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COORDINATION OF SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

In compliance with the provisions of Resolution XXXII of the XXVI Meeting of the Directing Council on "Coordination between Social Security and Public Health Institutions," the present document examines salient aspects of the coordination of health institutions that are particularly relevant to the situation of 16 Latin American countries where health service systems have developed under the ministries of health and the social security system.

A review of the present situation discloses changes in different countries stemming from policy decisions chiefly in the area of financing, and major changes in social security systems, whose health institutions and programs now cover significant proportions of the total population in those 16 countries.

The national and regional strategies and the Plan of Action proposed for attaining the health goals of the year 2000 provide a new frame of reference for institutional coordination efforts in the health sector. The Plan identifies areas in which these efforts would constitute practical approaches to the solution of priority problems calling for action in concert by the two types of institutions.

1. Background

At its XXVI Meeting in 1979 the Directing Council of the Organization took up the subject of coordination between social security and public health institutions and adopted Resolution XXXII in which it reiterated to the Governments the advisability of having social security and health ministry agencies coordinate their activities in the application of policies for extending the coverage of health services to the entire population. The Council also urged the Governments to develop schemes or arrangements for the organization and delivery of services that would achieve the financial and functional harmonization of the different components of the health sector, and requested them, when drawing up their investment plans, to provide for participation by the various institutions in the sector. In Resolution XXXII the Council also asked the Director to make the necessary budgetary provision for support of efforts in this direction at the national level, and to report to the XXVIII Meeting of the Directing Council on progress by the Member Countries and on the measures taken by the Organization in this field.

In compliance with the latter request of the Council, the present document supplies important background information on the movement toward the coordination of services in the countries of Latin America; provides, from this standpoint, a brief rundown of the present situation and features of their health services; and reviews possible new areas for coordinated approaches in the setting of the strategies and the Plan of Action proposed for attaining the health goals of the year 2000. Finally, the document explores possible areas and orientations for technical cooperation in this field.

2. Progress, Trends and Present Situation

The existence in about two thirds of the countries in the Region of personal health service delivery systems under, respectively, the ministries of health and the social security institutions, and particularly the implications of their parallel--and largely interconnected--operation, have been objects of particular concern and interest in this group of countries and in the international agencies working with them to develop their health services.

Thus, innumerable national and international meetings have considered a very wide range of conceptual and operational aspects of coordination, and have generated declarations, resolutions, recommendations, etc., which add up to practically a body of doctrine on the subject. An examination of the present situation and the documents relating to it reveals essential conceptual agreement on the advantages and importance of coordination among health institutions. In practice, however, gains by

essentially administrative approaches have been generally slow and of limited scope, except when policy decisions have been taken which have affected the character and the very nature of the institutions.

The principal constraints on the attainment of this coordination are traceable to factors of four major types: institutional, economic and financial, structural and bureaucratic, and political.

In general, measures in the administrative sphere, where coordination efforts were long concentrated, are continuing. Thus, various approaches to the improvement of services are still being pursued, and attempts at joint programs, as for the regulation of capital investments in facilities and the review and adjustment of interinstitutional service contracts, are still in progress. The most important change of recent years, however, seems to be more determined action by Governments to eliminate inequities in the services of both types of institutions, and to give effect to the right to health care which is equal for all citizens, and thus reduce the inequalities among different segments of the population.

The long years that have passed since the inception of social security have seen the development of social security doctrine and, in parallel, of its modes of operation. This process now seems to be reaching a stage of maturity in which the institutions are becoming true instruments for the implementation of government social policy. In a good many countries the trend of the last few years seems to be toward an increasingly active role for social security institutions and schemes in the provision of health services.

The gradual transformation of the old social security agencies and their evolution into components of national social security systems implies two basic corollaries: a tendency toward greater internal consistency and toward harmonization among the various social security agencies in a country, and their increasing articulation with the national economic and social development processes, which brings them closer to the public sector health services and increases their involvement in the implementation of the Government's social policies.

Another accompaniment to these political realignments in the social security sphere has been greater Government involvement in the forms and mechanisms for financing those agencies.

In view of these observed changes both in the health ministries and the social security agencies, and by way of summarizing the present situation, though no complete information is available on the matter, the following may be noted: in 5 of the 21 Latin American countries in which the social security systems have developed health protection schemes,

those systems have not undertaken to provide services directly, though in three of the five the systems contribute to the financing of services, which are provided under a variety of institutional arrangements.

In the 16 remaining countries, services are still delivered in parallel by systems operating under the ministries of health and social security. In some of these countries the number of subscribers to social security has grown to a high proportion of the population, while subscriptions to the services of the health ministries have proportionally declined.

In 1979 subscribers to social security regimes were estimated to have accounted for about 55.7 per cent of the total population of these 16 Latin American countries. The figures on those proportions are given in Tables 1 and 2.

It follows from the foregoing analysis that the provision of personal health services for much of the population in Latin America has now become the responsibility of the social security institutions. The general trend seems to be toward greater participation by these establishments in those programs. This trend heralds, on the one hand, major changes in the political and operational conception of social security and, on the other hand, a shift toward rational combinations of arrangements for financing the services.

In these circumstances, it would seem necessary to take a closer look at the redistributive effect of social security in its new orientations and to reassess its capacity to meet the challenge of the widespread application of these approaches in the more or less immediate future, as well as to reconsider whether the structure of the national systems should or should not be centralized, the proper roles of Government and the private sector, alternative financing mechanisms, and the relationship to health of social security programs in areas other than the provision of health services.

3. PAHO Technical Cooperation with Social Security Agencies

On the national level, a number of cooperative operations have been carried out with several countries. These operations have included the design of methods for generating information on hospital performance, yields and costs, the multidisciplinary study of the operation of the national social security agency in relation to national development, the evolution of its benefits in health services and money, the legal infrastructure for its funding and administration, its economic and financial situation, the strengthening of its technical-administrative capacity for programming, and the establishment and maintenance of its health facilities, and also the formulation of national guidelines, support to the

related institutional coordination and integration, and determination of the internal system for the planning and financial administration of the social security system.

PAHO has continued to cooperate in overall analyses to establish the basis for the development of national health services, in the design of national health plans, and in the drafting of proposals for changing and expanding the infrastructure of the health services.

Also noteworthy in this field are PAHO's extensive activities carried out through the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) in the area of occupation health, part of which are incorporated into the social security programs of some countries.

On the international and regional levels, PAHO has actively participated with international agencies cooperating with social security institutions. Activities have included participation in meetings and events organized by the Inter-American Social Security Conference and its Standing Committee, and by other international social security entities. These meetings over the last year dealt with, among others, the following subjects: Structure of Medical Care Services; Engineering Standards for the Design of Medical Units; Primary Care and the Role of Social Security in Attaining the Health Goals of the Year 2000; Social Protection of the Rural Population; Family Allowances; National Conference on the Aged; Levels of Care, and the Determination of Basic Cadres: Rationalizing Approaches in Health Services; Social Indicators in the Health Sector with Regard to the Health Goals and the Strategy Adopted for the Year 2000.

These technical cooperation activities have gone forward under the program for the development of medical care systems and also under other programs, especially those of regional scope.

4. National and Regional Strategies: Frame of Reference for New Coordination Approaches

The general approach of the strategies adopted by the countries for implementing their health care policies calls for a concerted effort to reorient and develop the national health systems with primary health care as their principal function.

The components of primary care as defined at Alma-Ata imply a departure from the traditional conception of health systems. The aim is

not only the delivery of health services but, essentially and above all the promotion, maintenance and development of health. This means that health systems must be made up of assemblages of interrelated components that start with the family and the community, and include the educational institutions, the localities and places of work, the health services themselves, and the services in other sectors that bear directly on health.

In this general frame of reference, the coordination of health institutions takes on new dimensions. While it is essential to continue with efforts for the functional and operational harmonization of the schemes and organizational arrangements devised for the delivery of services (the traditional approach to coordination), in the general setting of the maintenance and development of health established by the strategy of primary health care new areas must be identified for coordination, particularly in the policy-making field, of the ministering to and satisfaction of the basic needs of the different population sectors (minimum acceptable levels of welfare) in which institutions in the health and other sectors operate.

Important in this regard is the coordination of definitions in, for example, extending the scope of such aspects of social security as family allowances and allowances for special situations (unemployment, survival, coverage for deferred risks, etc.). Similarly, health measures will have to be harmonized with housing, employment and education programs, and with social protection services not dispensed by social security, etc. This function of general coordination of all spheres of national life bearing directly and indirectly on the health of the population devolves upon the agencies charged with overseeing health measures in the countries, that is, the health ministries. In most situations, this is a new role and a new function generated by the intersectoral view of health, and playing the one and performing the other will call for major transformations in the current structures and orientations of those institutions.

In the economic situation that most of the countries in the Region are expected to encounter over the next 20 years, and in the understanding that the models of public welfare (services to indigents) that prevail in several countries of Latin America suffer from serious limitations for purposes of universalizing the coverage of health care, other solutions will have to be chosen. Since the choice of funding arrangement is a crucial consideration in this weighing of alternatives, it seems reasonable to expect novel, composite financing schemes to emerge in which the institutional responsibility for the direct provision of personal services is located, or distributed around, the social security system. The formulation of and choice among these alternatives of institutional financing and orientation obviously rest with the decision-making bodies in each country.

Ideally, the coordination efforts involved should aim preferentially at clearly defining areas of responsibility, not only as to the population sectors which the different institutions are to service, but also as to the kinds of programs they are to conduct, and how those programs are to be oriented.

Whatever the final decisions in each country, it is clear that giving them practical effect will take time. Meanwhile, there can be no doubt of the need to harmonize measures in application of the primary care strategy, to carry on health services research in support of the interinstitutional effort, to set up effective machinery for the selection and adaptation of technologies, to make financial analyses of the health sector, to devise modes of intersectoral operation and, above all, to analyze in depth the arrangements for the production of services and their financial implications so that the necessary adjustments and changes may be made. These are all areas in which joint action--and hence the institutional coordination of health ministries and social security agencies--is of extraordinary importance for implementing the national and regional strategies for attaining the health goals of the year 2000.

5. The Plan of Action and the Identification of Priority Coordination Areas

In its XXVII Meeting in 1980 the Directing Council of PAHO decided that a "plan of action" was to be prepared for implementation of the national and regional strategies adopted for attaining the goal of health for all by the year 2000. Initially approved in the 86th Meeting of the Executive Committee, this Plan of Action is being presented for consideration by the Council in the present meeting, and will become a principal yardstick for the adjustment of national health plans and measures, and an equally important guidepost for charting the Organization's own technical cooperation programs and activities.

The purposes and general objectives of the Plan of Action stress goals of access to, and the use and organization of, health services which, together with contributions of funds from and measures in other economic and social sectors, will meet the basic needs of the different population groups, and particularly of those which have been traditionally deprived. The Plan also emphasizes that the measures must go forward throughout the sector, that is, with the participation of the various institutions making up the health sector in each country. Hence in the general framework of the Plan of Action it is advisable to try to establish areas and aspects in which priority must be given to efforts at coordination between the health ministries and the social security institutions.

For implementation of the primary care strategies the Plan provides two major fields of action: development of the health infrastructure and development of priority program areas.

The salient aspects in the first field are as follows:

a) Sectoral Restructuring

The Plan cites a need to analyze and redefine the sector's legal and functional structure, including the social security systems, with special attention, among other aspects, to its institutional composition, coordination machinery, formulation of the requisite interinstitutional agreements, and the drawing up of sectoral health plans in coordination with the interested national economic and social planning agencies. The performance of these analyses with the participation of the institutions, and particularly the introduction of the changes recommended as a result of them, implies major changes in the decision-making process and machinery of the countries' health sectors. A practical and potentially effective way of revitalizing approaches to and efforts at coordination would be to set up national health committees or councils, or other bodies for institutional representation, or, where they already exist, to restructure them both in the policy-making area and on their technical side, and to make the defining and allotment of institutional responsibilities their primary function.

b) Strengthening of Planning and Programming Processes and the Development of Intersectoral Articulation

The Plan of Action stresses, on the one hand, the importance of promoting and supporting the formulation of sectoral and institutional health plans and, on the other hand, the need for intersectoral action to solve current basic problems in the health status of communities. The requisite solutions can only be corrected by vigorous intersectoral action.

Because of the basic needs component of the health goals for the year 2000, and for the guidance of the health sector and the proper conduct of its relations with other sectors, the decision-making and technical authorities of that sector, whichever the institution in which they are lodged, must have better connections to the levels and agencies in charge of the planning for the economic and social sectors.

c) Adjustment of the Sectoral Financing and Service Production System

In regard to financing, the Plan underscores the need for sectoral and institutional analyses. Critical here are the search for and utilization of new financial sources and strategies, the devising of technical and administrative innovations for reducing costs, and control of the production, productivity, utilization and distribution of the services to selected population groups.

This is a particularly important area of institutional coordination in which a joint review and harmonization of the modes of service production will have priority.

d) Increasing the Installed Capacity

One aspect of extending the coverage of the health services to 100 per cent of the population is increasing the installed capacity and improving the availability of inputs and equipment. The former calls for a review and adjustment of institutional investment plans to arrive at a sectoral investment plan, the performance of studies of architectural alternatives, and the devising of appropriate maintenance systems. The latter requires the compilation of basic lists, and standardization on the basis of national specifications for essential inputs and equipment.

This is therefore a field of joint action for the agencies that make up the health sector of the countries, and for the health ministries and social security institutions in particular.

Special mention in this field should be made of maintenance activities, in which difficulties and limitations are universal, and affect equally the services of the health ministries and the social security systems. This is an area in which joint action stirs no opposition and, in fact, the early experience has proved very promising. Thus, approaches of this kind should be encouraged and bolstered in the countries.

The same approach should be taken for the standardization of critical equipment and inputs.

e) Manpower Programming and Development

Human resources are an essential ingredient in any process of change. Health systems will scarcely be made to function properly, much less the goal of health for all by the year 2000 be attainable, without human resources suitably trained and retrained to meet the new needs of the health care services and processes.

In these circumstances, there is pressing need for a thorough review of present personnel training programs and for new approximations that include a recasting of occupational and educational profiles along with a corresponding reinforcement of the institutional resources.

Moreover, manpower planning for health services carries with it the need to fit training programs to the prospects for employment of the personnel to be trained and to the nature of that employment.

In the situation of most Latin American countries, the social security institutions and health ministries--the big employers of health manpower--must share the concern and responsibility for the proper planning and utilization of these resources, and must coordinate the action they take with the education sector and the national planning units.

f) Research and Technology

The formulation and adoption of policies on health research and technology are essential to attainment of the objectives of the Plan. These policies must be implemented with a view to solving the priority problems and to bridging the gap between the acquisition and application of knowledge. The health ministries and social security institutions must jointly sponsor, encourage and carry on specific measures in this field, particularly to harmonize the choice and adaptation of the technologies used in their respective service delivery schemes.

In the second major component of the Plan, to implement the primary care strategies for the development of priority areas of the program, important situations and fields are identified which would undoubtedly benefit from specific measures to coordinate the institutions in the sector. Some of these are:

a) Development of Health Services in Major Cities

According to demographic estimates, 20 years from now one of every four Latin Americans will be living in urban centers, and particularly in large cities. The prospect of a large, heavily concentrated mass of people, many of them living in extreme poverty, already signals the need for a substantial increase in the capacity of the services and a very great diversification of their variety, for the sake of both the environment and the individuals themselves. If primary care is truly to be incorporated

into the schemes for the health care of this population, emergency care services properly organized, and new approaches devised for coping with the social pathologies generated by concentration and overcrowding, etc., priority measures will be required in which the health ministries and social security institutions will have to act jointly.

b) Health of Workers

The objective in this area of the Plan of Action is to expand the occupational health services. The coverage of risk prevention is estimated at only 30 per cent of the population in Latin America, through the social security systems. The appropriate development of these services will require, among others, the revision of laws, regulations and standards for accident prevention, work-place inspections, establishment of specialized institutions, training of appropriate personnel, and incorporation of occupational health measures into the general network of services.

This is a field in which social security will be particularly interested, and its efforts will have to be harmonized with those of other institutions in the sector.

c) Health Care of the Aged

In some countries of the Region, the population of advanced age is expected to increase considerably. Many of these people are pensioners under social security who, however, receive specialized care from health ministry services. Moreover, more knowledge is needed to promote the growth and coordination of community services such as social centers, home assistance, and social, occupational and vocational rehabilitation.

d) Health Care of the Handicapped

This area of the Plan of Action relates directly to the fields of social security work and is slanted toward prevention of the causes of disability and comprehensive care of the handicapped, so that they may lead comfortable and productive lives. Accomplishing these purposes requires intra- and intersectoral coordination, particularly with social services, education and employment, so as to promote and activate occupational, welfare, and recreational opportunities. To the extent that progress is made in these measures, outlays for these purposes in social security regimes will decrease.

The foregoing are specific areas and aspects of the Plan of Action for development of the health strategies of the year 2000 in which specific coordination is required between the health ministries and social security systems. As such, they should constitute virtual commandments by which all action should be guided over the coming years. The fact of identifying and stating them does not, of course, obviate the need to continue such efforts extensively in different aspects of the operation of the services, in accordance with the characteristics of each country. Concerted efforts in these areas, in some of which the approach has not met any resistance in the past, would make it possible to focus the joint action of the institutions on an organized search for solutions to concrete problems, which would give coordination clear-cut objectives and a broader meaning.

In this process of institutional coordination of the health sector in the countries the guidance and catalytic action of international technical cooperation is of vital importance.

As previously noted, the Pan American Health Organization, in compliance with instructions of the Directing Council, has endeavored to respond to the request of its Member Governments for collaboration in this field. In the revised situation, however, measures and mechanisms for cooperation must be stepped up and made to work more smoothly and flexibly. It would accordingly seem advisable to define the actions more clearly and energize their implementation under a definite, properly funded program that can generate regular activity to meet these needs routinely. In view of the volume of population covered by social security, it appears essential to give greater prominence and breadth to measures carried out in regard to these entities. Many of the obstacles to such action in the past apparently derived from political limitations in the countries. Properly interpreting the goals of health for all by the year 2000 as national and not merely institutional goals should help significantly to nullify these limitations. One of the purposes of the new lines of technical cooperation in this field should be to generate a greater awareness in this regard.

In the same direction and to unify technical and financial efforts and resources, it would seem advisable to establish in this area joint programs with other international agencies working in the social security field, particularly the International Labor Organization (ILO), the Organization of American States (OAS), and the Standing Inter-American Committee on Social Security (CPISS).

There is favorable experience of such joint actions which make this advisable.

TABLE 1

ESTIMATED POPULATION COVERED BY HEALTH BENEFITS OF SOCIAL SECURITY, LATIN AMERICA, AROUND 1979

Countries by Subregional Groups	Year	Percentage of Population Covered by Social Security	Estimated Total Population (thousands)	Estimated Population Covered by Social Security
ANDEAN AREA		15.2	69,426	10,553
Bolivia	1978	26.2	5,286	1,385
Colombia	1978	10.2	25,645	2,615
Ecuador	1979	5.0	8,080	404
Peru	1979[1]	11.7	17,293	2,023
Venezuela	1978	30.2	13,122	3,963
SOUTHERN CONE		71.2[2]	33,004	23,491
Argentina	1980	80.0	27,064	21,651
Chile[4]	1980		11,104	
Paraguay	1980	13.1	3,062	401
Uruguay	1979[1]	50.0	2,878	1,439
BRAZIL	1978	83.0	115,397	95,780
CENTRAL AMERICA		21.5[2]	18,054	3,883
Costa Rica	1977	82.0	2,070	1,697
El Salvador	1978	4.8	4,353	209
Guatemala	1976	13.6	6,430	874
Honduras	1977	6.6	3,320	219
Nicaragua[4]			2,740	
Panama	1979	47.0	1,881	884
MEXICO	1980	56.0	71,910	40,270
LATIN AMERICAN CARIBBEAN		4.0[2]	4,978	199
Cuba[4]			9,881	
Haiti[5]			5,009	
Puerto Rico[5]			3,479	
Dominican Rep.	1977	4.0	4,978	199
TOTAL, LATIN AMERICA		55.7[2]	312,769	174,176

Source: Financiamiento y Extensión de la Seguridad Social en América Latina - Instituto Mexicano del Seguro Social - Secretaría General, Departamento de Asuntos Internacionales.
Palmer, O.; Miller, M.; Elizando, M., Paper presented to the VII American Congress of Social Security Medicine, Mexico, 1981, pp. 27-30.

Footnotes:

1. This year corresponds to the reference year given in the source. It is not certain that it refers to that year precisely.

2. Refers to sixteen countries with parallel service delivery systems.

3. Estimate. The source supplies no data on this country.

4. Countries with national health services. The social security system provides no health care directly.

5. The social security system provides no health services directly.

TABLE 2

ESTIMATED POPULATION COVERED BY SOCIAL SECURITY
BY SUBREGIONAL GROUPS IN LATIN AMERICA, 1979

Subregional Group	Estimated Population (thousands)	Population Estimated by Social Security	
		In thousands	%
Andean Area	69,426	10,553	15.2
Southern Cone 1/	33,004	23,491	71.2
Brazil	115,397	95,780	83.0
Central America 2/	18,054	3,883	21.5
Mexico	71,910	40,270	56.0
Latin American Caribbean 3/	4,978	199	4.0
Latin America 4/	312,769	174,176	55.7

1/ Excluding Chile

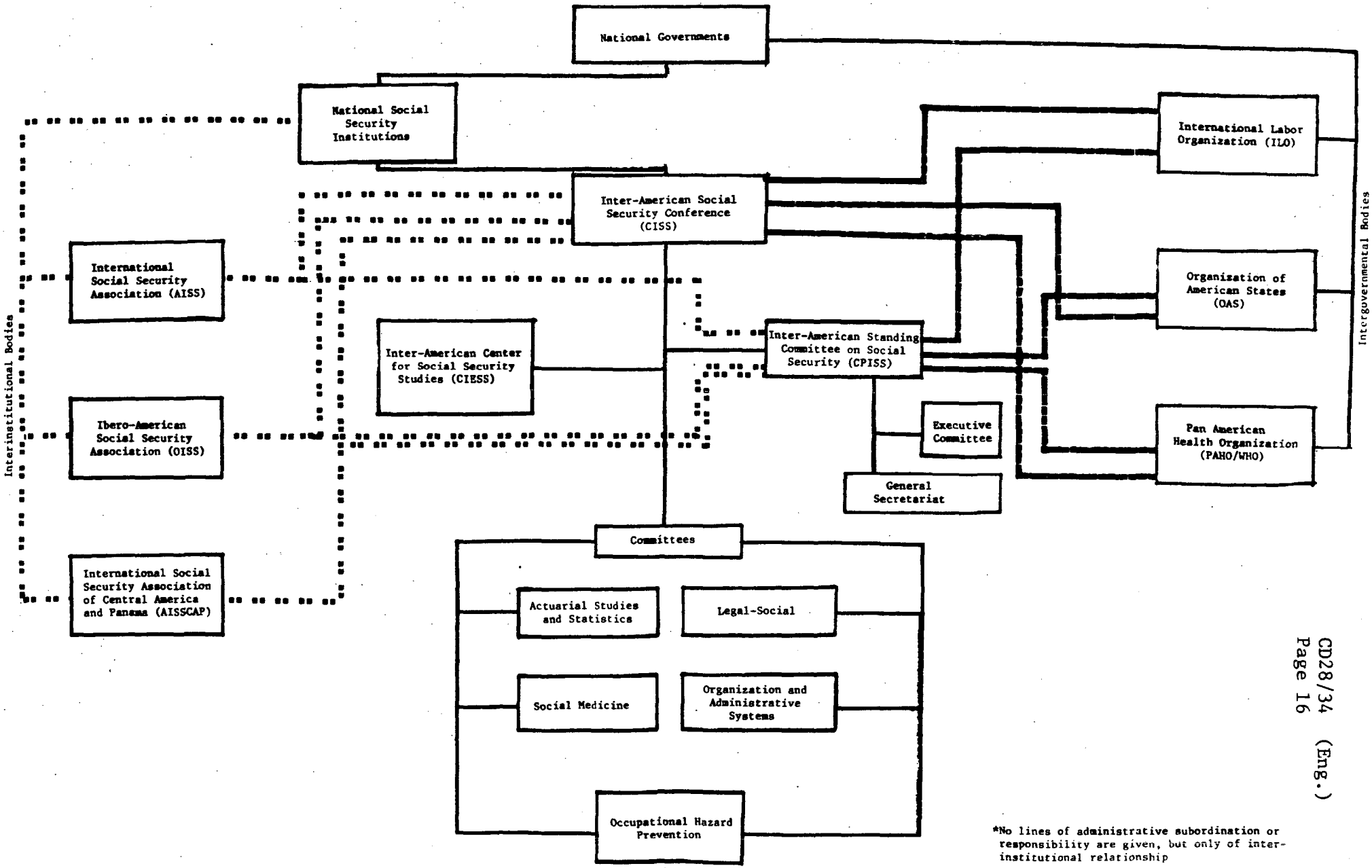
2/ Excluding Nicaragua

3/ Dominican Republic only

4/ Excluding Chile, Nicaragua, Cuba, Haiti, and Puerto Rico

INTERNATIONAL BODIES CONCERNED WITH SOCIAL SECURITY

(Scheme of Interrelationships)*



*No lines of administrative subordination or responsibility are given, but only of inter-institutional relationship