



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 124th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., 21-25 June 1999

---

*Provisional Agenda Item 5.9*

CE124/17 (Eng.)

6 May 1999

ORIGINAL: SPANISH

### MONITORING AND EVALUATION OF THE HEALTH SECTOR REFORM PROCESSES

The countries of Latin America and the Caribbean are introducing reforms that may have a profound influence on the way they provide basic health services and on the people who receive them. Health systems are being reformed in order to reduce inequities, improve quality, and correct inefficiencies in current health systems.

The Governments of the Region identified the need to design a process for monitoring health sector reform in the Americas at the Summit of the Americas in Miami in 1994 and at the Special Meeting on Health Sector Reform in 1995, in which an interagency committee of the United Nations, and multilateral and bilateral agencies participated.

In order to respond to this need, the *Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean* was designed and has begun to be used. This document explains the methodology and its contents, provides examples of how it has been used, and outlines future stages that have been considered.

This report, which was examined previously by the Subcommittee on Planning and Programming, is submitted to the Executive Committee to inform it of the progress made toward fulfilling the mandate of the Pan American Health Organization and to receive input from the Members on the steps to be taken.

## CONTENTS

|   | <i>Page</i> |
|---|-------------|
| 1. Background and Rationale for PAHO Action in Monitoring Health Sector Reform in the Countries of the Americas ..... | 3           |
| 2. Design of the Methodology for Monitoring and Evaluation of Health Sector Reform .....                              | 4           |
| 2.1 Conceptual Framework.....   | 4           |
| 2.2 Designing the Methodology .....   | 5           |
| 2.3 The Methodology .....   | 5           |
| 2.4 The Target Audience .....   | 6           |
| 2.5 The Information Utilized.....   | 6           |
| 3. Content of the Methodological Framework for Monitoring and Evaluation of the Health Sector Reform .....            | 6           |
| 3.1 Monitoring the Processes.....   | 7           |
| 3.2 Evaluating the Results .....  | 7           |
| 4. Application of the Methodology .....   | 9           |
| 4.1 Argentina.....  | 9           |
| 4.2 Dominican Republic.....   | 10          |
| 4.3 Guatemala .....   | 10          |
| 4.4 Honduras.....   | 11          |
| 4.5 Mexico .....  | 12          |
| 4.6 Panama.....   | 12          |
| 4.7 Paraguay.....   | 13          |
| 5. Next Stages .....  | 14          |

## **1. Background and Rationale for PAHO Action in Monitoring Health Sector Reform in the Countries of the Americas**

According to its basic documents, the Pan American Sanitary Code (1924) and the Constitution (1947), PAHO's mandate is to act as the authority responsible for promotion and coordination in matters pertaining to international health in the Region. The major technical cooperation activities of PAHO include strengthening the capacity of the Member States in the design, implementation, and effective use of methodologies and information systems for the purpose of: detecting and evaluating changes in the living conditions and health of populations; building capacity for analyzing, planning, and formulating policies; and strengthening the leadership and administrative capacity of the ministries of health and other sector institutions in both their regular operating areas and the sectoral reform processes.

The I Summit of the Americas, held in Miami in 1994, included a discussion on the national sectoral reform processes. The Summit called, among other things, for a special meeting of governments, interested donors, and international technical cooperation agencies, organized jointly by PAHO, the Inter-American Development Bank (IDB), and the World Bank to establish the conceptual framework for these processes, defining PAHO's role in monitoring and evaluating sectoral reform plans and programs in the countries of the Region and strengthening the health economics network.

The Meeting was held at PAHO/WHO Headquarters in September 1995, where a growing interest in reform strategies, policies, instruments, and results was observed among the countries, agencies, and other cooperation organizations working in the Region. Since then, both the national authorities and international organizations, as well as other pertinent actors, have frequently requested information on objectives, plans, programs, dynamic, content, instruments, and individual and institutional experiences in the different areas covered by the reforms. Until very recently, much of this information was unpublished, or its dissemination was restricted to very closed circles.

The PAHO Directing Council approved Resolution CD38.R14 (1995), which requested the Director "In accordance with the recommendations of the Summit of the Americas and taking into account the discussions at the Special Meeting on Health Sector Reform, to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas."

At the 39th Directing Council (1996), the Secretariat reported on progress in health sector reform activities in the Americas. The Directing Council ratified sectoral reform as a strategy to make health systems more equitable, efficient, and effective and urged the Member States to reaffirm their political commitment to health sector reform. It

recognized the need for coordination, external support, respect for national autonomy, and sharing experiences on the national health sector reform processes.

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

Through the Health Sector Reform Initiative, USAID and PAHO are attempting to identify a wide range of individuals and institutions working in health sector reform, with a view to developing partnerships to generate and share knowledge throughout the Region. The *Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean* and the *Clearinghouse on Health Sector Reform (SINAR)*, developed as part of this Initiative, were designed to collect and disseminate data on health sector reform efforts in the Americas.

## **2. Design of the Methodology for Monitoring and Evaluation of Health Sector Reform**

### **2.1 *Conceptual Framework***

In the Region of the Americas, health sector reform has been proposed as a process aimed at introducing substantive changes in the various sectoral entities and functions to improve equity in benefits, administrative efficiency, and the effectiveness of actions, thereby meeting the health needs of the population. It is an intensified phase of health system transformation, implemented at a particular time and defined by the particular situations that justify it and make it viable.

Indeed, sectoral reform is very diverse in the Region, with significant variations in the dynamic and content of the changes being introduced by the majority of the countries.

The main PAHO criteria in sectoral reform are equity, quality, efficiency, sustainability, and social participation. These concepts make it possible to determine the direction that current and programmed reforms are taking from the standpoint of their ultimate stated purpose. Thus, no reform should run contrary to these criteria, and the “ideal reform” would be one in which all five aspects had improved by the end of the process. Each of these aspects may in turn be subdivided into a series of variables that can be associated with quantitative or qualitative indicators adapted to the conditions in each country and that can help evaluate the degree to which reform objectives have been met.

## **2.2 *Designing the Methodology***

Design of the *Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean* (hereafter “the Methodology”) began in October 1997 with the development of the “Base Line for the Monitoring and Evaluation of Sectoral Reform” which was applied in 17 countries<sup>1</sup> of the Region.<sup>2</sup>

Based on that experience, a design process unfolded involving the following stages:

- preparation of the preliminary version of the Methodology by the Division of Health Systems and Services Development of PAHO, with the collaboration of staff from its Divisions of Health and Human Development and Health Promotion and Protection;
- a feasibility study in five countries (Chile, the Dominican Republic, El Salvador, Jamaica, and Peru), with contributions from the PAHO/WHO Representative Offices in eight others (Argentina, Colombia, Cuba, Guyana, Mexico, Panama, Paraguay, and Uruguay);
- an international advisory meeting, held in May 1998 at PAHO Headquarters in Washington, D.C.;
- preparation of the version currently in use;
- incorporation of this version in the “Guidelines for the Preparation of Health Systems and Services Profiles in the Countries of the Region;”
- adaptation of the Methodology on the basis of the experiences with its application in 17 countries. This was done by experts in the field at PAHO Headquarters in April 1999. It should be noted that this tool has always been part of an ongoing improvement effort, with changes incorporated as a result of its application and the experience acquired.

## **2.3 *The Methodology***

The Methodology is a tool to help country decisionmakers at the national and subnational levels, and the technical cooperation agencies that support them, prepare

---

<sup>1</sup> Bolivia, Brazil, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, and Suriname.

<sup>2</sup> The country reports were published in English and Spanish, along with other publications of the Latin American and Caribbean Regional Health Initiative. They can be consulted at the Web site (<http://www.americas.health-sector-reform.org/english/index.htm>).

reports that are as objective as possible, manageable in length, easily updated, and that systematically monitor and evaluate the health sector reforms.

The Methodology has been developed concomitantly with the “Guidelines for the Preparation of Health Services System Profiles in the Countries of the Region”. Although either may be used independently, the monitoring and evaluation of the reform processes benefit enormously from the results of the methodological analysis, in terms of the context in which the health services systems operate and of the general organization, resources, and functions. At the same time, in most countries it would be impossible to analyze the performance of the system and the health services without factoring in the effects, potential or real, of current or programmed reforms.

#### **2.4 *The Target Audience***

The potential users of the Methodology are numerous. They include professionals in the countries who are engaged in the planning and administration of health systems and services at both the national and subnational levels; professionals working in the field or at the headquarters of the technical and financial cooperation agencies or NGOs; managers and professionals in other public and private institutions that are part of or working with the sector; and educational and research institutions linked with the sector.

#### **2.5 *The Information Utilized***

Fundamentally, the Methodology utilizes information that is already available, preferring institutional information published in official national sources. It also employs published information from international technical and/or financial cooperation agencies (including PAHO) and unpublished information from official national sources, provided that its use is authorized. Finally, it uses relevant information published in unofficial sources (for example, signed articles).

### **3. *Content of the Methodological Framework for Monitoring and Evaluation of the Health Sector Reform***

The Methodology contains variables and indicators based on qualitative and quantitative information. The quantitative information is information that the evidence indicates is available in the majority of the countries. For qualitative information, the questionnaire tries to be explanatory and suggests the approximate length the topic could occupy in the Profile.

The Methodology has two main chapters: one on monitoring the reform process, and the other on evaluating the results.

### **3.1 *Monitoring the Processes***

#### **3.1.1 *Dynamic***

The reforms are processes in which, over time, it becomes possible to identify definite stages and a considerable number of actors. The Methodology seeks to identify the following stages of the reform processes: the genesis, or “remote origin;” the design, or “immediate origin;” the negotiation; the implementation; and the evaluation of results. As to the actors, it seeks to identify those who operate predominantly in society in general and those whose primary sphere of activity is the sector itself, whether national or international.

#### **3.1.2 *Content***

In this area the Methodology seeks information on the strategies designed and the action taken. It includes questions on the legal framework, the right to health care and insurance, the steering role in the health sector, the separation of functions, decentralization modalities, social participation and control, financing and expenditure, the services available, the management model, human resources, and health technology assessment and quality.

### **3.2 *Evaluating the Results***

The purpose of the evaluation is to analyze the degree to which sectoral reform may be helping to increase the levels of equity, effectiveness and quality, efficiency, sustainability, and social participation of and in the health systems and services.

#### **3.2.1 *Equity***

Equity in health implies reducing to a minimum all avoidable and unfair disparities in health conditions. Equity in health services implies that patients receive care according their needs (equity in coverage, access, and use) and that they contribute to the financing of that care according to their ability to pay (equity in financing).

The Methodology looks for evidence that the sectoral reform has led to an improvement in the variables and indicators of coverage, resource distribution, access, and resource use.

#### **3.2.2 *Effectiveness and Quality***

Technical effectiveness and quality imply that the users of the services receive effective, safe, and timely care; perceived quality implies that the care is provided under satisfactory physical, psychological, and ethical conditions that meet the reasonable expectations of the users.

The Methodology looks for evidence that the sectoral reform has improved variables and indicators of morbidity, mortality, technical quality, and perceived quality.

### *3.2.3 Efficiency*

Efficiency implies a favorable ratio between the results obtained and the cost of the resources utilized. It is analyzed from two angles: resource allocation and the productivity of the services. Resources are allocated efficiently if they generate the maximum possible health gain per unit of cost. They are used efficiently when the maximum amount of product is obtained for a given cost.

The Methodology looks for evidence that the sectoral reform has improved variables and indicators of resource allocation and resource management.

### *3.2.4 Sustainability*

Sustainability has a social and a financing dimension and is defined as the capacity of the system to resolve its current problems of legitimacy and financing and meet the challenges of long-term maintenance and development.

The Methodology looks for evidence that the sectoral reform has enhanced the legitimacy and/or acceptability of the main institutional health service providers; improved the medium-term sustainability of efforts to increase coverage; bolstered the capacity to adjust the income and health expenditure of the principal public sector institutions; increased the percentage of health centers and hospitals able to collect from third parties; and strengthened the capacity to manage external loans and, when applicable, replace them with national funds when they reach maturity.

### *3.2.5 Participation*

Social participation involves procedures that allow the general population and the different agents to influence the planning, management, service delivery, and evaluation of health systems and services, and to benefit from the results of that influence.



The Methodology looks for evidence that the sectoral reform has helped to increase the degree of social participation and control in the various levels and operations of the health services system.

#### **4. Application of the Methodology**

The Methodology has been used in the Latin American and Caribbean countries. To date, the profile of the health systems and services (which includes the part on monitoring and evaluation of the sectoral reforms) has been completed for Argentina, Brazil, Chile, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, and Trinidad and Tobago.<sup>3</sup>

By way of example, below are some country summaries that give an idea of the type of information obtained with the application of the Methodology.

##### **4.1 *Argentina***

The sectoral reform, launched in 1992, is consistent with the economic and State reforms and is based on the national health policies. The Government explicitly chose a strategy of gradual, measured change that has moved in the general direction of strengthening the regulatory role of the central and provincial sanitary authorities. The Ministry of Health and Social Welfare (MSAS) has exercised the steering role in sectoral reform, thanks to the technical leadership role established for it in the national health policies.

The principal lines of sectoral reform have been the creation of the Self-Managed Public Hospital (HPA); start of the transformation of the *Obras Sociales* (OS) with externally financed support; development of a regulatory framework for the private health sector; the compulsory provision of a basic package of benefits (Compulsory Medical Program) to beneficiaries of the OS and the Prepaid Medical Companies (EMP), consistent with the sectoral reform; establishment of the National Program of Guaranteed Medical Care; and the beginning of sustained concerted action for health promotion and protection, geared especially toward populations potentially at risk.

Sectoral reform has organizationally restructured the health scenario, restored an active role to the public hospital as a service provider, and incorporated new procedures and agencies responsible for the monitoring, regulation, and control of the quality of care.

---

<sup>3</sup> Accessible through the Web site of the Initiative (<http://www.americas.health-sector-reform.org/english/index.htm>).

It has created a compulsory coverage system, established the free choice of a third-party payer in the OS, and changed the relationships between the various actors of the sector.

It is not yet possible to analyze how this has contributed to improving the levels of equity, effectiveness, quality, efficiency, sustainability, and participation in the health services and thus assess the impact on health care.

#### **4.2 *Dominican Republic***

The first steps to develop the health sector reform process were taken in the early 1990s and were aimed at solving the problems of a centralized management characterized by limited capacity to act and unsatisfactory frameworks for regulation and oversight.

Sectoral reform was launched in 1996 with the participation of various actors from civil society. This translated into two projects that are being financed by the World Bank, the IDB, and other bilateral cooperation agencies, for a total of nearly US\$ 120 million.

The main objectives of the sectoral reform are: i) to reform the social security system; ii) to promote the deconcentration and decentralization of the public sector; iii) to develop a basic package of benefits for universal access; iv) to strengthen mechanisms for mixed public-private financing, in a collective context; v) to introduce public-private mechanisms for health insurance and health service delivery; vi) to promote hospital self-management; and vii) to strengthen the regulatory role of the State.

The Executive Commission on Health Sector Reform was created to manage the sectoral reform process.

To date, Provincial Health Offices (DSP) have been established as deconcentrated agencies of SESPAS, and a new model of care has been developed.

An interinstitutional technical group was recently formed to design the most suitable methodologies for monitoring and evaluating the country's sectoral reform process.

#### **4.3 *Guatemala***

The Government has promoted the Comprehensive Health Care System (SIAS) as a way of increasing service coverage. This system has been designed to provide a basic package of services to the population that currently lacks them. The System is based on a network of community workers and on subcontracting with NGOs for the delivery of services.

The SIAS is the most important initiative of the Program for Modernization of the Health Services currently under way in Guatemala and is being financed with a loan from the IDB.

Since the process has just begun, it is premature to evaluate the impact of health sector reform in Guatemala. The action taken to date, however, appears to have improved access by bringing health service providers closer to communities, and by referring cases to health centers when necessary. These changes have the potential to reduce the historical health inequities faced by rural and indigenous populations.

#### **4.4 *Honduras***

The three major problems that affect the efficiency and effectiveness of the network of public health facilities are the high percentage of the rural and urban population living in extreme poverty, the inaccessibility of the services due to the extreme geographical dispersion of the population, and the lack of financial resources to guarantee broader and better coverage.

These and other mounting problems and their adverse effects on the health of the population spurred reform initiatives in the sector. Thus, in May 1993 the “Program for Modernization of the Health Services System” was launched to improve the interaction between the levels of care and other public and private entities. Between 1994 and 1998 the “National Access Process” helped to democratize the management of the services networks by fostering decentralization and social participation, and access to the health services increased. Given the need to strengthen its steering role, the government began a major transformation of the model of care in 1998, along with the reengineering of systems and processes. This came together in a health policy document that declared sectoral reform “the New Agenda in Health” (NAS).

The NAS involves two basic lines of action (health promotion and education, and quality assurance and quality improvement); seven essential components (the steering role and regulation; departmentalization and reorganization of the model of care; evaluation of health problems and consolidation of plans and programs; human resources development; drug policy; the environment and health; and information systems) and six dynamic strategies (supervision, monitoring, and evaluation; decentralization and co-management in health; infrastructure, maintenance, and technology; the intersectoral approach; financial sustainability; and administrative modernization).

There is little information at this time for evaluating the results of the various stages of sectoral reform in Honduras. There is not enough evidence to say that the

sectoral reform up to now has improved equity in health status or in access to the services, or the efficiency of resource management in public facilities. There is some evidence that health sector reform may have helped to improve the technical quality of public hospitals in some regions, increase user choice in primary care, bolster the legitimacy of the facilities, and improve social participation and control.

#### **4.5 *Mexico***

The Program for Reform of the Health Sector 1995-2000 was announced in 1996. Its objectives are to develop instruments for promoting quality and efficiency in health service delivery; to expand the coverage of care offered by social security institutions, facilitating membership by the unsalaried population and workers in the informal economy; to conclude the decentralization of health services for the uninsured population; and to expand the coverage of services to marginalized populations in rural and urban areas, where current access is limited or nil.

By late 1997 the transfer of human resources (103,000 workers), infrastructure (7,400 facilities), and financial resources (6.132 million pesos) to all the states of the Republic was complete. The objective is to have a clearer definition of goals, responsibilities, and evaluation systems in the states to ensure better health policies, while the Ministry of Health gives priority to its regulatory and coordination functions. The Program for Expanded Coverage (PAC), based on a basic package of health services in the more marginalized areas, is being also implemented.

The Program for Reform of the Health Sector provides for specific actions via two routes: promoting and facilitating voluntary affiliation with the social security services and establishing health insurance for families; and bringing essential health services to marginalized population groups by means of the basic package of services. In mid-1998, the Secretary of Health publicly stated that, thanks to the PAC, health care had been extended to 7 million Mexicans who prior to 1995 had lacked access to any type of health service. According to this same source, services must still be brought to 3 million people living mainly in the states of Chiapas, Guerrero, Hidalgo, and Oaxaca.

#### **4.6 *Panama***

Although the sectoral reform is national in scope, it has begun in the health regions of San Miguelito, the Metropolitan area, and Coclé. The legal bases for the sectoral reform are contained in three laws that have facilitated the separation of functions, the strengthening of intrasectoral action, and social participation. Changes have also been

made in the national and subnational structure of the public health sector. Implementation of a new model of family, community, and environmental care has begun that includes stratification by level of care and the implementation of a referral and counterreferral system between the community level and the primary and secondary levels of care.

In the San Miguelito region, the San Miguel Arcángel Hospital has introduced management commitments and program contracts for health care. This hospital operates on the basis of business and self-management criteria.

Work is under way on the design of procedures for the accreditation of health facilities and for quality assurance. Mechanisms are also being developed for health technology assessment and the regulation of medical devices and equipment.

The sectoral reform process is still in its infancy, which means that an evaluation has not yet been conducted. The plan calls for an evaluation by the year 2000, for which PAHO technical cooperation for the development of a methodology has been requested.

#### **4.7 *Paraguay***

In December 1996, as a part of the sectoral reform strategy, the law creating the National Health System (SNS) was passed. This legislation seeks to provide equitable, efficient, and timely health care to all persons without distinction, through health promotion, recovery, and rehabilitation activities. It also seeks to rationalize the use of available resources and to establish intra- and intersectoral links.

The law gives the National Health Council (CNS) the responsibility for the coordination and control of the plans, programs, and activities of public and private health institutions. The CNS is headed by the Minister of Health, and all related sectors and institutions are under it. The law has created a series of agencies under the CNS, among which are the Supervisory Authority (SUPNS), the Medical Directorate, and the Public Health Fund (FNS), the latter of whose regulations have yet to be drafted. The new functions and organizational model of the Ministry of Public Health and Social Welfare (MSPBS) were established by Decree. The FNS will assume the financing functions in the sector. The new government (which took office in August 1998) will study measures to modify the composition of sectoral financing when implementation of the FNS is discussed. The SUPNS will be responsible for oversight of insurance functions, and service delivery will be the responsibility of public and private institutions.

The MSPBS is transferring material and financial resources to the municipios for administration by the Local Health Councils (CLS). This transfer, which does not involve human resources, is effected through "Commitment Agreements." Social participation is a

goal and a strategy of the sectoral reform and is becoming a reality through the Regional Health Councils (CRS) and the CLS.

To date, there have been no changes in the training, planning, or management of human resources to respond to the needs of sectoral reform. Reengineering of the National Institute of Health (INS) is in progress to make it the agency responsible for the development of these resources.

Paraguay's sectoral reform is in its initial stages, so it is premature to evaluate results. However, some recent studies (e.g., "Analysis of the Health Sector of Paraguay" and "Sectoral Study of Water and Sanitation") can serve as the basis for a preliminary evaluation.

## **5. Next Stages**

Programming for the current year provides the application of the Methodology to every country in the Region. With regard to periodicity, the idea is to update the information on each country at least every two years or when circumstances demand it.

The main activities under consideration for the development of the Methodology and the Clearinghouse on Health Sector Reform will involve:

- Establishing a clearinghouse on health sector reform that will collaborate effectively with the health authorities of the countries of the Region in decision-making that affects the reform processes;
- Ensuring that a comparative analysis of the information derived from the application of the Methodology makes it possible to obtain information that is useful in terms of the item in the preceding paragraph;
- Integrating databases and demographic and epidemiological analyses with information on health systems and services development;
- Better assessment of the impact of sectoral reform, measuring the reduction in coverage gaps, the articulation of networks, equitable access, and the effectiveness of actions.