

HEALTH SYSTEMS PROFILE ECUADOR

MONITORING AND ANALYSIS
HEALTH SYSTEMS CHANGE/REFORM

Third Edition
(October, 2008)



HEALTH SYSTEM PROFILE ECUADOR

MONITORING AND ANALYSIS OF THE CHANGE AND REFORM PROCESSES

Third edition

(October 2008)

Biblioteca Sede OPS – Catalogación en la fuente

Organización Panamericana de la Salud

“Perfil de Sistema de Salud: Ecuador, monitoreo y análisis de los procesos de cambio y reforma”

Washington, D.C.: OPS, © 2008

ISBN: 978-92-75-32944-3 (Impreso)

978-92-75-33267-2 (Electrónico)

I. Título

1. SISTEMAS DE SALUD – tendencias
2. POLÍTICAS, PLANIFICACIÓN Y ADMINISTRACIÓN EN SALUD
3. ACCESIBILIDAD DE LOS SERVICIOS DE SALUD
4. FUNCIONES ESENCIALES DE LA SALUD PÚBLICA
5. REFORMA EN ATENCIÓN DE LA SALUD
6. PERFIL DE SALUD
7. ECUADOR

NLM WA540 DE2

This publication was produced by the Health Policies and Systems Unit, Health Systems Strengthening Area (HSS/HP) of the Pan American Health Organization/World Health Organization (PAHO/WHO). This publication was made possible through support provided by the Office of Regional Sustainable Development, Bureau for Latin America and the Caribbean, U.S. Agency for International Development (USAID), under the terms of Grant No. LAC-G-00-07-00001. The opinions expressed in this publication are those of the author (s) and do not necessarily reflect the views of the U.S. Agency for International Development.

The electronic version of this document is available at the Web site for Health Systems Strengthening in Latin America and the Caribbean and can be accessed at www.lachealthsys.org. For any questions or inquiries regarding this document, please contact info@lachealthsys.org.

CONTENTS

Executive Summary	5
1. CONTEXT OF THE HEALTH SYSTEM.....	7
1.1 Health status analysis	7
1.1.1 Demographic analysis	7
1.1.2 Epidemiological analysis	8
1.1.3 Millennium Development Goals (MDGs)	13
1.2 Health determinants	15
1.2.1 Political determinants	15
1.2.2 Economic determinants	16
1.2.3 Social determinants	17
1.2.4 Environmental determinants.....	19
2. FUNCTIONS OF THE HEALTH SYSTEM	21
2.1 Steering Role.....	21
2.1.1 Mapping of the National Health Authority	21
2.1.2 General Health Policy Leadership	23
2.1.3 Sectoral regulation.....	27
2.1.4 Development of the Essential Public Health Functions (EPHF)	29
2.1.5 Orientation of financing.....	30
2.1.6 Guarantee of insurance	31
2.1.7 Harmonization of service delivery.....	32
2.2 Financing and assurance	34
2.2.1 Financing	34
2.2.2 Assurance.....	37
2.3 Health service delivery	39
2.3.1 Health services supply and demand.....	39
2.3.2 Development of health workforce	43
2.3.2.1 Human resources training.....	43
2.3.2.2 Human resources management and employment conditions.....	43
2.3.2.3 Human resources supply and distribution.....	44
2.3.2.4 Governance and conflict in the health sector.....	45
2.3.3 Drugs and other health products	46
2.3.4 Quality of services	47
2.4 Institutional mapping of the health system	47
3. MONITORING OF THE CHANGE AND REFORM PROCESSES.....	48
3.1 Effect on health system functions.....	52
3.2 Impact on guiding principles of the reform	53
3.2.1 Equity.....	53
3.2.1.1 Coverage	53
3.2.1.2 Resource allocation	54
3.2.1.3 Service delivery	55
3.2.2 Effectiveness	55
3.2.2.1 Maternal and child mortality.....	55
3.2.2.2 Incidence of communicable diseases	56
3.2.3 Efficiency	56
3.2.4 Sustainability	57
3.2.5 Social participation	57
3.3 Impact on the health system	58
4. REFERENCES.....	61
5. WORKING TEAM.....	63

Figures

Figure 1. Population pyramid. Ecuador. 2006	7
Figure 2. Percentage of chronic, acute and general malnutrition in children under 5	9
Figure 3. Vaccination coverage	10
Figure 4. Trend in maternal mortality rate	11
Figure 5. Reported cases of HIV/AIDS and deaths	12
Figure 6. Annual average percentage of health expenditure by income quintiles	17
Figure 7. Trend in the illiteracy rate*	19
Figure 8. Access to health services: travel and waiting time	26
Figure 9. Results of the EPHF measurement	29
Figure 10. Cantonal health councils	33
Figure 11. Per capita public health expenditure, 2000–2006	35
Figure 12. Per capita annual health expenditure (all households)	36
Figure 13. Financing mechanisms for hospitalization expenditures	36
Figure 14. Population with health insurance by quintile in 2004	37
Figure 15. Public hospitals: MPH, IESS, Armed Forces, Police and Municipalities	39
Figure 16. Percentage share of public health services in 2008	41
Figure 17. Number of health facilities with and without hospital inpatient care	42
Figure 18. Results of health emergency declaration	54

Tables

Table 1. Demographic Trends for Selected Indicators	8
Table 2. Incidence of poverty and extreme poverty by ethnicity and geographical area	18
Table 3. Access to health services (%)	25
Table 4. Financial resources for international cooperation in health (in millions of US\$) Ecuador. 2000–2004	27
Table 5. Relationship between health sector budget (%),	34
Table 6. Health facilities with and without inpatient care in the private sector	42
Table 7. Health workers by sector and class	44
Table 8. Type of personnel working in health facilities, by level of complexity	45
Table 9. Institutional mapping of the health system	47
Table 10. Periods of change and effect on health system functions	52
Table 11. Periods of change and impact on the health system	58

Acronyms

ADC	Andean Development Corporation
AFEME	Association of Ecuadorian Schools of Medicine and Health Sciences.
AGECI	Ecuadorian International Cooperation Agency
ART	Antiretroviral Therapy
AUS	Universal Health Insurance
CEPAR	Center for Studies on Population and Social Development
CIAR	Interagency Commission to Support Reform
CNRH	National Water Resource Board
CONAM	National State Modernization Council
CONARHUS	National Committee on Human Resources in Health
CONASA	National Health Council
CONELEC	National Electricity Board
EBAS	Basic Health Teams
EDC	Early Detection of Cancer
EOC	Essential Obstetric Care
EPHF	Essential Public Health Functions
EPI	Expanded Program on Immunization
FASBASE	Strengthening and Extension of Basic Health Services
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
ICD 10	International Classification of Diseases
ICPC	International Classification of Primary Care
IESS	Ecuadorian Social Security Institute
IMCI	Integrated Management of Childhood Illness
INAMHI	National Institute of Meteorology and Hydrology
INEC	National Institute of Statistics and Censuses
INHMT	Leopoldo Izquieta Prez National Institute of Tropical Medicine and Hygiene
ISSFA	Armed Forces Social Security Institute
ISSPOL	National Police Social Security Institute
JBG	Guayaquil Welfare Board

LOS	Organic Health Law
LOSNS	Organic Law of the National Health System
MAE	Ministry of the Environment of Ecuador
MAISFC	Comprehensive Family and Community Health Care Model
MCDS	Ministry for Coordination of Social Development
MDG	Millennium Development Goals
MPH	Ministry of Public Health
NCD	Noncommunicable Disease
NGOs	Nongovernmental Organizations
NHA	National Health Authority
ORAS/CONHU	Andean Health Agency/Hipólito Unanue Agreement
PAHO	Pan American Health Organization
PCU	Reform Project Coordinating Unit
PGC	Central Government Budget
PHC	Primary Health Care
EPI 2	Instrument of the Integrated Epidemiological Surveillance System
PNS-MPS	National Program for Prevention and Control of STD-HIV/AIDS
POAS	Annual Operating Plan
PRO-AUS	Universal Health Insurance Program
SENPLADES	National Secretariat for Development Planning
SIGEF	Integrated Financial Management System
SIGOB	Government Information System
SIISE	Integrated Social Indicator System of Ecuador
NHS	National Health System
SODEM	Millennium Development Goals Secretariat
SOLCA	Cancer Society
SSC	Rural Social Security
TB	Tuberculosis
SS+ PTB	Smear-Positive Pulmonary Tuberculosis
TSSE	Sectoral Transformation of Health in Ecuador
VPD	Vaccine-Preventable Diseases
WHO	World Health Organization

Executive Summary

Ecuador is a constitutional State organized as a republic and with a decentralized government. In 2006, the country had a total population of 13,408,270. With an aging index of 25.97 and 30% of the total population represented by children under the age of 15, the demographic structure of the population is primarily young. It is a multiethnic, multicultural country made up of indigenous, Afro-Ecuadorian, mulatto, mestizo, and white populations. There is evidence of an epidemiological concentration in which deficiency diseases and communicable diseases coexist with chronic degenerative conditions. The most common public health problems are motor vehicle accidents and assaults.

In the past 15 years, the political context of the country has been characterized by significant institutional instability and a high level of social conflict. Between 1992 and 2006, there were eight different national governments. This led to a significant governance crisis and social violence, as well as an increase in corruption, administrative instability, and lack of continuity in public administration. These problems have affected the dynamic of the health sector and its reforms.

The recently approved Constitution of 2008 establishes a legal framework for the creation of the National System for Social Equity and Inclusion, of which health is a component. The Constitution states that health is a right. The document outlines the characteristics of the national health system, which will operate according to the principles of universality and equity, with an integrated public health network under the steering of the national health authority. In this regard, the articles of the new Constitution favor reform of the health sector, which is referred to as Sectoral Transformation of Health in Ecuador (TSSE).

The health service delivery system is marked by fragmentation and segmentation, since there is a lack of coordination between actors and no separation of functions between the subsystems. Each subsystem has a subscriber or beneficiary population with access to differentiated services. Each institution in the health sector has its own organizational scheme, management, and financing. The public subsector includes the Ministry of Public Health (MPH), Ecuadorian Social Security Institute (IESS-SSC), Armed Forces Social Security Institute (ISSFA), and National Police Social Security Institute (ISSPOL) services,

and the health services in some municipalities. The Guayaquil Welfare Board (JBG), the Guayaquil Children's Protection Society, the Cancer Society (SOLCA), and the Ecuadorian Red Cross are private entities with activities in the public sector.

The budget for the health sector increased from \$115.5 million in 2000 to \$561.7 million in 2006. During the same period, the budget as a percentage of the central government budget (PGC) and GDP increased from 2.7% to 6.6% of PGC and from 0.7% to 1.4% of GDP. The population covered by public or private health insurance was slightly under 23% in 2004. If the population is analyzed by quintiles, the poorest sector (Q1) is that which is least protected, since only 12% have health insurance. This percentage is greater at higher income levels (36% in Q5).

In 2006, there were 55,578 people working in health care facilities, primarily physicians (19,299), nursing assistants (13,923), and nurses (7,499). The number of physicians per 100,000 inhabitants in 2006 was 14.4. There were 5.6 nurses and 10.4 nursing assistants per 100,000 inhabitants. The highest percentage of physicians (63%) work in general hospitals and clinics. Only 24.9% of the total physicians in health care facilities work at outpatient and primary care services.

Ecuador has not had any real health sector reform in terms of sustained, in-depth changes in the structure of the sector. From 1995 to 2005 this process was characterized by development and discussion of several initiatives with different approaches to insurance, the legal framework, and partial or targeted application of health service deconcentration and decentralization; programs for the extension of coverage; new primary health care-based family and community health care models, and the universal insurance program (AUS).

The political and administrative instability experienced by Ecuador during this period prevented the development of specific and sustained implementation plans as a result of the contradictory policies adopted in different periods by each new government, the resistance of progressive social organizations, and the lack of consensus among stakeholders.

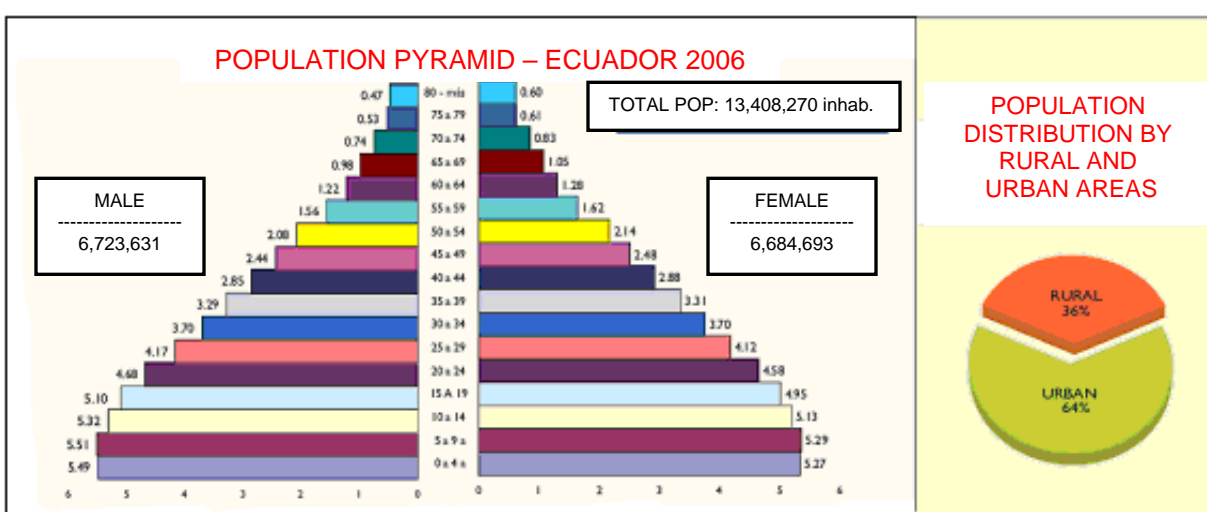
1. CONTEXT OF THE HEALTH SYSTEM

1.1 Health status analysis

1.1.1 Demographic analysis

According to the population forecasts prepared by the National Institute of Statistics and Censuses (INEC), the population of Ecuador in 2006 numbered 13,408,270, of which 6,723,631 were male and 6,684,693 female. The majority of the population (64%) lives in urban areas, where the population density is 52.3 inhabitants per km².

Figure 1. Population pyramid. Ecuador. 2006



Source: INEC. Prepared by: MPH, Quality assurance

The demographic structure reflects a primarily young population. Over 30% of the population is under the age of 15 and the aging index is 25.97% (adults over 60 years/population 0-14 years). From 1995 to 2000 and 2000 to 2005, life expectancy for both sexes increased from 72.3 to 74.2 years (from 69.6 to 71.3 years in men and from 75.1 to 77.2 years in women).¹ Annual growth during the 1990 to 2001 intercensus period was 2.1 per 100 inhabitants.

Ecuador is a multiethnic and multicultural country. A total of 6.1% of the population over the age of 15 is considered indigenous, 5% is Afro-descendant and mulatto, 77.7% is mestizo,

¹ INEC-CEPAL, Estimaciones y Proyecciones de Población 1950-2025

and 10.8% is white. The highest concentration of indigenous population is found in the provinces of the Sierra (Chimborazo, 70%; Cotopaxi, 60%; Imbabura, 45%; Bolivar, 40%; and Tungurahua, 28%).²

The crude death rate (per 1,000 inhabitants) was 5.8 in 2001³ and 5.0 in 2005.⁴ The infant mortality rate was 24.9 per 1,000 live births in 2001 and 22.3 in 2004. The birth rate has fallen steadily in the past 15 years.

**Table 1. Demographic Trends for Selected Indicators
Ecuador. Selected Time Periods**

Periods/Indicators	1990–1995		1995–2000		2000–2005	
	Male	Female	Male	Female	Male	Female
Total population (thousands) (1) *	5,727,121	5,669,571	6,175,859	6,122,886	6,628,368	6,586,721
Urban population (1) *	3,252,648	3,343,411	3,685,298	3,765,010	4,153,605	4,224,864
Percentage of urban population	56.8	59.0	59.7	61.5	62.7	64.1
Indigenous population	N/A		N/A		6.1	
Annual population growth rate (1)	2.08		1.52		1.44	
Total fertility rate (1)	3.40		3.10		2.82	
Crude birth rate x 1000 inhabitants	27.53		25.61		23.34	
Crude death rate (1)	5.84		5.29		5.03	
Life expectancy at birth (1)	67.56	72.63	69.65	75.11	71.3	77.2
Migration balance (thousands) (annual migration) (1)	-10		-60		-50	

Source: (1) Ecuador, population estimates and forecasts 1950-2025. INEC-ECLAC

* The information on estimated population refers to the last year of each 5-year period.

1.1.2 Epidemiological analysis

In Ecuador, rather than an epidemiological transition, the situation is one of accumulation. Deficiency diseases and communicable diseases coexist with chronic degenerative conditions and public health problems. The first category consists primarily of acute respiratory infections, diarrheal diseases, malaria, pulmonary tuberculosis, vaccine-preventable diseases, general malnutrition, chronic malnutrition, and anemia. Chronic degenerative conditions include cerebrovascular disease, ischemic heart disease, hypertension, diabetes mellitus, malignant tumors, AIDS, and mental health problems. The most common public health problems are motor vehicle accidents and assaults. This

² Ministry of Public Health (MPH). Informe de la Dirección Nacional de Salud de Pueblos Indígenas; Ecuador, 2005.

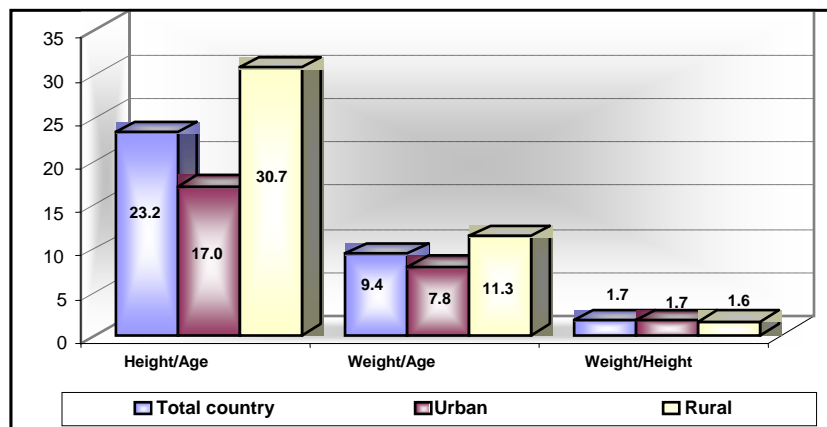
³ Pan American Health Organization (PAHO). Health Situation in the Americas: Basic Indicators. Washington, DC: PAHO; 2001.

epidemiological profile is related to a series of determinants such as the poverty and inequity in the country, which will be analyzed in this document.

According to INEC, in 2006, the most common cause of hospital visits was diarrhea and gastroenteritis of presumably infectious origin, with a rate of 25.6 per 10,000 inhabitants. The second was unspecified abortion, with a rate of 19.2 per 10,000 inhabitants. The third was unspecified pneumonia, with a rate of 18.2 per 10,000 inhabitants. Among the 10 leading causes of hospital visits was maternal care for known or presumed pelvic abnormalities, with a rate of 6.3 per 10,000 inhabitants. Of the notifiable diseases, acute respiratory infections (26.6 per 100,000 inhabitants in 2005) were the leading cause of outpatient visits to units run by the Ministry of Public Health (MPH). During this period, this type of infection was three times more common than acute diarrheal diseases.⁵

With regard to nutritional status, according to the most recent demographic and maternal-child health survey (2005), 23% of children under 5 suffer from chronic malnutrition. This figure is significantly higher in children of indigenous women (47%), in mothers with lower educational levels (38% in children of mothers with no education), and among the population living in the Sierra (32%) and rural areas (31%). In addition, 9.1% of children in Ecuador under the age of 5 suffer from acute malnutrition.

Figure 2. Percentage of chronic, acute and general malnutrition in children under 5 Total country, urban, and rural sectors. Ecuador. 2004



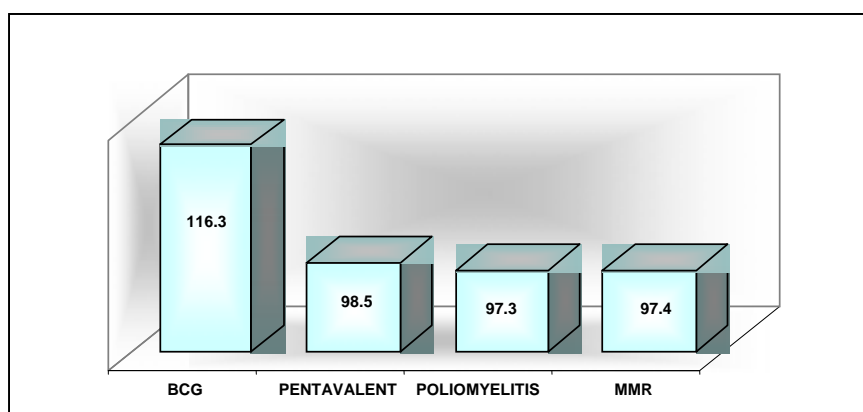
*Anthropometric indicators < 2 SD
 Source: ENDEMAIN 2004
 Prepared by: CISMIL

⁴ PAHO. Health Situation in the Americas: Basic Indicators 2005 .Washington, DC: PAHO; 2005.

⁵ Ministry of Public Health (MPH), National Zoonosis Program, Ecuador, 2001–2005.

The demographic and maternal-child health survey (2005) also highlights the pronounced and sustained reduction in morbidity and mortality associated with vaccine-preventable diseases (VPD) included in the Expanded Program on Immunization (EPI) implemented by the MPH since 1985. The impact to date has been the elimination of some diseases from the national territory. For example, measles was eliminated nine years ago; poliomyelitis was eliminated sixteen years ago; yellow fever six years ago; diphtheria, rubella and congenital rubella syndrome two years ago; whooping cough has been reduced; neonatal tetanus has been eliminated as a national and provincial public health problem; and pneumonia and meningitis due to *Haemophilus influenzae* type B has decreased.

Figure 3. Vaccination coverage Ecuador. 2006



BCG, pentavalent, and poliomyelitis vaccine coverage are in children under 1 year. MMR vaccine coverage is in children from 12 to 23 months of age. Of the total persons vaccinated, the number of children from other countries is not known.

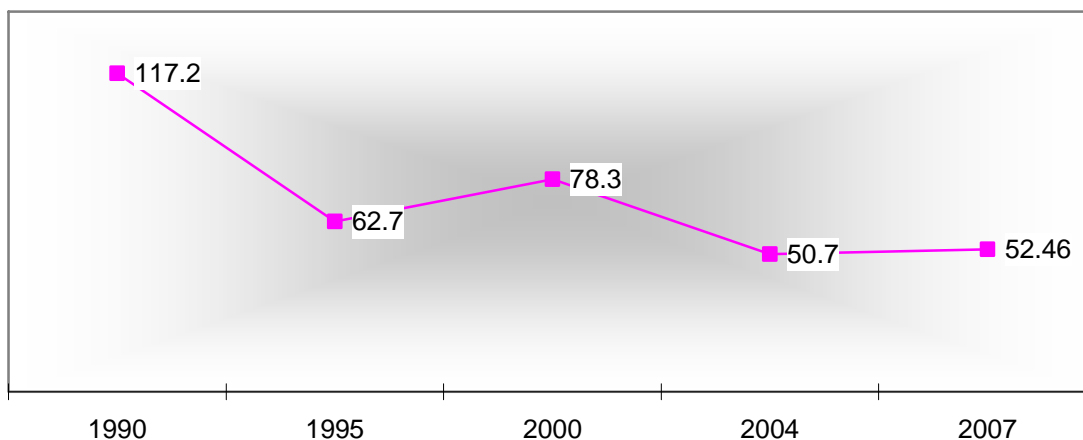
Source: MPH. Expanded Program on Immunization

Prepared by: CISMIL

The trend in the maternal mortality rate has been irregular: in 1990, the rate was 117.2 per 100,000 live births, whereas in 2007, a rate of 52.46 per 100,000 live births was recorded. Most maternal deaths are due to obstetric bleeding (43.3%), postpartum bleeding accounts for 31.8% of these cases. The second leading cause is eclampsia (32.7%) and sepsis (1.7%). The factors most often associated with maternal mortality include the location where the birth is attended, the staff providing the care, the timeliness of care, and the location and staff providing the care for complications and postpartum examinations. Some 75.9% of deliveries from 1999 to 2004 occurred in health care institutions and 24.1% in households. In 15% of the deliveries that occurred in households, care was provided by an unqualified midwife, a family member, or the mother herself. According to the demographic and maternal-child health survey (2005), postpartum monitoring is the least common health

service provided in Ecuador. Only 36.2% (44.4% in urban areas and 26.4% in rural areas) of women received at least one postpartum examination.

Figure 4. Trend in maternal mortality rate Ecuador. Selected Years

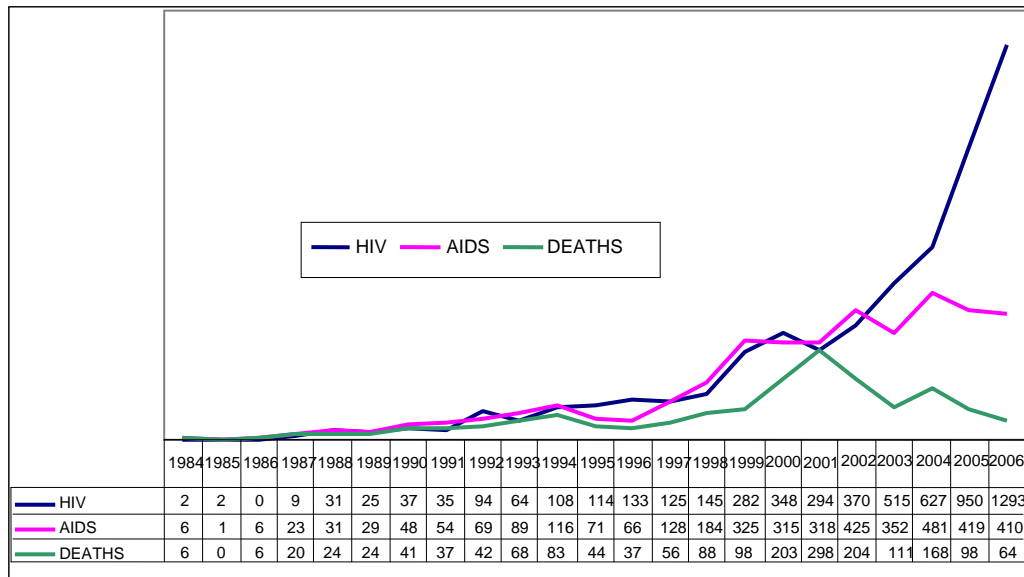


*Rate per 100,000 live births. Includes live births in the year of birth and those recorded 1 year later.
Source: INEC. Yearbook of Vital Statistics, Births and Deaths
Prepared by: CISMIL

According to UNAIDS estimates, approximately 40,000 people in Ecuador have HIV/AIDS.⁶ From 1984 to 2006, a total of 9,815 cases of HIV/AIDS were reported, 1,933 of which were fatal.⁷ The epidemic has shown a steady annual increase: in 2006, there were 1,293 new cases of HIV and 410 new cases of AIDS, which accounted for a total of 64 deaths. In 2006, the male/female ratio was 1.5:1, compared to nearly 6:1 in 1990. Infection patterns by gender show that in Ecuador, HIV/AIDS has spread among the homosexual and bisexual populations. It is also found in heterosexuals, with a more pronounced trend than in the other two populations. The heterosexual/bisexual and homosexual ratio increased from 0.5 in 1990 to 4.4 in 2006.⁸

⁶ MPH-UNAIDS, Multisectoral Strategic Plan for a National Response to HIV/AIDS, 2007-2015.
⁷ MPH. National Program for the Prevention and Control of STI/HIV/AIDS.
⁸ Ministry of Public Health (MPH). Informe Programa Nacional de SIDA, Ecuador, 2005.

Figure 5. Reported cases of HIV/AIDS and deaths Ecuador. 1984-2006



Source: National Program for Prevention and Control of STI/HIV/AIDS, MPH
Prepared by: CISMIL

Tuberculosis (TB) and malaria are major public health problems in Ecuador. In 2002, 5,506 cases of tuberculosis were reported (including all forms of TB), with a rate of 42.7 per 100,000 inhabitants. For new cases of smear-positive pulmonary tuberculosis (PTB), the rate reported was 32.7 per 100,000 inhabitants. By 2003, the rate of smear-positive PTB increased to 33.6, however, it decreased progressively after that year. In 2006, there were 4,348 new cases with a rate of 32.9 per 100,000 inhabitants (3,323 new cases of smear-positive PTB with a rate of 25.2 per 100,000 inhabitants).

The area at risk for malaria transmission is 182,886 km², or over 60% of the national territory. The geographic distribution includes urban as well as rural inhabitants, primarily populations with greater social vulnerability. In 2004, a total of 28,698 cases of malaria were recorded. In 2006, this figure fell to 9,440 cases. A reported 7,813 of the cases were caused by *Plasmodium falciparum* and a total of 1,627 cases were associated with *Plasmodium vivax*. The most affected age group was the economically active population aged 15 to 44, which accounted for 65% of the total cases.⁹

⁹ Ministry of Public Health (MPH), National Malaria Program; National Institute of Hygiene. Estudio de droga resistencia a los anti maláricos. Resultados preliminares. Ecuador 2004–2005.

In 2006, 57,940 deaths due to all causes were recorded (32,775 men and 25,165 women). Six out of the 10 leading causes of death were interrelated noncommunicable chronic conditions associated with common risk factors such as physical inactivity, unhealthy diets, obesity, smoking, and alcoholism. The ten leading causes of death ranked in order were: cerebral and cardiovascular diseases, influenza and pneumonia, diabetes mellitus, high blood pressure, ischemic heart disease, heart failure, ground transportation accidents, assaults (homicides), cirrhosis and other liver diseases, and conditions originating in the perinatal period. There has been a rapid and sustained increase in mortality from cerebral and cardiovascular diseases, high blood pressure, and diabetes. The information on hospital discharges from the MPH information system and EPI 2 shows a sharp increase in morbidity from diabetes mellitus and high blood pressure.

1.1.3 Millennium Development Goals (MDGs)¹⁰

The MPH is responsible for monitoring the health-related MDGs. With regard to MDG four, “Reduce child mortality,” a significant reduction was observed from 43.1 deaths per 1,000 live births in 1990 to 21.8 deaths per 1,000 live births in 2004. However, the improvement shown in the reduction of infant mortality is insufficient. Ecuador’s national infant mortality rate is among the highest in Latin America.

With regard to MDG five, “Improve maternal health,” although significant progress has been made in reducing maternal mortality, the figure is still very high. Indigenous women and women living in rural areas are most affected. The maternal mortality rate decreased significantly from 117.2 deaths per 1,000 live births in 1990 to 50.7 deaths per 1,000 live births in 2004. However, in order to reach the goal of 29.3 deaths, efforts must be scaled up through the sustained expansion of the Free Maternity and Child Care Program and the Comprehensive Health Services Program for Women and their Partners.

With regard to MDG six, “Combat HIV/AIDS and other diseases,” from 1990 to 2006, the HIV/AIDS rate increased by 1.675%. A total of 9,815 cases were recorded between the outbreak of the epidemic in 1984 and 2006. In 2006 and 2007, Ecuador developed the 2007–2015 Multisectoral Strategic Plan for a National Response to HIV/AIDS, which

¹⁰ UN System–SENPLADES–FLACSO Ecuador - CISMIL, 2nd National Report on Millennium Development Goals, Ecuador 2007.

includes a series of indicators that can be used to measure the dynamic of the epidemic. Several programs are currently in place to implement effective and sustainable intersectoral strategies to provide prevention, control, and comprehensive care for this disease.

The malaria incidence trend has been irregular and it is associated with climatic and unsanitary conditions. The situation is more intense within the large sectors of the population who live with limited access to basic sanitation services. In 2006, the incidence was 124.7 per 100,000 inhabitants, with significantly higher levels in Los Ríos and Esmeraldas, provinces in the Amazon Region. In the last five-year period, the percentage of *Plasmodium falciparum* malaria cases fell sharply, while morbidity from *Plasmodium vivax* showed a significant increase.

Tuberculosis is a major public health problem. In 2003, it was one of the leading causes of morbidity and the 10th leading cause of total mortality in 54.5% of the country's provinces. In 2006, the incidence rate was 32.9 per 100,000 inhabitants, a marked improvement over the rate of 67.9 estimated in 1990. However, several provinces are above the national average. Strengthening the National Tuberculosis Control Program through the DOTS strategy has facilitated the proper management of people with tuberculosis. The strategy highlights the direct observation of treatment, short-course patient monitoring and follow-up, provision of drugs with complete regimens and diagnosis based on sputum-smear microscopy.

Since 1995, no significant progress has been made in reducing extreme poverty. There is stagnation in the eradication of illiteracy and the achievement of the second MDG, which is to achieve universal primary education. The goal for secondary school enrollment rates for males and females will be met for the country as a whole, but not for the indigenous population. Moreover, gender violence has not decreased. With regard to environmental degradation, Ecuador is one of the countries with the greatest loss of vegetation.¹¹ In general, there has been a steady improvement in access to drinking water and sanitation. However, there are still significant gaps depending on the region.

¹¹ UN System – SENPLADES – FLACSO Ecuador - CISMIL, 2nd National Report on Millennium Development Goals, Ecuador 2007

1.2 Health determinants

1.2.1 Political determinants

Ecuador is a multinational, intercultural, social, democratic, sovereign, independent, unitary, constitutional lay State based on rights and justice. It is organized as a republic and has a decentralized government.¹² There are significant geographical, social, and economic differences between its four geographical regions: the Coast, the Sierra, the Amazon region, and the East due to its location in relation to the Andes. It also has an island region made up of the Galapagos Islands. For the administration of the State and political representation, there are 24 provinces, 221 cantons, and 1,205 parishes (408 urban and 797 rural), in addition to the indigenous and Afro-Ecuadorian territorial districts.

Over the past 15 years, the country's political scenario has been characterized by significant institutional instability and high levels of social conflict, which have led to a profound governance crisis. Between 1992 and 2006, there were eight different governments. This led to problems of governance and social violence, as well as greater corruption, administrative instability, and lack of continuity in public administration. These problems affected the dynamic of the health sector and its reforms. Repeated changes in authority (nine Ministers of Health between 2001 and 2005) and the introduction of each administration's own plans and programs weakened the National Health Authority, which has hindered the development and sustainability of coherent processes of change.

The current government has proposed new organizational models expected to eliminate fragmentation and promote links between institutional and sectoral functions. In its proposal on social inclusion, the National Development Plan includes strategic lines and objectives, as well as required policies to achieve the outlined goals. However, it will be difficult to meet these objectives due to the current structure of the health system in Ecuador. With regard to management, plans have been made to ensure viability and feasibility in the decentralization of national finances, to improve the availability and efficiency of national economic resources; in health care, plans will promote a comprehensive, integrated health care model that provides appropriate, compassionate, and high quality services through a plural health care network.

¹² Constitution of the Republic of Ecuador (Art.1)

The country's recently approved Constitution of 2008 establishes the legal framework for the introduction of the National System for Social Equity and Inclusion. The constitution, which recognizes health as a human right, will ensure the achievement of the development objectives. In addition, the constitution outlines the characteristics of the national health system that will operate based on principles of universality and equity and will include an integrated public network under the stewardship of the National Health Authority. The articles of the new Constitution favor reform of the health sector, which is referred to as Sectoral Transformation of Health in Ecuador (TSSE).

1.2.2 Economic determinants

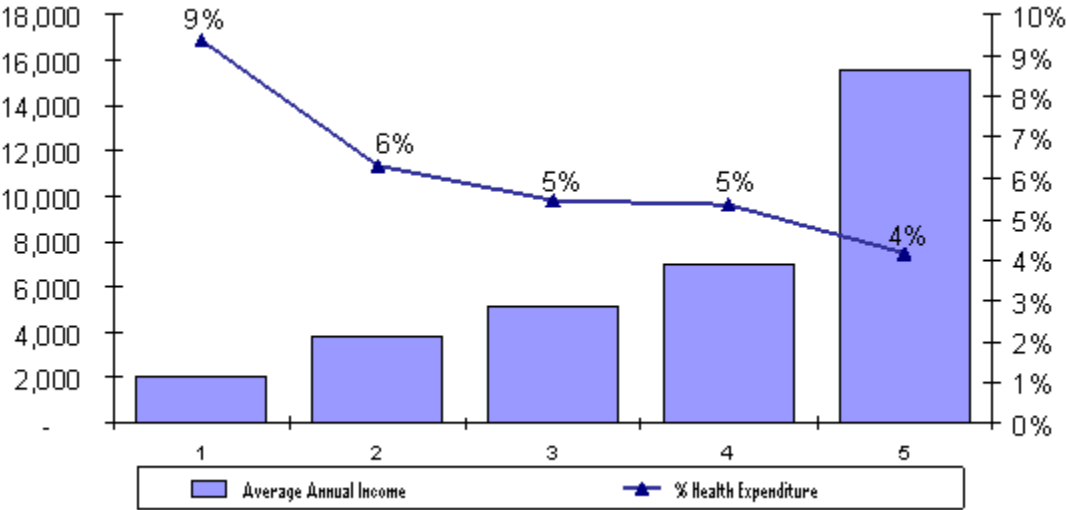
As a result of the economic crisis in 1999, Ecuador adopted the U.S. dollar as its official currency in 2000. Between 2001 and 2005, the national economy recorded an average growth rate of 4.9%. Economic performance resulted in an increase in the per capita gross domestic product (GDP), which rose by 3.5% per annum during this period, reaching US\$2,743 in 2005. Inflation also plummeted from an annual average of 40.26% in 2001 to 2.28% in 2007. A 10% average increase in the minimum wage, in real terms, was recorded between 2001 and 2005.

Unemployment rates have also fallen. The urban unemployment rate fell from 10.9% in 2001 to 7.9% in 2005. According to INEC, in December 2007, the unemployment rate in the total population was 6.1%. In 2004, roughly 56% of women aged 20 to 49 did not have a paid job. The percentage was slightly lower in the Sierra (51%) and the island regions (54%). Women account for some 40% of the economically active population. The unemployment rate of women is two to three times higher than that of men. Due to the segmentation of the job market, women usually work in specific sectors related to their traditional role as caregivers or as secondary providers in the sectors with the lowest levels of productivity, income, and social protection.

As a result of the economic crisis of 1999 to 2000, approximately one million people fled the country between 2001 and 2005 in search of better living conditions and economic opportunity. In 2005, over US\$1,700 million entered the economy in the form of remittances. This economic expansion occurred in the context of domestic political instability. There were three presidents during this period, even though the usual presidential term is four years.

Low-income families allocate a higher percentage of resources to meet their health care needs (9% of Q1 vs 4% in Q5).¹³ However, only 12% of the population in Q1 has health insurance, compared to 36% of the population in Q5.

Figure 6. Annual average percentage of health expenditure by income quintiles Ecuador. 2006



Source: INEC, CVD 2006

1.2.3 Social determinants

The main social problems that affect health status include the high levels of poverty and the significant increase in extreme poverty. An increase in poverty and extreme poverty was observed in the late 1990s; 39% in 1995 to 52% in 1999, respectively. This was attributed primarily to the “El Niño” effect in 1998, the banking crisis in 1999, and the global financial crisis.

In 2003, 41.5% of the population was living in poverty and 8.5% in extreme poverty, whereas in 2004, the percentages were 52% and 14%, respectively. For the period 2005-2006, the poverty rate in the rural population was 61.54% and 24.88% in the urban population. During the first half of this decade the nation experienced a reduction in poverty and extreme poverty. This decrease was not associated with structural changes aimed at

¹³ National Institute of Statistics and Censuses (INEC). Living Conditions Survey, 2006.

creating employment and reducing inequality, but rather with an increase in oil investment and remittances.

Poverty levels among the indigenous population, Afro-Ecuadorians, and rural dwellers were much higher than the national average (68%, 43%, and 62%, respectively). However, poverty in other ethnic groups is lower than the national average.

Table 2. Incidence of poverty and extreme poverty by ethnicity and geographical area (% of total population) Ecuador. 2005

Category	Poverty	Extreme Poverty
Geographical Area		
Rural	61.54	26.88
Urban	24.88	4.78
Ethnic group		
Indigenous population	67.79	39.32
Afro-Ecuadorian	43.28	11.64
Mestizo	30.78	8.28
White	27.41	7.58
Other	26.14	13.20
National	38.28	12.86

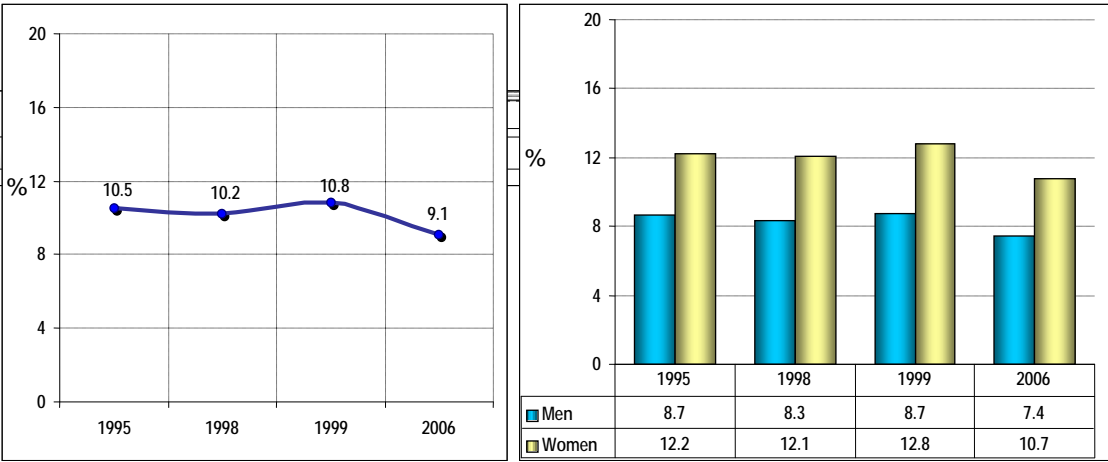
Source: SIISE-INEC, based on CVD 2005-2006, INEC

The ENDEMAIN 2004 shows that 41% of Ecuadorian women have been victims of violence. Women who live in urban areas report slightly higher rates than those living in rural areas. Indigenous women and women with lower levels of education report higher rates of violence. The incidence of violence in women with no education is 15% higher than the incidence in women with upper-level or graduate education.

The general illiteracy rate of the population over the age of 15 was 9.1% in 2006. However, this percentage was higher in the provinces with greater concentration of indigenous population (Chimborazo, Cotopaxi, and Bolivar). The rate was also higher in women (10.7%) than in men (7.4%). During the previous decade there was an increase in basic enrollment of approximately seven percentage points, reaching a figure of nearly 91% in 2006. This means that one in 10 children between the ages of five and 14 does not receive basic education.

When reviewing rates of access to and completion of basic education by income quintile and ethnic group, lower percentages are observed in quintiles one and two than in the country as a whole. Percentages are also lower for indigenous and Afro-Ecuadorian ethnic groups, less than 86% of whose members are enrolled in basic education and 34% have completed this level. In 2005, 66.8% of the population had completed primary education: 67.9% of the men and 65.8% of the women. The percentage of women with no education increased from 1% in the 15-19 year old age group to 10% in the 45-49 year old age group. In contrast, the percentage with higher and graduate education decreased from 23% in women 20-24 years old to 16% in those 45-49 years old.

Figure 7. Trend in the illiteracy rate* Ecuador. Selected Years



*Over 15 years of age
 Sources: CVD 1995, 1998, 1999, 2006
 Prepared by: CISMIL

1.2.4 Environmental determinants¹⁴

The national environmental authority is the Ministry of the Environment of Ecuador (MAE). Throughout the past four years, the MAE has instituted a major decentralization and deconcentration of environmental functions. The main challenge of the environmental sector in the late 19th century was to improve management efficiency to overcome constraints imposed by a centralized model. The environmental sector includes national entities responsible for the formulation and implementation of policies that focus on the

¹⁴ National Institute of Statistics and Censuses (INEC). Living Conditions Survey, 2006.

conservation, protection, and improvement of the country's environment and natural resources.

Most of the water consumed in Ecuador, or 80% of the total water harnessed, is used for irrigation. Domestic use is relatively low and only 5% of the water used for domestic purposes is treated. The remaining water returns to tributaries in the form of wastewater with a high organic and polluting content. The percentage of dwellings with access to water piped into the home by the public network has steadily increased; according to the INEC survey on living conditions, the national average was 37% in 1995, 40% in 1999, and 48% in 2006. The deficit in access to piped water is reflected by the urban-rural gap, with coverage of 66% and 14% respectively. This gap is also observed by poverty level, in which 11% of the poorest quintile (Q1) has water coverage, compared to 87% in the wealthiest quintile (Q5).

The percentage of dwellings with excreta disposal service increased from 84% in 1995 to 90% in 2006. There is a difference of up to 11% between urban and rural areas, and a 26% difference between Q1 and Q5, due to low consumption by the poor. Sewage system coverage increased from 44% in 1995 to 49% in 2006. Nevertheless, there are currently clear regional differences with respect to access to sewage systems. An estimated 69% of dwellings in the Sierra region have sewage systems, while coverage is reported to be less than 40% in the coastal and Amazon regions. Moreover, the figures for rural and urban areas differ, with coverage of 29% and 95%, respectively. There is 43% refuse collection coverage in the poorest quintile (Q1) and 94% for dwellings in the wealthiest quintile (Q5). In most provinces, coverage ranges from 50% to 75%.

As a result of its geographic location in the Pacific Ring of Fire, Ecuador lives under the constant threat of geological phenomena such as earthquakes, volcanic eruptions, and land instability, as well as meteorological phenomena that produce floods, droughts, hailstorms, and frost. In addition, human activity is responsible for deforestation, forest fires, oil spills, contamination with dangerous chemical substances, and surface and groundwater pollution. These conditions can lead to disasters and have a significant impact on health, either directly or by altering the availability of food and safe drinking water.

2. FUNCTIONS OF THE HEALTH SYSTEM

Article 32 of the Political Constitution of the Republic of Ecuador (2008) identifies health as a right guaranteed by the State through economic, social, cultural, educational, and environmental policies and permanent, opportune access, without exclusion to programs, actions, and services that promote and provide comprehensive general, sexual, and reproductive health services. Health service delivery is governed by the principles of equity, universality, solidarity, interculturalism, quality, efficiency, effectiveness, precaution and bioethics, and includes a gender and generational approach. In addition, article 358 states that “the national health system shall seek to develop, protect, and recover the capacity and potential for a healthy and full life [...]” Article 359 states that the “national health system shall be comprised of the health institutions, programs, policies, resources, actions and actors.” Article 360 indicates that “through its institutions, the system shall guarantee promotion, prevention, and comprehensive family and community care based on primary health care.”¹⁵

2.1 Steering Role

2.1.1 Mapping of the National Health Authority

Under the current constitutional and legal framework, the Ministry of Public Health (MPH) is the national regulatory entity for health. As such, it is responsible for managing all processes defined in government health policies. The MPH participates actively with the different health agents to reach agreements on policy at the sectoral level through the National Health Council (CONASA), presided over by the Minister of Health. The authority of the MPH is recognized by all health agents in the public and private sector, which have expressed the need to strengthen this role to improve the performance and management of the health system.

The social security institutions, represented by the Ecuadorian Social Security Institute (IESS), which includes Rural Social Security (SSC), the Armed Forces Social Security Institute (ISSFA), and the National Police Social Security Institute (ISSPOL), formally recognize the authority of the MPH in matters related to universal access to comprehensive services. These institutions are also members of CONASA.

¹⁵ Constitution of the Republic of Ecuador, 2008.

CONASA, which was created as an advisory agency of the MPH in 1980, has been an independent entity in terms of its administration and financing since 2002. Its purpose is to promote public policy consensus and coordination mechanisms for the organization and development of the national health system, pursuant to the Organic Law of the National Health System (LOSNS). Its governing body includes representatives from the public and private institutions that are active in the health sector. It functions primarily through meetings of committees of institutional experts (planning, drugs, human resources, bioethics) whose purpose is to reach agreements on policies, standards, regulations, and other general technical instruments.

Although there have been valuable achievements in previous years that culminated in the definition of policy documents and the LOSNS, the period since its enactment has been especially productive for CONASA. Some of the most noteworthy policies and work plans are in the areas of drugs, health research, health promotion, health and sexual/ reproductive rights, bioethics, guidelines for the formation of health councils and the drafting of health plans, the general forms for the Standard Medical Record, and all of the services and clinical protocols associated with the priority benefits. These instruments have facilitated the adoption of intercultural approaches to public health, harmonization of the national health accounts, and the orientation of policies in regards to human resources and public health education.

CONASA has promoted joint construction of the domestic health agenda with broad participation by the Ecuadorian society and its institutions, which were invited to attend three "Health and Life Congresses" (COSAVI) in Quito, Guayaquil, and Cuenca. At these congresses, there were productive discussions on the LOSNS, promotion of key policies and processes, and definition of collective guidelines that would later be used in the draft texts for the new Political Constitution of Ecuador in 2008. Preparations for the fourth COSAVI are currently under way. Its main theme will be the changes in the health sector under the new constitutional framework.

In short, the MPH is responsible for the management, control, coordination, regulation, and evaluation of health activities and services provided by public and private entities.

2.1.2 General Health Policy Leadership

Between 2002 and 2006, after a participatory national consultation with different State and civil society actors promoted by the MPH and CONASA, a proposal for a national health policy organized into three spheres of activity was approved: a) citizenship building in health, b) comprehensive health protection, and c) sectoral development. The stated policy objectives were to:

1. Promote citizenship in health and guarantee, respect, promote, protect, and enforce human rights to ensure a decent and healthy life;
2. Guarantee comprehensive health protection for the population, facilitating the means to promote physical and mental health, prevent and combat diseases and their causes, mitigate their biological, economic, and social impact; and
3. Develop health sector capacities through organizational and participatory processes that lead to the establishment and operation of the National Health System, the integral development of human talent, scientific and technological development, the promotion of information systems, and an adequate supply of material, technological, and financial resources.

Pursuant to its legal mandates, the MPH has established its mission and institutional vision as a regulatory entity of the health sector. Under its strategic guidelines: “[...] it shall guarantee universal collective access to health services with comprehensive quality care for all persons, families, and communities, especially those in the most vulnerable situations, to ensure a healthy population and environment, consolidate its governance of the sector, and promote community and health worker participation in the drafting of and decentralized, deconcentrated application of health policies.” Its mission is “to safeguard adherence to the principles set forth in the Political Constitution, wherein the State guarantees the inalienable right to health and its promotion and protection, including traditional as well as alternative medical practices, with the participation of all responsible sectors and actors from the national, provincial, and local areas, through the organization and operation of the National Health System, employing a deconcentrated, decentralized, and participatory approach based on the principles of equity, comprehensiveness, solidarity, universality, participation, plurality, quality, and efficiency.”

Since the international commitments in the Declaration of Alma-Ata in 1978, the MPH has included activities and resources to support and consolidate primary health care in its policies, plans, and programs. The recent document on the “Comprehensive Family and Community Health Care Model” underscores the importance of primary health care and health promotion as essential for improving the health of individuals and families.

The MPH acts as the facilitator between different sectors, sectional governments, and communities in drafting of health promotion policies and the standards and interventions to foster promotion activities. Health promotion has been strengthened by CONASA’s adoption of the National Health Promotion Policy and Plan of Action in July 2007. There are several health promotion programs, such as the Health-promoting Schools Program, community interventions and healthy municipalities, the Methodological Manual for Primary Environmental Care and Health, the Methodological Guide for Community and Social Participation, breastfeeding, the Anti-smoking and Alcohol Law, use of generic drugs.

For the formulation and implementation of health policies, the MPH has information from several institutional sources. The country’s official source of information is the National Institute of Statistics and Censuses (INEC), which provides information on vital statistics, installed capacity of the sector, and health activities and resources at the national level, in addition to studies on poverty and living conditions and satellite health accounts.

There are also other important sources of information for health sector analysis. One of them is the ENDEMAIN Survey 2004. This survey focuses on maternal and child health and was prepared by a nongovernmental organization, the Center for Studies on Population and Social Development (CEPAR). The system of social indicators produced by the Ministry for Coordination of Social Development (MCDS) through the Integrated Social Indicator System of Ecuador (SIISE) is also available. The MPH issues annual reports on the production of its facilities, outpatient centers, and hospitals, and on the epidemiological surveillance system. In addition, CONASA, with support from PAHO, provides information through the Observatory of Human Resources in Health and its technical committees.

The health authority promotes the availability of information on access to health services by socioeconomic group, geographical division, ethnic group, and gender (Table 3). The evidence shows a slight increase in access to health services in the past 10 years. The

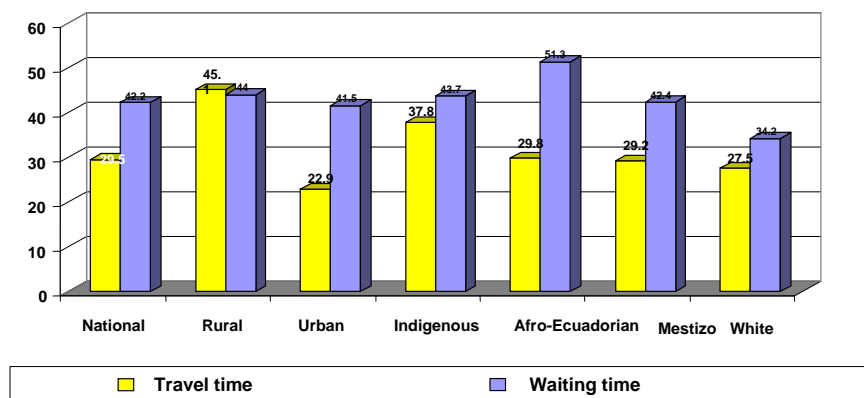
groups that received care most often were women, persons between 45 and 65 years of age, and the urban population. However, this data does not reflect the operation of the system as a whole. Rather, since there is no standardized integrated health information system, institutional databases predominate. Nevertheless, a report on health indicators containing important information about health status and service production has been published for the past 10 years as the result of collaboration with INEC and United Nations cooperation agencies.

**Table 3. Access to health services (%)
Ecuador. 1995, 1999 and 2006**

Breakdown by Category	Access	
	Men	Women
Period		
1995	15.7	19.3
1999	15.5	18.9
2006	16.4	20.2
Population group (2006)		
Children under 5	7.5	6.2
5 -17 years	16	17.1
17-45 years	15.4	20
45-65 years	21.9	29.7
65 years or older	N/A	N/A
Geographical area		
Urban	17.1	21.3
Rural	15.3	18.2
Ethnic group		
Target	17.3	23.4
Indigenous population	12.3	14.8
Mestizo	16.9	20.5
Afro-Ecuadorian	15.1	18.7
Economic level		
Extreme poverty	10.1	12.3
Relative poverty	14.6	16.8
Non-poor population	17.4	21.7
Level of care		
Primary	70	73.9
Secondary	81	80.9

Source: 1995-99 and 2006 Living Conditions Surveys.
Prepared by: SIISE/STMCDs.

**Figure 8. Access to health services: travel and waiting time
Ecuador. 2006**



Source: INEC, CVD 2006.

A standardized system for the monitoring, evaluation, and regulation of health policies is needed to evaluate progress and constraints on policy implementation from an evidence-based sectoral perspective. At the institutional level, the MPH analyzes service production and the achievement of its annual goals in order to monitor operating plans and prepare the annual budget.

There has been successful ongoing participation in international organizations by the health authority, particularly in PAHO and WHO bodies and forums. At the subregional level, the National Health Authority participated in the 60th World Health Assembly in 2007. Every year, the MPH is active in technical commissions on several different health topics in the Andean subregion attended by Presidents and Ministers of Health from South America. The current Minister of Public Health is the Vice-President of the World Health Assembly from 2007 until 2009. In April 2008, the Ministry of Health coordinated the 29th Meeting of Ministers of Health of the Andean Area in Quito.

It is fundamental to understand the role that external cooperation plays in the country, in general, and in particular for the health sector, both in economic terms and in regards to the representativeness of the stakeholders involved in the orientation, management, and execution of international assistance. In 2007, the Ecuadorian International Cooperation Agency (AGECI) was created under the National Secretariat for Development Planning (SENPLADES) to replace the Ecuadorian institute for International Cooperation (INECI). The role of the AGECI is to coordinate and monitor international cooperation in the country.

Ecuador has a National Development Plan 2007–2010 and an annual social agenda, which orient national priorities to align and harmonize international cooperation with social and health goals at the national level.

The primary actors in international cooperation are the United Nations agencies, including PAHO/WHO. Bilateral and multilateral health cooperation agreements are currently in place for programs such as: Program to Support the Health Sector in Ecuador/PASSE/MPH-European Union (2005–2009), Global Fund Agreement, Belgian Cooperation, Esmeraldas Health and Environment Project (SYMAE), and Ecuador Plan.

**Table 4. Financial resources for international cooperation in health (in millions of US\$)
Ecuador. 2000–2004**

Resources/Period	2000–2004
Reimbursable	15,688,813.67
Nonreimbursable	618,474.39
Total	16,307,288.06

Source: MEF(Data provided by Ministry of Coordination and Social Development)
Prepared by: STMCDs

2.1.3 Sectoral regulation

In 2002, the Organic Law of the National Health System (LOSNS) was enacted to establish principles and guidelines for the organization and operation of the NHS throughout the national territory. This legal instrument establishes the competency of the MPH as the national health authority at all levels and the coordination of relations between other functions and members of the system, supported by the health councils. In 2006, the Organic Health Law (LOS) was enacted to replace the Health Code.

The LOS defines health as a fundamental human right. Therefore, it determines the responsibility of the State in health promotion and protection and addresses the health problems associated with the current social, cultural, ethnic, generational, gender, economic, and environmental reality. It covers emerging, chronic degenerative, communicable, and noncommunicable diseases, social problems associated with accidents and violence, and traditional and alternative medicines; regulates the introduction of advances in science and technology, adapting them to current needs; and guarantees the

quality of health products, health activities, and health goods and services. This law is aimed at strengthening intersectoral coordination and providing a sound regulatory foundation for the State governance in health, facilitating the participation of society, and considering health a commitment by all. It sets standards and establishes regulations for health services and the practice of health professions.

With regard to medicines, the LOS states that the MPH shall formulate policies and develop strategies and programs to “guarantee access to and the availability of quality drugs at the lowest cost to the population, with emphasis on generic drug programs.” With regard to human resources, it states that the MPH shall regulate and direct the licensing and certification processes and set “standards for the accreditation of health services.” It also states that “professionals, skilled technicians, and health auxiliaries must register to practice” and establishes the responsibility of the MPH to “participate in health science and technology research and development, in coordination with the competent national entity, safeguarding human rights, in keeping with bioethical principles.”

Specific chapters are devoted to the health professions and health services, as well as traditional and alternative medicines. Standards are set for the regulation, licensing, monitoring, approval, and control of public and private health service operations, including nonprofit and for-profit, autonomous, community, private health, and prepaid health care organizations; and the granting of operating permits. In addition, the LOS calls for timely, efficient, and quality health care; sets the fees for health services and the plans and programs offered by prepaid health care organizations and health services; requires all health departments to have emergency rooms; and calls for respect for and the promotion of alternative medicines within the framework of comprehensive health care.

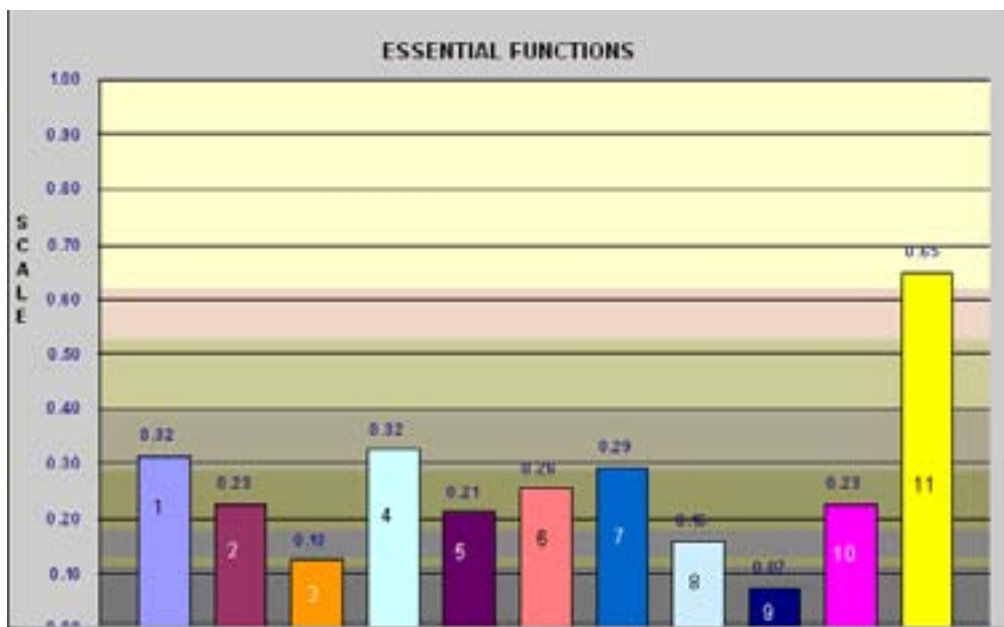
The NHA is authorized to identify, prosecute, sanction, and judge all persons or bodies that violate the LOS, acting as a vertical system, with honesty and proportionality. Intervention levels are based on the gravity of the health infraction, beginning with the Health Commissioner, followed by the Provincial Health Directors and the Director-General of Health, as provided in this legal instrument.

Preliminary steps are currently being taken to regulate medical professions and develop a Public Health Career System.

2.1.4 Development of the Essential Public Health Functions (EPHF)

In October 2001, the NHA conducted the EPHF performance measurement exercise with the participation of representatives from health institutions. This exercise, which was coordinated by the MPH with the collaboration of the PAHO/WHO Representative Office in the country, identified critical factors to be considered in the development of strategies to strengthen public health infrastructure, understood in the broader sense as referring to human capabilities, resources, and management models. The figure below is a graphic representation of the results for each of the 11 functions evaluated.

Figure 9. Results of the EPHF measurement Ecuador. 2001



The highest measurement result was obtained by EPHF 11 “Reduction of the Impact of Emergencies and Disasters on Health” due to the emphasis placed on this issue by the country as a result of past emergencies and disasters, as well as the work with several local organizations. Low intermediate results were observed for EPHF 1 “Monitoring, Evaluation, and Analysis of Health Status”, which is considered one of the traditional public health functions; EPHF 4 “Social participation in health,” and EPHF 7 “Evaluation and promotion of equitable access to necessary health services.”

At the other end of the spectrum, EPHF 9 “Quality assurance in personal and population-based health services,” EPHF 3 “Health promotion,” and EPHF 8 “Human resources development and training in public health” show minimum performance results. Poor performance was also observed for EPHF 2 “Surveillance, research and control of risks and threats to public health,” EPHF 10 “Research in public health,” EPHF 5 “Development of policies and institutional capacity for public health planning and management,” and EPHF 6 “Strengthening public health regulation and enforcement capacity.”

The lower score observed for EPHF 3, when compared to EPHF 4, can be explained by the fact that the country has strengthened social participation in all spheres of national work; however, only more recently has health promotion been a priority area for the NHA.

The low performance of EPHF 1 and EPHF 2 are striking. In addition, the functions related to public health management and the steering role, EPHF 5 and 6, also exhibited low performance, indicating weaknesses in the NHA’s role in the enforcement of standards. The low score observed for EPHF 8 and 10 reflects the lack of attention – as of the time of the measurement – to investment in the training of human resources.

After 2005, similar exercises focusing on some of the EPHF were conducted. In general, results were similar to those described above, although improvements were seen in EPHF 2, 3, 5, and 6. Consequently, at the subnational levels, the global profile of the EPHF should be updated to support the development of an action plan aimed at strengthening public health and NHA performance, as a priority issue for the development of the health sector transformation process.

2.1.5 Orientation of financing

The NHA follows the guidelines established by SENPLADES with regard to standards and regulations for plans, programs, projects, and financing. The standards of care and management that determine the allocation of resources are established by the General Undersecretariat, the Undersecretariat for the Extension of Social Protection in Health, and the General Bureau of Health. Furthermore, the services included in the comprehensive

health care model are defined and the priority programs with the necessary resources are determined.

The operations of the MPH services network is ensured by the general national budget, extrabudgetary funds, emergency and contingency funds, and contributions from national and international projects and agreements. Online implementation of the Ministry of Finance's Integrated Financial Management System (SIGEF) and the new planning model proposed by SENPLADES have facilitated the articulation of an institutional management model and budget structure, which guarantees the criterion for allocating and monitoring resource investment.

The mobilization of public resources (material, human, financial, and organizational) is under the general national budget, which allocates funds for the MPH and some nonprofit nongovernmental institutions, such as the Guayaquil Welfare Board (JBG) and the Cancer Society (SOLCA). With regard to MPH resources, the priorities include the development of programs and activities based on primary health care, the comprehensive care model, and prioritization of care for the poorest population (Q1-Q2). There is a growing effort to coordinate and implement action with health sector institutions within the framework of the proposal for a health sector transformation.

2.1.6 Guarantee of insurance

Insurance for certain sectors of the population is guaranteed by the IESS, which is in charge of insuring workers' health, public insurance (ISFFA and ISSPOL), and private insurance. There are also insurance programs for at-risk populations such as pregnant women.

According to the Free Maternity and Child Care Law, "every woman has the right to free and quality health care during pregnancy, delivery, and postpartum, as well as access to sexual and reproductive health programs. Similarly, health care will be provided free-of-charge for newborns and children under 5 years as a State public health measure." Periodically, the Free Maternity and Child Care Law enforcement unit informs user committees, collective health funds management committees, health areas, and hospitals about the moneys transferred according to the production of benefits reported by the health areas and

hospitals. Through different communication strategies, the population is continuously informed about the impact of the law and the 57 services it covers.

2.1.7 Harmonization of service delivery

The health service delivery system is fragmented and segmented, since there is no coordination between actors or separation of functions between subsystems. Each subsystem has an assigned subscriber or beneficiary population with access to differentiated services.

In 2007, the MPH was organized into three levels: health area, provincial level, and national level. The health area is made up of the management unit and the first- and second-level operational units with technical, administrative, and financial decision-making capacity. The provincial level is made up of the provincial health bureau, whose function is to provide technical and administrative support for the area supervisors and hospitals in its geographical jurisdiction. The national level is the regulatory agency of the health sector. It consists of several processes that result in the preparation and dissemination of technical, administrative, and financial standards applicable at the national level.

From the local perspective, the basic health teams (EBAS) work at the community level using a health promotion and disease prevention approach. In late 2007, a total of 1,702 EBAS were up and running in every province of the country and served more than 100,000 families.

Since the enactment of the LOSNS in 2002 and its general regulation in 2003, the creation and operation of cantonal and provincial health councils have been regulated by instruments that guide the participation of local and provincial actors in the system, with the goal of harmonizing the planning of annual operational plans and optimizing local health budgets. These tools are: the Methodological Guidelines for the Creation and Operation of Cantonal and Provincial Health Councils and the Guidelines for Preparation of the Cantonal and Provincial Health Plans. They were used in 2007 to create 83 of the 220 cantonal health councils and 8 out of the 24 provincial health councils.

**Figure 10. Cantonal health councils
Ecuador. 2007**



SOURCE: National Health Council, November 2007

The MPH has developed, validated, and implemented standards of care for outpatient services that focus on promotion and prevention by program components and life cycles. The pending task is to develop standards for the secondary and tertiary levels, particularly for the management model for technical and administrative processes and the standards and protocols for clinical and surgical care. The MPH and CONASA are currently developing treatment protocols based on the country's epidemiological profile. Age groups have been established by consensus, the NHS service units have been standardized, and a national coding system has been adopted.

Furthermore, general forms for the standard medical record are available, which will be an essential tool for proper operation of a comprehensive public health services network. The comprehensive public health network, established in the new Constitution, is one of the key elements of the TSSE and the mechanism that can promote implementation of these tools required for adequate operation of the NHS.

Users' rights are currently published and include the Patients' Rights and Assistance Law, published in the supplement to Official Gazette No. 626 on February 3, 1995; the Organic Health Law, published in Official Gazette No. 423 on December 22, 2006; and the Organic Law of the Office of the People's Advocate, published in Official Gazette No. 7 of February

20, 1997. No single entity is exclusively in charge of defending users' rights. However, there are agencies such as the Office of the People's Advocate, Consumer Protection Tribunal, and the inspectorates in some health areas and provinces.

2.2 Financing and assurance

2.2.1 Financing

The MPH budget increased steadily from 2001 (\$151.7 million) to 2006 (\$561 million). During this period, it accounted for an increase of 3.4% to 6.6%¹⁶ of the total national budget and an increase of 0.9% to 1.4% of GDP, respectively. In 2007, it was equivalent to \$647 million (6.2%) of the total national budget.

Table 5. Relationship between health sector budget (%), PGC, and GDP from 2000–2006

YEAR	Health Budget/PGC	Health Budget/GDP
2000	2,7	0,7
2001	3,4	0,9
2002	5,4	1,3
2003	5,5	1,3
2004	5,5	1,3
2005	5,7	1,2
2006	6,6	1,4

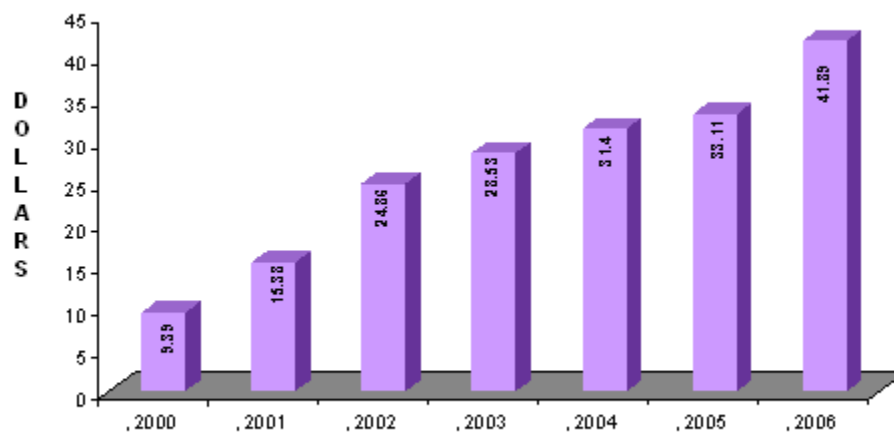
Source: MEF-BCE

According to the national accounts, total health expenditure in 2004 was between 4% and 5% of GDP. A total of 50.4% of the expenditures were in the public sector (MPH, IESS, ISSFA, ISSPOL, and sectional governments) and 49.2% in the private sector. Per capita public health expenditure in 2006 was US\$41.89, a US\$32.5 dollar increase from 2000. Total per capita health expenditure in 2005 was US\$150.7 (US\$109.5 households, US\$41.2 government). In 2008, per capita government expenditure (MPH and IESS) totaled US\$110.¹⁷

¹⁶ Ecuador, Ministry of Economy and Finance. Consolidated financial statements in December 2005. Available at: www.minfinanzas.ec-gov.net. Accessed 14 April and 15 May 2006.

¹⁷ INEC, National Health Accounts

Figure 11. Per capita public health expenditure, 2000–2006



Source: Health situation in Ecuador. Observatory of the Latin American Economy, Number 77, 2007

A total of 90% of private health expenditure was direct household expenditures (61% for the purchase of medicines and supplies, 24.3% for medical care, and 4.7% for laboratory exams, dental supplies, and orthopedic devices). A total of 74.7% of private expenditure was in the urban area and 25.3% in the rural area, where the majority of persons from the poorest quintile are concentrated. In percentage terms, low-income families spent a higher amount of resources to meet their health care needs, 9% in Q1 vs. 4% in Q5.¹⁸

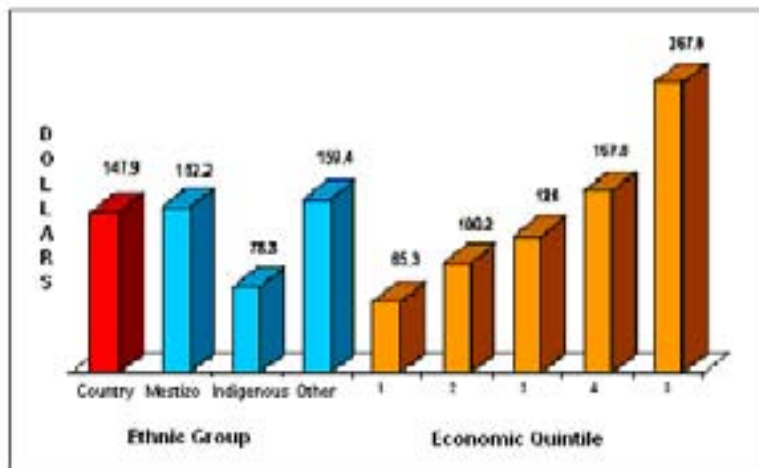
The poorest quintile allocates a greater percentage of its spending to medicines, unlike the wealthiest quintile. With regard to the regions, the Coastal area allocates more spending to medicine consumption than the Sierra. From an economic standpoint, drug expenditure represents a significant portion of the total health expenditure. In 2003, the total health expenditure was US\$1,480 million (5.5% GDP), US\$524 million of which was for drug expenditure (1.67% GDP). A total of US\$403 million of this figure was direct household expenditure.

Research on public spending on health and education¹⁹ shows that the wealthiest quintile of the Ecuadorian population received nearly 40% of the benefits, whereas the poorest quintile received less than 10%.

¹⁸ National Institute of Statistics and Censuses (INEC). Living Conditions Survey, 2006.

¹⁹ World Development Report. 2004

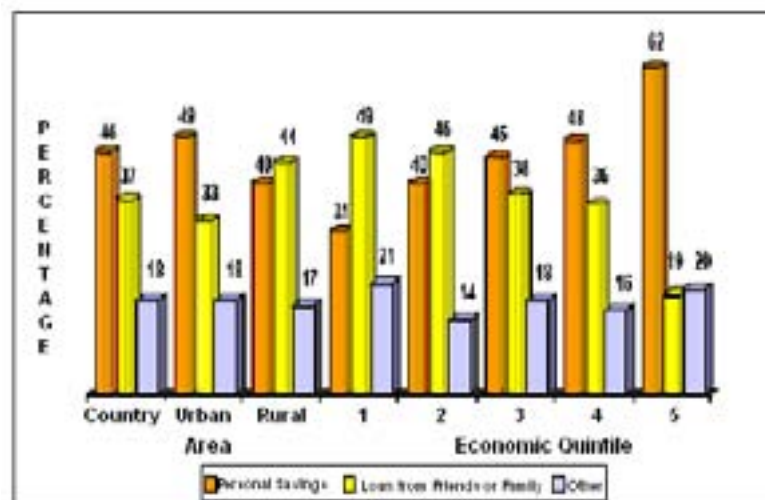
Figure 12. Per capita annual health expenditure (all households) by ethnic group and economic quintile in 2004



Source: ENDEMAIN, 2004.

The public sector allocates 81.2% of health expenditure to treatment and 18.8% to preventive care. A total of 34.1% is spent on primary care, 29.9% on secondary care, and 36% on tertiary care. A total of 34.4% of the expenditure is for the delivery of hospital-based services, 29.3% for drug supply, 23.6% for outpatient services, 11.7% for public health, and 0.9% for research. Only 31.8% of the expenditure is allocated to groups living in poverty, while 68.2% is distributed to the remaining groups.

Figure 13. Financing mechanisms for hospitalization expenditures by area and economic quintile in 2004

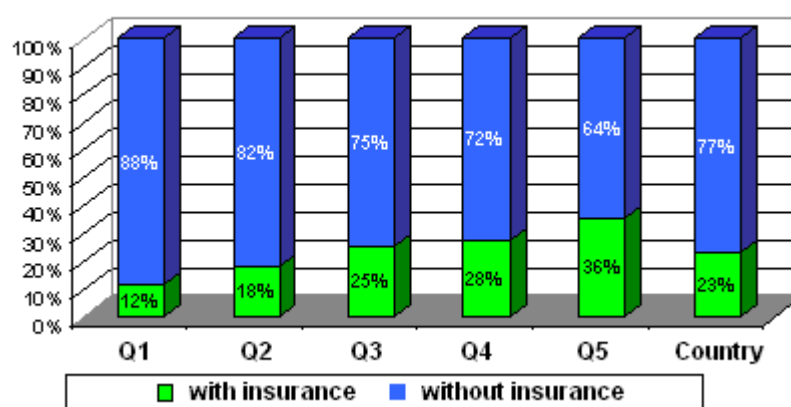


Source: ENDEMAIN, 2004.

2.2.2 Assurance

The Ecuadorian population covered by either public or private health insurance was slightly under 23% in 2004. There were significant differences between the quintiles: in the poorest quintile (Q1), as little as 12% had health insurance, whereas in the wealthiest quintile (Q5), 36% of the population had insurance coverage.

Figure 14. Population with health insurance by quintile in 2004



Source: MPH - MODERSA Project. CARE-UJH Consultancy. Design ÁUS 2003

The National Health System's package of services, approved by resolution of the CONASA Board of Directors on October 25, 2006, defines the benefits of this system. The inclusion and exclusion criteria for the list of benefits were based on the International Classification of Diseases (ICD-10) and the International Classification of Primary Care (ICPC-2). The types of services (outpatient, hospital, and supplementary), categories of interventions (clinical, surgical, and/or clinical-surgical), age groups (10 groups) were defined; the three levels of care in the health services offered by the system were standardized; the list of diseases or health situations was defined; and a glossary of terms was prepared.

A total of 144 outpatient benefits in the areas of promotion, prevention, recovery, and rehabilitation were established at the primary level. Furthermore, 378 clinical and surgical hospital benefits for the secondary and tertiary levels of care were defined. Additional benefits at the three levels of care for all age groups were established.

The inclusion criteria used in defining the package of services as a whole were: general mortality by age group at care levels I, II and III; total morbidity prevalence; promotion, prevention, treatment, and rehabilitation activities covered in the public services and national social security programs; clinical and surgical hospital activities; reconstructive plastic surgery (emergency burn care, follow-up, and sequelae); trauma, skin cancer (basal cell, squamous cell, melanoma, and reconstruction); scars; breast cancer reconstruction; and additional examinations associated with or required for the diagnosis of health status or disease included in the treatment protocol.

In 2006, the Ecuadorian Government implemented the universal health insurance program, PRO-AUS. The objective of this program was to provide an insurance system that offers comprehensive benefits characterized by quality, efficiency, and equity; includes social protection and public insurance; and gives priority to the population living in poverty and extreme poverty (most vulnerable groups).

However, in 2007, implementation of this strategy was limited to the city of Quito and the cantons of Guayaquil and Cuenca. The comprehensive family and community health care model (MAISFC) was proposed for the other areas in the country. This model seeks to improve access to health services for the vulnerable population (Q1 and Q2) by creating basic health care teams in the health areas. The teams are assigned a territory and population for which they provide social protection and care.

The most common form of payment in the health insurance models is capitation or payment per event. The institutions participating in health insurance are the MPH, as provider and source of financing; and the Metropolitan Health Corporation (Quito) and the Health Corporation (Cuenca) as budgetary models for the universal health insurance project (AUS) promoted by the MPH in 2006, and in Guayaquil, as an *ad hoc* modality that uses resources from the human development voucher issued to poor families by the government.

The MPH regulates health insurance through the Undersecretariat for the Extension of Social Protection in Health, an entity whose scope of action is still evolving. The current regulatory framework for the institutions participating in social protection is based on agreements signed with primary and secondary care providers that specify individual and community health efforts, in promotion, prevention and treatment, to be carried out.

2.3 Health service delivery

2.3.1 Health services supply and demand

Each institution in the health sector has its own organization, management, and financing. The public subsector is comprised of the services offered by the MPH, IESS-SSC, ISSFA, and ISSPOL (under the Ministry of Defense and the Government Ministry, respectively), and the health services in some municipalities. The Guayaquil Welfare Board (JBG), Guayaquil Children's Protection Society, Cancer Society (SOLCA), and Ecuadorian Red Cross are private entities that are active in the public sector.

Figure 15. Public hospitals: MPH, IESS, Armed Forces, Police and Municipalities Ecuador. 2007



Health services provided by the MPH are organized by level of complexity. Level I (low complexity) includes the health stations, health centers, and auxiliary health centers that offer outpatient care, health promotion, disease prevention, and health recovery. All of them

promote basic environmental sanitation and community participation. The auxiliary health centers also offer child birth, emergency, and dental care.

Level II (intermediate complexity) includes basic hospitals and general hospitals that offer short-stay hospitalization in addition to Level I care. Basic hospitals offer outpatient and hospital care for general medicine, obstetrics/gynecology, pediatrics, and emergency surgery. In addition to these, general hospitals provide some specialty care based on the epidemiological profile of the area they cover, as well as auxiliary diagnostic and treatment services.

Level III (high complexity) includes specialized and reference hospitals for care of the local, regional, and national population. These hospitals also conduct health research and education.

In regard to the services offered by the MPH, in 2006, there were 230 health stations, 127 health centers, and 1,226 auxiliary health centers at Level I; 82 basic hospitals and 33 general hospitals at Level II; and 15 specialized hospitals (9 acute and 6 chronic) and 1 specialty hospital at Level III. There were also 1,737 operational and administrative units.²⁰

In 2006, the IESS managed 16 Level I hospitals, five Level II hospitals, one Level III hospital, 34 outpatient centers, 294 community clinics associated with the IESS, as well as 577 Rural Social Security community clinics. The ISSFA had 53 Level I units, 12 Level II units, and no Level III units. The ISSPOL had 34 Level I units and two Level II units.

The JBG is an autonomous social service entity that is financed primarily by the national lottery. It has four hospitals, two for general medicine and two specialized hospitals in the city of Guayaquil. SOLCA is a private entity with social aims that covers part of the national demand for cancer diagnosis and treatment, based on regional institutions with administrative and financial autonomy located in major cities in Ecuador. In 2006, there were three Level I units and nine specialized hospitals.

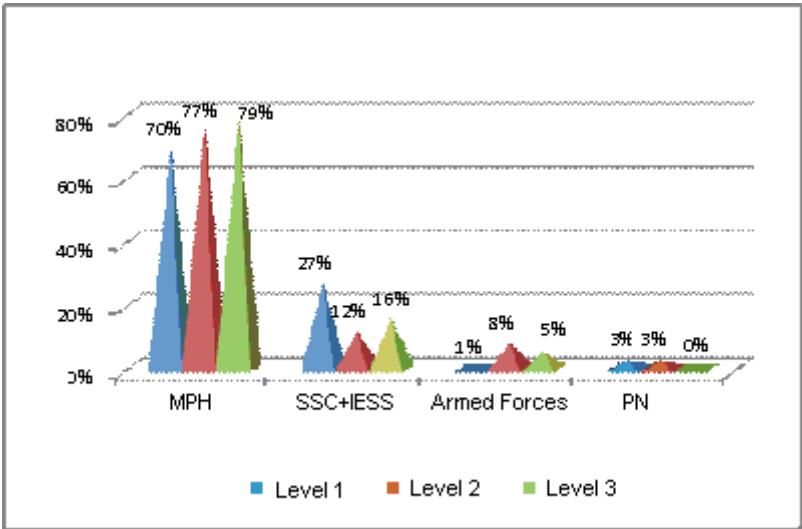
To address environmental health and sanitation issues, the municipal health services have sanitation bureaus, except for Quito and Guayaquil, which include some private hospital and

²⁰ INEC, Anuario Estadístico de Recursos y Actividades de Salud, 2006.

outpatient services. In 2006, there were 29 Level I municipal health facilities and eight Level II facilities.

The public sector consists primarily of basic hospitals (45.1%) and general hospitals (39.0%). Specialized hospitals account for 14.8% of the hospitals and hospitals with specialties represent 1.1% of the facilities. The MPH has the highest number of Level I, II, and III units in Ecuador. Therefore, it has a highest percentage share of the health services, greater than the total IESS, ISSFA, and ISSPOL units combined.

Figure 16. Percentage share of public health services in 2008

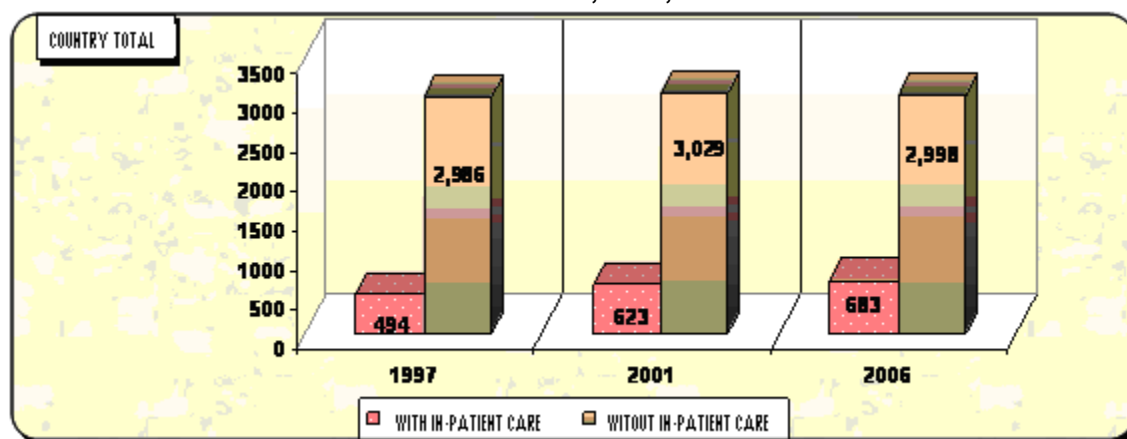


Source: MPH
Prepared by: TSSE Technical Team

In 2006, there were 3,681 health facilities, 2,999 public and 682 private, in Ecuador. A total of 683, or 18.6%, of these facilities offered hospital inpatient care and 2,998, or 81.4% did not. Of the total facilities with hospital inpatient care, 26.6% were in the public sector and 73.4% in the private sector. Four hundred fifty-four of the facilities were private clinics without specialties. The public subsector operates 25.6% of the health facilities. The MPH presently operates 17.6% of the facilities, whereas in 1994 this figure was 27.0%.

A comparison of the data from 1997 and 2006 indicates the number of facilities with hospital inpatient care increased from 494 to 683. The geographical region with the highest growth is the Sierra, which has experienced a 44.5% increase in the past 10 years. The island region was an exception, as the number of facilities remained the same. In the non-delimited zones, there was a significant increase in absolute terms from one to six facilities.

Figure 17. Number of health facilities with and without hospital inpatient care by geographical region Ecuador. 1997, 2001, and 2006



The private sector includes for-profit private entities (e.g., hospitals, clinics, community clinics, physician's offices, pharmacies, and prepaid health care organizations) as well as nonprofit private organizations such as NGOs, popular health service organizations, and social service associations, which account for 15% of facilities in the country.

Table 6. Health facilities with and without inpatient care in the private sector Ecuador. 2006

Sector and facility	Total facilities	total	basic health centers	primary health centers	specialized health centers	hospitals with specialties	Private clinics with specialties	specialized clinics	other specialized clinics	private hospitals with specialties	total	health center	auxiliary health center	health station	community clinic	other		
Private Sector:	602	591	-	9	-	1	-	454	20	2	5	2	101	6	-	-	127	46
For-profit	463	470	-	-	-	1	-	434	20	1	5	1	13	1	-	-	9	3
Not-for-profit	199	31	-	9	-	-	-	20	-	1	-	1	88	7	-	-	110	43

1/ Includes: First aid stations, infirmaries, family planning, mobile brigades and clinics, National Institute for Children and the Family (ININF), Red Cross, etc.
 2/ Includes: Autonomous companies (private hospitals and clinics).
 3/ Includes: Religious institutions, private institutions, and foundations.

Source: INEC, Database, Ecuador 2006.

Private services are financed by direct household expenditure. Private entities must be registered and licensed by the MPH to operate. There is an installed capacity of approximately 350 for-profit facilities with inpatient care, primarily clinics. Similarly, there are nearly 10,000 private physician's offices with basic technology and infrastructure, most of which are located in the major cities. There are also prepaid health care organizations, which cover less than 3% of the population in the medium- and high-income strata.

2.3.2 Development of health workforce

2.3.2.1 Human resources training

Human resources training is under the responsibility of the National Council for Higher Education (CONESUP), which serves as the regulator; the National Council for Educational Accreditation (CONEA) which is responsible for accreditation; the National Health Council (CONASA), which formulates policies; the MPH, IESS, Armed Forces, Police, JBG, SOLCA, and the municipalities, which are practice scenarios; the Association of Ecuadorian Schools of Medicine and Health Sciences (AFEME) which serves as the academic coordinator; and public and private universities that provide education and training. In 2008, there were 25 schools of medicine and health sciences, 13 of which were public and 12 private.

In order to prevent the problems described in this chapter and ensure the application of legal and constitutional principles in regards to the coordination between the Ministry of Health and educational institutions, agreements are signed regularly by MPH and AFEME for the development of undergraduate, graduate, continuing education, research, and community programs.

There is a trend toward specialization in human resources training, with Level IV specialization being the most common. However, it is not in line with the needs of the health system, since most public health problems can be resolved at Level I. In 2007, 12 universities offered a Master's degree in Public Health. Most of them were educational institutions in large cities (Quito, Guayaquil, and Cuenca). The curriculum for undergraduate and graduate professional education in health is not periodically reviewed or formulated.

2.3.2.2 Human resources management and employment conditions

The LOSNS (2002) and its General Regulations (2003) expressly recognize human resources in health. Since 2001, the National Committee on Human Resources in Health (CONARHUS) under CONASA brings together the main actors in the field: services, professional organizations, unions, universities, and regulatory agencies. CONARHUS is responsible for the Observatory of Human Resources in Ecuador, which produces important information about the field. It also prepared the provisional draft of the Public Health Career Law (2006), which was presented to CONASA.

2.3.2.3 Human resources supply and distribution

The MPH employs over half of all staff working in public health facilities. The next largest employer is the IESS. In this case, the percentage is determined by the total General Insurance, which includes facilities under the IESS (15.3%) and SSC (2.5%). In 2003, 54.6% of physicians, 59.6% of nurses, 68.8% of dentists, and 94.6% of midwives worked in MPH facilities. In that same year, health personnel distribution in the public sector was 49.95% physicians, 81.86% nurses, 91.82% dentists, and 80.95% midwives.²¹

**Table 7. Health workers by sector and class
Ecuador. 2006**

Sector	Total	specialized physicians	dentists	pharmacists/otubio-chemists	midwives	nurses	technologists	student interns	nursing assistants	resident physicians	rural physicians
Total Country	55,578	19,299	2,636	500	1,467	7,499	3,215	2,446	13,923	2,657	1,856
Sector											
Public Sector	36,654	8,212	2,386	291	1,273	6,175	2,175	2,003	10,458	1,830	1,854
Private Sector	18,924	11,087	250	209	214	1,324	1,040	443	3,465	827	5

Source: INEC, Database, Ecuador 2006.

In 2006, 55,578 people worked in health care facilities, including 19,299 physicians, 13,923 nursing assistants, and 7,499 nurses. This year there were 14.4 physicians, 5.6 nurses, and 10.4 nursing assistants per 100,000 inhabitants. Clinics and general hospitals account for the highest percentage of physicians (63%). On the other hand, 24.9% of all physicians that work in health facilities are employed by outpatient health care services that only provide primary care. Over half of the dentists (63.5%) work in auxiliary health centers and community clinics. In contrast, most nurses (43.4%) work in general hospitals or auxiliary health centers (32%). Like dentists, midwives work primarily in health centers and auxiliary health centers (39%).²²

²¹ Merino C; Observatory of Human Resources in Health in Ecuador; National Committee of Human Resources. Empleo de los recursos humanos en salud en instituciones del sector público. Quito; 2006.

²² CONARHUS-CONASA, MPH-MODERSA Project, PAHO/WHO, Merino, Cristina, Empleo de los recursos humanos en salud en instituciones del sector público. Quito; 2006, Observatory of Human Resources in Health in Ecuador, National Committee on Human Resources, Quito, Ecuador, 2006.

Table 8. Type of personnel working in health facilities, by level of complexity Ecuador. 2006

Staff	Total Staff	Facilities With In-Patient Care											Facilities Without In-Patient Care					
		Total	Basic Hospitals	General Hospital 1/	Specialized Hospital		Hospital with Specialties	Private Clinic without Specialties	Specialized Clinic		Other Specialized Clinics	Private Hospital with Specialties	Total	Health Centers	Auxiliary health center	Health Post	Medical Dispensary	OTROS 3/
					Acute	Chronic			Acute	Chronic								
TOTAL COUNTRY	78,768	68,808	7,243	19,961	6,193	2,626	2,859	19,127	883	52	114	1,830	19,257	4,225	3,909	529	7,349	1,090
Physicians 4/	19,298	15,320	798	2,907	723	588	305	8,415	597	8	88	359	4,079	838	915	34	2,513	379
Dentists	2,836	802	190	232	37	7	16	118	2	-	-	-	2,034	207	1,028	82	566	81
Biochemists/ Pharmacists	660	374	23	507	26	26	7	161	9	1	-	14	168	39	19	-	107	22
Midwives	1,467	721	147	354	57	8	-	123	15	-	1	-	755	189	443	25	58	45
Nurses	7,499	5,956	914	2,393	910	310	557	969	18	3	3	159	1,543	309	799	50	372	13
Social Workers	474	291	27	128	47	38	30	20	1	2	-	-	183	42	28	-	94	22
Technologists	3,215	2,497	190	929	231	223	145	660	41	1	3	110	660	133	52	-	419	50
Other Professionals 5/	914	611	39	212	98	50	10	200	8	3	-	12	303	50	40	1	195	17
Interns	2,448	2,308	261	1,398	145	12	57	404	24	8	1	-	138	110	1	-	27	-
Nursing Assistants	13,823	10,739	1,447	3,850	1,582	942	819	2,080	136	8	18	448	3,194	491	883	180	1,443	187
Technical Services Assistants	6,163	3,267	942	888	493	133	288	787	42	2	2	90	1,698	678	600	17	663	48
Social Work Assistants	70	38	5	2	26	-	-	3	-	-	-	-	34	3	2	-	8	21
Statisticians And Medical Records	1,210	850	192	359	112	46	20	98	10	2	1	2	360	167	72	-	101	8
Administrative	5,907	4,757	587	1,728	371	380	120	1,318	54	3	7	210	1,180	488	31	-	468	155
Resident Physicians	2,867	2,841	274	948	394	71	180	739	38	4	8	10	18	1	-	-	18	-
Rural Physicians	1,856	335	226	81	26	2	-	-	-	-	-	-	1,521	240	1,110	181	17	3
Service	10,451	9,251	1,434	3,547	1,183	416	277	1,966	101	13	14	286	1,200	348	285	-	823	59

1/ Includes: hospitals of the Ecuadorian Institute of Social Security (IESS).

2/ Includes: first aid stations, infirmaries, family planning clinics and mobile brigades, National Institute for Children and the Family (INNFA), Red Cross, etc

3/ Includes: nutritionists, psychologists, health educators, health engineers, environmental engineers and others: industrial psychologists and public relations.

Source: INEC database, Ecuador 2006

In the second semester of 2007, the MPH conducted a study of human resource needs in health at the national level. Over 4,500 human resources from different disciplines were hired to implement the new model of comprehensive family, community, and intercultural care and the need to extend outpatient visiting hours to eight hours was recognized.

2.3.2.4 Governance and conflict in the health sector

Mixed labor boards have been established where labor issues are discussed by representatives of union workers and ministry authorities to settle disputes. In addition, as stipulated in the LOSNS, participatory, consensus-based management and policy-making strategies, similar to those adopted by the health councils, have been established.

2.3.3 Drugs and other health products

A major goal of the 1999 national drug policy is to guarantee the availability, access to, quality, and rational use of drugs, as well as the lowest price. The 2000 Law on the Production, Importation, Marketing, and Sale of Drugs for Human Consumption establishes regulations that foster expansion of the generic drug market, provide incentives for national production, and facilitate registration through the equivalency procedure for imported products.

In 2004, the drug market in Ecuador included the private market (87%), as well as the institutional market (13%), with the following distribution: MPH (5.7%), IESS (4.9%), ISSFA (0.85%), JBG (0.75%), SOLCA, and Red Cross (0.8%).²³ That same year, the pharmaceutical market had approximately 225 laboratories, 170 distributors, 5,000 pharmacies,^{24,25} and 9,386 products officially approved by the regulatory authorities. Only 6,439 (68.60%) of these products were sold, and 1,539 (25.29%) were generic drugs.²⁶ The percentage of generic drugs increased from 16.2% in 2001 to 25.2% in 2005. The volume of generic sales in 2005 was less than 11.3% of the total, probably as a result of the cautious attitude of prescribers due to the lack of a guarantee regarding the safety and quality of these products.

In 2004, it was estimated that approximately 80% of drugs were purchased and used without a prescription. The National Committee for Drugs and Supplies of CONASA updates, publishes, and disseminates the national list of essential medicines on a biannual basis. In 2006, the sixth revision was approved. Use of the drugs on this list is required in all public health facilities and reference institutions in the private sector. The private market grew by 35.8% from 2001 to 2005, from \$407,079 million to \$553,157 million.²⁷

There are still several issues related to the availability, rational use, quality control, and pricing of drugs. Access is one of the most important issues and price is one of the determining factors.

²³ Paredes P, Romo H, Quevedo M. Estudio del Mercado Farmacéutico en el Ecuador. Quito; July 2004.

²⁴ Paredes P, Romo H, Quevedo M. . Estudio del Mercado Farmacéutico en el Ecuador. Quito; July 2004.

²⁵ Development Studies Corporation. Impacto económico sobre el sector farmacéutico ecuatoriano de la adopción de un capítulo sobre la protección de derechos de propiedad intelectual. Resumen ejecutivo. Quito; September 2005.

²⁶ Op cit 3.

²⁷ Ecuador, National Institute of Health. Auditoría mercado farmacéutico privado. Investigación de mercado en salud. Ecuador. 2001–2005.

2.3.4 Quality of services

In 2004, the MPH coverage extension program developed and implemented a licensing system for Level I and Level II health units in the 200 poorest parishes identified according to unmet basic needs. This program was based on the primary health care and comprehensive care model. A total of \$6,600,000 was allocated to adapt the units.²⁸

The data from the licensing process shows that 11.3%, or 150, of the operative Level I units have complete licensing, 51.7%, or 690, have conditional licensing, and 37%, or 489, are unlicensed.²⁹ The certification instrument used by the IESS for its operative units is based on higher standards than those of the MPH. This instrument can determine the amount of resources required to maintain intermediate operating standards.

2.4 Institutional mapping of the health system

The health system is characterized by the presence of a regulatory entity in accordance with national policy and several different institutions with financing and delivery functions.

**Table 9. Institutional mapping of the health system
Ecuador. 2008**

Functions Organizations	Steering		Financing	Insurance	Delivery
	Conduct/Lead	Regulation and Control			
Central Government Ministry of Health	X	X	X		X
Social Security Institutions	X	X	X	X	X
Regional government (province)			X		X
Local government (district, municipio)			X		X
Private insurers (nonprofit, for-profit)			X	X	X
Private providers (nonprofit, for-profit)			X		X

Source: Developed by author with information from different actors.

²⁸ Ecuador, Ministry of Public Health; Pan American Health Organization, Proyecto Modernización y Desarrollo de Redes Integrales de Servicios de Salud (MODERSA). Programa de extensión de cobertura en salud en base a la estrategia de atención primaria y el licenciamiento de la red de servicios de salud. May 2004

²⁹ MPH, Proceso de Normatización, 2005.

3. MONITORING OF THE CHANGE AND REFORM PROCESSES

Ecuador has not experienced an actual health sector reform process, defined at the 1995 Regional Meeting as sustained in-depth transformations in the structure of the health sector.³⁰ From 1995 to 2005, this process was characterized by the preparation and discussion of several proposals aimed at creating a national health system with an emphasis on insurance, the development of a legal framework for the health sector, and in some cases, the initial implementation of some of the processes on a partial basis such as: a) health services decentralization; b) extension of coverage programs in sectors with fewer resources (PROECOS); c) a proposal for new family- and community-oriented primary health care models and health promotion; and d) the universal insurance program (AUS).

The country's political and administrative instability during this period prevented the development of specific and sustained implementation plans. This was due in large measure to contradictory *ad hoc* policies issued by each new administration (seven presidents from 1995 to 2005). Resistance from progressive social organizations, and lack of consensus among stakeholders further complicated the scenario. Consequently, no reform model has been consolidated except within the legal-constitutional framework of 1998 and the health laws (1998 Free Maternity and Child Care Law; 2000 Generic Drug Law; 2002 Organic Law of the National Health System; and 2006 Health Law), whose implementation and enforcement are still incomplete.

This situation is reflected in the analysis shown below, which outlines the main events in the attempt to launch a health sector reform process in Ecuador. Debate on the need for sectoral reform began in the early 1990's. The reform process between 1992 and 2000 can be divided into five phases:³¹

- a. Introduction of the topic of health sector reform (HSR);
- b. Development and discussion of proposals;
- c. Interruption of the process;
- d. Initial implementation of HSR; and
- e. Consolidation.

³⁰ Special Meeting on Health Sector Reform, held in Washington in September 1995, organized by PAHO/WHO, IDB, World Bank, and other multilateral and bilateral bodies.

³¹Echeverría Ramiro. El Proceso de Reforma del Sector Salud en el Ecuador 1992-1997: Aportes para el Debate. CEPAR. Quito, July 1997.

a. Introduction of the topic of health sector reform

In 1993, the National State Modernization Council (CONAM) was created, followed in 1994, by the creation of the Social Security Reform Commission. This was also the year the MPH began executing the Strengthening and Extension of Basic Health Services (FASBASE) project and the first HSR workshop was held. At this workshop, agreement was reached on the “Kumbayá Document,” which established institutional commitments for the implementation of health sector reform and led to the subsequent creation of the Bi-Ministerial Committee (Health and Social Welfare) on HSR.

b. Development and discussion of proposals

In late 2004, the Bi-ministerial Committee, with assistance from FASBASE, submitted the HSR proposal to the new MPH authorities. At this time, CONAM also published the proposal for private-public social security reform, which recommended the privatization of the pension system and the creation of a social security system based on a mixed model. This proposal was rejected by most of the social and political forces in the country and later failed to gain approval at the November 1995 plebiscite.

In mid-1995, CONASA resumed operations to address the HSR issue comprehensively. An *ad hoc* technical group was formed, which produced the “General Guidelines for Health Sector Reform in Ecuador.” The Interagency Commission to Support Reform in Ecuador (CIAR) was also formed, with the participation of the World Bank, Inter-American Development Bank (IDB), United States Agency for International Development (USAID), Netherlands cooperation, and PAHO/WHO. At the same time, a draft “Health Sector Unification Law” was submitted to the MPH; its purpose was to integrate public and private health services from a budgetary and administrative standpoint. It was rejected by the Presidency due to the influence of the entities whose autonomy would be affected (primarily the Guayaquil Welfare Board and SOLCA).

By establishing a credit agreement with the World Bank through the FASBASE project, the Government of Ecuador financed the creation of a reform project coordinating unit (PCU), which would serve as the counterpart in two international studies: 1) Blueprint for Reform, conducted by Lewin/Health Redesign Group and Stanford University, and 2) Hospital Modernization, conducted by Johns Hopkins University.

In 1996, the first Provincial Council for Health Sector Reform was created in the province of Azuay. This was also the year that the PCU was dissolved and a new national technical staff group was formed. With support from PAHO/WHO and the World Bank, this group submitted a proposal in April 1996. However, the proposal was rejected by the then Minister, who submitted another proposal that was not consensus-based. This signaled the introduction of another proposal prepared by consultants to the technical secretariat of the *Frente Social* that focused on an integrated health system. CONASA presented a second version that focused on universal health insurance, while IESS submitted a proposal for comprehensive social security reform.

In short, as of mid-1996, an estimated 18 multiple health sector reform proposals were competing. In addition, there were 21 proposals for social security reform.

c. Interruption of the reform process

During this period, CONASA entered a time of inactivity and what is known as the “silent reform” began. This phase was marked by a reduction in the fiscal budget of the MPH, the proposal for autonomous management of services, and the agreements to transfer services from some hospitals to the municipalities.

d. Initial implementation of reform.³²

In March 1997, the new government revived CONASA and approved the terms for the preparation of an Operational Reform Plan, which was not well-received by the health institutions.

In December 1997, the National Constituent Assembly met and approved reforms to the Constitution that would take effect in May 1998. These reforms included a section on health that, for the first time, mentions the State as guarantor of the right to health, the steering role of the State, health promotion, the organization of a decentralized and participatory National Health System (NHS), and greater public financing for the health sector. In addition, the law regulating the operations of prepaid health care organizations was enacted. In May 1999,

³²Echeverría Ramiro. El Proceso de Reforma del Sector Salud en el Ecuador August 1997-August 2000: Aportes para el Debate. CEPAR. Quito 2000.

the regulations for implementing the autonomous health service management model were introduced.

Between August 1998 and January 2000, the MPH began the political and technical decentralization of the first cantonal health councils. During this period, it implemented the Free Maternity and Child Care Law, strengthened CONASA, and submitted its first proposals for a plural health system. In January 2000, the National Health Plan 2000-2005 was presented, which proposed a strategic vision of institutional and sectoral reform.

There are several noteworthy events between 1997 and 2000 that contributed to resumption of the HSR process: a) definition of the State role in health; (b) formulation of a national health policy framework; (c) constitutional health reform; (d) initial modernization of the MPH; (e) health decentralization experiences; (f) the NHS proposal; and, finally, (g) the Social Security Law reform proposal.³³

e. Consolidation phase: national health policy and the Organic Law of the National Health System

From 2000 to 2002, CONASA consolidated its position as the architect for the development of a national health policy and the LOSNS. Ecuador's national health policy laid out principles and objectives grounded in the principle of equity. In order to achieve reform objectives, this policy had three major lines of action: citizenship-building in health, comprehensive health protection, and sectoral development.

In 2002, CONASA held the 1st Congress for Health and Life in the city of Quito, which endorsed the proposed national health policy and promoted the provisional draft of the LOSNS bill, which was passed by the National Congress at the end of that year.

Universal health insurance (AUS)

In 2004, the mechanisms for implementing the AUS design (PROECOS) were defined. This task was assigned to the CARE-Johns Hopkins University consortium, which defined the

³³ Echeverría R. Health . Las Políticas de Salud y el Sueño de la Reforma. In "La Equidad en la Mira". PAHO/WHO – CONASA. Quito, 2007.

technical design for the national insurance. In 2005, after the change in government, the Presidency of the Republic promoted the Universal Health Insurance program for Ecuador, based on the proposal prepared by the consortium. Based on this experience, the Millennium Development Goals Secretariat (SODEM) was created in order to manage the AUS program outside of the Ministry of Health. In 2007, this entity's operations were discontinued during the government of economist Rafael Correa, as a result of the new direction defined for health and the health system at the time.

The current government has prioritized the social sector, including health, and introduced the Sectoral Transformation of Health in Ecuador (TSSE) process, which is based on the principle of equity and guarantees gradual universal access free-of-charge to quality public health services for the entire population. The establishment of a Public Providers Network will promote a comprehensive health care model that prioritizes promotion, prevention, and primary care. Moreover, duplication of activities by the main providers will be prevented and the efficiency of the system will be guaranteed. Equity and efficiency are especially relevant since they are cohesive factors that permit the establishment and integration of mechanisms, trends, and policies that can be agreed on by the various sectors participating in the health services.

3.1 Effect on health system functions

**Table 10. Periods of change and effect on health system functions
Ecuador. 1995–1999 and 2000–2005**

Period Functions	1995–1999			2000–2005		
	Public	Private	Social Security	Public	Private	Social Security
Steering	The Constitutional Reform of 1998 explicitly establishes the steering role of the State throughout the health sector	The need for regulation of private services, especially prepaid health care organizations, is established and draft legislation on this matter is prepared	Discussion of the Social Security reform law begins	The MPH, with the support of CONASA, strengthens its steering role with preparation of the National Health Policy and Organic Law of the National Health System, which define the functions of the system	Private services are subject to licensing standards of the health authority	Social Security Reform Law strengthens autonomy and management

Period Functions	1995–1999			2000–2005		
	Subsector	Public	Private	Social Security	Public	Private
Financing	Deconcentration of budget management in operational units	SOLCA becomes an autonomous independent institution	Actuarial calculations indicate that extending health insurance to the family members of subscribers is not feasible	- Regulations on partial cost recovery for services - Application of Free Maternity Law with own funds - National Health Accounts studies are updated		Increased contributions to health insurance by IESS (General Insurance and Rural Social Security)
Assurance	None		Pending implementation of the Social Security reform law	Initial implementation of AUS in the municipalities of Quito, Guayaquil and Cuenca	Supply of prepaid health care organizations increases	IESS insurance management is separated pursuant to the legal reform
Service delivery	Deconcentration of services in health areas in order to organize primary care networks		Hiring of private services is promoted. ISSFA and ISSPOL are formed	- Health services decentralization activities in some municipalities - Comprehensive health care model is officially approved - Health services licensing begins (Phase 1: PHC-MPH)	Investment and supply capacity increase, particularly at the urban outpatient level	Deconcentration of services management to regions and program-budget to units

3.2 Impact on guiding principles of the reform

3.2.1 Equity

3.2.1.1 Coverage

Most of Ecuador's population lacks explicit guarantee of access to health services. In addition, the institutional supply is not coordinated, and there are serious deficiencies in terms of coverage and quality. Consequently, one in four people do not receive care in any institution, and over 70% of the population does not have health insurance. The percentage of private or out-of-pocket expenditure is 49% and financing mechanisms are not equitable.³⁴

Several institutions and laws are involved in water and sanitation. From the standpoint of health promotion and disease prevention, the MPH issues health regulations and each local government is responsible for providing water service and wastewater treatment for the

³⁴ OPS/OMS/ASDI, Exclusión en salud; *en países de América Latina y el Caribe*; Resultados de Ecuador, Serie N° 1, Extensión de la Protección Social en Salud, Washington, D.C., 2003, pp. 25, 33.

population. There are inequities in the delivery of services in both urban and rural areas. Households with limited resources have less access to adequate water and sanitation services. The deficit in access to piped water reflects the urban-rural gap: in urban areas there is 66% coverage, whereas in rural areas coverage is 14%.

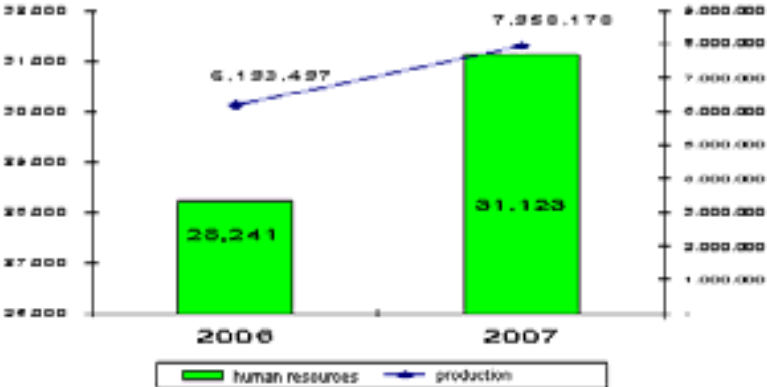
This same gap is observed in the poverty indicator, where the poorest quintile (Q1) has 11% water coverage compared to 87% in the richest quintile (Q5). There are also inequities among the different regions in the country. The coastal and eastern regions have lower coverage than the mountainous region.

3.2.1.2 Resource allocation

Although the public budget for health has increased during this decade, access and care indicators show a steady decline. Therefore, in percentage terms, low-income households spend more resources on health care than the rest of the population.

Human resources increased by 10% as a result of the state’s health emergency declaration. This led to a 28% increase in the benefits provided by the MPH. Free health care in the health units was associated with a savings of roughly US\$19.8 million for households.³⁵

**Figure 18. Results of health emergency declaration
Ecuador. Apr 06–Sep 07**



Source: MPH - Production in health facilities, April-September 2006, 2007

³⁵ MSP- Producción Establecimientos de Salud, April-September 2006, 2007.

3.2.1.3 Service delivery

There has been no significant change in public care capacity in the past 15 years, with the exception of an increase in noninstitutional primary care. There have been no significant changes in public infrastructure at the primary and secondary care levels. Private infrastructure, in contrast, has grown from 61.3% to 74.4%, which represents an increase from 277 to 514 establishments between 1994 and 2004.³⁶

The reorientation of services towards the implementation of a comprehensive health care model based on the renewed PHC strategy has begun with extramural care in family, community, and work environments. The MPH has organized the priority national programs for food and nutrition (PANN - 2000), micronutrients, maternal and child health (Free Maternity), early detection of cervical and breast cancer (EDC), immunization (EPI), epidemiological surveillance and control of communicable and noncommunicable diseases by adopting strategies such as integrated management of childhood illness (IMCI), essential obstetric care (EOC), and voluntary HIV/AIDS testing.

Over the past five years, the number of health care professionals that speak Quechua has increased. In addition, elementary knowledge of indigenous languages has been taught to MPH professionals, which has enhanced cultural accessibility and improved access to health in remote communities.

3.2.2 Effectiveness

3.2.2.1 Maternal and child mortality

The available information shows a reduction in the infant mortality rate from 30.3 deaths per 1,000 live births in 1990 to 20.1 in 2006. The maternal mortality rate of 117.2 deaths per 100,000 live births in 1990 decreased to 52.46 in 2007.³⁷ According to the SIISE, this is due to the extension of health services coverage; improvements in the educational status of the population; the influence of the media; access to preventive measures such as immunization; the urbanization of the population, which is closer to the health services

³⁶ PAHO/WHO. Health Situation in Ecuador, 2006. Pan American Health Organization, Washington DC. 2006. p.111.

³⁷ MSP – INEC. Indicadores Básicos de Salud, 2006.

offered in the cities; improvements in the sanitation infrastructure (water, sewage and waste disposal); and better epidemiological surveillance by the NHA.

3.2.2.2 Incidence of communicable diseases

The epidemiological surveillance system undertakes surveillance of HIV/AIDS, malaria, and tuberculosis. Reporting of these diseases is mandatory.

The trend in malaria incidence has been extremely irregular, due to climatological conditions and the poor condition of the sanitation infrastructure. According to MPH reports issued by the National Malaria Eradication Service, 11,991 cases were reported in 1996, which is equivalent to a rate of 102.5 per 100,000 inhabitants. In 2000, the number of cases soared to 97,007 (rate of 767.31). In 2005, it fell to 16,484, which is equivalent to a rate of 124.7 per 100,000 inhabitants. In 2007, there were 8,464 cases or 62.2 per 100,000 inhabitants.

National data is available from the National Program for Prevention and Control of STD/HIV/AIDS (PNS) developed by the MPH, an institution that has maintained the national registry of HIV/AIDS-related diagnoses and deaths since 1984. According to the PNS-MPS reporting system, between 2001 and 2007, the number of new infections increased from 294 to 2,413. This indicates that the epidemic was spreading in the population despite the efforts in promotion and service coverage in the form of early detection of HIV and large-scale training of health workers.

The decrease in the number of deaths is noteworthy. This trend is associated with the expanded coverage of antiretroviral therapy (ART) achieved by the MPH. The MPH covered 65% of the total ART, the IESS covered 27%, and other sources provided coverage for 17%. The absence of HIV case reports for children under one year of age in the period 2005 to 2006 is an indicator of the impact of the PNS-MPS program for the prevention of vertical transmission.

3.2.3 Efficiency

Efficiency is a variable that is rarely measured in the public services. At present, the aim is to improve this indicator through progressive introduction of cost methodologies and

information management systems. In order to ensure more efficient allocation of financial resources, a technical proposal that considers variables related to population, poverty, demand gap, resource supply, and decentralized management of health areas has been prepared. However, it has not been implemented owing to constraints at the central and provincial levels (MPH and Ministry of Economy).

3.2.4 Sustainability

There is no evidence that the reform process has lent greater legitimacy to institutional health care providers. Two types of information systems have been created under the current government: the financial and management information system (SIGEF) and the government information system (SIGOB). These systems are used to obtain data on government spending, disaggregated by administrative unit.

Extension of primary care coverage through the basic health care teams (EBAS) is considered in the annual operating plan under the specific heading that ensures its medium-term sustainability.

Under the new constitutional framework, the medium- and long-term financial sustainability of the national health system will be assured by an annual budget increase of at least 0.5% of the gross domestic product (Provisional article 22 of the current Constitution).

3.2.5 Social participation

There are agreements to empower the community in decision-making in the health councils (83 cantonal health councils and eight provincial health councils). The cantonal and provincial health councils (CCS and CPS) are venues for consensus-building, coordination, and dialogue that promote participation in decision-making in health by citizens and institutional representatives from the public and private sector. The councils seek agreement through a social pact to guarantee committed participation of all actors in the health needs and interests of the canton, the province, and the nation. Users' committees have also been created to monitor enforcement of the Free Maternity and Family Violence Prevention Law. Citizen participation has become one of the key elements of the sectoral transformation of

health, creating opportunities for the community to provide input for decision-making and social control.³⁸

3.3 Impact on the health system

The main challenges facing the Ecuadorian health system are: increased health care costs, the aging of the population, changes in the epidemiological profile, the curative care model, cultural and social changes among system users, and the presence of new technologies.

Over the past 15 years, the existence of several units not integrated into the health services network (known as fragmentation) can be observed. In addition, several subsystems coexist with different financing, membership, and health service delivery methods (known as segmentation).³⁹

Furthermore, there are specific challenges that warrant action focused on the reality of the country, with responses adapted to the problems faced by the health system. These include poor steering capacity by the MPH; an inadequate health care model; limited government investment in health, which has only recently begun to be corrected by the current administration; limited managerial capacity; institutional fragmentation; segmentation; and inadequate coverage and quality of services. These challenges are present in all provinces in Ecuador.

Table 11. Periods of change and impact on the health system Ecuador. 1990–2005

Periods and implications of changes	1990–1994	1995–1999	2000–2005	2008
Citizens' right to health		Political Constitution of the Republic establishes health as an economic, social, and cultural right	Political Constitution of the Republic	New Constitution, health as a right
Impact on the steering role	Specific function of Ministry of Public Health	MPH, with the support of the CONASA, as the agency for political consensus-building	Steering role of the MPH is maintained with the support of CONASA	Specifies the steering role of the National Health Authority

³⁸ MPS, Propuesta para la Reforma Estructural del Sector Salud, June 2008.

³⁹ OPS/OMS. *Sistemas Integrados de Servicios de Salud: Conceptos, opciones de política y hoja de ruta para su implementación en las Américas*. Organización Panamericana de la Salud, Washington DC, 22 April 2008. pp.1-2.

Periods and implications of changes	1990–1994	1995–1999	2000–2005	2008
Separation of health system functions	No health system and no separation of functions. Institutional fragmentation and segmentation of population	Insurance is provided by IESS and the service delivery functions include other actors	Insurance is provided by IESS and the health service delivery function includes other actors	NHS consolidation process begins Health service delivery through comprehensive public health network (Art. 360)
Deconcentration and/or decentralization	Partial deconcentration	Article 45 of the Political Constitution of the Republic provides for the organization of a national health system made up of public, autonomous, private, and community institutions from the sector, which shall operate in a “decentralized, deconcentrated, and participatory manner”	Attempts to decentralize health services in some municipalities based on special decentralization law of 1997 Article 45 of the Political Constitution of the Republic, Organic Law of the National Health System ⁴⁰ , and its General Regulations ⁴¹	Deconcentration is strengthened.
Promotion of civil society participation	Participation tends toward patronage and utilitarianism, rather than exercise of the right to participate in collective decisions	According to Article 42 of the Constitution, health promotion and protection shall be guaranteed by the State. This shall be achieved by “development of food security; delivery of drinking water and basic sanitation; promotion of healthy family, work, and community environments; and availability of permanent and uninterrupted access to health services in keeping with the principles of equity, universality, solidarity, quality, and efficiency”	Creation of health councils, users’ committees to monitor enforcement of Free Maternity and Family Violence Prevention Law	Art. 359 of the 2008 Constitution states that “citizen participation and social control shall be promoted.”
Impact on governance	No impact on governance	No impact on governance	No impact on governance	Unknown
Changes in health care model	Traditional model of institutional delivery of disease-centered health services. Pilot application of family and community care model.	Traditional model of institutional delivery of disease-centered health services	Introduction of PHC strengthening processes in pilot areas	Art. 359 of the Constitution of 2008 establishes that “promotion, prevention, recovery, and rehabilitation at all levels shall be guaranteed” Art. 360 states that “the system shall guarantee promotion, prevention, and comprehensive PHC-based family and community care.”
Changes in management model	No changes in management model	No changes in management model	No changes in management model	Art. 362 states that “state public health services shall be universal and free.”

⁴⁰ Law 80, published in Official Gazette 670 of 25 September 2002.

⁴¹ Executive Decree 3611, published in Official Gazette 9 of 28 January 2003.

Periods and implications of changes	1990–1994	1995–1999	2000–2005	2008
Barriers to access to individual and public health services	Cultural, geographic accessibility, geographic distribution of health services (urbanization), economic	Cultural, geographic accessibility, geographic distribution of health services (urbanization), economic	Programs with gender and intercultural approach. Economic and access barriers to secondary and tertiary care continue	Art. 363, No. 2, 3, 4, 5, 6 and 7 states that the State is responsible for increasing coverage and access for priority care groups Art. 50 guarantees care for catastrophic illnesses
Changes in the quality of care	No changes in the quality of care	No changes in the quality of care	No changes in the quality of care	Art. 362 states that “health services shall be safe, of good quality and compassionate”
Changes in job market and human resources in health	Schools training physicians specialized in clinical areas	Creation of the General Bureau of Human Resources in MPH. Master’s degree in Public Health. Accreditation process for technical training schools begins	More human resources at all levels of public health education, care, and health services management. 4-8 hour increase in work hours for health workers	Art. 363, No. 8 “promotes integral development of health workers”

Source: MPH
Prepared by: TSSE technical team

4. REFERENCES

1. MSP, Documento borrador, Modelo de Atención integral de salud, familiar, comunitario e intercultural, Quito, March 2008.
2. MSP/SNS, Política nacional de Promoción de la Salud, Plan de Acción 2007 – 2009. Quito, 2007
3. MSP, Lineamientos Estratégicos del Ministerio de Salud Pública 2007-2011, Quito, April, 2007.
4. MSP, Políticas Integrales de Salud para el adulto y adulto Mayr, Quito, March, 2007
5. MSP, Plan de Atención Nacional para la atención del Adulto – Adulto Mayr, Quito, March, 2007.
6. Guía de intervenciones perinatales basadas en evidencias para la reducción de la mortalidad neonatal, Quito, April, 2007
7. MSP, Manual para la vigilancia epidemiológica e investigación de la mortalidad materna, Quito, January, 2006
8. MSP, Normas y procedimientos para la atención de la salud reproductiva,. Manejo activo del tercer período del parto, Quito, March 2006
9. MSP, Manual de atención integrada a las enfermedades prevalentes de la infancia, Quito, May, 2006
10. MSP/UNFPA/USAID, Manual de estándares, indicadores e instrumentos para la calidad de la atención materno-infantil, Quito, September 2006.
11. MSP, Modelo de Gestión de Salud, Quito, DM, February, 2006.
12. R.O. No 423, Ley No 67, Ley Orgánica de Salud, Quito, 22 December, 2006
13. MSP, Política Nacional de salud y derechos sexuales y reproductivos, Quito, April, 2005
14. MSP/CONASA, Marco General de la Reforma Estructural de la Salud en el Ecuador, Quito, July 2005.
15. CONASA/MSP/MODERSA/OPS/UNFPA, Guía Metodológica para la conformación de los Consejos Cantonales y Provinciales de Salud, Quito, June 2005.
16. MSP/OPS/OMS, Programa de Extensión de Cobertura en Salud, en base a la atención Primaria y el Licenciamiento de los Servicios de Salud, Quito, May 2004.
17. R.O. No 09, Decreto Ejecutivo No 3611, Reglamento del Sistema Nacional de Salud, Quito, 28 January, 2003
18. R.O. No 670, Ley Orgánica del Sistema Nacional de Salud, Quito 25 September, 2002.
19. Arias Barriga Gonzáles, Constitución Política de la República del Ecuador., Edición Gab. Quito, July 2003, pp. 90-94.
20. R.O No 018, Decreto Ejecutivo 502, Quito 28 January, 1999
21. R.O. No 198, Acuerdo Ministerial No 1292, Quito, 26 May 1999
22. R.O. No 169, Ley No 27, Ley Especial de descentralización del Estado y Participación Social, Quito, 8 October 1997.

23. Lineamientos estratégicos del MSP 2007-2011: Visión y Misión
24. MSP/CONASA, Conjunto de Prestaciones del Sistema Nacional de Salud, Quito October 2006.
25. MSP/ CONASA, VI Revisión del Cuadro de Medicamentos Básicos, Quito, 2006.
26. MSP/CONASA. Plan de Acción de Salud Sexual y Derechos Reproductivos. Quito, 2007
27. Actas de la 60ª Asamblea Mundial de la Salud y Plan Estratégico de Organismos Andinos de Salud/Convenio Hipólito Unanue/ORAS/CONHU
28. Convenios de Programas de Cooperación en Salud vigentes: PASS/MSP/E (2005-2009), Convenio con el Fondo Global. Convenio con Holanda con mejoramiento de 10 hospitales.
29. Plan Nacional de desarrollo nacional. Directrices de Política del MSP 2002 – 2010.
30. Instituto Ecuatoriano de Cooperación Internacional (INECI). Cooperación para el desarrollo 2003 – 2004.
31. SEMPLADES, Modelo de Gestión Institucional.
32. Ministerio de Finanzas, SIGEF
33. MSP, Guía Nacional de Normas y procedimientos de Atención Integral a trabajadoras sexuales. Quito, May 2007.
34. MSP, Manual de Normas y procedimientos para la atención Integral de los y las Adolescentes. Quito, December 2005.
35. Guías para el Diagnóstico, Tratamiento y prevención de las Principales Enfermedades Crónicas No Transmisibles. Quito, October 2006
36. MSP/CONASA, Expediente Único para la Historia Clínica. Quito, August 2007.
37. MSP/CONASA, Política Nacional de Investigación en Salud. August 2007.
38. MSP, Lineamientos Técnicos y Operativos para la vacunación contra Influenza estacional y Neumococo. Quito, October 2007.

5. WORKING TEAM

We would like to express our appreciation to the institutions and individuals that participated and collaborated in the workshops held to validate the health system profile of Ecuador and for the valuable information provided for the preparation of this document.

List of institutions that participated in the preparation of the profile:

- Ministry of Public Health (MPH)
- National Health Council (CONASA)
- Ecuadorian Social Security Institute (IESS)
- Armed Forces Social Security Institute (ISSFA)
- National Institute of Statistics and Censuses (INEC)
- Pan American Health Organization (PAHO)
- Center for Social Research of the Millennium (CISMIL)
- Cancer Society (SOLCA)
- Guayaquil Welfare Board (JBG)
- Association of Ecuadorian Schools of Medicine and Health Sciences (AFEME)
- Directors of Schools of Public Health (public and private)

Individuals that participated in the preparation of the profile:

CONASA

- Dr. Hugo Noboa
- Dr. Jorge Alban

PAHO/WHO

- Dr. Cristina Merino
- Dr. Alvaro Campos
- Ms. Ana Quan
- Ms. Irene Leal
- Dr. Delmin Cury
- Dr. Celia Riera
- Dr. Luis Gutiérrez
- Dr. Víctor Arauz
- Dr. Edmundo Granda

- Dr. Ismael Soriano
- Dr. Ramiro Echeverría

MPH

- Dr. José Castro
- Dr. Washington Estrella
- Dr. Néstor Chicaiza
- Ms. Sara Naranjo
- Dr. Patricio Gavilanes
- Dr. José Avilés
- Dr. Benjamín Puertas
- Mr. Sebastián Oleas
- Dr. Carmen Laspina

IESS

- Dr. Guido Terán

ISSFA

- Dr. Juan Freire
- Dr. Alfonso Morillo

OTHER INSTITUTIONS

- Dr. Luís Sarrazín (JBG)
- Dr. Fernando Astudillo (AFEME–ECU)
- Mrs. Norma Montalvo (INEC)
- Dr. José Yépez (SOLCA)