)liberal political complex, placing them on a regional and global political agenda where their structuring basis is an alleged homogeneity, to maintain and encourage the interests of the development theory with a vertical *public illness*, functional to the productive-extractive needs of peripheral capitalism and pathophysiological care mitigating social damage, or promote the expansion of a market for health financial coverage that configures health insurance systems and segmented citizens. Even with the universalization of types of health coverage based on differentiation by service packages, tests of means and stratification. Both theses respond to study and classification typologies of social protection models and health systems that continue being Eurocentric and neoliberal, but which are installed in many universities, schools of Public Health, and study centers. [2].

How to break the *iron cage* of a Pan-American Eurocentric administrative rationality on the theories and policies of health systems in the global South?

Through the aperture of a decolonial twist [5], making visible the need for decolonizing as a task (pending) for the global South. Decolonizing theories and policies of health systems in Latin America and the Caribbean – following Catherine Walsh [6] – in large measure means to *interculturalize, plurinationalize, and decolonize* its structures, conceptions, and institutions. Bringing complexity and emancipation.

The decolonial – and decoloniality – are not new approaches nor are they theoretical-abstract categories. They are, since colonization and enslavement, axes of struggle of people subject to colonial modernity, racialization, inferiorization, and dehumanization.

Refounding health systems configures, then, a new epistemological starting point [4]. It assumes that government processes of the public sphere, including health systems, are always transitional processes.

It is not only the elimination of language, of the terminology and of the categories of the "reforms" of developmentalism or neoliberalism. *Refounding* seeks to propose a "categorical rethinking". The epistemic-theoretical intention is not limited to copying categories or concepts; rather, it seeks a problematizing incorporation of a new categorical corpus. Thus, reality thought with foregoing category is not the same; thereby, the epistemic intention inevitably becomes a transformation of the prior content of the concept or category, hence, the new content of the concept or category is relevant to the reality studied and addressed [7]. Lastly, it is to construct not so much new concepts and new analysis categories, but rather new "categorical frameworks", from where it Will make sense to use these new concepts and categories; *i.e.*, a categorical system expressed and materialized in argumentative systems of Latin American critical health thinking from the South.

The proposed categories for the refoundation and decolonization of health systems in the 21st century are presented.

1. Epistemology of health from the South and health sovereignty
2. Universal and inter-structural health systems as strategy to face the social determination of life and health
3. Comprehensive health care and living well
4. Territory and new territorialities. Cartographies of systems-networks
5. The public as a sphere and new health organizational architectures for the universalization of collective, integral, and interdependent goods
6. Political economy of comprehensive health care and living well
7. Democratization of government in health
8. Monitoring inter-sectionalities and health determinations

A categorical system is always an approach in transition and movement, placing the refoundation as the articulation of a popular, theoretical, technical, and political process in transformation dynamics. It does not constitute a proposal for "counterhegemony", but rather the production of an alternative framework from the global South.

Universal and intercultural health systems propose a critical revision in the construction of a new know-how, which treats the social determination of health and life [8] as the foundation of the bases of intercultural and decolonial universalism in the South. For Latin America and the Caribbean, this new know-how is, in turn, theory and strategy: the organization of universal systems; more than a final outcome, it is a strategy for coping with the determination and structuring inequities of inequality by social class, ethnicity, and gender [9]. This revision and comprehension demonstrate that it is not a mere medical perspective of universalizing biomedicine and vertical public health of population risk control. It is a universality in the 21st century, that does not presume itself to be a unique, mechanical and totalizing truth, but rather intercultural, territorial, intersectional and democratic.

For this reason, the organization itself, the care models, funding, work, management, and governance of health systems in the 21st century place at the core:

1. Comprehensive health care and living well, seeking to replace the myth of primary health care (PHC).
2. The territory and territorialities of collective ways of life.

Since the 1970s, with the Alma Ata meeting and declaration, passing through the assumptions of comprehensive PHC to the selective PHC of the United Nations International Children's Emergency Fund (UNICEF) and the Rockefeller Foundation, PHC became one of the axes and myths of the health discourse for the global South, raising relevant issues, such as health as a right, inter-sectoriality, participation, comprehensiveness; but also becoming a symbol of seduction of a kind of "totalizing truth" of a strategy that would solve everything the day it was implemented correctly. After more than 40 years since Alma Ata, after several evaluations, that PHC, in organizational materiality, it was condensed into a minimum of benefits for the poorest sectors of societies, such as the so-called "gateway" and an increasingly structured model within the basic packages that characterized neoliberal reforms. Currently, every agreement of the World Bank, together with the PAHO/WHO, about universal health coverage includes the PHC nomenclature as the center of "reform" strategies.

Of course, within this process, communities, people, organizations or actors and local health teams also sought to give it another meaning, with successes and errors [10].

From the From Latin American critical thinking in health, *comprehensive health care* (CHC) is proposed as the focus of the strategy of universal and intercultural systems. It has to do with articulating care and collective health, the production of "care", instead of "attention"; *comprehensive*, rather than "primary"; it is the intersection between *health* and *living well.*

In this sense, it is understood as a strategy focused on the territory in which health policies and actions combine categories, like *determination* and *intersectionality*, which intertwine social class, gender, and ethnicity with action strategies that privilege promotional-preventive enveloping spirals that act on collective ways of life, with timely response to singular health-disease processes and their rehabilitation. Strategies developed throughout the entire vital cycle: from birth to death, avoiding vertical programs aimed at a particular disease or segment of the vital cycle.

The territorial architecture of health systems has been constructed on the basis of hierarchical pyramidal logic, with a central place of health establishments (hospital, health center, others), population as "object", distribution of disease and death, universal homogeneity of medical care. In fact, theses in support of integrated health service networks imply a "functionalism" of health care services as a center and homogeneous institutional amalgam of articulated networks and hierarchical levels of resolution. These logics overlap the *health* approaches of the 21st century as agent of the State, which controls the social space with the ideal of achieving decisive health care-curative statehood and risk prevention and control of collective diseases.

The CHC epistemology, within the framework of refounding health systems, implies moving that institutional-bureaucratic geography of assistance and population control as an apparatus external to society, to a social geography where health systems are produced, intertwined, and constructed as a web of territories, territorialities, and dynamics of social reproduction at an urban-rural level. Here, health systems are expressed in open, heterogeneous, symmetrical health networks with institutional frameworks and territorialities of collective care and protection, not only articulated, but joined in strategies for living well and healthy quality of life.

The *molecular* expansion of a new institutionalism and territoriality, which places at the core *the territory* where life develops and collective health is socially produced, re-dimensions the morphologies required and the possible forms that health systems acquire in each country, territory, contextuality, without unique and canned recipes.

In synthesis, it would seem necessary to revise, from the critical health thought, the logic of living in a world of undisputed, totalizing, monocultural, scientific certainties.

A reconfiguration of knowing how we know in theories and policies about health systems in the 21st century is an invitation to suspend our habits of certainties, sophistry, dilemmas, liquid slogans, to develop from the potential of producing know-how alternatives from the South [11].

The butterfly effect, described by Lorenz [12], allows us to think about some coping approaches: studying small changes that, sometimes, from the local level, can produce "big" changes in health systems as complex systems. Identifying the key points of the reproduction dynamics of current matrices and locating transformation dynamics allow us to escape from theses of paralysis, subordination, reproduction, or determinism in the face of the complexity of thinking about health systems from the global South.

Promoting an epistemology to refound health systems and public policies is perhaps essential due to a triple need: theoretical, practical, and methodological for effective health sovereignty in Latin America and the Caribbean, as transformation horizon and reconstruction of hope.

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