directing council | *regional committee*

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XXXVIII Meeting | XLVII Meeting

Washington, D.C.
25-30 September 1995

Provisional Agenda Item 5.7

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IMPLICATIONS OF THE SUMMIT OF THE AMERICAS FOR THE PAN AMERICAN HEALTH ORGANIZATION: FRAMEWORK FOR HEALTH SECTOR REFORM

Taking into account the difficulties that the health sector faces, the countries of the Americas have manifested their intention to work together, share experiences, and mobilize international cooperation in support of the national processes of health sector reform. This initiative took shape at the Summit of the Americas, held in Miami on 9-11 December 1994, whose Plan of Action includes a resolution on "Equitable Access to Basic Health Services."

In this resolution, the countries of the Hemisphere that participated in the Summit of the Americas proposed holding a special meeting of American governments with the specialized cooperation agencies. The objectives of this meeting are as follows:

- To establish a regional framework for the mechanisms of health sector reform through a consensus of national governments, international organizations, and bilateral agencies;

- To define the objectives and mechanisms for regional monitoring of the implementation of national plans and programs for health sector reform, including the role of PAHO in this process;

- To plan the strengthening of the inter-American network, along with the required external support, which will be devoted to sharing knowledge and experiences on health sector reform among government authorities, private sector representatives, NGOs, researchers, and donors.

The Pan American Health Organization, the Inter-American Development Bank, and the World Bank organized a working group for the preparation of the special meeting. The working group held several meetings and incorporated the participation of four more agencies (the Organization of American States, the Economic Commission for Latin America and the Caribbean, the United Nations Children's Fund, and the United Nations Population Fund), as well as the United States Agency for International Development and the Government of Canada. In addition, it held consultations with health authorities of selected countries. After these consultations, the Pan American Health Organization drafted the attached document to serve as basis for the discussions that will take place during the meeting on health sector reform scheduled to be held in Washington, D.C., on 29-30 September, as a special session of the XXXVIII Meeting of the Directing Council of PAHO (see the attached Provisional Agenda).

In addition, as part of the documentation related to this activity, each Member State has been asked to prepare a report on the principal problems of the sector and the reforms that have already been implemented or whose future implementation is planned. The available reports will be distributed during the special session of the Directing Council.

Annexes

EQUITABLE ACCESS TO BASIC HEALTH SERVICES: TOWARD AN AGENDA FOR HEALTH SECTOR REFORM

PROVISIONAL AGENDA

Friday, 29 September

09:00 a.m.	Opening Session: Statements of Agencies Responsible for Coordination of the Meeting
10:00 a.m.	*Recess*
10:30 a.m.	Panel: Options for Reform: The Organization of Health Services
12:00 n.	*Luncheon*
02:00 p.m.	Panel: Options for Reform: Financing Health Services
03:30 p.m.	*Recess*
04:00-05:30 p.m.	Panel: National Processes of Health Sector Reform

Saturday, 30 September

09:00 a.m.	Panel: Monitoring and Cooperation in Health Sector Reform
10:30 a.m.	*Recess*
11:00 a.m.	Discussion and Adoption of Resolutions
12:00 n.	Closing Session

CD38/18, Rev. 1 (Eng.)
Annex B

Equitable Access to Basic Health Services:
TOWARD A REGIONAL AGENDA FOR HEALTH SECTOR REFORM

September 1995

Working document in follow-up to the Summit of the Americas prepared by PAHO on the basis of the deliberations of the interagency working group composed of IDB, the World Bank, ECLAC, OAS, PAHO, UNFPA, UNICEF, USAID, and the Canadian Government

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BACKGROUND

Many countries have stepped up the pace of health sector reform in the 1990s in response to the challenge of providing efficient, good quality services to meet the longstanding and emerging needs of all their citizens. Increasingly, the health sector must address the need to achieve greater equity and efficiency in the use of resources and emphasize care for the most vulnerable groups and the control of priority problems through high impact cost-effective measures.

Reform in the Region of the Americas is characterized by economic liberalization, consolidation of democracy, and reorganization of the State. An analysis of the reforms currently under way reveals the diversity of the models and strategies adopted by the countries to achieve universal coverage with good quality services, in conformance with national conditions. Health sector reform is a complex process whose implementation involves not only technical and managerial components, but also political, economic, social, and cultural elements; it does not follow a single script or blueprint.

In view of the difficulties facing the sector, the countries of the Hemisphere have manifested their intention to work together, share experiences, and mobilize international cooperation in support of national processes of health sector reform. This initiative took shape at the Summit of the Americas, held in Miami, 9-11 December 1994, whose Plan of Action includes a resolution on "Equitable Access to Basic Health Services" and an agenda that includes the following points:

- reaffirmation of the commitment of the World Summit for Children of 1990, the Nariño Agreement of 1994, and the International Conference on Population and Development of 1994, to reduce infant mortality by one-third and maternal mortality by one-half by the year 2000;

- endorsement of a basic package of clinical, preventive, and public health services, in accordance with the recommendations of WHO, PAHO, the World Bank, and the International Conference on Population and Development, designed to attend to child, maternal, and reproductive health, including prenatal care and care both during and after delivery, information and services on family planning and prevention of HIV/AIDS, immunization, and the prevention of other causes of infant mortality;

- a commitment to develop, in accordance with the mechanisms determined by each country, reforms designed to meet the targets of child, maternal, and reproductive health; universal and non-discriminatory access to basic health services; care to the poor, disabled, and indigenous populations; a more solid public health

infrastructure; alternatives for financing, administration, and delivery of services; quality assurance; and greater participation by social actors and NGOs;

- strengthening of the Inter-American Network on Health Economics and Financing (REDEFS) as a forum for sharing knowledge, information, and experiences; strengthening national capabilities; and promoting hemispheric cooperation on reform, with the participation of government officials, representatives of the private sector, nongovernmental institutions and actors, donors and experts;

- the convening of a special meeting of the governments of the Hemisphere with the donors and interested international organizations, sponsored by the IDB, World Bank, and PAHO, in order to establish the framework for reform, define the role of PAHO in regional monitoring of national plans and programs for reform, and plan the strengthening of the network, including contributions from its cosponsors.

The Declaration of Principles of the Summit urges the international organizations to support the agreements contained in the Plan of Action, which the countries commit themselves to fulfilling without delay. The private and public sectors, political parties, academic institutions, NGOs, and other interested actors were invited to cooperate and participate in national and regional efforts, thereby strengthening the bonds between government and society and creating a "Pact for Development and Prosperity in the Americas."

In response to this decision by the governments, the Pan American Health Organization led a working group with Inter-American Development Bank and World Bank representatives. Four international agencies (the Organization of American States, the Economic Commission for Latin America and the Caribbean, the United Nations Children's Fund, and the United Nations Population Fund), as well as the United States Agency for International Development and the Government of Canada, also participated. A preliminary report was discussed in a consultative group of national authorities which met in Washington, D.C., last June. The current version of the document incorporates suggestions made by the consultative group and others expressed by a few select countries. Therefore, its contents do not represent the official position of any organization or government. Its purpose is to serve as a background for the discussions that will take place in the Special Meeting on Health Sector Reform to be held in Washington on 29-30 September 1995.

I. THE REASON FOR HEALTH SECTOR REFORM

Health sector reform is a process aimed at introducing substantive changes into the different agencies of the health sector, their relationships, and the roles they perform, with a view to increasing equity in benefits, efficiency in management, and effectiveness in satisfying the health needs of the population. This process is dynamic, complex, and deliberate; it takes place within a given time frame and is based on conditions that make it necessary and workable.

The health sector, despite the fact that it is key to greater well-being for the population, the formation of human capital, and the existence of positive experiences in applying the primary health care strategy, has not kept pace with the momentum of change that the Region has experienced in recent years in other areas of economic, political, and social life.

Whereas the Region struggles to transform itself from within so as to be more competitive in the new world order, the health sector needs to cast off old moorings that prevent it from modernizing in organizational, technological, political, and administrative areas.

Public health services constitute an important ingredient of standards of living, and their impact will grow as the sector in its entirety operates better. If it is to fulfill its role, the health sector must be viewed as an integral and contributory sector of the economy and productivity must be a principal concern. Thus, it is imperative for the sector to improve efficiency in allocating resources in order to focus more of them on effective interventions to protect the health of the population.

In light of these problems, health reform processes in the Region have to take into account a series of guiding principles, consistent with reform of the State, so that the State is supported in its roles of:

- establishing overall health priorities;
- assuring care for essential needs of all citizens;
- reallocating scarce resources to address the inequalities affecting the most disadvantaged sectors of the population.

These roles assume that health of its citizens remains included among the fundamental responsibilities of the State.

1. Why Health Sector Reform in the Region is Necessary

What is health sector reform in the Region responding to? What are the events that justify the need for this change?

Answers could be found in the following:

- Significant opportunity exists to improve health status: in spite of progress over the last few decades, there are still a considerable number of preventable diseases and premature deaths, in absolute and relative terms; Latin America and the Caribbean have an excess mortality of around 50%.

- Changing demographics (particularly age structures) and lifestyles (mainly due to epidemiological profiles, urbanization and growing industrialization) highlight the need to reorient care models.

- Inequitable access to basic health services: vast regional areas and social groups have been left without equitable access to the basic health care that all citizens need.

- Lack of coordination between national institutions, subsectors, and intersectorally.

- Inefficient allocation of scarce resources.

- In some countries the health sector is underfinanced; this has led to quantitative and qualitative deficiencies in the delivery of health services and to growing gaps in basic care.

2. The Objectives of Health Sector Reform

What are the fundamental objectives for which health sector reform strives? What are the underlying premises of the implementation strategies for reform?

In essence:

- To improve the health and living conditions of all the inhabitants of the Americas.

- To become part of the social reform in the Region, one of the pillars of development, along with justice, well-being, and equity.

- To reduce health status inequalities, improve access to good quality health services, and foster shared responsibility between institutions, individuals, and communities.

- To modernize and decentralize the organization and operation of public institutions providing health services;

- To balance the public and private health subsectors in order to achieve complementarity in their efforts.

- To ensure that reasonable financial resources are available to the sector at a sustainable level to allow its objectives to be met.

Comprehensive reform cannot be expected to meet all its goals in a short period. However, it is a component of the social modernization that our countries require, and the problems which must be faced can be addressed through a combination of political will and technical and administrative resources.

The situation requires the processes of health sector reform to be implemented through a set of strategies that are not only politically, technically, and administratively viable, but economically sustainable as well. They must be mutually coherent and, to the degree possible, capitalize on the institutional achievements that have been made in each of our countries.

II. THE SCENARIO FOR REFORM IN THE AMERICAS

1. The General Context

The goal of health for all has braved myriad obstacles and challenges in recent decades. Diseases such as smallpox and poliomyelitis have been eliminated from the Americas, due to the efforts of the health sector and the development of the primary health care strategy, but inequalities persist in the health and living conditions of the population. The gaps in access to health services are growing, while rising service costs threaten to upset health budgets. Increasingly, inefficient services elicit dissatisfaction from users, providers, and society as a whole. The structural adjustment programs adopted in response to the crisis of the 1980s have also affected the health sector, exacerbating the inequalities in access to the services.

The Region has reached a special point in its development, a time in which macroeconomic adjustments introduced in the wake of the crisis of the 1980s are being consolidated. The opening of the national economies, the process of privatization, and the search for greater efficiency and credibility on the part of the State coincide with the unfolding of the regional integration processes, which are providing new opportunities for cooperation among the countries, even in the field of health.

In the political sphere, there has been a movement toward greater democratization, accompanied by a redefinition of the roles of the State and society in development. Moreover, a significant phenomenon has been the increase in participation by the community, the private sector, and local government. These phenomena have clearly had a positive impact on the health sector, which has been engaged since the last decade in the decentralization of its institutions and in fostering community participation at the local level.

It is an acknowledged fact that social inequities in Latin America and the Caribbean are among the most accentuated in the world and that they have been exacerbated with the application of structural adjustment policies. According to ECLAC, from 1980 to 1990, the number of poor in the Region rose by 60 million, reaching a figure of 196 million people with an income of less than US$ 60 a month. Currently, 10 million Latin Americans of working age who wish to work cannot find employment, while another 54 million subsist in the informal sector through low-productivity activities. Unemployment and poverty hamper access to reasonable living conditions and diminish the ability of people to participate in development. Hence, their health is adversely affected.

Toward the mid-1980s, the notion began to prevail that macroeconomic equilibrium is essential for development and that inflation has a greater impact on lower-income groups. In addition, pressure grew on the public sector to eliminate expenditures for the non-needy population and boost efficiency in service delivery. In light of this situation, social emergency or social investment funds were created in several countries to cushion the impact of the crisis and the adjustment programs on the most vulnerable groups in society. The funds, which are operated quite autonomously, were conceived as a complement to a public sector, whose effectiveness was being called into question.

The reality, however, was that just as economic growth in itself did not result in greater equity, the mere redistribution of wealth did not automatically lead to economic growth. One idea that regained a foothold was that an appropriate distribution of the benefits of economic growth, as reflected in better living conditions for the population, was what distinguished economy growth from economic development. This new perspective has been translated into the commitments made at recent world summits and international conferences on children, the environment, population, and social development, as well as the Summit of the Americas, all of which established global guidelines and solutions for overcoming the inequities that major population groups must face.

2. Regional Problems Concerning Equity, Efficiency, and Effectiveness in Health

Inequities in health are unnecessary, avoidable, and unjust differences in the health conditions of the population and its access to health services. These inequities exist within countries as well as between them, and they chiefly affect the more disadvantaged social groups, women and children, indigenous populations, and workers in the informal sector who live on the urban periphery and in rural areas.

By the late 1980s, life expectancy at birth in Latin America and the Caribbean was 70 years of age, a substantial increase over the 62 years of 1975. At the same time, the Region annually lost close to 233 years of disability-adjusted life years (DALYs) per 1,000 population, placing it midway between the industrialized and the developing countries. Infant mortality in the Americas shows tremendous variation, ranging from 7.5 to 109.8 per 1,000 live births and maternal mortality varies from 3 to 270 deaths per 1,000 live births. Ten countries had reducible mortality gaps of over 50%. Low birthweight affected from 5% to 18% of all newborns, and from 3% to 37% of the infant population suffered from malnutrition.

Furthermore, there was an increase in some communicable and deficiency diseases that had characterized the epidemiological profiles of the Region in past decades. Changes in the age structure and the urban-rural distribution of the population, as well

as in individual and collective lifestyles, generated a growing burden of chronic degenerative diseases, accidents, addiction, mental disorders, and other emerging pathologies such as AIDS. As a result, communicable diseases accounted for 42.2% of the lost DALYs, chronic diseases 42.8%, and injuries 15.0%. The disease burden falls unequally on both the individual countries of the Hemisphere and social groups within each country.

In the early 1990s, health expenditure per capita in Latin America and the Caribbean was close to $122 and represented 6% of the regional GDP on average, ranging from $566 to $9 and from 9% to 3.1% of the national GDPs. Meanwhile, per capita health expenditures were $1,945 in Canada and $2,763 in the United States, or 9.1% and 12.7% of their respective GDPs. The growth in absolute spending on health has been made possible by greater private expenditures, a situation with regressive consequences for low-income groups. Balance is required between public and private expenditures on health in order to ensure access to quality basic health services and to avoid regressive consequences.

Public expenditure on health in Latin America and the Caribbean declined from 1.6% to 1.4% of the regional GDP in the 1980s, at the same time that its composition changed. In fact, first, investment expenditures were reduced and then expenditures for maintenance and input supply, to the point where in some cases the available resources were sufficient to cover only wages.

Signs of inefficiency in service delivery have been observed in both public and private sector institutions. At the same time, the services provided often have little relevance for the control of priority health problems. This generates considerable waste in the utilization of the resources allocated to the health sector.

Major differences can be observed in the regional population's access to health services across the Region. A review of average national indicators shows that the availability of physicians ranged from 0.8 to 43.3 per 10,000 population and the number of hospital beds from 0.7 to 14.3 per 1,000 population in 1991. Average national hospitalization rates ranged from 2.3% to 14.2% of the population, and average national coverage ranged from 0.5 to 6.3 medical consultations per inhabitant per year. These differences are found both between countries and within them; they take a disproportionate toll among the underprivileged rural and urban groups, indigenous groups, and many other disadvantaged classes. Some countries succeeded in immunizing virtually all of their infant population, while others had vaccination coverage of less than 60%. An assessment of 1,610 maternal and child care facilities in 20 countries from 1990 to 1992 indicated that 80% were in unsatisfactory operating conditions. Coverage for contraceptive methods ranged from 10% to 74% of the female population, while prenatal care reached from 24% to 100% of pregnant women, and professional care in

childbirth, 27% to 100%. The overall situation of the Region is one in which more than 100 million people lack adequate access to basic health services.

Eliminating inequities in health is an essential prerequisite for human development, growth, regional integration, and the consolidation of democracy in the Americas. As the economies of the Region improve and sector efficiency increases, additional resources will become available to finance an expansion in coverage and increasingly complex services. Meanwhile, it is possible to advance toward universal access to basic health services with the resources currently available in most countries, in some cases, complemented by external assistance.

3. The Evolution of Health Policies

In the evolution of health policies both worldwide and in the Region, the emphasis of the interventions changes as health problems change. When communicable diseases dominated the scene, the public health approach, health inspection, and public health campaigns were the prevailing response. With the juxtaposition of traditional and emerging epidemiological profiles, new priorities have arisen that demand new approaches, and medical and hospital services are becoming increasingly important in health care plans.

In recent years, a convergence of elements peculiar to the different policies has been observed—for example, health campaigns, integration of the ministries of health with the social security institutions, basic health services, primary health care, decentralization, strengthening of the local health systems, and targeting of action toward vulnerable groups. Similarly, the proposals for structuring the health systems have changed. Unlike earlier decades, which were characterized by a search for unified health systems, the current trend is toward establishing multi-institutional systems with uniform rules of operation. Here, the differences between public and private providers tend to fade.

There is also a tendency to separate financing and provision of health services. Since the 1990s, financing of the system has been shared among the State (20%), social security institutions (24%), and households (56%). Competition between public and private service providers for sectoral resources has been intensified. The importance of NGOs in the field of health has grown—both conventional forms, such as charitable or community organizations, and groups engaged in health promotion.

Technological progress in health is positive when it opens new possibilities to prevent and cure disease and where it can be introduced on a cost-effective basis. At the same time, new resources make it possible to expand basic health care and more closely match social needs. After the hospital expansion of recent decades, a renewed emphasis

on outpatient care and self-care is noted. The decline over the last 50 years in the number of hospital beds from 3 to 2 per 1,000 population, the relative increase of some health professionals, particularly physicians, and the scarcity of nursing personnel, are indicative of changes in health care models. The incorporation and dissemination of new technologies depends on the resources that the government and the society of each country are able to allocate to health services. In addition, the inequities in health conditions and access to health services can be overcome at affordable costs and in relatively short order.

This process is unfolding in a context in which public opinion is increasingly well-informed about health problems and the new technological possibilities for controlling them. Old and new challenges strongly alter the demand for health services, requiring a reorientation of health care models and greater intersectoral action and community participation for their control. In this context, health systems and services research should be promoted as a way to increase knowledge on priority areas and for orientation of future developments.

III. THE FRAMEWORK FOR HEALTH SECTOR REFORM

Many countries in the Americas are engaged in some type of health sector reform. As of yet, it is too early to undertake an in-depth evaluation of the results of the reforms. Nevertheless, several indicators of the importance accorded reform in the current regional context can be identified. First, reform is among the top items on the policy agenda of the countries in the Americas. Deficiencies and inequities in health care are often mentioned in public opinion polls among topics considered to be most significant. In addition, reform has loomed large in campaign platforms as an option for solving these problems, and it has as been a subject of research and debate. The principal agencies for cooperation in health that are acting in the Region give consideration to health sector reform in their programs.

The objectives, scope, and substance of reform, as well as the strategies and mechanisms adopted for their implementation vary markedly. Some reforms are comprehensive, simultaneously encompassing the organization, the financing and the resources of the sector as a whole. Other reforms are intended to implement only partial changes among some of the institutions or roles of the health sector. In some cases, reform involves the promotion of greater private sector participation in health; whereas, in others making decentralized and democratic government more responsive is what has been attempted.

Despite the diversity of approaches within each national situation, a framework for health sector reform can be built by identifying accomplishments and problems that have appeared in different national experiences currently under way. This framework offers an options menu for countries to draft, implement, and evaluate reform, and for cooperation agencies that are willing to lend their support.

Implementation of this framework should first settle on the points on which the greatest consensus is found among the actors involved so that sufficient momentum can develop to confront the most controversial aspects of reform. This framework also constitutes a basis on which to implement and monitor the resolution of the Summit of the Americas on equitable access to basic health services and to orient international cooperation to support national health sector reform processes.

1. Options for the Organization and Management of Health Services

The subject of equity is central to most of the initiatives under way, although in many cases it is mere lip service. In general, the reform processes seek a better level of health for the entire population, equitable access to health care, and better quality and efficiency in systems and services. These last objectives include assurance of universal

coverage of basic health services and high impact public health interventions, focusing public expenditures on care for groups without protection or who are most at risk by virtue of their socioeconomic or biological conditions.

Expansion of coverage in health systems concerns the provision of services to social groups without access or with only limited access as well as new benefits not previously included in the package of services. The first case most concerns coverage for poor populations in peripheral urban and rural areas, mothers and children, indigenous peoples, and informal workers. The second case concerns attention to problems stemming from demographic and epidemiological changes. In addition, the globalization of service utilization patterns and new prospects offered by health technology development are continuous sources of pressure for the expansion of services.

Health is not simply the result of services provided to individuals or communities; it also depends on policies adopted by other sectors. Thus, reforms tend to emphasize the need to strengthen the ability of the health sector to mobilize, negotiate, and monitor the activities of other sectors that can make an impact on the health situation of the population.

Some current reform processes tend to change health care models, and stress outpatient care based on health promotion and disease prevention. Health technology development allows the sphere of treatment to be transferred from hospitals to outpatient facilities and from these facilities to patients' homes, in order to reduce the cost of services and improve the quality of treatment and user convenience. The search for greater community participation, in hand with the growing democratization in the Region, leads to cooperative, indigenous solutions to health problems.

There appears to be consensus that government and society cannot remain committed to providing unlimited services, especially when treatment possibilities continually increase and the resources to pay for them are limited. The need to rationalize health care in some way is beginning to gain acceptance in the Region. To this end, strategies that had been part of the primary health care approaches in the late 1970s are being considered.

Delineating appropriate packages of basic health care services, their characteristics, and varying scopes in relation to the prevailing epidemiological profiles, the availability of resources, user preferences, and sector policies adopted in each country is being used as a strategy to make access to basic health care universal. This delineation is also used as a point of reference for directing public health activities with preference for groups considered vulnerable on the basis of their income, risk, gender, ethnic origin, geographical location, occupation, or other conditions. In other cases, emphasis has been

placed on high impact interventions, based on acceptable and cost-effective technologies, such as reproductive health services, including family planning.

Reforms are bringing new ways of organizing and managing services in order to improve the efficiency and credibility of the health sector. In most of the cases, new assignment of roles is sought between government and civil society in the delivery and funding of health services. Implementation is sought for health care models of a pluralistic bent, that is, ones that can accommodate a variety of public and private health service providers.

Public hospitals are being restructured as social enterprises, with management autonomy and the ability to recover costs through agreements with social security and private sector entities. Organizational options for service providers and optimizing the mix of public-private participation in managed-competition types of arrangements are now being sought. Quality assurance programs are in place in order to license, categorize, and accredit health establishments. In order to increase the rational use of resources in the sector, it is proposed that the costs and results of health services be rigorously monitored. More efficient networks are being formed to supplement diagnostic and therapeutic services, supply drugs, and provide logistical and maintenance support, and these networks are taking on great importance in the operations of the sector.

Most of the countries are decentralizing health sector management and redefining the roles that central, intermediate, and local governments play in health. For this purpose, resources and decision-making authority are being transferred to the municipal and provincial/departmental levels, which is where community solidarity, equity in coverage, integration of programs, service financing, intersectoral approaches, and the public-private mix in health all come into play. The responsibilities of the ministries of health as direct service providers are diminishing, whereas their roles in policy management, regulation, and evaluation are increasing in order to ensure the equity, quality, and efficiency of the sector. At the same time, efforts are being made to coordinate the financing and service delivery of the social security institutions with other public and private health sector entities.

In addition, the reform processes are meant to adapt the scope and substance of technical and managerial training and education to the new demands of a competitive and modern sector. Human resource management is receiving priority attention, especially new forms of contracting, remuneration, and evaluation of health personnel performance, which encourage greater efficiency and better quality care.

2. Options for Financing the Health Sector

As with the changes in organization and service management, much variation is found among the changes in sector financing arrangements, which each country adapts to its own situation. In order to ensure financial sustainability, some countries have attempted to improve the use of traditional funding sources, including resources from different spheres of government, social security, employers, and households. Social security, which in several countries is the largest single source of funding, fulfills an important role in financing both the public and private subsectors. New arrangements have also been introduced in order to increase sector funding while making it more progressive, but at the same time seeing that traditional sources of funding not dry up as new sources appear.

Some reform processes envisage the need to separate the responsibility for financing health care from the responsibility for providing it, in order to ensure the efficiency, quality, and competitiveness of the system. To this end, public and private entities have been created that are responsible for collecting and administering health care funds regardless of whether they come from the State, households, or employers. These entities are also responsible for contracting services, generally in predefined packages, with either public or private sector providers that assume part of the financial risk of providing care. In addition, these entities supervise the contracted providers. In several cases, competition has been encouraged among the service funding entities themselves in order to offer users more options. These devices raise the need to create compensatory mechanisms to apply the principles of equity and solidarity in the health system.

Some reforms currently in progress are usually meant to introduce a greater share of private resources, in relation to public funds, in health financing. Health care insurance, both compulsory and voluntary, and cost recovery for State-provided services are being promoted. In this context, growing management autonomy in the public health facilities makes it easier to manage resources that are either allocated in the facilities or generated by them through their activities. Meanwhile, public financing is generally targeted at covering costs of basic health care packages for marginalized groups and high impact public health interventions. In addition, market mechanisms are being adopted in the public sector, while elements of state regulation are being introduced in terrain previously dominated by free market forces of supply and demand.

Other reform proposals attempt to overcome the constraints of conventional forms of payment to professionals and service providers. Conventional payment methods have failed to encourage greater efficiency, hampered effective control, and encouraged overuse of services and complex technologies. Thus, in contracting services in both the public and the private sectors, attempts are being made to replace fixed salaries and

historical budgets and positions with more efficient mechanisms, such as wages with productivity incentives, capitation and prospective payments according to the type of diagnosis or treatment.

The rescaling of expenditures is included as an element in some health reform proposals. New policies and strategies for health sector investment are being made in order to offset the obsolescence of health facilities, which was exacerbated by cut-backs in investment over the last decade, and in order to boost responsiveness to demographic growth and new health needs. Specific investment projects are crucial for the implementation of activities that help to reduce health inequities. The impact of the operating costs of new facilities on the current expenditures of parent institutions merits special consideration. Many investment plans are almost entirely directed toward changing policies, institutional modernization, or strengthening the technical and managerial capacity throughout the health sector in general or in its institutions in particular. These elements are crucial to the success of the reform processes.

IV. THE PROCESSES OF HEALTH SECTOR REFORM

1. Strategies Adopted for Reform

Several strategies are being used to implement reform processes; sometimes, a single process combines more than one strategy. Some reforms are the result of constitutional reforms that alter the legal foundations of national government and its relationship to society. In these cases political actors and legislative processes have dominated the determination of the objectives and courses of reform. In other cases, administrative measures are taken under existing legal frameworks.

In other countries, reform is part of a broader process of structural and functional adjustment of the State. In these cases, an economic logic is being applied for the purpose of increasing the regulatory role of the national government and reducing its direct participation in health services delivery. In other cases, health sector reform follows an overall decentralization of government.

Finally, there are cases in which reform is being promoted to address specific health care delivery problems, i.e., escalating costs, inefficient services, inequity of access, dissatisfaction of users and providers, or a combination of these elements.

2. The Political Dimensions of Reform

The political aspects of health sector reform are extremely complex. The pro-reform movement sometimes voices support for multiple proposals, not always compatible among themselves, and thereby hampers the consensus-building that would make the proposals viable. On the other hand, in a context of growing democratization, the capacity for government initiative is constrained by the need to negotiate with other forces in society in order to make proposals for change viable.

Many actors take part in reform processes, including authorities and officials of different civilian and military branches of government, parliaments, labor unions, business associations, universities, professional associations, service providers, insurance companies, and producers of intermediate goods and services. They need to be identified and their interests need to be known in order to negotiate their support for reform.

The management of the political variables of reform is sometimes a greater challenge than responding to the technical, managerial, or financial issues involved. Some recent initiatives—formulated with technical rigor and well-demonstrated economic-financial feasibility—have been significantly modified or rejected outright under pressure from political forces opposed to change or not yet persuaded of their validity.

Some countries have established national commissions for health sector reform as consensus-building mechanisms. Usually, these commissions are comprised of representatives from different agencies of government and civil society interested in health. These experiences can be useful to other countries that face political difficulties in carrying out their attempts at reform.

3. Problems Posed by the Reform Processes

Despite examples of progress, health sector reform in the Americas faces several problems:

- lack of consensus among actors within each country and the cooperation agencies on the nature and substance of reform;

- political viability, requiring considerable capacity for leadership, negotiation, and versatility in the face of rapidly changing circumstances;

- lack of continuity of those responsible for promoting reform, directing corresponding studies, and negotiating proposals;

- technical complexity, which sometimes makes difficult obtaining sufficient political support to overcome opposition to change due to the lack of appropriate knowledge of reform benefits;

- insufficient attention to community participation in the process.

Efforts to promote comprehensive reform (even if one has well-structured a priori "models") may encounter more difficulties and be far less politically viable than efforts aimed at partial reforms. On the other hand, partial reforms run the risk of producing contradictory piecemeal changes and, thus, a less consistent model than would result from comprehensive reforms. Pace is also important. Trying to implement reform in very short periods of time could complicate the process. But very long periods could fade the sense of change. Given the limitations, an approach based on incremental changes within a strategic framework is suggested.

Last but not least, in many countries reform has been spearheaded by economic considerations, while the health issues have taken a back seat in the reform dialogue. In these cases, a more effective intersectoral participation is needed to provide a broader vision of potential reform scenarios.

V. HEMISPHERIC COOPERATION IN SUPPORT OF REFORM

1. Interagency Coordination to Support Reform

International cooperation available to countries to support their health sector reforms is crucial. By the end of 1994, 24 countries in the Region had received technical and/or financial cooperation in health sector reform from PAHO, the World Bank, IDB, USAID, and other international or bilateral agencies. In many cases, multiple donors are involved in a single country.

These facts reflect that external support is available for reform in the region. However, the absence among agencies of a consensus on the strategies and instruments of reform can lead to a dispersal of national activities in separate proposals that may not form a coherent whole. Some countries have tried to coordinate external support activities, attempting to adjust the set of cooperation activities to national needs. This practice needs to be extended in order to leverage the impact of international cooperation on the national reform processes.

2. The Inter-American Network on Health Sector Reform

The Summit of the Americas called for the creation of a regional network to strengthen national capabilities for implementing health sector reform. It also suggested that the new network be based on the experiences of the Inter-American Network on Health Economics and Financing (REDEFS), established in 1994 to promote training, research and information activities in health economics and finance. Since REDEFS activities do not cover the entire region and only refer some dimensions of reform, its model will have to be expanded in terms of scope, membership and resources, to become the base for the Reform Network.

The Reform Network will be open to the participation of all interested institutions and individuals, such as health authorities and managers, parliaments, social security institutes, state and local governments, universities, research centers, NGOs, and international agencies. Taking into consideration the interests of such membership, the Network will perform the following functions:

a) to serve as an electronic forum for the exchange of ideas, information and experience about the reform;

b) to retrieve, process and disseminate, through electronic and other means, statistical data, technical and legislative information on relevant issues and regional trends in health reform;

c) to provide information about methods, instruments, institutions, experts, training opportunities and research projects available to support reform;

d) to help countries and agencies to better coordinate technical and financial cooperation in support to reform initiatives.

Resources will be sought from governments, agencies, and NGOs to ensure an effective Network operation. The Network will connect itself to similar initiatives in the Region, for better serving its subscribers. These resources will ensure an effective network cooperation with the governments, international agencies, and participating NGOs.

3. Monitoring National Processes of Health Sector Reform

The purpose of monitoring reform processes is to gauge the fulfillment of the commitments undertaken by the Presidents and Prime Ministers at the Summit of the Americas, which will depend substantially on national actors and conditions. In addition, monitoring should help to spur implementation in each country of the commitments made at the Summit and to orient the policy and management activities of those actors.

Monitoring is needed for most countries largely because it provides extremely useful information for each national process. Comparisons of national performance, in turn, can foster positive competition that encourages countries to implement their summit commitments. In addition, monitoring allows objective verification of the fulfillment of summit commitments on a regional basis.

From the standpoint of the international agencies acting in the Region, monitoring may orient resource allocation, technical advice, and assistance for countries or reform areas that have the greatest need for external support. In addition, it helps to appraise the performance of the countries as beneficiaries of cooperation from agencies. Finally, monitoring can help to coordinate cooperation and enhance its impact, detect gaps, duplication of efforts, and contradictions that need to be resolved.

Effective monitoring must be based on a knowledge of current status of summit commitments in the countries. As such, a baseline diagnostic is recommended as a reference to appraise progress and obstacles. In order to orient interventions in specific problem areas, it is essential that monitoring take into account the situation in specific

territories and in the populations at risk in each country. It should also take into account that reform is a dynamic and complex process that includes not only technical and financial components, but political, social, and cultural ones specific to the situation in each country.

Despite the diversity of the reform processes, it will be helpful to consider three phases (development, approval, and implementation) and follow the development of some critical issues through them. These issues could be: financial and access equity, quality assurance, efficiency, cost containment, financial sustainability, public and private collaboration, biomedical ethics, technology assessment, essential drugs availability, health sector regulation, health services management, community participation, and decentralization.

During the implementation phase, monitoring should be based on stated objectives and include a series of quantitative indicators for expected outcomes (i.e., access to basic health services among different social and gender groups, especially the poor, disabled, and indigenous populations), intermediate processes (i.e., coverage of specific preventive and clinical services), and required resources (i.e., expenditures and financing by type of care and source). Additionally, semiquantitative or qualitative indicators and methodologies must be developed to evaluate changes in legislation, biomedical ethics, institutional organization, health services management, technology assessment, and community participation, among others.

It is suggested that each country take into account the experiences of other countries in the Region in monitoring and evaluation and prepare an annual report on the achievements and obstacles in its processes of reform. Every four years, the countries would prepare more detailed reports that would also include an appraisal of the impact of the reform on equity of access to appropriate health services and the health situation of the population. In order to be more representative, the monitoring process should involve the participation of national commissions on health sector reform and receive support from highly capable national technical centers and cooperation agencies.

As was determined at the Summit of the Americas, PAHO has the responsibility to support the practical application of this monitoring. For this purpose, the Governing Bodies of PAHO should agree on the format of the annual and quadrennial reports of evaluation, review the country and agency reports, and recommend steps to overcome obstacles detected. The Secretariat of PAHO will collaborate with countries on implementing the monitoring and will deliver the corresponding reports to the Governing Bodies of the Organization.

It is also suggested that cooperation agencies prepare annual reports on their activities as support for the process of health sector reform in the Americas and that they indicate the resources allocated and the beneficiary countries and institutions.