directing council | *regional committee*

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XXX Meeting | XXXVI Meeting

Washington, D.C.
September-October 1984

INDEXED

Provisional Agenda Item 22

CD30/18 (Eng.)
24 August 1984
ORIGINAL: ENGLISH

COORDINATION BETWEEN SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

In accordance with the requirements included in Resolution XXXIV of the XXVIII Meeting of the Directing Council, which considered the topic "Coordination between Social Security and Public Health Institutions", this document summarizes the development of the coordination process and of the different coordination and integration mechanisms set up during the period 1979-1984 in 16 Latin American countries in which Ministries of Health and Social Security Institutions share responsibilities for the provision of health services.

Analysis of the present situation reveals a progressive trend toward better delimitation of the health sector in the respective national health systems, the framework within which the measures to bring about interinstitutional coordination are implemented. Progress is also apparent in the joint development of programs designed to provide health care to special population groups.

The review made points up as central elements of the coordination process the formulation of policy, the financing of health services and their delivery, and the coverage of these services; special emphasis is placed on the levels of coordination that will permit progressive implementation of national policies and strategies, and on the contribution of technical cooperation in the strengthening and furthering of the coordination process in order to carry out the national undertakings to provide health care for the entire population.

CONTENTS

Page

I. BACKGROUND 1

II. SITUATION OBSERVED 2

Changes in legislation connected with ministry/social security coordination 3
Interinstitutional Councils, Commissions and Groups . . . 3
Agreements and Contracts 4
Interinstitutional Programs 4
Administrative Mechanisms 5
Actions in the International Field 6

III. ANALYSES OF THE INFORMATION OBTAINED. PROGRESS ACHIEVED 7

Definitions of policy 8
Formalization and organization of the health systems . . 10
Ways of financing the health services 13
The coverage of the health services 15

IV. STRATEGIES THAT WILL PROGRESSIVELY ENHANCE COORDINATION 17

a) Establishment and development of a common doctrinal base 17
b) Joint development of health services research . . . 18
c) Analysis and review of the technological processes in the provision of services 19
d) Rationalization of investments in physical infrastructure 20
e) Harmonization of personnel policies and utilization 20
f) Joint development of support systems 21

V. TECHNICAL COOPERATION IN THE HEALTH MINISTRY/SOCIAL SECURITY INSTITUTIONS COORDINATION PROCESS 23

BIBLIOGRAPHY 26

I. BACKGROUND

Coordination between health ministries and social security institutions has been a matter of constant concern and interest in the Region for the past 25 years. On very many occasions (meetings, congresses, study groups, etc.), both in individual countries and in international bodies working in the health field, it has been recognized that this coordination is a vital principle in the organization of national health systems and a prerequisite for improving the efficiency, efficacy and equity of such systems. The analyses made and the extensive conclusions and recommendations produced on this subject, by the health ministries and social security authorities and also by representatives of the two acting in conjunction, form a significant body of documentation on the development of this process in the Region.

The Directing Council of the Pan American Health Organization has analyzed this topic on various occasions, the chief instances in most recent years being the Technical Discussions of the XXV Meeting (1977) and the progress reports on the situation prepared for the XXVI (1979) and XXVIII (1981) Meetings. Following the report presented at the latter Meeting, the Council, by its Resolution XXXIV (1981), resolved to recommend to the Member Governments that they set up or restructure interinstitutional representative bodies in the health sphere that would facilitate the demarcating of areas of responsibility and participation of the institutions in decision-making processes in order to maximize the efficiency and efficacy of their services; that the institutional coordination actions for the sector be directed toward the priority problems, solution of which will facilitate achievement of universal health service coverage with maximum efficiency; that sector studies be made of the financing of the health services, including analysis of alternative ways of obtaining and channeling resources; and that representatives of the Social Security agencies and of other health sector institutions be included in the delegations to the Governing Bodies of the Organization. By the same resolution, the Council also required that a report be submitted to the XXX Meeting (1984) on the progress achieved and the actions taken in regard to coordination between health ministries and social security institutions.

In compliance with the above mandate, information was gathered through the PAHO field offices in Member Countries on recent changes in legislation connected with the coordination process, the formation for the same purposes of councils, committees and working groups, the establishment of agreements, contracts or other machinery for interinstitutional relations, and the formulation and development of joint programs.

This information was supplemented and expanded by means of review of documents (health plans, studies and projects) produced in the countries, some of which were also visited in order to analyze specific situations.

The present document summarizes the highlights of these analyses and proposes possible strategic approaches for progressive articulation among the institutions as a step toward their functional coordination.

II. SITUATION OBSERVED

The degree of progress toward the shaping of the national health systems and, hence, in regard to health ministry/social security inter-institutional coordination is very varied in the countries of Latin America, where these entities share responsibilities in the provision of health services.

While recognizing the individuality of these processes, for the purposes of this review, the following categorization must nevertheless be made:

a) Countries where responsibilities for the provision of services rests solely or primarily with the Ministry of Health. This group is made up of Cuba and Nicaragua, which have developed single and integrated public-sector systems, and also Chile, where social security contributes to the financing of the system but does not provide services directly. In a wider sense, this group should also include Haiti and the English-speaking countries of the Caribbean. It should be noted, however, that in recent years some prepayment schemes and private insurances have begun to appear in the latter.

   The specific problem or ministry/social security cooperation analyzed in this document does not arise in this group of countries.

b) Countries where social security has responsibilities for the health care of the bulk of the population. This group comprises seven countries: Argentina, Brazil, Costa Rica, Mexico, Panama and Venezuela, plus Uruguay on account of the basic financing scheme adopted by that country (individual contributions to the health scheme).

c) Countries where health care responsibilities are chiefly a matter for the health ministries or are shared in varying proportions with social security without the latter yet covering half of the population. This group comprises nine countries: Bolivia, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Paraguay and Peru.

   The 16 countries making up groups (b) and (c) are those in which social security plays a direct part in the provision of services, so these are the countries to which this analysis specifically refers.

Changes in legislation connected with ministry/social security coordination

Viewed from the ministry/social security coordination angle, the most important changes in the nature and make-up of the health systems have occurred in the group (b) countries, where the legislative changes introduced in Brazil, Costa Rica and Mexico and the scheme of operational integration put into effect in Panama stand out in particular.

In these four countries, the advances observed are linked firstly to greater State participation in the financing of social security and, as a result, extension of services through it, and secondly, to a better definiton of the institutional components of the sector and of the respective health systems.

In the countries of group (c), although policy changes were introduced in most of them, the largest-scale changes in legislation have been in Bolivia and Colombia. In Bolivia, with the establishment of the Bolivian Social Security Institute (1979), which is responsible for the coordination of this subsector and reports to the Under-Secretariat of Social Security of the Ministry of Social Welfare and Health. In Colombia, with the establishment of the National Health System (1974), and of the National Superintendency of Health Insurance (1977).

Examination of the changes in legislation in these five countries (Brazil, Costa Rica and Mexico, on the other hand, and Bolivia and Colombia, on the other), and review of the information relating to the other eleven, reveals a progressive trend toward better delimitation of the health sector and of the respective national health systems, within which the ministry/social security coordination takes place.

Interinstitutional Councils, Commissions and Groups

The formation of councils, mixed commissions, committees and other groups is clear evidence of definite desire to move forward in the area of institutional coordination of the health services. In five countries national health councils have recently been set up, although in one of them the council is not yet operational. Bodies of this type in the form of mixed and permanent commissions exist in a further six countries. In another country a Technical Committee has been formed in which the two institutions (ministry/social security) are represented. The common element in these councils, commissions and committees is their interinstitutional character, and in general they are set up to operate as advisory bodies to the Ministry of Health.

In some other countries the bodies specifically established for coordination purposes have a suprainstitutional nature and are known under different names: health bureau, superintendencies of health or social security, etc. The basic objective of these councils,

commissions, committees, bureaus, superintendencies and subsystems is formal participation of the institutions making up the health sector in the establishment of rules and policies for the sector that should in theory be followed or applied by the institutions concerned. According to the information obtained, the experience with these different types of coordinating bodies is very variable. In general, they do not appear to be doing very much, at least as regards specific ministry/social security coordination. In this connection, those of a suprainstitutional nature appear more promising. However, some of them were only established very recently and should be allowed to operate for a reasonable time before judgement is passed on their true potential and achievements.

Agreements and Contracts

Over the period to which this report primarily refers (1979-1984), there appears to have been an increase in the use of agreements and/or contracts for the provision of services as mechanisms for coordination between ministries and social security.

Agreements of this type were noted in the majority of the countries studied, with two chief forms being most commonly found. These two forms are not exclusive, i.e., both may be found in one and the same country.

a) Contracting by the social security institutions with the health ministries (public sector) for a variety of items: purchase of services (outpatient services, emergency care, home care), utilization of installed capacity, with social security personnel and supplies (leasing of physical space) and utilization of installed capacity, including physical plant, personnel, equipment and materials supplied by the health establishment in question. Payment for such contracts may be per case cared for, area used, or service units furnished.

b) Contracting by the social security institutions with private sector entities. This type of contracting is more frequent in 5 of the 16 countries, and payment is made in most cases on the basis of service units furnished.

Interinstitutional Programs

Four reference areas were established in the analysis of joint programs: development of physical infrastructure; personnel training; development of support systems; and health-care services to special population groups.

The results of this analysis point to an increase in joint participation by health ministries and social security institutions in programs designed to serve special population groups. Without claiming that this list is exhaustive, special mention should be made of: the Santa Catarina Agreement in Brazil (1983); the Multilateral Agreement on Integral Health Planning, La Guajira, Colombia (1983); the Integrated Medical Care Program for Farm Workers in Argentina; the development of the Maternal and Child Centers of El Cerro in Montevideo, Uruguay; the Agreements on Tuberculosis Care and Care of the Traumatized in Venezuela; the agreements on Care of Tuberculosis and Cancer Patients in Paraguay; the Nutrition Education Program in El Salvador; the Pilot Coordination Plan in the Northern Area of Honduras; the Rural and Community Health Programs in Costa Rica; the Integrated Health Systems in Panama; the Silicosis Control Program that links the Office of Occupational Medicine and Hygiene with the work of the Bolivian Social Security with the Occupational Health Institute of the Bolivian Ministry of Health; the IMSS-COPLAMAR Program in Mexico and the National Cardiovascular Surgery Unit in Guatemala.

Regarding the joint development of support systems, examples are found especially in the supplies area. In most countries a start has been made and in some cases significant progress has been posted in the use of single lists of essential medications. There are also some joint activities under way in the area of maintenance and for the development of information systems and records, together with use of certain specialized services.

With respect to coordinated personnel training programs, seven of the countries analyzed report having carried out some joint activities. However, in the majority of the countries the institutional training programs operate independently, with occasional joint participation. The continued existence of differing employment conditions is also reported in most of the countries.

Another of the areas where there has been less progress in the coordination process is infrastructure development, although highly important projects are under execution in three of the countries and joint projects are reportedly in preparation in another five.

Administrative Mechanisms

Regarding administrative matters and with a view to coordinating the work of the health service system institutions, corporations have been set up in almost all of the countries with different titles, charters and decision powers. Each of these groups differs as to the coordination mechanisms between the two institutions. By way of example, two approaches can be cited.

In one country, a group made up of representatives of the Ministry of Health and of the Social Security Institute produced a document that sets out the priority areas for integration of care services, laying down general guidelines and determining the politically and technically feasible strategies and mechanisms that could help speed coordination of the services. Priority areas for the contracting of services are shown to be the national maintenance system, occupational health, care norms, health education and the planning process.

In another country an interinstitutional planning and coordination commission was set up which has prepared a project for the programming of integral health care actions, in order to establish levels of multi-institutional articulation, determine the establishment of decision-making echelons, reorient teaching programs and program the scope of coverage in accordance with financially feasible technical parameters.

Actions in the International Field

The integration or coordination of social security institutions and health ministries has benefited tremendously from analysis in the international fora. In this connection, recent happenings clearly demonstrate the interest there is in this topic and the innovational spirit that animates the thinking on it.

In August 1982, the International Labour Office in cooperation with the Pan American Health Organization, and the Permanent Inter-American Social Security Committee held a regional technical meeting on development strategies for health services in social security. This meeting (Mexico, August 1982) began a process, currently under way, that seeks to promote coordination between the institutions in order to achieve coherence between their objectives, congruence in the means they use and functional harmonization of their methods of operation (ILO, 1982),[1/] thereby opening up new dimensions and orientations for the coordination efforts.

In November 1983, the Ministers of Labor of the countries of the Andean subregion, acting in the context of the Simón Rodríguez Agreement,[2/] agreed to invite the Ministers of Health and Presidents or Directors of Social Security to an initial meeting to be held in the coming months in Quito. The general purposes of this meeting will be to consider "Formulation of a joint plan of action of the Simón Rodríguez and Hipólito Unanue Agreements in order to establish joint mechanisms for coordination and cooperation between the health ministries and the social security system bodies, based on a concerted planning process and plans of action designed to surmount the common priority health problems at Member Country level."

In April 1984, the Ministers of Health of Central America and Panama and the Directors of the Social Security institutions of those

countries jointly analyzed (Panama, April 1984)3/, the Plan for taking care of the priority health needs in the subregion, and decided that as of that date the Directors of Social Security should join and form part of the Meeting of Ministers of Health of the area (REMCAP) that is held annually. This decision will unquestionably result very soon in new changes in this group of countries, half of whom have already achieved significant progress in consolidating their respective health care systems. The great importance of this decision is evidenced by the analysis of the situation of health care for persons in Central America and Panama, which showed very clearly that without this integration of institutional efforts, it will not be possible to meet the priority health needs of large segments of the population (Plan of priority health needs in Central American and Panama).

The Ministers of Health of the Central American countries and Panama, of the Contadora Group,*/ of the Andean Group,**/ of Argentina, Brazil and Spain,***/ with the participation of Directors of Social Security Institutions, met again (Medellín, Colombia, July 1984) to establish the operational bases of technical cooperation for implementation of the Plan for Meeting Priority Health Needs in the Subregion (Central America and Panama). One of the three topics on the agenda for this meeting was Ministry/Social Security Coordination, regarding which the relevant Declaration states: "the conviction (of the participants) that it is urgently necessary to coordinate and mobilize all national resources and especially those of the Ministries of Health, of the Social Security systems and of the universities, in combined action to obtain effective solutions to the problems of the population and especially of those population groups that are as yet largely untouched by the benefits of health and progress."4/

III. ANALYSES OF THE INFORMATION OBTAINED. PROGRESS ACHIEVED

Interinstitutional coordination of the health sector is seen as an instrument for developing joint planning and execution methods for health programs with a view to better utilization of national resources to make the services viable and ensure egalitarian and timely access to them for the entire population according to their care needs. In the last analysis, therefore, ministry/social security coordination is a means for bringing about universal and equitable health care.

The above should accordingly be taken as valid analysis or evaluation criteria for ascertaining both whether such coordination is taking place and its results.

---

*/ Colombia, Mexico, Panama and Venezuela
**/ Bolivia, Colombia, Ecuador, Peru and Venezuela
***/ Specially invited

Undertaking an analysis of this type would inevitably lead to a case-by-case review for which there are not sufficient data available in the countries or, of course, at regional level either, while such a review would moreover be beyond the scope of this presentation. Instead, reference will therefore be made to aspects that have been used as evidence of coordination on the different occasions when this has been the subject of analysis and discussion.

Definitions of policy

Coordination or integration of the health sector institutions is a policy decision and the outcome of an action or a set of actions that are essentially policy-related. In other words, the configuration of the national health systems (a combination of parts or elements [institutions]), appropriately interrelated by a common purpose (health care of and for the population) depends on the nature, scope and content, and also the mutual consistency, of the definitions of a policy order adopted in each country or society with regard to the provision of health services, their financing, the means employed for providing them and the favorable or adverse factors that may have an impact on this process.

The experience of the Latin American countries would indicate that the basic condition for this process to take place in truly effective form is concertation at the highest levels of the national pursuit of social and economic goals and review and subsequent compatibilization of the complementary (institutional) policies considered feasible for attaining these global objectives.

Only with a frame of reference of this nature that genuinely recognizes the social function of the health services could the formal and implementing agreements between the institutions be put into practice and successfully executed. (PAHO/WHO, 1982).[5]

Examination of the documentation reviewed reveals that there is an abundance, maybe an excess, of policy formulation for coordination between health services, health ministries and social security. It would be hard to find areas or aspects that have not yet been covered in the definitions and recommendations produced in the public and social security sectors, both in individual countries and in the international fora.

Many of these policy formulations, however, are either just declarations or have focused more on the means than on the end. If what is important and desired is achievement of universal coverage, the private or institutional mechanisms through which it is attained, the model adopted for insurances or public services, who owns the establishments and suchlike matters, while remaining important, should occupy a secondary place in the discussions and debate on how to serve the entire population.

Since many of these policies have been adopted unilaterally, i.e., for a given institutional context and for specific groups or segments of the population, not only do they tend to be segregationist but they also help to perpetuate approaches or schemes that have been overtaken by present social circumstances in the countries. While at a particular time the idea of charity services for the indigent was acceptable within the prevailing social values, and the establishment of insurance schemes for specific groups of the population was understandable, today's focus on greater social equity, in which the extending of health service coverage is a key component, makes continuation of these approaches unwarranted.

Some of the policies formulated with regard to coordination are lacking in realism and feasibility, in that they either tend to establish responsibilities that go beyond the political, financial or technical capacity of the institutions, or else are not accompanied by legal or other instruments through which they could be applied.

The greatest constraints with regard to application of policies on coordination between ministries and social security entities and the health sector in general appear, however, to be connected with an only partial awareness of the complexity of the political process in which decisions pertaining to individual and collective health are taken, and hence of the political context in which coordination efforts would have to be carried out. This would appear to have been a field in which the bureaucracies held sway, and have in fact for some considerable time held the initiative and leadership in this respect, both in the public subsector and in social security.

Social groups that may occasionally be present in the debates on the action of the health services and coordination needs are usually labor union organizations or professional associations interested primarily in obtaining greater benefits and in maintaining their stability. None of these groups, of course, represents the interests of society as a whole, and even less those of the underprivileged or disadvantaged segments of society who, because of their lowly position on the socioeconomic ladder, have no capacity for expressing their needs or claiming their rights.

Policy definitions on ministry/social security coordination and, of course, their application require the development of extensive mechanisms for social participation through which all the groups and segments concerned will be involved in the process. For this to be done, it will be essential to stimulate interaction between the bureaucratic organizations and spark open debate to improve communication and remove prejudices and misunderstandings that have their origin in mistrust and a lack of mutual understanding between institutions. It would also be necessary to ensure participation at different levels of groups that are truly representative of the population.

The appropriate structuring of the health sector, including complementarity and not competition between ministries and social security and the planning that goes with it, will not be accomplished solely by the technique and efficiency route. These are important and valuable instruments, but they are not sufficient. In this undertaking it will be vital to gain, if not a consensus, at least a sufficient degree of social acceptance for the measures to be proposed.6/ These will, moreover, vary depending on the political, social and economic context of each country.

Within the framework of these considerations, three policy decision fields will have to be reviewed that constitute central elements in the ministry/social security coordination process: definitions as to the composition of the health systems, the financing of the services, and the coverage for the population.

Formalization and organization of the health systems

In virtually all the 16 countries covered by this analysis policy definitions have been adopted and even legislation enacted with a view to setting up national health systems. In certain cases, the definitions did not include social security to begin with, or did so only partially (PAHO/WHO, Evaluation of the Ten-Year Health Plan for the Americas, 1975).7/

Given the tradition of health service institutionalization in Latin America, one can be certain that these entities (social security institutions and ministries) will continue to be the central protagonists in the shaping of the respective health systems. However, going by documentation produced in the countries, additional considerations now appear to be receiving attention which will entail a technical and policy reconceptualization of the health systems. In this connection, reference should be made to three main aspects: more wide-ranging approaches regarding health systems; changes in social security; and influences exercised by the private sector.

a) Some countries are apparently envisaging these systems in a wider, sectoral, context, which would render coordination necessary with other institutions that are not directly involved in the provision of services but whose activities are directed toward the promotion and development of health.

   The review of recent legislation (Costa Rica and Mexico in particular) shows a clear recognition of the multisectoral nature of the determining factors for health, as a consequence of which deliberate decisions have been made to place health actions in the sphere of national planning and to pursue real interrelation of the services with other sectors.

   Tacitly or explicity, there are now appearing the sector ministry and health sector councils on which other sectors are

represented in addition to the institutions that provide services and which could conceivably be more effective for coordination than the National Health Councils. In this context, health ministry/social security relations refer basically to functional and not necessarily organic integration. "It is not a matter of creating a new bureaucratic apparatus, inevitably large and unwidely, but a system run by the health authority in which the health institutions, without prejudice to their individual legal status and assets or to their parastatal autonomy, can be functionally integrated and coordinated in order to prevent duplications and contradictions....", "so that more efficient use can be made of social resources....". (Mexico, 1984).8/

Within this orientation, the authority and competence of the ministries as the directing agencies of the system, and hence of the health policies and actions, are reaffirmed, but at the same time there seems to be a trend toward better identification of three large areas of institutional activity with respect to health the provision of services proper; the protection and development of community public health; and the strengthening of the so-called social services or social welfare, these three areas then making up the health systems. The need for appropriate development of these complementary facets of health activities appears to be bringing about a clearer defintion of responsibilities and areas of institutional competence.

b) In the social security field, special mention must also be made of changes and events with significant repercussions for the coordination process.

The first is the internal movement toward coordination and even integration into a single institution. The creation of the INOS in Argentina, the IBS in Bolivia, the Directorate General of Social Security in the Ministry of Labor and Social Security in Uruguay; the incorporation into the IMSS of various medical services of decentralized enterprises in Mexico, and especially the merging of the multiplicity of small funds into seven major funds to begin with, and subsequently the combining of these schemes in 1977 to form the INAMPS in Brazil, are some examples of this trend. The arguments in favor of having a variety of small funds have apparently been becoming less persuasive, primarily for reasons of a financial nature. In 11 of the 16 countries under consideration here there is for practical purposes one single social security institution that provides health services, either directly or indirectly. In Argentina, Bolivia, Colombia, Mexico and Venezuela, however, the system is still pluri-institutional.

The second significant change relates to the actual concept of social security. On various occasions, reference has been made to the development of a new doctrine of social security in Latin America (Tamburi, 1982).[9] The thinking is gradually moving away from the original, limited, view of obligatory social insurance to a broader concept of integral nation-wide social security programs or systems. While incorporation of the principles prompting this change seems to be proceeding very slowly and in a number of countries the prevailing philosophy is still protection of selected groups of the wage-earning population, it is clear that the trend toward horizontal extension, at least in the health field (protection of new population groups), is quite definitely progressing.

The third major factor, unquestionably connected with the previous one, is the greater participation of social security health protection systems in the total provision of services. In six of the 16 countries (Argentina, Brazil, Costa Rica, Mexico, Panama and Uruguay) the different social security schemes apparently have health care responsibilities for about 70% of the respective populations. This greater participation may be connected with degree of development expressed in terms of Gross Domestic Product (Zschock, 1983),[10] but primarily with a political decision and linked with greater participation by the State in the financing of the schemes concerned (Brazil and Costa Rica especially, and Mexico as administrator of federal funds for a special program).

c) The influences that the private sector can have in shaping the health systems, either directly or through its relations with the social security institutions, also deserve special consideration.

In various of the countries in recent years, but particularly in Argentina, Brazil, Colombia, Peru and Venezuela, a variety of organization schemes for health-care activities based on prepayment or private insurances have arisen. The existence of these schemes, the magnitude and characteristics of the services they provide, and their significance in the respective national scene, are phenomena that still do not seem to be sufficiently recognized in the countries, let alone adequately oriented and regulated to ensure that their actions are in line with the relevant national policies. The social security institutions provide the health services in two ways: directly, i.e., in their own establishments and with their own personnel, and indirectly, through the purchase or contracting of services, agreements, etc., with public or private sector establishments. In the majority of the countries, contracting with the private sector is the commonest form (Argentina, Brazil, Peru and Venezuela) and on occasions accounts for quite high proportions of total services provided.

In light of the foregoing, it is evident that the attempts and efforts made for 25 years to coordinate ministry/social security actions have been overtaken by the advance in knowledge in regard to health, the demands that this progress imposes on the organization of the services and by social change in the countries. New actors have appeared on the stage, and the challenge today for the ministries and social security institutions together would appear to be how to handle the interaction with these other entities in a concerted effort to make progress in the setting up of true national health systems. The growth of the private sector calls for better coordination among the public bodies for appropriate interfacing with it, and the systemic view of health services requires consistency among the institutional programs together with planning of the formal interrelations of the institutions. This is unquestionably an area of special interest, but one which has so far received intuitive and episodic attention.

Ways of financing the health services

The possibilities for extending the coverage of health services depend, to a large extent, on the mechanisms for financing the services. This is, therefore, a key element in the interrelationships between the health ministries and the social security institutions, but one which, as noted earlier, has not received sufficient consideration in the debates on the coordination process.

Universal coverage will not be possible as long as there are economic barriers or inequalities in access to the services deriving from how they are financed. The basic problem in this respect is accordingly adoption of suitable financing policies that render effective the acknowledgement of the entire population's right to health care, and therefore help to eliminate existing discriminatory situations and thereby promote better income distribution. In this, as in many other fields of health care, there are no single or universal formulas. Each country, in its own political, social and economic context, will have to select the alternative best suited to its characteristics and the orientations of its social policy.

In Latin America it is generally difficult to obtain data from which one could ascertain the total financial resources allocated to health and to determine the trends in such allocation. In general terms, it is agreed that the amount of these resources, from all sources, as an average for the Region, ranges between 4% and 6% of GDP (PAHO/WHO, 1980).[11/] It has been pointed out, however, that the percentages are lower in virtually all the countries (Zschock, 1983).[12/] Considered from the angle of public sector allocations, notwithstanding the well-established tradition of institutionalization of health in the Region, real per capita increases in public sector allocations to health only occurred in 10 of the 16 countries in recent years. In the majority of cases the percentages allocated have remained static or have even shrunk, at times considerably. (PAHO/WHO, 1981).[13/]

The fluctuations in these allocations, which necessarily create instability in the programs, are tending to increase, thereby reflecting the impact of the economic recession on the resources available to the governments. Studies made by the Inter-American Development Bank 14/ indicate that global per capita GDP shrank by 1.3% in 1981, and by over 3% in 1982. According to the Economic Commission for Latin America (ECLA), the 1980 per capita GDP level will not be reached again until 1990. This situation is inevitably reflected in government resource allocation and it is thought likely that in these circumstances future funding for the health sector may not reach 4% of GDP (PAHO/WHO, 1984).15/

The extending of services through social security would appear to be a valid option for Latin America. However, the criticisms (regressive taxation, among others) made of the conventional financing methods--bipartite or tripartite--used for these programs, especially when their coverage is very limited, are sufficiently well known. Manifestly, many of the problems in this area arise from the rules and criteria that govern the "field of application" of these programs. Of particular importance in this respect are the ceilings and minimum levels that regulate membership. Although in the majority of the countries these restrictions, and especially the minimum levels, may have been abolished by law, in practice they are continuing to be applied through the so-called "deferment clauses", use of which is based strictly on application of the dogmatic actuarial principle of financial equilibrium.

Recognition of these limitations has prompted efforts to introduce different ways of financing social security through general income. Although this approach has not made much headway in Latin America, some countries are partially following it by allocating the proceeds of the value-added tax for financing the programs (Argentina, Uruguay).

The repercussions of the economic recession will obviously make themselves felt in this sphere. The deterioration of the labor market in recent years, in terms both of employment and wage and salary levesl, is quite evident. The labor force is estimated at 120 million persons,16/ and around 30% of the work force is today underemployed or unemployed, which means that a growing number of workers are not involved in productive activity, in particular in the key sectors such as manufacturing and construction. It further means that the incomes for financing social security are also inevitably smaller.

Under these conditions it would appear clear that there is a pressing need for in-depth analysis of the financial systems of social security and of the health sector as a whole. These analyses should provide sufficient information to determine the most appropriate financing policies for the health services so that the ministry/social security interaction can be more effective in pursuit of the goal of universal coverage.

The coverage of the health services

The third field in which policy decisions are needed to complement the existing general statements (Health for All by the Year 2000--Primary health care strategies--Universalization of Social Security),17/,18/ which are contributing effectively toward promoting and stimulating ministry/social security coordination efforts, is that of health service coverage.

In the countries of Latin America with multi-institutional services, the real coverage of health care is not known. This is largely because of the differences in concepts and the limitations of the traditional indicators used for measuring this coverage.

At the beginning of the 1970s (Ten-Year Health Plan for the Americas, 1972)19/ it was estimated that approximately 40% of the Region's population lacked access to the services. This figure has since been used to indicate the proportion of the population without coverage.

The steps taken by the governments to develop road systems and the health service infrastructure have definitely made access to the services easier. The data available do not, however, make it possible to ascertain the degree of coverage achieved in the rural areas, or in the low-income periurban areas. There is nevertheless a near consensus that large population groups are still without access to basic health services. The estimates of actual numbers do of course vary from country to country, but there are not in general any figures that would show the effective coverage of the services of the public subsector.

The social security institutions have some statistics, but here a distinction has to be made between nominal and real coverage. The former relates to the population entitled to receive services, either contributors or beneficiaries, and the type of risk or contingency covered. Real or actual coverage refers to the population who are actually receiving the services. The statistics usually available are for nominal coverage. These figures are affected by numerous factors. In sickness insurance in some countries, beneficiaries do not use the services because social security does not have sufficient installed capacity--of its own or contracted--to take care of all the beneficiaries. In other cases, beneficiaries prefer to go to the private system or to use other state or parastatal services for reasons of a geographic or cultural nature.

In certain countries where the membership control and registration system has not been unified, one and the same person can contribute to various funds or schemes by virtue of holding more than one job, thus showing up in the statistics as two or more different contributors. On other occasions, employer companies may sign their personnel up with the fund operating in the place where their headquarters is located even though the people in question are working in another city, which also tends to distort the data.

Notwithstanding the above limitations, by using the figures supplied by the institutions themselves it has been estimated (PAHO/WHO, 1981)[20] that in the period 1976-1980 approximately 50% of the population of the 16 countries with health programs run by social security were covered by those programs. In three of these countries (Argentina, Brazil and Costa Rica) the figures exceed 70% of their population. In another three (Mexico, Panama and Venezuela) the proportions range from 30 to 60%. In the other ten (Bolivia, Chile, Colombia, Dominican Republic, El Salvador, Guatemala, Honduras, Paraguay, Peru and Uruguay) the proportion is less than 30%.

Even a very cursory glance at these figures serves to reveal the significant participation of social security in the provision of services in these countries. The variations between the percentages also reflects the differing levels of development of the social security institutions in the countries considered.

These programs do, however, have certain limitations that need to be noted. In general, they are still aimed at attracting and insuring the urban wage-earner. Their extension to the rural areas and to the self-employed has been held back by the actual or apparent presence of legal and technico-administrative barriers. Only in four countries (Bolivia, Brazil, Ecuador and Mexico) have social security programs designed for the rural population been developed.

It is also of interest to observe the differences in benefits granted (coverage) to members and beneficiaries. In eight countries (Argentina, Bolivia, Brazil, Costa Rica, Mexico, Panama, Paraguay and Venezuela) the health insurance protects the worker and his family, specifically his wife and children until they reach the age of majority. In the other eight countries, family protection is limited to maternity benefits and child care. Within this general scheme there are also certain variations: in four countries (Colombia, Ecuador, Peru and the Dominican Republic) the protection covers children through the first year of life only; in another three (Guatemala, Honduras and Uruguay) the protection continues through the first five years of life; and in one (El Salvador) children are not covered by the system.

Responsibility for the population not covered by social security is generally spread among the Health Ministries, the Armed Forces' health services, local authorities, state entities whose primary function is not health, and private profit or nonprofit organizations. This is, of course, a rather theoretic assessment, since no data are available that would show the actual coverage of these services.

Finally, from an operating viewpoint, the action of the health services has been concentrated in general on meeting the voluntary demand and on conventional programs such as maternal and child care and immunizations, among others. Sufficient attention has not therefore, generally speaking, been given to certain groups such as adolescents, the elderly, the mentally sick, the disabled and the handicapped.

The foregoing clearly points up the need to adopt a uniform health-care policy, to be applied in a consistent and harmonious fashion by the different institutions participating in the provision of services. Within this policy, abolition of the differentiations into "separate clienteles" based on ability to contribute or financial mechanisms, in conjunction with the establishment of more equitable conditions for health care, form a fundamental requisite for ministry/social security coordination.

IV. STRATEGIES THAT WILL PROGRESSIVELY ENHANCE COORDINATION

The experience of various countries of the Region in recent years shows that consolidation of the health systems is a gradual process with stages that may take some considerable time to come to maturity, both for truly substantive definitions and their effective application. The strategy actions that can stimulate this process will vary, of course, as regards nature and content, depending on each national situation. Nevertheless, based on the information obtained, certain areas can be suggested in which a concerted effort would progressively benefit better functional ministry/social security meshing.

a) Establishment and development of a common doctrinal base

The indispensable meshing in forms of organization and operation of the services provided by the ministries and by social security requires a common understanding of the advances in knowledge regarding the phenomena that affect health, the operational processes of the services and care procedures and techniques. It is also vital to improve the provision and flow of information, and of mutual knowledge concerning the purposes and characteristics of the institutions, in order to remove prejudices and doubts and develop attitudes of understanding. It will further be necessary to reconsider the systems and bodies of rules in order to explore the possibilities of harmonization and compatibilization.

In light of previous experience, the efforts in these and other fields should focus on the development possibilities offered by those aspects where there is agreement, rather that unfruitfully prolonging the discussion of those where there may be real or apparent divergences.

Joint examination of organizational activities and approaches, together with analysis of possibilities for their application in joint programs will help to establish a productive dialogue and accordingly constitutes a fundamental work area for interinstitutional groups, the organization and systematized functioning of which would be a priority in this coordination process.

b) Joint development of health services research

The greatest problems currently affecting the provision of services, whether by health ministries or social security, are connected with accessibility and adaptation of the services; their financing and cost; care technology and quality. There is every indication that these will continue being central areas of concern for the coming 15 years, especially the accessibility problems, which absolutely must be solved in the shortest possible time.

Introduction of the structural and operating changes necessary for this purpose in the health services, both those run by the ministries and those operated by social security calls for a better and broader understanding of those population groups for whom the services are designed, and of the multiple factors that bear on the utilization and acceptance of these by the population, together with the charcateristics of the technological composition and functioning of the services themselves.

In seeking to achieve this, it is essential to learn what really is the contribution of the services to the population's health; what the services really do; how they do it; how well they do it and at what cost, and what the most appropriate organization and care alternatives are. It is also vital to bring about a balance between the modernization requirements of the services and the incorporation of innovational elements at a pace that is socially assimilable in terms of costs, and the need for equality of utilization opportunities for all members of the population who need to use the services.

In all these fields, there are numerous questionmarks that will have to be dealt with appropriately, and whose nature calls for a systematic and shared effort of multifaceted research in health services (epidemiological, social and operations) that will open up the possibility of new lines of thinking and make it possible to expand and improve the bases for analysis, together with the instruments and procedures used for the planning, organization, administration and evaluation of health services. In general, there has only been a limited interest in this type of research in Latin America and in the present circumstances. This is definitely an area for joint strategic development on the part of the ministries and social security.

c) Analysis and review of the technological processes in the provision of services

In recent decades there has been an unprecedented worldwide development in medical technology, which includes basically personnel, drugs, facilities, materials, instruments, equipment and also care methods and procedures. The introduction of new means of diagnosis and forms of treatment has unquestionably resulted in significant advances in the control of certain diseases. However, not all the new procedures, techniques, equipment, etc., recommended today have proven to be efficacious and free of risk. Although in Latin America attention has only just begun to be given to these aspects, the experience of some countries has pointed up the need for determined rationalization efforts in this field.

In various spheres of activity, the use of theoretically more effective new technology leads to lower production costs. This is not the case in health services, where the more advanced and complex the technology employed, the higher becomes the cost, with the additional factor that utilization rates also rise (Lacronique, 1981).21/

The establishment of appropriate measures for rationalizing the selection and appropriate use of medical technology is, therefore a strategy for joint ministry/social security work. This is, however, a complex question that calls for different approaches. By means of basically educational and orientation-type mechanisms, it is essential to win the participation of the medical personnel in this process in order to obtain greater rationality in the use of diagnostic and curative means and equipment. A key point must be deployment of information machinery to neutralize or reduce the effects of publicity and propaganda that encourage inappropriate usage patterns. However, it is also necessary to develop evaluation methods in order to decide on technology elements that really ought to be incorporated.

The primary problem faced by ministries and social security in this field is nevertheless a wider-ranging one that calls for deeper-going actions. It is connected with the actual care practices and the service models currently in effect which, given their intrinsic technological organization, give rise to unjustified unit costs and therefore entail a squandering of the resources allocated to health. Joint efforts by the ministries and social security in this respect ought therefore, besides evaluating and rationalizing the incorporation of medical technology, to focus on detecting and remedying situations of technologically inappropriate services and on correcting the provision of totally unnecessary services.

d) Rationalization of investments in physical infrastructure

The problem of the unnecessary duplication of facilities, which is the result of parallel, uncompatibilized institutional investments, is characteristic of the dual ministry/social security systems, is sufficiently well known. However, in these situations the programming and development of health establishments also tend to be unsystematic and excessively long drawn-out (10, 15, 20 years on occasions). The lack of continuity in the development of projects and the fact that there is not a stable organization for these purposes hinder the rationalization, standardization and reuse of the relevant programming data. Each project therefore becomes an isolated exercise that can draw little if any benefit from national experience, so that frequently inappropriate standards and parameters will be adopted in its implementation.

Regulation and coordination of investments in health establishments, in both the public and the private sectors, is imperative, but the health ministries and social security institutions, by acting jointly, must be capable of bringing order into the planning procedures and fostering the indispensable recording of experience in order to establish truly national bases for standardization. Special consideration should be given in this field to the joint development of techniques and procedures for the programming of equipment and the joint organization of maintenance centers and other facilities.

e) Harmonization of personnel policies and utilization

The progressive meshing and homogenization of policies on health personnel and how they are used is something of particular importance in ministry/social security relations and forms a clearcut field for innovational actions of a strategic nature.

The problems here are extensive and varied.22/ Employment and unemployment situations, the factors that influence the establishment and operation of labor markets, the geographic distribution of health professionals, lack of consistency between education objectives and the requirements of the services, and the retraining and refresher training needs of the different categories of personnel, are common problems the analysis and solving of which should be handled on a fifty-fifty basis by the ministries and social security. As they are the largest health-sector employers in the countries, joint action by them is vital in those aspects pertaining directly to forms of remuneration, institutional hiring regulations and differences in the allocation of functions.

Several countries have been able to fix similar wage and salary scales in their health ministries and social security systems, thereby eliminating the proverbial problems arising from differences in remuneration, especially of medical staff. Nevertheless, in the majority of cases disparities still persist in benefits, e.g., retirement ages, which make for potential or actual conflicts.

Priority analysis of these situations, and of those deriving from individuals holding more than one job so that contracted times overlap, by means of interinstitutional commissions or groups, should make it possible to design joint solutions that will be of value for the relevant policy formulations. In the adoption and execution of these solutions special consideration ought to be given to regulating staff positions in such a way that staff can be interchanged between the institutions, and to the establishment of suitable incentive and personal and professional development systems.23/

The introduction of changes in the present personnel utilization patterns both in the ministries and in social security would not be possible without the participation of the various groups concerned or who may be affected in one way or another in this process. As part of the strategic approach involving priority analysis of these aspects it would then be necessary not just for the professional groups to know the changes that are to be introduced, but that they should be able to identify with the aims of these changes. Agreement in this respect is essential both for study of the problems and to develop attitudes and behaviors that are indispensable for converting coordination into concrete facts.

f) Joint development of support systems

As a complement to the foregoing, joint development of support services or systems is of special interest. Such services or systems are understood to be those basic elements or components of the administration which serve to create conditions propitious for the delivery of health services.

These support systems comprise a very wide range of functions, the nature and content of which, and hence the possibilities for joint development, will vary in each particular national situation. However, by way of a global approach, priority should be given to joint development of such systems in the following areas:

- Information and supervision. The first would be for compatibilization of the respective institutional systems and identifying and obtaining a better unerstanding of the

problems that can arise from joint local administration, and also facilitating decision-making and the performance of interinstitutional activities and programs. The supervision would be exercised both in the technical field and in the administration area, with an educational orientation also designed to develop attitudes that will stimulate and favor joint work.

- Rules and procedures for care, and for organization and administration of the services, giving priority to identification and review of those whose nature and characteristics constitute impediments or obstacles to coordination. In drawing up these joint rules and regulations it would be especially important to give special consideration to those guidelines or standards by means of which the quality of the care given to the population can be evaluated.

- Critical supplies and inputs, especially as regards the formulation of procurement and utilization policies for medications and equipment and their characteristics. In most of the countries, both the ministries and the social security institutions use lists of supplies, forms, requisitions, "basic tables", etc., prepared to control the use of these items and facilitate procurement, storage and distribution. An increased degree of compatibility between these lists, a process that has been started in some countries, is definitely a priority for coordination. Standardization of the specifications and rules regarding supplies, particularly drugs and equipment, will help to rationalize the use of these items which have a major impact on the smooth functioning and cost of the services, will stimulate the development of joint-work attitudes and will be exceptionally valuable for the adoption of policies on national production, imports, quality control, distribution, etc. In standardizing the existing lists, however, care should be taken to avoid the risk of creating rigidities which would make them less acceptable. To achieve the appropriate balance that is needed, it will be essential for the determining of the needs for and characteristics of these inputs to be aligned on the activities that it is planned to carry out in the operating units of the coordinated or integrated system of services that is developed. The use of "modules" or "standards" for these purposes would be basically indicative, and should in no way take the place of critical judgement and an active attitude for determining the inputs really needed in each unit or particular situation.

V. TECHNICAL COOPERATION IN THE HEALTH MINISTRY/SOCIAL SECURITY INSTITUTIONS COORDINATION PROCESS

In implementation of the requirements of Resolutions XXXII (1979) and XXXIV (1981), of the Directing Council, the Secretariat of PAHO has sought to respond to requests for cooperation from national social security bodies. These requests have increased over recent years both in numbers and in terms of the variety of fields or aspects covered.

Cooperation agreements have accordingly been concluded and are under execution with social security bodies in 6 of the 16 countries where these bodies have direct responsibility in the provision of health services. The areas of cooperation in these agreements, one of the central objectives of which in every case is helping to strengthen the respective coordination processes, cover a broad range of situations with special emphasis on the planning and organization of health programs, the development and maintenance of health establishments, administrative analyses and various aspects of human resource programming and development.

In this connection, the participation of the social security systems in programs such as vaccination and immunization, control of diarrheal diseases, maternal and child care, chronic diseases and occupational health has been expanded. Representatives of the institutions concerned are participating increasingly frequently--although still not often enough--in meetings, seminars, workshops and working groups organized and held in various countries under the guidance or sponsorship of PAHO and in which a variety of aspects of the provision of health services have been analyzed or discussed.

The social security entities also receive technical assistance from other international agencies of an intergovernmental (ILO and OAS) or interinstitutional (CISS, OISS, AISS, AISSCCAP) nature. PAHO has also strengthened its links with these entities, seeking to harmonize the approaches and orientations of the cooperation it furnishes with the national bodies operating in the health field.

Joint assistance missions have been made to various countries with the International Labour Office (ILO) in particular and in 1982 a joint program was started and is now under way to review and reorient the strategies for development of the provision of health services in social security.

As part of this program, First Regional Technical Consultation Meeting (Mexico, 1982) was held with eight countries taking part, at which incorporation of the primary care strategy into social security health programs was analyzed. In continuation of these activities, a Second Meeting (Medellín, Colombia, March 1985) will be held with 12 countries taking part, at which one of the central topics will be ministry/social security coordination.

A technical cooperation agreement has also been entered into with the Ibero-American Social Security Organization (OISS), in implementation of which joint missions have been made to various countries and PAHO is participating in the training programs for social security management staff.

The collaboration with international social security bodies has also included the reorientation of regional policies and strategies adopted by the PAHO Governing Bodies at meetings and events of various types organized by the Inter-American Social Security Conference, its Standing Committee and its working groups. This has also been the case at meetings of the International Social Security Association (ISSA) and the Association of Social Security Institutions of the Caribbean, Central America and Panama (AISSCCAP). A course has been held in conjunction with the latter for organizing emergency and disaster-preparedness services in the countries of the subregion and direct cooperation has been coordinated with the institutions to develop maintenance services for health establishments.

The available data indicate that the health programs run by social security institutions are responsible for covering rather more than some 175 million people, i.e., approximately one half of the population of the countries analysed. Programs of this magnitude certainly need and should receive extensive international technical assistance, which can perform an important catalytic function in the coordination and progressive articulation of these programs with the health ministries. Although PAHO has sought to respond to all requests for collaboration in this field it has received from Member Countries, difficulties are frequently encountered regarding cooperation with the national social security institutions, because of the reserve and even reluctance evinced about the possibility of sharing available technical resources with them.

The Directing Council has recommended to the Governments that representatives of the social security institutions be included in the national delegations to the Governing Bodies (Resolution XXXIV, 1981). This would make it possible to bring about a greater understanding in the upper echelons of social security of the policies, programs and orientations in regard to health that have been jointly adopted by the countries for the Region. However, it would appear that this recommendation has only been taken into consideration in special situations.

In light of the review made of progress in coordination and especially taking into account the joint commitment of the ministries and social security to ensure universal coverage of health care based on fairness and equity, a greater openness in regard to technical cooperation with social security would appear to be called for, particularly in those activities designed to bring about closer

institutional, program-wise and operating coordination with the health ministries. Such activities should form a definite part of the technical cooperation programs at national level, especially in those countries where this process needs to be strengthened and expanded in order to implement the national commitments to health care without discrimination for their entire population.

From the Regional standpoint, in response to these country measures, technical cooperation should be broadened and strengthened by allocating appropriate resources for the promotion of and support to analyses of political coordination processes and of the general organization of medical care services; financial studies done of social security and the sector as a whole; selective studies made of coverage extension to excluded population groups; and experimental schemes devised for the shared local programming and administration of health services with special reference to those population groups.

BIBLIOGRAPHY

1. Regional Technical Meeting on Strategies for the Development of Social Security Health Programs, ILO, Final Report, Mexico, 1982.

2. Hipólito Unanue Agreement. Proposal for the First Interministerial Meeting of Ministers of Health, Ministers of Labor and Presidents/Directors of Social Security Institutes or Funds. Lima, Peru, November 1983 (mimeographed).

3. Act of the Special Meeting of Ministers of Health of the Central American Isthmus and the Pan American Health Organization. Panama, April 1984.

4. Declaration of the Meeting of Ministers of Health and Directors of Social Security Institutions, Medellín, Colombia, July 1984.

5. Contribution to the celebration of the 40th Anniversary of the International Social Security Conference "Health for All by the Year 2000 and the Social Security Health Programs". PAHO/WHO. Castellanos, Jorge. August 1982.

6. Guerra de Macedo, Carlyle and César A. de B. Vieira. The Fate of Primary Health Care in Brazil. Published by the Institute of Development Studies, Sussex. Bulletin 1983, Vol. 14, No. 4.

7. Pan American Health Organization. XXIV Meeting of the Directing Council. Evaluation of the Ten-Year Health Plan for the Americas, 1971-1980. CD24/18, pp. Washington, D.C., August 1976.

8. Soberón, Guillermo. La Coordinación de los Servicios de Salud. "Hacia un Sistema Nacional de Salud", National Autonomous University of Mexico, 1983.

9. Tamburi, G. Evolución, tendencias y perspectivas de los sistemas de salud de la seguridad social en América Latina. ILO. Geneva, Switzerland, 1982.

10. Zschock, Dieter. Medical Care under Social Insurance in Latin America. University of New York at Stony Brook, 1983.

11. Pan American Health Organization. XXI Pan American Sanitary Conference. Plan of Action for the Implementation of Health for All by the Year 2000 Strategies. Financial and budgetary implications. Document CSP21/21. Washington, D.C., September-October 1982.

12. Op. cit., 10.

13. Contribution to the Pan American Social Security Workshop held in Paipa, Colombia. Health Costs in Social Security. PAHO/WHO. Castellanos, Jorge and Josefa Ippólito. September 1983.

14. Inter-American Development Bank. Economic and Social Progress in Latin America, 1983 Report.

15. The Economic Crisis in Latin America and the Caribbean and its Repercussions on the Health Sector. Document submitted to the Executive Committee of the Pan American Health Organization, PAHO/WHO, 92nd Meeting, CE92/16, Washington, D.C., June 1984.

16. Op. cit., 14.

17. Plan of Action. PAHO/WHO. Health for All by the Year 2000. Official Document 179, Washington, D.C., 1982.

18. Eighth Conference of the American Member States of the International Labour Organization, Ottawa, Canada, 1966.

19. Ten-Year Health Plan for the Americas. Official Document 118, PAHO/WHO, Washington, D.C., January 1973.

20. Technical Discussions. XXVIII Meeting of the Directing Council. Document CD28/34. Coordination between the Social Security and Public Health Institutions. Washington, D.C., August 1981.

21. Lacronique, Jean François and Sandiers Simon. Technological Innovation: Cause and Effect of Increasing Expenditures for Health. Publication of the Service Center, Office of the Secretary General, Berlin, 1981, p. 91.

22. Final Report of the Working Group on Health Personnel Research, PAHO/WHO, Washington, D.C., 21-25 May 1984.

23. Contribution to the Eighth American Social Security Medicine Congress. Human Resource Development Strategies in Light of the Trend toward Primary Care and the Goal of Health for All by the Year 2000. Jorge Castellanos, José Roberto Ferreira, Carlos Vidal and Ana L. Ruggiero. Panama, September 1983.

REPORTS PREPARED BY THE PAHO/WHO REPRESENTATIVES IN THE COUNTRIES

JUNE 1984

ARGENTINA: Dr. Pedro N. Acha, Dr. Italo Barragán and Dr. Guillermo Torres

CHILE: Dr. Miguel Angel Aguilar

COLOMBIA: Dr. José María Paganini and Dr. Vladimir Basabe

COSTA RICA: Dr. Emigdio Balbuena

ECUADOR: Dr. Carlos A. Pettigiani

EL SALVADOR: Dr. Raúl Paredes

GUATEMALA: Dr. Lelio Calheiros

HONDURAS: Dr. Hugo Villegas

MEXICO: Dr. Pablo Isaza

PANAMA: Sr. Mario Espinosa

PARAGUAY: Dr. Pedro Salas Conejo

PERU: Dr. Eduardo Aquino del Puerto

The bibliography and the reports for Bolivia, Brazil, Dominican Republic, Uruguay and Venezuela were prepared by Dr. Vladimir Basabe, Consultant in Medical Care, PAHO/WHO.

The analysis and compilation of country data were done by Ms. Ana Lucía Ruggiero, PAHO/WHO.

BIBLIOGRAPHIC REFERENCES AND COUNTRY DATA

- Reports on the coordination of health ministries and social security institutions provided by the PAHO field offices (June 1984) in Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru and Uruguay.

- Country reports and bibliographic data for Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Uruguay and Venezuela. PAHO/WHO, June 1984.

- Hospitals in the Americas. Scientific Publication No. 416, PAHO/WHO, 1981.

- Theory and Practice of Social Security, Instituto Boliviano de Seguro Social, June 1982, p. 17, La Paz, Bolivia.

- Decree-Law 056 of the National Health System in Colombia and Decree-Law 1650 of 1977 on the restructuring of Social Security.

- Report of the Central American countries on priority health needs. Operating plans: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama, March 1984.

- Statistical Yearbook. Instituto Nicaragüense de Seguridad Social y Bienestar Integral (INSSBI), 1981.

- Study of hospital bed requirements, Guatemala, PAHO/WHO, Guemez, José, 1982.

- Report of Advisory Services on Medical Care for Pilot Plan for Coordination between the Ministry of Health and the Instituto Hondureño de Seguridad Social. PAHO/WHO, Asis, Luis, 1982.

- National Health Plan 1978-1982. Guatemala, Ministry of Public Health. Vols. I and II, 1978.

- El Salvador: 1982-1983 Yearbook. Ministry of Public Health and Social Assistance.

- Costa Rica: "Estudio sobre la Producción de algunos Servicios de Salud a Nivel Nacional y Regional 1976-1982". Consejo Nacional Sectorial de Salud. Executive Secretariat, February 1984.

- Panama: Memorandum from the Minister of Health to the Office of the President, October 1983.

- Reorientação da assistencia à saûde no âmbito de previdência social. 3ra. edição, Ministerio da Previdência e Assistência Social, 1983.

- Basic Document. "Priority Health Needs in Central America and Panama". March 1984.

- Roemer, Milton I. Medical Care in Latin America. Pan American Union, General Secretariat. Organization of American States. Washington, D.C., 1963.

- Abel-Smith, Brian. Value for Money in Health Services. St. Martins Press, New York, 1976.

- La seguridad social en el proceso de cambio internacional. Instituto Mexicano del Seguro Social, Mexico, 1980.

- Employment, Growth and Essential Needs. ILO, Geneva, Switzerland, 1976.

- Technical Discussions. XXV Meeting of the Directing Council. "Coordination between social security systems and public health systems". (Working Document). Washington, D.C., September-October 1977.

- Novelo, Gastón. Acciones y evolución de la Conferencia Interamericana de Seguridad Social en las Prestaciones de Salud (Working Document), Regional Technical Meeting, ILO, Mexico, 1982.

- Pan American Health Organization. XXIV Meeting of the Directing Council. Evaluation of the Ten-Year Health Plan for the Americas. 1971-1980. CD24/18 (Eng.), pp. 16-19, Washington, D.C., August 1976.

- Country surveys on social security institutions, PAHO/WHO, 1977.

- Mesa-Lago, Carmelo. Financing Health Care in Latin America and the Caribbean with a Special Study of Costa Rica. A Study for the World Bank. Population, Health and Nutrition Department. University of Pittsburgh, March 1983 (mimeographed).

- Roemer, Milton I. "Evolución de los Servicios Médicos de la Seguridad Social en América Latina". In "Revista Internacional del Trabajo", Vol. 881 (ILO, Geneva, Switzerland, 1973).

- Preliminary Report of the Working Group on "The Organization and Provision of Health Services by Levels of Care", PAHO/WHO, Montevideo, Uruguay, 1983.