ANALYSIS OF HEALTH SECTOR REFORMS IN THE ANDEAN COUNTRIES*

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PROGRAM ON ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES

DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT

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I. MONITORING THE HEALTH SECTOR REFORM PROCESSES

By the mid-1990s virtually all the countries of Latin America and the Caribbean (LAC) had initiated or were considering health sector reform (HSR)[1]. Defining what is meant by "sectoral reform" was and still is a subject of debate[2,3]. In the Americas, an international meeting convened for this purpose in 1995[4] defined it as "a process aimed at introducing substantive changes into the different agencies of the health sector and the roles they perform, with a view to increasing equity in benefits, efficiency in management, and effectiveness in satisfying the health needs of the population. This process is dynamic, complex, and deliberate; it takes place within a given time frame and is based on conditions that make it necessary and workable.[5]"

The *Methodological Guidelines for the Preparation of Profiles of Health Systems and Services in the LAC Region* includes a section on the monitoring and evaluation of health sector reforms in LAC. The Division of Health Systems and Services Development at PAHO/WHO has been implementing the Guidelines since 1997[6,7,8]. They can also be used in countries that have not carried out health reform, but where fundamental changes have taken place that are referred to in another way and are not specifically labeled as "reform." Given the existing debate on what constitutes HSR, it is not surprising that are currently conceptual and methodological problems related to the monitoring and evaluation of HSR that are far from being resolved[9,10].

The present analysis is based on the information contained in the section on monitoring and evaluation in the second edition of the *Profiles of Health Systems and Services*. The first analysis of the dynamic (phases and principal actors) and content of health sector reform in six countries (Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela) which comprise the Andean Health Body of the Hipólito Unanue Agreement was completed in 2001[11]. The information for the analysis was included in the section corresponding to the *first edition* of the *Profiles of the Health Systems and Services*. The second edition was published between April 2001 and May 2002. Based on the recently concluded second edition of the Profiles, the following is an updated analysis of health sector reform, which includes new information from the documents mentioned[12].

MONITORING THE DYNAMICS

Andean countries have a similar history, culture, and level of development. Nonetheless, the different economic, political, and social contexts of each affect health status and the scope of sectoral reforms. For example, national populations vary significantly from Bolivia's 8,280,184 inhabitants to Colombia's 43,070,703. Ecuador has the highest percentage of rural population (39.4%), and Bolivia has the highest percentage of indigenous population (43.5%). There are also significant differences in terms of economic and social conditions. Between 1999 and 2000, while Venezuela had a per capita GDP of US$ 4,995 and Chile US$ 4,603, Bolivia's held constant at US$ 1,026, and Ecuador's was US$ 1,100. The per capita GDP of Colombia and Peru was approximately halfway between the two extremes, at US$ 1,920 and US$ 2,180, respectively. Between 1998 and 2000, 21.7% of Chile's population, 49.1% of Venezuela's, 54.1% of Peru's, 55% of Colombia's, 63% of Bolivia's, and 69% of Ecuador's lived in poverty.

At the end of the 1990s, life expectancy at birth was 62.2 years in Bolivia; 69.1 in Peru; 69.9 in Ecuador; 71.2 in Colombia; 72 in Venezuela; and 75.2 in Chile. Infant mortality rates were 67, 39, 18.8, 21, 19.1, and 10.3 per 1,000 live births, respectively. Despite these variations, heart disease was the leading cause of death in all the Andean countries, with the exception of Peru, where it was respiratory disease. However, mortality profiles differ as to the second leading cause of death. It was communicable diseases in Bolivia; cancer in Venezuela and Chile; external causes for men and communicable diseases for women in Ecuador, and violence in Colombia. Lastly, the proportion of GDP allocated to health between 1997 and 1999 ranged from 3.8% in Ecuador to 8.6% in Colombia.

Origin of the Reforms

The origin of the reform processes has varied from country to country. In some, such as Bolivia and Venezuela, the process has been under way for several decades, spurring major changes and having little impact in others. Substantial changes have been being introduced in Colombia since 1993. In Ecuador, health sector reform began between 1994 (when the National State Modernization Council, CONAM, presented a project for reforming the Social Security Institute) and 1995 (when the Ministry of Health presented another project based on creation of a National Health System). The first wave of health reform in Chile began in the 1980s under the military regime. Since 1990, health reform has been part of the government project to modernize the State. Health reform in Peru began in 1995 as part of a process to reform the State and was reflected in the health sector by the development of the 1995-2000 Health Policy Guidelines.

ORIGIN OF THE OF REFORMS

- and Venezuela, the process has been under way for several decades. Substantial changes have been introduced in Colombia since 1993. In Ecuador, the reform process began in 1994. Chile had two waves of reform. The first health reform efforts in Peru date back to 1995.

The reasons underlying health reform vary little from country to country. They include increasing the coverage of health services, improving the quality of health services, boosting the efficiency and effectiveness of services, and making greater community participation possible. Nevertheless, specific factors that have oriented the process can be identified. In *Bolivia*, a law on public participation was enacted in 1994, which strove to change the political system and pay back the accumulated social debt.

REASONS TO INITIATE HEALTH REFORM

The stated reasons for health sector reform vary little from country to country. They include:

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In Chile and Colombia, the greatest changes in the health sector have been part of efforts to restructure and/or modernize the State. The other countries also undertook health reform in this context, but in Ecuador and Peru, this process has been inconsistent because of political instability. In Venezuela, there have been five major attempts at reform in the last 12 years, and none have yielded results due to political instability and other reasons.

Several countries drew up explicit health reform agendas. In Bolivia, the reform was spelled out in a strategic health plan created in 1998 as part of the development plans and programs and efforts to modernize the State. In Chile, since the restoration of democracy, an agenda with three major phases can be identified: restoration of the public health system; modernization of this system; and reform of the social security system. This last phase is the effort of the current government. Colombia also drew up an

agenda centered on efficiency, universality, solidarity, and social participation. In other countries, such as Ecuador, reforms have been undertaken in specific agencies or regions—often without the necessary oversight and articulation. The sudden interruption of the Peruvian government in May 2000, the installation of a transitional government in November of that same year, and the general elections in April 2001 have stunted efforts at State reform, including health sector reform. In Venezuela, the National Assembly has been discussing a bill that could eventually provide the context for definitively developing a health sector reform agenda.

DYNAMICS OF THE REFORMS

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Design of the Reforms

The main entities responsible for designing the reform processes have varied from country to country in the different phases. In Bolivia, the Ministry of Health has always been the leader in this area and, since the 1980s, has received support from the World Bank and the Inter-American Development Bank. In Chile, health reform began in the 1980s under the military regime. Reform in the 1990s was led by the Ministry of Health, working in conjunction with the ministries in the social sector, the Ministry of Finance, the General Secretariat of the Presidency, and the commissions and political groups of the National Congress. Chile also has received cooperation from international organizations, such as the World Bank for overall project design and financing, the Inter-American Development Bank for strengthening health services, various bilateral cooperation arrangements, and PAHO/WHO by means of specific projects and a group to support health reform. In Colombia, the catalyst for reform was multisectoral consensus-building among the Ministries of Health, Education, Labor, and the Planning Directorate, with the support of the Legislative Branch. These entities conducted several studies with support from the World Bank and the IDB. Initially, the National State Modernization Council (CONAM) and the Ministry of Health in Ecuador were the main entities behind the health reform. In 1995, the Reform Commission of the National Health Council (CONASA) received a great deal of support from international organizations, coordinated by the Interagency Commission to Support Reform (CIAR). This commission was made up of the World Bank (for the FASBASE and MODERSA-Health Services Modernization Projects, with the technical support of PHR), the IDB, and USAID and with the

coordination of PAHO/WHO. Nevertheless, there was a period known as the "silent reform" because there were no visible leaders, and fairly major changes were introduced without appropriate discussion in the political and social spheres. In Peru, health reform has been centrally administered by Ministry of Health authorities since 1995. The reform was based on the guiding principles of the 1995-2000 Sectoral Policy Guidelines. Financing, field activities, and implementation of the process were carried out through projects financially supported by the IDB, World Bank, and the Public Treasury, as well as by international technical cooperation. In Venezuela, the Ministry of Health and Social Development, created at the end of 1999, is spearheading health reform within the context of State reform. At present, a law is being proposed, which, subject to discussion in the National Assembly, would provide the guidelines for developing a definitive reform agenda.

At first, the opinions and demands of the population were not taken seriously in the majority of the countries, except for Colombia, where various groups interested in both health and pensions helped to design the health reform. Subsequently, however, the importance of public participation was recognized. For example, Chile had created Committees on Development and Committees on Equity to strengthen social participation. In 1997, Ecuador enacted the Decentralization and Social Participation Law, transferring to its municipalities the responsibility of planning, coordinating, carrying out, and evaluating comprehensive health, nutrition, and food security programs. Also, in 1997 the Ecuadorian Ministry of Health initiated a participatory process for formulating national health policy. In the mid-1990s, Bolivia developed an analogous process based on its Decentralization and Citizen Participation Laws.

DESIGN OF THE REFORMS

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- awareness of its importance.
- presence when the majority of the reform processes were initiated.

Negotiation of the Reforms

Even though protagonists varied at the outset of some countries' reform processes, the health authorities in all six countries currently head up the negotiation of the objectives and/or contents of health reform.

The Ministries of Health have been given the task of overseeing the health sector and guiding reform processes. Policy negotiations on the reforms have involved various national actors, as well as international agencies, which have provided economic and technical assistance to the initiatives. In Peru, there were no negotiations with sectoral actors until 2000. In Ecuador, several provinces and cantons in the country questioned the centralism of the national plan and demanded more decentralized and participatory management, leading to the creation of cantonal health councils to promote reform in local contexts. Incorporation of the IESS (Ecuadorian Institute of Social Security) into the reform initiatives made it possible to involve more actors in the process directed by CONASA (National Health Council).

NEGOTIATION OF THE REFORMS

- reform process.
- consensus-building with international agencies, which have provided economic and technical assistance to the initiatives.

Implementation of the Reforms

Only Chile has a plan of action for implementing health reform through political action and quantifiable goals in the short, medium, and long term. In the short term, the goals focus on timely access to health care, guaranteeing people's right to health through public and private facilities that adhere to the current charter of patient's rights, and the creation of a national program to promote user participation. Analysis of the wait for outpatient care shows that 82% of the goals have been met. In Colombia, certain insurance objectives were set, and Law 100 is currently being amended to include universal coverage. Bolivia has a strategic health plan, created in 1998, that orients the reform process. However, it does not explicitly mention goals, deadlines, and responsibilities. Ecuador does not have a plan of action, but the political will exists. Strategically, its sectoral reform needs to be part of the national policy agenda. Between 1997 and 1998, CONASA approved the general terms for developing the Plan of Operation for the Reform, which was difficult to implement. It was not until 2000 that certain major elements were developed that revived the reform process that continues to this day.

IMPLEMENTATION/EVALUATION OF THE REFORMS

- quantifiable goals.

Evaluation of the Reforms

With the exception of Colombia, where different state organizations, NGOs, and academic institutions have conducted evaluations and made recommendations to improve the health system, none of the Andean countries established evaluation criteria from the outset of its reform processes. However, when Bolivia evaluated its two main initiatives (insurance for mothers and children and basic health insurance) in 1998 and 2000, it found that they were not reaching the target group and were not well-known. There were also problems with payments; supplies were not always readily available; and municipalities did not use the funds uniformly. Even though evaluation criteria are not explicitly mentioned in Chile, goals and indicators, such as the presentation of data, show that the Ministry of Health is conducting an assessment of the reform process, implying the incipient development of an information system to monitor it.

EVALUATION OF THE REFORMS

- process.

MONITORING THE CONTENTS

Legal Framework

Some countries have amended their political constitution to have a direct or indirect impact on the development of the health sector. In Ecuador, constitutional amendments were implemented to firmly establish the right to health, the responsibility of the State to guarantee its exercise, and the provision of free public health programs and medical services to those who need them (although the Constitution does not specify who these people are). The most relevant legislative acts in this country have been the State

Modernization Law (1993), the Free Maternity Services Law (1994), and the special Decentralization and Social Participation Law (1997). In 2001, CONASA laid the foundations for the Organic Law on the National Health System. Congress is also discussing reforms to the Social Security Law. In Venezuela, a new Constitution was ratified in 1999, which lays the groundwork for establishing the legal status and organizational model for the Venezuelan health sector. The legal framework set forth by the Constitution has made it possible to draft an Organic Health Law, which is currently under discussion.

In Colombia and Peru, health sector reform as led to changes in the legal system. In Colombia, reform hinges on Law 100 of 1993, creating a general social security system, including coverage for occupational risks, complementary social services, and the social security health system. Given the complexity of the model, adjustments have had to be made to regulations of Law 100, placing special emphasis on aspects related to coverage, basic packages (the individual component, or Compulsory Health Plan, and the collective component, or Basic Care Plan), health promotion and disease prevention, and financing. It also had to be harmonized with Law 10 of 1990 (Decentralization of Health) and Law 60 of 1993 (Competencies and Resources of Territorial Entities). In Peru, the legal framework of the health sector was revamped in 1997 with two laws: General Health Law (GLH) and the Law to Modernize Social Security in Health (MHSS). The GLH establishes State responsibility for providing health services and universal progressive individual health insurance. The MHSS introduces new forms of care for beneficiaries of the Social Security Health system with the participation of private service providers to handle less-complex problems. In Bolivia and Chile, no constitutional amendments related to health reform have been identified. Bolivia's Public Participation and Decentralization laws (1994), Bolivia issued supreme decree 24237, creating a participatory decentralized public health system. The assessment made of current social security schemes was an important point of reference for the proposal to create universal insurance, which is currently under discussion in the Senate. In addition, the government recently concluded that the health sector is a cornerstone for equity and that health reform therefore falls within the framework of fighting poverty. In Chile, the legal changes in private health insurance included the creation of the ISAPRES Authority. In recent years, the greatest changes were introduced by Law 19650, the new FONASA law and by Law 19664, the medical law. The first of these buttresses health standards and FONASA's authority to collect, administer, and distribute financial resources, as well as to expand the mechanisms for financing and for signing agreements with providers.

CHANGES IN THE LEGAL FRAMEWORK

- regarding health reform.
- the health sector, followed later by essential changes in the legal system.

Right to Health Care and Insurance

The right to health care is clearly established in the constitutions of all the countries except Peru, where the General Health Law confers responsibility on the State for providing public health services and universal progressive insurance. The countries define the right to health care differently. For example, in Bolivia and Chile, it is the right to "health protection;" in Venezuela and Ecuador, the right to "health;" and in Colombia, an inalienable right "to social security provided by the State." However, the public has not been adequately informed about this right disseminated in the majority of cases.

In Chile, Colombia, and Peru strategies have been designed to increase the coverage of health services. In Chile these strategies have been aimed at increasing the number of medical problems solved at the primary care level through Emergency Primary Care Services (SAPU) and Short-Stay Hospital Rooms (SHA). In Colombia the strategy has been based on promoting the regulated competition of insurers (public and private), in both the contributory regimen (EPS) and the subsidized one (ARS). Peru's goal has been to expand basic health care coverage through insurance mechanisms and the provision of free health care to the poor. In Venezuela and Ecuador, no specific strategies are mentioned in this regard.

Information on the creation of health service plans or packages for the delivery of basic services is available for Bolivia, Colombia, and Peru. In Bolivia, Basic Health Insurance is designed for children, women, and families. In Colombia, the Compulsory Health Plan contains individual, family, and group components, six of which correspond to the Basic Plan and one to high-cost illnesses subject to reinsurance. In 1994, Peru established a basic package of care for children, adolescents, women of childbearing age, and the adult population. In 1997, School Health Insurance was implemented, and, in 1998, a pilot program was launched to provide Maternal and Child Health Insurance.

RIGHT TO HEALTH CARE AND INSURANCE

- countries, except one.
- services.
- services.

Steering Role and Separation of Functions

The exercise of the steering role in health is clearly defined in Chile, Colombia, and Ecuador. Chile has reviewed health supervision and the functions of the agencies responsible for it. The Ministry of Health has been restructured, and the Public Health Institute has been charged with registering drugs and medical devices and ensuring their quality. The quality of laboratories has also been strengthened. The environment, labor, and social welfare sectors have been given responsibility for environmental and labor regulations, even though surveillance is still the province of the health sector. In Colombia, legislation has defined the functions of the Ministry of Health in this area, giving it the power to formulate and adopt strategies, programs, and projects for the sector; to set standards to regulate the mandatory provision of health services by Health-Promoting Companies (HPC), Health Provider Institutions (HPI), and territorial entities; and to formulate and apply criteria to assessing how the HPC and HPI are managed. There are agencies for inspecting, monitoring, and regulating health service providers, as well as the Food and Drug Surveillance Institute, which implements the policies on health surveillance and quality control of drugs, biologicals, and other inputs that could potentially impact individual and collective health. In Ecuador, the Ministry of Public Health, working with CONASA, exercises the steering role in the health sector. Several institutions are responsible for insurance; the goal is to progressively make the IESS the universal public insurance provider.

The separation of functions in the health sector has been undertaken chiefly in two countries, Chile and Colombia. In Colombia, a functional health-system structure was formed, comprised of: i) the Ministry of Health (MH), which issues policies and at the local level is represented by sectional health services and municipalities; ii) the National Social Security Health Council (CNSS), which is the steering agency and exercises other functions, such as determining the unit of payment for training and the contents of the

POS; iii) the Solidarity and Guaranty Fund (FOSYGA), which manages finances through four large subaccounts (internal compensation for the contributory regimen, solidarity of the health subsidies regimen, health promotion, and insurance against catastrophic risks and traffic accidents); iv) the National Health Authority (Supersalud), which oversees, monitors, and regulates insurance and the delivery of services; and v) the National Food and Drug Institute (INVIMA), under the Ministry of Health, whose purpose is to implement policies on health surveillance and the quality control of drugs, biologicals, food, and other products. The Health Promoting Companies (HPC) and the Subsidized Regimen Administrators (SRA) are in charge of insurance. The State's social enterprises are the institutional health service providers (IHSP) in the public sector. In the private sector, the delivery of services is independent or part of the services offered by the network of insurance providers.

In Chile, FONASA and the ISAPREs are responsible for financing and insurance. Public health care facilities (subsidiaries of the SNSS and the municipalities) and private establishments are responsible for providing health services. The MINSAL, the ISAPRE Authority, and the Public Health Institute are responsible for regulation and evaluation.

Venezuela is in the process of modifying the Ministry of Health's areas of authority to enhance its steering role, especially with regard to policy-making, technical standards, coordination of services, and the supervision and control of programs. In Bolivia, the strategy to strengthen the steering role is geared to defining and increasing the responsibilities of the health secretariats, and the steering role of the Ministry of Health and Social Welfare has not been studied in depth. Even though a universal insurance law is going through the legislative process, separation of the supervision, insurance, service delivery, and evaluation functions has not been proposed as an objective.

Bolivia and Chile taken relevant action to upgrade information systems to assist in decision-making; this aspect has been developed to a greater degree in Chile.

STEERING ROLE AND SEPARATION OF FUNCTIONS

- Health.
- delivery.
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Decentralization

In 1980, Chile decentralized the National Health Service, breaking it up into 26 Health Services (today 28) and transferring primary health care to the municipalities. In 1990, the outsourcing of staffing began. By the end of the decade, decisions were made at the regional level on about 40% of investment funds. Although the regions were had been demarcated before the SNSS was created, health service boundaries do not strictly conform to provincial borders. Functions, competencies, and resources for planning, management, and decision-making have been transferred from the central level to the site of services and from the administrative offices of the SNSS to hospitals. FONASA has opened regional offices, and the ISAPRE Authority has three decentralized offices.

In Colombia, technical, administrative, and financing responsibilities were transferred to territorial entities (departments and municipalities). At all territorial levels the SGSSS has administrative institutions, entities that promote health and deliver health services, and a basic package of actions for health and the control of risk factors in the respective jurisdictions and area of competence of action. Under the current legal provisions, especially Laws 10 and 60, the departments, districts, and municipalities are responsible for managing and organizing health services to guarantee public health and health service delivery through public institutions, through the hiring of services or through demand subsidies. However, as of 1999, only 38% of municipalities were actually decentralized. Many municipalities are very small and thus have had to ally themselves with other municipalities or departments based on economies of scale.

Bolivia has the Decentralization and Public Participation laws, enacted in 1994, which transfer health infrastructure and equipment from the central level to the municipalities. The municipalities were matching funds for maintenance, equipment, and construction works, in keeping with local needs.

Decentralization of the main public health service institutions is still in its infancy, and the Ministry of Health continues to administer human resources. There are some instances of autonomous hospital management and some management contracts with health districts. The Ecuadorian MPH began decentralizing its management functions in 1990 with the creation of "health areas." The FASBASE and MODERSA projects have supported this process, as has the World Bank. NGOs, such as CARE and CEPAR, have taken part in this decentralization, which has also included the cooperation of PAHO/WHO; the governments of Belgium, the Netherlands, and Germany (GTZ); and the initiative of municipalities. In Venezuela, the process began in 1990 and, as of 1997, various responsibilities have been transferred to the country's 14 states. This has made it possible to modify the financing of health activities in the decentralized states, because of the involvement of governors and mayors who directly manage resources with different sources of financing. In 2000, Peru enacted a municipal administrative decentralization law focused on health and education services. To date, it has yet to be implemented.

DECENTRALIZATION

- management of institutional public service providers.
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Social Participation and Control

Social participation and regulation has been a stated health reform objective in all the Andean countries, with the exception of Peru. Various mechanisms have been established to make it operational. Bolivia's Social Participation Law gave rise to surveillance committees where the population has an opportunity to discuss health problems. However, lack of economic resources and training has made it difficult to truly implement this initiative. Development Councils have been established in Chile; they comprise community representatives from inside and outside of outpatient health centers, hospitals, and local groups. The goals are to learn about the facility's progress, suggest priorities, and find additional resources. The councils have no specific resources and are not formal legal entities. There are also day-long regional workshops where social organizations reflect on and make suggestions about health priorities. A new government initiative is under way to pass a law on patients' rights and responsibilities. Colombia has established mechanisms for the social regulation of health service delivery. Community oversight committees are popularly elected, and members can lodge a complaint with a technical/scientific committee appointed by the health institution with which they are affiliated, or,

alternatively, with the health authority. In Ecuador, management participation and control committees were created, and modernization committees were established in hospitals. Although social participation and control are one of Venezuela's health reform objectives, there is no information on the mechanisms it has established to meet this objective.

None of the countries makes explicit reference to groups traditionally excluded from decision-making. Only Bolivia mentions cultural diversity and the gender approach in health as being included in the Strategic Health Plan. In general, participation mechanisms are not formally established, and they lack the resources necessary to carry out their assigned functions.

SOCIAL PARTICIPATION AND CONTROL

- Different mechanisms have been established to make it operational.
- making.

Financing and Expenditure.

	Bolivia	Colombia	Chile	Ecuador	Peru	Venezuela
Per capita GDP	US$ 1026 (1999)	US$ 1920 $ (2000)	US$ 4603 (2000)	US$ 1100 (2000)	US$ 2180 (2000)	US$ 4.995 (1999)
Total public expenditure	32.1% of GDP (1998)	N/A	24.5% of GDP	28.8% of GDP (2001)	27.2% of GDP (1999)	25.2% of GDP (1999)
Social public expenditure	16.5% of GDP (1999)	14.05% of GDP (1999)	16.6% of GDP	5.8% of GDP (2001)	7.9% of GDP (2000)	7.6% of GDP (1999)
Total health expenditure per capita based on official exchange rates	US$ 53	US$ 226	US$ 369	US$ 212	US$ 100	US$ 200
Health expenditure as a % of GDP	5.0% of GDP (1998)	9.3% of GDP (1998)	7.5% of GDP (1998)	3.6% of GDP (1998)	4.4% of GDP (1998)	4.9% of GDP (1998)

SOURCES: PAHO/WHO Country Profiles; World Health Report 2001: Table Nø 5–WHO.

In 1997, 39% of health-sector financing came from the private sector and 61% from the public sector. In Ecuador, 49.2% came from the private sector, and 50.4% from the public sector. In 1998 in Bolivia, 44.8% came of the private sector, 32.08% from households, 16.94% from the government, and 6.18% from international cooperation. In Peru, 38% came from households, 35% from employers, 25% from the

government, and 2% from international cooperation. In 1998 in Chile, 61,38% came from the public sector, and 36.48% from the Health Welfare-ISAPREs Institution; international cooperation was marginal. Sources of public financing included fiscal contributions, the premiums and copayments of people enrolled in the public system, and operating income. In 1999, the distribution by source was 54%, 39%, and 7% respectively, while in 1990 the figures were 41%, 53%, and 6%.

The majority of the countries agree that they must improve their information systems on health financing and expenditure. In Chile, these systems have been developed to a greater degree at the hospital level as a result of diagnosis-related payment systems, where individual accounts are generated by patient and by diagnosis, and invoices are generated for third-party payers. These systems are reliable and comparable, making it possible to consolidate information and calculate global indicators of health activities. The goal of Colombia's efforts to improve its information system is to prevent failure to pay into the system. Ecuador has completed its second round of efforts to prepare a national health accounts study. Venezuela is examining the need to upgrade its information systems on health financing and expenditure, but no specific strategy has been drawn up to date. In Peru, efforts have primarily targeted public subsidies. The greatest development has been seen in the search for methods to identify beneficiaries. Bolivia did not provide any information on this subject.

FINANCING AND EXPENDITURE

- financing and expenditure.
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Service Supply

New health care modalities are being introduced as a result of the changes brought on by health reform. Countries with a strong insurance component have based the supply of health services on the demand for them. In Chile, this has fostered a move toward a more integrated, family-based approach. Thus, primary care physician's offices are being transferred to Family Health Centers with per capita financing, and the goal is to increase the response capacity of outpatient care. However, articulation between primary care

and specialized care is still poor. To improve coordination between the two, ambulatory surgery, one-day hospitalizations, short treatments, and pre-hospital health care (SAMU) have been implemented.

In Colombia, the system is demand-based for the insured population and supply-based for people without insurance. Targeting strategies have been developed to provide health care to vulnerable groups by means of a system for identifying beneficiaries (SISBEN) and specific actions geared to the elderly, children, and victims of emergencies and disasters.

Bolivia has involved new actors in decentralizing its health systems (municipalities and prefectures), which have increased the supply of services. Actions have mainly targeted vulnerable groups, such as mothers and children under 5 (basic health insurance), and indigenous populations, as well as certain groups at epidemiological risk. Furthermore, some pilot programs have been launched to organize a network of providers, involving public/private coordination and decentralized management.

Actions are less targeted in Chile, although there have been improvements in managing the poorest communities through campaigns to reduce morbidity and mortality from respiratory illness among children under 3 months. In recent years, Peru has given priority to primary health care in an effort to strengthen prevention activities; also mentioned are targeting strategies through school and maternity insurance.

In Venezuela, the supply of services depends on the response capacity and is not demand-based. As in Bolivia, the available information corresponds primarily to the public sector, and there is less information about the private sector. No country has instituted concrete changes designed to improve the referral and counterreferral systems. Columbia has even encountered problems because insurers have created a network for themselves, making access difficult, particularly to the affiliated population.

SERVICE SUPPLY

- reform. Countries with a strong insurance component have based the supply of health care services on the demand for them.

Management Models

According to the information provided, Chile has made the most changes in this regard. The most important change in the management model of the public assistance network is the use of management commitments to generate greater interaction between technical-assistance and administrative-financing teams. These are formal agreements among the different entities of the health system, and they link the allocation of funds with the achievement of goals. In Chile, there is also the legal and institutional possibility of purchasing and selling services from and to third parties through the public subsystem. This generally applies to support services, specialized facilities, and territorial areas administered by the population. Services are also sold to private insurers and providers when supply is limited (in small cities, for example) or when the supply is very specific. Publicly-owned facilities have not been placed under private management.

In Bolivia, the Ministry of Health is slated to develop and strengthen four levels of management, administration, and territorial jurisdiction with multiple service providers selected on the basis of geographic, demographic, access, care, and financing criteria. Management commitments were introduced to handle maternal and child insurance. The year 2000 marked the beginning of autonomous hospital management, and management contracts were drawn up with some districts, although the mechanisms for regulating them were not well-defined. Peru states that, in addition to management agreements between the central level and five departmental health bureaus, efforts are being made to base health care reform on a model of care consisting of networks of health facilities and services, making it possible to mobilize users and resources according to response capacity and level of complexity.

Columbia's goal is to improve management by promoting competition between insurers and providers. Its main function is to manage risk, and it has a tool in the POS, whose content should guarantee its members preventative and curative care at the individual level. Ecuador has had many local and institutional experiences, from the ceding of hospital management to NGOs to local management models. However, none of them extends to the entire system.

MANAGEMENT MODEL

- commitments designed to generate greater interaction between technical-assistance and administrative-financing teams.
- between insurers and providers.
- administration, and territorial jurisdiction with multiple service providers selected on the basis of geographic, demographic, access, care, and financing criteria.

Human Resources

Health workers' participation in reform processes has been limited, and when it has occurred, it has generally been geared only to demanding better wages and labor conditions, as in the case of Chile and Colombia. In Chile, the changes in human resources planning and management have been based on a diagnosis of the supply to set the criteria for expanding the network. In Colombia, there have been isolated actions, more the result of the fiscal crisis than of authentic planning.

With regard to performance incentives, Chile has had an incentives system in place since 1977, based on the experience and performance of health services personnel and on individual or institutional performance in agencies of the health system that do not provide social services. Colombia has an incentives system in theory; however, it has rarely been applied, or the criteria have focused on performing certain tasks, not achieving an impact and promoting teamwork.

In a few cases, changes have been made in professional practice, with the adoption of a multidisciplinary approach. In Colombia, the Ministry of Health has begun to develop a program to turn general practitioners into family doctors through a concerted effort between medical schools and the local health services. However, this initiative aroused strong criticism at first.

In terms of training health workers, Bolivia has developed strategies to regulate the training of health service personnel and to establish health as a career path. Annual training courses are offered to management personnel in medicine, nursing, and dentistry on the management of priority programs and the administration of the national health information system (SNIS).

Two types of training have been introduced in Chile. One is conventional training to improve technical and management skills. With the help of the World Bank, a fund was created in which 1.5 million dollars are invested per year for six consecutive years. This has helped identify training needs, develop projects, and enabled health services to allocate an additional US$ 1.5 million. The second modality, dating from 1998, is continuing health education, which implemented education projects in eight health services, for critical units detected in the initial diagnosis. The Ministry of Health is studying the creation of mechanisms to certify health workers by determining labor competency profiles and staff accreditation systems.

With the leadership of PAHO, the economic assistance from the Ministry of Health, and logistical support from academic institutions and regional agencies, Colombia has worked for the last three years to plan in-service training through continuing health education in 13 departments. This process has made it possible to create a Continuing Health Education Center at Pereira Technical University.

Peru, Venezuela, and Ecuador did not mention any changes in the area of training. None of the countries made reference to certification and recertification mechanisms.

HUMAN RESOURCES

- it has generally only been geared to demanding better wages and working conditions.
-
- approach.
-

Quality and Health Technology Assessment

Bolivia, Colombia, and Peru have instituted accreditation processes at different levels.

In Bolivia, the goal is to strengthen the quality of services in the public network; this involves accreditation by levels and the analysis of quality indicators based on users' perception.

Since 1990, the Colombian Ministry of Health, with the support of PAHO and service providers, has been working to strengthen accreditation programs and guarantee quality. Decree 2174, which establishes the Compulsory Quality Assurance System, provides backing for this process. Resolution 4242 of 1997 establishes the essential requirement of the IPS.

In Peru, approximately 30 hospitals at different levels are in the accreditation process.

Bolivia, Chile, and Colombia report that they have instituted some initiatives in the area of quality programs. In terms of technical quality, Chile mentions training health workers and creating quality management centers. With regard to perceived quality, several patient surveys (SAP) have been conducted in health services and bilingual information centers for the Mapuche Indian population in the Araucanian region.

Only Chile and Columbia have paid attention to health technology assessment. In 1998, the Chilean Agency for Health Technology Assessment was recognized. In Colombia, the Office of Science and Technology Development at the Ministry of Health, with PAHO support, improved health technology assessment. Colombia also has standards for importing and assessing health technologies.

QUALITY AND HEALTH TECHNOLOGY ASSESSMENT

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- Columbia report having launched initiatives for health technology assessment.

II. EVALUATION OF RESULTS

Because health reform is very involved and complex, Ecuador has no specific data to evaluate the results of the process. All the Andean countries, with the exception of Columbia, feel that it is impossible to draw direct and unequivocal causal relationships between sectoral reform and changes in the indicators of equity, effectiveness, quality, efficiency, sustainability, and social participation and control.

For example, Peru mentions that sectoral reform is part of state reform and was preceded by a significant increase in public expenditure. This means that the results achieved are not exclusively attributable to reform, but rather to the public policies that accompanied a major economic revival between 1993 and 1997. In Chile, there is insufficient evidence to determine how much of an impact the reform has had on the health situation of the Chilean population.

Equity

There is limited evidence about how reform has influenced equity by reducing gaps in coverage, distribution, access, and the use of resources. Only Colombia attributes an increase in insurance coverage to the reform, noting that the figure jumped from 21% to 57% between 1994 and 1997. Nevertheless, between 1993 and 1998, coverage of the Expanded Program on Immunization among children under 1 year of age fell from 94% to 79% for BCG, and from 85% to 71% for polio. Peru reports that institutional care for all people suffering from disease or accidents increased from 32.2% to 43.5%, and that primary care coverage increased from 16% to 25% between 1994 and 1997. None of the Andean countries show evidence that the reform has influenced the five indicators selected to evaluate access, or the three selected to measure the use of health care resources.

Effectiveness and Quality

Likewise, there is no clear evidence that the reform has affected the overall effectiveness of the health services system. Nevertheless, at least Colombia and Peru are making changes that could affect quality. In *Colombia*, technical regulations and standards of quality have been formulated and the minimum areas to be developed by the health services have been identified, including the design and execution of plans to improve quality, to measure the degree of user satisfaction, and to handle claims and suggestions. In Peru, some progress has been made in the legal framework with the accreditation of facilities and human resources, the regulation of the private sector, and the preparation of guidelines for medical care and auditing.

Efficiency

In terms of efficiency in allocating resources, only Colombia shows evidence that the reform has influenced the country's health situation as it relates to the supply of drinking water and sewerage

services. In Chile's health situation, 97.5% of the population has toilet facilities, and 70% is connected to a sewerage system. However, this is not attributable only to health sector reform, but also to a series of political and technical decisions made to address social issues.

Both Colombia and Peru have substantially increased the availability of financial resources as a result of reform. In Colombia, reform has resulted in the mediation of financial flows by the Health-Promoting Companies, which has raised management costs and reduced the speed of these flows. Human and technical resources have been concentrated in the health services networks of the EPS, hindering access to the uninsured population. Nevertheless, health reform has led to the reallocation of resources toward the health promotion and disease prevention activities contained in the Basic Health Care Plan.

Peru has targeted spending to primary care, based on regional poverty levels. A programming and budget system has also been set up that allocates financial resources based on the annual goals of the plan, and various methodologies for financing services and delivering diagnoses have been developed. Chile is the only country that believes that its health reform has increased resources for prevention, self-care, investment in critical areas (such as highly complex pathologies and vaccines), and resources earmarked for primary care.

Colombia, Chile, and Peru show evidence that health reform has influenced the management of resources. Peru has introduced budget programming, execution, and monitoring methodologies, with emphasis on decentralization. Progress has been made in standardizing management procedures and in equipping health facilities. However, the lack of an incentives system and administrative complexity hinder their implementation. Chile has introduced tools such as management information systems, fees based on the diagnosis, economic and social evaluation of projects, criteria for cost-effectiveness, and management commitments. Procedures, interventions, and performance measurement indicators in all hospitals have been standardized. As a result, hospitals have reduced the average length of stay, increased the number of discharges per bed, increased the use of surgical wings, and provided information on the cost per diem of hospitalization and outpatient consultations. Colombia is in the process of improving the management of its secondary- and tertiary-level institutions.

Sustainability

Only Chile and Peru state that their reforms are sustainable. Chile has sufficient information on expenditures and both aggregate (public and private sectors) and disaggregated trends by institution and

geographic area. Medium- and long-term sustainability is guaranteed in terms of health policy and the financial decisions that affect programs and services.

Peru states that the creation of the Modernization Coordinating Unit in the public sector, which is in charge of promoting the reform agenda and balancing income and expenditures, supports the sustainability of the process. However, financial constraints seriously threaten the reform process. In Colombia, users and participating institutions have had problems accepting health reform. The financial sustainability of the system has been threatened by negative economic growth, the failure of beneficiaries to pay into the system, corruption in the management of some administrative institutions in the subsidized health regime, and the impossibility of financing the expansion of coverage.

Social Participation and Control

The reforms have created mechanisms to increase the degree of social participation and control in Chile, Peru, Colombia, and Bolivia. In Chile, the creation of Development Committees and Equity Committees (in hospitals and the social security system) is the result of health reform. In Peru, community participation in the organization and management of health services has been developed through the Local Shared Administration Committees in 20% of primary care facilities. In Colombia, reform has strengthened the mechanisms for social, individual, and collective participation through community participation committees in health, oversight subsystems, and community health care services. Bolivia also reports the creation of participation committees at the local level and in public health care facilities and networks.

EVALUATION OF RESULTS

- and unequivocal causal relationships between sectoral reform and changes in the indicators of equity, effectiveness, quality, efficiency, sustainability, and social participation and control.

CONCLUSIONS

Dynamic of the Processes

The social, economic, and political heterogeneity of the Andean countries is visible in the variety of health situations and diversity of processes for implementing health sector reforms. Thus, there seems to be no common point of departure or any two identical processes, even though similarities can be observed among the countries.

At the time of the analysis, all the countries have democratically constituted governments. However, the trajectory and stability of their democracies are not uniform, meaning that the amount of progress made in health reform is also not uniform. In fact, not all the reforms were initiated under democratic conditions, and, even in democratic countries, the degree of public participation was limited at the outset. In some of the countries, negotiations were held among sectors, while in others, this process did not occur. All the countries negotiated with external international cooperation agencies, ranging from international financing institutions to technical cooperation agencies.

The stated objectives of health reform are similar among the six countries. Increasing health services coverage, improving the quality of health care, improving equity, increasing the efficiency and effectiveness of services, and making greater public participation are the most significant. It is possible to identify elements that chart the course of reform and define the specific characteristics of the activities and measures adopted. In all instances, health reform has been part of plans to modernize the State. In some cases, it was part of the process from the outset, and, in others, it has become progressively autonomous. To a certain extent, its inclusion in these plans affects the intensity of changes over time, which in turn has an impact on the dynamic of the process and probably on the results of reform as well. However, the relationship between cause and effect cannot be seen clearly enough using the information currently available.

With the exception of Chile, at the outset none of the health reform processes included well-developed plans of action that laid out goals, dates, and responsibilities. In all cases, the guidelines were based on general health policies. Only Colombia and Chile evaluate health reform, through the preliminary findings obtained by their information systems.

Contents of the Reforms

Reform processes were developed on the basis of explicit sectoral reform agendas. The specific content of health reform in each country is determined by factors such as political traditions, the specific context surrounding the reform (negotiation and key actors), and the rate at which changes take place. Thus, a fast-paced global reform process in a country with a longstanding legal tradition, like Colombia, gave rise to a highly complex process with an extensive and long-lasting regulatory agenda. Chile, on the other hand preferred to progressively minimize the legal impact of the proposed changes.

Although the constitutions of some Andean countries have recently been amended, these changes have not led to great similarities among the respective reform processes. For example, the right to health care is clearly established in the constitution of all the countries (except Peru). However, how this right is manifested varies widely among them. Even though knowledge about it has not always been clearly disseminated among the population, all the countries have tried to make this right a reality, generally by means of different insurance models to increase service coverage.

Changes were made in the organization and administration of the health sector and in health service management models to decentralize services and separate the functions of financing, insurance, and service delivery. Health sector reform has not been consistent with the countries' level of development, although Chile is the country that seems to have made the most progress in this area. What *is* clear is that the greater and more widespread a country's poverty, the higher the private health expenditure; such is the case for Bolivia and Ecuador.

In all the Andean countries, the steering role is assigned to the ministry of health. All the countries express the need for action to strengthen this function. Separation of functions is more evident in countries with a robust insurance market, which tends to coincide with countries that have achieved a greater degree of decentralization and appear to have made more changes in their management models (although these changes do not reveal great similarities).

Although health reform has altered the relative share of the public and private sectors in total health expenditure, the lack of information systems and national health accounts makes it impossible to conduct an in-depth study on the effect of the reform on financing and expenditure variables in the health sector.

Certain features related to the supply of health services coincide with the development of the insurance component. Countries with mixed health systems (public, private, social security) have strategies to target vulnerable groups using a more epidemiological or health risk-based approach (women, children, and population at epidemic risk). Countries with more highly developed insurance systems center on demand-driven health care models geared to improving efficiency (strengthening primary health care and a regulated health market). In the second case, there are also basic programs and packages of health services for at-risk populations.

Even though all the countries have introduced changes to encourage social participation and control, all the forums created focus on social-welfare services. None of the countries has been able to make substantial changes in other areas (planning, allocation of resources, evaluation of results). This appears to be a continuation of the situation that prevailed when the reforms began and participation was limited.

No solid human resources planning system was observed, and the majority of actions in this field were geared to training systems with no impact on undergraduate education, continuing education, and accreditation. Thus, there were no changes in professional practices leading to a multidisciplinary orientation.

Chile and Columbia have made the most progress in terms of technology resources and quality services as result of changes to their health care and management models. As part of the efforts to assess health technologies, Chile created the Chilean Agency for Health Technology Assessment in 1998, and Colombia, with support from international technical cooperation, strengthened its Directorate of Science and Technology Development. Bolivia, Colombia, and Peru presented different initiatives and advances in accreditation.

Results of the Reforms

Certain indicators (equity, efficiency, effectiveness, quality, sustainability, and social participation and control) were selected to evaluate the impact of health reform on the overall performance of the sector and not on health situations. Still, it was not possible to make a clear determination of this impact due to the complexity of health reform in and of itself and to the lack of previously established evaluation criteria in the majority of countries.

However, with regard to equity and access, Colombia reports an increase in insurance coverage from 21% to 57% between 1994 and 1997 while at the time noting a decrease in access among the uninsured or unaffiliated population and a reduction in the coverage of certain vaccination programs. In Peru, even though it is impossible to assess the impact of health reform on equity in health care coverage, access, and the use of health services, the country reports an increase in the institutional care provided in health posts and health centers, but not in hospitals.

With regard to efficiency, Chile is the only country stating that reform has increased the resources for prevention, self-health care, primary health care, vaccines, and highly complex pathologies. Colombia has substantially increased the financial resources allocated to territorial entities, but weaknesses in supervision and regulation, the outsourcing of promotion and prevention services, and local political factors, among other things, have meant that these resources have not been used effectively and efficiently.

In Chile and Peru, sustainability is based on the available information regarding how the health needs of the population have evolved and the resources available to meet these needs in the medium and long term.

In some of the countries, like Colombia, the financial sustainability of health reform has been affected by economic recession, failure to pay into the system, and other financial constraints in the health system.

Social participation and control have increased in the majority of countries in the region through citizen committees that participate in the management of networks and public health facilities.

Difficulties in assessing the results of health reform increase the longer the time covered by the reform and the more gradually it is implemented. In other words, it appears easier to assess the results of a reform process that introduces many changes in a short period of time, as in Colombia, than of one that makes changes over several decades. It is also difficult to identify the cumulative impact of changes, and the intervention of different factors in the reform process is higher. This coincides with the fact that Colombia is the only country that mentions the possibility of attributing causality to the changes introduced.

The results presented show that the health reforms appear not to have had an aggregate positive effect on the health sector. The situation described shows the complexity of the processes and how context influences the success of reforms.

It has not been possible to match the content or genesis of the health reforms with the results achieved due to the lack of information on monitoring the processes and evaluating the results.

The current state of the reform processes described shows that models with a robust insurance component, such as Chile and Colombia, combine a social security regime with a competitive insurance system. The two components share financing that comes from the compulsory contributions of salaried workers. Colombia has an insurance scheme comprised of two regimens (contributory and subsidized) that covers around 50% of the population. The first regime is financed by the contributions of employers and workers, and the second by funds from this same source and other State resources. Public and private entities participate in insurance and health service delivery. The system currently exhibits problems in the areas of equity and financial sustainability.

There are traditional public, private, and social security systems in Bolivia, Ecuador, Peru, and Venezuela, which do not operate in a sufficiently integrated manner. Bolivia has tested and evaluated basic health insurance for the population without social security insurance and is also discussing draft legislation on universal insurance that would extend basic health insurance to the entire population. In Venezuela, an organic health law has been formulated and is currently under discussion. Its goal, among other things, is to put all public institutions, bodies, and facilities that provide health programs and services in the social security system under a single regime, creating a social security health system.

In short, with the partial exception of Chile, the rest of the Andean countries have still not adequately resolved how to combine the weak steering role, segmented health sector, fragmented service networks, and the predominance of private expenditure (particularly direct out-of-pocket payments) that, with few exceptions, characterize health systems in Latin America and the Caribbean.

* The second edition of the Analysis of Health Sector Reforms in the Andean Countries was conducted by Drs. P. Rivas-Loria, A. Infante, R. Murillo, and J. Pedroza of the Program on Organization and Management of Health Services, Division of Health Systems and Services Development, of the Pan American Health Organization/World Health Organization. The document was peer-reviewed by the Fundación ISALUD, Buenos Aires, Argentina. The ISALUD review was coordinated by Master Arturo Schweiger. The following five ISALUD professionals participated in the peer-review: M. Virgolini, C. Vasallo, A. Reale, C. Madies, and E. Tecilla.

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