GUIDELINES FOR THE PREPARATION OF HEALTH SYSTEM PROFILES FOR THE COUNTRIES OF THE REGION

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Division of Health Systems and Services Development
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0. FORWARD

Some of the most important actions undertaken as part of PAHO technical cooperation are those aimed at strengthening national capacity to design, implement, and make effective use of methodologies and information systems that are geared to:

1) Identify and assess changes in the living and health conditions of the population;
2) Develop capacity for the analysis, planning, and formulation of policy;
3) Strengthen the capacity for leadership and management in the ministries of health and other institutions of the sector both for normal operating conditions and for the Health Sector Reform (HSR) processes.[1]

A number of initiatives have been undertaken since the middle of the present decade in support of such efforts as the review of Strategic and Programmatic Orientations (SPOs) and the preparation of the Biennial Budget of the Organization)—for example: development of the "Basic Indicators" series (BI), [2] design of the 1998 edition of *Health Conditions in the Americas* (HCA 1998), and preparation of the "Base Line for Monitoring and Evaluation of Health Sector Reform" (BL).[3]

However, it was not until 1998 that a report on the health system was available for each country which provided a systematic synthetic and analytical description of the context in which the systems are operating, along with an overview of the general organization, operation, and resources of the respective health systems and the impact of HSR initiatives. Moreover, there have been no guidelines to facilitate the preparation and periodic updating of such reports. This is particularly important now that strengthening of the steering role of the ministries of health has been placed on the agenda of the countries and of PAHO itself.

The present Guidelines are an attempt to meet this need. Their overall frame of reference takes into account the WHO strategy of Health for All, the SPOs, and other documents approved by the PAHO Governing Bodies. Their specific frame of reference includes the documents "Cooperation of the Pan American Health Organization in Light of the Health Sector Reform Processes"[4] and Steering Role of the Ministries of Health in the Processes of Health Sectoral Reform..[5] It will be assumed that the users of the Guidelines are fully familiar with these references and with the categories, operational variables, and definitions that are used therein. Nevertheless, definitions have been included here when it was felt that they would aid in understanding and using the guidelines.

The purpose of the Guidelines is to facilitate the work of national professionals and the staff in the PAHO/WHO Representative Offices in the preparation of a report (hereinafter "the Profile") on the structure and dynamics of the health system in each country, intended for use by political decision-makers and other key players. The Profile should be as objective as possible, manageable in length, accessible through the PAHO Web site, and easy to update.

Producing the Profiles should not be regarded as yet one more initiative on top of all the others already under way (for example, the BI series). Rather, it takes those other efforts into account and goes on to add a qualitative and analytical component. Nor does it duplicate other efforts (for example, preparation of the chapter for "The Health System Response" in the *Health Conditions* series). Rather, it attempts to give continuity (through follow-ups) and systematization (through a common structure, which may be periodically revised) to what has often been seen in the past as an haphazard effort involving approaches that were not always compatible.

The Guidelines contain an Introduction, a Methodology section, and a section presenting the Analysis Variables and the Indicators. The Methodology section offers guidelines on how to utilize the next section to produce the Profile. The section on the Analysis Variables and Indicators has been

divided into three main chapters: The Context; The Health System; and Health Sector Reform. In each chapter, special importance has been given to the available numerical data, while emphasizing its dynamic nature and, when appropriate, its impact for the Profile. When it is considered indispensable, qualitative information is also requested. In addition, especially in the chapter on HSR, emphasis is placed on the importance of documenting any situations of inequity, based on the best available evidence, and indicating the policies adopted and the actions undertaken toward reducing or mitigating them. In all cases, an effort has been made to avoid or minimize personal opinions and value judgments.

A Glossary of Terms has been added to this edition of the Guidelines.

An initiative of this kind necessarily involves methodological problems and certain limitations.

First, in some countries the information available may be insufficient, unreliable, or not broken down to the necessarily level of refinement. Or the information may exist, but it is not readily available, it may not have been compiled systematically, or it may not have been adequately disseminated.

Second, the cultural diversity of organizational models makes for notable differences in the definitions of concepts and/or the terminology used. An attempt has been made to deal with this difficulty by including a Glossary with definitions of concepts and terms, including examples.

Third, as pointed out in the corresponding section, it is often impossible to establish a direct correlation between the actions taken by the health systems and services, whether or not they are part of HSR processes, and the changes that have taken place in the variables proposed for evaluating the results.

Fourth, it is no easy task to select the best Indicators for measuring changes in all the variables, nor is it free of controversy. A more detailed discussion of this challenge can be seen under Methodology.

Finally, the health systems are complex and dynamic realities in which the separation between the stages of continuity and the stages of rapid and deliberate change (i.e., those associated with HSR) cannot always be clearly identified. It is even more difficult to discern the separations between the different stages or phases of HSR, which are far from being planned processes and differ from country to country. What may seem clear in retrospect is much more complicated to analyze while it is actually taking place.

In addressing these problems during the preparation of the first version of these Guidelines (June 1998), the following resources were enlisted:

1) The past experience of PAHO in the design, collection, processing, validation, and dissemination of information on health conditions and trends;

2) The efforts contributed by the staff of the PAHO Division of Health Systems and Services Development, both at PAHO Headquarters and in the field,[6] as well as the assistance of staff from other divisions, units, and programs;

3) The experience of other international cooperation agencies working both within and outside the Region, particularly the WHO Division of Analysis, Research, and Evaluation,[7] the WHO European Regional Office,[8] the OECD,[9] the UNDP,[10] and the World Bank;[11]

4) The rich experiences of the 17 countries that undertook to apply the "Base Line for the Monitoring and Evaluation of Health Sector Reform" between October 1997 and May 1998 ;[12]

5) The results obtained from a feasibility test of a preliminary version of the Guidelines in five countries (Chile, Dominican Republic, Peru, El Salvador and Jamaica), as well as contributions of the PAHO/WHO Representative Offices in eight additional countries (Mexico, Panama, Uruguay, Paraguay, Colombia, Cuba, Argentina and Guyana);

6) The contributions of an international group of experts convened to consider this subject at PAHO Headquarters in April 1998.[i]

Between August 1998 and April 1999, 17 Profiles were completed and posted on the Web site of the Health Sector Reform Initiative (http://www.americas.health-sector-reform.org). In addition, a second international meeting of experts was convened to discuss the lessons learned during the preparation, publication, and dissemination of the Profiles, as well as to review the Guidelines and help to prepare a new version.[ii] The meeting produced valuable suggestions, and an effort has been made to include them in the current version of the Guidelines.

In July 1999 a report on the experience with this process to date was presented and discussed at the Andean Subregional Forum on HSR organized by the Health Sector Reform Initiative, and additional suggestions from this source were incorporated in the present Guidelines. The meeting also confirmed that the success of this undertaking depends above all on support from the health authorities and on the work of the staff and professionals in the countries. They are the main users of the results, and without their active cooperation it would be difficult to arrive at a successful outcome.

Since then, more countries have completed their profile, and an external review of an advanced draft of the second edition of the Guidelines has been conducted by the University of Chile's School of Public Health and the Osvaldo Cruz Foundation's School of Public Health in Brazil. Many of the suggestions were incorporated in this final version. Furthermore, an initial analysis of the contents of Section 3.3 (Monitoring and Evaluation of Health Sector Reform) was conducted and posted on the Web site mentioned earlier.

[i] See Annex 1 for List of Participants.
[ii] See Annex 2 for List of Participants.

1. INTRODUCTION

1.1. WHAT IS THE HEALTH SYSTEM PROFILE?

A country's Health System Profile is a document that should be as objective as possible, of manageable length (18-20 pages), and easy to update. The Profile systematically describes and analyzes the structure and dynamics of the health system of a given country, including any experience it has had with HSR. The outline of chapters, sections, and subsections, together with the development of the Profile's content, is designed to facilitate use of the Profile at both the national and subnational level and also to permit comparisons between countries. The Profile should include, moreover, an Executive Summary of not more than two pages.

The Profile does not purport to offer an exhaustive analysis of all possible topics, or even of all the topics that it mentions. It only addresses relevant aspects of a set of selected topics that are considered to be indispensable. Detailed analyses of the topics that have been included (or of others that have not been included) are possible and, in many cases, necessary. Other methodological instruments are being developed by PAHO for this purpose.[13],[14],[15] It is expected, however, that the synthetic nature of the Profile, together with the fact that it will be updated periodically, will make it a valuable instrument for national, subnational, and international decision-makers.

1.2. TO WHOM IS THE PROFILE DIRECTED?

The potential users of the Profile are numerous:

1) In the countries:

a) First of all, the health authorities at the central and subnational (intermediate and local) levels;

b) The national professionals who work in the planning and administration of health systems and services, as well as the field professionals from the technical and financial cooperation agencies and the NGOs;

c) Managers and professionals in other public institutions (for example, the ministries of planning and finance), as well as private institutions in or related to the health sector;

d) Teaching institutions related to the health sector;

e) Health professionals;

f) The communications media and the public.

2) At the international level:

a) The managers and professionals of PAHO and other bi- or multilateral technical or financial cooperation agencies;

b) National health authorities in the other countries of the Region;

c) Universities and centers devoted to education in public health, health administration, and health management;

d) Specialized journals and possibly some of the general communications media.

Although the Profile may be useful for a variety of purposes and users, while it is being drafted and/or updated, it may help to keep one or two main types of users in mind:[16] (1) in the countries, the health authorities and personnel involved in directing and managing institutions in or related to the health sector (national and subnational levels), and (2) at the international level, managers and professionals in the cooperation agencies, and health authorities in the other countries of the Region.

1.3. CONTENT OF THE GUIDELINES

The present Guidelines attempt to facilitate the collection, preparation, and periodic updating of the Profile based on the list of contents for the section on Analysis Variables and Indicators. There are three main chapters: the first refers to the context; the second, to the general organization, operation, and resources of the health system; and the third, to health sector reform. In addition, a glossary has been included. The terms that appear in the glossary have been underlined in the text.

The first chapter refers to the framework within which the health systems operate. It is intended to facilitate the collection, preparation, and updating of information referring to those aspects of the political, economic, social, demographic, and epidemiological context that are relevant to the sector's performance.

The second chapter is concerned with the routine operation of the health system, including both services to individuals and population-based services. It has been divided into three main sections, which deal, respectively, with general organization, resources, and operation.

The third chapter is on health sector reform. In keeping with the structure adopted in the Base Line, it has been divided into two sections: Monitoring the Process, and Evaluation of Results.

Each section is divided, in turn, into several subsections. This outline of chapters, sections, and subsections is also the one being proposed for the Profile and its Executive Summary.

Finally, the bibliography consulted in the preparation of the Profile will be cited in numerical order within the text, and the reference will appear at the end of it, in keeping with PAHO standards for publications.[17] Footnotes will not be used.

2. METHODOLOGY

The present Guidelines are designed for use by the working team responsible for preparing the Profile.

2.1. The Working Team

For the preparation and/or global revision of the Profile, it is suggested that the PAHO/WHO Representative appoint one person to be in charge, and that that person arrange for the cooperation of professional staff from the Representative Office in the country, as needed.

In addition, modalities will be decided on for securing cooperation with staff and professionals in the ministry of health and any other pertinent sector institutions (for example, entities from the social security system, the private sector, universities, etc.). These will be informed from the outset about the objectives and scope of the Profile, as well as the present Guidelines. It is suggested that at least one joint meeting be held at the start of the preparation and/or global revision of the Profile and another at the end.

The person in charge of the working team in the PAHO/WHO Representative Office will have the support at all times of the working group established for this purpose in the Division of Health Systems and Services Development of PAHO/WHO, and, in particular, with the professional designated to act as the focal point for this initiative.

2.2. The Information to Use and Where To Obtain It

The following sources should be used in the preparation and/or global revision of the Profile:

a) Information already available, with special importance given to institutional information published by official national sources;

b) Information published by international technical and/or financial cooperation agencies (including PAHO);

c) Unpublished information from official national sources ("gray literature"), provided that there is no objection to its use;

d) Information published in unofficial sources (for example, signed articles) that is regarded as relevant.

If there is no information available, or if deficiencies or bias have been documented or are commonly known to exist in the information available (for example, underreporting of mortality, or coverage limited to establishments under the ministry of health), these problems will be pointed out. When information or evidence exists but it could not be obtained during the preparation of the Profile, this fact will be expressly stated, with an indication of where it is and, if appropriate, why it could not be obtained.

When it is considered necessary, experts can be interviewed or the focus group technique can be used to validate the information. This procedure is especially recommended for Chapter 3.

2.3. Use of the "Analysis Variables and Indicators" Section

The topics included in the "Analysis Variables and Indicators" Section are considered indispensable for preparing the Profile. They should all be dealt with, in the order in which they are presented. Information referring to areas not mentioned may be included on an exceptional basis, but only if it sheds light on crucial aspects of the structure and/or dynamics of the country's health system and the total length recommended for the chapter in question is not exceeded.

This section asks for both quantitative and qualitative information. With regard to the quantitative information, an effort has been made to limit the requests for information to that which is known to be available and has been previously reported by most of the countries. When appropriate, reference is made to the number of the indicator as it appears in the publication "Basic Indicators, 1999" (BI99). Whenever possible, quantitative information should be presented in the form of a table or graph, followed by comments on the evolution of the data over time, if that information is available, the expected trends for the immediate future, and the causes or factors that contribute to the picture.

For the qualitative information, the Questionnaire tries to be fully self-explanatory (for example, clarifying the scope of the information requested and/or clarifying the terms) and suggest the approximate space that should be devoted to the topic in the Profile (for example, one line, a few lines, or a paragraph). In this regard, it is important to differentiate between "qualitative information," "expert opinion," and "value judgment." For example, if in a particular country a ministerial proposal for reform of the sector (or of an important aspect thereof) generated opposition and was finally discarded, this is relevant qualitative information that should be included. If the opposition came from various sources within or outside the government, the assessment concerning their relative contribution to the final outcome is a matter of opinion and should only be included if there is adequate consensus. The assessment of the reasons that each of these parties had for opposing the reform would fall under the heading of "value judgments" and should be omitted.

Most of the indicators have been introduced in the form of questions. Although the questions have been formulated as precisely as possible in terms of the topic being dealt with, it is essential to understand what they are intending to ask (and the context in which they are being formulated), and respond to them at that level, rather than just take them literally. Except when indicated otherwise, the concepts used in the section on Analysis Variables and Indicators (for example, "poverty," "rural population," or "hospital bed") should be interpreted according to the definitions commonly used in all countries. If there is evidence that some of them are being used in a sense that differs substantially from that used in most of the countries, it should be pointed out in the Bibliography and Notes that this might affect the comparability of the data.

2.4. PRESENTATION OF THE PROFILE

The Profile's synthetic and objective nature must be emphasized. This means that long, detailed descriptions should be avoided. The topics should be dealt with on the basis of the information available, avoiding value judgments and unfounded conclusions. Short sentences are recommended, with correct spelling and punctuation. Excessive use of embedded phrases and subordinate clauses is discouraged. Standard practice shall be followed in Spanish, Portuguese, and French with regard to numbering; that is, the "," for the decimal point and the "." for the grouping of thousands and millions. In the case of profiles prepared in or translated into English, the standard practice for that language shall be followed; that is the "." for decimals, and the "," for the grouping of thousands and millions.

The total length of the document, including the Bibliography and References, should be 18 to 20 pages, at 1.5 spaces, in 11-point Times New Roman (or Universal) font. An Executive Summary of no more than two pages shall be added , together with a page for the Bibliography and Notes. There should be no annexes.

A balance should be sought between graphics and text. It is suggested that the topical areas containing quantitative information in the form of tables or graphs be organized so that the latter do not exceed 40% to 50% of the total space devoted to that topic. The suggested lengths of the chapters of the Profile are as follows:

- Context: 3½ -4 pages
- Organization, Functions, and Resources: 7-8 pages
- Sectoral Reform: 7-8 pages
- Bibliography and References: 1 page

- Total: 18-20 pages

This is the recommended length for each chapter and the total Profile. Minor adjustments are permitted as long as they do not create any imbalances between the chapters.

2.5. PERIODIC UPDATING

The first edition of the Guidelines mentioned that the preparation of the Profile would not end with the drafting of the first version. From the beginning it underscored the fact that this is an ongoing process that will involve repeated approximations, emphasizing that, as experience elsewhere has shown, a country's Profile will not be considered fully satisfactory until the second or third version. Both the first version of the Profile and the successive updates must be approved by the Representative. The closing date (day, month, and year) of each version should appear at the end of the document.

This second edition of the Guidelines incorporates a number of changes. These can be broken down basically into five types:

- the inclusion of data corresponding to successive years (as, for example, in the table in section 3.1.2);
- the addition of new sections and/or questions (for example, all of section 3.1.4);
- changes in the order of the questions (for example, in section 3.1.3);
- the reformulation of some of the questions (for example, in section 3.2.3.2);
- improvements in the language, notation, and style (for example, designation of the introductory paragraphs of Chapter 3 as section 3.3.1).

The most relevant changes have been duly flagged in the text.

Since the launching of this initiative, some countries have begun a global revision of their Profile, because substantial changes have taken place in certain areas (for example, in their insurance, financing, management, and other models) or to update the data or improve aspects of language and style.

The global revisions undertaken with this second edition of the Guidelines should include at leas one external review. To this end, the PAHO/WHO Representative Offices in the countries may enter into an agreement with one or more national institutions of recognized repute on how to effect this review. The external review should take place before sending the new version of the Profile to the editorial team at Headquarters.

Subsequent global revisions of the Profile will be undertaken on a regular schedule, as yet to be determined (for example, every two years). As it is known, partial updates of specific chapters or sections can be made at any time. In such cases, it will be sufficient for the PAHO/WHO Representative (or whoever he or she so delegates) to send the proposed updates to the designated focal point in the Division of Health Systems and Services Development at Headquarters.

3. ANALYSIS VARIABLES

3.1. CONTEXT

The purpose of this chapter is to synthesize and to analyze the information on the political, economic, social, demographic, and epidemiological context of the country that is considered relevant to the performance of the health system. Much of this information is already available and has been dealt with, and often even published, before. For example, when the country reports were prepared for the World Summit for Social Development, held in Copenhagen (1995), use was made of the country chapters from HCA 1997, the III Evaluation of the Strategy of Health for All 1997, or other sources. The present task, in turn, involves consolidating, summarizing, and, only in exceptional bases, updating this information taking into account the Analysis Variables and Indicators included in the questionnaire that follows. Except where indicated otherwise, it is suggested that the observations requested be limited to one or only a few lines.

3.1.1. Political

- What type of state and government does the country have?
- What agencies are responsible for political, fiscal, and administrative decentralization? Which is subnational model for political and administrative organization?
- What are the national (or subnational) mechanisms for the planning and management of development?
- Which are the mechanisms for the implementation of social policy?
- How is health policy incorporated into the government's national (or subnational) programs?
- What are the three or four main political and social problems that affect the health situation or the performance of the health services?

3.1.2. Economic

Complete the following information, and comment on the trend in the data provided and the expected trends for the coming years:

Selected Economic Indicators

INDICATOR	YEAR						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Per capita GDP in constant US$ prices (BI97, 15A)							
Economically active population, in thousands							
Total public spending as a percentage of GDP							
Public spending on social programs as a percentage of GDP							
Annual rate of inflation							

Source (s): Note: Enter the abbreviation "ND" when information is not available.

- What is the contribution of each economic sector to the gross domestic product?
- What is the share of external financing in the total budget income of the public sector?

3.1.3. Demographic and Epidemiological Context

- What is the life expectancy at birth of the population as a whole and by sex? (BI97, 10T.10M. 10F) (Use data from the last available year, specifying what it is and describing the trend over the last decade).
- What are the average annual rate of population growth and the dependency ratio? (BI99, 6,9). Describe the expected trend in the distribution of the population. Analyze migration in the county and its incidence on the rate of population growth.
- Fill in the following table and describe the trend. If annual data are unavailable, include the median for the last five-year period.

	YEAR						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Crude birth rate (BI99, 2)							
Total fertility rate (BI99, 7)							
Crude death rate (BI99, 4)							
Maternal mortality rate (BI99, 23)							
Infant mortality rate (BI99, 19)							

Source: Note: Enter the abbreviation "ND" when information is not available.

- What is the estimated percentage of unregistered mortality (BI99, 28)?
- What is the percentage of deaths from ill-defined causes (BI99, 27). What is the trend in mortality from major groups of causes: (1) communicable diseases; (2) malignant neoplasms; (3) diseases of the circulatory system; and (4) external causes (BI99 30Te, 30Me, 30Fe, 31Te, 32Te, 32Fe, 33Te, 33Me, 33Fe), and age group? What are the five leading causes of mortality? Describe the trends.
- What are the trends for the most important chronic communicable diseases in the country (for example, tuberculosis and leprosy), the most important chronic noncommunicable diseases (for example, malignant neoplasms, diabetes, heart disease), nutritional diseases, accidents and violence? Note the mortality, morbidity, and disability they cause and the age of the affected population.
- What are the five leading cases of infant mortality. Indicate the trends. What is the percentage of deaths in children under 5 from acute diarrheal disease and acute respiratory infections? (BI99, 21, 22)
- Indicate the situation of the emerging and reemerging diseases considered most important in the country, or of those that are being targeted by special programs (for example, measles, cholera, malaria, dengue, and AIDS) and the male/female case ratio (BI99, 34, 36, 38, 39, 40, 41, 42, 43, 44).
- Is drug abuse a national problem? Have changes been observed in consumption that would constitute a significant health or social problem at the national or subnational level or in specific population groups?

3.1.4. Social Context

- What is the total population and what percentage of it is urban? (BI99, 1 and 8)
- If applicable, how is the population distributed between the different ethnic groups?
- What proportion of the population is illiterate? (BI99, 11T, 11M and 11F)? What are: a) the index of schooling and, b) the average number of years of schooling? Which is the spatial distribution and/or by groups population of both indicators?
- What percentage of the population is living in poverty? (BI99, 17) How is this population distributed in terms of rural/urban location, sex, and ethnic group? What has been the trend in the last five years and how is it expected to change in the coming years?
- What is the ratio between the top and bottom 20% in terms of income? (BI99, 18) What has been the trend in the last five years and how is it expected to change in the coming years?

- What is the unemployment rate? What is the estimated rate of informal employment? What are the expected trends for both rates in the coming years? (Informal employment is understood as employment without a formal contract).
- How does the country rank in terms of the Human Development Index (HDI)? What is the correlation between its HDI ranking and: (a) the per capita GDP, and (b) Gender-related Development Index (found in the UNDP Human Development Report)?

3.2. THE HEALTH SYSTEM

This chapter refers to the normal or ordinary performance of the health system, including both services to individuals and services to the population. It has been divided into in three main sections: General Organization, Resources, and Functions of the Health System. If reform processes have been implemented, the chapter will refer to the performance of the system before these processes began. If they have not been implemented, unless the national situation indicates otherwise, it is suggested that the chapter be written based on the status of the situation as of 31 December 1999. Transformations that are taking place during 2000, or are expected to be introduced in the immediate future, will be included in the corresponding section of the chapter on health sector reform.

3.2.1. General Organization

The purpose of this section is to synthesize and analyze basic information on:

a) The basic characteristics and general organization of the principal public and private institutions which together make up the health system; and

b) The relationships they have established among themselves for the performance of their activities (especially with reference to financing and service delivery), at both the central and the intermediate and local levels.

For the system as a whole:

- Over the past decade, what has the predominant organizational model for the health services been and, if appropriate, what model is currently emerging? Use only a few lines. If you need more space, use the space available at the end of Chapter 3.

Public Institutions

- What public institutions participate in the health sector (for example, ministry of health, other entities of the central government, intermediate and local governments, social security institutions)?

For each of the main institutions identified in the previous question, specify:

- What type of legal status and organizational model do they have? What modalities of decentralization? Is the decentralization consistent with that taking place in the State Administration?
- What are their principal sources of financing? What human and technology resources do they have for the delivery of services? If applicable, from whom and how are health services purchased?
- What institutional relationships have been established between the various public institutions at each level? How do the levels of care relate to one another within each institution?
- What form do the different public health care networks take in a given geographical area? How are they related to the networks in the private subsector?

Private Institutions

- What are the principal insurers and/or providers of nonprofit and for-profit services?
- For each main institution identified in the previous question, specify:
- What is its legal status and, if applicable, what its organizational model? What its predominant geographical distribution?
- What are its principal sources of financing? What human and technological resources do they have for the delivery of services? If applicable, from whom and how are health services purchased?
- How are these institutions related to one another and to the institutions in the public subsector at the central level and, if applicable, at the intermediate and local levels?

3.2.2. System Resources

The purpose of this section is to summarize and analyze basic information on:

a) The production and distribution of the sector's human resources;

b) Drugs and other health products;

c) Infrastructure, equipment, and other health technologies.

Except when otherwise indicated, the information in this section refers to the system as a whole and not merely the public subsector. The section is subdivided into three subsections, one for each of the areas stated.

3.2.2.1. Human Resources[iii]

[iii] The revision of this section was based on the first verson of the set of indicators to be included in the "Observaton of Human Resources" provided by the HHRR Program in the HSP Division.

- For the following indicators, document the trends since the beginning of the decade and comment in a few lines on the evolution expected in the immediate future:

HUMAN RESOURCES IN THE HEALTH SECTOR

TYPE OF RESOURCE	YEAR						
	1993	1994	1995	1996	1997	1998	1999
Ratio of physicians per 10,000 pop. (BI99, 46)							
Ratio of nurses per 10,000 pop. (BI99, 47)							
Ratio of dentists per 10,000 pop. (BI99, 48)							
Ratio of mid-level laboratory technicians per 10,000 pop.							
Ratio of pharmacists per 10,000 pop.							
Ratio of radiologists per 10,000 pop.							
No. of Public Health graduates							

Source (s): Note: Enter the abbreviation "ND" when information is not available.

- For the system as a whole, what is the ratio of general practitioners to specialists and how has it evolved over the decade?
- What is the percentage of unemployment in the professional categories in the table above? What has the trend been and how is it expected to evolve in the immediate future?
- For the main public institutions that provide health services, provide the following information for the last available year:

HUMAN RESOURCES IN PUBLIC INSTITUTIONS, YEAR:

Institution	Type of resource					
	Physicians	Nurses	Nursing auxiliaries	Other health workers	Administrative personnel	General services
Total						

Source(s): Note: Enter the abbreviation "ND" when information is not available.

- For the main public institutions that provide health services, what is the ratio of specialists to general practitioners?
- What has the average remuneration of general practitioners vs. specialists been during the past decade? How does it compare with that of other professionals?

- Is there periodic measurement of the productivity of health personnel in the main public institutions? If so, how many patients are seen by the medical staff of primary facilities per hour contracted and how has this evolved over the past decade?

3.2.2.2. Drugs and Other Health Products

- For the following indicators, document the trends since the beginning of the decade and comment, in a few lines, on the expected evolution in the immediate future:

INDICATOR	1993	1994	1995	1996	1997	1998	1999
Total nº of registered pharmaceutical products							
Percentage of brand-name drugs							
Percentage of generic drugs							
Total spending on drugs (selling price to the public)							
Per capita spending on drugs (sale price to the public)							
Percentage of public spending on health allocated to drugs							
Percentage of the expenditure executed by the ministry of health for drugs							

Source (s): Note: Enter the abbreviation “ND” when information is not available.

- What is the policy on drug prices?—free, totally controlled, or partially controlled? Please explain in two or three lines.
- What are the five top-selling products on the national market? What is the price per unit in each case? (Do not use name brands; indicate the active ingredient and take an average of the different brands for the selling price.)
- Is there a national drug policy? If so, what does it consist of? Please explain in a few lines.
- Is there a national drug list? If so, How many drugs are included? Who is required to use the list? How often is it updated? What percentage of the population has permanent access to the drugs on the list?
- Are there any distribution schemes and/or subsidies to facilitate access to the drugs by certain population groups, patients with certain pathologies, or certain insurance programs?
- Are there any treatment protocols (drug therapies or other treatment schemes) or standardized therapies for prevalent pathologies being applied by public institutions at the primary care level? In hospitals?
- Is the presence of a pharmacist required in private pharmacies? In hospitals?
- What is the total number of annual blood donations? What percentage of donations are remunerated, and how much on average is paid? Are there standardized protocols for the

control of blood? What percentage of the donations are controlled according to these standards?

3.2.2.3. Equipment and Technology

- For each of the questions below, if the requested information is available, comment on the situation and trends in a few lines. The information refers to the last available year:

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR, YEAR:

SUBSECTOR	TYPE OF RESOURCE			
	Beds available (BI97, 47) per 1,000 pop.	Basic diagnostic imaging equipment per 1,000 pop.	Clinical laboratories per 100,000 pop.	Blood banks per 100,000 pop.
Public				
Subtotal				
Private (nonprofit and for-profit)				
Subtotal				
T O T A L				

Source(s): Note: Enter the abbreviation "ND" when information is not available.

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR[iv], YEAR:

SUBSECTOR	Type of resource					
	Delivery room		Clinical laboratory		Diagnostic imaging equipment	
Public	1st level	2nd level	1st level	2nd level	1st level	2nd level
Subtotal						
Private (nonprofit and for-profit)						
Subtotal						
T O T A L						

Source: Note: Enter the abbreviation "ND" when information is not available.

[iv] Each country may report on as many levels as it uses. The two most common levels are mentioned by way of example.

- What percentage of the equipment is defective or out of order?
- Which percentage of the operating budget is allocated to conservation and maintenance?
- What percentage of the maintenance staff have only empirical training?
- What is the distribution of high-technology units and/or equipment? (Take one or more of the following examples as indicators—dialysis units, intensive care units, neonatology units, transplant units, CT scan units, or others—for tracking by geographical area or public vs. private subsector.)

3.2.3. Functions of the Health System

The purpose of this section is to synthesize and analyze relevant information on:

a) How the ministry of health performs its Steering functions;

b) Health sector financing and expenditure;

c) The various health insurance models;

d) Delivery of health services to the population.

The is divided into four subsections, one for each of the purpose above. If substantial changes have been announced or are being introduced in sectoral financing and expenditure as a result of the health sector reform processes, please mention this in the corresponding subsections of Chapter 3.

3.2.3.1. Steering role

- Who is responsible for management of the sector, and how is this done? Who is responsible for regulation of the sector and the health authority, and how is this accomplished? Have the essential public health functions been identified? If so, what are they?
- Who is responsible for the supervision and control of public financing of the sector, and how is this done?
- Are there mechanisms for public regulation of the different forms of health insurance, including private insurance? Note: If they are being designed or introduced within the framework of health sector reform, please provide a description in the corresponding subsection of Chapter 3.
- Who is responsible for supervision, evaluation, and control of health services delivery by the various public and private providers, and how is this done?
- Are intersectoral actions and/or programs promoted? How are these actions and/or programs linked to the institutional health service providers in the public and private subsectors?

- Do the health authorities—and specifically the ministry of health—have reliable and up-to-date information systems on the health situation, health financing, insurance, and delivery of services? Is the information available used effectively for decision-making? Comment in one or two lines.
- Is there an entity in the ministry of health that is responsible for policy formulation, planning, and coordination in the area of human resources? Comment on the results and problems in a few lines.
- What are the procedures for the accreditation of institutions that train health professionals? Comment on the results and problems in a few lines.
- What are the procedures for the accreditation of health facilities? Are they applied in both the public and private subsectors? If so, with what results?
- Are there public or private agencies responsible for evaluating health technology? Have policies been defined on the preparation, introduction, and use of guidelines for clinical practice?

3.2.3.2. Financing and Expenditure

- Is reliable and timely information available on the financing of health costs? Who prepares it? How?
- Complete the following tables and comment on the data presented as well as the anticipated trends:

Health sector financing, 1993-1999 (in US$ and % of GDP)

	1993	1994	1995	1996	1997	1998	1999
1. PUBLIC SUBSECTOR							
1.1. Ministry of health and other public institutions at the central, regional, and local levels							
1.1.1. Internal financing:							
Funds from the Treasury							
Ministry's own funds							
1.1.2. External financing							
1.2. Social security							
Member contributions							
Sale of goods and services							
Capital income							
2. PRIVATE SUBSECTOR							
2.1. Private insurance							
2.2. Nonprofit NGOs							
2.3. Household financing for private services							
TOTAL							

Source:

- Are there any forms of public financing of the private health insurance (for example, through public financing of a guaranteed basic package of benefits provided by private entities, or through tax breaks for individuals when they purchase health insurance policies)? If so, describe them in a paragraph. Note: If they are being designed or introduced within the framework of health sector reform, please to refer in the corresponding subsection of Chapter 3.

- Please comment on the percentage of health financing from international cooperation agencies. What percentage of this external financing is received as donations (or non-reimbursable loans), and how much of it is in the form of loans? Please rank the principal sources of the external financing according to the amounts provided.

- Is there reliable and timely information available on health expenditure[v]? Who prepares it? How is it prepared?

- Please complete the following table and comment on the data and anticipated trends:

[v] The information requested on health expenditure refers to expenditure actually executed, not to budgetary allocations.

	1993	1994	1995	1996	1997	1998	1999
Per capita public expenditure on health (in US$)							
Public expenditure on health /total public expenditure							
Total per capita health expenditure (in US$)							
Total expenditure on health as a % of GDP (BI97,49)							
External health debt /Total external debt							

Source (s):

- What was the national per capita expenditure on health in the last available year (BI99, 50), and how has the trend evolved since the early 1990s?

- Please complete the following table and comment on the data and the anticipated trends:

Health sector expenditure by subsectors and functions, 1993-1999 (in US$ and as a % of GDP)

	1993	1994	1995	1996	1997	1998	1999
1. PUBLIC SUBSECTOR							
Health promotion and preventive care							
Curative care							
Human resources development							
Production/purchase of supplies							
Administration							
Physical plant							
2. PRIVATE SUBSECTOR							
Health promotion and preventive care							
Curative care							
Human resources development							
Regulatory functions							
Production/purchase of supplies							
Administration							
Physical plant							
TOTAL							

Source:

- Please complete the following table and comment on the data and the anticipated trends:

Health sector expenditures by item, 1993-1999 (in US$ and as a % of the total)

	1993	1994	1995	1996	1997	1998	1999
1. PUBLIC SUBSECTOR							
Services to individuals							
Population-based services							
Medicines and pharmaceuticals							
Materials and supplies							
Medical and health equipment							
Other equipment and repairs							
Construction projects							
2. PRIVATE SUBSECTOR							
Services to individuals							
Population-based services							
Medicines and pharmaceuticals							
Materials and supplies							
Medical and health equipment							
Other equipment and repairs							
Construction projects							
TOTAL							

- What was the distribution of public expenditure on health by levels of care (primary, secondary, tertiary) in the last available year? If possible, comment on the trend since 1990 up until the last available year and on its anticipated evolution.

3.2.3.3. Health Insurance

This section will deal with health insurance only—that is, coverage against health risks and the treatment of health impairments, and not the provision of public or private services to the insured party, regardless of the insurance model.

- What institutions and/or organizations are providing insurance? Describe in a paragraph how they function.

- Do the health authorities have reliable and timely information on the degree of coverage and the ways in which health insurance is being provided in the different models, including private insurance?

- What percentage of the population is covered by the different insurance models (ministry of health, other government institutions, social security, private insurers)? Is data available on coverage by age and sex?

- What percentage of the population is without effective coverage under some form of insurance? What is the trend, and how is it expected to evolve? Is it the responsibility of the ministry of health to provide for this population? If so, how has it been doing in this respect?

Note: If there are government programs to increase coverage within the framework of health sector reform, please describe them in the corresponding section of Chapter 3.

- If this is the case, what have traditionally been the main differences between the benefits offered by the ministry of health and those provided by social security (or the welfare system) for the beneficiary population? Take a few lines to cite three or four examples.
- Does the social security system have uniform health benefits for all its subscribers? If not, what are the main differences between the social security programs? Take a few lines to cite three or four examples.
- Is there a basic set or plan of health benefits to which all citizens are entitled? If so, what does it consist of? Note: If it is being designed or introduced within the framework of health sector reform, please indicate refer to it in the corresponding section of Chapter 3.

3.2.3.4. Service Delivery

The purpose of this section is to synthesize and analyze the relevant information on:

a) Population-based services (i.e., those, such as actions to promote healthy lifestyles and protection against risks, which are mainly the responsibility of the health sector) and;

b) The delivery of health care to individuals.

The section refers to both types of services, regardless of whether they are provided through the public or the private subsector. The section is divided into two subsections, one on public health services, and the other on services to individuals.

- *Population-based Health Services*
- Do the health services carry out programs and/or activities aimed at health promotion and/or protection against risks? If so, who is responsible for them? What are they? What is the extent of their coverage? Have the results been evaluated?
- What specific prevention programs have been prioritized in recent years (for example, sexually transmitted diseases, hypertension, diabetes, others)? Who carries them out? What is the extent of their coverage? What results have been achieved to date? What problems have been encountered?
- What programs have been developed for the early detection of pathology (for example, cervical, breast, and other cancers)? What is the extent of their coverage? What results have been achieved so far? What difficulties have had to be faced?
- What has been the trend in coverage by the Expanded Program on Immunization for children under 1 year of age (BI99, 54, 55,56, and 57) over the past five years?
- What has been the trend in coverage of prenatal care (BI99, 52) and delivery attended by trained personnel (BI99, 53) over the past five years?

Health Services to Individuals

For both levels of care:

- Is the information provided by the information systems for the management of establishments and services usually considered timely and reliable? To what extent is it used for decision-making in the management of the services?
- In the public sector, since the beginning of the decade, has there been an increase in the possibilities for users in the urban environment to choose between different providers of a single type of service (for example, primary care physician or hospital) in the urban environment? In rural areas?

For primary care:

- What is the percentage of coverage by the different networks of public and private health service providers?
- What percentage of primary care centers have computerized information systems, at least for administrative and personnel management?
- Complete the following information for the last available year, and, if applicable, comment in a paragraph on the evolution of the production *of different provider network*s:

PRODUCTION OF SERVICES. YEAR:

	Number	**Rate per 1,000 population**
Consultations and controls performed by medical professionals		
Consultations and controls performed by nonmedical professionals		
Consultations and controls performed by dentists		
Emergency consultations		
Laboratory examinations		
X-rays		

- What are the five most frequent reasons for consultation?
- Are there arrangements available for home care by trained personnel? Comment in one or two lines.

For secondary care:

- What percentage of coverage is provided by the various networks of public and private health care providers?

- What percentage of hospitals has computerized information systems for administrative management? For clinical management (for example, registration of hospital admissions and discharges, clinical statistics, management of clinical services, etc.)?
- To what extent is the information used for clinical management (for example, for increasing the utilization of rooms and surgical suites, adapting service delivery to the pathologies most frequently admitted, reducing unnecessary procedures, or reducing the delays in attending to patients)?
- Complete the following information for the last available year and comment, if applicable, on how the production trend has evolved in the various networks of public and private providers. Allow one paragraph.

SERVICE PRODUCTION, YEAR:

INDICATOR	
Total no. of discharges	
Occupancy index	
Average days of stay	

- What are the five most frequent reasons for hospitalization cited at discharge for the principal networks of providers?
- Is there a significant problem with waiting lists or delays in attending to patients? If so, in which institutions? If so, what policies are being developed to deal with these situations? Please comment in a few lines.

Quality:

For the questions that follow, whenever possible, document the differences by subsector (public, private), principal network of providers, or some other characteristic of the establishments (for example, level of complexity, geographical location, type of population served, etc.).

Technical Quality:

- What percentage of establishments have a fully operational Quality program?
- What percentage of establishments have fully functioning ethics and/or professional oversight committees?
- What percentage of deliveries are done by cesarean section?
- What is the rate of hospital infections? What percentage of hospital establishments have a fully functioning committee on hospital infections?
- What percentage of patients is given a discharge report or care instructions at the time of discharge?

- What percentage of total hospital deaths are autopsied?
- What percentage of infant deaths are investigated? What percentage of maternal deaths?

Perceived Quality:

- What percentage of establishments have a fully operational program for improving user relations (for example, "Friendly" Hospitals)?
- What percentage of establishments have specific orientation procedures for users (for example, patient orientation services, posters informing patients of their rights and responsibilities)? Are cultural, ethnic, etc., factors taken into account?
- What percentage of establishments that carry out user satisfaction studies or surveys?
- What percentage of establishments have a fully functioning arbitration commission (or entities for handling complaints or problems)?

3.3 MONITORING AND EVALUATION OF HEALTH SECTOR REFORMS

3.3.1. Conceptual Framework

By mid-1999, most of the countries were at some point between the design and the early phases of implementation of health sector reform. In quite a number of countries, implementation is already well advanced. In one of the countries it is possible to identify two or three periods of sectoral reform in the last decade, whereas in another one it is still not possible to see any signs of an intention to introduce sectoral reform.. In a few of them there are already explicit mechanisms in place for evaluating either the process or the results of sectoral reform.

Following the methodology used for preparing the document "Base Line for Monitoring and Evaluation of the Processes of Health Sector Reform," this chapter has been divided into two sections: the first devoted to the process, and the second to the results of sectoral reform. The breakdown of the former into sections and the latter into categories and variables is substantially the same as what was used on that occasion. However, as a result of the International Advisory Meeting on "Methodology for Monitoring and Evaluation of the Processes of Health Sector Reform in Latin America and the Caribbean,"[vi] many of the indicators used then have been eliminated, replaced, or modified, and some new indicators have been added.

Even in those countries where reform initiatives are not yet envisioned, it may be useful to analyze the topics included under the heading "Monitoring the Dynamics," even if only to rule out many of them. It may also be useful to analyze most of those included under the headings "Monitoring the Content" and "Evaluation of Results." In such cases, "monitoring"" will refer to the content of the ordinary activities of the health system, and "evaluation of results" will not refer to actions under sectoral reform but rather to the regular work of the health authorities and other relevant protagonists.

[vi] The meeting was financed in part with funds from the US AID project "Equitable Access to Basic Health Services."

With even greater reason, the foregoing will also apply to those countries in which there have been significant changes but they were not undertaken in the name of "reform."

It is being done this way because the selection and approach to the topics in the present chapter are by no means arbitrary. They reflect the experience gained over several years, inter alia, through the following:

a) The country reports for the "Special Meeting on Health Sector Reform" (Washington, DC, September 1995);

b) The commitments assumed by the governments of the Region at various international conferences on the subject—for example, Vienna, Cairo, Copenhagen, and Beijing.

c) The progress report on sectoral reform activities presented to the Regional Committee of [WHO?] (September 1996).

d) The country chapters for the 1998 edition of *Health Conditions in the Americas*;

e) The reports prepared by the countries for the III Review of the Strategy of Health for All (1997);

f) The discussions in, and the document approved by, the Regional Committee of WHO[?], "Steering Role of the Ministries of Health in the Health Sector Reform Processes" (September 1997);

g) The seventeen reports of the countries prepared in fulfillment of the exercise "Base Line for the Monitoring and Evaluation of the Processes of Health Sector Reform" (October 1997–May 1998);

h) The discussions on sectoral reform at the meetings of the Ministers of Health of Central America, the Andean Area, and the countries of the English-speaking Caribbean; and

i) Cooperation with national commissions and support groups for reform in several countries of the Region.

It should be emphasized that this chapter is neither normative nor prescriptive. A format of sequential logic has been adopted for the section "Monitoring the Dynamics" in order to call attention to its analytical nature and the importance of some of the critical points (for example, negotiation and evaluation). Admittedly, in some cases the phases may overlap, and the results of some of them can affect the dynamics and content of the next. Finally, it should be kept in mind that if some topic that has not been included is relevant in a particular country, it can certainly be analyzed.

It is important to stress the need for consistency between the information collected and analyzed in Chapters 1 and 2 and what is included here—AND, wherever possible, between the data handled in monitoring the processes and that used for evaluating the results.

3.3.2. Monitoring the Process

The purpose of this section is to describe and analyze:

a) The dynamics of the Health Sector Reform process—that is, the different moments (design, negotiation, implementation, evaluation), as well as the characteristics, proposals, and

relationships of the main protagonists involved (social or institutional; public and private; national, subnational, or international);

b) The content of the process—that is, the strategies devised and the actions effectively undertaken.

3.3.2.1 Monitoring the Dynamics

Reforms are processes that go through different stages, or "moments," over time and involve many different protagonists. The moments may be identified, progressively, as: genesis ("remote origin"), design ("immediate origin"), negotiation, implementation, and evaluation of results. The protagonists may be divided into those whose actions take place mainly in society at large (for example, chambers of commerce, workers' unions, insurance companies, social movements, self-help groups, communications media, private universities etc., and those whose actions take place mainly in the public sector (for example, the various government agencies and institutions, the legislative branch and the judiciary, social security institutions, public universities, etc.). From this perspective, the following questions should be asked:

- What was the origin of the reform process? If possible, indicate when it began, the reasons for it, and the principal protagonists.
- Was the opinion and/or demands of the population taken into account at the time the reform was proposed? If so, how was this done?
- Does the country have an explicit agenda for sectoral reform? If so, What are its objectives?
- Is sectoral reform incorporated in the plans and programs for development and/or modernization of the State?
- Who was, or is, responsible for the design? How did they go, or are they going, about it? What was the role of the health authorities, and the ministry of health in particular, at that point?
- Did, or do, the health authorities assume leadership in negotiating the objectives and/or content of sectoral reform?
- What entities, associations, groups, etc., have participated in the negotiation process? At what point did each of them participate? What proposals did they advance?
- Is there a plan of action with goals, dates, and responsibilities for the implementation of sectoral reform?
- From whom, and how, was financing arranged for the studies, field testing, and implementation of sectoral reform?
- What is the current status of the reform? If it is under way, is it on schedule? If not, what changes have taken place, and why?
- Are steps being taken to explain the reform to the population and involve it in the implementation process? To explain it to, and involve, the health professionals?

- If the foregoing has been done, have some of the objectives and strategies changed? If so, when? Why?
- Were evaluation criteria for the reform process defined from the outset? If so, what are they? If not, why not?
- Has any evaluation been done of the development and/or impact of the reform process? If so, when? By whom? What were the results?

3.3.2.2 Monitoring the Content

Legal Framework

- Have changes been introduced, or is it intended to introduce them, in the Constitution and/or the basic health regulations (for example, the health laws, the sanitary codes, and their regulations)? If so, how was this done, or how is it planned to be done make (for example, through a constitutional amendment supported by lower-level normative changes, or through gradual changes in the laws that will ultimately make it imperative to change the Constitution)?
- Have the possible changes been proposed as a means of attaining the objectives of the health sector reform? If so, cite them.
- If the foregoing is true, list the principal legal instruments that are related to health sector reform (including adherence to international agreements).
- Is equity defined in the health legislation? If so, how?
- Do the changes in the laws reflect an intersectoral approach, in which the right to health is related to other rights (for example, the right to an education, to decent housing, to a healthy environment)?

Right to Health Care and Health Insurance

- How is the right to health care guaranteed?
- Is this right explicit? Have the necessary mechanisms been launched for disseminating it and making this knowledge accessible to the population?
- Have specific programs been introduced, or are they being designed, to increase coverage? If so, by whom? To what population groups are they targeted (for example, categorized by age, sex, ethnic group, social or economic status, or specific pathology)? What do they consist of?
- Have steps been taken, or are they being taken, to design a guaranteed plan or a basic set of benefits? If so, for whom? What does it include? Who decides on the benefits to be included, and how?

Steering role and the Separation of Functions

- Are steps being taken to review steering role in the health area and the functions of the institution(s) responsible for performing it? If so, how are the functions of steering role, financing, providing insurance, and delivering services being (re)organized?

- Have changes been made in the health authority structure(s) with a view to adapting it/them to a steering role role? If so, what are they? Give examples of the structural changes that have been made to improve institutional capacity.

- Have new public institutions been created, or are they being created, to be responsible for policy formulation, financing (for example, national health funds), insurance (for example, superintendencies), and/or delivery of public health care services to individuals? If so, name them, describe how they function, and explain how they are related to the ministry of health.

- Have steps been taken to ensure that the information systems are periodically delivering relevant reports for use in setting priorities, making decisions, and allocating resources at the different decision-making levels?

- What mechanisms are in place to ensure that the public institution(s) responsible for the foregoing functions are accountable?

Modalities of Decentralization[18]

- Are steps being taken to review and/or modify the various administrative levels in the health system, the functions of each of them, and the relationships between them? If so, are these proposals and/or changes related to the more general proposals for the decentralization of public administration and/or other social sectors?

- Are responsibilities, authority, and resources (equipment, human resources, etc.) being transferred to the subnational levels? If so, how is this transfer being accomplished?

- To what extent is deconcentration taking place within each major public health institution?

Social Participation and Control

- Has social participation been recognized as an objective of sectoral reform?

- What entities and mechanisms have been introduced, or are being introduced, to facilitate social participation and control in the health system?

- At what level—national, subnational and/or local—have these entities and mechanisms been introduced, or are they being introduced, and what functions do they have (for example, to mobilize resources, find out the needs of the population, support planning or management, assume responsibility for the delivery of certain services)?

- Have groups traditionally excluded from decision-making (for example, women and certain ethnic groups) been taken into account in their development?

- Are these entities and mechanisms being given some degree of legal formalization? If so, do these entities and mechanisms have enough resources and capacity to carry out the responsibilities they have been given?

Financing and Expenditure

- Are the information systems on financing and expenditure being strengthened to make them reliable and to enable comparisons between territorial units and/or establishments? If so, how?
- According to the analysis in 3.3.3.2, have any measures been taken to substantially modify the following:

  - The sources of financing, financing agencies, cash flows, criteria and mechanisms for the allocation of sectoral financing;

  - The distribution of public expenditure on health by spending agencies;

  - The distribution of public expenditure on health by levels of care;

  - The distribution of public expenditure on health by components (for example, human resources, procurement of goods and services, purchase of drugs and other supplies, investments and others);

  - The foreseeable trend in total expenditure and public expenditure on health?

  If so, give several lines of explanation.

- *Service Delivery*
- Has it been decided to modify the delivery of public health services? If so, in which public and/or private institutions and in which territorial units?
- Has it been decided to modify the services offered at the primary level? If so, in which public and/or private institutions and in which territorial units?
- Has it been decided to modify the services offered at the secondary level? If so, in which public and/or private institutions and in which territorial units?
- Are programs and actions being developed to identify and/or offer care to vulnerable groups, defined by such criteria as income, specific risk, age, sex, ethnic group, or marginalized status? If so, what are they?

Have priorities been established with regard to the different stages of the life cycle—i.e., childhood, adolescence, adulthood, and old age?

- Are the models of care being redefined? If so, in what sense, and what are their main characteristics? Has the demand been characterized as part of this process?
- Are new approaches to health care being introduced, such as day surgery, outpatient surgery, home care, etc.?

- Are the systems for patient referral and back-referral between the levels of care being strengthened? If so, how? In specific cases, are there links with certain agencies outside the health sector (for example, domestic violence)?

Management Model

- Are changes being introduced in the management model and in the relationships between the protagonists? If so, what type of changes? How is this being approached?
- Are changes being introduced in the management model and in the relationships between the protagonists, either outside or within the public health facilities? If so, what changes? How?
- In the private health facilities?
- Are steps being taken to introduce management contracts or commitments between the different levels of the public health system? If so, what steps? How?
- Are public establishments clearing up the legal obstacles and developing the institutional capacity to purchase and sell services to third parties? If so, how?
- Are public health facilities being organized according business standards, principles of self-management, or other criteria?
- Have any steps been taken, or is there any intention, to turn over the management public health establishments or services to the private sector?

Human Resources

- Have any modifications in human resources education been designed or introduced in order to respond to the needs created by sectoral reform? If so, please comment in a few lines.
- Have significant changes in labor law been introduced (statures, regulations, classification of health professionals, frameworks for negotiation, conflict resolution, and agreement)? Or changes in the professional regulations governing health workers (professional affiliation and unions)?
- Have any modifications been proposed or introduced in the multidisciplinary orientation of professional practice (for example, family medicine, general nursing, primary care technicians, etc.)?
- Are mechanisms being created or reformulated for the certification of health workers? Are the modifications consistent with the objectives of sectoral reform?
- How have health workers or their representatives participated in the sectoral reform process in terms of the subject of human resources?
- Have changes in the planning and management of human resources been designed or introduced in the public sector (for example, in recruitment, assignment to jobs, number of workers, mechanisms for functional and/or geographic distribution,, etc.)?
- Have any incentives been proposed to encourage the improved performance of health personnel in the public health establishments? If so, what are they? For what categories of personnel? Have they been introduced in the private subsector?

- What approaches are being introduced for the training of health workers? Indicate the volume of resources consumed in the last year by each of the main public service providers?

Quality and Health Technology Assessment

- Are procedures and/or the institutions for the accreditation of health establishments and programs being created or reformulated? Are they the modifications consistent with the objectives of sectoral reform?
- Does the sectoral reform include initiatives in the areas of technical quality and perceived quality for the different levels of care? If so, what are they? Please comment in a few lines.
- Does the sectoral reform include initiatives to develop mechanisms for evaluating health technology before it is introduced and/or while it is being used?[19] If so, what are they?

3.3.3. Evaluation of Results

The purpose of this section is to attempt to determine the degree to which sectoral reform is contributing to improvement in the levels of equity, effectiveness and quality, efficiency, sustainability, and social participation and control in the health systems and services.

These are all major categories that make it possible to assess the direction of a sectoral reform, either planned or already under way, from the standpoint of its stated ultimate objectives. Thus, no sectoral reform should be opposed to these criteria. An "ideal reform" would be one in which all five categories had improved by the end of the process. At the same time, these criteria constitute the conceptual frame of reference for a series of variables and indicators that attempt to measure the impact of the reform.

The authors of the present document are aware that it is impossible to establishing direct and univocal causal relationships between the sectoral reform actions and the changes taking place in many of the proposed indicators. This is seen particularly in the subsection on efficiency, but also in others as well. In many cases the effects of sectoral reform will only appear in the medium and long term and they will be mediated by factors not directly attributable to it. This is clear when it comes to the effect of sectoral reform on a number of indicators of health the situation. However, it would seem as if something better could be devised for the purpose of sectoral reform in such areas as equity, quality, resource management, sustainability, and community participation. Still, even in these cases, evaluation of the effects of sectoral reform, at least in the countries, will affected by the various viewpoints of the protagonists involved. There is no doubt that an adequate assessment of the impact of sectoral reform must be global; it must combine both quantitative and qualitative indicators, as well as tracking[?] and systematic ones; and it must take different viewpoints into account.

3.3.3.1 Equity[20]

Is there any evidence that sectoral reform has an impact on closing the gap (in a given geographical unit) for any or all of the following indicators? If possible, show the data in terms of sex, age, race, socioeconomic level, and form of coverage.

Coverage

- For the percentages of population effectively covered by a basic package of benefits.
- For coverage of infants under 1 year of age through the Expanded Program on Immunization (BI99, 54, 55, 56, 57)
- For coverage with prenatal health care by trained personnel (BI99, 52)
- For the percentage of women who use contraceptives (BI99, 58). If possible, break this figure down at least into surgical and nonsurgical methods.

Resource Distribution

- For some or all of the following indicators:
  - Total expenditure per capita on health (BI99, 50)
  - Public expenditure per capita on health
  - Physicians per 10,000 population. (BI99, 46)
  - Nurses per 10,000 population. (BI99, 47)
  - Hospital beds per 1,000 population. (BI97, 47)
  - (If possible, for the last three indicators, differentiate between the public and private subsectors.)

Access

- For the percentage of deaths in which there was no medical care.
- For the percentage of rural population located more than 1 hour away from a health care site, and urban population more than 30 minutes from a site.
- For the possibility of obtaining assistance the same day it is requested in the primary health service.
- For the percentage of health facilities that have reduced functional barriers to access (for example, schedule, language, etc.)
- For the number of people on the waiting list for surgery (or the average length of time they have to wait) for three selected procedures.

Resource Utilization

For the following indicators:

- Outpatient consultations per 1,000 population

- Hospital discharges per 1,000 population

- Percentage of deliveries attended by trained personnel (BI99, 53)

Note: If none of the headings above fits with the country's definition of equity or the changes that the country has decided to introduce, please indicate this and outline the changes that have taken place in the objectives established.

3.3.3.2 Effectiveness and Quality

- Is there any evidence that sectoral reform has had an impact on impact on closing the gap (in a given geographical unit) for any or all of the following indicators (and, if the information is available, by population targeted by the sectoral reform)?:

  - Infant mortality (BI99, 20)

  - Maternal mortality (BI99, 19)

  - Percentage of low birthweight (<2500 g) (BI99, 45)

  - Mortality from cervical cancer

  - Incidence of: HIV/AIDS (BI99, 43); Vaccine-preventable diseases

  - Mortality due to acute complications of: Diabetes mellitus II (< 25 years); Essential hypertension (< 25 years)

- Is there any evidence that sectoral reform has had an impact on some or all of the following indicators, globally or for certain service delivery networks, by geographical unit, and, if possible, by the population groups that the sectoral reform is designed to benefit (for example, groups categorized by age, sex, ethnic background, social or economic condition, or specific pathology):

Technical Quality

- Percentage of establishments at the primary level that have a fully functioning quality assurance committee;

- Percentage of hospitals that have a fully operational preventive maintenance program for their equipment;

- Percentage of hospitals that have a fully functioning quality assurance committee;

- Availability of essential drugs at the different levels of care;

- Incidence of hospital infections;

- Percentage of patients that are given a discharge report or care instructions at the time of discharge;

Perceived Quality

- Possibility for users to select their primary care provider, regardless of their ability to pay;

- Percentage of establishments that have a fully operational program for improving user relations (for example, "Friendly" Hospitals);

- Percentage of establishments that have specific orientation procedures for users;

- Percentage of health centers and hospitals that carry out user opinion surveys.

- Percentage of establishments that have a fully functioning arbitration commission (or equivalent);

- Degree of user satisfaction with the health services?.

3.3.3.3. Efficiency

Resource Allocation

- Are more efficient mechanisms being introduced for the allocation of resources? If so, what are they, and what are the results?

- Is there any evidence that sectoral reform has had an impact on some or all of the following indicators, globally, by geographical unit (and possible, by the population groups that the sectoral reform is designed to benefit—for example, groups categorized by age, sex, ethnic background, social or economic condition, or specific pathology):

  - Rural and urban drinking water supply (BI99, 13)

  - Rural and urban sewerage and excreta disposal services (BI99, 14);

  - Percentage of the health budget spent on public health services.

  - Expenditure on primary care as a percentage of total health expenditure?

- Is there any evidence that sectoral reform has had an impact on the reallocation of economic and human resources for the development of:

- Intersectoral action (for example, self-care, accident prevention, assistance for domestic violence, reproductive and sexual health programs, etc.);

- Programs for the prevention of highly prevalent pathologies (for example, hypertension, diabetes, cervical cancer, etc.)?

If so, list them and comment in a few lines.

Resource Management

- Is there any evidence that sectoral reform has contributed to an increase in:

- Percentage of health centers and hospitals that have standardized, operational systems for measuring activity and performance;

- Number of hospitals that have improved at least the following performance indicators (if possible, break down by public and private subsectors):

  . Occupancy index;

  . Average of days of stay;

. Number of discharges per bed;

. Percentage of cesarean sections relative to total deliveries;

. Degree of utilization of operating rooms;

. Cost per day of hospitalization;

. Cost per outpatient consultation;

- Percentage of health centers and hospitals that have negotiated management commitments.

- Percentage of public health facilities that are in a position to expand their expenditure framework of expenditure using new sources of income;

- Percentage of health centers and hospitals with budgets based on activity criteria?

3.3.3.4. Sustainability

- Is there any evidence that sectoral reform has increased:

  - The legitimacy and/or acceptability of the principal institutional health service providers;

  - The availability of information broken down in terms of public and private expenditure on health, by geographical unit, and the possibility of constructing trends (comment in a few lines);

  - The medium-term sustainability of efforts to increase coverage, both of the programs (for example, EPI, prenatal checkups, etc.) and the services (for example, delivery care by trained personnel, medical consultation on demand, promotion of quality, etc.);

  - The capacity to balance the income and health expenditures of the principal public institutions, including social security (please comment in a few lines);

  - Percentage of health centers and hospitals that have the capacity to collect from third-party payers;

  - The capacity to negotiate external loans and, if applicable, to swap them for national resources once they have reached maturity?

3.3.3.5. Social Participation and Control

- Is there any evidence that sectoral reform has contributed to an increase in the degree of social participation and control at the different levels and functions of the health services system? If so, is this in general and/or just in certain groups? Please comment in a paragraph.

3.4. BIBLIOGRAPHY AND NOTES

Add the entire list of references consulted in preparing the Profile, referenced as endnotes and cited in the standard style of PAHO.[21]

4. GLOSSARY[22,23,24,25]

As mentioned in section 2.4.3, unless indicated otherwise, the terms appearing in the section Analysis Variables and Indicators (for example, "poverty," "rural population," "drug," "hospital bed") should be used in the sense of the definitions commonly adopted in the respective countries. If it is known that in a given country a particular term has a meaning that differs significantly from the definition commonly accepted in the literature or by health workers in most of the countries, this will be stated in the Bibliography and Notes section of the Profile. In addition, definitions are provided below form some of the key terms for which a full understanding may be useful in preparing the Profile.

Access (accessibility): For purposes of the present document, "access" is understood to be the greater or lesser ease which users can reach the point of delivery of the health services. Access may be affected by the presence or absence of barriers, be they physical (for example, distance, inconvenient means of getting there, architectural barriers), economic (for example, cost of getting there, lost earnings while consulting the health service, fees charged for services), or cultural (for example, language, religious beliefs, myths or taboos, customs).

Member: A moral or physical person that subscribes to any public or private, voluntary or compulsory health insurance scheme, sometimes also called a "beneficiary." In some insurance system a distinction is made between "members," who enjoy the primary right to coverage, and "beneficiaries," a term that often refers to the immediate family of the member, who are covered as long as the member maintains his status as such. Beneficiaries are not always entitled to the same benefits as the member.

Health insurance: For purposes of the present document, "health insurance" refers to the generic function of covering individuals and/or populations against certain risks and/or damages to their health in exchange for a given economic consideration. The different types of insurance may be classified, in terms of the ownership of the insurance entities, as in public or private. Insurance is public when the agency that underwrites the coverage of benefits is in the public subsector (for example, the ministries of health, other State administrative agencies, or social security institutions). It will be understood that the insurance scheme is private when the entity that underwrites the benefits is governed by private law (for example, private insurance companies, prepaid medical companies, mutuals, etc.). In some countries, because of nature of their particular legal system, entities of the social security or welfare systems that offer health benefits may be classified in an intermediate group called the "social sector."

Quality: For purposes of the present document, "quality" is understood to mean that the users of the services receive timely, effective, and safe care ("technical quality") under adequate material and ethical conditions ("perceived quality"). Quality is a basic category of health systems. It is the end result of many factors, and it can be promoted using various strategies.

Coverage: "Coverage" has sometimes been defined as the possibility of "having access to effective care when it is needed," and "universal coverage," as the sum of access plus financial protection against the potentially impoverishing out-of-pocket costs of said access.[26] For purposes of the present document, the "coverage" (or "nominal coverage") provided by a public health insurance scheme is expressed as the percentage of people with the right to receive the care offered by said system relative to

the total population. "Effective coverage" is expressed as the percentage of people who, having the right to receive the care offered, will normally receive it if they need it. The difference between latter and the former type of coverage measures the percentage of population without normal or regular access to the health services provided by the different public health insurance schemes of a given country or territory. The existence, according to the countries, of sizable differences between the two types of coverage is one of the reasons most frequently cited as a justification for sectoral reform. The same is true at the level of service delivery.

Copayment: The contribution that a patient makes in order to receive a service (for example, a consultation or a drug). It is a form of participation in the cost of the service and one of the possible means of financing its cost. The most common copayments are monetary, but contributions in kind which in certain cases a patient has to make before or during the treatment process (for example, material used for treatment, linen, food) may also be regarded as a copayment.

Decentralization: "Decentralization" is a political and administrative process that involves transferring responsibilities and resources to subnational government units (at the level of the state, department, province, or municipio), which thereby gain their own status as a legal person, their own patrimony, and the capacity to act autonomously within the terms prescribed by law. In democratic regimes, these units are governed by authorities who are elected, not designated by the central government. Decentralization is not the same as "deconcentration," in which there is a (usually partial) transfer of resources and responsibilities to lower levels within the same entity (for example, the ministry of health or social security agency) and guidance continues to be given by the central level, which retains the power to appoint and terminate those responsible for the deconcentrated entities.

Effectiveness: For purposes of the present document, "effectiveness" implies that a given clinical procedure, program, or service achieves the outcome sought or produces the effects desired *in the concrete circumstances* in which it operates and/or is applied. It differs from the "efficacy," which is measured in ideal or laboratory conditions, whereas effectiveness is measured in real conditions.[27]

Efficiency: For purposes of the present document, "efficiency" implies a favorable relationship between the results obtained and the cost of the resources used. Resources are allocated efficiently if they generate the maximum possible gain (in this case, in terms of health) per unit cost. They are also used efficiently when a production units is obtained at minimum cost or when more production units are obtain for a given cost (assuming that the quality remains the same). Therefore, efficiency is a derived rather than a primary category of health activities, programs, and services. There are various ways of expressing efficiency, the most common of which are ratios that measure cost/efficiency, cost/effectiveness, cost/usefulness, and cost/benefit.[28] It has two dimensions: one related to the allocation of resources, and the other referring to the productivity of programs and/or services.

Efficiency in the allocation of resources: This means that resources are allocated to activities, plans, or services in such a way that there is a greater probability of obtaining better results and/or greater impact.[29] It requires that consideration be given to the effectiveness of the various possible alternatives (including the option of no action at all) and, given equal or similar effectiveness, to their respective impact and cost (for example, between allocating resources to finance new plastic surgery procedures for correcting defects that are quite rare, or extending coverage of the Expanded Program on Immunization).

Informal employment: For purposes of the present document, "informal employment" is understood to be employment in which there is no formalized labor contract.

Equity: For purposes of the present document, "equity" implies (a) with regard to the health situation, reducing avoidable and unjust differences to the minimum; and, (b) in terms of the health

services, receiving care based on need ("equity of access" and use)[30] and contributing based on ability to pay ("financial equity").[31]

Health technology assessment: The classical definition is: "the comprehensive investigation of the technical, economic, and social consequences of using health technology in both the short and the long term, as well as its direct and indirect, and desired and undesired effects." Another more modern definition is: "a process of analysis aimed at estimating the value and relative contribution of each form of health technology to the improvement of individual and collective health, taking into account its economic and social impact."[32]

Indicator: For purposes of the present document, "indicator" is a means of quantitatively (through a numerical index) or qualitatively (through informative words or phrases) measuring or qualifying a process or an outcome.

Generic drug: This is the designation of a drug by the name of its most important active ingredient rather than by its commercial name. The generic name is usually the international nonproprietary name` (INN) established by WHO. Another proposed definition: "any type of therapeutically active substance not protected by any type of patent (or product or process), which means that any manufacturer is allowed to make it."[33]

Subnational model (of organization): This refers to the form of political/administrative organization of the state in the territory—for example, by states, provinces, or departments at the intermediate level, and by municipios and communities at the local level.

Social participation and control: For purposes of the present document, "social participation and control" have to do with the initiatives and procedures adopted so that the general population and its relevant agents in the sector have an influence on the planning, management, delivery, and evaluation of the health systems and services, and that they enjoy the result of this influence.

Benefits[34]: The benefits that a public insurance system offers to its beneficiaries depend on numerous factors, including: the history of the entity itself, the financial and human resources available, the population's pattern of morbidity and mortality, the existing infrastructure, the priorities that have been set in the health policy, and the relationships of power between the different groups. Private insurers and most social security institutions make their "health benefit plans" explicit—that is, they spell out the benefits with greater or lesser precision, they review the plans periodically, and they publicize what they offer to their beneficiaries in exchange for the "premium" that they pay. Moreover, they usually try to introduce mechanisms that will guarantee the efficiency and effectiveness of their health plans. The ministries of health, for their part, are making increasing efforts to assist the networks that depend by organizing their "benefit plans" so that they will better identify the population covered, explicitly indicate the services offered, and clearly report the expenditure per person covered.

Steering role: There is a need for a form of leadership that will make it possible to hold a steady course protecting the health of the people in the midst of the processes of sectoral reform. This process of strengthening the steering capacity of the health sector should be guided, in the final analysis, by the intention to reduce the inequities in health conditions within the framework of comprehensive and sustainable human development. This means that health authorities must assume an active role in sectoral management and regulation, in development of the basic and essential functions of financing and insurance that are proper to public health, and in the delivery of health services.[35].

Sectoral reform: "Sectoral reform" has been defined as "a process aimed at introducing substantive changes in different entities and functions of the health sector with a view to increasing the equity of its benefits, the efficiency of its management, and the effectiveness of its actions, and, by so doing, achieve satisfaction of the health needs of the population. It is an intensive phase of health system

transformation, carried out during a given period of time and based on situations that justify it and make it viable."[36]

If this definition is taken in its strict sense, not all the changes introduced in the sector could be called sectoral reform. In fact, the actual situation in this regard is highly diverse across the Region, with significant variations in both the dynamics and content of the changes that most of the countries are introducing. In some cases, the changes are substantive and proposals for sectoral reform, defined as such, are under discussion but have not yet been implemented. In others, changes have been being introduced in such areas as financing, patient management, and the like without altering the fundamental responsibilities of the main public and private actors involved. Also, there are cases in which substantial changes are being made or planned but go under names other than "reform" (for example, "Plan for Modernization of the Sector"). And there are cases in which the scope of functions is changed in one of the key public institutions but not in the others.

Insurance: System for the provision of coverage against risks or uncertain events by distributing the resulting costs of such risks in advance among a certain number of people. Membership is voluntary, and the interested party must meet certain requirements in order to join and pay a sum of money (the "premium") in order to have a right to the benefits being offered.

Social security: Compulsory contributory and noncontributory national regimes, which are normally based on the principles of universality and general coverage against the risks of disease, accidents, old age, unemployment, and others. There is not always an adequate practical translation of these principles. For example, it is the exception more than the rule in Latin America and the Caribbean that a country's social security protection scheme will cover the entire population or offer the insured population general coverage against all risks.

Sustainability: For purposes of the present document, "sustainability" implies both a social and a financial dimension, and it is defined as the capacity of a system to deal with its current problems of legitimacy and financing as well as the challenges of future maintenance and development. Consequently, it entails social acceptance and support, as well as availability of the necessary resources. Another similar but briefer definition: "The capacity of a health system to function effectively over time with a minimum of external assistance."[37]

Analysis variables: "Analysis variables are the categories into which the present Guidelines have been organized in order to facilitate the description and analysis of phenomena being monitored and evaluated. In some cases, they correspond to the sections and subsections into which the chapter Variables and Indicators has been divided (for example, "political context," health system "human resources" or the "dynamics" of the sectoral reform process). In other cases, the variables break down into more finely-tuned categories (for example, under the heading "Monitoring the Content" of sectoral reform there are at least nine different analyses variables. Their methodological value resides in the fact that they serve as subject areas within which one or more indicators are presented, and they facilitate the coordinated analysis of the variations in these indicators.

ANNEX 1

LIST OF PARTICIPANTS, INTERNATIONAL MEETING ON METHODOLOGIES FOR THE MONITORING AND EVALUATION OF HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARBIBEAN
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