



December 1998

1

Methodology for Monitoring
and Evaluation of Health Sector
Reform in Latin America and
the Caribbean

TABLE OF CONTENTS

1. INTRODUCTION	1
2. CONCEPTUAL FRAMEWORK.....	3
3. WHAT IS THE METHODOLOGY AND HOW IS IT USED?	5
WHAT IS THE METHODOLOGY?	5
TO WHOM IS THE METHODOLOGY DIRECTED?	5
WHAT INFORMATION TO UTILIZE AND WHERE TO OBTAIN IT?	6
USE OF THE VARIABLE AND INDICATORS SECTION	6
HOW TO SUBMIT THE REPORT	7
4. VARIABLES AND INDICATORS	9
4.1 MONITORING THE PROCESS.....	9
4.1.1 <i>Monitoring the Dynamics</i>	9
4.1.2 <i>Monitoring the Contents</i>	10
On the Legal Framework.....	10
On the Right to Health Care and Insurance	11
On the Steering Role	11
On the Separation of Functions	11
On Decentralization Modalities.....	12
On Social Participation and Control	12
On Financing and Expenditure.....	12
On the Services Provided	13
On the Management Model.....	13
On Human Resources.....	14
On Quality and Assessment of Health Technologies.....	14
4.2 EVALUATION OF RESULTS.....	15
4.2.1 <i>Equity</i>	16
On Coverage.....	16
On Distribution of Resources	16
On Access.....	16
On Resource Utilization	17
4.2.2 <i>Effectiveness and Quality</i>	17
Technical Quality	18
Perceived Quality	18
4.2.3 <i>Efficiency</i>	19
In Resource Allocation.....	19
In Resources Management	19
4.2.4 <i>Sustainability</i>	20
4.2.5 <i>Social Participation and Control</i>	20
BIBLIOGRAPHYC NOTES	21
ANNEX: LIST OF PARTICIPANTS OF THE MEETING ON THE METHODOLOGY FOR MONITORING AND EVALUATING HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARIBBEAN	23

1. INTRODUCTION

As the WHO Regional Office for the Americas, the basic mandate of PAHO is to act as the governing and coordinating authority on international health matters in the Region. Its functions are "to provide technical cooperation...to seek consensus on the priority health problems identified by the countries...to mobilize resources and international action in order to support efforts to solve these problems...to support and cooperate with the countries in areas related to health in development, health systems development, health promotion and protection, environmental protection and development, and disease prevention and control".¹

The First Summit of the Americas, held in Miami in 1994, included discussion on national health sector reform processes. Among other things, the Summit convened a special meeting of governments, interested donors, and international technical cooperation agencies, co-organized by PAHO, the IDB, and the World Bank, to establish the conceptual framework for these processes, define PAHO's role in monitoring and evaluating health sector reform plans and programs in the countries of the Region, and strengthen the health economics network.²

The meeting was held at PAHO/WHO Headquarters in September 1995³, and confirmed the growing interest of the countries, agencies, and other cooperation organizations working in the Region in reform strategies, policies, instruments, and results. Since then, the national authorities, international organizations, and other actors involved frequently request information on the objectives, plans and programs, dynamics, content, instruments, and institutional and individual experiences in the different areas covered by the reforms. Even a short time ago, most of this information was unpublished, or its dissemination was confined to very limited areas.

At the close of the Special Meeting, the Directing Council of PAHO adopted a resolution in which the Director was requested "in accordance with the recommendations of the Summit of the Americas and taking into account the discussion at the Special Meeting on Health Sector Reform, to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas."⁴

As a result of the mandate for interagency collaboration, and in support of health sector reform efforts in the countries, the U.S. Agency for International Development (USAID) and PAHO opened talks to identify priority areas for regional cooperation on sector reform. To this end, other actors were considered who might contribute to the achievement of the common objectives in this field.

In 1997, the Health Sector Reform Initiative in the Countries of Latin America and the Caribbean was launched. This is a five-year project (1997-2002) of PAHO, USAID, the Partnership for Health Sector Reform (PHR), Data for Decision Making (DDM), and Family Planning Management Development (FPMD), whose main objective is to provide regional support to promote equitable access to basic quality services in the Region of the Americas.⁵

This “Methodology for Monitoring and Evaluating Health Sector Reform in Latin America and the Caribbean” is one of the results of this initiative.

Its preparation began in October 1997, with the drafting of the first version of the Methodology to prepare the “Baseline for Monitoring and Evaluating Sector Reform” in 13 countries of the Region. A second version of the country reports was prepared between March and May 1998, and four other countries were added⁶. The Methodology used was reviewed by a working group of the PAHO Division of Health Systems and Services Development and an international consultative meeting was subsequently convened to discuss and review the new version of the Methodology (ANNEX). The version presented here incorporates the contributions from that meeting.

2. CONCEPTUAL FRAMEWORK

Health sector reform in the Region of the Americas has been defined as a process aimed at introducing substantive changes into different health sector entities and functions with a view to increasing the equity of their benefits, the efficiency of their management, and the effectiveness of their actions and, thereby, meeting the health needs of the population. It involves intensive transformation of the health systems, carried out during a given period of time and justified by circumstances that make it a viable undertaking⁷.

Applying the above-mentioned definition strictly, not all changes introduced into the sector could be termed sectoral reform. In fact, the situation in this area is highly diverse in the Region, with significant variations observed in the dynamics and content of the changes being introduced by the majority of the countries. In some cases, sectoral reform projects defined as such are still in the discussion phase and have not yet been implemented. In others, changes in areas such as financing and patient management are being introduced without affecting the basic responsibilities of the principal public and private actors. There are cases in which the changes are substantive, but are called something other than reform, and others, in which the general nature of the functions of one of the major public institutions is changed, but not the rest. In one country it has been possible over the past decade to characterize two or three stages of health sector reform. Practically no country has explicit mechanisms for evaluating the process or its results.

The conceptual framework and criteria for reform activities have been constructed in recent years, thanks in part to the following initiatives: (i) the Plan of Action of the Summit of the Americas; (ii) the contributions of the countries to the Special Meeting on Health Sector Reform and the resolution of the subsequent Directing Council, (Washington, D.C., Sept. 1995); (iii) the follow-up report on health sector reform activities presented to the Directing Council of the Organization (Sept. 1996)⁸; (iv) the "PAHO Cooperation in Health Sector Reform Processes" document; (v) the Report on "The Steering Role of the Ministries of Health in Sector Reform" presented to the Directing Council of the Organization (Sept. 1997)⁹; (vii) the talks on sector reform at the meetings of the Ministers of Health of Central America, the Andean Area, MERCOSUR, and the countries of the English-speaking Caribbean; and (viii) monitoring and support for the national commissions and support groups on reform in several countries in the Region.

PAHO guiding criteria for sectoral reform, derived from the foregoing and upheld by the experience of the majority of sector reforms under way, are as follows: **equity, quality, efficiency, sustainability, and social participation.**

All are concepts that make it possible to judge the direction of the programmed or ongoing sectoral reforms from the standpoint of the stated final objective. Thus, no sectoral reform should be opposed to these criteria, and the "ideal reform" would be one in which the five aspects had improved by the end of the process. They, in turn, can be subdivided into a series of variables to which quantitative or qualitative indicators can be added when they are adapted to the conditions of each country and can help to evaluate the degree to which the general objectives of the reform have been achieved.

Equity implies: (a) in a health situation, to decrease avoidable and unjust differences to the minimum possible; and (b) in health services, to receive care in relation to need (equity of coverage, access, and use) and to contribute according to the ability to pay (financing equity).

Effectiveness and **technical quality** mean that users of the services receive effective, safe, and timely assistance; perceived quality means that they receive this care under proper physical and ethical conditions (perceived quality).

Efficiency implies a positive relationship between the results achieved and the cost of the resources used. It has two dimensions: resource allocation and the productivity of the services. Resources are allocated efficiently if they generate the maximum possible gain in terms of health per unit of cost; and they are used efficiently when a unit of product is obtained at minimum cost, or when more units of product are obtained with a given cost.

Sustainability involves both the social and financing dimensions and is defined as the capacity of the system to solve its current legitimacy and financing problems, as well as the challenges of future maintenance and development. Consequently, it includes social acceptance and support and the availability of the necessary resources.

Social participation has to do with the procedures required to enable the general population and the different agents to influence the planning, management, delivery, and evaluation of health systems and services and benefit from the results of their influence.

Even in countries where sectoral reforms are not being implemented, it may be useful to apply the Methodology, for example, to analyze the subjects included in the section "Monitoring the Dynamics," if only to rule out many of them and to indicate whether a subject was discussed in a sectoral reform proposal and, if need be, the reasons behind the decision not to implement it. It may also be useful to analyze the majority of those included in the sections "Monitoring the Contents" and "Evaluating the Results." In these cases, the "monitoring" will refer to the contents of the normal activities of the health services system, and the "evaluation of results" will not refer to sectoral reform activities, but to the normal activities of the health authorities and other relevant actors.

This holds true for countries where the changes, being substantive, are called something other than "reform."

3. WHAT IS THE METHODOLOGY AND HOW IS IT USED?

WHAT IS THE METHODOLOGY?

The Methodology for Monitoring and Evaluating Health Sector Reforms in Latin America and the Caribbean (hereinafter “the Methodology”) is a document to help decision makers at the national and subnational levels of the countries and the technical cooperation agencies that support them to produce the most objective report possible—a report that is of manageable length, easy to update, and that systematically follows and evaluates health sector reforms.

The purpose of monitoring reform processes is to describe and analyze them, indicating which actors are operating, the current phase or stage of the reforms, and their contents. The purpose of the evaluation is to discover to what extent the sectoral reforms are actually helping to improve the levels of equity, effectiveness and quality, efficiency, financial sustainability, and community participation of, and in, the health services systems.

The Methodology does not propose an exhaustive analysis of all possible subjects or of all the subjects it deals with. It refers only to the relevant aspects of selected subjects considered indispensable. Detailed analyses of the subjects included (or of others not included) are possible and, in many cases, necessary, and they can be addressed subsequently by the countries and/or PAHO. The concise nature and periodic updating of the Report drafted using this Methodology can, however, make it a valuable tool for decisionmakers and other interested parties at the national, subnational, and international levels.

This Methodology was developed at the same time as the “Guidelines for the Preparation of the Profiles of the Health Services System of a Country.” Although they can be used separately, the monitoring and evaluation of reform processes greatly benefits from the results of the previous analysis of both the context in which the health services systems operate and their general organization, resources, and functions. The reverse is also true; in most of the countries, it would be impossible to analyze the performance of the health system and services without incorporating the potential or real effects of the reforms programmed or in progress.

TO WHOM IS THE METHODOLOGY DIRECTED?

There are many potential users of the Methodology.

First, there are national professionals working in the areas of health systems and services planning and administration, both at the national and subnational levels. Second, there are professionals in the field or others working at the headquarters of technical and financial cooperation agencies and NGOs. Third, there are managers and professionals in

other public and private institutions in the health sector or related sectors. Finally, there are teaching and research institutions connected with the sector.

WHAT INFORMATION TO UTILIZE AND WHERE TO OBTAIN IT?

Information that is already available will be used, assigning special importance to the institutional information published in official national sources. In addition, information published by international technical and/or financial cooperation agencies (including PAHO itself) will be used, as well as unpublished information from official national sources, provided its use is authorized, and relevant information published in unofficial sources (for example, signed articles).

If there is no information or it is documented or commonly accepted that the information is deficient or biased, this will be stated. In cases where the information exists but was not accessible for analysis, this will be expressly stated, indicating why it was not accessible.

When necessary, the information can be validated through interviews with experts and, as an exception, using the focus group technique.

USE OF THE VARIABLE AND INDICATORS SECTION

The subjects included in the Variables and Indicators section should all be dealt with in the order indicated. Information on subjects not mentioned can be included, on an exceptional basis, only if it sheds light on critical aspects and the recommended overall length is not exceeded.

Regarding quantitative information, an attempt has been made to include information that appears to be available in--and has been previously reported by--the majority of the countries. Wherever appropriate, the number of the indicator in the publication "Basic Indicators 1997" (BI 97) has been included.

For the qualitative information, the Questionnaire tries to be explanatory (for example, clarifying the scope of the desired information and/or clarifying some term) and suggests the approximate amount of space the subject should occupy in the Report (for example, one line, a few lines, or a paragraph). On this point it is important to differentiate between "qualitative information," "qualified opinion," and "value judgment." or example, if, in a country, a certain ministerial proposal for sectoral reform (or an important aspect of sectoral reform) gave rise to opposition and was finally rejected, that is relevant qualitative information that should be included. If the opposition came from a number of actors (internal to the government itself or external), an assessment of the weight of each in the rejection is a matter of opinion and will be included only if there is sufficient consensus. The assessment of the reasons behind each actor's opposition would fall under "value judgments" and should be omitted.

Most of the indicators are formulated as questions. Although an attempt has been made to formulate these as precisely as possible for the subject at hand, it is essential to understand their sense (and the context in which they are formulated), rather than their literal meaning, and to respond to them accordingly.

The fact that the chapter is neither normative nor prescriptive should be emphasized. For the section on “Dynamics of the Processes,” a sequential logic has been chosen, with a view to emphasizing the analytical nature and importance of some critical activities (for example, negotiation and evaluation). However, it is recognized that in some cases the phases can overlap and that the results of some can change the dynamics and contents of those that follow. Furthermore, it should be noted that if a subject not included is relevant to a particular country, there is nothing to prevent its analysis.

It is also important to insist on consistency between the data collected and analyzed for monitoring the processes and that used to evaluate the results.

HOW TO SUBMIT THE REPORT

The report must be concise and objective; therefore long, detailed descriptions should be avoided. The subjects should be dealt on the basis of the available information, avoiding personal opinions, value judgments, or unfounded conclusions. Short phrases and appropriate punctuation are recommended, and parenthetical phrases and the excessive use of subordinate clauses are to be avoided.

The experience from the 17 countries that executed the “Baseline for Monitoring and Evaluating Sectoral Reform” indicates that, applying this Methodology, it is possible in a few weeks to produce a six and a half to seven page report in 1.5 spacing, using *Times New Roman* (or Universal) 11 point font, not including the Bibliography or Notes. Annexes will not be included. The bibliography consulted will be included at the end, with citations in accordance with PAHO publishing standards¹⁰.

More extensive reports (for example, of up to 10 pages) are possible, retaining the same structure, including some subject matter not addressed in the section on Variables and Indicators and making the section on observations slightly longer. In that case, the chapters and sections should be balanced.

If there is some section or specific subject that merits more in-depth treatment, the matters related to it in the Section on Variables and Indicators of this Methodology can serve as a starting point and a link to other subjects relevant to health sector reform.

4. VARIABLES AND INDICATORS

4.1 MONITORING THE PROCESS

The purpose of this section is to describe and analyze:

- a) the dynamics, that is, the different phases of the sectoral reform process (design, negotiation, implementation, and evaluation), as well as the characteristics, purposes, and relationships of the principal actors (social or institutional, public and private, national, subnational, or international) involved and;
- b) the contents of the process, that is, the strategies designed and the actions actually undertaken.

4.1.1 Monitoring the Dynamics

The reforms are processes in which, over time, significant phases and large numbers of actors can be distinguished. With regard to the phases, it is important to distinguish the genesis or “remote origin,” the design or “immediate origin,” the negotiation, the implementation, and the evaluation of results. With regard to the actors, it is important to distinguish both those who act predominantly in society (for example, employers’ associations, labor unions, insurance companies, social movements, self-care groups, the communications media, private universities, and others) and those whose action takes place predominantly in the public sector (for example, agencies and institutions of the various levels of government, the legislative and judicial branches, the social security institutions, the public universities, and others).

- What was the genesis of the reform process? If possible, indicate when it began, the reasons put forward, and the principal actors.
- Were the opinions and/or demands of the population considered when the reform was proposed? If so, how?
- Has a sectoral reform agenda been drawn up in the country? If so, what are its objectives?
- Is sectoral reform part of the State’s development and/or modernization plans and programs?
- Who was or were the people in charge of design? How did they do it or how are they doing it? What was the role of the health authorities and, especially, the ministry of health at that time?

- Do the health authorities assume (or did they assume) leadership in negotiating the objectives and/or contents of the sectoral reform?
- What entities, associations, groups, etc., participate (or have participated) in the negotiation process? At what time did each participate and for what purposes?
- Is there a sectoral reform action plan with goals, dates, and responsibilities for implementation?
- Who finances studies, field activities, and the implementation of sectoral reform? How are these activities financed?
- In what phase is the reform? If it exists, is the established timetable being followed? If not, what changes have taken place and why?
- If appropriate, have any of the objectives and strategies of the reform process changed? If so, when and why?
- Were evaluation criteria defined from the beginning of the sectoral reform? If so, what do they consist of? If there are no evaluation criteria, state why.
- Has some evaluation of the implementation and/or impact of sectoral reform already been done? If so, when? by whom? with what results?

4.1.2 Monitoring the Contents

On the Legal Framework

- Were changes introduced or are changes being introduced, or is the intention to modify the constitution and/or basic health regulations (for example, procedures of the health laws, the sanitary codes, and their regulations)? If so, how was this accomplished or how is it proposed (for example, through a constitutional change backed up by changes in lower-level regulations or through gradual legislative changes that ultimately make a constitutional change imperative)?
- Have potential changes been proposed as a way to meet health sector reform objectives? If so, cite them.
- If appropriate, list the principal legal norms governing health sector reform (including international agreements).
- Is equity defined in the legal norms governing health? If so, how?
- Do the legal changes favor an intersectoral approach, relating guarantees of the right to health with other rights (for example, to education, decent housing, or a healthy environment)?

On the Right to Health Care and Insurance

- How is the right to the health care guaranteed?
- Is that right explicit? Have the mechanisms necessary for ensuring that right and making knowledge about it accessible to the population been implemented?
- Have specific programs been introduced or are specific programs being designed to increase coverage? If so, by whom and what do they consist of?
- Has a guaranteed plan or basic package of benefits been introduced, or is one being designed? To whom is it directed? What does it include? Who decides what benefits are included, and how?

On the Steering Role

- Are exercise of the steering function in health and the functions of the agencies responsible for carrying it out being reviewed?
- Have changes in the structure of the health authority been introduced in order to adapt it to its steering role? If so, what do they consist of? Cite examples of the structural changes made to improve institutional capabilities.
- Have new regulatory institutions been created that affect the sector (for example, public health funds, authorities, or others)? If so, what is their relationship to the ministry of health?
- Have actions been taken to guarantee that the information systems periodically send relevant reports to the different decision-making levels in order to set priorities, make decisions, and allocate resources?

On the Separation of Functions

- How are the functions of regulation, financing, insurance, and health service delivery being organized?
- Have institutions responsible for policy-making, financing, insurance, and the delivery of public health care to individuals been created or are they being created? If so, identify them and describe how they function.
- What mechanisms ensure the accountability of the public agency or agencies in charge of the different aforementioned functions?

On Decentralization Modalitiesⁱ

- Are the administrative levels of the health services system, their functions, and the relationships among them being reviewed and/or modified? If so, do these proposals and/or changes bear a relationship to more general proposals for decentralization of the civil service and/or other social sectors?
- Are responsibilities, authority, and resources (equipment, human resources, etc.) being transferred to the subnational levels? If so, how is this transfer being effected?
- What is the degree of deconcentration within each of the main public health services institutions?

On Social Participation and Control

- Is social participation an objective of sectoral reform?
- What entities and mechanisms have been introduced or are being introduced to facilitate the social participation and control of the health services system?
- At what level--national, subnational and/or local--have these entities and mechanisms been developed--or are they being developed--and with what functions (for example, to mobilize resources, to learn the needs of the population, to support planning or management, to be responsible for providing certain services)?
- In developing them, have groups traditionally excluded from decision-making, e.g., women and certain ethnic groups, been taken into account?
- Are these entities and mechanisms becoming legally institutionalized? If so, do they have the resources and capacity to carry out the responsibilities assigned?

On Financing and Expenditure

- Are the information systems on financing and expenditure being strengthened in order to make them reliable and comparable by territorial unit and/or facility? If so, how?
- Based on the analysis in subsection 3.2.3.2, are measures to substantially modify the following being introduced:
 - the composition of the financing,
 - the expected trends in total expenditures and public expenditure in health,
 - the distribution of public expenditure in health by spending agents,
 - the distribution of public expenditure in health by levels of care,

- the distribution of public expenditure by component (for example, human resources, purchase of goods and services, procurement of drugs and other supplies, investments, and others)?

If so, document on several lines.

On the Services Provided

- Are the models of care being redefined? If so, in what sense, and what are the principal characteristics of the model(s)? Has the demand been described in order to do so?
- Are new health care modalities, such as one-day procedures, outpatient surgery, house calls, etc. being introduced?
- Are the systems for the referral and back-referral of patients between the levels of care being strengthened? If so, how?
- Are decisions being made to modify the public health services provided? If so, in what institutions of the public and private sectors and in what territorial units?
- Are decisions being made to modify the first level services provided? If so, in what institutions of the public and private sectors and in what territorial units?
- Are decisions being made to modify the second level services provided? If so, in what institutions of the public and private sectors and in what territorial units?
- Are programs and activities being carried out for the identification and/or care of vulnerable groups, as defined by income, specific risk, gender, ethnic group, or marginalization? If so, which?

On the Management Model

- Are changes being introduced in the management model and in the relationships among the actors? Which and how?
- Are changes being introduced in the management model and in the relationships among the actors, both inside and outside the public health facilities? Which and how?
- And in private health facilities?
- Are management contracts or commitments between the different levels of the public health care system being introduced? If so, which and how?

- Are legal potential and institutional capacity being developed, and is the purchase and sale of services with respect to third parties being implemented by the public facilities? If so, how?
- Are the public health facilities being organized on the basis of business criteria, self-management criteria, or others?
- Have public health facilities or services been handed over to private management, or is this programmed?

On Human Resources

- Have modifications been designed or introduced into the human resources education in order to respond to the needs generated by sectoral reform?
- How have health workers and their representatives participated in the sectoral reform process with respect to the subject of human resources?
- What have been the principal changes in human resources planning and management (for example in recruitment, job assignment, the number of workers, redistribution mechanisms, dismissal procedures)?
- Have performance incentives been proposed for the personnel of public health facilities? Which have been introduced? Have they been introduced in the private sector?
- Have modifications with a multidisciplinary approach been designed or introduced in professional practice (for example, family medicine, general nursing, primary care techniques)?
- What modalities are being introduced for the training of health workers? What volume of resources have they consumed in the past year in each major public health service facility?
- Are certification mechanisms for health workers being created or reformulated? Are these modifications consistent with sectoral reform objectives?

On Quality and Assessment of Health Technologies

- Are the procedures and/or institutions in charge of accrediting facilities and programs being created or reformulated? Are these modifications consistent with sectoral reform objectives?
- Does sectoral reform include initiatives in the areas of technical quality and perceived quality for the different levels of care? If so, which are being implemented?

- Does sectoral reform include initiatives to develop mechanisms for health technology assessment before such technologies are introduced and/or during their use?ⁱⁱ If so, which?

4.2 EVALUATION OF RESULTS

The purpose of this section is to try to analyze to what point sectoral reform can help to improve the levels of equity, effectiveness, quality, efficiency, sustainability, and social participation in health systems and services.

All are concepts that make it possible to judge the direction of the programmed or ongoing sectoral reform from the standpoint of the stated final objectives. Thus, no sectoral reform should be opposed to these criteria and the "ideal reform" would be one in which the five aspects had improved by the end of the process. They, in turn, constitute the conceptual framework for a series of variables and indicators that will be used to measure their impact.

Equity implies: *a)* in a health situation, to decrease avoidable and unjust differences to the minimum possible and; *b)* in health services, to receive care in relation to need (equity of access and use) and to contribute according to the ability to pay (financing equity).

Quality implies that users of the services receive timely, effective, and safe assistance (technical quality) under proper physical and ethical conditions (perceived quality).

Efficiency implies a positive relationship between the results achieved and cost of the resources used. It has two dimensions: resource allocation and the productivity of the services. Resources are allocated efficiently if they generate the maximum possible gain in terms of health per unit of cost; and they are used efficiently when a unit of product is obtained at minimum cost, or when more units of product are obtained with a given cost (implied constant quality).

Sustainability involves both the social and financing dimensions and is defined as the capacity of the system to solve its current legitimacy and financing problems as well as the challenges of future maintenance and development. Consequently, it includes social acceptance and support and the availability of the necessary resources.

Social participation has to do with the procedures required to enable the general public and the different agents to influence the planning, management, delivery, and evaluation of health systems and services and benefit from the results of their influence.

The authors of the present document are aware that it is impossible to establish direct and single relationships between the sectoral reform activities and the modifications in many of the proposed indicators. This is particularly evident in the section on efficiency, but not in it alone. In many cases, the effects of sectoral reform will be felt over the middle and long term, and they will be mediated by a multitude of factors not directly attributable to them. This is clear in the case of the impact of sectoral reform on certain health situation indicators. However, it seems possible to develop a better understanding of the impact of

sectoral reform in matters such as equity, quality, resource management, sustainability, and community participation. All things considered, even in these cases, evaluating the impact of sectoral reform will be affected, at least in the countries, by the different perspectives of the actors involved. Without a doubt, an adequate assessment of the impact of sectoral reform should be global, combining quantitative and qualitative, tracer and systematic indicators and taking different viewpoints into account.

4.2.1 Equity¹³

Is there any evidence that sectoral reform has led to a reduction in the geographical gap in some or all of the following indicators? If possible, show data according to gender, age, race, socioeconomic level, and coverage plan.

On Coverage

- On the percentage of the population regularly covered by a basic package of benefits.
- On coverage of the Expanded Program on Immunization of children under 1 year (BI97, 52, 53, 54, 55).
- On coverage of prenatal check-ups performed by trained personnel (BI97, 50).
- On the percentage of women who use contraceptives (BI97, 56). If possible, distinguish at least between surgical and nonsurgical methods.

On Distribution of Resources

- On all or some of the following indicators:
 - Total per capita health expenditure (BI97, 48)
 - Per capita public spending on health per capita
 - Physicians per 10,000 population (BI97, 45)
 - Professional nurses per 10,000 population (BI97, 47).
 - Countable hospital beds per 1,000 population (BI97, 47)
 - (If possible, for these last three indicators, differentiate between public and private sectors).

On Access

- On the percentage of deaths without any type of medical care.

- On the percentage of rural population more than one hour away from a health facility and urban population more than 30 minutes away from a care facility.
- On the possibility of obtaining care on the day of request at the primary health facilities.
- On the percentage of health facilities that have reduced the functional barriers to access (for example, schedule, language, or others).
- On the length of surgical waiting lists (or the average time it takes to be served) for three selected procedures.

On Resource Utilization

- On the following indicators:
 - Outpatient consultations per 1,000 population
 - Expenditures per 1,000 population
 - Percentage of deliveries attended by trained personnel (BI97, 51)

Note: If none of the previous sections fit the contents of the definition of equity developed by the country or the changes the country has decided to introduce, specify this and indicate the changes produced in the established objectives.

4.2.2 Effectiveness and Quality

- Is there some evidence that sectoral reform has reduced the geographical gap in some or all of the following indicators (and, if available, the gap between the target populations of the sectoral reform activities)?
 - Infant mortality (BI97, 19)
 - Maternal mortality (BI97, 23)
 - Percentage of newborns with low birthweight (<2500 g) (BI97, 43)
 - Mortality from cervical cancer
 - Incidence of:
 - HIV/AIDS (BI97, 41)
 - Vaccine-preventable diseases
 - Mortality from acute complications of:

- Diabetes mellitus II (< 25 years)
 - Basic hypertension (< 25 years)
-
- Is there some evidence that sectoral reform has influenced some or all of the following indicators, globally or for some provider network(s), by territorial unit? If available, to whom is it directed, by population group?

Technical Quality

- Percentage of primary level facilities with established and functioning quality control committees.
- Percentage of hospitals with established and functioning quality control committees.
- Availability of essential drugs at the different levels of care.
- In the incidence of hospital infections.
- Percentage of patients given a discharge or care report.

Perceived Quality

- Possibility of the user's selecting a primary care service provider, regardless of his ability to pay.
- Percentage of facilities with established and functioning programs for improving communication with the user and the treatment provided (for example, User-friendly Hospitals).
- Percentage of facilities with specific user orientation procedures.
- Percentage of health centers and hospitals that conduct surveys of users' perceptions or opinions.
- Percentage of facilities with established and functioning arbitration committees (or their equivalent)?
- Degree user satisfaction with the health services.

4.2.3 Efficiency

In Resource Allocation

- Are more efficient resource allocation mechanisms being introduced? If so, what are they and what are the results?
- Is there evidence that sectoral reform has influenced some or all of the following indicators globally, by territorial unit? If available by population group, to whom is the reform directed?
 - Rural and urban drinking water supply (BI97, 13)
 - Rural and urban sewerage and excreta disposal services (BI97, 14)
 - Percentage of the health budget spent on public health services
 - Spending on primary care as a percentage of health expenditure.
- Is there any evidence that sectoral reform has led to a reallocation of resources for the implementation of
 - intersectoral activities (for example, self-care in health, accident prevention, etc.)
 - programs for the prevention of highly prevalent pathologies (for example, hypertension, diabetes, or cervical cancer)? If so, cite and comment on a few lines.

In Resources Management

- Is there any evidence that sectoral reform has helped to increase
 - the percentage of health centers and hospitals with standardized and functioning measures of activity and performance
 - the number of hospitals that have improved at least the following performance indicators? (if possible, break down by public and private sectors).
 - Occupancy rate
 - Average length of stay in days
 - Number of expenditures per bed
 - Cesarean sections as a percentage of all deliveries
 - Cost per day hospitalized

- Cost for outpatient consultation
- the percentage of health centers and hospitals that have negotiated management agreements
- the percentage of public health facilities that can expand the framework of expenditures utilizing new revenues for this purpose
- the percentage of health centers and hospitals with budgets based on activity criteria.

4.2.4 Sustainability

- Is there any evidence that sectoral reform has increased
 - the legitimacy and/or acceptability of the principal health service delivery institutions
 - the availability of disaggregated data on public and private health expenditure by territorial unit and to construct trends (comment in a few lines)
 - the sustainability over the middle term of the efforts to increase coverage, whether of the programs (for example, EPI and prenatal check-ups) or services (for example, delivery by trained personnel, medical consultation on demand, promotion of quality)
 - the capacity to modify the health revenue and expenditures of the principal public sector institutions (Comment in a few lines)
 - the percentage of health centers and hospitals able to collect from third parties
 - the capacity for obtaining external loans and, if appropriate, their replacement by national resources at maturity?

4.2.5 Social Participation and Control

- Is there any evidence that sectoral reform has helped to increase the degree of social participation and control at the different levels and functions of the health services system? If so, in general and/or with respect to certain groups? Comment in a few lines.

BIBLIOGRAPHYC NOTES

1. PAHO/WHO: Strategic and Programmatic Orientations 1995-1998, Washington, D.C., 1995, p. 43.
2. Summit of the Americas: "Plan of Action", Miami, 3-5 Dec. 1994.
3. BID, BIRF, CEPAL, OEA, OPS/OMS, FNUAP, UNICEF, USAID: "Reunión Especial sobre Reforma del Sector Salud. 29-30 Sep. 1995", Washington DC, División de Salud y Desarrollo Humano, Jun. 1996, 159 pp.
4. BID, BIRF, CEPAL, OEA, OPS/OMS, FNUAP, UNICEF, USAID: Op. Cit., p. 129.
5. A detailed description of the scope and purpose, partners and activities and initiative outcomes is available through: <http://www.americas.health-sector.reform.org/>
6. The Methodology and 17 country reports are available through the web page mentioned in note No. 5. Printed issues could be asked to: Health Systems and Services Development Division, OPS/OMS, 525 23rd Street, Washington, DC 20037, USA..
7. PAHO/WHO: "Cooperation of the Pan American Health Organization in the Health Sector Reform Processes" Washington DC (Spanish and English), March 1997, p.13.
8. PAHO/WHO. XXXIX Meeting of the Directing Council: "Progress of activities in health sector reform", Washington DC, CD39/13, Rev. 1 (Eng.) 9 Sep. 1996.
9. PAHO/WHO, XL Meeting of the Directing Council: "Steering Role of the Ministries of Health in the process of Health Sector Reform", CD40/13 (Eng.) 23 Jul. 1997.
10. OPS/OMS: "Lineamientos Metodológicos...", op cit. Annex.
11. OPS/OMS: "La descentralización, los sistemas de salud y los procesos de reforma del sector. Informe Final. Valdivia, Chile, 17-20 Marzo, 1997", División de Desarrollo de Sistemas y Servicios de Salud – OPS/OMS, Washington DC, Oct. 1997.
12. PAHO/WHO: "Developing Health Technology Assessment in Latin America and the Caribbean" Health Systems and Services Development Division – PAHO/WHO, Washington DC, 1998 (English and Spanish).
13. WHO: "Final Report of Meeting on Policy-Oriented Monitoring of Equity in Health and Health Care", Geneva, 29 Sep. – 3 Oct., 1997.