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JOINT PAHO ECONOMIC COMMISSION FOR LATIN AMERICA AND THE CARIBBEAN (ECLAC) REPORT ON HEALTH, SOCIAL EQUITY, AND CHANGING PRODUCTION PATTERNS IN LATIN AMERICA AND THE CARIBBEAN

This document re-examines the topic of health in Latin America and the Caribbean, highlighting the complementary relationship that exists between health and economic development. Its frame of reference is the proposal by the Economic Commission for Latin America and the Caribbean (ECLAC) on social equity and changing production patterns and the policies proposed by the Pan American Health Organization (PAHO) in the area of health in development.

With a view to contributing simultaneously to social equity and increasing productivity, this document proposes a multisectoral approach to improve health conditions and health services to the population. At the same time, it emphasizes the need for innovation in organizing and developing health systems. It proposes to expand health coverage, incorporating those who up to now have been excluded, and to reform health systems and their financing, bolstering effectiveness in resource allocation and microeconomic efficiency in the use of health resources. Finally, it suggests policies aimed at making health an effective example of the fact that rapid advances can be made toward fulfilling the national commitment to social equity.

A summarized version of this document was presented at the 22nd Meeting of the Subcommittee on Planning and Programming in April 1994. The complete preliminary document was presented at the XXV Session of ECLAC in Cartagena, Colombia at the end of the month and at the 113th Meeting of the Executive Committee of PAHO in June 1994.

The document was well received by the members and observers of the Executive Committee, who made several suggestions and adopted the following resolution for consideration by the XXIV Pan American Sanitary Conference (Resolution CE113.R14):

THE 113th MEETING OF THE EXECUTIVE COMMITTEE,

Having seen the joint PAHO/ECLAC report presented in Document CE113/18, "Health, Social Equity, and Changing Production Patterns in Latin America and the Caribbean,"

RESOLVES:

1. To request the Director to introduce further refinements in Document CE113/18 taking into consideration the discussion by the Committee.
2. To recommend to the XXIV Pan American Sanitary Conference that it adopt a resolution along the following lines:

THE XXIV PAN AMERICAN SANITARY CONFERENCE,

Having seen the PAHO/ECLAC report presented in Document CSP24/20, "Health, Social Equity, and Changing Production Patterns in Latin America and the Caribbean";

Recognizing the mutually reinforcing relationship between health, health care, and the socioeconomic and political development of the American countries; and

Taking into consideration the resolution adopted on this subject by the XXV Session of the Economic Commission for Latin America and the Caribbean at Cartagena de Indias, Colombia, on 27 April 1994, which recommended to PAHO and ECLAC that this report be submitted to a Special Meeting of Ministers of Economy and Health to be held during the forthcoming XXIV Pan American Sanitary Conference,

RESOLVES:

1. To urge the Member States:
 - (a) To disseminate this report and promote debate thereon among representatives of government agencies, parliaments, universities, and civil society in general with a view to strengthening national commitment to the attainment of equity in health and development;
 - (b) To incorporate the basic elements of the PAHO/ECLAC proposal in agendas and policies on national development, so that health will be incorporated as both a focus and a condition for development with equity.

2. To encourage ongoing collaboration by the PAHO and ECLAC secretariats in the dissemination, refinement, and implementation of this proposal, particularly insofar as it refers to the monitoring, evaluation, and formulation of policy, and that efforts be made to extend this collaboration to other bilateral and multilateral organizations.

3. To ask the Director, within the limits of available resources, to support the implementation of this proposal by the Member States.

Annex

CSP24/20 (Eng.)
ANNEX

Pan American Health Organization (PAHO)

Economic Commission for Latin America and the Caribbean (ECLAC)

**HEALTH, SOCIAL EQUITY, AND CHANGING
PRODUCTION PATTERNS IN LATIN AMERICA
AND THE CARIBBEAN**

July 1994

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INTRODUCTION

This document reexamines the subject of health in Latin America and the Caribbean, emphasizing the "virtuous" circle that exists between health and economic development. The frame of reference for the document is provided by the proposal of the Economic Commission for Latin America and the Caribbean (ECLAC) on social equity and changing production patterns and by the policies formulated by the Pan American Health Organization (PAHO) in regard to health in development.

The central aim of the ECLAC proposal is to boost productivity in order to both achieve international competitiveness and contribute to greater social equity. Attaining this objective will require, *inter alia*, the development of technological and physical infrastructure, organizational capacity, and human resources. Within the framework of this systemic approach, the social sectors, in particular the health sector, have an important —though not yet adequately appreciated— role to play in the formation, maintenance, and enhancement of human capital. In addition, as the supplier of an extensive array of goods and services, the health sector has the ability to exert a powerful dynamic effect on the economy as a whole.

From the perspective of PAHO, there is an urgent need to call attention to the crucial role that health plays in the achievement of sustainable human development, inasmuch as it is health that makes it possible to improve the quality of human capital and promote social well-being —essential conditions for realizing the full creative and productive potential of the population.¹

With a view to contributing simultaneously to equity and to growth in productivity, this document proposes a multisectoral approach for the improvement of health conditions and services. It also points up the need to find innovative ways of organizing and developing health systems, which implies addressing the inequalities of access that have remained from the past while at the same time preparing for anticipated changes in epidemiological profiles, in the organization of health services, and in the cost of interventions. In addition, the document proposes the extension of coverage to those who up to now have been excluded and the reform of health care systems and financing, which will necessitate more effective allocation of resources and a more efficient use of those resources at the microeconomic level. Finally, it proposes policies aimed at making health an example of how it is possible to progress relatively quickly toward the achievement of equity, in accordance with the commitment made by the countries.

¹ PAHO/WHO (Pan American Health Organization/World Health Organization), "Strategic Orientations and Program Priorities, 1991-1994", Washington, D.C., 1991.

Chapter I

THE SCOPE OF THE PROPOSAL: HEALTH AND CHANGING PRODUCTION PATTERNS WITH SOCIAL EQUITY

Following a period characterized by falling rates of saving and investment, reduced employment and production, and high inflation, many countries of Latin America and the Caribbean have made notable strides in improving macroeconomic management and fiscal performance, and have also made headway in capital formation and modernization and restructuring of the productive apparatus. This has allowed them to attain a competitive position in the international market and has also made it possible for them to resume economic growth —although only to a modest extent in many cases (table I-1). These signs suggest that the region is headed for a recovery, which should be consolidated in the medium term.

With regard to the elimination of poverty, the situation remains rather discouraging, although since the beginning of the 1990s some signs of improvement have been noted, at least in those countries that have achieved the greatest success in the process of economic recovery.² Nevertheless, it should be noted that the crisis of the last decade did not result in a reversal of the long-term positive trends reflected in several important social indicators. This is apparent from the positive evolution of indicators such as coverage of the educational system (although the quality of that system continues to be a source of concern), access to drinking water and sewerage, infant mortality, and other health-related indicators. What must be done in the future, then, is to sustain and to intensify the momentum already achieved in the effort to promote social development and improve the health of the population.

Today there is greater awareness of the need to take action to assist the neediest segments of society. Generation of employment and elimination of poverty are priority objectives of the development strategies currently being advocated, and the importance of these objectives is a matter of growing consensus among the agents of development. This is so not only for ethical reasons, but also because the achievement of these objectives will enhance the governability of the countries, which is eroded when large segments of the population are unable to meet even their minimum needs. Moreover, the achievement of these objectives is essential for raising productivity and this, in turn, is indispensable in order for the countries to be truly competitive in the changing international economy. Productivity depends in large measure on the availability of qualified human resources, which add intellectual value and technical progress to the natural resources available.

² There is a certain asymmetry in the way poverty evolves in the various phases of economic cycles: Whereas poverty increases markedly in periods of recession, it decreases only slightly or remains unchanged once productive activity resumes.

Table I-1

LATIN AMERICA AND THE CARIBBEAN: GROWTH OF PER CAPITA GROSS DOMESTIC PRODUCT ^{a/}

	Annual rate of variation							Cumulative variation	
	1987	1988	1989	1990	1991	1992	1993 b/	1981-1990	1991-1993 b/
Latin America and the Caribbean ^{c/}	1.2	-1.2	-1.0	-1.6	1.8	1.1	1.3	-8.9	4.3
Oil-exporting countries	0.5	-0.2	-2.0	1.9	2.4	1.2	-0.8	-8.3	2.8
Bolivia	0.1	0.5	0.7	2.1	2.1	0.4	0.8	-21.2	3.2
Colombia	3.7	2.3	1.7	2.2	0.2	1.8	2.8	17.9	4.8
Ecuador	-7.0	6.2	-2.2	-0.4	2.4	1.0	-0.5	-6.6	2.9
Mexico	-0.4	-1.0	1.1	2.2	1.4	0.5	-1.3	-6.4	0.7
Peru	5.8	-10.3	-	-7.5	0.0	-4.7	4.4	-28.9	-0.5
			13.3						
Trinidad and Tobago	-5.9	-4.5	-1.8	1.0	0.6	-1.7	-2.0	-29.6	-3.2
Venezuela	1.3	3.4	-9.9	4.4	7.8	4.6	-3.1	-19.0	9.3
Non-oil-exporting countries ^{c/}	1.6	-1.9	-0.4	-4.1	1.4	1.0	3.0	-9.4	5.4
South America	1.7	-1.8	-0.4	-4.3	1.6	1.0	3.4	-9.0	6.2
Argentina	1.3	-3.3	-7.4	-1.3	7.6	7.4	4.8	-20.2	21.0
Brazil	1.6	-2.0	1.4	-6.1	-0.8	-2.5	2.9	-5.2	-0.5
Chile	3.9	5.7	8.0	0.3	4.1	8.5	4.4	12.2	17.9
Guyana	1.1	-2.3	-4.6	-3.1	4.8	6.8	3.0	-27.8	15.2
Paraguay	1.4	3.6	2.9	0.2	-0.5	-1.0	1.0	0.5	-0.6
Suriname	-8.0	6.1	2.2	-3.6	-4.3	-6.8	..	-13.8	-10.8
Uruguay	7.1	-0.9	0.8	0.3	2.3	6.8	1.4	-2.8	10.7
Central America and the Caribbean ^{c/}	2.1	-2.4	1.1	-1.0	-0.5	2.0	-1.9	-9.5	-0.6
Bahamas	2.7	0.5	0.2	3.0	-4.9	-0.7	0.9	8.1	-4.7
Barbados	2.3	3.1	3.3	-3.8	-4.6	-4.3	..	5.0	-8.7
Belize	9.2	3.3	9.5	7.6	1.0	5.4	1.4	19.6	7.9
Cuba ^{d/}	-4.8	1.1	-0.3	-4.1	..
Haiti	-2.6	-1.1	-1.0	-2.2	-1.4	-12.3	-12.6	-20.6	-24.4
Jamaica	5.5	1.3	6.5	4.4	-0.8	0.5	1.0	8.1	0.6
Panama	0.2	-17.6	-2.2	3.0	7.0	6.0	3.5	-13.6	17.4
Dominican Republic	6.3	-1.4	2.2	-6.9	-3.0	4.6	-0.1	-2.9	1.4

Table I-1 (concl.)

	Annual rate of variation							Cumulative variation	
	1987	1988	1989	1990	1991	1992	1993 a/	1981-1990	1991-1993 b/
Central American Common Market	0.7	-0.9	0.6	-0.4	-0.2	2.0	1.2	-15.0	3.1
Costa Rica	1.6	0.4	2.6	0.7	-0.4	4.2	3.5	-5.8	7.4
El Salvador	1.0	-0.3	-0.8	1.4	1.2	2.5	2.7	-13.5	6.5
Guatemala	0.7	1.0	0.8	0.0	0.6	1.8	1.0	-18.2	3.4
Honduras	1.7	1.7	1.6	-3.4	-1.0	2.6	0.7	-8.2	2.3
Nicaragua	-3.0	-15.6	-4.3	-3.2	-3.9	-3.0	-4.6	-34.5	-11.0
Countries of the OECS e/	5.4	8.0	4.2	3.8	1.9	2.6	..	59.2	..
Antigua and Barbuda	8.1	7.1	4.5	2.1	0.7	0.7	..	68.0	..
Dominica	7.1	8.1	-0.9	6.9	2.4	2.9	2.6	61.2	8.1
Grenada	5.8	5.6	5.5	5.0	2.7	0.4	..	55.1	..
Saint Lucia	0.7	10.5	3.2	2.5	0.3	5.2	..	37.5	..
Saint Vincent and the Grenadines	4.8	7.5	6.2	6.1	3.6	3.7	..	70.2	..
Saint Kitts and Nevis	7.9	10.3	7.7	3.0	3.7	3.6	..	83.6	..
Latin America and the Caribbean (excluding Cuba and Brazil)	0.9	-0.8	-2.3	0.8	3.1	2.8	0.6	-10.7	6.7

Source: ECLAC, based on official figures converted to constant 1980 dollars.

a/ Percentages calculated on the basis of figures adjusted to 1980 prices.

b/ Preliminary estimates subject to revision. The figures corresponding to 1993 were rounded to zero or five.

c/ Excluding Cuba.

d/ Gross Social Product.

e/ OECS = Organization of Eastern Caribbean States.

Growth based on the unsustainable exploitation of natural resources and the maintenance of inadequate working conditions and levels of remuneration is no longer justified nor is it viable in the long-term. The objective of development is to increase the well-being of the entire population, but, in the medium and the long terms, societies cannot aspire to increases in well-being unless they are compatible with growth in productivity.

The methods that will make it possible to advance simultaneously toward attainment of the objectives of growth and equity have been extensively analysed by the secretariat of ECLAC.³ As has been pointed out in various ECLAC publications, experience has disproved the thesis that economic growth will necessarily lead to greater social equity; it has also shown that greater economic growth cannot be ensured merely by redistributing existing wealth. Nevertheless, there are numerous countries in other developing regions, especially eastern Asia, that have achieved high growth rates while increasing social equity. In such cases attention has been focused on the areas in which policies that seek to promote growth and those that seek to enhance equity complement one another, rather than focusing on the trade-offs these policies may entail.

ECLAC has also noted that it is not possible to pursue growth with equity unless the two are objectives of both economic policy and social policy, since neither is neutral from the distributive point of view. In other words, the integrated approach proposed by ECLAC involves choosing economic policies that favor not only growth but also social equity, and emphasizing in social policy not only equity but also the effects of the policy on productivity and efficiency. This approach stresses, *inter alia*, investment in human resources, and particularly in education and knowledge,⁴ as elements that can contribute to growth, through increased productivity, and to the greater well-being of the beneficiaries of that investment.

The same argument is applicable to spending on health. The improvement of health increases the well-being of the population and creates a "virtuous" circle between health, changing production patterns, and social equity. The enhancement of health conditions in a population—especially among the neediest segments of that population—is an objective that can be achieved relatively quickly, and it should therefore be part of the overall effort to increase the productivity and competitiveness of the economy. A healthier population will, ultimately, be a more creative and productive population, because better health will reduce the number of days lost from work, school, and other social activities due to disease or premature death.

In the integrated approach, fundamental importance is given to consensus-building (a process in which the existence of opposing interests throughout society must be recognized) and to the need to facilitate negotiation, compromise, and agreement based on the conviction of social actors that greater equity and the consequent decline in poverty will benefit not only those who are most needy but the entire society. The foregoing should make it possible to keep conflicts within limits that are manageable under a democratic system. In order to achieve consensus, it is essential to provide the means for the most deprived sectors to make their demands known within established systems; ideally, negotiations should take place at the local level, which should facilitate the resolution of conflicts where and when they occur and help to prevent the accumulation of disagreements in macrosocial systems. Care should be taken to

³ ECLAC, Changing Production Patterns with Social Equity. The Prime Task of Latin American and Caribbean Development in the 1990s (LC/G.1601-P), Santiago, Chile, March 1990. United Nations Publication, Sales No. E.90.II.G.6; Social Equity and Changing Production Patterns: An Integrated Approach (LC/G.1701/Rev.1-P), Santiago, Chile, April 1992. United Nations Publication, Sales No. E.92.II.G.5; ECLAC/UNESCO Regional Office for Education in Latin America and the Caribbean, Education and Knowledge: Basic Pillars of Changing Production Patterns with Social Equity (LC/G.1702/Rev.2-P), Santiago, Chile, April 1992. United Nations Publication, Sales No. S.92.II.G.6.

⁴ ECLAC/UNESCO, Educación y conocimiento: eje ..., op. cit.

ensure that individuals, groups, and communities achieve social progress through their own efforts and that they take part in a joint search for solutions.

The foregoing also implies redefining the role of the State, which should abandon its pretensions of omnipresence and concentrate on a few key functions, carrying them out with greater effectiveness and efficiency, especially those that affect equity. At the same time, it is necessary to overcome the conflict between the State and the market. The creation of transparent, competitive, and easily accessible markets can contribute to the achievement of equity. And the creation of markets in those cases in which they do not exist or are inefficient can be an innovative aspect of social policies and can also be important in the area of health.

Inequities⁵ in terms of exposure to risks, health conditions, and access to health services can be overcome more cheaply and quickly than income can be redistributed and employment opportunities created. It is probable that even the least developed countries of the region would be in a position to develop the human resources and institutional capacity needed to meet this challenge, providing the necessary political will existed.

The health sector also contributes to economic development through the production of highly sophisticated goods and services, the development of scientific and technological knowledge, and the generation of jobs for highly qualified personnel, both in health institutions and in other areas with which the health sector articulates through its "forward" and "backward" linkages within the productive system. Through the demand for pharmaceutical inputs, equipment, and clothing, as well as information processing, hotel, food, construction, and transportation services, the health sector generates activity in numerous areas of the economy, many of which also make intensive use of qualified human resources and produce a tremendous flow of technological knowledge. In this way, a complex intersectoral network is formed which incorporates myriad technological innovations and which, in turn, has a multiplier effect on the economy. In addition, because the health sector encompasses an extensive array of goods and services involving a high wage cost, the option of accelerated development exists and should be taken advantage of with a view to achieving greater equity in regard to health. It should be noted that, in general, growing technological complexity in the health sector does not reduce the ratio of labour use, as happens in other sectors, but rather creates the need for more and, especially, better qualified labour. It is for this reason that the labour market in the health sector has tended to expand. In some countries of Latin America and the Caribbean close to 5% of the economically active population is currently employed in the health sector.

The contribution of the health sector labour market to social equity goes beyond the production of services. Because of its characteristics, the sector generates employment for people from all walks of life and with varying levels of professional training, and it provides employment for a large number of women. In the case of nursing services, the proportion of women exceeds 90%, and a marked trend toward feminization of the medical profession has also been noted. In several countries of the region women make up more than 50% of university enrollment.

⁵ "Inequity" in health is understood to mean systematic differences which, besides being unfair, are unnecessary and avoidable. (See M. Whitehead, The Concepts and Principles of Equity and Health, Copenhagen, World Health Organization (WHO), Regional Office for Europe, 1990.)

Effective use of the human resources of the health sector can be an important strategy in the process of changing production patterns with equity. This is a work force which, for cultural and ideological reasons, is in a position to contribute to the achievement of the objective of equity through the reduction of preventable diseases, disabilities, and deaths, which are the manifestations of inequity in the area of health. In addition, the work force is the principal agent of change in a sector that accounts for around 5.7%⁶ of the GDP of the countries of the region, and it is the crucial participation of professionals from health institutions, universities, and other research entities that makes the health sector a major generator of scientific and technological development.

Finally, health is enhanced through the progress made toward increased equity and competitiveness in the rest of the economic system, which completes the "virtuous" circle. A better trained and more productive population can participate more actively in the modification of health conditions and habits, with the aim of creating a culture of health.

Efforts to overcome inequities in the area of health contribute to the social integration of the groups that benefit from those efforts and, at least in the medium-term, benefit society as a whole by reducing the gaps between different groups with respect to life span, the development of physical and intellectual potential during the early years of life (which is essential for learning and productivity later in life), the risk of contracting diseases, and the opportunity to live a healthy life.

The link between health development and the process of changing production patterns with social equity is also seen in the sphere of international competitiveness. Policies on health complement policies on other matters, including education, training, and infrastructure, aimed at increasing overall competitiveness through the absorption of technical progress into the productive process. In international competition between companies, good health conditions among workers can constitute a significant advantage by enhancing worker performance and reducing absenteeism. Even more important, if a country can achieve a level of health for its work force that is comparable to that of workers in the countries that are leaders in world trade, and that level of health can be achieved at equal or lower cost than its competitors, that country will have a comparative advantage. Given the foreseeable evolution of sociodemographic and epidemiological profiles in the countries of the region, they are in a position to achieve this comparative advantage utilizing the institutional, technical, and financial capacity they already possess in the area of health.

It is not easy to realize this "virtuous" interaction between health, social equity, and changing production patterns. There are significant differences between the epidemiological profiles of poor and non-poor groups, urban and rural populations, and members of different ethnic groups. Various types of obstacles also exist that hinder access to a basic basket of goods and services and to the elements necessary for good health. What is needed, above all else, is to take action in all productive sectors and to implement public policies relating to basic sanitation, nutrition, education, and community and individual participation. This requires an active and consistent public sector and a public health policy that provides for ample intrasectoral and intersectoral coordination.

⁶ PAHO, Gasto nacional y financiamiento del sector salud en América Latina y el Caribe: Desafíos para la década de los noventa. [National expenditure and financing of the health sector in Latin America and the Caribbean: Challenges for the 1990s.] Project on Health Economics and Financing, Health Policies Program, Division of Health and Development. Washington, D.C., 1994.

The process of changing production patterns with equity calls for a health policy that allows for adjustment and recovery and is sufficiently flexible to accommodate decentralization and targeting of spending, diversification of sources and mechanisms of financing, and measures taken to enhance management. In addition, there should be a dynamic balance between public and private provision and financing of health services, in order to ensure microeconomic efficiency, the quality of the services provided, and distributive equity. Achievement of the foregoing is expected to lead to improved health conditions for the population, better qualified human resources and more productive use of those resources, and enhanced capacity to compete in world markets. This is the "virtuous path" of the proposal described in this document (see box I-1).

It is essential to improve the performance of health systems by increasing their microeconomic efficiency and the effectiveness of the health services provided. This implies institutional change and the acceptance of a pluralistic model of health services delivery, in which Ministries of Health, the various levels of local government, social security systems, businesses, nongovernmental organizations, international cooperation organizations, and the people themselves cooperate in order to develop an integrated system of health care. It also means diversifying the sources of financing and making more effective use of resources, although it must be recognized that the characteristics of the health sector are such that the free play of market forces will not necessarily ensure efficiency and equity. In the sector externalities exert an influence, the information provided to consumers is imperfect, and public goods of various types are utilized. In addition, a "third payer" frequently exists, so that it is not the consumer who decides what service he is going to receive. The party who decides is not the party who consumes,

Analysis of regional and extra-regional experiences suggests that a regulatory effort should be made to curb costs increases, which will have growing importance in the process of sectoral reform. Primary, secondary, and tertiary health services should be part of a cohesive network of referrals and consultations between levels.

Changes in population structure, the reduction of infant mortality, and the processes of urbanization and industrialization, among other factors, are leading to changes in lifestyle and in the environment, which in turn are engendering new health hazards. Cancer, cardiovascular diseases, accidents, and the consequences of violence, as well as perinatal problems, are at the top of the list of leading causes of death in many countries. Chronic degenerative diseases, mental disorders, and alcoholism, smoking, and drug addiction are producing more and more disability and morbidity. In addition, new problems of enormous magnitude have arisen, such as the world epidemic of acquired immunodeficiency syndrome (AIDS). Accordingly, it is imperative that sector programs focus on cost-effective interventions that will help to eliminate risks and prevent and control problems that are a threat to public health.

Account must also be taken of the profile of specific priority problems of groups at all social levels and in all geographic areas, and intersectoral interventions must be formulated to improve the living conditions and address the health problems of each group. Inequalities and inequities in the living conditions result in the persistence of needlessly high mortality among children 0-15 years of age in some segments of the population, as well as in high morbidity and mortality from communicable diseases that have been largely controlled in other segments of the population of the same country. A suitable combination of specific interventions aimed at individuals and comprehensive interventions intended to have an impact on communities and their living conditions will strengthen the effectiveness and efficiency of public health activities.

Box I-1

**FIVE REASONS FOR INVESTING IN HEALTH AS PART OF THE PROCESS
OF CHANGING PRODUCTION PATTERNS WITH SOCIAL EQUITY**

1. The improvement of health in a population has a positive impact on productivity and human capital formation. The reduction of morbidity in general, and child morbidity and malnutrition in particular, helps to reduce the number of days missed from work and school, enhances job performance, and produces a notable improvement in educational achievement. Disease prevention and health promotion measures, the prevention of occupational risks and diseases, and the prompt and effective recovery of health all contribute to the achievement of these ends. Moreover, the reduction of infant mortality, the increase in life expectancy (and in the number of years of healthy life), the adoption of healthful habits in the work and home environments, and the reduction of health risks increase the population's capacity to function effectively in the educational and occupational spheres.

2. The health sector is labor-intensive. In most cases, at least 55% of the sector's spending is devoted to payment of wages and salaries, which contributes to growth, both directly and indirectly through the absorption of large number of workers in tasks such as education and training of personnel, production and supply of general inputs, maintenance of facilities and equipment, and others.

3. In addition, the sector has considerable growth potential and has an energizing effect on the entire economy. On the one hand, as the countries grow the participation of the health sector in the GDP increases. In addition, the growing proportion of older persons in the population means that the cost of health care increases as degenerative diseases become more common, and the development of high-cost health technologies therefore accelerates. On the other hand, because the health sector is more closely related to the domestic economy than to foreign trade, is essential to promote competition within the sector in order to avoid price increases that do not reflect quantitative and qualitative increases in goods and services.

4. Compliance with health standards favors international competitiveness and makes it possible to progressively increase the competitiveness of the health sector while enhancing the quality of the goods and services it provides.

5. Health is one of the areas in which governments concentrate their efforts to increase social equity. The extension of access to health services can influence the distribution of income and raise the standard of living of the poor at a lower cost than housing initiatives and in a shorter period of time than education. In addition, the existence of greater equity in regard to health is perceived clearly by the beneficiaries as more just access to better living conditions.

Source: ECLAC, Division of Social Development, and the party who pays does not decide and does not benefit directly from consumption. All of this means that in the health field often only less-than-optimal solutions can be obtained in regard to microeconomic efficiency, effectiveness of health services, and social equity.

Reform of the health sector is a task that has either only just begun or has yet to be undertaken. The sector is faced with unmet needs that have accumulated over the years, coupled with a wide variety of other needs arising out of the diverse changes that have taken place in epidemiological profiles. There are problems relating to insufficiency and deterioration of the installed capacity of health services, and to imperfect sectoral organization and performance. These problems, too, have accumulated over the years, and were undoubtedly aggravated by the economic decline of the 1980s. Such factors alter both the objectives health systems need to pursue and the organizational models that are adopted in order to achieve them.

The actions required for health system reform and the introduction of a basic basket of health services will be carried out in a context of major economic change and restructuring of the productive apparatus, processes upon which the countries of the region have already embarked. In some cases, health sector reform will be accomplished in the midst of a process of structural adjustment and attempts to achieve a balance in the aggregate economic situation; in others, efforts to restore macroeconomic balance will have given rise to a phase of new economic growth and there will therefore be more freedom and more resources for bringing about sectoral reform. An increase in resources is not sufficient, however. In view of the new context—including new problems and new actors—in which health sector activity will be carried out in the coming years, it will be imperative to make effective use of available resources. Consequently, it will be essential to develop or to strengthen the capacity to monitor the impact that interventions have on the health status of the various segments of the population.

In the case of several countries that face serious macroeconomic imbalances, sectoral reform will take place in a context in which the health sector will continue to have adverse effects on the fiscal situation and macroeconomic balance. The crisis of social security systems and their need for public funds provide one clear explanation of why this is so. Health becomes a source of dissatisfaction among the population, and the operation of health services poses problems that make it difficult to adequately serve that population.

As far as macroeconomic balance and overall competitiveness are concerned, it is important that under-financing of the health sector contribute to a sustained increase in productivity through reduction of the number of days missed due to disease and disability without negatively affecting fiscal balance. To that end, not only is it necessary to mobilize more resources, but it is also essential to qualitatively modify the system. Analysis of cases in which economic recovery has occurred shows that the allocation of greater public and private resources to the health sector unaccompanied by organizational and operational reforms does not reverse the trend toward constant under-financing of the sector, spiralling costs, and exacerbation of inequities. In this way, poor sector performance has an adverse effect on economic performance.

The range of possible responses varies depending on the country, the economic situation, the form of organization, and the type of health care system involved. The choice of responses will therefore depend on the political options that each society is willing to accept. Nevertheless, in all cases, the basic objective is to advance, with a multisectoral perspective, toward the achievement of greater equity in health and in access to health services, which requires greater efficiency in the allocation of resources and greater effectiveness in interventions. Achieving these objectives means ensuring universal access to health care services, modifying the factors that determine morbidity and mortality, and fostering awareness of the importance of health. In any event, in order to promote reform it is necessary to achieve agreement, at least on the basic issues, among the major participants in the health system.

The process of reform should be attuned to the process of changing production patterns with social equity. If the proportion of economically active population continues to increase at a faster pace than the whole, and household income rises as a result of the combined effect of increases in the number of employed members and increases in their earnings, the age and occupational profile of the population should make it possible to achieve high levels of financial contribution from beneficiaries. This, in turn, should make it possible to reduce the State's participation in the provision of subsidies for health care, so that those resources can be devoted to the universalization of health-related social security coverage (health care plus payment of sickness and maternity benefits). The State contribution will be necessary—in all or some phases—in order to achieve universal coverage, within a framework of growing financial autonomy of social security systems, whose coverage and benefits would include the provision of a basic basket of health services. Government guidelines intended to promote equity, moderate cost increases, and foster scientific and technological progress in the health field will be specific in nature and will complement the contribution of agents and beneficiaries.

In regional integration agreements, health should help to bring about true competitiveness, based on the incorporation of technical progress, productive employment, the development of human resources, and the rational exploitation of natural resources. Accordingly, development of the labour and environment subsectors of the health sector is crucial in order to regulate—through the application of health criteria—areas of production in which workers are being exposed to hazardous working conditions or harm is being done to the environment. Regional integration should offer possibilities for the harmonization of national standards in such areas as social security, occupational health, and urban environmental health and for the control of foods, drugs, technology, and the delivery of transnational health services. It should also provide the opportunity to establish control mechanisms at the supranational level, especially in regard to foods, drugs, and technology transfer.

The public health activities carried out in the region throughout most of the 20th century have raised the life expectancy of the population; the task now is to ensure more years of healthy, autonomous, and creative life. Efforts thus far have centered on diseases that are closely related to poverty, and epidemiological profiles, life expectancy, and quality of life have been largely functions of income levels. By building on the progress made and the possibilities and demands of the economy and society, it will be possible to achieve more homogeneous epidemiological profiles that will not be determined by income level.

As the population of the region achieves higher levels of education, becomes more informed and is more exposed to mass media, and has greater access to health technology that makes it possible to expand the sphere of self-care, health systems can be established that focus on individuals and families, with emphasis on basic sanitation, nutrition, reproductive health, child health, and attention to communicable diseases. The center of gravity is shifting from the population group aged 0-14 to that aged 15-44, which alters the epidemiological profile that must be addressed, and accentuates the importance of a suitable environment (residential, occupational) and of interventions related to the health of the adults.

Consequently, the strategy proposed should be oriented toward progressively improving quality, productivity, and equity in the area of health. The transition from one scenario to another is far from spontaneous or homogenous. Indeed, the transition is a heterogeneous process owing to the wide range of responses the various countries have opted to use in their health activities directed toward poor and non-poor, and urban and rural populations. Nevertheless, it is possible to advance toward greater social

equity in the health field through actions that will make it possible to overcome the inefficiency of health systems and alleviate the financial crisis affecting them.

This proposal is being presented at an opportune moment: the countries of the Region are gradually becoming a part of a more open and competitive economy in which the governments are giving their citizens a voice in social issues. The reform of the health sector has been accelerated with the unprecedented participation of national entities within the sector and those belonging to other sectors, as well as international technical assistance and funding agencies. This document is intended to contribute to the processes of sectoral reform in the countries of the Region and be a tool for making political decisions regarding the use of regular budgetary funds and those obtained from loans and grants. It is hoped that out of the proposal presented in this document new approaches to health issues in Latin America and the Caribbean will be developed in close association with the process of changing production patterns with social equity. The first part of the proposal points out how it is possible to optimize the impact of changes in production patterns in order to improve health conditions and achieve greater equity in access to health goods and services. The second part discusses how to optimize the contribution of the health sector itself to human capital formation, overall productivity, and more equitable distribution of the fruits of development. This is a long-term undertaking, for which this document does not supply an exhaustive plan but rather seeks to provide general guidelines for the work to be done.

Chapter II

HEALTH CONDITIONS IN THE REGION

A. HEALTH IN LATIN AMERICA, THE CARIBBEAN, AND THE REST OF THE WORLD

It is instructive to draw a comparison between the region of Latin America and the Caribbean and the rest of the world on the basis of mortality indicators such as infant mortality, general mortality, and life expectancy at birth (see table II-1 and II-2), and the resources allocated directly to health care, as revealed by per capita spending on health, total spending on health as a percentage of GDP, and public spending on health as a percentage of GDP.⁷ Most of the countries of the region fall into the lower-middle income category; some are in the middle income category, although they are heavily indebted. For this reason, it is more instructive to make comparisons by geographical area.

The infant mortality rate registered in the region (44 per 1,000 live births) continues to be much higher than that of the high-income countries and the member countries of the Organization for Economic Cooperation and Development (OECD) (8 per 1,000 live births in both cases). However, it is lower than the world average (53 per 1,000) and that of other geographical areas, except for the countries of Europe and central Asia that have a similar income level. As for general mortality, the countries of region, along with the countries of eastern Asia and the Pacific with a similar income level, show the lowest average rate (7 per 1,000 population), which is explained largely by the stage of the demographic transition the region is currently passing through. The situation of life expectancy at birth in the region (68 years) is analogous to that of infant mortality—it is lower than that of the high-income countries and the member countries of the OECD (77 years), but exceeds that of other geographical areas and even the world average (66 years). It should be noted that life expectancy is comparable in the countries of eastern Asia and the Pacific and those of Europe and central Asia with a similar income level.

The developed countries have made significant headway in reducing the number of preventable deaths in the population under 65 years of age, as a result of which they have begun to accord greater importance to increasing the number of years of healthy life for the entire population. The countries of southeast Asia have also succeeded in reducing both infant mortality and preventable deaths among the population aged 5-65 years, and therefore can now concentrate on increasing the number of years of healthy life. In the countries of Latin America and the Caribbean, with the exception of those that have the best socioeconomic and health indicators, the reduction of infant mortality and preventable deaths continues to be an essential task.

⁷ The period examined encompassed the years around 1990, although most of the data correspond to 1991.

Table II-1

COMPARISON OF LATIN AMERICA AND THE CARIBBEAN
WITH THE REST OF THE WORLD:
HEALTH AND DEVELOPMENT INDICATORS

Groups of countries by income level	Infant Mortality ^{a/}	General Mortality ^{b/}	Life expectancy at birth ^{c/}	Per capita GDP ^{d/}
Low- and middle-income countries	61	10	64	1 010
Low-income countries	71	10	62	350
Middle-income countries	38	8	68	2 480
Heavily indebted middle-income countries	48	8	67	2 350
High-income countries	8	9	77	21 050
OECD members	8	9	77	21 530
Lower-middle-income countries				
Sub-Saharan Africa	104	16	51	350
Eastern Asia and the Pacific	42	7	68	650
Southern Asia	92	11	59	320
Europe and Central Asia	26	10	70	2 670
Latin America and the Caribbean	44	7	68	2 390
Middle East and North Africa	60	8	64	1 940
Entire world	53	9	66	4 010

Source: World Bank, World Development Report, 1993. Investing in Health. Washington, D.C., 1993.

^{a/} Death rate among children aged 0-1 per 1,000 live births.

^{b/} General mortality per 1,000 population.

^{c/} Life expectancy at birth, expressed in years.

^{d/} Per capita GDP, 1991 dollars.

Table II-2

NATIONAL SPENDING ON HEALTH PER CAPITA AND AS A PERCENTAGE OF GDP IN THE COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN: 1990

COUNTRY	NATIONAL SPENDING ON HEALTH AS A % OF GDP *	NATIONAL SPENDING ON HEALTH PER CAPITA IN US\$: 1988
Antigua	5.9	334.0
Argentina	9.0	337.2
Bahamas	5.0	566.6
Barbados	5.8	347.7
Belize	5.0	99.7
Bolivia	4.5	39.0
Brazil	5.8	128.8
Canada	9.1	1,945.0
Colombia	5.7	82.2
Costa Rica	9.2	155.8
Chile	6.2	155.5
Dominica	6.2	133.0
Ecuador	6.3	78.6
El Salvador	5.0	52.8
United States	12.7	2,763.0
Grenada	5.6	114.8
Guatemala	3.3	29.9
Guyana	5.9	29.2
Haiti	3.4	8.8
Honduras	5.8	44.0
Cayman Islands	4.7	1,166.8
Jamaica	3.7	54.3
Mexico	3.8	85.8
Montserrat	5.8	333.7
Nicaragua	5.0	26.9
Panama	8.7	172.5
Paraguay	3.2	49.2
Peru	3.1	41.3
Dominican Republic	4.8	32.4
St. Kitts and Nevis	6.3	213.9
Saint Vincent	6.1	124.8
Saint Lucia	5.0	116.6
Suriname	4.1	133.3
Trinidad and Tobago	4.4	181.2
Uruguay	5.7	158.1
Venezuela	6.5	220.3
Total Region ^{***}	5.7	133.0 ^{**}

Source: PAHO, Gasto Nacional y Financiamiento del Sector Salud en América Latina y el Caribe: Desafíos para la Década de los Noventa. [National Expenditure and Financing of the Health Sector in Latin America and the Caribbean: Challenges for the 1990s.] Project on Health Economics and Financing, Health Policies Program, Division of Health and Development. Washington D.C., 1994.

*/ With the exception of the United States, does not include private spending on health insurance, which may reach very significant levels in countries like Uruguay.

**/ Estimated regional weighted average, excluding Canada, the United States, and the Cayman Islands.

***/ In 1990 US\$.

Generally speaking, the region has registered significant gains in income level and in health and development indicators compared to other geographical areas. However, these average indicators obscure marked differences between the countries of the region, as well as major disparities indicative of inequalities within each country.

A comparison of the economic resources allocated to the health sector⁸⁹ reveals notable differences. The region allocates US\$ 133 per capita to health, whereas the developed countries allocate US\$ 1,620 (see table II-3). The world average is US\$ 323.

Over the last three decades, health care financing conditions have been favorable in the developed countries, as they are currently in the industrialized countries of Southeast Asia. In these countries, with few exceptions, the economically active population is equal in size to the dependent population. In Latin America and the Caribbean, based on conservative estimates, currently there is one economically active person for every two dependents. This situation has begun to change only in the present decade, and not until the year 2000 is the region expected to reach the level already attained in Spain (1:1.5).

The proportion of GDP spent on health in the region (5.7% according to estimates)¹⁰ is a great deal less than the average for the developed countries (7.8% of GDP). In this regard, it should be borne in mind that around 90% of world spending on health is done by the consolidated market economies and the European countries of the socialist bloc.¹¹ The effort expended by the governments is reflected in the indicator public spending on health as a percentage of GDP, which in Latin America and the Caribbean is 2.5% (including spending by ministries of public health and by social security systems). This percentage is less than half the average for the developed countries (4.9% of GDP), but is higher than or equal to that of other regions with a similar income level.

Although this comparison does not cast Latin America and the Caribbean in an entirely unfavorable light, it does indicate that the countries of the region need to increase their overall spending on health, improve efficiency, and strengthen government efforts, if they aspire to consolidate the progress already achieved with regard to health, reduce the disparities between and within countries, and adequately meet the greater health care needs arising out of demographic transition and changing epidemiological profiles, processes which have already taken place in many countries of the region and will have taken place in all of them within the next 25 years.

⁸ PAHO, Gasto y financiamiento..., op.cit.

⁹ World Bank, World Development Report, 1993..., op. cit., and Pan American Health Organization/World Health Organization. Health Conditions in the Americas, 1994 Edition, Washington, D.C., PAHO/WHO, 1994.

¹⁰ PAHO/WHO, Health Conditions..., op. cit.

¹¹ World Bank, World Development Report..., op. cit., p. 53..

Table II-3

**INDICATORS OF NATIONAL SPENDING ON HEALTH IN THE COUNTRIES
OF LATIN AMERICA AND THE CARIBBEAN AND IN
DEVELOPED COUNTRIES: 1990**
(in 1990 US\$)

INDICATORS	LATIN AMERICA AND THE CARIBBEAN 1990	DEVELOPED COUNTRIES 1990 ^{a/}
National Spending on Health as a % of GDP		
Total		
Public	5.7	7.8
Private	2.5	4.9
	3.2	2.9
Composition as a % of National Expenditure		
Total	100.0	100.0
Public	43.4	64.6
- Central Government	12.2	
- Decentralized Governments	7.4	
- Social Security	79.6	
Private	56.6	35.4
Per Capita Expenditure, in 1990 US\$		
Total	133.0	1,620.0
Public	58.0	1,010.0
Private	75.0	610.0
Private/Public Ratio	1,3	0,6

Source: PAHO, Gasto Nacional y Financiamiento del Sector Salud en América Latina y el Caribe: Desafíos para la Década de los Noventa. [National Expenditure and Financing of the Health Sector in Latin America and the Caribbean: Challenges for the 1990s]. Project on Health Economics and Financing, Health Policies Program, Division of Health and Development. Washington D.C., 1994.

a/ Average weighted by the GDP of 24 developed countries in the European Economic Community, Canada, and the United States. Expenditure per capita, in 1990 US\$. (OECD data, 1993).

B. EQUITY AND HEALTH

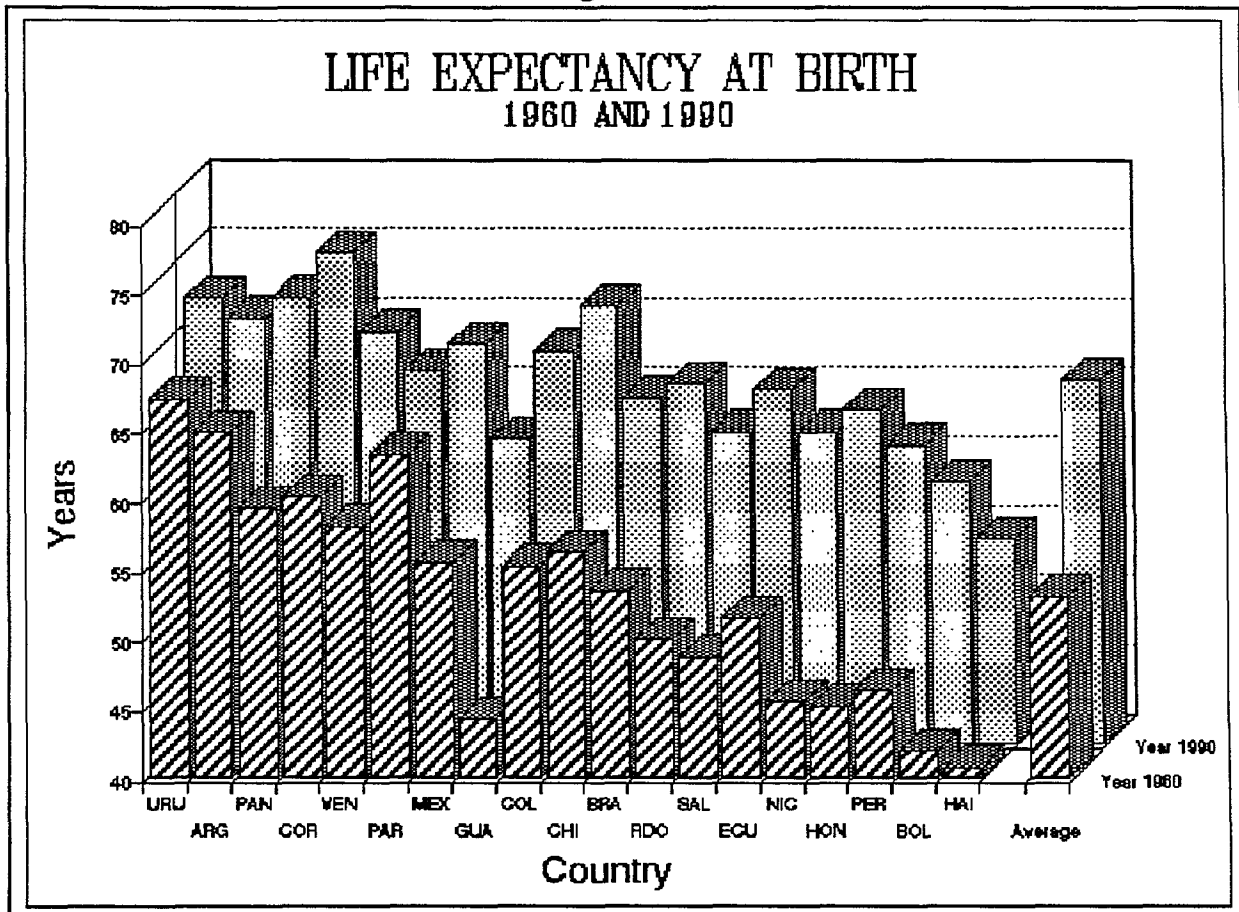
Inequities in the living conditions of different segments of the population translate into excess mortality in some countries and among some social groups within a single country. Health conditions are not homogeneous in Latin America and the Caribbean. The probability of becoming ill and dying

prematurely is higher in certain socioeconomic strata, as a consequence of problems relating to nutrition, unhealthy environmental conditions, exposure to hazardous working conditions or substances in the work place, unemployment, lack of appropriate education to enable the population to comprehend the advantages of self-care, and difficulties that hinder access to both preventive and curative health care.

1. Life expectancy at birth

Life expectancy at birth, an indicator that is inversely related to mortality, has increased in the region. Whereas in 1950-1955 life expectancy was 52 years, by 1985-1990 it had risen to 67, and it is estimated that a child born at the end of the century will live to be 70, which is the goal established under the World Health Organization's strategy "Health for all by the year 2000". The increase of almost 15 years was due primarily to the reduction of mortality from infectious diseases in early childhood (see box II-1), but also to the decline in fertility and the reduction of perinatal mortality.

Figure II-1



Source: Latin American Demographic Centre (CELADE), *Latin America: Population Projections, 1950-2025*, Demographic bulletin series, year 26, No. 51 (LC/DEM/G.128), Santiago, Chile, January 1993.

Box II-1

**TECHNOLOGICAL DEVELOPMENT, PRODUCTION, AND MARKETING OF
VACCINES, REGIONAL SYSTEM FOR VACCINES (SIREVA)**

Despite the difficult economic situation of the 1980s, the countries of the region succeeded in improving coverage to unprecedented levels for all the vaccines included in the Expanded Program on Immunization (EPI). Vaccine coverage of the child population, which in 1978 was 19.6% for diphtheria, tetanus, and whooping cough, 37.2% for poliomyelitis, 33.4% for measles, and 46.5% for tuberculosis, increased to 77.7%, 86.9%, 82.6%, and 90.2%, respectively, in 1993. Accordingly, during the same period there was a marked decline in the incidence of diphtheria (96%), whooping cough (84%), and measles (76%). Since September 1991, not a single case of poliomyelitis, a disease that in 1978 caused the death of 3,053 people, has been reported in the Americas.

In order to maintain and improve the results achieved in controlling these diseases, vaccination of children under 1 year of age and of pregnant women must be continued--a total population of nearly 40 million people a year. Satisfaction of this demand in turn requires commensurate doses of the various vaccines, in accordance with the respective immunization regimens. Although the region has the technological capability to produce them, most of the vaccines used in Latin America and the Caribbean are imported from other countries. Furthermore, the efficiency levels of regional vaccine production are still relatively low compared with international standards. The possibility of incorporating other vaccines into the immunization programs and improving the quality of the existing vaccines is currently being explored to simplify the current vaccination regimens and reduce per capita costs.

PAHO/WHO proposed the establishment of SIREVA to bolster scientific and technical cooperation between governments and institutions in the region to meet the demands of EPI, improve the quality of the existing vaccines, and develop new vaccines of regional interest. This initiative is aimed at encouraging the development, production, improvement, and quality control of the vaccines used in the region. SIREVA has been recognized as the regional counterpart of the Children's Vaccine Initiative (CVI), which has received support from international organizations such as UNICEF, UNDP, and the World Bank.

SIREVA is implemented through a systematic approach to all the stages necessary in developing vaccines. Among these are epidemiological studies on new vaccines, basic and development research, economic feasibility studies, pilot- and industrial-scale production, quality control, and clinical and field testing. A Master Plan for each vaccine selected, drawn up by an advisory group specifically assigned to this task, serves as the basis for coordinating the participants involved in developing the vaccine. SIREVA includes a program for the certification of vaccine-producing laboratories, providing them with technical assistance in order to satisfy the requirements of good manufacturing practices and guarantee the quality of the vaccines produced.

These activities are carried out through multicountry collaborative projects in the form of joint action networks or consortia of scientific-technological institutions and vaccine manufacturers associated through agreements, alliances, and specific conventions. SIREVA is a good example of the "future and previous" linkages that the health sector promotes with other development sectors. The demand of the health sector for high-quality vaccines in sufficient quantity requires a commensurate input on the part of the scientific, technological, industrial, trade, and regional integration sectors. However, the health sector is not always capable of indicating such demand to the other sectors or, conversely, the sectors are incapable of perceiving it. It thus loses an opportunity to increase the output and efficiency of vaccine production, which has an undeniable redistributive impact on the population as a whole.

These changes did not follow the same course, nor did they have the same point of departure in all the countries. At the extremes of the current reality are, on the one hand, Haiti and Bolivia, with a life expectancy at birth of under 60 years, and on the other, Cuba and Costa Rica, where life expectancy averages over 75 years. Notwithstanding the advances mentioned above, in 15 of the 20 countries comprising Latin America and the Caribbean, the average five-year increase in life expectancy was smaller during the period between 1970-1975 and 1985-1990 than the gains registered in the previous 20 years. The United States and Canada, despite low mortality, experienced a greater increase in life

expectancy in recent years, and some countries of eastern Asia had increases that were almost double those recorded in Latin America during the same period. At the regional level, a trend toward ever-smaller increments in life expectancy was observed, which is related to the growing difficulty of achieving further reductions in mortality once the most easily preventable and treatable diseases are brought under control. This is illustrated clearly by figure II-2, which shows that the countries that have achieved the greatest reduction are those in which mortality was highest.

2. Infant mortality

Infant mortality in the region declined more than 50% between 1950-1955 and 1985-1990. The contexts in which this occurred were very different, although there were common elements, such as the utilization of oral rehydration salts, the improvement and expansion of basic sanitation and health care coverage, and the positive influence of the decline in fertility. It was due in part to these factors that the economic crisis of the 1980s did not interrupt the process of decline in infant mortality, although it did slow the pace of that decline.

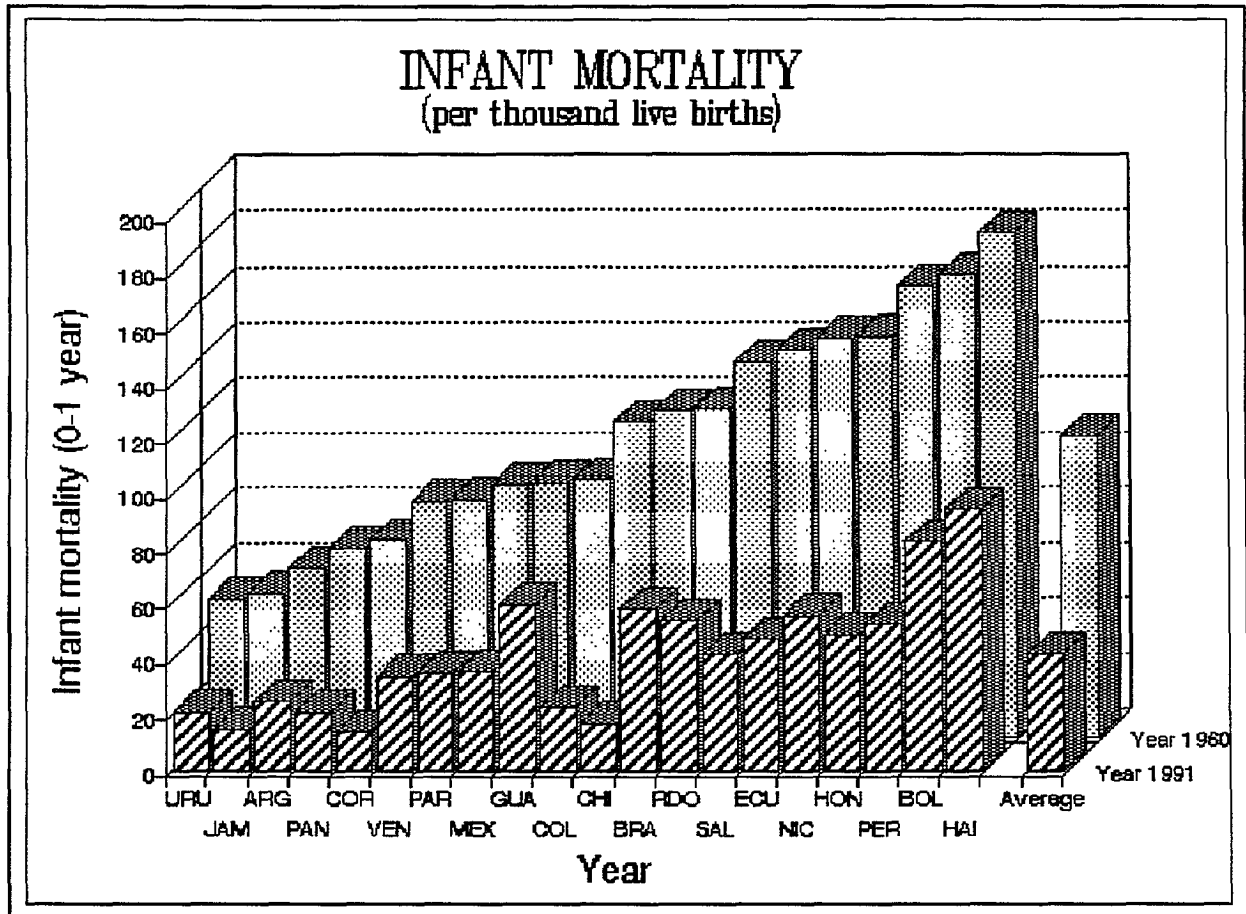
The lowest estimated infant mortality rates (IMR) in the region were around 12 per 1,000 live births (LB) in 1990, while the highest were over 90 —almost eight times greater. Although in general there is a correlation between the income level of the countries and their estimated rate of infant mortality, there are marked differences between countries with similar income levels, some of which show a closer correlation between infant mortality and the level of social development and degree of equity achieved. Thus, for example, whereas in 1990 countries such as Chile and Costa Rica had achieved an estimated IMR of under 20 per 1,000 LB, in Venezuela, Colombia, and Mexico the rates were over 35 per 1,000, and in Brazil infant mortality was more than 60 per 1,000 LB.

However, owing to their notable social development, countries such as Cuba and Panama, which have income levels lower than the aforementioned countries, had achieved estimated IMRs of 20 or fewer per 1,000 LB around 1990, while the IMRs of the Dominican Republic and Ecuador were over 60 and that of Peru was over 80, which reflects the lesser social development of these countries. Among the lowest-income countries in the region, Nicaragua and Honduras showed estimated IMRs of under 70 per 1,000 LB, while Bolivia and Haiti, owing to their relative lack of social development, had IMRs of over or around 100. It is noteworthy that, in countries with similar income levels, health indicators are so sensitive to differences in levels of social development. This development is reflected, *inter alia*, in access to health services, education, nutrients, and basic sanitation, and in the degree of income concentration.

Profound inequalities are also observed between different social groups within the countries. In Peru, for example, the infant mortality rate in Lima is 50 per 1,000 LB, whereas in some rural populations it may be as high as 150 per 1,000 LB. In Venezuela, the poorest *municipios* have an infant mortality rate (35 per 1,000 LB) that is three times higher than less impoverished *municipios*.¹²

¹² PAHO/WHO, Health Conditions..., op. cit.

Figure II-2



Source: World Bank, World Development Report, 1982, Washington, D.C., 1982, and World Development Report, 1993, Washington, D.C., 1993.

This data indicates that economic growth is a necessary condition for achieving substantive improvement in the field of the health, but it is not sufficient. That growth must translate into a substantial and sustained increase in social development.¹³

¹³ Ibid.

3. Change in the epidemiological profile

In recent years there have also been changes in the leading causes of death. These changes in the epidemiological profile are closely linked to changes in the organization of the health sector, and to variations in the living conditions of the population, fertility, the age structure, and the process of urbanization.

As preventable deaths have been reduced, especially among those under 15 years of age, the relative importance of mortality in older age groups is increasing, as is the proportion of deaths from causes that are more difficult to prevent, in particular chronic and degenerative diseases.

However, there are important differences between countries and social groups, which are linked to development levels and social conditions. In the countries with the highest income and social development levels in Latin America and the Caribbean, estimated mortality among those under 15 years of age constitutes less than 10% of total estimated mortality, while the group aged 45 and over accounts for more than 70%. In contrast, in the countries with the lowest levels of economic and social development in the region, mortality in the under-15 age group is generally over 50% of the total, and mortality among those 45 and over is under 40%.

Cardiovascular diseases (the leading cause of death in the region) and cancer (the second leading cause of death) —generally diseases of adults— and accidents and violence are taking on increasing importance, although the incidence of cardiovascular diseases is showing a downward trend in the region, except in Central America. In the last two decades there has been a considerable increase in proportional mortality from ischemic heart disease and a decline in the proportion of deaths caused by cerebrovascular disease.¹⁴ As for cancer, the types that show the highest incidence among men are bronchopulmonary, prostate, and stomach cancer, while among women breast, cervical, and stomach cancer are most common.¹⁵ The high incidence of and death rate from cancer of the uterine cervix in Latin America has been attributed to frequent exposure to risks and low coverage of services for early diagnosis and treatment.¹⁶ In addition, much remains to be done in order to reduce maternal mortality, which in some countries continues to be alarmingly high. Causes relating to childbirth are among the leading causes of death for women of childbearing age in countries with high fertility and deficient health care, in which women are not attended by specialized personnel during delivery, and the incidence of abortion is high.

In the future, degenerative diseases, which are more difficult and costly to treat, will be among the leading causes of death, but here, too, the situation in the region will vary from country to country. In some countries (Guatemala, for example), communicable diseases continue to be a major cause of death (accounting for 47% of all deaths), and diarrheal diseases are the leading cause of death among children aged 1-4. And while the number of deaths from acute respiratory infections —mainly influenza and pneumonia— among children has decreased, these continue to an important cause of death. Moreover,

¹⁴ A. Contreras, Promoción de la salud y equidad en la transformación productiva, Washington, D.C., PAHO, 1993.

¹⁵ D.M. Parkin, et al., Cancer Incidence on Five Continents, vol. 6, IARC Scientific Publications series, No. 120, Lyon, International Agency for Research on Cancer (IARC), 1992.

¹⁶ H. Restrepo, et al., Epidemiología y control de cáncer del cuello uterino en América Latina y el Caribe, Boletín de la Oficina Sanitaria Panamericana, vol. 102, No. 6, 1987.

Box II-2

MALARIA AND POVERTY

Malaria is most frequent in families whose living conditions are the most precarious. It causes losses during the period of disability and is associated with more long-term effects that threaten the well-being of families and are almost never taken into account when studying the effects of the disease. Malaria is a factor that exacerbates the precarious living conditions of the most socioeconomically disadvantaged, since it affects them more than any other group and has negative repercussions that persist even after the period of infection and disability.

Patients are disabled for an average of one week, affecting the entire time available for attending to normal family activities. Caring for malaria patients is also very expensive. In the case of La Tola, two-thirds of the disabled patients were taken care of by women, whose activities usually contributed to the income and well-being of the family more than did those of the patients.

The average time lost from work by patients due to disability is close to 27 hours (3.5 working days), while the time lost from domestic activity is 19 hours (2.5 working days) and from study, 24 hours (3 days). In addition, those who care for patients lose an average of 5 hours from work activities, 4 hours from domestic activities, 9 hours from study time, and 4 hours from free time.

One-third of total monetary loss is attributable to expenditures for physicians and treatment, and the remaining two-thirds to the time lost by reason of disability, care, and worker substitution. Although analysis of the effects of malaria usually takes into account only work time, the present investigation confirmed that income derived from these activities does not amount to even half of the total family income.

The length of disability is related to the time elapsed between the onset of symptoms and the diagnosis, since the shorter this period is, the shorter the period of disability. However, timely search for medical treatment does not depend solely on the presence of health care workers in the area. Although people are able to correctly identify the symptoms of malaria, clinical diagnosis is often put off until other causes are "empirically" ruled out in order to avoid spending that is not strictly necessary. Such behavior, as may be imagined, may have a negative effect on well-being when it results in delayed diagnosis, since this only lengthens the period of disability and also increases the expenditures incurred by the disease.

The position the patient occupies in the family is another important variable. The family is subject to the greatest loss of time through disability and the greatest loss of time in domestic activities when the patient is the wife or female partner. In rural areas, domestic activities often cannot be deferred and as a result, women tend to put off acceptance of disability, which, in turn, leads to intensification of the symptoms and results in prolonging their convalescence.

When the patient is the head of the household, the greatest loss of time occurs in work activities, accompanied, naturally, by the greatest losses in income. Family members become aware of the high economic value of the health of the head of the household and of the high monetary cost of his illness for the family as a whole; consequently, as observed in the qualitative analysis, they make special efforts to reduce the negative impact of the illness. Ill heads of household become disabled more rapidly and seek medical assistance in a more timely manner; they are therefore sick for shorter periods of time, and, in most cases, are cared for by other family members.

endemic problems such as malaria (see box II-2), Chagas' disease, and viral hepatitis persist, and others such as dengue, cholera, and tuberculosis have resurged in the last decade. In addition to these problems there is the AIDS epidemic (see box II-3), which calls for investment in preventive efforts, both for ethical reasons and because of the cost of treating the disease in a context of economic constraints. In other countries (Argentina, Uruguay, Cuba, Costa Rica), communicable diseases cause only 5%-8% of all deaths. However, cancer and diseases of the circulatory system are major causes of death in countries with low premature death rates (in Uruguay, for example, two out of every three people die from these causes).

Box II-3

THE ECONOMIC IMPACT OF AIDS

The epidemic of AIDS and infection with human immunodeficiency virus (HIV) basically affects sexually active men and women between 20 and 44 years of age in the most productive stage of their lives. It consequently has serious social and economic repercussions that include high direct costs related to medical care, absenteeism, reduced family income, and the substitution or disappearance of social and family roles and functions. AIDS is currently the leading cause of death among young adults in 79 cities in North America and is among the two or three leading causes of death in a growing number of Latin American and Caribbean urban centers. The results of several studies at the world level lead to estimates that the annual direct costs of AIDS may amount to as much as 1.8 times the per capita gross domestic product of some countries of the Caribbean (around US\$2,000), while the indirect costs in lost productivity are estimated at almost 16 times this figure. Based on this information, the Caribbean Epidemiology Center in Trinidad projected that the economic costs of the epidemic could reach between US\$400 million and US\$1,000 million--that is, from 2% to 5% of the annual gross domestic product of the Caribbean countries.

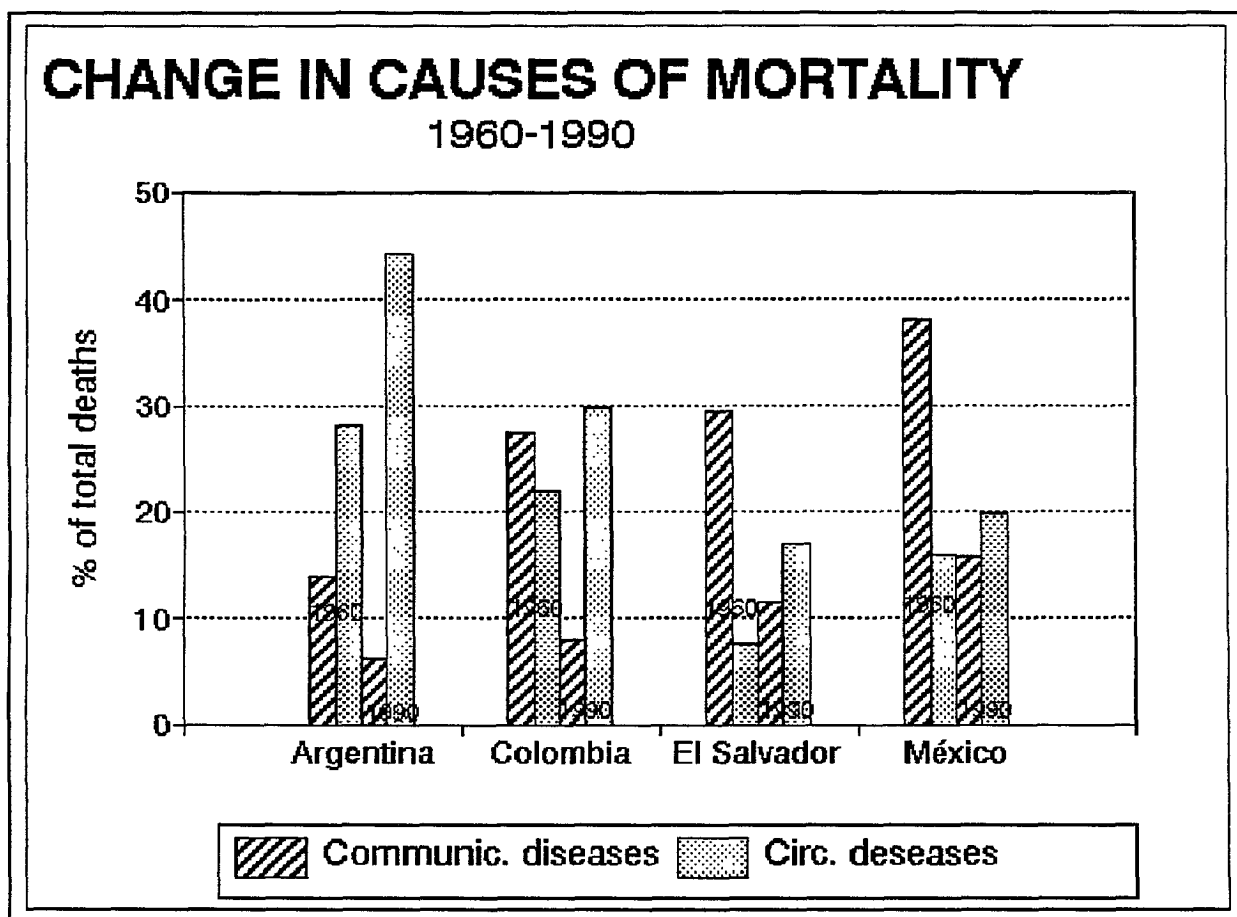
At the regional level, PAHO estimates of the annual direct cost of medical care for new cases of AIDS in Latin America and the Caribbean could reach US\$1,200 million. However, investment in HIV and AIDS prevention activities in funds channeled through the WHO Global Program on AIDS for the countries of Latin America and the Caribbean is less than US\$10 million a year, while the estimated total investment in the 38 countries and territories of the Americas that receive multilateral technical or bilateral cooperation does not exceed US\$20 million per year. Finally, since PAHO estimates that at least 1 million men and women in North America and more than 1.5 million in Latin America and the Caribbean are presently HIV-infected, it is reasonable to anticipate that the number of people requiring medical and social services as a consequence of AIDS will increase dramatically over the next five years, and that investment in preventive activities will have to be increased with national funds or some alternative source of financing provided by the international community.

In other words, the economic question at the national level may be summarized as a choice between investing now or investing 100 times more a few years down the road.

Tobacco and alcohol are the most frequently consumed drugs in Latin America. Together they cause most of the premature deaths from chronic noncommunicable diseases. The epidemic of smoking is of relatively recent advent in the region. After a period of fast growth in per capita tobacco consumption during the 1960s and 1970s, a decline occurred in the 1980s, mainly among young people and low-income groups. The prevalence of smoking is 37% among males and 20% among females. According to estimates, in 1985 tobacco use caused some 100,000 deaths in Latin America. These data are more encouraging than those of other regions, but given that the smoking epidemic is so recent, the cumulative effects of tobacco use will begin to be reflected in statistical data only in coming years. In regard to alcohol, the amount consumed varies considerably from country to country, although it is probably not possible to draw an adequate comparison with the figures currently available, which probably underestimate real consumption.

It should also be pointed out a growing proportion of deaths is being caused by violence, which constitutes a serious public health problem and is a factor in the deterioration of the quality of life. The consequences of this phenomenon for the health and well-being of communities, their social balance, and their economic stability are alarming. Violence affects all strata of society, but certain groups are especially vulnerable. Women and children are the principal victims of domestic violence, while young adult males are most often affected by violence outside the home. Violence, given its negative impact on health and on development, is one of the greatest challenges facing the region.

Figure II-3



Source: Pan American Health Organization, Health Statistics from the Americas. Mortality: Trends from 1960 to 1990 and Latest Data by Cause, Age and Sex; Morbidity: Annual Series of Reported Cases of Selected Communicable Diseases, Scientific publication series, No. 542, Washington, D.C., 1992.

Intentional and unintentional injuries are the third leading cause of death. Among the various types of injuries, motor vehicle accidents make up half the cases. Accidents are the leading cause of death among the population aged 15-24 and are also a major cause of injury and disability in non-fatal cases (see box II-4).¹⁷

¹⁷ I.M. Glizer, Prevención de accidentes y lesiones: conceptos, métodos y orientaciones para países en desarrollo, Washington, D.C., Oficina Sanitaria Panamericana, 1993.

Box II-4

THE ECONOMIC IMPACT OF VIOLENCE

During the past decade, a sustained increase has been observed in the incidence of injuries and wounds attributable to acts of violence and accidents, which have now become the leading cause of death among the economically active population in most of the countries.

In 1993, the total of number of deaths due to violence and accidents was 392,130. The estimated rate for the region was 88 deaths per 100,000 population, ranging from 21 deaths per 100,000 in Jamaica to 295 in El Salvador. The adjusted rates for Colombia, and Guatemala were over 120 deaths per 100,000.

The impact of violence on the economy of the countries has wideranging repercussions. Deaths and disability from acts of violence and accidents account for almost 12% of the total years of life lost adjusted by disability in Latin America and the Caribbean. Since the most affected population consists of young adults, losses in productivity due to premature death or disability are considerable. The economic cost for society as a whole also extends to a decline in tourism, the loss of investment opportunities, and spending on protection and security systems.

Health services are being obliged to devote a growing proportion of their resources to the treatment of injuries resulting from acts of violence and to rehabilitation from the disabilities they cause.

Violence is an area for intervention in which promotion and prevention measures have a strong impact on the economies of the countries and the health of their populations.

Despite the changes that have occurred in the epidemiological profile, there continues to be considerable excess mortality in most of the countries of the region.¹⁸ Around 1990, Chile and Costa Rica showed excess mortality of 19% and 10%, respectively; 26% of that excess mortality was in the under-5 age group. In contrast, in Bolivia an estimated 71% of total mortality in the population under the age of 65 was excess mortality, and 77% of that excess corresponded to children under 5.¹⁹

4. Obstacles that limit access to health care

The population's access to health services is conditioned by a variety of factors. These include the spatial distribution of the population, communications, and the degree of cultural and ethnic heterogeneity or homogeneity. Access to health services is also influenced factors related to social development and economic dynamics, such as the level of illiteracy, the concentration of income, and the percentage of wage earners. Finally, demands made by organizations with political power have an impact to the extent that the allocation of resources is determined by the capacity of various social actors to exert pressure.

¹⁸ This indicator is calculated by grouping the countries according to the population's access to several components of social development: health services, economic resources, educational system, nutrients, and basic sanitation. The lowest mortality rates in a given group serve as the reference point for calculating excess mortality, or the proportion of deaths that could be prevented through improvement of socioeconomic conditions in the country.

¹⁹ PAHO/WHO, Health Conditions..., op. cit.

The poor face numerous difficulties in obtaining health care. Not only is their access to private medical services limited because of the prohibitive cost of such services, but in many cases public allocations for health care benefit other social sectors more. In general, the poor are excluded from social security coverage, which benefits only certain occupational categories. When social security systems are unified and attempt to provide universal coverage, they run up against financial problems or obstacles relating to the location of services. In addition, budgetary constraints or inadequate sectoral organization can impede access by the poorer to health services. In Bolivia, for example, most public spending on health goes toward care for people belonging to the upper two income quintiles.²⁰

Universal health service coverage does not always lead to equity, since it can conceal a situation of stratified access, and a non-equitable distribution of public resources, in which the greatest proportion is concentrated among middle-income groups. It is also necessary to distinguish between universality and equity, on the one hand, and equitable provision of services, on the other. Equity with regard to exposure to risks and access to health services does not necessarily imply that the entire population receives the same services in terms of technology, quality, etc., since often it is possible to achieve equity through various combinations of preventive, curative, and health promotion interventions. A basic requirement for achieving equity is that health services be adapted to the specific needs and problems of the various groups.

Based on the degree of access to services²¹ and on how equitably they are delivered, the following categories of countries can be distinguished: i) countries with universal coverage and equitable delivery; ii) countries with close to universal coverage, but with discriminatory delivery; iii) countries with average coverage and very discriminatory delivery; and iv) countries with low or very low coverage and extremely discriminatory delivery. In this classification it is observed that as the degree of coverage declines, discriminatory treatment intensifies, and at the same time the private sector expands.

In the countries that are in the intermediate categories, it would be possible to achieve universality in terms of access, but it is difficult to ensure uniformity of the services, due to cost and political obstacles. In Mexico, for example, 9% of the poor population in isolated rural areas has access to low-cost primary health care through services offered under the National Solidarity Program of the Mexican Social Security Institute (IMSS). Without a doubt, this represents progress, since prior to implementation of the program this population had no access to health care, except that provided by traditional practitioners; nevertheless, this group remains at a disadvantage in comparison with those covered by the IMSS, who are entitled to comprehensive health care. The extension of the same health benefits to the entire population would be very expensive and would face opposition from IMSS beneficiaries.

The extension of coverage has been very important in the case of some interventions. During the last decade a growing number of countries has been expanding vaccination coverage and the use of oral rehydration therapy. However, in other cases, such as prenatal care, other preventive programs, hospital care, and specialized outpatient care, the gap between the poor and the non-poor has widened.

²⁰ Unidad de Análisis de Políticas Sociales (UDAPSO), Inversión en capital humano y focalización del gasto social. La Paz, 1993.

²¹ C. Mesa-Lago, Health Care for the Poor in Latin America and the Caribbean, Washington, D.C., Pan American Health Organization, 1992 (Scientific Publication 539).

The relationship between health and poverty varies depending on the institutional context (social security, centralized or decentralized national health service, private insurance, etc.). In those cases in which insurance plans offer universal coverage and the inequalities inherent in any multi-level system of financing are eliminated, subsidies are channeled toward the poor and are progressive in nature. This is feasible when the bulk of the work force is employed, in middle-income countries that have the financial resources and also the political will and administrative capacity necessary. This is the case in only a few countries. Based on the average annual rate of increase in the coverage of the economically active population during the period 1960-1985/1988, the universalization of social security coverage and its extension to the poor would take 45-64 years in Mexico, Nicaragua, and Colombia; 80-98 years in Peru and Ecuador; 176-272 years in Honduras, Bolivia, Paraguay, Guatemala, and El Salvador; and 530 years in the Dominican Republic.²²

The inequalities between the sexes are reflected in specific health problems of women, which are partially related to their biological condition. Among other things, mortality and morbidity from causes associated with childbirth and the perinatal period continue to be very high in Latin America and the Caribbean. These and other problems are largely preventable; however, overcoming them is dependent on the expansion of women's access to various resources, occupational and environmental conditions, and services for the promotion and protection of their health. Efforts in this regard may, in turn, help to reduce gender-related inequalities in other spheres.

C. PROFILES OF THE DEMAND FOR HEALTH SERVICES

In the past few decades, the demographic, epidemiological, educational, and occupational profile of the population in Latin America and the Caribbean has changed as a result of the combined effects of the processes of economic growth, agricultural modernization, industrialization, development of social services, demographic transition, urbanization, and others. However, this profile continues to be more heterogeneous than that of developed and recently industrialized countries.

While one segment of the population—the stratum with the highest income, the best education, and the greatest participation in the productive process—exhibits an epidemiological profile similar to that of the population of industrialized countries, other segments—especially rural and urban fringe populations—suffer from health problems that are characteristic of the poverty in the developing world: high child morbidity and mortality, greater exposure to infection owing to lack of sanitary infrastructure and health information, low coverage of basic health services, etc.

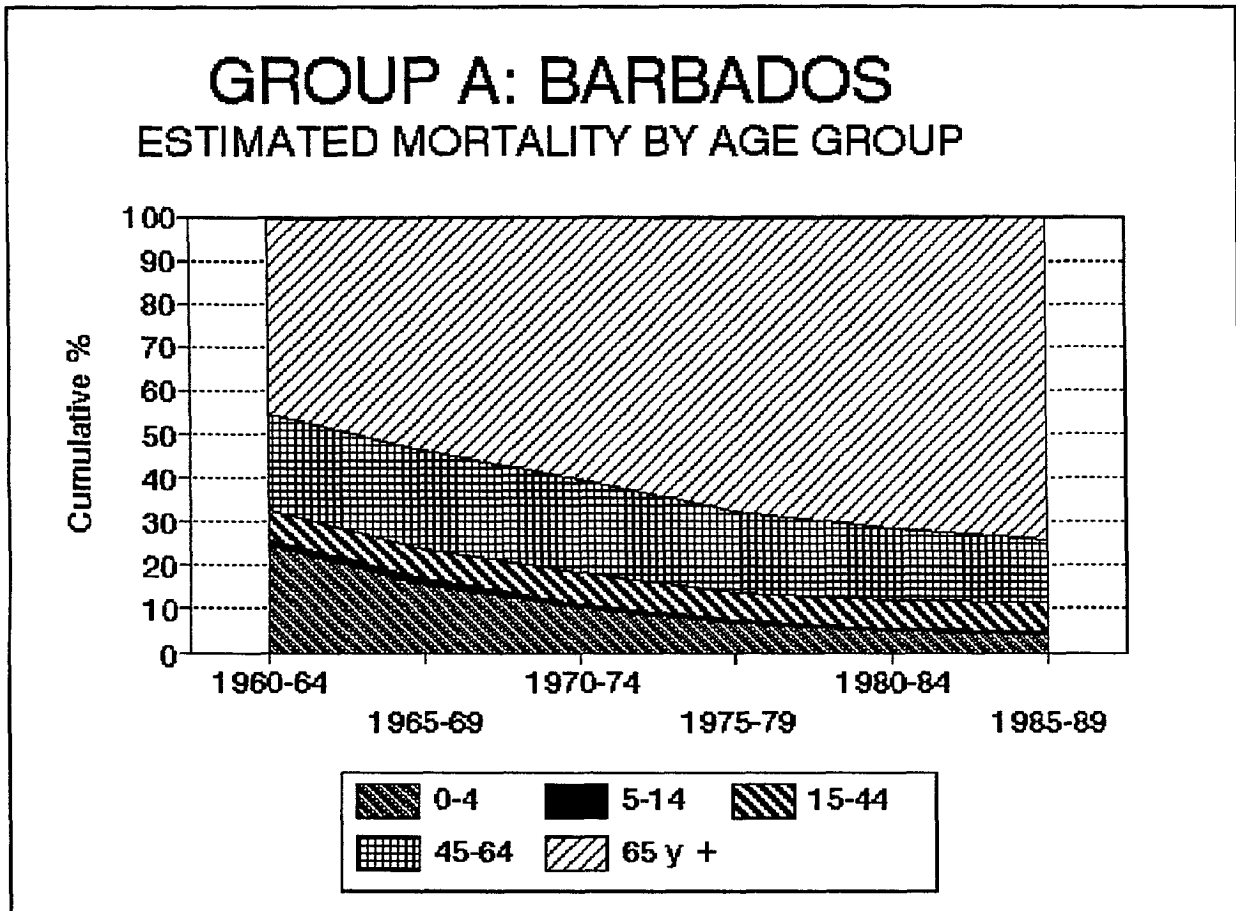
The changes that have affected the demand for health services have taken place at different rates and over different periods of time. Based on those variables, the countries may be classified in three categories: countries in which the change in the profile of demand for health services began during the 1950s (group A), those in which it began in the 1960s (group B); and those in which it began only in the late 1970s (group C). (See figures II-4, II-5, and II-6.) It should nevertheless be borne in mind that considerable diversity exists within each country.

²² Ibid.

In the countries of **group A** the change in the demographic profile began before it did in the others, and various social policies were applied with great intensity and over prolonged periods. The population of these countries is predominantly urban or inhabits rural localities that have basic sanitation and the people have physical access to primary health care services. In addition, few children are born without professional assistance, and few suffer from malnutrition, fail to complete primary school, or are not vaccinated. Workers in the urban informal sector, traditional rural occupations, and small companies with low productivity constitute a minority; nevertheless, the size of this population largely explains the persistence of poverty and the fact that a segment of the population continues to lack health care coverage. This segment may be up to 30% of the total population in some cases. Socioeconomic and urban-rural differences are related to the care provided for non-fatal diseases and the probability of death by age group. During the last decade the birth rate stabilized, which translated into an increase in the proportion of inhabitants in the age groups with the lowest risk of death (15-44 years). In that period of life the demand for health services is lower, as is the average cost of the care provided. Mortality becomes concentrated in the group age 65 and over, as illustrated by the cases of Barbados and Chile and by the evolution of the age structure of mortality in those countries between 1960 and 1990. The new age structure and epidemiological profile make it possible for health systems to redirect their efforts toward improving the quality of life —i.e., increasing the number of years of healthy life. This situation can be maintained during coming decades if the countries consolidate the advances achieved through their social policies in order to prevent deterioration and regression, taking into account that there are still large segments of the population living in poverty. Moreover, the context can be expected to become more difficult between the years 2005 and 2010, when the proportion of people of aged over 45—who are at higher risk for health problems and require more costly care— will exceed 25% of the total population. Argentina, Uruguay, the English-speaking Caribbean, and Cuba belong to this group. (The situation of Barbados is illustrated by Figure II-4.)

In the countries of **group B**, almost half the population dies before the age of 44. (See the case of Mexico, illustrated by Figure II-5.) As a result, the principal objective in regard to health must be to reduce the number of preventable deaths, which can be achieved, for example, by ensuring basic sanitation and by providing professional care and nutritional assistance to mothers and children. The non-poor segment of the population with a minimum of one legitimately employed worker per home has health care coverage and its health demands are oriented toward extending the number of years of healthy life and reducing the risk of death before age 65. However, those who work in the urban informal sector, traditional rural occupations, and small companies with low productivity still constitute the majority of the work force. Concentrated in such occupations are poor workers and people who are not covered by health insurance. This segment, which makes up half or more of the population in the countries of this group, lacks basic sanitation and suffers from malnutrition. The demand for health services among the poor urban population exceeds the response capacity of the services. In Mexico, mortality is similar, approximately 33%, in the different age groups—children and adolescents (0-14), adults (15-64), and the elderly (65 and more). This distribution is related to social and geographic gaps; most of the deaths among those over the age of 65 occur in non-poor urban populations, while the majority of those in the under-5 age group are of children in poor households located in areas that are not part of large cities. The countries in this group are characterized by profound social inequalities and marked contrasts between their potential, which is reflected in their income level, and the progress achieved in narrowing the

Figure II-4

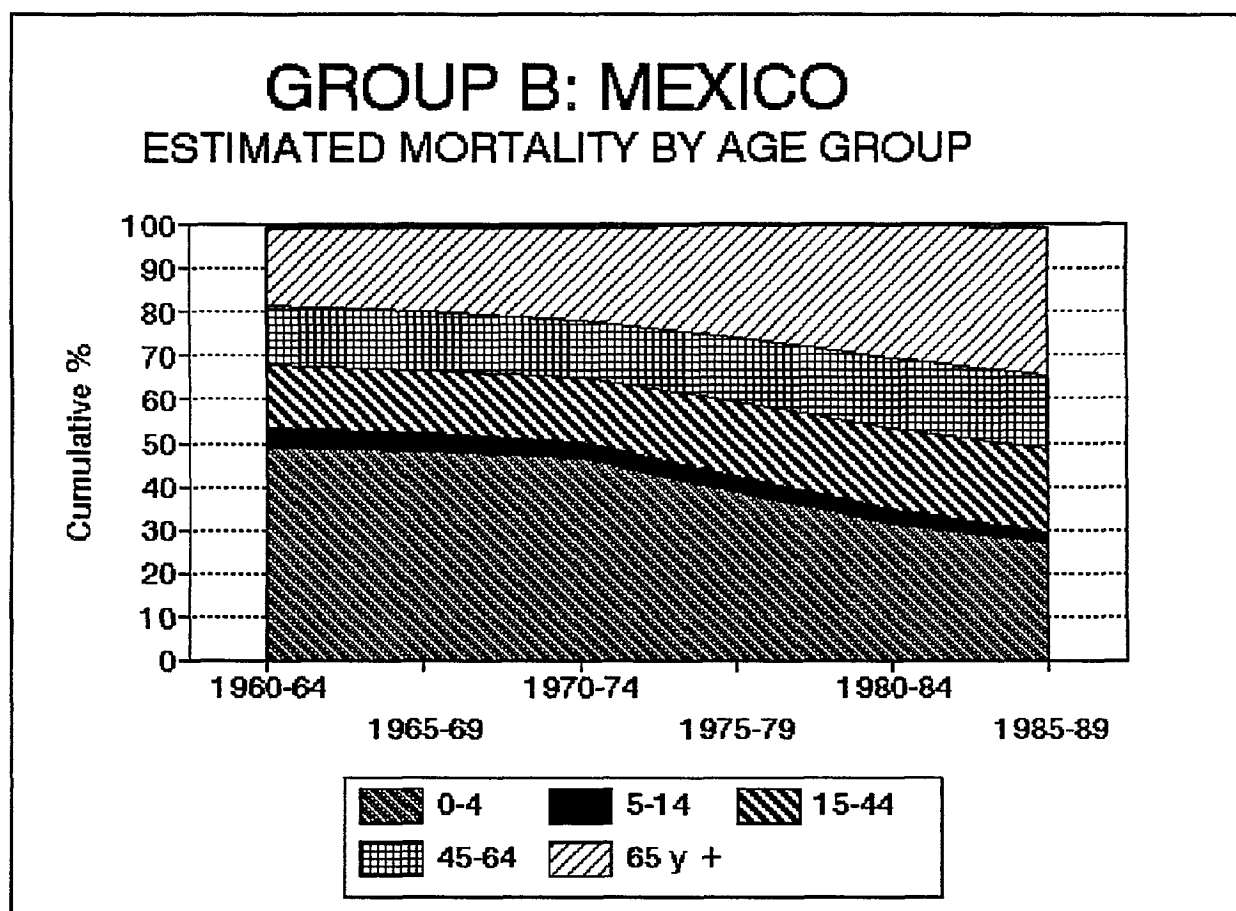


Source: ECLAC, Social Development Division, on the basis of information from CELADE and PAHO.

social gaps with respect to health and death. In addition to Mexico, Colombia, Venezuela, and Brazil belong to this group. In contrast, Costa Rica, which in the 1960s shared the same problems and has a similar population profile, has demonstrated what progress can be obtained in the area of health through vigorous social development policies.

In the countries of group C, 40% of the people die before reaching working age and the death rate is especially high among children under 5. (See the case of Bolivia, presented in Figure II-6.) These deaths are caused by diseases which can be prevented easily and at low cost. High female fertility rates in these countries largely explains the high infant morbidity and mortality, but the most serious problems are widespread poverty and lack of minimum sanitary and social conditions for most of the population. In such circumstances, the provision of health services should focus on improvement of environmental conditions in the home, nutrition, maternal and child health care, and immunization of the population under 14 years of age against communicable diseases. The society is divided into those who have a high risk of dying before reaching working age or dying from causes related to the reproductive and those who

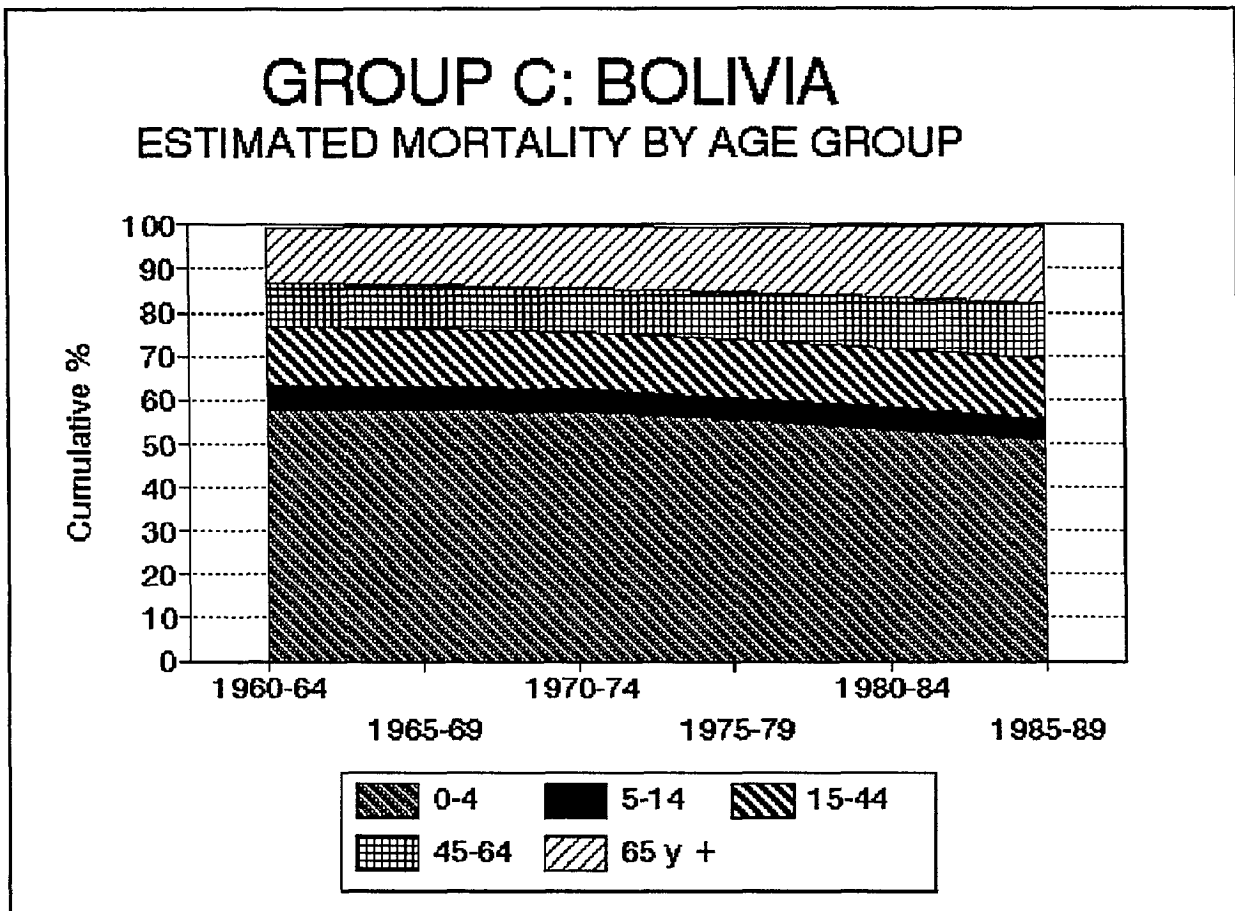
Figure II-5



Source: ECLAC, Social Development Division, on the basis of information from CELADE and PAHO.

struggle against preventable fatal conditions and suffer from diseases throughout their adult life (14-64 years). Accordingly, in the allocation of resources for health care, high priority must be assigned to mothers and children and to the segment of the population made up of adult workers. Most of the population is rural or lives beyond a reasonable distance from health services. A large proportion lacks basic sanitation, suffers from nutritional deficiencies, and lives in areas exposed to endemic diseases (malaria, Chagas', etc.). In this context, the poor health of the working-age population and its limited education contribute to the persistence of low levels of productivity. Consequently, poor health conditions are a basic determinant of mass poverty, which in turn contributes to the existence of poor health conditions. This group includes Bolivia, Guatemala, Haiti, Honduras, and Nicaragua.

Figure II-6



Source: ECLAC, Social Development Division, on the basis of information from CELADE and PAHO.

Given the acceleration of the trend toward lower fertility that took place in the 1980s, the birth rate can be expected to stabilize in most of the group-B countries before the end of the century and in the group-C countries before the year 2010. This will be a crucial change, which will reduce the demand for obstetric care and will contribute to a reduction in the number of deaths among children under 1 year of age. As long as the risks of disease and death remain constant, the evolution of the age distribution will create more favorable conditions in these two groups of countries through improvement of the relationship between population, risks of disease and death, and per capita costs.

As was indicated, the three categories of countries present different types of health problems and their capacity to address those problems varies tremendously. In the group-A countries, the total working population and the population employed in the formal sector continue to increase at a faster rate than the number of persons demanding health services. The same is true of the resources this group is contributing toward the satisfaction of its demands for health care. Household income is also increasing at a faster pace than the demand for and the cost of health services. This is because for this population group, owing to its age, the risk of disease and the cost of care are relatively low. The countries of group B entered

a similar phase during the last decade, but with lower income and fewer people employed per household. In addition, the average household in these countries has a greater number of members and the proportion of informal-sector workers is also larger. The advantage these countries have is that household income is growing at a higher and faster rate. In group C there are many persons who demand health services in comparison with the number of people contributing to the health care system, which has a negative impact on financing; nevertheless, the advantage is that the diseases that are most prevalent in these countries can be prevented and cured at low cost. The process of transition toward lower fertility rates, morbidity, and mortality among the highest-risk groups (children under 5 and women of childbearing age) may be more rapid than the growth in income and employment of the working-age population.

It is evident, then, that the reform of health systems should have different objectives and orientations in each group of countries in order to overcome the different degrees of inequity found in them. Those in group A need to maintain and intensify their social policies and prepare the system to meet a demand that will require growing expenditure on health care. In group B the priority must be to overcome inequities in living and working conditions and to incorporate the marginalized population, in order to thus to put an end to the dualism of the current system. Finally, in group C it is necessary to expand the coverage of primary health care, assigning priority to basic sanitation and nutrition in order to bring about a fundamental change in the health profile.

The three groups differ with regard to the time frame for these changes and with regard to the relationship between health and development. The countries in group C still have many years of work ahead of them in order to ensure universal coverage of basic urban sanitation services, while those of group A have reached the stage at which they need to begin addressing issues such as urban water pollution and occupational health. The group-B countries need to extend the coverage of basic sanitation services while at the same time dealing with water and air pollution. This is particularly true in the mid-size cities in these countries, in which the sanitation and housing deficit is growing worse, and pollution problems are being created as a result of explosive population growth (6%-10%).

In groups B and C there continues to be a large proportion of poor and indigent population in rural areas, and intensive action is needed to meet the needs of this population. In group A, on the other hand, efforts in this regard are diminishing, and greater attention is being focused on specific situations, such as intervention in rural areas affected by pollution, particularly water pollution originating in major urban industrial centers and mining areas, or in areas affected by the crisis in agriculture, mining, or forestry caused by depletion or deterioration of natural resources.

In spite of the differences that will characterize future scenarios, it is reasonable to assume that conditions will be favorable for overcoming the heterogeneity of epidemiological profiles through the control of infectious diseases and the reduction of deficiencies characteristic of poverty. This will be feasible provided that it is possible to achieve basic universal and progressive coverage of health services and basic sanitation, which are among the areas in which investments in human capital are most cost-effective. Moreover, such investments have a faster impact in terms of equity for the group-C countries and the poor population in the countries of groups A and B.

Chapter III

MACRODETERMINANTS AND CONDITIONING FACTORS THAT INFLUENCE THE HEALTH SITUATION

It is well-known that the health of a population depends not only on the country's health systems, but on numerous other factors, which can be broken down into two categories: macrodeterminants and conditioning factors. Among the macrodeterminants are the resources at the society's disposal, including natural resources; its overall level of development, expressed, for example, in GDP; the size and distribution of the population; the degree of political development—that is, the possibilities for the different groups to express themselves, etc. The conditioning factors that influence health status are the living conditions of the various population groups and the social responses to them. The interrelationships between these general (social) and specific (group) factors, as well as the situation with respect to some of them in Latin America, are described in greater detail below. It should be noted that some individual factors that also clearly affect health status are not analysed.

There is a correlation between health indicators and economic development indicators, demonstrating that a society's health status depends in part on macrodeterminants related to its level of development. This means that the level of health varies according to per capita income, although countries belonging to the same category with respect to this indicator reveal significant differences in their health conditions.

Something similar can be observed when the health situation of various social groups within a single country is compared; although the groups have the national macrodeterminants in common, there are major differences in their specific situation. For example, the life expectancy at birth of an inhabitant of northeast Brazil with a low income level can be more than 20 years less than that of an upper-income inhabitant of that country's southeast. These differences persist even when the level of income is the same. For example, some studies on nutritional status in Brazil show that both family income and the region of origin exert a significant and independent influence on the height/age indicator. The pattern of growth among children indicates that, even when income is equal, children are always smaller in the northeast than in the south-central region; this indicates that other factors also affect growth and nutritional status.

Still, in a developed country like the United States, rather significant differences among different social groups can be observed. For example, the national average for infant mortality is 9.2 per 1,000 live births; however, among the white population, the figure is 7.7, while for other races, it is 14.4, and among the black population, 17.0.²³

To understand these differences, the relationship between the macrodeterminants and the health situation of the various social groups should be taken into account —basically living conditions and the social responses to the health and disease profiles that they imply.

Living conditions depend on the insertion of the different social groups into the greater society and can be broken down into four major categories: biological conditions (for example, the genetic potential and immunological capacity); ecological conditions (including the residential and work environment); conceptual and behavioral conditions (cultural values, educational levels, and individual and collective lifestyles); and economic conditions (expressed in how the various groups participate in the production, distribution, and consumption of goods and services).

Each group has a profile of needs and problems derived from these conditions that requires specific health and welfare measures. As a result, to achieve equity, society must recognize the gamut of problems and facilitate adequate social responses in terms of health and welfare measures —measures that foster the development of healthy living conditions and provide for the prevention and cure of specific health problems.

All of this means that actions that influence macrodeterminants and contribute to the societies' overall development make it possible to expand the resources and potential for attaining better health levels. But this is not enough. In order to improve the general health of a society and eliminate inequalities, steps must be taken simultaneously to address conditioning factors such as those described below.

1. Size, growth, and distribution of the population

In recent years, the demographic dynamics of the region have undergone a transformation so profound that projections made in the 1970s and 1980s on the size, growth, and distribution of the population have been far exceeded.²⁴ The population of Latin America, which currently represents approximately 8.5% of the total world population, rose from 165 million inhabitants in 1950 to nearly 460 million in 1992 as a result of high demographic growth (nearly 3% or more up to mid-1960s in many countries). This high demographic growth can be attributed to a continuing decline in mortality since the postwar period and even before and to the persistence of high fertility rates. By the late 1970s, population growth in the region rate began to decline, owing to a decline in fertility, and this trend remained constant during the crisis of the subsequent decade. Annual population growth during the 1980-1990 period was 2.1%, however, while the forecast for the year 2000 is 1.7%. The explanation for this relatively high growth despite the changes in the fertility rate lies largely in the age structure of the population, in which young people predominate.

²³ National Center for Health Statistics (NCHS), Monthly Vital Statistical Reports, vol. 42, N° 2(S), Hyattsville, Maryland, August 31, 1993.

²⁴ See ECLAC/CELADE, Población, equidad y transformación productiva (LC/G.1758/Rev.1-P; LC/DEM/G.131/Rev.1-Serie E, No. 37), Santiago, Chile, 1993. United Nations Publication No. S.93.II.G.8.

The abovementioned changes have modified the age structure and, as is to be expected, the trend is toward the aging of the population—that is, a decrease in the percentage of children and a gradual increase in the percentage of adults and the elderly in the population. This is a slow process that can be clearly observed only in the medium and long term. Moreover, the situation in the region varies widely. In some countries, such as Haiti and Bolivia, the proportion of children and young people under 15 (42%) is very high, while the elderly population is very small (4%). On the other hand, in countries such as Uruguay, Argentina, and Chile, the percentage of the elderly (10%) is already double that of the countries of the first group, while the under-15 age group accounts for only 28% of the population. These changes will produce modifications in both the epidemiological profiles and the demand for health services.

2. Fertility

In 1950, the average fertility rate was approximately 6 children per woman, and the difference between the extreme values recorded in the various countries was 4.5 children. In 1965, a sharp decline in fertility began to be observed; this progressively spread to the entire region, to the degree that by 1985-1990, the average rate was 3.4 children per woman. While fertility levels in all the countries have declined, the difference between the extreme values has not varied a great deal, remaining at 4 children per woman. Since this process began only in recent decades and the age structure in many countries continues to be predominantly young, the annual number of births in the region rose from 7 to 12 million from the 1950-1955 to the 1985-1990 periods. However, in some countries in an advanced stage of demographic transition, the decline in fertility has already translated into a certain stabilization in the number of births. Cuba, Barbados, and Martinique already boast fertility rates that are below the reproduction rate.

The main factors behind the decline in fertility are increased education among women and access to birth control methods. This translates into a trend toward small families, which seems to be the ideal accepted by the majority of the population, perhaps as a result of certain lifestyle and consumption patterns.

Particularly important is the rise in adolescent pregnancies, which has an adverse impact on the health of mothers and children and constitutes a problem that demands a search for effective solutions. Pregnancy at an early age can lead to a higher rate of unwanted pregnancies, more abortions, and problems such as low birthweight and neonatal tetanus.

3. Urbanization and migration

There has also been a marked increase in urbanization, a phenomenon that has for some time distinguished Latin America from other developing regions. In 1950, almost 60% of the inhabitants of Latin America and the Caribbean resided in areas defined as rural; however, by 1990, this figure had fallen to less than 30%, and it is anticipated that by the year 2000, three-quarters of the population will be found in urban areas. The degree of urbanization varies from country to country, and in some nations—especially in the Caribbean and Central America—the population remains predominantly rural. Urbanization is generally considered one of the factors that has facilitated demographic transition, because it has permitted easier access to the educational system, to the rapid dissemination of new cultural patterns, and to modern technologies that foster low-cost reductions in mortality and fertility.

Migration from rural areas to the cities has been a key factor in altering the epidemiological profile and the health situation in urban and rural areas throughout the region. In particular, the explosive growth of the large metropolis and a large number of mid-sized cities in many countries (associated with the growth of the urban population in the former and with migration, by and large, in the latter) explains why health care demand in disadvantaged areas has special characteristics. It also explains the presence of major deficits in health services, basic sanitation, and housing. Furthermore, the spontaneous settlement of tropical rural areas for farming and mining activities, which intensified in the 1980s, explains the resurgence or persistence of communicable diseases like malaria. Particularly important are seasonal migrations, which can lead to outbreaks of communicable diseases and cause considerable annual variation in the demand for health services in the areas of origin as well as the zones that receive the migrants. In the medium term, the impact of migration on health is expected to decline in metropolitan areas and intensify in the mid-sized cities of countries with persistently high population growth (Peru, Bolivia, Honduras, Nicaragua) and in areas recently opened to settlement (humid tropical areas).

4. Poverty

The incidence of poverty in Latin America rose again from the mid- to the late 1980's, especially in the larger countries. Currently, two out of every five inhabitants in urban areas and three out of five in rural zones are poor. While most of the poor reside in urban areas, the incidence of extreme poverty remains higher in rural contexts.²⁵

The percentage of the population living in poverty rose from 19% to 22% during the same period; thus, at the beginning of the 1990s, 95 million people could be found in this situation. At present, one out of every five Latin Americans lacks the resources to feed himself adequately from a nutritional standpoint. In addition, despite the recovery of growth in some countries, poverty in the region continued to rise. Contributing to the increase in poverty were the marked economic downturn in Argentina, Brazil, and Venezuela and the sluggish growth in the income levels of poor households in the countries that experienced an upturn in the second half of the 1980s.

In Chile, Uruguay, and to a lesser extent, Colombia and Costa Rica, the index of poverty at the household level fell in the late 1980s, as shown in the analysis of the household surveys. Given the improved economic performance of the region as a whole since 1990, Argentina, Mexico, and Venezuela, can also be expected to make major progress in reducing poverty through a combination of growth and a moderate redistribution of income.

5. Employment and unemployment

Wage-earners continue to be the most numerous segment of the economically active population in Latin America. Seven out of ten persons employed in urban environments belong to this category, despite the increase in the number of self-employed, informal, and undocumented workers. For many, this latter type of work is a precarious form of insertion into the workforce; real wages in the sector are

²⁵ ECLAC, *Panorama social de América Latina*. Edición 1993 (LC/G.1768), Santiago, Chile, 1993.

lower than they were in the late 1970s, thus relegating to poverty groups in which it was heretofore unknown. However, the channels that facilitate greater participation in the labour environment are stimulating a recovery of real wages.

Other significant changes with respect to salaried employment are a slight reduction in its relative weight in total employment, a decline in the importance of industrial employment, an increase in wage earners in the service sector, a slight decrease in the share of public employment, a rise in employment in small businesses and microenterprises, and a reduction in the share of domestic employment in total employment.

Wages in the 1990-1992 period reflect the positive impact of economic recovery in some countries. The index of average wages in Colombia, Chile, Mexico, and Uruguay during the period rose by 2.9%, 9.6%, 9.1% and 6.4%, respectively.²⁶ Although these data are only partial, it is significant that improvements in wage levels in recent years have been achieved in countries where continued economic growth and rising employment have been accompanied by efforts at income redistribution. Furthermore, in countries marked by strong political tensions and recessionary adjustment programmes that have not resulted in higher growth and lower inflation, wages have fallen. Their lag has produced not only greater wage dispersion but has also contributed to the persistence of high levels of poverty and indigence in urban areas.²⁷

6. Food and nutrition

The food and nutrition situation is determined by social, economic, environmental, political, and biological factors that influence the capacity to produce, obtain, and consume the food necessary to meet nutritional needs and by the biological ability (state of health) to take full advantage of the nutrients ingested. The fact that food is grown in a particular geographic area does not ensure that it is available to the local population. For example, the state of Portuguesa in Venezuela has one of the highest rates of malnutrition in spite of being the country's largest producer of grain. Protein-energy malnutrition and micronutrient deficiency (particularly with respect to iodine, iron, and vitamin A) continues to have an adverse impact on the health and well-being of Latin America's population. According to the global data, the total number of children with low birthweight in Central America and the Caribbean rose from 2.8 to 3 million from 1985 to 1990. This retrospective indicator of the nutritional status of pregnant women makes it possible to predict to some degree the future nutritional status of the children. It should be stated, then, that food security policies will have lasting and effective outcomes only when the conditions that foster economic growth are present.

At the same time, an increase in chronic noncommunicable diseases associated with food and nutrition can be observed in nearly all the countries of the region. This phenomenon is occurring at a time of change in the population's lifestyle and quality of life and in the patterns and quality of nutrition and health care that affect the most privileged and the lowest income groups alike. The coexistence of obesity and micronutrient deficiency makes it essential to promote a healthy diet through activities that increase the availability of food and improve its quality and equitable distribution. At the same time, health services should address the problems of nutritional deficiencies and maternal and child malnutrition as well as others associated with chronic non communicable diseases in adults.

²⁶ ECLAC, Balance preliminar de la economía de América Latina y el Caribe, 1992 (LC/G.1751), Santiago, Chile, December 1992, table 6.

²⁷ ECLAC, Panorama social..., op. cit.

7. Environment

The prevalence of infectious intestinal diseases is closely linked to deficiencies in the water distribution and excreta disposal networks. In 11 out of the 23 countries of the region in which research is being conducted, diarrhea is one of the two leading causes of death in children under 1 year of age and is the leading cause of death in children aged 1 to 4.²⁸

Investment in water and sanitation services contributes to an improvement in health status and raises the countries' level of productivity, for it reduces absenteeism in school and the workplace by lowering the incidence of some infectious diseases, frees families from the domestic chores imposed by a lack of household or community hookups to drinking water, and mobilizes human and financial resources for investment projects. Addressing the problems of water and sanitation exclusively through the provision of oral rehydration salts may constitute an effective stopgap measure to reduce mortality, but it has no permanent or long-lasting impact on the well-being and productivity of the countries.

Measures for improving access to housing by the disadvantaged population are not simply an indisputable contribution to the revitalization of the economy. They also provide direct benefits to the health conditions of the population, facilitating the simultaneous provision of other public services, such as drinking water, excreta disposal, electric energy, etc. Preferential savings and credit systems, as well as participatory systems for collective subsidy or prepayment, also contribute to the provision of these services.

In the field of health, environmental pollution causes 120,000 cases of bronchitis annually in the elderly population and the loss of 55 million work days in the 15-59 year age group.²⁹ Furthermore, the methods for disposing of hazardous industrial waste are generally inadequate, which contributes to the existence of environmental conditions that are harmful to health.

Expanding health service coverage will increase the volume of hazardous hospital waste. Toward the end of the last decade, Brazil generated over 100,000 tons of this type of waste annually, while Argentina, Colombia, Mexico, and Venezuela produced over 10,000 tons. Hospital waste is usually processed in the same way as domestic waste, constituting a danger to both health workers and refuse collectors.

8. Education

The systems for education, training, and the dissemination of scientific and technological knowledge have expanded significantly in quantitative terms in recent decades. However, this process has been incomplete in most of the countries of the region, and there are obvious inadequacies in the quality of their outcomes, their adaptation to the demands of the economic and social milieu, and access to them by the various social strata.

²⁸ PAHO, International Drinking Water Supply and Sanitation Decade, Final Report, Washington, D.C., 1991.

²⁹ PAHO, Health and Environment, Washington, D.C., 1993.

The spread of values, the ethical dimension, and the behaviour proper to modern citizenship, as well as the training and education essential to achieving the international competitiveness that is increasingly grounded in technical progress, receive a decisive boost from education and the generation of knowledge in a society. Reform of the system for generating knowledge is therefore crucial.³⁰

Furthermore, the existing links between a population's educational level and appropriate behaviours from the health standpoint are close and numerous. For example, higher levels of education among women in the region have helped reduce infant mortality from infectious diseases; education moreover, has had a positive impact on maternal and child health conditions through the spacing of births associated with changes in reproductive behaviour.

As a result, an important component of modern citizenship is what could be termed "the culture of health" —that is, individual and community responsibility reflected in preventive and curative action. The links between education and health should therefore be strengthened, with particular attention paid to the values and knowledge that can help to develop such a culture.

³⁰ ECLAC/OREALC, Educación y conocimiento: eje..., op. cit.

Chapter IV

HEALTH SERVICES SYSTEMS

A. THE PUBLIC/PRIVATE MIX IN HEALTH SYSTEMS

Health systems can be classified as public and private, according to their sources of financing, management, and provision of services.³¹ Public financing comes from general taxes and from compulsory or voluntary contributions for health care; public administration is made up of the state system and semipublic entities, such as social security institutions, and the provision of the services can also come from public or private entities, with the latter being either for-profit or not-for-profit.

Based on those variables one can establish a theoretical continuum, at one extreme of which is the organizational model in which financing, management and provision of services is the responsibility of the State, and at the other extreme the private model. In the region we are concerned with, all the systems are located in intermediate positions and are mixed.

The purely state model is characterized by the fact that the State is responsible for financing and the provision of services. The resources come from the public budget and management of the system is also public, although it can differ in degree of decentralization. The physician is a state employee, who receives a wage. Hospitals have an overall budget and the price system only marginally influences the tariffs charged. Accordingly, there are limited incentives for cost reduction. When there are budgetary restrictions, the quality of health services is the main variable to be adjusted. Coverage is universal and access, theoretically, equitable. Users have very little choice and technological change is subject to the overall availability of resources of the public sector. In the region, the health systems that most closely approximate to this scheme are those of Cuba and the English-speaking countries of the Caribbean.

In the mixed models public and private agents coexist. The resources come from the 'regular' budget, from compulsory contributions for health and from voluntary contributions designed to expand the provision of services. There is no set pattern governing the transfer of financial resources, although it tends to be based on previous budgets; suppliers are paid for services effectively provided (fee-for-

³¹ Of the industrialized countries, the United States is usually considered a typical case of a private health system, whereas the United Kingdom, Sweden, or Italy are the best examples of systems in which the public sector predominates. Japan, Canada, France, and Holland have different variants of mixed systems, with most financing coming from the public sector, although services are basically provided by the private sector.

service). In the administrative area social security institutions predominate, but there are also private entities and the competition among them is not fully regulated. Provision of services can be public or private. However, in the more diversified models and those in which the non-State entities involved are important, individual providers play a larger role.

In one of the mixed models financing and management is public, but partially the responsibility of social security, and the provision of services can be both public and private. The methods used for transferring resources within the public sector and for paying private suppliers, as well as the achievement of effective competition between the different providers of services, affect the degree of efficiency of the system, cost pressure, and increases in outlays. The State has a monopsony, which makes it easier to control costs, but it has to make a deliberate effort to do so and exert a regulatory influence on the market. Social security coverage is, in general, limited to contributors in the formal labour market, which does not ensure universal coverage. It is only possible to achieve universality when the public sector is in charge of looking after health care for the poor and for self-employed persons, as happens in Costa Rica, where the Costa Rican Social Security Fund covers 83% of the population. Brazil is another example of this model, although prepayment for services is also common and access to them is much more discriminatory than in other models.³²

There is another mixed system which combines public financing of the social security institutions (SSI) with the management and public or private provision of services by the SSI. The social security institutions may have their own infrastructure and capacity for the direct provision of health services and the procurement of goods and services from both the private sector and public suppliers. In countries where social security is split among fund-gathering entities, there are marked differences in the resources available per member, due to the different levels of income of the workers of the various productive sectors. This is the case in Mexico, where there are notable differences between the coverage provided by the Institute of Security and Social Services of State Workers (ISSTE) and the Mexican Social Security Institute (MSSI). The same thing happens in Argentina, where there are 370 social insurance schemes, for which the financing per member ranges between US\$ 40 and US\$ 250 per year. Although the costs tend to be high, the public sector can make use of its faculty to contract out services as a way of reducing costs. Users have little freedom of choice and the pace of technological change—at least for the public subsector providing services—depends on the overall fiscal situation. This tends to widen the technological gap between public and private services.

The third mixed system is characterized by a greater volume of voluntary private funding designed to improve benefits. The compulsory contributions to the system can be collected and administered by public or private entities, which can either operate as direct providers of services or contract public or private entities to perform that function. Competition tends to grow when users can choose between public hospitals and private institutions and transfer their contributions freely from one sector to another. The competition that is generated between these two sectors will depend on the quality and the complexity of public infrastructure; the institutional limits on competition imposed by the State in the exercise of its regulatory function; and the capacity of the State to finance the process of technological change of public institutions.

³² Brazil has nearly universal coverage but provision of services is highly discriminatory, and 75% of hospital beds are administered by the private sector: the highest proportion anywhere in the region.

The public/private mix should be evaluated in terms of its efficiency and effectiveness in the provision of primary health care, second and third level services, urban sanitation services, and emergency services; in terms of the care provided in cases of work-related accidents and diseases; and in terms of its ability to provide medicine. Despite the fact that a national health system should integrate these different levels of care within the framework of a global programme of coverage of the population, the trend today is towards fragmentation of actions and decisions, in both the public and private sector.

In many countries of the region, public hospitals began to fall behind in terms of technology, due to the fiscal crisis of the 1980s and the drop in public spending on health. Social security also saw a marked decline in resources. By contrast, the private sector has gained ground as far as the overall supply of services of second and third degree complexity are concerned.³³ This process exacerbates the growing dichotomy between the two subsystems. On the one hand, the old infrastructure of the State subsists, endowed with limited economic efficiency and funded by compulsory contributions that have nothing to do with the state of health of the beneficiary, in which freedom of choice for the user is almost null and incentives to keep costs down practically non-existent. On the other hand, the private sector providers whose financing comes from voluntary contributions related to the beneficiary's risk rating deliver higher quality but socially exclusive care, which ends up having a negative impact on the overall equity of the system. Due to the incomplete information that users receive and the existence of a "third payer", the private sector shows a clear trend towards over-supply of services and spiralling costs and expenditure.

B. NEW MODELS OF FUNDING AND OF HEALTH CARE

The drop in the level of public spending on the health sector and, particularly, on investment in infrastructure during the 1980s has been amply discussed in documents and forums (see table IV-1). Although it is difficult to determine the immediate effects of this phenomenon, there is no doubt that it has had adverse consequences, both for the health sector and for education. One of them was the cholera epidemic. In 1992, it was estimated that the magnitude of the deficit in the environmental sanitation and health sectors of the region meant the existence of 130 million people without access to drinking water and 160 million without permanent access to health services.³⁴

The health sector received a smaller share of public spending in the countries of the region, even in those cases in which budgets were not cut. In countries where spending declined, the reduction of spending on health translated into a cutback in operational outlays and greater difficulties in obtaining funds to maintain and repair infrastructure and equipment, and it also severely reduced the margin for investment. Even in those cases in which spending on health has once again increased, the investment components of that expenditure have been slower to recover.

³³ The expansion of the private sector is based on voluntary contribution programmes, where the premiums charged are calculated on the basis of risk-rating and tend to vary according to the age and biological and medical state of the users.

³⁴ Pan American Health Organization, Regional Plan for Investment in the Environment and Health. Washington, D.C., September 1992.

Table IV-1

**CENTRAL-GOVERNMENT SPENDING ON HEALTH (CGSH). 1980-1990
LATIN AMERICA AND THE CARIBBEAN**

Countries	CGSH % of GDP 1980	CGSH % of GDP 1990	CGSH Per Capita. 1980 (in 1988 US\$)	GSGC Per capita 1990 (in US\$ of 1988)
Antigua	1.60	3.90	102.54	227.91
Argentina	0.43	0.30	12.60	8.02
Bahamas	2.30	2.80	263.12	292.10
Barbados	3.20	3.80	208.48	225.76
Belize	2.10	2.30	57.57	57.50
Bolivia	1.30	0.60	12.72	5.35
Brazil	0.76	0.64	18.47	14.18
Chile	2.00	1.75	55.42	44.22
Colombia	0.62	0.70	9.69	9.98
Costa Rica	0.92	1.27	17.00	21.40
Dominica	4.30	4.30	102.28	93.27
Ecuador	0.60	1.63	8.29	20.54
El Salvador	1.40	0.80	16.01	8.34
Grenada	3.90	3.70	87.80	75.96
Guatemala	0.80	1.16	7.90	10.45
Guyana	2.50	4.20	14.28	21.88
Haiti	1.80	1.30	5.17	3.41
Honduras	1.80	2.40	15.04	18.29
Jamaica	2.60	2.31	40.74	33.01
Mexico	0.60	0.30	14.91	6.80
Montserrat	4.40	3.79	280.74	220.51
Nicaragua	2.80	5.80	15.54	29.35
Panama	1.49	2.02	32.04	39.61
Paraguay	0.36	0.40	6.15	6.23
Peru	1.00	0.60	14.80	7.58
Dominican Republic	1.19	1.12	8.83	141.59
St. Kitts and Nevis	4.40	4.17	163.83	141.59
Saint Lucia	2.00	3.50	51.13	81.59
San Vincent and the Grenadines	4.00	4.30	89.28	87.52
Suriname	3.30	1.92	24.50	13.00
Trinidad and Tobago	2.00	3.10	89.38	126.33
Uruguay	1.07	1.18	32.39	32.57
Venezuela	1.32	1.09	47.70	35.92
Total LAC, % of GDP	0.8	0.7	18.8	14.6

Source: PAHO. Gasto nacional y financiamiento del sector salud en América Latina y el Caribe: Desafíos para la década de los noventa. [National Expenditure and Financing of the Health Sector in Latin America and the Caribbean: Challenges for the 1990s]. Project on Health Economics and Financing. Health Policies Program. Division of Health and Development. Washington, D.C., 1994.

It should be pointed out that one of the ways in which the health sector adapted to budgetary restrictions was to increase the efficiency of provision of services. Increased efficiency is one of the principal objectives of the proposal on health, social equity, and changing production patterns, but universalization of health care and an increase in equity are not a priori exclusively dependent on the progress achieved in this area.

The State and the social security institutions have funding problems. The crisis of the 1980s reduced fiscal income and that resulted, in some countries, in a decline in expenditure on social services, including the provision of health services.³⁵ The reduction or stagnation in the amount of resources available for the development and operation of health services has limited investment in basic sanitation and the replacement, maintenance, and conservation of equipment and installations. In addition, it has also translated into inability to maintain an adequate level of current expenditures, which has impeded the normal execution of programmes to deal with prevalent problems and has restricted the administrative development and training of personnel. The deterioration of the public sector has induced a privatization of spending on health, as the only way families can ensure services of acceptable quality.

Box IV-1

TRENDS IN EXPENDITURE BY SOCIAL SECURITY INSTITUTIONS ON HEALTH CARE PROGRAMS

The total expenditure of the social security systems as a proportion of GDP in the region declined from 4.8% in 1980 to 4.4% at the close of the past decade. Notwithstanding, there was an increase in real expenditure by the social security systems of roughly US\$1,300 million. This expenditure rose from approximately US\$36,200 million in the early 1980s to US\$37,500 at the close of the decade.

During the 1980s, changes also occurred in the structure of social security expenditures in this group of countries. The relative share of spending on medical care programs as a proportion of total expenditures declined from 27.6% at the beginning of the 1980s to 25.6% at the beginning of the 1990s.

The variations in the rates of participation in health expenditures by the social security systems and the increase in the total expenditures of the programs did not have a significant impact on the level of expenditure per beneficiary (or member). Between 1980 and 1990, the per capita health expenditure per beneficiary was maintained at approximately US\$47. This is because coverage for Brazil's social security system was legally universalized, expanding from 65% in 1980 to 100% in 1991. However, during this same period, spending on health by the social security system in Brazil increased by only 20%. In most of the other countries, coverage by the social security systems has remained relatively constant.

Source: PAHO, Gasto nacional y financiamiento del sector salud en América Latina y el Caribe: Desafíos para la década de los noventa. [National expenditure and financing of the health Sector in Latin America and the Caribbean: Challenges for the 1990s]. Technical Report Series No. 30, Project on Health Economics and Financing, Health Policies Program, Division of Health and Development, 1994.

³⁵ In any case, it is worth bearing in mind the limitations of taking social expenditure as an indicator of the quality of the services provided. That quality is a function of the efficiency with which available resources are used, of who the real beneficiaries are, and of the way providers perform their duties.

The income of the social security institutions also diminished because of higher unemployment, which reduced the volume of wage-related contributions; because of evasion and delays in making payments by employers, and because the State put off paying its contributions (see box IV-1). Incentives to evade payments also increased, because self-employed persons can opt to declare less than what they really earn or not to contribute at all. This phenomenon is more marked among professionals and technicians who can carry on their business independently. These processes led to families, even the poorer ones, defraying a larger share of expenditures to meet their health needs. This was possible thanks to the increase in the number of employed persons per home, to the part played by non-governmental organizations, to various forms of solidarity (among relatives or residents of the same area, etc.) and, frequently, to the diversion of scarce family resources to pay for medicine and health services.

The percentage of Official Development Assistance (ODA) corresponding to assistance to the health sector fell from 7% in the 1981-1985 period to 6% in 1986-1990.³⁶ In 1990 assistance to the health sector in all developing countries amounted to almost US\$ 4,800 million, of which approximately 4,000 million was Official Development Assistance, and 800 million contributions by non-governmental organizations and foundations. There is also a trend towards multilateral assistance: it represented 25% of total ODA for health in 1980 and 40% in 1990, which demonstrates the capacity of the United Nations system to mobilize resources in support of this sector.³⁷ PAHO/WHO is the multilateral agency that channels most resources to the health sector; they amounted to US\$ 500 million in 1990, which represents a third of the total contributed by the system. In percentage terms, the volume of funds that the system channels to Latin America (18%) is much greater than that contributed by Official Development Assistance (10.6% in 1990). On average, the proportion of ODA corresponding to the health sector in the region amounted to 14% in 1991,³⁸ although the percentage varies from one country to another.

Changes can also be seen in the distribution of the demand for medical care among the different subsystems. The demand for services dependent on the Ministry of Health, on other public agencies, and on non-governmental organizations increased because of the expansion of the informal sector, the emergence of new poor sectors, and the increase in the cost of private insurance. On top of this, insured workers entitled to a minimum package of benefits resort to services provided by the public sector, because they cannot afford services not foreseen in their health plans with incomplete coverage. In addition, in countries where social security protects non-contributing poor persons, the unemployed who before paid compulsory contributions also began to resort to these services. From this it can be deduced that the average expenditure per person receiving public sector health care declined and it is very likely that the health services provided by both the state sector and by social security institutions have deteriorated.

In response to this situation, in many countries of the region new organizational forms for funding and providing health services have arisen, either spontaneously or as a result of explicit public policies. This is associated with changes in epidemiological, demographic and socio-occupational patterns, as well as with the demand by higher income groups for technically more sophisticated and expensive health care. Either through explicit and deliberate state policies or in response to the crisis affecting both the public sector and social security institutions, in many countries of the region, since the last decade, important changes have been brewing with respect to the combination of public and private elements in health care, as regards both the provision and financing of services. In this last area, it is worth noting: i) the increase in household spending on health; ii) the increase in the relative importance of the expenditure by businesses, especially large firms and, to a lesser extent, by medium-sized corporations,

³⁶ World Bank, World Development Report, op. cit., chapter 7.

³⁷ Ibid., p. 171.

³⁸ PAHO/WHO, Health Conditions..., op. cit.

and iii) the increase in non-governmental organization funding for health activities, particularly in the poorer countries of the region. These phenomena merit more detailed analysis.

For a group of 11 countries (see table IV-2) spending on health amounted to 4.3% of household income or expenditures. The weighted average by income quartile shows that spending on health grows with the income level. Households in the first quartile, the poorest, spend 3.7% of the family income on health goods and services. This percentage increases in the second and third quartiles, reaching 4.9% of household expenditures in the quartile with the highest income. In the poorest quintile, most of the expenditure goes to medicine, the prices of which seem to have risen relatively fast. By contrast, most of the increase in the expenditure of the top quintile is in payment for hospital services and medical care, probably due to the increases in private sector fees in the last decade.³⁹ Box IV-2 illustrates the great inequalities in the distribution of spending in three countries in the region.

Table IV-2

**DISTRIBUTION OF HOUSEHOLD EXPENDITURES ON HEALTH BY
INCOME/EXPENDITURE GROUPS
(as a percentage of total expenditure)**

COUNTRY	YEAR	TOTAL	Income/Expenditure in Quartiles			
			1st	2nd	3rd	4th
Argentina	1985/1986	5.33	3.59	4.88	6.32	5.60
Colombia	1984/1985	4.10	3.89	3.62	3.96	4.25
Costa Rica	1987/1988	3.70	2.15	2.56	3.22	4.54
Guatemala	1979/1981	1.64	1.32	1.71	2.24	1.32
Cayman Islands	1983/1984	5.43	4.27	3.76	4.50	6.78
Jamaica	1991	1.70	1.52	1.60	1.78	1.82
Mexico	1989	3.46	4.60	3.40	3.10	3.62
Panama	1983/1984	3.04	0.86	0.89	2.32	3.54
Peru	1985/1986	3.90	3.20	3.30	4.00	4.64
Uruguay	1982/1983	3.83	3.08	3.61	3.43	4.14
Venezuela	1986	6.99	2.95	6.20	6.79	8.85
Weighted Average		4.31	3.66	3.92	4.33	4.86

Source: PAHO. Gasto nacional y financiamiento del sector salud en América Latina y el Caribe: Desafíos para la década de los noventa. [National expenditure and financing of the health sector in Latin America and the Caribbean: Challenges for the 1990s.] Project on Health Economics and Financing, Health Policies Program, Division of Health and Development. Washington, D.C., 1994.

³⁹ Estimates by ECLAC's Division of Social Development on the basis of surveys of income and expenditure in the 1970s and 1980s.

Box IV-2

EXPENDITURE PATTERNS AND INEQUALITIES IN THE POPULATION'S ACCESS TO HEALTH SERVICES IN PERU, MEXICO, AND JAMAICA

Income Deciles	Total	I	II	III	IV	V	VI	VII	VIII	IX	X
Peru, 1991											
Average per capita expenditure (in 1988 US\$)	23	0.7	2.7	4.1	8.7	10.3	14.2	17.6	20.4	41.5	108.6
Spending on health as % of spending on consumption	2.2	0.5	1.1	1.2	2	2	2.4	2.5	2.7	3.6	4.5
Percentage with symptoms who reported seeking medical care ^a	50.2		32.3		48.8		53.4		60.9		58.9
Mexico, 1989											
Average per capita expenditure per household (in 1988 US\$)	31	11.4	14.8	14.5	18	16.8	23.3	26.7	31.8	52.1	100.8
Spending on health as % of spending on consumption	2.3	3.7	3	2.5	2.6	2	2.3	2.2	2	2.6	2.2
Percentage of households reporting spending on health	64.1	46.6	59.2	65.8	60	64.7	65	68.4	67.5	67.2	76.1
Jamaica 1991 ^a											
Spending on health per capita (in 1988 US\$)	13.2		3.1		6.1		8.8		15.2		30.8
Spending on health as % of household spending	1.7		1.5		1.6		1.6		1.9		1.8
Patients with symptoms who reported seeking medical care	47.7		38.7		52.0		48.7		50.6		47.8

The differences in per capita spending on health and in the patterns of use of the health services between the lowest and highest income deciles point to major inequalities in access to health services by the population and a high concentration of private spending on health. In the case of Peru, the wealthy (the highest income decile) spend more than 150 times the amount a lower-income person spends (in the lowest income decile). The per capita expenditure on health in the poorest decile was only US\$0.7 per year, whereas in the wealthiest decile it was US\$108.6. These differences in expenditure levels are substantially smaller in the case of Mexico, and still smaller in the case of Jamaica.

If morbidity patterns were similar for all income groups, equitable access to the health services would be reflected in similar rates of use of the services, regardless of income group. However, the data show that in the wealthiest deciles, symptoms of disease or accidents were more frequently reported than in the lower income groups. In the highest income deciles, about 60% of the people with symptoms of disease or injuries sought health care in Peru, and around 70% in Mexico. Less than half of those from low income groups with symptoms of disease or accidents sought health care: 32% in Peru and 46% in Mexico.

The positive correlation between spending on health as a proportion of household income in the cases of Peru and Jamaica suggests that the concentration of private expenditure on health is even more unequal than the national distribution of income. In Peru and Mexico, the wealthiest 20% of the population accounts for more than 50% of private spending on health. The limited distributive impact of public spending on health suggests that the levels of concentration of the expenditure are at least similar to the concentration of the national income.

Source: Peru: Suárez, 1993; Mexico: INEGI, 1989; Jamaica: SLC, 1991.

Notes: a/ Information in quintiles instead of deciles.

b/ Refers to the number of households that reported medical expenses.

The contribution that companies can make to health care can take various forms, ranging from coverage programmes for personnel to affiliation to a private sector prepayment programme, social coverage provided by the trade union, or participation in a national social security system. In many of these cases there can be a double affiliation to social security institutions and, due to shortcomings in the coverage they provide, to an alternative private medicine programme. This can increase inequality, between companies which insure their workers and others, and it also can erode external competitiveness due to the increase in labour costs.⁴⁰

Box IV-3

Drinking water and sanitation in public health

The cholera epidemic in Latin America that began in 1991 demonstrated the direct linkage between the provision of efficient and effective of drinking water and sanitation services and public health, in addition to drawing attention to the deplorable state of facilities for the elimination of excreta in most cities of the region. The lack of sewerage is exacerbated by failure to treat wastewater, since it is estimated that only between 5% and 10% of the discharges from sewers receive some degree of treatment. Consequently, the waters that receive discharges from sewers in urban areas are highly contaminated and pose a permanent threat in terms of the transmission of diarrheal diseases through water or food. In this context, it is important to point out that the results of surveys carried out by PAHO (1984) and other later studies indicated that in 75%, or more, of the water supply systems the water was not disinfected or else there were serious operational problems impeding effective and continuous disinfection.

The revenue of the water supply and sanitation companies

Historically, the contribution made towards the cost of running water and sewerage systems by utility rates has been usually very low, on the one hand because the rates collected were unreal and, on the other, because of inefficient commercial management. In Mexico, for example, it has been estimated that the total cost of providing drinking water through household connections is approximately 240 pesos per cubic meter, whereas consumers are charged some 40 pesos per cubic meter.

More recently, the companies involved have been unable to offset the drop in appropriations in the general budget of governments with income from the services they provide. Barring a few exceptions—Chile, for example—, the resulting financial deficit has severely affected investment programmes and maintenance of current services. Furthermore, not all the countries have succeeded in maintaining even the nominal levels of service attained in the past. In Buenos Aires, the proportion of the population served by the system run by Obras Sanitarias de la Nación [Sanitary Works of the Nation] has declined continually in the last 50 years.

However, it is not just the rates which make for good financial and commercial management; there are other important factors. In most of the cities there are large volumes of water that are unaccounted for stemming from deficiencies in commercial management, mainly due to problems of billing, collection and inadequate policies concerning past due accounts, in addition to leaks in the distribution system as a direct result of insufficient spending on maintenance. In general, water losses in urban systems are estimated to be equivalent to between 40% and 60% of the water produced. Better commercial management may require administrative changes, that are difficult to apply, but they can replace or make it possible to postpone new investments.

One of the most serious consequences of the existence of inadequate commercial management policies—and the strongest argument in favor of the adoption of rates that reflect real total costs—is that the low rates that are currently collected do not benefit the neediest. The poor usually lack adequate access to public drinking water supplies, because of the low level of investment in this area. In addition, they find themselves obliged to purchase water from private water suppliers at prices 15, 20 and up to 100 times those the drinking water companies charge the middle and upper classes.

⁴⁰ This was one of the main arguments adduced by the Clinton administration its proposal for reforming the United States health care system.

Box IV-3 (concl.)

Some recommendations concerning policies

The only possibility of overcoming the financial restrictions of the drinking water and sanitation companies is self-financing. It is necessary to charge rates that will allow companies to have sufficient income to finance the expansion and maintenance of the system, and the construction and running of wastewater treatment plants. These changes can no longer be put off, especially if it is considered that in Latin America and the Caribbean there are more than 130 million people without access to drinking water, 145 million who do not have sanitary systems for the elimination of excreta, and 300 million who contribute to the contamination of waters due to the disposal of wastes that are not treated in any way; all this will require large investments that surely cannot come exclusively from the state budget.

Steps to make these services pay their way have to be taken without delay. The scarcity of resources could be overcome by establishing pricing systems that make it possible to cover the total cost of the provision of drinking water to the entire population through household connections, even in the poorest countries.

The establishment of a pricing structure of that nature is not easy and will require profound changes in attitude and administrative practices.

In general, for these companies to be self-financing on the basis of income for their services, the basic consumption rate will have to be the equivalent of a little more than 2% of the monthly income of the poorer population. The poor consume less water than the rest of the population. On the other hand, there are studies that demonstrate that, on average, 30% of higher income households consume 50% of the drinking water in several cities in Mexico, and something similar occurs in Santiago, Chile. The concentration of consumption is even greater in other cities, and these conclusions have been confirmed by several studies. This demonstrates that it would be possible to establish internal subsidies within the system, that would not only benefit the poor, but also make it possible to increase the economic efficiency of water supply and sewerage services. As a result, the social benefits could be expanded proportionately more than the drop in individual benefits.

Source: WHO/PAHO/Environmental Health Programme, Situation of Drinking Water Supplies and Sanitation in the Region of the Americas Towards the End of the 1981-1990 Decade, Outlook for the Future, vol. 1, Washington, D.C., July 1990; T. Lee and Andrei Jouravlev, "Una opción de financiamiento para la provisión de agua y servicios sanitarios" ("An alternative way of financing the provision of water and health services"), Revista de la CEPAL, nO. 48 (lc/g.1748-p), Santiago, Chile, December 1992.

The new forms of financing and health care that are more and more common are the private prepayment systems and the plans of the social security institutions offering various combinations of benefits. Some of them, such as Brazil's "Group medicine", started off by receiving State subsidies, but today constitute an alternative to social security, financed by companies and higher income users. Among the new private forms of provision of services financed by mandatory health premiums fixed by the State are the social security health funds (ISAPRES) in Chile, the Peruvian health insurance organizations, and the entities promoting and providing health services that are being established in Colombia. In other cases, the social security institutions require higher contributions and adopt various forms of participation in payment and cost recovery, which grant more freedom of choice to members and offer a broader range of solutions to health problems.

In many cases, when new institutionalized organizational forms arise,⁴¹ they are not accompanied by measures making it possible to reimburse the State and the social security institutions for the subsidies that they grant private sector beneficiaries. This aggravates their financing problem. The most notable example of this is that of the Chilean ISAPRES, whose members can transfer to them the totality of their mandatory premiums, while the composition of financing for the State, that has to be complemented with fiscal resources, continues to be based to a great extent on indirect taxes. On the other hand, in the reform of the Peruvian health insurance organizations the idea is to find ways to retain at least part of the subsidies to the private sector, which would at least cushion the impact.

Risk coverage takes various forms. The more spontaneous focus exclusively on general health care and in some cases only cover specific risks. The institutionalized forms, on the other hand, are established for the purpose of offering broad coverage—for example, through subsidies for health care for lower-income groups—and, even, to replace social security and the public sector, although in practice only high and medium-to-high income groups can afford these systems at present. What is more, the benefits of the prevention programmes tend to continue to depend on the State, even in the case of these groups.

These new forms of organization of the provision of services imply an increase in spending on health, financing for which tends to be parallel to the mandatory premiums that accrue to the State. The State and the social security institutions lose their monopsony *vis-à-vis* the providers of services and those insured have to pay increasingly high premiums. Due to the imperfections of the health market, especially in the absence of regulation, the supplier can induce increases in demand, in terms of quantity and costs; on the other hand, supply based on technological innovation and increases in quality also translates into higher costs.

In recent years, non-governmental organizations (NGOs) have become increasingly important and they make a major contribution to health care. Their activities acquire particular importance in many countries of the region in which the public sector has not fulfilled its function in this field very efficiently. These organizations handle a great volume of financial resources. Between 1980 and 1989 they channeled US\$ 6.4 billion to the developing countries, even more than the amount provided by the World Bank, once payment of the loans is discounted.⁴² The volume of funds from donor governments channeled through NGOs via joint financing mechanisms amounted to US\$ 1,500 million in 1988. That was 50% more than the amount contributed that year by donor governments to the United Nations Development Programme, the principal agency of the system for cooperation for development.⁴³ In addition, calculations made by the World Bank indicate that the contribution of NGOs to poverty relief in some countries of the region is similar to, or even higher than, that of the respective governments.⁴⁴

⁴¹ The term "institutionalized" is used here to mean that they are a response to explicit state policies and are governed by legal norms entailing various degrees of regulation and integration with the rest of the country's health system.

⁴² Clark, 1991.

⁴³ Sollis, 1992.

⁴⁴ World Bank, World Development Report..., op. cit.

Although the activities of non-governmental organizations have been characterized by isolated actions on a small scale, there seems to be a growing trend toward a sustained strengthening of their capacities and toward greater structural complexity, through the establishment of networks of organizations of this nature that work in the same sectors or in different areas. In addition, many of them manage to avoid the traditional assistance-oriented bias and lend impetus to community development by stressing organized participation and self-management.

To summarize, in the last decade public financing of health care has fallen, while the amount spent by families, large and medium companies, and NGOs has risen. In view of the emergence of new organizational forms and the fundamental importance accorded the market, it would be worthwhile to evaluate the impact they have in this area.

Box IV-4

THE CHILEAN ISAPRES

The health system in Chile, which was once one of the most advanced in Latin America, began to take shape back in 1924, with the Worker's Insurance Law. Key landmarks later on were the 1938 Preventive Medicine Law, the creation of the Employees' National Medical Service (SERMENA) in 1942, that of the National Health Service in 1952, and the promulgation of the Law on Curative Medicine in 1968, which enhanced SERMENA. In addition to these advances came the establishment of the work-related accident funds starting in the 1950s, and the passing of the Law on Work-related Accidents and Occupational Diseases in 1968.

The government that assumed power in 1973 introduced certain reforms into this system in the 1970s and 1980s. These led to decentralization—that includes municipal responsibility for primary health care—and the option of affiliation to a private system of financing and administration of social security benefits. That system is made up of the social security health funds (ISAPRES), that began to operate in May 1981.

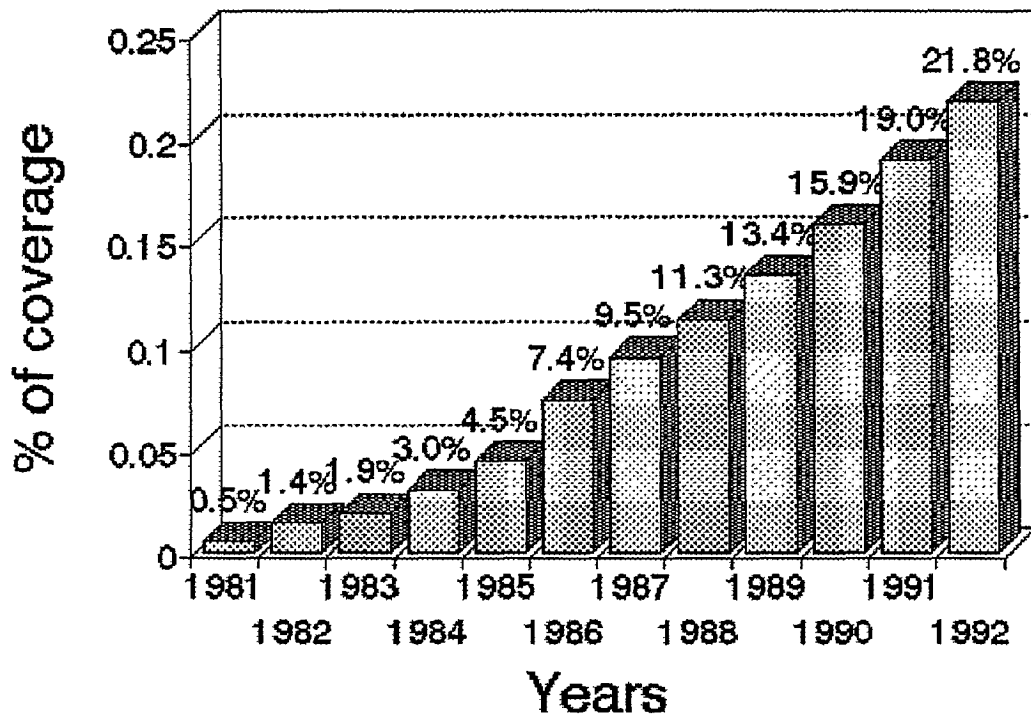
The ISAPRES were the product of a modernization trend which aimed to enhance the overall efficiency of the economy in order to improve its international competitiveness. It was considered that this would contribute to structural adjustment and to the application of a new export-oriented model of development. The new conception was based on subsidies, choice of the market as the appropriate mechanism for allocation of resources, and reinforcement of private property.

In the field of pensions, which was the main ingredient in the reform of the social security system, the concept of simple "distribution" was replaced by that of contributions deposited in each worker's account. With regard to the health services, workers can opt between different entities that finance, administer and provide health services, and choose to contribute their mandatory premiums to the state system or to the new private entities (ISAPRES).

There are certain features of the way the ISAPRES evolved that are worth mentioning. Among other things, it should be pointed out that affiliation to the ISAPRES has increased at an average annual rate of 33% and that in the last years of the period analysed membership increased at a rate of around 20% a year. By the end of 1992, approximately 22% of the population was affiliated to these institutions.

Box IV-4 (cont.)

FIGURE 1
COVERAGE OF THE POPULATION

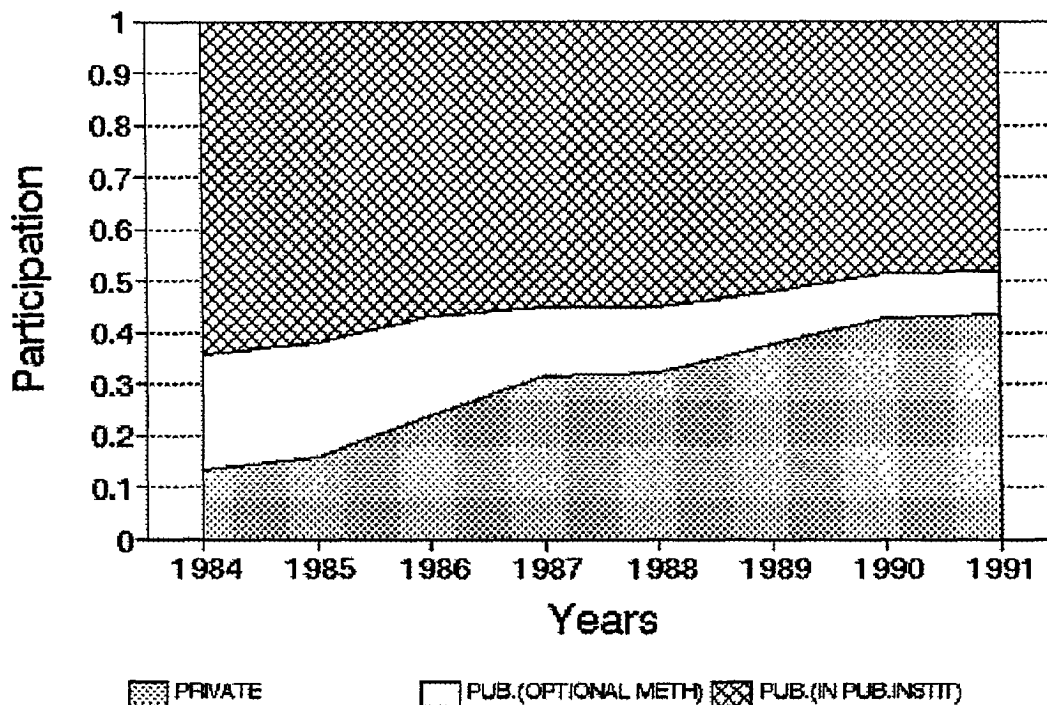


Since those affiliated to the ISAPRES are the better-paid workers, the share of these entities in overall health expenditure has increased; at the same time, the share of the State health system has declined (National System of Health Services —public establishments— and the free choice modality [FONASA]). Thus, by the end of 1991, the ISAPRES accounted for 50% of health expenditures. On the one hand, the average amount spent by ISAPRES members is several times more than that of those who have been obliged to stay in the state system because of their low income. On the other, while the state system is redistributive and progressive, the ISAPRES system is regressive, since those who earn more are entitled to more benefits. This has accentuated the internal inconsistencies of the Chilean health system, both between the state system and the ISAPRES system and among the latter.

Moreover, unlike procedures in the state system, the ISAPRES apply selective criteria, as a result of which they do not insure the most vulnerable people. The ISAPRES also discriminate against the elderly, even though they might have been affiliated to those institutions while they worked. Given all that, belonging to the state system is the only option available for the chronically sick, the most vulnerable people, old people, and also for members of ISAPRES who wish to avoid paying very high premiums. This situation has led to controversy, since, although the ISAPRES form part of Chile's social security system, there exist profound differences between the two.

Box IV-4 (concl.)

FIGURE 2
DISTRIBUTION OF HEALTH CARE EXPENDITURE



Given the shortcomings of the ISAPRES, a bill to reform these institutions was presented to Congress and has been in discussion since 1992. It will probably prove necessary to reform the whole of the Chilean health system, if the ISAPRES are to be made consistent with the system, while contributing to the achievement of overall health goals.

One of the strategies put forward to heighten the equity and efficiency of the system is the establishment of a "basic basket" of benefits that all the ISAPRES should offer their members. Apart from the obligatory minimum, and depending on how well off they are economically, the ISAPRES could provide other benefits or more specialized services, which would cost an additional, taxable, premium. The selection of benefits to be included in the basic basket should be based mainly on social considerations and cost efficiency criteria. The State would be responsible for monitoring compliance with the relevant standards through the Superintendency of the ISAPRES.

Source: E. Miranda, "Descentralización y privatización del sistema de salud chilena" [Decentralization and privatization of the Chilean health system], *Estudios públicos*, No. 39, Santiago, Chile, Centro de Estudios Públicos (CEP), winter of 1990; "Evaluación de la experiencia chilena con las instituciones de salud previsual" [Assessment of Chile's experience with the ISAPRES], *Tendencias económicas de los sistemas de salud* [Economic trends in health systems], M. Virgolini and Gines González García (eds.) Buenos Aires, Asociación de Economía de Salud (AES), 1993; and *Un análisis de la propuesta de modificación de la ley de ISAPRES (Ley 18.933)* [An analysis of the proposed amendment to the Law on ISAPRES (Law 18,933)], Working Documents series, No. 194, Santiago, Chile, Centro de Estudios Públicos (CEP), 1993.

C. PROVISION OF HEALTH GOODS AND SERVICES

The provision of health services entails various combinations of human resources (physicians and other health professionals), equipment, hospital establishments, health inputs and drugs. The price of these resources is determined in different markets, which are best analysed separately in spite of their close interrelationship. A brief analysis of some of these markets is given below.

1. The medical services market

Medical practice determines the demand for equipment, inputs, drugs and hospitalization services. Although there are obvious complementarities between these productive factors, it is up to the physicians to decide how they are to be combined.

The supply of services varies markedly in the region, both from one country to another and within each of them. This is reflected in the different indices of health professionals per number of inhabitants. In some countries of the region the number of physicians per thousand population is similar to the average European rate and much higher than the figure for industrialized countries.

One of the peculiarities of the health services market is the concentration of income in the most outstanding professionals. Specialists have displaced the general practitioners. On the other hand, there has been a relative reduction of the income of the young physicians, of women—who constitute a growing proportion of recent graduates—of the professionals working in a rural environment, and of others.

As private medicine expands, two models of health care tend to get consolidated. The fragmentation of the services and the two models of organization that this implies have a marked effect on the overall financing of the health sector, to the extent that linkages between the public area and the private sector exist. What occurs in this latter sphere ends up impinging on the public sector, which then joins the race to achieve technological modernization, raises medical fees, and adopts guidelines for excluding certain types of patients.

As health markets develop and become more formal, the income of physicians comes to depend increasingly on the return on ownership of the equipment that they use and that return, for its part, depends increasingly on income derived from technological innovation. This general trend is exacerbated in markets where the supply of medical services is abundant. Far from focusing on prices and on efforts to reduce costs, competition between physicians to attract a greater number of patients centers on differentiation of services on the basis of increasing technological complexity. This attitude leads them to achieve a greater degree of specialization, and to opt for the technologically most advanced therapies and equipment, to such an extent that their income depends more and more on investment and technological innovation. Naturally, this attitude leads to additional demands on the system of medical training, combined with ever-increasing restrictions designed to impose barriers on the incorporation into the market of specialized services (see box IV-5).

Box IV-4

HUMAN RESOURCES FOR HEALTH

The work force in the health area is growing faster than in other economic sectors. In Mexico, while the economically active population grew at the beginning of the decade at an annual rate of 3.9%, the health services increased job creation at an annual rate of 5%. The health sector currently employs 7% of the work force in Uruguay, 4% in Argentina and Brazil, and 3% in Mexico and Costa Rica.

Physicians are the segment with the highest growth and importance because of the pressure they exert on the health services market. In 1992, there were 418 schools of medicine in the Region, more than double the number for the 1960s. In this same year, the number of physicians per 1,000 population in Uruguay (36.8), Argentina (26.8), and Cuba (43) surpassed that of the United States and Canada. The trend during the past decade has been toward a progressive reduction in the number of professionals entering the market in these countries, whereas in the poorest countries with the fewest professionals, the number has increased.

Latin America and the Caribbean account for half of the physicians in the Hemisphere (the remaining 50% reside in Canada and the United States), but for only 12% of professional nurses. In the English-speaking Caribbean, the per capita rates of nursing resources surpass those of physicians, while in Latin America a health care model centered on physicians predominates.

Medical training continues to be biological and individualistic in nature, associated with university hospitals, centered on pathologies of little epidemiological relevance, and dependent for its approach on complex technology.

Medical education and the labor market consequently lead to inequalities in access to health services and contribute to raising the costs of providing health care. Health professionals orient the demand for highly complex services that are accessible to only a small percentage of the population. This is one of the main factors responsible for the increase in private spending on health in the Region to nearly 60% of the total.

Comprehensive reform of the health services system requires regulatory activities on the part of the State, both in professional training and in individual and corporate practices associated with health services delivery.

Source: PAHO, Health Conditions in the Americas, 1994.

2. The hospital services market

The hospital services market is also characterized by complexity in its organization and behaviour. In this sphere, too, the region presents huge disparities; in some countries (Argentina, Barbados, Cuba and Uruguay) the number of beds per inhabitant is higher than the average for OECD countries. The relationship between the public sector and the private sector is being transformed, due to the fast growth of private infrastructure in the last decade, at the start of which the private sector accounted for between 20% and 40% of the available beds. In Chile the number of private beds increased from 4,088 to 10,190 between 1980 and 1989, and eventually accounted for 25% of the total. Something similar occurred in Argentina, Brazil, and other countries of the region. In Uruguay public hospital infrastructure deteriorated in the last three decades (the number of beds fell from 14,000 to 8,100), while the private health funds managed to expand their hospital infrastructure considerably, so that by 1991 there were 2,500 beds in their establishments and 750 available in others, compared to 1,900 in 1962. In Argentina beds in private establishments (a little under 50,000 in 1980) constituted nearly a third of

the total available in the country. In the last two decades they have increased by an accumulated 4.5% per year, while beds in the public health services declined from 100,000 to 93,000, approximately. This redistribution of infrastructure is due, in many cases, to the demand for services that social security institutions have gradually been channeling to private providers.

Something similar to what happened in the medical services market is currently occurring with hospital services: ownership is passing into the hands of the most outstanding professionals, who also enter into commercial agreements that enable them to participate in the income from the hospitalization of their patients. A similar trend can be seen in the case of medical centers and diagnosis centers, which in addition establish favourable ties with the suppliers of the inputs used in therapeutic and diagnostic activities.

3. The market for medicines and pharmaceutical raw materials

Drugs are important elements in diagnoses and therapies and, as a result, they form part of the process of provision of health services, although, in some cases, they may even replace them. There are marked disparities in the region, both in terms of supply (production plus imports) and in the demand for medicine. At one extreme is Argentina, where consumption amounts to approximately US\$ 80 per capita per year at retail prices, an amount similar to that recorded in Spain and Portugal. This contrasts with the situation in some other countries where expenditure per capita barely amounts to US\$ 7 per year per inhabitant. These remarkable differences are a function of the average price of drugs, the habits of the medical community, the attitude of the population with respect to medicine, financing systems, relative ease of access, the behaviour of medicine manufacturers, and the degree of social development.

The pharmaceutical industry is dynamic with regard to innovation and the preparation of new products and, in addition, it uses a wide range of professionals. As a result, it has contributed significantly to the improvement of diagnostic technology and treatments used in health promotion, disease prevention, and restorative care. However, in practice the most profitable area has tended to be restorative care, a pattern which coincides with the predominant trend in the evolution of medicine.

Until recently, the prices of drugs were subject to control in much of the region. Recent deregulation of the economy has led to an increase in the absolute and relative prices of medicine, which has meant that both households and the community as a whole have had to devote a larger share of income to medical expenses. Medical social security institutions have reacted to this situation, which affects their overall expenditure, by reducing the coverage they grant in this category or by devising cost recovery mechanisms.

The origin of the drugs that are consumed in the region reflect at least three situations, corresponding to different stages in the development of the chemical-pharmaceutical industry. Some countries make practically all the drugs they consume and a certain fraction —between 10% and 30%, approximately— of the active ingredients and pharmaceutical raw materials. Others manufacture an important proportion of the medicine they consume, but do not yet possess a local industry capable of preparing active ingredients for pharmaceutical use. Finally, in the smaller or relatively less developed countries, a large proportion or all drugs are imported.

Each case poses very different problems, both from the point of view of how the drug market

operates and from the point of view of public policy. With the reduction of import tariffs, authorization to issue patents for pharmaceutical and biotechnological products, and freedom of access to certificates authorizing the launching of new products on the market, national producers of pharmaceutical raw materials are disappearing and being replaced by large transnational companies that dominate nearly 80% of the local market. This even occurs in some of the larger economies of the region, such as Brazil and Mexico.

There are factors that make it difficult for a local pharmaceutical industry to develop, such as the high cost and long duration of research and development programmes for new active ingredients. Such factors tend to prevent Latin American producers from having access to pharmaceutical innovation. Moreover, given the possibility of patenting products, the reduction of tariff barriers, and the suppression by the health authorities of the respective country of preferential treatment for national manufacturers, there is unlikely to be a national industry in this sector.

Chapter V

HEALTH AND CHANGING PRODUCTION PATTERNS WITH SOCIAL EQUITY

As mentioned in Chapter I, the proposal "Health and Changing Production Patterns with Social Equity" (HCPPSE) aims at moving toward greater equity with regard to health risks and access to health services, which in turn requires greater efficiency in resource allocation and more effective health interventions. This goal should be achieved progressively through health promotion and the guarantee of universal access to health care, changes in the conditions that cause morbidity and mortality, and agreements on the proposed reform among the main participants in the health system. In order to bring about a transition of the system and health conditions toward greater equity, quality, and productivity, the HCPPSE proposal is grounded in the following components:

- i) intersectoral and multisectoral action in health;
- ii) the design and implementation of a basic basket of health services;
- iii) the targeting of health programmes and actions;
- iv) reform of the health sector, which includes institutional change at the cultural level, plus decentralization; community participation in health promotion and a recognition of the growing diversity of agents and their roles in the financing, regulation, management, and delivery of health services; development of the capacity to monitor the profiles of priority health problems in different social sectors and the impact of interventions on the inequalities in health; and
- v) investment in the recovery and expansion of the productive capacity of both the health system and the basic health infrastructure.

It is recognized in the intersectoral and multisectoral action in the field of health that the headway made in health can be attributed to a multiplicity of causes, among which extrasectoral factors —drinking water, basic sanitation, nutrition, and education, *inter alia*— as well as basic health care and prevention play a major role. From this standpoint, it is therefore worthwhile to search for technologies that are less medical in nature, placing special emphasis on health promotion and disease prevention. This will also make it possible to take advantage of the links between the health sector and the rest of the productive sectors, given the health sector's potential for stimulating production, employment, and scientific, technological, and human resources development. Health promotion is an important part of this

component; its capacity for intersectoral mobilization makes it possible to incorporate the various factors involved in improving the health status of the population by promoting an awareness of the problems and inequities associated with access to health care and of the need for political commitments to address them.

One of the mainstays of the proposal is equitable access to a basic basket of health services that complies with medical and technical norms and methods, is affordable, and is accepted by society. Its purpose is to guarantee universal access to the population; it must therefore articulate appropriately with the services and conditions that impact on health—even if they pertain to other sectors of activity—to ensure that universality and equity are achieved among all these factors as well. The targeting component refers to the basic basket of health services and the rest of the accepted multisectoral factors. Targeting makes it possible to concentrate interventions on lower-income and higher-risk groups, as well as others that have been excluded or marginalized,⁴⁵ in order to ensure them effective access. The investment component chiefly involves the improvement of sanitation and environmental conditions, thus making it an expression of the intersectoral approach. At the same time, it seeks to recover the productive capacity of equipment and infrastructure, while reshaping and adapting it to respond to the demands stemming from the implementation of the basic basket of health services and the targeted interventions. This component also incorporates investments in institutional development (organizational structures, management and information systems) and human resources (technological and management capability), pursuing greater effectiveness, efficiency, and sectoral ties. Hence, the investment component is rather closely linked to the sectoral reform component, which seeks an increase in the resources allocated to health to achieve the maximum effectiveness and impact at the minimum cost, for a constant, predefined quality, when addressing the health needs of the population.

The components of the proposal will consider both the agents that participate in the health care delivery system and their links to the other sectors whose activities affect the macrodeterminants and conditioning factors that influence the health situation. This, in turn, will produce changes in the roles of these agents in an increasingly diversified environment and will especially require modifications in the role of the State. The **regulatory functions** of the State will become increasingly important, requiring changes in their modalities and in the state management and negotiating capability. The changes in the management modalities of all the agents will be crucial, with **decentralization** indispensable if local communities are to achieve greater autonomy and responsibility in addressing their health problems.

A. OBJECTIVES AND PRINCIPLES OF ACTION

Three values constitute the permanent frame of reference for the HCPPSE proposal: quality, productivity, and equity in the field of health. Special priority is assigned to the formulation and implementation of policies to increase equity in health—that is, policies that minimize disparities in the health conditions of the various social groups and guarantee access by all citizens to basic health care.

⁴⁵ Groups that have been "excluded" or "passed over" are sectors of the population whose access to health care through the regular delivery mechanisms is impeded by gender, ethnicity, or occupational or geographical profile, to mention the most important factors.

There is a conviction that the proposed health objectives cannot be met if the dynamics of development do not change. Among the factors that influence development —and most especially those that generate an improvement in the productive structure, competitiveness, and equity— the most basic one is the development and upgrading of a society's human resources; hence, education and health are also factors that affect these dynamics.

The guiding principles of the HCPPSE proposal are the objectives of the global strategy of Health for All by the Year 2000 and the strategic criteria contained in the proposal on social equity and changing production patterns. The targets of the strategy of Health for All in Latin America and the Caribbean include, *inter alia*: to increase life expectancy at birth to a minimum of 70 years, to reduce the infant mortality rate to an index no higher than 30 per 1,000, to immunize all children under one year of age against the principal childhood diseases, and to extend access to health services to the entire population. The key objective of the proposal on social equity and changing production patterns is for the countries of the region to resume the path toward development. This should be accomplished in a manner consistent with the new world order and within the framework of open economies, generating a dynamic that simultaneously fosters the modernization of production, competitive insertion into the world economy, and a sustained improvement in equity levels in all the countries. The majority of the countries of the region have a long way to go before they achieve the immediate health objectives and the objectives of sustainable development.⁴⁶

The region's economies are in various stages of the process of changing production patterns toward self-sustaining growth and equity. A few countries have already completed the structural adjustment and are well on the road to recovery, while others have implemented the adjustment effort and are now in the initial phases of recovery. In most of the countries, however, the adjustment process is just beginning. The overall economic capacity to finance the reforms varies accordingly, and this affects the possibilities for advancing in the desired direction.

The HCPPSE proposal seeks to reduce health risks and ensure **universal coverage** —that is, the extension of basic services to the entire population. Achieving this objective will make it possible to increase equity while encouraging people to become active agents of production. It will also help boost systemic competitiveness by interacting with the educational interventions and the rest of the social investment components.

Since HCPPSE is grounded in this systemic interaction between higher quality and greater equity in health, on the one hand, and human resources development on the other, the strategy here proposed assigns special importance to the use of measures that mobilize the various actors and simultaneously impact on different areas. Thus, for example, user copayments in the financing of the systems, combined with targeting, would contribute systemically (in several senses) to a reversal of the sector's recurrent tendency toward under-financing, to the progressive expansion of the coverage of a basic basket of health services provided to the poorer segments of the population, and to greater control over costs and the quality of the services.

⁴⁶ An eloquent case in point is that of drinking water, accessible to only 60% of the region's population; another is vaccination against preventable childhood diseases, where current coverage reaches only 70% of children.

The basic basket of services is also conceived within a systemic perspective consistent with the logic of HCPPSE. On the one hand, it promotes the transition of the health situation, since it requires a reorientation of most of the public resources currently utilized to subsidize the social security system and finance services to moderate- and higher-income groups toward the health of the poor, thus fostering greater equity in health. On the other hand, by eliminating the financial "protection" granted to private agents and the social security system, the State would be in a better position to assume a regulatory role, which would lead to the elimination of tax evasion on the part of enterprises, workers, and households. In exercising this regulatory function, the State can foster greater efficiency, cost containment, and the active participation of individuals and households in health promotion, disease prevention, and health care—all of which contribute to the transition process in health.

Based on the analysis presented in previous chapters, the proposal posits certain necessary shifts in current health policies toward others that will contribute to the fulfilment of the intended objectives. These shifts would be:

- i) from a strictly sectoral to an intersectoral approach;
- ii) a gradual shift from a predominantly curative to a preventive approach;
- iii) from an inefficient, omnipresent, or absent State, to an efficient State that acts as a promoter and a regulator;
- iv) from centralized management to a decentralized and autonomous system;
- v) from uncontrolled and mechanical public spending to controlled spending that gives priority to the needs of the poorer segments of the population;
- vi) from actions whose future impact is uncertain, to programmes and projects that have been adequately assessed on the basis of methodologies that relate cost to outcomes.

The basic principles of the proposal are as follows:

- i) an active State role in the formulation and implementation of health policies that deal with the health sector and other sectors whose activities have an impact on health conditions and the health services;
- ii) the ability of the State to monitor the health situation in the different population sectors, as well as how it is affected by the macrodeterminants, conditioning factors and health services;
- iii) the ability of the State to regulate the health system in order to correct deficiencies, control costs, and guarantee quality and equity in the services provided;
- iv) growing activism on the part of both the community and individuals in the activities and options related to their health care.

All this implies a decrease, insofar as possible, in the number of contribution and benefit schemes that currently characterize the fragmented social security systems. In most cases, the diversity of benefits bears no direct relation to the funds allocated to health, which exacerbates the inequity. State contributions

to social security institutions should be reduced, maintaining only the level necessary to guarantee that the poor have access to the basic basket of health services. This should be accompanied by changes in the role of the assorted agents to boost their efficiency and produce health care services that meet given standards of quality at the lowest possible cost.

B. COMPONENTS OF THE PROPOSAL

1. Intersectoral approach and health promotion

a) *Basic criteria for the intersectoral approach in health*

The resolution of health problems is a complex process, owing to the multiple causality of the factors that affect it. Accordingly, attention should not be centered on disease but on disease prevention, health promotion, and the control, reduction, and elimination of risks and harm (both individual and community). The foundation for this new approach is the recognition that health is subject to influences that begin with genetic inheritance, include individual behaviour and societal and familial circumstances, and extend to the social and physical environment.

The close connection between health development and determinants outside the health sector makes it necessary to establish intersectoral ties if a comprehensive strategy that fosters health development with equity is to be promoted. In the Declaration of the International Conference on Health Promotion (Bogotá, 1992), the relationship between health development and efforts to foster solidarity and social equity was clearly established. The persistence of poverty and the vicious circle that accompanies it reveal the importance of linking activities in the health sector with those in other sectors (such as education, housing, water and sanitation, labour, public works, transportation, agriculture, industry). Moreover, any set of problems related to the health conditions of the population cannot be resolved by the health service network alone but requires an adequate intersectoral complement; examples of situations of this type are risks deriving from the physical environment or the reduction of risk factors in marginal or scattered communities.

Intersectoral coordination helps enhance decision-making processes by ensuring, on the one hand, that the decisions at any given level are based on a wide range of information pertinent to the problem at hand and, on the other, that the policy issues are incorporated into comprehensive alternatives, instead of responding to individual demands.⁴⁷ The intersectoral approach requires, in turn, that conventional action be replaced by a multidimensional approach that incorporates the nonmedical factors that affect health status, the relationships among these factors, and access to health services—especially among the more disadvantaged groups—to ensure that the proposals are also intersectoral.

A critical factor in implementing intersectoral policies is the identification of marginal or risk groups. Intersectoral planning processes should also be instituted in line with the health promotion

⁴⁷ See M. Schaeffer, "Intersectoral Coordination and Health in Environmental Management", Public Health Papers, No. 74, Geneva, World Health Organization (WHO), 1981.

strategy.⁴⁸ The means for identifying and assessing the influence of the national programmes and macroeconomic policies on the health of the population should also be provided. To accomplish this, a variety of mechanisms can be designed, either individually or as a group. The ministry of health must improve its capacity to plan interrelated health activities, analyse the impact of extrasectoral factors on health goals, and offer alternatives for coordinating intersectoral action. This requires the adaptation or substitution of technologies, the establishment of new organizational frameworks, emphasis on primary care and health promotion, and modification of the professional profile of health care workers. In addition to these changes within the health sector, other transformations on the national front must be sought. Hence, for example, health and equity must occupy a priority position in the political agenda; the trust of other sectors must be gained, and they must be encouraged to participate in health-related matters; the negotiating capacity of the sector must be improved and political, legislative, and resource allocation objectives formulated. In terms of policy instruments, the reallocation of government expenditures toward health and activities to protect and promote it is important, as is convincing donors to redirect their financial support toward solving health problems through an intersectoral approach.⁴⁹

The articulation is strong if it is horizontal, and it can be handled at various levels: from the motivated community —when it participates in the decision-making process and is the focal point for defining needs and instigating changes— to the national government. The creation of community networks or other types of mechanisms at the local level represents a dual contribution: it puts pressure on the political authorities to provide the necessary resources and it bolsters the impact that initiatives originating outside the sector have on health conditions —initiatives such as the expansion of water supply and sewerage services or health promotion through community education or care for preschool children.

For health to become a concern of all, efforts must be made to reach the greatest number of people through information and education. Introducing pertinent information into the mass media, basic education, and community deliberations is essential to ensure that the decisions of the population with respect to individual, family, and community health have a solid foundation. It is also essential to appeal to health workers' organizations and to social and political leaders to enlist their support for improving and transforming the national health systems.

The region is seeing some important intersectoral initiatives in health development.⁵⁰ Special high priority national campaigns have been launched with the cooperation of different sectors and institutions. Other intersectoral health promotion activities have been carried out in the areas of family planning, nutrition, rural health, vector control, the environment, school health programmes, immunization, early health education, and the promotion of habits, attitudes, and practices that foster good health. Malaria control campaigns have been conducted, for example; these should be integrated and coordinated with

⁴⁸ The strategy of health promotion aims at formulating sound policies, protecting the ecosystem, modifying harmful lifestyles, and reorganizing health services.

⁴⁹ See Health Transition and Development: Sector Priorities and Reform, International Conference Report, Bellagio Study and Conference Center, Italy, June 22-26, 1992.

⁵⁰ Some Caribbean countries have intersectoral committees to formulate policies and plans. Venezuela already has studies on the impact of extrasectoral policies on health. In Brazil, a study has been conducted on the relationship between the agricultural structure, government, and food and nutrition policies to improve the health of vulnerable groups, urbanization and its effects on health, industrial policies, and applications for the manufacture of pharmaceuticals and other products utilized by the health sector. (See also, PAHO, "National Health and Social Development in Costa Rica: A Case Study in Intersectoral Action", Technical Papers series, No. 13, 1988.)

agricultural programmes, programmes for irrigation and the provision of drinking water, health services, housing, and educational facilities. Many of the programmes, however, continue to suffer from a lack of coherence and limited coordination, and health plans frequently remain limited to activities exclusively linked with the health services. Although the nature of the connection between health and the broader processes of socioeconomic development has become more evident, progress is still needed in formulating public policies and programmes that effectively improve the quality of life of the population while promoting equity. Finally, there are still some trends that do not facilitate the intersectoral approach, such as the excessive centralization of decision-making and resource management, vertical operational systems, and an institutional feudalism that fragments the sectors in charge of social policy.

Health promotion is a combination of many actions that transcend the bounds of the health sector, although its main objective is to give people greater control over their own health. It is based on a renunciation of the inequities that exist in each society and among countries. Eliminating these inequities demands a political commitment in which the resources allocated to health and its maintenance constitute a social investment instead of an irrecoverable expenditure. Within this framework, the Ottawa Charter for Health Promotion and the Declaration of the International Conference on Health Promotion of Bogotá identify the following as the principal areas of action for health promotion:⁵¹

- i) the formulation of a public health policy that goes beyond the curative dimension. This implies an intersectoral view that allows for action on the part of the population, the health services, the health authorities, and the productive social sectors;
- ii) the creation of environments that foster good health—in its physical, environmental, and social aspects—through the promotion of healthy cities;
- iii) the strengthening of community action in health. Organized community participation facilitates the identification of needs and priorities in order to modify the situation and raise the level of well-being;
- iv) the development of personal skills that give individuals control over their health and environment in order to reduce morbidity risk factors;
- v) reorganization of the health services to prioritize health promotion and disease prevention;
- vi) identification of the factors that foster inequities in order to promote action that will mitigate their effects. Health promotion should also serve as an agent of change that will lead to radical transformations in the attitudes and behaviours of the population and its leaders in this regard.

Health promotion contributes to an improvement in the health status of the population while bolstering the activities that stimulate other sectors, such as education. It furthermore promotes health

⁵¹ See World Health Organization (WHO), Ministry of Health and Social Welfare of Canada, Canadian Public Health Association. Letter from Ottawa on health promotion: an international conference on health promotion, Ottawa, November 1986; PAHO and the Ministry of Health of Colombia, Promoción de la salud y equidad. Declaración de la Conferencia Internacional de Promoción de la Salud, PAHO/WHO, Washington, D.C., 1992.

interventions that are highly cost-effective in terms of infectious and chronic and degenerative diseases. In fact, health promotion constitutes an important cost containment strategy, especially in systems dependant on high technology. It should be recalled, moreover, that in the coming years a major population cohort of productive age will be vulnerable to pathologies like AIDS, smoking, drug addiction, and alcoholism —pathologies that health promotion has proven highly effective in preventing. This can help to maintain labour productivity and contribute to potential savings in medical care. Social mobilization triggered by health promotion can also be capitalized on in other areas of development.

b) Strategic nuclei for the intersectoral approach in health

The first example of intersectoral dynamics is the one that occurs between education and health. The need for all children to start school at the appropriate age allows both parents to participate in the labour force and keeps the children under the care of the school. Owing to demographic factors and an increase in educational coverage and expected years of schooling, the population cohort that will be admitted to education within the next 6 to 10 years will be the largest in the history of most of the countries of the region. This same fact turns the educational establishment into a prime area for health action, since interventions in nutrition, immunization, and especially health education could be applied here.

The relationship between education, the mass media, and health promotion constitutes another strategic area. Fairly widespread access to formal education currently coincides with growing exposure to the mass media. This, combined with a knowledge of the link between the population's habits and health, creates a basic field for future intervention: health education, incorporated into the primary and secondary curricula of the formal educational system and into campaigns designed for the mass media. Integrated into the primary and secondary school curricula, health education would build up the initial social consciousness. Also, through simple regulations and joint action of the enterprises of the productive sectors and the communications media, it would be feasible to provide coherent and consistent health messages at little cost that promote awareness of issues with respect to adult health. Depending on the state of educational progress, media development, and the audience, intersectoral action would make it possible to capitalize on the cumulative experience of the developed countries in disease prevention and health promotion. This would have a positive impact, reducing the costs of curative medicine (in terms of out-patient and in-patient care).

Smaller-scale administrative political units provide greater flexibility and opportunities for intersectoral action, as noted in PAHO's programme for healthy cities. These settings make it possible to enhance multisectoral efforts by government authorities, public and private institutions, entrepreneurs, and workers and permit the investment of community resources to upgrade the living, working, and cultural conditions of the population. These environments, moreover, can benefit from appropriate use of the mass media, and they help increase coverage of the population.

The "Healthy Cities" project, conducted by the World Health Organization in Europe and in municipalities of Quebec in Canada, has spurred an attempt by the countries of Latin America and the Caribbean to adapt these experiences to local municipalities. PAHO has supported this effort, which promotes the transfer of power to the community, the mobilization of resources, and better managerial capacity among health workers. Although these projects are still not widespread, a certain amount of experience has been accumulated in parts of Argentina, Brazil, Colombia, Cuba, Mexico, and Venezuela,

which has demonstrated their feasibility and viability.

The environment is another dimension traditionally favourable to multisectoral action that has been growing in importance. The experiences connected with basic sanitation in large and mid-sized cities are especially interesting. Development in this area could combine past effectiveness in health and urbanization with greater efficiency and equity. The efficiency would be achieved through the autonomous and decentralized activity of the companies that provide water supply and sewerage services, and the equity, through greater use of progressive rates on consumption; there is also the potential for employing these resources to benefit the poor, who make less use of water and sewerage services. These ongoing experiences demonstrate the profitability of the companies and at the same time provide an important boost to expanding the coverage of these services. There are formulas that could also be extended to rural environments —water committees, for example, which involve turning over the responsibility for conserving water sources and keeping them in operation to community agencies, complementing their activities with technical and economic support from the State for the construction of small-scale works projects. The principle common to these formulas is autonomy and financing through decentralized entities. Central or regional agencies thus assume their regulatory and subsidiary support functions more fully.

The environmental health problems that are surfacing include housing, the workplace, and urban centers. As basic sanitation needs are met, housing, whose deficit in the region is chronic, is emerging as a major obstacle. Obviously, this does not mean that housing problems should become the purview of the health sector, but it does give rise to the creation of agencies to finance housing. Backed by the efforts of entrepreneurs, workers, the State, and international cooperation agencies⁵², these financial organizations promote the spread of formulas like community construction or low-cost commercial housing, depending on the type of country. Health authorities can thus complement the actions of other sectors by developing and updating health standards in housing and suggesting technical solutions that will make their fulfilment a reality.

The relationship between health and the environment in regard to labour has traditionally been associated with the prevention of accidents in the workplace. Issues related to the length of the workday, exposure to risk factors (for example, lighting and noise), stress, and other similar problems are increasingly being taken into account —issues that have a negative impact on health but are not as evident as accidents. To address these problems, the social security system and stronger unions will be decisive. The social security system must participate because of the costs represented by the days lost to disease, disability payments, and the rise in early retirements due to health problems; the unions, because of the attention demanded by this recurrent problem, put off up to now for the sake of higher wages. The relationship between these two factors in each country will determine the importance of environmental problems and their strategic weight. Occupational health should remain autonomous in its activities and financing. State participation will be centered on interministerial regulation (health and labour), and orienting it toward the promotion of social security benefits and health promotion —today absent— will be fundamental.

In urban environmental health, the bias should be toward institutional autonomy, administrative decentralization, and financing by users and those responsible for pollution (for example, application of the principle "he who pollutes, pays"). Here, however, the State's action should combine its general

⁵² From the financing of latrines to the creation of capitalization funds for housing credit.

regulatory role with support—including financial support—for the implementation of more wide-ranging interventions (industrial relocation, for example). It is also recommended that the ministry of health have an epidemiological surveillance system at its disposal to assess the impact of air pollution and climatic factors on the health of the population⁵³ in situations where urban air pollution is very serious, as in Mexico City and Santiago, Chile during the winter months.

One area of activity in which a comprehensive and intersectoral approach is increasingly important is that of women's health. The quality of health care, both physical and mental, should be upgraded, as well as access to it, and a comprehensive approach should be promoted that goes beyond the merely biological and physical. Measures should be adopted that impact on the health of women in the workplace. Such measures should include occupational safety and a reorganization of the health care process, so that the assessment and diagnosis take into account background information about specific living conditions that have an impact on women's health. This would make it possible to induce other sectors and social welfare programmes to participate.

The intersectoral link between women's health, health education, and population activities should continue to be strengthened. The gender approach, centered on the relationship between biology and the social environment, should be incorporated into the analysis of women's health. A special effort should be made to promote women's access to the basic resources for health promotion and protection, to provide them with information on reproduction and the means that will enable them to freely decide upon the number and spacing of children, and to promote programmes for the prevention and the comprehensive treatment of adolescent pregnancy and the battle against cancer in the female population. Perinatal maternal mortality and morbidity rates should also be improved.

2. The basic basket of health services

Under the HCPPSE proposal, the basic basket of health services is the mechanism that would make operational the goal of universal access by the population to a package of health care services. In coordination with the targeted interventions, for which it serves as a frame of reference, and interacting with the other sectors whose work has an impact on the health conditions of the population, the objective of the basic basket of services is to reduce the inequities in health due to income, risk, and other assorted factors, such as gender, ethnic background, geographical location, and occupational characteristics. Thanks to universal access to health care, it permits greater utilization of the positive externalities in health care, as in the case of the programmes for immunization and others for the prevention of collective risks—for example, the promotion of personal hygiene, prevention of traffic accidents, and the reduction of urban violence. Moreover, the basic basket of services helps alleviate poverty, since it guarantees access to health care by the poor and excluded, reducing their uncertainty in the face of disease and its implications in terms of lost income and diminished assets.

The basic basket of services is also a mechanism for achieving solidarity between different population groups (the non-poor and the poor and excluded) and generations (the economically active population and the elderly population). Hence, it opens up concrete paths for channeling and expressing solidarity through activities, services, and interventions whose nature and impact are clearly visible. In

⁵³ H. Sandoval, *La contaminación del aire y sus efectos sobre la salud* (LC/R.1025(Sem.61/24)), Santiago, Chile, ECLAC, 1991, p. 28.

addition, it deliberately and explicitly contributes to social integration by reducing the tacit exclusion of the poor and marginal population. Finally, it is a key instrument in health policy, for it makes it possible to associate the expected outcomes with resource use by helping to establish objectives and goals, quantify expenditures, and develop budgeting and control mechanisms—all of which facilitates the monitoring and optimization of the systems.

The basic basket of services consists of a specific set of services in the areas of health promotion, disease prevention, treatment, and rehabilitation that will be available to all members of society. Based on the epidemiological profile of the population and its diverse degrees of risk, it takes into account the resource availability, social preferences, and policies adopted in each country.

It is known that advances in the health status of peoples can be attributed chiefly to improvements in the macrodeterminants and conditioning factors that influence health, together with activities predominantly in the area of primary health care. It thus follows that improvements in health status must come through multisectoral strategies. As a result, since the basic basket of services is defined here only in terms of its health care components, its implementation should necessarily articulate multisectorally.

The modes of intervention⁵⁴ must be defined to establish the degree of emphasis to be placed on the activities in health promotion, disease prevention, and treatment. This definition will respond to the evolution of the epidemiological profiles—which will determine the optimal type of medical care—as well as the cost-effectiveness and cost-impact of these alternative solutions; it will also consider their contribution to systemic competitiveness and the traditions and "health culture" of each country.⁵⁵

The basic basket of services should reflect the epidemiological, economic, and social particulars of each country and its different regions, when these latter exhibit variations that make it advisable to deal with their health problems through differentiated baskets of services. This not only because the demands in each country are different—because of the differences in the epidemiological profiles, the degree of development, customs, and social preferences—but also because the health care delivery systems, and the social security systems in general, have different characteristics and varying degrees of development. Therefore, the health and care strategies that are adopted will differ, as will the availability of resources and social preferences with regard to the importance of health and the willingness of households, workers, and employers to pay.

Over time, the basic basket of health services of countries and regions with similar economic circumstances will no doubt become more alike. This will occur as the demand characteristics, the organizational and institutional structures of the health sector and the other sectors that influence health

⁵⁴ The expression "modes of intervention" refers to the diverse combinations of health activities in health promotion, disease prevention, and treatment that could be adopted to achieve equal health outcomes—for example, alternatives that emphasize treatment over prevention and health promotion, and vice versa.

⁵⁵ "Health culture" is understood as the customs and practices in each country with regard to health promotion, disease prevention, and the treatment of diseases once they appear. Thus, in some countries "medical health cultures" predominate, with a strong emphasis on the curative and little development of health promotion and disease prevention, while in others, in contrast, an emphasis on health promotion is the first priority.

status, development levels, evidence of greater efficiency in some of the solutions adopted, and finally, the degree of awareness about the influence of health on the standard of living and the quality of life become more homogeneous.

When defining their basic basket of health services, the countries should explicitly identify the health services to be included, based on the epidemiological profile of their populations. They must also evaluate the cost-effectiveness and cost-impact ratios of the various components of the basket, prioritizing them according to their contribution to health promotion, disease prevention, and health restoration, the achievement of systemic competitiveness, and their impact on equity. The countries, moreover, must determine what the total expenditures should be, which implies granting different degrees of coverage to the health needs of the population, and adjust expenditures related to the coverage alternatives to resource availability. Finally, they must make a commitment to guarantee access by the entire population to the basic basket of health services in order to achieve universality and equity in health. The basket serves as frame of reference for the targeted interventions⁵⁶ needed for the most disadvantaged and at-risk population groups, as well as those who are outside—or have insufficient access to—the regular systems and mechanisms for health care financing and delivery.

The design methodology for the basic basket of health services requires that epidemiological aspects and modes of health care delivery be consistent with social preferences and the economic and financial perspective. This latter aims at determining the cost of the alternative packages (alternative baskets) that could be prioritized to optimize the cost-effectiveness ratio. The experience of Oregon, in the United States of America, should be pointed out here as a practical, innovative, and recent approach that can serve as a methodology for dealing with this problem. Oregon has implemented a strategy that articulates epidemiological, economic, financial, and sociopolitical approaches in defining the health services to be offered to the population covered by its social security system. In addition, the World Bank's World Development Report 1993 includes a calculation of the cost of morbidity, based on the year of life adjusted by disability (AVAD). This is a measurement that combines the years of healthy life lost to premature death with those lost to disability, making it possible to calculate the cost-effectiveness ratio of the various interventions. Furthermore, in the Joint Programme on Social Policies for Latin America (PROPOSAL), carried out by ECLAC and the Organization of American States (OAS), a methodology has been developed for assessing health programmes and projects, opting in this way for those with the best cost-impact ratio.⁵⁷

The development of the basic basket of health services begins with an identification of the "gaps" in coverage.⁵⁸ Diverse basket options are then designed that would make it possible to reduce these gaps, determine the cost of the various options, and establish an order of priority among the alternative baskets, based on the intended reduction in the gaps and the overall expenditure that it implies. Finally, through a consensus among taxpayers, users, and their representatives, the basic basket of services that will be provided in each situation is chosen. As economic developments, technological progress, and changes in social preferences occur, the components of the basket may be modified to gradually close the gaps and improve the population's level of health.

⁵⁶ Targeting is dealt with in the next section, which discusses its scope and characteristics.

⁵⁷ E. Cohen and R. Franco, Evaluación de proyectos sociales, Mexico City, Siglo XXI Editores, 1992.

⁵⁸ The "gaps" in service and population coverage are the differences between the coverage required to respond to the needs determined and the coverage attainable with different levels of expenditure and resource use. Thus, these gaps will be reduced to a different degree, depending on the available resources.

Efficiency in the health systems is critical to cutting the overall expenditures implied in providing the basket of services. A fundamental part of the process of designing and selecting the basket, therefore, is sectoral reform and the optimization of intersectoral ties —aspects that are dealt with further on as other key components of the proposal.

Once defined, the basic basket of services can be a valuable tool for sectoral reform. It can be used to help determine the responsibilities of the various levels of care, in drawing up prioritized lists of essential drugs and medical-surgical inputs, in regulating private health services providers, in the exchange of services and charges between institutions in the system, in the allocation of budgetary resources, and, finally, in evaluating the impact of the interventions.

The basic basket of services constitutes a first essential step that opens the way and provides direction, as the countries move toward self-sustaining growth and further development, for the achievement of a universal system of health security within a time frame that varies from country to country.

3. Targeting

As will be seen in greater detail in the analysis of sectoral reform, eliminating the exclusion of the poor often implies a drastic transformation in administrative structures and in the levels, quality, and costs of the current benefits. Targeting is a complement to such reforms. Although it cannot in itself guarantee equitable access by the poor to health, it can effectively help to provide them with selective benefits packages. The concept of targeting is based on the heterogeneity of the population. It is therefore necessary to design appropriate measures specifically geared toward risk groups or similar groups with special needs, which will make it possible to boost efficiency and effectiveness.

Application of this criterion is more urgent in nations with deficient health coverage, health systems in need of coordination, and limited resources. However, it is also appropriate in countries where the benefits coverage is broad, since here targeting can help make universal access to health a reality. One example of this is the programme for the indigent linked to the social security services in Costa Rica.

Because of the epidemiological profile, the targeted benefits packages cannot be reduced to only the simplest of pathologies and must cover some complex curative services. The range of these benefits will be determined by the health services that each country includes in its basket.⁵⁹

Targeting has a redistributive impact that is more positive when the spectrum of groups that are particularly vulnerable from the health standpoint has been clearly defined. For this purpose, PAHO has postulated two criteria. The first is the social criterion, "which grants priority to the care of special risk groups, whose health is more acutely affected than that of the population at large or who tend to encounter barriers to health care. This group includes women, children, workers, the elderly, ethnic minorities, etc. The second is an epidemiological criterion, which emphasizes highly prevalent health problems that can usually be addressed with technologies of proven cost-effectiveness. This criterion

⁵⁹ The economic, political, and institutional development factors that determine how the basic basket of services is defined are discussed in the section on that topic.

covers communicable diseases, protein-energy malnutrition, micronutrient deficiencies, environmental problems, accidents, AIDS,..."⁶⁰

Errors of inclusion or exclusion can be committed in targeting. Errors of inclusion are the flow of benefits toward sectors outside the target population, which implies a waste of resources and greater inequities. Errors of exclusion are deficiencies in coverage and entail costs in terms of current well-being and losses in human resources.⁶¹ Targeted programmes, which seek to reconcile good use of resources with the care of the poor and at-risk populations, should avoid both types of errors.

Knowledge about the losses generated by the flow of benefits to outside populations is relatively broad, thanks to advances in the measurement of access by the poor to social services in general and to targeted programmes in particular. Less attention has been focused, in contrast, on errors of exclusion; knowledge in this regard, therefore, is limited, imprecise, and has not been quantified to a great extent.⁶² Errors of exclusion can result from the criteria utilized, budgetary cuts, or a combination of the two. However, there are signs that financial constraints have been the leading cause. The targeting criteria and the forms of service delivery—for example, where the services are provided—should be prevented from becoming factors that exclude potential beneficiaries.

Targeting may be either direct (when the beneficiaries are chosen on a case by case basis) or indirect (when general information on groups or households is employed to identify beneficiaries and their needs at the regional or community level). When opting among the different mechanisms, both the benefit to be provided and its value must be considered, as well as the type of potential beneficiary, the number of contacts required to obtain the benefit, the excluded sectors that would be interested in obtaining the benefit, the degree of exclusivity of the benefit for the specific objective, and the potential for intra-family dilution of the benefit.

The smaller the monetary value of the benefit or the greater its exclusivity of use, the less stringent the targeting requirements need to be. When the benefit is costly, as in the case of curative nutritional interventions, but the ultimate beneficiary is poor, the selection criteria can be lax. It should also be noted that the potential beneficiaries of a programme may lose interest when the number of contacts required to obtain the benefits is high.

These programmes' lack of impact is largely attributable to the absence of clearly defined criteria for the targeting of the interventions or the inappropriateness of the criteria. In some countries, poverty maps have been drawn up that are utilized by certain programmes to select their beneficiaries; such maps have proven useful in targeting food and nutrition interventions in priority areas. The poverty indices

⁶⁰ C. Vieira, "Estrategias y políticas de atención social a grupos vulnerables: un aporte desde el campo de la salud". Document presented to the Mexican Conference on Social Development and Poverty. Oaxaca, Mexico, September 8-9, 1993, p. 5.

⁶¹ For example, productivity losses occasioned by nutritional problems in adults; the effects of malnutrition and early growth retardation on productivity in the adult; cognitive deficiencies and learning disabilities as a result of malnutrition; intergenerational effects of maternal malnutrition, translated into low birthweight; birth defects or poor school performance, which can be transmitted down to two generations. See G.A. Cornia and F. Stewart, Two Errors of Targeting, Innocenti occasional paper, Economic policy series, No. 36, Florence, United Nations Children's Fund (UNICEF), March 1993.

⁶² In a recent comparative study of 23 targeted programmes in the region, it is recognized that "it was not possible to measure the errors of exclusion". See M. Grosh, From Platitude to Practice: Targeting Social Programmes in Latin America, vol. 1, World Bank. Washington, D.C., 1992, p. IX.

employed should be determined as a function of the types of vulnerability or deficiency that the programmes wish to address. It is inappropriate to employ only a single indicator to manage highly diverse subsidies, because its use impedes specific solutions and, due to the overestimation of values in some areas, excludes individuals with acute deficiencies in others.

The analysis of the risk of becoming ill, disabled, or dying, based on epidemiological factors, and the targeting of higher-risk groups make it possible to take more effective preventive and curative action, the more specifically the harm and each of the factors considered are defined. Hence, at the local level, it is essential that the priority health problems be defined not only in terms of harm but of risk factors, in order to improve the capacity to define functional coverage and identify target groups for specific interventions.

Self-selection is a targeting practice that implies no administrative costs and requires minimum information on the beneficiaries. It is employed when the services can only be of interest to the target population, as in the case of programmes to address high-risk malnutrition.

This targeting criterion should not be confused with the self-exclusion derived from supply deficiencies, such as poor quality benefits, frequent rejections, and long waits, that are indicative of inefficient management or extremely precarious resources —deficiencies whose implicit costs cause even the really needy to exclude themselves.

For the individual selection of beneficiaries, a detailed knowledge of their profiles and up-to-date information is necessary; this is applicable for the treatment of people affected by specific diseases, disabilities, or nutritional deficiencies.

Group selection of potential beneficiaries can be based on general information that permits an identification of risk groups, as in the cases related to occupational health. Finally, territorial, regional, and local variables make it possible to select the beneficiaries of a given programme by geographical location. The greater the spatial segregation of the health problems, the easier this is, as in the case of endemic communicable diseases.

4. Sectoral reform in health

The reform of the health sector, as a specific component of the reform of the State in the region, aims at greater equity, efficiency, and effectiveness in the formulation of health policies and in the regulation, financing, management, and delivery of health care.

As previously noted, the future configuration of the health systems will be influenced by the nature of the existing health system and the current and projected sociodemographic and epidemiological profiles in each national scenario. With regard to the health systems, of particular relevance will be the role of the political forces, unions, trade associations, and other groups that comprise the sociopolitical makeup of the different sectoral organization models. Another factor that will influence the operation of the sector will be each country's progress in terms of fiscal recovery and the resumption of the savings, investment, and economic growth processes.

The health status to which each society can aspire should take a variety of factors into account, namely: the trends in their health systems; the conditions that, while related to health, do not pertain to the sector *per se* (drinking water, sewerage, education, and occupational safety, *inter alia*); the impact

of the economic growth dynamic on the expansion of resources and the effectiveness of the health care; and the greater efficiency in health resources allocation that may derive from a reasonable balance between state regulation and the optimal operation of the markets. It is realistic to anticipate that the future sectoral scenario in most of the countries will be characterized by the existence of mixed health care systems. With regard to service delivery, the redefinition of roles in some cases will take place within the public sector itself, among centralized and decentralized entities; in areas related to financing, it will occur among the fisc, the companies, households, and the international cooperation agencies. In others, the State will reduce its role as a direct supplier and even financier of services, to be replaced by the social security institutions and private, collective, or non-governmental entities.

These changes will make it possible to diversify supply, and the new entities will be able to compete among themselves, offering users a wide range of alternatives. If this occurs within the framework of an adequate regulatory regime, then the microeconomic efficiency, the effectiveness of the benefits, and equity of the access to the system will certainly improve.

a) *Institutionality of the health sector*

Under the present proposal, several functions are assigned to the State institutions, including the social security institutions. Some of these functions are already being carried out in many countries of the region, and they are mentioned in this document to underscore their importance to the proposal's implementation. Others are new or just beginning in most of the countries or are carried out only in exceptional cases. At the same time, other functions, which today represent a considerable share of State action, will be delegated to subnational agencies or to private, collective, or non-governmental institutions. This will free the national State entities to discharge their new responsibilities effectively.

This reassignment of functions creates a new State profile that differs significantly from the current one in the area of health. Its functions and characteristics will be as follows:

- i) consensus-building to define the development policies aimed at increasing equity in health;
- ii) multisectoral action centered on providing the factors that positively influence health status and on the implementation and regulation of health investments;
- iii) programme development, financing, and management of the health system, in addition to decentralized service delivery;
- iv) regulation of the production of goods and services in the field of health and of the agents who participate in it;
- v) promotion and strengthening of the international ties that are pertinent to health; and
- vi) monitoring and evaluation of the impact of macrodeterminants, conditioning factors, and services on the health situation.

Box V-1

HEALTH REFORM IN COLOMBIA

The objectives of the General Social Security Health System are to regulate the basic public health service and create conditions that will ensure the access of the population as a whole to all the levels of care offered.

The System shall gradually provide health services of equal quality to all of Colombia's inhabitants, regardless of their ability to pay. In order to prevent discrimination for financial reasons or level of risk, the System shall offer special financing to the poorest and most vulnerable population, as well as mechanisms to prevent negative selection or exclusion.

All inhabitants shall be enrolled in the System, following payment of the required premium or through the subsidy, which shall be financed with fiscal resources, collective contributions, and revenues from the territorial entities.

Members shall be enrolled in a comprehensive health protection plan, known as the Compulsory Health Plan, which includes preventive, medical, and surgical care and the provision of essential drugs.

Collection of the premiums shall be the responsibility of the Solidarity and Guarantee Fund of the General Social Security System, which shall delegate this function to the Health Promotion Entities.

The Health Promotion Entities shall be responsible for the enrollment of users and shall administer the delivery of services by the Provider Institutions. The Health Promotion Entities may not apply clauses to their members that exclude pre-existing conditions.

The Health Service Provider Institutions are official, mixed, private, community, or collective entities, created to provide health services to the members of the General Social Security Health System, both within the Health Promotion Entities or outside them. The State may establish mechanisms to promote such organizations and open up lines of credit for the establishment of group professional practices and for community and collective Health Service Provider Institutions.

The health services provided directly by the State or the territorial entities shall be delivered chiefly through the State Social Enterprises. These constitute a special category of decentralized public entities with legal status, their own capital, and administrative autonomy -created by law or by the assemblies or councils, as the case may be, and subject to the legal regime provided under this law.

The General Social Security Health System shall be oriented, regulated, monitored, and controlled by the national government and the Ministry of Health and shall be responsible for formulating the government's policies, plans, and programmes, and for setting priorities in the struggle against disease and in health maintenance, education, information, and promotion, in keeping with the nation's economic and social development plan as well as the territorial plans.

For the members of the subsidized regime, the National Social Security in Health Council shall design a programme that will enable its beneficiaries to be incorporated gradually into the compulsory plan of the contributions system before the year 2001. In its initial stage, the plan shall include primary health care services for a value equivalent to 50% of the per capita unit of payment of the contributions system. Secondary and tertiary care services shall gradually be incorporated into the plan, in accordance with their contribution to healthy years of life.

Box V-1 (concl.)

During the transition period, the population under the subsidized regime shall obtain the more complex hospital services at the hospitals of the public health sector and the private institutions with which the State has a contract for service delivery. The health services included in the Compulsory Health Plan shall be revised by the National Social Security Health Council in line with changes in the population's demographic structure, the national epidemiological profile, the availability of appropriate technology in the country, and the financial condition of the system.

For the delivery of the Compulsory Health Plan services, all Health Promotion Entities shall establish a referral and counterreferral system, so that access to the highly complex services —except for emergency services— can be provided through primary care. The national government shall set the standards, without prejudice to the system that corresponds to the territorial entities.

The General Social Security Health System, with all the entities and elements that comprise it, shall have a maximum of one year from the time the respective law goes into effect to begin operations, with the exception of special cases provided for under that same law.

Source: Congress of the Republic of Colombia, "Law creating the Comprehensive Social Security System, and other provisions", Bogotá, December 1993.

The development policies should be adopted at the highest levels of the State to ensure the greatest possible commitment by society and the state apparatus to their implementation. The multisectoral functions take place at the level of coordination, cooperation, and consultation among the assorted State sectors whose policies affect the macrodeterminants and conditioning factors that influence the health situation and the health institutions themselves. These latter are responsible for the functions that pertain to them directly, especially those connected with the operation, regulation, and financing of the health sector, as well as the management of international relations and the surveillance of health conditions. Unlike the normative functions, which should remain with the national agencies, the direct delivery of services by the State should be transferred, preferably to subnational agencies, as progress is made in decentralization.

The central sectoral agencies —in particular the ministry of health— will concentrate on normative aspects and the regulation of the system. They will formulate the overall objectives to be achieved through sectoral reform and will set the standards and create the necessary institutions. These agencies should also draw up the programmes and sectoral budgets, be responsible for the epidemiological, economic, and financial monitoring of the system and supervise ex-post the fulfilment of the provisions.

b) Decentralization

To varying degrees and in different stages, many of the countries of the region are engaged in decentralization. Decentralization is an essential part of the governments' political agendas and is linked to the search for more efficient forms of management, to the deconcentration of resources and activities, and to greater community participation (see box V-2).

In the context of HCPPSE, decentralization would make it possible to foster greater equity by taking the heterogeneity of the population into account in terms of needs and access to services. This cannot be accomplished through a uniform supply organized from the center but, rather through a transfer of responsibilities to local government levels.

Box V-2

DECENTRALIZATION AND HEALTH, BASIC CONCEPTS

Decentralization is a political and administrative process that implies the transfer of functions and resources to subnational government units characterized by legal status, their own capital (expressed in an autonomously executed budget), and authorities elected directly—not designated by the central administration. These authorities will be responsible for health services within a politically and administratively defined territory (states, regions, provinces, departments, or municipalities). The main argument in favor of decentralization toward the municipalities is that it permits closer linkage between the authorities and the population, which can generate a synergistic movement of participation and control in health care delivery.

Deconcentration goes hand in hand with decentralization, and sometimes substitutes for it. Deconcentration is the maintenance of hierarchical relations without an authentic transfer of power to other sectorally-defined areas and to service providers. In practice, it is difficult to distinguish between the two processes, especially at the beginning, when they tend to be highly controlled by the central administration. There are also cases of functional decentralization, which implies the transfer of authority and resources to entities that have their own budget and particular functions—entities that act with a certain independence from the national authority to which they are hierarchically linked. In these cases, the authorities are designated by the central administration, although the entities are not government and administrative units with territorial jurisdiction.

In the field of health, the public debate, political reforms, and the very demands of the actors point to progressive decentralization. This implies transferring greater decision-making power to the local authorities—including decisions related to resource allocation and use—and granting direct service providers greater autonomy of action. Communications between managers and beneficiaries become less bureaucratic, and constant feedback permits a dynamic adjustment of the services to the needs and demands of the population. In addition, intersectoral activities at the local level are much more viable because of the more fluid communications among agents and the more manageable scale.

A new institutionality for the health systems implies a progressive transfer of authority and resources from the central administration to the subnational management levels through successive reforms. The distribution of functions will depend on how decentralization is defined in areas like financing, management, and service delivery.

Experience shows that decentralization should include appropriate financing mechanisms that guarantee adequate service delivery as well as fiscal consistency.⁶³ Motivating subnational administrations to act efficiently requires, at the very least, the transparent allocation of resources for all

⁶³ In Colombia, important advances were made in both senses; however, other experiences have been less positive. In Chile and Brazil, the income level of the inhabitants and the economic dynamic of each municipality were responsible for highly stratified municipal revenues, despite compensatory mechanisms such as transfers from the Common Municipal Fund. This fact, together with a lack of human resources in poor municipalities (which hinders the development of revenue-enhancing projects), has had negative repercussions on service delivery. To this day, the health deficit in poor municipalities continues to grow. In Venezuela the transfer of national funds is done in proportion to the number of inhabitants in each locality.

expenditures, which implies a transfer of responsibilities (wages, operational costs, and infrastructure). Requiring efficiency on the part of subnational entities means providing financing for the transfer and effective mechanisms to keep expenditures under control. This is normally provided for at the start of the process, but it is not always maintained throughout. Municipalities are often expected to contribute their own resources, forcing them to cut other expenditures in order to meet health demands —a situation that is hardly conducive to efficiency.

Concerning decentralized management, alternatives should be defined with respect to the very organization of the service: when it should be granted, how, and with what quality; if the staff depends administratively and financially on the decentralized entity, whether it will be necessary to establish criteria for recruitment, hiring, and wages; a decision should also be made regarding how community participation should be organized, both from the material and the structural standpoint.

Decentralization seeks to improve the quality of services and access. However, attention should be drawn to the fact that in some cases, services deteriorate during the transfer of authority as a result of the limited capacity of subnational administrative agencies to handle them, the limited technical staff of these entities —especially in the small municipalities— and the reluctance of central government personnel to be transferred. Effectiveness can be improved, nevertheless, with policies to train human resources. The introduction of the career in health administration, based on merit and competition, as in Colombia, can also constitute an important incentive.

For local governments to contribute to the defrayment of health expenditures, their fiscal revenues must be increased. This has been attempted in Brazil and Colombia through the redistribution of income sources and the establishment of revenue-sharing mechanisms. In Guatemala, 8% of the state income is transferred to the municipalities.

For decentralization to be successful, excess expenditures must be minimized, duplication of administrative functions must be reduced, and incentive programmes launched to encourage territorial entities and health workers to contribute to the decentralization of authority and services. (See table V-1.)

With regard to activities in the field of health, the most widespread initiative in the region related to decentralized units has been the creation of **Local Health Systems**. This modality has been promoted as part of a strategy for the governments with the support of the Pan American Health Organization —the object being to bolster efficiency within the health systems.

The local health systems are health entities with a defined geographic and demographic base and autonomous political, administrative, and technical units. In their particular areas, these entities should coordinate the use of the available health resources to address the health risks detected in the population.⁶⁴

Regional experience suggests that the following requirements should be met for the adequate operation of local health systems: population groups with the same needs should have similar opportunities of access to determinants and health care of equal quality (quality-equity axis); democratic participation should be extended to the direct area of health needs, which will permit individuals and communities to exercise direct control over the local authorities; it will also be necessary to promote changes that make it possible to attain economic development with equity and to raise the quality of the

⁶⁴ PAHO, *Desarrollo y fortalecimiento de los Sistemas Locales de Salud* (CD 33/14), Washington, D.C., 1988.

health services provided, through the use of appropriate technology, in order to increase effectiveness and minimize costs.⁶⁵

Local health systems are structured on the basis of local action units, which means that their establishment requires the existence, as a minimum, of an organized community and sanitary resources backed by institutions belonging to the health sector.⁶⁶ These action units articulate in local management areas that are responsible for coordinating them, establishing mechanisms for representation, and linking the actions of the units in the geographical areas covered by the programme. The units make up the local health system, where a health council or committee is set up, composed of representatives of health care providers, the providers of health determinants, and community organizations.

Local health systems should continue to consolidate their role of facilitator for the coordination of the public sector, social security systems, the private sector, and non-governmental organizations, for the purpose of attaining common goals concerning health care for the population within given territorial boundaries.

c) *Community participation*

Community participation plays a dual role. On the one hand, it facilitates the implementation of actions linked to disease prevention, control of infections, nutrition, basic sanitation programmes, and health education. On the other, it allows civil society to bring pressure for more control over the supply of health goods and services, and to participate in setting priorities and in demanding higher or better levels of care. Community participation can also be promoted by the State, through the debate of issues relating to health policies and programmes or the creation of mechanisms that permit beneficiaries to express their points of view regarding their health care requirements.

One sphere of participation that can be strengthened is unions, since many of the demands promoted through union organizations have a clear impact on health: better working conditions, that include enhanced physical safety measures for their members, better access to health services for them and their dependents, broader social security protection to cover costs in cases of accidents or prolonged illnesses and, on occasion, the creation of health services in the guild or union itself.⁶⁷ Moreover, the ties between health and labour are becoming increasingly visible. This may be because health care is channeled to a great extent through social security systems; because concerns over sanitary conditions at work are becoming increasingly important in the public debate and in negotiations between employees, employers, and public authorities; or because of the growing importance of the health industry itself in productive activity.

A second area is citizen participation in the field of health, which translates into community programmes for disease prevention and basic care promoted by non-governmental organizations and municipalities; associations to promote "traditional" health practices; or informal and adult education on disease prevention.

⁶⁵ J.M. Paganini and A.H. Chorny, "Los Sistemas Locales de Salud: desafío para la década de los noventa", Boletín de la Oficina Sanitaria Panamericana, vol. 109, No. 5/6, 1990.

⁶⁶ O. Niremberg and N. Perrone, "Organización y gestión participativa en los Sistemas Locales de Salud", Boletín de la Oficina Sanitaria Panamericana, vol. 109, No. 5/6, 1990.

⁶⁷ Health services of this kind generally introduce barriers and inequities in the terms and conditions of employment, which means that they are only justified in exceptional cases (for example, geographical isolation of a company and the consequent high cost of service).

Table V-1: MODES OF HEALTH SYSTEM DECENTRALIZATION IN SOME COUNTRIES OF THE REGION

Country	Decentralization to existing administrative units	Deconcentration to sectoral units	Financing mechanism	Transfer mechanism	Status of transferred personnel
Chile	Municipalities	Twenty-six national health services. Own structure, which does not coincide with provinces or regions.	The Ministry of Health reimburses municipalities for costs. The municipalities also contribute resources. The SNSSs are financed out of the State's budget, which they spend autonomously.	Agreements between the Ministry of Health and the municipalities. The latter can provide service directly or through a corporation. Creation under the Autonomous Services Act.	The personnel transferred to the municipalities are no longer public servants. They are regulated by the Labour Code. The municipalities set their wages. The SNSSs manage their personnel, but the positions and salaries are set at the national level.
Colombia	Municipalities and Departments		Financing on the basis of transfer payments to the departments, which distribute them to the municipalities. Contracts for the delivery of scheduled services at rates agreed upon in advance are signed between the municipality or department and hospitals.	Transfer by law to the municipalities (first level) and to the departments (second and third levels). They do not provide the service directly, but contract it out to public or private entities.	The personnel of the hospitals and health services (of departments, intendancies, commissariats and municipalities) is incorporated into the administrative career. Recruitment by competition.
Mexico	States	Health jurisdiction, formed by one or more municipalities. There are 245 in the country, with an average of 7 jurisdictions per state.	Financing from state contributions and federal subsidies regulated by cofinancing agreements that also empower the state to manage the funds recovered for services.	The General Health Act transfers the administration of medical care, public health, and social welfare to the states.	
Brazil	States Municipalities		Federal government grants, set by agreements between state government agencies and the federal Ministry of Health on the basis of the estimates of each health district.	Transfer of powers under the Basic Health Law, which establishes a unified health system (19 September 1990). The transfer is done through agreements with the states.	Personnel is transferred to the states and municipalities, but continues to be paid by the federal government, on the basis of uniform criteria.
Venezuela	States. They organize their municipalities autonomously.		The resources allocated to the sector are transferred to the states. Annual readjustment mechanism, based on variations in current revenues.	Through agreements requested expressly by the states. Initially they are provisional and afterwards sanctioned by law.	Personnel is transferred to the states, under the same labour conditions in effect at the time of the transfer.

Source: ECLAC, Division of Social Development.

Community participation in the improvement of health should be a tool for promoting greater equity in access to health care. In the same way, special attention should be paid to organizations in disperse sectors (rural and urban fringe) with problems of access. It is also necessary to seek mechanisms to give a higher public profile to health demands from sectors with the worst shortfalls in care. As noted recently by ECLAC, community participation is linked to decentralization to achieve greater equity in the area of the health: "This would make it possible to serve demands such as the following, in an effective and decentralized manner: greater presence of the poorer sectors in the management of social programmes; greater presence of local organizations in decisions on the channeling and use of resources in the municipal sphere; greater public and private support for the non-governmental organizations that work most closely with grassroots sectors; adaptation of health services, public education, and low-cost housing programmes to the specific needs of the different groups; and greater access to and presence in the mass media".⁶⁸

Local health systems, actions to improve environmental conditions (such as access to safe drinking water and refuse disposal, etc.), and solutions to specific health problems (such as the prevention of AIDS, drug use, and accidents) are fruitful fields for community participation on the local level.

By signing the agreement on attainment of the goal of health for all by the year 2000, the governments expressed their willingness to activate and strengthen the resources of the community so that it can address issues related to individual and collective health. Participative programmes in the area of health have been given different names: people's health committees in Bolivia, health and development community associations in Argentina and Colombia, and health committees in Ecuador, Honduras, Panama, and Peru.⁶⁹

With regard to citizen participation, consideration should also be given to the growing responsibility of families and individuals for their own health. There is a consensus that lifestyles have a great influence on health and the incidence of diseases. This makes it necessary to provide the public with information, as a way of fostering increased citizen participation in the field of health.

In the context of democratic societies with growing access to information, community participation in health should be strengthened, preferably in two areas. The first is the socialization of knowledge that promotes better disease prevention by the public and increases the capacity of users to assess the services they use; the second is concerted action by multiple agents for the purpose of guaranteeing the political commitment to provide a basket of services to the entire population. Since this implies a distribution of responsibilities among different public and private agents, concerted action for health constitutes not only an opportunity for participation, but for the legitimization and consecration of commitments of this kind.

The relationship between citizen participation and health also forms part of health system reform which, with different intensities, is under way in the region. The exchange of reform experiences among the countries of the region enables them to select appropriate mechanisms for promoting citizen participation in health policies and programmes. (See box V-3.)

⁶⁸ ECLAC, *Equidad y transformación productiva ...*, op. cit., p. 245.

⁶⁹ See the WHO/PAHO document *Evaluación de la estrategia de Salud para Todos en el Año 2000. Séptimo informe sobre la situación sanitaria mundial*, vol. 3, Región de las Américas, Washington, D.C., p. 17.

Box V-3

**THE INSTITUTIONALIZATION OF COMMUNITY PARTICIPATION
IN COLOMBIA**

The reform of the health sector in Colombia forms part of a broader process of decentralization of government. The purpose of Law 10 of 1990, ratified and incorporated into the Constitution of 1991, is to involve society as a whole, to mobilize and organize citizens in order to optimize their impact on the health culture, relying on the organizational potential of civil society.

The Law envisages the strengthening and creation of institutional mechanisms, through provisions relating to: i) establishment of community agents to promote health, prevent diseases, and address uncomplicated environmental and health problems in the community itself; ii) creation of community health and environment units to mobilize the community in order to promote comprehensive local social-development plans; iii) establishment of community committees to forge agreements on responsibilities with municipalities, health institutions, health and environment community units, other community organizations, and family and community health teams; iv) founding of community health and environment enterprises, preferably cooperative or associative in nature, that offer comprehensive health services; and v) establishment of extramural family health and community teams composed of representatives of institutions that work directly in the community, in order to bring health services closer to users and have an on-the-spot presence at the point where risk factors originate.

Another political/institutional aspect that should be pointed out is that concerted action by the actors in field of health has been institutionalized through a multiple advisory system for the formulation of new legislation concerning health. The system includes lawmakers, specialized personnel of the national health system, central and decentralized public entities, unions and professional associations of health workers, mayors, and specialized consulting firms. Citizen participation has lent legitimacy to the reform of the system and to the future actions of the State in the field of health.

Source: Miguel Eduardo Cárdenas, "Reforma de la seguridad social en salud: lineamientos para una propuesta", Reforma de la seguridad social en salud, Bogotá, 1992; and Colombia, Ministry of Health, La revolución de la salud, Bogotá, 1991; Reorganización del Sistema Nacional de Salud, analytical paper for Law 10 of 1990, Bogotá, 1990.

Finally, consideration should be given to extending consultative mechanisms to areas other than broad health system reform —areas more directly related to the daily life of the community, such as the management, operation, and allocation of resources in hospitals and local health systems or regional health services. The crisis in hospital systems, which affects most of the countries of the region, has become a topic for public debate and requires high levels of concerted action to address it.

d) *Financing*

With regard to financing, the core of the proposal consists of ensuring that the health sector has the funding necessary to extend the basket of services to the entire population and to implement targeted in this area, in the context of the current restrictions on resources and without creating additional pressures in the form of unbudgeted expenditures —which would jeopardize the overall macroeconomic balances—, while simultaneously moderating increases in overall spending on health. To achieve this will require a careful selection of instruments and measures that, while establishing appropriate incentives for

the different agents, will make the best possible use of financing and transfers of funding to the agents that provide and receive subsidies.

It will be necessary to pay due attention to current and foreseeable changes in the relative importance of the sources of financing, which include the revitalization of formal employment, that favors an increase in receipts from mandatory employer and employee contributions earmarked for health services; the increase in general tax revenues, which will be devoted to subsidies for the indigent and poor; greater willingness to pay by households, the opening of channels to increase voluntary contributions for health services, and provisions for those who are better off to pay for their own health costs instead of having them subsidized;⁷⁰ rechanneling of international cooperation financing to target it increasingly to the achievement of equity.

Advantage should be taken of the favourable circumstances that will be created by economic recovery, the gradual consolidation of the structural adjustment process, and self-sustaining growth, which will make more resources available. This will be favored by the demographic profiles that will predominate in the region over the three next decades. Family size will be smaller, and there will be more salaried workers per family, which will help to ease the "tax burden" for health care borne by each worker. Care should be taken, however, to ensure that these favourable circumstances do not drive health care spending up to levels higher than the public wishes, as a consequence of the well-known imperfections of health markets.

The State should play an active role in the process of redefining and adapting the sources of financing and transfer mechanisms, i.e., it should lead the process and ensure that such changes effectively help to raise the level of health of the entire population. In the area of State entities and the public sector, as well as for the health system as a whole and its interrelationships with the other sectors, governments will be called upon to propose legal reforms and regulations, establish the rules of the game, act as monitors, regulate the activity, and intervene selectively.

The need to increase the resources allocated to the social sectors in general and to the health sector in particular has been reiterated in various forums. Despite the fact that the efforts in this regard made by some countries of the region have not attained the levels that the consensus suggests, it should be recognized that it is not desirable to increase social spending in all cases. This is because social investment—including investments in health— must be harmonized with investments in other sectors, since total resources are limited. International cooperation and financing agencies concur that the distribution of social spending is regressive in most of the countries of the region and that, as a result, increases in public spending do not translate entirely into higher levels of well-being for the poor. Therefore, it is necessary to restructure systems and mechanisms to redirect them to the sectors with greater needs, and to improve the quantity and quality of the services delivered. In all cases, this will require efforts to improve efficiency in the allocation and use of resources in order to achieve greater effectiveness and impact.

⁷⁰ There is justification for providing different levels of subsidies for health care services that create positive externalities (for example immunization, measures to reduce occupational risks or traffic accidents, etc.) for the entire population. The levels of the subsidies would reflect the difference between the private benefits and the social benefits that are derived from such services.

The search for more resources for health care should take into account the requirements of greater equity and the positive impact that a healthier population can have on the national economy. However, it is necessary to avoid the spiraling costs that have forced some countries to spend larger percentages of the national product on health, without this being reflected in improvements in health indicators. Squandered resources can even affect the international competitiveness of exports.

In cases in which it is necessary to increase spending on health, the different sources of revenue should be studied. Traditionally, financing has come from government taxation. Furthermore, the usual way to obtain more resources has been to create new taxes or to raise the rates of existing taxes. It is argued that some countries have reached a "tax ceiling", which means that any new tax or tax increase would discourage productive investment. However, the tax burden in the region is lower than in developed countries and intraregional differences in it are very marked. It is therefore likely that in many cases funding for the social sectors can be obtained through increases in taxation. A second problem is how to collect taxes and what types of taxes to levy. Although this is a matter of tax policy, it is worth noting that there is room to improve tax collection in most of the Latin American countries, since evasion appears to be widespread and the excessively high rates of certain taxes probably encourage it, which means that their reduction could result in increased collections.

Another aspect to consider is whether taxes earmarked specifically for health care should be levied. In general, the experts oppose this solution, since they advocate a single pool of treasury funds and the need to maintain the greatest possible flexibility for the allocation of resources. However, many countries levy taxes of this type and they are considered to play an important role in protecting social spending from anticyclical effects, by cushioning cutbacks in times of crisis. Taxes on alcohol consumption and tobacco ("sin taxes"), which are used in many countries to finance health programmes, are interesting examples owing to their doubly positive impact.

The restructuring of public spending is also worth considering. Resources for health can be obtained by reallocating funds already available in government budgets, by altering their traditional or current destinations. "There is enormous potential for restructuring national budgets and international assistance for human development".⁷¹ In this regard, mention is often made of the desirability of reducing military spending and allocating the savings to the social sectors.⁷² In the last 15 years, the Third World has tripled its military spending, while the developed countries, and the large powers in particular, have cut back on theirs and are currently accelerating the process.⁷³ Although Latin America is not one of the regions of the world that spends most on the military, some countries earmark a large percentage of their income for it. The UNDP has demonstrated the strong inverse ratio that exists between military spending and social spending, and therefore it is reasonable to think that part of those resources could be channeled to other sectors. In addition, the Latin American States have spent a large part of their income on financing inefficient public companies that generate enormous deficits. Closing or privatizing them could free up resources to finance projects that effectively promote equity or growth. In Bolivia, for example, the current government is encouraging the capitalization of public companies by private shareholders. On the other hand, there are many instances of showcase projects that have little impact, regardless of the yardstick used to evaluate them.

⁷¹ UNDP, Informe sobre el desarrollo humano, 1991, Santa Fe de Bogotá, Tercer Mundo Publishers, 1991.

⁷² World Bank, World Development Report, 1990 ..., op. cit., and UNDP, Informe sobre el ..., op. cit.

⁷³ Recently President Clinton responded to a statement that his programme to extend health coverage to Americans who lack it would cause a increase in the fiscal deficit of 1.5% of GDP, by saying that he would avert the increase by reducing military spending.

Social security contributions are another traditional source of financing for the health sector. The financial base of the social security system should be strengthened, and transfers from other programmes to cover deficits in spending on curative and maternity care should be eliminated. The system should be self-financed through larger contributions or smaller outlays. There are many ways of increasing social security income, depending on the case: reducing evasion and delays in payments; levying social security taxes on the entire salary; renegotiating and indexing the social security debt of the State and individuals; increasing the contribution of beneficiaries, or other percentage-based contributions, if they are insufficient. Mandatory contributions should be proportionate to income, with limited tax exemptions, and should cover the costs of the basic health care basket. Individuals should be allowed to make additional voluntary contributions in order to obtain additional benefits, which would be taxed the same as other assets. It is also necessary to create incentives to encourage informal workers to join the system as contributors, which would help reduce the drain caused by spending on health services for those with the ability to pay for them.

Some incentives and financial mechanisms to facilitate the access of informal workers and the poor to social security are: i) to establish for independent workers, informal workers, and rural groups, a contribution that is lower than the employer equivalent (except in the case of individuals earning high incomes); ii) to guarantee a basic care package with benefits that are consistent with the contribution or supplemented with subsidies; iii) to use State subsidies to expand and improve care for the poor, either based on a basic universal health care model and social solidarity, or a dual care module;⁷⁴ iv) when effective control is impossible, to promote voluntary plans, together with social welfare programmes for the indigent.

Cost-effective actions must be chosen, which implies the selection of minimum cost alternatives and on-going evaluation of the impact on the target population of the actions undertaken. Also, the principle of accountability must be introduced for the purpose of improving the information at the disposal of users, increasing competition, and gauging the appropriateness with which resources are used. This requires strengthening the information systems and epidemiological capabilities of the countries.

International support in the area of health, channeled through loans and donations, should be encouraged, strengthening its complementary role to internal financing, particularly in targeted programmes that are related to the provision of a basic health care basket, basic sanitation, nutrition, and health education, in areas where these services are deficient and for population groups with unmet needs. This concentration on specific aspects will also favor closer coordination of international cooperation, starting from the levels already attained.

This policy of externally financed cooperation can and should be implemented quickly in order to take advantage of the increase in resources from multilateral agencies in particular (such as IDB and the World Bank), which will compensate for the lower contributions of some bilateral sources, as a consequence of the higher relative priority they have assigned to other regions. This new situation will demand a redoubled effort to improve project preparation and evaluation capacity, since the institutions that will increase their participation in total health financing will demand greater meticulousness.

⁷⁴ The definitions appear in the corresponding sections.

In view of the proliferation of public and private institutions as a consequence of the reforms, encouragement should be given to measures such as the creation of investment funds to which municipal, state, or provincial governments, local communities, non-governmental organizations, and health service providers in general can submit projects. Obviously, the processes of project presentation and evaluation will need to be geared to the capacity that can be developed through large-scale training programmes.

The adoption of health strategies such as those proposed here can favor new and larger action by creditor countries to swap foreign debt in exchange for increases in health spending and external investments in health. Operations to swap debt for the use of internal resources will be more welcome on the national level in the current climate of increased flows of external capital, revaluation of the exchange rate, and reductions in inflationary pressures.⁷⁵

Other resources may have a non-public origin. Non-governmental organizations (NGOs) and households spend large amounts directly on health. In some countries, NGOs handle resources that are larger than the public budget for the social sectors.⁷⁶ Household spending has been growing in recent years and currently accounts for 60% of total spending on health in the region.⁷⁷ The development of private health services, geared mainly to meeting the demand of those with the ability to pay who are interested in using private services, would make it possible for governments to focus public resources on poorer population groups.

Consideration should also be given to contributions by beneficiaries, which can be of different kinds and, in some cases, be limited to self-help or mutual assistance. Many countries have a tradition of donating labour to the community that can be tapped. The application of the criterion that "anything free of charge is not appreciated by the person who receives it" and that the community should make a commitment by sharing in the cost of the investment, entails the risk that it can lead to the marginalization of those who are not able to assume such financial responsibility.

The trend toward cost recovery, by setting user fees that cover all or part of the value of public services that were previously free, is becoming widespread. From the point of view of equity, it is fully justifiable to apply the principle that "whoever can pay should pay", especially because public services frequently favor the better-off sectors of society. However, in most cases, cost recoveries are not very significant; in others, their share has tended to grow and can grow even further, as in Jamaica.⁷⁸ It all depends on the type and size of the fees that are charged. Some are nominal fees that seek to discourage the use of a service in cases of allegedly excessive public use. But this only sets up barriers to access, in an attempt to balance demand and supply by reducing the former. Real charges, on the other hand, attempt to recover the cost of the service provided, which could represent from 15% to 20% of the

⁷⁵ PAHO, "Conversión de deuda por salud: una opción para financiación adicional", *Informes técnicos series*, No. 5, Washington, D.C., 1992; M. Mortimore, "Conversión de la deuda externa en capital", *Revista de la CEPAL*, No. 44 (LC/G.1667-P), Santiago, Chile, August 1991.

⁷⁶ Amalia Anaya, *El gasto social en Bolivia*, La Paz, 1992.

⁷⁷ PAHO/WHO, *Las condiciones de salud ...*, op. cit.

⁷⁸ T. Bossert, "Innovative health financing and management initiatives in Latin America", document presented to the seminar on "Los desafíos de política en el sector salud", organized by the University of Chile and sponsored by the Ministry of Health and the World Bank, with the support of PAHO, ECLAC, and CEDES, Santiago, Chile, November 1993.

amount spent.⁷⁹ However, cost-recovery mechanisms have drawbacks. Recent studies show that in some countries they have led to a substantial reduction in the demand for care.⁸⁰ A considerable part of that decline can be attributed to the fact that charges for this type of care marginalize the most disadvantaged groups, which do not have the minimum funds necessary to pay them. Thus, it is necessary to apply a model based on the ability to pay of those who receive a service. Persons with high incomes should pay the real cost, those with average incomes, at least part, while the poor should be served free of charge.⁸¹ In addition, the fees could vary according to the type of health service, in order to favor access to priority care and limit it in the case of less essential services or services with a lower cost-effectiveness ratio.

With regard to subsidies and discounts, the recipients should be aware of the costs and the desirability of keeping expenses down, which can be achieved through controls on use such as setting caps on normal use, beyond which the user must obtain specific medical approval, special authorization for prolonged treatments or chronic diseases, or other similar measures. Monitoring of spending levels is also recommended to limit excessive consumption and favor reasonable use. Subsidies should preferably benefit the poor and give them the option of choosing both the management entity and the service provider. It is also necessary to accord subsidized users the same status as better-off users, even allowing them to make decisions regarding payment for service, in order to establish their bargaining position *vis-à-vis* the supplier. Suppliers must be made to understand that their income depends on the quality of the service they provide.

The best ways of transferring resources to service providers that are integrated vertically should be studied. It will always be preferable to establish a proportional ratio between the supplier's level of activity and financing, and a direct ratio between rates and relevant costs for the supplier, in accordance with its degree of autonomy. If the supplier is private, the rates should cover the totality of the costs, a margin of profit based on the cost of capital, and an additional risk premium depending on the activity. If the supplier is public, does not handle its own investments, and receives additional resources for the maintenance and repair of equipment and installations, the rates should consider only operating costs.⁸²

Payment based on results (discharges of patients after treatment or surgery and by related diagnostic groups) tend to be more efficient than conventional fee-for-service payments. Budget-based payments should be forward-looking instead of reproducing historical budgets. This facilitates aggregate budget estimates of financial resources and makes it possible to set maximum caps on spending. The drawback is that differences between budget estimates and real needs are covered through quantity restrictions (implicit rationing that becomes higher towards the end of budgeted periods) or reductions in quality. For this reason, budgets are not the best way of transferring resources to health care suppliers, except in cases

⁷⁹ World Bank, Financiamiento de los servicios de salud en los países en desarrollo, Washington, D.C., 1990.

⁸⁰ M. Makinen and Bitrán, "Economic analysis and research tools for health policy in developing countries", paper presented at the conference on "Health Sector Reform in Developing Countries: Issues for the 1990s", Harvard School of Public Health, 1993.

⁸¹ G.A. Cornia, R. Jolly and F. Stewart (comps.), Ajuste con rostro humano, Madrid, Siglo XXI de España Publishers, 1987.

⁸² These rates are only used to transfer resources within entities that are integrated vertically. As a result, they do not necessarily coincide with the prices charged for the services; the latter should be set to cover all the costs, because otherwise they would create distortions in the allocation of resources between entities with different degrees of autonomy and lead to unfair competition with entities that are fully autonomous.

in which product lines are very stable in time or depend on other activities whose level of production is controllable.

Per capita payments consist of delivering to the supplier a fixed amount that corresponds to a basket of preventive, promotion, and restorative services based on certain risks, for each person under its responsibility. This method has the advantage of encouraging suppliers to control costs, inasmuch as the risk is transferred to them. Some of the conditions necessary for using systems of this type are: i) a sufficiently large pool of members to allow risks to be diversified; ii) the possibility of transferring risks to reinsurers, although selectively and with limitations, and making the supplier responsible for copayments to prevent it from losing the incentive to economize; iii) rates set on the basis of community-rating, in order to reduce the selection of risks that could be detrimental to the members of the community most prone to becoming ill; iv) prohibition on allowing suppliers to select risks; v) systems for monitoring personal health indicators and the effectiveness and quality of the care provided by the supplier —information that should be made available to the public, so that it can select its supplier on an informed basis.

e) The public/private mix

Although government presence is essential in the health sector, many of its responsibilities can be carried out through regulatory activities rather than through direct execution. Establishing "third payer" mechanisms is a key to increasing the efficiency and equity of the health systems of developing countries. Although there is broad scope for private sector involvement in the field of health, its limits are known and have been analysed in the literature on the subject. As a result, the private sector cannot replace the State in the provision of health services or of essential elements for public health, although it can help to achieve greater rationalization of the efforts of the public sector.⁸³

Chapter II pointed out that two separate health subsystems have tended to consolidate in many countries of the region during the last decade, both with regard to the arrangements under which health care is provided and the financing of services. This process has a negative impact on microeconomic efficiency and overall equity, which gives rise to situations that should be corrected in the course of sectoral reform. As is proposed in the report of the Cocoyoc Meeting (Mexico, July 22 to 26, 1991) organized by WHO/PAHO, the following are some of the areas of particular conflict in the public-private mix.⁸⁴

- i) the public and private sectors tend to compete for the same resources, especially human resources;
- ii) in the private sector profit is more important than in the public sector; thus, in many cases the private sector only provides the more remunerative services, leaving responsibility for the poor, for emergency care, and for training to the government;

⁸³ Ch. Griffin, "Strengthening Health Services in Developing Countries Through the Private Sector", Discussion Paper series, No. 4, International Finance Corporation (IFC), Washington, D.C., 1989.

⁸⁴ WHO/PAHO, "The Public/Private Mix in National Health Systems and the Role of Ministries of Health. A Report of a Meeting in Cocoyoc, Mexico", Document reproduction series, No. 22, Washington, D.C., Health Policies Development Programme, August 1992.

- iii) given that the principal criterion for determining access to the private sector is willingness and the ability to pay, it is likely that private sector expansion will create increasing inequity in the health care system, unless carefully controlled;
- iv) the government may have little control over some aspects of private sector activity (such as cost and price trends), which affect public sector operations; and
- v) without careful planning and monitoring, private sector activity may lead to duplication and waste.

As was noted at the Cocoyoc Meeting,⁸⁵ economic theory shows that there is no "correct" or universally valid public-private mix in the field of health. All proposals in that regard should be adapted to the existing health system structure, and the political judgement and freedom to maneuver of government. This does not imply, however, that suggestions cannot be made to the countries regarding strategic criteria they could adapt and apply within this framework. With this consideration in mind, and given the widespread problems of inefficiency and inequality, the following strategic recommendations are intended to avert possible negative aspects of the public-private mix, which can then be brought into line with specific national situations.⁸⁶

With respect to financing, various steps can be taken to improve equity and microeconomic efficiency:

- i) universalize mandatory employer contributions to the health coverage of their employees. This would not only eliminate a hidden subsidy in the productive apparatus, but also unfair competition by firms that do not contribute to social security health plans. It would also make it possible to generalize the access of employees in the formal sector to a basket of health goods and services. Of course this would involve an increase in the labour costs of companies that currently do not fulfill their obligations to contribute to social security. It would regularize an existing situation, since public hospitals —by not charging those without formal coverage— subsidize those companies in practice. Direct government subsidies would be required for some time while the companies adapt to the new model, but once the situation has been regularized, this method of financing services would be cleaned up once and for all;⁸⁷
- ii) the recovery of costs for second and third level services would make a major contribution to strengthening the health financing system;
- iii) in the case of the population not covered by social security or private insurance systems, the universalization of coverage with regard to second and third level benefits should be financed under a transparent scheme, so that the provision of services does not involve an implicit subsidy from the public hospital to the treasury.

⁸⁵ Ibid.

⁸⁶ These ideas closely reflect the content of the debate by the experts attending the meeting in Cocoyoc, Mexico. See PAHO/WHO, "The Public/Private Mix. . ., op. cit.

⁸⁷ This transition can be clearly seen in the proposal for health system reform recently put forward by the United States Government.

With respect to the mode of service, it is fundamental to create competition between the public and private sectors —and within each of them. Competition would create incentives to reduce costs, improve quality and, in general, make the sectors as a whole more responsive to the needs and ability to choose of the public. In the current debate on health system reform in the world, this point tends to be proposed as a modification to the scheme of financing the services, to enable "the money to follow the patient." This means shifting from models that subsidize supply, to others in which demand controls the use of the resources and, by improving information and the ability to choose, acts as a catalyst for greater efficiency, effectiveness, and equity.⁸⁸

In this same context, it is often proposed to extend freedom of choice on the demand side and on the supply side to promote the adoption of schemes that facilitate the purchase and sale of services between the public and private sectors. This would make it possible to reduce the duplication of investments in sophisticated equipment, which is expensive and used for very specific purposes, such as nuclear magnetic resonance units or facilities for highly complex surgery. It does not make sense for both sectors to install this type of equipment, since it ends up being under-utilized. Comprehensive planning, with a referral system between the public and private systems, would enable more efficient use to be made of the health sector's physical infrastructure, seen as a whole, and not as two independent and isolated spheres.

With a view to promoting competition between the two subsystems, the possibility should be explored of developing internal markets in the public entities that provide health services.⁸⁹ To bring this about, it would be necessary to move forward with the processes of decentralization and granting corporate status to State health care units, in order to enable them to design and carry out their own policies for subcontracting services (such as plant maintenance, laundry, food services, and others), and to train and contract qualified human resources. This would allow them to improve their relative competitiveness in the market, through cost reduction and better quality.

Consideration should also be given to the possibility of converting the large highly-complex public hospitals into autonomous State corporations.

Together with the foregoing, it will be necessary to consolidate the purchasing power of users in order to internalize, on the demand side, the improvements in productivity that are achieved in the supply side. This is one of the key elements of the health reform proposal that is currently being debated in the United States —which proposes the creation of regional health corporations—,⁹⁰ and also of the initiatives concerning the consolidation of social security entities in Argentina and in Colombia.

⁸⁸ In other words, in contemporary thinking it involves strengthening the independence of the consumer which, as has already been noted, is relatively limited in health services markets. (See A.C. Enthoven, "Managed competition of alternative delivery systems", Journal of Health Politics, Policy and Law, vol. 13, No. 2, 1988, pp. 305-332.)

⁸⁹ Along this line, a study of the experience in this area gained by the National Health Service of Great Britain in recent years could be very enlightening.

⁹⁰ See "Health Security Plan", Washington, D.C., September 1993; and The Washington Post, September 23 and October 28, 1993.

Box V-4

SUBSIDIES FOR SUPPLY OR DEMAND?

Today subsidies are the universally accepted way in which societies seek to reduce the inequalities between poor and non-poor with respect to income and access to essential goods and services. Subsidies consist of transfers, in cash or in kind, from higher income groups to the poor.

In the past, these transfers mainly took the form of voluntary contributions of a charitable or philanthropic nature, by means of which civil society—with different degrees of coverage, organizational structure, and permanence—served the most pressing needs and alleviated the risks of deprived groups. With time, thanks to the development of the principles of social security, the growing awareness of human rights, and the social desirability of diversifying insurance and health risks, governments have gradually assumed the responsibility of creating mechanisms to finance and transfer resources to achieve greater equity. Without diminishing the role of charitable and philanthropic organizations—since their importance has even increased with economic development—, financing has become compulsory and governments have sought to respond more adequately to the preferences of the community at large with respect to improving the access of all marginalized groups to more benefits.

In the specific area of health, a further influence has been scientific and technological advances that have reduced mortality and increased the life span, universally perceived as desirable and crucial objectives for the entire population, but possible to implement—to say nothing of finance—only on the basis of the association and voluntary contributions. On the other hand, in recent years the significant contribution of health to the development and maintenance of human capital, which empirical evidence identifies as the most crucial factor for development, has become increasingly clear. Today health subsidies are seen as a basic component in investments to strengthen the abilities of the poor in order to convert them into subjects of social progress.

As the trends described have become clearer, and especially in view of the magnitude of the resources that must be mobilized, increasing attention is being paid to the efficiency with which they are managed. This concern increases as the gap between commitments and available resources widens. Efficiency refers to the capacity to produce and provide at minimum cost—at a given quality—the goods and services that the public perceives as necessary and that help to increase its level of well-being. From this perspective, the form in which subsidies are transferred to individuals is important.

There are two main ways of transferring subsidies: subsidies for supply and subsidies for demand. In the first, health service providers receive the subsidy directly—in order to cover all or part of their costs—from the entity that administers the financing. Subsidies for demand occur when receivers of the subsidy are enabled in some way to have purchasing power equivalent to the total value of a health service, even if they have paid only a fraction of the technical cost of that value from their own pockets.

More general subsidies for users to supplement their own resources and enable them to pay the total cost of a premium necessary for admittance to a system of prepayments or health insurance also belong to the second group. In both cases, users can obtain benefits which they would not have been in a position to purchase without the subsidy. But their bargaining capacity and decision-making power will be much greater if they can choose between several alternative suppliers than if their only option is to accept what they are offered.

Box V-4 (concl.)

The existence of alternative suppliers does not necessarily mean that the user has freedom of choice, i.e., the ability to choose at all times among the many direct suppliers of health services and benefits. For reasons of economy, an individual can choose to join a prepaid or health insurance system that covers types of care agreed upon with predetermined groups of suppliers. These are known as "closed" health plans. Examples of such schemes are health maintenance organizations and preferred provider organizations in the United States, the ISAPRE in Chile, the prepayment institutions in Argentina, Brazil, and Peru, and others. Under these schemes, the institutions that manage the financing —prepaid or health insurance plans or the social security institutions themselves— can make decisions and bargain on behalf of individuals and act as contracting parties or buyers of health services. Thus, individuals can acquire technical advisory services that it would be difficult for them to obtain on their own, and the information gaps that are typical of health markets are successfully bridged. For this to happen, users must, of course, have alternatives with regard to the entities that manage the funds, so they can exercise their bargaining power and freely decide which to select.

The key, then, is for the receiver of the subsidy to have alternatives and control over the entities that manage the financing. The availability of alternatives in general, and subsidies for demand, by their own logic, make users sensitive to cost and insurers and providers sensitive to patients, since they know that their financing depends on the decisions of users.

The availability of alternatives necessarily means that there must be multiple insurers and providers of health services, both public and private (for profit and non-profit). They should operate in a competitive environment —in which the function of the State is to regulate, supervise, and intervene selectively when circumstances require— which induces them to minimize costs and continually adapt their responses to the needs of the public. The optimal public-private mix will depend mainly on the characteristics of each country, cost structures, the nature of the demand, the specifics of the health system and other systems, the gaps in coverage of the population, and health policies.

Experiments have been going on in Latin America and the Caribbean in recent decades, based on the development of multiple private insurers and health service providers; the results of such initiatives point to the need for caution. On the one hand, they have led to growing administrative efficiency, offer varied options —that are better adapted to the needs of the public— and exhibit great dynamism and flexibility. However, on the other, they have not had equal success in containing costs and have created growing disparities in access to health care. This warning bell should be kept in mind when implementing subsidies for demand —which in any case seems to be the direction that will be followed in the future— for the purpose of establishing regulatory and supervisory mechanisms to ensure attainment of the objectives: better public health, greater efficiency in the sector, and higher levels of equity.

Source: E. Miranda, "Salud para todos: ¿subsidio a la oferta o subsidio a la demanda?", Revista administración en salud, No. 10, Santiago, Chile, University of Chile, 1991; and "Sistemas de salud en el mundo: un marco conceptual", Sistemas de salud en el mundo, Documentos de trabajo series No. 203, Santiago, Chile, Centro de Estudios Públicos (CEP), November 1993.

Greater competition among health service providers may prove to be a necessary, although probably insufficient, condition to ensure efficiency, effectiveness, and equity of access in the field of health. It has already been seen that the private sector tends to develop exclusionary mechanisms that are difficult to counteract in a context of imperfect competition in which the power of the consumer is, by definition, limited —although it is expected to increase after the sectoral reform. As a result, it is not enough to promote competition between public and private providers or in the public health care system itself; it will also be necessary to promote the implementation of an adequate regulatory framework, both for the financing entities and for public and private health care providers. The regulations would have to focus on regulating health care and the mechanisms for paying health care providers, in order to establish modes of payment for sets of benefits linked to diagnoses —such as universal nomenclature, groups of related diagnoses, payments associated with diagnoses—, per capita payments, and others, both for public and private suppliers. This would make it possible to shift the weight of relative inefficiency to the supply side and would force service providers to rationalize their procedures, reduce costs, and improve quality. Public hospital systems suffering from major technological obsolescence that has built up over the last decade will have to be modernized and reorganized before they can enter the competitive system.

Finally, uncoordinated growth in the activities of NGOs frequently leads to the duplication of services in some geographic zones and specific fields, and to their absence in others. This means that ministries of health must act as coordinators between the public sector and charitable private entities, in order to optimize the latter's contribution and, when desirable, to free the public sector from the workload and the need to furnish resources in areas in which the NGO management is efficient. This is particularly important since nonprofit private organizations often share the goals of governments.

The proposed strategy refers mainly to second and third level care, since the premise is that primary care continues to be a nondelegable responsibility of the public sector (although with the help of NGOs, particularly in countries with fewer resources), at least during the initial stages of sectoral reform. It should be added that implementation of a programme for sectoral reform, such as the one suggested here, requires close collaboration between the health authorities —who will be responsible for establishing regulations to govern health services, the accreditation of agents, and control of the results—, and the economic authorities at the federal, provincial, and municipal levels which, in principle, will be in charge of implementing the financing model that lies at the heart of the proposal. The level of interministerial cooperation should be stepped up considerably, which will make it necessary to establish new channels for interagency organization within the government apparatus. The information base that an interministerial programme in this field requires is still weak, which means that it must be built up as a necessary requirement for any coordination efforts that are decided upon in the future.

f) Management and supply

The reform should include the development of management systems and methods in each entity engaged in financing, management, and supply; training in the operation of such systems and, especially, in decision-making; and a legal and administrative structure that incorporates all the agents —public and private— into the national health system, respects their freedom to maneuver, ensures cooperation among them, and regulates competition at the micro level.

For entities that are integrated vertically, ways must be sought of improving their ability to adapt to the needs of the public. A competitive context, with multiple agents, will tend to generate greater efficiency, but this will not suffice to surmount all the problems that affect those entities nor will it bring about a constant and instantaneous improvement in their productivity and effectiveness. To attain these goals, they must be provided with adequate financing and encouraged to develop their financial, administrative, and productive management capacity, and granted greater independence as they improve.

The granting of more freedom to these units should not be construed as the atomization or fragmentation of the institutional apparatus, but rather as a means of creating auspicious conditions for greater efficiency, while simultaneously ensuring the integrity of the system. It is for this reason that decentralization also includes the design of mechanisms for overall programming and budgeting, compliance with institutional guidelines and policies (which are formulated jointly by central and local management levels), and a varied range of information and accounting systems for productivity, efficiency, and results.

The following powers must be transferred to vertically integrated units if they are to become truly independent: i) purchase of inputs and drugs; ii) hiring and firing of personnel (with the freedom, within certain limits, to define job descriptions and the required skills and knowledge); iii) selection of technologies (subject to institutional technical and legal standards); iv) procurement of small pieces of equipment and maintenance and improvement of installations; v) contracting and sale of services (based on institutional rates and within ranges that allow for adjustments to accommodate local market conditions); and vi) collection of payments directly from users and authorization to retain a percentage as an incentive.

The delivery of services is the critical component of the health system. The results, costs, and expenditures depend on it. This section will deal mainly with the health care provided by public entities, since the care provided by the private sector is examined in the section on regulation. Health care should be effective, produce results, minimize the costs within given standards of quality, and respond to the needs of the public.

Effectiveness will increase if the levels of care are integrated through timely and effective referral and counterreferral procedures, whose implementation requires interactive information systems, that make it possible to obtain the clinical histories of patients and monitor pathologies, cures, and discharges.⁹¹

In order to minimize costs, it is necessary to design and establish a set of mechanisms for records, evaluation, administration, and information, including the following: i) systems for recording and evaluating production costs, as well as cost analysis centers for the monitoring and evaluation of the performance of the different units; ii) indicators of efficiency and productivity that identify the human resources, equipment, and installations with the greatest effect on costs; iii) management techniques based on the concept of total quality to minimize variations in health results in the production processes; and

⁹¹ In small units manual procedures are sufficient, but in larger units with higher volumes of activity, regularly-updated computerized systems are preferable, since they offer the advantages of lower cost and greater reliability.

Box V-5

PRIVATIZATION OF SERVICES IN COSTA RICA: HEALTH COOPERATIVES

In Costa Rica, the privatization of certain health programmes has been under debate since the 1980s. The most significant action to date has been the transfer of the Pavas and Tibás clinics from the Costa Rican Social Security Agency (CCSS) to two health cooperatives.

According to the directors of the new health entities, the cooperative movement in the field of health is intertwined with the principles of social security: to guarantee the population total and egalitarian coverage, with the public contributing collectively to its financing, and with the State chiefly responsible for its administration. They believe that private enterprise, although not intrinsically efficient, facilitates greater efficiency and the quality of the goods and services delivered. They propose the need for guaranteeing that privatization will not result in an increase in the cost of benefits, and maintain that the State is responsible for clearly defining the concept of public need, promoting private initiative through broad privatization programmes, and controlling and regulating the efficiency and quality of the services offered by non-governmental entities.

Under an agreement between the Ministry of Health and the CCSS, COOPESALUD took over the outpatient care of the population of Pavas, district of San José. The CCSS pays it approximately US\$ 30 a year for each insured resident in that health area to operate the clinic. The amount is negotiated annually and paid in monthly quotas; the Ministry of Health's commitment to make a monthly contribution of US\$ 15,300, has only been partially fulfilled. The Cooperative is paid to care for the health of the public, and not for each health care service provided. According to its associates, this system makes it possible to balance the economic interest of the cooperative and the social goal of the public service it provides, since if health care is not adequate, the cooperative jeopardizes its future resources because it will have to deal with an eventual increase in demand caused by higher morbidity.

To initiate the project, the CCSS contributed a new clinic (750 m² of construction and 9,000 m² of green areas and parking), approximately 80% equipped, with a value close to US\$ 1.5 million. COOPESALUD made a one-time token payment for rent of US\$ 20. The Cooperative is responsible for the maintenance of the physical plant, the equipment, and furnishings of the CCSS, that should theoretically be shared by the two. The cooperative can purchase the drugs and other products distributed by the CCSS and the Ministry of Health at cost, plus 15% for administration. The contribution of the CCSS is based on estimates of annual average spending for each person with health and maternity insurance.

Preventive care, which includes periodic home visits, occupies an important place in the strategy of the Cooperative. A basic health care team, made up of a physician, an assistant, and a community health worker is assigned for each 3,000 to 3,500 people covered to carry out primary care activities: house-to-house vaccinations, detection of hypertension and pregnancy, formation of groups to prevent early pregnancy, and programmes for the disabled.

Staff turnover is low, probably because it is offered better salaries, especially in the early years of service, a "personalized" administrative structure, and greater participation in the management of the clinic.

Box V-5 (concl.)

COOPESALUD is comparable to the type 4 outpatient clinics of the CCSS, which provide broader and more complex outpatient care, including medical care in four basic specialties and subspecialties and services such as clinical laboratories and X-rays. These clinics provide support for smaller establishments in their area. In comparison with type 4 clinics, COOPESALUD has more health care staff and less management staff. At the outset, its productivity in terms of medical consultations was lower than that of the other clinics; by 1990 it was 9% higher than their average. It should be pointed out that it is not possible to make a reliable comparison of the cost-effectiveness of the Cooperative with that of other clinics on the basis of the available information, since the Cooperative only reports the cost of depreciation of the equipment acquired by it, which amounts to approximately 30% of its total equipment, and does not include depreciation of the infrastructure or the equipment provided by the CCSS and the Ministry of Health. This means that its true costs are systematically underestimated. If the accounting method were corrected, the cost of consultations, which currently appears to be 30% lower than those of the other clinics, would rise.

Proposals to improve the model include amending the financing agreements and the estimates of the public contribution, to enable the cooperatives to reduce costs through more efficient use of resources, that does not merely reflect current average costs.

Source: Ana Sojo, "La política social en Costa Rica: panorama de sus reformas recientes", Reformas de política pública series, No. 17 (LC/L.784), Santiago, Chile, ECLAC, November 1993.

iv) adequate programming between levels of care of different complexity and between sectors so that actions and interventions are more timely, losses are reduced, and the quality and effectiveness of care are improved.

g) Regulation

The future structure and organization of the health sector will be marked by the presence of a larger number of agents and a wider range of options for individuals, which will improve the efficiency with which resources are allocated and services are produced. However, these positive effects will not come about spontaneously; instead they will require the State to play an active role.

In its new role the State assumes leadership in the formulation, monitoring, and evaluation of policies, and in the execution of selective interventions. Moreover, stronger regulatory activity by the State is decisive for coordinating the wide variety of agents that act in the field of the health, establishing standards of procedure to govern the action of those agents, and providing incentives to guide scientific and technological development and promote greater equity in the provision of services. This implies the need to: i) encourage the setting of standards to regulate the services and health care included in the basic basket; ii) establish technical, administrative, and operational rules for the public sector, and quality standards for the health services system; iii) strengthen government capacity to regulate the markets for

drugs and medications, highly-complex technology, and physical investment, in order to moderate price discrimination, monopolistic behaviour, the formation of cartels, and all practices that could lead to appropriation of the consumer surplus by financing entities or health care providers; iv) guarantee that individuals have a variety of options when selecting their insurance or management organizations and health care providers; v) regulate human resources education for the health sector to ensure balanced and equitable availability; and vi) establish rules governing environmental matters and occupational safety, coordination of public and private action, and intersectoral articulation.

Health sector reform obviously affects the agents that are involved in the financing, management, and provision of health care. It modifies their roles and reduces or expands their fields of action and management powers, with different emphasis and scope depending on the stage of the reform. In most of the countries, sectoral reform will begin in a period of economic adjustment and shortage of financial resources. The State will have to play an active role in its promotion and implementation, especially with regard to financing —for which purpose it should attempt to obtain more funds through traditional means and turn to complementary alternatives— and greater efficiency. The government is responsible for the political task of mobilizing social forces and obtaining their commitment to change. In addition, it must promote pilot projects for the purpose of evaluating sectoral reform.

In this stage, the public sector will maintain its predominant role in the direct provision of health care, but should improve public management capacity, especially that of the units responsible for designing and implementing the reforms. Another critical task during this phase will be the configuration of a coherent legal and institutional framework for the entire health sector, tailored to a scenario marked by the diversification of the agents, which makes room for all of them and regulates their functions, obligations, and powers.

h) Science and technology research and development, and methodologies to improve the effectiveness of programmes

The viability of HCPPSE in each country depends on how well it is adapted to national sanitary, economic, and political realities. This implies developing the capacity to analyse and monitor the profiles of the priority health problems of the different social groups, and the ability to prepare and evaluate proposals for intervention that take those profiles, the availability of resources, and the interests of the different actors into account. Another key to making the proposal viable is the availability of elements that are crucial for the operation of health services, particularly information and technologies. In other words, the promotion of research and technological development in the field of health is an essential component of HCPPSE.

Health research capable of serving as support for a proposal like HCPPSE cannot confine itself to the subjects and disciplines that are typical of biomedical and clinical research or to those traditionally pursued in public health research. Many of the problems that are fundamental for the HCPPSE proposal, such as sectoral financing, institutional organization, decentralization, role of the State, dynamics of the actors, distribution of power, inter alia, require the contribution of other disciplines, particularly the social sciences. The challenge is how to expand and diversify the critical mass of investigators and research institutions working in the field of health. Policies, funding, and reorganization are required to strengthen research, enabling it to respond to priority health problems and to surmount the barriers between the production of knowledge and its use.

Technological development in the health field, understood as the capacity to develop, adapt, and produce key components for care (for example, drugs, vaccines, and equipment), and to regulate and evaluate the incorporation and utilization of technology at the service level, is extremely important for consolidating the viability of HCPPSE. The availability of appropriate technologies to implement the basic basket and the possibility of making more efficient and equitable use of high-cost procedures hinge on this capacity.

Health research and technology are crucial elements in HCPPSE, not only because of their importance for health care, but also owing to their influence on scientific and technological progress in others sectors. Indeed, the network of services and components in the health sector permits and promotes the incorporation and development of new technologies that go beyond sectoral applications, as in the case of biotechnology.

i) Strengthening of epidemiological capabilities and of health information systems

In order to strengthen the processes of sectoral reform within the framework of HSECPP it is essential to develop the ability to evaluate the health situation in each territory and population group, to identify and analyze the profiles of priority problems, and to monitor the different impacts that corrective interventions can have on them. This requires transforming and developing epidemiological capabilities and systems that provide information on the health situation and vital records at all decision-making levels of the system, and increasing their utilization in decision-making processes. This will help to improve capability at the local, regional, and national levels, to select priority problems and the most appropriate interventions, including the groups to which they will be directed, and to monitor the impact of the interventions on the various sectors of the population and on social inequalities in the area of health.

Strengthening the capacity for health situation analysis is also fundamental as a means of assessing the use of public resources, increasing the efficiency of the interventions envisaged in the reform processes, improving the information available to the population, and ensuring the accountability of public authorities for their actions.

5. Investment

The recent economic recovery has made it possible to consider new investment priorities in the economic programmes and public spending policies of the countries of the region, given the visible deterioration in the standard of living, for the purpose of placing greater stress on the social sectors. Moreover, international financing agencies now have additional resources for those sectors.⁹²⁹³

⁹² Inter-American Development Bank, Economic and social progress in Latin America, Report 1993, Washington, D.C. October 1993.

⁹³ World Bank, Latin American and the Caribbean. A decade after the debt crisis. 1993.

Additional investments, which can be supplemented by instruments such as social investment funds, are required to provide the health services included in the basic basket and address the demands stemming from the changes in epidemiological profiles. Moreover, the shifts in public and private participation will make it necessary to provide a regulatory framework to govern these investments.

Considering that in the short term it will be mandatory to carry out physical infrastructure projects to recoup the production capacity lost in the 1980s, it is timely to review health-sector investment policy to turn it into a key bulwark for the process of health system reform in the countries of the region.

The kind of investment in question differs from the kind usually associated with national budgets. In addition to physical investment, it is proposed that in designing health investment policy other cost components be included that will have a direct effect on the productive capacity of the health sector as a whole or on specific health institutions. Projects should identify institution-building activities that include investment in human capital in the form of training as well as in equipment and reorganization of the productive agents. The component of institution-building at the project level is aimed at increasing the effectiveness of investment and ensuring that the project truly produces the desired impact.⁹⁴

Today, many health establishments, whose construction was financed with expensive international credits, are no longer able to provide the services for which they were built. Ex-post evaluations carried out by IDB to gauge the results of loans to the health sector in the seventies and eighties show that the goals for physical infrastructure were not met on schedule and that the costs exceeded the projections. Loan resources were not committed on time and projects often had to be reformulated, which mainly affected the most primary levels of care.⁹⁵ Both governments and international financing agencies must bear the responsibility for the results.

These realities point to the fact that the health sector needs to strengthen its ability to optimize the use of funding and make the most of the high priority that is currently assigned to it. Improving the quality of investments is a basic requirement for ensuring that the increase in financial resources has the greatest possible impact. To do so, the capacity of the sector itself to formulate and evaluate projects must be consolidated, since up to now activities of this kind have usually been performed or supervised by the economic sector. Accordingly, it is indispensable to assign higher priority to this area in health-sector training activities. These skills should also be fortified in the new actors linked to the decentralization process, such as the municipalities. The same holds true for the non-governmental organizations and the commercial and cooperative enterprises involved in the sector.

The evaluation of projects should consider organizational and institutional aspects linked to their future role in the sector. The design of health investment policy should include, in addition to investments in physical infrastructure, other cost components that have a direct effect on the productive capacity of the sector and on specific health institutions. The projects should identify institution-building activities, that include investments in human capital (training), equipment, and reorganization of the productive agents. In addition, investment proposals should take due account of the budgetary commitments that will

⁹⁴ PAHO. Hacia un nuevo concepto de inversión en el sector salud. [Toward a new concept of investment in the health sector]. Document Series No. 2, Regional Plan for Investment in the Environment and Health. Washington, D.C., April 1994.

⁹⁵ Inter-American Development Bank, Experiencias de la evaluación ex post y futura dirección del sector salud. Contraloría-Oficina de Evaluación de Operaciones, Washington, D.C. 1993.

be required to operate the services so that the services can be sustained with funds from the regular national budget in the medium and long term.

The object of the foregoing recommendations is to increase the effectiveness of investments and to assure that projects have the expected outcomes. In this regard it must be remembered that investments should have a two-pronged impact, which is to improve the conditions under which health care services are produced and the conditions under which they are consumed.

To improve effectiveness and efficiency, each country should evaluate the actual impact of health actions in terms of the solution of specific problems and should look at the potential impact that could be obtained by alternative combinations of actions.⁹⁶ Analyses of effectiveness and efficiency should consider institutional aspects and sector organization, such as the extent to which management capacity determines production levels, for the purpose of identifying organizational and institutional changes that should be introduced. The priorities for the basic basket of goods and services should guide sector investments, which will also have to take the redefined roles of the public and private sectors into account.

Given the close linkage between investment policy and the health sector reform process, investments in the sector will make it possible to achieve a double objective. On the one hand, production capacity lost owing to factors such as the halt in investments in physical capital will be recouped; on the other, the capacity to provide health care as a result of the reorganization of the productive factors that participate in the process will be strengthened.

C. THE POLITICAL AND ECONOMIC VIABILITY OF HEALTH SECTOR REFORM

A reform such as the one proposed here must be analysed from the viewpoints of its political and economic viability. Like any other public policy, a reform that modifies the status quo must be underpinned by political will and technical know-how. In the absence of the former there is no possibility of reform. This section presents a diagnosis of the health problems faced by the Latin American and Caribbean population, and proposes some guidelines for action that would allow them to be remedied in a relatively short time. The purpose is to draw the attention of public decision-makers to the desirability of undertaking this reform, not simply in response to ethical reasons or the need to raise the level of well-being of the population of their countries—which are already sufficient justification in themselves—but also because of the advantages of having a healthy population in order to improve the international competitiveness of the countries of the region. The combination of these reasons should help to fortify political will. As for technical know-how, although some progress has been made in recent years, efforts and resources must be devoted to research—as a component of the proposed reform—that will make the reform itself more viable, through the greater efficiency and effectiveness of health actions.

⁹⁶ PAHO, Proyecto control de la malaria, Nicaragua. PAHO/WHO report. PAHO/IDB Government of Nicaragua, April 1991.

An analysis of the viability of the proposed strategy requires identification of the strengths and weaknesses of the instruments available to the authorities responsible for carrying out the reform process, as well as the opportunities and risks of the different scenarios in which the reforms will be undertaken.

The risks come from the pressures of interest groups that believe they will be adversely affected by the reform because they will lose advantages linked to the status quo. Commercial and professional segments, unions, and certain users may risk losing some of their privileges as a consequence of the rechanneling of public resources to provide a universal basket of goods and services, or the elimination of tax breaks for health costs that are higher than the benefits and health services in that basket. These groups have the ability to organize and to exert political pressure to protect their interests.

In a democratic system, the authorities and the agents for reform should ensure that broad sectors of the society understand the desirability of the reform, from the viewpoints of the transformation of production patterns and of equity.

Therefore, the promoters of reform must not only focus on convincing the decision-makers, but also on building up a broad consensus in favor of the reform among the various social actors. This coalition should not be limited to the potential beneficiaries of the reform and people for whom the changes will be neutral, but should also attempt to attract those who may be adversely affected, whose losses can be reduced or compensated for in different ways. It is also necessary to try to bring other agents on board, such as international cooperation and financing agencies, certain groups of health professionals, non-governmental organizations, and elements of organized civil society.

Social security agencies will have to expand their programmes and coverage to include the health and the social well-being of groups that are currently excluded, which can create tensions with current beneficiaries, who are in a privileged situation.

The contribution of non-governmental organizations can be a determining factor in the implementation of reform, given their experience in projects to support low-income groups and in the financing, administration, and delivery of social services to these same groups. Accordingly, NGOs have an important role to play in the expansion of health coverage, especially in the case of remote areas or with regard to needs not covered by government services. They can also work to improve efficiency, both in their own programmes and in those carried out by the public sector, and help to obtain more funding, either through international cooperation, community mobilization, or cost recovery, which are areas in which they have been successful. The potential of NGOs can only be tapped adequately if government officials overcome old prejudices concerning the non-governmental sphere.

The use of the mass media is fundamental, since there is currently no clear perception of the common good that results from many public health actions, such as actions to control infectious diseases by immunization, and environmental sanitation to prevent enteric diseases and lung diseases caused by air pollution in cities. The lack of dissemination of information entrenches ignorance in this regard, which in turn strengthens the lack of solidarity that individuals feel toward their communities.

Special efforts must be made to convince health sector employees. The bureaucracies of ministries of health are often opposed to initiatives to modernize the public sector, which accentuates the image of their inefficiency and resistance to change. Ministries of health are one of the largest public sector employers and their employees are very prone to chronic labour conflict. Lengthy strikes by public

hospital workers form part of the political and labour panorama of the large cities in the region, which affects the already decaying efficiency of the sector and its public image.

Epidemic outbreaks of diseases such as cholera and measles make the public even more critical of ministries of health and more likely to blame them for the harm suffered. All this helps to limit the role and the political clout of ministries of health, which means that their proposals carry little weight when the time comes to make decisions.

Another element that adds complexity to the prospects of sectoral reform is the growing dichotomy between modern medicine, whose continuing incorporation of advanced technology is one of the principal factors in rising costs, and the persistence of basic health problems typical of poverty and substandard living conditions. In many cases, the inequalities that affect the very poor are not taken into account when health resources are allocated, and this omission helps to perpetuate them.

The process of transforming government involvement, from actions guided by centralized, planned models to actions that are decentralized in which the market predominates, also entails a reduction in the weight and leadership of the public sector. Such changes will make the sector look even more anachronistic and, as a result, it will be more susceptible to the criticisms of the advocates of privatization. This situation will be aggravated when the appearance of a supply of more modern and efficient private health services contributes to the fragmentation of the available resources and increases the visible differences between the care they offer and the care provided by the public sector, which is increasingly underfinanced.

A sine qua non for the political viability of reform is that it must be undertaken by the government as a whole —and not exclusively by the ministry of health— with an overall political approach that demonstrates the existence of a solid political will and assures that the ministry of finance will provide the resources necessary for carrying it out. Emphasis on the close relationship that has already been pointed out between better health, the impetus for changing production patterns, and genuine competitiveness can attract other members of the cabinet as strong allies, and prevent health reform from being seen as just a sectoral change.

Political action should be taken to build up a political and social alliance in favor of reform, that includes the principal actors: political parties, technocrats, health professionals, hospital workers, and representatives of the private sector and of industries linked to health care. Ultimately, health reform must be converted into State policy. It does not have to be viewed as the work of a particular government, because its implementation will outlast the mandate of any one government and because it will be almost impossible to carry out without a broad consensus on its necessity, shared by all political and social sectors.

It is also necessary to have a clear view of the obstacles that will have to be surmounted, such as the strong opposition from interest groups that stand to lose from the proposed changes. To win those sectors over to the cause of reform, or at least to neutralize them, will require skilled political management. An effective way of consolidating the political viability of reform is to divide it into proposals on which consensus can easily be reached, separate from those that require more complex consensus-building. This would facilitate the identification of critical points which will require special efforts to ensure that the reform does not fail.

It is also useful to set up a central technical team to take charge of the reform, whose members have a solid theoretical grounding in public health and great capacity for dialogue with the other institutions, to lead the reform process along the right track. The necessary incentives should be offered to keep the members of the team in the public sector for as long as possible, in order to ensure the continuity of the reforms. Otherwise, there is a risk that human teams will break up, and it is very difficult to have to rebuild them again and again.

The viability of reform also depends on the investments that are made in health. The different sources of financing that could be used to obtain the funding necessary for the reforms were discussed in the section on investment. International financing agencies can play an important role in the implementation of reform, since their loans for the health sector are conditional upon improved functionality and modernization of the operational mechanisms of health sector institutions.

The government agenda in many countries of the region is gradually incorporating the objective of improving the health of the population. However, there is considerable criticism of the fact that these priorities are not turned into concrete practice.

To change this situation and make it possible for a reform such as that suggested here to go forward, it is necessary, in the first place, to have an accurate diagnosis of the current situation to avoid starting off with the wrong assumptions. The complexity of the sector, its intersectoral relationships, and its distinctive characteristics are not always duly considered. These shortcomings are worse in countries where the public and private sectors have developed independently and unsystematically, which has led to the rise of interest groups that are not willing to cooperate to achieve greater efficiency and equity.

In second place, account should be taken of the complex mesh of actors and interests at stake in health systems, which may be affected by the reform. This holds true in the field of pharmaceutical products, where, as has already been pointed out, the presence of large transnationals it is a very important factor. As for social security, despite the inequities in financing and in the provision of health care, attempts to change it will be resisted by the groups that benefit from the current situation.⁹⁷ As was already mentioned, it is usual for the bureaucracies of ministries of health to oppose initiatives to modernize the public sector, which has increased its inefficiency. This, in turn, has encouraged higher-income groups to move to private care, eroding solidarity between social groups to the detriment of the poorer ones.

The ministries of health should take the initiative in building up a highly intersectoral approach and maintaining relations with multiple departments, such as finance, public works, agriculture, planning, environment, interior, defense, and especially, education. In practice, health is an activity in which almost all government departments have an interest.

To carry out the proposed strategies requires a continuing analysis of situation in order to take advantage of favourable situations and modify actions in adverse circumstances. Different strategic scenarios could result from the long-term development of economic and social policies, regardless of whether they are successful.

⁹⁷ A case in point are the sizeable transfers of resources that the different Brazilian public companies make for employee benefits, which are higher than those required by social security legislation, to the detriment of financing for other programmes that would benefit society as a whole.

The range of possibilities runs from an optimistic scenario, with high economic growth accompanied by effective redistribution policies that lead to an acceptable degree of equity, to a pessimistic scenario, in which both economic growth and social equity decline. The intermediate situations would be those in which economic growth remains high, but without substantial improvements in equity, or where economic growth is low but is accompanied by a gradual reduction in the social differences that separate the different strata of the population.

The difficulties in attaining the targets proposed (in the ideal scenario) stem from the pressures of interest groups that oppose reform. Some producers of goods and private health services—including health professionals, the pharmaceutical industry, producers of medical services, and private health entities—may oppose initiatives to regulate the provision of services and to target the model to prevention. These groups are better organized and have more political influence than the consumers of health care, which means that the central government, which is responsible for implementing the reforms, will have to open spaces for negotiation and consensus-building and establish alliances with actors who support the changes (international cooperation and financing agencies, public sector health personnel, some non-governmental organizations, and organized civil society—guilds, unions, and other entities).

Once the reforms have been implemented, the three subsystems that currently exist in most of the countries (state sector, social security and private sector) will continue to exist, but their participation will vary depending on the national situation. The presence of the state subsystem will continue to be significant in all cases, but it will be relatively less important and will tend to concentrate on lower income groups. Its function will be to rationalize the behaviour of the other two subsystems in the market through its rate policy, payments to suppliers, and regulation in general.

Regardless of the relative share of the subsystems, the State should guarantee the provision of conditioning factors and health services to the entire population and ensure equity and equal access. Its role will be irreplaceable with regard to financing, but with regard to the provision of health services, in some cases they will be provided by its own institutions (public and semipublic), and in others, through the contracting of services with private entities, whether for profit or nonprofit. This again highlights the need for governments to order and rationalize the system as a whole.

It is indispensable, then, to seek new forms of organization and resource use that will maintain, and even strengthen, the role of the State as guarantor of the social and health requirements of lower-income population groups and the sustainability of the development process, from the viewpoint of the preservation of the environment and natural resources.

The countries of the region should study the possibility of having social security systems expand their range of actions and their areas of intervention, by incorporating the development of public and environmental health programmes into their current responsibilities, and stepping up their participation in social welfare services that are increasingly acknowledged to be fundamental components of health care.

Along this same line, it is indispensable to make changes in social security systems to correct imbalances and the privileges of some groups, move toward the inclusion of the entire population in basic protection plans in light of fundamental risks, and replace the limited concept of social security with programmes and actions for health and well-being.

The activities of non-governmental organizations, for the reasons noted earlier, can help to link equity and efficiency. However, in order to make the most of their potential contribution, on occasion the State should make resources available as a contribution to the financing of their activities. In any case, it would be desirable to monitor NGOs in order to distinguish between those that work efficiently and those that do not help to offset the limitations of public services.

As has been recently stressed, it is important for the international community to boost its financial support for investments in health. A recent World Bank proposal recommends that assistance for health be brought back at least to its previous level of 7% of total transfers, and that it be increased gradually in the coming years. The beneficiary countries, in turn, have to permanently monitor international cooperation policy and flows in order to identify, on a timely basis, the opportunities they offer and make the most of them. To gain access to these funds they must operate in an expedite and creative manner. The task of identifying international cooperation agencies should be permanent and demands knowledge of their interests in terms of fields of action and geographic area, and of the procedures for requesting their cooperation.⁹⁸

Making the most of the possibilities offered by international cooperation is the responsibility of each State. To do so, the government agencies working in this area must step up their activities with respect to identifying needs and solutions, translate them into adequately designed and evaluated projects, negotiate them at the level of their own governments, improve execution (management of projects and programmes), and promote them in the international community.

As for the economic viability of reform, the growth indicators presented in table I-1 of this document point to moderately optimistic prospects for the recovery of Latin American economies in the 1990s. A number of countries in the region have already attained significant economic growth rates and it is likely that as the stabilization and adjustment efforts being made by other governments mature, their countries will also enter into processes of sustained growth. This will furnish additional resources to carry out the reform, which added to greater efficiency in the utilization of the resources of the State in general, and of the health sector in particular, will enable the reform to be financed. Moreover, various simulation exercises carried out for a sizeable group of countries in the region show that extension of the health care package currently offered by the public sector to the entire population included in these programmes, and even packages offering more benefits and greater technological complexity, would not require resources that are beyond the reach of almost any of the countries in the region.

In conclusion, all the aspects analysed throughout this document make it possible to close this preliminary version with an optimistic outlook regarding the desirability, opportunity, and viability with which the countries of the region propose to put into practice a strategy of health for all, closely linked to changing production patterns with social equity.

⁹⁸ This includes presentation of proposals, the existence or absence of guidelines for their preparation, financing levels, duration, types, etc.