Technical Discussions

Washington, D.C.
September-October 1977

CD25/DT/1 (Eng.)
13 September 1977
ORIGINAL: SPANISH

COORDINATION BETWEEN SOCIAL SECURITY SYSTEMS AND PUBLIC HEALTH

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1. Introduction

During the present decade the priority concern and objective of the governments of the countries of the Region of the Americas is to provide all the population and especially the underserved or as yet unserved groups with access to health services and to achieve universal and uniform health care coverage for all their citizens as soon as possible.

To achieve this goal, the importance of which has been widely and repeatedly recognized both nationally and internationally, the countries have undertaken a number of activities designed to rationalize the use of the resources of their health services and have assigned special priority to the examination of all the doctrinal, structural and operational aspects affecting the form of their health services.

Accordingly, the Directing Council of the Pan American Health Organization, at its XXIV Meeting, selected the topic "Coordination Between Social Security Systems and Public Health" for the Technical Discussions to be held during its 1977 meeting.1/ Special importance is attached to this topic because of the institutional composition of the health sector in most of the countries of the Region and the imperative need to improve the organization and productivity of those institutions and of the sector as a whole and to prevent dispersion and unnecessary duplication. Such activities would make it easier to achieve the objective of universal coverage of the population with health services.

As part of the preparatory work for the above-mentioned meeting, and in order to facilitate and guide the discussion, the staff of the Bureau has prepared this working document which deals with those aspects that in a review of the subject have emerged as the most important and the most significant.

The material used in this document is drawn primarily from three sources:

a) A summary of the information derived from international meetings at which top-level government representatives of the countries have adopted hemispheric policies in the matter and the recommendations and suggestions of seminars, working groups, technical discussions, congresses, etc., which have examined aspects of the coordination of health and social security systems. The details of this review are presented in Annex I.

1/ Resolution XXXVII, PAHO Directing Council, Proceedings of the XXIV Meeting, 15th Plenary Session, 6 October 1976

b) An analysis of the present situation based on the findings of the evaluation of the Ten-Year Health Plan for the Americas, which was carried out in 1975, as well as of a survey of social security institutions for the purpose of updating information of their relationship with the central government; number, type and location of their beneficiaries; number and type of service provided; sources of funds for their health systems; and activities for establishing better coordination with the ministries of health. The pertinent information appears in Annex II, Part I.

c) Interviews with leaders and representatives of ministries of health, social security institutions, employers, workers, and information media, the purpose of which was to ascertain how coordination is viewed in each country. A summary of the findings appears in Annex II, Part II.

The document also contains a number of considerations on the proposals and commitments of the countries as regards both the expected status of coordination and the implications and constraints of the process.

Finally, the document presents a number of possible solutions based on observation of the trends that appear to be emerging in the Hemisphere.

2. Definition of Services and Coordination

In view of the institutional pluralism of the health services in most of the countries of the Region, it is first necessary to delimit the area with which this background document deals.

For the purposes of this working document, social security system means the personal health, medical and hospital services social security institutions provide directly or indirectly to their members.

Public health system means all the personal health services, both curative and preventive, provided directly by the national, provincial, state, municipal or local governments to persons who are financially unable to pay for them directly and who do not contribute to social security. In these services as a whole, the ministers of health play a leading role regardless of which institution provides the service directly.

The line separating the two systems is essentially the method of financing, which permits a clear-cut classification of the services. The sources of the funds (and the channels for handling them) that finance public health, direct and indirect taxes and general revenues, are different from those that support social security activities (the budget of each institution depends on the contributions of its members).

Basically, coordination means to unite efforts to achieve common objectives and goals.

Institutional coordination is a process in which it is necessary to distinguish between the policy decision to establish it and the development of the necessary instruments for achieving it. For the first, institutional support is essential for underpinning the decision and for applying it. The application of a coordination policy requires the installation of operating mechanisms that will be used and adjusted as the process moves ahead.

This conceptualization of coordination clearly shows the areas of responsibility of the institutions in providing a basis for the decision, developing the necessary attitude, installing the required mechanisms, methods and procedures, and making the necessary adjustments at various stages.

In view of the common objective to provide the entire population with health care, the coordination of health sector institutions must be understood as the process of uniting efforts, through the pooling of resources, to obtain a common goal, that is to say, to meet the needs of the population as a whole for health services to the extent possible. In other words, to achieve maximum efficiency in the use of resources in order to ensure the entire population timely and equitable access to services and, consequently, universal health care coverage.

3. Hemispheric Health and Coordination Policies

3.1 General Policies

Through their highest authorities--presidents, ministers of foreign affairs, ministers of health, etc.--the countries of the Hemisphere have expressed at world and hemispheric meetings their aspiration to provide all their inhabitants with access to health services and have emphasized the relationship between health and social and economic development.

In the last 20 years, health sector institutions have repeatedly expressed the same aspirations.

Among these statements, special mention must be made both of the decisions adopted at general meetings and those adopted at specific health conferences, seminars, congresses, etc., which it is advisable to review, if only summarily, since they are more indicative and more relevant to the subject we are considering.

From this point of view, pride of place must be given to the Constitution of the World Health Organization, which specifies that "health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"2/ and consequently all the

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2/ World Health Organization. Constitution and Official Records, Official Record No. 2, Geneva, 1947.

inhabitants of a country or region should have appropriate access, according to their needs, to individual health services. The governments should ensure the exercise of this right and consequently "have a responsibility for the health of their peoples which can be fulfilled only by provision of adequate health and social measures."3/

The idea that health is an intersectoral product and the result of an overall development process, the final objective of which is the well-being of the population, has been accepted by virtually all the countries of the Americas, which have emphasized the need for harmonious economic and social development planning, the objectives of which are defined in such a way as to ensure the well-being of the population.

In September 1960, the representatives of the 21 American Republics met in Bogotá to consider "Measures for Social Improvement and Economic Development" and, when dealing with health aspects, recommended the extension of services to rural areas and "the progressive development of health insurance systems, including those providing for maternity, accident and disability insurance, in urban and rural areas."4/

One year later, in August 1961, in Resolution A2 of the Charter of Punta del Este, the Presidents of the countries recommended, among other things, the preparation of ten-year health plans, the establishment of planning units, and the improvement of the organization and administration of national and local health services and the provision of the entire population with financial access to those services.5/

3.2 Meetings of Ministers of Health

Within the framework established by the general policy lines mentioned above, the ministers of health of the countries of the Hemisphere have held three special meetings during the last 15 years, and a fourth is being prepared at the time of this writing. At these meetings various aspects of the extension of health services to the entire population have been considered.

At the first of these meetings, which was held in 1963, the ministers charted courses of action in this regard and referred specifically to the need to coordinate the services in the countries and recognized that "The ministries

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3/ Idem.

4/ Pan American Union. "Act of Bogotá: Measures for Social Improvement and Economic Development Within the Framework of Operation 'Pan America.'" OAS General Secretariat, Washington, D.C. 1961.

5/ Pan American Union. "Alliance for Progress," OAS General Secretariat, Official Documents Serv. H/XII.1 (Spanish), Washington, D.C., 1961.

health should take steps to secure the legal and institutional instruments required for the effective coordination of the planning and executive elements responsible for preventive and curative services of the State, as well as coordination between these and private, semiautonomous, and autonomous organizations providing health services of any type."6/

The ministers of health again considered coordination at their II Special Meeting, in which they stated: "Systems should be set up in each country without delay for the effective coordination of the health services of ministries of health with those of social security institutions, universities, and other private and public bodies. To assure that coordination is effective, it should be a permanent activity of all those who participate in the process of planning, administration, and provision of services."7/

The III Special Meeting of Ministers of Health, the objective of which was to plan a new decade, emphasized the relations between health and social development and established the following regional goal: "extend, in localities of under 2,000 inhabitants, minimal comprehensive health services coverage to all inhabitants still not covered, complementing it gradually with the provision of basic services,"8/ and pointed out that it was essential to clearly define the policy of the sectors as well as the functions and responsibilities of its component institutions and to devise mechanisms for coordinating them.

The principal topic of the IV Special Meeting of Ministers of Health, which is about to meet (26-27 September 1977), is the extension of health service coverage to the entire population. This meeting is expected to define the strategies to be followed in the years ahead for achieving that objective.

3.3 Meetings of Social Security Institutions

The foregoing general commitment assumed by government authorities (Bogotá and Punta del Este) and the specific commitments assumed by the health authorities (Special Meetings of Ministers) are also embodied in resolutions adopted by the social security authorities of the Hemisphere. Of special importance are those approved by the VIII Conference of the

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6/ Pan American Health Organization. "Final Report, I Meeting of Ministers of Health," PAHO Official Document 51, Washington, D.C., 1964, p. 37.

7/ Pan American Health Organization. "Final Report of the II Special Meeting of Ministers of Health of the Americas," Official Document 89, 1969, p. 43.

8/ Pan American Health Organization. "Final Report of the III Special Meeting of Ministers of Health of the Americas," Official Document 118, 1973, p. 73.

American States that are members of the International Labour Organization, held in October 1966, the general approach of which is expressed in the so-called "Ottawa Programme of Social Security," "...which indicates guiding lines for the development, the reform and the improvement of social security in the countries of America so that it may be a real instrument of social policy and, in particular, an instrument for the equitable distribution of the national revenue, which guarantees a balanced social and economic development."9/ This document gives priority to the extension of these principles to rural areas and to the rural population and emphasizes that it is necessary to coordinate health services provided by social security and public health institutions and such other medico-social services as may exist.

These same principles were reaffirmed more recently by the institutions of the Ibero-American countries that met in Buenos Aires in 1974 at the Inter-American Conference on Social Security Planning. On that occasion, it was again emphasized that the benefits of social security should be extended to the entire population and that it should be transformed into an important redistributive instrument by means of changes in economic planning 10/ and the definition by each country of a policy for developing health systems that would emphasize the participation of social security as an important component of those systems.

Also worthy of mention among this group of meetings are the five American Congresses of Social Security Medicine organized by international agencies that group the national social security institutions. At virtually all the five congresses, reports on the expansion of services have been presented and the need for coordination as well as the importance of the participation of social security institutions in national policies for the extension of coverage have been emphasized.11/

3.4 Joint meetings of Ministries of Health and of Social Security Systems

The health and social security authorities of Latin America have held a number of international meetings in the 1960's and in the early 1970's, at which the need for improving the coordination of public health and social security systems was discussed at length.

9/ International Labor Organization. "The Ottawa Program of Social Security for the Americas." Geneva 1966, p. 3.

10/ Inter-American Conference on Social Security Planning. "Informe final: Declaración solidarista de planificación americana de la seguridad social." Mimeographed, Buenos Aires, 1974.

11/ See Annex II.

Although this subject was a specific topic of debate and of resolutions on many occasions, some of them deserve mention because of their importance in changing the way of thinking in most of the countries.12/

Of special importance is the XI Meeting of the PAHO Directing Council (Mexico 1964) at which public health and social security authorities took part in discussions on the organization of health services and jointly recognized the need to plan the health sector as a whole and the importance of coordinating health services into a single national system.

In 1965 a Study Group consisting of representatives of ministries of health and of social security institutions met under the joint auspices of PAHO and OAS. The final report of this Group shows that an effort was made to reach an agreement, the need for which had been evident since 1964. Referring directly to the relations between the social security institutes (ISS) and the ministries, it mentioned elements in their historical development, particularly the direct form of service delivery by the ISS, in explaining the institutional differences between the two systems. However, it was understood that "one of the greatest obstacles to proper coordination is the fear, felt by both affiliated unions and social security authorities, that the funds collected in dues might, in a coordinated system, be used for other purposes or to make up the deficit in ministry of health facilities."13/ It expressed the consensus that most of the Latin American countries were not ready for the integration of services, by which was meant complete administrative and financial unification (national health service type) and proposed a high degree of coordination as a desirable alternative.

In 1969 a second Study Group met in Washington also under the auspices of PAHO and OAS. The final report of this Group is the most complete doctrinal document on the subject, the doctrine having been formulated by PAHO at the XVIII Meeting of the Directing Council in October of the same year.14/

The four sections into which the principal recommedations of the Group are divided emphasize coordination in the formulation and execution of health policy, in the delivery of services, in financing, and in manpower training and development.

12/ Annex I contains a detailed review of the international meetings at which the topic was discussed. See sections 2.1.1-2.1.5.

13/ Pan American Health Organization. "Administration of Medical Care Services. New Elements for the Formulation of a Continental Policy." Sci. Pub. 129, Washington, D.C., 1966, p. 51.

14/ Pan American Health Organization. "Coordination of Medical Care. Sci. Pub. 201, Washington, D.C., 1970, p. 71.

Two resolutions of special significance were adopted on coordination of financing, which is undoubtedly the most important aspect: "It was noted that the installed hospital capacity must be considered as common property which belongs to the country and which must benefit all its inhabitants without discrimination, irrespective of the institution that owns the establishment."15/ In accordance with this doctrine, it was decided to recommend the establishment "at a national level of a joint fund toward which would be channeled the resources of all national institutions interested in the medical care programs existing in the country."16/ Although an initial administrative mechanism was described, unfortunately the institution that was to handle this fund was not clearly defined. Recommendations or suggestions in this respect would have been very helpful in providing national coordinating committees with the necessary tools for implementing the decisions.

Although there was general agreement on the objectives to be pursued--the extension of coverage, elimination of inequalities, and improvement in administrative procedures--and various forms and areas of coordination were mentioned, differences of opinion, especially as regards strategy, were noted in the final report.

This brief review would be incomplete if it did not mention the fact that an examination of national documents shows that policy formulations at the international level have also been widely expressed at the national level. The countries have formulated plans and have designed measures for relating health services to the general development efforts and for establishing better coordination of institutions within the health sector. The actual application of such measures and their effectiveness are examined when the information supplied by the institutions themselves on the present status of the process is considered.

In the course of this process, and as an important stimulus, mention must be made, finally, of the activities of the international institutes that work in the area of social security--the International Social Security Association (ISSA), the Association of Social Security Institutions of Central America and Panama (AISSCAP), the Permanent Inter-American Committee on Social Security (CPISS), the Organization of American States (OAS), and the Ibero-American Social Security Organization (OISS)--which, by adopting a position favorable to coordination, have sponsored and guided national activities. In this regard mention must also be made of the International Labor Organization (ILO), which through its coordination meetings, held every two years since 1967, has helped to unite efforts in publications, research, personnel training, technical cooperation in the field, etc.

15/ Op cit, p. 15.

16/ Op cit, p. 17.

To sum up, "coordination of services" for the purposes of providing the entire population of the countries of the Hemisphere with better health care has been widely examined and discussed in many national and international meetings during the period mentioned above. At these meetings, although the basic theory and its rationale has been supported in general, agreement has not always been reached on the mechanisms to be used for applying it. The foregoing historical review shows that there is general agreement about the benefits to be derived from integration or coordination of services. Also to be noted is the fact that the focus of the discussion and analysis and especially the recommendations and guidelines derived from it have been predominantly on general policy, administrative, and structural aspects and only very superficially on financing mechanisms, despite their importance.

4. Present Status

4.1 General Characteristics of the Health Delivery Systems

The foregoing review clearly shows that coordination has been conceived as an instrument for achieving specific ends and purposes. The hope is that coordination will lead to the participation of all the component institutions of the health sector of the countries in national and hemispheric efforts to expand the coverage of health services. It is also hoped that coordination will lead to the establishment of joint mechanisms for the planning and execution of health programs. The intention is to ensure better use of national resources and thus to secure equal and timely access to the services for the entire population according to its needs. These should, therefore, be the criteria for judging whether coordination exists and its results.

However, given the information available in the countries and therefore at the regional level, it would be useless to attempt such an evaluation.

Accordingly, to obtain a more or less objective idea of the present status of the process of coordination in the countries, it is necessary to examine those operational elements that have been confirmed as substantive elements of coordination on the different occasions in which it has been discussed and examined.

The organization of the health system in the countries of the Region is the result of a process of evolution. Each country has evolved differently as the result of political changes and other socioeconomic factors. By and large, no two national systems are alike. When they are examined in detail, each is found to have its own characteristics and peculiarities that clearly differentiate it. Nevertheless, using the definitions of social security and public health systems proposed at the beginning of this document, and bearing in mind the financing and administration criteria, some tentative groupings may be established within the regional framework. Of the PAHO Member countries, two, Cuba and Canada, have a single health care system for the protection of the entire population. The National Health Service of Cuba, which is financed

exclusively by the State, administers almost all health services; there is no parallel social security system. In Canada, sickness insurance has evolved towards a universal health insurance scheme which covers ambulatory and hospital care. For the administration of the services it has retained the traditional method of community hospitals and individual medical practice.

In the United States of America, the Federal Government and, to a lesser extent, the State Governments, have introduced various schemes for financing services for needy persons. For the most part, the direct provision of services continues to be the responsibility of the private sector.

In seven Caribbean countries--Bahamas, Barbados, Grenada, Guyana, Jamaica, Surinam and Trinidad and Tobago--as well as in those territories linked to France, the Netherlands, and the United Kingdom, what are basically government health services have been established. In those countries, as in Haiti, where parallel with government services there are philanthropic organizations, social security in general has not become directly involved in health programs and, therefore, in addition to the public health system, there are only private services.

In 18 countries, health service systems administered by the ministries of health have developed parallel with social security systems. The services provided by the ministries are financed out of public funds.

In 13 of them, health systems administered by one or more social security institutes financed exclusively by the personal contributions of workers and employees and, in some cases, by the State as such, have developed and are responsible for the direct provision of services. These 13 countries are, in alphabetical order: Bolivia, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru and Venezuela.

In three of the remaining five--Brazil, Costa Rica and Chile--the financing of social security has changed significantly, the State having increased the percentage of funds coming from general taxes (Chile) or special taxes (Brazil and Costa Rica) to complement the workers' contributions to social security.

Finally, in Argentina and Uruguay, together with the public health system, there are a large number of social security institutions, or institutions similar to them, organized primarily by trade unions or mutual aid societies; however, the trend, particularly in Argentina, is towards the grouping of social institutions in a single institute, the National Institute of Social Institutions (INOS), although this does not apply to all the schemes.

In the above-mentioned grouping the criterion of direct provision of services by the corresponding social security schemes makes it possible to establish a further differentiation. In the 13 countries in the first-mentioned groups, social security as such is not directly involved in providing

personal services. In these groups of countries, institutional coordination is needed, but its connotation and aims are different. Coordination of this group is more concerned with measures for controlling cost increases and/or for ensuring better use of resources and thus fostering the development and expansion of the services.

In the last-mentioned 18 countries in which the social security agencies have established institutions and facilities and programs for providing direct services, unlike the others, the process of coordination also has a direct bearing on the real possibilities of extending health service coverage to the entire population.

4.2 Findings of the Evaluation of the Ten-Year Health Plan

This section presents those findings of the initial evaluation of the Ten-Year Health Plan for the Americas, made in 1975, that have the most direct bearing on coordination. They refer particularly to the status of coverage of the services and to substantive aspects of the organization and development of the national health systems (administration and information) and their financing.17/

- The analysis made shows that, in 15 countries that reported on coverage, despite the efforts these countries are making to establish 10,923 new units for minimum services in localities with less than 2,000 inhabitants (rural population) and to reduce the estimated average of 10,480 persons per unit in 1971 to 9,400 persons in 1980, there will still be a long way to go before the goals of the Ten-Year Plan are fulfilled. This, without taking into account the fact that one of the countries, which did not report, has a rural population equal to about one-third of the total rural population of Latin America and the Caribbean. In localities with more than 2,000 and less than 20,000 inhabitants, the information provided by the 13 countries shows that this population will not have basic service coverage by 1980. The same conclusion may be drawn from the information reported by 11 countries for localities with more than 20,000 and less than 100,000 inhabitants and from that from others for localities with 100,000 inhabitants or more. The foregoing estimates are based on the assumption that the mere presence of a health care unit in a locality ensures that its population is automatically served, which is not by any means certain. Of the 21 countries that reported on coverage, in 10 the policy for the expansion of coverage is not a sectoral but an institutional policy, that is to say, of only one or more of the institutions of the sector.18/

- From the point of view of the development of health service systems, activities aimed at defining the institutional elements that make them up and determine the actual form of the system is one of the

17/ Pan American Health Organization. XXIV Meeting of the Directing Council, "Evaluation of the Ten-Year Health Plan, 1971-1980." Document CD24/18, August 1976, pp. 16-19.

18/ Ibid.

basic indicators of the status of the process of institutional coordination in the country. In this regard, of the 21 countries reporting, by 1974 only 13 had defined their service system. Of the 10 of these that are considered to be public subsector systems, only six regard them as being made up of the ministry of public health alone or with the social security system. Where there are many autonomous institutions in the countries, delimitation of the system entails not only the identification of the component institutions but also of their interrelations. In this regard, six countries consider their health system to be a single system while 14 define it as coordinated, although they do not say in which way coordination has been achieved.

- As regards the definition of the administrative relations between the institutions, an area in which coordination is of special importance since it makes it possible to standardize methods and procedures and facilitates institutional rapprochement, of the 21 countries reporting, 15 had made an administrative analysis of the most important institutions of the sector, but in only seven of them did this analysis cover the social security scheme. In 10, it covered other institutions.

- The planning of the health systems and the general and administrative process involved in their operation requires the development of an appropriate system of information that feeds the decision-making processes promptly with the information they need. Of the 21 countries reporting, in almost half the information system embraces all the sectoral institutions. However, 13 countries consider that interinstitutional coordination of information is either partial or nonexistent. With respect to specific areas of the information system, only three countries state that they have taken steps toward effective organization of manpower supply and utilization. In the area of evaluation and control of specific programs, specifically with respect to medical care, which is a critical area for the purposes of institutional coordination, only three countries have an information system in operation, one is in the process of organizing it, and in another no provision is made for it.

- Finally, with respect to financing, which plays a basic role in coordination, in 13 of the 20 countries reporting, programs for the analysis of the forms of financing and of expenditure exist; only three countries are examining the production functions for the sector. In two of each five no such analysis is being made. In this regard, of 18 countries that provided data on financial resources, nine have organized the area of availability but only seven have done so for the area of use of such resources.

The foregoing notes show that, according to the information supplied by the countries themselves, advances in the definition and organization of service systems have been very slow, despite the efforts made, and consequently the

development of the process of institutional coordination is in most cases only getting started. Also important is the fact that "social insurance" is considered an integral part of the service system in only a small number of cases. This, without taking into account the fact that the designation "social insurance," is normally used to designate the most developed institution (institute or fund), and excludes all the other smaller social security institutions whose number and characteristics vary from country to country. It is therefore easy to state, on the basis of the information supplied by the countries for the evaluation of the Ten-Year Health Plan, that because of the characteristics noted, the institutional coordination developed is only in its initial stages.

4.3 Findings of the Survey

In response to the survey made before this background paper was prepared, the information supplied by the principal social security institutions in 13 of the 18 countries in which there are parallel social security and public health systems, and additional data from five other countries, make it possible to deepen the analysis of the many and varied factors involved in the coordination process.

With the provisos made with respect to the limitations presented by the information received, 19/ five main aspects that affect this process in varying degrees need to be emphasized.

4.3.1 To Whom Responsible, Organization and Financing

- In most of the 16 countries (11 in all) studied in this respect, 20/ the social security institutions and consequently their health care systems are under the authority of the State, through the ministry of labor; however, they maintain their administrative independence. In 3 of these 16 countries, the social security health systems are directly linked to the ministry of health; in the remaining 13, policy with respect to the organization of health services, which is constitutionally vested in the ministries of health, must be implemented bilaterally by these and the institutions under the authority of other ministries. Under these circumstances the establishment of coordination would require specific legal instruments.

19/ The reader may refer to Annex II, Section A, for a detailed description of the methodology used in analyzing the replies received. The 13 countries that answered promptly were: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominican Republic, Ecuador, Guatemala, Honduras, Panama, Peru, and Venezuela. The survey received from El Salvador refers solely to a small institution. The information from Paraguay could not be used because it was received too late. No reply was received from Mexico, Nicaragua or Paraguay.

20/ Table 1 of Annex II gives the details.

- From the point of view of general organization, two main facts warrant consideration: in the first place, the already mentioned characteristic of the preferably direct delivery of services, although in a good number of cases the institutions state that they contract with other units of both the public and the private sector; in the second place, the existence in four countries of institutions or agencies whose function is to establish coordination within the social security sector itself. However, the information obtained does not disclose how effective these mechanisms are. Furthermore, the reporting institutions, although in most cases the largest in the country concerned, are far from being the only ones.

- An overview of the situation reveals that there are many institutions, which only shows how difficult it is to analyze the problem. The difficulty is, of course, bound up with the low level of development of the information systems within the sector, to which reference was made earlier.

- With respect to financing, the information obtained shows that the health systems of the social security institutions are financed in accordance with the traditional model, namely, by bipartite contributions from employers and employees or by tripartite contributions, in which case the State is the third contributor. However, in three countries the State has increased its share of the financing of social security and by this means has extended the coverage of health services. This distinction between traditional forms (tripartite or bipartite contributions) and nontraditional forms of financing social security (larger participation of the State) is of interest because of its bearing on the extension of coverage of the health schemes. The percentage of the total population covered by them in the three countries mentioned above exceeds by far that in other countries at the same or a similar level of development.21/

4.3.2 Population Covered

The data supplied 22/ show that in almost all the 16 countries to which reference is made in Table 2 of Annex II, the proportion of the population covered by the social security health scheme has increased. It is also important to recall that the percentaje of the population covered is actually higher, since the information received relates solely to the principal social security institutions and not to all of them, as was explained earlier. This applies especially to Argentina and Chile.23/

21/ See Table 2 and Diagram 1.b of Annex II and explanations.

22/ See Table 2 of Annex II.

23/ See explanations of Table 2 of Annex II.

With the provisos noted, it must be emphasized that, in four of these countries, when the corresponding adjustments are made, the social security agencies provide health care to more than 50 per cent of the population. In three of them, the State share of the financing is larger.

In the other three countries, social security covers between 25 and 40 per cent of the population.

The foregoing illustrates the growing importance of these schemes in expanding the coverage of health care, although it must be pointed out that the percentages of the economically active population covered, the principal group for which social security is responsible, still appear to be low. 24/

Progress in extending social security to the rural population, a declared objective of social security agencies, appears to have been slow. In the 16 countries considered, leaving aside the three in which the State's share of financing is larger, the percentage of the covered population of localities with less than 20,000 inhabitants is still less than nine.

It is also interesting to note that there are substantial differences in the range of the services provided to members and their dependents by the social security schemes of the agencies analyzed.25/

An analysis of the relationship between the forms of traditional financing (bipartite or tripartite) and the percentage of the population covered tends to show that it is a direct function of two social parameters: economic development and income distribution.26/ This result is consistent with the general theory that participation in social security schemes is limited to population groups which are able to contribute and which by definition increase with development. The significance of this relationship is that, in the present conditions of development of the countries, there is a limit on the role of social security agencies in expanding coverage unless one or the other of the following decisions are taken: To change the traditional form of financing by making provision for a larger share to be paid by the State (some data analyzed appear to indicate that this is so) or to change the rules for and types of service and thus to reduce the costs per member so that more members could be covered with the same amount of funds.27/

4.3.3 Levels of Expenditure, Cost and Use

It has been difficult to obtain sufficient information about the public health systems to compare the levels of expenditure of those systems and of the social security systems and thus to clarify the possible relationship of this aspect with the coordination of the two systems. Accordingly, and solely for the sake of reference, it is pointed out that in 1970 estimated public health outlays in the Region represented approximately 1.6% of the regional GNP; it

24/ See Table 2 of Annex II.

25/ See Table 8 of Annex II.

26/ See Table 2 of Annex II.

27/ See Table 2 of Annex II.

has been estimated that, with an annual increase of 7% in the investments ot this sector, the percentage of the GNP deriving from the public health sector would only amount to 1.65% if the increase in the GNP were 6.6%.28/

The data obtained in this survey show that the share of the GNP expended by social security health schemes in 1975 varied greatly.29/

The total expenditures of any of the systems, either the public health or the social security system, is fundamentally the result of: the unit cost of the resources consumed in the production of services (for example, cost of a physician/hour); the level of the use of the services (for example, consultations and discharges per 1,000 inhabitants or members); and the technological combinations used in providing the service. The implicit or explicit decisions taken about these elements, taking into account costs, are bound up with the percentage of population the corresponding system can benefit.

Consequently, the adoption, for the purposes of planning and organization of services, of technological combinations and the establishment (in the form of standards--so many treatments per hour, for example) of patterns of use that are more or less recognized or recommended internationally, are decisions of great importance.

In this regard it has been pointed out that, in most cases, social security agencies tend to develop health service levels (standards of programming and patterns of use) which it would be very costly to extend to the rest of the population because of their complexity.30/ Estimates based on the information derived from the survey tend to collaborate the foregoing statement in several of the countries studied.31/

The most important conclusion to be drawn from this observation is that quality is frequently confused with complexity. There is a tendency to believe that the quality of a service depends on its complexity, which implies a more expensive technological combination; that is not true. This confusion leads to the operation of facilities, purchase of equipment, use of professional and specialized personnel, etc., with higher standards than those required. However, such elements only relate to a variable of quality, referring to the structure of the system, when the delivery of services, the adequacy of the content of the services, and the effect on the corresponding health conditions are perhaps more important in the final result.

28/ Pan American Health Organization. "Ten-year Health Plan for the Americas," Official Document 118, January 1973, p. 97.

29/ See Table 4 of Annex II.

30/ Abel Smith, B. "Health Policies and Investments and Economic Development. In: Kassalow, Evertt M. (ed): The Role of Social Security in Economic Development. Dept. of H.E.W., USA, Social Security Administration, Report No. 27.

31/ Tables 4, 5, 6 of Annex II and their explanations describe the methodology used in detail.

From the standpoint of coordination possibilities, it is obvious that, until a rapprochement based on the use of a simpler appropriate technology and on a better balance in the salary scales, which affect the unit cost of production, is achieved, the limitations the process must face are innumerable.

4.3.4 Availability of Resources and Yields

It is frequently stated that there is a wide disparity between the availability of human and physical resources for the general population, which for the most part come under the public health system, and those available for the groups that are members of or covered by the social security schemes. Examination of the information in this respect obtained from the survey and expressed in global indicators, given the limitations of the information obtainable for the ministries of health, confirms the foregoing statement. In six of the ten countries studied, the medical time available for those covered by social security schemes is greater than for the rest of the population, and the nursing time (nurses and auxiliary nurses) is also greater in those agencies than for the general population.

In 12 of the 14 countries studied, more short-term hospital beds are available for the social security population than for the rest of the population.32/ On the other hand, the use indicators show high use of specialized resources. In the public health services there were no data to document this point, but it is recognized that these services lack that kind of personnel.33/

The different per capita availability of resources shown by this comparison also indicates that a better distribution of such resources through more coordination must be achieved.

4.3.5 Elements of Coordination

According to the nature of the different recommendations initially reviewed, five basic elements were analyzed as indicators of the progress made

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32/ See Tables 9 and 10 of Annex II. It must be emphasized that there is an element of distortion in these comparisons that must be taken into account, since the nonbeneficiary population do not all have the same access to health services. In it, there are relatively large groups which do not have access to these services, while for others, especially the population that is covered by the private sector, the resources available are equal to or greater than those for the beneficiaries of social security.

33/ See Tables 11 and 12 of Annex II. As noted in the previous footnote, there is also a distortion that must be taken into account. While some specialities of the intermediate type are more available in social security, paradoxically advanced specialities are developed with greater frequency in the public health system. This would appear to be connected to the high cost of investment and operation their development implies.

in the process of coordination: legislation, joint action in medical care programs, joint action in institutional support programs, in programming of capital investments, and in manpower development.34/

Any attempt to summarize the variety of conditions existing in the Hemisphere would undoubtedly be incomplete. The only way of minimizing this limitation is to treat the matter on a case-by-case basis, country by country. However, that would not only unduly enlarge this document but, more importantly, would transform it from a regional analysis into a document concerned with the special features of each country. Nevertheless, certain fundamental aspects of ten countries for which information was obtained, in five of which there are or have been national coordinating committees, will be examined. How effective the committees are, however, is not indicated; only in two of these five countries do they have authority to program capital investments (buildings and equipment). In this area of investment, the information received shows that there is still a long way to go before planning and execution in accordance with a single plan is achieved. As regards joint programming of services, there are some countries in which, according to the information provided, most of the services are coordinated; in others, there are some programs that are more frequently coordinated than others, for example, tuberculosis and communicable and chronic disease programs.

As for human resources development, in five countries this is coordinated for all categories of personnel and in three considerable efforts are being made.

The inconsistency of some of the foregoing data supplied by the two systems (social security and public health), and particularly the impossibility of quantifying the efforts reported and the obvious lack of agreement in the description of the process, cast doubts on the real significance of this information. The direct evidence collected during interviews in some countries tends to confirm these doubts.

5. Additional Factors Affecting the Coordination of Health Service Systems

The findings outlined in the foregoing section indicate the factors limiting the process of coordination. The interviewes held in six countries also provided a direct assessment by some sectors.

These factors, whose nature varies greatly and which have features peculiar to each situation, are also more or less interrelated. For the purposes of analysis, however, they may be grouped into economic, institutional, bureaucratic and political factors.

The economic factors arise primarily from the disparity in per capita financial, human and physical resources. This is reflected in approaches and solutions whose technological complexity differs on the same type of problem

34/ The tables and explanation in Annex II give the details.

and in different salary scales and other employment conditions, particularly for the professional group. In the opinion of several of the persons interviewed, this last-mentioned aspect is one of the practical difficulties that has the greatest and most far-reaching implications. The unilateral use of more complex and costly technological solutions than those required, which is encouraged by the abundance of resources, is in contrast with the economic reality of the countries. This also creates situations at variance with the principle of distributive justice, which recognizes the universal right to health services and, what is even more serious, creates unjustified expectations and artificial and distorted patterns of service use in the population. In turn, these generate an inappropriate demand, which tends to create a greater demand for resources and thus creates what is virtually a vicious circle. This situation is also favored by the way the resources are collected. Because he pays his contribution, the beneficiary of social security demands the satisfaction of his right, whereas the user of the public health system rarely rationalizes his payment of taxes or his status as a citizen as a right to have access to the services. There is still a charity (received or given) mentality in most of the population, and not that of a right that can be demanded on an equal footing. As for institutions, the difference in the objectives of the two groups of agencies sharply divide them. Whereas the basic responsibility of the social security health schemes is protection against defined risks of defined and individualized sectors of the population, the public health systems have been traditionally responsible for providing services to persons medically underprivileged that do not have sufficient money to pay for their medical care or to pay contributions to social security schemes. These differences, which are embodied in the legal instruments establishing the institutions, reflect the political conception prevailing at an historical point of time at which they were established and which has changed. But the laws that set up parallel processes of decision-making, which are difficult to change once they are established and impede or limit the pooling of resources for achieving a more common general objective, have not changed or not changed sufficiently quickly.

The general conviction that the administrative and bureaucratic structures of the health systems (ministries and social security) are important sources of resistance to coordination was widely confirmed during the interviews. The existence at the higher level of competition for prestige and for power was frequently noted. This latter was associated chiefly with the amount of resources handled. These rivalries tend to infiltrate the intermediate structure of the bureaucratic organizations which, in turn, compete for stability and higher salaries and better working conditions. In this regard, the position of professional groups is to be noted; some of them also find tangible benefits in the possibility of more than one job, which is favored by the separation of the institutions.

The foregoing situations inevitably lead to politics. The decisions in this field, which are complicated _per se_, become even more difficult by reason of the pressures exerted by groups whose interests are obviously at variance with the purposes of coordination. In addition to the executives, the administrators, etc., these groups include the trade unions, which are more concerned

with structuring systems that will enable them to get back what they have paid in without taking into account the fact that this "payment" comes from a single source of national resources (Gross National Product) that is the result of the work of all the population; and the medical organizations, inspired by an ideology that emphasizes professional values and benefits and is primarily interested in the importance assigned to so-called "free choice," methods of payment, levels of remuneration, and forms of organization that make for professional independence, and higher levels of complexity of the services, regardless of the economic capacity of the society to bear them.

For these groups, the changes that coordination requires mean a potential threat: in the first case, to what is interpreted as a labor conquest and, in the second, to sources of work and professional stability.

6. Progress Achieved

This progress is reflected in the formulations of general development policy and specific health policy in the agreements and recommendations made by the representatives of the governments and of the institutions on the many occasions in which the subject of coordination has been dealt with at national and international meetings. A doctrine has been established and the operative elements for applying it have been identified and explained.

During the 12 or 14 years this movement has been under way, an awareness has been created in the institutions, and different degrees of coordination have been achieved in the countries. The integration of preventive and curative services has been accepted, and the need for their joint organization is no longer a matter of discussion; social security institutions have incorporated preventive programs into their activities. In some of the countries (still only a few) shared use (social security and ministry of health) of facilities and services has begun, as has the joint programming of such services and facilities. Social security institutions have also begun to cover workers in rural areas and even non-member population groups, for which purpose they receive substantial State subsidies. There is also greater concern about, and even specific activities for the planning of, human resources in the light of overall national needs.

Nevertheless, despite these and other positive findings of the regional analysis, the progress achieved does not reflect the intellectual effort made and even less the imperative need to coordinate the activities of the respective health sectors and thus to achieve the coverage goals that the countries have fixed. This is shown by the information just reviewed, which was supplied by the countries themselves. There are still large population groups to be covered, and needs are increasing continuously, both in number and in kind, as the population grows, its geographical distribution changes, and life expectancy increases. Meanwhile, most of the service systems, given the necessary provisos, recognize that they are still compartmentalized and unconnected. They consist of networks of services that are administratively and financially independent, unstructured, and lack prompt and appropriate information. Their different institutional components are moved by a philosophy of care for well-defined groups, usually exclusive groups, rather than by the recognition of the universality of the right to health services.

7. New Frame of Reference for Coordination

7.1 General Considerations

The initial priority protection of groups of industrial and commercial workers undertaken by the social security health schemes, which omitted the more needy sections of the population--rural workers, self-employed workers, those without a well-defined occupation and the unemployed, who were excluded from virtually all benefits--has required the ministries of health to make important changes, the gestation and development of which, despite the efforts made, does not yet appear to have been completed.

The personal health services that traditionally protected these socially underprivileged groups were curtailed as the philanthropic schemes that supported them decreased, when their financial capacity was exceeded by the increases in the cost of care. These services have, for the most part, been transferred to the State, although it is not always clear whether the concept of charity with which they were granted has been abandoned or whether the source of charity has simply been replaced.

The ministries of health called upon to play a role that was not their traditional one do not appear to have had either sufficient legal authority or the necessary administrative capacity and, even less, the resources required to perform it.

Furthermore, the organization of health programs intended to protect special population groups, which is the characteristic of social security health schemes, does not differ fundamentally from prepaid private collective insurance schemes except in the obligatory nature of the contributions, which make them into a tax mechanism. They tend obviously to create situations of discrimination that are not consistent with the social policy of universal coverage and whose effective contribution is limited since, however the benefits are distributed, in most cases they reach only the members of the groups covered by the program, although not always to the same depth or extent.

The policies and objectives of the service programs incorporated into the legal instruments which establish them and therefore govern the institutions (social security and ministries) that administer them need to be reexamined and updated.

A policy of universal coverage like that which has been formulated by the countries implies the need to complete the change in concepts, laws and operations of the State agencies responsible for executing it.

It is the responsibility of the appropriate government levels to adopt decisions that will bring the institutions closer together and create an environment in which the process of coordination can be effectively established. Furthermore, it is the responsibility of the institutions to appropriately report on the policy, technical, and administrative-financial implications of

the decisions to be adopted. The analysis required to reach the decisions cannot and should not, however, be made unilaterally. This is shown by the fact that the health institutions are under the authority of different State agencies. Joint action to this end, particularly by the ministries of health and of labor, is not only desirable but also imperative. In considering these problems, the international forum which provides an environment that is more objective and less subject to immediate pressures has proved useful, and it would perhaps be up to the international agencies to sponsor a new round of conversations and studies in which the basic concerns are less the means and the structural and operational aspects and more the objectives and final purposes and the ways of attaining them.

As a process, the coordination of health sector institutions needs to be viewed in historic perspective. The foregoing review would appear to indicate that the indispensable phase of collecting information and general discussion of the subject has been completed, and that a new stage of concrete achievements is beginning. This is evidenced by the changes that have taken place in some of the countries.

The coordination movement has had two central objectives: to obtain greater operational efficiency in the use of the available resources and to give new and larger population groups access to the services. It is recognized today, however, that, in the prevailing circumstances in Latin American countries and the Caribbean, extension of the existing services is by itself not sufficient, or would take a very long time, to achieve coverage of the entire population with health services. Furthermore, the concepts of coverage and accessibility have evolved and, in their new dimensions, require not only the operational efficiency of institutions but also, and what is more important, efficiency in decisions about the allocation of resources, i.e., allocation of resources in accordance with the objectives to be achieved. In these conditions, the context and the very contents of coordination vary substantially. To understand its true significance, the present concept of coverage and the consequent interpretation of the principles of accessibility and efficiency must be examined.

7.2 Present Concept of Service Coverage

Coverage with health services has been traditionally expressed as a ratio between the services provided and the recipient population or as the percentage of the population with physical access to services or even as their availability or their distribution with respect to the geographical location of population centers.

It is accepted that the state of health is the result of a process of intersectoral development, the final objective of which is the improvement of the living conditions of the population. This acceptance implies the recognition that a population will only enjoy a good state of health to the extent that its basic needs are receiving effective and sufficient attention, within

the possibilities offered by the maximum utilization of resources of the country concerned. It is therefore the responsibility of the health services to stimulate and participate actively in efforts for integrated multisectoral development.

In these conditions, coverage of health services becomes in reality an expression of a dynamic relationship involving, on the one hand, the care needs and aspirations of the population and, on the other, the available resources and their technological and organizational combinations that will make it possible to provide an appropriate supply of services to satisfy those needs. Coverage, then, means "the result of an effective and organized supply of basic health services that meet the needs of the entire population, are provided on a continuing basis in accessible places and in a form acceptable to the population, and afford requisite access to the various care levels of the health service system."35/

Health coverage of the entire population--the goal established by the countries for this decade, which is the consequence of the recognition that health is a right that the State must guarantee--requires within the foregoing context the participation of all the institutions of the sector and consequently the necessary adjustment of their policies, objectives and individual programs to make them compatible with the common objective.

The extension of services to increase coverage must respond harmoniously to the national interests (rather than to institutional interests) and be based on a single health policy that guides the formulation of institutional programs, according to the characteristics, resources and possibilities of the country as a whole. The new concept of coverage therefore requires the adoption of a clearly defined policy of coordination consistent with the foregoing premises, and presupposes a distribution of financial resources according to the responsibility of each institution for the population it is to serve. In turn, institutions must set up effective mechanisms for implementing that policy. The expansion of service coverage in the foregoing terms also requires broad participation of the community and the development of a new strategy of primary care, which will enable intersectoral activity to be mobilized in the communities.

7.3 Access to Health Services

For a long time it has been recognized that access to health services has three basic components: services within the geographical, economic and cultural reach of the population; appropriate volume, quality, and structure of the care provided; and acceptance of the services by the population.

35/ Pan American Health Organization. "Extension of Health Service Coverage Using Primary Care and Community Participation Strategies." Document for the IV Special Meeting of Ministers of Health of the Americas, Mimeographed, Washington, D.C., September, 1977.

Economic access, which is as important as, if not more important than, the appropriate location and geographical distribution of establishments and services, in terms of which accessibility is usally interpreted, requires the elimination of barriers arising from the methods of financing the services and the systems of payment or user contributions. To ensure that all the population has economic access to services, given the present system of financing health services in Latin America means:

In the first place, to establish equity in the availability or resources per capita; thereafter, to abolish the existing differences caused by the predominance of financially autonomous systems and consequently discriminatory systems. The foregoing implies a redistribution of all the health resources available and their channeling in accordance with a single policy aimed at satisfying the needs of the entire population.

In the second place, it would be necessary to change the standards or patterns of provision of services in order to make the cost of care compatible with the availability of such resources. As will be seen later, when the individual purchase of the service by direct payment is excluded, there are only two basic methods of financing the health system: prepayment or insurance, and financing through general revenue. These two methods are not, however, mutually exclusive and admit of combinations.

Such combinations for guaranteeing economic access should take into consideration:

- the need for an increase in the resources of the sector, derived from a better distribution of national resources;
- uniform availability of resources per capita, derived from an appropriate form of organizing financing;
- real economic capacity of the users, in order to prevent the establishment of inappropriate contribution schemes.

Making costs and resources compatible by means of changing the standards of service delivery is linked to the use of an appropriate technology, to which reference is made later.

7.4 Improving Efficiency in the Use of Resources

In order to deal efficiently and effectively with the needs of the entire population, the different institutions that provide care must follow the same public policy, have common objectives, conduct their programs in a consistent manner, use appropriate technology, and employ resources available in accordance with the need of the population they serve.

Maximum operative efficiency in the use of resources as an objective of coordination therefore depends on the health sector institutions and, in this case, specifically the social security health schemes and those of the ministries, forming a true health service system.

Two fundamental elements are important in the efficiency of the health systems: organization of services according to levels of care and use of an appropriate technology.

a) The concept of care levels is based on the fact that there are some health conditions or situations that occur more frequently than others. It recognizes the natural relationship between the characteristics of a specific health situation and the complexity of the technological response it requires for satisfying it. The application of the concept or notion of care levels is an important element of rationalization and efficiency, which makes it possible to align the care needs of a population with the resources available for dealing with them. Its use in the programming of the services leads to the organization of a stratified system, in which the different levels or technological combinations are appropriately interconnected. All the members of the population the system serves must have access to them, according to their needs. As a result of the ranking of health problems and of service functions, which is the basis of the definition of levels, it is possible to establish a scale in which the combination of least complexity, known as the first care level, groups the most fundamental, but not the least important, activities of the system and constitutes the level of initial contact of the system with the community (or as it is frequently called, the portal of entry of the community to a system), and the "occasion," with the criterion of efficiency, on which most of the situations can be initially solved and the others appropriately channeled towards other levels of greater complexity of the system. In this context, the starting point for the coordination of service programs of social security and public health schemes should be the alignment or redefinition of the respective scales of care levels and the joint adoption of realistic standards of service, according to the availability of human, technical and financial resources of the country rather than that of the institution in particular. In terms of the expansion of coverage, the central purpose of this alignment should be the redesign and development of the first care level in order to provide basic services to the unprotected communities, to enlist their participation in the process, and to establish the necessary referral mechanisms for providing those that require it with prompt access to levels of higher complexity.

b) The use of appropriate technology, technology being defined as ways of acting on health situations or conditions in order to transform them and to satisfy needs, recognizes the fact that most of the health problems can be dealt with technically and effectively in different ways that vary in terms of costs. The selection of an appropriate technology implies the identification of those methods, techniques, facilities, equipment, materials, drugs, personnel, etc.,

which, while effective, are also compatible with the availability of resources of the system.

A concerted effort of social security institutions and public health care systems to align standards or forms of service delivery would give real expression to coordination in this field. Investment in terms of real need and not in terms of satisfaction of prestige or of erroneous interpretations of quality should be the pattern.

The foregoing concepts and definitions constitute a new framework within which it will be necessary to reorient coordination efforts towards regionalization of services; to redefine methods of interinstitutional contracting; to jointly plan establishments and manpower; to achieve joint operation of support services and the rationalization in the use of drugs, etc. In short, it will be necessary to deepen the application of proposed solutions, some of which have not yet been seriously attempted, and to develop new approaches, particularly to the use of personnel and the strengthening of the primary care levels.

There should be four major purposes in attempting to align the activities of the institutions: the assignment of priority to activities for providing the entire population with basic services and reducing existing inequalities; the development of new forms of service, particularly at the primary level; the improvement of the efficiency of the sector as a whole; and the planning of institutional activities on a national basis and not for exclusive groups of the population.

8. Organization and Coordination Alternatives

From the general point of view, in the Region of the Americas as in other parts of the world four basic trends in the organization of health services can be distinguished: 1) a single organization in which the State is responsible for financing and provision of services; 2) the state finances the services but does not provide them directly; 3) the responsibility for purchasing the services is that of the individual and the State takes care of the financially and medically underprivileged; and 4) intermediate forms in which charity is combined with public assistance, private activity, and insurance schemes. The last pattern prevails in Latin American countries.

Two elements, however, appear to be fundamental in the analysis of a health system: its financing and its organization. Each one of these is the result of a different evolution and has definite policy implications. Although interrelated, the one does not necessarily condition the other. The selection or adoption of one form of financing does not imply a single organizational form and even less does it detemine that administration is the responsibility of the State or of independent bodies. The scheme of administration adopted does not presuppose a single form of financing.

In this regard, in the countries of the Region two additional facts may be emphasized:

In the philanthropic and public assistance services for the poorest groups of the population, the trend has been towards coordination with and integration into the ministry of health, and consequently towards financing out of general revenues. Although this process has not yet been completed in all the countries, philanthropic institutions as priority components of service delivery continue to exist in only some.

In the social security group, a form of insurance, an internal trend towards coordination or even integration into a single institution has become apparent. Generally this process has been slow, although it has become necessary in some cases because of the bankruptcy of smaller schemes. The arguments in favor of having a number of social security funds appears to be losing weight.

In view of the need to guarantee economic access to the entire population, there are not many financial alternatives. Different factors need to be considered in analyzing them.

Given the income situation of most of the inhabitants of Latin America and the Caribbean, greater personal responsibility for financing services is not applicable. The progressive increase in costs tends to lead to the abandonment of this approach, even by the more developed countries of the Hemisphere.

The data provided by the survey made in preparation for this background document, even with the major limitations pointed out, and the very tentative nature of some of the formulations, show that as long as the disparity in the capital resources of the systems persists, the real possibilities of universal coverage are very remote. This situation contrasts with that of some other countries, which have decided on a greater degree of unification of financing.

In these countries the population covered is definitely larger. The financing of social security requires a sound basis of individual contributions. The data provided by the survey indicate that it is difficult and even impossible to apply universally a model of financing such as that developed in these institutions. The incorporation into social security schemes of larger population groups in the countries that have achieved it has meant a greater share by the State in the financing of social security health schemes. The increase in the cost of providing health services has consequently led virtually everywhere to a greater share by the State in financing of such services. The increase in the State contribution, however, has a limit. There is a growing demand for the governments to make a greater commitment to the financing of services as an expression of the recognition of the social and political right to health.

The alternative therefore seems to be the adoption of an appropriate financing policy which, while it is reflected in an increase in the percentage of the GNP expended on health, fixes and regulates the share of all the institutional components of the sector in its use.

The alternative, then, is whether the universality of economic access to services--without which there can be no total coverage--is to be achieved through the insurance financing system or, on the contrary, whether it is more advisable to achieve it through government action. In some developed countries (Europe) the strategy appears to have been the first, as a step prior to reaching the second. However, to what extent this solution is viable and applicable in developing countries is still to be determined. In addition, there are other questions: Through which of the two systems would it be more effective to channel the increase in the State contribution? In which of them would it be more feasible to make the changes of complexity required? Is the solution the universalization of insurance, with the financial participation of the State covering the payments of those who cannot pay them, or should the extension of the services be achieved through the government system? With exceptions, financing by general revenue has been used in the Hemisphere for financing services to specific groups of the population. How feasible and operational is this scheme for universalizing the right to health? What mixed forms of financing could be used?

There are arguments for and against all these arrangements. It is pointed out, for example, that the government system offers less policy stability since the funds coming from general revenues can be easily changed. It is said that social security is less vulnerable; the contribution made to it develops a greater sense of right in the members and, once decisions to incorporate the general population are made, irreversable or intractable situations are created. The management of the funds of social security schemes, which, in most cases, are separate from those of its national budget, makes them more secure and more stable.

In the context of its politico-administrative situation, each country must decide on the arrangement it finds most advisable. The hope is that, out of the analysis and discussion of the subject, guidelines for such decisions will emerge.

Once a policy decision has been adopted about financing, and the mechanisms for applying it and making it effective have been designed, it is also important to take decisions relating to the forms of organization since the efficient use of resources depends on them.

Theoretically, the basic alternative is a single system or organization that protects all the population, or one made up of many institutions for different sectors of the community but based on a single health care policy which

is assured through the adoption of appropriate regulations. In reality, this distinction is never so clear cut, since even in a unified system there are supplementary organizations.

In order to facilitate the analysis, it should be pointed out that among the structural alternatives which have been adopted in other regions of the world, and also attempted by some countries in the Hemisphere, and could constitute possible reorganization options, are the following:

1. Creation of national health services in which all the institutions and resources, including the private sector, form part of the single organization, subject to a single command and to a single administration which is under the authority of the government. Financing comes from general taxes. This approach, which is used in some European countries, usually requires sociopolitical and administrative changes that go beyond the compass of the health sector.

2. Organization of government services for most of the population, including the working population, usually under the authority of the ministry of health but with the possible continuation of private practice. Financing is provided basically by the State, and social security does not normally provide health care benefits. Where this is so, it only plays a financing function.

3. Organization of national health systems in which the different institutions are coordinated for the achievement of a common objective, namely, the provision of services to which all the population has equal access. In developing this approach, which is perhaps more viable, the following different forms have been attempted in the Latin American context:

- Concentrating provision of services around the ministry of health and reserving for social security schemes the roles of financing and direct administration of economic risks. Mixed government/social security financing, but there is also room for private initiative.

- Assigning to social security schemes the provision of medical services for all the population, whether or not covered by social security, for which the State subsidizes them, and leaving to the ministries of health a policy-setting role and also one of direct administration of environmental services. Financing is as in the foregoing case.

- Creating a new agency that will be responsible for providing individual health services for the population, whether or not members. Social security acts as the financing agency and the ministries as policy-setting agencies, the one administering directly the economic risks and the other the general public health services. Financing would also be mixed. In most cases, this is a compromise.

- Creating national health councils, coordinating committees, etc., which, under the command of the ministry of health or attached to higher governmental levels (Office of the President), are called upon to establish the desired harmonization with the decision-making levels that determine the national policy. Different systems of financing and payment of personnel continue to exist and compete. This alternative, which includes attempts at mixed forms of coordination at the level of the administration of the institutions themselves, usually represents the status quo, the postponement of solutions and, possibly, the perpetuation of the problems.

As in the case of financing, in the light of its political, economic and administrative situation, each country should find the form of general organization of the health service system which, being in accord with its particular circumstances, makes it possible to channel and harmonize the use of all the national resources for making the right to health care universal.

It has been pointed out above, but it should again be emphasized, that the adoption of a form of organization of the system does not presuppose the choice of a set of inseparable elements. Although the above-mentioned options could take care of fundamental aspects of financing and of the structure of the service system, there are other elements inherent in the operation of the institutions that affect the process of coordination and will therefore require consideration in discussion of the topic.

A deeper analysis of these elements is not in order here. This analysis is in fact the reason for the discussion. However, the importance of considering the implications of the factors adverse to coordination, which have been pointed out by the representatives of the various sectors consulted in preparing this work and mentioned earlier, must be emphasized. They include: the attitude of users and their leaders; the position of the personnel, particularly professional personnel, who participate in the provision of services; the legal and administrative provisions governing the institutions; cost control; the alignment of contributions and services in the social security health schemes, etc.

Whether these are one or many institutions, what is important is their consistent endeavors under a single health care policy. The determination of this policy and the definition of the means to implement it is a responsibility the State must not and cannot delegate.

There is no doubt that in all these areas there are still major questions that call for appropriate answers. Which guidelines or approaches derived from experience should be recommended to the countries for structuring their solutions? Which areas should be further explored through systematic research designed to obtain new knowledge and new elements to underpin the decisions that are the basis of the coordination process? What is the role of international agencies and particularly of PAHO/WHO in this regard? And in what areas and at what levels would the technical cooperation of those agencies be more advisable in supporting national efforts for coordination?

Annexes

COORDINATION BETWEEN SOCIAL SECURITY SYSTEMS AND PUBLIC HEALTH

HISTORICAL BACKGROUND

Resolutions and Recommendations Adopted at the Inter-American Level

1. INTRODUCTION

In examining the present status of relations between the various systems that provide both outpatient and institutionalized personal health services in Latin America and Caribbean countries, it is essential to recognize the various important developments in the international and national spheres that have come about over the past 20 years, especially some that are significant in the process of institutional coordination, the subject of this paper.

First, one of the landmarks is the clear intent, beginning in the Region of the Americas at the end of the 1950's and the beginning of the 1960's, to achieve a more rational channeling of economic and social development, defining plans and programs for both operations and capital investment according to specified goals and terms, within a framework of intra- and intersectoral priorities. This intent, tending to localize responsibility and the need for planning at the central level of government as a prerequisite for decision-making, is directed at achieving a redistribution of benefits and income from development, accelerated improvement in the well-being of marginal population groups and equal opportunities for all members of the society. It also relies on the technological approach to national problems and solutions.

In this context, which reflects a value scale that is both humanistic and technologically oriented, planning for personal health services (virtually nonexistent prior to that time) emerges as a new model for the decision-making process, and its adoption implies a fundamental change with regard to existing situations and customary practice in the majority of the countries.

A number of private and public agencies and entities have participated in delivery of personal health services, in a strongly institutionalized Latin America, such as health ministries and departments, social security institutions, universities, charitable and welfare institutions, medical services of the armed forces, and the police and special medical services for private and public companies or groups of companies. At the same time there are the private medical services and hospitals--generally not institutionalized or only partly so, except in the case of the "mutual societies" in Argentina and Uruguay that are relatively unimportant in terms of the size of the population groups covered but significant in terms of the large proportion of the total funds spent for health that are channeled through such services.

As a consequence of such institutional diversity and the broad political, financial and administrative autonomy enjoyed by all of these institutions, the decision-making process was, and largely continues to be, extra-institutional, pluralistic (reflecting the essential compromise required between such diverse currents of opinion) and piecemeal in attempting to solve problems, one by one, as they arose. The model proposed by planning is, on the other hand, interinstitutional, rational and global or comprehensive, more suited to a pyramidal, unified and integrated health care structure than to the existing extended horizontal structure.

Attempts to develop such a model, and especially the design for methodology to arrive at an accurate and reliable measurement of the state of health in the community, the actual utilization of services and their impact on population at the same time that they contribute importantly to strengthening and technification of the health ministries, leads to the necessity of seeking out and finding new ways of organizing economic and human resources available in the health sector as a whole, to provide adequate care for the entire population.

Application of the humanistic principle of redistribution of care in the health sector (stemming from the overall development policies that were formulated and the consequent need to give concrete expression to the new forms of organization) inevitably means conflict with the established pattern for distribution of resources and benefits, and with the existing institutional interests and autonomy.

In the multi-institutional scene thus described, the social security systems emerge on a level with the health ministries, revealing in their origin the influence of Bismarck's Europe of the late 19th century when, with a motivation and spiritual values different from those that inspired the movement to rationalization referred to, the administration of insurance compulsory for specific occupations and financed through employer-employee contributions was left in hands of the existing Funds--that until that time had managed partially voluntary sick benefits. It is noted that such Funds acted solely as financing agencies and did not directly deliver the health services.

This general mechanism, with the important modification that the Funds became direct administrators of the services, was almost invariably repeated in most of the Latin American countries during the first half of the present century, which in turn gave birth to health services in the social security system. Such independent development was almost inevitably subjected to the influence of pressure groups (with the consequent need to devise formulas to accommodate the diverse interests). All of the foregoing was translated into greater limitation of the participation of these institutions in overall planning for the health sector.

In the complex of circumstances described, the conception of cooperation-coordination-integration of health care systems in each country was based on, and limited by, existing social, methodological and political realities. The closely related conceptions of extended coverage to rural areas, a policy for training professional and executive-administrative personnel, financing the health services and achieving a balance between collective and individual health services are hence in a similar situation.

It is in this context that the various declarations on the subject discussed herein have been produced, a context in which an evolution may be observed from the initial proposal of an integrationalist, planning and operating mechanism (1961-1962) to the pluralistic cooperation and/or coordinating mechanism encompassed in the concept of a health system in 1972. For purposes of a more orderly presentation, that in general coincides chronologically with significant events that have marked this trend, this summary review of recommendations made in the inter-American forum over the years 1959 to 1976 has been divided into three periods covering, respectively, the years 1959-1966, 1967-1971, and 1972 to the present.

2. RECOMMENDATIONS AND RESOLUTIONS

2.1 Initial Period, 1959-1966

2.1.1 A meeting of social security experts organized by the OAS in 1959 recommended that the latter Organization sponsor a study to examine relations between the social security medical services and those of other national institutions. The Monograph 1/ resulting from the study of five Latin American countries 2/ established four important points:

(a) the national base and source of funds for financing of social security, whether through taxes--when the State is one of the contributing parties--or through an increase of industrial prices or from the protected worker groups;

(b) the financial and operational autonomy of the social security institutions (SSI) designed to protect them from the vicissitudes of political instability. Such autonomy, Roemer concluded, may have led the institutions to implement decisions and programs that were poorly coordinated with other governmental medical care programs.

1/ Roemer, Milton I. "Medical Care in Latin America." OAS/PAHO Studies and Monographs III, Washington, D.C., 1963.

2/ Brazil, Costa Rica, Chile, Mexico and Peru

(c) the tendency of the social security institutions to become the organizers and administrators of health services for their members (the system of direct delivery of services) instead of discharging a purely financing role, buying services in private and public institutions (the indirect system). The shortfall of public hospitals, availability of a greater volume of funds and hence per capita benefits in the social security institutions and the preservation of their independent power, were noted as the principal causes of this trend;

(d) the marked inequalities created by the social security institutions' programs, since they concentrate an important proportion of health resources on a small percentage of the population.

The final chapter of the Monograph proposes the separation of the organization and the financing of health services. It recommended that prompt and definitive steps be taken (allowing appropriate flexibility) in the direction of integrating all of the health care systems into a single national service, planned and organized under the authority of the health ministry. Such a national service should be financed, over the short and medium term, through multiple channels, but with a future trend toward an increase in the proportion of funds derived from general revenues. In this way, a unified administrative system would precede the unified funding system, achieving the desired universal coverage with equitably distributed high-quality services.

2.1.2 While the recently revised Monograph was in preparation, two international meetings of importance were held:

2.1.2.1 In September 1960 representatives of the 21 American Republics were meeting in Bogotá, Colombia, to recommend "Measures for Social Improvement and Economic Development Within the Framework of Operation Pan Americana." The resolutions adopted are set forth in the "Act of Bogota," 3/ where it was recommended in the section referring to public health that public medical services be extended to the areas most in need (the rural areas) with "progressive development of health insurance systems, for maternity, accidents, disability and others, in urban and rural areas." 4/

2.1.2.2 In August of 1961, at Punta del Este, Uruguay, the Alliance for Progress was officially launched, of which Resolution A.2 established the Ten-Year Health Program. Among other things, it was recommended that ten-year health plans be prepared; planning and evaluation units be set up in the ministries of health integrated into the national planning mechanism;

3/ Pan American Union, General Secretariat of the OAS. "Act of Bogotá," Washington, D.C., 1961.

4/ Idem, p.7.

and organization and administration of national and local health services be improved, assuring financial access to such services for the entire population. 5/

2.1.3 In 1959 the International Labor Organization convoked the First Coordinating Group, designed to coordinate international support activities for social security in Latin America. 6/ This Group was defined as a multilateral effort to promote coordination programs and activities of the participating institutions so as to avoid duplication in research and studies, publications, etc. Coordination meetings of international advisory services acquired increasing vitality in the period 1967-1971.

2.1.4 In August 1962, the XVI Pan American Sanitary Conference met in Minneapolis, Minnesota. At that conference the Technical Discussions were directed to a study of the status of medical care in the Americas, with a view to its incorporation as the basic service in an integrated health program. The central theme was the relationship between programs for the protection, promotion and recovery of health, noting that the artificial separation of these fields of activity should be avoided in the future. With regard to financing, two aspects were highlighted:

(a) The obligation of the State to protect the health of its inhabitants, concluding that "the State has an obligation to the needy and must offer them services of an integrated nature through the types of organizations that are grouped generically under the denomination of public service, which does not imply that it must necessarily administer such services but may delegate certain functions in part or in whole." 7/

(b) The great extension and independence of operation of the social security medical services. In this sense it "recognized the progress made by social security in coverage of physiological, pathological, professional and social hazards, but there are important reservations on the high costs that result from independent administration and operation, on the discrimination introduced between insured and uninsured, on the competition from which it benefits in the recruitment of professional personnel and the resistance that a regimen of independence presents to effective coordination and integration." According

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5/ Pan American Union, General Secretariat of the OAS. "Alliance for Progress," Washington, D.C., 1961, pp. 30-31.

6/ The group consisted of the International Social Security Association (AISS), the Permanent Inter-American Committee on Social Security (CPISS) the Ibero-American Social Security Organization (OISS), the OAS and the ILO.

7/ Pan American Health Organization. "Atención Médica: Bases para la formulación de una política continental." PAHO Scientific Publication 70, Washington, D.C., November 1962, p. 103.

to these reservations it was recommended that the "social security institutions be assigned the primary function of financing that there must be in an integrated system of health services, since responsibility for the services must be in the appropriate ministry." 8/

2.1.5 Another important landmark in this initial period was the resolution approved by the Ministers of Health of the Americas at the I Special Meeting, held in 1963, which reads:

> "The ministers of health should take steps to secure the legal and institutional instruments required for effective coordination of the planning and executive elements responsible for preventive and curative services of the State, as well as coordination between these and private, semiautonomous and autonomous organizations providing health services of any type. The aim is to incorporate medical care activities of those institutions, including hospitalization, into the basic health services at all levels--local, intermediate or national--with the final objective of attaining a progressive integration of these services. Preventive and curative services are but parts of an integral whole. 9/

2.1.6 It is important to point out the consensus that had been reached by 1963. Concern with extension of coverage to rural areas and to the less favored groups, the decision to eliminate inequities in access to services and quality of services, the desire to increase efficiency by reducing administrative and structural duplication, and integration of preventive and curative services called forth three well-defined responses: planning by the central government of integrated health services; organization and administration of such services by the health ministries; and financing from multiple sources but principally from general revenue sources and from social security contributions.

However, this general consensus was not accompanied by an in-depth examination of the difficulties to be faced in attempting to implement it, or of the economic, social and political considerations that had grown out of the peculiar configuration of the health sector in the Latin American countries. Even more significant, this general consensus on the structure that ought to be given to the sector emanated primarily from the interaction between PAHO and the OAS on the one hand, and the health ministries on the other. The social security authorities, the medical schools and the professional health associations did not participate directly in this initial round of talks.

8/ Idem.

9/ Pan American Health Organization. "Final Report, Meeting of Ministers of Health." PAHO Official Document 51 (1963), p. 37.

Such initial accord reflects almost exclusively the interests of the health ministers. Since per capita expenditures of the social security institutions are considerably higher than those of the ministries, the act of sharing resources would improve services delivered by the latter, would eliminate discrimination and would make it possible to expand coverage without having to resort to an increase in taxes or in the proportion of the central budget earmarked for health. These last-named courses had proven difficult; on the other hand, there was less resistance to the tax represented by social security contributions. Such a redistribution of income from the most active economic sectors (workers in commerce, industry and public administration) in favor of the more needy groups would be strongly resisted by the social security authorities who were drawn into the deliberations in the latter stages of this first period.

In the second place, the proposal was attractive to the ministerial authorities, since monopoly of organization and administration of a health system for such broad segments of the population (social security beneficiaries and the needy or indigent) would substantially increase their power.

2.1.7 As a follow-up to the meetings previously cited, the Executive Committee of PAHO, at its 50th Meeting,10/ resolved to include the topic, "Study of Relationships between Social Security Medical Programs and those of the Health Ministries and Other Official Health Agencies," on the agenda of the XV Meeting of the Directing Council, which was held in Mexico in September 1965. In the course of the last-named meeting, a substantial change with regard to the preceding resolutions was noted for the first time. While it was recognized that allotment of resources between social security medical programs and those of the ministries was not equitably balanced, and that such balance could only be achieved through health planning under the sole authority of the health ministries, it was established that "relations between them (the social security institutions) and the ministries of health should be increasingly closer, through coordination of all services, it being clearly understood that coordination is not submitting, but living in freedom on the basis of mutual aid."11/ Furthermore, it was pointed out that each country should maintain absolute freedom to resolve this question in the way best suited to its individual interests, resources, legal structure, etc. Likewise, the Director of PAHO observed that the topic involved complex political, financial and institutional considerations and should be approached with caution. He suggested the establishment, jointly with the OAS, of a study group that would make a technical analysis of the subject and propose concrete measures.

2.1.8 It is appropriate at this point to recall another meeting at the ministerial level, held in 1963 in Cundinamarca, Colombia, that is, the Meeting of Ministers of Labor, sponsored by the OAS within the framework of the "Alliance for Progress."

10/ Pan American Health Organization. Official Document 60, p.213.

11/ Pan American Health Organization. Scientific Publication 129, p.9.

The Declaration of Cundinamarca recommended, among other things:

- extension, adoption and improvement of social security systems;
- integration of social security plans with national economic and social development plans;
- extension of international aid in the social security field and stepping up aid to the Inter-American Center for Social Security Studies, with headquarters in Mexico;
- financial support, within the framework of the Alliance, for the construction and equipping of hospitals, and promotion of health programs (especially preventive medicine) of the social security institutions. 12/

The contrast between the content and form of the two ministerial declarations is interesting, since it gives expression at the highest level to an underlying conflict that was evidenced during the meetings in 1964. In view of these differing positions, it was resolved to set up the Study Group, with representatives from the health ministries and the social security institutions, as well as from PAHO and OAS.

2.1.9 The Final Report of the Study Group which met in July 1965 represents an effort to formulate an agreement, for which the need had been made evident during 1964. With specific reference to the resolutions emanating from Punta del Este, the Group regretted the absence of the social security authorities at the said meeting and, as a consequence, from the movement toward planning and integration that grew out of the Alliance. "As a consequence of this circumstance (the absence of the social security representatives at the Punta del Este meeting), the statements contained in Resolution A.2 were very general in nature and did not take into account the influence of social security on socioeconomic development." 13/ Referring directly to relations between social security institutions and the ministries, the historical events in its development are cited, especially the direct form of delivering services, to explain the institutional prejudices between the two types of agencies. Nevertheless, it was understood that "one of the greatest obstacles to proper coordination is the fear, felt by both affiliated unions and social security authorities, that the funds collected in dues might, in a coordinated system, be used for other purposes or to make up the deficit in ministry of health facilities." 14/ Probably for these reasons, the group

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12/ Pan American Union, General Secretariat of the OAS. "Declaration of Cundinamarca," Washington, D.C., p.6.

13/ Pan American Health Organization. Administration of Medical Care Services: New Elements for the Formulation of a Continental Policy, PAHO Scientific Publication 129, 1966. p.50.

14/ Op cit, p.51.

reached the consensus that the majority of Latin American countries were not ready for integration of services, understanding such integration to be the complete administrative and financial unification (a type of national health service).

As a desirable alternative, the concept of coordination was defined as "an orderly arrangement in the use of all the available manpower and material resources in the various public and private health care institutions," 15/ with the institutions maintaining their administrative individuality and financial independence.

It was resolved to recommend extension of social security converage to rural populations, financing such extension through land taxes, promoting coordination, basically at the level of program execution, and standardizing contributions and benefits of the various social security medical programs in each country. Likewise, it was unanimously resolved to foster a positive attitude in the medical profession toward the social aspects of medical care and the necessity of coordinating efforts of the various institutional groups.

Three points that later acquired considerable importance were outlined by the Study Group:

(a) Maintenance of the independence and autonomy of the social security institutions, especially those with direct health services, vis a vis the ministries;

(b) The need to seek measures to improve the overall efficiency of the system that would be feasible from the political standpoint;

(c) The need to change the social awareness of the group that has the greatest weight in the health sector--the medical profession--so that implementation of the desired principle of redistribution might gain an important ally.

2.1.10 The year 1966 arbitrarily marked the end of this initial period. In the course of that year two international meetings were held:

2.1.10.1 The VIII Conference of American States Members of the International Labor Organization met in Ottawa in September, where the "Ottawa Program of Social Security for the Americas" was approved. At that meeting the governments, employers and employees, and directors of the social security institutions were represented, as well as the international agencies, including PAHO, which sent observers. The general philosophy of the program was set forth in the introduction, as an attempt to "indicate guiding lines for the development, the reform and the improvement of social security in the countries of

15/ Op cit, p.51.

America, so that it may be a real instrument of social policy and, in particular, an instrument for the equitable distribution of the national revenue which guarantees a balanced social and economic development." 16/

Pertinent to the topic under discussion, the following listed resolutions are of special interest: No. 2: Uniform Protection of Workers; No. 8: Maximum Priority to Extension of Social Security to Rural Areas and Their Working Populations, Financed Through National Solidarity, Common Social Security Funds and/or General Revenues; and, finally, Resolution No. 9, which is quoted in full, since it refers specifically to the field of medical care: "Medical assistance under social security schemes should be extended in particular beyond the urban centers and as broadly as possible. It is necessary to provide for appropriate coordination between the medical services of the social security institutions and those of the public health service and other medico-social services. In the rural areas in particular, this coordination should tend to forms based on protection of established communities or rural groups." 17/

2.1.10.2 Finally, the Technical Discussions at the XVII Pan American Sanitary Conference, held in Washington, D.C., October 1966, dealt with the topic: "Means of Promoting and Rendering Effective the Coordination Between Services and Programs of the Health Ministries, the Social Security Institutions and Others that Carry on Health-Related Activities." 18/ It is interesting to note that 17 (of the 73) participants were top-level officials of the social security medical services. The Final Report of these Technical Discussions reflects a philosophy similar to that of the Working Group that met the previous year:

(a) Maintenance of the independence and autonomy of the social security medical services. All of the groups agreed that the coordination of activities must not mean the absorption of one institution by another and, on the contrary, the juridical, financial and administrative independence of each participating institution must be respected and be allowed to discharge its legal obligations and social objectives.

(b) The need to seek general coordination measures that would be effective and feasible from the political standpoint. It was agreed that some of these measures might be:

16/ International Labor Organization. "Ottawa Program of Social Security for the Americas," Geneva, September 1966, p.3.

17/ Op cit, p.8.

18/ Pan American Health Organization. "Coordinación de los servicios médicos", OPS Publ. Cient. 154, Washington, D.C., October 1967.

- More emphasis on preventive and social aspects in education of the medical profession;
- Joint effort in the training of paramedical and administrative staff of the medico-social services;
- Joint effort to establish a common language and to improve interinstitutional information systems;
- Broad-based participation of all institutions of the sector in formulating health policy and in program planning;
- Promotion of standardization in social security medical programs with regard to the collection of contributions and delivery of medical and social services;
- Promotion of the extension of such programs to sectors as yet not covered.

(c) Finally, for the first time, the legal and administrative structures that would have responsibility for coordination were discussed. The importance of promoting coordination at the local, national and international levels, with flexibility to accommodate the differing circumstances of the various countries, was indicated, and there was a consensus that establishment of coordinating agencies at all levels should be fostered in the governmental agencies and in the other institutions responsible for public health in the countries.

2.1.11 It is evident that the agreement reached in 1963 was no longer valid in 1966. Joint participation of representatives from the various interested institutions had so modified the solutions earlier proposed that they were no longer directed to executive integration but rather to coordination among autonomous and independent agencies.

2.2 Intermediate Period, 1967-1971

2.2.1 It is of interest to refer to two articles presented at an international seminar organized in 1967 by the University of Wisconsin, with the cooperation of the Social Security Administration and the Agency for International Development of the United States of America, to discuss the role of social security in economic development, since they reflect the thinking of the academic world.

In the first, Professor Brian Abel-Smith 19/ justifies the rationalistic approach to planning for health expenditures, especially in the underdeveloped countries, and analyzes the types of decisions that would logically arise from such an approach: emphasis on preventive medicine programs, use of health auxiliaries, etc. In examining the role that medical programs of the social security institutions have played in development of the health sector in these countries, Professor Smith concludes that it is preferable to create a national health service (unified structure), basing his argument on the following factors:

- The necessity of developing preferably the preventive rather than the curative services, since the latter appear to have predominated in the social security systems.

- The effects of health services are often of a collective nature, which frequently results in benefits to third parties.

- Population groups with capability of paying higher taxes (or contributions) tend to enjoy a disproportionaly higher level of health benefits under the social security schemes. However, groups with less resources, either through taxes or the payment of higher prices, also contribute, at least to some extent, in financing these schemes.

- For the reason that they are limited to the modern sectors of the economy, the social security systems tend to develop more complex levels of health services that would be very costly to extend to the rest of the population.

In the second article, Marshall Wolfe, of ECLA, describes social security as a sector characterized by compartmentalization and administrative autonomy, a focus for strong and complex political pressures, and by protection of bureaucratic interests that it would be difficult to break. 20/

In his opinion, there has been created a strong opposition to economic and social planning on the part of "...the social security administrations and the organized social forces (the unions) that have been able to wring disproportionate benefits from the systems cannot help being aware that subjection to planing would mean painful changes, the cutting back of special privileges, and hypertrophied bureaucracies, and new principles for the obtaining, investing and distributing of social security resources." 21/

19/ Abel-Smith, Brian "Health Policies and Investments, and Economic Development." In: The Role of Social Security in Economic Development, U.S. Dept. of H. E. W., S.S.A., O.R.S., Research Report No. 27, Washington, D.C., pp.223-238.

20/ Wolfe, Marshall, "Social Security and Development: The Latin American Experience." In: The Role of Social Security in Economic Development, U.S. Dept. of H. E. W., S.S.A., O.R.S., Research Report No. 27, Washington, D.C., pp.155-185.

21/ Idem, Op cit, p.157.

Both articles, as may be observed, were highly critical of social security institutions in Latin America. While the generalized nature of these observations does not permit establishment of the fine points of differences in each individual situation, it does make clear the problems that the movement toward integration was encountering in Latin America.

2.2.2 Meetings to coordinate activities of international agencies that had been initiated in 1959 were resumed in 1967. It was decided to accord the matter greater importance, calling for meetings every two years, with exchange of reports on an annual basis on the activities to be carried out, and calling for special coordination meetings on specific topics, coordinating publication programs, scientific research works and manpower training.

2.2.3 In October 1967, the XVII Meeting of the Directing Council of PAHO adopted Resolution XX, point 3 of which reads:

> "To recommend to the countries that they undertake, as part of economic and social development, broad and coordinated planning of the health sector in which all the agencies concerned participate, especially social security institutes that provide health services, with a view to (a) providing, with participation of the community, as extensive coverage as possible in keeping with the main health problems and the capacity of the resources to satisfy the demand for services; (b) drawing up local integrated health programs covering both the preventive and the curative aspects of medicine; (c) organizing the local health service infrastructure on the basis of the decentralization of administration through a coordinated and regional system of hospitals and other health services; and (d) having universities and especially medical and paramedical schools participate in order to ensure the joint education and training of personnel necessary for reaching national health goals." 22/

It may be seen that emphasis was given to points of a doctrinal nature that, while they did reveal the general direction toward extension or coverage and local operating integration, were still sufficiently broad so as not to compromise the highly disparate national positions as to specific mechanisms. It is also interesting to note the call to the universities, especially medical schools and other teaching institutions in the health-related field, based not only on the predominant role such bodies play in the ideological training of professionals and administrators, but also on the influence they can exercise in formulating health policies.

22/ Pan American Health Organization. "Final Report of the XVII Meeting of the Directing Council." PAHO Official Document 82 (1968), p.77.

2.2.4 The VIII Inter-American Conference on Social Security (CISS) held in Panama in February 1968, accorded high importance to relations between social security institutions and the other agencies delivering medico-social care, and in a spirit similar to that of the earlier resolutions, agreed:

(a) To recommend that the member countries that do not as yet have a national planning agency create one in which the institutions related to the health sector may participate.

(b) To recommend vigorous action in promoting coordination of these institutions, following a methodology that will render their efforts effective, in accord with the characteristics of each country.

(c) To recommend to member countries the incorporation of the universities into the program of coordination, through manpower training and research studies. 23/

2.2.5 In October of that same year, the II Special Meeting of Ministers of Health was held in Buenos Aires, Argentina, at which two recommendations of very similar tenor were adopted:

"7. Systems should be set up in each country without delay for the effective coordination of the health services of ministries of health with those of social security institutions, universities, and other private and public bodies. To assure that coordination is effective, it should be a permanent activity of all those who participate in the process of planning, administration and the provision of services under the guidance of the health ministries or the corresponding agencies. In this way, closer institutional links will be forged at the central level, regionalization will be achieved at the intermediate level, and integration of curative and preventive services at the local level.

"8. We recommend that the countries prepare, as an integral part of their national health plan, a program for the construction, remodeling, and maintenance of hospitals and other health facilities, geared to the available resources and in consonance with the economic and social development investment plan." 24/

23/ Permanent Inter-American Committee on Social Security. "Influencia de la seguridad social en el progreso médico científico". Presentation to the First American Congress of Social Security Medicine. Seguridad Social 56, p.278.

24/ Pan American Health Organization. "Final Report and Speeches: II Special Meeting of Ministers of Health of the Americas," PAHO Official Document 89 (1969), p.43.

2.2.6 In January 1969, the First American Congress of Social Security Medicine met in Mexico City, at the convocation of the International Association on Social Security (AISS) and the Permanent Inter-American Committee on Social Security (CPISS). In its medico-social orientation, this Congress was by preference dedicated to problems of administration and coordination of medical services.

In response to the presentation of the AISS, "Medical Care Services of Social Security in the World," the Congress showed marked concern at the lack of coverage for majority groups of the population. Since this unprotected group is generally the one most in need of health services, the Congress ratified the "numerous declarations and resolutions adopted in the inter-American field in favor of a close collaboration and coordination of all entities that, in the national sphere, are concerned with health in any of its aspects." 25/

Dr. A. L. Bravo, in behalf of the Pan American Health Organization, presented a paper: "Social Security Medicine and National Health Programs," strongly favoring integration: "The final objective that is being sought is total technical, administrative and financial integration of services organized by the State to meet the health needs of the community." 26/ He further stressed the need for the activities of the national coordinating committees to penetrate down to the local operational levels, recognition of the competence and higher responsibility of the health ministries, regionalization at the intermediate level and integration at the local level. More specifically, Dr. Bravo outlined solutions that the Congress might have adopted as its own. As an example, he explained that "the regionalization proposed by PAHO is one in which all of the health resources of the Region are coordinated under a single technical-administrative command, designed to avoid duplication in execution of health programs." 27/ He went on to explain that "an organization of this type demands a high degree of delegated authority and especially demands the designation of a common regional director who is the highest health authority in the region and who can count on the delegated power of all signatory (concurring) authorities having services in the corresponding region." 28/

The Final Report of the Congress with regard to this presentation was extremely cautious, recommending among other things that a survey be made of the resources and their utilization, and that common statistical and administrative methods be adopted by all of the institutions.

25/ Permanent Inter-American Committee on Social Security. International Association on Social Security. "Primer Congreso Americano de Medicina de la Seguridad Social. Consideraciones finales," Seguridad Social 56, pp.190-191.

26/ Idem, op cit, p.204

27/ Idem, op cit, p.206

28/ Idem, op cit, p.206

The CPISS, in its turn, prepared a paper on the topic, "Medical and Social Education of the Physician and Social Security," recognizing the fact that modern institutionalized medicine, as direct result of scientific progress in the field, demands a different ideological baggage when faced with scarce resources than the traditional education that prepares the doctor for the free and individualistic practice of his profession. On the understanding that planning medical education is a multi-institutional responsibility (involving universities, State agencies, social security institutions, medical associations, etc.), it was resolved to propose a meeting in which all of these agencies would be represented to study the required curriculum changes.

The American Regional Medico-Social Committee made its presentation: "Programs for Coordination between Social Security and the Public Health Ministries. Application and Results." This paper examined the unequal distribution noted in all of the countries between benefits received by the population covered by social security and those not covered, and described the institutional efforts designed to improve the situation.

However, the Final Report, in regard to this presentation, reflects the cautious spirit reigning at the Congress, simply pointing out the advantages of effectiveness in obtaining coordination, the lack of resources for coverage of the rural areas, the necessity of bringing about changed attitudes on the part of professionals and administrators, and of creating national coordinating committees to set up such coordination.

In conclusion, the Report reiterated the point that coordination does not mean competition or submission, but rather a mutual responsibility and compromise appropriate to mature individuals and systems.

In summary, this First Congress revealed doubts, responding in a somewhat ambiguous way to the same theme (for example, the presentation by AISS and that of PAHO), but primarily by not carrying the analysis of the financial impact of some of the positions previously adopted to their ultimate results. Many of the objections raised by B. Abel-Smith at the beginning of this period were tacitly accepted, but the economic, financial and structural roads to a solution of the problems do not seem to be clear, at least in part due to the political and administrative facts-of-life so succinctly described by Wolfe.

2.2.7 In the same year (1969) the International Association on Social Security (AISS) at its World Round Table, held in Oaxtepec, Mexico, prepared a document evaluating "The Contribution of Social Security Regimens to Public Health Programs," in which the final statement set forth the following points:

"That social security systems based on organized collective solidarity make a potent contribution to the objectives of an integrated health policy, recognizing the right to health as one of the basic postulates in the scheme of economic, medical and social benefits."

"That it is of primary importance to health care and the better utilization of the structures and resources devoted to this objective that effective systems of cooperation and complementarity be established at the national and international levels of the agencies responsible for public health and for social security, through mixed coordinating committees, technical committees for the study of common problems, and tools for joint planning and execution."

"That as result of the inadequate technical and financial resources available to public health and social security institutions, it is desirable that all of such resources be placed at the disposition of the whole population, based on the coordination of the several interested agencies." 29/

2.2.8 In August 1969, the Second Study Group, sponsored jointly by PAHO and the OAS, met in Washington, D.C.

The Final Report of this meeting constitutes the most complete document on the subject from the doctrinary standpoint, which doctrine was adopted by PAHO by means of Resolution XVIII of its Directing Council, meeting in October of the same year. 30/ The most salient feature of this meeting, in consonance with the current of opinion gathering momentum over the two or three preceding years, was the participation of the universities, specifically the medical schools and university hospitals, in the coordination process. Although there was general accord on the goals to be sought--extension of coverage, elimination of inequities and improved administrative procedures--some differences of opinion in the matter of strategy were evident in the Final Report.

This Final Report is divided into four chapters:

(a) In the first, "Coordination in the Formulation and Execution of a Health Policy," the major difficulty seems to have developed with regard to the need and/or desirability of coordination as a preliminary step toward complete integration of the health services. "The majority of members of the Group agreed that coordination is a mechanism which is always necessary and which makes possible steady

29/ International Association on Social Security. "Mesa redonda mundial sobre la contribución de los regimenes de seguridad social a los programas de salud pública. Informe Final. Declaraciones Oaxtepec." Seguridad Social 58-59, p. 77.

30/ Pan American Health Organization. "Coordination of Medical Care," PAHO Scientific Publication 201, Washington, D.C., 1970, p. 71.

and orderly progress toward the ideal goal of integration of services. Some participants, however, advocated immediate integration without passing through the transitional stages of coordination." 31/

(b) The second chapter referred to "Coordination in the Provision of Health Care," discussing the alternative between programs of high technical complexity and high costs for limited population groups and basic medical care programs with broad coverage. The consensus, necessarily ambivalent, was that "from the medico-social viewpoint it is desirable to achieve as broad coverage as may be possible, of a quality compatible with the present advances in the medical sciences and with the available resources." 32/ As a desirable example, reference was made to the intensive care units, complemented by the progressive medical care services.

(c) In the third chapter, the report argues in behalf of coordination in developing manpower resources and recommends closer liaison among the responsible authorities for the purpose of participating in planning, execution and evaluation of a national health policy. Emphasis was given to the need to reorient medical education at the undergraduate level, to the desirability of carrying on the joint continuing education of personnel in all of the institutions and to the necessity of developing education for specialists at the postgraduate level.

(d) The fourth chapter, referring to "Coordination of Financing," was unquestionably the keystone of the problem. There was agreement on according priority to the development of outpatient care, to standardizing hospital administration of all institutions, and to fostering the joint use (under contract) of installed capacity. Two resolutions adopted on this topic are especially significant. "It was noted that the installed capacity must be considered as common property, which belongs to the country and which must benefit all its inhabitants without discrimination, irrespective of the institution that owns the establishment." 33/ According to this doctrine, it was resolved "to recommend establishment at the national level of a joint fund toward which would be channeled the resources (of capital) of all national institutions interested in the medical care programs existing in the country." 34/ Unfortunately, it was

31/ Op cit, p.5.

32/ Op cit, p.8.

33/ Op cit, p.15.

34/ Op cit, p.17.

not made clear who would manage this fund, thus the opportunity was lost of providing the national coordination committees with the necessary power to implement these decisions.

2.2.9 As evidence of the far-reaching effects that consideration of the various aspects of medical education had acquired in coordination of health services, the Second American Congress of Social Security Medicine was held in Bogotá, Colombia, in 1970, at which the central theme was "Social Security and Medical Education." At this meeting, topics of discussion were health manpower education in relation to social security and the teaching of social security at the universities, participation of social security personnel in teaching programs, evaluation of the contribution of social security to these programs, joint participation of medical schools and social security institutions in procedures for health planning and coordination among all of these institutions, aimed at maximum utilization of health resources. These last-named topics were developed in depth by the Vice Minister of Health of the host country, who proposed among other measures, to:

- gradually unify the medical care activities in the various health services;

- utilize to the maximum extent all installed capacity;

- decrease the autonomy of institutions that would later form a part of the national health system and not encourage establishment of new independent agencies for medical care;

- consolidate the financial contributions of social security systems;

- create a social security service with medical care for the entire community, closely coordinated with the academic and private sectors to constitute the national health systems. 35/

It should be recorded that, for the first time, a diminution of the independence enjoyed by the social security institutions was being proposed in the atmosphere of a congress sponsored by these same institutions.

2.2.10 During the year 1970, another international event with impact beyond that of the Region took place, in the form of a meeting of the Joint ILO/WHO Committee of Experts to discuss the current situation of personal health care and social security. Marking the spirit of the meeting, Dr. Halfdan Mahler, Assistant Director-General of the World Health Organization, focused

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35/ Comisión Regional Americana Médico Social. "Participación conjunta de las facultades de medicina e instituciones de la seguridad social en la planificación para la salud." Presentation to the Second American Congress of Social Security Medicine. Seguridad Social 66, pp. 103-138.

attention on the "discrepancy between the need to provide the best possible personal health care to rapidly growing populations, and the dramatic increase in costs that have placed such care beyond the reach of many individuals in many countries." Dr. Mahler pointed out that the "...lack of coordination of social security systems with national health policy and programmes has proven an obstacle to achieving optimal results.... It seems timely to develop a converted approach to the planning, administration and financing of personal health services." 36/

In the chapter, "Organization and Control of Personal Medical Care Services," the Committee made it clear that "any attempt at coordination meets practical and political difficulties, since the health services and the social security services are under different jurisdictions, which exercise different degrees of control...." 37/

The report later describes the examples of Mexico, Guatemala and Japan as countries in which there is a full separation between the administration of public health and administration of social security, and then refers to those countries of Western Europe and India, where there is a moderate amount of coordination. In the latter cases, it is evidenced that "the results are good where one ministry is responsible for both health and social security." 38/

Finally, the report recognizes that "some countries have managed to integrate the organization of personal health services for the whole population with the financing machinery with which the cost of these services is met. The whole is administered by the ministry of health. In countries with this type of system, the financing of personal health care is facilitated by the relative ease with which government revenues can be allocated, and adjusted when necessary." 39/

In summary, in its conclusions, the Joint ILO/WHO Committee of Experts recommends that the medical service of a social security system ought to be complete, that is, preventive, curative and rehabilitative. It should be formulated within the context of the general plan for health services at a national level, incorporating in this way the social security programs into the national public health plan of the country.

36/ World Health Organization. "Personal Health Care and Social Security, Report of a Joint ILO/WHO Committee." Technical Reports Series No. 480, Geneva, 1971, p.5.

37/ Op cit, p.16.

38/ Op cit, p.18.

39/ Op cit, pp. 19-20.

2.2.11 In 1971 there was no lack of opportunity in the international sphere, at both regional and subregional levels, to discuss this topic. In effect, representatives of the ministries of health of the six nations constituting the Central American Isthmus, their social security institutions and their medical schools, met to exchange ideas on topics directly related to coordination, such as: extension of coverage; integration of preventive, curative and social activities; coordination of statistical information; and the mechanisms for immediate application of a program to achieve coordination.

At the IV Colombian Public Health Conference, Dr. A. L. Bravo presented a paper, that was later to be published by the Pan American Health Organization, 40/ which once again defined the conceptual and methodological aspects of coordination and integration of services, and also included a series of concrete steps that must be taken to achieve the described objective.

2.2.12 Finally, the presentation covering this period is completed with a brief reference to an article by Professor M. I. Roemer on the justification for social security programs in underdeveloped countries. 41/ After recognizing the inequities created by medical programs of the social security institutions in the developing countries, Professor Roemer marshals various reason for the imbalance. In his opinion, these programs exist, they are necessary and even beneficial; social security funds increase the percentage of the GNP devoted to the social sectors; they are more stable than funds accruing from general revenues; they are utilized more efficiently than if they were channeled through private practice; they probably increase the resources of the health ministries; they promote an increase in the formation of health professionals and above all they meet the needs of a sector vital to economic development--the urban industrial worker. Many of these reasons are strictly conjectural since they cannot be supported by solid observation, and Professor Roemer acknowledges this fact. Later, the same author has presented somewhat more detailed evidence to justify this argument that greater expenditures on the social security medical programs increase (and do not reduce) the funds available for the more needy groups through the ministries of health. 42/ Professor Roemer does, however, highlight the need to coordinate medical services in these countries. "Many of the problems faced by ministries of health in Latin America and elsewhere have been caused, not by the existence of social security programs, but by their independence and separatism, with respect to

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40/ Pan American Health Organization. "Health Systems." PAHO Scientific Publication 234, Washington, D.C., 1972.

41/ Roemer, M. I., "Social Security for Medical Care: Is it Justified in Developing Countries?" Int. J. Health Services I, No. 4, pp. 354-361 (1971).

42/ Roemer, M. I. and N. Maeda, "Does Social Security Support for Medical Care Weaken Public Health Programs?" Int. J. Health Services VI, No. 1, pp. 69-78 (1976).

salary levels, location of health facilities, and other matters," and pointing out later that "...coordination of both investment policies and programs between social security and ministerial bodies makes sense regardless of any priorities in the receipt of services that may be accorded to certain insured workers." 43/

2.2.13 The presentation describing activities developed during this period--that for lack of a better label might be called the intermediate period--reveals, in the first instance, the constantly increasing participation of the social security institutions in formulating an international doctrine on the matter.

Secondly, it appears to be a feature of this period to accord greater importance to the education of professionals in policies for coordination, and this growing importance is evidenced by the participation of representatives from the medical schools in the more significant events of the period.

In the third place, marked advances were made in defining the practical implications of the recommendations adopted, so as to constitute a concrete, albeit flexible, guide for the coordination process.

In the negative aspect, it is worthy of note that during this period very little progress was made in developing the scientific research needed to study the repercussions of various methods of financing and organizing health services to individuals. Despite efforts to improve the data banks in the various countries, and efforts to analyze data growing out of the planning movement, there was no success in obtaining any in-depth study of the assumptions on which the coordination movement is based. The work of Professor Roemer clearly and concisely highlights the need for this type of research that would reveal many of the unknowns that interfere with the practical application of the recommendations adopted.

2.3 Final Period, 1972-1976

2.3.1 Under the sponsorship of the Ibero American Social Security Organization, the V Ibero American Social Security Congress was held in Buenos Aires, Argentina, in April 1972. At that meeting, among other topics, organization and coordination of health services was discussed, with recommendations on the following points:

- gradual implementation of coordination, first seeking cooperation of all the interested institutions so as to move later toward effective coordination;

43/ Roemer, M. I., "Social Security for Medical Care: Is it Justified in Developing Countries?", Int. J. of Health Services I, No. 4, p. 359.

- establishment of national coordinating committees, with representatives of all interested groups, including the teaching institutions;

- creation of mechanisms for liaison among the coordinating entities and the national planning agencies;

- encouragement of integrated programs at the local level for the promotion, protection and recovery of health;

- promotion of coordination among the international agencies. 44/

2.3.2 The topic of relations among the ministries, the social security institutions, the academic world and other entities that provide health services was debated in this period at various international meetings.

2.3.2.1 Accordingly, during the VIII Meeting of the Permanent Inter-American Committee on Social Security (CPISS) held in Mexico in September 1972, some very interesting presentations were made in the course of the discussion on organization of the social security services that are of interest to repeat herein since they describe the reality that must be confronted.

Dr. Rafael Rizquez, representing Venezuela, stated: "...but it is a fact that, in speaking of a national health service for many Latin American countries, there is an absolute necessity of moving toward unification of health services since they can no longer be financed solely by contributions of employers and workers but require contributions from the State." 45/ Dr. Rizquez continued to describe two experiences in his country in the joint training of personnel of the health ministry and social security "...so that they may acquire a common language and understand each other," 46/ and concluding "I believe that this experience is interesting and sufficiently pragmatic, since while every one talks of a national health service, no one wants to give an inch anywhere, neither the social security institutions nor the health ministries; hence the only formula that we believe to be fair is that the technical people of both institutions complement each other and learn to know each other and acquire a similar education." 47/

44/ Permanent Inter-American Committee on Social Security. "V Congreso iberoamericano de seguridad social. Informe Final" Seguridad Social 79, pp. 92-93.

45/ Rizquez, R. (Presidente del Consejo Directivo, Instituto Venezolano de los Seguros Sociales). En: Seguridad Social 77-78, pp. 61-62.

46/ Idem.

47/ Idem.

2.3.2.2 Another interesting comment, that outlines the difficulties encountered in implementing Point 9 of the Ottawa Program, was made by the Social Security Department of the ILO in a symposium also held in Mexico in November 1972. After indicating that signs of increased understanding of the program and of the fact that extension of coverage would require a greater volume, and that a better utilization of resources could be observed, the point was made that application of coordination measures runs head on against "...the institutional individualism that tends to preserve a certain independence in the social security medical services. This is quite understandable if it is considered that the employers and workers who provide the bulk of the funds for such services are not disposed to bear the cost of health programs that benefit other population groups, whose medical and social protection ought to be a responsibility of the State as such" (i.e., to be financed from general tax revenues). At the other extreme, we find those who are responsible for national health policy who "...invoke the argument that the excessive independence of the social security medical services can produce distortions in the distribution of medical services and utilization of medical and hospital facilities that are not rational from the overall national viewpoint." 48/ The ILO document concludes with high praise for the efforts being directed to find an effective balance between the two trends evident in the movement, by creating coordinated health systems that will assign to the various institutions a useful and effective role in behalf of the community, keeping properly in mind the legitimate and impartial concerns of each group.

2.3.3 Probably at no other point in the historic process are the difficulties confronting the search for such a balance more clearly exemplified than during the debates growing out of the Third American Congress of Social Security Medicine, held in Panama in November 1972. Virtually all of the papers presented at this Congress were more or less directly related to the theme of organization of medical services, extension of their coverage and the coordination needed to carry out such a program. However, specific reference is made to two of them that reflect both the efforts made, as well as the difficulties encountered, in obtaining the desired balance.

Professor M. I. Roemer, representing the International Labor Organization, presented the paper: "Development of Medical Services in the Social Security Systems of Latin America." He reiterated many of the points made in his earlier presentations that have already been reviewed herein. Professor Roemer concludes that even when the picture of accomplishments is generally favorable, certain shortcomings must be noted, such as:

- lack of coverage for the majority of the population, especially in rural areas (less than 1/6 of the economically active population is protected);

48/ ILO. "Evolución y perspectivas de la seguridad social en América Latina." Presentation of the Social Security Department of ILO to the Symposium on Social Security. Seguridad Social 77-78, pp. 313-315.

- rising costs (due in part to abuse by patients as well as by doctors);

- deficiencies in maintenance of quality;

- maintenance of the distinction according to social class in the right to services and types of medical care for different population groups;

- lack of adequate evaluation of accomplishments of the social security medical programs;

- lack of initiative on the part of the social security institutions in efforts to coordinate their activities with those of the health ministries.

Professor Roemer concluded his presentation with the following observation: "Activities to coordinate the health services and national health planning...are more fundamental than the simple intention to improve organization. These coordination efforts are primarily a response to the intensified pressures all over the world to recognize the fact that medical care constitutes a fundamental human right of all citizens, and for the States to take practical steps aimed at achieving this goal. This is probably the direction that social security programs in Latin America will follow in the future." 49/ The Congress resolved to accept and make these conclusions its own, stressing the need to continue and increase coordination efforts. 50/

Nevertheless, this same Congress exhibited a highly cautious reaction to a proposal made by Dr. A. L. Bravo, representing the Pan American Health Organization, that goes to the root of the problem, that is, the quality and cost of medical care as factors in coordination. 51/

The argument that relates quality, quantity and cost of medical services may be summarized in the following terms: The demand for health services has grown impressively since the governments desire and are committed

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49/ ILO. "El desarrollo de los servicios médicos en los regímenes de seguridad social en América Latina." Presentation to the Third American Congress of Social Security Medicine. Seguridad Social 80-81, pp.187-188.

50/ Third American Congress of Social Security Medicine. Final Report. Op cit, pp.195-196.

51/ Pan American Health Organization. "La calidad y el costo de las prestaciones médicas como factores de coordinación." Presentation to the Third American Congress of Social Security Medicine. Op cit, pp.315-336.

to cover the totality of their population. The volume of human and financial resources is not sufficient to satisfy such an increase in the quantity of services required, for which reason it is essential to coordinate the resources of all institutions so as to increase their productivity and in this way improve coverage. There would be a positive and direct relationship between the quality and cost of services, and in turn important inequalities in the two parameters between those of the social security institutions and the health ministries, which would make coordination more difficult. Logically, increased coverage in a framework of limited resources could only be obtained either by substantial increase in productivity and/or by limitations on the complexity of the services. Dr. Bravo concludes his presentation with the statement: "All of the foregoing is demonstrating that the equalization of quality is an essential element of coordination, and is often a necessary prerequisite that must be implemented before the coordination process can be initiated. The most serious problem is that, as we have said, a higher level of quality is accompanied by an increase in costs, and the institutions, owners of the establishments, are often not in a position to face the financing of higher operating costs in a health facility. In other words, quantity, quality, cost and coordination are steps in the same process that can with difficulty be carried out in isolation but that, on the contrary, ought to be a harmonious sequence that is gradually implemented, the ultimate goal of which is to increase coverage and improve quality to meet the demand for services from the population." 52/

The response of the Congress was clear in pointing out in the Final Report its determined defense of the social security beneficiaries' right to receive the highest quality medical care, without any compromise whatsoever:

"1. The users have the right to receive integrated medical care of the highest possible quality and the social security institutions have the obligation to make the effort to provide it to its insured and beneficiaries. High quality implies coordination with other agencies including the teaching institutions.

2. Quality should be required at all levels of integrated medical services.

3. It is essential to evaluate the qualitative and quantitative quality of medical services, for which purpose it is recommended that systems having such objective be established.

4. The increased costs resulting from improved quality are fully justified provided they are accompanied by a rise in the health levels of the community." 53/

52/ Op cit, idem.

53/ Third American Congress of Social Security Medicine. Final Report. Seguridad Social 80-81, p. 339.

On the financial side, this increase in costs can be minimized through a proper use of resources to increase productivity.

It is noteworthy that there is no mention of the concepts of coverage and coordination in the justification for the increased costs.

2.3.4 Concurrently with this Congress, a meeting was taking place in Chile that was of exceptional importance to health services in the American countries: the III Special Meeting of Ministers of Health of the Americas, that had as its objective planning for a new decade (1971-1980). The Ministers declared that their principal problem was that of providing available services to 37 per cent of their populations that had received no type of medical care until that time. In this connection, they pointed out: "One of the problems that aroused most concern during our debates was the inadequacy of coverage and the short supply of health care for all citizens. Not infrequently we find that our programs are the legacy of an archaic system which served a useful purpose in the past but is noteworthy today for its limited accessibility, its prohibitive cost, and its decided inadequacy for the giver and receiver alike. It was pointed out in general that even in the developed countries poor persons, remote or isolated groups, and indigenous populations lack proper care." 54/

The objectives and recommendations adopted in the chapters "Health Service Systems and their Coverage," "Medical Care and Health Systems," Health Administration, Planning and Information Processes and Intersectoral Coordination," clearly and precisely define measures designed to achieve the stated purposes. 55/ Those most directly pertinent to coordination are noted:

- "Define, in each country, a policy for developing health service systems, in terms of a national or sectoral policy that will set the bases for redefining the health sector by delimiting its fields of action, and for defining its institutional components and the geographic coverage of the population and of planned programs."

- "Increase the productivity of the systems by implementing technical-administrative and legal reforms that will strengthen the organizational and functional structure and the normative and directing authority of the health policy of the ministries and secretariats of health."

54/ Pan American Health Organization. "Ten-Year Health Plan for the Americas: Final Report of the III Special Meeting of Ministers of Health of the Americas." PAHO Official Document 118, January 1973, p. 17.

55/ Op cit, pp. 72-79.

- "Regulate the sector and its administration to serve as a frame of reference, with such regulation presupposing the organization of a viable national health service system adapted to the needs of each country and the implementation of the recommendations made in the above points. The participation of the social security medical services is an important element of this system and should be in line with the policy and patterns set by each government."

- "Adoption as a goal for the decade of the creation of national health services to plan and coordinate the available resources within a health system adapted to the characteristics of each country." 56/

The general message to be drawn from the III Special Meeting is the serious concern and firm resolve of those responsible for health in the Continent to extend health service coverage to populations that have not received such benefits up to the present. The practical aspects of coordination should be evaluated in this context and implemented to the extent that they directly contribute to achievement of this objective.

2.3.5 In mid-1974 the Inter-American Conference on Social Security Planning met in Buenos Aires, Argentina. At this same conference two basic themes were emphasized: the need to approach social security in the broad context of general economic and social planning (and thus coordinate it with other activities of the public sector) and the necessity of extending its benefits to all of the population, transforming it into an important instrument for redistribution. In this sense, the conclusions reached by the Conference, most closely touching on the topic of coordination of social security and public health, were:

> "To the extent that social security planning ceases to be the tool of certain sectors, becoming an overall instrument for the community, it tends to move away from the relation between man and the job and approaches the relationship of man as a social being."
>
> "Social security planning in the economic sphere must not be based exclusively on the achievement of objectives by traditional contribution methods, but on the participation of national wealth through collective unified distribution systems." 57/

56/ Op cit, pp. 73-76.

57/ Inter-American Conference on Social Security Planning. "Informe final: Declaración solidarista de planificación americana de la seguridad social." (Resolutions Nos. 118 and 119). Mimeographed, Buenos Aires, Argentina, 1974.

2.3.6 Toward the end of 1975, the VI Meeting for the Coordination of Social Security Activities in the Americas was held in Geneva. At this conference, Dr. A. L. Bravo, representing the Pan American Health Organization, presented a paper in which he concludes:

> "The results (of ten years of effort to coordinate social security services and those of the health ministries) have been slow in arriving for the reason that the process is difficult, involving a period of study that is long and complex, and another of adapting to a new methodology, something that is not always easy to accept since it implies relinquishing a part of the traditional autonomy of institutions as a basis for their unification."

> "The most compelling motive that has inclined the health and social security authorities to a favorable attitude toward coordination has without doubt been the economic factor. The introduction of economic and social planning as an integral part of the government's activities in deciding on allotment of resources to the various sectors of the economy has influenced the sector's planning activities and has led to the conviction that planning can succeed only if it is carried on as an integral part of the country's economic and social development. Inter-institutional coordination within the sector is thus made an indispensable condition in presenting a coherent health program and competing successfully for appropriation of funds to the sector. Social security institutions have a preponderant role in this process since, as part of the economic sector, they are responsible for what has been labeled the redistribution of wealth or, in other words, they tend to create a capacity to consume goods and services in the weakest economic groups of the population. On the other hand, as the institutions administering services, they are intimately linked to activities of the health sector and contribute in substantial degree to its financing. To all of the foregoing should be added the fact that the majority of the countries have centered management of international technical assistance in the national economic and social planning boards or in other agencies closely linked to them. The result of the foregoing is that international technical assistance to the health sector as well as to social security is constantly being more openly channeled through integrationist mechanisms in which each sector is weighted on the basis of its capacity for development and incorporated in the national development program of each country." 58/

This final period has been characterized by a somewhat more intensive treatment of the topic. The central concern is to achieve extension of coverage, with appropriate services to all of the population of the Americas.

58/ Pan American Health Organization, A. L. Bravo "Coordinación de los servicios de salud con los de la seguridad social a nivel nacional," Mimeographed, November, 1975, p. 57.

Within this context the social security health services must be a part of a viable national system of health services directed to achievement of the main objective. Coordination and/or integration of their services with those of the health ministries again appears as a basic and essential component of such change.

SUMMARY:

1. During the period under review the topic, "Coordination of Services," has been the motive for extensive examination and discussion in numerous international meetings in which the participants, while invariably supporting the basic concept and its philosophy, have not always been in accord on mechanisms to be employed in their implementation.

2. Based on the documents reviewed, it can be seen that there is a consensus in views on benefits to be derived from coordination and integration of health services, especially with regard to the increased return from the invested resources and a more equitable distribution of benefits among the various sectors of the population. However, the emphasis on the two factors, integration and coordination, seems to have changed in the course of time.

3. Schematically, and in very general terms, the trend observed from a study of resolutions and recommendations adopted at these meetings suggests the division of the period into three more or less well defined stages:

- Initial period: With participation primarily by the health ministries, in which mechanisms for integration and unification to achieve greater efficiency and more equitable distribution of health services were favored (1959-1966).

- Intermediary period: With more active and, on occasion, preponderant participation of representatives of the social security institutions, in which solutions were offered designed to develop coordination and cooperation mechanisms to increase efficiency in the use of resources and to prevent duplication (1966-1971).

- Final period: That apparently reflects a period of maturation and serious thought, following the very active past decade, directed more to an analysis of the financial results than to the process itself. The topic was discussed in specific form in but a few meetings, but when it was broached the positions were perhaps more definitive than expressed in the earlier periods.

4. This evolution would appear to be very closely related to the relative loss of power and influence by the health ministries in terms of the development of the social security institutions. As a corollary, some deterioration may be observed in the conceptual handling of the problem, changing from an initial concept of integration of services to that of coordination of services, and even going so far as to discuss the various forms of cooperation or collaboration among the different institutions as a preliminary step to coordination.

5. On various occasions, the highest levels of the governments have reaffirmed their commitment to guarantee the right to health for all of their citizens and, as a consequence, their access to the necessary health services.

6. During this period, it was observed that the discussion was predominantly focused on administrative and structural aspects and only in part on the financial mechanisms, although the latter are as important, or more important, than the former in achieving the desired objectives.

7. It is possible to affirm from the review of the literature that the concept of coordination has been discussed on the basis of the personal observations of the experienced directors of the different institutions. However, it would appear that there is a gap in scientific study or research that would have made it possible to quantify the actual facts objectively, thereby enriching the possibilities of analysis.

COORDINATION BETWEEN SOCIAL SECURITY SYSTEMS AND PUBLIC HEALTH

Main Findings of a Survey

Introduction

In order to prepare the working document for the Technical Discussions, PAHO/WHO found it advisable to carry out two types of activity, the findings of which appear in this annex:

i) A survey of social security institutions in order to update information on the relationship between these institutions and the central government; the number, categories and location of their beneficiaries; the number and type of services provided; the financial arrangements for their health systems; and, finally, areas in which they cooperate with the ministries of health.

ii) Interviews with the directors of the ministries of health, the social security institutions, the employers, the workers and the press in six countries of the Region in which significant changes were taking place. These interviews were intended to provide a more direct impression of aspects affecting the coordination process and to find out the opinions of different sectors concerning this process.

This document consists of two sections (A and B) in which the principal aspects of information obtained from the surveys (A) and interviews (B) are presented and analyzed.

It should be clearly stated that answers received in Section A usually contain data corresponding to the principal social security institution or institutions in the country. Therefore, some of the data, especially that concerning the population covered, would be lower than actual absolute figures. This limitation was taken into consideration when processing the information, and whenever possible the data was supplemented. Whenever this was done, it is indicated in the document. However, this limitation of absolute figures does not invalidate the general principles which actually constitute the main reason for preparing the analysis.

SECTION A: INFORMATION FROM THE SURVEY

1. General Remarks

There are 31 countries in the Region that are PAHO members. The survey was not sent to two of them (U.S.A. and Canada). Of the remaining 29, eight did not respond. For these eight countries, the Bahamas, Cuba, Haiti and the territories linked to France and the Netherlands, the survey, for

reasons similar to those given by some of the other Caribbean countries, is less applicable than for the rest of the Hemisphere. Mexico, Nicaragua and Uruguay did not respond. Of the 21 countries responding to the survey, six felt that the problem being studied did not exist in their countries since their social security system does not provide personal health services directly. As a result, they did not feel it was necessary for them to provide information. These countries are Barbados, Grenada, Guyana, Jamaica, Surinam and Trinidad and Tobago. Paraguay's response was received after the publication of this document, which made it impossible to consider that information.

In almost all countries responding to the survey, the answers refer only to the principal social security institution or institutions. Only three countries sent information from more than one institution. This fact reveals the difficulties experienced by the countries themselves in obtaining this type of data from all of their institutions. Therefore, for those countries with several smaller social security institutions with health systems, the data reported has been taken as representative for that country in the field of social security. This limitation must be considered when interpreting the data.

Eighteen countries in the Region were identified in which there is significant coexistence between ministry of health services and services administered directly by social security institutions. These countries are: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay and Venezuela. Information contained in the thirteen answers received was supplemented in the cases of El Salvador, Mexico and Nicaragua with data from yearly reports published by their respective institutions.

It was at times very difficult to extract complete information to made it possible to find the object of the analysis in the answers received. However, attempts were made to check the data obtained by using other sources of information in order to insure correct interpretation. The sources and procedures used for handling the data have been indicated in each table or graph.

Nevertheless, on the whole, two general types of problems appeared. Attempts have been made to minimize the extent of these problems.

i) The relative exactness of some of the data which, like other data in the social science sphere, can be affected by distortions in the definition or methods of calculation. This problem becomes more serious when making comparisons between countries since the definitions may vary from one country to another. Therefore, the survey placed special emphasis on prior definition of terms.

ii) The relevancy of the period which was selected for study. This survey focused on the 1965-1975 period. It can be argued that in the field of health services coordination important events have occurred before, and especially after, these dates and that it is, in general, a very short period of time for making conclusive observations. It must be emphasized that the observations made at three points during the selected period can reflect dominant tendencies in the countries during these years. Therefore, these observations should serve as indicators for a longer period.

These two difficulties would make it advisable to check primary observations for each country presented by using a longitudinal analysis of coherent and complete series of data. The fact that only three observations were made during the period as well as interest in reaching regional conclusions made it necessary to use crossed comparison of information as the dominant analytical method in this task.

For purposes of this analysis, the results presented concern five principal aspects of social security institutions' health systems: unit, organization and financing, covered population, expenditures, costs and utilization, availability and yield of medical-hospital resources, and coordination with the ministries of health.

2. Unit, Organization and Financing of Social Security Institutions

Table 1 presents a synopisis of the structural characteristics of the health systems of social security institutions. The part of the central government to which the institution is related or to which it is subordinate (Ministry of Labor, Ministry of Social Welfare, Ministry of Health), the type of unit (usually an autonomous entity which is subordinate to another agency in political and policy-making matters), the existence of one of several main institutions (supplementary information), and the principal sources of financing (employer contributions, private and public, employee and/or State contributions).

In analyzing the table, it is interesting to highlight the cases of Brazil, Costa Rica and Chile because of the important role of State financing in these countries. These funds may come from general taxes or from taxes allocated specially for financing social security health services. FUNRURAL in Brazil, SNS in Chile and the hospitals transferred to CCSS in Costa Rica are preferably financed by State resources as such in an effort to expand the health system's coverage.

Similar policies for expanding social security services have been tested in Mexico (Social Solidarity Program), in Colombia (Integrated Rural Development) and in Panama for the expansion of health services in rural areas, although on a smaller scale than in the three countries mentioned previously. The distinction between traditional means of financing social security (tripartite or bipartite) and nontraditional means (preponderantly

TABLE 1

COUNTRY	STATE	SEMIOFFICIAL	RESPONSIBLE TO	DATE FOUNDED	ORGANIZATION	FINANCING
Argentina	X		In the Department of Social Security, an agency of the Ministry of Social Welfare.	1934	1. Several autonomous institutions coordinated through a central agency: National Institute of Social Works. 2. Combines direct delivery with services contracted from third parties.	Employee/employer contributions.
Bolivia		X	Autonomous institutions under the Ministry of Social Security and Public Health of the Bolivian Institute of Social Security (IBSS)	1949	1. Several autonomous institutions coordinated by the IBSS. 2. Direct delivery of services.	Employee/employer contributions.
Brazil		X	Autonomous institutions subordinate to the Ministry of Social Security and Social Welfare (MPAS)	1923	1. MPAS provides policy guidance and controls several institutions with executive autonomy. 2a. The National Institute of Social Security (INPS) contracts 90% of its services from third parties by payment for services rendered. 2b. FUNRURAL contracts 100% of its services from third parties through "capitation". 2c. Other smaller institutions with direct delivery of services.	INPS- employee/employer contributions. - state contributions for administration and deficits FUNRURAL- Special tax on agricultural transactions - employee contributions.
Colombia	X		Autonomous institution, Colombian Institute of Social Security (ICSS) attached to the Ministry of Labor and Social Security.	1946	1. Principal institution (ICSS) and several smaller institutions. 2. Preferably direct delivery of services.	Employee/employer and state contributions

(2)

COUNTRY	STATE	SEMIOFFICIAL	RESPONSIBLE TO	DATE FOUNDED	ORGANIZATION	FINANCING
Costa Rica	X		Autonomous institution, Costa Rican Social Security Bureau (CCSS) attached to the Ministry of Labor.	1943	1. Single institution (CCSS) which cooperates with the Ministries of Labor and Health. 2. Direct delivery of services.	- Employee/employer and State contributions. - State contribution increased upon transferal of hospital care to CCSS.
Chile Sermena		X	Autonomous institution subordinate in health policy to the respective Ministry.	1942	1. Institution cooperates with the Ministries of Labor and Health. 2. Direct delivery without contracting third parties, through payment for services rendered.	Employee/employer contributions.
Chile SNS	X		Directly subordinate to the Ministry of Health	1952	1. Autonomous institution although linked to the Ministry of Health 2. Direct delivery of services.	- State contributions. Employee/employer contributions from the Social Security fro Workers cover a minimal part of its budget (10%).
Ecuador		X	Autonomous institution under the protection of the Ministry of Labor and Social Welfare.	1935	1. Principal institution, autonomous. 2. Direct delivery of services.	Employee/employer contributions.
El Salvador	X		1. Autonomous institution, the Salvadorean Social Security Institute (ISS) subordinate politically and in administrative matters to the Ministry of Labor and Social Security. 2. ANTEL Hospital subordinate to the Ministry of the Interior.	1949	1. Two unrelated, independent institutions subordinate to different Ministries. 2. Both institutions deliver services directly	ISS financed by state, employee contributions.

COUNTRY	STATE	SEMIOFFICIAL	RESPONSIBLE TO	DATE FOUNDED	ORGANIZATION	FINANCING
Guatemala	X		Autonomous institution, Guatemalan Social Security Institute (IGSS) subordinate to the Ministry of Labor and Social Security.	1946	1. Principal institution is autonomous. 2. Direct delivery of services	By state, employer and employee contributions.
Honduras		X	Autonomous institution, Honduran Social Security Institute (IHSS) subordinate to the Ministry of Labor.	1952	1. Principal institution is autonomous. 2. Direct delivery of services.	By state, employer and employee contributions.
México		X	Several autonomous institutions supervised by the Ministry of Labor and Social Welfare (MTBS)	1942	1. MTBS provides policy guidance for several institutions with executive autonomy. 2a. The Mexican Social Security Institute (IMSS) preferably delivers services directly. 2b. The Social Security Institute for Government employees (ISSSTE) preferably delivers services directly. 2c. There are other smaller institutions which deliver services.	IMSS through state, employer and employee contributions.
Nicaragua		X	Autonomous institution with political protection of the Ministry of Public Health.	1955	1. Single, autonomous institution. 2. Preferably direct delivery of services.	State. employer and employee contributions.
Panamá	X		Autonomous institution with political protection of the Ministry of Labor and Social Welfare.	1941	1. Single, Autonomous institution. 2. Direct delivery of services.	State. employee and employer contributions.
Peru	X		Autonomous institution "from the Labor Sector"	1936	1. Several institutions: National Bureau of Employee's Social Security and National Pension Bureau (CNSS, SSE, CNP) joined in a single, autonomous institution 2. Direct delivery of services.	State. employees and employer contributions.

COUNTRY	STATE	SEMIOFFICIAL	RESPONSIBLE TO	DATE FOUNDED	ORGANIZATION	FINANCING
Dominican Republic		X	Autonomous institution subordinate to the Ministry of Labor		1. Single, autonomous institution. 2. Direct delivery of services.	State, employer and employee contributions.
Venezuela		X	Autonomous institutions subordinate to the Ministry of Labor	1940	1. Several independent institutions 2a. The Venezuelan Social Security Institute (IVSS) delivers services directly although it contracts third parties for some hospitalizations. 2b. The Social Security and Social Welfare Institute of the Ministry of Education (IPASME) has an arrangement similar to that of IVSS. 2c. Other smaller institutions.	State, employer and employee contributions.

Sources: PAHO/WHO survey of social security institutions - 1977, except for the starting dates and data on financing taken from "Social Security Programs throughout the World - 1974". U.S. Department H.E.W., S.S.A., Office Research and Statistics, Washington, D.C. 1975.

State support) is interesting because of the influence these methods have on expansion of health services' coverage. This point is discussed in greater detail in the following section.

Another interesting aspect of Table 1 is the relationship of political subordination of social security institutions to the ministries of labor when they begin direct delivery of health services. An exception to this rule occurs in the cases of Argentina (Ministry of Social Welfare), Bolivia (Integrated Ministry for both Health and Social Security) and Chile and Nicaragua in which the social security health systems have been made subordinate to the Ministry of Health. In the other 12 cases, policy guidance for organization of health services, constitutionally a function reserved for the ministry of health, must go through a bilateral process involving the services and the ministries in accordance with legal instruments created specifically for this purpose. In these cases, coordination between the services of the ministries of health and the social security institutions must be carried out within a parallel or different legal framework than that implied by the natural subordinate relationship of these institutions.

Lastly, it is worth pointing out that several countries have mobilized to create a coordinating agency for executive supervision and standardization of health systems which were previously administered in complete autonomy by different offices. Argentina, Bolivia, Brazil and Peru have taken steps in this direction, although they have had different degrees of success in consolidating pre-existing agencies. In other countries, one institution has become preeminent and dominates the field of health services financed through social security. This is the case in Colombia, Costa Rica, Venezuela and, to a certain degree, Mexico, among other countries.

3. Population Covered by Social Security Health Systems

Table 2 presents information from the survey concerning the beneficiary population: historic evolution, relation to the economically active population and to the resident population in areas with 20,000 inhabitants or less. In order to study possible repercussions of two factors that theoretically may affect possibilities for expanding the coverage of social security services (defined as the proportion of the population with access to services) two indicators from other sources are included. One is an index of economic development, the Gross National Product (GNP) per inhabitant, and the other is the distribution of income by percentage groups of the population, which is summarized in the Gini Coefficient.

The basic assumption is that as development increases, the economically active population increases and the distribution of income also increases to a certain degree in the following stages of development. These two factors would cause a potential increase in the proportion of the population with the economic capacity to be affiliated with social security health systems.

Consequently, the participation of these groups in the expansion of health services coverage is more feasible. In other words, the capacity of these institutions to expand, since it is linked to their means of financing, is limited by the development conditions of the Latin American countries. Consequently, meeting the objectives for expansion as established by these institutions (incorporating the rural population and non-contributors, etc.) would require a very long period of time. Note that attempts have been made to discover the influence of these two elements only, without consideration of any other factors that may change existing conditions. Basically, such factors include decisions involving policy and structure.

There is a certain margin of error in all of these data as indicated below:

i) The accuracy of information concerning the percentage of the total population covered by social security health systems depends on the existence of complete records of affiliates and of the number and degree of autonomy of participating institutions in each country. The greater the number of institutions, and the more complete their autonomy, the greater the margin for error. The reliability of the record depends, in turn, on the method of contribution by beneficiaries (direct or indirect), the degree of tax evasion in the contributions, and administrative diligence in making changes in the records.

These difficulties would explain why some countries chose to provide overall estimates of the covered population (INPS-Brazil with 50,500,000 beneficiaries, or INOS-Argentina with 1,500,000 rural beneficiaries). Data of this type was adjusted as much as possible in accordance with yearly reports or other sources provided by the institutions themselves or by using publications from international social security agencies. It is worth remembering that the information provided in response to the survey generally covers only the principal institution in the country. Therefore, data on the covered population is an underestimation of the actual total covered population, although it does not substantially alter the relative expression (percentage). The importance of these indicators is basically the size of the figures, 5% or 10% or 75% for example, and not their accuracy. The second source of possible inaccuracy in population data arises from the characteristic of "estimating" the total population for each country. As estimates are made in the years following the census year, and as the population rate changes, these figures become even more inaccurate.

These causes of error, which are common to any research of this type, do not seem to have caused undue distortion of the information since it corresponds to previously published data.

TABLE 2

POPULATION COVERED BY SOCIAL SECURITY HEALTH SYSTEMS IN RELATION TO SOME SOCIOECONOMIC INDICATORS

Country	Protected Population			GNP per inhabitant 1975 (in US$1973)	Gini Coefficient	Active Population Insured 1975 %	Pop. Covered Area 20,000 (%)
	1965	1970	1975				
Argentina	-	-	57.5	1426	.4375	52.0	43.6
Bolivia (1) (1)	-	11.2	18.5	281	-	-	0.0
Brazil	-	68.7	77.6	769	.6093	68.2	76.0
Colombia	3.7	5.8	7.3	461	.5557	18.1	-
Costa Rica	30.0	46.6	65.6	785	.4445	52.5	21.3
Chile (3)	16.8	20.0	27.1	925	.4658	-	-
Dominican Rep.(7)	4.0	3.9	3.6	618	-	-	5.9
Ecuador	4.3	5.1	6.2	431	.6826	19.4	1.1
El Salvador (4)	3.0	4.0	5.8	433	.5460	12.7	-
Guatemala	9.1	10.6	12.0	621	-	29.6	9.0
Honduras	1.5	4.1	7.5	369	.6188	10.6	0.0
Mexico (5) (5)	13.3	20.3	27.7	777	.5827	-	8.7
Nicaragua	-	-	8.3	643	-	15.9	-
Panama	10.8	22.6	36.9	1030	.5567	49.5	-
Peru (6)	7.5	7.7	10.8	594	.6664	37.7	-
Venezuela	15.3	19.0	24.0	1486	.5445	28.0	0.0

SOURCES: Population protected: "PAHO/WHO Survey on Social Security Institutions, January-May 1977.

Gross National Product" Statistics Section, Inter American Developmen Bank, June 1977

Gini Coefficient of Income Distribution: Shail, John "Size Distribution of Income", World Bank Publication, Washington, D.C., 1975.

Economically active population: U.N. Statistical Year-book, 1975.

Population in areas with 20,000 inhabitants or less: Support Services Division, PAHO/WHO, June 1977.

Total population in 1965-70-75: IDB "Economic and Social Progress in Latin America Annual Report 1975".

TABLE 2 - cont'd

Notes

(1) Figure on population covered in 1970 corresponds to 1972. It was taken from "Organizational Plans for Providing Medical Services to Urban, suburban and Rural Family Nucleus," Social Security: 89, p. 176.

(2) Data for Brazil includes only INPS and FUNRURAL. FUNRURAL reported the estimated total rural population of Brazil as the protected population. Since, as in 24% of the country's municipalities, FUNRURAL has no arrangements for providing health services (see FUNRURAL: Statistical Bulletin, 1976) the population protected by this institution was adjusted by this proportion.

(3) SERMENA only. SNS has no record of beneficiaries. Its estimated coverage is 75% of the country's population which would result in a joint coverage for 1975 of 102.1%.

(4) Data for population covered are for 1967, 1971 and 1975 and were taken from "Synthesis and Development of I.S.S.S.," San Salvador, October 1976, p. 12.

(5) Data on population covered is for 1965 and 1970 from "Statistical Report" of IMSS and for 1975 f rom "Participation of Social Security Institutes in Family Planning Programs" ILO report at the V American Congress of Social Security Medicine, Caracas, July 1976.

(6) Data is for 1968 rather than 1965.

(7) Data for 1975 includes only affiliated beneficiaries since "The expectant spouse and children up to 8 moths of age are considered dependents." If dependents are taken as part of the covered population, then the percentage increases to 7.9%. For a similar reason, dependents were not included as covered population in Ecuador or in Peru.

ii) The GNP per inhabitant for 1975, expressed in 1973 dollars, is a measurement which also imprecisely reflects the countries' economic development. The method used by the IDB in making these calculations is perfect enough to provide reliable data, even when expressed in U.S. dollars. The GNP has been persistently attacked because it does not reflect all of a country's economic activity nor does it reflect the way in which income generated by this economic activity is distributed. Therefore, it is a relatively poor indicator of social welfare. It is for this reason that the Gini Coefficient, which summarizes the distribution of national income by percentage groups of the population, was introduced.1/ Although the Gini Coefficient has also been criticized for being an overall indicator which hides the situation of special groups, it is still the best available indicator of income distribution in a society. Income distribution is more egalitarian when the numerical value of the Gini Coefficient is lower. In the table, attempts were made to maintain comparability between countries by using only coefficients which refer to the entire population (urban and rural), preferably based on family income as a unit of observation and using the latest data available.

iii) The economically active proportion of the population affiliated as contributors is also presented, as well as the percentage of the population living in areas with 20,000 inhabitants or less and which are covered by social security health systems. Problems arose in calculating both of these columns.

Information on the economically active population comes from the last census year. A percentage of this year was used to estimate the 1975 figure. This calculation assumes that the proportion will stay more or less constant over short periods of time.

In two countries (Chile and Panama) it was impossible to reach an exact figue on the population living in areas with 20,000 or fewer inhabitants. In several countries (Colombia, El Salvador and Peru) it was simply not possible to calculate this data. In Mexico and the Dominican Republic the figures reflect the percentage of rural population according to the definition used by these countries for census purposes and not according to the criteria used in the survey. Furthermore, data on Mexico is for 1973, an important distinction, since several programs for extending social security to the rural population were started in 1973 or in the following years.

1/ The Gini Coefficient is an indicator which measures the difference between actual income distribution and ideal egalitarian distribution. Ideal distribution occurs when each group receives its corresponding share of total income, for example when each 10% of the population receives 10% of the country's income. The Gini Coefficient can be calculated for different subgroups in the population (urban, rural, economically active, low income) or for the total population. The calculation can also be based on individual or family income. These alternatives may cause changes in the numerical value of the coefficient in one country. The numerical value of the coefficient also changes over time.

These variables have been included in spite of the limitations mentioned here in order to give an idea of the extent of the problems which must be dealt with when proposing to extend social security health service coverage to the entire rural and even urban population.

The data in Table 2 shows that almost all of the countries included have increased the proportion of their populations covered by social security during the decade under study. This trend is in keeping with the desire expressed by the countries (III Meeting of Ministers of Health and the Ottawa Social Security Program) to provide universal access to health services and to social security protection.

In view of the countries' pledge to expand coverage based on the data available here, it is interesting to analyze the potential for expansion of the services models in social security health systems.

In analyzing the potential for expansion of complete social security systems, that is, those systems in which State financing is not a predominant component, the cases of Brazil, Costa Rica and Chile must be excluded. As has been stated, FUNRURAL in Brazil and the hospitals transferred to CCSS in Costa Rica are financed from sources which are completely different from traditional means of financing social security. The case of Chile must also be considered separately since the beneficiaries of the Workers' Security are protected under the SNS system. Therefore, the percentage covered by SERMENA is a considerable underestimation of what could be covered by social security financed through traditional means.

Economic development can have an important effect on increasing the population covered by social security. In studying the relationship that may exist between development (expressed as GNP per inhabitant) and the proportion of the population having access to social security health systems (potential theoretical coverage) the correlation between these two variables was calculated for the remaining 13 countries. Graphs 1.a and 1.b clearly show that, as was to be expected, there is a positive correlation between these variables. With the values on graph 1.b representing the 13 countries with typical social security financing (bipartite or tripartite, but with the State as a contributor), the following results were obtained:

$$a = -4.7502$$

$$b = 0.0314$$

$$r^2 = 0.59$$

The line on graph 1.b would indicate "typical" increase in possible access to social security health systems in relation to economic development as experienced by the 13 Latin American countries in 1975. According to this theoretical line, potential access for the total population (universal coverage) based on the two variables analyzed would occur only when per capita GNP reached US$3,350.

There are obviously other factors which influence the coverage provided by social security. Among possible variables, the influence of income distribution is worthy of study. The assumption is that for one level of economic development, the most egalitarian society would rather provide protection for a higher percentage of the population than increase the complexity and/or quantity of health services for a small group. Graphs 2.a and 2.b show the relationship between the Gini Coefficient and the proportion of the population covered, which, as can be seen, is negative. With a more unequal income distribution (the higher the Gini Coefficient) the lower the proportion of the population covered--in other words, the lower the proportion of the population with potential access to social security health systems. This statement supports the preceding conjecture.

The values obtained from the nine countries studied are presented below. Brazil, Chile and Costa Rica were excluded for reasons explained previously. The proper Gini Coefficient could not be obtained from Bolivia, Guatemala, Nicaragua and the Dominican Republic.

$$a = 114.5455$$

$$b = -164.5514$$

$$r^2 = 0.60$$

The line on graph 2.b would indicate the "typical" increase of social security health systems with a more egalitarian distribution of income as experienced by nine countries of the Americas in 1975. If the preceding statements are valid, then theoretically, even when the countries adopt an extremely egalitarian distribution, Gini = .2000 for example, the proportion of the population covered by social security health systems, based on the variables analyzed, would be only about 80 per cent.

These two factors--economic growth and income distribution--do not act independently. There is a clear relationship between the two since income distribution is known to be lower in the first stages of economic development and improves during more advanced stages of development.2/

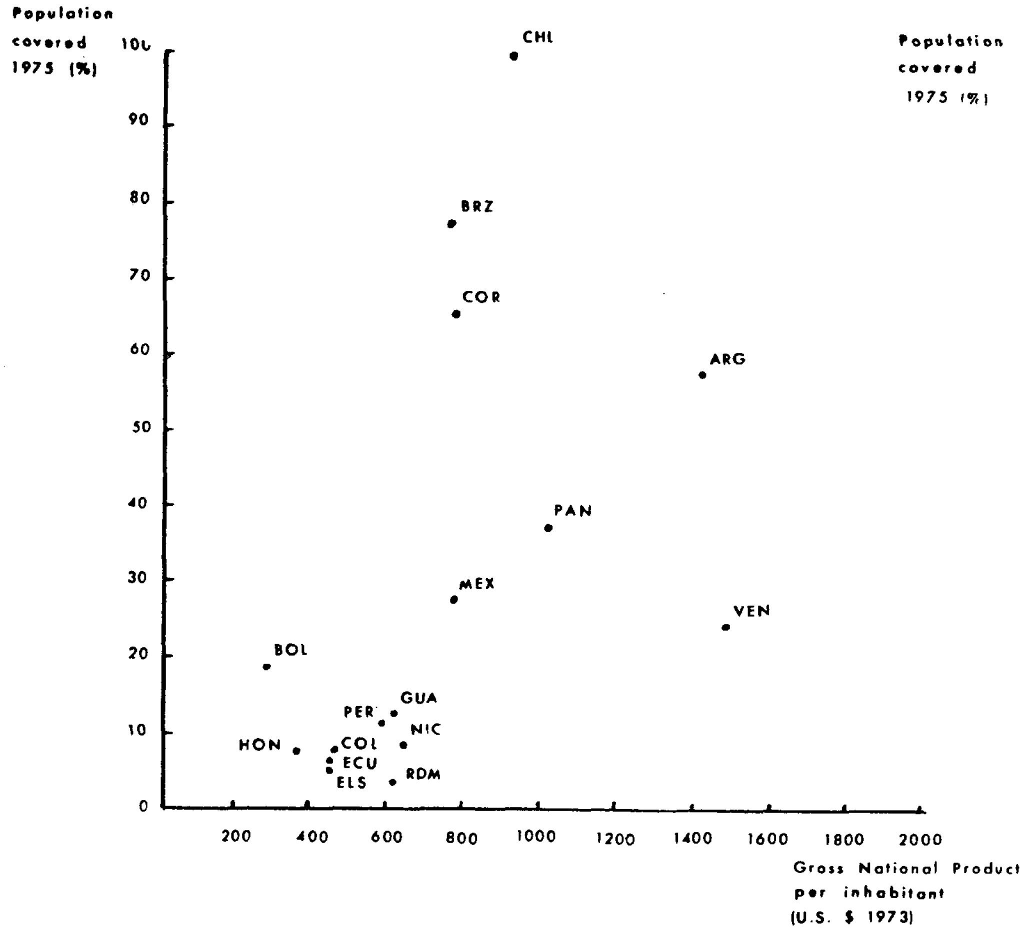
Since these factors are related to one another and also to the proportion of the population which may be covered by social security health systems, it would be interesting to know if these variables maintain their individual characteristics when acting together. In other words, it would be interesting to answer the following questions: when one of the variables is kept constant (economic development, for example) what would be the effect of the other variables (income distribution) on the proportion of the population with potential access to health systems? And, how would this proportion increase if a country undergoes further development and its income distribution becomes more egalitarian?

2/ Ahluwalia, Montek S. "Inequality, Poverty and Development", J. of Development Economics 3, 1976, pp. 307-342.

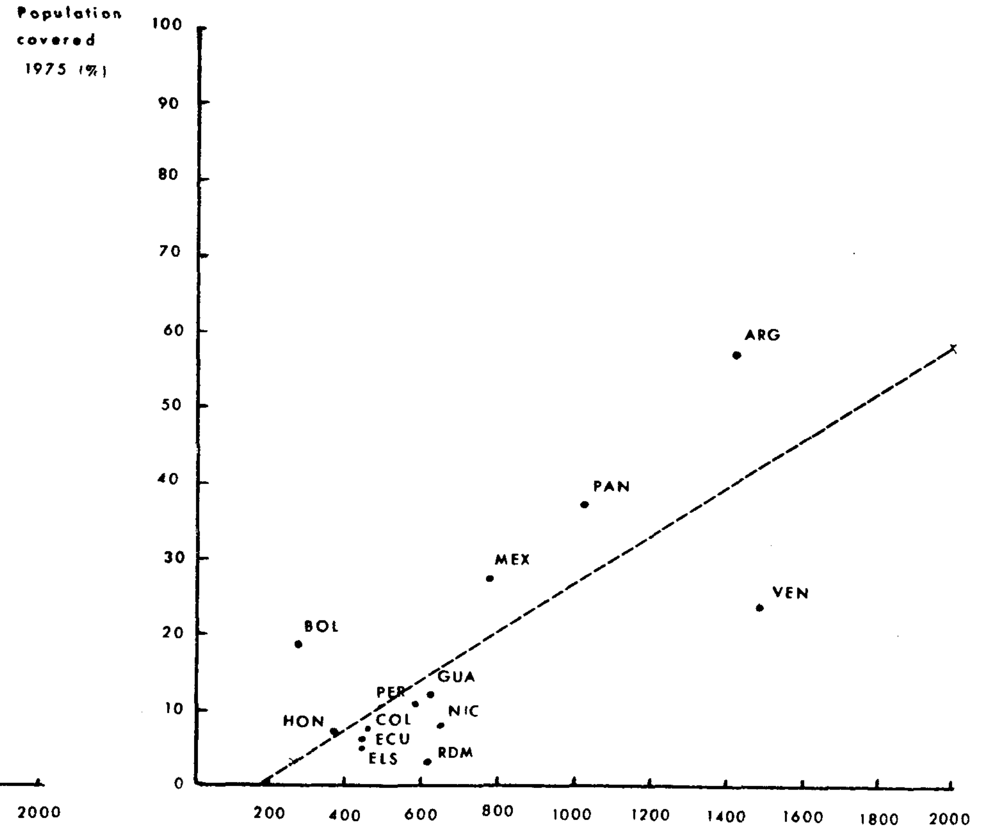
GRAPH 1

POPULATION COVERED AND GROSS NATIONAL PRODUCT

1.a



1.b



$$17.39 = -4.75 + 0.0314(705.38)$$

$$\bar{y} = a + b \bar{x}$$

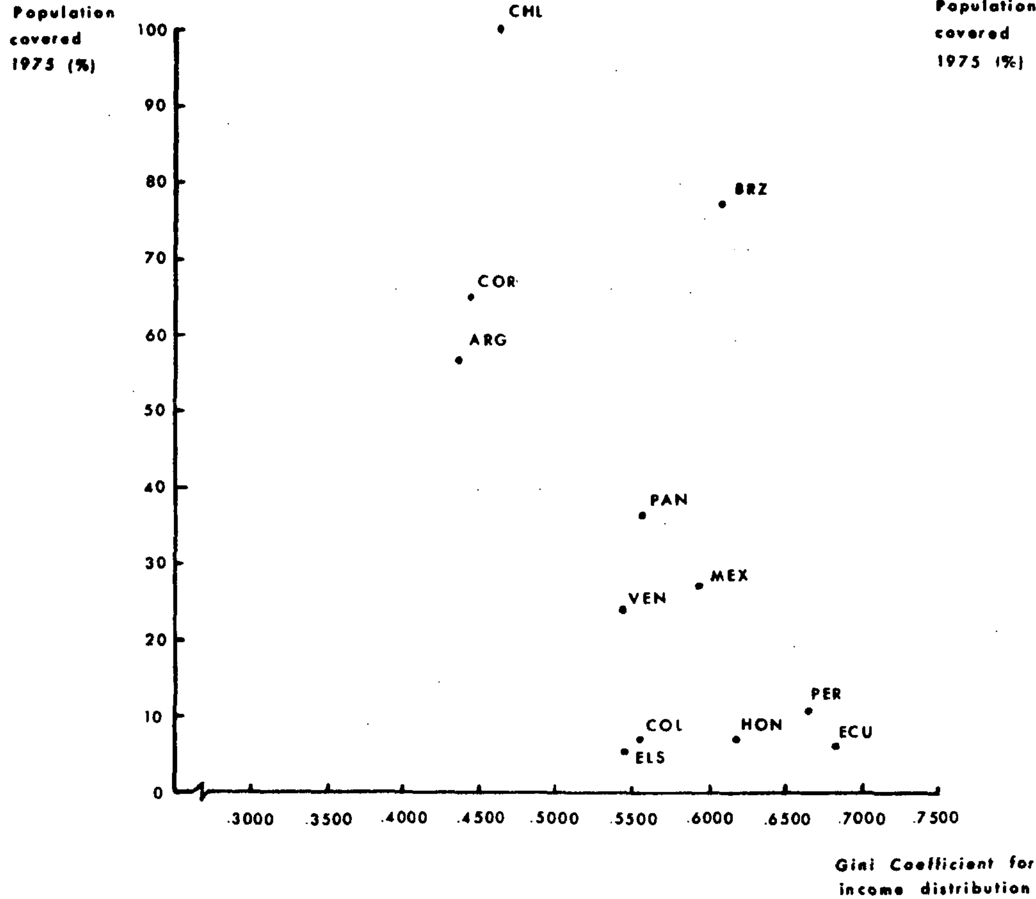
$r = .7701 \qquad n = 13$

SOURCE: see table 2

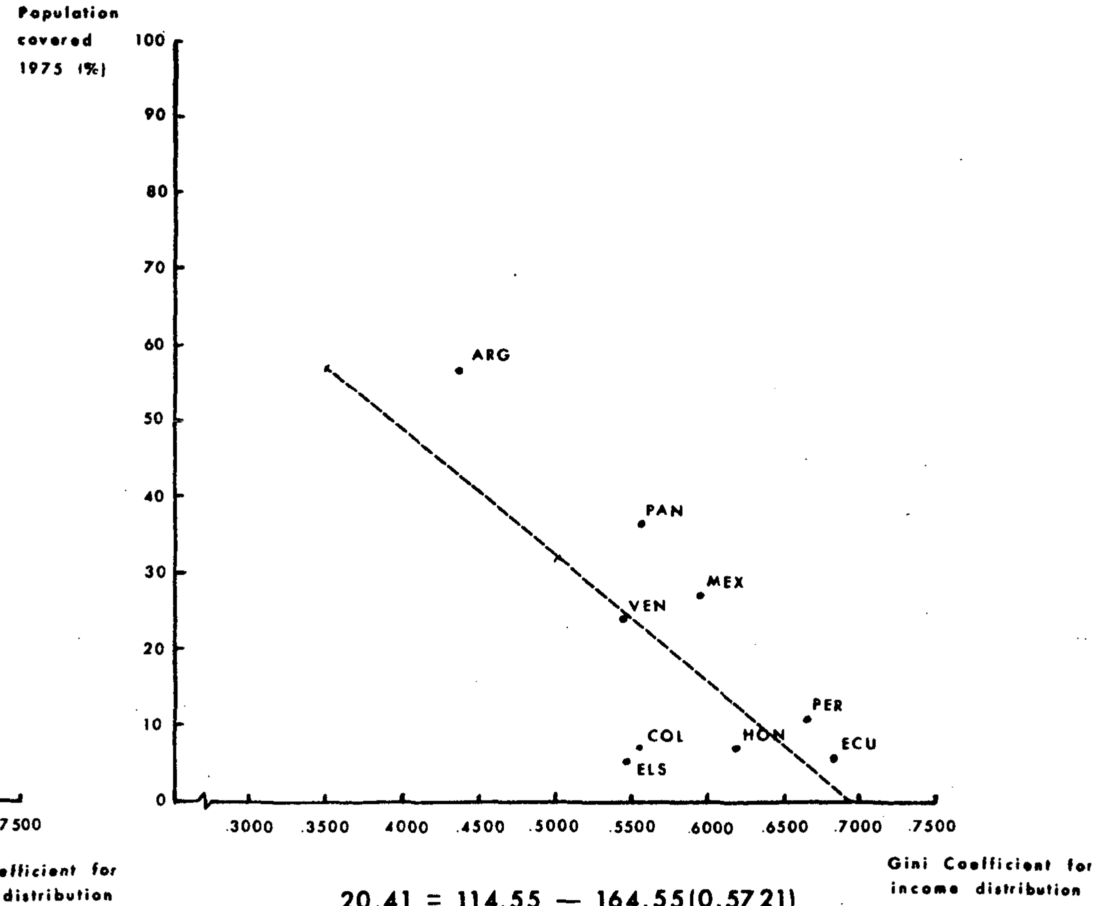
GRAPH 2

POPULATION COVERED AND INCOME DISTRIBUTION

2.a



2.b



$$20.41 = 114.55 - 164.55(0.5721)$$

$$\bar{y} = a - b \; \bar{x}$$

$r = .7740 \qquad n = 9$

SOURCE: see table 2

One statistical tool used for analyzing the combined effects of several independent variables on one dependent variable is multiple regression. The small number of observations (nine), the inaccuracy fo the data used, and, especially, the high number of other unknown variables that may have an effect make it impossible to formulate any general conclusions. The results of the corresponding exploratory exercise are included exclusively for illustration of a possible tendency which can be observed and an analytical method which may be used to study potential expansion of social security health systems on the basis of the variables described above if traditional means of financing health services are continued.

For example, GNP per inhabitant and income distribution in the nine countries on graph 2.b were estimated for 1990.3/ The results are presented under two different postulates.4/ It is possible to see from Table 3 that within the limitations indicated previously, three countries with social security health systems financed by traditional means will be able to expand their services to cover more than 50% of their respective populations.

The basic assumption in these estimates is that state financing for health services will not change significantly. However, one of the alternatives which must be considered is that funds from other sources may be used in attempting to expand social security services at their current level of complexity and with their present organization to a larger proportion of the population than is indicated by natural growth. The degree of success resulting from this solution will depend basically on the cost per beneficiary and on total expenditure generated in relation to the economy. These two aspects will be studied in the following section.

4. Expenditures, Costs and Utilization

The preceding section indicated the limited potential for expansion of social security health systems financed by traditional means. This section uses the economic point of view to study the possibility of extending these services to the whole population while maintaining present levels of complexity and cost per beneficiary.

3/ Several types of curves were examined using data from the 1970/75 five year period in order to find the one that was best suited for showing per capita economic growth. The most suitable curve turned out to be the exponential curve which was used for estimating GNP per inhabitant for each country. The method presupposes that the relation between population increase and economic growth will remain the same during the period for which the prediction is made.

4/ The first postulate assumes that income distribution will not be changed during the period under consideration. The second postulate assigns to each country the distribution corresponding to its level of development.

TABLE 3

ESTIMATION OF COVERAGE AND ECONOMIC

INDICATORS FOR 1990

Country	GNP per inhabitant	Postulate I		Postulate II	
		Gini Coefficient I	Coverage I	Gini Coefficient II	Coverage II
Argentina	2213.2	.4375	67.4	.3857	71.6
Colombia	676.9	.5557	19.5	.5854	17.2
Ecuador	650.4	.6825	8.7	.5888	16.2
El Salvador	581.7	.5460	17.9	.5978	13.8
Honduras	520.7	.6188	10.6	.6057	11.6
México	1222.8	.5827	31.0	.5144	36.5
Panama	2059.9	.5567	54.0	.4056	66.1
Peru	865.1	.6664	15.4	.5609	23.8
Venezuela	1994.0	.5445	53.4	.4142	63.8

Notes: Gini I: is the Gini Coefficient calculated around 1975.

Gini II: is the Gini Coefficient estimated for 1990 according to the level of economic development.

Coverage I: is the percentage of the population protected by social security health systems according to GDP and Gini I using the coefficients derived from multiple regression.

Coverage II: is the same as Coverage I but uses Gini II.

Economic feasibility will be given by a criteria that, although arbitrary, is the only one available: the percentage of GNP to be used for health services. The first column in Table 4 shows the percentage of GNP spent in 1975 on the social security health systems which provide information for this survey. The second column contains the percentage of the total population for which the amount in column 1 was spent and the last column extrapolates expenditure for 100 per cent of the population. This extrapolation must be handled carefully and deserves several comments.

i) The population covered by social security at the present time (active population, young adults with a relatively good income) is the group which has the lowest need for health services per inhabitant. On the average, the very young and the very old as well as people with limited resources have a greater need for services.

ii) The cost incurred in providing services in the traditional manner to population groups located at a distance from urban centers--which at the present time are usually not protected by social security health systems--may eventually be greater than the cost of services for the urban population.5/

iii) As indicated previously, data on the population covered is not totally accurate. One should also remember that health expenditures as reported in the surveys do not include the small or large subsidies that some social security institutions receive from other services systems. For example, in several countries, these institutions contract hospital beds for less than the actual cost of this resource.

4.1 For purposes of analysis, it is necessary to select a level of health expenditure compatible with the level of economic development. Unfortunately, there has been very little research in this area which could serve as a guideline. The percentage of GNP allocated by countries for health services has beed said to increase proportionally with development.6/ However, this does not indicate what should be the most suitable level for health expenditures. Social security health systems have concentrated their efforts and resources on acute medical-hospital care. Such expenditures, although they do represent an important part of total health expenditures, do not usually include chronic care, preventive medicine and public health or the expense of training health personnel.

5/ These costs are explained by higher costs for transportation of supplies, supervisory personnel, and maintenance as well as extra pay commonly used to attract the necessary personnel.

6/ Abel Smith, B. "International Study of Health Expenditures and Their Incidence in Planning Medical and Public Health Services," WHO Public Health Papers No. 32, Geneva, 1969.

TABLE 4

ACTUAL AND PLANNED EXPENDITURE FOR

SEVERAL HEALTH SYSTEMS

Country	Health expenditure in relation to GNP (%) 1975	Protected pop./ Total pop. (%) 1975	Health Expenditures in Relation to GNP Covering
Bolivia	0.96	16.7	5.7
Brazil	1.40	77.6	1.8
Colombia	1.14	7.3	15.7
Costa Rica	3.14	65.6	4.8
Chile	2.62	100.0	2.6
Dominican Republic	0.61	4.2	14.7
Ecuador	0.55	6.2	8.9
El Salvador	0.64	5.8	11.0
Guatemala	0.95	12.0	8.0
Honduras	0.81	7.5	10.8
Mexico (1973)	0.95	24.8	3.9
Panama (1974)	1.67	33.5	5.0
Peru	2.10	11.5	18.3
Venezuela	0.68	24.0	2.9

Sources: GDP in 1975 currency: IDB

Total population for 1975: IDB "Economic progress...." op cit.

Other data: "PAHO/WHO Survey on Social Security Institutions." 1977, except for El Salvador, Mexico and Panama for which annual statistics from the social security institutions were used.

Note: The population protected by social security may be slightly different from that in Table 2 since no corresponding data for health expenditures was available.

In view of these circumstances and the fact that 6% of GNP can be considered tentatively as the usual level of health expenditure,7/ then estimated expenditure for 100% of the population could be considered feasible when it is kept under 5%, doubtful when it is between 5 and 7%, and unlikely when it is higher than 7 per cent.

According to this criteria, out of the 11 countries studied, two are "feasible" (Mexico and Venezuela), two are "doubtful" (Bolivia and Panama) and the remaining seven are "improbable" (Colombia, Ecuador, El Salvador, Guatemala, Honduras, Peru and Dominican Republic). Within their limitations, these results seem to support Abel Smith's affirmation that "social security may well develop levels of health service facility that are too costly to be extended to the whole population for generations."8/

Another indirect method was used in attempting to study the feasibility of expanding insurance financed by traditional means to the entire society by analyzing the relation between cost per beneficiary-year and the financial capability of the population according to income level. In this method, average income per inhabitant was estimated for each one-fifth of the population. Twenty per cent of the lowest income group constitute the I fifth, the next 20 per cent the II fifth, and so forth. The cost per beneficiary-year is calculated below. The portion of the total cost paid directly by the beneficiary was estimated by calculating the proportion of total income from payments made by insured persons, which was then applied to observed cost per beneficiary. Finally, the proportion of income per inhabitant which this direct cost represents was calculated for each population group.

Table 5 shows these indicators in the eight countries for which it was possible to calculate them. The greatest problem in interpretation is lack of information concerning the most suitable level of personal income that can be allocated for financing health services. Not only is there a lack of information on what these values should be for different levels of personal income and economic development, but no information is available concerning the amount actually spent. The extreme cases of 42% for the I fifth in Honduras and 0.2% for the V fifth in Venezuela are obviously not suitable. Unfortunately, no information was requested concerning the location of the protected population within the income distribution spectrum.

7/ Ibid

8/ Abel Smith, B. "Health Policies and Investment and Economic Development." In: Kassalow, Evertt M. (ed.): The Role of Social Security in Economic Development, U.S., H.E.W., SSA. Report No. 27.

TABLE 5

TOTAL AND DIRECT COST PER BENEFICIARY IN RELATION TO INDUSTRIAL POWER OF INCOME GROUPS, 1975

Country	Average Cost-beneficiary	Average direct Cost-beneficiary		Income per person (a) and % to be allotted to cover average direct beneficiary cost (b)				
	(currency)	(%)	(currency)	I	II	III	IV	V
Colombia	2808	23.5	661.0	a. 3131 b. 21.0	5905 11.2	9752 6.8	16910 3.9	53773 1.2
Ecuador	1441	37.1	535.0	a. 1454 b. 36.8	2747 19.5	5898 9.1	12523 4.3	58173 0.9
El Salvador	172	27.4	47.3	a. 283 b. 16.7	361 13.1	566 8.4	966 4.9	3377 1.4
Honduras	82	31.0	25.6	a. 61 b. 42.0	182 14.1	360 7.1	714 3.6	2480 1.0
Mexico	605	22.5	136.1	a. 3232 b. 4.2	4618 2.9	7466 1.8	13008 1.0	48648 0.3
Panama	56	31.9	17.8	a. 185 b. 9.6	421 4.2	705 2.5	1201 1.5	3677 0.5
Peru	6640	32.2	2.141.0	a. 5988 b. 35.8	9073 23.6	15061 14.2	25768 8.3	125576 1.7
Venezuela	297	24.3	72.2	a. 1715 b. 4.2	3275 2.2	5963 1.2	10501 0.7	30672 0.2

Sources: Columns 1, 2 and 3 from PAHO/WHO Survey on Social Security Institutions, 1977
Income per person: I.D.B.
Percentage distribution of income: World Bank, "Size Distribution..." op cit.

Note: See text for explanation of calculations.

This data would have provided an idea of existing acceptable levels of direct cost.9/

The most interesting aspect of this table is the similarity of its results to the results in the preceding table. There are two countries (Mexico and Venezuela) in which the burden of the direct cost of the respective health systems seems "accesible" even for the lowest income groups. One country (Panama) is "intermediate" with values of less than 5% for all except the I fifth, while the five remaining countries (Colombia, Ecuador, El Salvador, Honduras, and Peru) show percentages greater than 5% for the I, II and III fifths. The same countries that appeared as "feasible" in Table 4 are "accesible" in Table 5. The "doubtful" are now the "intermediate" (Bolivia excluded, due to lack of data) and the "improbable" are the "inaccessible." According to the results of this calculation, and once the necessary reservations are made insofar as the reliability of the basic information, it would be evident that in the latter five countries even the direct cost of health systems would need to be highly subsidized for large groups of the population in order to provide universal access to this type of services.

The preceding exploratory analysis shows the limitations affecting any attempt to provide universal coverage by social security health systems or any similar plans from the standpoint of the economy in general and the financial capability of population groups in particular. These limitations would hold true as long as there were no changes in prevailing basic conditions. These results indicate the need to analyze factors which affect health expenditures.

4.2 Total expenditures of recently studied health systems are basically the result of three forces: the unit cost of resources consumed in producing services, for example the cost per medical hour; the level of utilization of services, for example visits and discharges per 1,000 beneficiaries; and technological combinations used in delivering the services. It is important to point out that these three areas involve decisions made either implicitly or explicitly that are closely related through costs to the proportion of the population to be covered by these benefits. The adoption of more or less internationally recognized utilization patterns and technological combinations in the planning and organization of services is, therefore, a decision which will have important consequences.

9/ This would also have made it possible to estimate the variability of this proportion, thus removing another of the difficulties presented in Table 5 in which the same fixed sum (direct cost per beneficiary-year) was applied to all income levels. Social security tax does not function this way. It is a proportional tax levied up to a certain maximum level on one source of income, the salary.

However, note that this methodological limitation does not invalidate the comparison of countries, since it is applied in the same way in all countries.

Table 6 shows utilization data (visits and discharges) which in some countries has been more or less maintained at four visits and 0.10 hospitalizations per beneficiary-year.10/ In certain institutions (Brazil-FUNRURAL and Chile-SERMENA) the number of reported discharges seems unduly low. In both cases, the method of payment does not guarantee that the information collected is complete.11/

In other institutions, the high level of discharges, whether in absolute terms (Colombia, El Salvador and Dominican Republic) or in terms relative to the number of visits (Brazil-INPS and Guatemala, as well as the three already mentioned) attracts attention. Probably the most important information that can be derived from the table is the lack of correlation between levels of utilization and the country's economic capacity (GNP). This correlation was calculated on the basis that economic development generates more resources for health services, which will be reflected eventually in increased levels of consumption.

The correlation between visits per beneficiary and GNP per inhabitant was not significant either. This lack of correlation indicates that the beneficiaries' levels of consumption are not related to the economic capacity of the society but are determined by other factors.

Lastly, the table lacks a great deal of data for attempting to analyze the historic tendency of service utilization by the beneficiaries. However, of the 10 countries for which there is complete information, five show increasing levels of consumption, three show decreasing levels of consumption and two remain the same.

Additional factors that can be used to explain health systems' expenditures are the costs of production and technological combinations. Unfortunately, information on these aspects is very scarce. By consulting sources which were not used for the survey, attempts were made to determine expenditure per beneficiary per year in different categories, such as: outpatient care, hospital care, medicine, dentistry, prosthetic apparatus, administration and others. The only data obtained was for unit costs of outpatient and hospital care. The source used did not know the degree of accuracy of this data and specifically indicated this fact.(*)

10/ Note that recommendations in the Ten-Year Health Plan for the Americas established at least one discharge for each 10 inhabitants and two visits per inhabitant-year for the total population.

11/ FUNRURAL because it pays for potentially covered population and SERMENA since its beneficiaries are hospitalized in SNS, which means that they are often not recorded as this institution's patients.

(*) These costs reflect the combined action of the two elements under study. For example, cost per visit depends on the level of remuneration for professional health workers and the support services involved in delivering services.

TABLE 6

VISITS AND DISCHARGES PER THOUSAND BENEFICIARIES
1965 - 1970 - 1975

Country	1965			1970			1975		
	Visits 1000	Dis-charges 1000	Visits Dis-charges	Visits 1000	Dis-charges 1000	Visits Dis-charges	Visits 1000	Dis-charges 1000	Visits Dis-charge
olivia	n/a	n/a	-	n/a	n/a	n/a	2713	52.0	52.1
rasil INPS[1]	n/a	n/a	-	1361	9.1	14.9	1756	105.3	16.7
FUNRURAL	n/a	n/a	-	n/a	n/a	-	405	28.0	14.4
olombia	5035	202.7	24.8	4315.9	154.4	28.0	4456	145.4	30.6
osta Rica	2675	92.6	28.4	2817	88.4	31.8	3381	95.9	35.2
hile SERMENA	n/a	n/a	n/a	1101	36.7	29.9	1147	37.1	30.9
ominican Republic	5494	211.9	25.9	5215	192.8	27.0	6019	174.1	34.5
cuador	-	41.3	-	3442	55.1	62.4	3833	82.1	46.7
l Salvador	n/a	n/a	-	n/a	n/a	-	5580	190.2	29.3
temala	145	89.3	1.6	971	97.3	9.9	1825	87.5	20.9
onduras	3827	13.4	28.5	3213	76.3	42.1	3961	79.5	49.8
exico IMSS	3968	75.0	52.9	3830	86.3	44.4	3763[2]	90.3	41.7
icaragua	n/a	n/a	-	n/a	n/a	-	n/a	109.5	-
anama	5011	55.6	90.0	4281	31.4	136.3	3753	36.9	101.5
eru	3363	71.0	47.4	3424	74.1	46.2	2900	52.9	54.8
enezuela	3988	53.4	76.6	5290	56.2	94.1	3996	51.9	77.0

ources: Survey of Social Security Institutions PAHO/WHO, 1977

1) Discharges for 1970 were corrected by 5% and visits by 10% according to estimates provided by INPS authorities.

2) Data for 1972. Information on IMSS was obtained from "Health and Maternity Insurance in the Mexican Social Security Institute, Volume and Cost of Medical Services." Social Security 85 and 86, page 90 and following.

/a Not available.

Table 7 presents some information of this type for institutions in 12 countries during 1975. Outstanding in this table is the relatively high expenditure for outpatient medical care, first for unit cost of visits and second for high utilization. In half of the countries, expenditures for medical visits per beneficiary-year are greater than the expenditures for hospitalizations per beneficiary-year. In only four countries is this relationship reversed, mainly because of the low cost per visit in relation to bed-day cost in these countries.

Since utilization of health services by beneficiaries is not related to economic development, it would be interesting to know if total expenditure per beneficiary-year is also an independent variable. Remember that correlation between levels of utilization and GNP showed very low coefficients which were not much greater than zero. Total expenditure is a variable which expresses the combined effect of three factors: utilization, cost of production factors and technological level.

The correlation between total expenditure per beneficiary and per capita GNP was positive, with a correlation coefficient (r^2) of .7371.

This result could indicate that levels of service utilization by beneficiaries (optimum standards) are fixed, and as the economy develops both payment and the complexity of the production factors increase. It is interesting to remember that the effect of development on expansion of social security health systems' coverage, although it does exist, is not as strong as has just been stated ($r^2 = 0.59$).

4.3 Lastly, it is interesting to present a table comparing services which the affiliated beneficiary and the dependent beneficiary have the right to receive from those social security health systems which provided information on this aspect. When studying this table, remember the prior tentative classification of countries with respect to the economic feasibility of expanding services to new population groups. The systems in Colombia, Ecuador, El Salvador, Guatemala, Honduras, Peru and Dominican Republic had been classified as unlikely to extend their services to the whole population. Table 8 shows that none of these institutions provides similar benefits for both the affiliated and the dependent beneficiaries. Colombia approximates equality, but only in partial health services. The proportion of the population covered and the extent of coverage (next to last and last columns in the table) are low in comparison with the other institutions presented. Comparing these indicators with combined expenditures for hospital-medical care per beneficiary (last column) makes it clear that these institutions, when confronted with the alternative of either increasing their coverage or increasing the cost of complexity of their services, seem to have opted, at least partially, for the latter.

TABLE 7

UNIT COSTS AND EXPENDITURES PER BENEFICIARY YEAR FOR OUTPATIENT AND HOSPITAL CARE

Country	Visits Benef.-year	Cost per visit (U.S.$)	Visit Expen. benef.-yr. (U.S.$)	Bed-days Benef. year	Cost per bed-day (U.S.$)	Hospital expen. Benef.-yr. (U.S.$)	Expenditures in proportion to GDP per inhabitant	
							Visit	Discharges
	1	2	3=1x2	4	5	6=4x5	7=3÷GDP	8=6÷GDP
Bolivia	2.713	3.60	9.77	.1390	19.44	2.70	3.48	0.96
Costa Rica	3.381	6.97	23.57	.6152	37.29	22.94	3.00	2.92
Dominican Republic	6.019	2.50	16.85	2.3224	13.41	31.14	2.73	2.17
Ecuador	3.833	4.00	15.33	.8524	18.00	15.34	3.56	3.56
El Salvador	5.580	3.39	18.92	1.0600	27.29	28.93	4.37	6.68
Guatemala	1.825	9.16	16.72	.7099	34.10	24.21	2.69	3.90
Honduras	3.961	2.85	11.29	.4270	32.49	13.87	3.06	3.76
Mexico	3.763	11.00	41.39	.4882	42.61	20.80	5.33	2.68
Nicaragua	-	6.20	-	1.0100	24.09	24.33	-	3.78
Panama	3.753	6.62	24.84	.3152	58.04	18.29	2.41	1.78
Peru	3.363	8.21	23.81	.7429	12.80	9.51	4.01	2.15
Venezuela	3.996	9.25	36.96	.6760	75.49	51.03	2.49	3.43

Source: -Visits and bed-days per beneficiary from the PAHO/WHO survey on social security institutions, 1977, except for El Salvador, Mexico and Nicaragua for which data was obtained from their annual reports.
-Costs per visit and per bed-day form the ILO statement at the V American Congress of Social Security Medicine - "The Participation of Institutions..." op cit., Table 24.
N -GNP per inhabitant, see Table 2.

TABLE 8

COMPARATIVE BENEFITS OF AFFILIATED AND DEPENDENT BENEFICIARIES

Country		General Medical visit	Specialized medical visit	Dental chekup	Medicine	Hospitalization	Maternity	Occupational accidents	Psychiatric	Eyeglasses	Orthopedics	Ambulance Service	Rehabilitation	Prosthesis	Social Services	% Pop./75	% Pop. increase 1970-75	Medical care hospital exp.US$1975
Argentina	A	x	x	x	x	x	x	o	o	*	*	*	o	o	o	57.5	n.a	n.a
	B	*	*	*	*	*	x	n.a	o	*	*	*	o	o	o			
Bolivia[1/]	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	18.5	7.3	12.5
	B	x	x	x	x	x	x	n.a	x	o	o	o	o	o	o			
Brasil INPS	A	x	x	*	*	x	x	x	x	o	*	o	*	o	o			
	B	x	x	*	*	x	x	n.a	x	o	*	o	*	o	o			
Brasil																77.6	8.9	n.a
FUNRURAL	A	x	x	x	x	x	x	x	x	o	o	o	o	o	*			
	B	x	x	x	x	x	x	n.a	x	o	o	o	o	o	*			
Colombia	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	7.3	1.5	n.a
	B	*	*	*	*	*	*	n.a	o	o	o	o	o	o	o			
Costa Rica	A	x	x	x	x	x	x	o	x	*	*	x	o	o	o	65.6	19.0	46.5
	B	x	x	*	x	x	x	n.a	o	*	*	x	o	o	o			
Chile	A	*	*	*	?	*	*	*	*	o	*	o	o	*	o	27.1	7.1	n.a.
(SERMENA)	B	*	*	*	?	*	*	n.a	o	o	*	o	o	*	o			
Dominican	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	3.6	- .30	48.0
Republic	B	x	x	o	x	x	x	n.a	o	o	o	o	o	o	o			
		8 mos.	8 mos															
Ecuador	A	x	x	x	x	x	x	x	x	x	x	o	o	o	o	6.2	1.1	30.7
	B	x	x	o	o	o	o	n.a	o	o	o	o	o	o	o			
		1 yr.	1 yr.															
El Salvador[2/]	A	x	x	x	x	x	x	x	x	o	x	o	o	x	o	4.0	1.8	47.8
	B	o	o	o	o	o	x	n.a	o	o	o	o	o	o	o			
Guatemala	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	12.0	2.6	40.9
	B	x	x	o	x	x	x	n.a	o	o	o	o	o	o	o			
		2 yr.	2 yr.															
Honduras	A	x	x	o	x	x	x	x	x	o	o	o	o	o	o	7.5	3.4	25.2
	B	x	x	o	o	o	x	n.a	o	o	o	o	o	o	o			
		5yr.	5 yr.															
Panama	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	36.9	14.3	43.1
	B	x	x	x	x	x	x	n.a	x	o	o	o	o	o	o			
Peru	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	10.8	3.1	33.3
	B	o	o	o	o	o	x	n.a	o	o	o	o	o	o	o			
Venezuela	A	x	x	x	x	x	x	x	x	o	o	o	o	o	o	24.0	5.0	87.7
	B	x	x	x	x	x	x	n.a	x	o	o	o	o	o	o			

A=affiliated; B=dependent; x=complete; *=partial; o=no report

Source: Survey on Social Security Institutions, PAHO/WHO, 1977

1/ For purposes of analysis, the different social security agencies have been grouped together since they offer the same services with the exception of dental prosthesis in cases of occupational accidents, a benefit provided by only two of the eight institutes.

2/ Information taken from "Organization Plans for Providing Medical Care to the Urban, Suburban and Rural Family Nucleus" a document prepared by CPISS-CRAMS for the IV American Congress on Social Security Medicine, Mexico, D.F., Sept.-Oct, 1974.

This table also shows another interesting phenomenon that indirectly supports the statement made recently. There is a great diversity of medical-social benefits in each program which cover areas inaccessible to the rest of the population due to their high cost--dental care, medicine, psychiatric care, and, in some programs, prosthesis and orthopedic equipment. The same choice between increasing benefits or expanding coverage seems to have been resolved in favor of the first alternative.

5. Availability and Yield of the Medical-Hospital Services

The preceding sections explored the potential of social security institutions' health systems for expanding their health services to the total population. Due to the limited data available, primary research was undertaken concerning the options these institutions have insofar as costs, utilization, complexity and coverage.

When analyzing inherent factors of social security that may have an effect on coordination between these institutions and the ministries of health, it is advisable to examine the comparative availability of human and physical resources for the beneficiaries and for the rest of the population. Attempts have been made to present overall indicators, since information concerning the ministries of health and other systems for delivering health services is limited.

It is general knowledge that the resources available to the rest of the population, those who are not social security beneficiaries, are not evenly distributed.

5.1 Table 9 shows a comparison of the availability of some human resources. It is necessary to provide some explanations of the data presented in this table:

i) Column 1 shows medical hours per 1,000 beneficiaries as contracted monthly by social security. The responses obtained in this category of the survey prove the difficulties in interpreting the concept of contracted month-hours. Therefore, all of the data was converted to calendar hours contracted by the institutions per month. Note that for Brazil (INPS), Costa Rica and Panama the data obtained is an underestimation of medical hours available for each 1,000 beneficiaries. In Brazil, this is due to the contracting method (payment for medical service rendered) and in the other two countries it is because only medical hours contracted for outside visits are recorded.

ii) There were also some difficulties in calculating column 2. For several countries it was necessary to estimate the total number of doctors for 1975. Although all professional health workers are not at any given time actively working in the field, due to retirements, fellowships or work

in other nonclinical branches of medicine, such as public health, administration, etc., it was impossible to calculate a suitable reduction coefficient. The number of medical hours available in a country is estimated below, assuming that on the average, physicians work 50 hours per week for 45 weeks out of the year. This figure takes into consideration vacations, illness, holidays and other idle periods. The number of hours contracted by social security was subtracted from the total number of hours available. This figure, when divided by the population not covered by social security, provides an index of medical hours available for each 1,000 inhabitants. This indicator, for the reasons stated previously, is an overestimation of medical time available in Brazil, Costa Rica and Panama, especially with respect to the population not covered by social security.

iii) Column 3 shows the number of graduate nurses contracted by social security.

iv) Column 4, unlike column 2, shows nursing resources available for the total population, including the social security beneficiary group. Once again, it was necessary to estimate the total number of nurses for 1975.

Columns 3 and 4 present certain difficulties in interpretation since one nurse may have more than one job, usually in different institutions. It was impossible to estimate this multi-employment factor for each country. It was also impossible to estimate the proportion of the two jobs performed in social security institutions or in other institutions. It was also not possible to determine the percentage of nurses that at any given time were not employed in their field. Both factors--multi-employment and inactivity--have an unfavorable effect on availability of resources for the country as a whole. For this reason, and in consideration of these exceptions, the figures presented in this table can be considered representative. The same factors were used when considering nurses aides. The data for this group is presented in columns 5 and 6.

The information presented shows two different tendencies. In six of the ten countries studied (Bolivia, Colombia, Dominican Republic, Ecuador, Guatemala and Honduras) there are more resources available for beneficiaries than for the rest of the population (medical time) or for the general population (nurses and auxiliaries). It is interesting to emphasize the consistence of the data since the levels for the three types of resources are the same, with the exception of medical time in Honduras. In three countries (Costa Rica, Panama and Venezuela) human resources for social security institutions are somewhat less than for the rest of the countries, even when considering that data on medical time in Costa Rica and Panama is distorted, for the reasons explained previously. It is impossible to reach any conclusions for Brazil because of the method used by INPS for contracting services.

TABLE 9

COMPARATIVE AVAILABILITY OF HUMAN RESOURCES FOR SOCIAL SECURITY INSTITUTIONS AND THE COUNTRY IN GENERAL 1975

Country	Physician Hours 1000 benef. (1)	Physician Hours 1000 inhab. (2)	Rate (1)÷(2)	Graduate Nurses 1000 benef. (3)	Graduate Nurses 1000 inhab. (4)	Rate (3)÷(4)	Nurses Aides 1000 benef. (5)	Nurses Aides 1000 inhab. (6)	Rate (5)÷(6)
Bolivia	119	77	1.55	0.81	0.19	4.26	0.64	0.17	3.76
Brasil -INPS[(a)]	45	181	0.25	0.06	0.08	0.75	0.20	1.30	0.15
Colombia	237	79	3.0	0.26	0.11	2.36	1.77	1.00	1.77
Costa Rica[(b)]	49	137	0.35	0.30	0.45	0.66	1.13	1.79	0.63
Dominican Republic	226	83	2.72	0.26	0.08	3.25	0.98	0.70	1.40
Ecuador	120	67	1.79	0.72	0.13	5.54	1.97	0.98	2.01
Guatemala	74	37	2.0	0.42	0.15	2.8	1.39	0.86	1.6
Honduras	60	64	0.94	0.19	0.12	1.58	1.73	0.67	2.58
Panama[(b)]	88	173	0.51	0.55	0.71	0.77	1.23	1.66	0.74
Venezuela	175	226	0.77	0.36	0.74	0.49	1.38	1.60	0.86

Sources: PAHO/WHO Survey on Social Security Institutions, 1977.
-Health conditions in the Americas 1973-75 (soon to be released) PAHO/WHO
-Population: IDB: "Economic and Social Progress..." op cit.

Notes: (a) Contracted physician hours only. Payment per medical activity makes it possible to account for available hours for beneficiaries.

(b) Physician hours contracted by social security for outpatient care only.

-In columns 1 and 2 the number of hours corresponds to one month.

-Column 2 to the population not covered by social security, while columns 4 and 5 refer to the entire population of the country, including social security beneficiaries.

Finally, note that all of the countries listed as unlikely to extend social security health system's services to their entire populations show inconsistencies in availability of human resources favorable to social security. Panama, qualified as doubtful, and Venezuela, qualified as feasible, show inconsistencies (although small) which are advantageous to the general population.

5.2 Table 10 shows similar comparisons for hospital resources for short-term stays. Column 2, beds per 1,000 inhabitants, shows hospital beds available to the population not covered by social security. This figure includes both beds that do not belong to social security and those which are not contracted by this institution. It is necessary to point out that beds belonging to and contracted by social security can result in an underestimation of hospital resources available to beneficiaries in those cases in which these institutions pay for hospitalizations without contracting the service on a permanent basis.

The information presented proves what had already been established with respect to human resources. Levels of delivery for social security beneficiaries are greater than those available for the rest of the population. An exception to this statement occurs in the cases of Costa Rica and Panama.

5.3 Tables 11 and 12 present several indicators of yield or utilization of health services. With respect to yield of medical resources (Table 11), attention focuses on the variations from one country to another in the quotient between specialized visits and medical visits. Part of this variation is probably a reflection of different definitions rather than a reflection of completely different models of medical practice. For this same reason, it would not be wise to draw conclusions concerning the level of specialization of medical services provided by social security health systems, although the high level of specialized visits is conspicuous.

Lastly, Table 12 presents some indicators of the yield of hospital resources. The high average of discharges per bed-year may reflect not only a high yield but also a high proportion of discharges due to maternity. Maternity discharges, because of their very nature, involve a shorter average stay than hospitalizations in general. The significant, positive correlation ($r^2 = 0.50$) between discharges per bed and the percentage of discharges due to maternity tend to confirm this impression. In most countries, the high percentage of hospitalizations for maternity reasons is potentially an area in which savings could be made if the institutionalization of delivery is debated effectively and rationally.

The range between days of stay for general hospitalizations is surprising. The length of stay varies from 5.3 days in Mexico to 18.66 days in Venezuela.

TABLE 10

COMPARATIVE AVAILABILITY OF HOSPITAL RESOURCES[1] FOR SOCIAL SECURITY INSTITUTIONS AND THE REST OF THE COUNTRY

Country	Bed/1000 benef. (1)	Beds/1000 inhab. (2)	Rate Soc.Sec/country (3)
Bolivia	4.09	1.01	4.0
Brasil -INPS	2.66	1.38	1.93
Colombia	3.13	1.66	1.88
Costa Rica	1.94	4.37	0.44
Dominican Republic	7.74	2.23	3.47
Ecuador	2.96	1.46	2.02
El Salvador	3.94	1.23	3.20
Guatemala	3.30	1.19	2.77
Honduras	2.29	1.36	1.68
Mexico	1.34	0.72	1.86
Nicaragua	2.78	1.64	1.69
Panama	1.36	3.83	0.35
Peru	2.29	1.64	1.39
Venezuela	2.65	1.96	1.35

Sources: Hospital beds and beneficiary population from the"PAHO/WHO Survey of Institutions..." op cit.

-Country's hospital beds from "Health Conditions in the Americas 1973-1975" (to be released) PAHO/WHO.
-Population: BID "Economic Progress..." op cit.

Note (1) Beds for short stays only. Beds for long stays usually belong to the Ministry of Health and serve the entire country regardless of the financing methods used.

-The rate in column 2 was calculated by subtracting the total number of hospital beds in the country from the number of beds which belong to the social security institute or are contracted by it. The total number of people in the "protected" population, which includes beneficiaries affiliated with the social security system and those dependents whose rights are not limited solely to maternity benefits, was sustracted from the total number of inhabitants in the country.

TABLE 11

UTILIZATION OF MEDICAL RESOURCES SOCIAL SECURITY INSTITUTIONS -1975

Country	Special medical visits/general medical visits	Medical hours/ month/1000 beneficiaries
Bolivia	0.45	119
Brasil -INPS	1.03	45.2
Colombia	0.49	236.9
Costa Rica (1)	0.45	48.5
Dominican Republic	0.12	226
Ecuador	0.71	120.4
El Salvador	1.22	n.a.
Guatemala	1.49	74.7
Honduras	1.06	59.6
Panama (1)	0.80	88.3
Peru	0.57	n.a.
Venezuela	0.92	174.5

Source: Survey on Social Security Institutions PAHO/WHO, 1977.

Note (1) Medical hours contracted for outside visits only.

TABLE 12

UTILIZATION OF HOSPITAL RESOURCES SOCIAL SECURITY INSTITUTIONS 1975

Country	Average days of stay for maternity	Average days of stay for other hospitalizations	Discharges per bed-year	% of discharges for maternity
Bolivia	3.94	11.27	19.2	14.7
Brasil[2] INPS	3.27	10.37	39.5	26.1
FUNRURAL	n.a.	n.a.	n.a.	26.5
Colombia	2.78	8.93	46.3	41.1
Costa Rica	3.30	8.08	49.4	35.0
Chile - SERMENA	2.68	5.81	n.a.	41.8
Dominican Republic	3.57	12.23	22.5	30.8
Ecuador	4.25	12.29	27.7	23.7
El Salvador[1]	3.24	7.89	48.3	46.8
Guatemala	3.54	10.31	26.5	32.7
Honduras	2.95	7.44	34.6	46.2
ɜxico - IMSS[2]	2.6	5.3	56.3	44.4
Nicaragua[2]	3.2	7.8	39.4	38.1
Panama	3.19	10.90	27.0	30.7
Peru	4.12	12.92	23.1	27.2
Venezuela	3.18	18.66	19.5	36.3

Source: Survey of Social Security Institutions, PAHO/WHO, 1977

Notes (1) Data taken from "Report 1975-1976" Salvadorean Social Security Institute

(2) Data taken from "Participation of Social Security Institutions in Family Planning Programs". ILO statement at the V American Congress on Social Security Medicine," Caracas, July 1976.

6. Coordination between Social Security Institutions and Ministries of Health

This section uses the information collected in the survey to study the coordination processes existing in these countries. We must point out the difficulty of attempting to summarize the varied conditions in a schematic presentation. Such a presentation implies the danger that specific situations will not be included totally. The only way to reduce this danger is through a country-by-country casuistic treatment of coordination activities. Such a process would not only have made this document very lengthy, but even more important, it would have changed it from a regional analysis into a document concerned with the peculiarities of each country.

This section also contains information obtained from a second questionnaire which was sent to authorities of the ministries of health in an attempt to collect data on coordination as they see it. As will be seen, the evaluation of this process by authorities from both institutions reveals some significant discrepancies which must be studied and resolved.

Tables 13 to 17 present information on existing coordination processes according to responses by social security authorities. The five aspects considered were: legislation, existing coordination in medical care programs, institutional support, capital investments, and the development of human resources. From a general point of view, there is an important degree of correspondence among the different aspects of coordination in each country. Thus, generally speaking, a country with coordinated programs in one area is very likely to have coordinated programs in other areas. According to this information, Venezuela and Panama seem to have covered all areas for coordination, followed by Costa Rica, Chile and Brazil.

In five of the ten countries for which information was received from ministries of health (Costa Rica, Ecuador, El Salvador, Guatemala and Venezuela), committees for coordination between these institutions and the social security institutions exist or have existed in the past. However, according to social security authorities, these committees have effective authority in only two of the five countries (Venezuela and Costa Rica) when dealing with capital investments--construction and equipment. Of the 13 social security institutions providing information, only four (Costa Rica, Peru, Chile and Colombia) cooperate with the Ministry of Health in capital investments. Eight cooperate with other ministries (Ministry of Finances) or with the national planning office. According to three social security institutions (Ecuador, El Salvador and Dominican Republic) there is no cooperation in this area, although comments by authorities from the Ministries in El Salvador and the Dominican Republic do not agree with this evaluation.

To be more specific, the information received could be an indication that there is insufficient legislation in several countries, as shown in Table 13. This lack of appropriate legislation could restrict more effective action in these countries, especially in activities for expanding coverage and in capital investments.

TABLE 13

LEGISLATION FOR COORDINATION OF SERVICES WITH THE MINISTRY OF HEALTH AND OTHER INSTITUTIONS

Country	Extension of coverage	Preventive care	Hospital care	Institutional support services	Capital investment	Development of human resources	Studies and research	Information systems
Argentina	o	o	o	o	o	x	o	x
Brasil - INPS	-	x	x	x	x	x	-	-
- FUNRURAL	-	x	-	-	-	-	-	-
Bolivia - CNSS	x	-	-	-	-	x	-	-
Colombia	-	x	-	x	-	-	-	-
Costa Rica	x	x	x	-	x	-	-	x
Chile - SERMENA	x	x	x	-	-	-	-	-
- SNS	x	x	x	-	-	-	-	o
Dominican Republic	-	-	-	-	-	-	-	-
Ecuador	-	-	x	-	-	-	x	-
El Salvador	o	o	o	o	o	o	o	o
Guatemala	-	-	-	-	-	-	-	-
Honduras	-	-	-	-	-	-	-	-
Panama	x	x	x	x	x	x	x	x
Peru	o	o	o	o	o	o	o	o
Venezuela	x	x	x	x	x	x	x	x

Source: PAHO/WHO Survey on Social Security Institutions, 1977

Notes: x= has

-= does not have

o= does not report

Table 14 refers to the field of service programs and shows two types of programs. In some countries, such as Brazil, Costa Rica, Chile, Panama and Venezuela, most of the services seem to be coordinated. In the remaining countries, coordination occurs more frequently in some programs than in others, for example, programs in tuberculosis and communicable diseases. It should be remembered that this area includes care of the chronic patient, an area which is not usually covered by social security health systems.

Table 15 proves the difficulty of coordinating institutional programs, with the exception of Panama and Venezuela, where there seems to be almost complete coordination. Such examples are rare and limited to a very few countries.

The field of capital investments, Table 16, refers to coordination of investments. This is a key area for coordination. Investments are a promise of long-term resources provided either directly through investment itself or indirectly through the operational expenditures that it generates. The table shows that there is still a long road ahead in attempting to plan and implement capital investments under one plan for the entire country.

Table 17 shows five countries in which the development of human resources is coordinated in all categories of staff. Activities are being undertaken in this area in another three countries.

Lastly, we should emphasize that it is impossible to establish the quantity of efforts for which information was received and especially their results. This difficulty, in combination with a lack of agreement on the definition of coordination, gives rise to some doubts concerning the true significance of the information which has just been presented. Direct evidence collected during interviews held in several countries, which will be presented in the second part of this Annex, tends to confirm these doubts.

TABLE 14

COORDINATION OF MEDICAL CARE WITH MINSAP AND OTHER INSTITUTIONS

Country	Tuberculosis	Communicable diseases	Enteric diseases	Nutrition	Maternal and child health	Dental health	Mental health	Chronic diseases	Industrial accidents	Rest homes	Food program
Argentina	o	o	o	o	o	o	o	o	o	o	o
Brasil - INPS	x	x	x	-	x	x	x	x	-	o	o
- FUNRURAL	-	x	-	-	-	-	-	-	-	o	o
Bolivia - CNSS	-	-	-	-	-	-	-	-	-	o	o
Colombia	x	x	-	-	-	-	-	-	-	o	o
Costa Rica	x	x	-	x	x	x	-	x	x	o	o
Chile (National Medical Service for employees)	x	x	x	x	x	x	-	x	-	o	x
Chile (National Health Service)	x	x	x	x	x	x	x	x	x	o	o
Dominican Republic	-	x	-	-	-	-	-	-	-	o	o
Ecuador	x	x	-	-	-	x	-	-	-	x	o
El Salvador	x	o	o	o	o	o	x	o	o	o	o
Guatemala	x	-	-	-	-	-	x	-	-	o	o
Honduras	x	-	-	-	-	-	x	-	-	o	o
Panama	x	x	x	x	x	x	x	x	x	o	o
Peru	x	x	-	-	x	-	-	-	-	o	o
Venezuela	x	x	x	x	x	x	x	x	x	o	o

Source: "PAHO/WHO Survey..." op cit.

Notes: x= has

-= does not have

o= does not report

TABLE 15

COORDINATION OF INSTITUTIONAL SUPPORT WITH MINSAP AND OTHERS

Country	Supply center	Maintenance	Laundry	Sterilization and Maternity	Ambulance	Laboratories	X-rays	Intensive Care	Cobalt bomb	Radiation therapy
Argentina	-	-	-	-	-	-	-	-	o	o
Brasil - INPS	-	-	-	-	-	-	-	o	o	o
- FUNRURAL	-	-	-	-	-	-	-	o	o	o
Bolivia - CNSS	-	-	-	-	-	-	-	o	o	o
Colombia	-	-	-	-	-	-	-	-	o	o
Costa Rica	-	-	-	-	-	x	x	x	o	o
Chile (National Medical Service for employees)	x	-	-	-	x	x	x	-	o	o
Chile (National Health Service)	x	-	-	-	-	x	-	-	o	o
Dominican Republic	-	-	-	-	-	-	-	-	o	o
Ecuador	-	-	-	-	-	-	-	-	o	o
El Salvador	o	o	o	o	x	x	x	o	o	o
Guatemala	-	-	-	-	-	-	-	-	o	o
Honduras	-	-	-	-	-	-	-	-	o	o
Panama	x	x	x	x	x	x	x	x	x	x
Peru	-	-	-	-	-	-	-	-	o	o
Venezuela	x	x	x	x	x	x	x	x	o	o

Source: "PAHO/WHO Survey..." op cit.

Notes: x= has

-= does not have

o= does not report

TABLE 16

COORDINATION OF CAPITAL INVESTMENTS

Country	Ministry of Health		Coordination Committee		Other Ministry Finances or Nat. Planning Office	
	Constr.	Equip.	Constr.	Equip.	Constr.	Equip.
Argentina	o	o	o	o	o	o
Bolivia - CNSS	o	o	o	o	x	x
Brasil - INPS	–	–	–	–	x	–
- FUNRURAL	o	o	o	o	x	x
Colombia	x	x	–	–	–	–
Costa Rica	x	x	x	x	x	x
Chile - SERMENA	x	x	o	o	o	o
Chile - SNS	x	x	–	–	x	x
Dominican Republic	–	–	–	–	o	o
Ecuador	–	–	–	–	o	o
El Salvador	–	–	–	–	–	–
Guatemala	–	–	–	–	x	–
Honduras	o	o	o	o	x	x
Panama	–	–	–	–	x	x
Peru	x	o	o	o	o	o
Venezuela	o	o	x	o	x	x

Source: "PAHO/WHO Survey..." op cit.

Notes: x= has

–= does not have

o= does not report

TABLE 17

COORDINATION IN THE DEVELOPMENT OF HUMAN RESOURCES

Country	Management Executive Staff	Physicians	Dentists	Graduate Nurses	Midwives	Pharmacists	Dietitians	Technologists	Social Workers	Other Professional Staff	Nurses Aids	Administrative Personnel
Argentina	-	x	-	x	-	-	-	-	-	-	x	x
Brasil - INPS	-	-	-	-	-	-	-	-	-	-	-	-
- FUNRURAL	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia - CNSS	o	o	o	o	o	o	o	o	o	o	o	o
Colombia	-	x	x	x	o	x	-	-	-	-	-	-
Costa Rica	-	-	-	-	-	-	-	-	-	-	-	-
Chile (National Medical Service for Employees)	x	x	x	x	x	x	-	-	x	-	-	x
Chile (National Health Service)	x	x	x	x	x	x	x	x	x	x	x	x
Dominican Republic	x	x	-	-	-	-	-	x	-	-	x	-
Ecuador	-	-	-	-	-	-	-	-	-	-	-	-
El Salvador	x	x	x	x	x	x	x	x	x	x	x	x
Guatemala	-	-	-	-	-	-	-	-	-	-	-	-
Honduras	-	-	-	-	-	-	-	-	-	-	-	-
Panama	x	x	x	x	x	x	x	x	x	x	x	x
Venezuela	x	x	x	x	x	x	x	x	x	x	x	x

Source: "PAHO/WHO Survey..." op cit.

Notes: x= has

-= does not have

o= does not report

SECTION B: INFORMATION PROVIDED BY COUNTRY VISITS

During the country visits, a series of interviews were held with authorities from the ministries of health, social security institutions and medical associations, and with press officials and representatives of the employers and the beneficiaries.

The interviews were conducted according to a previously established guide. The same guide was used for all countries and there were open answers to most of the topics discussed. The principal aspects considered in the interview guide concerned:

- Existing coordination
- Degree of coordination felt to exist
- Coordination that should exist (ideal)
- What is expected to occur in the next three years; will it be favorable to coordination
- Political-administrative level responsible for making decisions
- Definition of the concept of coordination

The individuals interviewed were encouraged to express any other opinions that would add to the topics discussed.

Attempts were also made to permit the person being interviewed to evaluate social security health systems as they exist in his country. The most relevant aspects of the information collected are presented in the remaining pages of this annex.

In order to insure that the remarks made by the persons interviewed are kept confidential, this section omits references from the transcriptions.

7. Conditions by Country

7.1 Jamaica

Of the six countries visited, Jamaica should be considered separately, since social security in this country does not provide direct medical-hospital services and there are no plans for establishing such services. Social security administers a compensation program for injuries suffered in industrial accidents and for certain occupational diseases, thus providing protection for workers in several fields. A law exists, but has not been implemented, which provides for the creation of universal health insurance in Jamaica. This law is in agreement with the stated policy "to provide the entire population with all services possible in view of the country's resources, and then to plan to improve these services."

There is no apparent agreement on the specific tools that should be created to implement these statements. Some of the people interviewed questioned the role of the State as administrator of a financial insurance and as the owner and administrator of direct services. Others emphasized the duplication and waste caused by private services which absorb a large part of the resources for the care of a small elite. The State shows an ambivalent attitude in financing 50 per cent of the (private) health insurance premiums of its employees while at the same time promoting an equal access policy.

In short, according to the opinions expressed by the people interviewed, the Jamaican Government would not be interested in adding a supplementary medical-hospital care program specifically for workers to its health and welfare program. On the other hand, it is considering making services of some kind available to all residents. To this end, the Government is carring out diagnostic research and planning for the necessary changes. However, there does not seem to be any agreement on the specific role of the State in the services system to be developed.

7.2 Brazil

In this country, social security is responsible for financing medical-hospital services for most of the population. In order to provide this service, the traditional means of financing has been changed by creating new sources of income. A well-defined policy for contracting services from public and private suppliers has been adopted which limits direct delivery of services as much as possible. These policy decisions and the law creating the National Health System (SNS) have changed conditions for coordination in this country in comparison with what they were 15 years ago. At that time, there were a series of independent social security agencies with their own services largely unrelated to the Ministry of Health (federal) and the State or municipal offices' services. The SNS law (No. 6229 of 1975) establishes areas for institutional responsibility with respect to service coverage by assigning operational duties to several ministries. The Ministry of Health (MS) is supposed to develop national health policy by increasing its policy-making responsibility with respect to public health and medical care. This Ministry should also supervise and implement collective programs of a basically preventive nature. The Ministry of Social Welfare and Public Assistance (MPAS) is concerned with medical-health care services either directly or through contracts. The Ministry of Education is responsible for training human resources on the intermediate and advanced levels, as well as for maintaining university hospitals. The Ministry of the Interior should be active in the fields of environmental health and housing sanitation. The Ministry of Labor is responsible for preventing job-related accidents and diseases. High-level political coordination for health and other areas of the social sector is the responsibility of the Social Development Council (CDS), which is directed by the President and composed of the above-mentioned ministries. The executive organ is the President's Planning Office. The law also

emphasizes coordination between ministries on programs of activities and in preregistration of some capital investments, such as hospital construction, etc. A study prepared by one of the ministries as background for this law (January 1975), and which was quoted during one of the interviews, states: "In all studies on Brazilian medical health and social welfare services published during the last twenty years, complete absence of coordination between agencies working in this sector has been conspicuous.... This situation can be explained in part by the lack of a legal mechanism which defines the authority and responsibilities of the three levels of government...."

The interviews, held two years after the time when the preceding remarks were made, showed significant changes in the way the problem was perceived. Although the opinions expressed were by no means unanimous, most of the people interviewed agreed that there is a coordination process, although some considered it incipient. They also agreed that the law helped to define responsibilities and fields of action and has helped establish coordination of MS and MPAS programs by forming a Permanent Consultation Committee. Some negative aspects were the lack of regulation in the law, the division of preventive medicine and health care operations into two different institutions, and the lack of coordination between health care programs and programs for training human resources. Most of the people interviewed preferred the development of a coordinated system to coordination of autonomous systems or the creation of a national health service, as long as conditions in the next three years are favorable for such a process. With respect to justification of social security services, answers can be classified as follows: good as it is; justified if it is a coordinated system; good if it is changed so it is not a discriminatory system, and if it covers 100 per cent of the population. The opinions of the people interviewed were divided between the last two answers.

The President, the CDS and the Congress were listed in that order as the levels which should be responsible for policy-making decisions needed to strengthen the process. However, there is not complete agreement on this aspect. On the other hand there was more agreement that coordination assumes "promising to carry out joint tasks according to standards jointly agreed upon for beneficiaries of both institutions."

These responses could partially reflect a much more complex situation as shown in the following opinion: "Notable progress has been made in Brazil in the last 10 or 15 years, but, as has been stated, there are still huge gaps. The tendency to discredit and demoralize public hospitals and to make them seem inefficient, as well as the commercialization of services due to extensive participation of the private sector, which has different interests and goals, are the basic causes of these gaps and limitations."

7.3 Costa Rica

This country also shows a special evolution. From a tripartite organization for providing services, composed of the Ministry of Health (M de S), the Social Welfare Board, and the Costa Rican Security Office (CCSS) there has been a division of responsibilities as a first step in creating a National Integrated Health Service (SNS). At the present time, health care levels I and II (non-professional and general outpatient) are the responsibility of the M de S through its Rural Health and Community Health Programs. Level III, basic specialization, and Level IV, high-level specialization, are the responsibility of CCSS. Eventually the four levels will operate as a single institution, which will probably be autonomous with policy controlled by the M de S. This institution will be financed at least partially by the CCSS. The common goal of authorities in both institutions is to put health services within the reach of the entire population.

The people interviewed agreed that the existing process could be classified as an integration process, although there was some minor disagreement with respect to its suitability and advantages. Some doubts were expressed on the effect of the political decision to integrate services, since there may be a change of administration (elections at the beginning of 1978). In spite of this, most of the people interviewed stated that integration will probably be completed in the next three years. As in the case of Brazil, social security health programs were felt to be justified as long as they are not discriminatory and they cover 100 per cent of the population.

On the other hand, there was no clear agreement on who should make future policy decisions. However, the Congress and the President were the institutions mentioned most frequently. Just as in Brazil, the people interviewed unanimously agreed that the concept of coordination involves a pledge to undertake joint tasks established through joint planning to serve the beneficiaries of both institutions.

Of course, unfavorable opinions such as the one repeated below were also collected: (The ideal is) "...to have several agencies for providing health services so there will be several employers of health service personnel, which will provide incentives that will improve services. (This person also thinks that) "...at the present time CCSS is providing services for the masses without considering the individual."

7.4 Mexico

The opinions collected in Mexico are especially interesting because of the power and prestige enjoyed by social security institutions in this country.

We must note briefly that public sector medical hospital services in the country are organized under three independent institutions: The Ministry of Health and Welfare (SSA), the Mexican Social Security Institute (IMSS),

and the Social Security Institute for Government Employees (ISSSTE). There are also some other agencies financed with public funds, but to a lesser degree.

We must also remember that the interviews in this country took place immediately after the change in administration. This is important since, although many opinions would inevitably reflect intentions rather than performance, they do indicate the trend that could be followed for some time to come.

It was generally agreed that cooperation between the SSA, the IMSS and the ISSSTE was an uncertain process depending almost entirely on the political desire of the President of the Republic. All of the opinions on existing coordination refer either directly or indirectly to the importance of the President in developing coordination. Indirectly, this suggests resistance or at least institutional indifference which must be overcome. However, this fact was indicated by only one of the people interviewed in this context: (Coordination) "...has not been very effective because of institutional jealousy. Due to the very different characteristics of health sector institutions, it is very difficult for coordination to produce good results."

With respect to ideal coordination, six of the eight persons interviewed expressed their satisfaction with the current process. Only two people were in favor of a single system for delivering health services which would eliminate existing autonomous institutions. Two representative opinions are presented to illustrate the importance given to institutional autonomy in the ideal coordination process. "Personal health care services should be delivered by a single health agency, but without eliminating the agencies which exist at the present time." "There should be a single national agency with responsibilities involving planning, standards, research and evaluation, but each agency should be allowed to continue to develope autonomously." Most of the people interviewed feel that events in the next three years will be favorable to their ideal of coordination. Only one of the people interviewed felt that development in the next three years will not be favorable, not because of a lack of coordination, but because it will not be possible to establish one single health service.

All of the informants felt that social security was justified since "it guarantees suitable service for a part of the population (workers) important to the country's development." On the other hand, there was no agreement on justification for existing social security plans. Of the eight opinions collected, two stated that social security needed institutional reforms in order to cover nonbeneficiaries. Another three people justified existing plans as long as there is coordination between them and other health institutions. The remaining three people expressed their unconditional support.

Policy decisions favorable to coordination of the services should be made by the President (8/8), by the health and social security authorities (5/8) or, thirdly, by the Congress (4/8). It is noteworthy that very few people mentioned union leaders as important in decision-making and none of them mentioned the Ministry of Labor as an important element.

Three activities were mentioned most frequently as specific areas in which coordination should take place:

- planning and joint implementation of services for beneficiaries of both institutions;
- staying informed;
- maintaining good institutional relations.

Finally, it is interesting to note the importance that the authorities interviewed gave to the socio-cultural background of the problem: (The person interviewed thinks) "...that one of the restrictions on coordination, one which I feel will be sufficiently overcome, is individualism which, for cultural reasons, is a characteristic of the Mexican people."

Another of the informants feels "that a single health service looks very nice in theory and can function in other countries, but not in Mexico, due to its cultural situation."

7.5 Panama

The situation in this country also presents very special characteristics. Traditionally there were two institutions, the Panamanian Social Security Office (CPSS) and the Ministry of Health, which provided most of the personal health services, although they operated independently. After 1972, this situation changed considerably when a slow process for integrating the services of these two institutions in eight of the country's nine provinces was started. These provincial integrated services are directed by a regional chief with authority granted to him by both institutions. In Panama City, the only province still to be integrated, the institutions continue to work separately with direct delivery of services. The CPSS does contract some services with the Ministry of Health. The purpose of this integration process is rapid creation (by 1980) of a single health service that indiscriminately covers 100% of the population.

The people interviewed were unanimous in their evaluation of this process, reflecting more or less exactly the conditions described above. However, there was one strong dissenting opinion in the evaluation: "Wherever integration has occurred, problems have been created and the autonomy of the office has been lost. I do not agree with this loss of autonomy." The majority classified the process as a positive and beneficial alternative which corresponded to their ideal of a health services organization. It was generally agreed that the integration process will be completed, although

there are various estimates of the time this will take. In keeping with the previous remarks, the majority feel that social security is justified only when it assures coverage for the entire population. The only unfavorable opinion is interesting, since it is the first one to relate coordination and integration with financing and its implications: "Social Security (is justified) by those individuals who are insured, as is cooperation (with the Health Ministry). Integration is not justified because the State would be acting irresponsibly by taking money from the fund to serve different sectors of the population which should be served with different funds."

Lastly, all of the people interviewed identified the Head of State as the source of decisions needed in the sector in order to complete the above-mentioned integration process.

7.6 Venezuela

All of the people interviewed felt that existing coordination is completely inadequate. They pointed out that there are many institutions in the public sector (about 100) that deliver health services directly. There are, however, six large institutions which are, in order of their importance: the Ministry of Health and Social Welfare (SAS), the Venezuelan Social Security Institute (IVSS), the State Officials' Social Welfare Offices, the Federal District Welfare Board, the medical services of the National Armed Forces, and the Institute for Pensions and Social Welfare for Employees of the Ministry of Education (IPAS-ME).

Coordination could be summarized by the ideas expressed in 1974 by a special committee charged with studying the health sector: (There is) "...a great deal of variability in the delivery of health services, and the beneficiary population is segmented with each section receiving different treatment. (Specifically)...there is a lack of effective coordination between the different institutions." In spite of this, examples of joint activities among these institutions have existed and do exist today. These activities indicate possibilities for the implementation of cooperative efforts:

- Creation of health regions through agreements between SAS and the State Governments

- Creation of the Committee for Coordination of National Health which designed a National Hospital Plan for the country

- Formation of several committees to study coordination and/or integration of institutional health services.

These efforts led to the creation of the Coordinated National Health System. This is an agency which makes it possible to combine the resources of several institutions without destroying their autonomy while preparations are under way for the establishment of a single national health service. It is noteworthy that in the Federal District, district authorities and authorities from the Coordinated System are establishing integrated programs for delivery of services according to specialization and geographic area in order to move towards implementation of the process.

The majority of the people interviewed consider the National Health Service to be the ideal type of service organization for the country.

Those interviewed were almost unanimous in believing that it is highly improbable that a single health service will be created in the next three years. The majority of the people are pessimistic with respect to current intentions to integrate the Coordinated National Health System. The following remark seems to summarize feelings on this aspect: "The creation of SNS, which I understand is necessary to eliminate discrimination against people with no coverage, who also subsidize IVSS, would bring down the Government in 48 hours because of opposition by social security officials, who enjoy great privileges, and the directors, who have great economic and political power. They would lose this power if SNS is integrated. There would also be opposition from the Workers' Headquarters which considers the institution to be a class victory that must not be lost."

In addition to these reasons, we can cite the political-administrative instability due to the coming election, the need for patterns and the need for a law to provide support for the coordination/integration process, since existing presidential decrees may cause objections. For example, one proposed law is blocked by several interest groups (professionals, bureaucrats, and labor unions). There seems to be formal acceptance of the coordination/integration of services by these interest groups at the same time as they are presenting what one of those interviewed called "cotton-wool resistance."

However, there were some people who felt more optimistic with respect to current efforts. They felt that the coordination strategy which has been adopted can and will be completed under present circumstances.

The majority of the people interviewed felt that social security health services are justified as long as they are not discriminatory and they help to provide services to 100 per cent of the population. Social security is considered to have universal obligations and responsibilities and therefore should not provide special protection for one group.

When asked about the existing concept of coordination, the people interviewed were unanimous in declaring that this means "joint agreement on implementation of common tasks for serving beneficiaries from all of the institutions" (who live in a certain geographic area) as well as "joint planning to indiscriminately provide services to the residents of specific regions."

There seems to be a serious contradiction between opinions expressed and actual progress. In Venezuela, as in the other countries visited, there are strong forces from different sources that are attempting to halt integration and even coordination of services.

7.7 General Ideas

The following pages present some ideas expressed by the people interviewed concerning objectives, tools, obstacles and factors that play an important role in coordination or integration of medical-hospital services.

It is difficult to present these ideas in an orderly fashion, since they are all interrelated. For purposes of analysis, however, they can be grouped according to institutional, economic, bureaucratic and political factors.

a) Institutional Factors

These factors are basically linked to differences in institutional objectives. The objectives of the two institutions have been different. Social security health systems are basically responsible for the administration of an insurance plan with direct delivery for people with moderate incomes--the salaried workers. On the other hand, the ministries of health have been responsible traditionally for delivering services for people with medical needs who do not have the resources to pay for this care and who do not pay dues to the social security system.

The differences that have existed historically between these two institutions with respect to objectives, economic and political power and the complexity of the services delivered have created unequal prestige which makes cooperation difficult. This inequality is partly responsible for what the authorities interviewed called "institutional jealousy" and which they identified as one of the strongest barriers to effective coordination.

b) Economic Factors

From the economic point of view, difficulties in coordination have been caused by disparities in the per capita financial, human and physical resources available to the two institutions. These disparities have resulted in programs characterized by different degrees of complexity, different pay scales and methods of payment for personnel, and different perceptions of the right of beneficiaries and non-beneficiaries to receive services. These three factors are very important.

Differences in the complexity of services arise from explicit or tacit acceptance on the part of social security authorities that their economic power allows them to establish advanced standards and procedures frequently imported from the more developed countries. These standards and procedures are contrary to the economic potential of the country in general and of the public health services in particular.

The new concept of social justice and the cooperation needed for its implementation require the establishment of guidelines and procedures which are adapted to the resources available to the entire society. These guidelines and procedures should make it possible to provide suitable minimum care to each member of the society regardless of his economic capacity, social level or geographic location.

Economic disparity has created levels of payment for personnel and other employment conditions, especially for professional staff, that are completely unattainable for the ministries' health services. Competition for a resource that in most of the countries is very scarce provides much greater benefits for social security beneficiaries than for the general population. In spite of specific recommendations for achieving a balance of personnel in both institutions, the authorities interviewed felt that this aspect was one of the greatest obstacles to coordination.

These differences in the level of resources, the method in which resources are collected and the availability of services creates a different attitude on the part of the beneficiaries. The beneficiary feels that by paying his dues he has acquired certain rights and he demands to be given his rights. The public health patient, on the other hand, rarely rationalizes his tax payments (which finance health services and social security in addition to other State activities) as giving him the right to receive these services. Most of the non-beneficiary population still feel that they are receiving charity rather than being entitled to receive services.

c) Bureaucratic Factors

There is a general conviction that the administrative structures of the ministries of health and the social security agencies are a source of resistence.

On the upper levels, there is often obvious competition between executives of both institutions to obtain the prestige and power associated with health service delivery, and especially the volume of resources handled. This makes it even more difficult to develop the necessary spirit of cooperation and understanding which form an indispensable basis for successful coordination. This rivalry on the upper levels also permeates the intermediate structure of the bureacracies through competition for higher levels of pay and better working conditions.

Lastly, there is more or less open resistence from small but powerful sectors of the medical profession who benefit from the possibilities for multi-employment resulting from the separation of the two systems and lack of coordination. Several leaders of the medical profession expressed their concern with respect to repercussions that such duplication (or triplication) of employment may have on physicians' time, the quality of the work and the morals and ethics of the profession in general. In their opinion, due to the higher level of remuneration offered by social security, the staff members often do not completely fulfill their responsibilities when working for the ministries.

They also indicated the difficulties presented by the predominance of a medical ideology which emphasizes professional values that are not always consistent with the goals of coordinating or integrating services. They also pointed out the importance given to free choice by the patient and to methods and levels of remuneration which facilitate professional autonomy. Another important aspect is the development, through the initiative of professional health workers, of high degrees of complexity and high quality services, regardless of the economic capacity of the society to pay for them.

d) Political Factors

From the political point of view, a basic factor is the existence of various pressure groups whose interests are not consistent with the goals of greater coordination or integration of health services systems. To the groups already discussed--administrators, health personnel and health services executives--we must add some labor union leaders and the leaders of political parties.

Labor leaders holding executive positions in social security agencies seem disinclined to accept the idea of sharing with all inhabitants what they consider "their resources." Legitimally, they are more concerned with the effectiveness and efficiency of social security programs themselves and in developing systems for supervision in order to insure that they receive the services for which they have paid.

Employers, as far as we could tell, did not seem to be concerned about coordination between the social security agencies and the ministries of health.

According to the opinions collected from newspapers, the general public is interested in access to health services and the system's efficiency. The countries visited were selected because they were undergoing important changes in the field of coordination. It was not surprising to discover that the public was well informed and that policies in favor of greater integration received general support. This was reflected in the opinions held by leading politicians, who expressed their understanding and their desire to adopt coordination policies.

This attitude on the part of the public is probably the result of a basic change in the aspirations and expectations of the population due to the growth of the idea that access to health services is an individual right that should be guaranteed by the State. This phenomenon is by no means universal and there are still sectors, especially among the less-privileged rural workers, where the people's perception of their rights is similar to that held by people who are being given charity.