METHODOLOGICAL GUIDELINES

HEALTH SYSTEMS PROFILES

Monitoring and Analyzing Health Systems Change/reform

Pan American Health Organization
Regional Office of the World Health Organization

USAID
FROM THE AMERICAN PEOPLE

PAHO HQ Library Cataloguing-in-Publication

Rivas-Loría, Priscilla
Methodological guidelines, health system profiles, monitoring and analyzing health systems change.
Special Edition N. 18 Washington, D.C: PAHO, © 2006.

ISBN 92 75 12621 6

I. Title II. Levcovitz, Eduardo
III. Aráoz, Candelaria IV. Suárez, Claudia V. Griffin, Andrew

1. HEALTH SYSTEM -- organization & administration
2. HEALTH PROFILE
3. HEALTH SECTOR REFORM
4. METHODS

NLM WA 540

ISBN 92 75 12621 6

Washington DC
2006

This publication was produced by the Pan American Health Organization/World Health Organization (PAHO-WHO) in collaboration with the United States Agency for International Development (USAID), Bureau for Latin America and the Caribbean. Financing was conferred by USAID under the terms of Grant number LAC-G-00-04-00002-00; and by PAHO/WHO regular budget funds.

AUTHORS

PRISCILLA RIVAS-LORÍA

Regional Advisor, Health Sector Reform
Health Policies and Systems Development, PAHO/WHO

CLAUDIA SUÁREZ

Resident, International Health Program
Health Policies and Systems Development, PAHO/WHO

CANDELARIA ARÁOZ

Technical Officer, Health Sector Reform
Health Policies and Systems Development, PAHO/WHO

EDUARDO LEVCOVITZ

Chief, Health Policies and Systems Development Unit, PAHO/WHO

TECHNICAL AND EDITORIAL COLLABORATORS

CAROLINE RAMAGEM

Technical Officer, Health Sector Reform
Health Policies and Systems Development, PAHO/WHO

ANDREW GRIFFIN

Consultant, Health Sector Reform
Health Policies and Systems Development, PAHO/WHO

Layout and Design

MARÍA LAURA REOS

Graphic Designer, Health Sector Reform
Health Policies and Systems Development, PAHO/WHO

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The document presented in the following pages is the product of a joint and multidisciplinary partnership between the Pan American Health Organization / World Health Organization (PAHO/WHO) and the United States Agency for International Development (USAID). Likewise, it is the result of the multiple experiences that were accumulated during the application of the first and second versions of the Guidelines published in 1998 and 2000 respectively. The comments and suggestions from the national teams of the countries of the Region as well as those which resulted from experts meetings, forums, and workshops served as the basis for the review, updating, and development of the third edition of the Methodological Guidelines for the elaboration of the ***Health Systems Profiles: Monitoring and Analyzing Health Systems Change/Reform***.

A special thanks is dedicated to the health professionals of the 36 countries of the Region that have contributed their time, knowledge and experience, between the years 2000 and 2005, to the application of the first version of the Health Systems Profiles: Monitoring and Evaluation of Health Sector Reforms in their countries.

In regard to the third edition of the Methodological Guidelines, the invaluable technical contribution of the following professionals is especially appreciated:

Alfaro, Gerardo
Health Systems and Services Advisor
PAHO/WHO – Dominican Republic

Brito, Pedro
Area Manager
Strategic Health Development
PAHO/WHO – Washington, D.C.

Castellanos Bran, Raúl
Director, PAHO/WHO Coordination Office
Puerto Rico

Gomes, Maria Angelica
Health Systems and Services Advisor
PAHO/WHO – Nicaragua

Gómez, Elsa
Regional Advisor
Gender, Ethnicity and Health Unit
PAHO/WHO – Washington, D.C.

González, Ana Cristina
Consultant, Gender, Ethnicity and Health Unit
PAHO/WHO – Washington, D.C.

Gordillo, Amparo
Consultant, Health Finance and Economy,
Health Policies and Systems Development
PAHO/WHO - Washington DC

Güemes, Armando
Health Systems and Services Advisor
PAHO/WHO – Honduras

Hernández-Pimentel, Federico
Health Systems and Services Advisor
PAHO/WHO – Guatemala

Montenegro, Hernán
Unit Chief, Health Services Organization
Technology and Health Services Delivery
PAHO/WHO – Washington, D.C.

Puentes-Markides, Cristina
Advisor in Policy Analysis
Health Policies and Systems Development
PAHO/WHO - Washington DC

Pichardo, Mario
Health Systems and Services Advisor
PAHO/WHO – Cuba

Ramagem, Caroline
Consultant, Health Policies and Systems Unit
PAHO/WHO – Washington, D.C.

Rigoli, Félix
Regional Advisor in Human Resources Development
Human Resources Unit
PAHO/WHO – Washington, D.C.

Rojas, Rocío
Indigenous People Health Initiative
Health Services Organization
Technology and Health Services Delivery
PAHO/WHO – Washington, D.C.

Saldaña, Kelly
Senior Public Health Advisor
USAID – Washington, D.C.

Santacruz, Javier
Health Systems and Services Advisor
PAHO/WHO – Costa Rica

Suárez, Julio
Health Systems and Services Advisor
PAHO/WHO – Brazil

Troya, Guillermo
Health Systems and Services Advisor
PAHO/WHO – Belize

Vargas, Gustavo
Health Systems and Services Advisor
PAHO/WHO – Panama

LIST OF ACRONYMS

ARI:	Acute Respiratory Infections
CCS:	Country Cooperation Strategy
CFTC:	Country-Focused Technical Cooperation Strategy
EAP:	Economically Active Population
ECLAC:	Economic Commission for Latin America and the Caribbean
EPHF:	Essential Public Health Functions
EPL:	Extreme Poverty Line
GDI:	Gender Development Index
GDP:	Gross Domestic Product
GEI:	Gender Empowerment Index
HA:	Health Authority
HDI:	Human Development Index
HIV/AIDS:	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HSR:	Health Sector Reform
IID:	Intestinal Infectious Diseases
LAC:	Latin America and the Caribbean
LACHSR:	Latin America and Caribbean Regional Health Sector Reform Initiative
M&E:	Monitoring and Evaluation
MDG:	Millennium Development Goals
NHD:	National Health Development
NGO:	Non-Governmental Organization
OECD:	Organisation for Economic Co-operation and Development
PA:	Position of Actor
PAHO:	Pan American Health Organization
RA:	Role of Actor
RPL:	Relative Poverty Line
TA:	Type of Actor
TB:	Tuberculosis
UNDP:	United Nations Development Programme
USAID:	United States Agency for International Development
WHO:	World Health Organization

FOREWORD

Throughout the 1990s and the beginning of the new millennium the countries of the Latin American and Caribbean (LAC) Region have attained several noteworthy accomplishments, such as an increase in the number of democratically elected governments, sound macroeconomic policies, and reforms that promote economic growth. Nevertheless, significant challenges persist, such as reversing the increase or stagnation in poverty levels in a large number of countries, reducing maternal and child mortality, addressing gender inequities in the labor market and at the political level, increasing access to basic water and sanitation services in low-income countries and for the poorest regions of middle-income countries, and most importantly, improving equity in the access to health services and in health outcomes.

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

At the Summit of the Americas in 1994, and the Special Meeting on Health Sector Reform in 1995 the Governments of LAC countries identified the need to develop a process for monitoring and evaluating health sector reforms in the LAC Region. To respond to this need, the ***Pan American Health Organization/World Health Organization (PAHO/WHO)*** and the ***United States Agency for International Development (USAID)*** embarked on the task of developing methodological guidelines to facilitate the preparation and periodic updating of a report (hereinafter "the Profile") on each of the LAC countries' health systems as well as to monitor and evaluate their HSR processes. In 1998, LAC countries determined that the guiding principles for the planning and implementation of HSR should center on improving access, equity, efficiency, quality and the sustainability of the health system. In 1999, Resolution CE124.R8 was adopted requesting PAHO/WHO to provide Member States technical support to institutionalize the continuous monitoring and evaluation of their HSR processes. As a result, the *Methodological Guidelines for the Preparation of Health Systems Profiles: Monitoring and Evaluation of Health Sector Reforms* was finalized and published in the year 2000.

At the present time, a Profile has been completed in 36 LAC Region countries. The evidence resulting from monitoring the HSRs in these countries has become the basis for preparing *LAC HSR Trends Analyses*. Accordingly, the *Trends Analyses* have been pivotal in the identification of the tendencies and progress in HSR, as well as the areas not tackled by the Reforms, such as the Essential Public Health Functions, Strengthening the Steering Role of the National Health Authority, Human Resources Development and Social Protection in Health. Moreover, the concise nature and periodic updating by the country technical levels of the Profile have made it a valuable tool for decision-makers at the national, sub-national, local and international levels.

PAHO/WHO has continued the dynamic process of developing, improving and adapting the Methodological Guidelines for the elaboration of the Profiles. The updated and revised version presented here comes as a result of the lessons learned from the application of the *Guidelines*; the emergence of new conceptual developments in the field of public health and health systems; and the growing evidence of the impact of HSR in the LAC Region.

The ***Methodological Guidelines for the Preparation of Health Systems Profiles and Monitoring Health Systems Change*** are particularly relevant at a time when health systems inadequacies have come under the spotlight, primarily because of the increasing recognition that weak health systems impede the achievement of the *Millennium Development Goals* (MDGs) as well as other global health goals.

Country commitment and efforts to monitor progress towards the achievement of health-related MDGs, in the areas of child and reproductive health, HIV/AIDS, tuberculosis, malaria and nutrition provide a golden opportunity to strengthen the countries national capacity to generate and use information to analyze, design, implement and monitor their health systems and their health sector reforms.

It is our hope that this publication will be used to train and empower LAC countries health personnel and policy makers to thoroughly comprehend their health system enabling them to reconcile and revitalize their HSR agenda with efforts to scale up health systems in order to reach the health-related MDGs and other public health objectives.

PRISCILLA RIVAS-LORÍA

Regional Advisor in Health Sector Reform
Pan American Health Organization

KELLY SALDAÑA

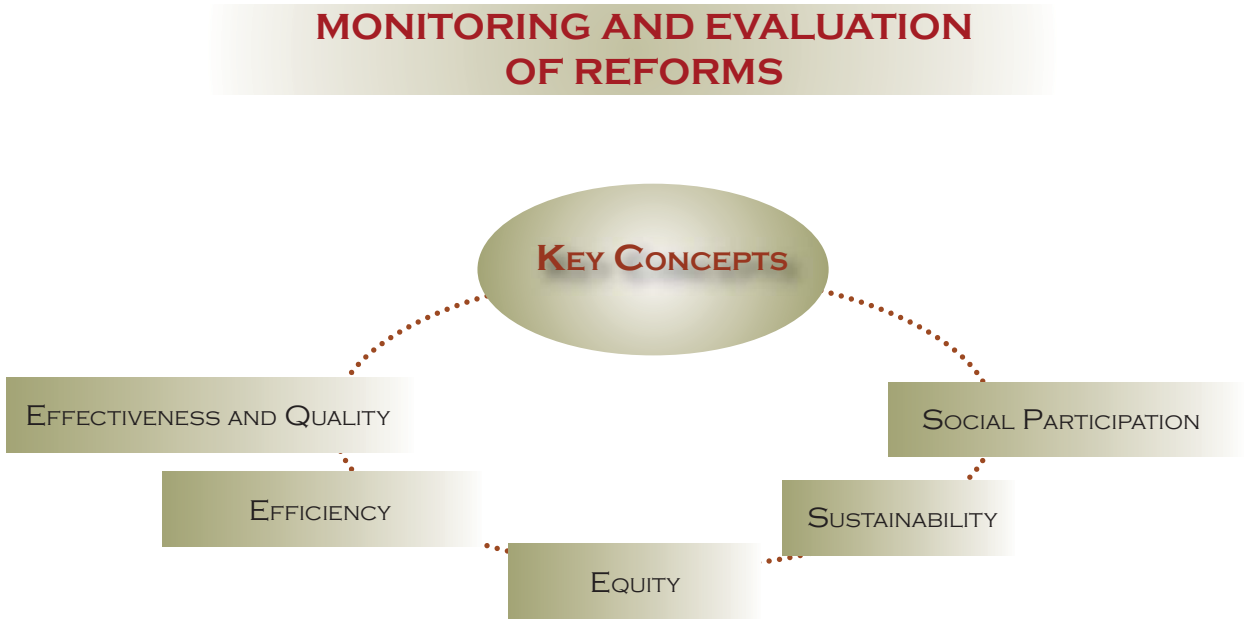
Senior Public Health Advisor
United States Agency for International Development

BACKGROUND

REQUEST BY THE COUNTRIES OF THE REGION OF THE AMERICAS

Throughout the 1990s, most of the countries of the Latin American and the Caribbean (LAC) Region have been introducing Health Sector Reforms (HSR) that have had a profound impact on health services delivery. At the "Summit of the Americas" in 1994[1] and at the Special Meeting on HSR in 1995,[2] Governments of the Region identified the need to develop guidelines to monitor and evaluate HSR in the Region. The Member States delineated 5 key concepts or guiding principles for health sector reforms that would serve as the basis for monitoring and evaluating the progress of HSR in their countries; namely Equity, Effectiveness and Quality, Efficiency, Sustainability and Social Participation. As a result, the Pan American Health Organization / World Health Organization (PAHO/WHO) designed the Methodology for the Preparation of Health Systems Profiles/ Monitoring and Evaluation of HSR in Latin America and the Caribbean. The guide's fundamental objective was to support countries in the monitoring and evaluation of their HSR processes through the application of guiding questions and indicators for each key concept related to the reforms.

FIGURE A



1. First Summit of the Americas: "Plan of Action," Miami-USA, 3-5 Dec, 1994.
2. IDB, IBRD, ECLAC, OAS, PAHO/WHO, UNFPA, UNICEF, USAID: "Special Meeting on Health Sector Reform." 29-30 Sep. 1995. Washington DC, Health and Human Development Division, Jun. 1996. 159 pp.

RESPONSE

In 1999, PAHO/WHO Member States adopted Resolution CD41.R12, entitled "Monitoring and Evaluation of Health Sector Reform Processes."[3] The Member States requested that PAHO/WHO provide support in institutionalizing the monitoring and evaluation of their health sector reform processes. However, it quickly became clear that in order to effectively apply the Monitoring and Evaluation (M&E) Methodology, countries would require a summary document and/or profile, consisting of a concise, analytical description of their health system's structure and dynamics. Accordingly, to facilitate monitoring of HSR trends and progress, PAHO/WHO – in close collaboration with the U.S. Agency for International Development (USAID) – undertook the task of formulating the ***Methodological Guidelines for the Preparation of Health Systems Profiles***, incorporating the ***Methodology for the Monitoring and Evaluation of HSR*** into these Guidelines.

FIGURE B

STRUCTURE RESULTING FROM BLENDING THE GUIDELINES FOR THE PREPARATION OF HEALTH SYSTEM PROFILES WITH THE METHODOLOGY FOR THE MONITORING AND EVALUATION OF HSR

1. **Context**
   Political, Social, Economic, Demographic/Epidemiological which Influences Health Systems Development and Performance

2. **Health System**
   General Structure
   Human Resources, Medicines, Equipment/Technology Functions of the Health System: Steering Role; Financing; Assurance; and Service Provision

3. **Health Sector Reform**
   Monitoring of the Process: Dynamics of the Reforms; Content of the Reforms
   Evaluation of Results: Equity, Efficiency, Effectiveness/Quality, Sustainability, Social Participation

Although each of the two sets of guidelines can be used separately, the monitoring and evaluation of health sector reform processes have benefited enormously from the results of the analyses generated by both sets of guidelines, including the analysis of the context in which the health system operates; its structure and general organization; its resources; and most importantly, the analysis of the key health system functions. In the majority of countries, it would have been impossible to analyze health system performance without incorporating the potential or real impact of the reforms that were planned or are in progress.

3. PAHO/WHO, 41st Directing Council, Resolution CD41.R12, 30 September, 1999.

METHODOLOGICAL LIMITATIONS

The development of the first and second cycle, in 1998 and 2000, respectively, of the Methodological Guidelines met some methodological limitations. First, in some countries the available information turned out to be insufficient and unreliable, and was not compiled with the required level of disaggregation, for example by sex, age, income or geographical distribution. In others, where information did exist, it was not systematically compiled or it was not adequately disseminated. Second, cultural diversity and multiple organizational models produced notable differences in the definitions of the concepts and/or terminology utilized. Efforts to minimize this limitation involved the inclusion of a Glossary with definitions of concepts and terms. Third, health services systems are complex and dynamic realities, in which the separation between stages of continuity and stages of rapid and deliberate change cannot always be clearly determined. It is even more difficult to identify separation between the different stages or phases of HSR, which are far from being planned processes and which differ from one country to another. Therefore, it is not possible to establish a cause-and-effect relationship between health systems' functions, Sectoral Reform (SR) processes and the impact on the variables used to evaluate their results.

To address these challenges, the following inputs were included in the preparation of the *first version* of the Guidelines:

(I) PAHO's previous experience in the design, collection, processing, validation and dissemination of information about the health situation and health trends;

(II) The work of personnel from the PAHO Division of Health Systems and Services Development, both at headquarters and in the field,[4] as well as collaboration with personnel from other divisions, units and programs;

(III) The experience of other cooperation agencies that work in and outside of the Region, particularly the WHO Division of Analysis, Research, and Assessment,[5] the WHO European Regional Office,[6] OECD,[7] UNDP[8] and The World Bank;[9]

(IV) The rich experience of the 17 countries that implemented the "Baseline for Monitoring and Evaluation of Sectoral Reform" between October 1997 and May 1998;[10]

(V) The results of the feasibility test of a preliminary version of the Guidelines in five countries (Chile, Dominican Republic, Peru, El Salvador and Jamaica), as well as the contributions of the PAHO/WHO Representative Offices in eight additional countries (Mexico, Panama, Uruguay, Paraguay, Colombia, Cuba, Argentina and Guyana);

4. Among them, the experience of carrying out Health Sector Analyses in Chihuahua (Mexico), Nicaragua and Paraguay.
5. WHO-Division of Analysis, Research and Assessment: "Methods for Evaluating Effects of Health Reforms: Current Concerns." WHO ARA, Paper No. 13, Geneva, 1997.
6. EURO/WHO: "Country Health Systems Profiles: Generic Template and Questionnaire" (draft), Copenhagen, Nov, 1997.
7. OECD: "OECD Health Data 97. A Software for the Comparative Analysis of 29 Health Systems," CREDES, Paris, 1997.
8. UNDP: "Human Development Report," years 1995, 1996 and 1997, United Nations, New York.
9. World Bank: "World Development Report 1993. Investing in Health," Oxford University Press, New York, 1993.
10. LACHSR: "Baseline for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean," (mimeo) Technical Series No.2, Washington DC, 1998.

(VI) The contributions of an international meeting of experts convened to discuss the issue at PAHO/WHO headquarters in April 1998.

In 1999 the experience was presented and discussed at the Andean Sub-Regional Forum on HSR, and additional suggestions were incorporated into the Guidelines. The meeting also helped to confirm that the success of this effort depends to a great extent on the support of National Health Authorities and the commitment of staff members and professionals from the countries, since they are the principal users of the results. Finally, the external review of a draft of the second edition of the Guidelines was carried out by the School of Public Health at the University of Chile and by the School of Public Health at the Oswaldo Cruz Foundation in Brazil. Many of the suggestions from both entities were incorporated into the *second* version of the Guidelines.

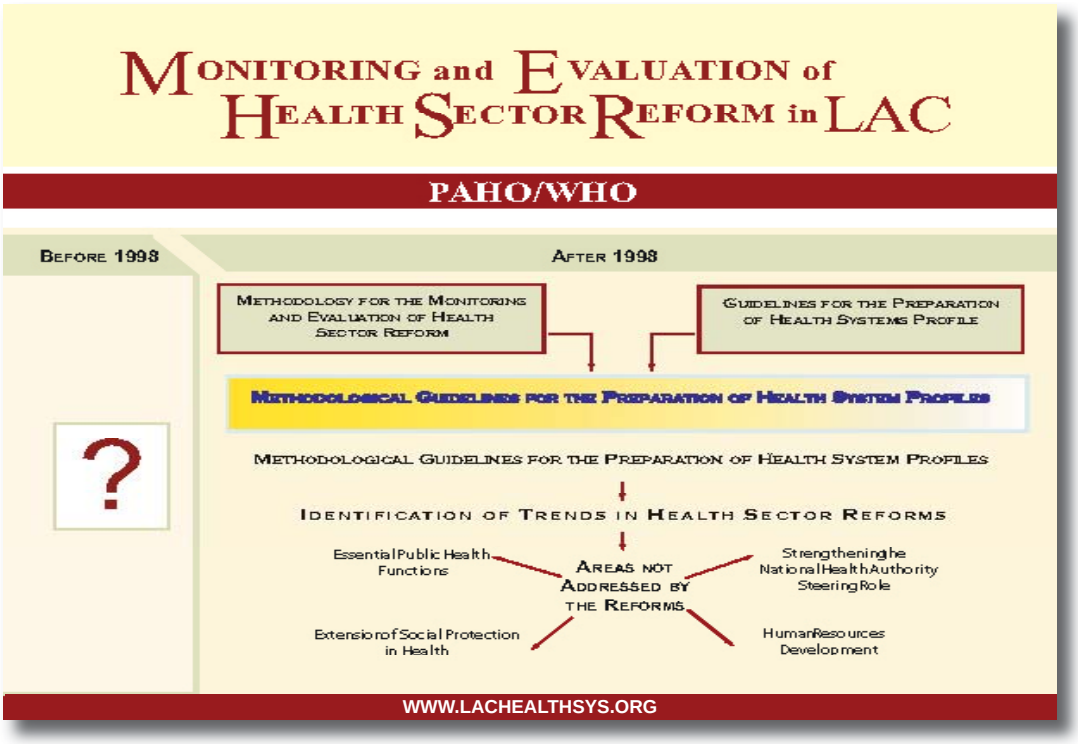
IMPACT

The concise nature and periodic updating of the Profile has made it a valuable tool for: (1) In-country professionals that work in the planning and administration of health systems and services; (2) Field professionals that work for financial/technical cooperation agencies and non-governmental organizations; (3) Managers and professionals from public sector institutions, such as the ministries of planning and/or finance, as well as private health institutions; (4) Health-related academic institutions; and (5) Health policy decision makers at the national, sub-national, and international levels. Consequently, the application of the methodology has resulted in country-level health officials who are trained and empowered with pertinent knowledge of their health system and health sector reform processes.[11] Currently, 36 countries in the Region have completed their Profiles, including the section on monitoring and evaluation of their HSR processes. Two-thirds of the Profiles have been reviewed and updated and are currently available in their second edition. Furthermore, one hundred percent of the Profiles have been submitted for peer review at recognized national academic institutions. The Profiles can be easily accessed through the Health Systems Strengthening's website: *http://www.lachealthsys.org*.

11. Rivas - Loría, P. Health Systems Analysis in Latin America and the Caribbean. Proceedings of the Symposium "Alliances for Public Health PAHO-US AID," PAHO/WHO, Washington DC, 13-14 September, 2004.

The evidence resulting from monitoring the HSR has become the basis for preparing the: *Sub-Regional Analysis of Trends in Health Sector Reform* in the *Central American Sub-Region*,[12] the *Andean Sub-Region*,[13] the *English-speaking Caribbean Sub-Region*[14] and for the *Region of the Americas*.[15] Accordingly, these analyses have been fundamental to the identification of trends and progress in HSR in the Region of the Americas, as well as in areas not addressed by the Reforms, such as the Essential Public Health Functions, Strengthening the National Health Authority Steering Role, Human Resources Development and the Extension of Social Protection in Health.[16]

FIGURE C



12. Rivas-Loría, P., Infante A., Pedroza J., Reinharz D. "Análisis de las Reformas del Sector Salud en la Subregión de Centroamérica y la República Dominicana," Iniciativa Regional de Reforma del Sector Salud en América Latina y el Caribe: USAID-OPS/OMS. Edición Especial No. 10. Washington DC, 2002. (*http://www.lachealthsys.org*).
13. Rivas-Loría, P., Infante A., Murillo R., Pedroza J., Schweiger A. et al. "Analysis of Health Sector Reforms in the Andean Countries" Latin America and Caribbean Regional Health Sector Reform Initiative: USAID-PAHO/WHO. Special Edition No. 11. Washington DC, 2002. (*http://www.lachealthsys.org*).
14. Rivas-Loría, P., Entwistle, M., La Foucade, A. "Analysis of Health Sector Reform in the English-Speaking Caribbean Countries" Latin America and Caribbean Regional Health Sector Reform Initiative: USAID-PAHO/WHO. Special Edition No.12. Washington DC, 2002. (*http://www.lachealthhsys.org*).
15. Rivas-Loría, P., Shelton C. "Health Sector Reform Trends in LAC: Are Health Reform and Health Systems Development Moving Forward?", Strengthening Health Systems and Reforms, LACHSR Bulletin, March 2005.
16. López-Acuna D. "La Nueva Generación de Reformas del Sector Salud: Fortaleciendo los Sistemas de Salud" Foro Regional de Reforma del Sector Salud, Antigua Guatemala, 19-22 July, 2004.

COUNTRY-FOCUSED TECHNICAL COOPERATION STRATEGY[17]

The evolution of the concept and practice of the technical cooperation of the Pan American Health Organization has focused on strengthening the capacity of the Country Offices. Currently, this process is aimed at consolidating the decentralization of responsibilities, resources, functions, and execution of technical cooperation. The content of PAHO's technical cooperation is based essentially on the needs of member countries, and is reflected in the strategic and programmatic priorities of the Organization.

Recently, both WHO and PAHO have placed emphasis on the articulation of the demands and resources of cooperation toward specific results that will help achieve the National Health Development in each country. This constitutes the basic principle for the organization, assignment of resources, management, and evaluation of the Organization's technical cooperation at its different levels of operation.

The scenario described above demands a permanent exercise of analysis and consensus-building with the countries around the needs and national priorities, as well as the national and international potential for cooperation through the joint formulation of the PAHO/WHO Country Cooperation Strategy (CCS).

The CCS is a methodology proposed by WHO within the framework of the "Country Focus Initiative," that makes it possible to develop a medium-term vision (4-6 years) for PAHO/WHO technical cooperation with each country. Its objective is to prepare an integrated cooperation proposal that responds to the policies and needs of the country, in the context of collective agreements, making it possible to develop a single strategy with a single budget.

One of the main inputs for the preparation of the Country Cooperation Strategy is the Health Systems Profiles: Monitoring and Analyzing Health Systems Change/Reform (*http://www.lachealthsys.org*). At the same time, it also relies on several other instruments and methodologies generated by the Organization such as: (1) Health Sector Analyses (*http://www.lachealthsys.org*); (2) Sectoral Analysis of Water and Sanitation; (3) Regional Core Health Data Initiative (*http://www.paho.org/english/dd/ais/coredata.htm*); (4) Measurement of the Performance of the Essential Public Health Functions; (5) Performance Evaluation of the Steering Role Function of the National Health Authority (*http://www.lachealthsys.org*); (6) Observatory of Human Resources on Health (*http://www.lachealthsys.org*); (7) Studies on Social Exclusion in Health (*http://www.lachealthsys.org*); and (8) Evaluation of the National Immunization Programs.

17. PAHO/WHO, " Experience with the Application of the Country Cooperation Strategy (CCS) Methodology in the Region of the Americas." CD46/INF/4, 57th Session of the Regional, Washington DC, 26-30 September 2005.

UPDATING OF THE METHODOLOGY

JUSTIFICATION

In response to the request that the countries of the Region made to the Directing Council in September 1999 through Resolution CD41.R12 (*http://www.paho.org/english/gov/dc/govbodies-CD.htm*), a meeting at which the Region's governments identified the need for technical support in monitoring health sector reforms in the Americas, PAHO/WHO has continued the dynamic process of developing, improving and adapting the *Methodological Guidelines for the Preparation of Health Systems Profiles* and *Monitoring Health Systems Change in Latin America and the Caribbean*. Furthermore, PAHO/WHO has been providing technical cooperation during the application of the Guidelines in all countries of the Region and in the preparation of their periodic reports.

However, growing evidence on the impact of Sectoral Reform processes in LAC and their contribution to new conceptual developments has led to the recognition that the *New Agenda for Sectoral Reforms*[18] should contribute to provide the tools to strengthen health systems. As a result, strategies and policies should be directed at (1) reducing health inequities, (2) increasing solidarity in financing, (3) targeting interventions toward vulnerable populations, (4) utilizing models of care based on health promotion and disease prevention, (5) strengthening the Essential Public Health Functions, (6) promoting comprehensive, sustained Human Resources Development, (7) Strengthening the Steering Role Function, and (8) promoting the Extension of Social Protection in Health. [19],[20]

The periodic updating, every three (3) years, of the Methodological Guidelines for the preparation of the Profiles and the incorporation of new conceptual developments into the Guidelines is crucial, not only for monitoring change/reform processes in health systems, but also as a mechanism to generate knowledge on health system performance improvement.

18. Mirta Rosés Periago, Opening Remarks, Regional Consultation on the Work of the Commission on Social Determinants of Health, PAHO/WHO, Washington DC, 5 July, 2005
19. de Savigny, D, Kasale, H, Mbuya, C, and Reid, G. In Focus: Fixing Health Systems. Canada: IDRC 2004; 126 (*http://web.idrc.ca/en/ev-64763-201-1-DO_TOPIC.html*)
20. Evans, T and Bennett, S. Making Health Systems Work. Health Systems Action Network. 2005:4 (*http://www.phrplus.org/Pubs/HSANFull_article.pdf*)

PURPOSE

The purpose of the *Guidelines* is to facilitate and strengthen country-level institutional capacity to prepare a report ("Health System Profile") that contains a brief description and analysis of four components related to the Health System, namely, (1) Context of the Health System; (2) Functions of the Health System; and (3) Monitoring Health Systems Processes of Change/Reform.

In order to facilitate and strengthen country-level institutional capacity to analyze, monitor and evaluate health sector reform, PAHO/WHO has prepared several tools and methodologies. Accordingly, the specific objectives of updating the Guidelines include:

- Standardization of the tools and methodologies prepared to facilitate and strengthen country-level institutional capacity to monitor and analyze change/reform;
- Incorporation of conceptual advances in public health/health systems development;
- Inclusion of issues not addressed by HSR processes, such as Essential Public Health Functions, the Steering Role, and Human Resources Development;
- Provide support for the development of the Country-focused Technical Cooperation (CFTC) Strategy;
- Simplify the Methodological Guidelines into a friendly format with the objective of facilitating its continuous update.

TARGET POPULATION

At the country level:

- Health authorities at the central level and at the sub-national levels (intermediate and local);
- National professionals who work in the areas of planning and administration of health systems and services, as well as field professionals from technical and financial cooperation agencies and NGOs;
- Managers and professionals from other public institutions (for example, ministries of planning and/or finance) and from the private health sector;
- Health-related educational institutions;
- Health professionals;
- The media and the public.

In the international arena:

- Managers and professionals from PAHO/WHO and other bilateral or multilateral technical or financial cooperation agencies;
- National health authorities from other countries and regions;
- Universities and centers devoted to public health education, administration and health management;
- Specialized journals; and
- The general media.

NEW STRUCTURE

The structure of the Methodological Guidelines seeks to facilitate the collection, preparation and periodic updating of the Profile based on the three thematic areas included in the methodology.

Likewise, it aims to standardize the structure of the Guidelines with the one used in the *Methodological Guidelines for Health Sector Analysis*. The Health Sector Analysis constitutes a collective and participatory process that seeks to strengthen the ability of the technical and political levels within the country to lead the health sector. The resulting document describes the health situation of the country as well as the performance of the health system. The analysis guides the identification and selection of priority interventions for the formulation of health policies and for health systems development. This process has been successfully completed in Bolivia, Costa Rica, Cuba, Guyana, Haiti, Nicaragua, Paraguay, and Puerto Rico.

The evidence gathered during the application of the first and second versions of the Guidelines indicates that the period of time between the implementation of a set of interventions and their eventual impact is too long for their effects to have been observed during the relatively short period of time in which the dynamics, process and content of the reform were monitored (starting in 1999). As a result, efforts to complete evaluations of the reforms produce imprecise information and evidence that is of little use to political decision makers. In light of this situation, it was determined that the Methodological Guidelines should be focused on Monitoring Change/ Reform Processes in Health Systems. Other instruments and knowledge generation processes should be developed and employed in the long term to address the evaluation component.

The current structure of the Methodological Guidelines incorporates three major thematic areas, namely:

(1) Context of the Health System

(2) Functions of the Health System

(3) Monitoring Change/Reform in Health Systems

(1) Context of the Health System. Consists of two sub-areas, namely, (i) Health Situation Analysis; and (ii) Determinants of Health. The Health Situation Analysis describes the general situation regarding the state of the population's health. The Determinants of Health section summarizes and analyzes the political, economic and social determinants that influence the health situation and health system performance.

(2) Functions of the Health System. Describes and analyzes the general organization, resources and performance of the health system's functions, including Steering Role; Financing and Assurance; and Service Provision.

(3) Monitoring Change/Reform in Health Systems. Characterizes and analyzes the phases or stages of intensified transformation of the health system and/or reform processes.

With the objective of ensuring relative homogeneity among countries regarding the terminology used in the Methodological Guidelines, a glossary is included at the end of this document.

ORGANIZATION OF THE WORK

WORK TEAM

The leadership of the ministry of health and other health sector institutions (for example, social security, the private sector, universities, etc.) is of crucial importance for the preparation and/or review of the Profile. These institutions should inform the actors in the health sector about the objectives and scope of the work.

The number of work team members should not be larger than six. Within the team, the assignment of one person as the individual responsible for each main component of the methodology is recommended.

It is suggested that at least one meeting of the general work team in charge of the preparation and/or review of the Profile be held at the beginning and end of the process and that frequent meetings be held by the work groups for each thematic area in the Profile.

The Area of Health Systems Strengthening at PAHO/WHO Headquarters will provide assistance to the country National Health Authority and the PAHO/WHO Country Office throughout the entire process.

WHAT TYPE OF INFORMATION WILL BE USED AND WHERE CAN IT BE OBTAINED?

The following sources should be used in the preparation and/or review of the Profile:

a) Information that is already available, giving priority to institutional information published in official national sources.

b) Information published by international technical and/or financial cooperation agencies.

c) Unpublished information from official national sources ("grey literature"), so long as disapproval to its utilization does not exist.

d) Information considered relevant published in unofficial sources.

In the case of inexistent or incomplete information (for example, under-registration of mortality) or documented or admitted biases, these should be clearly stated (for example, if the only information available is for establishments that depend on the Ministry of Health). In those cases where information exists but was not available during the preparation of the Profile, this should also be stated expressly, indicating where it can be found and, if relevant, the reason why the information could not be accessed.

APPROACH TO THE THEMATIC AREAS

The three thematic areas outlined in the Guidelines are considered essential for preparing the Profile and it is recommended that they *all be addressed in the order they are proposed.* Information concerning thematic areas not addressed can be included only as an exception, if it sheds light on crucial aspects of the country's health system and change processes, and so long as it does not result in the Profile surpassing the recommended total length. Quantitative and qualitative information should be included in each thematic area.

With regard to *quantitative information,* efforts have been made to include information that is known to exist and is available in most countries. Whenever possible, quantitative information should be presented in the form of a table or figure, with comments on the evolution of the time series (if available) for the last three 5-year periods, for example: 1993-1996; 1997-2000; and 2001-2004.

In regard to *qualitative information*, the Guidelines aim to be self-explanatory by clarifying the scope of intended knowledge, clarifying terms and suggesting the approximate amount of space that should be dedicated to the issue in the Profile (for example, a line, a few lines or a paragraph). At this juncture, it is important that the work team differentiates between *"qualitative information," "skilled opinion" and "value judgment."* For example, if in a country a given ministerial proposal for sectoral reform (or an important aspect of the reform) generated opposition and was eventually abandoned, this is relevant qualitative information that should be recorded. If the opposition came from various actors (internal or external to the government itself), assessment of each actor's influence on the rejection is a matter of opinion and will only be recorded if there is sufficient consensus on the issue. The assessment of the reasons for each actor's opposition would fall within "value judgments" and should be recorded as such.

PRESENTATION OF THE PROFILE

In the first stage, the Methodological Guidelines will be used as a practical guide for collecting the data requested about the health context, health system functions and monitoring of change processes. Based on the information collected, the second stage of work relates to the discussion about and consensus on the data obtained using appropriate data analysis. In the third and final stage, the work team will develop a narrative about the results obtained in the previous stages. The final narrative of the Profile should be an objective summary in which long, detailed descriptions should be avoided. Similarly, the use of a writing style with short phrases and appropriate punctuation and accentuation is recommended in order to avoid unrelated phrases and excessive use of subordinate sentences.

The notation in Spanish, Portuguese and French for the numbers should be respected, e.g., "," as the decimal symbol and "." as the symbol for grouping thousands and millions. In the case of those Profiles prepared in English, or in the translation into English of Profiles originally prepared in other languages, the existing notation in English should be respected, that is "." as the decimal symbol and "," as the symbol for grouping thousands and millions.

The total length of the document, including the Bibliography chapter, should be between 30 and 35 pages, with 1.5 spacing, in Arial size 11 font. This does not include the addition of the Executive Summary, which should be no longer than two pages. A balance should be sought between graphics and text. It is suggested that the sections that contain quantitative information (presented as tables or graphs) be organized so as not to exceed 40 to 50% of the total length of the document.

The Health System Profile should be as objective as possible, manageable in size, accessible through the PAHO/WHO portal (http://www.paho.org), as well as through the LACHSR portal (http://www. lachealthsys.org), and updated periodically; it is recommended that this updating be carried out at least triennially. Below, approximate lengths for each thematic area of the Profile are proposed and it is recommended that the total Profile not exceed 35 pages:

(1) CONTEXT OF THE HEALTH SYSTEM	3-4 PAGES
(2) FUNCTIONS OF THE HEALTH SYSTEM	10-12 PAGES
(3) MONITORING HEALTH SYSTEMS CHANGE/REFORM	15-20 PAGES
BIBLIOGRAPHY	1-2 PAGES
TOTAL	30-35 PAGES

PERIODIC UPDATING

Global revisions of the Profile should be carried out once every three years. Partial modifications for each thematic area are possible at any time. In this case, the National Health Authority should send the proposed modifications through the PAHO/WHO representative to the designated focal point at PAHO/WHO Headquarters.

The preparation of the new edition of the Profile and the global revisions should include at least one external review. To this end, the PAHO/WHO Representative Offices in the countries can arrange with one (or more) national institution(s) of recognized prestige the mechanism to be used for carrying out such a review. This external review should be completed before sending the new version of the Profile to the technical team at Headquarters.

METHODOLOGY

CONTEXT OF THE HEALTH SYSTEM

The purpose of this section is to synthesize and review available information on the country's health situation. Likewise, another purpose of this section is to analyze the information related to determinants external to the health situation that are associated with the political, economic and social context of the country and that affect health system performance. In this regard, the goal is to identify and analyze the determinants that are predominantly external to the health sector and that have an effect on health interventions and the results obtained. Much of this information is available, has been utilized in the past and is frequently published in the countries.

HEALTH SITUATION ANALYSIS

The objective of this section is to assess the state of the population's health. To this end, the level of development of national health information systems and more concretely, the availability of data disaggregated by gender, ethnic group, age group, etc., as well as the quality, integrity and internal consistency of this data, will affect the capacity of the work team to characterize the state of health of the population. To complete this section, it is recommended that the information be consolidated, summarized and updated according to the Variables of Analysis and Indicators presented below.

DEMOGRAPHIC ANALYSIS

Knowledge about the structure and trends in population growth is of great relevance since health system requirements are affected by population size, geographical distribution, age structure and growth.

The purpose of this section of the Profile is to analyze the demographic variables that act as conditioning factors of the health situation at the national level. To this end, the trend of the average for each variable will be examined for each of the three 5-year periods from 1990-2005.

Please complete the following table (No.1) and comment on the trend over the 5-year periods for each variable for the 1990-2005 period. If possible, please annex the population pyramid for each period.

TABLE 1: DEMOGRAPHIC TRENDS

Periods / Indicators	1990-1994		1995-1999		2000-2005	
	Men	Women	Men	Women	Men	Women
Total population (thousands)						
Proportion of urban population						
Indigenous population						
Proportion of population under age 15						
Proportion of population age 60 and over						
Annual population growth rate						
Total Fertility Rate						
Crude birth rate x 1,000 inhabitants						
Crude death rate						
Life expectancy at birth						
Migratory balance						

SOURCE (S):

Note: use the denomination N/A when the information is not available.

EPIDEMIOLOGICAL ANALYSIS

The epidemiological analysis should provide a descriptive summary of the state of the population's health; that is, it should present in summarized form a relevant set of descriptive health-related characteristics for a given population. The usefulness of this analysis in the preparation of the Health System Profile will depend on data availability and quality. Fortunately, in many of the health sector's administrative jurisdictions in the countries of the Americas, there is an established practice of periodically producing reports on the state of health. Thus, as part of the exercise for the construction of the Profile, it is recommended that the information from the country's existing studies on the state of the population's health and its trends in recent years be compiled and systematized.

Please complete the following tables and comment on the trend over the 5-year periods for each variable for the 1990-2005 period. In the case that the data are disaggregated by sex, please include them.

TABLE 2: MORBIDITY AND RISK FACTORS

Periods / Indicators	1990-1994		1995-1999		2000-2005***	
	Urban	Rural**	Urban	Rural**	Urban	Rural**
Prevalence of low birth weight						
Fertility rate in adolescent women (15-19 years old)						
Annual prevalence of moderate and serious nutritional deficiency in children under 5 years of age *						
Prevalence of exclusive breast-feeding up to 120 days of age						
Percentage of deliveries attended by skilled health attendants						
Number of confirmed cases of vaccine-preventable diseases *						
Annual incidence of Influenza infections						
Annual number of confirmed dengue cases *						
Annual number of confirmed malaria cases *						
Annual incidence of TB *						
Annual incidence of positive sputum-smear microscopy TB						
Annual incidence of HIV/ AIDS						
Ratio of HIV/AIDS cases (man/woman)						
Annual incidence of malignant neoplasms of the lung *						
Annual incidence of malignant neoplasms of the female breast						
Annual incidence of malignant neoplasms of the cervix						

SOURCE (S):

Note: use the denomination N/A when the information is not available.
** Please disaggregate by sex if this information is available.*
*** Please disaggregate into rural and indigenous if this information is available.*
****Please prepare a figure for the trend over the last 5 years.*

TABLE 3: MORTALITY RATE

	General	Maternal	Communicable Diseases (Compulsory Reporting)	TB	AIDS	Malaria	Circulatory system diseases	Malignant neoplastic diseases	External causes
Periods									
1990-1994									
1995-1999									
2000-2005									
Gender									
Men									
Women									
Geographical Area									
Urban									
Rural									
Ethnic Group *									
White									
Indigenous									
Mestizo									
Afro-Descendant									
Others									

SOURCE(S):

**Each country will specify the existing ethnic groups*

TABLE 4: INFANT MORTALITY *

	Neonatal (0 to 28 days)	Post neonatal (28 days to 1 year)	Infant (0 to 1 year)	Post-Infant (1 to 4 years)	Total (1-5 years) **
Periods					
1990-1994					
1995-1999					
2000-2005					
Causes					
Disorders originating in the perinatal period (birth trauma /asphyxiation and prematurity)					
Intestinal Infectious Diseases (IID)					
Acute Respiratory Infections (ARI)					
Birth defects					
Nutritional deficiencies					
Other causes					
Geographical Areas					
Urban					
Rural					
Ethnic Group***					
White					
Indigenous					
Mestizo					
Afro-descendant					
Others					

SOURCE(S):

**Infant Mortality per every thousand live births in the last 15 years.*
***Please disaggregate by sex if this information is available.*
****Each country will specify the existing ethnic groups.*

Millennium Development Goals (MDGs)

For the purposes of preparing the Health Systems Profiles, it has been deemed necessary to document the current status of the sector with respect to the objectives laid out in the Millennium Development Goals. The MDGs were established following the United Nations Millennium Declaration and Summit (2000) and include 8 goals, 18 targets and 48 indicators. The MDGs give more prominence to health-related issues than to international development goals: three of the 8 goals and eight of the 18 targets are directly health-related and include indicators to be monitored by WHO. (*www.un.org/millenniumgoals*)

The exercise of preparing the Health System Profile provides an excellent opportunity to establish a consensus-driven baseline for each health-related indicator, as well as to establish the magnitude of change required to meet the established targets, taking into account the changes observed between 1990 and 2000 with respect to each indicator. Moreover, it is possible to identify strategies and interventions that will contribute to the achievement of each goal, including proposals for stratification and/or targeting of populations and priority activities. Using the following table (No.5) as a frame of reference, briefly describe the country's situation with respect to each MDG and the information requested.

TABLE 5: MILLENNIUM DEVELOPMENT GOALS

MDG	Institution/s responsible	Standardized databases *	Up-to-date Information	Identification of gaps to meet goals by 2015 **	Identification of interventions ***	Strategic Plan 2015****	Budget Allocation
1. Eradicate extreme poverty and hunger							
2. Achieve universal primary education							
3. Promote gender equality and empower women							
4. Reduce child mortality							
5. Improve maternal health							
6. Combat HIV/AIDS, malaria and other diseases							
7. Ensure environmental sustainability							
8. Develop a global partnership for development							

SOURCE (s):

**Basic level of standardization of national and international indicators for example: poverty index, maternal mortality, access to drinking water, etc.*
*** Please present a graph/figure on trends with respect to the MDGs (if one exists).*
****Please mention those interventions that incur in more than one MDG (intersectoral interventions).*
***** Please describe the country's strategic plan for the attainment of the MDGs by the year 2015.*

1.2 DETERMINANTS OF HEALTH

The objective of this section is to help summarize and analyze information on the determinants external to the health situation or health system performance that are related to the country's political, economic and social context. It addresses determinants that are predominantly external to the sector but that influence its actions and results.

POLITICAL DETERMINANTS

On a global level, the beginning of the 1990s marked the start of a new stage of economic and social life. The disappearance of the so-called "real socialism" and the end of the Cold War marked the beginning of a new era characterized by unipolarity, the predominance of market incentives and tendencies toward the globalization of diverse spheres of political, economic and social life.

For the Latin American and Caribbean Region, it represented the end of the majority of authoritarian regimes and the expansion of democracy. The Region was also witness to an increase in poverty and unemployment levels. Phenomena such as political and social violence, democratic rights violations, accusations of corruption at the highest levels, border conflicts, and the pressure of drug trafficking increased in several countries. However, at the same time, support existed for the idea that strengthening democracy implied achieving a model of economic growth with development that would be capable of inserting the Region into the globalized world without being relegated to a subordinate position and that, in addition, would make it possible to reduce the high levels of existing inequity. Accordingly, two types of processes were catalyzed (or reactivated): (i) sub-regional integration and regional and hemispheric coordination; and (ii) profound modification of the relationships between society and the State.

The modification of the relationships between society and the State were initially brought about by structural adjustment policies, which advocated more market and less State. The redefinition of the State's role has implied its reinforcement in certain key functions (regulation, control, evaluation) and a greater weight for private enterprise in service delivery. Although the processes have followed different paths in each country, the majority of programs for reform and modernization of the State have aimed to respond to problems of fiscal deficit, foreign debt, excessive centralization, administrative inefficiency, low satisfaction of social demands and fragility of the democratic political system. In addition, they have incorporated policies that favor vulnerable groups and the struggle against poverty, in particular, against extreme poverty. Up to the present time, the effect of these programs has been unequal.[21]

Please refer to the following guide to briefly describe and analyze the political determinants of health. In each of the points described, a response of Yes or No is requested. In the case of a Yes response, please comment briefly, including examples.

21. Ffrench-Davis, R. " Reformas para América Latina después del Fundamentalismo Neoliberal" (Buenos Aires: Siglo XXI, 2005).

Situations of instability or political violence exist.

Yes

Comment on how this affects the health sector: _____

_____

No

The country is part of a sub-regional initiative or free trade zone.

Yes

Comment on whether there are studies about their overall impact on social policies: _____

_____

No

There are explicit proposals on the need to reform the state.

Yes

Comment on their principal components and analyze their development: _____

_____

No

There is international cooperation for the modernization of the State and the public sector.

Yes

Describe the organizations and the areas of cooperation: _____

_____

No

The following issues are priority political problems: public deficit, foreign debt, excessive decentralization, inefficient administration and management, or public dissatisfaction.

Yes

Comments: _____

_____

No

The struggle against poverty is a government priority.

Yes

Comment on how it is addressed, with which actors and which strategies: _____

_____

No

Violence is perceived as a political problem.

Yes

Comment on who suffers from violence (women, children, workers, immigrants): _____

_____

No

There is a Social Cabinet (Ministries of Social Development, Health, Education, etc.).

Yes

Describe its composition and operations: _____

_____

No

The executive levels of the Ministry of Health have publicized the national strategies for the attainment of the Millennium Development Goals.

Yes

Comment on whether sectoral initiatives related to this issue were adopted: _____

_____

No

There is coordination among actors from different sectors for the development and implementation of health-related public policies.

Yes

Comment on whether sectoral initiatives related to this issue were adopted: _____

_____

No

ECONOMIC DETERMINANTS

In order to identify the principal characteristics of the country's economic situation, it is necessary to determine and analyze the evolution of variables related to macroeconomic performance, public spending and social public spending (including the health expenditure component).

Please complete the following table (No.6) and comment on the trend over the 5-year periods for each indicator for the 1990-2005 period.

TABLE 6: TRENDS FOR SELECTED ECONOMIC INDICATORS

Indicator	Five-Year Periods		
	1990-1994	1995-1999	2000-2005
GDP per capita in US$, in constant prices relative to the base year			
Public expenditure per capita *			
Economically Active Population (EAP): EAP 15-59 years of age. * EAP population employed *			
Total public expenditure, as a percentage of GDP			
Public expenditure on health, as a percentage of GDP **			
Public expenditure on health services, as a percentage of GDP ***			
Private expenditure on health *			
Out-of-pocket expenditure (% of total health expenditure) *			
Annual Inflation Rate			
Remittances as a percentage of GDP			
Foreign debt, as a percentage of GDP			
Percentage of female-headed households			
Service of the foreign debt, as a percentage of GDP			

SOURCE(S):

Note: use the denomination N/A when the information is not available.
** Please disaggregate by sex if this information is available.*
*** Refers to the expenditures that the health sector realizes through the group of institutions that constitute the public health system.*
**** Refers to expenditures on medical care and public health (consult functional classification of expenditures).*

POVERTY LEVELS: The poverty-related dimension is measured by taking into account the per capita income and the monetary value of the basic food basket; or the extreme poverty line (EPL) and two times the value of the food basket or the relative poverty line (RPL).

TABLE 7: POVERTY LEVELS *

Area	POVERTY LEVEL		
	POOR	RELATIVE POVERTY	EXTREME POVERTY
TOTAL			
URBAN			
RURAL			
ETHNIC GROUP			
INDIGENOUS			
AFRO – DESCENDANT			
OTHERS			
GENDER			
MEN			
WOMEN			

SOURCE(S):

Note: use the denomination N/A when the information is not available.

** The use of household surveys and information from the national directorate of statistics and census suggested.*

EMPLOYMENT CONDITIONS: The analysis of employment conditions makes it possible to observe labor, migratory and demographic trends. This information reflects the number of people who enter the labor force per year or per periods. This information can be disaggregated in order to determine how many people join the labor market by geographical area (urban-rural) and by type of work (formal–informal).

TABLE 8: EMPLOYMENT CONDITIONS ACCORDING TO GENDER AND INCOME

OCCUPATIONAL SECTOR	POVERTY CONDITIONS			TOTAL
	EXTREME	RELATIVE	NON-POOR	
TOTAL				
FORMAL				
INFORMAL				
MEN				
FORMAL				
INFORMAL				
WOMEN				
FORMAL				
INFORMAL				

SOURCE(S):

Note: use the denomination N/A when the information is not available.

** The use of household surveys and information from the national directorate of statistics and census is suggested.*

SOCIAL DETERMINANTS

Countries routinely maintain more or less up-to-date indicators related to a series of basic variables, many of which are communicated to international agencies and whose evolution makes it possible to assess the social situation.

Since 1990, the United Nations Development Programme (UNDP) published the Human Development Report, where countries are ranked according to the Human Development Index (HDI), prepared using a matrix of variables that includes life expectancy at birth, literacy, school enrollment and per capita GDP. Between 1995 and 2000, the Report included the Human Development Profile for each country that, in addition to the previous variables, includes others such as population with access to health services, drinking water and basic sanitation, calorie supply per capita, distribution of daily press, access to television and others.

Furthermore, the Report devotes ample space to evaluating gender differences through the Gender-related Development Index (GDI), which includes information on the following indicators: life expectancy at birth for females and males, literacy rates for males and females, combined school enrollment rates for females and males, and per capita income for females and males based on participation in work-earned income. The Gender Empowerment Index (GEI) is also included, comprised of indicators that measure parliamentary seats occupied by women, women in executive and administrative positions, women in professional and technical positions, and per capita GDP for women.

There are numerous studies on poverty and extreme poverty in Latin America; among which those published by ECLAC are worth highlighting. Furthermore, the World Bank maintains a database for monitoring poverty in Latin America which use the “poverty assessments” conducted from 1993 to the present. An important aspect to consider is the geo-population distribution of problems, viewed from the perspective of living conditions. In some countries, a first approximation can be obtained from the so-called poverty maps prepared using census data. In fact, many countries have classified their sub-national demarcations (provinces, regions, states or municipalities) at different levels according to the degree of satisfaction of a series of basic needs (for example, food, housing, education and health) and have prepared poverty and extreme poverty maps at the municipal level.

Please complete the following table and comment on the trend over the 5-year periods for each indicator for the 1990-2005 period.

TABLE 9: TRENDS IN SELECTED SOCIAL INDICATORS

	Position that the country occupies according to the HDI	Population with access to drinking water (%)	Population with access to excreta disposal services (%)	Illiterate population ** (%)	Crude rate of primary schooling	School dropout rate	Child labor rate	Ratio for the income of the top 20% and the bottom 20% of the population *	Prevalence of domestic violence	Prevalence of depression
Periods										
1990-1994										
1995-1999										
2000-2005										
Gender										
Men										
Women										
Total										
Geographical Areas										
Urban										
Rural										
Ethnic Group * **										
White										
Mestizo										
Indigenous										
Afro-descendants										
Others										

SOURCE(S):

Note: use the denomination N/A when the information is not available.
** Please prepare a graph/figure showing the trend for the last 5 years.*
*** Please disaggregate by age groups if the information is available.*
**** Each country will specify the existing ethnic groups.*

ENVIRONMENTAL DETERMINANTS

Environmental risks and contamination contribute in a very important way to mortality, morbidity and disabilities associated with acute respiratory diseases, intestinal infectious diseases, physical traumas, poisoning, insect-transmitted diseases and infections. Mortality and morbidity due to causes such as poverty and malnutrition are also associated with unsustainable modes of development and the degradation of the urban or rural environment.

The identification of factors that are harmful to the environment and the corresponding protection of the population from these factors are an essential obligation of the health sector. Protection of our environment is a fundamental component of health promotion and prevention programs that should be addressed by national health policies.

Please refer to the following guide to briefly describe and analyze the environmental determinants of health.

Which institution/s is/are responsible for environmental issues?

Comment on how the health sector is involved in these issues: _____

_____

Health problems related (directly or indirectly) to environmental factors are identified in the country (respiratory and skin-related conditions, leukemia, hearing problems, diarrhea-related mortality/ morbidity in children under 5).

Yes

Comment on how the health sector intervenes to prevent these problems: _____

_____

No

Environmental indicators related to the population's health are identified and monitored in the country (skin cancer, diarrhea-related morbidity/mortality in children under two years of age, morbidity due to chemical factors, etc).

Yes

Comment on which indicators are identified and mentioned:_____

_____

No

There are legal mechanisms to regulate and oversee problems related to air pollution (harmful gas emissions).

Yes

Comment on which ones (if known) and whether the health sector is involved in their surveillance: _____

_____

No

There are legal mechanisms to regulate and oversee problems related to the disposal of excreta and waste.

Yes

Comment on which ones (if known) and whether the health sector is involved in their surveillance: _____

_____

No

There are legal mechanisms to regulate and oversee problems related to the disposal of toxic and radioactive products.

Yes

Comment on which ones (if known) and if the health sector is involved in their surveillance: _____

_____

No

There are legal mechanisms to regulate and oversee problems related to water pollution.

Yes

Comment on which ones (if known) and whether the health sector is involved in their surveillance: ____

_____

No

There are legal mechanisms to guarantee the population's access to drinking water.

Yes

Comment on which ones (if known) and whether the health sector is involved in their surveillance: ____

_____

No

2. FUNCTIONS OF THE HEALTH SYSTEM

One of the most important manifestations of the State's role in the health system can be observed through the separation of the health systems' functions and the designation of each function to one or multiple public or private actors/institutions. There is general consensus that this is an area that requires more in-depth study, given that health policy-makers and planners require methods to analyze and monitor the performance of these functions in order to gather information on whether they are being carried out appropriately, and whether a change in the manner in which one or more of the functions are executed will improve the sector's overall equity and efficiency.[22]

22. Adapted from PAHO/WHO, "Evaluación y Mejora del Desempeño de los Sistemas de Salud en la Región de las Américas", Washington, DC: PAHO/WHO, Health Policies and Systems Development Unit, 2001.

PAHO/WHO, based on the analysis of the processes of health system reform and reorganization in progress in the Region's countries, uses a classification that takes into account three basic functions, which should always be considered in an integrated, coherent and harmonious manner. These are: the (1) Steering Role; (2) Financing and Assurance; and (3) Service Provision. The purpose of this section is to synthesize and analyze the information that is relevant to these functions, which will be addressed independently in each sub-section.

2.1 STEERING ROLE

The Ministries of Health are the main public depository organizations of the "Health Authority" (HA) and are the primary entities responsible for exercising the sectoral steering role. Nevertheless, in some countries, the trend of not concentrating all of the sectoral Steering Role's dimensions or spheres of action in a single entity is observed. In such cases the concept of "Health Authority" is understood as the group of State actors/ institutions that is responsible for safeguarding public health and well-being.

1. MAPPING OF THE HEALTH AUTHORITY

As a first step toward the definition and strengthening of the Steering Role, it is important to identify, describe, characterize and graphically represent the actors and entities that form the Health Authority, and its sphere of action, establishing the interrelationship between the legal framework that grants public power to the State to carry out the Steering Role in health, and the institutional matrix that in fact carries out these powers. This process is known as the *Mapping of the Health Authority.*

For the purposes of the preparation of the Profile, the completion of the Organizing Framework for the Mapping of the Health Authority is recommended. Nevertheless, the country can decide to either complete the Organizing Framework as part of the elaboration of the Profile or complete it as part of the application of the *Methodological Guidelines for the Performance Evaluation of the National Health Authority Steering Role*. Both instruments can be accessed at *http://www.lachealthsys.org.*

2. CONDUCT/LEAD

The Conduct/Lead dimension of the Steering Role refers to the capacity of the HA to formulate, organize and manage the implementation of the *National Health Policy,* delineating viable objectives and feasible goals; and the capacity to prepare and implement strategic health plans.

Please use the following guide to briefly describe and analyze the conduct/lead capacity of the Health Authority (HA) to develop and execute the National Health Policy. In each of the points described, a response of* Yes or No *is requested. In the case of a* Yes *response, please comment briefly, including examples.

2.1 There is a formal definition of the vision and mission of the HA.

Yes

Comments/Examples: _____

_____

No

2.2 Information sources on the health situation are easily identified within the National Health System.

Yes

Comments/Examples: _____

_____

No

2.3 The HA promotes and guarantees the availability of information about access to health services by socioeconomic group, geographical division, ethnic group and gender.

Yes

Comments/Examples: _____

_____

No

Please complete the following table with the percentages (%) of people who have access to health services:

TABLE 10: ACCESS TO HEALTH SERVICES[23]

LEVEL OF DISAGGREGATION OF THE INFORMATION	ACCESS	
Periods	Male	Female
1990-1994		
1995-1999		
2000-2005		
Population group		
Children under 5 years of age		
People 5-17 years of age		
People 17-45 years of age		
People 45-65 years of age		
People age 65 or over		
Geographical areas		
Urban		
Rural		
Ethnic Group		
White		
Indigenous		
Mestizo		
Afro-descendant		
Others		
Economic Level		
Population in extreme poverty		
Population in relative poverty		
Non-poor population		
Level of Care		
Primary Level		
Secondary Level		

SOURCE(S):

Note: use the denomination N/A when the information is not available. Consulting household surveys is recommended.

23. Access to health services is understood as the probability of obtaining health care when it is needed.

2.4 The HA has the human, material and financial resources to use such information and make decisions, including the formulation of National Health Goals.

Yes

Comments/Examples: _____

_____

No

2.5 The HA takes primary care into account when it designs the National Health Policy.

Yes

Comments/Examples: _____

_____

No

2.6 The HA prepares and periodically updates the National Health Policy.

Yes

Comments/Examples: _____

_____

No

2.7 The National Health Policy defines the actors and their responsibilities in order to meet the National Health Goals.

Yes

Comments/Examples: _____

_____

No

2.8 The entities that comprise the HA, the remaining governmental sectors and civil society have easy access to the National Health Policy document.

Yes

Comments/Examples: _____

_____

No

2.9 The HA has a monitoring and evaluation system to measure the impact of health policies.

Yes

Comments/Examples: _____

_____

No

2.10 The HA promotes the achievement of consensus among the multiple actors in the health sector in order to make viable the formulation of the National Health Policy.

Yes

Comments/Examples: _____

_____

No

2.11 The HA mobilizes the resources (material, human, financial and organizational) of the health sector in order to carry out the National Health Policy.

Yes

Comments/Examples: _____

_____

No

2.12 The HA develops health projects to submit for the consideration of international cooperation agencies.

Yes

Comments/Examples: _____

_____

No

2.13 The HA actively participates as a spokesperson and representative of the health sector in international, regional and sub-regional organizations.

Yes

Comments/Examples: _____

_____

No

2.14 The HA defines goals that serve as a point of reference for evaluating health system performance.

Yes

Comments/Examples: _____

_____

No

2.15 The HA stimulates and promotes civil society participation in the identification of problems, and in the planning and implementation of health actions.

Yes

Comments/Examples: _____

_____

No

2.16 The HA manages the preparation of standards and interventions aimed at supporting health promotion actions.

Yes

Comments/Examples: _____

_____

No

2.17 There are mechanisms through which the HA guarantees the right to health.

Yes

Comments/Examples: _____

_____

No

The analysis of international cooperation for the country is of fundamental importance, in general terms, and with greater emphasis on cooperation directed at the health sector, both in economic terms and from the standpoint of the representativeness of the actors involved, management, administration and implementation.

2.18 Are the technical-financial cooperation entities that are present and active in the health sector in your country known?

Yes

Comments/Examples: _____

_____

No

2.19 Is the health sector informed about the legal and institutional frameworks and procedures for obtaining international cooperation resources for the health sector?

Yes

Comments:_____

_____

No

Comment on the characteristics and trends in international cooperation with the country in the health sector: _____

2.20 What are the expected trends in terms of international cooperation in the immediate future?

_____

2.21 Are there mechanisms to coordinate international cooperation for the programming and distribution of financial resources?

Yes

Comments:_____

_____

No

Please complete the table with information for the following time periods:

TABLE 11: FINANCIAL RESOURCES FROM INTERNATIONAL COOPERATION (IN US$)

Periods / Resources	1990-1994	1995-1999	2000-2005
Reimbursable			
Non-reimbursable			
Total			

SOURCE(S):

Note: use the denomination N/A when the information is not available.

3. REGULATION

The Regulation dimension has as its purpose to design and guarantee the fulfillment of the health regulatory framework that protects and promotes the population's health. The regulation and monitoring of its application are required in order to guarantee the role of the State in organizing the relationships between the production and distribution of health resources, goods and services based on the principles of solidarity and equity.

Using the following guide, comment on the strengths and weaknesses, achievements attained and deficiencies identified, as demonstrated by the HA with respect to sectoral regulation.

3.1 There is an institutional and legal framework for the execution of the Steering Role Function.

Yes

Comments/Examples: _____

_____

No

3.2 The legal framework assigns to the Health Authority the execution of the regulatory function either directly or through specialized agencies.

Yes

Comments/Examples: _____

_____

No

3.3 The implementation of the regulatory function has turned out to be positive in terms of its contribution to improving the population's health conditions.

Yes

Comments/Examples: _____

_____

No

3.4 The HA enforces regulations through effective sanctions related to the magnitude of damage to individual or collective health.

Yes

Comments/Examples: _____

_____

No

3.5 The diverse sectors involved perceive that the HA performs its enforcement function with a high level of transparency.

Yes

Comments/Examples: _____

_____

No

3.6 The central government entities provide support for the exercise of the enforcement function at the subnational level.

Yes

Comments/Examples: _____

_____

No

3.7 There are sanitary health standards for the operation of public establishments and the HA monitors compliance with such standards.

Yes

Comments/Examples: _____

_____

No

3.8 The HA characterizes the existent health labor force in the country, identifying gaps in terms of composition and availability, according to the epidemiological and demographic profiles.

Yes

Comments/Examples: _____

_____

No

3.9 The HA determines the mechanism for certifying health professionals.

Yes

Comments/Examples: _____

_____

No

4. DEVELOPMENT OF THE ESSENTIAL PUBLIC HEALTH FUNCTIONS (EPHF)

Describe the performance of the HA through a summary of the results of the EPHF measurement in your country, emphasizing the EPHFs with the highest and lowest scores. Comment on the actions taken to improve the performance of the EPHFs with lower scores.

5. FINANCING

The responsibility of the HA in this area involves guaranteeing, monitoring and adjusting the complementarity between resources from different sources in order to ensure equitable access to health services for the population.

In the following guide, comment on the strengths and weaknesses, achievements attained and deficiencies identified, as demonstrated by the HA with respect to Financing.

5.1 The HA develops and establishes policies directed at promoting equity through financing redistribution mechanisms.

Yes

Comments/Examples: _____

_____

No

5.2 The HA has mechanisms to monitor sectoral financing from the perspective of quality, efficiency and transparency (for example, mapping of funds; national health accounts; efficiency and quality studies).

Yes

Comments/Examples: _____

_____

No

5.3 The HA conveys its needs through dialogue and negotiation with the Ministry of Finance and national fiscal authorities.

Yes

Comments/Examples: _____

_____

No

5.4 The HA uses mechanisms to redistribute funds among different insurance providers in order to guarantee equitable access. For example, the transfer of subsidies between different schemes (contributory and subsidized); the creation of national solidarity funds; or funds for risk compensation.

Yes

Comments/Examples: _____

_____

No

5.5 The HA delineates criteria for resource allocation to select which interventions and services should be guaranteed and prioritized, thus allocating the necessary resources for their proper implementation.

Yes

Comments/Examples: _____

_____

No

5.6 The HA seeks sustainable financing in order to strengthen health systems.

Yes

Comments/Examples: _____

_____

No

6. ASSURANCE

Assurance is understood as access to a guaranteed package of health services for all inhabitants, or specific plans for certain population groups.

In the following guide, comment on the strengths and weaknesses, achievements attained and deficiencies identified, as demonstrated by the HA with respect to the Assurance.

6.1 The HA informs all inhabitants or certain population groups, as the case may be, about health goods and services to which they have a right under a guaranteed scheme of entitlements.

Yes

Comments/Examples: _____

_____

No

6.2 Are the guaranteed schemes of entitlements linked among each other and have they been published?

Yes

Comments/Examples: _____

_____

No

6.3 Is there a formal entity in charge of protecting citizens' rights?

Yes

Specify the mechanisms for channeling claims and settling complaints and note whether they are backed by sufficient budget allocation: _____

_____

No

6.4 Do standards to regulate the quality of health services delivery by the HA exist, and are they enforced?

Yes

Comments/Examples: _____

_____

No

6.5 Is the activity and performance of health insurance providers regulated and enforced (directly or through offices of the superintendent or similar agencies)?

Yes

Comments/Examples: _____

_____

No

6.6 Does the HA monitor the financial solvency of insurance providers with the goal of protecting consumers from a possible lack of solvency that could affect the availability and quality of the services they receive?

Yes

Comments/Examples: _____

_____

No

7. HARMONIZATION OF SERVICE PROVISION

This function refers to the capacity of the HA to promote complementarity among diverse service providers and user groups and to extend health care coverage equitably and efficiently.

In the next guide, comment on the strengths and weaknesses, achievements attained and deficiencies identified, as demonstrated by the HA with respect to the Harmonization of Service Provision.

7.1 The HA standardizes the action plans and management models of the different decentralized or deconcentrated public agencies that deliver health services in the country.

Yes

Comments/Examples: _____

_____

No

7.2 The HA evaluates possible duplication of services, with particular emphasis on the formulation of strategies to avoid service fragmentation and promote equity and access.

Yes

Comments/Examples: _____

_____

No

7.3 The HA establishes basic health care standards, or service delivery standards, both at the extra- and intra-hospital level.

Yes

Comments/Examples: _____

_____

No

7.4 The HA promotes and ensures the integration and coordination of primary, secondary and tertiary levels of care.

Yes

Comments/Examples: _____

_____

No

2.2 FINANCING AND ASSURANCE

FINANCING

The financing function includes determining the available financial resources in the health system, or, if need be, in each existing sub-system; collecting these resources through taxes, social security contributions, co-payments or other financial resources; and distributing and allocating the financial flows within the system. For the purposes of the methodology, a set of operational definitions has been adopted. For example, financing is defined as:

> *"the acquisition of funds from society (companies and households), the State and national and international donors/lenders, by agencies that are legally or contractually responsible (governmental, social security, associative/mutual/cooperatives or commercial) for this goal and the identification of the principal collection mechanisms (taxes, social security contributions, premiums, direct provider payments, donations, loans)."*

Based on this definition, financing has to do with the origin of the funds handled by the organizations in the health sector. For the purposes of this section, it is necessary to point out that financing is usually differentiated into public financing (derived from taxes, contributions, payment of service delivery charges and, ultimately, the division of assets and funds that are collected by the Government or social security entities) and private financing (derived from citizens, and delivered to insurance entities, private providers or public providers as payment for certain services).

Please complete the following table (No.12) with the percentages of the principal financing sources for the health system according to the institutional sectors and the multiple financing instruments.

TABLE 12: HEALTH SYSTEM FINANCING (in US dollars) *

	1990-1994	1995-1999	2000-2005
TOTAL NATIONAL BUDGET			
NATIONAL BUDGET ASSIGNED TO THE HEALTH SECTOR			
PUBLIC SUB - SECTOR (TOTAL)			
MINISTRY OF HEALTH			
SOCIAL SECURITY			
OTHERS			
PRIVATE SUB - SECTOR (TOTAL)			
PRIVATE INSURERS			
PRIVATE PROVIDERS			
CONTRACTUAL SERVICES			
OUT-OF-POCKET EXPENDITURE			
PRIVATE COMPANIES			
DONATIONS			
INTERNATIONAL ORGANIZATIONS			
OTHERS (SPECIFY)			

SOURCE(S):

Note: use the denomination N/A when the information is not available.
** Consulting the National Health Accounts Report, if it exists, and the National Health Budget is recommended.*

Several countries are carrying out efforts to improve their health financing and expenditures information systems, and thereby overcome historical difficulties in obtaining data on the volume and flows that influence political decisions regarding allocation. These endeavors have strengthened the initiative to establish and apply the National Health Accounts methodologies in order to compensate for this lack of information. If the country already conducted this type of study, or has plans to do so, it is important to make this known and incorporate its principal findings, conclusions and recommendations.

Expenditures on health goods and services can be reported with reference to the level of expenditure by the institutional sectors of the economy and to the type of health expenditure that is incurred for different purposes.

Please briefly mention if the country prepares National Health Accounts and which institution/s is/are responsible for completing them. Please complete the following two tables (No.13 and No.14) on health system expenditures.

TABLE 13: HEALTH EXPENDITURES OVER THE PAST 5 YEARS*

Expenditure Realized	1999	2000	2001	2002	2003	2004
Public expenditure on health per capita in USD						
Public expenditure on health / Total public expenditure						
Total expenditure on health per capita in USD						
Total expenditure on health, as a % of GDP						
Foreign health debt / Total foreign debt						

SOURCE(S):

**Consulting the National Health Accounts Report is recommended.*

TABLE 14: HEALTH EXPENDITURE BY SUBSECTOR AND FUNCTION IN USD

Functions* / Sectors	Medical Products, Instruments and Equipment	Outpatient Services	Hospital-based Services	Public Health Services	Health Research	Health (unspecified)
Public Sub-Sector						
Private Sub-Sector						
Total						

SOURCE(S):

*** Medical products, instruments and equipment** includes the supply of pharmaceutical products, general medical products (materials) and therapeutic apparatus and equipment.
Outpatient services includes general medical services, specialized medical services, dental services and paramedical services
Hospital-based services includes general hospital services, specialized hospital services, maternity-related medical services and centers, residential services for the elderly and for recovery.
Public health services include individual and collective public health services delivery.
Health-related research and development exclusively includes research related to public health and management.
Health (unspecified): Administration, management and support of activities such as the formulation, administration, coordination and monitoring of health policies, plans, programs, and general budgets; the preparation and implementation of legislation and standards of action related to health services delivery, including the granting of licenses to medical establishments and medical and paramedical staff; the production and dissemination of general information, technical documentation and statistics related to health.

ASSURANCE

Assurance consists on the guarantee of health services coverage and access to these services in the event of need. It comprises the organization and management of services delivery, operationalized through several risk management modalities that focus on the allocation and administration of resources to guarantee that the financial risk associated with health interventions is assumed by all members through a common fund or "pool," and not by each member individually.

A central element of assurance consists of determining a package of benefits and services to which a population group has a right based on certain circumstances (economic, personal, family), in exchange for an economic contribution: general taxes, contributions to social security, private insurance premiums or different types of mixed contribution schemes.

The analysis of health assurance requires a characterization of the following elements: (I) Legal Framework; (II) Benefits; (III) Structure and Management; (IV) Population Covered; (V) Common Fund or Pooling; and (VI) Provider Payment Mechanisms.

In the following guide, comment on the strengths and weaknesses, achievements attained and deficiencies identified with respect to Assurance.

(I) LEGAL FRAMEWORK

Are there legal document/s (constitution, law/s, regulation/s) that specify the beneficiaries of health care coverage, either the entire population –universal coverage; or specific population groups?

Yes

Specify the document/s and describe how the information about the beneficiaries and benefits is made explicit:_____

_____

No

Are there legal sanctions for individuals/institutions that do not comply with the provisions established in the legal documents?

Yes

Specify the legal sanctions:_____

_____

No

(II) BENEFITS

Are there explicitly defined benefits for the health system or for some of its subsystems?

Yes

Specify what they are, how detailed they are and what the inclusion criteria are:_____

_____

No

Do the benefits include only private goods or do they also include public health goods?

Yes

Specify what they are:_____

_____

No

Are public and private providers obligated to provide the same benefits package?

Yes

Specify if complementary private plans exist:_____

_____

No

(III) STRUCTURE AND MANAGEMENT

Identify the dominant health assurance modality:

_____

Indicate the institutions that participate in health assurance. Describe their functions in the assurance arena:

_____

Identify (if it exists) the entity that performs the function of regulating health assurance. Comment on the degree of development of this function:

_____

Indicate if the existing regulatory framework for institutions that participate in social protection refers to the financial aspects (liquidity, transparency in the collection of contributions or premiums, transparency in the collection of co-payments, transparency in refund mechanisms, etc.); or to the health aspects (type and magnitude of coverage, existence of prevention activities, quality of care on the part of the service provider):

_____

(IV) POPULATION COVERED

Please complete the following table which relates to the coverage level of the health system with respect to gender, population groups, geographical areas, and ethnic groups for each of the 5-year periods.

TABLE 15: HEALTH SYSTEM COVERAGE

	Percentage of population covered by the Health System (total)	Percentage of population covered by the State (Ministry or Secretariat of Health)	Percentage of population covered by Health Insurance	Percentage of population covered by the private sector	Percentage of population without coverage
Periods					
1990-1994					
1995-1999					
2000-2005					
Gender					
Men					
Women					
Population Group					
under 5 years of age					
5-17 years of age					
17-45 years of age					
45-65 years of age					
65 and over					
Geographical Areas					
Urban					
Rural					
Ethnic Group					
White					
Indigenous					
Mestizo					
Afro-descendant					
Others					

SOURCE(S):

Note: use the denomination N/A when the information is not available.

(V) COMMON FUND OR "POOLING"

Are there explicit criteria for administration of the risks associated with health interventions within the public subsystem, the private subsystem and social security institutions?

Yes

Comments/Examples: _____

_____

No

Are there specific regulatory mechanisms aimed at preventing skimming, moral hazard and adverse selection? Are there governmental agencies specifically devoted to enforcing these regulations?

Yes

Comments/Examples: _____

_____

No

(VI) PROVIDER PAYMENT MECHANISMS

Payment mechanisms that are used for each health service provider (for example, physicians, hospitals, pharmacists):

_____

Payment mechanisms for private and public providers:

_____

Are there plans to change the provider payment mechanisms?

_____

2.3 SERVICE PROVISION

The objective of this section is to describe and analyze the strengths and weaknesses of the health system's organization and structure, which serves as the foundation for Health Services Provision.

SUPPLY OF AND DEMAND FOR HEALTH SERVICES

The description of the supply of and demand for health services makes it possible to identify the gaps that exist in health care, to determine the areas where problems exist and to formulate recommendations with implications for developing policies, plans and programs. Supply is comprised of services designed to promote, prevent, recover and rehabilitate the health of a target population, both at the individual and collective level, in the current conditions of the population and the environment. Demand is considered to be a formal (explicit) request for health services, considering that the utilization or use of services expresses the demand that was satisfied through the provision of services, with regard to a target population and in a given period.

Please complete the two tables (No.16 and 17) below for the most recent available year with the information requested in reference to the number and capacity of health facilities (supply) and the global rate of service use (demand).

TABLE 16: USE OF HEALTH SERVICES *

Utilization (Global Rate)													
Levels of Care	Gender		Geographic Area		Ethnic Group				Age Groups				
	Men	Women	Rural	Urban	Whites	Afro-descendants	Indigenous	Others	< 5 years of age	5-14 years of age	15-49 years of age	49-64 years of age	>65 years of age
1st Level of Care Establishments													
2nd Level of Care Establishments													

SOURCE(S):

** Recommended sources: Population surveys on perceptions of health and health care needs.*

TABLE 17: NUMBER AND CAPACITY OF TREATMENT FACILITIES *

PUBLIC SECTOR	Nº Centers x 1,000 Inhab.	Nº Beds x 1,000 Inhab.
Hospitals		
- High Level Complexity		
- Medium (basic specialties)		
- Low (general medicine)		
Total (Hospitals)		
Outpatient Centers		
- Specialty Centers		
- General Primary Level Centers		
- Non-Professional Personnel Primary Level Centers		
Total (Outpatient Centers)		
PRIVATE SECTOR		
Hospitals		
- High Level Complexity		
- Medium (basic specialties)		
- Low (general medicine)		
Total (Hospitals)		
Outpatient Centers		
- Specialty Centers		
- General Primary Level Centers		
- Non-Professional Personnel Primary Level Centers		
Total (Outpatient Centers)		
Total (Treatment Facilities)		

SOURCE(S):

** Recommended sources: Population surveys on perceptions of health and health care needs.*

HUMAN RESOURCES DEVELOPMENT

The purpose of this section is to analyze the principal characteristics of the health sector's human resources and to analyze how they impact the system's structure and its transformations. To carry this out, observations and data collection need to focus on at least four complementary areas: personnel training; management of employment and working conditions; labor markets and their regulation; and finally, governance and sectoral conflict.

Human Resources Training

The first level of analysis is the availability of human resources, which requires using basic data to estimate the contingent of health-related human resources that are available for the population, the rate of their production and their adaptation to the needs of the health system.

Is it possible to prepare a list of the entities that train health professionals?

Yes

Specify the entities that train health professionals: _____

_____

No

What is the trend in regard to "generalists vs. specialists" in the country? Is it appropriate for the health system?

Yes

Comment on the trend and its appropriateness for the health system: _____

_____

No

How frequently are the curricula for pre-graduate and graduate-level professional training for health careers reviewed and reformulated?

Yes

Specify for pregraduate and graduate-levels: _____

_____

No

Management of Human Resources and Employment Conditions

The general objective of reforms in terms of maximizing results is closely linked to the successful adoption of new labor and management practices. The search for additional, higher-quality services at a lower cost per unit of product requires changes in work processes, personnel qualifications and labor conditions, as well as transformations in wage and incentive schedules, and in performance evaluation systems, among other aspects.

Efforts to increase the productivity and quality of labor during reform processes result in new modes of institutional organization (such as cooperatives and self-managed hospitals) and of labor relations (such as outsourcing, privatization and sub-contracting). This means that human resources management should confront new labor market conditions not only as a means for designating and fixing the price of the labor force in the sector, but also as a way of introducing new types of contracts and management. Labor force flows, which until recently occurred within the public sub-sector (ministries and social security), now exhibit a trend to move within increasingly autonomous units throughout the entire system. Political and administrative decentralization and changes taking place in professional careers, job security and incentive systems, have resulted in a situation in which the idea of labor, as a flow and not as a supply, has found its place within the logic of personnel management.

Are there studies on types of health employment, job flexibility and social protection for these workers?

Yes

Specify the studies and comment on the results: _____

_____

No

How is employment distributed between the public/private sectors, Ministry of Health/Social Security, and centralized agencies/decentralized entities?

Yes

Specify the distribution: _____

_____

No

What is the relationship between income and qualification level in the public sector? What is the relationship between income and qualification level in the private remuneration system?

Yes

Specify the relationship between income and qualification level: _____

_____

No

Are processes of repositioning, reclassification, severance payments and dismissals under way? What impact do they have on health personnel?

Yes

Comment: _____

_____

No

Are outsourcing schemes being incorporated into the sector? In what areas?

Yes

Comment: _____

_____

No

Supply and Distribution of Human Resources

The first approach to human resources problems in the sector should be guided by macro data on the existence and generation of human resources in the country or territory, and their main characteristics. Certain primary descriptors related to quantity and distribution by profession, sex, public and private sectors, and geographical regions, constitute the initial approach that makes it possible to obtain a general idea about which problems merit more in-depth exploration.

Is it possible to prepare a statistical table with the total number of workers in the health sector, disaggregated by profession, gender and geographical distribution?

Yes

Comment: _____

_____

No

Are there professional emigration or immigration processes? In which careers? From/to which places?

Yes

Comment: _____

_____

No

With the objective of identifying trends with regard to the availability of human resources in health, please complete Table 18 and Table 19.

TABLE 18: HUMAN RESOURCES IN PUBLIC SECTOR INSTITUTIONS

Time Period / Institution	1990-1994			1995-1999			2000-2005		
	Doctors	Nurses	Auxiliary Nurses	Doctors	Nurses	Auxiliary Nurses	Doctors	Nurses	Auxiliary Nurses
Total									

SOURCE(S):

Note: use the denomination N/A when the information is not available.
** Please disaggregate by sex, if this information is available.*

TABLE 19: HUMAN RESOURCES IN THE HEALTH SECTOR

Period / Type of Human Resource	1990-1994	1995-1999	2000-2005
Ratio of physicians per 10,000 inhab.			
Ratio of professional nurses per 10,000 inhab.			
No. who have completed graduate-level training in Public Health			
No. with graduate-level degrees in Public Health			
No. of Schools of Public Health			
No. of Universities with a Master's Degree in Public Health			
Contracting Modalities			

SOURCE(S):

Governance and Conflict in the Health Sector

Consistent with the leading role of human resources in transforming working conditions and restructuring systems, reforms have not been indifferent to individual and collective actors that represent health personnel. The difficulty of implementing changes in health services when those who would implement the changes oppose them is well known.

There is a long tradition of influential organizations of health workers, similar to unions or professional associations, which may have scientific and ethical boundaries but which usually take positions in defense of the working conditions of their associates. Individual and collective responses to reforms are of diverse types and intensity, but it is safe to argue that resistance to change exists, generally combined with an aversion to the risks generated by the new conditions for contracting and incentives. These responses typically result in a certain degree of conflict that retards, diverts or paralyzes the progress of the reforms.

An additional ingredient is the power restructuring within health organizations that originates from the hierarchy of decentralization. In many cases, conflict arises from new instances of decision-making, generating unequal implementation of changes and unequal conditions of governance. As a result, there is a need to understand, measure and acquire new tools to steer conflict toward paths that make it possible for personnel to understand the reform objectives and to commit their efforts to them. This process of involvement implies new forms of participation, giving substance to empowerment processes for the people responsible for carrying out the main health services processes.

Are there instruments to increase the capacity for conflict management?

Yes

Comment: _____

_____

No

Have strategies to build consensus on policies and participatory management been devised?

Yes

Comment: _____

_____

No

MEDICINES AND OTHER HEALTH PRODUCTS

Medicines and other health products such as vaccines, prostheses and implants are an important element in the everyday operation and reform processes of health systems, given their value as therapeutic instruments, the high proportion of health expenditures allocated to them, both public and private, as well as the economic importance of the sectors involved in the processes of research and development, production, distribution and dispensing of medicines and health products.

Given the existence of diverse sets of indicators for analyzing and evaluating this sector, the purpose of this section is to provide some basic information, from which relevant data can be extracted for the analysis and evaluation of the roles of the public and private sub-sectors.

Does the country have an essential medicines observatory?

Yes

Comment: _____

_____

No

Is there a national essential medicines policy?

Yes

Comment: _____

_____

No

Is the survey on access to and availability of essential medicines updated frequently?

Yes

Comment: _____

_____

No

Is there an entity that regulates the process for purchasing and distributing essential medicines in the country?

Yes

Comment: _____

_____

No

Is there a medicines pricing policy?

Yes

Comment: _____

_____

No

Is there a national list of essential medicines? How often is it reviewed?

Yes

Comment: _____

_____

No

Do treatment protocols for pathologies that are prevalent in public provider institutions exist and are they applied at the first level of care? Are they applied in hospitals?

Yes

Comment: _____

_____

No

Is the presence of a pharmacist required in private pharmacies? Is it required in hospitals?

Yes

Comment: _____

_____

No

TABLE 20: MEDICINES*

INDICATOR	1990-1994	1995-1999	2000-2005
Total Nº of registered pharmaceutical products			
Percentage of brand name medicines			
Percentage of generic medicines			
Percentage of public expenditure in health that goes to medicines			

SOURCE(S):

**Consulting the Medicines Observatory (if the country has this information) is recommended.*

EQUIPMENT AND TECHNOLOGY

The purpose of this section is to contribute to the analysis of the structure and dynamics of technological resources, medicines and biological products in the health services network. These elements, which constitute the material base of the health sector, integrate themselves into health programs and services in such a way that in each case they influence the regulatory framework and organizational models of the sector's institutions and organizations.

Please provide the information requested in the following table (No.21) for the following time periods: 1993–1996; 1997-2000; 2001–2004.

TABLE 21: AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR

TYPE OF RESOURCE / SUB-SECTOR	Number of beds per 1,000 population	Basic diagnostic imaging equipment per 1,000 inhab.	Clinical laboratories per 100,000 inhab.	Blood banks per 100,000 inhab.
Public				
Subtotal				
Private (for- and non-profit)				
Subtotal				
TOTAL				

SOURCE(S):

Note: use the denomination N/A when the information is not available.

Is the percentage of equipment that is defective or out-of-use known?

Yes

Comment: _____

_____

No

Is the percentage of the operating budget allocated to maintenance known?

Yes

Comment: _____

_____

No

QUALITY ASSURANCE

Are basic health care standards stipulated in specific documents?

Yes

Specify the document/s and describe the basic standards of care that it/they include/s: _____

_____

No

Have programs to improve health service quality been developed?

Yes

Specify through which mechanisms - licensing, certification, accreditation: _____

_____

No

Are there criteria and procedures for accrediting public and private health institutions?

Yes

Specify the existing criteria and procedures: _____

_____

No

Is there an accreditation entity? Describe the degree of autonomy with which it acts.

Yes

Specify the entity and its degree of autonomy: _____

_____

No

Are there instruments to measure health services' performance with regard to meeting established standards of quality?

Yes

Specify the instruments and comment on the results obtained: _____

_____

No

Are the specific mechanisms for channeling claims and settling complaints established for the different actors in the sector?

Yes

Specify the instruments and comment on the results obtained: _____

_____

No

Are standards for measuring health services' performance applied in terms of:

- **Trained human resources?**
- **Sufficient human resources?**
- **Sufficient financial resources?**
- **Adequate inputs and technology?**
- **Frequency of monitoring?**

Yes

Specify: _____

_____

No

2.4 INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM

Diverse approaches can be utilized to examine the structures, rules and standards that rule and govern the performance and operation of the health system. For the purposes of the present methodology, a systemic approach has been chosen, combined with an analysis of the basic functions for the operation and development of the system as a whole, as well as an analysis of its interrelationships. The preceding information justifies the growing consensus related to the critical role of the State in improving overall health system performance.

In the following table please identify the institutions involved in the execution of each one of the health system functions.

TABLE 22. INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM

FUNCTIONS / ORGANIZATIONS	Steering Role		Financing	Assurance	Service Provision
	Conduct/Lead	Regulation and Enforcement			
Central Government - Min. of Health - Min. of Justice - Armed Forces - Others					
Social Security Institutions					
Regional government (provincial, departmental)					
Local government (district, municipality, etc.)					
Private insurers - Non-profit - For-profit					
Private providers - Non-profit - For-profit					

SOURCE(S):

Note: use the denomination N/A when the information is not available.

3. MONITORING HEALTH SYSTEMS CHANGE / REFORM

The objective of this section is to depict the stages of the health reform process and/or of intense transformation of the health system. The goal is to link them to the specific periods in which these changes had an impact on the following:

- Transformations in health system functions;
- Guiding/key principles of health system reforms;
- Scope and effects of changes in the health system;
- Construction of the socio-political-economic coalition to sustain the changes.

It must be emphasized that the characterization of these movements/stages is a methodological subtlety that aims to facilitate understanding of the reform process. Nevertheless, it is necessary to consider their integration and overlap with existing political processes, where phases/stages tend to converge.

3.1 IMPACT ON THE "HEALTH SYSTEMS FUNCTIONS"

Using Table 23 as a guide, please refer to the information compiled in section *2 Functions of the Health System,* in order to analyze how the change processes have affected the functions of the Health System in the designated periods of the 1990s and the first 5-year period of the 21st century.

TABLE 23: IMPACT OF CHANGE ON HEALTH SYSTEMS FUNCTIONS

Periods / Health System Functions	1990-1994			1995-1999			2000-2005		
Sub-sectors	**Public**	**Private**	**Social Sec.**	**Public**	**Private**	**Social Sec.**	**Public**	**Private**	**Social Sec.**
Steering Role									
Financing and Assurance									
Service Provision									

SOURCE(S):

3.2 IMPACT ON THE "GUIDING PRINCIPLES OF HEALTH SECTOR REFORMS"

The purpose of this section is to analyze the degree to which reform processes have had an impact on the guiding principles of HSR and are helping to improve the levels of Equity, Effectiveness and Quality, Efficiency, Sustainability and Social Participation and Control in health systems.

The guiding principles of the reforms are major categories that make it possible to assess the directionality of the HSR that are in progress or planned, from the standpoint of the final objectives that have been established. Thus, no HSR should be opposed to these criteria and the "ideal reform" would be one in which the five categories are improved by the conclusion of the process. In turn, they constitute the conceptual framework of reference for a series of variables and indicators that seek to measure the impact of change.

The authors of the present document are aware of the impossibility of establishing direct and unequivocal causal relationships between HSR processes and modifications in many of the proposed indicators. In many cases, the effects of HSR will take place in the medium and long term and will be mediated by a multitude of factors that cannot be directly attributed to the reforms. This is clear in the case of the effects of HSR on certain indicators related to the health situation.

Finally, the evaluation of the effects of HSR will be affected, at least within countries, by the different viewpoints of the different actors who do and do not participate in the process. Accordingly, an adequate assessment of the impact of HSR should be global; it should combine quantitative and qualitative indicators, and systematic variables; and it should take into account different points of view.

Please use the following guiding questions and Table 24 to describe how change processes in health systems or reforms have affected HSR guiding principles in the designated periods of the 1990s and the first 5-year period of the 21st century.

- ## EQUITY

Is there evidence that the reforms have had an influence on reducing the gaps in some or all of the following indicators by territorial unit? [If possible, provide data according to: sex, age, race, socioeconomic level and coverage scheme].

COVERAGE

Have the gaps in the percentages of the population covered by a guaranteed scheme of entitlements been reduced?

[In order to answer, please refer to Table 15: Health System Coverage].

Yes

Specify the evidence and data on the reduction of gaps in coverage: _____

_____

No

DISTRIBUTION OF RESOURCES

Have the gaps in Total Health Expenditure Per Capita been reduced? How about the gaps in Public Expenditure in Health Per Capita?

[In order to answer, please refer to Table 13: Health Expenditures over the Past 5 Years]

Yes

Specify the evidence and data on the reduction of gaps in expenditures: _____

_____

No

Have the gaps in the Number of Physicians per 10,000 population been reduced? How about the gaps in the Number of Professional Nurses per 10,000 population?

[In order to answer, please refer to Table 19: Human Resources in the Health Sector]

Yes

Specify the evidence and data on the reduction of gaps in the number of physicians and nurses per 10,000 population: _____

_____

No

Have the gaps in the Number of Hospital Beds per 1,000 population been reduced?

[In order to answer, please refer to Table 19: Human Resources in the Health Sector]

Yes

Specify the evidence and data on the reduction of gaps in the number of countable hospital beds:

_____

No

ACCESS

Have the gaps related to the possibility that the patient can obtain care the same day that s/he requests primary care services been reduced?

[In order to answer, please refer to Table 10: Access to Health Services]

Yes

Specify the evidence and data on the reduction of gaps in access: _____

_____

No

Have the gaps in the percentage of health facilities that have reduced their functional access barriers (for example, language, hours, gender) been reduced?

[In order to answer, please refer to Table 10: Access to Health Services]

Yes

Specify the evidence and data on the reduction of gaps in access: _____

_____

No

• EFFECTIVENESS

Is there evidence that the reforms have had an influence on reducing gaps in some or all of the following indicators by territorial unit? [If possible, provide data according to: sex, age, race, socioeconomic level and coverage scheme].

INFANT AND MATERNAL MORTALITY

Has the infant mortality rate; maternal mortality rate; and percentage of newborns with low birth weight been reduced?

[In order to answer, please refer to Table 3: Mortality Rate; and Table 4: Infant Mortality and Morbidity]

Yes

Specify the evidence and data on infant and maternal mortality: _____

_____

No

MORTALITY DUE TO MALIGNANT NEOPLASMS

What have been the trends with respect to deaths due to breast and cervical neoplasms in women?

[In order to answer, please refer to Table 2: Morbidity and Risk Factors]

Yes

Specify the evidence and data on mortality due to malignant neoplasms: _____

_____

No

INCIDENCE OF MALARIA, TUBERCULOSIS AND HIV/AIDS

Has the incidence of malaria, tuberculosis and HIV/AIDS been reduced?

[In order to answer, please refer to Table #2: Morbidity and Risk Factors]

Yes

Specify the evidence and data on the incidence of malaria, tuberculosis and HIV/AIDS: _____

_____

No

• EFFICIENCY

Is there evidence that the reform has had an influence globally or by territorial unit on some or all of the following indicators? [If possible, provide data according to: sex, age, race, socioeconomic level and coverage scheme].

RESOURCE ALLOCATION

Has the supply of drinking water in rural and urban areas increased?

[In order to answer, please refer to Table 9: Trends in Selected Social Indicators]

Yes

Specify the evidence and available data: _____

_____

No

Have sewage and excreta disposal services increased in rural and urban areas?

[In order to answer, please refer to Table 9: Trends in Selected Social Indicators]

Yes

Specify the evidence and available data: _____

_____

No

Has the percentage of the health budget allocated to public health increased?

[In order to answer, please refer to Table 14: Health Expenditure by Subsector and Function]

Yes

Specify the evidence and available data: _____

_____

No

• SUSTAINABILITY

Is there evidence that the reform has increased the following?

Legitimacy of the institutions in the health system.

Yes

Specify the evidence:_____

_____

No

The capacity to manage financial resources from different sources.

Yes

Specify the evidence and available data: _____

_____

No

The capacity to manage and negotiate external and internal financing.

Yes

Specify the evidence and available data: _____

_____

No

- ## SOCIAL PARTICIPATION

Is there evidence that the reforms have increased the following?

Participation of civil society in the identification of problems, planning and implementation of health activities.

Yes

Specify if for the general population and/or for specific groups: _____

_____

No

TABLE 24: IMPACT ON THE GUIDING PRINCIPLES OF HEALTH SECTOR REFORMS

Periods / Key Principles of the Reforms	1990-1994			1995-1999			2000-2005		
Sub-sectors	**Public**	**Private**	**Social Sec.**	**Public**	**Private**	**Social Sec.**	**Public**	**Private**	**Social Sec.**
Equity									
Effectiveness									
Efficiency									
Sustainability									
Social Participation									

SOURCE(S):

3.3 IMPACT ON THE "HEALTH SYSTEM"

Using Table 25 as a guide, please refer to the information compiled in section*1 Context of the Health System* and *2 Functions of the Health System* to analyze how the change processes have affected the Health System in the designated periods of the 1990s and the first 5-year period of the 21st century.

TABLE 25: IMPACT ON THE HEALTH SYSTEM

Periods / Implications of the Changes	1990-1994	1995-1999	2000-2005
Citizens' right to health			
Impact on the Steering Role			
Separation of the health system's functions			
Deconcentration and/or decentralization			
Promotion of civil society participation			
Impact on governance			
Changes in the model of care			
Changes in the management model			
Access barriers to individual and collective health services			
Changes in the quality of care			
Changes in the labor market and human resources in health			

SOURCE(S):

3.4 ANALYSIS OF ACTORS

This section has as its purpose the identification of the actors involved in the reforms or change processes (who and how many), their position with regard to each objective and reform strategy, and their power or capacity for action.[24]

The processes of change that health systems experience--at different historical moments - are centered on an intensified phase of transformation, during a given period, generated by a specific context that justifies these changes and makes them viable. The identification and analysis of the multiple social and political "actors" who passively or actively participate in this process is of crucial importance. The identification of the actors is not a linear, but a dynamic process, which can hinder the analysis. In this section, the steps or stages of this process are outlined, taking into account that they can occur simultaneously.

They are called "actors" to stress that they are not objects that can be manipulated to reach a certain end, but active participants who interact and negotiate with other actors, such as individuals, institutions or other entities of a collective nature and which can represent interest and/or lobbying groups.[25] The actors that are relevant to the analysis in each country, and their power and position, depend on the reform proposal (content and specific objectives), the context (institutional, economic, political) and the dominant values in the society.[26]

USEFULNESS OF THE ANALYSIS OF ACTORS[27]

The goal of the analysis of political actors is the mapping of actors, where the potential support or resistance, opportunities and threats that each actor represents for the strategy at different stages of the process are identified. The number of actor mappings should be the same as the number of strategies that have been identified at different stages of the process. This comparison between the mapping of actors for different strategies and at different times gives an estimate of the viability of each strategy in given economic and social conditions.

24. There are various methodologies and instruments for carrying out the identification, analysis and mapping of actors, including software (Policy Maker); but for the purposes of this document, qualitative techniques, methods and instruments are proposed, in which direct information is obtained from the experiences of the process. The qualitative analysis makes it possible to understand and identify the role that actors have or have had in the processes of change, and to analyze or predict the position of actors in the historical, political, social, and economic context in which the changes take place within the health sector. The implementation, progress, and sustainability of these changes depend not only on technical and financial via bility, but also on political feasibility.
25. Interest Groups: In the language of projects, they often refer to the different actors as "interested parties" or "interest groups," because each one has their distinct interests, purposes, ambitions, needs, requirements, desires and perceptions.
26. Ham C, Hawkins L. Innovations in Health Care Delivery: Reform within the Public Sector; 1999.
27. Jaén, MH, Rivas, JC, Salvato, S. Propuesta de Análisis de Actores para las Estrategias de Reducción de la Exclusión en Salud. (Internal PAHO document).

From this analysis emerges the first decisions with regard to which change management strategies[28] to promote–due to their greater viability of implementation, and with regard to maintaining or mobilizing the actors who are influential in selected health system development strategies. The viability of these strategies will be greater to the extent that actors with high and medium capacity for action have a balance of power in their favor; on the contrary, the viability of the strategies will be lower if those same actors have a balance against them. In the latter case, the viability of the strategies can increase depending on the cost of tilting the balance of power in favor of those actors with high and medium capacity for action.

METHODOLOGICAL OUTLINE

There are various methodologies and instruments for carrying out the identification, analysis and mapping of actors.[29] For the purposes of the Health System Profile, the qualitative method is proposed, through which direct information on the experiences of the process is obtained, and which also makes it possible to understand and identify the role or position that these actors have or have had in change processes, and to analyze or predict the displacement of the actors in the historical, political, social, economic context in which the changes take place within the health sector. The implementation, progress and sustainability of these changes depend not only on technical and financial sustainability, but also on political feasibility.

STAGES OF THE PROCESS

i. Descriptive Summary of the Change Process in the Health System

- Summary of Policies
- Objectives of the Change Process
- Composition of the Work Team that Led the Process

ii. Identification of Actors who Participate in the Change Process

iii. Opportunities and Threats in:

- The Political Context
- The Social Context
- The Economic Context
- The Environmental Context

iv. Political Mapping of Actors: Shows the Number of Actors Involved, their Position, and their Level of Participation

28. When we discuss the change management strategy, this refers to a political process that has a specific action associated with it in order to attain it. Change management strategies are aimed at changing relationships of power and the positioning of actors in the context of the strategy.
29. "Stakeholder analysis guidelines/SAG (toolkit) prepared as part of the project "Partnership for Health reform project-PHR, 2000, Abt. Associates Inc., in "Strengthening Health Policy Reform in Latin America: An introduction to the toolkit and the policy process" Chapter 1: Stakeholder analysis guidelines/SAG (Toolkit) Bethesda, MD. Mimeo, and at www.phrplus.org; Jaen, Maria Helena and Paravisini, Daniel (January, 2000)
"Lineamientos para la realización de análisis estratégicos de los actores de la política sectorial en salud" en Serie Política del Sector Salud N.4, División de Desarrollo de Sistemas y Servicios de Salud. OPS/OMS.

SUGGESTED LIST OF ACTORS[30]

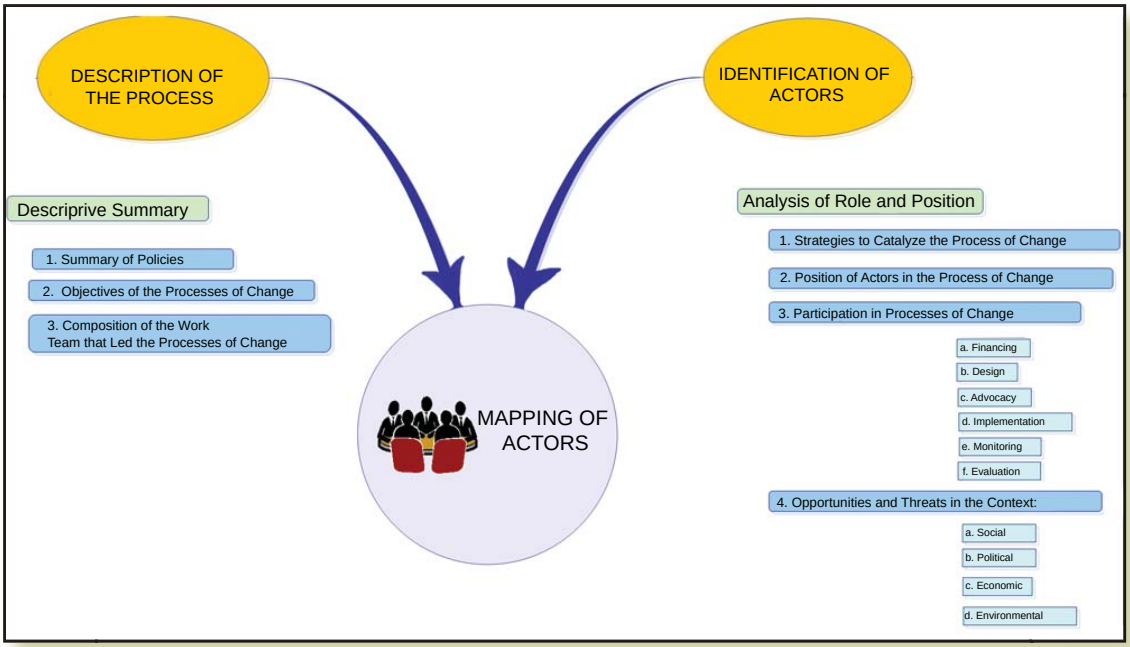
The list presented below constitutes a simple typology (to support the work team so that it considers all possible actors) and, thus, does not intend to be exhaustive.

As greater precision and specificity is achieved in the identification of actors, the analysis becomes more robust. In this regard, the type of health system that exists at the time the actors are selected should be considered, since the entrance or exit of actors, as well as their importance, will vary according to the type of system. The term actors, in this context, refers both to individual actors and to groups.

- Public Sector: Central government: Presidency of the Republic, Ministry of Health, Social Security, Social Cabinet (Ministries of Social Development, Health, Education, etc.), National Health Councils. Local governments: coordinating units for multilateral loans; Public Universities and Institutes of Higher Education; other institutions in the health services system.
- Private Sector: National and international for-profit or non-profit insurers, for-profit or non-profit service providers, health technology companies.
- Health-related Organized Civil Society: Trade associations, worker associations, unions, professional associations, health NGOs, health committees or councils, associations of health services users.
- Social Cabinet (Ministries of Social Development, Health, Education, etc.)
- Elites (entrepreneurs, academics)
- General Organized Civil Society: political parties, private companies, churches, the media, public defenders (*defensorías*), community associations.
- International Cooperation Agencies and Organizations

30. This list is an adaptation of table 4.1, from the document “Principal actors in the health system.” Washington, DC: PAHO-WHO; 1998.(p.34)

Mapping of Actors[31]



SUGGESTED QUESTIONS FOR THE IDENTIFICATION OF ACTORS:[32]

1. The changes proposed were initiated by the:

Economic sector

Public

Private

Other (specify) _____

International Cooperation (specify the agency) _____

Political sector

Health sector

Other (specify) _____

Specify if the change is in response to international or national agreements_____

_____

31. Suárez,C., Rivas-Loria,P. ; PAHO/WHO, 2005
32. Adaptation of Suárez, C. 2005, using two documents as the foundation: (1) M.H. and Paravisini, D. (1999). "Lineamientos para la realización de análisis estratégicos de los actores de la política sectorial en salud". Serie Política del Sector Salud. División de Desarrollo de Sistemas y Servicios de Salud. Organización Panamericana de la Salud y de la Organización Mundial de la Salud. January 2000. (2) Jaén, M.H. (2001) "Análisis Estratégico de Actores" with observations and comments by Barbara O' Hanlon of Abt Associates Inc ;OPS.

2. Are the changes formulated due to an action agreed upon by several involved actors or by a central authority?

Yes No

3. Please specify the type of health system in the country:

Segmented

Integrated

4. Has the proposal for change been adapted to the type of health system in the country?

Yes No

5. Who finances the processes of change (reform)?

State funds

International Cooperation

Private Sector

Reimbursable funds with national registry

6. Of the following actors, indicate which participated in the health systems change?

Governmental (Executive Branch)

Legislative Branch

Health-related Organized Civil Society

General Organized Civil Society

Private Sector

Academic sector

Other (Specify)

7. Which actors have veto power over decisions?

Legislative Executive Both Neither

8. **Do the changes witnessed in the health sector contribute to the national democratic process?** If the answer is affirmative complete the following table with the elements of the democratic process that have been strengthened.

Yes No

Elements of the Democratic Process	Yes	No
Greater Social Control		
Free Choice		
Social Participation		
Participatory Management		
Decision-making		
Others		

SOURCE(S):

9. **Indicate the current stage of the democratic process:**

Transition Construction Consolidation Non Existent

10. **What power do laws confer on the actors? Please specify in the following table:**

LAW	ACTOR	FUNCTION OR RESPONSIBILITY

SOURCE(S):

POSITION OF THE ACTORS (PA)

Analysis of the actors' position in health systems change. The following questions are suggested:

11. Where do these actors position the institutions/organizations they represent with regard to their capacity for action?

Strongly in Favor

Somewhat in Favor

Neutral

Somewhat against

Against

12. What is the prestige and image of the actor in society?

Positive

Negative

Neutral

ROLE OF THE ACTORS (RA)

13. What is the capacity for action (power) of each actor who participates in the reform to negatively or positively affect the results of each objective for change?

High Average Low

14. Does the actor have control over information about the processes of change?

Yes No

15. Does the actor have control over the means of communication for disseminating information about the processes of change?

Yes

Specify which ones: _____

_____

No

BIBLIOGRAPHY

Alleyne GAO. A Vision for Health System Reform in the Americas. *Pan American Journal of Public Health* 2000; 8(1/2).

Alleyne GAO. Equity and Health. *Pan American Journal of Public Health* 2000; 7(1).

Almeida-Filho N, Kawachi I, Pellegrini Filho A, Norberto J, Dachs W. Research on Health Inequalities in Latin America and the Caribbean: Bibliometric Analysis (1971-2000) and Descriptive Content Analysis (1971-1995). *American Journal of Public Health* 2003.

Buvinic M, Giuffrida A, Glassman A. *Gender Inequality in Health and Work: The Case of Latin America and the Caribbean.* Washington, DC: Inter-American Development Bank, Sustainable Development Department, Social Development Division; 2002.

Chackiel J. *El envejecimiento de la población latinoamericana: ¿hacia una relación de dependencia favorable?* Santiago, Chile: CEPAL; 2000.

Daniels N, Bryant J, Castano RA, Dantes OG, Khan KS, Pannarunothai S. Benchmarks of Fairness for Health Care Reform: A Policy Tool for Developing Countries. *Bulletin of the World Health Organization* 2000.

Diderichsen F, Evans T, Whitehead M. The Social Basis of Disparities in Health. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health - From Ethics to Action*. Oxford: Oxford University Press; 2004.

EURO/WHO. *Country Health Systems Profiles: Generic Template and Questionnaire (draft).* Copenhagen: EURO/WHO; 1997.

Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health - From Ethics to Action*. Oxford: Oxford University Press; 2004.

Feachem RGA. Globalisation Is Good For Your Health, Mostly. *British Medical Journal* 2001; 323:504-506.

Ffrench-Davis, R. *Reformas para América Latina después del Fundamentalismo Neoliberal* (Buenos Aires: Siglo XXI, 2005).

First Summit of the Americas. Action plan. Report of the "First Summit of the Americas"; 1994 3-5 December; Miami. (Available at http://www.summit-americas.org/miamiplan-spanish.htm)

Fleury, S. et.al. (eds) *Reshaping Health Care in Latin America: A Comparative Analysis of Health Care Reform in Argentina, Brazil and Mexico* (Ottawa: International Development Research Center, 2000).

Gupta N, Zurn P, Diallo K, Deal Poz MR. Uses of Population Census Data for Monitoring Geographical Imbalance in the Health Workforce: Snapshots from Three Developing Countries. *International Journal for Equity in Health* 2003; 2(11).

Gwatkin DR. Health Inequalities and The Health of the Poor: What Do We Know? What Can We Do? *Bulletin of the World Health Organization* 2000, 78(1).

Gwatkin DR. Poverty and Inequalities in Health within Developing Countries: Filling the Information Gap. In: Leon D, Walt G, eds. *Poverty, Inequality, and Health: An International Perspective.* Oxford: Oxford University Press; 2000:217-246.

Gwatkin DR. The Need for Equity-Oriented Health Sector Reforms. *International Journal of Epidemiology* 2001.

Gwatkin DR, Rustein S, Johnson K, Pande RP, Wagstaff A. *Socio-Economic Differences in Health, Nutrition, and Population in Bolivia.* Washington, DC: The World Bank; 2000.

Infante A, de la Mata I, López-Acuña, D. Reforma de los sistemas de salud en América Latina y el Caribe: Situación y Tendencias. *Revista Panamericana de Salud Pública* 2000; 81(1/2).

Jaén MH. *Análisis Estratégico de Actores*. Washington, DC: OPS; 2001.

Jaén MH, Paravisini D. *Lineamientos para la realización de análisis estratégicos de los actores de la política sectorial en salud*. Washington, DC: OPS; 1999.

Latin America and Caribbean Health Sector Reform Initiative (LACHSR). Baseline for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean. Washington, DC: LACHSR; 1998. (Technical Series No. 2 – Available at: *www.lachealthsys.org*)

Levcovitz E. Health Systems Profiles: Monitoring and Evaluation of Health Sector Reform. Proceedings of the Symposium "Alliances for Public Health PAHO-USAID"; 2004 Sep 13-14; Washington, DC.

López-Acuña D. La Nueva Generación de Reformas del Sector Salud: Fortaleciendo los Sistemas de Salud. Memoria del Foro Regional "Reforma del Sector Salud"; 2004 July 19-22; Antigua, Guatemala.

McPake B, Kutzin J. *Methods for Evaluating Effects of Health Reforms*. Geneva: WHO, Division of Analysis, Research and Assessment; 1997. (Current Concerns Series, ARA Paper number 13. WHO/ARA/CC/97.3).

Mintz P, Savedoff WD, Pancorvo J. *Prosalud and the Insurance Program for Mothers and Children (SNMN).* Washington, DC: The World Bank and the Inter-American Development Bank; 2000.

National Health Policy Forum. *Filling the Geriatric Gap: Is the Health System Prepared for an Aging Population–A Discussion Featuring Christine K. Cassel, Marthy Mezey, and Richard D. Della Penna.* Washington, DC: National Health Policy Forum; 1999 (No. 729).

OECD. *OECD Health Data 1997: A Software for the Comparative Analysis of 29 Health Systems.* Paris: OECD; 1997.

Östlin P, George A, Sen G. Gender, Health and Equity: The Intersections. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A and Wirth M, eds. *Challenging Inequities in Health - From Ethics to Action*. Oxford: Oxford University Press; 2004.

Organización Panamericana de la Salud, Departamento de Prevención de las Enfermedades No Transmisibles y Promoción de la Salud / Organización Mundial de la Salud. *Envejecimiento Activo y Saludable: Marco Político.* Washington, DC: OPS/OMS; 2002.

Organización Panamericana de la Salud, División de Desarrollo de Sistemas y Servicios de Salud / Organización Mundial de la Salud. *Evaluación y Mejora del Desempeño de los Sistemas de Salud en la Región de las Américas.* Washington, DC: OPS/OMS; 2001.

Organización Panamericana de la Salud / Organización Mundial de la Salud. *Contribuciones de Foros Subregionales en Envejecimiento y Salud en las Americas - 1998-2000.* Washington, DC: OPS/OMS; 2000.

Organización Panamericana de la Salud / Organización Mundial de la Salud. 41st Consejo Directivo - Resolución CD41. R12. 30 Septiembre 1999.

Organización Pan Americana de la Salud / Organización Mundial de la Salud. Informe sobre "Reunión Especial sobre Reforma del Sector Salud." Washington, DC: OPS/OMS; 1996.

Organización Panamericana de la Salud / Organización Mundial de la Salud. OPS/OMS Cooperación Técnica focalizada en los Países y el Desarrollo Nacional de la Salud SPP39/10. Memoria de la "39th Sesión del Subcomité de Planificación y Programación del Comité Ejecutivo"; 2005 16-18 March; Washington, DC.

Organización Panamericana de la Salud / Organización Mundial de la Salud. *Verificación de la Cobertura Universal de los Servicios de Salud. La experiencia de la Organización Panamericana de la Salud en México.* México: OPS; 2002.

Organización Panamericana de la Salud, Programa de Salud del Adulto Mayor / Organización Mundial de la Salud. *La Salud y el Bienestar de las Personas Adultas Mayores en América Latina y el Caribe*. Washington, DC: OPS/OMS; 2003.

Organización Panamericana de la Salud, Unidad de Género, Etnia y Salud / Organización Mundial de la Salud. *Indicadores Básicos para el Análisis de la Equidad de Género en Salud*. Washington, DC: OPS/OMS; 2004.

Organización Panamericana de la Salud, Unidad de Tecnología y Prestación de Servicios. *Programa Salud de los Pueblos Indígenas de las América: Ejes de Trabajo y Plan de Acción 2005-2015*. Washington, DC: OPS; 2004.

Pan American Health Organization/ World Health Organization. *Gender, Health and Development in the Americas 2003–Basic Indicators*. Washington, DC: PAHO/WHO; 2003.

Pan American Health Organization/ World Health Organization. *Health in the Americas: Volume 1*. 1998 Edition. Washington, DC: PAHO/WHO; 1998. (Scientific and Technical Publication No. 587)

Pan American Health Organization/ Swedish International Development Cooperation Agency (SIDA). *Exclusion in Health in Latin America and the Caribbean - Series No. 1–Extension of Social Protection in Health.* Washington, DC: PAHO/SIDA; 2004.

Planes Magriñá A. et. al. *Los Sistemas de Salud y las Necesidades y Demandas de los Ciudadanos* (Documento No. 1). I Cumbre Iberoamericana de Medicina Familiar. Sevilla, España: 14-17 Mayo 2002.

Potter C, Brough R. Systemic Capacity Building: A Hierarchy of Needs. *Health Policy and Planning* 2004; 19(5):336-345.

United Nations Development Program (UNDP). *Human Development Report 2003. Millennium Development Goals: A Compact among Nations to end Human Poverty.* New York: UNDP; 2003.

United Nations Development Program (UNDP). *Human Development Report 1999. Globalization with a Human Face.* New York: UNDP; 1999.

United Nations Development Program (UNDP). *Human Development Report 1997. Human Development to Eradicate Poverty.* New York: UNDP; 1997.

United Nations Development Program (UNDP). *Human Development Report 1996. Economic Growth and Human Development.* New York: UNDP; 1996.

United Nations Development Program (UNDP). *Human Development Report 1995. Gender and Human Development.* New York: UNDP; 1995.

Quigley R, Cavanagh S, Harrison D, Taylor L. *Clarifying Health Impact Assessment, Integrated Impact Assessment and Health Needs Assessment.* Yorkshire, UK: NHS Health Development Agency; 2004.

Rivas-Loría P. Health Sector Analysis in LAC. Proceedings of the Symposium "Alliances for Public Health PAHO-USAID"; 2004 Sep 13-14; Washington, DC.

Rivas-Loría P, Shelton C. Health Sector Reform Trends in LAC: Are Health Reform and Health Systems Development Moving Forward? *LACHSR Bulletin - Strengthening Health Systems and Reforms* 2005.

Rivas-Loría, P, Entwistle, M, La Foucade, A. Analysis of Health Sector Reform in the English-Speaking Caribbean Countries. Special Edition No. 12. Washington DC: LACHSR; 2002. Latin America and Caribbean Regional Health Sector Reform Initiative: USAID-PAHO/WHO. Special Edition No. 12. Washington DC, 2002. (http://www.lachealthsys.org).

Rivas-Loría, P, Infante A, Murillo R, Pedroza J, Schweiger A, et al. *Analysis of Health Sector Reforms in the Andean Countries.* Special Edition No. 11. Washington DC: LACHSR; 2002. (http://www.lachealthsys.org).

Rivas-Loría P, Infante A, Pedroza J, Reinharz D. *Análisis de las Reformas del Sector Salud en la Subregión de Centroamérica y la República Dominicana.* Edición Especial No. 10. Washington, DC: LACHSR; 2002. (http://www.lachealthsys.org).

Rosés M. Opening Remarks, Regional Consultation On the Work of the Commission on Social Determinants of Health, PAHO/WHO; 2005 5 July; Washington, DC.

Savedoff WD. *Policy Implications of Health Equity Focus for Latin America.* Washington, DC: Inter-American Development Bank; 1999.

Second World Assembly on Ageing. A society for all ages. Report on the "Second World Assembly on Ageing." 2002 8-12 April; Madrid, Spain.

Standing H. *El Género and la Reforma del Sector Salud*. Washington, DC: PAHO/ Harvard Center for Population and Development Studies; 2000.

The Economist. *Inequality In Latin America: A Stubborn Curse [editorial].* 2003.

The World Bank Group. *Inequality in Latin America and the Caribbean: Breaking with History?* Washington, DC: The World Bank; 2003.

The World Bank Group. *World Development Report 1993-Investing in Health*. New York: Oxford University Press; 1993.

Third Summit of the Americas. Declaration of Quebec City: Plan of Action. Proceedings of "Third Summit of the Americas;" 2004 April 20-22; Quebec, Canada. (Available at http:/www.summit-americas.org)

Travis, P et al. Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals. *Lancet* 2004;364:900-906.

Wagstaff A. *Research on Equity, Poverty, and Health Outcomes: Lessons for the Developing World*. Washington, DC: The World Bank; 2000.

Walt G. World Health: Globalization of International Health. *Lancet* 1998:351:434.

Watson SD. Equity Measures and Systems Reform ace Tools for Reducing Racial and Ethnic Disparities in Health Care. *The Commonwealth Fund* 2005. (Available at: http://www.cmwf.org/publications/publications_show.htm?doc_id=289303)

GLOSSARY

Access (accessibility): Probability of obtaining health care when it is needed. The term implies that the services provided meet the needs of the users of the health care system. Access can be affected by the presence or absence of physical barriers (related to the general supply of, availability of, and distance to health services), economic or financial barriers (related to the cost of seeking and obtaining health care) and cultural barriers (related to social or community perceptions of health services, for example perceived or actual discrimination on the part of health care providers, and language barriers).

Accreditation: The process by which an authorized agency or organization evaluates and recognizes an institution or an individual according to a set of "standards" describing the structures and processes that contribute to desirable patient outcomes. (WHO 1998)

Actors: Active participants who interact and negotiate with other actors, who can be individuals, institutions or other entities of a collective nature, which can represent interest groups and/or lobbying groups. Types of Actors:

- Active actors: those who affect or determine a decision or action in the system.
- Passive actors: those who are affected by the decision or action.
- Primary actors: those who seek to benefit from the changes.
- Secondary actors: those who serve as intermediaries.
- Key actors: those who have a significant influence on the success of the implementation of the change.

Adverse Selection: A situation where individuals are able to purchase insurance at rates below actuarially fair rates due to asymmetric information (individuals have access to information which is not available to insurers). (Witter 1997)

Affiliate: Refers to the juridical or natural person that registers or is registered for health insurance, public or private, voluntary or compulsory. They are sometimes referred to as "adherents," "beneficiaries", "policyholders" or "members." Some insurance systems distinguish between "members" or "policyholders," who hold the primary coverage rights, and "beneficiaries," who tend to be first-degree family members of those just described and who are covered while the "member" or "policyholder" maintains his or her condition as such. The "beneficiaries" do not always receive the same benefits package as the "policyholder."

Analysis of Actors: Process that involves several methods and techniques that aim to identify, analyze and understand the role of those responsible for the selection, implementation and results of a policy, project or program. The analysis also endeavors to clarify for the working team and decision makers which actors and interested parties should be taken into account in the process, and why. The analysis of actors is used in conjunction with the political mapping of actors in activities directed at determining the political viability of options.

Annual incidence of HIV/AIDS: Number of incident cases of Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS) registered in a specific year, expressed per 1,000,000 population, for a given country, territory or geographical area.

Annual incidence of influenza infections: Number of incident cases of influenza recorded in a specific year, expressed per 100,000 population, for a given country, territory or geographical area.

Annual incidence of malignant neoplasm of the cervix: Ratio between the number of incident cases of malignant neoplasms of the cervix recorded during a specific year in the female population, and the number of residents in that population, expressed per 100,000 population, in a given country, territory or geographical area.

Annual incidence of malignant neoplasms of the female breast: Ratio between the number of incident cases of malignant neoplasms of the female breast registered during a specific year in the female population, and the number of residents in that population, expressed per 100,000 population, in a given country, territory or geographical area.

Annual incidence of malignant neoplasms of the lung: Ratio between the number of incident cases of malignant neoplasms of the lung (including trachea and bronchia) recorded during a specific year for a given sex, and the number of residents in that population, expressed per 100,000 population, for a given year, in a given country, territory or geographical area.

Annual incidence of positive sputum-smear microscopy tuberculosis (BK+): Number of incident cases of tuberculosis confirmed bacilloscopically, registered in a specific year, expressed per 100,000 population, for a given country, territory or geographical area.

Annual incidence of tuberculosis: Number of incident cases of tuberculosis registered in a specific year, expressed per 100,000 population, for a given country, territory or geographical area.

Annual number of recorded dengue cases: Number of incident dengue cases recorded during a specific year, for a given country, territory or geographical area.

Annual number of recorded malaria cases: Number of incident malaria cases recorded during a specific year, for a given country, territory or geographical area.

Annual population growth rate: Annual average rate of change in the size of the population, for a given country, territory or geographical area, during a specific period. The ratio is expressed as the annual increase in the population size over the total population for this year, usually multiplied by 100. The annual increase in population size is defined as the sum of differences: the difference between births minus deaths and the difference between immigrants minus emigrants, in a given country, territory or geographical area, for a given year.

Annual prevalence of moderate and serious nutritional deficiency in children: Number of prevalent cases of moderate and serious nutritional deficiency in children under 5 years of age of a given sex detected during a given year, expressed as a percentage of the corresponding population at the mid-point in a year, for a given country, territory or geographical area. Moderate and serious nutritional deficiency in children under 5 is defined as a ratio of weight-for-age (W/A) lower than at least two standard deviations (-2DE) of the median reference point.

Assurance: Consists of the guarantee of health services coverage and access to these services in the event of need. It comprises the organization and administration of health services delivery, and the allocation of financial resources within the health system to guarantee that the risk associated with health interventions is assumed by all who receive this right and not by each member individually.

Basic primary health care services: Services that can be offered at the primary level; comprised of eight elements: education about frequent health problems and methods to identify, prevent and control them; promotion of adequate food supply and nutrition; adequate supply of drinking water and basic sanitation; maternal and child health care, including family planning; immunization against the principal infectious diseases; prevention and control of local endemic diseases; adequate treatment of diseases and common injuries; and promotion of mental health and provision of essential drugs (Alma Ata, 1978).

Benefits Package: In health insurance and social security systems, the benefits package provides entitlement to a comprehensive set of health care services to insured or covered individuals, who are defined according to a set of criteria specified in the scheme (WHO, 1998a).

Co-payment: Amount paid by the patient to partially cover the cost of the received health care. It is a form of participation in the cost of the service and one of the possible means of financing services.

Coverage: Share of population eligible to receive health care benefits under public programs (OECD 2000b). Coverage can be characterized as:

- Universal: provision of access to adequate health care for all at an affordable price.
- Nominal: expressed as the percentage of people with the right to receive care offered by the public health insurance system, with regard to the total population.
- Effective: expressed as the percentage of people who, having the right to receive the care offered, normally receive it if they need it.

Crude birth rate: Annual average rate of change in the number of live births in a population, for a given country, territory or geographical area, during a specific period. The ratio is expressed as the number of live births in a population during a specific year over the total population at the mid-point in a year, for the same year, usually multiplied by 1,000.

Crude death rate: Annual average rate of change in the number of deaths in a population, for a given country, territory or geographical area, during a specific period. The ratio is expressed as the number of deaths in a population during one specific year over the total population at the mid-point in a year, for the same year, usually multiplied by 1,000.

Crude rate of primary schooling: Total number of pupils of a given sex registered in primary schools, regardless of their age, expressed as a percentage of the population of the same sex and the age group that officially corresponds to the level of primary education, within a specific time period, usually one year, for a given country, territory or geographical area. In accordance with the International Standard Classification of Education in 1997 (ISCED-97), adopted by UNESCO, primary education is defined as the level of instruction whose principal function consists of providing the first elements of education, like that which takes place at elementary and primary schools.

Decentralization: Decentralization is a political and administrative process that involves the transfer of responsibilities and resources to sub-national government units (state, department, province or municipality) that are characterized by having their own legal status and financial resources, and the autonomous ability to act in terms established by specific laws. Decentralization differs from *deconcentration* in that the latter usually involves a transfer of administrative, not political, authority to the lower levels of a single institution.

Deliveries attended by skilled personnel (%): Number of deliveries attended by skilled personnel during a specific year, regardless of the location of the event, expressed as a percentage of the total number of births in that same year, in a given country, territory or geographical area. Skilled personnel include physicians, nurses and qualified midwives (comadronas); it does not include trained or untrained traditional midwives.

Demand for health services: This is the formal (explicit) desire by the consumer to receive health care provided to the general public at no cost. As an estimate, the *utilization or use* of services is considered to express the demand that was responded to through the service supply, with respect to a target population and in a given period.

Democracy: Political regime in which the sovereignty resides in the people and is exercised by the people directly or indirect. The word democracy derives from the Greek term *demokratia*, composed of *demos* that means “people”, *kratein* that means “to govern” and the suffix *ia*; the term literally means, “government by the people.” More concretely, democracy is a form of government in which, in theory, the power to change the laws and the structures of government, as well as the power to make all government decisions resides in the citizenship. In such system, both the legislative and executive decisions are made by the citizens themselves (direct democracy) and by selected representatives through free elections that represent the interests of the citizens (representative democracy).

Distributive policies: Policies that embodies programs or grants that provide some sectors or areas with resources of interest to society and benefit most people. As a result, although this type of policies frequently involve subsidies to the private sector, they do not generate a high level of controversy, since it is assumed that their products benefit most members of society and that they are not implemented at the expense of the majority or private groups. Examples include highway construction, college research grants, agricultural subsidies, police, construction of airports, roads, etc.

Economically active population (EAP): Comprises all persons of either sex, above a specified age, who furnish the supply of labor for the production of economic goods and services, during a specified time reference period. It can be calculated as the quotient between the number of economically active people and the total number of people of working age, at a given date and in a given territory, expressed per 100.

Effectiveness: Implies that a given clinical procedure, program or service obtains the intended results or produces the expected effects.

Efficiency: Obtaining the best possible value for the resources used. Resources are allocated efficiently if they generate the maximum possible gain in terms of health per unit cost.

Equity: Defined as the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically.

Ethnic group: An ethnic group is the group that is differentiated from the overall national society due to its socio-cultural practices, which can be seen in their customs and traditions. Ethnic groups can be formed by indigenous people, Afro-descendents, mestizos, the raizales, the rom, etc.

Extreme or absolute poverty (indigence): The degree of poverty below which the minimal requirements for survival are not being met. This is a fixed measure in terms of a minimum calorific requirement plus essential non-food components (ADB).

Female-headed households (%): Quotient between the number of female-headed households and the total number of households, in a given period and territory, expressed per 100.

Fertility rate in women 15 to 19 years of age: Annual average rate of change in the fertility of an adolescent population for a given country, territory or geographical area, during a specific period. The ratio is expressed as the number of live births to mothers who are 15 to 19 years of age during a given year over the female population 15 to 19 years of age at the mid-point in a year, usually multiplied by 1,000.

Final Provision: The final result of the productive process carried out within the health facility (hospital discharge, specialty and emergency consultations, surgical interventions, delivery care). These benefits are the overall result of the production of the network of health care facilities.

Financing: Function of a health system concerned with the mobilization, accumulation and allocation of resources to cover the health needs of the people, individually and collectively, in the health system (WHO, 2000b).

***Fragmentation*:** Co-existence of several non-integrated small sub-systems, which increases transaction costs and hinders the capacity to guarantee equitable access to and delivery of health services (Planes Magriñá A.).

Gaps in supply with regard to demand: The comparison between supply and demand makes it possible to estimate the *gaps* that exist between the available supply, and the supply that would be necessary to meet the population's demand in an effective and sufficient manner.

Gender: Dynamic concept, which looks at the interrelationship between men and women in the context of their society and roles in that society. Gender roles are defined as the social and cultural traits that different societies assign to males and females. Such gender roles are the patterns of behavior, rights and obligations defined by a society as appropriate for each sex. A gender perspective is a way of looking at situations and issues taking into account the respective roles and contributions of men and women in society (WHO).

Sex: Refers to the biological differences between women and men.

Gender Development Index (GDI): Indicator that includes the same basic data as the Human Development Index (HDI), but adjusts for gender inequalities in the three dimensions of human development (longevity, knowledge and standard of living).

Gender Empowerment Index (GEI): Indicator that measures the political and economic empowerment of women relative to men by looking at the number/percent of women in parliament, senior and management positions as well as women with professional and technical jobs.

General mortality rate, estimated: Total number of estimated deaths in a population of a given sex and/or age, divided by the corresponding number in that population, expressed per 100,000 population, for a given year, in a given country, territory, or geographical area. This represents an average estimate of the absolute risk of dying, for all causes, for each person in the corresponding reference population.

Generic medicine: Medicine that is identical in chemical composition to a brand name pharmaceutical preparation, but produced by competitors after the firm's patent expires (Getzen 1997).

Governance: Defined as the traditions and institutions by which authority in a country is exercised. This includes: 1) the process by which governments are selected, monitored and replaced; 2) the capacity of the government to effectively formulate and implement sound policies; and 3) the respect of citizens and the state for the institutions that govern economic and social interactions among them (Kaufmann, Kraay and Zoido-Lobatón, Banco Mundial).

Gross domestic product (GDP): The total money value of all final goods and services produced in an economy over a period of time (usually one year) plus net property income from investments abroad (WHO, 1998a).

Gross domestic product (GDP) per capita in international $ (PPP adjustment): Average market value per person of the total aggregate gross values for all resident institutional units devoted to production, for a given domestic economy, in a given time period, usually one year, expressed in international dollars using rates of monetary purchasing power parity.

Health: Defined by WHO as a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948).

Health Authority: The Health Authority is the custodian of health-related public goods and its basic purpose is the protection and promotion of the population's health. In entails the power of the State to influence the functions, responsibilities and substantive competencies which cannot be delegated, in order to effectively monitor health-related public goods. There are structural differences in the composition of the Health Authority based on the federal or unitary nature of the country and the institutional organization of the health sector. The Ministries of Health are the principal public depository organizations of the *Health Authority* and in that role are the primary entities responsible for exercising the steering role for the health sector.

Health care model: Schematic description of the type and combination of services that are usually offered in a country, region, or system, such as the package of basic services of a given country.

Health Outcomes: Changes in health status (mortality and morbidity) which result from the provision of health (or other) services (OECD 1992).

Health Planning: Set of processes whose purpose is to improve health, access to health services, and to promote efficiency in the delivery of health services and in the allocation of resources on a comprehensive basis for an entire community.

Health Policy: Health policies embody governmental decisions that set objectives related to the health sector with a view to improve health, to reduce risk and injury and to enable individuals to seek a better health status.

Health Promotion: The planned and managed process of encouraging and assisting improvement in the health of a population as distinct from the provision of health care services (WHO 1998a).

Health Sector Reform: Process that seeks major changes in national health policies, programs and practices through changes in health sector priorities, laws, regulations, organizational structure and financing arrangements, such as user fees. The central goals are to improve access, equity, quality, efficiency and/or sustainability.

Health Sector: Defined as the set of values, standards, institutions, resources and actors arranged together in accordance with established policies, who carry out activities related to the production, distribution and consumption of goods and services, whose primary purpose is to promote, restore and maintain the health of individuals or population groups. It includes government ministries and departments, hospitals and other health services, health insurance schemes, voluntary and private organizations in health, as well as the pharmaceutical industry and drug wholesale companies.

Health Sector Steering Role: Understood as the management of health-related public policies. In the context of the new scheme of relationships between government and society in the modern State, it is a characteristic competence of the government, performed through the national health authority. Its purpose is to implement decisions and public actions to fulfill and guarantee, within the framework of the adopted national development model, the health-related needs and lawful aspirations of the groups of social actors. It includes the following dimensions: formulate and lead, regulate and oversee, guarantee assurance, manage the financing, coordinate care delivery, and develop and promote the essential public health functions in the country.

Health services: Any service that can contribute to improved health, or to the diagnosis, treatment and rehabilitation of sick people, and not necessarily limited to medical or personal services (WHO, 1998).

Health services management model: Corresponds to the manner in which the managers of the health services system administer all of the system's resources with the aim of achieving the proposed goals.

Health services organizational model: Corresponds to the manner in which the components of the health services system are organized with the goal of contributing to their collective functioning.

Health system: Group of public and private for/non-profit national and sub-national institutions that endeavor to protect the health of the people. Essentially, the health system is the health sector categorized (with linkages) according to core functions (financing, provision of inputs and service delivery/coverage), main actors (government and consumers/households) and outcomes (health, fairness in financing and responsiveness. WHO defines the goals of health systems as: (i) Improving the health of the population they serve; (ii) Responsiveness, i.e., responding to people's legitimate expectations; and (iii) Fair financing, i.e., providing financial protection against the costs of ill-health.

Health system performance: Assessment of the extent to which the goals of the health system are attained, given the resources available to the system.

Hospital: A health care establishment that has beds, personnel and clinical technological resources where the patients can be admitted and receive health care 24 hours a day. The type of services can be outpatient (in adjoining physician's offices, either specialty or emergency units) and intra-hospital (hospitalization).

Hospital bed: A regularly maintained and staffed bed for the accommodation and full-time care of a succession of inpatients, situated in wards or areas of the hospital where continuous medical care is provided. It is a measure of hospital capacity (WHO 2000a).

Human Development Index (HDI): Indicator that measures countries according to their basic human capabilities. The HDI accounts for three dimensions of human development:

- Longevity: measured by life expectancy;
- Knowledge: measured by a combination of adult literacy and mean years of schooling;
- Standard of living: measured by purchasing power, based on real GDP per capita adjusted for the local cost of living.

Human Resources Management: Refers to the decision-making process that affects the nature of the relationship between the health institution and its employees. It consists of transforming the resources available in services that effectively and efficiently meet the needs of individuals and population groups within a context of permanent evolution (Gilles Dussault and Luis Eugenio de Souza, Universidad de Montreal).

Illiterate population (%): Proportion of the adult population age 15 and over that is not literate, expressed as a percentage of the corresponding population, for a given sex, in a given country, territory or geographical area, at a specific point in time, usually at the mid-point in a year. For statistical purposes, a person is literate if s/he can read and write, with understanding, short and simple communication about her/his daily life.

Income ratio top 20% / bottom 20%: Quotient between the average income of the wealthiest quintile divided by the average income of the poorest quintile in a given population, for a given country, territory or geographical area, within a specific time period, usually one year.

Indicator: Identified and measured variables which help to show changes directly and indirectly relevant to goals, objectives and targets (WHO 1998a).

Indicators of inequity: An ***i***ndicator of inequity should take into consideration the following variables: (i) the socioeconomic dimension of health inequities; that is, that health inequities are systematically related to socioeconomic status; (ii) the experience of the population as a whole, that is, that the indicator uses all of the information available from diverse population groups; and (iii) changes in population distribution and size; that is, that it is sensitive to the size of socioeconomic groups. Finally, that the indicator is sensitive to the average health status of the population.

Indigenous population (indigenous peoples, native peoples, autochthonous peoples, tribes,ethnicities, ethnic groups, nations, nationalities, first nations, societies, Amerindians): Although there are diverse definitions of the term indigenous, according to Convention 169 (1989) of the International Labor Organization (ILO), indigenous peoples are "... peoples in independent countries, considered indigenous since they are descendants of populations that inhabited the country, or a geographical region to which the country belonged, at the time of the conquest or colonization, and who conserve all of their own social, economic, cultural and political institutions, or parts of them." The concept of peoples refers to the set of features that characterizes a human conglomerate in territorial, historical, cultural and ethnic terms that provide them with a sense of identity.

Infant mortality rate: Quotient between the number of deaths in children under one year of age in a given year and the number of live births in the same year, for a given country, territory, or geographical area, expressed per 1,000 live births, according to information from the competent National Health Authority. Neonatal mortality (reported) is defined as the quotient between the number of live births who die before completing 28 days of age in a given year and the number of live births in the same year, for a given country, territory or geographical area, expressed per 1,000 live births, according to information from the competent National Health Authority. Post-neonatal mortality (reported) is defined as the quotient between the number of live births who die before turning one but have lived 28 days or more, in a given year and the number of live births in the same year, for a given country, territory or geographical area, expressed per 1,000 live births, according to information from the competent National Health Authority. The estimated infant mortality rate represents the values estimated at the mid-point in a year, obtained through linear interpolation of the corresponding United Nations 5-year population projections using the medium fertility variant.

Inflation rate (annual average growth of the consumer price index): Annual average rate of change in the cost, for the average consumer, of purchasing a market basket of goods and services, which can be fixed or change at specific intervals, such as every year, for a given domestic economy, during a specific time period.

Insurance: System for coverage of risks or uncertain events through the prior distribution among a certain number of people of the costs resulting from these risks. Enrollment is voluntary and the interested party should meet certain requirements in order to join and pay a quantity of money (the "premium") to have the right to the benefits that are offered to her/him.

Intermediate benefits: They correspond to procedures that are part of the productive process and that act as inputs for the final provision of health care (imaging and laboratory diagnostics, pathological anatomy, blood bank procedures; included here are also support actions such as laundry, sterilization, food providers and others).

Life expectancy at birth: Average number of years that a newborn would be expected to live, if during her/his life s/he was exposed to the age- and sex-specific mortality rates prevalent at the time of her/his birth, for a specific year, in a given country, territory or geographical area.

Migration: It consists of a change in residence from one boundary to another with the intention of staying. If this intention does not exist, the population should be included in another category (for example, displaced persons, visitors or tourists). A country (or region, province or state) receives immigrants and loses emigrants; the difference between gross immigration and gross emigration is called the migratory balance or net migration.

Millennium Development Goals (MDG): Eight goals – which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 – that form a blueprint agreed to by all the world's countries and all the world's leading development institutions. They were established following the United Nations Millennium Declaration and Summit (New York, 2000).

Moral Hazard: The possibility of consumers or providers exploiting a benefit system unduly to the detriment or disadvantage of other consumers, providers or the financing community as a whole, without having to bear the financial consequences or their behavior in part or in full (ILO 1999).

Mortality due to AIDS, estimated: Number of deaths of a given sex whose death certificates register Acquired Immunodeficiency Syndrome (AIDS) as the underlying cause of death, expressed per 100,000 population, for a given year, in a given country, territory or geographical area.

Mortality rate due to circulatory system diseases, estimated: Total number of estimated deaths due to diseases of the circulatory system in a population of a given sex and/or age, divided by the number in that population, expressed per 100,000 population, for a given year, in a given country, territory or geographical area. This represents an average estimate of the absolute risk of dying from this cause for each person in the corresponding reference population.

Mortality rate due to communicable diseases, estimated: Total number of estimated deaths due to communicable diseases in a population of a given sex and/or age, divided by the number in that population, expressed per 100,000 population, for a given year, in a given country, territory or geographic area. This represents an average estimate of the absolute risk of dying from this cause for each person in the corresponding reference population.

Mortality rate due to external causes, estimated: Number of estimated deaths from external causes in a population of a given sex, divided by the total number in that population, having eliminated the effect of differences in the age distribution, expressed per 100,000 population, for a given year, in a given country, territory or geographical area.

Mortality rate due to malignant neoplasms, estimated: Total number of estimated deaths due to malignant neoplasms in a population of a given sex and/or age, divided by the number in that population, expressed per 100,000 population, for a given year, in a given country, territory or geographical area. This represents an average estimate of the absolute risk of dying from this cause for each person in the corresponding reference population.

Mortality rate due to tuberculosis, estimated: Number of deaths of a given sex whose death certificates register tuberculosis as the underlying cause of death, expressed per 100,000 population, for a given year, in a given country, territory or geographical area.

Mortality rate in children under 5, estimated: Quotient between the number of deaths in children under five years of age and the number of live births in the same year, for a given country, territory or geographical area, expressed per 1,000 live births.

Mortality rate in children under 5 due to acute respiratory infections (ARI): Total number of children under 5 years of age, expressed per 1,000 births, whose death certificates register acute respiratory infection as the underlying cause of death, for a given year, in a given country, territory or geographical area.

Mortality rate in children under 5 due to infectious intestinal diseases (IID): Total number of children under 5 years of age, expressed per 1,000 births, whose death certificates register infectious intestinal diseases as the underlying cause of death, for a given year, in a given country, territory or geographical area.

Mortality underreporting (%): Difference between the number of estimated deaths, in accordance with the corresponding life tables, and the number of deaths currently registered, expressed as a percentage of the total of estimated deaths, for a given year, in a given country, territory, or geographical area. Mortality is considered underreported if death has not been registered in the civil registry until a year after the real date of death.

National Expenditure on Health: Measure of the total amount of resources spent on goods, services and research on health during one year. The measure includes public and private expenditures on health.

National Health Accounts: Information, usually in the form of indicators, that a country may collect on its health expenditures (WHO 2000b). Indicators may include total health expenditure, public expenditure, private expenditure, out-of-pocket expenditure, tax-funded and other public expenditure, social security expenditure, public expenditure on health.

Number of hospital beds: Average number of available hospital beds per every 1,000 inhabitants in a population, for a given year, in a given country, territory or geographical area.

Out-of-pocket payments (direct payment): Fee paid by the consumer of health services directly to the provider at the time of delivery. Payments borne directly by the patient. They include cost-sharing (and user-fees) and informal payments to health care providers (OECD, 2000b; modified OECD, 1992).

Outpatient services: Medical and paramedical services delivered to patients who are not formally admitted to the facility (physician's private office, hospital outpatient centre or ambulatory-care centre) and do not stay overnight (OECD 2000b).

Payment Mechanisms: Type of organization for economic compensation, normally monetary, that the health provider receives for the provision of health services.

"***Pooling"***: Consists of the administration of the financial risk associated with health interventions, through the assignment of available resources to the «pool» or group of members so that this risk is assumed by all members of the pool and not by each member individually.

Population: All of the inhabitants of a country, territory or geographical area, for a given sex and/or age group, at a specific point in time. In demographic terms, it is the number of inhabitants of a given sex and/or age group that live permanently within the border limits of the country, territory or geographical area at a specific point in time, usually at the mid-point in a year. The population at the mid-point in a year refers to the de facto population as of July 1st.

Population age 60 or over (%): Percentage of the total population of a country, territory, or geographical area that is 60 years of age or over, for a given sex and at a specific point in time, usually at the mid-point in a year.

Population below the national poverty line (%): Percentage of the population living below the national poverty line, for a given country, territory or geographical area, within a specific time period, usually one year. The operational definition of the national poverty line tends to vary from country to country and represents the amount of income that makes it possible for each household to meet the basic needs of all of its members.

Population of the Area of Influence: The area of influence corresponds to the population served by health facilities and does not necessarily represent a territory as such. The population provides the denominator for the diverse ratios in indicators of supply or use. According to need, specific indicators for population subgroups (for example, children under one year of age) can be constructed. The most relevant variables for describing the most complex levels are:

- The list of establishments, with their level of complexity and typology, following what is recommended in the section for the general characterization of the service supply.
- The supply of services, where distinguishing between intermediate and final benefits is recommended at this level.

Population under age 15 (%): Percentage of the total population of a country, territory or geographical area under 15 years of age, for a given sex and at a specific point in time, usually at the mid-point in a year.

Population with access to drinking water services (%): Size of the population with access to drinking water services in a given year, expressed as a percentage of the corresponding population at the mid-point in a year, in a given country, territory or geographical area.

Population with access to excreta disposal services (%): Size of the population with access to excreta disposal services in a given year, expressed as a percentage of the corresponding population at the mid-point in a year, in a given country, territory or geographical area.

Prevalence of exclusive breast-feeding up to 120 days of age: Number of children who, from birth until the end of the fourth month of life, are fed exclusively with breast milk, expressed as a percentage of the corresponding population at the mid-point in a year, for a given year, in a given country, territory or geographical area.

Prevalence of low birth weight: Number of live births with weight below 2,500 grams, measured at the time of birth or within the first hours of life, before significant postnatal weight loss has occurred, expressed as a percentage of the corresponding population at the mid-point in a year, for a given year, in a given country, territory or geographical area.

Primary care: The level of a health system " that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others." 56 The term is thought to date to about 1920, when the Dawson Report was released in the United Kingdom. That report mentioned "primary care centres", which were proposed to be the hub of regionalized services in that country. Another term, "Community Oriented Primary Care" or COPC originated in the 1940s in South Africa. The COPC approach continues today and is viewed, among others, as an important precursor to the Alma Ata conception of PHC.

Primary health care (PHC): In 1978, the Alma Ata Declaration defined PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain… It forms an integral part of the country's health system…and of the social and economic development of the community. It is the first level of contact on individuals, the family and community… bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

Primary health care-based health system: An overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness, quality orientation, government accountability, social justice, sustainability, participation, and intersectoriality. A PHC-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action. A PHC-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal management practices at all levels to achieve quality, efficiency, and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system develops intersectorial actions to address other determinants of health and equity.

Private expenditure in health: That part of total expenditure on health which is not public; it is mainly comprised by out-of-pocket payments and premiums for voluntary health insurance (sometimes by employers on behalf of the individual) (European Observatory on Health Care Systems, 2001).

Privatization: Involves the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit private organizations (European Observatory on Health Care Systems, 2001).

Public expenditure in health per year as a percentage of GDP: Value of the total public expenditure on health care goods and services for a given domestic economy, in a given time period, usually one year, expressed as a percentage of the corresponding gross domestic product (GDP).

Public expenditure in health per year per capita (current US$): Average value per person of the total public expenditure on health care goods and services for a given domestic economy, in a given time period, usually one year, expressed in current North American dollars.

Public policies: Defined as authoritative decisions made by the legislative (statutory language in laws), the executive (implementation of rules) and the judicial bodies (interpreting, court decisions). They are associated with formally approved policy goals and means (resources, mechanisms), and they communicate objectives, principles, strategies and rules of decision used by government administration and legislation. As such, public policies satisfy a public need or

values expressed in outputs and outcomes framed in a set of normative guidelines adopted by a public entity, implemented and enforceable through the coordinated action of social agents. They are translated into regulations, laws, standards, taxation and other economic incentives or disincentives.

Quality: It means that health services users receive timely, effective and safe care (technical quality); with adequate physical resources; and under ethical conditions (perceived quality).

Ratio of AIDS cases man/woman: Quotient between the number of incident cases of Acquired Immunodeficiency Syndrome (AIDS) in men relative to the number of cases in women, for a given country, territory or geographical area.

Ratio of physicians: Average number of available physicians per every 10,000 inhabitants in a population, for a given year, in a given country, territory or geographical area.

Ratio of professional nurses: Average number of available registered nurses per every 10,000 inhabitants in a population, for a given year, in a given country, territory or geographical area. Registered nurses do not include auxiliary nursing personnel.

Redistributive policies*:* Those that affect broad groups of individuals, including the redistribution of financial resources, physical properties and individual rights, and where the effects tend to be aligned with the socioeconomic position of these groups.

Regulatory policies*:* Are designed to influence the actions, behaviors and decisions of the private sector, and are accompanied by sanctions. They are justified because they are directed at protecting public well-being and, like redistributive policies, tend to generate confrontation between different groups.

Relative poverty: Relative poverty is another measure of economic well-being expressed in terms of income, consumption or well-being. If we use the approach of relative income, a person is considered poor when s/he lacks a certain income level derived from the average or median income in a given society.

Sectoral Analysis: Process that leads to the preparation of a study or group of studies about the production, distribution or consumption of goods or services in a sector in a country; of the elements that comprise the sector and the relationships between them, taking into account the historical, political, social, economic and cultural context. The sectoral analysis constitutes more than a situational diagnosis since it links descriptive and analytical components and retrospective and prospective approaches. It is, therefore, an analysis of the sector's dynamics that includes the construction of hypotheses and the formulation of policy recommendations.

Sectoral Management: Consists of the capacity of the "National Health Authority" to formulate, organize and manage the execution of the national health policy, through processes that, based on shared values at the national level and the social determination of public goods in health, defines viable health objectives and implements strategic plans with feasible goals. For that purpose, the efforts of public and private institutions within the sector and other social actors should be coordinated, in order to achieve through participatory mechanisms and consensus-building, the mobilization of the necessary resources for carrying out the proposed actions.

Segmentation: Health systems characterized by the coexistence of the following: (i) social security system, which covers workers employed in the formal sector; (ii) a health ministry that carries out some public health interventions and provides health care services for the lower and middle classes; and (iii) a very large and diverse private sector that covers the richest, the poorest, and, increasingly the middle class.

Services (benefits): The services (benefits) that a public insurance entity offers to its beneficiaries depend on numerous factors, including the following: the history of the entity itself, financial and human resources, the patterns of morbidity and mortality in the population, the available infrastructure, health policy priorities, and power relationships among the different groups. Private insurers and most Social Security institutions explicitly describe their "Service Plans (related to health or benefits)." That is, they define benefits more or less precisely, carry out periodic reviews and publicize what they offer their beneficiaries in exchange for the "premium" they pay. In addition, they tend to try to introduce mechanisms to guarantee the efficiency and effectiveness of their health plans. Ministries of Health, in their capacity, increasingly try to organize their "Benefit Plans," better identifying the population covered, explicitly indicating the supply of services, and making available the expenditure per person covered.

Service Provision: Consists of direct care for people on the part of professional trained staff. It can be of different natures— individual or collective promotion and prevention, diagnosis and treatment, recovery and rehabilitation—developed in and from health facilities of very diverse types: in houses and work places; in the residence of physicians, nurses, or primary or intermediate level personnel; in basic health units; in clinics or specialized outpatient services; in complex hospitals, where sophisticated and expensive technologies are used.

Skimming: A process whereby an insurer tries to select the most favorable individuals with expected losses below the premium charged (or the capitation payment received) in order to increase profits (World Bank 2000).

Social Determinants of Health: Are factors in the social environment that contribute to or detract from the health of individuals and communities. These factors include, but are not limited to the following:

- Socioeconomic status
- Transportation
- Housing
- Access to services
- Discrimination by social grouping (e.g., race, gender, or class)
- Social or environmental stressors

Social participation and control: Defined as the establishment of forms of social relationship, based in the need to include all social actors, empowered to take part and promote the processes that seek the collective well-being through the resolution of conflicts. It implies the incorporation of the population, as social actor, in the analysis of the situations/problems that affect them, in the consideration of the options to deal with these issues and in the execution of the resulting actions (Haddad,J/Roschke, M.A./Davini, M.C: Educación permanente de personal de salud. Washington, D.C.: OPS, Serie Desarrollo Recursos Humanos No. 100).

Social Security: Compulsory, contributory and non-contributory national regimens, generally based on the principles of universality and general coverage against the risks of disease, accidents, old age, unemployment and others.

Supply of health services: Quantity of a good or service in the condition to be used or consumed by a target population, in a given period. The resources dedicated to providing those goods or services are also considered to be (an estimate of the) *supply*. This is realized through services designed to promote, prevent, recover and rehabilitate the health of a target population, both at the individual and collective level, in the current conditions of the people and the environment.

Sustainability: The capacity to meet the needs of the present without compromising the ability to meet future needs (WHO 1998a). For the purposes of the present document, sustainability involves both a social and financial dimension, and is defined as the capacity of the system to solve its current problems of legitimacy and financing as well as the challenges of future maintenance and development. Consequently, it includes social acceptance and support and the availability of necessary resources.

Systemic variables that are determinants of health services: Corresponds to variables of a systemic type, which are beyond the arena of service provision as such, but that are important determinants of health services. Variables such as level of financing, provider payment mechanisms, and quantity and allocation of human resources are included within this group.

Total fertility rate: Average expected number of children that a woman would have during her lifetime, if during her childbearing years she experienced the age-specific fertility rates prevalent in a given year or period, for a given country, territory or geographical area.

Urban population (%): Percentage of the total population of a country, territory, or geographical area that lives in areas defined as urban, in a specific point in time. The term urban refers essentially to cities, towns, and other densely populated areas. The demarcation of urban areas is usually devised by the countries as a part of their census procedures and is based usually on the size of the localities and/or the classification of areas as administrative centers or according to special criteria as population density or type of business activity of its residents. There is no internationally agreed definition of urban area and the national operational definitions can vary from country to country.