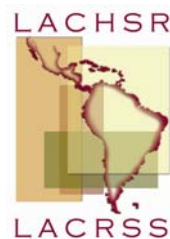


ANALYSIS OF HEALTH SECTOR REFORMS REGION OF THE AMERICAS



No. 12



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WASHINGTON, D.C.

JULY 2004

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No. 12



This publication was produced by the Pan American Health Organization. Partial financing was received by the United States Agency for International Development's Regional Office for Sustainable Development within the Bureau for Latin America and the Caribbean under the terms of Grant number LAC-00-97-007-00. Regular funds of PAHO/WHO were also used. The opinions expressed in this document are those of PAHO/WHO and do not necessarily reflect those of USAID.

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Graphic Design and Layout: Matilde Cresswell

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EXECUTIVE SUMMARY

In 1998, the Pan-American Health Organization (PAHO) requested countries in Latin America and the Caribbean (LAC) to submit country profiles based on the “*Guidelines for the Preparation of Health System Profiles for the Countries of the LAC Region.*” Such profiles were prepared by health sector national teams and submitted to peer review by recognized national academic Public Health institutions.

The Health Sector Reform Regional Analysis that follows includes information from 36 countries that submitted profiles by the end of 2003 and seeks to consolidate, compare and examine the similarities, differences and especially the progress countries have made in health sector reform (HSR). The content of this document, prepared by PAHO/WHO, is based exclusively on information reported by the countries National Health Authorities in their respective health systems profiles.

The health sector reform process in the LAC Region has varied in terms of its progress and added value in each country. Given that the LAC Region as a whole has a diverse range of cultures, languages, histories and levels of development, these differences are also reflected in the variety of reforms currently underway in each country. Though there are differences in each country’s process, design, and content of reforms, striking similarities across the Region do exist. For example, most countries in the Region began their reforms in the 1990s with the exception of a few such as Cuba, Brazil, and Mexico who began in the 1960s, 70s and 80s, respectively.

Quality health care that is accessible in an equitable manner to the entire population has triggered reform in most countries. Moreover, many countries report that the challenges faced by its public health system included the attainment of equity, quality of care and financial protection. Therefore, many reforms have focused on the means of obtaining equitable health systems that provide quality health care in a financially sustainable manner. This has proven to be an enormous challenge that countries of the LAC Region are struggling to achieve.

Most countries have developed specific agendas for the reform process, which revolved around basic objectives: the reorganization of the institutions that provide for the country’s health; the introduction of new modalities in the provision of health services; the improvement of the overall quality of care; and the reorientation of public resources to achieve efficiency and equity.

As many countries are undergoing economic structural adjustment and State Reforms, health has been incorporated into Modernization of the State and Health Sector Reform processes. Therefore, simultaneous changes are occurring within government structures and health care delivery systems, which impact the overall effectiveness and efficiency of HSR. However, at the time of submitting the country profiles, many countries still had not drawn up formal action plans that delineate quantifiable goals, deadlines and responsibilities. Although many countries do not have formal action plans, many are already in the process of implementing the reforms. Therefore, reforms have been implemented, in many cases, without specific quantifiable goals used as an endpoint. This is a less than ideal situation, which countries need to take notice of and improve as further reforms are designed and implemented.

Although the constitutions of several countries have been amended to include the right to health how this right is manifested varies widely among them. The term 'right to health care' has also been defined differently in each country, ranging from explicit definitions in St. Lucia to much more vague terminology, such as 'health protection' and 'social security by the State' in other countries.

Very few countries have reported clear evidence that the health reforms have influenced the overall effectiveness and quality of the health system. Nevertheless, indicators, such as infant mortality and maternal mortality, used to monitor these two objectives have improved in a few countries. It is difficult to assess the sustainability of the various health reforms due to their recent nature and the general lack of monitoring systems to evaluate them. Systems are currently being created in some countries to monitor financial sustainability in the health sector. Many countries have stated however, that their intentions and capabilities to create sustainable health systems still face constraints that hinder this process.

The LAC Region has progressed in many ways since the inception of the health reforms. However, a strong emphasis on a New Agenda for Health Reform¹ to include the following must be placed and maintained within all ranks of government and society in order to make quality health care a reality for everyone.

1. Interventions which improve health outcomes;
2. Health care models based on promotion and prevention;
3. Enforcement of the Essential Public Health Functions;
4. Comprehensive development of Human Resources;
5. Socially conscious financing mechanisms; and
6. Extension of Social Protection in Health.

¹ Mirta Roses, Director, Pan American Health Organization, *"The Steering Role of Ministries of Health: Challenges for the 21st Century"* Bridgetown, Barbados, 6 – 7 November, 2003.

1. MONITORING THE HEALTH SECTOR REFORM PROCESSES

BACKGROUND

By the mid-1990s virtually all countries of Latin America and the Caribbean (LAC) had initiated or were considering health sector reform (HSR).² However, defining the term “sector reform” has been a subject of constant debate.^{3,4} In the Americas, an international meeting convened in 1995 defined health sector reform as *“a process aimed at introducing substantive changes into the different institutions of the health sector and the roles they perform, with a view to increasing equity in benefits, efficiency in management, and effectiveness in satisfying the health needs of the population. This process is dynamic, complex, and deliberate; it takes place within a given time frame and is based on conditions that make it necessary and workable.”*⁵

In 1998, PAHO made available to the countries guidelines to facilitate the preparation and periodic updating of a report or profile of their respective health system.⁶ The *“Guidelines for the Preparation of Health System Profiles for the Countries of the LAC Region”* provide a systematic, synthetic and analytical description of the context in which the health systems are operating. It also includes an overview of the general organization, operation, and resources of the respective health systems. Lastly, it includes a section on monitoring and evaluation of HSR initiatives.^{7,8}

The Guidelines can be used in countries that have not yet carried out health reform, but where fundamental changes have taken place, which are not necessarily labeled as “reform.” Given the existing debate on what constitutes

² PAHO Executive Committee of the Directing Council, 26th Meeting of the Subcommittee on Planning and Programming: *“Progress of Activities in Health Sector Reform”*, SPP27/7, Washington DC, 25-27 March 1996.

³ Berman, P.: *“Health Sector Reform: Making Health Development Sustainable”*, Health Policy 32 (1995), pp. 13-28.

⁴ Saltman, R.B.; Figueras J.: *“Reforma Sanitaria en Europa. Análisis de las Estrategias Actuales”*, EURO-OMS y Ministerio de Sanidad y Consumo (esp.), Madrid, 1997, pp. 2-4.

⁵ OPS/OMS: *“Reunión Especial sobre Reforma Sectorial”* Washington DC, 1995.

⁶ As a result of an “International Meeting on Health System Profiles and Monitoring and Evaluation of Health Sector Reforms in Latin America and the Caribbean” which took place in PAHO/Washington DC in 1999 the Guidelines were reviewed and a new edition published in 2000.

⁷ PAHO 41st Directing Council: *“Monitoring and Evaluation of the Health Sector Reform Processes”*, CD41/14, San Juan, Puerto Rico, 27 September – 1 October 1999.

⁸ PAHO 124th Session of the Executive Committee, Resolution CE 124.R8 *“Monitoring and Evaluation of the Health Sector Reform Processes”*, Washington DC, 21-25 June 1999.

HSR, it is understandable that there remains conceptual and methodological problems related to the monitoring and evaluation of HSR that are far from being resolved.^{9,10}

The present analysis, hereafter called Regional Analysis, is based on the information contained in the section on monitoring and evaluation in the second edition, where available, of the *Profiles of Health Systems and Services*. The main objective of the Regional Analysis is to examine trends throughout the LAC Region. Table 1 shows the countries included in the Regional Analysis.

Anguilla	Bolivia	Costa Rica	El Salvador	Honduras	Panama	St. Kitts and Nevis
Antigua and Barbuda	Brazil	Cuba	Grenada	Jamaica	Paraguay	Suriname
Argentina	British Virgin Islands	Dominica	Guatemala	Mexico	Peru	Trinidad & Tobago
Barbados	Chile	Dominican Republic	Guyana	Montserrat	St. Lucia	Uruguay
Belize	Colombia	Ecuador	Haiti	Nicaragua	St. Vincent & the Grenadines	Venezuela

MONITORING THE DYNAMICS

Monitoring refers to the content of the ordinary activities of the health system. Reforms are processes that go through different stages or “moments” over time and involve many different protagonists. The moments may be identified progressively as: genesis, design, negotiation, implementation and evaluation of results. The protagonists may be divided into those whose actions take place mainly in society at large and those whose actions take place mainly in the public sector. These broad definitions laid the framework for qualitative data collection and analysis regarding the dynamics of HSR in the LAC Region.

The LAC Region as a whole has a diverse range of cultures, languages, histories, and levels of development. For example, national populations vary significantly from a hundred thousand in some Caribbean nations to over 170 million people in Brazil. Rural populations are much larger in some countries such as Ecuador or Haiti, than in other countries. Economic and social conditions vastly

⁹ Frenk, J.: “Comprehensive Policy Analysis for Health System Reform”, *Health Policy* 32 (1995) 257-277.

¹⁰ Infante A.: “La elaboración de perfiles de sistemas de servicios de salud y el seguimiento y evaluación de las Reformas del Sector como instrumentos para el desarrollo de políticas sanitarias en las Américas,” en: Mesa redonda sobre investigación en salud pública y desarrollo. Jornadas de Cooperación Sanitaria: Salud, la clave del Desarrollo. 29 junio-1 julio, Ministerio de Sanidad y Consumo, OMS y AECl (mimeo) Madrid, 1998.

differ including a range of GDPs as well as varying percentages of national budgets spent on health systems and services. Health conditions also differ across the region, where life expectancy at birth, infant and child mortality and maternal mortality are key indicators of the health of a country. With these differences in mind, looking for trends across such a diverse region can pose a challenge in that the analysis must be accurate and precise without being so broad that concrete conclusions are unattainable. In this case, trends have been identified in countries that clearly exemplify similarities based on the content of the country profiles.

ORIGIN OF THE REFORMS

The origin of the reform processes has varied by country. In Bolivia and Venezuela, the process has been underway for several decades, spurring major changes in some instances and having little impact in others. Cuba is one of the few exceptions that began HSR in the 1960s along with the reform process after the Revolution. However, for the most part a majority of the countries began HSR in the 1990s.

TABLE 2: ORIGIN OF THE REFORMS

1960s	1970s	1980s	1990s	2000-present
Bolivia, Cuba, Trinidad and Tobago				
	Brazil, Jamaica			
		Chile, Costa Rica, Guatemala, Mexico, Venezuela		
			Argentina, Paraguay, Suriname, Uruguay, remaining English-speaking Caribbean ^a , Caribbean ^b and Andean ^c countries	
				Haiti

^a Anguilla, Antigua and Barbuda, British Virgin Islands, Barbados, Grenada, Guyana, Montserrat, St. Lucia, St. Vincent and Grenadines
^b Dominica, Dominican Republic
^c Colombia, Ecuador, Peru

A number of factors influencing HSR can be observed across the region. For example, reform occurred in most countries because of the need for quality health care that was accessible and equitable to the entire population. Mexico noted three challenges faced by its public health system: equality, quality, and financial

protection. Similar concerns were echoed throughout the region as HSR was initiated. Other countries, such as Barbados, Suriname and Argentina, indicated that HSR began with structural adjustment measures and/or public sector reform of the State. A few instances of HSR were instigated by natural disasters, such as volcanic activity and hurricanes in Dominica and Montserrat. Specific factors, such as Bolivia's 1994 law on public participation, catalyzed HSR in certain countries.

TABLE 3: REPORTED FACTORS FOR INITIATING HEALTH SECTOR REFORM

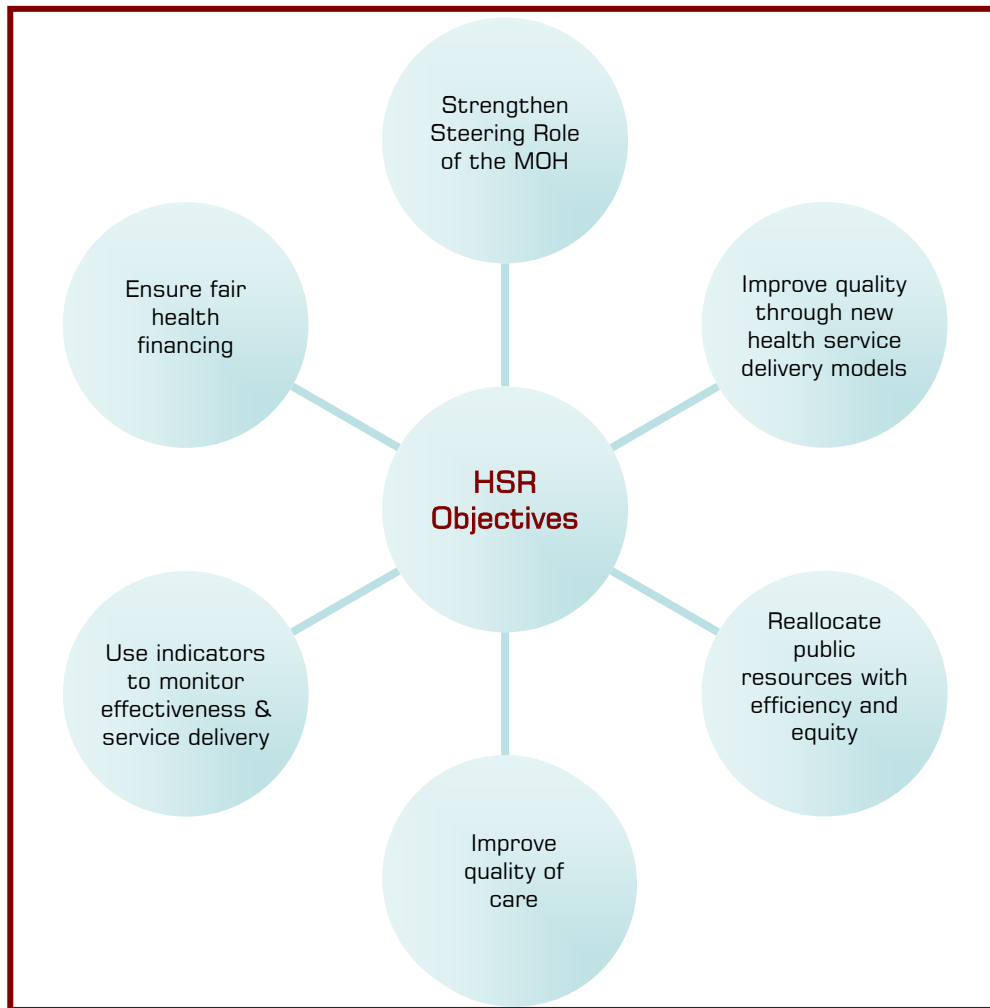
COUNTRY	FINANCIAL STABILITY, QUALITY & EQUITY OF HEALTH SERVICES	STATE REFORMS	FOSTER PRIMARY HEALTH CARE STRATEGIES	IMPROVE MANAGEMENT	IMPROVE PUBLIC PARTICIPATION	NATURAL DISASTERS
Anguilla			X			
Argentina		X				
Barbados		X				
Belize	X					
Bolivia					X	
Brazil	X					
Chile		X				
Costa Rica	X			X		
Colombia		X				
Cuba	X	X				
Dominica			X			X
Dominican Republic	X					
El Salvador	X					
Grenada		X				
Guatemala	X					
Guyana				X		
Haiti		X				
Honduras	X				X	
Jamaica	X					
Mexico	X					
Montserrat						X
Nicaragua	X					
Panama	X					
Paraguay	X					
St. Lucia		X				
Suriname		X				

TABLE 3: REPORTED FACTORS FOR INITIATING HEALTH SECTOR REFORM						
COUNTRY	FINANCIAL STABILITY, QUALITY & EQUITY OF HEALTH SERVICES	STATE REFORMS	FOSTER PRIMARY HEALTH CARE STRATEGIES	IMPROVE MANAGEMENT	IMPROVE PUBLIC PARTICIPATION	NATURAL DISASTERS
Trinidad & Tobago			X			
Uruguay				X		

The principal protagonist of the reforms was primarily the Ministry of Health (MOH), which in some cases worked in collaboration with an Institute of Social Security. Other organizations that were involved include: the Inter-American Development Bank (IDB), the World Bank, the Pan American Health Organization (PAHO)/World Health Organization (WHO), and a variety of non-governmental organizations.

In order to include the opinions and demands of the population, approximately one-third of the countries reported some form of community involvement during the planning stages of the health reform process. For example, in Honduras, rural organizations, professional colleges, hospitals, municipal associations and private companies were involved in the development of the HSR. In the countries of the Andean region, the opinions and demands of the population were initially not taken very seriously. However, the importance of public participation was later recognized and acknowledged through the creation of committees and laws that strengthened public participation. For example, in 1997 Ecuador enacted the Decentralization and Social Participation Law that mandated. A few countries (e.g. Guatemala and Haiti) explicitly mentioned that the population was not involved in the planning process, whereas others did not address social participation in the profiles.

DIAGRAM 1: CORE HSR OBJECTIVES IN LATIN AMERICA



Nearly all countries have drawn up specific agendas for reforming the health sector, which vary between each country. As a sub-region, the Caribbean countries have all declared health promotion as an HSR objective, as stated in the 1993 Caribbean Charter for Health Promotion. Other common objectives across the entire LAC region were: the reorganization of the institutions that provide for the country's health; the introduction of new modalities in the provision of health services; the improvement of the overall quality of care; and the reorientation of public resources to achieve efficiency and equity.

Health Sector Reform has been incorporated into the plans and programs for modernization of the State in most countries. All of the countries in Central America reported that health sector reform was included in the larger national public sector reform process. In Peru and Venezuela however, government instability has hindered efforts in State reform, thus destabilizing health sector reform as well. As a whole, all countries included the health sector in the development and modernization of the State.

TABLE 4: REPORTED HEALTH SECTOR REFORM OBJECTIVES CLASSIFIED BY COUNTRY

Strengthen Steering Role of the MOH	Improve quality through new health service delivery models	Reallocate public resources with efficiency and equity	Improve quality of care	Use performance indicators to monitor effectiveness and service delivery	Ensure fair health financing
Argentina	Argentina	Anguilla	Anguilla	Barbados	Anguilla
Belize	Brazil	Barbados	Barbados	Dominica	Argentina
Bolivia	Costa Rica	Belize	Cuba	Montserrat	Barbados
Chile	Cuba	Brazil	Dominica	St. Lucia	Dominica
Costa Rica	Dominican Republic	Colombia	Jamaica		Grenada
Cuba	El Salvador	Costa Rica	Mexico		Guyana
Dominican Republic	Mexico	Cuba	Saint Lucia		Mexico
El Salvador		Dominican Republic	Trinidad & Tobago		Paraguay
Haiti		Grenada			St. Lucia
Guyana		Guatemala			
Mexico		Jamaica			
Nicaragua		Mexico			
Panama		Panama			
Paraguay		St. Lucia			
		Suriname			
		Trinidad & Tobago			

DESIGN OF THE REFORMS

The main entities responsible for designing the reform processes were primarily the Ministries of Health, in collaboration with other ministries, legislative bodies, institutes, universities, national government aid agencies, and multilateral donor organizations. For example, the Ministry of Health in Bolivia has always been the leader in health reform since the 1980s; however it has also received support from the World Bank and the IDB. In Colombia, multisectoral consensus-building was the catalyst for reform among the Ministries of Health, Education, Labor, and the Planning Directorate, with the support of the Legislative Branch. Other parties involved in the reform process across the region include the World Bank, the Inter-American Development Bank, government aid agencies (United States

Agency for International Development, Canadian International Development Agency, UK's Department for International Development, the Dutch Government, the European Union, Japan, the French Technical Cooperation Agency, and the German Technical Cooperation Agency), PAHO/WHO and universities.

NEGOTIATION OF THE REFORMS

In every country the Ministries of Health exerted leadership in the negotiation of the health reform process. In several countries, such as Cuba, Guyana, and Jamaica, a variety of stakeholders were involved in the negotiation process to determine the objectives and content of the Health Sector Reform Project. Policy negotiations on the reforms have involved various national actors, as well as international agencies, which have provided economic and technical assistance to the initiatives. In several instances, the multilateral lending organizations played a significant role in determining the content of the health sector reform in order to comply with loan specifications.

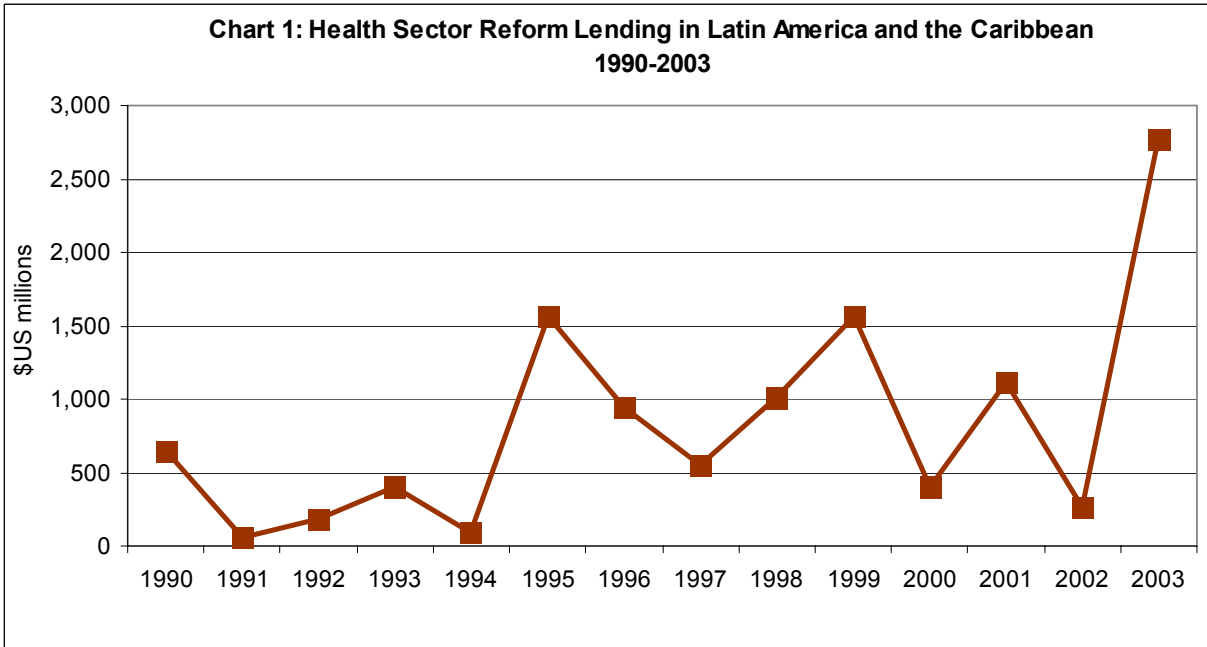
IMPLEMENTATION OF THE REFORMS

At the time of submitting their profiles, many countries still did not have plans of action that delineated quantifiable goals, dates and responsibilities. Of the Andean countries, Chile was the only country that had a with an action plan for implementing health reforms through political action and quantifiable goals in the short, medium and long term. In the Caribbean, specific action plans with goals and responsibilities were identified in Anguilla, Barbados, Dominica, Guyana, Jamaica, Saint Lucia, Suriname, and Trinidad and Tobago. Most of these countries have moved into the implementation stage with some being in a more advanced stage than others. Brazil, Cuba, Costa Rica, Mexico, Panama and The Dominican Republic also have plans of action that include goals, dates and responsibilities.

FINANCING OF THE REFORMS

In most of the countries, health reform was funded by external sources such as the Inter-American Development Bank (IDB) and the World Bank in the form of loans, credits as well as analytical studies to support the reform process. These donors, along with others mentioned in the "Design of the Reforms" box above, have funded a variety of studies ranging from examining the public expenditures for health care to the burden of specific illnesses on the health care system. To illustrate the magnitude of investments in health sector reform, Chart 1 shows World Bank and Inter-American Development Bank (IDB) lending from 1990-2003 for health sector reform operations in Latin America and the Caribbean.¹¹

¹¹ Data based on information available on the World Bank and Inter-American Development Bank (IDB) websites.



STATUS OF THE REFORMS

Currently, the health sector is undergoing a reform process is underway in most countries of Latin America, though it is in different stages throughout the region. Some countries, where government instability has hindered the process, the HSR is at a standstill. Countries such as Haiti and Peru have had problems initiating the HSR process due to changes in their respective governments. Haiti faces several challenges due to a lack of external funding and lack of political commitment to promote the reform process. Countries such as Guatemala have already begun implementing reforms have had to make changes to the objectives and strategies. In Guatemala it was necessary to include the Guatemalan Institute of Social Security in the initiatives that extend coverage to informal workers. In other countries, such as Panama and Costa Rica, no changes were made in the objectives and strategies once implementation of the reforms had begun.

PARTICIPATION AND INVOLVEMENT OF THE POPULATION

Several countries documented that a variety of stakeholders were involved in the implementation of the reforms including: health officials, private hospitals, health workers as well as the general population. For example, in Brazil 99% of the municipalities and all of the states have formed health councils where health workers, users of the health facilities, and public loaners participate in discussions on health reform. In Honduras, the relevant actors in the negotiation process were the Association of Municipalities of Honduras, college professionals, private companies, civil society organizations, lawmakers and policymakers.

EVALUATION CRITERIA

With the exception of Colombia, where different state organizations, NGOs, and academic institutions have conducted evaluations and made recommendations to improve the health system, none of the Andean countries established evaluation criteria from the outset of its reform processes. However, when Bolivia evaluated its two main initiatives (insurance for mothers and children and basic health insurance) in 1998 and 2000, it found that they were not reaching the target group and were not well-known. Similarly, in the English-speaking Caribbean region, Jamaica was the only country that presented evidence that evaluation criteria or monitoring mechanisms for the reform process were included at the outset. In Central America, Costa Rica was the only country that established general criteria for evaluation for one of the specific projects in the HSR. The other countries were all in the process of defining and creating mechanisms for evaluation at the time the second version of their profiles were complete. Mexico and Cuba have both designed evaluation strategies to monitor HSR.

A few countries have evaluated certain aspects of their reform processes. In Nicaragua, the World Bank initiated the first evaluation of the process looking at the advances, strengths, and weaknesses of the reform process. Recent data indicated that a small increase in health coverage was attributable to the reforms. Cuba has already performed several evaluations that look at the basic health indicators, the participation of sectors, the development of the costing system, and indicators for the budget of health services, among others.

CONCLUSION

A majority of the countries in the LAC region began their processes of health reform in the early 1990s. However, a few countries, such as Cuba, Jamaica, Mexico and others, initiated their HSR as early as the 1960s.

The most common issue that spurred HSR in the region was the need for financial stability, quality, and equity of health services. Many countries also cite that HSR occurred in conjunction with State reform processes and structural adjustment programs.

In most cases, HSR processes have been incorporated into the plans and programs related to the modernization of the State. Approximately one-third of the countries reported that the opinions and demands of the population were taken into account when designing the reforms. As a whole, Ministries of Health have had a leading role in the design of the reforms. However, several multilateral lenders and bilateral aid agencies, as well as academic institutions have been instrumental in providing technical and financial support to the reform processes.

Nearly all countries have drawn up specific agendas for reforming the health sector, which vary between each country. In every country the Ministries of Health exerted leadership in the negotiation of the health reform process. In several countries a variety of stakeholders were involved in the negotiation process to

determine the objectives and content of the Health Sector Reform Project. However, at the time of submitting their profiles, many countries still did not have plans of action that delineated quantifiable goals, dates and responsibilities.

Nevertheless, the reform process is underway in most countries, though it is in different stages throughout the region. Evaluation of the processes has occurred in a handful of countries. It is assumed that once plans of action are formalized in each country, the evaluation criteria will follow suit.

2. MONITORING THE CONTENT

LEGAL FRAMEWORK

As part of the reform process, many countries have amended their political constitution to have a direct or indirect impact on the development of the health sector. In the Andean sub-region, all of the countries with the exception of Bolivia and Chile made constitutional amendments regarding health reform. For example in Ecuador, constitutional amendments were implemented to firmly establish a right to health, the responsibility of the State to guarantee its exercise, and the provision of free public health programs and medical services to those who need them (although the Constitution does not specify those who are in need). Legislative acts in Ecuador have materialized through the Modernization Law (1993), the Free Maternity Services Law (1994), and the special Decentralization and Social Participation Law (1997). Other countries in the Andean region—Peru, Colombia, Bolivia and Chile—also passed similar laws that focused on issues such as modernization of social security in health, decentralization of the health sector, health financing and the involvement of private service providers in health systems.

In countries where new governments have recently formed, opportunities to incorporate health into legal frameworks have emerged. For instance, in Venezuela a new Constitution was ratified in 1999, laying the groundwork for establishing a legal status and organizational model for the Venezuelan health sector.

Modifications to the Constitutions and/or basic regulations in the health sector were made in Costa Rica, the Dominican Republic, Nicaragua, Guatemala, and Panama. The Dominican Republic has had four Presidential Decrees regarding HSR, focusing on the creation of an executive commission on HSR, the development of provincial health administrations, the access and sale of medications, and the general regulation of hospitals. In addition, to these decrees, a variety of laws were passed with regards to public health. Similar laws on decentralization, social security, and health services have been created throughout the region.

Modifications to the Constitution or the legal framework have also been made in a few Caribbean countries, including Jamaica, Guyana, Trinidad and Tobago, Suriname, and Dominica. Over the past few years, Cuba's development in the public health sector has gone beyond the stipulations in the Public Health Law. A new legal framework will be adopted that is in accord with the involvement of other sectors and the central role of the community. In Mexico, the General Health Law has incorporated modifications that make health deregulation more effective, such as introducing a new classification of medications and permitting the development

of generic drugs in the private market. Brazil, Argentina, and Paraguay also have similar laws focusing on decentralization and the quality of health services.

Few countries have defined the term 'equity' in their legal framework. In Costa Rica it is defined in the General Health Law; in Guatemala it is in the Health Code; and in Nicaragua it is in the Constitution. Most countries did not address this issue in their profiles, making it difficult to assess the number of countries that do not define equity in their legal frameworks.

A few of the judicial changes in certain countries reflect an intersectoral approach to health. For example, Panama's Law No. 2 establishes a regulatory framework for the provision of drinking water services and sewage systems. In Costa Rica, the judicial instruments has allowed the Ministry of Health to work in collaboration with other sectors on emerging problems such as HIV/AIDS and reemerging problems like malaria.

LEGAL FRAMEWORK

- Most countries in the LAC region have made changes to their Constitutions and/or regulatory frameworks with regards to the health sector.
- Costa Rica, Guatemala and Nicaragua are the few countries with definitions of "equity" in their legal frameworks.

RIGHT TO HEALTH CARE

The right to health care is defined in most countries, either in their constitutions or laws. In the Andean sub-region, the right to health care is clearly established in the constitutions of all countries, except Peru, where the General Health Law confers responsibility of the State for providing public health services and universal progressive insurance. Health care is considered to be a fundamental right to all citizens in the English-speaking Caribbean sub-region, though a few countries such as Trinidad and Tobago do not explicitly state the right to health care in its Constitution, but rather in legislative mandates. Other countries, such as Paraguay, Cuba, Haiti, Brazil, and Mexico, refer to the right to health care within their constitutions.

Some countries have explicitly defined the right to health care. For example, St. Lucia envisages that the right to health care is to be guaranteed through increased access to health services, anti-discriminatory legislation, equitable financing arrangements, a basic package of health services, and regulation/licensing of health care providers. Other countries have defined it in broader terms, such as "health protection" in Bolivia and Chile, and as an inalienable right to "social security provided by the State" as defined by Colombia. In many countries, health care is designed to be free or minimally expensed in the public sector. In Belize, the right to health is specifically mentioned in the Manifesto of the governing party and is well-known throughout the population. Brazil has also effectively conveyed its right to universal health care through

programs that focus on increasing the attention to health care. However, in most countries efforts to inform the public about this right have not been adequately undertaken.

Challenges remain for several countries that have recognized the right to health care but are unable to produce the desired outcomes. For example, although the right to health is explicitly addressed in Honduras, no mechanism exists to make it a reality. The right to health care is sometimes not even guaranteed, in the case of Guatemala.

In a variety of countries, strategies have been designed to increase the coverage of health services. In Mexico, the principal strategy of reform from 1996 to 2000 was to increase health coverage for the uninsured populations. By the year 2000, only half a million people did not have access to the health system in comparison to 10 million in 1996. In Colombia, the strategy has been based on promoting regulated competition among insurers (public and private), in both the contributory regimen and the subsidized one. In Haiti, the strategy to increase coverage focuses on the formation of community health units, which incorporate community participation in local health facilities. Programs in El Salvador emphasize an increase in health coverage amongst the indigenous population.

Several countries have taken steps to design a plan that includes a basic set of health benefits. In Cuba, the entire population has health care coverage. The benefits of the national health plan include education and promotion programs, treatment, rehabilitation, and the use of diagnostic and therapeutic services. In the English-speaking Caribbean sub-region, a basic package of health services at the primary level has been defined in Antigua, Dominica, Montserrat and Trinidad and Tobago.

In Jamaica, as in many of the English-speaking Caribbean countries, a national insurance/social security system is in place. However, as in the case of most of the countries, it only includes a limited retirement program and some provisions for sick leave and reimbursement for selected services. In Bolivia, basic health insurance has been designed for children, women, and families. Similarly, Colombia and Peru have established basic packages of care for children and families.

RIGHT TO HEALTH CARE

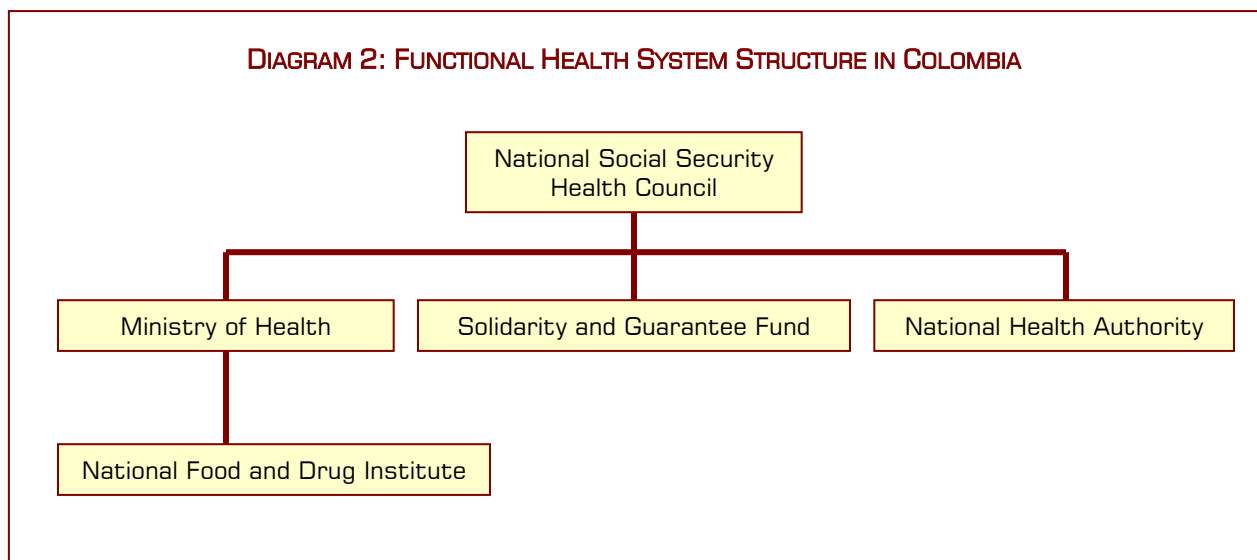
- The following countries declare the right to health care in their Constitutions: Anguilla, Antigua and Barbuda, Barbados, Bolivia, Brazil, Chile, Colombia, Cuba, Dominica, Ecuador, Grenada, Guyana, Haiti, Jamaica, Mexico, Montserrat, Paraguay, Suriname, Venezuela
- Many countries have designed strategies to increase the coverage of health services and establish a basic set of health benefits.
- Basic health insurance systems have been developed in a select number of countries.
- Challenges remain for several countries that have recognized the right to health care but are unable to produce the desired outcomes.

STEERING ROLE

Many countries in the LAC region are taking steps to revise and review the steering role of institutions involved in the health sector. Ministries of Health have the primary steering role in all countries. In Chile, the Ministry of Health has been restructured, and the Public Health Institute has been charged with registering drugs and medical devices and ensuring their quality. Although the Ministry of Health in Mexico is the primary navigator for health, the states are responsible for the provision of health services through the Decentralized Public Agencies that were established from 1997 to 1999 in every state to administer, direct and supervise health services. In the Andean and English-speaking Caribbean sub-regions, all of the countries participated in an exercise that measured the basic public health functions of each country. This has led to reviews and evaluations of current steering role functions in most of the countries. For example, in Costa Rica, the Ministry of Health is working on the design of its strategic functions and its overall organizational structure, while developing a new financial model. Thus, changes are being made to the hierarchy structure of health authorities throughout the region in order to adapt them as the primary steering role.

The separation of essential functions in the health sector has been undertaken in a few countries in the region. In Paraguay, a public law on the National Health System helped lead to the creation of the Health Authority, the National Medical Office, and the Public Health Fund under the National Health Council.

Diagram 2 demonstrates the functional health system structure that was formed in Colombia, with the National Social Security Health Council as the primary steering agency.



This structure is comprised of: 1) the Ministry of Health, which issues policies and at the local level is represented by sectional health services and municipalities; 2) the National Social Security Health Council, which is the steering agency and exercises other functions, such as determining the unit of payment for training; 3) the Solidarity and Guarantee Fund, which manages finances; 4) the National Health Authority, which oversees, monitors, and regulates insurance and service delivery; and 5) the National Food and Drug Institute under the Ministry of Health. Many countries however, do not explicitly separate financing, procurement and service delivery responsibilities. For instance, in Brazil all three levels of government participate in financing, though most resources originate at the federal level.

Very few countries have documented the presence of mechanisms for holding public institutions accountable for their designated functions. Of the few, Panama instituted a law, Law 28, where one of its regional hospitals is obligated to report to the Ministry of Health on its provision of services and agreements.

STEERING ROLE

- The Ministry of Health has the primary steering role in all countries.
- The following countries have revised the steering role of the leading health institution: Brazil, Chile, Colombia, Ecuador, Jamaica, Mexico, Paraguay, Trinidad and Tobago, Uruguay.
- Many countries do not have an explicit separation between financing, procurement, and service delivery.
- Very few countries reported the presence of systems to hold public institutions accountable for their functions with the exception of Panama.

MODALITIES OF DECENTRALIZATION

Decentralization is occurring at a rather slow pace in most countries. Most countries in the LAC region are currently undergoing or have already gone through a process of decentralization within the governments and the health sector. Although processes of decentralization are underway, the health structure is still very centralized. In Guyana and Suriname, the administrative levels of health systems are being reviewed to decentralize health services; however, these efforts are not necessarily linked to other efforts to decentralize public administration. Chile decentralized its National Health Service in 1980, dividing it up into 26 Health Services and transferring primary health care to the municipalities. Functions, competencies, and resources for planning, management, and decision-making have been transferred from the central level to the site of services. However, in many cases the act of decentralizing the health sector is still in its infancy. For example, Bolivia enacted the Decentralization and Public Participation Laws in 1994, which calls for the transfer of health infrastructure

and equipment from the central level to the municipalities. However, to this date the Ministry of Health continues to administer human resources.

In many countries, responsibilities, authority, and resources are being transferred to the subnational level. For example, in Jamaica and Trinidad and Tobago, decentralization has been achieved through the establishment of Regional Health Authorities (RHA). The RHAs primarily manage the delivery of health services, though resources are centralized. In Brazil, a new instrument for regulating decentralization established the Health Care Operating Standard which expands the primary care responsibilities of municipalities; defines the process for regionalizing care; creates mechanisms for strengthening the Unified Health System management capacity; and updates criteria for the authorization of states and municipalities. Despite a number of existing instruments, activities in the areas of health promotion, protection, and recovery continue to lack coordination in sector planning.

MODALITIES OF DECENTRALIZATION

- Most governments are currently going or have gone through a process of decentralization within the governments and the health sector yet in many cases the act of decentralizing the health sector is still in its infancy.
- The following countries have transferred responsibilities from the national to the sub-national level: Belize, Bolivia, Chile, Colombia, Ecuador, Guatemala, Guyana, Jamaica, Nicaragua, Panama, Paraguay, Suriname, Trinidad and Tobago, Venezuela.

SOCIAL PARTICIPATION

Social participation and regulation has been a stated objective in many countries in the LAC region. A few countries which have not included participation as one of the objectives of sectoral reform, such as Costa Rica and El Salvador, indicate that it is still included in its components, principles and values.

Various mechanisms have been established to make social participation operational. In Argentina, some jurisdictions have Local Health Boards and Area Health Boards. The former plays a decisive role in formulating and implementing local policies to complement those in force at the area and provincial levels. In addition to technical personnel, they include community representatives and health workers. The latter are also political entities responsible for the relationship between the communities and hospitals of the area and the higher jurisdictional level. They provide a forum for discussion of area health problems and are made up of technical personnel, Local Health Boards, and health worker representatives.

Similarly, in Paraguay, Local Health Councils prepare a plan jointly with all the local actors indicating the community's most pressing health needs and the action strategies that can be implemented. This plan eventually becomes a legal

document, signed by the responsible officials in the community who will carry it out, after defining systems for obtaining funds.

Other countries have Social Participation Laws, which in the case of Bolivia gave rise to surveillance committees where the population has an opportunity to discuss health problems. However, lack of economic resources and training often makes it difficult to truly implement such initiatives. Guatemala also indicated that the mechanisms to facilitate participation are rather weak. In Guatemala, there are no formal community organizations and legal constituencies that ensure health promotion and care. Therefore, many countries still need to establish formal and perhaps legal entities that will ensure that social participation is appropriately included in the reform process. Additionally, more resources are required to promote the process of social participation.

Very few countries have made reference to groups traditionally excluded from decision-making. Costa Rica and Bolivia mention cultural diversity and the need for gender focused approaches in the health sector. In Honduras, the participation of the indigenous population and rural women has been encouraged in certain regions of the country.

SOCIAL PARTICIPATION

- Social participation and regulation has been a stated objective in many countries.
- Lack of economic resources and training has made it difficult to ensure that social participation initiatives are upheld.
- Very few countries have made reference to groups traditionally excluded from decision-making with the exception of Bolivia, Costa Rica and Honduras.

FINANCING AND HEALTH INFORMATION SYSTEMS

The majority of the countries agree for the need to improve information systems on health financing and expenditure and various countries are making efforts to do this. Many are working towards the establishment or elaboration of National Health Accounts (NHAs). The following countries have begun the process of creating NHAs: Argentina, El Salvador, Guatemala, Honduras, Panama, Paraguay, Ecuador, Barbados, Dominica, Guyana, Jamaica, St. Vincent and the Grenadines, Suriname and Trinidad and Tobago.

In Chile, these systems have been developed to a greater degree at the hospital level as a result of diagnosis-related payment systems, where individual accounts are generated by patient and by diagnosis. These systems have been reliable and comparable, making it possible to consolidate information and calculate macro-level indicators of health activities. The Dominican Republic is working on a total financial reestablishment in order to orient resources to the poorest groups by means of a decentralized system of contract assignments.

Brazil is working on creating a number of information systems that track specific information for different purposes. The Ministry of Health created the Hospital Pricing Index as a means of providing managers with up-to-date information for comparing prices for drugs and medical/hospital equipment, as well as supplies and services used in the health system. The Hospital Pricing Index serves as a market regulatory instrument and a tool for improving management practices for the procurement of basic health care supplies. Another project underway is the Public Health Budget Information System, designed to track public health expenditures and monitor compliance, linking sector resources.

The Caribbean sub-region has benefited from a variety of initiatives and regional trainings on financial reform. For instance, the Office of Caribbean Program Coordination PAHO/WHO established a Working Group on Health Financing Reform for Barbados and Eastern Caribbean countries. The major focus of this Working Group is to contribute to the necessary coordination to successfully move forward on a five-year plan of action for health financing reform in this region. The components of the action plan are: improvements to health financing models; development of a set of health benefits; modifications to provider payment mechanisms; skills development in health economic analyses; and improvements in health financial management systems.

In the English-speaking Caribbean sub-region, policy makers have expressed the need to have a frame of reference to assess the pertinence of national health insurance proposals. In response to this need, the Office of Caribbean Program Coordination PAHO/WHO undertook an initiative to develop a guidebook designed to assist Eastern Caribbean countries in the decision-making process with regards to introducing national health insurance. In Dominica, a low acceptance of a national health insurance scheme led to the implementation of a user fee system. However, due to gross under collection, negative impact on access to care, over-priced services and significant public dissatisfaction, a schedule of reduced fees with exemption for certain categories was implemented. In other countries, such as Argentina, health services have traditionally been free and universal.

A few countries have also taken action to upgrade information systems to assist in decision-making. In most Central American countries information systems are either being developed or are in the implementation phase. In Costa Rica, various information systems exist with regards to health, insurance, health financing, and the provision of services. However, the heterogeneity has limited the analysis and the opportunity to make decisions. In Cuba, a large emphasis is placed on guaranteeing that information systems generate periodic reports containing pertinent information in order to set priorities, make decisions, and allocate resources at the different decision-making levels of the National Health System.

FINANCING AND HEALTH INFORMATION SYSTEMS

- The following countries have begun the process of creating National Health Accounts: Argentina, El Salvador, Guatemala, Honduras, Panama, Paraguay, Ecuador, Barbados, Dominica, Guyana, Jamaica, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.
- Plans and discussions to design a National Health Insurance Scheme are underway in some parts of the Caribbean.

SERVICE DELIVERY

As a result of the changes brought on by health reform, new health care modalities are being introduced and countries with a strong insurance component have based the supply of health services on the demand for them. For example, in Chile this has fostered a move toward a more integrated, family-based approach. Thus, primary care physician's offices are being transferred to Family Health Centers with per capita financing with the goal of increasing the response capacity of outpatient care. In Mexico, the creation of Popular Health Insurance represents a de facto modification in the model of care provided by the Ministry of Health, clarifying that user benefits are a right while replacing the fees charged to patients for services rendered with a prepayment. Other countries are making changes according to the immediate needs of their country. For example, Nicaragua has indicated that it is modifying its delivery of health services with regards to the epidemiologic transition that is currently facing the country.

Various countries are making changes in all three levels of health care. In Nicaragua services offered at the primary level have been modified following the results of investigations with vulnerable populations, with a focus on gender and zoning, and defining criteria for the commencement of programs and the exoneration for the payment of services. In Brazil, outpatient and home services continue to be expanded and strengthened through a variety of strategies ranging from modification of the basic model of care to the preparation of plans for the regionalization of services.

Several countries are giving priority to vulnerable groups. For example, Paraguay's new administration is centralizing the management of the programs in a General Programs Office, which will give priority to maternal and child care and focus attention on rural and indigenous populations. Bolivia and Colombia both have programs that target vulnerable groups, such as mothers and children under five, indigenous populations, the elderly, and groups at epidemiological risk.

In Cuba, new and efficient services such as outpatient surgery, early discharge, and house calls have been introduced. Referral and back-referral systems have been strengthened, performing systematic analysis of qualitative and quantitative indicators, which have helped assess situations in order to make timely decisions. In the Andean sub-region, no countries have instituted concrete changes designed

to improve the referral and counter-referral systems, whereas several countries in Central America are strengthening this aspect of their health systems.

Though many countries have expressed their commitment to improve and modify service delivery, some have not yet realigned new resources to achieve these goals. For instance, one of Guyana's primary objectives of health reform is to improve Primary Health Care; however it has not allotted new resources or services to achieve this.

SERVICE DELIVERY

- Service delivery is being modified in most countries in the LAC region.
- The following countries specifically mention services focused on vulnerable groups: Argentina, Bolivia, Colombia, Mexico, Paraguay, Suriname
- Many countries have not addressed the inclusion of new approaches such as outpatient surgery, early discharge, and house calls as well as the need to strengthen referral and back-referral systems.
- Although many countries have expressed their commitment to improve and modify service delivery, some have not yet realigned new resources to achieve these goals.

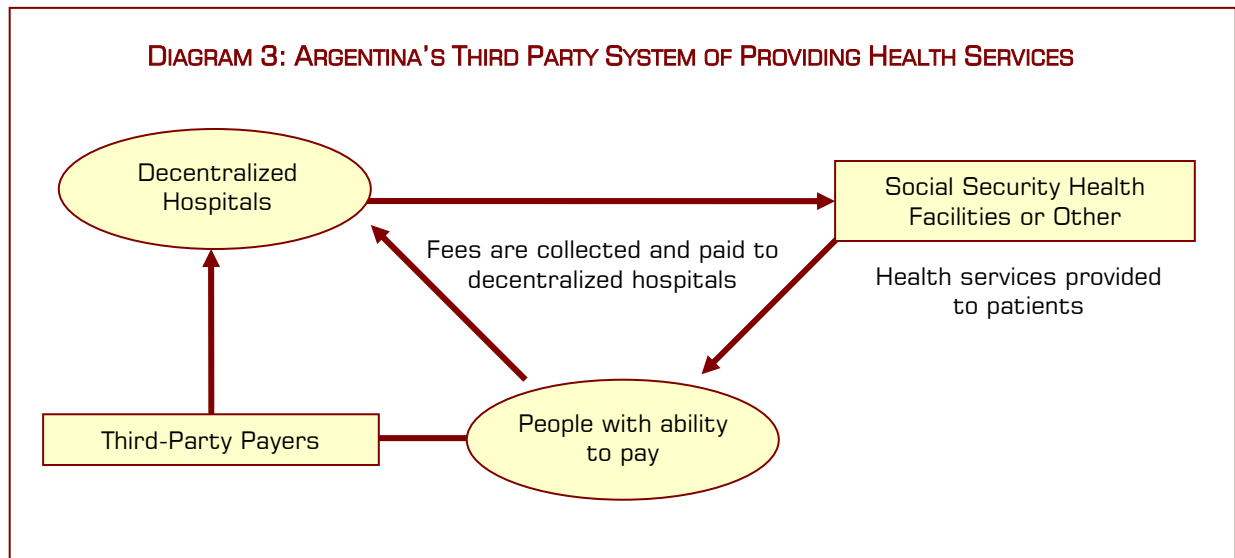
MANAGEMENT MODEL

Most countries have introduced general changes to the management model. In Panama, the principal change has been the active participation of the Management Council and the National Health Coordinator who both act as protagonists in coordination with the Ministry of Health and the Social Security Office. Cuba has seen a profound transformation of the health management model which has served to strengthen the grassroots level, promote a greater exchange of information and increase the regulatory presence of the Ministry of Public Health. This has fostered improved program implementation and control in the provinces and has enhanced the expertise of key actors to identify priority problems in the sector and propose solutions.

Commitments and management contracts between different levels of the public health system have been made in a select few countries. Guatemala has created commitments between the Ministry of Health and the managers of regional areas to ensure increased coverage and the reduction in the level of certain illnesses. Nicaragua has introduced similar commitments. Management commitments were introduced in Bolivia to handle maternal and child insurance. In Bolivia, the year 2000 marked the beginning of autonomous hospital management and management contracts were drawn up with some districts, although the mechanisms for regulating them were not well-defined.

A few countries have mentioned the issue of clearing legal obstacles to purchasing and selling services to third parties. In Argentina, regulations for

decentralized hospitals have provided the legal framework for the purchase and sale of third party services. Diagram 3 demonstrates the relationship between the various actors involved in the provision of health services in a third party system as reported by Argentina.



These regulations permit hospitals to enter into agreements with social security facilities or other entities, collect fees for services from people with the ability to pay or from third-party payers and set up service networks.

The Social Security Institute has launched a study looking at the feasibility of subcontracting certain specific services, such as housekeeping and food service to third parties. In Chile, there is also the legal and institutional possibility of purchasing and selling services from and to third parties through the public system. This generally applies to support services, specialized facilities, and territorial areas administered by the population.

While introducing changes to management, very few countries are leaning towards privatizing public facilities. For example, Argentina documented that the decentralization of hospital management has given hospital managers administrative flexibility, making it possible for local authorities to privatize some services. El Salvador and Guatemala are evaluating the possibilities of potential management of public facilities by private institutions. On the other hand, Chile, Costa Rica, Cuba, Honduras, Nicaragua, Paraguay and Uruguay explicitly document that no public facilities have been turned over to private entities. In order to ensure that all citizens have an equal right to health, Cuba has no plans for privatization, additional insurance systems, or new expenses that families would have to cover. Therefore, Cuba insists on the principle that the State should continue to finance health and maintain universal coverage and access to health care services.

MANAGEMENT MODEL

- Most countries have started making changes in the management models.
- A few countries have introduced legal techniques in order to purchase and sell services to third parties.
- Very few countries expressed their desire towards privatizing public facilities.

HUMAN RESOURCES

Human resources development has occurred in a variety of ways throughout the LAC region. The centrality of human resources development in health systems and services in the Caribbean has been recognized by Governments in the sub-region and endorsed as one of the priority areas in the Caribbean Cooperation in Health (CCH). The CCH is a mechanism that promotes collective action and resources on common regional priorities in health and identifies practical target areas and approaches in addressing these priorities. A four-year project, Human Resources Training and Development in Health Information Systems for the English-speaking Caribbean represented a major achievement in human resource training and development. This has served as a model for successful partnerships between PAHO and other funding agencies.

With regards to the formation of regulations to govern human resources, Brazil has currently developed the Observatory of Human Resources Network as an Internet-driven international survey network used to prepare, analyze, and circulate human resources data and studies in health. This network is promoted by PAHO, the International Labor Organization (ILO) and the UN Economic Commission for Latin America and the Caribbean and is instituted by an Administrative Rule.

Cuba has introduced professional practices that have been developed with a multidisciplinary orientation, including comprehensive general medicine, comprehensive dental care, and general nursing. Other countries that make specific mention of multidisciplinary approaches are Costa Rica, Panama, and Guatemala.

Nursing shortages in the Caribbean is a major challenge in the delivery of safe, effective and efficient health services. In order to address the shortage, a harmonization of curricula for basic nursing, family physician training programs and a regional registration examination now qualifies nurses to practice in any country in the Caribbean. Additionally, a movement for a single, standardized approach to medical registration in the sub-region has led to the creation of the Caribbean Association of Medical Councils as the regional mechanism for the registration and monitoring of the practice of all categories of health personnel.

Other countries within the LAC region, such as El Salvador and Panama, have also introduced changes in the university curricula to improve and bolster the quality of health professionals. The Dominican Republic is experimenting with

transformations in the system of incentives and certification of health professionals. Cuba has also developed a system to provide incentives for improving the performance of health personnel. In addition to academic credits, the system includes components to evaluate competence as well as professional and technical performance, which makes it possible to identify training needs and develop training methods. In Dominica, financial incentives are being introduced that are based on performance appraisal. And in Suriname incentives include offering a bonus to the general practitioner if a predefined target for preventative care services for the patient population is reached.

For the most part, the participation of health workers in the sectoral reform process has been limited throughout the LAC region. For example, in Belize participation has consisted of general debates regarding health reform, which has not led to a substantial inclusion of health workers.

Few countries expressed their interest in the improvement of human resources, but have faced a variety of obstacles that have hindered advancement in this area. For instance, in Uruguay a State reform policy has prohibited the filling of budgeted public administration positions for the past 10 years. This has crippled the country's ability to lure newly trained health professionals into administrative positions. In Paraguay, several institutions were deemed "unhealthy" by the Ministry of Justice and Labor; however changes have not yet been designed for the human resources education process to meet the needs outlined in the health sector reform.

HUMAN RESOURCES

- Modification in human resources education has occurred in the following countries: Bolivia, Brazil, Chile, Colombia, Cuba, Dominican Republic, El Salvador, Guyana, Jamaica, Panama, Paraguay, St. Lucia, Trinidad and Tobago, Suriname
- The Caribbean sub-region has initiated several commendable programs to address the need for improved human resources in the areas of nursing and general practitioners.
- Cuba, Dominica, the Dominican Republic and Suriname are experimenting with various incentives for health professionals as a means to improve performance.
- The participation of health care workers in the reform process is minimal throughout the LAC region.

QUALITY AND HEALTH TECHNOLOGY ASSESSMENT

Several countries have created procedures for the accreditation of health facilities. For example, El Salvador is revising the requirements for accreditation in the superior education centers with the objective of improving the quality of professionals. In 2000, the Dominican Republic created the National Quality Commission to normalize processes and create protocols in order to improve services. In Argentina, new procedures have been put in place for the

authorization, accreditation, and classification of health care facilities, professional certification and recertification, sanitary control and supervision, and evaluation of the quality of medical care and the health services. However, it is difficult to assess compliance with these procedures as the provinces are responsible for carrying out these functions. In the Andean sub-region, Peru, Bolivia and Colombia have also instituted accreditation processes at varying levels.

Many countries are also developing quality improvement programs within the Ministry of Health. Trinidad and Tobago has established a Directorate of Quality Management which is mandated with the development of systems to support improvements in quality of care. It includes a system for accreditation of both hospital and primary health care facilities and the development of clinical audit systems. It also includes a plan for development of health technology assessment and management capacities and systems. In Honduras, the New Health Agenda includes initiatives on technical quality and perceived quality. Costa Rica also has similar initiatives focusing on the perceived satisfaction of the public.

Few countries have programs that are evaluating health technology. For example, Colombia's Office of Science and Technology Development at the Ministry of Health has improved health technology assessment and also has standards for importing and assessing health technologies. In Cuba, the national Department of Technical Assessment was created in 1996 to determine the impact and scientific viability of health technology in existing systems and identify equipment that may be incorporated. Other national centers have also been created to evaluate health technology during the implementation phase and monitor them thereafter.

QUALITY AND HEALTH TECHNOLOGY ASSESSMENT

- Procedures for the accreditation of health establishments are being created in the following countries: Argentina, Belize, Bolivia, Colombia, Costa Rica, Dominican Republic, El Salvador, Honduras, Jamaica, Peru, Suriname, Trinidad and Tobago
- Few countries have initiated mechanisms for evaluating health technology with the exception of Colombia and Cuba.

CONCLUSIONS

The content of health sector reform has varied throughout the LAC region. Some countries are further along in the reform process, while others are just beginning. However, all countries are taking steps towards reform which is exemplified through the content of their reform programs.

Many countries have amended their political constitutions to have a direct or indirect impact on the development of the health sector. New legislative acts and modifications to basic regulations in the health sector have been made in several countries.

Almost all countries have established that the right to health care is a fundamental right to all citizens. However, the right to health care has been defined differently in a variety of countries, ranging from specific terms to broad generalizations. Moreover, the public has not been well-informed about their right to health care in most countries. Several countries have established plans to increase coverage to health care and supply a basic set of health benefits to the public. Many countries are also creating and strengthening their basic health insurance programs.

Ministries of Health have acted as the primary steering role throughout the region. The separation of functions in the health sector has occurred in a few countries, however many countries do not have an explicit separation between financing, procurement, and service delivery. On the whole, few countries have documented the existence of mechanisms to monitor the accountability of public institutions.

Most countries in the LAC region are currently undergoing or have already begun a decentralization process. In many cases, health sector decentralization is still at an incipient stage. However, many countries are slowly transferring responsibilities, authority and resources to sub-national levels.

Social participation and government regulation have been a stated objective in many countries. However, lack of economic resources and training often makes it difficult to implement these objectives. Very little reference was made to the inclusion of groups traditionally excluded from decision-making.

A majority of the countries agree that they must improve their information systems on health financing and expenditure. The Caribbean sub-region as a whole has organized a variety of initiatives and regional trainings on financial reform in order to address needs specific to the sub-region.

Service delivery modalities are being modified as a result of the changes brought on by health reform. Some of the changes are more institutional and go along with the decentralization process and the creation of national health insurance schemes. Other countries are making changes according to immediate needs of their country. Several countries are giving priority to vulnerable groups such as women, children, rural and indigenous populations, and the elderly. Though many countries have expressed their commitment to improve and modify service delivery, several countries have not yet allocated sufficient resources to achieve these goals.

In general, most countries have introduced changes to the management model. Commitments and management contracts between different levels of the public health system have been made in a few countries. Additionally, a few countries have mentioned the issue of clearing legal obstacles to purchasing and selling services to third parties. While introducing changes to management, very few countries support the privatization of public facilities.

Human resources development has occurred in a variety of ways throughout the LAC region. The Caribbean sub-region's project for Human Resources Training and Development in Health Information Systems has served as a model for successful partnerships throughout the region. Nursing and medical professional shortages have instigated movements towards standardizing medical registrations in the Caribbean sub-region, as well as introducing changes in the university curricula throughout the LAC Region. Several countries have created procedures for the accreditation of health establishments while many are also developing quality improvement programs within the Ministry of Health.

3. EVALUATION OF RESULTS

Many countries in the region have not yet commenced an evaluation of the reform process. Several countries reported that the implementation of the health reform process has moved slower than expected and therefore is difficult to evaluate at the moment. Many countries also indicated that it was not possible to draw direct and unequivocal causal relationships between sectoral reform and changes in the indicators of equity, effectiveness, quality, efficiency, sustainability, and social participation and control. For example, Peru reported that health sector reform is part of a state reform and was preceded by a significant increase in public expenditure; therefore the results achieved are not exclusively attributed to health reform, but rather to public policies that accompanied a major economic revival between 1993 and 1997. Nevertheless, certain countries have initiated evaluation processes which will be discussed in this section.

COUNTRIES INCLUDED IN THE EVALUATION OF RESULTS

- Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, Venezuela

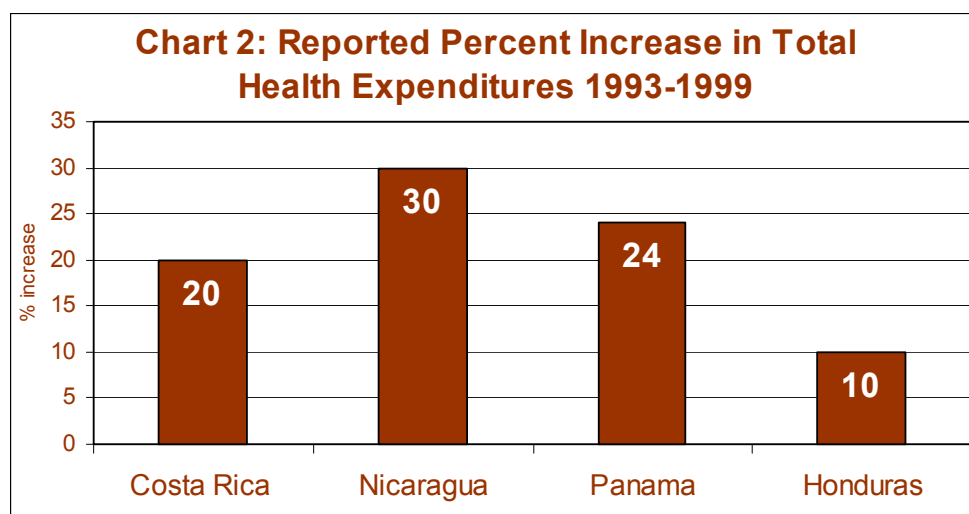
EQUITY

A few countries noted that the reforms have influenced equity by reducing gaps in health coverage, distribution and access to services, and resource allocation. In Mexico, the expansion of formal health care coverage occurred in two basic areas. The provision of family health insurance to people outside the formal economy led to a large increase in the numbers of people insured. Additionally, the uninsured population without regular access to health services plummeted from 10 million in 1995 to half a million in 2000. Mexico also witnessed an increase in the numbers of women using birth control; a large increase of children less than 1 year with a complete vaccination series from 49% in 1995 to 89% in 1999; and in hospital births, which rose from 76% in 1995 to 86% in 1999.

Brazil and Paraguay also reported increases in these health indicators. Brazil indicated that despite the expansion of activities, a significant lack of access to oral care services with extremely large per capita differences between various income groups.

HEALTH EXPENDITURES

Many countries experienced an increase in the amount of funds spent on the health sector. For example from 1993 to 1999, Costa Rica, Nicaragua, Panama and Honduras showed an increase in the total health expenditure by 20%, 30%, 24%, and 10%, respectively.



Panama indicated that the increase could not solely be attributed to the reform process. Paraguay indicated that although the total health expenditure and per capita public health expenditure fell from 1996 to 1999, the health sector increased its share of public sector expenditure. Total health expenditure of the central government as a percentage of total central government expenditure went from 20% to 25% from 1996 to 1999. In contrast, Mexico indicated that from 1995 to 2000, health expenditure did not increase due to the economic crisis in 1995.

HUMAN RESOURCES

Countries have also experienced an increase in human resources. Cuba indicated the highest numbers of human resources per population in the LAC region. In 1997, there were 56.8 physicians and 73.7 professional nurses per 10,000 people and 6.1 hospital beds per 1,000 people. El Salvador indicated that the number of physicians increased by 25% from 1994 to 1999. Paraguay also mentioned that the numbers of physicians and nurses have increased from 1999 to 2000. Guatemala indicated that increasing human resources was not an objective of its health reform process. Costa Rica has also experienced an increase in the number of health professionals. However, the increase in the number of educational centers and their costs is surpassing the absorption capacity in the public sector and is leading to higher unemployment among health professionals. In 2000, Brazil's Federal Medical Council identified 1,200

municipalities with no resident doctors. To correct this deficiency, the Ministry of Health created the Equitable Health Services Program designed to encourage voluntary service to support and strengthen the Family Health Program.

In Paraguay, a preliminary report measuring social exclusion in health indicated that 38% of the population is not covered by any social safety net in health and that 22% of the sick or injured who seek care is more than 30 minutes away from a health facility in urban areas and more than 60 minutes away in rural areas. Costa Rica has implemented a schedule in its primary health centers to reduce barriers to access. In Cuba, all patients are able to seek same-day care in a family physician's office. These offices have flexible hours, which reduces access barriers to care that may result from fixed office hours. Additionally, Cuba saw a two-fold reduction in the number of patients on wait-lists for surgical procedures. In order to achieve this reduction, multidisciplinary groups were formed at the hospital, provincial, and ministerial levels, made up of representatives from medical facilities, the state-run medical supply company, and the state-run pharmaceutical company. These groups were formed to guarantee the necessary resources and to carry out systematic controls on activities to increase the number of surgical procedures and improve productivity per operating room.

Changes in resource utilization have been observed in a small number of countries. Costa Rica indicated a small increase in the number of outpatient consultations. In Brazil, a considerable increase in the number of consultations per inhabitant in the North, Northeast, and Center-West significantly reduced existing disparities. Moreover, these same regions have experienced an increase in the number of hospital admissions, whereas all other regions have witnessed a decrease due to technological advances, greater emphasis on prevention and outpatient care, and broader private system coverage. On the other hand, in Mexico disparities were not reduced in terms of the benefits received by the user population of the different health service providers. In Costa Rica, the percentage of deliveries attended by a trained birth attendant stayed the same before and after the reform process was initiated.

Though a few countries were able to determine the effects that health reform had on equity, several could not. None of the Andean countries show evidence that reform has influenced the five indicators selected to evaluate access, or the three used to measure resource utilization. Additionally, in Jamaica there has been no evidence that HSR has had an impact on equity.

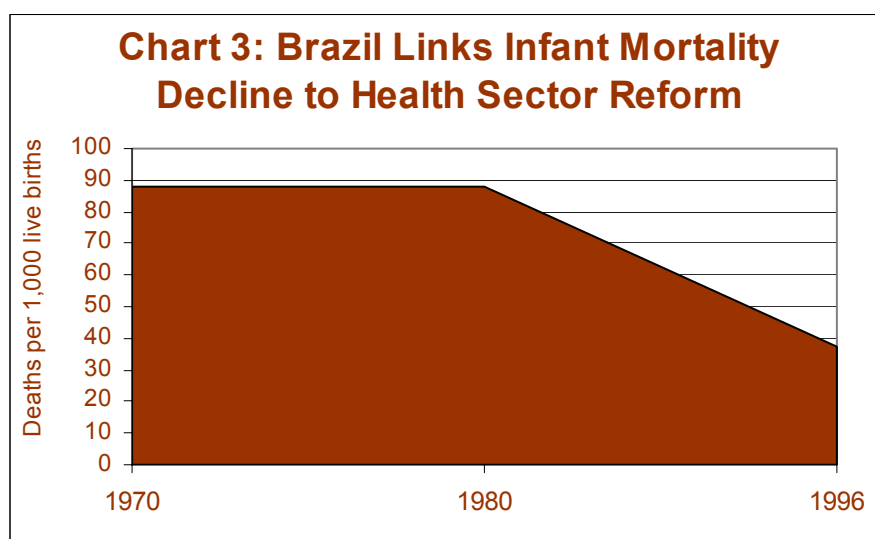
EQUITY

- Few countries experienced increases in the indicators measuring health coverage.
- Total expenditure on health care increased in most of the countries, except Mexico.
- Increase in access to resources and resource utilization was reported in a few countries.
- Several countries were not able to identify links between health sector reform and equity.

EFFECTIVENESS AND QUALITY

Very few countries have reported clear evidence that the health reforms have had an impact on the effectiveness and quality of the health services system. Nevertheless, several countries have seen a decline in infant mortality (IMR), maternal mortality (MMR), and rates of low birth weight (LBW). For example, Costa Rica has seen a drop in IMR from 12.6 per 1,000 live births in 1998 to 10.2 in 2000. Based on the indicators, Mexico's effectiveness shows progress in some cases and stagnation in others. Infant mortality declined, in terms of national values, however MMR has been steady in the last decade. Mortality from cervical cancer exhibited a moderate decline, but the number of deaths from this cause in 1999 was nearly 9% higher than in 1990. Prenatal care indicators do not reflect a high degree of effectiveness, since the percentage of pregnant women seen in the first trimester nationwide was only 33.6% and the average number of prenatal check-ups per pregnant woman was 4.1 in 1999. Cuba has seen a decline in infant and maternal mortality rates in all territories.

Brazil is the only country that directly links health reform with the progress seen in the indicators. Health indicators have made significant progress during the 1990s when the reforms were implemented. Between 1970 and 1980, the average IMR was 87.88 deaths per 1,000 live births.



According to estimates based on the 1996 National Household Sample Survey, the country's total IMR was 37.5 per 1,000 live births. However, disparities still exist in less developed regions in the Northeast compared to more developed regions in the South.

Technical quality has improved in a few countries due to the reforms. In Colombia, technical regulations and standards of quality have been formulated and

the minimum areas to be developed by the health services have been identified, including the design and execution of plans to improve quality, to measure the degree of user satisfaction, and to handle claims and suggestions. In Jamaica, all public hospitals have quality assurance committees however the percentage of fully functioning committees is unknown. Honduras and Nicaragua indicate that 10% of establishments at the primary level have quality assurance committees. In Panama and Costa Rica, all of the hospitals are in the process of creating quality assurance committees. While in Cuba, all health facilities at the primary and secondary levels have quality control committees in place.

In Brazil, progress has been made in improving the quality of care, including measures aimed at improved patient intake; centralized procedures for making appointments; more patient-friendly care; better care for expectant mothers, care in childbirth, and care for newborns; improved performance of emergency care systems; measures geared toward elderly care; as well as the evaluation of minimum quality standards for infrastructure, human resources, and the ethical, technical, and scientific routines at each hospital facility. The Ministry of Health founded the Hospital Quality Award for facilities with the most outstanding evaluations by users participating in the Quality of Care and User Satisfaction Survey.

In Mexico, quality improvement has been addressed through a variety of strategies. The first is the work of the National Medical Arbitration Commission, a body with the technical autonomy to mediate complaints about irregularities in service delivery or the failure to provide necessary care. A second strategy, similar to Brazil, was the performance incentive program and another strategy is to certify institutions enrolled in the incentive program.

Whenever available in Cuba, essential drugs are dispensed at primary and secondary health facilities in all territories. Guatemala, Honduras, Costa Rica, El Salvador, and Nicaragua are all improving the availability of essential drugs in different levels of care.

In Mexico, an unmet objective of the reforms is the patient's right to choose a family physician in social security facilities. The National Survey of Satisfaction with Health Services 2000 revealed that 76% of Mexicans are convinced that fundamental changes are needed, while 19% believe that services function rather well and require only small changes. In Cuba, users have the option of seeing a family physician other than the one assigned. All health institutions have programs in place to improve the quality of care and treatment received by the user. A sample user survey conducted by the National Health Trend Analysis Unit in December 1997 indicated that 46.6% were dissatisfied with the services for the following reasons: difficulties with instruments and equipment; lack of reagents, prescription medicines and/or others; lack of essential drugs; uncomfortable and deficient physical conditions of facilities; and to a lesser extent, difficulties with treatments and discourteous personnel.

In El Salvador, a program has been created which attends to patients' opinions and demands. 70% of primary and secondary health facilities are using patient satisfaction surveys. In Honduras, although a variety of hospitals and rural health centers administer patient satisfaction surveys, the information is not necessarily used. However, Panama's Social Security Office analyzes the satisfaction survey results.

EFFECTIVENESS AND QUALITY

- Very few countries have reported clear evidence that the health reforms have affected the overall effectiveness and quality of the health services system.
- Brazil is the only country that directly links health reform with the progress seen in its health indicators.
- The following countries have indicated that they have instituted quality assurance committees in hospitals and clinics: Costa Rica, Cuba, Honduras, Jamaica, Nicaragua, Panama
- Patient satisfaction surveys are administered in certain countries, however it is difficult to determine whether/how the information is being used.

EFFICIENCY

A few countries have demonstrated more efficient mechanisms for allocating resources through the health sector reform process. In Costa Rica, HSR has contributed to improving the assignment of resources to the primary level of care. Before the reforms, primary levels of care only received 12% of the total health budget, whereas after the reforms it received 21%. The reforms also gave priority to rural and urban marginalized populations, assigning more resources to infrastructure, equipment, and human resources.

Both Colombia and Peru have substantially increased the availability of financial resources as a result of reform. In Colombia, reform has resulted in the mediation of financial flows by the Health-Promoting Companies, which has raised management costs and reduced the speed of these flows. Health reform has led to the reallocation of resources toward the health promotion and disease prevention activities contained in the Basic Health Care Plan. Peru has targeted spending to primary care, based on regional poverty levels. Additionally, a programming and budget system has also been set up that allocates financial resources based on the annual goals of the plan.

In Brazil, the MOH is working to implement a proposal for integrated, consensus-based programming of actions and services (PPI). The PPI has been prepared in all states and is designed to strengthen programming activities for health actions and services. The Basic Care Plan has also been implemented which the MOH uses as a vehicle for the transfer of resources, calculating a per capita value for municipalities that agree to implement a specific set of actions and basic

services. In 1999, Mexico's MOH completed the transfer of human, material, and financial resources from the federal government to the states, with state participation in the health budget increasing from 50% in 1996 to 73.7% in 2000. Moreover, in 1996 the MOH introduced a formula for allocating resources based on health needs; this formula is used to distribute available resources after covering regular wages and expenditures, gradually promoting equity in financing. In Cuba, the percentage of total health sector spending on primary health care has increased, while spending on hospital care has decreased.

Colombia has shown evidence that the reform has influenced the country's health situation as it relates to the supply of drinking water and sewerage services. Costa Rica's new methods of resource allocation have improved the supply of rural and urban drinking water, as well as waste management services. In Brazil, increased dissemination of information on health determinants has led to improvements with regards to sanitation. For example, in 1992 83% of households were connected to a general water supply system, whereas by 1999 it had risen to 89%. In 1999, 52.5% of households were connected to sewerage networks compared to 48% in 1992. Also, in 1995 76% of households were served by a refuse collection service, increasing to 85% in 1999.

A couple of countries indicated that sectoral reform has had an impact on the development of intersectoral action and preventative programs. Chile reported that health reform has increased resources for prevention, self-care, investment in critical areas (such as highly complex pathologies and vaccines) and resources earmarked for primary care. In Brazil, the MOH, along with state and municipal health secretariats, is working to carry out, strengthen, and disseminate activities and materials in the areas of health promotion and disease prevention. Activities include programs to discourage violence, in coordination with schools; anti-smoking campaigns; disease prevention and health recovery campaigns, especially those targeting young people; and campaigns for the early detection of breast and cervical cancer.

Resource management has been affected by health reform in several countries. Peru has introduced budget programming, execution, and monitoring methodologies, with emphasis on decentralization. Progress has been made in standardizing management procedures and in equipping health facilities. Chile has introduced tools such as management information systems, fees based on the diagnosis, economic and social evaluation of projects, criteria for cost-effectiveness, and management commitments. Procedures, interventions, and performance measurement indicators in all hospitals have been standardized. As a result, hospitals have reduced the average length of stay, increased the number of discharges per bed, and increased the use of surgical wings.

In Costa Rica, a 1997 survey showed improvements in the indicators used to measure hospital management. Improving hospital efficiency is one of the objectives of Cuba's health sector reforms. Efforts have been made to reduce the length of hospital stays to minimum, decrease hospital admissions and increase the number of outpatients and improve operating room productivity. Costa Rica

indicated that all of the hospitals have signed negotiated management commitments with goals and specific objectives. In Guatemala and Honduras, negotiations are underway in a certain number of health establishments.

EFFICIENCY

- Colombia, Costa Rica, Cuba, and Peru have stated that there has been an increase in financial resources for the health sector as a result of the reforms.
- Colombia, Costa Rica, and Brazil stated that the reforms have improved health situations as they relate to the availability of drinking water and sewer systems.
- Chile and Brazil have created programs that have an intersectoral action and focus on preventative programs.
- Chile, Costa Rica, Cuba, and Peru have improved the management of their health sector as a result of the reforms.

SUSTAINABILITY

A few countries have indicated that their reforms have been sustainable. As the health reforms have begun to be implemented in Brazil, significant progress has been made in terms of increasing accountability of the public system and social legitimization and awareness of the Unified Health System. Additionally, constitutional linkage of revenues to public health actions and services is a product of the reform movement and ensures financial sustainability of the health system. In Honduras, there is some evidence that the modernization and reform process has increased the legitimacy and acceptability of the principal institutional health service providers.

With regards to finances, Chile has sufficient information on expenditures--both aggregated (public and private sectors) and disaggregated trends by institution and geographic area. Also, medium- and long-term sustainability is guaranteed in terms of health policy and the financial decisions that affect programs and services. In El Salvador, HSR has permitted the development of systems to analyze information on public and private spending on health. In Costa Rica, the reforms have contributed to the collection of information on medium-term sustainability efforts to increase coverage. The reforms also appear to have contributed to the increase in the capacity to balance the income and health expenditures of the principal public institutions.

Cuba has developed new methods to capture external monetary resources, through drug exports, health care for foreign patients, technical assistance abroad, training courses and specialized education, and special projects. This in turn has led to increased sustainability of the health system. In Mexico, several state and local health units introduced mechanisms to attract additional funds through hospital wards for pensioners, the sale of services according to a set rate or through outsourcing agreements with other public and private providers.

Very few countries specifically discuss the issue of third-party payers. El Salvador indicated that 80% of its establishments in the public health system are authorized to obtain payments from third party payers for the recuperation of costs. At the same time, the Ministry of Public Health and Social Assistance is creating norms and systems to facilitate the management of payments from third party payers. In Honduras, only two hospitals have the capacity to collect third party payments.

Panama indicated that between 1994 and 1998 it has had access to an increased amount of loans for the health sector. These loans present two challenges: in the short-term to ensure the coordination and consistency between distinct projects; and in the medium-term not to exceed the capacity of sectoral debt and to guarantee the sustainability of actions with its own resources. Honduras has also indicated capacity to negotiate external loans, but it has not evaluated its capacity to swap them for national resources once they have reached maturity.

TABLE 5: WORLD BANK* LOANS TO PANAMA TO SUPPORT THE HEALTH SECTOR				
Project Name	Approval Date	Closing Date	Total Amount (\$m)	Project Status
Public Policy Reform Adjustment Loan	19-Nov-98	22-Feb-99	61.0	Closed
Health Sector Reform Pilot Project	16-Jul-98	31-Dec-04	4.3	Active
PA RURAL HEALTH	07-Feb-95	30-Jun-03	25.0	Closed
Social Investment Fund Project	17-Jun-97	30-Jun-04	28.0	Active
Total	118.3			
*Applicable Inter-American Development Bank (IDB) data for this timeframe not available.				

Though many countries have stated their intentions and capabilities to create sustainable health systems, several countries continue to face constraints that hinder this process. Peru reported that the creation of the Modernization Coordinating Unit in the public sector, which is in charge of promoting the reform agenda and balancing income and expenditures, supports the sustainability of the process. Financial constraints however, seriously threaten the reform process. In Colombia, the financial sustainability of the health care system has been threatened by negative economic growth, the failure of beneficiaries to pay into

the system, corruption in the management of administrative institutions in the subsidized health sector and the impossibility of financing expanded coverage.

SUSTAINABILITY

- Few countries have indicated that their reforms are creating sustainability within the public health system.
- Chile and El Salvador collect and analyze data on public and private sector expenditures.
- Mexico and Cuba have developed methods to attract external monetary resources in order to maintain the sustainability of state and local health units.
- Peru, Colombia and many other countries face financial constraints that hinder the sustainability of the reform process.

SOCIAL PARTICIPATION

Several countries have reported that the reforms have led to an increase in the degree of social participation and control at different levels of the health care system. In Chile, the creation of Development and Equity Committees in hospitals and the social security system is a result of the health reforms. In Peru, community participation in the organization and management of health services has been fostered through the Local Shared Administration Committees in 20% of primary care facilities. In Colombia, reform has strengthened mechanisms for social, individual and collective participation through community committees in health, oversight subsystems and community health care services. Bolivia has also reported the creation of participation committees at the local level and in public health care facilities and networks.

In Trinidad and Tobago, mechanisms used to increase social participation have included use of consumer representation on committees and councils and public meetings by the Regional Health Authorities. In Jamaica, HSR has contributed to an increase in social participation and control in the health system through the decentralization process.

In 1999, Panama had 18 Committee Federations that consisted of 1,135 health committees. Approximately 40,000 to 50,000 people participate in these health committees, with the majority being in the rural areas. In Costa Rica, social participation has been active primarily in the management process. El Salvador and Honduras have also indicated that the mechanisms and methodologies of participation have improved with the reform process. In El Salvador, the reforms have supported the formation of health committees where health agendas are defined as part of the local development agenda. Similarly, Mexico's strategy of improving participation is to promote the work of the local health committees and to develop the Healthy Municipalities movement, which involves over 1,500

municipalities that generate initiatives for the improvement and development of health.

In Cuba, the strengthening of the family physician and nurse program, as well as the creation of health councils within the framework of current health sector reforms has fostered greater social participation in the identification and solution of general health problems. In Brazil, health information is exchanged amongst the various stakeholders through a large number of health councils consisting of patients, service providers, health care professionals and system managers.

In Argentina, with regard to quality, the participation of institutions such as the Argentine Medical Association, the Academy of Medicine, the Professional Schools, and other academic and professional institutions is ongoing. Decentralized hospitals also offer avenues of participation for staff and the surrounding community. Additionally, in the context of Argentina's health emergency, greater opportunities for social participation have arisen, stemming from the Ministry of Health and Social Welfare's call for a meeting on an "Agreement for Health." At this meeting a variety of stakeholders were represented, ranging from the National Government to unions, the Church, scientific societies and others.

SOCIAL PARTICIPATION

- Many countries have reported that reforms have led to an increase in the degree of social participation and control.
- The most widely reported method of participation is through health committees at primary care facilities and hospitals.

4. CONCLUSIONS

DYNAMICS OF THE PROCESSES

The Health Sector Reform process in the LAC Region has varied in terms of its progress and added value in each country. The monitoring and evaluation of HSR has been particularly difficult due to the complex nature of defining and identifying reforms. As defined in an international meeting in the Americas in 1995, health sector reform is *“a process aimed at introducing substantive changes into the different institutions of the health sector and the roles they perform, with a view to increasing equity in benefits, efficiency in management, and effectiveness in satisfying the health needs of the population. This process is dynamic, complex, and deliberate; it takes place within a given time frame and is based on conditions that make it necessary and workable.”*¹²

The LAC Region as a whole has a diverse range of cultures, languages, histories and levels of development. These differences are also reflected in the variety of reforms underway in each country. Though there are differences in each country's method of reforms, similarities across the region do exist. Most countries in the region began their reforms in the 1990s with the exception of a few such as Cuba, Brazil, and Mexico who began in the 1960s, 70s, and 80s, respectively.

Reform has occurred in most countries due to the need for quality health care that is accessible and equitable to the entire population. Mexico noted three challenges faced by its public health system: equity, quality of care, and financial protection. Similar concerns were echoed throughout the region as HSR was initiated. Therefore, many reforms have focused on the means of obtaining equitable health systems that provide quality health care in a financially affordable manner. This has been an enormous challenge that countries continue struggling to achieve.

For the most part, the Ministries of Health (MOH) have taken the lead role in developing and implementing health reform. In some countries, the MOH has worked in collaboration with the national institutes for social security as well as other organizations such as the Inter-American Development Bank (IDB), the World Bank, the Pan American Health Organization (PAHO)/World Health Organization (WHO), and a variety of non-governmental organizations.

Public participation in the development of the reforms has been somewhat limited in most countries. Approximately, one-third of the countries reported that

¹² OPS/OMS: “Reunión Especial sobre Reforma Sectorial” Washington DC, 1995.

some form of public involvement occurred during the development of the reform process. However, very little mention was made as to how the public's participation was incorporated or used in the actual creation of the reforms. For example, it is unclear as to the value-added of committees that were created to enhance public participation.

Most countries developed specific agendas for the reform process which revolved around basic objectives. Some of the common objectives across the LAC region for HSR have been the reorganization of the institutions that provide for the country's health; the introduction of new modalities in the provision of health services; the improvement of the overall quality of care; and the reorientation of public resources to achieve efficiency and equity. Additionally, the Caribbean sub-region, has agreed that health promotion is one of its main objectives of HSR as stated in the 1993 Caribbean Charter for Health Promotion.

As many countries are undergoing State reforms, health has been incorporated into these modernization and reform processes. Therefore, simultaneous changes are occurring within government structures and health delivery, which impact the overall effectiveness and efficiency of HSR. However, at the time of submitting the country profiles, many countries still had not drawn up formal action plans that delineate quantifiable goals, deadlines and responsibilities. Although many countries do not have formal action plans, many are already in the process of implementing the reforms. Therefore, reforms have been implemented in many cases without specific quantifiable goals used as an endpoint. This is a less than ideal situation, which countries need to take notice of and improve as further reforms are made.

In most of the countries, health sector reform has been funded from external financing sources such as the IDB, the World Bank, and a variety of aid agencies from developed countries. It is important to note how health sector reform fits into the larger reform process and agenda established by these outside funding agencies. For example, many structural adjustment programs that were implemented in the past had negative impacts on the health sector in many countries.¹³ Therefore, it is crucial that the overall State reforms are holistic and keep a strong emphasis on the improvement of the health sector with regards to improving equity, quality of care, and financial affordability. In that sense, it is critical that evaluation criteria are established in order to monitor and evaluate the status and progress of the reforms. At the time of submitting the country profiles, only Brazil, Costa Rica, Cuba, Jamaica and Mexico stated that they had created mechanisms to evaluate the reforms.

CONTENT OF THE REFORMS

The specific content of health reform in each country is determined by factors such as political traditions, the specific context surrounding the reform

¹³ Jayarah C., Branson W. Structural and Sectoral Adjustment. World Bank Experience 1980-1992. A World Bank Operations Evaluation Study. World Bank, Washington, D.C. 1995.

(negotiation and key actors) and the rate at which changes take place. Thus, a fast-paced global reform process in a country with a long-lasting legal tradition, such as Colombia, gave rise to a highly complex process with an extensive and long-lasting regulatory agenda.

Although the constitutions of several countries have been amended to include the right to health, these changes have not led to great similarities among the respective reform processes. For example, the right to health care is established in the constitution of many countries, however how this right is manifested varies widely among them. The term 'right to health care' has also been defined differently in each country, ranging from explicit definitions in St. Lucia to much more vague terminology, such as 'health protection' and 'social security by the State' in other countries. Nevertheless, most countries have not done an adequate job of informing the public about this right. Thus, incorporating the right to health in constitutions is not particularly valuable if the public is left unaware of this legal right.

In order to increase health coverage, schemes are being introduced throughout the region that focus on providing insurance to the uninsured. Competition between private and public forms of insurance is being encouraged as a way of increasing coverage. This inevitably results in concerns regarding the entry of the private sector into the realm of public health service provision. A few countries have created national insurance/social security systems. However, these programs are limited in nature, often providing basic retirement benefits, some provisions for sick leave and reimbursement of selected services.

The Ministry of Health acts as the primary steering role in most countries, though a few countries are also trying to achieve a separation of functions between the MOH, various institutes and other public health organizations throughout the country. The separation of functions ideally provides each organization or ministry the ability to focus on certain aspects of the health sector as to avoid overlap or gaps in coverage. However, many countries do not have an explicit separation between financing, procurement, and service delivery. Additionally, many countries still lack information systems that help public health institutions monitor the progress of certain programs. Also, there is a general lack of systems in place to hold public institutions accountable for their work. Therefore, it is impossible to conduct an in-depth study on how the reforms have had an impact on financing, expenditure variables, and health outcomes without these systems in place.

Most countries in the LAC region are currently undergoing or have already gone through a process of decentralization within the governments and the health sector. The decentralization process has given local authorities more power to institute reforms, however it has also put certain financial restraints on local health systems which inevitably trickle down to the populations at most-risk.¹⁴ In

¹⁴ Kivumbi G., Kintu F. Exemptions and waivers from cost sharing: ineffective safety nets in decentralized districts in Uganda. *Health Policy and Planning*. 17(Suppl 1): pp. 64-71, 2002.

some cases, the problems of policy management are compounded by decentralization.¹⁵ In this new environment, the MOH's ability to control activities of the decentralized organization is sharply curtailed. It has been stated that the evidence for policy analysis in the form of performance indicator information or health service outcome statistics will have to be obtained through information systems created in decentralized health organizations or through the commissioning of surveys and studies.¹⁶ Additionally, the commitment for decentralized bodies to provide this information may be questionable, especially if they do not perceive any real benefit. Ministries of Health, in their steering role capacity, need to maintain their authority with regards to regulations of local health authorities and health clinics, financial assistance, overall coordination of health programs and the provision of technical guidance in order to benefit the whole population, without further marginalizing certain population groups.

A majority of the countries agree that they must improve their information systems on health financing and expenditure. A few countries have already established such information systems. In addition, some countries are beginning to create national health insurance schemes in order to improve coverage rates. Some countries have shifted to user-fees, which have been accepted in some cases and rejected in others, due in part to the public's inability to pay for health services.

Several countries have modified their management models in order to address the changing roles of Ministries and health organizations throughout the reform process. In some cases, commitments and management contracts were made between the MOH and the regional health authorities to ensure proper regulations and oversight of specific duties and health outcomes. While introducing changes to management, very few countries are leaning towards privatizing public facilities.

In order to address the lack of human resources in the health sector, many countries are focusing on training and accreditation programs, as well as improving university curricula in order to bolster health professionals. A select few countries are also experimenting with incentives as a means to improve the performance of health personnel. Several countries made changes to professional practices to encourage an increased multidisciplinary orientation to health care. However, exclusion of health workers continues to exist even with an emphasis placed on human resources. For the most part, the participation of health workers in the sectoral reform process has been very limited throughout the LAC region.

Even though most countries have introduced changes to encourage social participation and control, most of the forums created only focus on social-welfare services. Very few forums allow the public to assist in the creation of policies. Additionally, many countries indicated that the mechanisms to facilitate

¹⁵ Hornby P., Perera H.S.R. A development framework for promoting evidence-based policy action: drawing on experiences in Sri Lanka. *International Journal of Health Planning and Management*. Vol. 17, pp. 165-183, 2002.

¹⁶ *Ibid.*

participation are rather weak and groups that have been traditionally left out of decision-making continue to be excluded.

RESULTS OF THE REFORMS

Certain indicators (equity, efficiency, effectiveness, quality, sustainability, and social participation and control) were selected to evaluate the impact of health reform on the overall performance of the sector and not on health situations. Still, it was not possible to make a clear determination of this impact due to the complexity of health reform and the lack of previously established evaluation criteria in the majority of countries. As stated earlier, many countries did not have evaluation criteria, specific agendas of action, or information systems in place at the time of writing their country profiles. Therefore, these same countries were unable to report on the impact of reforms in any substantive manner.

Exploring if equity between different socioeconomic groups exists with regard to health utilization and seeking explanations for why or why not differences exist can be very complex. According to WHO, health inequity is represented by inequalities in health status, health care utilization and health care financing.¹⁷ Braveman defines equity in health care as health care resources allocated according to need, health services received according to need and payment for health services made according to one's ability to pay.¹⁸

A few countries indicated improvements in the health indicators used to monitor equity (i.e. number of women using birth control, percentage of children under the age of 1 who have received all immunizations, etc.). Many countries also experienced an increase in the amount of funds spent on the health sector. However, many of these same countries indicated that social exclusion from the health sector was still rampant in many areas. Therefore, equity still remains an objective yet to be reached in most countries.

Additionally, very few countries have reported clear evidence that the health reforms have affected the overall effectiveness and quality of the health system. Nevertheless, indicators, such as infant mortality and maternal mortality, used to monitor these two objectives have improved in a few countries. With the exception of Brazil, no country is able to directly link the reforms to the improvement in these health indicators. To monitor the quality of care, several countries have quality assurance committees in various health facilities. The value placed on these committees has not been reported, thus it is difficult to determine whether these committees enhance the quality of care throughout the country. A couple of countries provided data from preliminary survey results, indicating that a large percentage of the public is dissatisfied with the public health services provided. Unfortunately, this issue was not expanded upon in the profiles to address how countries plan to address survey results.

¹⁷ WHO. *Equity in health and health care: a WHO/SIDA initiative*. Geneva: World Health Organization, pp. 15-23, 1996.

¹⁸ Braveman P. *Monitoring equity in health: a policy-oriented approach in low- and middle-income countries*. Equity Initiative paper No. 3. WHO/CHS/HSS/98.1. Geneva: World Health Organization, 1998.

Several countries have indicated that the reforms have positively impacted the management of resources in the health sector. A few countries have demonstrated more efficient mechanisms for allocating resources through the health sector reform process. In certain countries, there has been an increase in resources to the health sector, especially to the primary health care level. Resources have been used to improve access to drinking water and sanitation services in a handful of countries. Preventative programs and inter-sectoral actions have hardly been influenced by the reforms.

It is difficult to assess the sustainability of the various health reforms due to their recent nature and the general lack of monitoring systems to evaluate them. Systems are currently being created in some countries to monitor financial sustainability in the health sector. Nevertheless many countries that have stated their intentions and capabilities to create sustainable health systems still face constraints that hinder this process.

Social participation has increased in the majority of countries in the region through the creation of citizen committees that participate in the management of networks and public facilities.

The reported results presented demonstrate that health reforms appear not to have had an aggregate positive impact on the health sector throughout the region. This may be due to the lack of conclusive evidence resulting from inadequate monitoring and evaluation of the current reforms. This can also be attributed to the vast complexity of the processes involved in health sector reform, as well as how the political and economic context within each country influences the success of reforms.

Focusing on equity as opposed to efficiency is a much more challenging and holistic way of improving the health status of all populations. However, for the most part, the reforms did not achieve the objective of increasing equity and access to services for the poor and vulnerable across the LAC region.¹⁹ Health reforms have not only failed to live up to their promise of improving efficiency, effectiveness and equity, but also in many countries, the privatization of higher levels of services has led to a situation where those who fall seriously ill or need secondary or tertiary care may be driven into poverty due to the costs of care.²⁰

The need for strong political will is necessary for health sector reform to work. The drive for health reforms is largely political and ideological, and often times removed from the public's influence. Greater support of evaluation and descriptive studies focusing on the reform process rather than on single measures of outcomes such as clinic attendance, drug availability or waiting times, would better assess the overall impact of these changes.²¹ The lead agency, in most

¹⁹ Blas E., Hearst N. *Health sector reform and equity—learning from evidence?* Health Policy and Planning. Vol. 17 (Suppl 1): pp. 1-4, 2002.

²⁰ Sen K., Koivusalo M. *Health care reforms and developing countries—a critical overview.* International Journal of Health Planning and Management. Vol. 13, pp. 199-215, 1998.

²¹ Ibid.

cases the MOH, must take the necessary actions to create evaluation criteria and specific action agendas that outline in detail the quantifiable goals, dates, and responsibilities assumed by various health authorities. Efficiency and quality must continue to be a prime objective, while equity remains the ultimate goal of the reforms.

The LAC region has progressed in many ways since the inception of the health reforms. A strong emphasis on health needs to be placed and maintained within all ranks of government and society in order to make quality health care a reality for everyone. Therefore, the reforms must be taken to another level where each country undergoes serious evaluations to assess the status of the reforms and proceed with improving the reform process on a regular basis to achieve the goals set out at the inception of the HSR.

