

directing council



PAN AMERICAN
HEALTH
ORGANIZATION

XXXII Meeting

Washington, D.C.
September 1987

regional committee

WORLD
HEALTH
ORGANIZATION

XXXIX Meeting



Provisional Agenda Item 5.5

CD32/17 (Eng.)
31 July 1987
ORIGINAL: SPANISH

COORDINATION OF SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

In compliance with the provisions of Resolution XV of the XXX Meeting of the Directing Council of PAHO (1984) on the subject of "Coordination of Social Security and Public Health Institutions," the annexed document (CE99/19) summarizes the development of this process over the period 1984-1987.

Coordination among health institutions has been a fact for almost 30 years in 16 countries of Latin America, where the health ministries and social security institutions are jointly responsible for the delivery of health care to the population.

This process has evolved variously in the different countries, but in terms of the merging of coverages and rationalization of financing the 16 countries may be divided into three groups: a) two countries in which the process is very far advanced, with extensive coverage by social security (more than 70%), regulated financing, and undifferentiated care for all population groups; b) nine countries where the process is relatively advanced, with intermediate coverage by social security (50-70%), nonstandardized financing methods, and differentiated care for different population groups; and c) five countries in which the process is in its beginning stages, with very limited coverage by social security (less than 50%), fragmented financing, and services to only selected population groups.

The report presented gives examples of legislative and administrative changes. These changes include sectorization and decentralization in Mexico, contracts between social security and the Health Secretariats in Brazil, the social security initiative in Argentina, functional integration of health services in Peru, the regulation of interinstitutional contracts in El Salvador, and the introduction of a new kind of care in Costa Rica. These are all examples of national activities.

In the different subregions the most important changes in Central America have been accession of the social security institutions to membership in the Meeting of the Health Sector of Central America and Panama (RESSCAP), the adoption of strategies for progressive articulation, and the connection of the social security institutions to the Plan on Priority Health Needs of Central America and Panama. Also worth mentioning are a variety of developments in the countries of the Caribbean, where schemes are emerging for the organization and financing of services, in which situations are already arising that require specific coordination efforts.

The document notes four important areas in which reinforcement is needed as soon as possible: better definition of the responsibilities of the institutions and the strengthening of the political and technical management of the health ministries; continuation and development of financial analysis to identify alternatives for change that will make better use of resources; the development of local administration as an instrument for sectoral coordination and, finally, the need to facilitate the development of mechanisms for exchanges of information on country experiences in the coordination process.

The Director submitted the annexed document to the 99th Meeting of the Executive Committee (June 1987) for its consideration. During discussion of the topic the members of the Committee expressed agreement with the proposals presented and emphasized the need to deepen the analysis of matters of vital importance to the development of health systems and make headway in the formulation and implementation of alternatives that will afford reforms of true strategic scope. Among these issues, reference was made to the consolidation of national sectoral health policies, analysis of the characteristics of the political process that makes the change more and less workable, the devising of strategies for progressive articulation in the programs and operating procedures of the institutions, the management of financial matters with a high standard of equity, and the development of cooperative relations in support of country initiatives.

On the basis of the document presented and the discussion that took place on it, the Committee adopted the following Resolution XV:

THE 99th MEETING OF THE EXECUTIVE COMMITTEE,

Having examined the document "Coordination of Social Security and Public Health Institutions" (Document CE99/19);

Considering that the process of coordination of health sector institutions has particular interest and importance for the developing of national health systems in Member Countries; and

Noting the need to continue encouraging and supporting national activities in this field to achieve full access to health services on the part of the entire population,

RESOLVES:

1. To request the Director to present to the XXXII Meeting of the Directing Council the report on "Coordination of Social Security and Public Health Institutions."
2. To suggest to the XXXII Meeting of the Directing Council that it adopt a resolution along the following lines:

THE XXXII MEETING OF THE DIRECTING COUNCIL,

Having seen the report on "Coordination of Social Security and Public Health Institutions" for the period 1984-1987 (Document CD32/17);

Noting that in various countries of the Region lack of functional and operational coordination still persists among the institutions of the health sector, and particularly between the Ministries of Health and Social Security Institutions, and that this has unfavorable repercussions on the health care of the population and on the efficient and equitable use of the health resources of those countries; and

Recognizing the growing significance and importance of the health programs being carried out by Social Security institutions in Member Countries, as well as their potential to help in the attaining of universal health care coverage in this Region,

RESOLVES:

1. To receive the report on "Coordination of Social Security and Public Health Institutions" (Document CD32/17).
2. To reiterate to Member Governments the recommendations included in Resolution CD30.R15 of the Directing Council (1984), especially those recommending that governments "include representatives of social security agencies and other health sector institutions in delegations to the meetings of the Organization's Governing Bodies."
3. To recommend to the governments of Member Countries where problems of coordination persist between Ministries of Health and Social Security institutions that they adopt a strategy with clearly programmed and defined activities to:
 - a) Extend Social Security coverage to the entire population as a way to avoid "separate clienteles" for Ministry of Health and Social Security programs, aiming at universal health care coverage and the establishment of truly integrated national health policies, based on the strategy of primary health care and the principles of health for all by the year 2000;

- b) Improve the efficient use of resources by formulating and adapting joint investment plans; information, programming and budgeting processes; the selection, incorporation and use of medical technology; and the organization of supply, maintenance and other support components. To this end they should also promote functional integration arrangements between Ministries of Health and Social Security institutions by developing common systems for the organization and administration of services at the local level;
- c) Make rational use of the financing for the health sector by coordinating the resources provided in contributions to Social Security and the allocations made on public budgets, and also by tightening production costs and adjusting outlays to priorities;
- d) Study alternative ways of increasing the amounts received in the aforementioned forms of financing, in view of the rising costs of the sector;
- e) Work jointly toward the strengthening of health infrastructures and develop firm decentralization policies that permit financing to be used at the local level and participation by the public, private and teaching sectors with a view to functional integration of the network of services and the conciliation of their respective outlooks in the particular circumstances of each country.

4. To urge Member Governments to use and to share experiences regarding coordination of health sector institutions in the Region, which may serve as a reference in the selection of alternatives for the organization and financing of health services.

5. To request the Director, subject to the policies and resources of the Organization, to:

- a) Promote the inclusion of Social Security entities in the technical cooperation programs of PAHO at the national level;
- b) Encourage the exchange of experiences among countries and groups of countries through the preparation of case studies to analyze the legal, organizational, financial and operational aspects of the health services, while emphasizing institutional coordination aspects within the sector;

- c) Establish an adequate mechanism, such as an advisory group, to assist the Organization in the promotion of improved coordination of Ministry of Health and Social Security institutions;
- d) Strengthen PAHO's working relationship with international organizations involved in fields related to Social Security, and other intergovernmental agencies, to improve technical cooperation activities in this area;
- e) Circulate among the governments information that is considered to be of interest, is available, or is generated, in the area of country studies and analyses of experience, and any other data relating to the aforementioned coordination problems; and
- f) Promote the follow-up of measures taken for the evaluation of progress achieved and include this subject in his Annual Reports.

Annex

*executive committee of
the directing council*

PAN AMERICAN
HEALTH
ORGANIZATION



*working party of
the regional committee* CD32/17 (Eng.)
ANNEX

WORLD
HEALTH
ORGANIZATION



99th Meeting
Washington, D.C.
June 1987

Provisional Agenda Item 4.6

CE99/19 (Eng.)
22 May 1987
ORIGINAL: SPANISH

COORDINATION OF SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

In compliance with the request made in Resolution XV of the XXX Meeting of the Directing Council on the subject of "Coordination of Social Security and Public Health Institutions," this document reports on the development of this process over the period 1984-1987.

The situation shows a trend toward better delimitation of the health sector and the national health systems. In several countries there have been major changes in the legislation and schemes for the organization and administration of health services.

Progress in the functional consolidation of the health sector has not been uniform, however. The economic and financial crisis in the countries, as in several of the English-speaking countries of the Caribbean, has created in the services new situations requiring special consideration. There are still major gaps in the coordination of health services in relation to coverage of the population. In addition, new requirements have emerged for coordination with the economic sectors and with other components of the social sector.

It is clear from the general situation that basic determinations are needed in elements that remain central to the coordination process, that is, real recognition and consideration of the context and political components of the process, and the selection of service financing options that are appropriate for the attainment of universal coverage. In these circumstances, more technical cooperation is needed and should be provided by all the institutions in the sector.

The Executive Committee is requested to review this report and state its comments thereon, which will be transmitted to the Directing Council for consideration.

CONTENTS

	<u>Page</u>
1. Background	1
2. Salient Recent Developments in the Coordination Process . .	5
2.1 Situation in the Countries	5
a) Legislative Changes	7
b) Policy Decisions	7
c) Changes in Organization and in the Administrative Process	8
2.2 Subregional Situations	9
a) Central America and Panama	9
b) The Caribbean	11
2.3 International Activities	13
3. Areas of Analysis in the Coordination Process	15
3.1 The Political Process in the Health Field	15
3.2 Financing Schemes and Arrangements	16
3.3 Extension of Coverage. A Challenge to Coordination between Ministries of Health and Social Security	18
4. Outlook for Action	19
4.1 Decentralization as a Strategy for Integration at the Local Level	20
4.2 Strengthening the Political and Technical Management of the Health Sector. Institutional Responsibilities	21
4.3 Development of the Sector's Financial Analysis Capability	21
4.4 Local Administration of Services. A Way to Strengthen Coordination.	22
4.5 Technical Cooperation Among Countries	23
5. Bibliography	25

COORDINATION OF SOCIAL SECURITY AND PUBLIC HEALTH INSTITUTIONS

1. Background

Of special interest in the historical development of the health services of the countries in Latin America is the movement toward coordination between health ministries and social security institutions. In the 16 countries in which services have developed in parallel in the ministries and social security institutions over the last 27 years, the policies and diverse administrative approaches implemented in this regard make up a whole--as yet uncompleted--stage of this historical development, and constitute major orientations and efforts at rationalization to make the best possible use of the health sector resources in each country. Despite these efforts, the continued lack in some countries of functional and operational coordination among health institutions seriously aggravates the problems created by inequitable access to services.

In the traditional situation of limited resources confronted by health services, aggravated by the constraints imposed by the economic and financial crisis in the countries, coordination among health institutions becomes an essential condition for attainment of the national and regional goals of universal health care coverage.

The health systems of most of the countries in Latin America are aware of institutional pluralism as one of their own foremost characteristics. The current political, economic, and social trends suggest that this multi-institutionality will not only continue but in some cases will actually be accentuated. In this context, the proper implementation of policies and strategies adopted by the countries for improving articulation within the health sector will strengthen the operating capacity of the services and improve the flow and use of resources in furtherance of the aim of equal coverage for the entire population. The introduction of these new orientations into the relations among the institutions that make up the health sector requires a better and clearer definition of the functions and areas of responsibility of those institutions and the establishment of appropriate mechanisms--different from or complementary to those used in the past--for favoring cooperative interaction among the various areas of institutional activity.

The measures taken in this direction in different countries, and their results, have varied very widely. A case-by-case review of the various movements toward the coordination of health services in the countries is, of course, beyond the scope of this report. The approach must therefore be to identify and examine the trends in groups of countries or in the Region as a whole. In this approach it is worth noting that interest in and concern for coordination between health ministries and social security institutions first emerged in the Region

about 30 years ago. During that time this subject has been taken up in countless international meetings, study groups, congresses, etc., which have generated many recommendations and resolutions for the promotion of and support to that process in the countries.

On the whole, the resolutions and recommendations adopted in regional agencies, doubtlessly reflecting views in the countries, stress the development of the national health systems but focus particularly on the specific area of integration or coordination of the health ministries and social security institutions, which has thus become a subject in its own right in Latin America.

A summary review on this last topic* yields a classification of the principal occasions on which it was discussed at the international level based on the rank of the participants. The most important of these occasions have been the four Special Meetings of Ministers of Health of the Americas (1963, 1969, 1973 and 1977) and the meetings of the Directing Council of the Pan American Health Organization (1964, 1977, 1979, 1981 and 1984) in which the subject was on the agenda.

Noteworthy among the meetings of social security institutions were the VIII Conference of the American States Members of the International Labor Organization (Ottawa, 1966), the Inter-American Conferences on Social Security, and the VIII Conference in particular (Panama, 1968), and several meetings of the Inter-American Permanent Committee on Social Security. Also, the nine American Congresses on Social Security Medicine, begun in 1969 under the auspices of the Medical-Social Commission of the Inter-American Conference on Social Security, whose agendas have frequently included topics on coordination. This group includes several other meetings sponsored by the Organization of American States (OAS), the International Labor Organization (ILO), the International Social Security Association (ISSA), and the Ibero-American Social Security Organization (OISS), which has always been interested in the subject.

A third group of events in which coordination has been a central object of attention is the Joint Meetings of Ministries of Health and Social Security Systems, held since 1959, which include, in the early stages of this movement, the Meeting of Experts (1959) convoked by the OAS, which recommended the carrying out of a study on the organization of medical care; the Technical Discussions of the XVI Pan American Sanitary Conference (1962) and the XXI Meeting of the Directing Council of PAHO/WHO (1964); and the two Study Groups (1966 and 1969) convoked by PAHO/WHO in collaboration with the OAS, whose reports constitute a compendious statement of the doctrine on the subject.

* The working document prepared by the Secretariat for the Technical Discussions of the Directing Council of PAHO in 1977 presents a detailed review of the international events down to that year in which institutional coordination was an object of consideration.

More recent noteworthy gatherings were the two Regional Technical Consultations (1982 and 1985) jointly convoked by the International Labor Organization (ILO), the Pan American Health Organization (PAHO/WHO), and the Inter-American Permanent Committee on Social Security (CPISS).

From an examination of the reports of all these meetings and of other documentation referred to above on the subject, it may be concluded that:

- The coordination and integration of the health programs of social security institutions with their counterparts in health ministries have been fairly intensively discussed and studied in the Region as part of a general approach to the structuring of the health sector and of conceptual definition of national health systems. However, the discussion of inefficiencies caused by duplication of facilities and the closed and exclusive character of the population groups covered by the two services, which prevent the yield of their resources from being increased, has apparently been based primarily on personal observations and opinions. There is here a gap in which research would provide useful objective information.
- On the whole, there is a consensus on the philosophy of and the benefits to be derived from the integration or coordination of health services. However, there has not always been a unity of views on the mechanisms to be used for the accomplishment of these purposes. The emphasis on these two approaches--integration and coordination--appears to have shifted over time, and the preference for one over another appears to have been governed preeminently by considerations of the moment. While at the inception of this movement (1959-1966) the emphasis was primarily on integration, since the 1970s the preference has shifted to coordination in recognition of the political and institutional realities in the countries. More recently (since 1981) the orientations "apparently reflect a period of maturation and reflection;... (and) the emphasis is more on the analysis of final results (universal coverage) than on the process itself" (PAHO/WHO, 1977). This is the context in which coordination of the health sector is now proposed with a view not so much to an administrative merger as to functional articulation, harmonization of purposes, and operational consistency.
- Most of the countries have enacted legislation to place their national health systems on a formal basis. On the whole, however, the process of conceptual definition, design and construction of these systems appears to have progressed at a very slow pace and, except in a few cases, the development of coordination between health ministries and social security systems has barely begun and will remain a subject of discussion in the coming years, although the discussion will doubtlessly center on such topics as the financing of services and universal coverage.

- Except in a few specific situations, it has not proved possible for policy statements on coordination between social security and ministries, or even the changes made in the legislation of some countries, to be considered in the actual decision-making process for the organization and provision of services.
- The historical differences of the economic and political power between the two institutions, of their administrative rank in the public sector, in the availability of resources to them and in their responsibilities for care of the population remain major constraints on the coordination process in some of the countries. To this is added more or less overt opposition by small but powerful sectors in their respective bureaucracies.

The interest with which the building of coordination between ministries of health and social security institutions has been followed in the Region is reflected in the provisions of Resolution XV adopted by the Directing Council of PAHO at its XXX Meeting (1984):

"...2. To reiterate the recommendations included in Resolution XXXIV of the XXVIII Meeting of the Directing Council (1981), especially those recommending that the Governments 'establish or restructure the bodies for interinstitutional representation in the health field ... to ... give these institutions a role in decision-making' within the health sector and 'include representatives of social security agencies and other health sector institutions in delegations to the Meetings of the Organizations' Governing Bodies....'"

"...4. To urge the Member Governments to:

..."c) Analyze the financial systems of social security institutions and the health sector as a whole with a view to the adoption of policies and programs that will promote adequate interaction between ministries of health and social security institutions.

"5. To recommend to the Member Governments that they include the health programs of the social security system in the preparation and implementation of technical cooperation plans and programs for the health sector as well as specific activities for promoting and supporting the legal, institutional, and operational coordination of ministries of health and social security institutions.

"6. To request the Director to take the steps necessary for the establishment and conduct of a well-defined program of technical cooperation with national and international social security agencies that will ensure the appropriate broadening and strengthening of activities for encouraging and supporting the above-mentioned actions...."

2. Salient Recent Developments in the Coordination Process

2.1 Situation in the Countries

In recent years progress toward the building of national health systems, and therewith toward interinstitutional coordination between health ministries and social security, has varied very widely in 16 countries of the Region. However, the most recent important changes appear to be associated with stronger government action in both groups of institutions for the main purposes of redressing inequity in the delivery of services and of responding to the need to give effect to the equal right of all citizens to health care, as a contribution to the reduction of social inequalities among different population groups.

In presenting the current general picture, we will refer to, among other salient aspects, the changes of policy and legislation and in the organization of health systems that help explain the participation of institutions in this process of interinstitutional and sectoral articulation. Through these changes the countries are seeking to take measures that will bind health services to and involve them in economic and social development, and make them participate more in the implementation of their government's social welfare policies.

Given the nature of these changes both in the health ministries and the social security agencies, and by way of summing up the present situation, it should be noted that this document considers the situations in the countries in whose health systems the social security system provides services through different types of institutional organizations. Hence it disregards the United States of America and Canada, nor is it concerned with the countries of the Caribbean, though some special points will have to be made on them further on. Latin America also has another four countries in which social security does not participate directly in the provision of services: these are Cuba and Nicaragua, which have single, unified service systems; Chile, where social security contributes to the financing of these services, and finally Haiti, where social security is barely in its beginnings and provides no services directly.

In these circumstances a more searching examination is needed of the evolutionary stages in the organization of health services, the effect on social security with its new orientation toward the universalization of medical services, and the degree of its articulation and coordination within the health sector.

The reason for this is that the institutional and organic mosaic of the health sector reflects a mosaic of political forces in search of an alignment that will harmonize and orchestrate the needs of the different social groups interested in services under an overall sectoral policy as a workable means for surmounting the current economic crisis in

the sector. Thus, the 16 countries considered in this document may be classed in three different groups on the basis of the stage they have reached in the organization of their health services.

The first group comprises two countries in which this process is very far advanced, with:

- medical care services for a single clientele;
- extensive coverage of medical care services by the different mechanisms of social security;
- new financing arrangements other than the conventional deduction from wages; and
- a wide range of services for all subscribers.

Nine countries may be placed in the second group, in which the evolution is regarded as at an advanced stage, with:

- a beginning toward administrative coordination;
- separate clienteles for the provision of medical care services;
- a beginning toward changes in legislation for functional integration (sectorization, sectoral programming, and decentralization);
- financing not entirely defined; and
- middling coverage by social security (50 to 70% of the total population).

Finally, the third group has five countries in which the organization process is in its beginning stages, with:

- very little or virtually no interinstitutional coordination;
- narrow coverage by social security; and
- pluri-institutional and uncoordinated medical care.

The classing of the situation in a given country in one or another of the three above evolutionary stages does not mean that all the different factors proposed for the assessment have evolved to the same extent: a country may be advanced in regard to coverage but barely at the initial stages in regard to financing or to legislative or organizational changes.

Though they have been divided into three groups, the 16 countries considered still have parallel service-delivery systems in their ministries and social security institutions.

One fact that stands out clearly from the study is that in Latin America functional coordination and integration do not proceed in parallel, and comparing them poses difficulties of establishing with certainty indicators that can convey qualitative and quantitative gains. However, some common elements for evaluation can be identified, such as: a) changes in legislation; b) policy decisions; and c) changes in organization and the administrative process. These measures are intended to streamline the provision of medical services, which are an established fact in some countries, but in others still have much ground to cover. Hence the need for a revamping of social policy and for its articulation throughout the country with other sectors so that the limited and incomplete traditional schemes of today can be replaced.

a) Legislative Changes

In some countries in recent years national health systems have been structured which show advances in the articulation of insurance schemes at the national level and the implementation of machinery for coordination with different ministries and state secretariats, planning, control, and inspection agencies, and other institutions directly connected with health and social security, which articulate with their coverage extension policies.

Health systems have continued to develop gradually propelled by legislative change. Argentina, Brazil, Costa Rica, and Panama have made gains toward the consolidation of this process in the search for greater consistency and rationality within the health sector. Notable instances are Mexico and, lately, Peru, the former for the implementation of interinstitutional programs of the health sector as a contribution to the consolidation of the National Health System in a functional and programmed integration of its constituent institutions into a coherent, harmonious and flexible whole, so that the services provided can be extended to the entire population. Peru very recently (September 1986) charted the basic guidelines of the present national health policy and multisectoral action toward greater consistency in the policies of other sectors so that they may see to the aspects of their own policies in which they can help improve the health of the population. At the same time, it has been decided that the health services of the Ministry of Health and the Peruvian Social Security Institute are to be functionally integrated.

In the remaining 10 countries there is a move to review the administrative structures of the health sector institutions with a view to the adoption of joint plans that will harmonize and coordinate the institutions of the social security system and health ministries, so that the coverage of their services can be extended to the entire population.

b) Policy Decisions

Coordination between a health ministry and a social security institution is largely determined by decisions at the highest level of government, which are directly connected with decisions on social

policy. The experience of the Latin American countries that have made substantive progress (Brazil, Costa Rica, Mexico, Peru, and Panama) suggests that such progress requires agreement on social and economic goals at the highest level in the conduct of the country's affairs and a review and harmonization of complementary (institutional) policies deemed capable of attaining those overall goals. The coordination of these institutions is a political process in which the financial aspects and the population coverage provided by the systems are areas of special interest along with their structures.

The results seen in most of the countries in the Region indicate that the limitations of some policies on coordination of ministries and social security establishments and of the health sector as a whole appear to be associated with incipient development of the political process that leads to the formulation of these policies and is essential for their implementation, for they are the basis for the decisions taken that concern individual and collective health.

In view of that situation, some projects in search of concrete policy statements have been unable to take hold in the countries owing to the growing participation of the professional organizations and interest groups in the sector, which seek to counteract them by representing their own proposals as the demands of broader social groups. The development of coordination between health ministries and social security institutions observed under the policy decisions of the countries has been neither similar nor balanced. Hence, their health systems cannot be regarded as homogeneous, but must be seen as complexes in which highly dynamic components push for change while others remain static.

c) Changes in Organization and in the Administrative Process

In Latin America the institutionalization of health services continues a responsibility shared between ministries of health and social security institutions. They have been organized under different schemes depending on the sector's administrative policies and the institutional areas legally assigned to each of them. Most of the countries have organized their services into different levels of complexity and with regionalized administrative systems. Lately, decentralization of the service programming, performance and evaluation functions have been reflected in a general trend to establish this process for more rational resource utilization. This is what is being seen in Mexico (1983), where the process is directed at coordination of the social security services with those of the government health sector in a broader framework consisting in the extension of coverage and integration of services at the state level. A similar but more recent (September 1986) process has been seen in Peru, where everything relating to programming, execution and evaluation of health activities has been decentralized and authority delegated down to the most peripheral local facility. The process is reinforced by the functional integration of the health services of the Ministry and the Peruvian Social Security Institute, essentially for the shared use of human and technical resources and of installed capacities through joint programming.

An important effort is being made in Costa Rica, where a new medical care model has been established essentially as a program for functional integration between the Ministry of Health and Social Security (February 1987). Another feature is that the user is free to choose his own physician, who receives a basic income for his work of promoting health and preventing disease, and an additional amount for the number of persons enrolled. The model integrates and coordinates interinstitutional measures for the promotion and improvement of health and prevention of disease through health and social security boards in whose work the community is an active participant.

To promote cooperation among countries and the strengthening of their health services, in supporting the Plan on Priority Health Needs of Central America and Panama, the countries of the Central American Isthmus have included a subregional project calling for the adoption of administrative procedures and of solid bases for institutional transformation.

The other countries are also making efforts to meet the enormous organizational and operational challenges facing the health sector. In particular, it is common to see waste of resources either through inaction, the performance of needless services, organizational and managerial shortcomings, or the use of inappropriate technologies, which have been the main obstacles to interaction between ministries and social security institutes, and with other establishments in the health sector and of other sectors that are part of true national health systems.

2.2 Subregional Situations

a) Central America and Panama

One of the most important strategic areas for assuring a joining of efforts, wills and resources in a unified approach to common health problems has been the dynamic adoption and implementation by the Government of the Central American Isthmus of the Plan on Priority Health Needs in Central America and Panama.

At Panama City in April 1984 the Ministers of Health of Central America and Panama and the Directors of the Social Security Institutions of those countries adopted and undertook to implement the projects of the Plan on Priority Health Needs in the Subregion, and decided that thenceforth the Directors of Social Security would become members of the Meeting of Health Ministers of Central America and Panama (REMCAP) held every year, which since then has been known as the Meeting of the Health Sector of Central America and Panama (RESSCAP). This decision of major importance for the countries of the Central American Isthmus was very soon distinctly reflected in new changes in this group of countries, half of which have made important gains toward the consolidation of their health care systems. The importance of this decision is conveyed by the analysis of the situation of personal health care in Central America and

Panama, which showed clearly that without that integration of institutional efforts it would not be possible to meet the priority health needs of large masses of population.

Other aspects of this movement of importance for the accomplishment of these purposes are:

- The devising by the two institutions (ministry and social security) of a joint doctrine on the concept of health operational processes and care techniques. The latter relates to the general problem of technology and costs.
- The development of attitudes of understanding between the two institutions, which do not really know each other and have hence harbored mutual prejudices. Strategies must be adopted for bringing people together to know each other better and exchange information.
- Recognition of the need to universalize health care. Critical here is the recognition that the two institutions are jointly responsible for the entire population. Integration is impossible so long as they serve different clientele. A revision of the system for the financing of the social security system and the entire health system is essential.
- Development of the political process so that agreement can be reached on the new legal schemes that may be needed. Functional integration is the outcome of a process whose culmination must be reached through rising levels of articulation. In this process, and even without functional integration, there are steps that can be taken to promote this progressive articulation: a) arriving at an identity of purposes through discussion; b) raising the level of present-day communication and exchanges of information within Central America; c) seeking a level of articulation among interinstitutional policies and strategies until common standards are attained for the design and conduct of programs and projects, including the development of common support systems, such as those for critical inputs, information, supervision, etc.

This Plan on Priority Health Needs in Central America and Panama was again considered in the Joint Meeting of Health Ministers and Directors of Social Security Institutions held in Medellin, Colombia (July 1984).

The process was continued in the I Meeting of the Health Sector and the I Meeting of General Directors of Health and Chiefs of the Medical Area of the Social Security Institutes of Central America and Panama, held in San Salvador, El Salvador (August 1985). Resolution IX urged the Governments of the countries in the Subregion to adopt specific

coordination policies and establish the machinery for that coordination between health ministries and social security institutions in keeping with the situations in their respective countries, for the purpose of ensuring the functional consolidation in the health sector needed to maximize the coverage of health care to the entire population.

In II RESSCAP, held in Tegucigalpa, Honduras (August 1986) it was considered that the countries of the Subregion had made major gains in that process but it remained necessary to reinforce measures in progress by adding new approaches and arrangements for the organization of health services that would improve the social efficiency of available resources. The social security institutions and health ministries were also urged to conduct specific experiments of coordination in the delivery of health services and to facilitate the dissemination of those experiments to the other countries in the Isthmus. Finally, it was recommended to the Governments that, with the collaboration of PAHO/WHO, they set up interinstitutional working groups to formulate criteria and methods for guiding and facilitating activities for coordination among the institutions in the health sector.

Thus, agreements for cooperation with social security establishments have been signed and are in effect under which those establishments have direct responsibility for the delivery of health services. One of the central purposes of all these agreements is to help strengthen coordination processes, and the areas of cooperation under them cover a broad spectrum of situations, notably aspects of the planning and organization of health programs, the development and maintenance of health establishments, administrative analysis, and a variety of aspects of human resource programming and development.

It has also been possible to broaden the participation of social security in such programs as immunizations, diarrhea control, maternal and child care, chronic diseases, and occupational health. Representatives of these institutions are increasingly frequent participants--although in several countries not yet to a sufficient extent--in meetings, seminars, workshops and working groups guided or sponsored by the Organization and in which different aspects of the delivery of health services are considered and discussed.

However, some country situations have not evolved in the same way, which attests to the great difficulties of this kind that slow down the attainment by social security institutions of an equal share with the ministries in the technical cooperation received by the countries and for the strengthening and consolidation of articulation between themselves and their health ministries.

b) The Caribbean

In major national efforts over the last decades, the countries of the Caribbean have considerably improved the state of health of their

peoples. However, there has been a marked deterioration of some health indicators, which has been aggravated by the economic crisis that besets them, for their funds have shrunk and they have been unable to provide for the needs of a growing population. The low-income earners suffer the most in these small and economically fragile countries, which now view with great concern the reductions of their health budgets and the consequences thereof for the low-income population.

In these circumstances the health services of the Caribbean countries labor under the constraints of inadequate budgets, insufficient manpower, administrative deficiencies, scarcities of critical inputs and essential drugs, and the absence of an information system to assist in the administrative, planning and evaluation processes.

In an effort to solve these problems, which are met with everywhere in the Caribbean area, following an intense discussion within and among the countries in the region, PAHO/WHO, the Caribbean Community (CARICOM) and the countries agreed to construct profiles of projects for the Caribbean Health Cooperation Plan for the strengthening of their health services so that the coverage of those services could be extended to the entire population.

The services are organized for the most part in the public sector, which has 93.3% of the 128 hospitals and 19,161 beds, leaving only 6.7% in the private sector. The health services are divided into three areas: hospital care, and district medical and public health services. Every country has at least one general hospital, whose services are not integrated with the other health services.

The countries are making efforts to establish mechanisms that will bring about a functional integration of their services so that the sector will be able to meet the demand and which will remedy not only the technical and administrative shortcomings, but supply the lacking resources for essential inputs and drugs, and permit the establishment of a reliable, appropriate and responsive information system.

To solve the financial problems of their health sectors, some countries are considering new service-delivery models that offer other ways of organizing the sector for the attainment of coverage of the entire population. Thus, Jamaica is considering three alternatives such as charges to the user, obligatory insurance, and voluntary insurance, the latter based on a service-delivery model such as the health maintenance organization (HMO), which serves a specific population group and in which the physician is salaried or is paid a fee for each person enrolled. The organization is generally nonprofit, though there are tendencies in commercial direction. Something similar is happening on Barbados, where efforts have focused on the implementation of a national health service and on improvement of the Queen Elizabeth Hospital. In the Bahamas, where efforts are in progress to find new ways of financing health as an alternative to traditional reliance on the exchequer, a

preliminary proposal has been drawn up for a single method: a governmental National Health Insurance Plan. Other possible methods are also under study, including systems in the private sector alone or mixed systems of that sector with government.

The foregoing points bring out the different trends in the Caribbean countries, in whose development the regional experience of Latin America might usefully support the efforts being made not only through regional arrangements such as CARICOM (the Caribbean Community), but in the countries themselves through joint efforts between PAHO/WHO and other international agencies, which include the Agency for International Development of the United States (USAID), the United Nations Children's Fund (UNICEF), the Inter-American Development Bank (IDB), the International Development Agency of Canada (CIDA), the United Nations Environmental Program (UNEP), and the European Development Fund (EDF), which are collaborating toward the establishment of health services accessible and available to the entire population and responsive to its needs.

2.3 International Activities

In compliance with the provisions of Resolutions XXXII (1979), XXXIV (1981) and XV (1984) of the Directing Council, the Secretariat of the Organization had endeavored to respond to requests for collaboration from national social security agencies, which have been on the rise in recent years both in number and in the variety of fields and matters involved.

The social security agencies are also receiving technical cooperation from other international agencies, some of an intergovernmental nature (ILO and OAS) and others interinstitutional, as the Inter-American Conference on Social Security (IACSS), the Ibero-American Social Security Organization (OISS), the International Social Security Association (ISSA), and the Association of Social Security Institutions of the Caribbean, Central America and Panama (ASSICCAP). PAHO has strengthened its links to these agencies, too, for the harmonization of approaches and orientations to its cooperation with national agencies in the health field.

Joint cooperation missions to several countries have been carried out with the International Labor Office (ILO) in particular; these missions began in 1982 as part of the 1982-1987 program and are directed at the inclusion of primary care and health strategies in the social security institutions of Latin America.

With a view to the implementation of this joint ILO/PAHO/WHO/CPISS program, a First Regional Technical Consultation Meeting was held in Mexico in 1982. The meeting was attended by eight countries and examined the introduction of the primary care strategy into social security health

programs. These activities were continued by the Second Meeting (held at Medellín, Colombia, in March 1985) attended by 12 countries, one of whose main subjects was coordination between the ministry of health and the social security system. The valuable material of its proceedings was put out as a joint publication of ILO/PAHO/WHO in cooperation with the Inter-American Permanent Committee on Social Security (CPISS) in 1986 as a special edition under the title "Atención Primaria y Estrategias de Salud en la Seguridad Social en América Latina" (Primary Care and Health Strategies in Latin American Social Security).

As a follow-up to the technical consultations, three country meetings were held in 1985 and 1986, the first at Cuenca, Ecuador (April 1985), which considered subjects of intra- and interinstitutional coordination between the Social Security System and the Ministry of Health and establishments in the sector in keeping with national policy, in addition to the operational scope of the regionalization of health services in the Ecuadorian Social Security system. In the second meeting, held in Guatemala City (August 1985), the Guatemalan Social Security Institute and officials representing health sector establishments examined the machinery of interinstitutional and sectoral coordination. The third meeting, at San Pedro Sula, Honduras (November 1986) examined and discussed the problems of and strategy for the extension of health services in the country through programs coordinated between the Honduran Social Security Institute and the Ministry of Health. Similar meetings are envisaged in other countries in the course of 1987.

A technical cooperation agreement has also been signed with the Ibero-American Social Security Organization (OISS) under which joint missions have been conducted in several countries. PAHO/WHO is participating in the programs for the training of management personnel of social security institutions. The possibility of joint training in the organization and administration of services for social security institutions through the OISS's Subregional Center at Lima is under study.

Collaboration with international social security agencies has also included the presentation of regional policies and strategies adopted by the Governing Bodies of PAHO/WHO in meetings and events organized by the Inter-American Social Security Conference (CISS), its Inter-American Permanent Committee on Social Security (CPISS) and its working committees, the International Social Security Association (ISSA) and the Association of Social Security Institutions of the Caribbean, Central America and Panama (ASSICAP).

As part of the Regional Program for 1987, in an effort to raise interinstitutional resources in support of the National Health Ministry-Honduran Social Security Institute Seminar held at San Pedro Sula, Honduras (November 1986), training will be initiated in conjunction with the CISS and the Health Training Program for Central America and Panama (PASCAP), particularly in problem areas identified by the Honduran Social Security Institute and the Ministry of Health.

To support the Plan on Priority Health Needs in Central America and Panama and the Plan for Caribbean Cooperation in Health, a revolving fund and joint procurement system for drugs, biologicals and vaccines, and basic equipment has been set up and is strengthening the inter-country cooperation programs, including not only the health ministries but the social security institutions as well.

3. Areas of Analysis in the Coordination Process

3.1 The Political Process in the Health Field

In the last decades the production of health services has risen without any proportional reduction of the differences in utilization of those services by the different social groups. Broadly speaking, inequalities in the use of health services do not differ from those seen in the Region or in the distribution of other goods and services, including access to decision-making structures.

However, economic development and the modernization of Latin America and the Caribbean area are gradually bringing emergent social forces into play in the political processes of the countries, making them more complex and dynamic.

In this setting, the political power of the different social groups to influence government action for the furtherance of their particular interests differs with their socioeconomic importance in their respective countries. These general characteristics are apparent, with variations from country to country, throughout the Region. Thus, the previously mentioned institutional and organic mosaic of the health sector corresponds to a mosaic of political forces that exert pressure on the institutions on behalf of their own demands.

Though the political process in the regional health sector has not been properly studied, it appears to be dominated by institutions and sectoral interests. Professional organizations and interest groups in the sector are increasingly militant in the assertion of their proposals as if they were the demands of broader social groups. The risk of corporate domination of the political scene in the sector will remain until effective participation develops for social forces that are more legitimate advocates of the interests of the population, and particularly of the groups at greatest disadvantage from the inequality of access to services.

It is essential that the sectoral political process reach the maturity that will assure unrestricted access to these services by the different groups interested in them if it is to become a force for emergence out of the present critical situation in the health sector.

3.2 Financing Schemes and Arrangements

In the coming decades the strategies for the financing of health services must strive to the utmost for solutions that include and combine the public sector, the organized community and the private sector in a way that makes the system both equitable and financially feasible both in its financing and its delivery of services. Thus, the problem of financing the health sector goes beyond the merely monetary sphere to the area of real resources and the productivity and equity of the system. Even when financing has been obtained, the social purposes implied in the delivery of comprehensive health services to the entire population compel the conclusion that financial feasibility alone is not enough. To accomplish these purposes it is necessary that health services be economically efficient and effective, that is, that resources be used without waste and that the set purposes be accomplished. This applies to health ministries and social security institutions alike, but particularly to the latter, since the main source of additional resources for health services is expansion of the medical services of social security. It is immediately manifest that the way to do this is through coordination and not by shifting funds from one institution to another. This would entrain the benefits of progressive articulation, which improves coordination and more clearly demarcates the responsibilities and functions in health services delivery systems in their concern to rationalize and articulate programs and extend their coverage to the entire population.

As to the central sectoral problem of how to obtain an allocation of funds, strategies must take into account that in recent decades both the proposals and the traditional mechanisms for the financing of health systems have become increasingly unsatisfactory. The productiveness of additional sources and effectiveness of the various devices fashioned for the channeling of funds have been on the wane in recent years. The additional financing needed to make up the shortage of services is of a magnitude manifestly beyond the capacity of these customary devices and proposals if the present arrangements for the financing and delivery of services are continued. Probably no country is in a position to finance its health service shortages by traditional means without significant sacrifices of other social purposes, also for society as a whole.

This problem is made worse by the acknowledged need to achieve health by improvement in all the components of a given welfare profile. Thus, the problems of financing the sector so that it can provide comprehensive health services for the entire population are much broader and complex than those that the sector has traditionally had to contend with. They involve all sectors that contribute to the overall welfare of the population and are hence consubstantial with the basic problems of national development.

In this context, health services can be financed by schemes that vary from country to country depending on whether they are provided by the public or the private sector. In the public sector the sources of

financing include general tax revenue; this includes the arrangement of financing through compulsory social security, which obtains its income in contributions based on wages on the classical model of charges against employees, employers, and government. This is the scheme operating in most Latin American countries; its sphere of application varies, but it generally enrolls workers in employment situations. Its appeal lies in its status as an important source of financing for health care. Its main disadvantage is its limited coverage because, though there are exceptions in the Region of the Americas, it generally covers only workers employed by firms. Social security can be the spearhead of improvement efforts in developing countries, but its subscribers are always a relatively small proportion of the labor force. It follows from this that the sphere of application of social security needs to be revised so that it can be extended to embrace other groups of workers (the self-employed, farm workers, and the liberal professions) and its benefits made available to more members of the subscriber's family, so as to achieve universalization of the system and make the coverage of the population complete. Narrow coverage on the other hand, would not include the indigent and very low-income population on an equal footing. And while the socioeconomic structure has been progressively evolving toward industrialization and increasing urbanization, more solid progress toward the spread of social security has not materialized owing to persistence of the conceptual basis of the existence of an employer, the firm as a juridical-administrative structure, and workers earning regular wages.

The evolution of social security systems, international trends and economic and social changes signal the need for a study to extend the field of application of social security with a new philosophy for the coverage of new groups, and financing not obligatorily tied to contributions based on wages. The scheme so proposed must avoid imposing onerous burdens on persons of small means, and take account of the economic situation of the categories of insured persons.

Arrangements in the private sector include, among others, independent and voluntary insurance covering only health care and providing no pensions. The extent of the coverage under any of these types of insurance depends basically on the paying capacity of the insured. Some countries in Latin America and the English-speaking Caribbean have this alternative scheme.

Finally, there is the charge per user in which, by means of a recovery rate or contribution (tariffs), payment is made for the service rendered to the user, who has previously undergone socioeconomic assessment to determine the payment to be made by him.

The two latter schemes are finding a place in some subregions of the American hemisphere, and should be watched in order to evaluate their impact on the delivery of health services.

3.3 Extension of Coverage. A Challenge to Coordination between Ministries of Health and Social Security

As we approach the end of the 20th century, the countries of Latin America and the Caribbean face a situation that is acquiring the proportions of an emergency in their efforts to cover not only the marginal population with difficult access (130 million) but also the people that will be added to that population over the next 13 years (160 million).

In light of the world economic situation, the scarcity of funds and the enormous disparity among the countries, and among regions and groups of people within them, the sector cannot unaided attain the goal of health for all by the year 2000. The sector and its component institutions can develop only under a general social and economic development plan designed to reduce disparities, eliminate poverty, and achieve social justice. Attainment of the objectives to which a country's policies, plans and programs are redirected requires not only close cooperation among the different sectors of the national economy, but also synergic interaction among those objectives.

These facts make it necessary for the sector to gradually redirect and adjust its undertakings and operations in line with the new situations as they arise. It would be well to examine in the immediate future the situation as to the availability of health services to communities, the kind of service provided and the priority structural and operational problems of the institutions and operating units of the system. Since 1984 efforts have been made to redefine the sector, achieve interinstitutional coordination, improve the legal instruments, and organize the subsystems, such as investments, procurement, personnel and maintenance. These efforts have had no significant impact, however, with coordination among the institutions in the health sector continuing to be absent on the whole, particularly between social security and the health ministries and secretariats, both at the decision-making and regulatory levels and in the service-providing units. This situation must be corrected if coverage is to be extended to the entire population, and there is urgent need of a thoroughgoing reorganization of the present health service systems of the ministries and social security institutions. In this process the Pan American Health Organization must work harder to support increasing articulation between health ministries and social security institutions for the full universalization of medical care.

Coverage extension under coordinated health ministry-social security programs, which are directed not just to workers but to the entire population, requires special treatment with programs suited to the health profile, to the pattern of use of services, and to distribution of the population in the physical area. There thus emerges a group that is becoming important: the marginal urban populations, most particularly

those of the large cities, which are crowded into poverty belts and have become an object of special concern to governments.

Under the broadened definition of coverage, that is, universalized coverage, and in view of the advance of industrialization, social security must meet a demand for health services for an ever-growing body of cases associated with the working environment, the prevention of accident risks, and the development of appropriate forms of rehabilitation. Similarly, as a result of changes already conspicuous in the patterns of morbidity and mortality, other groups of cases are emerging within the family of social pathologies, manifested in mental disorders of adolescence, alcoholism, drug addiction and dependence, old age and disablement who have become a numerous stratum with needs of their own. This extension of coverage to those groups gives expression to a demand that the sector will be hard put to meet without the joint participation of the ministries of health and social security.

4. Outlook for Action

The world economic crisis has hit countries of Latin America and the Caribbean very hard and contributed to internal economic maladjustments that are expressed in high rates of inflation and unemployment, a reduction of income and worsening of its distribution, and in uncontrolled fiscal deficits that are undercutting the standard of living of the populations. Added to this is accelerated population growth and the accentuated growth of the major cities, with its ensuing and growing problems of infrastructure, pollution, unemployment, violence, insecurity and marginalization. In addition to the social maladjustments mentioned, these changes are causing substantive changes of behavior in relation to health, and particularly in regard to the demand for and use of services.

In view of this situation in the countries of the Americas, the 1980s are emerging as a decisive stage in the evolution of social security, and particularly of its health programs, which cannot continue operating in isolation because, now more than ever before, efficient use of the resources allocated for health requires articulation among those of all components of the sector. This articulation has advanced to different stages in the Region and, as the situation in each country permits, will have to be directed at spelling out policies on the financing of the sector, including the contribution of the private sector; delimiting the areas of responsibility of the sector's components; and determining the real coverage of the services provided through local programming as a means to the rationalization of all resources.

The main obstacles to effective coordination between the components of the sector stem, as previously noted, from the complexity of the political process, the nature of the financing, and the coverages of specific population groups by the social security institutions. In

this situation, coordination between ministries of health and social security institutions is only a means to progressive articulation within the health sector, and of this sector with national development planning.

4.1 Decentralization as a Strategy for Integration at the Local Level

The XXX Meeting of the Directing Council of PAHO (1984) identified strategic measures to stimulate this progressive articulation to achieve greater interinstitutional coordination between health ministries and social security institutions. According to studies done in the period 1984-1987, the recommendations made by the Directing Council to its Member Governments have found limited application, although there is evidence of a continued tendency toward better delimitation both of the sector and of the national health systems, and hence of their interinstitutional relations. Also discernable is moderate progress toward interinstitutional articulation for the conduct of programs to bring health care to special population groups. During the period covered by this report there has been persistent concern over the problems associated with technological processes in the provision of health services, the development of projects for investment in physical infrastructure and its maintenance both in plant and in equipment, the planning and acquisition of technology and its rational utilization, and mechanisms to ensure the quality of and equitable access to the services. Joined to these problems, and as a constraint on health ministries and social security institutions alike, a prominent component of this process is the insufficient development of human resources to manage and operate the services, aggravated by uneven geographic and functional distribution of those human resources, the ways of remunerating them, the institutional regulations for hiring them, and differences in the allocation of functions.

Finally, the gains made in some complementary support systems (critical supplies, drugs, replacement parts for equipment, laboratory reagents, biologicals and vaccines, and basic equipment), which have caused the fewest problems in the institutional articulation process, are an example for the shared development of support systems defined as the basic elements or components of administration by which conditions favorable to the delivery of health services are realized. Another important area to which attention must be given is that of standards and procedures for care, and the organization and administration of services, with priority to the identification of the aspects that are bound to pose impediments and obstacles to coordination.

In addition to the foregoing, other areas persist that merit special attention and hence figure as important avenues for action to strengthen coordination between health ministries and social security institutions.

4.2 Strengthening the Political and Technical Management of the Health Sector. Institutional Responsibilities

In most of the countries, to establish the limits of the health sector it is first necessary to draw the boundaries of the institutions' responsibilities for meeting the needs of communities.

In these circumstances, the role of the health ministry acquires primary importance in the sectoral process, and it becomes the source of coordination for all health services on the strength of its constitutional and legal competence. This goes beyond the traditional idea of becoming the sole source of services through growth and development of its own installed capacity. At present, its real power embraces only the public sector, and sometimes only part of that. In the last decades the health ministries of Latin America have characteristically concerned themselves with the administration, development and operation of their own services, which in some countries are steadily diminishing as proportions of total installed capacity, they include establishments for the production of inputs and semifinished products, and they assume little or no responsibility for the guidance and regulation of the health system as a whole.

From the sectoral standpoint, the institutions, and particularly those of the ministries of health and social security, require an examination of the responsibilities and management methods adopted for the production of services in light of the complexity and dimensions of the health establishments. This examination should imply greater decision-making decentralization and real local programming. The transformation of the sector must be presented by linking the work it does to the country's general political and economic context, in the manner of a system in which the institutional components are constantly interacting.

The tasks involved in an appropriate structuring of the health sector, including not competition but complementarity between ministries and social security institutions and the associated planning, will not be accomplished with technology and efficiency alone; these instruments are important and useful, but not sufficient. In this effort it will be essential to win, if not a consensus, at least a sufficient degree of social acceptance for the measures that have to be proposed. Moreover, these measures will vary with the political, social and economic setting in each country.

4.3 Development of the Sector's Financial Analysis Capability

One of the problems that many of the countries of Latin America and the Caribbean have had to face in their efforts to extend the coverage and improve the structure of services and to satisfy the basic needs of the population is the relatively narrow character of government income and, by extension, its limited capacity to finance programs for extending the coverage of health services, which are largely dependent on the financial arrangements used.

This limitation on funding becomes a basic element in the relationships between health ministries and social security institutions. Hence, special importance attaches to what is done to rationalize the financing of the sector through a comprehensive analysis that must lead to the formulation and implementation of alternatives that permit structural reforms of truly strategic scope in connection with financing as such and with the expenditures and costs of health.

Because of this, it becomes necessary to devise methods for the systematic analysis of the financing for the sector and its institutions and to plan, operate and oversee sectoral financing systems. These systems must eliminate barriers to accessibility through the application of solidarity criteria of social security in the financial area of health; coordination of the financial resources of the sector; enhancement of the productivity of existing and additional resources; their use in accordance with priorities; and the identification and analysis of critical areas that affect expenditures for health (inputs, technology and organization).

All this implies, in addition to a policy decision, the urgent need to set up information machinery and regulations to favor the development of the sector's financial analysis capability. This includes a capacity to determine the source and magnitude of the funds allocated to the sector; to establish the purpose and use of the services it produces, in terms of socioeconomic groups that truly benefit from them; to regulate the intensity, cost and structure of the services; and to evaluate the productivity of the resources assigned to the sector.

4.4 Local Administration of Services. A Way to Strengthen Coordination

The local programming of services to extend coverage implies the appropriate development of the first level of care as a priority, which in turn implies the establishment of a broad package of responses to the basic health problems of the entire population. This means the development of different types of services which as a whole permit the diagnosis and solution of a high proportion of the health problems of the population targeted by the programming.

The foregoing requires the establishment of appropriate forms of local administration. The articulation and coordination of these basic administration units or centers are not confined to the physical, technical and institutional resources of the sector, but must also embrace nonmedical resources such as welfare and other institutions of the social sector to expand the scope of the services and improve their quality as comprehensive responses to the diverse needs of specific population groups.

Properly conceived and developed, these basic units for the administration of health services are doubtless of enormous potential as instruments and mechanisms for the rationalization of health care resources in general, but particularly of those of the public sector (the ministries of health and social security institutions). It is through these units that the local coordination and the joint programming of services could be appropriately channeled; they would be the natural depositories of the decentralized administrative functions.

4.5 Technical Cooperation Among Countries

The decisions of the Organization's Governing Bodies give prominence to the need to promote and support the mobilization of the resources and will of the countries to strengthen their capacities and self-confidence and encourage cooperation among them. The international economic crisis in the Region and the political crisis in such areas as Central America interfere with and check these processes. In the health sector, however, this very situation is being exploited to strengthen collaborative action. The Plan on Priority Health Needs in Central America and Panama and the special undertaking of Cooperation in Health in the English-speaking Caribbean have made it possible to promote and make use of technical cooperation among countries, and on the promotion side are also mobilizing technical and financial resources in the international community.

In this setting, special interest is being drawn to the process of progressive articulation between health ministries and social security institutions. The identification of needs, the combining of capabilities and the will to bring about horizontal inter-country collaboration in the health field on both a bilateral and a multilateral basis, which has been achieved not only in the countries of the Central American Isthmus, but in other subgroupings in the Region as well, must be turned to full advantage.

Moreover, the Organization is serving as a catalyst for more active coordination with other national and bilateral technical cooperation agencies operating in the health field. Activities such as those going forward in Central America with the United States Agency for International Development, as also with the Governments of the Netherlands, Spain, France and Italy, are opportunities for promoting coordination. Under a technical cooperation agreement, the Inter-American Development Bank and the Organization are working together on the design and preparation of projects to be presented to the Bank for financing; and, with the United Nations Development Program, the Organization is engaged in a project for the strengthening of management capacity at the subregional level in the Central American Isthmus; these are also proper areas for coordination. The strategy wielded by PAHO/WHO is accepted by bilateral and multilateral institutions and agencies of financial cooperation and, while the projects are not directed outright at coordination between ministries of health and social security institutions, most of

them, and most particularly those in Central America and Panama, have components that will facilitate progressive articulation for attainment of the aim of the countries of providing health services to the entire population.

In the process of making efficient use of resources assigned to health, technical cooperation for articulation among the sector's main components--those of the health ministries and the social security institutions--has been becoming particularly important. In view of the weak part played by social security in technical cooperation programs in the American Region as a whole, however, it becomes necessary that the Organization expand its cooperation with social security as recommended by the Directing Council in Resolutions XXXIV and XV of 1981 and 1984, respectively.

This will make for greater consistency and interaction between the ministries of health and social security institutions while at the same time mobilizing resources for the provision of regional support to these country activities in a mechanism that would intensively promote the process.

5. Bibliography

1. Roemer, Milton I. Medical Care in Latin America. Pan American Union, General Secretariat, Organization of American States. Washington, D.C., 1963.
2. Abel-Smith, Brian. Value for Money in Health Services. St. Martin Press. New York, 1976.
3. Tamburi, G. Evolución, Tendencias y Perspectivas de los Sistemas de Salud de la Seguridad Social en América Latina. ILO. Geneva (Switzerland), 1982.
4. La Seguridad Social en el Proceso de Cambio Internacional. Instituto Mexicano del Seguro Social. Mexico, 1980.
5. Empleo, Crecimiento y Necesidades Esenciales. ILO. Geneva (Switzerland), 1976.
6. Technical Discussions, XXV Meeting of the Directing Council: "Coordinación entre los Sistemas de Seguridad Social y los Sistemas de Salud Pública" (Working Document). Washington, D.C., September-October 1977.
7. VII Conferencia de los Estados de América Miembros de la Organización Internacional del Trabajo. Ottawa (Canada), 1966.
8. Novelo, Gastón. Acciones y Evolución de la Conferencia Interamericana de Seguridad Social en las Prestaciones de Salud (Documento de Trabajo), Consulta Técnica Regional. ILO. Mexico, 1982.
9. Op. cit., 6.
10. Pan American Health Organization, XXVI Meeting of the Directing Council. Evolución del Plan Decenal de Salud de las Américas, 1971-1980, CD24/18, pp. 18-21. Washington, D.C., August 1976.
11. Encuesta de Países sobre Instituciones de Seguridad Social. PAHO/WHO, 1977.
12. Atención Primaria y Estrategias de Salud en la Seguridad Social en América Latina. ILO. Geneva (Switzerland), 1986.
13. Cuauhtémoc Valdes Olmedo, et al. "Descentralización de los Servicios de Salud". Cuadernos Técnicos de Planeación, Vol. I, No. 8, Coordinación de Estudios y Proyectos, S.S.A., October 1984.

14. Soberón, Guillermo. Hacia un Sistema Nacional de Salud. Comisión de Salud y Seguridad Social. Coordinación de los Servicios de Salud. Universidad Nacional Autónoma de México, 1983.
15. Pan American Health Organization. Las Condiciones de Salud en las Américas 1981-1984. Publicación Científica No. 500, Vol. I. Washington, D.C., 1986.
16. Pan American Health Organization. Principios Básicos para la Acción de la Organización Panamericana de la Salud, 1987-1990. Washington, D.C., 1987.
17. Novelo, Gastón and Palmero, Olga. Organización y Financiamiento de la Seguridad Social en América Latina. Revista Seguridad Social. Año XXXIV. No. 155-156 Epoca VI. Mexico, D.F., 1985.
18. Conte Grand, Alfredo. Problemas de Organización y Financiamiento de la Seguridad Social. Aportación ILO. Revista Seguridad Social. Año XXXIV. No. 155-156 Epoca VI. Mexico, D.F., 1985.
19. Moles R., Ricardo. Contribuciones de la AISS al Estudio de los Problemas del Financiamiento de la Seguridad Social en América Latina. Revista Seguridad Social. Año XXXIV. No. 155-156 Epoca VI. Mexico, D.F., 1985.
20. Castellanos R., Jorge. Condición entre las Entidades del Sector Público que Prestan Servicios de Atención de Salud. Publicación OIT, Primera Edición. Geneva, Switzerland, 1986.
21. Castellanos R., Jorge. Políticas y Metas Regionales de Salud: Conceptos Básicos y Componentes de la Atención Primaria. Publicación OIT, Primera Edición. Atención Primaria y Estrategias de Salud en la Seguridad Social en América Latina 1986. Geneva, Switzerland, 1986.
22. La Seguridad Social en el Perú. Centro de Altos Estudios Sindicales. Fundación Friedrich Ebert. Peru, 1985.
23. C. Mesa Lago. El Desarrollo de la Seguridad Social en América Latina. Publicación de las Naciones Unidas. Estudios e Informes de la Cepal 43. Santiago, Chile, 1985.
24. C. Mesa Lago. La Crisis de la Seguridad Social y la Atención de la Salud. Fondo de Cultura Económica. Primera Edición Español 1986. Mexico, D.F., 1986.
25. Tamburi, G. La Seguridad Social en la América Latina. La Crisis de la Seguridad Social y la Atención a la Salud. Pp. 76-107. Fondo de Cultura Económica. Primera Edición Español 1986. Mexico, D.F., 1986.

26. Ugalde, A. La Integración de Programas de Salud en un Sistema Nacional de Salud. La Crisis de la Seguridad Social y la Atención de la Salud. Pags. 136-176. Fondo de Cultura Económica. Primera Edición Español 1986. Mexico, D.F., 1986.
27. Zschock, D.K. Financiamiento de la Salud en el Tercer Mundo. Ediciones Tercer Mundo. Primera Edición. Bogotá, Colombia, 1980.
28. U.S. Department of Health and Human Services. Social Security Administration. Office of Policy-Office of Research, Statistics and International Policy. Social Security Programs Throughout The World - 1985. SSA Publication No. 13-11805. Washington, D.C., 1986.
29. Pan American Health Organization. Aumento de la Capacidad Operativa de los Servicios de Salud con Vistas al Logro de la Meta de Salud para Todos en el Año 2000. Publicación Científica No. 482. Washington, D.C., 1985.
30. Universidad de Antioquia. Ministerio de Salud. Foro Salud Siglo XXI. Memoria Volumen I. Medellín, Colombia, 1984.
31. Pan American Health Organization. Coordinación de los Servicios Médicos. Publicación Científica No. 154. October 1967. Washington, D.C., 1967.
32. Woodward, R.S. "Atención médica en Brasil durante un período de recesión económica". Boletín Oficina Sanitaria Panamericana. 98(2):107-115, 1985.
33. Pan American Health Organization. "La Crisis Económica y su Repercusión en la Salud". Boletín Oficina Sanitaria Panamericana 100(6):648-659, 1986.
34. Veronelli, J.C. "Ministerios y Sistemas de Servicios de Salud en América Latina". Boletín Oficina Sanitaria Panamericana 100(1): 1-27, 1986.
35. Castellanos R., J. "Racionalización de Recursos en la Administración, el Funcionamiento y la Prestación de Servicios de Salud". XI Primera Reunión de la Comisión Americana sobre Organización y Sistemas Administrativos. Buenos Aires, Argentina, November 1985.
36. Pan American Health Organization. "Acta Reunión Especial Ministros de Salud Centroamérica y Panamá y la OPS, con la participación de los Directores de Seguridad Social de Centroamérica y Panamá y los Ministros de Salud de Colombia, México y Venezuela." Panama, April 1984.
37. Pan American Health Organization. Consejo Directivo. Informe de Progreso. XXX Reunión. Tema 22 "Coordinación entre las Instituciones de Seguridad Social y las de Salud Pública". Washington, D.C., 1984.

38. Pan American Health Organization. Directing Council. XXVIII Meeting, Item 23. Informe de Progreso. "Coordinación entre las Instituciones de Seguridad Social y las de Salud Pública". Washington, D.C., 1981.
39. Ministerio de Salud, Perú. "La Política Nacional de Salud". September 1986.
40. Ministerio de Salud. Instituto Peruano de Seguridad Social. "Integración Funcional de Servicios de Salud del Ministerio de Salud y del Instituto Peruano de Seguridad Social". Decreto Supremo No. 022-86 S.A. de 28 julio 1986. Lima, Peru, 1986.
41. Ministerio de Salud - Caja Costarricense del Seguro Social - Ministerio de Planificación y Política Económica. Instituto de Acueductos y Alcantarillado. Instituto Nacional de Seguros. Universidad de Costa Rica. OPS/OMS. "Situación de Salud en Costa Rica. III Parte. V. Desarrollo del Sistema de Servicios de Salud". Reunión de Análisis de Cooperación Técnica de la OPS/OMS a Costa Rica. San José, 1987.
42. Pan American Health Organization. "Informe del Director. Cuadrienal 1982-1985. Anual 1985". Documento Oficial No. 207. Washington, D.C., July 1986.
43. Reunión del Sector Salud y Directores Generales de Salud y Jefes de Area Médica de los Institutos de Seguridad Social de Centroamérica y Panamá. II RESSCAP/1986. Informe Final. Tegucigalpa, Honduras, August 1986.
44. Reunión del Sector Salud y Directores Generales de Salud y Jefes de Area Médica de los Institutos de Seguridad Social de Centroamérica y Panamá. I RESSCAP/1986. Informe Final. San Salvador, El Salvador, August 1985.
45. Pan American Health Organization. II RESSCAP/1986. "El Proceso Tecnológico y su Impacto en el Sector Salud". Documento de Trabajo. Tegucigalpa, Honduras, August 1986.
46. Pan American Health Organization. OPS/AISSCAP. II RESSCAP/1986. "Proceso de Coordinación Sectorial. Bases Doctrinarias Comunes". Tegucigalpa, Honduras, August 1986.
47. Ministerio de Salud del Uruguay. OPS/OMS. "Estudio de Prefactibilidad (Proyecto URU-0021). Ampliación y Mejoramiento de los Servicios de Salud". Montevideo, Uruguay, November 1986.
48. Registro Oficial. Año III, No. 585. Acuerdo No. 2188 "Reglamento del Convenio Interinstitucional entre el Ministerio de Salud Pública y el Instituto Ecuatoriano de Seguridad Social para Prestación de Salud". Quito, Ecuador, 16 December 1986.

49. OPS/OMS-CARICOM. "Programa de Cooperación en Salud para el Caribe", 1985.
50. Op. cit. "Programa de Cooperación en Salud para el Caribe", Draft, 1985.
51. Op. cit. "Perfiles de Proyectos", September 1986.