PROFILE OF THE HEALTH SERVICES SYSTEM
OF THE BOLIVARIAN REPUBLIC OF VENEZUELA

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PROGRAM OF ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES
DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT
PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE SUMMARY

The Bolivarian Republic of Venezuela has a landmass of 916,445 km2. It encompasses 23 States and a Federal District, the seat of the city of Caracas, and the federal territories. The Government is divided among the Municipal, State, and National authorities. The National Government is divided into the Legislative, Executive, Judicial, Citizen, and Electoral branches. The entity in charge of planning and coordinating policies and interventions is the Federal Council of Government, which by law is presided by the executive vice president and includes the ministers, governors, one mayor for each State, and representatives of organized society. The per capita GDP for 1999 was estimated at US$ 4,995.77. The ratio between the income of the top 20% and the lowest 20% was estimated at 11.6 : 1 for the period between 1994 and 1996.

In the period 1996-2000 the percentage of the population under the poverty line, according to the index of Unmet Basic Needs (NBI), rose from 48.9 in 1996 to 49.1 in 2000. During that time frame the percentage of the population in extreme poverty according to the NBI rose from 21.7 in 1996 to 21.8 in 2000. In 1999, 69.4% of households had a family income of less than 350,000 Bolivars. Total public spending, as well as public social spending as a percentage of GDP, has been on a downward trend.

The population for 2000 was estimated at 24,896,379 inhabitants. Due to the large-scale migratory movements of recent years, in the three-year period of 1998-2000 the majority of the population was concentrated in urban areas with the subsequent increase in marginal populations. Of this population, 50.3% are men and 49.7% are women; 45.2% are less than 19 years old, 50% are between 19 and 65 years old, while 4.3% are over 65.

There has been a decline in the crude death rate, to 4.40 for 1999. Deaths from diseases of the circulatory system occupy the first place (30.0%). There has been a decline in mortality from communicable diseases (from 12.2% to 8.5%), accompanied by an increase in mortality from external causes (13.6% to 16.6%). In 1998, 6.22% of the population aged 10 or older were reported as illiterate. The highest illiteracy rates are found in the group of persons older than 45 and among women. The human development condition of Venezuelans deteriorated significantly over the last decade. The Human Development Index (HDI) has declined from 0.8210 in 1990 to 0.6912 in 1996; the projection for 1999 is for an HDI of 0.6504.

The Ministry of Health and Social Development (MSDS) was created in late 1999. It has been promoting a transformation of the health services delivery model. The priority strategies proposed include: restructuring the central level of the ministry, implementing a new model of care, and creating a national public health system. The health sector is made up of a public subsector, with a multiplicity of institutions that operate in unintegrated, centralized, and deconcentrated manner, and by the private subsector. The Ministry of Health and Social Development is the regulatory entity for the sector and is responsible for the formulation, design, evaluation, supervision, and monitoring of the health policies, programs and plans,

sector regulation, integration of financing sources, and the allocation of resources of the National Public Health System.

In 1999 the ratio of physicians and nurses per 10,000 population was 19.7% and 7.9% respectively. In 1998, 50.5% of the registered physicians were specialists and 49.5% were general practitioners. Nevertheless, in some states the percentage of specialists was less than 20%, while in others the specialists were clearly predominant. As of 2000 there were 40,675 beds at the governmental public level (17.68 beds per 10,000 population). For the population of influence of the MSDS this indicator was 21.95; for the beneficiary population of the IVSS it was 8.87.

Health expenditures as a percentage of GDP were 4.06 percent showing a tendency to decline. Such decline is sharper in the area of public spending.

The low utilization rate of hospital establishments is clearly reflected in the total number of discharges and the bed-occupancy rate (53%). As with the outpatient network, the problem-solving ability of the hospitals is precarious; there are long waiting lists for surgery and outpatient care, and there are often shortages/deficiencies in essential supplies for care. Over the last twelve years the country has gone through five major macro-reform efforts. For a variety of reasons the first three reforms were ineffective and limited. The discussion of the reforms of 1999 was differed in the National Assembly, which this year will consider a bill to provide a definite context for the health sector reform in Venezuela. Since 1999 a model to transform the organization of the health services has been pursued. The transformation's first stage hinges on proposals to restructure the central level of the MSDS and implement a new model for comprehensive health service. The development of the new model of care enjoys the political support of the authorities of the central level of the Ministry of Health and Social Development, as well as the support of the Governments of the States and the State Health Bureaus. This has made possible successful implementation in over 55% of the outpatient facilities that make up the network of services.

1. CONTEXT

***1.1. Political Context*:** The Bolivarian Republic of Venezuela has a landmass of 916,445 km2. It encompasses 23 States, a Federal District, the seat of the city of Caracas, and the federal territories. The latter are maritime islands unincorporated to the territory of a State.

The government is divided into Municipal, State, and National entities. The National Government is divided into the Legislative, Executive, Judicial, Citizen, and Electoral branches. The entity in charge of planning and coordinating policies and interventions is the Federal Council of Government, which by law is presided by the executive vice president and made up of the ministers, governors, one mayor per State, and representatives of organized society.[1]

The main function of the Bureau of Management Models, Social Organization, and Local Development, of the General Bureau of Policies and Plans of the Ministry of Health and Social Development, is to design, implement, and coordinate national policies to promote and strengthen the structure and operation of the social networks.

The Constitution addresses widely health issues. Article 83 establishes that health is a fundamental social right, a State duty, which must be guaranteed as an integral part of the right to life. The State must promote and implement policies to improve the quality of life, collective well being, and access to services. In order to guarantee the right to health, Article 84 mandates the creation and exercise of the steering role, and the management of a national public health system which is intersectoral, decentralized, and participatory, integrated into the social security system, and governed by the principle of universality, comprehensiveness, equity, social integration, gratuity, and solidarity. Article 85 declares that financing the national public health system is an obligation of the State, which must integrate fiscal resources, the compulsory premiums for social security, and any other financing source determined by law. Finally, Article 86 establishes that every person has a right to social security as a nonprofit public service that safeguards health and guarantees protection against a variety of contingencies.

Government policy (including health policy) is executed by specific Government agencies and by the Federal Council of Government. The latter entity is in charge of planning and coordinating policies and actions to implement the decentralization process and transfer responsibilities from the National level to the States and the Municipalities. By law, this Council is presided by the executive vice president and includes the minister, the governors, and one mayor for each State, and representatives of organized society.

The living conditions of Venezuelans have been affected by a variety of factors, including deepening poverty and rising informality, with a significant rise in the crime rate, a decline in educational indexes, and worsening performance of health services. Factors that have definitely had an impact on the poor performance of health care delivery include the limited steering role and regulatory capacity of the State, and the disintegration of financing, insurance, and health services delivery. Furthermore, the health system lacks defined institutional arrangements, or adequate and transparent mechanisms for supervision and

accountability between the different sanitary levels (geographical and care). All this, coupled with the existence of divergent mandates for the various financing, insurance, and provider agencies, means that the scarce available resources are not allocated or distributed in the best interest of the citizens.

***1.2. Economic Context*:** As part of the policy of economic stabilization the 1999-2000 Economic Transition Program (PET) was created, which intends to promote the sustained and diversified growth of the economy, reduce inflation, and increase the level of employment.

The increase in per capita GDP was maintained up to 1998. Total public spending, as well as social public spending as a percentage of GDP has displayed a downward trend.[2]

SOME ECONOMIC INDICATORS

INDICATOR	Year						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Per capita GDP in constant US Dollars	2,843.00	2,760.00	3,020.00	3,020.00	3,480.00	5,133.00	4.995,77
Economically active population in thousands.	5,493,500	8,025,928	8,608,653	9,024,627	9,507,125	9,907,127	10,225,014
Total public spending as a percentage of GDP.	28.6	49.9	31.7	29.1	29.3	27.6	25.2
Social public spending as a percentage of GDP.	9.3	10.2	9.7	8.9	8.9	8.4	7.6
Annual inflation rate	38.1	60.8	60.2	94.4	52.2	36.0	21.9

Source: Anuario estadístico de Venezuela, 1998.

In December 1999, several regions of the country were ravaged by torrential downpours, with the loss of many human lives and the destruction of physical and productive infrastructure. ECLAC estimated the material damages at some US$ 3.240 billion (3.3% of GDP). Non-oil activities account for 72% of the Gross Domestic Product (Table 2). Among these, the services sector (trade, restaurants, real estate, and others) accounts for over 60%.[3]

Venezuela's public sector has been modifying the structure of its indebtedness throughout the last three-year period of the 1990s. Indebtedness has displayed a downward trend, dropping from slightly more than 20% of the total 1995 budget for central government sector expenditures, to 9.4% in the 2001 budget. Nevertheless, internal indebtedness now represents 10.7% of the budget, while in 1995 it was around 4.6%.

***1.3. Demographic and Epidemiological Context*:** The population in 2000 was estimated at 24,896,379 inhabitants with a demographic density of 26.37 inhabitants by km2. In 2000, 87.2% of the inhabitants lived in urban areas and 12.8% in rural areas. Of this population, 50.3% are men and 49.7% are women. In terms of age, 45.2% are younger than age 19, while 50% are between 19 and 65, and 4.3% are older than 65. Between 1995 and 1999 the life expectancy at birth remained steady at 72 years. The States with the highest population density are on the coast (Carabobo, Nueva Esparta, Miranda, and Aragua) and had population densities ranging between 211.2 and 453.0 inhabitants per km2. The border States (Apure, Bolivar, Delta Amacuro, and Amazonas) have the lowest demographic density, ranging from 0.6 to 6.1

inhabitants per km2. Demographic density has increased in both groups of States. Nevertheless, for the Border States, this increase was only 1.1%. Due to internal migratory movements, the population density of marginal urban areas has also increased.[4]

Demographic Indicators, 1994-1998

Indicators	1995	1996	1997	1998	1999
Crude birth rate 1/	26.17	25.66	25.18	24.72	22.3
Crude death rate 1/	4.69	4.68	4.66	4.65	4.40
Infant mortality rate	21.82	21.36	20.90	20.45	19.1
Maternal mortality rate	66.3	60.4	59.6	51.0	59.3
Total fertility rate	2,83	2,63	2,72	2,55	2,60

Source:Anuario estadístico de Venezuela, 1998, OCEI. 1/: Rates per 1,000.

There was a decline in the crude death rate for the period. The rate is not homogeneous, and remains high in the most impoverished states of the country. The structure of mortality by major groups of causes has not varied much during the three-year period. Diseases of the circulatory system remained the number one cause of death (30.0%), while there has been a noticeable decline in mortality from communicable diseases (from 12.2% to 8.5%), and a rise in mortality from external causes (13.6% to 16.6%). Underreporting of mortality ranges between 8% and 10%. An analysis of mortality by years of potential life lost (YPLL) for 1999 reveals that the first place belongs to accidents of all types (15.8%), followed by malignant neoplasms (8.13%), suicides and homicides (6.8%), and heart diseases (5.1%).[5] The leading causes of maternal death are Sepsis, Hemorrhages, and Hypertension during pregnancy. Infant mortality declined from 20.9 to 19.1 (deaths per 1,000 live births) in the three-year period. Infant mortality was 19.1 per 1,000 live births in 1999, and is on a downward trend. This reduction is due to postneonatal mortality, which was 7.3 per 1,000 live births. Neonatal mortality was reported at 11.9 per 1,000 live births, with most complications occurring during the early neonatal period. The leading causes of death in children under one year of age are the Perinatal Disorders (10.1 per 1,000 live births), Birth Defects (2.5); Diarrheal diseases (2.2); Pneumonias (1.1); Malnutrition (0.8); Meningitis (0.3), and Sepsis (0.3 per 1,000 live births).[6]

Cardiovascular diseases, cancer, and external causes were the leading causes of death in 1999 (Table 4). In that year there were a total of 769 deaths diagnosed as "deaths from ill-defined symptoms and causes" (0.74% of total mortality). During 1998 there were 37,586 reported cases of Dengue, 21,863 cases of Malaria, and 313 cases of Cholera. The population affected by these diseases was primarily that of poor and rural areas. Since 1983, when the first case of AIDS was detected, up to 31 December 1999 there have been 8,047 recorded cases and 4,726 deaths. Approximately 60% of the detected incidence has died and underreporting is estimated at 80%. In 1997 cholera behaved in epidemic fashion, with an incidence of 2,551 cases (rate of 11.2 per 100,000 population). In 1998 the incidence of cholera declined to 1.3 while in 1999 it was 1.6. The incidence of pulmonary tuberculosis was 17.4 per 100,000 population in 1990 and

15.5 in 1999. Drug consumption is a public health problem that primarily affects the adolescent population. Within this group, use of Marijuana is 1.8% and Cocaine of 1.3%.

1.4. Social Context: As of 2000 the population was estimated at 24,896,379 inhabitants. During the three-year period 1998-2000, as a consequence of the strong migratory movement of recent years, the majority of the population was concentrated in urban areas characterized by high marginality.

The human development condition of the Venezuelans registered a significant deterioration in the current decade. The Human Development Index (HDI) shows a decline for the period 1990-1998 from 0.8210 in 1990 to 0.6912 in 1996; the projection for 1999 is 0.6504.[7] With regard to the correlation between variations of the indexes and other variables, it can be noted that they are worse for the rural area and for women.

In 1982, 33.5% of the people lived under the poverty line; by 1997 this had increased to 67.3%, of which over half lived in extreme poverty. The ratio between the income of the top 20% and the lowest 20%, was estimated at 11.6 : 1 for the period between 1994 and 1996 inclusive. Household poverty according to family income in 1998 showed that, 44.3% lived under the poverty line, while for 2000 the figure was 44.1%.[8] Unemployment has fluctuated during the period 1996-2000, peaking in 1999: in 1996 (12.4), 1997 (10.6), 1998 (11.0), 1999 (14.5). In 2000 (13.1) there was a slight drop with respect to 1999. Breaking down the unemployment figures for this period by gender shows that, in all years, the figures for women were 2% to 6% higher. The age group with the highest unemployment rate is that of 15 to 24 year olds, reaching 26.8% in 1999. This age group has the largest gap between men and women, in the order of 10%.[9]

Although the unemployment rate fell during 1999-2000, an increase is expected in the first quarter of 2001, and it is estimated that Venezuela's unemployment rate will not decline significantly in coming years. The informal sector of the economy has grown continuously, from 48.9% in 1995 to 53% in 2000.

In 1998, 6.22% of the population age 10 and older were registered as illiterate. The highest illiteracy rates are among people older than 45 years and among females.[10] The schooling rates by educational level remained stable between 1991 and 1998. The low level of schooling for middle and high school should be noted. The average number of schooling years has not been estimated, but much of the population that attends school gets no further than ninth grade. Neither the territorial distribution index of schooling years, nor the distribution by population groups has been estimated.

According to the latest census, in 1992 the indigenous population of Venezuela was 308,762 inhabitants, belonging to more than thirty ethnic groups. The Wayuu ethnic group predominated, representing 54.5% of the indigenous population (168,310 people), along with the Warao ethnic group, representing 23.9% (23,957 people). Of the total of indigenous population, 42% (129,601) live in urban areas and 58% (179,161) in rural areas.

2. HEALTH SERVICES SYSTEM

2.1 General Organization: The health sector comprises a public subsector, made up of multiple institutions that operate in an unintegrated, centralized, and deconcentrated fashion, and by the private subsector. The public subsector is made up of the Ministry of Health and Social Development (MSDS), the Venezuelan Social Security Institute (IVSS), the Institute for Social Welfare of the Ministry of Education (IPASME), the Institute of Social Welfare of the Armed Forces (IPSFA), and the Mayoralty of the Capital City (*Alcaldía Mayor*, previously Government of the Federal District). The network of public health facilities includes several levels of care and is distributed throughout the country.[11] The Ministry of Health and Social Development (MSDS) was created in 1999, as the result of a merger between the Ministry of Health and Social Welfare and the Ministry of the Family. The MSDS is made up of the Office of the Minister and two Vice-Ministries: the Vice-Ministry of Health and the Vice-Ministry of Social Development. There are 23 Regional Bureaus of the MSDS throughout the country. The MSDS functions as a deconcentrated and/or decentralized intergovernmental health system, based on levels of care, with state health Bureaus and health districts. It has a network of hospitals and outpatient clinics, and conducts promotional activities, prevention, and health education. Internal Regulations to determine the definite structure of the MSDS are currently being prepared. The MSDS has been promoting the transformation of the model of organization of the health services; the top priorities that have been proposed are a restructuring of the central level of the ministry, the implementation of a new model of care, and the creation of a national public health system.[12]

The IVSS is a centralized agency with a single authority in the central area, which performs the functions of financing, insurance, and provision. It has a network of hospitals and outpatient clinics. Its financing is derived from three sources: the State, workers, and employers. The sources of financing are public and private.

The IPASME is a centralized agency with a single authority in the central area, which performs functions of financing, insurance, and provision. It has only outpatient clinics, and contracts with other agencies.

The principal public financers are: the MSDS, the IVSS, the states, the Institute of Social Welfare of the Armed Forces (IPSFA), and the IPASME. The principal financing source is the central government via the MSDS, and contributions made both to the IVSS and for the procurement of hospitalization, surgery, and maternity policies for employees, working, pensioners, and retirees. Other public institutions also participate in the financing: the Ministry of Justice finances penitentiary health and the Ministry of Urban Development finances investment in the construction of health centers. The MSDS draws its funds from the national budget. The states are funded out of the national budget and by constitutionally mandated health funding. Because of decentralization, this source of resources is different from the MSDS transfer to the states. The revenues of the IVSS come from contributions paid by employers and workers. This money is distributed in various funds, but the Medical Care Fund (FAM) is the one which finances health

expenditures. Financing of the private health sector in Venezuela has been scarcely studied. The data on health expenditures by families are drawn from the Household Consumption Survey.

2.2 Resources of the System.

Human Resources: The ratio of physicians and nurses per 10,000 population declined until 1998, and then registered an increase between 1998 and 1999, to 19.7 for physicians and 7.9 for nurses.[13]

Human Resources in the Health Sector

Type of resource	Year			
	1996	**1997**	**1998**	**1999**
Ratio of physicians per 10,000 pop.	13.9	12.8	12.2	19.7
Ratio of profess. nurses per 10,000 pop.	6.9	6.5	4.9	7.9
Ratio of dentists per 10,000 pop.	3.7	3.4	0.7	5.3
Ratio of mid-level lab technicians per 10,000 pop.	N.D	0.7	N.D	N.D
Ratio of pharmacists per 10,000 pop.	N.D	N.D	N.D	N.D
Ratio of radiologists per 10,000 pop.	N.D	N.D	N.D	N.D
No. of graduate degrees awarded in Public Health	N.D	N.D	N.D	N.D

Source: Ministry of Health and Social Development.

In 1997, 50.5% of the physicians registered with the Venezuelan Medical Federation were specialists and 49.5% were general practitioners. Of the total of physicians, 46.8% were working part- or full-time in the public subsector (MSDS and IVSS). There is no information on persons who work in other public institutions, but it is estimated that the figure may be as high as 60% of the labor market. Of the dentists, 17.2% worked part- or full-time in the public subsector (MSDS and IVSS).

Human Resources in Public Institutions, 1997 AND 2000

Institution	Type of Resource					
	Physicians	**Nurses**	**Nursing Auxiliaries**	**Other Workers**	**Admin. Staff**	**General Services**
MSDS 1/	11,242	8,023	22,011	10,973 (*)	21,823	26,210
IVSS 2/	6,063	N.D	N.D	30,729 (**)	12,937	N.D
IPASME 3/	994	137	981	1,690 (**)	314	N.D
INAGER 4/	146	95	365	576 (**)	529	884

Sources: Ministerio de Salud y Desarrollo Social, Instituto Venezolano de Seguro Social, Instituto de Previsión y Asistencia Social del Pensionado del Ministerio de Educación, Instituto Nacional de Atención Geriátrica. 1/ Data corresponding to 2000; 2/ data corresponding to 1997; 3/ data corresponding to 2000; 4/ data corresponding to 2000; *: Includes 7,639 dentists, 775 nutritionists, 1,642 bioanalysts, and 917 radiation technicians; **: Includes all support personnel.

The average remuneration for a general practitioner of the MSDS is around US$ 1,000.00. The average remuneration of a specialized physician of the MSDS is US$ 1,200.00. Despite adjustments decreed by the Government, this remuneration has declined progressively over the last decade as the national currency devalued. Nevertheless, by comparison with other professionals of the public sector this is considered

high. Substantial differences (between 10% and 20%) exist between the remuneration of the professionals of the MSDS, the IVSS, and the *Gobernaciones*. No information is available on the average productivity of health workers of the principal public institutions. Also, there is no registry of degree-holding postgraduates, particularly in public health.

Drugs and Other Health Products: The National Executive has formulated a policy to ensure the availability of effective, safe, and high-quality pharmaceutical and related products, as well as their rational use and access by all people, within the framework of a national health policy, and consistent with the principles of the National Public Health System. The Law of Health, the Law of Drugs, and their respective regulations govern all matters concerning national pharmaceutical policy. The "Rafael Rangel" National Institute of Hygiene is the entity of the Ministry of Health and Social Development in charge of evaluating and monitoring the quality and safety of pharmaceutical and related products.

The Ministry of Health and Social Development prepares an annual National Drug Formulary in coordination with the national universities. Facilities of the National Public System of Health may prescribe and dispense only pharmaceutical products that are included in the list prepared by the MSDS, which also establishes exceptions to this provision, as warranted.

Drugs and Other Health Products

Indicator	1998	1999	2000
Total No. of pharmaceutical products marketed	3,918	4,700	5,760
Percentage of brand-name drugs	83.6 %	82 %	80 %
Percentage of generic drugs	17.6 %	18 %	20 %
Total spending on drugs (cost to the public, US$)	1,200,000	1,400,000	1,600,000
Percentage of the MSDS budget devoted to drugs	10%	12%	12%
Per capita spending on drugs (cost to the public)	N.D	N.D	N.D
Percentage of private health expenditure, destined to purchase of drugs	14.3%	16.8%	N.D
% of public health spending allocated to drugs	N.D	N.D	N.D

Source: Ministry of Health and Social Development, Pharmaceutical Industry.

The five best-selling products on the national market are: Acetaminophen, vitamin C, Ampicillin, Acetyl Salicylic Acid, and Procaine penicillin. There is no available information on the price per unit. The list for 2000 of essential drugs compulsory at public health institutions includes 280 active ingredients; this list is reviewed annually. Only 2% of the population has permanent access to the drugs on the list. The SUMED program aims to facilitate access to drugs, by providing an 80% subsidy of the list of essential drugs prescribed in public health facilities.

The first level of care has treatment protocols, but it is difficult to apply them, if they are applied at all. Some hospitals have their own individual protocols. Pursuant to the Law of Drugs, the presence of a pharmacist is required at private pharmacies and hospitals, although compliance with the regulations is not supervised adequately and sufficiently.

The total number of blood donations in 1999 was 302,000. The modality of remunerated donations does not officially exist; donations are by replacement. The "Law of Transfusions and Blood Banks of 1997"

establishes the regulations and national regulation on transfusions and blood banks. Pursuant to this law, the MSDS is in charge of monitoring and supervision of the activities of public and private Blood Banks. 100% of blood donations are supervised under the current standards.

Equipment and Technology: In 2000, there were 40,675 beds at the government public level (17.68 beds per 10,000 population). For the population of influence of the MSDS, this indicator is 21.95, while for the beneficiary population of the IVSS it is 8.87.

In 1996, the percentage of equipment that was defective or not in use was 86% (in the services of: blood banks, emergencies, radiology, laboratory, operating rooms, maintenance teams, oncology, gynecology, delivery room, supply plant). Information for other years is not available.

Availability of Equipment in the Health Sector, 2000

Institution	Type of resource			
	Total Beds Counted	**Total Basic Diagnostic Imaging Equipment**	**Total Clinical Laboratories**	**Total Blood Banks**
MSDS	28,546	202	375	85
IVSS	7,103	N.D	68	28
INAGER (*)	2,204	N.D	N.D	N.D
MIN. DEFENSE	1,994	N.D	N.D	N.D
PDVSA	312	N.D	N.D	N.D
OTHERS	N,D	N.D	81	30
Subtotal	**40,159**	**202**	**525**	**143**
Private (nonprofit and for-profit)	N,D	N.D	N.D	120
Subtotal	N,D	N.D	N.D	120
TOTAL	**40,159**	**202**	**525**	**263**

Source (s): Ministry of Health and Social Development. (*) corresponds to "long-term stay beds."

For 2000, 7.6% of the operating budget at the central level was allocated to equipment preservation and maintenance. That same year, 24% of the staff in the maintenance department had only empirical training. At the level of technical staff and labor, the figure was 82%. The high-technology units and/or equipment are concentrated in the national capital and in the capitals of the most developed states (for both the public and private sector); however, specific information in this regard is not available.

2.3 Functions of the Health System:

Steering Role: The Ministry of Health and Social Development, as the representative of the National Executive, is the regulatory entity of the health sector, and is responsible for: the formulation, design, evaluation, control, and monitoring of health policies, programs, and plans; sector regulation and the integration of the financing sources and allocation of resources of the National Public System of Health. Although there is evidence that over the last two decades the Ministry's capacity to exercise the steering

role and regulate the sector has eroded, the proposed new comprehensive health law –delivered the President of the Republic in March 2001- provides for the steering role of the Ministry of Health,[14] and creates mechanisms to enable it to perform this role. To this end, the creation has been proposed of entities such as the "Intergovernmental Council of the SNPS (National Public Health System)" and the "Intersectoral Health Council" as instruments for defining the organization needed to coordinate the different levels and sectors that participate in the SPNS. Furthermore, the "Autonomous Financing Service" would be created, an institutional entity with fiscal and financing autonomy, assigned to the MSDS, which would consolidate and administer the financial resources of the SPNS. Furthermore, it would create a system for the accreditation for service-providing establishments.

At the state level, the Regional Bureaus of Health and Social Development are responsible for the delivery of health services and programs, through a single agency that consolidates all public facilities. The municipal level owns the Bureaus of Municipal Health and Social Development, and various responsibilities are delegated according to the special characteristics and capacities of each region. The possibility is thus open for innovation in the management of health at the municipal level. The municipal responsibilities include management of the comprehensive health promotion services and the public health facilities under their stewardship, disease and accident prevention, preventive medicine, and environmental sanitation. The Municipalities may jointly take on the services and health programs that appertain to them.

The Ministry of Health and Social Development regulates and controls the public and private establishments that provide health services. To this end mechanisms are being designed for registration, qualification, classification, and accreditation, so as to guarantee the structural and functional conditions that these establishments should display; likewise for the quality of care. Qualification and registry are compulsory for all public and private health facilities, and must be renewed annually.

The Comprehensive Law proposes the creation of a National Commission for Technology Assessment as an interdisciplinary and intersectoral agency assigned to the MSDS, charged with evaluating the relevance, efficacy, and safety of techniques, procedures, products, and equipment that the SPNS uses or plans to use. The MSDS has begun implementing the National Health Information System, in which the information necessary for achieving the objectives and goals of the SNPS will be obtained and analyzed.

Financing and Expenditure: The financing of the SPNS encompasses the national fiscal, state, and municipal budgets in health, the revenues of the states and municipalities destined to health, transfers from other subsystems of Social Security, special health taxes, resources from cost recovery by the services of the Registry and Office of the Comptroller of Public Health.

Public Spending in Health as a Percentage of GDP

INDICATOR	1995	1996	1997	1998	1999
Health spending of the Central Government as a percentage of GDP.	1.46	1.46	1.45	1.47	1.27
Private health expenditure as a percentage of the GDP.	1.45	1.25	1.59	1.59	1.59

Source (s):OCEPRE, Leyes de Presupuesto de cada año. Anuario estadístico de Venezuela, 1998.

The contributions of the central Government were rising until 1998. The remarkable drop in expenditures in 1996 reflects the foreign exchange situation of that year. Since 1996, public spending in health has remained virtually constant, while the share of private expenditure has increased, accounting for more than 50% of total expenditures for 1998. Public spending is thus being replaced with household contributions, creating further access barriers to the health services.

Sources of Financing of the Health Sector in Millions of US$ and as a Percentage of GDP

Source	1995		1996		1997		1998		1999	
Central Government	1,097.4	1.5	781.6	1.5	1,221.6	1.5	1,411.2	1.5	1,363.9	1.3
IVSS and HCM Contributions	64.5	.1	38.1	.1	50.2	.06	58.4	.06	80.4	.1
States	405.4	.5	161.2	.2	254.7	.03	318.7	.3		.3
Municipios		.02	10.8	.02	15.8	.02	30.7	.03	23.8	.02
IVSS	327.8	.4	459.4	.7	528.1	.63	704.1	.7	785.3	,7
IPASME	15.1	.02	12.9	.02	14.9	.02		.02		.02
FFAA	45.6	.1	25.1	.04	29.3	.03		.03		.03
Private	1,086.4	1.5	846.2	1.25	1,331.9	1.59		1.59		1.59

Source:OCEPRE, Leyes de Presupuesto de cada año; (*) Informe económico de CEPAL 1999-2000

Health expenditures as proportion of GDP are 4.06 %, and on a descending trend, which is sharper in terms of public spending. This situation is the opposite of results seen elsewhere in Latin America, where the regional average of health expenditures as a proportion of the GDP was 7.67% at the end of the decade, and on a rising trend.

Furthermore, there is a high degree of dispersion and fragmentation of resources, due to the multiplicity of institutional sources, such as the Central Government (MSDS and other ministries), state Governments, mayoralties, IVSS, IPASME, FAN, and the private subsector.

External financial cooperation has been channeled largely by the IDB (approximately 90% of the total). Official Development Assistance fell from US$ 81 million in 1990 to US$ 49 million in 1993 and US$ 31 million in 1994. The MSDS is currently conducting the final stage of the Project for Modernization and Strengthening of the Health Sector, with a total of US$ 300 million, of which the IDB is providing 50%.

Health Insurance: No information is available to ensure the reliability or timeliness of data on the degree of coverage; nor is their information on methods for providing the various modalities of health insurance.

There is no data on the coverage of private insurance, and no estimates have been made of the population with duplicate coverage.

In 1997 the population with some type of insurance included 65% of the population. The IVSS is the institution with the highest coverage, reaching 57% of the total insured population, between policyholders and beneficiaries.

Since the role of the MSDS and the states as public insurers is not defined, by default they are assigned a percentage of the population lacking social security. In practice, however, the MSDS and the states are the primary providers of health care and they do not exclude the indicators related thereto. The group lacking coverage or with restricted access or coverage includes numerous indigenous ethnic groups, as well as many groups from marginal urban sectors. Public financing of a "basic set of benefits" has not been defined. There is no information on the existence of modalities for public financing of private health insurance.

2.4. Delivery of Services: The Municipal Bureaus of Health and Social Development are responsible for management of the health services. The network of public health facilities includes several levels of care which are spread throughout the entire country. There are notable shortcomings in health services coverage. Primary Care Level: Establishments which seek to deliver comprehensive health services of the public subsector should adjust to the characteristics that appertain to them in keeping with the following classification:[15] *Rural Outpatient Type I and II*, which provide comprehensive, general, and family medical care at the primary level, except for hospitalization, and which are located in populations of less than 10,000 inhabitants. *Urban Outpatient Type I, II and III*, which provide comprehensive general, family, and specialized medical care, do not provide hospitalization, and are located in populations of over 10,000 inhabitants. In practice, coverage is limited, and most interventions of health promotion, community participation, and disease prevention are conducted the physicians during their year of social service, and by Simplified Medicine Auxiliaries in the Outpatient Rural I and II setting, oriented to scattered rural environments and populations of less than 1,000 inhabitants. At this level, the health workers (nursing auxiliaries and social promoters) make house calls to promote health and improve lifestyles.

Venezuela's health care model has centered on isolated public health programs, with a fragmented, care-centered vision, at the expense of comprehensive actions for prevention and promotion. The coverage of care for special groups ---prenatal, children, and preschoolers--- reveals serious deficiencies by states at 25.5%, 36.7%, and 15.2%, respectively for 1997.

Production of Services in the Public Subsector, 1997

Type of Service	Number	Rate per 1,000 Pop.
Consultations and supervision by physicians	55,042,063	2,416.5
Consultations and supervision by non-physicians	6,300,351	276.6
Consultations and Supervision by Dentists	5,849,350	256.8
Emergency Consultations	3,.674,600	161.3
Laboratory Tests.	10,854,083	476.5

Source: MSDS Consolidados Servicios Diagnósticos. 1997

Except for vaccination with BCG, which achieved 99.5% coverage in 2000, the traditional vaccine coverage (Trivalent bacterial, Anti-Polio,and Trivalent viral) failed to reach the international standard of 95.%; for that year coverage of 77.2%, 86.0% and 83.7% respectively were reported. Starting in 2000 the official scheme incorporated the Hepatitis B, Haemophilus influenza, and Anti malarial vaccines. However, coverage was under 50%, due partly to delays in their arrival to the country and in national distribution.

Since 1999, the MSDS has been promoting the implementation of a new model of comprehensive health care. The actions proposed include: (1) To consolidate health programs geared to population groups, classified by age and family groups, with emphasis on health promotion, prevention, risk factors, early detection of diseases, and early and timely treatment; (2) To create and improve referral and back-referral systems in the services network and define the operational levels of complexity of the facilities, in order to adapt them to the epidemiological profile and living conditions of the Venezuelan population; (3) Establish new modalities for management of outpatient facilities in order to implement the model of comprehensive care; (4) Promote projects for comprehensive training of human resources for health, so they can respond to the needs of the population and the requirements of health policy; (5) Strengthen surveillance of health problems, emphasizing analysis of the health situation, research on causality, impact assessments of the services, and epidemiological surveillance, based on the identification of risk groups as a function of nutritional variables, living conditions, and other considerations.

Secondary Level of Care: Facilities that seek to deliver hospitalization services to the public subsector provide comprehensive medical care at the primary, secondary, and tertiary level. They are classified as Type I, II, III, and IV Hospitals, as a function of several characteristics, most notably by the population served, number of beds, and level of complexity. *Type I Hospitals* are located in populations of up to 20,000 inhabitants, with a demographic catchment area of up to 60,000 inhabitants. They have between 20 and 50 beds and are organized to provide medical services, surgery, pediatrics, and gynecology and obstetrics. *Type II Hospitals* are located in populations of more than 20,000 inhabitants, with a demographic catchment area of up to 100,000 inhabitants. They have between 50 and 150 beds and are organized to provide services of greater complexity than the previous level. *Type III Hospitals* are located in populations of more than 60,000 inhabitants, with a demographic catchment area of up to 400,000 inhabitants. They have between 150 and 300 beds and are organized to provide services of greater complexity than the previous level. *Type IV Hospitals*, are located in populations of more than 100,000 inhabitants, with a demographic catchment area of up to 1,000,000 inhabitants. They have more than 300 beds and are organized to provide services of greater complexity than the previous level.

The hospitals with the highest problem-solving ability are located in the capital city and in the State capitals. The hospitals have low utilization rates, as reflected in the total discharges generated and the bed occupancy ratios (53%). The problem-solving ability of the hospitals is very limited; there are long

waiting lists for surgery and outpatient care, and there are often shortages/deficiencies in essential supplies for care. In order to cope with these issues, a National Commission has been created to coordinate a response to the hospital problems. This commission has relative autonomy, and enjoys political and financial support. It has identified the principal problems, and formulated projects to provide short, medium, and long-term solutions. In the short-term, private services have been contracted and agreements entered into with friendly countries, making it possible to meet the most pressing demands for care that could not be met through the government network. In addition, a major extrabudgetary item was allocated for equipment and for strengthening the infrastructure of selected hospitals. Furthermore, a proposal for a legal and administrative framework was formulated that would allow for the development of autonomous management.

Most hospitals have some kind of computerized information system for cost and human resources accounting, though not necessarily for clinical and/or administrative management. The MSDS recently initiated the implementation of an information system for hospital management, based on WINSIG/PAHO. The proposal consists of the development of a hospital management module within the SISMAI, which has been promoted for outpatient establishments, so that in the medium-term a single information system will be available. Implementation of this tool has begun at five hospitals of the Federal District and five in the State of Bolivar. The hope is to expand it throughout the country by the end of the year. The central level of the MSDS does not register the five most frequent causes of hospital discharges for the main network of providers.

Quality:

Technical Quality: The issue of quality was only recently raised at public health institutions. In 1998 the Technical Bureau of Services hosted a Quality Assurance Workshop with the participation of 7 States, to be followed by implementation at the National Level. Nevertheless, there is no information available on the percent of establishments with quality programs that are up and running. During 1999 and 2000 three national workshops were held to craft a proposal for a national quality assurance program and the accreditation of facilities. This has been formulated and is currently awaiting implementation.

No information is available on the existence of committees for ethics and/or control of professional behavior. There is no register available on hospital infections. At the end of last year the MSDS conducted a national survey to evaluate and strengthen the hospital epidemiology units at the national level, and to reduce the indexes of nosocomial infections. The survey was sent to the 214 hospitals of the country but only 21 responded (9%). Of these, 11 reported that they have an established and functioning "committee of hospital infections" (5% of the total of hospitals). According to information provided by the MSDS, in 1998, 21.62% of deliveries in the public hospitals ended in Ceasarean Sections: the ratio of Deliveries/Ceasarean Sections was 3.6 : 1.

Patients are not routinely provided a discharge or care report, except in special cases, and then only upon request. Upon discharge, patients are given an "appointment control card." Nevertheless, the medical records are duly filled out and stay with the clinical history of each patient.

Some 90% of the autopsies done in the country are completed by forensics. The highest percentage of non-forensic autopsies is conducted at Type III and IV University (teaching) hospitals and is conducted for academic purposes. In 1998, 9.46% of autopsies were reported as non-forensic. The percentage of audited deaths in children was 9.7% in 1999 and has declined steadily since 1995, when it was 12.8%. The percentage of audited maternal deaths is barely 0.3%.

Perceived Quality: Perceived quality is not determined or evaluated, either systematically or sporadically. The Comprehensive Health Law, currently under discussion, establishes a legal framework for the development of the people's rights, and thus, the development of quality and bedside manner programs.

3. MONITORING AND EVALUATION OF SECTORAL REFORM

3.1. Monitoring of the Process

Monitoring of the Dynamic: Over the last twelve years the country has undergone five major macro-reform efforts: the Law of the National Health System of 1987; the Social Security laws approved with the authorization of the Enabling Law of 1998; amendments to the framework of the Enabling Law of 1999; the legal framework established in the new Political Constitution; and the New Comprehensive Health Law, currently under discussion. For a variety of reasons, the first three reforms were ineffective and limited. The 1987 Law of the National Health System was never fully implemented. The laws of 1998 helped strengthen negative characteristics of the system for public financing of health. The discussion of the 1999 reforms was deferred to the National Assembly, which this year will consider draft legislation to provide a definite context for the implementation of health sector reform in Venezuela.[16]

Monitoring of the Contents

Legal Framework: The Political Constitution approved in December 1999 lays the foundation to develop a legal framework and organizational model for the Venezuelan health sector. The legal framework established by the Constitution has allowed a proposal to be drafted for a "Comprehensive Health Law" (currently under discussion), whose objective is to develop the constitutional right to health and make it effective. It will regulate issues related to: the comprehensive health of people and communities, the development of a healthy environment, organization and operation of the health sector, financing, the delivery of health services and products, the duties and rights of the people, the responsibility of the different sectors with regard to health, the activities of health workers and facilities (whether public or private) and their relationships.

Right to Health Care and Insurance: In order to guarantee the right to health, the State will create the National Public System of Health, as part of the Social Security System, under the Health Subsystem of

Social Security. This will consolidate under a single regime all institutions, agencies, and public establishments that provide health programs and services, as well as those which receive State financing.

Steering role: The Ministry of Health and Social Development, as the representative of the National Executive, is the regulatory entity of the health sector and will be responsible for: the formulation, design, evaluation, control, and monitoring of health policies, programs, and plans; sector regulation; and the consolidation of the sources of financing and resource-allocation of the National Public System of Health.

In order to implement the comprehensive health policy, the Ministry of Health and Social Development coordinates the participation of the sector institutions, and coordinates with institutions and organizations whose activities have an impact on the health of the population, including: education, culture, environment, roads, housing, economy, communication, science, technology, and defense. It will furthermore promote the consolidation of the National Public Health System at all intergovernmental levels, and for the functions of the steering role, financing, and delivery of services. To this end the new Law proposes the creation, at the national, state and municipal levels, of intersectoral health councils, in order to guarantee the participation of the different sectors in the operations of the National Public System. These councils will have the following functions: A) Serve as entities for coordination between various ministerial offices, or their state and municipal equivalents, for the design of policies, plans, and programs and standards related to comprehensive health; B) Serve as an advisory and counseling body for the Ministry, State and Municipal Directorates of Social Health and Development, as warranted. C) Convene nongovernmental organizations involved in health issues; D) Distribute among the members the responsibilities and commitments for execution of such activities as may be decided upon by the Council.

Separation of Functions: The National Public Health System encompasses the functions of the steering role, regulation, information, execution, control, financing, and public provision of health services. It is organized as an intergovernmental system under the steering role of the Ministry of Health and Social Development. It has exclusive competence at the national level, and parallel competences at the national, state, and municipal levels, pursuant to the Comprehensive Health Law, the Comprehensive Law for Decentralization, Delimitation, and Transfer of Responsibilities of the Branches of Government, the Comprehensive Law for Municipal Governance, and other current related provisions.

The Ministry of Health and Social Development and its State and Municipal Directorates will prepare health plans annually for their areas of competence ---ranging from the municipal to the national arenas. To make the right to health a reality, they will implement policies and include programs or projects, objectives, goals, means, actions, costs, allocation of responsibilities, mechanisms for accountability, criteria and time frames for the fulfillment and evaluation of the activities conducted. These plans will include qualitative and quantitative goals addressing the health conditions of the population, and for the elimination of health inequities due to gender, geographical location, social class, ethnic group, and other population categories. They will furthermore include actions for the development of public institutions to eliminate existent shortages and deficiencies. In preparing the plans they will have the active and effective

participation of the community. The plans should be published at each level of government in a timely fashion, so they can be discussed collectively.

Decentralization Modalities: the State Bureaus for Health and Social Development implement the national health policies in their respective territories. They design and execute the state health programs and plans, consolidate financing sources, allocate resources from the national and state levels, and provide health services and programs, through a single agency which includes all public establishments and facilities that receive State financing.

The Municipal Bureaus for Health and Social Development are responsible for managing the health services, as a function of the competences transferred to them by other levels of government, depending on the specific characteristics of each municipality, and according to the transfer agreements and other existent provisions.

Participation and Social Control: The new Comprehensive Health Law establishes that participation is a political right, to be performed at all levels of the National Public Health System, so as to democratize the design of the plans, projects, programs, standards, and management evaluations to achieve individual and collective health. Mechanisms and channels are being developed in order to guarantee the participation of community organizations at the different levels of the National Public Health System, and in its public facilities, in order to actively include them in health management. All management entities of the institutions of the Public Health Network should include the effective representation of the community. Communities may also propose candidates for high-level administrative positions at any public establishment, management agency, or health Bureau, including officials of the Bureaus of Health and Social Development and the Office of the Ministry. The community representatives should be democratically elected at Citizen Assemblies. They will be accountable to the public for their actions and subject to recall. The National Executive will regulate the mechanisms and channels for community participation.

Financing and Expenditure: The financing of the National Public Health System is collective and integrated. It comprises the national fiscal, state, and municipal budgets in health, revenues of the states and municipalities earmarked for health, transfers from other subsystems of Social Security, special health taxes, resources derived from cost recovery by the services of the Registry and Office of the Public Health Comptroller, and other resources pertinent to health.

Resources allocated by the State or the Municipal Health Bureaus will finance health facilities in the public health network. The criteria to be considered for assignment of resources to facilities of the public health network include indicators of effectiveness, equity, efficiency, and facility performance.

The new Comprehensive Health Law proposes the creation of an Autonomous Financing Service of the SNPS, to have functional and financing autonomy, under the Ministry of Health and Social Development. This system will consolidate and administer financial resources of the National Public System of Health originating from sources other than the National Treasury, comprising transfers from other subsystems of

Social Security, taxes, and any other source of non-fiscal (non-tax) financing. Financial resources deriving from the fiscal budgets will be under the control and supervision of mechanisms set forth in the Organic Law of the Office of the Comptroller of the Republic. Such non-fiscal resources will be controlled and supervised by the Social Security Authority, pursuant to basic criteria of effectiveness and efficiency. The Ministry, the State and Health Municipal Bureaus, and the autonomous institutes thus allocated must publish budget and execution reports semiannually in the media.

By Law, any information requested by the Ministry of Health and Social Development must be provided, consistent with the deadlines and periodicity established in the regulations. This obligation includes the State and Municipal Bureaus of Health and Social Development, public and private providers of services and health programs, and industries producing goods and services related to the health of the people and the community.

Services Provision: The public institutions providing health services and programs, and others with State financing, are organized under the health network modality as a function of levels of care and degrees of complexity, geographical coverage, population segmentation, and response capacity. Entrance to the public health network is conducted through the first level of care, which is provided at the outpatient establishments, except in emergencies.

All the public hospitals will be integrated into the health network and will respond to the direction, coordination, and supervision of the corresponding State Health and Social Development Bureau. They may have administrative autonomy in the areas of human resources and administration of operational expenditures, if so authorized, to achieve the objectives of the National Public System of Health. Such "hospital autonomy" will be subject to a special regulation.

In the event of deficiencies or nonexistence of health services in the public health network, any level of the National Public System of Health may contract with private establishments to provide such services. In all cases, the contracting of services will be limited to achieving the objectives of the National Health Plan. The Ministry of Health and Social Development will regulate, without prejudice to laws governing the insurance system, the supply of health services covered or protected by the policies and health plans offered by insurance companies, prepaid health companies, administrative third parties, health cooperatives, and so forth. It shall be compulsory for policies and health plans offered by insurance companies, prepaid medicine companies, third party administrators, health cooperatives and so forth to cover maternal and infant care, to include services of prenatal check-up, delivery care, postpartum supervision, treatment of disorders related to lactation, monitoring of child growth and development, and compulsory immunization. Assurance Companies that operate health insurances will allocate 3% of the premiums collected annually to set up a fund, to be administered by them, for conducting joint health education campaigns in coordination with the national health authorities, based on the epidemiological profile of the country. The Social Security Funds Authority and the Insurance Authority will supervise the use of these funds.

Health Care Model: In order to guarantee the comprehensive nature of care and effective access to health programs and services, for the last two years the Ministry of Health has promoted the implementation of a new model of comprehensive health care and social development. The model of comprehensive health care for people and communities includes activities of health promotion and education, disease prevention, preventive medicine, recovery, and rehabilitation. It responds to people's needs throughout their entire life cycle, consistent with special features related to gender and ethnicity. This model of care recognizes the diversity of theories, methods, techniques, equipment, materials, and drugs used to solve health problems, and will thus seek to incorporate all scientific and technological advances in health, based on evidence, and subject to bioethical principles and social sustainability.

Management Model: All public health facilities may enjoy administrative autonomy in the areas of human resources and administration of operational expenditures, contingent on prior authorization to do so. This "management autonomy" will be subject to a special regulation.

The Ministry of Health and National Social Development, as a regulatory entity of the Public Health System, recently created the National Health Information System, which collects and analyzes data on: epidemiology, health programs and services, activities of the blood banks, sanitary authorizations, costs and expenditures, certification and accreditation of public facilities and private service providers, registry and recertification of health professionals and technicians, information on fulfillment of health policies, impact assessments of interventions geared to meeting the health needs of the population, and other issues relevant to accomplishing the objectives and goals of the National Public Health System.

Human Resources: The Ministry of Health and Social Development will perform the regulation, surveillance, control and supervision of the practice of health professionals and technicians, based on good practice principles, ethics, teaching, and research, without prejudice to stipulations of other applicable provisions. The new Law proposes the implementation of incentive systems for human resources, with a view to encourage quality and efficiency in the delivery of the services, and to promote the education, training, and permanent updating of health workers. Individual performance and group and institutional performance will be encouraged. The incentives will seek the achievement of goals, adherence to principle, improvement of health indicators, and cost control. The Regulations to the law will establish the necessary procedures. In order to exercise any health profession or technique it shall be necessary to have a title, diploma, or certificate duly recognized by the State, be registered with the Ministry of Health and Social Development, and follow through with recertification as needed. The Ministry of Health and Social Development will certify the updating of competences and knowledge of health professionals and technicians. A Commission will be created for this purpose, made up of the ministries of Health and Social Development (who will coordinate it), Education, Culture and Sports, Science and Technology, the National Universities, and the National Academies and scientific associations.

Quality and Assessment of Health Technologies: The Ministry of Health and Social Development regulates and controls private and public facilities that provide health services. To this end, it has

designed mechanisms for registration, qualification, classification, and accreditation that guarantee the structural and functional conditions that should govern these establishments; likewise for the quality of care provided. Qualification and registry are compulsory requirements that must be observed by all health facilities, public or private, and should be renewed annually. A system for accreditation of facilities providing health services is currently being developed in order to guarantee the quality of care and adherence to the principles of the National Public System of Health. The system will determine the compulsory and voluntary criteria for accreditation.

3.2 Assessment of Outcomes. The development of the new health care model began only in 1999. The other reform initiatives have not been implemented. Thus, there is still not enough evidence to evaluate what influence the reforms might have had on the indicators of equity in access, coverage, and use; on efficiency in the distribution and use of resources; on the effectiveness and quality of care; on the sustainability of the system; or on social participation.

* The second edition of the Profile was prepared by a group of 19 professionals and national policy decision-making representatives of the Ministry of Health and Social Development, the Venezuelan Institute of Social Security, the National Institute of Geriatric Care, the Center of Public Policies of the Institute of Advanced Management Studies, and PAHO/WHO. PAHO/WHO Venezuela country office was responsible for the technical coordination of the National Group. The School of Public Health of the Central University of Venezuela was commissioned to conduct the external review. The responsibility for the final review, editing, and translation corresponds to the Program of Organization and Management of Health Systems and Services of the Division of Health Systems and Services Development of PAHO/WHO.

BIBLIOGRAPHY AND NOTES.

[1] Gaceta Oficial Extraordinaria N° 5.453 de la República Bolivariana de Venezuela. Constitución de la República Bolivariana de Venezuela, Caracas, Marzo de 2000.
[2] Oficina Central de Estadísticas e Información: Anuario estadístico de Venezuela, 1998.
[3] OPS/OMS. Informe Final del Proyecto desastres en Venezuela. Caracas, Diciembre de 2000.
[4] Oficina Central de Estadísticas e Información: Anuario estadístico de Venezuela, 1998.
[5] OPS/OMS: Condiciones de Salud en Venezuela. Caracas, Marzo de 2001.
[6] Ministerio de Salud y Desarrollo Social: Anuario Estadístico de 1998, Caracas, Venezuela.
[7] Oficina Central de Estadísticas e Información, PNUD: Indice de Desarrollo Humano 1999 Venezuela. Caracas, 2000
[8] Dirección de Información Social, Ministerio de la Familia: Cálculos Propios. cifras revisadas, Enero de 2000.
[9] Riutort, M: Causas de la Pobreza en Venezuela, UCAB, 1998.
[10] Oficina Central de Estadísticas e Información: Anuario estadístico de Venezuela, 1998.
[11] Subcomisión de Salud de la Comisión Presidencial de la Seguridad Social. Documento de trabajo de la Ley Orgánica de Salud. Caracas, Febrero de 2001.
[12] Gaceta Oficial N° 36.935 de la República Bolivariana de Venezuela. Reglamento interno del Ministerio de Salud y Desarrollo Social, Abril de 2000.
[13] Ministerio de Salud y Desarrollo Social. Dirección de Recursos humanos. Marzo de 2001.
[14] Jaén, M.H. Centro de Politicas Públicas del Instituto de Estudios Superiores de Administración, 2001.
[15] Gaceta Oficial 32.650. Caracas, Enero de 1983.
[16] González, M.J: Retos del sistema de salud en Venezuela, Caracas, 1999