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STRENGTHENING HEALTH SYSTEMS AND REFORMS

Issue #7 2004

CHALLENGES TO SCALING-UP HEALTH SYSTEMS

The Region of the Americas has begun the new millennium with numerous achievements, such as an increase in the number of democratically elected governments, sound macroeconomic policies and reforms to promote economic growth and social progress. Nevertheless, significant challenges persist, such as reversing the increase in poverty levels in a large number of countries, reducing child malnutrition, addressing gender inequities in the labor market and at the political level, increasing access to basic water and sanitation services in low-income countries and in the poorest regions of middle-income countries, and most importantly, improving equity in access to health services and in health outcomes.

Experience accumulated over more than two decades of structural adjustment policies; State Reforms and Health Sector Reforms (HSR) have not had a definite positive influence over health systems development in the Region.[1,2] Presently, Latin American and Caribbean (LAC) countries are faced with an inadequate public health infrastructure, underutilized, yet available, health services, a regressive pattern of out-of-pocket expenditures in health, extreme inequity in access to health services; and an array of deleterious health outcomes.

In 1998, LAC countries determined that the guiding principles of HSR should center on improving access, equity, efficiency, quality and the sustainability of the health system.[3] Despite these initial objectives, efforts in the Region have primarily addressed management and economic efficiency issues as it relates to the increasing separation of the health system functions of financing and providing health services. Reforms also focused on increasing private sector involvement and in promoting competition among providers and health insurers. Within this context, considerations of equity, quality, social protection in health, and investment in, and maintenance of, the public health infrastructure have been relegated to a secondary level.[4]

Evidence gathered within the framework of the *LAC Regional Health Sector Reform Initiative,*[5] supports the notion that the intended outcomes of health sector reform have not fully materialized.[6] For example, despite limited evidence that market-oriented reforms improve the efficiency of health services delivery, the small gains in efficiency attained were often made at the expense of improving equity and access to health services. This has been exemplified in the increasing demand for health systems that are more responsive to population needs, value quality, incorporate social participation, and protect the rights of civil society.

Moreover, it is illustrated by the limited development of the steering role function of the entities that comprise the National Health Authority (e.g. Ministry of Health, Social Security Institute), particularly in its capacity to conduct/lead, regulate, and carry out the Essential Public Health Functions (EPHFs) (see Table 1). As a result, PAHO/WHO in close collaboration with the Centers for Disease Control and Prevention (CDC) and the Latin American Health Systems Research Center (CLAISS) developed a methodological instrument to assess the performance of the EPHFs. Within the framework of the *Public Health in the Americas Initiative,*[7] the instrument was applied in 41 countries and territories of the Region of the Americas with the objective of strengthening the National Health Authority's institutional capacity to effectively fulfill its responsibilities of promoting and protecting the health of the population. The results of the application made evident the pressing need to restore the public health infrastructure, including the development of the public health workforce. The *Public Health in the Americas Initiative* proved to be a proactive mechanism to strategically place Public Health issues at the core of the health sector reform agenda in the Region.

Thus, the priority given to the EPHFs within the health sector reform agenda has constituted a strong mechanism to strengthen health systems and ensure that socially excluded groups fully benefit from the world-wide efforts to attain the Millennium Development Goals[8] (MDGs) in the areas of child and reproductive health, HIV/AIDS, tuberculosis, malaria and nutrition. Thus to carry out the interventions that will enable the attainment of the MDGs, it is absolutely essential to reconcile and revitalize the HSR agenda with efforts to scale up health systems and strengthen public health infrastructure.

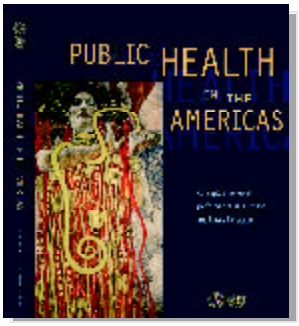
TABLE 1: ESSENTIAL PUBLIC HEALTH FUNCTIONS

1. Monitoring, Evaluation, and Analysis of Health Status
2. Public Health Surveillance, Research, and Control of Risks and Threats to Public Health
3. Health Promotion
4. Social Participation in Health
5. Development of Policies and Institutional Capacity for Regulation and Enforcement in Public Health
6. Strengthening of Institutional Capacity for Planning and Management in Public Health
7. Evaluation and Promotion of Equitable Access to Necessary Health Services
8. Human Resources Development and Training in Public Health
9. Quality Assurance in Personal and Population-based Health Services
10. Research in Public Health
11. Reduction of the Impact of Emergencies and Disasters on the Health

The MDGs are an important milestone for poverty alleviation and human development. Country commitment and efforts to monitor progress towards the achievement of health-related MDGs provide a golden opportunity to strengthen national capacity in generating and using information for the formulation and evaluation of social and health policies. However, to achieve the health-related MDGs it is essential to incorporate a *systemic approach* which goes beyond the MDGs scope to address health system limitations amenable to intervention. We can no longer afford to ignore "the missing middle" in the quest to strengthen and improve health systems and health outcomes in Latin America and the Caribbean, namely:

- Strengthening the Public Health Infrastructure;
- Improving Equity through the Extension of Systems of Social Protection in Health;
- Prioritizing the Development of Human Resources in Health; and
- Developing the operative capacity of Health Systems to respond to population needs.

This has led to a consensus on the need to *Scale-Up Health Systems and Health Systems Performance* through *effective* strategies and actions to strengthen the Steering Role and the Essential Public Health Functions (EPHFs).[9,10] To address these issues, PAHO/WHO and the U.S. Agency for International Development (USAID) recently signed a new three-year $20 million regional Partnership agreement *to improve maternal and child health, reduce infectious diseases, and strengthen health systems.*[11] The ultimate goal of the ***Health Systems Strengthening*** component of the new joint agreement is to improve health systems performance through public health capacity-building, comprehensive development of human resources for health, and scaling up health systems and the public health infrastructure in an equitable, efficient and sustainable manner. Therefore, joint activities between USAID and PAHO/WHO in the 2004-2007 period will emphasize*: (1) Strengthening the Essential Public Health Functions, Infrastructure and Public Health Services; (2) Strengthening the Health Sector Steering Role Function; and (3) Cross Cutting Issues in Health Systems, Maternal/Child Health and Infectious Diseases.* ■



PUBLIC HEALTH IN THE AMERICAS

...a recognition of the inspiration, knowledge, and commitment of the numerous public health workers whose efforts are contained and reflected in this study of the essential public health functions, in which 41 countries and territories in the Region of the Americas participated.

[1] Pan American Health Organization/World Health Organization (PAHO/WHO), *Health Systems Performance Assessment and Improvement in the Region of the Americas*. Washington, DC: PAHO/WHO; 2001.

[2] Pan American Health Organization/World Health Organization (PAHO/WHO). Special Issue on Health Sector Reform. *Pan American Journal of Public Health* July/Aug. 2000; vol.8 n.1-2.

[3] Health Sector Reform (HSR) is defined as a set of activities and efforts that aim to improve the performance of the health sector, by improving access, equity, efficiency, quality, and financial sustainability. These activities represent sustained efforts to achieve fundamental changes in the provision, financing, purchasing, and utilization of the public and private health sectors, and are guided by an overall legal and regulatory framework.

Pan American Health Organization/World Health Organization (PAHO/WHO). *Monitoring and Evaluation of Health Sector Reform Process*. Washington, DC: PAHO/WHO; 1999 (XLI Directing Council: Document CD41.R12).

[4] López-Acuña, D. *Una Nueva Generación de Reformas del Sector Salud: Fortaleciendo los Sistemas de Salud*. Keynote Address at the LACHSR Regional Forum on Health Sector Reform, Antigua, Guatemala, July 2004. Available: http://www.lachsr.org/static/ForoGuatemala/pdf/DrDanielLopezAcuna.pdf.

[5] The Initiative is a partnership between the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID) and other collaborating partners which seeks to promote more equitable and effective delivery of basic health services by supporting regional activities for informed decision-making on health policy and management, health financing, health services improvement, decentralization and institutional development. *Latin American and Caribbean Regional Health Sector Reform Initiative* Website: http://www.lachsr.org .

[6] Rivas-Loria P, Shelton C, and Saldaña K. Health Sector Reform Trends in the Region of the Americas. *Pan American Journal of Public Health.* Washington, DC: PAHO/WHO; 2005. (Forthcoming.)

[7] Pan American Health Organization/World Health Organization (PAHO/WHO). *Public Health in the Americas.* Available: http://www.campusvirtualsp.org/eng/pub/PublicHealthAmericas/index.html.

[8] The Millennium Development Goals are the first global development vision combining global political endorsement with a clear focus on, and means to engage directly with, the world's poor people. They are an indivisible package of measurable goals and targets to be achieved by 2015. The MDGs were adopted at the Millennium Summit in September 2000, and expressed in the United Nations Millennium Declaration. Countries of the world affirmed their commitment to achieve the MDGs at the Monterrey Consensus, in March 2002. This commitment forms the basis for the Millennium Development Compact that calls all stakeholders to orient the efforts towards ensuring the success of the goals, in a system of shared responsibilities.

[9] Pan American Health Organization/World Health Organization (PAHO/WHO). *The Steering Role of the Ministries of Health in the Processes of Health Sector Reform.* Washington D.C.: PAHO/WHO; 1997. (XL Directing Council: Document CD40/13).

[10] Pan American Health Organization/World Health Organization (PAHO/WHO). *Essential Public Health Functions*. Washington D.C.: PAHO/WHO; 2000 (XLII Directing Council: Document CD42/15).

[11] Umbrella agreement between USAID and PAHO/WHO: 2004-2007, September 30, 2004. Available: http://www.lachsr.org.

BUILDING ON VALUES
THE FUTURE OF HEALTH CARE IN CANADA

CAROLYN SHELTON AND PRISCILLA RIVAS-LORIA
PAHO/WHO

Rising pharmaceutical costs, advanced medical technology, increased pressure from a growing aging population and high public expectations of health care are some of the driving factors that led Canada's Prime Minister to order a Royal Commission to review the future of health care. During the 1990s, Canadian provinces were harboring huge deficits and debts. As a consequence, the Federal government and the provinces joined forces to reduce public spending. Given that the provinces' largest annual expenditure is on health care and other social services, room for cutting back was limited. As a result, public funding for health care gradually decreased.

A larger debate ensued among government officials, excluding public involvement, about whether the financial shortfall could be made up by private-for-profit, user fees or additional premiums. Four main ideological positions dominated the proposed reforms: 1) Private for profit; 2) More public money attached to conditions for change; 3) Privatization; and 4) Reorganization.

In 2001, Roy Romanow[1] was appointed by the Prime Minister to lead the Royal Commission on the Future of Health Care in Canada and to engage Canadians in a national dialogue on how to enhance the system's quality and sustainability. The Commission presented its report to Parliament entitled, *"Building on Values: The Future of Health Care in Canada,"* in November 2002. The key message is that Canadians favor public provision of health care and view universal access to primary health care as a right of citizenship, "a public good, a national symbol and a defining aspect of their citizenship."

"This is the most cherished social program because it's based on the philosophy that this (health care) is a public good, it's a social good. It's not a commodity to be governed by the marketplace..."

In February 2003, the Provinces and the Federal Government agreed to the Commission's recommendations to expand and strengthen the government funded health sector. The agreement will provide $8.9 billion (CAN) in new federal funding over the next 3 years and further funds beyond that; however it falls $1 billion short of the Commission's recommendation.

"This is the most cherished social program because it's based on the philosophy that this (health care) is a public good, it's a social good. It's not a commodity to be governed by the marketplace..."

The Royal Commission was given 18 months to present its recommendations to Parliament. Almost immediately, a *national dialogue* process began. The Commission traveled across Canada to listen to experts and citizens. Twelve sessions in 12 different locations invited Canadians to discuss health care. Forty participants were selected in each location to represent a cross-section of the general population with respect to gender, minorities, income, education and occupational backgrounds. Participants were given four options to consider for the future of health care: 1) private for profit; 2) more public money attached to conditions and transformative change; 3) privatization and 4) reorganization. Participant responses diverged at the start, yet as the day progressed, participants unanimously agreed with options 1 and 4.

After the Commission's report was released, public opinion polls showed that approximately 79% of Canadians endorsed its recommendations. Even a year after the report's release, another poll demonstrated that over 70% of all Canadians endorsed the Commission's recommendations, showing the public's lasting commitment to its most cherished program.

Parliament reacted quickly to the Commission's report. The report was presented in the first part of December and by February the Prime Minister convened the Premiers and the territory leaders to take major preliminary steps. They endorsed the idea that more money could buy transformative change and all the First Ministers, i.e. the Prime Minister and the Premiers, bought into the principles of the Canada Health Act and the National Health Council, although it still has not been established.

The Commission recommended establishing five transformational funds for: 1) Primary health care—including 24 hour/7 day a week physician clinics; 2) Coverage against catastrophic drug costs—anything over $1,500; 3) Home care; 4) Rural and remote care; and 5) Advanced diagnostics, (e.g. MRIs and CAT scans).

[1] Roy Romanow, Former Premier of Saskatchewan and Chair of the Royal Commission on the Future of Health Care in Canada, was presented with the 2003 PAHO Award for Administration at the 44th Directing Council Meeting in September 2003. Romanow was recognized for his outstanding contribution to the development of the Canadian Health System, particularly in the creation of the Saskatchewan Human Rights Commission, and in leading the Commission on the Future of Health Care in Canada.

The 2003 First Minister's Accord eliminated the proposed fund for Rural and Remote Care, retained the proposed fund for advanced diagnostics and combined three (primary health care, catastrophic drug coverage and home care) of the five proposed funds into one, naming it the Medical Reform Plan. The provinces have the option of selecting in which area they need funds. For example, if a province does not need funds to cover home care services, but lacks the money for primary care, they would have access to money for primary care. Although provinces have a great deal of flexibility, Romanow expressed his reservations that the guidelines for these funds do not specify how much of that money is attached with conditions for change.

"In my judgment, I fear that this may become another large pot for accessing money from the provinces without buying change. The Health Council is a tangible example to Canadians about whether or not governments are serious about reform and the longer you make them wait for the actual reform, the more their patience wears thin…"

Despite quick government action, many criticize the financial sustainability of the Commission's recommendations. Romanow's response is, "show me any evidence that you have that it is not sustainable," and recognizes the difficulty in balancing resources with needs. A free market system allows the economy to set this balance, whether it's a fair balance or the just one or along health outcomes. A prominent Canadian economist who testified before the Commission said, "You can talk about the economy all you want, but this is a political decision."

Canada spends less on health today (9%) in percent of GDP than 10 years ago (10%).

According to Romanow's experts, the debate over fiscal sustainability is confused. When government shifts costs to individuals or households, total costs often increase, mostly due to a loss in the continuum of care. If government is to represent the public's interest, total costs must be monitored to ensure that the average citizen can bear the cost, both through taxes and direct payments.

"Systems like the US or in many Latin American countries with large private sectors, including direct out of pocket payments or private insurance, may claim that they do not have a fiscal sustainability problem, particularly those countries that do not subsidize for purchasing insurance. However, this does not mean that governments do not have a problem with sustainability. From the perspective of the individual citizen, there's a huge sustainability problem."

Fiscal sustainability ensures that whatever is paid out of the public purse is being expended as effectively as possible and that the results produce the best health outcomes as possible. Canada has made tremendous strides in measuring health sector performance and its impact on health outcomes over the last 3 to 4 years.

"My hope is that this quest for better health care be seized by a determined leadership, by the national government, and all governments in Canada to act quickly lest this most cherished program in Canada just dissipates through inattention, attrition, and neglect."

"Universality of coverage, I feel very profoundly about this. That our time of greatest need, when we're ill, sick, or injured should be a time when a civil society comes together. It should be based on your need for health care, not your money."

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"Universality of coverage, I feel very profoundly about this. That our time of greatest need, when we're ill, sick, or injured should be a time when a civil society comes together. It should be based on your need for health care, not your money. In many parts of the world, this would be a principle that I think would be foremost for people. I don't think it's a matter of ideology or religion or a political determination, it just makes common sense, if you have a healthier population, you'd be better off in every way."

After 30 years and some success, Canada still struggles to provide primary health care. One of the most important lessons for other countries to take from Canada's experience is the value of an independent study inclusive of the public, with transformative changes that would benefit others. Many of the aspects identified as part of the foundation for building on the future of Canada's health care system are transferable to the Latin American and Caribbean Region: its values, philosophies, structures, organizations, objectives and citizen engagement in the health of the population.■

THE GUYANA HEALTH SECTOR ANALYSIS

AN INTERVIEW WITH THE HONARABLE MINISTER OF HEALTH OF GUYANA, DR. LESLIE RAMSAMMY

ANDREW SKERRITT AND PRISCILLA RIVAS-LORIA
PAHO/WHO

The Honorable Dr. Leslie Ramsammy, Minister of Health of Guyana, led the implementation of Guyana's, first ever, Health Sector Analysis (HSA) in May of 2002 with the support of the Pan American Health Organization/World Health Organization (PAHO/WHO). The HSA exercise provided a systematic overview of the health sector in the country. In addition, it revealed areas in need of further research and health issues not being addressed. The document described the overall health situation including its social, political and economic determinants. Most importantly, the HSA helped identify, and recommend priority interventions for the planning of health policies and the development of the health system and its services.

According to Dr. Ramsammy, the HSA process was vital in the formulation of the country's National Health Plan which was developed concurrently. The inclusive nature of the HSA process led to the involvement of the technical levels of the National Health Authority in collecting information, discussing issues, prioritizing sanitary objectives and making policy recommendations. Consequently, the inter-sectoral approach utilized helped to build institutional capacity for policy implementation, while strengthening the steering role of the Ministry of Health.

Out of the five Health Sector Reform key concepts, which include social participation, equity, efficiency, quality, and financial sustainability, the Ministry of Health pointed out that social participation and equity remain his Ministry's priority. Dr. Ramsammy explained that he conceives social participation to be an element of equity, given that in his country those who are excluded from social participation are also those who suffer from inequity in health. By increasing social participation in the process of formulating the HSA and the National Health Plan, the Ministry is also addressing the issue of equity.

From left to right: Dr. Bernadette Theodore-Gendi, PAHO/WHO Representative, Guyana; Dr. Leslie Ramsammy, Minister of Health, Guyana; Dr. Jay MacAuliffe, CDC, Atlanta, GA; Dr. Priscilla Rivas-Loria, Regional Advisor in Health Sector Reform, PAHO/WHO, Washington, D.C.

"...middle level technical staff were able to see that the outcome of all this [HSA process] was going to be not just recommendations but there would be a National Health Plan and I think because of that there was much greater interest and engagement,...we now have a health plan approved by Cabinet for 2003-2007..."

Dr. Ramsammy lauded the timeliness of the HSA given the concurrent drafting of the National Health Plan. For this reason, he argued, "middle level technical staff were able to see that the outcome of all this [HSA process] was going to be not just recommendations but there would be a National Health Plan and I think because of that there was much greater interest and engagement," he said. As a result, "we now have a health plan approved by Cabinet for 2003-2007," he affirmed.

"I'm satisfied that we do have a comprehensive set of recommendations and, if implemented, will lead to significant improvement in the sector," asserted Dr. Ramsammy. The Guyanese HSA yielded specific recommendations to strengthen the country's health system. Among these recommendations, was the use of public private partnerships to address some of the unmet needs within the sector. The need for public private partnerships in health is a means of supplementing limited Government revenues. The Minister has followed up on this recommendation: "At the moment, much of the private sector participation is at the secondary and tertiary level. Our goal is to integrate the public private sector mix so that it plays a much larger role in primary health care, health promotion and so on. At the moment, diagnostics such as CT scans and echocardiograms are offered in the private sector and are accessible by the public sector. We are working with the private sector right now in providing family health care and so on. So it is a very important part of the program we are developing right now," said the Minister.

> *"...it was the HSA that finally brought everything together [all the technical documents], resulting in a new National Health Plan. So, as I stated over and over again, not just today, but all the time that I saw the HSA as having accomplished this process for me and that is why I hope that this is not only a one shot deal for Guyana."*

As in most countries with large hinterlands, Guyana has difficulty attracting health professionals to remote areas. Another significant recommendation included in the HSA, was that incentives be given to health care providers to fulfill the needs in rural and remote areas. Currently, there is no incentive program in Guyana, however, the Ministry of Health is revising the contracts that it signs with students who are financed by the Government to study abroad to ensure that the students will serve for a period of time in the hinterland upon completion of their training and return to the country. Applicants for Government scholarships in medicine from remote areas are given special consideration in the hopes that they will want to return and serve in their own communities. To fill the immediate need, Dr. Ramsammy's Ministry "recruited approximately 20 doctors from India by the end of August 2003 and hopefully that will relieve the situation, but it is an ongoing struggle to attract doctors and dentists to these areas," he said.

A further recommendation stemming from the Guyanese HSA was the importance of developing National Health Accounts (NHA) as a systematic mechanism for assessing how resources are generated and spent. NHA serves as an important tool for policy makers in determining how resources will be allocated in the health sector. In Guyana, NHA are being treated as a pilot strategy for the larger modernization of the public sector which would include national accounts for all sectors. To establish the country's first NHA, the Ministry of Health is working with the Ministry of Finance. Dr. Ramsammy is confident that the systematic production of NHA could be sustained in Guyana and is currently negotiating with donors for international technical cooperation for institutional capacity building in this area.

Recommendations also offer a starting point for health planning and for ascertaining areas of possible technical cooperation by donors and multilateral agencies with the country. In Guyana, the HSA was done with the participation of all the technical and donor agencies. In fact, a health sector thematic group that meets quarterly to discuss the issues arising from the HSA was developed and includes donor agencies, technical agencies, ministry of health staff and some private sector participants. This exercise fosters coordination among agencies, facilitates prioritization, reduces duplication and provides the situation analysis for future strategic documents such as the Country Cooperation Strategy (CCS).

The Country Cooperation Strategy is a medium-term adaptable country specific strategy that provides the framework for cooperation between PAHO/WHO and a country. When asked about his appreciation of the HSA's contribution to the strategic planning of his Ministry, Dr. Ramsammy said: "it was the HSA that finally brought everything together [all the technical documents], resulting in a new National Health Plan. So, as I stated over and over again, not just today, but all the time that I saw the HSA as having accomplished this process for me and that is why I hope that this is not only a one shot deal for Guyana."■

HSA Working Group in Guyana.

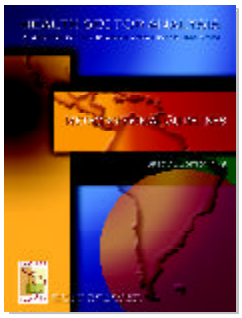
THE HEALTH SECTOR ANALYSIS EXPERIENCE IN L AC

HEALTH SYSTEMS STRENGTHENING AND CAPACITY-BUILDING THROUGH THE COLLECTIVE GENERATION OF KNOWLEDGE

PRISCILLA RIVAS-LORIA AND PEDRO CROCCO
PAHO/WHO

Throughout the 1990s, health sector decision-makers and technical staff in the countries of the Region of the Americas were faced with the predicament of having to design health sector reform schemes, negotiate, and defend their proposals to obtain financing from non-traditional health sector partners, namely international financial institutions. As a result, LAC countries became aware of the degree to which their technical staff lacked a comprehensive understanding of the multi-sectoral nature of their respective country health situation, of its determinants, and the performance of their health system. Simultaneously, monitoring and evaluating the health sector reform processes[1] in the Region of the Americas was increasingly providing evidence of the compelling need to strengthen in-country health sector analytical capacity. Thus, the Pan American Health Organization/ World Health Organization (PAHO/WHO) Governing Bodies stressed the need to strengthen Member Countries' capacity to analyze their health sector, its resources and operation.[2, 3, 4, 5]

Within the framework of the *LAC Health Sector Reform Initiative*, PAHO/WHO and the United States Agency for International Development (USAID) responded to the countries need to strengthen health systems analytical competencies. Hence, in 1996 the first edition of the *Methodological Guidelines for Sectoral Analysis in Health* (originally in Spanish)[6] was designed. The lastest version, *Health Sector Analysis: A Health Policy Formulation Enabling Tool - Methological Guidelines*, will be published in March 2005.



WHAT IS A HEALTH SECTOR ANALYSIS?

A Health Sector Analysis (HSA) is a collective and participatory process which seeks to strengthen the capacity of policy-makers and technical staff within the country to steer and conduct the health sector. This process contributes to strengthening the steering role function of the National Health Authority.[7]

Moreover, the HSA process facilitates the inclusion of all health sector actors in the collective identification, interpretation and analysis of essential health knowledge derived from existing secondary information sources. Thus, it does not require a financial investment in the collection of new information.

The HSA document outlines the country's health situation as well as provides a description of how the health system is organized. This description provides an indication of how well the system is performing, i.e. adequately addressing the country's health situation. The Analysis also orients the identification and selection of priority interventions for health policy formulation and health systems development. This process typically results in the identification and recommendation of policies and/or plans, programs, projects/and or interventions oriented to maximize the impact of the health sector in reaching national health objectives and/or priorities.

By utilizing a shared multisectoral participatory process, the HSA ensures that all health sector actors are provided an opportunity to identify and interpret essential health knowledge derived from secondary sources. The result is a manageable volume of relevant and up to date information on: a) the health situation and its determinants and, b) the functions of the health system. Each of these thematic areas assists in summing up main problems, strategies and actions.

> *The Health Sector Analysis utilizes a collective participatory process and fosters a multisectoral approach to health. It allows for a systematic assessment of health sector challenges, weaknesses and strengths, and constitutes a sound foundation to improve the performance of the health system. Equally, it helps reorient, if necessary, a Health Sector Reform process.*

The HSA process facilitates the empowerment of policy-makers and technical staff at centralized and decentralized levels with the knowledge required to:

1. Identify the most appropriate policies or interventions to maximize the impact of the sector in the formulation and implementation of national health objectives;
2. Define, by consensus, priority problems, the most suitable health strategies, and actions to be taken by the National Health Authority.
3. Lay the foundation for knowledge-based national health plans and for master plans of investment.

Methodological Framework

Since 1998, the HSA methodology has undergone continuous revisions by incorporating comments and feedback from experts meetings, pilot testing, and in-country applications. This has led to the incorporation of new conceptual and methodological developments into the methodological framework. The analysis process is organized in three successive stages. Each successive stage benefits from the findings and analysis of the previous stage. The figure below presents the three stages of the Health Sector Analysis.

STAGES OF THE HEALTH SECTOR ANALYSIS METHODOLOGY

STAGE 1

PRELIMINARY ANALYSIS
INITIAL INFORMATION GATHERING

- Composition of the Work Team
- Discussion of the Methodology

STAGE 2

FIELD WORK

1. Section I: Health Situation and its Determinants
   - Health Situation Analysis
   - Health Situation Determinants
   - Health Sector Structure and Policies
   - Social Exclusion in Health
2. Section I Summary: Implications for Health Sector Development
3. Section II: Health System Functions
   - Steering Role of the National Health Authority
   - Financing
   - Insurance
   - Health Services Delivery
4. Section II Summary: Implications to Ascertain Priority Health Policies

STAGE 3

BEYOND THE ANALYSIS
DETERMINING PRIORITY ACTIONS

- Implications to Determine Health Sector Priority Actions
- Determine and Promote a Sustainable Health Agenda for Change

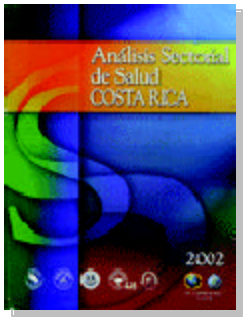
The first stage of the HSA tries to make the most objective assessment of the countries' health situation and the external determinants of that health situation; and to look at the health sector and its relationship to other sectors within the country. The second stage focuses on the assessment of the steering role function of the National Health Authority, health sector financing and expenditure, and health service delivery. The final stage of the process is the identification of policies and/or plans, programs, projects and/or interventions oriented to the development of the health care system and the health sector.

Application and Impact of the Health Sector Analysis

By outlining the country's health situation and the performance of the health system, the HSA has facilitated the identification of health policies and selection of priority interventions for health system development and health sector reform in each of these countries. In **Costa Rica,** the HSA Methodology was applied in 2002 at the beginning of the present government tenure with the active participation of more than 100 representatives from the health sector. The resulting HSA recommendations have been utilized as the basis for the development of the Concerted National Agenda; the National Health Plan, and for negotiating with the Costa Rican Congress on the National Health Sector Budget.

COUNTRIES OF THE HEALTH SECTOR ANALYSIS

Bolivia	Haiti	Paraguay
Chihuahua State, Mexico	Puerto Rico	Costa Rica
Guyana	Nicaragua	Cuba



This health sector analysis in Costa Rica is comprised of a critical review of the components of the health sector. The objective is to reveal the elements required to improve the current social, economic and technological events and the population's demands for accessible and quality health services. The framework of this analysis stems from the principle that health is a fundamental public good and, as a result, vital to achieve sustainable human development.

In the health sector, these joint efforts must be governed by principles of universality, equity, solidarity, and quality of services. With the aim of introducing possible improvements into the health system, one of the objectives of the sector analysis is to deepen and expose those aspects of the health system that have experienced relevant deficiencies. Finally, the Costa Rica health sector analysis is an important step to formulate evidence-based health policy and public health objectives aimed at reducing inequities in health.

In **Guyana**, the HSA process was vital in the formulation of the country's National Health Plan which was developed in conjunction with the HSA. The inclusive nature of the HSA process led to the involvement of technical staff in collecting information, discussing key issues, prioritizing public health objectives and making policy recommendations. Furthermore, the HSA's validated recommendations offered a starting point for identifying areas of technical cooperation with international technical and donor agencies. In Guyana, all of the technical and donor agencies were involved in the HSA process. In fact, a health sector thematic group was developed to discuss the issues that arouse from the HSA process. This group meets on a quarterly basis and includes participation from donor and technical agencies, Ministry of Health staff as well as participants in the private sector.

Middle level technical staff, were able to see that the outcome of all this [HSA process] was going to be, not just recommendations, but there would be a National Health Plan. I think because of that there was much greater interest and engagement. As a result, "we now have a health plan approved by Cabinet for 2003-2007."

Dr. Leslie Ramsammy
Minister of Health, Guyana
LACHSR Interview July, 2003

In **Haiti,** the HSA process enabled the country to obtain fresh analytical information. In turn, the country used this information in the negotiation of the components of the health sector reform loan with the Inter American Development Bank. Moreover, the recommendations resulting from the analysis were incorporated into the document presented by Haiti to the international donor community in June 2004.

The Way Forward

International cooperation in health has become more complex in recent years as a result of new global investment priorities, the change to less systemic and more specialized project profiles financed by multilateral development banks, greater participation by bilateral agencies, and the presence of nontraditional actors (private foundations, global funds). In addition, macroeconomic initiatives proposed by international financial institutions for foreign debt negotiation and poverty reduction, such as the Heavily Indebted Poor Countries (HIPC) Initiative and Poverty Reduction Strategy Papers (PRSP), usually contain components related to health. Also, national, regional, and international efforts to meet the global commitment to attain the Millennium Development Goals represent an opportunity to improve health systems.

In this scenario the HSA methodology is much more than a useful tool, it is an essential input for evidence-based health policy making, particularly considering that the new international health development milieu requires a concerted effort to strengthen national institutions, management skills, and human resources capabilities.

Presently, the HSA process is nearly complete in Puerto Rico. The Analysis will be published and disseminated by early 2005. National health authorities in Paraguay have requested a second application which is scheduled for April 2005. PAHO/WHO is also in the process of finalizing an updated version of the Analysis Guidelines with the inclusion of best practices and lessons learned thus far.

The Health Sector Analysis process has resulted in a set of valid policy recommendations for the health sector. These recommendations have served as a meaningful starting point for identifying areas of in-country cooperation with technical and donor agencies. Based on the HSA experience in the Region thus far, consensus around the validated recommendations has improved coordination among national and international agencies and has also contributed to reducing the duplication of efforts to improve health system performance in the Region.■

[1] Pan American Health Organization/World Health Organization (OPS/OMS). *Guidelines for the Preparation of Health Systems Profiles/Monitoring and Evaluation HSR in the Countries of the Region*. Washington, DC: PAHO/WHO; 2000. Available: http://www.lachsr.org/en/profiles.cfm.

[2] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Implementación de las OEPP para el Cuadrienio 1991-1994.* Washington DC: OPS/OMS; 1991:21.

[3] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Orientaciones Estratégicas y Programáticas 1995-1998.* Washington DC: OPS/OMS; 1995.

[4] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Orientaciones Estratégicas y Programáticas para la Oficina Sanitaria Panamericana 1999-2002.* Washington DC: OPS/OMS; 1998.

[5] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Plan Estratégico de la Oficina Sanitaria Panamericana para el Período 2003-2007. XXVI Conferencia Sanitaria Panamericana*. Washington, DC: OPS/OMS; 2002.

[6] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Lineamientos Metodológicos para la Realización de Análisis Sectoriales en Salud.* Washington, DC: OPS/OMS, Plan Regional de Inversiones en Ambiente y Salud (PIAS); 1996. (Technical Report Series No.6.)

[7] The main public sector institution entrusted with carrying out the National Health Authority function is the Ministry of Health. As such, the NHA is the primary entity responsible for exercising the Steering Role function for the health sector. Yet, in many countries the observed tendency is to elude the assignment of all Steering Role responsibilities to one institutional body. In this case, the National Health Authority is comprised by a set of government-level health actors, leading to the development of diverse and complementary institutional mechanisms that facilitate the exercise of the Steering Role function through more strategic, specialized and agile institutions. For more information see, Levcovitz, E. *Chapter 3: Analysis of the Structure, Organization and Policies of the Health Sector*. In: Pan American Health Organization/World Health Organization. *Health Sector Analysis: A Health Policy Formulation Enabling Tool - Methodological Guidelines.* Washington, DC: PAHO/WHO; 2005. (Forthcoming.)

HEALTH SECTOR REFORM TRENDS IN LAC

ARE HEALTH REFORMS AND HEALTH SYSTEMS DEVELOPMENT MOVING FORWARD?

PRISCILLA RIVAS-LORIA AND CAROLYN SHELTON
PAHO/WHO

In 1998, PAHO/WHO began working in cooperation with countries of the Region on the "*Guidelines for the Preparation of Health Systems Services Profiles in the Countries of the LAC Region*". Since then, nearly 35 country health systems profiles have been prepared by national health sector teams and submitted for peer review by recognized, national academic public health institutions. Due to political changes and progress made in the reform process, a large percentage of countries have updated their profiles and a second edition have been completed.

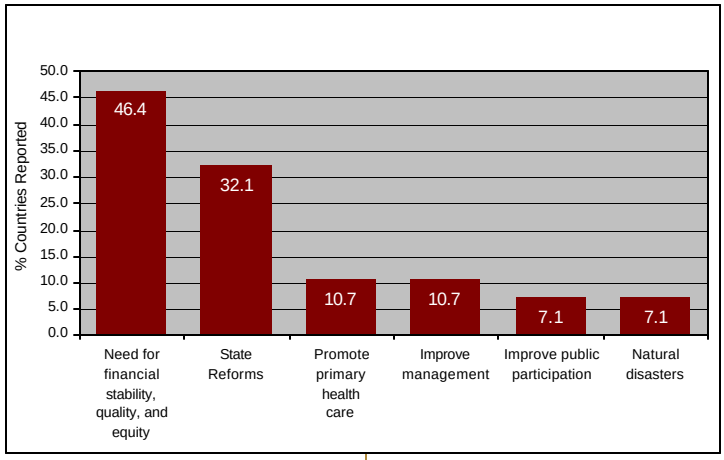
Based on the Health Systems Profiles, the *"Regional Analysis of Health Sector Reform in the LAC Region,"* seeks to consolidate, compare and examine the similarities, differences and especially the progress countries have made in their health sector reform efforts. The Analysis is based exclusively on information reported by the countries' National Health Authorities in their respective health systems profiles.

REPORTED FACTORS FOR INITIATING REFORM

The need for quality, accessible and equitable health care for the entire population has prompted reform in most countries of the Region. Chart 1 illustrates that nearly half of the countries in the Region initiated a reform of the health sector to achieve financial stability, quality and equity in the health system. This goal has proven to be an enormous challenge for which LAC countries continue striving to achieve.

Given that equity is the major pillar of the health sector reform objectives, the majority of LAC countries have made constitutional amendments to uphold the right to health for all, but *how* this right is manifested varies widely. The term *"right to health care"* is defined differently in each country, ranging from explicit definitions to general terms, such as *"health protection"* and *"social security by the State"* in other countries.

CHART 1: REPORTED FACTORS FOR INITIATING HSR
N=28 COUNTRIES



ORIGIN OF THE REFORMS

Given that the Region as a whole represents a diverse range of cultures, languages, levels of socio-economic development and health outcomes, these differences are also reflected in the reforms currently underway in each country. Despite differences in the process, design, and content of reforms, similarities across the Region do exist. For example, most countries in the Region began their reforms in the 1990s, with the exception of Brazil and Mexico in the 1970s and 1980s, respectively.

As many countries are undergoing economic structural adjustment and State reform, health has been incorporated into modernization of the State processes. Therefore, simultaneous changes are occurring within government structures and health care delivery systems, which impact the overall effectiveness and efficiency of the health reform process. Nearly one-third of LAC countries reported that the HSR process was initiated due to macro-level State reforms focalized on reducing public expenditures.

A smaller number of countries cited natural disasters as the driving force behind HSR. For example, in Montserrat, reform of the health sector was initiated after a prolonged volcanic eruption. This event resulted in negative economic growth, high unemployment and 60% of the population leaving the country.

Health Sector Reform Objectives

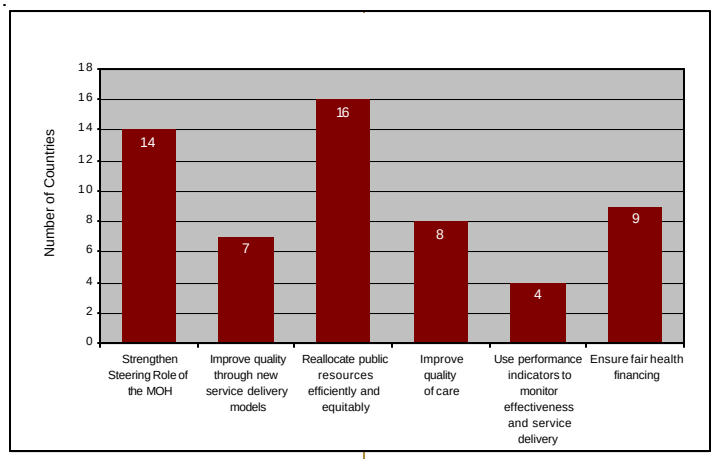
Most countries reported having developed specific agendas for the health reform process. Chart 2 illustrates the HSR objectives countries cited in their Health Systems Profiles.

Therefore, while many countries have identified HSR objectives, reforms have been implemented in many cases without specific quantifiable goals. Without the existence of a strategic action plan which delineates responsibilities and timelines, assessing improvements in health system performance will be nearly impossible.

Impact - Effectiveness

Few countries reported clear evidence that HSR has influenced the overall effectiveness and quality of the health system. Nevertheless, indicators such as infant and maternal mortality used to monitor these objectives have improved in selected countries. Brazil was the only country that attributed a direct link between improvements in infant mortality rates (IMR) and health sector reform efforts (Chart 3).

Chart 2: Reported HSR Objectives
N=35 countries



Design of HSR

The design of the reform process in the majority of the Region was undertaken by the Ministry of Health (MOH) with technical and financial support from international organizations such as the PAHO/WHO, the United States Agency for International Development (USAID), the Inter-American Development Bank (IDB) and the World Bank. Although most countries report that the MOH has exercised the leadership role in the design of health reforms, the economic sector led the initiation of health reforms in countries such as Nicaragua. Aside from donor involvement, international non-governmental organizations have also played significant roles.

Action Plans

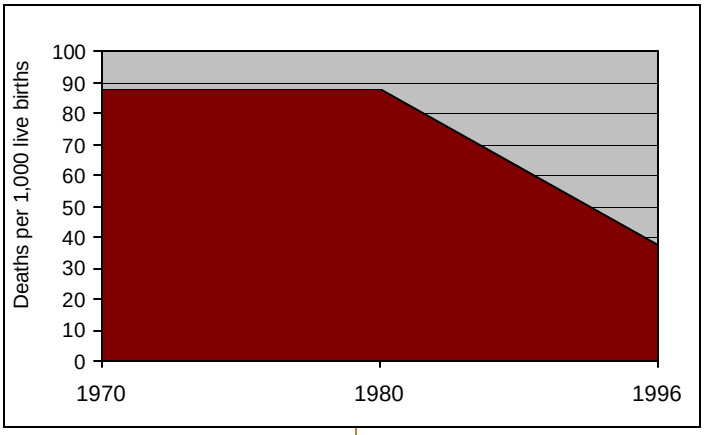
At the time the health systems profiles were submitted, countries implementing health reforms reported that formal action plans delineating quantifiable goals, deadlines and responsibilities had not yet been established. However, three countries emphasized the existence of action plans, which included specific goals, timelines and responsibilities for the implementation of reform activities. Chile reported the formulation of an action plan which outlines political actions and quantitative goals. Although Bolivia and Ecuador have demonstrated the existence of political will for implementing HSR, goals, timelines or fixed responsibilities have not been designated. Only Colombia reported that evaluation criteria had been defined at the beginning stages of the reform process.

Admittedly, it is difficult to assess the sustainability of various health reforms due to their recent nature and the general lack of monitoring systems to evaluate them. However, it is encouraging that **some countries are currently establishing mechanisms to monitor financial sustainability in the health sector while also noting that their intentions and capabilities to create sustainable health systems continue to face constraints that hinder this process**.

Social Participation

Generally, countries reported limited participation from the population, particularly in the beginning stages of the reform process. However, Colombia involved different interest groups during the initial phases of the reform process. Ecuador and Bolivia established laws to legally mandate social participation in the decision-making process. In Brazil, nearly all municipalities and states formed health councils comprised of health workers and users of health facilities to participate in discussions on health reform. In Honduras, the negotiation process included Association of Municipalities, academics, private companies, civil society organizations, lawmakers and policymakers.

CHART 3: BRAZIL LINKS INFANT MORTALITY DECLINE TO HEALTH SECTOR REFORM



WHERE IS HEALTH REFORM GOING IN LAC?

The evidence gathered from monitoring and evaluating health sector reform processes in LAC shows that despite gains in expanding coverage and improving the efficiency of health services delivery, many of the intended outcomes of health sector reform have not fully materialized. The aforementioned evidence suggests that strong political commitment to national health development is required for health sector reform and health systems development to have a positive impact. Within this context, National Health Authorities in the Region are increasingly faced with significant changes in health sector organization, with a trend towards the separation of health system functions and fragmentation of the health system. This has led to an increased demand by LAC countries for technical support and guidance to improve the leadership and institutional capacity of the National Health Authority.

Although HSR processes have centered on improving health systems by focusing on reducing inequities in access to services, financing health care, and promoting quality of care, to date the results obtained are questionable. It is noteworthy, that *Public Health* has been absent from the Health Sector Reform agenda, hence, i *mproving public health practice and strengthening the steering role of national health authorities* has been neglected. This has led to a consensus[1,2,3,4] on the need to Scale-Up Health Systems and Health Systems Performance improvement through *effective strategies and actions to strengthen the Steering Role and the Essential Public Health Functions (EPHFs).*[5,6]

The complete report "Health Sector Reform Trends in LAC" will be available March 2005 at http://www.lachsr.org.■

[1] Pan American Health Organization/World Health Organization (PAHO/WHO), LACHSR Regional Initiative. *Scaling Up Health Systems to Respond to the Challenge of HIV/AIDS in Latin America and the Caribbean*. Washington, DC: PAHO/WHO, LACHSR Regional Initiative; 2003. (Special Edition #8).

[2] Pan American Health Organization/World Health Organization (PAHO/WHO). *Public Health in the Americas.* Washington, DC: PAHO/WHO; 2002.

[3] Pan American Health Organization/World Health Organization (PAHO/WHO). *Health Systems Performance Assessment and Improvement in the Region of the Americas*. Washington DC: PAHO/WHO; 2001.

[4] Pan American Health Organization/World Health Organization (PAHO/WHO). *The Steering Role of the Ministries of Health in the Processes of the Health Sector Reform.* Washington DC: PAHO/WHO; 1997 (XL Directing Council: Document CD40/13).

[5] For a listing of the EPHFs refer to page 2 (Editorial) of this issue.

[6] Pan American Health Organization/World Health Organization (PAHO/WHO). *Steering Role of the Ministries of Health in the Processes of the Health Sector Reform.* Washington, DC: PAHO/WHO; 1997. (XL Directing Council: Resolution CD40.R12).

HUMAN RESOURCES AND HEALTH SYSTEMS
A NEW DEVELOPMENT PERSPECTIVE

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PAHO/WHO

The 1990s were characterized by a series of transformations in health systems which were primarily driven by economic and operational rationale. These changes left a profound imprint on the countries' social systems, especially in the areas of health and education. They also denoted a significant shift in the role of the State, focusing *inter alia* on structural aspects of the health services system and modifying it through decentralization, separation of health care financing and delivery roles, and the introduction of market mechanisms.

Notwithstanding, a series of major problems persist, such as inequitable access to services, the neglect of public health, the countries' lack of autonomy (specifically, that of the health authorities to run the sector and further the development of human resources in health). These problems intensified during the 1990s and have become significant components of an unfinished national health development agenda for the coming years. As in other areas of social development, the demands of old and new problems in human resources for health, such as those cited below, clamor for attention.

IMBALANCE BETWEEN THE AVAILABILITY AND DISTRIBUTION OF HUMAN RESOURCES

Serious imbalances exist between the availability and distribution of human health resources. Consequently, the Region suffers from deficiencies in the type, quality, and distribution of human resources required to meet its health needs in quantitative and qualitative terms.

In the year 2000, more than 50% of the countries of the Region exceeded the standards set in the 10 year Health Plan for the Americas of 1971 (8 physicians per 10,000 inhabitants).[1] However, the distribution and concentration of health professionals in urban areas remains the Region's most serious problem.

IMBALANCES IN OPPORTUNITIES FOR EDUCATION

Over the past three decades, the Region has witnessed an increase in education supply, in terms of the number of schools and vocational training programs. Given the current climate of strict austerity in public education, the number of medical schools, mainly private in nature, has increased fivefold in the past 40 years. Moreover, the supply of postgraduate and business-oriented continuing education programs has expanded unchecked without the concomitant creation of national systems to oversee quality or consider employment opportunities for new graduates.

Specialization is one of the most consistent trends in the Region. A study of eight selected countries[2] reveals that the number of accredited specialties range from 38 in Chile to 91 in Costa Rica. Moreover, the figure for specialization in general surgery and clinical medicine ranges from 45% of medical residents in Argentina to 82% in Panama.

Evaluations of health and medical education systems in conjunction with attempts to adjust training programs has led to a better understanding that health and medical education is a continuum. The process of acquiring knowledge does not only include the initial phases of training (general and specialized), but also learning inherent in the exercise of professional practice.

DETERIORATION IN THE WORKING CONDITIONS OF HUMAN HEALTH RESOURCES AND ITS IMPACT ON SECTOR GOVERNANCE

Several studies clearly show the transformation of working conditions in the health system, which in the past decade has been marked by growing job insecurity and the proliferation of incentive and temporary contract systems. The result has been a deterioration in the working conditions of human health resources that has adversely affected the quality of the work itself.

The impact of fiscal crises and subsequent State-level reforms combined with lengthy processes of institutional modernization has aroused resistance among those working in the public sector, particularly those working in public health services. This resistance has perpetuated conflicts and breakdowns in sectoral governance.

In 2003, a study of unions and professional organizations in the Region's health sector[3] compiled information on 37 nationwide conflicts in 12 countries of the Region. In fact, the study itself made it possible to set up a system for monitoring conflicts among human resources in the health sector.

Study findings indicated little consideration for human resources as an important asset as well as the lack of legal frameworks, resources or initiatives to retain and improve the workforce required to address the health needs of the population. Every day, health worker outmigration (i.e. *"brain drain"*) figures make this problem increasingly clear.

Future Challenges

After a decade of neglect, there is finally a global consensus on the central role of human resources in the transformation of health systems. For the past two years, the *Joint Learning Initiative (JLI)*[4] has worked to bring a series of global actors, agencies and donors together to develop an agenda for action. The Initiative is now making an effort to bring the human resources in health agenda to the fore in discussions with political leaders.

The World Health Organization has decided that World Health Day 2006 will focus on the weakest link of health systems, human health resources. Furthermore, emphasis will be placed on the need for joint action to eliminate the qualitative and quantitative staffing deficiencies that assume tragic proportions in Regions ravaged by malaria and other diseases.

A far-reaching action-oriented strategy is planned to tackle issues such as staffing shortages, the out-migration of health care professionals, staff retention problems and the need to match staff distribution and capabilities with the needs of the population. This approach is expected to denote the beginning of a decade of sustained effort to develop human resources in health.

PAHO/WHO has undertaken pioneering work along these lines making seminal contributions to best practices in human resources development.[5, 6] Its actions have centered on providing technical assistance to LAC countries in their efforts to establish sustainable consensus-building through their Observatories of Human Resources for Health.[7] Moreover, significant technical cooperation efforts have centered on institutional capacity building through country-focused technical cooperation, and in promoting the reorientation of teaching and practice methods and content for health professionals and public health.

The Directing Council of PAHO/WHO recently issued a mandate specifically emphasizing the centrality of human resources policies in the Region,[8] underscoring:

- The need to establish permanent ties with national education and labor authorities to bring about change through a multisectoral approach.
- The construction of subregional agendas based on the reality of expanded labor markets that transcend national borders and are linked to the migration of health care professionals.
- The intensification of efforts in key countries, where human resources constitutes the foundation for strengthening health institutions.

PAHO/WHO intends to adopt this mandate as a guide for action and a framework for revitalizing the commitment of health workers and health organizations to achieve compassionate high quality care, and scientifically sound professional practice.■

http://www.lachsr.org/observatorio/eng/index.html

[1] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Plan Decenal de Salud para las Américas. Informe Final de la III Reunión Especial de Ministros de Salud de las Américas. Santiago, Chile 2-9 de Octubre de 1972*. Washington, DC: OPS/OMS; 1973. (Official Document No.118).

[2] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Especialidades Médicas en América Latina: Análisis de su Disponibilidad e Institucionalidad en 8 Países Seleccionados*. Washington, DC: OPS/OMS; December 1999. (Human Resources Development Series No.22.)

[3] Scavino, Julio J. *Panorama de Organizaciones de Profesionales y Trabajadores de la Salud en las Américas*. Washington, DC: Organización Panamericana de la Salud/Organización Mundial de la Salud; Novermber 2003. (Human Resources Development Series No. 35.).

[4] The Joint Learning Initiative (JLI), a network of world leaders in health, was launched by the Rockefeller Foundation and supported by the secretariat of Harvard University's Global Equity Initiative (GEI).

[5] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS), Iniciativa Regional LACRSS. *Estabilidad y Remuneraciones: El Personal de Salud del Ecuador a Inicios del Siglo XXI*. Washington, DC: OPS/OMS, Iniciativa Regional LACRSS; 2004. (Special Edition No.10).

[6] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS), Iniciativa Regional LACRSS. *Profesionalización de Auxiliares de Enfermería en América Latina*. Washington, DC: OPS/OMS, Iniciativa Regional LACRSS; January 2005. (Special Edition No.13).

[7] Pan American Health Organization/World Health Organization (PAHO/WHO). *Observatory of Human Resources in Health, 27 September - 1 October, 2004.* Washington, DC: PAHO/WHO; 2004. [XLV Directing Council: Resolution CD45/9 (Eng.)].

[8] Ibid.

USING BLENDED LEARNING TO STRENGTHEN MANAGEMENT AND LEADERSHIP IN LATIN AMERICA

S. JOHNSON AND J. SELTZER
MSH

Management Sciences for Health's Management and Leadership (M&L) Program has strengthened leadership and management in Latin America through innovative uses of electronic communications to support managers at all levels. Two USAID-funded blended learning programs, the Virtual Leadership Development Program and the Business Planning Program, combine face-to-face learning with ongoing coaching using electronic technologies. M&L offers managers approaches to management and leadership development that can be customized to match their learning styles and organizational context.

VIRTUAL LEADERSHIP DEVELOPMENT PROGRAM (VLDP)

The VLDP is an interactive, Internet-based program that helps health managers to strengthen their leadership skills and competencies by working on challenges from their own organizations. Participants in the VLDP have improved team performance, addressed critical issues in their workplaces, initiated institutional changes, and improved organizational results. Teams from Ministries of Health, NGOs, and other institutions throughout Latin America have successfully completed the VLDP.

THE CHALLENGE: RESPONDING TO EMERGING HEALTH SECTOR NEEDS

In today's rapidly changing health sector environment, organizations and governments require strong leadership to contend with diminishing resources, emerging health problems, and changing political and economic circumstances. Traditional ways to build organizational capacity, such as sending individual staff to off-site workshops and courses, can be slow and costly, and may disrupt services. Other disadvantages of traditional approaches include a theoretical rather than practical focus and participation of too few staff from the same organization. The trainees are likely to find it difficult to generate support for institutional change, and their learning does not benefit from the perspectives of people from other countries and institutions facing similar issues.

THE RESPONSE: CONTINUOUS MANAGEMENT AND LEADERSHIP DEVELOPMENT

In response to demand from public and private health care organizations for cost-effective, practical, and accessible leadership and management development, MSH designed the 12-week Virtual Leadership Development Program. The program consists of an introductory module, five leadership development modules, and a final module for reflection and evaluation. Each team participates using the VLDP Internet site, a CD-ROM, and a print workbook. After completing the program, participants become members of a virtual network called LeaderNet, through which they receive coaching and support to advance further with their challenges.

Virtual facilitators support teams from individual organizations as they work through the modules to address the real challenges they face in their organizations. Teams are enrolled so that all the skills needed to address different types of challenges are represented, and team members can work together to initiate changes in their organizations. Participants identify and address these challenges, examine their leadership skills and styles, and learn how to be better managers and teams.

USING BLENDED LEARNING TO ADDRESS REAL ORGANIZATIONAL CHALLENGES

Challenges that teams have addressed include diversifying funding sources, institutionalizing a quality assurance program, and redesigning the referral process. MSH staff facilitate the program, providing support and feedback to participants via email, telephone calls, and Web site postings.

Expert facilitation is vital to the program's success. Experienced facilitators work closely together, rotating responsibility for the facilitation. The facilitators post daily announcements, drawing attention to a particular topic in the readings, commenting on participants' discussions, or raising provocative questions. They also review and respond to each team's homework and provide feedback on each team's progress in addressing its organizational challenge.

POSSIBILITIES FOR REPLICATION

The VLDP was developed in Spanish for delivery in Latin America and has been translated into Portuguese and English. The program materials, including the workbook and CD-ROM, make it possible to participate even without good connectivity. The program is appropriate for senior management teams in public-sector institutions and NGOs, as well as managers at a decentralized level.

The VLDP can be delivered to several organizations simultaneously or to multiple teams from a single institution. It can be offered to managers of reproductive health, HIV/AIDS, or tuberculosis programs and other health programs. The training and leadership development activities of the program can be easily integrated with other management and leadership development training and technical assistance and tailored to the needs of client organizations.

Virtual Leadership Development in Honduras

ASHONPLAFA is an IPPF affiliate that has provided education and clinical and community reproductive health services through six regional centers for more than 20 years. ASHONPLAFA'S top management team actively participated in the VLDP. The challenge they chose to work on was "Developing Marketing Strategies" for their NGO. Since completing the VLDP, they have created a new marketing program in their organization, with marketing indicators and a database. Because they were very satisfied with the program, they enrolled two more management teams in the VLDP. Since the second VLDP ended in June 2003, they have continued to work on their challenges, which include improving drug logistics and the quality of eyeglasses. They have also registered for virtual coaching to continue to get support and feedback from MSH on addressing their challenges.

"Congratulations to the coordinators. They helped us to recognize our strengths and weaknesses to improve our personal and organizational performance." —Humberto Cerrato, ASHONPLAFA, Honduras.

Through the VLDP, blended learning efficiently and effectively supports managers who lead health service organizations. Participants who evaluated the first VLDP felt that the program was stimulating and innovative, and supported them in working on their institutional challenges. One participant commented that *"The program helped to solidify the need to deal with this challenge. We were motivated or pushed by the program to deal with it head on."*

MSH'S BUSINESS PLANNING PROGRAM (BPP)

The BPP helps NGOs expand and diversify their funding sources, so they can finance the development and introduction of new products and services that will meet their clients' needs. This program, entitled "The Art of Crafting a Business Plan for Social Return on Investment," equips organizations to develop business plans that advance their missions. During the program, participants learn how to capture and package breakthrough ideas, identify target markets and marketing strategies, determine the best staff to develop the ideas, and navigate the financial aspects of a business plan, including projections of social and some financial returns.

The Challenge: Diversifying Funding Streams and Financial Risk

Many NGOs face reductions in their funding from traditional donors and need to diversify their funding streams. For example, PROCOSI, a Bolivian health network of national and international NGOs, works to improve the health of the neediest populations, especially children and women, by improving institutional coordination, strengthening member institutions, and advocating for effective national health policies. Financial support for PROCOSI, which has been primarily provided through USAID funding, allowed PROCOSI to give subgrants to member organizations. These grants represented 5% to 80% of the members' total annual funding. As USAID phases out its funding, if PROCOSI members do not diversify their funding sources, they will have to rely more on paying clients to recover their costs.

The Response: Crafting Business Plans for Social Return

MSH designed the Business Planning Program to deliver critical skills to NGOs like PROCOSI. The participants gain experience in designing and introducing new products and services that can make a measurable difference in the health and welfare of their target populations. The program uses language and a format that is familiar to the private business and philanthropy sectors, so participants increase their abilities to successfully present new products and services to potential funding sources in these sectors.

Using Blended Learning to Build Capacity

The BPP combines face-to-face and electronic methodologies to allow participating organizations to build expertise in developing business plans. During the program, participants develop sound business plans and acquire skills they can use to draft business plans in the future.

The BPP consists of six self-contained modules housed on a CD-ROM. Each module contains questions, assignments, and reference materials, and culminates in the completion of one section of the business plan. After a one-week, face-to-face program orientation, participants return to their worksites, where they draft sections of their business plans, while consulting via e-mail with an assigned reviewer. Reviewers are content experts who coach the participants and address any

questions and concerns before the final version of each section is completed. A team of three to six people from each organization authors the business plan, soliciting help from others in their organization as needed. A team captain oversees the completion of the assignments and communicates with the team's reviewer.

Possibilities for Replication: Establishing Program Partners

The model for replication has three steps:

- MSH identifies one or two NGOs in the region to be trained as program partners. These partners must have a reputation for delivering cutting-edge management and leadership programs in the region and have enough staff to participate in the program and incorporate it into their consulting practice.
- The program partners participate in the BPP and receive training and materials to deliver the program to other groups in the Region.
- The program partners promote and deliver the BPP to organizations in their region who are working to improve public health in the developing world. MSH provides updated materials, learning aids, and market leads to the partners.

The business model of the BPP affords the program partners three potential streams of revenue: funding for their business plans; revenue from the sales of products and services introduced to their target communities; and income to cover costs from BPP enrollment fees.

Many participants in the BPP have received funding for their business plans. For example, the Ministry of Municipalities is considering a contract with PROCOSI to deliver the BPP to more than 300 municipal officials. PROCOSI has already received requests for the BPP from Brazil, Ecuador, Guatemala, Nicaragua, and Paraguay. APROSAR has received a large grant for the development and production of their manual.

The use of blended learning has advanced the capacity of PROCOSI's member organizations to significantly expand their funding base, while improving their ability to make a difference in the health of Bolivia's poor communities by targeting programs to their specific needs. One participant stated that "*this business planning program allows us to reflect carefully about not only what our organizations are today, but also what they could be tomorrow.*"

A Bolivian Nonprofit Generates a Breakthrough Idea

Bolivia has two distinct health systems: the western medical system and the indigenous medical system. In the altiplano city of Oruro, over 80% of the population consults exclusively with traditional healers. Despite the complementary relationship between traditional and western medicine, the Bolivian medical system does not provide a mechanism for practitioners of either system to learn from the experiences of the other.

The Asociación de Promotores de Salud de Area Rural (APROSAR) seeks to address this lack of cross-fertilization. APROSAR, a nonprofit organization, proposed to develop and produce a manual that will cross-reference western and traditional practices and treatments. The manual will help educate practitioners to deliver treatments in a culturally sensitive fashion while elevating levels of adherence to treatment. ■

DETERMINING THE EFFECT OF HEALTH SECTOR REFORM ON PHARMACEUTICAL SUPPLY SYSTEMS IN LATIN AMERICA

EDGAR BARILLAS
MSHPLUS

In the early 1990s, the convergence of social, economic, and political factors in Latin America trigered what is known today as Health Sector Reform (HSR). The most important of these factors were the consolidation of market economies; the increasing costs of health care; the renewed importance of human capital as an engine of economic development; and a perceived inefficiency and inequity of the public sector, particularly in the areas of health and education. Within this context, the Inter-American Development Bank (IDB) and the World Bank made a decision to include HSR in their technical and financial agendas for the region.[1] With their support, by the end of the last decade most Latin American countries were somewhere between the design phase and the initial implementation phase of reform.

Although HSR proposals differ from country to country, most of the planned reforms share similar components: decentralization, separation of functions, social participation, private contracting, changes in the management model, increased private participation in financing models, increased prepaid financing, and the design of basic health packages.

The HSR changes implemented may have a direct or indirect effect on the components of the pharmaceutical supply cycle (selection, procurement, distribution, and use), resulting in a process affecting the structures and organization of the pharmaceutical supply system.

In El Salvador, the administrative decentralization of 30 public hospitals led to the delegation of pharmaceutical procurement to the respective procurement units in those hospitals. While providing more administrative autonomy, the new system led to high unit prices for procured medicines, due to lack of economies of scale, as well as difficulties in assuring product quality. A recent study[2] revealed that acquisition prices were 48 percent higher in hospitals, compared with prices obtained by the Ministry of Health (MOH) through a centralized tender for its primary care facilities. Following up on these findings, the MOH decided to restructure its pharmaceutical supply system. It worked with the decentralized hospitals to carry out a joint tender in 2003 for hospital and primary care center medicine requirements and obtained a savings of 18 percent relative to the approved budget.[3]

Although other public sector pharmaceutical supply systems in the region are undergoing changes, decisions to restructure these systems may not have benefited from an analysis of lessons learned from reform experiences, as in El Salvador, and baseline data may not have been collected for impact evaluation. *Management Sciences for Health's Rational Pharmaceutical Management Plus* (RPM*Plus*) *Program* is developing a conceptual framework to guide a systematic approach to analyzing and understanding ongoing changes in pharmaceutical supply systems. With this framework, national experiences in the region will be assessed to determine the direct or indirect effects of HSR on the pharmaceutical supply system, as well as the impact of these reforms on institutions and consumers. Work on the framework has begun and a couple of countries will be selected for case studies to test the framework. A report on the framework and country case studies is expected by December 2004. The information collected can serve as a baseline for countries initiating the reform process; as a comprehensive evaluation of the effects of the changes on the structure and the users of the pharmaceutical system; and as a source of much-needed evidence for countries planning to undertake similar reform processes. For further information regarding pharmaceutical supply systems and health reform and the proposed conceptual framework, please refer to **www.msh.org/rpmplus/**.

[1] Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). *Vol.I. La Salud en las Américas.* Edition 2002. Washington, DC: OPS/OMS; 2002. (Scientific and Technical Publication No.587).

[2] Chaves, A., et al. 2002. *Sistema de Suministro de Medicamentos en El Salvador*. Arlington, VA: Management Sciences for Health.

[3] Center for Pharmaceutical Management. 2003. Strategies *for Enhancing Access to Medicines Year 3 Report*. Prepared for the Strategies for Enhancing Access to Medicines Program. Arlington, VA: Management Sciences for Health.

EXCLUSION IN HEALTH IN LAC

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OPS/OMS

Exclusion in health is a subject of growing importance in the public policy arena, not only as a problem that should be confronted and resolved, but also as an analytical tool to evaluate interventions designed to improve people's health status.

Despite the importance of exclusion in health as a social phenomenon and public policy problem, it is not currently on the list of priority issues for the socio-political agenda of countries in the Region. Furthermore, sectoral reforms have touched on this issue in an indirect and fragmented manner.

One factor that hinders the discussion of exclusion in health in the Region's countries is that its magnitude, causal factors and affected populations are not accurately known at the present time. It is also unclear which interventions have proven more efficient in addressing exclusion. This is primarily due to the:

- Multi-causal nature of exclusion in health, which makes its measurement complex; and
- Scarcity of methodological instruments for characterizing and measuring the problem.

Thus, it is necessary to generate tools to analyze the subject in-depth and with accuracy. Specifically, instruments are required to make it possible to analyze exclusion in health as an important determinant of the health situation of a country, region, province, or state; to identify the political, social, economic, and demographic characteristics associated with social exclusion in health; to identify its contributing factors; and to pinpoint the interventions or strategies most effective in reducing it. With the development of these areas, it will be possible to identify the most adequate mechanisms for expanding social protection in health under different conditions and to contribute to better decision-making in this area.

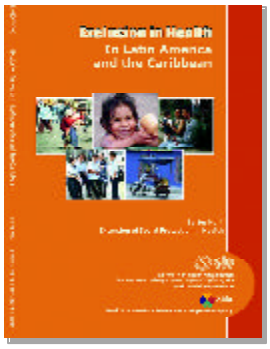
A join initiative between the Pan American Health Organization (PAHO/WHO) and the Swedish International Development Cooperation Agency (SIDA) was consolidated in 2000 to address the problem of exclusion in health in the Region, through the expansion of social protection in health. As part of this Initiative, the publication, "Exclusion in Health in Latin America and the Caribbean[1]," presents the results of 6 country studies conducted between 2001 and 2003 with the objective of characterizing and measuring exclusion in health. The country studies were conducted in Ecuador, Guatemala, Honduras, Peru, Paraguay, and the Dominican Republic.

The study shows that exclusion in health appears to be strongly linked to:

- poverty;
- marginality;
- racial discrimination and other forms of social exclusion; as well as cultural patterns including language;
- informal employment structures;
- underemployment and unemployment;
- geographical isolation, especially linked to rurality;
- lack of basic services such as electricity, drinkable water, and basic sanitation; and
- low level of education or insufficient information for health service users.

Dimensions of exclusion in health also appear to depend on variables related to the health sector itself, such as the service delivery model; the deficit of adequate infrastructure to respond to the demand for health; and the allocation of human and financial resources within the health system.

The group of methodologies utilized for the measurement of exclusion in health in the aforementioned study proved to be highly explanatory of different dimensions of exclusion in health as well as the phenomenon as a whole. The measurement of exclusion in health using this methodology may constitute an important instrument for the definition of social policies in the countries.■



Exclusion in Health in Latin America and the Caribbean

This publication presents the results of 6 country studies conducted between 2001 and 2003 with the objective of characterizing and measuring exclusion in health. The country studies were conducted in Ecuador, Guatemala, Honduras, Peru, Paraguay, and the Dominican Republic.

[1] Pan American Health Organization/World Health Organization (PAHO/WHO). *Exclusion in Health in Latin America and the Caribbean.* Washington, DC: PAHO/WHO; 2003. (Extension of Social Protection in Health Series No.1.)

NATIONAL HEALTH ACCOUNTS IN LAC

PAST AND PRESENT NHA ACTIVITIES OF THE LACHSR INITIATIVE

JACK GALLOWAY
PHR*PLUS*

National Health Accounts (NHA) is a tool for gathering national health financing and expenditure data over a defined period of time. NHA maps the way financial resources for health are generated as well as expended, tracks expenditure flows, and links the sources of funds to service providers and their end users. This information is indispensable for policy makers who determine how resources will be allocated in the health sector.

NHA is a useful tool for understanding many health care financing issues in low- and middle-income countries. While individual countries have addressed these issues on their own, there are significant benefits from cross-country collaboration in the development of NHA estimations. The Partnerships for Health Reform Project (PHR), a predecessor to The Partners for Health Reform-*plus* Project (PHR*plus*), in collaboration with the Pan American Health Organization/World Health Organization (PAHO/WHO), brought together technical representatives from Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua and Peru to form the LACNHA Regional Network.

This NHA Regional Network was developed through three workshops and in-country technical assistance over a sixteen-month period from April 1997 through July 1998. The workshops allowed technical country teams to learn NHA methodology; formulate a regional conceptual framework, comparable definitions, and data sources; and collaborate in solving problems encountered in developing their respective national accounts. Technical representatives from Haiti, Jamaica and Honduras also attended the third regional workshop to familiarize themselves with the NHA methodology and learn how to use NHA data.

Following the initial development of the LAC NHA network, PHR and PAHO/WHO collaborated in the spring of 1999 to bring international donors, regional policy makers and technical staff from eleven countries to a seminar in El Salvador. The seminar focused on the need to increase the policy relevance of NHA results and incorporate them into policy formulations as well as the need to communicate the NHA data effectively to high-level policymakers within the LAC Region. The seminar also highlighted the need for and benefits of NHA for health sector planning and the need for further attention to specific technical needs of technical teams as they continue to implement NHA and attempt to institutionalize it in their respective countries.

In order to build on the previous work of the LACHSR Initiative and update NHA technical teams throughout the LAC Region on the most current international standards for the estimation of NHA based on the recently published *Guide To Producing NHA with Special Applications for Low-and Middle-Income Countries*,[1] PHR*plus* conducted an intensive six-day training workshop in Montelimar, Nicaragua from July 27 – August 2, 2003. Technical teams attended the workshop from Bolivia, the Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru. The PHR*plus* technical team, accompanied by additional NHA international experts from the LAC Region, presented the most current methodology for estimating NHA as well as new analytic tools such as the NHA sub-analysis on HIV/AIDS and TB and the sub-national NHA estimations. The workshop also provided NHA teams from twelve LAC countries an opportunity to share experiences, identify areas of inquiry, and discuss the use of NHA in the formulation of health policy.

To provide continued support within the LAC Region as well as provide ongoing support to technical country teams who attended the NHA Workshop in Montelimar, Nicaragua, in 2004 PHR*plus* technical experts:

1. Proactively solicited questions and concerns from NHA technical teams that participated in the workshop in Montelimar and facilitated dialogue via the internet with the NHA Experts' Panel that was established in December, 2003. PHRplus translates concerns and issues raised by LAC non-English speakers to the Experts' Panel and ensures that responses are translated and transmitted to our LAC country partners.

2. Constructed and sent methodological updates as well as a synthesis of the questions/responses and discussions which take place through the Experts' Panel web page to our LAC partners on a regular basis. This information is sent by e-mail in language appropriate form in order to eliminate both language and technology barriers.

3. Tracked the progress of NHA institutionalization in LAC countries to determine:
   - How countries are implementing NHA
   - Who is involved with NHA in terms of individuals as well as institutions
   - What policy issues are being addressed with NHA data

These activities promote conversion to internationally accepted NHA estimation methodology for international comparability while maintaining national health accounts for national/domestic health policy formulation; s upport institutionalization of NHA; and increase knowledge and use of NHA for tracking expenditures on HIV/AIDS in the LAC Region.

For further information related to items mentioned in this article, please contact: Mary_Diehl@abtassoc.com.■

[1] Guide To Producing NHA with Special Applications for Low- and Middle- Income Countries, published by the World Bank, WHO and USAID is available at: http://whqlibdoc.who.int/publications/2003/9241546077.pdf.

THE NEXT GENERATION OF REFORMS, PUBLIC HEALTH, AND THE MILLENNIUM DEVELOPMENT GOALS IN LAC

CAROLYN SHELTON
PAHO/WHO

On March 15, 2004, a technical seminar co-sponsored by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the United States Agency for International Development (USAID) was held at the National Press Club in Washington, D.C. to discuss, *"The Next Generation of Reforms, Public Health, and the Millennium Development Goals in Latin America and the Caribbean."* In addition, the redesigned and updated *LAC Regional Health Sector Reform (LACHSR) Initiative* Website (*www.lachsr.org*) was launched.

Dr. Ruth Frischer of the Health and Nutrition unit in the LAC Bureau, USAID, moderated the seminar. The panelists included:

- Dr. Daniel Lopez-Acuña, Director of Program Management, PAHO/WHO;
- Dr. Ilona Kickbusch, PAHO/WHO Senior Advisor for Millennium Goals and Health Targets;
- Dr. Riita-Liisa Kolehmainen-Aitken, Principal Program Associate, Health Reform and Financing Unit, Management Sciences for Health (MSH); and
- Dr. Priscilla Rivas-Loria, Regional Advisor in Health Sector Reform, Health Policies and Systems Unit, PAHO/WHO.

The panelists contended that to effectively implement interventions that will enable the attainment of the MDGs it is necessary to reconcile and revitalize the health sector reform agenda with efforts to scale up health systems and to strengthen public health infrastructure.

Within the context of this discussion, a brief presentation marked the launching of the redesigned and updated database-driven *Latin America and Caribbean Regional Health Sector Reform Initiative* Website. The presentation emphasized the Initiative's efforts to increase access to evidence-based information on Health Sector Reform and Extension of Social Protection in Health.

Information on the *LACHSR Initiative* website effectively gathers, systematizes and disseminates the evidence resulting from monitoring and evaluating the Health Sector Reform processes, the performance of the Essential Public Health Functions and the nature of social exclusion in the Region. The ultimate goal of the LACHSR Initiative site is to inform health policy decision makers to address the major challenges and opportunities health systems face to attain the MDGs, formulate the next generation of health reforms, and promote Extension of Social Protection in Health.■

Dr. Ruth Frischer of the Health and Nutrition unit in the LAC Bureau, USAID, moderated the seminar. The panelists included, Dr. Daniel Lopez-Acuña, Director Program Management, PAHO/WHO; Dr. Ilona Kickbusch, PAHO/WHO Senior Advisor for Millennium Goals and Health Targets; Dr. Riitta-Liisa Kolehmainen-Aitken, Principal Program Associate, Health Reform and Financing Unit, Management Sciences for Health (MSH); and Dr. Priscilla Rivas-Loria, Regional Advisor in Health Sector Reform, Health Policies and Systems Unit, PAHO/WHO.

5TH EUROLAC FORUM: IMPROVING HEALTH SYSTEMS PERFORMANCE AND HEALTH OUTCOMES

RECIFE, BRAZIL - APRIL 13-16, 2004

CAROLYN SHELTON
PAHO/WHO

On April 13-16, 2004, the Pan-American Health Organization/World Health Organization (PAHO/WHO), together with the World Bank, the Ministry of Health of Brazil and the Inter-American Development Bank hosted the 5th EUROLAC Forum in Recife, Brazil. Forum participants represented health ministries and health related institutions from Latin American, Caribbean and European countries. The 2004 Forum focused on themes related to improving health systems performance and health outcomes in the LAC Region within the context of achieving progress towards the Millennium Development Goals (MDGs). The Forum objectives were to promote:

- **Debate and discussion on issues related to MDGs** in the context of improving health system performance and health outcomes;
- **Exchange of experience, innovative technologies, and new information** on improving health system performance and health outcomes through approaches that address issues of accessibility, availability, and quality, especially in meeting the needs of the poor;
- **Greater understanding of the challenges faced by other countries** in confronting these issues, the steps that have been taken to address them, and how these may be relevant to countries in the LAC Region.

Dr. Daniel López-Acuña, Director of Program Management, PAHO/WHO, participated in the opening session of the Forum by setting the stage for facing the challenges and implications of the MDGs for the LAC Region. Dr. López-Acuña emphasized that the level of MDG attainment in LAC countries is directly linked to the effectiveness and performance of the health system. In order for countries to reach the current MDG targets for 2015, health systems must scale up their efforts in: health information systems, monitoring and evaluation of health indicators, incorporation of excluded groups and human resources development, among other areas. Dr. López-Acuña concluded that it is crucial for countries to take a system-wide approach in the planning and implementation of interventions to achieve the MDGs by fostering a multisectoral dialogue with key national and international actors in the health sector.

The LAC Regional Health Sector Reform Initiative participated in the recent EUROLAC Forum by showcasing health policy decision-making and health management tools and methodologies developed by the Initiative in an Innovations Fair which included additional booths of programs and tools of various ministries of health and/or international organizations.

Each item displayed in the Initiative booth responds to a specific need in an area of health sector reform and represents different innovations in the reform process. A selection of the tools highlighted in the *LACHSR Initiative* booth included:

- Strengthening the Steering Role of National Health Authorities
- Health Sector Analysis Framework
- Framework for the Formulation of National Policies on Human Resources in Health Methodology for Monitoring and Evaluating Health Sector Reforms in LAC
- National Health Accounts (NHA)
- AIDSTREATCOST
- Decentralization Mapping Tool (DMT)

The Health TV Channel Inc., an international non-profit organization with a mission to provide health education and training, included the EUROLAC Innovations Fair as part of its worldwide broadcast. Kelly Saldaña, Public Health Advisor in the Latin America and Caribbean Health Bureau of the US Agency for International Development (USAID) and Dr. Priscilla Rivas-Loria, Regional Advisor on Health Sector Reform of PAHO/WHO, were interviewed about the work of the Initiative in the LAC Region. Both discussed the importance of disseminating the products of the Initiative in forums such as EUROLAC.

From left to right: Julio Suárez, PAHO/WHO, Brazil; Evelyn Martinez, PAHO/WHO, Washington, DC; Edmundo Gallo, Ministry of Health, Brazil; Eduardo Levcovitz, PAHO/WHO, Washington, DC; Nata Menatbe, WHO/EURO; Priscilla Rivas-Loria, PAHO/WHO, Washington, DC; Pedro Brito, PAHO/WHO, Washington, DC; Candelaria Araoz, PAHO/WHO, Washington, DC; Carolyn Shelton, PAHO/WHO, Washington, DC; Manuel Vidaurre, PAHO/WHO, Washington, DC.

HEALTH SECTOR REFORM

- The pressing issues that prompted HSR include the need for financial stability, improvement in quality of health care, and the attainment of equitable access to health services.
- Few countries report more efficient mechanisms for resource allocation. *Chile, Costa Rica, and Peru* reported that HSR has positively impacted the management of resources in the health sector.
- All countries of the Region report that the Ministry of Health exercises the primary steering role function of the health sector. The countries that report having examined the steering role function include: *Brazil, Chile, Colombia, Ecuador, Jamaica, Mexico, Paraguay, Trinidad and Tobago, and Uruguay.*
- Several countries, such as *Argentina, Bolivia, Colombia, Mexico, Paraguay, and Suriname,* have focused their efforts on increasing access to health services for specific vulnerable groups.
- *Costa Rica and Brazil* experienced declines in infant mortality (IMR) and maternal mortality (MMR) rates and in low birth weight (LBW) prevalence throughout their HSR processes.
- *Brazil* is the only country that directly links health reform with improvements in health indicators. Between 1970 and 1980, the average IMR was 87.8 deaths per 1,000 live births and according to most recent national estimates (2000), the country's total IMR was 28.3 per 1,000 live births.
- *Brazil, Colombia and Costa Rica* report that HSR has influenced the country's health situation as it relates to the supply of drinking water and sewerage services.

Source: PAHO/WHO, *"Health Sector Reform Trends in LAC" (publication forthcaming March 2005).*

ESSENTIAL PUBLIC HEALTH FUNCTIONS

- The Essential Public Health Functions (EPHF) performance evaluation, undertaken in the LAC Region, reveals the highest attainment for the functions related to "Reduction of Emergencies and Disasters Impact;" and "Public Health Surveillance."
- The lowest attainment reported was in the functions of "Human Resources Development and Training in Public Health"; "Quality Assurance in Health Services"; and "Public Health Research."

Source: PAHO/WHO,*Public Health in the Americas: Conceptual Renewal, Performance Assessment and Bases for Action*, Washington DC: PAHO/WHO; 2002.

EXTENSION OF SOCIAL PROTECTION IN HEALTH

- A strong association between low public expenditure in health and lack of coverage in health has been established.
- A strong correlation between lack of coverage and lack of health insurance among the rural population has been determined as well as a disproportionably high out of pocket expenditures among rural populations.
- Poverty is highly correlated with lack of basic health services.
- Indigenous origin is strongly associated to lack of coverage for basic health services leading to high out of pocket expenditures and high infant mortality.

Source: PAHO/WHO.*Exclusion in Health in Latin America and the Caribbean.* Washington, DC: PAHO/WHO; 2003. (Extension of Social Protection in Health Series No.1).

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