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MONITORING AND EVALUATION OF THE HEALTH SECTOR REFORM PROCESSES

The countries of Latin America and the Caribbean are introducing reforms that may have a profound influence on the way they provide basic health services and on the people who receive them. Health systems are being reformed in order to reduce inequities, improve quality, and correct inefficiencies in current health systems.

The Governments of the Region identified the need to design a process for monitoring health sector reform in the Americas at the Summit of the Americas in Miami in 1994, and at the Special Meeting on Health Sector Reform in 1995, in which an interagency committee of the United Nations, and multilateral and bilateral agencies participated.

In order to respond to this need, the *Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean* was designed and has begun to be used. This document explains the methodology and its contents, provides examples of how it has been used, and outlines future stages that have been considered.

This report is submitted to the Subcommittee on Planning and Programming to inform on the progress made towards fulfilling PAHO's mandate, and to receive input from the Members on the steps to be taken.

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EXECUTIVE SUMMARY

Health sector reform has been defined as a process for introducing substantive changes in the entities and functions of the health sector in order to obtain more equitable benefits, more efficient management, and more effective actions, and to satisfy the health needs of the population. It is an intense transformation of the health systems, conducted over a given period of time, and based on situations that warrant reform and make it viable.

The following initiatives constitute the foundations for the conceptual framework and criteria for action constructed in recent years to serve as the underpinnings for PAHO technical cooperation: (a) the Plan of Action of the Miami Summit; (b) country contributions to the Special Meeting on Health Sector Reform and the resolution of the subsequent Directing Council (1995); (c) the follow-up report on health sector reform activities presented to the Directing Council of the Organization (1996); (d) the document *Cooperation of the Pan American Health Organization in the Health Sector Reform Process*; (e) the report *Steering Role of the Ministries of Health in the Processes of Health Sector Reform* presented to the Directing Council (1997); (f) discussions on sectoral reform at the meetings of the ministers of health of Central America, the Andean area, MERCOSUR, and countries of the English-speaking Caribbean; and (g) the follow-up and support for the national commissions and support groups for reform in several countries of the Region.

At the end of the Special Meeting of 1995, the 38th Directing Council of PAHO adopted Resolution CD38.R14 which requested the Director “In accordance with the recommendations of the Summit of the Americas and taking into account the discussions at the Special Meeting on Health Sector Reform, to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas.”

This mandate led to preparation of the “Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean.” Work began in October 1997, with the preparation of the “Base Line for the Monitoring and Evaluation of Sectoral Reform.”

This Methodology makes it possible to describe and analyze the dynamic—that is, the various phases of the sectoral reform process (genesis, design, negotiation, implementation, and evaluation), as well as the characteristics, proposals, and relationships between the principal actors (social or institutional, public and private, national, subnational, or international); the contents of the processes (i.e., the strategies designed

and the action effectively taken; and the results (i.e., the degree to which sectoral reform may be helping to raise the levels of equity, effectiveness and quality, efficiency, sustainability, and social participation in health systems and services).

The Methodology has been used in the Latin American and Caribbean countries. Reports are currently available for Argentina, Brazil, the Dominican Republic, Guatemala, Guyana, Honduras, Mexico, Panama, and Paraguay. Application of the Methodology to all the countries of the Region has been programmed for the current year, along with a review of its results.

1. Background

The major technical cooperation activities of PAHO include: strengthening national capacity for the design, implementation, and effective use of methodologies and information systems to detect and evaluate changes in the living conditions and health of populations; building capacity for policy analysis, planning, and formulation; and strengthening the leadership and administrative capacity of the ministries of health and other sector institutions, in both their regular operating areas and the sectoral reform processes.

The First Summit of the Americas, held in Miami in 1994, included a discussion on the national sectoral reform process. The Summit called for a special meeting involving governments, interested donors, and international technical cooperation agencies, organized jointly by PAHO, the Inter-American Development Bank (IDB), and the World Bank. The purpose of this meeting was to establish the conceptual framework for these processes, define PAHO's role in monitoring and evaluating plans and programs for sectoral reform in the countries of the Region, and strengthen the health economics network.

The 38th Directing Council, through resolution CD38.R14 (1995), requested that the Director "In accordance with the recommendations of the Summit of the Americas and taking into account the discussions at the Special Meeting on Health Sector Reform, to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas." At the next meeting of the Directing Council (1996), the Secretariat reported on progress in health sector reform activities in the Americas. The Directing Council ratified sectoral reform as a strategy to make health systems more equitable, efficient, and effective and urged the Member States to reaffirm their political commitment to health sector reform. It recognized the need for coordination of external support, respect for national autonomy, and the sharing of experiences on the national health sector reform processes.

In 1997 the Health Sector Reform Initiative for the Latin American and Caribbean countries was launched. This is a six-year project (1997-2002) sponsored by PAHO and the Agency for International Development (USAID), in collaboration with the following NGOs: Partnership for Health Sector Reform (PHR), Data for Decision-making (DDM) and Family Planning Management Development (FPMD). The main objective is to provide regional support to promote equitable access to quality basic services in the Region of the Americas.

The Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean and the Clearinghouse on Health Sector Reform (SINAR)

were developed as part of this Initiative. Their purpose is to collect and disseminate data on health sector reform in the Americas.

2. Methodology for Monitoring and Evaluation of Health Sector Reform

2.1 *Conceptual Framework*

The Strategic and Programmatic Orientations, 1999-2002, indicate that the Secretariat is to implement a regional system for monitoring the dynamic, content, and impact of sectoral reforms, in such a way as to encourage the systematic and periodic exchange of information on national experiences.

In the Region of the Americas, health sector reform has been proposed as a process aimed at improving equity in benefits, administrative efficiency, and effective action, thus meeting the health needs of the population.

In terms of sectoral reform, the Region in reality presents a highly diverse picture. There are major variations in the dynamic and the content of the changes that most countries are introducing.

The main criteria that PAHO is promoting in sectoral reform are: equity, quality, efficiency, sustainability, and social participation. These concepts make it possible to judge the direction of current and programmed reforms, from the standpoint of their stated ultimate purpose. Thus, no reform should run contrary to these criteria, and the ideal reform would be one in which all five aspects had improved by the end of the process. Each of these aspects may in turn be subdivided into a set of variables that may be associated with quantitative or qualitative indicators adapted to the conditions in each country, and that can help evaluate the degree to which reform objectives have been met.

2.2 *Usefulness and Design Process of the Methodology*

The process of preparing the Methodology for the Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean began in October 1997 with the preparation of the Base Line for the Monitoring and Evaluation of Sectoral Reform which was applied in 17 countries¹ of the Region.²

Based on that experience, the first version of the Methodology was prepared with the participation of various units and programs of PAHO. It was subjected to a feasibility

¹ Bolivia, Brazil, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, and Suriname.

² The country reports were published in English and Spanish, along with other publications of the Latin American and Caribbean Regional Health Initiative. They can be consulted at the Web page (<http://www.americas.health-sector-reform.org/english/index.htm>).

test, discussed in an international advisory meeting (1998), and adapted for the preparation of the current version. The Methodology is a tool to help decision-makers (at the national and subnational levels in the countries) and the technical cooperation agencies that support them to produce reports that are as objective as possible, manageable in length, easily updated, and that systematically monitor and evaluate the health sector reforms.

The Methodology has been developed in tandem with the Guidelines for the Preparation of the Health Services System Profile in the Countries. Although either one may be used on its own, monitoring and evaluation of the reform processes benefit enormously from the results of the methodological analysis, in terms of the context in which the health services systems operate, and of the general organization, resources, and functions. Likewise, in most countries it would be difficult to analyze the performance of the system, or potential and/or actual health services, without factoring in the effects of programmed or current reforms.

Potential users of the Methodology include national professionals engaged in the planning and administration of health systems and services, at both the national and subnational levels; professionals from the countries or the headquarters of the technical and financial cooperation agencies, or NGOs; managers and professionals of other public and private institutions in or allied to the sector and institutions, educators, and researchers.

For input, the Methodology basically employs the information that is available, favoring institutional information published in official national sources. It also uses information published by international technical and/or financial cooperation agencies (including PAHO). Furthermore, it uses unpublished information from official national sources, provided that their use is authorized. Finally, it uses information published in nonofficial sources (for example, signed articles) that are considered relevant.

2.3 *Contents*

The Methodology contains variables and indicators that rely on both qualitative and quantitative information. The quantitative information is essentially the information that appears to be available in most of the countries. For qualitative information, the questionnaire attempts to be explanatory and suggests the approximate length the topic could occupy in the Profile. It has two main chapters: one on monitoring the reform process, and the other on evaluating the results.

3. Monitoring of the Processes

3.1 *Dynamic*

The reforms are processes in which, over time, it becomes possible to identify definite stages and a large number of actors. With regard to the stages of the reform process, the Methodology seeks to identify the genesis or “remote origin,” the design or “immediate origin,” the negotiation, the implementation, and the evaluation of results. With regard to the actors, it seeks to identify both those whose principal area of impact is society in general, and those whose principal area of impact is the sector, whether national or international.

3.2 *Contents*

In this area the Methodology seeks information on the strategies designed and the action actually taken. It includes questions on the legal framework, the right to health care and insurance, the steering role, the separation of functions, decentralization modalities, social participation and control, financing and expenditure, the supply of services, management models, human resources, and the quality and assessment of health technologies.

3.3 *Evaluation of the Results*

The purpose of this chapter is to analyze the degree to which sectoral reform may be helping to improve the levels of equity, effectiveness and quality, efficiency, sustainability, and social participation in the health systems and services.

3.3.1 *Equity*

Equity implies reducing to a minimum all avoidable and unjust disparities in health conditions. Equity in health services implies receiving care according to need (equity in coverage, access, and use) and financing that care according to the ability to pay (equity in financing).

The Methodology seeks evidence that the sectoral reform has improved variables and indicators of coverage, resource distribution, access, and resource use.

3.3.2 *Effectiveness and Quality*

Effectiveness and technical quality imply that users of the services receive effective, safe, and timely assistance; perceived quality implies that they receive it under adequate material and ethical conditions.

The Methodology seeks evidence that sectoral reform has improved variables and indicators of morbidity, mortality, technical quality, and perceived quality.

3.3.3 *Efficiency*

Efficiency implies a favorable relationship between the results obtained and the cost of the resources utilized. It is analyzed from two angles: one referring to the allocation of resources and the other referring to the productivity of the services. Resources are allocated efficiently if they generate the maximum possible health gain per unit of cost. They are used efficiently when a unit or product is obtained at minimum cost, or when additional units of product are obtained for a given cost.

The Methodology seeks evidence that sectoral reform has improved variables and indicators of resource allocation and resource management.

3.3.4 *Sustainability*

Sustainability, which has a social and a financing dimension, is defined as the capacity of the system to resolve its current problems of legitimacy and financing, as well as the challenges of future maintenance and development.

The Methodology seeks evidence that sectoral reform has improved: the legitimacy and/or acceptability of the principal institutional health service providers; medium-term sustainability of efforts to increase coverage; the capacity to adjust the income and health expenditure of the principal public sector institutions; the percentage of health centers and hospitals with the capacity to collect from third parties; and the capacity to manage external loans and, when applicable, to replace them with national funds when they reach maturity.

3.3.5 *Participation*

Social participation has to do with procedures that allow the general population and diverse agents to influence the planning, management, service delivery, and evaluation of health systems and services, and to benefit from the results of this influence.

The Methodology seeks evidence that sectoral reform has helped to increase the degree of social participation and control in the various levels and functions of the health services system.

4. Application of the Methodology

The Methodology has been used in Argentina, Brazil, the Dominican Republic, Guatemala, Guyana, Honduras, Mexico, Panama, and Paraguay.³ Below are summaries from some of the countries that indicate the type of information obtained with the application of the Methodology.

4.1 Argentina

Sectoral reform began in 1992; it is consistent with the economic and State reforms and is based on the national health policies. The Government explicitly chose a strategy of measured, gradual change, whose general direction has been to strengthen the regulatory role of the central and provincial health authorities. The Ministry of Health and Social Welfare has exercised the steering role in sectoral reform, thanks to the technical leadership function established for it in the national health policies.

The principal lines of sectoral reform have been: creation of the Self-Managed Public Hospital (HPA); beginning of the transformation of the *Obras Sociales* (OS) with externally financed support; development of a regulatory framework for the private sector; the compulsory provision of a basic package of benefits to beneficiaries of the OS and the Prepaid Medical Companies (EMP), consistent with the sectoral reform (the Compulsory Medical Program); establishment of the National Program of Guaranteed Medical Care; and the beginning of sustained, concerted action for health promotion and protection, especially through the targeting of populations in potentially high-risk situations.

Sectoral reform has served to organizationally restructure the health scenario, restore the public hospital as a service provider, and incorporate new procedures and agencies responsible for the monitoring, regulation, and control of the quality of care. It has created a compulsory coverage system, established the free choice of a third-party payer in the OS, and changed the relationships between the various actors of the sector. It is not yet possible to analyze how this has contributed to improving the levels of equity, effectiveness, quality, efficiency, sustainability, and participation in the health services.

4.2 Dominican Republic

The first steps to formulate the process of health sector reform were taken in the early 1990s and were aimed at solving the problems of centralized management characterized by a limited capacity for implementation and unsatisfactory regulatory and supervisory frameworks.

³ Accessible through the Web page of the Initiative (<http://www.americas.health-sector-reform.org/english/index.htm>).

A sectoral reform process began in 1996, with the participation of various actors from civil society. This translated into two projects financed by the World Bank, the IDB, and other bilateral cooperation agencies totaling nearly US\$ 120 million.

The main objectives of sectoral reform are: to reform the social security system; to promote the deconcentration and decentralization of the public sector; to define a basic package of benefits for universal access; to strengthen mechanisms for mixed public-private financing, based on solidarity; to introduce public-private mechanisms for insurance and supply; to promote hospital self-management; and to strengthen the regulatory role of the State. The Executive Commission on Health Reform was created to manage the sectoral reform process.

To date, Provincial Health Offices (DSP) have been established as deconcentrated agencies of SESPAS, and a new model of care has been developed.

An interinstitutional technical group was recently formed to design the most appropriate methodologies for monitoring and evaluation of the country's sectoral reform process.

4.3 *Guatemala*

The Government has promoted the Comprehensive Health Care System (SIAS) as a way of increasing service coverage. This system is meant to provide a basic package of services to the population that currently lacks them. The System is based on a community worker network and on subcontracting with NGOs for the delivery of services.

The SIAS is the major initiative of the Program for Modernization of the Health Services currently being implemented in Guatemala; it has the financial support of an IDB loan.

Since the process is quite recent, it is premature to evaluate the impact of health sector reform in Guatemala. The action taken to date, however, seems to have improved access by drawing suppliers closer to the communities, and by referring cases to health centers when necessary. These modifications have the potential to redress the health inequities that have historically affected rural and indigenous populations.

4.4 *Honduras*

The three major problems that undermine the efficiency and effectiveness of the network of public health facilities are: the substantial proportion of the rural and urban

population living in extreme poverty; lack of access to services, owing to the extreme geographical dispersion of the population; and the lack of financial resources to guarantee broader and better coverage.

Initiatives for sectoral reform were facilitated by these and other mounting problems, and their adverse impact on the health of the population. Thus, in May 1993 the “Program for Modernization of the Health Services System” was promoted, in order to improve the interaction between levels of care and other public and private options. Between 1994 and 1998 the “National Process of Access” helped to democratize the management of the services networks by encouraging decentralization and social participation, and access to health services increased. Given the need to strengthen the steering role, a major transformation of the model of care was instituted in 1998, along with the reengineering of systems and processes. This was manifested in a health policy document in which sectoral reform was declared the “new agenda in health” (NAS).

The NAS has two basic lines of action (health promotion and education, and quality assurance and improvement); seven essential components (steering role and regulation; departmentalization and reorganization of the model of care; evaluation of health problems and consolidation of plans and programs; upgrading of human resources; drug policy; the environment and health; and information systems) and six dynamic strategies (supervision, monitoring, and evaluation; decentralization and co-management in health; infrastructure, maintenance, and technology; the intersectoral approach; financial sustainability; and administrative modernization).

There is not enough information to date to evaluate the results of the different stages of sectoral reform in Honduras. There is not enough evidence to say that sectoral reform so far has improved equity in health status or in access to the services, or the efficiency of resource management in public facilities. There is some evidence that sectoral reform may have helped to improve the technical quality of public hospitals in some regions, user choice in primary care, the legitimacy of the facilities, and social participation and control.

4.5 *Mexico*

The 1995-2000 Program for Reform of the Health Sector was announced in 1996. Its objectives are: to establish instruments for promoting quality and efficiency in service delivery; to expand the coverage of care offered by social security institutions, facilitating the membership of the unsalaried population and workers in the informal economy; to conclude decentralization of the health services for the uninsured population; and to expand service coverage to marginalized populations in rural and urban areas, whose current access is limited or nil.

By late 1997 the transfer of human resources (103,000 workers), infrastructure (7,400 facilities), and financial resources (6,132 billion pesos) to all the states of the Republic had been concluded. The objective is for the States to have a clearer definition of goals, responsibilities, and evaluation systems for better health policies, while the Ministry of Health prioritizes its regulatory and coordination functions. The Program for Expanded Coverage (PAC) is being also implemented, based on a basic package of health services in the more marginalized areas.

The sectoral reform program envisages specific two-way actions to promote and facilitate voluntary affiliation with the social security services, to establish health insurance for families, and to bring essential health services to marginalized population groups through the basic package. In mid-1998, the Secretary of Health publicly stated that, thanks to the PAC, health care had been granted to 7 million Mexicans who prior to 1995 had lacked access to any type of health services. According to this same source, services must still be brought to 3 million people, living mainly in the States of Chiapas, Guerrero, Hidalgo, and Oaxaca.

4.6 *Panama*

Although the sectoral reform is national in scope, it has begun in the health regions of San Miguelito, the Metropolitan area, and Coclé. The legal foundations for sectoral reform are contained in three laws that facilitate the separation of functions, the strengthening of intrasectoral work, and social participation. Changes have also been made in the national and subnational structure of the public health sector. Implementation of a new model of family, community, and environmental care has begun, which includes stratification by level of care and the implementation of a referral and counter-referral system between the community level and the primary and secondary levels of care.

In the region of San Miguelito, the San Miguel Arcángel Hospital has introduced administrative commitments and program-contracts for health care. This hospital is conceived along business and self-management lines.

Work is being done on the design of procedures for the accreditation of health facilities, and to develop the procedures for quality assurance. This is also true for mechanisms for technology assessment and the regulation of medical devices and equipment.

The sectoral reform process is still in its infancy, which means that an evaluation has not yet been conducted. The plan envisages an evaluation by the year 2000, for which PAHO technical cooperation for the formulation and design of an evaluation methodology has been requested.

4.7 *Paraguay*

In December 1996, as a part of the sector reform strategy, the law establishing the National Health System (SNS) was passed. This seeks to provide equitable, efficient, and timely health care to all persons without distinction, through promotion, recovery, and rehabilitation activities. It also seeks to rationalize the use of available resources and to establish intra- and intersectoral relations.

The law confers on the National Health Council (CNS) the coordination and control of plans, programs, and activities of public and private health institutions. The CNS is presided over by the Minister of Health, and all sectors and related institutions belong to it. The law created a series of agencies under the CNS, such as the Supervisory Authority (SUPNS), the Medical Directorate, and the Public Health Fund (FNS), with regulations still to be drafted. The new functions and the organizational model of the Ministry of Public Health and Social Welfare (MSPBS) were established by Decree. The sector's financing functions will be assumed by the FNS. Measures to modify the composition of sectoral financing will be studied by the new government (which took office in August 1998), when the implementation of the FNS is discussed. Insurance functions will be under the supervision and control of the SUPNS, and service delivery will be the responsibility of public and private institutions.

The MSPBS is transferring physical and financial resources to the municipios for administration by the Local Health Councils (CLS). This transfer, which does not include human resources, is effected through "Commitment Agreements." Social participation is a goal and strategy of the sectoral reform and is being brought about through the Regional Health Councils (CRS) and the CLS.

To date there have been no changes in education, human resource planning, or management to respond to sectoral reform needs. Reengineering of the National Institute of Health (INS) is under way, with the intent of converting it into the agency responsible for the development of these resources.

Paraguay's sectoral reform is in its initial stages, so it is premature to evaluate results. However, some recent studies (e.g., "Analysis of the Health Sector of Paraguay" and "Sectoral Study of Water and Sanitation") can serve as the basis for a preliminary evaluation.

5. *Next Stages*

Programming for the current year includes application of the Methodology to all countries of the Region. With regard to the periodicity of its use, the idea is to update

information for each country on an annual basis. A usage-based review of the Methodology that incorporates the gender approach has also been programmed. The development of this instrument has consistently been considered within the framework of a continuous improvement process, in which the necessary changes will be made as a result of actual use and the experience acquired.

The main activities under consideration for future development of the Methodology and the Clearinghouse on Health Sector Reform will seek to:

- Establish a clearinghouse on health sector reform that will collaborate effectively with the health authorities of the countries of the Region in decision-making that affects the reform processes;
- Ensure that information derived from the application of the Methodology is effective in helping to obtain information that is useful in terms of the proposal in the preceding paragraph;
- Move forward with the integration of databases and demographic and epidemiological analysis, with information deriving from progress with respect to systems and services;
- Strengthen assessment of the impact of the sectoral reforms in terms of reducing coverage gaps, the articulation of networks, equitable access, and the effectiveness of actions.