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PAN AMERICAN HEALTH ORGANIZATION

XXVI Meeting

regional committee

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COORDINATION BETWEEN SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

Background

The institutional makeup of the health sector in most of the countries in the Hemisphere and the urgent need to reinforce the organization of services and improve the productivity of health care institutions have made "coordination between social security and public health systems" a subject of special concern in the Region. In recent years, the country governments have emphasized the review of the structural and operational aspects of their service systems and have undertaken a variety of measures to ensure that these resources are more efficiently and effectively utilized.

The analysis prepared for the Technical Discussions of the XXV Meeting of the Directing Council of the Organization highlights a number of findings in this connection:

It was found that the process of integration and coordination of health sector institutions had been amply documented in the Region. Over almost 20 years different facets of that process had been studied in many national and international meetings. Review of the documents resulting from these meetings revealed a consensus on the benefits accruing from the integration and coordination of health services, although the emphasis on modalities of integration and coordination seems to have shifted with the passage of time. In addition, as a result of systematic discussions, a series of principles had been generated, designed to increase the return from health care resources and apportion them more equitably among the various sectors of the population. The varying application of these principles within the countries has wrought major changes in their health care systems.

Despite these efforts and gains, many of the structural and organizational problems that have beset health care services since the beginning of the coordination movement were still evident at the time of the analysis, and on occasion seemed to have been aggravated by the increased

demand for services made by an expanding population, and by the development of the institutions themselves, which tended to make it more difficult to introduce the requisite changes and modifications. In addition, review of the analyses conducted and recommendations formulated indicated that the concept of coordination had been discussed essentially on the basis of the personal observations of experienced managers in the different institutions, and that there was a lack of scientific research by which to objectively define the actual situation and thereby improve the possibilities of solutions. Moreover, it was observed that the discussions had focused predominantly on administrative and structural aspects, and only to a limited extent on financial mechanisms, which were at least as important as the others for attaining the objectives pursued.

On the basis of the results of the Technical Discussions, held during the XXV Meeting of the Directing Council of the Organization, Resolution XXIX was adopted, which urged the Governments to define and structure their national health systems within their own political-administrative context for the purpose of applying a uniform policy of health benefits to the entire population, and to develop and apply solutions of a technological complexity appropriate to problems affecting the entire population, regardless of social insurance coverage.

The same resolution requested the Director of the Pan American Sanitary Bureau to extend technical cooperation programs to the social security health system and to promote and organize research for developing new ways of providing personal health services that would make it easier to coordinate the approaches of ministries of health and social security institutions.

Progress and Present Situation

The two years that have elapsed since the analysis and the recommendations were made is perhaps too short a period of time in which to detect any fundamental regional changes from the situation of 1977. From a general standpoint, however, it should be pointed out that, in one way or another, a variety of measures have been taken in several countries that attest to an intensification of national efforts toward the functional unification of their health sector institutions and toward making more feasible the goal of universal health care coverage adopted by the countries of the Region.

The following examples are illustrative of the direction of more recent measures undertaken at the macroinstitutional level:

In one country decisions have been taken to restructure the services under the responsibility of the social security agency, with the

government paying the premiums for population groups that cannot afford to pay them directly, thereby abolishing the former difference between insured and noninsured persons.

In another country consolidation has taken place essentially within the area of social security itself, with all the existing institutions being merged into a single one to which is now entrusted the delivery of personal health services for practically the entire population, under a program of progressive extension of the coverage of social security.

Yet another country has put a stop to the creation of new social security agencies and has placed those already operating under the general direction of a combined Ministry of Health and Social Welfare in order to strengthen the mechanisms for coordination both among the various social security funds and schemes and between them and the public services operated by the Ministry.

Under a novel scheme that preserves the individuality of the institutions at the central level, another country is integrating the operations of the services on the regional and local levels, and is using the establishments and personnel for the attention of both the general public and the groups covered by social security.

To foster and stimulate coordination through the application of unified operating rules and a pooling of institutional efforts in capital investment programs, yet another country has set up within its health ministry a new agency to supervise and evaluate the functioning of the principal social security institution in the country and the plans and programs for the expansion of its services, and to encourage it to comply with the rules of the national health system.

Finally, one country has resumed exploratory studies begun several years ago toward the establishment of a national health service that will integrate into a regionalized system the various public institutions providing health services.

Other examples of not general but more specific coordination are the programs of several countries for extending the health services of the social security system to the rural population. Though no clear-cut tendency is yet discernible, these programs frequently take organizational forms that tend toward integration or coordination with other services, usually those of the health ministries. Other examples of new approaches in this area that help bring institutions closer together are attempts made to adapt traditional social security financing arrangements to the specific situation of the agricultural worker. The clear trend toward increased government participation in the financing of these programs implies a displacement of the conventional arrangement of dues

or premiums paid by employee and employer by arrangements that suggest an acknowledgement of the responsibility of the Government in the delivery of social security services and an acceptance of the function that social security can perform in the redistribution of national income toward low-income groups.

At the request of these countries, the Pan American Sanitary Bureau has collaborated in some of those processes and, in compliance with the request of the Directing Council in previously cited Resolution XXIX, has extended the scope of its technical cooperation to include social security institutions. Examples of recent operations in this direction are those for cooperation in one of the aforementioned countries in the establishment of a regionalized service system based on social security, and collaboration in another in programming for new hospitals. In several other countries agreements for specific technical cooperation with the social security agencies, and to which the ministry of health is also a party, have been signed or are in the final stages of consideration. By participating in these agreements these ministries have not only made possible direct cooperation with the social security agencies, but the agreement itself has served as a channel for strengthening the mechanisms for relations between the two institutions.

In contrast with the past, a salutary tendency seems to be emerging in the ministries of health to further these relations, which suggests, on the one hand, a recognition of the increasingly important role of the social security agencies in the delivery of personal health services and, on the other hand, an acceptance that common technical approaches help realize possibilities of interinstitutional coordination.

In furtherance of this expansion of technical cooperation to include social security institutions, the Bureau has participated in several meetings of international social security agencies, and at them has made presentations of various aspects of the policies and programs of the Pan American Health Organization, particularly those bearing on the purposes of coverage extension and the strategies of primary care and community participation. As a complement to this activity, in conjunction with the international agencies that collaborate with social security institutions, particularly the International Labor Organization, the Organization of American States and the Permanent Inter-American Committee on Social Security, pertinent aspects of their respective programs have been reviewed for purposes of coordinating technical cooperation activities in some of the countries.

New Approaches to Institutional Coordination

Despite the foregoing examples of the efforts that the countries are making toward the functional consolidation of their health services,

progress toward interinstitutional coordination is generally slow and limited. Hence it is recognized that new approaches and orientations are needed in a general frame of reference given by the policies for the universalization of service coverage and by the goal that the countries have adopted of attaining this objective by the year 2000.

There is virtually a consensus in the Region on the need of a general reorganization of health services to an extent that goes further than primarily structural approaches or intentions or the merely administrative sphere in which institutional coordination has hitherto been contemplated.

The reorganization of health services required to extend their coverage and attain the goal of health for all by the year 2000 is associated essentially with the adoption at the government level of a single, uniformly applicable policy of health care for the entire population, which must govern the harmonized programs of all the institutions operating in the sector. For that policy to be truly implemented, the schemes for financing the services must be reviewed and adjusted in different ways and their modes of operation revised, and a thorough review made of the technologies now in use.

In all these areas major questions persist for which suitable answers must be found; however, such answers are ever more urgently needed in the area of appropriate financial organization.

There can be no universal health care coverage as long as there are economic barriers raised by systems for financing the services, and of user payments or contributions that impede access to those services or limit them to certain individuals or groups. It is recognized, however, that the historical development of the services has organized them, to some extent, along the lines of the population's economic stratification. In this situation, the greatest difficulties have been occasioned more by this fragmentation or segmentation of health care based on the capacity of the individual to pay for it, rather than by the multiplicity of the service institutions alone. Unless appropriate decisions on the policy for financing the health sector are taken that will remedy these situations, efforts to extend the coverage of health care can scarcely succeed.

In most of the countries in the Region current coverage extension policies are based on an idea of health that differs from the traditional one and by a new philosophy of provision of services. These new departures, which are reflected in the postulates both of governments and of institutions, and in the program approaches and strategies proposed in most of the countries, confront a baseline situation that is the outcome of the historical development of the services, and in which the usual public assistance schemes for the care of the indigent administered by the

health ministries coexist side by side with a variety of social security services and other insurance schemes, and of private operations as well. Each of these schemes serves selected segments of the working population, and individually they can do little to extend their coverage or are even impeded from doing so.

Clearly, the traditional arrangements for financing social security, and consequently the laws and other legal instruments that established these institutions and regulate their financing and operations, impose a major restriction. In social security institutions the concept of coverage has more of a legal than a social basis. Moreover, the social security laws grant the status of beneficiaries to some members of the insured's immediate family in a degree that varies from country to country. This recognition discriminates, however, between the benefits granted to the direct subscriber and to the beneficiary, and hence gives rise to inequities within the same family.

The great problem faced by the countries, then, in attaining the goals of universal coverage, is twofold:

In the first place, and considering that the model of public welfare (services to indigents) restricts the purpose of the extension of coverage, other alternatives must be chosen which make it possible to develop services that are accessible on a basis of social equity. Secondly, it must be decided how the transition from the present system to the chosen alternative is to be effected to assure its feasibility. The options in this direction are apparently two: either government service, or insurance systems to which the government is a substantial contributor.

Financing health care as a public service in which the government is a direct producer of services is largely tantamount to nationalizing the delivery of those services, that is, to the creation of a single national health service. The nationalization, which derives from a particular conception of the functions of government in society, entails much more profound political and social changes that could scarcely be attempted with any chance of success if they were confined to the health sector alone. This is borne out by several experiences in the Hemisphere. Hence, the options worthy of consideration are various forms of national health insurance systems. It would appear that this alternative is being favored by several countries in the Region which have launched measures aimed squarely in this direction, including those cited earlier.

However, establishing a national health insurance system is a complex process that is not without risks or constraints. Many different arguments and warnings have been offered against it, notably the possible

impact of increases in the demand for services, rising costs, inflationary effects, and political and administrative difficulties in managing it, etc.

The latter is perhaps the most cogent argument. It is held that the organization of a national health insurance scheme is fraught with the risk of an overconcentration of political and administrative power. This might be true to some extent; however, it does not imply--and this is attested by the experience of several countries in other regions--that the problems or situations are necessarily unmanageable. Moreover, there are different ways of designing and conducting a uniform national health service program without necessarily arriving at monolithic administrative or institutional concentration. Besides, even if it were arrived at, the question is to decide what is more important and of greater interest to the population: either to avoid the risk of concentration of political and administrative power or to secure access to services for large masses of population.

While this alternative does seem to offer possibilities of a solution, in the economic and social setting of most Latin American countries the ways in which this approach could be applied would have to be, in principal, mixed. The financing cannot be expected to come solely from government sources. Nor would it be feasible, at least within a reasonable period of time, to rely on the conventional tripartite financing of social security alone for the expansion of the services needed to arrive at universal coverage. Nevertheless, as has been demonstrated in some countries, these institutions are important bridgeheads where the appropriate measures can be started and from which the coverage of health insurance can be universalized.

There is a host of factors and new information to be carefully weighed before effective decisions can be taken for the establishment of a solid sectoral financial policy and for bringing about changes in the orientation and organization of the services, all of them essential to attain the objectives of universalization of the coverage of health care in the short time available.

It is up to both the social security and the public sector institutions to supply that information, either from their own direct experience or as the fruit of specific research which, conducted jointly and systematically, should constitute, in the present circumstances and state of development of the services, the proper field for the application of institutional coordination measures.

The purpose of this research would be to develop for the individual agencies charged with setting the policy and formulating the guidelines

for the operation of the services, a broad range of options adaptable to different social and economic situations, and to help those agencies make an informed choice among given courses of action.

This approach of coordination will focus the concerted efforts of the institutions on the joint, systematic study of the problems restricting or impeding the extension of health coverage, and unlike earlier approaches, which began with acceptance of the existence of two or more service delivery systems but did not look into the economic, social and political factors that gave rise to that situation, will give coordination a new and doubtlessly more productive dimension, and make those approaches a means or instrument for finding solutions rather than ends in themselves, as they have been regarded so far.

Prospective Lines of Action

In 1978 the Bureau convened an internal working group to review aspects of the situation described and explore possible lines of action and technical cooperation. Highlights of this group's analysis and conclusions were as follows:

- It is of fundamental importance that each country, in pursuit of its policy for the extension of coverage and on the basis of overall studies and analyses of the socioeconomic-financial system of the respective health sector, take legislative and administrative steps to abolish the existing division of its citizenry into two classes, the insured and the noninsured.

- Given the per capita income in most Latin American countries, they should explore the possibility of a greater contribution from the government and the social security system as sources of financing for the extension of coverage, and a reduction of the individual's direct obligation or responsibility for financing the services.

- In intimate connection with the problems of financing services, it frequently happens that the kinds of health care benefits are widely dissimilar in the countries of the Region. This dissimilarity obtains not only as between those who are and are not insured, but also between those covered by different social security schemes. As part of the efforts to make the health sector functionally coherent, the concepts and the benefits granted under the various existing social security schemes must be standardized, at least as far as health services are concerned. The ultimate objective, however, should be to arrive at one single social security system whose components are integrated in one functional design that eliminates overlapping and the squandering of resources.

- For objective, perceptive analyses to be made of the existing situations in this regard, from which concrete recommendations could be made on how to promote the consolidation of health operations, the participants in such analyses must all be guided by the same preference points. Hence, the concepts and definitions currently used in health documents must be reviewed and updated, and the use of a standard nomenclature for the services offered to individuals and communities should be promoted. Many of the terms in current use are unsatisfactory, perhaps because they are translations that have failed to capture the intended meaning of the original term, and so fall into restrictive and at times mistaken interpretations that impede communication and distort the comparative analysis of institutions.

- The requisite rationalization of the use of resources of the health sector to extend its coverage is dependent on the development of efficient ways of organizing the services and on the selection and use of appropriate technologies.

- In the first case, though the concepts of levels of care and functional reorganization of services are generally widely known, their actual application in the organization of health services has been, on the whole, very limited. A more thorough study must be made of why these concepts are not applied, what are the requirements for and implications of their application, and what real scope there is for them in the solution of health problems.

- The conduct by the social security agencies and the health ministries of initially limited experiments in joint service programming on the basis of these concepts will yield valuable information for the use of such programming on a progressively larger scale.

- In relation to the selection, development and use of appropriate technology, in addition to creating national mechanisms with the participation of the various institutions in the sector to evaluate and choose technologies for application, it is of primary importance to stimulate and strengthen the national production of critical inputs like drugs, biologicals, equipment, etc.

- The technical cooperation of international agencies has played an important part in the design of health systems in the countries of the Region. Making the changes in those systems that are needed to attain universal service coverage also requires adjustments in the forms, breadth and orientation of international technical cooperation.

The statement of most of the foregoing points, all of which are pertinent, constitutes a reaffirmation of the solutions proposed in various forms in the extensive regional documentation on the coordination of

services, and which we must persist in advocating. In a renewed effort to accelerate the process of change in health systems required to attain the coverage goals adopted by the countries, these proposals could be grouped into the following four major lines of action:

a) The promotion of and stimulus to the adoption of policies on care that are uniformly applicable to the entire population and of sectoral financing policies, by supporting national meetings to analyze these subjects and disseminate experience and for the presentation of case studies of their own situation by countries of the Region that choose to do so. Guidelines for the preparation of the case studies should be prepared in advance to provide a common basis for comparison and analysis of those studies. In each country the ministry of health and the social security agencies would participate in the national study.

b) The promotion and support of research on health services in the agencies of the ministries and in those of the social security system, and in the two on a comparative basis. In this research there would be special emphasis on the financial aspects and on studies to evaluate technologies in current use, and on analyses for the introduction of new technologies.

c) Support to the design of models or alternative arrangements for the organization and delivery of services with the participation of the health ministries and social security agencies. In the design of these alternative arrangements special attention would be paid to inclusion of the strategies of primary care and community participation and to application of the concepts of levels of care and functional regionalization of services.

d) Bolstering technical cooperation with social security institutions in three principal ways:

i) through support to specific programs;

ii) by encouraging the exchange of experience and facilitating cooperation between countries and institutions; and

iii) by coordinating activities with other agencies having programs for technical cooperation with social security institutions primarily in the area of health care.

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Despite these efforts and gains, many of the structural and organizational problems that have beset health care services since the beginning of the coordination movement were still evident at the time of the analysis, and on occasion seemed to have been aggravated by the increased

demand for services made by an expanding population, and by the development of the institutions themselves, which tended to make it more difficult to introduce the requisite changes and modifications. In addition, review of the analyses conducted and recommendations formulated indicated that the concept of coordination had been discussed essentially on the basis of the personal observations of experienced managers in the different institutions, and that there was a lack of scientific research by which to objectively define the actual situation and thereby improve the possibilities of solutions. Moreover, it was observed that the discussions had focused predominantly on administrative and structural aspects, and only to a limited extent on financial mechanisms, which were at least as important as the others for attaining the objectives pursued.

On the basis of the results of the Technical Discussions, held during the XXV Meeting of the Directing Council of the Organization, Resolution XXIX was adopted, which urged the Governments to define and structure their national health systems within their own political-administrative context for the purpose of applying a uniform policy of health benefits to the entire population, and to develop and apply solutions of a technological complexity appropriate to problems affecting the entire population, regardless of social insurance coverage.

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government paying the premiums for population groups that cannot afford to pay them directly, thereby abolishing the former difference between insured and noninsured persons.

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At the request of these countries, the Pan American Sanitary Bureau has collaborated in some of those processes and, in compliance with the request of the Directing Council in previously cited Resolution XXIX, has extended the scope of its technical cooperation to include social security institutions. Examples of recent operations in this direction are those for cooperation in one of the aforementioned countries in the establishment of a regionalized service system based on social security, and collaboration in another in programming for new hospitals. In several other countries agreements for specific technical cooperation with the social security agencies, and to which the ministry of health is also a party, have been signed or are in the final stages of consideration. By participating in these agreements these ministries have not only made possible direct cooperation with the social security agencies, but the agreement itself has served as a channel for strengthening the mechanisms for relations between the two institutions.

In contrast with the past, a salutary tendency seems to be emerging in the ministries of health to further these relations, which suggests, on the one hand, a recognition of the increasingly important role of the social security agencies in the delivery of personal health services and, on the other hand, an acceptance that common technical approaches help realize possibilities of interinstitutional coordination.

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progress toward interinstitutional coordination is generally slow and limited. Hence it is recognized that new approaches and orientations are needed in a general frame of reference given by the policies for the universalization of service coverage and by the goal that the countries have adopted of attaining this objective by the year 2000.

There is virtually a consensus in the Region on the need of a general reorganization of health services to an extent that goes further than primarily structural approaches or intentions or the merely administrative sphere in which institutional coordination has hitherto been contemplated.

The reorganization of health services required to extend their coverage and attain the goal of health for all by the year 2000 is associated essentially with the adoption at the government level of a single, uniformly applicable policy of health care for the entire population, which must govern the harmonized programs of all the institutions operating in the sector. For that policy to be truly implemented, the schemes for financing the services must be reviewed and adjusted in different ways and their modes of operation revised, and a thorough review made of the technologies now in use.

In all these areas major questions persist for which suitable answers must be found; however, such answers are ever more urgently needed in the area of appropriate financial organization.

There can be no universal health care coverage as long as there are economic barriers raised by systems for financing the services, and of user payments or contributions that impede access to those services or limit them to certain individuals or groups. It is recognized, however, that the historical development of the services has organized them, to some extent, along the lines of the population's economic stratification. In this situation, the greatest difficulties have been occasioned more by this fragmentation or segmentation of health care based on the capacity of the individual to pay for it, rather than by the multiplicity of the service institutions alone. Unless appropriate decisions on the policy for financing the health sector are taken that will remedy these situations, efforts to extend the coverage of health care can scarcely succeed.

In most of the countries in the Region current coverage extension policies are based on an idea of health that differs from the traditional one and by a new philosophy of provision of services. These new departures, which are reflected in the postulates both of governments and of institutions, and in the program approaches and strategies proposed in most of the countries, confront a baseline situation that is the outcome of the historical development of the services, and in which the usual public assistance schemes for the care of the indigent administered by the

health ministries coexist side by side with a variety of social security services and other insurance schemes, and of private operations as well. Each of these schemes serves selected segments of the working population, and individually they can do little to extend their coverage or are even impeded from doing so.

Clearly, the traditional arrangements for financing social security, and consequently the laws and other legal instruments that established these institutions and regulate their financing and operations, impose a major restriction. In social security institutions the concept of coverage has more of a legal than a social basis. Moreover, the social security laws grant the status of beneficiaries to some members of the insured's immediate family in a degree that varies from country to country. This recognition discriminates, however, between the benefits granted to the direct subscriber and to the beneficiary, and hence gives rise to inequities within the same family.

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In the first place, and considering that the model of public welfare (services to indigents) restricts the purpose of the extension of coverage, other alternatives must be chosen which make it possible to develop services that are accessible on a basis of social equity. Secondly, it must be decided how the transition from the present system to the chosen alternative is to be effected to assure its feasibility. The options in this direction are apparently two: either government service, or insurance systems to which the government is a substantial contributor.

Financing health care as a public service in which the government is a direct producer of services is largely tantamount to nationalizing the delivery of those services, that is, to the creation of a single national health service. The nationalization, which derives from a particular conception of the functions of government in society, entails much more profound political and social changes that could scarcely be attempted with any chance of success if they were confined to the health sector alone. This is borne out by several experiences in the Hemisphere. Hence, the options worthy of consideration are various forms of national health insurance systems. It would appear that this alternative is being favored by several countries in the Region which have launched measures aimed squarely in this direction, including those cited earlier.

However, establishing a national health insurance system is a complex process that is not without risks or constraints. Many different arguments and warnings have been offered against it, notably the possible

impact of increases in the demand for services, rising costs, inflationary effects, and political and administrative difficulties in managing it, etc.

The latter is perhaps the most cogent argument. It is held that the organization of a national health insurance scheme is fraught with the risk of an overconcentration of political and administrative power. This might be true to some extent; however, it does not imply--and this is attested by the experience of several countries in other regions--that the problems or situations are necessarily unmanageable. Moreover, there are different ways of designing and conducting a uniform national health service program without necessarily arriving at monolithic administrative or institutional concentration. Besides, even if it were arrived at, the question is to decide what is more important and of greater interest to the population: either to avoid the risk of concentration of political and administrative power or to secure access to services for large masses of population.

While this alternative does seem to offer possibilities of a solution, in the economic and social setting of most Latin American countries the ways in which this approach could be applied would have to be, in principal, mixed. The financing cannot be expected to come solely from government sources. Nor would it be feasible, at least within a reasonable period of time, to rely on the conventional tripartite financing of social security alone for the expansion of the services needed to arrive at universal coverage. Nevertheless, as has been demonstrated in some countries, these institutions are important bridgeheads where the appropriate measures can be started and from which the coverage of health insurance can be universalized.

There is a host of factors and new information to be carefully weighed before effective decisions can be taken for the establishment of a solid sectoral financial policy and for bringing about changes in the orientation and organization of the services, all of them essential to attain the objectives of universalization of the coverage of health care in the short time available.

It is up to both the social security and the public sector institutions to supply that information, either from their own direct experience or as the fruit of specific research which, conducted jointly and systematically, should constitute, in the present circumstances and state of development of the services, the proper field for the application of institutional coordination measures.

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for the operation of the services, a broad range of options adaptable to different social and economic situations, and to help those agencies make an informed choice among given courses of action.

This approach of coordination will focus the concerted efforts of the institutions on the joint, systematic study of the problems restricting or impeding the extension of health coverage, and unlike earlier approaches, which began with acceptance of the existence of two or more service delivery systems but did not look into the economic, social and political factors that gave rise to that situation, will give coordination a new and doubtlessly more productive dimension, and make those approaches a means or instrument for finding solutions rather than ends in themselves, as they have been regarded so far.

Prospective Lines of Action

In 1978 the Bureau convened an internal working group to review aspects of the situation described and explore possible lines of action and technical cooperation. Highlights of this group's analysis and conclusions were as follows:

- It is of fundamental importance that each country, in pursuit of its policy for the extension of coverage and on the basis of overall studies and analyses of the socioeconomic-financial system of the respective health sector, take legislative and administrative steps to abolish the existing division of its citizenry into two classes, the insured and the noninsured.

- Given the per capita income in most Latin American countries, they should explore the possibility of a greater contribution from the government and the social security system as sources of financing for the extension of coverage, and a reduction of the individual's direct obligation or responsibility for financing the services.

- In intimate connection with the problems of financing services, it frequently happens that the kinds of health care benefits are widely dissimilar in the countries of the Region. This dissimilarity obtains not only as between those who are and are not insured, but also between those covered by different social security schemes. As part of the efforts to make the health sector functionally coherent, the concepts and the benefits granted under the various existing social security schemes must be standardized, at least as far as health services are concerned. The ultimate objective, however, should be to arrive at one single social security system whose components are integrated in one functional design that eliminates overlapping and the squandering of resources.

- For objective, perceptive analyses to be made of the existing situations in this regard, from which concrete recommendations could be made on how to promote the consolidation of health operations, the participants in such analyses must all be guided by the same preference points. Hence, the concepts and definitions currently used in health documents must be reviewed and updated, and the use of a standard nomenclature for the services offered to individuals and communities should be promoted. Many of the terms in current use are unsatisfactory, perhaps because they are translations that have failed to capture the intended meaning of the original term, and so fall into restrictive and at times mistaken interpretations that impede communication and distort the comparative analysis of institutions.

- The requisite rationalization of the use of resources of the health sector to extend its coverage is dependent on the development of efficient ways of organizing the services and on the selection and use of appropriate technologies.

- In the first case, though the concepts of levels of care and functional reorganization of services are generally widely known, their actual application in the organization of health services has been, on the whole, very limited. A more thorough study must be made of why these concepts are not applied, what are the requirements for and implications of their application, and what real scope there is for them in the solution of health problems.

- The conduct by the social security agencies and the health ministries of initially limited experiments in joint service programming on the basis of these concepts will yield valuable information for the use of such programming on a progressively larger scale.

- In relation to the selection, development and use of appropriate technology, in addition to creating national mechanisms with the participation of the various institutions in the sector to evaluate and choose technologies for application, it is of primary importance to stimulate and strengthen the national production of critical inputs like drugs, biologicals, equipment, etc.

- The technical cooperation of international agencies has played an important part in the design of health systems in the countries of the Region. Making the changes in those systems that are needed to attain universal service coverage also requires adjustments in the forms, breadth and orientation of international technical cooperation.

The statement of most of the foregoing points, all of which are pertinent, constitutes a reaffirmation of the solutions proposed in various forms in the extensive regional documentation on the coordination of

services, and which we must persist in advocating. In a renewed effort to accelerate the process of change in health systems required to attain the coverage goals adopted by the countries, these proposals could be grouped into the following four major lines of action:

a) The promotion of and stimulus to the adoption of policies on care that are uniformly applicable to the entire population and of sectoral financing policies, by supporting national meetings to analyze these subjects and disseminate experience and for the presentation of case studies of their own situation by countries of the Region that choose to do so. Guidelines for the preparation of the case studies should be prepared in advance to provide a common basis for comparison and analysis of those studies. In each country the ministry of health and the social security agencies would participate in the national study.

b) The promotion and support of research on health services in the agencies of the ministries and in those of the social security system, and in the two on a comparative basis. In this research there would be special emphasis on the financial aspects and on studies to evaluate technologies in current use, and on analyses for the introduction of new technologies.

c) Support to the design of models or alternative arrangements for the organization and delivery of services with the participation of the health ministries and social security agencies. In the design of these alternative arrangements special attention would be paid to inclusion of the strategies of primary care and community participation and to application of the concepts of levels of care and functional regionalization of services.

d) Bolstering technical cooperation with social security institutions in three principal ways:

i) through support to specific programs;

ii) by encouraging the exchange of experience and facilitating cooperation between countries and institutions; and

iii) by coordinating activities with other agencies having programs for technical cooperation with social security institutions primarily in the area of health care.