LAC HSR
HEALTH SECTOR REFORM INITIATIVE

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REFORM IN MOTION

A Bulletin for the Dissemination of Information on Health Sector Reform in Latin America and the Caribbean

In this Issue

Equity

The theme of equity is highlighted in this issue of *Reform in Motion* because improving equitable access to basic health services is very much what the Latin America and Caribbean Regional Health Sector Reform Initiative (LAC HSR) is all about.

Equity is a familiar concept that has lent itself to varying definitions. It is also closely linked to the concepts of social justice, resource allocation and transformation of health systems. Inequity in the context of health sector reform can be seen as "unjust inequality." It is based on the belief that differences in people's health conditions are attributable to their unequal socioeconomic circumstances, and that such inequalities are not only unethical but are also remediable.

The challenge to improve inequities in health is a concern that is publicly acknowledged in official statements and messages from the international health and development community.

The United States Agency for International Development (USAID), in its Web Page document on the LAC (Latin American and Caribbean) Regional Program, makes reference to "helping LAC countries design, implement, and monitor" country health reform "to increase equity of access to basic health services."

Dr. Gro Harlem Brundtland, the Director-General of the World Health Organization (WHO), in her message for the 1999 World Health Report, made it very clear that the "need to reduce greatly the burden of excess mortality and morbidity suffered by the poor" was a "first and foremost" challenge to be addressed. The report went on to list "reducing health inequalities" as a core goal in health system development. Consistent with this theme, a survey sent out to WHO regional and country office staff in early 2000 included questions that addressed the relationship between health system performance and inequities in health.

Dr. George A. O. Alleyne, the Director of the Pan American Health Organization (PAHO), in his message for the 1998 Annual Report of the Director, referred to "the search for equity" as a guiding principle for PAHO. He indicated that the Organization's "technical cooperation must measure its results not only by how much national averages improve, but also by the extent to which the gaps between and within countries are reduced." In line with this mandate, the quest for equity in health was chosen as the topic for

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Health Sector Reform as a Tool to Improve Equity in Health

Linking Equity and Health Reform

The concern for equity is central to health reform goals. Equity is about fairness. In health, it refers to whether differences in certain health parameters among different groups of people are morally acceptable, and whether the conditions underlying these disparities are unavoidable. If they are neither, then should something be done to change them so that people can have more equal opportunities to reach their full health potential? Health sector reform is about introducing changes into the various functions of the health sector and provides an excellent means whereby health systems can be transformed so that the highest possible level of equity can be achieved.

Recognizing Social Variables as Determinants of Health

It is generally accepted that attributes such as age, gender, race and ethnicity are risk factors for health outcomes, and while this is not always fair, these biological traits are not preventable. Other qualities pertaining to income, education, occupation, housing and lifestyle are also determinants of health outcomes, but these characteristics are acquired and they can be modified. Recognizing that, countries are paying more attention to incorporating criteria like socioeconomic status, quality of life, sanitary living conditions and safe working environment into the context of health reform.

Developing Indicators to Measure Inequities in Access

A fundamental component of health reform projects is the development of indicators that monitor equitable access to health services and help identify mechanisms to reduce health disparities as countries undergo reforms. Measurements of health outcomes, availability and utilization of health services, as well as basic health system characteristics such as financing and coverage rates provide information for exposing gaps that are both unjust and unnecessary. For instance, inequities in the distribution of health service resources can be detected by examining data on numbers of physicians, nurses, hospital beds, ambulances, health centers, etc. per unit of population. Similarly, discrepancies in utilization of health services due to inequitable yet correctable situations can be derived from differences in the numbers of ambulatory visits, hospital admissions, laboratory and diagnostic services, etc.

Analyzing the Impact of Reform on Vulnerable Groups

Although health conditions are improving in many countries of the Americas that are actively pursuing reforms, the quantity or quality of progress may not be the same in different countries or among different population groups within a country. In some cases, groups with greater needs are not necessarily the ones benefiting from the improvements. To make sure that reforms benefit the most vulnerable groups, the data needs to be segregated and then comparisons made using measurements stratified by socioeconomic status. Similarly, claims of progress must be examined critically. If life expectancy has improved for the country as a whole, how much of that improvement comes from the wealthier segments of the population and how much from the poorer segments? If country A reports a higher increase in life expectancy than country B over the same period, do we know how the two countries compare in terms of the size and distribution of the most economically disadvantaged population?

Coordinating Policy-Making at the National Level

Policies that can result in health inequities can come from inside or outside the health sector, e.g., the financial and private sectors among others. It is important that equity-oriented policies be given a high priority by decision makers from different government ministries. Health authorities are naturally positioned to coordinate national policies that impact on health. As health sector reform strives to strengthen the steering role of ministries of health, they will assume a stronger leadership role and develop the capacity to negotiate with other sector leaders to safeguard equity objectives.

Keeping Equity Goals on the Reform Agenda

In the Region of the Americas, international organizations help to translate equity policies into action by supporting reform programs through technical and advisory channels. By focusing on results oriented activities such as the development of methodologies, information dissemination and exchange of experiences, technical cooperation and donor agencies can help countries stay focused on equity goals through different phases of reform and across electoral terms. By working in close collaboration with government authorities, programmatic strategies can be integrated with national polices in a way that would lead to more effective interventions in reducing inequities. ◆

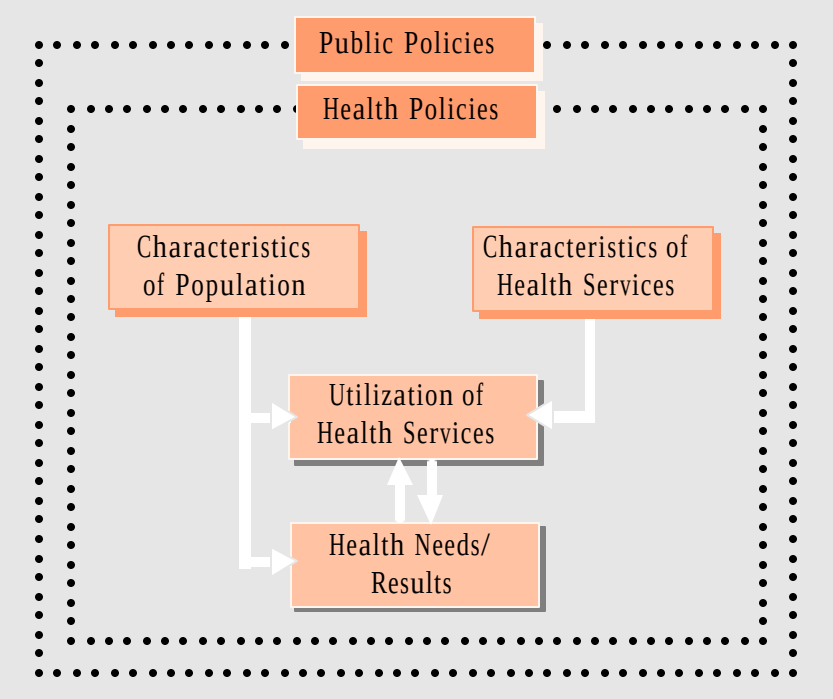
Contributed by PAHO: Edwina Yen

MONITORING EQUITABLE ACCESS

The first Summit of the Americas (Miami, December, 1994) established that promoting Equitable Access to Basic Health Services is one of the main goals of Health Sector Reform in Latin America and the Caribbean. Since 1997, PAHO, USAID and other partners have joined forces to support national efforts to achieve this goal through a regional initiative.

As a part of this Latin America and Caribbean Health Sector Reform Initiative (LACHSR), PAHO has undertaken to develop a Guideline for Monitoring Equitable Access to Basic Health Services. The document will be specific for the conditions in Latin America and the Caribbean and take into account the capacity for data collection and analyses on a regular basis and in a manner that can reasonably be sustained by member countries.

A research team was selected in March 1999, two draft papers were prepared, a two-day International Consultation Meeting was held at PAHO headquarters, and a preliminary version of the Guidelines was issued in December 1999. The research team presented a model outlining the relations between population characteristics, health needs, health resources and use of services. Based on this model, a working group within PAHO is continuing the work to develop an instrument for practical use by the countries in the Region.



In the Methodology for the Evaluation and Monitoring of Health Sector Reform in Latin America and the Caribbean (PAHO, 1998), equity in terms of health services is defined as ***receiving care according to need***. The method for monitoring that is being developed is based on the collection of data from geographical areas within a country, analysis of differences between the areas, and establishing the magnitudes of existing inequities and changes over time.

For monitoring purposes the number of indicators have to be limited and data must be easily available, ideally from already existing information systems, or possible to collect with reasonable resources. The following are good examples of this type of indicators that can be tested:

- immunization rate of children under 1 year
- outpatient consultations per 1,000 population
- hospital admissions per 1,000 population
- percentage of deliveries attended by trained staff

As the model indicates, the utilization of health services is related to the characteristics and health needs of the population and the availability of health services. Data will therefore also be collected for a few indicators of health needs (infant mortality and life expectancy) and for distribution of the resources for health services (physicians, nurses and hospital beds per 10,000 population). Population data and socioeconomic data will be collected as well.

With equitable access to health services, persons having the same needs for health care should also have the same possibilities of receiving care. But differences do not necessarily mean inequity. Differences turn into inequities when they are both unfair and avoidable. If data shows that utilization and resource distribution are very different for the different areas, the differences could be explained, for instance, by differences in health needs. The indicators will therefore be analyzed in relation to the characteristics of the population and their health needs according to the model above.

The differences in utilization are also related to the availability of services. In areas where services are easily available to the population, the use of services can be expected to be higher than in areas where few services exist. In an area where health needs seem to be high, but utilization of services is low and the availability of services is also low, the necessity for more services to be accessible in that area is indicated.

In order to develop policies and take actions to improve equitable access, it will be important to analyze the relation between low access and socioeconomic factors. This facilitates a better understanding of barriers to access and the characteristics of the population groups with low access. Generally, inequities in access to health services are related to age, gender, education, ethnicity, income and modality of insurance. If low income and/or low education characterize geographical areas with low access, and health services exist in these areas, there may be economic, cultural and/or administrative barriers for access.

The new instrument for monitoring equitable access to basic health services will be tested in some countries and presented to the members of LAC HSR in September 2000. ◆

Contributed by PAHO: Bernt Andersson and Alberto Infante

Policy Process of Health Reform in Latin America

Few countries have successfully made major systematic changes in their health systems, despite the wave of international interest in health reform. In Latin America two countries have embarked on major reforms–Chile's private insurance reform in the early 1980's and Colombia's managed competition insurance reform in the early 1990's. Mexico has also made several attempts to initiate major reforms, but has not reached any consensus for implementation. The DDM project, with support from the USAID LAC Bureau's Health Sector Reform Initiative, has done in-depth studies of these three experiences in order to develop lessons for the policy process of health reform in other countries. The studies were directed by Thomas Bossert at Harvard School of Public Health and implemented by country teams of researchers under the supervision of Alejandra Gonzalez-Rossetti.

The studies have shown significant similarities in the Chilean and Colombian "success stories" that were lacking in the Mexican case that did not produce reform. What is evaluated is the success of adopting and implementing a reform program, not whether or not that reform achieved its objectives. Here we review some of the findings of the studies. These findings should be taken in the context of the limited amount of research that has been done on policy process and should be evaluated against similar in-depth analyses of other reform experiences.

Politics Occurs in All Types of Regimes

It is often argued that it should be easier to implement broad reforms in authoritarian regimes because they can make decisions without having to respond to different interest groups that, in democratic systems, can often block reforms. Contrary to this expectation, we found that reforms could occur in a "democratic" regime as well as a "dictatorship", and yet a "limited democratic" regime did not produce reforms. Furthermore, we found that within the restricted range of political actors in a "dictatorship", there was significant bargaining as well as negotiating among major stakeholders that succeeded in delaying the reforms and in limiting their reach during the adoption and implementation of the changes.

Change Teams Matter

We found that a major factor in the success of reforms was that a relatively stable and coherent "change team" was formed. This team was formed with individuals from, and with continuing links to, a macro-economic "change team" which had successfully developed policies of economic reform. The health sector change team was made up of technical experts with a coherent shared ideological commitment but who did not see themselves as politicians. These teams were supported by the presidents and other major political actors in the governments of Chile and Colombia. Their members were from the Ministry of Planning and the Ministry of Finance and had initially worked on macro level reforms and pension reforms, usually with significant success. Successful teams were initiated and recruited with a conscious effort, usually by cabinet level officials or their immediate subordinates. Members of the macro-economic change team then turned their attention to the health sector and sent key members to work in the Ministry of Health.

Political Strategies

The health sector change teams pursued different strategies to get their policies adopted. One of the strategies was to isolate the change team from the broader political process until it had developed a significant technically defined package of reforms. This strategy appears to have been more successful than a broadly public participatory debate that is often recommended before the development of a health reform package. The reform package was then presented as a complete reform and as the president's own proposal for legislative attention. During the legislative process (which occurred even in a "dictatorship") the change team was able to overwhelm the opposition with well-developed technical arguments. It was important throughout the process that the change team demonstrated full technical command of the issues and present evidence-based arguments. The team's own legitimacy and effectiveness in building and maintaining high level support depended on credible rational arguments.

Lessons for Major Health Reform Efforts

The studies suggest the following lessons for major reform efforts:

- Develop support for reform by the *presidency and cabinet*, and in the *planning and finance ministries*. Reform initiated only in the health sector is not likely to have sufficient support to be pushed through the executive and legislative processes.
- Pay attention to *recruitment of a like-minded and competent technical "change team"* with strong vertical links to high level officials and horizontal links to officials in other sectors.
- In political processes *technical arguments and good data matter*. The legitimacy and effectiveness of change teams depend on their ability to marshal strong arguments and good data. This is the source of their power and linkage to other stakeholders.
- *Isolation of the change team in the formulation of policy* may be an effective strategy to create a single and coherent reform package that has the support of major political actors. ◆

Contributed by DDM: Thomas Bossert

THE COST REVENUE TOOL (CORE)

During the health sector reform process, health managers often need to ask themselves the following questions:

- *What are our most profitable and least profitable services?*
- *What level of prices for each service will allow us to break even?*
- *What is an appropriate mix and volume of services for our facility?*
- *What is the best use of human resources (i.e., staffing pattern)?*
- *How many of the poor can we serve and how much should be charged?*

Management Sciences for Health (MSH) has developed a new tool to help health managers answer these questions. It is the Cost Revenue Tool (CORE).

DESCRIPTION AND PURPOSE

CORE is an analytical, spreadsheet-based tool used for determining cost and revenues at the individual service level for both current situations and under different scenarios. It is designed to be used at different personnel levels and to provide a general picture with clear indication of problem areas. A key aspect of CORE is that it is not a cost accounting system or a routine report, which may not be available at the individual service level. Rather, it is a tool that can be periodically applied to monitor financial performance and to explore opportunities for improving efficiency and revenue generation.

THE APPLICATION

CORE is built around a set of Excel spreadsheets that are easily adaptable to an individual situation. It uses data that are usually available or easily calculated by a team of staff familiar with both the financial and clinical aspects of the organization. Using this information, CORE calculates unit costs based on standard inputs (i.e., supplies and staff time). It has the capacity to adapt to different staff payment systems (i.e., salary, commission, fee for service, fee for session) and will incorporate and allocate other fixed costs across services. The CORE analyses can also be reconciled with accounting reports for validity check.

HISTORY

The CORE tool was created in response to increasing pressure on both public and non-governmental organizations (NGOs) to become more financially sustainable. It originated from mechanisms developed by MSH/FPMD in Zimbabwe to compare costs under different service delivery models (static clinics, mobile clinics, and community-based distribution-CBDs). The Initiative has produced a Spanish version and has sought to expand its application in the Region. To date, CORE has been used by organizations in Guatemala, Honduras, Haiti and Mexico, with applications planned for Ecuador and Paraguay.

THE PACKAGE

The CORE package is currently available in Spanish and English at a nominal charge. It consists of a manual describing how to apply the tool and a diskette with a total of six files, three example files and three worksheets. More information about obtaining CORE can be accessed through the MSH web site at http://www.msh.org. ◆

Contributed by FPMD: Stacey Irwin Downey

SOCIAL INSURANCE MECANISMS IN LATIN AMERICAN HEALTH SYSTEMS

Health systems in Latin America are highly heterogeneous in terms of coverage, equity, financing structures, and outcomes. Social insurance models are called to play a key role in the design of a strategy in health that will compensate for budgetary constraints and offer their populations a better quality of life. This work provides decision makers with a tool that summarizes the diversity of social health insurance models currently in place in the Region and recent reforms in key countries, emphasizing the advantages and disadvantages of each model in terms of equity, coverage, and financial sustainability.

According to this study, the ideal social insurance system is comprised of four elements: a specific group of available health services; a system of financing that facilitates subsidies from high-income groups to low-income groups; a system for spreading risks that generates implicit subsidies from healthier to less healthy people; and a beneficiary population that has been defined and identified.

Under these premises, the study compares the sources of financing and collection mechanisms of each social insurance model, outlining the differences between the terms "fund," "plan" and "service delivery" in each. Moreover, from the standpoint of health services supply, it concentrates on the coordination between social insurance systems and the public sector and on the internal organization of the provider model, its decentralization schemes, ownership of the facilities utilized, and provider incentive structures. ◆

Contributed by PHR: Daniel Maceira

Flagship Course on Health Sector Reform and Sustainable Financing for the LAC Region

There is considerable diversity in the status and processes of health sector reform in the Region of the Americas. Significant variations in both dynamics and content are observed in the changes that are being introduced by the majority of the countries. Key decision makers at the national level are constantly challenged by the need to assess what reform approaches would make the most sense in their own country setting. The tools developed under the Latin America and Caribbean Regional Health Sector Reform Initiative (LAC HSR) can help this process but they are useful only if they can be applied appropriately by people who have been properly trained.

The World Bank Institute, Bitrán y Asociados, University Alberto Hurtado, and the Latin America and Caribbean Regional Health Sector Reform Initiative (LAC HSR), represented by USAID and PAHO, have agreed to be partners in the Flagship Course on Health Sector Reform and Sustainable Financing for the LAC Region. The Flagship operates in Santiago, Chile, where it will teach a total of five courses: one course in the year 2000 (June), and two courses in each of the following two years. Each course lasts 10 days and is expected to accommodate about 50-60 participants.

The Health Reform Initiative collaboration contemplates the following: a) Make existing training materials developed within the Initiative available for use at the Flagship; b) Provide funding or human resources to adapt existing teaching materials, or to write new materials; c) Provide funding or human resources to teach at the course; d) Promote the course by distributing brochures, explaining course aims and contents, etc.; e) Provide grants to pay for participants from Initiative "target countries.[1]"

The Initiative has made considerable progress since it was first launched in 1997. The first year laid a firm foundation for collaboration among the Partners. In the second year, solid groundwork was laid in the development of strategic activities for capacity building, including the developing and testing of tools and methodologies to aid the analysis, design, implementation and monitoring of health reform in the countries. As the Initiative ends its third year, a natural next step is to focus on disseminating some of the instruments that have been pilot tested, and to develop national capabilities to use them. For LAC HSR to become a partner of the Flagship Course on Health Sector Reform and Sustainable Financing is a logical and effective way of achieving both goals. ◆

[1] Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

Contributed by PAHO: Pedro Crocco

Study Tours to Canada

One of the activities of the USAID/PAHO Health Sector Reform Initiative in LAC is to conduct study tours. High level decision makers from the health sector Initiative countries are invited to participate in a one-week tour to a selected country. The main purpose of these study tours is to gain knowledge and experience on specific topics related to health reform which may be applicable to reform processes in their own countries.

In September, 1999, 11 delegates from the Dominican Republic, Ecuador, Jamaica, Nicaragua and Paraguay were invited to Canada to study National Health Insurance and the Structure and Function of the Canadian Health Care System. The first study tour to Canada was so well received that it was repeated in May, 2000. In the second Canadian study tour, 12 delegates from Bolivia, Honduras, Mexico and Peru were invited to participate.

The Canadian Society for International Health worked closely with PAHO, putting together a one-week program in Ottawa, Ontario and Victoria, British Columbia.

The program was designed to address several key themes such as Insurance, Health Policy-Reform Measures, Separation of Functions, Regionalization and Decentralization. Other important topics covered included Health Promotion, Population and Health, Hospital Governance and Management, Issues of Funding and Medical Staff Organization. In addition to an overview of the Canadian Heath Care System, there were also detailed presentations on Advocacy for the Canadian Health System and Public Health Associations, Nursing, Healthcare Policy within the Provincial Healthcare Structure, Medical Services Plan of British Columbia, Acute and Continuing Care Programs and Pharmacare.

Photo: Canada Study Tour (Sept.'99). From left to right: Cesar Herminda, Viceminister of Health of Ecuador; Roberto Dullak, Director of Planning and Evaluation, Ministry of Health Paraguay; Felix Saborio, Medical Advisor to the Presidency of Nicaragua; Raj Sharda, Resident Program of PAHO; Steve Kenny, Executive Director, British Columbia Health Industry Development Office; Luis Enrique Plaza Velez, General Director of the Social Security Institute of Ecuador; Rosajilda Velez, General Technical Sub-secretary of the Presidency of the Dominican Republica; Fulgencio Severino, Member of the Reform Commission of the Dominican Republic; Janet MacGregor, Assistant Deputy Minister of Corporate Programs, Ministry of Health of British Columbia; Margaret Lewis, Director of Panning and Evaluation, Ministry of Health Jamaica, Rhonda Lecky, Ministry of Health Jamaica; Fernando Sacoto, Sub-secretary of Institutional Development, Ministry of Health Ecuador.

Foto: Canada Study Tour (May '00). Back row left to right: Rosa Godoy Arteaga, Honduras; Maria Sandoval, Planning Unit, Ministry of Health Honduras; Alberto Castro, Director of SEDES Potosí, Bolivia; Edwina Yen, Consultant PAHO; Diego González, President, Coordination Unit for Modernization, Ministry of Health Peru; Ocatavio Barreiro, Medical Advisor, Social Security Institute of Mexico; Peter Czerny, CSIH. Middle row left to right: Carlos Godoy Arteaga, Advisor to the Minister of Health of Honduras; Jaime Telleria, National Director of health care, Ministry of Health Bolivia; Maria Elena Zabala, Consultant, Ministry of Health Bolivia; Manuel Lorenzo Hurtado, Manager of External Programs in Health, Social Security Institute of Peru; Manuel Gamero, General Director of Hospitals, Ministry of Health Honduras; José Manuel Matheu, Sub-secretary of Health, Policy and Institutional Development, Ministry of Health Hondruas. Front row left to right: Roman Rosales, Hospital Division, Social Security Institute of Mexico; Roberto Bohrt, Director of the Maternal and Child Hospital of the Social Security Institute of Bolivia;Serge Lafond, Chief of Health Systems and Policy, Division of Health Insurance, Health Canada; Nick Previsich, Senior Science Advisor, International Health Directorate, Health Canada; Patricia Schroeder, Consultant PAHO; Maria Victoria Palacio, Translator, CSIH.

Experiences such as these are beneficial in providing officials who are at the decision making level in the area of health reform with ideas, information and knowledge that will place them in a better position to direct reform processes in their country. The study tours also promote exchanges and networking amongst professionals from different countries faced with many similar issues with regard to health reforms, thus enabling them to establish contacts for technical cooperation in specific areas. ◆

Contributed by PAHO: Patricia Schroeder

Dissemination of Printed Publications in LAC Countries

An important group of activities of the USAID/PAHO Health Sector Reform Initiative in LAC has to do with disseminating Initiative publications throughout the countries of the Region of the Americas. In the last issue of the Newsletter, we analyzed access to electronic dissemination. For the current issue, we conducted a review of selected major activities whereby printed copies of Initiative materials were disseminated, to get a sense of the scope and pattern of distribution. Products distributed included technical documents, public information materials and the newsletter.

Figure 1 shows the major channels of distribution used. Nearly two-thirds of the publications were distributed during forums, workshops and meetings. About one-third of the publications reached professionals engaged in health sector reform work by mail.

Figure 1: Major Channels of Distribution

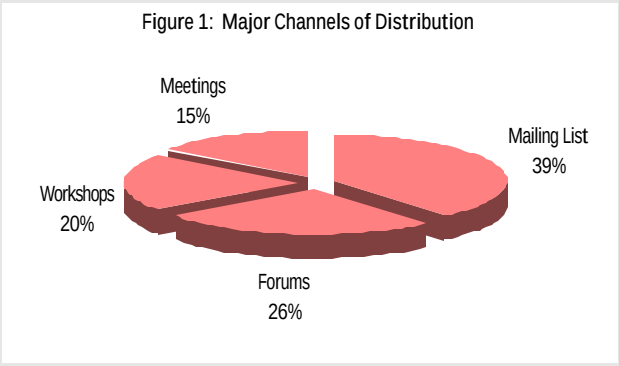


Figure 2 gives a breakdown of the institutional affiliations of the recipients of print products. It shows an even distribution between government agencies and international development and aid organizations at 42% each. 6% were affiliated with academic institutions, and 4% with non-governmental organizations (NGOs). Health professional associations and service provider institutions counted for 3%. A miscellaneous category that included private firms and individual consultants made up the rest.

Figure 2: Institutional Affiliations

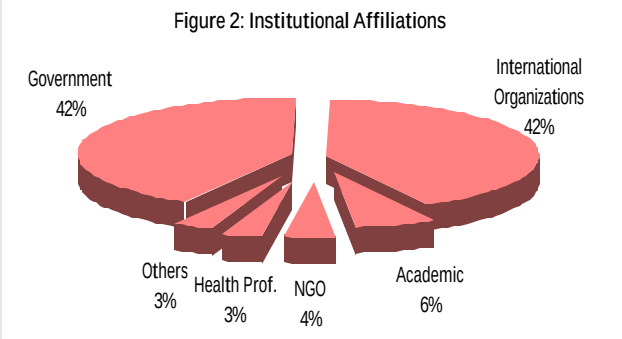
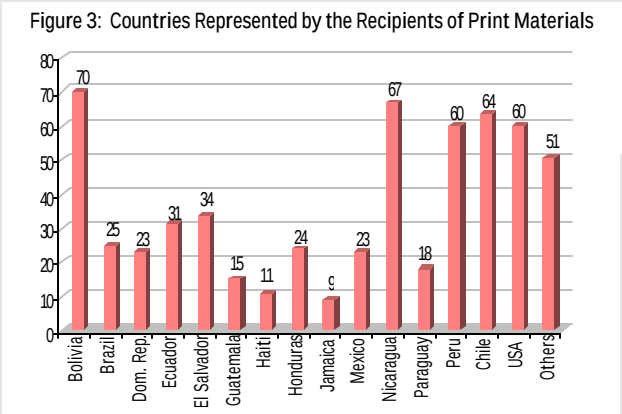


Figure 3 illustrates the countries represented by the recipients of print materials. All Initiative "target countries" were identified individually. For "non-target countries," only those with a significant number of recipients were identified; the rest were included in the "Others" category.

Figure 3: Countries Represented by the Recipients of Print Materials



The results of the review point to several interesting observations:

- *All 13 "target countries" were represented, reflecting the regional nature of the Initiative.*
- *Dissemination efforts reached all major institutional types expected to be involved in national health sector reform activities.*
- *Wider audiences were reached in countries that hosted the events, demonstrating a bias that could be used as a planning strategy, i.e., hosting events in countries where a greater promotion of Initiative activities is desired.*
- *Large numbers of US-based participants received printed materials, consistent with USAID's active role in support of the Initiative.*

Although the observations were based on data from the supply side of print product dissemination, they suggest that the traditional method of publishing in print still serves a purpose in an age where electronic communication is becoming increasingly popular. Further studies may help to elaborate on demand factors and circulation potential.◆

Contributed by PAHO: Edwina Yen

ECUADOR

Ecuador is one of the LAC Initiative countries. Results of Initiative activities can be grouped into the following areas:

- *Use of data in health reform policy making.*
- *Health sector collaboration on reform issues.*
- *Use of regional experiences to develop and implement health reforms.*

Increased use of data in health reform policy making. Ecuador had demonstrated increased use of data for health reform policy and decision making with the National Health Accounts (NHA) tool disseminated through the LAC/NHA Network. With LAC Initiative support, Ecuador completed an estimation of NHA based on 1995 data, and then began work on a 1997-based estimate using resources from USAID/Quito and the Ministry of Health (MOH). Data was used by the government to inform health sector discussions on the geographic equity of health expenditures, the need for emphasis on preventative versus curative care, and the high level of household expenditure on drugs. The 1995 data was particularly important in informing health laws adopted during a revision of the National Constitution in 1998.

Increased health sector collaboration. The LAC Initiative helped to increase collaboration among the health sector actors in Ecuador. Specifically, conducting NHA encouraged cooperation among the public, private and non-profit actors in the sector by requiring collaboration in the provision and use of NHA information. Sector cooperation was also reinforced through the participation of four Ecuadorian nationals (two from the MOH and two NGO representatives) in a LAC Initiative-sponsored workshop on NGO involvement in health policy.

Increased use of regional experiences to develop and implement health reforms. Ecuador also benefited from lessons learned from regional counterparts through LAC Initiative-sponsored regional exchanges. For example, the LAC Initiative hospital reform study tour to Colombia reinforced, in a timely manner, the hospital modernization efforts that were underway in Ecuador. Following the study tour, many of the lessons learned were applied by the MOH officials who had participated. Specifically, assessment and strategic planning tools presented by the Colombians were used to better guide the Ecuadorian hospitals that were undergoing reforms at the time. The national hospital modernization plan that was being implemented at the time was also adjusted based on the lessons learned in Colombia.

The LAC Initiative activities also created three regional networks, all of which included the participation of Ecuadorian nationals. One was through regional NHA seminars, one was through a listserve on hospital reform, and one was through informal connections among NGOs in the Region. These regional networks led to intra-regional consultations via e-mail and directly through visits, which helped the Ecuadorians further their knowledge of other experiences in the Region.◆

Contributed by PHR: Kammi Schmeer

HONDURAS

Honduras is another of the LAC Initiative countries. Results of Initiative activities can be grouped into the following areas:

- *Use of data in health reform policy making.*
- *Capacity for monitoring and evaluating health reform.*
- *Use of regional experiences to develop and implement health reforms.*

Increased use of data in health reform policy making. Honduras has increased its use of data for health reform policy and decision making using the National Health Accounts (NHA) tool disseminated by the LAC/NHA network. The LAC Initiative included Honduras in the regional NHA network and invited representatives from the country to the fourth regional seminar. Both the seminar and the connection with global and regional NHA experts have been particularly useful for the NHA team in improving their ability to promote the importance of NHA to national-level policymakers and gain their support. Lessons learned helped the Hondurans to better organize their NHA team and to better define their NHA estimation to ensure policy relevance.

In addition, during the second year of the project, the development of the Framework for Detailed Implementation Plans of Health Sector Reform and Master Plans of Investment was finished and the tool was pilot tested in Honduras as well as in Nicaragua.

Increased capacity for monitoring and evaluating health reform. The LAC Initiative developed a monitoring framework based on five guiding principles: equity, effectiveness and quality, efficiency, financial sustainability, and community participation. Honduras prepared its report based on the framework and supported the use of the results in MOH policy making as well as the institutionalization of the monitoring and evaluation framework.

Increased use of regional experiences to develop and implement health reforms. The Honduran Ministry of Health participated in a LAC Initiative-sponsored regional exchange in Panama to learn about the San Miguelito Project on decentralization of health services and hospital autonomy. During the exchange, various topics were presented and discussed such as the conceptual framework of Panama's health sector reform, primary health care model, hospital autonomy model, finance model, health policy, community, family and environmental health care model and the WINSIG health information system among others. This regional exchange provided the Honduran delegates with a greater understanding of decentralization to help them plan for their own efforts to decentralize the health sector.

To further promote the process of decentralization in Honduras, PHR and the Honduran Ministry of Health invited Thomas Bossert from the Harvard School of Public Health to participate in a national seminar on decentralization. The approach and preliminary findings from the DDM decentralization applied research, which was funded by the LAC Initiative, was presented at this seminar. The seminar generated interest in conducting a study to assess the current level of health sector decentralization, which would set the stage for developing additional proposals for expanding decentralization in Honduras.◆

Contributed by PHR: Jennifer Graff

Resource Guide

CHECK OUT THESE ITEMS IN THE CLEARINGHOUSE!

A user survey to tell us what you think about our Web site and links to other sites containing information about health sector reform in Latin America and the Caribbean

LAC HSR AND CLEARINGHOUSE USER SURVEY

LAC HSR — Welcome to the Home Page of the Latin America and Caribbean Regional Health Sector Reform Initiative

http://www.americas.health-sector-reform.org

The LAC HSR User Survey: Help us orient our services to your interests by telling us about your organization and field of work.

The survey is designed to be brief and simple to complete so that it should take no more than a few minutes of your time. By telling us something about where you are from, the nature of your work and the type of organization you are affiliated with, you can help us make our Web site more interesting and useful.

You can access the survey (see sample below) through multiple entry points on the Initiative web site located at: http://www.americas.health-sector-reform.org. You can enter by clicking on the survey logo on the main page and also via navigational links strategically placed at the bottom of the other pages. ◆

In order to help us make a Health Sector Reform Website that reflects your interests, let us know a little about you and what comments and suggestions you might have on this site's usefulness.

Please fill out the form below and click the "**Submit Info**" button when finished.

Do you find this site useful? click to select / yes

In what country do you live? click to select / Afghanistan / Albania

What is the name of the institution you work for?

Has your institution received informational materials through the LAC HSR Initiative? click to select / yes / no

In what Sector do you work? click to select / Government / Public

Comments and suggestions about the usefulness of this site

Submit Info | Clear Form

ELECTRONIC RESOURCE CENTER

The Manager's ELECTRONIC RESOURCE CENTER

http://erc.msh.org

The Management Sciences for Health's Electronic Resource Center (ERC): Find the information you need to be an effective manager on the ERC.

Now health professionals can find practical answers to management questions, along with easy-to-use tools, information on good management practices, and reviews about the latest management trends in the ERC. The ERC includes information and resources on health sector reform and the issues associated with reform. Many of these resources are available in French and Spanish.

Another valuable resource on the ERC is the "Health Manager's Toolkit." The Toolkit offers management tools designed and tested by experienced agencies around the world to help managers of health programs in critical areas, such as *Managing Policy and Reform* and *Managing for Sustainability.*

Other features of the ERC are:

- Electronic forums and discussion groups on many different topics.
- An ERC Calendar to help you stay informed about professional development opportunities, conferences, training courses, etc. You can also search for events on a particular topic, or add events for others to find on the ERC Calendar.
- A database in which you may find colleagues who share your concerns and interests. When you search the ERC, add yourself to the Network!

The ERC is located at http://erc.msh.org and can also be accessed via the Initiative's home page at http://www.americas.health-sector-reform.org. ◆

Informando & Reformando

http://www.insp.mx/ichsri/Newslett.html

"Informando & Reformando" is published by the Inter-American Clearinghouse of Health System Reform Initiatives (ICHSRI). It is a Spanish language newsletter that targets the Latin American and Caribbean region. It includes narratives on reform initiatives and general information on health system reforms in the developing world.

For example, its January/March 2000 issue included the following five sections:

- *"Panorama,"* featuring reform experiences from Colombia, Peru, Paraguay, Guatemala and Chile;
- *"Monitor de la Salud,"* with a focus on medium-high economy countries;
- *"Páginas de le Reforma,"* which contains information on recent publications;
- *"Noticias,"* with reports on new reform initiatives and other news items; and
- *"Cita con la Reforma,"* listing specific reform related events. ◆

JLB Network

http://www.funsalud.org.mx/red-jlb

The "Jose Luis Bobadilla" Inter-American Network for Health Policy (the "JLB Network") was established by the Inter-American Development Bank (IDB), with the Mexican Health Foundation (FUNSALUD) as executing agency, to support the development of health system reforms in the Region.

The program of activities of the JLB Network, as indicated on its web site, includes the following components: Policy Toolbox, Inter-American Leadership Forum on Health, Inter-American Clearinghouse of Health System Reform Initiatives, ICHSRI information base, Scholarship Program, and the "José Luis Bobadilla" Fund for the Promotion of Public Health Policy. ◆

Latin American Newsletters

http://www.latinnews.com

This web site provides information about a conference held in 1999 on *"Reforming Latin American Healthcare Systems: Learning from the Successes and Failures of Others."*

The conference presented experiences of healthcare reform from different parts of the world, which can serve as guidelines for countries that are undergoing health sector reform. Speakers included experts from international organizations such as the Inter-American Development Bank (IDB), the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID), and the World Health Organization (WHO). ◆

The Economic Intelligence Unit

http://www.eiu.com

Developments in health reforms in Latin America were analyzed in the 3rd quarter 1999 issue of "Healthcare Latin America," a publication from The Economist Intelligence Unit (EIU) that analyzes trends and issues in Latin America's healthcare systems.

Topics discussed included the importance of the private sector, the steering role of the ministries of health, and the need for better accountability. The role of the Pan American Health Organization and the mission of the LAC HSR Initiative launched by USAID and PAHO were also explained. ◆

continued from front page

The need for action is supported by findings of persisting inequities in health situations published in *Health in the Americas (PAHO, 1998).* A number of basic health and development indicators were examined, including life expectancy, infant mortality, total fertility, health expenditure, access to safe water and sanitation. Despite a general trend towards better living conditions, the data showed inequalities that were consistent with regional economic differences based on per capita GNP in the countries of the Americas over a 25 year period.

The beginning of a new millennium is certainly an opportune time to re-energize efforts towards reducing equity gaps in health.◆

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